

Releasing Time to Care

The Productive Community Hospital™

Toolkit

Version 1



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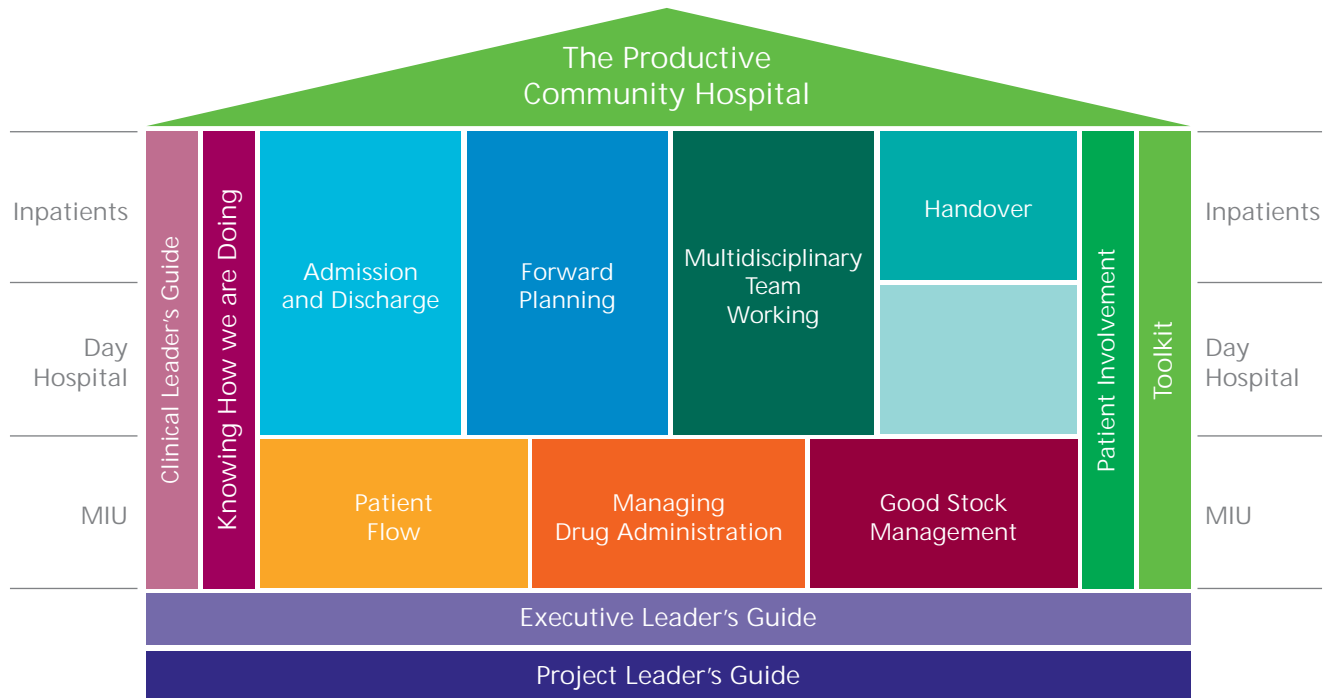
What is a Toolkit?

A reference manual for all the tools mentioned in The Productive Community Hospital modules:

- each tool is clearly and simply explained
- the index on pages 04 and 05 will signpost the location of each tool

The tools are not designed to be used in a stand alone fashion. They should be used as you implement the modules in The Productive Community Hospital.

The Productive Community Hospital modular structure is detailed below:





The Productive Community Hospital Toolkit

Tools are the easy and fun bit but these alone will rarely get you results. They will help you get results only as part of a radical change in your clinical area. The real challenge will be leading your team towards your defined vision of a safer, more timely and more dignified experience for your patients.

It is very tempting to jump straight for the Toolkit when starting The Productive Community Hospital. You need to remember that tools are just a means to an end. In the same way as having a set of wrenches and spanners does not necessarily mean you can fix a car, just possessing The Productive Community Hospital Toolkit is not enough for successful implementation.

Start to use these tools only after you are confident you have prepared to the level the Clinical Leader's Guide module recommends.

It will help you implement The Productive Community Hospital in your clinical area and overcome specific problems.



Toolkit Index

| Tool | Access | Format |
|--|--|----------------------------------|
| General | | |
| 1. <i>Creating a Vision</i> | <i>Toolkit 07</i> | <i>Book</i> |
| 2. <i>Interviews</i> | <i>Toolkit 09</i> | <i>Book</i> |
| 3. <i>Process Mapping</i> | <i>Toolkit 13</i> | <i>Book</i> |
| 4. <i>Photographs and Video</i> | <i>Toolkit 21</i> | <i>Book</i> |
| 5. <i>Meetings</i> | <i>Toolkit 26</i> | <i>Book</i> |
| 6. <i>5S</i> | <i>Toolkit 30</i> | <i>Book</i> |
| Executive Leaders Guide | | |
| 1. <i>Capability Development Tool</i> | <i>Website/CD</i> | <i>Print</i> |
| 2. <i>Framework for Spread</i> | <i>Website/CD</i> | <i>Print</i> |
| Knowing How We Are Doing | | |
| 1. <i>Direct Care Audits</i> | <i>Toolkit 35</i> <i>Website/CD</i> | <i>Book</i> <i>Calculator</i> |
| 2. <i>Patient Satisfaction Audits</i> | <i>Website/CD</i> | <i>Calculator</i> |
| 3. <i>PCH Measures Self Assessment</i> | <i>Website/CD</i> | <i>Print</i> |
| 4. <i>Score Card</i> | <i>Website/CD</i> | <i>Calculator</i> |

Key

Access

- Toolkit 07* available in this Toolkit on page 07
- Website/CD* available from the NHS Institute website, www.institute.nhs.uk/productivecommunityhospital and on the enclosed CD

Format

- Book* available in this Toolkit
- Print* printable products
- Calculator* on-screen spreadsheet / calculus application



| Tool | Access | Format |
|--|------------|------------|
| Admission and Discharge | | |
| 1. <i>Point in Time Audit</i> | Website/CD | Calculator |
| 2. <i>Day and Hour of Discharge Audit</i> | Toolkit 42 | Book |
| 3. <i>Good Practice Example of Admission Policy</i> | Website/CD | Print |
| 4. <i>Discharge planning template</i> | Website/CD | Print |
| Forward Planning | | |
| 1. <i>Time to Care Audit</i> | Website/CD | Calculator |
| 2. <i>Forward Planning Tool</i> | Toolkit 46 | Book |
| | Website/CD | Calculator |
| 3. <i>Staff Skills Matrix</i> | Website/CD | Calculator |
| 4. <i>Day Care Scheduler</i> | Website/CD | Calculator |
| Multidisciplinary Team Working | | |
| 1. <i>Good Practice Induction Questionnaire</i> | Website/CD | Print |
| 2. <i>Good Practice Induction Template</i> | Website/CD | Print |
| 3. <i>Roles and Responsibilities for Induction</i> | Website/CD | Print |
| 4. <i>Shared Care Records Examples 1 and 2</i> | Website/CD | Print |
| 5. <i>Good Practice MDT Summary Document</i> | Website/CD | Print |
| Handover | | |
| 1. <i>Handover Audit Template</i> | Website/CD | Print |
| 2. <i>Good Practice Handover Template</i> | Website/CD | Print |
| Patient Involvement | | |
| 1. <i>Patient Information Audit</i> | Website/CD | Print |
| 2. <i>Patient Information Booklet</i> | Website/CD | Print |
| 3. <i>Patient Comment or Request Form</i> | Website/CD | Print |
| Patient Flow (MIU) | | |
| 1. <i>First Contact Protocol</i> | Website/CD | Print |
| 2. <i>First Assessment Protocol</i> | Website/CD | Print |
| Managing Drug Administration (MIU) | | |
| 1. <i>PGD Management Audit</i> | Website/CD | Print |
| 2. <i>PGD Formulary</i> | Website/CD | Print |
| Good Stock Management (MIU) | | |
| 1. <i>Room Usage Audit</i> | Website/CD | Print |
| 2. <i>Distance Travelled Audit</i> | Website/CD | Print |
| 3. <i>Standardised Treatment Area Tools 1, 2 & Trolley</i> | Website/CD | Print |
| 4. <i>Sample 5S Sorting Labels</i> | Website/CD | Print |



1. Creating a Vision

What is a vision?

A compelling statement that tells everyone your ambition for your clinical area.

Why spend time creating one?

- it sets the bar for what you would like to achieve
- it provides a context to set your improvement activities against, eg, 'we're doing x because it will help us achieve y taking us closer to z'
- an exciting vision can galvanise your team towards reaching it
- it helps those outside your area to understand your aspirations and provide support or even join in!

Where to begin?

- talk to your team, convince them of the benefits in creating a vision
- encourage them to give some thought to what they want for their clinical area

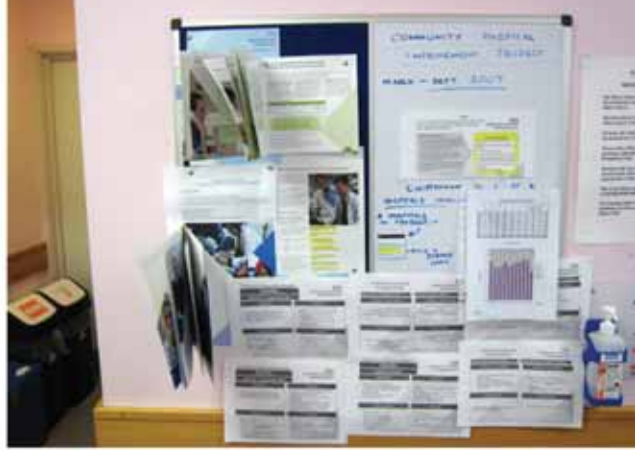
How to create your own

- developing your own vision is very much a creative process. The steps detailed below are intended to provide a loose structure to help you move forward
- arrange 5-10 mins to spend with the team (try to find a quiet place where you are unlikely to be disturbed)
- try to visualise the perfect ward or department:
 - what would it look like?
 - how would it feel to work in?
 - what would patients say about it?
 - how would clinicians and managers describe your ward or department?
- ask yourselves these questions and jot down all your thoughts on sticky notes. Attach these to a poster or wall – they may inspire other ideas from your team members
- try to describe your perfect department in terms of Quality, Safety, Efficiency and Cost
- decide what are the most important elements to you as a team from what you have created so far
- draw some of these together to form a sentence or statement that best sums up these ideas – keep it descriptive and try to use dynamic terms

What to do once you've created your own vision

- display it in a prominent place, eg on your communication board, at the entrance to your department, at your nursing station, etc.
- use it to help you choose what to improve first when you're unsure of your priorities
- work hard to make it happen!

Keep it simple!
No essays, no
jargon and no buzz
words! Keep it real



2. Interviews

| | | | |
|---------------------|--|--------------------------|--|
| <p>What is it?</p> | <p>Talking to colleagues, staff or patients to get information – either opinions, facts or both!</p> | <p>Why do it?</p> | <p>Knowing what people ‘think’ and ‘feel’ before looking at facts puts a different spin on the facts</p> <p>Sometimes that is all you have to go on!</p> |
| <p>When to use?</p> | <p>Before starting a module, to understand how staff or patients feel about:</p> <ul style="list-style-type: none"> • the way the process runs currently • what needs to change • the possibilities of change <p>After running a module to understand how they feel about the new ‘way’:</p> <ul style="list-style-type: none"> • is it an improvement? • are they excited and willing to participate? • are there any issues? | <p>Material required</p> | <ul style="list-style-type: none"> • notepad • pen • some people prefer to use a dictaphone but it is not essential |



Remember, when planning to interview patients seek guidance from nursing director/public and patient involvement lead.

Interviewing – top tips

1. Make sure the interviewee has sufficient time for the interview.
2. Always have an 'interview guide' prepared before you start talking – this is simply a list of questions to ask, and information you require.
3. When coming up with the questions, keep the interviewees' perspective in mind – how will they feel about being interviewed, what are their priorities, are they in a position to answer your questions honestly.
4. Start the interview by explaining the purpose for the interview, and what you will do with the information you gather.
5. Make it explicit whether what you ask will be attributed back to the interviewee or not.
6. Before starting, ask if the interviewee has any questions for you.
7. Run through your questions list – but listen to the answers – sometimes they may take you down another path. Feel free to abandon your scripted questions if more valuable information is forthcoming.
8. Take notes or use a dictaphone – if using a dictaphone, make sure the interviewee is comfortable with it.
9. Convert the notes to a formal record as soon as possible – this is essential to capture the detail, if the written notes have missed it.
10. Ideally, share the interview notes with the interviewee to make sure you have captured it right.
11. Use 'open' questions ie, questions that don't inadvertently lead to pre defined answers (see next page).



Interviewing – using ‘open’ questions

Informal conversations with staff, patients and stakeholders can be a valuable and efficient research method.

When you are working on a particular project you may be looking for a particular type of answer or seeking a particular result. Usually this will influence the way that you ask your questions.

The fundamental thing about ‘open’ language is being aware of where you are leading people with your questions.

Being aware of, and using, ‘open’ questions will help you to minimise your influence on your interviewee.

‘Open’ questioning can help you find out what your interviewee really thinks.

‘Open’ questions are questions that do not direct people to give particular answers and they do not have any major pre-suppositions.

For example, after running a project, you might ask:
‘What do you think of the improvements on this ward?’

This question is problematic in numerous ways:

1. It presumes that the person has noticed that some changes have been made.
2. It presumes that a project has produced improvements.
3. The framing of the question forces the person to answer in the positive. They could be seen as rude if they answer negatively.

An ‘open’ version of the same question might be:
‘What is your experience of this project?’

No question is entirely ‘open’ and you will always inject your own interests and motivations into a conversation. However if you can become aware of how you are directing the conversation you can begin to gather much more detailed and honest information.

Try to think about the category of information that you want to collect information under. For example, staff satisfaction. You may want to think of a few ‘open’ questions under this category such as:

- how long have you worked here?
- has it changed?
- what is it like to work here?
- how do you feel about your work?

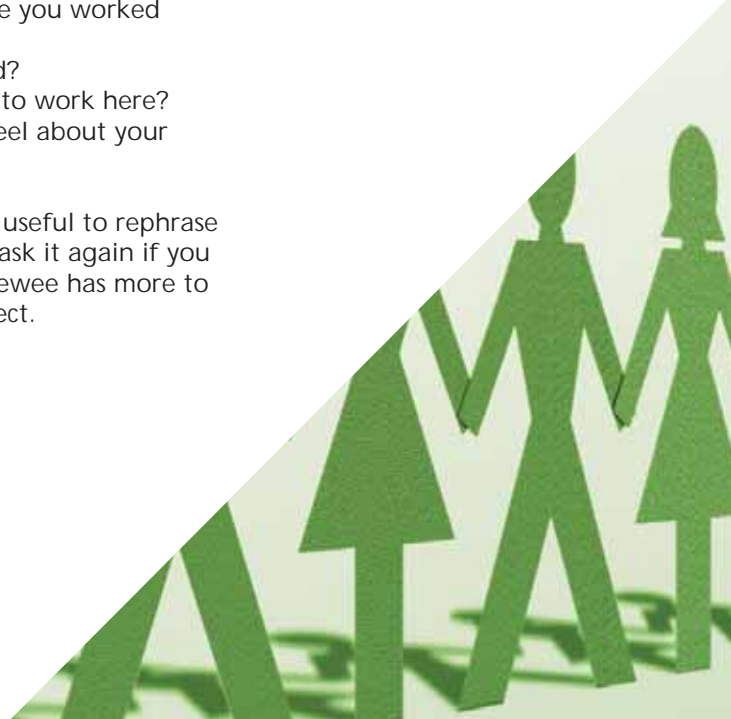
You may find it useful to rephrase a question and ask it again if you think an interviewee has more to say on this subject.

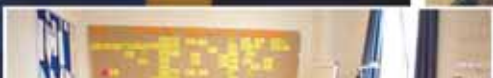
If you are getting useful results and you want the interviewee to continue speaking in the same vein, you may find it useful to repeat back to people what they have just said to you. This can encourage them to keep speaking and often they will go deeper into their thoughts on a particular issue.

Interviewee example:

- ‘I feel we could have gone much further with the improvements if we had involved more people’
- ‘if you had involved more people...’
- ‘if we had involved more people the project would have happened much more quickly, it seemed... it seemed that people who weren’t told about it at the beginning started to slow the whole thing down’

Practising these techniques can help you become more aware of the way that you are asking questions and to get more useful results. You can also practise by listening to the way that other people ask questions.





3. Process Mapping

It is very easy to think that everyone in the team has a common view of what is going on in our wards and departments. This is often not the case. The value of getting everyone to agree on how things currently work, and what the future should look like, should not be underestimated. Process Mapping sets out to do just that.

| | | | |
|--------------|---|-------------------|--|
| What is it? | <ul style="list-style-type: none"> • a tool to map current status of a process (eg, admission process, patient journey, handover) | Why do it? | <ul style="list-style-type: none"> • to allow representation of a process in a systematic manner, making it open to debate and change |
| When to use? | <ul style="list-style-type: none"> • when mapping existing processes • to identify issues • to brainstorm solutions for the identified issue | Material required | <ul style="list-style-type: none"> • flip chart • marker • post-its • big piece of paper |

Process Mapping originates from a technique used in industry – value stream mapping. The aim of process mapping is to provide a framework in order to re-design processes, so that the steps of the process deliver greater levels of value. Value in our case is a safer, efficient, dignified and more timely patient journey.

The technique:

1. Collect data and understand the process.
2. Create the current state map.
3. Analyse the current state map.
4. Look for areas of improvement.
5. Create a future state map.
6. List change items and create a plan.
7. Implement the changes and confirm results.
8. Future state = current state.

Example: Map how we currently do our handover

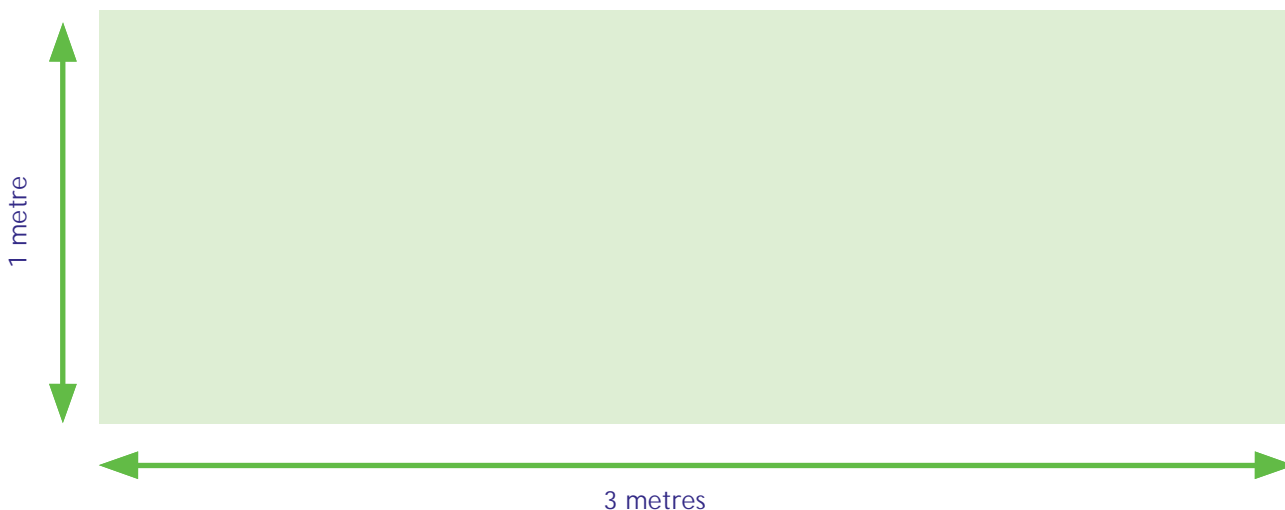
1.

Collect data and understand the process
 If possible video your process from start to finish. If this is not possible then it is important that you 'go and see' to observe and make notes of what actually happens. Try to gather any data that can be used to show the true picture.



2.

Create the current state map
 Use a large piece of paper roll to allow you to attach sticky notes representing each step of your process. It is important to involve all of the relevant staff at this stage. So if your process involves external resources then these should be included now.



If you do not have enough room on one wall, you can bend the paper round a corner as illustrated in this picture.



Start to map out your process using one sticky note for each step. If watching the video, start/stop the video at each step, note the time elapsed and place

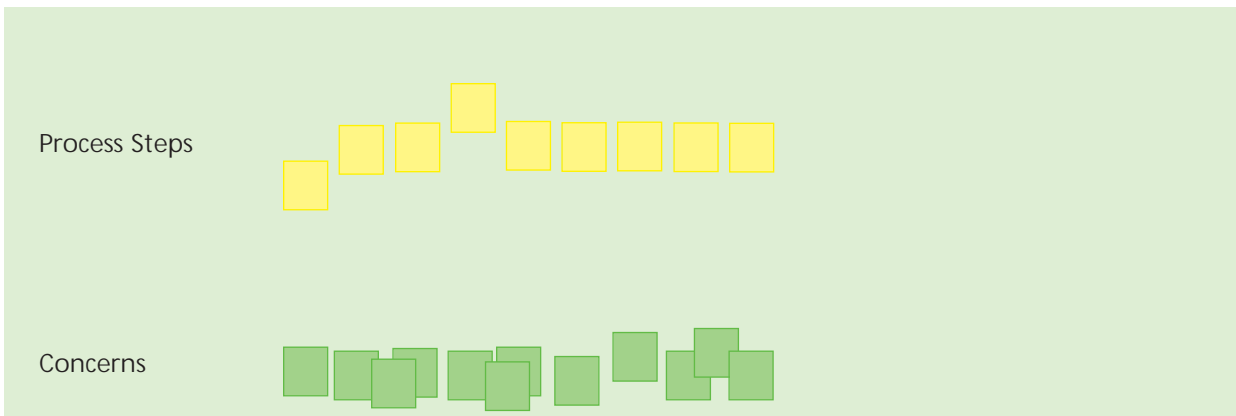
onto the paper roll sequentially. Actively involve all present to identify concerns or activities that should not be happening using different coloured sticky notes.

Remember this is not about blame, more about highlighting areas that can be improved.

Continue to do this until you have reached your end point. Now agree that what you have created is a true representation of what actually happens. Have you captured all of the concerns?

Add all of the concerns to the map under each related step. If any documentation is used within the process add it to your map.

Example of process steps with related concerns in a line of sticky notes underneath.



Key Point: Don't try to make your map look like ones you may have seen elsewhere. As long as you have enough detail and the map is a true representation of the process then this is your current state map.



Summary of the seven different types of waste normally assessed in a lean process review.

| Waste type | Description |
|----------------|--|
| Waiting | Tasks that cannot be performed due to waiting for people, equipment, information or materials |
| Stock | Any build-up of stock that is in excess of that which is required to meet demand |
| Motion | Any queuing of work and/or clients |
| Transport | Unnecessary movement of people Unnecessary movement of materials and equipment |
| Rework | Repeated work due to a prior failure to deliver a correct service. This could be due to poor information at the time |
| Overprocessing | Work that adds no value from the client's point of view |
| Overproduction | Doing more than is required or earlier than it is required |

3.

Analyse the current state map
Now ask some key questions:

- what waste is there (see table above)
- what are the slowest parts of the process, that keep other parts waiting?
- are the right resources used?
- what drives the process?

4.

Look for areas of improvement
Now together look for ideas or suggestions on how to improve. Add these suggestions to a flip chart using sticky notes. All ideas no matter how big or small should be captured.

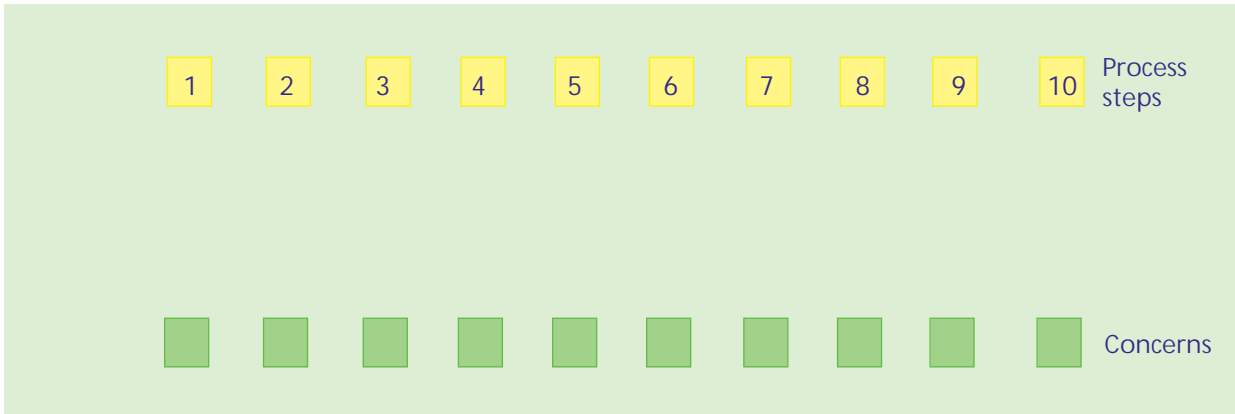
5.

Create a future state map
At this point it is important to aim for the ideal process. By aiming for this it will push you beyond just putting right all of your current concerns. Your ideal future state map should have NO concerns. Remember to think 'out of the box', remove yourself from the constraints within your current process. What would be the safest, most dignified process for the patient?

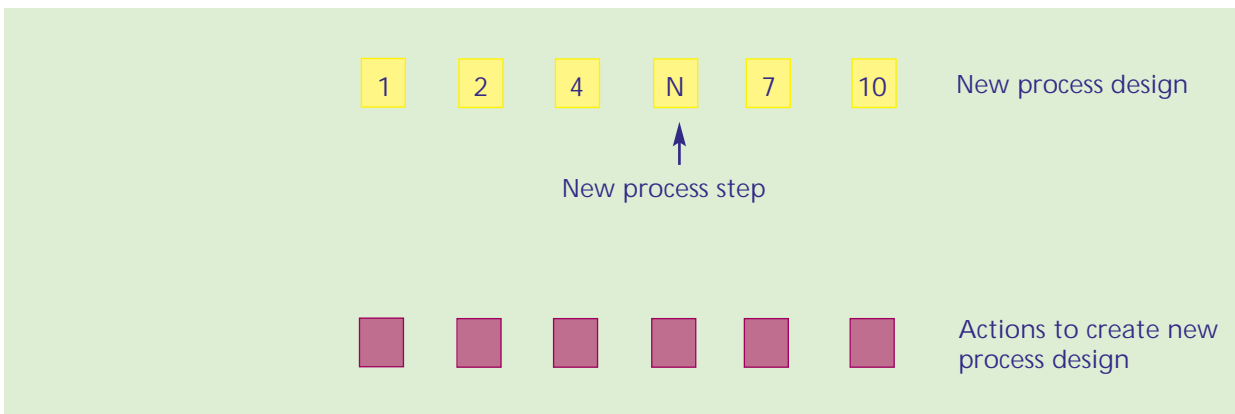
Build your future state map in the same way as before only this time use a sticky note for each of your new steps but now at each step write down the action needed to achieve it.

Continue this method until you have reached your end point. Now you can cross reference back to your current state map to ensure that the actions will eliminate all of the concerns raised within your current process.

Current State:



Future State:



6.

List change items and create a plan

Decide which are your priority actions by using your action notes on your future state map. You may wish to categorise them into actions that:

- will improve patient safety
- will provide the best patient experience
- are the simplest to accomplish
- will release time for patient care

7.

Implement the changes and confirm results
 Monitor your KPIs to understand impact of changes made. Try to quantify improvements made where possible or collect quotes from staff / patients to help raise awareness and enthusiasm as you progress. Confirm your results and feed back to all involved.

8.

Future state = current state
 Once we have created and implemented our future state map, we have effectively set a new standard and so the future state map now becomes the current state from which we can continually improve.

Summary

Process maps allow processes to be broken down into small manageable chunks which can be analysed and understood at a glance by everybody.

Process maps help engage the attention of all participants, whereby their contribution and knowledge is fundamental in making the process maps what they are.

Process maps help identify the current state of a process and when changes and modifications are made they can also illustrate the future state process with all the waste and inefficient processes removed.





4. Photographs and Video

| | | | |
|---------------------|---|--------------------------|---|
| <p>What is it?</p> | <p>Taking photographs is a good tool to collect data that also doubles as a presentation tool</p> | <p>Why do it?</p> | <p>Captures 'perishable evidence' such as meetings and unfilled charts etc.</p> <p>Avoids 'hearsay'</p> <p>Is a very good communications tool</p> |
| <p>When to use?</p> | <p>Photographs should be used to capture:</p> <ul style="list-style-type: none"> • events (meetings and workshops) • displays (boards, signs) • situations that change (eg, unattended drug trolley, unmade beds etc) <p>Especially useful to demonstrate the difference 'before' and 'after' a change</p> | <p>Material required</p> | <ul style="list-style-type: none"> • a camera (digital preferred, ideally >2 mega pixels) • camcorder (digital or mini DV recommended) • communications, A&E and imaging departments often have these cameras |



Photographs – top tips

1. Use a digital camera – photos can then be transferred to a computer, mailed, printed, and included in presentations.
2. Ask staff and patients for permission to photograph: get written consent (see below) - If patients are in a confused state then assume you do not have their permission and do not photograph them.
3. Ensure the area being photographed is well lit.
4. Always keep your back to the light source.
5. Determine exactly what is needed in the photo – try and include that, but nothing else.
6. Steady yourself, and the camera.
7. Allow a few seconds for the camera to focus.
8. If photographing text, ensure you take photographs with and without the flash – different surfaces react differently.
9. If using a digital camera (usually with a large memory), click 2 photographs every time – one as back-up.
10. If people are photographed, show the photograph to them before using it in a presentation/meeting.

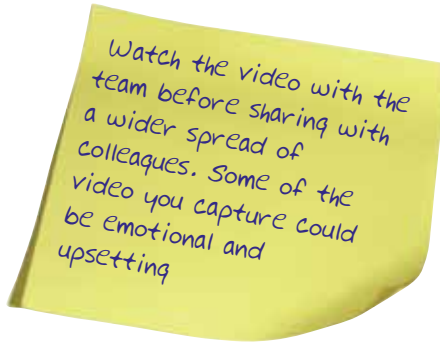
Photographs – written consent

Under no circumstances should you take photographs, or videos, without the consent of those involved.

Ask your communications department for your trust's photograph / consent form. Have one filled out by everyone involved in your photographs.

Be extra careful when photographing patients. If a patient is in a confused state then make the presumption that consent has not been given.





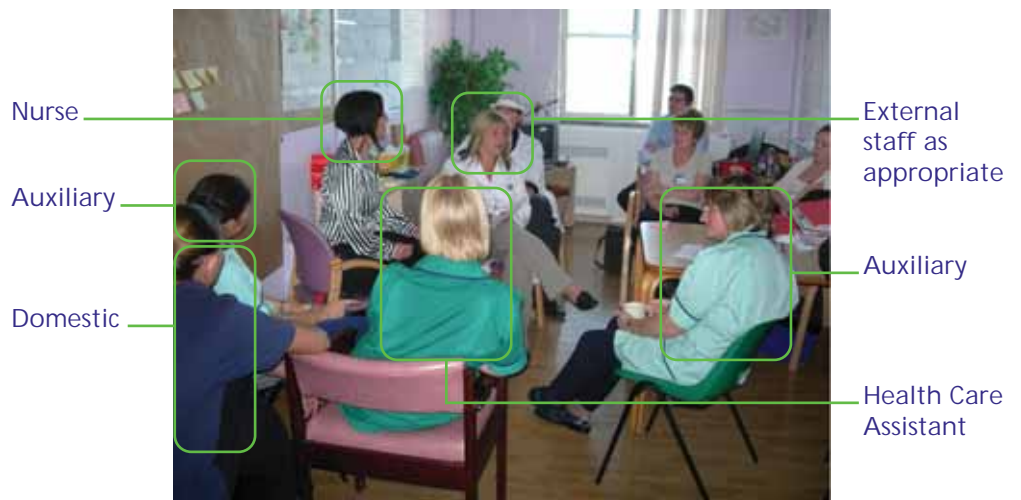
Video – top tips

1. Practise using the camcorder before you record anything:
 - find out how to start and stop recording
 - practise how to hold the camera to avoid shaking and jerky movements
2. Ask staff and patients for consent to video: get written consent - If patients are in a confused state then assume you do not have their consent and do not video them.
3. Give staff members at least one day's notice of the intention to video.
4. Choose someone who has used the camcorder before to do the recording if possible.
5. Make sure the camera is charged, and that you have an empty tape.
6. Ask staff to behave exactly how they would normally.
7. Try to stand back and film from a distance to allow staff to work unhindered.
8. Pick one member of staff to follow.
9. Before sharing the video with the ward team, watch the video back to make sure the video has recorded properly, to iron out any technical playback problems and to begin to understand the issues presented by the video.

Watching the video back

Involve all relevant parties

Follow simple ground rules



- observe, do not judge or comment (just yet)
- note everything you see!
- it is OK to be uncomfortable - if you are on the video, do not defend yourself - this is an opportunity to see what can be improved and learn together!

Advanced tips for shooting video

After you have done a few videos, you should consider some of the advanced tips below. They will help you produce better quality videos that are easier for the team to use.

Use the widest lens setting possible

A 'wide lens' means the camera is fully 'zoomed out'. If you are hand holding the camera always use the widest lens setting that you can. This will minimise any shaking and make it much less apparent to the viewer. You will get a cleaner and sharper image too. Set the lens to the widest or something close to the widest setting and leave it there.

Avoid zooms

Zooming in and out can be very distracting for the viewer. If you are hand holding the camera it is often better to physically move rather than zoom. In general you should find your shot and stick to it. If you do zoom (for instance, to show some detail or to emphasise something or to gently change the frame because there is something you want to include or exclude) do it deliberately and smoothly, but in most cases it is best avoided.

Keep steady / hold the frame

Avoid unnecessary movement - let the subject move rather than the camera. Be confident - keep the frame steady and allow action to come in and out of it rather than trying to follow everything. Don't cut or move to another shot too quickly - allow the action to unfold.

Don't make your shots too short

Some video cameras take a little time to come to 'speed' so never shoot less than five seconds and preferably at least ten. Those few seconds extra will also make editing much, much easier.

Try to avoid filming people against the light

Often the most dramatic shots are filmed against the light, but film someone against a window and they will be a silhouette. Most video cameras don't cope very well with contrast and if you are doing an interview try to make sure that they are lit brighter than the background behind them.

Look at the overall frame, not just through the viewfinder

Be aware of what is in the background of the shot. Good material can be rendered unusable if the activity or images in the background are distracting or inappropriate. Compose the shot - mentally step back and look at it as a frame with objects positioned in it. Most people can recognise what a good shot is when they see it on a monitor or look at a photograph but the untrained eye can forget this when looking at the world through the camera viewfinder.

Asking junior staff to do the videoing is less intimidating for the staff being filmed

Make sure the video is representative of real life! Avoid the temptation to put on a 'good show' for the camera



Always be prepared.
Don't leave staff
waiting - whether
it's for weekly
meeting, a handover
or to work on a
module

5. Meetings

Having a meeting can be a useful tool to generate discussion and ideas

| | | | |
|--------------|--|-------------------|--|
| What is it? | <ul style="list-style-type: none"> a structured gathering to discuss and set actions on specified subjects | Why do it? | <ul style="list-style-type: none"> discussing issues and coming to solutions is often better with several people coming together in a 'huddle' at regular intervals keeps everyone feeling 'part of the team', and ensures ideas are not missed people involved in finding the solution believe in it more! |
| When to use? | <ul style="list-style-type: none"> weekly to review ward level measures when issues are simmering, but need to be identified when specific issues need to be resolved to communicate decisions | Material required | <ul style="list-style-type: none"> flip chart marker other materials depend on the type of meeting – eg, a measures display board for the weekly review |

Top 12 tips!

- Understand the objective of the meeting – decide accordingly who needs to be present.
- Make sure all present know the objective.
- Have a set agenda.
- For every item on the agenda – ask the question: Is this best discussed with everyone present?
- Decide who will take notes.
- Always start the meeting with an explanation of the objectives and agenda.
- Pause, and ask for questions/clarifications.
- Capture next steps (actions) as they arise through the meeting, on a flip chart.
- For every next step, mark the responsible person and deadline.
- Start the next meeting by reviewing next steps from the last one.
- Ensure all participants prepare for the meeting.
- More practical guidance and advice on making meetings productive, and guidance on how to make things like email less of a burden, can be found by exploring the NHS Institute for Innovation and Improvement's Productive Leader programme. Visit www.institute.nhs.uk/productiveleader.

If you are not prepared then it gives staff an excuse to bring up things like releasing time to care ... This meeting is taking me away from patients...

The four Ps of productive meetings are underpinned by golden rules for each stage of the meetings process.



You have a responsibility to yourself and others to run productive meetings, maximising your own and their time.

| The 4 Ps of productive meetings | | |
|---------------------------------|---|---|
| Plan | <p>Top Tips</p> <p>Think about the following:</p> <ul style="list-style-type: none"> • do you need a meeting? • what do you want to achieve? • who needs to be there? • is this a formal or informal meeting? • where should you hold the meeting? | <p>Agenda</p> <p>An effective agenda is vital:</p> <ul style="list-style-type: none"> • don't leave important items until the end • assign people to items • assign timings to items • schedule breaks if meeting is over an hour |
| Prepare | <p>Top Tips</p> <p>You need to have given thought to:</p> <ul style="list-style-type: none"> • why you are attending the meeting? • what your contribution will be • do you need to do pre-reading? • have you done actions from previous meetings? | <p>Venue</p> <p>Choosing the right venue for your meeting is really important. Make sure everybody can:</p> <ul style="list-style-type: none"> • see • hear <p>It is also important that you limit distractions</p> |
| Participate | <p>Top Tips for Participants:</p> <ul style="list-style-type: none"> • know why you are there • be there on time • stay on subject • don't cause problems for the Chair • be open to the ideas of others • help the Chair control the meeting • share your thoughts and ideas | <p>The Role of the Chair:</p> <ul style="list-style-type: none"> • agree note/actions taker who uses the actions/decision sheet • start and finish on time even if people are late • be clear about the purpose of the meeting • keep the meeting to time • keep track of agreed actions • review actions with agreed timescales • confirm date and time of next meeting |
| Pusue | <ul style="list-style-type: none"> • ensure that any lessons learned are communicated to all the team • make sure that the actions and decisions sheet is circulated to everybody within 48 hours • read the actions and decisions sheet and allocate time to follow-through on your actions • prepare for next meeting | |

If your staff don't like the word 'agenda' then approach the meeting by stating 'this is what we are going to cover today'

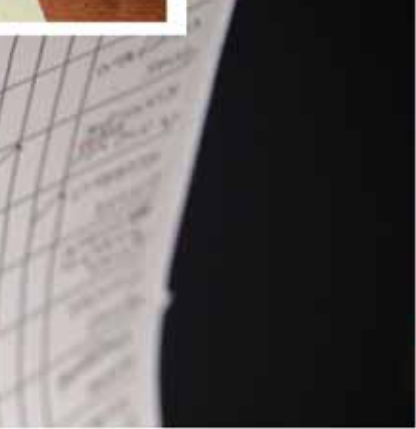
A good agenda should look like this

| Items | Who | Time |
|---|-----|---------|
| 1. Objectives for today | AB | 5 mins |
| 2. Next steps from last week – where are we now | AB | 10 mins |
| 3. Content topic 1 | EF | 15 mins |
| 4. Content topic 2 | GH | 15 mins |
| 5. Next steps and responsibilities | AB | 10 mins |
| 6. Any other business | All | 5 mins |

What is the role of the meeting chairperson?

| This | Not this |
|---|---|
| <ul style="list-style-type: none"> • agree an agenda – and ensure all topics are covered • set the context for discussion – and hear other's opinions • encourage brainstorming to reach a collective decision • reflect on other's experiences, to bring in all points of view • ensure no meeting ends until next steps, with responsibilities and deadlines are defined | <ul style="list-style-type: none"> • discuss what seems interesting at that point • state own opinions as context • decide oneself and then convince others • treat what they've seen as the 'right' way to do things • end meetings with a few words of summary |

When you are chairing a meeting you need to make sure everyone has had an opportunity to contribute. Ask people directly



6. 5S

| | | | |
|---------------------|---|---------------------|---|
| <p>What is it?</p> | <p>A simple technique used to create and maintain an organised, clean, safe, and high performing workplace</p> | <p>What is it?</p> | <ul style="list-style-type: none"> • to standardise processes which should always be the same • to reduce unnecessary variation in layout, stock or equipment • to quickly identify a shortage of tools or materials |
| <p>When to use?</p> | <ul style="list-style-type: none"> • To improve ward/department layout • To improve cluttered or busy work areas • To systematise stock and equipment flow | <p>When to use?</p> | <ul style="list-style-type: none"> • sticky labels • tie tags • sorting boxes • marker • colour coding mechanisms (labels, tags) |

Simply put, 5S stands for:

- Sort: identify items that are needed.
- Set in Order: create a place for all of these items
- Shine: create a clean and safe working environment.
- Standardise: put standards in place and monitor.
- Sustain: continually review the working practices to ensure that the working environment supports the process.

5S is a Lean Thinking technique that can be used alongside and independent of other techniques and will rapidly affect the workplace with little or no investment.

For more information about Lean Thinking and its application in the NHS Institute for Innovation and Improvement's 'Going Lean in the NHS', www.institute.nhs.uk

5S – things to consider

- untidy, cluttered work areas are not productive, but merely tidying up will only make a marginal improvement to the productivity of the operation
- when performing 5S, the focus is not about being more tidy and more organised. The focus is on understanding what tools and materials support the processes being delivered and how they can be stored, cleaned and maintained in order to best support that process For every next step, mark the responsible person and deadline
- take photos of the work area before you start, of the items that are removed from the process and of the work area at the end of the process. These will act as good documentation of the 'before', 'during' and 'after' and may help prioritise which areas to work on during the process
- the 5S process is sometimes referred to as the '6S' process with a sixth overarching focus on Safety. It is important that throughout a 5S initiative focus is always placed on the safety of the workplace, or clinical environment
- estimate the value of out-of-date and surplus stock



5S – examples of the steps

| | |
|---|--|
| <p>Sort: Separate what is needed from what is not, keep only what is needed. This will remove clutter, free up floor space and improve work area efficiency.</p> <p>Tag each item as follows: Green = Keep; Yellow = Unable to classify; Red = Remove. Establish a holding area for all 'Yellow' items and keep them there for an agreed period of time. If they are not Green tagged then remove.</p> <p>Document all items that have been removed and what has been done with them.</p> | <ul style="list-style-type: none"> • sort out and remove old, broken and redundant equipment • remove out-of-date stock in cupboards, sluices, store rooms and medicines cupboards • archive or destroy old documents (both physical and electronic) |
| <p>Set in Order: Have a place for everything and put everything in its place.</p> <p>Arrange, label and store items so that they are easy to find and use and within a close proximity of the staff who require the equipment.</p> <p>Sort things, alphabetically, numerically or use photos to enable things to be found quickly. Document what and where items are stored so that this can be maintained and staff not used to the work area know where to find things.</p> | <ul style="list-style-type: none"> • clear labels and descriptions in store rooms and medicines cupboards • use colour coding • organise files in logical order in a filing cabinet • sort pharmacy stock in the order of the most frequently used items |
| <p>Shine: Also referred to as 'Sweep and Shine'. Having ordered your work area create a clean and tidy working environment.</p> <p>Modify cleaning arrangements to support the new work area.</p> <p>Provide sufficient and appropriate waste disposal mechanisms for refuse and recycling.</p> | <ul style="list-style-type: none"> • keep nursing station and ward office clutter-free with sufficient bins • locate and label appropriate bins within easy reach of the working environment • maintain the best standards of infection control and hand washing |
| <p>Standardise: Ensure the first three S's are being maintained and this maintenance is incorporated into everyday activities.</p> <p>Agree, document and implement standard procedures for routine work area maintenance and cleaning.</p> | <ul style="list-style-type: none"> • have clear roles and responsibilities for staff around work area maintenance • provide maintenance and cleaning charts to support the roles and responsibilities |
| <p>Sustain: The final step is maintaining the set work standards and actively removing any causes which obstruct the maintenance of these standards. Sustaining is the most important "S," and it requires the most discipline.</p> | |

5S Drawer Game

A quick simple game to illustrate the concept and principles of 5S

Preparation

Find a box / container and fill with items that could be found in a typical ward clerk's drawer in a ward environment.

For example:
pens, blue tack, highlighter pens, rubber bands, correction fluid, and ruler, hole punch, stapler and staples etc. Vary the amount and don't forget the paper clips all loose in the drawer.

Then add the other items that you know you would also find: Old Christmas cards, sugar, tea bags, loose change, gloves syringes, odd tube of KY jelly, tissues, packets of sugar, post it notes, scissors, calculator, screws, tube of hand cream etc.

Don't forget the one item that is always found in the drawer... something that no one knows what it is... a piece of broken equipment or broken bit of plastic. Add a teaspoon or two...

Prepare areas / boxes to replicate where items should be stored i.e., kitchen, store room, bin. Also include an area / box for items where the team are un-decided.

Collect your staff (do not use a ward clerk). The minimum number of staff required for this game is 2 but it is better if played with more.

A 5S numbers game is available on the NHS Institute's Productive Ward web pages at www.institute.nhs.uk/productiveward

Playing the game

Stage 1

- run through a short introduction on the principles of 5S

Stage 2

- ask your staff to use the 5S process and sort, set, shine, standardise and use the general rule of audit to sustain the improvement
- staff should ask for an inventory sheet. If not requested then suggest that they may need one and hand out
- explain they can write on the box and mark the box in any way
- when using the inventory sheet, ask the team to estimate the cost of each item.
- the group will need between 10 and 15 minutes to complete this

Stage 3

- if more than one team is playing, ask the teams to audit each other's work and feedback comments. If just one team is playing, the facilitator should audit the drawer
- encourage the team to talk through the exercise
- ask them to highlight any savings made
- ask the staff what their rationale was for setting the stock levels?
- what items did they return and bin?
- what visual management did they use?
- ask the teams who they felt should be involved in the process?
- ask the team what they would need to do in order to sustain the changes?
- explore with them how they would do that

Stage 4

- ask the team how the ward clerk felt about his/her new well organised drawer?
- did any one in the group pick up that the exercise was completed without engagement from the ward clerk?
- how did you decide the stock levels of her equipment?



3. How to carry out a direct and indirect care audit

Management preparation for the audit

| | |
|---|--|
| Identify which clinical areas will undertake the audit | |
| Inform all staff participating and any others that might need to know (managers, patients) Consider putting up a poster | |
| Ensure you have demonstrated how to complete the audit to those participating. Go through the descriptions of the activities to ensure they are consistently understood | |
| Print out the audit sheets in A3 and provide clip boards or identify a flat surface for the duration of the audit. Display the activity descriptions clearly. | |
| Identify who will be the observers (non participant) | |
| Arrange to count and record: occupied beds at 12MD or 12MN for inpatients, or total attendances during the time period for MIU, or total patients for day hospital | |
| Establish a safe collection point for completed forms and how you will return them to your support team member | |

Who should take part

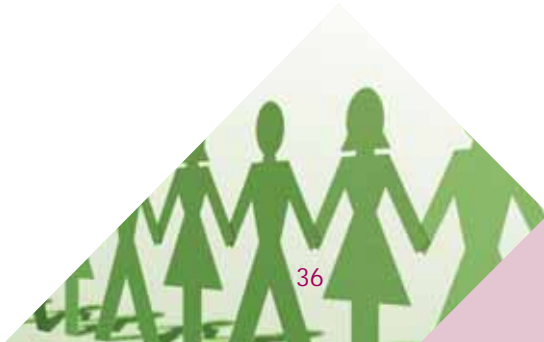
Staff included:
medical, allied health, nursing, and health care assistant staff.
Administration and clerical support staff directly supporting clinical activities. Pharmacist when providing intervention to patient ie, advise.

Not included:
House-keeping/cleaning staff, maintenance and kitchen/catering staff. Volunteers. Hairdresser. Pharmacist when dispensing.

Example of audit sheet

| Activity Study Sheet | | Date | Start time | Hours of Shift | Paid hours on duty | | | | | | | | | | | | | | | | | | | | | | | |
|--------------------------------|----|--------|------------|----------------|--------------------|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|---------------|-------------|------|--|
| Zone / Area | | Person | Observer | | Signature | | | | | | | | | | | | | | | | | | | | | | | |
| | | Role | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Activity description | 08 | 09 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 | 31 | TOTAL 5th min | Grand Total | | |
| Direct Patient Contact | | | | | | | | | | | | | | | | | | | | | | | | | | 0:00 | 0:00 | |
| Clinical Meeting | | | | | | | | | | | | | | | | | | | | | | | | | | 0:00 | 0:00 | |
| Clinical Administration | | | | | | | | | | | | | | | | | | | | | | | | | | 0:00 | 0:00 | |
| General Administration | | | | | | | | | | | | | | | | | | | | | | | | | | 0:00 | 0:00 | |
| Non Clinical meeting | | | | | | | | | | | | | | | | | | | | | | | | | | 0:00 | 0:00 | |
| Telephone contact | | | | | | | | | | | | | | | | | | | | | | | | | | 0:00 | 0:00 | |
| CPD given or received training | | | | | | | | | | | | | | | | | | | | | | | | | | 0:00 | 0:00 | |
| Research/Comm Contact | | | | | | | | | | | | | | | | | | | | | | | | | | 0:00 | 0:00 | |
| Clinical/medical work | | | | | | | | | | | | | | | | | | | | | | | | | | 0:00 | 0:00 | |
| Breaks | | | | | | | | | | | | | | | | | | | | | | | | | | 0:00 | 0:00 | |
| Activity waiting for patient | | | | | | | | | | | | | | | | | | | | | | | | | | 0:00 | 0:00 | |
| Waiting including collecting | | | | | | | | | | | | | | | | | | | | | | | | | | 0:00 | 0:00 | |
| TOTAL | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

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Equipment required

Easy access to the time



A3 sized clipboard



or easy access to flat surface



A3 size copy of audit sheet

| Activity Study Sheet | | Date | Start time | Hours of Shift | Paid hours (if applicable) |
|------------------------------------|-------------|-----------|------------|----------------|----------------------------|
| Activity description | Zone / Area | Person | Observer | | TOTAL (min:sec) |
| | Role | Signature | | | |
| Direct Patient Contact | | | | | |
| Clinical Meeting | | | | | |
| Clinical Administration | | | | | |
| General Administration | | | | | |
| Non-Clinical meeting | | | | | |
| Telephone contact | | | | | |
| CPD give or receive training | | | | | |
| Relative/Carer Contact | | | | | |
| Clinical/medical with | | | | | |
| Breaks | | | | | |
| Activity waiting for patient | | | | | |
| Waiting for/looking for/collecting | | | | | |
| TOTAL: | | | | | |

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Basic methodology for staff completing sheet

The audit sheet is designed to allow a staff member to accurately capture the activity undertaken in the timeframe set.

The audit sheet works in five minute intervals it captures the specific piece of data about what the staff member is doing.

Place the audit sheet where you have easy access to it. You do not need to return to it every five minutes but at the end of a task/activity, return to it and record how many five minute intervals it took.

Use the nearest five minutes interval. ie, an activity takes 12 minutes record 2 five minutes. An activity takes 18 minutes, record 4 five minutes.

To record, you need to put a mark in the appropriate box. Do not go outside the line.

If the activity does not exactly match, use the closest to it: the main analysis will be total direct care and total indirect care.



Elements of the audit

Elements of the audit

The diagram illustrates the components of an activity diary form. Callout boxes provide the following information:

- The date you are completing this**: Points to the date field at the top of the form.
- Name of person, assisting/checking/validating**: Points to the signature line.
- Your name and title**: Points to the name and title fields.
- The start time of your shift. Please use 24 hour clock**: Points to the start time field.
- Your paid hours on duty, i.e. without breaks.**: Points to the paid hours field.
- The hours of your shift. i.e. total time on duty**: Points to the total time on duty field.
- Your ward of Unit name**: Points to the ward/unit name field.
- MIU will do 5 hours between 9 and 2**: Points to a specific activity slot in the grid.
- Day Hospital will do 8 hours between 9 and 5**: Points to another activity slot.
- Inpatients will do 24 hours in total divided into 8am to 8pm and 8pm to 8am**: Points to the bottom section of the grid.
- All staff on duty on the identified day will take part, BUT Inpatients may choose just one team, rather than whole ward**: A central instruction box.
- Time intervals of 5 minutes**: Points to the 5-minute grid intervals.
- Activity types Eg direct patient contact, Clinical meetings etc**: Points to the activity description column.



COMMUNICATIONS BOX



Example completion of electronic tool

This person started at 09.00 and:

- undertook 20 minutes of direct patient care from 09.00 to 09.20
- followed by a 30 minute clinical meeting
- followed by a 10 minute phone call

| Activity descripti | Hour start: 9 | | | | | | | | | | | | |
|---------------------------------|---------------|---|----|----|----|----|----|----|----|----|----|----|--|
| | 0 | 5 | 10 | 15 | 20 | 25 | 30 | 35 | 40 | 45 | 50 | 55 | |
| Direct Patient Contact | x | x | x | x | | | | | | | | | |
| Clinical Meeting | | | | | | | | | | | | | |
| Clinical Administration | | | | | x | x | x | x | x | x | | | |
| General Administration | | | | | | | | | | | | | |
| Non Clinical meeting | | | | | | | | | | | | | |
| Telephone contact | | | | | | | | | | | x | x | |
| CPD/ give or receive training | | | | | | | | | | | | | |
| Relative/Carer Contact | | | | | | | | | | | | | |
| Clinical/medical audit | | | | | | | | | | | | | |
| Breaks | | | | | | | | | | | | | |
| Actively waiting for patient | | | | | | | | | | | | | |
| Waiting for/Looking for/Collect | | | | | | | | | | | | | |
| TOTAL | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | |

You do not need to add anything into any of the totals, this will be collated for you when the information is entered into the tool.

The observer

The observer should be impartial and not one of the staff taking part.

They should be available to answer queries, and to check periodically that the audit is being completed accurately.

The role is likely to be undertaken by more than one person, so they need to be briefed in detail about the audit and handover progress and concerns when they swap.

Your Site Lead could undertake this, or Unit Manager, colleague from another dept/ward etc or the Site Support if you have the audit when they are present.

Activity descriptions

Activity Descriptions

Below is a list of the activities with a brief description of the activities under each category

| Activity | Description |
|-------------------------------|---|
| Direct Patient Contact | This is time spent with a patient or several patients at once. Including ward rounds and handovers done in the presence of the patient. Drug administration to patient. |
| Clinical Meeting | Meetings where patients or any clinical issues are discussed. Would include ward rounds and handovers not in the presence of patients. |
| Clinical Administration | Reviewing, completing and updating patient and clinical documentation. Preparing for drug administration. |
| General Administration | Such as ordering supplies, photocopying, doing the off duty and other such tasks. |
| Non Clinical meeting | Staff meetings including staff appraisals etc, and management meetings such as finance meetings. |
| Telephone contact | All time spent on the telephone in the course of your work. |
| CPD/ give or receive training | Any training courses or teaching sessions - either attending or giving them. |
| Relative/Carer Contact | Any time spent discussing a patient with their relatives or friends. |
| Clinical/medical audit | Any time spent looking at information or supplying information for auditing purposes. |
| Breaks | Time spent on formal breaks such as morning coffee, afternoon tea and lunch. |
| Actively waiting for patient | Waiting to do something for a patient, such as waiting for another professional to finish with the patient or waiting for them to come back from another department. |
| Looking for/collecting | Looking for supplies/equipment, collecting a patient, collecting supplies/equipment.. |

Variation in discharge.... tool instructions

Day of week and hour by hour analysis of discharge

Why do it?

This tool will be useful to help you to understand the variation that currently exists in your discharge process and where you might need to work to assist with streamlining the flow of discharge for your patients.

1. Devise a mechanism to collect the number of discharges by day of the week and hour of the day such as the spreadsheet in screenshot 1. This could be a simple table that is printed out and stuck on the wall on the ward to record daily discharge information.
2. Complete this spreadsheet everyday across a 6 week period. This will give you enough data for it not to be just a 'one off' occurrence.
3. Once you have all the data you will need to add up the total across the 6 weeks for each hour. As in the screenshot below so that you have a cumulative total of each hour across the 6 week period.

| | 01/01/2007 | 02/01/2007 | 03/01/2007 |
|-------|------------|------------|------------|
| 12-1 | 0 | | |
| 1-2 | 0 | | |
| 2-3 | 0 | | |
| 3-4 | 0 | | |
| 4-5 | 0 | | |
| 5-6 | 0 | | |
| 6-7 | 0 | | |
| 7-8 | 0 | | |
| 8-9 | 0 | | |
| 9-10 | 2 | | |
| 10-11 | 2 | | |
| 11-12 | 1 | | |
| 12-13 | 4 | | |
| 13-14 | 1 | | |
| 14-15 | 2 | | |
| 15-16 | 1 | | |
| 16-17 | 5 | | |
| 17-18 | 2 | | |
| 18-19 | 1 | | |
| 19-20 | 2 | | |
| 20-21 | 0 | | |
| 21-22 | 0 | | |
| 22-23 | 0 | | |
| 23-24 | 0 | | |

Screenshot 1



- Once you have the total then highlight the data in the total column and the time column as shown in screenshot 2. Click on the chart wizard and choose a line graph from the chart type. Click next and name the chart and the axis appropriately as shown in screenshot 3.

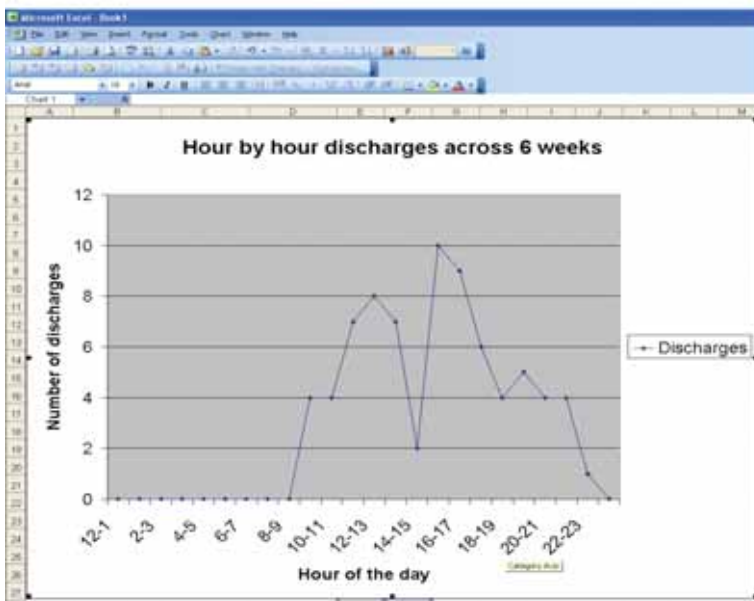
| | 01/01/2007 | 02/01/2007 | 03/01/2007 | total |
|-------|------------|------------|------------|-------|
| 12-1 | 0 | 0 | 0 | 0 |
| 1-2 | 0 | 0 | 0 | 0 |
| 2-3 | 0 | 0 | 0 | 0 |
| 3-4 | 0 | 0 | 0 | 0 |
| 4-5 | 0 | 0 | 0 | 0 |
| 5-6 | 0 | 0 | 0 | 0 |
| 6-7 | 0 | 0 | 0 | 0 |
| 7-8 | 0 | 0 | 0 | 0 |
| 8-9 | 0 | 0 | 0 | 0 |
| 9-10 | 2 | 1 | 1 | 4 |
| 10-11 | 2 | 0 | 2 | 4 |
| 11-12 | 1 | 5 | 1 | 7 |
| 12-13 | 4 | 0 | 4 | 8 |
| 13-14 | 1 | 4 | 2 | 7 |
| 14-15 | 2 | 0 | 0 | 2 |
| 15-16 | 1 | 4 | 5 | 10 |
| 16-17 | 5 | 3 | 1 | 9 |
| 17-18 | 2 | 2 | 2 | 6 |
| 18-19 | 1 | 0 | 3 | 4 |
| 19-20 | 2 | 3 | 0 | 5 |
| 20-21 | 0 | 2 | 2 | 4 |
| 21-22 | 0 | 0 | 4 | 4 |
| 22-23 | 0 | 0 | 1 | 1 |
| 23-24 | 0 | 0 | 0 | 0 |

Screenshot 2

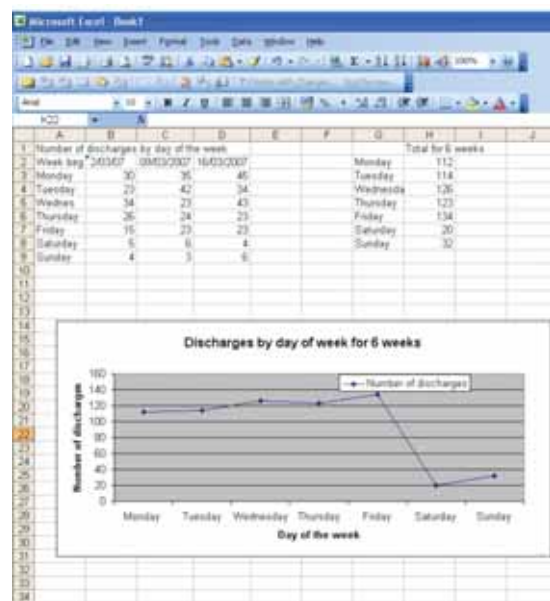
| | 01/01/2007 | 02/01/2007 | 03/01/2007 | total |
|-------|------------|------------|------------|-------|
| 12-1 | 0 | 0 | 0 | 0 |
| 1-2 | 0 | 0 | 0 | 0 |
| 2-3 | 0 | 0 | 0 | 0 |
| 3-4 | 0 | 0 | 0 | 0 |
| 4-5 | 0 | 0 | 0 | 0 |
| 5-6 | 0 | 0 | 0 | 0 |
| 6-7 | 0 | 0 | 0 | 0 |
| 7-8 | 0 | 0 | 0 | 0 |
| 8-9 | 0 | 0 | 0 | 0 |
| 9-10 | 2 | 1 | 1 | 4 |
| 10-11 | 2 | 0 | 2 | 4 |
| 11-12 | 1 | 5 | 1 | 7 |
| 12-13 | 4 | 0 | 4 | 8 |
| 13-14 | 1 | 4 | 2 | 7 |
| 14-15 | 2 | 0 | 0 | 2 |
| 15-16 | 1 | 4 | 5 | 10 |
| 16-17 | 5 | 3 | 1 | 9 |
| 17-18 | 2 | 2 | 2 | 6 |
| 18-19 | 1 | 0 | 3 | 4 |
| 19-20 | 2 | 3 | 0 | 5 |
| 20-21 | 0 | 2 | 2 | 4 |
| 21-22 | 0 | 0 | 4 | 4 |
| 22-23 | 0 | 0 | 1 | 1 |
| 23-24 | 0 | 0 | 0 | 0 |

Screenshot 3

5. The graph will give you an indication of where the peaks and troughs currently exist with your current discharge process. See screenshot 4.
6. You will need to repeat the process from step 3 to step 5 but replace the hours of the day with the days of the week (see screenshot 5) ie, so how many discharges happened every Monday, then every Tuesday etc. Looking at your discharges by day of the week across a 6 week period will give you an indication of what your discharge process is able to deliver.
7. You may want to think about what you could change in the discharge process to smooth out this variation and you can repeat this exercise as part of your 6 phase improvement process to see if it has made a difference.



Screenshot 4



Screenshot 5



Forward planning tool instructions

This tool enables the day hospital to monitor which patients are attending on each day and calculate the amount of staff input required.

This will be compared to the staff capacity for that day to identify when the day hospital has exceeded or is close to exceeding capacity.

The tool has been developed so that most data entry is quick and easy and it is possible to navigate between each day easily.

The tool contains information about the staff working in the unit, what staff type they are (ie, nurse, physio etc.) and a default amount of time they each have to see patients.

The tool also contains information about the patients currently attending the unit and a number of default 'Patient Types'.

For each patient type there is assigned a default amount of time that is required of each staff type in a single attendance.

Examples of Patient Types may include 'New Admission', 'Standard Follow Up', and 'Follow-up – No Physio'. The default time is derived from the Time to Care Audit which you have already carried out.

For each day that the unit is open there will be a page in the tool where the patients attending are added and assigned a patient type for that day. A patient can be assigned any 'Patient Type', this may vary for each of their visits.

The staffs on shift for that day is added and the tool compares the total amount of predicted time required for all of the patients attending that day against the available staff time and any shortfalls in staff time versus predicted demand are highlighted.

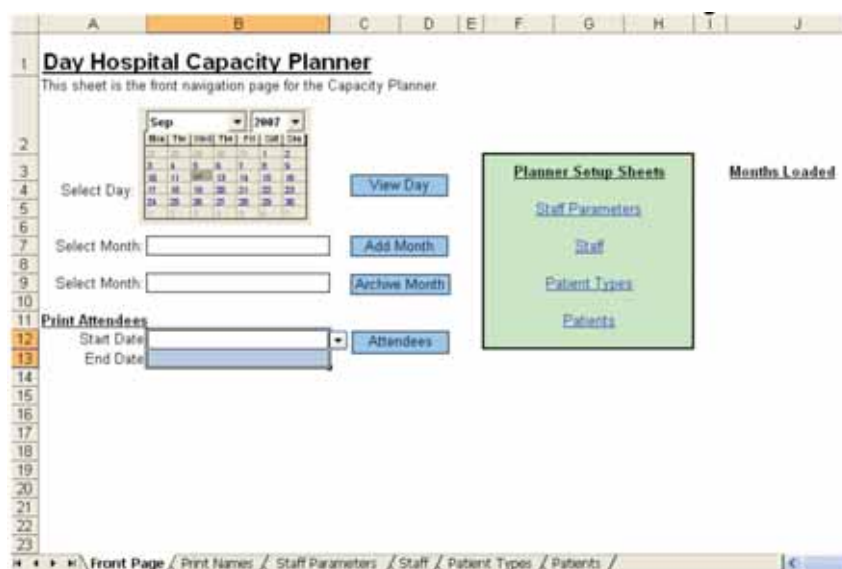
The tool is designed to be quick and simple to use and allows the users to manually override any of the default data that is entered in the tool.



Guidance material

The following is a brief system user guide on how the tool is operated.

1. Enter the following password in lowercase to open the tool:
 - productive
2. When the tool is first opened it will open onto a sheet called 'Front Page'. This sheet is used to maintain the default information in the tool. Screenshot 1 shows the 'Front Page' sheet.
3. The tool will eventually contain a separate sheet for each day loaded into the tool
4. The tool can only hold 12 months worth of days at a time. Eventually it is necessary to maintain the tool by adding months to be used in the future and by archiving months that have been completed.



Screenshot 1



5. To add months to the tool you should select a month from the drop down list next to the button 'Add Month' (see Screenshot 2). Having selected the month, pressing the button 'Add Month' will add all of the weekdays within the month selected as new sheets. If the month is already added then the user will be told and no further action is taken.



Screenshot 2

6. At the end of the procedure to add a month to the tool the system will automatically save, close and reopen the tool. This is to ensure that the loading is completed. As such it is important that the tool is not renamed otherwise it will not be possible to complete this procedure and the days will not be added. During this step you will be required to enter the password for the tool.

7. Selecting a month from the drop down list next to the 'Archive Month' button and pressing the button will move all of the sheets for that month into a new file named after the month archived (ie, archiving November 2007 will move all of the days in the tool for November 2007 into a file called 'Nov-2007'. If the month selected is not currently loaded into the tool then the user will be informed and no further action will be taken.

8. The names of the months currently loaded into the tool are shown on the front page (see Screenshot 3).



Screenshot 3

9. The tool uses default information and active patient and staff details. Therefore there are a number of maintenance sheets which need to be updated at the start of the model use and throughout its use. These sheets can either be selected using the page tabs at the bottom of the sheets or by pressing the blue links on the front page (see Screenshot 4).

10. 'Staff Parameters' holds the names of the staff roles that are being used in the tool and the names of extra duties that you may wish to assign staff time to. These names are entered into the two blue tables on the sheet (see Screenshot 5).

11. Pressing the button 'Front Page' at the top of the sheet will take you back to the main front page sheet. This applies to all of the sheets within the tool.

Staff Parameters

[Front Page](#)

This sheet is where the Staff Parameters for the Planner can be defined

| Staff Roles | This table contains the different roles that staff can be allocated to. Only the entries in the blue table will be used. |
|-------------|--|
| Nursing | |
| MDT | |
| Physio | |
| OT | |
| Doctor | |
| | |
| | |
| | |

| Extra Duties | This table contains the extra duties that staff can perform during their core hours. Only the entries in the blue table will be used. |
|--------------|---|
| Home Visit | |
| Training | |
| Admin | |
| | |
| | |
| | |
| | |

Screenshot 4

Day Hospital Capacity Planner

This sheet is the front navigation page for the Capacity Planner.

Select Day:

| | | | | | | |
|-----|------|-----|-----|-----|-----|-----|
| Sep | 2007 | | | | | |
| Mon | Tue | Wed | Thu | Fri | Sat | Sun |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 8 | 9 | 10 | 11 | 12 | 13 | 14 |
| 15 | 16 | 17 | 18 | 19 | 20 | 21 |
| 22 | 23 | 24 | 25 | 26 | 27 | 28 |
| 29 | 30 | 1 | 2 | 3 | 4 | 5 |

Select Month: [Add Month](#)

Select Month: [Archive Month](#)

Print Attendees

Start Date: [Attendees](#)

End Date:

Planner Setup Sheets

[Staff Parameters](#)

[Staff](#)

[Patient Types](#)

[Patients](#)

Screenshot 5



12. The 'Staff' sheet holds the names; role and effective working hours for each staff member (see Screenshot 6). Effective working hours should be the amount of time that this member of staff has available to see patients when they are on shift.

13. The 'Patient Types' sheet holds the different patient types and default timings that will be used in the tool (see Screenshot 7).

If 'Yes' is selected in the 'Use Default' column then these default times will be assigned to a patient when the associated patient type is selected for that patient. If 'No' is selected then the name of the patient type will be available to be assigned to the patient but no default times will be assigned to the patient. The roles at the top of the table reflect the staff roles entered into the 'Staff Parameters' sheet.

Setting up 'Patient Types' is the key to the model. Each patient type can have a different amount of time for each member of the MDT assigned to them.

Staff Details

Front Page

This sheet is where the Staff details for the Planner can be defined

| Staff Name | Role | Effective Working Hours |
|------------|---------|-------------------------|
| Sister | Nursing | 6 |
| MDT 1 | MDT | 6 |
| MDT 2 | MDT | 6 |
| MDT 3 | MDT | 6 |
| Nurse 1 | Nursing | 6 |
| Nurse 2 | Nursing | 6 |
| Physio | Physio | 6 |
| OT | OT | 6 |
| Doctor | Doctor | 6 |
| | | |
| | | |
| | | |

This table contains the names
The effective hours should be
DO NOT include time spent in
Only the entries in the blue table

Screenshot 6

Patient Types

Front Page

This sheet is where the patient types for the Planner can be defined.

Patient types are used to define default timings for a certain type of patient with each member of the team

Add as many Patient Types as are required.
Setting the column 'Use Default' to Yes will indicate that a patient given this type will use these minutes for capacity planning.
Only the entries in the blue table will be used.

| Patient Type | Use Default | Default Time Required (Minutes) | | | | | |
|---------------|-------------|---------------------------------|-----|--------|----|--------|--|
| | | Nursing | MDT | Physio | OT | Doctor | |
| Transfusion | Yes | 120 | 0 | 0 | 0 | 30 | |
| New | Yes | 45 | 30 | 30 | 30 | 30 | |
| Falls Clinic | Yes | 15 | 45 | 0 | 0 | 0 | |
| Fast Track | Yes | 45 | 30 | 30 | 30 | 30 | |
| FAJ Typical | Yes | 40 | 20 | 20 | 20 | 20 | |
| FAJ No Physio | Yes | 40 | 20 | 0 | 20 | 20 | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |

Screenshot 7

- 14. The 'Patients' sheet holds the list of current patients attending the day hospital (see Screenshot 8). This should be updated as new patients are admitted.
- 15. Any changes made to these maintenance sheets will be reflected throughout the tool.
- 16. For each month loaded into the tool there will be a day to represent each weekday in the month. On each day you can select the patients that are attending and allocate a patient type for that patient. Clicking 'Update Default' will enter default times for each patient split by each member of the MDT (see Screenshot 9).
- 17. You can manually overwrite any of the default timings for each patient and these will be used instead.

Patient Details Front Page

This sheet is where the patient details for the Planner can be defined

Sort Patients

| Patient Name |
|--------------|
| Patient A |
| Patient B |
| |
| |
| |
| |
| |
| |
| |
| |

This table contains the patients. The location field is for information. Only the entries in the blue table.

Screenshot 8

Wednesday - 1 Aug 2007 Front Page

Enter the details of patients attending the unit on this day and the staff available

Jul | 2007

Select Day on calendar and press button to view the day selected

View Day

Update Default Press this button to update the default

Sort

| Patient | Ambulance Item | Type | Nursing | MDT | Physio | OT | Doctor | Time Required |
|-----------|----------------|-------------|---------|-----|--------|----|--------|---------------|
| Patient A | | New | 45 | 30 | 30 | 30 | 30 | |
| Patient B | | FAJ Typical | 40 | 20 | 20 | 20 | 20 | |

Screenshot 9



18. All of the staff will be represented in the table below the patients. Initially each member of staff will have an available time that matches their default available hours. If the staff member is not working that day, or they have additional duties that day then the numbers in this table should be changed to reflect their availability (see Screenshot 10).

| Staff Member | Role | Available Time | Home Visit | Trainin |
|--------------|---------|----------------|------------|---------|
| Sister | Nursing | 360 | | |
| MDT 1 | MDT | 360 | | |
| MDT 2 | MDT | 360 | | |
| MDT 3 | MDT | 360 | | |
| Nurse 1 | Nursing | 360 | | |
| Nurse 2 | Nursing | 0 | | |
| Physio | Physio | 360 | | |
| OT | OT | 360 | 120 | |
| Doctor | Doctor | 360 | | |

Screenshot 10

19. The available time for each role is compared to the patient requirement and a balance is shown. If the balance is negative then it is highlighted in red (see Screenshot 11).

| | Nursing | MDT | Physio | OT | Doctor |
|----------------------|---------|------|--------|-----|--------|
| Capacity Requirement | 720 | 1080 | 360 | 240 | 360 |
| Requirement | 40 | 20 | 400 | 20 | 20 |
| Remaining | 680 | 1060 | -40 | 220 | 340 |

Screenshot 11

20. On each sheet there is a calendar at the top. Selecting a date on the calendar and pressing the 'View Day' button will take you to the page for that date. If that date is not loaded in the tool then you will be told. (see Screenshot 12).

Enter the details of patients attending the unit on this day

Jul 2007

| Mon | Tue | Wed | Thu | Fri | Sat | Sun |
|-----|-----|-----|-----|-----|-----|-----|
| 25 | 26 | 27 | 28 | 29 | 30 | 1 |
| 2 | 3 | 4 | 5 | 6 | 7 | 8 |
| 9 | 10 | 11 | 12 | 13 | 14 | 15 |
| 16 | 17 | 18 | 19 | 20 | 21 | 22 |
| 23 | 24 | 25 | 26 | 27 | 28 | 29 |
| 30 | 31 | 1 | 2 | 3 | 4 | 5 |

Select Day in calendar a

View Day

Sort

| Patient | Ambulance Run |
|---------|---------------|
|---------|---------------|

Screenshot 12

21. On the front page you can select a range of dates next to the 'Attendees' button (see Screenshot 13). Pressing the button will copy the names of the patients attending on those days (up to a maximum of five days) onto a separate sheet that can be printed. This will be split by whether they are attending in the AM or PM or whether they are coming by their own transport.

Print Attendees

Start Date

End Date

Screenshot 13



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