Provider Collaboration Opportunities

Sussex ICS

December 2020

Introduction

Introduction

The NHS is experiencing significant, sustained, growth in demand across all core services as a result of population growth and health trends. Between 2011/12 and 2016/17, national referrals rose annually by an average of 3.7% per year. In 2017/18 there were 119.4 million outpatient appointments, which is almost double the number in 2007/8[4]. Extended waiting times have been exacerbated by the shock retraction in capacity caused by the Covid-19 pandemic. Like elsewhere in England, Sussex now faces a very significant challenge.

Western Sussex Hospitals NHS Foundation Trust
1,012 52-week waits[2]
4.4% increase in referrals FY19-FY20[3]
2,271 patients on Cancer waiting list[2]

Queen Victoria Hospital NHS Foundation Trust
555 52-week waits[2]
391 on Cancer waiting list[2]
7.52% decrease in referrals FY19-FY20[3]

East Sussex Healthcare NHS Trust (ESHT
174 52-week waits[2]
4.9% increase in referrals FY19-FY20[3]
1,416 on Cancer waiting list[2]

Brighton and Sussex Universities Hospital NHS Trust
2,713 52-week waits[2]
852 on Cancer waiting list[2]

10% projected increase in Sussex population size between 2016 and 2030[5]

In addition to restoration and recovery, Commissioners and Providers across Primary, Community, Mental Health and Acute Care are also collaborating to manage system pressures by transforming services.

Existing work programs include, for example:

- Implementation of a clinical advisory service, A&E appointments and a multidisciplinary home visiting service for low risk patients contacting 111 or 999;
- Standardisation of Urgent Treatment Centres, with all Sussex UTCs now able to meet the 27 national standards;
- Development of the 3Ts site; and
- Development of emergency floors through ESHTs HIP2 development Programme "Building for our future".

Vertical integration in the East is anticipated to drive improved collaboration with community services, as is the horizontal integration of acute providers, initially including a merger between Western Sussex NHS Foundation and Brighton and Sussex Universities Hospital NHS Trust.

As is the case elsewhere, this doesn't go far enough, fast enough, with patients continuing to experience long waits and cancellations variably across the footprint.

Purpose of the report

This report has been developed by Commissioners and Providers, on behalf of the ICS, to outline additional collaboration opportunities that acute providers can explore to achieve a material improvement in patient access and quality of care in the short, medium and longer term.

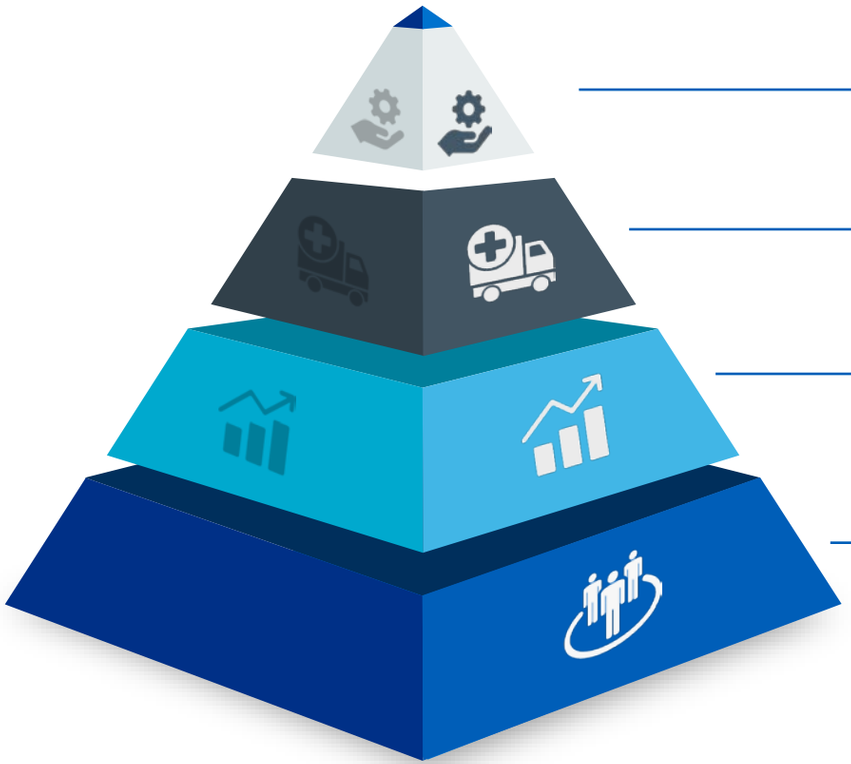
1. Provider SUS data
2. Sept. 2020 Provider waiting list data
3. Provider referrals data
4. Transforming Elective Care Services, Ophthalmology, Learning from the Elective Care Development Collaborative NHSE/NESTA, 2019
5. Our Population Health Check, Sussex and East Surrey Sustainability and Transformation Partnership

Approach

How has the review been undertaken?

During October and November 2020, 39 senior leaders and 28 clinicians and network leads were engaged in assessing the planning of services across the Sussex geography, using the Pyramid System Planning model, below, to guide the identification of issues and pragmatic, achievable solutions.

Pyramid System Planning Model



Highly Specialised care, delivered by specialists for the region

High complexity care, delivered on few sites where teams are attracted to a critical mass of complex work, staffing, facilities and technology and patients are required to travel for specialist, once in a lifetime care.

High volume care delivered on local acute sites, with care that needs to be delivered on an acute site managed either on a "hot site" with wrap-around services or high throughput "cold"/"warm" sites, via highly efficient, consistent, digitally enabled pathways

Care best delivered in primary care/ the community

High level observations

Through the course of the work it was clear that 8-10 challenged specialties accounted for the pareto of issues facing the system. Whilst some of these, such as ENT, had already been identified as fragile, or in need of reconfiguration to meet standards, a number of other core, high volume services were also observed to be increasingly challenged by growth in demand, constrained workforce and physical estate and the impact of Covid-19. The specialities and priorities are set out lower left. The exploration of speciality level issues, described right, and detailed in the body of the report, led to the identification of four practical solutions that could be taken rapidly progressed These were:

1. **Implementation of a system wide view Patient Targeting List (PTL) with live visibility of patient journeys across the ICS and projection of bottlenecks**
2. **Earlier clinical decision making through integrated community diagnostics**
3. **Protecting elective care flows by increasing the activity undertaken at sites that don't manage A&E demand**
4. **Deploying innovative workforce models to increase capacity**

The following sections describe the ICS roadmap to take forward each of these outline opportunities.

Fragile and challenged specialties

1. Diagnostics	8. Ophthalmology
2. Musculoskeletal/Orthopaedics	9. Dermatology
3. Stroke	10. Burns
4. ENT	11. Sleep
5. Cardiology	12. Major trauma
6. Paediatrics	13. Critical Care (adult)
7. Cancer	14. Maternity

Collectively these specialities account for the majority of planned care across the Sussex acute providers, and therefore represent the clear priority areas for focus.

Key System Observations

…Specialist care is sometimes being delivered in low volumes, in services that don't meet extant specifications

…There is potential for planning of high volume, low complexity surgery on highly efficient cold/warm sites and complex activity on fewer sites.

…There is significant scope to build on innovative workforce models to deliver patient care as a mixed team and reduce overreliance on the limited Consultant workforce

…A significant reduction in diagnostics capacity as a result of Covid-19 is a particular bottleneck for core services

…There are opportunities to improve variation in access and reduce very long waiters through shared PTL Governance and digital clinical workflow

…Digital by default, with access for those patients that need or prefer an alternative, remains a significant opportunity

…There is scope to bring forward simple diagnostics and decision making in high volume pathways

Opportunity 1: A Single View PTL

The challenge: Significant variation in waiting times between providers driving inequity of access for patients

In detail

In September 2020 there were 4,457 fifty two week breaches across Sussex providers, and 47,398 patients were waiting over 18 weeks.

Within these headline numbers there is significant variation in access times within the same specialty across the four acute providers. In some specialties this variation is greater than 10 fold, a potential area of focus for the ICS.

Figure 1: 52 week waits by provider and specialty

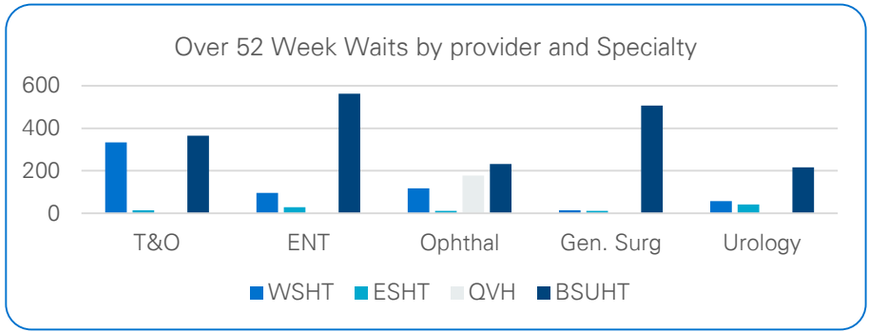
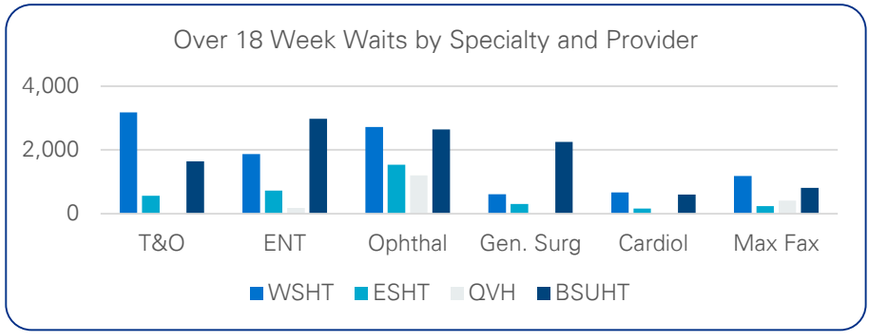


Figure 2: 18 week waits by provider and specialty



The opportunity

An explicit goal of the ICS is to establish equity of access for patients across the system. Evidence shows this will yield improved experience and outcomes for patients as a consequence of being able to drive down excess waiting times which we know can impact patients physical and psychological well-being. The first step to achieving this is to implement a system level PTL view to give full visibility of patient waits at all points in their pathways.

Both the recent ICS guidance and Phase 3 recovery letter from the Summer set the clear expectation that providers will work collaboratively across the system. A joint PTL has now been deployed in Lincoln ICS. Although the three main acute hospitals and two further "cold" sites sit under one Trust, the geographic isolation and demographics make it an excellent case study to consider. Furthermore the technology solution has been successfully developed and deployed and is directly applicable in Sussex.

Snapshot of the evidence

- The level of variation in access and treatment times across the four providers is significant.
- The Covid-19 Phase 3 recovery letter set the expectation that Elective waiting lists and performance should be managed at both system and Trust level to ensure equal patient access and effective use of facilities.
- The technical solution to facilitate end to end pathway visibility across a system has been developed and could be deployed.
- Combined with development and delivery of a revised pan-ICS operating model across targeted specialities it will be possible to smooth access times and, with increased and protected capacity, drive down waiting times across the whole system.

Opportunity 1: A Joint PTL

How?

1. **Deploy an ICS level PTL tool that can provide system wide visibility of all planned care NHS patients, whether in the NHS or private providers.**
2. **Building on that technical solution, pilot the application of a new operating model in one of the Fragile Services as well as a higher volume speciality to begin to normalise waiting times for those specialties across the ICS.**

Scalable case studies…

A joint Cancer PTL has been adopted in Lincoln ICS. Although the multiple hospital sites do sit under one Trust, which means that the system is not subject to some of the operational challenges that might be anticipated elsewhere, the technology solution has been successfully developed.

- **Lincoln Cancer Centre Manager:** "The Cancer Dashboard gives our operational teams an innovative solution to the age-old issue of planning resource utilisation within a constantly moving arena. It gives our diagnostic teams better sight on future volumes that will need to be managed, thereby improving patient flow and giving a better patient experience. Another bonus will be the reduction in the number of 'immediate reactions' to rapidly changing referral patterns, allowing for better planned and cost-effective solutions to be sought in a timely manner".
- **Lincoln CCG Cancer Programme Manager:** "The vision was to develop a real time tool to gain visibility and aid patient flow. This will allow the CCG to gain access to critical and timely information. The tool will benefit patients by alerting operational teams to potential pathway delays."

Patient

"In spite of the effects of Covid 19 on my local hospital I was able to access my treatment at Grantham Hospital just over 40 minutes away."

"I knew my care was as safe as it could be, since I opted to be treated at the Green site, rather than the green pathway at my local hospital."

"I got my surgery quicker than could be offered at my closest hospital and wasn't worried that it would be cancelled due to no bed being available on the day."

Ops Manger

"We have a clear view of demand end to end, and can integrate this with outpatients and diagnostics."

"I have clear visibility of high risk patient cohorts which I need to address."

"I no longer have to manually spend time collecting data to be able to gain insights."

"Dynamic insights gives me the current position, enabling me to make live operational decisions and see the impact."

Clinician

"I can now see clinical demand for my speciality and understand it based on clinical risk."

"A greater level of insight allows me to proactively manage patients and prevent them moving from P4 towards P2."

"In addition I can now identify opportunities with other providers across the system to help manage demand effectively."

Finance

"I can understand current demand in the system, allowing the forecast of costs to address patient demand."

"Future forecasting allows for better financial planning and can now align with actual activity plans across the system."

"Interactive dashboards give clear insights into where costs are."

Opportunity 1: A Joint PTL

Potential benefits

- Dynamic and Live Visibility of Total Waiting Lists across all systems, end to end
- Improved accuracy of waiting lists and clear understanding of system risk profile for patients waiting
- Understanding of speciality constraints at a provider and system level, allowing for delivery optimisation
- A forecasted view of waiting list size, profile and risk level, reflecting the impact of Covid-19 and upcoming winter pressures
- Clear visibility and understanding of current and future backlogs by speciality, at a provider and system level

Initially the system can be used to take targeted decisions to allow pan provider choice across the ICS to normalise waits and delivering equity of access. Over time, whole pathway views will facilitate targeted operational interventions to reduce waiting times in the most effective way possible.

Costs and risks

- The costs of developing a single view PTL (technical solution) will need to be determined through normal procurement routes.
- Data sharing will need to be navigated, along with the complexities of different booking and patient record systems, processes and teams.
- The implications for Trust performance management and financial flows will also need to be considered.

Roadmap

The intention of the ICS is to trial a single view PTL in one speciality. Key steps might include the following:

1. Confirm the pilot specialty and assign a lead Trust.
2. Assign project resources/funding.
3. Develop a business case that outlines the solution, including the specification for the technology and the practical arrangements that will need to be in place to support it, learning from the Lincolnshire example. For example:

- How will the PTL view be maintained – is a lead organisation required?
- Which roles would use the data (e.g. operational managers) and what decisions should they make?
- If there is an opportunity to offer patients faster access at a neighbouring Trust, what should the process be? Would the patient be repatriated?
- How would financial flows be adjusted?
- How would Trust performance be affected/adjusted?
- What are the data sharing considerations?

Describe the costs, benefits, risks and implementation options/plan.

4. Make an ICS decision on progression.
5. Secure external support for the technical development of a single view PTL through normal procurement routes. An example timeline is:

- Discovery (4 weeks) – engage with IG teams and other stakeholders, agree data sharing arrangements, develop user requirements, identify the data and develop and wire frames
- Build and test (8-12 weeks) – develop the model, connect the live data, complete User Acceptance Testing/security testing
- Deploy – Make the tool available to users

6. As the technical work progresses, support the internal project team to concurrently complete a detailed design document that describes the supporting operational processes.
7. Implement and monitor.

Opportunity 2: Early community diagnosis

The challenge: Unsustainable growth in high volume services

In detail

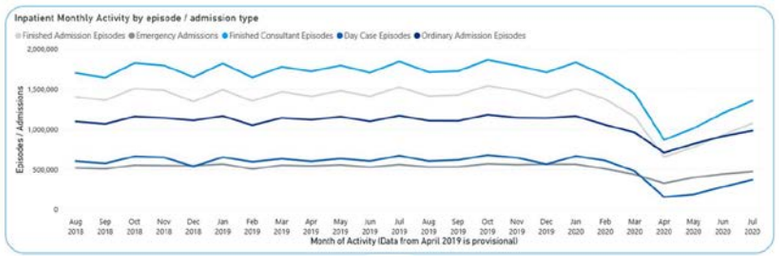
As a result of population growth, ageing and trends in population health, demand for a number of core, high volumes services is growing.

With access to workforce, revenue and capital finance, and often physical estates, constrained, continuing to expand the existing model of care to meet this demand is ultimately unfeasible.

This challenge requires an immediate response. Key indicators, such as waiting times and health inequalities, show that patients care is already being impacted by these trends in every core, high volume service. In some cases, such as ENT, services are becoming fragile.

The sizeable backlog generated by the crash in national NHS activity as a result of Covid-19, makes a rapid and transformation response more urgent.

Figure 3: Provisional Monthly HES data for Admitted Patient Care



Snapshot of the evidence

- 10% projected increase in Sussex population size between 2016 and 2030
- 28% projected increase in over-65 Sussex population between 2016 and 2030
- Annual increase of 4.6% in total referrals – Cardiology 21%, 9% in ENT (28.8% increase for WSHT), Dermatology 8.81%[1,5]
- Annual increase of 4.3% in number of new outpatient appointments[1,6]
- Annual increase of 76.9% in RTT incomplete pathways over 18 weeks between Sept. 2019 and Sept. 2020 – 181% in Dermatology
- Nurse vacancy rate of 7.7% (601 FTE) and Consultant vacancy rate of 5.5% (63 FTE)
- 4,438 52 week waits across Sussex Providers in Nov. 2020[4,] an increase from 2,581 in July 2020

The opportunity

There is an opportunity to embed "earlier community diagnosis" in high volume challenged services, with primary/community services provided with integrated acute support, the skills and equipment to complete simple diagnostics, make more decisions and provide more care in the community, giving patients earlier diagnosis, closer to home.

1. 2018/19 to 2019-2020, all Sussex acute provider specialties
2. Provider data shared with this review, October/November 2020
3. Across all acute specialties
4. Weekly Performance and Activity Report – November 4th 2020 – Final.pptx
5. This figure is only for ESHT and WSHT. BSUH is excluded due to lack of data, and QVH is excluded due to it being outside the DGH model.
6. This figure is only for ESHT and WSHT. QVH is excluded due to it being outside the DGH model

Opportunity 2: Early community diagnosis

How?

1. **Use targeted interventions to increase use of the advice and guidance system to refine referrals.**
2. **Develop specialist community hubs or networks, capable of simple diagnostics, decision-making, care plans, follow-ups and management of PIFU pathways.**

Scalable case studies…

1. **Cardiology in the community:** Integrated Cardiac Solutions provide a community cardiac hub in East Sussex for most non-urgent cardiac patients, delivering tests including Echocardiography and Cardiac rhythm analysis, providing care plans and making decisions on onwards referral.

   The service is led (virtually) by Cardiac GPs and delivered by sonographers and cardiographers, with mobile equipment. Most patients are provided with a care plan, with only 10% of referrals referred on for Consultant-led care. In 2019/20 Integrated Cardiac Solutions patients were, on average, seen in 4-5 weeks compared to 11-18 weeks for an acute referral.

2. **Dermatology in the community:** Sussex Community Dermatology Service provides dermatology patients with a link that allows them to access an app and submit their medical history and an image.

   95% of images are of suitable quality, 30% of patients are discharged with a management plan (which the service aims to deliver in 3 days) and 35% are referred for minor surgery in the community. The remainder are asked to attend a face-to-face appointment with potential for onward referral to Consultant-led care. The service supports 12,000 patients year, c.50% of total demand.

3. **Integrated Respiratory Teams :** There are some good examples of integrated community respiratory teams in East Sussex and Brighton and Hove. These teams have formal access to support from a respiratory consultant or GP with a special interest and have allowed people to be supported in their own home, reducing both outpatient appointments and acute bed stays but also reducing pressure on primary care. They have also shown that with this specialist input they are able to support more vulnerable respiratory patients that are often struggle to attend outpatient services, (for example people with agoraphobia or more chaotic lifestyles) thus preventing further unplanned admissions.

4. **Ophthalmology in the community:** In Manchester, Optometrists refer to twenty Enhanced Referral Optometrists.

Using their existing equipment, additional diagnostics, such as a Van Herick assessment of anterior chamber depth, Visual Fields and Dilated optic disc assessment, are completed, allowing a decision to be made on whether to refer into secondary care. A reduction in unnecessary referrals has been evidenced and similarly the Trust has recently published a paper confirming the avoidance of "false negatives" (where referrals are missed). Whilst the optometrists were initially trained in Manchester by the acute team, off-the-shelf training is now available. Ways of working are now well established. Next steps are to use the CUECS system to transmit diagnostics from the community to the Trust. The Trust are also agreeing the management of a cohort of low risk Glaucoma patients in the Community (with protocols for retrieval to Consultant-led care).

Opportunity 2: Early community diagnosis

Scalable case studies…

5. **Patients Know Best (PKB)** has been branded as **My Health and Care Record** (MHCR) across Sussex and is now being offered to patients in all three Sussex acute trusts and Sussex Partnership Foundation Trust. In addition, there is a programme of providing MHCR to patients through their GP surgeries to support patients within various clinical groups. Four practices are actively registering patients with a further 16 practices about to go live. In total 53921 patients have registered for MHCR to date. There is also an active programme in place that offers MHRC to all patients across Sussex, within a variety of clinical settings with the focus on allowing patients to have access to their health and care information and be more in control of their own health care. The Sussex Health and Care Partnership Diabetes Programme have developed this tool further and is now offering MHRC for the following areas:

   Type1 Diabetes education

   Blood pressure monitoring

   Type 2 Diabetes annual reviews and care planning

6. **Integrated Community Models for Diabetes Cardiology in the community** Diabetes in the Community – In 2016, Sussex Community Foundation NHS Trust launched Diabetes Care for You, a consultant-led, multidisciplinary, community based diabetes service in Brighton & Hove and East Sussex. Diabetes Care for You uses a range of digital and tele-monitoring options, including electronic prescribing, integrated electronic patient record digital education, home blood pressure monitoring, freestyle libre and urine testing, to support the virtual proactive monitoring and management of service users via a Power Business Intelligence digital platform. The service is responsible for the annual review of people with type 1 diabetes and achieved 75% of patients having all eight care processes vs national average of 42%.

   Diabetes in the Community – In 2019, Integrated Community Diabetes Care (ICDC) was formed in East Sussex as an integrated, consultant-led, multidisciplinary community based intermediate care service for people living with type 2 diabetes at the greatest risk of hospital admission. ICDC brings together GPs, hospital specialists and mental health professionals from a number of providers to deliver patient-centred, personalised care close to home. ICDC annually proactively identifies the 10% of people living with diabetes most at risk and offers them a joint MDT assessment by a GP and Diabetes Specialist Nurse and development of a care plan. If required, the patient can be directly referred to a co-located CBT therapist, dietitian or pharmacist for further support.

7. **Use of targeted interventions to increase use of the Advice and Guidance system[1]:** In 2016, at University Hospitals of Morecambe Bay NHS Foundation Trust referrals into 16 specialities, including paediatrics, were reduced by developing a dashboard that monitored use of Advice and Guidance (A&G) and subsequent referrals by GPs. Where A&G use was low and referrals high, a team directly engaged with the GP practice and individual GP in a targeted way to improve usage (and quality of usage, including provision of diagnostic results). During the project, where GPs opened conversations to discuss a referral, 28% of referrals were avoided. A similar approach was adopted in 2019 by Sherwood Forrest NHS Foundation Trust. In October 2020, the year-to-date position was 2552 conversations opened, of which 58% (1469) resulted in no referral. Over the year the monthly figures ranged from 47% to 77%. A GP education and engagement programme is underway with a target of increasing conversations opened by 50%.

Opportunity 2: Early community diagnosis

Potential benefits

- A reduction in patient waiting times
- More follow-ups managed in the community, closer to home, with more PIFU pathways, enabling patients to initiate care when they need it
- Optimal use of the constrained acute workforce to manage more complex patients
- Efficiency savings (a lower comparative cost in the community)

Potential costs

- Costs may include resourcing of a small A&G referral refinement project to develop the learning from other programmes and size the impact (if internal resource is not available).
- There will also be some cost associated with piloting a community diagnostics solution (offset against reduced acute costs). For community ophthalmology, for example, this might include:
  - Attracting and training 20 community optometrists, drawing on existing Ophthalmic Practitioner Training (endorsed by the Royal College of Ophthalmologists) and
  - Funding of community appointments with Enhanced Referral Optometrists (offset against the comparative cost of a secondary care referral).

Some solutions may required capital investment. For example, a cardiac diagnostics hub requires access to cardiographer and sonographer equipment. Many of the pilots and working examples referenced can be used as the basis of cost-benefit estimates.

Potential risks

- The implications for the workforce will need to be modelled and workforce constraints considered. For example, if the cardiac hub solution were progressed, are sufficient cardiographers and sonographers available to support expansion of the cardiac hub concept? Could private providers scale up existing initiatives?
- The implications for financial flows will need to be considered.
- The implications for performance monitoring will need to be considered – acute provider, place, ICS?
- Programmes that increase diagnostics and decision-making in the community will need sufficient controls to ensure that the quality of patient care is maintained, and should build on examples where this has been achieved.
- Increasing diagnostics and decision-making in the community may result in increased acuity in secondary care. The implications for secondary care should be modelled and planned for.

Opportunity 2: Early community diagnosis

Roadmap

The intention of the ICS is to:

- **Redesign one of the identified pathways, building on existing examples and resolving practical issues such as monitoring of patients through the pathway and financial flows;**
- **Complete a cost-benefit analysis as part of due diligence;**
- **Model the impact on acute services and generate a plan to reduce stranded costs whilst retaining a sustainable service; and**
- **Agree a plan to pilot (if not already operating locally) the opportunity and assess its potential for scaling-up across the ICS more broadly.**

The roadmap for this work is as follows:

1. Identify which pathway will be redesigned and identify a pilot 'place'.
2. Agree how the project will be funded.
3. Appoint clinical leadership within the pilot 'place' and agree how clinical, operational staff, commissioners and patients will be engaged across the system
4. Appoint a SRO/Programme Lead, resource a small team and confirm where the project sits (e.g. if and where it features within the SACN portfolio).
5. For the selected specialty, document the model of care ("as-is") and challenges ("case for change"), building on this scoping document.
6. Engage stakeholders in designing the new clinical model of care/pathway, building on existing examples.
7. Document the business case, describing:
    - The as-is and case for change;
    - The proposed clinical model;
    - Its feasibility (e.g. availability of workforce, equipment and estate);
    - The impact on patients and acute services (e.g. training);
    - Costs, benefits and risks (within the pilot and if scaled up);
    - The implementation options;
    - How the pilot will be monitored;
1. Make a decision on whether to progress the pilot.
2. Launch, monitor and review the pilot and make a decision on scaling it up.

Opportunity 3: Innovative Workforce Roles

The challenge: Significant shortages of key clinical roles, impacting on the system's ability to meet growing demand

In detail

The ability of the system to manage the pressures of growing demand in core services and diagnostics and reduce existing waiting lists is limited by workforce constraints.

Additional capacity can be generated by transitioning Consultant-led and delivered work to a mixed team and optimising innovative roles.

Example opportunities include:

Ophthalmology

- Nurse/optometrist-delivered primary care clinics
- Nurse practitioner emergency eye clinics
- Optometrist, Nurse Practitioner and Orthoptist-delivered AMD, medical retina and glaucoma clinics

Cancer

- Nurse-delivered immunotherapy
- Nurse-delivered follow-ups of breast, ovarian, oral, prostrate and testicular cancer
- Nurse delivered targeted breast cancer therapies
- Nurse-led patient access programmes for patients living with cancer/with long term care needs
- Nurse-led PIFU pathways

Snapshot of the evidence

- **7.7% nursing vacancy rate (601 FTE)[1]**
- **5.5% Consultant vacancy rate (63 FTE)[1]**
- **Evidence of novel roles being adopted in Sussex and nationally, for example**:
  - At the Royal Manchester Eye Hospital, Emergency Eye Clinics are run by Nurse Practitioners with access to junior doctors
  - In Manchester, in-house optometrists also work with delegated clinical autonomy to manage low and medium risk Glaucoma patients
  - Nationally, Advanced Clinical Practitioners are providing support in critical care and emergency medicine and HEE supported atomised workforce roles, such as Healthcare Support Worker, are being used in Endoscopy and Radiology

The opportunity

There is a clear opportunity for each provider to take the lead in developing and piloting an innovative role on behalf of the ICS, which can then be spread and adopted by all providers. It will drive quality, access and financial benefits to the system.

1. Trust data Oct./Nov. 2020

Opportunity 3: Innovative Workforce Roles

How?

1. **Diversify the workforce, adopting novel roles or ways of working to generate additional capacity and reduce costs.**

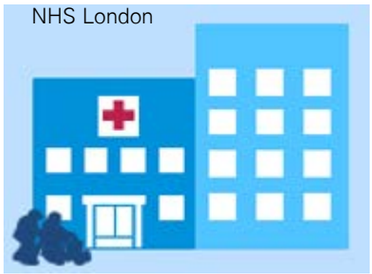
Scalable case studies…

OLGA Service – Optometrist Led Glaucoma Assessment (and treatment) Clinic

In house optometrists have been trained to diagnose (e.g. visual field test), initiate treatment, prescribe and discharge Low and medium risk patients for ocular hypertension

The service is able to stream significant numbers of patients away from the consultant ophthalmic surgeons releasing them to focus on patients that require their specialist care.

As a build to the service, it is possible for these clinics and roles to be deployed into the community, thereby reducing unnecessary attendances to the acute provider, whilst delivering safe, high quality, lower cost care close to home.



Endoscopy Clinical Support Worker

Following the experience of Nightingale London where the Clinical Support workers were pivotal in being able to move safely from a 1:1 Critical Care Nurse to ventilated patient ratio to 1:6 ratio, the NHS London team are exploring the potential for this model to be leveraged in endoscopy.

Building on the existing role the Endoscopy Clinical Support worker is intended to work within the multidisciplinary team, in the planning, implementation and evaluation of care for patients undergoing endoscopic procedures. They assist the Registered Nurses in the Unit, in all aspects of endoscopy work, including caring for patients undergoing diagnostic and therapeutic procedures, and the preparation of the environment and that of patients for their procedures.

Opportunity 3: Innovative Workforce Roles

Potential benefits

- Better use of Consultant resource to manage higher complexity/risk tasks
- Reduced workforce cost or increased capacity (e.g. through repurposing of unfilled Consultant posts)

Potential costs

- Costs will include resourcing of a project team and developing and delivering a programme of training in conjunction with the appropriate bodies
- Ongoing revenue costs of the new roles needs to be determined as part of the revised clinical operating model for the specialty

Potential risks

- The ability to recruit to new roles will need to be considered
- Due to the new / innovative nature of the roles and the targeted applicants there isn't yet strong data for retention over the longer term
- The novel roles need to considered and deployed within a strong clinical governance framework for professional and specialty level accountability.

Roadmap

The intention of the ICS is to trial one new role/workforce model with the aim of scaling it up.

1. Agree whether to adopt innovative use of the workforce observed elsewhere (e.g. Manchester's Enhanced Referral Optometrists and OLGA service), pilot new roles (e.g. the Endoscopy Clinical Support worker role) or develop an entirely new role.
2. Identify a lead/pilot Trust, responsible for delivering the programme and managing system and national stakeholders and agree how the project will be led, funded and resourced.
3. Appoint a Clinical Lead and Clinical Reference Group, with representation from across Sussex.
4. Develop the business case, describing:
    - the "as-is" workforce model and case for change (e.g. vacancies);
    - the proposed new role/staffing model, drawing on existing examples or by developing an entirely new role (as below);
    - feasibility e.g. implications for I&E, recruitment and training considerations etc.;
    - The roadmap for the pilot and approach to monitoring and evaluation.
5. Make a decision on whether to progress the pilot.
6. Launch, monitor and review the pilot and make a decision on scaling it up.

Developing an entirely new role

1. ***Engage with HEE, the relevant college and other stakeholders and confirm the approach.***
2. ***Atomisation of work****: Map the tasks involved in each step of the clinical pathway, noting which roles could complete the task (now or with additional training).*
3. ***Design the roles:*** *Design the new role by grouping tasks. Ensure staff with the most in-demand skills are relieved of as many other duties as possible. Identify low complexity tasks and consider the creation of a clinical support worker role. Ensure the process is clinically led, maintains patient safety and creates clinically fulfilling and sustainable roles for staff.*
4. ***Generate a new staffing model:*** *Identify staffing ratios and scale the staffing model according to local demand. Some roles will remain unchanged as the service expands (e.g. Unit Manager), some will expand proportionally in line with the number of patients (e.g. Endoscopist, Clinical Support Worker) and some will remain static until there is a step change.*
5. ***Complete defined approval processes.***

Opportunity 4: Growing access to highly efficient planned care sites

The challenge: Cancellations and waits for care at local sites that provide A&E services

In detail

As a result of long term growth in demand, constrained capacity, and Covid-19, patients are waiting longer for care across a number of core services.

The opportunity

Offer more patients access to sites that don't provide A&E and can offer faster access and lower cancellation rates, delivering high volume care highly efficiently.

Snapshot of the evidence

- In September 2020 there were 4,457 fifty two week breaches across all Sussex[2].
- With capacity not yet restored to 100% (85.6%) the position, for some services, is likely to continue to deteriorate[3].
- Last minute elective operation cancellations ranged between 76 and 411 per Trust in Quarter 3 of 2019/20[1].
- Access to sites that don't manage emergency flows can be increased, as below.

Figure 4: Ophthalmology activity that is suitable to be delivered at a site without A&E or critical care

Organisation Name	Number of spells (FY20)[2]
SOUTHLANDS (existing cold site)	3,256
BRIGHTON AND SUSSEX UNIVERSITY HOSPITALS NHS TRUST	2,503
EAST SUSSEX HEALTHCARE NHS TRUST	4,235
WESTERN SUSSEX HOSPITALS NHS FOUNDATION TRUST	5,059
QUEEN VICTORIA HOSPITAL	2,399

- Orthopaedics care, similarly, is often suitable for management on a site with no A&E (as demonstrated by the Brighton Orthopaedics Centre). Of other high volume services, analysis of ENT activity indicates that few activities (gromet surgery, for example) could be conducted on a site without access to critical care due to the risk of bleeding.

Scalable case studies…

- Whilst A&E sites offer patients emergency care and access to co-dependent services, sites that don't provide A&E, such as the Brighton Orthopaedics Centre, Southlands, Uckfield and QVH benefit from no or lesser emergency flows and may be able to offer patients the option to travel further for faster access to care, with lower risk of cancellations[4].
- Recognising that there are a number of good examples of sites able to operate highly efficiently in the absence of emergency flows, the national GIRFT team have recently piloted 8 'cold sites', evidencing a positive impact on cancellations and waiting times.
  - A the Royal Cornwall Hospital the number of patients waiting more than 12 months reduced from 130 in April 2018 to 38 in December 2018.
  - On-the-day cancellation rates at ULHT reduced by more than a third, with no cancellations at the "cold"/green Grantham site due to a shortage of beds. Length of stay has also improved, with the average LOS for orthopaedic procedures falling from 2.9 days to 2.4 days.

1. http://www.england.nhs.uk/statistics/cancelled-elective-operations/cancelled-ops-data/
2. Provider SUS data, excluding QVH
3. Sussex Health and Care Partnership weekly performance report Nov. 2020
4. Capacity will be generated (e.g. QVH theatres are currently in use)

Opportunity 4: Growing access to highly efficient planned care sites

Potential benefits

- Reduction in cancellations
- Increased efficiency
- Recovery of 18 and 52 week waits position
- Improved patient experience

Potential costs

- Access to workforce may be a limiting factor
- An increase in activity at sites that don't provide A&E may be offset by a reduction elsewhere. Stranded costs and comparative efficiency will need to be considered.

Potential risks

- The availability of workforce to deliver a 'cold site' model of care alongside trauma / non elective commitments.
- Some patients may choose not to travel.

Roadmap

1. **Appoint clinical leadership and a project lead.**

2. **Develop a case for change, building on the outline opportunity, including:**

- Setting out the high volume, low complexity ophthalmology and T&O activity that is currently being delivered at an A&E site that could be delivered at a site with no A&E and
- Reviewing national evidence.

3. **Document the options available to offer patients access at sites that don't provide A&E including:**

- Delivering 3 sessions days at Sussex's Southlands, Brighton Orthopaedics and QVH sites;
- Development of the QVH@ model, with complex care, currently delivered at 13 sites, consolidated to fewer spokes, achieving better access for local patients and more efficient working and releasing on-site capacity;
- Use of QVH Burns capacity (c. 1 theatre and six beds) if the service is transferred by Spec. Comm; and
- Development of existing estate to generate additional capacity (e.g. 2 rooms on the Southlands site that could be repurposed for low complexity Ophthalmology).

5. **Assess the feasibility and impact of those options including:**

- Impact on activity, beds, theatres, workforce, critical care and I&E
- Availability of estates and workforce other operational considerations.
- Costs, benefits and risks

5. **Make a decision on next steps.**

Taking the work forward collaboratively

A focus upon maximising patient access and outcomes and efficiency at the system level

The work has been conducted with a rigorous focus upon maximising utility at the ICS level. Whilst there are areas of opportunity that improve or have a positive impact for all providers, a number (particularly those related to load balancing and equalisation of access) require in the short-term for the average performance of an individual provider to be impacted for the gain of the whole. Due to the interconnected reality of delivering high quality care for patients, we know many of these interventions will require providers across Primary, Community, Mental Health and Acute Care to work cohesively beneath the coordinating governance of the ICS. This will require careful consideration and impact assessments to manage known and unintended consequences. To help this we believe the following principle will help to take the opportunities forward collectively.

Guiding Principles

One | Seek to optimise for the ICS, whilst limiting impact on individual Trusts

As the work is taken forward it will be crucial to keep focussed on the ICS vision. In doing so it will guide help guide the governance framework and evaluation of impact for patients. Solutions should be piloted within organisations on behalf of the whole system – ***Do the work once, then adopt and adapt to drive pace.***

Two | The voice of the patient must guide the work

Whilst extensive work has been done with clinical and leadership teams to diagnose the issues and identify solutions, as these are taken forward **the voice of the patient should be quickly incorporated** to ensure it has the widest possible support.

Three | Solutions will be Clinically led & managerially supported

Clinicians from across the system have been deeply engaged in defining the problem statements and proposing solutions. It is crucial that this is augmented further and formalised within the Programme governance arrangements as the work is taken forward.

Four | Don't allow perfection to be the barrier to progress

Where there is strong evidence and alignment move to **pilot with an agile PDSA cycle** to make improvements. Without intervention the challenges will keep building making resolution more difficult, costly and defer gains for patient access and experience.

Five | Joint funding of initiatives will spread financial risk and accelerate pace

As solutions are developed and cost benefit analysis completed, a **commitment to joint funding will help to mitigate** one individual provider being excessively exposed to **financial risk** during the pilot phase. Novel commissioning mechanisms can then sustain the gains as the models are adopted and adapted across all providers.

Six | Delivery through the ICS Governance

There is a strong identity and need for **commitment to the Sussex Integrated Care System**. The recent NHSE/I ICS guidance re-enforces the need for formal provider collaboration to drive improvements at scale. It is crucial that providers speak with one unified ICS voice, whilst representing the interests of their individual constituent organisations.

Leadership behaviours for success

Delivering the ICS vision is going to challenge the leadership at all levels. Whilst the ICS has a clear vision and commitment there is a great opportunity to underpin this with a behavioural framework that can set the programme up for success. Below is a modified framework derived from Patrick Lencioni's 5 dysfunctions of a team. Focussing on the positive counterfactual of that model can be really helpful. Ultimately it demonstrates that delivering outstanding results for the patients of Sussex will require each of the leaders within the system to hold each other individually and collectively responsible for living these behaviours. Attached to the framework (right) are a set of composite quotes from the interviews with each of the Steering Group members, that demonstrates the collective commitment to the concepts described and the desire to make it work this time.

Source: Patrick Lencioni's 5 dysfunctions of a team ForChiefs materials

> **Ultimately this is about improving the health and outcomes for our populations so we need to ensure the ICS governance is used to focus upon what matters to patients and our staff.**

> **This opportunity is critical for us to deliver the improvement in patient access and outcomes that underpins our vision for the ICS – we need to get the accountability right to drive success**

> **In the past we have attempted similar work but we haven't collectively committed to the outcomes, or when we did it hasn't always been followed through**

> **We work best when we openly raise areas that concern us, sometimes we don't always say what is on our mind.**

> **We have all made commitments to the ICS and SACN – we work best when we're together. It's important we keep talking so that we all trust each others intent.**