Integrated Care Webinar series 2021/2022

Webinar Two: The benefits, capabilities and governance of Provider Collaboratives

NHS England and Improvement System Transformation, in partnership with the Social Care Institute for Excellence (SCIE)

31 August 2021

NHS England and NHS Improvement

scie social care institute for excellence

Your Panel today

Chair: Julia Grace, Deputy Director, Leadership and Learning, NHS England and NHS Improvement

Professor Des Breen, Medical Director, South Yorkshire and Bassetlaw Integrated Care System

Andrew Burnell, CEO at City Health Care Partnership CIC, Kingston upon Hull

Sondra Roberto, Provider Policy Assistant Director, Provider Development, NHS England and NHS Improvement

Jeremy Walsh, Head of Service Delivery, South West London and St George's Mental Health NHS Trust

Sondra Roberto
Provider Policy Assistant Director
Provider Development
NHS England and NHS Improvement

NHS England and NHS Improvement

scie social care institute for excellence

The ICS Design Framework defines provider collaboratives as a key component of effective integrated care systems

The *Working together at scale* guidance:

Sets out the **benefits of scale and mutual aid** that collaboratives can deliver and the **expectations for systems and providers**.

- All trusts providing acute and mental health services, including specialist trusts, are expected to be part of one or more provider collaboratives by April 2022. Community and ambulance trusts and non-NHS providers (for example, community interest companies) should be part of provider collaboratives where this would benefit patients and makes sense for the providers and systems involved.
- ICS leaders, trusts, and system partners, with support from NHSEI regions, are working to identify shared purpose, appropriate membership and governance, and ensure activities are well aligned with ICS priorities
- Provider collaboratives will agree specific objectives with their ICSs, focused on priorities requiring trusts to plan services at scale

- **What they are:** Provider collaboratives are **partnership arrangements** involving at least two or more trusts working at scale across multiple places, with a **shared purpose, effective decision-making arrangements within a core set of capabilities**.
- There are already several acute and mental health provider collaboratives across the country with a history of joint working over several years.
    - West Yorkshire Association of Acute Trusts (WYAAT)
    - Greater Manchester Provider Federation Board (GM PFB)
    - South Yorkshire and Bassetlaw Acute Federation
    - South West Mental Health Provider Collaborative
    - South London Mental Health and Community Partnership (SLP)
- These collaboratives work together to deliver joint programmes across clinical, clinical support and corporate services where it makes sense to do so to achieve benefits of scale:

Single West Yorkshire vascular single service and standardised referral criteria and protocols (WYAAT)

Development of five new forensic pathways including a new single point of access for referral across three trusts (SLP)

SWL joint recruitment hub of four acute trusts, reducing time to recruit and vacancy rates, and generating cost savings

Provider collaboratives need to be purposeful and proportionate, locally developed to deliver benefits, and evolutionary

Simple	Local	Evolutionary
• Collaboratives must be purposeful; function and form driven by the purpose • Governance and resources devoted to running collaboratives should be proportionate to expected benefits • Collaboratives can enable more effective and speedy restoration/recovery	• Policy is permissive and flexible • Local systems to decide what arrangements make the most sense • Recognition that benefits will vary based on populations, geographies, system characteristics • Collaboratives will need to work with system partners, place based partnerships, clinical networks...	• Recognition that building strong relationships underpins success • Systems and collaboratives will vary in where they are now and how much further they need to go • The legislation will support more efficient joint working and enable mature collaboratives to take on more functions where appropriate

SOUTH LONDON Mental Health and Community Partnership

NHS

NHS Oxleas NHS Foundation Trust

NHS South London and Maudsley NHS Foundation Trust

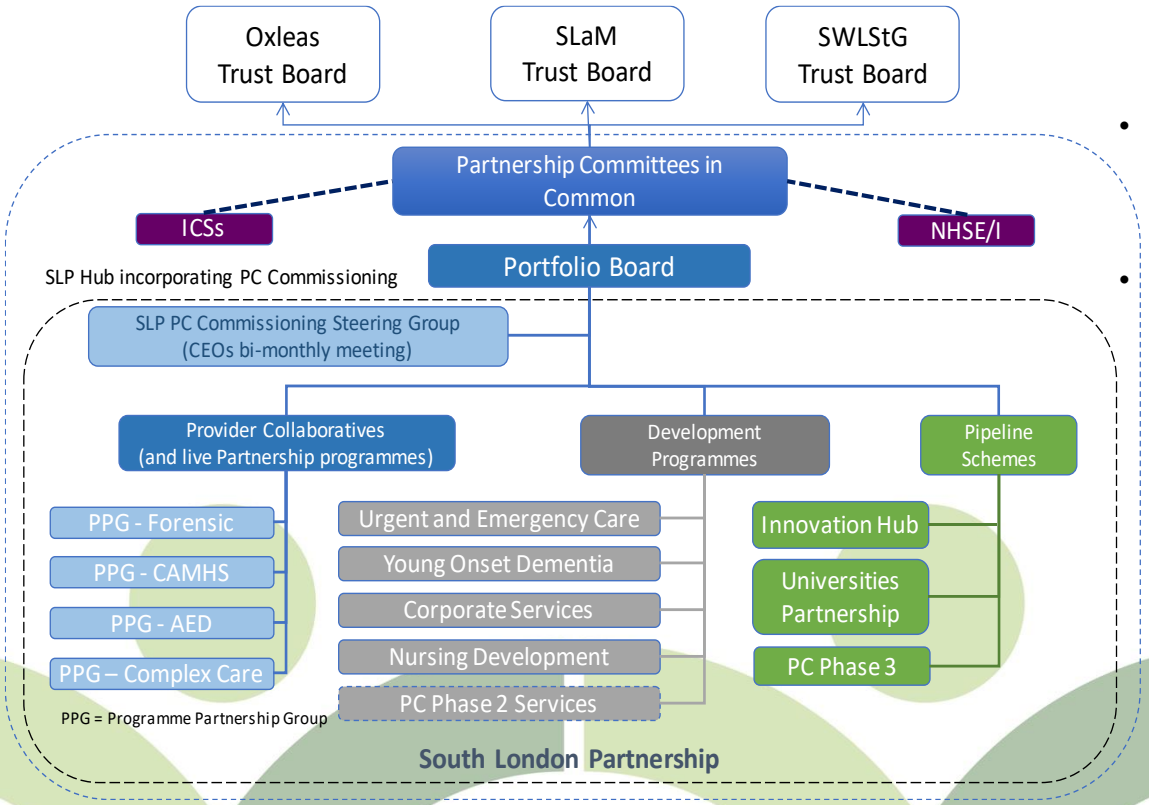
NHS South West London and St George's Mental Health NHS Trust

Driving opportunities to transform mental healthcare across South London through collaboration not competition

ICS Webinar
Jeremy Walsh, Director

31 August 2021

Robust partnership governance and positive culture enabling innovation and collaboration to thrive



- Shared risk and savings; commitment to reinvest – south London-wide **and** targeting Borough needs
- Culture of collaboration, not competition
  - Shared values, goals, savings + risk
  - Clear vision and aims; robust outcome measures; total focus on better care, experience and outcomes for patients
  - Agile programme management and purposeful engagement
  - Population and partnership view - aligned objectives with those outside the Trusts

CAMHS

Key Achievements

- £3.7m (16%) of budget reinvested into new services including:
  - SLP CYP Crisis Line
  - Community based DBT services delivered across the PC footprint
  - Bed Management
  - Crisis Services
- No Out Of Area GAU or PICU admissions
- Clinically driven work streams

Wider Collaboration Across London

- Systems meetings established with North London CAMHS PCs:
  - Commissioning - Audit of CYP presentations to A&Es, NHSB deep dive, programme support
  - Joint action plan to respond to the audit findings with key stakeholders – acute, MH, paediatrics, social care
  - Mutual aid - London-wide dashboard with daily bed availability
  - LoS data driving new initiative to reduce unwarranted variation

- Regional / System / Place – Collaboration to permeate along the entire CAMHS pathway

Complex Care

Background

Three year journey of collaboration spanning 12 health and 12 social care organisations

Single Point of Referral established providing consistency and knowledge

Clinical expertise located in a complex care assessment team

‘Coalition of the willing’

October 2020 - Delegation of CCG budgets for 100% health funded placements for 3 years

April 2021 - 3 pilot sites developing new approaches in partnership with social care

Work in Progress

Working at multi-system / system / place

c200 complex patients stepped down and 45 in the process of being supported to move

Efficient contract management driving value for money and new opportunities for investment

New partnerships with Voluntary and Independent sector providers

Making the case for change by delivering better outcomes for complex patients

Appendix, A

South Yorkshire and Bassetlaw Integrated Care System

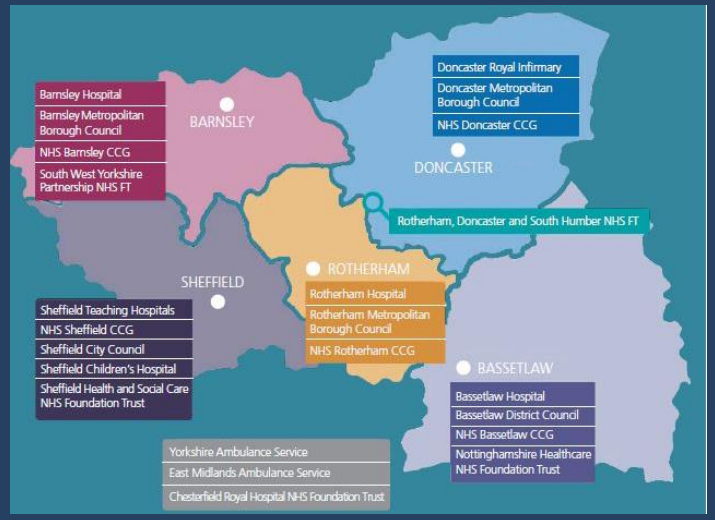
A

NHSE/I

Provider Collaborative Webinar

31st August

Prof Des Breen



Provider collaboration – some SYB examples

Clinical examples

- Vulnerable specialities

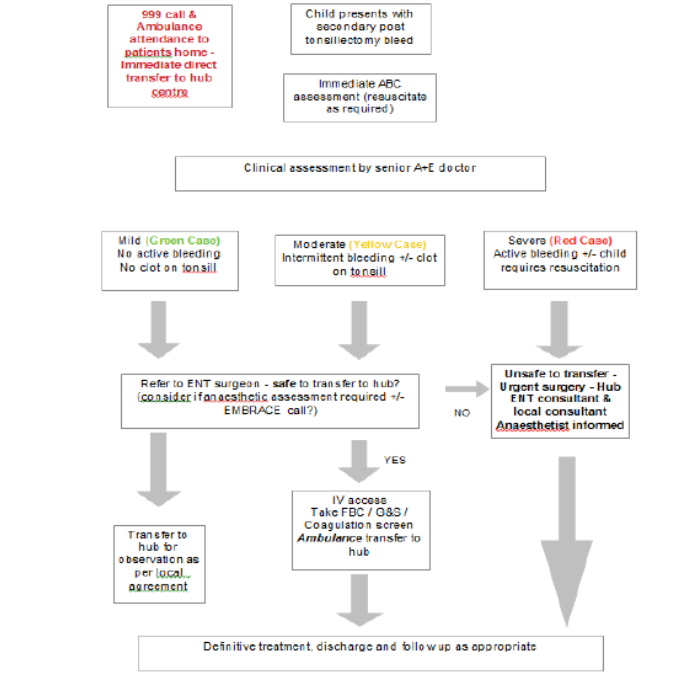
NOSE

Presenting Symptoms	Advise and Treatment
Trauma	
Nasal injury with no swelling, cosmetic deformity or other factors:	No intervention needed.
Minor soft tissue wound with no cartilage involvement::	Suture, glue or steristrip as appropriate.
Nasal injury with swelling and deformity but no active bleeding or other features:	Head injury advice, review ENT emergency clinic in 5-7 days.
Nasal injury with active bleeding, septal haematoma, open wound with cartilage involvement, CSF rhinorrhoea: Associated facial bone fracture, dental damage or reduced eye movements	All need urgent ENT referral. All need urgent OMFS referral.
Foreign Body in Nose	
Small inert foreign body in nostril:	Only attempt removal if superficial. Remove hard object with wax hook, soft object with crocodile forceps. No FU if successfully removed.
Stable foreign body in nose, especially if chronic:	Next available ENT emergency clinic
Unstable foreign body with risk of aspiration, sharp object, button battery:	Urgent ENT referral WITHIN THE HOUR.

NOSE

Presenting Symptoms	Advise and Treatment
Epistaxis	
Minor recurrent bleeds, not actively bleeding, well patient:	Naseptin cream if evidence of vestibulitis / crusting, follow-up in ENT emergency clinic within 7 days.
Active bleeding, severe bleed, unwell patient:	Urgent ENT referral. Will need resuscitation if severe: IV access, FBC, PT/INR if anticoagulants, group and save / X match, consider nasal pack (e.g. Rapid Rhino) prior to transfer.
Inflammatory Conditions	
Rhinitis / sinusitis with no adverse features:	Antibiotics not usually indicated. See GP if problem persist, especially if chronic.
Cellulitis or swelling involving nose, face or eyes:	Urgent ENT referral.

Child Post Tonsillectomy Bleed Pathway



Provider collaboration – some SYB examples

Clinical examples

- HASU
- Hosted networks

HASU

- Consolidation

Stroke network

- MDT
- Primary & community care

Children's network

- Acutely ill child
- Surgery & Anaesthesia

Provider collaboration – some SYB examples

Clinical examples

- Cancer Alliance
- SACT

SACT

- Lead provider model
- Different delivery model
- Care closer to home
- New financial/contracting model

Provider collaboration – some SYB examples

Clinical examples

- Covid 19
- Recovery

Covid-19

- Cohorting
- ICU surge principles
- G&A mutual aid principles
- Daily system surgical huddle
- Children's surgery divert

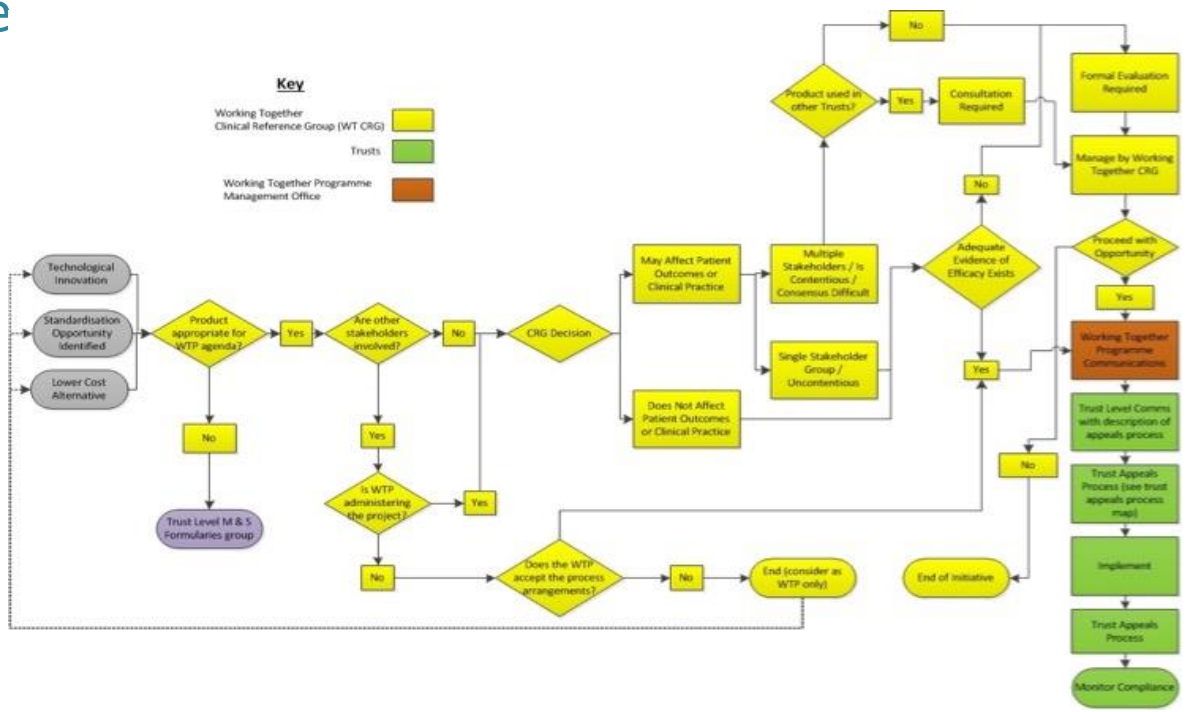
Recovery

- Elective Activity Coordination Hub
- Harm minimization
- FIT in high risk, primary care

Provider collaboration – some SYB examples

Non-clinical examples

- Digital
- HR/Workforce
- Back office
- Procurement



Humber, Coast and Vale Health and Care Partnership

Community Health and Care Collaborative Overview

Andrew Burnell, Erica Daley, Wendy Balmain, Carol Waudby

- **Unique in the North Region**
- Committed to delivering 'integrated care closer to home' whilst improving population health outcomes, well being and prevention.
  - Purpose, vision, principles and objectives developed
  - Work to do to embed across the partnership
- Approach: ICS **(20% - 80% rule)**
  - Focus on system learning through sharing of data and best practice to develop consistency wherever possible whilst recognising each **'Place'** is different
  - Delivery at the right level and avoiding duplication
  - Agreed terms of reference which has enabled strong engagement from a diverse group (including local authorities) that has good relationships and lots of enthusiasm!!
- Objectives:
  - To deliver wherever possible person centred care closer to or at home
  - To secure the sustainability of the Community Health and Care Sector
  - To enhance the quality, safety and effectiveness of services
  - To demonstrate the value of this wide sector in managing access and demand
  - To influence the strategic workforce approach
- Already leading across HCV ICS on:
  - Ageing Well Policy Implementation
  - Discharge to Assess, 2 hour Community Rapid Response, Anticipatory Care and Nursing Care Home support.
  - End of Life Care
  - Carers

Challenges / Obstacles:

- Community is still seen as the **add on** to other collaboratives (national)
- **Vision for the value of "community" (Out of Hospital space) can be diluted without a collective voice#**
- The development of a true **"Primary Health Care"** collaborative#
- Ensuring resources are made available to support delivery of ambition
- Further clarity required on the role / function of the collaborative working within the Partnership

#Vision - Primary Health Care – the concept

Primary Health Care is a whole-of-society approach to health and wellbeing that is centred on the needs and preferences of individuals, families and communities. It addresses the broader determinants of health and focuses on the comprehensive and interrelated aspects of physical, mental and social health and wellbeing.

It provides whole-person health, care and wellbeing needs throughout the lifespan, and is not just focused on a set of specific diseases. A Primary Health Care approach ensures people receive comprehensive care - ranging from promotion and prevention to treatment, rehabilitation and palliative care - **as close as is feasible to people's everyday environment** (home, neighbourhood / community).

Current Membership

Social Enterprise

- City Health Care Partnership
- NAViGO
- Care Plus Group

Local Authority

- East Riding of Yorkshire Council
- Hull City Council
- North Lincolnshire Council
- North East Lincolnshire Council
- City of York Council
- North Yorkshire County Council

Geographical Partnerships

- Humber
- North Yorkshire and York

Mental Health Community

- Humber Teaching NHS Foundation Trust
- Tees, Esk and Wear Valley NHS Foundation Trust

Acute Trusts Community

- York Teaching NHS Foundation Trust
- Harrogate and Rural District NHS Foundation Trust
- Northern Lincolnshire and Goole NHS Foundation Trust

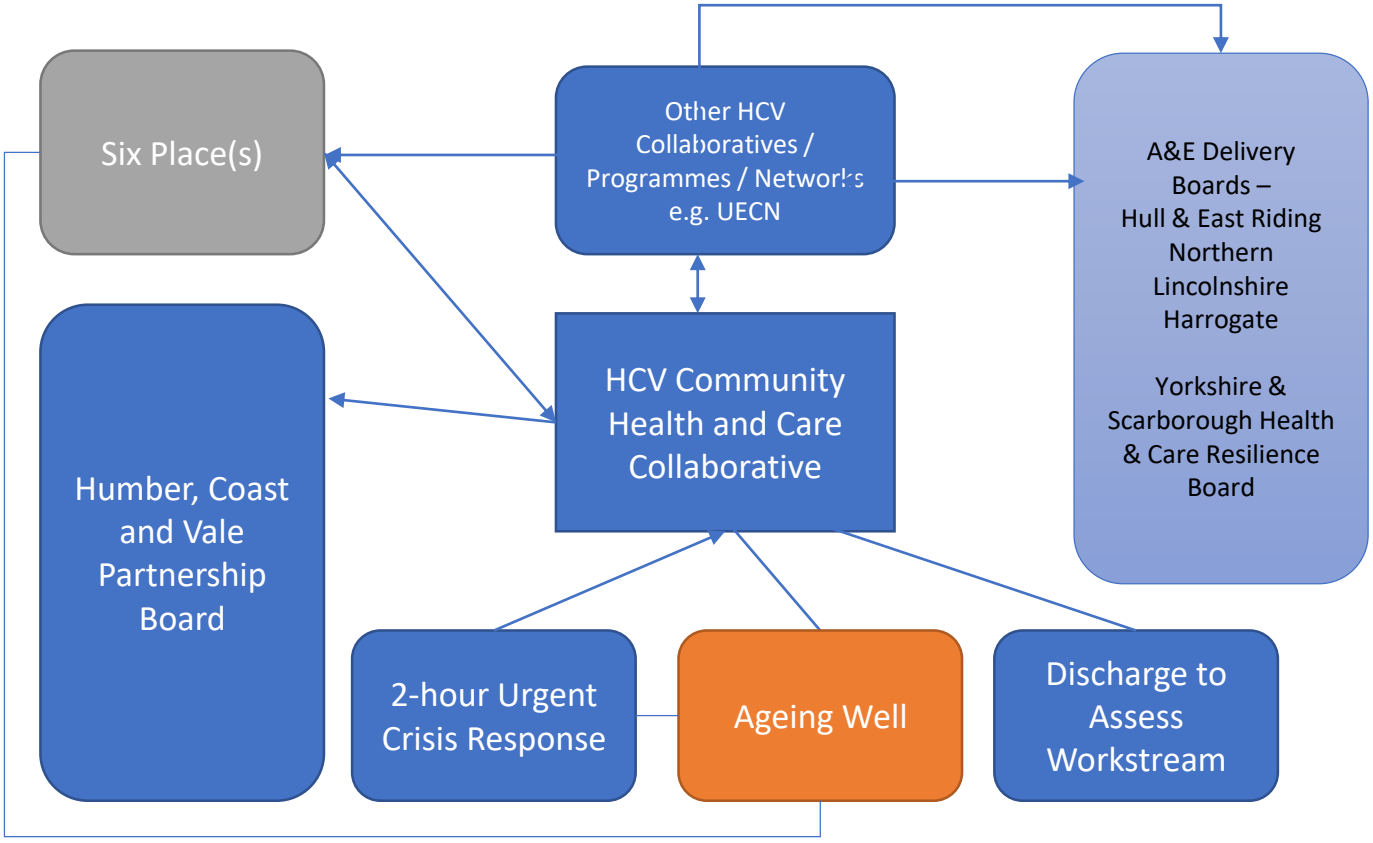
Ageing Well

- Established HCV - Ageing Well collaborative Network

Purpose

- To have collective oversight of the implementation / delivery of the Ageing Well Programme(s) across HCV

Governance


Six Place(s)
Other HCV Collaboratives / Programmes / Networks e.g. UECN
A&E Delivery Boards –
Hull & East Riding
Northern
Lincolnshire
Harrogate
Yorkshire & Scarborough Health & Care Resilience Board
Humber, Coast and Vale Partnership Board
HCV Community Health and Care Collaborative
2-hour Urgent Crisis Response
Ageing Well
Discharge to Assess Workstream

Objectives / Responsibilities

Work collaboratively to:

- support what is right for localities / communities and build solutions from place
- limit variation and have common approaches where appropriate e.g. risk stratification
- have oversight of delivery and implementation and understand the challenges and gaps for escalation
- share plans, ideas, best practice and be a community of practice for the areas in scope
- lead areas of work that make sense to do once across HCV e.g. digital, anticipatory care plans with Ambulance services etc.
- determine the approach to the allocation of any resources

Plans for 2021/22

North Yorkshire and York

Admission Avoidance

- 2 hour crisis response implementation & Joint health & social care team integrated approach across NYY

Frailty & Ageing Well

- **Q1** - Finalise PHM / Anticipatory Care model for Frailty, High-level integrated service model described, Prevention strategy focused on deconditioning – from May 2021
- **Q2 -** Whole System Frailty Pathway**,** built on RightCare principles, incl. use of community-based assets, Rockwood Scale (CFS), Frailty Stratification Assessment Tool (FAST), ACPs, EHCPs & MDT care co-ordination described & implementation plan developed – June 2021
- **Q3** - 7 day frailty turn-around at hospital front door

Humber

Frailty

- Anticipatory management – risk stratification, early intervention and prevention
- Taking learning from Hull model across Humber
- Responsive – urgent care and crisis response to prevent admissions
- Enhanced Health in Care Homes

Transformation of community services to provide 2-hr crisis response

- Q1 – determine baseline, scope and activity projections - aim to achieve 15% increase in 2 hr response from initial baseline on agreed pathways. Agreement on priority pathways (frailty, respiratory, falls and stroke)
- Q2 – finalise integrated model, agree phased delivery plan, alignment with PCNs
- Q3 - agree standard operating procedures and run pilots on key pathways (focus on frailty respiratory and falls to support resilience plans)
- Q4 - adjust implementation plan ready for mobilisation.

Project 2 Hour Urgent Community Crisis Response

Reporting Period: 20/8/21

York Teaching Hospital NHS Foundation Trust

Summary Reporting period: As outlined in the NHS Plan there is a requirement, as part of the overarching Ageing Well Initiative for each Place to have a 2 hour urgent community crisis response service. Initially guidance was to have a service in place by 1st April 2022. However, due to the impact of the Covid-19 pandemic the rollout of this initiative has been escalated. The HCV planning submission, June 2021 confirmed that funding would be available in 21/22 and Places/Systems worked collectively to submit high level mobilisation plans, which included workforce and financial plans and rollout trajectories relating to service delivery. As per the planning submission, places across Humber have plans in place start to mobilise delivery from Q3/H2. A number of KPIs have been developed and will be reported via CSDS from Q3 and across Humber, a number of locally/stretch targets and KPIs have been suggested as outlined below.

KPI	Baseline	Target	Comments
People in Crisis, meeting criteria are seen within 2 hours			
People are provided with 2 days care and support if required			
Dispositions recorded and monitored e.g. pathway offered			
Patient Satisfaction/ PROMS			

	Initiative	Lead	RAG	Achievement prev month
1	Confirm model, workforce and resource requirements and draw down funding	PH		All places have delivery groups that are working up their plans; Paul Hillary DOF CHCP has been identified as lead for funding distribution and is working with Karina Ellis to develop a plan on a page type template to enable each place to draw down agreed funding based on envelope and population size.
2	Recruitment of workforce	Project Leads		Due to delays in funding draw down providers in H&EROY have gone at risk to advertise posts.
3	Development of pathways into the service	Project Leads		Current services are profiled on the DOS, work up DOS for new services and agreed pathways via non NHS111 partners – including YAS/999
4	2 day offer	Project Leads		Providers are working up plans for 2 days H&S care support either directly or via LA
5	IM&T	CW		Agreed to work with UECN to align projects – Sue Rogerson invited to ageing well group.

Next steps for XXX

Place Leads to share plans on pages with CHCP DOF
Draw Down Funding
Continue Recruitment
Refine model and mobilisation plans
UECN rep to attend Ageing Well Group to discuss C2C and direct booking etc. tech
Confirm links to Community Diagnostic Hub initiative as this is an enabler for admission avoidance.

Risks and Support needed

- Timeliness of funding draw down
- Ability to recruit workforce
- Availability of Care Calls to support pathways post 48 hours, e.g. across H&EROY

HCV Community Collaborative - Discharge Group

- To have a collective view of how HCV is delivering discharge policy through a single conversation with the 6 Places
- Working with single coordinators and other key stakeholders to identify and amplify risk across sectors NHS and Local Government
- To provide a single point of discussion to review performance, share learning and build solutions
- To accelerate progress implementing findings from the HCV Discharge Review in the 6 Places
- To monitor any unintended consequences on service delivery
- To monitor changes to funding arrangements on service delivery and collect evidence ensure that HCV key issues are reflected in regional discussions

Example - Improving Discharge Metrics 09/08/21

Key Metrics	York	Harrogate	South Tees	Airedale	Narrative
Bed Occupancy Covid position	5% York site 3% Scarborough	2%	11%	2%	National metric is 5% bed occupancy COVID + below. STEES are significantly higher. NY patients at STEES have access to Designated Settings and we are supporting out STEES system to establish designated settings for all patients to prevent infection.
Stranded patients - % against national ambition **(<40% for 7 + days)**	39%	52%	50%	40%	York remain within target although increased %. Harrogate remain over target, and worsened position STEES are above target and are developing an strategy through an intensive ECIST review by ward this week (commencing 9th August).
Stranded patients - % against national ambition **(<12% for 21+ days)**	8%	18%	18%	10%	York remain in within target. Position in Harrogate has worsened.
% of patients who do not meet the criteria to reside, and who were discharged by 5pm on that day **(70% & by March 2021 – 80%)**	21.6%	26.6%	26.5%	11.0%	Reduction for Harrogate which has been noted as best in the region. Worsened position primarily due to Community pressures/ staffing (Opel 3) Position has remained consistent across other Trusts. STEES are working with ECIST to complete an intensive review to develop a strategy to improve performance.
Discharge performance - national ambition 95% patients pathways 0-1 discharged home	85-92 % people within York boundaries	88 -85% people with NY boundaries			Work is underway to ensure sight of pathway data for all pathways 0-3. Current position is as of May 2021 overall system position (NY & York) 92% of people discharged Pathway 0 & 1.
Discharge activity	163 recorded delays 22 % decrease from previous week	112 recorded delay 37% increase from previous week.	91 recorded delays 5% increase from previous week.	52 recorded delays 18 %increase from previous week.	• Airedale increased for the second week in a row • HARA has seen another large increase and has again recorded it's highest figure for a second consecutive week • South Tees has seen a light increase, after last weeks decrease • York NY and CYC have both had decreases, having seen their highest recorded figures the prior week • The average number of delays has decreased by 5%, this follows 4 weeks of consecutive increase prior to this week
System Opel Levels Highest reported Opel Level reported	LA Opel 3 Trust position Opel 3	LA Opel 4 Trust Opel 3	LA Opel 4 Trust 2	LA Opel 4 Trust 3	Craven and STEES have remained consistent over the week. York and Harrogate have been changeable with escalated positions for both and Scarborough at the end of the week. NYCC position remains unchanged at Opel 4 impacting our ability to support discharges.

Integrated Care Webinar series 2021/2022

Next webinar

Monday 27 September 2021 at Midday.

Invites will be sent via SCIE's newsletter, SCIELine.

Register for SCIELine www.scie.org.uk/myscie/register

NHS England and NHS Improvement

scie social care institute for excellence

Integrated Care Webinar series 2021/2022

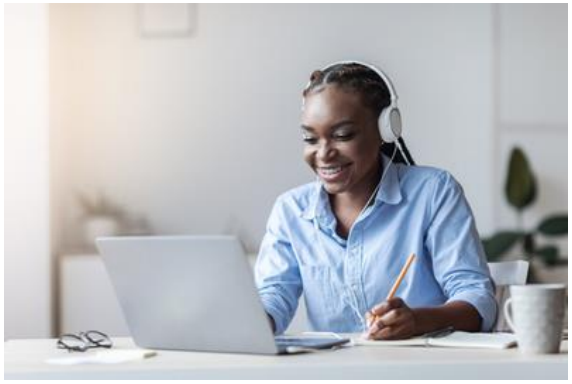
A recording of the webinar, slides and resources will be shared on the **Integrated Care Learning Network**.

To join the network email integratedcare-manager@future.nhs.uk.

NHS England and NHS Improvement

scie social care institute for excellence

www.scie.org.uk/consultancy/co-production



NHS England and NHS Improvement