

**Clinical Administrative and Clerical Review**

**Consultation Document**

**August 2018**

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| 1. **Introduction and Background to proposal**
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| The current patient experience of our clinical administration model is frequently inconsistent, disconnected and duplicated. This is particularly apparent where patients are required to deal with multiple services where the experience is comparable to dealing with separate organisations rather than a single unified team. The same frustrations are also experienced by staff within the Trust and across our external partners including Primary Care, independent healthcare providers, health care professionals, social care, and neighbouring trusts. The Trust embarked on a review of its administrative and clerical functions over two years ago with the aim of identifying ways in which to improve the quality and consistency of administrative functions, reducing waste and variability to improve efficiency and ensure standardised, flexible services for all Care Groups which will be ‘**patient focused’**, dedicated to providing an excellent, user friendly, and expert admin facility to support DBTH core mission of providing safe and quality services to our patients.When the Trust embarked on this large piece of work the project team took time to speak to staff and patients, understand the administrative functions and how they worked but also listened to staff’s frustrations and concerns as well as reviewing patients feedback and in some cases complaints. It was felt that the administrative function within the organisation had not been reviewed for a long time and there was an opportunity to improve process for both the benefit of staff and patients. |

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| 1. **Current position and case for change**
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| There are currently 6 Care Groups plus central Patient Administration, soon to be restructured into 4 Divisions. Clinical administration is currently a combination of both a devolved and centralised structure. Administration for outpatient appointments is in the main managed centrally by the Patient Administration team with the exception of 2ww appointments which is managed centrally by the corporate Cancer Services Team. In-patient administration is also a combination of central and devolved management, the majority being managed within the care groups (example of central management would be Bassetlaw booking team). Medical administration is devolved within the care groups.As described above the current patient experience of our clinical administration model is frequently inconsistent, disconnected and duplicated. The current structure results in the following issues:* Variation in roles and processes across the Care Groups impacts on patient and user experience for those accessing multiple services
* Variation in process has arisen overtime due to localised decisions from a devolved structure
* A vast number of job descriptions exist across functions.
* Data Quality team outside of care groups validating high level of RTT pathways.
* Common functions are distributed across a wide span of staff and management structures.
* Lack of clear training strategy linked to Standard Operating Procedures and Access Policy
* Management structure variable
* Variation in processes across the Care Groups results in lack of clarity of roles and responsibilities by others across the organisation and outside.
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| 1. **Strategic Context**
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| The Trusts Strategic Vision Update for 2017-21 identifies four strategic objectives: * Optimising the use of elective care facilities at BDGH and MMH
* Developing appropriate capacity for increasing specialist and emergency care at DRI
* Increasing partnership working to benefit local population
* Supporting increased community based and self-care

This proposal directly supports the strategic objectives by focusing on the quality, consistency and productivity of clinical administrative services. This will be enabled by reducing variability and standardising (as appropriate) end-to-end business processes offering a robust, safe and responsive clinical administrative service.  |

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| 1. **Objectives of the proposal**
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| * To empower our admin staff to apply their skill and expertise to help deliver excellent patient care across the organisation, as efficiently as possible.
* To manage and retain an engaged, productive, dynamic workforce of administrative staff who have the appropriate skills to deliver a patient centric administrative support service
* To improve key performance indicators and drive through economic efficiencies
* To ensure a consistent and standardised model across all Care Groups
* To develop an clinical admin model which is sustainable and flexible with the ability to adapt to future technological solutions (when available)
* To enhance consistency of our patient pathways between areas and departments
* To provide a coherent structure for the role, with room for advancement and development
* To improve operational performance, communication and data collection
* To truly define the role of an admin at the Trust – currently we have over 60 job descriptions for members of Team DBTH doing similar roles
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| 1. **Description of the proposal**
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| Focusing on the roles that facilitate the elective care pathway and consist of generic functions that are applicable across the Care Groups:* Booking of patient appointments and amendments to any bookings and cancellations
* Waiting List management and overview
* Typing of letters / notes
* Medical Secretary overview of a patients journey through the correct pathway
* Associated administrative functions; filing
* Reception duties / welcoming patients into the Trust

The new model looks to standardise these functions/roles, in order to create a standard foundation ensuring equity in roles, pay structures and resource allocation. |

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| 1. **Other options considered**
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| ***Option 1*** (Preferred Option – Streamline Processes & Standardise Roles within existing model. This is the option that has been pursued as part of the admin and clerical review. ***Option 2*** – Single Management of Patient Administration – this option was considered initially and the pros and cons evaluated, however senior colleagues within Care Groups felt very strongly that this was not the most suitable option to pursue, the Executive Team supported this view and wanted to ensure management teams had the accountability for managing their services, it was felt a centralised model would not achieve this.***Option 3*** – Devolve all Patient Administration – this option was also considered, however it was felt that there were a number of benefits with regards to some of the administrative functions being centralised to ensure consistency, medical records and some of the patient booking process were two such areas where a complete devolvement of administrative functions was felt to be backward step***Option 4*** – Do nothing – Given the context outlined in this document, some of the issues where patient care has been detrimentally effected due to current administrative process and the feedback from some of our administrative staff it was felt that top do nothing was not a viable option. |

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| 1. **Equalities Impact Assessment**
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| [EIA Template Clinical Admin](https://www.dbth.nhs.uk/wp-content/uploads/2018/08/EIA-Template-Clinical-Admin.docx)  |

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| 1. **Resource Implications**
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|  It is acknowledged that through the review of the admin and clerical function across the Trust there will be a potential reduction of 8 WTE members of staff. Month 11 data from the previous financial year which will be validated by Divisional Management Teams as part of the consultation process indicated that the Trust had approximately 36 WTE fixed term posts across the Trust.It is therefore anticipated that the new Admin & Clerical structure could be implemented with minimal impact on members of staff and it is planned staff will maintain band, hours and area of work but will be asked to change the way in which they work, focusing on one or two key task and responsibilities rather than performing a range of tasks. It is hoped that this can all be achieved within Divisional Management Team and that down-banding will only be used as a last resort when other options have been exhausted. In addition it is anticipated that there will be development opportunities for staff and following the consultation process there will be permanent positions advertised for staff to consider. |

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| 1. **Financial Implications**
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|  The drive behind the admin and clerical review has always been to improve the service we provide to our patients and improve roles for staff within the admin and clerical function, professionalising the role and improving access to training and development. However, given the work undertaken and the numbers identified to efficiently and effectively run the service there will be a cost saving associated with this scheme which equates to approximately £231,747 recurrent per annum. |

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| 1. **Activity Implications of Proposal**
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| The Divisional Management Teams will hold a number of meetings with staff effected as part of this consultation and review their current structure and roles with a view to providing a clear plan of how the intend to proceed to moving to the new model. Management Teams have been asked to provide clear plans that attain the new structure within the next two years and will submit detailed plans to illustrate how they intend to achieve this. |

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| 1. **Outcomes and Benefits of proposal**
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| * Improved patient experience through efficient information / communication
* A clear structure for the role, with room for advancement and development
* An expert and efficient admin function – defined processes ‘do things once’
* Trust wide standardised operation procedures and job descriptions
* Enhanced key performance indicators and MI dashboards
* Training and development programme
* Greater opportunities for sharing best practice skills and expertise
* To have defined points of contact to help patients navigate their way through their hospital episode of care
* Minimise temporary staff costs and recruitment costs
* Redefine roles responsibilities and structure to support the clinical teams
* Consistency in working practice will deliver flexibility to ensure cross-cover arrangements as necessary
* Improved staff engagement through transparent and equitable job roles
* Providing the underpinning administrative framework which will support the transition towards a paper light/less organisation
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| 1. **Impact on other services provided**
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| This is to be defined by Management Teams but will not be known until discussions have taken place with effected staff and plans have been identified to support the transition. |

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| 1. **Risks and contingency plans**
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| This is to be defined by Management Teams but will not be known until discussions have taken place with effected staff and plans have been identified to support the transition. |

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| 1. **Details of any consultation (public/patients/staff) undertaken in the development of the proposal.**
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| During the current state mapping stage of the Clinical Admin review between July and August 2016 Admin staff, managers and Clinician were engaged in a variety of ways to ensure that staff experiences including their views were captured. For example;* 1:1 meetings with clinicians
* Workshop events
* Survey’s
* Briefing sessions
* Bulletins
* Lunchtime Lectures

Focussing on crucial points in the care pathway that could be developed to enable more efficient and effective processes that will support the Administrative process from referral to discharge. This approached was used to ensure data captured allows service improvements to be patient centred. General Managers and Business Managers were engaged throughout all stages of the review, Business Manager met at least on a bi-weekly basis with the project team, and were involved closely in shaping roles and job descriptions.The project team worked closely with Nottingham University Hospitals to take learning from their own Clinical Admin Review and also use some of the tools to capture data from staff to define the current state and help shape the review.The Clinical Administration Steering group has included membership from the Medical Director, Clinicians and General Managers throughout, and the SRO and DCOO have presented proposals and updates at regular intervals to the TMC.The below table provides an overview of the detail of some of the engagement meetings and discussions held in the early stages of the project.

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| **Start Date** | **Frequency** | **Activity**  | **Audience/Membership** | **By whom** |
| 05/07/2016 | n/a | Request in Buzz for admin staff to be involved review video | N/A | Amy Lee |
| 13/07/2016 | Weekly | 21 process mapping workshops | Admin Staff | KA/LP |
| 13/07/2016 | Quarterly | Clinical Reference Group | Clinicians/BMs/GM/CGDs | KA/LP |
| 01/08/2016 | n/a | Online Survey | Admin staff | KA/AT |
| 01/08/2016 | Monthly | Steering Group Meetings | Clinicians/BMs/GM/CGDs | DP/EC |
| 14/08/2016 | n/a  | Clinical Admin Video - link avaible in Buzz for a number of weeks | All Staff | LP/AT |
| 24/08/2016 | n/a | Staff Brief - Bassetlaw Lecture Theatre  | Admin Staff | DP |
| 31/08/2016 | n/a | Staff Brief - Montagu Boardroom | Admin Staff | EC |
| 01/09/2016 | n/a | Staff Brief - Bassetlaw Lecture Theatre | Admin Staff | KA |
| 23/09/2016 | Weekly | Business Managers Meetings | BMs | KA/PA |
| 27/09/2016 | n/a | Staff Brief - DRI Education Centre | Admin Staff | KA |
| 30/09/2016 | n/a | Staff Brief - Education Centre | Admin Staff | KA |
| 21/11/2016 | 2 week exercise | Data Capture Exercise | Admin Staff | KA |
| 09/12/2016 | n/a | Lunchtime Lecture Presentation | All staff | KA/LP |
| 09/12/2016 | n/a | Govenors Presentation | Governors | KA/LP |
| 16/01/2017 | n/a | Staff Brief - Montagu Boardroom | Admin Staff | KA |
| 18/01/2017 | n/a | Staff Brief - Bassetlaw Boardroom  | Admin Staff | KA |
| 19/01/2017 | n/a | Staff Brief - DRI Lecture Theatre | Admin Staff | KA |
| 30/01/2017 | n/a | Briefing to management board | SLT | DP |
| 02/05/2018 | n/a | Informal brief for manager conversations with staff | BMs/GMs to support conversations with staff | DP/BB |
| 10/10/2017 | n/a | Medical Secretary observations | Medical Secretary roles  | PA/BB |
| 11/11/2017 | n/a | Medical Secretary observations | Medical Secretary roles  | PA/BB |
| 19/10/2017 | n/a | Medical Secretary observations | Medical Secretary roles  | PA/BB |
| 20/10/2017 | n/a | Medical Secretary observations | Medical Secretary roles  | PA/BB |

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| 1. **Implementation Timetable (Key Milestones)**
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| This is to be defined by Management Teams but will not be known until discussions have taken place with effected staff and plans have been identified to support the transition.***Next Steps:***This consultation, in agreement with union colleagues will be for a minimum of 6 weeks from 16 August 2018. Management Teams will submit the workforce plans and changes within this timescale and further review and discussions will take place. During the 6 week period you will be invited to attend a number of meetings with Divisional Management Teams, staff side colleagues will also be involved as will People Business Partners from P&OD. |