Minus 9 Proactive Care

NHS Hertfordshire Community NHS Trust

10 Year Plan in Action

- Hospital to community
- Analogue to digital
- Sickness to prevention

Dr Elizabeth Kendrick,
Chief medical officer

Outstanding services ealthier communities

The future of an ageing population

Hertfordshire Community NHS Trust

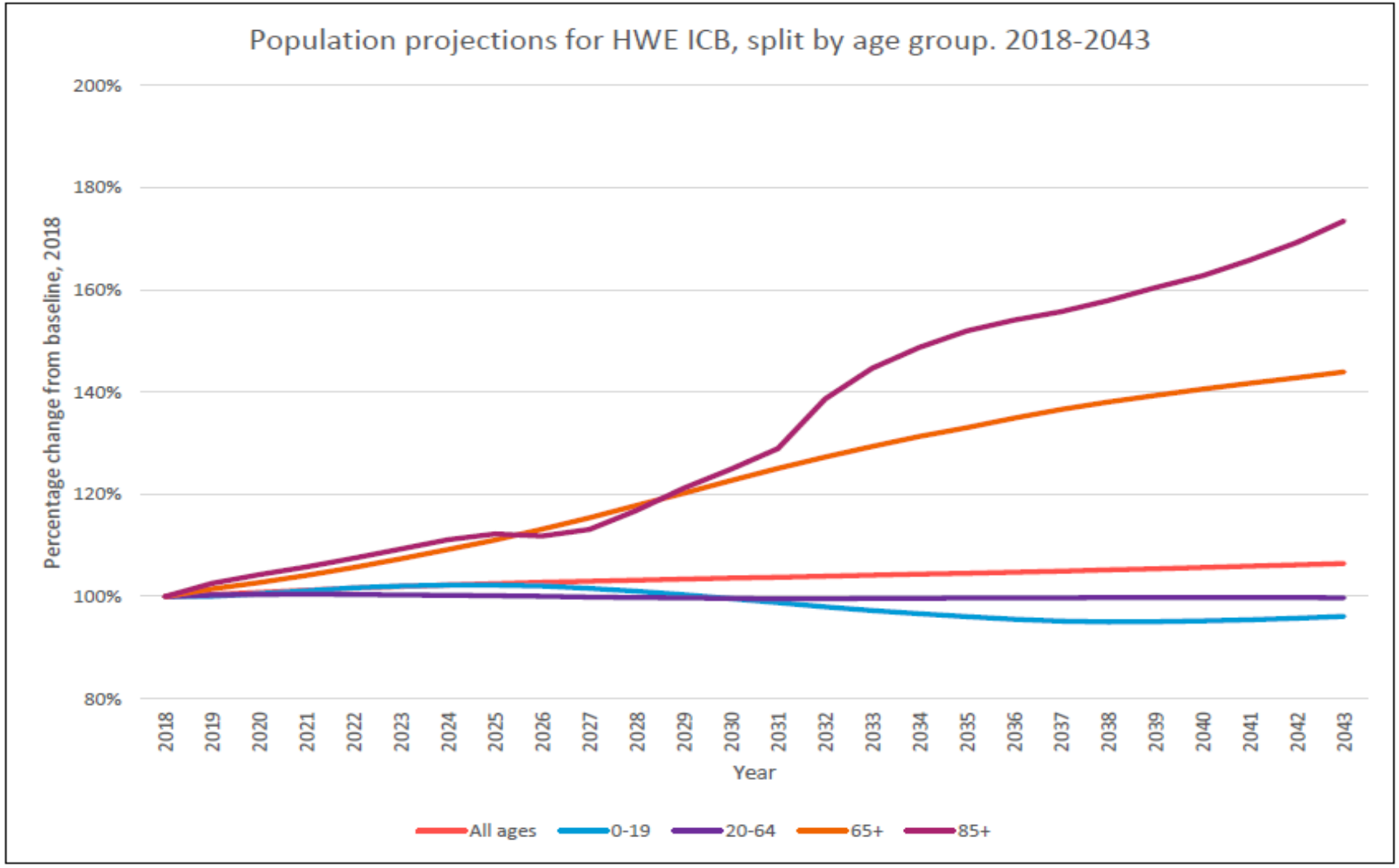
The population of the HWE ICB is expected to increase by 6% overall between 2018 and 2043.

There will be significant differences in growth across age bands.

Whilst there will be limited growth (or reductions) in children and working age adults, there will be significant growth in over 65-year olds and very significant growth in 85-year olds

There is a sharp incline in the number of people aged over 85 years after 2030 as ‘baby boomers’ age.

UEC population needs analysis expansion of over 85 population (inc. when this will double)



Our Hospital at Home service operates at the heart of the community, meaning we are able to prevent hundreds of hospital admissions every month, and support patients to come out of hospital more quickly

Since it started in 2022, our Hospital at Home Service has cared for c. **23,500 patients**

We have proactively designed our Hospital at Home Service to maximise the range of patients we can care for at home

Our service is primarily focussed on **admission avoidance** as we know that is where we are able to provide the greatest benefits for patients and the system

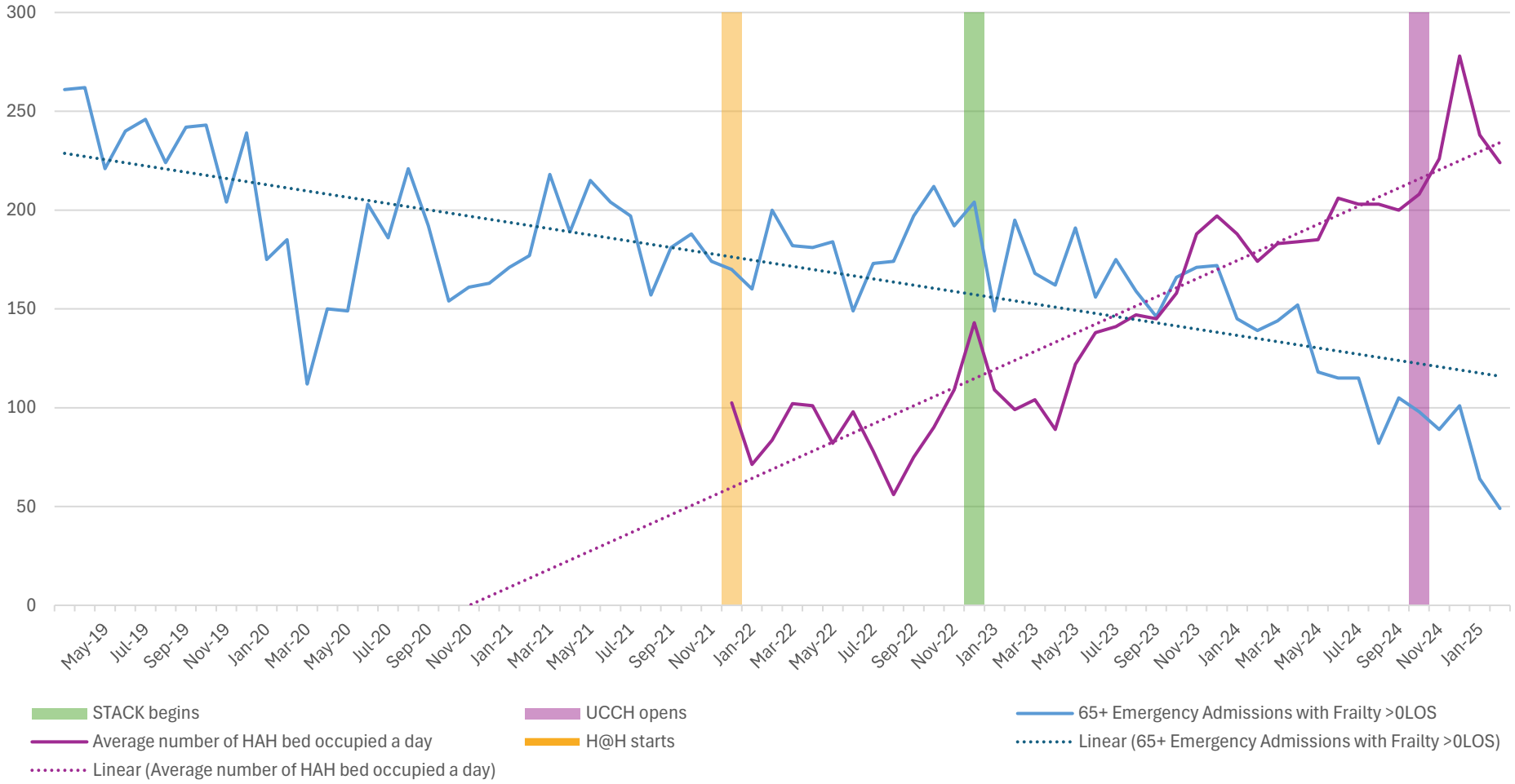
We use **state-of-the-art tech**, delivered straight to a patient's door

We run a **'generalist' service**, run by doctors, nurses, paramedics, pharmacists and therapists - meaning we can care for a wide variety of patients

As a **community led service**, we accept any patient that can be safely cared for in the community, and link with the other specialist services we provide

Successfully shifting from hospital to community

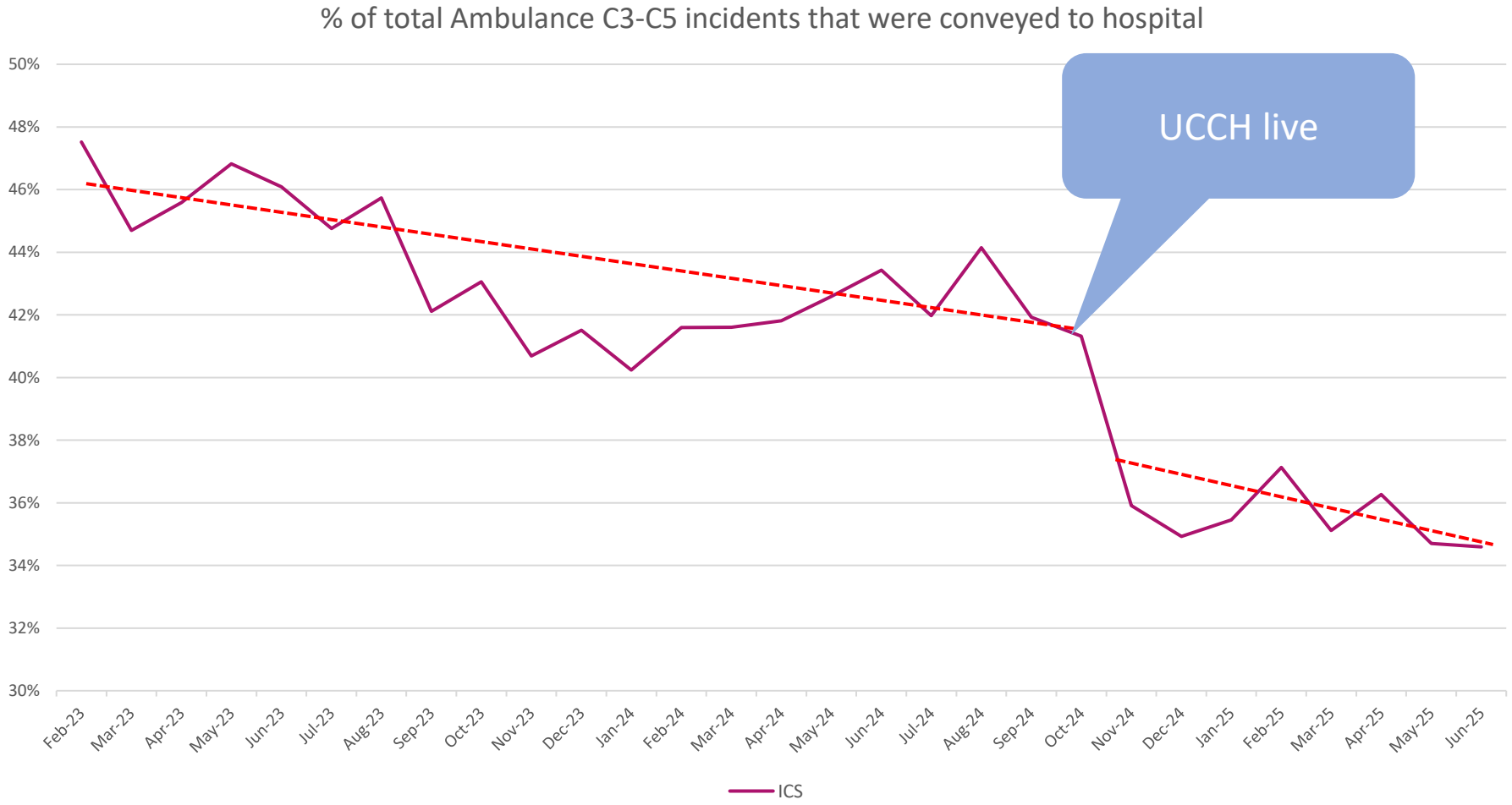
We have seen a direct impact on our Hospital at Home success, and new targeted initiatives, on the number of frailty admissions into Lister Hospital



Maintaining the rates of admissions since both Stack and UCCH have opened, compared with the same time in 2022 – this equates to **1,500 fewer frailty patients being admitted to hospital per year** – having their needs fully met in their own home

Successfully shifting from hospital to community

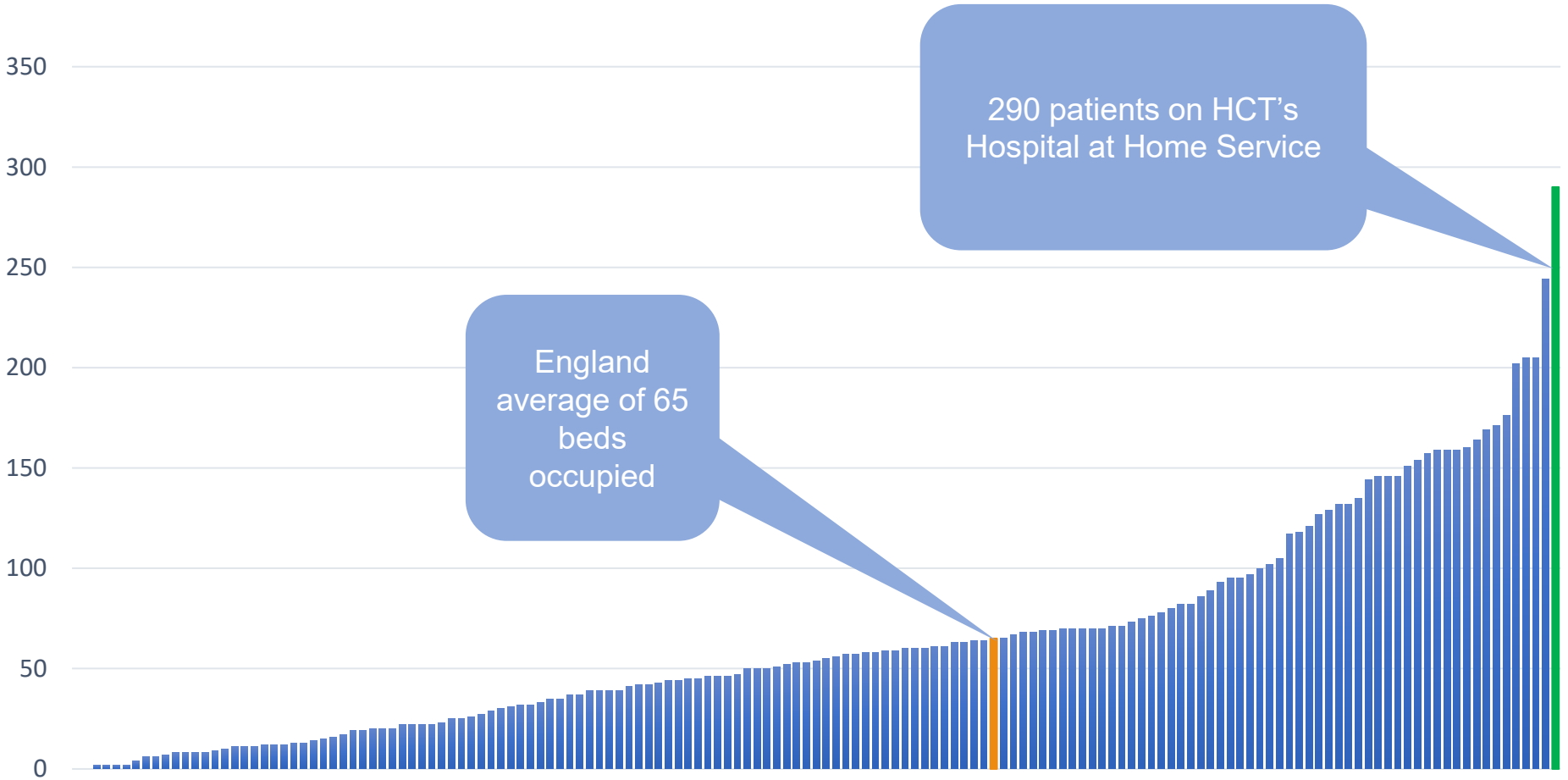
Our ‘prevention of admission’ approach includes working with East of England Ambulance Service, where we have materially reduced the number of ambulance conveyances and hospital admissions



- We are working with EEAST to directly respond to category 3-5 999 calls
- This has been enhanced since we launched our ‘Unscheduled Care Coordination Hub’ on behalf of the whole ICS – working directly with ambulance crews on the ground, and with paramedics working in our Hub

Our H@H service improves resilience and patient safety during winter

During the peak of winter pressures in January 2025, we had 290 patients on our virtual ward, equating to over half of in-patient capacity of the Lister Hospital – with more funding we can do more



Added system benefits from Hospital at Home:

- Hospital at Home patients **do not typically see an increased social care need** following their care
- A thriving Hospital at Home service **reduces the need for escalation beds**, **reduces corridor care** and **supports elective recovery**

Our service is supported by a wide range of robust data, which we use to ensure we are efficient, effective and meeting the needs of the population

806 total patients cared for in June 2025

1,200 referrals - 26% of total - direct from **999/A&E** Jan-June (up to 35% in some months)

76% of patients are **over 75**, with **27% over 90 years old**

Cost per bed day is £85 (compared with £450 for equivalent in hospital)

80% of referrals are **prevention of admission** (step up)

Consistent high levels (90%+) of **positive patient feedback**

84% of patients received **face to face** care

Average **length of stay is 7 days**

c. 50% of patients on H@H are being treated for heart failure, frailty or respiratory conditions

We accept referrals from a wide range of sources including:

- 999
- Patient self-referral
- Careline
- Care Homes
- Social care
- Community Services
- 111
- A&E
- Primary Care
- Hospice
- Nursing Home
- Acute in-hours visiting

We have cared for patients with:

- Heart Failure
- Respiratory
- Bowel conditions
- Renal problems
- Post operative care
- Wound care
- Delerium
- End of life care
- Musculoskeletal problems
- Frailty
- Cellulitis
- UTIs
- Diabetes
- Neurological problems
- Dehydration
- Cancer
- Catheter Care
- Endocrine disorder

Hospital at Home patient testimonials

Hospital at Home service

"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."

"All the staff were absolutely brilliant. I couldn't believe I had such good service. All of them were marvellous."

"Kept my husband out of hospital... his greatest dread. Prompt and efficient, delivering exactly what was needed. Professional but empathetic."

"Everyone is very kind – I feel so lucky"

"I have never experienced anything like this. Everyone that worked there, including the nurses to collecting the equipment, were lovely. It was nice being at home than in hospital."

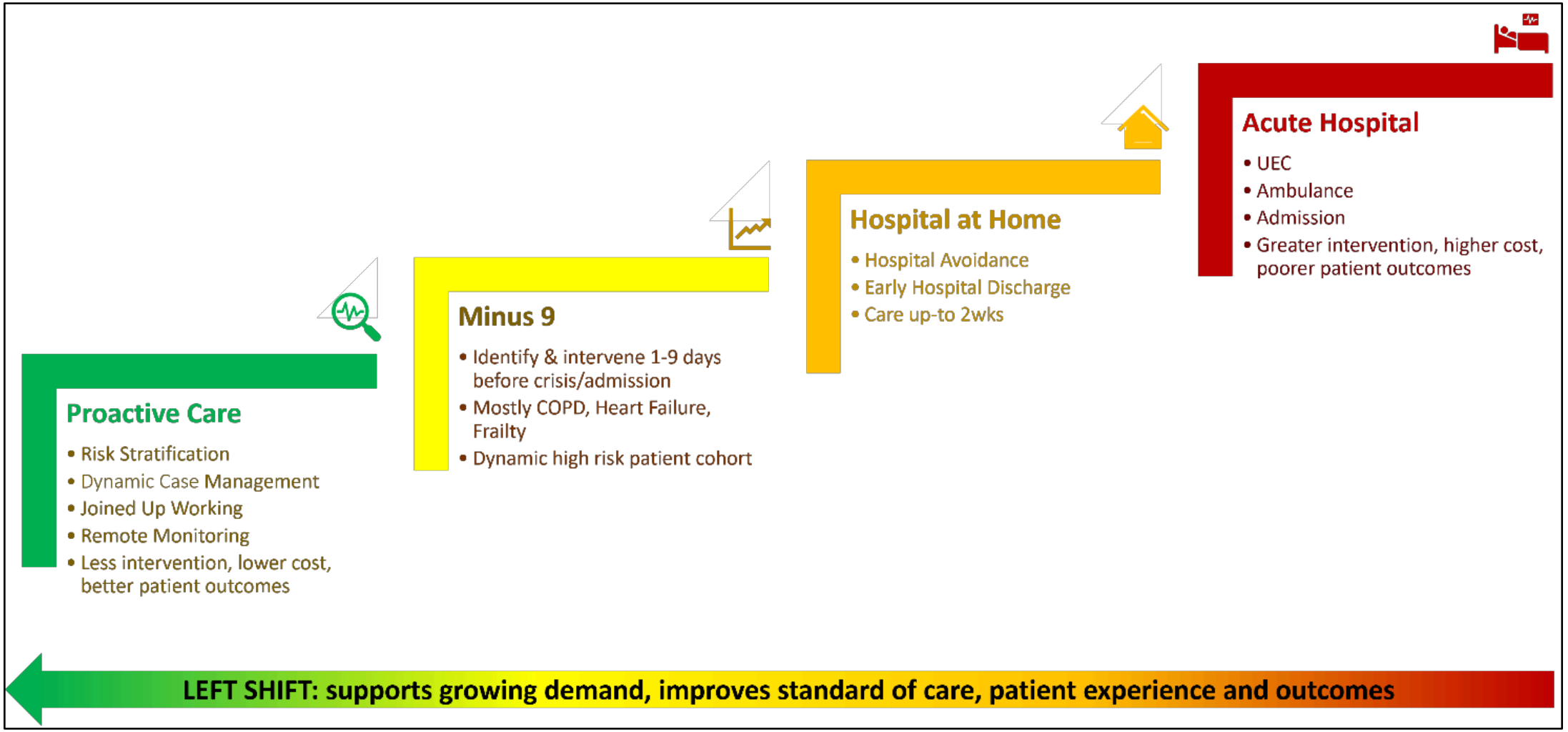
"Absolutely marvellous. Kept me informed and everyone I spoke to was great. So happy with it."

"Staff were really on the ball – first class."

"As someone who was sent home from the GP with bad news, it was resolved in a very quick space of time and that gave me amazing peace of mind.
If I'd have been sent to A&E I'd have been sat there for hours. This approach took the stress out of everything and saved everyone a lot of time.
You want to know you are in the right hands - I felt very well looked after."

"The approach was wonderful, they were so polite and caring. They made sure we understood, especially as we are older folk.
I shall miss them all"

Hospital at Home is a core part of how we are successfully shifting from hospital care to community care, and shifting from sickness to prevention



Mission statement

To provide a system wide proactive healthcare model that will enable early detection, prevent deteriorating health and provide a robust home healthcare program that utilises remote monitoring and data for people with long-term / complex conditions - allowing for better health outcomes and improved quality of life for the patient.

Clinical Evidence Based Interventions for Proactive Care

To be undertaken by INTs

Evidence-based interventions

Benefits to all patients on Proactive Care will include:

- **Advance Care Planning**
- **Holistic assessment**
- **RESPECT Documentation**
- **Osteoporosis assessment**
- **Reduction in Anticholinergic Burden / Medication Review**
- **Falls risk**
- **Proactive remote monitoring to spot early deterioration**
- **Encouragement of vaccination status**

Remote Monitoring process

The cohort

Step up: high-risk patients using PHM Risk Stratification.

Step down: PHM Risk Stratification alongside Hospital and @ Home, Community Hospital patients

Introduction

Send an introductory letter from the practice to explain the project and invite participation.

Onboarding

Patient is contacted by phone to explain the service.

Equipment

Provide patients with a mobile phone or tablet, thermometer, pulse oximeter, blood pressure monitor, weighing scales and Activity tracker.

Monitoring

The Remote Monitoring Nursing team reviews patients' responses and takes appropriate action as needed.

Discharge

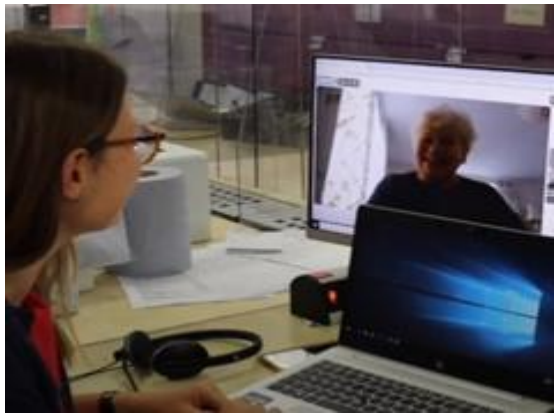
After 6-12 weeks of Remote Monitoring Case Management. patients have a final review before being discharged but flagged as a “ESD Proactive patient”.

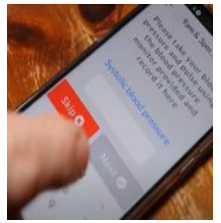
Urgent Care Response

Patients can access our 8am – 8pm Care Coordination Centre if they experience early warning signs of deterioration so we can provide a timely, appropriate response. .

What’s involved?

1. Patients answer weekly questions via their smart device, covering clinical, mental health, social wellbeing, and health promotion domains.
2. Questions trigger RAG-rated notifications to advise if intervention is required.
3. Alerts are managed by the Remote Monitoring Nursing team
4. The Remote Monitoring Nursing team may escalate referrals to appropriate services or alert emergency services as needed.
5. All resident data is entered into an automatically created entry in the patients' records.





Any questions?