

Foundations for change

The development of the Foundation Healthcare Group 2016/17

Dartford and Gravesham NHS Trust

Guy's and St Thomas' NHS Foundation Trust



*“Our set of shared values is
always at the forefront of our
discussions”*

Specialist Networks Manager, Paediatrics

Foundation Healthcare Group on a page

What is it?

The Foundation Healthcare Group is a partnership between Guy's and St Thomas' NHS Foundation Trust and Dartford and Gravesham NHS Trust. As one of 13 acute care collaborations within NHS England's New Care Models programme, the Group is seeking to develop a sustainable model of care that makes best use of scarce resources and can be replicated across the NHS. It aims to improve outcomes and access, reduce costs and meet the challenge of increased demand.

Crucially, the Group's approach seeks to achieve the benefits of collaboration without the changes to management control necessary for mergers or acquisitions. The partnership represents more than a network as it is based on shared vision and values underpinned by a firm mutual commitment to work together in a different way. It is being designed in order that it can continue to grow, bringing new members into the Group to support a sustainable system.

What has happened?

The Group was accepted onto the New Care Models programme in September 2015, a joint memorandum-of-understanding was signed in April 2016, and financial resource followed in June 2016.

During this period, the Group has focused on six workstreams which have best addressed the opportunities and needs of both partners: three clinical (cardiology, paediatrics, and vascular care), and three non-clinical (IT, location, and organisational design of the overall model), as well as the programme support and governance. These areas have had flexibility as to how they best approach collaboration within the framework of the model, creating a wealth of insight regarding the successful development of mutually-beneficial partnerships.

While the clinical workstreams have only been mobilised since June 2016, after only nine months all three are reporting early signs of benefits for both patients and staff. For example, in paediatrics, a specialist epilepsy nurse has been recruited; in cardiology, progress has been made in mapping patient pathways across the two trusts; and in vascular the successful 'proactive care for older people' service developed by Guy's and St Thomas' has been successfully introduced at Dartford and Gravesham. A formal evaluation is currently being undertaken by Kings College London.

What next?

While the Group has been run as a programme that will finish at the end of 2017/18, Guy's and St Thomas' and Dartford and Gravesham are keen to continue to develop their partnership into a new form of sustainable Group Model from April 2018 onwards. The expectation is that this would expand to include new members and hence share the benefits realised to support the wider system. Over the next year, the two Trusts will work together to design this new model, including defining flexible membership offers which will best suit the range of potential new members. There is also significant learning emerging relevant to others across the NHS seeking to collaborate across provider boundaries.

About this report

This report tells the story of the Foundation Healthcare Group through a set of 'Spotlights' – specific changes which have been made possible by collaborative working as part of the Group. It provides a description of the journey the Group has been on, from the impetus behind the collaboration, its vision, how it has worked in practice, and some of the learning generated to date.



Sharing expertise

Proactive care for older people service *Vascular Clinical Faculty*

Challenge

Increasing numbers of older people are undergoing both elective and emergency surgery. Whilst older people have much to gain from surgery, they remain at high risk of adverse postoperative outcome. This is true across clinician-reported, patient-reported and process related measures. The literature provides evidence that older people are more likely than younger patients to experience post-operative medical complications, functional deterioration and consequently a longer length of stay. Such data has led to the growing recognition of the need for involvement of geriatricians in the care of complex older people undergoing surgery.

Dartford and Gravesham is anticipating a significant increase in population over the next twenty years due to rapid housing developments such as the Ebbsfleet Garden City. Population projections for 2015-2025 show an increase in the population of 38% for those aged 60-79 and 45% in those over 80 years. It is clear and recognised that the demand for services for elderly people will continue to increase over the next 10 years.

Currently Dartford and Gravesham are 'red' outliers in the National Emergency Laparotomy Audit (NELA) who suggest a target of 80% of patients over the age of 70 should be seen by a geriatrician. In 2015 only 2% of patient were reviewed by a geriatrician and in 2016 that number was only 8%. Finally, the median length of stay in emergency general surgery is longer at Dartford and Gravesham than that at Guy's and St Thomas' (7 days versus 5 days) despite this being a younger population.

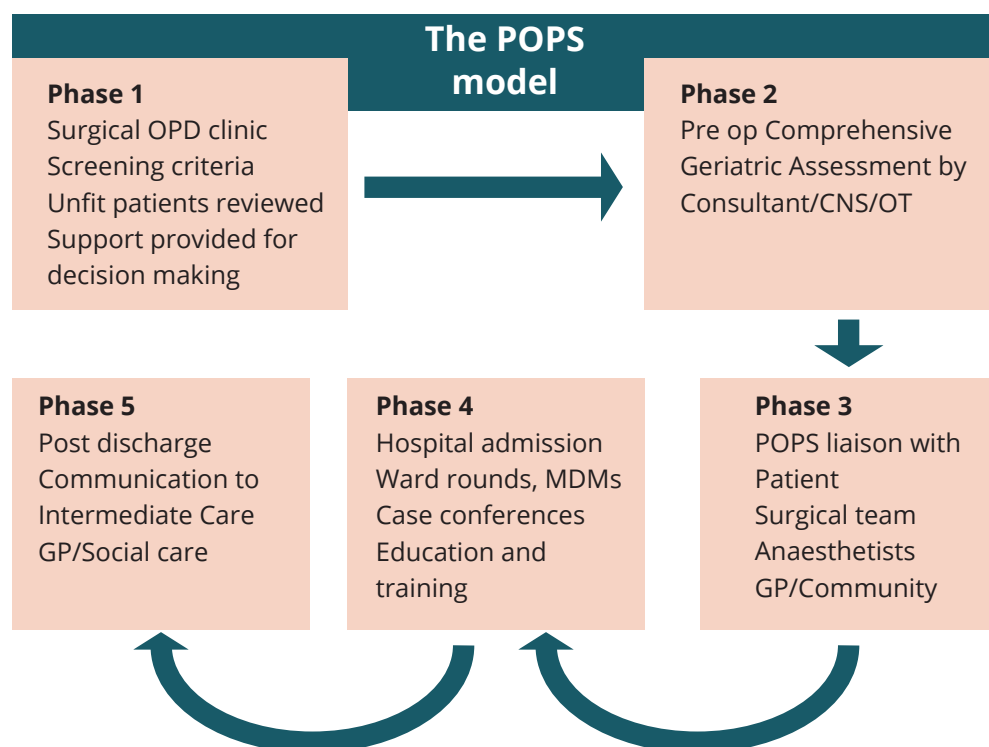
Vascular patients are either referred directly to Guy's and St Thomas' for elective care where they undergo all preoperative assessment, optimisation and follow through within the Trust, or they wait for vascular review on a ward at Dartford and Gravesham without access to specialist vascular services or the associated 'proactive care for older people' service (POPS). Those patients and carers travelling to Guy's and St Thomas' incur time and travel costs as well as inconvenience.

Solution

The POPS team is an established multi-disciplinary team involved in peri-operative care at Guy's and St Thomas'. There is growing research evidence to support the implementation of teams such as POPS. In a pre and post study in older elective orthopaedic patients at the Trust, those who underwent POPS had reduced medical and multidisciplinary complications and a 4.5 day reduction in length of stay despite higher comorbidities (Age and Ageing 2007).

To be effective, this approach needs a patient-centred and a holistic approach using the skills of a multidisciplinary team to support every aspect of patient care. The POPS team is an example of effective multidisciplinary working; comprising of surgeons, anaesthetists, critical care staff, geriatricians, occupational therapists, physiotherapists and social workers working together to optimise; assessment, intervention, post-operative care and discharge.

Diagram 1: Proactive care for older people service



To support the scoping, design and development of POPS within vascular services, two specialist registrars are supported to spend a day a week each at Darent Valley hospital. There are multi-disciplinary meetings every week in which surgical cases are reviewed.

The Group model has enabled the scoping, design and development of POPS by:

- creating an environment focused on collaboration;
- funding a project manager post; and
- funding clinical backfill to support the design and implementation of POPs in vascular services.

Impact

Through the framework of the Group model, POPS tests the translation of a teaching hospital initiative to a district general hospital.

Establishing the POPS service at Dartford and Gravesham, will enhance the reputation of Dartford and Gravesham as a centre delivering innovative and quality care and providing education and training. Furthermore, it will provide opportunities for the Trust to be involved in research (both single centre and multicentre).

Having POPS at Dartford and Gravesham has the potential to deliver a range of benefits, including:

- providing standardised, safe, effective care for older people undergoing elective and emergency general surgery at the Trust;
- delivering local preoperative assessment and optimisation to elective vascular and general surgery (including upper and lower GI cancer) patients in the outpatient setting;
- ensuring 'fitness' for surgery; reducing late cancellations for surgery;
- proactively identifying inpatients requiring POPS input and providing timely and evidence based in-patient assessment, optimisation and coordinated management;
- collaborating with the vascular clinical nurse specialist to facilitate an effective surgical pathway to and from Guy's and St Thomas' for both elective and emergency vascular patients;
- ensuring early safe repatriation of patients from Guy's and St Thomas' to Dartford and Gravesham for post-operative care and rehabilitation, ensuring their care can be delivered as locally as possible;
- reducing incidence and severity of post-operative medical complications in surgical patients at Dartford and Gravesham;
- identifying and treating post-operative medical complications early and thus reducing the impact on functional status and cognitive status;
- utilising community services more effectively (through establishing relationships with intermediate care to facilitate early discharge);
- reducing length of stay for surgical inpatients at Dartford and Gravesham; and
- reducing readmissions.

The start of the collaboration

Guy's and St Thomas' and Dartford and Gravesham sit barely 20 miles apart. Being so close, collaboration between the two trusts did not start with the publication of the NHS Five Year Forward View in October 2014; many clinical relationships pre-date this. However, the funding and impetus behind the successful bid to become one of the 5YFV New Care Models Programme Acute Care Collaboration (ACC) vanguards enabled the formation of the Foundation Healthcare Group and a deeper level of partnership.

Despite their geographical proximity, the two trusts are different in size, culture, and history.

Dartford and Gravesham provides a full range of local hospital services for people living in North Kent and Bexley, South East London. The trust works with partners to provide a range of specialist services locally and offers a number of regional services including kidney care. It employs around 3,000 staff, and has an annual turnover of £215m.

The trust faces opportunities such as how to capitalise on a range of new housing developments, including the 'Healthy New Town' at Ebbsfleet. It also faces challenges to providing high quality healthcare. This includes how to attract a high quality clinical workforce – particularly specialists – to be able to treat patients locally and provide reliable access to high quality healthcare. The constraining financial environment makes it difficult to achieve the benefits of scale to allow Dartford and Gravesham to save money or make significant investments independently.

Therefore, Dartford and Gravesham saw a collaboration with another provider as being important to help them continue to deliver sustainable, local healthcare services. Many organisations choose to follow a merger or acquisition approach which can prove expensive and distracting, while others choose to stay as a single organisation which poses its own financial challenges. Dartford and Gravesham chose to explore a third option of working with Guy's and

St Thomas' in a more structured partnership, using international examples of hospital groups as inspiration.

Guy's and St Thomas' is an integrated healthcare organisation providing a full range of local hospital and community services for people living in the South East London boroughs of Lambeth and Southwark. The trust also provides specialist care for patients from further afield, including cancer and cardiothoracic services. The Evelina Children's Hospital provides general and specialist services for children from London, South East England and further afield. The trust employs around 15,000 staff, and has an annual turnover of £1.4bn.

Guy's and St Thomas' saw a partnership with another provider as helping them meet their five-year strategic plan. Set in 2014, it confirmed the trust's mission to provide world-class clinical care, education and research that improves the health of the local community and wider populations that the trust serves. Guy's and St Thomas' aims to build on its track record of being part of numerous local, regional and national clinical networks that support the provision of co-ordinated patient pathways.

Both trusts were already seeking new collaborations before the call as part of the New Care Models programme for applicants to become an acute care-collaboration 'Vanguard'. The initial idea was simply to explore how the two trusts could both be stronger working together, in terms of quality of care provided and financial sustainability.

The executive teams first met to discuss an application in June 2015. These first conversations focused less on specific clinical opportunities, but the extent to which there were shared values between the two organisations. Both teams were encouraged by these discussions and the level of alignment in terms of organisational values (as shown in Table 1 overleaf).

Table 1: Organisational values

Dartford and Gravesham NHS Trust	Guy's and St Thomas' NHS Foundation Trust
Care with compassion	Put patients first
Respect and dignity	Take pride in what we do
Striving to excel	Respect others
Professional standards	Strive to be the best
Working together	Act with integrity

In addition, these conversations highlighted strong alignment in terms of the importance of clinical leadership, and the need to have a partnership of co-leadership and equal representation, yet while maintaining existing systems of management control for each provider. This last point was especially important given the asymmetrical nature of the two trusts.

It was at this stage that the collaboration determined it would not seek to follow a merger or acquisition approach, but rather look to base the partnership on firm mutual commitment to work together in a different way.

The resulting partnership, named the 'Foundation Healthcare Group' for the New Care Models Programme, aims to:

"Develop a sustainable local hospital model that makes best use of scarce resource and can be replicated across the NHS. It aims to improve outcomes and access, improve cost effectiveness, and meet the challenge of increased demand."

Following submission in September 2015, the Group was successful a month later in becoming one of the 13 acute-care collaboration Vanguard. A formal memorandum of understanding was signed between the two trusts in April 2016. An overview of key milestones is shown at Table 2.

Table 2: Key milestones

Date	Milestone
June 2015	Exploration of shared values between the trusts through meetings of executive teams and key individuals Submission of application to New Care Models Programme
September – October 2015	Submission, and acceptance, of application to New Care Models Programme
February 2016	Submission of the value proposition setting out how the partnership could meet the aims of the 5YFV triple aim and the New Care Models programme
April 2016	Memorandum of Understanding signed in public by the two Trusts
June 2016	Confirmation of programme funding and programme fully mobilised
April 2017	Start of making the partnership part of core business with shift of reporting lines from the programme into Guy's and St Thomas' Board reporting structure



Improving patient experience

Epilepsy nurse specialist *Paediatrics Clinical Faculty*

Challenge

Within the paediatrics clinical faculty, neurology was identified as a key area for improvement. A particular aim has been to examine how some elements of care that might currently be referred to the Evelina London Children's Hospital could instead be carried out in Dartford and Gravesham, enabling patients to receive care closer to home.

The additional resources provided through the New Care Models Programme enabled the paediatrics clinical faculty to recruit a paediatrician consultant post with a special interest in neurology. The consultant identified four key challenges facing neurology services at Dartford and Gravesham:

- the gap between care delivered at the Evelina London Children's Hospital and Dartford and Gravesham (e.g. lack of support for families in the local community following care provided in London);
- unnecessary visits to hospital that could be prevented if patients were well supported at home;
- lack of capacity to ensure liaison between staff groups to ensure clinical pathways, outcomes and training programmes are all in place and functioning properly; and
- length of time patients spent on wards.

Solution

As part of the delivery of a comprehensive service it was recognised that to 'complete' the neurology service, an epilepsy specialist nurse needed to be recruited. As with many organisations nationally, Dartford and Gravesham has found it difficult to recruit and retain clinicians. Therefore, innovative solutions to fill this post were employed.

Roald Dahl's Marvellous Children's Charity helps to make life better for seriously ill children in the UK, and its Roald Dahl Nurses provide support to children with serious illnesses, and their families. Roald Dahl nurses are offered professional development training and a range of networking opportunities.

The charity was contacted, and the Chief Executive visited Darent Valley Hospital to have a meeting with the paediatrics Clinical Director and hospital management. An agreement was made whereby the epilepsy specialist nurse post would be funded by the charity for two years, followed by a guarantee of funding from the trust for three years. This was the first Roald Dahl Nurse position in Kent.

To engage the team, staff were involved in the recruitment process, and five high calibre candidates were shortlisted for the position. The job interview process was designed to be different; five interview stations were set up to reflect Dartford and Gravesham's five core values, and at each station interviewees were asked questions relating to the value and their clinical competencies. The interview panel included over twelve people, including a parent of a patient (who was able to ask interviewees a question written by their child), nurses, consultants, a paediatrics registrar and a representative from the safeguarding group.

An epilepsy specialist nurse has now been appointed and begins work in July 2017. As a Roald Dahl specialist children's nurse, it is hoped that the new team member will provide support, information and practical care for patients, and provide support for families too. Roald Dahl nurses are highly trained, senior professionals who can 'make things happen' both within the hospital and provide coordination for services in the community. They can advise on a range of medical, emotional and social issues.

Impact

The recruitment process has already had a positive impact on team spirit, and has raised the profile of epilepsy and neurology within the paediatrics department.

The team at Darent Valley Hospital are now looking at the possibility of an honorary contract with the Evelina so that the epilepsy specialist nurse can share their time between the two trusts and attend clinics at both sites.

Feedback from parents on the proposed changes have been hugely positive so far. This has included parents being pleased that they can access more services closer to home, and in the event of having to travel into London they feel reassured that there will be more support available when they return to the community.



Reducing variation

Pathway mapping

Cardiology Clinical Faculty

Challenge

Most cardiology patients do not need specialist care and can be effectively managed and treated locally closer to home, often outside of an acute hospital setting. Some however, do need access to specialist opinion and equipment.

For locally delivered care, the Five Year Forward View emphasis is on improving the integration of care across settings, organisations and networks and delivering more care in primary and community settings facilitated by new technologies. For specialised care, where there is a strong evidence base for concentrating care in specialist centres, NHS England will continue to drive consolidation into fewer, higher volume centres that have the critical mass of activity and staff to deliver the best clinical outcomes and provide 24/7 sub-specialist services¹.

The cardiovascular risk in the Dartford population is high and there are significant co-morbidities, in particular a high prevalence of type 2 diabetes. The directly age-standardised premature death rate from heart disease and stroke for people living in Dartford, at 74.2 deaths per 100,000 people, is significantly higher than England overall (67.5). There are also a large number of people living with Coronary Heart Disease (CHD) in the local population – in 2012/13 there were over 7,500 people with CHD on GP practice registers. However, this only represents c.70% of the total expected, suggesting that there are potentially more than 3,000 others who have CHD but, as yet, not been diagnosed or presented with their condition.

There are already significant referral flows from Dartford and Gravesham sites to St. Thomas' for complex planned elective, urgent and emergency cardiology patients. However, the current model of care for specialist cardiology is sub-optimal; patient pathways are fragmented, care is poorly co-ordinated, there are significant delays along the pathway and a wide variation in patient experience.

Solution

The team aim to improve outcomes for patients from primary to secondary through to tertiary care by:

- focusing on the reduction of waiting time from referral to treatment;
- reducing variation of care by standardising pathways across Dartford, Gravesham and Swanley CCG, Guy's and St Thomas' and Dartford and Gravesham; and
- reducing the number of (unnecessary) appointments and tests/diagnostics, patients have across both trusts and using IM&T as an enabler.

¹ Cardiovascular Project, The Case for Change, NHS Commissioning Support for London, 2010

To better understand the challenges the team mapped the pathways of 20 patients (identified by informatics as having had an AF and HF ablation at Guy's and St Thomas'). This exercise has given the team detailed, granular data about the patients in their care and the relationship between the two organisations. For example, they now know that:

- 52% of Dartford and Gravesham patients treated at Guy's and St Thomas' have one of three primary diagnoses;
- Dartford and Gravesham patients occupy on average 1-1.5 beds at Guy's and St Thomas';
- the inconsistencies in the pathway (e.g. more tests are performed and more follow ups are offered at Guy's and St Thomas' than at Darent Valley Hospital);
- patients who were double booked at both hospitals would cancel their Dartford and Gravesham appointment and attend their Guy's and St Thomas' one; and
- waits to access the service are between 6 & 10 weeks depending which hospital the patient is referred to

The Vanguard enabled pathway mapping through:

- creating an environment focused on collaboration;
- funding a project manager post; and
- funding clinical backfill to support the design and delivery of pathway mapping

Table 3: Mapping the patient pathway

Inclusion criteria	Have had an AF & HF ablation at Guy's and St Thomas'. 20 patients identified by informatics team
Pathway scope	Guy's and St Thomas'/Dartford and Gravesham patients; outpatient activity, 1st, follow ups, DNAs, A&E, diagnostics (invasive and non-invasive)
Source of mapping	TOMCAT* (Cath Lab Patient Information System)
Commissioners covered	Dartford Gravesham & Swanley CCG (local activity) NHS England (specialist activity)
Care period	2015 -2016 (1 year). This included patients who had an ablation within 15/16 but may have been on the system longer.
Time to complete	10 hours consultant time across both trusts 12 hours of project management time
Limitations	Access to Primary and Community Care data/missing data in TOMCAT

Impact

Pathway mapping has given the team a much clearer sense of the actions they should take to improve patient care. To this end they are shaping their work programme to support focused improvement, including:

- improving the pathway in primary care to support management and reduce demand in acute care. This could include GPs education by providing in-reach AF/HF specialist clinics in practices; and
- providing joint MDMs via skype and video conferencing to reduce waits. This will also support knowledge transfer from tertiary care to acute care to build on specialist input and support to complex patients.

The vision for the group

An important part of the deepening of the partnership and the sense of purpose was the development of the shared vision. The resulting visual tells a very compelling story about putting in place the building blocks to create a sustainable future. The development of this vision took almost six months' worth of discussion and engagement with a wide range of stakeholders including Board members, Governors, lead clinicians, staff and patients from both organisations. This has meant that both organisations really identify with the vision and it underpins much of the work of the FHG and beyond.

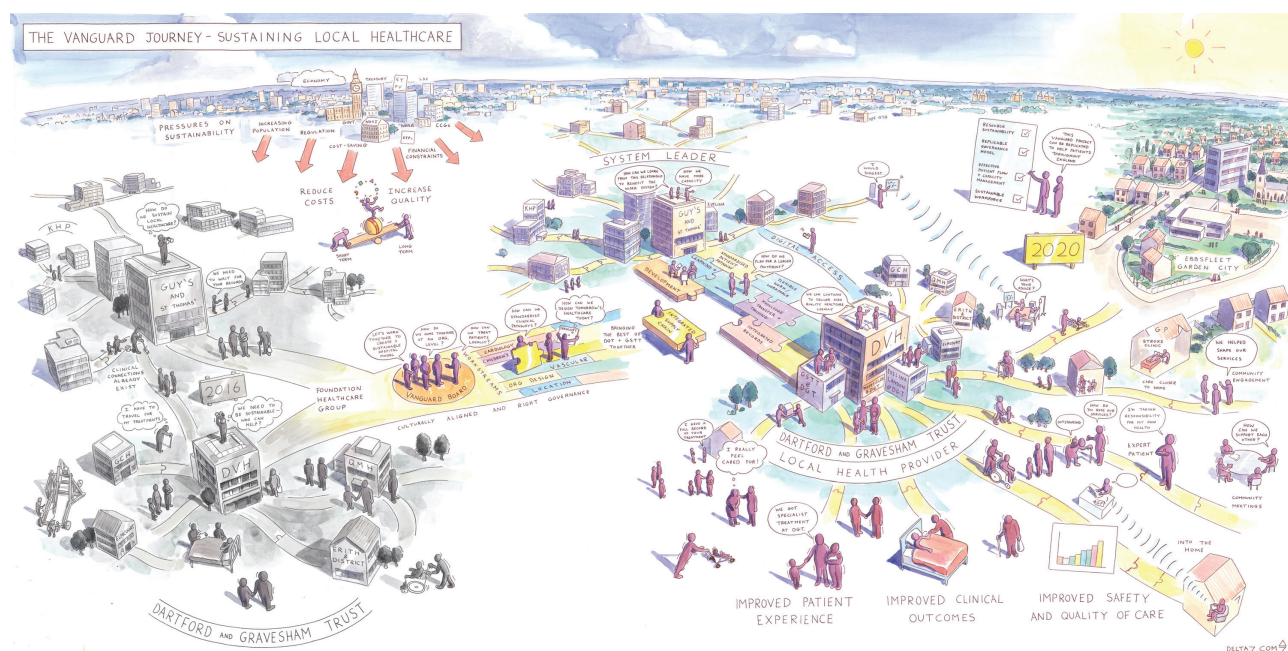
The creation of the value proposition and subsequent mobilisation and delivery of the programme has generated a lot of learning about how organisations can collaborate, and how other organisations could develop similar partnerships. This has created a robust yet flexible framework to encourage collaboration and drive results for patients and staff.

The partnership has sought to deliver benefits to patients and populations in four ways:

1. Improved patient experience

- Care delivered in a localised setting – by exploring how those travelling to Guy's and St Thomas' but living closer to Dartford and Gravesham could access care closer to home. For example, this has been shown in the work within the neurology improvement work within the paediatrics clinical faculty.
- Information and expertise shared between clinicians in both trusts – by building partnerships of trust and collaboration between clinical specialisms. For example this has been shown in the transfer of the POPS service from Guy's and St Thomas' to Dartford and Gravesham.
- Reduction in the duplication of diagnostics – by sharing data between the two trusts so that patients did not have to undergo multiple tests.

Diagram 2: Foundation Healthcare Group Vision



2. Safety and quality

- Reduction in unwarranted variation in outcomes – by sharing best practice and learning across the two trusts. For example, this has been shown in the patient pathway mapping within the cardiology clinical faculty.
- Increased capacity to meet the demands of a growing population – exploring mutual opportunities to share services, and build up specialist expertise.
- Transfer knowledge ‘downstream’ – exploring how to reduce admissions to specialist units by working with colleagues in local services such as primary care. This has also been a particular theme within the cardiology clinical faculty.

3. Clinical outcomes

- Standardised pathways – by working together and sharing data to examine variation between clinical specialisms, and jointly agreeing the best way to deliver care.
- Digital collaboration – exploring technological opportunities together, such as shared patient records and video-conferencing between the Trusts.
- Redesigned workforce – supporting each other to design new roles and recruit and retain the right staff. For example, this has been shown in the recruitment of the epilepsy specialist nurse within the paediatrics clinical faculty and the development of the POPS service.

4. Resource sustainability

- Creation of the Foundation Healthcare Group Model – by exploring a model which could be replicated both with other partnerships by the trusts, and by others across the NHS.

- Shared knowledge and expertise – by fostering joint working between non-clinical staff in functions such as finance and procurement.
- Financial savings generated through a shared approach to procurement that enables Dartford and Gravesham to leverage the benefits that of an organisation of scale has on price reductions.

The work undertaken by both trusts since the formation of the Foundation Healthcare Group has explored how to generate these benefits over a small set of workstreams, as shown in Table 4, overleaf.

For each of these workstreams an explicit decision was taken not to impose a single model of how benefits were likely to be generated. Instead, early in 2016 fifteen potential benefits (from standardised pathways to workforce redesign) were identified for the workstreams to explore.

The links between the objectives, benefits, measures and workstreams for the Group is set out in Diagram 3 on page 17. The plans for the Group were wider than those which have currently been explored given restrictions in funding, meaning there remain a range of potential benefits which have not been pursued to date.

In this way, The Foundation Healthcare Group ‘model’ represents a *framework* for how to generate benefits of partnership working rather than a prescriptive set of rules.

This approach has had the benefit of generating far greater learning than if all areas tried to work in the same way. It has also built flexibility into the Group, meaning that it can continue to evolve over time, including with potential new members.

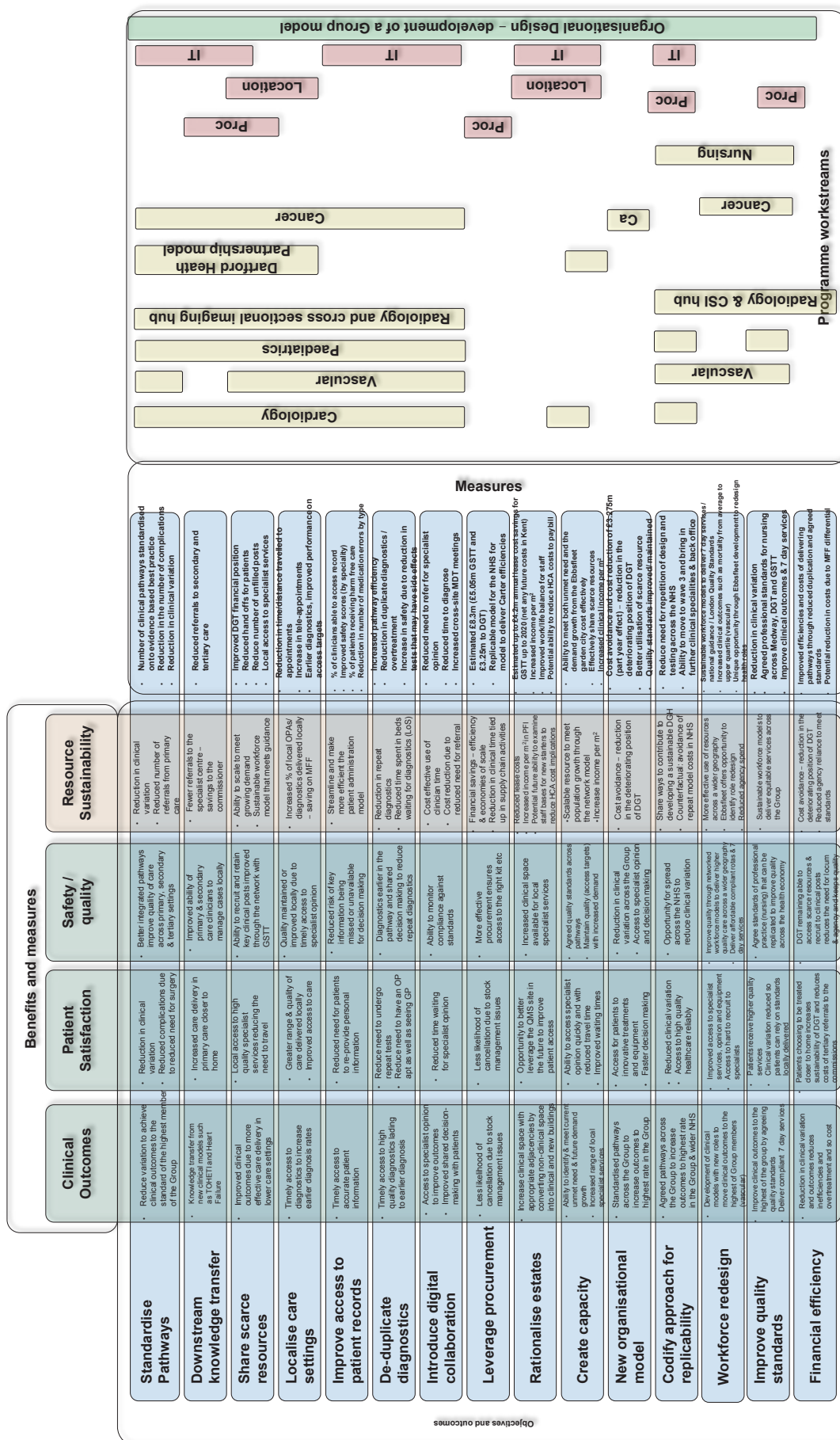
Table 4: Workstreams of the Foundation Healthcare Group (April 2017)

Workstream		Rationale and purpose
Governance		Delivered through a committee-in-common model (the Programme Board) to enable decisions relating to both trusts to be made effectively and integrates into each trusts own governance processes and oversight.
Clinical	Cardiology	The concept of 'clinical faculties' was created to foster collaboration between clinical specialisms.
	Paediatrics	Three areas were selected based on the trusts' strategic priorities, and the engagement shown by clinical teams in using collaboration to work on a particular improvement priority. The areas were: <i>cardiology</i> because of pressure from commissioners over unwarranted variation in existing pathways; <i>paediatrics</i> because they already provide outreach to roughly 25 other organisations; <i>vascular</i> because they had a particular workforce challenge with the single consultant model.
	Vascular	
Non-clinical	IT	To examine ways to use technology to link up the two trusts and support the development of new services including a shared patient record and teleconferencing.
	Location	To develop a tool-kit for agile working so as to support both organisations transform their ways of working.
	Organisational design	Beyond the programme and related to Guy's and St Thomas' being accredited as a Foundation Group Leader by NHSI, to explore how to bring the two organisations together into a collaborative group model.

Diagram 3 – Overview of the Foundation Healthcare Group model

This diagram aims to show in one place the linkage between:

- objectives/outcomes – i.e. what will be done (the rows),
- benefit areas (columns),
- the programme workstreams





Resource sustainability

Creation of the agile location project toolkit *Location workstream*

Challenge

The two trusts operate separate non-clinical functions at, or close to, their core clinical sites. Pressure on both trusts to improve effectiveness and efficiency in their use of space meant that options for agile and 'hub' working by non-clinical staff was both increasingly attractive and possible, due to enabling emerging technologies.

Guy's and St Thomas' has significant estate costs due to the number of sites (both clinical and non-clinical) which it runs in central London locations. The trust believes that an approach to agile working for eligible staff would provide benefits including improving the wellbeing and retention of staff.

Dartford and Gravesham faces a different challenge due to the projected increasing population demands over the next 5 to 10 years, which will have an impact on the trust. A combination of 5,000 new homes in Dartford and 12,000 new homes in the Ebbsfleet Garden City development will put additional pressure on the acute services provided at Darent Valley Hospital.

The existing Estates and Facilities Strategy at Dartford and Gravesham calls for "better utilisation of the PFI estates ensuring that clinical activity is focused in the right areas with administration transferring to clinical use" as part of its five-year plan. The related 'Space Utilisation Strategy' details how space could be used more effectively and efficiently within the hospital and describes utilising the main hospital building as clinical space in order to benefit patient experience and meet future patient demands in terms of growth.

Solution

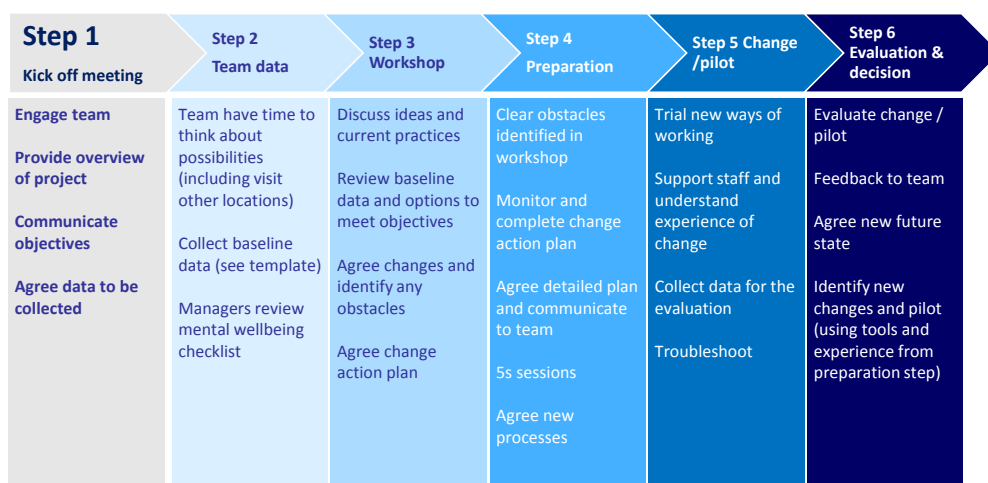
The 'Location workstream' looked to develop, test and evaluate the principle of agile working. One of the key goals for this workstream was to create a toolkit and approach that could be replicated for other NHS organisations.

The learning from this workstream has been developed into an agile working toolkit which:

- supports organisations, leaders and teams to assess and evaluate opportunities to improve wellbeing and reduce demand on estate by working differently;
- provides leaders with tools to enable the change; and
- shares learning.

This toolkit is underpinned by a 6-step model (shown in Diagram 4) devised from best practice change and project management methodologies. The sequential steps enable teams to move to new ways of working. The duration of each step depends on the size and complexity of the change. The minimum time frame is twelve weeks (including the initial evaluation in step 6). The model can be used to pilot or implement sustained change.

Diagram 4: 6-step model to support the agile location toolkit



The toolkit is a live document, accessible on Guy's and St Thomas' trust website including a short guide for managers that will be updated with learning and adapted across organisations. It is intended to be used as a guide, as not all elements of the model will be relevant in all cases. It is supplemented by a document outlining learning collated by the workstream called "Ways of Working Learning Summary". This document goes into more detail around the benefits of working differently. It includes learning from the NHS and other organisations who have transformed how they work.

The Group model enabled toolkit development through:

- creating an environment focused on collaboration
- providing acceleration through the programme structure
- funding project set up and delivery.

Impact

The agile working toolkit is now a business as usual function within the trusts and is underpinning the Guy's and St Thomas' Transforming Our Ways of Working programme and as such supporting teams to work differently to support employees and ensure the best utilisation of expensive, clinical real estate.

The work of the Location workstream is another example of how the New Care Model Vanguard Programme has provided an accelerator to work that was already underway within both organisations to identify cost savings and improvement through flexible working and estate rationalisation. That this work has now passed to the business as usual teams within each trust indicates how quickly the workstream has been able to move things forward.

The Location workstream seeks to the following direct and indirect monetary benefits as well as non-monetary benefits:

- Reduced estate costs (measured by: rental costs)
- Released capacity for clinical use as the percentage of non-clinical staff based in acute hospital sites is reduced (measured by: additional clinical capacity)
- Enabler in the advancement of shared back office functions (measured by: savings released from economies of scale relating to shared provision of administrative and corporate functions)
- Improved staff wellbeing (measured by: staff reported happiness; retention and recruitment data)

Learning to date

The Foundation Healthcare Group has only been fully operational since June 2016, and yet significant changes have been demonstrated across all of the programme workstreams in this short space of time. The two trusts have been encouraged by the energy and progress seen across the workstreams, and now see opportunities to transition the approaches developed into core ways of working with clear evidence of the desired benefits being realised.

The work to date has generated a range of learning, including three particular themes.

1: Shared values and strategic alignment are essential

Prior to discussions, both trusts had strategic cause to start a new collaboration with another provider; this strategic alignment, alongside existing clinical relationships, were the catalyst for initial discussions. These initial conversations then focused on shared values, and whether there was alignment between how the two trusts operated and were seeking to achieve.

The level of shared values identified in those conversations enabled the collaboration to form, and has kept the programme operating since then.

2: Put in the time, and follow the energy

A significant amount of time has been put in by the executive teams of both trusts throughout the process. For example, the monthly Programme Board is attended by the Chief Executive and Director of Strategy and Planning for Dartford and Gravesham, and the Chief Executive, Executive Vice-Chair and Chief Medical Officer of Guy's and St Thomas', along with additional executives from both trusts.

In addition, the two trusts wanted to explore issues relating to clinical collaboration with clinical teams interested in making the concept work. As such, the three clinical faculties were chosen because they actively wanted to use the opportunity presented by the FHG to work on particular improvement issues. This approach gave the programme the

best chance of success in showing that the model was viable, and generating enthusiasm for other clinical teams to follow on.

The Group has been supported financially by being part of the New Care Models programme, enabling the two trusts to recruit specialist staff with the 'headspace' to design new ways of joint working which would have been harder to do within existing roles. However, it has also been about the impetus to deliver change, coupled with the ability to learn from other new care models, which has made exploring this collaboration a greater priority for both trusts.

3: Data and joined up IT are key to track progress (and difficult to do)

This is a wide-ranging programme impacting a large number of staff across the two trusts. How to evidence the benefits of the collaboration is challenging, particularly at a speed which enables lessons to be learnt quickly.

For the two trusts, this is still work in progress. The speed of setting up the collaboration created difficulties in rapidly agreeing common measures and a shared view of the baseline from which the trusts were starting. The clinical faculties have consistently identified the need for data to support their improvement work, which continues to be a priority for the programme.

Clinicians across the three clinical faculties have also been keen to explore how technology can further their collaboration. This has particularly focused on how specialist services and diagnostics can best support remote access to specialist opinion. To achieve this requires, as a minimum, shared patient information including patient records and digital imaging.

This is being developed as part of the Group model, with the planned rollout of the Local Care Record as developed by King's Health Partners (KHP) that will enable Dartford and Gravesham clinicians to see records from both Guy's and St Thomas' and King's College Hospital as the two tertiary centres for the Trust.

The future

To date the collaboration has generated learning for the trusts on two levels:

- how to further develop and improve their specific bilateral partnership; and
- how future partnerships the trusts enter in to (either together or separately) can have the greatest chance of success.

The Foundation Healthcare Group is being run as a programme that will finish at the end of 2017/18, along with the funding and support from the New Models of Care Vanguard Programme. The two trusts are keen to develop their partnership into a new form of sustainable Group Model from April 2018 onwards, with the expectation this Group will continue to expand its mutual benefit across the system through new members joining over time. Over 2017/18 the two trusts will explore the model in greater depth, with the need to make the Group part of core business for both organisations by April 2018.

From April 2017, the governance for the programme shifts from being co-led between the two trusts to being led by Guy's and St Thomas'.

This new governance will oversee how the bilateral partnership can develop, for example on key areas such as data and IT. It will also oversee the development of a new Group Model as a broader partnership between Guy's and St Thomas' and other trusts. This will involve further analysis and design of how the model can best deliver benefits to patients and populations, as well as working with potential future members to best understand how the model can support them.

Most important will be finding new partners who share the same values as the current two trusts. The new group will continue the FHG focus on collaboration without the formal process of merger or acquisition. Instead, the distinctive feature of this model of acute care collaboration is a partnership based on shared values and a flexible framework with strong clinical leadership.

The continued growth of the model provides exciting opportunities for collaboration to deliver better health and care to its members' populations, and learning for the wider NHS.

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www.dvh.nhs.uk; www.guysandstthomas.nhs.uk