Outpatients: The future

RCP Webinar, 20 September 2019, 1-2pm
Case Studies – Outpatients: The Future

Delegate questions and answers from the speaker panel:

Speakers included:

- **Dr David Fluck,** Medical Director at Ashford and St Peters Hospital, speaking on behalf of Surrey Heartlands;
- **Janet Castrogiovanni,** Head of Performance & Transformation, Greater Manchester Health and Social Care Partnership;
- **Tracey Hall,** Head of Service, Elective Care, NHS Dorset CCG.

Webinar Chair: Professor Frank Joseph, Consultant in Diabetes, Endocrinology & Internal Medicine, Divisional Medicine, Director for Urgent Care at Countess Of Chester Hospital NHS Foundation Trust, chairing on behalf of the RCP.

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 1: David, what are you seeing as the extended scope practitioner? Are they physios, or are they occupational therapists and what courses are they doing to get the extra skillset they need to manage things as extended practitioners?

Answer:
(Dr David Fluck) They mainly have a physiotherapy background, and then they need to get skills for assessment and diagnosis, which is just an extension of their role, but they need support in that process. I think that more and more people are going to come from very different backgrounds in the health sector, and we're going to extend their roles. The classic examples are pharmacists in accident and emergency, or paramedics in accident and emergency, and as you said occupational therapists. I think there's going to be much more blurring of the margins. I think what's good about where people come from originally is that as clinicians, and I can say this, we've been trained in a certain way, and that's part of the problem that we deliver healthcare and as Janet was saying and Tracey was saying, this is now about the patients and making clear what's important to them, and what choices are available, rather than being prescribed something from a clinician. I think that's the really important thing with extended scope practitioners, and with supporting the development in our Trust for the orthopaedic surgery.

Answer:
(Janet Castrogiovanni) The physios in the MSK service have made that big difference. What I will say is that when we get into neighbourhoods, we've had district nurses and social workers working really, really closely together on real issues around, for families. So, some of that has been starting to develop the skills in

This webinar was hosted by Consultant Connect

across health and social care and that's been really interesting for us in Greater Manchester.

Question 2: David, you know one of the things that people perceive is the need to see a specialist, and, although we try and put in new ways of handling, chronic musculoskeletal pain and arthritis related issues for example, when we measure outcomes and patient experience, and patient choice, do you get feedback from people saying, "well actually I wanted to go see the orthopaedic surgeon and you're taking that away from me"?

Answer:
(Dr David Fluck) Yes, but I suppose if you do look at the patient related outcome measures around orthopaedics, and I'm a cardiologist by background, so in replacing people's needs 20% of them wish they'd never had their knee replaced, 20% of them feel that they're worse than they were, and about 40% think oh it was a good idea. So, we haven't got it right as it were, and I think the idea that particularly in something which is not a life threatening condition, it's a lifestyle condition, and it's how you're operating everything, and by having a graded response to doing some things which aren't destructive, which may help, I think patients do get involved with that. I also think that on one of the things that we specifically did when we were setting up the pathways in our MSK pathway, and it sounds like Janet and Tracey have done the same thing, is you've got to get the right type of clinicians seeing the patients early on in the pathway. This is because if you get someone who sets them on "oh this clearly needs replacing", that's the mindset they go with and that's the really difficult bit to unravel there. I like what you're saying Janet about, it's the neighbourhoods, it's listening to the experts within the neighbourhood because they do know what their communities need and require and they are very different from wherever you go and we've got to do more of that I think in the hospital side.

Question 3: Tracey, the technology that you guys are embracing sounds really exciting. We all grapple with Skype and all that kind of stuff, and actually there are always going to be people that are challenged by the use of technology, and one of the questions is what about, the use of that kind of technology for older individuals, or patients who aren't able to use technology? How have you tackled that group of individuals?

Answer:
(Tracey Hall) Yes, there will always be patients who either don't have that technology at home or don't want to use it. So, we are looking at putting that technology in places locally, so that patients could go maybe to their library or to their GP practice, or to a community centre, where people would be able to help them use their technology. There will always be a cohort of patients who we will need to see face-to-face, so it's not about trying to change everybody to use one

Outpatients: The future

option, or one way of accessing specialist services or advice, or treatments, but it is about I think providing that choice and where we can offer alternatives to patients then, you know, we should be doing that.

Question 4: An extension to the previous question for you Tracey is when you offer something new and something convenient, and something that works well, there is almost always a mission creep in terms of, almost an unmet demand being found because you have something that you can use – Is that something you experience? How do you deal with that, if we take it from the technology point of view with dermatology – did you notice that it was so easy to take a picture and share with the app that, people were being deskilled, i.e. I don't need to think about this now because I can just send it to my colleague down the road?

Answer:
(Tracey Hall) Yes, similar I guess, but slightly different. What we found was where we wanted the GPs to use it for dermatology and send us photographs of lesions to secondary care, we found the take-up was really high, but the take-up was for a different purpose. It was the nurses using it for a leg ulcer clinic, or it was so that GPs could have their own conversations internally within their practice – so you introduce it for a reason and for a purpose but you find that it's actually being used for a different reason. We don't want to discourage that at all because the PhotoSAF app has got so many benefits, everybody should use it if it helps their role, but we, like Janet, have an acute problem in dermatology where we have got a huge number of inappropriate referrals going to secondary care, so that is one of the solutions to help that service, and we've really got to focus on GPs using it for the purpose with which we launched it for.

Professor Frank Joseph: I'm going to extend that question onto Janet, just around the dermatology service. Janet, for example if you were using teledermatology and the dermatoscope programme and pictures etc, any thoughts on moves towards kind of centralising the service, so that it's not provided by three or four different providers within a geographic area?

Answer:
(Janet Castrogiovanni) We have got quite a big programme of work going on in Greater Manchester about, making sure that services are provided in the right place, and that will be subject to consultation. So, there will be changes in the coming years, not necessarily for dermatology but for other services that would be better served in different locations for the population. So yes, that type of work goes on, but with regards to dermatology particularly we don't have dermatology in all of our hospitals across Greater Manchester. We do in quite a lot of them actually as it's such a high demand medical specialty but not in all. And I'm sure everybody will

Outpatients: The future

have experienced this, because we have one of the centres that take more complex cases, the demand on that particular service where it's more of a tertiary service is far higher than it is in the other areas. Our hospitals can become a little bit overwhelmed as well with the demand for those services. I think dermatology is an exception to the rule at the moment, alongside ophthalmology where the demand is also extremely high, so yes and no really. Yes, we have, and we are thinking about where they could best be, I'm sure others are as well, but I think some of it is we're trying to look at customer best practice, and what those pathways across Greater Manchester are. The one thing, although Greater Manchester is very intense, it's got a big population, and it's not spread very far, it's quite tight, so our hospitals aren't a million miles apart, and so you know, that we're not rural, so, it is reasonable to ask people to travel, not everybody wants to, but it's not so unreasonable to ask people to travel to other centres.

Professor Frank Joseph: Tracey, did you want to add anything to that?

Answer:
(Tracey Hall) Yes, so we do have dermatology services in all of our providers, our three acutes and our community hospital. We've just started a specific piece of work to look at that model of care, and one of the things that we are doing is looking at how we provide one service for Dorset, so one single point of access, and that's not commissioner driven, that's what the system, the dermatology services in Dorset came up with when we had a recent away day, so yes, that is specifically a piece of work that we're looking at.

Question 5: David, when you do a virtual clinic and you ask the orthopaedic registrar to come down to A&E and be the front door practitioner, how does that go down in terms of the registrar wanting to be in theatres all the time, trying to operate on people, how do you square off that resource shift?

Answer:
(Dr David Fluck) I suppose my objective is then we need to turn them into good clinicians who can look after patients, and it's not just about a technical intervention, it's about knowing some of the other bits around the care of the patient. I think that we've shifted a bit now from where we were, the fact that we're doing things differently has freed up resources in certain areas. It has freed up the amount of operating that we're doing in the hospital, but actually we need to use their skills to look after patients earlier in the pathway. I think to be honest that Health Education England, in some of the ways that we educate our doctors coming forward, we've got to get them ready for the need of the patients that they're going to be looking after, and have the skills to be able to deliver that care, and that's either working with technology or knowing about a more holistic approach and working further downstream and with the communities and with the neighbourhoods about

This webinar was hosted by Consultant CONNECT

promoting good health. It's not just sitting in the hospital waiting for ill health to occur. I have started that discussion, but you're right, it's not received by everyone.

Question 6: I think a running theme is that there are some interventions that you have tried that have helped release resource, but there are some interventions that have only identified that actually we can make the patient experience, and the patient journey and maybe say resource in terms of outpatient estates, but actually when it comes down to clinician time with using technology, sometimes you don't always see that benefit, because actually a quantification of time is a quantification of time whether it's face-to-face or technologically, and there may be some efficiency to be made there. I don't know if anybody disagrees with that, Tracey because you mentioned the job planning aspect around the dermatologists and the volume that it generated, do you agree with that?

Answer:
(Tracey Hall) Yes, it's not always about saving appointments or saving time it is about making that experience better, saving time for the patients so they don't have to travel, arrange childcare, time off work, that sort of thing. So, it's as much about the quality as it is about the efficiency.

Answer:
(Dr David Fluck) I think that's a really good question and I agree exactly with what you're saying Tracey, but I suppose that's why it's really important that we look at the other stream. The stream is about how can we close the time people spend in chronic ill health, and what are the things that are driving that ill health, which starts in the neighbourhoods, and starts before they ever reach the doctors, and I think we've just got to link those things up. And the other bit I'd say is that we've got to look at the whole system, so if outpatient transformation just becomes a hospital orientated thing, that then it will probably fail. Because most outpatients are carried out in primary care, and about 50% of the appointments in primary care have got nothing to do with health-related needs, and what we need to do is we need to free up the primary care physicians to do what their skills are. I mean 25% of primary care is dermatology, and the question we've got to work out is, do we need to help them extend in their scope of what they can look after in this area as well, but then they'd only be able to do that if we relieve some of the other work that they're doing by enabling the neighbourhoods to look after them, so I think we have to look at them in the whole round.

This webinar was hosted by Consultant CONNECT

Outpatients: The future

Question 7: Have you experienced any drop-in quality outcomes? Including patient experience and patient choice?

Answer:
(Dr David Fluck) Patient choice is still maintained and offered, and some patients still wish to choose a particular surgeon – but they all go through the ESP directed pathway and intervention before they see (if they need) a surgeon. We haven't seen any patient experience issues, but it is important that primary care are completely aware and bought into the pathway otherwise the patient will be given conflicting advice and guidance.

Question 8: How can these new models can be used in cardiology?

Answer:
(Dr David Fluck) We haven't looked at cardiology for a biopsychosocial model – the majority of outpatient review is for reassurance that patients do not have a life threatening condition but I agree it would be good to look at patients who have symptoms – angina, breathlessness and palpitations and be clear what choices are available and what the benefits are or aren't.

Question 9: How did you create the appetite for change amongst the orthopaedic consultants. What motivated them and how did you engage them? What were the challenges with the interface with ED?

Answer:
(Dr David Fluck) It was not all straightforward as clinicians generally do what they believe is right. Initially the CCG were driving change with the high rates of intervention visible in our pathways and they were looking for other providers. We were then lucky to find a few clinicians who were able to see the benefits of the new (biopsychosocial) model and able to lead the change engaging with other professional groups, the CCG and primary care and make the case with their colleagues. The key change was to expose patients to all the non-operative choices at an early stage and also explain the issues with joint replacements

Outpatients: The future

Question 10: Are patients in your systems now having fewer 'replace' operations? Anecdotally, because of our BMI based delays to surgery policy I have seen a number of patients whose symptoms have improved, and they've decided they don't need replace operations (hip and knee) at present and we have seen some reduction in waiting times. That in itself has led to some operations being done faster now than local GPs think is wise - because patients haven't had a chance to change their lifestyles - increase activity and lose weight.

Answer:
(Dr David Fluck) We are seeing many less interventions in our patients – I have sent the graphs of activity. Our waiting times have certainly improved but the fact that they do not reach the surgeon until later in the pathway prevents operating before lifestyle changes have been implemented

Question 11: How do you collect information around GP special interests? Is there a specific dataset that you can access?

Answer:
(Janet Castrogiovanni) We identify GPs with special interests through our localities as those who are doing additional sessions or accessing training. There is nothing more sophisticated than that.

Question 12: Could you expand upon the role of the Neighbourhood teams as pathways go back into the community, please?

Answer:
(Janet Castrogiovanni) The neighbourhoods in Greater Manchester are made up of between 35 to 50k population and are at different phases of development. They are made up of health and social care staff working together to support the most vulnerable members of the community, with care which ranges from local health services to social prescribing.

Question 13: Please can you share whatever you've done to reduce endoscopies?

Answer:
(Janet Castrogiovanni) We haven't reduced endoscopies in Greater Manchester. Capacity for endoscopy has been a real challenge to us for some time now. Our developments in this area include detailed capacity and demand work to ensure we make the most of the people and kit we have, buying in additional support where necessary and we also have some new facilities in Greater Manchester which are helping us to manage to additional pressures of screening and increasing cancer

referrals. We are working to support direct to test to endoscopy and putting in place nurse triage to support this.

Question 14: How are you looking at measuring the impact of the individualised care on demand for outpatients?

Answer:
(Janet Castrogiovanni) This is very much part of our outpatient transformation work going forward. To date this has been difficult to do because of increasing demand for services and our work to support straight to test for diagnostics. However, in our MSK services in one locality we have seen an increase in the number of patients attending outpatients and conversion into theatre slots. This is telling us that only those patients who need theatre are now attending outpatients and other patients who require pain management and physio are being supported outside a hospital setting.

Question 15: With the advent of more teledermatology initiatives, what sort of changes are the hospital dermatology teams making to their job plans re physical v virtual clinics?

Answer:
(Janet Castrogiovanni) Despite a considerable amount of work to introduce dermatoscopes and telemedicine in Greater Manchester, we are still seeing increasing demand for dermatology. In our tertiary service we are encouraging GPs with special interest and working to develop our community service for dermatology.

Question 16: What experience have you of some consultants who aren't so comfortable with triage doing less of it and spending their time seeing patients?

Answer:
(Janet Castrogiovanni) We have seen a lot of resistance, but things are changing, and we are working with early adopters and those who want to try and change. This is usually in areas where the demand is such that the service is overwhelmed and putting in advice and guidance and triage is the only way of meeting and prioritising demand. Another issue is repeating diagnostic tests when patients have had initial investigations outside hospital. We are overcoming this by starting the engagement and collaboration of services early, working to engage all clinicians from the very start of transformation programmes.

Outpatients: The future

Question 17: As demand has increased (perhaps as a result of the identification of unmet demand, do local public health bods, or anyone else, believe that overall patient care / health / quality of care is improving?

Answer:
(Janet Castrogiovanni) That is really difficult to measure but we do measure all of these separately and take note of patient/public feedback and comments.

Question 18: Interesting to note that Dorset/Manchester have made significant impact on dermatology, but this is still an issue. What are thoughts on more creative thinking and perhaps the two areas joining forces to develop any further solutions?

Answer:
(Janet Castrogiovanni)
Absolutely, in Greater Manchester we feel we have made a lot of progress but are still struggling with demand. In Greater Manchester we are looking to increase our out of hospital provision and continue to support GPs to use dermatoscopes.

Answer:
(NHS Dorset CCG on behalf on Tracey Hall) Absolutely – we would welcome the opportunity to share our stories and work with Manchester.

Question 19: At our trust we do a lot of virtual clinics exp in T&O and ENT, we use consultant connect and the photo element in Derm as well as rolling out Zesty app where patients can see their own letter and rebook their appointments from their mobile phone. One area we have not investigated yet are RAS services (referral advice services) as opposed to directly bookable. Has anyone had any good experience as I'm looking at Cardiology?

Answer:
(Janet Castrogiovanni) It sounds like you are making good progress and testing a number of systems. In Greater Manchester we are recommending the use of the NHS system and have seen some success with cardiology for advice and guidance.

Answer:
(NHS Dorset CCG on behalf on Tracey Hall) Sadly, we don't have any particular experience of this with Cardiology, although they have expressed an interest in AA. We are looking at RAS as part of our Transforming Outpatients so would welcome any feedback / learning.

This webinar was hosted by Consultant CONNECT

Outpatients: The future

Question 20: There is a big issue with lack of numbers of GPs and special interest, what is the RCP going to do about this? How can we attract the young and new GPs to take up a speciality? We in the CCG have the ideas about what we can do but some patients do need some primary care management, so have had to build special services covering larger group of practices.

Answer:
(RCP) While the RCP is concerned about the number of GPs, the Royal College of General Practitioners takes the lead. Delegates may be interested to read the RCGP's *Fit for the Future: a vision for General Practice.*

Key to providing the best and health and care lies in person centred integrated care, with clinicians of all types and other professionals working alongside each other in multidisciplinary teams. They should all be able to focus on what they are trained for and where they are most needed. In this respect, we agree with RCGP that GPs should be able to focus on diagnosing serious health conditions, managing multiple long-term conditions, and undifferentiated symptoms.

Question 21: Has anyone experience of redesign of Neurology? We have major capacity issues; we don't have any GPwSI or GPwER.

Answer:
(RCP)

- Frimley Health and Care: Trailblazing the redesign of neurological services
- Surrey Heath CCG: Improved service for neurology patients
- Clinical medicine: Hyperacute neurology at a regional neurosciences centre: a 1-year experience of an innovative service model
- Clinical medicine: Acute neurology service

Question 22: Is that a common problem for all? A lack of GPwSI nowadays?

Answer:
(RCP) Refer to RCGP.

Question 23: I work in specialised commissioning - are there examples of outpatient efficiencies within this area?

(RCP) The RCP doesn't have any examples to share but wants to hear from organisations that are undertaking this work. They also want to know what support you might need, either from the RCP itself, or NHS or other organisations. You can contact them via policy@rcplondon.ac.uk.

This webinar was hosted by Consultant CONNECT

Outpatients: The future

<u>Question 24</u>: Please share details on the browser-based consulting tool. Did you rule out any technologies before coming to Attend Anywhere? Which areas are Dorset looking at using Attend Anywhere in the acute setting?

Answer:
(NHS Dorset CCG on behalf on Tracey Hall) Please click here for more information about Attend Anywhere – this is currently being used by Dorset Healthcare NHS Foundation Trust, our community and mental health provider, and will, over the coming months, be rolled-out to our acute trusts. It is also rolled out for the whole of NHS Scotland.

When Dorset Healthcare NHS Foundation Trust considered remote consultations, other products were reviewed but Attend Anywhere provided the best solution against the agreed criteria and therefore, was agreed on a 12-month test and learn basis. With regards to rolling this out across our acute providers, acute trust staff (both clinical and non-clinical) were keen to ensure, where possible, standardisation and consistency of technology / solutions across Dorset to avoid patient confusion. Whilst a formal evaluation of AA is underway, the initial findings and feedback from staff and patients are extremely positive.

With the acute setting, the following areas / services have expressed an interest in using Attend Anywhere – dermatology, rheumatology, cardiology, urology, gynaecology, stroke, maternity and haematology.

<u>Question 25:</u> The biggest challenges in dermatology are a shortage of consultant dermatologists and an ageing workforce ,variation in diagnosis and management in primary care due to the lack of training for GPs ; limited and fragmented use of available technology , inadequate triage in both primary and secondary care; limited and inconsistent coding of outpatient activity , in particular coding for follow-up appointments and treatment. Tracey - you have addressed few of these challenges and well done but any plans to address the other big challenges?

Answer:
(NHS Dorset CCG on behalf on Tracey Hall) The vision for Dorset's Dermatology Service is "*By 2021 to redesign and deliver a sustainable dermatology service across Dorset that provides patients with responsive and equitable care and our staff with a great place to work."* These services need to deliver:

- Integration – patients must be able to move seamlessly through services that meet their needs - right person, right time, right place
- Sustainability
- Develop and use our workforce differently, and
- Transformation of the way outpatient services are provided

This webinar was hosted by Consultant Connect

Outpatients: The future

We recognise that there is not a single solution for Dorset's Dermatology Services but a number of solutions which will go some way to easing the current pressures including:

- Referral Assessment Service – as you mention, triage in secondary care is minimal and this is something that our consultants and staff are considering
- Relationship with Primary Care Networks – at present there is a pilot taking place within one of our PCNs for a GPwER to review all routine / urgent referrals for triage, review etc. before then sending to secondary care, if needed. Initial findings suggest that this is having a positive impact, whilst supporting the development of skills, knowledge and experience of GPs within the area.
- Use of Technology – we recognise the benefit of using photography and therefore intend to do another 'push' on this amongst all GP Practices. We are also considering encouraging photographs for 2WW referrals as has been done in other counties.
- Education & Training – we have established a steering group to consider and focus on this – accreditation, supervision etc - as we appreciate it will continue to have an impact

<u>Question 26:</u> Remote consultations - has this been adopted by clinical teams. Has there been local success, what's been the challenges in implementing this?

Answer:
(NHS Dorset CCG on behalf on Tracey Hall) Adoption of AA across Dorset Healthcare has been extremely positive – it is being used in a significant number of services and has made a positive impact on patient experience and staff travel.

For example, during Storm Emma large parts of Dorset's rural road network were unusable due to very heavy snow. One consultant psychiatrist reported being able to deliver 100% of his appointments over the two disrupted days despite being personally snowed in at home.

Of course, there are always challenges and, in particular, with AA the following are recognised:

- Ensuing all consultation rooms have the right equipment - a computer with video and microphone functionality.
- Changes to admin processes / procedures-for example video consultation works best if letters are sent digitally to enable the patient to 'click on the link'
- Staff engagement – as you would expect some areas have been more enthusiastic and willing to trial this new and innovative way of working but, that was to be expected.

This webinar was hosted by Consultant CONNECT

Outpatients: The future

- Our population / patients – this is, and can be, a very different method of delivery for patients so we are mindful to ensure this is correctly communicated.

There are many services within the acute setting keen and enthusiastic to make use of similar technology (see above). This appetite was evident in our Outpatient conference.

Telephone consultations are also increasing – there has been successful implementation of virtual fracture clinics in T&O at Poole / Bournemouth, which has positively impact patient experience – reduced trips to hospital – and clinic capacity with quite a speedy adoption.

Question 27: What experience have you of some consultants who aren't so comfortable with triage doing less of it and spending their time seeing patients?

Answer:
(NHS Dorset CCG on behalf on Tracey Hall) Across many specialties there are some individual clinicians and teams who want to "hold on" to activity that could be either better done elsewhere or in a different way- or in some cases not done at all. This is driven by a variety of motives- old style PbR mind-set, lack of trust in new methods, new partners, new technology, a genuine belief that only they or their team can deliver this- and we need to listen to those views-and where appropriate use other clinical voices to test and challenge these (and be prepared to think again if the triage /other change has too high a risk).

Resolution is often a slow burn by building up trust between multiple clinical and managerial stakeholders across providers. We sometimes do this through an "OD programme" run by Our Dorset Workforce Team (team drawn from 4 providers and CCG). This team deliver our "Leading and Working Differently" STP programme. They help clinicians from multiple organisations develop shared visions- address population health need- not just "the patient in front of them"-behavioural aspects of change etc. The team also provide and develop many of the practical solutions in support of our plans (e.g. easier staff passporting between different organisations, scaled up approaches to apprentices, workforce planning, retentions and recruitment).

We try to "nudge" rather than push change - and this is of course far more likely to succeed when the problem is identified by clinical teams and they lead in designing solutions. The motivation to develop solutions not unsurprisingly increases when the pressure on services becomes worse-burning platform prompting a more proactive approach to change.

Question 28: What areas have you managed to move money around in Dorset?

Answer:
(NHS Dorset CCG on behalf on Tracey Hall) As an ICS, the three acute trusts, one community and mental health trust and the CCG have a shared control total (i.e. we manage the money on system-wide rather than on an individual organisation basis - doing what is best for Dorset as a whole). Clinical Pathway changes and investment decisions are taken by system-wide partners together (Operational and Finance Reference Group and Clinical Reference Group respectively). There are complex governance arrangements around this to reflect both ICS aspirations and current misaligned national statutory duties.
We have shared “Collaborative Agreement” that details how money moves-within the ICS partners we move money at cost-not tariff where services move. There are lots of small examples on small services or small elements of service e.g. -andrology, ophthalmology, dietetics.

With “new” money we decide together where to invest. The most significant example has been in 2017/18 when the OFRG (all Directors of Finance and all Chief operating Officers) agreed that all new money (i.e. growth) should be put into widening the community services MDT support around frailty-wrapping around groups of practice- and no growth to acute services. This was approx. £6m.

Question 29: We have also used Telederm from consultant connect for Paediatric Dermatology - but take up is not great at moment, have you got any tips? We are not an ICS.

Answer:
(NHS Dorset CCG on behalf on Tracey Hall) The two ‘top tips’ would be:

1. Make the technology and the process of using photograph (downloading and uploading etc) as easy as possible, and
2. Continued and targeted communication and engagement – using the data / information to contact those practices not using the service to remind them of its availability, the positive impact etc. it can have to patients and likewise, those that are using the service to celebrate the success. If you can also find some Primary Care champions, that also helps!

Being called an ICS isn’t a pre-requisite to the kinds of change we have seen- the trusted relationships between providers and commissioners (and between providers themselves) are what make the difference- and they had been growing in Dorset since our Clinical Services Review from 2014 onwards. Having a shared understanding of the pressures in the system-and supporting more links between

Outpatients: The future

primary care and secondary care clinicians are needed to make e.g. PhotoSAF work- but also help develop those relationships further.

Question 30: I'm going to ask for a quick final message in ten seconds from each of you, Janet, you first, ten seconds, take home message.

Answer:
(Janet Castrogiovanni) My take home message will be - listen to your population and listen to the people who are in your neighbourhoods and develop those services to meet their needs.

Answer:
(Tracey Hall) I think I'd say collaboration is key, stick with it, it will take longer but you will get there.

Answer:
(Dr David Fluck) I agree with Janet and Tracey, I think those were the two main things actually, I think listen to the population and work with all the partners in the system.

This webinar was hosted by Consultant CONNECT