West Yorkshire and Harrogate Health and Care Partnership

West Yorkshire & Harrogate Joint Committee of Clinical Commissioning Groups

Summary report			
Date of meeting: 7 July 2020		Agenda item: **84/20**	
Report title:	**Improving Planned Care: Programme Refresh**		
Joint Committee sponsor:	Jo Webster		
Clinical Lead:	James Thomas		
Author:	Catherine Thompson		
Presenter:	Jo Webster and Catherine Thompson		
Purpose of report: (why is this being brought to the Committee?)			
Decision	✓	Comment	✓
Assurance			

Executive summary

This paper presents a summary of the changes to the Improving Planned Care programme through the response to the Coronavirus-19 pandemic. It outlines changes to deliver integration of the previous WY&H Elective Care and Standardisation of Commissioning Policies programme and the WYAAT Elective Surgery programme and sets out the proposed new priorities for the programme to support the stabilisation and reset of health and care services in West Yorkshire and Harrogate.

Recommendations and next steps

The Improving Planned Care programme recommends the WY&H Joint Committee of CCGS:

a) Note the integration of the two programmes to form the Improving Planned Care programme
b) Support the proposals to address access to diagnostic testing and elective surgery
c) Support the proposals to address referral and support proactive approaches to managing planned care

Delivering outcomes: describe how the report supports the delivery of STP outcomes (Health and wellbeing, care and quality, finance and efficiency)

N/A

Impact assessment (please provide a brief description, or refer to the main body of the report)

Clinical outcomes:	N/A
Public involvement:	See paragraph 3
Finance:	N/A

Risk:	N/A
Conflicts of interest:	Dr James Thomas: GP Chair of NHS Bradford and Craven CCG; partner of Modality GP partnership; Dr Kate Thomas (spouse) is also a partner of Modality GP partnership. Jo Webster: Chief Officer of NHS Wakefield CCG Catherine Thompson: none declared

Improving Planned Care: Programme Refresh

1. The immediate response to and system reset as a result of the Coronavirus-19 (C19) pandemic has required a review of programme priorities across the programmes of the West Yorkshire and Harrogate Health and Care Partnership (WY&H HCP). For the Improving Planned Care programme this will ensure that the work of the programme meets the needs of Places during the stabilisation and reset period and support the 're-start' of planned care services which have been reduced or suspended as part of the immediate pandemic response.

2. Prior to the pandemic the programme leadership had started the process of bringing together into a single programme the work of the WY&H Elective Care and Standardisation of Commissioning Policies programme and the West Yorkshire Association of Acute Trusts (WYAAT) Elective Surgery programme. The programmes' response to the pandemic has expedited this and all work will now be done as a single WY&H Improving Planned Care programme. The combined programme has a refreshed leadership team with Jo Webster (Chief Officer, Wakefield CCG) and Steve Russell (Chief Executive Officer, Harrogate and District Foundation Trust) as co-chairs and Dr James Thomas (Bradford CCG) and Dr Sal Uka (Calderdale and Huddersfield Foundation Trust and WYAAT Clinical Lead) providing clinical leadership and integration with the Clinical Forum. The programme held its first Alliance Board on 12 June 2020.

3. The Alliance Board discussions identified some principles about how members wished to address planned care transformation. These were that we would get the balance right between system and place, doing only through the programme those things that are best done at scale and which can't be done at place; the work would be clinically led, linking closely to the WY&H Clinical Forum and the emerging clinical strategy; the programme would think, plan and work across all sectors and organisation; the programme would do work 'with' people not 'to' people, putting engagement and co-creation at it's heart; and that the work would centre on approaches to improving population health and reducing health inequalities. These principles will be applied to the work of the Board, alongside the National Voices principles for the next stage of the Covid response.*
   *https://www.nationalvoices.org.uk/sites/default/files/public/publications/5_principles_statement_250620.pdf

4. The Alliance Board identified some planned care priorities for all Places in WY&H: supporting the restart of elective surgery; and helping to limit the growth of the waiting list for elective surgery by thinking differently about planed care pathways, taking a cradle to grave approach.

Supporting elective surgery 'restart'

5. In early June, NHE England and NHS Improvement requested the ICS teams submit bids for funding to provide Elective Hubs, similar to the model promoted through the national cancer programme earlier in the year. The Improving Planned Care (IPC) submitted a proposal to address demand and capacity for diagnostics, cancer and non-cancer elective procedures and we await a decision about the success of the bid and the funding allocated. See Appendix 1 for details of the proposal submitted.

6. In the short term the IPC programme in close collaboration with the Cancer programme will commence work on demand and capacity for, and optimising utilisation of CT and endoscopy services.

Thinking differently about planned care pathways

7. Members of the Planned Care Alliance Board were keen to see a renewed focus on whole pathway approaches to planned care, which addressed the whole life course of a person. There is an ambition to really address prevention in a meaningful way (linking to the Improving Population Health programme), strengthen the emphasis on shared decision making, self-management and conservative management approaches (linking to the Personalisation and Primary and Community Care programme including Ageing Well), and re-thinking the concept of 'referral'.

8. Initially the IPC programme will work to support the primary and secondary care interface through approaches such as advice and guidance. Appendix 2 provides an example of how this is being considered in part in one of the places of WY&H. The programme will work to understand and support Places to have a local approach, using a 'do once and share' approach as per the existing ethos of the programme.

9. The existing programme of Out-Patients Transformation delivered by the AHSN as part of the Innovation programme will also be integrated into this programme.

Pre-existing work programme

10. The programme had a number of projects that were underway prior to the pandemic and these were all paused to allow the team's capacity to be redeployed to support the immediate system priorities. Some of these projects will, in the short term, remain suspended and others will restart as soon as possible. Projects that will restart include:
    - The WY&H Area Prescribing Committee, which will have its first meeting on 5 August
    - First Contact Practitioner Development programme delivered through the University of Bradford with additional programme support and evaluation

- Musculoskeletal Services / First Contact Practitioner insight project being delivered through QA Research Ltd.

11. Some additional work has continued in the Eye Care programme to support system-wide planning for restarting cataract surgery and managing medical retina services effectively through the pandemic period.

12. Additional work which will continue, aligned to NHS England and NHS Improvement priorities and deliverables from the planning guidance will include:
    - Evidence Based Interventions
    - Reducing long waits and Elective Hubs
    - Outpatients transformation

Governance

13. The Governance processes for the work of the Improving Planned Care programme are being reviewed and developed to support the creation of a single programme. This will include both WYAAT governance processes and the WY&H Joint Committee of CCGs, and be a development of the suggestion outlined during the JCC development session in August 2019.

Recommendations

14. The WY&H IPC programme recommends that the WY&H Joint Committee of CCGs supports the proposals for the short-term programme priorities.

Appendices

Appendix 1: NHS England Elective Hub Bid
Appendix 2: Example of approach to primary / secondary care referral process

West Yorkshire and Harrogate
Health and Care Partnership

Appendix 1

West Yorkshire and Harrogate Health Care Partnership
Proposal for the creation of an Elective Care Hub
5 June 2020

Vison

Building on the work already undertaken across West Yorkshire and Harrogate Health and Care Partnership on the development of elective care capacity and demand maps across the six acute trusts we would like to apply for resources to establish an elective care virtual hub to allow the effective management of the available elective capacity between the places of WY&H, and optimise clinical outcomes. We will consider the elective waiting list as an active caseload and review it using digital capacity, health contact tracers and the resources of primary care.

Some core principles underpin the approach, namely:

- Accountability for delivery of elective care remains with the hospital trusts
- Minimum disruption to existing patient pathways and as far as possible patients will be treated in their usual local hospital
- Equitable access to elective care across WY&H through collaboration and system working
- Optimise capacity of available NHS and Independent Sector facilities Share risk and capacity informed by clinical prioritisation and patient safety in line with national guidelines
- Decisions on transfers of care would be clinically led and prioritised, and with patient agreement
- Ensure patient safety with regard to infection control and access to facilities
- Maintain safety of staff undertaking surgery and other care
- Ensure all treatment is undertaken within the agreed framework of designated Multidisciplinary Teams (MDTs) and Specialist Multidisciplinary Teams (SMDTs) across WY&H

The virtual hub brings Provider teams (including cancer/ non-cancer clinical experts and senior managers) together, supported by the WYAAT PMO, to co-ordinate the use of NHS and IS capacity to ensure equity of treatment between patient groups based on clinical prioritisation. This would primarily include surgery for cancer, high priority non-cancer diagnoses, and those who are ‘long waiters’. The Cancer Alliance will lead on the arrangements for protecting all key elements of cancer care, namely radiotherapy; SACT (Chemotherapy and other related treatments); acute oncology; haemato-oncology alongside surgery.

Each NHS Provider will retain responsibility for managing its own waiting list of patients for cancer and non-cancer surgery. The hub will have visibility of NHS and IS capacity in WY&H, waiting times and patient prioritisation in each trust/place.

Where providers are unable to treat patients in an appropriate waiting time for their clinical priority within their own resources the virtual hub will coordinate between the trusts so that patients are offered the opportunity to be treated in line with their clinical priority across WY&H. This will ensure clinical priority cases are aligned with diagnostic and treatment capacity across the system. A clinical panel will be convened, if necessary, to support patient prioritisation at WY&H level.

The hub will ensure clinical priority cases are aligned with surgical specialty capacity across the system. At this time, it is expected that there will be sufficient system capacity across NHS and IS providers to accommodate all prioritised patients.

It is envisaged the WY&H Hub will therefore have 5 elements:

1. Surgery (cancer and non-cancer)
2. Diagnostics (Imaging and Endoscopy)
3. Urgent specialties
4. Reducing long waiters
5. Use of Independent Sector (IS) capacity according to clinical need, not geography

Resource Requirements

A financial investment of £1.2m is requested to support the hub over an 18-month period ending March 2022 to support stabilisation and reset following Covid19. The role, operation and sustainability of the hub beyond March 2022 as the system enters “new normal” business as usual will be reviewed and agreed through WYAAT and the WY&H HCP during this period.

The resource will be used as follows:

- Data and analytical capacity to understand the collective capacity and demand for surgery, and constraints to activity such as availability of workforce and PPE
- Financial modelling in the context of AIC contracts
- IT infrastructure as an enabler for the transfer of patient lists across providers and the development of live capacity maps for theatre utilisation
- Administration and operational management capacity to enable visibility of capacity, waiting times and patient prioritisation at system level, and coordination between trusts.
- Clinical leadership for standardisation and prioritisation processes, and providing resource to a clinical prioritisation group to support the hub
- Programme Management Office
- Embed video conferencing for non-face-to-face outpatients
- Facilitate a Rehearsal of Concept (ROC) approach

Scope

The virtual hub will cover the West Yorkshire & Harrogate Association of Acute Trusts (WYAAT), namely:

- Airedale NHS FT
- Bradford Teaching Hospitals NHS FT
- Calderdale & Huddersfield NHS FT
- Harrogate and District NHS FT
- Mid Yorkshire Hospitals NHS Trust
- Leeds Teaching Hospitals NHS Trust

NB. HDFT is located within the Humber Coast and Vale ICS for planning purposes, but is a member of WYAAT and the WY&H Cancer Alliance for patient pathways and programmes. Further discussions will take place with Humber Coast and Vale (HCV) ICS regarding the alignment and relationships with Harrogate and District NHS FT. The trust operates across two geographies and will be considered in this proposal as well as that of HCV. The development of a model that works effectively for the trust will be carefully defined and ensure it is based on prioritising patient choice and clinical need.

ID	Theme / Question	Answers	Notes	Guidance Notes
1	**Expression of interest**	Building on the work already undertaken across West Yorkshire and Harrogate Health and Care Partnership on the development of elective care capacity and demand maps across the six acute trusts we would like to apply for resources to establish an elective care virtual hub to allow the effective management of the available elective capacity between the places of WY&H, and optimise clinical outcomes. We will consider the waiting list as an active caseload and review it using digital capacity, health contact tracers and the resources of primary care. Some core principles underpin the approach, namely: • Accountability for delivery of elective care remains with the hospital trusts • Minimum disruption to existing patient pathways and as far as possible patients will be treated in their usual local hospital • Equitable access to elective care across WY&H through collaboration and system working • Optimise capacity of available NHS and Independent Sector facilities Share risk and capacity informed by clinical prioritisation and patient safety in line with national guidelines • Decisions on transfers of care would be clinically led and prioritised, and with patient agreement • Ensure patient safety with regard to infection control and access to facilities • Maintain safety of staff undertaking surgery and other care	**Key Contacts:** Lou Auger Deputy Locality Director, West Yorkshire and Harrogate NHS England and NHS Improvement – (NE and Yorkshire) l.auger@nhs.net 07500095847 Catherine Thompson Programme Director, Improving Planned Care, West Yorkshire and Harrogate Health and Care Partnership Catherine.thompson13@nhs.net 07825142815 Matt Graham Director, West Yorkshire & Harrogate Association of Acute Trusts	*Please ensure that you add your region and lead details Inc. email / contact number / any other relevant information regarding the area specifics*

		• Ensure all treatment is undertaken within the agreed framework of designated Multidisciplinary Teams (MDTs) and Specialist Multidisciplinary Teams (SMDTs) across WY&H	Matthew.graham3@nhs.net 07780 702124	
2	**Scoping and timescales**	A financial investment of £1.2m is requested to support the development and embedding of the hub over an 18-month period ending March 2022. Longer term planning for sustainability would be considered within this period.	The timescale corresponds with the current pandemic planning period.	*Also include any early thoughts on this fluid situation*
3	**Potential Resourcing requirements**	The resource will be used as follows: • Data and analytical capacity to understand the collective capacity and demand for surgery, and constraints to activity such as availability of workforce and PPE • Financial modelling in the context of AIC contracts • IT infrastructure as an enabler for the transfer of patient lists across providers and the development of live capacity maps for theatre utilisation • Administration and operational management capacity to enable visibility of capacity, waiting times and patient prioritisation at system level, and coordination between trusts. • Clinical leadership for standardisation and prioritisation processes, and providing resource to a clinical prioritisation group to support the hub • Programme Management Office • Embed video conferencing for non-face-to-face outpatients • Facilitate a Rehearsal of Concept (ROC) approach	Significant data and analytical capacity will be required to create and prioritise a single PTL, and to model ongoing requirements in a proactive way to respond to local surges in C19 infection and corresponding reduction in surgical capacity. This will also require investment in clinical time as the prioritisation across specialties is not well defined in non-cancer conditions and will require standardisation to ensure equity of access across the ICS footprint.	*To include, at high level, staffing / all/any resources as identified in your scoping*

4	**Other**	IT infrastructure requirements • Mapping and allocation of available capacity • Transfer of patients between providers • Ensure integration of IS providers into NHS IT systems where required for seamless working Governance and Accountability • We will work to understand the additional governance requirement for the delivery of the virtual hub	Investment in additional IT capacity will be required to facilitate the effective operation of the virtual hub, and with the appropriate information governance requirements, support the transfer of care across and between places within WY&H HCP	*Please add any other relevant information in this box / NOT mandatory*

Appendix 2

Options for Routine Referral Pathway

Step 1: Primary care led early intervention with the patient – supported by Ardens
Step 2: eCons used for all pre appointment referral communication between Primary & Secondary Care (potentially including diagnostic requests and results reviewed)
Step 3: Decision to refer, clinic and clinic type (FTF, Virtual – Video or Phone) made between Primary and Secondary Care clinician

Option 1 – Using Existing Systems	Option 2 – Hybrid	Option 3 – Refer with SystmOne
Step 4: ERS for the referral, with information from the eCons contained in the referral (attached / embedded)	Step 4: Consultant to complete ICE referral for patient to be referred into Secondary Care	Step 4: Referral requested by Primary Care using SystmOne
Step 5: Non Clinical RAS to pick up clinic and consultation type from eCons and book appointment	Step 5: Referral manually updated on CaMIS and CITO	*Step 5: Non Clinical RAS to pick up clinic and consultation type from eCons and book appointment*
Step 6: No triage required as this has in effect been done with eCons	Step 6: No Triage needed as the consultant has made the referral	Step 6: Referral manually updated on CaMIS and CITO
		Step 7: No triage required as eCons has taken place and decision to refer has been made

Decision –
Based on the Benefit / Issue analysis which option above should we take for referring a patient
Do all referrals for specialities that have eCons have to go through eCons
Do all specialities need to be set up on eCons