WELCOME TO

NHS Elective Care Conference North

18th May 2023 - 8:00am – 2:30pm – Manchester

Conference hosted by Convenzis Group Limited

NHS Elective Care Conference North

Chairs Opening Address

Mr Anil Vara

Director, Elective Care & Recovery - **North Yorkshire and Humber ICB**

NHS Elective Care Conference North

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Welcome to the conference, what are you looking to gain out of today’s conference?

ⓘ Start presenting to display the poll results on this slide.

NHS Elective Care Conference North

SPEAKING NOW

Mr Anil Vara

Director, Elective Care & Recovery - **North Yorkshire and Humber ICB**

I will be discussing...

"Demand tools/techniques for demand management and ongoing care for the patient"

NHS Elective Care Conference North

SPEAKING NOW

Sir James Mackey

National Director of Elective Recovery / CEO NHS England / Northumbria Healthcare NHS Foundation Trust

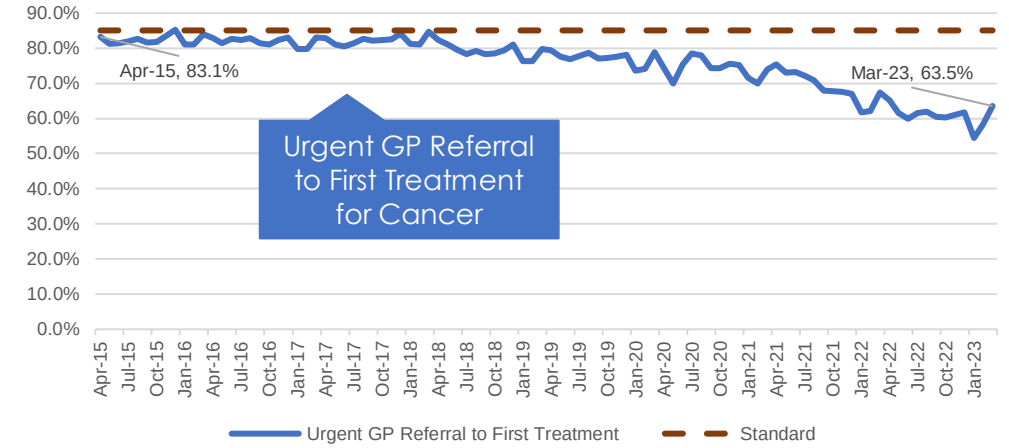
I will be discussing…

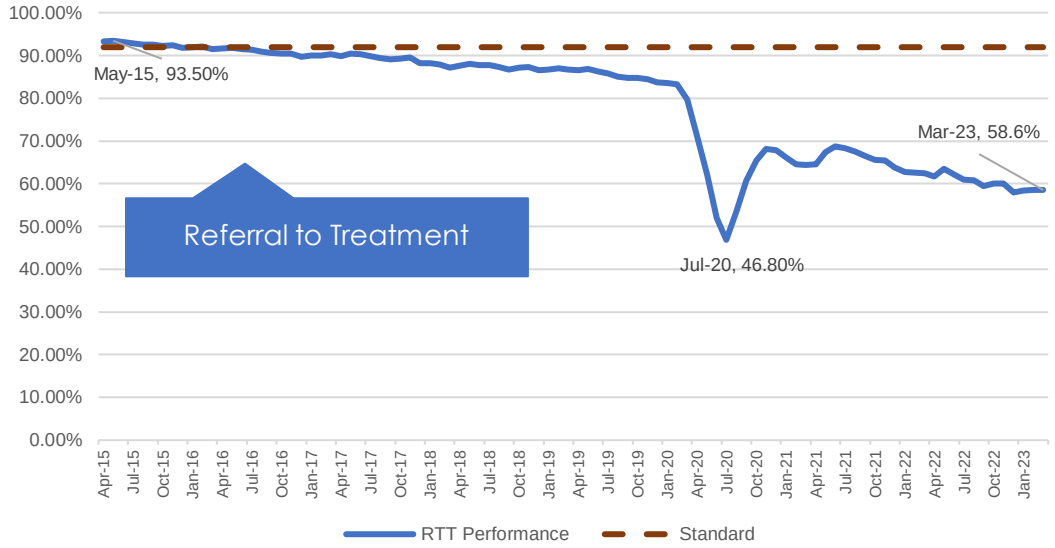
"Elective Recovery"

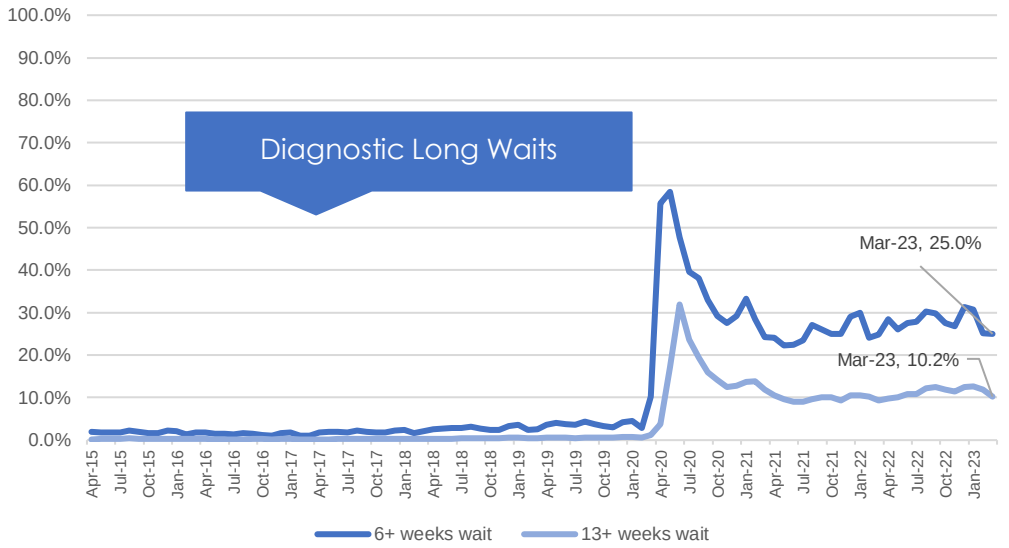
Elective Recovery
Sir James Mackey

May 2023

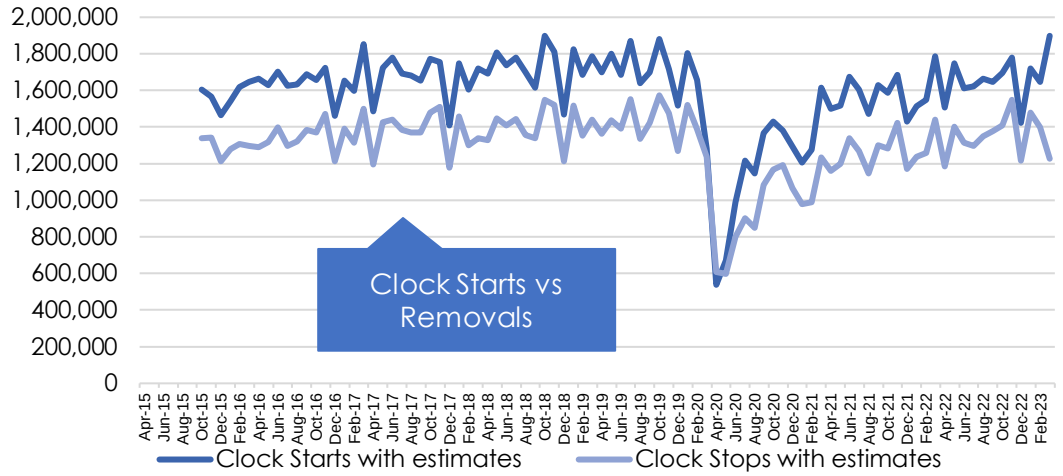
Performance was already declining and the pandemic has made the situation more challenging

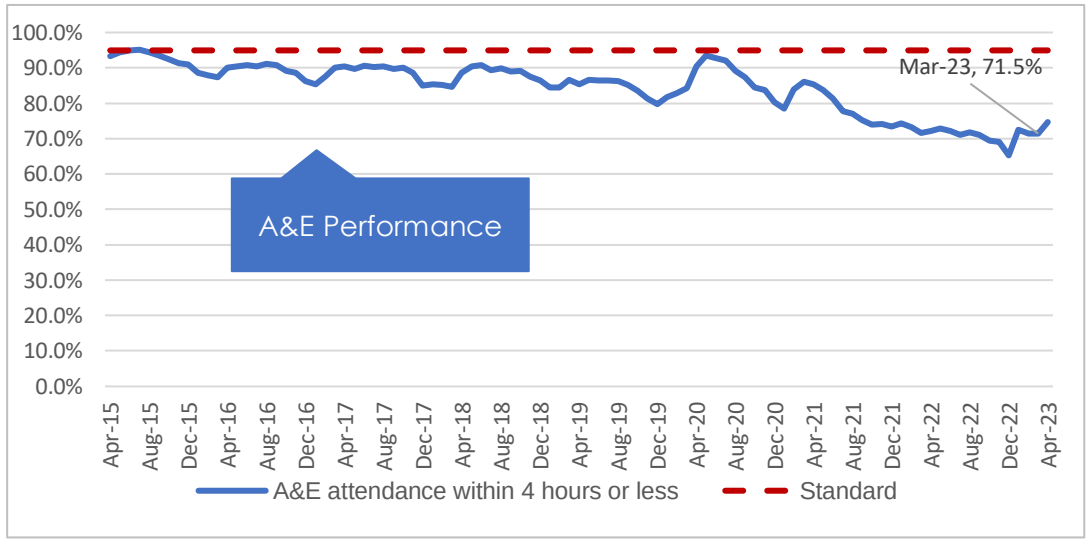


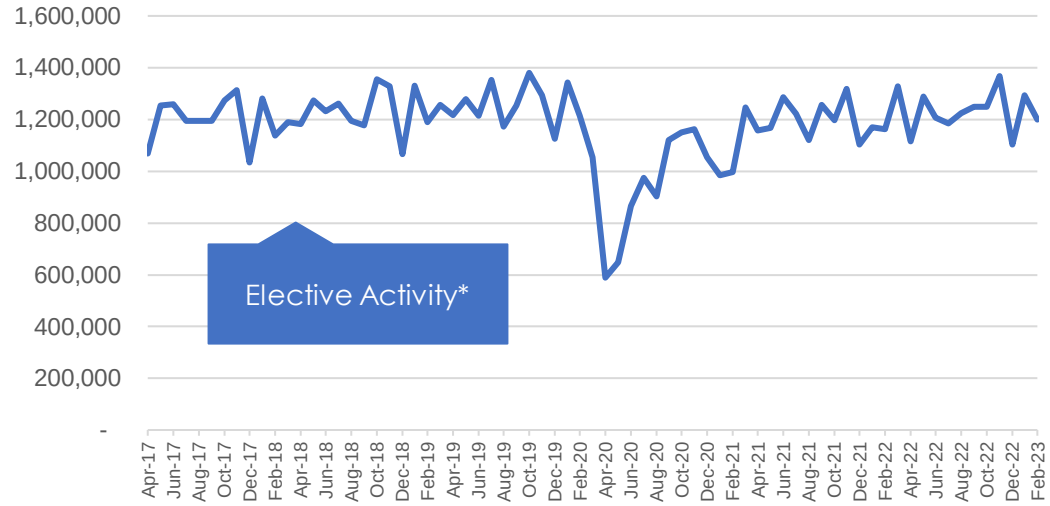




Performance was already declining and the pandemic has made the situation more challenging cont.



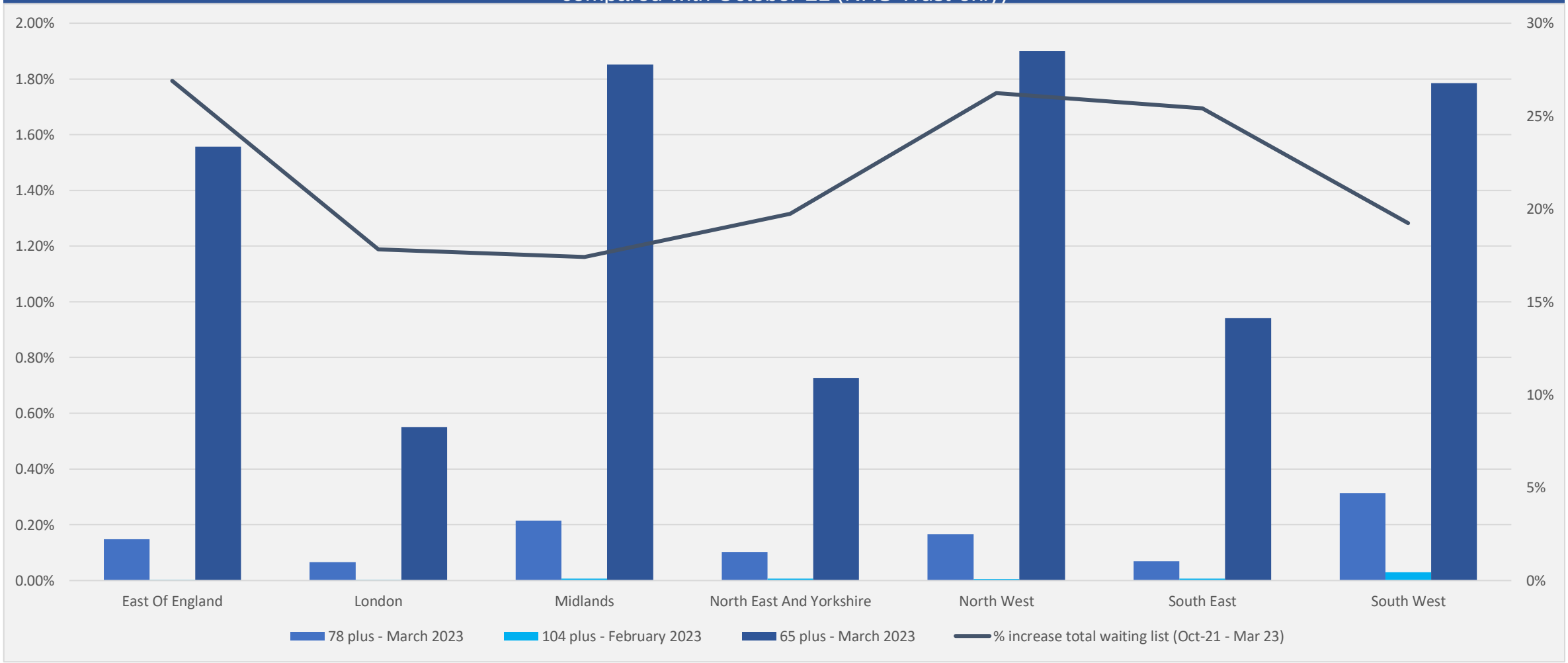




*Cost Weighted Activity Volumes Across Elective PODs (DC, Ordinary Elective, OPFA, OPFU)

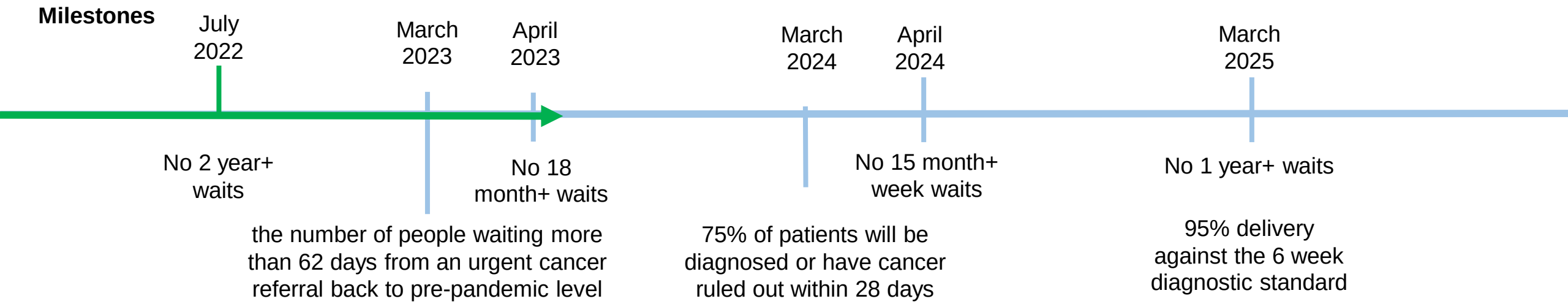
The wider waiting list challenge is not equal across regions

Proportion of patients waiting 65ww/78ww/104ww as a total of overall waiting list (31st March) and overall % growth in total waiting list March 2023 compared with October 21 (NHS Trust only)



Source: Monthly RTT (published) includes estimate for missing

We are just over one year in to a three-year recovery plan



We have made very good progress on reducing the number of long waits, which is at the centre of the 'Delivery plan for tackling the COVID-19 backlog of elective care'. We have developed a delivery architecture which enables a focus on long waiting patients, whilst also delivering service transformation and improvement support.

Whilst it is important to take this opportunity to reflect on the successes and learning in the last year, there is still a lot to do. Each cumulative target in the delivery plan asks more of the system, in a time when there are multiple system pressures and the workforce, our people, are incredibly stretched.

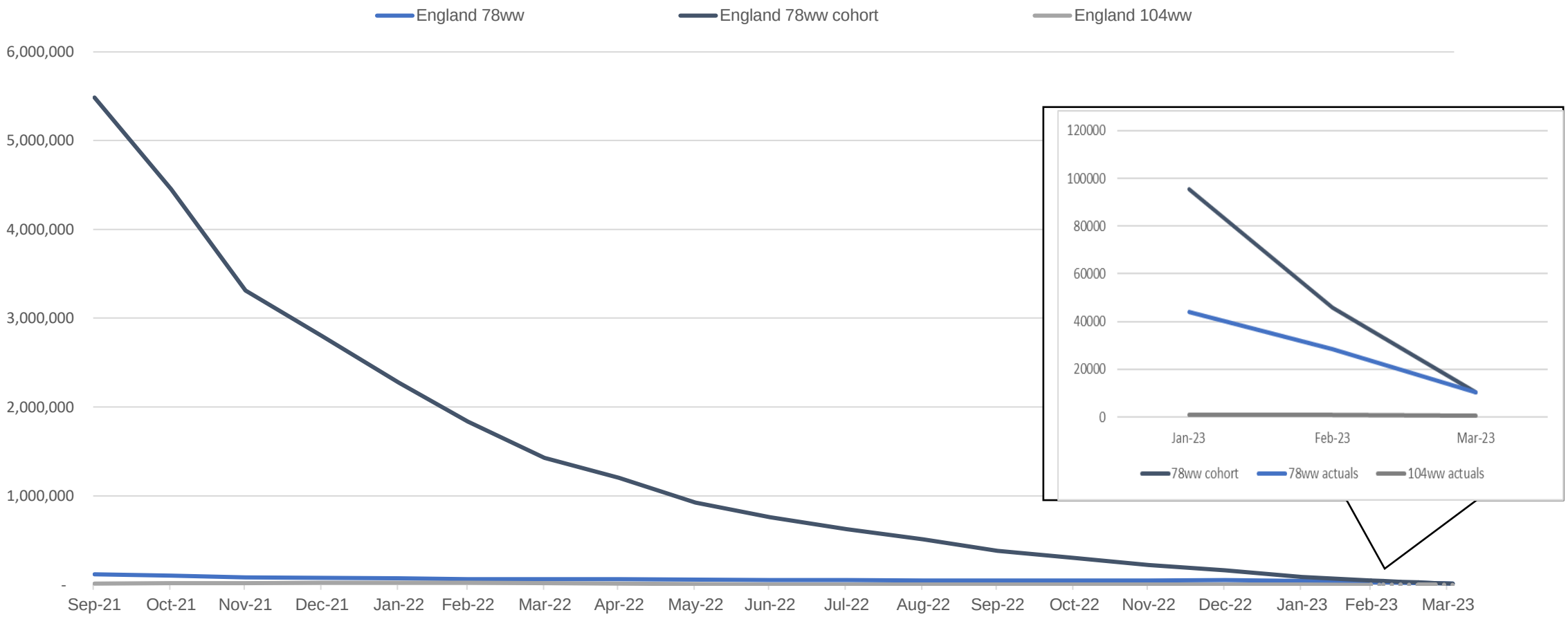
We will achieve our ambition to recover services only through real transformation: separating emergency and elective, getting the basics right, rethinking outpatients delivery, implementing best practice in clinical services and empowering patients to be partners in their own pathway.

The published ‘Delivery Plan for tackling the COVID-19 backlog of elective care’ sets out our recovery priorities

The plan makes clear the actions that we are going to take, that ultimately support increased activity levels to address waiting times and experience of elective care

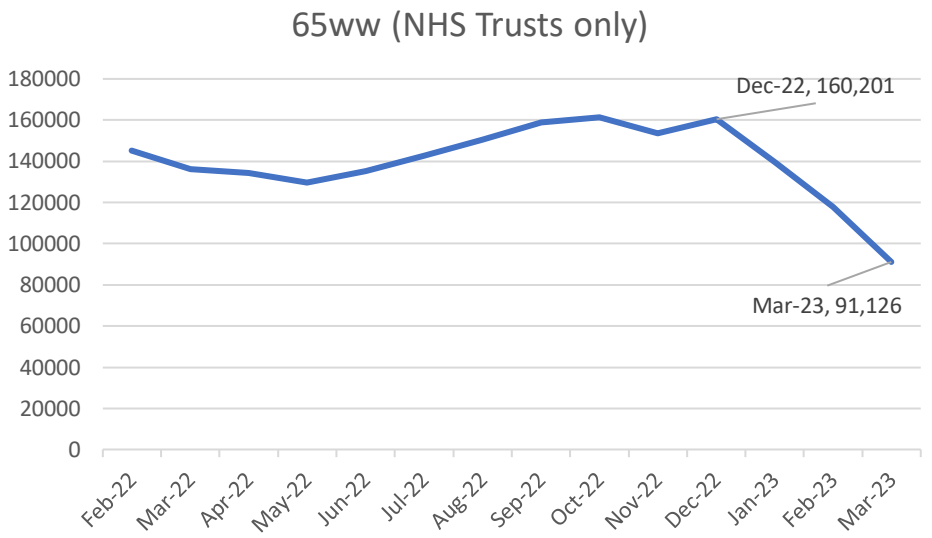
Transform services	Prioritise those in greatest clinical need
Maximise the potential of data and technology	Giving patients more information and choice
Expand our workforce	Improving patient experience
Expand and separate our physical capacity	Addressing inequalities in health outcomes

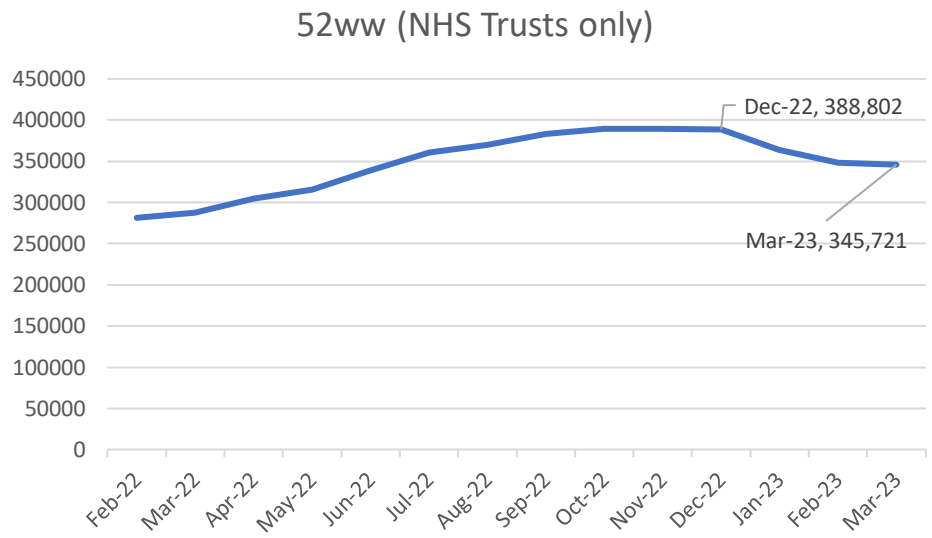
What have we delivered on for long waiting patients?



Data Source: RTT Monthly Published / WLMDS

How are we delivering on 65 and 52 week waiters?



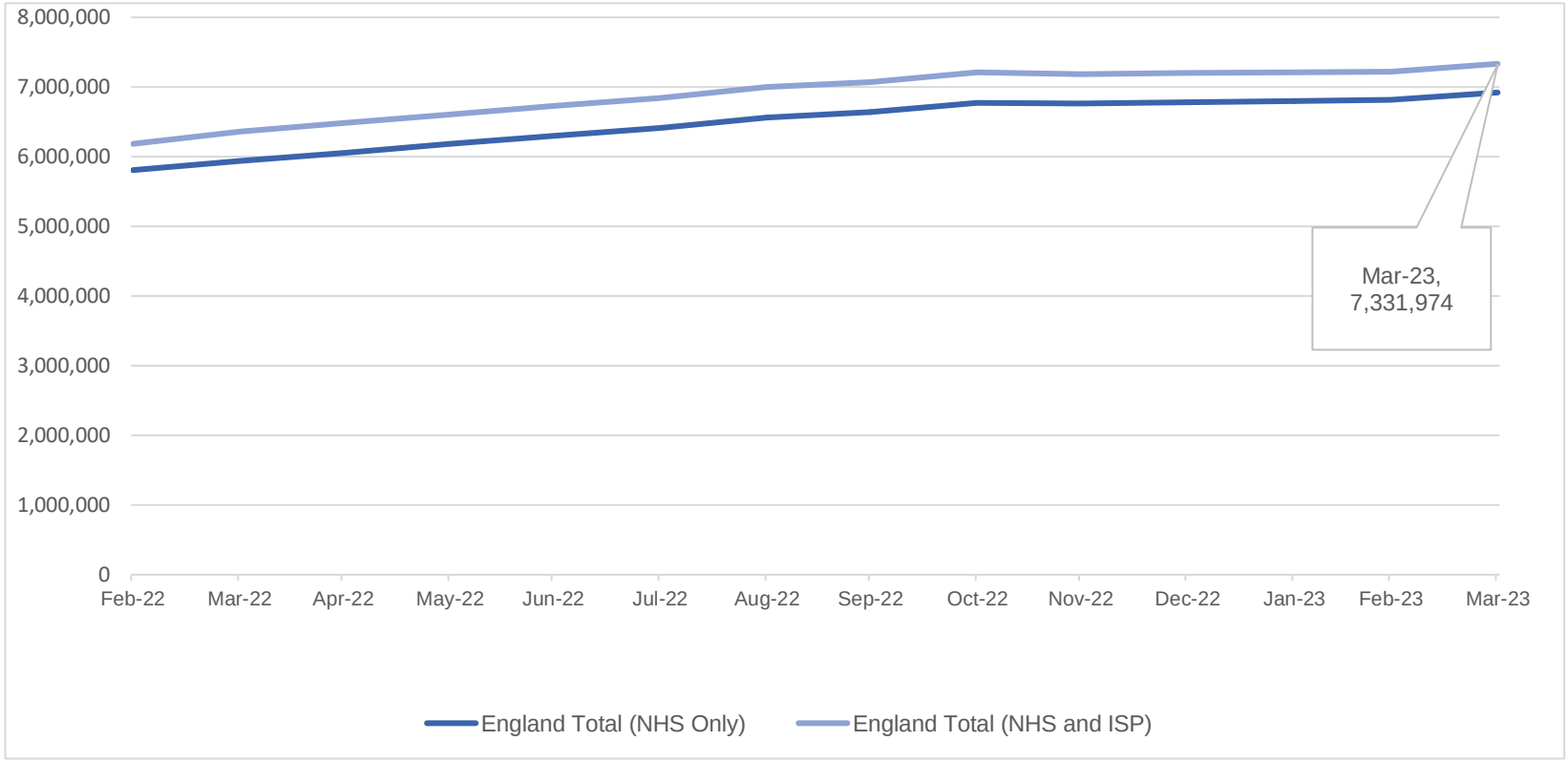


Since Christmas both the volume of patients waiting over 65ww and 52ww have consistently reduced each month. With March 23 position reducing by 43% for 65ww and 11% for 52ww compared with December 2022.

In addition, we are starting to see the waiting list stabilise

The Delivery Plan did not put a timescale or target on the overall waiting list reducing, but clearly this is key to overall recovery

We are pleased to see that the overall waiting list numbers are starting to stabilise, as a result of the actions we have been taking to address long waits and improve efficiency



What have we learnt?

We have made massive progress over a very tricky period and the NHS should take confidence from this. All delivery takes place in the context of the broader health and care system (UEC, cancer, social care, primary care)

We need to continue to be very clear about prioritisation and impact – ***for the people involved and affected.*** We need to transform services whilst keeping the patient at the heart of them.

What we know works

- Identifying the cohorts of long waiters
- Booking the cohort
- Challenging prioritisation and order
- Working with the most challenged providers through the tiering system
- Understanding and improving the quality of local and national level data
- Delivering excellence in basics- operation management of booking and validation
- The utilisation of mutual aid

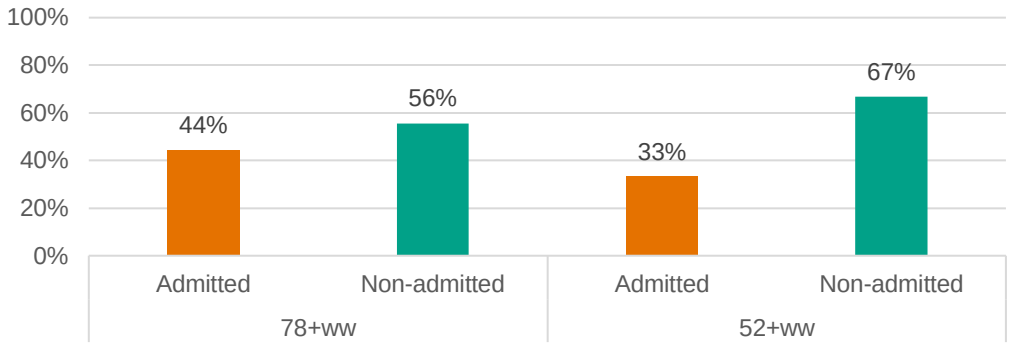
Case study: North Bristol Trust (NBT)

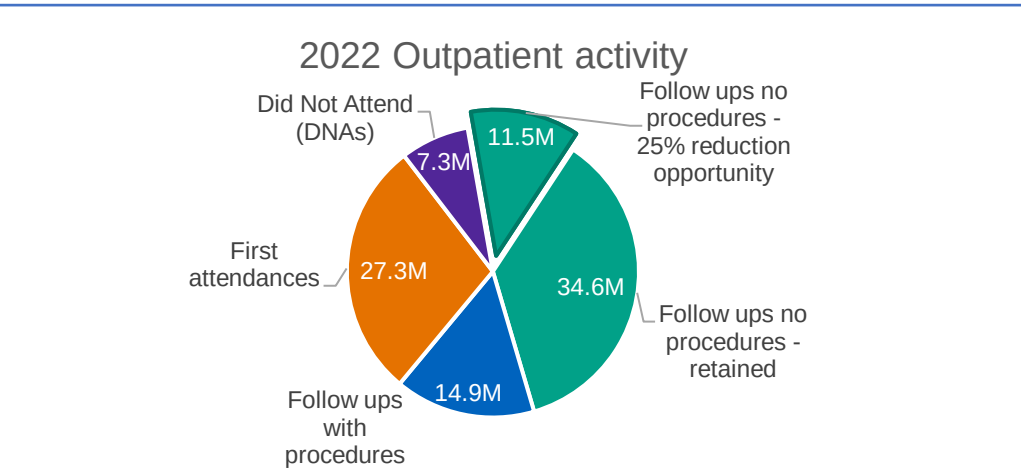
End of July 2022, NBT were at position 1 nationally as having the worst Cancer backlog position (34.4% of waiting list was >62 days) mostly due to reactionary approach to managing PTL, process issues and engagement and vacancies. **Within 10 weeks** they were at position 65 with 7.7% of patients waiting >62 days.

What did they do?

- Recruitment and retention focus for Cancer Services team: Exec sponsorship and engagement, HR support for rapid recruitment; training lead in cancer services team
- National, regional and local engagement: on-site weekly improvement support from Regional Cancer Improvement Lead and additional validation support (including funding for external validators and regional support in validating PTL)
- Reviewed and strengthening PTL processes: supported by Regional Cancer Improvement Lead, linking in with national team, other Trusts elsewhere

The vast majority of the waiting list is Outpatients - as such, transforming Outpatient services and increasing Outpatient activity remains a focal point of delivering our long waits ambitions





- As of December 2022, **of the 7.2m patients with an active RTT pathway, c.85% were on a non-admitted pathway**. Of the **406k** 52+ week waiters, **c. two thirds** were on a non-admitted pathway.
- In 2022, **88m** outpatient appointments were attended nationally. Of these, first attendances accounted for **27.3m** appointments whilst **follow ups accounted for 61m appointments**. In the same period, Did Not Attends (DNAs) accounted for **7.3m** appointments.
- A **25%** reduction in follow up attendances without procedures could **release the capacity of up to 1m appointments per month and 11.5m freed up appointments in the year.**
- To achieve this, we need to reduce follow up appointments by c.**1m** per month, or **22,600** per week nationally. To note, it will not be clinically appropriate to reduce follow up appointments across all specialties. Decisions of which specialties the reduction ambition should apply to, will be clinically led and locally managed.
- A key component of reducing follow ups is making progress on PIFU. There has been varied performance on the **5% PIFU ambition** (which was due to be met by March 2023), **with many providers not having met the target, so the new Outpatient Productivity Plan will be key to promoting action and addressing variation.**

7.2m patients on waiting list

c.**85%** of the waiting list is in Outpatients

70% of 52+ WW are in Outpatients

69% of Outpatient appointments are follow ups

Key interdependencies to elective recovery

We are committed to delivering on the next milestones of the Elective Recovery Plan, but in order to do this we need to be aware of the key interdependencies and work together on the challenge ahead.

- Workforce, including supporting the development of the admin and clerical workforce
- Urgent and Emergency Care
- Industrial Action
- Finance
- Primary care (key link for delivery of Outpatient objectives)
- Digital development in support of waiting list validation, including the Improving Elective Care Coordination Programme (IECCP)
- Health Inequalities, including children and young people

Some specific challenges for us now…..

- Workforce, including supporting the development of the admin and clerical workforce
- Waiting list just over 7m (broadly stable before IA)
- This is c6m people (patients on multiple pathways, duplicates, errors etc)
- 80% will end their episode in OP or diagnostics
  - Of these, a very large proportion will have limited clinical action sinister diagnoses ruled out, lifestyle and aging symptoms etc etc)
- Only 3% will have an IP overnight stay
- We could see 60-70m patients in OP reviews this year
- We could have c10m DNAs (8m of which are for reviews)
- Forecasts suggest c 200k 52 week waits at end March ‘24

Some specific challenges for us now…..

- Continue with focus on long waits
- Sustainable change and shape of the curve…
- 52 Weeks and the OP challenge
- Interplay with UEC, Primary care, social care etc
- IA disruption and workforce
- More local focus and drive

But……..
Have confidence…. and thanks…….

NHS Elective Care Conference North

SPEAKING NOW

Aimee Robson

Deputy Director – Personalised Care - **NHS England**

I will be discussing…

"Supporting elective recovery- the pivotal role of personalised care"

Supporting elective recovery- the pivotal role of personalised care

Aimee Robson, Deputy Director of Personalised Care Community health services
NHS England
@AimeeRobson4

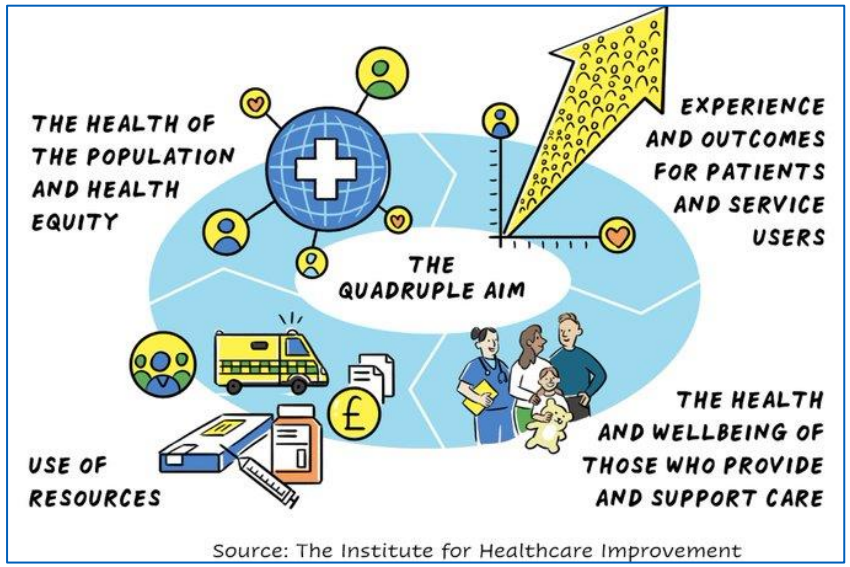
May 2023

Facts to get us going …

1 in 7 people have “post decision regret” in England

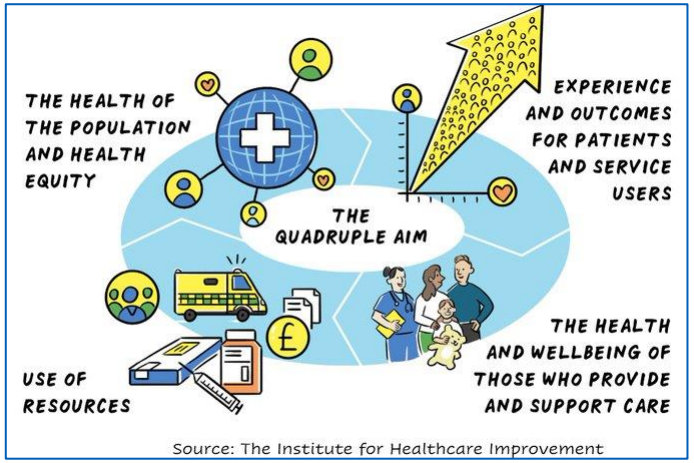
5 in 10 people don’t feel included in the decisions about their care in England nor have done for the past 10 years

Where people lack confidence around health and wellbeing, they are 10x higher utilisers of health and care services



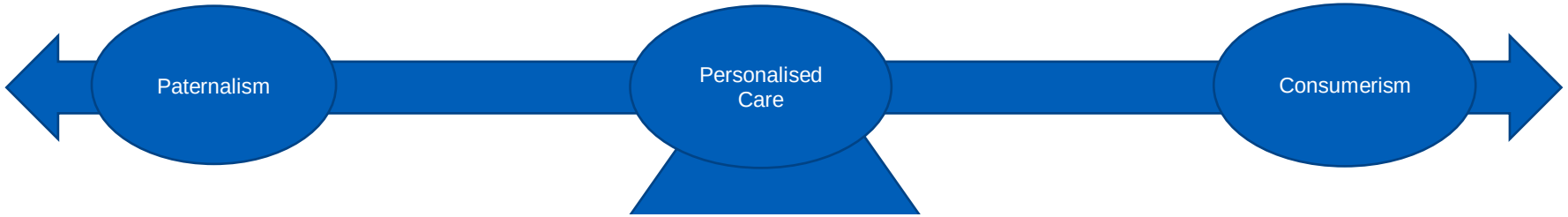
Key points and take away messages

- Personalised care is not consumerism
- Shared decision making (SDM) improves system efficiency and reduces litigation
- We don’t do SDM well (patient data tells us this)
- Clinically Validating Elective Surgical waiting lists- must include SDM to deliver effectively
- If you’re not already using DSTs in your elective units for HVLC - you're missing opportunity for better outcomes and more efficiency
- Short e-learning SDM refreshers available for free including virtual patient for immediate feedback on SDM skills



Source: The Institute for Healthcare Improvement

Personalised Care is enabling approach to care, supporting a person's agency



Power in the community- essential support to elective recovery is admission avoidance

- **High frequency users of primary care** are often those highest at risk of unplanned admissions. Identifying and offering proactive personalised care through care coordination, health coaching and social prescribing can provide non clinical interventions. 20% of unplanned admissions are due to non-medical reasons. If we address these well we could reduce unplanned admissions by 120k in England per annum.
- **Personal health budgets** put people and their families in control, help them to tailor these resources to their needs and wishes, and can support people – particularly those experiencing health inequalities – to leave hospital earlier and safely. We are on track to meet the LTP commitment of **200,000 people** having received a personal health budget by 23/34, which includes some one-off personal health budgets that facilitate hospital discharge.
- **Acute Respiratory Infection (ARI) Hubs** have continued to grow with 355 hub sites being reported as already set up or planned. The number of face to face appointments between December 2022 and March 2023 was 552,098 and the total number of appointments delivered to include remote and expanded usage was 694,831. ARI hubs address same day urgent demand, by making better use of capacity and reducing pressure on primary and acute care.
- **Urgent Community Response** services have been consistently meeting or exceeding the 70% 2-hour standard, reducing pressure in Out of Hours services and Primary Care

552,098

ARI Hub appointments delivered between December 2022 and March 2023.

100,000+

Individuals with a Personal Health Budget including some one-off personal health budgets that facilitate hospital discharge.

81%

Coverage of 2-hour Urgent Care Response 8am-8pm, 7 days a week at a minimum, across all 42 integrated care boards (ICBs), April 2023.

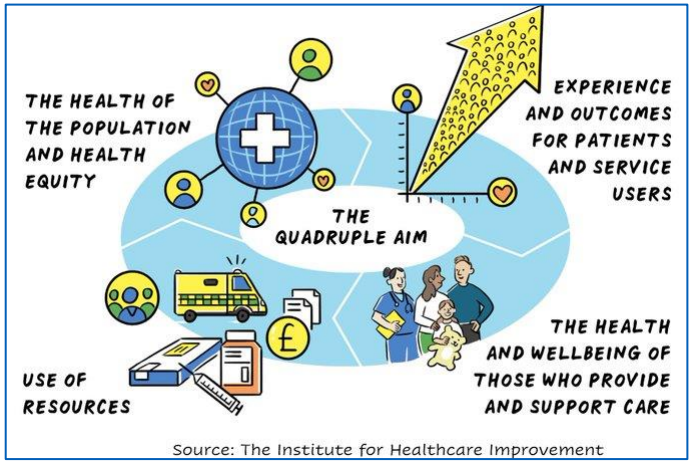
Why? So what?

Moral, ethical and legal imperative for personalised care

1. People/patients want their preferences understood, respected and acted upon- **Moral, ethical & medio-legal imperative** ***(Montgomery v Lanarkshire)***

2. **Evidence based healthcare** = evidence + clinical expertise + *individual patient preferences*

3. **Outcomes of care are better** – higher value of care, workforce more satisfied, patient outcomes better system outcomes improved, financial savings, less litigation

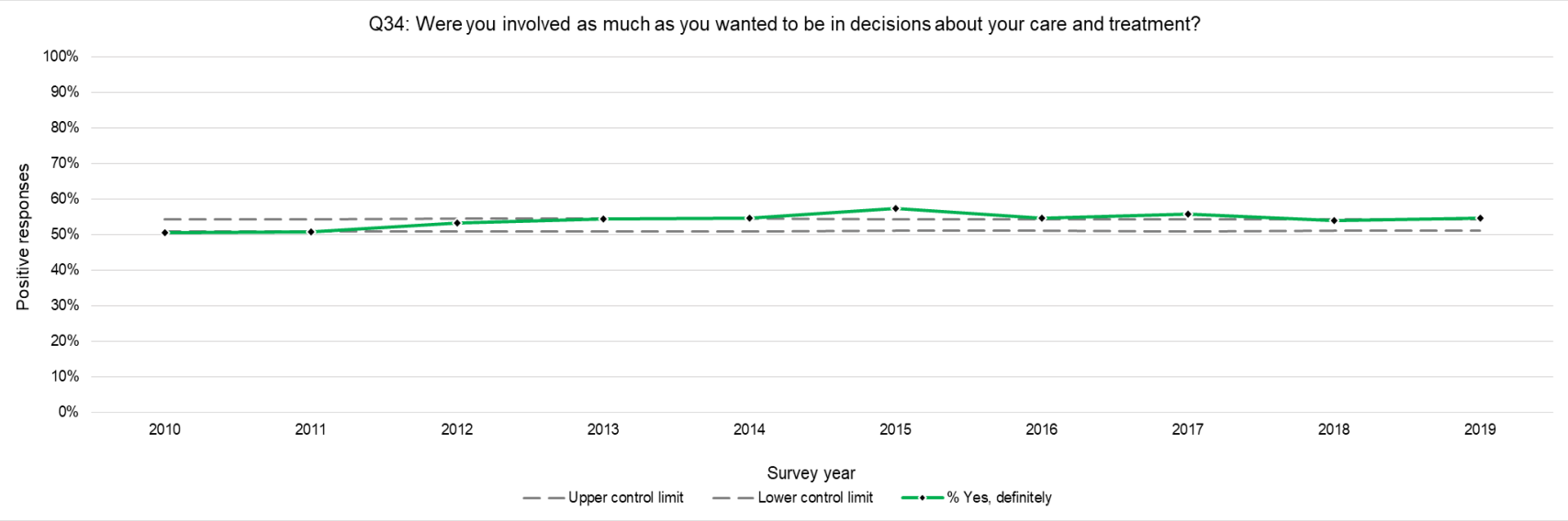


Isn't this happening anyway?

Sharp rise in NHS negligence claims for lack of informed consent

Negligence claims against the NHS due to failure to inform patients before they consent to procedures have spiralled up since a landmark legal ruling in 2015, a new study has found.

19 March 2020

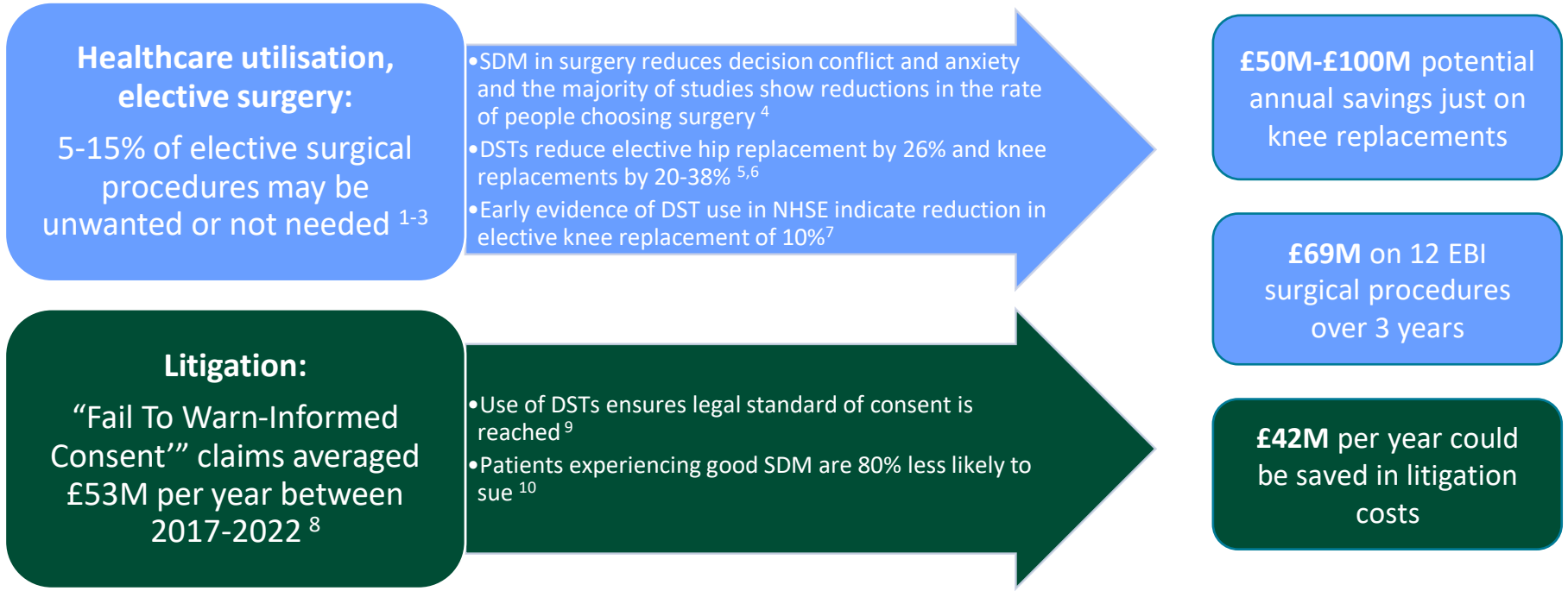


N respondents= 64,794
(2019- acute survey)

Data library - NHS Surveys

Benefits to be realised of Shared decision making: elective care and litigation

Shared decision making (SDM) and tools to facilitate this in clinical consultations lead to significant cost savings



Decision support tools and High Volume Low Complexity (HVLC)

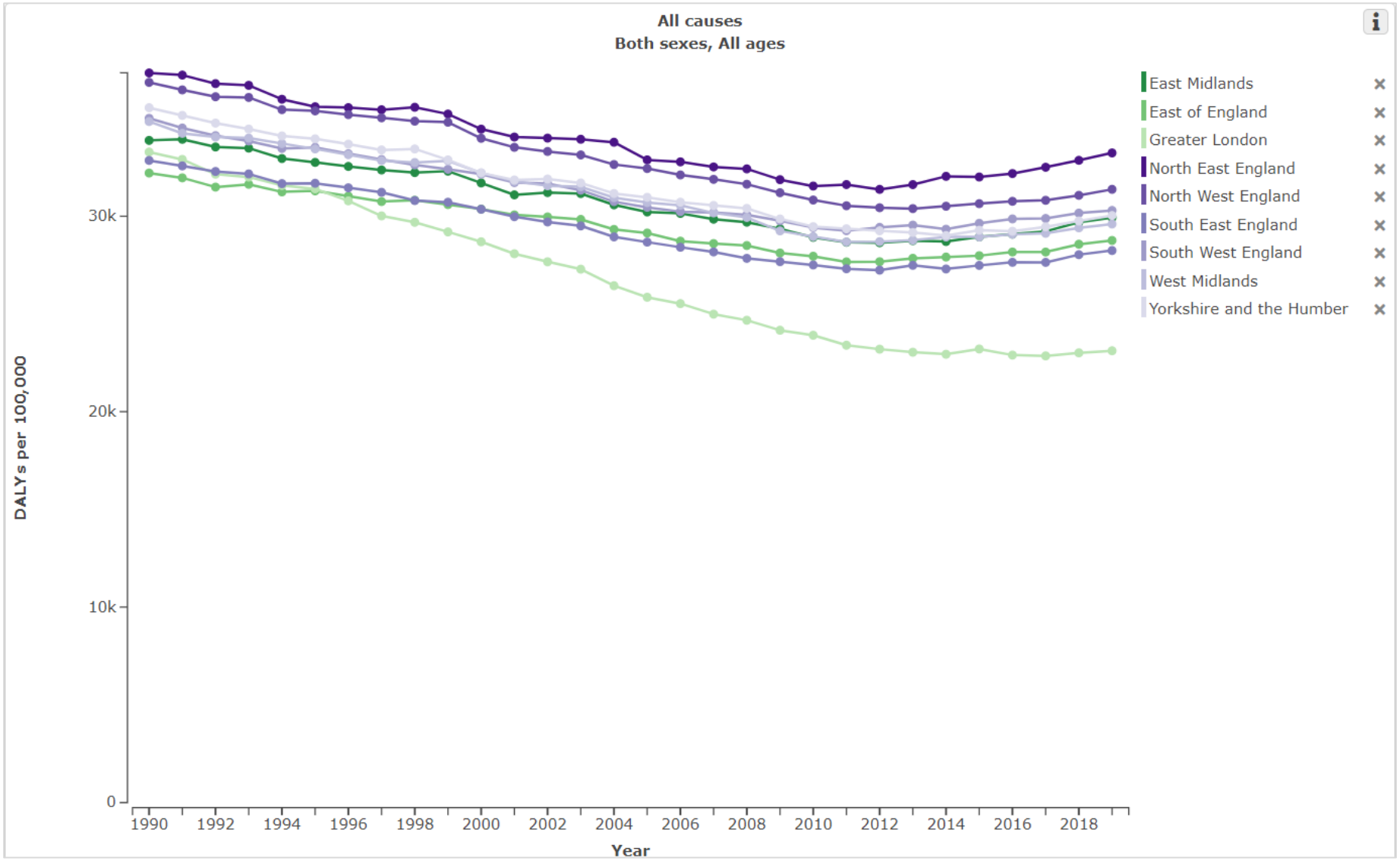
Since April 2021, we commissioned DST to align to elective priorities in England in the large 6 specialities for volume to reach most people for benefits to be realised

Tools prioritised by OPCS and HVLC in April 2021

T&O	Ophthalmology	Cardiac	ENT	Urology	General surgery	Gynae	NOT relating to elective
OA knee (TKR)	Cataracts	Atrial fibrillation	Tonsillectomy (referral and surgical decisions)	23/24	23/24	23/24	23/24
OA hip (THR)	Wet AMD	TAVI vs open (severe aortic stenosis)					
Dupytrens	Glaucoma						
CTS release							
✓	✓	✓	✓	🎯	🎯	🎯	🎯

[NHS England » Decision support tools]

Global burden of disease: Disability Adjusted Life Years (DALY)



https://vizhub.healthdata.org/gbd-compare/

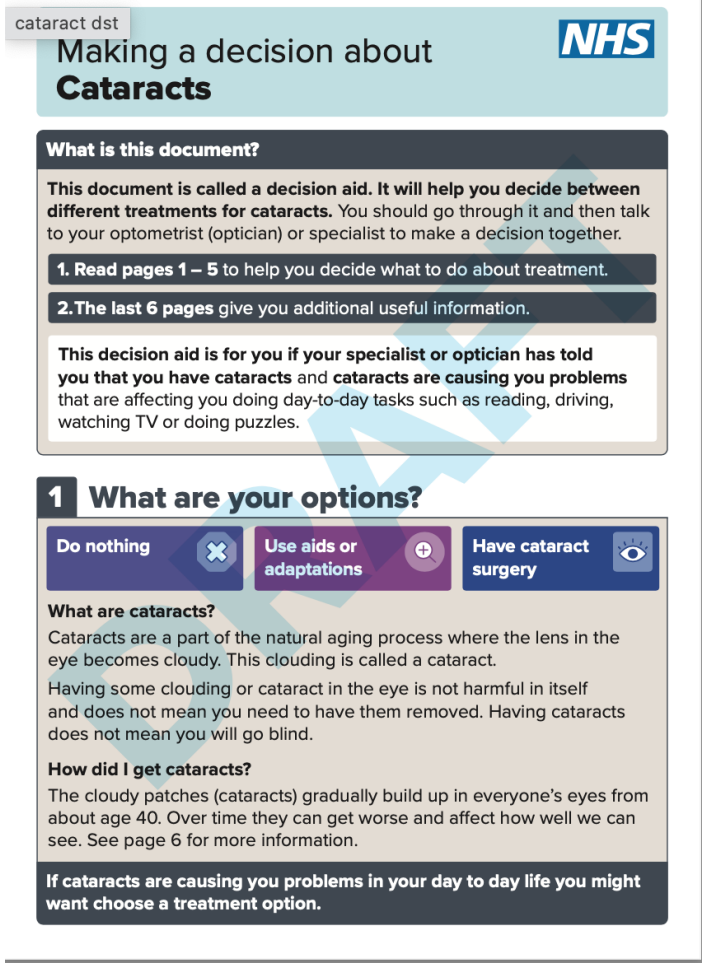
> “Variation in care is rarely a problem of recalcitrant doctors and nurses being unwilling to learn or resistant to change, but rather is the result of a system that has evolved to perpetuate variation.”

https://catalyst.nejm.org/doi/full/10.1056/CAT.19.1083?cid=DM83521&bid=124047460

What works to address this??

https://www.england.nhs.uk/ourwork/clinical-policy/ltc/house-of-care/

Decision support tools & Consent
And in every GIRFT pathway



cataract dst

Making a decision about
Cataracts

What is this document?

This document is called a decision aid. It will help you decide between different treatments for cataracts. You should go through it and then talk to your optometrist (optician) or specialist to make a decision together.

1. Read pages 1 – 5 to help you decide what to do about treatment.

2. The last 6 pages give you additional useful information.

This decision aid is for you if your specialist or optician has told you that you have cataracts and **cataracts are causing you problems** that are affecting you doing day-to-day tasks such as reading, driving, watching TV or doing puzzles.

1 What are your options?

Do nothing | Use aids or adaptations | Have cataract surgery

What are cataracts?

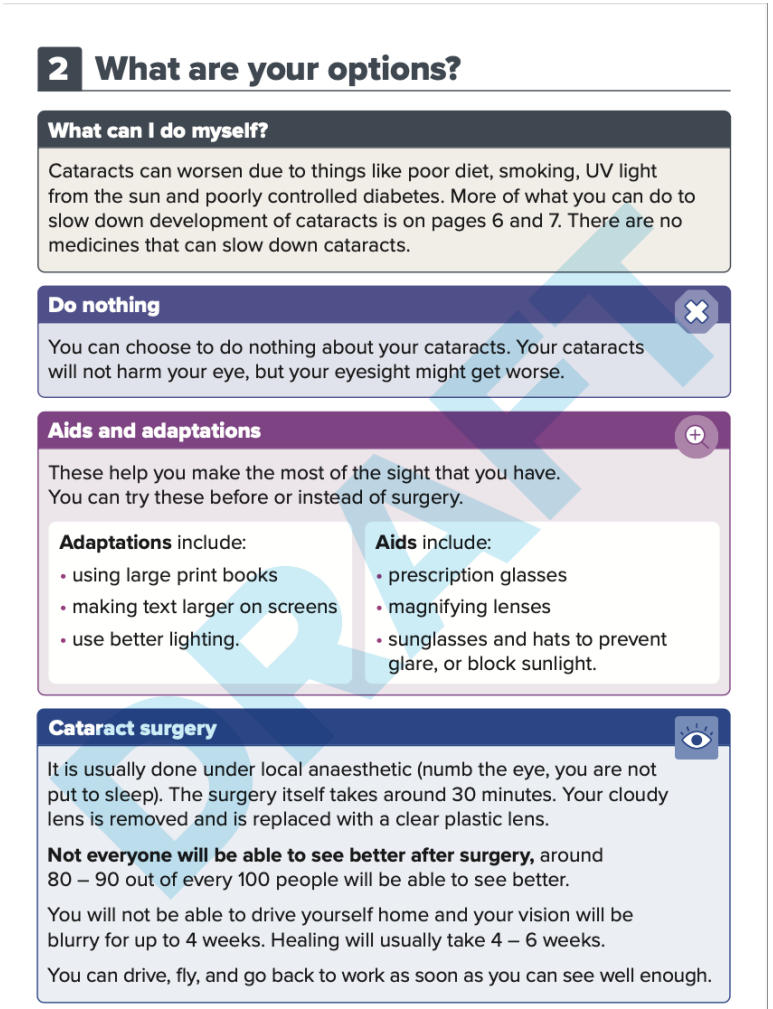
Cataracts are a part of the natural aging process where the lens in the eye becomes cloudy. This clouding is called a cataract.

Having some clouding or cataract in the eye is not harmful in itself and does not mean you need to have them removed. Having cataracts does not mean you will go blind.

How did I get cataracts?

The cloudy patches (cataracts) gradually build up in everyone's eyes from about age 40. Over time they can get worse and affect how well we can see. See page 6 for more information.

If cataracts are causing you problems in your day to day life you might want choose a treatment option.



2 What are your options?

What can I do myself?

Cataracts can worsen due to things like poor diet, smoking, UV light from the sun and poorly controlled diabetes. More of what you can do to slow down development of cataracts is on pages 6 and 7. There are no medicines that can slow down cataracts.

Do nothing

You can choose to do nothing about your cataracts. Your cataracts will not harm your eye, but your eyesight might get worse.

Aids and adaptations

These help you make the most of the sight that you have. You can try these before or instead of surgery.

Adaptations include:
- using large print books
- making text larger on screens
- use better lighting.

Aids include:
- prescription glasses
- magnifying lenses
- sunglasses and hats to prevent glare, or block sunlight.

Cataract surgery

It is usually done under local anaesthetic (numb the eye, you are not put to sleep). The surgery itself takes around 30 minutes. Your cloudy lens is removed and is replaced with a clear plastic lens.

Not everyone will be able to see better after surgery, around 80 – 90 out of every 100 people will be able to see better.

You will not be able to drive yourself home and your vision will be blurry for up to 4 weeks. Healing will usually take 4 – 6 weeks.

You can drive, fly, and go back to work as soon as you can see well enough.

[NHS England » Decision support tools]

About Virtual Patient

The PCI's Virtual Patient learning resource, commissioned by NHS England, uses non-immersive virtual reality to explore the key shared decision making (SDM) microskills of agenda-setting, teach-back, exploring patient preferences and reaching a shared decision.

Using Virtual Patient, health and care professionals can navigate a series of lifelike virtual consultations, allowing them test and develop their skills in a risk-free environment.

Virtual Patient has been launched to support the development of shared decision making skills after research by the Patient Association found that 46% of health and care professionals report gaps in their knowledge of SDM and 70% would like to learn more.

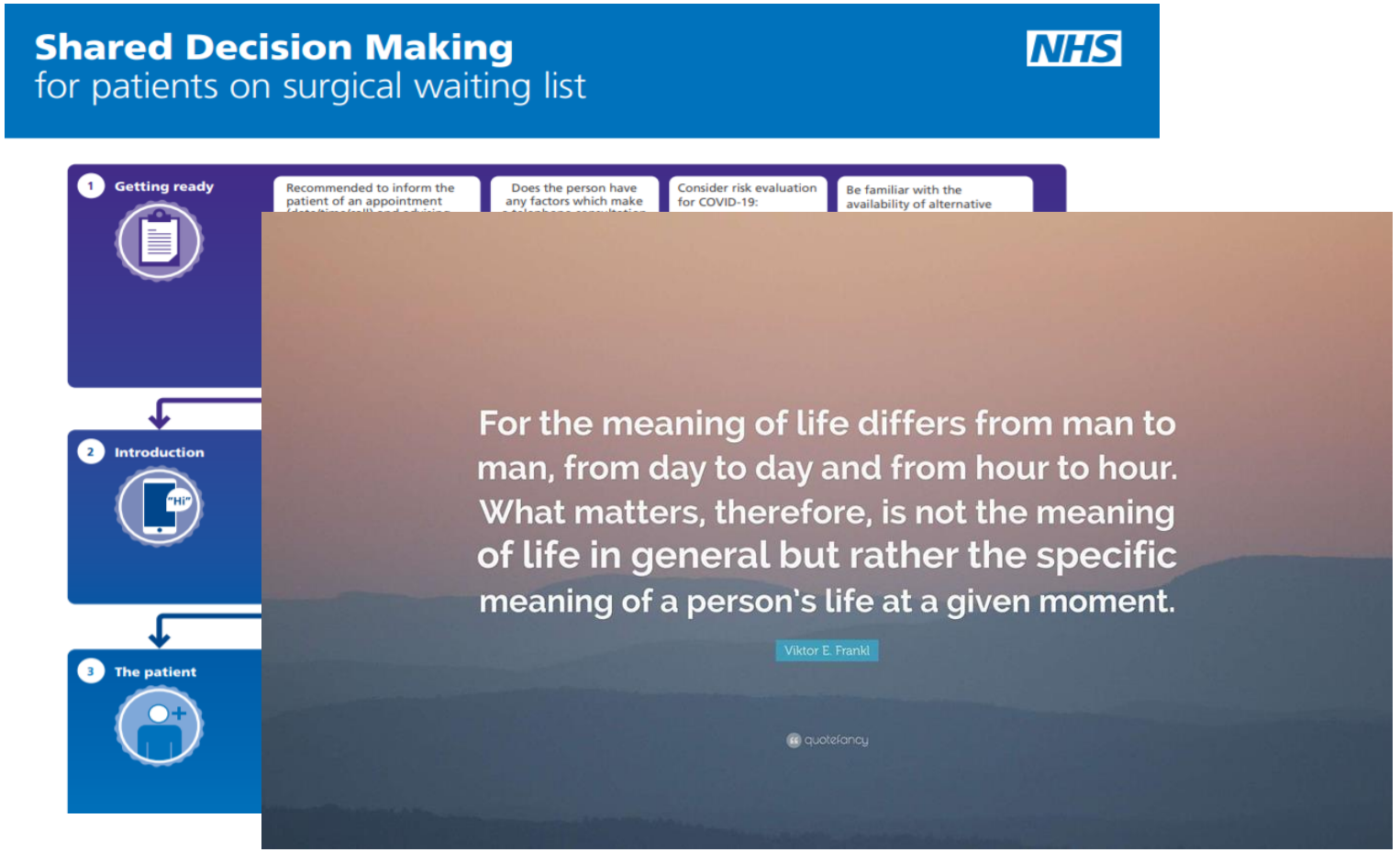
Shared decision making is a vital part of personalised care. It is an approach that has been shown to result in better patient outcomes and is increasingly welcomed by patients, with the 2022 GP Patient Survey finding that 44.6% of patients want more involvement than they currently have in their healthcare decisions

Video - Virtual Patient (osteoarthritis) in action

Personalised Care Institute

[Virtual Patient Avatars (personalisedcareinstitute.org.uk)]

Clinical Validation of Elective surgical waiting lists => Shared decision making



Care coordinator (workforce role in supporting peri-operative care setting

GETTING IT RIGHT FIRST TIME

Benefits for patients

- people feel more prepared for surgery;
- people are more empowered, active and involved in their care;
- better communication between people having surgery and healthcare teams;
- greater patient satisfaction with their care; and
- fewer complications after surgery, meaning people may feel well sooner and are able to resume their day-to-day life and employment more quickly.

Benefits for the NHS

- reduction in the length of time people stay in hospital after surgery;
- less use of intensive care units after surgery;
- fewer complication rates after surgery, helping the NHS make better use of resources; and
- reduced cost of care (or cost the same as conventional care).

Key points and take away messages

- Personalised care is not consumerism
- Shared decision making (SDM) improves system efficiency and reduces litigation
- We don’t do SDM well (patient data tells us this)
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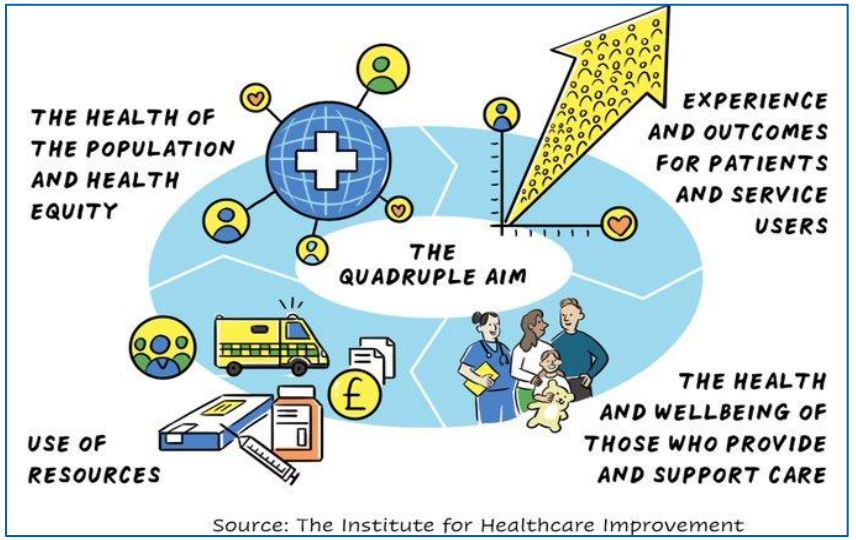

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8.Source: NHS Resolutions FOI

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NHS Elective Care Conference North

Q&A PANEL

Mr Anil Vara

Director, Elective Care & Recovery - **North Yorkshire and Humber ICB**

Sir James Mackey

National Director of Elective Recovery / CEO NHS England / Northumbria Healthcare NHS Foundation Trust

Morning Break, Networking & Refreshments

NHS Elective Care Conference North

Chairs Morning Reflection

Mr Anil Vara

Director, Elective Care & Recovery - **North Yorkshire and Humber ICB**

NHS Elective Care Conference North

CONVENZIS

UP NEXT...

sword

NHS Elective Care Conference North

SPEAKING NOW

Fernando Correia, MD PhD

Founding Team & SVP Clinical Affairs -
Sword Health

I will be discussing...

"How to fix waiting lists around Musculoskeletal Care"

sword

How to fix waiting lists around Musculoskeletal Care

May 2023
Fernando Correia, MD , PhD
Founding team and SVP Clinical Affairs

The Musculoskeletal epidemic

33%

Suffer from MSK Pain

£5bi

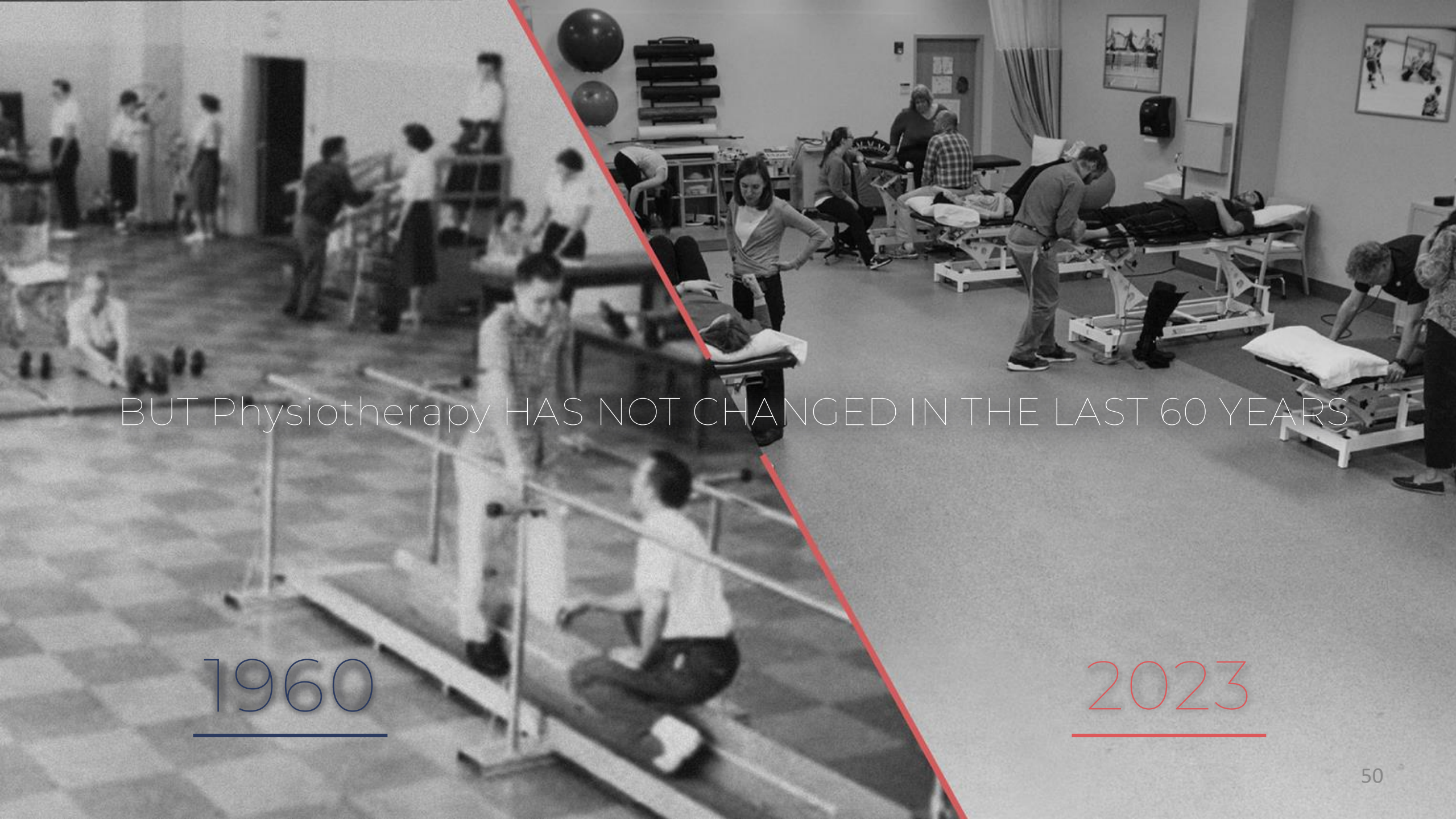
NHS spend per year

3rd largest area of spend

Source: https://www.gov.uk/government/publications/musculoskeletal-health-applying-all-our-health/musculoskeletal-health-applying-all-our-health

Physiotherapy should be the solution

Source: Br J Sports Med. 2020 Jan;54(2):79-86


BUT Physiotherapy HAS NOT CHANGED IN THE LAST 60 YEARS
1960
2023

Waiting lists

6–8 Weeks is the average time that patients wait to access physiotherapy in NHS UK[1]

1–2 Years for elective surgeries

[1] https://www.equipsme.com/blog/up-to-four-months-to-see-a-physiotherapist/.

Enter Sword Health

Tele-rehabilitation

OUR VISION

A pain-free world.
Powered by technology
Enhanced by people
Accessible to all

Sword's footprint

2015

Founded in Europe

Three

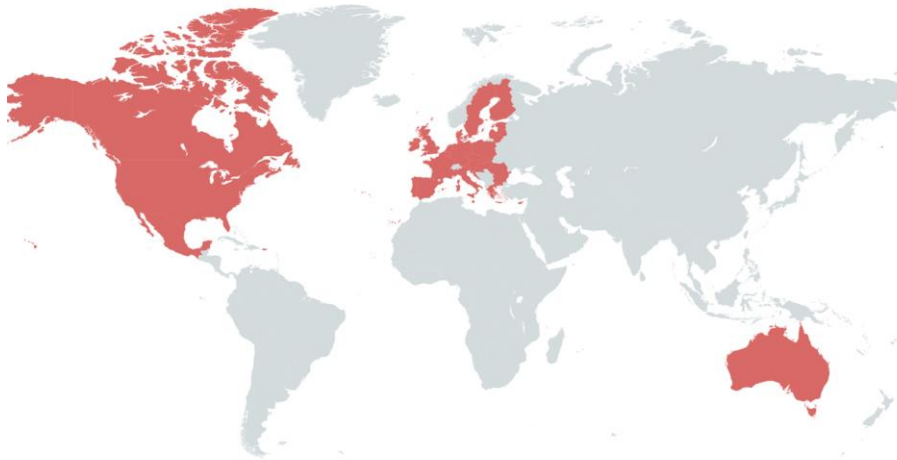
Continents and counting

6M+

Lives supported today

150k+

Patients Treated per year



GENERALI Humana QBE Allianz ZURICH cisco DELL pepsi ebay

Sword is the market Leader in Clinical Papers And Patents

The flagship innovation company for Digital MSK

22

Published
Scientific Papers

30

Submitted
Patents

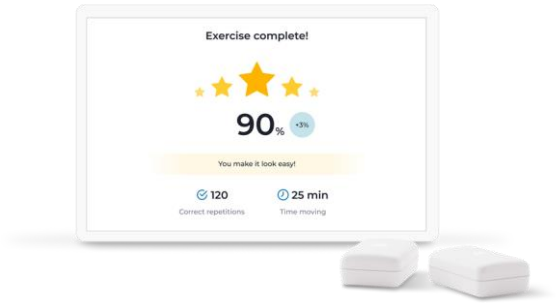
Sword Care Model

Sword programs are based on these 3 pillars

Addressing MSK disorders throughout the body while upholding the highest clinical standards

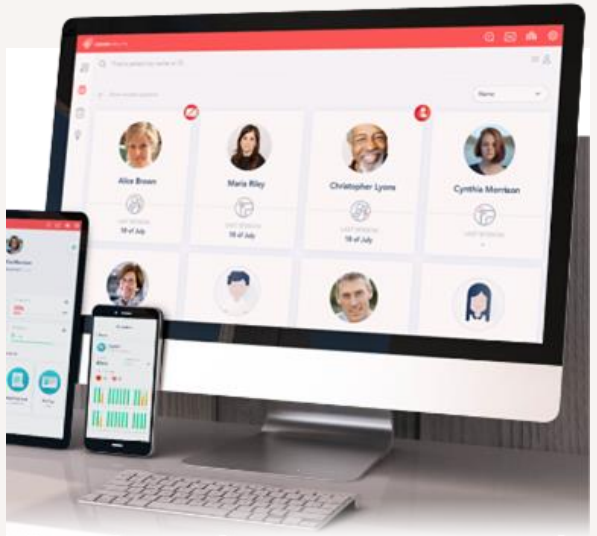
Clinical experts provide all the care

Physios provide all member care, never non-clinical staff



Biofeedback from Certified Device

Wearable sensors and computer vision measure the quality of every exercise



Fully tailored experience

Biofeedback collected from our tech makes it possible to provide truly personalized experience

Clinical Validation

Sword's commitment to clinical integrity

Two-tiered approach

Controlled trials

Tier 1 validation:
Controlled trials comparing digital programs against gold standard of care (i.e. high intensity in-person PT)

+

Real World Evidence

Tier 2 validation:
Real-world evidence
prospective, multi-disorder studies to assess the impact of our programs on every member

Source: J Med Internet Res 2022;24(6):e37677

Controlled trials: overview

Quality of care demonstrated through studies comparing our digital programs with gold standard PT

Post-surgery

Chronic MSK conditions

2016 **2018** **2020** **2021** **2022**

2016-2018
Knee replacement

69 patients
8 week outcomes
24% better function
23% better quality of life
Nature Sci Reps 2018

6 month outcomes
22% better function
49% better quality of life
JMIR Rehabil Assist Technol 2019

2016-2018
Hip replacement

66 patients
8 week outcomes
38% better function
17% better quality of life

6 month outcomes
24% better function
14% better quality of life
JMIR Rehabil Assist Technol 2019

2018-2020
Shoulder tendon repair

41 patients
12 week outcomes
17% greater functional improvement

12 month outcomes
39% greater improvement shoulder function
Am J Phys Med Rehabil 2022

2021-2022
Chronic low back pain

140 patients
Emory Spine Center, Atlanta, Georgia

8 week outcomes
Similar improvement both groups

In Publication route

2021-2022
Chronic shoulder pain

82 patients
UCSF, San Francisco, California

8 week outcomes
Similar improvement both groups

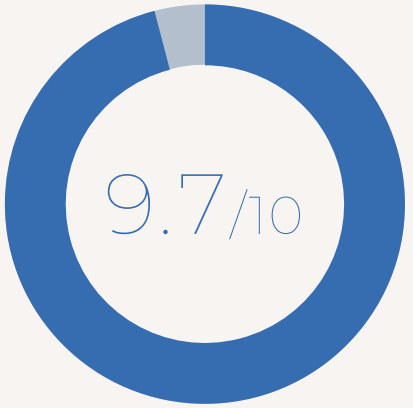
In Publication route

The highest engagement and retention rates

Attracting the right members and keeping them engaged is what we do

31

Avg. Sessions Completed



Member Satisfaction

Quality & Outcomes measures

Collected at baseline and throughout the program

- Demographics and general characteristics
- Pain (NPRS)
- Intent to pursue surgery (0-100 scale)
- Anxiety (GAD-7 scale)
- Depression (PHQ-9 scale)
- Productivity (WPAI scale)
- Body-area specific PROM

Neck
Neck Disability Index (NDI)

Shoulder/elbow/wrist
Quick Disabilities of the Arm, Shoulder and Hand (QuickDASH)

Low back
Oswestry Disability Index (ODI)

Hip
Hip disability and Osteoarthritis Outcome Score (HOOS)

Knee
Knee disability and Osteoarthritis Outcome Score (KOOS)

Ankle
Foot and ankle ability measure (FAAM)

Real world evidence

Impact across all dimensions

69%

Improve pain by at least 30%

49%

Stop taking painkillers by end of program

52%

Avg decrease in the intent to pursue surgery

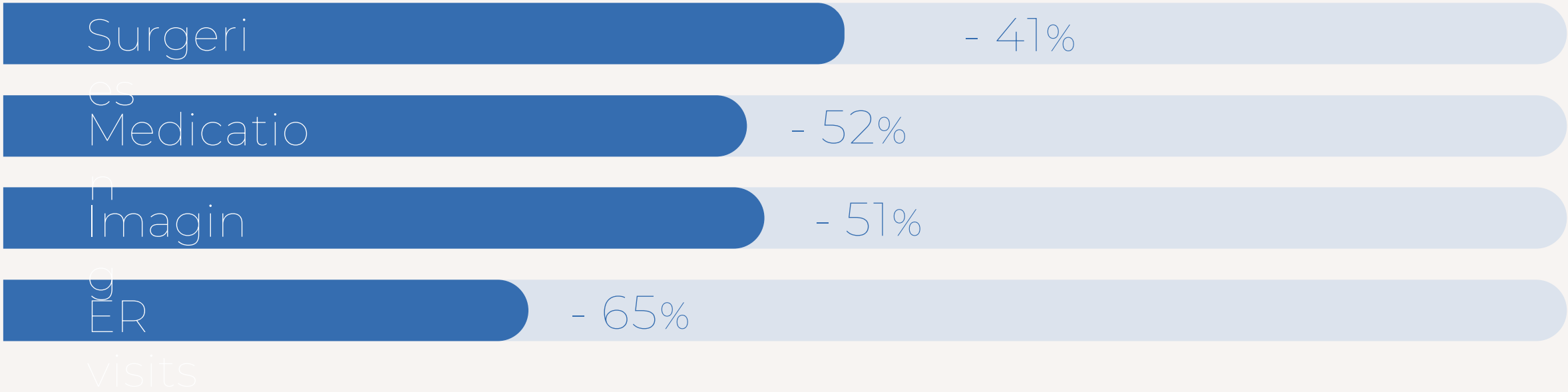
47%

Reduction in productivity losses

45%

Reduction in anxiety/depression

Economic impact



“

I thought I was destined for surgery and this program has saved me from that.”

Jacqueline, neck pain

How can we help?

Chronic Management

Patients in need of physiotherapy but that don't have access due to their location or to waiting lists..

Surgical Avoidance

Tackle patients that are on waiting lists for elective surgeries and deliver conservative treatment to potentially avoid surgery altogether

Pre-surgery rehabilitation

Improving patient condition prior to going to surgery, aiming to improve outcomes and reduce complications.

Post-surgery rehabilitation

Facilitate access to high-intensity post-surgery rehabilitation programs, maximising outcomes both short- and long-term and minimising recovery times.

Let’s outsmart waiting lists together.

sword

slido

How would you like to follow up with Sword post-event?

ⓘ Start presenting to display the poll results on this slide.

Reflections from Workforce Transformation in Elective Care Recovery

Marc Lyall – Associate Head of Workforce Transformation; Workforce Transformation, NHS England

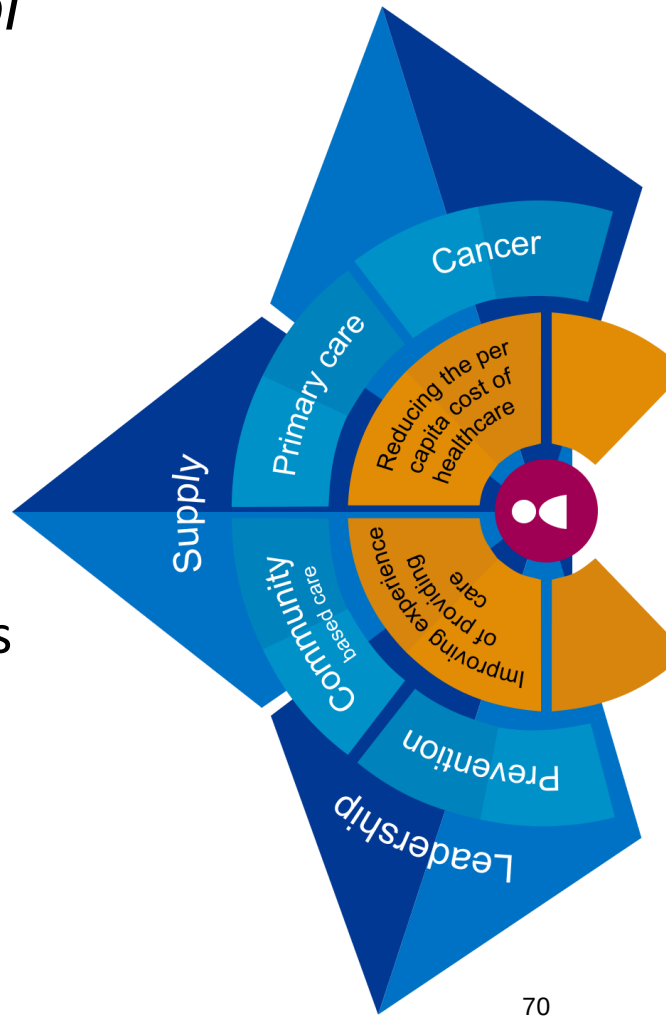
People Promise

Workforce Transformation | What is Workforce Transformation?

"Transformation is a process of profound and radical change, that takes an organisation in a new direction and to an entirely different level of effectiveness".

From a **workforce perspective** this requires us to:

- Understand the current context
- Understand the future of work
- More, or **different?**
- Explore the broader skills requirement, beyond traditional competencies and roles
- Nurture a future integrated workforce that is more agile/flexible
- Support leaders and talent at all levels

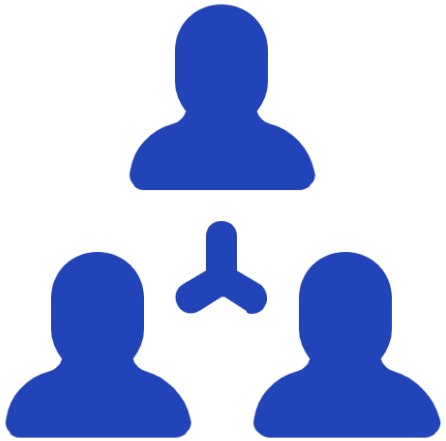


Workforce Transformation | Key Challenges and Opportunities

Challenges	Opportunities
Too many priorities for systems, **little standardisation of processes** and **limited ICS capacity** for service and workforce redesign, all compromising the development and delivery of workforce redesign plans	A mandate to work as system partners and 'new' NHSE (integrating workforce redesign alongside service transformation and digital enablers, reducing duplication and variation, maximise collective expertise)
System partnerships/governance/cultures in their infancy, coupled with **limited understanding of workforce redesign** models, where to start and what's needed to deliver locally driven changes (more of the same considered 'easier' and safer, than doing differently	The common goal of needing to attract and retain, fill difficult gaps and grow their own across the system footprint and our universal offer to co-produce progressive workforce redesign investment plans with every ICS Wider workforce redesign potential, including social care, third sector, volunteers…
ICS **capacity to capture impact and evidence base** to inspire spread and adoption	Tools and frameworks to support the process end to end, including the culture of change
No single place to source best practice to accelerate spread of what works, nor any clear evidence of international best practice of skills mix	Online Repository of Information being developed to support Elective Care Recovery programme of work
The **growing need for responsive education and development packages** to address the range and pace of supply and up-skilling challenges across health and care	Expand training and development routes by building on well-developed relationships with Royal Colleges and Higher and Further education, as well as maximising technological solutions e.g. e-learning for healthcare, Blended Learning

Workforce Transformation | Working differently

Multi-disciplinary teams with the optimal skills mix



Integrated working

Embracing technology

Personalised and holistic care

Workforce Transformation| Possible solutions

Examples of practical solutions include:

Supply
- System wide recruitment and attraction
- Workforce planning and modelling
- Return to Practice
- Retention initiatives
- Respond to increased need for new roles

Up-skilling
- Advanced practitioners
- Critical care skills
- Non-medical prescribing training
- Apprenticeships
- Use of Blended Learning, TEL

New roles
- General Practice Assistants
- Physician Associates
- Nurse Associate Preceptorship programme

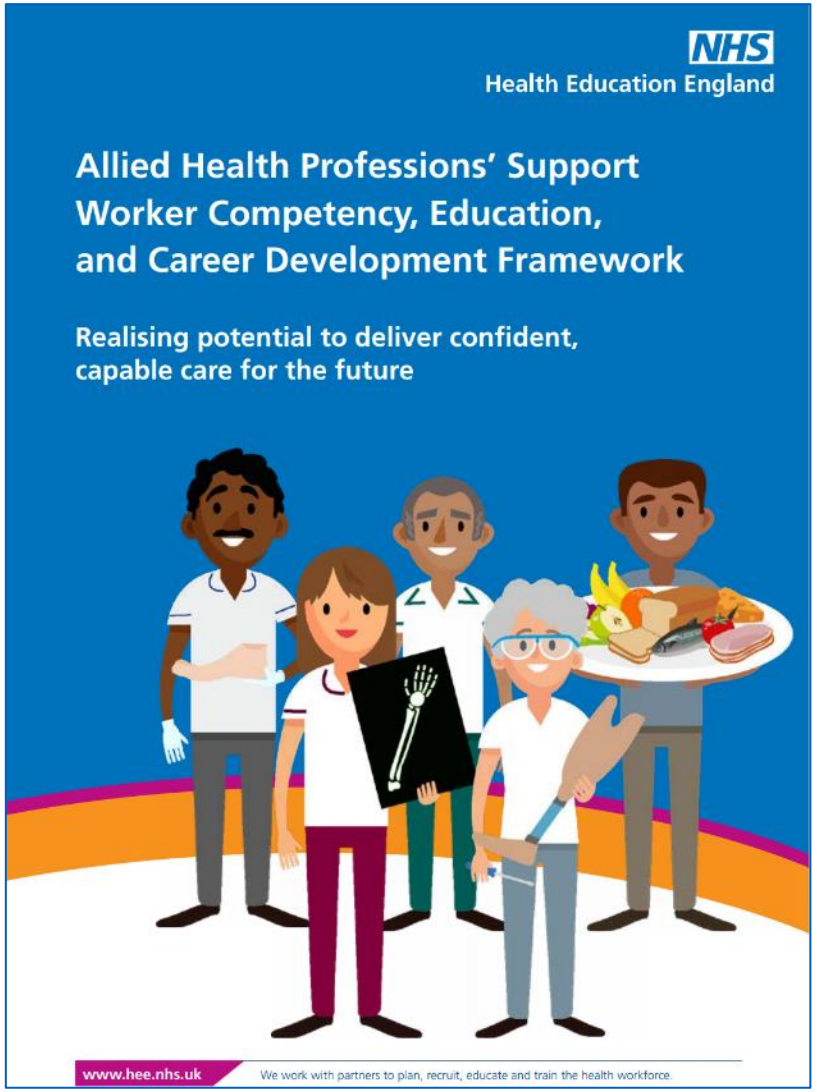
New ways of working
- Community Diagnostic Hubs rapid staff up-skill
- London Breast Screening Recovery Training
- Rotational programmes
- Digital working

Leadership
- Leadership programmes
- Organisational Development
- Health and wellbeing
- Equality and diversity
- System infrastructure

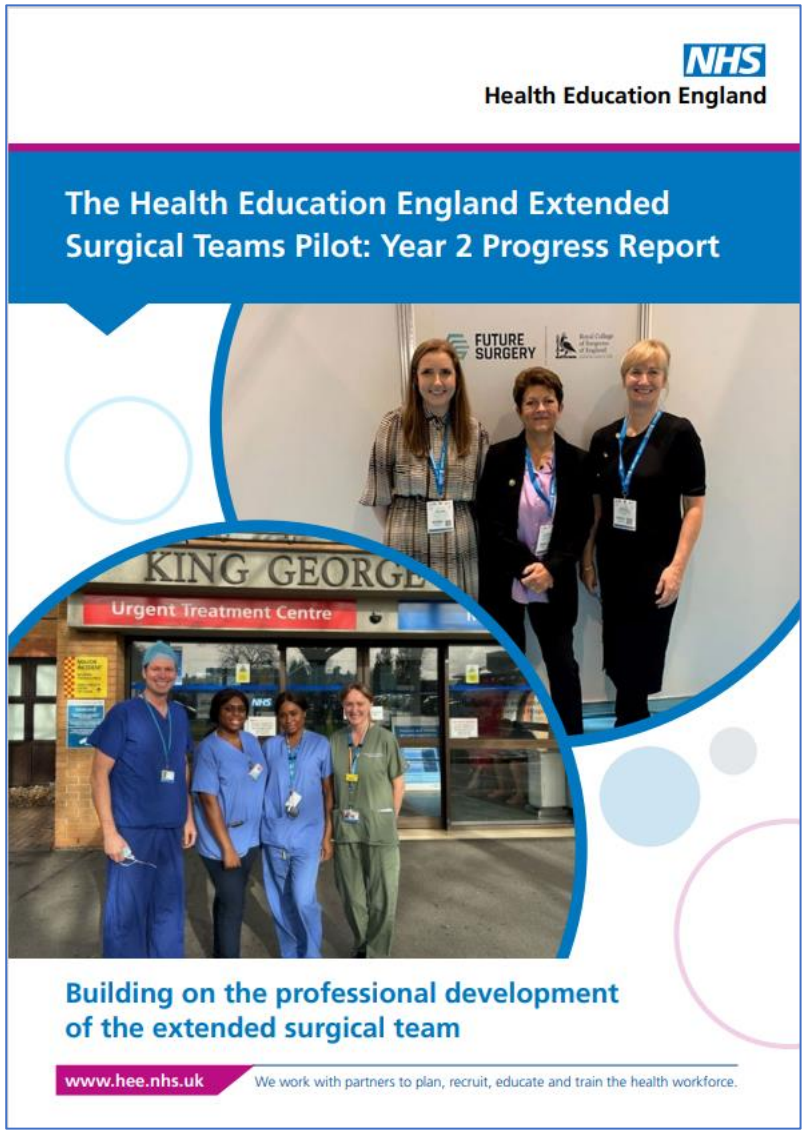
Workforce capacity | Theatre Support Workforce

- Allied Health Profession (AHP) Support Worker Competency, Education and Career Development Framework
- Readiness toolkit
- Grow your own workforce strategies
- Making learning work for support workers
- Education qualification mapping tool
- Supervision, accountability and delegation of activities

- Nationally-led procurement for Level 3 Senior Healthcare Support Worker apprenticeship (including Theatres pathway) and Level 5 Assistant Practitioner apprenticeship (including Theatres pathway)
- The Role of the Perioperative Healthcare Assistant in the Surgical Care Team, The Perioperative Care Collaborative (2020)
- https://www.hee.nhs.uk/our-work/allied-health-professions/enable-workforce/developing-role-ahp-support-workers



Workforce capacity | Extended Surgical Teams (EST) pilot



The Health Education England Extended Surgical Team (EST) pilot commenced in November 2020.

Aimed at new 'extended' surgical teams, which include consultants, doctors in training and SAS doctors, but the focus of the pilot is the role of multi professional team members.

Reproduceable model which sees service improvement and added value for surgical units.

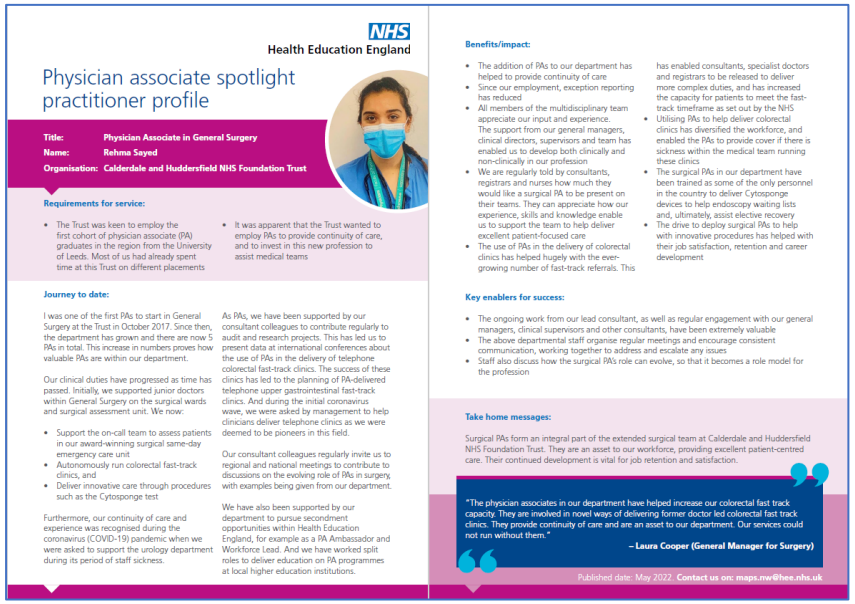
Compared to usual practice, the EST is expected to generate value:

- providing a cost-effective alternative to "usual practice" staffing models, improved system efficiency and improved workforce longevity and productivity,
- enabling more time for surgeons in training to focus on activities which promote training and learning,
- providing opportunities for clinical career progression and skills enhancement for advanced clinical practitioners.

Year 1 report Year 2 report Return on Investment Tool

Extended Surgical Team (EST) pilot | Health Education England (hee.nhs.uk)

Workforce capacity | Medical Associate Professions (MAPS)



NHS
Health Education England

Physician associate spotlight practitioner profile

Title: Physician Associate in General Surgery
Name: Rehma Sayed
Organisation: Calderdale and Huddersfield NHS Foundation Trust

Requirements for service:

- The Trust was keen to employ the first cohort of physician associate (PA) graduates in the region from the University of Leeds. Most of us had already spent time at this Trust on different placements
- It was apparent that the Trust wanted to employ PAs to provide continuity of care, and to invest in this new profession to assist medical teams

Journey to date:

I was one of the first PAs to start in General Surgery at the Trust in October 2017. Since then, the department has grown and there are now 5 PAs in total. This increase in numbers proves how valuable PAs are within our department.

Our clinical duties have progressed as time has passed. Initially, we supported junior doctors within General Surgery on the surgical wards and surgical assessment unit. We now:

- Support the on-call team to assess patients in our award-winning surgical same-day emergency care unit
- Autonomously run colorectal fast-track clinics, and
- Deliver innovative care through procedures such as the Cytosponge test

Furthermore, our continuity of care and experience was recognised during the coronavirus (COVID-19) pandemic when we were asked to support the urology department during its period of staff sickness.

As PAs, we have been supported by our consultant colleagues to contribute regularly to audit and research projects. This has led us to present data at international conferences about the use of PAs in the delivery of telephone colorectal fast-track clinics. The success of these clinics has led to the planning of PA-delivered telephone upper gastrointestinal fast-track clinics. And during the initial coronavirus wave, we were asked by management to help clinicians deliver telephone clinics as we were deemed to be pioneers in this field.

Our consultant colleagues regularly invite us to regional and national meetings to contribute to discussions on the evolving role of PAs in surgery, with examples being given from our department.

We have also been supported by our department to pursue secondment opportunities within Health Education England, for example as a PA Ambassador and Workforce Lead. And we have worked split roles to deliver education on PA programmes at local higher education institutions.

Benefits/impact:

- The addition of PAs to our department has helped to provide continuity of care
- Since our employment, exception reporting has reduced
- All members of the multidisciplinary team appreciate our input and experience. The support from our general managers, clinical directors, supervisors and team has enabled us to develop both clinically and non-clinically in our profession
- We are regularly told by consultants, registrars and nurses how much they would like a surgical PA to be present on their teams. They can appreciate how our experience, skills and knowledge enable us to support the team to help deliver excellent patient-focused care
- The use of PAs in the delivery of colorectal clinics has helped hugely with the ever-growing number of fast-track referrals. This has enabled consultants, specialist doctors and registrars to be released to deliver more complex duties, and has increased the capacity for patients to meet the fast-track timeframe as set out by the NHS
- Utilising PAs to help deliver colorectal clinics has diversified the workforce, and enabled the PAs to provide cover if there is sickness within the medical team running these clinics
- The surgical PAs in our department have been trained as some of the only personnel in the country to deliver Cytosponge devices to help endoscopy waiting lists and, ultimately, assist elective recovery
- The drive to deploy surgical PAs to help with innovative procedures has helped with their job satisfaction, retention and career development

Key enablers for success:

- The ongoing work from our lead consultant, as well as regular engagement with our general managers, clinical supervisors and other consultants, have been extremely valuable
- The above departmental staff organise regular meetings and encourage consistent communication, working together to address and escalate any issues
- Staff also discuss how the surgical PAs role can evolve, so that it becomes a role model for the profession

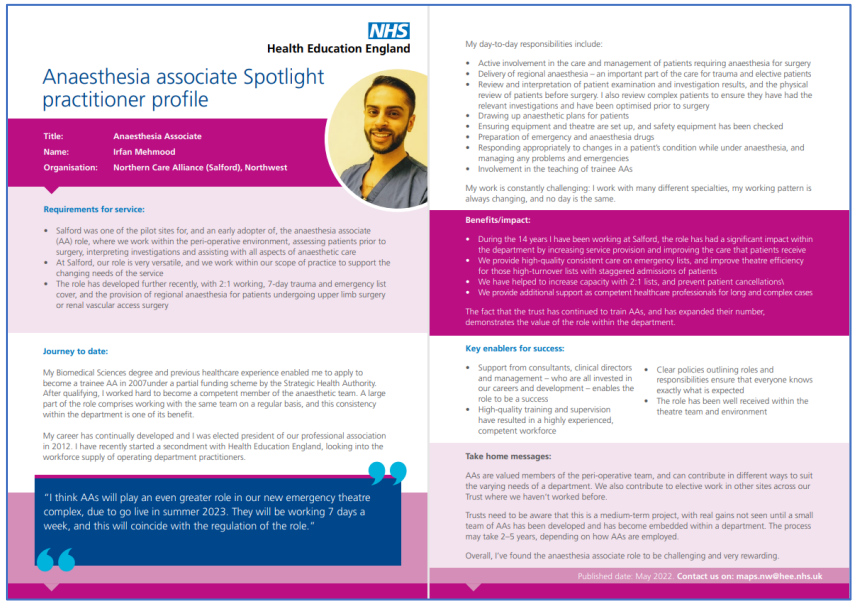
Take home messages:

Surgical PAs form an integral part of the extended surgical team at Calderdale and Huddersfield NHS Foundation Trust. They are an asset to our workforce, providing excellent patient-centred care. Their continued development is vital for job retention and satisfaction.

"The physician associates in our department have helped increase our colorectal fast track capacity. They are involved in novel ways of delivering former doctor led colorectal fast track clinics. They provide continuity of care and are an asset to our department. Our services could not run without them."

– Laura Cooper (General Manager for Surgery)

Published date: May 2022. **Contact us on: maps.nw@hee.nhs.uk**



NHS
Health Education England

Anaesthesia associate Spotlight practitioner profile

Title: Anaesthesia Associate
Name: Irfan Mehmood
Organisation: Northern Care Alliance (Salford), Northwest

Requirements for service:

- Salford was one of the pilot sites for, and an early adopter of, the anaesthesia associate (AA) role, where we work within the peri-operative environment, assessing patients prior to surgery, interpreting investigations and assisting with all aspects of anaesthetic care
- At Salford, our role is very versatile, and we work within our scope of practice to support the changing needs of the service
- The role has developed further recently, with 2:1 working, 7-day trauma and emergency list cover, and the provision of regional anaesthesia for patients undergoing upper limb surgery or renal vascular access surgery

Journey to date:

My Biomedical Sciences degree and previous healthcare experience enabled me to apply to become a trainee AA in 2007under a partial funding scheme by the Strategic Health Authority. After qualifying, I worked hard to become a competent member of the anaesthetic team. A large part of the role comprises working with the same team on a regular basis, and this consistency within the department is one of its benefit.

My career has continually developed and I was elected president of our professional association in 2012. I have recently started a secondment with Health Education England, looking into the workforce supply of operating department practitioners.

"I think AAs will play an even greater role in our new emergency theatre complex, due to go live in summer 2023. They will be working 7 days a week, and this will coincide with the regulation of the role."

My day-to-day responsibilities include:

- Active involvement in the care and management of patients requiring anaesthesia for surgery
- Delivery of regional anaesthesia – an important part of the care for trauma and elective patients
- Review and interpretation of patient examination and investigation results, and the physical review of patients before surgery. I also review complex patients to ensure they have had the relevant investigations and have been optimised prior to surgery
- Drawing up anaesthetic plans for patients
- Ensuring equipment and theatre are set up, and safety equipment has been checked
- Preparation of emergency and anaesthesia drugs
- Responding appropriately to changes in a patient's condition while under anaesthesia, and managing any problems and emergencies
- Involvement in the teaching of trainee AAs

My work is constantly challenging: I work with many different specialties, my working pattern is always changing, and no day is the same.

Benefits/impact:

- During the 14 years I have been working at Salford, the role has had a significant impact within the department by increasing service provision and improving the care that patients receive
- We provide high-quality consistent care on emergency lists, and improve theatre efficiency for those high-turnover lists with staggered admissions of patients
- We have helped to increase capacity with 2:1 lists, and prevent patient cancellations\
- We provide additional support as competent healthcare professionals for long and complex cases

The fact that the trust has continued to train AAs, and has expanded their number, demonstrates the value of the role within the department.

Key enablers for success:

- Support from consultants, clinical directors and management – who are all invested in our careers and development – enables the role to be a success
- High-quality training and supervision have resulted in a highly experienced, competent workforce
- Clear policies outlining roles and responsibilities ensure that everyone knows exactly what is expected
- The role has been well received within the theatre team and environment

Take home messages:

AAs are valued members of the peri-operative team, and can contribute in different ways to suit the varying needs of a department. We also contribute to elective work in other sites across our Trust where we haven't worked before.

Trusts need to be aware that this is a medium-term project, with real gains not seen until a small team of AAs has been developed and has become embedded within a department. The process may take 2–5 years, depending on how AAs are employed.

Overall, I've found the anaesthesia associate role to be challenging and very rewarding.

Published date: May 2022. **Contact us on: maps.nw@hee.nhs.uk**

NHS
Health Education England

Physician associate spotlight practitioner profile

Title: Physician Associate
Name: Rachel Atherton
Organisation: Royal Preston Hospital, North West

Requirements for service:

- This role was developed initially to increase continuity of care, coordinate jobs and take part in ward rounds
- In 3 years, the role has developed to include assisting in elective and emergency theatre, the delivery of outpatient clinics and triaging urgent cancer referrals

Journey to date:

I started work with another colleague at the Royal Preston Hospital 3 years ago – we were the first physician associates (PA) employed in the Colorectal team. I was attracted to the position, having previously completed a very enjoyable and proactive work placement there as a student. I subsequently developed a keen interest in surgery, which motivated me to apply for the role.

Initially in 2019, a work plan was organised to develop our skills in assisting in theatre, facilitating clinics and supporting ward rounds. After a period of shadowing in what was a steep learning curve, we took part in weekly clinics and theatre days. A structure was in place to ensure that a PA was present on the ward to coordinate jobs and provide continuity of care.

As part of our training, we gained our Basic Surgical Skills qualification, which increased our scope of practice in theatre, particularly in suturing and handling tissues/instruments as a second assistant. In my first year, I assisted in approximately 40 operations, ranging from laparoscopic to open cases, and elective to emergency cases.

We currently also work one clinic per week as part of a team of consultants, registrars and advanced clinical practitioners to triage the urgent (2-week) referrals.

Benefits/impact:

- PAs provide cover on the ward, enabling junior doctors to gain experience in theatre during their surgical placement, thereby providing real benefits within a junior team
- PAs bring increased efficiency to the ward, enabling smoother patient flow and faster, safe discharges
- Nursing staff have commented on the increased efficiency on the ward as a result of the work of the PAs
- Administrative queries are dealt with quickly and efficiently, minimising the likelihood of difficulties and miscommunication
- As a result of PAs delivering one clinic per week, approximately 48 more patients per month now receive an urgent specialist review. This has also yielded financial benefits, allowing our service to reduce wait times for patients without the costly hire of locum staff
- PAs have become part of the multidisciplinary team, with close links to essential services such as the nutritional team and stoma nurses. Having the knowledge of, and respect for, other departments has streamlined our patient care within the Colorectal team

Key enablers for success:

- Job satisfaction – being valued in our team, having opportunities to build a reputation within our Trust and working closely with supportive consultants and colleagues has led to a great deal of job satisfaction on our part
- Adaptable – PAs can adapt and evolve into many types of service provision
- Resilient – PAs are a resilient group of highly skilled individuals, ready to help shape and enhance any team

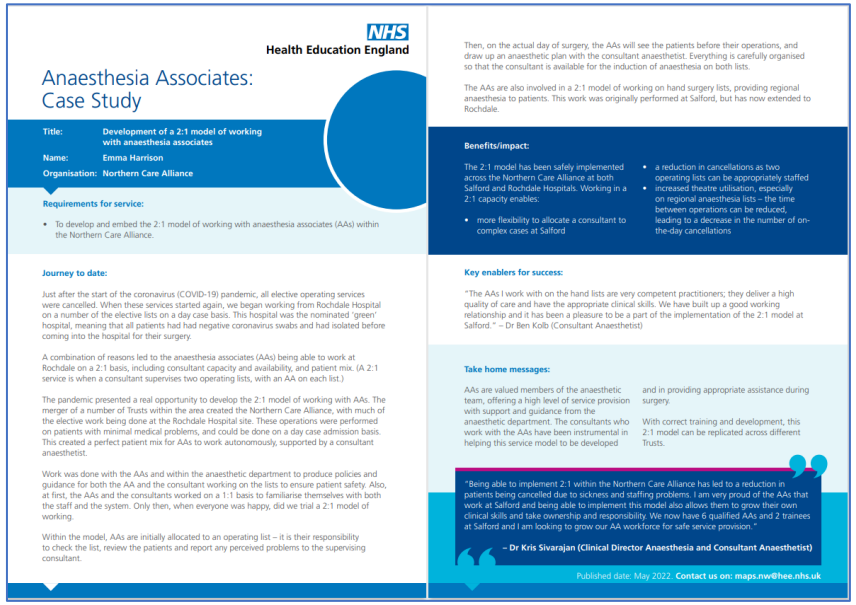
"The addition of PAs to the colorectal team has made a significant impact, particularly in terms of inpatient care and the support/training of junior doctors. They essentially run the ward, knowing every patient on the colorectal emergency and elective ward round lists. They always know where we are up to, and what are the issues relating to that patient at that particular part of their recovery. Their work ethic has been exemplary. They have continued to develop in their role, and their willingness to learn is evident as they develop their colorectal and general surgery knowledge on the ward, in the clinic and in theatre. They have been a tremendous support to junior doctors who rotate through the ward every four months. They have, without a doubt, made the patient care smoother and safer."

– Mr Mitchell (Colorectal consultant)

"To me, this a true success story. There is a unanimous chorus amongst the junior doctors attributing enhanced continuity and quality of care to our PAs, as well as providing them with direction, guidance and leadership. It is a pleasure to have PAs in theatre, too, where there is yet more valuable support."

– Mr Bhowmick (Colorectal consultant)

Published date: May 2022. **Contact us on: maps.nw@hee.nhs.uk**



NHS
Health Education England

Anaesthesia Associates: Case Study

Title: Development of a 2:1 model of working with anaesthesia associates
Name: Emma Harrison
Organisation: Northern Care Alliance

Requirements for service:

- To develop and embed the 2:1 model of working with anaesthesia associates (AAs) within the Northern Care Alliance.

Journey to date:

Just after the start of the coronavirus (COVID-19) pandemic, all elective operating services were cancelled. When these services started again, we began working from Rochdale Hospital on a number of the elective lists on a day case basis. This hospital was the nominated 'green' hospital, meaning that all patients had had negative coronavirus swabs and had isolated before coming into the hospital for their surgery.

A combination of reasons led to the anaesthesia associates (AAs) being able to work at Rochdale on a 2:1 basis, including consultant capacity and availability, and patient mix. (A 2:1 service is when a consultant supervises two operating lists, with an AA on each list.)

The pandemic presented a real opportunity to develop the 2:1 model of working with AAs. The merger of a number of Trusts within the area created the Northern Care Alliance, with much of the elective work being done at the Rochdale Hospital site. These operations were performed on patients with minimal medical problems, and could be done on a day case admission basis. This created a perfect patient mix for AAs to work autonomously, supported by a consultant anaesthetist.

Work was done with the AAs and within the anaesthetic department to produce policies and guidance for both the AA and the consultant working on the lists to ensure patient safety. Also, at first, the AAs and the consultants worked on a 1:1 basis to familiarise themselves with both the staff and the system. Only then, when everyone was happy, did we trial a 2:1 model of working.

Within the model, AAs are initially allocated to an operating list – it is their responsibility to check the list, review the patients and report any perceived problems to the supervising consultant.

Then, on the actual day of surgery, the AAs will see the patients before their operations, and draw up an anaesthetic plan with the consultant anaesthetist. Everything is carefully organised so that the consultant is available for the induction of anaesthesia on both lists.

The AAs are also involved in a 2:1 model of working on hand surgery lists, providing regional anaesthesia to patients. This work was originally performed at Salford, but has now extended to Rochdale.

Benefits/impact:

The 2:1 model has been safely implemented across the Northern Care Alliance at both Salford and Rochdale Hospitals. Working in a 2:1 capacity enables:

- more flexibility to allocate a consultant to complex cases at Salford
- a reduction in cancellations as two operating lists can be appropriately staffed
- increased theatre utilisation, especially on regional anaesthesia lists – the time between operations can be reduced, leading to a decrease in the number of on-the-day cancellations

Key enablers for success:

"The AAs I work with on the hand lists are very competent practitioners; they deliver a high quality of care and have the appropriate clinical skills. We have built up a good working relationship and it has been a pleasure to be a part of the implementation of the 2:1 model at Salford." – Dr Ben Kolb (Consultant Anaesthetist)

Take home messages:

AAs are valued members of the anaesthetic team, offering a high level of service provision with support and guidance from the anaesthetic department. The consultants who work with the AAs have been instrumental in helping this service model to be developed and in providing appropriate assistance during surgery.

With correct training and development, this 2:1 model can be replicated across different Trusts.

"Being able to implement 2:1 within the Northern Care Alliance has led to a reduction in patients being cancelled due to sickness and staffing problems. I am very proud of the AAs that work at Salford and being able to implement this model also allows them to grow their own clinical skills and take ownership and responsibility. We now have 6 qualified AAs and 2 trainees at Salford and I am looking to grow our AA workforce for safe service provision."

– Dr Kris Sivarajan (Clinical Director Anaesthesia and Consultant Anaesthetist)

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[Medical Associate Professions | Health Education England (hee.nhs.uk)]

[Core Capabilities Framework for Medical Associate Professions]

[Anaesthesia associates | The Royal College of Anaesthetists (rcoa.ac.uk)]

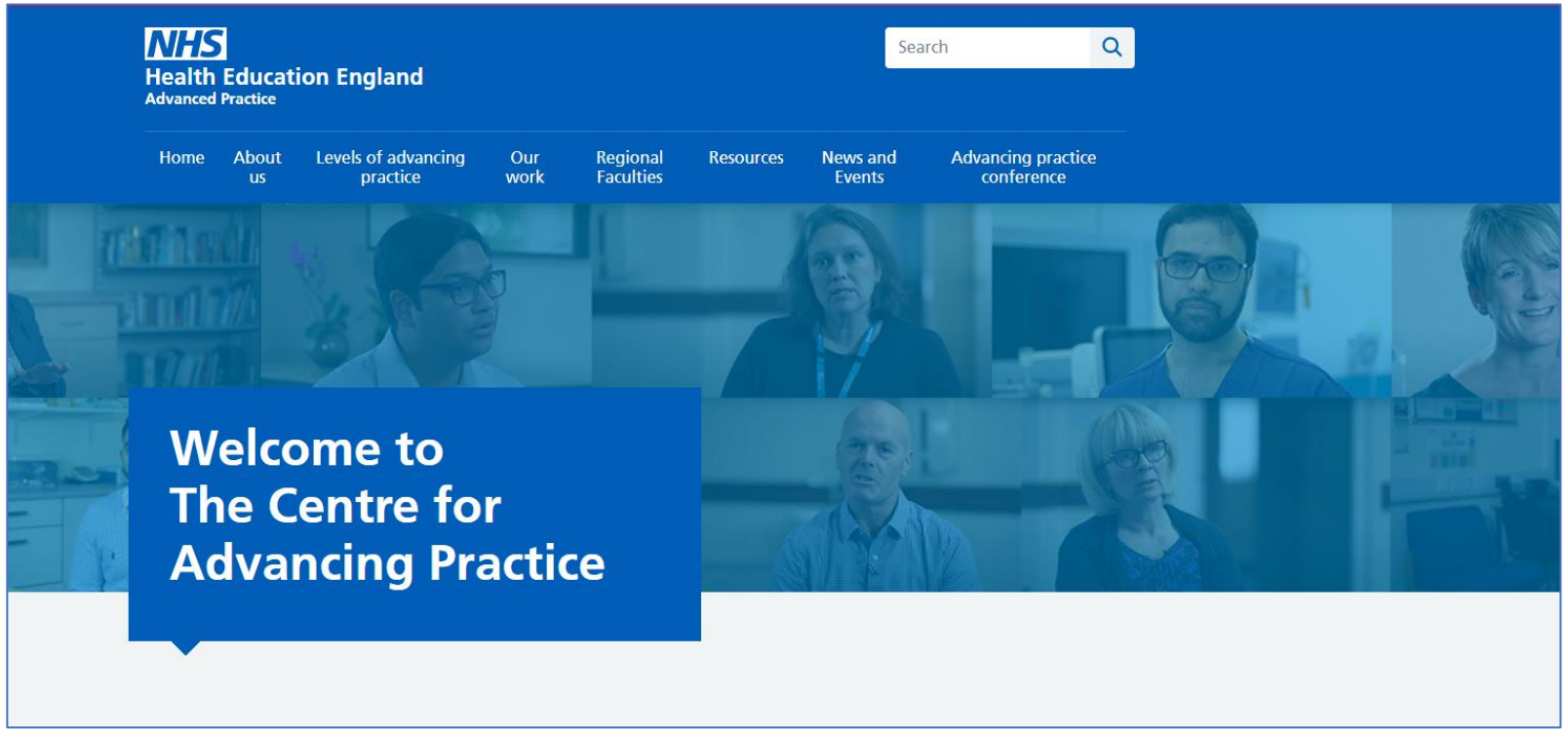
[The surgical care team — Royal College of Surgeons (rcseng.ac.uk)]

[Guidelines | Centre for Perioperative Care (cpoc.org.uk)]

Workforce capacity | Advanced Practice

https://advanced-practice.hee.nhs.uk/

- 2023 Curriculum Framework for Advanced Practice in Surgery: revised version due to be published shortly.
- Defines advanced practice requirements in surgery, setting out the specific capabilities practitioners need to develop and demonstrate.
- Encompasses roles based predominantly outside theatres (e.g., inpatient, outpatients and emergency areas) as well as roles based predominantly within the theatre setting.
- Surgical assisting capabilities included as an optional capability and mapped to Association of Perioperative Practice guidance.



- 9 domains of professional capabilities
- 3 domains of clinical capabilities: core, generic surgery, speciality surgery
- Optional capabilities in practice

Options:

1. Integrate within a post-registration NHS England accredited MSc in advanced practice
2. Subsequent to an MSc in a relevant healthcare subject using the NHS England Support Portfolio route (or approved alternative)

Workforce Transformation| Systematic approach to designing pathway 'blueprints'

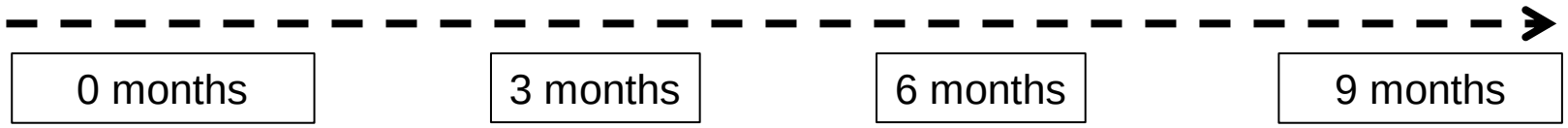
Data Analysis – service demand, population health and workforce supply

CLEAR (Clinically-Led workforcE and Activity Redesign)

Workforce redesign workshops held over time

HEE resources – HEE Star online directory, Roles Explorer, MDT Toolkit, COM-B

- Working across all key stakeholders
- NHS resources e.g. SWIM



Data - Provides insight for focus of service and workforce transformation
CLEAR - Training programme which equips clinicians with the skills to model optimum workforce skills mix to deliver service improvements
HEE Star methodology used to explore workforce challenges and determine realistic workforce interventions/solutions
HEE tools, approaches and capacity to facilitate workforce redesign at regional and ICS level

Workforce Transformation| Star example - Shortage of reporting radiographers and sonographers in Kent & Medway

Context

- Demand in diagnostics outstrips capacity with 98% of Trusts not able to meet reporting requirements
- Lack of capacity has led to increased expenditure on agency staffing and outsourcing
- Significant variation, deployment and supervision of reporting radiographers, and limited, structured training opportunities
- Limited sonography workforce data with variety of staff undertaking ultrasound activity
- A third of the sonography workforce is approaching retirement
- Sonographers more likely to leave NHS posts to work in independent sector
- No direct entry route qualifications for sonographers

Prompts

Supply
- Is there oversight of the current profile of reporting radiographers & sonographers (WTE, location, priority areas, gaps)?

Up-skilling
- Are the career development opportunities well defined and promoted?
- Is there an agreed 'menu' of core competencies for reporting radiographers & sonographers?

New roles
- Has the role of Mammography associate been considered in Kent and Medway?

New ways of working
- Are there any joint arrangements in place which underpin positive partnership working, e.g. shared objectives, training, shadowing, buddying? If not, what are the future opportunities?

Leadership
- Have we identified and made links with our system leaders/clinical champions both regionally and nationally?
- Is there a talent management plan in place?

Outcomes

Almost 30 improvement projects identified, including:

Supply
- Identify future population health need and quantify workforce requirement
- Work with education providers to influence cohort sizes and placements
- Scope best practice retention programmes

Up-skilling
- Map and define the career pathway
- Explore the scope and value of apprenticeships
- Explore advanced practitioner roles to maximise skill mix

New roles
- Evaluate the impact of the Pathway Co-ordinator role
- Explore potential of Physician Associate role

New ways of working
- Explore how First Contact Practitioners can support in reducing referrals
- Establish oversight of best practice examples of shadowing and buddying, locally, regionally, nationally

Leadership
- Identify regional and national leaders in radiography and sonography
- Scope leadership development programmes locally and nationally

Workforce Transformation| Workforce levers

More people…	Recruitment / supply	Improving our ability to attract and source staff, especially into the most critical roles/gaps. Incl. via international, apprenticeship schemes and other wider participation routes
	Retention	Addressing the levers and drivers of retention, including specifics for key staff cohorts (e.g., newly joining HCSWs, pensions for 50+)
	Attendance	Addressing the drivers and root causes of sickness absence, including stress/anxiety and policy levers (e.g., Long Covid)
	Reward / T&Cs	Aligning total reward (pay, pensions etc) to encourage staff to work more flexibly and in ways that meet changing patient demand
	Outsourcing	Exploring all options to access workforce capacity beyond the NHS, such as Independent Sector and non-NHS employed people
…. in a compassionate, inclusive culture	Culture	Focusing on staff engagement and morale as a driver and enabler of frontline innovation and productive working
	Leadership	Equipping leaders to bring about these changes, promoting a compassionate and inclusive culture and a hopeful narrative
	EDI	Fostering an improvement-focused culture that openly addresses health inequalities and systemic issues
Working differently …	Training / skills	Investing in upskilling the existing workforce rapidly as well as the longer-term training pipeline managed by HEE
	Standards / skills mix	Changing and matching skills mix to patient needs (e.g., theatre staffing, anaesthetic cover), including fully using existing skills
	Pathways / practice	Redesigning end-to-end pathways to simplify things for patients and apply a competency-based model to workforce redesign
	Digital / technology	Investing in and leveraging digital technology to enable changes in models of care and workforce redesign (e.g. virtual wards
	Deployment	Deploying our staff more flexibly in response to needs, including across organisational boundaries within ICSs

Building Outstanding Theatre Teams Programme|

Governance

Ignition event attendee

- HEE
- NHSE People Directorate
- NHSE GIRFT
- Regional / Provider Theatre leads
- Professional / Student / Union reps
- #solvingtogether network

BOTT1 Working Group – Workforce Spec & Planning

BOTT1 Sub-group

BOTT2 Working Group – Skills, competency and career pathways

BOTT2 Sub-group

BOTT3 Working Group – Culture & Leadership

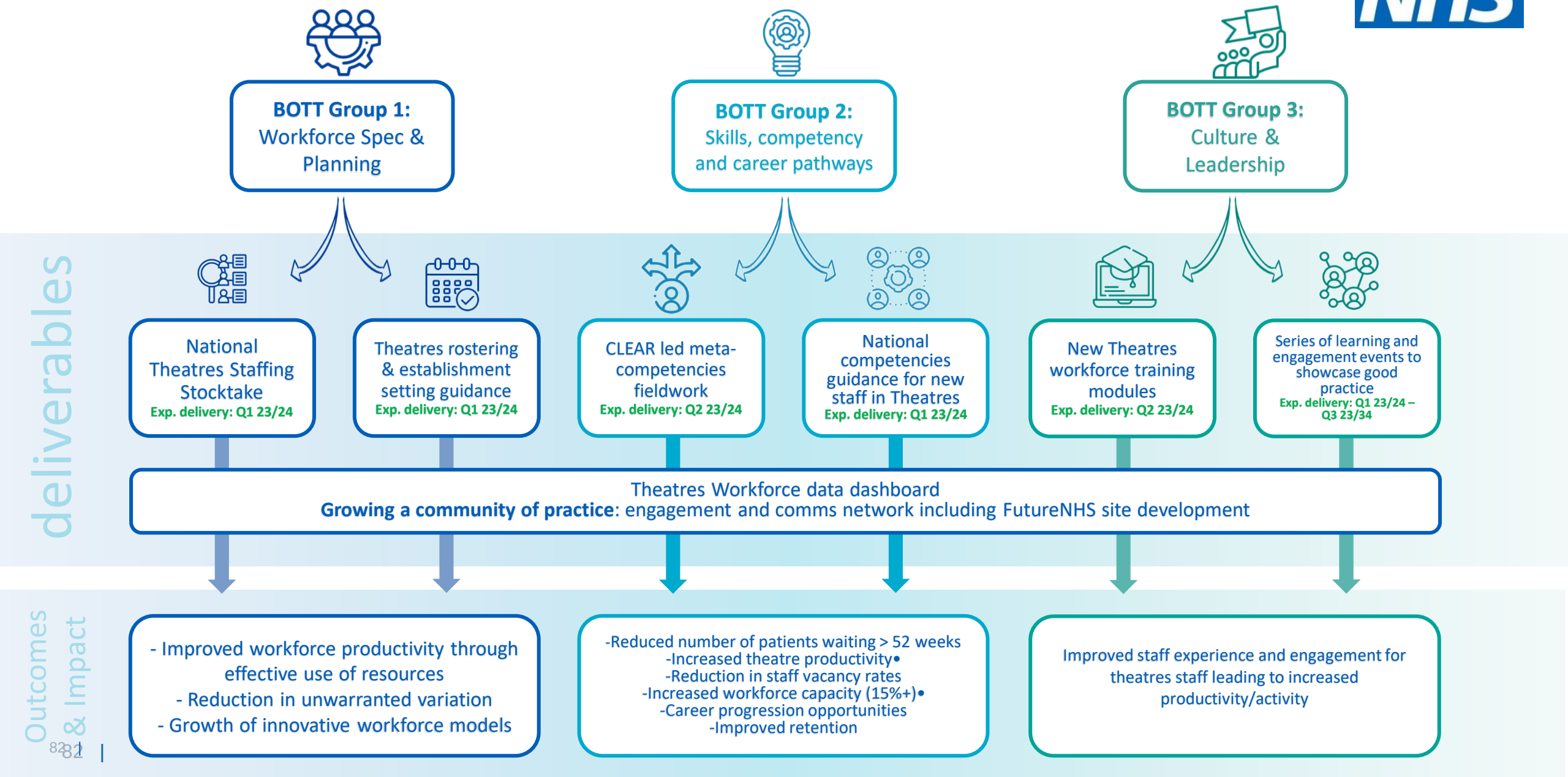
BOTT3 Sub-groups

Building Outstanding Theatre Teams Oversight group

National ER Programme Board

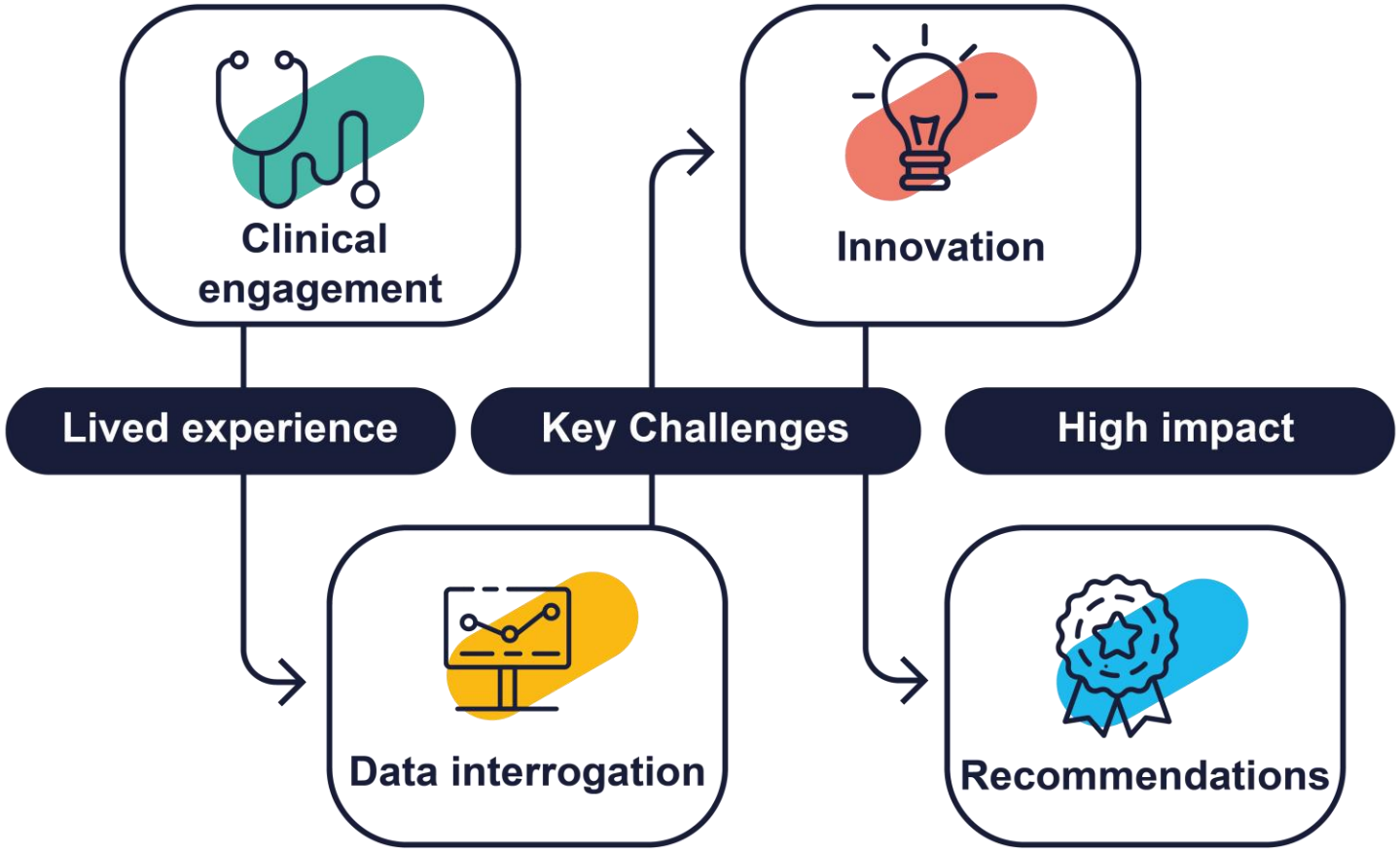
National Theatres Board

BOTT Programme| Deliverables



BOTT Programme| CLEAR

What is CLEAR?



CLEAR stands for Clinically-Led workforcE and Activity Redesign.

The national programme places **clinicians at the heart of healthcare decision making and innovation**. The integrated learning and working programme enables clinicians to develop new skills in data science, transformation and leadership while delivering live redesign projects in the NHS.

With its unique methodology, CLEAR delivers solutions that are clinically owned, increase control of clinical teams in healthcare delivery and provides an efficient solution to complex change programmes.

BOTT Programme| CLEAR

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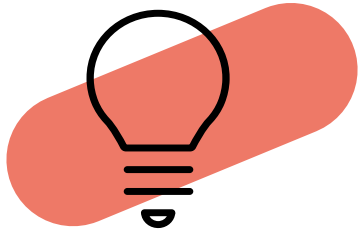
Clinical engagement
Understand baseline models of care, form relationships and discover key issues through qualitative data collection. This secures buy-in and gains operational insights about the service and challenges.

Digital visualisation
Find evidence for key challenges, link qualitative themes to deeper insights, use qualitative data to find impact of change. Our data tools offer accessible data analysis and visualisation, allowing you to evidence issues and possible solutions.



Innovation

Create solutions for key issues with new models of care using bespoke modelling techniques, co-design and collaborate with staff and other CLEAR teams, share best practice and examples of innovation

Recommendations

All elements of the previous phases come together to communicate the need, evidence and the benefits of the recommended changes

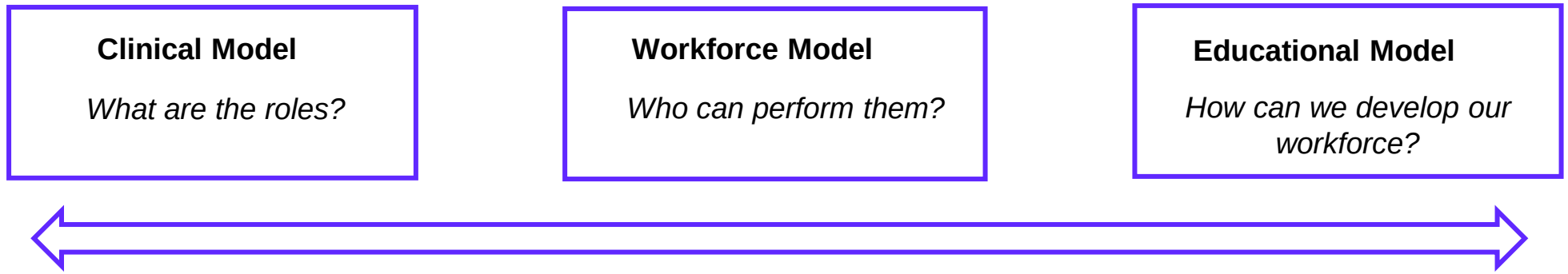
BOTT Programme| Working Group 2 - Toolkit

- To create a toolkit (previously described as “a capability framework”) to support organisations with understanding their operating theatres workforce with three specific components:

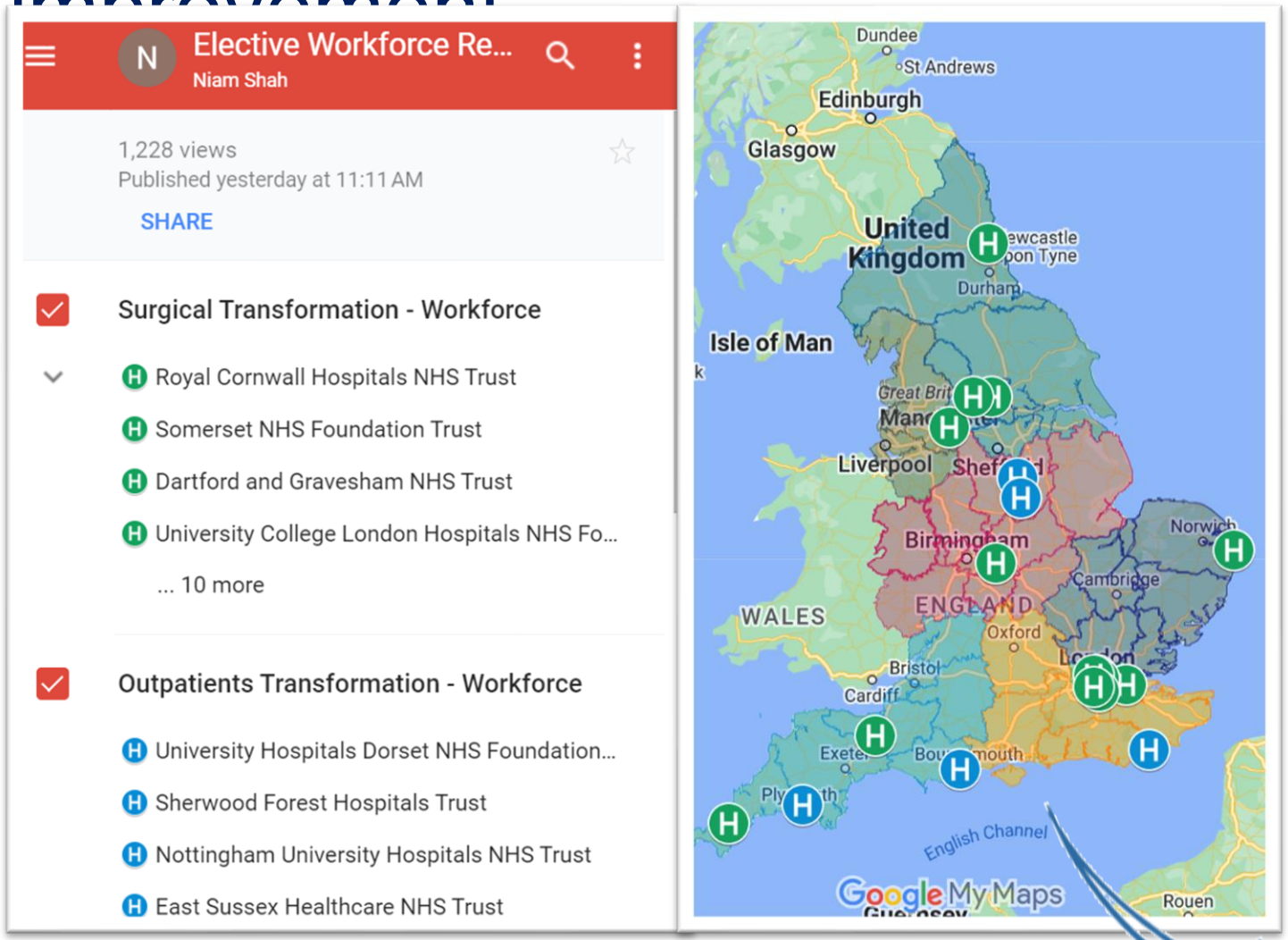
1. A **clinical model**, which defines the intraoperative roles within theatres and a consensus on the healthcare professionals that can perform these roles.
2. A **workforce questionnaire** designed to reflect the clinical model with workforce information on skills and experience. This information may be brought together to create a workforce profile across operating theatres.
3. A **development model** which maps the key development areas required within the clinical model.

Due to the nature of the CLEAR Compact projects (performed by our team at 33n) the local workforce will be involved in the codesign of new models of care but will not undergo education, supervision or the development of portfolio careers.

BOTT Programme| Working Group 2 - Toolkit

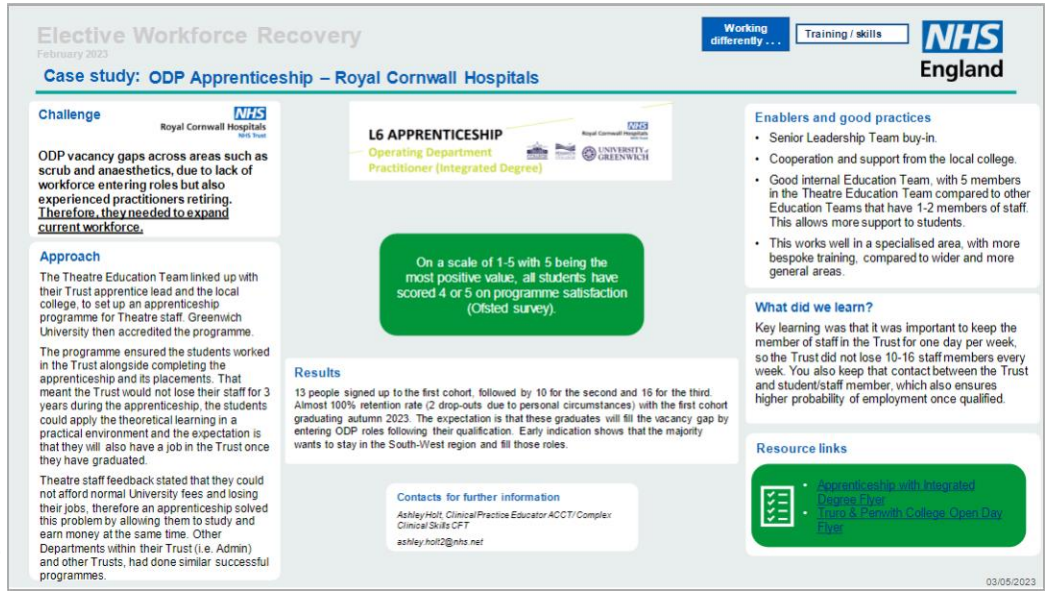


BOTT Programme| Building a network for improvement



Community of practice for Theatre teams:

- What is happening and where…
- Case Study development
- National engagement map
- Communication plan to raise awareness and maximise impact of learning



Workforce Transformation| Conclusions

- Workforce Transformation/redesign/optimisation can be difficult for providers – you are trying to run high quality services day in day out, to work differently whilst doing this is a challenge

- Our job has been to try and make transformation doable, accessible and a no brainer, with tools which are easy to use and create impact

- We know evaluation and demonstrating impact is a challenge but there are examples of change which can inspire, give confidence and provide a platform to build on

- There is support through the National Programme Teams e.g. BOTT and what will be the new Workforce Pathways team in NHSE

NHS Elective Care Conference North

2023

NHS Elective Care Conference North

SPEAKING NOW

Dr Julia Schofield

Dermatology Clinical Lead NHS England Outpatient Recovery and Transformation Programme / Consultant Dermatologist United Lincolnshire Hospitals NHS Trust / Associate Professor University of Hertfordshire - **NHS England Outpatient Recovery and Transformation team**

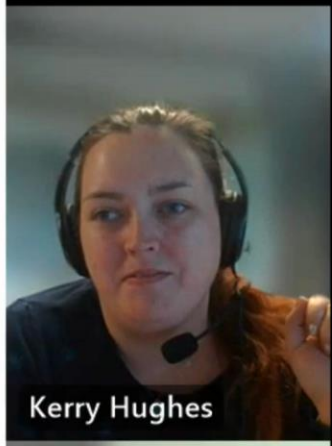
I will be discussing...

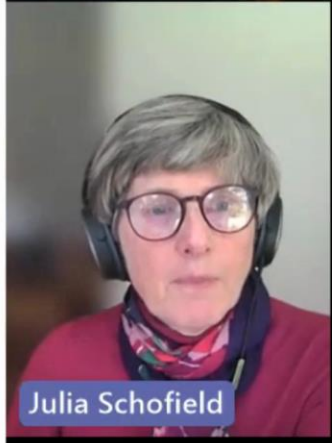
"Why patients miss their appointments and what we can do about that"

National Outpatient Recovery and Transformation Programme: the role of teledermatology in elective recovery

NHS Elective Care Conference North 2023: 18th May 2023

Dr Julia Schofield Consultant Dermatologist Lincolnshire
Clinical Lead Dermatology NHSE Outpatient Recovery and Transformation Programme
Associate Professor University of Hertfordshire





National Outpatient Recovery and Transformation Programme: the role of teledermatology in elective recovery

NHS Elective Care Conference North 2023: 18th May 2023

Dr Julia Schofield Consultant Dermatologist Lincolnshire
Clinical Lead Dermatology NHSE Outpatient Recovery and Transformation Programme
Associate Professor University of Hertfordshire

What am I going to talk about?

- What is the Dermatology Outpatient Recovery and Transformation Programme
- Guidance documents to support pathway redesign and elective recovery
- Importance of teledermatology to support elective recovery
- Challenges of developing teledermatology services
- The potential role of Community Diagnostic Centres (CDCs)
- Supporting implementation of teledermatology: the teledermatology roadmap
- The importance of developing teledermatology *without increasing inequity of access to care*
- Can we do elective recovery as part of business as usual?
- Other providers

Elective recovery why does it matter?

"*I've had psoriasis for the majority of my life, I am not currently under a dermatologist because it was manageable.*

I am having the worst flare up I can ever remember having.

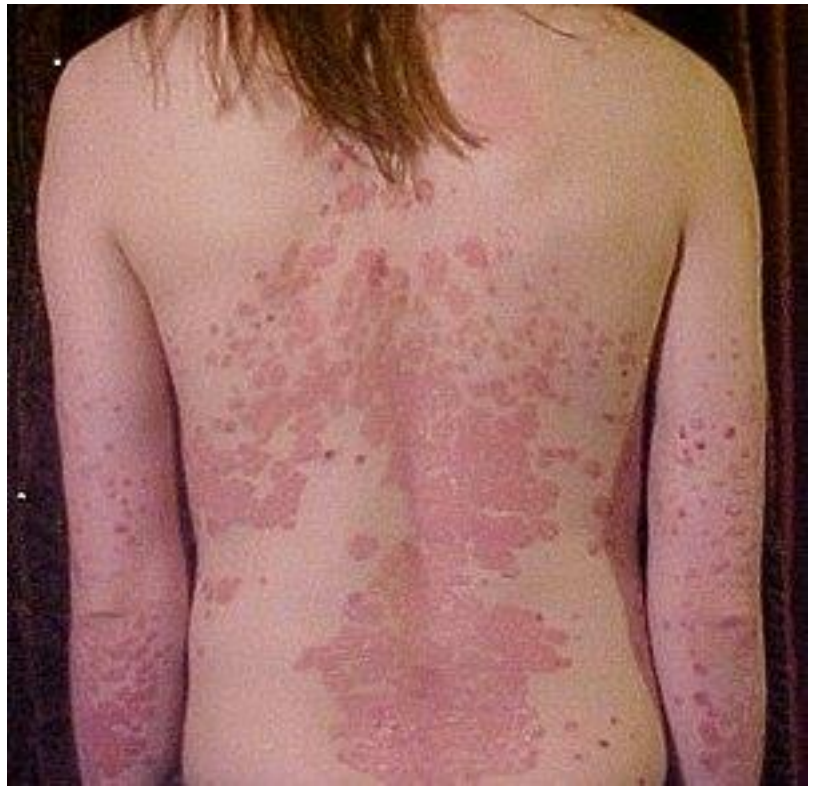
My GP has referred me back to the dermatologist however the wait (because of the backlog) is extremely long.

The GP told me the only way to be seen soon is to pay private. The GP said he doesn't have an alternative cream to try.

I'm currently approximately 80% covered. I went to the out-of-hours service. Again, I was advised to go private so I don't have to wait.

This flare is ruining my life, it's effecting my work, my social life and my relationships.

Il's not fair. If I had suspected skin cancer I would be seen in 2 weeks.'

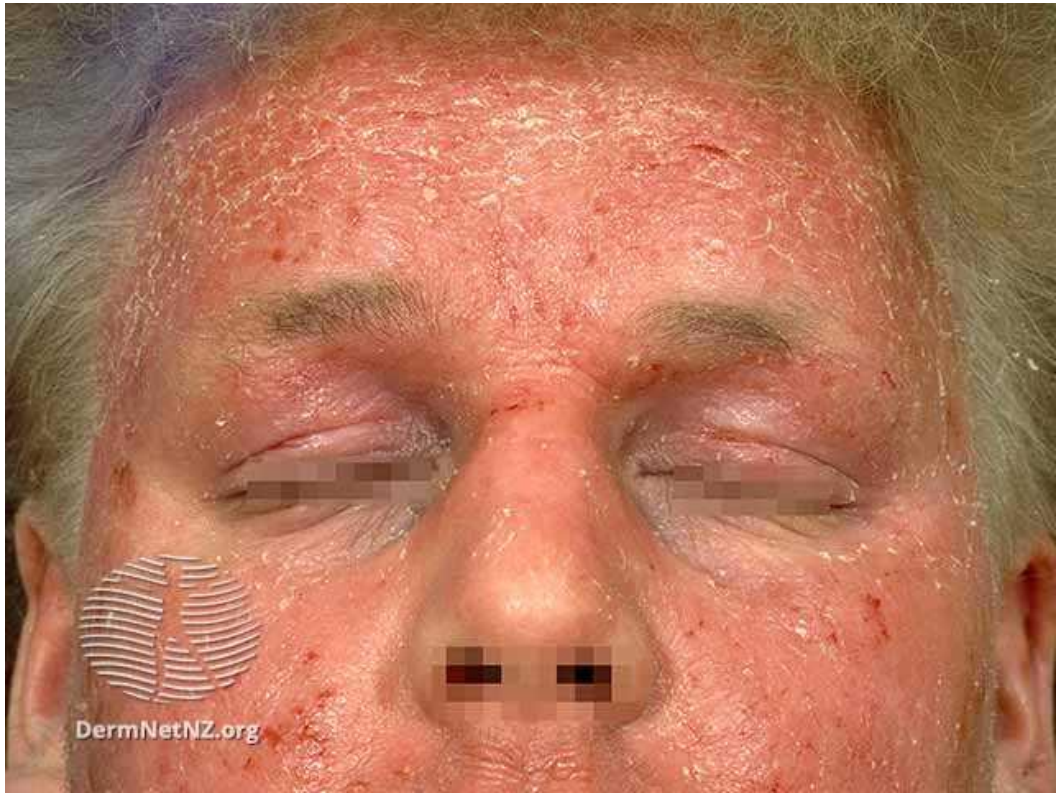


NOTP Dermatology workstreams and guidance

1. Tele-dermatology roadmap: use of digital images with referral
2. Patient Initiated Follow-Up (PIFU)
3. Remote consultations: telephone and video
4. Referral optimisation
5. Optimisation of the two week wait skin cancer referral pathway
6. Pathways redesign consideration (linked to EHIA)
7. Joint working with elective recovery team: waiting list validation and clinical prioritisation
8. Skin cancer Faster Diagnosis Pathway

Dermatology elective recovery plan

- Large numbers of people with skin disease on routine waiting lists (360,000)
- Some people may no longer need an appointment
- Some people may be much worse
- How do we manage this?
- Validation and clinical prioritisation

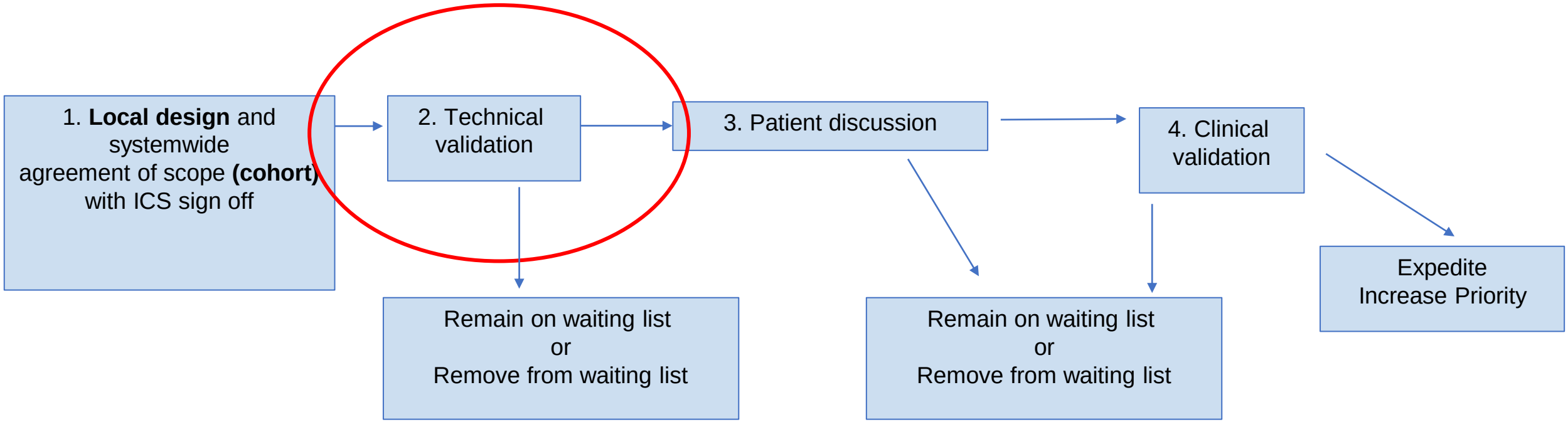


DRAFT: Clinical prioritisation of the dermatology non-admitted (outpatient) waiting list

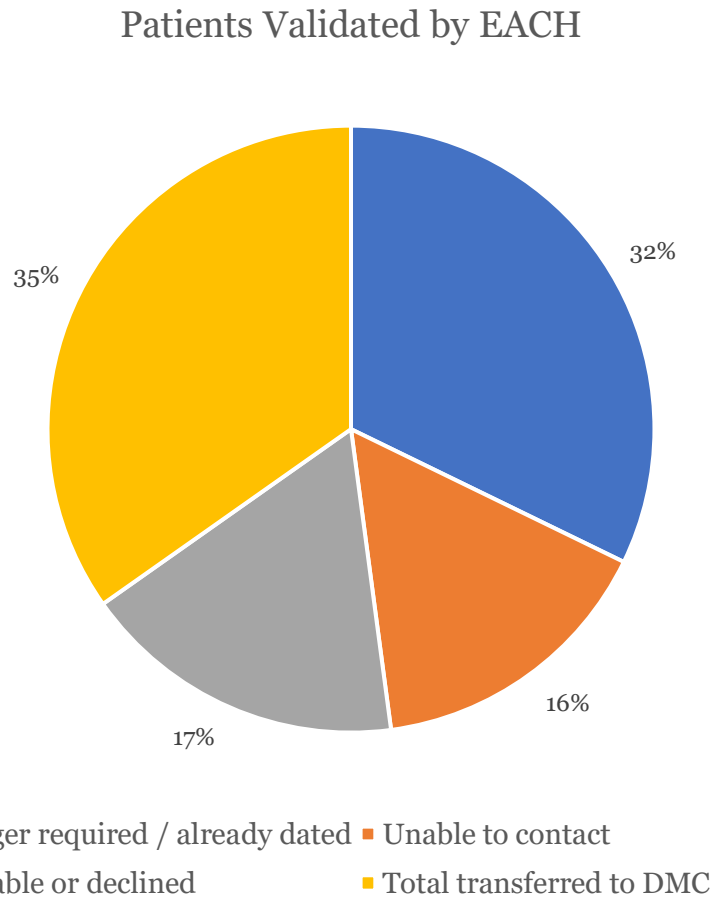
Framework to aid COVID-19 elective recovery

https://future.nhs.uk/connect.ti/OutpatientTransformation/view?objectID=146648293

Stages of validation and prioritisation



Joint working United Lincolnshire Hospitals NHS Trust and DMC: technical validation



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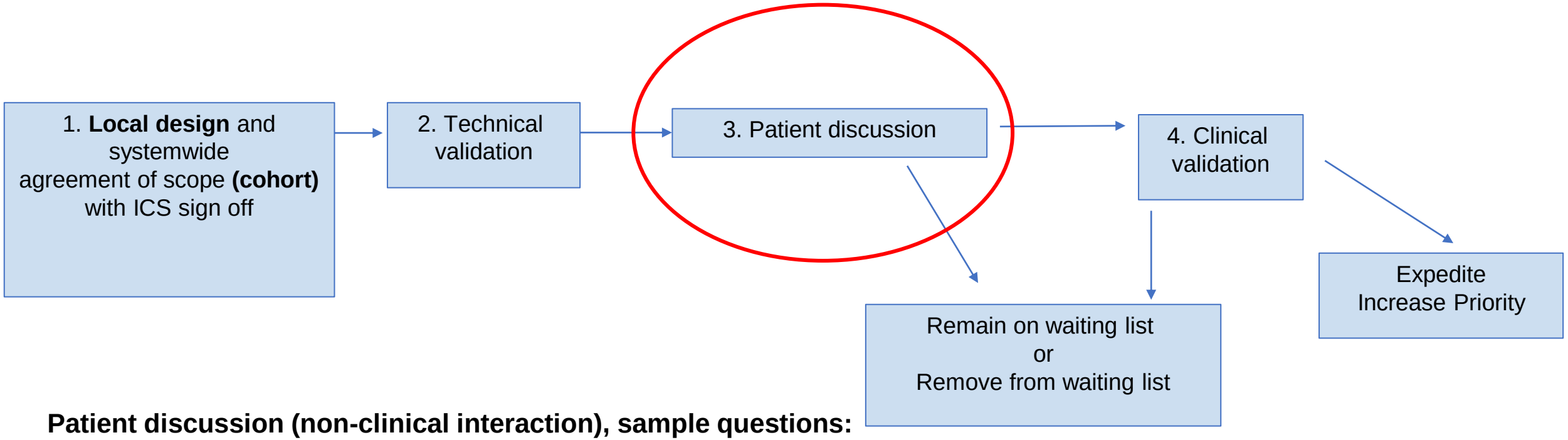
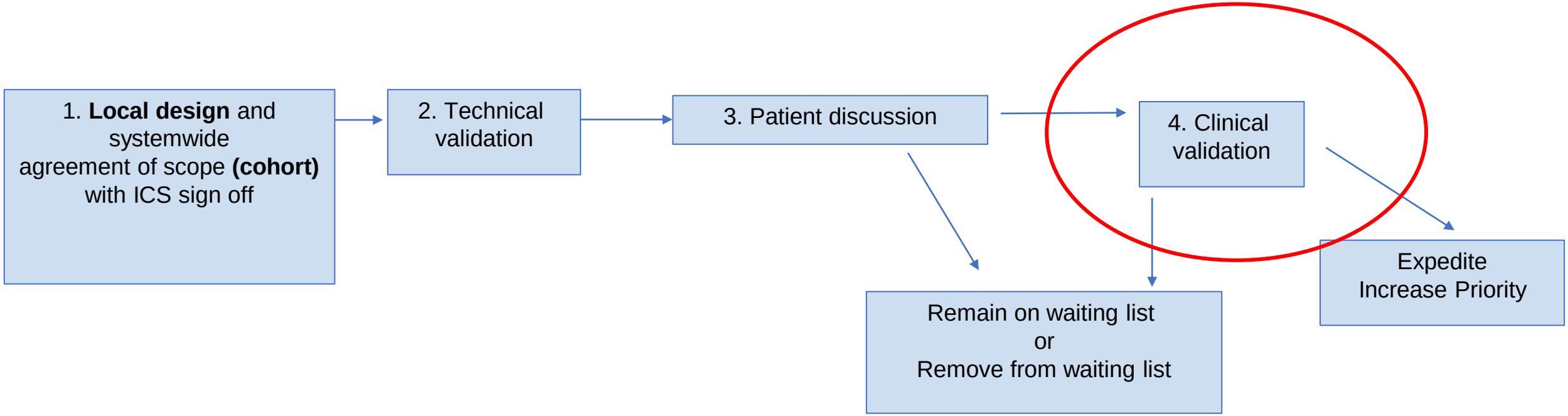


Patient discussion (non-clinical interaction), sample questions:

- Does the patient still want to see a dermatology specialist?
- Is the skin condition/skin lesion the same, worse or better than when the person was referred for a specialist appointment?
- What is the impact of the skin condition on the patients work and lifestyle, family and carers, sleeping etc
- Is the person able to take and send in photographs of their skin condition or to travel to an agreed location to have photographs taken?

Stages of validation and prioritisation



Clinical validation

- Review of all available information including outcome of patient discussion, referral letter
- **Requires up to date images wherever possible**
- Prioritisation of the outpatient appointment; urgent or routine
- No direct patient interaction, outcome communicated with patient and primary care

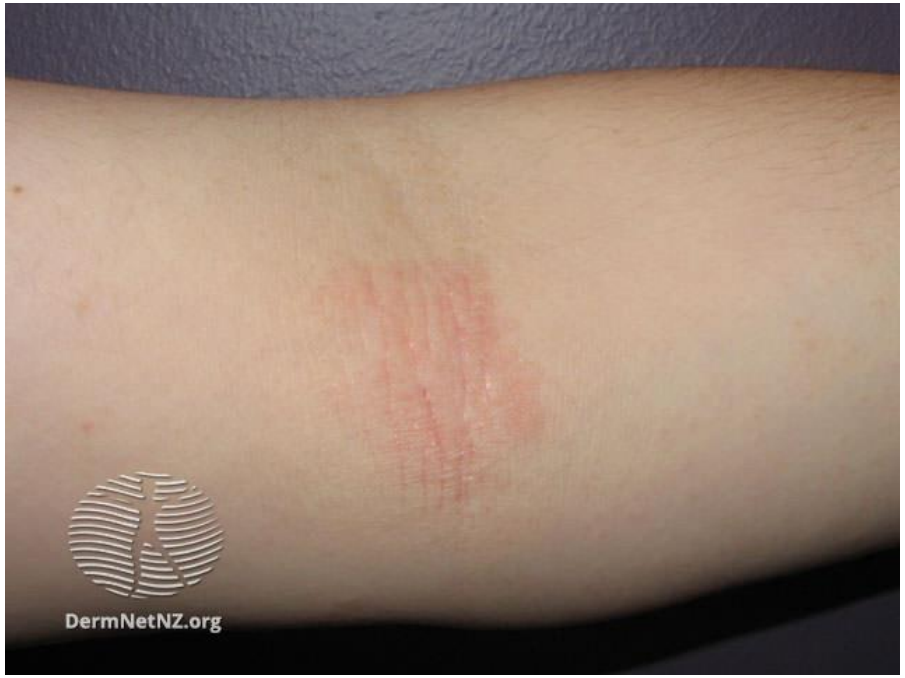
Clinical validation and prioritisation triage: proposed model

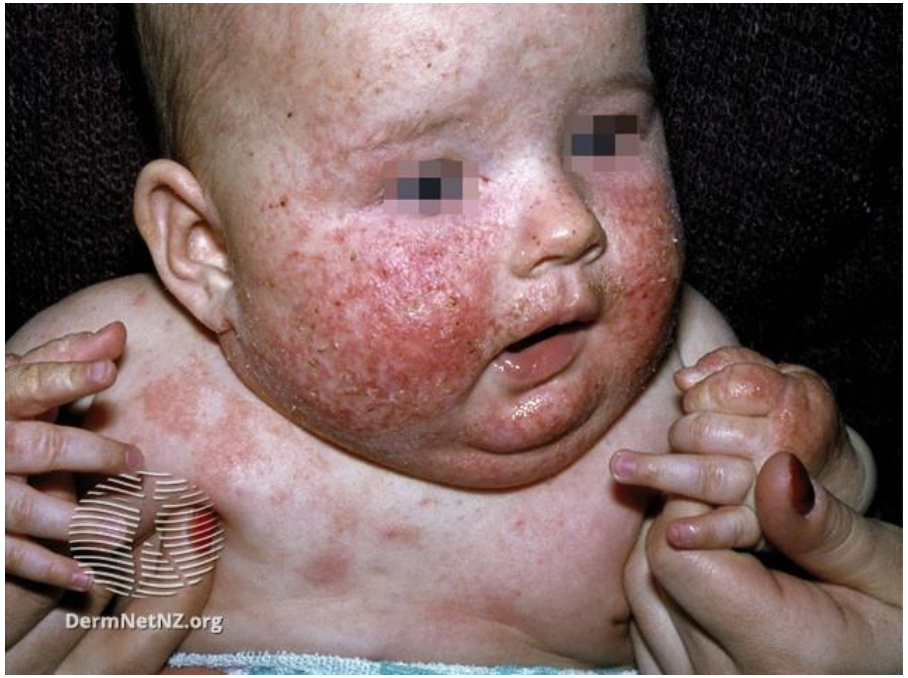
- Agreed locally by dermatology providers working in partnership with administrative support staff and representatives from primary care.
- Review of all available information including outcome of patient discussion, referral letter and **up to date images**
- This process will take place **without a direct patient interaction**
- Once the prioritisation triage process is complete it will be followed by communication with the patient and primary care clinician about next steps by letter
- The prioritisation will reflect the need and urgency for a face to face consultation; this prioritisation will be the same as for new patients being referred
- The process will consider whether the patient could be seen in an intermediate rather than secondary care dermatology service

Importance of up-to-date images

Enables prioritisation appropriately: urgent or routine

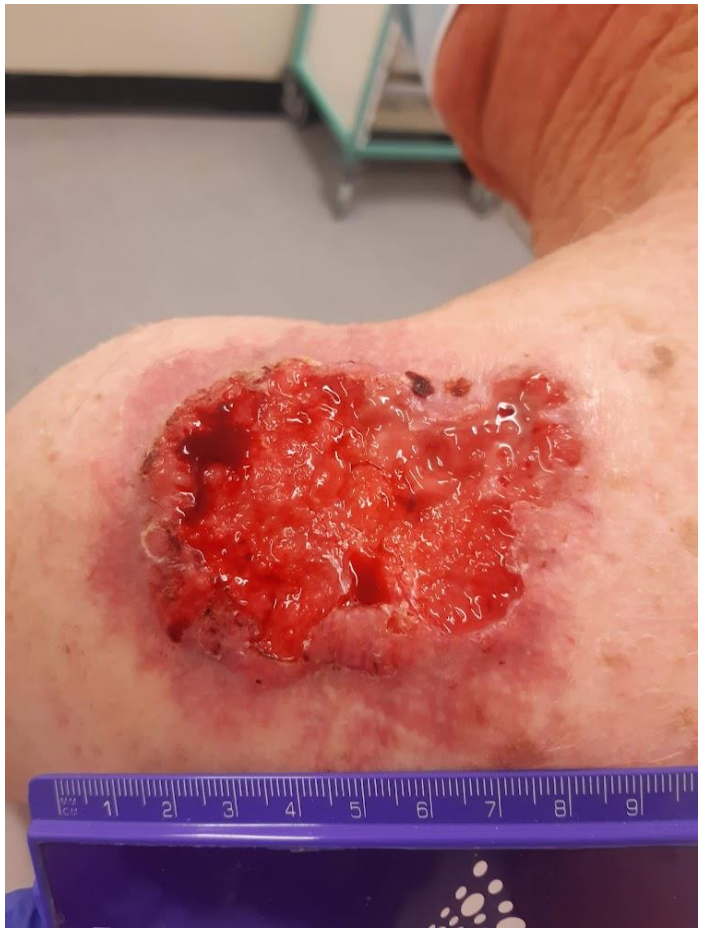
Importance of up-to-date images

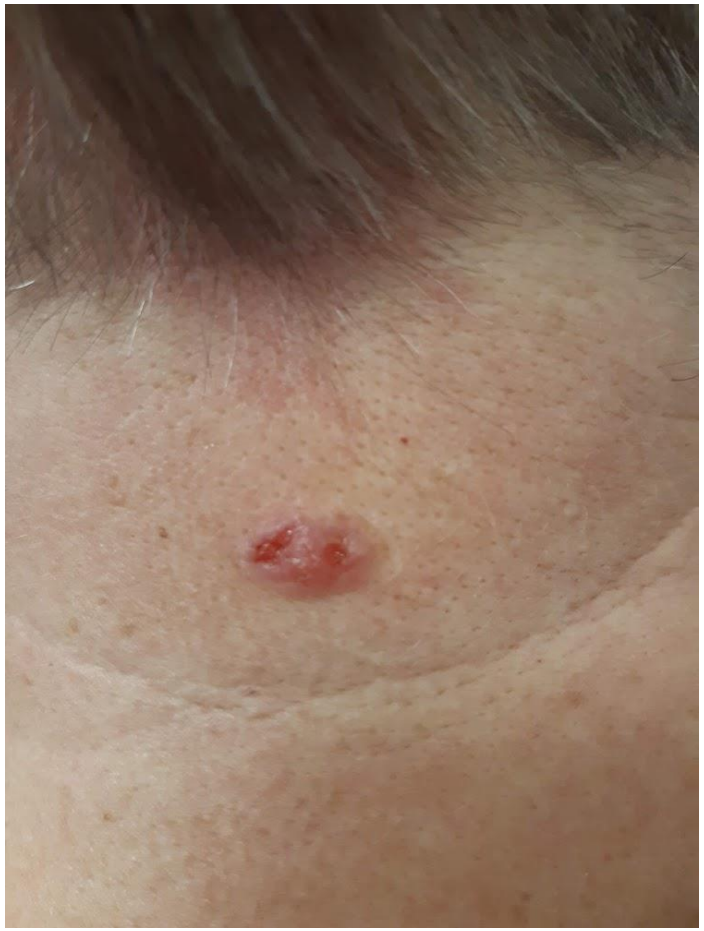




Enables prioritisation appropriately: urgent or routine

Importance of up-to-date images

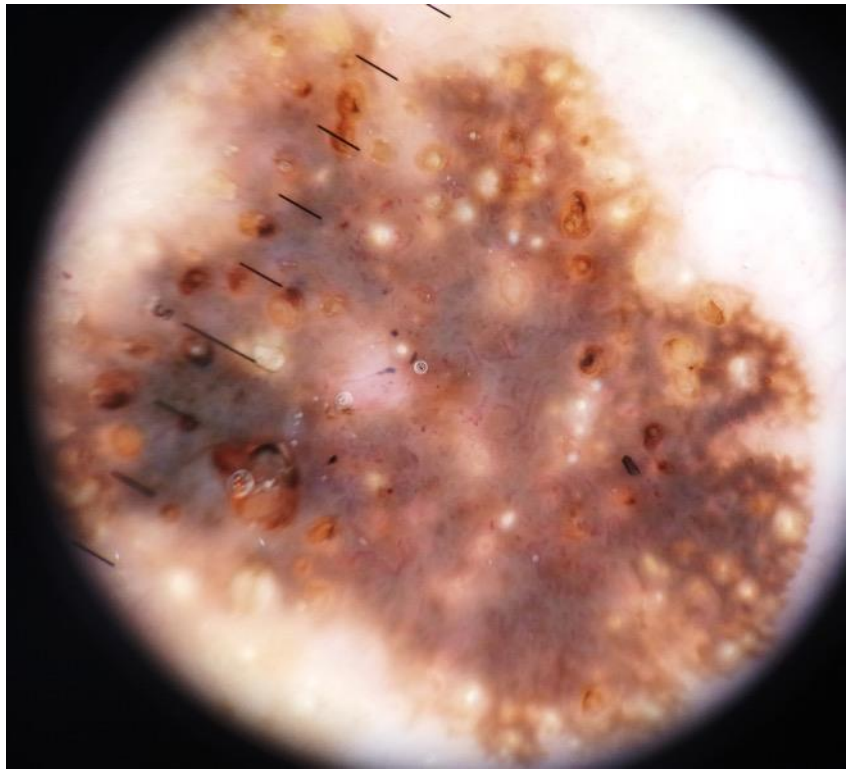


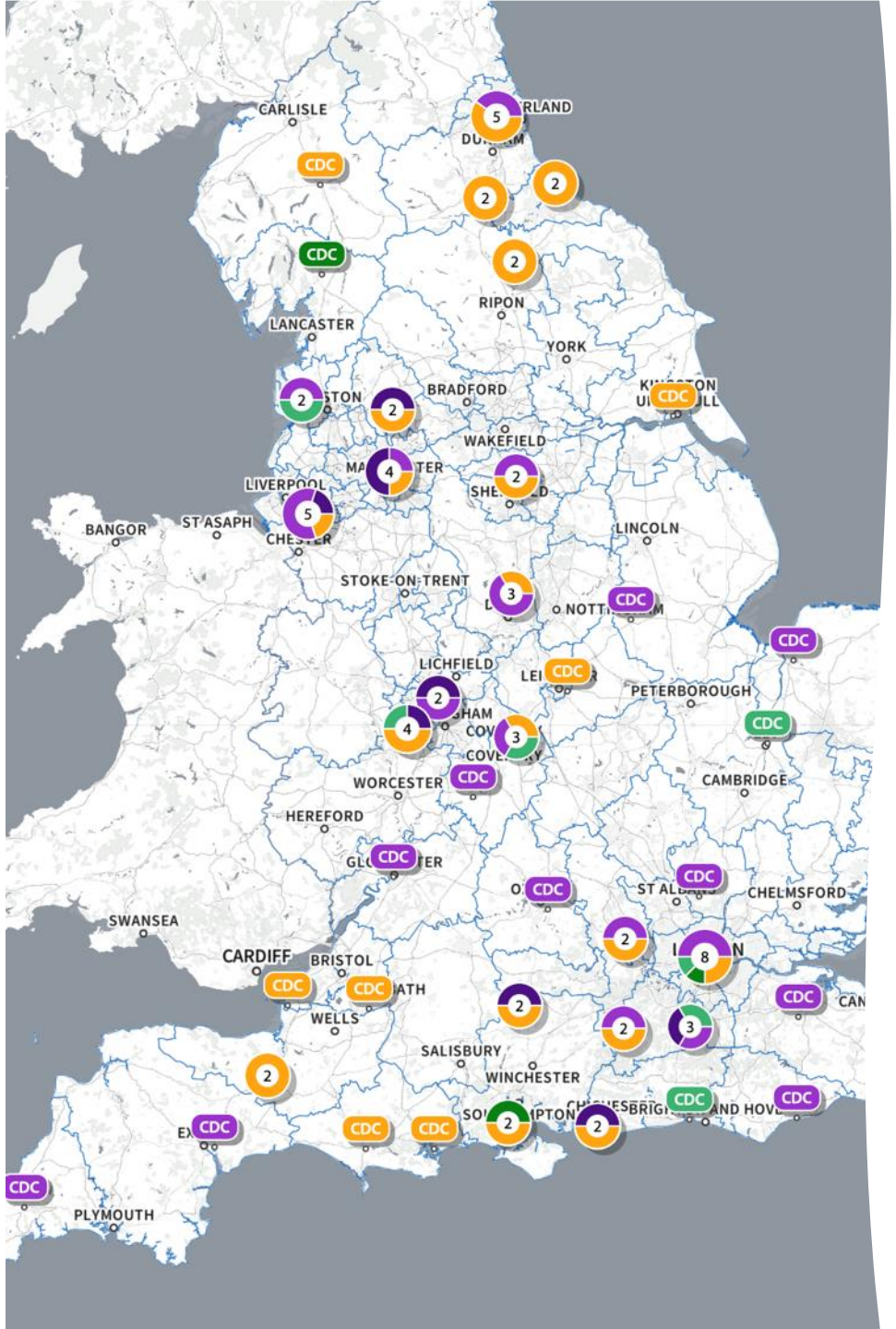


Enables prioritisation appropriately: urgent or routine

Teledermatology: challenges!

- Variable quality images from patients
- Need for dermoscopic images for skin lesion diagnosis
- Double activity: poor images, face to face interaction needed as well
- Primary care limited capacity to take images
- Who should be taking the images?
- Need for community hubs for image taking; community diagnostic centres (CDCs)
- Avoiding inequity of access using teledermatology





CDC Update

- The establishment of CDCs were a key recommendation of the 2020 Richards Review of Diagnostics in England.
- 106 CDC sites are live and multiple sites approved and opening in 2023/24.
- CDCs have delivered over 3m tests since the first CDC went live in July 2021.
- Over 98% of CDC activity is elective.
- There is evidence that CDCs are helping to retain staff who may otherwise have left, and are attracting unprecedentedly positive reviews by patients.
- CDCs represent a growing proportion of NHS capacity, and with the continued surge of unplanned activity in acutes, CDCs are an essential cornerstone of recovery.

CDC Update

New pathways and models of care needed including tele-dermatology

Implementation of skin lesion diagnostic pathways including the two week wait virtual pathway requires **high quality images** including dermoscopic images

CDCs offer an optimal environment to support the delivery of high quality images to support teledermatology pathways

As part of the tech-enabled dermatology transformation programme of work, ICBs were asked to identify at least one CDC from which to provide dermoscopy services.

23 systems have confirmed that they will set up photography services; support in place for this to be delivered in Q3.

Joint working to develop specification for ‘studio’ with Institute of Medical Illustrators and training standards for those taking images

Underpinned by update of ‘teledermatology roadmap’

Teledermatology roadmap update: why?

- Provide updated actions for Integrated Care Boards (ICBs); stressing importance of pan-system development
- Asked for more detail on image taking models (eg community hubs), who and where
- Need to link to relevant guidance documents that require images
- Request to include section on Artificial Intelligence for ICBs and providers
- In final stages of development

Updated teledermatology roadmap: content

Principle 1: patient centred care

Patients need to be kept informed about the use of images in their care pathway - in a clear, compassionate and timely way

NOTE: teledermatology pathways should not increase inequity of access to care

Principle 2: avoid additional burden

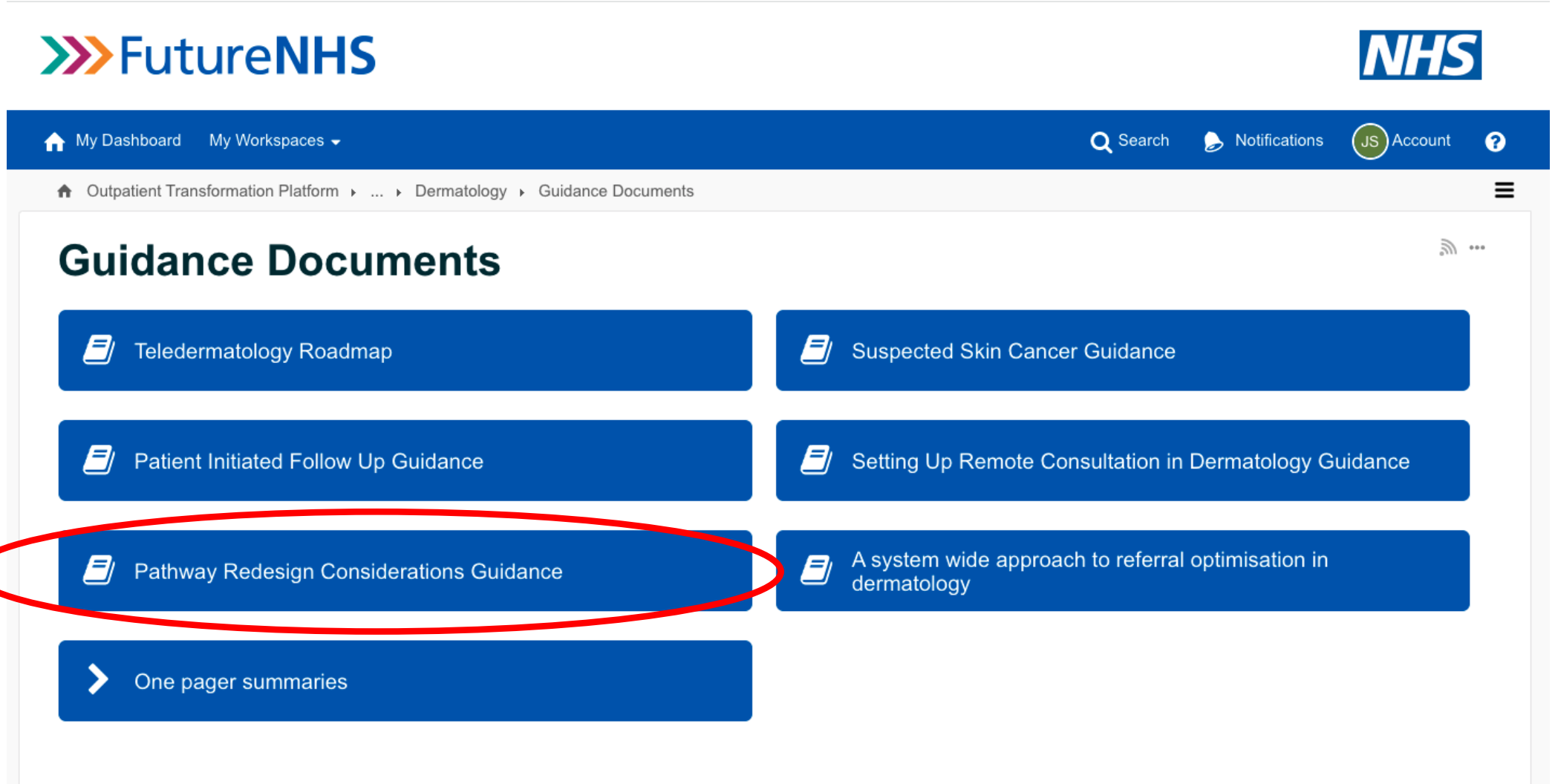
Teledermatology should not create extra burden to healthcare professionals or create additional steps in the patient pathway

NOTE: everyone needs to be involved in setting up the service from the outset, project management is needed and careful modelling

Teldermatology roadmap: contents

- Step 1: identify the role of teledermatology in the service
- Step 2: designing the service: taking the images
- Step 2: designing the service, sending and reviewing the images
- Step 3: identify the resources (£££) required to set up the service
- Step 4: training and development
- Step 5: audit, metrics and quality assurance
- Step 6: teledermatology payments

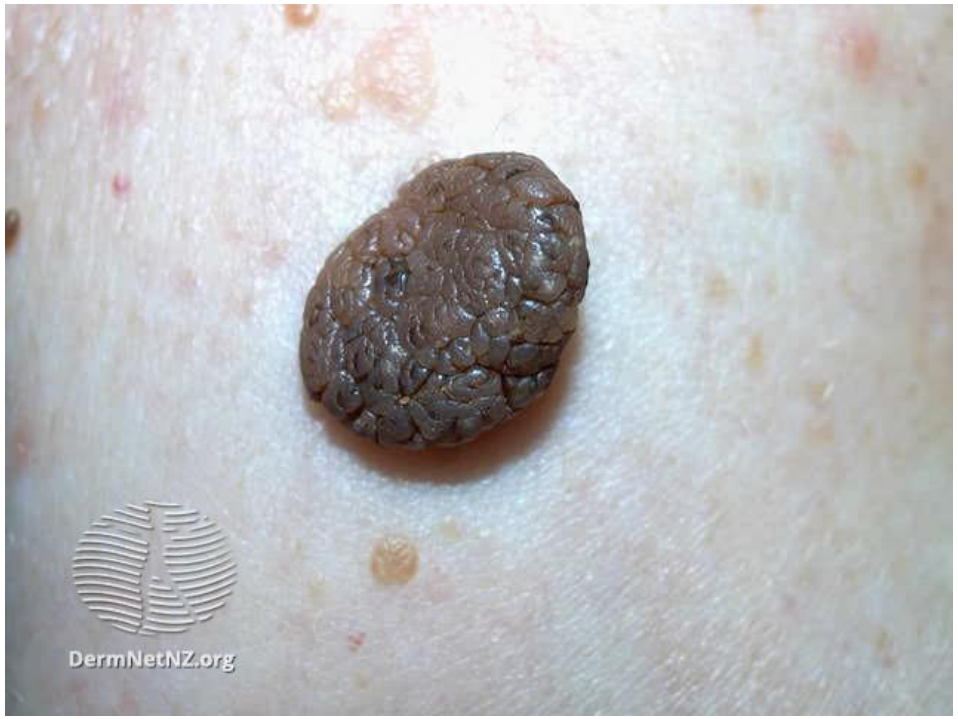
What about teledermatology and equity of access to care?



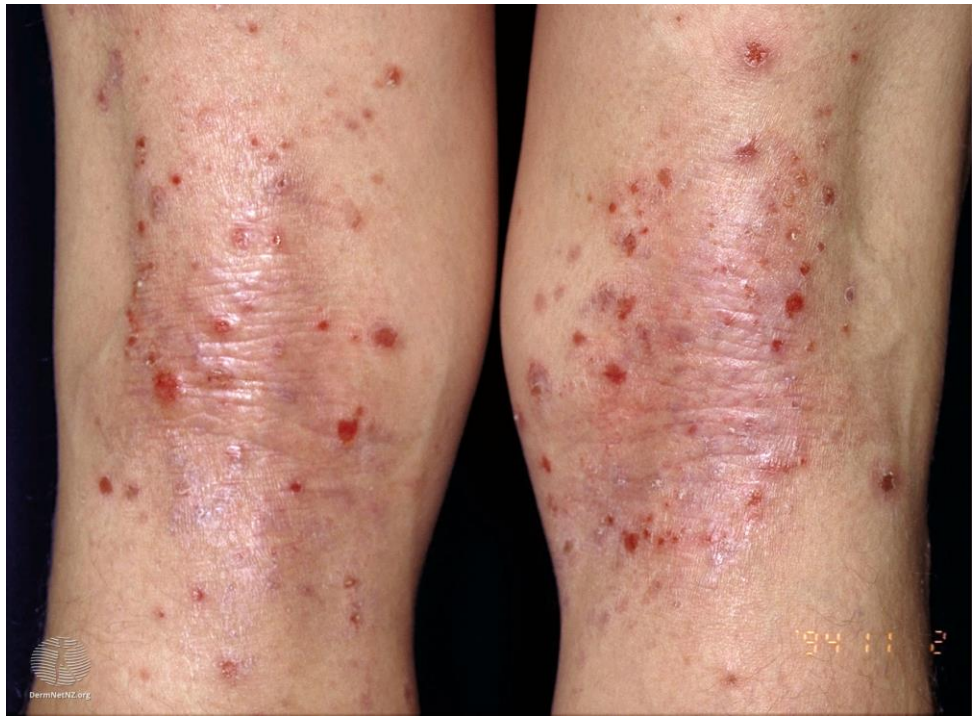
Teledermatology for skin lesions: challenges and mitigations to equity of access

- Patients may not have access to image-taking equipment and/or be able to send good quality images, meaning teledermatology care pathways are unavailable to them
- Lack of access to suitable image-taking services will mean patients have to attend hospital appointments
- Substituting a face-to-face consultation with an exchange of images and text may miss important points in the history and examination, with attendant clinical risk
- Without direct communication between the specialist and patient (communication is via the primary care clinician), there is the potential that the diagnosis and management are not as well explained to the patient
- Reduction in face-to-face interactions and move towards ‘single lesion’ diagnostic services will reduce the number of skin cancers discovered as incidental findings

Can we do elective recovery as part of business as usual?



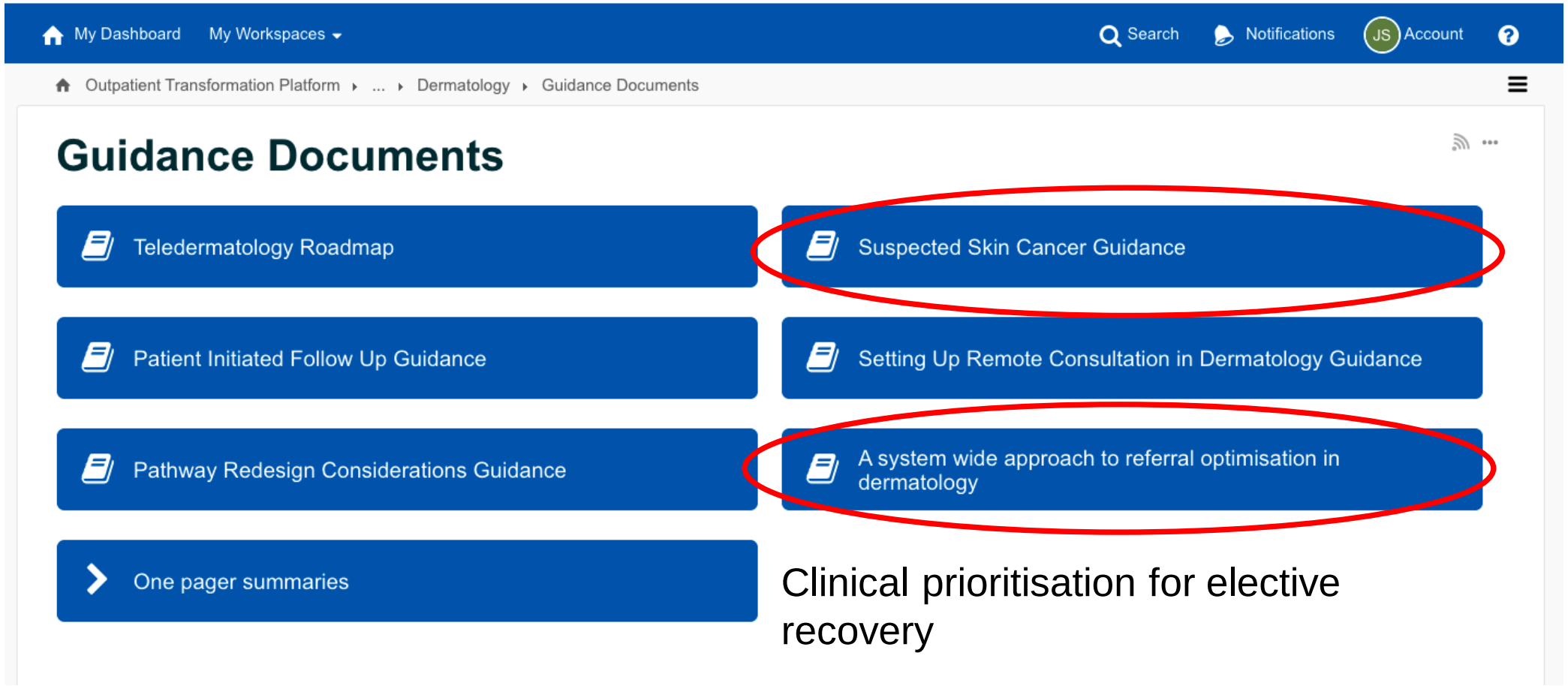
2 week wait referral



Routine referral

Need a new pan-system approach to ensure equity of access in future

Business as usual and elective recovery: pan-system reform



Clinical prioritisation for elective recovery

Summary

- Pan-system approach needed to optimise care for people with skin disease
- New referral management pathways using ‘Advice and Guidance’
- Use of images for ‘store and forward’ teledermatology pivotal
- Images to support A&G referrals, skin lesion diagnosis pathways and triage patients on long waiting lists
- Optimising skin lesion diagnostic pathways will free up capacity for people with inflammatory skin disease

Thank you

j.k.Schofield@herts.ac.uk

NHS Elective Care Conference North

Q&A Panel

Fernando Correia, MD PhD

Founding Team & SVP Clinical Affairs - **Sword Health**

Marc Lyall

Associate Head of Workforce Transformation - **NHSE**

Dr Benyamin Deldar

Co-CEO Deep Medical, Innovation fellow - **Mid and South Essex FT, Deep Medical**

Networking and Lunch

NHS Elective Care Conference North

Chairs Afternoon Address

Mr Anil Vara

Director, Elective Care & Recovery - **North Yorkshire and Humber ICB**

NHS Elective Care Conference North

NHS Elective Care Conference North

SPEAKING NOW

Marc Lyall

Associate Head of Workforce Transformation
- **NHSE**

I will be discussing...

"Reflections from workforce transformation in Elective Care Recovery"

Reflections from Workforce Transformation in Elective Care Recovery

Marc Lyall – Associate Head of Workforce Transformation; Workforce Transformation, NHS England

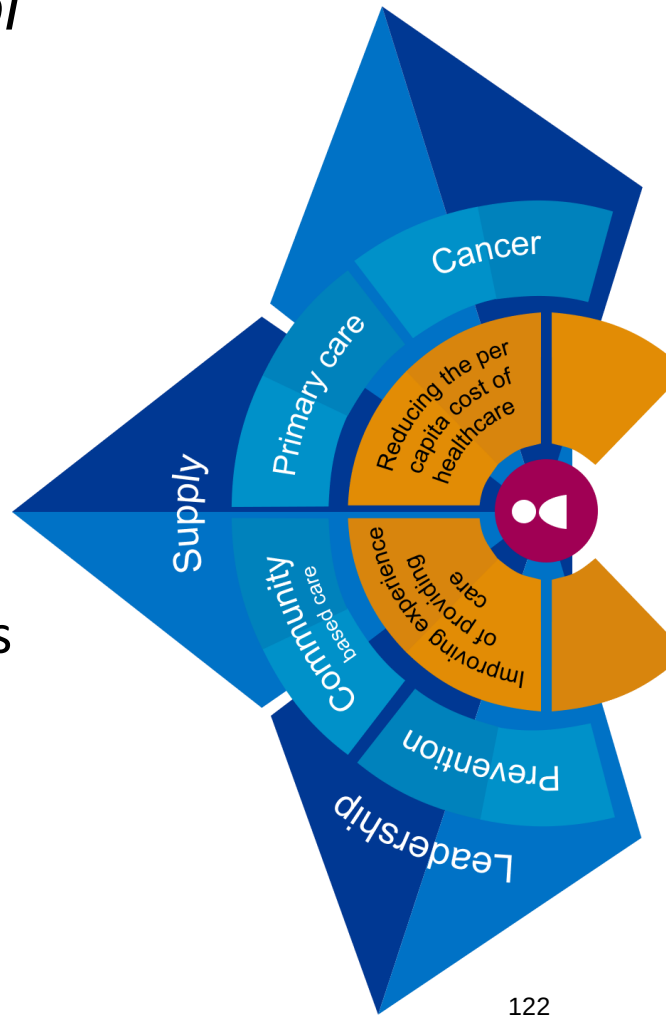
People Promise

Workforce Transformation | What is Workforce Transformation?

"Transformation is a process of profound and radical change, that takes an organisation in a new direction and to an entirely different level of effectiveness".

From a **workforce perspective** this requires us to:

- Understand the current context
- Understand the future of work
- More, or **different?**
- Explore the broader skills requirement, beyond traditional competencies and roles
- Nurture a future integrated workforce that is more agile/flexible
- Support leaders and talent at all levels

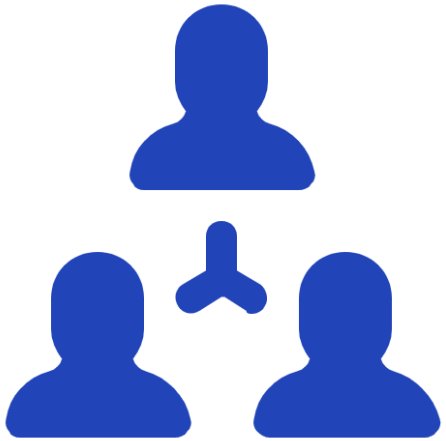


Workforce Transformation | Key Challenges and Opportunities

Challenges	Opportunities
Too many priorities for systems, **little standardisation of processes** and **limited ICS capacity** for service and workforce redesign, all compromising the development and delivery of workforce redesign plans	A mandate to work as system partners and 'new' NHSE (integrating workforce redesign alongside service transformation and digital enablers, reducing duplication and variation, maximise collective expertise)
System partnerships/governance/cultures in their infancy, coupled with **limited understanding of workforce redesign** models, where to start and what's needed to deliver locally driven changes (more of the same considered 'easier' and safer, than doing differently	The common goal of needing to attract and retain, fill difficult gaps and grow their own across the system footprint and our universal offer to co-produce progressive workforce redesign investment plans with every ICS Wider workforce redesign potential, including social care, third sector, volunteers…
ICS **capacity to capture impact and evidence base** to inspire spread and adoption	Tools and frameworks to support the process end to end, including the culture of change
No single place to source best practice to accelerate spread of what works, nor any clear evidence of international best practice of skills mix	Online Repository of Information being developed to support Elective Care Recovery programme of work
The **growing need for responsive education and development packages** to address the range and pace of supply and up-skilling challenges across health and care	Expand training and development routes by building on well-developed relationships with Royal Colleges and Higher and Further education, as well as maximising technological solutions e.g. e-learning for healthcare, Blended Learning

Workforce Transformation | Working differently

Multi-disciplinary teams with the optimal skills mix



Integrated working

Embracing technology

Personalised and holistic care

Workforce Transformation| Possible solutions

Examples of practical solutions include:

Supply
- System wide recruitment and attraction
- Workforce planning and modelling
- Return to Practice
- Retention initiatives
- Respond to increased need for new roles

Up-skilling
- Advanced practitioners
- Critical care skills
- Non-medical prescribing training
- Apprenticeships
- Use of Blended Learning, TEL

New roles
- General Practice Assistants
- Physician Associates
- Nurse Associate Preceptorship programme

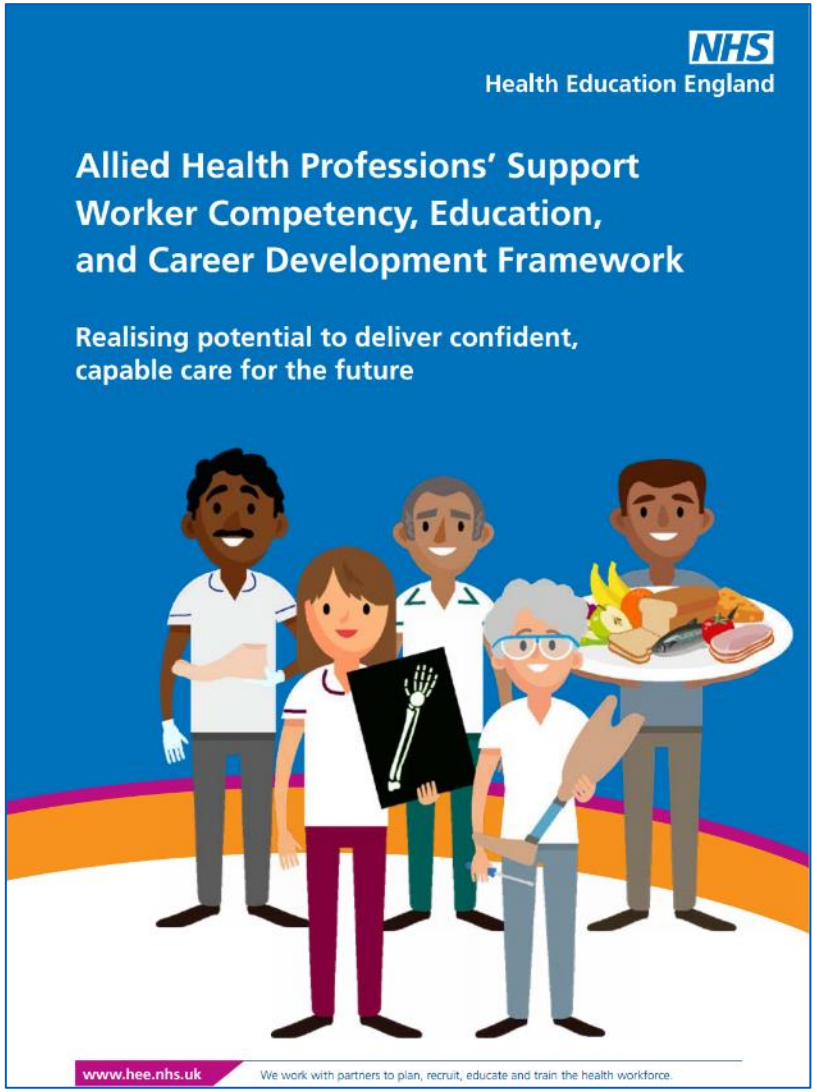
New ways of working
- Community Diagnostic Hubs rapid staff up-skill
- London Breast Screening Recovery Training
- Rotational programmes
- Digital working

Leadership
- Leadership programmes
- Organisational Development
- Health and wellbeing
- Equality and diversity
- System infrastructure

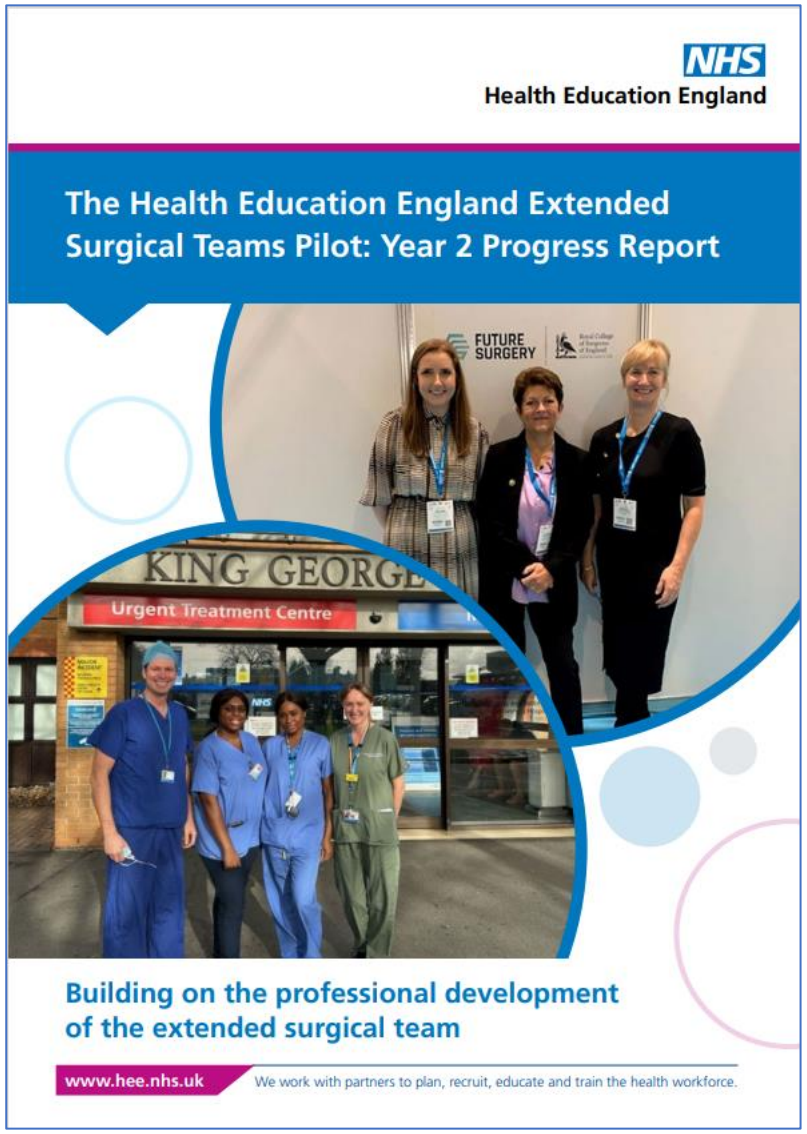
Workforce capacity | Theatre Support Workforce

- Allied Health Profession (AHP) Support Worker Competency, Education and Career Development Framework
- Readiness toolkit
- Grow your own workforce strategies
- Making learning work for support workers
- Education qualification mapping tool
- Supervision, accountability and delegation of activities

- Nationally-led procurement for Level 3 Senior Healthcare Support Worker apprenticeship (including Theatres pathway) and Level 5 Assistant Practitioner apprenticeship (including Theatres pathway)
- The Role of the Perioperative Healthcare Assistant in the Surgical Care Team, The Perioperative Care Collaborative (2020)
- https://www.hee.nhs.uk/our-work/allied-health-professions/enable-workforce/developing-role-ahp-support-workers



Workforce capacity | Extended Surgical Teams (EST) pilot



The Health Education England Extended Surgical Team (EST) pilot commenced in November 2020.

Aimed at new 'extended' surgical teams, which include consultants, doctors in training and SAS doctors, but the focus of the pilot is the role of multi professional team members.

Reproduceable model which sees service improvement and added value for surgical units.

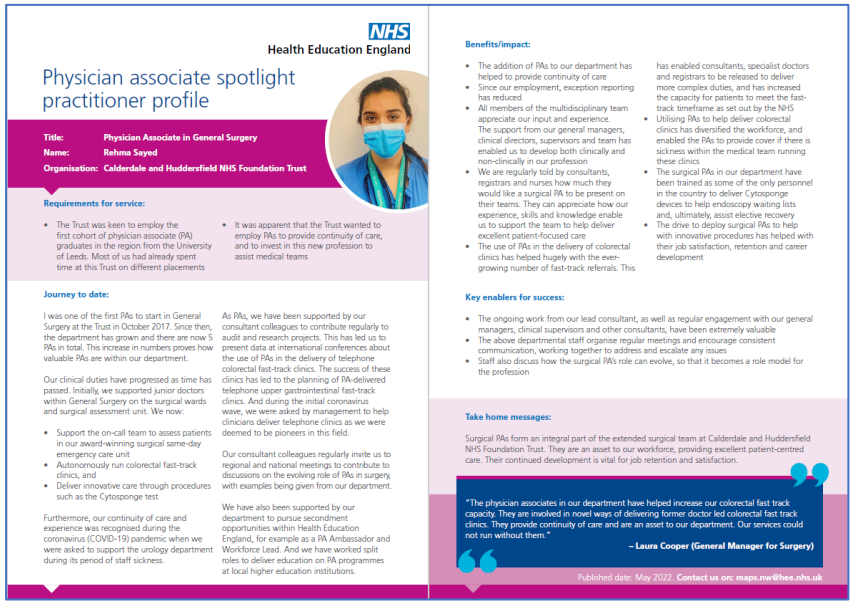
Compared to usual practice, the EST is expected to generate value:

- providing a cost-effective alternative to "usual practice" staffing models, improved system efficiency and improved workforce longevity and productivity,
- enabling more time for surgeons in training to focus on activities which promote training and learning,
- providing opportunities for clinical career progression and skills enhancement for advanced clinical practitioners.

Year 1 report Year 2 report Return on Investment Tool

Extended Surgical Team (EST) pilot | Health Education England (hee.nhs.uk)

Workforce capacity | Medical Associate Professions (MAPS)



NHS
Health Education England

Physician associate spotlight practitioner profile

Title: Physician Associate in General Surgery
Name: Rehma Sayed
Organisation: Calderdale and Huddersfield NHS Foundation Trust

Requirements for service:

- The Trust was keen to employ the first cohort of physician associate (PA) graduates in the region from the University of Leeds. Most of us had already spent time at this Trust on different placements
- It was apparent that the Trust wanted to employ PAs to provide continuity of care, and to invest in this new profession to assist medical teams

Journey to date:

I was one of the first PAs to start in General Surgery at the Trust in October 2017. Since then, the department has grown and there are now 5 PAs in total. This increase in numbers proves how valuable PAs are within our department.

Our clinical duties have progressed as time has passed. Initially, we supported junior doctors within General Surgery on the surgical wards and surgical assessment unit. We now:

- Support the on-call team to assess patients in our award-winning surgical same-day emergency care unit
- Autonomously run colorectal fast-track clinics, and
- Deliver innovative care through procedures such as the Cytosponge test

Furthermore, our continuity of care and experience was recognised during the coronavirus (COVID-19) pandemic when we were asked to support the urology department during its period of staff sickness.

As PAs, we have been supported by our consultant colleagues to contribute regularly to audit and research projects. This has led us to present data at international conferences about the use of PAs in the delivery of telephone colorectal fast-track clinics. The success of these clinics has led to the planning of PA-delivered telephone upper gastrointestinal fast-track clinics. And during the initial coronavirus wave, we were asked by management to help clinicians deliver telephone clinics as we were deemed to be pioneers in this field.

Our consultant colleagues regularly invite us to regional and national meetings to contribute to discussions on the evolving role of PAs in surgery, with examples being given from our department.

We have also been supported by our department to pursue secondment opportunities within Health Education England, for example as a PA Ambassador and Workforce Lead. And we have worked split roles to deliver education on PA programmes at local higher education institutions.

Benefits/impact:

- The addition of PAs to our department has helped to provide continuity of care
- Since our employment, exception reporting has reduced
- All members of the multidisciplinary team appreciate our input and experience. The support from our general managers, clinical directors, supervisors and team has enabled us to develop both clinically and non-clinically in our profession
- We are regularly told by consultants, registrars and nurses how much they would like a surgical PA to be present on their teams. They can appreciate how our experience, skills and knowledge enable us to support the team to help deliver excellent patient-focused care
- The use of PAs in the delivery of colorectal clinics has helped hugely with the ever-growing number of fast-track referrals. This has enabled consultants, specialist doctors and registrars to be released to deliver more complex duties, and has increased the capacity for patients to meet the fast-track timeframe as set out by the NHS
- Utilising PAs to help deliver colorectal clinics has diversified the workforce, and enabled the PAs to provide cover if there is sickness within the medical team running these clinics
- The surgical PAs in our department have been trained as some of the only personnel in the country to deliver Cytosponge devices to help endoscopy waiting lists and, ultimately, assist elective recovery
- The drive to deploy surgical PAs to help with innovative procedures has helped with their job satisfaction, retention and career development

Key enablers for success:

- The ongoing work from our lead consultant, as well as regular engagement with our general managers, clinical supervisors and other consultants, have been extremely valuable
- The above departmental staff organise regular meetings and encourage consistent communication, working together to address and escalate any issues
- Staff also discuss how the surgical PAs role can evolve, so that it becomes a role model for the profession

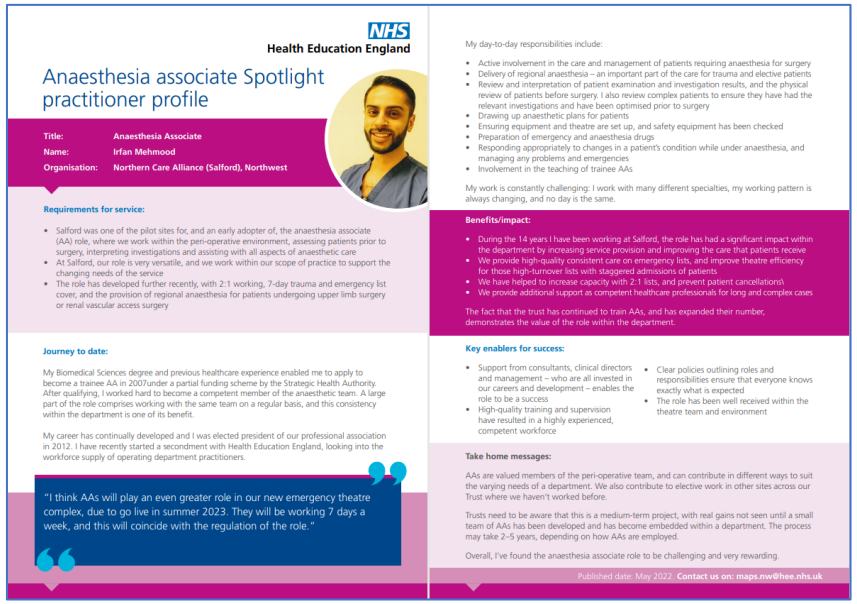
Take home messages:

Surgical PAs form an integral part of the extended surgical team at Calderdale and Huddersfield NHS Foundation Trust. They are an asset to our workforce, providing excellent patient-centred care. Their continued development is vital for job retention and satisfaction.

"The physician associates in our department have helped increase our colorectal fast track capacity. They are involved in novel ways of delivering former doctor led colorectal fast track clinics. They provide continuity of care and are an asset to our department. Our services could not run without them."

– Laura Cooper (General Manager for Surgery)

Published date: May 2022. **Contact us on: maps.nw@hee.nhs.uk**



NHS
Health Education England

Anaesthesia associate Spotlight practitioner profile

Title: Anaesthesia Associate
Name: Irfan Mehmood
Organisation: Northern Care Alliance (Salford), Northwest

Requirements for service:

- Salford was one of the pilot sites for, and an early adopter of, the anaesthesia associate (AA) role, where we work within the peri-operative environment, assessing patients prior to surgery, interpreting investigations and assisting with all aspects of anaesthetic care
- At Salford, our role is very versatile, and we work within our scope of practice to support the changing needs of the service
- The role has developed further recently, with 2:1 working, 7-day trauma and emergency list cover, and the provision of regional anaesthesia for patients undergoing upper limb surgery or renal vascular access surgery

Journey to date:

My Biomedical Sciences degree and previous healthcare experience enabled me to apply to become a trainee AA in 2007under a partial funding scheme by the Strategic Health Authority. After qualifying, I worked hard to become a competent member of the anaesthetic team. A large part of the role comprises working with the same team on a regular basis, and this consistency within the department is one of its benefit.

My career has continually developed and I was elected president of our professional association in 2012. I have recently started a secondment with Health Education England, looking into the workforce supply of operating department practitioners.

"I think AAs will play an even greater role in our new emergency theatre complex, due to go live in summer 2023. They will be working 7 days a week, and this will coincide with the regulation of the role."

My day-to-day responsibilities include:

- Active involvement in the care and management of patients requiring anaesthesia for surgery
- Delivery of regional anaesthesia – an important part of the care for trauma and elective patients
- Review and interpretation of patient examination and investigation results, and the physical review of patients before surgery. I also review complex patients to ensure they have had the relevant investigations and have been optimised prior to surgery
- Drawing up anaesthetic plans for patients
- Ensuring equipment and theatre are set up, and safety equipment has been checked
- Preparation of emergency and anaesthesia drugs
- Responding appropriately to changes in a patient's condition while under anaesthesia, and managing any problems and emergencies
- Involvement in the teaching of trainee AAs

My work is constantly challenging: I work with many different specialties, my working pattern is always changing, and no day is the same.

Benefits/impact:

- During the 14 years I have been working at Salford, the role has had a significant impact within the department by increasing service provision and improving the care that patients receive
- We provide high-quality consistent care on emergency lists, and improve theatre efficiency for those high-turnover lists with staggered admissions of patients
- We have helped to increase capacity with 2:1 lists, and prevent patient cancellations\
- We provide additional support as competent healthcare professionals for long and complex cases

The fact that the trust has continued to train AAs, and has expanded their number, demonstrates the value of the role within the department.

Key enablers for success:

- Support from consultants, clinical directors and management – who are all invested in our careers and development – enables the role to be a success
- High-quality training and supervision have resulted in a highly experienced, competent workforce
- Clear policies outlining roles and responsibilities ensure that everyone knows exactly what is expected
- The role has been well received within the theatre team and environment

Take home messages:

AAs are valued members of the peri-operative team, and can contribute in different ways to suit the varying needs of a department. We also contribute to elective work in other sites across our Trust where we haven't worked before.

Trusts need to be aware that this is a medium-term project, with real gains not seen until a small team of AAs has been developed and has become embedded within a department. The process may take 2–5 years, depending on how AAs are employed.

Overall, I've found the anaesthesia associate role to be challenging and very rewarding.

Published date: May 2022. **Contact us on: maps.nw@hee.nhs.uk**

NHS
Health Education England

Physician associate spotlight practitioner profile

Title: Physician Associate
Name: Rachel Atherton
Organisation: Royal Preston Hospital, North West

Requirements for service:

- This role was developed initially to increase continuity of care, coordinate jobs and take part in ward rounds
- In 3 years, the role has developed to include assisting in elective and emergency theatre, the delivery of outpatient clinics and triaging urgent cancer referrals

Journey to date:

I started work with another colleague at the Royal Preston Hospital 3 years ago – we were the first physician associates (PA) employed in the Colorectal team. I was attracted to the position, having previously completed a very enjoyable and proactive work placement there as a student. I subsequently developed a keen interest in surgery, which motivated me to apply for the role.

Initially in 2019, a work plan was organised to develop our skills in assisting in theatre, facilitating clinics and supporting ward rounds. After a period of shadowing in what was a steep learning curve, we took part in weekly clinics and theatre days. A structure was in place to ensure that a PA was present on the ward to coordinate jobs and provide continuity of care.

As part of our training, we gained our Basic Surgical Skills qualification, which increased our scope of practice in theatre, particularly in suturing and handling tissues/instruments as a second assistant. In my first year, I assisted in approximately 40 operations, ranging from laparoscopic to open cases, and elective to emergency cases.

We currently also work one clinic per week as part of a team of consultants, registrars and advanced clinical practitioners to triage the urgent (2-week) referrals.

Benefits/impact:

- PAs provide cover on the ward, enabling junior doctors to gain experience in theatre during their surgical placement, thereby providing real benefits within a junior team
- PAs bring increased efficiency to the ward, enabling smoother patient flow and faster, safe discharges
- Nursing staff have commented on the increased efficiency on the ward as a result of the work of the PAs
- Administrative queries are dealt with quickly and efficiently, minimising the likelihood of difficulties and miscommunication
- As a result of PAs delivering one clinic per week, approximately 48 more patients per month now receive an urgent specialist review. This has also yielded financial benefits, allowing our service to reduce wait times for patients without the costly hire of locum staff
- PAs have become part of the multidisciplinary team, with close links to essential services such as the nutritional team and stoma nurses. Having the knowledge of, and respect for, other departments has streamlined our patient care within the Colorectal team

Key enablers for success:

- Job satisfaction – being valued in our team, having opportunities to build a reputation within our Trust and working closely with supportive consultants and colleagues has led to a great deal of job satisfaction on our part
- Adaptable – PAs can adapt and evolve into many types of service provision
- Resilient – PAs are a resilient group of highly skilled individuals, ready to help shape and enhance any team

"The addition of PAs to the colorectal team has made a significant impact, particularly in terms of inpatient care and the support/training of junior doctors. They essentially run the ward, knowing every patient on the colorectal emergency and elective ward round lists. They always know where we are up to, and what are the issues relating to that patient at that particular part of their recovery. Their work ethic has been exemplary. They have continued to develop in their role, and their willingness to learn is evident as they develop their colorectal and general surgery knowledge on the ward, in the clinic and in theatre. They have been a tremendous support to junior doctors who rotate through the ward every four months. They have, without a doubt, made the patient care smoother and safer."

– Mr Mitchell (Colorectal consultant)

"To me, this a true success story. There is a unanimous chorus amongst the junior doctors attributing enhanced continuity and quality of care to our PAs, as well as providing them with direction, guidance and leadership. It is a pleasure to have PAs in theatre, too, where there is yet more valuable support."

– Mr Bhowmick (Colorectal consultant)

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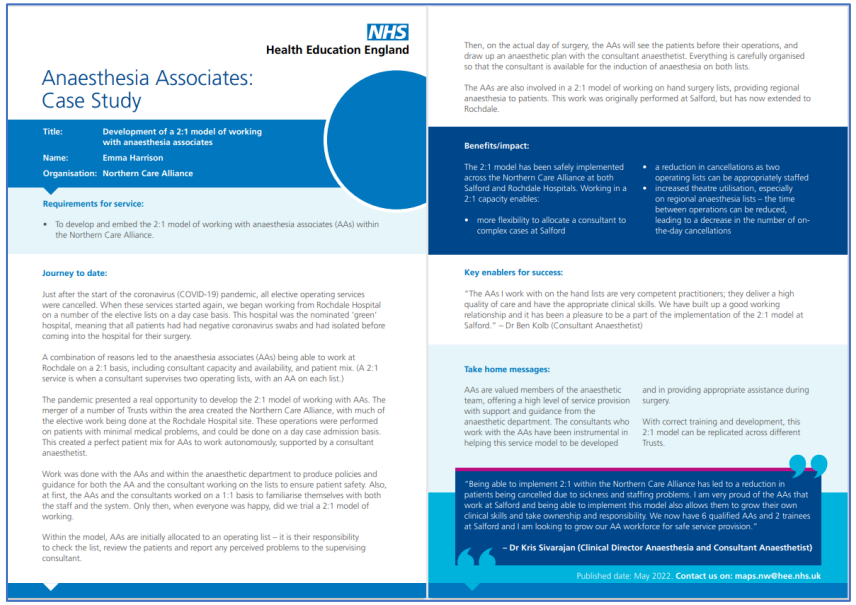

NHS
Health Education England

Anaesthesia Associates: Case Study

Title: Development of a 2:1 model of working with anaesthesia associates
Name: Emma Harrison
Organisation: Northern Care Alliance

Requirements for service:

- To develop and embed the 2:1 model of working with anaesthesia associates (AAs) within the Northern Care Alliance.

Journey to date:

Just after the start of the coronavirus (COVID-19) pandemic, all elective operating services were cancelled. When these services started again, we began working from Rochdale Hospital on a number of the elective lists on a day case basis. This hospital was the nominated 'green' hospital, meaning that all patients had had negative coronavirus swabs and had isolated before coming into the hospital for their surgery.

A combination of reasons led to the anaesthesia associates (AAs) being able to work at Rochdale on a 2:1 basis, including consultant capacity and availability, and patient mix. (A 2:1 service is when a consultant supervises two operating lists, with an AA on each list.)

The pandemic presented a real opportunity to develop the 2:1 model of working with AAs. The merger of a number of Trusts within the area created the Northern Care Alliance, with much of the elective work being done at the Rochdale Hospital site. These operations were performed on patients with minimal medical problems, and could be done on a day case admission basis. This created a perfect patient mix for AAs to work autonomously, supported by a consultant anaesthetist.

Work was done with the AAs and within the anaesthetic department to produce policies and guidance for both the AA and the consultant working on the lists to ensure patient safety. Also, at first, the AAs and the consultants worked on a 1:1 basis to familiarise themselves with both the staff and the system. Only then, when everyone was happy, did we trial a 2:1 model of working.

Within the model, AAs are initially allocated to an operating list – it is their responsibility to check the list, review the patients and report any perceived problems to the supervising consultant.

Then, on the actual day of surgery, the AAs will see the patients before their operations, and draw up an anaesthetic plan with the consultant anaesthetist. Everything is carefully organised so that the consultant is available for the induction of anaesthesia on both lists.

The AAs are also involved in a 2:1 model of working on hand surgery lists, providing regional anaesthesia to patients. This work was originally performed at Salford, but has now extended to Rochdale.

Benefits/impact:

The 2:1 model has been safely implemented across the Northern Care Alliance at both Salford and Rochdale Hospitals. Working in a 2:1 capacity enables:

- more flexibility to allocate a consultant to complex cases at Salford
- a reduction in cancellations as two operating lists can be appropriately staffed
- increased theatre utilisation, especially on regional anaesthesia lists – the time between operations can be reduced, leading to a decrease in the number of on-the-day cancellations

Key enablers for success:

"The AAs I work with on the hand lists are very competent practitioners; they deliver a high quality of care and have the appropriate clinical skills. We have built up a good working relationship and it has been a pleasure to be a part of the implementation of the 2:1 model at Salford." – Dr Ben Kolb (Consultant Anaesthetist)

Take home messages:

AAs are valued members of the anaesthetic team, offering a high level of service provision with support and guidance from the anaesthetic department. The consultants who work with the AAs have been instrumental in helping this service model to be developed and in providing appropriate assistance during surgery.

With correct training and development, this 2:1 model can be replicated across different Trusts.

"Being able to implement 2:1 within the Northern Care Alliance has led to a reduction in patients being cancelled due to sickness and staffing problems. I am very proud of the AAs that work at Salford and being able to implement this model also allows them to grow their own clinical skills and take ownership and responsibility. We now have 6 qualified AAs and 2 trainees at Salford and I am looking to grow our AA workforce for safe service provision."

– Dr Kris Sivarajan (Clinical Director Anaesthesia and Consultant Anaesthetist)

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[Medical Associate Professions | Health Education England (hee.nhs.uk)]

[Core Capabilities Framework for Medical Associate Professions]

[Anaesthesia associates | The Royal College of Anaesthetists (rcoa.ac.uk)]

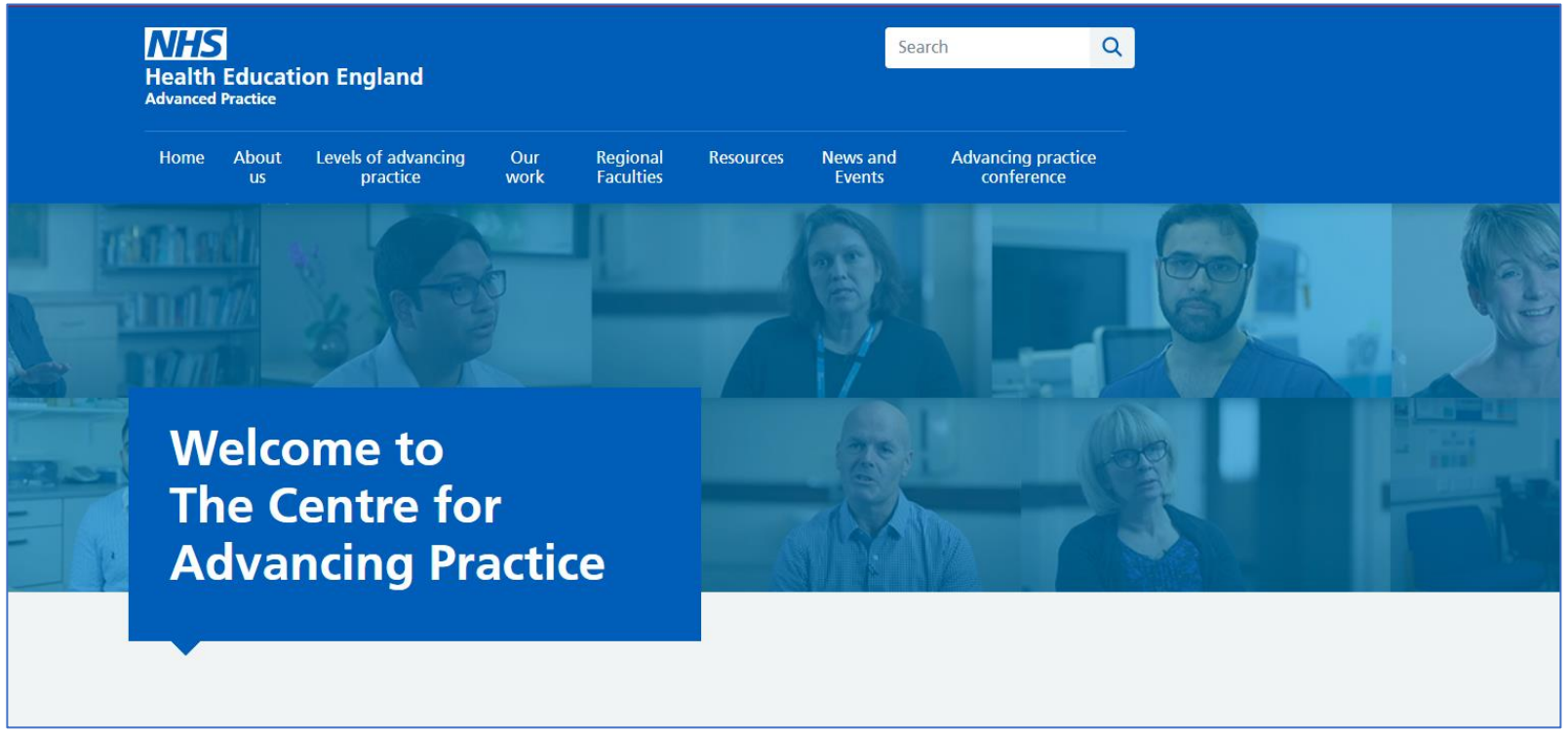
[The surgical care team — Royal College of Surgeons (rcseng.ac.uk)]

[Guidelines | Centre for Perioperative Care (cpoc.org.uk)]

Workforce capacity | Advanced Practice

https://advanced-practice.hee.nhs.uk/

- 2023 Curriculum Framework for Advanced Practice in Surgery: revised version due to be published shortly.
- Defines advanced practice requirements in surgery, setting out the specific capabilities practitioners need to develop and demonstrate.
- Encompasses roles based predominantly outside theatres (e.g., inpatient, outpatients and emergency areas) as well as roles based predominantly within the theatre setting.
- Surgical assisting capabilities included as an optional capability and mapped to Association of Perioperative Practice guidance.



- 9 domains of professional capabilities
- 3 domains of clinical capabilities: core, generic surgery, speciality surgery
- Optional capabilities in practice

Options:

1. Integrate within a post-registration NHS England accredited MSc in advanced practice
2. Subsequent to an MSc in a relevant healthcare subject using the NHS England Support Portfolio route (or approved alternative)

Workforce Transformation| Systematic approach to designing pathway 'blueprints'

Data Analysis – service demand, population health and workforce supply

CLEAR (Clinically-Led workforcE and Activity Redesign)

Workforce redesign workshops held over time

HEE resources – HEE Star online directory, Roles Explorer, MDT Toolkit, COM-B

- Working across all key stakeholders
- NHS resources e.g. SWIM

0 months | 3 months | 6 months | 9 months

Data - Provides insight for focus of service and workforce transformation
CLEAR - Training programme which equips clinicians with the skills to model optimum workforce skills mix to deliver service improvements
HEE Star methodology used to explore workforce challenges and determine realistic workforce interventions/solutions
HEE tools, approaches and capacity to facilitate workforce redesign at regional and ICS level

Workforce Transformation| Star example - Shortage of reporting radiographers and sonographers in Kent & Medway

Context

- Demand in diagnostics outstrips capacity with 98% of Trusts not able to meet reporting requirements
- Lack of capacity has led to increased expenditure on agency staffing and outsourcing
- Significant variation, deployment and supervision of reporting radiographers, and limited, structured training opportunities
- Limited sonography workforce data with variety of staff undertaking ultrasound activity
- A third of the sonography workforce is approaching retirement
- Sonographers more likely to leave NHS posts to work in independent sector
- No direct entry route qualifications for sonographers

Prompts

Supply
- Is there oversight of the current profile of reporting radiographers & sonographers (WTE, location, priority areas, gaps)?

Up-skilling
- Are the career development opportunities well defined and promoted?
- Is there an agreed 'menu' of core competencies for reporting radiographers & sonographers?

New roles
- Has the role of Mammography associate been considered in Kent and Medway?

New ways of working
- Are there any joint arrangements in place which underpin positive partnership working, e.g. shared objectives, training, shadowing, buddying? If not, what are the future opportunities?

Leadership
- Have we identified and made links with our system leaders/clinical champions both regionally and nationally?
- Is there a talent management plan in place?

Outcomes

Almost 30 improvement projects identified, including:

Supply
- Identify future population health need and quantify workforce requirement
- Work with education providers to influence cohort sizes and placements
- Scope best practice retention programmes

Up-skilling
- Map and define the career pathway
- Explore the scope and value of apprenticeships
- Explore advanced practitioner roles to maximise skill mix

New roles
- Evaluate the impact of the Pathway Co-ordinator role
- Explore potential of Physician Associate role

New ways of working
- Explore how First Contact Practitioners can support in reducing referrals
- Establish oversight of best practice examples of shadowing and buddying, locally, regionally, nationally

Leadership
- Identify regional and national leaders in radiography and sonography
- Scope leadership development programmes locally and nationally

Workforce Transformation| Workforce levers

More people… 	Recruitment / supply	Improving our ability to attract and source staff, especially into the most critical roles/gaps. Incl. via international, apprenticeship schemes and other wider participation routes
	Retention	Addressing the levers and drivers of retention, including specifics for key staff cohorts (e.g., newly joining HCSWs, pensions for 50+)
	Attendance	Addressing the drivers and root causes of sickness absence, including stress/anxiety and policy levers (e.g., Long Covid)
	Reward / T&Cs	Aligning total reward (pay, pensions etc) to encourage staff to work more flexibly and in ways that meet changing patient demand
	Outsourcing	Exploring all options to access workforce capacity beyond the NHS, such as Independent Sector and non-NHS employed people
…. in a compassionate, inclusive culture 	Culture	Focusing on staff engagement and morale as a driver and enabler of frontline innovation and productive working
	Leadership	Equipping leaders to bring about these changes, promoting a compassionate and inclusive culture and a hopeful narrative
	EDI	Fostering an improvement-focused culture that openly addresses health inequalities and systemic issues
Working differently … 	Training / skills	Investing in upskilling the existing workforce rapidly as well as the longer-term training pipeline managed by HEE
	Standards / skills mix	Changing and matching skills mix to patient needs (e.g., theatre staffing, anaesthetic cover), including fully using existing skills
	Pathways / practice	Redesigning end-to-end pathways to simplify things for patients and apply a competency-based model to workforce redesign
	Digital / technology	Investing in and leveraging digital technology to enable changes in models of care and workforce redesign (e.g. virtual wards
	Deployment	Deploying our staff more flexibly in response to needs, including across organisational boundaries within ICSs

Building Outstanding Theatre Teams Programme|

Governance

Ignition event attendee

- HEE
- NHSE People Directorate
- NHSE GIRFT
- Regional / Provider Theatre leads
- Professional / Student / Union reps
- #solvingtogether network

BOTT1 Working Group – Workforce Spec & Planning

BOTT1 Sub-group

BOTT2 Working Group – Skills, competency and career pathways

BOTT2 Sub-group

BOTT3 Working Group – Culture & Leadership

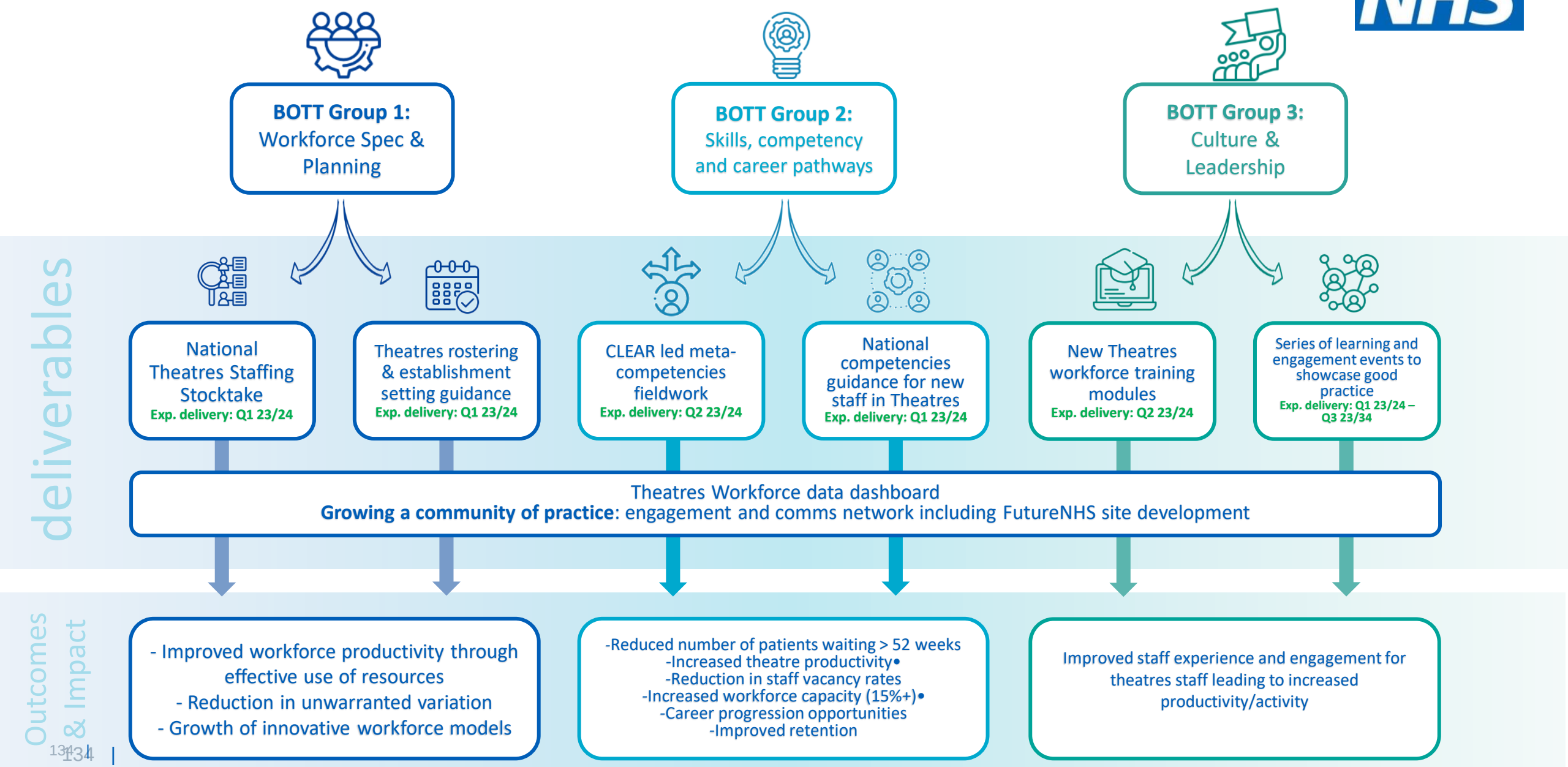
BOTT3 Sub-groups

Building Outstanding Theatre Teams Oversight group

National ER Programme Board

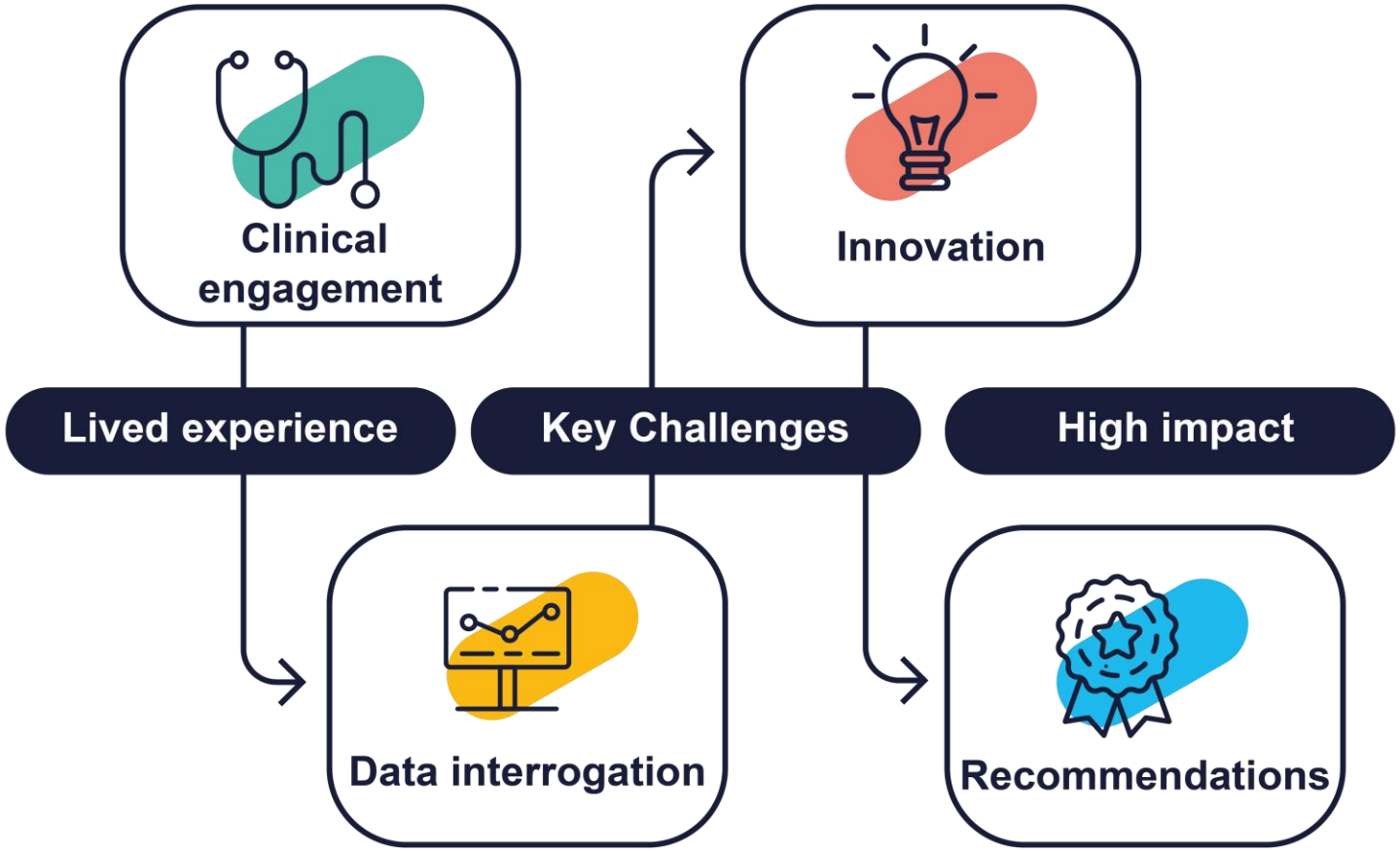
National Theatres Board

BOTT Programme| Deliverables



BOTT Programme| CLEAR

What is CLEAR?



CLEAR stands for Clinically-Led workforcE and Activity Redesign.

The national programme places **clinicians at the heart of healthcare decision making and innovation**. The integrated learning and working programme enables clinicians to develop new skills in data science, transformation and leadership while delivering live redesign projects in the NHS.

With its unique methodology, CLEAR delivers solutions that are clinically owned, increase control of clinical teams in healthcare delivery and provides an efficient solution to complex change programmes.

BOTT Programme| CLEAR

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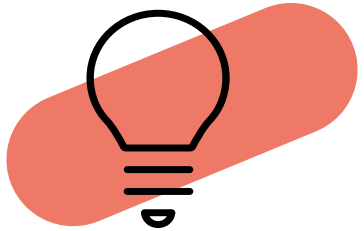
With its unique methodology, CLEAR delivers solutions that are clinically owned, increase control of clinical teams in healthcare delivery and provides an efficient solution to complex change programmes.

Clinical engagement
Understand baseline models of care, form relationships and discover key issues through qualitative data collection. This secures buy-in and gains operational insights about the service and challenges.

Digital visualisation
Find evidence for key challenges, link qualitative themes to deeper insights, use qualitative data to find impact of change. Our data tools offer accessible data analysis and visualisation, allowing you to evidence issues and possible solutions.



Innovation

Create solutions for key issues with new models of care using bespoke modelling techniques, co-design and collaborate with staff and other CLEAR teams, share best practice and examples of innovation

Recommendations

All elements of the previous phases come together to communicate the need, evidence and the benefits of the recommended changes

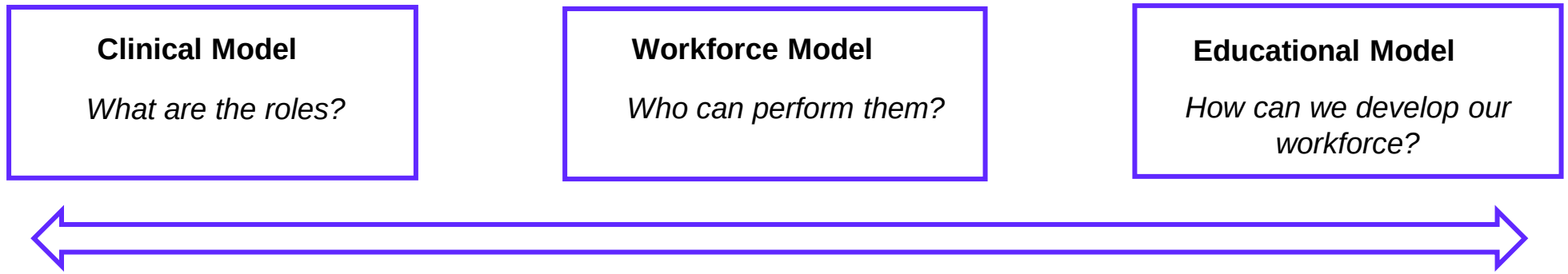
BOTT Programme| Working Group 2 - Toolkit

- To create a toolkit (previously described as “a capability framework”) to support organisations with understanding their operating theatres workforce with three specific components:

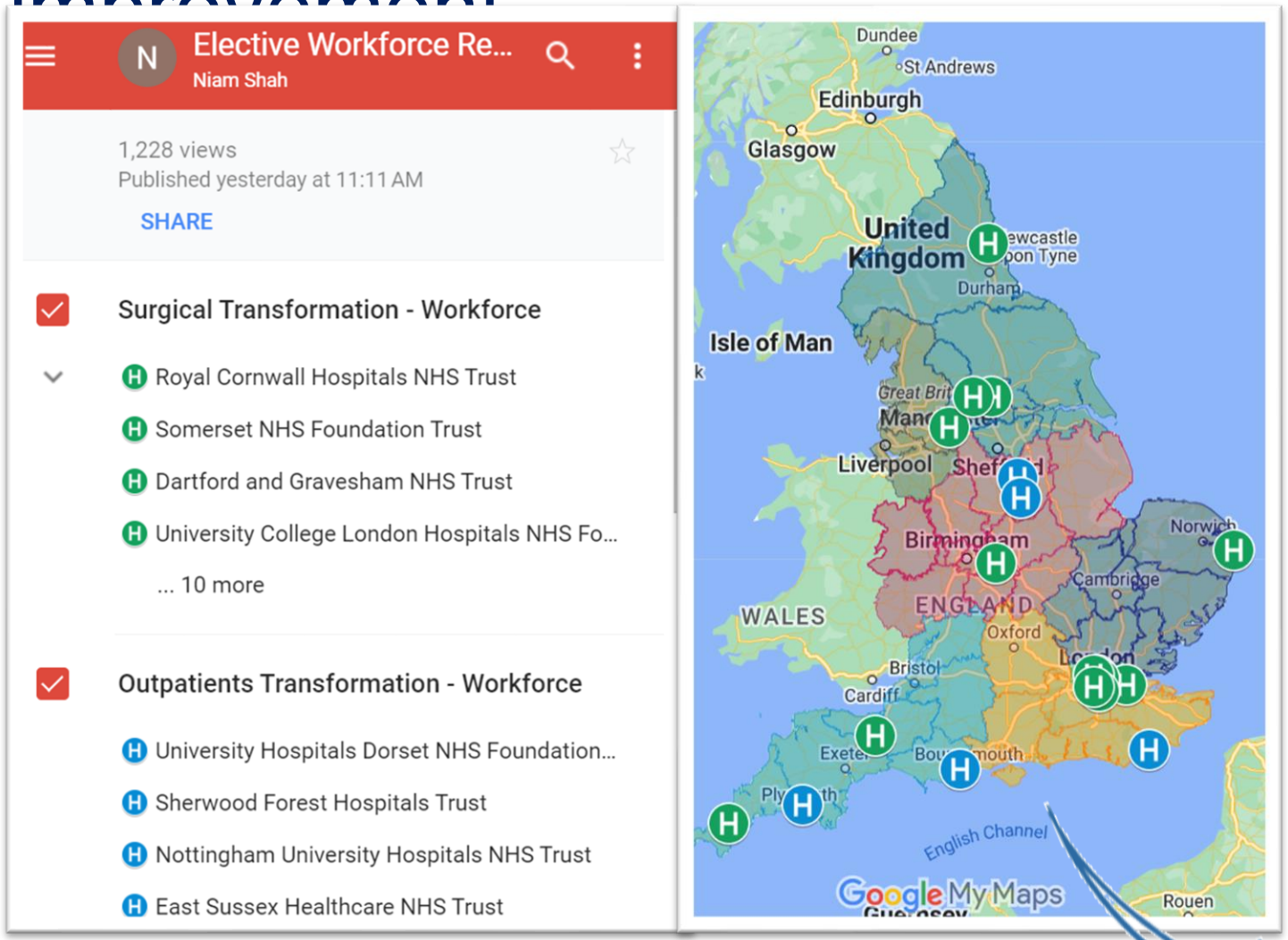
1. A **clinical model**, which defines the intraoperative roles within theatres and a consensus on the healthcare professionals that can perform these roles.
2. A **workforce questionnaire** designed to reflect the clinical model with workforce information on skills and experience. This information may be brought together to create a workforce profile across operating theatres.
3. A **development model** which maps the key development areas required within the clinical model.

Due to the nature of the CLEAR Compact projects (performed by our team at 33n) the local workforce will be involved in the codesign of new models of care but will not undergo education, supervision or the development of portfolio careers.

BOTT Programme| Working Group 2 - Toolkit

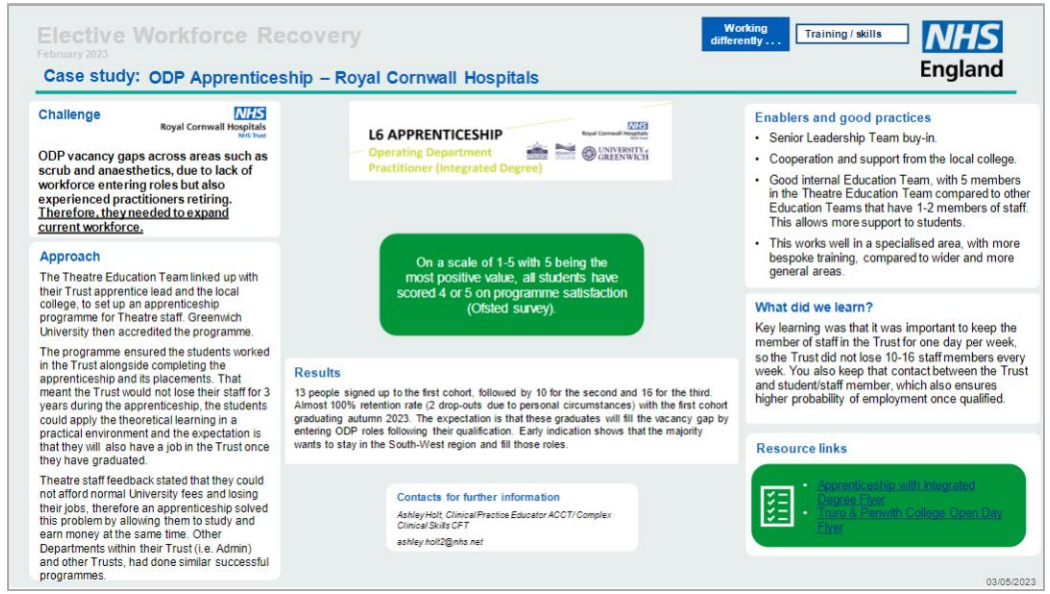


BOTT Programme| Building a network for improvement



Community of practice for Theatre teams:

- What is happening and where…
- Case Study development
- National engagement map
- Communication plan to raise awareness and maximise impact of learning



Workforce Transformation| Conclusions

- Workforce Transformation/redesign/optimisation can be difficult for providers – you are trying to run high quality services day in day out, to work differently whilst doing this is a challenge

- Our job has been to try and make transformation doable, accessible and a no brainer, with tools which are easy to use and create impact

- We know evaluation and demonstrating impact is a challenge but there are examples of change which can inspire, give confidence and provide a platform to build on

- There is support through the National Programme Teams e.g. BOTT and what will be the new Workforce Pathways team in NHSE

NHS Elective Care Conference North

NHS Elective Care Conference North

SPEAKING NOW

Dr Sunil Nedungayil

Clinical Director & GPwSI, Musculoskeletal Medicine -
Integrated MSK, Pain & Rheumatology Service (IMPReS) East Lancashire Hospital NHS Trust

I will be discussing...

"Managing Demand & Optimising referrals- Lessons from the MSK 'SMART' Template & Guidance pilot"

NHS Elective Care Conference North 2023
18th May 2023
Manchester

MANAGING DEMAND & OPTIMISING REFERRALS- LESSONS FROM THE MSK 'SMART' TEMPLATE & GUIDANCE PILOT

Dr Sunil Nedungayil
GP& GPSI, Clinical Director
Integrated MSK, Pain & Rheumatology Services (IMPReS)
East Lancashire Hospital NHS Trust

Dr Sunil Nedungayil

MBBS, MRCGP, D.Orth, DNB ORTH, MSc Orth Engg (Cardiff)
General Practitioner

Clinical Director & GPwSI, Musculoskeletal Medicine
Integrated MSK, Pain & Rheumatology Service (IMPReS)- East Lancashire Hospital NHS trust

NW Regional GP Clinical Advisor for Outpatient Transformation- NHS England (North-West)

Member, National BESTMSK Health, Osteoporosis & Fragility Fracture Collaborative-NHS England & Improvement

Honorary Clinical Senior Lecturer, University of Central Lancashire

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- The best opportunity to make a difference to demand on specialist input is at a point **before** a referral decision is made

- The absolute need to involve primary care in any referral optimization and outpatient transformation initiative
- The need to collaborate and joint working between primary care and specialist services

The pilot

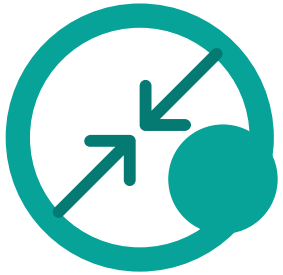
Funded by the Lancashire and South Cumbria ICB through the Primary Care Digital First programme (21-23)

Clinical Engagement, Collaboration, Co-production

- 5 GP practices(20 clinicians)
- Integrated MSK Service (IMPReS)- Tier 2 MSK service- (ELHT)
- Trauma and Orthopaedics East Lancashire Hospital NHS Trust
- Midlands and Lancashire Clinical Support Unit (MLCSU)

- 5 MSK end to end clinical pathways,
- SMART Template digital consultation and referral tool for primary care
- Clinical Guidance/ Decision aids

The ‘smart’ template & guidance pilot



Reducing variation & optimizing management

- Adhering to evidenced based care (clinical pathways)
- Optimizing care at each level (investigation/Treatment)
- Responsibility of care
- Referral Ready (all investigations and management complete before referral)

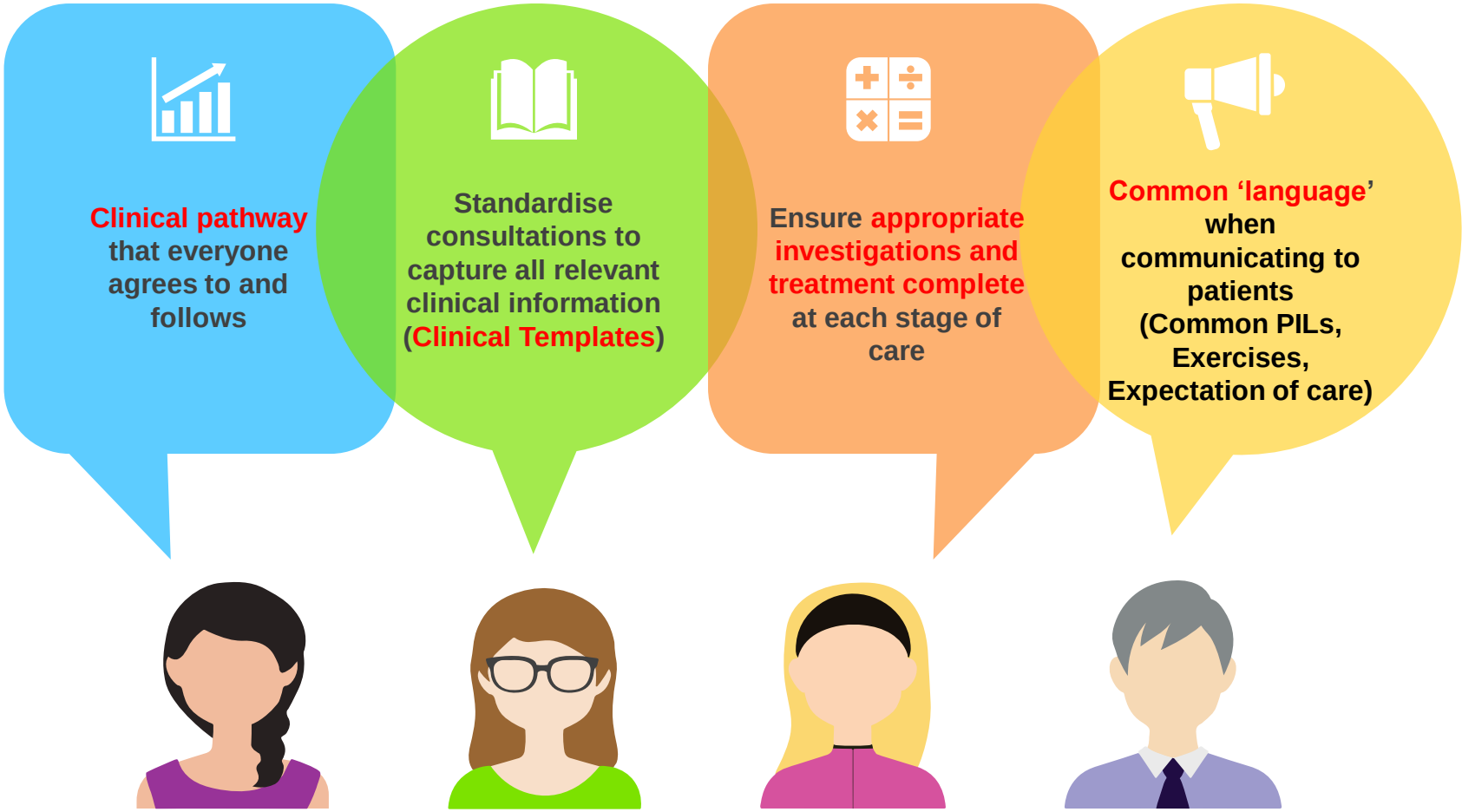
Improving quality of communication

- Consultation
- Referral Letters
- Expectations of Treatment
- Correspondence

Patient centered approach

- Patients involved in their care
- Patient education, self-management , motivation
- Clear expectation of level of care provided
- Clear understanding of decisions for investigation, referral and treatment

Value stream mapping of spinal back pain management- Feb 2020



EVIDENCE

- Candace Imison, Chris Naylor -Referral management- Lessons for success- The King's Fund 2010
- Catherine Foot, Chris Naylor, Candace Imison- The quality of GP diagnosis and referral- An Inquiry into the Quality of General Practice in England, The King's Fund 2010
- Jeremy Dawson, Anna Rigby-Brown; Measuring general practice productivity- Development and evaluation of the general practice effectiveness tool. National Institute for Health Research Health Services & Delivery Research Programme (project number 13/157/34) February 2019

NHS England

Right person, right place, first time

Transforming **musculoskeletal and orthopaedic** elective care services

A handbook for local health and care systems

https://www.england.nhs.uk/wp-content/uploads/2017/11/msk-orthopaedic-elective-care-handbook-v2.pdf

Contents

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Opportunities for improvement: Rethinking referrals

2. Standardised referral template

What is a standardised referral template?

A standardised MSK referral template is a document available on primary care IT systems that guides referrers to provide appropriate referral information. The template **improves the quality of referrals** and **underpins effective triage**, thereby helping patients to be directed to the right care setting, first time. It complements a single point of access covering, for example, a T&O and MSK service.

Why implement a standardised referral template?

A standardised referral template can **reduce the number of inappropriate referrals** and **improve the quality of referral information received**, ensuring that referral criteria are met and sufficient details are transferred with the patient at the point of referral. This means that patients who need to be seen by a hospital consultant are seen as quickly as possible, ensuring the patient is directed to the right person, in the right place, first time. CCGs must have clear referral criteria for MSK services, including conditions covered and clinical indications for referral, which are communicated to all GPs. A standardised referral template can ensure that these criteria are explicit and understood.

Implementation - how to achieve success:

- ☐ **Establish a cross-system implementation team** that includes all stakeholders such as orthopaedic consultants, MSK service, GPs, practice managers and hospital-based managers, and both CCG and Acute trust leads.
- ☐ **Engage and communicate regularly with key stakeholders throughout the implementation process.** Use CCG communication networks such as newsletters and GP events to build awareness and uptake among GPs; sharing positive feedback can be powerful.
- ☐ **Agree outcome measures** to evaluate the impact of the template (e.g. feedback from referrers, number of referrals received). Ensure sufficient administrative support resources for evaluation.
- ☐ **Review the standardised referral template and work with lead clinicians** from primary, secondary and community care to tailor it to local services.
- ☐ **Ensure the form integrates with local Advice & Guidance services.** Consider how this will work and involve stakeholders from the start.
- ☐ **Seek IT advice and support as early as possible** to ensure the form can be uploaded to GP clinical systems and adjustments to improve usability can be made (such as automatic pop-up and pre-population of patient details).

To refer or not to refer- that is the question

Grade of Clinician

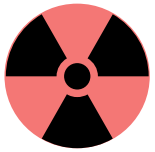
Breadth of knowledge and experience

Attitude to Uncertainty

Experience, Subject Knowledge

Decision Making

Risk averse, Defensive, Subject knowledge



Attitude to Risks

Patient centric, Patient-led, Doctor centric

Managing Patient Expectations

Elements of a good referral

Necessity- Done for the right reason at the right time
A&G, Investigation, Referral

Destination

Consultant, Nurse/AHP Clinic, Investigation unit, One-stop-shop clinic etc

Process

Quality of clinical information
Referral Ready
Shared understanding for the referral

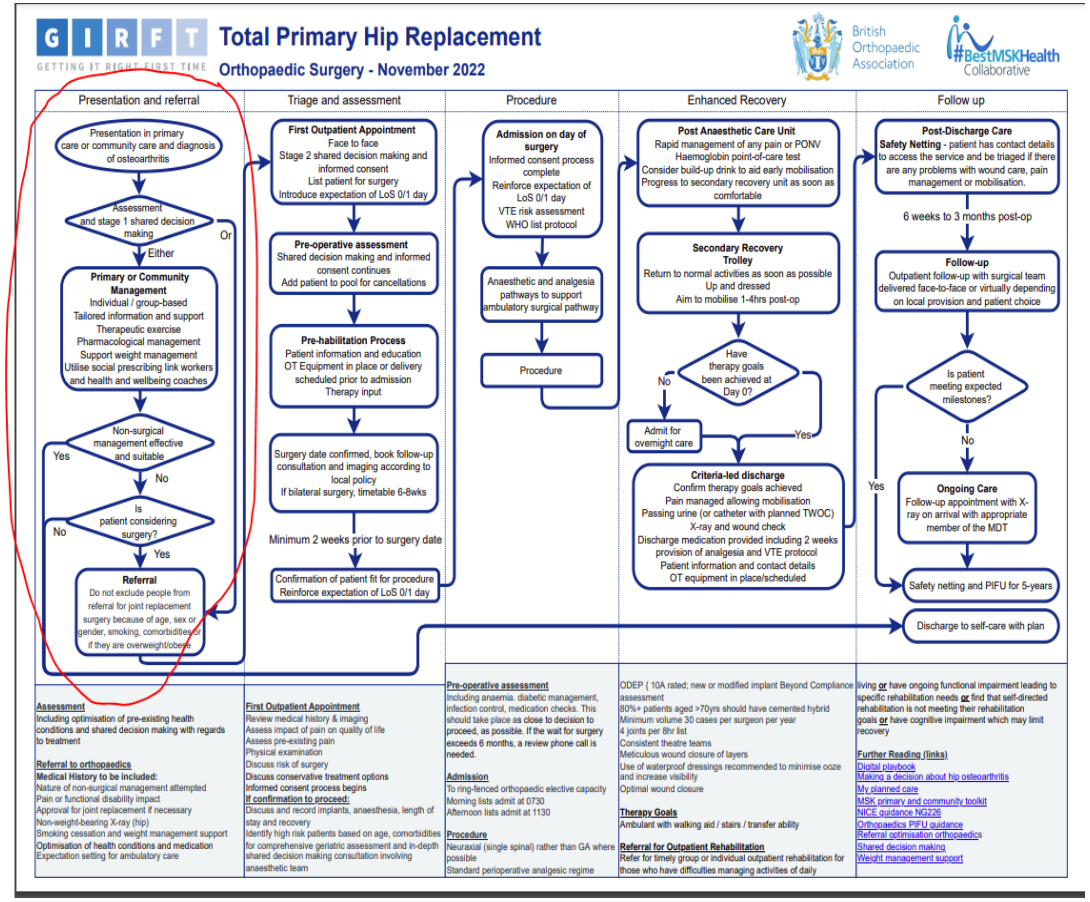
Necessity

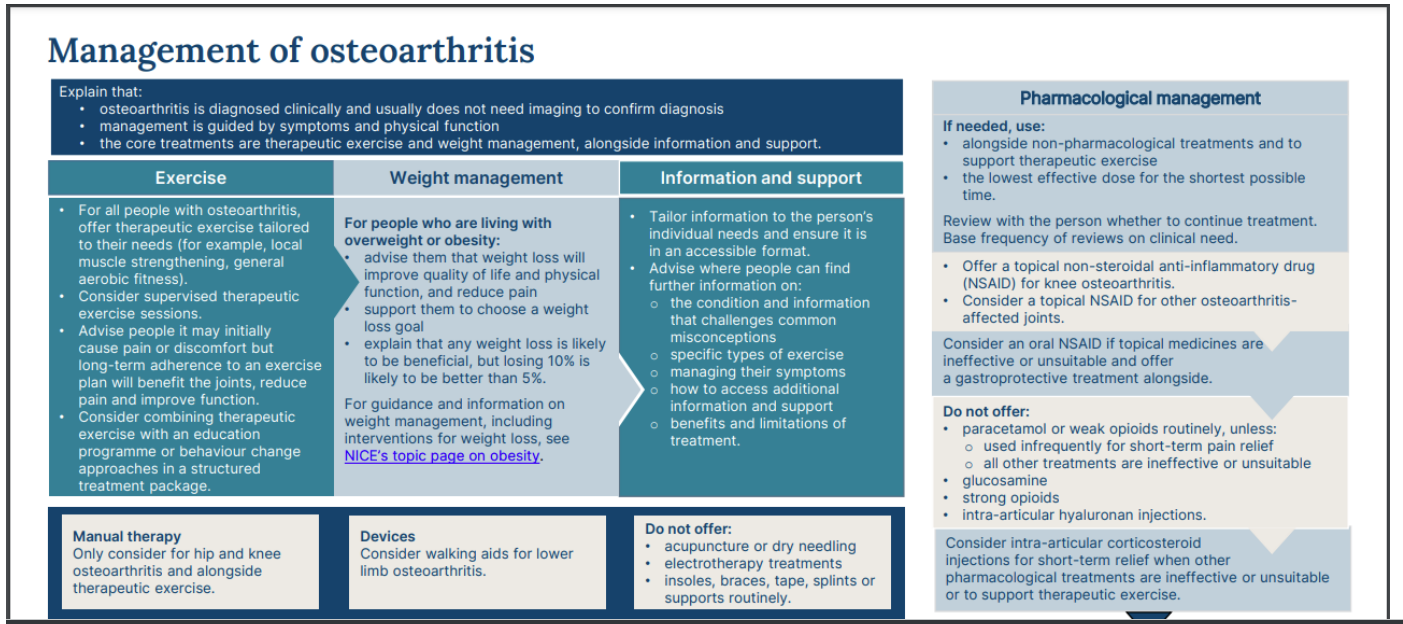
Destination

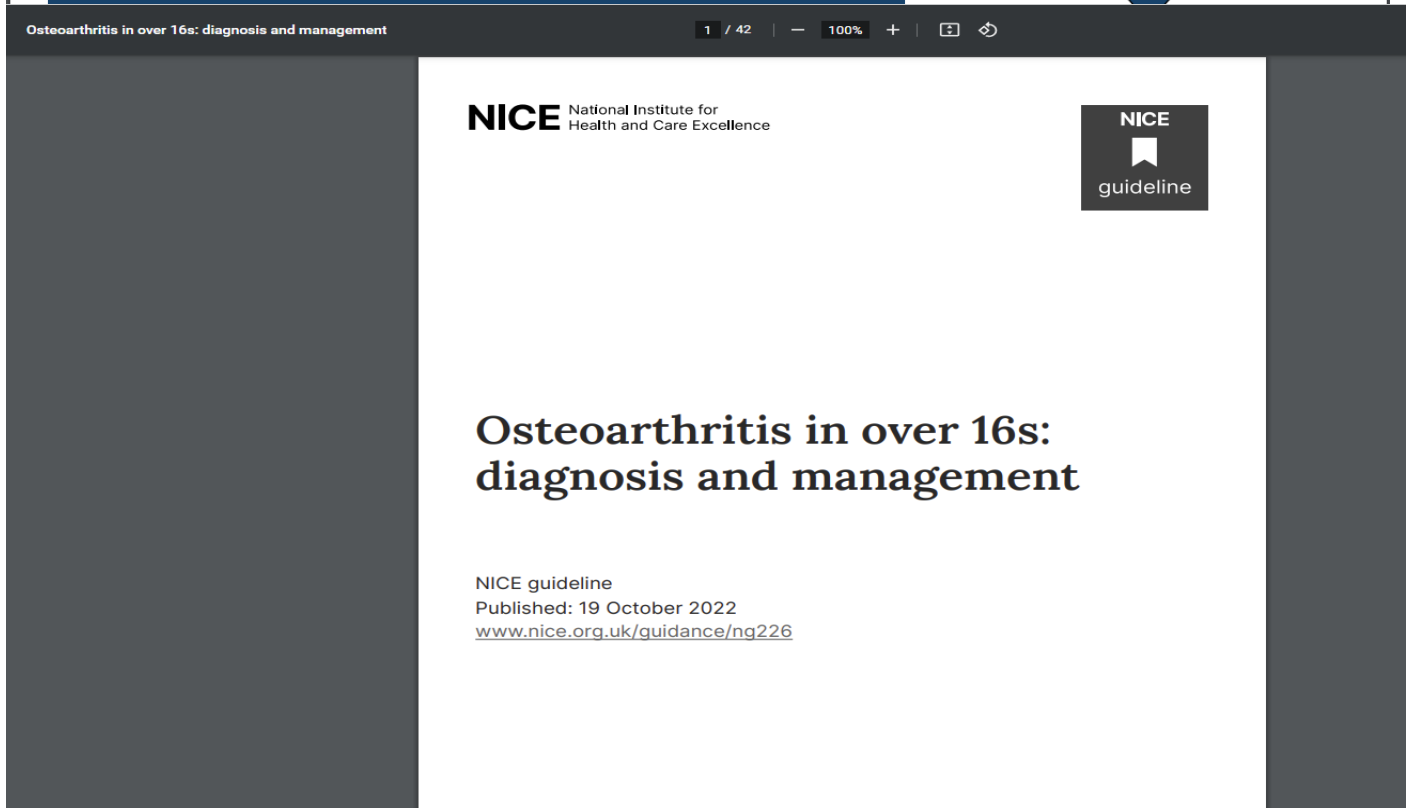
Process

THE CLINICAL PATHWAY

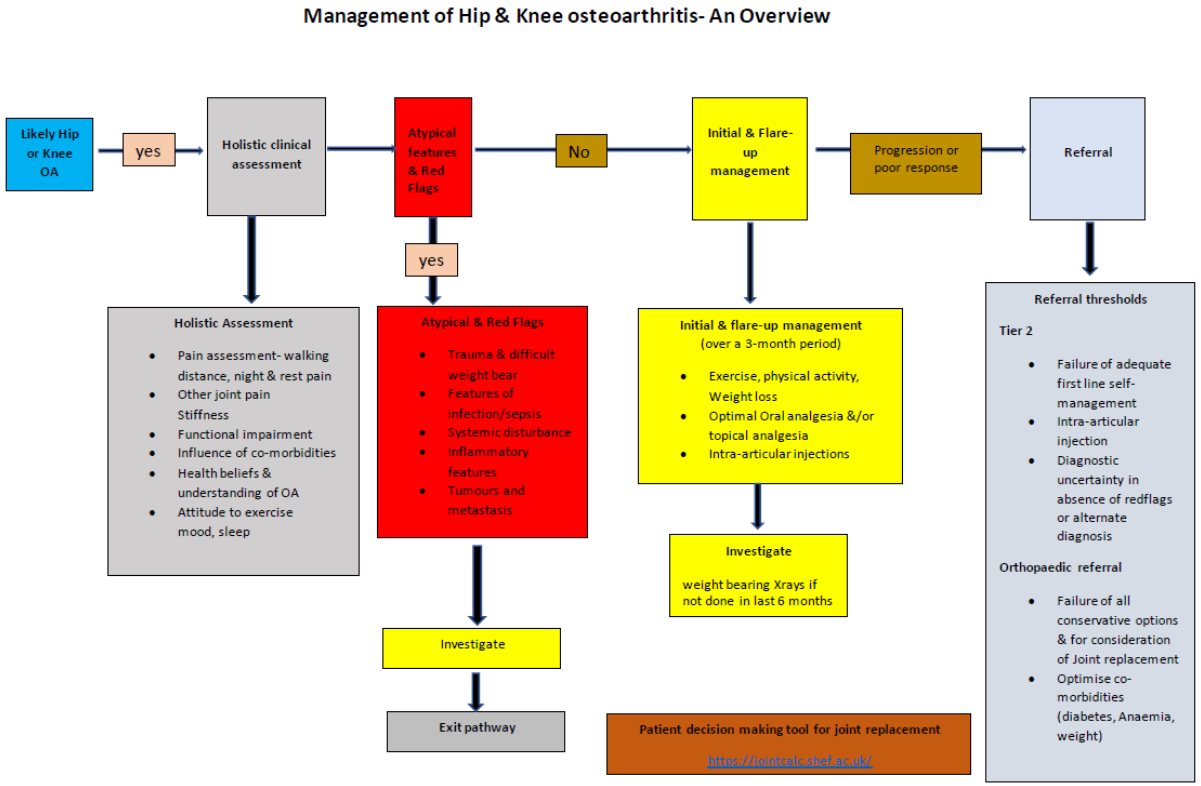
Clinical pathway







Clinical pathway



Adapted from NICE CG 177, GIRFT Hip and Knee replacement pathways

Hip Osteoarthritis

Diagnosis

- Activity-related joint pain and stiffness over months or years, and
- No morning joint-related stiffness, or morning stiffness lasting no longer than 30 minutes
- Pain can be referred to referral into anterior thigh and knee
- No signs of true mechanical instability
- Absence of significant recent trauma

Risk factors

- Genetic influence
- Biological- Increasing age, Female (Hip OA), Obesity
- Biomechanical- Joint injury and damage, Joint laxity, malalignment, reduced muscle strength, occupational and exercise stresses

Consider the following

- A diagnosis of OA does not necessarily mean a continued deterioration in the joint.
- Changes on x-ray do not correlate with pain that the person may experience, therefore other factors play an important role.
- OA is described as a degenerative joint disease or 'wear and tear' this is a misleading description.
- There is no cure but research has proven that remaining active can make a significant positive difference

Differential Diagnosis

- Inflammatory arthropathy
- Septic joint
- Fracture of the bone adjacent to the joint
- Malignancy including bony metastases

Red Flags

Suspected Joint sepsis	Referral to A&E via Orthopaedics on-call
Suspected fracture	Referral to A&E
Suspected Avascular necrosis	urgent elective hip clinic referral
Suspected stress fractures	fracture clinic (urgent)
Suspected malignancy	follow 2 week rule pathway

First line management (for a period of at least 3 months)

- Analgesia
- Advise on self-care management- Recommend weight loss, local muscle strengthening, supervised therapeutic exercise and aerobic fitness training (leisure centres) (link to MSK website- https://elht.nhs.uk/application/files/3015/2293/8973 _Patient_Information_and_Exercises_-_PHYSIO_001
- Therapeutic exercise with an education programme (https://escape-pain.org/support-tools/escape-pain-o

Referral Thresholds

Primary Care

- First line management of acute and recurrent flare up of OA
- Signposting to self-management programmes & well-being services

IMPReS

- For supervised rehabilitation- Acute or recurrent flare up episodes not settling in 3 months despite initial first line management
- Unclear diagnosis (not redflag conditions)

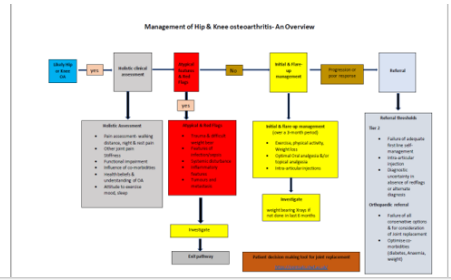
Orthopaedic surgeons- T&O

- Patients with progressive worsening pain and dysfunction and having exhausted all standard conservative options- with a view to joint replacement

Prior to referral- Please ensure

- Co-morbidities are stabilised
- Anaemia (if any) investigated and corrected (link to pathway)(awaited)
- HBA1C within accepted levels (60)
- BMI optimised (35, wherever possible)
- Shared decision making on joint replacement (links to NJR) https://www.njrcentre.org.uk/patients/patient-decision-support-tool/

Overview of management



Information for patients

Factsheet- https://www.versusarthritis.org/media/22306/osteoarthritis-of-the-hip-factsheet.pdf

Booklet- https://www.versusarthritis.org/media/22728/osteoarthritis-of-the-hip-information-booklet.pdf

General information- https://www.versusarthritis.org/about-arthritis/conditions/osteoarthritis-oa-of-the-hip/

Decision making in Hip OA- https://www.england.nhs.uk/wp-content/uploads/2022/07/Making-a-decision-about-hip-osteoarthritis.pdf

Exercises for Hip OA- https://www.versusarthritis.org/about-arthritis/exercising-with-arthritis/exercises-for-healthy-joints/exercises-for-the-hips/

Exercises for Hip OA- Video- https://www.youtube.com/watch?v=H5K55p01AwM&t=30s

Resources for clinicians

Hip Examination- https://www.versusarthritis.org/about-arthritis/healthcare-professionals/training-and-education-resources/clinical-assessment-of-patients-with-musculoskeletal-conditions/the-musculoskeletal-examination-rems/examination-of-the-hip/

Hip Examination video- https://www.youtube.com/watch?v=oaIVeMgnpmE

Hip Replacement pathway- GIRFT- https://gettingitrightfirsttime.co.uk/wp-content/uploads/2022/11/Orthopaedics-Elective-Primary-Total-Hip-Replacement-Pathway-Nov-2022.pdf

Scholarly articles

Hip Osteoarthritis- https://www.bmj.com/content/bmj/354/bmj.i3405.full.pdf

Hip Osteoarthritis: A Primer- https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5760056/

CLINICAL PATHWAY- WHAT DOES PRIMARY CARE DO

Baseline Clinical assessment

- Essential clinical information
- Psychosocial assessment
- Rule out red-flags
- Rule out non-MSK cause of symptoms
- Patient information
- Expectations of treatment

VALUE

- Standardized assessment
- **Risk management**
- **Manage uncertainty**
- Scope for peer support
- Triage decisions

Baseline Investigations

- Usually X-Rays
- Avoid scan except for specific indications
- Baseline Blood tests

VALUE

- Standardize Investigations
- **Reduce inappropriate investigation**
- **Reduce pressure on diagnostics**
- Manage expectations

First Line Management

- Self management
- First Line exercises
- First line medication management
- Standard patient information

VALUE

- **Standardize initial management**
- Managing expectation

Referrals

- Full clinical information
- Referral thresholds – For tier 2 and T&O
- Advice and Guidance

VALUE

- At the right time
- To the right Service
- **Referral ready**
- Aware of expectations of referral

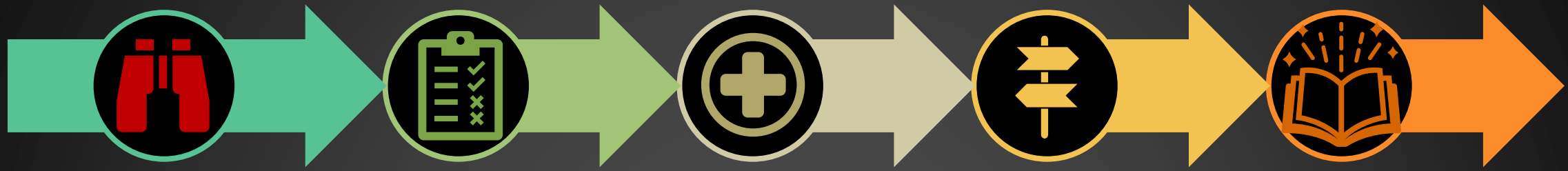
Education and Peer support

- Quick Reference Guides during consultation
- Full pathway guidance on Digital Library
- In house peer support
- MSK Protected learning events

VALUE

- Joined up working
- **More confidence in managing conditions**
- Routes for peer support and CPD

CLINICAL PATHWAY- TIER-2 & T&O DOMAINS



Align Pathways

- Detailed clinical information
- Psychosocial assessment
- Patient information
- Expectations of treatment

VALUE

- **Standardized assessment and specialist treatment**
- **Risk management**
- Manage uncertainty
- Scope for peer support

Align Investigations

- Specific investigation thresholds for Tier 2 (scans, Nerve conductions tests)
- Specific investigations in T&O (complex scans)

VALUE

- Standardize Investigations
- Reduce inappropriate investigation
- **Reduce pressure on diagnostics**
- **Reduce Duplications**

Management

- Therapy
- Injections and other intervention
- Shared decision making

VALUE

- **Standardize management**
- **Managing expectation**

Referrals

- Referral thresholds – to T&O

VALUE

- At the right time
- **Referral ready**
- Aware of expectations of referral

Education and Peer support

- Internal MDT
- Informal Advice and Guidance (Liaison Consultant- MDT)
- Combined CPD events

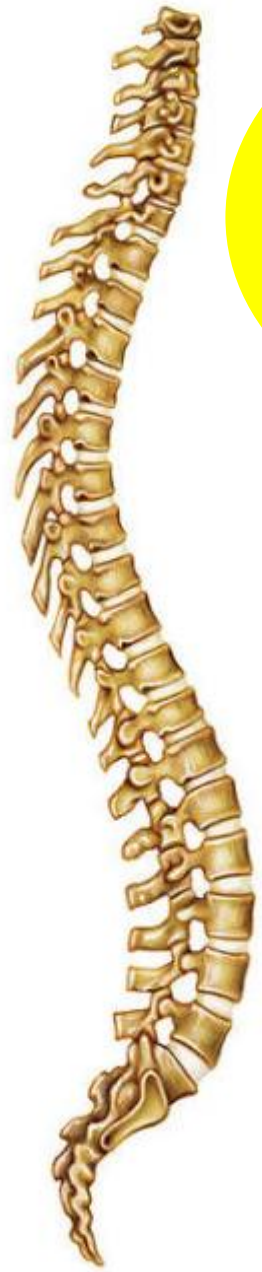
VALUE

- Joined up working
- More confidence in managing conditions
- Routes for peer support and CPD

THE SMART TEMPLATE AND GUIDANCE TOOL

The digital tool- MoSCoW

Must	Should	Could	Wont
'Live' prompts during consultation (trigger codes)	All information in coded format (audit/KPI)	Link to self-management resources	Need to move to another browser/webpage
Integrated with Primary care EPR	Auto-populate all relevant past back pain episodes and other relevant red-flag conditions (cancer)	Link to detailed guidance (digital library)	Lengthy template Multiple forms to fill
Collect all relevant clinical information including risk-stratification	Auto-populate previous investigations	Link to CPD activity	Disengage clinicians
Provide red flag screening	Provide summary of guidelines		Expensive to replicate and scale-up
Provide safety netting prompts	Provide investigation guidelines		
Record mandatory information on 'treatment so far' and 'patient safety domains'	Provide referral guidelines		
Template easy to replicate and scale up	Autogenerate referral letters as required		
Not incur significant costs			
Clinicians should use as part of routine consultation			



Clinical Pathway

Smart templates

Standardised Clinical entries

Risk Stratification, Self populating referral letters

Software algorithms

CODES

Decision Aids

Treatment/ Intervention guidance

Referral thresholds

Overview

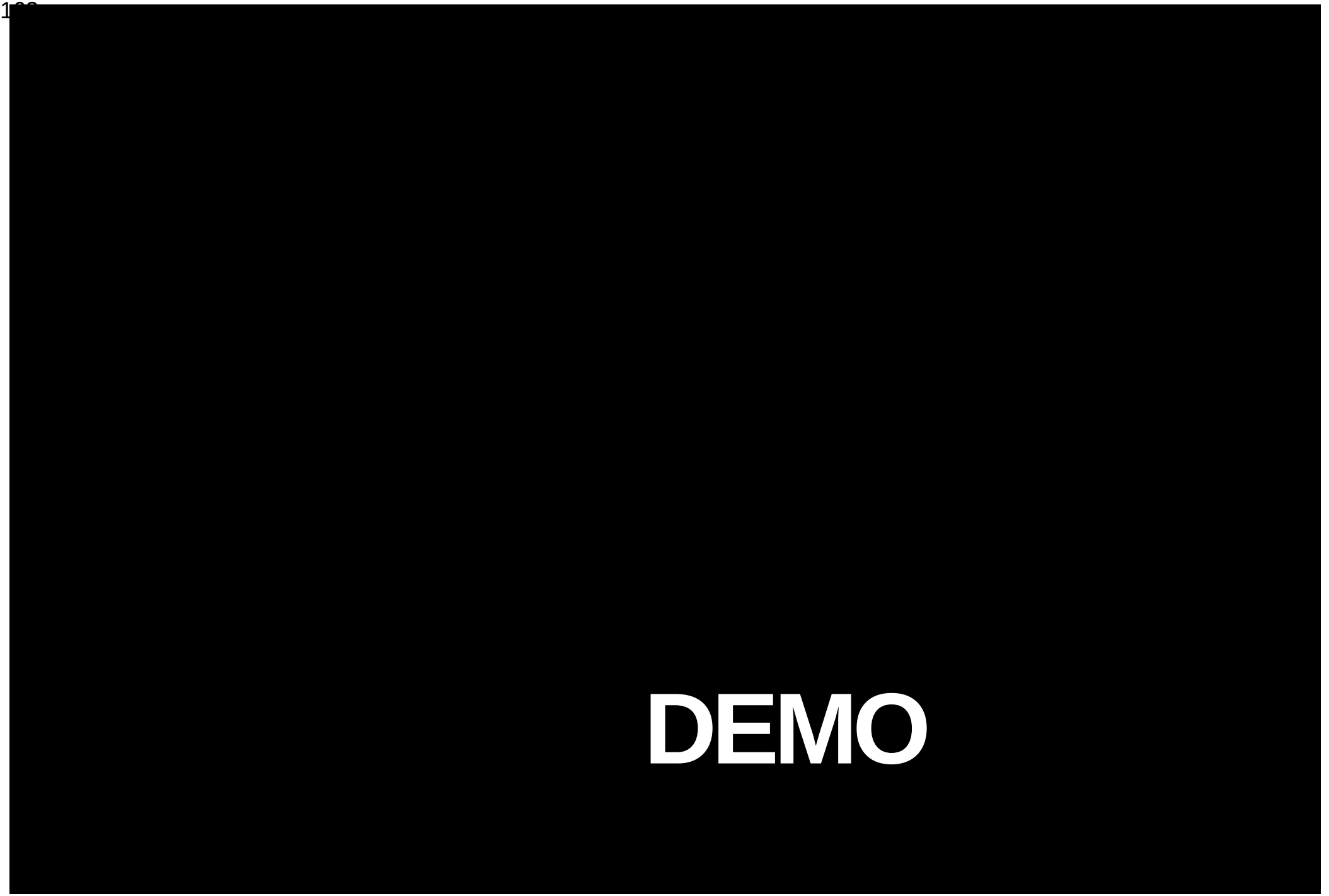
- **EMIS EPR based smart template**
- **2021-22- Spinal back pain pilot**
- **22-23- (4 Pathways) – Hip and Knee Osteoarthritis, Carpal Tunnel Syndrome, Non-Trauma shoulder pain**
- **Focus on common end to end clinical pathway**
- **Proof of concept of use of digital consultation tools & 'live' decision support tool in day to day practice in Primary care**
- **Streamlining pathway between Tier 2 and T&O**

- To reduce variation of care
- Ensure first line management of the conditions
- To avoid unnecessary investigations and treatments
- To optimise management in primary care before any referral
- To help self-management of the condition
- To risk stratify patients and address patient safety
- To refer to the right service at the right time
- As an education and peer support tool

- Manage patient expectation
- Patient decision making support

Pilot Themes

- Can be incorporated into daily practice
- Will it increase the workload
- Will it reduce administrative burden
- Will the quality of consultation be improved
- Will it improve referral practices


DEMO

Microsoft Teams

MSK Recordings

2023-05-11 13:38 UTC

Recorded by
Barry Johnson (MLCSU)

Organized by
Julie Moorcroft (MLCSU)

RESULTS

The questions

- Can be incorporated into daily practice
- Will it increase the workload
- Will it reduce administrative burden
- Will the quality of consultation be improved
- Will it improve referral practices

The answers

Easy to use
Will use it on a daily basis (77%)

Template prompts helps with clinical records
Guidance (decision aids) helps with management in primary care (investigations)
Decision aids helps with patient information, exercises etc

Guidance improved emphasis on patient safety, self-management and first line management
Repeated use of the guidance increased familiarity with management, investigation and referral
Reduced administrative burden due to auto-populating referral letters

Would like it to be used in other specialities- Yes
Mandatory- Yes, but only for referrals

CLINICAL INFORMATION

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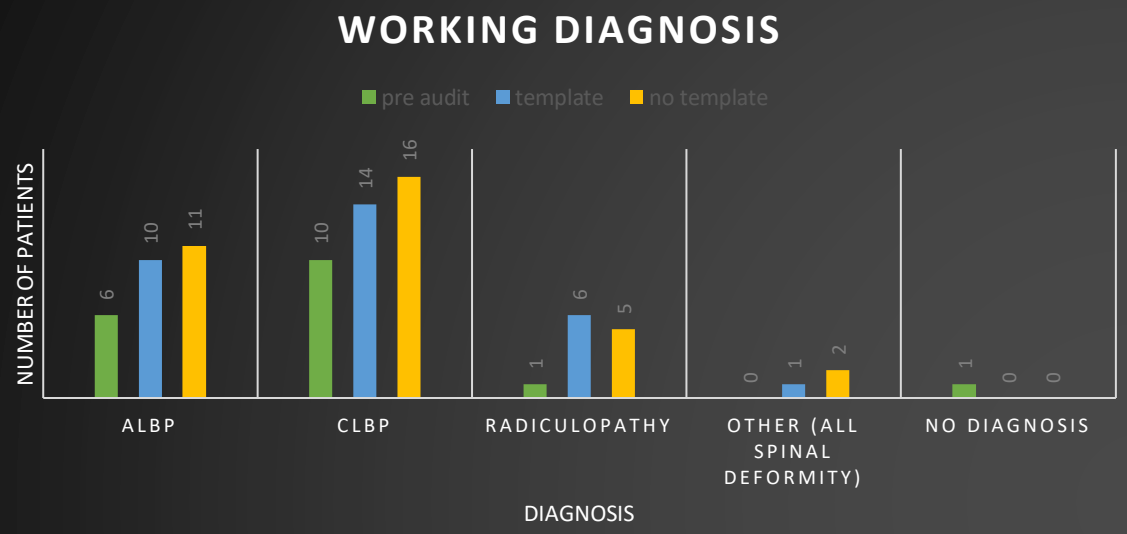

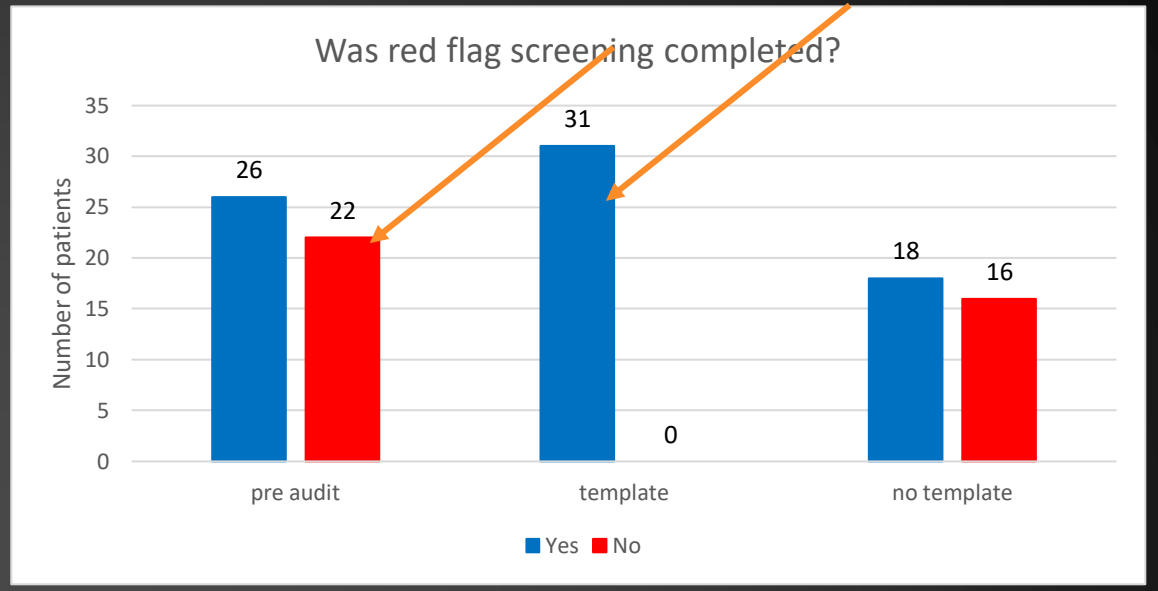

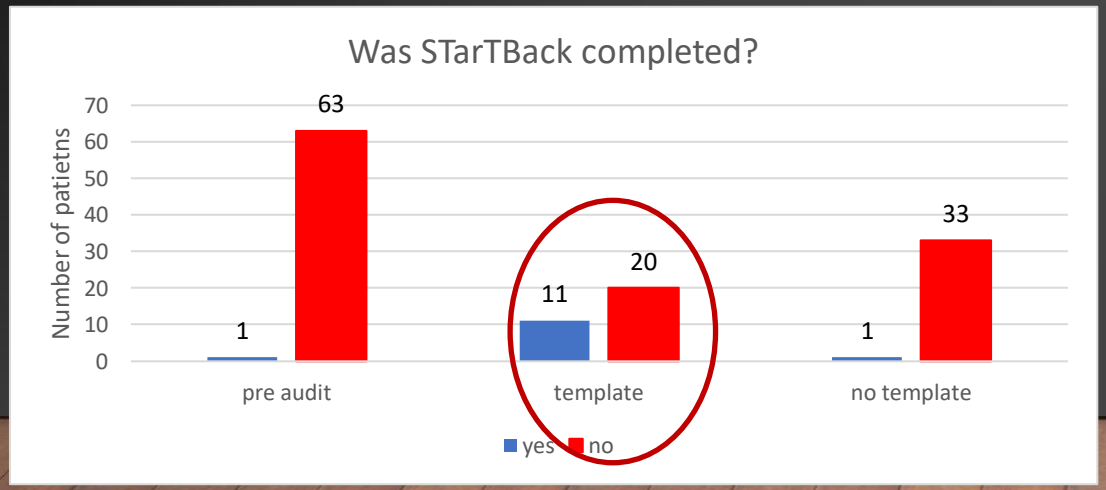

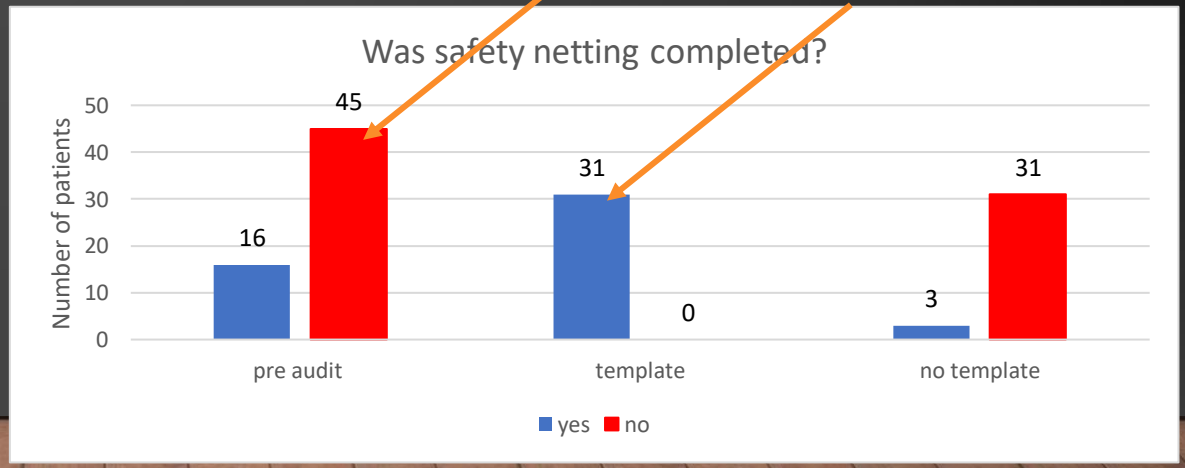

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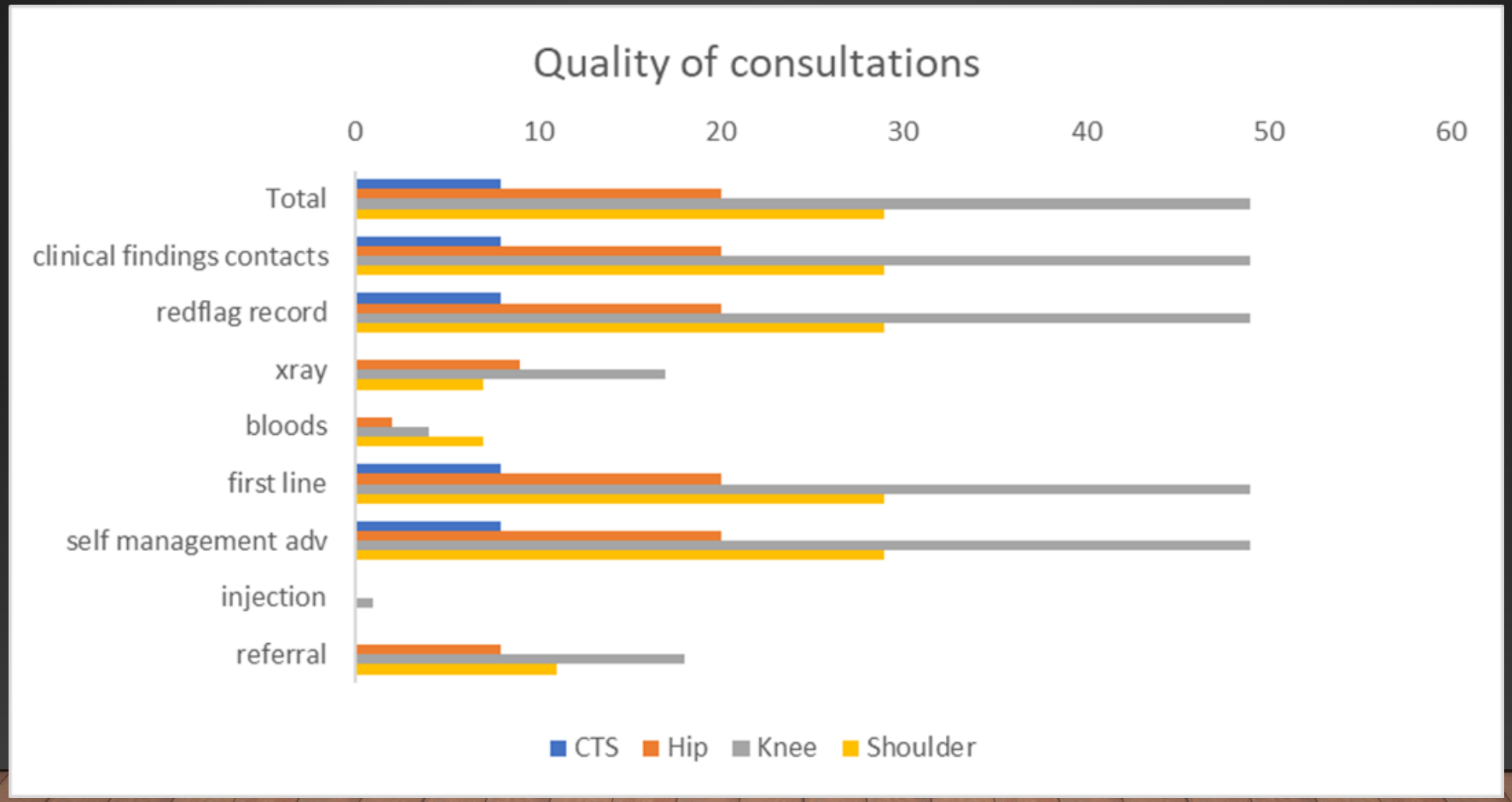
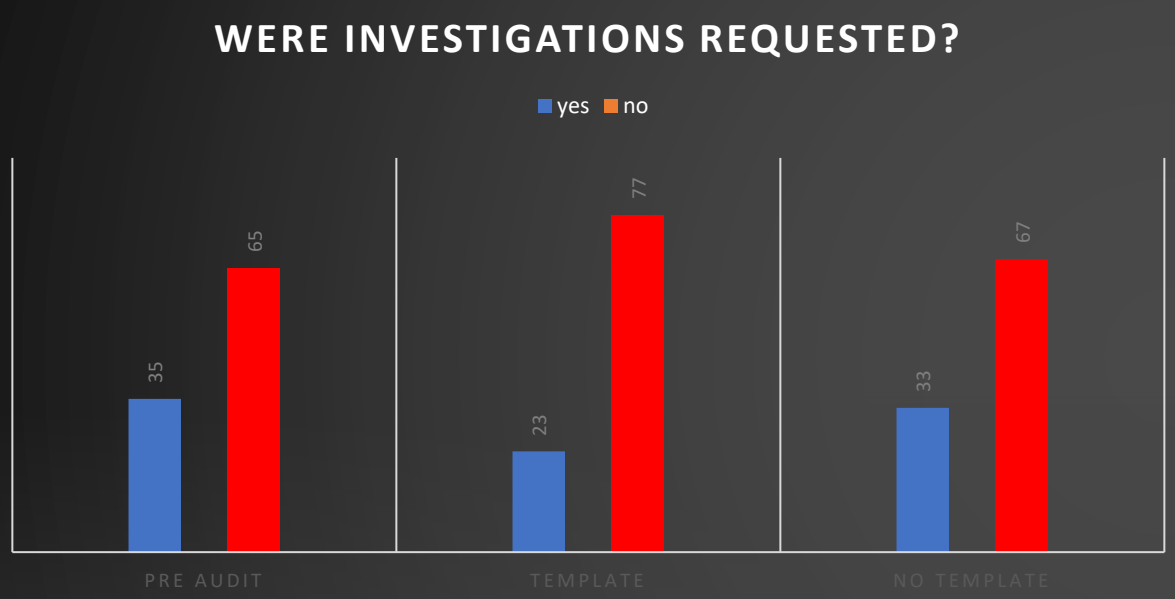
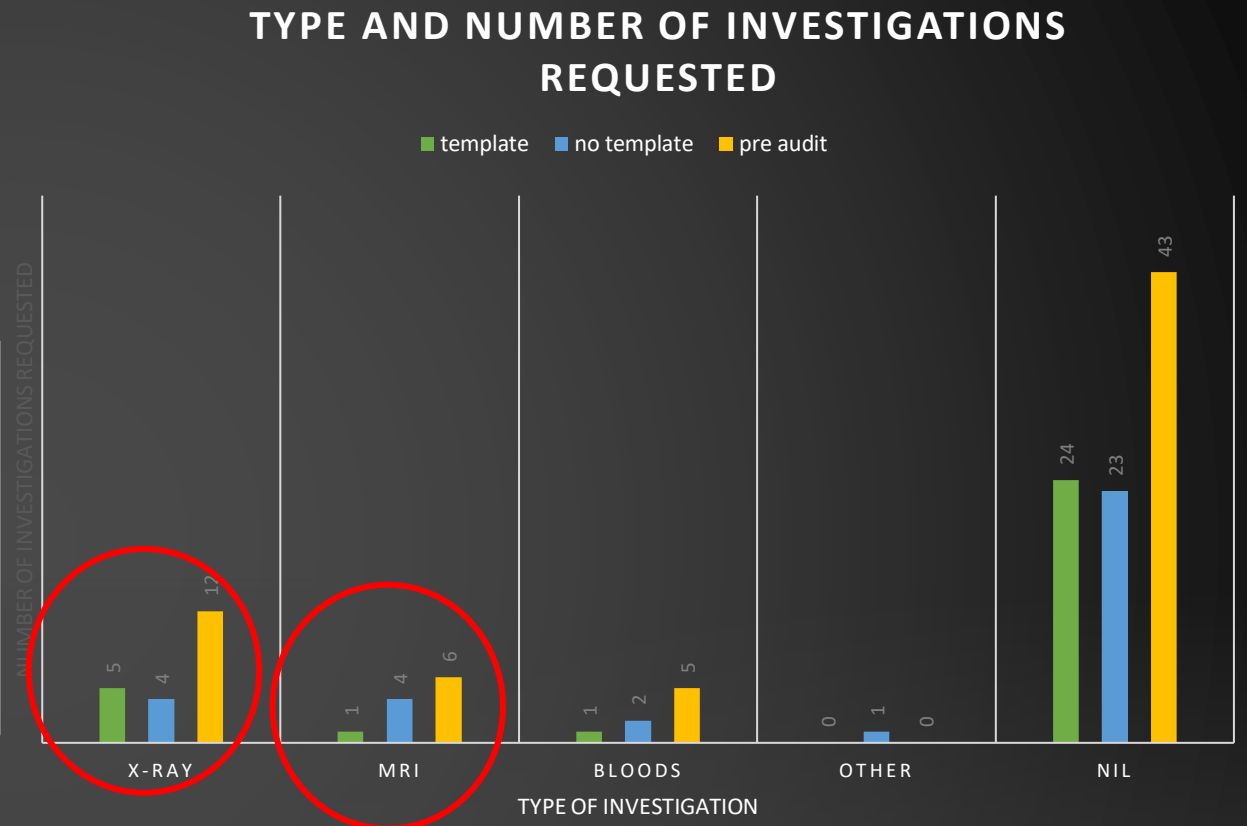


INVESTIGATIONS

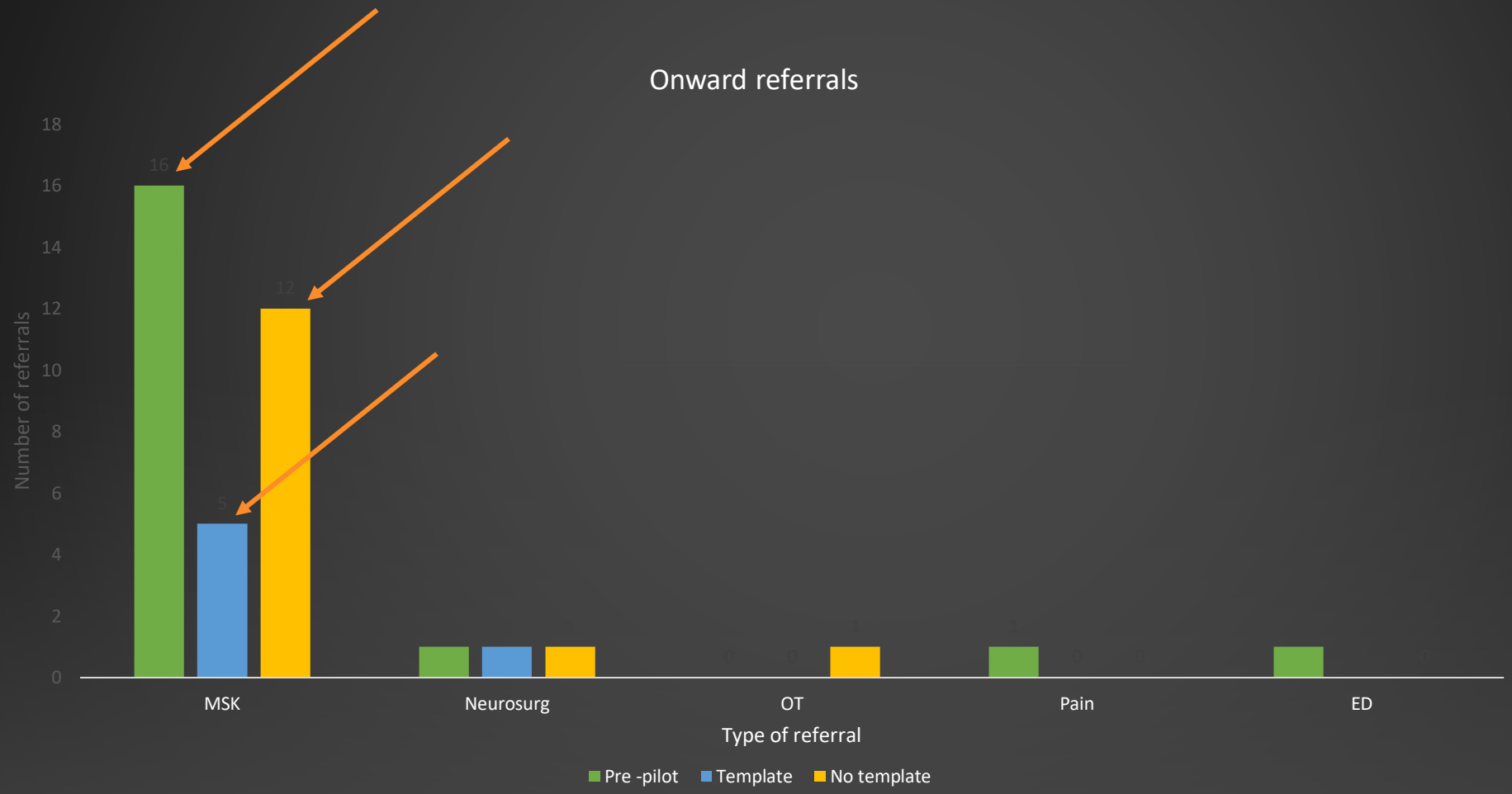




Less number of investigations were done when using the template, but it is not clear whether this is statistically significant

REFERRALS

171



What works well

Peer review and feedback alongside the use of guidelines and structured referral sheets appears to offer the greatest hope of a cost-effective approach to referral management.

Referral management- Lessons for success
Candace Imison, Chris Naylor
The King's Fund 2010

WHAT NEXT?

- Proof of concept
- Replicable
- Scalable — Can be scaled across L&SC as primary care uses EMIS EPR
- Cost implications — No cost implication

- **Can be incorporated into daily practice**
- **Will it increase the workload**
- **Will it reduce administrative burden**
- **Will the quality of consultation be improved**
- **Will it improve referral practices**

WHAT'S BEYOND

- Digital repository (Ongoing)
- Self-Referral pilot (Ongoing)
- 'Waiting well' programme (ongoing)
- Robotic Process Automation (Administrative>>>Clinical)

175

- The best opportunity to make a difference to demand on specialist input is at a point **before** a referral decision is made

- The absolute need to involve primary care in any referral optimization and outpatient transformation initiative
- The need to collaborate and joint working between primary care and specialist services


A1130
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THANK YOU

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NHS Elective Care Conference North

Q&A Panel

Dr Sunil Nedungayil

Clinical Director & GPwSI, Musculoskeletal Medicine -
Integrated MSK, Pain & Rheumatology Service (IMPReS) East Lancashire Hospital NHS Trust

Marc Lyall

Associate Head of Workforce Transformation - **NHSE**

slido

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ⓘ Start presenting to display the poll results on this slide.

THANKS FOR ATTENDING

NHS Elective Care Conference North

CONVENZIS

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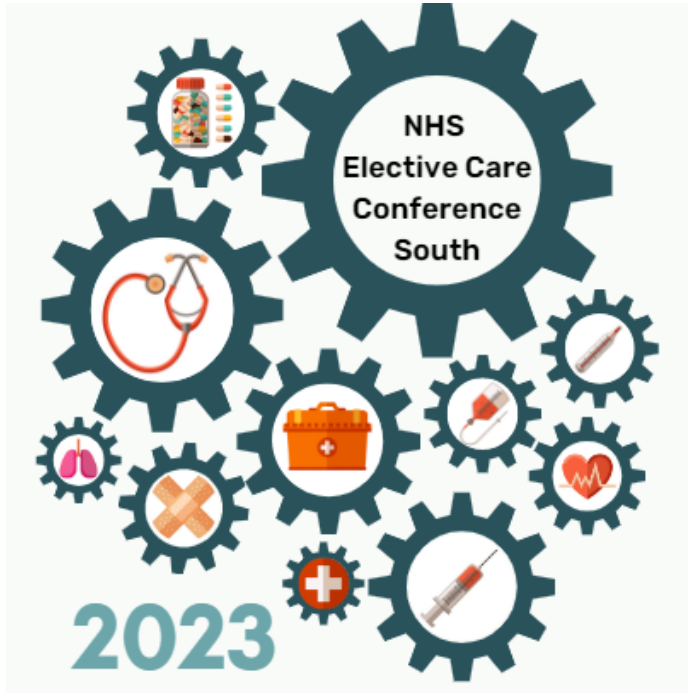

Drinks Reception, Networking and End of Day