RCP Webinar, 3 June 2019, 1-2pm
Outpatients: The Future

Delegate questions and answers from the speaker panel:

Speakers included:

- **Professor Stephen Powis,** National Medical Director, NHS England;
- **Dr Toby Hillman,** Sustainability Programme Clinical Lead at Royal College of Physicians;
- **Dr David Fluck,** Medical Director at Ashford and St Peters Hospital, speaking on behalf of Surrey Heartlands.

Webinar 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 and written responses from the expert panel for questions which were not answered during the live webinar:

To watch the webinar recording, click here.

Question to all speakers: 'Shifting the balance of care' by Nuffield Trust notes that the costs are not necessarily reduced if balance of care is shifted as for example you need the infrastructure (e.g. x-rays, spreading clinicians thinly, etc.). Keen to hear the panel's thoughts on this…

Answers:

(Dr Toby Hillman) The Royal College of Physicians report identified areas where outpatient care could be delivered in different ways and is not a call to shift care from one setting to another. Indeed, primary care services are under such strain that simply asking them to absorb ever more work is not appropriate. It should also be noted that GP referrals account for only 50% or so of outpatient activity. Instead, it is more of a call to steward resources within the health economy by examining closely the purpose of the current outpatients system and identify ways in which the same care can be delivered more efficiently, using different delivery methods, and avoiding waste where it is evident. As such, where intense diagnostic pathways are required, they should still be available, but where routine chronic management of long term conditions can be managed in a less intensive way, whilst assuring patient access and good clinical outcomes, these should be the preference.

(Dr David Fluck) It is a good question but possibly the wrong question. The prime aim is not about reducing costs but meeting the needs of the population. By understanding the cost of delivery at each point it is possible to show how expanding care delivery in the lower (less acute) parts of the system benefits more individuals and provides opportunities to prevent care needs escalating. We need to understand more about what is driving need and how we could meet that need in a very different way (transformational or efficient) or how we can attenuate that need. Tariff structures do not enable this, and probably hinder this approach, and systems need to spend their money commissioning outcomes rather than activity. Health also needs to recognise that it is only a small part of the Health and

Wellbeing of the population and the wider determinants of health need to be considered as huge opportunities for reducing need and making citizens have healthier and longer lives. Whilst in the short term it may be necessary, as outlined in the Nuffield report, for much of the fixed costs to remain in place, a reduction of the underlying health risk in the population would both improve lives and help to mitigate the potential growth in high-cost interventions.

(Professor Stephen Powis) One of the key tasks for Integrated Care Systems (ICSs) as they make plans for local implementation of LTP is to get this balance right. My expectation is that clinicians will play a key role in designing these new care pathways.

Questions to Dr Toby Hillman:

Question 1: Dr Fluck mentioned the need to break down OP services to better understand how to improve them. On Page 16 the report discusses personalised care - but a major challenge must be how to deliver OP services for patients with co-morbidity - the traditional speciality function is very inefficient involving multiple OP visits. So, what are the plans to create multispecialty consultations?

Answer:
(Dr Toby Hillman) There are examples of well co-ordinated multidisciplinary clinics that address these problems, or symptom based services that allow patients to have in-depth diagnostic testing by specialists who cross over between the traditional boundaries of specialist services – for example breathlessness services, with input from cardiology, respiratory, psychology and physiotherapy.

For those with multi-morbidity, there is an increasing awareness that specialists cannot exist in isolation, and the Royal College of Physicians is championing the increasing prevalence of General (Internal) Medicine provision amongst a wider range of specialist training schemes to allow a broader scope of practice in all medical clinics, rather than having the inefficient round of clinics with each “ologist” as is often experienced by patients.

<u>Question 2:</u> How have you managed to resolve the information governance concerns related to providing clinical information by text or via email? The 'letter of the law' suggests that patients should consent to receiving clinical information via these media and the opt-in process can be cumbersome.

Answer:
(Dr Toby Hillman) There are multiple platforms for patient communication that are approved through information governance. As such practices become more widespread, and user experience information is fed back to system vendors, I expect that the opt-in processes will simplify.

<u>Question 3:</u> What are your recommendations around - what can be addressed in the short, mid and the long term?

Answer:
(Dr Toby Hillman) In the short term I would recommend concentrating on understanding the 'agenda' at the consultations your service conducts. How many are simple information exchange, how many require face to face interaction for practical or ethical reasons (eg requiring in-situ imaging / examination or delivering bad news) and other how many are for other external factors – eg fulfilling monitoring requirements / ensuring patient access. Once this is understood, it is possible to rationalise those visits whose 'agenda' could be managed using alternative means.

In the medium term, changes to services that take into account these findings will need to be agreed with commissioners and providers to ensure there are no penalties for changing modes of care delivery.

In the long term, I hope that work at a national level will incentivise these new models of care, and reward care pathways that deliver high value to patients and the health economy as a whole.

<u>Question 4:</u> How about measuring patient experience?

Answer:
(Dr Toby Hillman) Patient outcomes in terms of clinical outcomes and patient experience measures (PROMS and PREMS) should be collected, and acted on. This is an area of active research in multiple areas, and service leaders should take heed of lessons learned from schemes that report their findings in the literature. Undoubtedly mixed methods and qualitative research will be required to ensure patients are not harmed by any shift in clinical practice towards a less face to face model.

<u>Question 5:</u> How do you provide a 'virtual' fracture clinic appointment? Attend anywhere?

Answer:
(Dr Toby Hillman) There are examples of virtual fracture clinics at many different hospitals. They tend to rely on specialist reviews of radiography and management that is carried out acutely, and determination of next steps in telephone consultations – allowing clinicians to focus on more complex or urgent cases in the face to face clinic consultations – eg where re-alignment is required or operative therapy is indicated. The clinic is generally run by clinicians in the provider institution where the patient attended the emergency department, but it does not require the patient to attend in person.

<u>Question 6:</u> Are you able to measure outcomes in terms of reduction in harm and reduction in need for ongoing care as well as reduction in face to face consultation?

Answer:
(Dr Toby Hillman) These outcome measure would need to be measured in a service by service or a speciality specific manner as broad statements about management of non-admitted care are particularly prone to error given the highly varied nature of care that is currently carried out in the outpatient department. Future research priorities will undoubtedly include the measures you have asked about above.

<u>Question 7:</u> How much of a hindrance is the current payment system in incentivising our system to make these changes?

Answer:
(Dr Toby Hillman) I believe that the current national tariff and commissioning system has incentivised increasing activity, and as such, we have had many years where the incentives have not been towards providing high value care, but high-quality care in increasing volumes. The Royal College of Physicians is looking forwards to working closely with NHS England and other partners to identify potential policy changes that will enable innovation by clinicians on the front line without forcing them to swim upstream against the commissioning structures that currently exist.

Questions to Dr David Fluck:

Question 1: Please can you explain a little more about what you have done to work towards the 'integrated care' objective? How have you engaged with multi-speciality consultants focused on a specific patient needs?

Answer:
(Dr David Fluck) It is all about collaboration and talking with people. We recognise in an acute trust that physical health and mental health co-exist more than they don't. The success of our iMSK pathway has not been in replicating the service somewhere else or delivering what we do in a slightly more efficient way. It was about meeting the needs of the patient in a different way and allowing them more information. The introduction of the bio-psycho-social model allowed all these things and has resulted in better patient outcomes in patients with arthritis, with a dramatic reduction in intervention and joint replacement – but the patient coming to a decision that suits them. We have spent time with Surrey and Borders Partnership NHS FT and Dr Justin Wilson, MD and have talked about how we can better care for patients in the emergency pathway where mental and physical health co-exists. We have challenged the concept of a liaison service because we feel that unless the teams looking after people consider themselves as one team there will always be optionality about delivery. Similarly, we've engaged with consultants across our Trust to agree an integrated acute assessment model which will be the basis of a new build we're currently planning. This has many attractions as it enables direct and immediate advice to be provided between specialties without relying on the current referral process, which saves time for clinicians and improves care for patients.

Question 2: How are all these interventions recorded in the patient electronic record?

Answer:
(Dr David Fluck) Virtual Fracture Clinic interventions are recorded on the Patient Administration System as a Virtual Clinic attendance, and the episode is entered into the Patient Electronic Medical Records via a letter written to the GP as normal clinic outcome letter, plus the VFC team write Clinical Record Notes to record they have contacted the patient with clinic outcomes and have given clinical patient information booklets and clinical management advice.

<u>Question 3:</u> How do we get the consultants onboard to change from the old model of face-to-face consultation?

Answer:
(Dr David Fluck) We have talked quite widely about the strategy and the approach, but where would you suggest we start? We're not formed well into ICSs and we are in the process of understanding solutions - such as advice and guidance and how that can be rolled out effectively across the patch, is that something you would recommend?

The main driver for change is making sure you are clear about why you are doing something and that this is recognised as required by the teams and patients. I asked Cathy Parsons, Director of Clinical services iMSK what she felt the driver was in the orthopaedic fracture clinic.
"Face-to-face Fracture Clinics were completely overbooked with up to 120 patients in a morning clinic. The patients would wait a long time to be seen, long waits then for x-ray, then frustrated patients would be unhappy with their experience. The patient feedback from the Fracture Clinic was poor in relation to their environmental experience and their waits in clinic. This was made worse by the long waits for first appointment to be seen, which was 10 days at its height. This was then added to long waits for subsequent follow up appointments. We took patient experience and feedback and added this to our poor staff experience to engage our team in the benefits of a virtual fracture clinic (VFC). At the same time we engaged with the team in a new Consultant of the Week model of care for emergency pathways and this included the VFC as a part of the new role. This meant that clinicians were timetabled – dedicated time - to be the VFC Consultant everyday.
This intervention has transformed the experience for staff and patients"

<u>Question 4:</u> You spoke about trusting patients with their data and the example of banking. This is an interesting concept. Is there an existing model of this to refer to give an idea of what this looks like?

(Dr David Fluck) Patient held maternity records have been around for a long time and in our ICS we introduced electronic patient accessed records in maternity. I asked our Divisional Director (Dr Faris Zakaria) in Women's and Children Services what he felt about its introduction and how it had gone:

"Dear David,

The concept of electronic records (EPR) is not new but our adoption of Badgernet, although having challenges, is essentially now complete and what is abundantly clear is that it has been accepted, seen as a significant improvement on paper records and interestingly has thrown up some additional benefits that we never envisaged.

- It not only acts as an accurate and contemporaneous record of care, it's great for audit purposes, investigations and a well of information that we can trawl at our leisure.

- I initially had my doubts as to Governance issues and although we still have problems with incomplete information or inappropriate data entry, these are becoming less frequent merely because we can now identify errors more easily, target certain personnel and make changes to the system to reduce the likelihood of recurrence.
- As a specialty we are not new to having patients hold their records so the fact that they can now access their records through an app is no big change. I suspect there will be concerns about this issue from other specialties but there is essentially nothing to fear as the Read Only aspect makes alterations/deletions/inclusions either impossible or easily traceable.
- Patients have been very positive on the whole but I do have my concerns that some groups will be excluded from the benefits of holding their record e.g. non-English speakers, the illiterate and probably the largest group - the very elderly. This does need some thought but I suspect will not be sufficient an issue to turn the tide with no doubt some very clever software development.
- Clinicians outside the Trust were slow to see the benefits but that's clearly changing….there was a genuine fear that somehow care would be adversely affected but in reality this hasn't materialised.

As mentioned previously the EPR is something that can continue to evolve. We add new features, remove extraneous details and produce new outputs. At present these changes are reliant on the system compilers but I see no reason to believe that future super-super users won't be able to do this in house.
Overall if you chose a system that can interface with existing programs and is flexible enough there are tangible benefits and to my mind (and others) no significant concerns. However, I can't stress enough the importance of users in the development of such systems; had we been involved from the start the journey would have been less painful and much quicker.

BW
Zak"

Questions to Professor Stephen Powis:

Question 1: How do we balance the relationship with primary care and Acute Trusts by 'pushing' more activity their way? (It feels like unless increased services are commissioned in the community with primary care, we can't possibly reduce F2F appointments by 5%.)

Answer:
(Professor Stephen Powis) Shifting activity into other parts of the system such as community and primary care may be appropriate in certain circumstances. Using the skills of our multi professional workforce is also a key to this balance.

Question 2: How about utilising the skills of UK-trained foreign doctors who had left the UK but are willing to help through telemedicine? I am one such doctor- served as a consultant geriatrician in the NHS.

Answer:
(Professor Stephen Powis) This is one example of the sort of models that I'm sure ICSs will want to look at.

Question 3: Any suggested models for those of us whose patients with Long Term Conditions that come mostly from other CCGs (i.e. not local)?

Answer:
(Professor Stephen Powis) ICSs cover a size where it should typically be possible to manage LTCs within ICS partners, there will always be circumstances where care and advice needs to be sought from outside the ICS. In many respects this is a familiar issue for those who sit on the boundaries of different health providers/health economies.

Question 4: Do you run into any ethical dilemmas when changing an approach from person-centred to service-oriented? Could this necessitate different labour divisions?

Answer:
(Professor Stephen Powis) I think this is better framed as person centred and population centred, both of these are essential to deliver high quality care. As doctors we're trained to a high level in person-centred care. We will need to improve our skills in population health management and population centred care.

<u>Question 5:</u> Once the ice has been broken (via new commissioning) by the likes of NHS Dudley CCG with its Multi-speciality Community Provider contract, and the work on Surrey of course, we are more likely to see changes ... Back to Professor Powis's earlier point, how is change going to be spread?

Answer:
(Professor Stephen Powis) Spread is a key component of transformation, it's often the case that solutions to problems have already been found elsewhere but have not been disseminated widely. One of the purposes of ICSs is to foster a cultural change to facilitate spread. At a national level we must ensure that we support systems to learn from each other.

<u>Question 6:</u> The Babylon app has been shown to increase the frequency of consultations. Could the ambition to move consultations to virtual carry a risk of increasing the use of secondary care consultations rather than the reverse?

Answer:
(Professor Stephen Powis) The important principle that we need to work to is ensure that we provide the most appropriate consultation for the needs of the citizen, whether in primary or secondary care settings. As long as we focus on that principle then we should get this right.

<u>Question 7:</u> User expectations have changed in that people are not prepared to wait for outpatient appointments. Once consequence of this has been an inappropriate shift of specialist out-patient activity to 'same day ambulatory care services' in acute trusts. These services were established as alternatives to A&E attendances/admissions, but they seem to act as magnets for those who are not prepared to wait or whose GPs are not prepared to wait. Such patients do not generally get access to the correct specialist team. We need to make specialists more readily available in the new models. What are your thoughts?

Answer:
(Professor Stephen Powis) Same day care is one way of ensuring that we provide appropriate care to patients with urgent and emergency conditions, but it has to be seen as part of a suite of services, alongside things like extended hours and 111 help to ensure that patients are seen in the right place by the right staff. When same day care works well it can avoid unnecessary admission to hospital, which will not only be distressing and inappropriate for elderly patients but can exacerbate frailty and can lead to disruptions to social care support.

<u>Question 8:</u> Does Professor Powis agree that the current limitations to GP capacity will compromise the ability of our health system to reduce the number of patients referred to secondary care?

Answer:
(Professor Stephen Powis) We clearly need more GPs and NHS England/Improvement are working to achieve this. We can also support GPs through better use of our multi-professional workforce in primary care, many practices are already doing this, and investment in PCNs will allow this model to be expanded.