Appendix A

iCAN Collaborative

Case for Change and Story Board – Summary Proposal 3.2

Purpose of the paper

What are we asking for?

Our Case for change sets out the journey, the rationale and the detail behind the proposal ***to develop an iCAN (Integrated Care Across Northamptonshire) collaborative***.

A summary of iCAN aims, progress and next steps was presented to the Integrated Care Board (ICB) on 21st April 2022. The ICB supported the broad direction and progress of iCAN and the plans to deliver specific improvements for winter/surge activity. Work has also progressed on shaping the iCAN collaborative and road map for the contractual development of the collaborative.

This document summarises the proposed operating model and initial scope for our collaborative and steps we need to take to formalise that. **The ICB is asked to:**

- **agree that iCAN aims and objectives remain valid**
- **agree scope of tranche 1 services to form a collaborative arrangement from April 2023**
- **agree iCAN should proceed to Gateway 4 and develop proposals in relation to**
  - **delegated budgets** (including alignment of the BCF) **,**
  - **workforce and**
  - **contractual format:**
- **agree we should progress service user and staff engagement to inform arrangements for April 2023.**

Background and context

We have committed to transforming and improving care for our frail and elderly population through our ICAN programme and we've seen significant success across national priorities like Age Well, the Better Care Fund, Urgent Community Response, National Discharge programme and Enhanced Care in Care Homes.

However, despite this progress we are still not able to consistently deliver the best outcomes **and we are not managing our demand effectively to ensure more people stay well at home and we avoid unnecessary admissions**. This is impacting the quality and continuity of care people receive. **It is also significantly affecting our financial position**. Our demographic means that without action demand will outgrow our resources and reduce our ability to meet the standard of care we should aspire to deliver.

Patient experience for people aged 65+ has also been varied and sometimes unsatisfactory for too long. We know we have more stranded and super stranded patients than other areas (with many patients in acute and community beds no longer needing to be there) and we are not maximising the opportunity to return people to independence and their normal place of residence. **High Acute occupancy is also creating significant pressure at the front door when admissions are needed because of delays in getting people out.**

All these issues have been exacerbated by a previous lack of widescale community preventative and support services to help people stay well at home and not using our limited resources effectively.

But if we are to make sustained change, we need to formally commit to work within integrated service arrangements, with pooled finances and staff across a range of out of hospital services. This will mean all partners are working together in a patient-centred approach, across our community and hospital pathways to improve outcomes. It will also build the foundation of future wider integrated services that shift our focus to prevention and community and **enabling people to choose well, live well and stay well.**

This is what people, clinicians and staff tell us they want. We believe that the collaborative structure is the best route to deliver the sustained improved outcomes and make our money go further.

What are we proposing and why?

Our vision is to support more people to choose well, stay well and age well at home resulting in reduced unnecessary admissions to hospitals and better outcomes for people. Where they do experience a crisis, we will ensure that they get the right care at the right time and in the right place ensuring, where possible, they return to independence and ideal outcomes.

Outcome Focused

For too long we have measured our success on the basis of system outputs and acute performance. These are often indicators that have little meaning or relevance to the outcomes our residents wish to achieve.

Our vision starts with a shift of focus to community based care – measuring our success predominantly on the delivery of outcomes for our population and helping people age well.

From whole pathway redesign to individual Care Plans, coproduction will be the defining principle. The approach will be strengths-based, goal-oriented, and recovery-focused. Our residents will feel ownership over their own health and care process.

We believe this will produce better longer-term health outcomes, fewer escalations and admisisons, and relieve key system pressures (such as on Urgent care and Primary care)

Person Centred

To do this, we must recognise that we have been operating with a process and not person centred approach – whereby risk thresholds, strict specifications and different drivers create the conditions for duplication and gaps in our system.

Our vision continues with the development of 'person-centred' care – whereby we do more to recognise what an ideal outcome looks like as a resident. To be truly person-centred, physical health and social care needs must be factored in to holistic care plans, and we will broaden our approach to MDT working at 'Place' and 'Sub-Place' to meet service user expectations.

We believe this will support residents to manage their own care, avoid escalation, reduce admissions and help people stay well and at home for longer.

Responsive

Ensuring all care is person-centred will require a programme of transformation, during which we will consolidate system resources to achieve this within set timescales.

Our vision involves a gradual devolution of resources to a dedicated collaborative of system partners. The ultimate aim of the collaborative would be to manage a left-shift in system spend by targeting investment on the most effective initiatives at any time, as well as efficient withdrawal/ reinvestment according to changes in population need or healthcare policy (e.g. NHS Long-Term Plan).

We believe delegation of unplanned over 65 care will allow for faster transformation, and ensure the best use of system resource in the achievement of defined population health outcomes.

Integrated

The ICAN programme can demonstrate examples of partnership working for better outcomes. However, integration at pace and at scale will require partnerships to become more formalised.

Our vision includes the development of a single contract for the management of over 65 out of hospital care, and for the delivery of all Age well outcomes. The collaborative of system partners would co-design operational strategy and assure achievement of desired outcomes.

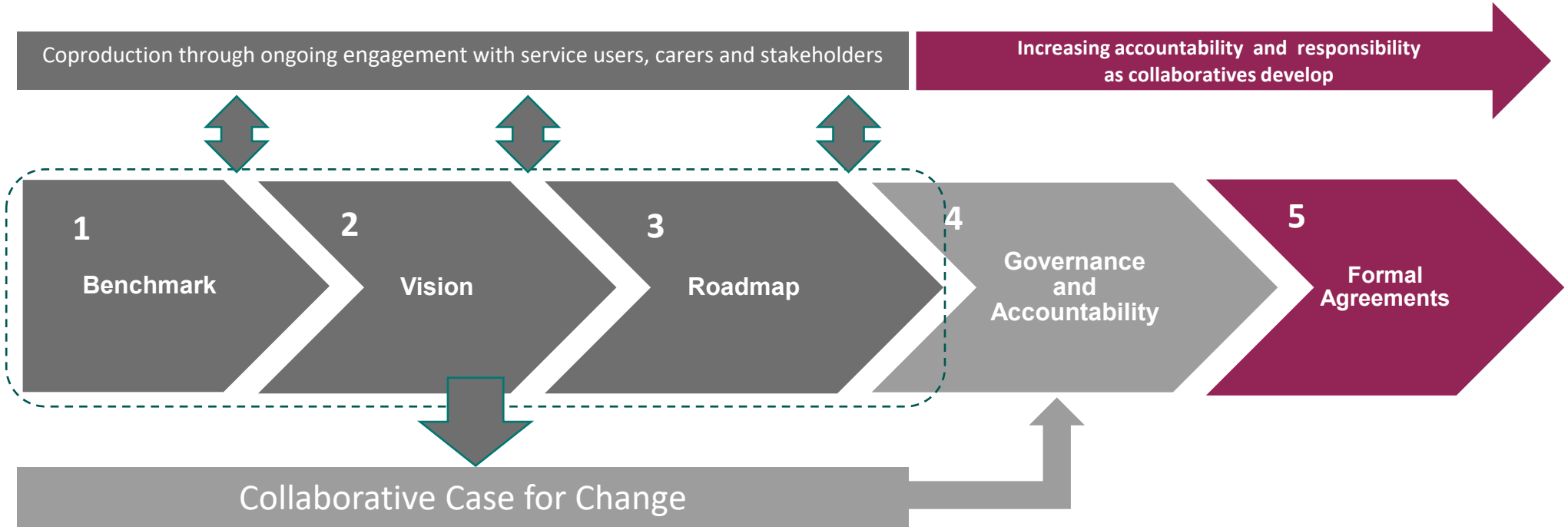
A collaborative would manage financial administration and subcontracting arrangements with all partner organisations required to deliver against the agreed Outcomes-Framework, and provide accountability to the Integrated Care Board.

What are we proposing and why?

- The ICAN programme is a five-year transformation journey, it has already achieved good results in our hospitals and community.
- ICAN Phase 1 and the external support ends December 2022 - we need to secure existing and new ongoing benefits from our work
- We now need to **move from a programme to a permanent way of working** by developing a service delivery model that formalises/embeds what's been achieved and creates the conditions for long term integrated working and better outcomes
- We are proposing that a range of out of hospital services (see next slide) and partners are brought together as pooled resources to develop and deliver more integrated pathways of care – these would form **Tranche 1 of our collaborative**
- Our focus will be helping the frail and over 65s live well, stay well and age well in their community, avoiding an escalation to acute hospitals where possible, ensuring people don't stay in hospital too long and that we return them to independence and home where possible.
- We already have a set of pooled budgets and contracted out of hospital services within the Better Care Fund (BCF) that support much of the activities in ICAN. The BCF is already the responsibility of the Health & Wellbeing Boards, subject to section 75 arrangements and has a national performance framework that aligns to ICAN.
- Using the BCF funding as a foundation for future arrangements and the pooling of resources, we can create a single contract for our ICAN Tranche 1 collaborative services that binds us to common outcomes and improved performance to meet system and national objectives
- **We believe such arrangements are required to change our focus from an organisational one to a system view.**
- We still have work to do on what this means for our workforce, budget delegations and contracting but require confirmation of our direction of travel and scope for the collaborative to commence the detailed design and engagement as set out in the next slide.

The iCAN collaborative development gateways (proposed)

We are seeking ICB support to move through Gateway 3 and commence work on Gatweays 4 and 5



Gateway Requirements

- Scope of services
- Assessment of current provision
- Problem statement
- Collaborative Partners

- Transformation Priorities
- Vision Statement
- Resource Analysis (Service provision and Collaborative support)

- Key Deliverables
- Tranches (if required)
- Strategic Overview
- Roadmap of Collaborative Development including:
  - Key Deliverable Dates
  - Tranche Dates (if required)
  - Key Decision Dates
  - Preferred Formal Agreement Type(s)

- System agreement of case for change
- Shadow governance arrangements (pending formal agreements)
- EQIA/QIA
- Evaluation methodology
- Detailed operational delivery plan including
  - Finance
  - Activity
  - Workforce
  - Outcomes

- Collaborative Agreement (if required)
- Contractual Agreement(s) or Delegation Agreement(s)

iCAN proposed operating model and scope of services

The operating model will build on our ICAN work with tranche 1 including all the services from ICAN and the BCF detailed in sections 1 to 4 in the diagram to:

- create formal structures and shared ownership of pathways
- develop more trusted assessor approaches with shared referral points in hospitals and from the community
- operate integrated Pathway 1 and Pathway 2 models with shared SLAs, less hand-offs and shared outcomes
- increase avoided escalations to hospitals with step up services to be developed working with GPs
- develop a flexible shared workforces that can respond to surges/Winter using data to inform joint interventions
- expand ICAN pilots and integrate more prevention and wellbeing services that can help avoid escalation for e.g. falls, supporting independence
- work within the Neighbourhoods and interact with the emerging Local Area Partnerships and wider services that effect wider determinants of health

- The model excludes services commissioned through GP contracts – we would develop the ICAN collaborative services working with GPs and system partners to ensure we are aligned to the future CAS/Same Day/Urgent Care strategy when agreed

iCAN plan to address priority issues (1)

Our priority issues	What we have put in place or intend to implement
Too many escalations to acute care • Need to develop anticipatory care • Default to acute care and ED too often • Lack of past capacity in the community for prevention activity	✓ MDTs (Multi-disciplinary teams) for prevention and management of long-term conditions will support more patients at home ✓ Joined up strengthened primary and community care to help people make the right lifestyle choices ✓ Integrated multi-disciplinary neighbourhood teams will meet the needs of an ageing population and patients with complex conditions to provide better care locally and reduce reliance on urgent and emergency care.
Too many people admitted to hospital unnecessarily • High number of falls that lead to admission • Need to expand capacity of pathways 1 and 2	✓ integrated intermediate care offer for step up and step-down care in the community where short intervention is needed to avoid an admission or help someone return home ✓ Development of 2-hour rapid response service that can attend emergency calls in the community and where possible implement a short-term intervention to avoid an admission to hospital ✓ Pressure on emergency care reduced via same day emergency care and frailty units at the front door.
People stay too long in Hospital • Discharge processes not optimised • 40% of patients had no reason to reside • Diagnostic tests unnecessarily delay discharge • Deconditioning from long stays	✓ Integrated multi-disciplinary discharge hub works to maximise flow and optimal paths ✓ Extension of Virtual wards for patient management in the community through central monitoring hubs ✓ System dashboard and systems to manage flow effectively and target actions where they have most impact
We are not maximising independence • Lack of understanding of optimal pathways • Capacity in reablement • SCCs rehab under-utilised and community hospitals bed blocked • Over reliance on community beds	✓ Joint “Home First” approach to care for people at home or in community facilities, avoiding unnecessary hospital stays or rehabilitating them when they leave hospital as they regain their independence. ✓ Shared monitoring hub for telehealth and crisis calls linked to community and Dr support ✓ joint health, care and VCS (Voluntary Care Services) welfare teams in the community ensure people stay safe and well at home ✓ Integrated intermediate reablement service with single pathway and increased shared capacity ✓ Integrated rehabilitation service using shared bed base improved lengths of stay and outcomes

iCAN plan to address priority issues (2)

System issues	How a collaboratives will address the issues
We cannot meet demand or afford what we do • Hospitals are regularly full and overflow beds are regularly needed • Demographic will increase elderly demand • Need to build a new hospital if unchecked • Bedded solutions and staffing expensive • Onward costs rising from deconditioning	✓ Collaborative delivery model under single management administering collaborative planning and delivery ✓ Outcomes based commissioning focused on delivering end to end pathways with clear and supportive formal arrangements ✓ Potential for risk and reward incentivisation to reduce cost while improving service delivery ✓ Best allocation of available resources to deliver transformational change, reducing duplication and reinvestment in community services and prevention (left shift)
We are too tactical in commissioning • Many contracts are short term or use one off funding • The BCF is used as a means to transact funds not deliver integrated care based on common and contracted aims • We don't combine our spending power • Contracts tend to focus on single organisations not system working • The BCF has been a transactional relationship with aligned budgets not pooled resources and shared outcomes	✓ The collaborative will coproduce and support the delivery of an outcomes-based contract for out of hospital care' (initially for the frail and elderly, but with the ability to expand to unplanned care for all ages) ✓ The collaborative will work to a shared set of strategic aims, principles and behaviours, formalised through a Collaborative Agreement ✓ Longer term contracts are essential for the voluntary sector and primary care to maximise their potential and hold risks etc. A formal collaborative approach would be a key stage to achieving that goal. ✓ The BCF will be reset and aligned to iCAN collaborative governance structures to ensure the correct formal agreement are in place and that subsequent service delivery supports the strategic aims of the collaborative

iCAN plan to address priority issues (3)

System issues	How a collaboratives will address the issues
General Practice is operating under significant pressure • reducing ability to deliver preventative measures to keep patients with complex care well in their home • There is a growing crisis in this sector and without the development of new ways of working, we will see more patients escalating in to urgent care services.	✓ We will support General Practice to build on the ICAN/Age well work develop a new model for complex patients with more wraparound services to help GPs manage caseloads and prioritise their work ✓ Develop an integrated urgent / same day service supported and delivered by systemwide partners ✓ Review pathways and the role of the GP being the gatekeeper to some services ✓ We will develop our step up offer and services so that there are viable and effective services for GPs to use rather than using Acute care.
Our workforce is siloed and stretched • We compete for staff • Staff shortages or sickness mean we are not always using the most skilled and experienced staff in the best way • We struggle to attract and retain community care staff while the acutes attract more	✓ The collaborative model with draw staff together in a collaborative and more integrated manner ✓ We can explore the rotation of staff through different settings bringing us more flexibility to manage surges and gaps and creating joint ownership of issues and care ✓ We can aspire to create a new type of combined workforce for the future ✓ we will work to create terms and conditions which appropriately value all team members working within the collaborative.

How will ICAN make things better in future?

For Patients

- I am linked in to the wider voluntary and community support networks in my area
- I am supported to remain at home and in the community
- I am involved in my care and understand my condition
- my care is reviewed regularly with me and shared across partner agencies.
- I can access crisis response services in a timely way day or night
- I understand alternative options to the Emergency Department
- If admission is necessary, I will have a comprehensive plan for my discharge in place and I will not be in hospital for longer than is necessary.
- I will be returned home as the first and preferred option.

For GPs

- I can find and access a range of services to support my work and help patients make choices about their care
- Co-ordinated care supported by a frailty MDT including the voluntary sector working with health and care staff enables people to look after their own health and facilitate professional communication
- I can access hospital and social care records to understand my patients journey better.
- Improved wrap around community services and telehealth solutions help me manage the workload for patients at home and in care settings
- Efficient and easy routes to diagnosis, therapies and other treatments to reduce patient, carer and staff frustrations
- I can access step up care and short term interventions as a viable alternative to hospital conveyance

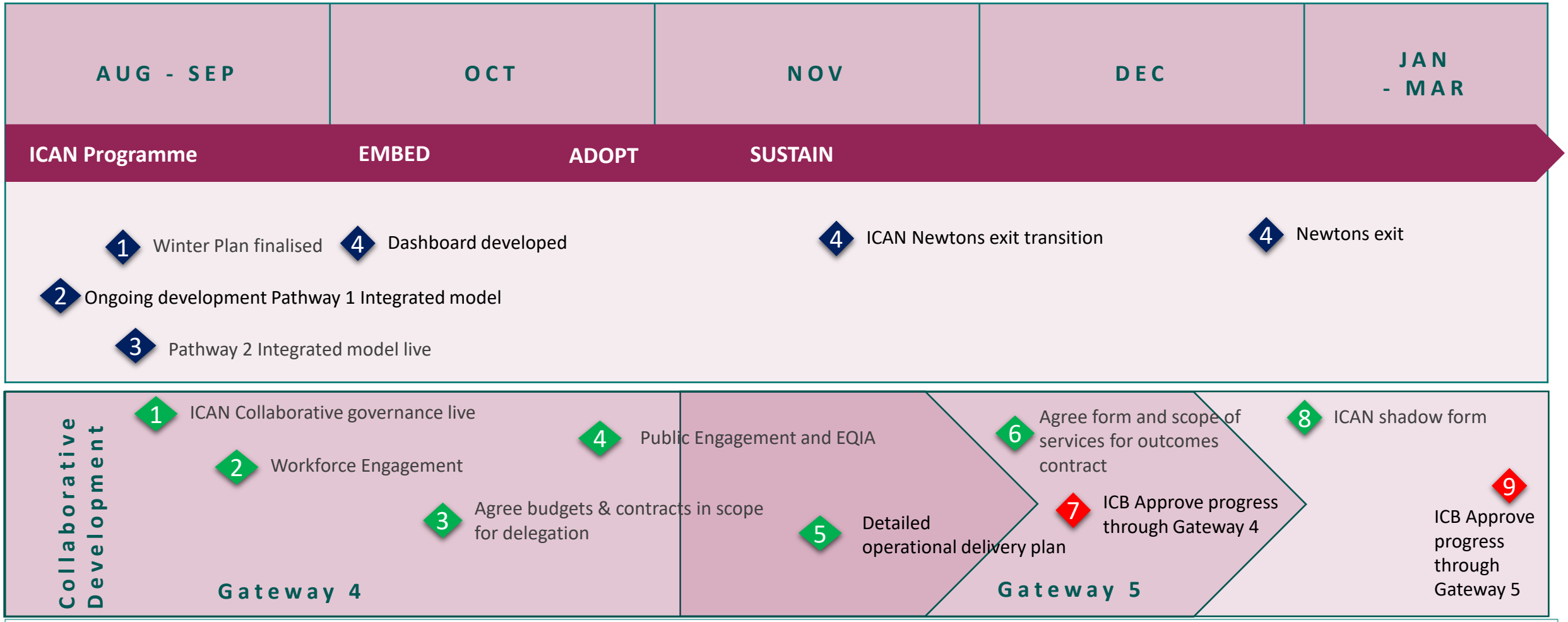
For the ICS

- We focus clinical time across the system on those that require acute or urgent interventions with more services available to help address long term conditions, monitor recovery and help people self care
- We will reduce hospital occupancy and stranded patients, so we have more capacity for electives and surge activity if required
- We will create value for money by sharing resources and estate amongst providers
- We will reduce the high costs incurred from rising unplanned care
- We will invest in preventative work and community services that also improve people's outcomes
- We will make our money go further by doing things once

For Our Staff

- I will be working in an innovative county wide collaborative offering a full range of services that delivers the best outcomes for people
- Hospitals pressures are more manageable with partners helping us manage peoples care in other settings not just acute beds
- There are more opportunities to work across settings and get more experiences that would be available in a single provider.
- I will have excellent training and development that will support me to work across the collaborative to develop my career.
- People doing the same job as me will be paid the same rates no matter where they work.

The iCAN collaborative timescales and stages



Commentary:

The timelines above represents initial thinking for the development of the collaborative and key steps in engagement, agreement on financials and delegated budgets and agreement on the contract construct as well as completion of the final two gateways of ICB approval before the collaborative could go live. They allow for the final scope of services to flex and change.

iCAN Collaborative

Case for Change and Full Story Board – version 3.2

Contents

Do last, once all content and Gateway content is agreed, and reflect slide titles here (and on Gateway slide in Exec Summary

Gateway One

Baseline

Problem statement

Too many older people get admitted to hospital stay too long resulting in poor outcomes and unsustainable pressure on staff and resources.

*How do we reduce the unnecessary admissions to the acutes, improve flow and outcomes **at the same time** as increasing and transforming our community services so that we can support more people to stay out of hospital and stay well in their own communities and homes?*

"Health is made at home, hospitals are for repair"

Nigel Crisp, 2021

Do we understand the nature of the problem?

The pressure on our acutes is a symptom of the problem we face, we still rely on too much unplanned care. We needed to be clear if this was just a result of our demographic demand or if not and where we could make changes to permanently improve performance, cost and outcomes for people. Our 2020 diagnostic findings showed a clear focus for change:

Home or Community?

Are we preventing escalations from occurring in the community?

35% of escalations were non-ideal and may have been preventable

First Response

Are we ensuring people go to the right place upon escalation?

29% of escalations reviewed could have gone to a lower acuity setting

Front Door Services

Are we ensuring the right people are admitted?

25% of admissions reviewed could have been avoided

In Hospital

Are people discharged as soon as possible?

37% of patients reviewed had no reason to reside

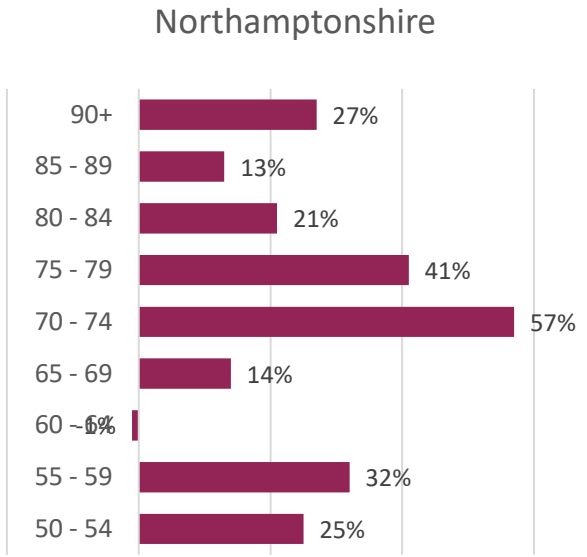
Home or Community

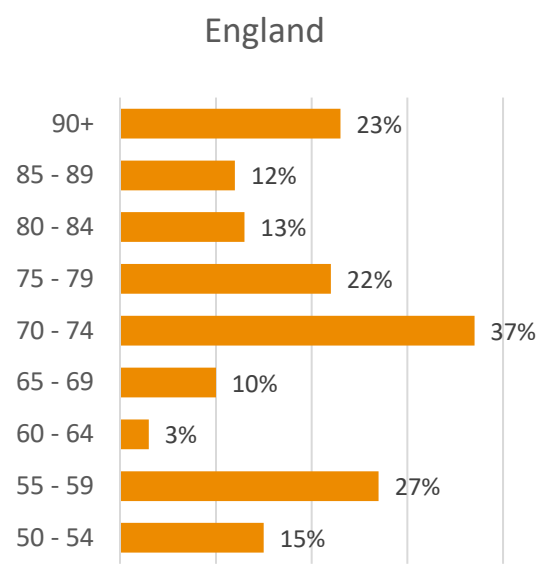
Are people discharged to the optimum setting?

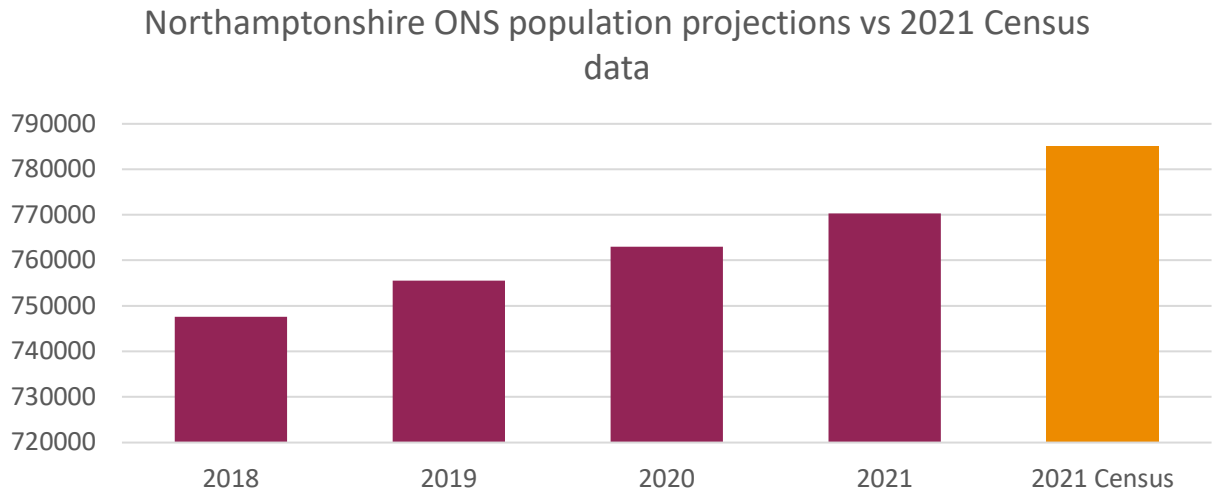
40% of patients could have received a more independent outcome

iCAN business case: the demographic challenge

- Our challenges were set to get worse if we did nothing.
- The NHSE business case for iCAN originally set out to mitigate an expected 2% increase in over 65s demand with increased numbers and increased complexity of needs
- The programme targeted an annualised £13.3million of operational savings, all of which was cost avoidance
- In the 2021 census (figures opposite), the most notable increase is in the over 70s. Frailty increases with age, therefore having more people over 75 creates a disproportionate demand for support services.
- We need to continue the ICAN work to mitigate the potential impacts of this growth on both cost and quality
- Across the county, the overall population increase according to the 2021 census data was 13.5% - over twice the England rate of 6.6%.







Progress against ICS comparators

At the start of our transformation journey, we admitted more older people to hospital, who stayed longer and were more likely to exit hospital into 24 hour care settings.

Our first improvement in 2018 was to go from the second worst nationally for discharge from hospital to residential or nursing homes to one of the top twenty authority areas in the country.

Our second improvement was to decrease our super stranded patients from almost 400 to just above 200 achieved in 2019.

The third and more recent positive change was to admit fewer older people.

We are going further with integrated community bed pathways in 2022/23.

We still have a lot to do but with our demographic growth above the average for England (particularly in the over 75s) we need to build on this and go further just to stem the effects of this growth on health and care.

STP / ICS	Unplanned Hospital Admissions May 2022	Population	NEL as % Rate of pop	Change from 2021 same three month period
Northamptonshire	**5,559**	**736,219**	**0.755**	**-8.90%**
Nottingham and Nottinghamshire	11,192	1,043,665	1.072	-6.60%
Peterborough and Cambridgeshire	8,082	892,627	0.905	-5.70%
Coventry and Warwickshire	9,829	949,454	1.035	-3.80%
Dorset	8,116	773,839	1.049	-3.70%
Beds, Luton and Milton Keynes	8,328	950,874	0.876	-0.70%
Joined up Derbyshire	9,331	1,026,426	0.909	-0.40%
Hereford and Worcestershire	6,421	788,587	0.814	0.10%
Leicester, Rutland and Leicestershire	7,797	1,100,306	0.709	1.50%

GP practice demand and priorities

Primary care sits at the heart of our communities with a multitude of dedicated staff delivering care around the clock in every neighbourhood. Our GPs are the first front door to health with 17,000 consultations a day in general practice across the county.

Despite record numbers of appointments patient satisfaction is low due to challenges in accessing care …. At the same time, primary care teams are stretched beyond capacity, with staff morale at a record low. There are also significant workforce gaps with many GPs retiring and no one to replace them

The recently published Fuller Report states "***Left as it is, primary care as we know it will become unsustainable in a relatively short period of time".***

The Fuller report goes on to propose a new vision for integrating primary care, improving the access, experience and outcomes for our communities, which centres around three essential offers:

- **Streamlining access to care and advice** for people who get ill but only use health services infrequently: providing them with much more choice about how they access care and ensuring care is always available in their community **when they need it**
- **Providing more proactive, personalised care with support from a multidisciplinary team** of professionals to people with more complex needs, including, but not limited to, those with multiple long-term conditions
- **Helping people to stay well for longer** as part of a more ambitious and joined-up approach to prevention.

ICAN is helping GPs build these services for over 65s but we have more to do together to develop a health and care offer that's sustainable longer term.

Supporting GP practices

- To optimise opportunities in the iCAN programme, we need general practice to be at the heart of neighbourhood teams supported by and working with community MDTs, social care and voluntary care services.
- The current model of care and the significant demands placed on general practice for ‘same day demand’ services, does not currently enable general practice to fully engage in this ICAN programme.
- We know that patients with complex health needs benefit most from continuity of care and therefore we need to empower general practice to design a new model of integrated care to keep patients well, in their home and supported by local communities.
- Significant progress has been made with the development of remote monitoring, caseload management and virtual wards, all of which could be integral to a new model which is focused on delivering preventive interventions for people with complex care needs
- We need to build on the national specification for *'Enhanced Health in Care Homes'* but equally ensure patients that are able to live independently in their own home are well connected to a support network.
- GPs could play a significant role in supporting patients in community beds (step up) and collaborate with other partners such as ICT and EMAS to avoid admissions and in facilitating early discharges on a supported package.
- We have over 700 (350 WTE) GPs working in the county, if we could protect their time to deliver continuity to complex patients, then we can transform care to patients that most need it in a way that previous transformation projects have not achieved.
- Our ambition is to keep patients with complex health needs out of our urgent care system by providing an integrated proactive service.

Developing an integrated model

- To support a new model of care, **we collectively need to redesign our urgent / same day demand services**.
- There is an opportunity to radically change the way the ICS partners deliver these primary care services in an integrated model with the potential of a single front door, centred around a clinical assessment service with a co-ordinated network of services to meet patient demand.
- **General practice is a critical partner in this model** and any changes to ways of working and approaches needs to be in a controlled way to enable our complex care model to be fully realised.
- Equally there is an important role for primary care - pharmacists, opticians and dentists to work with GPs and other system partners to support the management of complex patients and ensure effective health and care integration
- We need to think differently about how patients access some services and potentially move away from the GP being the gatekeeper to some pathways, this will require redesign across the ICS.
- To achieve this, the ICS needs to develop a different relationship with general practice: built on trust and recognition of the central role and impact that general practice has at a neighbourhood, locality, place and system level.
- The ICS needs to facilitate an environment for a sustainable, resilient and flourishing general practice sector.

- **A key next step in progressing our ICAN collaborative will therefore be working with our GPs (and wider primary care) to ensure that the design and development of Tranche 1 ICAN collaborative services works for them we connect in the additional services and offers to help manage community demand**

Public Co-production and development of “I” statements

At the heart of ICAN sits people. So we asked them what they wanted from health and care of the future. They said **“I want…..”**

Time to be listened to by health professionals who consider all of my needs not just a single medical presenting issue

Services to be available locally to me, timely access to my GP and less time spent travelling to hospital for appointments.

To have a support person to help me through my Ageing journey who I can go to and can help me to navigate where needed

To tell my story once and it be heard by all those who are supporting me

For me to gain skills and confidence to help me manage my long term conditions rather than my long term conditions managing me

To have the same choice and opportunities whether I am living alone, whether I have a carer or whether I am in 24 hour supported accommodation

When I am in a crisis I want to receive timely and coordinated care in the best place for me at the time

For me and those supporting me to make use of technology but not to the exclusion of actual personal contact – the choice is important for me

Outcomes: Resident "I" Statements – iCAN in 2025

If we get it right, what would ICAN mean for people in 2025 and what would their care look like?

Self care and prevention	Timely access to primary and community care	Enhanced care and support in the community	Rapid and coordinated urgent care and crisis response	Emergency and acute care
I am able to look after my physical and mental well being day to day. I am able to access self-care advice when needed. I know where to get guidance on the resources I can use from the health and social care system. I will be able to access patient education courses. I feel supported to manage my own condition. I know who to call if I want more information	If I need an appointment on the same day I can get one with a member of the community health and social care team who knows what care I have been receiving elsewhere. I am referred promptly to other services when needed. I am linked in to the wider voluntary and community support networks in my area. My mental health needs are given equal priority to my physical needs.	I am central to creating my care plan – no decisions about me without me - I have a named key worker who helps me to navigate the system. My care plan is based on what matters to me and is shared across partner agencies. I can access short or long term care depending on my needs. My care is reviewed regularly with me.	I can access the same level of treatment at any community care facility. I can access crisis response services in a timely way day or night. I have rapid access to community services when needed. I understand alternative options to the Emergency Department and am given support to access them where needed.	I will be seen promptly if I need to attend ED. Decisions about my diagnosis and care will be made quickly. If admission is necessary, I will have a comprehensive plan for my discharge in place I will not be in hospital for longer than is necessary. I will be returned home as the first and preferred option.

Engaging patients – the People Advisory Group (PAG)

It was important at the outset of the ICAN transformation that we engaged the view of patients and voluntary sector partners in our design and the development of our offer..

The PAG gives the people group (including those who will benefit from the use of services or who care for people who use them) oversight of the developments that occur within the iCAN programme. Meeting monthly, the PAG also promotes, aids and helps to develop co-production of services.

Membership is formed of patients, carers and service users, and includes key professionals and service leads will also on occasion be invited to present to, or update the group on key issues.

Key features of the PAG

- Experts by experience collective
- Oversight and advisory function for iCAN from patients, carers and service users
- Co-production promotion
- Specific brick and workstream co-production work
- Meets monthly and produces key messages that are shared within iCAN
- Supports specific case study learning
- Action log working method

Who else is involved in iCAN – the collaborative partners

The iCAN programme has engaged a number of organisations and system partners in the design and delivery of services. The voice of the patient and VCS is also represented by the People Advisory Group (APG), the chair of which sits on the Executive Board and Delivery Board.

NHS Northamptonshire Integrated Care Board

Primary Care

NHS Northamptonshire Healthcare NHS Foundation Trust

NHS Northampton General Hospital NHS Trust

NHS Kettering General Hospital NHS Foundation Trust

Northamptonshire Carers

Public Health Northamptonshire

West Northamptonshire Council

North Northamptonshire Council

The iCAN programme continues to build its partnership to include a wide alliance of partners including:

VOLUNTARY IMPACT NORTHAMPTONSHIRE IN

Community Pharmacy

Northamptonshire Police

People with Lived Experience

NHS East Midlands Ambulance Service NHS Trust

PCNs and GP Confederations

healthwatch North Northamptonshire and West Northamptonshire

What will iCAN mean for professional care staff and clinicians

iCAN care will be personalised for the frail person who needs support, with coordination of health and care professionals who will have access to a menu of responsive and available services to preserve independence and autonomy.

Co-production and coordination of care with people and their carers, connecting with the community in the place where they live.

Range of services available to choose from and support for people to make choices about their care

Co-ordinated care supported by a frailty **MDT** including the voluntary sector working with health and care staff enables people to look after their own health and facilitate professional communication

Proactive care and plans to reduce the reliance on reactive care currently provided in the hospitals in our system

Shared digital information to support efficient working and adherence to individual choices and to avoid people having to tell their storey multiple times

Efficient and easy routes to diagnosis, therapies and other treatments to reduce patient, carer and staff frustrations

Support for independence in the person's own home and community as much as possible, with focussed and brief contact with inpatient services when necessary

Patients leaving hospital as soon as they have no reason to reside via a timely and efficient discharge and returning **home as soon as possible**, avoids long term deconditioning and loss of function

What care staff and clinicians say about iCAN

Working across the system has allowed staff to cross fertilise ideas and learn about people and service delivery they had no knowledge of before

The iCAN programme has engaged staff and they see their feedback being listened to and acted on improving staff satisfaction

The ability to improve quality outcomes supports the clinical staff and engages them in transformation

Staff feel part of something bigger and believe they can effect positive change

iCAN gives staff across the system a single vision and purpose focussed on patients and outcomes rather than organisation which they feedback is highly motivating

iCAN benefits and outcomes for people

What difference could we make if we embed ICAN ways of working permanently across our over 65 pathways?

The latest ONS data shows there are **138,200** people over 65 live in Northamptonshire

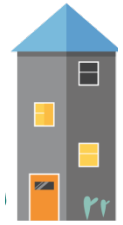
Every day, on average, **26.5** over-65s access urgent community intermediate care

Every day, **149** over-65s come to ED, **93** are admitted into hospital as an emergency admission, with **711** in a hospital bed at any time *

Some people will still have a need that must be addressed, but we could support more people with a mix of urgent and routine **community based** services

By supporting people differently in our community, some of those people could remain healthy and well at home, their **needs not escalating**

By supporting people differently in our community, some of those people could remain healthy and well at home, their **needs not escalating**



Some people will still have a need that must be addressed at the Emergency Department but we could help more of them, potentially with short term support, to **go home, rather than be admitted**

We could support more people who have had a need that must be addressed by admission to hospital to be **discharged home** on Pathways 0 or 1 rather than Pathways 2 or 3

75-79 people a day will still have a need that requires them to be admitted to hospital, but we could help them **return home quicker**

By 2025

HOME

At any one time, **170** more people every day would be at home, not in hospital

* June 2022 snapshot data

What our plan means in practice for our residents

Stanley's story – a case study of the lack of preventative additional planned care

Stanley

Stanley was living with and being cared for by his daughter.
His daughter was struggling to cope with supporting her father's complex care needs.

Non-Compliance

Stanley actively stopped taking the medication prescribed for his increasing oedema as he felt a burden to his daughter and wanted access to respite care.

Escalation

One day, Stanley's daughter called the ambulance when she found that her father was unable to mobilise due to the swelling in his legs.

He ended up remaining in hospital until his oedema had been brought under control. By this stage he had to be put on the complex discharge list and was facing a long wait.

Before the Escalation

Hospital

Formal Support

He was receiving support from the community nursing team to dress diabetic ulcers on his leg twice a week.

Since it was not the same community nurse dressing Stanley's leg each time, the nursing team did not flag Stanley's oedema worsening.

Admitted to Hospital

Stanley was conveyed to the ED at Kettering General Hospital and admitted.
Because Stanley was unable to mobilise he could not be assessed by the therapists within 72 hours.

"Everyone is looking at a part of a patients care and assuming someone else is doing the rest...surely the therapist will do this.. surely the oncologist will do this....there are a lot of assumptions...which is my frustration with the system and leads to patients missing out"

General Practitioner

Stanley's story
How would our practitioners could have done things differently

Stanley

Stanley was living with and being cared for by his daughter.
His daughter was struggling to cope with supporting her father's complex care needs.

Non-Compliance

Stanley actively stopped taking the medication prescribed for his increasing oedema as he felt a burden to his daughter and wanted access to respite care.

If Stanley had received a **structured medication review** to better understand his non-compliance and with access to a **step-up bed,** the workshop think that his oedema could have been brought under control and the escalation to A and E averted.

Before the Escalation

Hospital

A holistic assessment of Stanley's needs had the potential to avoid this decline altogether.
Had the underlying cause of Stanley's non-compliance been addressed: accessing a carers assessment for his daughter, access to respite care, carer support, a wellbeing assessment for Stanley.
Intervening early and planning for Stanley's needs could have helped avoid the decline.

With **greater continuity** of the practitioners involved, the declining condition may have been flagged before it reached crisis point.
This could be achieved through more comprehensive **care planning** to look out for certain signs, or a **digital solution** to share images between the practitioners involved in Stanley's care.

All changes are vital to supporting Stanley to live well in the community

Stanley

Stanley was living with and being care for by his daughter.
His daughter was struggling to cope with supporting her father's complex care needs.

Non-Compliance

Stanley actively stopped taking the medication prescribed for his increasing oedema as he felt a burden to his daughter and wanted access to respite care.

Sometimes Stanley and other frail residents will experience a crisis. Ensuring our escalation and community teams have the knowledge and support to make the best **escalation decision** will ensure that Stanley can access any of the urgent community care provisions in the county that would benefit him.

Support our community and escalation teams to have an accurate **perception of the urgent community care** provisions will help break down and blockers that exist to access these services.

Before the Escalation

Hospital

A holistic assessment of Stanley's needs will ensure that we have the **right plan** for when he escalates. It will set his baseline so practitioners know when his needs are increasing.

It will also mean that he can access the **right people** so that he receives the planned services in a timely manner to enable him to live independently in the community.

Having a baseline and a plan will enable practitioners to have the **right support** to fully appraise whether someone's needs are increasing.

However, without better communication between services, we won't be able to meet Stanley's increasing needs. Ensuring the **right people** are available to our community practitioners to enable Stanley to stay in his home.

What will iCAN mean for - Mavis Ageing Well in 2025… "I will have…"

Ageing Well is a national programme that recognises people **can now** expect to live for far longer than ever before.

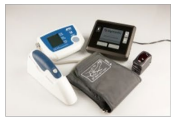
But these extra years of life are not always spent in good health, with many people developing conditions that reduce their independence and quality of life.

Our Age well plans with ICAN working with GPs aims to help older people manage these long-term conditions, making sure they receive the right kind of support to help them live as well as possible and have greater control over the care they receive, with more care and support being offered in or close to people's homes, rather than in hospital.

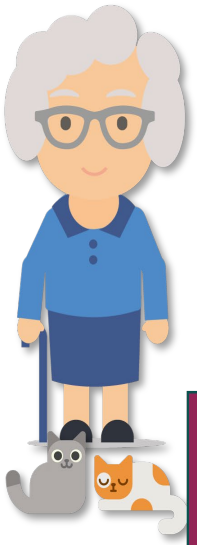
Befriending if I want this

Assistive Technology to maintain my independence

Personalised Equipment to help me self manage my health



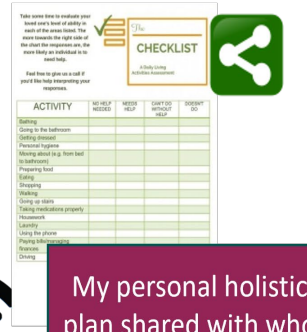
Access to range of local community activities and support groups (in person or virtual)



Mavis

Free Wi-Fi and digital platforms

Proactive remote monitoring and reassurance that support is quickly available if I need it



My personal holistic plan shared with who I choose and reviewed regularly with me.

Backed up with timely access to specialists as my needs change

My go to named person from my local integrated team

What happens if we do nothing?

Without iCAN Improvements:

Outdated ways of providing care with an over reliance on bedded care, in the face of escalating demand and elderly population, increasing emergency hospitalisations and long stays,

Elective backlogs remain and duplication of services result in a struggling workforce, high running costs, inefficiency and overspending.

With iCAN Improvements:

Shift care into the community relieving pressure on hospitals and reducing the cost of unplanned care;

Undertake major reorganisation of care to remove waste and duplication;

Improve efficiency by reducing demand supporting a reduction in escalation beds and remodelling of hospitals.

Without iCAN Improvements:

Health outcomes decline as GP/ community based care struggles to cope with increasing demand; more patients suffer health crises and require emergency hospitalisation and long stays;

Planned care cancelled as emergencies rise and beds are blocked; duplication of services undermines timeliness, quality and safety of care.

With iCAN Improvements:

Health outcomes improve by strengthening primary, integrated and urgent care to support Home First approach for patients with long term conditions;

Reduce unplanned care and shift services out of hospitals into the community; reorganise hospitals to focus on acute care and support elective recovery

Gateway Two

Vision

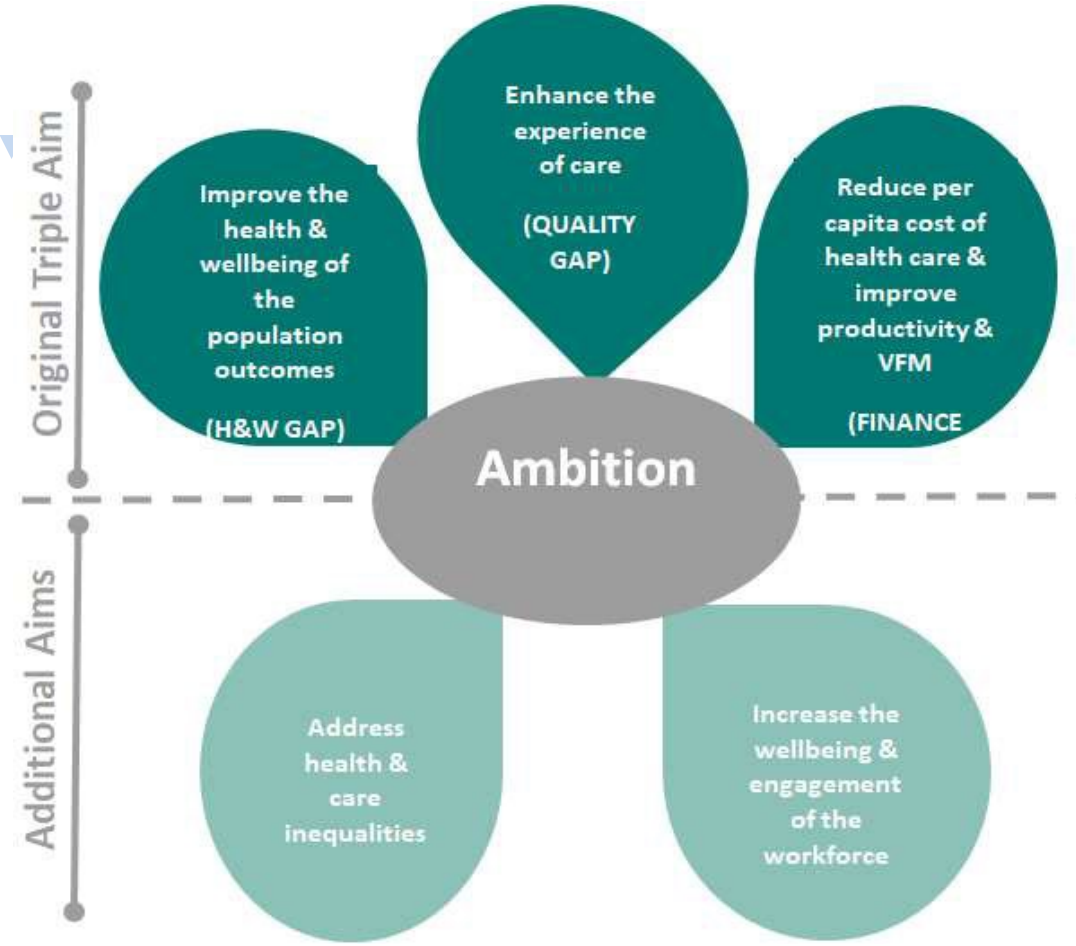
iCAN strategic alignment to our ICS

There is a strong alignment between iCAN and our ICS core objectives and ambitions

Our ICS vision	Through joined-up effort and shared resources we create a positive lifetime for all, of health, wellbeing and care in our communities
Our iCAN ambition	Greater integration across health, care and the voluntary sector will allow people to tell their story once, navigate between organisations and experience greater continuity of care

A strong sense of purpose

"Our plan is ambitious and aims to address the long-term population health needs and sustainability of our health and care system. Not only will we work in a more joined-up way in the future by delivering the health and care services people really need, but we will also transform the way we work with and provide care to the people of Northamptonshire." NHCP December 2020 Paper



iCAN collaborative aspirations

The collaborative is committed to transforming services for our patients, simplifying pathways for our stakeholders and tackling health inequalities for our residents. To this end, the collaborative is aligned to **five system goals**, the **10 ICP ambitions** and is underpinned by a framework of measures that demonstrate our progress towards them

Five System Goals

Improve outcomes for patients, service users, carers and residents of Northamptonshire who have are frail and have both planned and crisis care needs

Delivery of both **known and emerging requirements** – including NHS Long-Term Plan, Public Health Outcome Frameworks, Care Act and local Service User 'I' Statements.

Make the **best use of limited resources**, by addressing duplication and gaps within pathways and reinvesting in preventative initiatives (left-shift of system spend).

Through Neighbourhoods and place-based working enable longer-term transformation, via cross-system partnerships and integrated commissioning approaches

Reframe system relationships in **support of the Integrated Care System** aspirations, to drive sustainability, transparency and accountability.

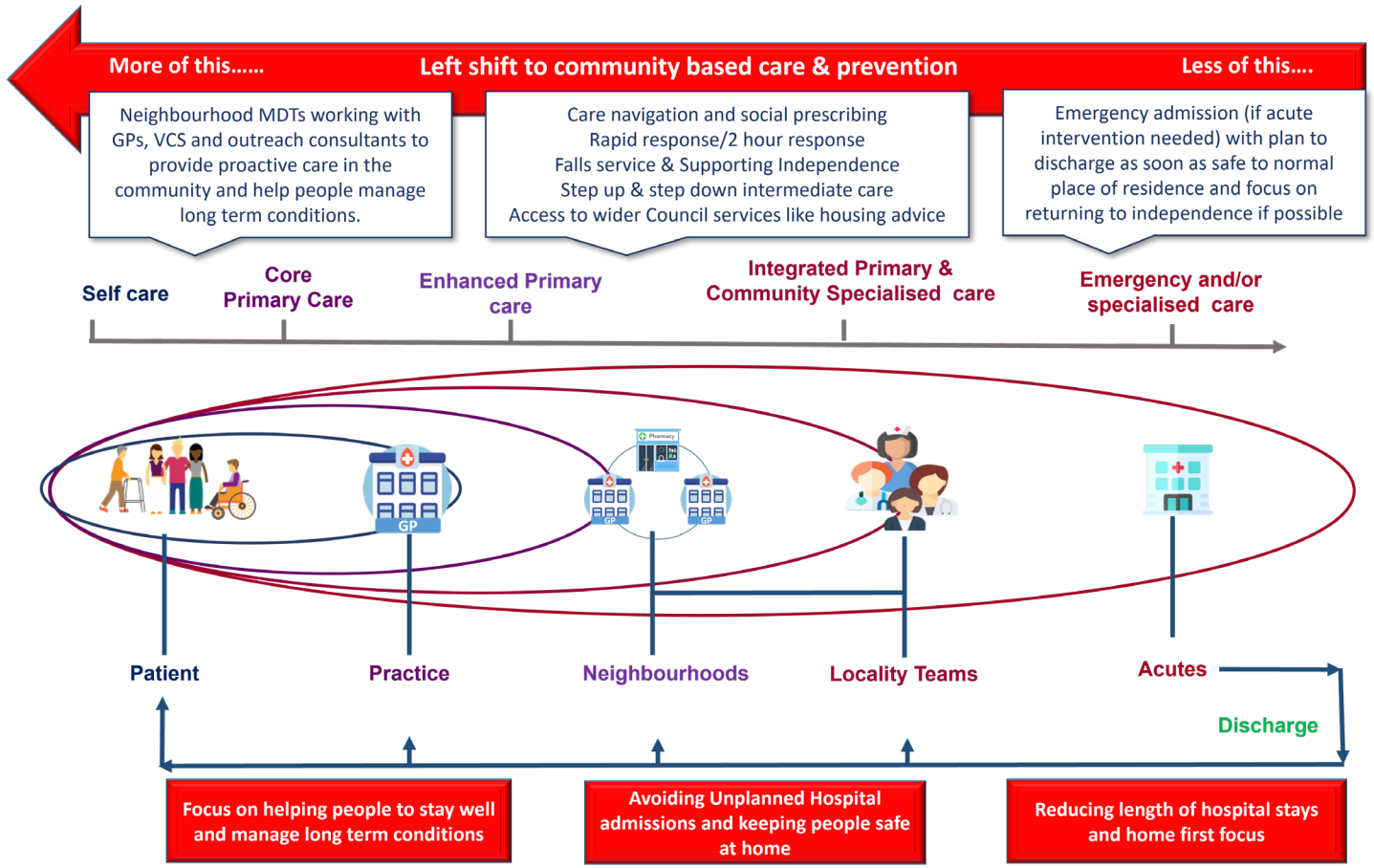
Meeting the 5 goals through ICAN – A left shift

We propose to move to a **new model of integrated proactive neighbourhood care** and away from unplanned care with a default of acute based care.

This means we will be keeping more people well or supported at home for longer, avoiding escalations and ensuring that when people do go to hospital they do not stay longer than necessary and are supported to recover in the best setting for them.

This is better for people, better for our finances and our system sustainability.

Funding might need to be refocused to the community and prevention with more delegated budgets and resources targeted based on local area profiles and health needs and less spent on unplanned care.



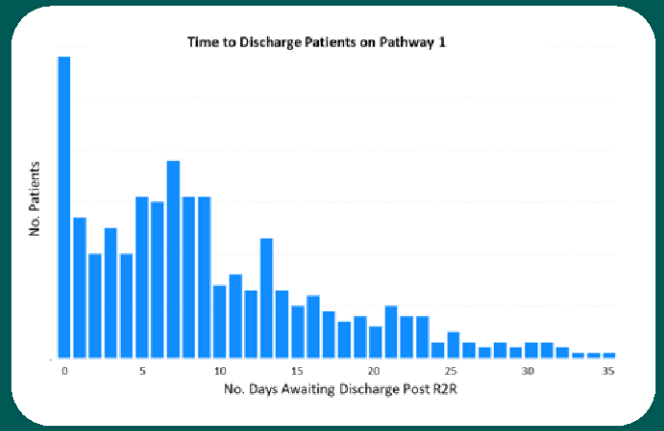
To be as effective as possible neighbourhood health and care teams need to be plugged into the wider determinants of health and a wide range of local authority and other partner services that connect to health and wellbeing including for e.g. housing, debt advice, leisure and community groups. These wider offers would be part of Local Area Partnerships put in place by the local authorities to facilitate links, access and a comprehensive community offer.

Pathways improvement: an example of collaboration

The challenge facing intermediate care pathways

- Patients who require intermediate care pathways* upon discharge from hospital are frequently waiting several days to be discharged
- This is not ideal for patients with increased deconditioning, which will increase their rehabilitation requirements and may impact their ultimate outcomes
- This is also a major contributor to long length of stay patients, leading to bed pressure in the acute hospitals
- This is caused by a combination of capacity constraints in the community, and process delays
- Through improving capacity and flow we will make the system more resilient to Winter surge pressures

The graph shown to the right shows how many people were discharged to Home-based intermediate care (P1), and how long it took from the point they were first able to be discharged. This shows while some people are discharged same-day, the majority of people take much longer.

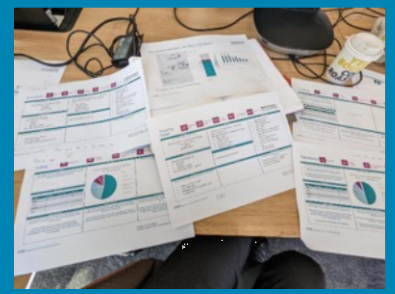


Working together collaboratively to tackle this

Working on the discharge pathway improvement sees acute, community and social care colleagues collaborating extensively:

- Improved visibility and transparency of queues and delays – working with both the Transfer of Care Hubs and the Out of Hospital services
- Referral processes – where process delays are impacting length of stay, working together to resolve root causes of delays
- Pathway 1 services working to improve their capacity via scheduling and length of stay improvements
- Pathway 2 services to improve their length of stay and therefore bed availability
- Transformation of our out of hospital beds, working in a more integrated way to maximise the community resources and deliver better outcomes for people

Colleagues from across Community Health and Social Care sharing data on Pathway 2, and collaborating on opportunities and redesigns to improve flow and outcomes for patients.



*Home-based = Pathway 1, Bed-based = Pathway 2

What success looks like: “At a glance” future benefits from ICAN

Gateway Three

Roadmap

National priorities, 'Age Well' and improved discharge

ICAN seeks to address a number of national and system priorities

- Promote a **multidisciplinary team approach** where partners work together in an integrated way to provide tailored support that helps people live well and independently at home for longer and **Give people more say about the care and support they receive**, particularly towards the end of their lives
- Offer **more support for people who look after family members, partners or friends** because of their illness, frailty or disability
- Develop more **rapid community response teams**, to support older people with health issues before they need hospital treatment (in line with the Community Service 2 hour Community urgent care response guidelines of March 22) and help those leaving hospital to return and recover at home
- Offer **more NHS support in care homes** including making sure there are strong links between care homes, local general practices and community services including the Enhanced Care in Care Homes model.
- Create a sustainable **primary care** model addressing the recommendations of the Fuller Report and building community services capacity to deliver more a robust neighbourhood model that supports care at home
- Sustained improvement in delayed discharges from health working with local authority partners and supported by the **Better Care Fund and the investment in Virtual Wards** in line with national direction
- Improve the responsiveness of urgent and emergency care and **build community care capacity**– keeping patients safe and offering the right care, at the right time, in the right setting

An underpinning objective for all will be ensuring inequalities are not created and existing ones addressed

Urgent and emergency care

The system is working to **six goals for urgent and emergency care**. These goals, in synergy with and complementary to the aims and ambitions of the iCAN programme are:

- Coordination, planning and support for people at greater risk of needing urgent or emergency care,
- Signposting to the right place, first time,
- Access to clinically safe alternatives to hospital admission,
- Rapid response in a physical or mental health crisis,
- Optimal hospital care following admission, and
- Home-first approach and reduce risk of readmission.

Why a collaborative ?

As a system we agreed in November 2020 to focus our energies on changing the way we help our older population to age well. This has been reinforced through subsequent national publications, such as The Health and Social Care White paper, ageing well programme, the Fuller report and now the national refocus of the 2022-23 Better Care Fund on two themes, "***stay well, stay safe and stay at home longer***" and "***right care, right place, right time***". These two key themes couldn't be better aligned to iCAN and what we aim to achieve.

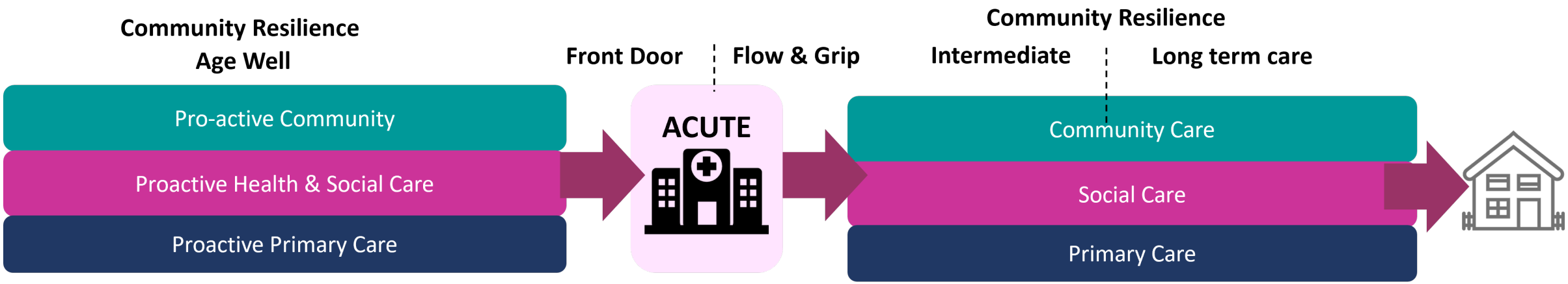
We have made fantastic progress in building a platform for the new ways of working in the community. We are already seeing signs that we are making a real difference for the people we have supported, who report feeling far more engaged in their care planning, and for professionals across the system who can see that improved practice and more joined up working is helping us deliver better services for the residents we serve. We want to consolidate these gains into a first stage collaborative structure (Age Well Service Development Funding elements) in 2023/24 to protect and ensure the new approaches are sustained.

We will continue to test new approaches to deliver a sustainable primary care-based model. We will then build onto these an extended range of services, agreed through full coproduction, to strengthen place and neighbourhood delivery in a phased sequence of additions in line with our stated five-year vision **to enable patients to choose well, live well and stay well.**

In parallel, we will continue to tackle the symptoms of an urgent care system under strain as a result of demographics and past failure to build our community resilience and offer. This has led to too much focus on urgent care and our investment has been in reactive approaches with an over reliance on bedded care and missed opportunities to return people to independence and their normal place of residence.

We have made good progress in stopping unnecessary admissions by working at the front door and implementing good practice in effective, timely discharges and step-down intermediate care and the quality of care and safety of patients. **Outcomes will continue to improve if we commit to a collaborative construct that commits us to maintaining and building on the results so far.**

Where is iCAN focusing its work?



Prevention & Avoidance

(1) Pro-active community health and social care: How are community services working together to support and maintain people in their homes
(2) Primary care: Primary services actively pre-empting and preventing escalation to urgent care and supporting people in their homes
(3) Acute admissions: The right services in the community and at the front door to prevent unnecessary acute admissions

Hospital Flow Discharge

(4) Acute length of stay: Ensuring people only in acute beds for as long as they need to be and leave when no reason to reside
(5) Acute discharge: Making the best possible decisions regarding onwards care to maximise independent outcomes and flow

Integrated Intermediate Care

(6) Community health care short term: Rehabilitation and reabling services maximising people's potential to remain independent
(7) Social care provision short term: Giving reabling care to the right people, in the right setting, and achieving the best possible outcomes for them

Ongoing support

(8) Community & Social care long term: Are people receiving the right services, meeting all their needs and achieving the best outcomes
(9) Primary Care Long term: supporting people with long term conditions management and required interventions

(10) Foundations: Single dashboard version of demand, flow and capacity and command centre oversight

How are we targeting improvement ?

From the analysis of the issues we identified key areas of opportunity and improvement to relieve system pressure and improve performance against national metrics and policy, while in parallel investing on long term community change.

Are we preventing escalations from occurring in the community?

Are we ensuring people go to the right place upon escalation?

Are we ensuring the right people are admitted?

Are people discharged as soon as possible?

Are people discharged to the optimum setting?

5% reductions in over-65 escalations that would have resulted in admission

5% reduction of over-65 attendances that would have resulted in admission

5% reduction in over-65 admissions from ED

7% reduction of over-65 bed-days through reducing the Length of Stay

A reduction in the number of 'Stranded' and 'Super Stranded' patients *

An improvement in the number of patients with a 'Reason to Reside' recorded **

5% reduction in the cost of care for over-65s upon discharge

These targets were set for the first two years of iCAN while we were supported by externally contracted partners

* Against a baseline of 660 patients per month
** As measured against October 2021's baseline data

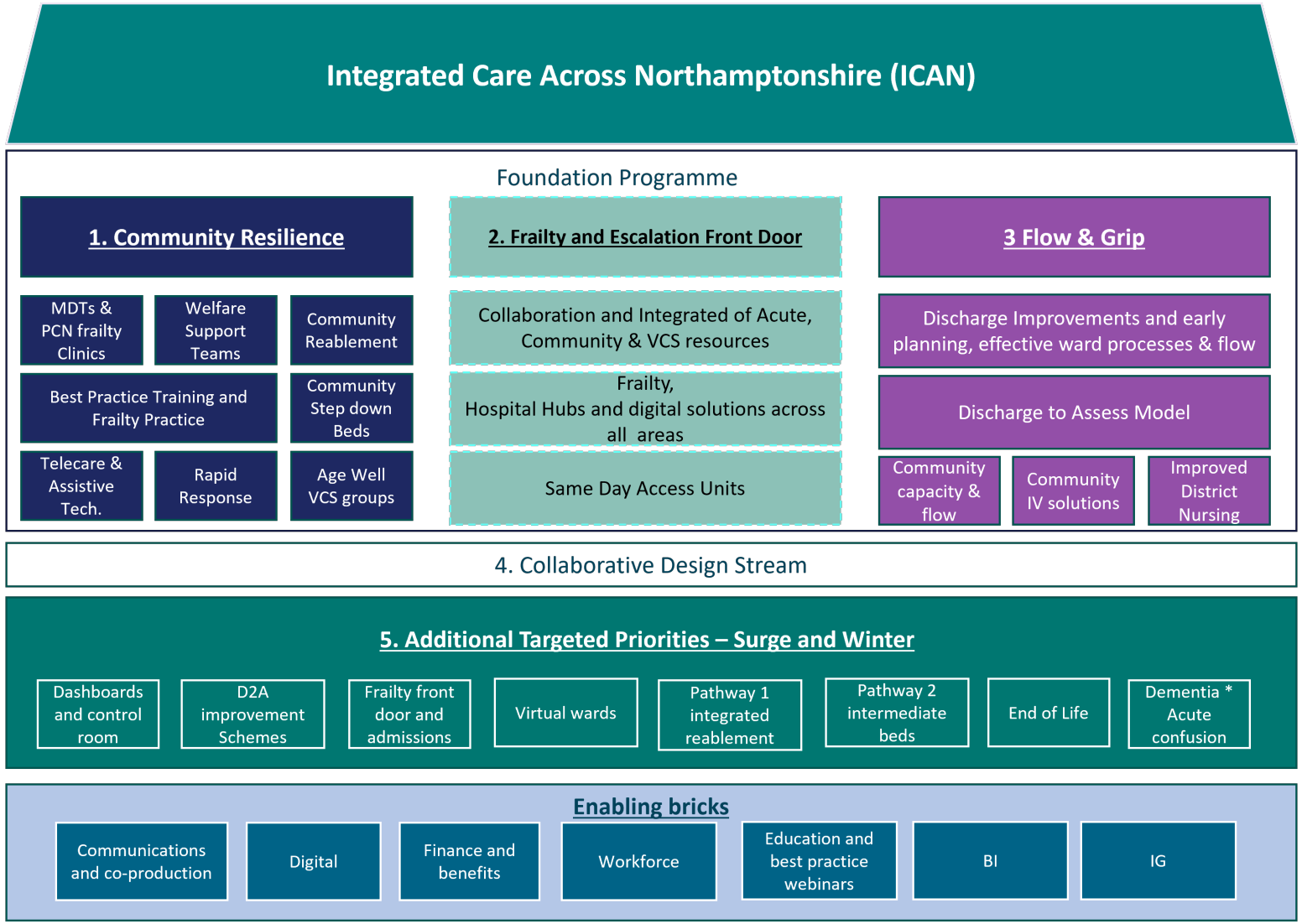
How will iCAN deliver it objectives

Partners across the system worked together to define how the programme would target these areas for improvement.

The programme began with three core streams or ‘pillars’, one for each of our focus areas and the delivery of improvements across our settings of care and all partners (‘foundation programme’).

A fourth stream of work is focused on the development of our collaborative (our collaborative Design Stream) and building on our programme learning and success to gain system agreement on the shape and scope of a formal collaborative for future delivery.

Given the repeated challenges of COVID surges and winter in 2022, we created a fifth short term focused stream to accelerate key activities and improvements needed for Winter 2022 and to stop future winters and surges leading to Tactical actions that undermine our goals (‘Winter and Surge Stream’)



Community Resilience Summary

Our Community Resilience mission is to...

Maximise independence and long term happiness by helping more people remain at home and thriving in their community

Provide holistic planned care in the community which reduces avoidable escalations

Reduce unplanned primary and community care demand

through...

Taking a strengths based approach to independence

Providing linked community services of the right size and quality to meet demand

Making appropriate interventions to reduce escalation

To achieve this we will...

Forge a strong network of community links, volunteer, health and social care services

Put the person at the centre of their care, leveraging remote monitoring and anticipatory care as appropriate

Provide urgent community response and deliver the aging well vision

Proactively support the hospital discharge and recovery programme

Use data and technology to inform people's needs and give us live visibility of what actions we need to take

What the Frailty, Escalation and Front Door work is targeting?

Our frailty, escalation and front door mission is to...

Enable people with frailty to access the services they need

Prevent avoidable admissions into the acute setting

Give people input into the care they receive

through...

Providing easy access to the information required for decision making

Listening to what our population wants and needs

Co-production between acute, community, and voluntary sector services

To achieve this we will...

Use data to guide improvement processes and ensure positive change

Increase knowledge of frailty system-wide through training

Connect ED staff to community and specialist services

Keep people informed and involved in care decisions

Support EMAS to utilise the appropriate pathways

Promote connections between primary care (GPs) and ICT

What our Flow and Grip work is targeting?

Our flow and grip mission is to...

Reduce unnecessary time in hospital beds

Maximise independence by helping more people return home

Improve the experience of people in our care

through...

Improving ward flow and control

Embedding true discharge to assess

Putting the person at the centre of their care

To achieve this we will...

Use data to give us live visibility of what actions we need to take

Connect hospital teams to community services

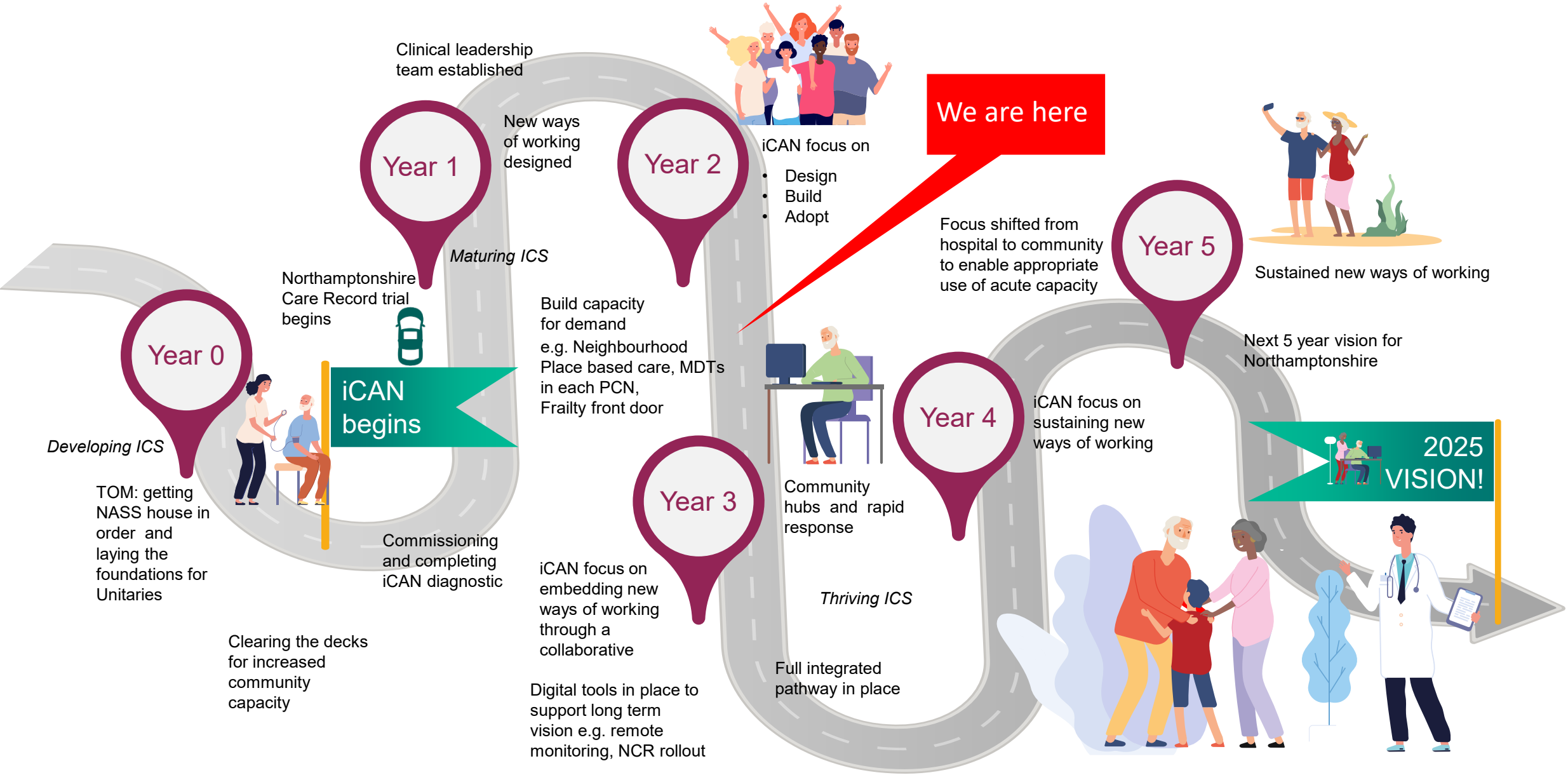
Keep people informed and involved in care decisions

Optimise tests and procedures both in hospital and in the community

Stop long-term care assessments in hospital

Commissioning the right services to meet peoples needs

The iCAN five year transformation programme



Building the collaborative in phases

We believe the collaborative will need to be built in phases or Tranches as our ICS strategic plans develop. The proposed Tranche 1 collaborative services for iCAN reflect the work in the iCAN transformation Programme and include the out-of-hospital services that we think will achieve our aims. This will mean a continued focus on building community resilience, reduced admissions and ensuring timely discharges but also building integrated Health and Care teams around key pathways like pathway 1 and 2 services.
The model excludes services commissioned through GP contracts – we would develop the iCAN collaborative services working with GPs and system partners to ensure we are aligned to the future CAS **(Clinical assessment services)** /Same Day/Urgent Care strategy agreed

Tranche One:
Collaborative live April 2023 includes all services

Tranches Two onwards:
Commence as/when additional partners are ready to align activity with iCAN Outcomes Contract structure and/or the urgent care strategy is developed

ICAN Collaborative Tranches

Tranche One:
Most services set out in slide 7 including: 1) Shared Access points 2) Integrated MDT Approach to Community Health & Care 3) Integrated Discharge / intermediate Care Service (including P1 & P2 services) and 4) Winter and Surge Planning & Response

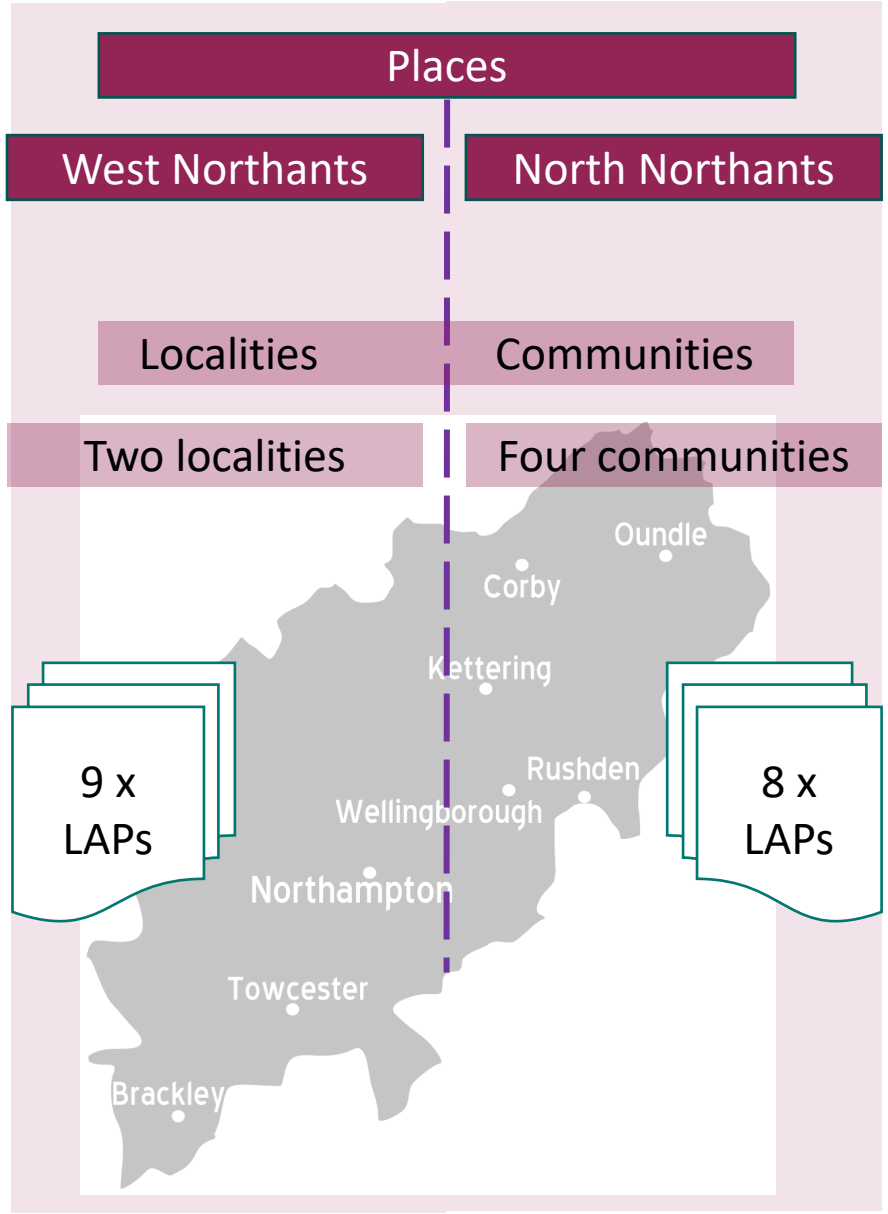
Tranche Two:
Tranche 1 services plus wraparound services required for CAS and agreed health and Care neighbourhood model for Same Day Services

Tranche Three:
Tranches 1 and 2 plus acute services (outreach), unplanned care for extended age range

iCAN Programme - Foundation Services

- Prevention and avoidance
- Hospital flow and discharge
- Community Resilience

Northamptonshire's approach to place development



Place: Understanding and working with communities; Joining up and coordinating services around people's needs; Addressing wider determinants that influence health and wellbeing; Supporting quality and sustainability of local services

Localities/Communities: Consolidating the views of residents, local providers and local area partnerships, oversight and co-ordination of care, unblock challenges, support local area planning.

Local Area Partnerships (LAPs): Represent local areas and give a voice to residents, translating strategy into local action by delivering the outcomes framework. They contribute to system-wide priorities as the delivery vehicle, providing a strong evidence base through quantitative data (digital footprint) and deep local insight from frontline partners, empowering local leaders to take accountability for local action. **For health and care specifically, neighbourhood teams service delivery will support LAP approaches**

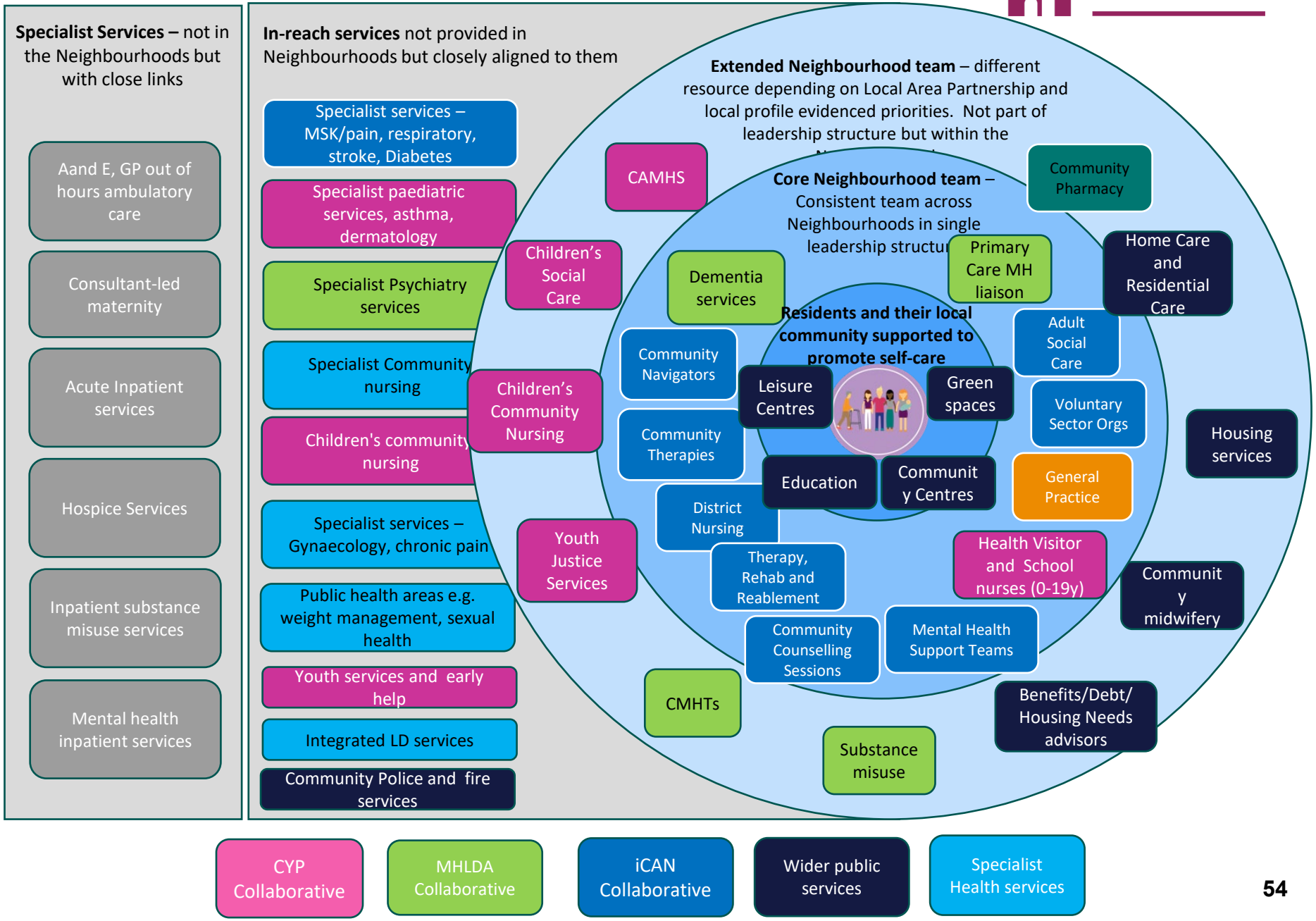
How might the future model of integrated community care look?

A new comprehensive Neighbour model of integrated Health and Care will take time to develop. We will need to engage with stakeholders and communities to design it.

A range of services will operate based on locally identified need as part of wider Local Area Partnerships (LAPs) with health and care and GPs, police, community safety, housing, leisure, voluntary sector services working as collaborative services.

More specialised services will be delivered on a different footprint as appropriate for the usage, cost and location requirements.

Health and Care will operate on a neighbourhood model aligned to GPs to help



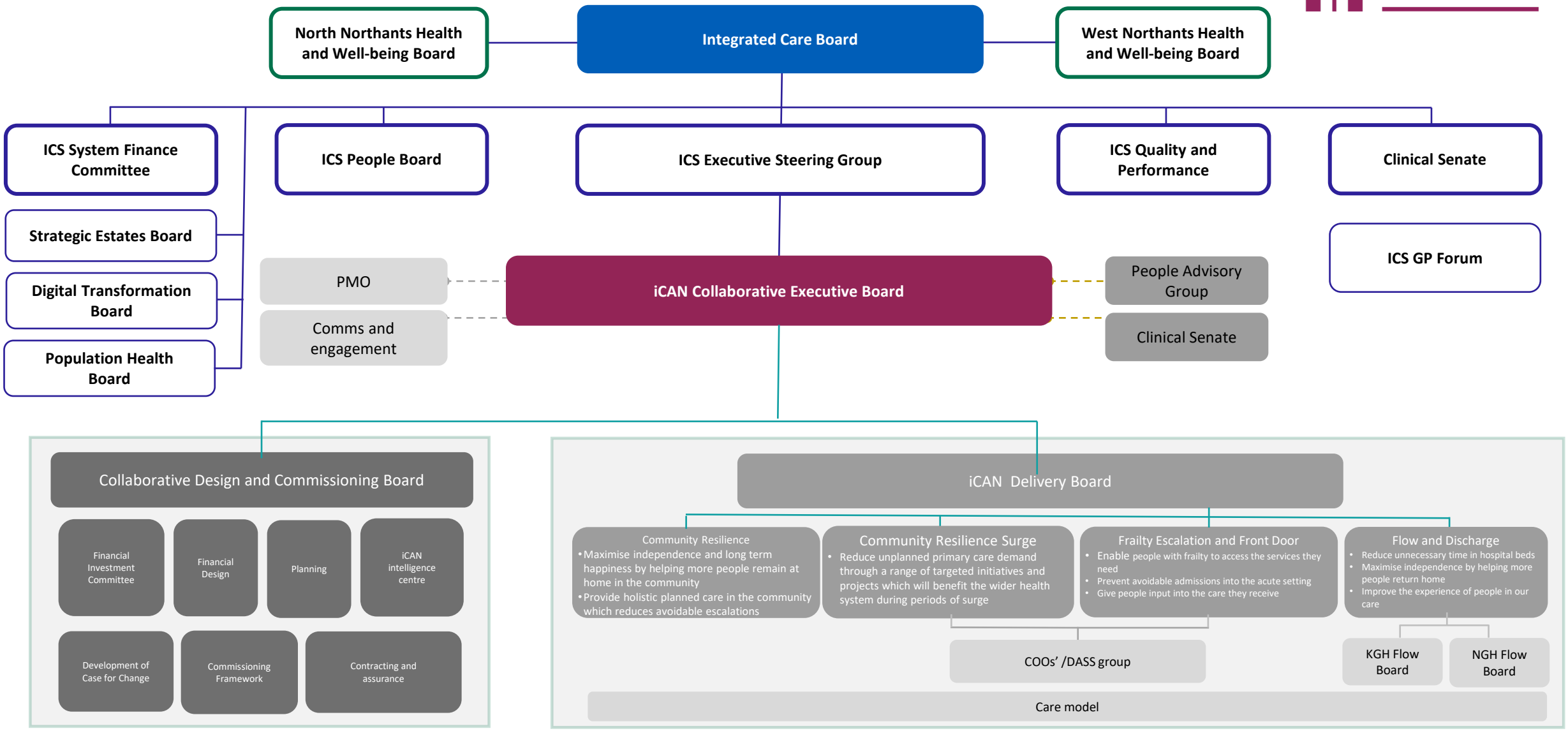
Gateway Four

Governance and accountability

Developing our new delivery vehicle

- In order to deliver our ambitions, we have developed a proposed governance structure that will help transition us from a transformation programme to a service delivery model. This new governance arrangement would take effect from September 2022.
- Between September 2022 and the end of the year, we would need to enter discussions on the scope of services we have proposed and what resources and delegated Budgets would be aligned under an ICAN collaborative and contract or delegation agreement.
- We would also need to develop an iCAN collaborative outcomes-based contract and performance framework to support the commissioning, planning and delivery of iCAN services.
- If we have agreed the scope, notional budgets and contracting arrangements then in 2023 we would propose the iCAN Executive Board would exercise functions jointly with the ICB in shadow delegation with the ambition of full delegation from April 2023, subject to appropriate assurance processes and ICB approval.
- Discussions with stakeholders to date have been high level, we would therefore seek to progress co-design work with service users on the proposed outcomes contract as well as engagement sessions involving clinical and non-clinical staff from across the acute providers, primary care, community and mental health services to make sure we had a defines set of services for Tranche 1 and understanding on how they would be accessed and operated.
- The final detailed model, scope of services and phasing will be developed with stakeholders over time as the collaborative matures and as new system models for things like the CAS and urgent care are developed and agreed by partners.
- We believe working together in a collaborative way will help us get the best from our workforce, creating opportunity and learning for them and ensuring we recruit and retain staff who work together for common aims.
- There are no plans at this stage to make any Transfer of Undertakings (Protection of Employment), also known as 'TUPE transfers' for Tranche 1 services but we want to explore how colocation and secondment models might work to ensure the collaborative functions as a single organisation.

Transitional collaborative governance structure

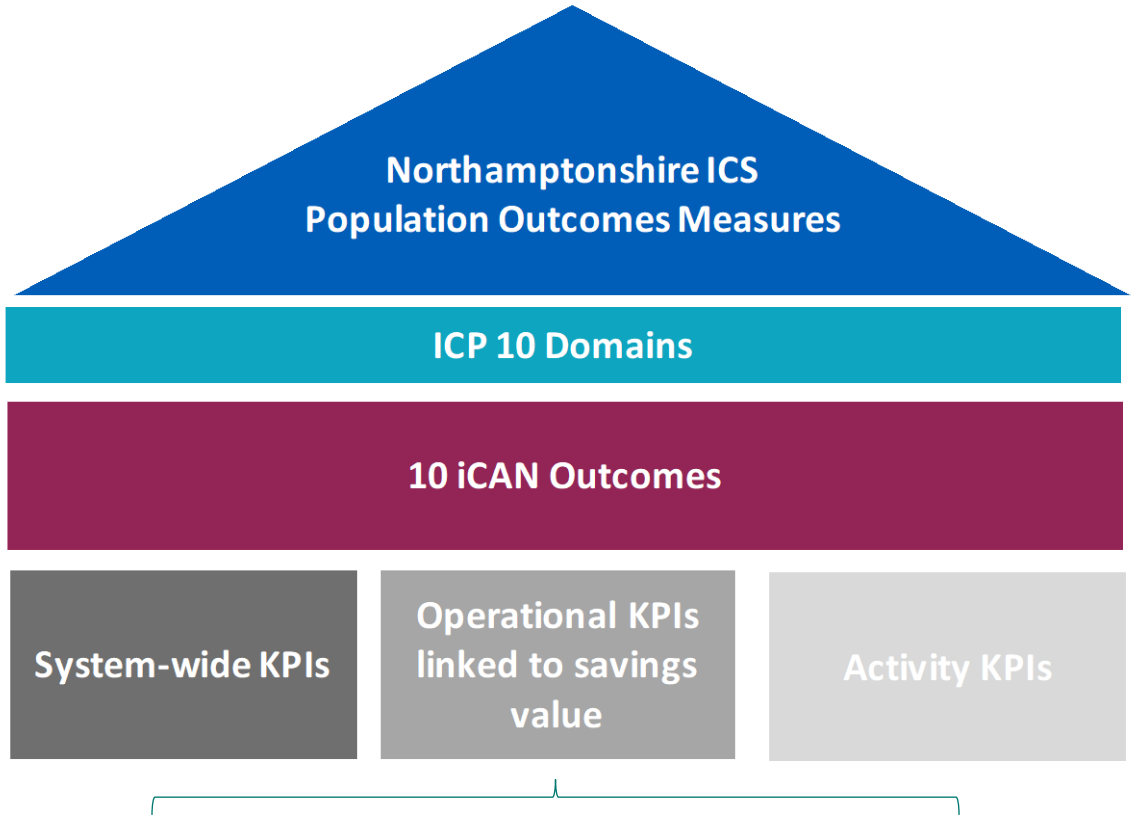


iCAN accountable decision making

Governance	Duties
Collaborative Executive Board	• Chaired by the Executive Sponsor, Chief Executive, West Northamptonshire Council • Representatives from West Northamptonshire and North Northamptonshire Councils, University Hospitals Northamptonshire, Northampton Healthcare NHS Foundation Trust, primary care, clinical leaders, Integrated Care Board, community and voluntary sector and Healthwatch • Responsible for ensuring a collaborative approach to the planning and delivery of integrated care in Northamptonshire and achieve a fully integrated model of care based on the needs of the population • Responsibility for ensuring the vision and strategic direction for the future of iCAN services in Northamptonshire is delivered, addressing the challenges of the long-term plan and population health needs • Work collaboratively and in accordance with the governance of the Integrated Care System
Delivery Board	• Reports to the iCAN Collaborative Executive Board, chaired by the Executive SRO, Director of Transformation and Quality, University Hospitals Northamptonshire • Representatives from West Northamptonshire and North Northamptonshire Councils, University Hospitals Northamptonshire, Northampton Healthcare NHS Foundation Trust, primary care, clinical leaders and the community and voluntary sector • Deliver the iCAN ambition through a series of projects that not only contribute to the longer-term development of the collaborative, but also to the shorter-term surge challenges of the system • Deliver the improvements and savings identified in the iCAN business case and move from transformational to operational activity • Define how programmes are delivered, including risks, costs, timeframes and outcomes
Collaborative and Commissioning Design Board	• Reports to the iCAN Collaborative Executive Board, chaired by the Deputy SRO, Deputy Chief Executive, Northamptonshire Healthcare NHS Foundation Trust • Representatives from West Northamptonshire and North Northamptonshire Councils, University Hospitals Northamptonshire, Northampton Healthcare NHS Foundation Trust, primary care, clinical leaders, Integrated Care Board and the community and voluntary sector • Responsible for ensuring the vision and strategic direction for integrated care services in Northamptonshire is delivered through a collaborative model which is evidence and outcome based and co-produced • Support the design and development of the iCAN collaborative model, the scope and the phasing of services therein and support the transition from transformation programme to collaborative delivery Agree and oversee commissioning activity, propose contracting and service improvements, support the development and oversight of formal arrangements

ICS outcomes framework

The following draft outcomes framework could be used for management of outcomes within the iCAN contract and Collaborative



These ICAN outcomes describe what we are trying to achieve. i.e. what service will look like when we make the changes and transform

These are the system measures and national metrics that demonstrate improvements in key areas that lead to the savings of £13m after 3 years

The 10 ICP domains have been adopted by both North and West as the key wider population wellbeing outcomes to be addressed at place level through Local Area Partnerships and neighbourhood delivery

These measures may not be directly linked to financial value but will indicate a real on the ground change happening across the system. There should be a measure for each brick

These are the KPIs which have been agreed by the BRG as the controllable measures which demonstrate real impact of the programme. These could be linked to bricks, pillars or a combination depending on the impact of the work

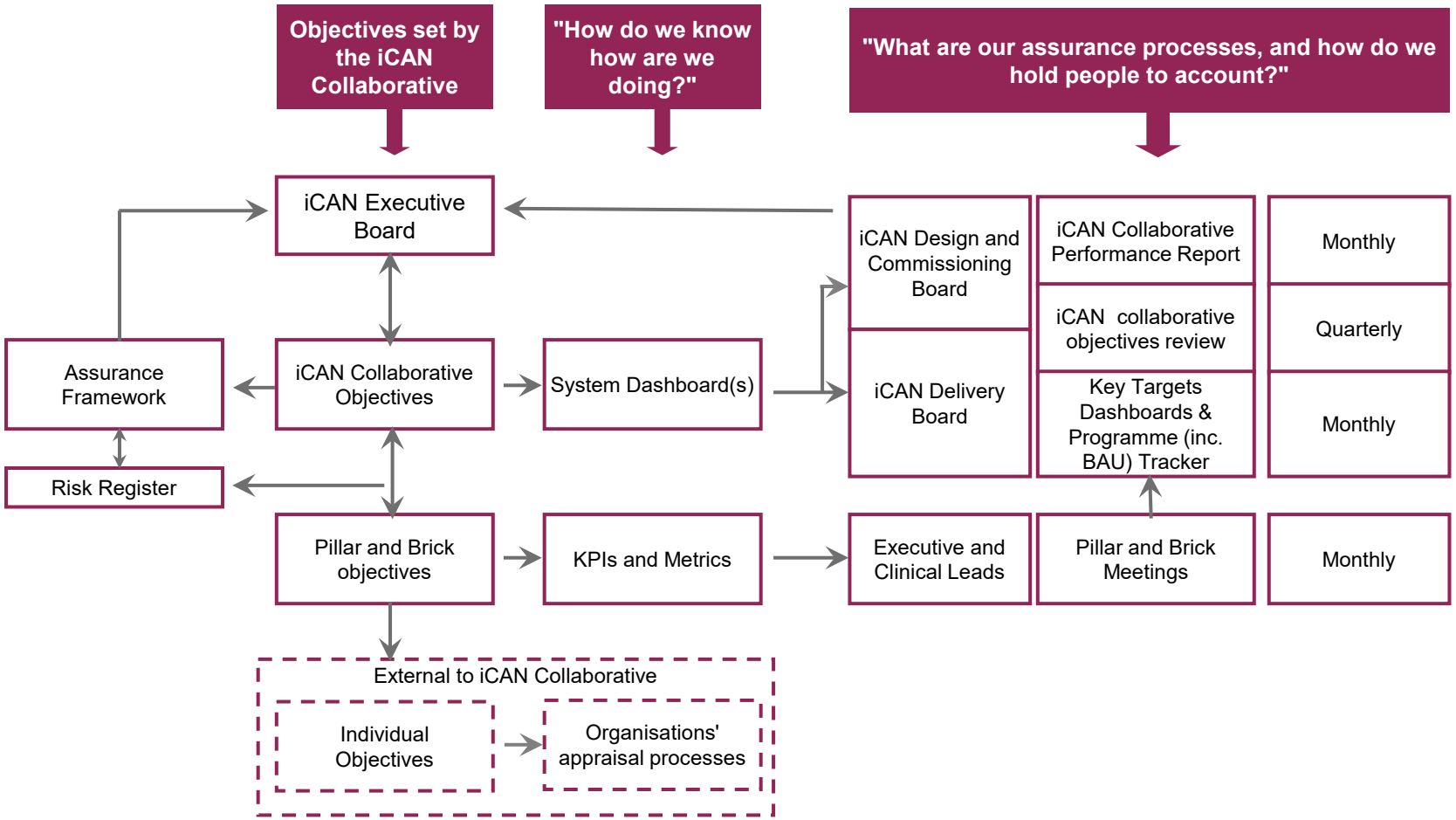
10 iCAN outcomes

1 More people remain at home in the community	6 People have input into the care they receive
2 Holistic planned care provided in the community	7 Prevented avoidable admissions into the acute setting
3 Reduced avoidable escalations	8 Reduced unnecessary time in hospital beds
4 Reduced unplanned primary care demand	9 Maximised independence by helping more people return home
5 People with frailty access the services they need	10 Improved the experience of people in our care

iCANs Three core Pillars of work have 10 outcomes related to care outcomes and peoples experiences

iCAN outcomes overview

Within a programme as complex and ambitious as iCAN it is important that we are rigorous with how we are monitoring the effectiveness and value for money the programme is delivering

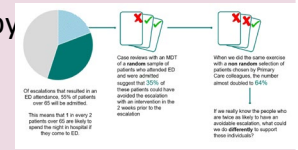
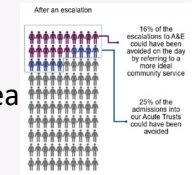
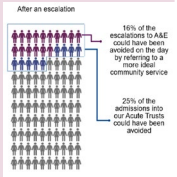
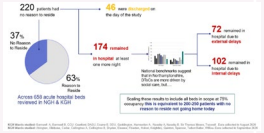


The iCAN Executive Board needs to have a simple and digestible method for regularly reviewing the progress against the objectives set by the iCAN collaborative. It will also be necessary to communicate this clearly to the ICB.

The majority of the measures relating to these objectives are monitored somewhere in the system or programme but not in one single location. The slides below set out a summary structure which could be used to link the objectives of the programme and help to easily navigate existing reporting.

It will also be necessary to understand the sustainability of our progress against these objectives, especially given the planned roll-off of the Newton team by November

iCAN is targeting specific operational benefits

What activities were carried out?	What was the "perfect world" opportunity	What would need to change?	What is the "real world" target?	What will the impact be for people?
Case reviews of a random selection of cases of people who attended ED	Randomly selected cases reviewed by an MDT of practitioners from the Northamptonshire system showed that **35%** of older adults who attended ED could have had avoided an escalation with a different intervention in the 2 weeks immediately prior to their admission. 	The majority of individuals were already in receipt of some form of care; we need to ensure that professional are aware of the range of services available, simplify and speed up referral processes and ensure appropriate community-based capacity	A **5%** reduction in the total number of escalations	People will have escalating needs addressed before they escalate to the point of an intervention, allowing them to safely remain at home
Case reviews of a random selection of people who attended ED	Case reviews showed that **16%** of the older adults who attended ED could have avoided attending ED by being referred to a more idea community-based service that would have met their needs 	People would need to access community services instead of coming to ED; the biggest opportunity was the use of ICT. We need to increase awareness of the needs that ICT can meet, ensure the capacity is used, and review OOH services.	A **5%** reduction in the total number of attendances	People will have urgent support in their home, or in a community hub to avoid attending ED
Case reviews of a random selection of people who were admitted to hospital	Case reviews showed that **25%** of the admissions into the acute trusts could have been avoided by discharging someone home from ED, either with or without additional community-based support. 	People would need to access community services instead of coming to ED; the biggest opportunity was the use of ICT, then people needing an outpatient referral.	A **5%** reduction in the total number of admissions	People will go home where appropriate, or go home with support to avoid an unnecessary admission and the associated decompensation in hospital
A review of the next steps for the patient in 658 Acute beds	**37%** of the patients in the Acute Hospital beds had no reason to reside, and yet 174 of the 220 remained in hospital at least one more night. 72 due to external delays, 102 due to internal delays. Scaling to the full number of beds means over 200 people who should have gone home today will still be in hospital tomorrow. 	The specific changes would be reducing diagnostic delays (1 in 7 patients waiting for a diagnostic test, but ¾ of these were actually waiting for communication between teams, not the test), increasing the use of community based IVs (1 in 12)	A **7%** reduction in the length of stay	More people will be able to go home rather than to a community based bed, and people will also be able to go home sooner

iCAN outcomes framework example scorecard

Each KPI Links up to a population or system ambition and back to an I-statement to ensure we have a golden thread between them and can see the difference we are making at each level

ICS Population Outcome	ICP Ambition	iCAN Outcome	iCAN Lead KPI	iCAN Operational or activity KPI	iCAN I-statements
Stay Well	Opportunity to be fit, well and independent	Prevented avoidable admissions into the acute setting	Reduced escalations to Acute Hospitals	Avoided attendances due to Community Resilience Intervention	I understand and can access alternative options to the Emergency Department
Stay Well	Access to health and social care when they need it	Reduced avoidable escalations	Reduced ED attendances	Projected additional packages per day to Rapid Response	I understand and can access alternative options to the Emergency Department
Age Well	Opportunity to be fit, well and independent	People with frailty access the services they need	Reduced escalations to Acute Hospitals	Number of people discussed in GP Reviews	I am involved in my care and understand my condition.

Financial benefits – the ICAN Programme

- ICAN is a five year programme. The initial 18 month transformation programme (ending December 22) is designed to embed change and ways of working that secure £6m of savings across a range of interventions that they accumulate over the 5 years as shown opposite .
- By 2025, the iCAN programme was anticipated to be delivering a recurrent gross saving of £13.3m per year (stretch target of £18m)
- The baseline for comparison and savings calculations is 2019/20 as 2020/21 was such an abnormal year with COVID.

	YR1 (2021/22) £'000	YR2 (2022/23) £'000	YR3 (2023/34) £'000	YR4 (2024/25) £'000	YR5 (2025/26) £'000	Over 5 year period
BENEFITS						
Reduce A&E attendances (including associated admission & LoS)	1,078	2,695	5,390	5,390	5,390	19,943
Reduce Admissions (including associated LoS)	512	1,280	2,560	2,560	2,560	9,472
Reduce admissions avoidance packages	224	560	1,120	1,120	1,120	4,144
Reduce bed days	734	1,835	3,670	3,670	3,670	13,579
Reduction in cost of CHC packages	120	300	600	600	600	2,220
Total Benefits	**2,668**	**6,670**	**13,340**	**13,340**	**13,340**	**49,358**

- All savings and costs were translated from operational targets (signed off by operational teams) and modelled through by the finance community using a series of equations.
- The costs and benefits were been split by organisation and built into the financial plans for the system from 2022-23.
- The benefits are being tracked via a benefits realisation group/process with operational sign off that improvements have been made.
- Benefits could be avoided cost (e.g. reduced demand), operational cost reductions (e.g. reduced staff and bed closure) or reduced ongoing spend (e.g. long term care costs). The decision to realise them remains an operational one along with decisions to "cash the benefits" or not. But the targets remain with the organisation is which the benefits are identified.

Investments

- The Business case assumed additional costs and investment as follows
  - £2.74m for additional community health resource
  - Internal programme costs to run the programme and support the enablers at £1.85m for year 1 and 2 and reducing over five years
  - a maximum contingency envelope for any other potential costs that emerge

COSTS						
Non-recurrent						
Internal costs (PMO & Backfill)	1,850	1,850	1,000	1,000	500	6,200
Newton	8,000	0	0	0	0	8,000
Total	**9,850**	**1,850**	**1,000**	**1,000**	**500**	**14,200**
Recurrent						
ICT & DN Pay Costs	462	2,740	2,740	2,740	2,740	11,422
Additional IV Costs	-	TBC	TBC	TBC	TBC	-
Additional resource within maximum resource envelope	*958*	*4,360*	*4,360*	*4,360*	*4,360*	*18,398*
Total	**1,420**	**7,100**	**7,100**	**7,100**	**7,100**	**29,820**
Total Costs	**11,270**	**8,950**	**8,100**	**8,100**	**7,600**	**44,020**

- The programme and External consultant investment was secured. But the recurring assumed operational investment costs shown above were not found.
- To date the main additional spend in the community has been via the Age Well programme investment into primary care provided by the CCG/ICB and one off Discharge to Assess funding.
- We are currently piloting a new model of Pathway 2 Intermediate Care following system agreement. One off Pilot funding of £2.7m has been secured and ongoing funding will be subject to the pilot proving successful and showing a return on investment for the system.
- The future capacity and cost for the left shift to a community offer will need to form part a new business case and system financial planning once the collaborative is agreed and final pathways and services are confirmed.

Budgets for a collaborative delivery model (1)

- Between now and the end of 2022 ICAN would need to work with system partners and finance to confirm the final scope of services and to agree;
  - the associated budgets that might be delegated or pooled,
  - any new investment needed for pathway 2 services (if the pilot is successful),
  - any contracts that might be transferred, and
  - any programme surplus budgets that would transfer to the collaborative

Existing BCF Schemes Potentially aligned to ICAN	
Carers Support	£1,488,437
Integrated Discharge teams	£1,915,164
Telecare and Assistive technology	£648,000
Community Equipment	£4,342,031
pathway 1	£17,060,586
Pathway 2	£2,818,457
Council Occupational therapy	£1,882,029
Disabled facility grant	£5,120,697
Safeguarding (Assurance) Teams	£909,164
	£36,184,566

- It is suggested the Better Care Fund (BCF) services (with some changes) becomes the budgetary foundation and mechanism for pooling the resources that will sit in the iCAN collaborative.
- The national 2022/23 BCF guidance and metrics align well to all the ICAN aims with National Condition 4 setting out two national objectives as
  - **Keeping more people safe and well at home and independent for longer, and**
  - **providing the right care, in the right place at the right time.**

- The majority of services effected by the ICAN vision and plan already sit in the BCF and the table above shows the value of the relevant services for the proposed ICAN tranche 1 collaborative. further complimentary services could be added. See next slide. Further information about the BCF is shown in the next slide.

Budgets for collaborative delivery model (2) The Better Care Fund?

The Better Care Fund (BCF) is one of the government's national vehicles for driving health and social care integration. It requires ICBs and local government to agree a joint plan, owned by the Health and Wellbeing Board. At a local level, the programme spans both the NHS and local government to join up health and care services, so that people can manage their own health and wellbeing and live independently in their communities for as long as possible.

These joint plans are for using pooled budgets to support integration, which are governed by an agreement under Section 75 of the NHS Act (2006).

Launched in 2015, the aim of the BCF is to reduce the barriers often created by separate funding streams. The minimum contributions to the BCF in 2022 to 2023 are detailed in the table (right):

The flexibility of local areas to pool more funding than the mandatory amount will remain.

The iBCF (Improved Better Care Fund) Grant determination was issued on 22 April 2022, with a condition that the grant is pooled into the area's BCF plan albeit that funds are paid directly to Local Authorities. This funding is excluded from our proposed ICAN tranche 1 service budgets as the majority of the funding is used to directly meet social care placements cost from rising demographic pressure and maintain the care market .

The DFG (Disabled Facilities Grant) is paid to local government through a Section 31 grant. This capital grant is used to implement property adaptions and minor works that help people remain at home but can be used more creatively around accommodation to help with step up0 and step down care. At this stage we are proposing that some elements of minor works or care and repair services could be part of the ICAN collaborative pooled budgets but not the whole grant which is fully committed with requests made to Council housing services for property changes.

Further information can be found here:
https://www.gov.uk/government/publications/better-care-fund-policy-framework-2022-to-2023

Budgets for a collaborative delivery model (3)

- There will need to be a discussion on the current BCF schemes that do not align to ICAN (for example Learning Disability domiciliary care) as they may be better placed in other collaboratives like mental health.
- If we remove any existing schemes by agreement, we will need to agree what schemes that do align to ICAN aims should be substituted into the BCF to maintain the statutory requirements for a minim CCG contribution and investment in out-of-hospital services for e.g., District Nursing.
- It is also suggested that we explore other services and budgets which, if integrated into ICAN may help us create true end to end community to hospital pathways and services that support our outcomes, for example Occupational Therapy in the Acutes, minor adaptions and care and repair and other voluntary sector contracts.
- We would propose the revised BCF would be subject to a new Section 75 agreement to recognise the partners whose services make up the collaborative delivery, the contributions and responsibilities of each partner and the common SLAs that we would work to.
- Having all ICAN services in one funding stream will make it easier to deliver a single contract, set of outcomes and meet national aims and to construct s75 arrangements to oversee the budget and contract.

Budgets for a collaborative delivery model (4)

- The mismatch between iCAN, which will measure outcomes for 65+ population, and the BCF which contains funding for service provision for persons under 65 is understood and will be managed as part of the collaborative design.
- Services included in the BCF which provide additional reach to under 65's will not be expected to separate out functioning and budget where to do would result in an inability to maintain safe and effective service delivery
- There are elements of primary care funding which, whilst not formally part of the BCF, are planned to be aligned to the Collaborative to ensure integrated delivery solutions e.g. Collaborative Care Team funding, PCN investment into Age Well Teams etc
- Decisions around scale of appropriate delivery would be through the iCAN Collaborative Delivery Group eg 2 Hr Rapid Response to be a single countywide model delivered through two place based teams.
- Delivery of Enhanced care in care home programme will be within the remit of the collaborative even though the funding is separate to primary care recognising that majority of care home residents will be 65+
- we will need to also ensure that the full three year of NHSE Ageing Well SDF allocation is correctly assigned to the BCF.

Workforce opportunities

Working as a collaborative we will be able to think differently across key aspects of the workforce to address challenges posed by and following the pandemic. Building upon the opportunities already seized to work more closely together, the iCAN collaborative will change and improve how we deliver services. This includes:

- Creative answers to workforce challenges in the system, such as rotating staff through settings,
- Sustainable and good value staffing models such as those established in dementia hubs and community asset groups,
- Partnership working, collaborative ethos and culture,
- One-stop-shops for patients and carers,
- High-level induction, training and learning for staff,
- Staff empowerment with staff as equals, and able to access key systems and in MDTs, take basic health measurements and prescribe low level equipment, and
- Learning partnerships with the Open University, the University of Northampton and the East Midlands research fund

Gateway Five

Formal Agreements

Integrated Care Across Northamptonshire

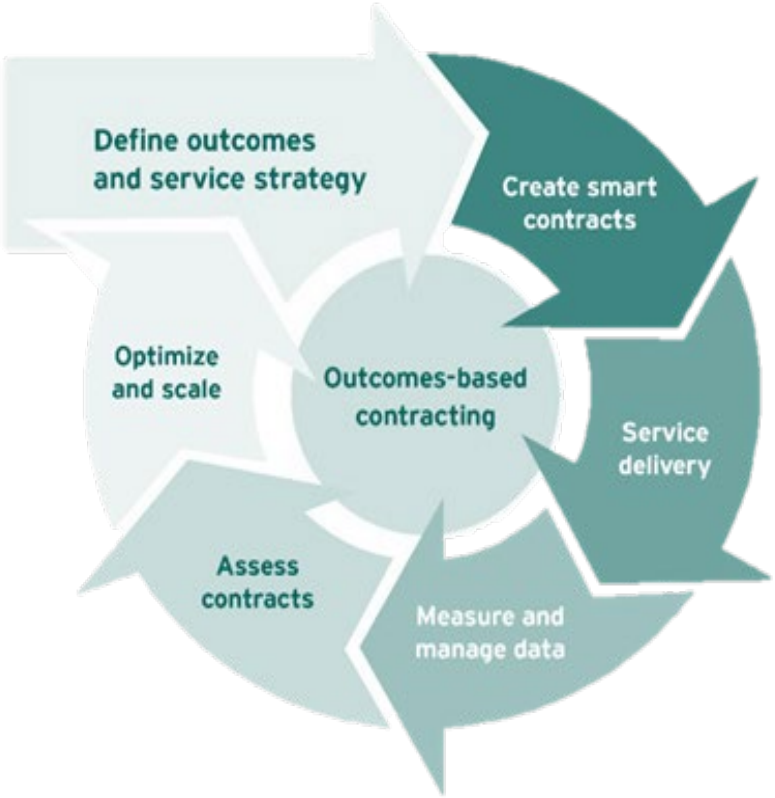
Contracts that enable transformation

The iCAN Collaborative

1. **Collaborative Contracting Arrangements** offer the most effective way of enabling desired population health outcomes and transformation goals, and give scope for wider heath and care outcomes (e.g. Public Health and Social Care) to be considered as part of a whole-pathway approach to improving outcomes for our people. This could include bold approaches for bringing health and social care workforce, contracts and packages of care under one integrated model
2. **Lead Provider** models can allow clear lines of accountability to the Integrated Care Board, but a Collaborative Agreement offers additional assurance that strategic planning is being system-led and system-owned
3. The addition of a **Collaborative Agreement** provides support to the all providers ensuring that all partners have an equal voice and decisions/ activities are assured to be system-led

The Collaborative aims to be live with the first tranche of the iCAN Collaborative Contract from 1 April 2023, with initial delegation and budget pooling for service using the BCF funding mechanisms .

Proposed contracting cycle for an Outcome-Based Collaborative Contract



Contract types that enable transformation

Creating the right environment for the positive change

Contracts do not, in themselves, produce good outcomes for our residents. However, the right contractual/collaborative framework can be an enabler for systems to work differently. Conversely, a poor contracting approach can be a barrier to achieving desired outcomes. In short, we should choose the contract to fit the vision, not the other way around.

Most, but not all of the services that are within the iCAN scope, are part of the BCF arrangements and Age Well SDF. Whilst the BCF is intended to encourage pooled budgets and integration it misses some of the key components for integration success because:

- Budgets are aligned and not pooled with the exception of community equipment
- The BCF is used as a means to transact not integrate services or share ownership
- There are no associated contracts based on population or system outcomes,
- There are no risk and reward or incentive measures, and
- Services operate within silos as there have been no overarching service design or integrated pathways

Various contracting options have been looked at, which are:

Historical contract approaches
Status quo with growing likelihood of barriers as collaboration increases

Alliance contracting
Published NHSEI approach generally considered as non-compliant with NHS standard contracts

Lead provider arrangements
Delegative approach in which a lead provider sub-contracts with other system partners on behalf of the ICB

Collaborative outcome-based contract arrangements
An approach (which may include a lead provider) which shares responsibility between commissioners & provider partners operating in the context of a collaborative agreement

Potential delegation of commissioning functions?

Discussions will be needed to agree what functions might be delegated to the iCAN collaborative alongside budgets and services. The table below illustrates the potential functions we might consider for delegation working on the basis that the collaborative will have responsibility for all aspects of delivery and the "how" and the ICB would retain the ownership of defining the "what" (outcomes & performance) and assurance that statutory duties are being met.

The aspiration would be for the iCAN to take on full delegation of commissioning functions from April 2023, subject to national guidance and final ICB approval. But the exact range of day 1 services in scope might start small and grow over time based on good performance.

	Commissioning / Provider Contracting		Potential Collaborative contracting arrangements		Potential delegation of commissioning functions	
Functions and Operations	CCG/ICB	Providers	CCG/ICB	Providers	CCG/ICB	Providers
Better Care Fund services	●	●	●	●	●	●
Age Well SDF	●		●			●
Surge and Escalation	●	●	●	●		●
Urgent Care Schemes	●	●	●	●		●
Discharge to Assess	●		●	●		●
Transformation Delivery	●	●	●	●		●
National Returns	●		●		●	●
Strategic Planning/Procuring services	●		●			
Assessing needs	●	●	●	●	●	●
Service quality and monitoring	●		●	●		●
System performance	●		●	●	●	●
Risk sharing	●	●	●	●		●
Investment / Disinvestment	●		●	●	●	●

Commissioner agreements that enable transformation

The submission of a Better Care Fund (BCF) Plan and its local formalisation through a Section 75 (S75) Agreement remains a national expectation in 2022/23. The minimum combined value of the schemes included in the 2022/23 BCF is circa £53.4 million (although the final value is to be confirmed.

In previous years, the potential for the pooling of these funds under joint commissioning arrangements has not been fully utilised with 4.8% of the value of the schemes included in the 2021/22 agreement being commissioned in this way. Although the majority of schemes have related closely to iCAN scope, previous year agreements have also included schemes that are associated with other Northants collaboratives, particularly MHLDA.

The national BCF policy for 2022/23 states two objectives:

- enable people to stay well, safe and independent at home for longer
- provide the right care in the right place at the right time

The alignment of these objectives with iCAN's, the mandatory nature of the BCF S75 and the need for a formal agreement between commissioners working together to deliver the iCAN vision all suggest the use of the BCF S75 as a key vehicle for iCAN delivery.

To become the key vehicle for health & social care commissioning bodies supporting iCAN, the following incremental actions are required:

1. Alignment of the scheme content within the BCF plan to the scope of iCAN (through removal of schemes associated with other collaboratives and the addition of those associated with tranche 1 of iCAN)
2. The creation of further collaborative commissioning arrangements and their formalisation through Individual Partnership Agreements (IPAs) within Schedule 2 of the BCF S75. Over time, this may lead to the establishment of a Lead Commissioner for iCAN delivery through delegation of commissioning responsibilities to one commissioning organisation.

The iCAN outcome-based collaborative contract

If we progress to formalise iCAN collaborative arrangements, a Section 75 agreement would be used to capture the arrangements between health and the Councils to be commissioned by the ICB. To ensure the contract is based around outcomes, the following specific content needs to be considered for inclusion.

Outcome-Based Payment Mechanism

This mechanism builds on the incentivised risk and reward model for the iCAN transformation and would function in a similar manner to the established CQUIN mechanism, with a percentage of total core contract value dependent upon the evidenced improvement of iCAN outcomes and KPIs.

The KPIs and pathways are based upon national best practice for Age Well, community discharge and the extensive i-Statement coproduction work undertaken with service users and carers between 2017 and 2019.

The majority of the desired outcomes expressed through these i-Statements can be measured and aggregated via service user feedback or specific purpose focus groups.

While the acute service delivery is not considered for inclusion in the formal iCAN collaborative for Tranche 1, it will be essential that from the outset the dependencies on the acute trusts and their responsibilities in terms of maintaining the good practice from the Frailty Escalation and Front Door (FEFD) and Flow and Grip (F&G) transformation streams are clearly set out in a Memorandum of Understanding (MOU) or other service level agreement. This is because the iCAN collaborative does not control the clinical admission and discharge decisions identified in the iCAN diagnostic as contributing to the high hospital occupancy and length of stay.

Assuring this operational performance

In a programme as broad and complex as iCAN, it is important to have robust and agreed methods of tracking progress against targets and return on investment

KPIs across the programme

How will these be produced and used to provide assurance

System-wide KPIs

Attendances, admissions, LoS, Bed days and CHC spend

These measures will be used in two ways

1. External factors mean they can be significantly impacted by things other than the programme so while they may not be individually used to indicate programme benefit, any discrepancies should be explainable
2. Operational KPIs will be translated into a net impact on these measures to demonstrate system wide benefit (i.e. if our LoS has dropped by 3 days and our operational indicators show a process improvement of 2 days, 2 days of impact will be reported against the programme and 1 to other impacts i.e. Covid)

Operational KPIs linked to financial value

These are the KPIs which have been agreed by the BRG as the controllable measures which demonstrate real impact of the programme. These could be linked to bricks, pillars or a combination depending on the impact of the work

These measures will go through a rigorous process alongside the BRG and then reported at Delivery Boards:

Current opportunity and future state outlined	Level of measurement agreed (i.e. Do we measure the impact of a single brick or multiple)	Agreement on the operational KPI	Reporting set up	Baseline and target agreed by BRG and operational owner	Formula to translate into system-wide impact agreed	Realisation plan and owner agreed with BRG	Operational owners and BRG sign of value when workstream at sustainable target

Activity KPIs

These measures may not be directly linked to financial value but will indicate a real on the ground change happening across the system. There should be a measure for each brick

All bricks will have an activity measure, regardless off their independence or link to value. These will be regularly reported by brick leads to ensure real change is being adopted on the ground at the required pace

NB: Within each brick there are likely to be many other measures which will support the management of individual bricks and services. Many of these will likely not be needed to assure programme financial delivery unless they highlight specific opportunities / challenges which impact the measures above

Options for measuring and agreeing delivered performance

There are five principal methods that we could monitor as a Benefits Realisation Group to become confident in programme delivery. In all likelihood, the most rigorous method for tracking financial performance will be a pre-agreed combination of all of the below

Tracked changes to ways of working

Methodology:

Judge successful delivery based on a series of criteria which demonstrate that new ways of working are happening on the ground. These would come alongside a trusted operational owner confirming the sustainability of the new ways of working and the fact that they were having a positive impact

Positives:

- Easy and agile to measure
- Can be tracked back to real patient experience on the ground
- Allow practitioner judgement to account for external factors

Limitations:

- Not robustly linked to financial delivery
- May not indicate scale of delivery

Measurable activity KPIs against new ways of working

Methodology:

Judge successful delivery based on a series of criteria which demonstrate that new ways of working are happening on the ground and to a scale which would lead to the level of system wide impact initially targeted by this brick / pillar

Positives:

- Easy and agile to measure
- Can be tracked back to real patient experience on the ground
- Allow practitioner judgement to account for external factors

Limitations:

- Not robustly linked to financial delivery

Scaling local trials / analysis to demonstrated impact

Methodology:

Using an isolated trial or robust cause and effect analysis to demonstrate the system-wide impact of a given change. Benefit is then scaled based upon the adherence to the proven process across the system

Positives:

- Proven link to financial value
- Not impacted by external factors
- Low level of effort required to track ongoing after initial agreement of methodology

Limitations:

- May be directionally correct but may not specifically show the exact impact when scaled up across the system

Bottom Up Operational Indicators

Methodology:

Using a controlled operational KPI which is isolated and not impacted by external factors and measuring our performance against a baseline

Positives:

- Proven link to financial value
- True demonstration of operational impact across the system accounting for any external impact

Limitations:

- Requires time and collaboration to agree and set up

Top Down System Wide Measures

Methodology:

Judge the successful delivery of the programme based on the system-wide measures

Positives:

- Proven and direct link to value
- Easy to measure

Limitations:

- Extremely difficult to isolate the impact of the programme from external factors such as Covid

Proposed process to identify bottom-up delivery

Current opportunity and future state outlined	Defining what will actually be different on the ground as a result of this work and linking this back to the opportunity that was originally identified
Identification of whether this brick drives financial value	Identifying whether we need a fully rigorous benefits process for this brick or whether we can leave the measurement and management for other forums
Identification of whether this brick drives value independently	Identifying whether the bottom up measures we are looking at should be used to evaluate a single brick or a series of bricks together which cannot be broken down into their own individual impact
Agreement on operational KPI	Singling out the individual measure which will both demonstrate the impact of the programme, be relatively isolated from external factors (or at least have external factors understood) and can be linked up to our programme measures
Financial benefit formula and fixed variables agreed	Identifying the calculation that needs to be completed alongside the fixed variables required to turn a bottom up operational measure into a comparative impact on the top level financial measures
Approach to measurement agreed	Agreeing how the measurement will be completed, when impact would be expected to be seen, and clarifying the evidence that demonstrates how the potential impact has been calculated or estimated
Reporting set up, with baseline and target agreed	Agreeing with a technical owner that the data we are using to assess performance is the right information and is being used in the right way. Setting up visibility of this agreed performance /KPI, including the level against which we will measure our impact. This may be a static performance target or may build in some element of natural growth /shrinkage depending on recent trends
Realisation plan and owner agreed	The written and agreed plan and owner which will support the system to do the most appropriate thing when realising the impact of the improved performance. This may be as direct savings, reinvested or used in another way
Overall signoff	The step taken by BRG to confirm the value delivered by any performance improvement, recognise the financial value to the system using the mechanism set out in the business case (whether or not this is how the system has chosen to best realise the value)

Next steps

The iCAN outcome-based collaborative contract next steps

We will need to:

- Agree the scope of services for inclusion in the collaborative
- Agree the associated budgets for the services and that can be delegated to collaborative delivery
- Agree what commissioning and contract resources would sit within the collaborative from the partners to help manage performance and supply
- Finalise the outcomes contract and incentive mechanisms
- Develop the post Newton Europe/transformation programme running costs
- Agree the management structure for the delivery of services (as opposed to the programme structure)