The Planned Care Improvement Programme
The Planned Care Improvement Programme
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FOREWORD

Over the last few years the NHS in Scotland has taken great strides to improve the care it offers when patients need it. In December 2005, the service met the target that no patient would wait longer than 26 weeks for their first outpatient appointment, day case or inpatient procedure. The service is on course for making sure that this is reduced yet further to 18 weeks by December 2007. The challenge is to sustain these dramatic improvements.

Improving the NHS is a continuous process and Delivering for Health, our strategy for the NHS in Scotland, sets out the framework of how we will achieve this. It clearly describes how we will shift the balance of care to provide patients with care that is delivered by the right team member, in the right place and at the right time. The NHS has made many service improvements to achieve faster waiting times but the challenge for the future is to join up these achievements, to spread the learning and to create pathways of care that flow for patients with the minimum of delay and duplication.

The Planned Care Improvement Programme is an 18 month initiative that will support the NHS to roll out and incorporate the good practice that exists in planned care and make the experience offered to some patients, the norm for everyone. The Programme will build on and relate to other national improvement programmes that NHS Boards are engaged with in Unscheduled Care and Diagnostics and will apply the tools and techniques for the benefit of planned care services.

This document, built on consultation with improvement leaders and the service earlier this year, sets out the Programme scope and its objectives. If you would like to know more or have an idea, or a local innovation that you would like to offer the programme for national consideration please do not hesitate to contact Robert Thomson, Programme Manager or one of his team.

Stephen Gallagher
Head of Improvement and Support
SEHD, Delivery Group
Chapter 1

Introduction
Delivering For Health:

The Planned Care Improvement Programme is a key element in the national Delivering for Health Planned Care Work-stream, it is a national level action and in common with other national improvement programmes, all Health Boards are expected to participate in the programme.

In implementing Delivering for Health, boards have been tasked with achieving the shift in the balance of care. Boards should have projects planned to rebalance their portfolio of services and ensure improvements are made in productivity and capacity, whilst sustaining improvements in waiting times, and reducing the need for hospital admissions.

This exciting two year programme will build upon the improvement endeavours of the Outpatient Programme and will work closely with the Unscheduled Care Collaborative, the Diagnostics Collaborative and the Eye Care Redesign and Cataract Programme. The programme will draw upon the growing body of clinical systems improvement science from across the world and provide a framework to allow the application of these evidence based changes and best practice to create local solutions for local problems.

Strategic vision for the next 5 years

In implementing Delivering for Health, NHS Boards have been tasked with achieving the shift in the balance of care. Boards should have projects planned to rebalance their portfolio of services and ensure improvements are made in productivity and capacity, whilst sustaining improvements in waiting times and reducing the need for hospital admissions.

Integral to delivering these improvements will be the implementation of the 5 simple changes identified in the Kerr report. Boards should have produced 3-year improvement plans to introduce and implement the changes listed below.

- Improve referral and diagnostic pathways;
- Treat day surgery (rather than inpatient surgery) as the norm;
- Actively manage admissions to hospital;
- Actively manage discharge and length of stay;
- Actively manage follow up.
Implementation of these improvements will enable the NHS in Scotland to make further progress in the delivery of efficient patient focused services by improving access, flow and safety along planned care journeys, enabling more care to be delivered locally, ensuring that patient pathways are planned in advance, and that patients have a seamless experience and are informed about their programme of care.

**Programme Vision**

The vision of the programme is to improve the flow of patients along their healthcare journey by ensuring their experience of assessment, diagnosis and treatment is based on augmented, safe and reliable clinical systems.

The Planned Care Improvement Programme will support NHS boards to raise their performance to the standard of the best and ensure that they systematically implement the five simple changes described in Delivering for Health as well as further spreading the use of support processes such as Patient Focused Booking and Referral Management Services to support the changes in the healthcare delivery process in Scotland.

**Programme Goals:**

- Improving the patient experience by the delivery of care at the right time in the right place by the right person.
- Promoting a culture of improvement based on rigorous data analysis and common principles that empower clinical teams to transform the way they deliver their services from existing resources.
- Leading a whole system change in how we provide planned care by the identification, spread and adoption of good practices in Planned Care.
- Promoting data management to support innovation and performance improvement, national and local measures will be developed with regular national reporting to ensure that performance improvement is taking place within local sites and nationally across the programme.
- Promotion of sound system and process design making sure that variation from non-standardised processes is eliminated. The regular collection of good quality data will help to support robust, tested business cases for such investment.
- Developing robust and streamlined patient booking and referral management systems to improve access and confidence to patients and GPs by improving flow of information between clinicians and patients, primary and secondary care and within clinical teams.
Chapter 2
Programme Scope
Programme Objectives:

The Planned Care Improvement Programme will support NHS Boards put in place the processes and adopt the appropriate high impact changes to ensure the long term sustainability of current performance improvements. The programme must deliver results that impact on access and waiting time targets, day case rates, length of stay, patient journey time and whole system capacity.

The Planned Care Improvement Programme will support projects that work across whole systems to achieve long term sustainable improvements in patient journeys by redesign of processes using flow modelling principles and implementing the high impact changes relevant to the patient flow being improved.

To that end funding is available for local projects and improvement teams that support the implementation of the 5 simple changes, Patient Focussed Booking, Referral Management Services and all projects must clearly demonstrate alignment with the strategic programme objectives illustrated on pages 8 and 9.

Programme Funding Exclusions:

Programme funding is not available for external consultancy, IT systems and software or to fund service developments.

In order to achieve the goals of the programme will require a shift in the traditional design of projects in order that they truly produce long term sustainable results. They must be truly cross functional with a view of the whole system and the whole patient journey and they will need to examine how they contribute to the delivery of the strategic goals of the NHS in Scotland.

Programme constraints:

- The programme is time limited to 31st March 2008
- The programme will not resolve IM&T issues
- The programme does not have recurring funding to sustain innovations beyond project / pilot phase. NHS boards must ensure continuation of improvements to allow benefits to be mainstreamed.
- The programme has no line management responsibility for NHS systems
- The day to day performance management of waiting times targets does not form part of the programme of work detailed in this work stream. The programme is however, legitimately concerned with ensuring that NHSScotland has the capacity to sustain performance improvements over the long term

Programme Interfaces

The programme will interface with the following Delivering For Health work-streams and stakeholders:-

- Shifting the balance of care
- Unscheduled Care
- Diagnostics
- eHealth
- Rural healthcare
- Regional Planning
- NES
- QIS
- SAS
| To support activities that increase whole system working and support the concept of FLOW across healthcare systems. | By spreading successes of Referral Management Services, Patient Focussed Booking, the use of patient pathways and extended role practitioners. |
| Spreading and encouraging the use of one stop shops and sending patients straight to test. |
| Encouraging the reduction in the requirements for return outpatient appointments and the maximising of follow up at or close to home. |
| To support activities that reduce overall length of stay for patients. | The programme will work to identify national high volume, high cost HRGs based on the current work by the Institute for Innovation and Improvement on Delivering Quality and Value that offer the opportunity to reduce overall length of stay. |
| Health boards will be encouraged to create best practice whole system pathways and to share exemplar practice to achieve improvements in Average Length OS across Scotland. |
| The programme will promote improvements in patient focussed booking for preadmission, pre-admission services and active discharge planning, improvements in theatre throughput to reduce Length of Stay in elective flows. |
| To support activities that lead to improvements in day case rates. | By analysing variation in day case rates and sharing exemplar practice to increase overall % of day cases by encouraging the use of flow modelling techniques, same day admission, preadmission services, patient focused booking systems and list validation. |
| To build NHS capacity in Clinical Systems Improvement and Clinical Systems Management. | By developing an integrated approach across programmes and a national education programme in Clinical Systems Improvement and Management. |
| Creating a culture of data measurement and rationality, where decisions are driven by the collection, access to and use of good meaningful data. |
| To develop a robust overarching programme framework that supports improvement and sustainability of current access, productivity and waiting time performance. | By developing a national database of good practice to inspire improvement in planned care, developing national plans and providing guidance on local projects. |
| To support NHS systems facing difficulty in meeting targets by offering expert advice and support. | By providing tailored support as required and drawing from UK and International experts. |
Chapter 3

Improving our Healthcare Systems
Patient Experience

Patients expect planned care to be a timely and co-ordinated experience. Increasingly, when they develop symptoms of ill health or need follow up care, they expect to see the right clinician, in the right place, at the right time. If they need to be admitted to hospital for a procedure, they expect that episode of care to be well organised and for care to be planned around their needs and not around the requirements of the hospital.

Planned Care provision is complex. It involves community and hospital care and back again, it can cross interagency boundaries and it can involve the independent healthcare sector. Planned Care shares certain diagnostic and support services with unscheduled care. Some clinical specialties more than others require support to modernise and some areas of Scotland are further ahead than others in their development and implementation of modernisation strategies for planned care.

We have created some islands of excellence where we are truly world class, but as we have already seen our functional view of service delivery means that we never optimise the service across a whole system, and for this reason we rarely achieve a service that ultimately meets patient expectations.

This complexity can be reduced when Planned Care is considered as a number of patient flows, rather than by the setting in which the care is provided and where flows are defined by similar patient needs where non value adding steps and batching of patient flows are reduced. Working in flows also develops the “whole journey thinking” necessary to delivering a whole journey approach to waiting times.

The successful achievement of these flows involves improving and redesigning every key process along the patient journey and restoring an organisation’s work to its natural rhythm and allowing it to flow naturally, and in doing so it is often easier to make better use of departmental capacity.

Improving our Systems

In recent years the NHS in Scotland has made significant progress however, there is still a wide variety in practices and performance and there are still opportunities to make significant improvements and a need to address systemic issues around inefficiency, capacity, waiting lists, average lengths of stay, day case rates, new to return appointment rates, costs, hospital acquired infections and avoidable injuries and deaths.
Our systems are inherently complex, and traditional improvements carried out by means of isolated initiatives have often resulted in a failure to systematise “Best Practice” and poorer than expected results. Fundamental service change is best achieved through an integrated whole system approach that reflects the full patient journey through our myriad processes.

Consistent themes are emerging as improvement science is applied to healthcare systems internationally including demand and capacity measurement and queue management, process improvement based on added value, reducing variation, and identifying and then optimising patient flow. Delivering for Health and The 10 High Impact Changes (NHSMA) and latterly work by the Institute for Innovation and Improvement describe “what” needs to happen to improve planned care.

Healthcare systems are inherently complex, and traditional improvement carried out by isolated initiatives often results in a failure to systematise “Best Practice” and sub optimal results. Fundamental service change is best achieved through integrated whole system approaches.

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As improvement science is applied to healthcare systems internationally, consistent themes are emerging including demand, capacity and queue management, process improvement based on added value, reducing variation, and identifying and then optimising patient flow. Delivering for Health and The Ten High Impact Changes (NHSMA) and latterly work by the Institute for Innovation and Improvement describe “what” needs to happen to improve planned care.

We should focus on the whole patient journey

- First seen by GP, AHP, etc
- Referral, Diagnosis, DTT, etc
- Admission and Preparation
- Treatment
- Discharge and follow up

- Referral Management Information
- Technology as an Enabler
- Capacity and Demand
- Process Capability and Process Maturity
- Optimised Clinical Mix
- Staff Skill Mix
- Local Protocols

Local Practice

Safest and most effective best practice pathways. Productivity by HRG, savings available to reinvest, what are the examples, what is best practice and where are the opportunities to improve.
Modernisation Agency Ten High Impact Changes for Service Improvement and Delivery

The ten high impact changes (NHSMA 2004) draw upon the best available learning on making organisations work effectively and have been evaluated in real life NHS settings. They see the service through the patient’s eyes and are based upon a systems view of the world. Healthcare is a complex process and high quality service is only possible by viewing the whole picture. The ten high impact changes are not one off initiatives but are a fundamental shift in the way healthcare services should be run.

The philosophy underpinning the ten high impact changes starts from a different mindset. The system should be designed to enable continuous improvement across the whole organisation. The approach takes a process view, following the patient journey through the health and social care system. Performance is improved by removing activities that do not add value for the patient and by simplifying and speeding up processes. The starting point is to focus on high volume flows of patients who follow broadly similar process steps, rather than individual specialties or conditions.

The 10 High Impact Changes are:

1. Treat day surgery as the norm for elective surgery.
2. Improve patient flow across the whole system by improving access to key diagnostic tests.
3. Manage variation in patient discharge and thereby reduce length of stay.
4. Manage variation in the patient admission process.
5. Avoid unnecessary follow ups for patients and provide necessary follow ups in the right care setting.
6. Increase the reliability of performing therapeutic interventions through a care bundle approach.
7. Apply a systematic approach to care for people with long term conditions.
8. Improve patient access by reducing the number of queues.
9. Optimise patient flow through the service bottlenecks by using process templates;
10. Redesign and extend roles in line with efficient patient pathways to attract and retain an effective workforce.

Institute for Innovation and Improvement – Delivering Quality and Value

The NHS Institute has identified a number of areas where real improvements can be made to healthcare delivery systems, by focusing on productivity and efficiency. The key areas addressed are:

- Reduction in avoidable emergency admissions;
- Reduction in unnecessary outpatient appointments, follow ups and DNAs;
- Avoidance of unnecessary procedures;
- Improvement in day case performance;
- Reduction of wasted bed days;
- Improvement in the accuracy of clinical coding;
- Reduction in the variation in the length of stay;
- Improvement in staff productivity;
- Actively managing staff and recruitment costs.
Whole Systems and Process flows

Whole system

Often traditional approaches to efficiency improvement can actually have a negative impact by focussing on the wrong things, and the improvement of one service may still not actually improve the time it takes a patient to receive all of their treatment. The Planned Care Improvement Programme will recommend modelling and improving the flow across whole systems in order to deliver significant improvements in the delivery of healthcare.

The Planned Care Improvement Programme will support NHS Boards on the “how” to make these changes happen in a way that is consistent with other modernisation activities and that delivers sustainable outcomes.

We should focus on the whole patient journey

Based on patient flows

![Diagram showing patient flows]

- Outpatient: 11.3 million contacts per annum
- Day Case: 0.4 million contacts per annum
- Inpatient: 0.2 million contacts per annum

The fundamental measure of currency for the programme is the whole patient journey time and all efforts are geared to reduction in that journey time.

Improving patient flows

NHS organisations have evolved over many years and in that time have incorporated a variety of practices that waste time and energy on activities that ultimately do not add any value for patients. In some cases there are several layers of these activities going on making it hard to see the true picture of the process, making patient care responsibilities hard to identify, continually creating unnecessary work and creating disjointed healthcare delivery processes.

A great deal of work has already been done in the NHS to make changes, however it has often resulted in isolated improvement activities which are short lived or have not led to substantial changes in the overall system. The planned care improvement programme will recommend the use of whole systems, flow-based thinking as an overarching framework to ensure that benefits are delivered. This means when a process is redesigned that the appropriate high impact changes are applied in the right context.

The Planned Care Improvement Programme will link to the Unscheduled Care Collaborative to extend the utilisation of Clinical Systems Improvement tools and techniques and the insights gained so far from the Collaborative on our health care systems to guide, inform and clarify our whole system views.
We should be focusing our improvement efforts on the things that matter to patients and clinicians and the things that get in the way of delivering effective care. Our thinking should be based upon value as defined from the patient’s perspective. Anything that is of benefit and helps to treat the patient is value adding, anything else is waste. We should be aiming to eliminates waste and reinvest released resources in creating added value for our patients and clinical teams.

Systems Improvement is NOT about restructuring the work itself through changing structures and organisations; it is about changing the way the actual work is done. If the actual work people do does not change and improve, organisational restructuring is irrelevant.

The greatest challenge lies in making transformations across whole systems and looking at whole patient care processes. Just as clinical staff strive to provide good continuity of care, continuity must be present across the processes experienced by the patient. It must be stressed that improving value adding components in isolation without addressing the whole process may not improve efficiency at all. A faster machine to carry out tests may not actually improve the time for the patient to complete their journey through their entire care process.

The programme will recommend adoption of the following principles:

- Value is defined from the patient perspective and to ensure we only create value we should only provide services in line with demand, no more, no less. Delivering services in line with demand also means all work, resources and information should be pulled towards the task as and when needed not before and not after. Any time spent waiting or queuing is another form of waste that blights the patient’s experience of our system and should be eliminated.
- The identification and mapping of value streams and flows. For flow to happen we need to design and manage each value stream as a whole (i.e. the steps that add value from a patient perspective from the beginning to the end). By pulling patients through the process we work towards the creation of FLOW where patients are seen one at a time and passed onto the next step in the process without delay. The goal of our systems design is to identify blockages and obstacles that cause delay and remove them.
- Each step in a process has to be designed with an eye to the overall effect it has on the steps before and after it in order that they link the patient pathway together seamlessly. Having been changed the creation of clear, standardised processes creates a platform for continuous improvement of the patient journey and the clinical working environment.

**Planned Care Flows**

Initially there appear to be 3 main flows around “outpatients” (11.3 million contacts per year), day cases (0.4 million contacts per year) and inpatient care (0.2m planned contacts per year). However, analysis of inpatient activity and the introduction of 23 hour surgery reveals further flows discernable as 23 hours, up to 72 hours and over 72 hour stays.

The Planned Care Improvement Programme will promote the concept of patient flows based on time, streamlining patient journeys and implementing the High Impact Changes that have been identified as beneficial to each flow.

The objective of each flow group should be to streamline the patient journey within the flow while seeking to optimise, through safe and efficient design, the volume of patients that can be treated through each preceding flow. For example 72 hours to 23 hours, 23 hours to day cases, day cases to community outpatients, etc.
Flow One – The first flow is what is traditionally known as outpatients. It is however increasingly completed in the community and covers a multiple number of flows that encompass assessment, diagnosis, treatment and follow up and review. Already nearly 50% of this activity in Scotland is undertaken in a community setting and the CCI Outpatients Programme demonstrated that there is significant scope for further review of practice.

Flow Two – The second flow relates to Day Case Surgery, which should be treated as the norm, with all other flows of inpatient surgery being clinically justified and audited. The Programme will focus on improving true day case rates across the system and promote the High Impact Changes of pre-operative assessment and an end to day before admission (unless clinically necessary). The Programme will promote patient focussed booking / primary targeting lists and referral management and pooling of lists.

Flow Three – The third flow relates to elective surgery where patients are admitted for procedures that cannot be done as a day case. This flow can be further broken down into time based flows where depending on the procedure patients are on site for durations of 23 hours, less than 72 hours and greater than 72 Hours. The Programme will focus on the application of the following High Impact Changes: up front pre-operative assessment and discharge planning where emphasis should be placed on working to improve hospital discharge with local authority partners, patient focussed booking, primary targeting lists, referral management and list pooling should apply.
Chapter 4

Project Components
The Planned Care Improvement Programme covers seven of the Modernisation Agencies’ ten high impact changes, the five simple changes outlined in Delivering for Health and the 5 key changes outlined in Delivering Quality and Value. Whilst the programme is not entirely limited to these areas, this will be the main focus of the improvement works. Each change is representative of a step along the patient journey and the interactions between these two stages. NHS Boards will be asked to benchmark current practice, to ascertain which steps they should focus on.

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<th>Optimise patient flow through service bottlenecks using process templates</th>
<th>Improve patient flow across the whole NHS system by improving access to Key diagnostic tests</th>
<th>Manage variation in the patient admission process</th>
<th>Treat day surgery as the norm for elective surgery</th>
<th>Manage variation in patient discharge thereby reducing length of stay</th>
<th>Avoid unnecessary follow ups for patients and provide necessary follow ups in the right setting</th>
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<td>Five Simple Changes</td>
<td>Improve referral and diagnostic pathways</td>
<td>Actively manage admissions to hospital</td>
<td>Treat day surgery as the norm</td>
<td>Actively manage discharge and length of stay</td>
<td>Actively manage follow ups</td>
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<td>Delivering Quality and Value</td>
<td>Avoid unnecessary procedures</td>
<td>Reduce avoidable emergency admissions</td>
<td>Reduce wasted bed days</td>
<td>Improve day case performance</td>
<td>Reduce variation in length of stay</td>
<td>Reduce unnecessary outpatient appointments, follow ups and DNAs</td>
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<td>Electives</td>
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Improving patient access by reducing the number of queues

Comment and Features
Multiple queues are a feature of the NHS today and symptoms of poorly designed systems. Reducing the number of queues helps to drive improvement in waiting times and reduce the effects of variable demand.

Improvement focus
- Map the existing flow of patient referrals to services, measure the demand and capacity and identify how the queues are subdivided in the system;
- Reduce the number of queues, contact and referral points;
- In outpatients ensure that patients are treated by the most appropriate healthcare professional in the most appropriate setting;
- Utilise patient focussed booking systems to minimise DNAs;
- The bulk of referrals in most specialties should be managed in general clinics;
- Use referral management services following process redesign. This will allow for other team members to work to shared protocols of care across the team, single points of contact and single queues and produce systems that are more straightforward, easier to manage with reduced risks of errors. This will allow patients with complex needs can be assigned to the most appropriate clinician;
- Ensure that consultants in a specialty share referrals as a team;
- Eliminate carve out.

Optimising patient flow through service bottlenecks using process templates

Comment and features
Process mapping and time studies are used to build up a picture of the time and resources required by a patient during their overall care journey. Value stream mapping will identify sources of waste, overproduction, work in progress, waiting, over processing, defects, transportation, and excess motion. Used in combination, these techniques can be used to remodel services to eliminate non value adding steps, identify pathway bottlenecks and reduce the effect of variation in demand and capacity.

Improvement Focus
- Map the process;
- Identify how long each step takes;
- Identify and eliminate blockages to flow;
- What is the end to end process time and how can it be reduced through eliminating non value adding steps?;
- How many handovers are there and how many of these do not add value to the patient journey and can be eliminated?;
- Ensure that process templates are used to model resources for a whole specialty or unit, not just an individual clinician or sub specialty;
- To ensure success clinic capacity needs to be pooled and templates used to schedule the flow of patients through the whole resource;
• Use the process of creating the template to map, redesign and then manage variation in scheduling of admissions and discharges;
• Process templates and clinical protocols should be created simultaneously to detail the whole system;
• Use process templates to identify patient groups and manage them accordingly;
• Process templates provide improved patient information. These should be used in conjunction with referral services and booking systems to minimise the number of queues through a whole system.

**Improving patient flow across the whole NHS system by improving access to key diagnostic tests**

**Comment and features**
Improving patient flow can reduce the amount of time patients spend in hospital and free up inpatient capacity. Streamlined processes can result in fewer hospital visits and reduced length of stay. Clinically unnecessary X-rays or other diagnostic procedures can be eliminated. Referral between primary and secondary care can often result in process bottlenecks.

**Improvement Focus**
• The root cause of problems is often the mismatch between the variation in demand and the variation in capacity;
• Redesign of services and matching demand and capacity to improve the flow of patients through the system are essential;
• Measure and understand the true nature of demand for services;
• Map existing referral flows and aim to smooth the flow;
• Aim for standardisation and the current best way to do a task;
• Seek out tests that are no longer clinically relevant, necessary or have been superseded;
• Create standardised protocols and pathways and ensure that all adhere to them;
• Identify potential savings available in waiting times if access to diagnostic tests can be redesigned;
• The use of Patient Focussed Booking systems and referral services ensures that patients get choice and certainty of appointment time and location, in addition to ensuring DNA rates are reduced and reducing lost diagnostic slots;
• Put in place local systems to monitor and feedback to GPs on referral and admission rates and actively manage referrals;
• Analyse admission ratios and benchmark against other services to identify where these are out of line;
• Ensure that PFB, team referrals and reduction in the number of queues are used to improve the process;
• Reduced turnaround times for tests will release inpatient bed days and free up capacity;
• Remodel referral pathways to ensure that patients are placed on the right route for care at the beginning of their journey;
• Establish referral protocols to clearly identify how and where patients are managed.
Managing variation in the patient admission process

Comment and Features
Repeated case studies have shown that elective admissions are often a major source of variation across systems, due to the way elective surgical scheduling is planned. Resources will be freed up due to less cancellations where patients need to be re-booked and less waiting list management, as patients will pass the surgery pre-assessment and be booked directly into a surgical slot.

The Pre-assessment service should be looked at in conjunction with the discharge process and should include all relevant parts of discharge planning before the patient even has surgery. Admitting patients to beds a day/days in advance of procedures for non clinical reasons wastes valuable hospital bed space and increases costs. Similarly patients are often admitted to hospital but have no main procedure carried out, either because they were admitted for diagnosis only, which could have been carried out without an admission, or were found to be unfit for surgery, which could have been picked up by pre-assessment.

Improvement Focus

- Map the patient value stream and processes and link the value adding steps in each process, combine steps or perform them in parallel;
- Measure and analyse elective and emergency demand by day of week and hour of day;
- Analyse the impact of patients with frequent admissions and work with the whole system to ensure that all possible alternatives to admission are properly aligned;
- Ensure that the process is not ‘admit to decide’ but is ‘decide to admit’;
- Analyse admissions before day of surgery and admissions without the procedure noted for all specialties to identify variation;
- Reduce variation in elective admission processes and patterns;
- Agree changes in clinical practice and processes to ensure all specialties are in line with national performance and agreed standards;
- Put in place nurse led pre-admission services for surgery with support from anaesthetic services;
- Reduce the need for patients to be admitted in advance of procedures by using pre-operative assessments; investigate the use of surgical admission units that allow patients to go directly to theatre;
- Reduce the level of patients admitted without a procedure by use of improved access to diagnostics on an outpatient basis;
- Improve planned bed management;
- Eliminate the non-clinical cancellations of operations;
- Put in place patient focussed booking for pre-admission clinics to minimise DNAs and map the process such that after the clinic the patient is directly booked into surgery producing certainty of elective dates. This will ensure no on the day cancellations of patients;
- Examine how to utilise referral management and booking services to provide co-ordinated centralised admission services;
- Set planned date for discharge on day of admission or pre-admission using agreed protocols;
- Plan transport and tests in advance according to lead times.
Treat day surgery as the norm for elective surgery

Comment and Features

The benefits of increasing day surgery are well known, yet the increase in day surgery rates has been slow. The Healthcare Commission recommends that if all appropriate procedures were treated as day cases, it should be possible to achieve overall day case rates of 75%. Day surgery is a more efficient use of NHS resources than inpatient surgery. Patients have a preference to be treated on a day case basis with minimum disruption to their lives. Research by the NHS Modernisation agency suggests that hospitals do not have a day case mindset. Treating day surgery as the norm suggests a change in the way we plan elective care.

This high impact change is also about moving care to the most appropriate setting based on clinical judgement, such as moving day case surgery to outpatients and outpatients to primary care. Where clinically appropriate look at the options to shift from inpatient to 23hr stay, 23hr stay to day case and day case to outpatient. The healthcare delivery process should be designed so that the only time a patient spends in hospital adds value for them.

Improvement Focus

- Day case surgery should be considered the norm for the majority of elective procedures and the hospital’s systems should be organised on this basis;
- Work across the system to assess whether surgery is necessary at all or if alternatives are available;
- Ensure that remodelled evidence based patient focused pathways are put in place;
- Assess day case rates against the PCIP basket of procedures;
- Compare current performance and, for procedures where undertaking more than 30 admissions, aim to raise performance to reach the upper quartile performance as a minimum;
- Analyse day case rates by procedure and specialty to identify scope for improvement;
- Improve accuracy of clinical coding in order to ensure patients planned as day cases are not coded as inpatients;
- Undertake a campaign to ensure full implementation of correct coding rules;
- Set ambitious goals for day case rates on procedure specific, specialty and board wide basis;
- Undertake a baseline diagnosis of day case potential activity by comparing current day case rates;
- Put clinical leads in place for day surgery;
- Focus improvement efforts on specialties identifying and overcoming barriers to change;
- Adopt a day case surgery strategy and address operational issues such as ending admission of patients the night before and patients kept in overnight for non clinical reasons;
- Optimise theatre utilisation for elective and day case patients (85%);
- Make sure standardised processes for admission and discharge of day surgery patients are put in place;
- Measure and aim for zero day case cancellations.
Managing variation in patient discharge thereby reducing length of stay

Comment and Features
One of the most effective strategies for reducing total patient journey time is to focus on bottlenecks in the process. Focus on discharging patients as soon as they are ready rather than when the system is ready to discharge them. Variation in discharge processes leads to variation in patient length of stay. Evidence shows that there is scope for reducing average length of stay by introducing a dynamic discharge process.

Improvement Focus
- Analyse all inpatient stays by length of stay to identify where improvements in discharge will have the greatest impact;
- Day to day variation in the way discharge is managed should be addressed;
- Hospital processes should ensure that seven day working applies to both admission and discharge and peaks and troughs should be smoothed out;
- Focus on the high volume, same process patients;
- Processes need to be mapped and value streams analysed to remove bottlenecks and waste in the way ward rounds are carried out, wards are managed, inpatient tests and results provided and pharmacy services supplied;
- Map the information flows and responsibilities for patient care at all points of the patient journey;
- Discharge planning protocols should be put in place to allow patients to be discharged when fit;
- Predictive discharge methods should be put in place to reduce variation and eliminate delays;
- Effective bed management processes should be put in place to address forecast demand and capacity mismatches;
- Planned day for discharge should be set on day of admission or pre-admission using agreed protocols;
- Daily decision making ward rounds should be established and discharge delegated to nurses, where clinically appropriate;
- All tests and transport arrangements should be put in place in advance;
- Discharge lounges should be put in place to ensure beds can be freed up when planned;
- Work across the system to determine appropriate lengths of stay is key. Production of agreed protocols and ensuring that early discharge schemes are closely aligned rather than competing;
- Length of stay by admission type, HRG and benchmark against other Boards should be measured and monitored;
- Systems to allow real time feedback on length of stay profile to frontline clinical staff on a regular basis should be put in place;
- Weekend discharge rates should be improved by ensuring discharge is driven by clinical factors and not hospital cycles;
- Patients and their families should be involved in discharge planning so they are prepared.
Avoiding unnecessary follow ups for patients and providing necessary follow-ups in the right setting

Comment and Features
Every year there are a number of follow up appointments where patients are asked to return in order to monitor progress, undergo tests or get test results. Evidence demonstrates that a significant number of these follow ups are clinically unnecessary, create inconvenience for the patient and waste valuable resources. Up to 75% of all outpatient DNAs are for follow up appointments. The follow up DNA rate varies but ranges between 10% - 40%. The adoption of Patient Focussed Booking systems and streamlining of processes should be used to actively manage and reduce DNA rates in outpatients. Follow up ratios and DNA rates should be monitored by specialty and reported on a monthly basis. Much emphasis is placed on the front end of the healthcare delivery process, such as demand management and avoiding admission, however the planning of the whole patient journey is essential.

Improvement Focus
• Make sure that follow ups are planned at the front end of the patient journey and that they are only offered for specific reasons, clinical or patient led;
• Redesign the patient journey such that all relevant tests are planned and booked to occur in one visit;
• Look at new to return ratios and aim for a reduction in follow up appointments where the ratio is greater than 1:3;
• Agree changes to clinical practices and processes to bring new to return ratios for all specialties in line with national standards;
• Implement standardised procedures and protocols to support the process;
• Redesign the process and value stream to ensure that follow up after treatment takes place in the right healthcare setting and is delivered by the right healthcare professional;
• Benchmark services to see how they compare with other Health Boards;
• Proactively investigate alternatives to consultant led hospital based outpatient clinics;
• Aim for patient led follow ups in a primary setting with automatic secondary care follow up only used where clinically appropriate;
• Investigate and implement alternative follow up methods such as telephone calls, questionnaires, web based services and group visits to replace traditional visits where clinically appropriate;
• Set up and utilise patient focussed booking systems to manage waiting lists and queues and reduce DNAs;
• Aim to reduce current level of DNAs to 5%;
• Train clinical nurse specialists to handle appointments;
• Introduce non face to face follow up where clinically appropriate;
• Develop discharge and follow up protocols.
Reference

10 High Impact Changes for Service Improvement and Delivery (2004) NHS Institute for Innovation and Improvement

A Guide to Service Improvement (2005) Centre for Change and Innovation, SEHD

Building a Health Service Fit for the Future (2005) SEHD

Delivering for Health (2005) SEHD

Fair to All, Personal to Each (2004) SEHD

Improvement Leaders’ Guides (2005) NHS Institute for Innovation and Improvement

• Improvement knowledge and skills
• Process mapping, analysis and redesign
• Working with groups
• Involving patients and carers
• Evaluating improvement
• Measurement for improvement
• Matching capacity and demand
• Improving flow
• Working in systems
• Managing the human dimensions of change
• Redesigning roles
• Building and nurturing an improvement culture
• Leading improvement