A Step-by-Step Guide to Developing Protocols...
A number of NHS organisations are already required to produce protocols as part of the implementation of NSFs, for example:

- all secondary care providers should have had protocols for the management of coronary heart disease in place since April 2001
- ambulance services should have had protocols for the management of acute myocardial infarction since April 2001
- primary care should have had protocols for the secondary prevention of coronary heart disease, heart failure and rehabilitation since April 2002.

However, a protocol can improve care in almost any setting. It is a valuable tool for people who are delivering care across a department, as part of a clinical network or on a multi-agency basis, and to those working in a small, discrete team.
Protocols can be developed in a variety of different ways. The purpose of this guide is to offer one option for a step-by-step approach towards development and implementation.
1. The topic to be covered by the protocol should be selected through two main routes:
   - the publication of national standards
   - the identification of local service improvement priorities.

It is also important to consider the context in which the protocol will be used, because this will determine the basis for its development. Examples are given below.

**National standards**

2. These contain detailed guidance – based on research evidence – on the processes of care that need to be in place at a local level to deliver and achieve best practice. They will provide a framework for local groups to develop protocol-based care; an example is the NICE guideline on pressure ulcer risk assessment and prevention.

**Identification of local service improvement priorities**

3. NICE guidance, National Service Frameworks (NSFs) and other national standards do not cover all areas of patient care. A number of organisations have used the development of protocol-based care to review and improve complex local systems, and to streamline the delivery of care – for example in hospital accident and emergency departments, or in treating stroke patients – according to local priorities.

4. The following considerations may be useful in selecting an area to work on:
   - priority should be given to development of protocols to support the implementation of NICE guidance, NSFs, Department of Health (DH) strategies and modernisation initiatives
   - also look for topics with one or more of the following characteristics:
     - the disease follows a relatively predictable course and the process of care is relatively standardised
     - large numbers of people require care for the condition or disease
     - the procedure is very high cost
     - the procedure is low volume
     - the area represents a high risk to the organisation
     - the area is highlighted for action by the Commission for Health Improvement, the Audit Commission or Mental Health Act Commissioners
     - clinical governance considerations indicate that action is necessary
     - information from patient complaints suggests that action is necessary
     - new evidence has become available
     - patients and service users express interest in a particular issue or area.

### Examples of types of protocols

<table>
<thead>
<tr>
<th>Type of protocol</th>
<th>Example</th>
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<tbody>
<tr>
<td>disease-based</td>
<td>diabetes, asthma, stroke, cancer</td>
</tr>
<tr>
<td>problem-based</td>
<td>chest pain, disturbed behaviour, anxiety</td>
</tr>
<tr>
<td>treatment-based</td>
<td>hip replacement, cataract removal</td>
</tr>
<tr>
<td>client-group-based</td>
<td>people with learning disabilities, neonates, older people</td>
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</table>
5. Experience has shown that the involvement of the staff responsible for the hands-on delivery of care is central to the successful development and use of protocols. The first step in the process, therefore, is to set up a multi-disciplinary team, made up of all clinical and non-clinical staff involved in care delivery.

6. In selecting members for the team, a number of roles will need to be agreed, and some people may fill more than one role. Although there are no hard and fast rules about how many people to have in a team, experience suggests that large groups can become unwieldy, and that the optimal number of people to have in a team is between 6 and 10. Those setting up the team should consider including:
   - a clinical leader to:
     - facilitate discussions
     - ensure integration with clinical audit
     - link work with teaching and change management
     - maintain momentum for the project
     - help group members to challenge current practice constructively
   - a clinical champion
   - patient and user representation (see Step 3)
   - an information specialist or analyst to advise on the organisation’s systems for information management, the analysis of local information, and the use of information technology
   - a Caldicott guardian (or equivalent) to advise on information sharing to support the delivery of care
   - clinical and non-clinical staff representatives who cover the wide range of groups involved in the delivery of care
   - administrative and clerical support to:
     - arrange meetings
     - minute discussions and decisions
     - prepare documentation
   - a protocol co-ordinator to:
     - link protocol development projects across the organisation
     - provide expert advice on the development of protocols
     - support the clinical leader
     - support implementation
   - information support from NHS library services, such as document search and delivery.

7. The team should have access to clearly identified resources, for example, to make notes of meetings, to record decisions taken and to prepare documentation. In the early stages at least, the team may benefit if its work is facilitated by a co-ordinator who has credibility with all its members. Most importantly, the team should reflect a broad range of opinions and ideas in order to identify, and then implement, the most effective standards of care.

8. The team should also look at how it will link into local priorities and its organisation’s processes to secure and provide services relevant to its population.

9. Once the team is established, it will need to agree the role of the group and its terms of reference. It may be helpful for the group to manage its progress by agreeing:
   - a communications plan (see Annex 2)
   - the timescale for the project
   - a project plan and meeting schedule (see Annex 3)
   - an implementation plan with links to local commissioning and contracting processes (see Step 10)
   - goals and objectives for the protocol (see Step 4).

10. Although there is no set view on the time that it should take to develop a protocol, the experience of people who have successfully developed them suggests that it is reasonable to expect the process to take between three and six months from start to implementation.
Key steps to developing protocols

Step Three
Involve Patients and Users

11. Involving patients is essential in planning service improvements. Indeed, one of the key principles underpinning the NHS Plan and the Government’s overall strategy for modernising the health service is that the views of patients and their carers, relatives and representatives should inform the way local NHS services are designed and delivered. The involvement of patients and service users is, therefore, an essential part of the process of developing a protocol, and it is extremely important that they should be actively involved in the decision-making process. It may be useful to produce a summary of the protocol for patients and service users.

12. Various mechanisms can be used to involve patients and users in the decisions on current service development. For example, information could come from:
   • patient representatives on the protocol development team
   • consumer or interest group representatives on the protocol development team
   • patients’ forums – Patient Advice and Liaison Services (PALS) need to be included because their reports will provide views
   • patient associations
   • complaints
   • analysis of patient and user feedback – both positive and negative.

Step Four
Agree Objectives

13. It is important that any protocol should be associated with clear objectives that are specific, measurable and have targets for achievement (see table right). In setting objectives, the development team should identify targets that are achievable, but sufficiently challenging to lead to real service improvements. NSFs and guidance issued by NICE contain audit criteria that can be used to inform local objectives.

14. It is important to ask staff what particular problems or barriers to effective care delivery they experience, and agree which of these can be translated into objectives for the protocol. The patient perspective will also be useful here.
### Examples of objective setting

<table>
<thead>
<tr>
<th>Objective</th>
<th>Measurement</th>
<th>Target</th>
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<tbody>
<tr>
<td>Elimination of unexpected overnight stays in acute unit after day surgery</td>
<td>Number of overnight stays, with reason</td>
<td>50% reduction in one year</td>
</tr>
<tr>
<td>Reduction of inappropriately prescribed antibiotics</td>
<td>% of antibiotics inappropriately prescribed/per month</td>
<td>reduction by 50% in each of the next 3 years</td>
</tr>
<tr>
<td>Reduction in the number of medication errors</td>
<td>% of medication errors/per month</td>
<td>Increase reporting but decrease severity</td>
</tr>
<tr>
<td>Increased patient satisfaction with care through the provision of information</td>
<td>Documented patient agreement to care (including information sharing)</td>
<td>100% of patients</td>
</tr>
<tr>
<td>Elimination of long waits (&gt; 4 hours) in A&amp;E departments</td>
<td>Number of patients waiting over 4 hours in A&amp;E departments</td>
<td>Nil</td>
</tr>
<tr>
<td>Introduce nurse-directed requests for radiology in A&amp;E departments</td>
<td>% of requests initiated by nurses</td>
<td>Could be variable, depending on the type of request. For example, 100% requests from a minor injuries patient stream or suspected fracture neck of femur, 50% increase in nurse-requested chest x-ray</td>
</tr>
<tr>
<td>Increase the number of patients transported after 999 calls to minor injury units, walk-in centres and primary care centres as alternatives to A&amp;E departments</td>
<td>% of patients attending each service (separated by condition/presentation)</td>
<td>Differentiate for different conditions. For example, 15% of the total with an increasing target year by year</td>
</tr>
<tr>
<td>Reduction in the number of patients in hospital awaiting transfer of care</td>
<td>Present measures of delayed transfer of care. % of patients delayed for NHS reasons</td>
<td>Reduce to &lt;3% of acute beds</td>
</tr>
</tbody>
</table>
Step Five
Build Awareness and Commitment

15. The implementation of protocol-based care can only be successful if there is visible, high-level support and awareness within an organisation. Strong clinical support is essential, not only from medical and nursing directors, but also from the wide range of professions involved in the care of patients. Patients’ forums will also need to understand and be engaged with the process.

16. The commitment of the chief executive, senior managers, medical and nursing directors, and non-executive directors will ensure that the programmes implementing protocol-based care are supported, and become fully integrated into the organisation’s way of working. In particular, ensure that the finance department is consulted so that any financial implications are considered, and that strong links are made at an early stage with clinical governance, Caldicott and information governance, workforce development, and corporate governance.

17. Consideration should be given at an early stage as to how current resources can be used to support the development of protocol-based care. Some organisations have found it helpful to identify a protocol co-ordinator who can provide expertise to support the development of protocols as well as maximising learning throughout the organisation.

Suggestions for raising awareness and gaining commitment

18. The benefits of developing protocol-based care could be maximised by:
• actively engaging with patients, users and carers
• using NICE guidance, NSFs and DH guidance requirements as the basis for protocol development
• identifying a range of activities already taking place in the organisation as a basis for protocol development
• making presentations or giving short seminars to key groups of staff, patients’ forum members and board members to raise awareness of the benefits of protocol-based care.
Step Six
Gather Information

19. Information should be sought on:
   • national standards
   • published evidence of good practice
   • other organisations’ experience and protocols
   • the views of patients and service users, through local information and the programme of national surveys of patient experience, and in relation to NSFs.

20. The development team should clarify and build on the arrangements within their own organisation for receiving national standards such as NICE guidance and NSF publications, and ensure that these are distributed to the appropriate areas and their implementation monitored.

21. The development team will also find it useful to have a clear understanding, perhaps from their organisation’s business plan, of their service objectives and of any plans to change or develop the organisation’s strategic direction. This will help them decide which areas should be priorities for action.

22. The booklet Where to Get More Help and Information describes a number of sources of information and how these can be accessed. The National electronic Library for Health contains examples of protocols that have been used elsewhere in the service. While these may need to be adapted or enhanced to satisfy emerging requirements, they can be useful to the development team, since they can give ideas on the content and format of the protocol. NHS libraries can also offer access to a wide range of relevant knowledge sources, and early contact with library staff will enable them to best assist the team. Some areas have designated clinical librarians working within clinical teams.

23. Protocols should be built on an evidence base of what is required to achieve good care. If there are limited sources of information about the area of care under consideration, then the team will need to reach a consensus on good practice. It is not always easy to reach a well-founded judgement when there is a lack of reliable evidence. Therefore, it may be wise – at least in early work – to develop protocols for diseases or conditions where there is a national standard of good practice.

24. Sources of data for establishing a baseline of current performance can also be identified at this stage. Remember to seek advice from Caldicott guardians if handling confidential patient information. Links should also be made into the local audit team and their procedures. The published national indicators of clinical performance may also be a fruitful source for identifying areas for development. Likewise, the annual consultation exercise on what should be included in national performance indicators, and the responses to consultation, may help identify areas for future coverage by protocols (see also paragraph 47).
Key steps to developing protocols

Step Seven

Baseline Assessment

25. The next step is to determine the baseline of current performance. This can help the team to analyse local services and to identify where improvements might be made. Sources of data for evaluating the baseline will have been collected during the information-gathering stage, and analysis of the data should begin to highlight where there are shortcomings in the current service and where the most valuable improvements can be made.

26. The development team will need to map the care provided for the chosen group of patients. For some conditions this can be complex. The Service Improvement Directorate, part of the Modernisation Agency, has worked with more than 500 local clinical teams and their experience has shown the clear benefits of the creation of a simple, high-level process map giving the main elements that are currently used to deliver the care objective. An example of a process map is given in Annex 4. To establish the areas for improvement, a process map will need to go to a deeper level, revealing a greater number of process steps.

27. The high-level map will form the basis of a more detailed mapping process. This process should describe how care is delivered in practice, and should include a timeframe of interventions and the points at which decisions are normally taken. An analysis of case notes may also offer a good insight into how care is delivered under the current arrangements. It may also be helpful to use one-to-one interviews with key stakeholders, and group sessions with patients and staff, to get a wide perspective on service provision.

28. An important objective will be to understand who needs to see what information about patients. This will ensure that a clear statement of information-sharing proposals are provided to patients and agreement/consent on these is obtained at the same time as agreement to the protocol.
Step Eight

Produce the Protocol

29. The development team will need to review and confirm their objectives for the protocol before starting the creation of the document. Successful protocols are simple documents that guide staff through the process. They are not comprehensive documents that describe how each procedure is delivered to the patient.

30. Electronic patient records and decision-support systems can be an integral part of the development and application of a protocol. However, good, paper-based records systems are currently the most frequently used, can readily support protocol-based care, and can form the basis of an electronic system once the necessary information technology infrastructure is in place. The use of protocols will also link into the use of disease management registers and standard templates.

31. The team will need to agree an appropriate format and try it out to ensure that it is easy to use. Some organisations may have developed a corporate format for protocols that contains standardised core elements. This has benefits for staff caring for patients on more than one protocol, for example a patient with diabetes who also requires a hip replacement. However, there can be merit in allowing flexibility for non-core features, to make sure that it meets the needs of staff who will be using the subsequent record as their principal record of care. As always, care will need to be taken to ensure that patient agreement and consent is gained for the treatment plan, including the use of the protocol and to the information sharing described in it.

32. The level of patient and carer access to the protocol should also be agreed at this stage. Ideally this will be full access, perhaps to a concise, lay reader’s version, since the protocol is a valuable source of information and supports effective communication between the patient and the professional team.

33. The protocol should be submitted for approval so that it can be signed off at a corporate level before proceeding to the pilot phase. Each organisation should have its own system of delegated authority for such approval, which could include the patients’ forum. As a final check before sign off, the development team may find it helpful to confirm that their protocol:

- focuses on the needs of patients and users of the service
- creates a single record of care (it should contain information about all aspects of the care and treatment delivered to the patient during a sequence of care)
- is simple in design and easy to use
- is short and concise
- follows a logical sequence
- makes information easy to find – some organisations use colour coding of sections to assist rapid retrieval of information
- includes realistic goals, timeframes, and measurable outcomes
- makes variations from care, the reasons for them, and the alternative actions taken, easy to record
- facilitates audit
- highlights responsibilities, including accountability for the completion of each part of the protocol

- specifies which groups of staff, in which organisations, will require access to confidential patient information, and links appropriately to information-sharing protocols and security policies developed through work on Caldicott and information governance
- can be tested against the targets and objectives agreed at the start of the development process
- gives a name and contact number – the clinical leader or protocol co-ordinator, for example – for questions or further copies of the protocol
- has a reference at the bottom of the document to the date of the protocol or version number, and the review date.
34. Implementation should start with a pilot phase. This will help to address any operational problems, and will provide reassurance to staff that the new system is not set in stone but can be modified if necessary to make sure that it delivers the expected benefits.

35. Before work starts, the team should make sure that staff who will be using the protocol fully understand it and have received any training they need to use it. They will also need to agree how the pilot phase will be evaluated and how long it will last. It is important to nominate a particular person to be responsible for collecting the information necessary for evaluation.

36. At the end of the pilot phase, the protocol will need to be evaluated for its ease of use, its effectiveness, and its impact on:

- patients
- staff
- clinical and social care teams
- supporting departments
- clinical governance and clinical audit.

37. It should be audited against the agreed objectives. Comparative before-and-after studies could be helpful, depending on the length of the pilot phase.

38. Once the pilot phase has been completed, the protocol should be amended if necessary and then submitted for approval so that it can be signed off corporately as well as at an operational level.

Suggestions for implementation of the pilot phase

39. Factors that may need to be considered when setting up the pilot include the following.

- When will the pilot phase start and finish?
- Which part of the service(s) will do the pilot?
- How many patients should be included in the pilot and, if a sample is used, how will monitoring be undertaken to see how well the protocol is being followed?
- Is the number of patients included in the pilot sufficient to ensure that it can be properly evaluated?
- How will staff be trained to use the protocol?
- How will staff be supported in the use of the protocol after the initial training?
- How will compliance with the protocol be monitored and how will patients and users of the service be involved in the process?
- Is the data on variances collected and can this be incorporated into clinical audit?
- How can good feedback be obtained and who will collect it?
- How will issues and problems be dealt with as they arise?
- How will people know what is happening during the pilot phase?
- How will the success of the pilot phase be evaluated?
40. The pilot phase should iron out the majority of operational problems with the protocol and highlight areas for training, and its evaluation should provide clear evidence of its effectiveness. Early links should be made with local commissioning and contracting processes. This will support the implementation of the protocol and commissioners may want to include agreed protocols in their Service Level Agreements. Once the team is satisfied that the protocol is operating satisfactorily and capable of delivering the expected results, staff should proceed to implementation.

41. Experience has shown that full implementation should be supported by a detailed training programme for the staff who are to use the protocol. Members of the development team could undertake this, or be involved in the design and planning of training to be carried out by others, since they will be familiar with the protocol and the rationale behind it.

42. Training should be supported by written instructions on how to use the protocol and contact details of a nominated member or members of the development team in case there are difficulties in using the protocol document.

43. Many organisations have found it useful to identify an individual within the team delivering care to be responsible for maintaining the protocol, in order to ensure that it forms an integral part of daily practice and is sustained over time.

44. Documenting variations from the protocol helps to establish what happens in practice. It provides a mechanism that allows staff to seek feedback from a patient or a user group, to assess if patients are progressing as expected, and to use their clinical judgement to agree with the patient what action is best, or to review the overall operation of the protocol. It also makes it easier, should something go wrong or become the subject of a complaint, to explain why a particular course of action was taken.

45. The information recorded as a variation should include:
   • details of the variation
   • the action taken
   • the date and time
   • the signature of the person completing the information.

46. It is important to keep protocols under review to:
   • measure and quantify benefits to patients and staff
   • ensure that objectives continue to be met and remain appropriate
   • ensure that all new staff receive training in the use of protocols
   • take account of additional information such as new and revised NICE guidance, or patient safety alerts issued by the National Patient Safety Agency
   • keep up-to-date with changes in clinical practice
   • ensure full integration with clinical governance arrangements
   • support the implementation of national standards, which are regularly reviewed to ensure that they remain up-to-date.

47. The review process will also feed back into the account of the Trust’s performance against the Performance Assessment Framework (www.doh.gov.uk/nhsexec/nhspaf.htm), support local clinical governance arrangements, and inform the further development of local planning (www.doh.gov.uk/ldp2003-2006/).

48. In addition, results from the review process may be useful in informing national consideration of the information needed to support clinical care, and the implementation of electronic patient records as part of the Information for Health initiative. The review process may also help to inform responses to the annual national consultation on performance indicators by giving evidence of the derivation of standards, and ways of monitoring quality, that are applicable nationally as well as locally.

Step Ten
Implement the Protocol

Step Eleven
Monitor Variation

Step Twelve
Review the Protocol
PRODIGY

PRODIGY is a computer-based decision and learning support tool for GPs, offering a series of recommendations for the treatment of a condition. The GP enters a diagnosis during a consultation, and PRODIGY suggests a range of therapy options, specific non-drug advice, and patient information leaflets, or recommends a referral. It also provides a wealth of clinical background information for use outside the consultation.

More information about PRODIGY can be found at www.prodigy.nhs.uk/

NHS Clinical Assessment System

In giving advice to callers, NHS Direct nurses use a computer-based clinical decision support system – the NHS Clinical Assessment System (NHS CAS). NHS CAS is an assessment tool that supports the safety and consistency of advice given to callers and provides a clinical record of the consultation. The system takes the nurse through a structured list of questions to decide the most appropriate course of action for the caller’s symptoms.

In addition to its use in NHS Direct, NHS CAS is also being developed to be used in face-to-face nurse consultations, for example, in NHS walk-in centres, A&E departments and primary care settings.

Further information is available from the NHS Direct team at the Department of Health, Room 1N35c, Quarry House, Quarry Hill, Leeds LS2 7UE. Telephone: 0113 2545021.
The communications plan

It is important to develop a formal, written communications plan. This will enable you to share the plan, gain agreement and commitment to it, and demonstrate an organised, systematic approach.

In preparing a communications plan, there are a number of steps to take:
• identify the audience
• agree themes and messages
• identify and develop tools
• implement and receive responses
• review effectiveness.

Identify the audience

The first step is to identify those people with whom you want to share the protocol. The audience may include:
• patients and service users
• the local community
• staff who will be expected to use the protocol, including locum and agency staff
• the wider organisation, including the chief executive, senior managers and non-executive directors
• other local organisations
• other organisations regionally and nationally, in order to share learning.

You may want to make a list of contacts.

Agree themes and messages

In deciding on the themes and messages you want to convey, it may be helpful to define the objective of the protocol, and then take from this the information that you want to emphasise. It is vital to keep the audience in mind, and to make sure that the messages you share are:
• clear
• simple
• precise
• concise
• relevant to users.

Identify and develop tools

The communications plan needs to take account of the resources available locally, and to decide which internal and external vehicles will be most effective in reaching the target audience. A number of different tools can be used, such as:
• information leaflets – for example for patients and service users
• posters and presentations
• newsletters
• regular reports to the Board
• the annual report
• clinical governance reporting processes
• liaison meetings with partner organisations
• study days
• the organisation’s website.

At this stage, it will also be important to decide on the best person or people to develop each of the tools, and the schedule for doing so.

Implement and receive responses

Having developed a communications plan, ensure that it is followed by monitoring progress against the agreed schedule. An important part of the implementation process will be to receive feedback from the target audience which could come from:
• questionnaires and surveys
• evaluation and feedback forms
• an interactive website
• local networks
• meetings.

Review effectiveness

The audience’s responses will help you to test the success of the communications plan, to evaluate whether it has influenced the audience’s behaviour, and if necessary, to revise and re-deliver it.
Annex 3 Preparing a Project Plan

Project definition

The first step is to define your project simply and clearly. A three-pronged approach is helpful:
• say what you want to do
• say what will happen
• say when it will happen by.

It is important that you write this definition down. Doing so will help avoid misunderstandings, will clear up any contradictory assumptions, and will focus people’s minds on what they are agreeing to do.

Project work breakdown

The next step is the project work breakdown – a description of the project, broken down into a set of simpler, separate activities. If, having broken it down, any of the activities are still too complex to organise easily, simply break them down again into another level of even simpler descriptions, and continue doing so until you have a set of clear tasks. What you are trying to achieve is a description of each activity that will:
• provide a clear instruction for the person who will do the job
• permit a reasonable estimate of the time and resource involved.

Task allocation

You now have to allocate tasks to the appropriate people and order the tasks so that they are performed in a sensible sequence. You should consider the skills of each team member and match these to the required tasks. Training will be required if people do not have the necessary skills. The allocation of tasks is also an opportunity for staff to increase their skills and experience by taking on new challenges.

Estimate of resource requirements

The project work breakdown provides a framework to estimate the project’s resource requirements, including staff, material and equipment costs. It is important to be realistic about costs. Although making estimates is not always easy, a helpful approach might be to:
• begin at the bottom of your project work breakdown structure, look for the longest path back to your starting point, then aggregate the cost of each element
• use experience from previous projects.

Project scheduling

Project scheduling is the act of converting the list of activities in your project work breakdown into an operating timetable. You will need to look at how long you think certain tasks will take and bear in mind the various constraints that may influence how quickly the project can move forward. These constraints include dependencies (where one piece of work cannot be taken forward unless another precedes it), resources and people’s availability. Scheduling sets the project to calendar days, enables you to see how long each element of the project is expected to take, and enables you to set start and end dates for the project.

Project review

Project review is an important way of monitoring and influencing the project’s progress as it is being carried forward. Milestones are a key element in the review process. They should be clear and unambiguous, and allow the team to judge how well things are going.

A simple way of constructing milestones is to take each activity from your project work breakdown, together with your estimates of how long they will take, and identify a completion date for each of them. These then become your milestones. Another method is to identify stages within the project that have several elements to them and are recognisable as steps towards the project’s completion, such as a pilot phase or the first draft of an information leaflet.
## Annex 4 Preparing a Process Map

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<th>Project Name</th>
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<table>
<thead>
<tr>
<th>Start Date</th>
<th>Present Date</th>
<th>Update Number</th>
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<thead>
<tr>
<th>Scheduled Completion</th>
<th>Status</th>
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<tr>
<td>Project Definition</td>
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<td>Project Work Breakdown</td>
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<td>Task Allocation</td>
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<td>Estimate of Resource Requirements</td>
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<td>Project Review</td>
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A process map is, in essence, a plan of the patient’s journey through care. It allows the care team to identify each of the stages in delivering care to a client group, and to understand the relationships between these stages. It also enables the care team to identify points of potential improvement in the care process, points at which unnecessary duplication is likely to occur, and to identify staff roles/hand-offs. Often, a process map will be quite straightforward, but this depends on what you are trying to show. An example of a process map is included below. (NB For the purpose of process redesign and the delivery of a service improvement, the process will need to be mapped in more detail, to reveal the many process steps.)

**Non-acute admission to community hospital**

- Onset of Illness
- GP Visit
- GP Referral
- Referral Processed
- Admission
- Assessment
- Care Plan
  *(PLUS ARRANGEMENTS FOR DISCHARGE)*
- Care Management
- Care Needs Review
  *(SOCIAL AND MEDICAL)*
- Discharge
  *(HOME OR PRIMARY AND/OR COMMUNITY HEALTH AND SOCIAL CARE)*