Shift from Hospital to Community – Frequently Asked Questions (FAQs)

September 2025

1. What changes should we expect as more NHS services move into the community, how will this make a positive difference?

To help explain the shift towards more community-based care in Shropshire, Telford and Wrekin, we've outlined the following services that are part of our plans.

We've also provided details on what each service involves and how they are expected to work in practice.

The Integrated Community Front Door (the right help without going to hospital):

This is a service model designed to help people access the right care, in the right place, at the right time – often as an alternative to going into hospital. In simple terms, the Integrated Community Front Door acts like a single point of access for health and social care services in the community. It brings together different professionals – such as nurses, therapists, GPs, mental health workers, and social care teams – to quickly assess and respond to a person's needs, usually on the same day.

The service is mainly for people who are unwell or in crisis, but who don't necessarily need to go to hospital. This could include older adults with frailty, people with long-term conditions, or someone recovering from illness who needs short-term support. By responding quickly and coordinating care across different teams, the Integrated Community Front Door helps to keep people out of hospital where possible, speeds up access to care and support, and helps people to stay safe and well at home.

2-Hour Domiciliary Care Bridging (Urgent Home Care Within 2 Hours):

This service offers urgent, short-term care in your home, usually within two hours of being requested. It's designed to support people who are either leaving hospital or who need help quickly in the community, so they can remain safe at home instead of going into hospital unnecessarily.

The term 'bridging' means this care is temporary – it's there to fill the gap while a longer-term care plan is being arranged. For example, if you're ready to leave hospital but your regular care package isn't in place yet, this service makes sure you're not left without support.

Care is provided by trained home care workers who help with everyday tasks, including:

- Washing, dressing, and using the toilet
- Preparing meals and ensuring you're eating and drinking
- Prompting you to take your medication
- Offering general support and checking on your wellbeing.

The service helps people to return home from hospital more quickly, stay out of hospital when it's safe to do so, and remain independent in their own homes. It's especially helpful for older people or those recovering from illness or surgery who need quick, short-term support, even just for a few days.

Extended Discharge Planning (planning a safe discharge from hospital):

This is a more detailed and personalised way of preparing someone to leave hospital. It is mainly used for people who have complex needs and require more support than usual to return home or move into another care setting safely. Extended discharge planning helps reduce the risk of people being readmitted and supports them to regain independence.

Not all patients can be discharged quickly or with a standard care plan. Some people have multiple health conditions, limited mobility, or may live alone without support. Others may need specialist equipment, adaptations to their home, or placement in a rehabilitation unit or care home. If these needs aren't carefully planned for, the person may struggle at home or end up being readmitted to hospital.

A range of health professionals usually work together to plan a safe discharge for a patient, by organising any services or support the patient may need at home - such as care workers, equipment (like a hospital bed or mobility aids), medication, transport, or even help with meals.

GP Support at the Hospital Entrance:

A dedicated General Practitioner (GP) decision-making service will be established at the hospital front door, operating independently of standard General Practice resources. Its primary focus will be to reduce avoidable hospital admissions through early clinical assessment and appropriate patient streaming.

Care Transfer Hub System Manager:

A Care Transfer Hub is a service that co-ordinates the safe and smooth transfer of patients from hospital into community care. It acts as a central point of contact between hospitals, community health teams, social care, and other services. The hub helps ensure that patients don't stay in hospital longer than necessary, and that the right support is in place for them to continue their recovery at home, in a care home, or in another appropriate setting.

As part of plans to strengthen the Care Transfer Hub in Shropshire, Telford and Wrekin, a System Manager will take on a key leadership and coordination role across health and care services. This role will help improve the way patients move through the system, ease pressure on hospitals, and ensure more people receive the support they need to stay well in the community. To further enhance the service, additional weekend therapy cover will also be introduced to support timely discharges and continuity of care throughout the week.

Enhancing Urgency Community Response (UCR) (fast care at home):

This will involve extending opening hours from 8pm until midnight and implementing a new medical model for Urgent Community Response (UCR). The expanded UCR service will continue to be delivered by community teams, supported by enhanced medical oversight to reduce avoidable referrals to GPs and emergency departments.

2. How will the shift to more community-based services make a positive difference for patients?

Moving more NHS services into the community means patients can get the care they need closer to home, rather than having to go into hospital. This helps people stay comfortable and supported in familiar surroundings.

The Government's 10 Year Plan supports this shift, aiming to improve health outcomes by focusing on preventative care and better managing long-term conditions outside of hospitals. By providing care in the community, we can also help with winter resilience planning, making sure vulnerable people get timely support during busy periods when hospitals and emergency services are under the most pressure.

This shift also helps to relieve pressure on emergency services and hospitals by reducing unnecessary admissions and allowing ambulance and A&E teams to focus on the most urgent cases. Overall, we believe this will mean faster access to the right care, improved patient experience, and a stronger, more sustainable health system.

3. How much is being invested in the shift to community care, and will this match any savings made from closing the Rehabilitation and Recovery Units (RRUs)?

The reinvestment in community-based services is £3.6 million per year. Discussions are still underway between NHS Shropshire, Telford and Wrekin (NHS STW) and the Shropshire Community Health NHS Trust; however, the Trust does not anticipate making a financial saving as a direct result of this shift.

Importantly, the primary goal of this shift is to improve the urgent and emergency care (UEC) pathway and align services with national priorities for delivering care closer to home.

4. Will the extended Urgent Community Response (UCR) service to 12pm be delivered from community facilities or directly in patients' homes?

The extended hours for UCR are designed to enhance same-day response capacity, with delivery remaining primarily in patients' homes or usual place of residence. The service is mobile and multidisciplinary, with rapid access to diagnostics, therapy, and clinical oversight. The community-based, patient-facing element is fundamentally home-based, reflecting the ambition to support people to remain well in their own homes and avoid hospital admission where possible.

5. How will the shift from hospital to community impact General Practice?

The core aim of this model is to expand existing community services so they can operate for longer hours, including evenings and weekends. We do not anticipate any increase in workload for General Practice and Primary Care colleagues. In fact, services such as the Urgent Care Response (UCR) team will see strengthened medical support to provide enhanced clinical oversight and better integration with Primary Care.

It's worth noting that the Chief Medical Officer for NHS Shropshire, Telford and Wrekin (NHS STW), Dr Lorna Clarson - who is a practising GP and a member of the Urgent and Emergency Care (UEC) Delivery Group - is closely involved in overseeing these developments. Additionally, the system's GP Board has been kept updated on this work.

6. Is the reinvestment in community-based services being provided by HealthHero Integrated Care (the new provider for the GP Out of Hours Service)?

The £3.6 million reinvestment into community-based urgent and emergency care services is being delivered through a broad partnership across the Shropshire, Telford and Wrekin Integrated Care System (ICS). While HealthHero has been appointed as the new provider of the GP Out of Hours Service from October, the wider investment is not limited to this single contract.

The funding is supporting a system-wide transformation, including the expansion of Urgent Community Response (UCR) to operate until midnight, enhancements to the Care Transfer Hub, additional therapy and rehabilitation services, and increased acute bed capacity at the Shrewsbury and Telford Hospital (SaTH) through two new modular wards.

Significant funding is being directed into an expanded community offer including UCR, the Care Transfer Hub, step-up care, modular ward capacity at SaTH, and enhanced same-day access pathways. This transformation involves multiple providers across the system and is part of a broader programme to deliver a more integrated and resilient urgent and emergency care system across Shropshire, Telford and Wrekin. The full details were outlined in our press release issued on 28 July 2025, which can be accessed here: Health leaders launch major shift to community-based care this winter.

7. How will this impact our current community facilities?

We recognise the importance of local community facilities in our wider care infrastructure. The initial press release for this work focused on system-wide strategic

shifts rather than detailing all contributing sites, but community hospitals and Minor Injury Units (MIUs) will continue to play a role in the delivery of community-based care.

As we operationalise the model further over the coming months, we will be working with place-based teams to ensure each facility is aligned to the broader aims of admission avoidance, timely discharge, and localised care where clinically appropriate.

8. With the closure of the Rehabilitation and Recovery Units (RRUs), where will those patients go?

Patients who would have previously used the Rehabilitation and Recovery Units (RRUs) will be supported through a combination of enhanced community-based rehabilitation services and existing community beds within our health and care system. This includes investment into home-based therapy models, enhanced reablement support, and use of alternative step-down bed capacity where required.

The main aim is to move away from bed-based models, where clinically safe to do so, and instead offer more personalised, timely recovery support in people's homes. For those who do need a short period in a bedded environment, access to community hospital beds or short-stay placements remains part of the discharge pathway options. This aligns to the Government's NHS 10 Year Plan, and the left shift to community care.

9. Why has this change not involved engagement with the public?

The Rehabilitation and Recovery Units (RRUs) at our two hospital sites (the Princess Royal in Telford and the Royal Shrewsbury) were introduced 18 months ago. This decision was made in response to delays in the arrival of the two new modular wards that were originally planned for the site.

The RRUs were created and designed to bridge the gap between hospital and home, providing tailored support for individuals recovering from illness or injury. Since then, as a health and care system, we have developed a more sustainable, long-term approach that aligns with the national shift towards enhancing community-based care.

The RRUs will return to acute hospital use alongside the introduction of the two new modular wards, maintaining the overall number of acute beds and supporting more people to recover closer to home in familiar and supportive environments. This will help ensure that acute hospital beds are available for those who need them most and will reduce reliance on temporary or unconventional care settings. It also puts us in a strong position to manage rising demand over the winter months.

Whilst the shift from hospital to community-based care does not constitute a significant service change for patients, system partners are planning several engagement activities as part of this work to better understand patient views and experiences of urgent and emergency care and community pathways, and to identify opportunities for further

improvement.

When the units close, we will continue to work with patients to ensure they can access care to meet their needs, which, where possible, will be met through enhanced community services.

10. What will happen to the staff currently working at the Rehabilitation and Recovery Units?

Shropshire Community Health NHS Trust (Shropcom) will ensure that staff are well supported throughout the transition. Any changes to their employment will be managed in line with the Trust's Organisational Change Policy which will always fully explore opportunities for redeployment to other parts of the local health and care system. A staff consultation is currently underway to explore these options and to help our staff through this period of change.

11. How will you make sure care remains safe and of high quality in the community?

All services will continue to be delivered in line with national NHS quality standards and local governance arrangements. Community services are being enhanced with stronger medical oversight, integrated multidisciplinary teams, and closer links to Primary Care. Regular monitoring of outcomes, safety incidents, and patient feedback will ensure that quality of care remains consistent wherever it is delivered.

12. Will everyone be able to access these services, especially people living in rural areas or those with additional needs?

Yes. Services are designed to be delivered at home or as close to home as possible, with mobile teams able to travel across Shropshire, Telford and Wrekin. We are also working with local authority partners and voluntary organisations to ensure services are accessible to people with disabilities, language needs, or transport challenges. Equality and accessibility remain key priorities in the design and delivery of these services.

13. How will we know if these changes are making a difference?

We will measure success using a range of indicators, including:

- Reduced avoidable hospital admissions
- More timely hospital discharges
- Shorter lengths of stay in hospital
- Improved patient and carer satisfaction
- Better health outcomes for people living with long-term conditions

14. How will you make sure patients don't fall through the gaps between hospital and community services?

The Care Transfer Hub and Integrated Community Front Door will act as key coordination points to ensure continuity of care. Shared care records and regular communication between hospital teams, GPs, community teams, and social care will help avoid duplication and ensure patients experience a seamless journey across services.

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