Commissioning for Patient Pathways
A practical guide to achieving and sustaining 18 weeks
Foreword

The health service in England is undergoing significant transformation. For commissioners, the move towards Practice Based Commissioning, new contractual arrangements and the 18 week patient pathway presents real opportunities to influence the pace of change in the NHS. The delivery of 18 weeks not only brings the benefit of reducing waits, thereby improving the lives of patients, but also provides the chance to reshape local services based on patient need.

Achieving 18 weeks will be a significant milestone in the move towards an English health service that puts the patient at its centre. Making this achievement sustainable requires collaboration across all partners within the health service: 18 weeks is a challenge for whole health economies, and not just the responsibility of any single part of it.

By forging stronger and more effective relationships across primary and secondary care, it will become easier to both commission and provide delay-free services to patients in England, and achieve efficiency savings across the NHS.

Research carried out by the NHS Institute for Innovation and Improvement concludes that 18 weeks can only be achieved and sustained if there is a concerted focus on commissioning for service improvement and redesign, alongside more traditional measures such as purchasing additional activity. This approach, combined with rigorously developed activity plans based on a sound understanding of variations in capacity and demand and a proactive performance overview of pathways, means that a reduction in waiting times can be secured.

This shift in focus towards pathway-based commissioning will enable commissioners to transform services in order to improve health outcomes and enhance the patient experience.

The NHS Institute compiled Commissioning for Patient Pathways in collaboration with a range of stakeholders in primary and secondary care, within and beyond the NHS. It builds upon a foundation of service improvement, relationship development and good practice in commissioning.

We hope you find it useful, accessible and even a little challenging on your journey towards commissioning an NHS that is truly world class.

Bernard Crump
Chief Executive of the NHS Institute for Innovation and Improvement

Philippa Robinson
DH 18 Week National Implementation Director
Commissioning for Patient Pathways

Introduction

This practical guide aims to support commissioning managers by creating a structured approach to commissioning planned care pathways. It is not an exhaustive list of commissioning actions. The purpose instead is to provide a focus on an immediate issue concerning commissioning: how to achieve 18 week pathways, and achieve this sustainably for the health economy.

You can use the guide by following four steps:

**Step 1:** review the scale of the challenge and put 18 weeks in the context of other health economy priorities

**Step 2:** select pathways to maximise impact on 18 weeks

**Step 3:** review the pathway commissioning matrix and using this as a guide, select the actions you need to take

**Step 4:** use your selection to build, implement and review your work programme

The pathway commissioning matrix forms the heart of the guide. It segments key actions for commissioning across macro-level commissioning functions for commissioners and down through elements of pathway based commissioning. The functions were adjusted from the Good Practice PCT Commissioning Services report, with patient and public engagement becoming part of the relationship management function. The need to make this adjustment and the elements were identified by research carried out by the NHS Institute. The following are the functions and elements:

**Four macro-level commissioning functions:**
1. assessment and planning
2. relationship management
3. contracting and procurement
4. performance management, settlement and review.

**Five key elements of pathway based commissioning:**
1. patient outcomes
2. service improvement and pathway redesign
3. demand and capacity
4. pathway performance
5. planned versus unplanned care.

The design of the matrix deliberately allows commissioners to develop their own work programme depending upon their current needs and their work context. This means that you may feel drawn to some elements of the matrix more than others. This is fine, there is no right way or wrong way to use this guide, the selection depends entirely upon your needs.

The up to date online version is available on www.institute.nhs.uk/nodelays and contains an additional section on resources and guides for each action.

“**This guide is a summation of the things that we know are fundamental for commissioning. Although there are no surprises, this does not mean that they do not continue to be important and our attention must now focus on rigour of application. If something is not being done, why not and what is our intention to make it happen?”**

Professor Edward Peck, Health Service Management Centre 2007
### Pathway Commissioning Matrix

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<thead>
<tr>
<th>Performance management, settlement and review</th>
<th>Contracting and procurement</th>
<th>Relationship management</th>
<th>Assessment and planning</th>
<th>Demand, capacity and pathway management</th>
<th>Patient outcomes</th>
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<td><strong>Establish the effectiveness of the pathway by assessing patient outcomes</strong></td>
<td><strong>Achieve positive patient outcomes through contracting and procurement</strong></td>
<td><strong>Build relationships on a shared improvement and planning basis</strong></td>
<td><strong>Ensure the effectiveness of the pathway by assessing patient outcomes</strong></td>
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<td>1. Review patient outcomes to ensure continuous quality improvement</td>
<td>1. Review key outcomes and indicators across the pathway</td>
<td>1. Develop clinical leaders, clinical and workforce development to support the pathway</td>
<td>1. Establish the effectiveness of the pathway by assessing patient outcomes</td>
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<td>2. Ensure the pathway designs are cost-effective and deliver health improvements centrally across the pathway</td>
<td>2. Support patient involvement in setting the pathway and review with providers</td>
<td>2. Develop patient and public involvement to bring in new ideas</td>
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<td>2. Review the impact of unplanned care on the planned pathways</td>
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<td>3. Implement continuous quality improvement programmes and processes across the pathway</td>
<td>3. Establish the effectiveness of the pathway by assessing patient outcomes</td>
<td>3. Build on existing clinical governance arrangements, and clarify roles which enable improvement with providers</td>
<td>3. Establish the effectiveness of the pathway by assessing patient outcomes</td>
<td>3. Support patients and offer additional support, including self-care initiatives</td>
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<td>4. Use monitoring and evaluation alongside implementation of the pathway to guide future action and service improvement</td>
<td>4. Set clear linkages to pathway performance</td>
<td>4. Establish the effectiveness of the pathway by assessing patient outcomes</td>
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<td>4. Support patient and provider education and support, including health literacy initiatives</td>
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### Plan to achieve highly performing pathways

<table>
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<tr>
<th>Develop positive relationship behaviours to support pathway performance</th>
<th>Contract effectively to ensure smooth planned and emergency pathways</th>
<th>Build cross-organisational relationships to support pathway management</th>
<th>Identify the impact of emergency care on planned pathways</th>
<th>Identify the impact of unplanned care on the planned pathways</th>
<th>Pathway performance</th>
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| 1. Develop positive relationship behaviours to support pathway performance | 1. Contract effectively to ensure smooth planned and emergency pathways | 1. Build cross-organisational relationships to support pathway management | 1. Identify the impact of emergency care on planned pathways | 1. Identify the impact of unplanned care on the planned pathways | **Pathway performance**
| 2. Ensure that key patient outcomes are delivered to the agreed standards and expectations of the patients and providers across the health economy | 2. Develop the pathway to ensure smooth transition from planned to emergency care | 2. Establish mechanisms to support cross-organisational pathways | 2. Identify the impact of unplanned care on the planned pathways | 2. Identify the impact of unplanned care on the planned pathways | **Pathway performance**
| 3. Ensure that there is good communication and coordination between the health economy, providers and patients | 3. Develop a plan to support the pathway and ensure effective communication | 3. Confirm the core elements of the pathway | 3. Identify the impact of unplanned care on the planned pathways | 3. Identify the impact of unplanned care on the planned pathways | **Pathway performance**
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### Pathway Performance

- **Plan versus practice**
- **Performance management, settlement and review**
- **Contracting and procurement**
- **Relationship management**
- **Assessment and planning**
- **Demand, capacity and pathway management**
- **Patient outcomes**
**STEP 1**
- assess the scale of the challenge
- 18 weeks in context of health economy priorities

**STEP 2**
- select the pathways to maximise impact on 18 weeks

**STEP 3**
- review the matrix

**STEP 4**
- select ‘boxes’ to develop your work plan

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**How to use the Pathway Commissioning Matrix**

**STEP 1**
Review 18 weeks challenge and put in the context of other health economy priorities, for example delivering a balanced budget.

**STEP 2**
Select pathways by potential impact on 18 weeks and ability to lever change across a range of specialties.

**STEP 3**
Examine the pathway based commissioning matrix.

**Exploration:** a commissioner explored the whole matrix. She dipped in and out of the detail, taking a systematic approach. The result was a selection of actions that met her immediate needs.

**Discussion:** a PCT commissioner takes the matrix to a meeting with Practice Based Commissioners. They all use the matrix as a prompt for their discussions.

**STEP 4**
Select actions, build, implement and review your own work programme.

**At a planning stage:** a PCT service improvement manager selected this route in this order. He deliberately selected ‘boxes’ and reviewed the high level actions. This formed the backbone of his work plan to transform audiology services.

“At the end of service redesign, I would look at some of the boxes in the performance management column. For example, I would look at the suggested actions in patient outcomes, service improvement and redesign, and pathway performance”

A commissioning manager
Assess the scale of the challenge and identify pathways that need extra attention

1. Ensure 18 weeks is set in the context of health economy priorities and plans
   - some general prompts include:
     - how 18 weeks fits into the agreed strategic objectives
     - current budget and relative levels of spend by specialty, for example use programme budgeting
     - the history of service improvement and clinical engagement, clinical leadership and relationships across organisations
     - any existing plans and direction for providing care closer to home
   - ensure a programme management approach is used for service transformation initiatives.

2. Identify the specialties and pathways with the highest risk around 18 weeks
   - build on and review existing plans for 18 weeks, for example:
     - who are the leads for which pathways? within the PCT? within the provider?
     - what is the scale of the challenge? has it changed?
     - what resources are available?
   - with providers, jointly identify and agree risk around specialties in their ability to meet 18 weeks, build on any existing analyses, for example:
     - current performance and how this relates to volume of activity
     - financial risks
     - operational management, for example variation in capacity and demand
     - underlying trends in performance and activity levels.

3. Identify the high volume problematic pathways within these specialties
   - identify the high volume pathways using Pareto charts within the specialties and assess their level of risk in meeting 18 weeks
   - review relevant national pathways, for example the 18 week commissioning pathways
   - consider what is already known about the pathway and identify any gaps in local knowledge.

4. Examine the commissioning pathway matrix and select your actions
   - review the commissioning pathway matrix in this guide and the actions:
     - select sections that are most relevant for your current focus of work
     - use the guide as a check list and add your own reminders.

“... changed one pathway has had an impact across the whole specialty, for example reduced length of stay, if a new process involves admission on the day of surgery. “

SUMMARY

The first step to commissioning for 18 weeks pathways is to review the scale of the challenge and develop an approach that meets immediate requirements and is sustainable in the long-term.

The second step is to identify those pathways that require more attention than others. From a commissioning perspective, it is helpful to identify any problematic pathways jointly with their main providers and weigh up the following issues:

- the risk around achieving 18 weeks and resource requirements
- opportunities for efficiency gains, service transformation and service improvement
- other aspects of pathway performance.

A joint in-depth focus on some problematic pathways will help the health economy achieve a sustainable 18 week strategy. Selecting pathways for specific focus across a range of specialties will help diffusion of best practice across specialties. As one pathway is transformed, then collective attention can move to another.

KEY ACTIONS

1. Ensure 18 weeks is set in the context of health economy priorities and plans
2. Identify the specialties with the highest risk around 18 weeks
3. Identify the high volume problematic pathways within these specialties
4. Examine the commissioning pathway matrix and select your actions
Programme budgeting provides a useful context for 18 weeks

Programme budgeting is an approach that allows PCTs to compare their expenditure patterns in comparison to national, local or cluster profiles. It provides contextual information to help investment decisions. For example, a PCT may have different conversations with providers if 18 week commissioning pathways are part of a specialty that has relatively higher per capita expenditure compared to ones with a low expenditure.

1 Review current performance along 18 weeks

The chart shows variation by phase of treatment, and specialties are ordered by volume of activity. The data originates from the No Delays Achiever.

In this example, the PCT can assess its performance by an indicator of risk: the total number of days patients wait above 18 weeks for a specialty. This is a measure of both volume and variation.

2 Review programme budget

The data are available from the Department of Health and originates from submissions made by providers.

This is an extract from the PCT’s Programme budget. It shows the per capita relative expenditure by condition grouped by ICD codes. For example, this PCT spends £534,425 per 100,000 people more than the national average on Musculo-Skeletal System Problems. Understanding the different spend profiles is an important area for discussion. For example, is it due to different health needs, referral or admission rates?

3 Review pathway performance in the context of relative spend

Although Programme Budgeting uses ICD codes not HRGs, they still provide useful contextual information for 18 week pathway performance. Some potential areas of discussions with providers and Practice Based Commissioners include:

- for those specialties at high risk of not meeting 18 weeks and high relative expenditure: how can we combine a joint focus on reducing delay and use resource more effectively? how can we transform services?
- for specialties at high risk of not meeting 18 weeks but with low relative expenditure: how can we be assured that our activity plans are set in line with demand?
Commissioning for Patient Pathways

Patient outcomes
Establish the effectiveness of the pathway by assessing patient outcomes

1. Review any existing indicators of patient quality and safety
   - develop a shared understanding with key providers, drawing on national sources of information:
     - what national or local indicators exist for this pathway?
     - how were they set? what is the evidence base?
     - are there clinical concerns about the pathway? ask your Practice Based Commissioners and providers
     - what is the wider public health context of the pathway? talk to your public health leads
     - how are these indicators linked to the provider’s Local Delivery Plan?
   - identify any clinical governance concerns.

2. Gain patients’ perspectives on service quality
   - develop a baseline understanding of patient perspectives in discussion with key providers:
     - review any Patient Advisory Liaison Service (PALS) intelligence, provider-initiated patient involvement or patient satisfaction information
     - consider visiting the clinical setting and meeting the staff, as this will help you to understand the service you are commissioning from a patient’s perspective
   - consider opportunities to incorporate patient feedback and input into this pathway:
     - what do patients understand about their own responsibilities in improving clinical outcomes, for example compliance with treatment and living well?

3. Review key elements of evidence-based care
   - NICE guidelines
   - Healthcare Commission
   - Relevant Royal College and Professional Association guidelines
   - National Service Frameworks.

4. Identify potential indicators of patient outcomes to test out with providers
   - discuss the opportunity to test the use of patient-reported outcome measures (PROMS) or other clinically relevant outcome measures with provider organisations:
     - plan how you will use data jointly with clinical staff, including Practice Based Commissioners
     - try out the approach on this pathway, using small tests of change.

SUMMARY

Patient outcomes are the key indicators of the success of a pathway. They include indicators of clinical outcomes, patient safety and patient experience. Such outcomes can help commissioners to identify any quality issues across the patient pathway.

The focus is on how commissioners and providers can work together to test out ways to introduce routine monitoring of patient outcomes as a collective. This section also provides working examples of where organisations have used these principles to effect positive change.

KEY ACTIONS

1. Review any existing indicators of patient quality and safety
2. Gain patients’ perspectives on service quality
3. Review key elements of evidence-based care
4. Identify potential indicators of patient outcomes to test out with providers
BUPA hospitals monitor patient-reported outcome measures routinely

BUPA hospitals measure the physical and mental health status in all its hospitals before and after surgery for nine conditions; this example is a total hip replacement.

This information is available to patients and commissioners on the web. The hospital uses statistical process control-based methods to monitor any change in patient outcomes.

Source: BUPA Hospital, 2007

**EXAMPLES**

Measuring patient-reported outcomes allows commissioners and providers to monitor patients’ health gains

The BUPA experience offers lessons for any initiative to introduce routine outcome measures in the NHS:

- staff must be involved at all levels if their usage is to be successful
- care must be taken over how results are fed back to organisations
- routine outcomes measurement is feasible and can help to improve individual organisations’ performance.


Research commissioned by the Department of Health identified the following Patient-Reported Outcome Measures (PROMs) for routine use in treatment centres:

- Visual Function Index (VF-14) for cataract surgery
- Aberdeen Varicose Vein Questionnaire or varicose vein surgery
- Short Form Health Questionnaire (SF36) for patients undergoing hernia repair
- Oxford Hip Score for patients requiring hip replacement surgery
- Oxford Knee Score for patients requiring knee replacement surgery
- EQ5D, as a general measure.

These measures are a good place to start if you want to trial measuring PROMs for a patient pathway.

A suggested approach for commissioners to test out patient reported outcome measures are:

- measure at the point of decision for referral
- measure post-treatment (3-6 months): ideally this should link with a follow-up review in a clinically appropriate timescale.

Use the first small tests of change to test out the processes of capturing the information. For example, try the measure for one patient. The focus in the first instance is to test data capture systems, monitor and use. Once these are in place, build up the numbers. Again, test feedback mechanisms to providers and frontline staff.

“What an experience. What a significant group of enthusiastic and committed colleagues – it was fantastic. It’s a pleasure to see that patients are involved in the process – so often the patient has been ignored in the past, but the Collaborative is involving patients at all levels.”

Patient attending Coronary Heart Disease Collaborative workshop
HOW TO CARRY OUT ACTIONS - TIPS AND GUIDANCE

1 Develop clinical leaders, clinical partnerships and networks across the health economy, focusing on patient outcomes
   - emphasise leadership development through the Professional Executive Committee (PEC), and the Directors of Public Health
   - build on the existing engagement of clinical teams from across the economy in supporting positive pathway outcomes
   - support clinical leaders from across the patch
   - build on existing partnerships and networks with a focus on ensuring clarity of purpose and preventing duplication
   - understand different clinical perspectives along the pathway, both from a process and a patient outcomes perspective
   - share knowledge and data about patient outcomes, quality and best practice across the health economy
   - use process mapping or review existing nationally available pathways such as 18 Week Commissioning Pathways and Map of Medicine as a useful way to establish a common approach.

2 Develop patient and public involvement to bring in patients’ views
   - Apply key principles for effective patient and public involvement:
     - be clear about what involvement means i.e. gain a shared understanding of what is meant by involvement
     - focus on improvement i.e. demonstrate change following involvement
     - be clear about why you are involving patients i.e. be clear about objectives, rationale and relevance
     - identify and understand your stakeholders i.e. define who needs to be involved, informed and affected by the issue
     - involve people, especially from the hard to reach and vulnerable groups of patients.
   - Source: NHS National Centre for Involvement

3 Build on existing clinical governance arrangements, and clarify roles which enable improvement in patient outcomes
   - set up and build on collaborative relationships between clinical governance leads, for example PBC, commissioner, provider and SHA teams:
     - how do these link across the pathway?
   - assess what the local accountability arrangements for governance are, and who plays a role across the pathway, for example GPs with special interests
   - build a focus on aligning commissioning discussions to improve clinical and public health outcomes.

SUMMARY

The focus of this section is on supporting the development of clinical partnerships, networks and other mechanisms in order to strengthen a collective focus to improve patient outcomes along the patient pathway.

Strong clinical leadership and clinical engagement helps to drive improved patient outcomes, for example through a focus on clinical audit and changing clinical practice along pathways.

Clinical partnerships and networks, linking in clinicians who work along the pathway, can ensure a shared focus on patient outcomes and service improvement.

KEY ACTIONS

1 Develop clinical leaders, clinical partnerships and networks across the health economy, focusing on patient outcomes
2 Develop patient and public involvement to bring in patients’ views
3 Build on existing clinical governance arrangements, and clarify roles which enable improvement in patient outcomes
Clinical networks and partnerships are important across the health community

Research shows that there are a range of different types of network. The type of network or partnership will depend upon the stakeholder objectives.

Characteristics of an effective network:
- strikes a balance between autonomy and dependency
- establishes a position from which to exercise leverage
- avoids tight regulation
- ensures inclusiveness
- secures professional engagement
- fosters interdependency
- resists ‘capture’ from particular special interests or individual parties
- fosters a feeling of ‘net worth’ from membership
- secures ownership through contracts and agreements
- reviews and evaluates the network.


“In the residential development industry it is common for competing organisations to share the cost of surveys. This doesn’t prevent the competition between organisations and recognises that the potential market gain of having independent surveys is so marginal that it isn’t worth the additional cost.”
Andrew Taylor Land Director Taylor Wimpey Developments

This type of co-operation is common in the private sector. Are there potential gains for always sharing intelligence in patient and public involvement, audit and monitoring? For example, as part of a foundation trust application process a lot of work is required in this area. It would be helpful if providers could share this with commissioners.

“How about commissioners having contracts with patients and the public?”
No Delays Commissioner’s Network Meeting July 2007
HOW TO CARRY OUT ACTIONS - TIPS AND GUIDANCE

1 Ensure that key patient outcomes and indicators are agreed centrally across the pathway
   - test your approach to contracting patient outcomes on a couple of pathways, as a focus on patient outcomes is a new area for commissioning
   - use the provisions set out in schedule 3 of the NHS Acute Hospitals Services Contract to do this
   - set out key quality indicators or standards in the contract that clinicians support, the following is a checklist:
     - who will monitor the outcomes and what systems are needed to do this?
     - what are the implications of ongoing poor performance?
     - what is the mechanism for ensuring the ongoing development and implementation of key performance indicators which reflect local priorities against specific outcomes?
     - once Patient Reported Outcomes Measures (PROMS) have been tested, how will these be built into contracting processes?

2 Support the setting of ambitious health outcomes
   - develop these using locally agreed outcomes, within existing accountability frameworks, with clinical leaders from across the health economy
   - ensure flexibility in the contracting process to support setting ambitious health outcomes
   - establish a clear monitoring framework with specific outcomes within specified timescales
   - ensure the outcomes adhere to organisations’ strategic objectives
   - agree and build in a performance tolerance within the contract
   - there should be a demonstrable link to the public health agenda and improving health and well being for patients.

3 Ensure clear links to pathway performance
   - establish what actions will take place if patient outcomes are poor and what resolution procedures are needed and in place
   - understand the role of dispute and arbitration when setting health outcome indicators within the contract.

SUMMARY

Agreeing specific patient outcomes by phases of treatment helps to identify how well pathways are performing against agreed standards.

This is a new activity for commissioners to manage as any requirements for specific patient outcomes need local agreement. A focus is required to ascertain efficient and effective ways to achieve this focus on quality.

It will highlight if a pathway is underperforming, and supports the development of a multi-organisational approach to outcome setting and management. The following sections provide key guidance and steps in using the contracting process to set specific, measurable outcomes for patients in partnerships with their provider organisations.

KEY ACTIONS

1 Ensure that key patient outcomes and indicators are agreed centrally across the pathway
2 Support the setting of ambitious health outcomes
3 Ensure clear links to pathway performance
The Greater Manchester and Cheshire Cardiac Network monitors cancer survival rates on behalf of 10 PCTs.

Percentage range of patients expected to survive taking into account patients’ risk factors

Illustration reproduced with the permission of the Commission for Healthcare Audit and Inspection.
Source: http://heartsurgery/healthcarecommission.org.uk

For the latest online version of this guide, with resources, go to www.institute.nhs.uk/nodelays
Review patient outcomes to ensure continuous quality improvement

1 Clarify appropriate timings and timescales to review and monitor patient outcomes
   - clarify the appropriate timings and timescales to monitor and review outcome indicators, for example conduct a quarterly outcomes overview
   - ensure that existing clinical networks, partnerships and clinical assessments tie up with these reviews
   - some checks that may be useful are:
     - what outcomes and measures have been set and at what phase in the pathway?
     - who are the organisational contacts?
     - what mechanisms are already in place if outcome performance becomes problematic?
   - review any associated improvement plans and new measures of patient outcomes, such as Patient Reported Outcome Measures (PROMS).

2 Use Statistical Process Control to differentiate between usual or common variation and unusual or special cause variation
   - set the expectation that patient outcome data is monitored using Statistical Process Control charts to allow real-time monitoring
   - build on existing mechanisms to highlight issues or concerns with clinical governance
   - have a focus on joint problem solving with providers and ensure strong clinician to clinician input and engagement.

3 Review patient outcome measures periodically for usefulness and impact on quality
   - utilise patient experience and perceptions to drive change and ensure quality
   - review patient outcome measures, other indicators of quality of care and the evidence base with providers
   - assess the drivers or service characteristics that increase likelihood of better patient outcomes
   - identify any requirements for change in practice or services emerging from the reviews i.e. service re-provision or transformation.

SUMMARY

Quality indicators such as patient outcomes and patient experience are key measures of pathway performance.

Ongoing monitoring of patient outcomes can provide commissioners with a lever to drive service improvement. A focus on quality with regard to patient outcomes should be included in contract monitoring mechanisms. Clinical involvement is essential in this, and effective clinical networks or partnerships offer a mechanism to achieve this.

This section outlines mechanisms to review indicators of patient outcomes. Historically, the focus has been on the use of benchmarking as a catalyst for change, although in exceptional cases other interventions may be required.

KEY ACTIONS

1 Clarify appropriate timings and timescales to review and monitor patient outcomes
2 Use Statistical Process Control to differentiate between usual or common variation and unusual or special cause variation
3 Review patient outcome measures periodically for usefulness and impact on quality
Bristol Royal Infirmary was an outlier in Paediatric Cardiac Surgery death rates
Mortality Rate for Paediatric Cardiac surgery by trust, all open operations, aged under 1 year, HES April 1991 to March 1995

Example
The Bristol Inquiry on mortality rates for paediatric cardiac surgery

The Inquiry highlighted that even though data were available, no single organisation took responsibility for monitoring and raising concerns around quality. A lot of things have changed since the Inquiry and there are clearer structures around clinical governance in the NHS. A key check is to make sure that there are clear lines of responsibility and regular overviews.

The Bristol Inquiry showed that there were significant issues in quality of care, which could have been picked up by routine monitoring of data.

Commissioning for Patient Pathways

Service improvement and pathway redesign
HOW TO CARRY OUT ACTIONS - TIPS AND GUIDANCE

1 Assess the current work being undertaken to improve pathways
   - assess which service improvement initiatives are being undertaken to support the transformation of pathways:
     - how was the pathway prioritised, for example current pathway waiting times for high volume conditions?
     - what structures and methods exist for managing change for these initiatives, for example formalised project and programme methodologies?
     - who is accountable for these and how is progress being reported?
     - what opportunities are available to accelerate improvement?

2 Assess the potential impact of service improvement on pathway efficiency and effectiveness
   - assess performance of the pathway against key deliverables and standards:
     - how were these agreed within the local health economy?
   - identify potential impact of service improvement:
     - what are the high level patient flows across this pathway? use techniques such as value stream mapping and utilise best practice pathways
     - how well is the pathway performing? identify and review measures around pathway performance, resource utilisation and patient outcomes
     - what are the key issues in referral to treatment times? use charts within the No Delays Achiever to gain a baseline understanding
   - assess opportunities for more radical pathway transformation:
     - what are the opportunities for shifting services to alternative settings?
     - do the anticipated benefits outweigh the costs? quantify along a range of indicators to ensure the change is viable.

3 Identify requirements for change, for example workforce, planning, and finance
   - ensure from a commissioners perspective:
     - how can expectations be set out in plans? when is it appropriate to invest in change?
     - what strategies will be undertaken when setting out expectations for leading and facilitating change?
     - when and how could contracts flex around anticipated change?
   - ensure a healthcare community based perspective for planning:
     - what are the workforce requirements?
     - what, if any, are the changes in financial flows or finances?
     - what do different organisations need from each other to enable change?
     - who is responsible for leading multi-organisational pathway projects and programmes?

SUMMARY

Successful service improvement and transformation will deliver improved quality and value for patients for the long term. They provide opportunities for both providers and commissioners to utilise resources more effectively and identify potential for savings and opportunities for reinvestment.

Improving services for patients requires time for careful planning and preparation. Time spent on reviewing opportunities and planning often works out to be a worthwhile investment.

KEY ACTIONS

1 Assess the current work being undertaken to improve pathways
2 Assess the potential impact of service improvement on pathway efficiency and effectiveness
3 Identify requirements for change, for example workforce planning and finance
A systematic, health-community wide approach assessing the potential of service improvement and pathway redesign

The health community of Calderdale PCT, Calderdale and Huddersfield Foundation Trust and Kirklees PCT have co-ordinated their approach in looking at patient flow across whole care pathways, to support pathway redesign.

They have developed a tool using hospital data to look at pathways in a consistent way, regardless of specialty. Using the analysis as a starting point, each pathway is researched, a new pathway agreed and then implemented. This approach has also proven to be a good introduction to the health community for looking at data in this way. It has required an open and transparent approach, and has resulted in the feeling of the two PCTs and acute trust being in it together. They have succeeded in unifying pathways across the health community.

They looked at the top 20 high-volume HRGs, and began with the hip replacement pathway to test the tool and approach, setting up the systems and pulling the data together. Either side of PCT reorganisations, this first pathway took 4-5 months. Having learned through redesigning other pathways, the approach is being formalised to decrease the time from viewing the data to implementing the new pathway. Buy-in from primary and secondary care clinicians is growing continually.

They have found that even changing one pathway has had an impact across the whole specialty, for example reduced length of stay if a new process involves admission on the day of surgery.

They have applied the approach to endoscopy, pain services and minor skin surgery.

“Taking this approach, we really get a sense that we are in it together. The organisations were already working together at high-level, reconfiguring acute services. This was a natural step to look at the nitty gritty, building on existing relationships.”

Service Improvement Manager, Calderdale & Huddersfield Health Community

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**Calderdale, Huddersfield and Kirklees data analysis tool**

<table>
<thead>
<tr>
<th>GP referral</th>
<th>Out patients</th>
<th>Decision to treat</th>
<th>Treatment</th>
<th>Discharge</th>
</tr>
</thead>
<tbody>
<tr>
<td>Greater than 5 weeks?</td>
<td>Greater than 1 week?</td>
<td>Greater than 6 weeks?</td>
<td>Is an inpatient stay involved?</td>
<td></td>
</tr>
<tr>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td></td>
</tr>
</tbody>
</table>

**Greater than 5 weeks**

- What is the process for referral from GP, and are there delays?
- How many queues are there into outpatients, and can they be reduced?
- Should some patients be referred to a different health professional?
- What is the DNA rate or lost capacity?

**Clinical considerations**

- What is the new to follow-up ratio, and is it in the top quartile nationally?
- What is the conversion rate? If high, could there be direct referrals?

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HOW TO CARRY OUT ACTIONS - TIPS AND GUIDANCE

1 Develop relationships between PCTs, PBCs and providers based on a shared improvement focus
   - establish and enable a collective and collaborative approach to problem sharing and solving across organisations along the pathway:
     - build on existing multi-organisational boards and groups that already have an overview of the pathway
     - have clear and defined roles across organisational relationship boundaries
     - ensure that there are clearly defined processes in place to address problems when they arise.

2 Understand stakeholder groups through their motivations, needs and requirements
   - understand the requirements of commissioners and providers involved in service improvement:
     - undertake a stakeholder analysis to ascertain the individual benefits required by groups and individuals to deliver the identified changes
     - identify and agree outcomes as a collective
     - identify what tools and techniques are available to support relationship building
     - assess the skill set commissioners have to lead and, or to enable service improvement, for example negotiation, influencing and managing the human dimensions of change.

3 Ensure that there is clinical leadership capability across the health community
   - create or build upon any existing networks of people who lead improvement initiatives across the health community with appropriate links to the PEC
   - actively develop and appoint strong clinical leadership within the local economy:
     - use their expertise to identify what changes need to take place
     - work with them to focus on key indicators that assess the current position of the pathway, for example looking at new to follow up ratios within outpatients
     - consider releasing GP time to work with providers in making sustainable changes to the pathway.

4 Develop strong relationships that can flex according to roles and requirements
   - anticipate and plan for how you wish to relate to others in your different roles and in different situations
   - focus on building trust between key individuals
   - ensure a focus on those individuals who are highly influential and can support change.

SUMMARY

Successful relationship management enables organisations to approach and solve identified problems as a collaborative, and therefore facilitates service improvement and service redesign.

Shared understanding and ownership of the patient pathway also empowers organisations to react quickly when making pathway changes, and supports the establishment of good network and communication systems.

KEY ACTIONS

1 Develop relationships between PCTs, PBCs and providers based on a shared improvement focus
2 Understand stakeholder groups through their motivations, needs and requirements
3 Ensure that there is clinical leadership capability across the health community
4 Develop strong relationships that can flex according to roles and requirements
Practice based commissioners lead service redesign

A Service Development Manager in Ealing PCT used the 18 week commissioning pathways as a way to engage practice based commissioners (PBC) in service redesign. Each PBC considered several pathways in detail and undertook a gap analysis comparing their current practice with that shown in the pathways. Once the groups had considered the pathways, they shared their discussions with the other groups, so all PBC groups eventually considered all the pathways. The pathways generated lively discussions about 18 weeks, and GPs went on to request the involvement of secondary care colleagues for joint pathway redesign work.

Real clinical engagement and clinical leadership make service improvement happen

Influencing
- Direct one to one discussions
- Group presentations
- Personal example
- Challenge unhelpful behaviours

Communicating
- Clarity about vision and objectives
- Providing successful examples from early work
- Public speaking to stakeholders

“Clinicians will make varying contributions to improvement work, depending on their aptitudes, areas of interest and degree of commitment. However, they will definitely need support from other improvement leaders as well as peer support from others in similar roles. Their role is challenging and it is important that they maintain credibility with colleagues.”

Leading Improvement: Improvement Leaders Guide, NHS Institute for Innovation & Improvement

EXAMPLES

Thinking and behaviour in complex systems

Commissioners have a range of levers they can apply to ensure that services for patients improve, and that they develop in the context of an overall aim of health improvement. A part of this role is to understand what drives thinking and behaviour in complex systems. Paul Plesk and Sarah Garrett developed the following perspective called ‘patterns’. Patterns include values, trust and how various groups communicate with one another. Their research identified that fundamental improvement often occurs when patterns in the system are changed and challenged.

They identified five dimensions of patterns:

- **Relationships**: do the interactions among the various parts of the system generate energy and innovative ideas for change, or do they drain the organisation?
- **Decision-making**: are decisions about change made rapidly and by the people with the most knowledge of the issue, or is change bogged down in a treacle of hierarchy and position authority?
- **Power**: do individuals and groups acquire and exercise power in positive, constructive ways toward a collective purpose, or is power coveted and used mainly for self-interest and self-preservation?
- **Conflict**: are conflicts and differences of opinion embraced as opportunities to discover new ways of working, or are these seen as negative and destructive?
- **Learning**: is the system naturally curious and eager to learn more about itself and about what might be better, or is new thinking viewed mainly as potentially risky and threatening to the status quo?

Service improvement initiatives often focus on improved structures and processes. An approach that provides a safe environment to enable honest dialogue about the five key patterns above and ways to modify these can enable service transformation to take place.
HOW TO CARRY OUT ACTIONS - TIPS AND GUIDANCE

1 Set appropriate improvement outcomes within the contracting process that allow for pathway changes to take effect
   • build service improvement initiatives into the contracting process by setting the expectations for service improvement:
     • how has the anticipated impact been defined and linked with the contract or service specification?
     • do they allow realistic timescales for pathway changes to take effect?
     • how will the contract flex as the impact of service improvement has been realised, taking into account uncertainties of size and timing of impacts?
     • how will the anticipated outcomes be monitored and reviewed?

2 Have a whole pathway focus, ensuring primary care elements are considered
   • identify the service improvements associated with the pathway that will deliver the best outcomes against cost and time:
     • have a mechanism to agree initiatives locally, for example through the PEC
     • ensure that changes are in line with best practice
     • ensure that the changes have set out the expected impacts and benefits and tie in with local priorities
     • ensure that there is clarity on who is leading the change and the role of commissioners, for example PCTs or Practice Based Commissioners (PBC) leading on providing ‘Care Closer to Home’ initiatives
     • how is this being managed? establish the assessment and monitoring framework and clarify who has accountability for delivery
     • how will these initiatives support PBCs and GPs in driving changes?
     • how are lead clinicians involved in the contracting process, including PBC?

3 Use contracting as a positive lever for service change
   • agree improvement outcomes within the contract and directly with providers, to help ensure delivery of the aims and objectives of the initiative:
     • ensure that aims and objectives are realistic, and reflected in the contract specification
     • identify, plan for and implement contact changes required as a result of service redesign; for example, changes in local agreements and activity plans
     • use the contract cycle to identify risks within the change cycle, so that proactive risk management can occur
     • ensure that contracting takes account of the inherent uncertainties around delivery of service improvement, with an approach that is developmental and enabling rather than punitive.

SUMMARY

Commissioning for service improvement to improve outcomes, efficiency and timeliness should be a joint activity across the local health economy. There has been an historical pattern of organisations setting and delivering the service improvement agenda independently from one another. Agreeing and setting outcomes of service improvements within contracts means that focus is sustained by all involved in the patient’s journey.

KEY ACTIONS

1 Set appropriate improvement outcomes within the contracting process that allow for pathway changes to take effect
2 Have a whole pathway focus, ensuring primary care elements are considered
3 Use contracting as a positive lever for service change
All parties need see the benefits of service transformation

A lot of service transformation focuses on providing care closer to home or in community settings. The threat of losing services can impede innovation and result in organisations trying to maintain the status quo. Acute trusts need to explore potential for providing services in alternative settings.

“We have found out that it is better to develop shared principles around what services can be provided by the local Acute trust in a different setting, and what needs to go out to tender. We do this early on in the process of planning for change. By doing this openly, and jointly creates the environment for staff to be creative and engage in the process, without the anxiety that their work will transfer elsewhere.”

Director Integrated Services Strategy

Service transformation requires partnerships in the long-term.

EXAMPLES

Leeds PCT’s service improvement business plan template

Leeds PCT have developed a structured approach with Practice Based Commissioners (PBC) to plan service improvement and ensure links with national and local priorities. The PCT developed a draft template, which PBC used as a working document, so that the PCT could revise and develop the approach through use.

The business planning approach builds in information from activity plans for example, describing the capacity available in the local acute trust, alongside the anticipated activity requirements on the pathway.

Central Manchester PCT

Central Manchester PCT initiated a project through their main acute care provider Central Manchester and Manchester Children’s University Hospitals NHS Trust.

The PCT worked with practices to develop a PBC cluster model for commissioning locally agreed services from October 2006. This included establishing a PBC board that has identified priority services for development, such as emergency care and outpatient services.

The PBC Board identified the need to review and improve gynaecology care, with a particular focus on shifting inappropriate outpatient activity to primary care. The purpose of the project was to: define the activities currently undertaken within secondary care that could reasonably be delivered within primary care, identify the obstacles preventing primary care from undertaking this work, and to test the impact of a redesigned care pathway.

They agreed an infertility clinical pathway with referral protocols to ensure consistency in the management of patients in primary care. This pathway now reinforces current good practice, and sets out appropriate primary care management including the investigations to be undertaken prior to referral to secondary care.

Source: NHS Institute for Innovation and Improvement.
Case studies from the Care Closer to Home: Making the Shift programme (2006)

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**HOW TO CARRY OUT ACTIONS - TIPS AND GUIDANCE**

1. **Monitor the impact of service improvements, anticipating time-lags for change to take effect**
   - monitor the anticipated impact on performance measures, for example a phase of treatment or referral to treatment times
   - where performance has improved:
     - is change associated with short-term waiting list initiatives?
       - if so, retain the focus on service improvement
     - is change associated with underlying service improvements?
       - if so, focus on extracting what worked
   - where performance remains the same:
     - short-term solutions may be needed alongside long-term sustainable options
   - discuss options with providers:
     - is the process stable? if so, consider supporting short-term solutions
     - is the process unstable? if so, service improvement is a high priority as short-term solutions are at greater risk of not being sustained
   - follow an agreed project or programme management framework to review and monitor progress.

2. **Support providers as required, to accelerate improvement across the pathway**
   - lead or oversee whole system transformation initiatives that shift patient care, for example diagnostic procedures performed within the community as opposed to acute hospitals
   - ask providers how commissioning could help to speed up progress, for example:
     - setting up whole system pathway redesign groups
     - using commissioning levers to help unlock problems that are outside one provider’s control
   - ensure that service improvements and redesign demonstrate good practice
   - consider acting in the role of a ‘critical friend’.

3. **Celebrate successes and value the learning from mistakes, to build expertise across the health community**
   - build on existing networks to identify areas of best practice, what does and does not work across providers
   - support the learning and sharing of best practice across the whole health community
   - review the commissioning role in service improvement and pathway redesign.

**SUMMARY**

Commissioners can actively set and review service improvement initiatives as part of a drive for better services. They have additional roles in: leading projects that shift care from providers to alternative settings; using commissioning levers to help unlock problems that are outside a single provider’s control; and taking a whole health economy approach.

The emphasis should be on:

- being positive and encouraging a service improvement focus
- enabling and facilitating change
- challenging progress as a ‘critical friend’.

This requires taking a realistic view of service improvement, particularly what to expect and when to expect it.

**KEY ACTIONS**

1. **Monitor the impact of service improvements, anticipating time-lags for change to take effect**
2. **Support providers as required, to accelerate improvements across the pathway**
3. **Celebrate successes and value the learning from mistakes, to build expertise across the health community**
A typical service improvement trajectory: performance can get worse before it gets better

![Graph showing referral to treatment times for Ear, Nose and Throat Services. Services are underperforming but stable prior to commencing service improvement. As changes take effect, performance becomes more variable. This is typical and should not cause alarm. For example, it takes time as staff learn new systems and processes or tackle the backlog of patients. Allow time for the new systems and processes to take effect, as this period of disruptive change settles into a stable, higher-performing service.

The time it takes from a service improvement initiative from start to the point of gaining sustainable results will also vary depending upon the scale and complexity of the project and the engagement of staff.

Examples

A typical service improvement trajectory

Often service improvement follows a typical trajectory, although specific timescales and the degree of impact differ between projects. These should form the foundation of a supportive, yet challenging, approach to commissioning for service improvement.

The graph shows referral to treatment times for Ear, Nose and Throat Services. Services are underperforming but stable prior to commencing service improvement.

As changes take effect, performance becomes more variable. This is typical and should not cause alarm. For example, it takes time as staff learn new systems and processes or tackle the backlog of patients. Allow time for the new systems and processes to take effect, as this period of disruptive change settles into a stable, higher-performing service.

The time it takes from a service improvement initiative from start to the point of gaining sustainable results will also vary depending upon the scale and complexity of the project and the engagement of staff.

Critical friend’ service improvement questions

How has the provider:

- ensured that best practice improvement methods are being used, for example process mapping, and clinical engagement?
- designed services to increase the number of parallel processes and value added steps? for example one stop clinics, direct access to diagnostics, improved booking processes, and fewer outpatient follow-ups
- reviewed capacity and demand, and variation in capacity and demand?
- reduced variation in processes, for example tackled batching and carve-out and ensured that patients, their paperwork and tests, are seen and treated in order?

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Commissioning for Patient Pathways
Demand, capacity and activity
Establish activity and capacity plans in line with projected demand

1. Analyse the total available capacity across the patch
   - identify available services, include the independent and community sectors
   - review use of resources and capacity constraints with the provider; waiting lists can indicate capacity problems.

2. Plan activity based on forecast demand, backlog and appropriate clearance times
   - develop an understanding of current demand, future demand and reduction in backlogs required to meet access targets:
     - use patient demographics and joint needs assessment as a useful starting point
     - review benchmarked indicators of demand and activity, for example referral rates, conversion rates and existing information on thresholds
     - identify activity requirements along the pathway, for example outpatient appointments and length of stay
     - anticipate the potential impact of patient choice across local provider and specialist services
     - ensure links with clinical governance groups around affordability of relevant NICE guidance recommendations and understand the PCT views
   - develop an understanding of the dynamic aspects of demand over the previous year:
     - obtain data directly from providers or the NHS Information Centre, use third party suppliers as necessary
     - plot total number of referrals, (for example GP, consultant to consultant and others), on a weekly and monthly basis in a statistical control chart
     - check if there is variation in conversion rates and subsequent activity
     - plot demand and activity on the same graph; remember that non-recurrent activity and time-lags mean that activity in one month can be greater than new demand.
   - identify existing backlogs along the pathway and review historical management of this:
     - identify the number of patients on active and hidden waiting lists
     - review variation in last year’s activity with providers to understand underlying cause, for example seasonal patterns.

3. Set activity plans in the context of the budget
   - plan future activity requirements based on forecast demand and the required reduction in backlog
   - discuss providers’ operating capacity to meet variation in demand, usually 85 per cent of variation in demand
   - plan for the current and future commissioning years
   - be clear about exclusions to treatment and communicate these to both GPs and providers.

SUMMARY

Activity requirements are driven by demand for services and backlog. In turn, demand is driven by a number of factors including patient needs, clinical decision making and patients’ choice. Available capacity within local services determines the actual activity that is carried out.

Forecasting activity requirements is a core commissioning function. There are a range of elements within this function, including forecasting in and beyond the current commissioning year, reviewing resource utilisation, and understanding the dynamics of demand and meeting access targets.

KEY ACTIONS

1. Analyse the total available capacity across the patch
2. Plan activity based on forecast demand, backlog and appropriate clearance times
   - develop an understanding of current and future demand, and backlog
   - develop an understanding of the dynamics of demand
   - identify existing backlog along the pathway and historical management of backlog.
3. Set activity plans in the context of the budget
If a provider has greater than expected admission rates for a procedure or diagnostic test, it is likely that they have low thresholds for interventions.

Any organisation above the yellow line, as shown on the opposite control chart, is statistically different from the others. Understanding the reasons and acting on these could save resources and reduce interventions that may not be beneficial to patients. Clinicians can provide a good insight through peer review.

Comparisons like this can be used to look at referral rates by GPs.

**Examples**

If a provider has greater than expected admission rates for a procedure or diagnostic test, it is likely that they have low thresholds for interventions.

Any organisation above the yellow line, as shown on the opposite control chart, is statistically different from the others. Understanding the reasons and acting on these could save resources and reduce interventions that may not be beneficial to patients. Clinicians can provide a good insight through peer review.

Comparisons like this can be used to look at referral rates by GPs.

**Benchmarking and review of outpatient referrals**

Birmingham East and North PCT has a programme of reviewing and benchmarking outpatient referrals that has produced an average 21 per cent reduction in outpatient referrals, 31 per cent in some localities since April 2006. This has resulted in an estimated £2 million saving by the end of the financial year.

“I met with a hospital the other day and their approach to achieving 18 weeks was to use Primary Targeted List. Each month the hospital reviewed the PTL and pulled patients who were about to breach through the system to speed up their access to treatment. Each month the same problem occurred. This is a very expensive way to manage waiting lists in terms of costs, human resources and risk. The hospital is constantly working on the edge of its capacity and one month this strategy won’t be successful.”


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Ensure realistic activity planning through relationship building

SUMMARY

Activity plans are a common and contractual focus in commissioner and provider relationships. This section focuses on building relationships that use the processes around activity planning and monitoring.

A key requirement is good and transparent communication. The focus should be on developing or sustaining relationships that are agile, with commissioners and providers taking different roles depending upon circumstances.

KEY ACTIONS

1. Understand providers’ perspective and expectations of activity, income and commitment to quality improvement
2. Develop an approach around activity planning that builds upon good communication
3. Identify situations where the type of relationship may need to change
4. Engage with other key stakeholders

HOW TO CARRY OUT ACTIONS - TIPS AND GUIDANCE

1. Understand providers’ perspectives and expectations of activity, income and commitment to quality improvement
   - sign off headline principles around strategy and objectives for the pathway:
     - set the pathway in the context of an agreed vision across the health economy
     - understand the contracting and SLA opportunities in setting out what commissioners need and what providers can deliver
   - understand your main providers’ perspectives, including non-acute providers:
     - share objectives, aspirations and concerns
     - carry out joint scenario analysis around activity planning as one way to determine perspectives
     - identify risks and opportunities in proposed activity plans for the immediate and long term
     - understand each others financial bottom line.

2. Develop an approach around activity planning that builds upon good communication
   - aim to set and sign off the organisational ground rules as a starting principle. Early agreement ensures that clear, specific expectations are understood by all
     - investing time in relationships helps support achievements in the longer term
     - exercise tolerance and flexibility when there are genuine problems in delivery and this allows for quicker resolution
     - communicate any headline messages to your providers regularly.

3. Identify situations where the type of relationship may need to change
   - identify the characteristics that define your current relationship with the provider for this pathway:
     - is it reactive, proactive or collaborative?
     - is it developmental? does it inherently embrace performance management?
     - is communication transparent?
     - is it transactional or strategic?
   - identify what circumstances might change this:
     - along the commissioning cycle
     - whilst reviewing the performance of the pathway
     - use scenarios to help to discuss likely events.

4. Engage with other key stakeholders
   - support the development of provider markets and Practice Based Commissioning:
     - support enthusiasm in Practice Based Commissioning yet enable shared focus of key problem areas in the health community
     - overcome any ideological barriers in the use of the independent sector in a pluralistic economy
     - establish relationships with long-distance providers and lead commissioners.
Commissioning needs sophisticated and agile working relationships

The sophisticated element is about having the ability, insight and control to use the most appropriate relationship at the most appropriate time to achieve the right outcomes.

<table>
<thead>
<tr>
<th>Buyer/supplier relationship</th>
<th>Approach</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reactive</td>
<td>A competitive approach might be adapted to breath new life into the market to promote creativity in cost and function</td>
<td><strong>An ideal conversation:</strong> Tackle variation in demand and capacity head on to reduce the risk of waiting lists forming and to reduce operating costs</td>
</tr>
<tr>
<td>Proactive</td>
<td>Whilst initial competition might support the establishment of the contract, commissioners may wish to encourage an increasingly cooperative relationship as trust is built over time</td>
<td><strong>Commissioner:</strong> “We need to commission 30 day case procedures per week within an 18 week referral to treatment pathway. What is the likely pattern of variation per week?”</td>
</tr>
<tr>
<td>Collaborative</td>
<td>Here a cooperative relationship is preferred as trust is well established and some relational contracting exists</td>
<td><strong>Provider:</strong> “We are able now to count all the referrals (through our Choose and Book service) and all the additions to the waiting list. This is the pattern of the weekly additions to this day case waiting list. You can see the average additions are 30 day case procedures a week, but the normal variation can be from 25 to 35.”</td>
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<td></td>
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<td><strong>Commissioner:</strong> “To provide a service that prevents a waiting list you need to provide 32 day case operating slots a week to meet our activity requirements per week and meet 18 week pathways.”</td>
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<td></td>
<td></td>
<td><strong>Provider:</strong> “We need to reduce operating costs to be able to do this. we believe we can reduce these operating costs by reducing the variation in demand. Part of the variation is due to case mix and part is due to the numbers added to the day case list.”</td>
</tr>
<tr>
<td></td>
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<td><strong>Commissioner:</strong> “So where do we go from here? Do you have information that will help us to review these together?”</td>
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<td></td>
<td></td>
<td><strong>Provider:</strong> “Yes. Our starting point is to look at these peaks in the additions to the day case waiting lists. These seem to have a monthly pattern to them. Let’s check: are these due to a monthly dermatology clinic you are running in the PCT? Could you smooth those clinics to fortnightly or weekly? Meanwhile, if we look at a Pareto chart of the demand we can see that 50 per cent of the day case procedures are excisions of skin lesions under local anaesthetic. I think we could provide a room in theatre every morning to deal with these – your GPSI and any dermatologist could book these directly. This would deal with 50 per cent of the day case demand and that demand could have minimal variation in relation to the volumes going through. We could get this to run very efficiently.”</td>
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<td><strong>Commissioner:</strong> “OK. let’s start planning from here. I understand that another potential area is to ensure a focus of reducing variation in capacity. For example making sure that staff are scheduled around demand and that work is segmented according to the type and volume of patients. We could use a Pareto analysis and look at referral patterns together. Let’s build this into our plans.”</td>
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By Kate Silvester, BSc MBA FRCOphth Osprey Programme Coach

Source: Dickenson, 2006
HOW TO CARRY OUT ACTIONS - TIPS AND GUIDANCE

1 Negotiate and agree activity and local delivery plans
   - identify total activity requirements for the pathway based on knowledge around demand, capacity and backlog:
     - focus on areas such as recurrent activity, both the monthly averages and likely upper and lower control limits, and likely changes due to a change in demand
     - understand the non-recurrent activity requirements, for example backlog when referral to treatment times are reduced
   - identify the key ‘supply-side’ characteristics required to deliver the planned activity levels along the pathway, for example:
     - Care Closer to Home initiatives
     - providers’ capability in managing normal variations in demand across pathways
   - identify core indicators that give an overview of pathway performance and shift in demand against an agreed tolerance range, examples include:
     - referral rates
     - conversion rates from referral to inpatient and daycase treatments
     - referral to treatment time and phase of treatment over known bottlenecks
     - compliance with prior approval and utilisation management schemes
   - ensure that there are plans to improve the timeliness and quality of data, for example:
     - weekly data for high volume pathways can indicate early changes in performance or demand
   - monthly data should be available, and this should be reflected within local agreements.

2 Develop scenarios to anticipate and plan for actions on deviations around original plan
   - develop scenarios to plan actions with providers around the upper and lower range of expected activity plans and performance profiles; some simple scenarios include:
     - higher than expected average activity, for example due to an increase in real demand
     - higher than expected variation in activity, for example indicating an operating issue of a pathway
     - lower than expected average activity, for example the effect of patient choice.

3 Plan for, and use the NHS Contract for Acute Hospital Services
   - ensure mechanisms are in place to review, monitor and change activity plans regularly
   - use financial incentives and sanctions to mitigate risk for over performance and compliance with pathway performance
   - implement capacity review mechanisms to ensure that providers are operating at a reasonable level of efficiency.

SUMMARY

The procurement and contracting processes provide the mechanisms for commissioners to secure effective and efficient delivery of appropriate activity levels, and supports the management of demand.

These processes can unlock opportunities to shape the local health economy to deliver services along redesigned pathways, including the ability to provide care closer to home. The NHS Contract for Acute Hospital Services and GMS Contract provide mechanisms to manage demand and activity. This includes proactive monitoring, care and resource utilisation schemes and the use of incentives and sanctions.

KEY ACTIONS

1 Negotiate and agree activity and local delivery plans
2 Develop scenarios to anticipate and plan for actions on deviations around the original plan
3 Plan for, and use the NHS Contract for Acute Hospital Services
A scenario: developing a framework to reduce ‘in-house’ referrals

A PCT wanted to develop initiatives which encouraged effective referral patterns and strengthened contract management, linked to improving patient pathways to support achievement of 18 weeks.

They collectively developed and agreed the strategic context with partner organisations. These include:

- improving the quality of patient care
- meeting national targets
- delivering financial savings.

They collectively agreed and set the strategic content into specific, achievable goals. These include:

- ensuring GP is a central co-ordinator of care
- ensuring patients have the opportunity to discuss treatment options and choice
- setting ambitious targets for acute trust performance over a three year period
- ensuring patients receive care in the right place: are not referred unnecessarily to the acute setting.

The PCT then developed these into a service specification based on:

- clear definitions
- clear processes
- any exceptions
- what is included in the contract
- what is assumed in the activity
- how performance is managed
- what will be measured.

The strategy was agreed by PCTs and providers and implemented through the service specifications.

For example:

A review identified that a provider trust had significantly lower surgical thresholds for a treatment compared with national indicators. The host PCT discussed this with their provider, and based on a clinician to clinician discussions, they agreed an improvement trajectory. To support this, both parties agreed a clear care pathway for patients, and the revised treatment thresholds were built into the amended contract. They jointly monitored the change in the thresholds to review progress.

This approach, although difficult to agree in the first instance, supported an increase in the procedural threshold levels and changed the provider’s performance.
Monitor and review activity and demand

**HOW TO CARRY OUT ACTIONS - TIPS AND GUIDANCE**

1. **Use Statistical Process Control to monitor activity and demand**
   - regularly review Statistical Process Control charts, based on at least 12 months activity data to help identify changes in pathway performance:
     - if a Statistical Process Control rule is broken, for example a data point is above or below the control limit, work with your providers to identify what happened
     - monitor weekly activity and demand to speed up the detection of change
     - monitor other indicators of pathway performance, especially those that are directly related to activity, for example conversion rates
     - use trends to support decision making.

2. **Develop monitoring systems to identify when demand and activity profiles are outside the activity plan**
   - ensure the clear delegation of roles and responsibilities for monthly contract monitoring meetings
   - ensure that Practice Based Commissioners have timely access to information on provider and GP activity and demand
   - apply predetermined plans of action where demand, activity or performance falls outside the expected or required range, for example:
     - what are the underlying reasons? this will build up knowledge for future activity planning and help decision making about next steps
     - are there exceptional circumstances?
     - what steps do the provider and commissioner need to take, either to solve the problem or to reduce its impact?
     - do financial adjustments need to be applied, and how are these reflected within the contract?
   - the focus of these monitoring systems should be on joint problem solving and developing a shared knowledge base to refine future activity planning.

3. **Monitor the impact of patient choice**
   - monitor the total numbers of patients exercising choice, on a weekly or monthly basis
   - identify where patients are choosing to go for treatment to allow for necessary re-evaluation of activity profiles.

4. **Review resource utilisation**
   - Identify and review specific indicators, for example:
     - pre-operative length of stay compared to national average and day-case utilisation rates
     - check independent sector treatment centre utilisation rates for planned and diagnostic procedures
     - monitor activity and impact of services such as Clinical Assessment and Treatment services.

**SUMMARY**

Commissioners will have clear mechanisms to monitor actual activity against planned activity.

This section focuses on the use of Statistical Process Control (SPC) as a tool to help commissioners and providers to monitor activity and demand. It will help to distinguish between normal variation within processes and more significant changes to processes. SPC can highlight when something exceptional has occurred within a process, supporting providers and commissioners in joint problem solving and tracking service improvements.

**KEY ACTIONS**

1. Use Statistical Process Control to monitor activity and demand
2. Develop monitoring systems to identify when demand and activity profiles are outside the activity plan
3. Monitor the impact of patient choice
4. Review resource utilisation
East Lindsey PBC Cluster

The graph to the left is an activity report showing information analysed using Statistical Process Control methodology. The data were taken from an acute hospital trust.

This chart shows a trend of weekly activity, by discharge date, for a PBC cluster. This activity is for patients attending acute trusts and excludes mental health and treatment centre activity. The PBC cluster used these reports to monitor performance.

The Head of Performance at the PCT commented “Yes, we are now using SPC charts for most monitoring purposes. Anecdotal feedback from GPs is that they like it.”

Run chart of planned versus actual activity; is there a change in the level of activity?

The SPC chart shows the difference between planned and actual activity

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Commissioning for Patient Pathways

Pathway performance
Plan to achieve highly performing pathways

HOW TO CARRY OUT ACTIONS - TIPS AND GUIDANCE

1  Review key data, and benchmark where possible
   • build on any existing reviews of pathway performance and examine any nationally available information such as the 18 week commissioning pathways
   • capture and review data that indicates the level of provider performance
   • identify areas of best practice and replicate these across the pathway
   • actively engage and support practice based commissioners to review data and develop their own monitoring systems
   • provide a focus for identifying the causes of problems, in particular those areas where patients are transferred between organisations.
   • assess what pathway redesign activities, for example process mapping are taking place with key stakeholders.

2  Understand the risks around meeting 18 weeks
   • review, or support a review, of patterns of variation and risks in meeting 18 week pathways
   • identify and agree trigger points along the pathway that indicate a change in performance has taken place, for example:
     • referral to treatment times
     • referral patterns, like consultant to consultant referrals
     • changing patterns of referrals as patients exercise choice
     • phases of treatment around existing, identified pathway bottlenecks, for example diagnostics, theatres or beds
     • readmission rates
   • review existing escalation plans, revise and agree plans with providers.

3  Anticipate the potential impact of service change on pathway performance
   • proactively commission and plan appropriate service improvement initiatives to allow improved performance
   • anticipate the impact of service improvement on pathway performance, bearing in mind that there can be temporary dips in performance before measurable progress.

4  Develop mechanisms to monitor pathway performance for choice
   • are patients exercising choice, and if so where are they moving from, to?
   • is there a single information system that captures where a patient is on the pathway when exercising choice?
     • how can the Choose and Book system be used?
     • how can PBC support pathway performance?
   • is there any local information on the reasons for patients choosing alternative providers, for example, location, distance, waiting times?
   • is this having an impact on the performance of the pathway, for example saturation of a provider service?
   • what process is in place to ensure maximum distribution of referrals to support the efficient use of provider services?

SUMMARY

Commissioners and providers should assess pathway performance from a risk assessment and management perspective. As well as setting out expected levels of performance and agreeing plans for improvement, there should be a focus on proactive performance management.

Both commissioners and providers will benefit from an overview of high volume ‘at risk’ pathways. This means, for example, that they can set and agree early warning signs that allow interventions to be developed and implemented. Areas of performance may include referral to treatment times, resource utilisation, and reliability of pathways for patients exercising choice.

KEY ACTIONS

1  Review key data, and benchmark where possible
2  Understand the risks around meeting 18 weeks
3  Anticipate the potential impact of service change on pathway performance
4  Develop mechanisms to monitor pathway performance for choice
High readmission rates can indicate a problem along a pathway and are an inefficient use of resources. Although there will always be some readmission rates, rates that are significantly higher than the norm warrant investigation.

Unnecessary readmission rates impact an organisation’s ability to manage patient flow, and may mean other patients waiting longer than necessary.

Source: Focus On: Cholecystectomy NHS Institute for Innovation and Improvement (2006)
Develop positive relationship behaviours to support pathway performance

SUMMARY

At a strategic level, relationships should focus on joint decision making and shared risk taking across organisations in the health community.

However, effective management of pathway performance is within the control of clinical and operational teams. This is because it is within their influence to make changes quickly if there are problems. Commissioners therefore need to develop a proactive approach to performance management that does not interfere with clinical management. They can also ensure that teams located in different organisations along a pathway have access to timely information about performance.

KEY ACTIONS

1. Focus on developing a greater shared understanding of pathway constraints and risks
2. Ensure robust relationships and supporting communication systems
3. Discuss and plan for the use of available contractual levers

HOW TO CARRY OUT ACTIONS - TIPS AND GUIDANCE

1. Focus on developing a greater shared understanding of pathway constraints and risks
   - improve the shared understanding of pathway constraints, using the following as a prompt:
     - for example, radiology or within the diagnostic phase of the pathway?
     - have organisations formalised and shared pathway risks?
   - what pathway ‘trigger points’ exist as an early indication of pathway performance?
     - were these set in conjunction with providers, or clinicians?
     - have they been signed off as a collective?
   - clarify communication systems across the pathway and the escalation mechanisms to be used if problems are not resolved.

2. Ensure robust relationships and supporting communication systems
   - have a collective aim that local clinical teams own and manage the performance of the patient pathway
   - encourage GP interest by framing performance from their perspective, for example 18 weeks gives:
     - reduced waiting times for patients
     - the potential to provide direct access to some diagnostics tests
     - the potential to improve discharge information for patients and GPs
     - provide outpatient activity closer to home
   - ensure that there are clear communication and feedback mechanisms on performance, with a focus on format and use of language
   - build on existing organisational forums and ensure that there are clear roles and remits for when issues are flagged up
   - identify who has accountability within organisations to implement corrective actions, and be clear in the approach and expectations within and between organisations.

3. Discuss and plan for the use of available contractual levers
   - understand the principles and processes underpinning the use of contractual levers and their likely impact on relationships
   - build a shared understanding of what actions can be taken, for example, if pathway performance does not improve:
     - use the commissioning framework and proactive relationship management
     - identify how the levers support pathway management, for example change of provider or pathway redesign.
In February 2006, Oldham PCT developed an action plan for 18 weeks based on four key themes:

1. **Technical strategy:** to refine measurement systems and develop a “Primary Targeted List” system that tracks patients on a pathway by phase and by time. At the core is a series of key performance indicators based on a critical path (the shortest time possible to complete the pathway within normal expected variation). These indicators act as trigger points. If patients experience unusual delay at any phase, this signals a warning that allows providers to solve the root cause of the problem and reduce the impact of the delay.

2. **Alignment:** to ensure that achievement of 18 week pathways is seen as being part of an overall scheduled care strategy including quality and value.

3. **Clinical pathways:** the PCT strategy to improve quality and value through a care management approach.

4. **Commissioning system changes and supply system management:** the use of supply chain management approaches and appropriate contracting and performance monitoring to ensure that trajectories for improvement are agreed and delivered through contracting systems.

Oldham PCT performance management strategy focuses on trigger points along patient pathways. They have ensured that there is strong clinical ownership of these, as they involved the Intermediate Care Assessment Team’s clinical leads in the development of measurement systems.

Although the PCT expects the acute trusts and other providers to supply data on a weekly basis to help the PCT’s performance overview, the PCT feels that a more strategic role in pathway management is required. Through discussion with local senior clinicians, they recognise that care pathway management is a significant priority for the health economy. Whilst the PCT and the commissioning GPs are keen to define care pathways and set commissioning and contractual standards, they also feel that clinical teams within contracted suppliers should be given the autonomy to control their own clinical domains. This is within a commissioned, governance backed framework.

Oldham PCT plans to use the levers in the NHS Acute Hospital Services contract, both building on the NHS experience of use of levers for private sector providers and in discussion with NHS providers.

They are anticipating changes in the relationship with providers when negotiating contracts, but anticipate that a joint approach to work through their application will ensure a fair, transparent and sustainable process.

“Supermarkets don’t have individual contracts for the 60,000 different items they have on sale. They have terms of business - both the supplier and the supermarket have their own terms of business which the other party agrees to accept or not. The focus of discussion is on a deal: price and where in the store the item is located.”

Expert in commissioning, 2007
HOW TO CARRY OUT ACTIONS - TIPS AND GUIDANCE

1 Create expectations of data and information exchange
   • ensure that the data requirements for providers and Practice Based Commissioners are identified and met through the contracting process
   • build on the monitoring mechanisms already developed by acute providers, for example highlight and exception reports
   • build on the data template in the NHS Contract for Acute Hospital Services for data requirements
   • consider requesting weekly data for areas of particular concern as this will allow earlier identification of shifts in performance, for example:
     • conversion rates at different phases from referral to treatment
     • time taken by patients over the phase of referral to treatment that covers the pathway bottlenecks
     • follow-up rates
     • indicators of batching, carve-out and waiting list initiatives
   • set out responsibilities for monitoring information needs.

2 Establish expected standards in performance
   • 18 week referral to treatment time standards, and in the medium-term good process capability
   • identify referral thresholds based on clinical criteria and agreed protocols
   • avoid systems that increase pathway inefficiencies:
     • avoid setting minimum referral to treatment times
     • avoid using fixed stages of treatment timescales across the board, instead move towards measuring referral to treatment times
   • discuss and determine the levels of accuracy for clinical coding systems within providers.

3 Identify and agree mechanisms to monitor pathway performance that enable early issue identification
   • link pathway performance with activity plan monitoring
   • further develop trigger mechanisms, based on Statistical Process Control to identify early changes in performance.

4 Agree policies and plans, incentives and penalties around pathway performance
   • agree accountability and set out clear mechanisms for performance monitoring of pathways, use the following questions as prompts:
     • have discussions taken place with providers to alert them of the issues?
     • were any plans developed, and have these been shared?
     • can alternative services (within either primary or secondary care) be utilised, and what are the contract ramifications of doing this?
     • is there any additional support which can be provided, for example additional funding or shift of referrals on a temporary basis?
     • has a capacity review been undertaken?

SUMMARY

Commissioners have access to a range of mechanisms to ensure the regular review and monitoring of pathway performance and undertaking interventions, incentives or penalties.

It is important that these are set out and planned for. For example in some pathways, in particular high volume and high risk pathways, commissioners may wish to actively monitor indicators that act as early warning signals to changes in pathway performance. This means that any problems can be identified early enough to implement corrective actions and bring pathway performance back on track.

KEY ACTIONS

1 Create expectations of data and information exchange
2 Establish expected standards in performance
3 Identify and agree mechanisms to monitor pathway performance that enable early issue identification
4 Agree policies and plans, incentives and penalties around pathway performance
EXAMPLES

The distribution of referral to treatment times can highlight issues within operational performance

The proportion of patients who waited longer than 18 weeks is the same in these two graphs. However, Provider A has processes that are performing better than Provider B. Provider B is running their processes at the limit, possibly using waiting list initiatives, and performance is at risk if something unexpected happens. A medium-term sustainable commissioning and procurement plan for 18 weeks should focus on step-wise improvement in performance until the majority of pathways look like Provider A’s.

The problem with setting minimum waiting times

Minimum waiting times cause operational difficulties for provider organisations. They cause sub-optimal performance along pathways and add an unnecessary layer of complexity in systems that are already complex.

A better approach is having a shared focus between commissioners and providers on reducing costs across the health economy. Focus on improving productivity for providers and ways they can make savings on operating costs as an alternative approach. Minimum waiting times are a short-term, artificial stop gap to resource management.
Review and monitor pathway performance to manage and resolve problems

**SUMMARY**

Commissioners need a flexible approach to monitoring performance of pathways, knowing when to monitor performance closely and when to have a lighter touch. They need timely signals to identify if performance is off-track so they can take action.

This section identifies key actions which use performance monitoring as a mechanism to drive improvement. Its focus is, wherever possible, to build on the existing mechanisms already used by providers, for example Patient Tracking Lists (PTL).

**KEY ACTIONS**

1. Monitor the timely exchange of information that drives pathway performance
2. Monitor key indicators that have been set to be sensitive to changes in pathway performance
3. Ensure effective monitoring of Patient Tracking Lists
4. Anticipate the impact of service improvement on pathway performance

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HOW TO CARRY OUT ACTIONS - TIPS AND GUIDANCE

1. **Monitor the timely exchange of information that drives pathway performance**
   - monitor and review to make sure the fundamentals are in place, for example:
     - ensure clarity on who is responsible for the collection, submission and sharing of timely information
     - ensure clarity on use of information and limitations of data
     - likely time-lags and the ability of measures to provide early warning signals of change in performance
     - take action if the information is not shared between organisations as planned.

2. **Monitor key indicators that have been set to be sensitive to changes in pathway performance**
   - decide when to monitor and when to use exception reporting, depending upon your relationship with the provider
   - key indicators should focus on the phases of treatment that are most problematic
   - use Statistical Process Control to determine a shift within pathway performance
   - monitor referral to treatment times for the whole pathway.

3. **Ensure effective monitoring of Patient Tracking Lists**
   - work with providers to understand the function of PTLs in provider organisations
   - encourage providers to use PTLs as a mechanism to forward plan their capacity to meet patient demand, rather than fire fighting potential breaches
   - ensure a focus on sustainable management, for example use root cause analysis to identify the cause of a problem and develop potential solutions.

4. **Anticipate the impact of service improvement on pathway performance**
   - anticipate the normal and acceptable changes in pathway performance during service improvement and redesign activities:
     - there is often an increase in variation during service improvement activities; performance appears more erratic for a short time
     - following successful service improvement, there will often be a small reduction in performance as the focus moves away to another area for improvement
     - identify shifts that reflect best practice performance
     - consider putting systems in place to identify and disseminate best practice.
Using timely data to engage providers in constructive dialogue to resolve problems before they escalate

The graph shows the phases of treatment for a cardiac pathway, leading to angioplasty. The highest average wait is the time from decision to treat to first definitive treatment. However, the time from outpatient appointment to decision to treat, i.e. waits for angiography, has a higher degree of variation as shown by the ‘tail’ in the graph. This phase has the poorest performance and should therefore be prioritised, as it poses a high risk in meeting the 18 week pathway.

Monitoring a phase in referral to treatment times using individual patient records can be used as an early warning sign of pathway performance. It is necessary to have real time, prospective data as shown below.

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Commissioning for Patient Pathways
Planned versus unplanned care
HOW TO CARRY OUT ACTIONS - TIPS AND GUIDANCE

1 Assess the likely impact that emergency care has on planned pathways
   - jointly review relevant information for planned and emergency care with providers:
     - review or develop high level process maps of the emergency patient flows that may impact this planned pathway
     - plot high volume, emergency flow data associated with the planned pathway, for example map HRGs for fractured neck of femur alongside hip replacement
     - review additional indicators that reveal how pathways impact each other, for example the number of cancelled appointments with reasons
     - understand what pathway constraints have been identified between the planned and emergency interface
     - check if these are being resolved by, for example, capacity and demand studies.

2 Review patterns of emergency and planned demand, including seasonal variations
   - using Statistical Process Control, plot patterns of demand for this pathway and related demand for associated emergency specialties, for at least twelve month's worth of data: look for:
     - monthly, weekly, daily patterns of demand, for example total referrals by source or length of stay
     - review patients’ use of alternative out-of-hours services
   - key questions include:
     - what level of capacity is planned to meet the variation in demand from emergency care? a common rule is that capacity should be set at 85 per cent of the variation in demand
     - is capacity for planned work being scheduled around known peaks in demand for emergency admissions, including seasonal fluctuations?

3 Review demand management opportunities
   - support a Practice Based Commissioner led review of primary care management to discuss the prevention of emergency care, focusing on:
     - relevant QOF indicators
     - patterns of emergency admissions to the main provider, by practice
     - costs of referrals
     - use of resources
   - review care management and available services for patients with chronic conditions.

4 Support provider focus on bed management and patient flow
   - identify what plans are in place to increase efficiencies within inpatient beds and any plans to change providers bed stock
   - check whether there is optimum use of day case unit capacity as opposed to inpatient bed usage
   - check whether a whole system approach has been implemented across discharge planning.

SUMMARY

Planned care pathways often share resources with emergency care pathways, such as beds, staff and theatres. Providers need to manage these resources efficiently and ensure that there is sufficient flexibility in the capacity to meet the normal seasonal and daily patterns of demand. Commissioners need to work with a range of provider organisations with a clear focus on “right patient, right place and right treatment at the right time.”

This section outlines key areas to assess when looking at the impact of emergency pathways on planned pathways and managing that interface.

KEY ACTIONS

1 Assess the likely impact that emergency care has on planned pathways
2 Review patterns of emergency and planned demand, including seasonal variations
3 Review demand management opportunities
4 Support provider focus on bed management and patient flow
The Statistical Process Control charts show planned and emergency admissions per week for two hospitals, over the course of a year.

**Hospital A**
The admission profile of Hospital A suggests that it is an organisation driven by emergency admissions. Planned admissions may be at risk if the hospital does not manage patient flow.

This means that it needs to ensure it has sufficient bed capacity to manage this variation in demand for beds or reduce the variation in demand. Planned admissions are likely to need to be scheduled around emergency demand, for example demand on beds and theatres. A focus on making sure admissions are appropriate from a whole health economy perspective may reduce total emergency demand and improve efficiency.

**Hospital B**
The admission profile of Hospital B suggests an organisation that is driven by planned admissions, rather than emergency admissions. It has more control over its bed capacity. However, there is a noticeable degree of variation across the inpatient admission profile. This hospital has the opportunity to plan its bed requirements around the known needs of its patients. Careful planning will reduce variation in demand and therefore reduce operating costs.

**Examples**

“Optimal delivery of high quality, short stay emergency care for patients is an achievable goal. The opportunities for quality improvement in this area are immense: improved outcomes for patients, supported by evidence-based delivery of services; reduced use of hospital beds; and increased ambulatory care. Good quality care costs less than sub-optimal care, as length of stay, and complication rates are reduced.”

Delivering Quality and Value. Focus on Short Stay Emergency Care (2006)

“I'm happy to share imperfect data with commissioners who understand and work through the limitations of the data with me. It helps them and helps me.”

Head of Service Improvement, Acute Hospital Trust

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HOW TO CARRY OUT ACTIONS - TIPS AND GUIDANCE

1 Identify key providers and partners associated with chronic care, planned and emergency care pathways
   - develop or build on a relationship matrix of providers and services along high level patient flows
   - identify who is responsible for managing these relationships within your organisation
   - identify and build on existing cross-organisational partnerships that have an overview of emergency and planned flows for this pathway; some prompts are:
     - are the right people involved?
     - what works well within the relationship?
     - which areas need attention?
     - what training and skills are needed to develop partnerships?
   - ensure clarity of roles and communication systems, if there are problems along the emergency-planned interface
   - consider rotating staff between organisations to give them an understanding of the different pressures faced by colleagues.

2 Understand different organisational perspectives
   - what is the organisational view of the future services for patients along the pathway?
   - how are organisational-specific issues being identified and addressed?
   - what mechanisms are in place to discuss these?
   - is there an understanding of each others’ perspectives?

3 Agree a common purpose for the pathways
   - focus on the patients’ perspective, as they are the people who make up the planned and emergency care flows
   - ensure clinical leadership and engagement across the pathways
   - agree the balance and priorities for targets, standards and guarantees between emergency and planned flows
   - work through scenarios to understand when roles or expectations may change, for example contingency planning for pandemic flu
   - ensure an ongoing focus on communication.

SUMMARY

Effective working relationships across services and organisations are vital to the successful delivery of delay-free planned care. Commissioners have a key role in setting the tone, and co-ordinating the input from stakeholders to negotiate and secure their actions. They need to create alliances in order to enable delivery of the best possible care for the communities they serve.

As services from one area can impact another, a shared focus on patients’ perspectives and underlying problems and opportunities will help forge effective cross-organisational relationships.

KEY ACTIONS

1 Identify key providers and partners associated with chronic care, planned and emergency care pathways
2 Understand different organisational perspectives
3 Agree a common purpose for the pathways
Developing and supporting relationships across organisations can take a number of different forms

When organisations have mature relationships built on trust with strong leadership, they have the ability to work differently from the norm.

The example to the left describes a whole health community approach where there was a collective ambition to improve patient flow, as well as other aspects of patients’ health and health care services. The organisation had strong leadership, and chief executives of the acute trust and primary care trusts met on a monthly basis to review and plan how they could ‘pursue perfection’ for the community.

They had an idea about allowing their project managers to work in a fully integrated way, speeding up progress.

This principle challenges the view that everyone needs to reach a consensus about exactly what needs to be done. This is not necessarily the case. Try developing simple rules. If everyone involved in the system can agree to a set of rules, and the roles and responsibilities are clear, they can each get on with quite a lot of action without having to involve others on a day to day basis.

Simple rules are fundamental specifications of what is required (must be done), prohibited (must not be done) and allowed (could be done). Remember all key stakeholders have to agree with the simple rules, and constant communication is vital.

EXAMPLES

Working across networks and organisations

People who are good at working across different networks have three characteristics. These are:
- committed
- predicable
- enterprising.

These are the types of people that are good at getting the right people into the room at the right time. They get things done and can break new ground. They are often good at managing varied relations, in different contexts and settings.

Commissioners already use some, if not all, of these skills and capabilities, but may not have had the experience of applying them in different settings.

Characteristics adapted from “Leading and managing interrelationship” in: Interrelationship Management by Peck and Dickinson (to be published in 2008)
HOW TO CARRY OUT ACTIONS - TIPS AND GUIDANCE

1 Anticipate the impact of emergency activity planning on 18 weeks
   • develop linked activity profiles for both emergency and elective pathways, focusing on activity thresholds, cost and demand
   • undertake joint planning exercises with providers to understand activity requirements and the impact on both pathways
   • ensure mechanisms are in place to review and monitor changes in activity plans based upon variations in demand and activity
   • what process is in place if emergency over- or under-performance occurs?
     • if unreasonable over-performance is identified, implement an admission threshold review of A&E attendances as a resource utilisation scheme.

2 Identify mechanisms which support the management of patient flow across the emergency and planned interface
   • identify the key characteristics required to deliver the planned activity levels along the pathway, for example:
     • providers’ ability to manage normal variation in emergency and planned demand across pathways
     • providers’ ability in scheduling planned activity around known peaks and troughs in emergency demand
   • identify and agree joint indicators of emergency and planned pathway performance, for example:
     • emergency referral rates from GPs
     • readmission rates
     • average length of stay
   • ensure that there is focus on improving the timeliness and quality of data as part of the local contract.

3 Monitor extended primary care services and ensure effective use of resources across planned and emergency flows
   • monitor planned activity and effectiveness of out-of-hours emergency GP services and urgent care centres
   • monitor any anticipated decrease or stabilisation in emergency activity levels
   • monitor any mechanism to move activity from acute providers to the community and ensure these are reflected in the contract
   • understand how demand management and resource utilisation schemes are being prioritised.

SUMMARY

A coordinated approach to contracting across key patient flows will ensure that patients are treated in the right place, with the right care, at the right time.

A focus on prevention and avoidance of emergency admissions will help elective patient flows. Scheduling planned care around known variations in planned demand, and effective step-up and step-down facilities improves whole system patient flows.

Effective contracting will ensure that interfaces between organisations are managed, and expected outcomes are realised. The following section provides key guidance, hints and tips on the use of contracting systems to support emergency and elective activity planning.

KEY ACTIONS

1 Anticipate the impact of emergency activity planning on 18 weeks
2 Identify mechanisms which support the management of patient flow across the emergency and planned interface
3 Monitor extended primary care services and ensure effective use of resources across planned and emergency flows
The provision of out-of-hours services in England

**EXAMPLES**

**Out-of-hours services**

Good quality out-of-hours services prevent unnecessary emergency admission to hospital. The National Audit Office concluded that at present: “There is now a wide array of new out-of-hours providers, including GP co-operatives, NHS Direct, PCTs themselves and private sector companies, and it is common for commissioners to enter into contracts with multiple providers to provide different elements of the service.”


The report also highlighted that at the moment there is no relationship between cost and quality. Even though the quality of services is better than ever, there are still opportunities for commissioners to improve. As there is no relationship between cost and quality, this suggests improvements can be achieved without additional investment.

The following case study also originates from this report. It shows good practice in terms of identifying a problem, ensuring consultation and sign-up on behalf of all GP practices whose patients will use the service. The thoroughness of an approach like this will help the transition process.

**Hereford PCT**

Hereford PCT identified GP out-of-hours arrangements two years before the onset of the new contract as a major source of concern for GPs. The urban GPs were well covered, but the rural areas had no option other than to provide the cover themselves or use locums. This lack of satisfactory rural arrangements was contributing to recruitment difficulties and increased stress on GPs. It was often difficult to find locums to cover, and multiple locums reduced continuity of care. The PCT therefore identified this as one of the top priorities for the development of primary care in the area. The PCT were clear from the outset they did not have the skills, experience or desire to deliver this service themselves.

The PCT took the initiative to work with all GPs to develop a service specification and arrangements which would ensure all GPs could be relieved of out-of-hours responsibilities, but made it clear that if local GPs wished to work in the service they could. The specification and service model was agreed with all practices and the PCT added additional funding to ensure that no GPs were net losers, and that the service would have adequate resources. The service was put out to OJEC (Official Journal of the European Communities) procurement and awarded to a commercial provider.
HOW TO CARRY OUT ACTIONS - TIPS AND GUIDANCE

1 Monitor emergency care activity and demand
   • monitor referrals of key emergency care HRGs associated with the planned care pathway, using Statistical Process Control charts
   • monitor emergency care demand alongside planned care, and review patterns of variation
   • monitor any other associated elements of demand that are of importance, for example length of stay and bed utilisation
   • monitor indicators of problems with flow, for example the number of operations cancelled due to capacity problems.

2 Monitor demand management and prevention plans
   • monitor activity and impact of services such as walk-in centres and out-of-hours services on supporting admission avoidance, for example:
     • how is the success of these services measured? for example, the level of acute hospital emergency attendances
     • are they proving to be cost effective?
     • if admissions are avoided, how are the financial flows being altered to reflect this?
   • monitor and review the impact of chronic disease management initiatives, for example:
     • have patients who frequently attend emergency departments been identified and have their needs been assessed and met?
     • is a model of self-care management being applied for patients with chronic diseases? are these effective?

3 Review the impact of patient flow between planned and emergency care
   • work with providers to review cancellation rates of operations with reasons
   • develop a shared understanding of any pressures, for example diagnostic services across planned and emergency flows
   • review patterns of emergency referral by GP practice, by PBC cluster and by type of emergency referral
   • review resource utilisation, for example length of stay by discharge date.

SUMMARY

Emergency care and planned care are both important. As emergency and planned care patient flows often share the same resources, one can impact the other.

Although it is counter-intuitive, emergency activity varies less than planned care and is therefore largely predictable. With appropriate planning, providers can ensure that there is minimal disruption on 18 week care pathways due to emergency admissions.

This section describes how commissioners can monitor the impact of emergency care pathways on 18 week pathways to ensure minimum disruption and ensure efficient use of resources.

KEY ACTIONS

1 Monitor emergency care activity and demand
2 Monitor demand management and prevention plans
3 Review the impact of patient flow between planned and emergency care
A study by the Department of Health shows that demand for beds in an acute hospital setting depends not only on the total number of beds, but primarily on how well numbers and timing of admissions and discharges are matched, and how long patients spend in hospital.

The study also shows that emergency admission numbers and timings vary considerably less than elective admissions. It showed that trusts should plan elective flows against known emergency demand, rather than traditional staffing schedules and timing of consultant ward rounds. Changing practice in this area can reduce length of stay and improve patient flow.

In some areas, patients are transferred from acute hospitals to community hospitals or other step-down facilities. A focus on patient flows and discharge arrangements from community hospitals can also improve patient flow.

Take a whole system view, and understand the real cause of bottlenecks for the majority of patients pays dividends.

Source: NAO Report Improving Emergency Care in England 2004
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