NHS
Dartford and Gravesham
NHS Trust

NHS
Guy's and St Thomas'
NHS Foundation Trust

The vanguard of clinical collaboration

The development of clinical faculties as part of the Foundation Healthcare Group

Kaleidoscope Health & Care, 2017

KALEIDOSCOPE

www.kaleidoscope.healthcare

Contents

Acronyms used	
DGT	Dartford and Gravesham NHS Trust
DVH	Darent Valley Hospital (a DGT hospital site)
ECCN	Emergency Care Clinical Network
ELCH	Evelina London Children's Hospital
GSTT	Guy's and St Thomas' NHS Foundation Trust
ACC	Acute Care Collaboration
FHG	Foundation Healthcare Group
HEE	Health Education England
CCG	Clinical Commissioning Group
JHM	Johns Hopkins Medicine
MDT	Multidisciplinary team
QI	Quality Improvement
POPS	Proactive care of older people going to have surgery
UAS	Ultrasound Angiology Service

About this report

- Guy's and St Thomas' NHS Foundation Trust (GSTT) and Dartford and Gravesham NHS Trust (DGT) have been in partnership through the NHS England New Care Models Programme as an Acute Care Collaboration (ACC) Vanguard since September 2015.
- This partnership, called the Foundation Healthcare Group (FHG), seeks to develop a sustainable local hospital model 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 challenges of increased demand.
- This review examines one aspect of this partnership: the development of three 'clinical faculties' in cardiology, paediatrics and vascular services. The review was carried out by Kaleidoscope Health & Care between January and March 2017. It was commissioned by FHG and supported by Health Education England (HEE).
- The review seeks to support learning, both within FHG and across the NHS, about how clinical collaboration across large providers can be supported most effectively. It draws upon a range of interviews with members of FHG, a set of international case studies of clinical collaboration, and a literature review.

The report – and additional resources, including full write-ups of the international comparisons case studies – can be found at www.healthcarecollaboration.co.uk/fhg.html

Key points

- This review examines a particular form of structured clinical collaboration across different providers. For consistency, the term 'clinical faculty' has been used throughout this report to describe the collaboration in the three chosen clinical areas (cardiology, paediatrics and vascular services).
- Collaboration in the three chosen clinical areas pre-dated the Vanguard programme, albeit at a limited scale. The programme resources have enabled clinicians working within the three areas, and FHG more broadly, to accelerate the development of the collaborations.
- FHG provided the ethos for clinical faculties, as well as the permission and resources to work in new ways. The areas were not given a specific model to follow and could develop their ideas as they went. As such, care is needed in extrapolating the progress made in these areas to other specialties.
- All three areas approached collaboration between the two trusts – and how they could best deliver benefits to patients – differently. They used the programme resources differently. All three areas are clear that collaboration has already delivered benefits.
- There are a number of similarities between each of the three FHG clinical faculties, and with international examples. The review discusses what appear to be critical and common components of developing models of clinical collaboration.
- Five features were identified as critical to successful collaborations. These provide the necessary, but not sufficient, building blocks for developing such models. The five critical features are:

    - the work being co-designed involving clinical teams from the outset
    - organisational commitment providing permission to accelerate collaboration
    - involving the right roles and individuals in the leadership and running of the collaboration
    - the need for reliable data to support joint working
    - the basic infrastructure, such as IT, to support the work.
- A further four features were identified as common to successful collaboration – likely to be present in successful collaborations, but not essential. The four common features are:
    - presence of existing relationships between teams
    - use of nationally agreed pathways
    - strong patient engagement
    - a clear approach to celebrating success.
- Running through these features is an acknowledgement that, in order to thrive, clinical collaborations need support from organisational functions outside the remit of individual clinical teams. For example, basic IT support to enable interoperability across different providers, shared data systems and strategic alignment with wider quality improvement work.
- Sustaining the work across the three FHG clinical faculties needs careful consideration, particularly in terms of the clinical energy and leadership required.

Background

Each FHG Trust is influenced by its local area and exists within a distinct set of circumstances. Dartford and Gravesham NHS Trust (DGT) is a small acute trust serving a population across North Kent and part of South East London, and is part of the New Cavendish Group for small hospitals. DGT is looking to secure its future and sees working as part of a wider system of care as critical to doing so.

Guy's and St Thomas' NHS Foundation Trust (GSTT) is a large acute teaching hospital and community trust delivering care via a range of community, local and tertiary specialist services across South East London. GSTT is a system leader, providing strategic and operational, clinical and management support to NHS organisations.

DGT have an annual budget of £215 million employing just under 3000 staff. In comparison GSTT have an annual budget of £1.3 billion and employ around 15,000 staff. This asymmetry between the trusts was explicitly acknowledged from the outset of the collaboration to ensure the trusts could approach collaboration as an equal partnership.

The Ebbsfleet Garden City development, which will build 15,000 new homes, and the corresponding increase in population growth, has the potential to impact both trusts and was a critical factor when identifying strategic priorities for the Vanguard. This, combined with a range of other national and local opportunities and challenges, has resulted in both trusts being keen to build upon their shared culture, values and their history of collaboration to create sustainability in the hospital sector. As a mechanism to achieve this, the trusts applied for Vanguard status in 2015.

Prior to forming the FHG, GSTT and DGT already had good clinical relationships, with GSTT providing tertiary care to some DGT patients. There was also a clear alignment of culture and values that merited exploring a closer governance arrangement. The two trusts are located in North Kent (DGT) and South East London (GSTT), with specialist networks covering a much wider geography.

This review examines one aspect of this partnership: the development of three 'clinical faculties' in cardiology, paediatrics and vascular services. While 'clinical faculty' has been used as a consistent term throughout, the specialities use different terms to describe themselves. For example, the cardiology clinical faculty refers to itself as the cardiology working group, while paediatrics and vascular both refer to themselves as clinical workstreams.

The review was conducted between January and March 2017. An overview of the methodology can be found in appendix 1.

Learning: Desiging sustainable clinical faculties

Approach

Kaleidoscope used insights from our work with the trusts and interviews, international case studies and a literature review to identify key features for success. We mapped them into two categories: critical and common.

Critical features are those that the analysis suggests are essential for the creation of a clinical faculty. Without these present, or a plan to address them, it is unlikely the clinical faculty will be a success. Common features are those most clinical faculties shared (whether they are internal to the trusts or examples taken from the literature review).

Case studies of the international examples can be found on Kaleidoscope's website.

International Comparison: Victorian Clinical Networks (Australia)

40 emergency departments (EDs) make up the ECCN. The ECCN runs annual cycles of nine-month quality improvement projects for its members.

Each year the EDs are presented with six possible projects they can participate in. The project options are developed by the ECCN steering group based on state priorities. The steering group is comprised of a multidisciplinary group of clinicians, including representatives from nursing. A central or core team comprised of a full-time manager, clinical advisor (currently an academic emergency doctor), project officer and administrative support work with the EDs to tackle issues that they find important.

The success of this project approach is evidenced by 90% of EDs choosing to take part in 52 projects last year.

Critical features

Co-design

A large number of interviewees commented on the fact that the clinical teams had been encouraged to own the problems and solutions within their clinical faculty. This was consistently described as a very positive experience, and one that set the tone for the work going forward.

The benefits of creating an environment where the programme aims and work schedule are self-generated are clear – as well as giving the work ownership, focus and energy, this creates a sense of good will which translates to more flexible working to enable to the programme of work to succeed.

Permission

Although all three clinical faculties described a history of working across organisations, the organisational commitment underpinning the programme to encourage participation as a Vanguard clinical faculty gave them

the opportunity to accelerate this work. Through participation in the Vanguard, teams had board-level permission and organisational commitment to take managed risks, and the work of the teams was legitimised. Teams were able to access pump priming in the form of resources. They were forced to think specifically about the aims of their network and were then held to account for their progress through a combination of internal (trust level) and external (NHS England) reporting.

Vanguard status and corresponding funding has allowed the clinical workstreams to provide proof of concept that this model of networked, multisite working is possible.

By setting the faculties up as projects a clear process was followed:

- Diagnosing of opportunities.
- Mapping out a programme of work.
- Implementing the programme of work, delivered in a structure of accountability.

Membership

The membership of the clinical faculty was also viewed as a critical component. This ranged from the recruitment of the right leadership through to ensuring that there was access to the right technical skills to resolve issues.

All the clinical faculties had some form of project group that was multidisciplinary, with a mix of doctors, nurses, allied health professionals and management. These groups were the forums in which project progress was tracked, and problem solving took place.

All the international models of clinical faculties we analysed included core support teams. The name of these teams varied, but it is clear that they are integral to a clinical faculty's success. The international examples of clinical faculties selected vary in size, however they all require more than one person to be in the supportive core.

International Comparison: Cincinnati Children's Learning Networks (US)

The governance structure between each network varies. However, typically the governance panel will consist of 2-3 physicians, 1-2 parents, an epidemiologist or statistician, and a manager who is an expert in network science. Underpinning this is a broader advisory panel.

International Comparison: JHM Clinical Communities (US)

An administrative core supports the communities with project management and access to resources, such as data analysis and improvement tools.

Clinical leaders were viewed as key to the process feeling like a genuine partnership from the outset, and encouraging clinical buy-in. Openness, the ability to ensure clinicians do not feel threatened by potential partners and insight into an organisation's culture were deemed critical clinical lead features.

All three clinical workstreams were unequivocal about the benefit of having project managers working with their faculty. Every person we interviewed praised the two managers supporting the network; they were viewed as being critical to ensuring that the faculties progressed.

The paediatrics workstream highlighted the value of working with a clinical Quality Improvement (QI) fellow, who had dedicated time to focus on clinical pathways, data collection and measurement. The cardiology and vascular workstream are both in the process of applying for a clinical fellow.

In terms of technical support, one interviewee commented that the clinical faculties initially accessed IT support through the business as usual route, causing frustration and delay as they met the "usual" organisational blocks. A project level IT lead with the ability to fast-track issues was highlighted as an important asset to each clinical faculty.

International Comparison: JHM Clinical Communities (US)

Clinical communities are typically led by one academic and one community physician. They set safety and quality priorities, determine project goals and maintain accountability for measurable results.

JHM Clinical Communities are typically founded in two ways; either through clinicians coming forward with an identified area for improvement, or proposed by hospital administration as an area of concern. In terms of success to date, there has been no significant difference between the two. For the latter, JHM cite the importance of taking the time to identify a suitable clinical lead with the necessary enthusiasm and clinical reputation to be able to bring other clinicians on board. In terms of capacity building, JHM recommend clinical community leaders participate in leadership training.

Data

Data was a recurring theme in our discussion with the clinical faculties. All three of the faculties felt that they had struggled to access reliable data to give them both a baseline on performance and an insight into progress against their aims. Conversations with clinical faculties revealed that they would like to be in a position where data is collected for improvement, which needs to be timely and comprehensive so that changes can be made in real time.

All three of the clinical faculties had undertaken a level of patient pathway mapping; they unanimously felt that although this was resource intensive and took time the benefits of actually understanding what was happening on the pathway outweighed the disadvantages of the approach.

International Comparison: Cincinnati Children's Learning Networks (US)

The teams involved in Learning Networks use registries to track data over time. Data collection methodology varies between networks, for example some more advanced centres can see outcomes on a daily basis. Data from the networks are used to generate monthly quality improvement reports, to enable sites to benchmark against other centres and celebrate success. Using the "all teach, all learn" philosophy, teams discuss reports, address barriers and share what works in learning sessions and monthly webinars.

International Comparison: Victorian Clinical Networks (Australia)

The Emergency Clinical Care Network (ECCN) ensures that the data it requests from participating sites is as easy to collect as possible, and is suited to driving and evaluating change in a timely manner. The ECCN asks each ED to collect relatively small numbers of cases, usually 20-50 per site, and for data collection to be yes/no regarding key processes, outcomes or time-defined. They purposely choose not to collect demographic or detailed clinical data. The resultant data is highly focused, very accessible to clinicians, and suitable for aggregation and system-wide analysis.

Infrastructure

Having the right infrastructure to enable network working was a recurring theme from our discussions. This infrastructure took two forms – the physical "enabling" logistics (e.g. access to teleconferencing facilities, meeting room availability, IT solutions) and the less tangible infrastructure provided by the approach design (e.g. the governance and accountability, the methods of programme level decision making, resourcing at set up).

From an enabling angle, the two infrastructure themes are critical in supporting the acceleration of the clinical faculty work. From the perspective of goodwill, the value of the physical infrastructure should not be underestimated. For example, a lack of shared IT access between sites was highlighted as an initial challenge within the clinical faculties. IT systems in the NHS are notoriously tricky to manage across organisational boundaries. However, there are basic requirements clinical faculties seem to need to support cross site working. A project level IT lead provided dedicated support to the clinical faculties to address these issues.

Common features

Existing relationships

Although agreeing that existing good relationships are not be an essential prerequisite for establishing a clinical faculty elsewhere, all three clinical faculties highlighted their benefits in terms of getting things off the ground quickly. For example, the paediatrics clinical faculty described how they were not starting from zero because of the existing Evelina London Specialist Network. The vascular clinical faculty described the good working relationships between consultants based at GSTT, who also worked at DGT or other local sites. The cardiology clinical faculty referenced preexisting professional links between clinicians.

Use of nationally agreed pathways

Use of nationally agreed clinical pathways, or a shared understanding of basic agreed pathways, formed part of the foundation for collaboration between the Trusts. For example, the cardiology clinical faculty agreed from the outset to use the NICE pathways for Heart Failure and Atrial Fibrillation. Using agreed pathways also helps with alignment across Clinical Commissioning Groups (CCGs). In addition, using nationally agreed pathways can help standardise quality improvement and audit approaches across organisations.

International Comparison: Johns Hopkins Medicine (JHM) Clinical Communities (US)

JHM have developed a Patient Advisory Pathway Clinical Community (PAPCC). The PAPCC brings together Patient and Family Advisory Councils (PFACs) from across the health system to share best practice. It is drawn on frequently as a resource for other clinical communities in terms of how they best engage patients and families.

This is done through inviting Patient Advisory Pathway clinical community members to another community, or asking for help to develop standard models of patient engagement to enable patients to learn about their care. Examples of this include developing notebooks patients can take along to their appointments, setting up group lectures and using technology more skilfully so patients can engage with their electronic patient records.

Patient engagement

Across the three clinical faculties there has been an effort to engage with patients using a variety of methods including questionnaires and coffee mornings. All three recognise the importance of hearing from patients as the faculties develop. For example, in the paediatrics clinical faculty parents of patients were part of the selection panel for

the epilepsy specialist nurse. In addition, a parent coffee morning has taken place and connections have been made with the friends and family coordinator at DGT. When asked about patient engagement, the paediatrics workstream discussed the importance of finding a meaningful way of involving patients and parents.

International Comparison: Cincinnati Children's Learning Networks (US)

Clinical networks have found it useful to establish a framework through which patients can make the contribution they want. This involves 4 levels of possible engagement:

- Awareness (e.g. through providing flyers for parents to read)
- Participation (e.g. parents attend meeting)
- Contribution (e.g. parents help develop content for a meeting)
- Ownership (parents' co-own and lead networks)

International Comparison: Alberta Health Network Strategic Clinical Communities (Canada)

Alberta SCN's have engaged with patients through the development of the Patient and Family Advisor role. They are recruited to each individual SCN based on their specific health care experiences and their passion to make positive change. In addition, patients involved in existing province-wide advisory councils are also asked to contribute to relevant SCNs.

Celebrating success

The paediatrics clinical faculty have begun to consider the benefits of celebrating success within their team. For example, they have introduced a "team member of the month" award to help maintain engagement among staff. In the vascular clinical faculty, the POPS team hold an annual conference and publish literature on their work. On a programme-wide level, the FHG are holding an event in July 2017 to showcase the new clinical models and discuss the legacy of the programme.

International Comparison: Victorian Clinical Networks (Australia)

The Emergency Care Clinical Network (ECCN) highlighted the importance of celebrating success as a means of maintaining momentum and engaging project participants. As well as encouraging writing blogs about the projects, the ECCN hosts an awareness raining forum annually, hosting over 200 people. It aims to celebrate the project successes from the previous year and introduce the next year of projects, as well as running 'expert in the room' sessions for attendees. The subject matter for these sessions change, and previous examples include paediatrics and mental health.

The ECCN also encourages project leaders to present their work when possible, and make particular reference to encouraging nurses to present their work. To date, three nurses have been winners at national conferences.

Review: Development of the FHG clinical faculties

Initial set-up

The concept of furthering clinical collaboration was a key theme between the two trusts throughout the design and development of the group model. The collaboration has been conceptualised as the development of 'clinical faculties'.

FHG deliberately did not provide a prescribed idea or template of what a clinical faculty should look like. Instead, it intended for clinical faculties to provide an initial proof of concept, and so provided the ethos, gave permission and resource for them to work in new and innovative ways, and selected them based on where there was obvious energy to undertake the work at pace. The FHG required the clinical faculties to demonstrate that they:

- delivered clinical, patient and/or staff benefits for both organisations
- were an equal partnership between trusts
- involved clinicians willing to work together and meet in person when necessary
- included examples of shared patient pathways
- were strategically aligned for both organisations

In 2016 FHG selected cardiology, paediatrics and vascular services as their initial clinical faculties. Individual governance was established for each clinical faculty, feeding into an overarching Clinical Reference Group. The Clinical Reference Group was established to bring together

clinical leads from each faculty to provide quality assurance for the clinical models, ensure each faculty stayed on track, share learning both internally and from other national and international examples, highlight common issues such as IT and help think outside of their own speciality area.

There was a spectrum of partnership starting points across the three services, and they all approached collaboration between the two trusts, and how they could best deliver benefits to patients, differently.

Cardiology

Context

NHS Dartford, Gravesham and Swanley CCG were experiencing some very specific issues within their cardiology pathways; namely a lack of consistent primary care management which translated into high referral rates for the conditions of atrial fibrillation and heart failure. A 'Cardiology Working Group' was set up with the aim of supporting clinicians to resolve these issues. The formal aims of the Working Group were described in the clinical faculty's project initiation document as:

- resolving duplication across patient pathways
- creating shared patient pathways across primary, secondary and tertiary care

Prior to the successful Vanguard bid there was already a small amount of clinical collaboration and shared pathways being developed between the GSTT and DGT. In addition, and critically for the cardiology team members we spoke to, there were also existing relationships between some of the clinicians.

Project set up

The additional resources provided through the Vanguard have enabled the Cardiology Working Group to:

- backfill clinical time, creating space for clinical leaders to think
- support secondees into new roles, to help embed new clinical practice
- create a joint locum post between the two trusts
- access project management time.

Given the nature of and existing issues within the clinical pathways the team were clear that they needed to involve the local CCG (NHS Dartford, Gravesham and Swanley) from the outset. This meant that when it came to delivering revised pathways, the CCG endorsement saw a higher level of adoption within primary care.

Operational features

The creation of the cardiology clinical faculty has resulted in several changes to the way services are organised and how clinicians work across the pathways. These include:

- cross-site multidisciplinary team meetings (MDT); the cardiology clinical faculty believe that bringing people together in a room was critical to their success
- cardiology outreach and valve clinics; previously delivered at GSTT but can now be accessed by patients at DGT
- use of Skype for Business to share ECGs etc
- GP education events.

Key learning

Leadership

Critical to the leadership of the clinical faculty was the co-chairing arrangement. This meant that the process felt like a genuine partnership to clinicians from the outset, rather than feeling like a takeover. The leadership roles fell to the existing clinical leads because they seemed to be the obvious choices at that stage. The critical requirements for a clinical faculty leader would be a demonstrable ability to work collaboratively with their partners in the other hospital.

The cardiology team stressed the importance of those leading and participating in the project requiring time and space to be able to design and implement their ideas.

Standardisation of pathways

Clinical teams led the co-creation of all the pathways across primary, secondary and tertiary care. The cardiology team agreed from the outset to use the NICE pathways for heart failure and atrial fibrillation as their definitive clinical pathways. This was further supported by the availability of data from the CCG in relation to high referral rates and inconsistent referral practice from primary care. This made it very easy for the clinical teams to agree on dual aims for the working group.

Partnership working

The team describe a history of some network working between GSTT and DGT, and good working relationships between some of the clinicians. This meant that it was much easier for them to move at pace when agreeing their pathway aims.

To further partnership working, cardiology peer review sessions between GPs and cardiology consultants have been organised, feedback of which has been very positive. A number of clinical cases

were put forward to the cardiology consultants which addressed certain pathway issues, especially concerning palpitations and chest pain which are areas of focus for the Vanguard. A review of referrals also took place across the three geographical areas – Dartford, Gravesend and Swanley. This has resulted in a surge in requests for advice from GPs to consultants via email and telephone, suggesting that the demand to refer will subsequently go down. Consultants are offering more email advice via the Choose and Book systems. This is seen as a positive outcome.

> "There is good will within the group which translates to people being prepared to work more flexibly, attending a 8am MDT or going to work out in a GP practice" **Clinical lead – cardiology**

Partnership working has also enabled developments such as the Valve Clinic to flourish across both sites. This is a cardiac physiologist led clinic which replaces a service traditionally provided by the medical team. Physiologist led clinics were already being delivered at GSTT, and under the framwork of the FHG the physiologist team at DGT have been empowered to introduce this at their own site.

Set up of these clinics is reasonably time intensive, requiring a training programme of up to 12 months before clinics can be run independently. This training is provided by the team at GSTT and without the context of the FHG may not have been possible. The benefits for patients include a reduction in tests (due to the protocol based nature of the clinic) and access to a specialist valve opinion. However, for the organisation there are the added benefits of improved recruitment and retention within a traditionally hard to recruit group of staff (physiologist led clinics are part of the Modernising Scientific Careers programme, making services offering this appealing to this professional group) the release of the medical team to support more complex patients.

The future

The cardiology clinical faculty are expanding their original brief in order to respond to a new pressure identified through the CCG and are setting up a syncopy clinic. They are also thinking about other strategic clinical network relationships they might want to build to reflect existing patient pathways.

Paediatrics

Context

DGT and Evelina London Children's Hospital (ELCH) have a history of shared working, with Evelina London specialist consultants delivering regular clinics from Darent Valley Hospital (DVH), a DGT hospital site. DVH is a key referral partner into Evelina London specialist services. Therefore, there were existing clinical relationships from which to build further pathways and opportunities for improvement.

Before the Vanguard, paediatric clinical pathways faced a number of issues. For example, children who arrive via accident & emergency were managed by emergency services rather than paediatrics, sometimes resulting in a longer patient pathway than necessary.

The paediatrics clinical faculty was established to develop a fully integrated networked model of specialist care covering a range of conditions. Care would be carried out at Evelina London as the 'hub' where necessary, and enhanced services delivered locally on the DGT hospital sites (the 'spokes').

The faculty aims to:

- support primary care clinicians to better manage children's day-to-day care needs

- reduce variation in the way the most frequent causes of presentation at A&E are treated and managed
- establish an identifiable network of providers
- develop specific specialist services that directly support high quality accessible care to local children and families
- support a strategy for the development of a sustainable workforce model at DGT.

Project set up

The additional resources provided through the Vanguard have enabled the paediatrics clinical faculty to:

- recruit a paediatrician consultant post with a special interest in neurology
- recruit a QI fellow.

Operational features

The creation of the paediatrics clinical faculty has resulted in changes to the way services are organised and how clinicians work across the pathways. This includes more regular meetings between staff at GSTT and DGT, organised by the Project Manager, and with attendance including a Quality QI Fellow and Specialist Networks Manager.

In terms of tools for improvement, the paediatrics clinical faculty have also looked internationally for guidance. For example, the clinical faculty has been influenced by Intermountain's[1] approach to tackling variation.

[1] https://intermountainhealthcare.org/

Key Learning

Leadership

The paediatrics clinical faculty highlighted the importance of not underestimating the 'human factors' involved in developing a clinical faculty. This was thought to be particularly important in terms of selecting the right clinical lead who can encourage buy-in through clinician-to-clinician conversations. Openness, the ability to ensure clinicians do not feel threatened by potential partners and insight into an organisation's culture to navigate it appropriately were deemed critical clinical lead features.

> "The diagnostic period needs to be done together, rather than remotely on a piece of paper. Spending time together discussing why a problem needs to be solved makes it a lot easier for it [the solution] to happen"
> **Project Manager – Paediatrics**

Standardisation of pathways

The paediatrics team highlighted the benefit of working with a QI fellow, whose work was particularly valuable in the initial phase of developing and embedding the clinical faculty. The QI Fellow dedicated time to mapping the paediatrics pathway through A&E, one of the priority areas for partnership working within the faculty. The fellow also considered data collection.

When asked about the mapping of clinical pathways, the paediatrics clinical faculty discussed the need for a thorough diagnostic period. They felt this would have allowed a stocktake of the current situation, and enabled decision points in the pathway to be mapped out.

Partnership working

The existing Evelina London Specialist Network meant that members of the paediatrics clinical faculty were used to working in a collaborative way, and that a network approach to care delivery was embedded within the programme. For example, Evelina clinicians spent time at DGT sharing learning from work carried out locally in Southwark and Lambeth, which helped foster strong clinical relationships.

The paediatrics clinical faculty described the importance of a project manager in fostering a sense of partnership between the two sites. The project manager highlighted that spending significant amounts of time in person at both Trusts was crucial.

In terms of partnerships with primary care, the paediatrics clinical faculty have worked hard to develop positive relationships with the local CCG through providing peer support workshops, receiving very positive feedback from GPs.

> "Our set of shared values is always at the forefront of discussions between Darent Valley and GSTT. I've talked to lots of other trusts across the region and I wouldn't say this is always at the forefront of discussions, but it always is at DVH and GSTT" **Specialist Networks Manager – Paediatrics**

The future

The paediatrics clinical faculty believe that work will continue to develop once the Vanguard programme ends. For example, funding for an epilepsy specialist nurse is secure for five years in total.

The paediatrics clinical faculty would like to develop shared learning between clinical workstreams, encouraging an informal approach.

Vascular services

Context

There is a history of collaborative working within vascular services in London and its surrounding areas. By 2012, a network of trusts – or 'hub and spoke model' – was developed, with all complex work performed in the high-volume specialist centre at St. Thomas' (the 'hub'), and with enhanced vascular services delivered locally at Kings College Hospital, DVH, Tunbridge Wells, Lewisham, Greenwich and Sidcup (the spokes). The focus in the last three years has been on developing services in the spoke sites. The Vanguard programme provided an opportunity to further develop DVH as a high-volume referrer to GSTT.

The vascular clinical faculty, particularly at DGT, is facing a workforce challenge due to consultant retirement.

The aims of the vascular clinical faculty have been described as:

- ensuring the consistent provision of safe, sustainable, excellent vascular services locally
- providing timely, appropriate access to world-class specialist vascular surgical services and expert vascular input
- delivering more vascular care closer to the patient's home
- enhancing the level of vascular support and input for patients and clinicians in other clinical specialties in DGT, and to those working in primary care in north west Kent, via virtual clinics and remote consultations
- improving patient flows across the end-to-end pathways

- delivering a comprehensive education programme that ensures specialist nurses, GPs and other health professionals develop their skills in assessing, monitoring and managing vascular conditions locally
- providing better access for local patients to clinical trials.

Project set up

A vascular services model was proposed whereby DVH could be used as a test site for a networked vascular ultrasound service, a 'Proactive care of older people going to have surgery' (POPS) service to optimise patients for surgery and enhance pathway flow, and better communication with primary care and other clinicians.

The additional resources provided through the Vanguard have enabled the vascular clinical faculty to:

- scope, design and develop the POPS service at DVH (involving two registrars working across sites)
- recruit a specialist vascular nurse to support DVH consultants with their workload locally
- extend the hours of the ultrasound angiology service.

Operational features

Recognising the interdependencies with other clinical specialties, clinical pathways are being developed for:

- diseases of the aorta
- carotid artery disease
- peripheral vascular disease
- venous/arterial vascular malformations/lymphatic disease.

The creation of the vascular clinical faculty has resulted in several changes to the way services are organised and how clinicians work across the pathways. This includes weekly half-day MDT meetings which take place at GSTT involving consultants, POPS registrars and therapists.

> "Engagement in a digestible way for all staff is crucial, and the story needs be sold to everybody" **Consultant – Vascular**

Key learning

Leadership

The vascular team referenced the importance of clinical leadership across the branches of services provided, including POPS and ultrasound angiology service (UAS). When pressed to describe why the UAS has been successful, interviewees cited the lead clinician's ability to share the vision and recruit and train specific staff.

Standardisation of pathways

The vascular clinical faculty led the mapping process for the elective and emergency pathways. The elective pathway has been fully mapped from primary to tertiary care to reduce unnecessary patient travel and the number of appointments needed, and an A&E protocol has been developed.

> "It has been amazing to have an opportunity like this, you don't often get to experience developing a new service" **POPS Registrar**

Partnership working

Partnership with the POPS service has been consistently cited as an area of success within the vascular clinical faculty. There are now plans to replicate the POPS model across further services from October 2017 onwards. Further information about the POPS service can be found on the GSTT website.

With regards to partnership between trusts, a lead vascular consultant is employed by GSTT but divides their time between GSTT and DVH. This has enabled closer partnership between sites. More generally, the vascular workstream reflected that collaborative working across sites needs to be communicated carefully, with the emphasis on benefits to patient care and services in the future, to avoid notions of a 'takeover' by the larger trust.

The future

The vascular clinical faculty have been awarded a Fellow from the Darzi Fellowship in Clinical Leadership programme. The future of the vascular clinical faculty is the network model of working, highlighted diabetic foot care and stroke collaboration as areas to focus on next. The clinical faculty is also aiming to establish vascular education programmes in primary, community and acute care, working in collaboration with a range of staff, including community diabetes specialists and podiatrists.

Implications

Implications for the Foundation Healthcare Group

Although individual characters and pre-existing relationships between teams have been cited as enabling factors, this review suggests that there is the belief amongst existing teams that clinical faculties can be part of a sustainable organisational culture.

The Vanguard programme has offered the clinical faculties a level of oversight and accountability that, while requiring significant resource, ensures momentum and keeping focus. Without this, mechanisms and resource (for example adequate management time) need to be put in place to ensure existing clinical faculties are encouraged to begin to transition from a programme of work to business as usual. This would mean further clinical faculties can be introduced.

Implications for others in the NHS looking to introduce a clinical faculty

This review has condensed information from a number of sources and proposed critical and common features necessary to establish a clinical faculty. This learning can be used by other NHS organisations to replicate the clinical faculty model elsewhere. Appendix 3 is an example diagnostic tool created to support the identification of future clinical faculties. Its purpose is to support an evaluation of change readiness, and as part of that evaluation to help organisational thinking around possible support options required.

Implications for the system as a whole

Clinical Faculties offer an insight into the workforce of the future; one that can work flexibly across providers to deliver the best possible care to patients. This is an exciting area of work, and in the future the network approach could help alleviate some of the resource sustainability challenges facing Trust workforces; through increased engagement with, and retention of, staff.

The network approach to working across providers is a particularly valuable opportunity for those early on in their healthcare careers. Feedback from junior doctors and other professions involved in the Clinical Faculties to date has been very positive. In addition, when recruiting an Epilepsy Nurse Specialist, the paediatrics clinical faculty reported that there was increased interest in the job advert because of its link to the vanguard programme and opportunity to work collaboratively across Trusts. Furthermore, the framework offered by a formal collaboration seems to provide a positive impact in terms of recruitment and retention across different professional groups – the valve clinic being just one example of how this collaboration has improved recruitment and retention within a traditionally difficult staff group.

For other Trusts or areas, insight into this new model of working could be gained in a number of ways, including working as a Clinical Fellow or in training roles being hosted by multiple sites.

To provide an insight into what learners in the system think about the FHG and the opportunities it has provided, blogs written by those involved in the clinical faculties can be found on Kaleidoscope's Healthcare Collaboration website. For further information about the FHG please see GSTT and DGT's websites.

Appendix 1: Methodology

Kaleidoscope Health & Care were commissioned to do a rapid review of the development of the clinical faculties within the FHG. This review is aimed at supporting learning within and outside FHG. It does not seek to be a systematic review.

The review was conducted between January and March 2017, and structured over three phases:

1. **Review.** A study of the three emerging clinical faculties within FHG, conducted between January and March 2017. This included:
    - interviews with staff (a detailed brief for interviews can be found in Appendix 2)
    - observation at key meetings
    - review of relevant papers related to the clinical faculties
2. **Compare**. A rapid study of a number of alternative clinical network models with the specific aim of comparing to the clinical faculties. This included:
    - using a literature review to identify suitable case studies (see Table 1)
    - developing case studies using published literature and interviews with key figures involved from the case study areas.

Table 1. International examples

Structure	Country	Organisation
Clinical Community	US	Johns Hopkins Medicine
Strategic Clinical Network	Canada	Alberta Health Services
Learning Network	US	Cincinnati Children's
Clinical Network	Australia	New South Wales Agency for Clinical Innovation Victoria State Government

3. **Advise**. A discussion of the findings of phase 1 and 2, in order to develop learning as to:

    - the key components needed to build sustainable clinical faculties
    - how to articulate the benefit of clinical faculties
    - the organisational context that helps or hinders the development of successful clinical faculties.

This work was overseen by the Clinical Faculties Task and Finish Group (see Table 2), with responsibility within the FHG from Sarah Morgan, Director of Organisational Development at GSTT.

Figure 2. Task and Finish Group membership

Organisation	Name	Role
GSTT	Sarah Morgan	Director of Organisational Development Vanguard Programme Director
	Dr Kate Langford	Deputy Medical Director Vanguard Clinical Lead
	Amanda Price	GSTT Associate Director Education, Training & Development
	Joanne Shand	Vanguard Head of Workforce
DGT	Andy Brown	Director of HR
	Louise Lester	Deputy HR Director
HEE South London	Alison Smith	Head of Workforce Transformation

Appendix 2: Interviewees and interview approach

Interviewees

Due to the short nature of the review, Kaleidoscope were unable to interview every staff member working within a clinical faculty. Kaleidoscope Health and Care would like to thank the following GSTT and DGT staff members for speaking with us:

Clinical Faculty	Name	Role
Cardiology	Dr Gerry Carr-White	Clinical Faculty Clinical Lead, Consultant Cardiologist
	Dr Jagdip Sidhu	Clinical Faculty Clinical Lead, Consultant Cardiologist
	Dr Helen Rimington	Consultant Physiologist
	Dr Richard Todd	Senior Partner
Paediatrics	Dr Alok Gupta	Clinical Faculty Clinical Lead, Consultant Paediatrician
	Dr Ronny Cheung	Clinical Faculty Clinical Lead, Consultant Paediatrician
	Harriet Ward	Specialist Networks Manager
	Dr Birgit Konig	Quality Improvement Fellow

Clinical Faculty	Name	Role
Vascular	Mr Mark Tyrrell	Clinical Faculty Clinical Lead, Consultant Vascular Surgeon
	Miss Rachel Bell	Consultant Vascular Surgeon
	Mr Michael Dialynas	Consultant Vascular Surgeon
	Dr Jugdeep Dhesi	Clinical lead for POPS
	Dr Anna Whittle	POPS registrar
Project Management	June Okochi	Project Manager (Cardiology and Vascular)
	Fiona Martin	Project Manager (Paediatrics)
	Donna Wallace	Project Manager

Interview approach

We recognise that each of the clinical faculties have evolved differently and to reflect this the interviews were semi-structured rather than scripted. However, to enable a level of consistent information collection the Kaleidoscope team covered each of the following in their discussion:

1. **What is a clinical faculty? (How do they self-define?)**
    - What do they call themselves?
    - How are they led?
    - What is their membership, and how do they define it?
2. **Why do they exist?**
    - Was there a particular problem they were seeking to resolve? Or, what is the goal of the clinical community?
    - Why did they think a clinical faculty was the right solution?
    - Were there any external or international examples that provided the inspiration for developing a clinical faculty?
    - What factors contributed to their creation?
    - What factors contributed to their continuation?
3. **How do they work?**
    - What are the values or assumptions that shape their working relationships?
    - What would they describe as the culture within their clinical faculty? How does this align or differ from the wider organisational culture/s?

- What are the practical details of the way in which they work? i.e. meetings, quality assurance, communication
- How do they decision make?
- How do they deal with conflict within the faculty?
- How do they use different professional groups?
- How have they achieved standardised pathways?
- How do they implement learning from working together?

4. How do they measure?

- What data do they collect? Why?
- How do they discuss or feedback this data?
- Do they see any gaps in this data?

5. What are their plans to develop?

- How do they see the faculty developing in the future?

6. What have they learned?

- What do they feel has been particularly successful during their set up?
- Reflecting on their journey would they have done differently?
- What were the organisational levers that supported their creation? (Including support services)
- What were the organisational blocks that hindered it? (Including support service

Appendix 3: Clinical faculty diagnostic

Based on the findings of this report, a simple tool has been developed to support the creation of future clinical faculties. Its purpose is to support an evaluation of change readiness, and as part of that evaluation to help organisational thinking around possible support required to enable the clinical faculty to develop at pace and be sustainable. The proposed support options are drawn from a pool of those likely to be within a "normal" Trust portfolio i.e. accessible in house, utilising common skills or resource within healthcare or requiring only minimal funding to enable.

Readiness for change element	Element	Yes	No	Partially (comments required)	Possible Support Options
Clear aim	Do we have a shared understanding of the presenting problem/main issues affecting the pathway?				Patient pathway mapping (physical/virtual) Workshop/meeting/ facilitated discussion to create shared understanding QI support; Development of driver diagrams, Plan/ Do/Study/Act cycles of improvement National guidelines (e.g. NICE) Data from CCG, internal or external (e.g. national audit) mechanisms

Readiness for change element	Element	Yes	No	Partially (comments required)	Possible Support Options
Networks	Is there already a formal/ informal history of network working between the clinical faculty members?				Organisational development support around building new teams Access to meeting rooms Access to teleconferencing facilities Access to facilitator support during initial value proposition/ strategy development meetings
Relationships	Does the pathway require CCG input?				Identified CCG Lead/ Liaison Access to corporate structures for influencing CCG discussion (e.g. contracting teams/ meetings)
Leadership	Are there clinical leaders willing to work across sites and take on the additional responsibility?				Communications support to engage with clinicians and potential clinical leaders Access to leadership training

Readiness for change element	Element	Yes	No	Partially (comments required)	Possible Support Options
Pathways	Are there already clear national or local guidelines describing "best practice" for patient pathways?				Process/Patient pathway mapping (physical/virtual) to describe current practice Facilitator support to help define a pathway QI support to identify PDSA opportunities
Infrastructure	Do we understand the anticipated level of IT infrastructure required to support pathway development?				Patient data mapping to understand hand offs IT Lead for cross site working Data Protection compliant methods for sharing patient level data at a clinical delivery level
Data	Is there data for measurement available for the pathway/s?				Access to QI support, to help identify & agree a data for measurement dataset.

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