Skills Maximisation Toolkit

Maximising the Contribution Made by Allied Health Professions to the Patient Journey
Maximising: making the best use of
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The role that the Allied Health Professions have to play in enabling Scotland to become a healthier nation is increasingly being recognised. The change in emphasis away from a traditional illness treating model of care and towards a more preventative and health promoting service was a key theme in Building on Success – Future Directions for the Allied Health Professions in Scotland. More recently, The Kerr Report and Delivering Care, Enabling Health, continue to demand further change to ensure health inequalities are addressed and reversed. For such a dramatic change in service provision to be achieved, a closer look at the way our services are designed is needed. NHS Education for Scotland aims to provide educational solutions for workforce development. For AHPs, NES work to date has had a major focus on role development and commissioning educational opportunities for AHP staff across Scotland to help extend their roles, e.g. commissioning of HNC for support staff, radiography role development programme. There have been numerous requests for help to structure the re-design of services. A tool first used with NHS Lothian and then used extensively during the radiography role development programme and with the Additional Support for Learning (ASL) group, has become known as the ‘Uniqueness Exercise’. Combining the uniqueness exercise with a wider range of information and techniques about re-design processes has produced this series of skills maximisation workbooks which will support services to maximise the contribution made by AHPs to the patient journey.

It is with great pleasure that I introduce you to this series of workbooks and associated half day workshops, which will bring the activities that have already helped many services in Scotland make significant changes to the benefit of patients and their families who rely on AHP services, to a much wider audience. You will read the stories of people who have tried it throughout the workbooks – many of these examples are taken from NHS Lothian where the uniqueness exercise was first used. I hope you and your services will make use of the materials provided and learning from each other be challenged to see how your own service could be transformed.

Sonya Lam,
AHP Director,
NHS Education for Scotland
Acknowledgements

As AHP Programme Director for NHS Education for Scotland (NES) I would like to gratefully acknowledge the contributions from AHPs working across Scotland who offered their services as ‘critical friends’ and as contributors providing many of the ‘Stories from people who have tried it’ sections within this workbook. I am especially thankful for the advice and input from the AHP regional workforce planning officers and from members of the Improvement Support Team and look forward to future collaborative work. Thanks too for Fiona MacNeill, commissioned to write a first draft of this toolkit, and for Kate Lyons and Rebecca Milligan at NES in their provision of project management support.

Helen McFarlane,
AHP Programme Director,
NHS Education for Scotland

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Skills Maximisation Toolkit

Introduction to the Resources

The workbook provides a step-by-step process for you (and the team that you work with) to follow. It aims to build on existing learning and practice and be a pragmatic resource for AHPs at all levels.

The workbook will use the analogy of a journey and try to avoid unnecessary jargon and complex language, using images and symbols to represent key stages and messages.

The workbook will pose questions and leave space for you to complete your responses, it will also offer suggestions and frameworks as well as provide space for you to plan practical activities to improve the contribution of AHPs where you are.

The workbook is not a text book on any of the areas referred to, however, you will be able to source more in depth information, with various references to useful websites being provided at the end of the workbook.

1. Clarifying the Patient Journey
   Starting the journey of improvement - we need to know where we are

2. Capturing Uniqueness
   What’s the real added value that AHPs bring and where do we bring that?

3. Creating Improvements
   Supporting the team in making the changes, measuring the results and celebrating success
This Open Learning Workbook has been designed to support AHPs in the following key areas:

**Stage 1:** pages 7-18

**Clarifying the Patient Journey – what’s happening now?**

This part of the workbook provides the first steps in the process. It is critical to have a clear picture of the journey from the perspective of everyone who impacts on the patient experience. This is not about what AHPs think of what administration and clerical colleagues or consultants do but about what these people themselves think. It may be that when you come to stage 2 you are focussing on the AHP unique contribution, but first of all we need the big picture.

This stage is aligned to a series of tools called Lean Thinking and is a way of looking at streamlining the patient journey, helping health care professionals maximise the use of current resources to treat more patients, more effectively. Originally developed by Toyota it is now being successfully applied in Acute and Community settings within the NHS in Scotland.

You can complete this stage with or without the workshop of the same name, if at all possible we recommend using the workshop as this will improve your result.

**Stage 2:** pages 19-38

**Capturing Uniqueness – what’s the best AHP contribution?**

This stage is all about you. It guides you through key processes to support you in identifying, in a valid and reliable way, the unique contribution that AHPs make to the patient journey:

- Activity Analysis analyses where staff groups are spending time
- Workforce Profiling by grade provides the opportunity to look at making the best use of the team
- Capturing Uniqueness Exercise builds on the previous steps and the work completed in stage one, giving you the opportunity to really see where AHPs have most impact and use that information to use the workforce effectively, provide development opportunities and improve the journey for the patient.

You can complete this stage with or without the workshop of the same name, if at all possible we recommend using the workshop as this will improve your result.

**Stage 3:** pages 39-51

**Creating Improvement – Making it Happen, Measuring Impact**

Improvement and making a better journey for patients is really what this whole workbook is about. Having completed all your analysis you may be able to go ahead and implement the improvement without having to do much more. However we do recognise that some of the improvements may need to be authorised by someone at a higher level of responsibility to you or that you may require a resource change to implement and manage the improvement in the long term. This stage provides information on how people cope in times of change, their actions and reactions to help you anticipate challenges or indeed your own feelings and responses and in addition it provides guidance to support you in preparing a business case.

You can complete this stage with or without the workshop of the same name, if at all possible we recommend using the workshop as this will improve your result.
Making Best Use of the Resources

In terms of using the resources the following is a suggested way forward:

- Read through the workbook noting questions as you go.
- Reflect on the questions and decide what you need to do to get the answers you require, then action that.
- Having had your questions answered, start to think about a patient journey that you think could be improved. It’s important to remember about the new thinking here. A starting point might be a journey where there is high demand on the service, where you are aware of problems and challenges in terms of blocks in the system or simply an area where you think it could work better.
- Now revisit the workbook and think about what a realistic timeline would be to complete the process and make an initial timetable.
- Decide if the process will need the support of the workshops and if so how will you manage the logistics of that.
- Make best use of naturally occurring meetings and learning time to get the process started. It will take time, but the pace is dictated by you.
- If you are leading the process, issue each member of the team with the workbook and talk them through the next stage.
- Then it’s just a case of working through the process, remember the importance of being well prepared at each stage.

The most important thing is that you get what you need from the resource, use the parts that you need when you need them, make it real for you. The depth that you go into will be dependent on the size of the patient journey that you choose to examine.

The process and steps are equally valid and reliable for a journey around outpatient clinics or indeed for a complete overhaul of department ways of working. The only difference is the amount of time that the process will take, the number of journeys you need to consider and the amount and level of authority of the people you will need to influence.

In addition we suggest that you think about stakeholders, their needs and how they like to get information at each of the stages. These are the critical influencers that can support your improvement if you have influenced them effectively, more information on this in section 3.

Best wishes for you and your service

This workbook and the accompanying Facilitator’s Handbook are available electronically at [www.nes.scot.nhs.uk](http://www.nes.scot.nhs.uk)
Stage 1: Clarifying the Patient Journey

Journey: distance travelled going to a place
Stage 1: Clarifying the Patient Journey – Why Do We Need to Think About This?

Much has been written in the past few years about examining the patient journey through service redesign, designed healthcare and process improvement techniques. All of these ways of clarifying the patient journey have raised awareness about the importance of the “right treatment in the right place at the right time from the right person”. The real purpose of all of this is to identify the value in each stage of the journey, where the journey flows and where there are blocks in the system. In addition this allows everyone involved to see the whole journey from the patient perspective. By beginning to think about this, you are beginning to think about improving the way AHPs contribute effectively to the patient journey and experience.

This is about improvement and building on best practice not about giving up your area of clinical expertise or involving administration and clerical or assistant staff in roles they have not been appropriately trained for.

This is where Lean Thinking can help:

Lean Thinking looks at streamlining the patient journey, improving clinical outcomes and the overall patient experience.

- Lean Thinking looks at the whole journey from beginning to end and whilst you may not be responsible for changing the whole process you can use your findings to influence change.
- Lean Thinking will also help you to look at the AHP parts of the journey, so in AHP terms it will help you to maximise current resources and see who adds real value along the journey.
- Lean Thinking will help to identify common patient journeys promoting improvement across similar service provision.

Process Mapping:

- Process Mapping is the first stage in Lean Thinking. It allows us to map the journey.
- The important thing to remember is that the process that is officially laid out in terms of what is “supposed to happen” is unlikely to be what really happens!
- To ensure that you map the process as accurately as possible you need to observe the process from the outside and ask good questions of all the contributors along the way.

Don’t forget to ask around, it may be that someone who works in your area has had training in Process Mapping and would be willing to help out OR it may be that process mapping activities are underway already in your organisation and your role here might be to ensure AHPs are involved and included.

Stories from People Who Have Tried It!

The Occupational Therapy department in NHS Lothian undertook some process mapping activity. One of the OTs who took part advises, “Check what process mapping activities are already happening within your service and see if AHPs are included”. Before you start to introduce any change, she also suggests:

- Highlight the patient journey
- Consider high levels of activity
- Identify any waiting areas.

Process mapping enabled the OTs to consider the range of assessments and questions already carried out with the patient by other healthcare staff. Knowing what information was already recorded, the OTs could make sure specialist AHP assessment builds on, rather than duplicates, this information. The Lothian OTs also found that using a process mapping approach has led to better links between sections and departments within their service.
Stage 1: Clarifying the Patient Journey –
Mapping the Journey (Process)

What constitutes a process?
All the work that is done in an organisation can be described in terms of processes. The terms used were developed within industry but have been applied to a health service setting. Often this requires a major change in thinking because in the past we may have thought only in terms of departments and functions. A process is a collection of cause factors that interact to produce a given output. In our case these cause factors are the elements which are applicable in terms of their impact on the process (patient journey) and the output (quality of services provided to the patient).

Patients’ needs are always changing. The process should continually change to meet patients’ changing needs, through process improvement.

Cause factors are often called inputs, and include the following:
- People
- Materials
- Machines
- Method
- Environment.

Activity and Transformation
Activity is what transforms the input into the final product or service, and may be:
- Diarising an appointment using a computer system or traditional diary
- Discussions between multi-disciplinary team members
- Creating an x-ray
- Passing information from one person or department to another.

Product / Service and Outputs
Products and services are what come out of the process and could include:
- Treatment or therapy
- Another appointment
- An operation
- An assessment
- A support package.
Reflecting on the journey

In terms of starting to think about a journey that you might like to look at, it is important that you remember that this process is not about more of the same staff or more resources or time to do more of the same. It is about looking as objectively as possible at the effectiveness of what is happening now and then about realising and acting on new ways of achieving improved outcomes.
Mapping the Journey (Process)

Below is an example of the mapping process in terms of the sequence that you should go through to get results, the following pages take you through things to think about at each stage.

The Ten Steps to Process Improvement

1. Select a process (Patient Journey)
2. Assemble the team (As many contributors to the journey as possible)
3. Study the process (Patient Journey)
4. Make immediate improvements
5. Agree focus for improvement
6. Redesign the process
7. Study the new process
8. Implement the new process
9. Review learning and next steps
10. Stabilise and monitor performance

Is the process stable?

Identify and remove variables
Clarifying the Patient Journey – Making It Real Where You Are

To get the best learning from this workbook we suggest that you use a real example of a change or improvement that you want to explore. Select an area you believe can deliver a result that positively impacts on patient care. The workbook will guide you through the process. It is always more successful if you can involve as many of the contributors to the patient’s journey as possible.

Which specific journey are you thinking about looking at improving?
It might be helpful to think about journeys where you know there are blocks in the system or there is high demand on the service.

Why have you chosen this journey?

Stories from People Who Have Tried It!
Analysing the activities undertaken by the Medicine of the Elderly, physiotherapists in NHS Lothian flagged up that Mondays were the busiest day of the week in respect of numbers of new referrals received by them. 35% of new patients were referred on a Monday. As the department staffing included part-time staff, decisions were taken to employ more staff on Mondays rather than spreading part-time staff hours equally throughout the week. The outcome was measured by comparing the numbers of patients who were not receiving assessment or treatment on the desired day over two 2 month periods. These were immediately prior to the change and during the period of altered staffing. Despite a 14% increase in patient admissions during the trial period, the patients prioritised out of treatment fell by 12.5%. Staffing has now permanently been adjusted with snapshots being taken to ensure that staffing continues to be targeted appropriately.
Understanding the Process

The following questions need to be addressed in order to begin to standardise, stabilise and improve a process. Use this as thinking and planning space.

What is the purpose of the process?
The process’s reasons for existence must be clearly stated and understood by all who work in the process and this remains constant even if the process is improved or innovated.

What are the outputs from the process?
Process outputs in the NHS are the services that we provide to patients whether that be a prescription, a consultation, training/advice for carers or therapeutic activities.

Who provides input and what are their capabilities?

What data is available or could be collected to help us understand the current process?
Who is the process owner?
The process owner is ultimately accountable for overall process performance, co-ordination of all functions involved in the process, and ensuring patient satisfaction. A process owner must understand: what the process is supposed to do, how the process works and what the process is capable of doing. We recognise that this is challenging within an NHS environment where accountability and responsibility is often shared, but getting as much clarity as possible will be helpful.

How does the process operate?

Who are the patients and what are their requirements?
Stage 1: Clarifying the Patient Journey –
Mapping the Journey (Process)

These four steps describe how to flowchart:

• Get the people involved in the process together in a meeting, this generally requires people from various departments and levels.
• The atmosphere must be one in which participants feel comfortable bringing up problems. Document these as you go along.
• Recognise that different people will view the process differently.
• Clearly define which process you are studying.

It would be useful to use the workshop approach described in the ‘Facilitator’s Handbook’ at this stage see www.nes.scot.uk. You might want to use big pieces of paper and post it notes so that everyone can see and you can move things around as a result of discussion.

People who work in the process know best how it actually operates. Procedural manuals gather dust for good reason – as new workers join the process, as equipment ages, as patient needs change so does the process. It is not surprising that the actual process often bears little resemblance to the official process.

Remember that the important thing is to map it as it really happens not as it should, this is the only way to improvement.

In pencil, draft out a basic flow chart mapping the journey as you see it from the information that you have gathered. Try and keep it as simple as possible. Now go back and show this to all the key people who meet the patient on their journey and make adjustments based on their feedback. If you and your team are using the ‘Facilitator’s Handbook’ to organise workshops, bring the flow chart you have produced to the workshop where this wider discussion and agreement will take place.

Use a flow chart to gain a common understanding of the process the team is to improve.
Delegates who attended a series of NHS Education for Scotland consensus events for radiography role development in 2004 analysed the processes undertaken for a routine chest x-ray. Delegates at each of the events worked in small groups to identify the activities involved and the steps were combined to form the following process map.
Stage 1: Clarifying the Patient Journey – Getting Feedback From the Patient

Naturally the most important person in the process is the patient so it is critical to gain feedback from their perspective of the journey. You may be able to do this via existing patient involvement groups or from current data that is readily available. If not you may want to invite feedback from patients that have been recently discharged from your service and their families and carers.

How will you ensure you have the patient’s perspective of the journey reflected in your map?

After gaining your patient’s perspective, record your findings in the space below and go back and modify or add comments to your map.

Who are the stakeholders in the process and how might you get information from them and to them?

It is highly recommended that you use the workshops outlined in the Facilitator’s Handbook that accompany this workbook.
Many people find that by mapping the process and capturing the range of views of people who experience the process is, in itself, a powerful way of highlighting simple changes that could be made to improve the patient journey.

**Stories from People Who Have Tried It!**

The Occupational Therapy department in NHS Lothian considered their inpatient rehabilitation service pathway. They found that trying to provide patients with a rehabilitation focussed programme of intervention had very practical limitations by the timings of ward activities. Visiting times, medical ward rounds, meal times etc. combined to leave only a few hours in the day when the OT programme was likely to be effective but OT input was competing with other input – including from other AHPs. The patient was therefore likely to be bombarded with therapeutic activities and advice in a 2 hour mid-morning time slot. Introducing flexible working hours on a voluntary basis for staff now means that many OT staff work 8am-8pm or 8am-6pm 2 days a week and take a day off in lieu.

This change means:
- OTs are available at a range of different times.
- OTs have been more effective in seeing family members visiting in the evening.
- OTs have been able to access patient notes at more convenient times.
- OTs have been able to provide training for ward staff at times more appropriate for shifts.
- A 30% higher patient input in the same total number of working hours.

Core assessments like washing and dressing practice can be done at more appropriate times and washing and undressing practice, which is just as valuable, can now be incorporated.

Are there any changes about the process you have been considering you would want to suggest at this stage?
Stage 2:

Capturing Uniqueness

Unique: Being the only one of its kind, having no like or parallel
Stage 2: Capturing Uniqueness – How Can We Do That?

The process of identifying uniqueness is like capturing snapshots of the journey. It looks at the bits that we would like to keep in terms of the special moments of the journey like the great meal or amazing beach. It also looks at the bits that we would rather forget, like queuing in the airport for a delayed flight!

In stage 1: Clarifying the Patient Journey, we drew attention to the importance of ‘the right treatment in the right place at the right time from the right person’. Stage 2 encourages you to focus on the ‘right person’ part of the journey by identifying the unique contribution that qualified professionals make to the overall patient journey.

It’s all about getting a picture that could improve that critical journey for the patient.

So we can do that by:
- Activity Analysis – who’s doing what where?
- ‘Unique’ Exercise – who really needs to do what?
- Skills Maximisation – are we making the best of the above?

Stories from People Who Have Tried It!

Various departmental tasks came under the spotlight when the OT department of NHS Lothian considered their activity analysis. The weekly role of allocating tasks was one traditionally rotated amongst all qualified members of the team. Recognising that this was not a task that required the unique skills of a qualified OT, this was changed so all team members take turns to undertake this allocation role – including support staff. The benefits have been not only releasing time for qualified staff but has led to better inclusion of support staff as team members, helped each team member’s understanding of the balance and priorities to be considered when allocating tasks throughout the team and, for newly qualified team members, helped underline the value and scope of the roles support staff play within the team.
Stage 2: Capturing Uniqueness – Why Do We Need to Think About This?

AHPs are increasingly being asked to deliver services in different and new ways. Doing it the way that we always did is no longer an option. The demographic profile of the population, the move to more services being provided in the community, the skills shortage in many AHP areas, are all real and valid reasons for us to look at the way that we provide our services. This is not about giving up your clinical expertise but about developing and improving services.

In addition, by really measuring where AHPs add value you can promote your service more effectively, use the information to influence the development of new roles and pose questions about the best use of existing resources. This is about getting the best from the team for the patient.

This may mean you want to present a business case for any improvements that you identify and may also mean you may need to lead that change. For more information on both of these areas you might want to refer to Stage 3: Creating Improvement.

In relation to the use of support staff, newly qualified, specialist, and/or consultant staff, we have found much variation across the 9 AHP professions and, within each profession, variations between AHP interventions from one care group or setting to another. Physiotherapy and Occupational Therapy, for example, have a longer history than most AHPs in using support staff. At 1:5, they also often have a higher ratio of support staff to qualified staff. Use of consultant posts also varies across each profession. In January 2006, of the 100 consultant AHP posts that had been established across the UK, 50% of them were held by physiotherapists (Gray, 2006).

Speech and Language Therapy have a longer tradition of using support staff in children’s services than with other care groups. There is more variety of grades of support staff undertaking a wider range of activities within children’s speech and language therapy services than other speech and language services.
Stage 2: Capturing Uniqueness – Workforce Profiling

On the next few pages there are a variety of questions and activities designed so that you can assess the uniqueness of the AHP contribution and its current value. The first step is to consider the members of the team and consider their grades, age profile, skill mix and any vacancies.

For the first part of the ‘Capturing Uniqueness’ Exercise, it will be helpful to think about your team and consider each specific profession in relation to the following:

Use of newly qualified, specialist and/or consultant staff?

Ratio of qualified to support staff in comparison to other AHP groups?
What are the variations in how support staff are used?
What grades are used? How does this compare to other AHP groups?

What vacancies exist within the team?
Are there any predictable vacancies arising in near future e.g. consider the age profile of the team?
Vacancies can provide natural opportunities for service re-design so this provides you with some time to plan for introducing any changes the workbook helps you to identify.
Stage 2: Capturing Uniqueness – Activity Analysis

Using the map you created in Stage 1: Clarifying the Patient Journey, identify the tasks and activities carried out at each step on the journey. In this section you will see an example of how radiography staff analysed the activities involved in the provision of routine chest x-ray. You might want to follow their approach and adapt and use the table overleaf to help you answer the following questions.

Identify which of the tasks/activities require the unique skills and expertise from a qualified member of staff.

Which tasks/activities require a specialist, highly experienced or consultant level of qualified staff?

Which tasks/activities could be carried out by a.n. other? (At this stage, do not worry whether or not another member of staff exists to do these tasks but focus on the tasks that do not require the unique skills of a qualified AHP)
Having gained a detailed picture of the patient journey with the tasks and activities mapped out, it is useful to consider how much time is spent on the range of activities, by all staff. Consider the time currently spent by qualified staff undertaking tasks and activities that do not require the unique skills of a qualified AHP.

**Estimate the time spent on all these tasks/activities.**

<table>
<thead>
<tr>
<th>Activity (Each Step Of Process)</th>
<th>Time Spent On This Activity</th>
<th>Who Currently Delivers This Activity?</th>
<th>Is This Activity “Unique” To Qualified AHP?</th>
<th>If No, Who Is The Most Appropriate To Deliver This Activity?</th>
</tr>
</thead>
<tbody>
<tr>
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</tr>
</tbody>
</table>
Consider the map of patient journey alongside the information you have now included about tasks and activities that are unique and those that are non-unique. Use the following questions to make some observations about the patient journey. Be as objective as you can based on your map of the journey and the feedback that you have received.

What are the perceived problems in the process?

What has a positive impact on the journey that you would want to keep?

What has a negative impact on the journey that you would want to dispose of?

Where do you see opportunities to streamline the journey?
Are there opportunities to make better use of the AHP team?

**Stories from People Who Have Tried It!**

Another outcome following undertaking an activity analysis and identifying the unique contribution of qualified OTs has been to make better use of administration support for computer inputting of data.

The Scotland AHP Additional Support for Learning (ASL) group have all taken part in workshops exploring the unique contribution AHPs make to children in a school setting. Considering better use of classroom assistants and teachers within the school as well as AHP specialist or generic support staff has been a key outcome.

Delegates attending the NHS Education for Scotland Radiography role development consensus event considered the activities involved in a routine chest x-ray and considered which of the activities required the unique skills from a qualified radiographer or from an advanced practitioner. Delegates also identified which activities could be carried out by other staff such as assistant radiographers, administrative staff or dark room technicians. One of the groups findings from that event is provided overleaf as an example.
<table>
<thead>
<tr>
<th>Activity</th>
<th>Who Currently Delivers This Activity?</th>
<th>Is This Activity ‘Unique’ To Qualified Radiographers?</th>
<th>If No, Who Is The Most Appropriate To Deliver This Activity?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Booking</td>
<td>Clerical Assistants/Helpers Radiographers (OOH)</td>
<td>No</td>
<td>Clerical for diagnostic Assistant for therapeutic</td>
</tr>
<tr>
<td>Appropriate investigation</td>
<td>Assistants/Helpers Radiographers/ radiologists</td>
<td>No</td>
<td>Assistants/Helpers</td>
</tr>
<tr>
<td>• Checking patient details</td>
<td></td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>• Justification</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prepare the patient</td>
<td>Assistant/helper Radiographer/Assistant Practitioners/helpers Radiologists/ radiographers</td>
<td>No</td>
<td>Assistants</td>
</tr>
<tr>
<td>• Physically</td>
<td></td>
<td></td>
<td>Assistants with increased training</td>
</tr>
<tr>
<td>• Emotionally</td>
<td></td>
<td></td>
<td>Assistants with increased training</td>
</tr>
<tr>
<td>• Imparting more detailed information/ counselling</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prepare the room</td>
<td>Radiographers Assistants/Helpers</td>
<td>No</td>
<td>Assistants/Helpers</td>
</tr>
<tr>
<td>Prepare the equipment</td>
<td>Radiographers Assistants/Helpers</td>
<td>No</td>
<td>Assistants/Helpers</td>
</tr>
<tr>
<td>Select projection</td>
<td>Radiographers</td>
<td>No</td>
<td>Assistants/Helpers with proper training and following departmental protocols</td>
</tr>
<tr>
<td>Irradiation</td>
<td>Radiographers</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Processing</td>
<td>Radiographers/ Assistants</td>
<td>No</td>
<td>Assistants/Helpers Dark room technician Auxiliary nurse</td>
</tr>
<tr>
<td>Maintain equipment</td>
<td>Technicians/helpers</td>
<td>No</td>
<td>Technicians/Helpers</td>
</tr>
<tr>
<td>Quality check of image</td>
<td>Radiographers</td>
<td>No</td>
<td>Assistants/Helpers</td>
</tr>
<tr>
<td>Evaluate image</td>
<td>Radiographers</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Report prescribing</td>
<td>Radiologist or radiographer or other medical staff</td>
<td>No</td>
<td>Radiographer or advanced practitioner</td>
</tr>
</tbody>
</table>
Skills Maximisation – Are We Making Best Use of the Team?

The information you have produced can be translated into actual changes to posts within the AHP process of the patient journey. The percentages of time currently spent by qualified AHPs undertaking tasks and activities that do not require the unique skills of a qualified AHP can be calculated and then represented as time available for re-design. If, following an analysis as described above, it was found that 10% of time spent by qualified AHPs could be carried out by non-qualified staff here is an example of how to calculate the potential change in service establishment.

Skills maximisation – an example

Steps/Purpose – a working example

- Established staff base = 4.5 whole time equivalent (wte) qualified staff
- Contracted hours per wte = 37.5 hours/week x 52 weeks = 1950 hours per annum
- On-duty hours (Contracted hours minus predictable absence allowance* of 22.5%) * time lost to annual leave, sickness etc as calculated by Audit Scotland and adjusted for agenda for change
  - 37.5 (hours) x 22.5% (predictable absence) x 52 (weeks per year) = 438.75 hours (predictable time lost per wte)
- Assuming on-duty hours per year of 1950 - 438.75 (predictable time lost) = 1511.25 hours per annum
- Total number of on-duty hours for 4.5 wte x 1511.25 = 6800.62 per annum
- 10% of on-duty hours identified as non-unique in an established qualified staff base of 4.5 wte. Equates to 680 on-duty hours per annum
- 680 on-duty hours equates to 0.45 wte of a qualified member of staff (16.9 hours per week)
- If the gross cost of each wte qualified member of staff = £30k and the gross cost of each wte assistant = £15k
- The gross cost of 0.45 wte = £13.5k which equates to 0.9 wte of an assistant (=1360 on-duty hours incorporating predictable absence allowance).

Description

- A process to support the development of efficient and effective use of the workforce
- Allows the calculation of the number of potential hours from registered staff to other staff groups to improve clinical effectiveness, patient journey and staff development and morale.

Things to look for

- Bottlenecks
- Redundant tasks
- Duplication.
Skills Maximisation Toolkit

Skills Maximisation –
Are We Making Best Use of the Team?

Following the above formula is a useful means of calculating some possibilities for re-designing your service. Of course, you will always need to be aware of other drivers and priorities within your service and take into account practicalities that arise from the availability of specialist skills and the impact on retention and recruitment that any re-designed role may involve. Ensuring flexibility within the workforce, especially when the team is a small service will be of paramount importance. Some of these factors will be addressed in Stage 3 of the workbook when we consider the human dimensions to change.

Bear in mind advice from workforce planning officers who describe the need for all staff to engage in tasks that require a range of levels of concentrated effort. Peak level working is the work we are all capable of doing when working to our full potential, however sustaining long periods of peak level working can often have a negative effect and, in the worst case scenario, result in burn out. This advice has a special relevance when considering use of specialist and/or consultant staff but workforce planning officers highlight the need for a range of tasks and activities to ensure optimum maximisation of skills all the team members can offer.

Skills maximisation is both a science and an art.
Clarifying the Patient Journey, Capturing Uniqueness, Creating Improvement

The Dietetics Team in Moray Community Health and Social Care Partnership (NHS Grampian) have undertaken incremental redesign of their service and workforce as a result of process mapping and task analysis tools.

The drivers for change included:

- recruitment challenges in senior grades of staff
- coping with short term project funding
- responding to increasing demand
- implementing shorter and more equitable waiting times
- supporting shifts in the balance of care towards shorter lengths of stay and more community based support.

At the start of the process, referrals were coordinated by individual clinicians in a variety of ways. Task analysis identified significant amounts of specialist dietetic time taken up in administrative duties and other clinical tasks which could be devolved to support workers or administrative staff. However these posts did not exist within the skill mix of the team.

With a blend of opportunistic redesign as vacancies arose, temporary funding for projects and redistribution of existing recurring funding in the dietetic staffing budget, the workforce has changed to include 2 administrative staff, 3 support workers and 3 new graduate posts within a team of 15. Despite significant increases in demand and patient throughput, waiting times have been managed successfully in most areas, with a few exceptions. Further redesign is likely to move to group based and self managed care wherever possible.

The incremental approach has been successful in having a positive effect on the dietetic team, with specialist and experienced staff having opportunities to develop their role, taking on for example team leadership functions and focusing on where their specialist skills are of most value with the multi-disciplinary team.

---

**Stories from People Who Have Tried It!**

The Dietetics Team in Moray Community Health and Social Care Partnership (NHS Grampian) have undertaken incremental redesign of their service and workforce as a result of process mapping and task analysis tools.

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**Stories from People Who Have Tried It!**

When NHS Lothian AHP Director wanted to identify time spent on each activity by different team members, a Therapy Activity Codes and Therapy Activity Analysis Audit were developed. Codes were created for all the steps involved in the patient journey and staff completed the audit to give a snapshot of time spent. You could develop a similar audit tool based on each step identified in Stage 1 of this workbook. Here are some extracts of the NHS Lothian tools as an example for you.
<table>
<thead>
<tr>
<th>Code</th>
<th>Short Description</th>
<th>Full Description &amp; Inclusions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Patient Related Work</td>
<td></td>
</tr>
<tr>
<td></td>
<td>The time a staff member uses on work which is directly 'chargeable' to a case</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Direct Casework - Inpatients</td>
<td></td>
</tr>
<tr>
<td>01.</td>
<td>One therapist to one patient</td>
<td>Include adjusting splints/aids and issuing equipment with the patient</td>
</tr>
<tr>
<td>05.</td>
<td>One therapist and one student</td>
<td></td>
</tr>
<tr>
<td>07.</td>
<td>Group</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Indirect Casework - Inpatients</td>
<td></td>
</tr>
<tr>
<td>09.</td>
<td>Teaching carers, helpers</td>
<td>Teaching &amp; supervision of others to whom some aspects of treatment is being delegated e.g. helpers, nurses, carers, junior therapists</td>
</tr>
<tr>
<td>12.</td>
<td>Telephone – patients/relatives/ carers</td>
<td>Telephone liaison</td>
</tr>
<tr>
<td>16.</td>
<td>Documentation</td>
<td>Case notes, discharge letters, case reports, statements of need or progress, transfer letters, solicitors reports</td>
</tr>
<tr>
<td>21.</td>
<td>Nutritional calculations</td>
<td>Analysis of results &amp; record charts</td>
</tr>
<tr>
<td></td>
<td>Non-patient Related Work</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Teaching/education</td>
<td></td>
</tr>
<tr>
<td>43.</td>
<td>Therapists</td>
<td></td>
</tr>
<tr>
<td>46.</td>
<td>Other disciplines</td>
<td></td>
</tr>
<tr>
<td>49.</td>
<td>Preparation of displays, handouts, lectures</td>
<td></td>
</tr>
<tr>
<td>51.</td>
<td>Other professional development</td>
<td>eg. reviewing articles</td>
</tr>
<tr>
<td></td>
<td>Service Management</td>
<td></td>
</tr>
<tr>
<td>52.</td>
<td>Operational meetings</td>
<td>General staff meetings; team meetings</td>
</tr>
<tr>
<td>56.</td>
<td>Dealing with correspondence</td>
<td>Opening email; distribution of email; actioning email</td>
</tr>
<tr>
<td>61.</td>
<td>Booking appointments</td>
<td>By telephone; face to face; written. Cancelling appointments</td>
</tr>
<tr>
<td>68.</td>
<td>Filing</td>
<td>Filing patient notes and other, includes retrieving notes</td>
</tr>
<tr>
<td>Therapy Activity Analysis Audit</td>
<td></td>
<td></td>
</tr>
<tr>
<td>---------------------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Name (in BLOCK CAPITALS please)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Surname:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Enter activity code number for each 10 minute block:</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Profession:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>o'clock</td>
<td>10</td>
<td>20</td>
</tr>
<tr>
<td>(enter code)</td>
<td>7.00</td>
<td></td>
</tr>
<tr>
<td>1=Physiotherapy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2=Occupational Therapy</td>
<td>8.00</td>
<td></td>
</tr>
<tr>
<td>3=Speech Therapy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4=Dietetics</td>
<td>9.00</td>
<td></td>
</tr>
<tr>
<td>5=Arts Therapy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6=Podiatry</td>
<td>10.00</td>
<td></td>
</tr>
<tr>
<td>7=Radiography</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8=Prosthetist or Orthotist</td>
<td>11.00</td>
<td></td>
</tr>
<tr>
<td>9=Orthoptists</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10=Admin and Clerical</td>
<td>12.00</td>
<td></td>
</tr>
<tr>
<td></td>
<td>13.00</td>
<td></td>
</tr>
<tr>
<td>Grade/A4C Band</td>
<td>14.00</td>
<td></td>
</tr>
<tr>
<td>Day:</td>
<td>15.00</td>
<td></td>
</tr>
<tr>
<td>(enter code)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1=Monday</td>
<td>16.00</td>
<td></td>
</tr>
<tr>
<td>2=Tuesday</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3=Wednesday</td>
<td>17.00</td>
<td></td>
</tr>
<tr>
<td>4=Thursday</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5=Friday</td>
<td>18.00</td>
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<tr>
<td>6=Saturday</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7=Sunday</td>
<td>19.00</td>
<td></td>
</tr>
<tr>
<td>Date:</td>
<td>20.00</td>
<td></td>
</tr>
<tr>
<td>DD/MM/YY</td>
<td>21.00</td>
<td></td>
</tr>
</tbody>
</table>
Stage 2: Capturing Uniqueness – What Have You Found Out?

This stage is all about logging the results of your research. Try not to be emotionally attached to the results or their potential impact, just work your way through the series of questions responding with factual notes.

Where are AHPs really adding value to the journey?  
Be specific. List each profession involved and describe the unique contribution.

Are you confident that it is the right AHP who is providing the right service at each of these stages – circle your response?

YES    NO

If you responded ‘yes’ to the above question can you justify your response?
If you answered ‘no’ to the above question can you justify your response?

What changes would you like to recommend now (if any) and how does this sit with your original process mapping activity?

Having considered unique contributions of all team members, look back at the map of the patient journey you created. What would the new map look like if it was all working the way you want it to work?
Stories from People Who Have Tried It!

After focussing on the unique contribution of qualified AHPs in NHS Lothian “A step too far” exercise has also been started. Different staff groups have been asked what they do and what they feel an adequately trained assistant would be able to do. Two areas have come out consistently from the groups. These are Collection of Pre-Admission Profiles for OT and Stair Assessment for Physiotherapy. Currently work is underway to have robust competencies and criteria to enable assistants to perform these in all areas.

How will you test the changes quickly and safely to gain the evidence that you need?
What evidence can you now present to show that the change will improve the outcome for the patient and impact on targets?

<table>
<thead>
<tr>
<th>Evidence</th>
<th>Impact on Patient</th>
<th>Impact on Targets</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>
Having got the evidence, what challenges would you face in implementing the change you see as beneficial to the patient and how would you overcome these?

<table>
<thead>
<tr>
<th>Challenges</th>
<th>Ways of overcoming these, including engaging with stakeholders</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

For more information about introducing changes to the patient journey and submitting a business case to support any changes you intend to make, please move on to Stage 3: Creating Improvement.
Stage 3: Creating Improvement

Improvement: action that makes better through good use of opportunity
Stage 3: Creating Improvement – Why Do We Need to Think About This?

This is the stage in the journey when we want to change direction and help ensure our patients reach their destination by a different and better route.

The NHS is changing and AHPs are in a great position to promote their service, demonstrate where they make a real difference through evidence based practice and use their natural affinity for team and collaborative working to make real and sustainable improvement for patients. This in turn impacts on colleagues and fellow professionals, morale and motivation to continue to have a positive impact on the patient journey.

To recap, Stage 1: Clarifying the Patient Journey allowed us to look at what was really happening.

Stage 2: Capturing Uniqueness then enabled us to capture the unique contribution of AHPs to that patient journey.

The next logical stage is to make the case for the change/improvement to be taken on board by the team and change the patient journey for the better. Sounds simple, however we all know that gaining resources to sustain an improvement and getting people to change their historic, comfortable ways of working is not always easy.

To support you in this area you have already given some thought as to who you need to influence and how you might overcome the challenges. It is important to reflect on this now.

This stage will provide information on:
• The emotional side of leading change
• The business side of leading change.

Stage 3: Creating Improvement, will be useful for thinking about responses that the change might bring from you or the team, and also to think about presenting the business case of the change as is required. As stated in the introduction you may use as much or as little of this section as you deem to be appropriate.
Stage 3: Creating Improvement –
The Emotions of Change

The model below is a “Change Curve” adapted from the work of Elisabeth Kübler-Ross on bereavement.

- Management theorists recognised that the death of someone close was one of the biggest changes that we had to deal with in life and took her model on bereavement and adapted it as a tool to help individuals manage other changes.
- The stages of the curve represent the stages that we may go through, or become stuck at, when change occurs whether that change is positive or negative.
- It is important to realise that the curve is not a continuum, there is no need to go through each stage in order to progress to the next, indeed individuals may hit the curve at different stages. All of which makes the role of the AHP leading the change more challenging given the position they may have on the curve themselves.
- Whilst the curve is applicable to change that is acceptable and welcomed, or unacceptable and imposed, this workbook deals with the latter state as that is the area which is more difficult to deal with.
- Like all of the models and information that have been provided as part of the workbook this is not a tick sheet of certainties that will guarantee a result every time, as we know people are different!
<table>
<thead>
<tr>
<th>Area of Change Curve</th>
<th>Things you might see and hear</th>
<th>Influencing change</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Shock</strong></td>
<td>The verbal communication may be non-existent or aggressive and confrontational. The behaviours that accompany shock are firmly in the emotional zone and may be happening subconsciously.</td>
<td>No matter what is happening for individuals here it may not be what it seems. Important not to get hooked into the behaviour. Use questioning to find out where the individual/s are really coming from and what you can do to support and help them. Lots of listening and not too much talking.</td>
</tr>
<tr>
<td><strong>Retreat</strong></td>
<td>The word describes what may be happening for people, a withdrawal, verbally and even physically. Limited verbal communication, internalising of the situation and events.</td>
<td>Team members/individuals are no good to you if they are not making a contribution. You need to find ways to bring them back from the outside through empathy, encouragement and asking them what they feel concerned/afraid of and really listen to the answers.</td>
</tr>
<tr>
<td><strong>Self Doubt</strong></td>
<td>Change brings concern and fear. This naturally gets people to box themselves into a corner where they decide what is going to happen and that there may not be a place for them in the new regime. Many of the behaviours from retreat are still likely to be evident at this stage, however it is important to recognise that self-doubt sometimes presents as over confidence.</td>
<td>Paint the picture for individuals of what the future will look like and the role that you see them playing in that future. Confirm successes and achievements. Provide small incremental milestones for individuals and the team and be proactive with feedback to provide an impetus towards continuous improvement. Usually this will bring individuals around, this is about self-belief and worth not about not wanting to be part of the change.</td>
</tr>
<tr>
<td><strong>Apathy</strong></td>
<td>Apathetic people are around in the workplace anyway, with or without change. Recent studies reckon that we only get something like 28% capacity from individuals. You will know whether the apathy is unusual and due to the change or just part of the ‘character’ of the individual. This is typified by a ‘don’t care’ attitude, a lack of team-work and generally a lack of personal responsibility. Can be self-centred.</td>
<td>We often spend lots of time and energy with individuals who are in apathy, this often creates time management pressures and resentment from the rest of the team who are trying to get on with things. Do not reward poor performance, attitude and behaviour by providing the individuals with your most precious commodity, your time. Make sure that you are clear that the person is in apathy and not self-doubt as the strategies for dealing with these are different. A wake-up call may be required here regarding the potential consequence of continued inappropriate behaviour - hopefully as a last resort!</td>
</tr>
<tr>
<td>Area of Change Curve</td>
<td>Things you might see and hear</td>
<td>Influencing change</td>
</tr>
<tr>
<td>----------------------</td>
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</tr>
<tr>
<td>Resolve</td>
<td>At this stage the behaviour is more positive than it has been up to this time. Even if the feeling is ‘we have no choice but to get on with it’ there is a definite feeling of movement here that doesn’t exist in the previous stages. This presents itself as physical and emotional change as people begin to get on, get going, go with the flow and make a start.</td>
<td>This is the time for you to capture the change in mood and set out the vision, influence each individual appropriately and energise the moving forward that has begun. Setting out the importance of everyone’s contribution, providing structure and guidance around requirements and communication.</td>
</tr>
<tr>
<td>Taking Stock</td>
<td>The next logical stage from resolve and likely to follow on. An analytical and problem solving area likely to be accompanied by lots of discussion and questions, reflections and predictions. Engages left brain thinkers, those who like detail and structure.</td>
<td>Time to keep the team with you. Lots of listening to their ideas and perceptions, a different perspective now can often save a lot of time, energy and team hassle later on. Remember that everyone is entitled to contribute to the vision, otherwise how will they own it and begin to feel passionate about it?</td>
</tr>
<tr>
<td>New Goals</td>
<td>The exciting beginnings of planning to deal with the change. Team members may not all necessarily be delighted, proactive and dynamic about the change and there will still be traces of ‘because we have to’ attitude. Enthusiasm may run away with itself and initial excitement may soon wane.</td>
<td>Watch out for the ‘bench sitters, the under-miners and the ‘we’ve done this before’ brigade’. Give these people important roles and monitor closely! Make the best use of the team, delegate within areas of competence, agree ground rules for communication, action planning and feedback. Crucial to keep energy up now and take the team with you. Watch out for setbacks, predict and positively influence areas where challenges appear. Make sure that you provide training and support for the team, time out to think and lots of praise for achievements, no blame for setbacks. Finally remember to look after yourself!</td>
</tr>
</tbody>
</table>
Stage 3: Creating Improvement – The Emotions of Change Making It Real
Where You Are

Here is another copy of the change curve. You can choose what to do with this depending on whether you are leading the change and want to get the team to plot where they think they are collectively or perhaps more usefully for everyone to think about their own position, the impact of that and then exchange views. It is recommended that you use the workshops and the Facilitator’s Handbook that accompany this workbook as a means to facilitate this discussion with the team members.
What have you found out?

List the key actions you will take to move the individuals or yourself to a more positive place and consider who is responsible for those.

How will you engage the members of the team that are proactive and positive in helping you to deal with those that are less so?

Any other things you need to think about at this stage?
Skills Maximisation Toolkit

Stage 3: Creating Improvement – The Business of Change

We are more aware than ever as AHPs about the importance of maximising the use of resources and yet the concept of business or anything to do with business still seems like an alien one to most of us. However using business processes and ideas such as presenting a ‘Business Case’ can help us to get what we want in terms of securing resources or even just the authority to make the improvement that we believe will improve the patient journey.

Stage 3: Making it Real Where You Are

Everyone in the system has something that they need to deliver on. The smart move is to build your business case around those desired deliverables whilst using the evidence gained from completing stages 1 and 2 to clearly describe the benefit to the patient.

What do the stakeholders in your planned improvement need to deliver on?
Remember this could be about people, materials and equipment, ways of working, the working environment or financial or service delivery targets linked to these. This can be found in business plans, NHS Board Annual Plan, targets, personal objectives of senior managers within the NHS system and partner agencies.

How can you tie your planned improvement to these delivery targets?

What direct and specific patient improvement issues can you tie your business case to, based on the work at Stage 1?
This may be the same things as the previous question.
What direct and specific AHP role development or workforce planning issues can you tie your business case to based on the work at Stage 2?

Stage 3: Creating Improvement – The Business of Change, Making it Real Where You Are

Remember that a business case doesn’t need to be complex, but it does need to be well written, should appeal to the recipients and be clear in its message.

Some pointers that might be helpful:

• It would be really good if this wasn’t the first time that the stakeholders were hearing about the planned improvement!
• Give people information in the way they like to get it not in the way you like to give it.
• Finance people will generally like figure graphs and charts, there will be little point in providing lots of emotional ‘patient stories’ with no back up.
• Colour makes a difference, recent research suggests it increases our attention by 75%.
• Think about how you feel when you see another ‘high importance’ document in your in-box!
• If it really matters then behave as if it does, use meetings, clinical forums and other existing mechanisms to share your message with passion and enthusiasm.
• Believe that you will get what you want, that way you have a chance of getting something.
• Do your best and whatever the outcome you will have learned, go back and share that learning with everyone who has supported you along the way, then next time they will be motivated to have a go again.

Taking all of the above into account what do you need to think about now?

Now go and do it! The following is a simple outline to help you in creating a business case.
Business Case Development

1. Executive Summary

A summary of the key elements. Complete this last and remember it may be the only bit that others read!

2. Strategic Context

This sets the context for the case, allowing the reader to understand how it relates to the delivery of the NHS targets or objectives.

The drivers should be quantified as much as is possible e.g. a 10% increase in demand for service X and a clear rationale provided.

This section should also include an analysis of the views of stakeholders on the goal of the case. Cases that do not have stakeholder support are very unlikely to be successful.

Stakeholders could include some or all of:
- staff (inc. the Partnership forum)
- patients and other service users (in a wide sense i.e. not restricted to patients but all who get services from the Department, including ‘internal customers’ such as other NHS departments)
- representative groups of stakeholders
- partners/Suppliers
- SEHD/Government
- public.

3. Objectives & Constraints

Objectives should be SMART: Specific, Measurable, Achievable, Relevant and with a Time element. To ensure this, measures of success may need to be identified alongside each objective. Good objectives use words like ‘improve’, ‘reduce’, or ‘maintain’ and specify quantified targets: for example, to improve by 10% or to increase by a specific amount by a given date.

The case should also identify any constraints on the means of achieving the objectives of the investment e.g. a limited amount of a key resource or facilities, laws, policies etc.

4. Benefits Criteria

Benefits criteria are created and they will be used to select and evaluate the options that will be generated in the next stage of the process. They are derived from the service objectives and constraints developed and described earlier. They should be developed jointly by all interested parties directly affected by the proposals and have their support. You could use information you collated during Stage 1 and Stage 2.

Benefit criteria fall into three categories:
- benefits which can be quantified financially
- benefits which can be quantified, but not in financial terms
- benefits which cannot easily be quantified.
5. Options

The purpose of this step in this process is to identify as wide a range as possible of options available to meet the objectives identified in Section 3, which could provide the identified benefits. A basis for comparison will also be required (the ‘do nothing’ or ‘do minimum’ option).

Option generation involves two main stages: conceiving a long list of possibilities by reference to the objectives, followed by refinement to produce a short-list. The ‘do nothing’ or a ‘do minimum’ option should be retained as a baseline in the shortlist since the implications of doing nothing/little must be assessed.

The options are then analysed to identify how well they perform against the non-financial benefits criteria already produced. The benefits criteria should be weighted and the options scored.

6. Cost of the Options

The aim of this step of the business case process is to identify the total net cost of the options relating to the planned investment i.e. the additional costs less any savings as discussed under quantifiable financial benefits in Section 4 above. This requires estimates to be made of:

- capital/one-off costs of the new investment
- revenue running costs
- savings in costs (recurring and one-off)
- opportunity costs of resources already owned (i.e. where resources could be put to alternative beneficial use)
- costs related to changing the work and practices of the organisation
- consequential costs borne by others
- when costs will be incurred/savings made (cash flow).

The main output from this process will be to rank the options on an economic basis. The outcomes of the assessment against the benefits criteria and the economic analysis can then be combined to rank the options. This will identify the provisional preferred option.

7. Risks and Uncertainties

Risk arises from the possibility of more than one outcome occurring, with the likelihood that something will not turn out as planned or expected. The categories of risk to be considered include:

Uncertainty: The projected costs and benefits of an option will always be subject to some uncertainty.

Optimism Bias: When the possibility that something will turn out differently is not fully allowed for, optimistic bias occurs.

Variability: Where the range of possible out-turns of an option is wide, it is subject to variable risk.

The ranking of the options is then retested to see if it is sensitive to the risk factors e.g. by adjusting projected savings associated with an option to reduce the optimistic bias, it ceases to be the lowest net cost option.
The final assessment and ranking can now be done.
In the case of ‘variability’, a plan should be provided for the preferred option showing how the risks will be managed to maximise the likelihood of the benefits being achieved. This should also show any residual risk that might still be after the risk management programme is put in place. The format and method is shown at the end of this section.

8. Project Management

This Section should describe the project management arrangements e.g. the governance structure (Project Board, Project Management Team). The management arrangements should be commensurate with the size and complexity of the project.

9. Conclusions and Proposal

This should tie up the case by clearly stating the outcome and the proposal. The envisaged source of funding must also be identified. Much of this will be included in the Executive Summary.

Business Case Risk Analysis and Management Plan - Project Risk Register

<table>
<thead>
<tr>
<th>Ref.</th>
<th>Description of Risk and Impact</th>
<th>Assessment</th>
<th>Risk Management Control Processes</th>
<th>Residual Combined Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Likelihood (Hi/Med/Low)</td>
<td>Impact (Hi/Med/Low)</td>
<td>Combined (Hi/Med/Low)</td>
</tr>
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<td>1.</td>
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<td>2.</td>
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<td>3.</td>
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<tr>
<td>Etc</td>
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</tbody>
</table>

Description
Insert a description of the risk and the impact it would have on the project if it occurred.

Assessment
Likelihood and Impact should be assessed as if there were no control mechanisms. The combined assessment matrix is as shown below.

Control Processes
Identify the ongoing control measures to prevent the risk occurring.

Residual Risk
The revised combined risk assessment assuming the risk management processes are in place and working effectively.
Risk Assessment Matrix

<table>
<thead>
<tr>
<th>Impact</th>
<th>Likelihood</th>
</tr>
</thead>
<tbody>
<tr>
<td>High</td>
<td>M</td>
</tr>
<tr>
<td></td>
<td>H</td>
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<tr>
<td></td>
<td>H</td>
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<tr>
<td>Medium</td>
<td>L</td>
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<td>H</td>
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<tr>
<td>Low</td>
<td>L</td>
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<tr>
<td></td>
<td>L</td>
</tr>
<tr>
<td></td>
<td>M</td>
</tr>
</tbody>
</table>

- M: Medium
- L: Low
- H: High
Conclusion

We hope the workbook has been of help. In addition to this there are three half day workshops which can be used to facilitate Stages 1, 2 and 3 in groups. We would suggest that you get participants to work through these stages and record their perceptions about the Patient Journey that you are choosing to look at prior to the workshop then you will get maximum benefit.

Good luck with everything that you do. Here are a few thoughts to leave you with:

• If you do what you have always done you will get what you always got
  – to get a different result you need to do something different.
  Fiona Macneill Associates

• For things to change, you must change. For things to get better, you must get better.
  Heide Wills

• Most of the things worth doing in the world were said to be impossible before they were done.
  Louis Branderis

• Learning is not compulsory, but neither is survival.
  W Edwards Deming

• If you can’t do things with feeling, don’t.
  Patsy Cline

• It is not who is right, but what is right, that is of importance.
  Thomas Huxley

• No one rises to low expectations.
  Les Brown

• If you want to do something, you will find a way. If you don’t want to do something you will find an excuse.
  Dawn Bauer

It’s your life, your patients, your choice, you decide!
References and additional information:

- www.CCI.scot.nhs.uk
- www.leanhealthcare.org.uk
- www.leanuk.org
- www.mindtools.com
- www.fmahrd.com Fiona macNeill associates leadership provider organisation
- www.ihi.org/IHI/Topics/Improvement/ImprovementMethods/Tools
- Delivering Care, Enabling Health www.scotland.gov.uk/Publications/2005/11/02102635/26356
- Framework for Role Development for AHPs www.show.scot.nhs.uk
- www.ElisabethKübler-Ross.com
- www.eiro.eurofound.eu.int/2004/03/inbrief/de0403102n.html