Reducing the Need for Acute Care:
The Third Sector in Leeds

A report prepared by Forum Central | July 2017

Forum Central

A collective voice for the health and care third sector

Leeds Older People's Forum | tenfold The Learning Disability Forum for Leeds | PSI Physical and Sensory Impairment Network | volition The voice of Leeds mental health voluntary sector

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Introduction

Since 2012, health and social care in Britain has seen some radical transformation. Legal changes alongside shrinking budgets and rising demand, has expanded the role for third sector organisations (TSOs) in the design and provision of services. TSOs have a long history of working with communities to improve health and wellbeing, particularly among the most vulnerable.

This report has been commissioned by Forum Central to take a focussed look at the ways in which TSOs help to directly reduce the need for acute care.

The research used to compile this report was carried out between February and June 2017 by Lucy Jessop, a Master's student from the University of Sheffield, and was funded by Care Connect through the Postgraduate Advantage Scheme.

The focus of the research began in Leeds, and entailed a local scope of service provision and the identification of five in-depth case-studies, each of which demonstrate in different ways how Leeds TSOs are having an impact on the need for acute care. In addition, a broader literature review was undertaken to explore whether any learning could take place from TSOs nationally and internationally who might be delivering similar services.

The research is by no means exhaustive. However, what it points towards is that Leeds, as a city, is leading the way in demonstrating a clear commitment to the third sector as a valued partner in tackling some of its greatest health and care challenges. The examples featured in this report make it clear that TSOs have the expertise to deliver high-quality, cost-effective service provision. What's more, these services typically have a disproportionate impact on the people with greatest need in the areas of greatest deprivation, something that sits hand-in-hand with Leeds's vision to improve the poorest people's health fastest.

This report hopes to be of use to TSOs, commissioners and health and care stakeholders alike, and provides the beginnings of an evidence base of third sector acute care reduction services. It can

be read as a whole, or can be used more flexibly as a source of information to support projects or find exemplar services in Leeds.

About Forum Central

Forum Central is a network of health and care third sector organisations, established in April 2016. It is a partnership bringing together the members of Leeds Older People's Forum (LOPF), PSI-Volition (Physical and Sensory Impairment and Mental Health) and Tenfold (Learning Disability Forum). Our combined membership stands at almost 300 organisations – large and small.

We work with the Third Sector to influence strategic developments across health and social care. Members are supported through sharing good practice, networking and partnership opportunities, and are kept informed about what is happening across mental health, older people, learning disabilities and physical and sensory impairment and wider health and care services.

Local Scope of Provision:

Prevention is Better than Cure

In February 2017, a call for evidence was sent out to Forum Central's network of almost 300 Leeds-based TSOs. The call requested information about services that might be considered as reducing the need for acute care. The response was positive, with a variety of organisations indicating interest, offering support and providing high-quality evidence of the impact they make. In total, there were some 20 responses.

It was found that the vast majority of submissions focussed on broader and longer-term preventative services:

The **Live at Home** schemes in Leeds, delivered by **MHA** (Methodist Homes Association), for example, support and enable older people to retain their independence and live in their own homes for longer. With socially prescribed health referrals forming the second highest route into Live at Home schemes between 2015-2016, MHA actively contributes to delaying and minimising the need for acute care services by providing targeted assistance to meet older people's needs.

This can range from providing home visits and befriending services which help to build support networks, to signposting and referrals for additional support which improve an individual's standard of living, as well as their health and wellbeing. Interventions can be as small as changing lightbulbs, and thus reducing the risk of falls, or can be more intensive with support workers attending – and advocating at – doctors' appointments.

Burmantofts' Senior Action, as part of the Neighbourhood Network Schemes, deliver a similar service, and **Carers Leeds** also ran a Health and Wellbeing Programme in North and South & East Leeds, but this came to an end in May 2017.

The Conservation Volunteers, deliver 'Green Gyms' across the city, equally recognise the role that preventative services play in steering its service users away from crisis. The assistance they

provide can range from emotional support in the form of listening and guidance, to helping service users access additional aid, through referrals to housing services, food banks and mental health respite.

Otley Action for Older People (OAOP) 'Healthy Together' programme, operating in Otley, Pool and Arthington, seeks to reduce primary and secondary care visits and admissions by improving self-management of long-term health conditions and access to preventative healthcare services through the provision of community transport and alternative modes of healthcare delivery. For example, last year, OAOP was able to support 40 service users to receive their flu vaccine by inviting nurses from The Chevin medical practice to attend their Thursday Lunch Club and by setting up a Saturday surgery.

Different Strokes, a UK stroke charity operating in North and Central Leeds, empowers younger stroke survivors to optimise their recovery and regain independence through active support and weekly exercise classes. Importantly, these classes extend the care provided by physiotherapists, tailoring exercise programmes to individuals' needs with the aim of improving function and quality of life.

The Patient Empowerment Project (PEP), delivered by **Barca Leeds** launched in October 2014 in West Leeds, and aims to improve the wider health and wellbeing of patients with long-term health conditions by providing a referral route between GP practices and local TSO activities, groups and services. Evaluation of the project indicates that all participants increased their confidence in managing their conditions and judging whether it was appropriate to visit a GP.

By addressing the wider social determinants of health, these TSOs, and the services and support they provide, all clearly play an important, longer-term preventative role that indirectly reduces the need for acute care. The following case-studies have been collated to explore and highlight the ways in which Leeds-based TSOs are delivering innovative services that have a direct impact on the requirement for emergency care.

Case Study 1: St Gemma's Hospice

Nurse-Led End-of-Life Care

St Gemma's Hospice, a Leeds-based charity and the largest hospice in Yorkshire, provides specialist, free-of-charge palliative care. The hospice offers care and support through its community team, its day services – which includes a Day Hospice and Out-Patient Department – and a 32 bed In-Patient Unit; which is part-funded through a grant from the Leeds CCGs (Clinical Commissioning Groups), with the rest of the running costs (some 70%) coming from the local community.

In 2015, St Gemma's launched a pilot project, which sought to extend their in-patient services to people with generalist palliative care needs. Typically, such people do not meet the eligibility criteria for admission to the specialist care provided by the in-patient unit, and as such, would have to spend their final days in hospital, despite expressing a desire to die in a hospice. The aim was thus to increase the hospice's capacity to accept patients without complex medical needs by developing a Nurse-Led End-of-Life service. This entailed transferring responsibility for four of the 32 in-patient beds from medical consultants to a nurse consultant, with experienced hospice nurses admitting, assessing and prescribing medication for dying patients.

This novel project has been a remarkable success and has **increased access to hospice-based, end-of-life care services for previously excluded groups**. For instance, the mean age of patients admitted to nurse-led care was 88, compared to a mean age of 71 for specialist care. What this indicates is that, during the pilot, an older group of patients was able to access hospice care. This is also the case for patients with diagnoses other than cancer, as a much more equal share of nurse-led beds went to those without cancer than generally occurs for consultant-led beds.

The pilot has also had an immediate and **measurable impact on the need for acute care**. Of the 50 patients admitted to the

nurse-led end-of-care beds between September 2015 and July 2016, 74% were referred from Leeds Teaching Hospitals NHS Trust or other acute hospitals. By calculating the time from admission to the hospice and eventual death, it has been identified that transferring care to St Gemma's **saved 132 hospital bed days and reduced the number of in-hospital deaths**, thus increasing capacity within acute settings. The cost saving related to this is not yet available, however St Gemma's are presently engaged in a project with NHS England and Hospice UK which will result in accurate analysis of the financial benefits of nurse-led care.

Throughout the project, St Gemma's has maintained its **high quality of care**. Indeed, in a feedback questionnaire completed by the newly bereaved families, 100% of respondents suggested that they were very satisfied by the level of personal care received by their loved one, the levels of care co-ordination, and the compassion, respect and dignity shown by staff.

> *"Nothing was too much trouble for the staff. …You felt as if you were the only person that mattered whilst they were dealing with you"*
>
> *"I'm still as ill as I was in hospital but I feel safer here"*
>
> *"All of them, from the cleaners up to whoever runs the place, are all in one mind: the quality of life that the patients have left should be the best quality that they can give them"*

Delivering nurse-led care within the pre-existing 32 bed In-Patient Unit has been calculated as costing the hospice £110,960 less per year than the standard specialist palliative care model. This might be surprising, as cost-reduction often leads us to think that something has to be sacrificed. However, Nurse-Led End-of-Life Care has been shown to widen access to hospice care, reduce use of acute care resources, maximise the use of hospice beds and minimise hospice waiting times, without jeopardising quality.

Case Study 2: Age UK Leeds

Hospital to Home

Founded in 1975, **Age UK Leeds** is a charity operating across the Leeds area with the aim of improving the quality of later life, particularly for those who are vulnerable or in poverty. As well as providing free advice, campaigning, and running the Arch Café, Age UK Leeds has three strategic priorities for service delivery: digital inclusion, social care, and health and wellbeing.

It is within this remit that Age UK Leeds began delivering Hospital to Home, a service based at St James's University Hospital and commissioned by the three Leeds CCGs. Its main goal is to support patients aged 60 and above who attend Accident & Emergency to **avoid admission to a hospital base ward**. The service, which operates 7 days a week between the hours of 10am and 8pm, offers patients a holistic assessment of their needs, and provides immediate support to reintegrate them safely within their own homes. When patients are settled, they receive short-term assistance to gain their independence and **avoid readmission to hospital**. This can range from providing information about relevant community services, including those provided by the third sector, to making more active referrals for longer-term support.

In July 2016, Hospital to Home received a rigorous local evaluation by the Leeds Intelligence Hub, which detailed the cost savings of its admission avoidance service between July 2015 and March 2016. The outcomes are impressive. When compared to a matched cohort of patients who did not use the service, it was found that:

- **Hospital to Home had saved 2,345 hospital bed days over the period**. Providing service use remained consistent, this would account for 3,126 occupied bed days annually, or the equivalent of an additional 10 hospital beds. Hospital to Home has thus significantly **increased the capacity of acute care services**, with 89.4% of patients being

discharged from the hospital on the same day they were referred to the service.

- The net saving for the period, taking into account the cost of running the service, was £89,021, with an annual net saving of £118, 695. Put simply, this represents a **40% return on the money invested into Hospital to Home**.

The evaluation also demonstrated that Hospital to Home added value as a third sector service provider. Of the 971 people who interacted with the service during the evaluation period, 40% were signposted or referred to additional services, of which the vast majority were provided by the third sector. Directing need toward TSOs thus **reduces the demand on statutory services**.

Furthermore, qualitative evidence indicates that Hospital to Home is valued by staff at St James's University Hospital, who recognise **a vast improvement in patient flow and patient experience**, and service users alike; 97% of whom felt supported to return home safely. A further 79% of patients thought the support they received would help them to remain independent and out of hospital.

> *"This is the first time I have ever used your service and hope it's there if we ever need it again. Thanks so much for your support and kindness…"*

> *"We felt really supported and reassured and can't thank them enough for their kindness"*

Hospital to Home has continued to go from strength to strength with data from 2016/2017 reporting that the service supported 2,813 referrals, the equivalent of 7.7 patients per day, 50% more than the initial target of three patients per day.

Age UK Leeds is using its expertise in supporting people in later life and its position as a TSO to help Leeds residents aged 60+ access the most appropriate services, while successfully and cost-effectively reducing avoidable hospital admissions.

Case Study 3: Barca - Leeds

Urgent Care Outreach Support Service

An independent, multi-purpose charitable organisation, **Barca-Leeds** supports children, young people and adults to overcome a broad range of health and social issues, many of which stem from socio-economic deprivation.

In November 2015, Barca-Leeds launched its Urgent Care Outreach Support Service, with the goal of **supporting high-volume users of acute care**. Preliminary research for the pilot using the Secondary Users Service identified that 413 services users had presented at Leeds NHS services on more than 12 occasions between the period January 2014 and January 2015. In total, these 413 individuals attended Accident and Emergency (A&E) 8,775 times over the period, and used an ambulance on 5,431 of these occasions. It was thus calculated that, across the two services, these **high-volume users accounted for a total spend of approximately £2,123,165**.

Located in St James's University Hospital, the Urgent Care Outreach Support Service aims to work with this identified group of users to establish the underlying causes of their frequent attendances. **Recognising the significance of social determinants of health, the service undertakes a holistic, person-centred needs assessment using the Leeds City Council Wellbeing Wheel, and works in collaboration with service users to create individual support plans to achieve solutions that service users have identified as priorities**.

Support can range from assisting individuals with housing concerns, liaising with appropriate agencies to ensure long-term issues are resolved, to helping find relief for outstanding debt. The service has also recently enlisted the support of a volunteer peer mentor, who is able to provide advice as someone who has shared similar experiences.

In the first year of the pilot, the service received 41 referrals. For the 20[1] service users who had received support for long enough to make data analysis worthwhile, there were an average of 52 contacts with A&E per month for the 12 months before intervention. Following support from the Urgent Care Outreach Service, the average number of contacts reduced to 26.6 per month, which represents **a 49% reduction in contacts**. This could signify **an annual saving to the NHS of up to £26,471.84** for these 20 service users alone. Tentative findings from the **West Yorkshire Police Service and Yorkshire Ambulance Service also indicate a decrease in use of their services**, which could result in further significant cost-reductions.

Furthermore, results from **periodic reassessments of service users' Wellbeing Wheel scores are resolutely positive**. Across the six areas of intervention, users' scores have increased by a minimum of 30%, with the highest improvements being witnessed in social networks, meaningful use of time, and looking after themselves better.

> *"You're the only ones helping me. You've been brilliant; no-one else cares what happens to me"*

> *"I feel better able to express myself now; things are getting there slowly"*

> *"I will get more help from other agencies now; the more help I get, the better things look"*

[1] Data was in fact collected for 21 service users, however, one individual unfairly skews the results of the analysis and is not representative of the rest of the data gathered. On average, this service user attended A&E 10.7 times per month prior to intervention, and 15.5 times per month post intervention. Only two other users increased their attendance, and then only very marginally from 0.66 and 2.2 contacts per month before, to 1.13 and 3 per month respectively. All of the other 18 users decreased their use of acute care services. Including the anomalous high-frequency user significantly reduces the prospective impact of the service. The calculations including all 21 users for which data was available is as follows: in the period before intervention took place, there was a combined average of 62.66 contacts with A&E per month. Following intervention, the average number of contacts for the cohort reduced to 42.1 per month, which accounts for a 33% decrease in contacts, potentially representing an annual saving to the NHS of up to £21,465.

The pilot is due to run until November 2017, and with improved referral routes, it is thought that the Urgent Care Outreach Support Service will have an even greater impact in its second year.

Fundamentally, what the service demonstrates is the interconnected nature of health and social problems, and that only by supporting people to overcome barriers to social inclusion will there be improvements in people's health and wellbeing and reductions in health crisis.

Case Study 4:
Leeds Survivor Led Crisis Service

Dial House and Connect

Established in 1999, Leeds Survivor Led Crisis Service (LSLCS) provides services for people in acute mental health crisis that exist as **alternatives to hospital admission and statutory provision**.

LSLCS offers out-of-hours crisis support through three main channels:

- **Dial House**, based in Halton and commissioned by the three Leeds CCGs, is open Monday, Wednesday and Friday-Sunday, 6pm-2am. With space to support up to 10 visitors per night, the service offers one-to-one support sessions in a safe and welcoming environment, as well as space to socialise with staff and other visitors.
- **Dial House @ Touchstone**, located in Harehills, is open Tuesday and Thursday, 6-11pm. Lottery-funded, the Touchstone Support Centre is a place of sanctuary and support run by, and for, people from black and minority ethnic backgrounds.
- **Connect**, a telephone helpline open 6pm-2am every night of the year, provides emotional support and information for people experiencing distress.

The support provided by LSLCS is qualitatively different from that which is available elsewhere. All services are confidential, provided in a non-clinical setting – which helps to make service users feel safe – and feature a person-centred, empathic and non-judgemental approach. In feedback, users of the different services regularly indicate how much they value the personalised care they receive, which makes them feel understood, accepted and respected.

> *"When I try to talk with my doctor about my mental health they are really dismissive and they make me feel worse so I don't talk to them anymore. The staff at Connect are really nice and kind and understanding they make you feel like you are somebody"*
>
> *"I have felt put down and humiliated by other mental health services, but I've talked to many people on Connect and never felt that"*

Feedback also indicates that LSLCS plays **a significant role in reducing the number of people accessing other crisis and emergency services**, such as A&E, psychiatric inpatient beds, and the police and ambulance services. Whilst no externally produced evaluation has been undertaken to quantify this impact, feedback questionnaires administered by Dial House in 2015 to frequent users of the service suggest a 40% reduction in both visits to A&E and hospital admissions. Comments made by service users would appear to corroborate this:

> *"The number of hospital admissions has been reduced because when I feel suicidal or I'm hearing voices I prefer to come here"*
>
> *"The ambulance service was considering taking legal action against me because they said I called them too much, I didn't have any one else and I felt like I was going to die or have a heart attack, they kept telling me it was just anxiety. Now I call Connect when I feel that bad, they do help me and I feel cared about for a while"*
>
> *"I am able to get there even if I don't have a penny to my name. There's somewhere to go other than A&E"*
>
> *"I was very close to calling an ambulance because I felt so poorly in the head. I called Connect and the person I spoke to was so kind and helped me feel safe, they kept me out of hospital that night"*

Social Return on Investment analysis undertaken for the period 2010/2011 further demonstrates LSLCS broader social value and cost-effectiveness, as every £1 invested into the service was calculated as delivering a wider return for society of at least £4.

LSLCS not only creates additional capacity for statutory services by offering **alternative provision for people experiencing mental health crisis**, it provides a service that its users actively prefer, finding it more suitable for their needs than anything else that is available.

Case Study 5: Leeds Housing Concern

Emergency Accommodation

Established as a charity in the 1970s, **Leeds Housing Concern** (LHC) has expanded its range of services to offer time-limited housing and support to people with a range of health and social needs, with specialist services for women, men, people experiencing homelessness, mental health issues, substance misuse, and Black, Asian and Minority Ethnic groups. Funded from a variety of sources, including Leeds City Council, partner organisations and charitable giving, LHC aims to help move people into independent accommodation and increase their social inclusion.

Whilst the services and support LHC provide undoubtedly help to address the wider social determinants of health in the long-term, it is perhaps **LHC's emergency hostel accommodation that has the greatest impact on reducing the demand for acute care**:

- Oakdale House, provides 24-hour staffed accommodation for up to 10 homeless women for a maximum period of 14 days. From here, women have access to Cross Francis Street for another 28 days, before being supported into sustaining a more durable tenancy.

- Cemetery Road, offers support to seven homeless men at any one time for up to 28 days, with the intention of identifying suitable further accommodation within two weeks of admission.

When people present at the emergency hostels, they are allocated a key worker who develops **individual, person-centred support plans to assist in meeting holistic needs**. Service users meet their key workers daily, with referrals being made to appropriate follow-up services, such as counselling, psychiatry and advocacy support.

LHCs emergency hostel accommodation provides an intensively supported environment for its service users, many of whom have been discharged directly from acute services. Whilst no external evaluation has been undertaken to quantify this impact, evidence suggests that a minimum of 20 women have been accommodated by the service following discharge from acute mental health services in the past year from the women's service alone. The support received in these times of crisis means that **service users are much less likely to be readmitted** to hospital, with key workers assisting service users to overcome issues that could lead them to present at acute services.

Furthermore, by providing accommodation, LHC are able to work with community health teams so that **support can be delivered outside of the acute care setting**, something which is incredibly difficult if an individual is homeless.

LHC helps to reduce demand for acute services in other ways through Carr Beck, a 'wet' hostel that provides individual packages of care to alcoholic women who choose to continue drinking whilst addressing their other complex needs. By working on harm reduction through agreed drinking plans, service users minimise the risks associated with alcohol misuse, which can result in the need for acute care. The availability of 24-hour support means that the risks of self-harm or attempted suicide by alcoholic women experiencing poor mental health are reduced. In addition, staff at Carr Beck suggest that both the **police and ambulance services benefit from a reduction in anti-social behaviour associated with alcohol misuse**, as service users are no longer making inappropriate calls and requests for assistance.

The value of having a fixed abode cannot be underestimated. Poor, or no, housing is one of the key social determinants of ill-health. LHC, by delivering **emergency support and accommodation** to the homeless and vulnerable, provide a safe space for people to go after being discharged from acute care settings, reduce readmissions, and improve the likelihood that its service users will live healthier lives in the future.

Acute Care Reduction, Beyond Leeds

A Literature Review

As part of the remit of this report, Forum Central wanted to investigate whether services that reduced the need for acute care were being delivered by TSOs elsewhere, either nationally or internationally. If any such services were identified, the interest was in exploring their models of service delivery and how these models fitted more broadly within their local health economies.

To ascertain this information, a review of academic and grey[2] literature was undertaken, using the AgeLine, MedLine and Academic Search Research and Development databases. Variations of key terms were used to identify relevant papers, which were then read more fully to determine their applicability. Further literature was discovered through a snowball search of citations in key documents, and was supplemented by searches on Google and Google Scholar.

Much of the literature returned by the searches was deemed to be irrelevant to this report, with a large proportion comparing the effectiveness of 'not-for-profit' hospitals and private hospitals in the United States. Where relevant literature was identified, a consensus emerged within these papers that there is **very little academic evidence to demonstrate the impact of the third sector in the realm of health and social care**, and especially with regards to the delivery of services that reduce the need for acute care (Scottish Government & Scottish Third Sector Research Forum, 2011).

Where there is evidence, it is primarily qualitative in nature, and is typically found in the form of case studies. Indeed, in what is considered as one of the 'most comprehensive sources of evidence on interventions for unplanned hospital admissions' (Purdy *et al*., 2012: 68), it was found that there was very limited economic data available, particularly regarding cost-effectiveness. What became

[2] Grey literature is defined as research and material published outside of commercial and academic channels, and is typically produced for online consumption in the form of reports and articles by any number of organizations, including TSOs, governments, and NGOs.

clear, therefore, was that evidence of third sector activities, services, and impact is incredibly hard to access as, where it is published, it is done so outside of academia in the form of specific evaluations of projects that are not widely available. It may well be that, in order to identify the full array of services provided by health and care TSOs, a greater number of in-depth, local, evidence-gathering case-studies of the type undertaken in this report need to be produced.

Examples of projects having an impact on the need for Acute Care outside of Leeds

Established in 2003, the **Housing Support, Outreach and Referral** (HSOR) pilot aimed to support people living with HIV who were homeless or at risk of homelessness in two boroughs of London (Cameron *et al*., 2009).

Forming part of the Supporting People Health Pilot programme – which sought to explore how services could be developed to bridge sectors and meet the health needs of vulnerable people – the HSOR pilot supported individuals to gain and maintain housing tenancies, as well as ensuring they were registered for, and knew how to access, the full range of health of primary, secondary and specialist healthcare services. Fundamentally, housing is 'a crucial part of the overall system of support services to enable people to live independently within a community-based setting, thereby avoiding costly and unnecessary hospitalisation and institutionalisation' (*ibid*.:390).

The HSOR evaluation corroborated this, finding evidence of 'significant improvements for individual service users, in terms of their housing status, their contact with health services and their own perception of their health status' (*ibid.*: 394). Integral to the effectiveness of the service was the role of the support worker, who acted as a networker and navigator, as well as an advocate.

For over 20 years, the **British Lung Foundation** (BLF) has been running nationwide **Breathe Easy** groups to support people with chronic lung conditions, with a number of support and exercise

groups existing in Bramley, East Leeds and Middleton. However, in 2014, with funding from NESTA, BLF started a nationwide project to integrate their Breathe Easy groups into existing healthcare pathways (Merritt *et al.*,2016). This entailed being formally recognised by commissioning organisations, and gaining support and sign-up from healthcare professionals, who as well as participating in Breathe Easy groups, would promote them to service users and carers.

The **Integrated Breathe Easy groups** are run by volunteers, many of whom suffer from lung conditions themselves, and offer peer support, education and information giving, and are fully-connected to healthcare referral pathways.

According to the evaluation of the service, undertaken by the Centre for Health Service Studies at the University of Kent, Integrated Breathe Easy groups are 'a cost-effective programme which has positive outcomes in terms of self-efficacy, health outcomes and wellbeing for attendees, providing cost savings and wider social benefits for local communities' (*ibid*.:8).

Furthermore, during the two-year pilot, a 57% reduction in hospital admissions was identified when compared to the unintegrated Breathe Easy groups, with 87% of people in converted and new Integrated Breathe Easy groups stating that they felt less likely to be admitted to hospital because of their lung condition (*ibid*.:7).

The Value of Commissioning Services

Delivered by Third Sector Organisations

It is evident that health and care TSOs have a number of key distinguishing features that mark them out as qualitatively different to other service providers.

In a review of four anonymised local health economies, Allen *et al*. (2012: 26) found evidence that TSOs were commissioned as service providers either for their "niche expertise in specific areas of healthcare or because they had access to parts of the population not covered by Clinical Commissioning Groups".

In this sense, TSOs were seen as having the capacity to bring health services into the community and transcend the boundary between healthcare and other forms of community activity (*ibid*.: 28). It is this bridging role that appears to be one of the most valued characteristics of third sector service delivery, and was pinpointed as being integral to the success of the Housing Support, Outreach and Referral pilot, outlined above (Cameron *et al*., 2009).

The established network of contacts within the wider voluntary sector to which the TSO delivering the service had access to meant that support workers were able to refer people to a broad range of additional services, thus increasing the impact of the intervention.

The expertise of TSOs goes further than understanding the dynamics of complex and diverse communities. TSOs are increasingly perceived as instrumental to the consolidation of community engagement in the design and delivery of services (Myers, 2017). From the perspective of service users, the relative independence of TSOs from statutory services can make them more approachable (Allen *et al*., 2012).

Furthermore, given the 'not-for-profit' status of TSOs, they are considered to be less likely to forfeit quality in the pursuit of efficiency, and are therefore more focussed on service users than their own self-interest (Heins *et al*., 2010: 516).

In summary, “TSOs are more flexible and responsive to local need, have a higher level of public trust, are better able to develop innovative services and better engage service users in the services they receive; and may produce benefits for the local community by, for example, engaging volunteers and using local resources” (Harlock, 2014).

The Role of Commissioners

Commissioners play an integral role in shaping local health economies (Allen *et al*., 2012). By determining which services are commissioned and by which providers, commissioners – and local health authorities – influence the extent to which TSOs are included in service delivery.

In fact, where TSOs are viewed as 'crucial players', the results of service provision can be much improved, particularly if there is a culture of collaboration among the central partners (Cameron *et al*., 2009). This is especially relevant when it comes to addressing the broader social determinants of ill-health.

Overcoming the wide range of socio-economic factors that impact a person's wellbeing cannot be achieved in hospitals or doctors' surgeries alone. Instead, it necessitates action from a coalition of actors, of which TSOs form an integral part (Orton *et al*., 2011).

However, it must also be recognised that as much as commissioners can actively choose to include TSOs as key partners in service delivery, they can equally – albeit indirectly – establish obstacles to TSO participation in the provision of services. With a shift in recent years toward outcome-based commissioning and increasing expectations to demonstrate a service's effectiveness (Harlock, 2014), bidding processes can tend to favour larger organisations – from both the private and third sectors – who have the time, experience and expertise in compiling competitive bids (Myers, 2017).

Furthermore, the pressure within the NHS for meeting short-term targets has created a system where commissioners focus on what can be measured, rather than what is important; one which precludes commissioning services that centre on longer-term preventative approaches (Orton *et al*., 2011).

Payment mechanisms are thus seen as rewarding activity, regardless of the quality of the service provided (Steedon, 2012). Even where quality is a factor in commissioning decisions, price is

seen as equally important, with broader social implications forming a marginal part of considerations (Harlock, 2014).

All of this has significant consequences for TSOs, and particularly those operating at a small scale. Demands for monitoring and evaluation can be burdensome, especially if organisations do not possess sufficient personnel or expertise to fulfil the rigorous requirements (Myers, 2017).

Excessive administrative work, resulting from the need to undertake data collection for monitoring purposes (Harlock, 2014), can distract from more pertinent tasks, such as service delivery itself. Moreover, given the often sensitive nature of the work that TSOs undertake and the vulnerable groups for whom they deliver services, acquiring data of any sort can be challenging and, in some instances, problematic.

Much of the impact of the services delivered by TSOs is intangible and difficult to quantify, such as the difference made to an individual's sense of isolation or confidence (*ibid*.). Where attempts to capture this data are made, they result in qualitative rather than quantitative data, which fit far less easily into funding applications.

Key Learning

Researching and compiling the case studies featured in this report has been a beneficial process. Not only has it enabled Forum Central to explore and develop our understanding of the work being carried out by health and care TSOs in Leeds to reduce the need for acute care, it has also helped us to identify some key areas of learning to carry forward:

- Leeds CCGs are supporting TSOs to pilot and deliver innovative, local solutions to high and increasing demand for acute care. By commissioning TSOs to provide services, Leeds CCGs are demonstrating a commitment to fostering a culture of collaboration which includes a range of social actors, who together are more likely to overcome the broader determinants of ill-health. Given the success of the case-studies featured in this report, it would not be inappropriate to suggest that a greater number of pilot projects – delivered by TSOs – should be funded, with careful consideration being given to developing strategies and revenue streams that enable services to be mainstreamed as their funding comes to an end.

- Leeds TSOs are successful in securing revenue from a variety of national bodies. This contributes to Leeds's ambition to be the best city for health and wellbeing in the UK, and demonstrates that national bodies have faith in the work being undertaken by Leeds-based health and care TSOs.

- The success of many of the services featured in the case studies depends on support workers who have an in-depth awareness of the wide-range of statutory and third sector services to which they can refer service-users. It is only through joint-working that crosses the boundaries between healthcare and community services that the root causes of inappropriate acute care use will be addressed. Such 'boundary-crossing' work is exemplified by services such as Hospital to Home and Urgent Care Outreach Support, both of which were able to improve their effectiveness when they gained direct access to acute hospitals and systems.

- The requirements for monitoring and evaluation needed to fulfil contracts can be difficult to achieve, particularly where TSOs do not have pre-existing expertise, or where outcomes are indirect or intangible.

  If commissioners wish the services they fund to be properly evaluated, with full statistical analysis, they should provide additional funding for this express purpose. In this way, TSOs can concentrate on delivering the service for which they have been commissioned, and additional, specialist resources can be sought to undertake the evaluation. This will undoubtedly produce more rigorous and accurate results, as can be seen by the evaluation produced by the Leeds Intelligence Hub for Age UK Leeds's Hospital to Home service.

  However, commissioners must equally be aware of the need to apportion greater value to qualitative evidence, as this is often the most significant source of evidence to which TSOs can offer. Leeds Survivor Led Crisis Service (LSLCS) is a good example here. Quantifying their direct impact on reducing the need for acute care is challenging, however, it is clear from the abundant qualitative evidence gathered that LSLCS plays a significant role in limiting demand.

Acknowledgements

We would like to thank everyone who took the time to contribute to the production of this report. Particular thanks go to the individuals and organisations who kindly responded to our call for evidence, and to those with whom we had even greater contact in the compilation of the case-studies.

For providing detailed information for the case-studies, many thanks go to:

- Kerry Jackson and Catherine Malia, St Gemma's Hospice
- Heather O'Donnell, Age UK Leeds
- Joe Kent and Samantha Clewley, Barca-Leeds
- Fiona Venner, Leeds Survivor Led Crisis Service
- Sharon Brown, Kay Stewart and Matthew Newman, Leeds Housing Concern

For responding to the call for evidence with offers of support and information, thanks go to:

- Angela Smith, Leeds Jewish Welfare Board
- John Preston, The Conservation Volunteers
- Brian Garbett and Gail Rowe, MHA
- Gill Trevor, Phoenix Health and Wellbeing
- Anne Forbes, trustee of Leeds Older People's Forum
- Helena Bladon, Carers Leeds
- Paul Holland, Advonet
- Sue Trainor, Otley Action for Older People
- Kathryn Waldegrave, Trainee Lecturer in Adult Nursing
- Kenneth Watson, member of the public
- Melanie Ndzinga, Burmantofts' Senior Action
- Peter Brook, People Matters
- James Burleigh, Different Strokes
- Laura Able, British Lung Foundation
- Trude Silman, former trustee of Leeds Older People's Forum

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