



Worried about Winter? WEBINAR Practical alternatives to hospital attendances and admissions

Q&A

Speaker panel:

- Caroline Capell, Associate Director of Unplanned Care at NHS Luton CCG (NHS Luton & Dunstable University Hospital);
- David Smith, Associate Director for Performance – Planned Care, SE London CCGs;
- Siva Anandaciva, Chief Analyst, The King's Fund.

To watch the webinar recording, [click here](#).

The following Q&A is a transcription from the verbal responses and written responses from the expert panel for questions which answered/not answered during the live webinar.

Questions to Caroline Capell only

Question 1: What is the clinical grade of the streamer who sends patients to bookable appointments, can you give us an idea of their seniority?

Answer (Caroline Capell): “So, the direct bookable appointments are via 111 and they’re done by the health advisor (who answers the initial call) based on the disposition a list of available slots will appear. The health advisor goes through NHS pathways, and then depending on the disposition, we use the selection of dispositions of up to 12 hours, they will be directly booked into those slots. In relation to ED streaming: it’s a Band 7 nurse, supplied by the hospital who will then do the streaming.”

Question 2: Caroline, I think you actually made the point that some of the early comms around it were challenging, particularly in the national media, so could you say a little bit about what you have done to communicate the improvements in the 111 service to the public, and the wider community?

Answer (Caroline Capell): “We do extensive comms and engagement across our population anyway, and we’ve got quite an ethnic mix, so we have things in multiple languages, we use the GP screens around communicating, but what we don’t do is communicate that you ring 111 to ‘get a GP appointment’ – the comms is about ringing 111 if you have an urgent medical need and you may be directly booked to see a clinician. The pathway is we will assess if a face to face is the requirement and then the patient may be booked in. So, the population is starting to recognise that they may be booked into a multitude of different places across Luton.

We also have lots of communication targeted for the children and the 20 to 40 year old population – for example all year long in the Luton Town Football Club – promoting 111 and GP access appointments. Because one of the issues, and I’m sure David also came across it, was

how we increased the usage of GP extended access, of which now we're nearly at 100% of utilising the direct bookings. In the hospital in particular with the urgent GP clinic the targeted communications, we used our A&E delivery board and our transformation board very much around our comms messaging, and I think that's key and that we have the whole system sharing this. For example, we had a picnic in the park last week where we had very much targeted 111(so the children's clinic and using 111).

We have very transient population, so it's that ongoing marketing and communication around it that is key. I think what we find is once you've used 111 more people will then use it. It's about sending that message across all the population. Our practices have been excellent, we have really good engagement with them now. It's taken a good 18 months to get them to where we are now, but now they can see the real benefits. And because they've been able to see the real shift, they're more than welcome to support any comms and engagement that we do. I'm very interested in David's model on how we actually get people away from the hospital, because whilst we stream into a primary care setting, it's actually that measurement of appropriateness based on your needs, not on your demand, and needing to look at how to change that across the system."

Question 3: Caroline, could you say a little bit about what you feel about selecting the people who are doing the streaming, just picking up on that issue of there's more to it than just professional competency, what other things are you looking for in the people coming through?

Answer (Caroline Capell): "So very much similar to what David was saying, there's a clinical protocol that the streaming nurse will follow on deciding which patients could be sent over to the urgent GP clinics or into ED. We have a monthly clinical governance meeting, with the provider of the urgent GP clinic and the hospital, that's very much about looking at those referrals that may not have needed to have gone over or are inappropriate. We're actually reviewing and amending the protocols on a regular basis. The nurse is also part of the Luton and Dunstable Hospital, so they have no vested interest in sending them over, and this has been running since 2012, so it is a well-established service there."

Questions to David Smith only

Question 1: You have six CCGs that you look after, could you say a little bit about how you implement change across six CCGs?

Answer (David Smith): "It's not always straightforward. There are ways in which, as CCGs, we are actively trying to work together, and I think Consultant Connect is a good initiative as it allows us to see the applicability at each of the sites. Generally, what we would try to do is a pilot in one area, and then if it was successful, we would try to scale up. It would be the exception rather than the rule if we didn't scale up, so I think that is something which as CCGs we've got to get quite used to doing rather than everything needing to be done individually in each CCG."

I think it's really important that we make sure that we've got good links with both our hospitals, but also involving the urgent care or the planned care commissioners at each of those CCGs. Particularly when you're designing these protocols and the comms around them to GPs and to patients. I think you can absolutely design some of these things once and probably should design them once, but then it's about making sure that you've got people on the ground who know the local community and know the local GPs – that will really help with the implementation. That's what we try to do. In some of the initiatives, for example the redirection ones, that's where the principle is sound, and makes sense, but then it is really up to local determination about how you do that, and recognising that if you are in a really concentrated urban environment is probably more doable if you are looking at one where actually the hospital is some way away from local practices. There's actually a need to think of different ways of managing that. So,

we've explored if we could; do video consultations or lay on transport to move people. It's taking the same principles but making sure you can still adapt it for local uses."

Question 2: You have talked about how you work together with your 6 CCGs; do you have regular formal channels of communications between you all to share ideas e.g. meetings/newsletters/forums?

Answer (David Smith): "We do have formal meetings for us all to get together – we even did a workshop last week to discuss how we can work more collaboratively! However, you are right that there is no single way to crack this. We try and run regular meetings and workshops to showcase what is happening across all of the boroughs to share learning and agree approaches for roll-out, and we also centrally produce a lot of common materials (comms, how to guides, newsletters etc). Our Planned Care Boards also help us set the agenda and key priorities, and we use those as a vehicle to agree what needs to be done where – i.e. what can be done once for the system, and what needs to be driven locally."

Question 3: A question around response, and the GP consultant pharmacist pathway for the rapid response team, do they actually physically travel to see the patients or is it a virtual consultation service, and if it is physically, could you say a little bit more about how you made this work, because the question is would it be applicable to other settings that are perhaps less urban?

Answer (David Smith): "Yes they do respond physically. Essentially the ambulance service will call the 'at home' team, and the 'at home' team will talk them through a series of structured questions. The ambulance team know what questions they're going to get asked, so have prepared that prior to the call, so then they can talk through what the patients' needs are, what have the crew seen, what is required, and then they can get a match in terms of who is going to be the best person or persons to attend. The team itself is made up of consultant, physicians, GPs, advanced nurse practitioners, OTs, pharmacists and support workers - to provide that short-term package of care. There's a whole list of patient categories that are accepted, and I'm very happy to share this* after the webinar, if that's something that people are keen to look at and to see what those criteria area."

*If you would like a copy, please email laura.mackrory@consultantconnect.org.uk

Question 4: Just a follow-up question on the example you used of someone who turns up and might be offered an appointment booked tomorrow, could you say something about the grade, and it's a common theme I think, the grade and seniority of the decision maker who's doing that?

Answer (David Smith): "It's a senior nurse who is doing the streaming, we use the same criteria or triage criteria that they use for A&E. The criteria are agreed jointly between the hospitals and the practices, and that again is one that can be standardised. I'm happy to share more detail about the criteria* offline. And actually, what we have looked at also is the difference in terms of the streaming, if it is a GP doing it, if it is a consultant doing it, if it's a nurse doing it. Interestingly the results weren't wildly different between any of those groups. It's been interesting to see actually, and it is really down to the professional discipline of the person or actually the personality type of the person doing it. So, similar to Caroline, it's generally a Band 7 nurse that does the triage"

*If you would like a copy, please email laura.mackrory@consultantconnect.org.uk

Question to Caroline and David

Question 1: Could you say a little bit about how you got clinicians to buy into these new initiatives, both in secondary care and primary care, how easy was it and was there any hold out? And are these schemes cost neutral, and how you sustain the initiatives without any additional incentives to the providers of care?

Answer (Caroline Capell): “From an out-of-hospital perspective it was very much around utilising areas we can work in, so we have a member’s forum, and we have a practice manager forum, and focusing on our clinical directors and very much finding champions. I know that’s a clique, but actually it did work. When we first approached our practices about the 111 and direct bookings - I think if they had a gun, they would have shot me! (laughs). They were really quite anti the movement. Luckily, we found two practices that were willing to give it a go. One of the GPs sits on our LMC so that’s made a significant impact, because she has seen for herself the direct improvement and impact. It’s about utilising your champions to then help support the cause across the whole system.

From a hospital perspective it was slightly more challenging. In Luton we have a very embedded and strong A&E delivery board and it’s very much working across the system. We have been fortunate that the performance is high that we’ve been able to concentrate on transformational work rather than focusing on performance, and that means then we have had that wider buy-in. Also, we use the opportunities of national funding. For example, we have used primary care access funding since 2017 to support urgent primary care. This has meant we’ve been able to then enhance those models, so it’s about being smart on where there are opportunities to use funds. This provides some incentive. It’s then about proving that it works that enables us to then deliver it where we no longer have to fund our practices to. And it’s about getting our Acute Trusts to support us on some of our models, so they see the benefits.”

Answer (David Smith): “That is clearly going to be a critical element, and I’ll give examples of how I think we have achieved some of that. If we think about the redirections from ED one of the things staff were very anxious about was: they could be seeing a patient that could be suitable to go to pharmacy or redirected or told “please go and get a GP appointment”, and that left them very uncomfortable. This was because actually they weren’t happy with just sending a patient away and not knowing if the redirection had been done - they were very worried about the clinical risk.

So actually, being able to be in a position where we can say there is a guaranteed slot really overcomes some of those obstacles. Making sure that staff know there is something solid for that patient to go to, rather than just telling them to please go away and make another phone call to someone else - that really helped. Equally then with the ambulance team, they really welcomed this. One of the things the ambulance team had fed back to us was that lots of different areas have tried to do these ‘appropriate care pathways’ and their experience is that if: once it fails, those messages go to all of the crews and actually the crews are a lot less likely to be motivated by that. It’s about really making sure that someone responds each and every time, so they’ve got the confidence that they’ve seen how it works and really helps. I know Guy’s Hospital have invited the paramedics to shadow or be part of the ‘at home team’, so they can see it from the inside as well, so that those teams know exactly what is going to be offered. I think that’s something that is common to all clinicians - they want the right thing done, but they also want to make sure that they know that there is a common standard of care, so I think that’s been important. And just on the money side, then yes probably these are cost neutral, so actually having a GP appointment instead of being seen in A&E, technically will save money.

I think it's also about recognising you're not going to be at 100% utilisation every day, so it works out much of a muchness. The way that we did it was initially to pilot it using the 'winter resilience' funds that you generally have available every winter. Then if that's successful then you can mainstream it into the following year. Equally with things like the costs associated to the 'at home' team, it works out much of a muchness because many of those patients probably would have been admitted, so I think it actually it doesn't really cost anymore. However, clearly from a quality perspective and for the patient they are so much better."

Question to Caroline, is that something you'd agree with on the cost neutrality?

Answer (Caroline Capell): "So direct bookings are very much using GP access in a different way, so the appointments are still the same appointments, it's just using them differently. From the streaming perspective, then it's because we don't class it as an ED attendance as such it is cheaper, than if they are then streamed across to the urgent GP clinic, so from that perspective we do utilise that as a potential saving going forward. But it is around looking very much at that whole urgent care model across the whole system, and not just looking at them in isolation."

Questions to Siva Anadaciva, Chief Analyst, The King's Fund only

Question 1: You mentioned (in a podcast in May) that 'sharing staff where needed over a region' would be a good idea to consider – can you explain this idea in more detail please?

Answer (Siva Anadaciva): "Sure, though it's still more of a premise than something I've seen that could be replicated. And at its heart it is about supply and demand. If you run an emergency department and know you have peaks in activity you would design rotas to match those peaks (alongside redesigning services to see if the peaks can be avoided). This would do the same but change the unit of planning from a trust to a system or region. There are certain key staff groups in the urgent and emergency care pathway where the position for individual units or trusts is very challenged, while neighbouring trusts are in a better position. One could argue that if we measured the performance of a local system (e.g. the A&E performance of 'East London' is of primary importance) then that might free you up to move staff around to better match demand."

I've seen some places think about this, but it is more from a 'shared bank' perspective than specifically targeting U&EC clinical services. Where a few places were thinking about this, they saw staff contracts as an issue – I don't have the details of this.

Fundamentally, this is a philosophical issue not only an operational issue. Staff are employed by organisations, not systems. The primary measure of performance are trusts not systems (nor individual departments). I so I would like to consider whether for some clinical services you could have a contract held by a regional or system, and then a rota that is designed around the needs of the system rather than organisations. That's easy to say but difficult to do (from the technical contractual issues, to morale and travel time and implications for team-work, to the underlying issue of not having enough staff in the first place at organisation- or system-level), but it's worth considering whether we are making the best of the staff we have."

Question 2: What are your predictions for winter 2019/20 in the NHS? How will it compare to previous NHS winters?

Answer (Siva Anadaciva): "It's too early to call, but I am more worried this year that I have been for a long time. There are three reasons for this. First, we are starting from a lower baseline position in performance than in previous years. Second, the potential risk of a bad flu year, with worrying data from Australia on this. And third, that changes that are going on with ICS and PCNs, which mean the strategic landscape is shifting. So, a lot on instability."

Question 3: Do you have any funding advice to share?

Answer (Siva Anadaciva): Although it's quite general advice, I think I would say that for funding urgent and emergency care services in particular there were a few general things I encountered:

- The first was, don't expect service redesign to deliver cash-releasing savings. So, predicate your funding model on a return on investment or productivity gain argument rather than this saving lots of money.
- The second was to not overcomplicate things. Rather than having fixed payments, variable payments, quality premia etc. just strip it down to what you really want and what you're willing to pay for. So if you need an A&E department in a certain part of the country and the reality is that you will need to pay high locum fees to staff it, and you are not prepared to close it for a variety of reasons, then a capacity payment might be better than a complex set of financial incentives.
- And third, make sure your funding model works multi-laterally, which is an overwrought way of saying that if you have multiple commissioners and multiple providers of care then designing a system that works for some of them can reduce complexity but not produce a step change in the support and stability you are after.

Question 4. How does the NHS compare with other countries during winter?

Answer (Siva Anadaciva): "As a general comment – it's hard to get comparable data on this. But the best article I've seen recently from this is from John Appleby here: <https://www.nuffieldtrust.org.uk/news-item/is-it-just-the-uk-finding-winter-pressures-hard#swedish-stabslge> "

Please note

David Smith mentioned sharing the following documents in the webinar:

1. The exclusion/inclusion criteria for redirection
2. The LAS@home service
3. The Mental Health LAS/Police Protocol

If you would like to see a copy of any of these, please email laura.mackrory@consultantconnect.org.uk