Centre for Perioperative Care

CPOC Position Paper about the Perioperative Workforce

November 2024

Executive Summary

There is irrefutable clinical, financial and patient associated benefit, for establishing a seamless, joined up perioperative care pathway.

To enable this transformational change in our patient's surgical journey requires a skilled, motivated and high performing perioperative care team.

Despite commissioning intent, currently there is an absence of any co-ordinated perioperative care people strategy.

To ensure that the multifaceted opportunity afforded by perioperative care is not lost, CPOC is offering to coordinate the development of a perioperative care workforce strategy. This paper supports this approach.

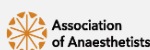
A good perioperative workforce would improve patient care, efficiency and staff satisfaction

1. **Efficiency:** The wider NHS should understand that a perioperative approach is more efficient, saving time and resources immediately (for example more day case surgery means fewer overnight staff are required; streamlined pathways mean less duplication for clinical staff; good patient understanding and preparation results in fewer complications and good Shared Decision Making means fewer unwarranted interventions).

2. **Working together:** The perioperative workforce includes staff from a wide variety of backgrounds working at multiple levels. The patient-centred nature of perioperative care should be emphasised. Staff need to work together well. To deliver better and more efficient care and to reduce the waiting list, support for the workforce requires a focus on:
    a. Time for team meetings
    b. Time for planning services together
    c. Education of staff in key skills
    d. Reorganisation of some services
    e. Recruitment, induction, retention and support for all staff
    f. Time for audit and review of outcomes

3. **Activities to assist team-working:** Staff in perioperative teams should be funded, supported and encouraged to:

A partnership between:

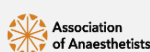


a. create pathways (including discharge planning and patient optimisation from the outset)
b. create patient information together (this helps define the pathway and keep the patient at the centre)
c. identify what skills are needed (especially at bottlenecks or when obtaining information that could change a trajectory) and share key skills (eg motivational interviewing for optimisation, use of some assessment tools, discharge concepts or practicalities).
d. be clear about what deviations from the standard pathway require a senior review
e. ensure that Shared Decision Making is incorporated
f. meet together regularly

4. **Culture and behaviours:** The culture of the working environment should include respect and professional ways of working. This is better for staff retention, staff wellbeing and patient safety.

   a. Poor behaviours should not be tolerated
   b. More diverse teams work better – this requires time to clarify expectations and discuss how to maximise everyone's contribution.
   c. The Team brief (in NatSSIPs) should be embedded into ways of working.
   d. Initiatives that improve behaviour should be promoted, for example: active bystander work, allyship, cup of coffee conversations, unconscious bias awareness and work by our partners. CPOC's Board members have worked on improving culture
      i. Association of Anaesthetists 'KnockitOut'
      ii. Royal College of Surgeons of Edinburgh 'Anti-Bullying & Undermining Campaign'
      iii. Royal College of Surgeons of England 'Avoiding Unconscious Bias'
      iv. Royal College of Surgeons of Edinburgh 'Sexual Misconduct in Surgery- 'LetsRemoveIt'
      v. Royal College of Surgeons of Edinburgh 'Addressing Conflict in Surgical Teams'
      vi. Royal College of Surgeons of England 'Code of conduct'

5. **Different staff groups:** Tasks should be defined for each staff group. This can help determine numbers of each type of staff required. (NB There is separate work about the workforce within operating theatres.) There are four main staff groups:
   a. Administrative, managerial, portering and other non-clinical staff should be valued as an essential part of the team.
   b. Clinical support workers (usually at Bands 2-4 of the Agenda for Change payscale, without a registered professional qualification) should be developed within teams. These include care coordinators, Doctors' Assistants, therapy assistants and Senior Healthcare Support Workers. They can have clear tasks, such as taking blood tests or teaching patients how to get up from a chair. They are not autonomous practitioners and should understand clear red flags when senior clinical input is indicated.
   c. Registered clinical staff (including nurses, Allied Health Professionals (AHPs) and pharmacists) are highly trained and should be supported by support staff to use



their clinical skills. They should be appraised and developed to maximise their potential.

d. Senior clinicians (including GPs, surgeons, anaesthetists, SAS doctors, Clinical Nurse Specialists and AHPs or pharmacists with additional roles) have experience, knowledge and skills that include clinical judgement, technical interventions and operations, Shared Decision Making (understanding BRAN = Benefits, Risks and Alternatives to surgery and what happens if we do Nothing) and leadership. They should understand and support the work of others in each pathway. Those in training for senior clinical roles, such as resident doctors, need opportunities to develop these wider skills.

6. **Education - levels of knowledge, skills and experience:** There should be a threshold level of knowledge and skills for every staff member. Some skills can be shared across groups, especially to reduce bottlenecks. Certain tasks should only be undertaken by registered qualified clinical staff. There should be a career framework which clearly articulates levels of skills development, for example, novice, clinician and leadership. Those training whilst working (e.g. resident doctors) need access to learning opportunities to develop skills. CPOC has developed educational packages, including training for care coordinators, a perioperative curriculum for doctors and a framework for nurses and Allied Health Professionals. All staff - even established consultants and senior nurses - need access to Continuing Professional Development (CPD) to improve practice.

7. **Commitment to holistic health:** All staff should be committed to the general improvement of patient health. Administrative and clinical support staff should undertake 'Making Every Contact Count' training or equivalent and use motivational interviewing skills when required. Although registered clinical staff and senior clinicians should already understand how lifestyle factors impact on health, they should ensure that they can include this in their consultations and support the rest of the team to be involved in optimisation.

   This commitment should include supporting the mental and physical health of the workforce, including initiatives such as 'Fight Fatigue'.

8. **I.T. systems set up to reduce workload:** Documentation and I.T. systems should be designed and developed with staff. This would save time for the registered clinical staff. For example:
   a. Staff should be able to access relevant information easily.
   b. The discharge summary should partially self-populate from the operation note.
   c. Every patient attending a surgical outpatient clinic should clearly have specific records covering:
      i. What matters to me or equivalent
      ii. Previous medical history including relevant mental health
      iii. Medications and allergies
      iv. Why the intervention is being considered
      v. (after the clinic) what has been agreed with the patient, including what the patient will do
   d. An electronic patient health screening questionnaire could be completed in clinic and used to plan care and optimise health.

e. All pathways should be reviewed for unnecessary duplication and overly burdensome screening.

9. **Patient-centred care:** There should be a commitment to patient-centred care. This also means that patients should:
    a. Be ready to be involved in Shared Decision Making
    b. Understand the importance of optimisation
    c. Be screened early in the pathway (e.g. any patient being listed for surgery should have assessments, perhaps in the surgical clinic (e.g. BMI, body muscle, blood pressure)
    d. Be given info about their condition
    e. Be ready to prepare well. The key interventions are:
        i. smoking cessation
        ii. exercise
        iii. nutrition
        iv. alcohol moderation
        v. medication review/senior review
        vi. psychological preparation and mental health optimisation
        vii. practical preparation.
    f. Be prepared for discharge

10. **Leadership and workforce planning:** Time requirements for running the service and planning the future workforce should be acknowledged.
    a. There should be time in job plans to review notes and to lead the service
    b. Workforce data should be collected and used to plan services