Advice and Guidance

Evaluation Report (12 months)

1. Background

Purpose

This report provides an outline of delivery of the Advice and Guidance (A&G) pilot supported by GM Transformation Fund allocated by Salford Together. This report has been reviewed and approved by the A&G Steering Group.

Project Goals

Aim

To pilot and evaluate the use of an A&G system between primary and secondary care:

> *To reduce the number of first outpatient appointments (OPFA) by 2376 and follow up outpatient appointments (OPFU) by 3168 per year (full year implementation effect) across three pilot specialties: cardiology, respiratory and gastroenterology.*

Objectives

- To provide a simple easy-to-use system for GPs looking for specialist advice on the best treatment option or whether specialist treatment is required which may offer an alternative to unnecessary referral to an outpatient clinic or hospital attendance
- To explore the potential to improve patient journeys by reducing the number of people discharged from outpatients without any treatment and reduce short stay admissions within pilot specialties
- To free up consultant capacity to support delivery of 18 week RTT
- To improve GP/consultant dialogue and reduce variation in methods for accessing advice in a standardised format to improve safety

Description of the project

The PIID outlined the project delivery broadly as:

Phase 1. Specify and procure A&G communication platform (3-6 months)

Phase 2. Phased roll out platform to Salford GPs with live testing in 3 pilot specialties with backfill funding to support consultant time (6-12 months)

Phase 3. Evaluate and review learning (12 months)

Phase 4. Scale up to additional specialties if appropriate (12+months)

Concurrent to this transformation project, the provision of A&G was included in the NHS England CQUIN 2017-19[1]

The CQUIN requires the specialties which provide 75% of all elective outpatient appointments to be accessible to GPs via a form of A&G with quarterly performance milestones.

An alternative course of delivery was pursued in the light of the challenging timescales of delivering the pilot alongside meeting CQUIN requirements.

> Phase 1: initial engagement and small scale "technical" testing of tool as preferred tool between single specialty and single GP practice (3 months)
>
> Phase 2: large scale testing of tool in 3 pilot specialties across all GP neighbourhoods (3-6 months)
>
> Phase 3: staged roll out of new specialties to meet CQUIN requirements (neurology, ENT, neurosurgery, dermatology, trauma and orthopaedics and gynaecology) (6-12 months)
>
> Phase 4: evaluation and learning from pilot to inform wider roll out to specialties identified as value added for primary care, or eager to provide service (12+ months)

2. Evaluation Framework

Evaluation Questions

The following evaluation questions are addressed in this report:

Process questions:

- What is the right A&G system (technology platform) to use?
- What information is required to roll out A&G?
- Should an A&G request be attached to a tariff payment?

Impact questions:

- Does A&G provide better quality of care for Salford residents and patients?
- Does A&G system reduce demand for secondary care?
- Does primary care value the service provided by A&G?

Methods

This evaluation comprises of a blended approach to formative and summative evaluation methodologies. A mixture of qualitative and quantitative data has been collected at regular intervals throughout the 12 months with review by the A&G Steering Group using the rapid cycle evaluation structure. Informal interviews with both engaged and disengaged GPs has provided additional feedback. The evaluation plan highlights the data sources and collection processes which have informed the production of this report.

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[1] Indicator 6 "Provision of Advice and Guidance" – available online at: https://www.england.nhs.uk/nhs-standard-contract/cquin/cquin-17-19/

The Logic Model and Evaluation Plan and RCE Template are attached in **Appendices A and B** respectively.

Evaluation Team

This report was co-produced by representatives from Haelo and Salford Together, with regular input and guidance from the A&G Steering Group. A full list of individuals involved is available at **Appendix C**.

Limitations

Throughout the early phases of the project, access to the required data was not available due to limited resource allocated to extract and interpret data. It has not been possible to conduct a full case note analysis of patient journeys to retrospectively understand the impact of an A&G conversation on their pathway of care as this requires more time to have elapsed in the patient's journey. A primary and secondary care clinician survey is currently in progress as part of the Safer Handover programme, which will provide additional feedback on the value and use of A&G as a communication tool.

3. Evaluation Findings: Process

Has the programme been delivered as intended?

A&G provided via eRS is now live and available to all Salford GPs provided by the following specialties:

- Cardiology
- Respiratory
- Gastroenterology
- Trauma and Orthopaedics
- Gynaecology

Additional specialties are providing A&G via alternative routes:

- Dermatology (provided by SRFT services in Stockport only)
- Neurology (consultant-led triage service)
- Neurosurgery (consultant-led triage service)
- ENT (via eRS but not advertised to GPs until service specification prepared)

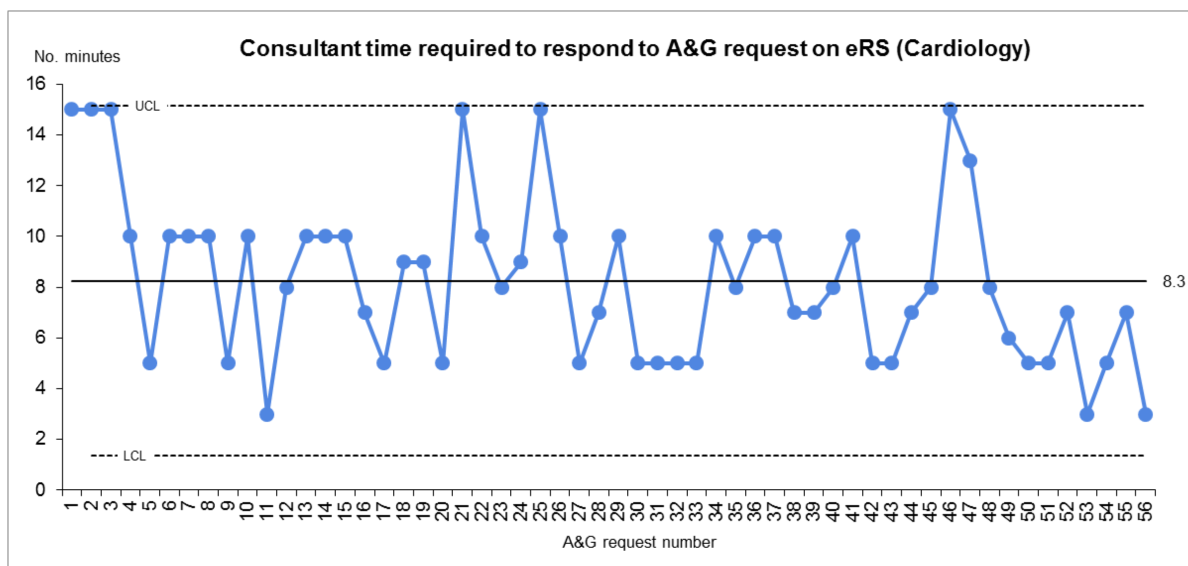
A Standard Operating Procedure (full version available at **Appendix D**) has been co-designed and drafted with input from clinicians in primary and secondary care, with regular review at RCE meetings. This specifies that the responsibility for an A&G request remains with the requesting clinician (i.e. primary care) – see process below:

Was the project able to secure all necessary inputs?

The options appraisal in the initial PID identified procurement of a bespoke electronic "conversation" via email / messaging tool as the preferred option (scoring 17.5). Early phases of this project focused on the preparation of a procurement specification based on a review of platforms currently available and in use in other localities. A guiding principle for any technology solution is the ability to source a single universal system across Salford, which would be easily integrated alongside existing systems (both within and external to Salford). A lack of local experience of how clinicians would utilise A&G meant it was not possible to develop a specification in sufficient detail to facilitate value for money procurement exercise. In addition, limited capacity within SRFT Digital team due to requirements to deliver GDE programme meant it was not possible to fully support the development of an additional software solution.

The project utilised a less preferred option of utilising the existing A&G function of eRS (electronic-Referral System, scoring 14 on the options appraisal). This option was selected over the equally scored telephone-based system as this was not a desired process for local clinicians. eRS is a pre-existing system currently available to primary and secondary care clinicians for the management of referrals, therefore set-up costs are minimal. The eRS system has the benefit of being linked to patient demographic information and allowing ease of converting an A&G request into a referral, the A&G functionality had not previously been utilised beyond a small innovation project led by Dermatology.

Providing A&G takes time, both in primary and secondary care. During the pilot phase, funding was made available to cardiology, respiratory medicine and gastroenterology to enable clinician resource to be made available to service requests. Data collected in Cardiology (see below) demonstrates that on average it takes 8 minutes to respond to each request from the time eRS is opened, to when a response is submitted and eRS closed.



A lack of a payment structure or tariff arrangement to cover this time has been identified by clinicians as a significant barrier to ongoing provision of A&G beyond the pilot phase. The current funding model in Salford does not sufficiently incentivise clinicians, practices and

specialties to reduce demand for outpatient appointments[2]. This factor was referenced in discussions with the following specialties, but overcome with the additional incentive of the CQUIN: gynaecology, trauma and orthopaedics, neurology / neurosurgery; and prevented the following specialties, who initially expressed interest, from providing A&G: diabetes and endocrinology, urology and lower GI surgery.

To access eRS, clinicians are required to use an activated SMARTcard and SMARTcard reader. Within the Trust the provision of SMARTcards is overseen through the HR team provided intermittent on-site capacity to support allocation of SMARTcards to consultants within the Trust. Training resources for eRS are available through online videos and "how-to" guides. These were supplemented by free training provided by NHS Digital arranged alongside specialty meetings attended by all consultants. 3 training sessions were arranged:

- Service managers
- Respiratory consultants
- Primary care (this session was poorly attended with limited representation from primary care)

Formalising data collection protocols took longer to establish than expected due in combination to the need to create a new data extract from eRS (alongside some teething troubles from NHS Digital in providing the extracts) and limited capacity within to interpret raw data into usable format for the purposes of monthly evaluation. A regular data extract from eRS is now in place to track utilisation of eRS. Functionality due to be developed by NHS Digital to provide data relating to outcome of A&G discussion as to whether a referral was avoided is awaited.

The need to add additional specialties to the project to achieve CQUIN target led to significant dilution of available capacity to lead and deliver the project, which may have contributed to the lower than expected outcome data from this pilot. During the final 3 months of the project additional resource was re-allocated from the transformation team to support specialties participate in the pilot.

Was the project able to carry out all of its intended activities?

It took significantly longer than anticipated for two of the target pilot specialties to become "live" providers of A&G services. This delay is attributable to a number of factors, including co-ordinating training for consultants, accessing SMARTcards and SMARTcard readers and need for significant engagement due to uncertainty around future incentives to provide A&G (tariff payment).

The chart below shows the timeline for specialties providing A&G services as a proportion of their contribution towards the CQUIN target (numerator: the number of referrals received by each specialty, denominator: total number of referrals received by the trust, including Salford and non-Salford patients, as specified by the CQUIN guidelines).

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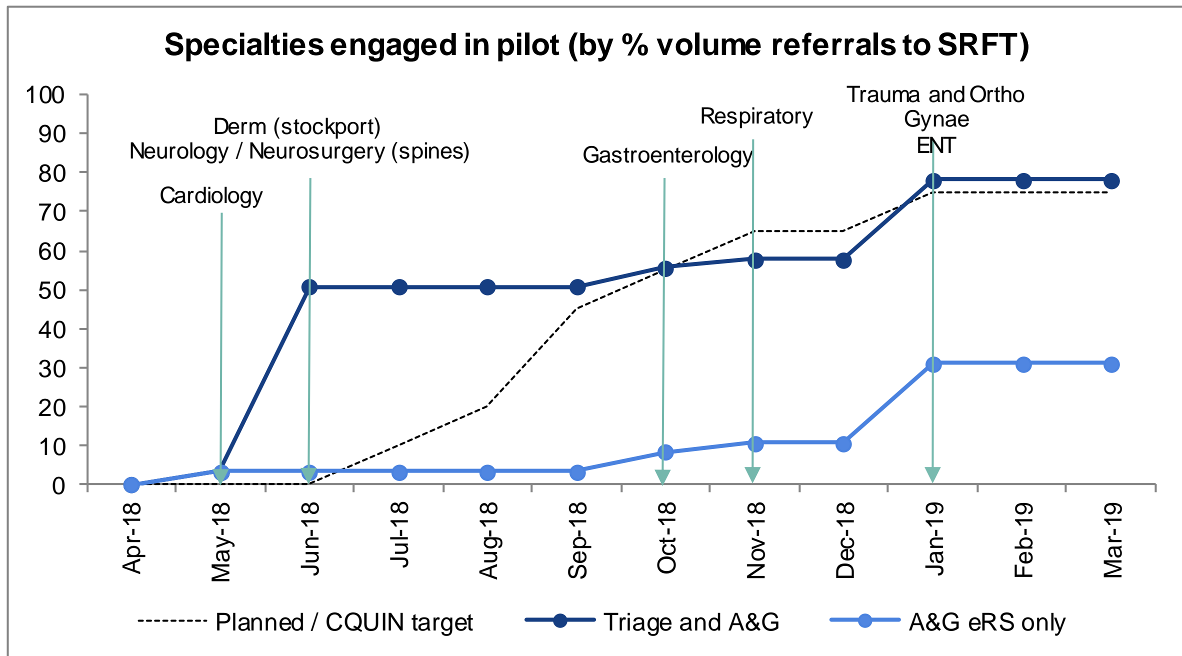
[2] Further discussion of this point can be found in a Kings Fund paper: "*Payments and contracting for integrated care: The false promise of the self-improving health system*", March 2019, available online at: https://www.kingsfund.org.uk/publications/payments-contracting-integrated-care



It has not been possible to provide A&G for Dermatology services for Salford GPs due to testing of an alternative system (MD SAS) for Dermatology provided by SRFT commissioned for Stockport CCG. Initial testing of A&G for Dermatology identified a fundamental need for secondary care clinicians to have access to images of patient skin conditions for review. In comparison to MD SAS, eRS does not provide easy functionality for GPs and clinicians to upload images taken on a device in primary care and attach to a request[3].

Neurology and spinal (neurosurgery) services in Salford are commissioned via the Manchester Centre for Clinical Neurosciences pathway which includes provision of a triage service on referral whereby senior clinicians / consultants review referrals with the option to carry out additional diagnostics (such as headache forms, or MRI scans) with the patient prior to converting the referral into an outpatient appointment[4].

A&G is available to all GP practices in Salford. GPs were engaged through a variety of mechanisms:

- Regular content included in CCG newsletter, including a headline article authored by CCG Chair highlighting A&G and summary of learning from cardiology requests received to date provided by lead A&G consultant
- Updates at GP neighbourhood meetings for all neighbourhoods, accompanied by Standard Operating Procedure and poster to engage staff within practices
- Social media campaign via Salford Together and Safer Salford channels
- Session at the CCG Members Event led by cardiology consultant and gastroenterology service manager

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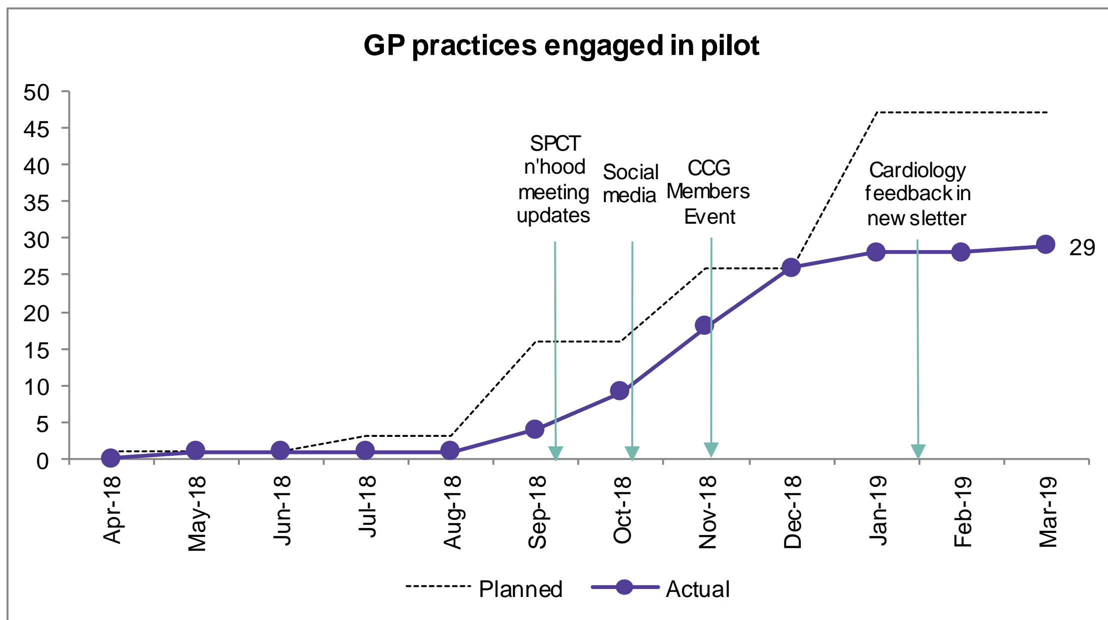
[3] MD SAS provides a "QR code" which is scanned and automatically uploads an image taken on a smartphone device to an A&G request without storing a local copy of the image. Although eRS provides functionality to attach images, this requires clinicians to capture an image on a device, transfer this onto the device where the request is being generated from, and manually upload this, creating 2 copies of the image and requiring time to transfer images between devices.

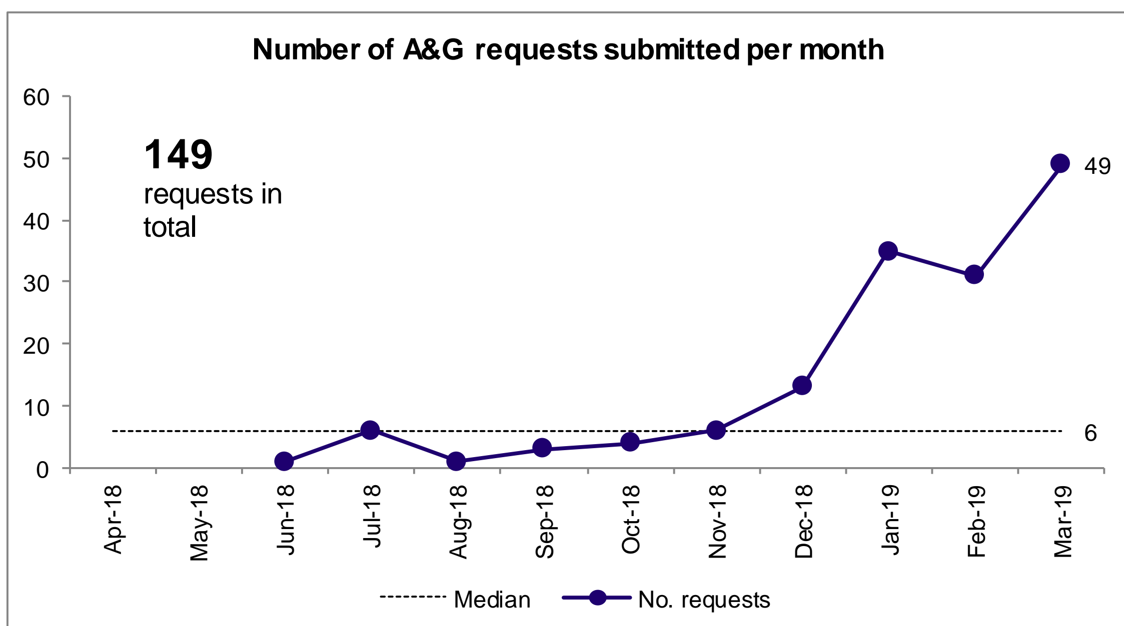
[4] A full referral to secondary care is required to access the required tests which are not available by direct referral from primary care clinicians.

- Provision of training on eRS for A&G to GPs and practice managers / administrators

The below chart presents the number of GP practices actively engaging with the A&G pilot.



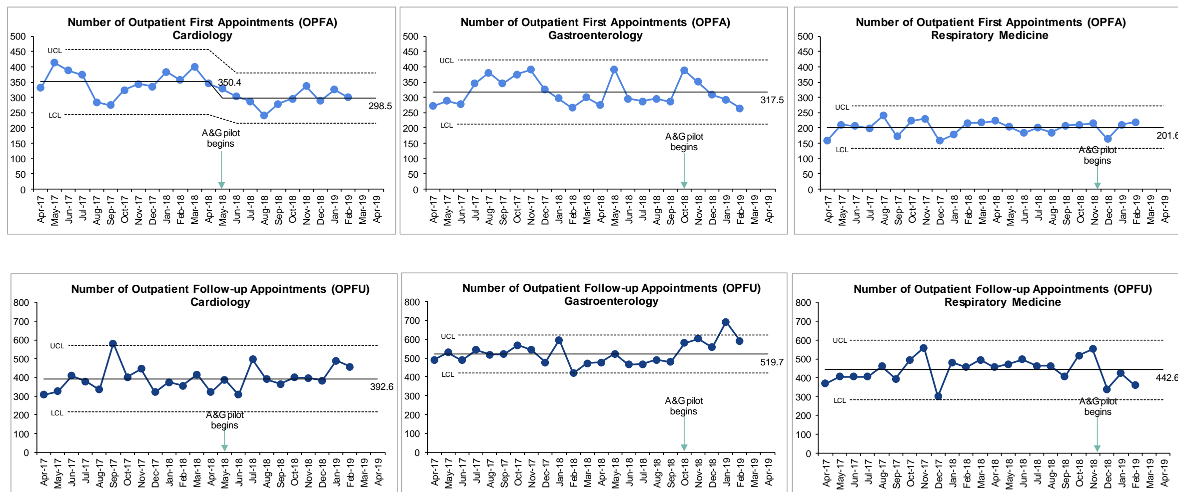
Utilisation of A&G services has been significantly lower than anticipated across all specialties providing the service during the pilot phase. The below chart presents the number of A&G requests submitted to specialties providing A&G via eRS (data only available from June 2018).



4. Evaluation Findings: Impact

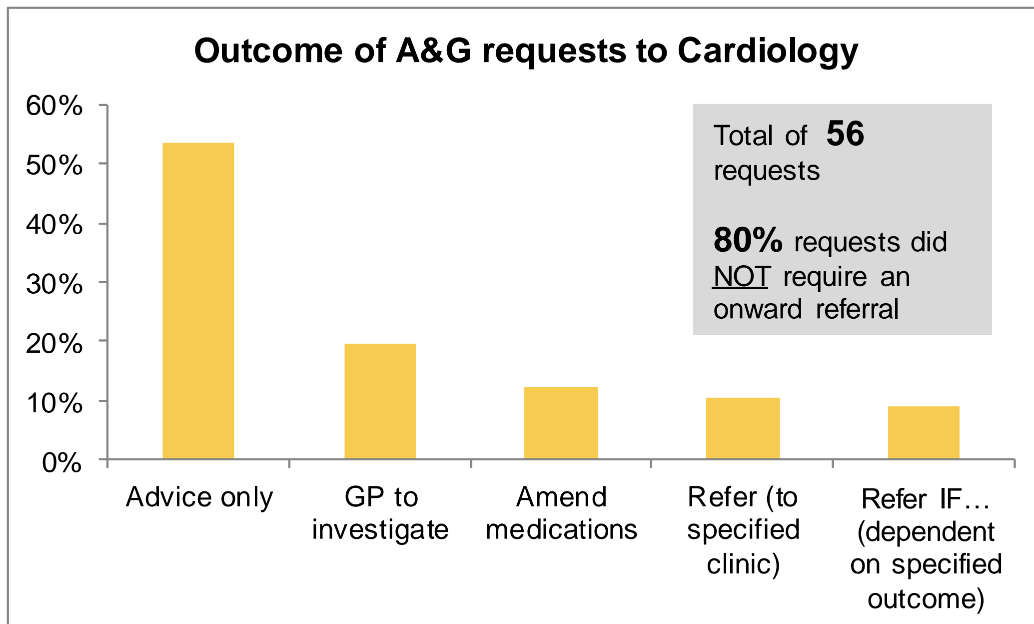
To what extend has the project achieved it’s aims and objectives

Due to the relatively small number of requests received via A&G, we would not expect to see a change in the outcome data (presented below) at the magnitude of the projected aim outlined in the PID.



The limited impact of A&G on referrals and outpatient appointments can be attributed to a number of factors discussed in this report: the delay in bringing target specialties “live” on eRS, an initial assumption in the PID that all referrals would initially be required to go via an eRS service prior to a referral and lower than anticipated uptake from primary care.

An ongoing challenge with the data available will be identifying a causal link between an A&G request and avoidance of a referral (although this functionality is planned for eRS data extracts from NHS Digital). However additional analysis during the pilot of the nature of requests submitted begins to present a picture of the added value of an A&G system. The data presented below shows the outcome of requests to Cardiology, whereby 80% of requests received were able to be dealt with as A&G only and did not require an onward referral.



It is clear that only a small proportion of the requests received are resulting in a referral being generated, with a high degree of confidence that these referrals are both appropriate and directed to the right clinic. Feedback from GPs has been sought to provide additional information in relation to whether A&G provided a positive outcome:

> *"One patient I was advised did not need an appointment and could be referred directly to respiratory physio. The other patient I was advised did need an outpatient appointment."*

Further discussion at RCE meetings identified A&G provides patients with an improved experience, in terms of realising the potential to shorten patient pathways, for example, by reducing the need for appointments and having an agreed plan for care in place quicker (e.g. were queries relate to specific medication changes).

> *"Really helpful – much easier than writing and guaranteed of getting a timely response. I wasn't sure whether to refer so consultant shared a plan and I will reassess in 6 months."*

It should be noted that the process of requesting advice on a patient's care by a primary care clinician from secondary care is not a new one. Prior to A&G being available in Salford via eRS, requests were submitted by other means, such as letters and phone calls, albeit with low satisfaction rates from GPs[5]. A key benefit of A&G via eRS is that it provides an easily traceable communication trail whereby requests can be tracked and followed up on if a response is not received within an acceptable turnaround time, but also allows real-time interaction between clinicians. It is not possible to directly compare this with the "do nothing" option as previously letters or phone calls cannot be traced or easily followed up if not responded to within an established time limit.

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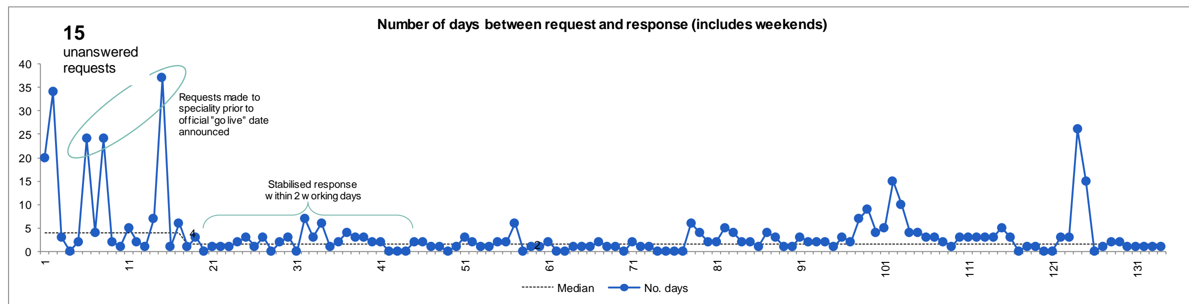
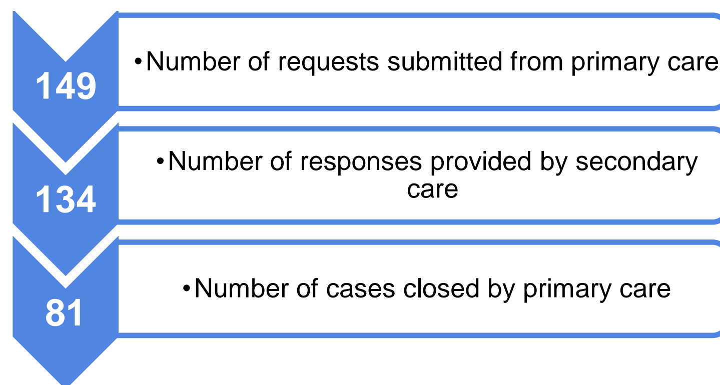
[5] As articulated at the Safer Handover Rapid Improvement Event held in May 2017, notes of discussion can be accessed online at: http://safersalford.org/safer-handover-rapid-improvement-events/

Data from the pilot supports this feedback, on average requests submitted by primary care are responded to within 2 working days.



The SOP specifies that responsibility for a patient subject to an A&G query remains with the requesting primary care clinician. Data collected during the pilot demonstrates a 'drop-off' rate in the completion of A&G requests, suggesting that further work is required to improve reliability of the process within GP practices to ensure that all A&G requests are safely completed and any required actions taken.



Have there been any unintended consequences (positive or negative) of A&G?

Delivery of the pilot has to some extent improved relationships and communication between primary and secondary care clinicians, for example, attendance of secondary care consultants and managers at the CCG Annual Members Event to promote A&G provided an opportunity for in-person interaction. This is supplemented with capture of additional learning for specialties as to the content of requests received from primary care, helping identify areas of uncertainty in primary care. As a result of the A&G pilot, a cardiology consultant was able to identify a common theme in queries received, and provide pre-emptive information to GPs via the CCG newsletter.

The need to establish a single platform for the provision of A&G and selection of eRS as the preferred option during the pilot phase, could be seen to have stifled the development or scale up of more innovative solutions across the system, for example, PatientPass which is currently used to support communication between secondary and tertiary care in Renal outpatients.

5. Discussion

What worked well? How and why did it work?

Prior to and during the pilot, clinicians have shown a high level of buy-in to the principle of providing an A&G service. This is demonstrated by frequent engagement at Steering Group meetings and willingness among early-adopters to test the service prior to having systemic factors better established.

The use of eRS as the platform for A&G enabled quicker set up of the pilot as this is already an established IT system integrated within SRFT and Salford GP practices.

What could be improved for scale up?

Throughout delivery of the pilot, a number of systematic barriers presented which require addressing to enable a wider scale roll-out of A&G, particularly if eRS is selected as the preferred solution in Salford.

Firstly, there is no standardised process across SRFT for managing referrals for outpatient appointments; this is true both between and within specialties. Although all referrals are now required to be submitted from GPs electronically via eRS, specialties have evolved different processes for triage, assessment and allocation of referrals. In places this is reflective of differing needs between specialties relating to the nature of the conditions referred, for example introduction of a commissioned triage service in neurology to allow for scans to be requested by secondary care prior to appointment. However, although the "what" may differ across patient pathways, this doesn't automatically require variation in "how" actions are completed. In some specialties this goes down to micro-level where adaptations are in place to respond to individual consultant needs (e.g. printing out referrals in advance of appointments vs accessing directly via eRS). This individual approach creates an environment which requires additional administrative input to support. Work is ongoing internally to reduce unwarranted variation in approaches.

If eRS is selected as the preferred option for A&G, limited capacity within support teams, such as the HR team which is required to allocate and activate SMARTcards, places delay to rolling out A&G across specialties and the Trust as a whole.

Finally, the requirement for more innovative payment systems to reward quality of care, rather than a process-based mechanism whereby specialties receive financial reward by volume of outpatient appointments provided cannot be underestimated. The provision of A&G is viewed as "extra" work, this is more so in secondary care than primary care, although it is a factor in both settings.

6. Recommendations

Throughout the pilot, substantial feedback and input has been sought from clinicians and managers supporting outpatient care and managing patients in primary care. The principles of advice and guidance are generally accepted to be an improvement to how patients are managed within the health and care system, offering clinicians the opportunity to review and discuss a patient prior to making a referral. During the pilot a range of views have been presented as to how the mechanics of providing A&G can be optimised to meet the project

objectives. The recommendations below seek to outline the next steps required for A&G provision in Salford.

The increasing trajectory of utilisation of A&G service suggests there would be value in continuing to support the pilot to maintain momentum gathered both in primary and secondary care.

- Allocate project support resource to oversee an extended pilot phase, continuing engagement with both primary and secondary care clinicians.

Low numbers of requests submitted during the initial pilot phase have limited the ability to determine the effectiveness of A&G in managing referrals, in particular to meet the project aim of a significant reduction in referrals.

- Ongoing data collection of number of requests, responses (time taken) and changes to wait times for patients registered with a Salford GP (key as overall wait times to services may not change as patients from other areas utilise reduced wait times). Evaluation of patient outcomes could be focused in GP practices with high utilisation.
- Data collection should be used to support creation of a learning system, for example, specialties providing A&G should seek to complete audits of requests received, identifying common themes and issues, which could be fed back to primary care.
- Learning from this pilot should be combined with that from other alternative models of referral management, e.g. neurology triage model and applicability for different specialties and NHS England's 100 day challenge

Servicing A&G requests requires time, both in primary and secondary care

In the short term, existing payment structures should be utilised as appropriate to incentivise provision and safe, effective and efficient use of A&G as part of OPD referral pathways.

The greatest efficiency gains will be seen when outpatients can be managed by a single system (or what appears to be a single system at the user interface). At present eRS provides this functionality, however there are some gaps, Appendix E outlines the core requirements for a platform.

- Increase capability and capacity within existing digital teams based within SRFT and CCG to support us
- Facilitate use of eRS, for example, provision of training. Where SMARTcards are required by clinicians, support should be provided on-site.
- Explore technical options for a 'plug-in' to streamline the process of sharing images to facilitate access to and provision of A&G for Dermatology.

Pursuing A&G as the single solution to improve access and reduce outpatient pressures is a stalking horse, A&G should be utilised as a tool to support development of redesigned service pathways which enable greater interaction and bring care closer to patient.

Options

	Advantages	Disadvantages	Costs
Stop using advice and guidance		Has no impact on outpatient appointments, Disengages the GPs and clinicians who are positive about its use Improvements to patient management and experience are lost	Communications time
Continue to use advice and guidance in those areas currently using it	Possible impact on outpatient appointments Positive for small number of patients and GPs	Potential confusion if alternatives are explored elsewhere in system Clinician time is not resourced Lack of strategy leads to confused legacy	Tariff payments (need resolving) – block contract for OPD may incentivise pathway innovation Clinician time needs to be built in Support services (ICT, HR, BI)
Expand A&G via e-RS as requested by clinicians	Potential for improvements in patient experience and outpatient appointments. Clinicians are engaged so adoption should be easier.	Risk of inconsistent use of A&G between specialities Requires ownership within system	Communications and engagement with GPs Support services
Test making A&G a step in process of booking non urgent appointment	Increased potential for improvements in patient experience and outpatient appointments. Consistent use and implementation of A&G	Impact on GP/Clinician time	Communications and engagement with GPs and clinicians Project support Support services

Appendix A – Logic Model (attached separately)

Appendix B – Evaluation Plan (attached separately)

Appendix C – Advice and Guidance Steering Group

Andrea Popplewell	SRFT	IM&T
Andrew Gardner	SRFT	Clinical Support: Dermatology and Endoscopy
Annette Donegani	CCG	Service Improvement Team
Ian Senior	CCG	Service Improvement Team
Jim Ritchie	SRFT	Consultant (Renal) and Control Centre Clinical Lead
Nawar Bakerly	SRFT	Consultant (Respiratory)
Paul Bishop	SPCT	GP / Clinical Lead Neighbourhoods
June Roberts	ICO	Ass Director Transformation
Tom Regan	GP	GP / Clinical Lead IT
Tony Holmes	SRFT	Service Manager (TBC)
Toni Coyle	SRFT	Clinical Support Services
Julie Perkin	SRFT	Health Records Management
Jo Evans	Haelo	Senior Improvement Advisor
Sam Dickens	SRFT	Acting Divisional Director (neurosciences)
Peter Paine	SRFT	Consultant (gastroenterology)
Stephanie Carlisle	SRFT	Lead Operation Manager (Respiratory)
Chris Marshall	SRFT	Management Accounts (Finance)
Vicky Beresford	SRFT	Service Manager (Cardiology)
Mel Norton	SRFT	Service Manager (Gastroenterology)
John Macdonald	SRFT	Consultant (Cardiology)
Kirsty Macdonald	SRFT	Service Lead (General Surgery)

Appendix E – Standard Operating Procedure (attached separately)

Appendix F – Core requirements of an Advice and Guidance platform

Developed based on learning from pilot testing with eRS system and feedback from MDSAS in Dermatology services:

1. Automatic inclusion of all patient demographic information to a request, including name, DOB, registered GP, NHS number.

2. Full integration with eRS referral tools / chosen referral management software, to enable a request to be automatically converted into a referral either to clinic or for further investigation without requiring new/duplicated input of information and also so the tool is accessible to services outside of Salford referring to SRFT

3. Automatic population and integration of conversation into patient records on both primary and secondary care side (EMIS, Vision and Patient Access) once closed

4. Logins synchronised with existing login or do not require complex password resets or SMARTcard access

5. Enable immediate text-based communication between consultants and GPs

6. Ability to upload images from device immediately, e.g. via QR scanner, compliant with information governance requirements (no copies of image saved)

7. Ability to attach other items easily, e.g. copies of test results and scans, medication lists, etc.

8. Intuitive user-friendly interface with immediate access to training and how-to-guides

9. Alert system to enable clincians in both primary and secondary care to be notified that a request is pending action (e.g. an alert of a new request or a new response), as well as straightforward functionality to manage and access current requests and their status (e.g. “awaiting response”)

10. Ability to extract content of A&G requests submitted over a time period to enable thematic analysis of requests to establish a learning system for clinicians