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Questions and answers from the webinar:

"Rise of the Superimprovers", Monday 12th November 2018, 2-3pm

Speakers included:

Dr Linda Charles-Ozuzu, Head of Elective Care Transformation Programme at NHS England;

Jim Mackey, CEO Northumbria Healthcare NHS Foundation Trust and former CEO NHS Improvement;

Dr Ruth Grabham, Medical Director at NHS Bath and North East Somerset Clinical Commissioning Group;

Dr Patrick Davey, Consultant Cardiologist, Lecturer and Writer chaired the webinar.

Question 1: What is different in your winter 2018/19 plan compared to the previous plans?

(Jim) It's a good question. We're actually in the process of coming back, the winter plans have kind of already been passed, they are either part-time in December, and then sort of full-time during January. So, I think the difference this year is I've taken, and I think that colleagues have taken, an awful lot of things at face value. There was an awful lot of "that might work, this might work, etc. you know", things that had worked previously but hadn't been fully recognised like the world had changed quite a bit. This year we started much earlier, we really kicked the tyres earlier and so the plan was sort of probably cast in about July. We then subsequently tested and tested and tested to the point where we had a big wobble a couple of weeks ago around half-term, so it's been retested again now to understand it.
So I think if you look at the content, it would look quite similar, but we're more confident now on the things that will definitely work, versus the things that might work with some risk and then what do we do if that doesn't happen because we've had a longer run at it and there's been much deeper conversations with colleagues in the system about when we really start coming under pressure, a bit like Ruth was saying earlier on, what are we actually going to do.

Question 2: Jim, you mentioned testing, is that testing in terms of conversations with those who'll implement it, or modelling, or how do you test?

(Jim) There's loads of data analysis, big room conversations, big workshops, clinical teams trying to work through scenarios, and so everyone gets used to knowing what their kind of normal numbers are. So we built a department that was built for 250 attendances, it runs around 350 now. In the summer we stated we expected to break 400, what does that look like, 150 ambulances versus 100 that we've got and what does that look like, from a leadership point of view give context, give shape to the conversation.

<u>Question 3</u>: The handbooks are very comprehensive, and how can individuals gets started on implementing the recommended approaches to have an impact on this winter?

(Linda) I would say absolutely, to start basically, as I said before, just get stuck in. I mean the wonderful thing about our handbooks is that they are so accessible, what we do is describe what the intervention is, why actually implement that particular intervention, and actually how to implement it and what the impact is. They're very, very clear, if you need any support whatsoever, obviously just contact us.
We also have the Community of Practice, so in addition to these very accessible handbooks, which I've just described, we have a wealth of information on the Community of Practice, we have forums, and people are asking questions, we're responding real time, and we're also going to be uploading videos as well, so there is lots of stuff there. And of course the magic ingredients, as well as these interventions is of everything that I've already talked about, so the exec sponsorship, the whole system team, because I don't think you can look at the elected care pathway in isolation, you need to look across the pathway. What you don't want is unintended consequences in different parts of the pathway, so get stuck in and if there's anything that me or my team can do to help we'd be more than willing to assist.

<u>(Patrick, Webinar Chair)</u> And you'd be happy to contact by email or phone, or?

(Linda) Absolutely, we're here to help

<u>Question 4</u>: Did you find that local IT had a role to play in improvement, and is there any key data that you needed to track, or was it a range of data across the spectrum?

(Ruth) Yes, we do, we have a local IT platform that holds all our referral forms. The system was developed locally in Wiltshire by a clinician, and it enables all our referral forms to have the same presentation. Our GPs can navigate their way around all the forms, because it's very consistent, and it's all in one place. It absolutely has a fundamental role in making it more efficient to access the requirements, referral details and red flags for each sort of condition that someone might be referring. So IT is definitely a big player, yes. It doesn't apply across the system yet into the hospital, we can't quite see each other's records, but it's top of our agenda to implement that.

<u>(Patrick, Webinar Chair)</u> So that would apply for most of the elective referrals, for urgent referrals as well, or only elective referrals?

(Ruth) Elective referrals.

<u>Question 5</u>: Did you find that local IT had a role to play in improvement, and is there any key data that you needed to track, or is it a range of data across the spectrum?

(Jim) It's a key part of it, we've had a big IT strategy refresh this year, because we were really lagging behind in lots of things, and various things that were agreed a few years ago haven't been enacted, and frankly I'm very deeply allergic to the kind of big national systems thing. So we have deliberately gone small system and agility as our strategy. Just thinking back to Ruth's comments there, we are looking for opportunities all the time for facilitating clinical information exchange, where a lot of our hospital specialties are using SystmOne and I want to really try and roll that out - because nearly all of our primary care use SystmOne – so I'm just opportunistically trying to find a way to make it easier for the clinician in front of the patient to do the right thing – I really don't get how ripping everything out and replacing it with 100 million three in one does that, so we've trying to not to do that.

If you have any questions about the webinar, Q&A or Consultant Connect, please email hello@consultantconnect.org.uk or call us on 01865 261467.

Extra materials:
After the Q&A Linda sent the below examples of the type of impact already demonstrated as part of the elective care development collaborative. They include:

- A reduction in RTT wait times from 13.7 weeks to 8.8 weeks for Inflammatory Bowel Disease (IBD) patients
- In Stockport the local team implemented Advice and Guidance and Teledermatology for dermatology and only 18% of referrals required an outpatient appointment.
- Referral was avoided in 54% of calls from GPs to their advice and guidance service for Gastroenterology in Somerset
- In Lincolnshire, the conversion rates for cataract surgery increased from 57% to 93% following the introduction of a standard cataract referral form that contained clear criteria for referral.
- Waiting times for glaucoma patients referred to secondary care reduced from 20 weeks to 13 weeks following the introduction of triage for referrals into secondary care.

To join the Community of Practice at https://future.nhs.uk/connect.ti/ECDC/group please email: England.electivecare@nhs.net