Northamptonshire

Health and Care Partnership

Elective Collaborative Case for Change Summary Presentation

(V 9.4)

Northamptonshire
Health and Care **Partnership**

Executive Summary

Contents

1. What is the 'ask' of Elective Care Provision in the NHS? What is it that we need to respond to and prepare for in the short and medium term?
2. What are the problems we need to try to fix locally?
3. Why is a collaborative the most effective way to respond to these issues?
4. What could the ambition for Elective Care in Northamptonshire really be?
5. How might we initially approach achieving this ambition?

Questions to Consider

1. Is the case for change to develop an Elective Collaborative strong enough?
2. Have we been ambitious enough?
3. Do we all agree that the proposed approach is the right one?

The 'Ask' - National Priorities Elective Care

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- Establish and maintain ring-fenced elective capacity at system level for high volume, low complexity (HVLC) procedures, adopting ‘hub’ models where appropriate
- Engage fully in the national clinical validation and prioritisation programme to ensure continued improvement in waiting list data quality with a regular cycle of clinical validation and prioritisation
- Work closely with independent sector (IS) providers to maximise the capacity and services available via the IS, including for cancer and over winter
- Deliver the requirements of the 22/23 Planning Guidance to maximise elective activity and reduce long waits, taking full advantage of opportunities to transform the delivery of services
- All systems are asked to demonstrate monthly increases in referral optimisation, with assessments to monitor the impact on avoiding referrals, and on improving patient experience and outcomes.
- Planning guidance requires elective recovery plans to deliver activity that is higher than pre-pandemic. Plans must ensure health inequalities are included and progress is tracked through board level performance reports.
- All providers are asked to increase the proportion of outpatient attendances they move to PIFU month-on-month, evidenced through returns to the EROC dataset

The 'Ask' - 2022/23 Planning Guidance

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Deliver significantly more elective care to tackle the elective backlog, reduce long waits and improve performance against cancer waiting times standards taking full advantage of opportunities to transform the delivery of services

- Ambition for systems to deliver 10% more elective activity in 22/23 than before the pandemic (2019/20); moving up to 30% by 2024/25
- Eliminate 104 week waiters, reduce waits over 78 weeks and develop plans for overall reduction 52 weeks
- Reduce follow-up outpatient appointments by 25% compared to 2019/20 by March 2023; moving or discharging 5% of outpatients to PIFU pathways by March 2023
- Delivering 16 specialist advice (including A&G) per 100 outpatient first attendances by March 2023
- Diagnostic activity minimum 120% of pre-pandemic levels across 2022/23. Deliver further capacity through Community Diagnostic Hubs
- Improve performance against all cancer standards
- Return number of cancer patients waiting >62 days to February 2020 levels
- Implementation of further cancer patient stratified follow-up (PSFU) pathways

'The Problems' - Stakeholder view of the issues need to fix?

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Capacity	Diagnostic waits	Covid Impact	Not Person Centric - Service Centric	Non Elective Impact	Multiple Waiting Lists	Limited Early Diagnostics

Not maximising whole system elective capacity equitably

Growing Population and Increasing Demand

Activity delivery not optimally planned for system VfM

Community diagnostic service issues

Prior approval adds administration, additional time and uncertainty during the process

Need to maintain elective care capacity

Fragmented Pathway with multiple handovers can confuse patients

We have health inequalities on our waiting lists

Difficulty to retain and recruit staff

Number of patients deteriorating during wait

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We often duplicate work

Clinical variations in care delivery

Inefficiencies of working as separate organisations

Information not transparent for patients or GP's

Working in silos, different contracts, limited aligned incentives

Longer waiting times than we would want, particularly to diagnosis

Preventative care to reduce elective demand

NHCP Elective Collaborative

Reductions in unwarranted variation in outcomes and access to planned care services

Our current priority issues	How working as a collaborative would address these
Increasing elective waiting lists • Each organisation holds different pieces of the elective care jigsaw and multiple waiting lists • There is no single version of the truth • Patients deteriorating during wait • System digital innovation on single PTL	✓ A single PTL resulting in equitable access to care ✓ Standardising protocols, policies and pathways ✓ System wide transformation to improve efficiencies, create capacity and introduce innovations ✓ Delivering consistency in diagnosis, treatment and care; new service and pathway development meaning equal access to high quality services
Understanding our capacity • We plan capacity at organisational level • We don't have the ability to share knowledge at specialty level to ensure space/equipment and staff resource are maximised	✓ Demand and capacity is planned at system level ✓ Knowledge is formally shared to ensure capacity and resources are maximised ✓ Opportunities are maximised to create dedicated elective facilities enabling us to protect our elective capacity, provide timely care, minimising infection rates and reduce length of stay in hospital
Not person centric • Fragmented pathways with multiple handovers • Confusing for patients and heavy communication burden on all partners	✓ Commissioning end to end pathways enabling us to focus on prevention and out of hospital care ✓ More assessments, diagnosis and treatment being offered in a one-stop pathway, in the community or virtually to minimise disruption to patient's lives ✓ Working to engage with patients to design and transform services to deliver improved outcome
Workforce constraints • Each organisation competes for staff with separate skill mix models for the same service • Recruitment and retention managed separately	✓ Integrated teams will increase rota resilience and reduce workloads, reducing reliance on temporary staffing and improving staff wellbeing ✓ By working across the system, we will have the scale to explore and pilot new roles and workforce models
Value for Money is compromised • Pricing and activity is based on organisational activity and not pathways or outcomes • Variation in costs across the System • PBR and National contractual directives issues	✓ A lead provider model, offering a single provider lead for administering collaborative planning and delivery ✓ Outcomes based commissioning focused on delivering end to end pathways ✓ Best allocation of available resources to deliver transformational change, reducing duplication and reinvestment in community services and prevention (left shift)

'Our Ambition' - The eventual scope

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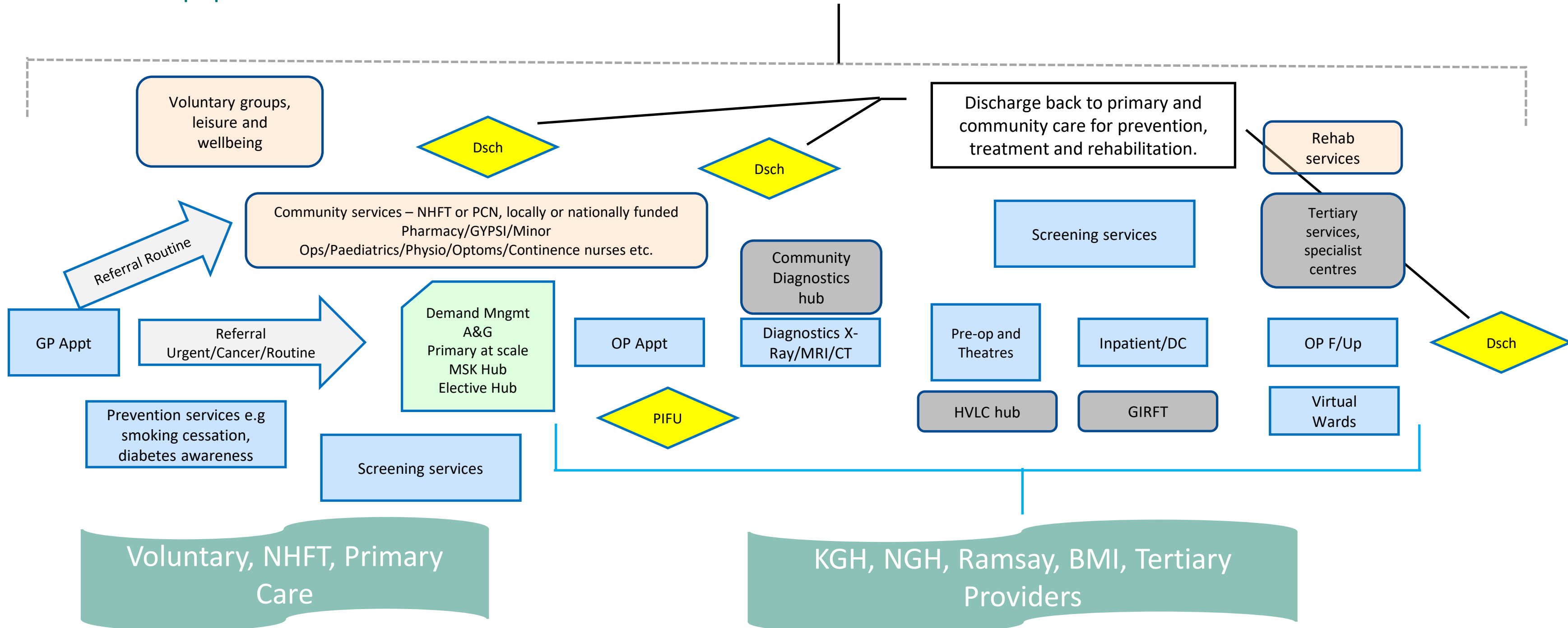
The elective pathway is not as simple as it seems, there are many hand offs and fragmented elements of the pathway, which can lead to duplication and delays for patients. There is limited focus on prevention and psychological support for those with long term conditions. Pathways can be different by provider even within specialties. There is not a collective elective service offer for the Northants population.



'Our Ambition' - What our stakeholders have told us they want

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We engaged our stakeholders to understand their priorities. The following are the elective collaborative aspirations derived from this engagement with service users, GP's, acute and community service providers and social care

- Provide advice and care as close to homes as possible
- Improved communication to patients
- Reduced Waiting Times
- Improve self-responsibility and engagement with the community
- Equitable Services for All
- Open dialogue with patients about what can be provided
- To provide service users with the best elective service possible
- Improve patient outcomes within the resources available
- Be exemplar in how we work together across organisations to benefit the patient
- Create an environment where innovation is harnessed to reduce inequalities
- Efficient use of resources and minimise duplication
- Ensure we focus/prioritise resources on the areas of elective delivery that are a priority
- Develop a 'one stop shop' approach providing clarity and ease for patients
- Provide care in the right place at the right time
- Provide care as quickly and early in the patient's journey as possible
- Keep patients well in their homes
- Standardise best practice patient pathways
- Reduce variation in practice outcomes

'Our Ambition' - A whole system approach to elective delivery

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- Slick seamless access
  - **Single referral hub** that makes it seamless for primary care, supported by a **system PTL** that triages and directs referrals to where the capacity exists in a prospective way (rather than retrospectively moving patients to providers when their length of wait is long)
  - Prior approvals and consultant to consultant referrals managed within the hub to **reduce bureaucracy on system clinicians** and speed up access.
  - **Health inequalities** directing access to care

- Acute Provision – protected elective capacity, reducing patient cancellations
  - High volume low complexity care **close to patient homes** – dedicated capacity in the North and West of the county
  - **Specialist cancer surgery** on a single site – co-locating specialist staff and equipment to drive up clinical outcomes
  - **Non-specialist elective** work on a single site, with nationally exemplar theatre utilisation and single pathways for patients
  - The four providers working together to **maximise capacity**

- In the community
  - Integrated informative **public health messaging** to keep patients well
  - **Advice and guidance** direct to patients to ensure conditions are escalated to the right clinician to prevent delay associated deterioration and A&E attendances
  - Prevention and Living Well forefront
  - **Community Diagnostic Hubs** – with primary, community and secondary care access into one stop clinics
  - A range of prevention and schemes **keep communities well**
  - Voluntary sector groups supporting the chronically unwell
  - **Psychological support** for those with chronic conditions

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'Our Ambition' - Some examples of what will success feel like?

If I am a Patient

- I will know at point of referral how long I can expect to wait for treatment, and I can get regular updates on that from my GP, the referral hub or a digital solution on my phone or tablet.
- Whilst I will be offered choice of provider, I will be able to make an informed choice on the total expected length of my pathway at each provider, rather than just on first outpatient consultation.
- I will get the same treatment, outcomes, after care and support at any provider I choose.
- I will get the same equitable access to the range of services available in the county, and if I have health inequalities then I will get prioritised in a way that ensures I am not disadvantaged by my situation.
- There will be a range of community-based services to help support me to keep well and manage my own health

If I am a GP

- I know how long my patient will wait for treatment before I even make a referral. This means I can give advice, and direct to community or voluntary services that will help them to self-care whilst they wait, and not clinically deteriorate.
- I do not have to waste my clinical time undertaking bureaucratic prior approvals, or re-referring for consultant to consultant referrals, I know the collaborative referral hub will be managing that for me.
- When patients phone me up to enquire about their wait, I will be able to tell them at the touch of a button how much longer they can expect to wait and what clinical urgency they are.
- My time can be saved and re-focussed to clinically managing patients.

For the System

- We will release clinical time across the system by reducing bureaucracy and duplication through implementing a central referral hub for all elective patients, supported by a suite of digital solutions that work across the collaborative.
- We will shorten waiting times for patients by reducing 'handing patients' from provider to provider or sector to sector, and maximising the available capacity across providers. This will reduce attendances at A&E due to deterioration during long waits.
- We will create value for money by delivering the same best practice pathways at the same cost, sharing resources and estate amongst providers.
- We will transform pathways through the ability to invest collaborative funds in out of hospital schemes.

If I am a staff member

- I will be working in an innovative county wide collaborative, offering a full range of elective services from HVLC procedures to specialist procedures usually undertaken at tertiary providers. This provides an exciting place to work for me with lots of opportunities to 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.

'Proposed approach' - Phase 1 Collaborative Options

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An options appraisal process was undertaken to identify and evaluate options. The three options reviewed included risks and benefits of each option and assessed against the HCP asks for Collaboratives (slide 7). A summary of each option (details of the options and the scoring matrix are included in appendix 1). The preferred option is Option 3.

Option 1: Collaborative to commission and deliver all acute level system activity

- This will include outpatient, inpatient and day-case services, delivered through a single PTL across the four acute providers
- May also include community diagnostic and referral hub(s)
- Opportunity to maximise whole system elective capacity equitably
- Enables us to better manage our growing population and increasing demand for services
- Reducing variation and streamlining services

Option 2: Collaborative to commission end to end pathways

- Opportunity to pilot an agreed number of pathways e.g. MSK and Cardiology
- Visibly putting the patient first from the outset, with care wrapped around the patient
- Supports investment and transformation in demand management and out of hospital schemes to control demand
- Avoid duplication across the system to reduce cost and minimise poor patient experience

Option 3: Hybrid of options 1 & 2

- To include some elements of elective capacity and system PTL and some end to end patient pathways.
- Reflects and incorporates all system partners to some degree, so all can be a part of the collaborative in a meaningful way
- More in line with our final vision, just an initial step on the journey

What will be included in the collaborative?
Preferred Option Scope for Phase 1, from July 22

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Collaborative to commission and deliver all acute level system activity. This will include outpatient, inpatient and day-case services, delivered through a single PTL across the four acute providers. May also include community diagnostic and referral hub(s).
Opportunity to pilot an agreed number of pathways e.g. MSK/Spinal and Cardiology to prepare for commissioning end to end pathways in a later phase.

BENEFITS/OPPORTUNITIES	RISKS/ISSUES/DISADVANTAGES
• Opportunity to maximise whole system elective capacity equitably	• Doesn't involve/include/acknowledge the non-acute elements of an elective pathway
• Enables better management of a growing population and increasing demand for services	• Risks alienating other system partners, doesn't reflect a true collaborative at system level and continues to support the wide belief the acutes 'think it is all about them' – compromises the 'lead provider' direction?
• Reducing variation and streamlining services	• Maintains the limited ability to transform out of hospital care, so still reaction-based response rather than proactive
• Joint planning and use of acute capacity	• Does not allow for demand management and long-term condition management schemes
• Information sharing across providers	
• Joint workforce planning & scheduling to meet capacity demands	
• Proof of concept of the different approaches, to enable learning and further refinement before wholescale responsibility shift	• More complex benefit realisation and monitoring programme required, and more complex change management with multiple partners
• Reflects and incorporates all system partners to some degree, so all can be a part of the Collaborative in a meaningful way	
• More in line with our final vision, just an initial step on the journey	

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Full Pack

National priorities for elective care

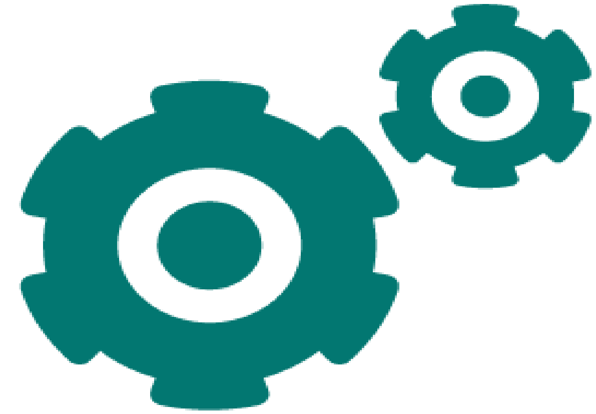
The ask from NHCP Board for collaboratives

What issues are we trying to fix?

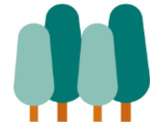
A single system approach – Vision and art of the possible?

Benefits of working as a collaborative

Options and scope



National Context



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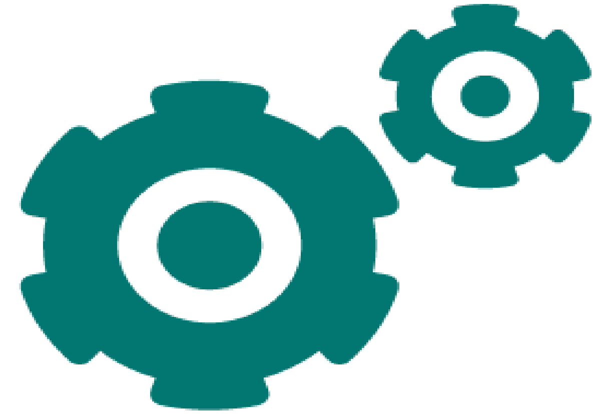
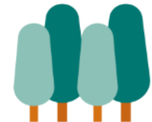
Local Context





Our Design Principles - Northamptonshire (NHCP) emerging Integrated Care Board ask of collaboratives

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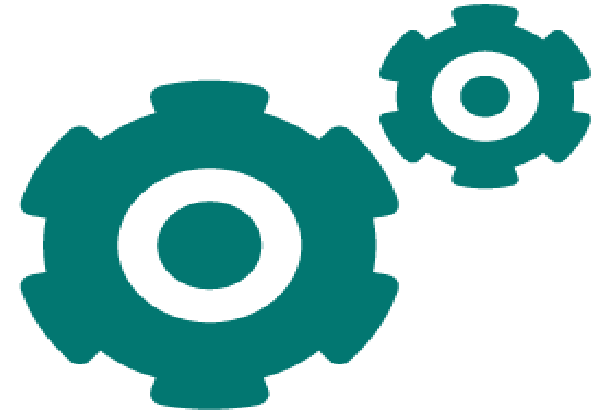
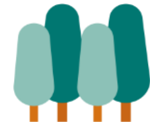
1	The collaborative will be inclusive involving all system partners to plan, transform and deliver services – including the Integrated Care Board; NHS providers; local authorities; independent sector; and the VCSE sector
2	The collaborative needs to transform services and improve population health in specific areas, reducing unwarranted variation and inequity in health outcomes, access to services and experience
3	The collaborative needs to take a whole pathway approach to their transformation and consider the life course approach to ensure services are fit from conception to death
4	The collaborative will need to include specialised and direct commissioning
5	The collaborative will need to include places and local government to ensure services are designed to meet the needs of the different communities across Northamptonshire
6	The collaborative needs to improve resilience across providers particularly in relation to the workforce – we expect collaboratives to jointly plan their workforce
7	The collaborative needs to consider where specialisation and consolidation would provide better outcomes and value
8	The collaborative will need to work across all partners and where appropriate with national and regional networks to transform services
9	All partners will have an equal voice

What are the **issues** we are trying to fix?

Views from partners and patients





What issues are we trying to fix?

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NHCP Elective Collaborative

Reductions in unwarranted variation in outcomes and access to planned care services

Some examples

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Northamptonshire population is projected to increase by 14% 2018 - 2038. In 20-64 yr olds there is projected to be a 7% increase, in the 65yrs+ there is projected to be a 50% increase

There are multiple separate waiting lists patients can be on at different stages of their pathway.

- Organisational level; KGH, NGH, NHFT, BMI, Ramsey.
- Within organisations: Planned treatment, Diagnostic waiting, Treatment waiting, Outpatient waiting etc.

There are specific shortages in nursing, ODP's, therapies and Anaesthetists. Northamptonshire nursing vacancy rates are around 9%, with a yearly turnover of 6.8%.

As at September 2021 there were over 800 Northamptonshire patients waiting over a year for treatment

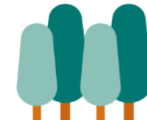
NHCP Elective Collaborative

Day case levels, Northamptonshire in lower Quartile, with high conversion from day case to inpatients

Monthly cancellation rates on average 7% prior to the pandemic

Reductions in unwarranted variation in outcomes and access to planned case services

Long waiters have increased . There were 51 waiting over 2 years and 1,029 over 1 year at October 21.



The scope of elective care is very broad

Northamptonshire Health and Care Partnership

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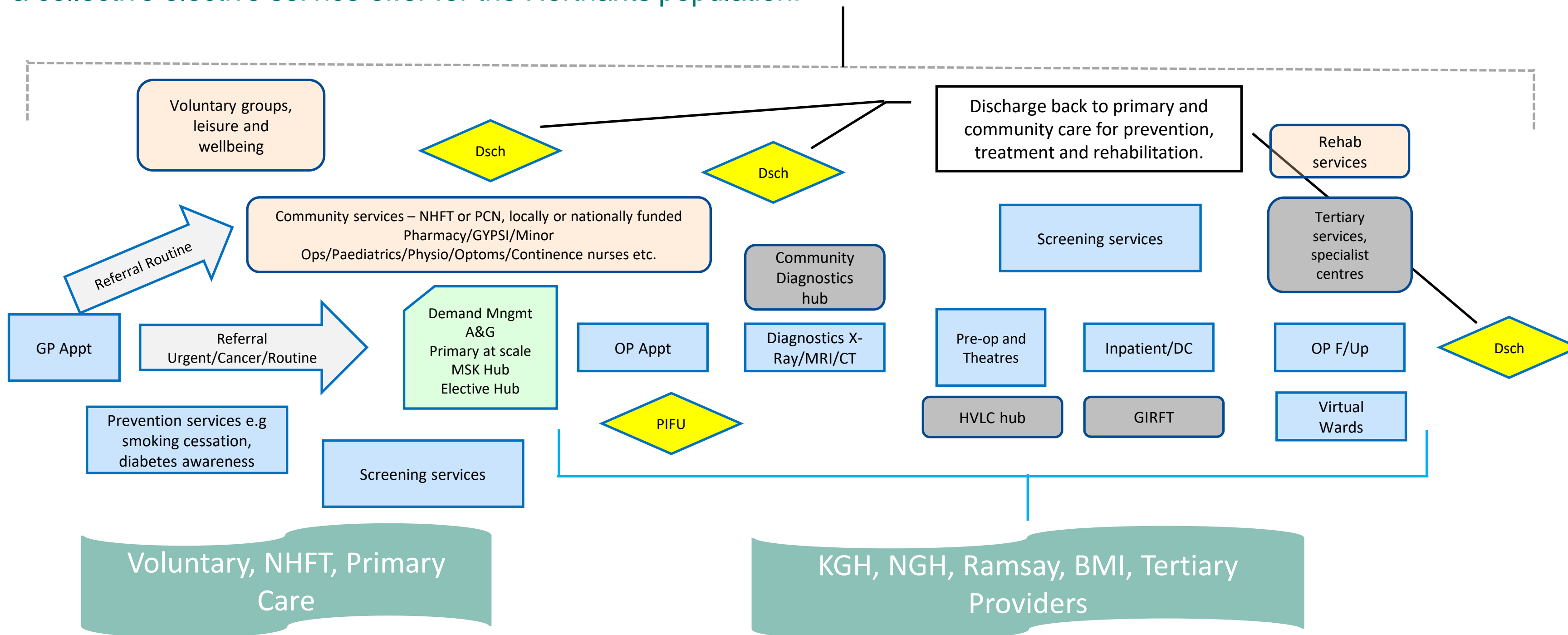

Why a collaborative?

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The Collaborative will commission and deliver the required **improved patient outcomes and experience** by working together within robust governance. This will allow the **delivery of care to be re-imagined and transformed** through aligned resources (capacity, money and workforce) and operations to address problems by:

- Working with patient representatives to ensure **patient-centred** consistent whole pathways are delivered with effective engagement with patients throughout their journey
- Providing **seamless pathways** for patients, working to keep patients well in their homes and providing advice and care as close to their homes as possible
- Bringing teams' expertise, experience and innovation together to transform services and improve outcomes through **clinically-led**, outcomes-based commissioning
- Developing a patient-centred culture to ensure **quality outcomes** based on shared patient and clinical needs
- Improving quality, using resources most effectively, and delivering best practice to all patients – working at scale across the county to deliver **value for money and reduce duplication** across clinical and corporate services thereby releasing savings for re-investment in further pathway development
- Providing staff with a supportive, rewarding environment to learn, develop and grow their careers in stable, **highly skilled teams** with seamless movement between organisations that will deliver a sustainable workforce

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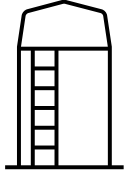
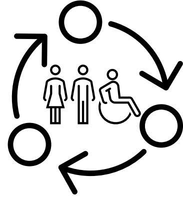
Life Before the Collaborative

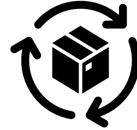
Working in silos



Competing for limited workforce

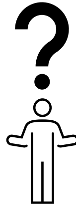


Long waits / cancelled operations



Avoiding difficult conversations

Fragmented pathways can confuse patients

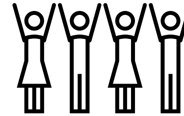


Organisation centric

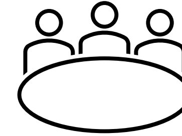
Multiple organisations commissioned individually

Life After the Collaborative

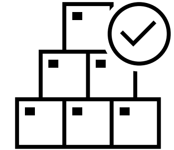
Shared / Pooled workforce



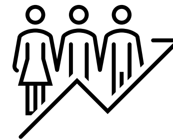
Strong relationships: Collaboration and Co-operation



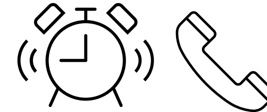
Streamlined pathways and services



Improved patient outcomes



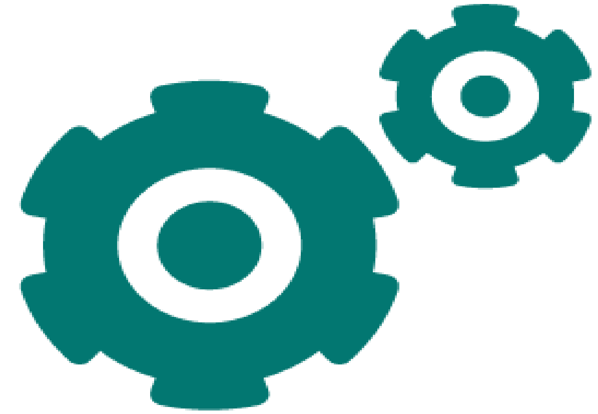
No long waits / patients engaged

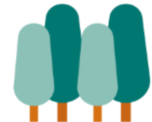


Strategic System Planning

Collaborative clinically led outcomes commissioning

The “vision” for elective care and the art of the possible in a collaborative





Vision for the Elective Collaborative

Northamptonshire Health and Care Partnership

To improve health outcomes, inequalities and quality of life through a single system patient-centred approach across the whole elective pathway transforming delivery of services to ensure equitable access to timely treatment for patients across the county and to enable patients to be supported to keep well.

What our stakeholders have told us

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We engaged our stakeholders to understand their priorities. The following are the elective collaborative aspirations derived from this engagement with service users, GP's, acute and community service providers and social care

- Provide advice and care as close to homes as possible
- Improved communication to patients
- Improve self-responsibility and engagement with the community
- Reduced Waiting Times
- Equitable Services for All
- Open dialogue with patients about what can be provided
- To provide service users with the best elective service possible
- Improve patient outcomes within the resources available
- Be exemplar in how we work together across organisations to benefit the patient
- Create an environment where innovation is harnessed to reduce inequalities
- Efficient use of resources and minimise duplication
- Ensure we focus/prioritise resources on the areas of elective delivery that are a priority
- Develop a 'one stop shop' approach providing clarity and ease for patients
- Provide care in the right place at the right time
- Provide care as quickly and early in the patient's journey as possible
- Standardise best practice patient pathways
- Reduce variation in practice outcomes
- Keep patients well in their homes

A future whole system approach to elective delivery

- Slick seamless access
  - Single referral hub that makes it seamless for primary care, supported by a system PTL that triages and directs referrals to where the capacity exists in a prospective way (rather than retrospectively moving patients to providers when their length of wait is long)
  - Prior approvals and consultant to consultant referrals managed within the hub to reduce bureaucracy on system clinicians and speed up access.
  - Health inequalities directing access to care

- Acute Provision – protected elective capacity, reducing patient cancellations
  - High volume low complexity care close to patient homes – dedicated capacity in the North and West of the county
  - Specialist cancer surgery on a single site – co-locating specialist staff and equipment to drive up clinical outcomes
  - Non-specialist elective work on a single site, with nationally exemplar theatre utilisation and single pathways for patients
  - The four providers working together to maximise capacity

- In the community
  - Integrated informative public health messaging to keep patients well
  - Advice and guidance direct to patients to ensure conditions are escalated to the right clinician to prevent delay associated deterioration
  - Prevention and Living Well forefront
  - Community Diagnostic Hubs – with primary, community and secondary care access into one stop clinics
  - A range of prevention and schemes keep communities well
  - Voluntary sector groups supporting the chronically unwell
  - Psychological support for those with chronic conditions

A single system approach – art of the possible

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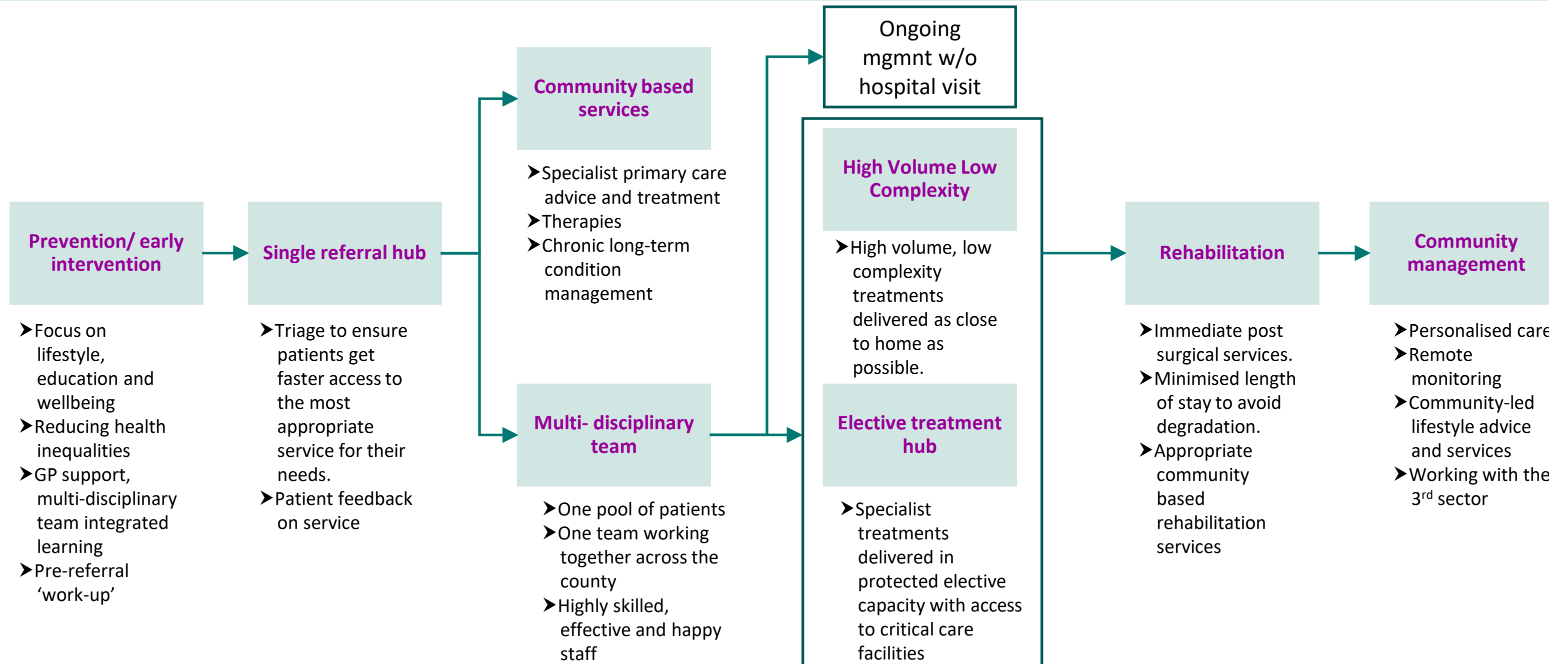
A single system approach would improve care along the whole elective pathway over the next 3 – 5 years



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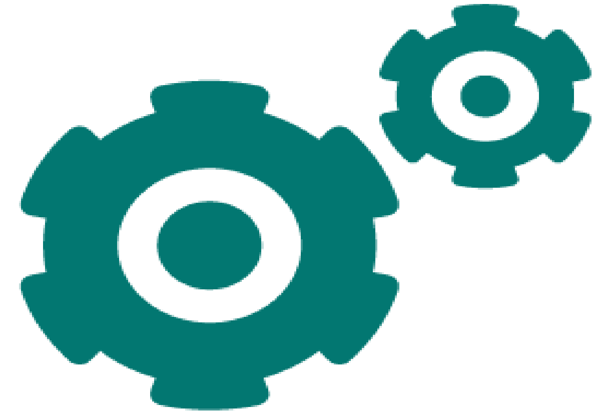
Preferred Option and Scope of the collaborative



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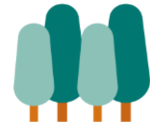

How will we develop as a collaborative?

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- A new contractual framework will be developed, which is designed to facilitate collaborative working, set clear lines of accountability to the Integrated Care Board, and allow financial/ operational resources to be deployed to achieve the required outcomes, performance and quality ambitions in a sustainable way. This will include;
- A **Lead provider approach** - creating a single point of delegation and accountability for the Integrated Care Board. Unlike other approaches, this ensures that system efforts, plans and data are centralised
- **Delegated budget** - a delegated budget allows for resources to be rapidly moved or re-aligned according to emerging needs, creating a more agile and responsive health and care system
- **Collaborative agreement** - a document that clarifies the arrangements for partnership working, flexibility, transparency, and shared commitment to deliver ambitions aligned to local and statutory expectations for the system. This will include a risk and gain share agreement.
- **Agreed outcomes framework** - resetting the measure of success to align with the overarching outcomes the system and its residents seek to achieve

Phasing – There is a need to agree what can meaningfully be started on delivering the whole vision, and what a phased approach might be in terms of steps. This should be:

1. Focussed on the priority problems to be resolved
2. Testing solutions in a safe environment, to enable a more robust roll-out of the scope through 2022/23.
3. Timely and at pace, with a clear risk management framework.

Collaborative Options Considered

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An options appraisal process was undertaken to identify and evaluate options. The three options reviewed included risks and benefits of each option and assessed against the HCP asks for Collaboratives (slide 7). A summary of each option (details of the options and the scoring matrix are included in appendix 1). The preferred option is Option 3.

Option 1: Collaborative to commission and deliver all acute level system activity

- This will include outpatient, inpatient and day-case services, delivered through a single PTL across the four acute providers
- May also include community diagnostic and referral hub(s)
- Opportunity to maximise whole system elective capacity equitably
- Enables us to better manage our growing population and increasing demand for services
- Reducing variation and streamlining services

Option 2: Collaborative to commission end to end pathways

- Opportunity to pilot an agreed number of pathways e.g. MSK and Cardiology
- Visibly putting the patient first from the outset, with care wrapped around the patient
- Supports investment and transformation in demand management and out of hospital schemes to control demand
- Avoid duplication across the system to reduce cost and minimise poor patient experience

Option 3: Hybrid of options 1 & 2

- To include some elements of elective capacity and system PTL and some end to end patient pathways.
- Reflects and incorporates all system partners to some degree, so all can be a part of the collaborative in a meaningful way
- More in line with our final vision, just an initial step on the journey

What will be included in the collaborative?

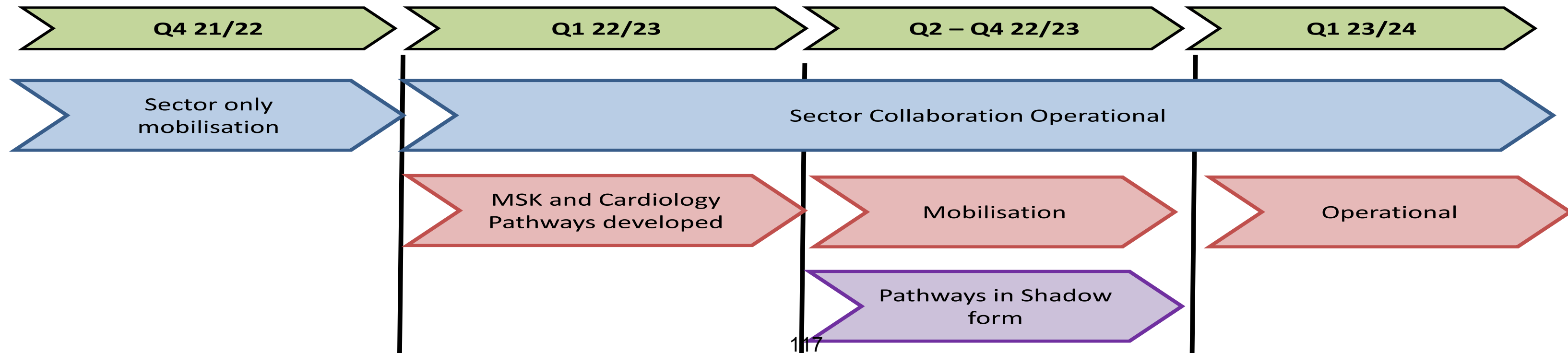
Option 3 is the preferred option and is described in more detail on the next slide.

Implementation of this option will be phased across 22/23. Step 1 will be to collaborative to commission and deliver all acute level system activity from July 2022 (in shadow form from April 22) with a devolved budget, collaborative agreements and accountability framework in place. The proposed phased timeline is shown below.

Step 2 will be to test the proof of concept of transforming and commissioning two end to end pathways; Cardiology and MSK from April 2023. Pathway budgets are complicated and need to be understood and agreed before a budget can be devolved. The intention will be to run the pathway in shadow form from Q4 2022/23.

The Collaborative will develop commissioning intentions with patient representatives to ensure service transformation meets the strategic objectives.

The Collaborative scope includes surgical and medical services for adults, children and young people.



What will be included in the collaborative? Preferred Option Scope for Phase 1, from July 22

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Collaborative to commission and deliver all acute level system activity. This will include outpatient, inpatient and day-case services, delivered through a single PTL across the four acute providers. May also include community diagnostic and referral hub(s). Opportunity to pilot an agreed number of pathways e.g. MSK/Spinal and Cardiology to prepare for commissioning end to end pathways in a later phase.

BENEFITS/OPPORTUNITIES	RISKS/ISSUES/DISADVANTAGES
• Opportunity to maximise whole system elective capacity equitably	• Doesn't involve/include/acknowledge the non-acute elements of an elective pathway
• Enables better management of a growing population and increasing demand for services	• Risks alienating other system partners, doesn't reflect a true collaborative at system level and continues to support the wide belief the acutes 'think it is all about them' – compromises the 'lead provider' direction?
• Reducing variation and streamlining services	• Maintains the limited ability to transform out of hospital care, so still reaction-based response rather than proactive
• Joint planning and use of acute capacity	• Does not allow for demand management and long-term condition management schemes
• Information sharing across providers	
• Joint workforce planning & scheduling to meet capacity demands	
• Proof of concept of the different approaches, to enable learning and further refinement before wholescale responsibility shift	• More complex benefit realisation and monitoring programme required, and more complex change management with multiple partners
• Reflects and incorporates all system partners to some degree, so all can be a part of the Collaborative in a meaningful way	
• More in line with our final vision, just an initial step on the journey	

What will be included in the first phase of the Elective Collaborative from April 22

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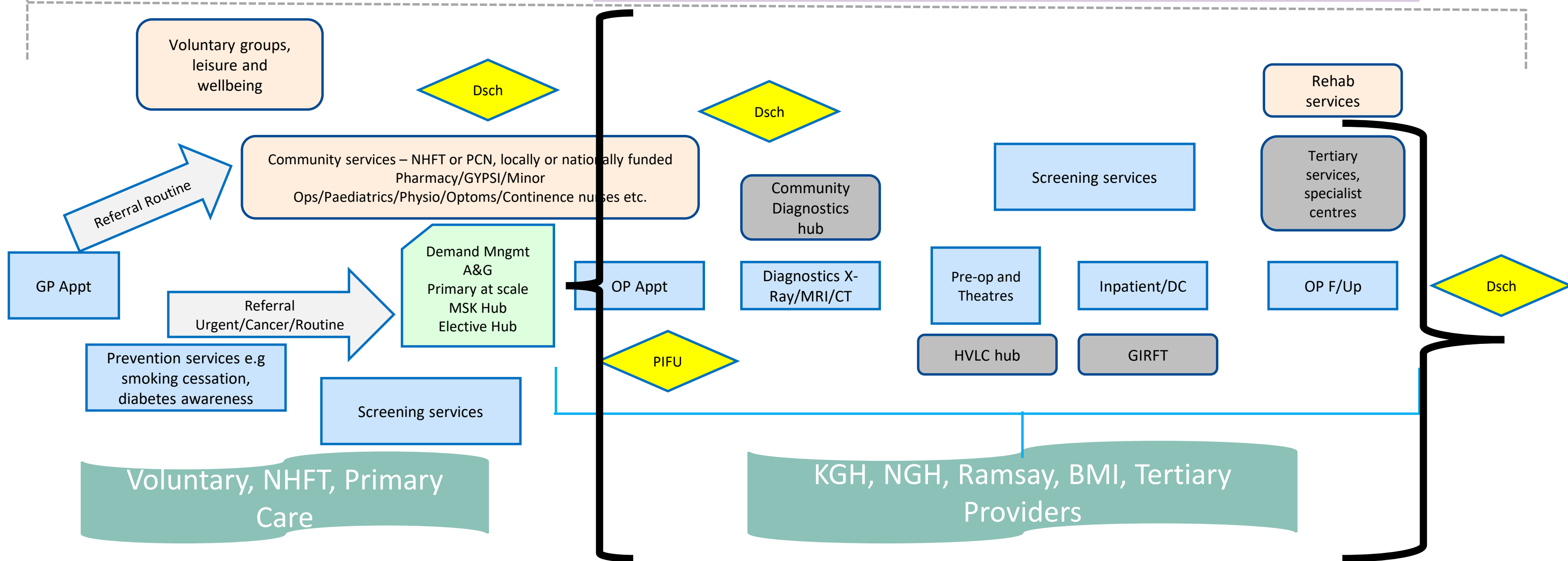
We will collaborate to commission and deliver all acute level system activity. This will include outpatient, inpatient and day-case services, delivered through a single PTL across the four acute providers. May also include community diagnostic and referral hub(s). From April 22



We will pilot an agreed number of pathways, e.g. MSK and Cardiology, to prepare for commissioning end to end pathways by April 23

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Mobilisation questions and next steps:

- Case for change approval through the system governance as per the Collaborative approvals process
- Confirm the detail of the operating model and what will be done by ICB and what will be done by the collaborative (functions of each)
- Finalise the outcomes framework to agree the required System outcomes, measures and KPIs and use a logic model to track population health outcomes
- Develop the collaborative and contracting arrangements, ensuring all partners and patients are represented.
- Confirm the legal form for the collaborative.
- Accountability Framework to be developed to include finance, performance and risk/gain share
- Establish governance of Collaborative and the interdependencies with the other collaboratives (CYP, MHLDA, iCAN).
- Develop case for progression through Collaborative Gateways 3-5

Appendices

Scope Option 1

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Collaborative to commission all acute level system outpatient, inpatient and day-case capacity, and deliver through a single PTL
To include independent sector, community diagnostic and referral hub(s)

BENEFITS/OPPORTUNITIES	RISKS/ISSUES/DISADVANTAGES
• Opportunity to maximise whole system elective capacity equitably	• Doesn't involve/include/acknowledge the non-acute elements of an elective pathway
• Enables us to better manage our growing population and increasing demand for services	• Risks alienating other system partners, doesn't reflect a true collaborative at system level and continues to support the wide belief the acutes 'think it is all about them' – compromises the 'lead provider' direction?
• Reducing variation and streamlining services	• Maintains the limited ability to transform out of hospital care, so still reaction based response rather than proactive
• Joint planning and use of acute capacity	• Does not allow for demand management and long term condition management schemes
• Information sharing across providers	
• Joint workforce planning & scheduling to meet capacity demands	

Scope- Option 2

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Collaborative to commission end to end pathways

Opportunity to pilot an agreed number of pathways e.g. MSK and Cardiology

BENEFITS/OPPORTUNITIES	RISKS/ISSUES/DISADVANTAGES
• Visibly putting the patient first from the outset, with care wrapped around the patient	• Complex pathways to understand, with multiple providers and more resistance to change
• Supports investment and transformation in demand management and our of hospital schemes to control demand	• Multiple contracts and commissioning relationships
• Opportunity to improve the patient experience through streamlined less fragmented pathways with multiple handovers	• Doesn't allow for maximising acute capacity utilisation for inpatient and day case work aligned to elective recovery
• Opportunity to reduce variation in pathways and access to voluntary and community services across the system	• Longer time period to implement
• Avoid duplication across the system to reduce cost and minimise poor patient experience	
• Provide a clear patient pathway that all stakeholders understand and agree	
• Get the right patient to the right place at the right time	

Scope Option 3

Hybrid of options 1 & 2 to include some elements of elective capacity and system PTL and some end to end patient pathways

BENEFITS/OPPORTUNITIES	RISKS/ISSUES/DISADVANTAGES
• Offers all the practical benefits of Option 1 and 2, but with an ability to implement and deliver the benefits over time	• Larger breadth of diverse programmes may dilute impacts
• A greater degree of 'testing' of the different approaches, to enable learning and further refinement before wholescale responsibility shift	• More complex benefit realisation and monitoring programme required, and more complex change management with multiple partners
• Reflects and incorporates all system partners to some degree, so all can be a part of the collaborative in a meaningful way	
• More in line with our final vision, just an initial step on the journey	

We reviewed the following options to identify and agree the scope for phase 1 of the collaborative

	What issues are we trying to fix		NHCP Board ask of collaboratives (Design Principles)								
PHASING OPTIONS	BENEFITS	RISKS	Inclusive involving all system partners	Reduce unwarranted variation and inequity in outcomes and access	Whole pathway approach to transformation services & delivery	Specialised and direct commissioning	Meet the needs of different communities	Improve resilience across providers	VFM via specialisation and consolidation	Working with national and regional networks	All partners will have an equal voice
Collaborative to commission all acute level system outpatient, inpatient and day-case capacity, and deliver through a single PTL To include independent sector, community diagnostic and referral hub(s)	1. Maximise whole system capacity equitably 2. Better manage increasing demand 3. Reducing variation and streamlining services 4. Joint planning and use of acute capacity 5. Information sharing across providers 6. Joint workforce planning & scheduling to meet capacity demands	1. Doesn't involve/include/acknowledge the non-acute elements of an elective pathway 2. Risks alienating other system partners, doesn't reflect a true collaborative at system level 3. Maintains the limited ability to transform out of hospital care, so still reaction based response rather than proactive 4. Does not allow for demand management and long term condition management schemes	✓			✓		✓	✓	✓	✓
Collaborative to commission end to end pathways Opportunity to pilot an agreed number of pathways e.g. MSK and Cardiology	1. Supports demand management and our of hospital schemes 2. putting the patient first from the outset, with care wrapped around the patient 3. improve the patient experience through streamlined less fragmented pathways 4. reduce variation in pathways and access to voluntary and community services across the system 5. Provide a clear patient pathway that all stakeholders understand and agree 6. Get the right patient to the right place at the right time	1. Complex pathways to understand, with multiple providers and more resistance to change 2. Doesn't allow for maximising acute capacity utilisation for inpatient and day case work aligned to elective recovery 3. Multiple contracts and commissioning relationships 4. Longer time period to implement	✓	✓	✓	✓	✓		✓	✓	✓
Hybrid of options 1 & 2 to include some elements of elective capacity and system PTL and some end to end patient pathways	1. Offers all the practical benefits of Option 1 and 2, but with an ability to implement and deliver the benefits over time 2. A greater degree of 'testing' of the different approaches, to enable learning 3. Reflects and incorporates all system partners to some degree	1. Larger breadth of diverse programmes may dilute impacts 2. More complex benefit realisation and monitoring programme required, and more complex change management with multiple partners	✓	✓	✓	✓	✓		✓	✓	✓

Overall Elective Collaborative Governance Roadmap

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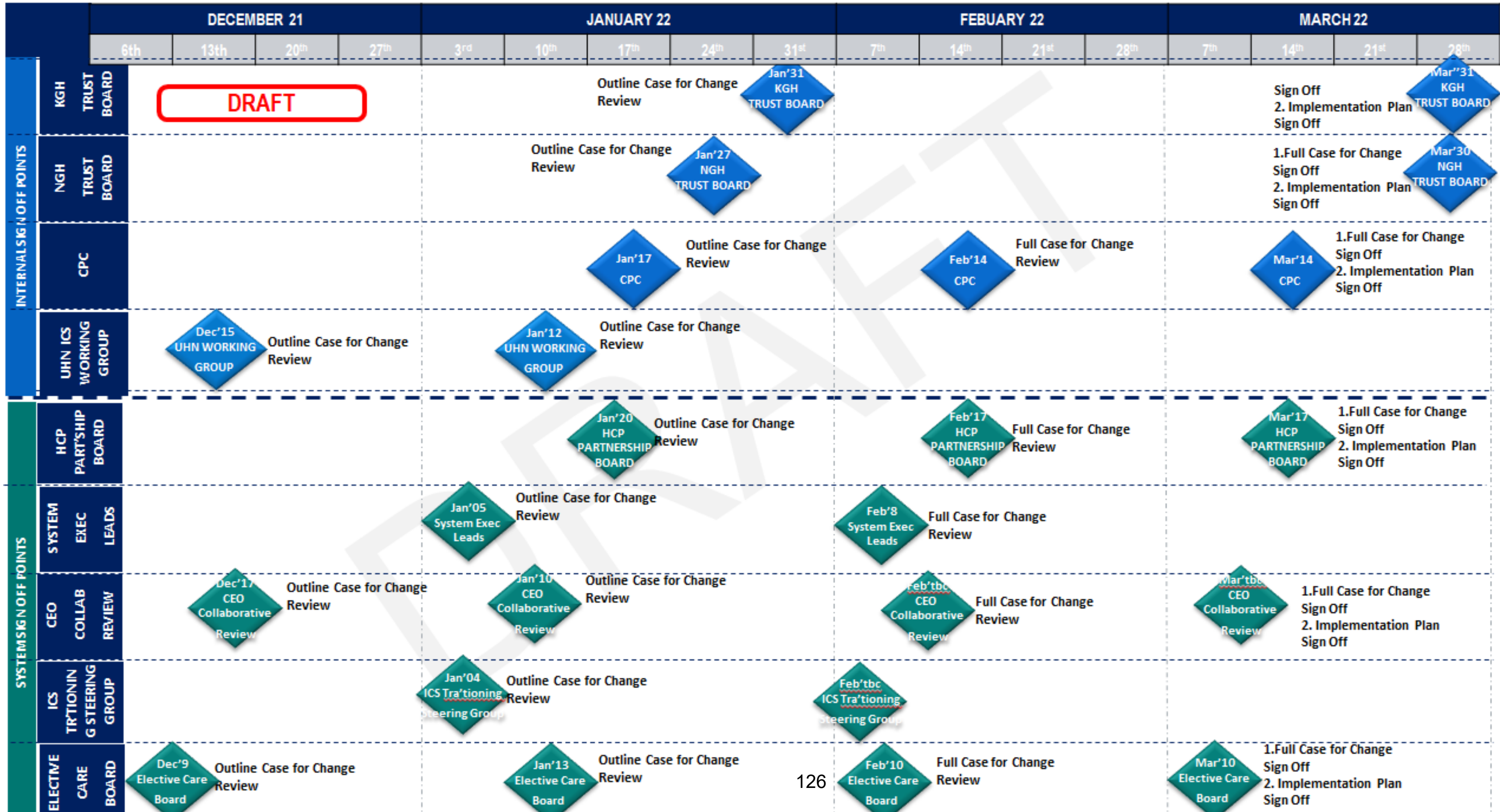
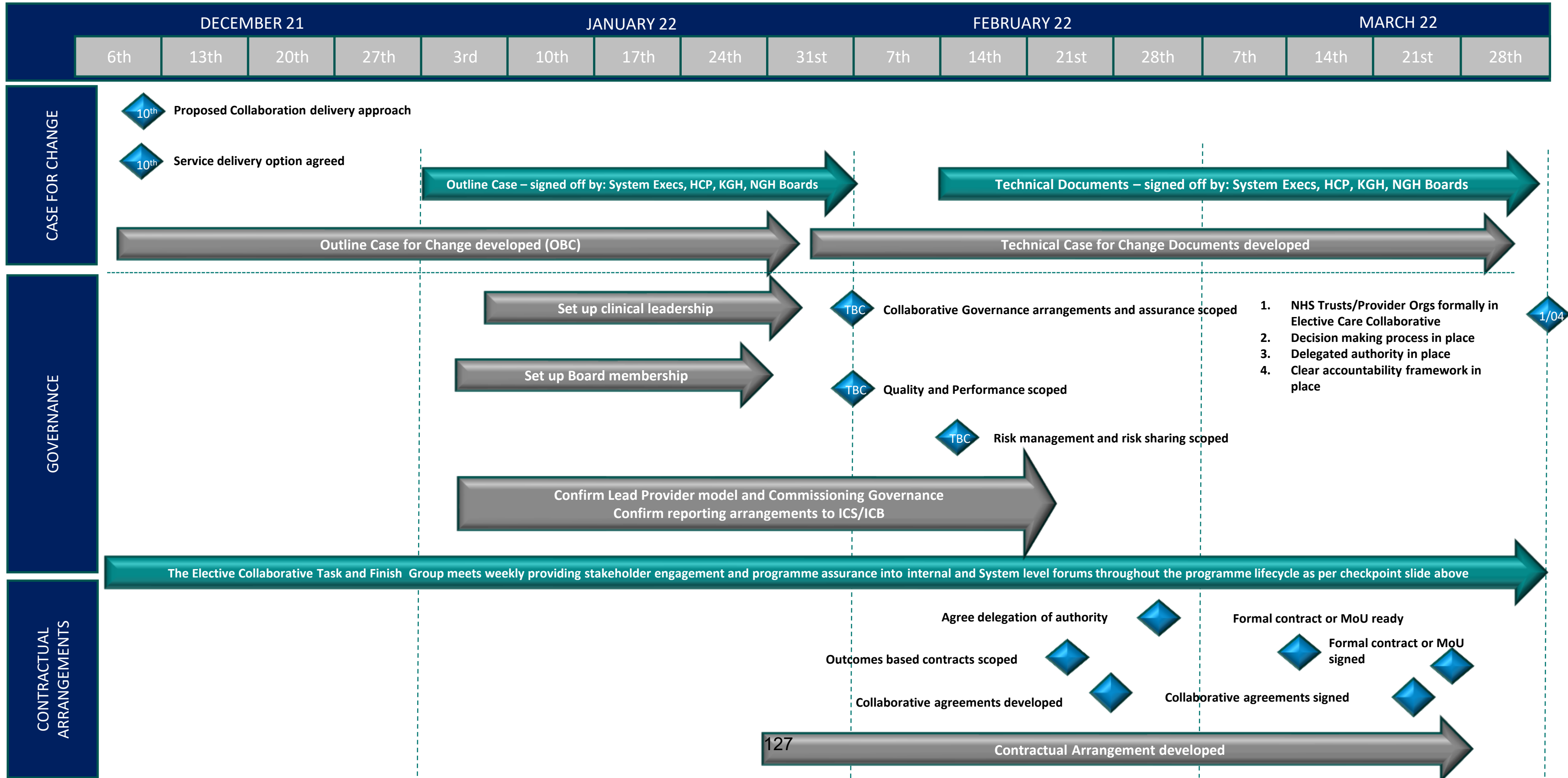


The Elective Collaborative Task and Finish Group meets on a weekly basis focussed on the design, development and implementation of the Elective Collaborative. Responsible for Assurance documentation.



127