# High Volume Low Complexity Hubs

## *Patient and staff insights*

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NHS

# Contents

# Glossary

- **AHSN**: Academic Health Science Network.
- **ASA score**: the ASA (American Society of Anaesthesiology) score is a metric to determine if someone is healthy enough to tolerate surgery and anaesthesia.
- **Clinical Frailty Scale**: the scale was introduced in the second clinical examination of the Canadian Study of Health and Aging (CSHA) as a way to summarize the overall level of fitness or frailty of an older adult after they had been evaluated by an experienced clinician.
- **Elective Hubs**: surgical centres focusing on high-volume routine surgery so more patients can get seen more quickly, and creating extra capacity so emergency cases do not disrupt elective operations and cause cancellations or delays. They used to be called HVLC hubs.
- **ENT:** Ear, Nose and Throat.
- **GIRFT**: Getting It Right First Time (GIRFT) is a national programme designed to improve the treatment and care of patients through in-depth review of services, benchmarking, and presenting a data-driven evidence base to support change. The programme has developed standardised best practice pathways across the six HVLC specialties.
- **HVLC**: High Volume, Low Complexity (HVLC) Surgery. GIRFT's HVLC programme is focusing initially on driving improvement in six high-volume specialties – ophthalmology, general surgery, trauma and orthopaedics (including spinal surgery), gynaecology, ENT and urology – but will support with other surgical and medical specialties going forward.
- **NHSE**: NHS England.
- **Stand-alone elective hub**: an elective surgical unit in a dedicated building, separate and remote from any other acute hospital. It exclusively performs planned surgery (including semi-elective trauma).

# Acknowledgements


- This project was conducted by the Health Innovation Network (the Academic Health Science Network for South London) on behalf of NHS England.
- It would not have been possible without input from the staff and patients interviewed.
- Carl Owusu at NHS England also provided valued assistance and advice throughout the project.
- Special thanks also go to our patient representatives: John O'Toole, Smarajit Roy and Douglas Taylor.
- Finally, the HIN would also like to thank the following persons for helping shape the design of the research and/or helping us draw recommendations from the insights gathered: Bisi Aiyeleso, Dr Ben Ayres, Joanne Barnes, Althea Bart, Marie Clough, Fiona Feighney, Kevin Finlinson, Alvin Magallanes, Rebecca Marett, Victoria Medhurst, Dr Evelyn Mensah, and Dr Aditi Shah.

# 1

# Executive Summary

# Background and methodology

**Initially rolled out in London, the HVLC programme is now being scaled up nationally**. As part of seeking continuous improvement of its service, including gathering insights to inform best practice surrounding surgery generally, NHS England commissioned the Health Innovation Network, the Academic Health Science Network (AHSN) for South London, to deliver a qualitative evaluation of the effects of deployment of elective hubs on patient and staff experience.

**This evaluation provides a qualitative account of patient and staff experiences and perceptions of working or receiving treatment at an elective hub.**



This evaluation deployed a qualitative approach with a total of **37 interviews, 18 with patients and 19 with staff**. They were carried about between February and June 2022 across four London elective hubs.

**Scoping workshop and patient engagement**

**Fieldwork**
**18 patient interviews, and 19 staff interviews**
(including clinical, administrative, operational staff and programme staff)

**Insights workshop and patient consultation**

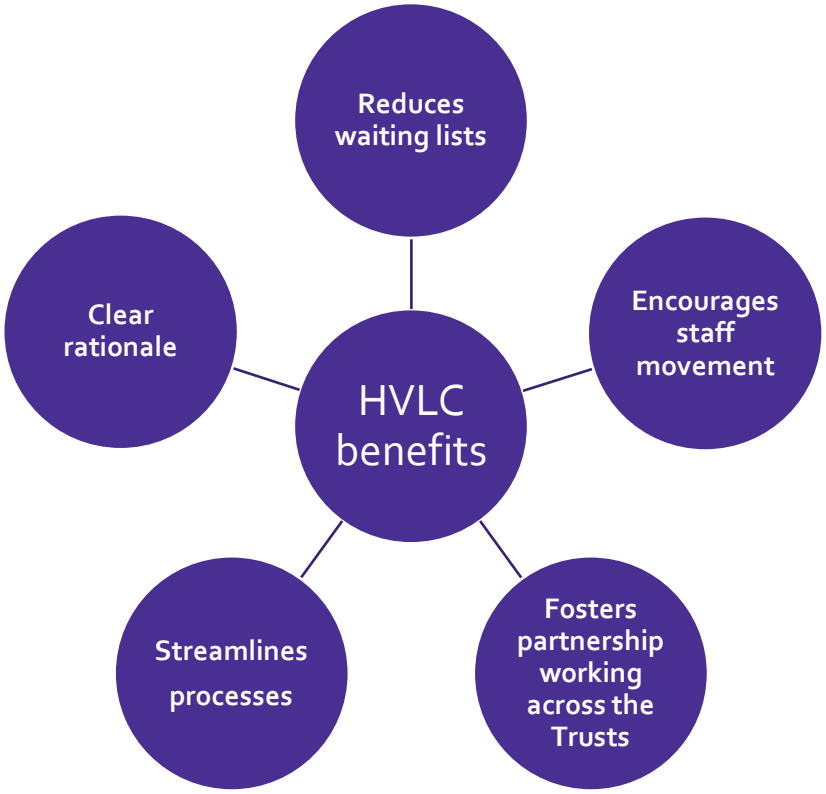
# Staff Insights: overall views of the programme

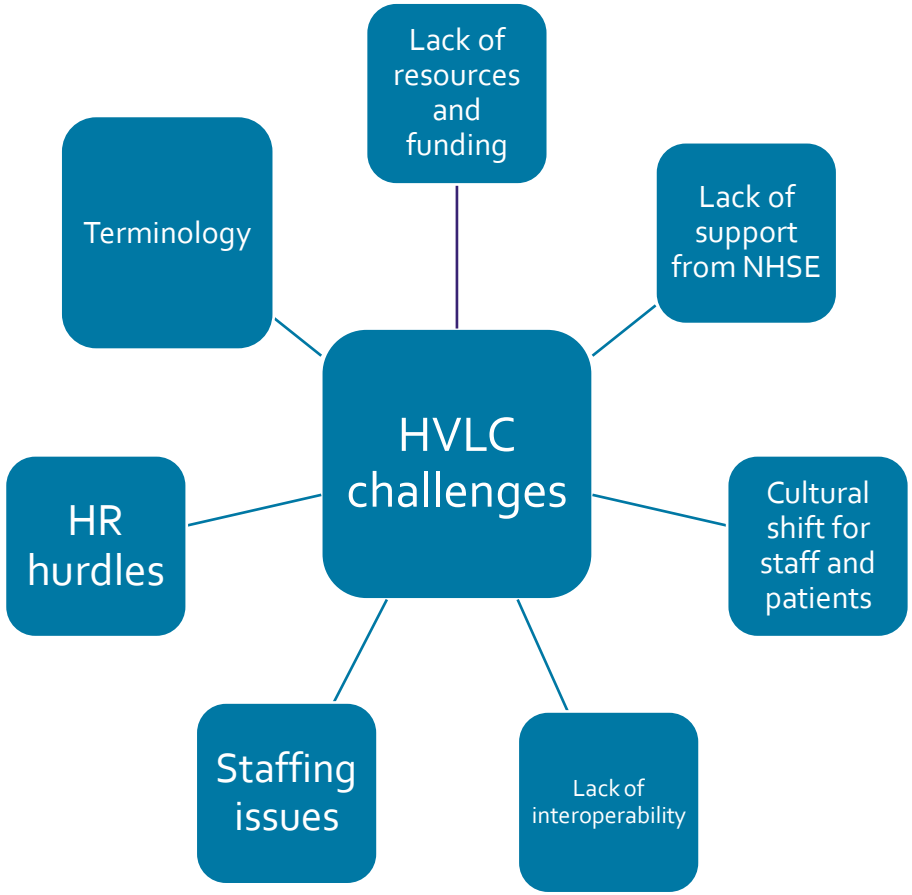
**While the rationale behind the introduction of the HVLC programme was clearly understood and generally accepted, views on whether implementing the HVLC programme in their respective hubs had been successful were mixed.**

On one hand, there were examples of success stories, with hubs reducing waiting lists, improving theatre efficiency through streamlined processes, and establishing fruitful relationships with other hospitals within their Trusts and beyond.

On the other hand, staff identified challenges around the practicalities of its implementation and delivery. Some staff talked about a disconnect between the programme's objectives and the realities of running HVLC lists on the ground.





# Staff Insights: programme-related and cultural factors

Participants discussed a number of barriers and enablers relating to the programme itself.

### Eligibility criteria

Some participants thought the patient eligibility criteria were **too restrictive**.

As such, the hubs therefore tended to have **different thresholds** to assess patient eligibility – for instance one hub decided to safely lower the threshold, looking to use frailty scores instead of ASA scores.

### Impact on health inequalities

It was felt overall there was **no clear evidence** on whether it had the potential to exacerbate health inequalities, as long as lists were scheduled in a fair manner.

Beyond service transformation, participants agreed that HVLC was about culture change, both for staff and patients.

### Moving away from patient choice

It was felt the programme required a seismic shift for patients to have less say in where they would be treated. As such, staff needed support to have **challenging conversations around choice**.

### Encouraging staff movement

There was a view that HVLC also required a cultural shift from staff, and especially from **consultants to encourage them to work across sites**.

This could be facilitated by supporting them with IT, arranging inductions, liaising with them ahead of surgery to find out their equipment needs, and holding debriefs with the surgical teams.

# Staff Insights: contextual factors

**THE PANDEMIC:** this was identified as a major barrier to delivering HLVC objectives because it:

- **Exacerbated workforce issues** and staff burnout, leading to change fatigue.
- Generated **competing priorities** (such as cancer or paediatrics waiting lists).
- **Disrupted day to day scheduling,** with operations cancelled due to patients having COVID.
- Led to an **increasing complexity of cases**; some participants noted the major deconditioning effect it had on patients.

Yet, it was also acknowledged the pandemic had also presented an **opportunity to rethink processes and fast-track changes** to maximise theatre efficiency.

**LACK OF FUNDING AND RESOURCES:** this was one of the most commonly identified barriers. This was linked to participants raising **concerns about the programme's sustainability**.

**LACK OF CONSULTATION:** staff felt key hub staff could have been more involved in designing the programme and setting targets, noting that they perceived **a top-down approach** from NHS England.

Participants asked for more support, in addition to wanting more resources and funding:

- **Allowing more time** for elective hubs to fully develop HVLC pathways.
- **Including key hub staff early on**, at the design stage, so they are clear about what the programme aims to achieve.
- **Adjusting objectives** around volume of patients to reflect the reality on the ground.
- **Providing more clarity** around the eligibility criteria.
- **Providing practical support** including concise and user-friendly standard operating procedures (SOPs) and guidance documents.
- **Rebranding** the programme, as it was felt the current terminology has negative and misleading connotations for staff and doesn't fully reflect what the programme aims to achieve.

# Staff insights: operational factors

## RESOURCING HUBS

This was one the biggest challenges identified by participants. This meant that some hubs had to **rely on agency staff or hub staff working overtime,** and run their lists over the weekend.

To respond to resourcing issues and HVLC demands, some hubs had put measures in place aiming to streamline processes, such as:

- Standardising the triage of patients
- Liaising with GPs to ensure patients' stable condition before coming to the hub
- Taking all medical history prior to a patient's arrival at the hub
- Getting nurses to facilitate obtaining consent from patients (i.e. ensuring consent forms are completed and signed)
- Setting up workstations at pre-assessment clinics

## INTEROPERABILITY BETWEEN IT SYSTEMS AND HOSPITALS

Without it, it could be complex to:

- manage referrals and lists of patients from another hospital, and
- facilitate staff working across a number of sites.

Some hubs had put measures in place to ensure the **digital capabilities** needed to manage HVLC lists were in place, such as creating a central tracking system which could also be accessed by referring hospitals.

## STAFF MOVEMENT

Enabling staff movement could be challenging due to lack of interoperability, but also having to navigate **Human Resources issues**.

Good practice identified to facilitate staff movement included arranging inductions, organising non-hub staff parking, and collecting smartcard details of all non-hub consultants coming to work there ahead of their shifts.

# Staff insights: operational factors

**Staff agreed effective scheduling is central to delivering HVLC. Yet, they felt that the scheduling of HVLC patients can be a complex and time consuming task, due to:**

- Covid testing, IPC measures and cancellations
- Booking out-of-area patients for operations
- Filling HVLC lists (i.e. Identifying suitable HVLC patients, and asking patients to get operated on at short notice)



**Involving schedulers in discussions around programme implementation, and providing training and support to schedulers were key priorities identified by hubs.**

Support mentioned included:

- **Helping them to identify HVLC patients**; for instance by adding a 'fit for HVLC' category on the operating lists and providing user-friendly and concise Standard Operating Procedures.
- **Helping source information on HVLC patients;** for instance by increasing interoperability of information systems between the hubs and referring hospitals.
- **Providing additional training and support materials** on having challenging conversations with patients around patient choice.
- **Having regular touchpoints** with teams.
- **Making sure consultants consistently support schedulers** by also having conversations around patient choice with patients.

# Staff insights: experiences of working at a hub, and perspectives on patient care

**Although programme staff and those in senior roles noted that working on HVLC had brought additional pressures, the clinical staff tended to be positive about their day to day roles at their elective hub,** because of:

- **the pace at which operations were scheduled,** which made the day go quicker.
- the satisfactory feeling of working on **clearing the backlog of patients** waiting for surgery.
- the **low stress** of working on non-complex operations and patients.
- **working within smaller teams within smaller settings;** participants working at a standalone hub were especially positive about their experience of working this way and believed this allowed for better communication and understanding between colleagues, as well as better interaction with patients.
- being kept up to date about **success and progress**.

**But overall, staff wanted a more consistent training offer going forward.** In the absence of this, peer support and team working were key enablers to delivering HVLC.

**The perception of staff was that there were limited barriers to accessing care at HVLC hubs; however, travelling to a hub was the most commonly identified issue faced by patients.**

Some additional barriers included:

- Being given **little notice** before the scheduling of an operation.
- **Feeling loyal** to a familiar hospital.
- Having **concerns over the reputation** of an elective hub.
- Having **concerns over the continuity of care** if being treated in an unfamiliar hub.

**Yet, those concerns were mostly outweighed by patients wanting to be treated speedily.**

Such barriers point towards the **key role of communicating** clearly, consistently, and transparently to patients.

# Patient Insights

**The patients we talked to were overall very satisfied with the quality of care received at the hubs, including how quickly their operation was scheduled, and how caring the clinical staff were.**

- **Being treated quickly clearly outweighed being treated somewhere local**, but providing explanations for being referred to a hub was perceived to be important.

- When patients reported issues, these tended to be down to perceived **poor communication or miscommunications** from the hubs' administrative staff, often in relation to transport or when to come for surgery.

**Travelling:** while travelling to the hubs was not flagged as a major inconvenience, participants who had to rely on private transport reported issues around costs, not being able to book a taxi ahead of time, and having concerns about their taxi not turning up. There was also some **inconsistency** on whether hub staff had told them that **transport could be arranged** for them or not.

**Being told when to come for surgery:** there were some reported **inconsistencies around when patients were told to come on the day of their surgery**, with some patients not being told precisely when to arrive, and showing up at the wrong time.

- While participants were **understanding about being given a time window rather than a specific time** for the operation, there were some differing views about what constitutes a good waiting environment (with some finding hospital cubicles isolating).

- **Staff communication** was particularly key to a good surgical and recovery experience, with participants valuing being kept in the loop and **interacting with staff**.

- The discharge process was described as positive when patients felt they were given **enough information**, whether verbally, in written format, or ideally both, about what to expect next and what to look out for.

# Recommendations-1

**Improving the HVLC programme's implementation and delivery across elective hubs by:**

- Rebranding the programme, as the current terminology was perceived as misleading.
- Ensuring the pathway selection criteria is kept under regular review.
- Developing a consistent and systematic approach to sharing good practice.
- Evaluating more thoroughly the impact the HVLC programme on health inequalities.
- Developing principles to support greater standardisation of common SOPs to facilitate implementation and encourage consistency across sites.

**Improving the experiences of clinical and administrative staff working in elective hubs by:**

- Supporting scheduling and booking teams in their day to day role, through tailored training, (including how to handle conversations with patients and patient choice, and how to develop their digital capabilities needed to manage HVLC list), opportunities to shadow clinical staff, and additional practical support.
- Encouraging clinicians including consultants, pre-op staff and GPs also to have conversations with patients about rationale for referring them to a specific hub.
- Enabling staff movement by arranging inductions and providing practical support to visiting staff.

# Recommendations-2

Recommendations on how to **improve the experiences of patients treated at elective hubs** largely focused on the role of communicating clear and consistent information throughout their care journey.

## PRE SURGERY

**Patients need to be fully informed of what being treated at an elective hub involves**. Clinicians including GPs and consultants have a key role in:

- increasing awareness of elective hubs and helping patients making informed decisions.
- providing clear and consistent explanation to patients about what to expect when being booked for surgery at an elective hub.

Because patients might have to travel further for their care, scheduling and booking teams should :

- help patients identifying **the appropriate transport solution.**
- **providing clear and consistent information** on whether they are eligible or not for free transportation.
- alerted as soon as possible on **when to come for surgery** so they have enough time to arrange transportation.
- try and ensure that **travelling to the hub pre-surgery is kept to a minimum.**

## ON THE DAY OF SURGERY

**Waiting should always be minimised,** however where waiting is necessary both pre and post surgery regular staff checks on patients should be undertaken to assess any sign of distress and offer appropriate support.

Communications with HVLC patients should be **constant, consistent, compassionate**.

## POST SURGERY

Postoperative follow-up should include a **rapid phone call** on the day after the surgery.

# 2

# Background and Methodology

# Background and context to this research

**High Volume Low Complexity (HVLC) surgical hubs were set up during the COVID-19 pandemic to respond to the backlog of patients requiring elective surgery**, with over 387,000 people in April 2021 waiting more than 52 weeks for treatment in England, the highest number since records began in 2007 (the number has gone down since then and was around 323,000 in June 2022).

To get the NHS back on track and support post-COVID-19 elective recovery, the Getting It Right First Time (GIRFT) programme has been working with local health care systems towards reducing the backlog of patients waiting for operations and procedures, and to improve access to care and outcomes. **As a key element of the NHSEI elective recovery plan, in collaboration with GIRFT, the HVLC programme was developed, focusing on 27 standardised patient pathways across six specialties.**

This work is initially focusing on driving improvement in six high-volume specialties: orthopaedics, gynaecology, urology, ear, nose and throat, general surgery and ophthalmology.

**The programme has supported the establishment of fast-track surgical hubs for high-volume procedures, where possible, and helped partners develop surgical hubs and patient pathways, pooling capacity and resources, and agreeing system-wide operating theatre principles and efficiencies**. In line with population needs, local systems are encouraged to identify their own priorities and use the GIRFT specialty 'gateways' to benchmark and review their performance against relevant metrics, focusing on clinical outcomes and equitable access to care.

**Initially rolled out in London, the HVLC programme is now being scaled up nationally. As part of seeking continuous improvement of its service, including gathering insights to inform best practice surrounding surgery generally, NHS England commissioned the Health Innovation Network, the Academic Health Science Network (AHSN) for South London, to deliver a qualitative evaluation of the effects of deployment of elective hubs on patient and staff experience.**

# Evaluation aims and objectives

**The purpose of this evaluation is to understand patient and staff experiences of elective hubs in London.**

- It is important to note that this evaluation did not aim to measure the impact of the elective hub model on staff and patient outcomes.
- Instead, it has sought to provide **a qualitative account of patient and staff experiences, and of their perceptions of working or receiving treatment at an elective hub**. In doing so, it aimed to gather a series of lessons and recommendations, highlighting good practice and seeking to improve overall staff and patient experience of the hubs.

**List of questions the evaluation sought to answer:**

**What are patient experiences of elective hubs?**

- What are their experiences of being treated at an elective hub?
- What are their perceptions of the quality of care received (including care pre- and post-surgery)?

**What are staff experiences of elective hubs?**

- How do they understand the rationale and process of delivering HVLC pathways?
- What are their perspectives on the nature of their work environment?
- How satisfied are they working in an elective hub?
- What are their perspectives on patient experiences?

**How to improve:**

- Patient experiences of receiving treatment at an elective hub?
- Staff experiences of implementing and delivering a HVLC service and/or working at an elective hub?

# Methodology

**To explore staff and patient experiences, this evaluation deployed a qualitative approach with a total of 37 interviews carried about between February and June 2022 across four London elective hubs.**

**Pre-fieldwork engagement**

We held a **scoping workshop** in December 2021 with a range of stakeholders to gather their thoughts on the research design, questions, and the proposed recruitment approach.

Three **patient representatives** helped review the patient fieldwork materials, including the interview schedule and information leaflet.

**Fieldwork**

- Across four hubs: Central Middlesex Hospital, Whipps Cross Hospital, Queen Mary's Hospital Roehampton, and Chase Farm Hospital.
- Focus on ophthalmology, gynaecology and urology for patients.
- Focus on ophthalmology, gynaecology and urology as well as ENT and orthopaedics for staff.

**Qualitative fieldwork with patients**

- We carried out 18 patient interviews.
- Participants were recruited by staff, and by a HIN researcher face to face at one of the hubs.
- Interviews were carried out over the phone and incentivised £15
- Topics explored comprised participants' surgery experiences, including their experiences of pre- and post-surgery care.

**Qualitative fieldwork with staff**

- We carried out 19 staff interviews.
- Staff included clinical staff, administrative staff, operational staff and programme staff.
- Interviews explored understanding and views of HVLC pathways, experiences of working at a hub, and views on patient care.

**Pre-fieldwork engagement**

We held an **insights workshop** with a range of stakeholders, most of them had also taken part in the scoping workshop. It aimed to gather their feedback on the evaluation findings and help us drawn practical recommendations.

Two of the **patient representatives** involved at the scoping stage also provided their thoughts on the patient insights.

# How to read this report

- **This report presents the findings from in-depth interviews with staff and patients** which took place in the first half of 2022 as part of a qualitative evaluation designed to explore their experience of the HVLC programme.
- **Qualitative research is used to shed light on why people hold specific views rather than how many people hold those views**. We are confident that the views and perspectives presented in this report are valid and credible thanks to the following strategies throughout the project: accounting for bias, transcription of interviews, meticulous record keeping, and using a systematic structure to manage and analyse the qualitative data collected and to identify themes. The culmination is this report, which provides detailed and nuanced insights into staff and patients' views and experiences of the elective hubs.
- **Recommendations from this report have been drawn from the qualitative insights** that emerged as part of this fieldwork. Some recommendations have also been derived from a workshop held with a range of stakeholders, and feedback gathered from the patient representatives.
- **This report uses the conventions of qualitative social science reporting**: "a few" is used to indicate views which were mentioned infrequently, and "many" or "most" for views which are more frequently expressed. The use of "some" reflects the balance between these views which were mentioned by some participants, i.e. more than a few but not the majority of participants. This report focuses on perceptions rather than facts and any proportions used in the reporting should be considered indicative, rather than exact.
- **Verbatim quotes are used throughout the report** to demonstrate a viewpoint expressed during the in-depth interviews in the participant's own words.

# 3

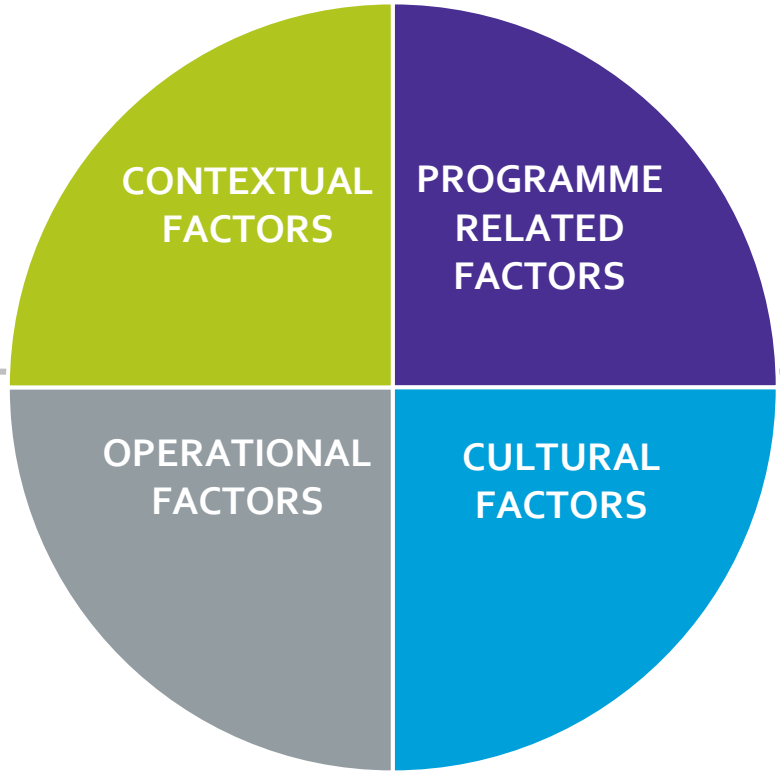
# Staff Insights

# Staff identified a number of issues and themes around the implementation and delivery of the HVLC programme

When discussing their views on the programme, staff identified a number of challenges, but also some enablers. Some of the challenges frequently identified by staff were linked to the pandemic and the combination of ongoing pressure on services, the backlog of care, and chronic workforce shortages. However, participants (especially those involved in programme delivery and senior clinical staff) also discussed a number of barriers and enablers relating to practical and structural factors, and to the programme itself.



- Pandemic related-factors:
  - Staff burnout
  - Competing priorities
  - Patient complexity
  - Opportunity to fast track change
- Workforce issues and shortages




- Clear rationale
- Problematic terminology
- Tight timelines
- Perceived top-down approach
- Restrictive inclusion criteria
- Ambitious objectives but lack of resources

- (Lack of) interoperability between IT systems and hospitals
- Human Resources hurdles
- Complex scheduling
- Reliance on agency staff, and staff working overtime
- Reinforcement of team relationships
- Partnership working across Trusts

- Cultural shift required from both staff and patients


# *Staff insights*
# Programme-related factors

# The rationale behind the introduction of the HVLC programme was clearly understood and generally accepted, but staff felt expectations around the pace of implementation and delivery were unrealistic

**Staff who took part in interviews were all familiar with the terminology 'High Volume Low Complexity', and with its overall aim of reducing the elective backlog by maximising theatre efficiency.**

**Participants agreed the programme was laudable and praised its intended aims.** They tended to agree that on principle it could improve patient experience.

**However, there were also contrasting views among the different hubs on how innovative the HVLC programme was**. For some participants, the management of HVLC lists was felt to only be a continuation of what they had previously done. However, for others, it was felt that the implementation of the programme had required major re-organisational efforts.

> *From my point of **view [HVLC] isn't a new concept - it's got a new name** - but it's a little bit like perfect days, it's a bit like booster lists or whatever people call them. It's about making sure we've got the right patients on a list which makes it as efficient as possible. **That's just good theatre management**."*

**Whilst views about the programme and its aims were very positive, participants across different hubs talked at length of the challenges around the practicalities of its implementation and delivery.** Those interviewed involved in programme delivery or in senior clinical roles noted they felt a disconnect between the programme's objectives and the realities of running HVLC lists on the ground. This meant they felt expectations around the volume of patients to be treated through HVLC pathways were set too high from the start. Some discussed the pressures of '*having to learn to run before learning to walk'.*

> ***The concept is great. The practicalities, it's tough.** I think the expectations that were put into the Trust, the ICS, were really high in terms of, 'You have to get it done asap. You have to start straightaway and I'm going to measure what you're doing from day one,' without thinking that actually, **this is a change of way of working, a change of mentality, a change from the patient**. Patients have been waiting for quite a long time, so their procedure and the complexity may have changed."*

# Staff were also keen to highlight successes and examples of good practice; although there were differing views on what the HVLC programme had managed to achieve to date

**Overall, views on whether implementing the HVLC programme in their respective hubs had been successful were mixed**.

It is important to note that participants were often keen to share success stories of:

- 'obliterating' their waiting lists.
- streamlining processes, and maximising theatre efficiency (see slide 35).
- successfully working collaboratively with other hospitals within their Trusts and beyond (see slide 40).

> *So the high volume low complexity hub work for us is an absolute winner for everybody. We can get through those low complex cases (…)* ***It means us taking the low complex cases away from that acute hospital which then frees them up to do the higher complex acute higher acuity patients****."*

**In doing so, participants also shared examples of good practice and measures put in place to help deliver HVLC goals;** such as providing additional support to schedulers (see slide 38), cascading down information and decisions, communicating successes to frontline staff (see slide 42), and developing interoperability strategies (see slides 36 and 38).

> *I thought [I needed] to demonstrate to my colleagues was that the plan was working, and that our numbers were dropping week-on-week, and so to* ***use that positive message to reinforce the hard work that everybody was putting in****. In that sense, it was a positive. It made me feel very positive."*

**However, some concerns were expressed on the programme's sustainability, including lack of resources and insufficient number of eligible patients over time.** There were also varying views between the hubs, due to different contexts, profiles and demographics. For instance, participants from the standalone hub included in the research were especially positive, whilst participants from another hub had experienced major challenges introducing HVLC pathways. Regardless of their views, all participants were keen to highlight the considerable amount of work that went into their hubs implementing HVLC pathways and maximising theatre efficiency.

# Some participants thought the patient eligibility criteria were too restrictive, and hubs therefore tended to have different thresholds to assess patient eligibility

**Whilst the ask to focus on high volume low complexity procedures was understood and accepted by participants, there were some questions raised around the patient eligibility criteria, which many found too restrictive**. In practice, this meant that some hubs struggled to fill HVLC lists and had to open up their lists to patients who were not 'strictly HVLC' i.e. patients with slightly more complex needs.

Some participants commented on how patient demographic could sometimes mean that some patients listed for HVLC procedures were not actually suitable for HVLC lists. This seemed especially the case for urology patients who were more likely to be elderly patients and require post-op support.



> *Practically it means that you cannot do an HVLC list with these patients, so your number of patients that you're eligible to do in this quick, fast way reduces significantly. Practically it means that you ....* ***don't have enough patients to book as many lists as you've promised*** *whoever that you will do. "*

Staff from one hub explained how they had decided to safely **lower the threshold,** looking to use frailty scores instead of ASA scores.

> *Initially we were just being quite strict with our HVLC criteria. The last meeting that we had, we mentioned that we were struggling with having the volume of patients to book (...) Currently, we're booking Frailty 3 or 4, we're planning to expand it. It's more, I don't want to say more complex, but pushed the boat out* ***a little bit to be more inclusive with the patients that we have currently on the waiting list****."*

Staff in the standalone hub expressed **caution over adding more complex patients** to their HVLC lists.

> *We've had a couple of cancellations of patients say who have some comorbidities that would,* ***because we're a stand-alone unit and we're away from the main [hospital], we're (...) slightly restricted in what we can do."***

# The potential impact of the programme on health inequalities was raised by a few participants, but it was felt overall that there was no clear evidence on whether it had the potential to exacerbate them

**Some participants wondered if focusing on HVLC lists could increase health inequalities, because hubs would focus on scheduling less complex patients. But overall, it was felt that the programme did not increase health inequalities, as long as lists were scheduled in a fair manner.**

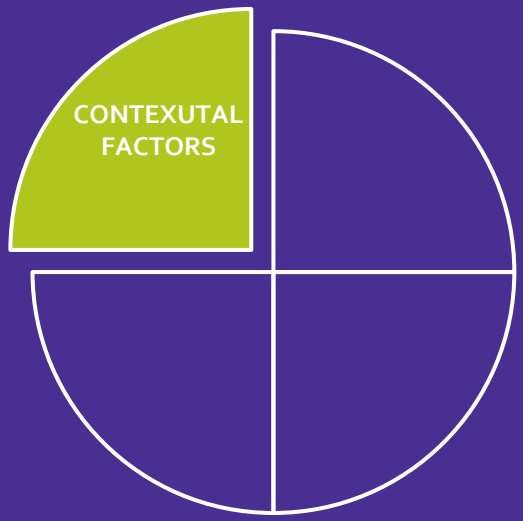
- **On one hand, some participants noted that there was potential for the programme to increase health inequalities by disadvantaging some cohorts of patients.** As such, they felt it was critical to carefully examine the composition of waiting lists when scheduling HVLC lists, in order to avoid creating "*waiting lists within waiting lists*". They also acknowledged doing so was time consuming and required input from senior clinical staff.

- **On the other hand, it was acknowledged that the programme could also have a positive impact on more complex patients being treated more quickly** as a result of the elective backlog going down, as long as the right balance of HVLC lists vs non-HVLC lists was maintained.

- It is also worth noting that one of the hubs included in this research completed an internal review and did not find any evidence of health inequalities.

> *The pool of suitable HVLC patients for a speciality like urology, is actually quite limited.* ***What we don't want to do is create lists within lists with this inequality****."*

> *I think that if you have a programme that is targeted for a specific cohort and you say, 'I'm doing HVLC lists every three weeks to get rid of backlog and, even though that benefits the lower complexity,* ***I don't see that as inequality because you are enabling the list, the list they've given you, and the other list to be focussed on complex patients*** *(...) If you say every single day of the year is HVLC,' then yes, but if you're saying, 'We're thinking about... In a holistic way and the way of doing it is once every month,' then let's do it. "*




# *Staff insights*
# Contextual factors

# Staff identified the pandemic as a major disruptor to implementing and delivering the HVLC programme

**The pandemic was identified as a major barrier to delivering HLVC objectives because it exacerbated workforce issues, generated competing priorities, and disrupted day to day scheduling,** with the following challenges being discussed by participants:

- **Staff fatigue and burnout** leading to change fatigue.
- **Increasing complexity of cases -** some participants noted how the accumulation of increased waiting times, months of isolation and reduced levels of activity at home had a major deconditioning effect on a number of patients who would have originally been eligible for HVLC. This could add complexity to the management of HVLC lists.
- **Cancellation of operations** due to patients having COVID posed an additional challenge to reaching HVLC objectives.

> *With COVID ongoing, and that causing challenges in terms of the operation side and the staffing. People, especially clinical colleagues, felt that we were entering a period of rest and recovery, which was kind of a Trust strategy, and there was very much, 'Take your annual leave. Make sure you're having rest', because we worked incredibly hard last year, but then we were also saying at the same time,* ***'We want you to operate on 20 patients in one session back-to-back.'You know, there was a conflict there, which it was hard to justify****."*

However, it was acknowledged by some that the pandemic, and the elective care backlog it caused, also presented an opportunity to rethink processes in place and fast-track changes to maximise theatre efficiency.

> *It's just that* ***the pandemic fast-tracked a lot of things that people were actually doing****. So I think that's why it made it easier for us to sit as the [clinical reference groups] and to also be embedded within the high-volume, low-complexity work. It was already in the pipeline."*

# Staff felt implementing the programme had been challenging and would have liked to be consulted by the regional team early on

**Staff recurrently talked about the difficulties of implementing the programme in challenging circumstances** marked by staff sickness, burnout and fatigue. A number of participants also discussed how the tight timelines and the ambitious objectives they had to meet had put enormous pressure on them to deliver the programme whilst they had competing priorities, such as cancer or paediatrics waiting lists.

> *I think **it was a bit of a challenge developing the pathway robustly and sustainably because the focus for other specialities obviously are things that are life-limiting**, like cancer (...) So there's the dichotomy between our surgical procedures and our outpatient procedures; the backlog that we're trying to deal with. "*

Some programme and clinical leads also discussed what they perceived to be a top down approach from the regional team. They felt key hub staff could have been more involved in designing the programme and setting targets.

> *NHS England asks for these numbers (...) so maybe from a national point of view, I would say always get a bit of a higher-level metric rather than trying to go into, Mr F, what are you doing? That just doesn't help because from the staff point of view, you feel micro managed for a thing that is not really the best thing in that particular context because you're not doing it. You feel you are failing, but you're not because you're actually increasing the number of patients through other means. "*

**Lack of funding and resources was one of the most commonly identified barriers** to explain some of the challenges they had faced and were still facing with implementing and delivering the HVLC programme. This meant that even participants who were especially positive about the programme had concerns over its sustainability.

> *We have not recruited more staff because, basically the honest answer is the funding and whatever was promised before this High Volume Low Complexity never materialised on the ground floor. This is why we've run this clinic on a Saturday where we pay everybody extra rates to actually come in and do this in an extra clinic."*

# Staff suggested some ways the regional team could help with implementation, and could support them going forward

**In addition to wanting additional resources and funding, some participants discussed how they would like more support, information, and flexibility from the regional programme team**, including:

- **Allowing more time for elective hubs to fully develop HVLC pathways**: several participants mentioned that they were told '*to run before learning to walk*'. However, they also understood that tackling the Covid elective care backlog meant that changes had to be implemented quickly.
- **Including the key hub staff early on**, at the design stage, so they are clear about what the programme aims to achieve. This also involved getting the clinical leads' buy-in. One participant noted the efforts made by the regional team to build a HVLC network as key to share learnings and experiences. However, she would have liked its meetings to be more inclusive, as they always took place on the same weekday which was her non-working day.

> *I know it's difficult because obviously, we were in the pandemic and that was something that needed to be designed quickly (…), but just if you want to get that established,* ***you still need to go back to people to make sure everyone is onboard****."*

- **Adjusting objectives about patient volumes** to reflect the reality on the ground, including competing priorities.
- Providing more **clarity around the eligibility criteria** for identifying HVLC patients (see slide 26).
- Providing practical support including concise and **user-friendly standard operating procedures** (SOPs) and guidance documents, and templates for patient facing materials .
- **Rebranding the programme**: most participants felt calling the programme "High Volume Low Complexity" had been doing it a disservice, with some staff worrying it would involve increased workloads. It was suggested a 'rebrand' could help frame it differently and get staff buy in.

> *The high volume, some people may see that as, 'Oh,* ***we're just a machine of operating and it's not safe for patients,' rather than we are basically optimising****. Basically, a good branding would have been good."*


# *Staff insights*
# Cultural factors

# Beyond service transformation, participants agreed that HVLC was about culture change, both for staff and patients

**Participants had wider reflections on the major behavioural shift needed, from both a staff and a patient perspective.** In doing so, they discussed how the HVLC programme has wider implications relating patient choice and staff movement.



## Moving away from patient choice

It was felt the programme required a seismic shift for patients to have less say in where they would be treated. Some participants talked about how staff, including schedulers and nurses, needed support to have challenging conversations around choice (for instance, being provided with tailored communication materials or training), (see slide 31).

> *How do we move from that role to, 'Sorry, you have no choice, you have to come to [hospital].' **That's a big shift**. I understand why we're doing it and definitely, yes, I'm up for it and I get it, but if you're a patient you're saying, 'Right, so first I can choose and now I cannot.' Unless we do a comms that supports the staff in the Trust to communicate that with the patients in a more natural way."*

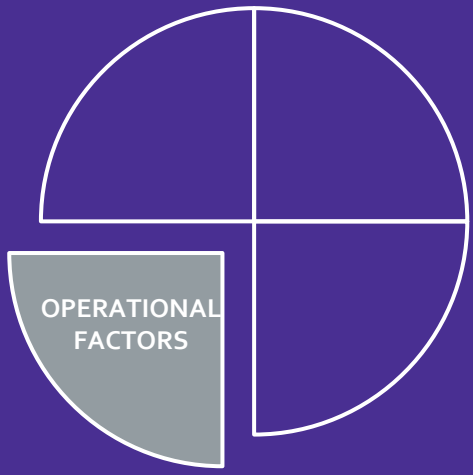
## Encouraging staff movement

Several participants talked about the cultural shift required from staff, and especially from consultants. Overall, there was a view that getting their buy-in was central to HVLC's success.

> ***If the consultant is not supportive, it makes your job [for schedulers] impossible** (...). Then the knock-on effect that this has on the theatre staff because they fear all the criticism from the consultants. Then they take that as their opinion and that's what they voice."*

In addition to settling them with IT (see slide 36), they made a number of suggestions on how to make their experiences of working across a number of sites smoother. These included inductions, liaising with them ahead of surgery to find out their equipment needs, and debriefs with the surgical teams.

One participant also mentioned the need to move away from what they described as a consultant's culture of "*the bigger your waiting list, the better*".




# *Staff Insights*
# Operational factors

# One of the biggest challenges identified by participants related to issues of resourcing the hubs

**A recurring theme in staff interviews was the discussion of wider workforce challenges, beyond the pandemic-related fatigue and re-deployments, which meant that resourcing the elective hubs was often challenging.**

This meant that some hubs had to:

- **rely on agency staff or hub staff working overtime -** this was compounded by the fact hubs didn't use trainee clinicians.

- **run their lists over the weekend -** in addition to resourcing implications, one participant noted that minimal staff cover meant that she sometimes found it hard to escalate issues or seek advice.

> *My personal view is that isn't sustainable because we're relying on our nurses to work on the bank and working on the bank is not a sustainable way forward for a service.*

> *[Consultants] can't use HVLC lists for trainees because it stops the high volume nature of it because the trainee will take longer.*

> *As a Band 7, I didn't have a Band 8 with me (...) I didn't have any other Band 7s around, which normally during the week I would do. So I suppose from actually a leadership point of view it felt a little bit isolated....*

**To respond to resourcing issues and HVLC demands, some hubs had put measures in place aiming to streamline processes** and free up clinical staff and consultants' time, such as:

- Standardising the triage of patients to help identify those who may be ready for intervention.
- Liaising with GPs to ensure patients' stable condition before coming to the hub.
- Taking all medical history prior to a patient's arrival at the hub.
- Getting nurses (rather than consultants) to obtain consent from patients.
- Setting up workstations at pre-assessment clinics.

> *We just make sure that all the paperwork is ready for the admin side. Then the [nurses] make sure that whatever needs to be done before they list the patient. All the tests which are required prior to the surgery. Then they pass all the case notes to us and we make sure that everything is there and then - it's all like step-by-step."*

# Without the right systems in place, it could sometimes be a struggle to enable staff and patient movement across hospitals

**Staff also discussed organisational challenges, linked to practical issues around how the elective hubs and their hospitals were set-up.**

A major blocker identified by participants was the **lack of interoperability between IT systems and hospitals.**

Without interoperability, staff noted it could be complex to:

- Manage referrals and lists of patients from another hospital (see slide 38).
- Facilitate staff working across a number of sites

In light of this, **some hubs had put measures in place to ensure the digital capabilities needed to manage HVLC lists were in place.**

Another challenge mentioned stemmed from having to navigate complex HR hurdles when tyring to enable staff movement, so that consultants from other hospitals could come and operate at their sites.

> *"Obviously, everyone that is new hired, everyone is put in a [Trust] contract, so you can work across sites and that's new, but if you're talking about consultants and surgeons, they've probably been there for a while. They probably were there before [new trust] was created, so that has been a big issue. It's always been a big issue."*

Participants from one hub explained how they had created a **central tracking system** which could also be accessed by referring hospitals; this enabled a smooth and efficient flow of information between the hospitals, in real time.

The same hub, to **facilitate staff moving working across hospitals,** had also put some measures in place such as: arranging inductions, sorting out non-hub staff parking, and collecting the smartcard details of all the non-hub consultants coming to work there ahead of their shifts so they could access their network and log into their computers straight away.

# Staff agreed effective scheduling is central to delivering HVLC, but felt that scheduling HVLC patients can be a complex and time consuming task

**Participants mentioned a number of reasons for this, some were directly related to infection prevention control (IPC) measures introduced during the pandemic, whilst others were linked to what they felt was lack of manpower and resources to effectively schedule and manage HVLC lists.**

**Covid testing, IPC measures and cancellations had made scheduling more time consuming.**

- **Having to arrange Covid swabs** for patients.
- **Backfilling lists,** which had become harder due to the three day isolation period.
- **Arranging interpretation** or asking family members/carers to accompany a patient, which was not always possible at short notice.

**Booking out-of-area patients for operations** had made scheduling more complex as it involved:

- **Working with other hospitals** with different operating systems.
- **Sourcing out of area patient information** from colleagues across the Trust.
- **Reassuring out of area patients** about being treated at a hub.
- Discussing **and arranging transport to the hub**.

**Filling HVLC lists.**

- Asking patients to get operated on at **short notice,** and trying to fill HVLC lists whilst fulfilling various requirements (as previously discussed).
- **Identifying HVLC patients** with some schedulers unsure about the inclusion criteria.

> *From a scheduling side it's been a bit of a task obviously because trying to get that volume of patients through for starters.* ***We've not had the correct resources to be able to do that****. We've been short-staffed, we've had lots of sickness and annual leave and things like that.* ***For us to be able to get these patients booked, it was an additional piece of work that we had to do."***

> *There's a lot* ***more into identifying those patients and working closely with pre-assessment*** *than it would be for non-HVLC lists"*

# Providing training and support to schedulers was identified as a key priority by the hubs going forward

**Participants shared examples of good practice of involving schedulers in discussions around programme implementation. They also suggested how to support them managing HVLC lists going forward.**

There was an agreement that increasing schedulers' job satisfaction and sense of fulfilment by providing them with **additional support** was critical, especially as the scheduling ask required additional communications skills to handle patient questions (see slides 39 and 60).

> *Band 3 staff don't really have much career progression, so there isn't that much motivation to do that and it's quite a skilled role actually to be able to persuade a patient and answer all their questions."*



Participants discussed some measures put in place in their hubs to support schedulers, such as:

- Including schedulers in discussions around HVLC at the implementation stage to make sure 'everyone is on the same page'.
- Helping them to identify HVLC patients- for instance by adding a 'fit for HVLC' category on the operating lists.
- Helping them source of information on HVLC patients- for instance by increasing interoperability between the hubs and referring hospitals (see p.25).

> *It's more around that encouragement of these individuals when they have not much motivation. For them it was, 'Oh my God, there's another tick box I need to do.' When we were doing this, we had a lot of mixing priorities."*

> *What we do now through pre-op assessment is that, normally, we use to write, comes up on our operating list, 'Fit as per pre-op assessment.' It now actually says, 'Fit for HVLC,' so the schedulers know that those patients are suitable for an HVLC list. That was the step that we were missing beforehand."*

# In addition to measures already in place, staff made a number of practical suggestions around what kind of support schedulers would need going forward

They included:

- **Additional training on having challenging conversations** with patients around patient choice, as well as the provision of scripts, shadowing and peer learning, as there might be some patients concerned around continuity of care. It was felt it is critical for schedulers to frame the conversations the right way.
- **Having regular touchpoints** with teams to understand patients' reactions and concerns.
- Making sure **consultants consistently support schedulers** by also having conversations around patient choice with patients.
- Giving schedulers further help in **identifying HVLC patients**, for instance through providing user-friendly and concise Standard Operating Procedures (SOPs), and information packs with key contacts at each of the referring Trusts to make sure they easily know who to reach out to if they want to discuss a patient.

> *[Schedulers] don't really have the **empowerment or the resources or the confidence to actually have those conversations**, so it gets very tricky at that level."*

> *There are some very skilled schedulers who manage to get anyone to say yes to anything. It's like salesmen, isn't it? They're very skilled in... **We're finding it works when clinicians list patients in clinic 'We've got a consultation, I'm listing you for surgery, I'm operating next week at [hospital] but we're at [other hospital]. You're coming with me. I'm your surgeon it's just that's the place we're doing it.' If at that stage we get the patient listed they go**. If the scheduler then phones later and says, 'We're moving you to [hospital] or other hospital],' they don't want to go."*

# The implementation of the programme had also brought a number of benefits, including encouraging partnership working across Trusts

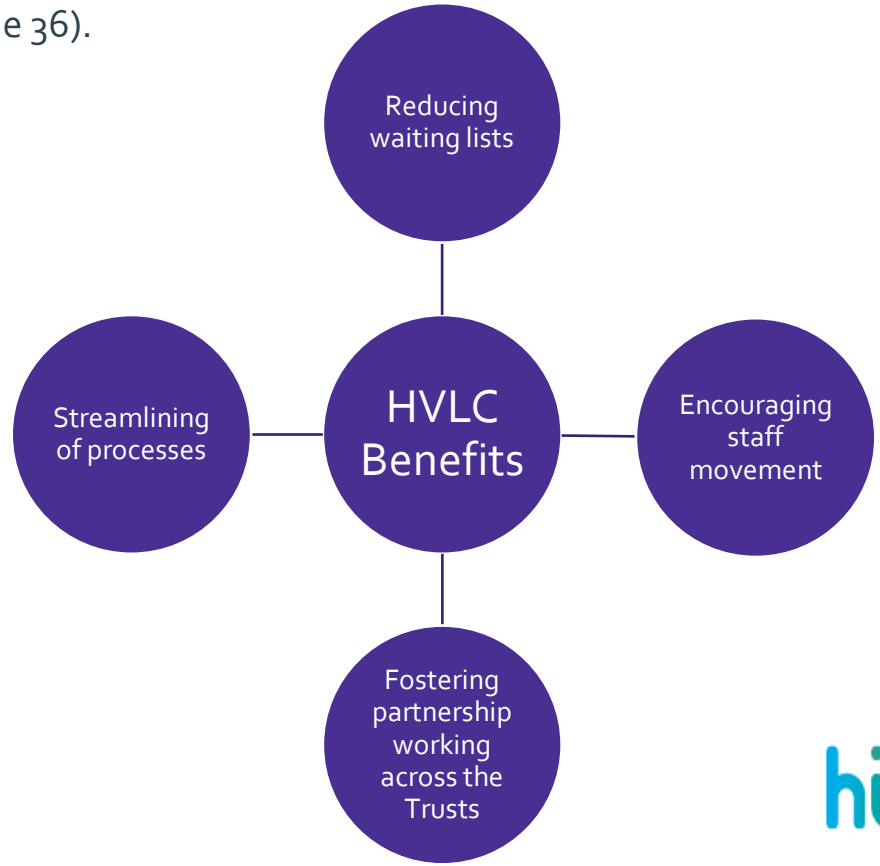
**In addition to streamlining processes (see slides 25 and 35), reducing waiting lists (see slide 25), and encouraging staff movement (see slides 33 and 36), some participants also highlighted how HVLC had opened up partnership working across Trusts.**

A few participants shared examples of **working collaboratively across their Trusts** to implement the programme, and how this had **benefits beyond the management of HVLC lists.** They noted that, when partnership working happened, there were higher levels of engagement and faster progress in agreeing and implementing new approaches to care in support of elective recovery, including HVLC.

> *It's just **building up relationships with those external hospitals and partnerships** with them to make this work. It's not any one person that can put this in place, it has to be a team effort, and it's worked really well."*

For big hospital trusts, establishing connections across the hospital network to implement HVLC had been especially critical. This had meant reinforcing pre-existing relationships within the Trusts, especially on the administrative side. It has also been an opportunity to develop and work on weaker relationships.

Practically, this had led in some instances to more efficient sharing of patient information between different hospitals and smoother and greater staff movement (see slide 36).



# *Staff Insights*
# Experiences of working at an elective hub

# Even among those more critical about the impact of the programme, the clinical staff interviewed seemed satisfied with their roles treating HVLC patients

**Although the programme staff and those in senior roles noted that working on HVLC had brought additional pressures (see slides 12, 24 and 44), the clinical staff tended to be positive about their day-to-day roles at their elective hub.**

Whilst acknowledging that shifts could be demanding, notably because of the busy nature of the elective hubs as well as volume of patients to treat, some also discussed how they enjoyed:

- **the pace** at which operations were scheduled, which made the day go quicker.
- the satisfactory feeling of working on **clearing the backlog** of patients waiting for surgery.
- the **low stress** of working on non-complex operations and patients, with some noting its positive impact on their health and wellbeing.
- working within **smaller teams** within smaller settings, with a shared understanding of what they are trying to achieve.
- being **kept up to date about success and progress**, suggesting the importance of cascading information to front line staff.

In addition, the clinical staff we talked to **did not express any concerns over deskilling,** as long as they could also carry on working with non-HVLC patients.

However, **views about working at weekends were mixed**. Some expressed concerns over tired staff taking additional shifts on the weekends and how this would not be sustainable over time. However, one participant noted that this could be a positive, and an opportunity for team building.

> *I think that speed of having quite a large number of patients, personally (...)* ***the day goes quicker. You're constantly going,*** *there's not a lot of downtime periods, which can be stressful, but [the cases] are not extremely complicated, I haven't had anyone complaining to me that there's too much on the list, or that, so they're not finding that the cases are boring to work with."*

> *We know what we're here for, everyone has an understanding exactly of what their role entails, there's no confusion.* ***With the smaller team and the smaller area of the hub, it does mean that you have a really good level of communication between the team.*** *I think it's just something that makes everything run a little bit smoother."*

# Participants working at a standalone hub were especially positive about their experience

**Participants working at a standalone hub tended to be especially positive- whether this was about their day to day role, or about their perceptions of patient experiences at their hub.**

Like participants in other hubs, they agreed that **working in smaller teams**, in well-contained settings, allowed for **better communication and understanding between colleagues, as well as better interaction with patients.**

> *At the hub, we are in such a small space, every new face is a noticed face. If you see someone and you're not sure who they are, you know this is either a patient or a new surgeon or a new SHO. **Everyone is very familiar with what's going on**, where I think in a larger hospital, you don't know who is who".*

In addition, they noted how their set-up (i.e. being physically set up away from the main hospital) had positive repercussions on staff wellbeing. One senior clinical staff emphasised that this meant he could concentrate on getting on with the scheduled operations at the hub, rather than feeling pulled in every direction.

> *From a... health and well-being point of view, that can be incredibly stressful where you're being pulled four or five ways at one time and, therefore, to have days where you know actually, **I'm just going to sit and focus on one operating list and not have to necessarily think about different solutions I think is quite good for our health and well-being at times**."*

Participants from the standalone hub also mentioned receiving positive feedback from patients, whether it was on the care received or the hub itself.

> *Having everything close to one another you can wander, and you can talk to patients, and interact with the patients, and give them the **best sort of communication experience that you would hope for. I think that's an advantage to patients**."*

It is important to note that there could be a dichotomy of views between clinical staff, and some of the programme and senior staff interviewed felt additional pressure because of HVLC's objectives (as discussed on slides 24, 30 and 31).

> *I would say there's a bit more pressure purely from just the fact that you have to make sure that everything - **you've got a criteria to meet, and there's much more of a focus on making sure that we do hit that KPI of patients not being here for the whole day** if we can reduce it, and that really does come down to making sure that everything is 100 per cent."*

# Staff agreed that an adequate training offer and support were requirements going forward

**There was some variation in the support and training offer for staff to deliver the HVLC programme. However, hubs noted that they planned/needed to put more in place going forward. They thought this was an area of additional support that could be provided by the regional team.**

- **The training offer varied from hub to hub.** For instance, one of the hubs had some teaching time set aside, whilst others had a more impromptu approach, with training provided on an ad-hoc basis. There didn't seem to be any HVLC-specific training, which was perceived to be especially problematic for schedulers considering the additional responsibilities they faced (see slides 11, 38-39). Although some hubs provided them with scripts, it was felt that overall the training offer was inadequate, with one scheduler commenting on how she had to 'learn on the job'.

- **In the absence of a consistent approach, peer support and team working were identified as key enablers to delivering HVLC.** Participants noted that strong team work and relationships had been key to the running of elective hubs. This was perceived to be even more important in the context of staff burnout and workforce pressures. Some participants described a sense of comradeship between staff members, with support from colleagues across bands and roles helping one another out.

Although staff seemed to be well supported by colleagues within the hubs, one participant highlighted a potentially missed opportunity for **cross-site learning and support**.

A few participants also highlighted they would value more support from the policy team. This included greater information sharing from the start, with a clear understanding of the purpose and processes of the hubs.

> *"**We really support each other. We will relieve each other**. If that theatre finishes early, the colleagues from that theatre will prep for the next day. If someone needs to be relieved for lunch, even our line manager will step in and assist."*

# *Staff Insights*
# Perspectives on patient care

# The perception of staff was that there were limited barriers to accessing care at HVLC hubs; however, travelling to a hub was the most common issue identified by staff

**Participants identified a number of barriers for patients to access HVLC care- whether they had direct experience of dealing with patients hesitant about being treated at an elective hub, or simply reported anecdotal evidence. However, it was felt that overall such barriers were not common issues for patients, and (as discussed on slide 27) concerns around health inequalities were limited.**

- **Having to travel to a hub was the most commonly identified barrier** by participants. They discussed how the location of the hub could present an obstacle to patient attendance as they might struggle to arrange transport to travel there, especially if they had to get there first thing in the morning (see slides 53-54).

- As such, there were a few reported examples of patients preferring to be treated at their local hospital, even though it meant waiting longer for care. However, this did not appear to be a common issue.

- Although all the hubs offered to arrange transportation for patients who might need it, participants noted there could be some confusion and inconsistency on how this was offered to patients, something also flagged by the patients interviewed (see slide 52).

> *"One of the disadvantages that I've seen is the 7:30 starts, they seem to be harder to book. The booking teams come back to me and say, 'Nobody wants to get there for 7:30 in the morning, they all want a later in the day slot', so clearly **there is something about getting to [the hub] that is slightly more challenging**."*

> *"There were quite a few [patients who refused to be treated at hub]. I **think because the communication, it wasn't great to start with**. I think they'd said, well, you have to arrange a taxi and we didn't know, in admissions, that that was getting sorted. We were like, 'Well, we're not booking a taxi. If you want the operation, you'll come.' It turns out we could have booked taxis for them. Now, we've got that information, as soon as you tell them that they're quite happy."*

# Staff identified some access barriers linked to misconceptions or concerns around the quality of care received, and felt they had a key role to play in reassuring patients

**In addition to having to travel to a non-local elective hub, additional barriers to HVLC care were identified by staff.**
They included:

- Being given little notice before the scheduling of an operation. This could be problematic for some patients with work or caring responsibilities.
- Feeling loyal to a familiar hospital.
- Having concerns over the reputation of an elective hub .
- Having concerns over the continuity of care if being treated in an unfamiliar hub.

Yet, participants were keen to point out that **those concerns were mostly outweighed by patients wanting to be treated speedily,** whether it was because they had had to wait a long time for their operation, or because of the impairment their condition had on their quality of life

> *Some have been waiting for their cataract surgery for three years or more, so **for them just the opportunity to go anywhere to have their surgery is a blessing to be honest, and these are the words of the patients.** They're really grateful to come."*

Such barriers or concerns point towards **the key role of communicating clearly, consistently and transparently to patients,** not only around **transport** but also to **tackle misconceptions or concerns** around the quality of care received at the elective hubs.

> *The other thing about the hubs are that they need to **not come across as sausage factories** as sometimes it's been mentioned, but to demonstrate high-quality effective care."*

Participants also noted the need for more communication support - mirroring findings from the patient interviews (see slides 54 and 56).

> *So recently the regional team did a video on waiting well when you're waiting for your own surgery. What they didn't do was to explain to patients that if you're offered this procedure at a different site, please be reassured that this will be as high-quality and feel confident enough to move to that site and so there was a bit of a missed opportunity there."*

# 4

# Patient Insights

# The patients we talked to tended to be very satisfied with the quality of care received at the hubs

**Overall, all but one participant described very positive experiences of care, whether it was pre-, during, or post-surgery.** Some participants even mentioned being surprised about the quality of care received amidst the pandemic.

> *"**I thought considering we've come out of COVID (…), I just thought the level of service was excellent.** [The staff] didn't really leave you for very long; they made sure I was okay. They brought me something to eat afterwards and when I was waiting for my son, I'd already had a cup of tea and they said, 'Oh, so you're waiting for an hour; we'll just bring you another cup of tea.' It **was really nice, really good service and very efficient**."*



When describing their experience of being treated at a hub, participants were keen to emphasise:

- How **quickly their operation was scheduled** after the initial appointment with their consultant.
- How **caring the nursing staff** were during their pre-assessment appointments, and even more so on the day of surgery .
- The **quality of care received from their consultants**. This was whether they were operated on by their initial consultant or somebody else.

However, **beyond the quality of care received, participants' experiences could vary**. When patients reported some issues, those were, more often than not, down to perceived poor communication or miscommunication from hub administrative staff. More specifically, patient interviews highlighted how there could be some **inconsistency in how information was relayed to them by schedulers and administrative staff,** whether it was related to transport or when to come for surgery.

# Patients were overall accepting of travelling for their care, but providing explanations for referring them to a hub was important

**Most of the participants were referred to a hub which they would not consider to be part of their local/closer hospital.** It is unclear whether participants were more accepting to travel for their care because of the pandemic. However, it was apparent that **being treated quickly clearly outweighed being treated somewhere local** for participants (which mirrored staff's perspectives). Doing so also seemed to prevail over continuity of care, although participants tended to think this was still also an important factor.




While patients did not feel they were given the choice about where to get treated, most of them were accepting, especially if that meant they could 'follow' their consultants. However, there were some notable differences in how this had been explained to them. **Consultants had a key role to play in providing information to patients**, such as the rationale for being treated at a specific hub, what patients should expect next, and on the day of surgery. They could also be instrumental in **alleviating patients' concerns around continuity of care** (if they were not to perform the surgery themselves). And while in most instances consultants appeared to do this well, a couple of participants felt they were told very little, which led to confusion further down the line.

> ***I thought that the consultant I saw at [hospital] would be the person doing the procedure, but I think I got a gentleman doing the procedure who I didn't see*** *(...) The person who came to talk to me about the procedure, I think she was a junior doctor, said to me, 'Oh I'm one of the doctors on the...' whichever department I was in. She went through everything with me, went and spoke to the consultant, and she said, 'Oh I've just had a word with my consultant...' who I assume is the person that did the procedure."*

Additional confusion could also occur when patients received their appointment letters- for instance one patient reported that their letter stated they would received general anaesthetic; another one had the wrong location for their surgery.

# Patient experiences prior to surgery were mostly positive, with some caveats

As part of the interviews, participants were asked about the experiences pre-surgery.

**Participants reported positive experiences of attending pre-operative assessment appointments and one- stop clinics**.

Most appointments were carried out at the hubs, but a few had telephone appointments which participants didn't seem to mind, suggesting that acceptability of virtual appointments for some had increased during the pandemic.

> *"It didn't concern me, it was just, I guess, unusual, because I didn't have a pre-op or anything. I had two surgeries before. I never had one over the phone, it was always going in and doing the tests and stuff. I was fine about it, yes, it was just different."*

**Although most participants were amenable, as they were keen to get treated quickly, some raised the inconvenience of having to travel to the hub several times within a short period of time,** especially when they lived far away. This suggests that making sure patients' Covid tests are booked on the same day as their pre-op assessment appointments would be welcome.

For instance, one participant explained how she had a pre-op appointment on a Monday, a COVID test on a Tuesday and her surgery performed on a Friday.

**Most participants reported feeling well prepared ahead of surgery; this was mainly due to the conversations they had with nurses during their pre-op assessment appointments.** A few however noted that more information (in a written format, as would provide more easily digestible) detailing the different things to expect on the day of surgery, could be helpful:

> *"It would almost be useful if somebody handed you a piece of paper [telling you] these are the things that are going to happen before your surgery. You'll see your surgeon, you will see the anaesthetist, you will have your ops check, and we'll ask you to get into your gown. They will normally happen in this order".*

Some participants noted gaps in the information they were given around the practicalities of getting to their hub (see next slide).

# There was some inconsistency around how information about hospital transport was relayed to patients

**While travelling to the hubs was not flagged as a major issue for participants, with most of them relying on relatives or friends for travel to and from the hub, some had to rely on private transport such as taxis.**

Among those who did, several issues came up, including:

- The **costs** associated with taking a taxi.
- Not being able to book a taxi **far in advance**: for those booked early in the morning, taxis had to be booked in advance. However, they could only be told quite late into the day when their surgery would be, which could cause some stress.
- Having concerns about **their taxi not turning up** as cab companies are not always reliable.

> *Not everybody has the convenience of owning a car, being able to drive, have somebody to drive them there. So I had to book a taxi, but I couldn't book a taxi because I didn't know when the operation was going to be. They were going to phone me on the Friday, the day before the operation, to confirm the time and everything was going ahead.* ***Which was rather stressful, because trying to get a taxi these days for a Saturday, it's near impossible. I had to phone two or three companies*** *because it's, no, we don't have drivers for that time (...) It's early in the morning, and also there's a shortage of drivers."*

**There was also some inconsistency on whether they were told transport could be arranged for them or not**. This could be because whilst the programme has resourced transport funding for those for whom a cab ride would be financially challenging, it is not a general offer – and most patients would be expected to organise their own travel arrangements.

While some participants were made aware of it by their consultants or the schedulers, others had just found out about it going through the information they were given. But some participants did not recall being told or given any information about this.

> *I did read it somewhere in the information that I was given, but I just assumed that was for old people and more needy people."*

# Patient case study

One urology patient explained how transport was arranged for him by the hospital team. He was asked to be at the hub at 7.30am but his surgery wouldn't be that early. The driver picked him up at 6am and arrived at the hub at 6.40am, long before it opened. Confused and not knowing where to wait, he walked back to the main hospital reception and waited there until 7.30am.

> *"I had to go and wait in the main building and there was a little bit of confusion regarding that which needs to be looked into. Several people that were there, were in the same situation. The main building had no-one on the reception. There was no-one there, so I just waited."*

While he was discharged and was ready to go home at 1.30pm, he had to wait until 5pm for the hospital transport to turn up.

> *"I just wanted to get back so it was a very long day. So I ended getting home about half-past-six in the evening. So it had been a long day. I was up at 5.00 in the morning, and yes... a couple of the nurses had actually chased up where the transport was and they said that no-one's been allocated to take me home so that was definitely a big negative. To have the transport isn't great at all. So If I know what I know now I definitely wouldn't use hospital transport."*

# Some participants flagged issues relating to lack of information or miscommunication around when they were told to come in for surgery

To improve patient flow, elective hubs stagger operations throughout the day, with patients generally split between morning and afternoon shifts. Although doing so means some patients might have to wait several hours for their operations, participants were generally understanding about this (see next slide). **However, they mentioned issues around how they were told when to come for surgery.**

In most instances, participants had been told after their pre-op assessment that a scheduler would call them the day prior to surgery to confirm what time they should come to the hub. This meant some participants **waited several hours to be called,** which could be inconvenient, and sometimes distressing. It also meant that **they were not always able to confirm travel plans until late in the day.** Those relying on private transport found it especially inconvenient (see previous slide).

**There were some reported inconsistencies around when patients were told to come on the day of their surgery**. For example, one participant was confused at being told by a scheduler to come at a different time to what was on her appointment letter.

> *Well, **this is a point of poor communication**, my letter said my operation, I had to be there at 8:30. (...) Every time I spoke to somebody at [hospital], they said, 'Get there for 7:00.' So I got there for 7:00, along with a lot of people, and I think the consultants and surgeons and things like that came around about 8:30, the anaesthetist came round at a similar time. I don't think I went down to surgery 'til about 11:00/11:30, which I was expecting, but my letter said 8:30 but when I spoke to the hospital they said 7:00. I queried it, because I was, like, **'Well, my letter says this and you say that**."*

**There were also reported instances of patients not being told when to come, and showing up at the wrong time**. One participant, who was told to come in the afternoon for her operation, recounted how some patients waiting with her were not informed on when to come in, so decided to arrive first thing in the morning, but were actually scheduled for the afternoon.

> *So they called me and let me know to come in because I was in the afternoon slot but [some other patients] said no one called them before, that they were waiting. They came in in the morning and they're waiting until evening time."*

# Participants were accepting about having to wait sometimes several hours to get surgery, but had mixed views about hospital cubicles

**As discussed on slide 54, patients were understanding about being given a time window rather than a specific time for the operation. However, there were some differing views about what constitutes a good waiting environment.**

**Participants were satisfied with the waiting environment- especially communal waiting rooms.** Some commented how waiting with others had been helpful to appease their anxiety:

> *It's nice to have people there. I think, yes, **I'm reassured with other people being there**, and somebody else is going through it as well as me. You do start to chat. (…) **Being left sometimes by yourself, you do feel a bit lonely**. Actually I have to say, I've had that in the private sector. You're put into the private room, and at times you wonder what's happening with you, because you don't see anybody."*



Views about cubicles were a bit more mixed. Some participants liked the privacy they offer.

> *The little cubicle was quite private and you could draw the curtains, or you could have it open and interact with other patients that were there. That was your choice."*

However, some patients found them isolating, and they did not suit those with anxiety issues. As such, one participant suggested that information about one's mental health should be collected as part of the pre-op assessment so that nurses were aware and could keep an eye on patients who were more vulnerable.

> ***It can be a little bit overwhelming to be in a cubicle** where you can hear nurses going to see the other people and **wondering when it's going to be your turn and what's going on**. Actually, there was a woman across from me who was really, really struggling with her anxiety and I could hear she was really upset and quite stressed about the whole process."*

Some participants also commented that they found it hard to not drink water or eat for several hours. However there was **some inconsistency with the advice given**, with some participants told they were allowed to drink some sips of water while others were told they could not. In any case, not having a set time for surgery meant that patients did not really know how long they had to last without food and water, which they could find difficult.

# Ongoing communication from clinical staff with patients on the day of surgery was a key driver to satisfaction

**Reflecting on their experiences of being treated at an elective hub for surgery, patients tended to be very positive. Participants especially valued being kept in the loop and interacting with staff, suggesting the importance of maintaining ongoing communication with patients throughout the day.**

As discussed on slide 49, most participants commented on how attentive hub staff were. Being offered food and drinks was especially appreciated.

**Staff interaction was particularly key to a good surgery and recovery experience**. Patients valued above all clinical staff checking on them, and sharing information with them about their surgery. As mentioned in staff interviews (slide 42), the ways hubs are set up (i.e. confined smaller places and smaller teams) lend themselves to such exchanges between staff and patients.

**The discharge process was described as positive when patients felt they were given enough information,** whether verbally, in written format, or ideally both, about what to expect next and what to look out for.

A few participants explained how they would have liked a bit more aftercare. For instance, one participant noted she would have liked a nurse to call her the day after surgery to check on her, as the information she was given was a bit too generic:

> *I think a follow-up phone call would have been better, because a follow-up phone call is always going to be more specific to the person than a leaflet because everybody's different."*

> *The actual people themselves were very, very nice. The anaesthetist was so nice, and the nurses were nice as well.* ***It's just keeping you informed because I personally didn't know when the procedure was going to be."***

> *Just the whole thing, really, from, the nurses on the ward I was on were very attentive, checking I was okay. The surgeon came to chat with me, and a doctor that gives you the anaesthetic, they came to chat with me.* ***They explained everything and the procedure. Yes, no, they were very, very thorough."***

# 5
# Recommendations

# Formulating recommendations

- The following recommendations have been drawn from the **staff and patient insights** gathered as part of this research, as well as **subsequent discussions** held with some of the stakeholders involved in the co-design group, and patient representatives.
- The following slides present these recommendations, which have been grouped into three categories:



**1.**

**Recommendations around how to improve the HVLC programme's implementation and delivery across elective hubs going forward.**

**2.**

**Recommendations around how to improve the experiences of clinical and administrative staff working in elective hubs.**

**3.**

**Recommendations around how to improve the experiences of patients treated at an elective hub.**

# Improving the HVLC programme's implementation and delivery across elective hubs

Implementation change is often challenging. In order to ensure the successful delivery and sustainability of the HVLC model going forward, a number of suggestions were made, including:

- **Rebranding the programme:** there was an agreement among the staff interviewed that the current terminology has negative and misleading connotations for staff, and doesn't fully reflect what the programme actually aims to achieve.
- **Ensuring the pathway selection criteria is kept under regular review**, to see how thresholds can be lowered safely without risk to either patient or undermining the effectiveness of patient treatment through the hubs
- **Developing a consistent and systematic approach to sharing good practice**: this research has highlighted success stories and good practice happening across sites. NHS England has a key role to play to ensure that good practice, and key implementation and delivery lessons are shared widely and consistently among elective hubs.
- **Evaluating more thoroughly the impact the HVLC programme has on health inequalities, including assessing equity of access, uptake, experiences and outcomes across different patient cohorts:** the impact of the programme on health inequalities is currently unclear.
- **Developing principles to support greater standardization of common SOPs to facilitate implementation and encourage consistency across sites.** In addition, NHS England could provide sites with guidance documentation, Q&As, and script templates to help administrative teams and alleviate the additional workload associated with implementing a new programme.

# Improving the experiences of clinical and administrative staff working in elective hubs- 1

Recommendations stemming from the staff insights and discussions with stakeholders mainly focused on the **need for training and addition support for schedulers, and facilitating staff movement.**

A number of measures could be put in place in order to **support scheduling and booking teams in their day to day role**, such as:

- **Providing additional training for schedulers around how to manage conversations with patients**, including how to: communicate clearly and simply the benefits of getting treated at an elective hub, alleviate concerns around continuity of care, provide consistent information about transport options, and explain what to expect on the day of surgery.
- **Developing their digital capabilities**, so they can effectively to manage HVLC lists.
- **Providing schedulers with opportunities to shadow clinical staff, and to be included in operational conversations.** Doing so would give them a more rounded and holistic understanding of their service works, and could increase their job satisfaction, self-efficacy and work engagement.
- **Providing generic templates, scrips, FAQs documents** they can use to help them in their day to day work (see previous slide).
- Beyond schedulers developing their capabilities, and being provided with practical support, clinicians including **consultants, pre-op staff and GPs also have a key role to play in supporting schedulers** by ensuring they have conversations with patients about rationale for referring them to a specific hub.

# Improving the experiences of clinical and administrative staff working in elective hubs- 2

**Staff movement** could be facilitated by:

- **Arranging inductions**, so staff travelling to a hub (i.e. operating surgeons, anaesthetic staff, etc) get to meet other members of the clinical team and see how the theatre they will work in is organised ahead their shifts.

- **Providing practical support to visiting staff** to ensure everything is in place before their shift starts. This can involve sorting out their parking, and collecting their smartcard details so they can access hubs' IT systems straight away.

# Improving the experiences of patients treated at an elective hub pre-surgery

Recommendations stemming from the patient insights and discussions with stakeholders and patient representatives overwhelmingly focused on **the role of communicating clear and consistent information pre-, during and post- surgery.**

## AHEAD OF SURGERY

- **Patients need to be fully informed of what being treated at an elective hub involves**, so their decision-making is rooted in facts, rather than assumptions. This also means that those who refused treatment at a hub understand the implications of doing so, including **having to wait longer for surgery**.

- **Primary care staff have a key role in increasing awareness of elective hubs**, and should have frank conversations with patients around waiting times, and the pressures experienced by the NHS.

- Clinicians including GPs and consultants have a key role to play in:
  - **helping patients making informed decisions about HVLC care** by explaining the rationale for recommending them to be treated at a specific hub.
  - **providing clear and consistent explanation to patients about what to expect** when being booked for surgery at an elective hub- this would not only help alleviate any concerns patients might have but also help schedulers in managing conversations around patient choice.

Because patients might have to travel further for their care:

- Elective hubs should be required to identify **the most appropriate transport solution for patients**.
- Hospital transport should be fit for purpose, minimising unnecessary waits for patients on the day of surgery.
- **Schedulers should provide clear and consistent information** to patients so they are clear on whether they are eligible or not for free transportation.
- Patients should be alerted as soon as possible on **when to come for surgery** so they have enough time to arrange transportation.
- **Travelling to the hub pre-surgery should be kept to a minimum,** for instance by considering where multiple pre-surgical appointments can be held on the same day or within a one-stop clinic.

# Improving the experiences of patients treated at an elective hub on the day of surgery, and post-surgery

## ON THE DAY OF SURGERY

- **The waiting environment is a key element to patient experience and can have a major impact their wellbeing and mental health ahead of their operation**. Waiting should always be minimised, however where waiting is necessary both pre and post surgery regular staff checks on patients should be undertaken to assess any sign of distress and offer appropriate support if required. This is particularly important for patients waiting alone in cubicles which may be very isolating.



- **Ongoing communications of staff throughout the day**, whether it is ahead of or during surgery, and during recovery greatly matters to patients.
- **Communications with HVLC patients should be**:
  - **constant**, throughout the patients episode of care at the surgical hub.
  - **consistent**, between patients and throughout the episode of care at the hub.
  - **compassionate**, demonstrating empathy and understanding of not only the clinical condition but also the emotional stress of waiting for surgery.

**POST-SURGERY:** postoperative follow-up should include **a rapid phone call on the day after the surgery**. Although this might not be medically necessary, this could help optimise patients' experience of HVLC care and alleviate any concerns they might have.