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## NHS Elective Care Conference: Transforming Planned Care

Wednesday 23rd November 2022- 10:50am – 15:00pm – GoTo Webinar

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# The NHS Elective Care Conference: Transforming Planned Care

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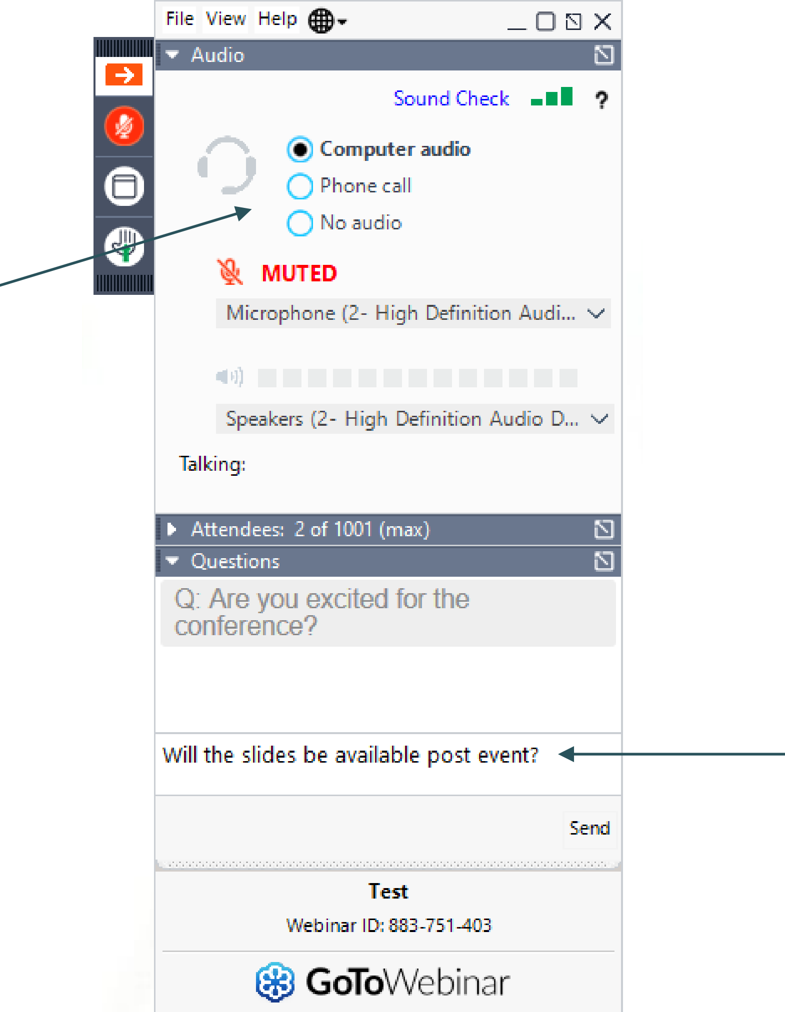


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# The NHS Elective Care Conference: Transforming Planned Care

Now viewing **Rhea Okine**'s screen
Talking:

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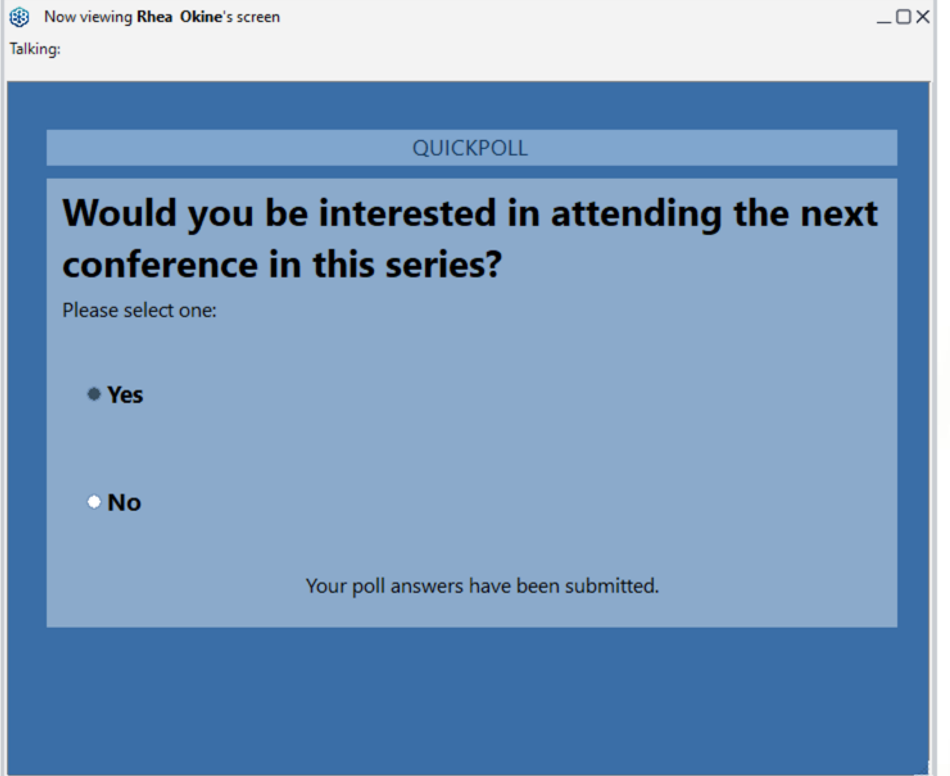


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NHS Elective Care Conference 2022

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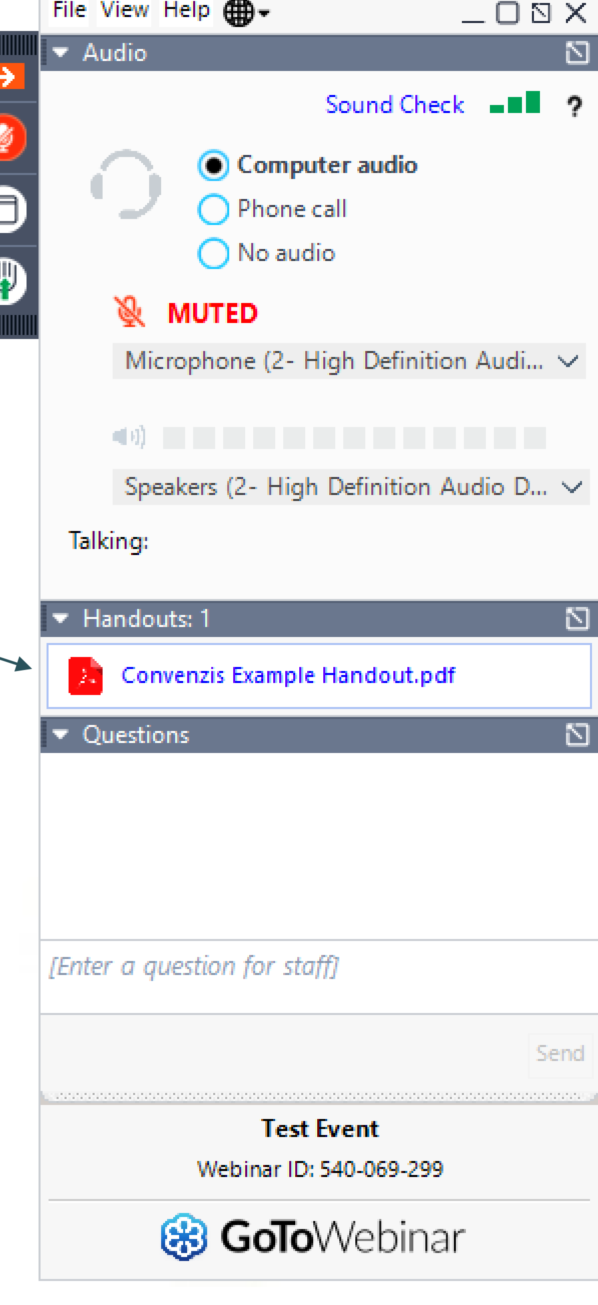


# The NHS Elective Care Conference: Transforming Planned Care

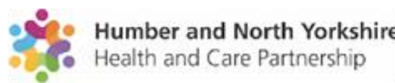
# SPEAKING NOW

Mr Anil Vara

Director, Elective Care & Recovery
North Yorkshire and Humber ICB

## I will be discussing…

"Humber and North Yorkshire Elective Recovery Transformation Programme Synopsis (Overview of the Elective Recovery Programme)"



# Humber and North Yorkshire Elective Recovery Transformation Programme

Anil Vara

Director, Elective Care and Recovery

# HNY Partnership Overview

Partnership comprises of NHS organisations, local councils, health and care providers and voluntary, community and social enterprise (VCSE) organisations

The Partnership is one of 42 Integrated Care Systems (ICSs) in England to meet health and care needs across an area, coordinate services and plan in a way that improves population health and reduces inequalities between different groups

Our partners include Humber and North Yorkshire Integrated Care Board, 5 acute trusts, 3 mental health trusts, 6 local authorities, 2 ambulance trusts and 4 community providers

6 Place Locations covered are York, North Lincolnshire, North Yorkshire, North East Lincolnshire, Hull and East Riding

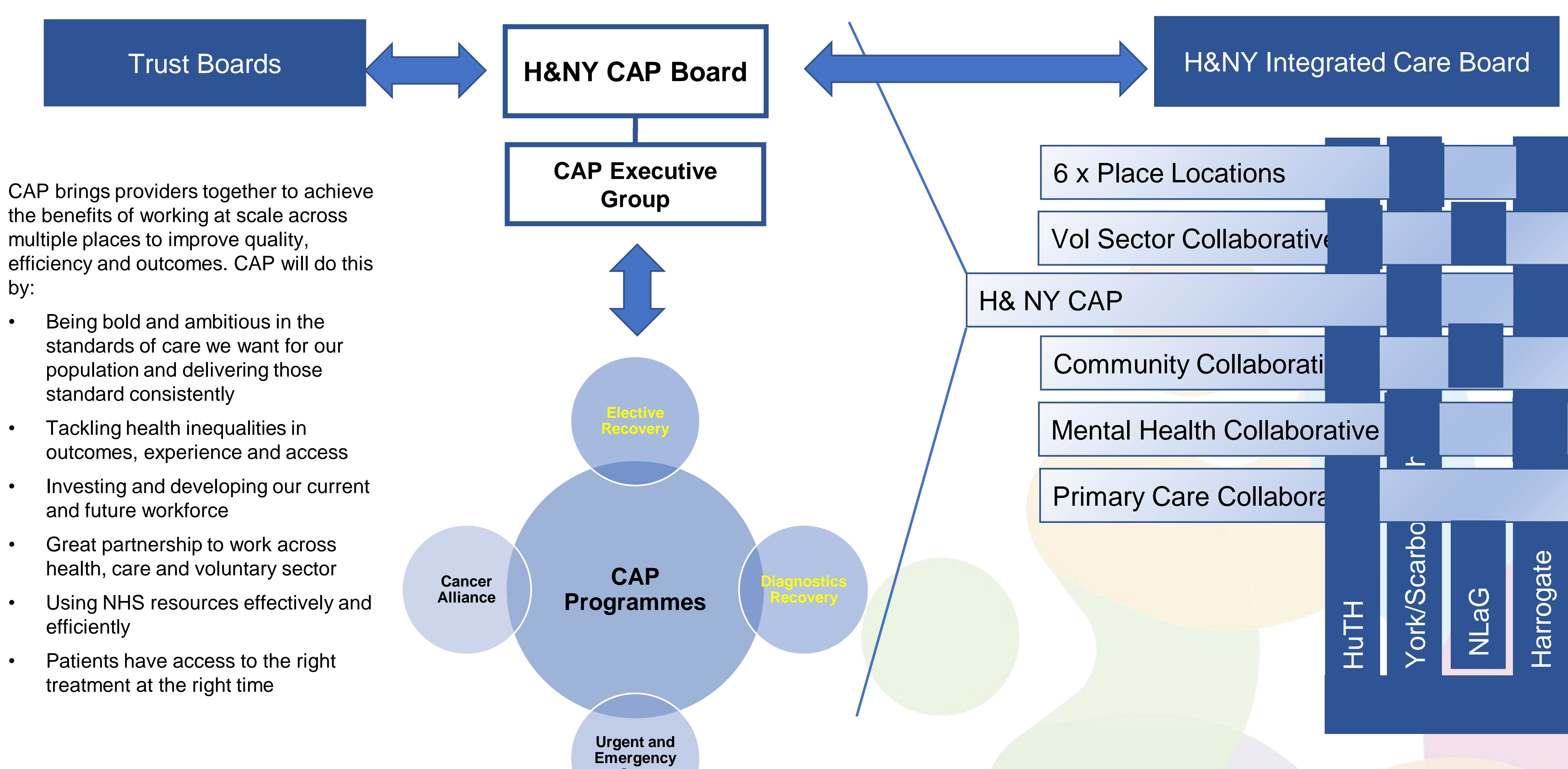
We work across a geographical area of more than 1,500 square miles and serve a population of 1.7 million people, all with different health and care needs

Our area includes the cities of Hull and York and the large rural areas across East Yorkshire, North Yorkshire and Northern Lincolnshire

There are around 230 GP practices, 550 residential care homes, 10 hospices, 180 home care companies and many voluntary and community sector organisations all helping to keep our local people well

Humber and North Yorkshire
Health and Care Partnership

# Collaborative of Acute Providers (CAP)



# HNY Elective Recovery Programme

**National Delivery Strategy**

- Increasing Health Service Capacity
- Prioritising Diagnosis and Treatment
- Transforming Elective Care
- Better Support for Patients

**HNY Programmes**

- Waiting well
- Outpatient transformation
- Mutual aid
- Clinical health Pathways
- Diagnostics

Health inequalities | Performance review/BI | Digital | Waiting list management

**National Ambitions**

March 2025

- 52 week waits eliminated
- 95% of patients receiving diagnostic tests within 6 weeks
- Reducing the time to first outpatient appointment

# HNY Elective Recovery Programme

Governance

Supporting work streams

Supporting Programmes

Collaboration of Acute Providers Board

Strategic Elective Recovery Board

- Diagnostics Programme Board
  - Various Work streams
- Clinical Health Pathways Programme Board
  - Clinical Networks
  - GIRFT data/Theatre Efficiency
- Mutual aid Programme Board
  - Mutual aid Hub task and Finish group
  - Mutual aid Process task and Finish group
- Outpatient Transformation Board
  - Various Work streams
- Waiting well Programme Board
  - Risk Stratification Task & Finish Group
  - WW Dashboard and Health Inequalities task and Finish group

Supporting Programmes:

- Health inequalities
- Waiting list management
- Digital
- Performance Review/BI

# Elective Clinical Networks

- HNY elective clinical networks have been developed with specific focus on redesign of pathways through adopting best practice initiatives from GIRFT
- These networks are delivered through clinical, operational, programme teams working together. The networks are clinically led and supported by regional GIRFT members/ambassadors, speciality regional clinical GIRFT lead

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Humber and North Yorkshire
Integrated Care Board (ICB)

GIRFT Clinical Ambassador | GIRFT Speciality Lead | Provider Clinical Leads | Provider Operational Leads | National GIRFT Theatre Team | CNS/AHP's | Elective/Digital Programme Lead | Speciality GP lead

**June 2022** → Orthopaedics | Urology | Eye Care | Theatre Efficiency Group | Gynecology | ENT | General Surgery → **March 2023**

**Clinical Networks Established** (Orthopaedics, Urology, Eye Care, Theatre Efficiency Group, Gynecology)

**Clinical Networks in Development** (ENT, General Surgery)

**Elective Clinical Network Objectives**

- Provide accountability and strategic direction to improve clinical outcomes for the population across Humber & North Yorkshire.
- Reduce variation in clinical outcomes across providers within HNY through reviewing model hospital and Elective data metrics
- Driving continuous quality improvements across the clinical pathway
- Delivering clinical leadership and direction to recover our elective services inclusively
- Interface with Region/National initiatives and directives, to ensure interpretation of National Guidance and accessing good practice and innovation

# HNY Elective Recovery Priorities 2022-23

**PIFU**
- Using analytical modelling quantify impact of using PIFU in clinical specialities
- Using our Elective Clinical networks to lead in implementing PIFU pathways

**HNY Elective Strategy**
- Development of the ICS planned Care Strategy for 2023-25

**Waiting Well**
- Optimise patients that are complex on the orthopaedic waiting list for surgery by working closely with primary care teams
- Review ICS Risk stratification algorithm work in partnership with the Elective clinical networks
- Waiting Well Programme review of CHN will support Risk Stratification

**HVLC Hubs**
- Develop ICS Orthopaedic HVLC hub site by Jan 2023: Pooled waitlist for clinics, surgery; digital pre op, clinical optimisation
- Using the Orthopaedic hub model and blueprint to commence development of further hubs e.g. Urology, Gynaecology

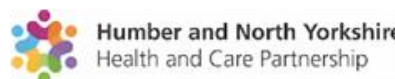
**Mutual aid**
- Continue with the significant benefits of system wide mutual aid through (NLAG/HUTH/Y&S/Harrogate
- Develop an ICS wide coordination centre to support mutual aid for both admitted and non admitted patients

**Managing Waiting Lists**
- Standardised training programmes through local and national developments
- Connected Health Network demand management and follow up approach
- Waiting list validation e.g. text messaging, digital tools to clinically review patients, validation tools for waiting lists
- ICS wide Access policy and to ensure inequalities of access is reflected within the policy

**Diagnostics**
- Review of the Diagnostic Programme Board
- Expansion of capacity through year 2 CDC investment (mobile scanners, workforce resource)
- Understanding our data (demand, capacity, waiting list validation)

**Reduce the Number of Patients >78 weeks**

# HNY ICS Mutual Aid Coordination Centre (Hub)



## We have ambitions for the HNY ICS Mutual Aid Co-ordination Centre (Hub) to target inequity of waits at speciality level across providers, promote better patient choice and reduce inequalities

- Successful investment bid to support the development of an ICS Mutual Aid approach, with a co-ordination centre to drive increased volumes of mutual aid aiding the reduction of long waiting patients at risk of breaching 78 weeks by March 2023.
- This will be alongside enabling the ICS to develop a sustainable hub as part of its longer-term strategy to allow patients to choose their preferred provider and create equitable access across the ICS.

### Our vision for our ICS Mutual Aid Hub:

The vision for our hub is to increase collaboration and communication across the system to more efficiently transfer patients, staff and equipment across the system to support areas of pressure in a more agile way, whilst creating equity across our ICS population.

The hub will have a phased mobilisation and once fully operating by March 2023, will provide six core functions (outlined below) to support mutual aid across the ICS, with ISPs and wider NHS (Regional and National).

**Six capabilities within the hub:**

**Policy and guidance**

**Case management** (Patient communication)

**Governance and central co-ordination**

**Analytics and forecasting**

**Demand management**

**Performance monitoring**

Whilst the hub model is yet to be completely designed, the idea is there will be at least four core teams as well as input from Executives and senior operational and clinical people across the ICS. The teams (as a minimum) will:

- **Co-ordination team:** with some roles based in Trusts, working alongside operational and clinical teams to identify opportunities whilst working collaboratively to match requests as well as sharing areas of capacity. Ensuring that transferred patients are booked and treated with outcomes shared.
- **Patient facing team(s):** managing patient communications throughout the end to end process as well as updating relevant Trust systems (e.g. PAS) and being responsible for trackers and IPT'ing patients
- **An analytics team:** to work collaboratively with the co-ordination team and Region to highlight opportunities for improved equity of waits, measure impact on all Trusts as well as advancing a central BI function to support elective recovery (e.g. single PTL, measuring health inequalities, demand and capacity)

### What benefits are we expecting to deliver in the short and medium term?:

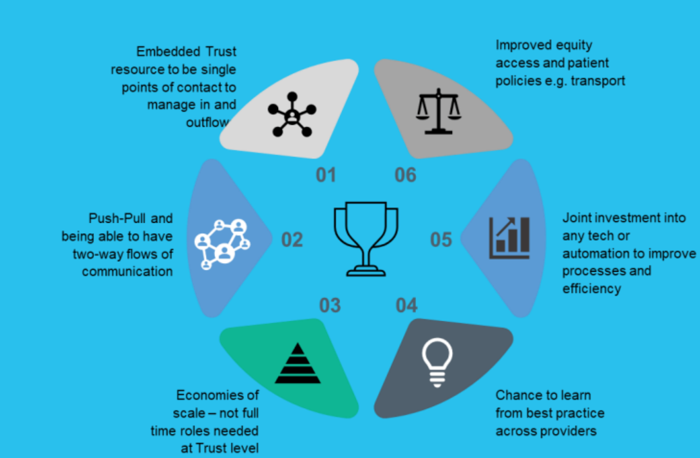
**Short Term (FY22/23):**

1. Across the ICS we are expecting our uptake of mutual aid by specialty to increase
2. We would expect a lower volume of returned patients (~15%) through improved collaboration
3. Noting the increased operational pressures through Q4, we'd expect our risk cohort in our Tier 1 and 2 organisations to reduce to support meeting the next long wait milestone

**Longer Term (FY23/24 and beyond):**

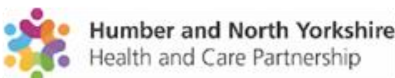
1. Across the ICS we'd expect our 52+ position to be improved by 10-20% in H1
2. We expect our wait for treatments (by Trust) to be equalised by April 2025 (Trusts will have a similar wait by specialty, not all specialties will have the same wait)
3. We would expect our health inequalities to improve but further work to quantify this is underway

IMPROVED COLLABORATION WILL ALLOW FOR WIDER QUALITATIVE BENEFITS



# Examples of Innovations across HNY

# PIFU Patient Animations

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- The HNY Outpatient programme developed patient animation videos with an aim of supporting and empowering patients by explaining what Patient Initiated Follow Ups (PIFU) are and describing how patients can undertake their appointments virtually if required. Animations went live at the end of July 2022
- Available on You Tube and circulated to acute providers and other stakeholders to utilise locally either in clinic as part of a shared decision making conversation, or on external websites / social media to promote to patients. Each lasts approx. 40s
- Lot of national and regional interest and compliments received – both directly and via NHS Futures
- **Next steps:** evaluate the effectiveness of the animations and soon launching animations in different languages

## PIFU

**As 4th October:**
**Views** – 409
**Impressions** – 540
**Click through rate** 13%
Most accessing through Google search and HNY website (same percentage)

## Virtual Consultations

**As 4th October:**
**Views** – 148
**Impressions** – 642
**Click through rate** – 7.9%
Most accessing through HNY website

I came across this wonderful and simple video for PIFU. I want to reach out to see if it can be used by own organisation

***Frimley Health NHS FT***

We would all be interested in using these animations too

***South Yorkshire ICB***
***North West region***
***South East ICS***
***Barts Health NHS Trust***
***Lancashire Teaching Hospitals***

**Definitions**
- **Views** – number of times the video has actually been watched
- **Impressions** – the number of people the video has been shown to (but only in thumbnail form) e.g. in a list of recommended videos on You Tube or Facebook etc.
- **Click through rate** – shows how many people have accessed the animations via a link they've clicked through (so via website/social media posts)

# Connected For Health

## What is it

The Connected Health Network (CHN) model represents a transformative break from the traditional model of patients being referred by primary care into secondary care

The model is based around the patient and operates across traditional boundaries, seeing GPs working in partnership with specialists to provide ongoing care to patients when they need it

## What was the Outcome

The backlog of 500 follow up patient appointments for Meridian PCN cardiology patients was cleared within 4 months

Now running pilots in 6 specialities with 8 PCN's

Approximately 30-80% of patients managed in primary care across the various specialities

## What did we learn

GPs can access specialist advice for patients and vice versa

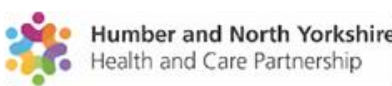
Model facilitates education and understanding between both GPs and the specialists and encourages the management of patients in a primary care setting

Allows specialists to have direct access to GPs primary care information system which reduces the risk of duplication

Model minimises 'in person' clinical attendances for patients and encourages / supports patients to make use of digital communication

Waiting Well Programme could benefit from CHN providing opportunities to support risk stratification and clinical optimisation

# Rapid Expert Input (REI)



## What is it

System that improves the process of optimising referrals to secondary care specialist clinicians

The system helps to Improve turnaround times for referral guidance whilst reducing the burden on administration

## What was the Outcome

Full REI has provided between 41-52% diversion rate of referrals away from the hospitals across 3 specialties

Full REI operating in Neurology, Rheumatology and Dermatology

Very positive initial feedback from primary and secondary care (both clinical and administrative)

## What did we learn

Plans to expand REI/clinical triage to all specialties

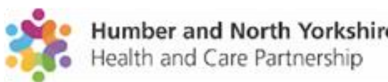
Current A&G pilot improves functionality, cementing two way dialogue to better manage patient and optimise primary care management

Review of themes for new clinical pathways and guidelines with supporting educational events

Scoping underway to identify further opportunities to reduce outpatient attendances by incorporating the ability to arrange required secondary care diagnostics **prior to** OPFA to reduce FUs and ensure swifter pathway of care for patients

Tool has the potential to support waiting list validation and reduction

# Risk Stratification of Waiting List



## What is it

Northern Lincolnshire & Goole NHS Foundation Trust (NLAG) partnered with North Lincolnshire and North East Lincolnshire Place and their GPs to undertake a review and risk stratification on overdue follow ups

Aim was to review patients on the overdue follow-up list, provide recommendation for future care and for those remaining on waiting list were risk stratified, using a standard matrix to assist prioritisation for booking.

## What was the Outcome

Total of 6,623 patients reviews were identified with 4,683 patients reviewed by GP's

25% of the patients GPs reviewed were suitable for discharge

Remaining cohort were risk stratified into Red (16%), Amber (36%) and Green (48%)

## What did we learn

Red flag list of conditions for GPs on how to complete the reviews were useful documents to refer to

Two approaches taken: (1) GPs who work as a group practice (2) GP undertakes own pts review

(1) Showed review process was quicker whilst (2) showed the GP knew there patients better

Review process for patients identified as "straightforward" discharge. Not mandated, but consultants could review prior discharge

It was advantageous using the EPR system WEBv as GPs are already familiar with it as it's used for results.

Waiting Well Programme plans to build further on risk stratification algorithm and review with other models being used in other regions e.g. HEARTT tool from Coventry which support reducing Health Inequalities

# Text Message Validation

## What is it

Text messaging system was used to contact patients to determine if the wish to remain on the waiting list

Patients were provided 6 questions on the text message to respond too. Pts could also respond using free text fields. Cancer pts were excluded

## What was the Outcome

25,615 text messages have been successfully delivered from 26,731 since 8 July 2022. 67% pts responded to their text

819 (7.9%) of Non admitted patients removed from the waiting list as of 17 Oct

120 (3.3%) admitted patients removed from the waiting list as on 17 Oct

## What did we learn

Manual letters had to be sent to pt. where the message failed or did not have phone

More pts than usual where telling booking teams their condition had cleared – Texting allowed quick process to keep the wait list up to date

Social media posts and internal communications were completed to 2 weeks prior to go live in case the pts through the text was spam

The order of the messaging was determined by our performance team based on list size and length of waits
Pts between 70-12 weeks RTT were targeted

User guides had to be produced for administrative teams for the text outcomes together with training

# (IBD at Home - IBD App)

## What is it

Inflammatory Bowl Disease (IBD) pts are invited to join a virtual 'Home' The 'Home' consist of clinicians, dietician, nurses in a virtual environment

Application used on both IBD flare and stable pathways

IBD Home provided home Calprotectin testing for flares, instant updates on pts symptoms, digital therapeutics and physiological support

## What was the Outcome

c. 80% of the patients are using the digital process. Main users range from 18-55 years of age however pts over 55 are using the process

Reduction in hospital admissions – 37 pts admissions avoided

Environmental impact: avoided 111 pts appointments and approx. 394 Kg Co2 offset

## What did we learn

High number of pts reporting process easy to follow and feel confident to contact team

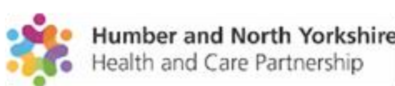
High proportion of pts feel the process allows them more control and improves self confidence

Healthcare system and indirect patient costs are being determined

HNY Elective programme working collectively with Professor. Sebastian at Hull and team to determine if this application can be scaled up across the ICS

Patient survey results, patient engagement, PROMS was important to complete and helped to understand how pts were impacted from this process

# What are our Patients and Hospital staff saying?

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**CHN** "Happy with Cardiology side of things, had a quick response and understand what is happening going forward. Wouldn't change anything." **Patient feedback**

**REI:** Quick response time and ease of use for attaching multiple documents at once rather than having to upload individual documents via e-RS. We are looking forward to the further introduction of specialities over time'
**Brook Square Surgery**

**CHN** "It is great to have timely useful advice on how I can best manage the patient with clear instructions. No longer get a letter with a long list of can you do this, can you do that – as that is directly organised between consultant and shared admin team. I can be left to do proper GP work." Dr Ekta Elston, **GP feedback**"

**REI:**:'Personally as Medical Secretary have found this very good. I have only had to use the Dermatology specialty so far but it was very encouraging with responses coming back within hours. Bring on the other specialties'

**Terrington Surgery**

**PIFU Animations** "We would all be interested in using these animations too

**South Yorkshire ICB**
**North West region**
**South East ICS**
**Barts Health NHS Trust**
**Lancashire Teaching Hospitals**

**CHN:** There is early evidence that the number of referrals are starting to reduce as GPs are able to manage patients more confidently having direct access to specialists
**NLAG**

**PIFU Animations: I came across this wonderful and simple video for PIFU. I want to reach out to see if it can be used by own organisation**

**Frimley Health NHS FT**

# The NHS Elective Care Conference: Transforming Planned Care

# SPEAKING NOW

Dr François Taljard

Consultant Anaesthetist
NHS Lanarkshire

## I will be discussing…

"Digital transformation of patient elective pathways: How NHS Lanarkshire transformed pre-operative assessment to digital and optimised waiting list management"

# The NHS Elective Care Conference: Transforming Planned Care

# SPEAKING NOW

## I will be discussing…

"High Intensity Theatres Lists: A new way of working?"

Dr Imran Ahmad

Consultant Anaesthetist Deputy Clinical Director of Theatres, Anaesthesia & Perioperative medicine (TAP) - Guy's & St Thomas NHS Foundation Trust

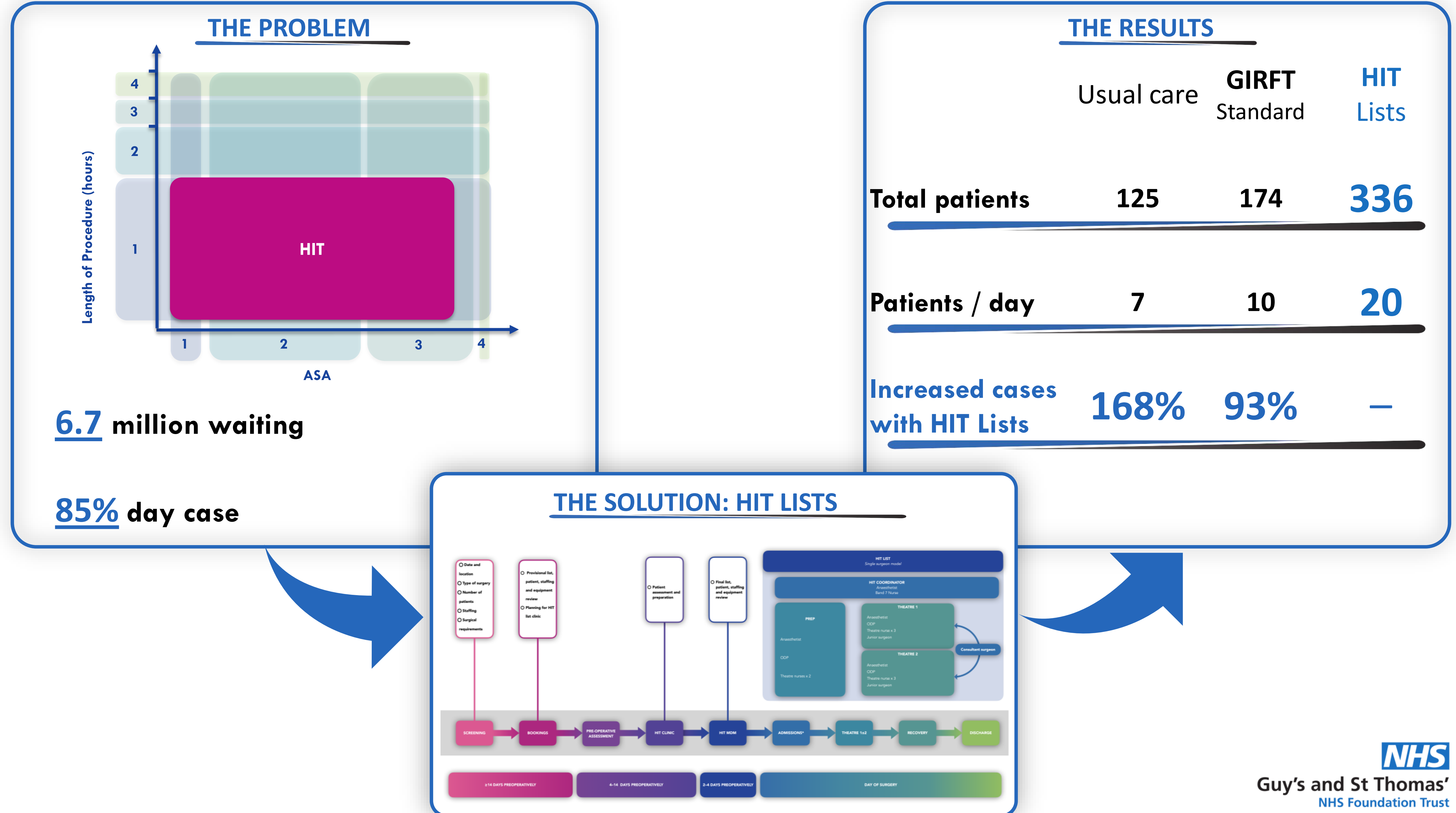
# High Intensity Theatre (HIT) Lists

Dr Imran Ahmad

Consultant Anaesthetist

Deputy Clinical Director, TAP

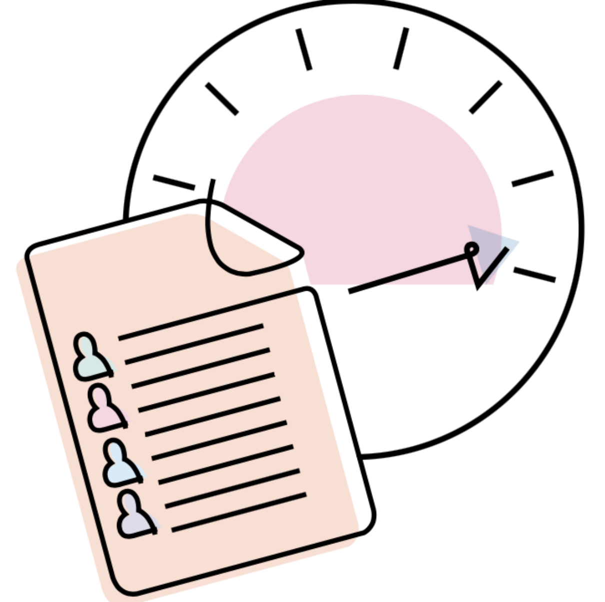
Guy's & St Thomas' NHS Foundation Trust


THE PROBLEM
Length of Procedure (hours)
4
3
2
1
HIT
1
2
3
4
ASA
6.7 million waiting
85% day case
THE RESULTS
Usual care
GIRFT Standard
HIT Lists
Total patients
125
174
336
Patients / day
7
10
20
Increased cases with HIT Lists
168%
93%
–
THE SOLUTION: HIT LISTS
NHS
Guy's and St Thomas'
NHS Foundation Trust

# PROBLEM

# NHS backlog data analysis

Analysis of monthly data releases by NHS England to highlight the growing backlogs across the NHS - including operations data, cancer waiting list GP referrals and A&E waiting times.



The latest figures for June 2022 show:

- a record of over 6.73 million people waiting for treatment
- 2.54 million patients waiting over 18 weeks for treatment, an increase from last month
- 355,00 patients waiting over one year for treatment - 7 times the number waiting over a year in June 2020
- a median waiting time for treatment of 13.3 weeks – significantly higher than pre-Covid duration.

# Number of people on NHS waiting lists for consultant-led elective care

September 2015 to June 2022

Start of the pandemic

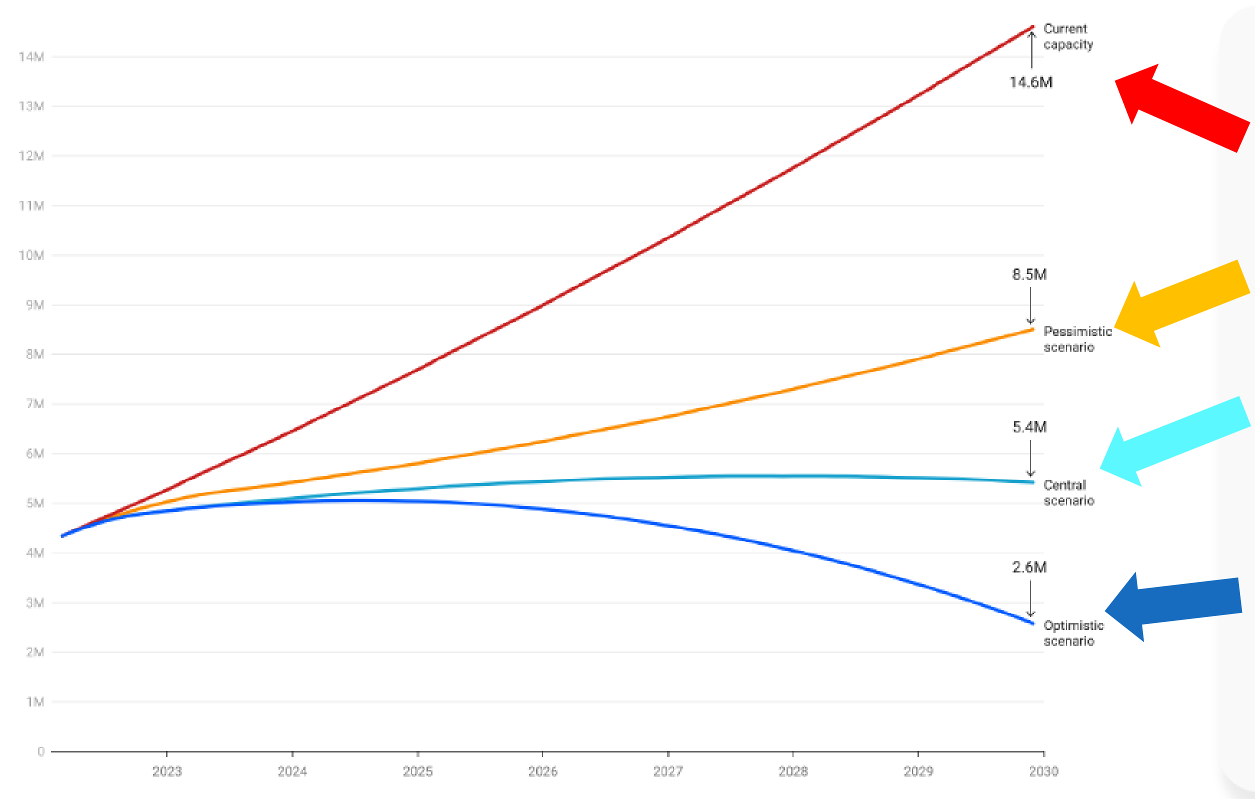
**Total Waiting (Millions)**
**Jun-22:** 6.63 million

7 million
6.5 million
6 million
5.5 million
5 million
4.5 million
4 million
3.5 million
3 million
2.5 million
2 million
1.5 million
1 million
0.5 million
0 million

Sep-15 Jan-16 May-16 Sep-16 Jan-17 May-17 Sep-17 Jan-18 May-18 Sep-18 Jan-19 May-19 Sep-19 Jan-20 May-20 Sep-20 Jan-21 May-21 Sep-21 Jan-22 May-22

# PROJECTIONS

# Possible scenarios




**Scenarios** (elective procedures needed by 2030)

**Current capacity:** Elective procedure volume remains at current levels (14·6 million).

**Pessimistic scenario:** Elective procedure volume returns to pre-pandemic volume in July 2023 and remains at that level (8·5 million).

**Central scenario:** Elective procedure volume returns to pre-pandemic volume in December 2022 and then increases by 2% per year (5·4 million).

**Optimistic scenario:** Elective procedure volume returns to pre-pandemic volume in December 2022 and then increases by 4% per year (2·6 million).

**Note:** the pre-pandemic NHS waiting list was 753,116.

20 key low-risk procedures account for

70% of total need

Making day-case procedures more accessible and deliverable will address

85% of need

# Need for elective procedures split by specialty and admission type

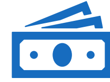
| | Day-case | Inpatient |
|---|---|---|
| Orthopaedics | 657,797 | 319,078 |
| Colorectal surgery | 636,961 | 13,436 |
| Oesophagogastric surgery | 447,254 | 22,891 |
| Opthalmology | 390,328 | 1,355 |
| Urology | 317,910 | 68,061 |
| Head & Neck surgery | 316,268 | 16,013 |
| Plastic surgery | 227,140 | 4,193 |
| Gynaecology | 162,365 | 84,608 |
| Cardiology | 152,762 | 1,691 |
| General surgery | 144,944 | 29,348 |
| Vascular surgery | 77,524 | 26,377 |
| Hepatobiliary surgery | 73,893 | 6,770 |
| Thoracic surgery | 44,652 | 15,385 |
| Breast surgery | 36,015 | 6,953 |
| Neurosurgery | 5,131 | 11,538 |
| Cardiac surgery | 1,433 | 27,395 |

# EXISTING PROPOSALS

More theatres

More medical staff

More nursing staff


Huge costs and time

# WHY NOT USE WHAT WE ALREADY HAVE

# **DIFFERENTLY?**

# SOLUTION

# SOLUTION

# HIT LISTS

# WHAT IS A HIT LIST?

# WHAT IS A HIT LIST?

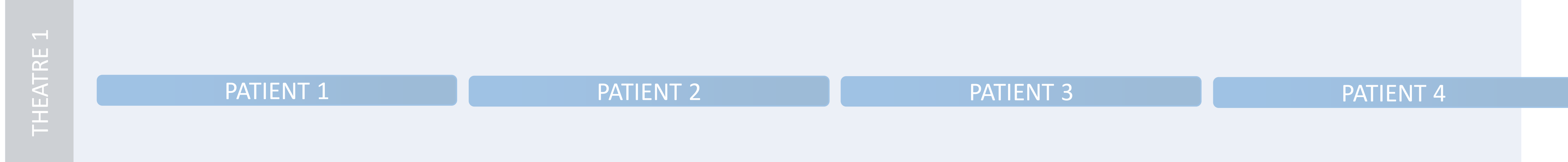
## TRADITIONAL LIST

THEATRE 1

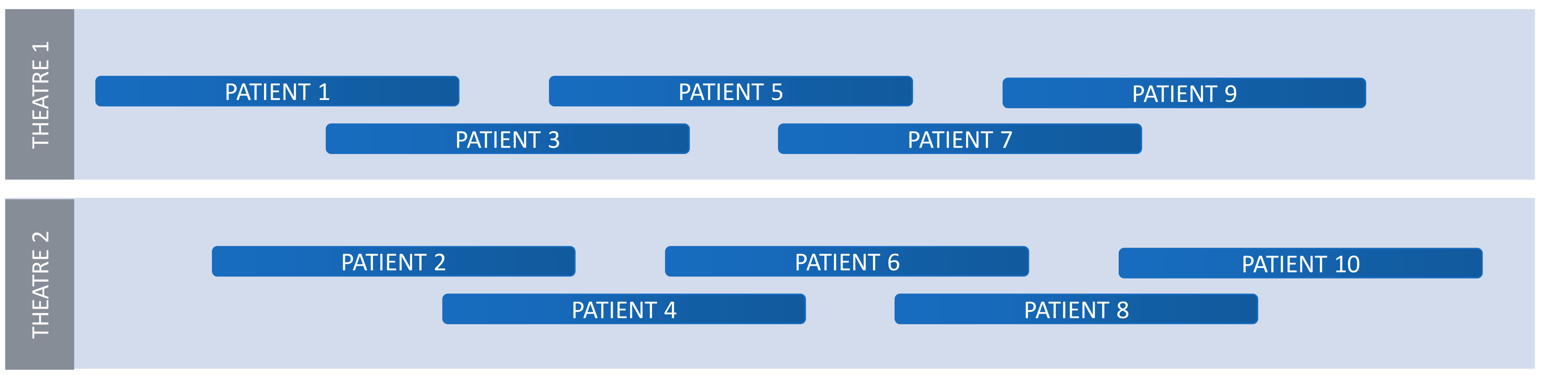
PATIENT 1 | PATIENT 2 | PATIENT 3 | PATIENT 4

# WHAT IS A HIT LIST?

## TRADITIONAL LIST




## HIT LIST



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NHS Foundation Trust

# HOW?

# HOW?

MDT
- HIT COORDINATOR
- SURGEON
- SENIOR THEATRE NURSES
- AHPs
- SERVICE MANAGERS
- BOOKINGS OFFICERS

- Date and location
- Type of surgery
- Number of patients
- Staffing
- Surgical requirements

- Provisional list, patient, staffing and equipment review
- Planning for HIT list clinic

- Patient assessment and preparation

- Final list, patient, staffing and equipment review

**HIT LIST**
*Single surgeon model*

**HIT COORDINATOR**
Anaesthetist
Band 7 Nurse

**PREP**
Anaesthetist
ODP
Theatre nurses x 2

**THEATRE 1**
Anaesthetist
ODP
Theatre nurse x 3
Junior surgeon

**THEATRE 2**
Anaesthetist
ODP
Theatre nurse x 3
Junior surgeon

Consultant surgeon

SCREENING → BOOKINGS → PRE-OPERATIVE ASSESSMENT → HIT CLINIC → HIT MDM → ADMISSIONS* → THEATRE 1±2 → RECOVERY → DISCHARGE

≥14 DAYS PREOPERATIVELY | 4–14 DAYS PREOPERATIVELY | 2–4 DAYS PREOPERATIVELY | DAY OF SURGERY

# NOVELTY

- MDT involvement
- MDT planning meetings
- HIT List clinics
- Fewer patient hospital visits
- Floating/Prep Team
- HIT Coordinator

# INCLUSION CRITERIA

## PATIENTS

ASA 1 / 2 / stable 3

## SURGERY

< 60 min surgical time

Low risk of acute pain, PONV, bleeding

< 60 min PACU time

# INCLUSION CRITERIA

## PATIENTS

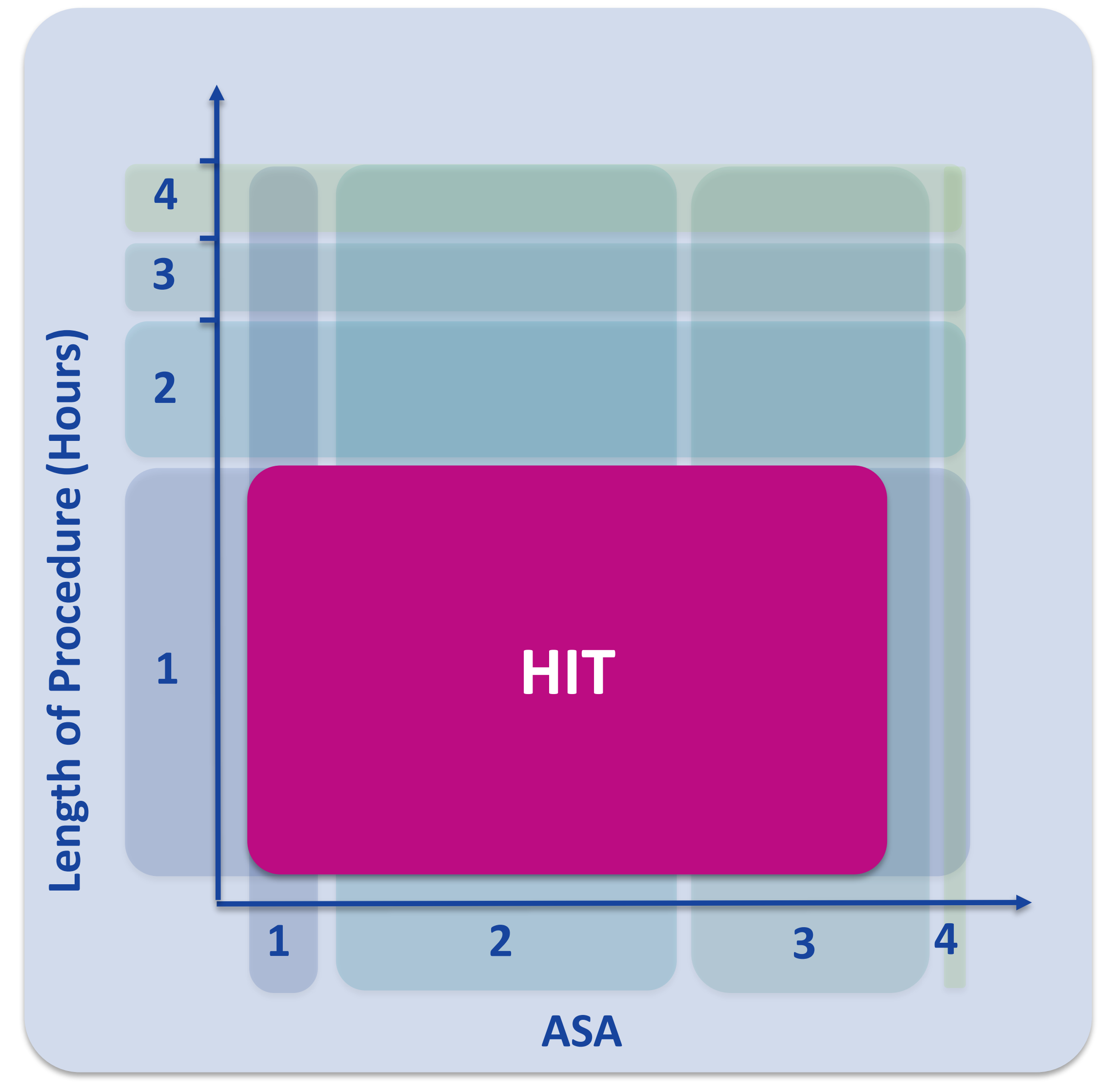
ASA 1 / 2 / stable 3

## SURGERY

< 60 min surgical time

Low risk of acute pain, PONV, bleeding

< 60 min PACU time

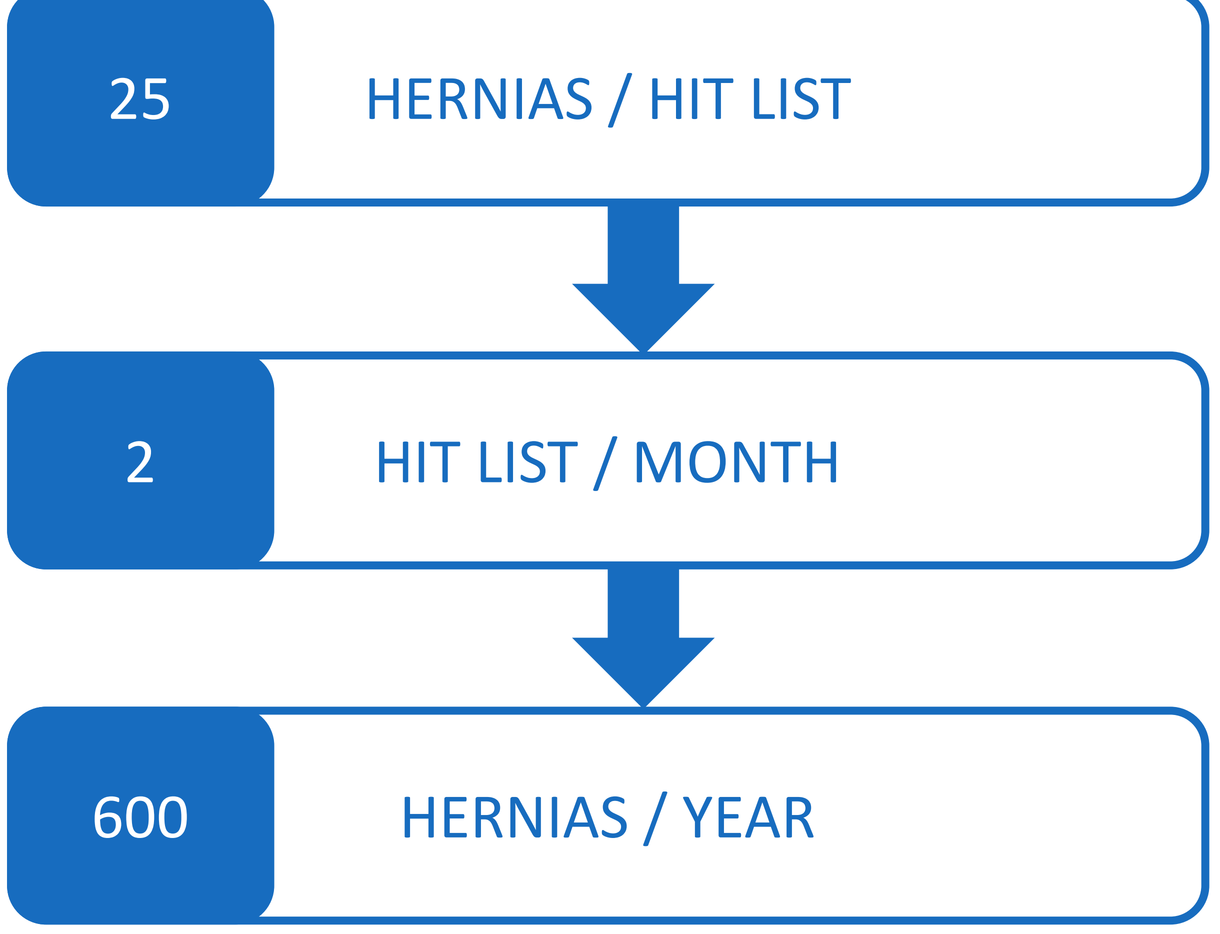


# POTENTIAL IMPACT

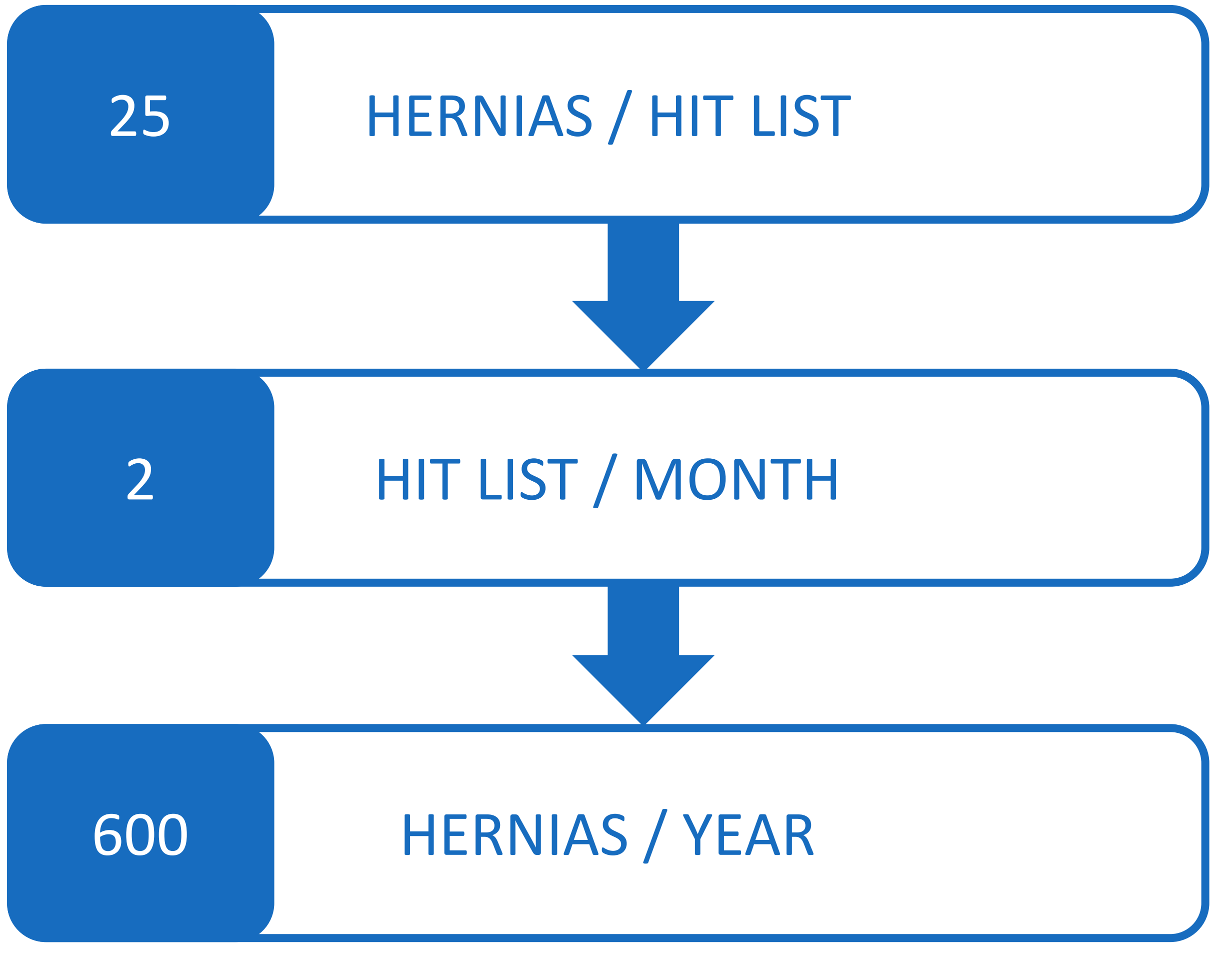
# HERNIAS

# UK HERNIA WAITING LIST

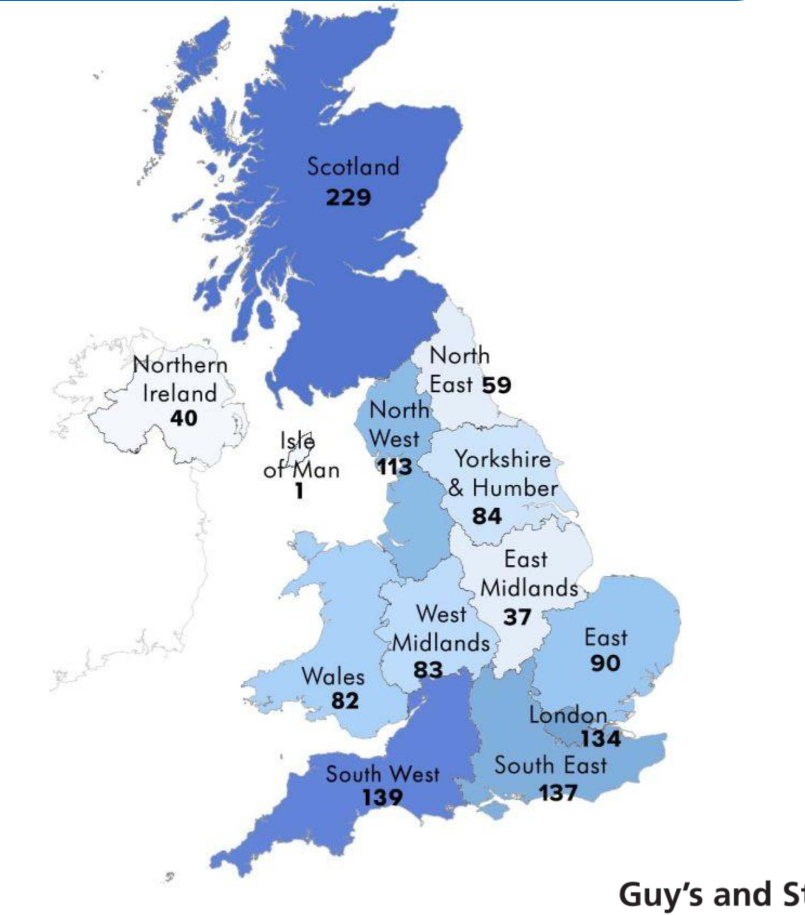
# USING HIT LISTS



# USING HIT LISTS




> 1000 HOSPITALS




NHS
Guy's and St Thomas'
NHS Foundation Trust

# USING HIT LISTS

HERNIAS / YEAR

70,000
60,000
50,000
40,000
30,000
20,000
10,000
0

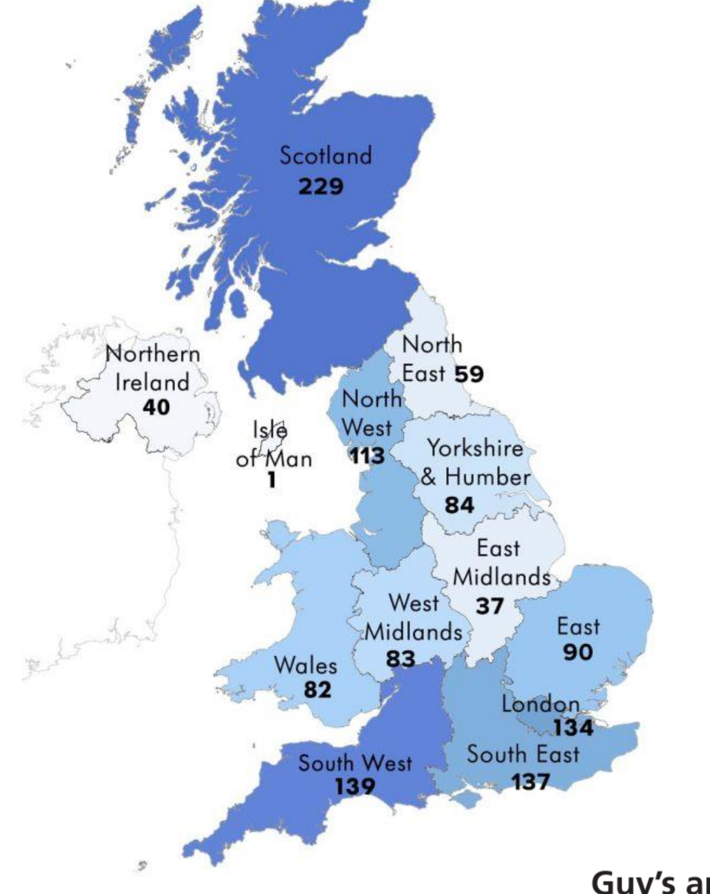
2 YEARS

1 YEAR

50 HOSPITALS

100 HOSPITALS

> 1000 HOSPITALS




Guy's and St Thomas' NHS Foundation Trust

# RESULTS

| Date | Specialty | N | Finish time |
|---|---|---|---|
| **2021** | | | |
| 23/4 FEB | Ortho (ACLs) | 23 | 14:00 |
| 27 MARCH | ENT | 15 | 14:00 |
| 15 MAY | Spine | 34 | 12:00 |
| 22 MAY | Gynae | 27 | 15:00 |
| 19 JUNE | ENT | 25 | 14:00 |
| 24 JULY | Upper GI | 19 | 14:00 |
| 7 AUG | Colorectal | 18 | 12:00 |
| 14 AUG | Ortho (THR) | 12 | 15:00 |
| 16 AUG | ENT | 24 | 15:45 |
| 28 OCT | Vascular | 28 | 14:30 |
| **2022** | | | |
| 23 APRIL | Upper GI | 17 | 15:00 |
| 14 MAY | Ortho | 12 | 15:45 |
| 11 JUNE | Breast | 15 | 13:30 |
| 18 JUNE | Vascular | 23 | 15:30 |
| 16 JULY | ENT | 27 | 14:00 |
| 30 JULY | Urology | 17 | 14:15 |
| **TOTAL** | | **336** | |

| Date | Specialty | N | Finish time |
|---|---|---|---|
| **2021** | | | |
| 23/4 FEB | Ortho (ACLs) | 23 | 14:00 |
| 27 MARCH | ENT | 15 | 14:00 |
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| 16 JULY | ENT | 27 | 14:00 |
| 30 JULY | Urology | 17 | 14:15 |
| **TOTAL** | | **336** | |

16 LISTS

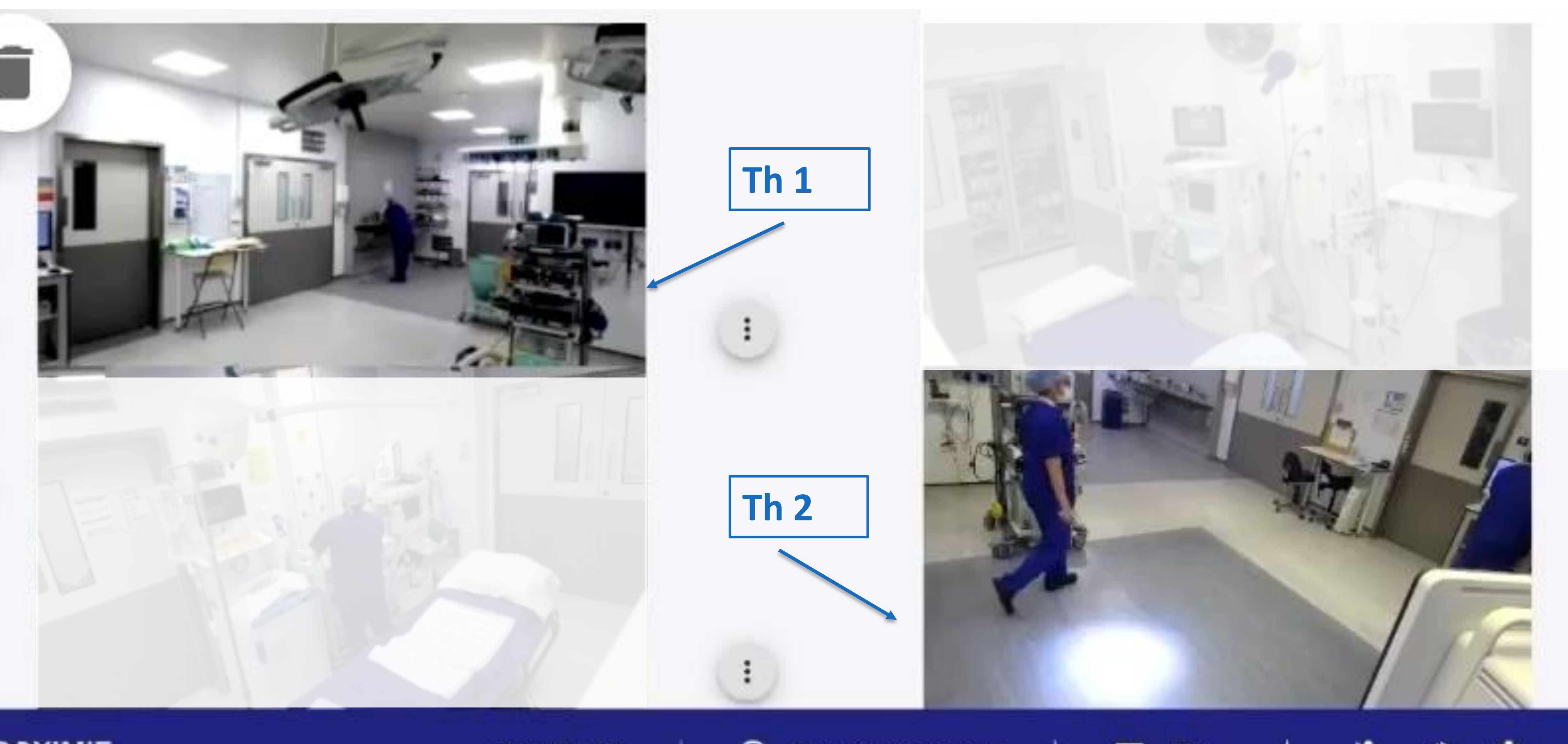
9 SPECIALTIES

0% OVERRUN

0.5% CANCELLATION

| | Traditional list | HIT Lists |
|---|---|---|
| **Total patients** | **125** | **336** |
| **Patients / day** | **7** | **20** |

**2.7 x MORE CASES**



Th 1
Th 2
ROXIMIE
12:30:24
Recording in progress

# EXPANSION OF HIT LISTS

- Hip replacement
- Robotic surgery
- Surgery >60 mins (eg Aquablation & Cochlear implants)
- Interventional radiology

IN FOCUS

**Kelly Cook** speaks to patients who have benefited from an innovative programme that is tackling waiting lists for non-urgent surgery.

# A hit with patients

"The care from start to finish was excellent. I'm getting my quality of life back and feel like a weight has been lifted."

NEWS

Check for updates

London

Published: 26 July 2022

## Concurrent surgery across two parallel operating theatres carries risks, say researchers

Matthew Limb

Researchers have warned of the risks of having a single surgeon work across two parallel operating theatres and cast doubt on the method as a means of treating more patients to cut NHS waiting lists.

They say there is no evidence that "overlapping surgery" delivers increased productivity compared with two surgeons focused on their own lists, and warn that there are proven "small but very real risks" to patient outcomes, safety, and training.

Researchers led by Jaideep Pandit, clinical director of operating theatres at Oxford University Hospitals NHS Foundation Trust, express their concerns in a paper published in *Anaesthesia*.[1]

Some NHS trusts, including Guy's and St Thomas', in London, are trialling versions of overlapping surgery, known as high intensity theatre (HIT), to help reduce the backlog for non-emergency surgery caused by the pandemic.

Pandit told *The BMJ* that he could not comment on individual trusts' initiatives and there was potential for overlapping surgery to have some positive impact in certain situations. But he said that given that a lot of infrastructure and support seemed to be going into making overlapping surgery happen, he was concerned there had been "no literature based discussion around the policy in the UK."

"The point of our paper is to say we need to be extremely cautious before we start," he said. "Particular caution is needed to take into account patient safety and consent and training, and what one gets out of it in terms of productivity."

### What is overlapping surgery?

Overlapping surgery involves organising surgical lists in parallel, with a single senior surgeon moving across two operating theatres. Anaesthetists induce anaesthesia and junior surgeons commence and complete the operations in both theatres.

A single senior surgeon performs the critical parts of surgery on the first patient before joining the second patient to carry out the critical parts of surgery for them.

This requires trainees of sufficient seniority to start non-critical parts of surgery as well as not being adversely affected by missing out on being present for critical parts.

Safety concerns have been raised previously. In their review, the *Anaesthesia* paper authors cited evidence from Canada showing overlapping surgery led to an almost doubling of risk of complications for both hip fracture and hip arthroplasty.

"The greater the overlap, the more risk there is of overlap impinging on the 'critical portion' of the surgery and, therefore, the greater the risk of harm," they wrote.

According to the paper, a "disastrous attempted rollout" of overlapping surgery in the US resulted in multimillion dollar lawsuits, driven by lack of proper consent. Patients and insurers did not know the senior surgeon would not be present throughout the surgery.

### Productivity claims

The authors said claims for the success of the method in raising productivity were wrong—because they focused only on the gains made by a single surgeon, maximising the time that individual spent operating, rather than viewing total productivity across two operating theatres.

They said, "The downside of the one senior surgeon eliminating their own wasted time is that all other members of the team—across two operating theatres—increase their own downtime, needing to wait for the surgeon to move across theatres."

The authors added, "It is inevitable that if an extra operating theatre is available to a single surgeon, then that surgeon's number of cases will increase compared with operating from just one theatre. However, it is impossible (for mathematical reasons shown in the paper) for this to exceed the number of the same operations performed by two surgeons in separate theatres."

Overlapping surgery could even result in fewer cases being completed than in two independent theatres, they said.

The authors said, "The real question is how productivity of one surgeon working across two overlapping operating theatres compares with two surgeons focused on their own lists."

The researchers said overlapping surgery could be useful in the NHS in hard pressed specialties where there are not enough surgeons to staff more than one theatre, or where only one surgeon has volunteered for extra evening or weekend lists where there are anaesthetists and nursing staff available.

They said there was potential for positive impact in situations where turnover times between cases are long, operations are short (two hours or less), and where "critical portions" of surgery constitute about half of the total operation time.

The US experience showed there should be advanced agreement from all specialties and stakeholders, including patient or lay representatives, before overlapping surgery is introduced, the researchers



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News

# News

## NHS staff praised as London's waiting lists continue to fall

9 August 2022

News

Thanks to the dedication of healthcare staff across the capital, the NHS in London has virtually eliminated the longest waits for scans, checks, surgical procedures and other routine care, treating more than 1,000 patients who had been waiting more than two years, since January.

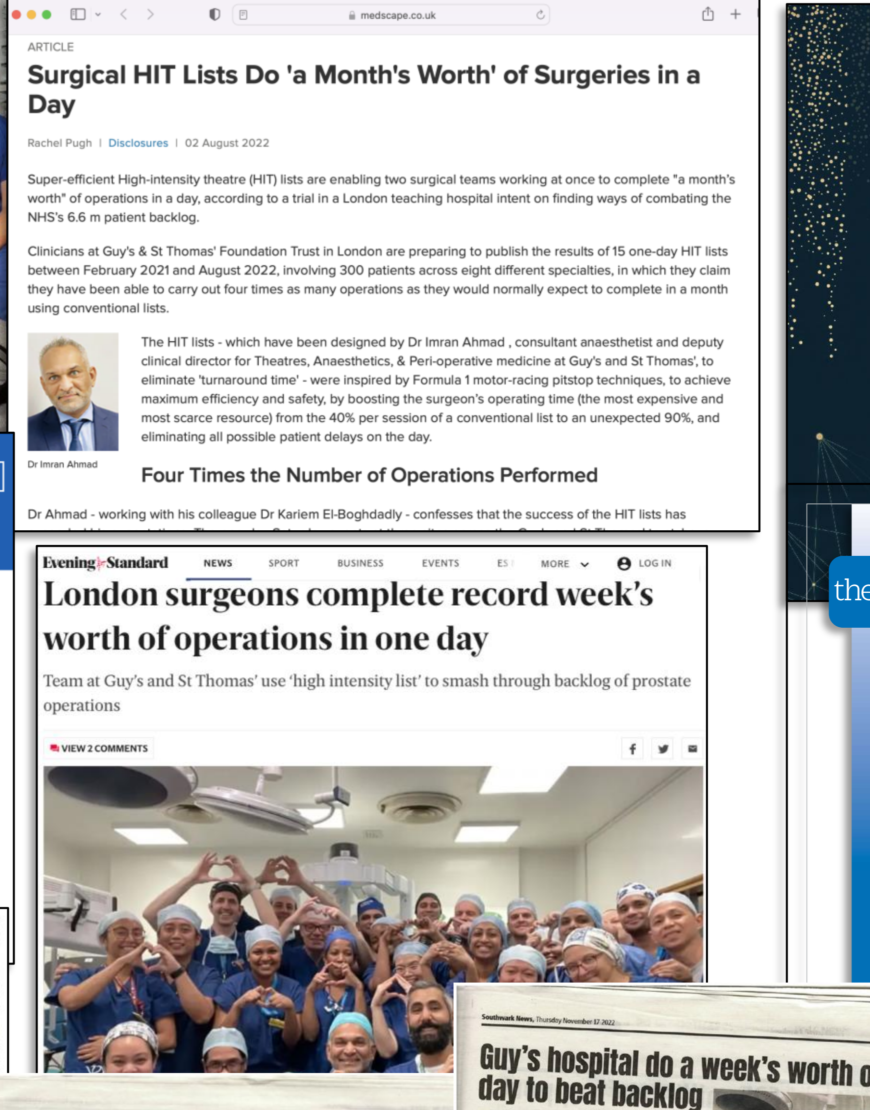
Delivering this target has only be[...] of staff, making effective use of [...]

EMERGENCY DEPARTMENT

HEALTH

## NHS must increase its weekend work to hit targets, says doctor

NHS hospitals are like the "Mary Celeste" on Friday afternoons, a leading doctor has said. Dr



ARTICLE

# Surgical HIT Lists Do 'a Month's Worth' of Surgeries in a Day

Rachel Pugh | Disclosures | 02 August 2022

Super-efficient High-intensity theatre (HIT) lists are enabling two surgical teams working at once to complete "a month's worth" of operations in a day, according to a trial in a London teaching hospital intent on finding ways of combating the NHS's 6.6 m patient backlog.

Clinicians at Guy's & St Thomas' Foundation Trust in London are preparing to publish the results of 15 one-day HIT lists between February 2021 and August 2022, involving 300 patients across eight different specialties, in which they claim they have been able to carry out four times as many operations as they would normally expect to complete in a month using conventional lists.

The HIT lists - which have been designed by Dr Imran Ahmad , consultant anaesthetist and deputy clinical director for Theatres, Anaesthetics, & Peri-operative medicine at Guy's and St Thomas', to eliminate 'turnaround time' - were inspired by Formula 1 motor-racing pitstop techniques, to achieve maximum efficiency and safety, by boosting the surgeon's operating time (the most expensive and most scarce resource) from the 40% per session of a conventional list to an unexpected 90%, and eliminating all possible patient delays on the day.

Dr Imran Ahmad

## Four Times the Number of Operations Performed

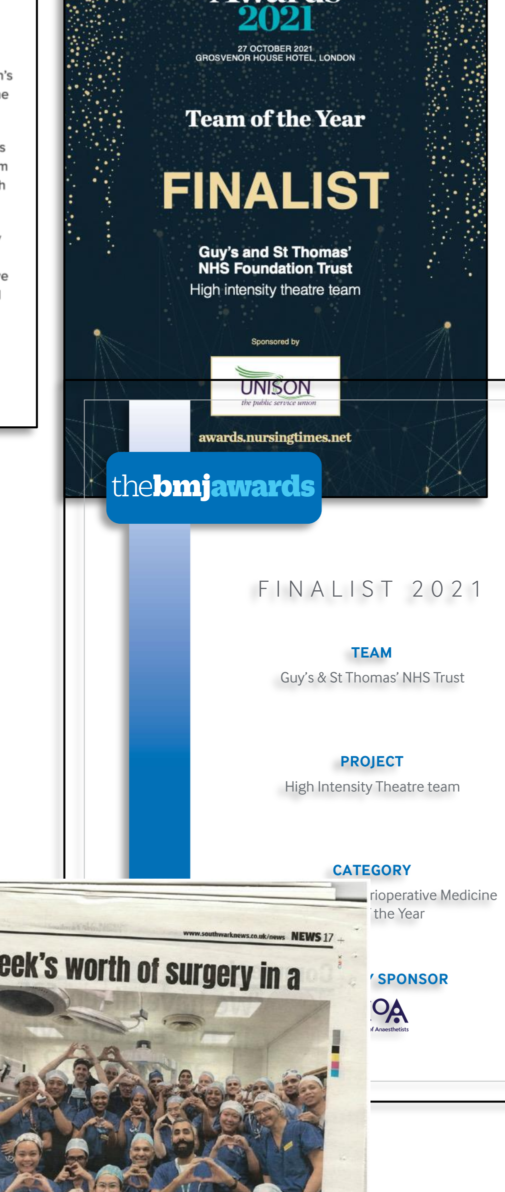
Dr Ahmad - working with his colleague Dr Kariem El-Boghdadly - confesses that the success of the HIT lists has

Evening Standard | NEWS | SPORT | BUSINESS | EVENTS | ES | MORE | LOG IN

# London surgeons complete record week's worth of operations in one day

Team at Guy's and St Thomas' use 'high intensity list' to smash through backlog of prostate operations

VIEW 2 COMMENTS




Southwark News, Thursday November 17 2022 | www.southwarknews.co.uk/news NEWS 17

## Guy's hospital do a week's worth of surgery in a day to beat backlog

By Isabel Ramirez

The independent voice of the borough

Southwark News

MILLWALL EXCLUSIVE

DANNY DARES TO DREAM

GUY'S DO A WEEK'S WORTH OF SURGERY IN A DAY

Robots helped carry out eight prostate cancer operations on local men



# Robots help to increase the number of operation[s]

Surgeons at Guy's and St Thomas' hospital carried out a week's worth of operations in one day to help reduce the surgery backlog.

Eight men with prostate cancer underwent a robotic-assisted radical prostatectomy, which was the first time in the UK that one hospital has completed eight cases of this kind in one day.

The trust said it had developed a "super-efficient" but safe programme to increase the number of patients treated using high intensity theatre lists – known as HIT lists.

They focus on one type of procedure at a time, take place at weekends and require careful planning to select suitable patients.

So far the trust has held 17 HIT lists and treated 344 patients across eight

Guy's and St Thomas' staff involved in the HIT list
Picture: Guy's and St Thomas' Hospital Trust

specialities, including gastrointestinal, gynaecology, orthopaedics and ear, nose and throat (ENT).

Mick Jennings, from West Dulwich, was one of the eight men who recently had a robotic-assisted radical prostatectomy at Guy's Hospital.

The 59-year-old said: "It was great – I was told that the surgery was part of a HIT list before[e]hand, so I was prepared for everything to be quicker than usual.

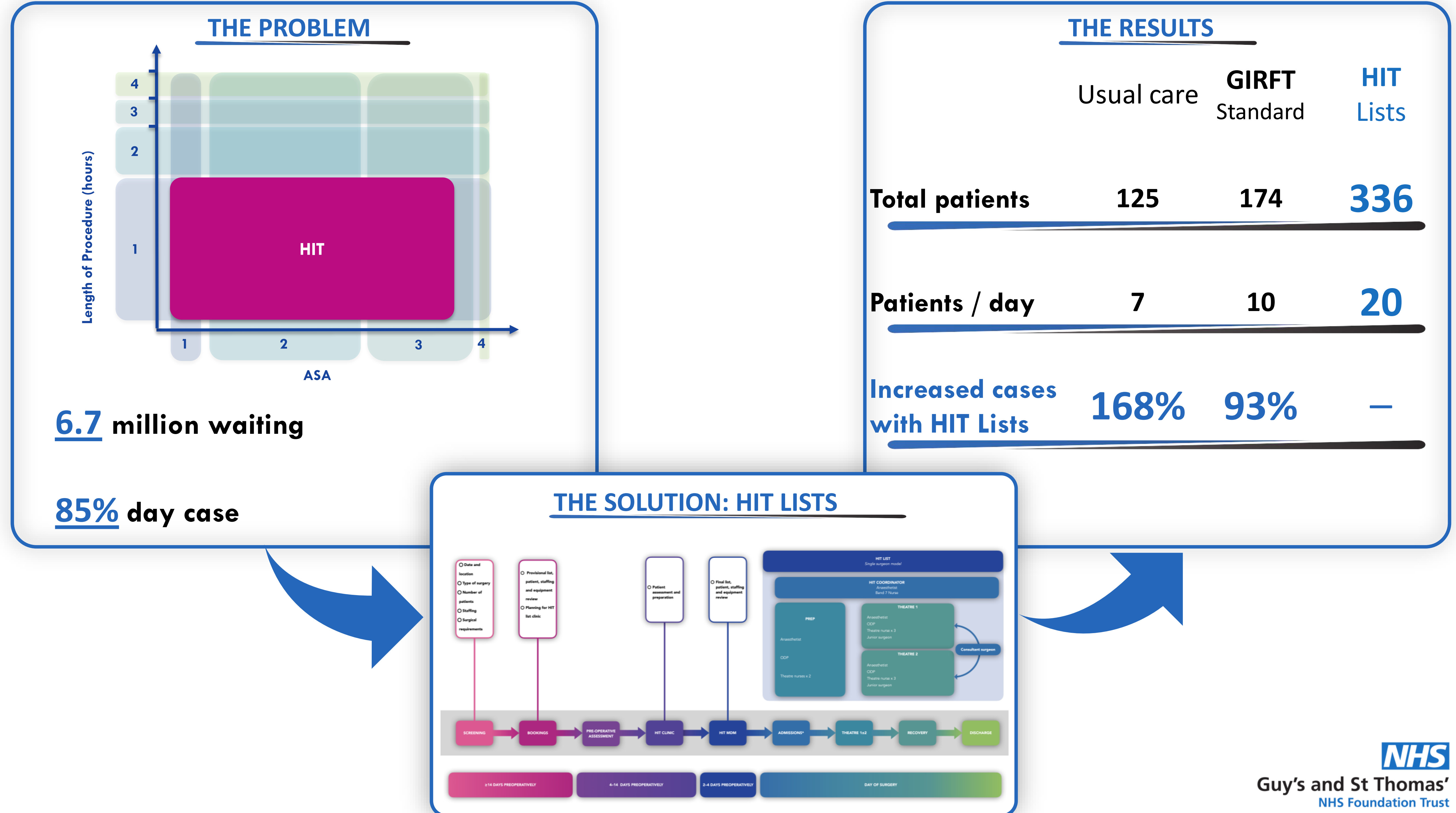
"You could tell the staff were really energised with the concept and really keen to do their best. I didn't find the pace a problem at all – I found they were trying super hard to do it well."

Dr Ben Challacombe, who led the surgery,

said: "We have taken a week off our wa[iting] list by carrying out these surgeries in on[e day] – usually we would do six to eight of thes[e pro]cedures in a week."

The innovation and organisation of th[e HIT] lists has been led by Dr Imran Ah[mad] consultant anaesthetist and d[...] clinical director, who said: "For surgical procedures, the time required t[o per]form the actual surgery is significantl[y less] than the time spent preparing anaesthetising the patient, setting u[p] equipment and helping the to recover – in some cases operating time can be as little as [...] cent of the duration of the whole oper[ating] list."

# SUMMARY



THE PROBLEM
Length of Procedure (hours)
4
3
2
1
HIT
1
2
3
4
ASA
6.7 million waiting
85% day case
THE RESULTS
Usual care
GIRFT Standard
HIT Lists
Total patients 125 174 336
Patients / day 7 10 20
Increased cases with HIT Lists 168% 93% –
THE SOLUTION: HIT LISTS
Date and location
Type of surgery
Number of patients
Staffing
Surgical requirements
Provisional list, patient, staffing and equipment review
Planning for HIT list clinic
Patient assessment and preparation
Final list, patient, staffing and equipment review
HIT LIST
Single surgeon model
HIT COORDINATOR
Anaesthetist
Band 7 Nurse
PREP
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Theatre nurses x 2
THEATRE 1
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Theatre nurse x 3
Junior surgeon
THEATRE 2
Anaesthetist
ODP
Theatre nurse x 3
Junior surgeon
Consultant surgeon
SCREENING
BOOKINGS
PRE-OPERATIVE ASSESSMENT
HIT CLINIC
HIT MDM
ADMISSIONS*
THEATRE 1±2
RECOVERY
DISCHARGE
≥14 DAYS PREOPERATIVELY
4-14 DAYS PREOPERATIVELY
2-4 DAYS PREOPERATIVELY
DAY OF SURGERY
NHS
Guy's and St Thomas'
NHS Foundation Trust

# Challenges we had to overcome…

- Implementing a new way of working
- Convincing the sceptics
- Staff incentivisation
- Surgeon buy-in
- Theatre access
- OPC access
- Additional staffing/costs

# The NHS Elective Care Conference: Transforming Planned Care

# UP NEXT...

FOUREYES INSIGHT

# The NHS Elective Care Conference: Transforming Planned Care

# SPEAKING NOW

Brian Wells

Founder
FourEyes Insight

## I will be discussing…

"Can Elective Care Hubs make the difference this winter?"

# Can elective hubs make the difference this winter?

Brian Wells

November 2022

Brian is a Founder of FEI who trained as a Registered Nurse in the Army specialising in theatres and anaesthetics. Following a long clinical career, he went on to hold senior management posts in the NHS including, Managing Director of SWLEOC (a centre of excellence in elective orthopaedic care), and as Director of Orthopaedics at Guy's & St Thomas' NHS Foundation Trust where he provided senior leadership with a focus on clinical productivity, process standardisation and operational grip and control.

# CONTEXT

In Healthcare, demand and access tend to outstrip available resources, even at the best of times. But this has been seriously compounded by;

- the massive impact on traditional pathways from the recent pandemic, and,
- a highly pressured acute service that overflows into what was traditionally seen as protected elective capacity.

In response, a national initiative, with a focus on clearing backlog at a system level – is to develop elective hub sites (GIRFT May 2021).

It is estimated that over 60% of patients waiting for surgery are routine elective cases highly suitable to be treated through elective hubs.

**These elective hubs are Covid protected, remote from the acute pressures and are expected to be efficient, highly productive units able to maximise patient safety.**

There are already established examples of highly effective surgical units that look to follow a similar mission of ; exceeding expectations for patients, using their resources optimally. providing an environment of learning and measuring the impact of what they do.

**So, can our elective hubs make the difference this winter?**

# Benchmarking Elective Hubs and ring-fenced pathways – a spot check on performance – There's some way to go!

| Number of Cases | Number of Lists | Average Cases per List | Average Cases per 4-hour Session | Theatre Utilisation | Capacity | Capacity Ex OTD Cx | Capacity Ex OTD Cx% | Date Range (3 months) |
|---|---|---|---|---|---|---|---|---|
| 1261 | 328 | 3.8 | 2.2 | 80.0% | 387 | 321 | 25.4% | 02/03/22 – 31/05/22 |
| 5348 | 1662 | 3.2 | 2.2 | 74.4% | 2025 | 1744 | 32.6% | 01/04/22 – 30/06/22 |
| 566 | 150 | 3.8 | 3.8 | 76.4% | 86 | 56 | 9.9% | 01/04/22 – 30/06/22 |
| 336 | 102 | 3.3 | 3.3 | 55.9% | 170 | 152 | 45.3% | 01/04/22 – 30/06/22 |
| 264 | 65 | 4.1 | 4.1 | 49.8% | 224 | 210 | 79.6% | 01/04/22 – 30/06/22 |
| 2450 | 662 | 3.7 | 2.8 | 77.7% | 1031 | 902 | 36.8% | 01/04/22 – 30/06/22 |
| 1694 | 524 | 3.2 | 2.4 | 75.0% | 670 | 581 | 34.3% | 01/04/22 – 30/06/22 |
| 1454 | 492 | 3.0 | 2.4 | 72.0% | 485 | 409 | 28.1% | 01/02/22 – 30/04/22 |
| 4470 | 1109 | 4.0 | 3.1 | 75.7% | 884 | 649 | 14.5% | 01/05/22 – 31/07/22 |
| 1913 | 600 | 3.2 | 2.0 | 69.6% | 757 | 657 | 34.3% | 01/05/22 – 31/07/22 |
| 695 | 207 | 3.4 | 1.9 | 73.0% | 295 | 259 | 37.2% | 01/05/22 – 31/07/22 |

# Cross cutting themes that are impinging on higher levels of performance

- **In-session Theatre utilisation** has struggled to reach an average of 80% for the past three financial years and are off national expectations of 85%.
- A single point of accountable Leadership is key, but Hubs are experiencing a similar, and somewhat, **confusing amount of invested stakeholders** similar to the acute setting.
- There needs to be **greater ambition on workforce strategies** to address the workforce challenges specific to theatres with a view to achieving higher levels of productivity and capacity. Upskilling Theatre Support Worker roles to scrub, training Associate anaesthetists, deploying transfer support and instrument technicians for high intensity operating such as Superlists and High Intensity Theatre (HIT) lists etc.
- **Clinical engagement** is proving difficult and challenging, with operational teams hesitant to address difficult conversations with clinicians about the productivity potential. Further training and coaching for operational teams is critical, giving them the tools to be able to discuss and mobilise response towards in-session productivity, annual leave policy, cross cover arrangements, session flexibility and backfilling etc.
- It is imperative to **make better use of the overall theatre estate** as part of recovery plans. Estimates from validated analysis suggests that the overall theatres estate usage ranges between 75%-80% after mitigation for a range of operational imperatives. This provides a significant opportunity of latent capacity if workforce and theatre floor plans can look towards optimal take-up.
- **Under scheduling of lists** is driving opportunity for in-session productivity. There are issues around significant last-minute churn due to cancellations etc. that are likely to be dampening ambitions to book to optimum, but these business-as-usual processes need tackling with a refocus on achieving optimally booked operating lists.
- There is a **modest uptake in undertaking high productivity operating sessions** such as Superlists/HIT lists primarily due to significant operational and scheduling challenges. Greater ambition towards high productivity lists is part of the answer in driving up performance and treating more patients and will need further focus going forwards.

June 2022

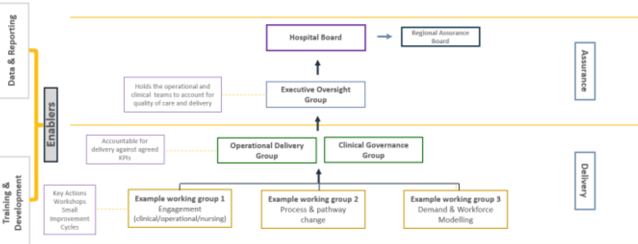
| Theatre role | Nurse | Operating department practitioner | Nurse associate/ theatre assistant practitioner | Healthcare support worker | Anaesthetic associate | Surgical care practitioner | Surgical first assistant |
|---|---|---|---|---|---|---|---|
| Scrub practitioner | ✖ | ✖ | ✖ *(under supervision)* | | | | |
| Anaesthetic practitioner | ✖ | ✖ | | | | | |
| Recovery practitioner | ✖ | ✖ | | | | | |
| Circulator/runner | ✖ | ✖ | ✖ | ✖ | | | |
| Anaesthetics | | | | | ✖ | | |
| Surgical assistant | | | | | | ✖ | |
| Surgical operator | | | | | | ✖ | ✖ |

# What are the dynamics that make an elective hub highly effective?

- Productivity is key to an elective hub's existence, therefore seeking every way to deliver care in the most effective and efficient way should be central to their ethos. This includes;
  - having **dedicated and accountable senior clinical and managerial leadership** with strong governance processes that monitor and measure detailed KPIs closely
  - Being on **a mission to be best in class** on clinical outcomes, research, education and, critically, to deliver high levels of productivity
  - having **dedicated clinical and operational teams** who master at their skills and competencies
  - **standardising clinical pathways** and protocols that safely allow the wider clinical team to extend their roles and skills. All know what needs to be done with minimal clinical variation
  - Seeing **standardisation as a great philosophy** and every effort to standardise the clinical pathways is expected and pursued.
  - piloting, testing and **advancing new ways** of achieving higher levels of productivity as BAU such as HVLC lists, Superlists and High-Performance lists etc, with an ambition to go beyond historic levels of performance.
  - **measuring the outcomes** of what they do, looking to perfect their clinical approach and pathways
  - acknowledging **incentive schemes** to reward efforts beyond BAU performance

# Engagement, Governance and Accountability

If you're not where you need to be then set up a reporting and accountability framework with focused improvement workstreams to safely drive change



| Workstream | Deliverable |
| --- | --- |
| Engagement | o 1:1 & group engagement with key operational/clinical staff<br>o Ongoing training, coaching & mentoring of key stakeholders<br>o On the ground collaborative working alongside clinical/operational teams<br>o Dedicated team to lead and collaboratively deliver change<br>o Delivery of tailored training workshops aimed at cultural change |
| Process and Pathway Change | o Implantation of robust governance & assurance framework<br>o Implementation of effective patient selection and booking processes<br>o Implementation of robust validation processes<br>o Admin & Clerical structure/function review<br>o Capacity planning meetings across the pathway<br>o Realignment of supporting SoPs/ToR with clear escalation routes<br>o Implementation of best practice on the day processes<br>o Implementation of best practice peri/post-op processes i.e criteria led discharge & enhanced recovery processes |
| Demand & Workforce modelling | o Agreement and signoff milestone plans and action plans<br>o Agreement to Scenarios and mitigations that close any workforce gaps e.g. extended roles<br>o Dynamic Workforce planning and strategy that aligns with capacity<br>o Modelling demand suitable for the Elective pathway and alignment to funded capacity<br>o Review and provide recommendations |

**Executive Oversight Group:**
**Membership**: FEI Executive and Site Lead, Exec Team
**Frequency**: Weekly
**Purpose:**
1. provide feedback on progress and review of KPIs
2. Ensures that the operational and clinical teams are, once agreed, held to account against delivery of KPIs
3. Identifies and tackles any issues or barriers that prohibit the programme from achieving success, s
4. Reviews the programmes risk-register and agrees mitigating actions

**Operational Delivery Group:** Two-way communication would follow with Operational Delivery and Clinical Governance Groups
**Membership:** Executive Leads, Operational Leads, Clinical Leads, Nursing Leads, PMO & Transformational Support
**Frequency:** Weekly
**Purpose:**
1. Ensures key actions, essential to delivery of the programme, are on track
2. Provides a point of interface between workstreams and ensures any key operational decisions are made and sign-off is gained at each step
3. Holds the critical enablers in the Working Groups to account
4. Shows clear leadership by example and sets the culture for the programme

Workstreams will be established that report into the Operational Delivery and Clinical Governance Groups where these key members would provide assurance on delivery to the Executive Sponsor. Each Workstream would have one or more Working Groups within it to deliver the programme objectives.

FOUREYES INSIGHT

# Training & Coaching

**Best not assume everyone is aligned or skilled up to deliver.** The capability and capacity of the workforce to adapt and adopt is critical

**Closing knowledge and skills gaps** within operational and clinical teams, that are managing and delivering care, provides the firm foundations to run and deliver an optimal service

**Consider targeted training, coaching and mentoring workstreams** with the aim of upskilling the capability of staff working across the planned care pathway in the delivery of an optimal service.

Develop skills to;

- translate and implement best practice
- measure outcomes, patient experience and use of resources

# Data & Reporting

**Use detailed data analysis to evidence change**.

This is key to effective clinical engagement and buy-in, which is critical to the delivery on performance.

Detailed and reliable analysis informs effective decision making and overcoming barriers to improvement.

Consider;

- Implementing a performance reporting framework that enables stakeholders to review performance at a site, consultant and even procedure level.
- Establishing a sustainable KPI monitoring structure to benchmark performance against agreed standards and call out those opportunities for improvements
- Using performance data to target opportunities to improve productivity performance through high performance operating lists such as Superlists/Parallel lists and HIT lists

# It can be done - An elevation in performance

- The following images show some approaches of increasing productivity through operating theatres
- These approaches are not overly complicated to do and can reap significant rewards, but there are some 'givens' to think about such as, the ability of the whole perioperative pathway to keep up.
- The need for an effective admissions process (inflow) and post operative capacity to discharge out (outflow) is essential.
- The big-ticket items to consider;
    - **Anaesthetic rooms**
    - **Clean lay-up capability**
    - **Sufficient recovery capacity**
    - **Available inpatient beds/DSU ward capacity**
    - **Patient selection criteria**
    - **Extra theatre staff/roles**
    - **Extra anaesthetists**

# Increasing productivity

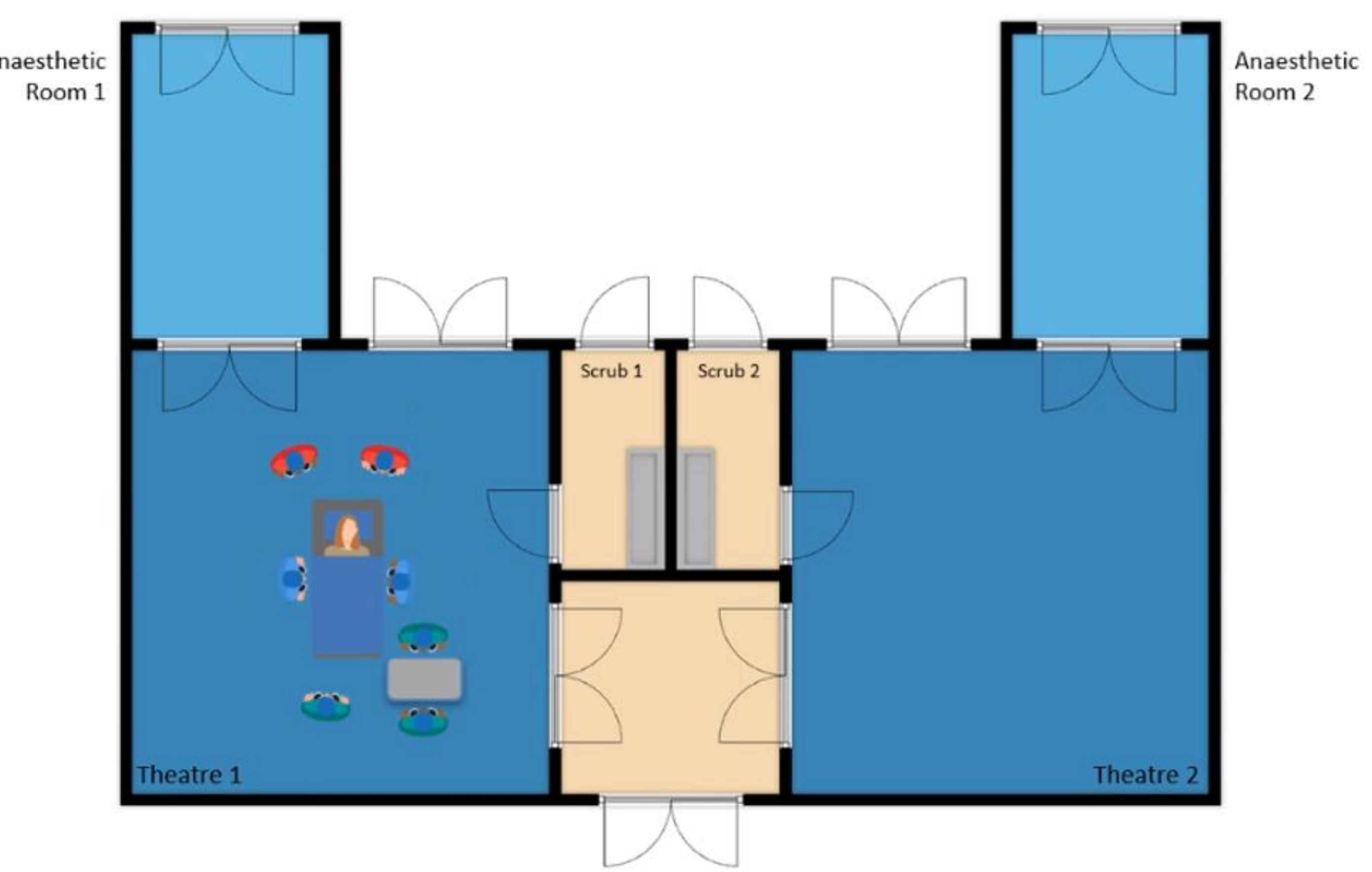
- The next slides demonstrate an escalating approach to high levels of surgeon productivity.
- The modelling simply demonstrates the principle and flow of how to maximise the opportunity.
- There are several assumptions taken:
  - *No individual is having to 'go faster' in any of these models*
  - *Clinical practice remains unchanged*
  - *There is no reason to compromise on patient safety*
  - *Lists are enhanced to achieve productivity to mitigate downtime/wasted time rather than affect touchtime*

This proposal is provided as commercial in confidence.

For further information about this proposal please contact <Name> at <name>@foureyesinsight.com

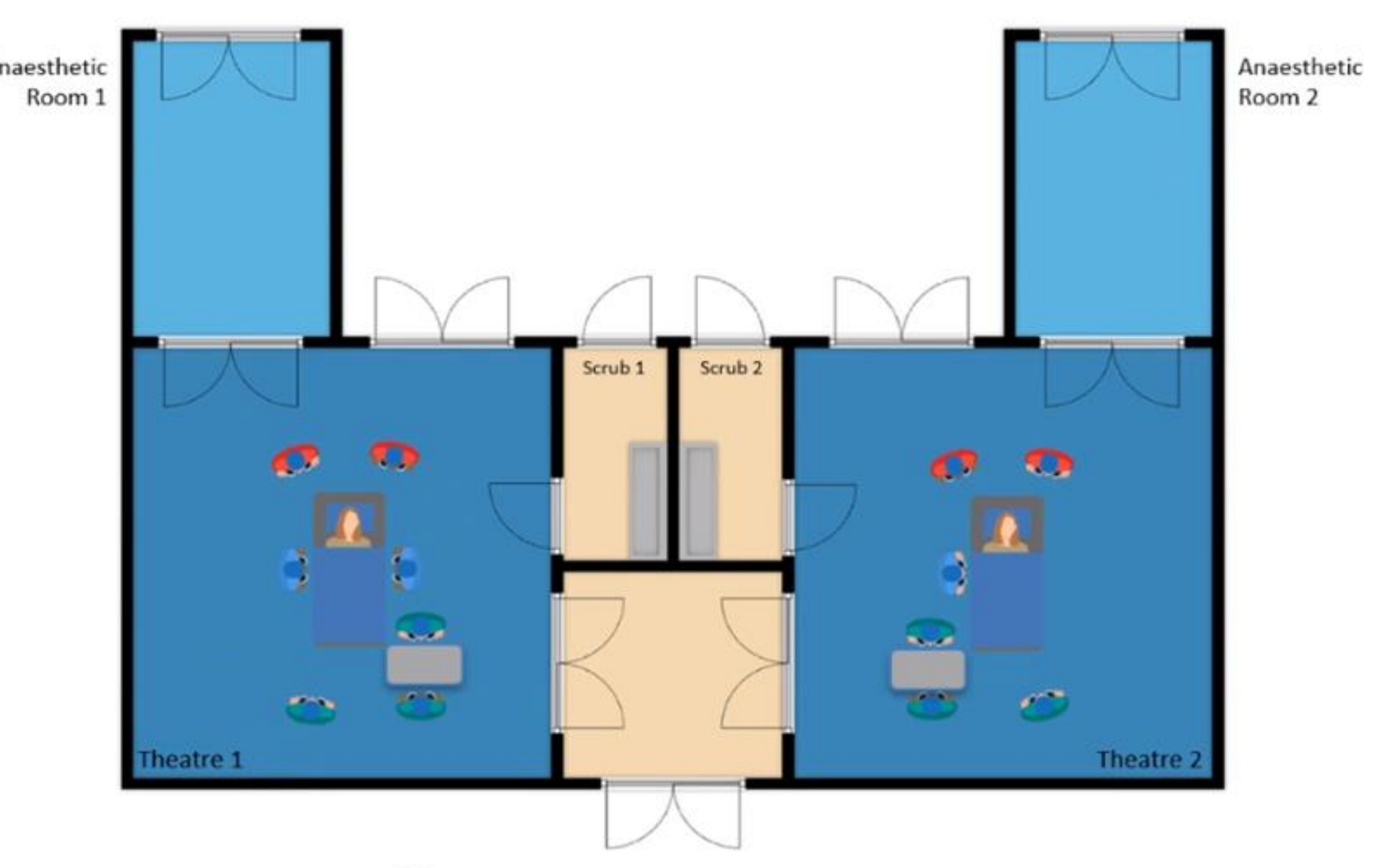
# Standard Listing

- **Single** operating consultant with;
- **Single** anaesthetic team through a;
- **Single** operating theatre



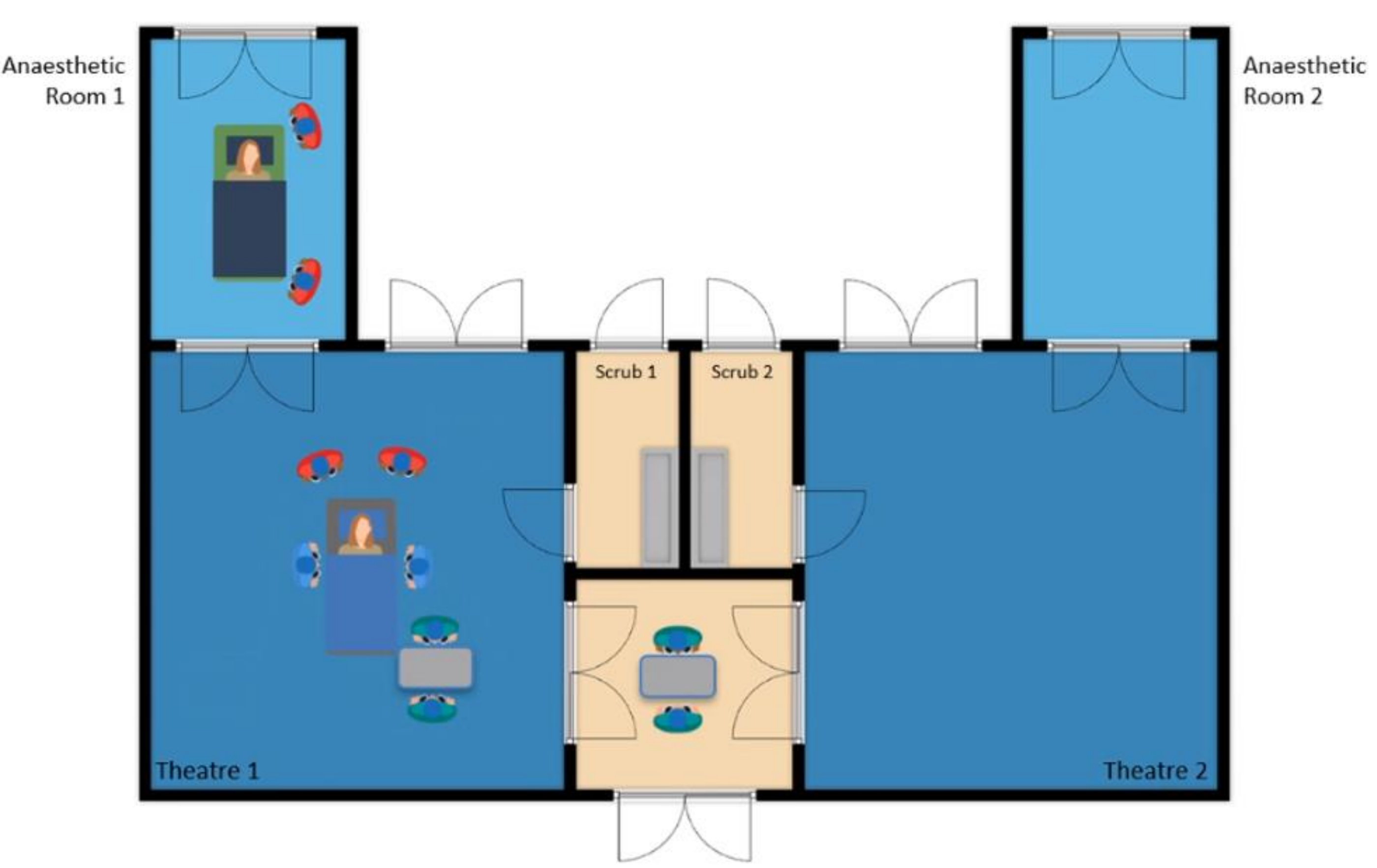
# Parallel Listing

- When additional theatres are available.
- Single operating consultant ‘**flipping**’ between **two theatres** of independent teams.
- Enhanced surgical support (Fellows/Top of training) to potentially prep, open and close, dependent on level of experience and required supervision.



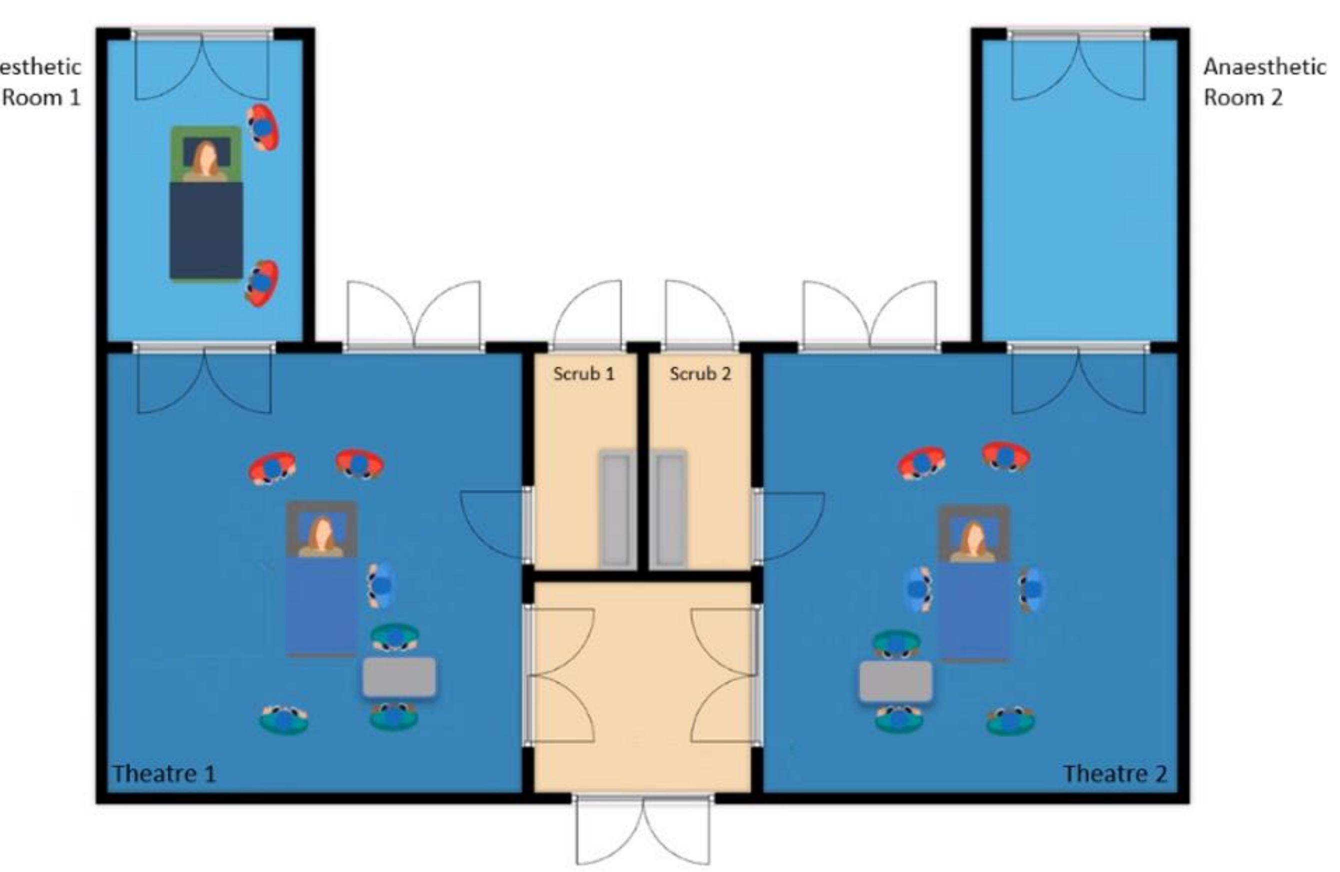
# Superlisting

- When only a single theatre is available high levels of productivity are still achievable.
- Single operating consultant, supported by second anaesthetic team and enhanced scrub team, allowing for early preparation of the next patient and instrument lay up.
- This increases significantly the surgical touchtime of a single operating list.



# High Performance Listing

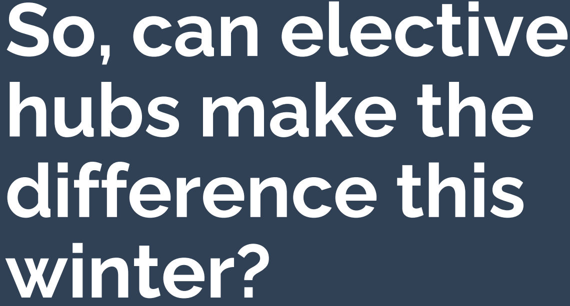
- When additional theatres are available.
- Single operating consultant ‘flipping’ between two theatres of independent teams.
- Enhanced surgical support (Fellows/Top of training) to potentially prep, open and close, dependent on level of experience and required supervision.
- An additional (third) anaesthetic team and enhanced scrub team, allowing for early preparation of subsequent patients and instrument lay up.



# Superlist Pilot

| Time | Pt 1 | Pt 2 | Pt 3 |
|---|---|---|---|
| 08:25 | Team Brief | | |
| 08:32 | Theatre Preparation | | |
| 08:40 | Instrument Prep in Lay-Up & Anaesthetic Start | | |
| 08:50 | Patient into Theatre & Surgeons' Scrub | | |
| 08:55 | Patient Skin Prep | | |
| 08:57 | Time Out | | |
| 09:00 | Procedure Start | | |
| 09:40 | | Patient Sent For | |
| 09:41 | Start Wound Closure | | |
| 09:43 | | Arrives into Anaesthetics | |
| 09:43 | | Instrument Prep in Lay-Up | |
| 09:45 | First Surgeon De-Scrub | | |
| 09:50 | Procedure End | Anaesthetic Start | |
| 09:54 | Second Surgeon De-Scrub & Sign Out | | |
| 09:56 | Patient Leaves Theatre | | |
| 10:05 | | Patient into Theatre & Surgeons' Scrub | |
| 10:10 | | Patient Skin Prep | |
| 10:14 | | Time Out | |
| 10:15 | | Procedure Start | |
| 10:30 | | | Patient Sent For |
| 10:43 | | Start Wound Closure | |
| 10:48 | | | Arrives into Anaesthetics & Instrument Prep in Lay-Up |
| 10:50 | | First Surgeon De-Scrub | Anaesthetic Start |
| 11:02 | | Procedure End | |
| 11:03 | | Second Surgeon De-Scrub | |
| 11:07 | | Sign Out | |
| 11:08 | | Patient Leaves Theatre | |
| 11:15 | | | Patient into Theatre & Surgeons' Scrub |
| 11:18 | | | Patient Skin Prep |
| 11:24 | | | Time Out |
| 11:25 | | | Procedure Start |
| 12:05 | | | First Surgeon De-Scrub |
| 12:17 | | | Procedure End |
| 12:20 | | | Second Surgeon De-Scrub |
| 12:23 | | | Sign Out |
| 12:24 | | | Patient Leaves Theatre |
| 12:40 | | | Team Brief PM Patients |

| Time | Pt 4 | Pt 5 | Pt 6 |
|---|---|---|---|
| 12:50 | Instrument Prep in Lay-Up & Anaesthetic Start | | |
| 13:02 | Patient into Theatre & Surgeons' Scrub | | |
| 13:09 | Patient Skin Prep | | |
| 13:13 | Time Out | | |
| 13:14 | Procedure Start | | |
| 13:32 | | Patient Sent For | |
| 13:40 | First Surgeon De-Scrub | Arrives into Anaesthetics & Instrument Prep in Lay-Up | |
| 13:42 | | Anaesthetic Start | |
| 13:48 | Start Wound Closure & Procedure End | | |
| 13:51 | Second Surgeon De-Scrub | | |
| 13:52 | Sign Out | | |
| 13:53 | Patient Leaves Theatre | | |
| 14:01 | | Patient into Theatre | |
| 14:03 | | Surgeons' Scrub | |
| 14:08 | | Patient Skin Prep | |
| 14:11 | | Time Out | |
| 14:12 | | Procedure Start | |
| 14:46 | | | Patient Sent For |
| 14:50 | | Start Wound Closure | |
| 14:56 | | | Arrives into Anaesthetics |
| 14:57 | | First Surgeon De-Scrub | |
| 14:58 | | | Instrument Prep in Lay-Up |
| 15:00 | | | Anaesthetic Start |
| 15:07 | | Procedure End | |
| 15:08 | | Second Surgeon De-Scrub | |
| 15:12 | | Sign Out | |
| 15:13 | | Patient Leaves Theatre | |
| 15:21 | | | Patient into Theatre |
| 15:24 | | | Surgeons' Scrub |
| 15:27 | | | Patient Skin Prep |
| 15:30 | | | Time Out |
| 15:32 | | | Procedure Start |
| 15:50 | | | Start Wound Closure |
| 15:59 | | | First Surgeon De-Scrub |
| 16:10 | | | Procedure End |
| 16:12 | | | Second Surgeon De-Scrub |
| 16:14 | | | Sign Out |
| 16:15 | | | Patient Leaves Theatre |




# Yes, but……..

- **There needs to be much greater ambition and expectation** from elective hubs, that takes them well beyond the performance levels witnessed in an acute setting with all those complex challenges.
- The modest pilots of high-performance pathways need to **transition from fringe to mainstream** practice.
- All clinicians practicing in an elective hub should be **championing high productivity** pathways and pathway standardisation,
- All staff need to **invest in a vision to be best of a class**, seeking opportunities to refine and advance their input to the mission.

…and to do that, let's coach and train our people to do what we need them to do, share emerging best practices for high performance and develop our dynamic workforce through an accountable improvement programme.

# FOUREYES INSIGHT

## Our vision

To lead the way in driving Elective care pathway optimisation in pursuit of a world where no patient waits unnecessarily for planned care.

## Our mission

To reduce patient treatment lists by establishing the root cause of care pathway inefficiencies, implementing interventions to optimise these pathways and monitoring their effectiveness; ensuring that a culture of continuous improvement to drive long term, sustainable change is embedded along the way.

For more information contact us on

info@foureyesinsight.com 020 3880 1247

www.foureyesinsight.com

# The Integrated Care Summit: Challenges and Best Practice

# COMFORT BREAK

# The NHS Elective Care Conference: Transforming Planned Care

# UP NEXT...

# The NHS Elective Care Conference: Transforming Planned Care

# SPEAKING NOW

Dr. Debashish Das

CEO

Ortus Solutions Limited

Nathan Roberts

Cardiology Clinical Network Manager

Barts Health NHS Trust

## We will discuss...

"The London Regional Cardiology Elective Care Transformation Project"

# London Regional Cardiology Elective Care Transformation Project

Guy's and St Thomas' NHS Foundation Trust

Royal Brompton and Harefield hospitals

Imperial College Healthcare NHS Trust

King's College Hospital NHS Foundation Trust

St George's University Hospitals NHS Foundation Trust

Royal Free London NHS Foundation Trust

# Meet the Presenters

***Dr Debashish Das***
*Consultant Cardiologist &*
*St. Barts Cardiology Transformation Lead*
*(CEO of Ortus Solutions Limited)*

***Nathan Roberts***
*Network Manager North London Cardiac*
*Operational Delivery Network*

# Agenda

1. Introduction
2. Change Management
3. Technology as an enabler
4. Lessons Learned
5. In Summary
6. Q and A

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# 1. An Introduction

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Royal Free Hospital

NHS
Barts Health
NHS Trust

St Bartholomew's Hospital

NHS
Imperial College Healthcare
NHS Trust

Imperial Hospital

Harefield Hospital

NHS
Royal Brompton & Harefield
NHS Foundation Trust

Royal Brompton Hospital

NHS

NHS
Guy's and St Thomas'
NHS Foundation Trust

Guy's and St Thomas' Hospital

NHS
King's College Hospital
NHS Foundation Trust

Kings College Hospital

NHS
St George's University Hospitals
NHS Foundation Trust

St George's Hospital

Guy's and St Thomas'
NHS Foundation Trust

Royal Brompton and Harefield hospitals

Imperial College Healthcare
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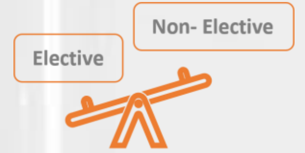
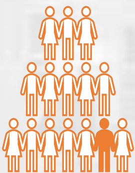
# The Cardiac Challenge and Need



- Growing waiting list and backlog of elective care procedures.

- Siloed approach to delivering care across the region.

- Need for an efficient pre-operative phase, enhancing patients' experience and reducing avoidable cancellations.



- Need for effective patient prioritisation.

- Early discharge for patients' post-procedure.

# The Solution Overview

- Pan London deployment – of a Scalable and flexible platform, supporting Pathways, Specialties, ICSs and Regions.

- Automated pre-operative care plans, with pre-assessment forms, e-consent, nudge behaviour and reminders.

- Risk mitigation through configurable virtual ward dashboards, enabling patient prioritisation and early discharge

- Remote monitoring of patients, with 2-way communication for deteriorating patients.

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# Cardiac Surgery Virtual Ward and Remote Monitoring

- We envisage the remote monitoring program will be able to facilitate three cohorts of patients.
  1) The surgical patient on an elective P2-P4 waiting list pathway
  2) The semi-acute patient who can be discharged into a virtual ward to wait at home for their surgery with a semi-urgent date given
  3) Facilitate early discharge of post-operative surgical patients
- Cohorts 2/3 were optional dependent on staffing and willingness
- The immediate priority was for the first cohort, however implementation of remote monitoring in cohort two/three would facilitate much needed early discharge and increase bed capacity.
- Cohort 1: This is split into patients who are:
  - ***Currently were already on the waiting list***
  - ***Those added prospectively***

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# 2. Change Management

- Task & Finish Groups were identified in each site
- **Unified Patient Pathway & SOP agreed across sites:**
- Patient Information Sheet and Communication letter standardised through NHS Coms teams. Approved & Shared
- Only variance between sites: Virtual Ward/Patient list segmentation
- Efforts made to improve pre-operative phase on each site using other digital tools:
  - Digital Pre-assessment form (standardised across each site)
  - Patient digital library (PDFs/video)
  - eConsent
  - PROMs/PREMs

# Pathway SOP: Elective Cardiac list

The Elective Cardiac Surgery Patient Cohort is defined as those patients on an elective cardiac surgery waiting list, who are appropriate for adding to a virtual ward for remote monitoring throughout their pathway.

Current waiting list will be batch uploaded on to Ortus (save admin time) but each site will supplement with a posted letter and patient information sheet explaining the pathway

Prospective patients: The hospital team will onboard the patients who are listed for surgery onto the Ortus Platform within 4-weeks of being listed for surgery

Patients will be prompted to submit a **'Cardiac Surgery Waiting List: Symptoms Checker'** questionnaire twice a week, on a **Monday and a Thursday before 11am.**

Additionally, patients can input symptoms freely into the Ortus App that can be reviewed by Hospital Teams in a Virtual Ward and Patient Profile.

# Pathway SOP: Ward Round Tasks

Ward Round Tasks (allocate additional time for Mondays and Thursdays post-patient questionnaires)

1. Review that all patients in a Virtual Ward(s) have submitted their questionnaire responses (directly in the Virtual Ward).

2. Send a reminder/message to all those patients who have not submitted a questionnaire response (through the Ortus messaging functionality in the Virtual Ward).

3. Action Red Flags (in-line with 'Red Patient' escalation plans below).

4. Action Amber Flags (in-line with 'Amber Patient' escalation plans below

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# Pathway SOP: Escalation Plans

## Red Patients

Identified patients should be reviewed within 1 working day & discussed with the responsible Consultant for the patient.

## Amber Patients

Identified patients should be reviewed within 2 working days.

If patients have not submitted a questionnaire response within **1-month** from being registered on the Ortus Platform or have had **> month of inactivity** from previously submitting answers, then the Hospital Team should contact that patient directly by phone.

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# 3. Technology as an Enabler

- Provide structured **configurable Virtual Ward Dashboards** to monitor those on an elective waiting list, **enabling patient prioritisation**.

- Virtual Ward Dashboards **supporting and facilitating early discharge**, with **remote monitoring** to **identify deteriorating patients early**.

- Dashboards providing a **central hub** to communicate with patients, with **integrated telehealth** functionality, including **Video Conferencing**, and **Asynchronous Messaging** for both individuals and groups.

# Configurable And Scalable Virtual Ward Dashboards

Ortus-iHealth

Cardiac Surgery Test Ward - Ward 3 | Group Mail

| Patient Details | Questionnaire | Symptoms | Heart Rate | Blood Pressure | Weight | SPO2 | Temperature | Blood Glucose |
|---|---|---|---|---|---|---|---|---|
| JWP OrtusTest4<br>Age: 37<br>Hospital No: 0123456789<br>NHS: | | Chest Pain<br>May 16, 2022 05:54<br>Severity:Moderate<br>Actioned | 144<br>Jun 06, 2022 06:56 | 150/111<br>Jun 06, 2022 06:55 | 101.2<br>Jun 06, 2022 06:55 | 98<br>Jun 06, 2022 06:56 | 36.8<br>Jun 06, 2022 06:57 | 7.3<br>Jun 06, 2022 06:56 |
| JWP OrtusTest3<br>Age: 28<br>Hospital No: 0123456789<br>NHS: | 22 Days Ago<br>Aug 17, 2022 08:58<br>Actioned | Chest Pain<br>Sep 05, 2022 09:47<br>Severity:Severe<br>Action | 122<br>Sep 05, 2022 10:48 | 133/112<br>Sep 05, 2022 10:48 | 88.5<br>Aug 18, 2022 10:17 | 99<br>Aug 18, 2022 10:17 | 36.9<br>Aug 18, 2022 10:17 | |
| JWP OrtusTest2<br>Age: 58<br>Hospital No: 0123456789<br>NHS: 0011223456 | 22 Days Ago<br>Aug 17, 2022 09:04<br>Action | Chest Pain<br>Sep 06, 2022 15:07<br>Severity:Severe<br>Action | 120<br>Sep 06, 2022 10:00 | 117/104<br>Sep 05, 2022 10:40 | 88.4<br>Sep 05, 2022 10:42 | 98<br>Sep 05, 2022 10:41 | 36.5<br>Aug 18, 2022 10:11 | |
| JWP OrtusTest1<br>Age: 33<br>Hospital No: 0123456789<br>NHS: | 22 Days Ago<br>Aug 17, 2022 09:05 | Chest Pain<br>Sep 05, 2022 09:43<br>Severity:Severe<br>Actioned | 120<br>Sep 05, 2022 10:45 | 133/101<br>Sep 05, 2022 10:44 | 97.3<br>Aug 18, 2022 10:15 | 98<br>Sep 05, 2022 10:46 | 36.3<br>Aug 18, 2022 10:14 | |
| Dummy TestPatient8<br>Age: 22<br>Hospital No: 008<br>NHS: 0000111129 | 2 Days Ago<br>Sep 06, 2022 19:59<br>Action | Chest Pain<br>Sep 06, 2022 19:04<br>Severity:Mild<br>Action | 101<br>Sep 06, 2022 20:03 | 110/78<br>Sep 06, 2022 20:03 | | | | |
| Dummy TestPatient7<br>Age: 22<br>Hospital No: 007<br>NHS: 0000111128 | 2 Days Ago<br>Sep 06, 2022 19:57 | | 56<br>Sep 06, 2022 20:01 | 88/67<br>Sep 06, 2022 20:01 | | | | |

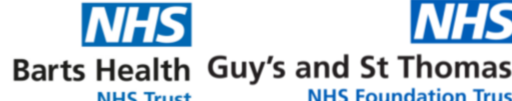
1. Observations Tracking

2. Symptoms Monitoring

3. Deteriorating patient questionnaire

4. Templated Individual and Group Messaging

5. Prioritise Patients and Take Action



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# Treatment Pathways And Care Plans - Automated

Add New Treatment

**Treatment Information** (1)

Location : London

Diagnosis* : Coronary Artery Disease (2)

Treatment : Coronary Angioplasty

Pathway* : Select pathway

Clinician* : Jack Willson-Patel

Start Date* : 31/10/2022 (3)

**Additional Information**

Notes:

### Coronary Angioplasty - Questionnaire

| Pathway Name | Interval | Period | Questionnaire |
|---|---|---|---|
| Coronary Angioplasty | Before | 20 Days | Coronary Revascularisation Outcome (Pre Percutaneous Transluminal Coronary Angioplasty) |
| | After | 30 Days | Coronary Revascularisation Outcome (Post Percutaneous Transluminal Coronary Angioplasty) |
| | After | 180 Days | Coronary Revascularisation Outcome (Post Percutaneous Transluminal Coronary Angioplasty) |
| | After | 360 Days | Coronary Revascularisation Outcome (Post Percutaneous Transluminal Coronary Angioplasty) |

(7)

### Coronary Angioplasty - Medications

Add Medication

| Pathway Name | ☑ | Drug Name | Directions | Start Date | End Date |
|---|---|---|---|---|---|
| Coronary Angioplasty | ☑ | Clopidogrel Actavis (Tablets) 75 mg Qty: 28 | 75 mg Tablets of strength 75 mg,frequency Daily for 1 Day(s) | 31/10/2022 | 01/11/2022 |

### Coronary Angioplasty - Goals (4)

| Pathway Name | ☑ | Goal Name | Initial Value | Target Value | Start Date | End Date |
|---|---|---|---|---|---|---|
| Coronary Angioplasty | ☑ | Daily Walk | 0 mins | 10 mins | 31/10/2022 | 31/12/2022 |

### Coronary Angioplasty - Consents (5)

Add Consent

| Name | Printout |
|---|---|
| Percutaneous coronary Angiogram +/- angioplasty | ☑ |
| Stage 1: coronary angiogram | ☑ |
| Stage 2 Angioplasty | ☑ |
| What does it involve? | ☑ |
| Risks | ☑ |
| Risks | ☑ |
| Uncommon possible later issues: | ☑ |
| Potential Extra Procedures | ☑ |
| What to expect on the day | ☐ |

(6)

☑ Send Questionnaire ☑ Send Consent (8)

Cancel Save

- Treatment pathway/care plan is configured in Ortus and associated with a diagnosis.
- Patient is added to a treatment or pathway with the matching diagnosis.
- Clinician inputs: Location, Diagnosis, Start Date, Clinician.
- Patient receives: Condition information, Questionnaires, Goals/Tasks, Medication reminders.
- Configured eConsent is sent to the patient for completion and sign-off.
- Live View and PDF of patient responses are sent back to Hospital team.
- Automated delivery of follow-up questionnaires for PROMs/PREMs.
- Hospital team can review responses and prioritise patients.

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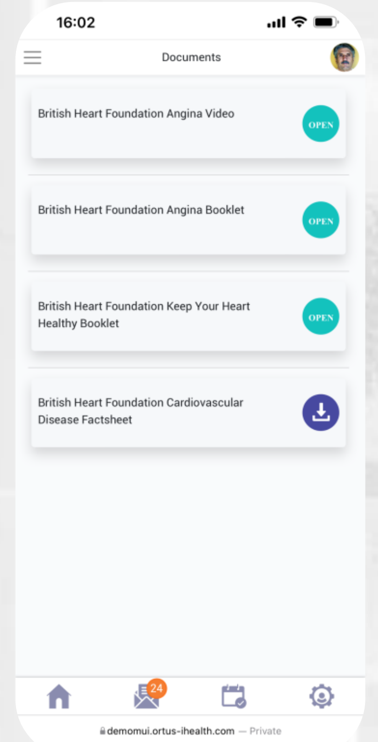
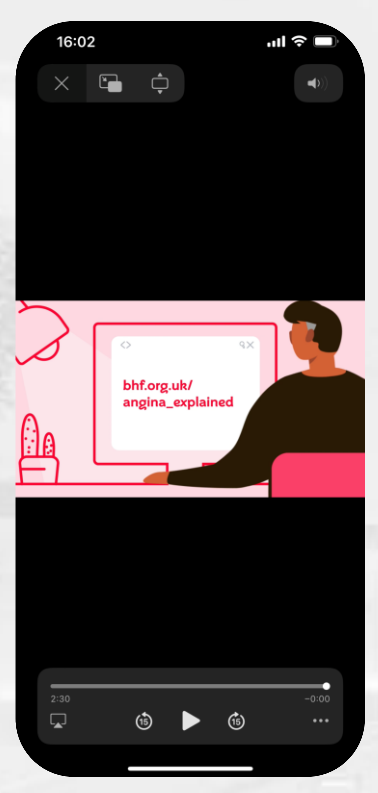
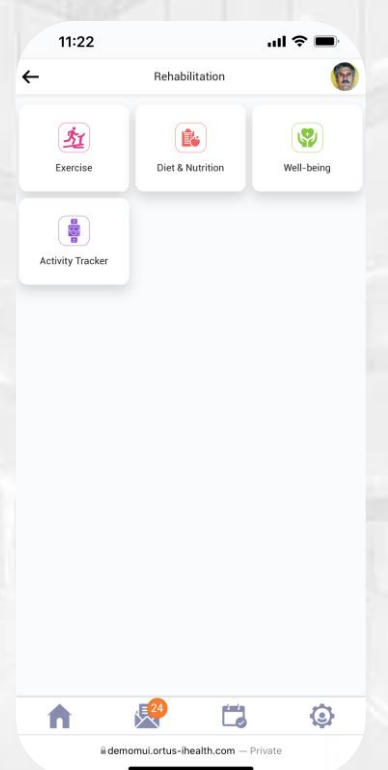
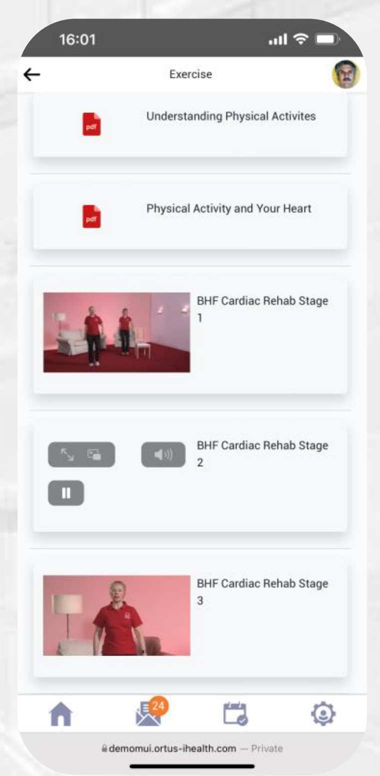
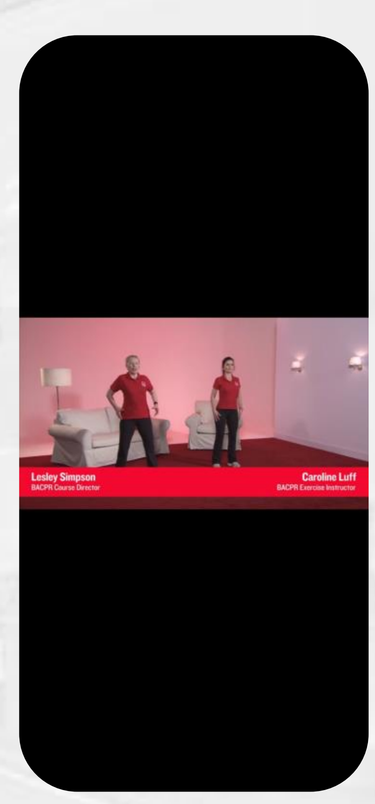
# Patient Support and Self-Management





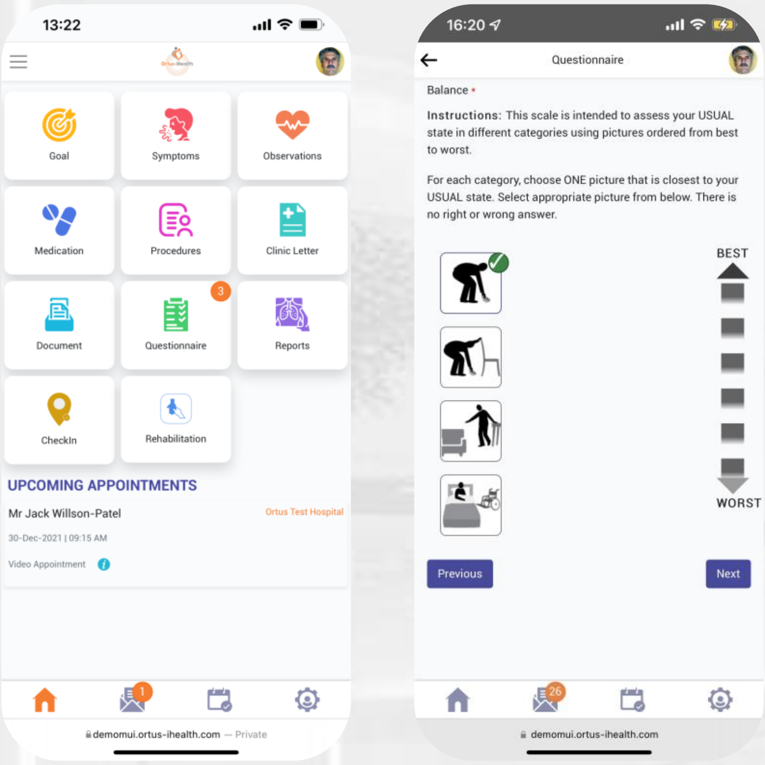



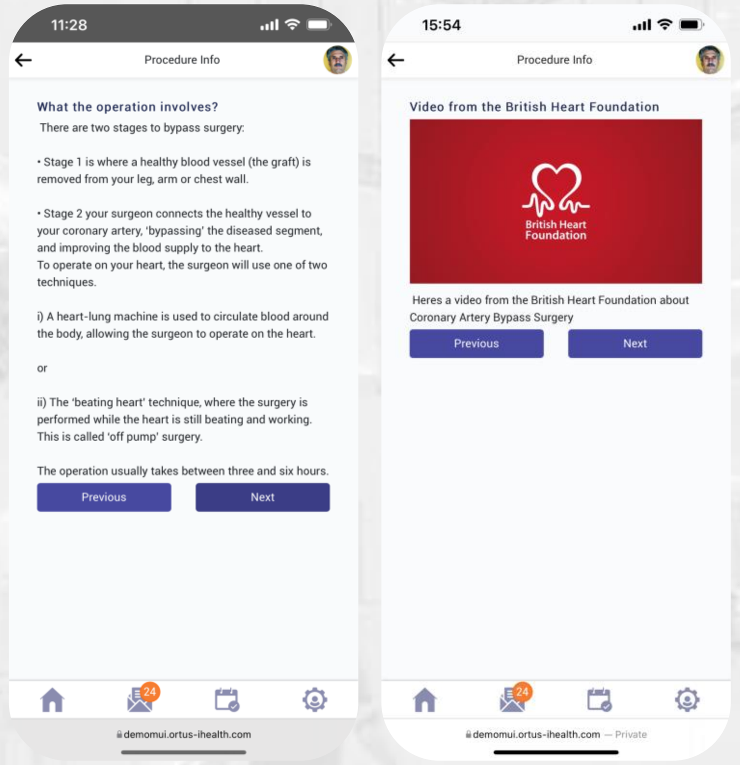

Customisable Patient Education Libraries

Condition-focussed Rehabilitation Documents

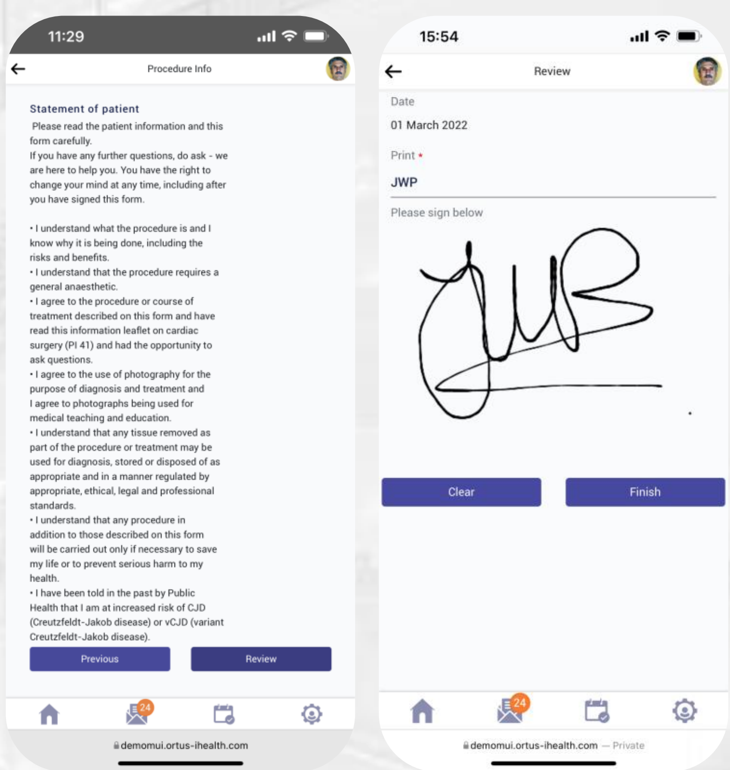
# Digitally enhanced Peri-Operative Phase




Pre-Assessment Questionnaires




Automated Care plans




Configurable and sharable E-Consent

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# 4. Lessons Learned and Future Opportunities

- **What has been key to success to date:**
  - At a concept level, there has been a high level of enthusiasm from the teams engaged with across the deployment sites
  - Recognising and understanding that any concerns raised to date are valid e.g., with workforce concerns
  - Early identification of Task and Finish Groups, Key Stakeholders, and associated roles
  - Development of SOPs to support standardised change management process across sites
  - Staff training process, focussing on current use case, enabling discussions for future opportunities using Ortus
  - Patient onboarding and engagement process, including patient awareness and management of transfer to new system
- **Future opportunities identified to date:**
  - Further standardisation of patient care and resources across semi-acute patient lists (within cardiology) e.g., with remote patient monitoring hub at ICHT
  - Further opportunities to support a pan-London approach to supporting different condition areas e.g., through a centralised LHCRE

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# Question 1

## What have been the challenges & lessons that you have gained during the implementation of a digital solutions across multiple trust/ the cardiac network?

- Repeated IG/DP processes
- Introduction of new workforce models and resourcing
- Key SOPs across network
- High levels of enthusiasm from team involved
- Effectiveness of the Clinical Council Model with procurement
- Concerns over patient safety
- Engagement of site CTOs at an early stage
- Early identification of Task and Finish Groups
- Great opportunity for multi-approach evaluation
- Importance of OneLondon LHCRE

# Question 2

## Based upon your learning so far, how might we best support patient onboard, engagement and empowerment to retain high levels of patient activation?

- Established comms plan (multi-medium)
- Key patient information pre-onboarding (pre-hab and rehab)
- Clear avenues for support (technical vs. clinical)
- SOPs for patient follow-up for non-engaging patients
- Clear applicable patient cohorts (elective vs. semi-acute)
- Accessible resources = patient self-management and PIFU
- Enablement of self-registration
- Continuous and automated collection of patient and staff feedback
- Forms a key part of the UCLP evaluation
- UAT and UCD with platform design (staff and patient focussed)

# Question 3

## What is the expected or seen impact of digital solutions on Cardiac Network performance, waits and patient outcomes; and how might we sell the benefits to other cardiac networks?

- Increased patient uptake on RPM solution
- Early identification of deteriorating patients
- Effective patient prioritisation
- Improved efficiency for waiting list management
- Scalability of project across specialties, models of care
- Improved patient satisfaction
- Improved clinical outcomes
- Reduction in unplanned admissions and bed days
- Removal of cross-site variation with SOPs
- Enhanced patient to care provider connection and communication

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# Pan-London Deployment – Onboarding and Activation

| Deployment Site | Go-Live Date | Total Patients Onboarded | Total Patients Activated | Total Patients Activated % | Total Patients Escalated and Treatments Brought Forward |
|---|---|---|---|---|---|
| Harefield Hospital | 07-Sep-22 | 396 | 310 | 78% | 8 |
| St Bartholomew's Hospital | 16-Sep-22 | 413 | 329 | 80% | 18 |
| Royal Brompton Hospital | 22-Sep-22 | 262 | 169 | 65% | 17 |
| St Thomas' Hospital | 07-Oct-22 | 65 | 44 | 68% | 2 |
| Totals | | 1136 | 852 | 75% | 45 |

St George's University Hospitals
NHS Foundation Trust

# Challenges to date

- **Scale and engagement** across multiple sites.
- **Procurement process** and specification definition.
- **Expertise and new challenges** of delivering digital projects.
- **Time and new ways of working** for Hospital Teams.
- **Repetitive Information Governance process** across the deployment sites.
- **New experience for patient groups** with concerns/queries from patients

# Key Successes

- **Implementation of deployment and escalation SOPs** across networks.
- **Clinical expertise, engagement, and shared vision** from Hospital Teams, Transformation Leads, and Ortus.
- **Regular communication and clear feedback channels** between Hospital Teams and Ortus.
- **Clear instructions for patients** with onboarding experience
- **Early-stage feedback has been positive,** with constructive criticism enabling shared learnings and opportunity for improvements.

# 5. In Summary

# Managing the Complete Population

**Different Protocols and support depending on the severity of the condition**

### Virtual ward protocol

- Monitoring most severe patients Connie, clinical bed at home
- Early discharge of patients to recover at home or managing exacerbations at home with frequent remote patient monitoring
- Episodic care, early discharge, hospital lead (acute care)

### Remote patient support protocol

- Aiming to reduce in person visits and ensure timely interventions in case of deterioration of vitals or symptoms
- Digital care pathways with monitoring, education, Coaching and contact
- Chronic and epidural episodic care
- Hospital or GP practice led

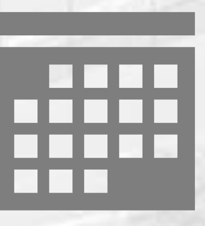
### Self care protocol

- Supporting patients to cope with their disease and coax them in self management
- Focused on prevention
- (auto) triage, screen and (automated) Coaching
- Hospital, GP practice or patient lead

# Patient at Low Risk/Acuity on List

75 - 300
Monitoring
List

Standard
Device kit



6-12
Monthly
Monitoring/
PIFU

Long Term
Monitoring
& Conditions
Team

# Patient at Medium Risk/Acuity Virtual Bed

20-50

Virtual ward

Appropriate Monitoring

Monthly

Multi-disciplinary team

# Patient at High Risk/Acuity in Virtual Bed

10-40

Virtual ward

Premium monitoring

7 x 24h x 14d

Monitoring

Multi-disciplinary team

**Frailty, Heart Failure at Home, ARI**

# Managing the Complete Population

**Different Protocols and support depending on the severity of the condition**

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- (auto) triage, screen and (automated) Coaching
- Hospital, GP practice or patient lead

Ortus-iHealth

# Q & A

# The NHS Elective Care Conference: Transforming Planned Care

# SPEAKING NOW

Mr Luke Farrow

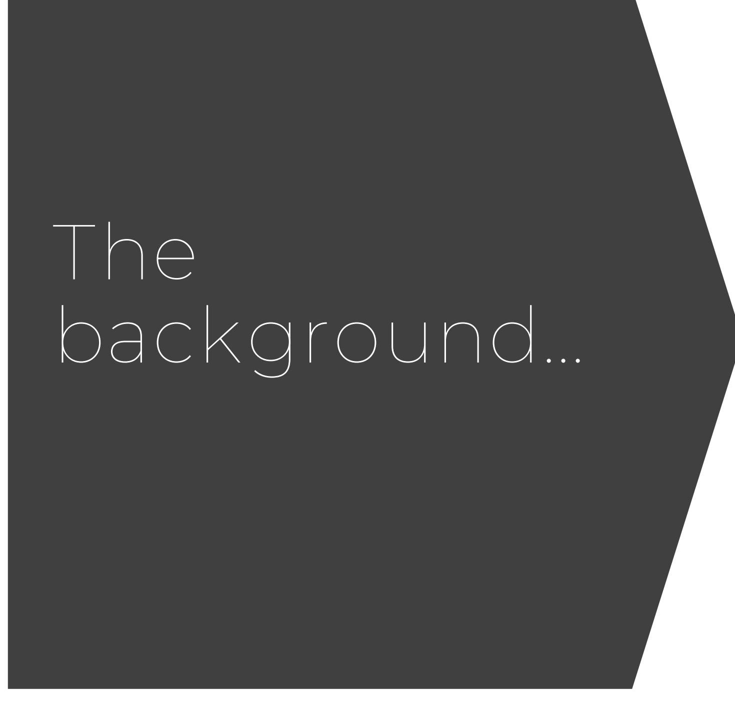
Speciality Registrar in Trauma and Orthopaedics/Clinical Research Fellow - North of Scotland Rotation/University of Aberdeen

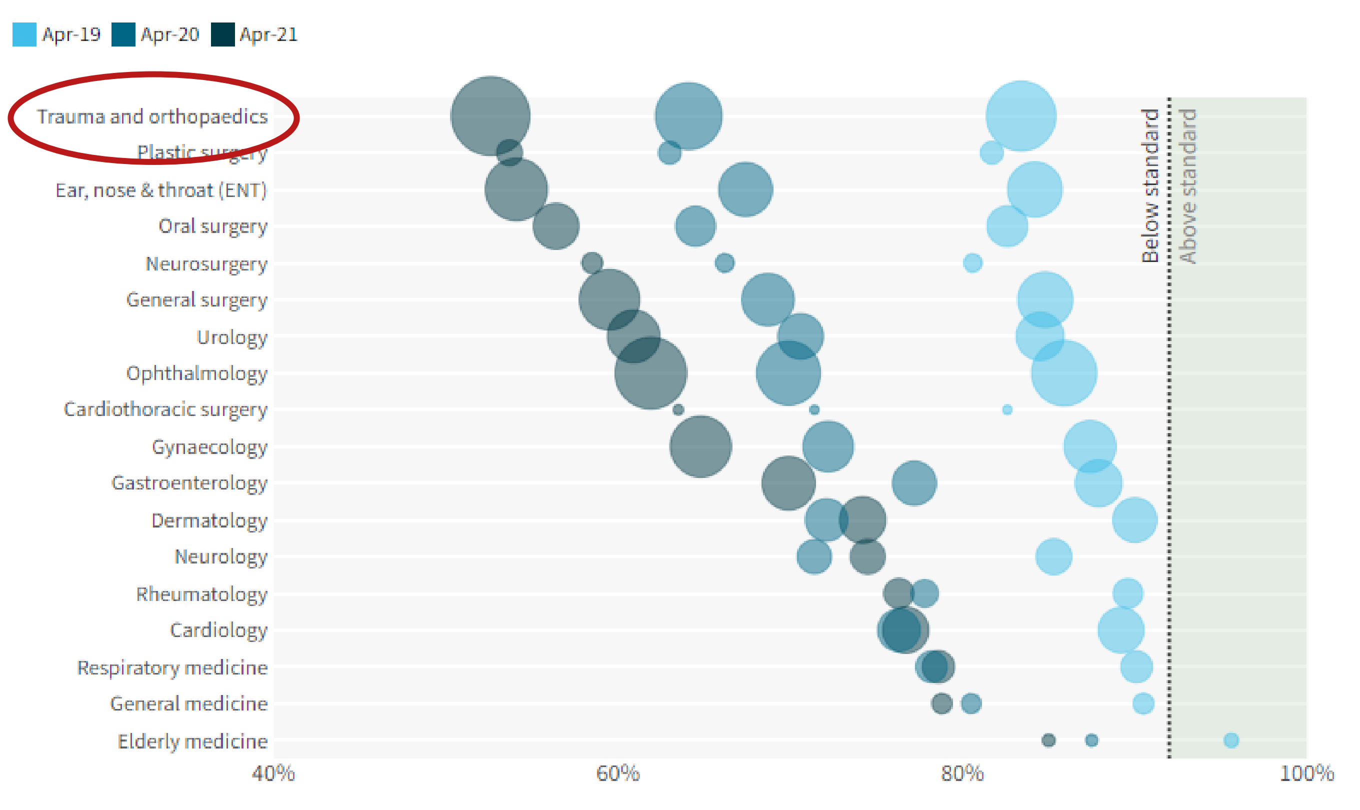
## I will be discussing…

"Waiting for Routine Orthopaedic Surgery in Scotland"

# Waiting for Routine Orthopaedic Surgery in Scotland

Luke Farrow – Clinical Research Fellow, University of Aberdeen


The background…


All specialties have seen a fall in performance against the RTT standard between April 2019 and April 2021
Dots scaled to show the size of the waiting list
Apr-19
Apr-20
Apr-21
Trauma and orthopaedics
Plastic surgery
Ear, nose & throat (ENT)
Oral surgery
Neurosurgery
General surgery
Urology
Ophthalmology
Cardiothoracic surgery
Gynaecology
Gastroenterology
Dermatology
Neurology
Rheumatology
Cardiology
Respiratory medicine
General medicine
Elderly medicine
Below standard
Above standard
40%
60%
80%
100%
Percentage waiting less than 18 weeks
Source: NHS England
Excludes 'other'. x-axis truncated to show trend more clearly.
The King's Fund
A Flourish scatter chart

ARCHERY
Taking AIm at delays to arthritis treatment

HEALTH ECONOMICS
*Hea*
Publ

T

■ ARTHROPLASTY

# The number of patients "worse than death" while waiting for a hip or knee arthroplasty has nearly doubled during the COVID-19 pandemic

A UK NATIONWIDE SURVEY

**Nick D. Clement, Chloe E. H. Scott, James R. D. Murray, Colin R. Howie, David J. Deehan, IMPACT-Restart Collaboration**

News

# New national targets to tackle long waits for planned care

Published: **06 July 2022 11:00**
Part of: Health and social care

Ambitious targets to end long waits.

Ambitious new targets have been set out for NHS Scotland to address the impact of the pandemic on long waiting times for planned care.

Health Secretary Humza Yousaf announced NHS Scotland will aim to eradicate waits of more than two years, and then one year in most specialities by September 2024.

Mr Yousaf has asked health boards to take a focussed approach to tackle the waiting lists now that activity in the NHS is beginning to recover from the pandemic.

The targets are to treat those patients waiting longer than:

- two year waits for outpatients in most specialities by the end of August 2022
- eighteen months for outpatients in most specialities by the end of December 2022
- one year for outpatients in most specialities by the end of March 2023
- two years for inpatient / daycases in most specialties by the end of September 2022
- eighteen months for inpatient / daycases in most specialities by the end of September 2023
- one year for inpatient / daycases in most specialities by the end of September 2024

# Waiting-list times longer than on 'grossly misleading' NHS site

Health boards said the figures, touted by Humza Yousaf, the Scottish health secretary, would give a false impression
ANDREW MILLIGAN/PA

Patients are waiting months longer for operations than suggested by a "grossly misleading" revamp of an NHS website driven by the Scottish government.

# Aims

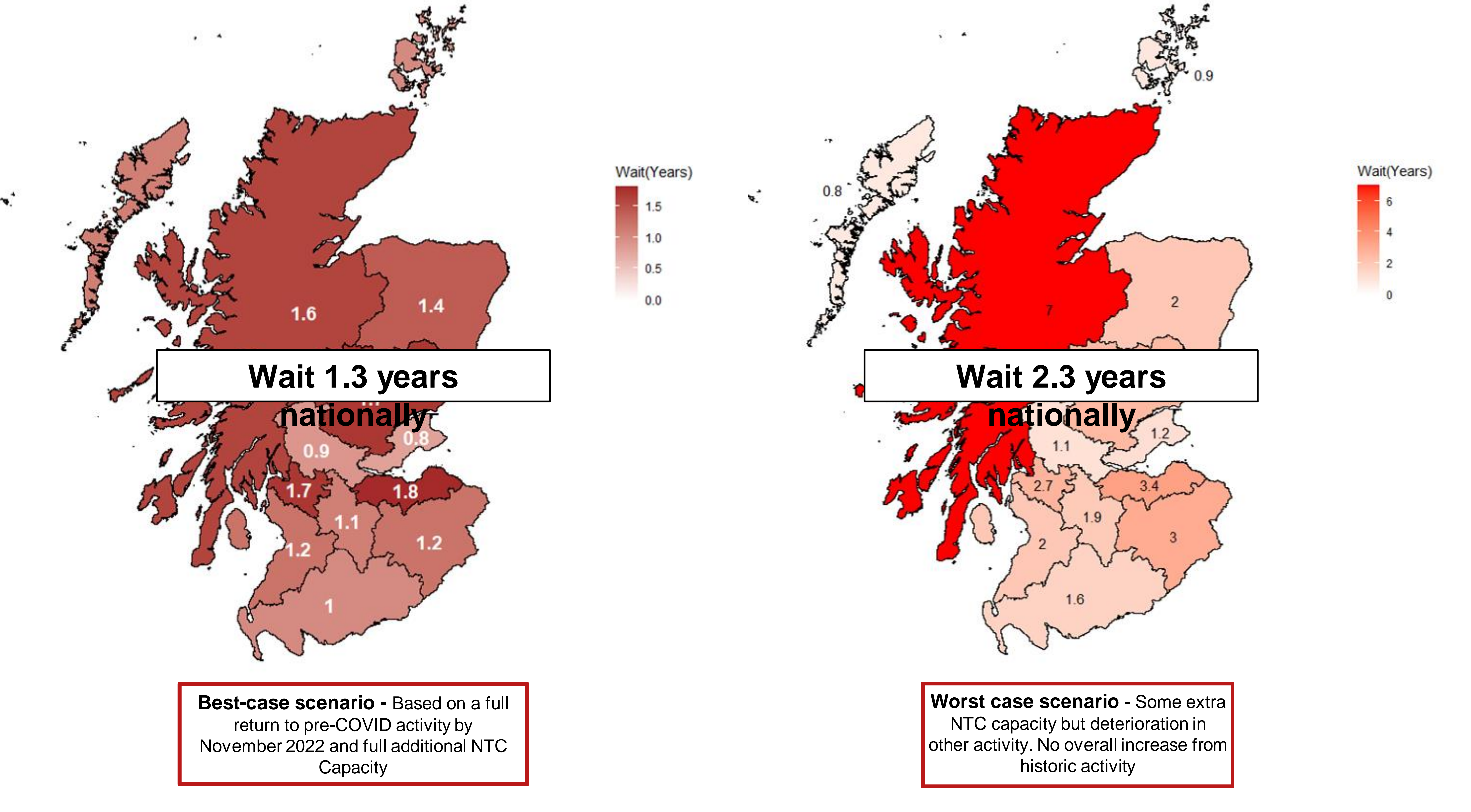
Examine predicted waiting times for orthopaedic surgery

Assess how this may change in the future, including impact of additional capacity

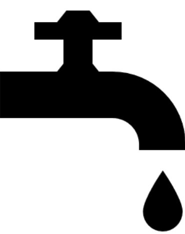
Determine the feasibility of achieving the current government targets of a 1 year wait for surgery by September 2024

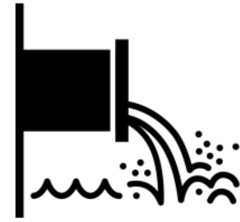
# Methods

- Publicly available data from https://publichealthscotland.scot/publications/nhs-waiting-times-stage-of-treatment/stage-of-treatment-waiting-times-inpatients-day-cases-and-new-outpatients-30-june-2022/clinical-prioritisation-dashboard/ - September 2022.
- Primary outcome =
  - Predicted wait for new patient added to waiting list as of July 2022 – calculated from 1-year historical activity against approximate time required for patient to reach top of waiting list. Adjustment for impact of NTC utilisation.
- Secondary outcomes =
  - Change in activity required to reach one year wait by September 2024 (Patients added to waiting list September 2023)
  - Predicted change in future waits based on historical and predicted future capacity



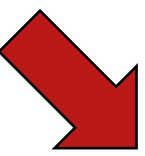
1.6
1.4
Wait(Years)
1.5
1.0
0.5
0.0
Wait 1.3 years nationally
0.9
0.8
1.7
1.8
1.1
1.2
1.2
1
**Best-case scenario -** Based on a full return to pre-COVID activity by November 2022 and full additional NTC Capacity
0.9
0.8
7
2
Wait(Years)
6
4
2
0
Wait 2.3 years nationally
1.2
1.1
2.7
3.4
1.9
2
3
1.6
**Worst case scenario -** Some extra NTC capacity but deterioration in other activity. No overall increase from historic activity

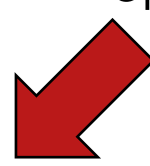




New waiting list additions per annum = 37,083

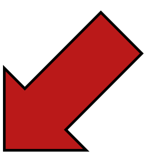
Operations per annum = 16,975

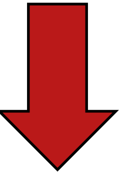


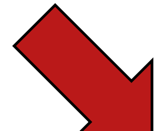


Current case deficit per annum = **20,108**

- **16,362** with full additional NTC capacity alone





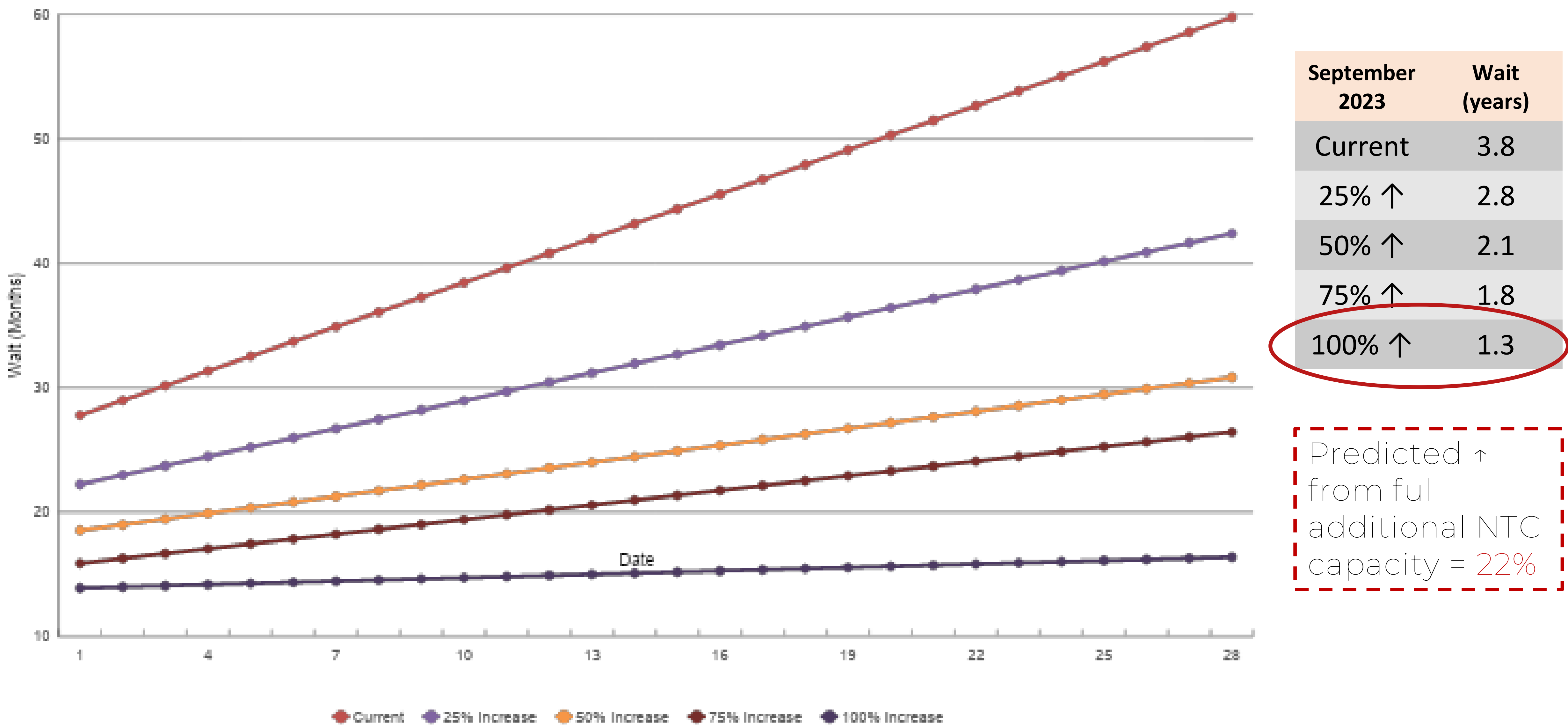


- **6367** with return to Pre-COVID activity and full additional NTC capacity

With full additional NTC capacity average waiting time will continue to grow by **0.5** years per year

Based on recent historical activity alone average waiting time will continue to grow by **1.1** years per year

Even with a return to Pre-COVID activity and full additional NTC capacity the waiting list will continue to grow by **0.2** years per year

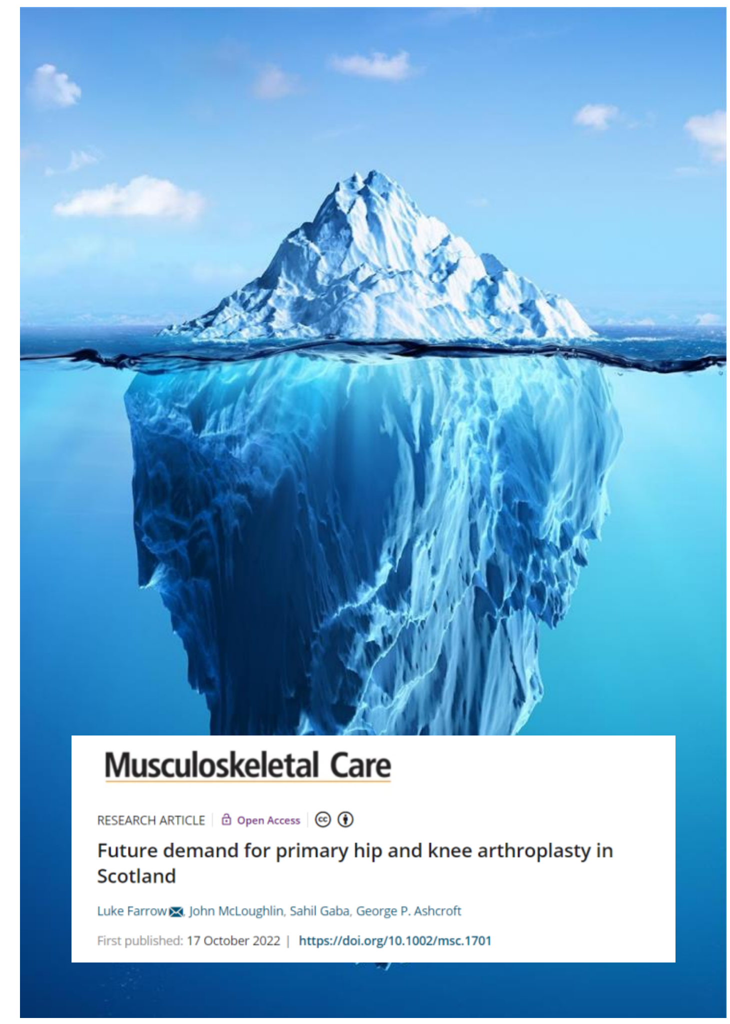

Predicted routine elective orthopaedic waiting time (months) across Scotland by change in historical activity
Wait (Months)
Date
Current
25% Increase
50% Increase
75% Increase
100% Increase
September 2023
Wait (years)
Current 3.8
25% ↑ 2.8
50% ↑ 2.1
75% ↑ 1.8
100% ↑ 1.3
Predicted ↑ from full additional NTC capacity = 22%

# Conclusions

Current predicted orthopaedic surgery waiting times for a patient listed in July 2022 are approximately 2 years. If full NTC capacity is not achieved waits in some health boards will exceed 3 years.

Wait list additions and admissions for treatment remain significantly below 2019 levels. Even with a prompt full return to pre-COVID activity and additional NTC capacity waiting times will continue to deteriorate.

Current targets of a 1-year maximum wait by September 2024 need urgent and intense action if they are to be achieved



# Thanks for listening

Any Questions?

Luke.farrow@nhs.scot

# The NHS Elective Care Conference: Transforming Planned Care

# SPEAKING NOW

Chris McAuley

Programme Delivery Manager
NHS Benchmarking Network

## I will be discussing…

"Findings from the 2022 Outpatients and Operating Theatres Benchmarking Projects"

# Findings from the 2022 Outpatients and Operating Theatres Benchmarking Projects

**Chris McAuley**

**Programme Delivery Manager**

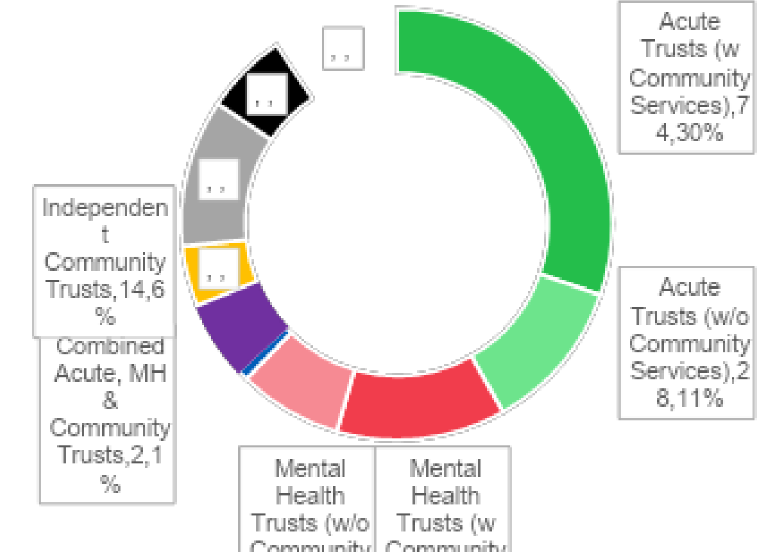
# Welcome and introduction

# Network membership

240+ member organisations and c.10,000 clinicians and managers using the service

In England:

- 75% of acute providers
- 87% of NHS Trusts providing community services, plus 11 Social Enterprises
- 100% of mental health trusts
- 31% of ICBs by population covered




- 100% coverage in Wales Health Boards
- 100% coverage in Northern Ireland HSCTs
- 100% coverage of Scottish Health Boards, plus the Scottish Government

*as of 31st August 2022*

# 2022/23 work programme

## Core Network projects

**Acute Sector**

- **Acute Transformation Dashboard**
- **Acute Therapies**
- **Emergency Care**
- **Managing Frailty in Acute Settings**
- **Operating Theatres**
- **Outpatients**
- **Pharmacy & Medicines Optimisation (Provider)**

**Community Sector**

- Community Indicators (monthly)
- Community Services
- Community Hospital Bed Survey
- Intermediate Care

**Mental Health Sector**

- Adults & Older Adults Mental Health
- Children & Young People's Mental Health Services (CYP MH)
- Learning Disabilities
- Mental Health & Learning Disabilities Covid-19 Dashboard (monthly)

**Whole System**

- Cost Collection Analysis
- Integrated Care System Benchmarker
- ICS Pilots and Whole System Events
- Summary Opportunity Reports
- Whole Systems Beds

**To view the 2022/23 work programme calendar, click here.**

# Project timetable

| Period | Project Stage |
|---|---|
| **January to April** | Project consultation and development |
| **May to August** | Data collection |
| **16th June** | Elective Care Share Learning Webinar |
| **August to September** | Data validation and analysis |
| **August** | Draft online analysis toolkit |
| **September** | Draft reports released |
| **13th October** | Findings Webinar |
| **October** | Outputs released |

2022 is the seventh iteration of the Theatres project, and the sixth iteration of the Outpatients project.

Within each Benchmarking project, we produce a range of network resources:

**Online project toolkits**

**ICS Benchmarker**

**Summary Report**

**Knowledge Exchange Forum**

**Shared learning & good practice**

**Webinar presentations and recordings**

# The Network's Acute team

**Nick Westmoreland**
Senior Project Manager

**Freddie Girling**
Assistant Project Manager

**Niamh Stimpson**
Graduate Project Coordinator

**Chris McAuley**
Programme Delivery Manager

**Stan Fleming**
Graduate Project Coordinator

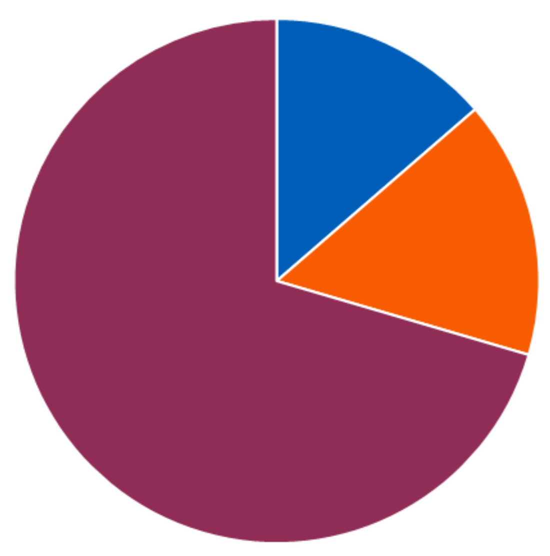
**Lillie Phillips**
Graduate Project Coordinator

# Outpatients Benchmarking findings

# Key themes: Elective care backlog

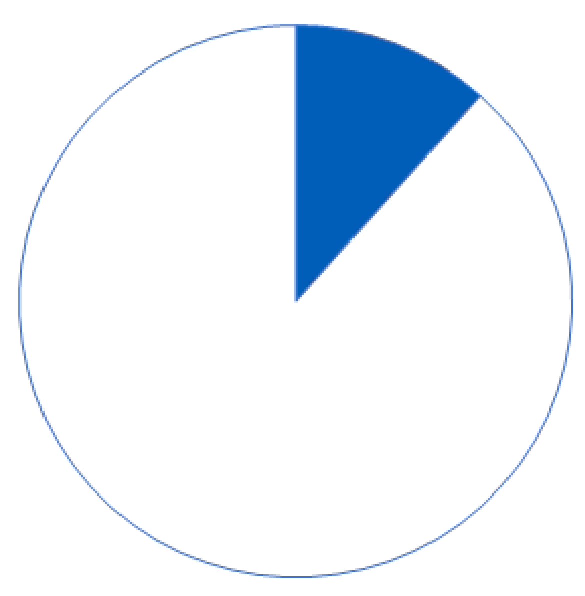
# Management structure of outpatients

## How are outpatient services managed?



| | | |
|---|---|---|
| Shared management function overseeing all specialities | | 14% |
| Separate management of different specialities | | 16% |
| Mix of shared and separately managed models | | 70% |

## Did the management structure of outpatients become more centralised during COVID-19 and will changes be retained?



| | |
|---|---|
| % Yes | 12% |
| % Yes (2021) | 17% |

NHS
Benchmarking Network

# Clinic delivery

## Percentage of scheduled clinics delivered in 2021/22

100%
80%
60%
40%
20%
0%

| Year | Mean |
|---|---|
| **2022** | **79%** |
| 2021 | 76% |
| 2020 | 86% |
| 2019 | 85% |

# Clinic delivery

## Percentage of clinics delivered that were Consultant led in 2021/22

| Year | Mean |
|---|---|
| **2022** | **64%** |
| 2021 | 69% |

# Electronic/paper

## Percentage of patient healthcare records for appointments that are electronic, as opposed to handwritten (%)

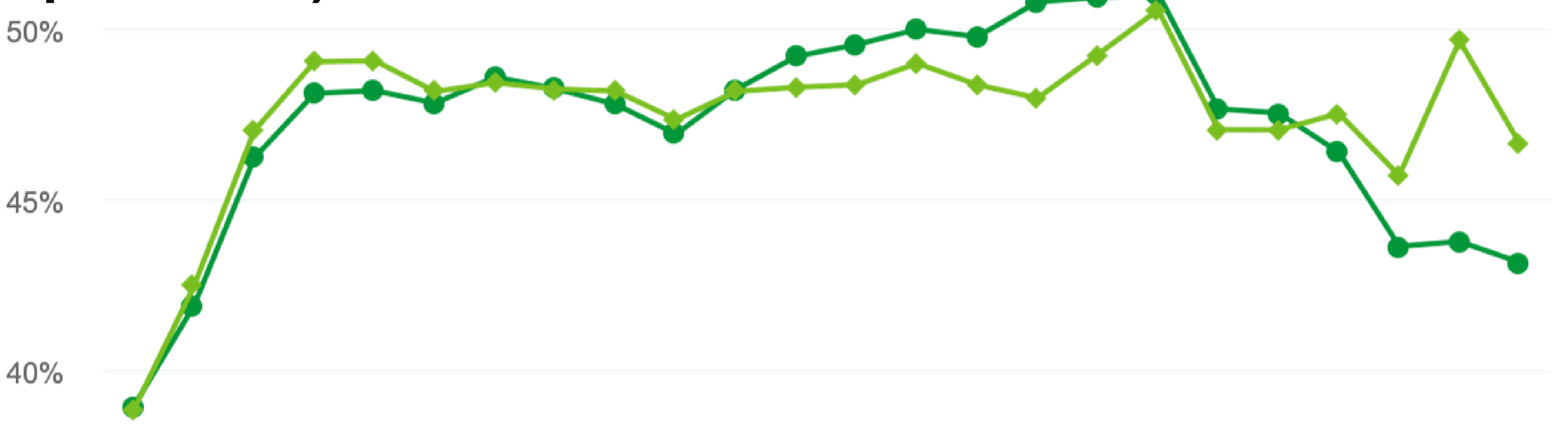
100%
80%
60%
40%
20%
0%

| Year | Mean |
|---|---|
| **2022** | **68%** |
| 2021 | 47% |

# Key themes: Referral Streaming

# Referrals

## Percentage of all referrals received from GPs in 2021/22 (all specialities)

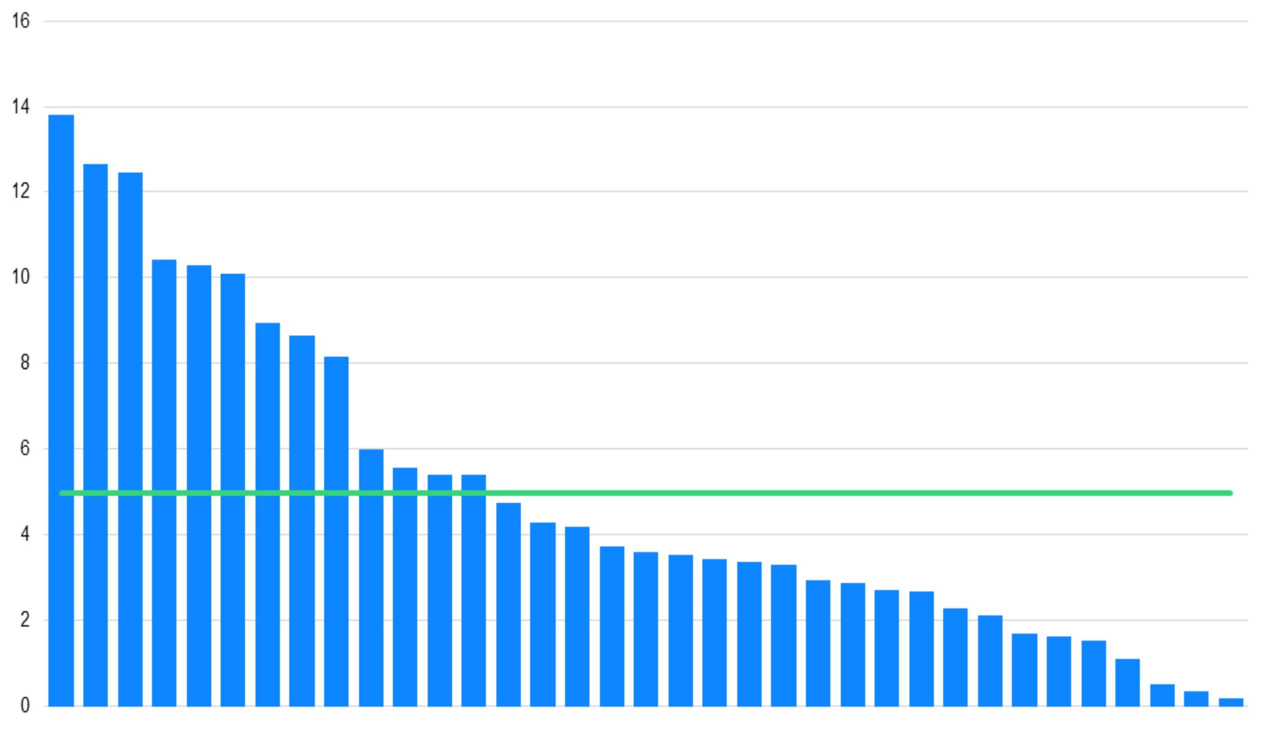


NHS Benchmarking Network

CELEBRATING 25 YEARS OF THE NETWORK

# Advice & Guidance

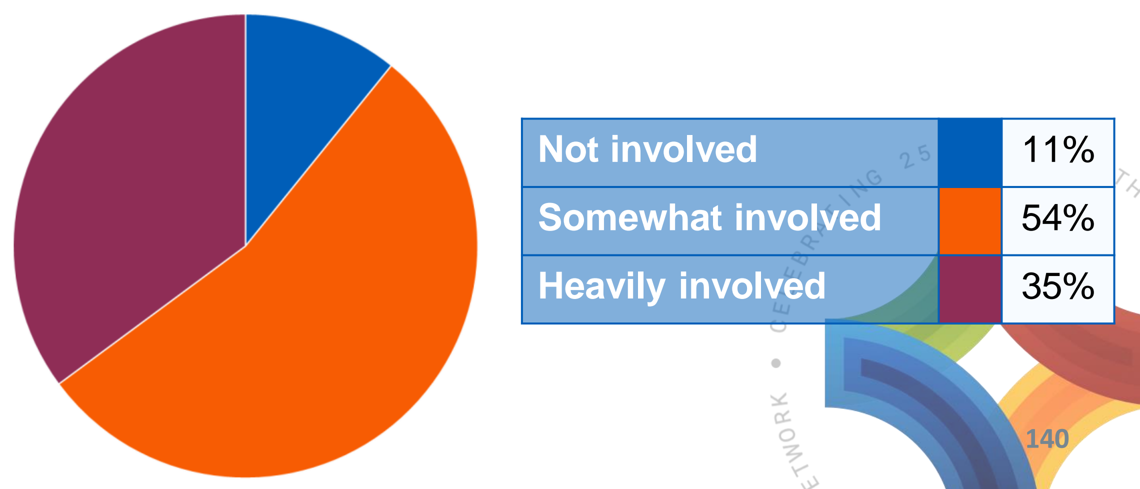
## Advice & Guidance requests per 100 new appointments in 2021/22 (all specialities)




| Year | Mean |
|---|---|
| 2022 | 4.7 |

## Confidence in achieving the target of delivering 16 specialist advice requests per 100 OP first attendances by March 2023

## Extent to which the local commissioning body was involved in the development/delivery of Advice & Guidance in the local area



# Advice and guidance

**Please outline any good practice you wish to share with your implementation of Advice & Guidance – Your responses**

*“To maximise the effectiveness of A&G it is important clinicians are given job planned time to deliver this service.”*

*“A supporting and embedded dashboard that allows operational teams to manage their cohort of A&G requests and monitor trends and outcomes. Monthly place-based A&G steering group with representation from primary/secondary care.”*

*“We have setup a designated virtual hub, which includes 9 rooms.”*

# Key themes: Outpatient Follow-up

# Remote attendances

## Percentage of all attendances delivered remotely in 2021/22 (all specialities)

45%
40%
35%
30%
25%
20%
15%
10%
5%
0%

| Year | Mean |
|---|---|
| **2022** | **27%** |
| 2021 | 41% |
| 2020 (first) | 3% |
| 2020 (follow-up) | 5% |

# PIFU activity

## Patients on a PIFU pathway at 31st March 2022 per 10,000 outpatient attendances

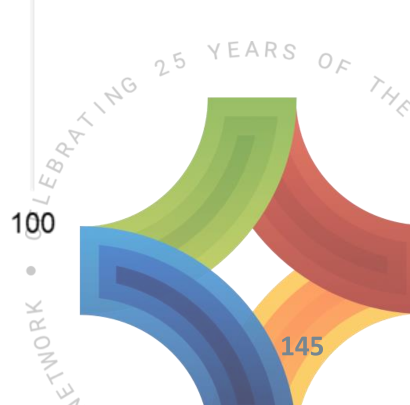
| Year | Mean | Median |
|---|---|---|
| **2022** | **80** | **43** |
| 2021 | 51 | 14 |

# PIFU speciality provision

## Specialities providing PIFU pathways

| Speciality | % |
| --- | --- |
| Paediatrics | 57% |
| Clinical Haematology | 36% |
| Respiratory Medicine | 56% |
| General Surgery | 44% |
| Ear, Nose and Throat | 71% |
| Urology | 65% |
| Gynaecology | 75% |
| Dermaology | 71% |
| Cardiology | 66% |
| Trauma & Orthopaedics | 68% |
| Opthalmology | 50% |

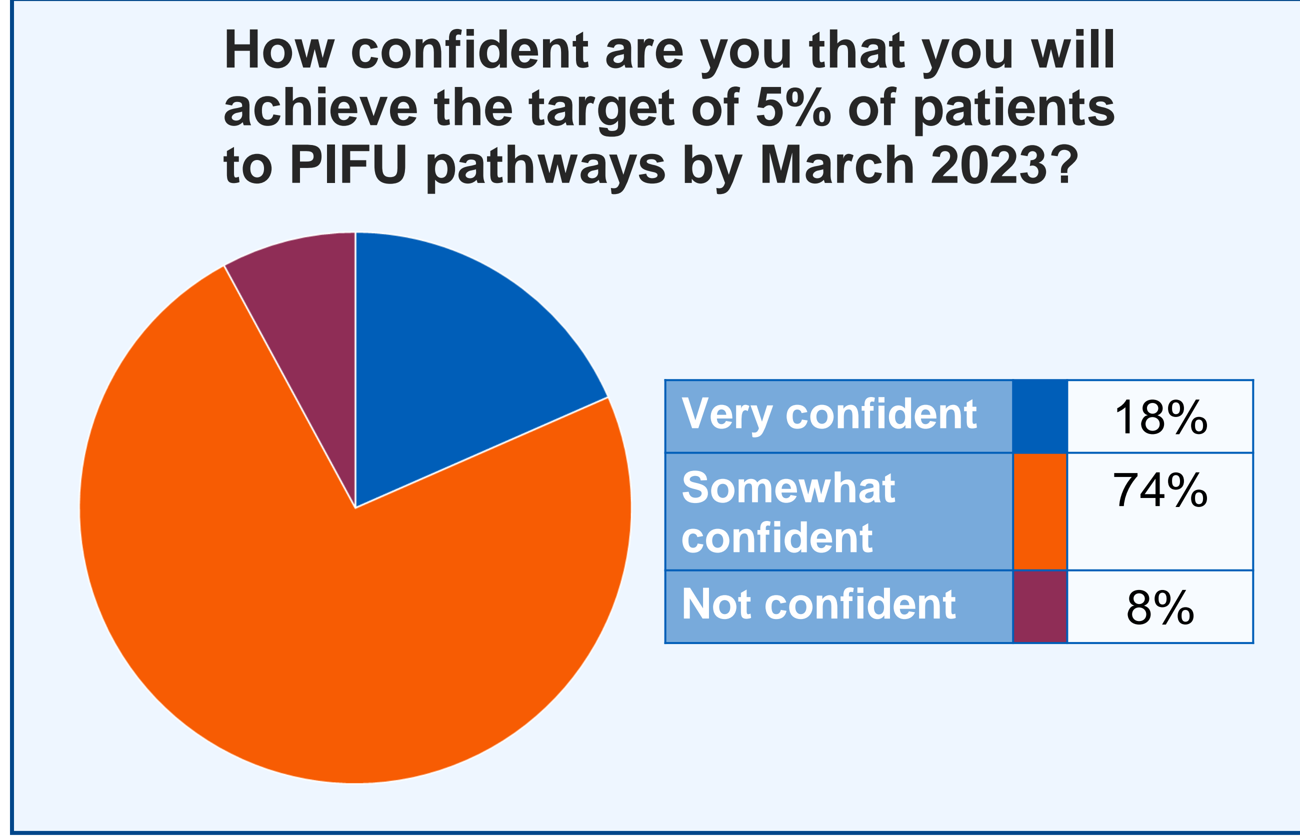
0 10 20 30 40 50 60 70 80 90 100



# Implementing PIFU

**Please describe any innovative practice in the implementation of PIFU within your organisation**

- *"An understanding that PIFU is not to compensate for a failure in Outpatient capacity to deliver essential follow-up but is instead an opportunity to give capacity to patients who need support at a time when they most need it."*
- *"We produced bespoke information leaflets for each speciality and implemented a process within the PAS System."*




- *"We pulled together a PIFU Implementation Team … produced bespoke information leaflets for each speciality and implemented a process within the PAS System to be able to easily identify the patients on a PIFU pathway."*

# Key themes:
# Healthcare Inequalities

# Learning disabilities

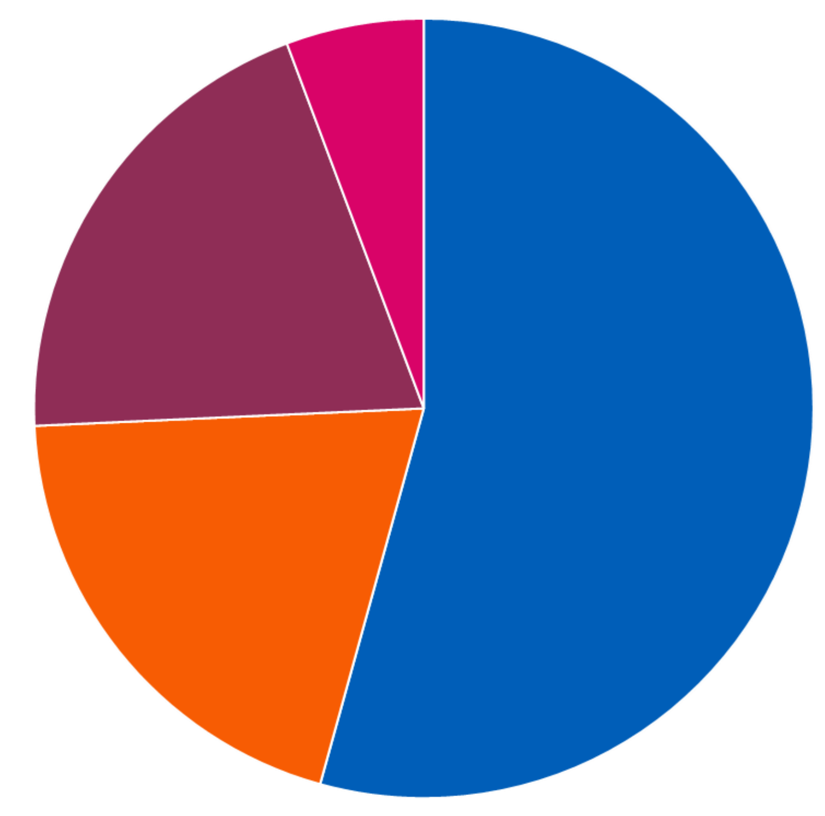
## Reasonable adjustments

| | | % Yes – all specialities |
|---|---|---|
| Is there a designated lead for learning disabilities/autism in outpatient service? | | 55% |
| Does your organisation have a policy on reasonable adjustments for patients with learning disabilities/autism in outpatients? | | 63% |
| Do you provide increase length of appointment time for patients with learning disabilities/autism? | | 71% |

# Key themes: Workforce challenges

# Workforce challenges

## Have workforce challenges caused clinics to be cancelled?



| | | |
|---|---|---|
| Rarely | | 54% |
| Monthly | | 20% |
| Weekly | | 20% |
| Daily | | 6% |

# Wellbeing Initiatives

| | % YES |
|---|---|
| Do you have a wellbeing lead in your outpatients department? | 43% |
| Is there a wellbeing strategy for outpatients? | 34% |
| Is there any funding available for wellbeing initiatives? | 55% |

# Operating Theatres Benchmarking findings

# Key themes:
# Capacity & Demand Planning

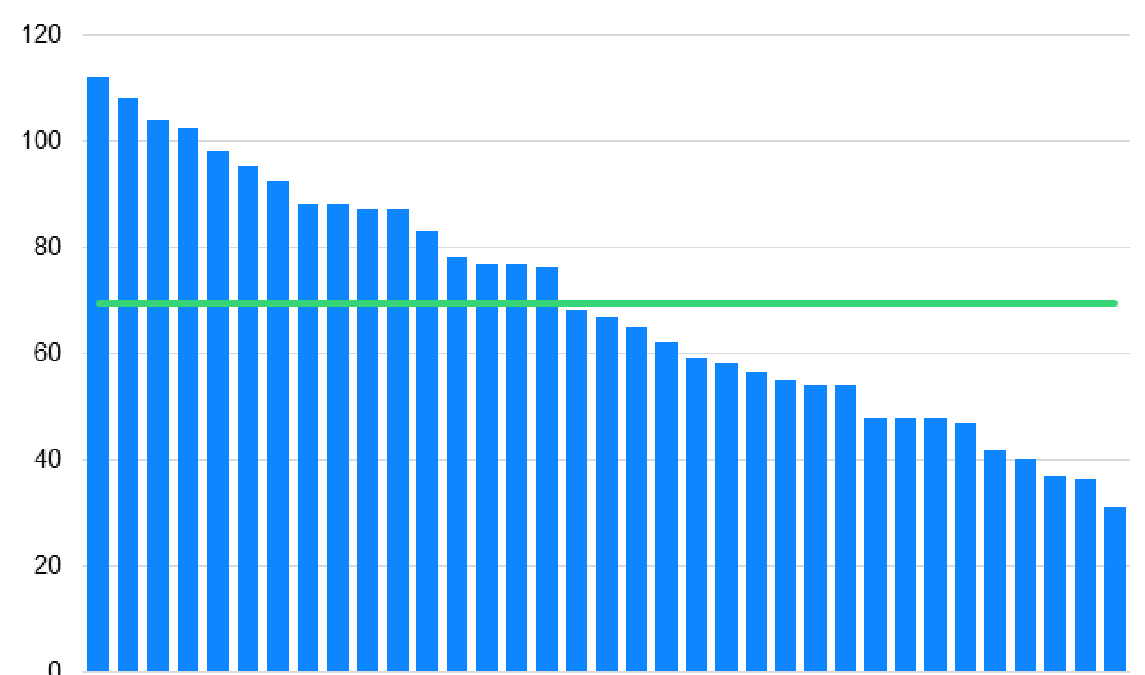
# Theatre capacity

## Operating theatres per 1,000 operating theatre lists

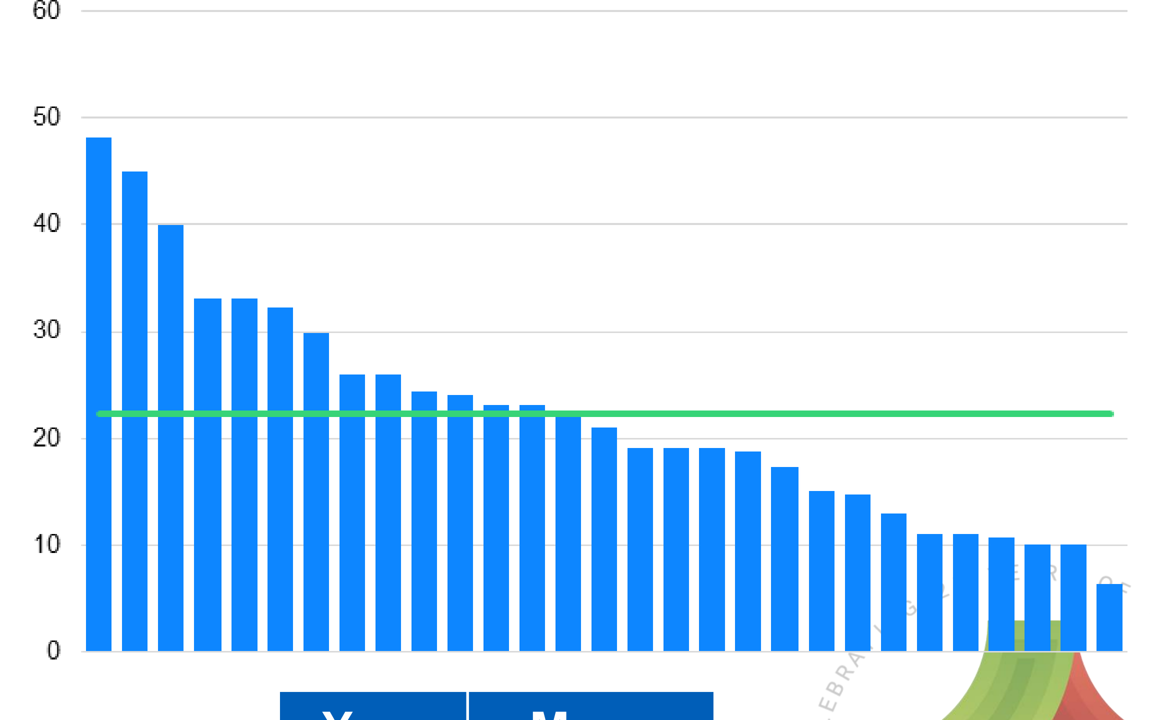
| Year | Mean |
|---|---|
| **2022** | **2.6** |
| 2021 | 3.3 |
| 2020 | 2.4 |

# Timeliness

## Average operating & turnaround time per case for all specialities in minutes




| Year | Mean |
|---|---|
| **2022** | **69 mins** |
| 2021 | 66 mins |




| Year | Mean |
|---|---|
| **2022** | **22 mins** |
| 2021 | 25 mins |

# Cancellations

## Percentage of cases cancelled last minute in 2021/22 (all specialities)

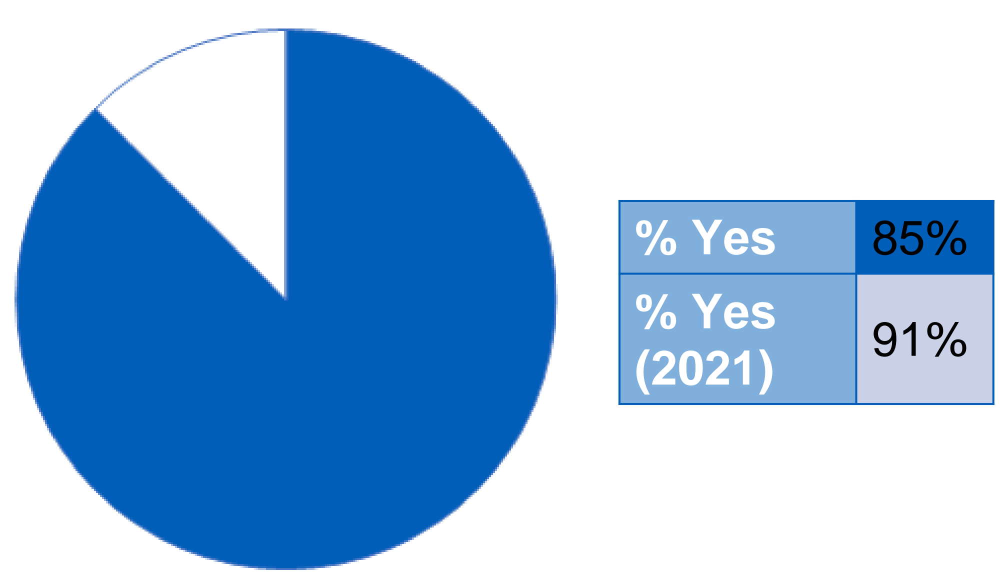
18%
16%
14%
12%
10%
8%
6%
4%
2%
0%

| Year | Mean |
|---|---|
| **2022** | **6%** |
| 2021 | 3% |
| 2020 | 9% |

# Key themes:
# Elective care recovery

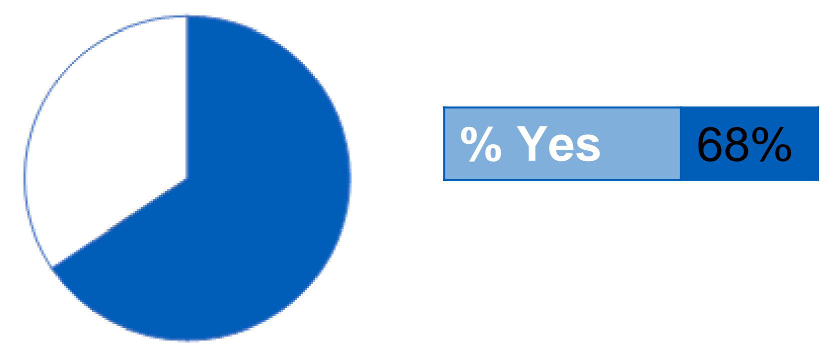
# Operating theatres recovery

## Do you have an operating theatres recovery plan?



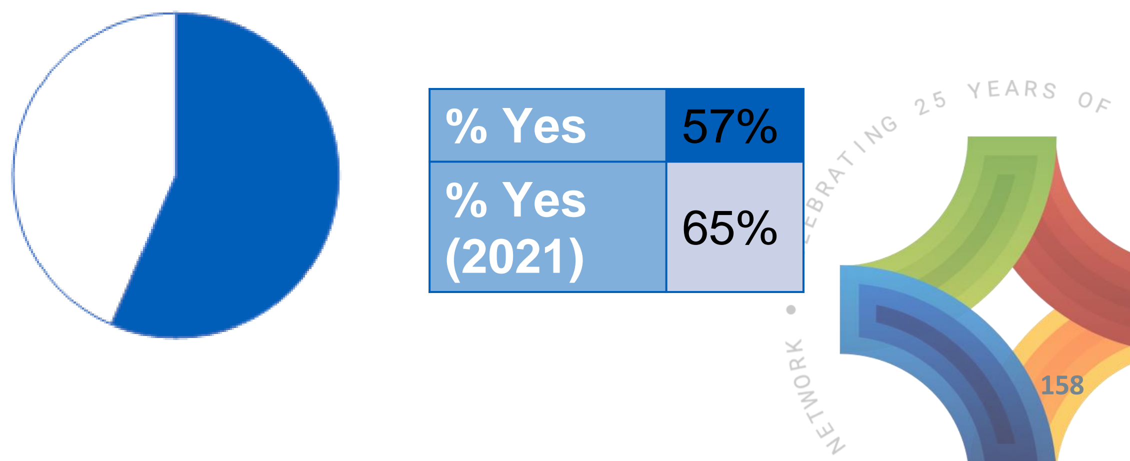
| % Yes | 85% |
|---|---|
| % Yes (2021) | 91% |

## Do you have beds ring-fenced for elective activity only?



| % Yes | 68% |
|---|---|

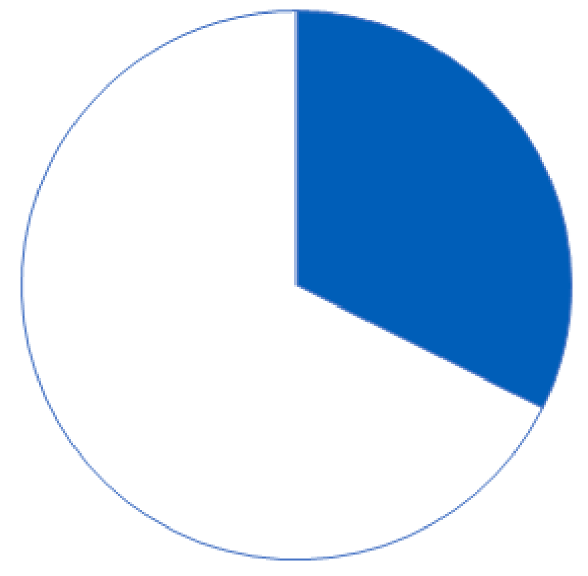
## Will the operating theatres recovery plan involve consolidation across multiple trusts/sites?




| % Yes | 57% |
|---|---|
| % Yes (2021) | 65% |

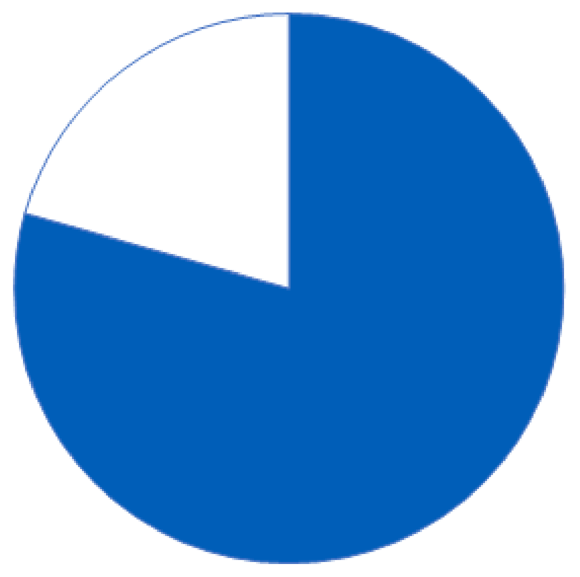
# Outsourced activity

## Did you outsource to other NHS providers in 2021/22?



| % Yes | 34% |
| --- | --- |
| % Yes (2021) | 37% |

## Did you outsource to independent sector providers in 2021/22?



| % Yes | 77% |
| --- | --- |
| % Yes (2021) | 85% |

# Workforce

## Number of staffing in operating theatres per 1,000 operating theatre lists

| Year | Mean |
|---|---|
| **2022** | **44** |
| 2021 | 50 |

# Recruitment strategy

## Please outline any recruitment strategies in theatres

- *"Peri-operative group established to look at workforce and recruitment. Weekly review of workforce."*

- *"We are currently working with Temporary Staffing, Recruitment and Comms to tackle our staffing shortfall. We are in the early stages of a strategy, but it will involve using a specialist company to arrange Open Days along with advertising on social media, a re-branding of our theatres and some work on the local area as a great place to live and work."*

- *"Overseas recruitment, wellbeing and retention initiatives, engaging with local university to offer more apprentice courses such as ATP/ANP and Anaesthetics assistants."*

# Concluding remarks and next steps

# Thank you for listening

# The NHS Elective Care Conference: Transforming Planned Care

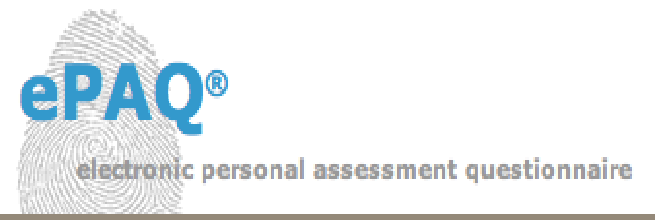
# SPEAKING NOW

Professor Stephen Radley

Programme Delivery Manager
NHS Benchmarking Network

## I will be discussing…

"Web-Based Pre-Operative Assessment: Development, Validation & Clinical Deployment of ePAQ-PO (Electronic, Personal Assessment Questionnaire)"




# Elective Care Recovery
# Transforming Planned Care (13:55 – 14:20)

## Web-Based Pre-Operative Assessment
## Development, Validation & Deployment of ePAQ-PO
## (electronic Personal Assessment Questionnaire Pre-Operative)

Professor Stephen Radley

Sheffield Teaching Hospitals NHS Foundation Trust

ePAQ Systems Ltd: An NHS spin-out technology company

# Why do we use questionnaires?

PROM - Patient Reported Outcome Measures
PREM - Patient Reported Experience Measure

'Instrument' = Questionnaire

**Research:** Valid, Reliable, Responsive, Sensitive to change

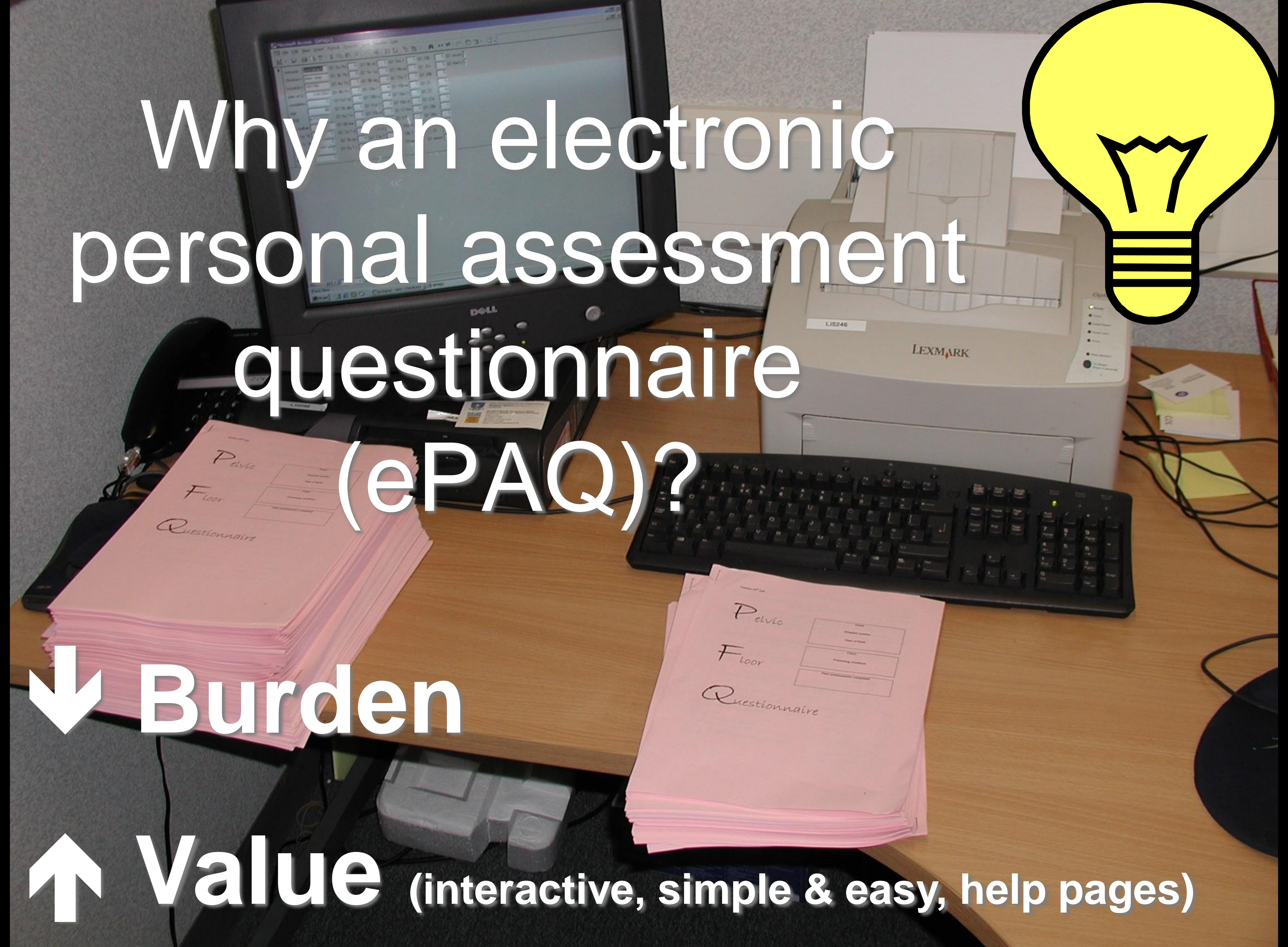
**Clinical:** All of the above and…

- Value & Burden
- Utility & Feasibility
- Cost & Impact
- Quality & Efficiency

# Questionnaires to improve discussion & disclosure

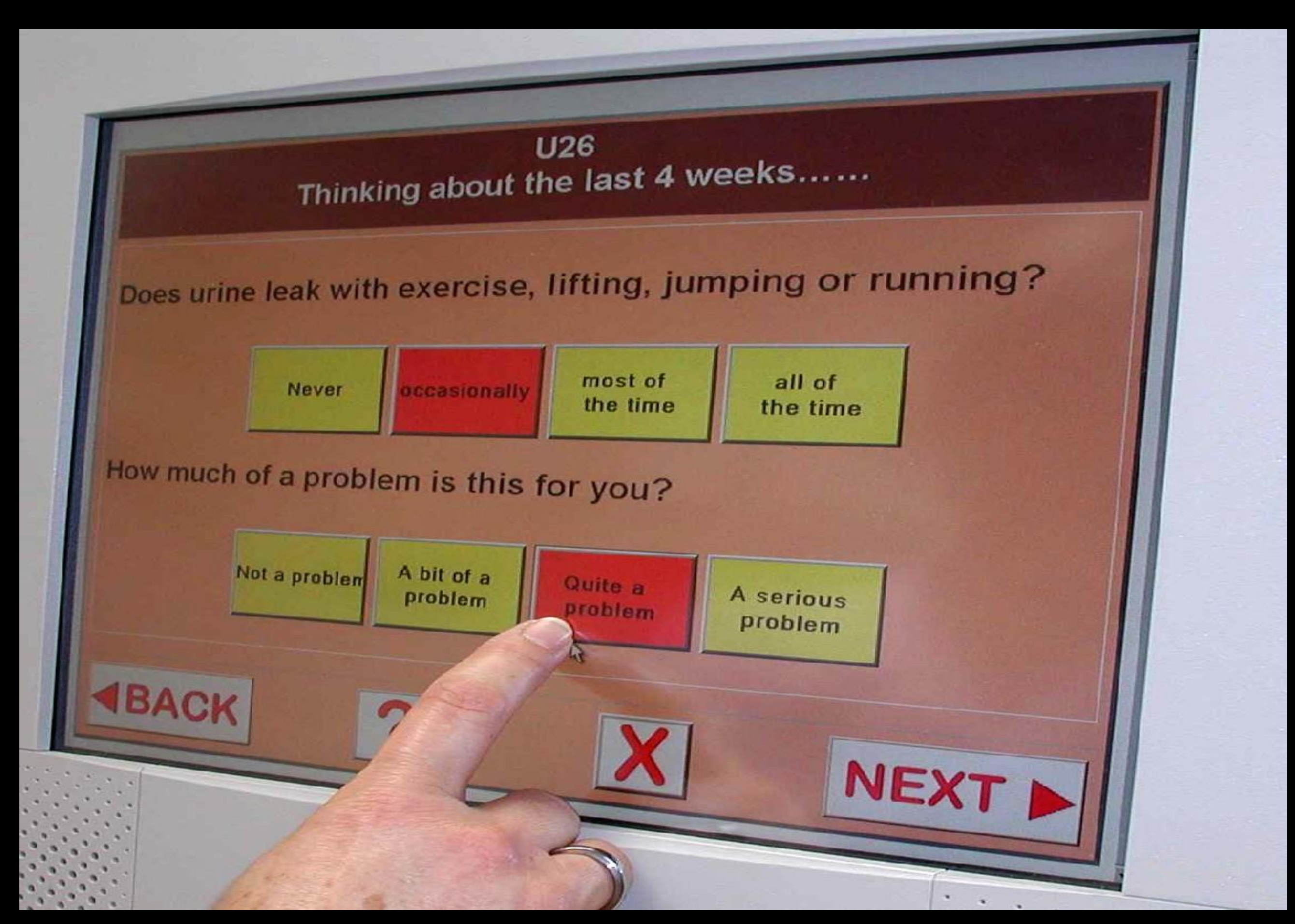
## Prevalence of coital incontinence in urogynaecology clinics

| Author(s) | Number | Outcome measure | Prevalence |
|---|---|---|---|
| Moran et al, 1999 | 2153 | Interview | 10.6% |
| Serati et al, 2008 | 132 | Interview | 11.6% |
| Madhu et al, 2015 | 11689 | Interview | 11.8% |
| Monsterrat et al, 2008 | 633 | Questionnaire | 36.2% |
| Bekker et al, 2009 | 136 | Questionnaire | 56% |
| El Azab, 2011 | 90 | Questionnaire | 66% |
| Jha et al, 2012 | 480 | Questionnaire (ePAQ) | 60% |
| Gray et al, 2016 | 2312 | Questionnaire (ePAQ) | 47% |



Why an electronic personal assessment questionnaire (ePAQ)?
↓ Burden
↑ Value (interactive, simple & easy, help pages)
Pelvic Floor Questionnaire
Pelvic Floor Questionnaire
DELL
LEXMARK

# ePAQ – Pelvic Floor
# A questionnaire for clinical use



# Example: ePAQ-PF Summary Report

| Height | | Weight | | BMI | | Age | 53 |
|---|---|---|---|---|---|---|---|
| Treatment? | No | Condition change | | Children | | Pregnancies | |

| | |
|---|---|
| Concerns & goals | 1. Bowel urgency and seepage<br>2. Leaking wind<br>3. Cant go out because of fear of accidents |
| Questions | 1. Why did this happen to me?<br>2. Can I have any treatment?<br>3. Should I have a caesarean section next time? |

| Bladder & urinary symptoms | | Score (0 - 100) | Impact |
|---|---|---|---|
| Pain | | Dimension skipped | |
| Voiding | | Dimension skipped | |
| Overactive bladder | | Dimension skipped | |
| Stress incontinence | | Dimension skipped | |
| Quality of life | | Dimension skipped | |

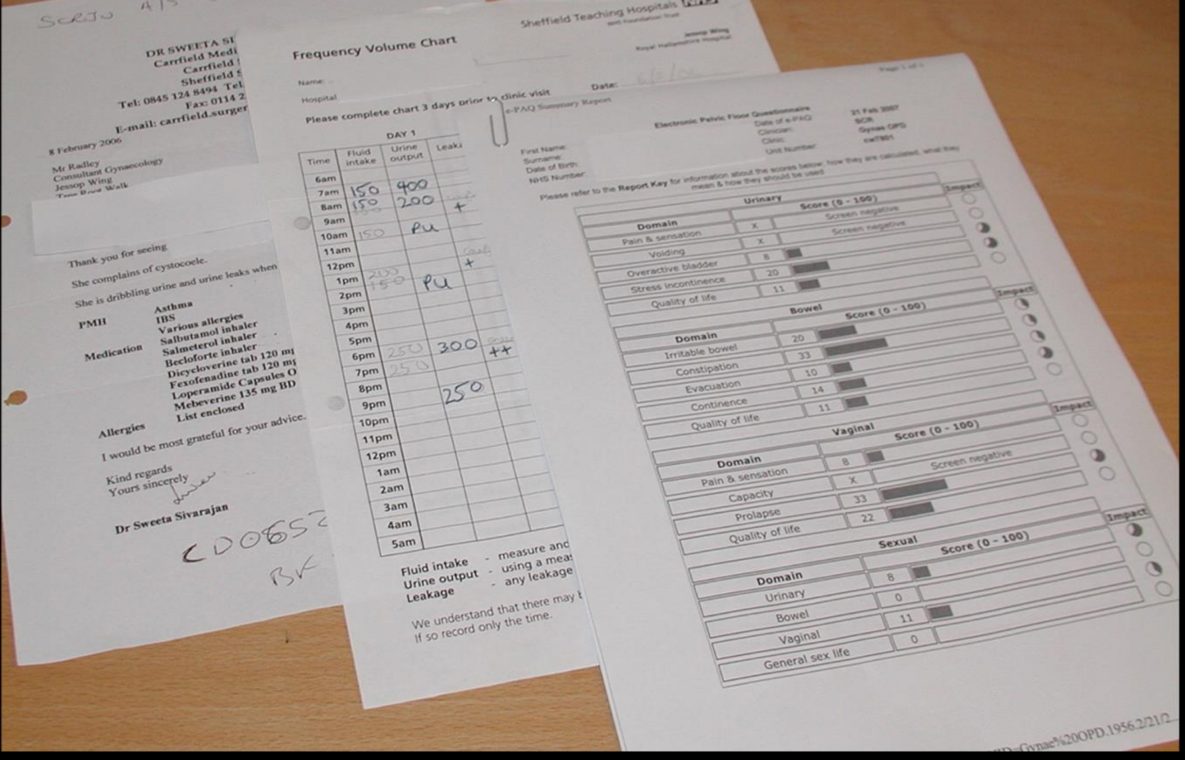
| Bowel symptoms | | Score (0 - 100) | Impact |
|---|---|---|---|
| Irritable bowel | 33 | | |
| Constipation | 0 | | |
| Evacuation | | Screen negative | |
| Continence | 33 | | |
| Quality of life | 67 | | |

| Vaginal symptoms and prolapse | | Score (0 - 100) | Impact |
|---|---|---|---|
| Pain & sensation | | Dimension skipped | |
| Capacity | | Dimension skipped | |
| Prolapse | | Dimension skipped | |
| Quality of life | | Dimension skipped | |

| Sex life | | Score (0 - 100) | Impact |
|---|---|---|---|
| Urinary | 0 | | |
| Bowel | 58 | | |
| Vaginal | 0 | | |
| Dyspareunia | 33 | | |
| General sex life | 58 | | |

| Name | Tel | Time |
|---|---|---|
| Anna Smith AS1234 | 078212344 | 14:00 |
| Beryl Jones BJ8765 | 0114 3098909 | 14:10 |
| Connie Lewis CL2345 | 0114 3897890 | 14:20 |
| Diane Cole DC4567 | 07989997654 | 14:30 |
| Edna Rose ER3847 | 07635668234 | 14:49 |
| Fiona Groves FG2783 | 0114 3897890 | 14:50 |
| Greta Holmes GH1783 | 0114 3897890 | 15:00 |
| Heidi Hill HY7896 | 0114 3897890 | 15:10 |
| Ida France TA1256 | 0114 3897890 | 15:20 |
| Joanne Davies JD3456 | 0114 3897890 | 15:30 |
| Kay Somers KS2365 | 07885668234 | 15:40 |
| Lisa Tandy LY5698 | 0757 3897890 | 16:00 |
| Margaret Smith MS3452 | 0114 3897890 | 16:10 |
| Nora Bates NB2344 | 0114 3897890 | 16:20 |
| Orla Charles OC3567 | 07835668234 | 16:30 |
| Penelope Roper PR5702 | 07835668234 | 16:40 |
| Rose Doyle RD5098 | 07835668234 | 16:50 |
| Selena Bird SB8090 | 07835668234 | 17:00 |
| Tina Moores TM3409 | 07835668234 | 17:10 |
| Ursula King PL0987 | 07835668234 | 17:20 |
| Violet Bonnett VB0934 | 07735668239 | 17:30 |

# The Virtual Clinic

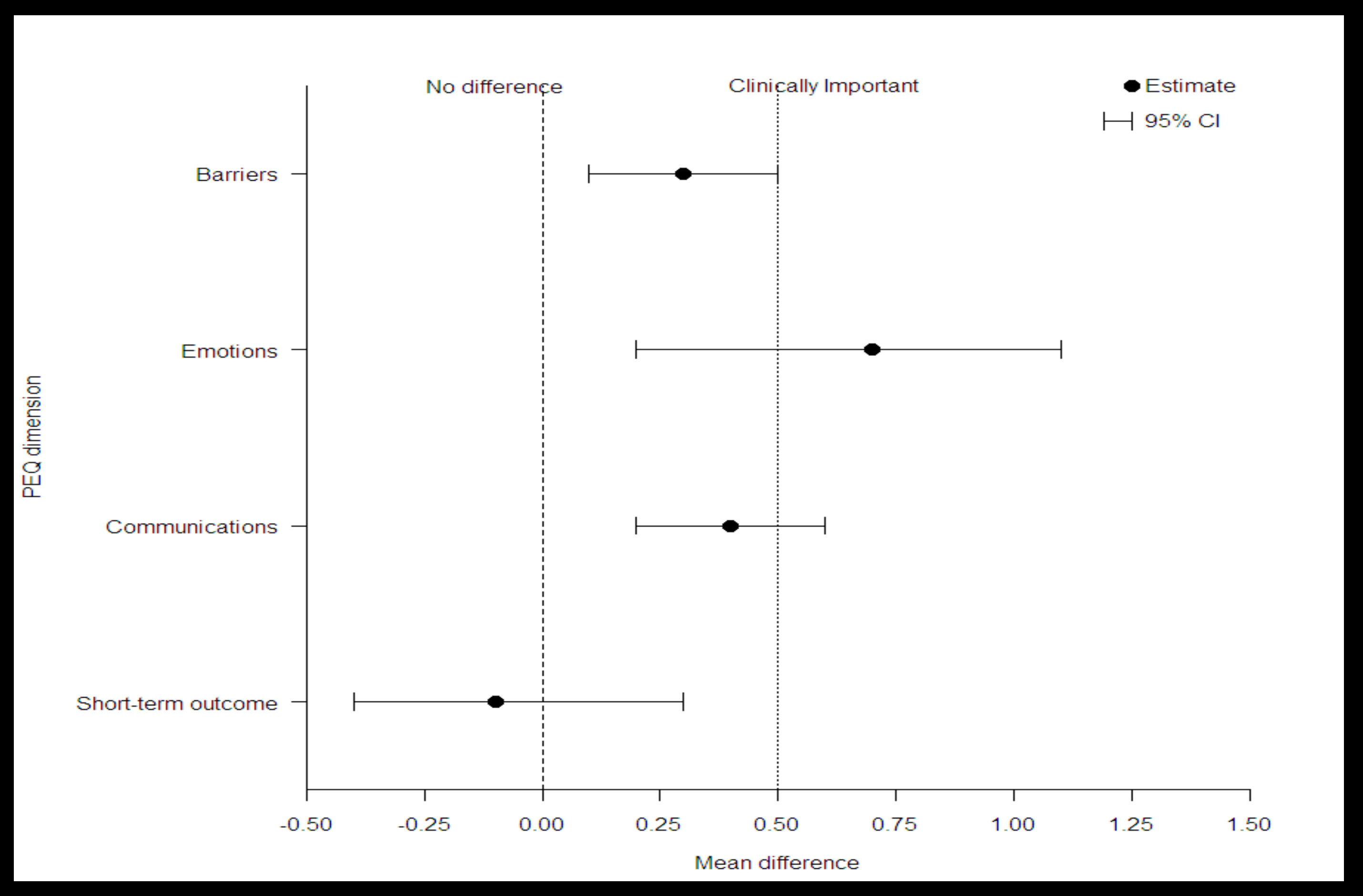


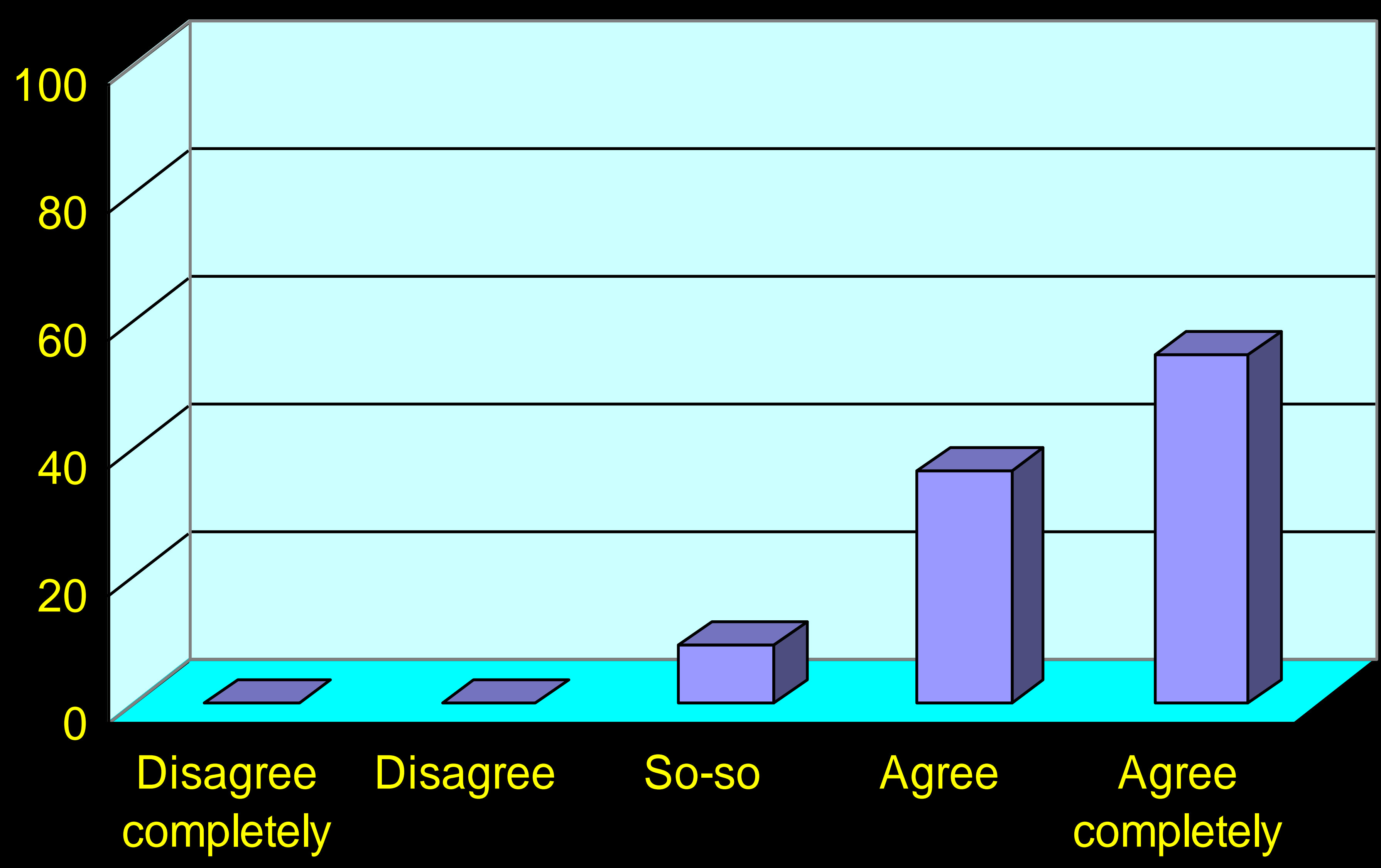
## Evaluating the impact of a ‘virtual clinic’ on the quality and cost of patient care in urogynaecology: An RCT

Jones GL, Radley SR, Jacques RM, Wood HJ, Brennan V, Dixon S.

195 Women: New patient referrals to urogynaecology clinic

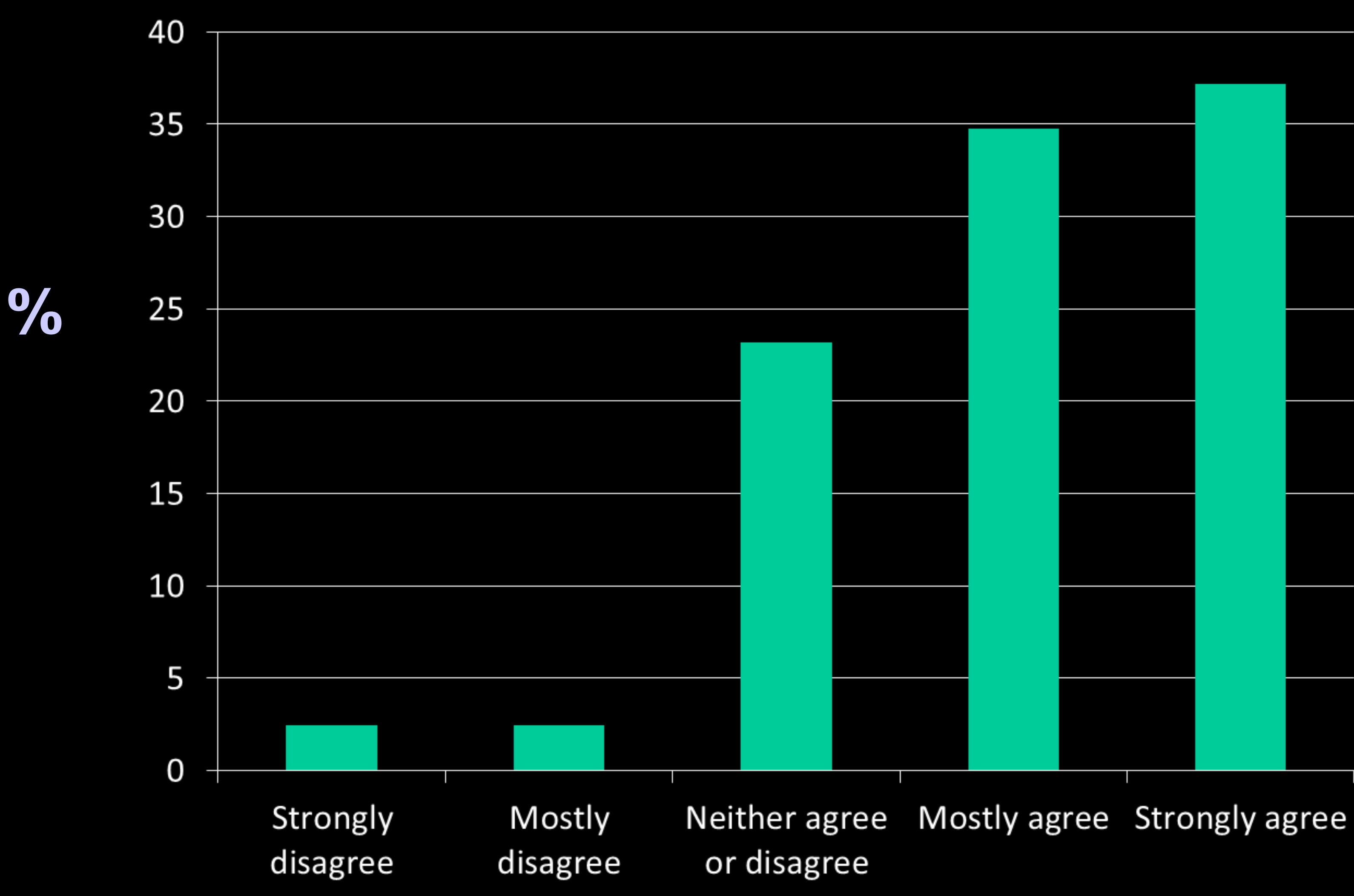
Mean difference between groups (95% CI) for post consultation Patient Experience (PEQ) score





'I felt taken care of'
%
100
80
60
40
20
0
Disagree completely
Disagree
So-so
Agree
Agree completely

# ‘The questionnaire helped with communication’



# Patient comments…

I preferred answering embarrassing questions via the questionnaire

Helped focus on urgent and relevant problem

Made me realise the extent of my problem

Helped talk at ease about my problems

It was really easy to use

**Not having to worry about childcare**

**Not being examined**

# Summary of RCT Findings in Urogynaecology

Virtual Clinic does appear to positively improve patient experience of consultation, particularly communication

Virtual clinics may prove beneficial in overcoming barriers, improving emotional wellbeing and enhancing communication

Significant difference between the duration of consultations (Approx 50% shorter) and associated consultation costs

**Patient selection important factors in cost / benefit**
**<u>Follow-up care</u> & Long-term conditions**
**Patient Initiated Follow-Up (PIFU)**

*Eur J Anaesthesiol* 2016; **33**:1–9

ORIGINAL ARTICLE

# Patient-completed, web-based and preoperative anaesthetic assessment questionnaire (electronic Personal Assessment Questionnaire Preoperative)

*Development and validation*

Iain M. Goodhart, John Andrzejowski, Georgina Jones, Mireille Berthoud, Andy Dennis, Gary Mills and Stephen Radley

Supported by £50,000 Grant from STH Charitable Trustees

# Phase 1: Item generation, content and face validity.

- 30 patients age >18 years
- Completed paper and electronic versions of the questionnaire (Aimed at reading age of 12)
- Structured interview
  - Positive and negative comments analysed
    - ease of use, content, language and relevance.
- Modifications made and ePAQ-PO v2 generated.

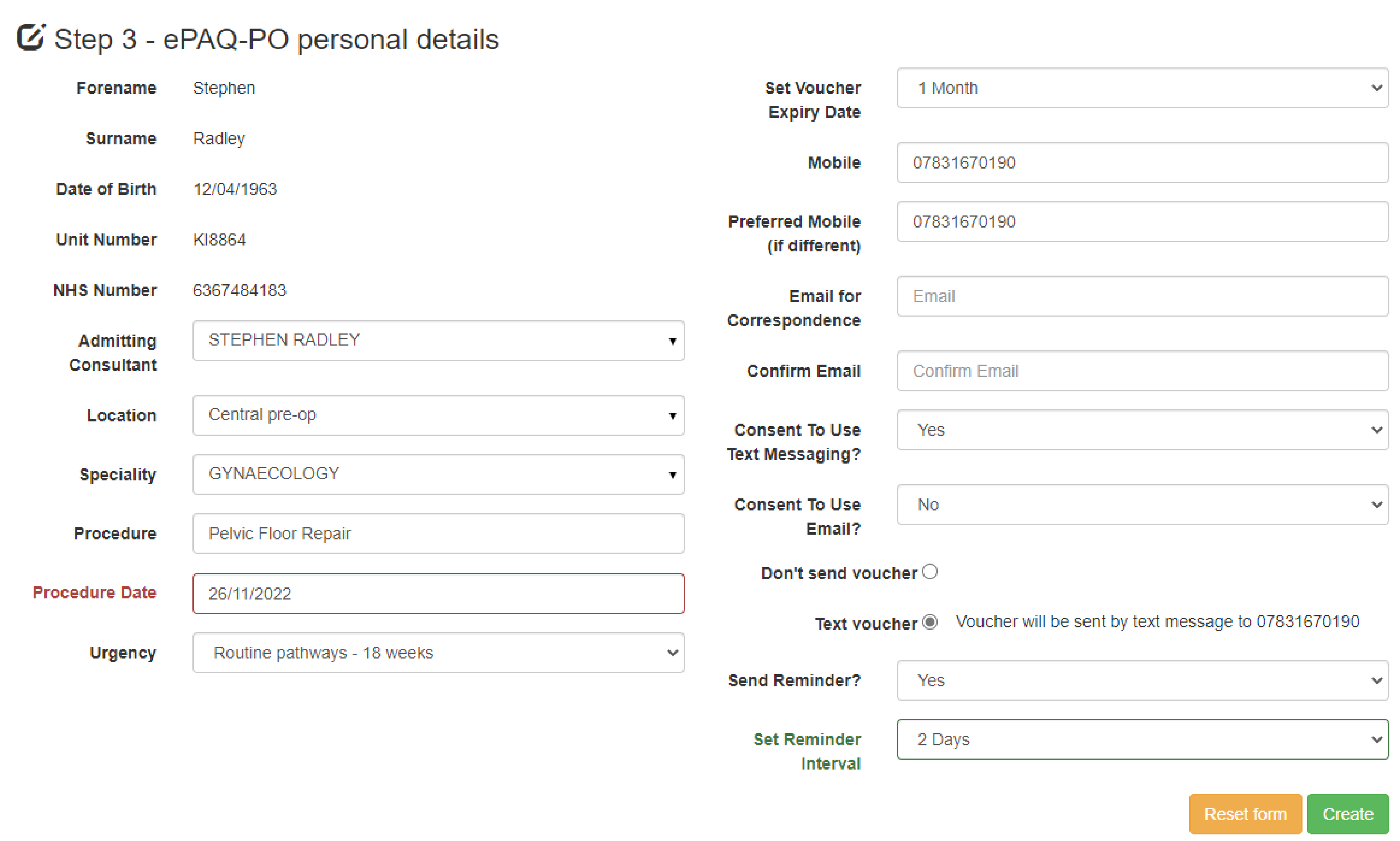
# Phase 2: Validation & Test-Retest

- 300 patients recruited
- Standard face-to-face POA
- Completed ePAQ-POv2 using a touch-screen computer terminal in the research department.
- Retest in 150 patients
- Reliability of items & scoring algorithms:
  - Body Mass Index
  - ASA

# Response to error analysis

- Expert panel considered all questions <95% accurate (POA <0.95)
- Patient Public Involvement event
  - Snoring question and NSAIDs changed
- Responses and feedback from QQ10 and free text data
- Questionnaire modified
- Inclusion of STOPBANG, AUDIT-C scores

# Issuing a voucher
# Staff with personal log-on to PC on HSCN



# Voucher

email
Print
SMS

Your Pre-Operative Assessment

EPAQONLINE, Sth (SHEFFIELD TEACHING HOSPITALS NHS FOUNDATION TRUST) <sth.epaqonline@nhs.net>
To RADLEY, Stephen (SHEFFIELD TEACHING HOSPITALS NHS FOUNDATION TRUST)

Wed 23/11/2022 10:50

**IMPORTANT – PLEASE READ**

Dear **Mr Stephen Radley**,

As part of your pre-operative assessment, you are asked to complete an on-line questionnaire (ePAQ)

Please complete this as soon as you can; **TODAY** if possible. This will take approximately 20 minutes using a computer or mobile device

The Pre-Op team will then send you an appointment to attend for any tests before your admission

We have created a personal voucher for you to use:

**39EC-6BC1-1DC3-4D92**

Go to the web-site **https://start.epaq.co.uk**

Enter your voucher number and your **Date of Birth**

ePAQ is securely linked to the NHS computer system, to which your questionnaire will be safely transferred

If you have any problems completing the questionnaire, please contact the Sheffield Pre-Operative assessment unit on: **0114 2266235**

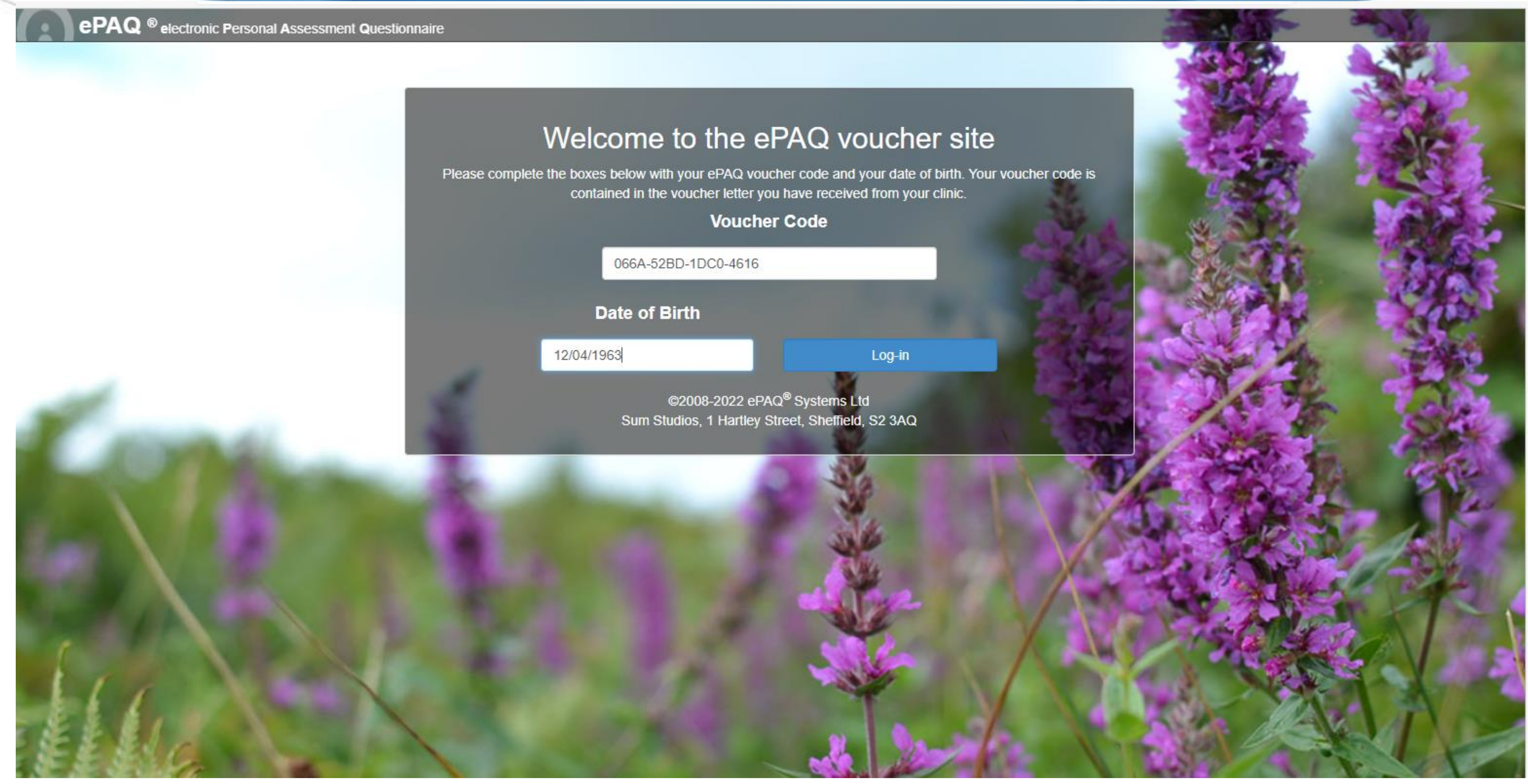
Thank you

Pre-Op Team

Sheffield Teaching Hospitals NHS Foundation Trust

This is a no-reply email; do not reply to this email

# On-line completion



ePAQ ® electronic Personal Assessment Questionnaire

### Pelvic Floor questionnaire

This questionnaire is designed to assess any problems you may have with your pelvic floor

Welcome to your ePAQ questionnaire. You should find the questionnaire simple and easy to use; it will take approximately 15 – 20 minutes to complete. If you wish to view a short tutorial, click the 'Tutorial' button.

By completing this questionnaire, you will be consenting to digital data collection on behalf of your healthcare provider and accepting the terms of our Privacy Notice, which you can access here..

The questionnaire will ask you to confirm your consent before starting to answer any further questions. On completion of the questionnaire, you will also be asked whether or not you are willing to give your consent for use of your data and information for non-clinical purposes, including approved research, service evaluation and audit projects carried out under the rules and regulations set out by your healthcare provider, current UK law and Data Protection Regulations currently in force in relation to these activities.

Your data, personal information and questionnaire answers will be treated confidentially at all times. You have the right to request access to your healthcare record, of which this questionnaire may form a part. You also have the right to request that your questionnaire be deleted or erased from your healthcare record at any point in the future.

**Please access this Privacy Notice** here

YES Start Questionnaire

**Would you like to view a tutorial?**

Click the button to view the tutorial - you will be taken back here once you have completed this.

Tutorial

Completion of this questionnaire is entirely voluntary. Data collected from this questionnaire will form part of your clinical record. The questionnaire is provided for you to help with your personal assessment, to help with communication and understanding of your health, your personal circumstances and needs. The questionnaire includes questions about any symptoms, conditions or concerns you may have. Your personal data and any answers you give will be treated in strictest confidence.

Your data will be treated in accordance with the UK General Data Protection Regulation (GDPR 2018).

Are you willing to complete this questionnaire?

Yes No

Previous Help Skip Next

Think about any disability you may have, for example impaired mobility or a condition that means you need extra help or support in everyday life…

Do you have any disability that limits how active you are or your ability to care for yourself?

- No
- Yes - Disability that does not impair day to day living
- Yes - Disability that moderately impairs my daily activities
- Yes - Severe disability seriously affecting daily life

Please describe your disability

Previous | Help | Skip | Next

ns may be skipped automatically)

planted electrical devices, such as a pacemaker, defibrillator, pump or other implanted device...

Do you have a heart pacemaker, defibrillator or other implanted electrical device?

No | Yes | Don't know

Has your pacemaker or defibrillator been checked in the last 12 months?

Yes | No

s | Help | Skip | Nex

Think about your drinking of alcohol over the last year…

How often have you had six or more drinks on one occasion in the last year?

Never | Less than monthly | Monthly | Weekly | Daily or almost daily

Are you able to go for a day or more without drinking any alcohol?

Yes | No

Previous | Help | Skip | Next

Think about smoking... Do you smoke? Include cigarettes, cigars or pipe smoking as well as any drugs such as cannabis. Do not include vaping.

What is your smoking status?

Never smoked | Ex-smoker | Light-smoker (less than 10 a day) | Moderate smoker (10 - 19 a day) | Heavy smoker (20 or more a day)

When did you quit smoking?

More than a year ago | Between 2 months to a year ago | Less than 2 months ago

Previous | Help | Skip | Next

Think about rheumatological or auto-immune conditions…

Have you been diagnosed as having any of the following conditions? (Click all that apply)

None of these | Rheumatoid arthritis (RA) | Systemic lupus (SLE) | Inflammatory bowel disease | Scleroderma | Other autoimmune disease

How much does this affect your life?

Not at all | A little | Moderately | Severely

Previous | Help | Skip | Next

Friends & family question

Any comments or answers you give to this question will not be shown or included in your questionnaire report. Your comments may be used to help evaluate the service provided for you and will be treated anonymously and in strictest confidence. Thinking about the ward or department where you have been seen or treated.

How likely are you to recommend the clinic, ward or department where you have been most recently seen or treated to friends and family if they needed similar care or treatment?

Extremely likely | Likely | Neither likely nor unlikely | Unlikely | Extremely unlikely | Don't know

Please use your own words to explain the answer you have given

Staff on the ward were very kind and helpful
Surgery has changed my life thank you!
Telephone follow up is very helpful for me

Previous | Help | Skip | Next

# GDPR: Dual Consent

**Initial consent** (prior to starting ePAQ)

Completion of this questionnaire is entirely voluntary. Data collected from this questionnaire will form part of your clinical record. The questionnaire is provided for you to help with your personal assessment, to help with communication and understanding of your health, your personal circumstances and needs. The questionnaire includes questions about any symptoms, conditions or concerns you may have. Your personal data and any answers you give will be treated in strictest confidence.

Your data will be treated in accordance with the UK General Data Protection Regulation (GDPR 2018).
Are you willing to complete this questionnaire?

Yes No

**Final consent** (on completing ePAQ)

D10 Final question
Consent
This is the final item of the questionnaire
The answers you have given may be useful in assessing the quality of the service that is provided, health issues, conditions and their treatment.
We seek your permission to use your data confidentially and anonymously in order to do this

Are you willing to allow confidential use of your answers to this questionnaire for appropriately approved and regulated research, audit or service evaluation projects?

Yes No

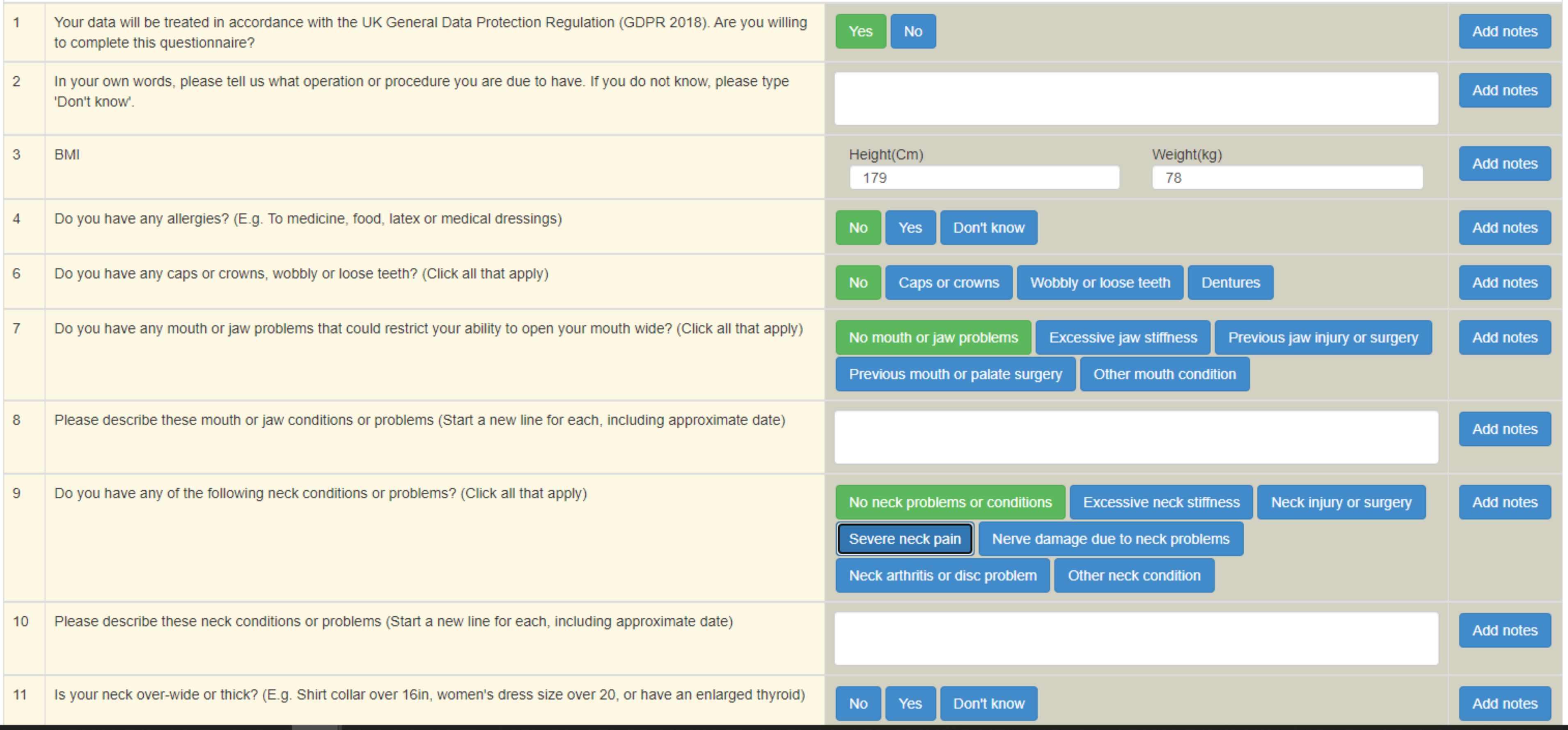
# NHS ‘Friends & Family’ data

| Would you recommend this service to Friends & Family?<br>2 year data – Follow up patients | N | % |
|---|---|---|
| Extremely likely | 445 | 66 |
| Likely | 173 | 26 |
| Neither likely nor unlikely | 35 | 5 |
| Unlikely | 7 | 1 |
| Extremely unlikely | 12 | 2 |
| Total | 672 | |
| | | |
| | | |
| ‘Likely’ or ‘Extremely likely’ | | 92 |

# ‘Friends & Family’ data

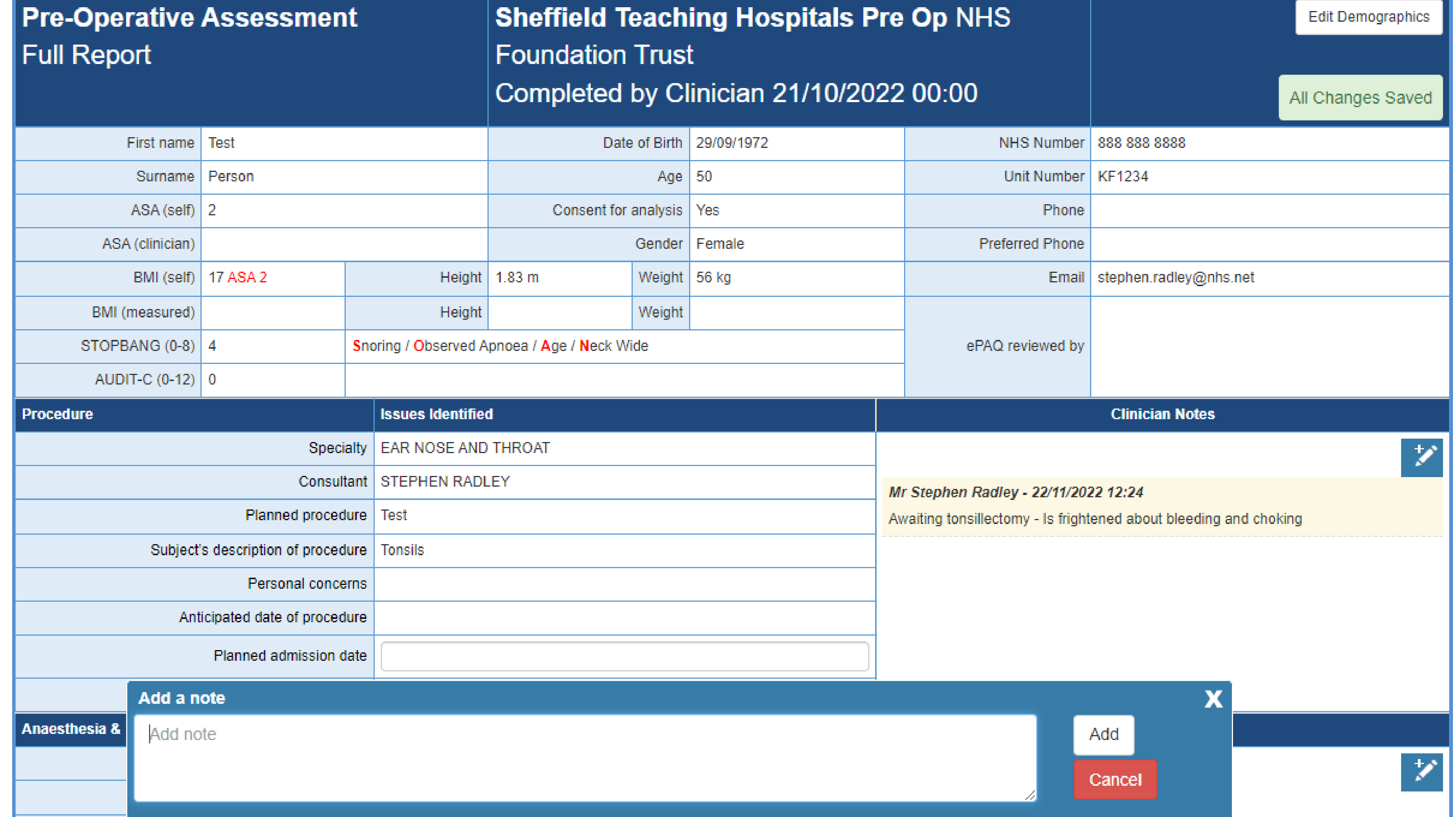
| Would you recommend this service to Friends & Family?<br>2 year data – Follow up patients | N | % |
|---|---|---|
| Extremely likely | 445 | 66 |
| Likely | 173 | 26 |
| Neither likely nor unlikely | 35 | 5 |
| Unlikely | 7 | 1 |
| Extremely unlikely | 12 | 2 |
| Total | 672 | |
| | | |
| | | |
| ‘Likely’ or ‘Extremely likely’ | | 92 |

# Clinician Completion



| | | | |
|---|---|---|---|
| 1 | Your data will be treated in accordance with the UK General Data Protection Regulation (GDPR 2018). Are you willing to complete this questionnaire? | Yes No | Add notes |
| 2 | In your own words, please tell us what operation or procedure you are due to have. If you do not know, please type 'Don't know'. | | Add notes |
| 3 | BMI | Height(Cm) 179 Weight(kg) 78 | Add notes |
| 4 | Do you have any allergies? (E.g. To medicine, food, latex or medical dressings) | No Yes Don't know | Add notes |
| 6 | Do you have any caps or crowns, wobbly or loose teeth? (Click all that apply) | No Caps or crowns Wobbly or loose teeth Dentures | Add notes |
| 7 | Do you have any mouth or jaw problems that could restrict your ability to open your mouth wide? (Click all that apply) | No mouth or jaw problems Excessive jaw stiffness Previous jaw injury or surgery Previous mouth or palate surgery Other mouth condition | Add notes |
| 8 | Please describe these mouth or jaw conditions or problems (Start a new line for each, including approximate date) | | Add notes |
| 9 | Do you have any of the following neck conditions or problems? (Click all that apply) | No neck problems or conditions Excessive neck stiffness Neck injury or surgery Severe neck pain Nerve damage due to neck problems Neck arthritis or disc problem Other neck condition | Add notes |
| 10 | Please describe these neck conditions or problems (Start a new line for each, including approximate date) | | Add notes |
| 11 | Is your neck over-wide or thick? (E.g. Shirt collar over 16in, women's dress size over 20, or have an enlarged thyroid) | No Yes Don't know | Add notes |

# Full Report



RESEARCH ARTICLE

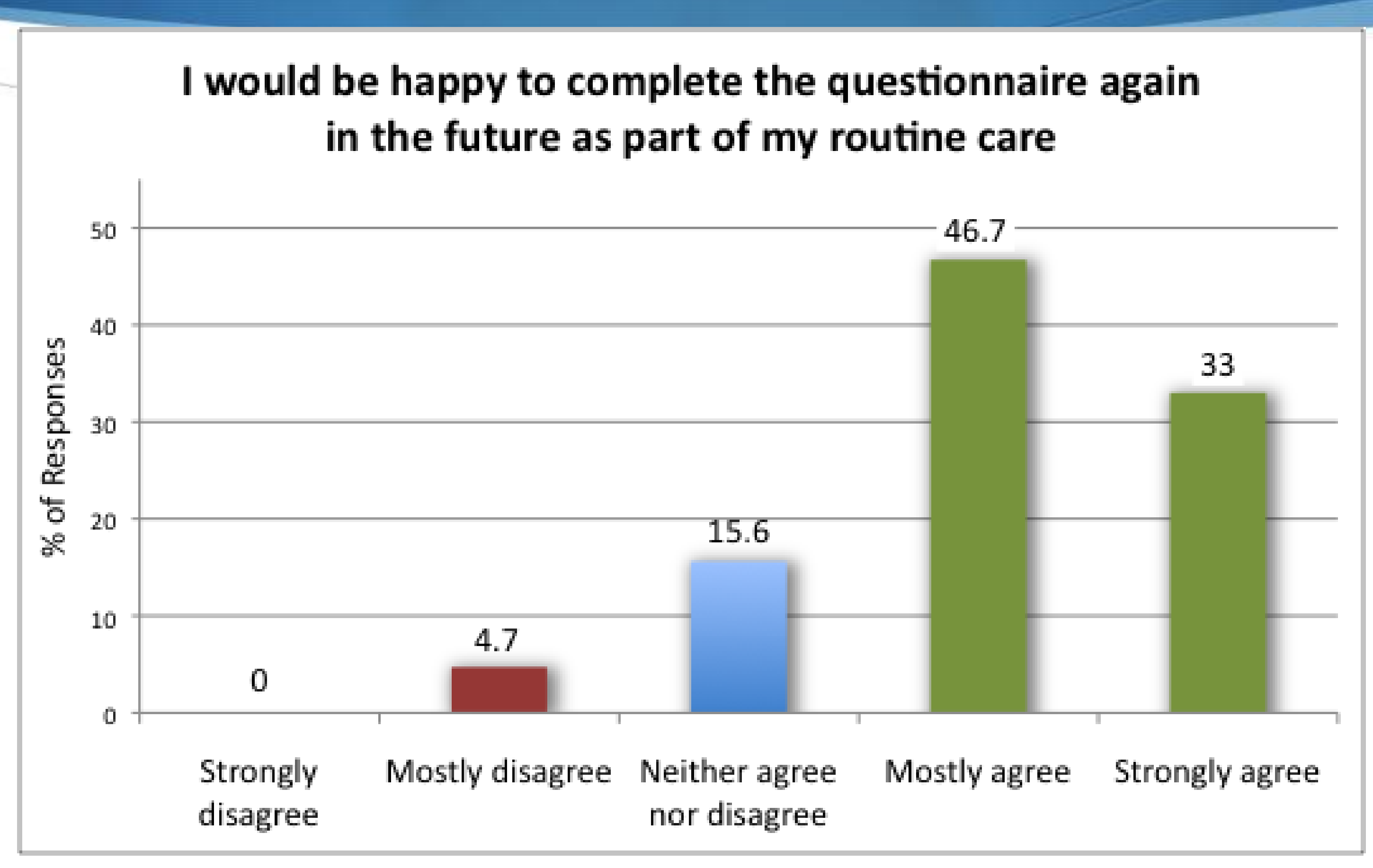
# A prospective observational study of the impact of an electronic questionnaire (ePAQ-PO) on the duration of nurse-led pre-operative assessment and patient satisfaction

**Sarah K. Taylor[1], John C. Andrzejowski[2]*, Matthew D. Wiles[2], Sarah Bland[3], Georgina L. Jones[4], Stephen C. Radley[5]**

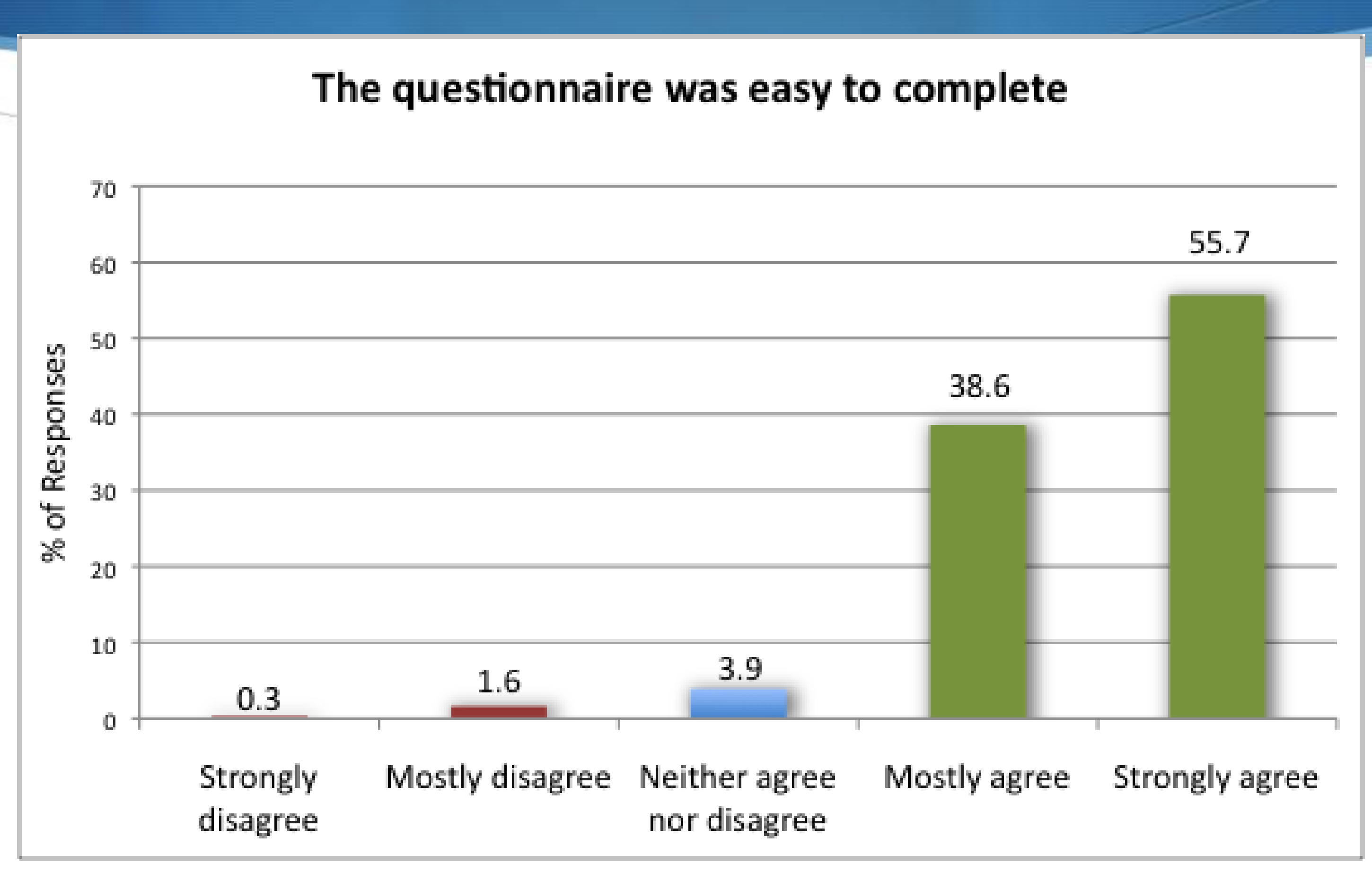
**1** University of Sheffield, Sheffield, United Kingdom, **2** Department of Anaesthesia, Sheffield Teaching Hospitals NHS Foundation Trust, Sheffield, United Kingdom, **3** Pre-operative Assessment, Sheffield Teaching Hospitals NHS Foundation Trust, Sheffield, United Kingdom, **4** Leeds Beckett University, Leeds, United Kingdom, **5** Department of Obstetrics and Gynaecology, Sheffield Teaching Hospitals NHS Foundation Trust, Sheffield, United Kingdom

* john.andrzejowski@sth.nhs.uk

# I would be happy to complete the questionnaire again…



# Patient Experience: QQ-10
# The questionnaire was easy to complete



# Findings of observational study

Table 1. **Demographic data and results for standard vs ePAQ-PO groups.** Times are median (IQR [min-max]) values. Adjusted consultation time = measured consultation time—examination time.

| | Standard | ePAQ-PO | p value |
|---|---|---|---|
| Number of patients | 43 | 43 | |
| Males | 18 | 21 | |
| Females | 25 | 22 | |
| ASA 1 | 5 | 17 | |
| ASA 2 | 38 | 26 | |
| Mean (SD) age in years | 45 (14) | 42 (12) | 0.18 |
| Consultation time (mins) | 29 (22–37 [14–53]) | 12 (8–17 [4–45]) | <0.001 |
| Examination time (mins) | 4 (3–5 [2–10]) | 0 | <0.001 |
| Adjusted consultation time (mins) | 25 (18–33 [10–49]) | 12 (8–17 [4–45]) | <0.001 |

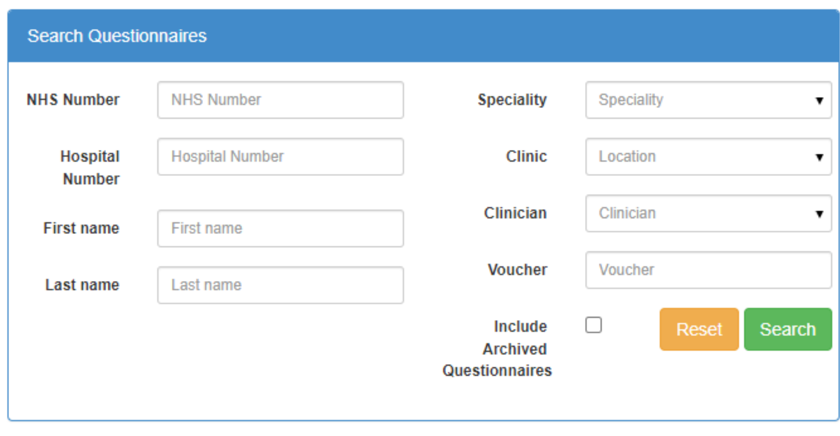
## Conclusion

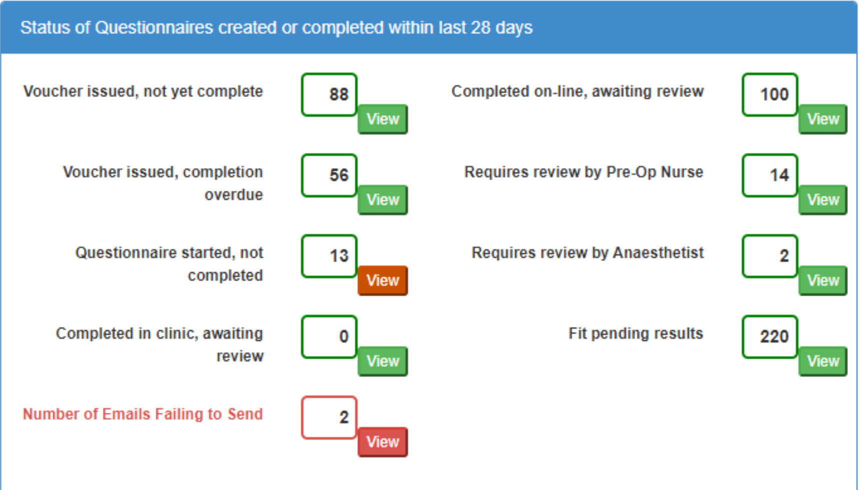
Pre-operative assessment using ePAQ-PO is associated with a significant reduction of over 50% in the duration of the assessment without impacting on patient satisfaction.

# Walk-in Pre-Op Assessment

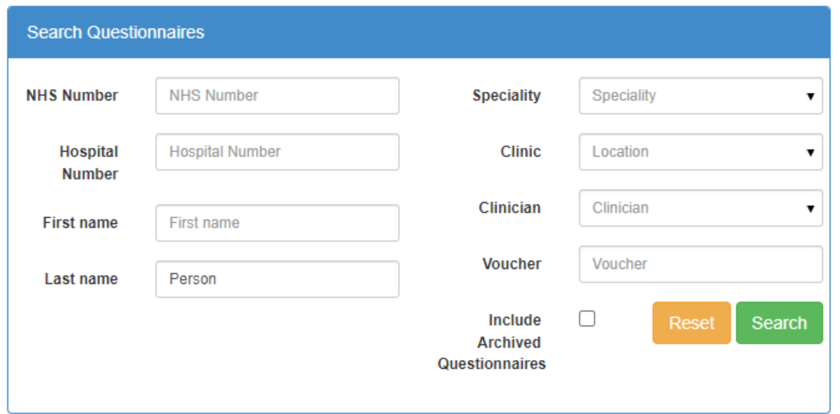
- 2 sites (NGH & RHH)
- 12 touchscreens
- Support Worker
- POA Nurse
- 5 day service
- 8,000 patients…

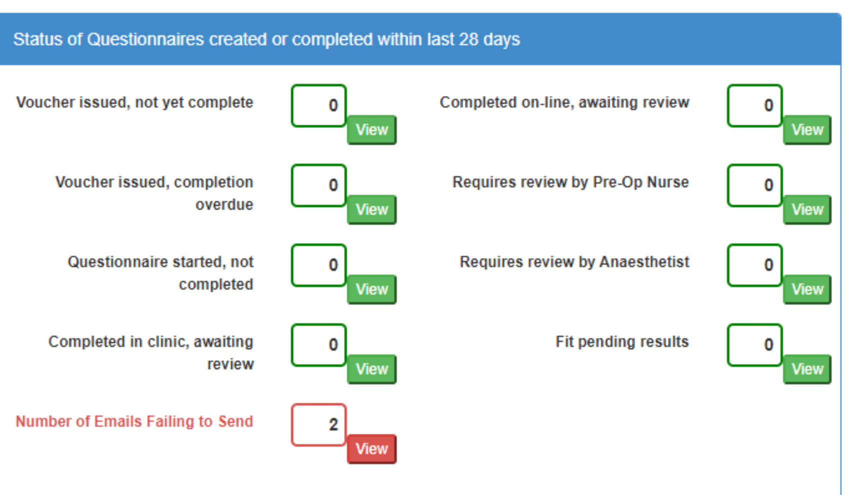
# Dashboard




# Dashboard




| | Name | Hospital Number | NHS Number | Date of Birth | Questionnaire Status | Report |
|---|---|---|---|---|---|---|
| | Mr Test Person | AA0000 | 098 765 4321 | 12/04/1963 | Completed in clinic 21/10/2022, awaiting review Review | PDF - Full Summary PDF - Summary |
| | Ms Test Person | KF1234 | 888 888 8888 | 29/09/1972 | Completed in clinic 21/10/2022, awaiting review Review | PDF - Full Summary PDF - Summary |

# Summary Report

## Pre-Operative Assessment Summary Report

**Sheffield Teaching Hospitals NHS Foundation Trust**
Completed On-Line 21/06/2022

| First name | Test | | Date of Birth | | 12/04/1963 | NHS Number | 0987654321 |
|---|---|---|---|---|---|---|---|
| Surname | Person | | Age | | 59 | Unit Number | AA0000 |
| ASA (self) | 3 | | Consent for analysis | | Yes | Phone | 07831670190 |
| ASA (clinician) | | | Gender | | Male | Preferred Phone | |
| BMI (self) | 39 | Height | 1.78 m | Weight | 123 kg | Email | stephen.radley@nhs.net |
| BMI (measured) | | Height | | Weight | | ePAQ reviewed by | Mr Stephen Radley : 21-06-2022 13:11 |
| STOPBANG (0-8) | 3 | BMI > 35 / Age / Gender Male | | | | | |
| AUDIT-C (0-12) | 0 | | | | | | |

| Procedure | | Clinician Notes |
|---|---|---|
| Specialty | GYNAECOLOGY | *Stephen Radley- 21/06/2022 13:09* |
| Consultant | STEPHEN RADLEY | |
| Planned procedure | TBC | |
| Subject's description of procedure | Hernia | |
| Personal concerns | | |
| Anticipated date of procedure | 21/09/2021 | |
| Planned admission date | | |
| Urgency | | |

| Anaesthesia & Surgery | Issues Identified | Clinician Notes |
|---|---|---|
| Previous anaesthetics | (*6) | *Mr Stephen Radley 21/06/2022 13:12*<br>(*6) Clinician Amendment: actually had GA for CS 2 years ago |

| Treatments & Medications | Issues Identified | Clinician Notes |
|---|---|---|
| Detail | Paracetamol<br>Aspirin<br>(*1)(*4)(*5) | |
| Detail | St Johns Wort<br>(*2) | |
| Allergy | No Issues | |
| Cardiovascular | No Issues | |
| Fitness | No Issues | |

| Airway | Issues Identified | Clinician Notes |
|---|---|---|
| Mouth problems | Mouth or palate surgery | |
| Neck problems | Severe neck pain<br>Neck arthritis or disc problem ASA 2 | |
| Respiratory | No Issues | |
| General Health | No Issues | |
| Hepatic | No Issues | |
| Renal | No Issues | |
| Gastro | No Issues | |
| Endocrine | No Issues | |
| Haematology | No Issues | |
| Neurology | No Issues | |
| Infection | No Issues | |

### Observations

| Pulse | | 1st BP | | 2nd BP | | O2 Sats | |
|---|---|---|---|---|---|---|---|
| ASA Score | | Weight | | Height | | BMI | |
| Urinalysis | | | | | | | |

**Teeth**
C = Cap or crown
M = Missing
X = Chipped
L = Loose

| R | 8 | 7 | 6 | 5 | 4 | 3 | 2 | 1 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | L |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | C | C | | | | | | | | | | | |
| | | | | | C | | | | | | | | | | | | |
| | 8 | 7 | 6 | 5 | 4 | 3 | 2 | 1 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | |

| Physical Examination | Issue | Clinician Notes |
|---|---|---|
| Mallampatti score | 1 | |

| Investigations | Ordered | Reviewed | Clinician Notes |
|---|---|---|---|
| FBC | ✓ | | *Mr Stephen Radley- 21/06/2022 13:13*<br>note |
| U and E | ✓ | | |
| Clotting INR | ✓ | | |
| Increased DVT Risk | No | Yes | |

| Items Discussed |
|---|
| |

| Pre-Op Plan | | Clinician Notes |
|---|---|---|
| Day case | ✓ | |
| Preferred anaesthetic | Spinal | |
| Admit how many day(s) prior to surgery | 0 | |

| Pre-Operative Assessment Status | | | Clinician Notes |
|---|---|---|---|
| ePAQ reviewed, requires further ePAQ review | | | *Mr Stephen Radley - 21/06/2022 13:11*<br>discussed stopping aspirin |
| Patient requires review by PO nurse | | | |
| Patient requires review by Anaesthestist | ✓ | | |
| Fit pending results | | | |

| Signatures | | | | | |
|---|---|---|---|---|---|
| *Signature* | *Digitally signed* | *Name* | *Mr Stephen Radley* | *Date* | *21-06-2022 13:11* |

| Summary Report | | Completed On-Line 21/06/2022 | | | | | |
|---|---|---|---|---|---|---|---|
| First name | Test | | Date of Birth | | 12/04/1963 | NHS Number | 0987654321 |
| Surname | Person | | Age | | 59 | Unit Number | AA0000 |
| ASA (self) | 3 | | Consent for analysis | | Yes | Phone | 07831670190 |
| ASA (clinician) | | | Gender | | Male | Preferred Phone | |
| BMI (self) | 39 | Height | 1.78 m | Weight | 123 kg | Email | stephen.radley@nhs.net |
| BMI (measured) | | Height | | Weight | | ePAQ reviewed by | Mr Stephen Radley : 21-06-2022 13:11 |
| STOPBANG (0-8) | 3 | BMI > 35 / Age / Gender Male | | | | | |
| AUDIT-C (0-12) | 0 | | | | | | |

| Procedure | | Clinician Notes |
|---|---|---|
| Specialty | GYNAECOLOGY | ***Stephen Radley- 21/06/2022 13:09*** |
| Consultant | STEPHEN RADLEY | |
| Planned procedure | TBC | |
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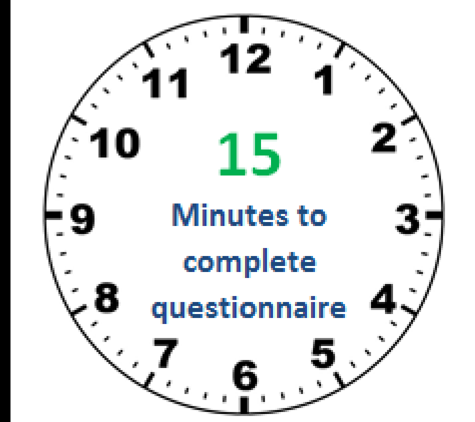
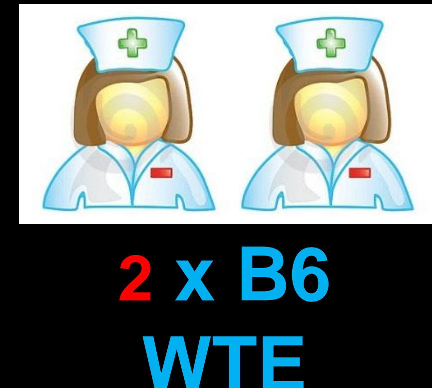
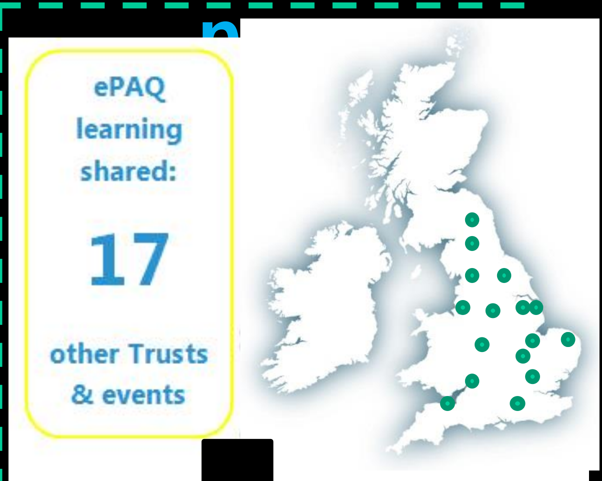
| Personal concerns | | |
| Anticipated date of procedure | 21/09/2021 | |
| Planned admission date | | |
| Urgency | | |

# Number of patients completing ePAQ-PO

# Summary of 1st year: ePAQ-PO @ STH…






12 SURGICAL SPECIALTIES USE ePAQ

# Before, During and Now

## Sites at Royal Hallamshire Hospital / Northern General

- Patients walked round
- Multiple paper and electronic systems (Paper forms and ePAQ)
- Face to Face service, supported by written information

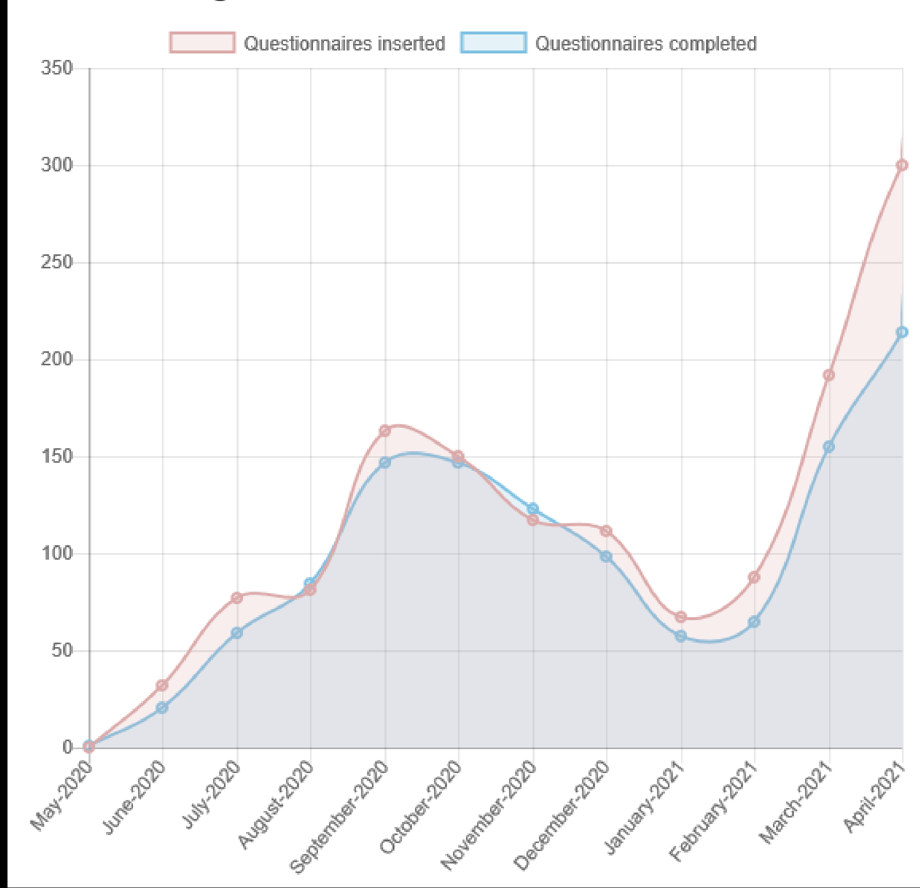
## No face to face services

- Essential services maintained by virtual and limited consultations
- Staff re-deployed
- Limited activity

## Moved sites, reorganised services, most things changed

- Single central site
- Multiple changes to elective pathways, some things improved…

# During COVID
# Pre-Op Assessment using ePAQ-PO




| Month | Questionnaires inserted | Questionnaires completed |
|---|---|---|
| May-2021 | 349 | 287 |
| April-2021 | 300 | 214 |
| March-2021 | 192 | 155 |
| February-2021 | 88 | 65 |
| January-2021 | 67 | 57 |
| December-2020 | 111 | 98 |
| November-2020 | 117 | 123 |
| October-2020 | 150 | 147 |
| September-2020 | 163 | 147 |
| August-2020 | 81 | 84 |
| July-2020 | 77 | 59 |
| June-2020 | 32 | 20 |
| May-2020 | 0 | 1 |

November 2022 400

# ePAQ-PO - changes in response COVID 19

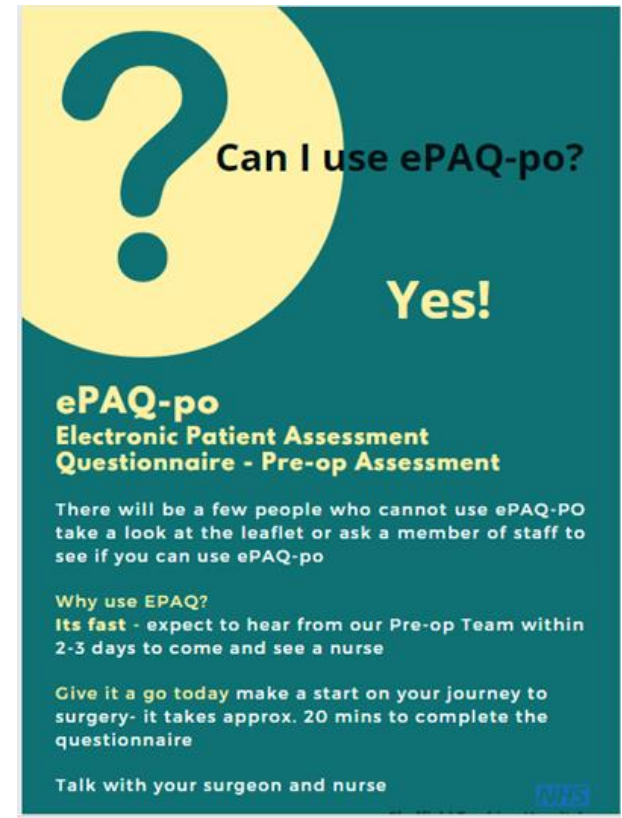
- From July 2020 adapted ePAQ-PO to *ePAQ-PO (anywhere)* for patients to complete at home, supporting virtual outpatient appointments

- Vouchers for ePAQ-PO issued via email

  (now SMS)

- Refined criteria to use by the right patients

  (ASA1 & 2)



# The process now:

- Waiting list coordinator: Patients voucher email or SMS to complete ePAQ on smartphone, tablet, laptop or PC within 24 hrs.
- Using ePAQ dashboard Pre Op Staff Nurses monitor when patients have completed their questionnaire.
- Pre-op visit: Swabs, Bloods, BP

Complete ePAQ: Same day

Review information

Attend Pre-op Assessment

Await surgery

# Next steps

- **Work with specialties: Increase ePAQ numbers: *"Make it easy"* (all stakeholders)**
- **Review patient information & resources**
- **Updates to instrument & management system**
- **Integration: SMS & API to EPR**
- **Re-assess 'rePAQ' – enable patients to wait well, improve efficiency, reduce burden & repetition**

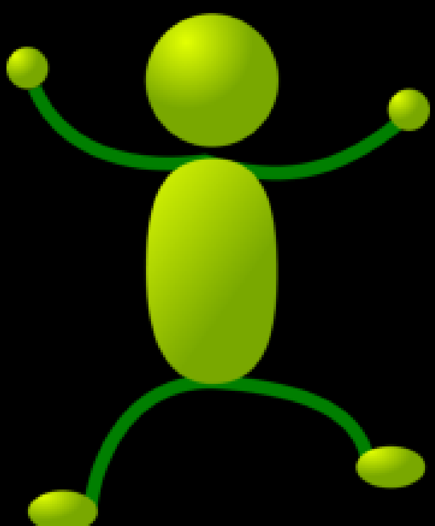
# Key learning:

| | |
|---|---|
| Engagement with all Stakeholders | Regular meetings<br>Visible metrics that matter<br>Clinical & managerial champions |
| Responsive support | Improvement engages people motivates capability to tackle strategic challenges. Shared purpose |
| Adaptation | No one size fits all – different contexts need different approaches |
| Integration | New & existing systems, PAS, EPR |

# Conclusion…

e-assessments **will** be used routinely in healthcare:

Patients will be…



| | |
|---|---|
| Prepared | Optimal communication |
| Informed | Making best decisions |
| Engaged | Responsible |
| Empowered | Right place, right time |

# Web-based assessment

## Supporting patient-centred, effective & efficient healthcare

Communication
Assessment
Diagnosis
Decision-making
Monitoring

Quality

Efficiency

Standardisation
Clinical governance
Appraisal,  revalidation, accreditation
Research, Audit, Service evaluation

# Thank you

**stephen.radley@nhs.net**

**sarah.bland8@nhs.net**

- Impact of an electronic pre-operative assessment questionnaire (ePAQ-PO) on consultation length and patient satisfaction. Taylor S, Andrzejowski J, Radley S, Jones G, Wiles. British Journal of Anaesthesia Research Forum/ARS 5th April 2017

- Patient-completed, preoperative web-based anaesthetic assessment questionnaire (electronic Personal Assessment Questionnaire Pre-Operative) Development and validation. Goodhart IM, Andrzejowski JC, Jones GL, Berthoud M, Dennis A, Gary Mills G, Radley SC. Eur J Anaesthesiol 2016; 33:1–8

- An evaluation of factors influencing the assessment time in a nurse practitioner-led anaesthetic pre-operative assessment clinic. Hawes R, Andrzejowski J, Goodhart I, Berthoud M, Wiles M. Anaesthesia 2015.

- Electronic Personal Assessment Questionnaire Pre-Operative: Patient experience and face validity of an interactive, electronic questionnaire for the preoperative assessment of patients due to undergo general anaesthesia: Goodhart I, Andrzejowski J, Berthoud M et al. British Journal of Anaesthesia 2012; 109: 655- 668

- How valid are patient-reported height and weight using an interactive computerised pre-operative assessment questionnaire (ePAQ-PO)? Andrzejowski, JC. Goodhart, IM ; Berthoud, M ; Radley, SC; Hawes, RH. British Journal Of Anaesthesia, 2013 May, Vol.110(5), pp.861-861

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## The NHS Elective Care Conference:
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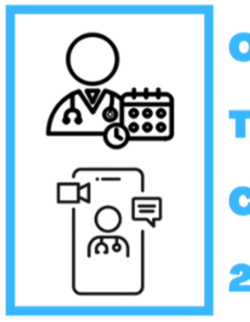

Outpatient Transformation Conference 2022