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"Quick Fixes for Winter" – Webinar

Wednesday 13 November 2019, 1-2pm

Delegate questions and answers from our speaker panel:

Speakers included:

- **Angela Wadmore,** Divisional Director: Urgent and Emergency Care at South Tyneside and Sunderland NHS Foundation Trust;
- **Pam Green,** Chief Operating Officer at NHS North East Essex CCG;
- **Sophie Sennett,** General Manager, Contact Centre and Outpatients at Yeovil Hospital NHS Foundation Trust.

The following Q&A is a transcription from the verbal responses and written responses from the expert panel for questions that were not answered during the live webinar:

To watch the webinar recording, click here.

Question 1: The first question relates to this idea of collaboration, multidisciplinary and bringing people together, and it's for Angela. You talked about this idea about pairing up hospital doctors and triage nurses so that they work together, can you give some further information on that?

Answer:
(Angela Wadmore) Certainly, it was actually GPs who we tried it with as opposed to hospital doctors during that Perfect System Week. Just because of the different way that clinicians do work. We often talk don't we about how doctors in an acute setting work and how risk averse people are, or not? But it was a GP that had been working alongside the nurse navigator who used to manage people out in the community, people who looked quite unwell but actually that's their norm, so that was the challenge that we'd really set ourselves as a system. And it was that enhancement of having both individuals and both professions doing that, the nurse has very extensive knowledge about what's available both in hospital and out of hospital, such as same day emergency care, direct to speciality pathways, and currently stream away to collocated urgent treatment centres, GPs, etc. Having a GP there was really helpful. I think the GP found it challenging at times, and was much more comfortable with a 'see and manage' approach (take the patient away, quickly see them and then be able to discharge them). And I think having those open and honest conversations really helps in a system, so it's always easy isn't it to think that maybe things could

be done a little better by a different part of the system, but when you're all doing that together it really works to understand what is a myth, what is the right thing to do, and actually we've had some really, really challenging surges over the last few weeks. And that the GP has done some of that 'see and manage' and be able to help get through some of those patients who are in the 'queue'. So it's not necessarily about saying it needs to be a GP streaming, but actually on a certain day getting some GP. We've got what we call a 'surge protocol', so actually any member of the system can call up if they feel under pressure, and it will convene within a two hour period, over seven days a week. So actually it could be that two GP practices have gone down with sickness, etc, and extended access providers will normally provide the support for that, but we can alert the system and talk about how we can work that through by having that surge protocol mechanism.

Question 2: Pam, could you say a little bit about how you got clinicians to buy into these new initiatives? Have you had any pushback at all, both in secondary care and in primary care? How easy was it and was there any hold out?

Answer:
(Pam Green) It's been a long journey, and I think initially we had (across the three sites), quite a significant amount of pushback around role definition and understanding autonomous working, even down to pay bands which were different for seemingly similar jobs. So there were some tensions around the development of this model. And what we tried, is to create a sort of clinical setup that was helping us, a clinical majority that was helping us to design and look at the protocols, so there's a whole process of pathways, so that every site would understand, the most typical presentations that would be coming in, and where they could get help. And actually, Consultant Connect forms part of that because the consultants are accessible to the GPs, they're accessible to our community provision. And again making sure that we build those relationships really strongly, so understand people's strengths, and build on what's good and not build on what's broken. I think there was a mass realisation between the acute A&E site and our remote minor injuries unit that they were managing a significant level of injury presentation, and doing it really, really well. I think when you get into illness management that is where people become much more fearful of is that a sepsis and have we responded properly and are we too far away from the consultant to escalate and start to do more, a higher level of intervention. And that's where we needed to bump people together around their skills, so that we could make sure that the risk averse nature wasn't defaulting to anybody that had got a urine infection and could potentially be vulnerable to sepsis because they came from a care home, etc, was not managed in a very quick escalation way, they were managed in a "do we know this patient, what information have we got?" It's not perfect, you know, we haven't solved all of that yet, but there was a lot of time put into building that clinical understanding between the sites so that they just knew each other and how

they worked better together. I think one very defining moment was when our A&E consultant came to meet with the GPs that were interested in working together, and as the point that Angela made, was we actually said we're very risk averse in the hospital and we know as GPs you manage risk on a daily basis to a much higher level, how can you help us, and for the first time somebody had sat in front of them and said, instead of saying you refer all the wrong things in, said how can you help us. And it really changed, it was a sea change of how people were willing to work together, and how they felt that they could really make a system benefit. So I think yes we have had pushback in the beginning, but I think as we start to, you know, really form as an alliance things have improved. I think also there's an element of making sure systems are connected, so that people have got the right information, and you know, we're using SystmOne across the UTC, and across A&E, but that's not perfect, it doesn't connect all of our practices up, you know, we do… occasionally we don't have all the information that we need, but my sense of importance would be if you're designing something like this make sure the systems support that communication and share so that people aren't in the dark when they're trying to have conversations.

Question 3: Sophie, a question regarding the Home First service. How do you ensure that there is medical support available when out of hours GPs are very limited? Do you have a doctor in the hospital, they ask, to offer general advice?

(Sophie Sennett) The Home First service is made up of quite a collaboration of staff across the hospital, so there is always that level of support, to ensure that we're doing the right thing for any patient, and we have different pathways that patients leave the Trust on, so that the Home First service is relatively young… it's just had its first birthday, so the clinical people involved make sure that we are ensuring that patients have the right level of care and support so that they can then go safely onto the next protocol.

Question 4: Has anyone put in place anything specifically around care homes, and or frail patients, to reduce unnecessary referrals from this patient cohort, obviously a key area here and particularly in areas where's that higher than average population group who are older or frail. Does anyone have any specific interventions that they've looked at for that specific group of patients?

Answer:
(Pam Green) It isn't as novel as probably I'd like it to be, but I think it worked this time, and that's an early intervention vehicle with our Ambulance Trust with extended scope paramedic prescribing, and OTs as well, so we can do a range of care home visits as well as, you know, making sure that people that have gone into crisis because they might have a care package problem, and have become unwell, can be supported. We tried it for numerous years, and we didn't get the success, we didn't get the number of calls we ever intended to it, but this time when we've done it it's worked, because again on the foundation of those better relationships in the system we've

matched the design of that for this, to the needs that the Trust were seeing, as opposed to it being a little bit, you know, there's some good practice elsewhere, so it came out of the basis of building information, and systems buying into that, a way of working. Importantly we funded that through the IBCF, so our social care colleagues were very supportive, and also analytical about the benefit and provided the occupational therapists to help people have equipment if they were in sheltered accommodation, or you know, extra things in their home if they were frail to stop them being admitted. Then of course services would be able to come in and support them. Also using our voluntary sector, befriending services, etc, so that we could just deal with that crisis of frailty which we see very often as a problem. One other thing just very quickly with that group, we implemented for our end of life patients something called My Care Choices, and it was very clear about people either wanting to be transferred to hospital or not if they ended up in an end of life scenario and good planning for that, a year out or 18 months out for potential end of life scenarios. And we did that with our frail patients, so they have a handheld document that defines their wishes, which I think, you know, when you're coming in as an Ambulance Trust and if you've got a protocol within care homes but somebody's got their wishes set out in something that is personal to them, actually you could start to challenge whether we should just be admitting them to hospital, and the families then are much more in tune with what the patient actually wants.

Answer:
(Sophie Sennett) We do have a frailty unit now, within one of our wards, so it's a dedicated space for that important cohort of patients, and also in the bed meetings we talk about allocations that have been identified that have come into ED that are appropriate for that unit, so they're certainly a group of patients that we are very focused on there.

Answer:
(Angela Wadmore) Just probably to add about that system wide working, we've mentioned alliance before, there is an alliance, an all together better alliance that we're working within and those workstreams are to look at, you know, transformational work around that so that the work that I described earlier sits under an urgent and emergency care programme, but there are three other programmes and one of those is looking at care homes, frailty, so we have frailty services within the hospital but actually how does that frailty service sit with the wider system side frailty service and what is the frailty offer for everybody within our localities, and I think that's really important rather than segregating it. So that that's a key piece of work that sits under one of the programmes as part of the alliance.

Question 5: Can Pam and Sophie give one top tip on how to get public consultation right, how do we get a group of people involved, including harder to reach communities, and making sure we're not always reaching out to the same people, what's the one ingredient for success, if you can only have one to a successful public consultation?

Answer:
(Pam Green) Go where the people are, don't expect people to come to big halls to tell you about what they want services to look like for the future, you are decidedly unappealing in the way that you construct yourself if you do it in that way, that you go out to groups, service user groups, you get much richer information. If I was allowed a second thing - So when we did the UTC we did have, it was, you know, when we'd done our evaluation of service users actually it's quite a significant amount of younger people that are using our A&E and we don't always tailor our information so well to them, I think our traditional core group has not been so social media driven, we learnt from examples around the country and actually we had an animation that really helped us get the message out to why were we asking questions, and we wanted to listen and how things could be different for the future, and those sort of things have really helped.

Answer:
(Angela Wadmore) Just building upon that really isn't it, it's local and early engagement, so reaching as many people as you possibly can.

Question 6: A final question for each speaker, what would be the one top thing that you think is important for anybody who is watching this webinar who is working in the NHS who's grappling with these pressures, to be doing in the run up to winter? What's the one thing that they should be doing tomorrow which might set them on a path to improving things overall?

Answer:
(Angela Wadmore) Probably pace, but with preparation. So everything's rapidly come in which we need to do at pace, but ensure that there is some preparedness behind that.

Answer:
(Sophie Sennett) Making sure you communicate your clear strategy.

Answer:
(Pam Green) Slightly different angle, but to see your workforce as one workforce. Treat everybody else's workforce as you would treat your own, and you know the sum of our parts is greater if everyone pulls together, so offer things like training, etc, in these tough times because it's hard working in the front and there doesn't seem to be any high points when winter lasts six months of the year, so what can we offer.

Question 7 Pam, can you tell us about how you address mental health pressures?

Answer:

(Pam Green) Mental health workers are embedded in our Urgent Treatment Centre (UTC), we continue to have challenges around mental health demand in the A&E but we have the opportunity to support coastal prevalence in the Clacton at our remote UTC by developing mental Health crisis cafes and mental health suites in A&E

Mental Health first aid training is a core requirements for all alliance staff.

If you have further questions about the webinar content, please contact Laura Mackrory: lauramackrory@consultantconnect.org.uk