PROVIDER COLLABORATION

Welcome to the Provider Collaboration webinar

How are provider collaboratives helping to reduce care backlogs across systems?

Thursday 8 December 2022

This virtual event will be recorded and published to our website.

Lancashire and South Cumbria Provider Collaborative

Elective Care Recovery Programme – working as one to reduce our backlogs

Karlyn Forrest
Programme Director – Elective Recovery

Lancashire and South Cumbria Provider Collaborative

The Provider Collaborative consists of the five provider NHS trusts in Lancashire and South Cumbria

We want:

- patients to have equal access to the same high-quality care wherever they live
- our colleagues to have the same high-quality experience wherever they work

Together we will drive up quality by:

- agreeing joint priorities and how to best join forces to deliver them
- sharing skills and best practice
- pooling our resources
- standardising the way we work to reduce variation and duplication

By working together all of the trusts benefit. We will achieve more for our patients and communities than if we work separately

Lancashire and South Cumbria Provider Collaborative Vision

Lancashire and South Cumbria Provider Collaborative is currently made up of:

- Blackpool Teaching Hospitals Foundation Trust • East Lancashire Hospitals Trust
- Lancashire and South Cumbria Foundation Trust • Lancashire Teaching Hospitals Foundation Trust
- University Hospitals of Morecambe Bay Foundation Trust

Proud to be part of

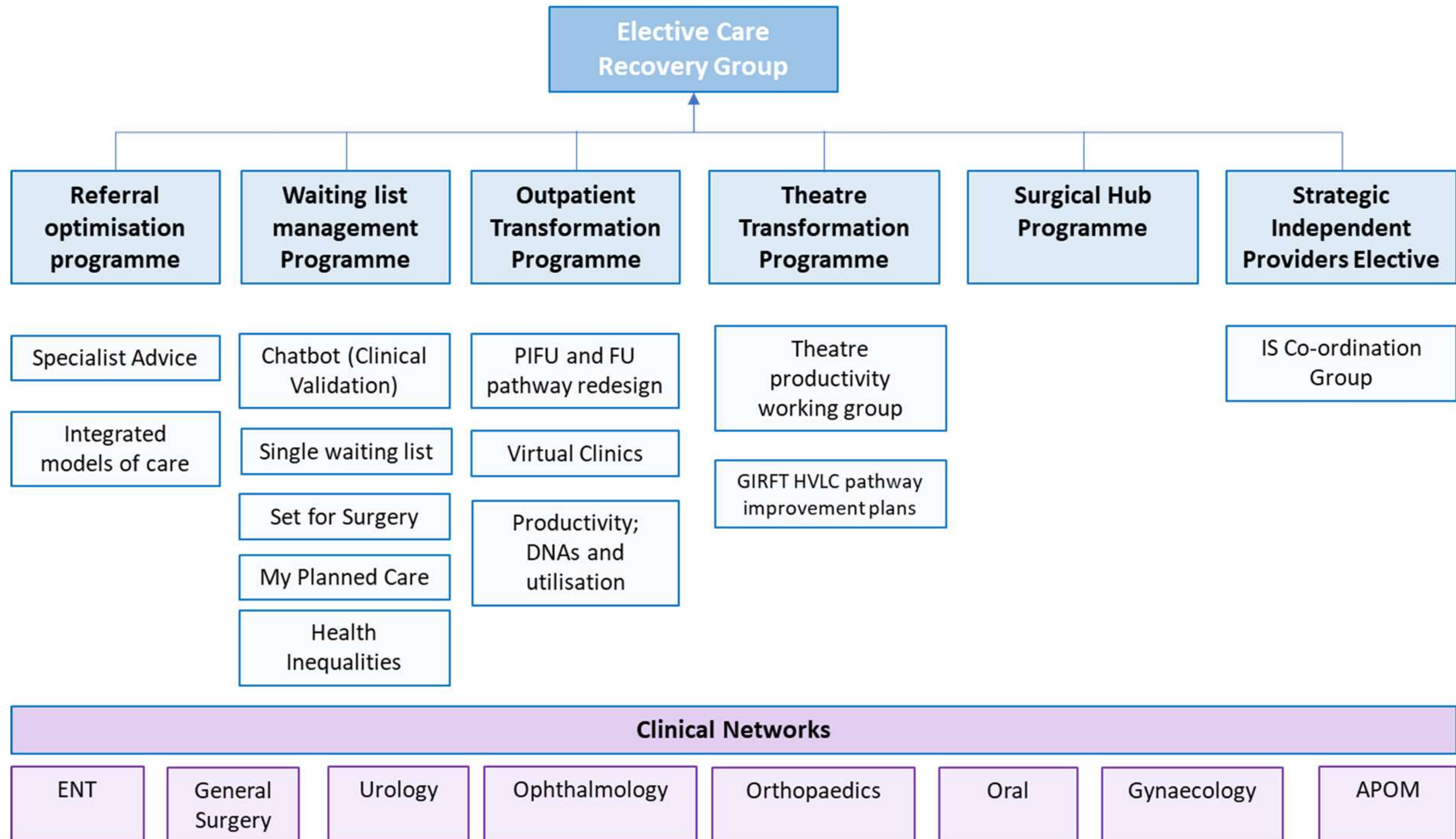
Elective Care Recovery Group

- Lancashire and South Cumbria (LSC) Elective Care Recovery Programme was formed in the summer of 2020 to support all acute Trusts to work on key actions within the National Operational Planning guidance, to provide clear direction and ensure a collaborative system-wide approach to managing elective recovery.

- Evolved and grown since this time and has delivered tangible improvements to reducing our waiting times for patients.

- Currently refreshing the programme; able to now place greater focus on the transformative stage of our programme and make clearer the outcomes to be delivered.

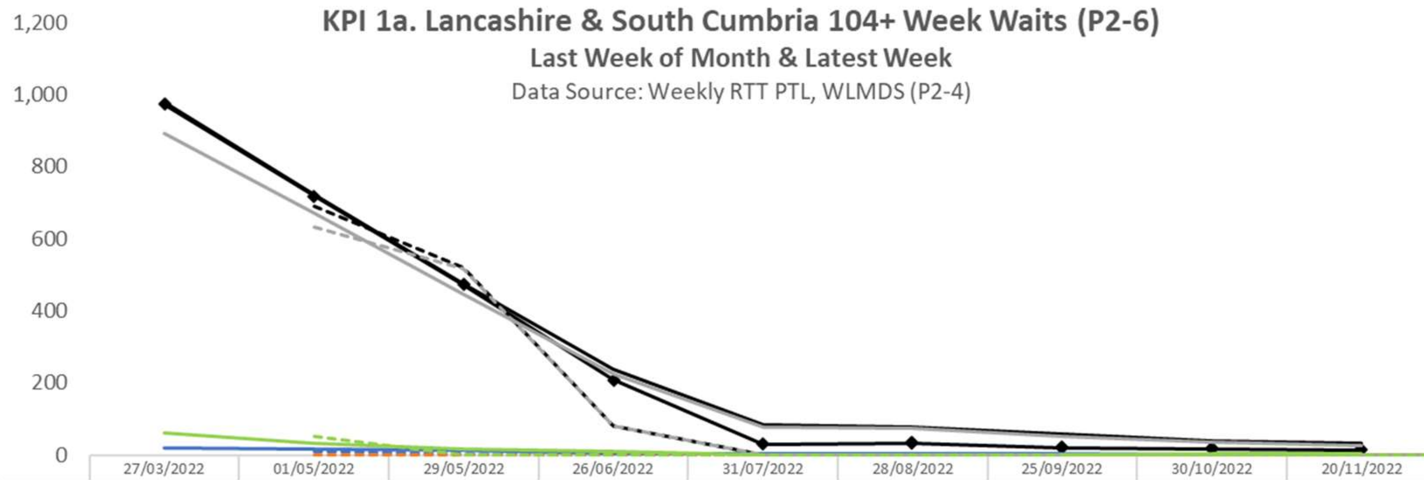
Overview of the Programme



Elective Recovery Programme Principles

- Our programmes will be cognisant of and align with long-term commitments and ambitions, not just meet the current recovery imperatives.
- Use the programme to address challenges shared by all Trusts to realise the benefit of doing things once rather than four times.
- We will use the programme to share and rapidly rollout examples of good practice.
- We will use the programme to standardise delivery.

Mutual Aid – system approach to achieving 104 weeks



- Our four Providers started 2022/23 with different levels of challenge to achieve the elimination of 104 week wait standard.
- Instigated the creation of a Mutual Aid protocol and weekly meetings, identifying specialities and patients to be transferred to another Provider to support the required reduction in waiting times.
- Weekly meetings continue and to date over 1,116 patients have transferred and been treated by another Provider.
- Mutual aid includes diagnostics and cancer

Building on our Mutual Aid ambitions

- COOs and MDs are currently working together to plan how our collective capacity can be used to mitigate risks to the achievement of the 78 week wait standard whilst also reducing our 62 day cancer backlog.
- Shared ambition to develop and evolve our Mutual Aid process to be more prospective and truly achieve the aim of having equity of waits for our patients:
  - Appraising options to introduce a single system-wide PTL
  - Process mapping to improve the current process whilst also considering how the process can evolve to identify the need for mutual aid earlier in the patients' pathway
  - Initiating a transformation project to consider single waiting lists for particular procedures

Reflection on Mutual Aid

- Trust and openness between Providers and buy in to working together
- Not easy; requirement to navigate the conflict between the responsibility to work as one whilst being four statutory organisations
- Clinical engagement and engagement with operational teams is key: looking at waiting times at a system level is a big movement away from our well embedded ways of working and focus on individual provider performance
- Needs co-ordination support and capacity
- Difficult to move patients once on a pathway; easier to use mutual aid before a patient is seen
- Need to bring patients with us in this new way of working

System-wide approach to waiting list validation - Chatbot

- Designed by Lancashire Teaching Hospitals, Chatbot is an automated call system that supports the clinical validation of patients on waiting lists.

- It reduces clinical and administrative burden through providing a high volume, rapid response regarding patients' conditions. As a consequence it generates additional booking capacity through removing patients who no longer require specialist support.

- Following clinical validation scripts, Chatbot asks patients questions about their health condition, enabling them to confirm whether they would like to remain on the waitlist, be removed or, mostly importantly, whether their condition has worsened.

- Clinical teams are notified and then review all patients who indicate they wish to leave or symptoms have worsened.

- Clear clinical and operating procedures are in place, ensuring those who are not appropriate or will not benefit from this new system are excluded (e.g. children, patients with dementia).

Chatbot – Pilot and system-wide adaption

- We piloted Chatbot in 2021/22 with 2,282 waiting list patients in University Hospitals of Morecambe Bay and Lancashire Teaching Hospitals receiving a call asking about their health condition. Pilot results were positive; 75% of patients responded to the automated call and 15% of patients indicated they could leave the waitlist.

- The 2022/23 Chatbot programme is seeing the roll out to all hospitals and clinical specialties in Lancashire and South Cumbria and will contact over 30,000 patients before the end of March 2023.

- To date, 17,299 patients have been contacted this year. 13,583 have been validated at a response rate of 79%, with almost 1,200 patients reviewed by clinical teams following the patient indicating they could leave the waitlist.

- LSC ICB programme results to date – 2022/23:
  - **2%** of all patients indicated a worsening of symptoms and required an appointment sooner.
  - **9%** of all patients indicated they could leave the list.
  - **89%** of all patients indicated they could remain on the list.

Chatbot next steps

- Took a system-wide approach to responding to the clinical validation requirements for two of our four Trusts who were in Tier 1 in October 2022, building Chatbot into the process to be followed.
- Now using to keep in touch with patients referred under the cancer two week wait rule
- In 2023/24, use the outcome of the Chatbot evaluation to design a system-wide clinical validation protocol, ensuring all benefit from having a cost effective process in place that supports elective recovery going forward by reducing the size of our waiting lists

Further examples of tackling our backlogs as a collaborative

- Ensuring effective use of the independent sector through an IS co-ordination group; allows waiting list and capacity pressures from all four providers to be used to ensure best use of IS capacity.
- System-wide clinical Networks:
  - Anaesthetic and Peri-operative medicine network have agreed a No One at Home policy for adoption across all Providers. Now looking at pre-operative assessment pathways and standardising to support mutual aid
- Increasing productivity
  - Theatre working group; bringing theatre colleagues together to address shared challenges
  - Outpatient Transformation Board; each Provider reviewing minimum of 2 pathways to reduce follow ups to then share and rollout at a system-level

Lancashire and South Cumbria

Health and Care Partnership

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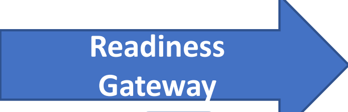
NHS
Coventry and Warwickshire

Provider Collaboratives

Danielle Oum
Chair

Laura Nelson
Chief Integration Officer

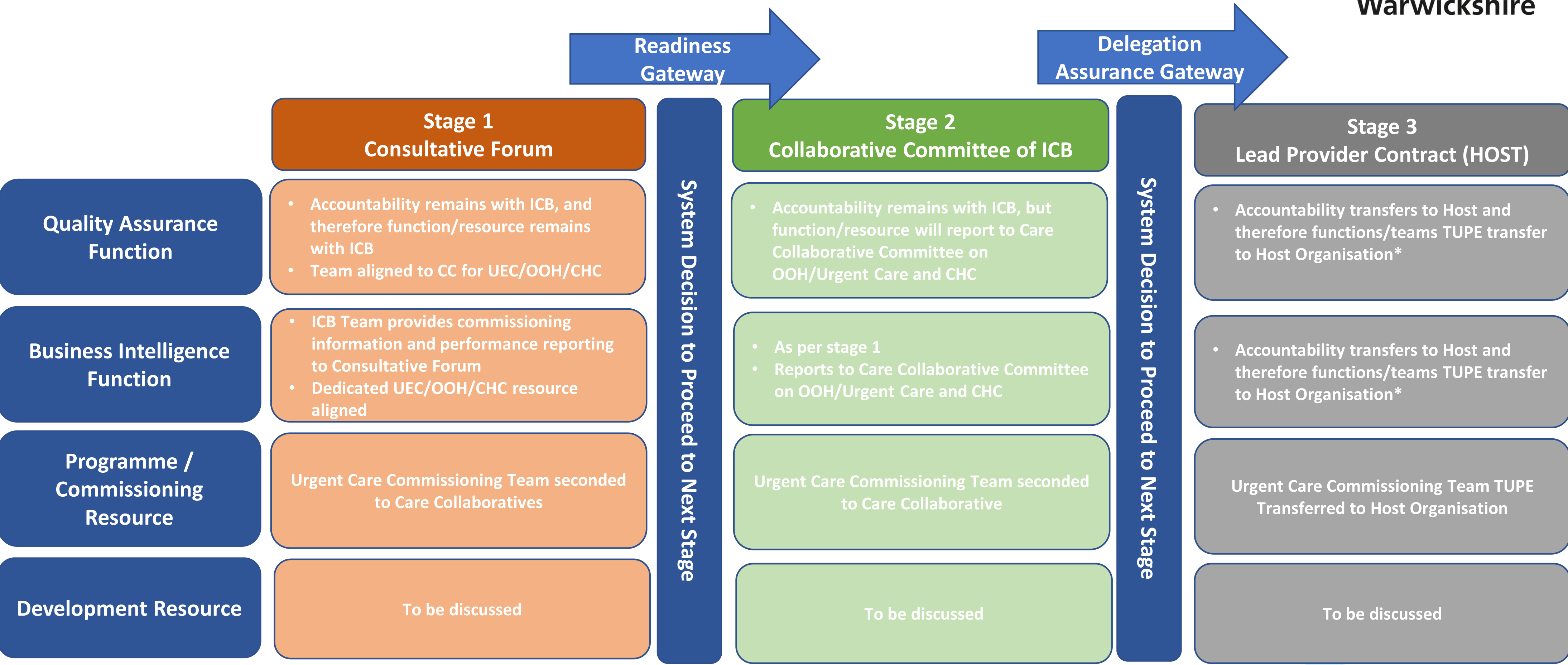
Potential Governance Road Map (Urgent Care/OOH/CHC example)



	Stage 1 Consultative Forum		Stage 2 Collaborative Committee of ICB		Stage 3 Lead Provider Contract (HOST)
Core Purpose	DECISION SHAPING Advise on all commissioning decisions in relation to CHC/OOH/Urgent Care	System Decision to Proceed to Next Stage	SHARED DECISION MAKING Members take decisions on all CHC/OOH/Urgent Care Decisions with and on behalf of the ICB	System Decision to Proceed to Next Stage	DECISION MAKING Care Collaborative partnership* takes decisions supported by Host Organisation Governance Structure
Membership	Need CC input – likely to align to Thriving Places guidance		As per Thriving Place guidance: Acute, Community, Mental Health, Provider Collaborative, Local Authority, Primary Care, Third Sector, ICB representative		As per Thriving Place guidance: Acute, Community, Mental Health, Provider Collaborative, Local Authority, Primary Care, Third Sector, ICB representative
Decision Making	Relevant ICB Committee / ICB Board		2 Care Collaborative Committee* / ICB Board (Host) Organisation		2 Care Collaborative* / Lead Provider (Host) Organisation
Financial Risk	ICB		ICB		Lead Provider (Host) Organisation
Contracts	• ICB remains the awarding body • Contract accountability remains with ICB • Contract team employment remains with ICB • ICB contracts team resources aligned to Care Collaborative re: contract decisions, negotiations and ongoing monitoring.		• ICB remains the awarding body • Contract accountability remains with ICB • Contract team employments remains with ICB • ICB contracts team responsible to committee for contract delivery/decisions in relation to UEC/OOH/CHC		Accountability transfers to Host and therefore functions/teams TUPE transfer to Host Organisation*

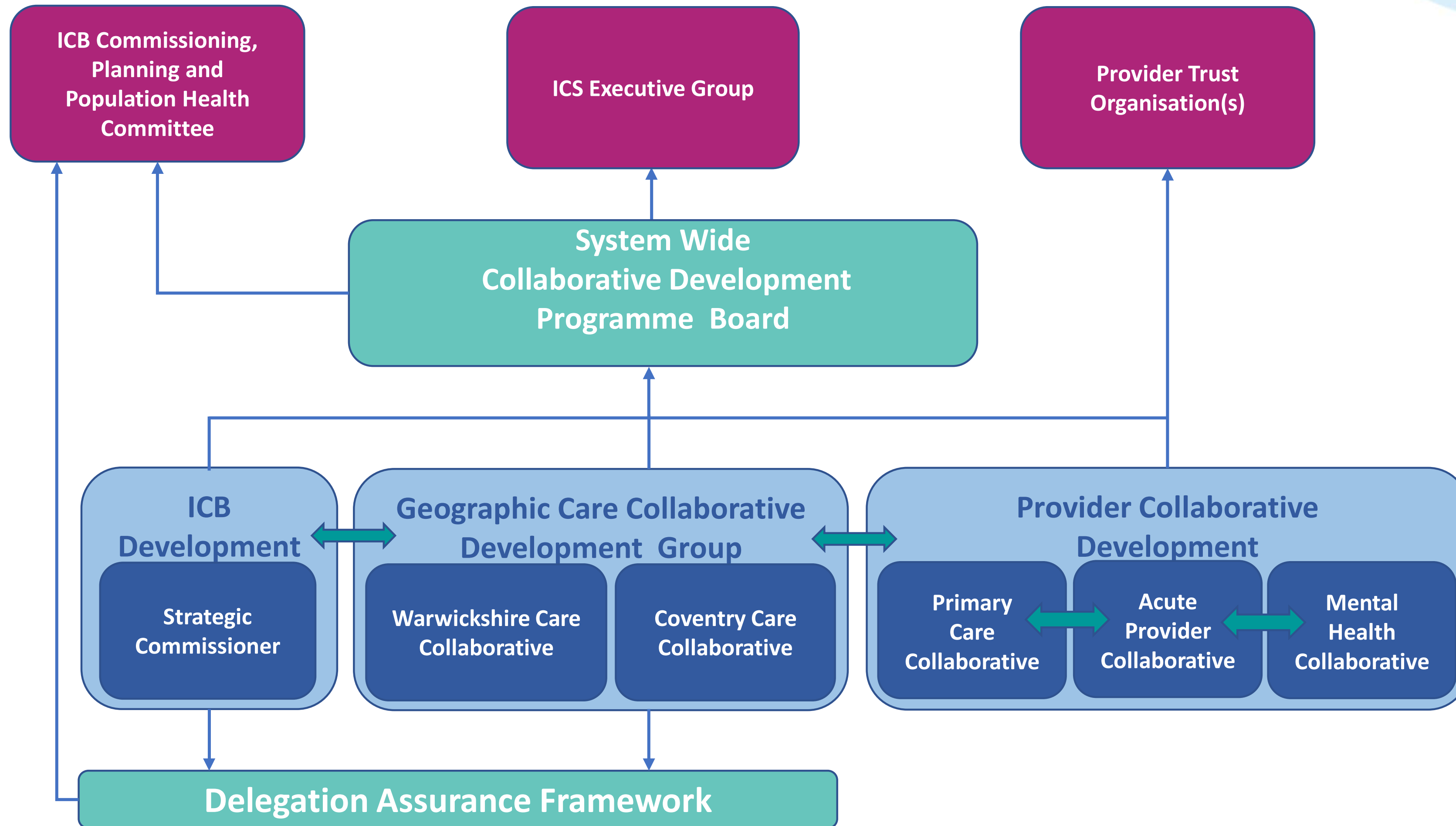
* Decisions taken by the Care collaborative (In Warwickshire made up of the 3 place partnerships) via the agreed Governance Structure hosted by a designated NHS provider

Potential Resource Implications through Transition



*Consideration as to the preferred operating model for service functions such as contracting/BI. E.g. Options appraisal to be undertaken whether this will be a system offer 'CSU' style, individual teams within each care collaborative/Host, opportunities for alignment/merge with LA teams

Proposed Collaborative Development Programme Structure



Mental Health Collaborative

- Mental Health Provider Collaborative agreed
- No commissioning function transferred at this stage – to be considered in later phases
- Collaborative made up of all provider partners
- Work programme in place and agreement that once the scope of the Demand and Capacity work is defined this will be commissioned from the MH Collaborative

Primary Care Collaborative

NHS
Coventry and Warwickshire

Purpose:

The Coventry and Warwickshire Primary Care Collaborative will:

- Bring together **key primary care stakeholders** at a Coventry and Warwickshire level;
- Form part of the broader governance structure of the Coventry and Warwickshire Integrated Care System (ICS);
- **Link to**, not replace, **existing Place-based Primary Care Leadership** Groups.

Responsibilities of the Collaborative will be as follows:

- To act as an **expert reference group** to the ICS (including other formal boards and groups) around general practice issues;
- To act as a **single point of contact for general practice engagement** representing grassroot general practice views through **a clear and co-ordinated voice**;
- To develop mechanisms to ensure that general practice can **influence, contribute to and/or respond to all ICS changes and developments** from now onwards;
- To **share information and communicate** on national and local ICS areas of strategy, planning and development impacting GP practices and PCNs;
- To **support the delivery of general practice in the ICS**, including the alignment of Integrated Care Board (ICB) resource;
- To promote and facilitate GP providers to **share learning to ensure equity** and consistency of innovation;
- To provide a forum for ICS workstreams and programmes to **engage with general practice around future proposals and areas of transformation**;
- To support and coordinate general practice (clinical and non-clinical) representation in ICS workstreams and programmes;
- To play a leading role in the **design and development of the ICB primary care strategy** and to support the implementation of the associated delivery programme once approved;
- To support the **development of PCNs and Place based working**;
- To establish a strategic work programme that enables general practice to be an effective and influential partner in the ICS.

Priorities:

- Primary Care Collaborative are currently developing priorities in terms of the context of Terms of Reference – potential areas under review include:
  - ✓ **Fuller** implementation
  - ✓ Providing strategic direction and **support for PCN/place-based priorities**
  - ✓ Leading strategic **developments at system level**
  - ✓ Advocacy **and promotion of general practice** locally

Acute Provider Collaborative

NHS
Coventry and Warwickshire

The Acute Provider Collaborative is in its final stages of formation with TOR being drafted for approval in December 2022.

The Coventry and Warwickshire Acute Care Collaborative will:

- Bring together **Acute Providers** at a Coventry and Warwickshire level;
- Form part of the broader governance structure of the Coventry and Warwickshire Integrated Care System (ICS);
- Formally report into the **System Wide Collaborative Development Programme Board** (shown on previous slide) allowing cross boundary collaboration. (Mental Health, Primary Care, Care Collaboratives and Acute Provders)
- Allow Governance into each **Sovereign Board** for agreement on key decisions
- Align to the wider **ICS Transformation Board** via delivery outputs

Proposed Priorities

- **Acute Clinical Service Recovery** aligned to unequal access and experience driving out variation in quality, efficiencies and access.
- Acute effective **productivity** across the collaborative**, reducing variation** and potential adverse events supporting the ICS **financial sustainability** objective
- Forum for **sharing of best practice** on quality and productivity improvements providing governance and roadmaps for each area identified aligned to care integration at both Place and between **varying health care populations** within our ICS
- Targeted improvement on prevention aligned to population needs and acute demand
- **Centres of excellence** for acute specialties (including tertiary) and **HVLC procedures/centre** exploration aligned to Acute productivity opportunities identified through **GIRFT programme** and agreed local reviews
- **Economies of scale** for corporate areas and support services supporting provision of a sustainable workforce through efficiency identification

It is proposed that we have core members and associate members and clear decision making criteria within out Acute Provider Collaborative TOR outlining decision making processes, delegations and the aligned process to the associated sovereign trust boards.

Key successes

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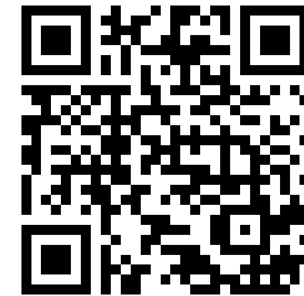
- Long waiting patient recovery 104 weeks, 78 week trajectory
- System wide patient tracking list
- Primary care gynaecology pathway (5 hubs in situ)
- Primary care triage for gynaecology
- Outpatient transformation
- Theatres transformation and alignment to GIRFT
- Effective use of tele-dermatology
- Clinical Diagnostic Hub development and appropriate capital allocation across Coventry and Warwickshire based on population profiles and demand.
- Cancer recovery and shared best practice and system clinical collaboration on challenged specialties.

PROVIDER COLLABORATION

Thank you for attending the webinar today

Please complete our evaluation form by scanning this QR code with your mobile or click on the link in the chat.



Our next webinar is taking place on **Thursday 9 February 11.00am-12.15pm, tackling pressing workforce challenges**