# Clinical process redesign — can the leopard change its spots?

Paddy A Phillips and Clifford F Hughes

*Redesigning the processes underlying clinical care in Australia can unleash its potential*

The notion that health care systems in Australia and, indeed, worldwide, are straining under the increasing age of our patients, the complexity of disease in the ageing population, and the technical intricacies of new technologies has only served to hasten the need for effective and sustainable change. The traditional approach was, of course, to restructure the whole organisation. The failure of restructure to drive change has led to the mantra of health — you cannot get the leopard to change its spots — which, interpreted, reads "why bother!". It has been shown that restructure just serves to delay progress, dislocate staff and produce an unsettled climate of fear, distrust and apprehension, with little gain in confidence.[1]

In this supplement to the Journal, a group of experts presents six articles outlining a radical approach to improvement and, indeed, to safety and quality of clinical care. The evidence base around such system improvements, of necessity, lags well behind the interventions and processes that are undergoing rapid, substantial and concurrent change. This is very different from the controlled clinical trial where all but a single, specific intervention remains unaltered. Therefore, contributions in this supplement represent the philosophy of, early experience with, and lessons learned from, what is really "early work in progress".

The lessons learned are now having an effect far beyond the Australian hospitals in which the work was done, and they cross the spectrum of health care delivery sites and professionals, as demonstrated in the Australian-based international conferences on health care redesign that now occur annually.[2]

It is important to understand that the redesign program identifies the "disconnects" in current clinical services and how they affect the final outcome. This is fundamental because this redesign is not about clinical practice redesign, but rather about improving the processes underpinning the delivery of clinical care.

We recommend reading the contributions in this supplement, not because this redesign work is complete (far from it), but rather to promote dialogue about our health care system and whether the way we do things now and the outcomes achieved are what we want for the foreseeable future, and to show that things can change.

The first article introduces the problems that required specific action, and the approach developed in New South Wales with its complex, diverse and geographically disparate health care centres and the more tightly confined experience at Flinders Medical Centre in South Australia (*page S9*).[3] The daily work pressures and demands that require the radical solution described are compounded by an increasing individual focus among all clinicians and, indeed, patients and their carers, on a balance between work and life.

Despite these expanding challenges, the individual transactions of care must still occur, and with increasing frequency and rapidity. The processes that enable excellent care must be refined to allow each clinical interaction to take place optimally with respect to time, place, interaction and reaction with other decisions, and with greater security for all concerned. Among all the drivers for such change are the experiences expressed by our patients (and, indeed our own friends and relatives) as they regale us with stories that are no longer tenable in safe and high quality health care.

The second article details the process of clinical redesign (*page S14*).[4] Traditionalists may feel that their ability to exercise their clinical judgement and professional autonomy is threatened by such change, but this article asserts that these are process changes, not practice changes.

Ben-Tovim and his colleagues explain the process of mapping the patient journey, identifying the points at which clinical interaction is essential and the problems which delay, frustrate and fragment effective clinical decision making.

Engaging staff and patients in the redesign process allows those with the greatest experience at the clinical workface to come up with process solutions that enhance each of the critical clinical steps necessary for a successful journey.

The third article focuses on the management of unplanned admissions in our hospitals and the stresses experienced in emergency departments (EDs) in Australia, which are far removed from the glamour and drama of TV shows like House, ER, and All Saints (*page S18*).[5]

The high-profile nature of emergency medicine has politicised this area of health care beyond what are reasonable or healthy expectations by consumers and politicians. Clinical process redesign focuses on the processes at the coalface and uses the experience of the clinicians involved in care to bring about sustainable change.

O'Connell and colleagues discuss the issue of variability, the impact of smoothing the load of ED arrivals, and techniques to identify and manage patients who either do not require admission or whose admission is for a very short period of time (less than 2 days).[5]

The traditional argument against such improved practices is that we free up one bed only to have somebody else occupy that bed. Such a view is short-sighted and focused only on the acute care hospital phase of the patient journey. By improving flow of patients through EDs and back to the community, the protracted wait of many other patients in the community is shortened and the access to appropriate care greatly enhanced.

The fourth article addresses the other side to the admission coin; planned arrivals (*page S23*).[6] MacLellan and colleagues focus on the patterns of planned arrivals, waiting list control, and operating room and theatre use. The authors focus on areas of significant economic impact on the entire system.

They also highlight the role that clinicians themselves may play, not in cutting back services, but in liberating existing resources and deploying them more effectively to allow more work to be done. The positive effect that commitment from senior staff to attend operating sessions on time and to ensure that, when they are on leave, their allocated sessions are reallocated, has been well documented.[7]

**The eight-stage process of creating major change**[12]

1. Establishing a sense of urgency
↓
2. Creating the guiding coalition
↓
3. Developing a vision and strategy
↓
4. Communicating the change vision
↓
5. Empowering broad-based action
↓
6. Generating short-term wins
↓
7. Consolidating gains and producing more change
↓
8. Anchoring new approaches in the culture ◆

The fifth article relates a specific industrial redesign process ("lean thinking") to health care, particularly at Flinders Medical Centre (*page S27*).[8]

There are a number of industrial models that could be considered in health. Lean thinking[9,10] is one that has been used effectively to smooth the processes around care to match the smoothing of variability in patient flows.

The value of preadmission planning, roster detailing and early estimation of expected date of transfer is the health care equivalent of processes that are mainstream in most efficient commercial enterprises. By specifically training staff in these methods, Ben-Tovim and colleagues have demonstrated the value of a well-trained and coordinated team.[8] By standardising work patterns and standardising flows, not only is health care more efficient, but there is significant and sustainable improvement in quality and safety. There is also a much greater expectation that the patient journey will be as predicted. The system will then have the capacity to respond to unexpected variation with much more flexibility when necessary.

The final article (*page S32*) focuses on the implementation and sustainability of the lessons learned from clinical process redesign.[11] It highlights the need to engage management, to train clinical leaders, and for a multidisciplinary approach to redesign which must also include input from patients and carers. The processes described are not dissimilar to the eight steps in managing change described by John Kotter (Box ),[12] which move from an established crisis to work plans embedded in normal everyday practice. The secret of the improved quality with clinical process redesign is that it has made safe and quality care the easiest way to proceed.

So has the leopard changed its spots? No. Good clinical care has always been the hallmark of the Australian health care system. But that care has been unnecessarily caged, restricted and frustrated by the systems that have been imposed on that care. Clinical process redesign is not about changing spots on the leopard but about "unleashing" the suppressed potential of the Australian health care system.

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