



Medical Administrators Study

Report to Health Education England

February 2019



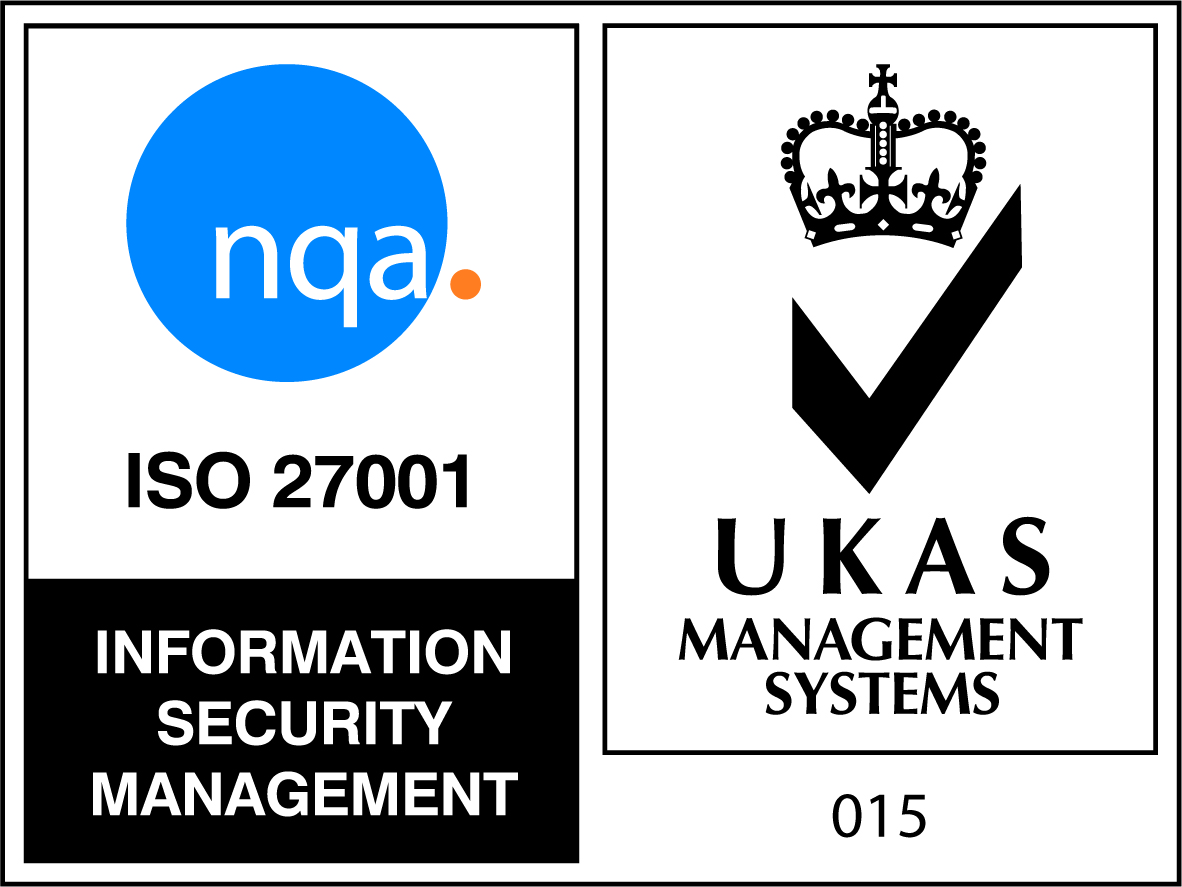
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# Executive summary

This study was commissioned by HEE and was delivered by [Traverse](https://traverse.ltd/), an independent employee-owned research and consultancy organisation. The study aims to understand the scope and impactof administrative roles in primary and secondary Urgent and Emergency Care settings (including mental health) across the HEE Midlands and East region.

The research has sought to understand:

* What **kinds** of medical administration roles exist and what are the **commonalities and differences** between different roles?
* What **skills and experience** are required for the roles?
* What are the **enablers and barriers** to achieving impacts?
* What does the **scale and shape** of this workforce look like across the region? What are the size of the impacts and costs avoided?
* What **role might HEE have** in developing and standardising this workforce?

The definition of “medical administrators” (MAs) that we have used has two main components:

a) Roles which are **completely (or broadly) administrative** so this would not include administration being undertaken by for example, Healthcare Assistants or Nurses.

b) Roles which provide administrative support to clinical staff, and which **displaces work from** them, freeing them up to do other work.

We considered both **specific medical administrator roles** (e.g. a Clinical Administrator) and **specific types of work** (e.g. workflow) which can be carried out as part of another non-clinical role (e.g. by a receptionist).

The study has involved the following activities:

**Desk research and scoping**

**Feb ‘18**

**Depth case studies (9 settings)**

**Mar-Oct ‘18**

**Online survey of settings (25) Oct-Dec ‘18**

**Coproduction workshop Feb 19**

To explore attitudes towards & prevalence of MA across Midlands & East

To share the key findings & generate recommendations

To understand the types of roles & tasks by running online job searches

Interviewing MAs & colleagues in primary & secondary settings & economic analysis

## Key findings

|  |  |  |
| --- | --- | --- |
|  | **Primary care** | **Secondary care** |
| **What roles did we find?** | Several different roles carrying out workflow administration (e.g. medical summarisers) alongside several distinct MA roles: care navigators, complex prescriptions clerks (who add new scripts onto patient records, change titrations, or take scripts no longer relevant off the template) and collaborative care team coordinators (who identify and support patients at risk of hospitalisation). | We found lots of overlap in the types of tasks being undertaken by different MAs. This included collating notes, patient discharge and supporting ward rounds and MDTs. Some roles specifically focus on supporting foundation doctors, others focus on assist with tasks across the patient pathway. |
| **Recruitment & progression** | MAs are often recruited internally. It can be a welcomed form of career progression for receptionists. There is limited scope once they are in an MA role, especially in small practices. A big emphasis on learning on the job and support from a lead clinician. | There is a greater emphasis on external recruitment in secondary care. There is more scope for career progression once in an MA role (to a Band 4 or 5 role) although many settings have only recently introduced, so there are few examples of progression. |
| **Role requirements** | It can take years to gain full confidence and competence in some MA roles in primary care. Staff successfully carrying out this work are often long-standing employees who are jealously guarded from other local employers. | It typically takes several months to develop confidence and competence. Backgrounds and requirements vary (e.g. psychology degree vs. a basic education and strong administrative experience). The patient facing nature of roles is often a key attractor. |
| Across all roles in primary and secondary care, having demonstrable administrative experience was a core requirement, as was;   * Accuracy and attention to detail * Ability to follow protocols * Ability to multi-task and manage high workloads * Strong verbal and written communication skills * An ability to think on one’s feet and problem solve * A curiosity to learn and develop   Although health and care experience is always preferred, it is not always an “essential” requirement in an effort to avoid losing out on potentially suitable applicants. | |

**Impacts**

The settings who took part in the case studies had a clear appreciation of the benefits and impacts of MAs. We found that MA lead to impacts:

* **For patients**: in terms of a smoother and in some cases faster patient journey; and an improved patient experience and outcomes as a result of freeing up clinicians to do more clinical work.
* **For clinicians**: as MAs reduce clinician’s workloads, both during their working day and in terms of overtime working, this has knock-on benefits, including improved morale and work life balance, improved energy and concentration levels; and better training experiences (Foundation Doctors). These benefits in turn led to an improved ability to attract new clinical staff.
* **For providers**: as MAs have the capacity and technical knowledge to carry out tasks which their settings may otherwise struggle to do. In some cases, this is resulting in better compliance with regulatory requirements and improved ability to meet organisational targets.

Economic analysis undertaken as part of this study (see Annex 2) found that there is a strong financial case for introducing MAs. This is both in terms of:

* The **adverse costs avoided** by reducing clinician overtime working (we considered reductions in staff turnover, sickness, and medication errors).

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Nursing staff** | **GPs** | **Junior doctors** | **Consultants** |
| **Staff turnover** | £10,610 | £33,650 | £20,365 | £31,895 |
| **Sickness absence** | £3,520 | £5,850 | £780 | £2,370 |
| **Medication errors** | £4,700 | £4,700 | £2,960 | £2,960 |
| **Total** | **£18,830** | **£44,200** | **£24,105** | **£37,225** |

* The **differential in staff costs** where MAs instead of clinicians carry out tasks within their working days, with no undue overtime. For example:

|  |  |  |
| --- | --- | --- |
| The Clinical Administrator in Northamptonshire can potentially save the service £37,200 PA | Complex Prescriptions Clerk in Northamptonshire can potentially save the service £55,000 PA | The part time Back Office Manager in Birmingham can potentially save the service £23,000 PA |

**Risks and benefits of the role**

The exact nature of the MA role varies depending on the skills, competencies and ambition of the individual post holder and the specific needs of the setting. Furthermore, across the settings we found that to optimise the scale of benefits and risks associated with MA roles staff must consider a number of interdependencies:

**Enablers to introducing the roles**

Drawing on the case studies, some common enablers and success factors were identified when it came to introducing MAs. These are summarised below.

* Identify **an** **appropriate lead clinician** to develop the role (e.g. commitment, attention to detail)
* Assess the **risks and benefits of the MA role**, considering each task (given that the scale of risks can vary across tasks) and develop a risk mitigation approach.
* Develop **protocols** androbust **training and induction** programmes
* Provide staff with **clarity about the nature of the role** and the **safeguards and training** that are in place.
* Provide **buddying arrangements and close supervision** for new joiners.
* **Encourage a culture where MAs ask questions and challenge**.
* Provide regular forums led by **clinicians to review MA’s work**, and support peer learning and development.
* Build in **flexibility to develop/ modify the role** in line with post holder’s experiences and the setting’s needs.
* Ensure that MAs **work in close proximity with clinicians** and have opportunities to interact with them
* Emphasise **clinician accountability** and conduct **regular audits of MA’s work**.

## Recommendations

Medical Administration as we have defined it in this study is not a recognised category of work and there is no common language or set of job titles to describe it. However, whilst colleagues across the NHS are not defining it as such, there are both established and emerging examples of medical administration taking place across primary and secondary care in the Midlands and East.

The following recommendations were co-produced with a small group of HEE colleagues and representatives from providers who oversaw and contributed to the study.

**1. Within HEE, develop a business case for the continued promotion and development of medical administrator roles, marshalling the economic and qualitative evidence set out in this study.**

**Rationale**: clear benefits of the role for patients, clinicians and services who use MAs. Study demonstrates a strong financial case for the use of MAs. Benefits of MAs align with NHS workforce challenges (e.g. recruitment and retention challenges).

**2. Explore levels of awareness and attitudes towards medical administration across key stakeholders, such as NHS England, the Royal Colleges and regulators.**

**Rationale**: Medical administration as defined in this study is not widely recognised across the health system. An appreciation of the benefits is therefore likely to be low. There is the potential to explore how medical administrators fit within the multi-disciplinary team.

**3. Produce a suite of resources aimed at secondary and primary care which can be used flexibly by settings to develop their MA workforce. This should include standardised job titles and role profiles, case studies, implementation guidance and progression paths (e.g. for psychology graduates, as a stepping stone for those interested in a career as a nurse, nursing associate or physician associate).**

**Rationale**: Settings who participated in the case studies and who responded to the online survey had a great appetite for further promotion of MA roles. However, they also emphasised that medical administrators need to be tailored to the local setting context and that if the entry requirements are too high or specific this could potentially limit the pool of suitable applicants.

**4. Invest in training and development opportunities for prospective and current MAs, to increase the size and quality of this workforce. In developing offers, consider engaging with existing providers, such as AMSPAR (the Association of Medical Secretaries, Practice Managers, Administrators and Receptionists).**

**Rationale:** Settings who participated in case studies welcomed the increased provision of training and develop opportunities to support the growth and development of the MA workforce. Courses covering medical terminology and common medical conditions were consistently valued across settings and types of roles.

**5. Consider establishing a network or community of practice for settings who are on the vanguard in terms of MA, to share their learning and provide peer-to-peer support for settings interested in replicating their approaches.**

**Rationale**: Many of the settings who participated in the study had lots of appetite to share best practice and work with other settings to develop similar roles.

**6. Establish a workstream around workflow administration to assess the variability in approaches; identify best practice and potential minimum standards; and consider the accessibility and quality of training across England.**

**Rationale:** From the available evidence, it appears that workflow administration is becoming increasingly common, especially in primary care. The economic analysis makes a strong financial case for the use of a workflow administrator.

**7. Conduct stakeholder mapping and engagement to grow the pipeline of applicants interested and aware of medical administration opportunities (e.g. careers advisors based in FE and higher education, NHS employers)**

**Rationale**: Medical administrator roles come from a range of backgrounds and can support a number of career paths. For example, they can provide a stepping stone into something more complex for basic administrators and receptionists, and they may provide a stepping stone for people who want to work in a patient focused role (e.g. nursing associate, physician associate).

**8. Consider the case for developing medical administrator apprenticeships.**

**Rationale**: Medical administrator apprenticeships could help to raise awareness of medical administration opportunities, provide an option to ‘earn and learn’ and support the development of more standardised and recognised training paths.

1. Introduction

## Aims and objectives

In 2018 HEE commissioned Traverse to conduct a study to understand the scope and impact of administrative roles in primary and secondary Urgent and Emergency Care settings (including mental health) across the HEE Midlands and East geography.

The study aims to identify and stratify different non-clinical administrative roles and to understand:

* How they are used in different settings;
* What skills and experience are required;
* The commonalities and differences between roles;
* What works and what doesn’t to deliver impact in the role.
* The scale and shape of this workforce across the region.
* The size of the impact and the sorts of costs avoided through these roles.

The study also aims to establish whether there is a role for HEE in developing and standardising this workforce, e.g. by setting out best practice or helping to train and retain this workforce.

The definition of “medical administrators” (MAs) that we have used has two key criteria:

**a) Roles which are completely (or broadly) administrative so this would not include administration being undertaken by for example, Healthcare Assistants or Nurses.**

**b) Roles which provide administrative support to clinical staff, including those which displace work from clinicians, freeing them up to do other work.**

This study is interested in both specific medical administrator roles (e.g. a Clinical Administrator) and types of work (e.g. workflow administration) which can be carried out as part of another non-clinical role (e.g. by a medical summariser).

Whilst medical secretaries do some forms of medical administration, we chose not to include these roles in our study. Instead we have focused our resource towards understanding more emergent and less established roles and ways of working.

## Methodology

Our approach has sought to understand the landscape of medical administration across your region which has developed organically and extract from this what a more standardised workforce might look like and if/how HEE might support its development. Our approach is described below.

a) Initial round of desk research to understand the job titles and tasks associated with MAs.

b) Follow-up MA job searches, to understand prevalence and compare what came out of case studies with wider job market

**Desk research**

Conducted with a diverse range of primary and secondary care settings. Each case study involved a 1 day visit and follow-up interviews with clinicians, MAs and their managers. Included consideration of the economic impact of the roles

**Depth case studies x 9**

A survey with a wider number of settings to understand: whether they have any of the identified MA roles or others, their appetite to develop/ introduce such roles, potential role for HEE in developing this workforce.

**Online survey of settings (25 responses)**

We invited the HEE project team and representatives from LWABs to a webinar to present our draft findings and co-produce recommendations and next steps

**Findings and recommendations workshop**

To recruit the case studies and distribute the online survey we worked with Local Workforce Action Board (LWAB) representatives across the Midlands and East region to cascade our invitation to providers. LWABs are multi-agency boards focused on the workforce and education of the current and future healthcare workforce.

## Background

**The national picture**

The driving agenda for the NHS today is the need to do more with less. The service is under intense pressure, for example to reduce waiting times for A&E and deliver 7-day services, whilst making efficiency savings and undergoing unprecedented service reconfiguration.

Amongst the GP workforce, morale is low and services suffer from recruitment issues, large numbers of GPs approaching retirement and over-reliance on temporary staff. Acknowledging these pressures, the GP Forward View announced £19.5m to be set aside to support GPs suffering with burnout and stress, and to support retention.

In addition to clinical duties, the burden of administrative duties affects clinical staff at all levels. Time spent on administration can come at the expense of face-to-face time with patients. Often administrative tasks are pushed down to trainee doctors and nurses, at the expense of actual training time. Roles have been developed to help ease the clinical and/or administrative burden on clinical staff, for example nursing associates, physician associates and medical assistants.

Key national policy thinking such as the Carter Review and Getting it Right the First Time focuses on the need to reduce unwarranted variation across the NHS. This is in the context of a drive to commission services around the needs of the local population (whilst making efficiency savings). Achieving consistency whilst reflecting local need is a delicate balance to achieve.

It is therefore timely to evaluate the impact of administrative roles to review how the roles are being used, understand their impact and understand whether there is a benefit to reducing unwarranted variation (e.g. through a curriculum framework or common standards). HEE Midlands and East aims to fill this key evidence gap, providing an evidence base and potentially tools that will be valuable at a local, regional and national level.

## How to read this report:

This report summarises the findings from a combination of desk based research, eight case studies (involving face-to-face visits to settings to speak to a cross section of staff), an online survey of settings, and an economic analysis of medical administrators.

Throughout the report we use MA as an abbreviation for Medical Administrator or Medical Administration.

In terms of the layout of the report:

* **Section 2**: provides a summary of the key findings from across the nine MA case studies, the online survey and the economic analysis.
* **Section 3**: draws on evidence from the case studies, desk research and online survey to explore the size and shape of the MA workforce.
* **Section 4**: summarises the research conclusions and recommendations which were co-produced with stakeholders based at HEE.
* **Annex 1**: Brings together the nine medical administrator case studies.
* **Annex 2**: Sets out the economic analysis of MAs, describing the assumptions and evidence underpinning our findings and approach.
* **Annex 3**: Provides a table summarising the roles identified in the online search.

1. Key findings from the case studies and survey

In this section of the report we provide a summary of the key findings, drawing on the nine case studies and the online survey. This section is structured as follows:

* Roles and ways of working across primary and secondary care
* Backgrounds and qualifications
* Training and development needs
* Management and supervision
* Opportunities for professional development and progression
* Impacts of the roles
* Risk management and accountability
* Success factors and enablers to introducing MA roles
* The potential role of HEE in developing the medical administrator workforce

## Roles and ways of working across primary and secondary care

MA’s roles tended to develop over time rather than remain static. The nature of the MA role and their responsibilities was influenced by settings’ specific needs, by MAs interests and skill sets, by settings’ attitudes to risk and innovation and by whether there were clinicians who were able and willing to invest time in overseeing and developing the role. MAs emphasised the value of managers and colleagues setting clear expectations, and providing at a minimum a core set of responsibilities, which could be added to or adjusted over time.

**Primary care**

In primary care, we identified several roles focused on managing the high volumes of online and paper based clinical correspondence that practices receive. Sometimes described as workflow administration, this task involves MAs reading, coding and actioning clinical correspondence and passing on to GPs the items requiring clinical input. This task helps to reduce the volume of post that GPs would otherwise have to review. MAs receive specialist training to do the role; their work is closely supervised by a lead clinician and decisions are guided by a protocol which is regularly reviewed.

Other distinct tasks include:

* **Basic and Complex Prescriptions Clerks and Medications Managers**, who displace work from clinical pharmacists and GPs, by processing medications correspondence received from hospitals requesting prescriptions changes, handling medications-related telephone enquiries and actioning tasks given to them by other healthcare professionals, including acute hospitals.
* **Collaborative Care Team Coordinators,** who identify and support patients at risk of hospitalisation, by producing care plans, making referrals to voluntary organisations to initiate home visits, and by supporting and attending MDTs where at-risk patients’ cases are reviewed.

A summary of the primary care based medical administrator roles and tasks is provided in the table below.

Table 1. Summary of Medical Administrator roles in primary care

|  |  |
| --- | --- |
| Roles/ job titls | Types of tasks |
| Medical Summariser  Clinical Administrator  Duty Administrator  Back Office Manager | - Managing clinical correspondence – which involves reading, coding and actioning clinical correspondence and passing on to clinicians those requiring clinical input  - Helping to run clinics (referrals/appointments/results/bookings)  - Carrying out EMIS related tasks  - Supporting vaccination programmes  - Updating patient records and entering new joiner information |
| Complex Prescriptions Clerk  Medications Manager | - Reading, coding and actioning letters from hospital, including those related to medications changes  - Handling medications-related telephone calls (e.g. from reception, pharmacy, patients)  - Renewing repeat prescriptions, supporting annual reviews and compliance monitoring  - Requesting blood tests and filing ‘normal’ blood results  - Contacting patients for other relevant services, such as flu vaccinations |
| Collaborative Care Team Coordinator | - Identifying and ensuring support is put in place for patients who are at risk of hospitalisation/ being admitted to A&E |
| Care Navigator | - Guiding patients face to face and by telephone to the most appropriate services |

**Secondary care**

Across secondary care settings, we found **more of an overlap in the types of tasks undertaken by different medical administrator roles.** MAs in secondary care settings tend to focus on the tasks associated with admitting and assessing patients, conducting patient reviews (ward rounds) and discharging patients. This is summarised in the table below.

Table 2. Summary of Medical Administrator roles in secondary care

|  |  |
| --- | --- |
| **Job title** | **Role** |
| Clinical Administrator  Ward Administrator  Clinical Medical Assistants  Doctors’ Administrative Assistant  Emergency Department Administrative Assistant  Ward Clerk | - Managing the paper work relating to admissions e.g. collating service user information  - Inputting/ updating patient records  - Compiling information to support patient assessments  - Preparing documentation for ward rounds and clinical meetings  - Recording and documenting clinical discussions and decisions from patient reviews (ward rounds)  - Chasing test/scan results/appointments  - Compiling discharge summaries and discharge packs  - Reminding clinicians of key actions  - Typing up notes and letters  - Diary and email management for clinicians, answering telephone calls, other types of basic office administration  - Actions to help improve patient experience and wellbeing e.g. buying Christmas gifts  - Distributing/ ordering patient friendly information |

## Backgrounds and qualifications

Primary care

In primary care, MAs were often **recruited internally**, drawing on staff in existing administrative roles within the practice (e.g. receptionists or administrative assistants). It was common for staff to say that it would be difficult to recruit people externally to do complex prescriptions and workflow administration given the amount of experience and confidence that was required.

Where Medical Administrators were not internal recruits, there were several examples of recruiting **former medical secretaries or retired nurses**. Employers often reported “feeling lucky” to have found these people with prior medical experience, as there was not a plentiful supply of them in the local workforce.

Experience of **working in administrative roles** was an essential requirement, as was an ability to show **attention to detail** and to **follow protocols** and **instructions**.

Other requirements included:

* Strong verbal and written communication skills
* An ability to think on one’s feet and problem solve
* A curiosity to learn and develop
* The confidence to make clinically related decisions based on protocols

In roles that were patient facing (such as the Care Navigator and Collaborative Care Team Coordinator) the ability to show **compassion and empathy** were desirable qualities.

In some of the more senior MA roles (e.g. Complex Prescriptions Clerk), some settings called for at least **two years of experience** of working in a relevant healthcare setting.

Secondary care

In terms of backgrounds and qualifications, strong **administrative experience** again emerges as an essential requirement, as does having strong communication skills (gained from customer experience roles) and a proficiency in Microsoft office.

Other requirements included:

* Accuracy and attention to detail
* The ability to follow protocols
* The ability to multi-task and manage high workloads

In secondary care settings it was more common to **externally recruit** for medical administrators.

There was some **variation in terms of education qualifications** that were required. Several employers called only for a ‘good basic education” which included a good standard of maths and English, evidenced by passes in GCSEs or A-Levels.

In the case of Clinical Medical Administrators, who worked in mental health settings, employers called for a psychology higher education qualification. In this instance, the MA role was very much seen as **a stepping stone towards some sort of clinical role**, rather than a career in administration.

At one site, a Ward Clerk, a Band 2 MA based in an acute setting, called for either a QCF Customer Service Level 2 or a QCF Business Administration Level 2 in addition to having A-C in Maths and English and the ability to demonstrate sympathy and compassion.

In several settings, having **NHS experience was described as desirable**, which would give applicants the underpinning knowledge and familiarity with medical terminology and ways of working. **NHS experience was desirable rather than essential,** to avoid **excluding potentially suitable applicants**, although in most cases the MAs we interviewed had this on their CVs.

When it came to MAs who came from backgrounds outside of the health sector, we found a **wide range of previous roles**, including school secretaries, local authority personal assistants and travel agents.

## Training and development needs

Settings typically had **induction and training programmes** for newly recruited MAs, focused on getting them up to speed with internal IT systems and processes (e.g. document management systems, EMIS systems) as well as training in Microsoft Office. In secondary care settings, it was felt to be especially important that the requirements of the MA role and the training had to be **tailored to particular wards and departments** which worked in different ways.

Across some of the secondary care and in some primary care settings, staff had **ongoing development sessions** which were led by clinical leads. These provided a space where MAs could have their work reviewed and audited, discuss difficult tasks or cases, and identify and address skills gaps, particularly where the medical administrator role was expanding in its scope. In some secondary care settings where MAs were being piloted, regular training and development sessions had not initially been factored in, and were introduced by a clinician who saw this as a gap.

Across primary and secondary care, it was common for MA’s work to be guided by some sort of **protocol** **or guidance** which had been developed by the lead clinician which was updated on an ongoing basis. Nevertheless, staff managing and supervising MAs emphasised that there was lots of learning on the job required, and that it took time to become effective in the role.

The time it took for MAs to become effective in their role varied and was dependent on post holder’s **professional background** and on the **level of supervision and support** they received. In secondary care settings, staff reported that it took between two and three months for them to become effective in the role. In primary care, the length of time to become effective was more variable, especially when it came to clinical and medications correspondence; where in some cases staff reported that it took several years.

In terms of external training courses, a small number of examples emerged:

* Courses focused on medical **terminology and abbreviations** were widely seen as helpful across both primary and secondary settings, with one setting identifying free sessions run by the NMC as having value.
* Courses delivered by the **Association of Medical Secretaries** were identified as helpful in a couple of cases although it was not common for staff to say that they had taken part in them.
* A few examples emerged of external courses focused on specific skills, including clinical correspondence training **organised by the local CCG** and prescribing courses.

## Management and supervision

Across primary and secondary care, we found that MAs tended to be **line managed by staff in operational roles**. In primary care, practice managers often fulfilled this role. In secondary care, we saw examples of ‘operations leads’ and medical secretaries who took on this role. In secondary care, where MAs were employed to support clinicians, it was felt to be crucial to have a line manager who had a strong understanding about how to work with clinicians and what their needs were.

MAs tended to have **ongoing support and supervision from a lead clinician**, whose role was to: help them settle into the role; provide ongoing catch-ups and training sessions; oversee their day-to-day tasks, and run audits and reviews of their work.

Where MAs worked in teams, it was common for the **most** **experienced MAs to provide informal and ongoing support and supervision** to those who were less experienced.

## Opportunities for professional development and progression

Primary care

It was common for staff in primary care to start out in receptionist roles, and then progress on to MA roles, which were typically operating at a Band 3 or equivalent. Staff welcomed the opportunity that MA roles gave them, and pointed out that having a greater diversity of roles within practices was supporting **staff retention.**

Once in MA roles, there were often **limited opportunities to progress to more senior roles.** This was especially the case in smaller practices. However, MAs based in primary care tended to report that they **felt content in their roles** and many were keen to stay in them until retirement age.

When pressed, a few MAs suggested that a progression route could be to apply for the role of Assistant Practice Manager, or to take on an administration role at the local CCG, although staff were not able to point to examples of this taking place.

In terms of progressing within the role, even those who had been in the role for over a decade reported that there was **lots of scope to learn and develop**, and the roles could be expanded, providing clinicians invested time in making this possible.

Secondary care

In secondary care we found examples of MAs **operating at bands 2, 3 and 4**. In an acute mental health setting, staff could start working as a Band 3 Ward Administrator (focused on basic administrative support for wards), and then progress on to a Band 4 Clinical Administrator role, which involved more complex tasks, including minute taking and supporting and attending patient reviews (ward rounds) and other clinical meetings. In the same setting, a Clinical Administrator had recently been seconded to a Band 5 personal assistant/ medical secretary role, and this was seen by staff as a next logical step.

In the case of the Doctors’ Administrative Assistants and the Clinical Medical Assistants, staff across both settings noted that the roles had only recently been introduced, and in both cases, it was felt that **further work was needed to develop progression opportunities**:

* In the case of the Doctors’ Administrative Assistant, staff pointed out that staff who had applied to the roles would **not want to move up to an entirely office-based role**, such as a medical secretary. Instead, they would prefer a career that involved working with doctors and patients. Additionally, staff felt that the scope of this role could not be expanded until **the educational qualification requirements** were updated to include some sort of science qualifications.
* In the case of the Clinical Medical Assistants, staff overseeing the introduction of MAs were less focused on exploring how people in the role could progress and more on **creating a clearer framework for the role** covering a training curriculum and role profile, that could be tailored to various settings.

The **professional identity** of MAs was seen as important. In secondary care, in the case of Clinical Medical Assistants and Doctor’s Administrative Assistants, efforts were made to build links and a closeness to the clinical teams (e.g. by asking them to attend FD’s training sessions). In primary care, MAs tended to identify with the administrative team.

## Impacts of the roles

Patients

Across a range of secondary care settings, it was reported that having MAs was resulting in a **smoother and in some cases faster patient journey**; and in improved **patient experience and outcomes**. This was as a result of:

* Freeing up clinicians to do more clinical work.
* MAs, in some cases[[1]](#footnote-1), were felt to be performing specific tasks to a higher standard, and or more quickly than clinicians. For example:
  + In a secondary care setting, MA-led coordination of patient discharge has meant that they are able to get **faster and more consistent input from multiple professionals**.
  + In primary care, it was reported that MAs have **greatly sped up correspondence** between Consultants and GPs, where previously there were backlogs of up to six weeks, which was a patient safety risk.

In primary care, we identified MA roles which involved directly working with patients to deliver services, information and signposting. In primary care this included:

* Receptionists performing a care navigation role which is helping patients to **access the most appropriate services** and sources of support.
* The Collaborative Care Team Coordinator enhances **patient safety** by identifying patients **at risk of hospitalisation** and working with them to produce holistic care plans.
* The Complex Prescriptions Clerk, who **sped up the complex prescriptions process,** with the GP simply reviewing and signing what they had prepared.
* In mental health settings, some MAs have the **capacity to complete physical health audits** for mental health patients, which settings had previously struggled to do, due to a lack of capacity.

In secondary care, MAs working in a specialist mental health setting were able to directly **provide** **assistance and information** (of a non-clinical nature) to patients, to avoid having to take a nurse away from what they were doing.

In one secondary care setting, ward based MAs were encouraged to take actions to **improve patient experience**. For example, over the Christmas period, a MA reported that they had coordinated gift giving and organised small celebrations for patients. They were also empowered by colleagues to make recommendations about how patient experience could be improved. In other secondary care settings, MAs reported wanting to have more opportunities to support/interact with patients, but this proved difficult to accommodate.

In primary care, the Complex Prescriptions Clerk who had an oversight of complex prescriptions was contributing to patient safety, by identifying **potential drug seeking behaviour**.

Clinicians

Across both primary and secondary care, clinicians reported that having MAs in their teams had helped to **reduce their workloads**, both during their working day and in terms of out of hours working. As a result of this, clinicians pointed to the following benefits:

* Improved **morale and work life balance**, which in turn was felt to be supporting improved retention of clinical staff. Having MAs in the team could also be used to **attract new clinical staff** to the setting, in a competitive labour market.
* Improved **energy and concentration levels** during the day, which in turn could reduce the chances of clinicians making mistakes and errors.
* The ability for clinical staff to **prioritise and focus on the clinical elements of their work**, such as clinical decision making.
* More time and space for trainee doctors to focus on their **training and development** during placements**,** including more patient facing work, as MAs carry out the majority of particular tasks (e.g. producing discharge summaries).
* Trainee doctors benefiting from **pastoral support provided by MAs** and **improved wellbeing and reduced stress**, as the MA roles lead to a reduction in their workloads.

Providers

MAs have the capacity and technical knowledge to carry out tasks which their settings would otherwise struggle to do and can do certain tasks more efficiently than clinical colleagues. In some cases, this is resulting in better compliance with **regulatory demands** and the ability to meet **organisational targets**. Examples included:

* A primary care setting, where it was noted that referrals to secondary care now always happen within 72 hours, which was supporting positive CQC ratings.
* An acute trust where the use of MAs was helping them to meet organisational objectives, including the percentage of discharge letters sent on time, and the need for more timely diagnostics and test requests.

Examples of **cost savings and efficiencies** also emerged from the case studies:

* In primary care settings MAs were supporting swift and comprehensive QOF and QIF coding, which was helping practices to **maximise income streams**.
* With their extensive knowledge of prescription drugs, the Complex Prescriptions Clerk was able to identify **less costly generic versions**, and advise on more **intelligent purchasing decisions**. In one 14-month period this was estimated to have made a saving of 27K for the CCG.
* In a trust that introduced ward based MAs, **clinical staff were better utilised** leading to lower overall staff costs.
* In secondary care settings, MAs have provided the **additional capacity** to meet the requirements of the new **foundation doctor contract**.

In the next section of the report we further explore the economic impacts of MAs.

## Economic Analysis

We carried out an economic analysis of medical administration taking place across primary and secondary care. We examined two scenarios for what would happen without an MA being in place:

a) The roles that would be done by an MA are undertaken by other members of staff (which may include GPs in respect to primary care, and consultants in relation to secondary care), through an **increase in unpaid overtime**;

b) The roles that would be done by an MA are undertaken by other members of staff, with the level of FTE staffing being held at a level consistent with **no undue overtime**.

Below, is a short summary of the key findings. The full analysis and the assumptions underpinning our analysis are provided in Annex 2.

a) MAs tasks completed through unpaid overtime

In the indicative assessment below, we compare a medical administrator role against a scenario in which their time is allocated among existing staff who work extra hours of unpaid overtime accordingly. In such a scenario, we anticipate three adverse effects occurring:

**(1) an increase in staff turnover**, which leads to recruitment costs, agency costs, and loss of educational trainings costs, if the member of staff leaves the NHS;

**(2) an increase in staff sickness** among the wider team, due to increased stress and risk of burnout; and

**(3) errors in medication** (other errors, such as medical problems being more slowly picked up, may also be a factor, but are not considered here).

Table 3 below summarises the economic costs associated with existing staff increasing their levels of unpaid overtime. These calculations are based on a range of evidence sources, as set out in Annex 2.

Table 3. Assessment of economic cost of increased unpaid overtime

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Nursing staff** | **GPs** | **Junior doctors** | **Consultants** |
| **Staff turnover** | £10,610 | £33,650 | £20,365 | £31,895 |
| **Sickness absence** | £3,520 | £5,850 | £780 | £2,370 |
| **Medication errors** | £4,700 | £4,700 | £2,960 | £2,960 |
| **Total** | £18,830 | £44,200 | £24,105 | £37,225 |

It should be noted that the above excludes the risk of other types of errors (such as misdiagnosis of symptoms) and legal costs.

b) Roles undertaken by other members of staff – no overtime used

Our approach has been to consider the cost of the tasks undertaken by Medical Administrators, and to compare this against the cost of those tasks when they are undertaken by other staff in the absence of such support. We considered seven specific roles/settings across primary and secondary care (see table on next page).

As part of this process, we have assessed:

* Cost per hour worked of Medical Administrators;
* Cost per hour worked of a range of staff (GPs, practice nurse and practice manager in primary care; HCA, nurse, Foundation doctor, consultant, and combination of Foundation doctor / consultant time in secondary care);
* Tasks undertaken by Medical Administrators during a typical working day, and cost of undertaking these tasks (which comprises cost per hour times number of hours);
* Time taken by alternative staff to undertake those tasks if not supported by a Medical Administrator, and cost of undertaking these tasks (which comprises cost per hour times number of hours).

Table 4 below summarises our calculations from the various case studies. Our approach and the assumptions underpinning the values is set out in Annex 2.

Table 4. Summary of relative costs of Medical Administration tasks

|  |  |
| --- | --- |
|  | Cost change p.a. (£) (+ if more expensive / - if less expensive) |
| **Primary care** |  |
| Case study 1 Complex Prescriptions Clerk, Northamptonshire | -£55,000 |
| Case study 2 Back Office Manager, Birmingham | (part-time role) -£23,000 |
| Case study 3 Collaborative Care Team Coordinator, Northamptonshire | (part-time role) -£18,400 |
| **Secondary care** |  |
| Case study 3: Doctors Administrative Assistant, Northamptonshire (Ward a) | -£7,000 |
| Case study 4: Doctors Administrative, Northamptonshire (Ward b) | -£1,000 |
| Case study 5: Ward Administrator, Northampton | -£14,400 |
| Case study 6: Clinical Administrator, Northampton | -£37,200 |
| Case study 7: Clinical Medical Administrator, Lincolnshire | -£3,000 |

Conclusions

The above calculations demonstrate that there is a strong case for the use of Medical Administrators in primary care, which reflects the high costs of GPs. If they are directly involved in tasks that would be undertaken by GPs, then costs are lower; if GP overtime is used instead then there are costly consequences for recruitment, sickness absence, and errors.

By comparison, savings vary considerably in secondary care and in some cases the financial case is less strong. Case studies 3 and 4 have a counterfactual that implies the (short term) alternative use of Foundation Doctor staff. However, such calculations ignore the knock-on effects in terms of disengagement, turnover of staff and a poorer quality training experience. Case study 5 involves more use of experienced nurses, and Case study 6 implies the use of medical consultants, leading to savings closer to those shown in the primary care case studies.

## Risk management and accountability

Across primary and secondary care settings, MAs and their colleagues identified **managing risk and having clear lines of accountability as critical success factors** to introducing the roles. Across the settings we found that:

* Most settings, but not all, had some form of **induction and training programme** for new joiners, so that MAs felt clear about the parameters of their role and the basic safety considerations (e.g. what can they do or not do in relation to patients?). Some sites had gone through a process of expanding these programmes, as MAs had encountered challenges in the role.
* Settings, especially primary care settings, had developed **protocols and guides** to provide greater clarity about the scope and processes associated with the MA role. These were reviewed and updated on an ongoing basis as the scope of the roles shifted, or as challenges emerged. MAs valued both constructive feedback from clinicians, as well as feedback on what they had done well. Protocols were seen as particularly important in the primary care roles focused on clinical correspondence, where MAs had to review high volumes of post, and process items that a GP may never review.
* There was an expectation that clinicians had the ultimate accountability for MAs’ work. In secondary care, this meant that clinicians **reviewed and signed off** MA reports and other outputs. In one setting this included a process of MAs flagging content that was particularly important for clinicians to review, to minimise the risk that they did not give it their full attention.
* It was common to report that clinicians were conducting ongoing **audits and spot checks** of MAs’ work and were then addressing any shortfalls. However, we found variations in MAs’ confidence in the robustness of audit and oversight processes.
* In some cases, clinicians were leading **regular practice development sessions** for MAs, which were comprised of training, peer support and exploring challenging elements of the roles.
* Settings talked about the value of **fostering strong working relationships** between MAs and the clinicians. This included working in close proximity to one another and encouraging MAs to ask questions and to challenge colleagues where something was not clear, or if they were asked to do something that fell outside of skills and comfort zone.
* Where possible, settings tended to **recruit people with health and social care backgrounds** (e.g. ex-medical secretaries or nurses) as they possessed the right skills/knowledge and represented less of a risk.

Settings emphasised that it was important to consider the **scale of the benefits and risks** associated with an MA role. This should include consideration of each task, and an appreciation of the following **interdependencies**:

Figure 1. Factors impacting on the risks and benefits of an MA role

To illustrate these interdependencies:

* If the MA role is limited in its scope, in an attempt to minimise risks, then the scale of the benefits is reduced, since less work can be displaced from clinicians.
* If the supervision and risk management approach is time consuming for clinicians, the benefits of the role are again reduced, since less work is displaced from clinicians.
* The risks associated with a role can be mitigated by raising the skills/qualifications requirements during recruitment. However, if these requirements are too high the pool of available applicants could become too small and salary expectations may become too high.

## Success factors and enablers to introducing MA roles

Looking across the case studies, a number of success factors and enablers to introducing MA roles emerged:

* Identify **an** **appropriate lead clinician** to develop the role (e.g. commitment, attention to detail)
* Assess the **risks and benefits of the MA role**, considering each task (given that the scale of risks can vary across tasks) and develop a risk mitigation approach.
* Develop **protocols** androbust **training and induction** programmes
* Provide staff with **clarity about the nature of the role** and the **safeguards and training** that are in place.
* Provide **buddying arrangements and close supervision** for new joiners.
* **Encourage a culture where MAs ask questions and challenge**.
* Provide regular forums led by **clinicians to review MA’s work**, and support peer learning and development.
* Build in **flexibility to develop/ modify the role** in line with post holder’s experiences and the setting’s needs.
* Ensure that MAs **work in close proximity with clinicians** and have opportunities to interact with them
* Emphasise **clinician accountability** and conduct **regular audits of MA’s work**.

## Role of HEE in developing the medical administrator workforce

Across the case study sites and the survey respondents, there was lots of appetite for HEE and similar bodies to invest in promoting and developing MA roles in England.

**Awareness raising and promotion**

Medical Administration as defined in this study – that is, roles and ways of working that displace administrative duties from clinicians – was not a widely recognised category of work. In trying to identify and recruit case study sites, staff frequently struggled to distinguish between this type of work and more basic forms of administration. Furthermore, many found it difficult to point to specific MA roles in their local areas, and an awareness of the rationale and benefits of MA was limited.

Staff across settings felt that HEE and its partners could help to address this by developing a shared language to describe MA roles and a business cases for developing them. It would also be important to think about national and regional campaigns and awareness raising activities supported by case studies which could help to bring MA to life and address concerns.

**Training and implementation guidance**

Settings welcomed HEE developing implementation guidance for the introduction of specific MA roles, as well as workshops aimed at supporting staff who are considering introducing MAs into their settings.

Several of the settings who took part in the case studies that had achieved positive impacts expressed an interest in helping to support other settings to achieve what they had.

Across the case studies and survey responses, there was a keenness for HEE to develop training programmes for current and prospective MAs, covering core skills, such as medical terminology and basic training on common conditions and treatments. The starting point should be to consider whether it is possible to identify, adapt and scale-up existing training programmes, rather than ‘starting from scratch’.

**Promoting standardised role profiles and job specifications**

There was wide support for HEE to invest in the promotion of standardised role profiles and specifications, which would make it easier to recruit the right people and would support performance management. Staff also welcomed guidance about how MAs fit within multi-disciplinary teams.

Whilst settings welcomed a move towards greater standardisation, many settings felt that it was also important to have some room to tailor the role to the context and to the person in the role. In one secondary setting, this flexibility was seen as desirable for the MA post holder, staff in the setting and the trust’s commissioners.

Career progression and qualifications

Most settings felt they needed to invest further in establishing progression routes for MAs, so that a broad range of applicants found the prospect of applying for the role appealing. There was also a view that for certain types of MAs, in secondary care settings, it might be necessary to make science qualifications an essential requirement, in order to recruit staff well suited to carrying out more complex tasks and who could integrate with the clinical rather than administrative team.

1. Understanding the size and shape of the medical administrator workforce

The concept of a “Medical Administrator” – as we have defined it – is not widely recognised in the health sector. There also does not appear to be a common set of job titles or language used to describe these ways of working. This has made identifying MAs and understanding the size and shape of this workforce difficult.

To better understand the size and shape of the medical administrator workforce we:

* **Ran an online survey of settings** in the Midlands and East region to help us understand the prevalence of MAs. This involved working with the 17 LWAB leads to cascade an invitation and survey link to a broad range of relevant settings, offering each £50 for completing the survey. Despite encouraging a range of settings to complete the survey, the majority of responses (23 out of the 25) were from primary care.
* **Ran a series of online job searches** using [www.jobs.nhs.uk](http://www.jobs.nhs.uk) using the MA job titles from our case studies (see Section 3), to understand the types and numbers of roles that exist across England. We used the following search terms:
  + Clinical Medical Administrator (CMA)
  + Doctor’s Administrative Assistant (DAA)
  + Junior Doctor Administrator (JDA)
  + Clinical Administrator (CA)
  + Ward Administrator (WA)
  + Complex Prescriptions Clerk (CPC)
  + Care Navigator (CN)
  + Collaborative Care Team Coordinator (CCTC)
  + Workflow Administrator (WkA)

Drawing on these two activities we can report the following:

* **Workflow administration as a way of working appears to be quite common in primary care**, with five GP practices who answered the survey reporting that this type of MA was taking place. In all but one case, this had been introduced in the last 4 years. The online job search identified just one vacancy for a dedicated ‘workflow administrator’, although this type of MA was included in several job descriptions.
* **We did not identify any CPC or CCTC** roles**,** in either the online survey or job search, indicating low prevalence.
* **The online search found 14 roles, mostly in secondary care**. In line with the case studies, the roles were at Band 3 or 4. See Annex 3 for the list of roles.
* **Analysis of the job descriptions gathered as part of the online job search indicates that workflow administration is being incorporated into MA roles within secondary care settings.**
* **In the online search we found a few MA roles that resembled what we found in our case studies**:
  + **Several of the vacancies resembled the DAA role** that was described in our case study, that is a role focused on providing administrative support to FDs (Band 3).
  + **We found several WA roles** that resembled the role described in our case study.
  + **A few vacancies resembled the CMA and CA** roles that were described in our case studies.
* **The online job search found several roles focused on administrative support across the patient pathway: “patient pathway administrators”, “patient navigators” and “patient pathway coordinators” (Band 3-4).** These roles were not identified during our case studies although in the types of tasks are similar. These roles aim to provide a point of contact for all administrative issues relating to a patient’s pathway of care. They typically work as part of a multi-disciplinary team providing expertise in the proactive management of the patient pathway from referral to discharge, ensuring the entire pathway is managed smoothly.

1. Conclusions and recommendations

Medical Administration as we have defined it in this study is not a recognised category of work and there is no common language or set of job titles to describe it. However, whilst colleagues across the NHS are not defining it as such, there are both established and emerging examples of medical administration taking place across primary and secondary care in the Midlands and East.

Across primary and secondary care settings differences emerged in the types of MA that are taking place and in terms of how they tend to be recruited, how they develop in the roles and in terms of the progression opportunities that they have.

|  |  |
| --- | --- |
| **Primary care** | **Secondary care** |
| Several distinct types of MA were identified, including care navigators, workflow administration and more exceptionally complex prescriptions clerks and collaborative care team coordinators. | We found lots of overlap in the types of tasks being undertaken by different MAs. This included collating notes, patient discharge and supporting ward rounds and MDTs. Whilst some roles specifically focus on supporting foundation doctors, others assist with tasks across the patient pathway. |
| MAs are often recruited internally. It can be a welcomed form of career progression for receptionists. There is limited scope once they are in an MA role, especially in small practices. | In secondary care there is greater scope for career progression once in an MA role although many of the settings had only recently introduced the roles so there a few examples of how MA’s progress |
| It can take years to gain full confidence and competence in MA roles in primary care. Staff successfully carrying out this work are often long-standing employees who are jealously guarded from other local employers. | There is a greater emphasis on external recruitment in secondary care. Backgrounds and requirements vary (e.g. a psychology degree alongside having a basic education and strong administrative experience) |

The settings who took part in the case studies had a clear appreciation of the benefits and impacts of MAs. We found that MAs can have the following impacts:

* **For patients**: a smoother and in some cases faster patient journey; and an improved patient experience and outcomes as a result of freeing up clinicians to do more clinical work.
* **For clinicians**: a reduction in clinician’s workloads, both during their working day and in terms of overtime working, this has knock-on benefits, including improved morale and work life balance, improved energy and concentration levels; better training experiences (Foundation Doctors); and an ability to attract new clinical staff.
* **For providers**: MAs have the capacity and technical knowledge to carry out tasks which their settings may otherwise struggle to do. In some cases, this is resulting in better compliance with regulatory requirements and their ability to meet organisational targets.

Economic analysis undertaken as part of this study found that there is a strong financial case for introducing MAs. This is both in terms of:

* The costs avoided through reducing clinician overtime working and therefore reducing staff turnover, sickness, and medication errors.
* The differential in staff costs where MAs instead of clinicians carry out tasks within their working days, with no undue overtime.

We found that the exact nature of the MA role varies depending on the skills, competencies and ambition of the individual post holder and the specific needs of the setting. Furthermore, across the settings we found that to optimise the scale of benefits and risks associated with MA roles staff must consider a number of interdependencies:

Figure 2. Factors impacting on the risks and benefits of an MA role

## Recommendations

The following recommendation were co-produced with a small group of HEE colleagues and representative from providers who oversaw and contributed to this study.

**1. Within HEE, develop a business case for the continued promotion and development of medical administrator roles, marshalling the economic and qualitative evidence set out in this study.**

**Rationale**: clear benefits of the role for patients, clinicians and services who use MAs. Study demonstrates a strong financial case for the use of MAs. Benefits of MAs align with NHS workforce challenges (e.g. recruitment and retention challenges).

**2. Explore levels of awareness and attitudes towards medical administration across key stakeholders, such as NHS England, the Royal Colleges and regulators.**

**Rationale**: Medical administration as defined in this study is not widely recognised across the health system. An appreciation of the benefits is therefore likely to be low. There is the potential to explore how medical administrators fit within the multi-disciplinary team.

**3. Produce a suite of resources aimed at secondary and primary care which can be used be flexibly used by settings to develop their MA workforce. This should include standardised job titles and role profiles, case studies, implementation guidance and progression paths (e.g. for psychology graduates, as a stepping stone for those interested in a career as a nurse, nursing associate or physician associate).**

**Rationale**: Settings who participated in the case studies and who responded to the online survey had a great appetite for further promotion of MA roles. However, they also emphasised that medical administrators need to be tailored to setting the local and setting context and that if the entry requirements are too high or specific this could potentially limit the pool of suitable applicants.

**4. Invest in training and development opportunities for prospective and current MAs, to increase the size and quality of this workforce. In developing offers, consider engaging with stakeholders such as AMSPAR (the Association of Medical Secretaries, Practice Managers, Administrators and Receptionists).**

**Rationale:** Settings who participated in case studies welcomed the increased provision of training and develop opportunities to support the growth and development of the MA workforce. Courses covering medical terminology and common medical conditions were consistently valued across settings and types of roles.

**5. Consider establishing a network or community of practice for settings who are on the vanguard in terms of MA, to share their learning and provide peer-to-peer support for settings interested in replicating their approaches.**

**Rationale**: Manty of the settings who participated in the study had lots of appetite to share best practice and work with other settings to develop similar roles.

**6. Establish a workstream around workflow administration to assess the variability in approaches; identify best practice and potential minimum standards; and consider the accessibility and quality of training across England.**

**Rationale:** from the available evidence workflow administration is becoming increasingly common, especially in primary care. The economic analysis makes a strong financial case for the use of a workflow administrator.

**7. Conduct stakeholder mapping and engagement to grow the pipeline of applicants interested and aware of medical administration opportunities (e.g. careers advisors based in FE and higher education, NHS employers)**

**Rationale**: Medical administrator roles come from a range of backgrounds and can support a number of career paths. For example, they can provide a stepping stone into something more complex for basic administrators and receptionists, and they provide a stepping stone for people who want to work in a patient focused role (e.g. nursing associate, physician associate).

**8. Consider the case for developing medical administrator apprenticeships.**

**Rationale**: Medical administrator apprenticeships could help to raise awareness of medical administration opportunities, provide an option to ‘earn and learn’ and support the development of more standardised and recognised training paths.

Annex 1 – Case studies

## What we did

The case studies were recruited through close working with the LWAB (Local Workforce Action Board) leads who are based across the Midlands and East region. Traverse produced an information flyer and invitation letter and the LWAB leads cascaded this out to their local contacts in each of the 17 LWAB areas. Sites who participated received an incentive of £250, to encourage participation.

Each case study involved a review of key documentation, a one-day case study visit to speak to a cross-section of staff, and 1-2 follow-up interviews with any key stakeholders not available on the day of the visit. As part of each case study, we aimed to speak to:

* The MAs
* MA’s line manager/s
* Clinicians who the MAs were supporting/working with

We asked interview participants to spend 45 minutes talking to us. However, in the case of clinicians, we generally had a limited amount of time to speak to them (typically 15-25 minutes). During the interviews we explored:

* What you view as the role of the MA
* What you feel the requirements are for this / these role[s] in terms of experience / skills
* Any benefits and impacts of the role[s]
* Any limitations of the role[s]
* What your experience has been with recruitment and retention to the role[s]
* What might help your setting hire and train people for the role[s]

To support the economic analysis, during MA interviews we asked them to provide: a breakdown of the tasks they carry out each week and estimates of how long they spend doing tasks each day/week and who would otherwise be doing them. Wherever possible we also explored clinicians’ perspectives about which tasks MAs support them with, and how much time this saves them each day/ week.

Table 5. summary of MA case studies

|  |  |  |  |
| --- | --- | --- | --- |
| **Setting** | **Location** | **Role** | **Type of MA** |
| 1. General hospital | Northamptonshire | Doctors’ Administrative Assistant | Administrative support for FDs |
| 2. Secondary care, mental health | Northamptonshire | Clinical Administrator and  Ward Administrator | Administrative support for consultants |
| 3. Secondary care, mental health / Community setting mental health [[2]](#footnote-2) | Lincolnshire | Clinical Medical Assistant | Administrative support for FDs |
| 4. GP practice, primary care | Staffordshire | Medical Summariser | Workflow administration |
| 5. GP practice, primary care | Northamptonshire | Collaborative Care Team coordinator | Identifying and putting support in place for patients at risk of hospitalisation |
| 6. GP practice, primary care | Northamptonshire | Complex Prescriptions Clerk | Processing complex prescriptions |
| 7. GP practice, primary care | Birmingham | Back Office Manager (BOM), and the Administrative Assistant (AA) | Workflow administration |
| 8. GP practice, primary care | Cambridgeshire | GP Receptionist | Care navigation |

# 1. Doctor’s Administrative Assistants, Northamptonshire

## Introduction

This case study focuses on the piloting of Doctors’ Administrative Assistants (DAAs) in a general hospital in Northamptonshire, who supports the work of training Foundation Doctors (FDs). In September 2018, Traverse interviewed six members across two wards at the hospital:

* 1 Divisional Director of Medicine and 1 Medical Secretary who line manages the Doctors’ Administrative Assistants (interviewed together)
* 1 Consultant (Clinical Lead for DAAs)
* 2 Foundation Doctors
* 2 Doctors’ Administrative Assistants

At the time of the interviews, DAAs had been working in the setting for the last 15 months. So far six DAAs have been recruited, with the aim of recruiting a further three. In the last recruitment round when three DAA positions were available, 54 people applied for the post and 16 were shortlisted. The Divisional Director observed that the quality of the candidates has improved over time as the advertisement and understanding about the requirements of the role have improved.

## Background and qualifications

The Divisional Director emphasised that while NHS experience was valuable, it was not essential for DAA candidates. Instead, the recruiters look for administrative experience, strong communication skills, and a good standard of maths and English. The Divisional Director noted that recruiting solely from the NHS ran the risk of ‘depleting the pot’ elsewhere in healthcare services. There are, however, barriers to entry for candidates applying from outside of the NHS system. For example, the length of the hospital recruitment processes could be a challenge for some.

Traverse interviewed two DAAs, both of whom had a health and social care employment background. They both considered this experience to be helpful in their roles as DAA. Both the DAA from the Pretty Ward and the Divisional Director noted that having knowledge of medical vocabulary and NHS abbreviations had helped them to be effective in the role and settle in quickly.

## Tasks associated with the DAA role

The main responsibility of the DAA role is to relieve the Foundation Doctors (FDs) of certain non-clinical duties, freeing up their time to focus on delivering clinical care and on their training and development. The tasks carried out by DAAs include:

* **Checking and updating patient lists**, e.g. ensuring correct labelling, up to date blood results, dementia screening, checking next of kin and co-morbidities details.
* **Supporting morning board rounds** which take place before patients are seen by consultants.
* **Preparation for discharge** e.g. readying letters, chasing outstanding requests for tests, adding results for test and scans, arranging post discharge appointments.
* **Supporting ward rounds** to discuss patient needs, potential discharge, take notes on afternoon actions, update information on discharges.
* **Sending referrals off and chasing test results**.

DAAs core duties are set out in a ‘daily working’ checklist, which is given to DAAs during their induction. The checklist was seen as helpful by them, providing a clear sense of their duties and the expectations of the role, which was especially helpful when they were new to the role. While DAAs share a core set of responsibilities, the role is tailored to the wards where they are based. The Divisional Director explained that retaining local flexibility in terms of the specifics of the role is important for both the ward and the individual DAA.

## Management, supervision and clinician buy-in

The DAAs are all line managed by a medical secretary who also works as a personal assistant to Consultants in the department. Initially, a ward manager undertook the line management responsibilities, but they struggled to have enough time to devote to the role. Management of the DAAs was welcomed as a professional development opportunity by the medical secretary. The Divisional Director feels that medical secretaries are a suitable role for a DAA line manager:

“[The medical secretary’s] role as line manager of the team has been crucial – I don’t think we would have the same outcomes from them being managed by ward managers, nurses. As a medical secretary she understands about how to support doctors, she’s helped to keep the focus of the role on freeing up clinical time.” – Divisional Director of Medicine

A key success factor for the DAA role is FD’s buying into the role and utilising them. The Divisional Director emphasised that they are only placed in wards where *‘clinicians are going to embrace them’* and give the DAAs opportunities for professional development. The buy-in of ward Consultants has also increased over the course of the programme as they have become clearer about the benefits of the role.

At a cardiology presentation [a doctor] said he wanted a doctor’s admin. In fact, all the doctors are now asking us for one. It can be hard to implement changes like this in Cardiology. I think it’s quite an achievement. – Divisional Director of Medicine

The value of Consultant support for the role was also confirmed by the Pretty Ward DAA.

“The [ward] consultants are really passionate. From the get-go they brought me on board and welcomed me. They are really open to having me here… I was nervous when the new rotation of FDs was coming up, but [the Consultant] spoke to me and asked me to be involved in their induction, to give a talk on my role. So, they really understood what I do, and involved me as part of the team.” – DAA

## Training and progression

A programme of induction and training sessions has been set up for new DAAs, covering the core elements of the role, including the terminology and tasks related to pharmacy. DAAs also attend weekly one-hour training and development sessions together which provide a space for them to share challenges and address development needs. Topics covered at the sessions have included medical terminology, IT skills, dementia screening, sepsis and deep vein thrombosis, and managing patient grievances.

DAAs have been pleasantly surprised by the amount of learning in the role and by the extent to which they’ve been encouraged to work closely with medical colleagues. One of the ways this has been supported is by asking DAAs to attend weekly medical teaching sessions aimed at the FDs.

“I didn’t think I would learn as much as I have. I didn’t expect to be included in the medical team – they do include me, support me.” – DAA

“I have learned a lot more than expected. I’m inquisitive, I do ask questions. And doctors like to explain things if you ask.” – DAA

The Trust has yet to start fully exploring career progression routes for DAAs. The Divisional Director suggested that the most obvious next step could be them moving on to the role of a Medical Secretary. However, there was a feeling that not all DAAs would want to move towards a more office/ administrative role. This was confirmed in interviews with DAAs who said that a desire to work with patients and clinicians were key motivations for applying for the role.

“In Olympus Care the next step up would be being in an office which I didn’t want.” – DAA

“I wanted to be in a patient-facing role, not in the background – I was attracted to the prospect of working directly with clinicians.” –DAA

It was suggested DAAs could progress to a Physicians Associate role which would give them scope to continue working with doctors and patients.

## Impact

Trust and patient impacts

Staff interviewed as part of the case study identified the following impacts associated with the role which they hope to further explore and quantify:

* **A** rise in the proportion of discharge letters completed on the day of discharge, from 68% to 96%.
* Fewer instances of missing test requests.
* **More efficient ward rounds**.
* A reduction in the number of internal “red” delays **for diagnostics**.

These impacts were felt to be a result of either DAAs undertaking the tasks themselves, or reminding the FD to complete tasks. Taken together it was suggested that they have helped to reduce patient waiting times for test results and discharge approvals which are key objectives for the Trust. These impacts have also resulted in a smoother and more streamlined patient journey.

“I did a stint on call in the admissions unit … There were loads of discharge letters outstanding and we (the FDs) were tasked with doing them. But the DAA had already completed them and the letters just needed proofreading and printing – this saved us half a day’s work. It made a big difference in the admissions unit which requires a rapid flow: a potential bottleneck is caused if we get held up.” – FD

Impact on colleagues

FDs reported that DAAs were helping to reduce their workloads, which was in turn reducing stress levels and giving them more time in the day to focus on their training and development of clinical skills.

“Because we’ve removed the admin tasks from the day, it allows us to spend more time on valuable learning experience. Time spent preparing a discharge can be spent discussing and reflecting on a particular scan or result. Whereas prepping a discharge letter has no clinical learning benefit. Once you’ve done one you can do them all. DAA frees up our time to focus on the learning aspects of a case.” – Pretty Ward FD

The Divisional Director of Medicine felt that the way in which DAAs work with and support FDs, especially those who are recently out of university, was having a positive impact on their morale and wellbeing and their ability to settle into the role.

*“FDs are just out of university it can be very daunting. The DAAs give pastoral support to the FDs – it’s coming back to us from the Deanery Education Lead that FDs with DAAs are feeling better supported and have a better induction experience.”* – Divisional Director of Medicine

FDs reported that they valued the pastoral and emotional support that DAAs were able to provide and their ability to help them manage the expectations that are placed on them by colleagues.

“*A lot of [FDs] are young and miles from home – I make sure they are eating, taking breaks – support them that way. Or, if they’re not well go home rather than struggle. Emotionally I support them. They all say they miss me when I’m not there. They have to do all the letters and it’s a difficult day.”* – DAA

*“The DAA is quite a guardian of the clinicians. If nurses are getting insistent on you to do something or are getting upset, they can push back. It’s nice to have someone that can account for you in that sense. You want to please everyone and do as much as you can, but you need to prioritise. The DAA can step in and manage expectations.”* – FD

As the wellbeing benefits for FDs have become clear, the Trust now highlights the DAAs in the department as a key benefit in its job adverts for doctors.

## Managing risk

Concerns exist within the hospital, particularly among pharmacy staff, about non-clinical staff transcribing discharge letters. Most interviewees, including the Divisional Director, were clear that the responsibility for discharge letters remained with the FD who must identify and fix any errors during their proof read. The Clinical Lead echoed this point, but added that it is also important to explore approaches to risk management and accuracy with DAAs on an ongoing basis.

The DAAs interviewed seemed clear that the responsibility for their work ultimately lay with the clinicians and felt confident that their work was being adequately checked. During her interview, the Pretty Ward DAA noted that mistakes could also be made when busy FDs without DAA support write discharge letters. She felt that her work had improved the quality, accuracy, and ease of comprehension of letters.

## Next steps

When it comes to the future development of the role, the Divisional Director feels that training is needed in medicines management and coding for DAAs. Added to this, it was suggested that a competency framework around pharmaceutical management and an accreditation process were possible routes to building buy-in amongst pharmacists for the DAA role.

The Consultant Clinical Lead felt the potential for the DAA role to develop further and assist clinicians in a greater capacity could not be achieved until additional educational qualifications were requested, especially in relation to science. Without science qualifications there was a concern amongst those interviewed that DAAs could have unrealistic expectations placed on them.

# 2. Ward Administrator and Clinical Administrator, Northamptonshire

## Introduction

This case study focuses on two well-established medical administrator roles in a secondary mental health setting based in Northamptonshire. The two administrator roles are:

* Ward Administrator
* Clinical Administrator

In the same setting, a third administrative role exists that will also be described in this case: the CPA administrator (Care Programme Approach). We did not consider it to be a medical administrator role because the post-holder felt that it does not displace clinicians’ tasks. However, interview participants from this site emphasised that it could act as a stepping stone to the above two medical administrator roles.

In May 2018, Traverse spoke with six members of the team:

* 2 Clinical Administrators
* 1 Ward Administrator
* 1 CPA Administrator
* 1 Compliance and Administration Manager, who until recently managed all the administrators (they will in future be managed by nurse managers in each integrated practice unit (IPU)).
* 1 Responsible Clinician

## Background and qualifications

The administrators’ background is quite varied. Some administrators have a medical background and worked as NHS receptionists and medical secretaries, or for medical distribution companies in the past. Others have a general administrative or PA background, e.g. a school secretary, local authority PA, and at travel agents. One administrator joined the administrative team after working as a healthcare assistant (HCA) elsewhere in the practice.

It was felt that candidates applying for the roles who had previously worked in a medical setting would be more likely to get the roles as they have an understanding of the processes and terminology. Specific qualifications were not felt to be necessary for the roles, although one MA did have an RSA in secretarial skills.

Staff identified the following requirements when recruiting to one of the medical administrator posts:

* Microsoft Office proficiency
* Communication skills and organisational skills
* Some experience of working in a medical setting

During the interview process, the hiring team may do assessments of the following if required for the specific roles:

* Ability to use Excel
* Proofreading and editing letters

Staff reported that they have not had trouble recruiting to the roles. Newly recruited staff have tended to be a good fit for the roles, and have stayed in post or at the site for a long time.

## Tasks associated with the administrative roles

### Ward administrator

Ward administrators (WA) work in a specific ward and are responsible for providing administrative support to wards. It is a Band 3 position. Tasks include:

* **Basic administration** e.g. photocopying, filing paperwork and tidying office
* **Ordering stationary and clinical stock**
* **Technical tasks,** e.g. creating discharge summaries for patients, typing up care plans, and dealing with admissions-related paperwork

### Clinical administrator

The purpose of the clinical administrator (CA) is to support the clinical team. It is a Band 4 position. The CAs supports specific wards and clinicians. Tasks varied between the two CAs interviewed, but included:

* **Starting reports** by compiling the necessary information – the clinician can then continue with the report once basic information has been entered.
* **Proofreading and formatting reports** after the clinician has inputted on them.
* **Updating patient records**
* **Ensuring clinicians** have the right paperwork for ward rounds
* **Compiling** **discharge summaries and discharge packs**
* **Taking notes** on the ward round, and typing up notes and letters
* **Supporting patients and family members** e.g. answering non-clinical questions
* **Compiling information** **to support assessments**, and managing the administration to do with assessment visits and typing up notes
* **Organising meetings** **and minute taking**
* **Creating patient logs**, which give doctors the important information about patient
* **Creating presentations and posters**
* **Managing clinician’s diaries and emails**
* **Organising events for patients (an added extra that clinicians would not do in their absence)**

Other ad hoc tasks which are not displacing work from clinicians include:

* **Managing annual leave and arranging cover**
* **Ensuring the ward has patient-friendly information available**
* **Supporting social workers with safeguarding**

### CPA administrator

As part of the Care Programme Approach, every patient has a CPA meeting every 3 or 6 months involving patients, families, carers, commissioners, home care team, and the Responsible Clinician. We did not feel that this qualified as a medical administrator role because the post holder we interviewed felt that the tasks completed by the CPA administrator are not ones that would otherwise be completed by a clinician. Tasks include:

* **Arranging meetings**
* **Supervising the compilation of a report on patient’s progress and formatting it**
* **Sending out reports to meeting attendees**
* **Attending the meeting and taking minutes**
* **Uploading reports and minutes and sending out final report**
* **Managing professional contact lists**

It was felt that the skills needed for this role are highly transferrable to the Ward and Clinical Administrator roles and could be an option for career progression for administrators who want to be more involved in the clinical side of the practice.

## Management, supervision and buy-in

The administrators are managed by operations leads who are managed by the Compliance and Administration Manager who was interviewed by Traverse.

Both the management style and the roles of the WA and CA are flexible, and different wards are using the clinical administrative support in different ways.

## Training and progression

MAs are offered induction training around internal systems such as patient records, procurement, and HR systems. They are also encouraged to go on internally run minute taking courses. A process directory has also been developed which aims to help new employees to settle into the role. The MAs are also encouraged to complete MBQs at level 2 and 3 and to take part in wider training sessions run by the organisation.

Staff felt that there is scope for professional growth and development within the MA roles and staff can point to examples of where they have taken on new responsibilities as their capabilities have grown. The MAs interviewed generally agreed that the roles were more clinical than they expected and most valued the fact that the roles were not purely administrative.

There are opportunities for promotion within the setting. CPAs can progress to the role of ward administrator, and ward administrators can progress to become clinical administrators, if they can demonstrate the key competencies.

Recently, a clinical administrator has been seconded to be a Band 5 PA and this is seen by some to be the next logical step providing they have some management training. One Medical Administrator expressed interest in becoming a nurse.

## Impact

### Service and patient impacts

WAs have lots of direct contact with patients and can act as a key point of contact for them on the wards. If a patient has needs, the administrator may be able to address them, rather than taking a nurse away from another patient.

MAs have been encouraged to take actions that support improved patient experience. For example, helping to organise events, purchasing small gifts over Christmas or baking cakes. MAs valued the chance to contribute to the service in this way and were empowered to make suggestions about how the service could improve patient experience.

Service quality and efficiency benefits were also identified. For example, the MAs are generally felt to be better at Microsoft Office than clinicians, resulting in better quality and more quickly produced outputs.

The MAs are also responsible for effective stock management, and ensure resources are allocated efficiently and there is not overspending.

### Impact on colleagues

Consultants felt that their support on administrative tasks across the patient pathway were leading to cost savings as consultants had additional time to devote to clinical and patient facing work. For example, the CAs are able compile information for discharge summaries and care plans, then the doctor can then check them and insert medical content.

“Getting someone who is an experienced doctor to do things that could be done better, and more efficiently, by an administrator, is a complete no-brainer. They are worth much more than we pay them.” – Clinician

“They’d need to take on more doctors [if my role didn’t exist], and doctors are expensive. Because those doctors would not be able to do the number of wards and the number of patients that they actually do, because they wouldn’t have time to do that admin.” – MA

“[Because of administrators,] most of the stuff I do is with patients, very little of it is in front of a computer.” – Clinician

As clinician’s workload and administrative burden reduced it was noted that clinicians had improved wellbeing and morale.

“I think the impact is, I’ve got people smiling because I’ve taken on those tasks. Because they are thinking, ‘thank god for that, I can breathe for a minute’.” – MA

“I’d be utterly lost, utterly lost without good admin support, you know, and quite frustrated actually. I’d be quite a bit more grumpy and not enjoy my job anywhere near as much.” – Clinician

In turn, the benefits in terms of morale and wellbeing have helped the service to attract and retain clinicians, which has previously been a challenge.

## Managing risk

A core element of the risk management approach was consultants having ultimate accountability and responsibility for signing of reports and other outputs. With this in place the clinician did not see any significant risks or limitations with the use of MAs and noted that his comments and changes to the work he reviewed were usually minimal.

The clinician stressed that a readiness to give and receive feedback was important to making the MA work. The clinicians must also be approachable, and MAs should feel comfortable feeding back, for example, if the clinician is being unclear in dictation.

The clinician felt that there were opportunities for further efficiencies if medical administrators had slightly broader roles and could cover for each other. This would also help to mitigate the risk of administrators becoming too specialised in their role.

## Role of HEE

Staff felt that there currently does not seem to be any standard expectation of what a medical administrator should be able to do, which made recruitment and performance management difficult. For this reason, staff welcomed the development of recognised role profiles and training packages to help scale up and standardise the roles. Training in medical terminology and on common conditions and treatments would be particularly welcomed.

Whilst some staff felt there could be value in an accredited role, other suggested that this could limit the pool of suitable applicants who may have the right skills but who come from diverse backgrounds and circumstances.

Thinking about the future of the role, a manager suggested that some of the administrative work could ultimately be replaced by automation and that, from a compliance and cost saving point of view, automation of recording and gathering of data would be good. However, minute taking at meetings and ward rounds would remain important.

# 3. Clinical Medical Assistant, Lincolnshire

## Introduction

This case study focuses on the introduction of three Clinical Medical Assistants (CMAs) who worked across four wards in a mental health setting in Lincolnshire. The CMA positions were introduced as part of a pilot project in 2018. The role aims to support the medical workforce, in particular, freeing up Foundation Doctors (FDs) to do more clinical work and to focus on their training and development. The name Clinical Medical Assistant was chosen to make clear that this is to make clear that this is a clinical support role for consultants and FDs. The choice of job title was an attempt to avoid the role getting absorbed into the multi-disciplinary team.

The CMAs work at the following units:

* An acute psychiatric unit located within an acute general hospital. It has two wards for male and female patients aged 21-65.
* A residential psychiatric unit serving adults age 65+. One ward serves patients with personality disorders, schizophrenia; and the other ward serves patients with dementia.

In July 2018, Traverse interviewed eight members of staff who worked across these settings:

* 3 Consultant Psychiatrists
* 3 Clinical Medical Assistants
* 1 Foundation Doctor
* 1 Medical HR Manager

## Background and qualifications

All 3 CMA’s employed have psychology degrees, which is felt to be an essential requirement for the post. In terms of backgrounds:

* One CMA was previously a bank support worker for the Trust and therefore had a good understanding of the patients;
* One had been part of a workforce pilot programme in a prison which had been successful;
* One had previously worked as a Medical Secretary to two consultants and therefore had a good working knowledge of clinical systems, the medical workforce, and the patient group.

The Foundation Doctor interviewed felt that the CMA with the previous experience of working as a medical secretary had made them highly effective in supporting FDs:

“The CMA who had worked as a medical secretary was ideal – she is familiar with the terminology we use, it’s less of a learning curve. The Medical Secretary background means if I use acronyms etc she knows what we mean. And the summaries she writes make sense- I was surprised how much they made sense, clear reasoning – really helped. Someone out of university would have more of a learning curve.” – FD

## Tasks associated with the CMA role

The setting decided make a psychology qualification a requirement for the CMA role because they support the delivery of clinical care and need a specific knowledge base and an understanding of patients’ conditions. The project team was aware that similar pilot projects elsewhere were employing people who had worked as assistant psychologists. The Medical HR Manager explained that advertising the post with a psychology qualification resulted in a high number of applicants because the job market is saturated with psychologists who cannot get a role and require more patient contact experience to progress their careers. When the roles were advertised there were 27 applications, and seven of these were appropriate to invite to an interview.

FDs and Consultants allocate duties to the CMA, which include:

* Gathering and collating clinically relevant information on patients, including medical histories
* Inputting patient notes into the patient record system
* Updating and maintaining clinical summaries
* Recording and documenting clinical discussions from ward rounds and internal Care Programme Approach meetings, entering these notes into patient records, and distributing them to staff as appropriate

Across the three CMAs, the balance of duties varied according to the needs identified by the ward consultants, and also the skillsets and preferences of the individual CMAs.

## Management, supervision and buy-in

The CMA role is modelled on a similar role used in private mental healthcare settings. It is sponsored by the Medical Director within the Trust, and the Medical HR Manager is the pilot project manager.

## Training and progression

The CMAs received an induction from the medical and non-medical workforce, and are given a summary of the ward and its key personnel. Training and development includes a focus on medicines management.

A bi-monthly CMA Forum has been set up to provide ongoing support. The nature of the role and the training is tailored to the needs of the specific wards and the CMA’s career and development goals.

“We are trying to match what we want as a ward and what she wants as career aspirations. … One size doesn’t fit all. There are some unique needs and differences in different wards – generic training wouldn’t work.” – Consultant

Reflecting on the role, one of the CMAs had been pleasantly surprised by the learning opportunities that clinical staff give them and in the extent to which the role focuses on clinical work, alongside the purely administrative elements:

“When I got the job, I expected to be a junior doctor’s dogsbody – that’s what I expected, to free them up to do more clinical work. But they’ve made me feel more than that. I thought it would be 90% admin for JDs and 10% learning for me – but it has been more like 70/30%. For example, the Consultant showing me what to look for on brain scans re dementia, I am learning. … junior doctors are really good like this too, showing me things. I really feel part of the junior doctor team.” – CMA

In contrast, another CMA based in another ward felt that the role was still more administrative that they would have wanted. A focus on patient and learning was seen as important because the CMA to them was very much a stepping stone to going to medical school and a career in clinical psychology. The CMAs had yet to have any psychologist input into their training and development at the time of this site visit. This had been planned for later in the year.

## Impact

Trust and patient impacts

Several interviewees highlighted that CMAs are improving the Trust’s compliance with administrative requirements. For example, CMAs are completing 96% of the proformas relating to patient admissions, reviews and discharge, where previously this had been 50%. They are also completing physical health audits, a task which FDs struggled to make time for. Support with these tasks is supporting the services’ CQC inspections, their compliance with CQUIN goals and potential legal challenges.

The Connolly Consultant highlighted the benefits of the CMA being a consistent presence on the ward, which meant that they could regularly scribe at ward rounds and could facilitate family members’ attendance at these meetings:

“Foundation Doctors are learning a curriculum and they can’t be everywhere at once. They have protected time. Having the CMAs consistently scribing has made our life smoother and easier, and there are benefits for patients. Ward rounds are not cancelled when there is an emergency, we can be more flexible with the timings of the ward rounds were and family members can more easily attend, with the CMA facilitating this. That is very beneficial in terms post-discharge care, and for helping prevent re-admissions**.”** – Consultant

The CMA presence at ward rounds and other meetings has also allowed clinical staff to contribute discussions more easily and to participate in decision making**.** When the nurses and FDs were responsible for scribing at meetings this level of participation was not possible. The Consultant noted that the ward rounds also progress more quickly when the CMA contribute to them by providing information about the patient, such as blood test results.

CMAs role in producing complex patient history summaries was also felt to be improving the quality of service for patients. The consultants interviewed noted that in mental health settings it was often not possible for the on-call admitting doctor to take a patient history, however this “collateral information” is crucial to providing a good service.

“Because I have the time to do in-depth history of the patient the consultant knew that anti-psychotic drugs would not be suitable in this case. The patient summaries I produce also provide the consultant with those small but important details, like the name the patient likes to be known by. They also help to avoid the patient having to provide the same information all over again.” -

CMA

The FD felt that patient history summaries, along with the CMA’s chasing test results and hospital appointments had improved patient’s treatment during and after their hospital stay, and had reduced the likelihood of errors occurring.

Impact on colleagues

With the support of the CMAs, with producing patient history summaries, chasing appointments and supporting ward rounds, the consultants reported having more time to focus on their clinical work and they also saw a reduction in overtime, which had improved their work-life balance.

“The CMA is there as a back-up – a safety net – they can stop things falling through the cracks… I would be chasing appointments if she wasn’t there to do it; that’s 1-2 hours a week saved. You can be stuck [on phone] waiting. It slows you down. Those saved hours are used for medical reviews of patients, tasks that only a doctor can do – decision-making about drugs, discharge summaries.” – FD

Consultants reported that the reduction in workload and overtime had resulted in improved energy levels and they felt that they could be more effective in their roles. This included an improved bedside manner with patients.

With the administrative support from the CMAs, the FDs reported having more time and space to focus on their learning and development and to complete competence assessments. The CMAs were also able to provide guidance and support to new FDs about the administrative responsibilities that are otherwise difficult to pick-up:

“Doctors are taught to do medicine. … Documentation is key for legal, safety, monitoring point of view. As a student I wouldn’t have thought twice about chasing scans, finding appointment times – this is all completely new to us. Having someone accustomed to that is really helpful”. – FD

## Managing risk

The ward Consultants who supervise the CMAs did not believe there to be major risks associated with this role. The main challenges associated with the role were the result of unclear role boundaries, particularly relating to contact with patients. These had since been tightened up. The Consultants suspected that initially there had been a lack of clarity about the role and inadequate inductions for the CMAs.

It was felt that a lack of a detailed role profile and implementation guidance had also contributed to challenges. In one ward the CMA initially had too little to do, and so had become more involved in-patient care than was appropriate.

## Next steps

The Medical HR Manager welcomed HEE creating a CMA Career Pathway. A core curriculum and role profile would also be helpful as long as it was possible to retain local flexibility and ensure the role met the particular needs of a mental health setting. The importance of local flexibility was emphasized by the consultants.

Some interviewees highlighted concerns raised internally that the CMA role might adversely affect FD training, as they would have less exposure to certain tasks. One of the consultants felt that this could be avoided by ensuring that FDs continued to play a role in supporting tasks such as ward rounds and other tasks that fall within the CMA’s remit. A consultant noted that the CMA pilot role had been modelled on the private sector, which did not include trainee doctors in the equation. It was emphasised that in the NHS the development of the CMA role and training package needed to be align and complement what is in place for FDs.

The FD felt that the CMA role was helpful in a mental health setting as patient information is “all over the place” and needs to be brought together. They felt that the CMA role could be even more helpful in an acute physical health setting where CMAs could help reduce stress and the amount of overtime worked by FD, and speed up patient treatment and discharge. The Consultants, on the other hand, were less sure about whether the role could transfer to physical health acute settings.

# 4. Medical Summariser, Staffordshire

## Introduction

The practice is located in a former mining town in Staffordshire and serves approximately 12.5K patients. The local population is ageing and there are high rates of co-morbidities. There are also many young families and complex patients who use the practice.

This case study focuses on the practice’s Medical Summarisers (MS) work around workflow administration which has been developed under the GP Forward View initiative. The workflow administration involves the MS’s reviewing and processing around 3000 items of post and communications each week. Staff anticipate that this is displacing around 45 minutes of work a day for each GP.

The following staff were interviewed as part of this case study:

* Practice manager and the assistant practice manager
* GP
* Three medical summarisers

## Background and qualifications

The practice has three MSs who are all supporting the workflow project to different degrees. All of them work part time and between them provide 1.85 FTE. Two of the MAs are long standing members of staff. One had been at the practice for 22 years and the other for 12 years. Both began as receptionists, and started medical summarising work 13-14 years ago. A third MA started more recently, and she has more limited responsibilities and she develops her skills.

The MSs had developed the role iteratively and they suggested that it would take a few years for each summariser to become and effective and confident with workflow. The Practice Manager suggested that it would be difficult to recruit for these roles externally:

“It would be very hard to recruit these roles. Training is also done by the team working and supporting one another, with the most experienced supporting the least experienced. You can't come into the role and expect to be operating at their level quickly. It takes time.” – Practice Manager

Both the Practice Manager and the GP shared some of the role requirements they would look for if they were recruiting someone externally:

* Good communication skills including approachability
* Knowledge of medical terminology and basic medical knowledge
* Knowledge of IT systems, including the Microsoft Office
* Interest in the work and a willingness to expand one’s knowledge base
* Experience of working in a GP practice

Both MAs had a background in reception at the practice, and during the interview they expressed that they appreciated moving away from the reception and having to deal with that demanding front facing role.

## Tasks associated with the medical summarisers role

Medical summarisers spend a significant part of their role supporting the practice doctors with a workflow administration. This involves sorting and processing all of the mail which comes to the practice. The less experienced summariser focuses on scanning and sorting the mail, whist the two more experienced medical summarisers do the more complex work. Each summariser spends about 4 hours per day on the workflow work. Their work is dictated by a protocol that is regularly updated and modified. The role is always developing, it’s a work in progress.

Medical summariser tasks include:

* Processing paper based and electronic mail, e.g. discharge summaries, outpatient clinic appointment letters, results letters, etc.
* Highlighting areas of post where actions/clinical decisions are needed, allowing the GP to action them more quickly
* Coding for QOF and QIF
* Reading and summarising new patient notes
* Supporting screening services, e.g. vaccinations for schools.

## Management, supervision and buy-in

The MAs are line managed by the practice manager. However, one of the practice GPs oversees the workflow administration. This GP carries out spot checks of their work and holds regular development meetings review the process and their decision making and to discuss how tricky cases were managed. The MSs are also encouraged to attend weekly practice meetings.

The Practice Manager felt that it has been important for a Practice GP to invest the necessary time and effort to ensure that the process is safe and effective. It was also important to select the right GP to lead the work.

“A key enabler is that you need to commit resource to manage and optimise the approach. The approach needs the right kind of GP, someone who has that extreme attention to detail, a finisher. Personality is important.” -- Practice Manager

The practice has also ensured that there is a culture where MSs are empowered to inform the workflow approach, and to push back if they don’t feel comfortable working in a particular way. They are also encouraged to ask questions and to hold meetings where something isn’t working.

“You need trust between colleagues and it must be a two-way conversation. The summarisers need to be able to put their foot down at what they will and won’t file. It’s not just the GP dictating. The opinions of the medical summarisers matter…” - Practice Manager

“Our GPs are more open to new ways of working. If something is not right, we can ask questions or set up a meeting. Being able to discuss things openly and make recommendations is crucial.” - MS

## Training and progression

The GP leading the workflow project provided the initial training and then ongoing support and supervision. The MSs agreed that much of what they had learnt had been on the job, with the three of them supporting one another and consulting colleagues where necessary.

"We work as a team, if we worked in isolation it would be quite difficult, we bounce ideas of each other, even after 20 years in the role I like to ask and discuss. No matter how long you do the role there are always points to discuss." – MS

The MSs had recently attended a workflow training day which had given them new tips and training and had affirmed how much they knew and what valuable about their approach.

None of the medical summarisers wanted to progress from this role, all were keen to carry on with their current responsibilities and objectives. They did note however, that they felt progression would be more possible in a hospital setting. Primary care, in their eyes, was less mobile, but this was not a drawback to working in primary care, it was a choice they had made. The practice manager said that she was committed to exploring the potential for them to take on new tasks to help them stay interested and motivated in their roles.

It was suggested that the MSs could progress to a Practice Manager-type position if they wanted to develop a broader skill set. Alternatively, they could move to a larger practice, or to a data handling/ administration role in the local CCG or Commissioning Support Unit.

## Impact

Trust and patient impacts

The MSs are more consistently carrying out QOF and QIF coding, which is supporting compliance and is ensuring that the practice maximises its income. It was also felt that patients are benefiting because referrals and correspondence between secondary care and the practice is processed and actioned much more quickly.

“With system in place we know that everything is scanned and logged in 48 hours - there is never a backlog of post. Without the role there could be a backlog of about six weeks - which is just not safe for patients.” – MS

Before the development of the medical summariser’s role a patient could wait 3-4 weeks for a correspondence between a consultant and a GP, whereas now it is a matter of a few days. – Practice manager

The Practice Manager also highlighted the demographic of the areas means that there are a lot of ESA letters to do. As a former mining town with ageing population and co-morbidities, young families, and complex patients. The MAs are able to independently fill out the form having gone through patient records, and then the GP can sign them.

Impact on colleagues

The MA role has reduced workload for GPs. Previously, there were 40-50 items of post for each GP to work through every day, now they have 5-7 items to review. This gives them more time focus on patients and on the more complex elements of their role.

The practice manager felt that this is having a benefit in terms of patient safety, as the GPs are less likely to make mistakes. With a reduction in GP workload, this has also translated into less overtime hours worked and a better work-life balance for GPs, which in turn supports better staff retention at a time when there is a shortage of GPs.

## Managing risk

The workflow approach is guided by a protocol document which is maintained by the lead GP. This aims to support consistency of approach and it sets out clearly where GP input and decision making is needed. It is hoped that the protocol reduces the changes of the MSs making errors and putting patients at risk.

Staff agreed that if the two most experienced MSs left their roles the workflow approach would be hard to continue with. There was also a view that the workflow administration could not easily be added to a receptionist’s role, especially at a practice as large as theirs.

The Practice Manager feels that it would be hard to find and train new staff, and she therefore feels that some future proofing needs to be done. To safeguard against the MAs leaving, the Practice Manager has ensured that their pay is competitive which reduces the chance of them being poached by another practice.

## Next steps

It was suggested that HEE should give the practice funding to deliver training for the role for other practices. The Practice Manager was also keen for the MSs to do more types of medical administration which displaces the work of clinicians. This could include more work around blood test results, and medical reports for insurance. There is also hope that the MAs will begin providing assisting with tasks related to prescriptions.

# 5. Collaborative Care Team Coordinator, Northamptonshire

## Introduction

The practice is part of a cluster of GP practices who serve a population of over 30,000 patients. Funding from HEE to develop this role was spread across all three practices and they have developed administrative support in different ways. Traverse conducted interviews with three members at the practice to discuss the Collaborative Care Team Coordinator (CCT) Coordinator role:

* The GP – who was originally responsible for the task of the CCT Coordinator
* The Practice Manager – who manages the CCT Coordinator
* The CTT Coordinator

The Collaborative Care Team is a model of working which attempts to identify the top 20% of patients at most risk of hospital admissions due to complex conditions and chronic diseases. Having identified these patients, they take actions to prevent them going to hospital. Patients are contacted by the Coordinator by telephone or letter and are invited to produce a care plan, which is supported by a home visit from Age UK. The plans typically promote enhanced self-management, social prescribing and making modifications to patient’s homes.

CTTs from all three practices attend monthly MDT meetings to review the existing and new cases and to make referral decisions. These meetings bring together the GPs, practice managers, and CCT Coordinators and the district nursing team, palliative care team, and Age UK Northamptonshire.

## Background and qualifications

Practices taking part in the project felt that recruiting internally for the Coordinators was the approach that would work best. The CCT Coordinator was an internal recruit who the clinical team felt confident could do the job. The hiring team looked for the following skills and characteristics:

* Precision and accuracy
* Attention to detail
* Ability to multitask and think on one’s feet
* Strong interpersonal skills, including the ability to challenge GPs
* Compassion and tolerance
* Leadership qualities and ability to put a point across
* Customer service skills
* Basic IT skills
* Familiarity with medical terminology and patient records system

The CCT Coordinator has a background in retail, in local supermarkets and clothing stores. She started doing administrative work at the practice one year before beginning as the CCT coordinator. Her previous role included scanning, opening post, booking coil and implant appointments and more. The Coordinator role has been a step up in terms of responsibility; including being the lead decision maker and developing new processes related to the role. Staff at the practice feel that recruitment would be easier now that the processes are in place and staff feel clear about what the role entails.

## Tasks associated with the CCT Coordinator role

The post holder divides her time between the CCT coordinator role and her previous administrative role. With funding from HEE coming to an end, the practice has decided to continue with the role for at least 18 months and has found further funding.

The daily work of the CCT Coordinator includes:

* **Contacting patients who are at risk of hospital admissions** – which involves working from a regularly updated list of patients which draws on various data sources and places those at the highest risk at the top.
* **Producing care plans** – If someone wants a care plan, the CCT Coordinator initiates the process by creating the document and sending it on to Age UK who will arrange a visit. She also prepares a copy of the plan for the MDT.
* **Corresponding via telephone and email with Age UK** regarding medical issues
* **Attending MDTs** to talk about previous month’s cases and the new ones
* **Updating patient records**
* **Completing client closure reports** – These reports come from Age UK. The CCT coordinator scans the report and uses it to update the patient record

The CCT Coordinator noted that her position requires flexibility and the ability to take on new tasks. For example, she has created a care plan letter as an alternative to making a phone call, for people with hearing difficulties on the list.

## Management, supervision and buy-in

The CCT Coordinator has ‘advice on tap’ from the GP who used to do the role as part of his job, particularly regarding complex cases. The Practice Manager is her supervisor and meets with her once per month.

Training and progression

The training for the CCT Coordinator role was relatively informal and took place within the practice. The GP who had been doing the work sat down with the CCT Coordinator and talked them through what was required. The GP still serves as the CCT Coordinator’s advisor and answers questions as they arise. The post holder was also offered IT training and an NMC-run medical terminology training, but she did not feel that either was needed as she already had strong IT skills and had developed medical knowledge whilst working in the administrative role at the practice.

Now that the practice is familiar with the CCT Coordinator’s skill set, colleagues are keen to consider how they can extend the role further.

While progression hasn’t been explored in any great detail, staff at the practice suggested that the CCT Coordinator could potentially progress into a Care Navigator role. This would involve managing a patient hotline and would require basic knowledge of medical diagnoses.

## Impact

Trust and patient impacts

The practice team identified quality and cost saving benefits for the Trust. By transferring responsibilities held by GPs to the CCT Coordinator, an estimated £604 in GP time is saved across the three practices each week. The care that patients receive through the care planning process can also release capacity at the practice as these patients no longer need appointments.

Staff identified enhanced patient safety as patient records are updated more quickly and comprehensively, and by identifying and implementing interventions at an earlier stage. Although hospital admission avoidance cannot be proven at this early stage of the program, staff anticipate that these are the ultimate benefits for both patients and the Trust.

The GP and Practice Manager both felt that the new role provided improved outcomes and care for patients as the Coordinator initiated holistic care plans and social prescribing. Staff pointed out that for some patients it was social issues (e.g. isolation and loneliness) that were the root of their problems, rather than medical ones. In such cases, the GPs have been able to identify and refer these cases on to the Coordinator, leaving them free to focus on their clinical work.

The CCT coordinator reflected on her impact on patients, highlighting the personalised nature of her role:

“[I am] making [the patients] feel special, because I feel like a lot of older people feel like they don’t want to bother GPs, they are from that kind of generation, so I think it’s nice that someone is checking up on them.” – CCT Coordinator

Impact on colleagues

Staff reported that the time saving effect of introducing the CCT Coordinator role had been good for GPs’ mental health and work-life balance, and it had freed them up to focus more on clinical work:

“It takes away a lot of the background noise from me so that I can use my time more effectively. Then, actually, my time at home is my own time.” – GP

The GP explained that he feels “refreshed” now that he no longer needs to take this administrative work home. With a reduced workload, he feels able to provide a better service, including improved decision making:

“There’s only a finite number of medical decisions you can actually make before you’re absolutely shattered, and actually if some of those decisions were being taken up by CCT work and answering queries, then actually it would detract me from other things.” – GP

The CCT Coordinator role has improved communication between the practices and community organisations, with the Coordinator providing a single point of contact for them, and greater clarity about who should do what during the referral and planning process.

Staff reported that the CCT Coordinator approach has also improved integrated working. Prior to the role, they did not have an MDT meeting and there was no consistent approach amongst practices to working with wider teams and local organisation. GPs also had less knowledge about local services and sources of support, which had hampered other projects where integrated working was required.

## Managing risk

As well as close ongoing supervision from GPs, the practices have developed a flag system to prioritise and categorise patients on their list who are more at risk and who require GP attention. An end of life diagnosis is red flagged, and they are given priority. Complex patients who need a fast intervention get orange flag.

## Next steps

When developing the role, the team pointed out that it would have been useful to be able to draw on learning from another site who had done something similar before.

The practice team suggested that an area of standardisation that would be helpful would be in relation to handling patient data, and consent.

# 6. Complex Prescriptions Clerk, Northamptonshire

## Introduction

Albany House is part of a cluster of GP practices serving a population of over 30,000 patients. As a practice they have been developing the role of the Complex Prescriptions Clerk. Traverse interviewed the following six team members about this new role:

* Complex Prescriptions Clerk
* GP partner and Practice Manager (PM) (joint interview by phone)
* Medical Secretary (standard role actioning tasks sent through by)
* Administrator (mainly deals with patient results, phone interview)
* Administrator (mainly deals with opening/actioning GP correspondence. She also supports GP on care register)

## Background and qualifications

The CPC has worked at the practice for 21 years. She started as an administrator and has also worked as a receptionist. As an established member of the team, the GPs at the practice asked her if she would be interested in progressing in her role. She expressed a desire to learn more about medications and was trained up by the GPs and previous prescriptions clerk.

“I thought it would be interesting to do different bits and pieces around medication and to learn what different medications are for. For my role I’ve had to learn about hospital-only-prescribed medications.” – CPC

After working initially as the basic prescriptions clerk (issuing repeat prescriptions) she progressed to complex prescriptions (e.g. adding new scripts onto patient records, changing titrations, or taking scripts no longer relevant off the template).

## Tasks associated with the Complex Prescriptions Clerk role

The main responsibilities of the CPC include:

* **Receiving and processing** hospital letters
* **Updating** patient records
* **Communicating** prescription changes to patients
* **Answering phone calls and inquiries** from reception, the pharmacy, and from patients and districts nurses via the practice inquiry line
* **Actioning HCP tasks**

The CPC spends most of her day (5 out of 8 hours) dealing with **hospital letters sent through to her by the correspondence administrator**, e.g. discharge letters. The correspondence administrator emphasised that she always sends anything which mentions medication, even if it is not the focus of the letter, to the CPC to be safe.

“If any sort of medication is mentioned in a hospital letter I always send it across to the [complex] prescription clerk to be sure – even if it is not stated that there is a medication change.” *– Correspondence Administrator*

The CPC **amends the patient record** if medication has been stopped, increased or decreased, and **writes to the patient** to inform them of the alterations. The CPC was confident that these responsibilities would otherwise go to the GPs. The CPC noted that these responsibilities had fallen under her remit since she began the role, but in conservations with prescription clerks from other surgeries she has learnt that she is the only one who deals with hospital letters. At these surgeries the GPs process the hospital letters.

Another key task (2 out of 8 hours) is answering **phone calls and inquiries** from reception, from the pharmacy, and from patients and district nurses via the practice inquiry line. A proportion of the inquiries would otherwise be handled by the GP, and others could be handled by the Basic Prescriptions Clerk, although in the past people in these roles had not felt confident in fielding inquiries, highlighting a training need.

“It would be nice for other colleagues to have more understanding of medications and prescriptions – that would take my workload off from the enquiry line and reception - if they could just look at the screen and see if it’s been done. You get interrupted for little things that they could have seen.” – CPC

The third key area of work is **actioning medications related tasks** sent to the CPC from the GPs or other healthcare professionals, such as the diabetes nurse and community mental health team.

“It’s not just processing letters – its calls from local pharmacists – the phone is red hot the whole time. I have to make over 100 complex decisions in a day… 100% of her work would come on to my plate – all GPs would be inundated with decisions for minor and major stuff and there is no easy way for staff to discriminate whether they are major or minor.” – GP

“Only a limited number of people know how to process these [complex prescriptions] – and in a lot of other surgeries GPs deal with them.” – Medical Secretary

## Training and progression

The CPC has been given training related to complex prescriptions. For example, she went on a prescribing course in Northampton, which was a NHS course consisting of 6 sessions, each day long every few weeks. However, the CPC found that she already knew most things covered in the courses. The CPC has also had access to on the job training from the GPs and from prescribing advisors.

“I have learned things from the doctors. And from prescribing advisors – they come in every week, so I can get in touch if any queries.” – CPC

The CPC is highly satisfied with her job and says that the practice feels like a second family where it’s common for employees to work into their 70s. She is keen to continue in the role but would potentially drop her hours as she approaches retirement age. She also wants to continue to learn about the clinical aspects of the role which is what had attracted her to it in the first place.

“I’ve always said I would like to know more about what the tablets are actually for, from a GP, for example. I know some of the basics, but I would like to know more about what they’re actually for – to do the job and also for job satisfaction.” – CPC

## Supervision and management

The CPC is line managed by the Practice Manager. The Practices’ prescribing lead doctor and medicine management team also work closely with the CPC, providing supervision and support. She has also been encouraged to approach GPs whenever this is needed.

“She’s very experienced, keeps a list of queries. We’ve developed a medicine managements team and a buddying system. CPC has easy access to a number of GPs and is not one to shy away from coming to GPs and saying she doesn’t want to do something. – Practice Manager

## Impact

Practice and patient impacts

The GP highlighted the CPC’s impact on patient safetythrough her awareness of individual patients and their prescriptions, and her close attention to detail. This includes an ability to identify potential drug seeking behaviour.

“She has a local radar and she names patients who are trying to order scripts too early – i.e. drug-seeking behaviour. This is important from a patient safety point of view. She literally counts them one by one to work out how many they should have. She can keep GPs informed on this.” – GP

Both the Assistant Practice Manager and the GP highlighted that the CPC had helped to achieve cost savings to the NHSTrust due to her knowledge of generic alternatives to medications.

“She has saved money when local stocks have run out and they hike up the prices – she’s proposed alternatives.” – GP

“The CPC has saved the CCG significant money, by proposing cheaper alternatives drugs. In the last 14 months she’s saved the CCG £27k.” – Practice Manager

Impact on colleagues

The GP considered the work of the CPC in terms of saving GP time had two effects: freeing them up to see more patients, and reducing their out of hourswork:

“We see more patients face to face than other practices. Other practices would have at least one sessions as an admin session to catch up on this sort of stuff. And I get away at 6pm whereas other practices are working into the evening. Because only the complex stuff comes my way.” – GP

The Practice Manager emphasised that the CPC was particularly helpful in terms of saving GP time for those GPs who were less ‘tech savvy’.

“Collectively she saves the GPs a significant amount of admin time. She’s 37.5 hours a week – she’s saving the doctors that 37.5 hours and more. She’s saving more time in particular for the older GPs who are less techy than.” – Practice Manager

“They’re glad when I’m here because I answer their questions quickly – otherwise receptions would have to wait until GP came out of surgery and ask them. GPs say, ‘what would we do without you’. Sometimes a GP will ring out and say they’ve got a patient in here – ‘what do we normally prescribe them?’ Or ask, ‘what strength injection do we give them?’” – CPC

The GP also emphasised that the CPC’s impact was significant in terms of time saved *overall*in the prescriptions process. The speed at which she is able to do this work is often faster than the GP.

“She would be quicker than me at setting up titrating doses etc – all the liaison in between with pharmacy and patient, double checking – she’s quicker than me.” – GP

The GP emphasised that the significance of the CPC’s impact was related to her long experiencein the role, describing her as an integral part of the practice and acknowledging that she has, ‘experience you can’t buy’. The GP confirmed the CPC’s value in terms of GP time saved and as a reliable source of accurate information for GPs and other roles in the practice.

## Managing risk

The CPC was very aware of the risks inherent in the tasks being delegated to her and the reliance placed on her. She was highly aware of the importance of prescriptions being accurate and of the potential implications for patient safety if there were mistakes relating to medications. Though, she noted she has not ‘had any mishaps’, she was keen to emphasise that the responsibility remained with the GPs.

On joining the practice, the Practice Manager met with the CPC to review the role and ensure that they were taking a ‘safety first’ approach. The practice manager introduced a ‘must consult the GP’ medications list which was put together by the prescribing lead doctor. The CPC has also initiated a ‘yellow flag’ system, so that any changes being made to prescriptions (e.g. titrations) were looked at rather than ‘ticked through’ by the GPs.

“I print the letter off and put a yellow flag on it to alert the doctor, to alert the doctor to read it and to make sure I’ve done it right. I came up with this – in case I did get it wrong. If I do make a mistake I want it picked up. Yellow flags are where it’s a change, an addition to medications that’s come about e.g. from a hospital prescription advice sheet.” – CPC

The Practice Manager shared the view of GPs that the risks associated with the role were mitigated by depth of the CPC’s experience; her assertiveness and ability to challenges colleagues; and through their oversight and supervision from the prescribing lead doctor in the practice, engagement with the National Performance Advisory Group, and through carrying out significant event audits.

The GP felt that risks were mitigated by the close relationships between those working in and with the practice and the fact that key colleagues were located close to one another:

“We have a close relationship with the pharmacist below our office – a lot of conversations go on. And we can go to the CPC in break times to ask her to sort things out.” – GP

## Next steps

Both the Practice Manager and the GP saw the potential to roll this role out across the NHS, as it would be an attractive role in terms of recruitment, and would be beneficial in terms of enabling clinical pharmacists to focus on patients. The Practice Manager had already alerted the Local Medical Committee of the value of this role.

However, staff at the practice did not consider rolling out this role to be a straightforward process given the risks involved. It would require training, with local training seen as more helpful than national training given the different systems that practices have in place.

“It’s very dependent on the person to be honest. A formal induction process/job description would be difficult to do. So local training for them to update, tap into, would be essential… There are clinical pharmacists coming online but want them in a patient-facing role – this fills that gap.” – GP

Staff also welcomed HEE creating and promoting a role profile and potentially a risk management approach and accreditation scheme for the role.

“Accreditation gives gravitas for role. If we were recruiting to this role it would be really helpful.” – Practice Manager

# 7. Back Office Administrator & Administrative Assistant

## Introduction

The practice is located in the Birmingham area. It is a big and busy practice with lots going on. In 2016, it federated with 23 other practices and became the hub for the area which saw it extend its opening hours. It is a training practice which employs clinical pharmacists and physician associates and has contracts for various community services, and a virtual GP providing services 12 hours a day to take pressure off GPs. District nurses and physiotherapists run clinics most days of the week

The number of patients registered with the practice increased from 3.5k to 7.5k when it joined the federation and became a hub. In the midst of this change, the work carried out by medical administrators has been in particular the focus on managing clinical correspondence.

“Medical admin is becoming a role on its own now – more patients, so more post; and what GPs want us to do and them to do has changed completely. GPs want to do 30% of the follow through actions from post and us to do 70%.” – BOM

This case study focused on the clinical correspondence work done by the Back Office Manager, and the Administrative Assistant. In June 2017, Traverse interviewed four team members in the practice connected to this administrative work:

* Back Office Manager (BOM)
* Administrative Assistant (AA)
* GP
* Assistant Practice Manager

## Background and qualifications

### Back Office Manager

The BOM has a background in administrative work. They were an HR co-ordinator for two years in the private sector, and before that a PA in a local authority. At the practice she initially started as a receptionist. She didn’t take on a reception manager role because she had a baby and couldn’t manage the hours. Twelve months ago, a BOM role was created, which she took on. However, she still spends a lot of her time doing the administration of her previous role as there is a lack of administrative capacity at the practice.

“The role has evolved as we take on more from the GPs. But the team is shrinking – lot of young people don’t stay long. We need to have a knowledge base, so I haven’t been able to pass on the medical admin stuff - so I’m juggling that with my back office manager role.” – BOM

It is hoped that the AA role will be developed in order to release the BOM from doing the medical admin side of her work.

### Administrative Assistant

The AA started at the surgery as an apprentice 5 years ago – the practice is her only employer so far. She has been in the AA post for 2 years. She was not happy doing the receptionist role, and wanted a more “back office” role, so this post was created for her.

“Someone like the AA is perfect because she has great attention to detail, is conscientious, and likes working on computer but is less keen on patient facing work as she is very introverted.” – Assistant Practice Manager

## Tasks associated with the Back Office Manager role

The BOM spends 5 hours of her 4 weekly work days on medical administrative work. These tasks include:

* **Processing electronic and paper post** – this involves reading, coding, and filing post and passing posts requiring GP input.
* **Coding and EMIS tasks** – GPs get x ray, ultrasound, or blood results, and they will action and turns into an EMIS task for BOM to action e.g. call in patient, pharmacist issue tablets*.*
* **Updating a blood recalls spreadsheet**
* **Managing the My Healthcare App** – patients book appointments and order medication through the app. The BOM can decline or approve these requests to go into the GP.
* **Managing requests issued by the Prescription Ordering Team** – if the issued request is acute it will go into queries queue. The BOM will triage it and send it through to the GP, or decline it and contact the patient if there appears to be a problem.
* **Redirect misaddressed post**.
* **Creating new patient records** when new patients joins and coding them onto electronic system.

In theory the BOM does medical admin all day Tuesday but often is not able to start till 3pm because of the phone is always ringing – this results in her regularly doing more hours than she is paid to do. She is meant to spend Wednesday and Friday mornings on management but that is currently not happening. The medical admin work is therefore being achieved at an opportunity cost to the practice and to her own career satisfaction and development:

“I could be used in so many other places – I need stretching.” – BOM

## Tasks associated with the Administrative Assistant role

The AA works part-time 3.5 days a week. One day (Wednesday) is spent covering for the medical secretary and completing classic medical secretary tasks such as tasks sent by the GP, including hospital referrals and insurance reports. She does the medical administrative work listed below on Thursdays and Fridays.

* **Appointment booking** for referrals, blood results, and bookings for anti-coagulant clinics.
* **Workflow administration** for a half day each Sunday. This involves opening and actioning clinical correspondence (e.g. coding and inputting test results). She goes through the GP post and decides if the GP needs to deal with it or if it can be actioned by the AA.

“It used to be the GP who opened post and created a to do list for the administrators (e.g. coding related tasks). Now if we can do it they don’t see it.” – AA

* **Filing, updating and creating patient’s medical records**.
* **Clinic system check** – The AA puts all the clinics on the system once a month.
* **Other** tasks include PPA claiming back (the prescription money claiming back), ordering drugs, ordering supplies from the lab, sending reports back to CCG (e.g. a bad discharge from hospital that needs to be investigated), and attending, minuting and actioning child safeguarding meetings.

The AA felt her impact would be greater if she had **increased delegation of powers** in relation to clinical correspondence. She could, for example, log in access to send documents directly through to reception rather than via the GP; and being able to take medication directly off a patient’s medication screen when a hospital letter comes in saying a patient is no longer going to be taking a medication, rather than sending it through to the GP to do this.

The BOM highlighted that the trend to try and reduce the work of the GP was affecting staff’s work across the practice and not only the management of clinical correspondence:

“The receptionists and medical admins are triaging more – a care navigator role - steering patients away from GP e.g. to the clinical pharmacist if the patients don’t need to see the GP.” – BOM

## Training and progression

The APM recognised that the proposal to develop the AA further to enable her to become a medical administrator would require more training and development with input from the GPs. This was needed not only to increase her clinical and technical knowledge, but also to boost her confidence in undertaking tasks that would previously have gone to the GP.

The GP recognised that more training would be beneficial to enable medical administrative work to be done more effectively and with confidence by a wider groupof administrative staff. The GPs’ initial decision to delegate the clinical correspondence had been very unwelcome to many administrative staff as it was seen as too risky a task for non-clinicians.

The BOM felt previous work experience and length of service in the practice was relevant to staff’s ability and confidenceto undertake this task effectively:

“I tried it with a non-confident member of staff and she was taking hours – reading things several hours as she was so frightened. I have been training and supporting her over several months to take her forward. She used to be a hairdresser. I’m from a council background so I’m used to systems and documents.” – BOM

The AA felt confident in the work she was doing as she had been opening the clinical correspondence for 5 years and this had given her the knowledge needed to be able to use her own judgment:

“I feel confident knowing what they need to see or don’t. The main question is ‘is the doctor going to do anything with this?’ There’s a lot of using your own judgment, knowing the patients, knowing which doctor typically sees this patient.” – AA

The AA’s confidence was also increased by having an open communications channel with the GPs.

The BOM felt a more systematic approach to training and development for administrative staff was needed at the practice and this should include more robust induction training. It was felt that the practice was more focused on training aimed at the clinical rather than the administrative staff. This was creating pressures on admin staff as more work was being delegated which the BOM was trying to address:

“We have created more of a structure, I’m putting learner guides in place. There’s a lot in place for clinical staff but not the admin staff – they don’t just take phone calls and handle repeat prescriptions anymore. That needs to be recognised and valued. The feedback from all admin staff is ‘why aren’t we getting more training before we start the work?” – BOM

The BOM also felt that all admin staff should have systems trainingso they know how to operate the information systems used by the practice such asEMIS, and DocMan.

The AA had received in-house training only on how to use DocMan and EMIS systems, which included how to process medical records, how to transfer data onto electronic system, and how to log them and chase them. She has been given updated instructions as things change. With her current role opening clinical correspondence she received training on which letters to send through to the GP and which not to send. As time has passed GPs have given different instructions. The AA felt this training had been sufficient for her but felt other people might have preferred something more formal.

Both the AA and BOM mentioned medical terminology training as a specific gap:

“Medical terminology training would have helped some people – one receptionist is doing this. I didn’t need it - I learned as I go along – it comes with experience. But some people might not be happy to wait that long.” – AA

“A bit of medical terminology training is needed. Not just reading it and thinking ‘what does that mean?’ An admin member of staff has booked herself onto a course herself in her spare time.” – BOM

## Impact

### Patient impacts

The GP felt the reduction in his workload, which was the result of medical administrators undertaking tasks that were formerly the responsibility of GP, had direct benefits for patients. These benefits include patient safety because the GP’s quality of work is improved, increased speed of processing patient issues, and increased contact between GPs and patients. GPs are less tired and therefore less likely to make mistakes, and also have more time to devote to each correspondence item and to speedily take any actions required:

“If I had 300 letters, it’s natural to rush, to not be as careful. If you have half that number, you’re going to be more careful. So the letters we have got, we can spend more time reading them. If something needs actioning, because I have more time I do the action straight away, I pick up the phone rather than send it to the administrators. … There is a safety issue if people are tired and rushing.” – GP

The delegation of medical admin work had also freed up GPs to do more patient-facing and educational work.

GPs would have previously looked at letters outside of working hours, and so there could be delays in contacting patients and completing other actions. With the correspondence work taking place in working hours actions could be taken more quickly. TheBOM also highlighted increased speed and efficiency with which patients’ issues are now dealt with.

“Patients’ issues are dealt with quicker and more efficiently. For example, an order for patient stockings being actioned on the day not sitting in a GP tray for 3-4 days.” – BOM

“It’s done more quickly – it’s not a receptionist having to fit these tasks in and around reception work, or not finding time to do it.” – AA

### Impact on colleagues

The GP interviewed confirmed that the BOM and AA’s support with opening and actioning clinical correspondence had impacted on the workload of himself and the other two GPs, estimating that it had halved the amount of post coming through to GPs. The letters that are now sent through to him are those which are more complexand need more time. He felt that the proportion of letters which GPs did not need to see had increased as people were copying them in to ‘cover their backs’:

“A lot of things we get don’t need to be actioned by a GP – such as requests for patient notes, summaries, or notifying of an appointment today. The default option is to copy in a GP in case anything goes wrong, so we get copied into a lot of things we don’t need to see.” – GP

He estimated that he now gets 30-50 letters a day compared to 70-100 letters a day previously; and spends 2-3 hours a week on these - 1-2 hours a week less than previously. He felt that this had had an impact on his free timerather than his practice time, which improves GP work-life balance as opposed to saving surgery time.

The AA felt her clinical correspondence work had lessened the burden on the GPs who had fed this positive impact back to her. Both the APM and the GPs recognised that she was increasingly taking the initiative to proactively check and suggest actions that should be taken:

“The AA is going into patient record and checking if actions have been done. For example, have appointments been booked? Pre-empting what the GP is going to ask. That saves the GP having to look through the patient record. Or if bloods have been requested by the hospital, she is checking if those have been booked – and gives the information to the GP so they can decide whether to close it down without checking.” – APM

The BOM also highlighted the need to reduce the pressure on the GPs in terms of out of hours working and the impact of doing this on GPs’ wellbeing, job satisfaction and ability to communicate effectivelywith colleagues:

*“It had got to the point where we had the senior partner doing all his admin work at weekends remotely. … Clinicians are happier, less stressed and have more time to speak to us when we do have queries.” – BOM*

As a result, she felt her medical administrative work to be highly valued.However, when she is absent there is a strong negative impact both on her and on the GPs:

“If I’m on leave there is no capacity to pick it up, so I dread what will be waiting for me. If I’m off work, the GPs feel it.” – BOM

The BOM felt that while the delegation of medical administrative work by the GPs has led to increased pressure in terms of staff time, it had also had benefits in terms of the quality of back office work and job satisfaction.

## Managing risk

Both the BOM and the GP said the main risk is that medical administrative staff may not send through items of correspondence to the GPwhen they should have been sent. The BOM explained she had worked with the GPs to minimise this risk by establishing a protocol with a safety-first approach.

“I’ve been creating a guide of what does and does not need to be workflowed to a GP. If in doubt, send it to a GP.” – BOM

“At the start we did sit down with them. devised a stringent list of things they shouldn’t send to us, and a list of things that must be spent to us even if no GP action: e.g. if children are missing appointments (this could be a child protection issue) or A&E discharges. We wrote them down, it’s not left to the girls to decide.” – GP

The Assistant Practice Manager emphasised that the post was regularly audited in order to manage risk. The BOM highlighted the importance not only of auditing work but also of the GPs communicating ongoing feedback. However, the BOM felt still more could be done to make the approach to risk management more systematic, with training playing an important role in ensuring that the delegation of medical admin tasks is done safely and that staff feel more confidence.

## Next steps

The GP and Assistant Practice Manager highlighted the importance of sharing best practice and developing training and accreditation for these new roles. This would enable a more consistent approach based on best practice to be taken across the board, facilitate the career progression of admin staff within and across GP practices, and make them more confident and willing to do medical admin work. The APM emphasised that while a formal curriculum would be useful it would need to be highly flexible to allow for local variation, given the different systems used in different GP practices.

The BOM felt accreditation and training of medical administrative work would be popular because it would become a more recognised route for admin staff to progress from front office receptionist work to the more demanding back office medical admin work.

# 8. Care Navigator, Cambridgeshire

## Introduction

This practice based in rural Cambridgeshire has 8,000 patients and a staff base of 2.5 GPs and 3 FT nurse practitioners, who consult, refer and prescribe as doctors do. This case study focuses on the work of two of the receptionists in a GP practice in rural Cambridgeshire, having participated in a one-day Care Navigator training session. The Senior Receptionist explained that the training took place after the company contacted the Practice Manager to invite them. All five of the receptionists at the practice took part in the session which was delivered in their practice.

Traverse interviewed three members of the practice in September and October 2018:

* 1 Practice Manager
* 1 Senior Receptionist (full-time)
* 1 Receptionist (part-time)

The Practice Manager explained they went for the training programme because they had had trouble recruiting GPs and there were concerns amongst GPs about rising workloads. The recruitment challenge is owed to the rural location, with urban areas tending to attract young doctors. Added to this, the local disease prevalence in their area is twice the national average (e.g. obesity). The GPs are advocating for the development of medical administrative and nurse practitioner roles to lighten their work loads, and are blocking off dedicated administrative time during their work days so that do not have to work in the evenings.

## Background and qualifications

The Senior Receptionist’s employment background was administrative office work outside the NHS which she felt had given her relevant customer service experience. She had worked her way up within the Riverside Practice from a part-time post that involved learning on the job.

The Receptionist whose employment background was also office and customer service work outside the NHS, felt well-prepared for the administrative and customer facing sides of the job, but found navigating the ‘care’ aspects of the role very challenging.

## Tasks associated with the care navigator role

The Practice Manager emphasised that the Care Navigator training had enhanced a previously existing role rather than creating a new one. Prior to the training, the practice already had two different types of receptionists. Those with:

* Primarily **administrative duties**, such as booking appointments
* **Care navigation responsibilities**, such as assigning patients to Nurse Practitioners for straight forward cases and to GPs for complex cases, which is done over the phone and face-to-face

The Care Navigator training provided the latter type of reception with more tools to properly to their jobs, and create the basis for increased patient trust. The Program Manager explained that previously patients did not trust receptionists to perform signposting:

“Regular criticism of receptionists is they shouldn’t be asking me what my problem is, expect to see a doctor, they’re not trained. Navigator training enabled me to say we’re taking part in national approved training programme which enables receptionist to advise authoritatively. Patient groups liked the additional training, receptionists liked it as gives them the wider picture.” – Program Manager

The Senior Receptionist acknowledged that it was important to be clear about the difference between navigating care and triaging patients, which required a different level of knowledge and expertise. Both the Receptionist and Senior Receptionist felt the training has improved their confidence in completing these aspects of their job:

“The training gave me more confidence in the signposting elements of the role, to say ‘ring 111, I think you need to attend A&E’. I’m still new and training – to say ring 111 or 999, it’s still hard to do that when you’re first starting – what if something goes wrong? The course gave me more confidence.” – Receptionist

“The amount of appointments we save for a GP is quite a lot every single day. [Patients] say they want an appointment. What we’re trying to say is ‘can you indicate what it concerns so I can get you to the right person?’ They say they just want an extension of a sick note – we can put that through to the GP without an appointment. Or repeat prescriptions – we explain to people you don’t need to see a GP to get it. And we do have access to patient records - a patient will say the hospital consultant is writing to the GP – we can look and say, ‘the letter has not arrived’. We will explain that medication can’t be started till the letter is received, so they need to chase the hospital for the letter. We can look at blood test results – if GP has filed as normal we can pass that on and say they’re normal.” – Senior Receptionist

The Receptionist reported that care navigation, whether on the phone or face to face on the counter, was 100% of her role on a busy day, 80% on a quieter day when she would fit in other tasks such as scanning hospital letters, NHS electronic mail handling. The Senior Receptionist saw it as 99% of her role:

“I am constantly taking calls in back office or speaking to people on front desk – navigating to correct pathways, hospitals etc. Every call you take even if it’s to book an appointment you ask questions to get them to the right people – to me you’re navigating all the time.” – Senior Receptionist

She noted that she could spend 9 hours a day doing calls or conversations on the desk of this kind. She also reported that because of having to ask the care navigation questions the conversations with patients had lengthened – a typical patient call about an appointment would now last 2-3 minutes.

## Management, supervision and buy-in

The management and supervision of receptionists have remained the same since the training took place. The Receptionists tend to access support as and when they need it. For example, it is quite common for the receptionist to ask questions of more experienced colleagues throughout the day.

“I still don’t feel 100% confident – I am still new to the job, still learning. If I’m not 100% I ask Senior Receptionist and another Receptionist who’s been here 20 years. I will always double check, want to make sure it’s right, it’s patient care I’m dealing with. Even if simple I would rather ask than get it wrong.” – Receptionist

Receptionists were unclear about whether there was a system of checks on the accuracy of their care navigation work. They also felt that the induction training needed to be expanded for new joiners because of the daunting nature of this work and risks associated with it. She noted that inadequate induction offered to her had almost led to her leaving the job soon after she arrived. She reported that she was not alone in coming close to resigning initially.

“I nearly left in the first few months – I found it very stressful – I thought ‘I can’t do this’. My worry was that I was putting patients in the wrong place – there are so many clinics – diabetes, asthma, blood pressure – it can feel daunting… I would have preferred to have sat and watched and listened for longer – rather than be introduced and sit down for 5 minutes, then told to pick up the phone when it rings… Some other ladies had worked here and left.” – Receptionist

## Impact

Patient impacts

The Practice Manager felt that by saving of GP appointment for more complex cases care navigating receptionists were having a positive on overall patient satisfaction and quality of care.

“I want a patient with a problem to walk out of a practice and feel a GP has had time to see and discuss their case, and if they need one they should have a referral. I don’t want them to feel short-changed. But demand for that exceeds the capacity. And not all that demand should be pointed at a GP. GPs are not the only person who can solve that.” – Practice Manager

The Practice Manager felt that participation in the Care Navigator training programme had improved receptionist’s communication approaches and it had given them a greater ability to gain the trust of patients when they were making navigation suggestions.

The Receptionist gave an example of positive feedback from a patient’s wife about being navigated away from coming in to see the GP, and emphasised the importance of saving time for particular symptoms:

“Yesterday I signposted someone on the phone to 111 to get telephone triage, and paramedics if needed. The patient had low blood pressure, and we were fully booked. She [called 111] and paramedics attended and stabilised the patient. She rang back to thank me, she was pleased with the outcome. It’s hard when doctors are fully booked, but by the time you’ve put a task through, it’s quicker to ring 111 and get the triage done. But it depends on the symptoms.” – Receptionist

She felt the role was particularly helpful for older people, or people without a family to support them in navigating services to find the most appropriate and timely source of support:

“Sometimes a different service can help more… e.g. [they] may need to see podiatry or social services – where they think the doctor should be sorting, you can put them through to that. If they need a special bed or stool after they come out of hospital, they assume it’s the doctor who will do it, it helps us talking to them about what they need. Especially if they’ve got no family they think the first place to call is the GP.” – Receptionist

The Senior Receptionist, in contrast, felt older people were less likely to be willing to adapt to the new system of navigating patients away from seeing the GP, or to be suitable for it:

“Older patients are used to always seeing the GP. And they probably need to see the GP more anyway as have more complex needs.” – Senior Receptionist

She was confident however that many patients benefited from being educated about new services and access routes, such as opportunities for self-referral, and/or being guided towards professionals who could see them more quickly and appropriately. She reported instances where patients had recognised this benefit and thanked staff for their care navigation work.

Impact on colleagues

Receptionists feel that care navigation is now being delivered more **consistently and confidently** by staff. The training has particularly benefited less experience receptionists, who now feel clear and more confident about the approach that they should take.

“Receptionists have changed way they speak to patients – they back off if people say they don’t want to discuss, it has helped to stream patients more efficiently, more co-ordinated and more consistently. Previously the more experienced might do it well, but less experienced might not. I definitely recommend the training.” – Practice Manager

GPs at Riverside Practice reported that the improved approach to care navigation alongside other medical administrative initiatives is **reducing the number patient appointments** and is **reducing their administrative** **workload**.

“All the initiatives are to try and maximise the time for the doctors. … They’ve got on top of their admin work – hospital letters etc – because they’ve reduced the volume of tasks. We have days where Nurse Practitioners’ [appointment slots] are full but not GPs’. GPs are blocking themselves off for admin, but are available for overflow. … The patients who see the NPs and GPs now are more appropriate than they were a year ago, they are doing less admin.” – Practice Manager

As doctor’s workloads reduces it is allowing them to devote more time to the most complex cases. It is also **making it easier to recruit new GPs**. A doctor from one of the super practices in Bedford has recently decided to join the practice. In Bedford she was seeing 50-60 patients a day, whereas in March following the implementation of administrative initiatives the GPs see 30, which has attracted her to come and join them. The practice manager noted that the BMA recommendation is for GPs only to see 25-30 patients a day. She felt this was important given the increased pressure on GPs:

“The demand on GPs is outweighing what they can actually do. Our role is important in their daily work to signpost and protect their time.” – Senior Receptionist

## Managing risk

The Receptionist felt that trying to balance care navigation with other tasks such as scanning hospital letters could potentially lead to mistakes:

“Trying to [scan] and answering phones – the two don’t seem to go together. Scanning should be a separate job. That’s when mistakes happen. You see something urgent the doctor needs to see, then the phones go, and you’re distracted. You have to come out of the screen you’re scanning on and go into patient notes on screen.” -- Receptionist

The Senior Receptionist explained that care navigators manage the risks related to referring people with urgent symptoms by immediately informing the GP after they have suggested a 999 call to the patient. The care navigators have knowledge of heart attack and stroke symptoms, but the Senior Receptionist finds it assuring to get the message back from the GP confirming that they have made the right decision.

The Senior Receptionist reported that some patients still react negatively to the concept of the care navigator role despite the fact that they have had the training and wear care navigator badges. She felt that the fact that reception staff had been trained had been insufficiently promoted to the practice’s patients, which had reduced the impact and value:

“In people’s eyes we’re still receptionists who don’t know anything… We have received training and can signpost people – our patients and general public don’t understand that. Sometimes they think we are preventing them from getting what they want… Sometimes people get quite nasty... We were all really excited about the Care Navigator training. I gained different approaches, questioning styles. We are doing it, but it’s not out there. I feel disappointed in that respect.” – Senior Receptionist

## Next steps

The practice us due to merge with another where all requests for appointments go to a GP, who phones the patient to decide who they should see them. In the week before the interview, a GP had made 65 patient calls in one day, but had only seen 4. The patients allegedly like this system as they go straight to a doctor rather than through a receptionist, and the system has been in place for many years so may be difficult to change.

Both the Receptionist and Senior Receptionist felt that their roles needed a name change with these added care navigator responsibilities. The Receptionist felt that her job title was a misnomer. When she thinks of ‘receptionist’ she thinks of the type of administrative work that would be done at the front desk of a hotel, and care navigation does not fit under this. The Senior Receptionist noted that the role was advertised as ‘receptionist administrator’, but she shared the view that a name change was needed and that this would be beneficial both to staff morale and to patients. It was felt that a better label would bring greater assurance to patients.

“If someone says: ‘what do you do?’ and I say ‘I’m a receptionist’ – you think of someone answering the phone, letting people in, booking appointments – our role is far beyond that. Care Navigator would be better. … This term ‘receptionist’. We are human beings, we care, we treat people as we would want our family to be treated. “Care Navigator” is saying to people that we have had training. We are about care, trying to help you get to the correct person first time. I’m passionate about my job, and hate that people see us as the person trying to stop them seeing the doctor or nurse.” – Senior Receptionist

# Annex 2 – Economic Analysis

**1. Introduction**

This note sets out an approach to determining an indicative cost benefit assessment in respect to the employment of Medical Administrators (MA) in the NHS.

We have examined two scenarios for what would happen without an MA being in place:

The roles that would be done by an MA are undertaken by other members of staff (which may include GPs in respect to primary care, and consultants in relation to secondary care), through an increase in unpaid overtime;

The roles that would be done by an MA are undertaken by other members of staff, with the level of FTE staffing being held at a level consistent with no undue overtime.

We consider these two scenarios in turn, before moving on to assess the likely effects based upon the experiences highlighted by the case studies that have been examined.

**2. Unpaid overtime used to fulfil Medical Administrator tasks**

In the indicative assessment below, we compare a medical administrator role against a scenario in which their time is allocated among existing staff who work extra hours of unpaid overtime accordingly. In such a scenario, three adverse effects which occur are:

* an increase in staff turnover, which leads to recruitment costs, agency costs, and loss of educational trainings costs, if the member of staff leaves the NHS;
* an increase in staff sickness among the wider team, due to increased stress and risk of burnout; and
* errors in medication (other errors, such as medical problems being more slowly picked up, may also be a factor, but are not considered here).

We consider these in turn.

***2.1 Staff turnover***

When hours increase, so too does the risk of stress and consequent loss of staff. Our analysis has proceeded in three parts:

* Determining the expected change in the numbers leaving;
* Estimating the cost per person leaving; and
* Calculating cost by multiplying expected change by cost per people leaving.

We have calculated the approach using a base case of turnover amongst nursing staff, and used the same methodology for assessing effects in relation to GP staff, junior hospital doctors and consultants. Appendix 1 shows the full methodology in respect of nursing staff.

Table 2.1 below shows analysis on expected turnover for the four groups of staff.

Note that:

* We assume the same level of productivity in tasks for nurses versus medical administrators, but a faster rate of productivity for GPs and Foundation doctors;
* In estimating the increased risk of staff turnover, for GPs we use the same risk profile for nurses (using a factor of 49% that reflects the greater increase in hours); and a scaled back profile for junior doctors, to reflect a lower proportion with stress.

***Table 2.1 Effects of staff turnover by staff type***

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Nursing staff** | **GPs** | **Junior**  **doctors** | **Consultants** |
| Unwell due to work-related stress in past year1 | 41% | 50% | 34% | 31% |
|  | | | | |
| Number of staff allocated extra work (indicative) | 8 | 3 | 3 | 3 |
| Increase in hours per staff member (indicative) | 1.0 | 2.0 | 2.0 | 2.0 |
| Proportional increase in hours per staff member | 12.5% | 25% | 25% | 25% |
|  | | | | |
| Current rate of turnover of staff (NHS average) | 15% | 15% | 15% | 15% |
| Increased risk of leaving, based on % change in hours2 | 22% | 49% | 43% | 30% |
|  | | | | |
| Expected number to leave3 | 1.20 | 0.45 | 0.45 | 0.45 |
| Expected number leaving adjusting for increased risk4 | 1.46 | 0.67 | 0.64 | 0.62 |

Sources:

(1) NHS 2017 staff survey for nursing staff and hospital consultants, BMA (2018) “Working in a system under pressure” for GPs;

(2) see Appendix 1 for basis of assessing increased risk of turnover if working 1 or 2 extra hours per day, note that additional risk is scaled down for junior doctors as discussed in text;

(3) calculated as number of staff allocated extra work \* current rate of turnover;

(4) number of staff allocated extra work \* current rate of turnover \* (1 + increased risk of leaving).

The next task is to assess the unit costs of a given member of staff leaving. Again, we consider the three types of staff separately, as shown in table 2 below.

***Table 2.2 Unit costs of leaving by type of staff***

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Nursing staff** | **GPs** | **Junior doctors** | **Consultants** |
| Qualification cost \* 25% (£) | 16,525 | 98,450 | 79,950 | 129,100 |
| Recruitment (£) | 2,500 | 2,500 | 2,500 | 3,500 |
| Agency fees @ 30% uplift (£) | 12,000 | 30,000 | 11,400 | 34,600 |
| Productivity loss – 1/6th of staff cost (£) | 6,665 | 16,665 | 6,335 | 19,115 |
| Management supervision – 5% (£) | 2,500 | 5,000 | 5,000 | 5,000 |
| Overall unit cost (£) | 40,190 | 152,615 | 105,185 | 191,300 |

Lastly, we consider the overall financial impact, which is equal to the expected change in staff leaving multiplied by the unit cost per leaver. Table 2.3 below shows the results.

***Table 2.3 Expected financial impact of staff turnover***

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Nursing staff | GPs | Junior doctors | Consultants |
| Financial impact | £10,610 | £33,650 | £20,365 | £31,895 |

***2.2 Cost of sickness absence***

When hours increase, so too does the risk of stress and consequent levels of physical and mental ill-health, leading to increased levels of sickness absence. Our analysis has proceeded in three parts:

Determining the expected change in sickness absence in terms of days; and

Multiplying this against staff costs per day.

Table 2.4 below sets out calculations in relation to expected increases in staff absence.

***Table 2.4 Expected sickness absence with and without additional hours***

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Nursing staff | GPs | Junior doctors | Consultants |
| Unwell due to work-related stress in past year | 41% | 50% | 36% | 31% |
|  |  |  |  |  |
| Number of staff allocated extra work | 8 | 3 | 3 | 3 |
| Increase in hours per staff member | 1 | 2 | 2 | 2 |
| Proportional increase in hours per staff member | 12.5% | 25% | 25% | 25% |
|  |  |  |  |  |
| Current sickness absence1 | 4.5% | 2.7% | 1.1% | 1.2% |
| Increased risk of staff sickness | 30% | 71% | 62% | 54% |
|  |  |  |  |  |
| Expected days sickness | 9.90 | 5.90 | 2.40 | 2.60 |
| Expected days sickness (with increased risk) | 12.90 | 10.20 | 3.90 | 4.10 |
|  | | | | |
| Change in days (per person) | 3.0 | 4.3 | 1.5 | 1.5 |
| Change in days (per person affected) | 24.0 | 12.9 | 4.50 | 4.50 |

Source: Moberly, T. (2018) Sickness absence rates across the NHS, BMJ 361 k:2210

The second step in the process is to multiply the change in days against the cost per day. Table 2.5 below shows results.

***Table 2.5 Financial impact of increased staff sickness***

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Nursing staff | GPs | Junior doctors | Consultants |
| Unit cost per day (£) | 148 | 455 | 173 | 524 |
| Impact per person (£) | 440 | 1,950 | 260 | 790 |
| Impact per team (£) | 3,520 | 5,850 | 780 | 2,370 |

***2.3 Errors***

Our approach to assessing medication errors has four aspects:

Collate information on rate at which medication errors occur, first with regard to an individual, and then taking into account the team size that is affected by increased workload;

Multiply the expected rate of errors by the level of increase in risk (which we assume to be of the order of 30%, in line with burnout rate effects discussed in section 2.2);

Determine economic costs of medication errors, based on the assumption that serious symptoms require two inpatient episodes, moderate symptoms require two outpatient attendances, and low-level symptoms require one GP visit; and

Multiplying together the increase in errors against the unit costs of such errors.

Our calculation (see Appendix 3) is that the economic cost per error is of the order of £19.60 per case. On this basis, Table 2.6 below sets out calculations in relation to expected increases in medication errors.

***Table 2.6 Assessment of economic cost due to increased levels of medication errors***

|  |  |  |  |
| --- | --- | --- | --- |
|  |  | Primary care | Secondary care |
| Number of medications per day | (1) | 10 | 10 |
| Number of medications per year | (2) = (1) \* 200 | 2,000 | 2,000 |
| Error rate | (3) | 5% | 8.40% |
| Number of errors (individual) | (4) = (2) \* (3) | 100 | 168 |
| Number of errors (individual rate \* team size) | (5) | 800 | 504 |
| Increase in risk due to burnout effects | (6) | 30% | 30% |
| Increase in errors | (7) = (5) \* (6) | 240 | 151 |
|  |  |  |  |
| Economic cost @ £19.60 per error | (5) = (4) \* 19.6 | £4,704 | £2,960 |

***2.4 Summary of effects***

Table 2.7 below summarises the effects identified above.

***Table 2.7 Assessment of economic cost of increased unpaid overtime***

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Nursing staff | GPs | Junior doctors | Consultants |
| Staff turnover | £10,610 | £33,650 | £20,365 | £31,895 |
| Sickness absence | £3,520 | £5,850 | £780 | £2,370 |
| Medication errors | £4,700 | £4,700 | £2,960 | £2,960 |
| Total | £18,830 | £44,200 | £24,105 | £37,225 |

It should be noted that the above excludes the risk of other types of errors (such as misdiagnosis of symptoms), legal costs, and any medium-term effects on staff turnover due to over-work.

**3****. Roles undertaken by other members of staff – no overtime used**

Our approach is to consider the cost of the tasks undertaken by Medical Administrators, and to compare this against the cost of those tasks when they are undertaken by other staff in the absence of such support.

In doing so, we have assessed:

* Cost per hour worked of Medical Administrators;
* Cost per hour worked of a range of staff (GPs, practice nurse and practice manager in primary care; HCA, nurse, Foundation doctor, consultant, and combination of Foundation doctor / consultant time in secondary care);
* Tasks undertaken by Medical Administrators during a typical working day, and cost of undertaking these tasks (which comprises cost per hour times number of hours);
* Time taken by alternative staff to undertake those tasks if not supported by a Medical Administrator, and cost of undertaking these tasks (which comprises cost per hour times number of hours).

In the remainder of this note, we consider cost per hour worked, tasks undertaken, and assessment of relative costs in undertaking medical administration tasks.

***3.1 Cost per hour worked***

Our main source of data on salary and pensions/national insurance (NI) costs for different staff grades is the PSSRU publication Unit Costs of Health and Social Care (2018).

Staff costs for Medical Administrators are assumed equal to those for Band 3 administration and support staff (implying an average salary of £18,840 p.a. according to PSSRU 2018), except for one instance where the Medical Administrator held a Band 4 post.

Appendix 4 sets out our calculations on unit costs for a range of staff.

***3.2 Tasks undertaken***

Our source of data for tasks undertaken are a series of interviews undertaken with medical administrators and with medical staff. Our small sample suggests that:

* Medical Administrators in primary care are mainly engaged with dealing with post (physical and email), with some engagement in coding work;
* Medical Administrators in secondary care spend most of their time on preparing for discharge, while tasks for the morning and afternoon ward rounds (in preparation, and in minuting) are also significant, as is chasing scans, tests and appointments;
* Medical Administrators in a mental health secondary care setting spend most of their time scribing and prepping ward rounds and compiling patient records, with significant time spent chasing tests and appointments.

Table 3.1 below sets out our analysis in relation to a primary care instance, where most of the work would be undertaken by a GP if the medical administrator was not available.

***Table 3.1 Hours by task for Medical Administrator versus alternative***

|  |  |  |  |
| --- | --- | --- | --- |
|  | GP correspondence management | Updating patient records | Supervision (MA and supervisor) |
| Medical Administrator |  |  |  |
| Hours of Medical Administrator | 4.50 | 0.50 | 0.13 |
| Hours of Medical Administrator - scaled to contract hours | 3.43 | 0.38 | 0.12 |
|  | | | |
| Alternative category of staff | GP | Practice Nurse | Practice Manager |
| % of time taken by alternative category | 77% | 100% | x |
| Hours of task by alternative category of staff | 2.62 | 0.38 | x |

The following shows analysis in relation to a secondary care example.

Table 3.2 below sets out our analysis in relation to a primary care instance, where a significant part of the work would be undertaken by a mixture of Foundation doctors (80%) and consultants (20%) if the medical administrator was not available.

***Table 3.2 Hours by task for Medical Administrator versus alternative***

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Administration (ward patient round)** | **Minuting meetings** | **Discharge tasks** | **Patient records (chase tests)** |
|  |  |  |  |  |
| Alternative category of staff | FD and consultant mix | FD and consultant mix | Nurse | FD and consultant mix |
| Staff costs of alternative category | 25.63 | 25.63 | 18.23 | 25.63 |
|  |  |  |  |  |
| Hours of Medical Administrator | 1.50 | 0.50 | 5.00 | 0.50 |
| Hours scaled to contract hours | 1.45 | 0.48 | 4.84 | 0.48 |
|  |  |  |  |  |
| % of time taken by alternative category of staff on each task | 80% | 100% | 100% | 100% |
| Hours of task by alternative category of staff | 1.16 | 0.48 | 4.84 | 0.48 |

***3.3 Relative costs of tasks***

Knowing the number of hours that would be undertaken by alternative staff, we can compare annual costs against those that occur for a Medical Administrator, and so determine the net financial change.

Table 3.3 below summarises our calculations from the various case studies.

***Table 3.3 Summary of relative costs of Medical Administration tasks***

|  |  |
| --- | --- |
|  | Cost change p.a. (£) (+ if more expensive / - if less expensive) |
| **Primary care** |  |
| Case study 1 Complex Prescriptions Clerk, Northamptonshire | -£55,000 |
| Case study 2 Back Office Manager, Birmingham | (part-time role) -£23,000 |
| Case study 3 Collaborative Care Team Coordinator, Northamptonshire | (part-time role) -£18,400 |
| **Secondary care** |  |
| Case study 3: Doctors Administrative Assistant, Northamptonshire (Ward a) | -£7,000 |
| Case study 4: Doctors Administrative, Northamptonshire (Ward b) | -£1,000 |
| Case study 5: Ward Administrator, Northampton | -£14,400 |
| Case study 6: Clinical Administrator, Northampton | -£37,200 |
| Case study 7: Clinical Medical Administrator, Lincolnshire | -£3,000 |

A first point to note is that the primary care roles all show strong financial benefits to the use of medical administration staff, which reflects the high costs of GPs.

By comparison, savings vary greatly in secondary care. Case studies 3 and 4 have a counterfactual that implies the (short term) alternative use of Foundation Doctor staff, whereas Case study 5 involves more use of experienced nurses, and Case study 6 implies the use of medical consultants, leading to savings closer to those shown in the primary care case studies.

From a short-term perspective, case studies 3 and 4 illustrate that, with high levels of knowledge of medical agendas, Foundation doctors can undertake tasks quickly, even though their pay rate is much closer to medical administrators than consultants. However, such calculations ignore knock-on effects in terms of disengagement and turnover by such staff.

**4. Conclusions**

The above calculations demonstrate that there is a strong case for the use of Medical Administrators in primary care. If they are directly involved in tasks that would be undertaken by GPs, then costs are lower; if GP overtime is used instead then there are costly consequences for recruitment, sickness absence, and errors.

By contrast, the case for the use of Medical Administrators in secondary care is more variable, and is not always immediately visible – in some instances, where Foundation Doctors are available to undertaken task, since their pay rates are much closer to Medical Administrator pay than GPs, the immediate financial case is weaker.

However, when such factors as the use of consultant time (even on a limited basis), costs of non-medication errors due to overwork, legal bills, and medium-term (if not short-term) effects on recruitment and retention are taken into account, the financial case is also positive. A realistic appraisal of a sustainable counterfactual is that in the medium-term, Medical Administrators would be taking over tasks that would be otherwise done by consultants and nurses, and in such cases, the financial advantages are clear.

**Appendix 1: Assessing impacts of staff turnover in relation to nursing staff**

Our approach has three aspects:

* Determining the expected change in the numbers leaving;
* Estimating the cost per person leaving; and
* Calculating cost by multiplying expected change by cost per people leaving.

This Appendix focusses on the expected change in staff leaving, and on the cost per person leaving. We consider these in turn.

***Estimating expected change in people leaving***

Our basis for determining the extent to which this occurs is the academic article Stimpfel et al (2012) “The Longer The Shifts For Hospital Nurses, The Higher The Levels Of Burnout And Patient Dissatisfaction” (Health Affairs, 31(11), pp. 2501–2509.

This article suggests that moving from a shift length averaging 8 to 9 hours to one averaging 10 to 11 hours increases intention to leave by a factor of 49%, and burnout by a rate of 71%.

We use this data to model the effects on intention to leave by modelling a scenario in which 8 workers currently on 9 hours per shift have that allocation increased by one hour each.

***Table A1.1 Assessing changes to intention to leave***

|  |  |
| --- | --- |
| Hours per shift | Index on intention to leave (average = 100%) |
| 8.5 (range of 8 to 9 hours) | 100% |
| 9 | 112% |
| 10 | 137% |
| 10.5 (range of 10 to 11 hours) | 149% |
|  |  |

Based on a simple interpolation, then the index of intention to leave can be seen to grow from 112% to 137%, a proportional increase of 22%, since [137 – 112] ÷ 112 = 122%.

We can then use this figure to assess estimated turnover, which stands at an average rate of the order of 15% among the NHS[[3]](#footnote-3).

For a team of 8, this indicates an increase in expected numbers leaving each year from 1.20 (calculated as 15% \* 8), to 1.46 (calculated as 15% \* 8 \* 122%).

***Cost per person leaving***

When a new member of staff has to be recruited, there are several costs which are incurred:

Loss of educational training costs – NAO (2016) reports “a new nurse costs around £79,000” (p9), while PSSRU (2018) (“Unit costs of health and social care”) reports training costs of £66,100 for a nurse, £393,800 for a GP, and £516,400 for a consultant. A 2001 study[[4]](#footnote-4) reported in a 2014 HEE literature review on nurses leaving the NHS[[5]](#footnote-5) indicates that up to a third of those leaving posts do so due to dissatisfaction with professional circumstances, and we assume that this occurs in a quarter of cases;

Recruitment costs – NAO (2016) (“Managing the supply of clinical staff in England”) reports that “recruiting a nurse from overseas costs between £2,000 and £12,000 and return‑to‑practice costs some £2,000 per nurse” (p9). Based on 15% of nurses being recruited from outside the UK[[6]](#footnote-6), this suggests a cost of around £2,500[[7]](#footnote-7);

Loss of productivity as new person gets up to speed - we assume that compared to an experienced person remaining in post, the extra time taken amounts to 1/6th of the work conducted during a year;

Need for greater supervisor time – we assume that this is equal to an addition 0.1 WTE work by a supervisor for a period of 6 months;

Agency costs - Mullins, C. (2018) “NHS Agency staffing and the impact of recent interventions”[[8]](#footnote-8), (p7) provides an assessment of average prices per hour of agency staff being around 15% above the cap in respect of nursing staff, and 80% above the cap in relation to medical staff. The cap is in turn some 15% above standard rates to provide a margin for the agency. We therefore apply a rate of 30% (15% above cap plus 15% margin within cap) to £40,000 nurse salary and NI/pensions.

These are shown in table A1.2 below.

**Table A1.2 Assessment of costs per worker who leaves**

|  |  |
| --- | --- |
| Unit costs | £ |
| - Qualification – 25% \* £66,000 | 16,500 |
| - Recruitment | 2,500 |
| - Agency fees – 30% \* £40,000 | 12,000 |
| - Productivity loss of worker – 16.67% \* £40,000 | 6,670 |
| - Management supervision - 1/2 \* 10% \* £50,000 | 2,500 |
| Overall unit costs | 40,170 |

**Appendix 2: Assessing impacts in relation to staff sickness through increased overtime**

Our approach here is to adapt the analysis in relation to assessing the expected number of staff leaving, which was set out in Appendix 1.

Instead of using changes in likelihood in relation to “intention to leave” we instead use changes in likelihood in relation to burnout, as shown in table A2.1 below.

***Table A2.1 Assessment of change in risk of burnout***

|  |  |
| --- | --- |
| Hours per shift | Index on burnout (average = 100%) |
| 8.5 (range of 8 to 9 hours) | 100% |
| 9 | 118% |
| 10 | 153% |
| 10.5 (range of 10 to 11 hours) | 171% |

Source: Stimpfel et al (2012) “The Longer The Shifts For Hospital Nurses, The Higher The Levels Of Burnout And Patient Dissatisfaction” (Health Affairs, 31(11), pp. 2501–2509.

We assume that hours shift from 9 to 10, so increasing the risk of burnout by a factor of 30%, since 153% / 118% = 130%.

Since sickness absence is some 4.5% among nurses in the NHS[[9]](#footnote-9), an increase in sickness by a factor of 30% implies an increase in sickness absence of some 1.4%, which equates to some 3 days per year.

At a salary plus on-cost rate of £40,000 per year, this implies an additional cost of £75 per person, and since this risk applies to 8 colleagues picking up a share of the additional burden, it implies a cost of £600 for the team (calculated as: £75 \* 8 = £600).

**Appendix 3: Assessing financial and social effects of medication errors**

Our approach to assessing medication errors has four aspects:

* Collate information on rate at which medication errors occur;
* Determine economic and (major) social costs of medication errors;
* Derive a figure for cost of medication errors for a medical team, by multiplying together the rate of such errors against the unit costs of such errors;
* Derive an indicative figure for the increased cost of medication errors by applying a scaling factor equal to the increased risk of staff burnout set out in Appendix 2.

Our source for data on medication errors in GP practices is Avery et al (2013)[[10]](#footnote-10), which suggests a 5% prevalence of prescriptions with prescribing or monitoring errors. For hospitals, Dornan et al (2009)[[11]](#footnote-11) found an error rate of 8.4% by junior doctors.

In table A3.1 below, we set out:

* (column A and B) data on the number and proportion of outcomes from medication errors based on table 5 in Cousins et al (2011)[[12]](#footnote-12); and
* (column C) costs of treatment[[13]](#footnote-13) from NHS reference costs (for hospital care) and PSSRU unit costs of health and social care (for GP visit).

Actual clinical outcome Incidents

***Table A3.1 Relative proportions and impact of medication errors***

|  |  |  |  |
| --- | --- | --- | --- |
|  | Number1 | Proportion2 | Economic3 |
|  | A | B | C |
| Death | 271 | 0.05% | £7,800 |
| Severe | 551 | 0.10% | £7,800 |
| Moderate | 1,742 | 0.33% | £280 |
| Low | 68,578 | 13.03% | £50 |
| No harm | 439,318 | 83.46% | - |
| Other | 15,919 | 3.02% | - |
| Weighted average (£) |  |  | £19.6 |

The above table implies that when a medication error does occur, though most are identified and rectified by other staff, on average it implies an economic cost of £19.60.

Our approach to estimating the cost of errors in the counterfactual then proceeds by:

* Outlining the number of medications given,
* Estimating the number of errors in those medications processes,
* Multiplying errors against unit cost of an error to obtain a view on the overall scale of the problem, and lastly
* Multiplying the overall cost by a factor of 30% for the increase in risk as set out previously.

Table A3.2 below shows results in applying this process.

***Table A3.2 Assessment of impact of use of overtime on costs of errors***

|  |  |  |  |
| --- | --- | --- | --- |
|  |  | Primary care | Secondary care |
| Number of medications per day | (1) | 10 | 10 |
| Number of medications per year | (2) = (1) \* 200 | 2,000 | 2,000 |
| Error rate | (3) | 5% | 8.40% |
| Number of errors (individual) | (4) = (2) \* (3) | 100 | 168 |
| Number of errors (individual rate \* team size) | (5) | 800 | 504 |
| Increase in risk due to burnout effects | (6) | 30% | 30% |
| Increase in errors | (7) = (5) \* (6) | 240 | 151 |
|  |  |  |  |
| Economic cost @ £19.60 per error | (5) = (4) \* 19.6 | £4,704 | £2,960 |

The results suggest that the economic cost rises by £4,700 per year in primary care, and £2,960 in secondary care.

**Appendix 4: Unit cost calculations for primary and secondary care staff**

Based on data from PSSRU (2018), we have calculated unit costs for staff grades as shown in tables A4.1a and A4.1b below:

**Table A4.1a Salary and other staff costs by grade of staff (Primary care)**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Type of staff member** | **Salary (£) p.a.** | **NI / Pension add-on (%)** | **Staff cost (£) p.a.** | **Working hours p.a.** | **Staff cost per hour (£)** |
|  |  |  |  |  |  |
| **Medical Administrator** | 18,840 | 24.7% | 23,490 | 1,575 | 14.92 |
|  |  |  |  |  |  |
| **Primary care** |  |  |  |  |  |
| **GP** | 109,600 | 0.0% | 109,600 | 1,739 | 63.02 |
| **Nurse** | 32,253 | 24.7% | 40,217 | 1,593 | 25.25 |
| **Practice Manager** | 41,391 | 24.7% | 51,611 | 1,593 | 32.40 |
| **Practice Nurse** | 26,321 | 24.7% | 32,546 | 1,575 | 20.66 |
| **HCA** | 17,734 | 3,805 | 21,539 | 1,591 | 13.54 |

Table A4.1b Salary and other staff costs by grade of staff (Secondary care)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Type of staff member** | **Salary (£) p.a.** | **NI / Pension add-on (%)** | **Staff cost (£) p.a.** | **Working hours p.a.** | **Staff cost per hour (£)** |
| **Secondary care** |  |  |  |  |  |
| **Nurse** | 23,625 | 5,531 | 29,156 | 1,599 | 18.23 |
| **Foundation doctor and consultant mix** | 42,473 | 10,817 | 53,289 | 2,079 | 25.63 |
| **Foundation doctor** | 30,354 | 7,427 | 37,781 | 2,138 | 17.67 |
| **Nurse manager** | 39,181 | 9,915 | 49,096 | 1,599 | 30.70 |
| **Consultant** | 90,947 | 24,375 | 115,322 | 1,842 | 62.61 |

Appendix 3 – MAs identified in online search

|  |  |
| --- | --- |
| MA Vacancy |  |
| Junior Doctors Assistant, Band 3, Acute Cardiac Unit, Ashford and St Peters Hospital  [Job listing](https://www.jobs.nhs.uk/xi/vacancy/?vac_ref=915436478) |  |
| Patient Pathway Administrator, Band 4, Oxford University Hospitals  [Job listing](https://www.jobs.nhs.uk/xi/vacancy/?vac_ref=915443610) |  |
| Patient Pathway Coordinator, Band 4, Kingston  [Job listing](http://jobs.kingstonhospital.nhs.uk/job/UK/London/Kingston_Upon_Thames/Kingston_Hospital_NHS_Foundation_Trust/Gynaecology/Gynaecology-v1534927?ref=Indeed&) |  |
| Clinical Assistant, Band 3, Airedale NHS Foundation Trust  [Job listing](https://www.jobs.nhs.uk/xi/vacancy/?vac_ref=915438501) |  |
| Colorectal Pathway Navigator, Band 4, Mid Essex Hospital Services NHS Trust  [Job listing](https://www.jobs.nhs.uk/xi/vacancy/?vac_ref=915446695) |  |
| Clinical Coordinator Assistant, Band 3, Oxford University NHS Foundation Trust  [Job listing](https://www.jobs.nhs.uk/xi/vacancy/?vac_ref=915427085) |  |
| Clinical Office Administrator, Band 3, Ashford and St Peter’s Hospitals  [Job listing](https://www.jobs.nhs.uk/xi/vacancy/?vac_ref=915454143) |  |
| Assistant Patient Pathway Administrator, Band 3, Oxford University Hospitals  [Job listing](https://www.jobs.nhs.uk/xi/vacancy/?vac_ref=915414585)  Ward Administrator, Band 3, CSH Surrey  [Job listing](https://www.jobs.nhs.uk/xi/vacancy/?vac_ref=915454285) |  |
| Ward Administrator, Band 3, UCLH  [Job listing](https://www.jobs.nhs.uk/xi/vacancy/?vac_ref=915455113) |  |
| Ward Administrator, Band 3, Greater Manchester Mental Health  [Job listing](https://www.jobs.nhs.uk/xi/vacancy/?vac_ref=915446173) |  |
| Administration Assistant, Band 3, UCLH  [Job listing](https://www.jobs.nhs.uk/xi/vacancy/?vac_ref=915456098) |  |
| Administration Coordinator, Band 4, UCLH  [Job listing](https://www.jobs.nhs.uk/xi/vacancy/?vac_ref=915452469) |  |
| Clinical Office Administrative Coordinator, Band 4, St Peters Hospital / Ashford Hospital  [Job listing](https://www.jobs.nhs.uk/xi/vacancy/?vac_ref=915451513) |  |



1. It’s important to note that views about MAs impact on quality of services were sometimes mixed and a definitive judgement had not always been reached. [↑](#footnote-ref-1)
2. This case study incorporates two separate visits and sets of interviews, where CMAs were being used in two different settings [↑](#footnote-ref-2)
3. Buchan et al (2017) “Rising pressure: the NHS workforce challenge”, Health Foundation (p41) [↑](#footnote-ref-3)
4. Buchan J (2001) “Nursing and Midwifery Workforce Data 2000/01. A special report”, Chamberlain Dunn Associates. [↑](#footnote-ref-4)
5. Health Education England (2014) Growing nursing numbers: literature review on nurses leaving the NHS [↑](#footnote-ref-5)
6. Royal College of Nursing (2017) The UK nursing labour market review (p5) [↑](#footnote-ref-6)
7. Taking overseas costs to be some £5,300 (weighting 2/3rds £2,000 cost and 1/3rd £12,000 cost), and then taking the weighted sum of 15% \* £5,300 overseas costs and 85% \* £2,000 for domestic recruitment [↑](#footnote-ref-7)
8. Office of Health Economics Seminar Briefing 22 [↑](#footnote-ref-8)
9. # Moberly, T. (2018) Sickness absence rates across the NHS*,* BMJ 361:k2210, www.bmj.com/content/361/bmj.k2210

   [↑](#footnote-ref-9)
10. “The prevalence and nature of prescribing and monitoring errors in English general practice: a retrospective case note review”, British Journal of General Practice, e543-e553 [↑](#footnote-ref-10)
11. Dornan T, Ashcroft D, Heathfield H, et al (2009) “An in-depth investigation into causes of prescribing errors by foundation trainees in relation to their medical education”, General Medical Council [↑](#footnote-ref-11)
12. “A review of medication incidents reported to the National Reporting and Learning System in England and Wales over 6 years”, British Journal of Clinical Pharmacology, 74:4, pp. 597–604 [↑](#footnote-ref-12)
13. Our assumptions here were: two elective inpatient episodes undertaken for death and severe cases; two cases of outpatient attendances undertaken for moderate, and one GP visit for low harm. [↑](#footnote-ref-13)