Understanding and Documenting Service Pathways

January 2023

BAILEY & MOORE

Housekeeping

- The presentation usually lasts 60 minutes, plus time for questions
- But we are happy to stay online as long as you want us to ☺
- Ask questions as we go, using the chat box or raise your ‘hand’
- All slides will be on our web site – link at the end
- If you’re using someone else's invite, send us your email address if you would like a copy of the slides or to be sent details of further courses

Navigating the new world: part 1

As we move away from activity x price and towards risk sharing contracts… what will we measure and how will we pay for it?

1. Understanding and documenting service pathways

- Shared understanding of the services required
- Simple charts & maps
- Getting the right people in the room
- Some practical tips

2. Commissioning for patient outcomes

- Distinguishing outcomes from inputs and outputs
- Why commission for outcomes?
- Measuring outcomes using KPIs

3. Costing and benchmarking

- Why look at provider costs?
- How does provider costing work?
- National guidance
- Benchmarking efficient costs

Why document your service pathways?

Why do we need to map pathways?

- Sets out a common understanding of what is to be delivered within the payment mechanism… and how
- Developing/revising a pathway supports other reviews – cost, quality, etc.
- Sets out part of the wider plan – showing the context in which services sit
- Promotes consideration of the whole pathway and links to other services
- Good for patients and clinicians – clear about what is possible/not possible
- Clarity about services promotes effective commissioning, integrated care and focus on patient outcomes

How would you map a service?

Whatever sets out the way services should be provided and sets out the expectations for all parties…

It could be:

- a service specification/description, or a detailed policy or procedure
- a description of a process or a simple map of a pathway

And may be:

- condition specific – e.g. MH for young people
- pathway specific – e.g. urgent and emergency treatment

What do patients want?

- to see someone they trust
- who knows what they are doing and can come up with a plan to help them – as quickly as possible
- to have things explained clearly
- to know what will happen to them
- or help them to understand their options

They don’t care about pathways, allocations, organisational boundaries – they want to know will this get better or not!

What do clinicians want?

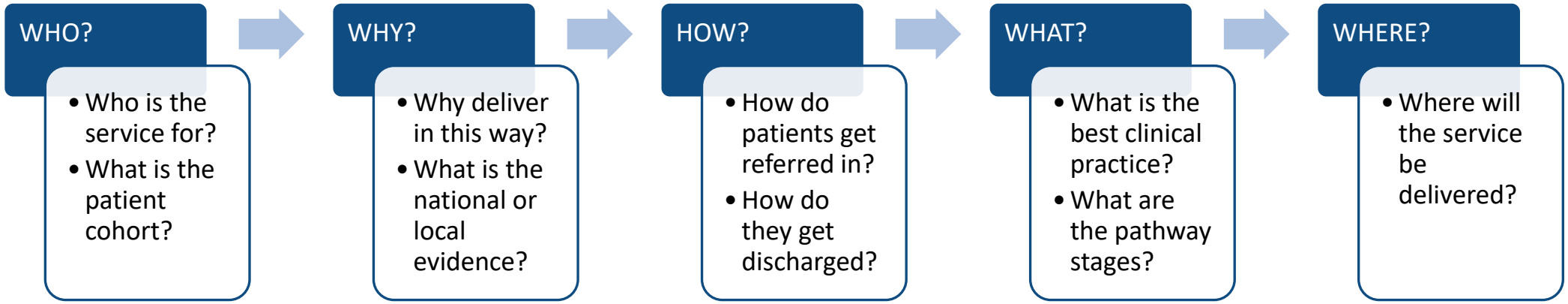
- to give their patients what they need
- clarity about what outcomes should be delivered and how
- respect for their clinical judgment
- to manage patient expectations within the service - and to have a plan for any over heating

They don’t care about resource allocations, contracts and organisational boundaries – they want to do the best for their patients!

What does an ICS need?

- clarity around the services that are to be provided within the system…
- and what won't be provided by the NHS locally
- and to understand where it is necessary to state this explicitly
- to shift the system focus towards **key outcomes** for patients, rather than inputs (e.g. staff employed) or outputs (e.g. activity volume)
- assurance that clinicians/patients are content with the service model
- to leave operational issues for the provider collaboratives/place-based partnerships to manage

Documenting in a service specification



You might set this out using the NHS Standard Contract service spec template or in other policies, e.g. referral policies, prior approval schemes, etc

Managing the process

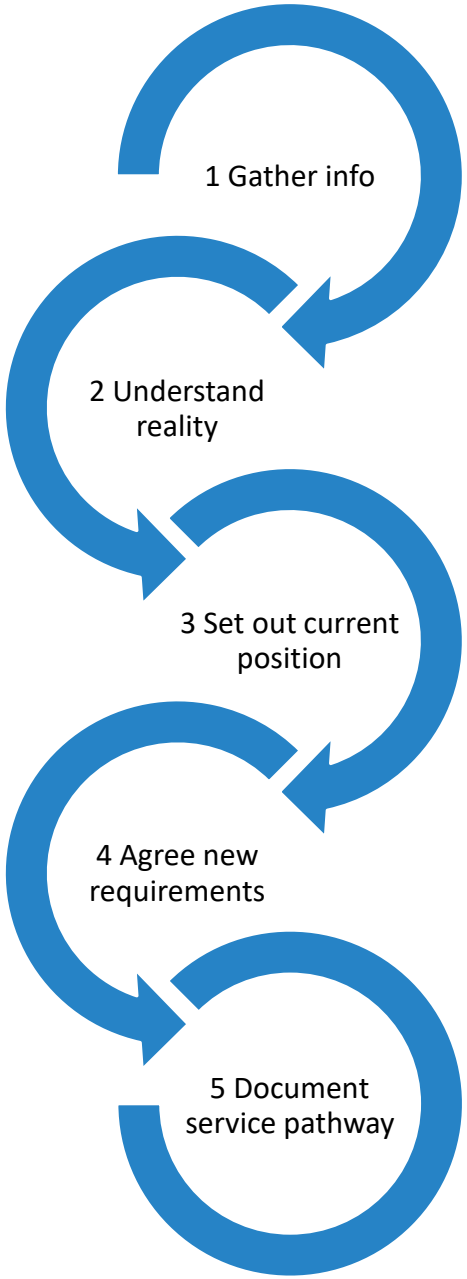
How to avoid…


Despite being cautioned against it, Derek went ahead and reinvented the wheel
Shovel

…reinventing the wheel

- Usually a lot of national clinical evidence (e.g. NICE) – work with other ICS to use what is already out there
- Clinical networks can help over a larger geography
- Set up a peer review process to learn from each other
- Consider how specs relate to each other, e.g. cardiac rehab and heart failure rehab – is an overarching spec or policy needed? Are you sure there is no duplication/overlap?
- Search https://library.nhs.uk/, https://scholar.google.com, https://fabnhsstuff.net/ and other peer-reviewed evidence bases

5 key stages in the process



Stage 1:
Gather info on the service:

- current service specs (if they exist)
- local intelligence – GP groups, clinical networks, user groups
- provider's operational policies/processes
- provider intelligence… from multiple providers, links to related services
- current research and evidence base
- policy docs, such as referral policies, and clinical audits
- consultation events?
- partner agencies

Stage 2:
Understand the operational reality:

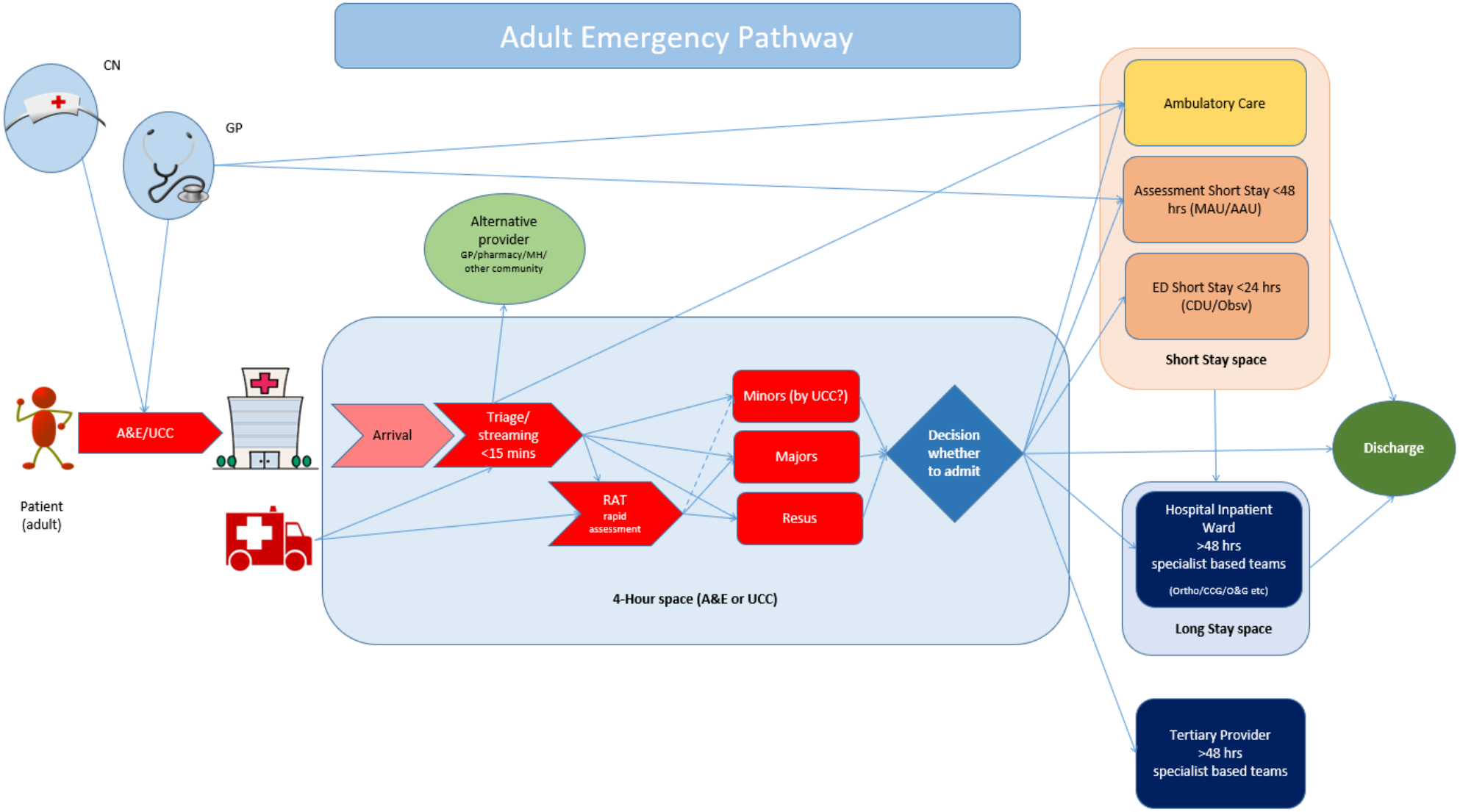
- A vital step when writing a specification for more complex services is to physically walk the patient pathway with the clinician(s) providing the service
- A “desktop” exercise will not give you a full understanding of the operational reality of the service
- For example, you may need to understand the restrictions that estates will impose – there is no point specifying that elements of a service must be co-located if the estate will not allow this (although this could be addressed in longer term plans)

Stage 3:
Set out the current position:

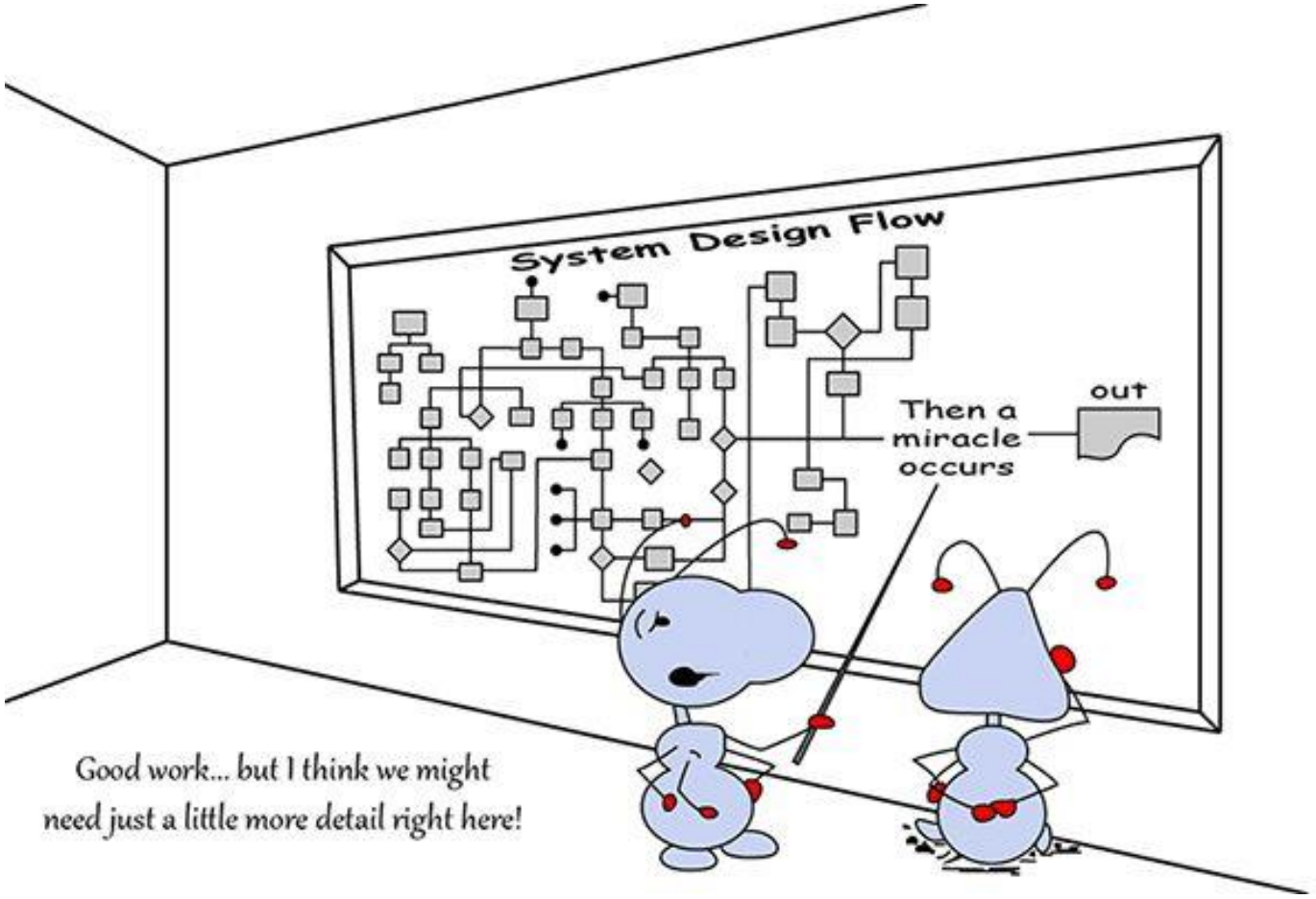
Prepare a simple map or process chart, being clear about:

- entry/referral points to the service – how patients will get **IN** to the service including self-referral
- what happens once they are in – what **PROCESSES** and **STEPS** are required
- what happens at end of pathway – how **DISCHARGED** from the service
- identify any “counting points” for activity… such as admissions, OP attendances
- protocols or criteria that need to be specified, e.g. eligibility, age, referral route to ensure the service is delivered as envisaged

Example of a simple pathway map



How not to do a pathway map!



Stage 4:
Agree requirements of new service:

Once baseline established, identify changes and developments proposed:

- Place service, safety and quality at the core of the specification
- Collate and review relevant evidence gathered in stage 1 – demonstrate proposed requirements are objectively based
- Consider restrictions imposed, such as legislation or contract guidance that determines how the service should be delivered, for example ambulance response times
- Identify protocols or criteria that might be needed to ensure the service is delivered as envisaged (such as eligibility/acceptance criteria)

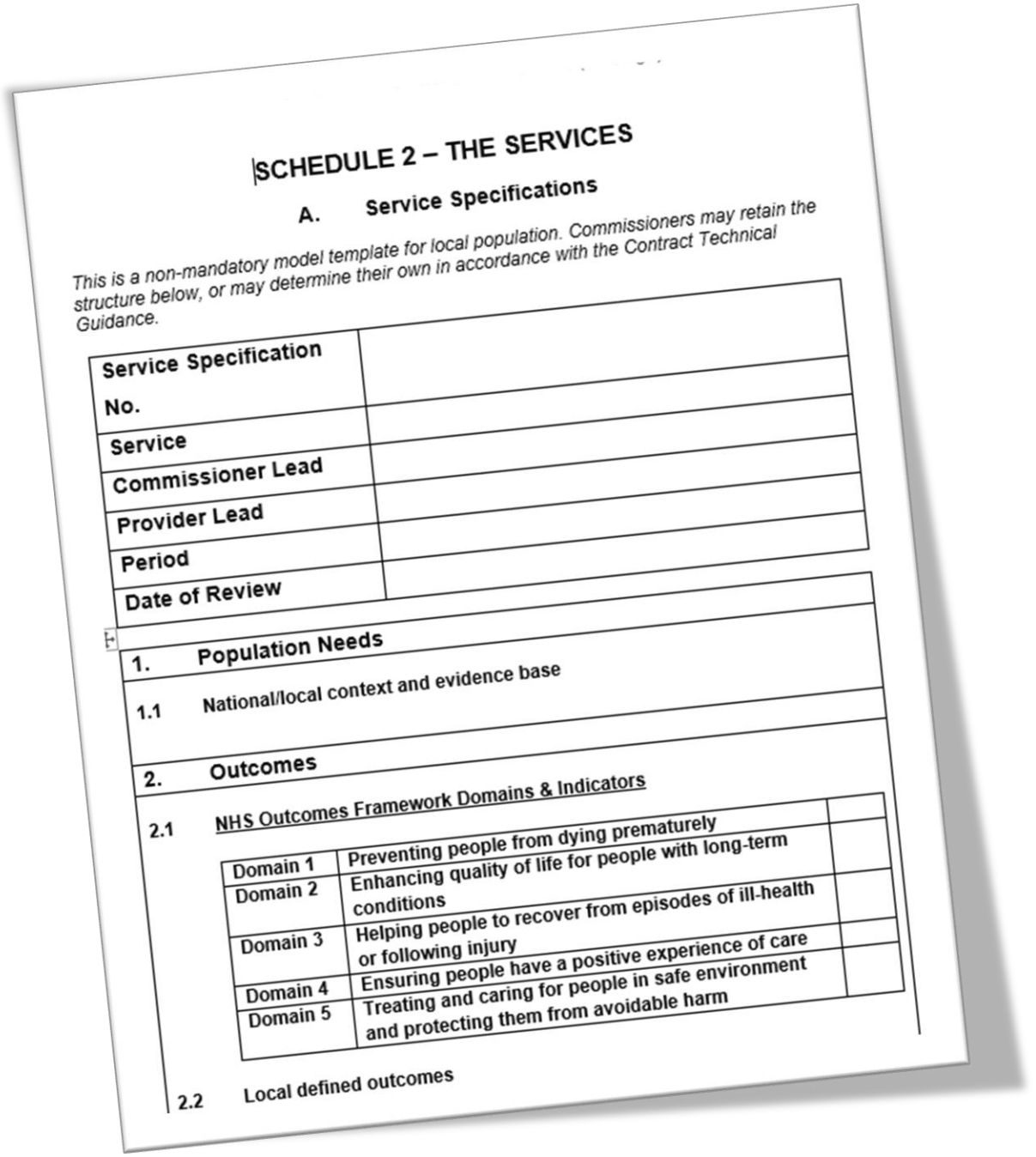
Stage 4:
Agree requirements of new service:

Then…

- List key patient outcomes required, linking back to national NHS Outcomes Framework
- Consider how delivery of quality and outcomes will be measured – identify key metrics/KPIs/thresholds
- Identify source of data for metrics (may be obvious but often isn't!)
- Identify appropriate payment mechanism (within NHS Payment Scheme rules)
- Fully document and agree proposed new service so there is clarity and understanding (stage 5)

Stage 5:

Documenting the service pathway



SCHEDULE 2 – THE SERVICES

A. Service Specifications

This is a non-mandatory model template for local population. Commissioners may retain the structure below, or may determine their own in accordance with the Contract Technical Guidance.

Service Specification No.	
Service	
Commissioner Lead	
Provider Lead	
Period	
Date of Review	

1. Population Needs

1.1 National/local context and evidence base

2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

Domain 1	Preventing people from dying prematurely	
Domain 2	Enhancing quality of life for people with long-term conditions	
Domain 3	Helping people to recover from episodes of ill-health or following injury	
Domain 4	Ensuring people have a positive experience of care	
Domain 5	Treating and caring for people in safe environment and protecting them from avoidable harm	

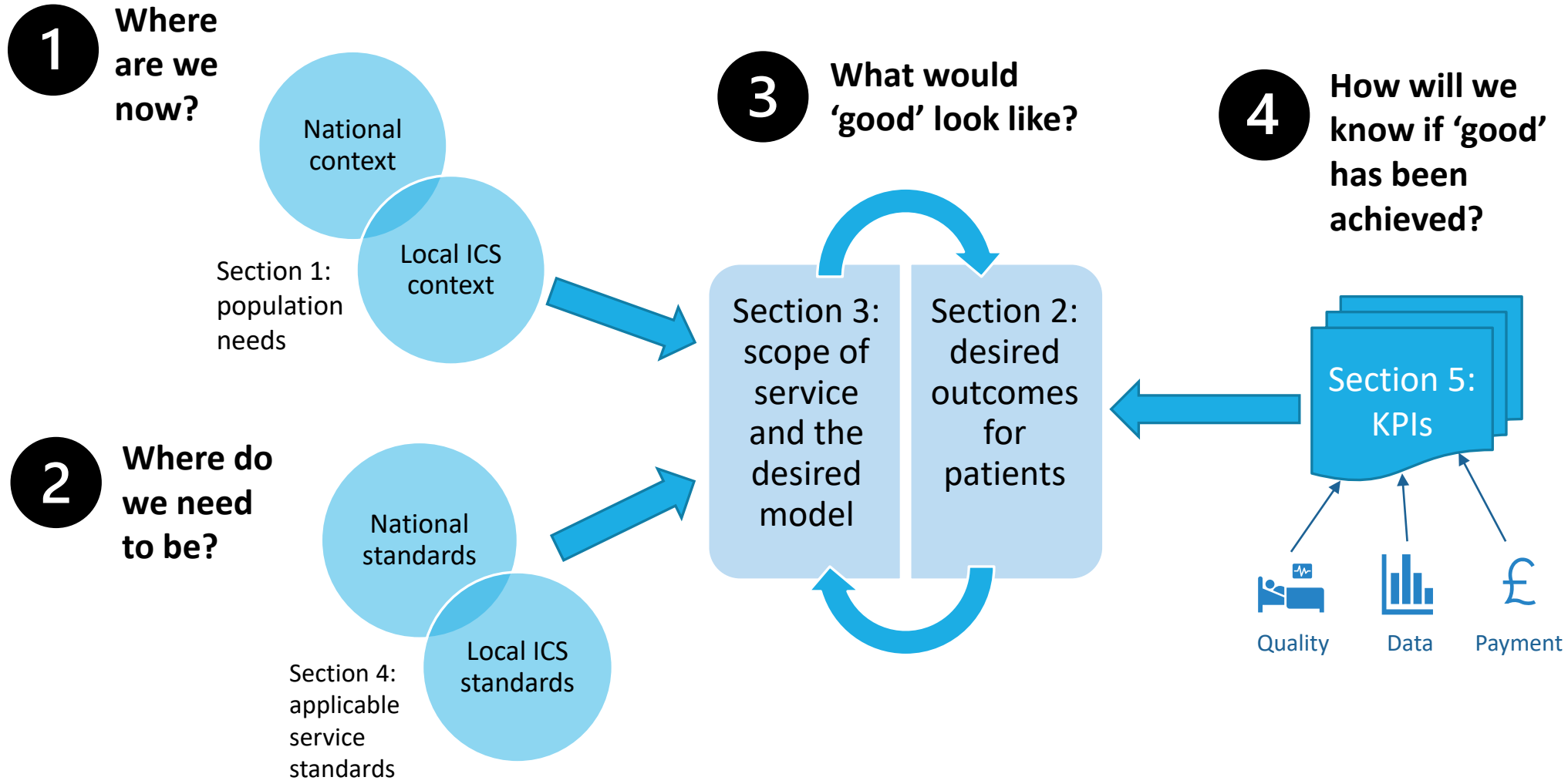
2.2 Local defined outcomes

NHS Standard Contract template for service specs

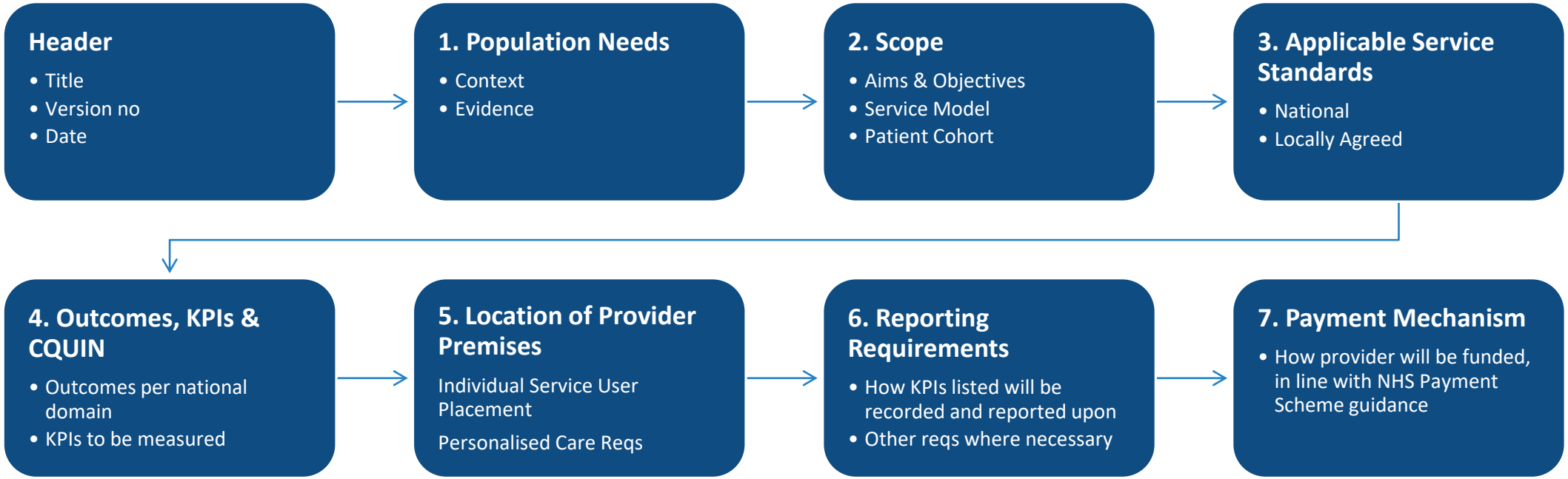
Blank non-mandatory template included in the NHS Standard Contract (schedule 2A):

1. Population needs
2. Outcomes
3. Scope
4. Applicable service standards
5. Applicable quality requirements and CQUIN goals
6. Location of provider premises
7. Individual service user placement
8. Applicable personalised care requirements

Using the contract template in 4 questions

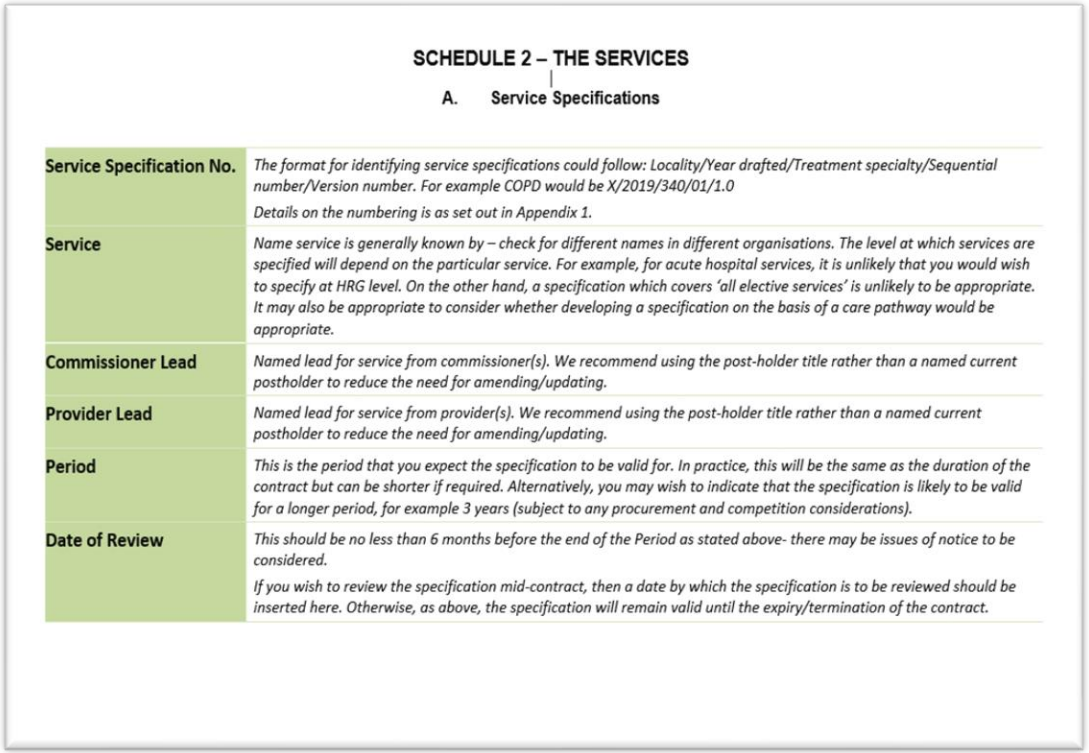


Our suggested format for service specs



Our suggested format for service specs

- Please ask for our version of the service spec template if it would be useful
- Or go to: http://baileyandmoore.com/resources/templates-briefings/
- Includes explanatory notes within each section
- More detail on each of the sections is also appended to the end of these slides for future reference…



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Focusing on patient outcomes…

Understanding commissioning for outcomes in 10 seconds…

Do outcomes matter?

The key principle behind commissioning for outcomes is a clear **focus on the actual results being achieved** for the individual and for populations and putting in place commissioning models and/or pathways of care to achieve those results

NHS Outcomes Framework Domains & Indicators

The NHS Outcomes Framework sets out high-level national key outcomes:

Domain 1	Preventing people from dying prematurely
Domain 2	Enhancing quality of life for people with long-term conditions
Domain 3	Helping people to recover from episodes of ill health or following injury
Domain 4	Ensuring that people have a positive experience of care
Domain 5	Treating and caring for people in a safe environment & protecting them from avoidable harm

https://digital.nhs.uk/data-and-information/publications/statistical/nhs-outcomes-framework

Inputs vs outcomes – realising benefits

- Understanding and documenting pathways helps the ICS to focus on patient outcomes and experience…
- Rather than commissioning based on staff WTE or a specified volume of activity
- **Inputs** – *e.g. how many staff WTE are required* – are **NOT** outcomes!
- **Outputs** – *e.g. how many ED attendances have been commissioned* – are **NOT** outcomes!

Inputs vs outcomes – realising benefits

- Important to define measurable outcomes as precisely as possible so they can be tracked using KPIs
- **Some** is not a number… **Soon** is not a time!

Improve life expectancy?

OR

Reduce premature mortality by 3 years by 2024?

What are the desired outcomes?

Choose a school…

School A	employs 150 staff
School B	delivered 55,000 lessons last year
School C	85% of students achieved grade 5 or above at GCSE

What are the desired outcomes?

Now choose a hospital…

Trust A	employs 3,200 staff
Trust B	delivered 105,000 A&E attendances last year
Trust C	was in the lowest 10% nationally for emergency readmissions last year

What are the desired outcomes?

Which of these is an **outcome** from an investment in the smoking cessation service?

Successfully recruited 3 WTE smoking cessation advisers
Increased the number of patients successfully quitting smoking by 15% compared to last year
Reduced the county's mortality rate from respiratory and cardiovascular disease to below the average for England

Designing shared outcomes and incentives

- What is best clinical practice – from evidence and research?
- Outcomes can be secured by pathway steps – e.g. in ED, if patients are streamed within 15 minutes and seen by senior decision-maker within 1 hour, this has been shown to result in better clinical outcomes
- What are the key KPIs/metrics that show the service is being delivered as commissioned and the outcomes are as required? e.g. 90% of DVT cases treated in outpatients/SDEC without being admitted
- Use payment mechanism to incentivise outcomes prioritised by the ICS
- **Much more on this in the separate session on designing outcomes and KPIs!**

Tips for completion…

some “dos and don’ts”

Tips… some “dos and don’ts”

Get the right people in the room…

- Best specs have **strong clinical involvement** – not a desktop exercise
- Development of ICS means that **providers and commissioners should work together**
- **It’s a team effort** – commissioning, contracts, quality, finance, BI need to work together to produce a rounded spec. Talk to clinical colleagues with one voice. Don’t work in isolation!
- Process and resources required depend on the **value/complexity/risk associated with service**
- **May require consultation and scrutiny** and number of drafts before it before it can be agreed, ensuring it reflects the views of stakeholders and is ready to be used by the provider
- **Get buy in** – spec won’t happen if the clinicians, finance or service managers don’t want it to… it will work best as a joint effort, so make sure everyone is involved

Tips… some “dos and don’ts”

- **Keep it as brief as possible** – consider whether you actually need a spec, and if you do…

TG 36.2: *“specifications in contracts should be less restrictive and input-driven in future than is often the case currently, allowing the provider more leeway to adapt and refine over time how services are best delivered”*

- **Avoid generic statements such as** *“we constantly need to review our population against how care is delivered for similar populations to ensure we are effective in our use of clinical and patient time for the whole population”…* save the generic stuff for strategic documents etc
- **Make it a standalone doc** – TG 36.6 says don’t duplicate info from other parts of the contract, but we recommend you do where necessary, so it can be shared. Watch version control!
- **Obviously** – don’t contradict the national contract terms or national guidance…

Tips… some “dos and don’ts”

- **Get it agreed** – before the service/contract starts preferably!
- **Respect the experts** – read the document as if you were one of the clinicians involved. Is it necessary to say “respect the service user” or how many band 5s are needed?
- **Remember this will be a working document for clinicians** – don’t treat it like a desktop exercise to secure financial benefits
- **Don’t fixate on bricks and mortar –** the “where” is less important than the pathway e.g. Same Day Emergency Care (SDEC) is an ethos, doesn’t matter where it is delivered. Operational matters should be provider responsibility wherever possible.
- **Or clinic hours –** SDEC can/should be 24 hours…

Tips… some “dos and don’ts”

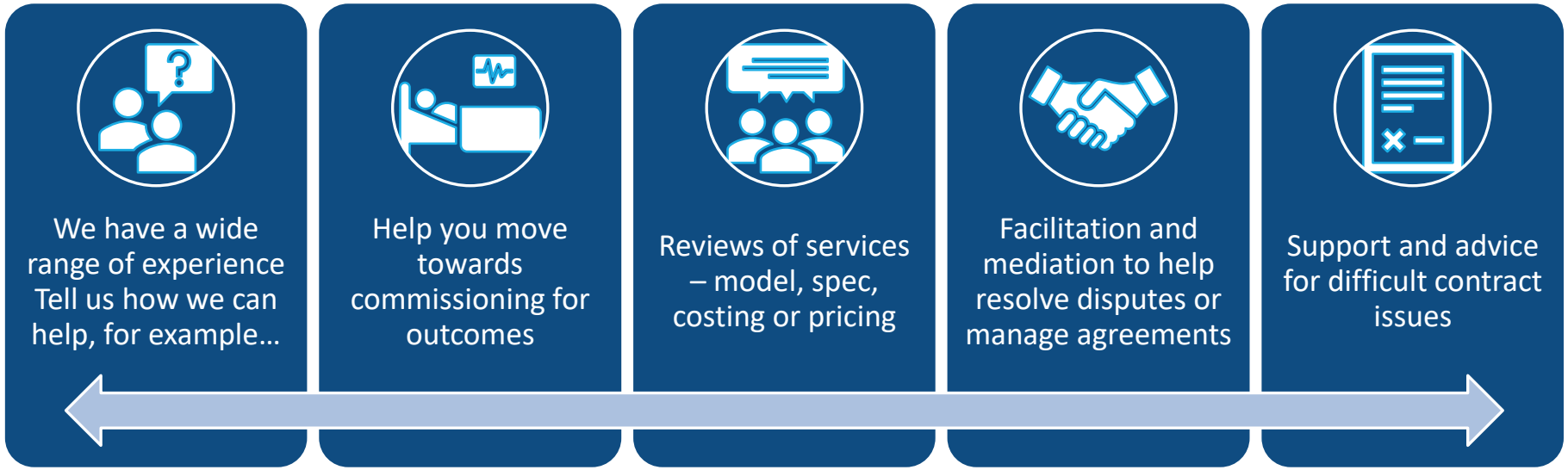
- **Limited number of robust metrics** – Make sure the information required is clearly stated in the spec. A few well-targeted metrics will tell you more than a long list that no-one looks at
- **Beware of unintended consequences** – e.g. unmet demand, (un)affordability…
- **Allow time to circulate draft specifications** for comment, amending and re-circulating
- **Use a “guinea pig”** – helpful to get someone who knows nothing about the service to read it
- **Be clear** – readers should be able to understand what it is you expect to be delivered, so avoid using jargon or local shorthand to describe the service.

This is not a quick process!

In summary…

- It’s not just about contract documentation, it’s about providing clarity on how the priorities identified by the ICS get delivered!
- Start with a simple pathway map of existing/desired services – walk the pathway to understand the operational reality and where service sits in wider pathway
- A clear agreement about the desired pathway will help shift system focus away from activity volumes/inputs and towards securing **key outcomes** for patients
- An understanding the service supports the understanding of **system costs**
- Not a quick process and success requires a **multi-disciplinary approach**

Can we help?



We have almost 30 years' experience at senior level within the NHS and can provide practical support across a wide range of issues

Email us at info@baileyandmoore.com to discuss how we could help

BAILEY & MOORE

Other courses we offer include

- *Brave New World? Life in the NHS after the Health & Care Act*
- *Commissioning for outcomes – adding value not volume*
- *Why costing matters more than ever*
- *Preparing for April 2023 – a practical guide*
- *Tips for managing and avoiding disputes*

If you are interested in these or other topics, email us at training@baileyandmoore.com and we can discuss your requirements

Thanks for listening!

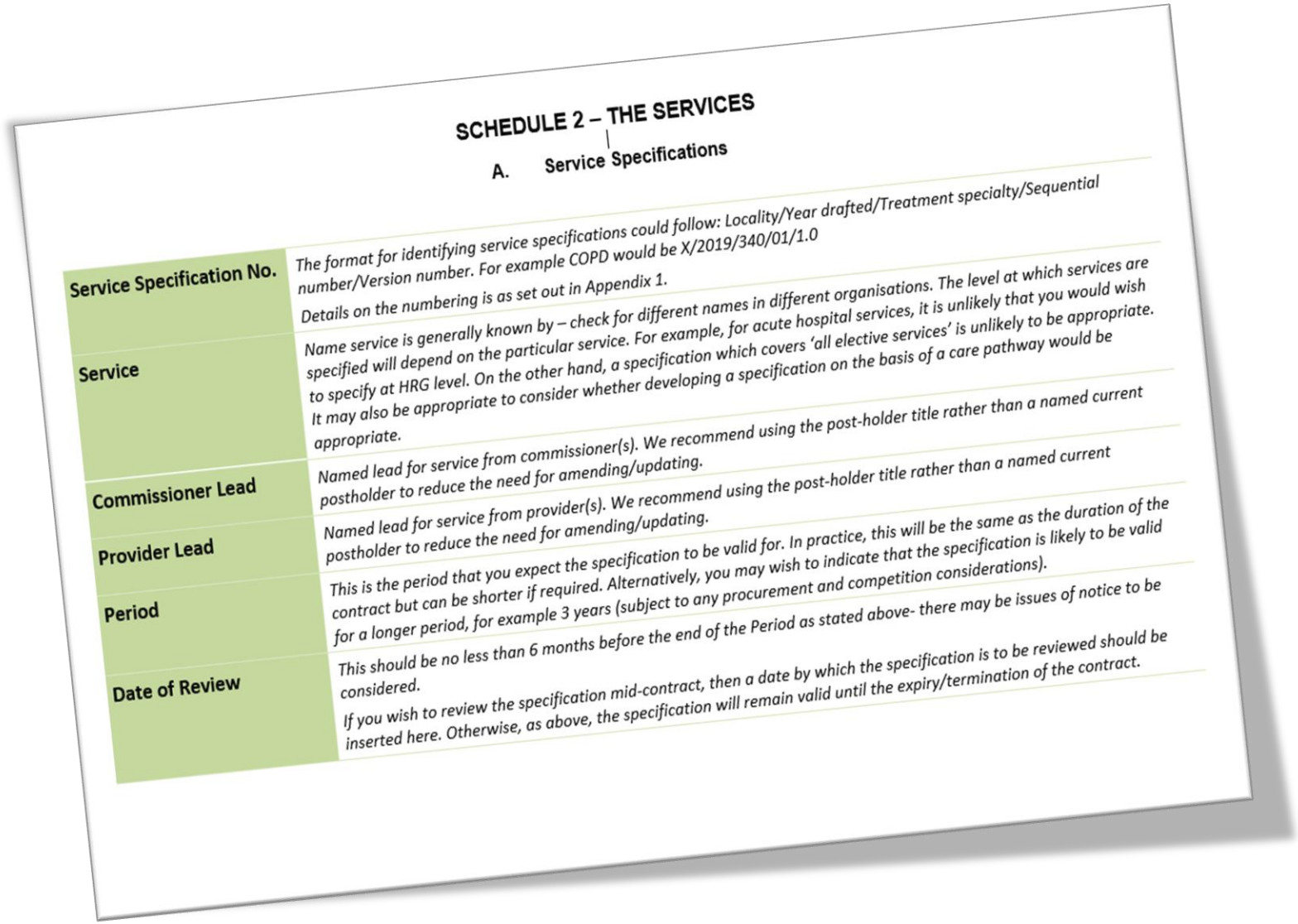
BAILEY & MOORE

Email us with any comments or requests for training courses at:
training@baileyandmoore.com

Slides available at:
http://baileyandmoore.com/resources/training-slides/

Service Spec format in more detail (B&M version)

(for reference only)



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Header

Service Specification No.	• Sequential number for easy reference, especially if service referred to by different names • Include the year the spec was created to aid version control
Service	• Level depends on service – By HRG is too low, “elective” too high • Or care pathway basis might be appropriate
Commissioner Lead Provider Lead	• Named lead for service from commissioner/provider(s) • Use post-holder title rather than individual’s name - reduces need for amending/updating.
Period	• Period spec is valid for, usually the duration of the contract (or shorter) but can specify longer (subject to any procurement and competition considerations).
Date of Review	• Even if no plans to review, suggest an indicative date for reviewing the specification for planning purposes – like a “best before” date. • Should be at least 6m before end of period (above) – may need to give notice • If reviewing mid-contract, then put date here, otherwise specification will remain valid until the expiry/termination of the contract

Section 1: Population needs

National/local context and evidence base

- Describes the service for a specific cohort of service users
- It should set out the evidence base which underpins the spec

Strategic context - include key points from any national reviews on the service eg for ED use “Safer Faster Better”, a national report which sets out the framework and principles for improving urgent care services.

Local context - local reviews, such as those by Networks, particularly where it provides a stocktake of the current service provision. Include ICS reviews where sufficiently detailed.

Background & current service provision - analysis from local reviews of where specific improvements are required, setting out key recommendations plus activity data from recent period

Section 2: Scope

Aims and objectives of service (2.1)

- Brief description, ideally
  - Aim - a sentence setting out the mission statement for the service
  - Objectives - around 5-10 bullet points setting out the main goals
- If necessary, explain what the service will not do as well as what it will
- Only set out “must haves” if critical - not to micro-manage, for example this step was considered critical to the delivery of the aim (95% A&E standard)

  Stream patients to the appropriate service within 15 minutes of arrival

Section 2: Scope

Service description/care pathway (2.2) – include a brief description of the service being commissioned, including the care pathway. Refer to any service maps/process

Population covered (2.3) – where the service is not subject to patient choice and where the service is limited to a defined population, include description of that population

Any acceptance and exclusion criteria and thresholds (2.4)

- Set out any specific clinical criteria used to manage referrals to this service
- PLCV policy not replicated in full

Interdependence with other services/providers (2.5) – where part of a wider care pathway, set out how the service links into and works with other services or providers

Section 3: Applicable Service Standards

List the most relevant papers – no need to include them in full

Evidence base is included in section 1 as part of the context

- **Applicable national standards (e.g. NICE)**
- **Applicable standards set out in Guidance and/or issued by a competent body (e.g. Royal Colleges)** – used to identify relevant national standards and guidance the service is expected to follow
- **Applicable local standards** – used to add any specific locally-agreed ICS service standards where applicable

Section 4: Outcomes, KPIs, CQUIN goals

This section is used to set out:

- Expected patient outcomes
- Quality requirements/KPIs and threshold for achievement
- How this is measured and how frequently
- Consequences of achieving KPIs, e.g. incentive payments

Section 4: Outcomes, KPIs, CQUIN goals

NHS Outcomes Framework Domains & Indicators

- Start with the 5 ***National Domains***
- Then add any ***Overarching indicators*** and ***Improvement areas***
- Indicate which indicators in each domain apply
- Then add any locally defined outcomes – where necessary

Section 5: Location of Provider Premises
Section 6: Individual Service User Placement
Section 7: Personalised Care Requirements

Only where it is necessary to specify, e.g.

- a particular site or a site accessible to a particular population
- details of individual long-term patient placements, including any specialist equipment
- arrangements for developing personalised care and issuing personal care budgets (link to contract schedule 2M)

Section 8: Reporting Requirements

- Specify source data required to measure KPIs and other measures detailed in section 4 of the spec
- Including frequency of reporting and any data quality requirements
- Plus any other reporting requirements – but consider whether anything else is really justifiable?
- Reporting requirements will be included in contract schedules 6A/6B but list here for completeness and so spec can be read as a standalone document

Section 9: Pricing Mechanism

Specify the pricing mechanism/incentives that apply to the service, such as:

- Basis and amount of block funding included in the contract fixed element
- Additional funding that can be earned against each outcome/KPI/CQUIN scheme set out in section 4 of the spec (if any)
- Any other variable incentive payments, links to other services outcome-based payments, etc.
- Should be covered in schedule 3 of the contract, but list here for completeness and so spec can be read as a standalone document