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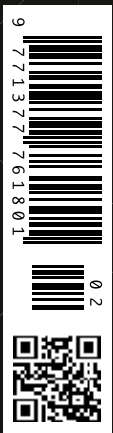
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Award-winning new doctors' assistants freeing time in acute NHS hospitals

Pilot reduces doctor overtime and improves efficiency

Developing staff as doctors' assistants from HealthCare assistants in acute National Health Service (NHS) hospitals is safe, efficient, high value and improves patient care.



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There is a crisis in the UK NHS, with reductions in doctors' working hours and a relentless increase in numbers and complexity of patients (HEE, 2017). Other reports catalogue that doctors in training posts spend half their time on administrative work (RCS, 2016), dominated by repetitive and menial tasks (Morrow, 2012), with 99 percent in posts which fail standards for educational opportunities (ASiT/BOTA, 2017), morale is low (GMC, 2016) and there are excessive vacant posts - an average of 9.6 percent vacancies in hospital doctor posts (HEE, 2017).

The workforce challenges, including vacancies of doctors, mean lengthy waiting times for patients in busy acute hospitals for essential tests, treatments or discharge paperwork, across seven-day services.

In the UK NHS, most staff are on pay bands of 'Agenda for Change'; Band 5 is typically for a Staff Nurse on qualification or similar degree-level staff who often have Registration with a national body; Bands 6, 7, 8a and 8b signify progressively more autonomous clinical or managerial roles with additional training, expertise and salary (NHS employers, 2017). There are many good initiatives to develop Registered autonomous staff into Practitioner level (Band 6, 7 or 8a) (HEE, 2017). Developing practitioners can be perceived as expensive and competing with doctors for training and complex tasks (Matthews, 2017) not always fulfilling the local need (Bruce et al, 2016) and depleting other staff groups. Even Band 4 roles have been criticised for excess autonomy (Bodkin, 2016). Conversely, there are very few NHS clinical roles at Band 3, an assistant

role, with minimal autonomy and no requirement for registration. The Carter review (2016) and NAO (2017) recommend sustainable development of local staff, which our development of Band 2 into Band 3 staff aims to deliver.

We report a project developing a new NHS role of doctors' assistant at Band 3 (£18,000 mid-point + on-costs) and its progress through planning, successful six-month pilot, evaluation, business case development and dissemination.

“ AT BASELINE, DOCTORS' LOGS SHOWED 44 PERCENT TIME DOING ADMIN ”

Methods

We undertook a six-month pilot of appointing/developing six doctors' assistants at pay Band 3 from our existing healthcare assistants, initially through a process of secondment. Initial work with a wider group of clinicians, the Education team and managers identified key delegable tasks traditionally done by ward/training/on-call doctors (cannulation, dementia screening, drafting discharge summaries, venepuncture, writing in notes, finding test results and taking requests) and devised a two-week induction course. We created robust processes, including recruitment process, pre-reading dossier, two-week induction, communication strategy, rotas, uniform and weekly tutorials. We worked across departments (initially Clinical Education, finance, IT, Medicine, Surgery



Doctors' Assistants and team at East Sussex Healthcare NHS Trust

and Cardiology; later rolled out to Orthopaedics and Urology). We acknowledge learning from other pioneers (Brighton and Southampton) (Kause, 2016).

NHS Health Research Authority approval/ethics (ref 215636: REC ref17/HRS/0019) was obtained through Proportionate Review. This was an Action Research project. Quantitative data included recordings of times and activities of doctors at baseline. Similar data were collected pro-actively from doctors' assistants time sheets. Routinely collected Trust data were scrutinised. Feedback was sought from staff. Qualitative data were analysed thematically.

We prioritised communication with stakeholders including hospital staff, GPs and patients. Fears over 'dumbing down' were ameliorated with our 'no-involvement-with-medication' rule. We listened and responded to feedback (eg business cards listing tasks/bleeps, targeting teaching, checklists, ward round trolleys, etc). We had articles in internal and local press and attended team and individual meetings.

Results

At baseline, doctors' logs showed 44 percent time doing admin. 78 percent of exception reports

(overtime from junior doctor contract) were for tasks that could be delegated. Doctors reported 88 percent greater likelihood of attending teaching/operating sessions if a doctors' assistant was present.

Qualitative assessments demonstrated pride, support and very positive feedback from all grades of staff. Three themes identified as vital for success were: supportive line management, communication with stakeholders and defining role boundaries (eg no contact with medication to reduce perceived risk).

The doctors' assistants were especially useful at evenings, weekends and bank holidays, when there are fewer doctors, with multiple instances of improved care or improved patient flow. For elective wards 8am-6pm Monday-Saturday worked better than long shifts.

Our new curriculum was very clear on the skills expected and the level of knowledge and attitudes required. We also involved the doctors' assistants in other initiatives: this included additional workshops on 'Making Every Contact Count' so they were empowered to discuss general health with patients; induction included sessions on behaviours, to identify behaviour that could be perceived as bullying and to have a way of dealing with this. These aspects of



Doctors' Assistant team winning Skills For Health award

culture change merit future development.

The project proved cost-effective. Doctors' overtime reduced 80 percent comparing a week with and without a doctors' assistant. The new Junior doctor contract allows for overtime to be paid if 'exception reports' are completed with a total cost including fines of £24-£85 per hour. Exception reports in Urology fell from £195/week to £0/week and in Orthopaedics from £197/week to £24/week with doctors' assistants present, but a simultaneous change of personnel reduced the clear comparison.

Analysis of doctors' assistants shifts demonstrated multiple patients whose care/discharge was expedited. This reduced the need to open escalation areas. Doctors' assistant day-time shifts were successfully redeployed to cover doctor vacancy. This saved financing day-time doctor locums at £50/hour, whilst using the doctors' assistant for any delegable tasks at £9.70/hour. (Six shifts covered in this way saved £2,500.)

For our project, the first six months were with

educational funding from Health Education England. This stage proved safety, quality, acceptability, robustness of the educational package and proof of concept. The project was extended to demonstrate value. Reduced locum spend, reduced 'exception' doctor overtime, improved patient flow and attention to items on the Trust risk register all helped develop the business case for continued Trust funding. Four of our original six doctors' assistants have chosen to remain and are now in substantive posts.

Discussion

A communications strategy was essential to reinforce to staff that doctors' assistants are support staff (not Practitioners/Registered) performing delegated work and that their work needs 'signing off' by a doctor, and that they are very different from the physician associates, surgical care practitioners or other practitioners. Line management within education or the same as for the doctors was vital.

“ A NEW ROLE OF DOCTORS' ASSISTANT CAN BE HIGHLY EFFECTIVE, INEXPENSIVE AND WITH NO SAFETY CONCERNS ”

Prior healthcare assistant experience and a clear task list makes a two-week induction possible. This role stimulates clinically-focussed motivated staff in the gap between Band 2 and Band 5, to contribute and develop, with future Apprenticeship opportunities.

There is a financial area of challenge, in that our Trust has devolved budgets to each department and specifies revenue items (eg staff salaries) and capital items (equipment). There is no budget for additional staff and none for 'unexpected items' (complaints, cancellations, locum spend, etc). Doctors' assistants cannot replace doctors. The Trust executive team had the vision to use regular staff at Band 3 to mitigate unexpected overspends. Although the results in surgery and urology demonstrated high workload, high satisfaction and improved patient flow, the managerial teams did not prioritise accepting them into their fixed budget. The substantive posts were created in medicine which has vacant doctor posts and in ortho-geriatrics, which has issues of excessive workload and sub-optimal documentation (Haycock, 2014).

Conclusions

A new NHS role of doctors' assistant can be highly effective, inexpensive and with no safety concerns. With healthcare assistant experience, a two-week induction is satisfactory. Communication with stakeholders should reinforce their role as support staff (neither practitioners nor registered) performing delegated work.

The doctors' assistants role should be introduced immediately at all NHS sites where doctors in training are overloaded. It fits with Carter review (2016), NAO (2016) and HEE (2017). Our two-week induction and weekly tutorial could form the basis for an apprenticeship.

So far, this workforce model has been presented at 11 national or regional events; 12 interested Trusts have requested information or visits. We have made our job description and tips available on the websites: <http://www.bit.do/dr-assistants> and www.scarlettmcnally.co.uk. Careful line management, clear skill description and good communication is essential.

The doctors' assistants project has won the Gold Award in Skills for Health for developing staff, runner-up in BMJ Awards and finalist in HSJ awards. The doctors' assistants themselves won the Trust award for workforce and the project was shortlisted for innovation. We are grateful to Health Education England (HEE-KSS) for a grant of £80,000 to cover all costs, including salaries for six doctors' assistants for the six-month educational pilot phase. ■

KEY POINTS



- ✓ Around 50 percent of ward/on-call doctors' time is on tasks that do not require a medical degree or autonomous practitioner status
- ✓ There are very few 'Band 3' clinical roles in acute NHS hospitals. The cost is half that of a doctor or practitioner
- ✓ We defined clear tasks that could be delegated
- ✓ We recruited from experienced healthcare assistants (HCAs), developing them with an empowering two-week training course, uniform, structure and weekly tutorials
- ✓ A thorough evaluation confirmed no safety issues, high quality of tasks, multiple patients who had their discharge, diagnosis or treatment expedited, doctors' time freed up to attend education and reduced exception reports from doctor overtime
- ✓ Qualitative findings confirmed excellent feedback from doctors at all levels and other staff
- ✓ Developing staff requires: good line management, regular clinical supervision, stakeholder engagement and communication (eg clear tasks on business-style cards)
- ✓ The business case was built on mitigation of over-spend: reduced need for day-time doctor locums, fewer exception reports (relating to overtime for doctors in training posts), better documentation, fewer delayed discharges and help with difficult items on Trust risk register across the seven-day acute service



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