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NHS Grampian

Using data to prioritise remobilisation: identifying your 'missed' referrals and health 'debt'

NHS Grampian's experience

March 2021

Following the initial surge of COVID-19, NHS Grampian were keen to ensure that they could continue to deliver care to patients and minimise clinical risk. Read how they implemented a new approach.

Deciding which elective care services to remobilise, and when, whilst also maintaining social distancing protocols, required NHS Grampian to implement a new approach.

They introduced a three step approach:

1. **Established 11 key principles about remobilisation that all services had to consider and confirm prior to restarting.**
2. **Each service was required to conduct a clinical risk assessment.**
3. **The use of the illuminate data dashboards to review COVID-19 referral impact data.**

> **We were looking at what activity we could restart but wanted to do that in a planned way.**
>
> Head of Transformation for Acute, NHS Grampian

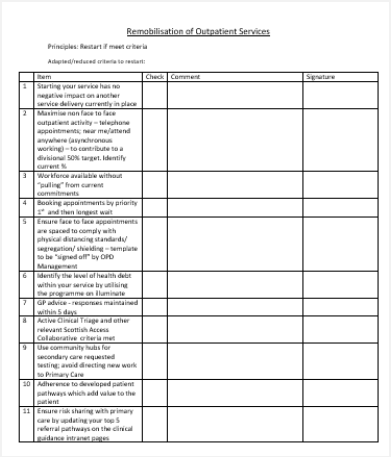
Find out more about each step

Step 1

They established **11 key principles about remobilisation** that all services had to consider and confirm prior to restarting. This then helped determine the rating of the service. The service was given a **'green'** rating if they managed to address all 11 principles, **'amber'** meant the service had some impact on other services in the organisation and could not confirm all 11 principles at that time, and a **'red'** rating meant the service was not ready for remobilisation. The 11 principles included key considerations such as (but not limited to):

a) Do you have the workforce to do this without anything else having to give?

b) Have you considered the impact on other services? Does it have no impact on other services?



Remobilisation of Outpatient Services

Principles: Restart if meet criteria

Adapted/reduced criteria to restart:

	Item	Check	Comment	Signature
1	Starting your service has no negative impact on another service delivery currently in place			
2	Maximise non face to face outpatient activity – telephone appointments; near me/attend anywhere (asynchronous working) – to contribute to a divisional 50% target. Identify current %			
3	Workforce available without "pulling" from current commitments			
4	Booking appointments by priority 1* and then longest wait			
5	Ensure face to face appointments are spaced to comply with physical distancing standards/ segregation/ shielding – template to be "signed off" by OPD Management			
6	Identify the level of health debt within your service by utilising the programme on Illuminate			
7	GP advice - responses maintained within 5 days			
8	Active Clinical Triage and other relevant Scottish Access Collaborative criteria met			
9	Use community hubs for secondary care requested testing; avoid directing new work to Primary Care			
10	Adherence to developed patient pathways which add value to the patient			
11	Ensure risk sharing with primary care by updating your top 5 referral pathways on the clinical guidance intranet pages			

Step 2

Each service was required to conduct a **clinical risk assessment**. This would highlight the ongoing risks associated with the service's current activity level, both to the patients but also to the staff themselves. It required services looking to remobilise to consider a large number of risks such as education, patient safety, staff wellbeing, as well as any impact on other parts of the system. **This was based on (and adapted from) the NHS Scotland risk matrix but applied to a service level rather than a wider and higher organisational level.**

Step 3

The use of the illuminate data dashboards to review **COVID-19 referral impact data** in order to determine, at both the whole sector and individual service level:

- **outpatient and inpatient waiting list size at month's end**
- **new outpatient referrals overtime (2017 to current) including 'straight to test', and**
- **new outpatient appointments attended.**

Identifying ‘missed’ referrals

By looking at this data, staff were able to identify those potential ‘missed’ referrals. That is, by looking at **previous patterns in referral, appointment outcomes and allocations data**, staff could predict those ‘missed’ referrals due to COVID-19.

Therefore, they could not only highlight where they would have expected the **referrals to originate from** (covering both those within secondary care services as well as elsewhere), but also the **‘pathways’ the referrals may have been placed on**, as well as the proposed procedures those ‘missed’ referrals going ‘straight to test’ would have likely been allocated to.

Furthermore, the dashboard **included Elective Surgery Categorisation System (ESCatS) data** for each procedure provided by the service.

> **Looking at how we were going to plan our outpatient services, and prioritise the space that we had left.**
>
> Head of Transformation for Acute, NHS Grampian

ESCatS

ESCatS were introduced by NHS Grampian in 2017 to help **inform their ‘treatment time guarantees’ (TTG) targets**. The TTG target is applied equally to any inpatient procedure and NHS Grampian were acutely aware that the clinical risk of waiting for treatment would differ among patients dependent of their medical history and the procedure they were waiting for. Therefore using the **ESCatS enables clinicians to prioritise patients based on their clinical presentation and manage the risk of waiting**.

The ESCatS categories are:

ESCatS 1 = patient needs to be operated on within 30 days.

ESCatS 2 = patient needs to be operated on within 90 days.

ESCatS3 = patient needs to be operated on within 365 days.

This process ensures that services across Grampian are able to plan their capacity to ensure they can deliver the most urgent treatment as quickly as possible.

What has this meant for NHS Grampian?

By including details of **every procedure within a service and utilising past patterns** as to which ESCatS category it would normally fall into, alongside data of 'missed' referrals all included in each service's dashboard, the medical director for acute in NHS Grampian was able to **comprehensively review and allocate a high, medium or low risk rating to each service**.

This would then be reviewed alongside the **clinical risk assessment** and **11 principles data** to create their prioritisation matrix.

Having a small group of the senior Medical, Nursing and Operational Managers review all the data **ensured consistency in the decision-making**.

This streamlined three step approach ensured **decisions were made at pace** and that the organisation was able to **deliver care in a safe manner**.