One St Aldates | Oxford | OX1 1DE
consultantconnect.org.uk

Delegate questions and answers from our speaker panel:

"How to make sure your Advice & Guidance delivers the Long Term Plan Webinar"

Friday 5 April 2019, 1-2pm

Speakers included:

- **Prof. Sir Muir Gray,** Director at the Oxford Centre for Triple Value Healthcare, Adviser to Public Health England, and Author;
- **Sarah Hayden,** Locality Commissioning Manager at NHS Sunderland CCG;
- **Christine Powell,** Senior Relationship Manager at NHS Greater Huddersfield, Calderdale and North Kirklees CCGs;
- **Jonathan Patrick,** CEO at Consultant Connect.

Chair: Claire Read, writer, editor and journalist who has specialised in healthcare throughout her 20-year career.

The following Q&A is a transcription from the verbal responses of our expert panel:
To watch the webinar recording, click here.

Question 1: Muir, you've talked about the importance of a culture change in the sense that you feel it's happening. If there was one thing that you think that would speed that along, and inform the shift that you think is needed, what is it that people could do to help accelerate that shift?

Answer:
(Muir) Well, culture. The distinction between leadership and management is that leadership changes culture, and management works within it, and I know we've got a lot of leaders watching here, so I'd do two things:

Firstly it's very important for people not to bad mouth one another, so I think it's a good rule, you know, if the specialists start moaning about the GPs or vice-versa if other people are in the room and we have it (the discussion) face-to-face, and I'm sure you guys do a lot of this.

The second thing is actually involving the people we call patients, so I think it's if we took Sunderland and start thinking of the people with Type 2 diabetes in Sunderland. Let's really think of them as a group, and include them in the network, because the face-to-face consultation can only do so much. I think it's this population based approach. For instance I'm interested in care for people with Type 2 diabetes and whether it's better in Huddersfield

or Sunderland, we should be able to address those questions. We can't at the moment, but that's the way it is, so an obsession with outcomes defined at the level of the population, and the second thing for the culture is let's not allow people to speak with disrespect, and the amount of moaning I have heard over the years has been terrific and it doesn't do any good, if you've got trouble let's get in a room and just sort it out.

<u>Question 2</u>: What are your top tips in your experience of working in this area of how we measure the difference that one of these services can make?

Answer:

(Jonathan) I think what it basically boils down to is what are you trying to achieve with your Advice and Guidance service (in the context of the Long Term Plan). There are plans for a third of outpatient attendances to be avoided, and therefore it seems quite sensible that the main ways you would measure the success, would be to look at the impact (of Advice & Guidance) on the number of people that are attending.

Then obviously there's lots of sources for data. We collect data at Consultant Connect, such as what's happening - the outcome of a call e.g has a referral been avoided, has a referral been made. There's loads of sources of data, and I don't think it's controversial to say that data is the main thing that NHS England is probably looking at. But I think that is to miss the point of what we're doing here quite a lot.

I think, we should also be doing a lot more talking about patient experiences, and patient stories. We should be hearing the stories from the clinicians who are using it and how they feel it's improving their local networks, but we should also be hearing the war stories, not just for people who are avoiding a lengthy wait for their treatment, but for those who are getting the right treatment possibly when the doctor wasn't expecting that they needed it.

I saw Dr Patrick Davey, who's a cardiology consultant recently. He was telling me a fantastic story about how he had a GP call him and the GP was wondering whether a referral was necessary, and, during this conversation, Patrick established that the patient was considerably sicker than the GP suspected. This of course is exactly why the GP was using the service, to answer their questions. The GP, in this case, didn't know what they didn't know, but Patrick did, and what happened was he ended up arranging an immediate ambulance transfer and the patient had a heart attack as they arrived at the hospital and survived, precisely because this call had been picked up.

I think we can talk about avoided attendances, avoided referrals, and meeting those things in the Long Term Plan, but actually I think the stories that underpin those achievements are much more interesting, and much more compelling than the numbers on their own.

<u>Question 3</u>: How have you gone about measuring the impact that using the facility within e-RS has had on care locally?

Answer:

(Christine) We have the majority of our Advice and Guidance come from haematology, endocrinology and cardiology, and one of the really positive things that's come out of this is the trust that it's built up between the clinicians. We had a lead GP, endocrinologist and cardiologist compile documents as a result of questions and answers. These documents are on our intranet, it's like an 'at a glance' type thing. When we sent it out, our lead GP at the CCG read the intranet page and said "I've learned more in half an hour of reading this than I

realised, I just didn't know"… as Jonathan said, he didn't know what he didn't know. So that was a real success point, of course we spread that out across the first CCG, then the other, then we went to cardiology. It was fantastic learning. Some people say "oh, you're trying to cut corners financially", and we said, no, this has become about sharing the knowledge, and helping the patients, and that's worked for us so that's one of my success stories.

(Sarah) To date, we've looked more at the data side of it, so just pulling together what it's been used for, and the breakdown within each specialty, what kind of Advice and Guidance was given. And I think I'm going to be stealing Christine's idea there and using that. We can feed that back through our education sessions for example. Also we've done some surveys with the GPs to get feedback on issues that they're having with the system, so that we can put them right – because sometimes they'll just sit in their office and not use it – but they're not always telling you why they're not using it. That's why we've started doing some of that qualitative stuff with the GPs to try to get that data through, about what works well and what doesn't work as well in order for us to fix any issues.

<u>Question 4</u>: How did you convince GPs to use e-RS, in the context of Advice and Guidance?

Answers:

(Sarah) It's been about going to our education events, discussing which areas were coming onboard, why they were coming onboard, giving them the data about how the waiting lists were, and how capacity was being met and reached and also how we could reduce that maybe by using some of these technologies. And then also because it was linked to the paper switch off, it was about giving them another option, another way of contacting the hospital.

(Christine) Well when I realised it was coming, once I got to understand it, test it myself, I'd then go out to some of our network meetings, all the GPs together, address the nurses, address the practice managers, address the GPs and hear sometimes there was some angst, other than that just tell them we are here, we will help them all through it and we will hand hold if need be. We offer a good service, and we're true to our word, and that was the only real convincing that we did. We let them know, yes, you may have some difficult days, bad days, they will probably end up sending less referrals, but encouraged them give it a try, and for us to do it together.

(Claire) Jonathan, how about you, what are your thoughts on that, and what have you found helps in the areas you're working with to encourage GPs to make sure they use the service?

(Jonathan) I'd obviously agree with what Christine and Sarah are saying, but I'd add an extra thing, which is that it's one thing to communicate, and it's one thing to make sure that everybody is aware of what's available. There is sometimes more of a barrier between achieving that and then achieving usage. As much as they may not appreciate me saying it, there are some GPs who don't want to engage with yet another initiative, and I have a great

deal of sympathy with that. But we've been lucky that we've seen quite a few approaches from around the country, and you can divide these into carrot and stick approaches.

We are aware of some areas that have been incentivising GPs to use their Advice and Guidance services, Consultant Connect and e-RS, by including contractual provision, so that there's some sort of connection with a payment at the end of the day. In terms of the GPs that's a carrot approach.

There's also a really interesting stick, which is used in one of the areas that we're working with. They effectively built up a 'naughty step' of practices they felt were referring a lot. Now they weren't necessarily saying there was anything wrong with that but what they then did was cross-refer that list with how much they were using the Advice and Guidance services in the area. They ended up doing some focused work with each of those practices to give them a positive incentive for using the service. They would give them things that were going to make a difference for them locally, like focusing on particular groups of patients for example in cardiology. But then also what they were doing was keeping an eye on how the service was being used, and indeed what they did find, and what we found in that area was that usage did pick up.

Question 5: Who pays for Advice and Guidance?

Answer:

(Jonathan) With e-RS it's a fairly straightforward thing which is the service is free, but there is a tariff that is payable by the CCG to the trust normally, depending on their local contractual relationship. That tends to be something that we see as well, and we obviously do charge fees for what we do, it's over and above what's included by NHS England, but our experience is that, in the vast majority of cases, our fees are paid by a commissioner, and then the commissioner will then also pay a tariff for the Advice and Guidance that's received. There are lots of different models, including if hospitals are on blocks, if anybody is interested in that, then they can get in touch with us, I'll happily talk them through. I think we must have seen every model of payment that's out there.

Question 6: What is the one main message about Advice and Guidance that you'd like to take away from this webinar?

Answers:

(Christine) I think Advice and Guidance works if you have a named lead in secondary care and a named lead in primary care, who are willing to work together.

(Sarah) Well mine was basically going to be bringing primary and secondary care together and doing it as a joint initiative rather than in silos, so very similar.

(Jonathan) I would say that for me it's both of those things Christine and Sarah said. But also that it's a thing that you will not finish, you've got to keep at it, it is highly unlikely you will ever finish this project, and shut the door and turn the lights off. There's always more to do. We've got projects that have been going for four years that are very well embedded and we still see usage growing and new specialties coming onto the system. So take heart from

the fact that, even if you have a slow start, there is plenty of time and just keep going at it.

(Claire) For me I was very much struck by this idea that Muir began with, of healthcare being a knowledge business, and to me if we accept that proposition, which I think most of us would, then it becomes quite clear that actually finding means of sharing that knowledge is really important, whether between primary and secondary, or generalist and specialist, or as Jonathan terms it, between clinician-to-clinician. It strikes me that from what Christine and Sarah have said, that's the sort of setup that is going to work. It all fundamentally comes down to the relationships. It fundamentally is going to come down to making sure you've got connections between primary and secondary, that you're having open and honest conversations where difficulties arise, and that you're using the data to identify those difficulties. You can use data to identify successes but you also need to share patient stories.

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.