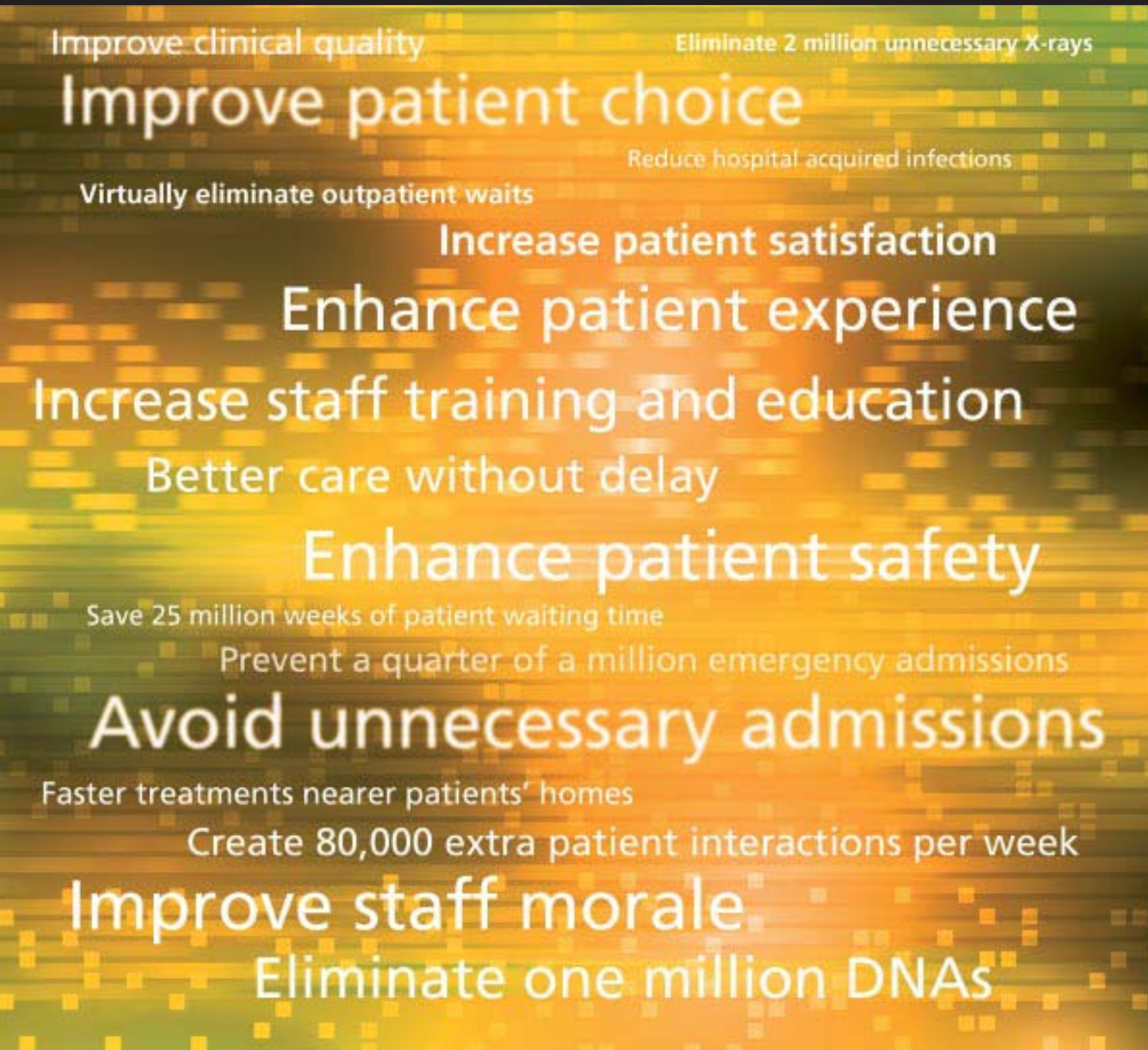
NHS
Modernisation Agency

The PCT Guide to Applying the 10 High Impact Changes

A guide from NatPaCT



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For Recipient's Use		

The PCT Guide to Applying the 10 High Impact Changes

Many primary care organisations have already demonstrated significant success in the areas covered by the 10 High Impact Changes.

Contents

Introduction

PCTs can utilise the 10 High Impact Changes to:

- underpin their local improvement strategy
- improve the services they provide
- negotiate a better deal for patients from the services they commission and the organisations they contract with.

The 10 High Impact Changes have been identified by the NHS Modernisation Agency through its work with thousands of local clinical teams. Each of the ten changes has already been implemented by some NHS organisations. If all the changes were applied systematically across the NHS, to a standard already being achieved in some places, the experience of millions of patients would be transformed, clinical quality significantly improved, hundreds of thousands of clinician hours, appointments and hospital bed days would be saved, patient waiting would be virtually eliminated, and staff satisfaction would be enhanced.
(See opposite page.)

Feedback

Through their work and consultation throughout the NHS, Modernisation Agency staff have consistently received two requests from PCT, Trust and SHA senior leaders who wanted to build modernisation more strongly into their delivery plans:

> Tell us which service redesign improvements will make the biggest difference

> Tell us what (quantifiable) benefits can potentially be achieved through modernisation

The 10 High Impact Changes are included in *National Standards, Local Action: Health and Social Care Standards and Planning Framework 2005/06 - 2007/08.* Whilst, they are not mandatory they are applicable to PCTs, NHS Trusts, and Foundation Trusts. They can be a useful component of any local performance improvement strategy. Many local NHS organisations and communities are adopting the changes as part of a community wide whole system partnership, focusing on those aspects of the changes that fit with the local context and local priorities.

To obtain a hard copy of the original 10 High Impact Changes please call 08701 555 455 and quote ref MAHICRES.

To obtain further copies of The PCT Guide to Applying the 10 High Impact Changes please call 08701 555 455 and quote ref MAHICPCT.

For further information and resources on any aspect of the 10 High Impact Changes please visit the website at www.modern.nhs.uk/highimpactchanges

Implementing the **10 High Impact Changes** across the NHS – to the level that has already been achieved by frontline teams – could produce dramatic improvements. For example:

1 **Change Nº1:**
Treating day surgery (rather than inpatient surgery) as the norm for elective surgery could release nearly half a million inpatient bed days each year.

2 **Change Nº2:**
Improving patient flow across the NHS by improving access to key diagnostic tests could save 25 million weeks of unnecessary patient waiting time.

3 **Change Nº3:**
Managing variation in patient discharge, thereby reducing length of stay, could release 10% of total bed days for other activity.

4 **Change Nº4:**
Managing variation in the patient admission process could cut the 70,000 operations cancelled each year for non-clinical reasons by 40%.

5 **Change Nº5:**
Avoiding unnecessary follow-ups for patients and providing necessary follow-ups in the right care setting could save half a million appointments in just Orthopaedics, ENT, Ophthalmology and Dermatology.

6 **Change Nº6:**
Increasing the reliability of performing therapeutic interventions through a Care Bundle approach in critical care alone could release approximately 14,000 bed days by reducing length of stay.

7 **Change Nº7:**
Applying a systematic approach to care for people with long-term conditions could prevent a quarter of a million emergency admissions to hospital.

8 **Change Nº8:**
Improving patient access by reducing the number of queues could reduce the number of additional FFCEs required to hit elective access targets by 165,000.

9 **Change Nº9:**
Optimising patient flow through service bottlenecks using process templates could free up to 15-20% of current capacity to address waiting times.

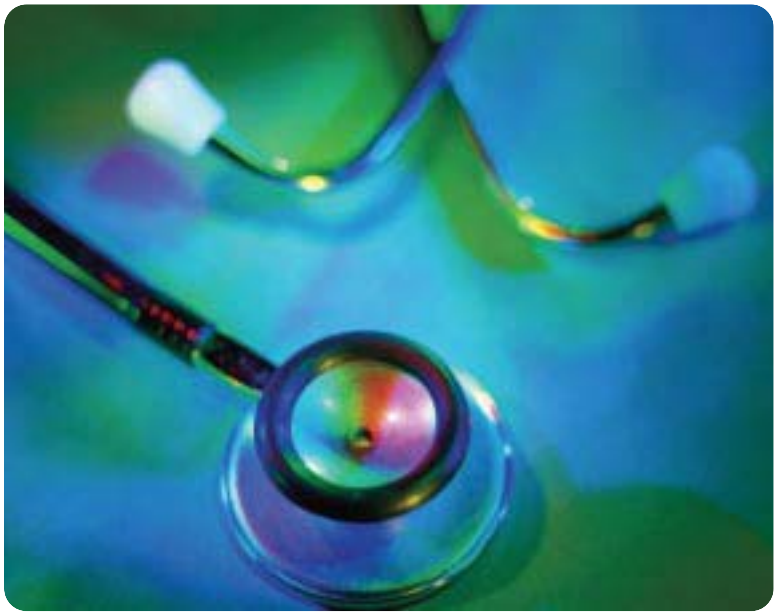
10 **Change Nº10:**
Redesigning and extending roles in line with efficient patient pathways to attract and retain an effective workforce could free up more than 1,500 WTEs of GP/consultant time, creating 80,000 extra patient interactions per week.

How PCTs can use the 10 High Impact Changes

Evidence tells us that the 10 High Impact Changes can be a lever for improving clinical outcomes, patient experience, value, appropriateness of care. They can help to reduce or eliminate unnecessary delay. The changes are equally applicable across primary care, mental health and hospital settings.

Many primary care organisations have already demonstrated significant success in the areas covered by the 10 High Impact Changes and we can all learn from their experience. However, no PCT and no local health and social care community is applying best practice in all of the areas. **Annex A** (page 9) provides a list of issues arising from each of the 10 High Impact Changes along with some key questions that might be useful in dialogue with service providers or at PCT Board level.

PCTs are well placed to engage practices and incentivise them to provide services which are responsive to local needs. The 10 High Impact Changes can be useful in key areas such as improving access, caring for patients with long-term conditions and role redesign which may assist with retention and recruitment of staff.



An effective local healthcare system should not be designed to avoid performance failure but to enable continuous improvement across the whole organisation or community. PCTs can lead the way in identifying and removing activities that do not add value across the patient journey as well as simplifying and speeding up processes as part of a whole system approach. The 10 High Impact Changes can also be used as a lever for increased patient autonomy and patient-centred decision making.

The 10 High Impact Changes can play a powerful role in the commissioning of services (or, in the case of Foundation Trusts, in framing contracts) resulting in commissioners building the changes into their local service agreements with secondary care or mental health providers. In addition they can be an integral part of any practice based commissioning developments.

The 10 High Impact Changes also provide a foundation for the Professional Executive Committee to develop a local improvement strategy as well as helping with capacity planning at the local level which will ideally be integrated into any local delivery plans.

PCTs can also use the 10 High Impact Changes to improve the services they deliver for patients within primary care

The starting point should be to focus on the high volume flows of patients who follow broadly similar process steps, rather than individual specialties or conditions. Evidence from the 10 High Impact Changes tells us that improvement of clinical processes can achieve apparently contradictory goals: improving the quality of care, patient and staff experience as well as reducing waste and enhancing value for money.

High Impact Changes Nos 5, 6, 7, 8, 9 and 10 are virtually directly transferable to primary care. Avoiding unnecessary follow-ups and providing the necessary follow-ups in the right care setting **(Change NO5)**, a systematic approach to patients with long-term conditions **(Change NO7)**, reducing the number of queues **(Change NO8)** and role redesign **(Change NO10)** are as relevant in primary care as they are in secondary care.

A care bundle approach **(Change NO6)** and the use of process templates **(Change NO9)** can easily be applied in primary care, for example to increase the reliability of therapeutic interventions such as in coronary heart disease, or to optimise patient flow through service bottlenecks.

Smoothing variation in admissions **(Change NO4)** can be tackled in several ways. In a purely PCT setting, admissions can be read as patient appointments. Can we smooth the traditional batching of patients into morning and afternoon surgeries? However PCTs also have a role to play in smoothing emergency admissions into secondary care. It is well recognised that the peak time of arrival at a hospital for acute admissions is early afternoon. The major cause of this is the traditional pattern of the GP working day, with home visits following morning surgery. Can home visits be smoothed out through the morning (as the requests arrive) or can a "doctor of the day" approach be used?

PCTs should work in tandem with their secondary care colleagues to improve the access to key diagnostic tests **(Change NO2)** – these impact on all patients.

Obviously, improvements in secondary care will positively impact on primary care – less unnecessary delay, improved clinical quality, improved patient and staff experience all lead to a lower unnecessary workload for the entire health and social care system.

As a lever to improve secondary care services
Organisations that systematically adopt these 10 High Impact Changes will be amongst the best placed to take forward the transformational challenges facing the NHS in the next five years. PCTs can work with other local providers of health and social care to provide the partnership and leadership commitment required to support fundamental improvement in the overall performance of a healthcare organisation or community.

The 10 High Impact Changes provide valuable knowledge about what healthcare organisations can do to significantly improve their services for both patients and staff. This knowledge, combined with a robust needs assessment of the local population should result in a much more responsive and timely service for patients across any pathway of care.

Any local service level agreements can incorporate the 10 High Impact Changes as part of the local commissioning arrangements to ensure that the aims of patient choice and more personalised services based on local population needs are established. For example **High Impact Change NO1: Treat day surgery (rather than inpatient surgery) as the norm for elective surgery** will result in greater convenience and choice for patients.

There is a growing acceptance that our current focus within the NHS on managing some long-term conditions in an acute care setting is no longer appropriate. The 10 High Impact Changes linked to commissioning arrangements can present opportunities for looking at alternative care settings as well as putting the patient at the heart of any decision making around their episode of care.

PCTs can also use the 10 High Impact Changes to develop more robust information and measurement systems which can enhance local decision making processes and identify more easily value-adding processes.

Finally the 10 High Impact Changes can provide a useful framework around which clinical protocols can be developed across the healthcare community.

Conclusion
The changes described here are an invaluable source of ideas. But identifying what's possible is the easy part. The real challenge lies in implementation. PCTs have a unique opportunity to take a systems view of the local community and provide the leadership to deliver patient-centred services which are based on evidence to transform the healthcare experience for their local population.

NHS case studies

Proving that the 10 High Impact Changes work

South Somerset PCT
South Somerset PCT has a newly established multidisciplinary clinical forum with members from primary and secondary care who plan to look at joint initiatives, beginning with stroke services. Their future programme will cover each national service framework, as well as musculoskeletal services.

South West Peninsula Cardiac Network
Clinicians and commissioners from across primary, secondary and tertiary care in the South West Peninsula Cardiac Network have been involved in radically redesigning patient flows for cardiac surgery, including pre-assessment in primary care, commissioner-held waiting lists, alternative providers and follow-up in primary care. This has taken place alongside the redesign of heart-failure services.

This work has involved considerable Commissioning clinical engagement, and would have been impossible without the multi-professional team being involved in strategic steer of the work as well as frontline involvement.

Sedgefield PCT
Sedgefield PCT's nurse representative, a health visitor and a dermatologist in secondary care developed guidelines to manage eczema in primary care.

Ealing PCT
Community optometrists are working with Ealing PCT, Ealing Hospital and local GPs to provide diabetic retinopathy screening using digital retinal photography. Agreement was reached on a joint approach, with GPs registering diabetes on the chronic disease register and Ealing Hospital offering patients a choice of appointment with either the hospital, a health centre or an accredited community optometrist. It is planned to extend the service to more optometrists, using NHSnet to transfer the retinal picture.

NHS Modernisation Agency
www.natpact.nhs.uk
National Primary and Care Trust Development Programme

The above case studies have been taken from the *Can Do!* document produced by NatPaCT. For further information and copies please visit www.natpact.nhs.uk/can_do/index.php

The 10 High Impact Changes can play a powerful role in the commissioning of services

Annex A

Issues and questions PCTs may wish to consider as part of any High Impact Change implementation discussion

Professional Executive Committees might wish to consider the following questions as part of the dialogue around any local improvement strategy or delivery plans:

Strategic Direction

- Have we addressed the **10 High Impact Changes** by incorporating them into our Strategic Vision for the next phase of local improvement?
- Does the Board have a robust system of real measurement for real improvement and data collection to support local improvement? Are we being able to provide timely information to aid decision making?
- Has the Board incorporated the **10 High Impact Changes** into its local performance monitoring arrangements?
- Do the non-executive and lay members of the Professional Executive Committee have an awareness of the **10 High Impact Changes** and where appropriate have some of them form part of their personal development plan? This may be worth considering where a non-executive is leading or participating in any local steering group around a particular local priority, e.g. improving access.

Clinical Protocols

- Are we incorporating the **10 High Impact Changes** into local clinical protocols or care pathways which deliver care to local people in a whole systems way?
- Are we using the **10 High Impact Changes** as an opportunity to put patients at the centre of any local improvement strategies and also use as vehicle to gain the active participation and involvement of local people?
- Are we applying the **10 High Impact Changes** to ensure:
  - robust decisions are made in relation to referral patterns and population needs
  - local service improvement is both personalised and prioritised particularly in terms of long-term conditions?

Service Level Agreements

- Do the local community commissioning arrangements support commissioning using a needs-based model as opposed to an activity-based model?
- Does the local community have robust service level agreement in place which offers choice and timely treatment?
- Do the local commissioning arrangements provide opportunities to strengthen partnership arrangements across health and social care?
- Do the local service level agreements set out milestones for achievement in relation to the **10 High Impact Changes**?
- Do the commissioning monitoring arrangements outline robust data requirements for performance monitoring and progress reports?
- Do the service level agreements incorporate both clinical and non-clinical specifications that address both governance and patient safety arrangements?
- Are the **10 High Impact Changes** being utilised to encourage greater participation involvement of local commissioning of services, both at the GP practice level and within secondary care?

Issues that might be useful in dialogue with service providers

1 Change Nº1:
Treat day surgery (rather than inpatient surgery) as the norm for elective surgery.

- What are your day case rates? Are you an upper quartile provider for the procedures in the Audit Commission basket? Are your day case rates improving?
- What steps are you taking to convert inpatient cases to day cases, and day cases to outpatients? Have you set some aims for this?

2 Change Nº2:
Improve patient flow across the NHS system by improving access to key diagnostic tests.

- What is your average wait for common diagnostic tests? What is the maximum wait?
- What is the DNA rate for a given diagnostic case?
- What steps are you taking to reduce unnecessary wait for diagnostic tests (e.g. demand & capacity analysis, process redesign (**Change Nº2**), waiting list validation, clinical guidelines, scheduling (**Change Nº9**), personalised team referrals (**Change Nº8**) etc)?

3 Change Nº3:
Manage variation in patient discharge, thereby reducing length of stay.

- What is your weekly pattern of discharges? Have you introduced improved weekend discharge procedures?
- What is your daily pattern of discharges? What steps have you taken to expedite clinically appropriate discharges (e.g. availability of ward rounds/discharge processes; availability of test results and medication to take home)? What steps have you taken to enable patients to be discharged home earlier in the day?
- What is the average length of stay for common conditions? How does it compare with hospitals in your peer group?
- What is the variation? What steps have you taken to reduce the variation?
- What is your cancellation rate? How does it compare with hospitals in your peer group?
- What local arrangements are in place with social services to keep people well in their own home and avoid inappropriate hospital admission?

4 Change Nº4:
Manage variation in the patient admission process.

- Have you analysed your day-to-day admission patterns for emergency and elective patients? Is the way that you schedule elective patients creating difficulties in admitting emergency patients?
- What steps have you taken to reduce the day-to-day variation in elective admissions?
- How many elective surgical patients get admitted on a Sunday? Have you reduced "day-before" surgical admissions?
- What is your cancellation rate?

5 Change Nº5:
Avoid unnecessary follow-ups for patients and provide necessary follow-ups in the right care setting.

- What is your ratio of first outpatient appointments to follow-up appointments? How does it compare to that of organisations of a similar size and case mix? Is the ratio of first appointment improving and if so through what methodology?
- What are your outpatient DNA rates?

6 Change No6:
Increase the reliability of performing therapeutic interventions through a Care Bundle approach.

- Are you adopting care bundles for your clinical processes? In which specialities/situations? To what extent? What impact have they had?

7 Change No7:
Apply a systematic approach to care for people with long-term conditions.

- What approaches have you taken to improving the care of patients with long-term conditions?
- Have you developed an Expert Patient Programme?
- Have you developed clear guidelines for the management of patients with long-term conditions? Have these been developed in partnership with primary care?
- Have you reduced the number of acute admissions of patients with long-term conditions?
- Are your diabetic complication rates decreasing?
- What progress is being made locally in relation to the National Service Frameworks? Are there any local 'expert' patients groups or voluntary agency support available locally to support people to self manage their long-term conditions?

8 Change No8:
Improve patient access by reducing the number of queues.

- Have you adopted the Clinically Prioritise and Treat (CPaT) methodology for every specialty where there are waits for outpatient and inpatient services?
- Have you adopted a policy for the ethical management of waiting lists?
- To what extent have personalised team referrals been adopted? In which specialities?
- What has been the impact of adopting personalised team referrals? Have waiting times reduced?

9 Change No9:
Optimise patient flow through service bottlenecks using process templates.

- Are you using process templates as part of the business case for new investment in capacity?
- In which fields and to what extent are you using process templates to make optimal use of existing capacity? What arrangements do you have for their introduction?
- What has been their **impact so far**?

10 Change No10:
Redesign and extend roles in line with efficient patient pathways to attract and retain an effective workforce.

- Are you regarding role redesign as a fundamental component of service redesign?
- Has this had an effect on waiting times and/or unnecessary patient delay?
- Have retention and recruitment rates or staff satisfaction improved as a result of role redesign?
- Has role redesign been applied to aid compliance with European Working Time Directive in relation to junior doctor hours?
- Is role redesign a component of progress towards key milestones for Agenda for Change?

The NHS Modernisation Agency is part of the Department of Health

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