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ACTIVE CITIZENSHIP NETWORK • Reducing waste and inefficiency in the healthcare systems, increasing quality of patient care



## Reducing waste and inefficiency in the healthcare systems, increasing quality of patient care

European collection of good practices



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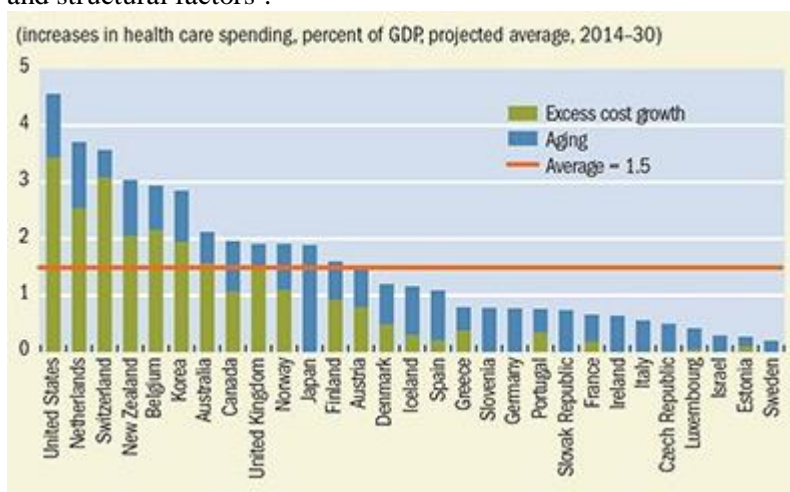
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# CHAPTER 1 - Introduction

## 1. Sustainability and waste in healthcare

Ensuring that European healthcare systems remain sustainable represents a major challenge for governments, healthcare providers and patients. In the context of austerity policies and slow economic growth across Europe, it is increasingly difficult to reconcile the growing pressure to adopt new technologies and address the complexity on healthcare services of multimorbidity in an ageing population<sup>1</sup>.

Public healthcare spending will increase by about 1.5% of GDP in advanced economies over the next 15 years. Less than half will be from aging populations; the rest is from technology, rising incomes, and structural factors<sup>2</sup>.



<sup>1</sup> Acting Together: A Roadmap for Sustainable Healthcare - Università Cattolica del Sacro Cuore. 2015

<sup>2</sup> Clements, Benedict. 2014. Bill of Health. Vol. 15, No.4. International Monetary Fund. <http://www.imf.org/external/pubs/ft/fandd/2014/12/clements.htm>

Besides these factors, there is ample evidence of pervasive inefficiency in the process of transforming resources into health outcomes, generating economic waste and being a contributory factor for the excessive health expenditure growth<sup>3</sup>. The 2010 WHO report<sup>4</sup> estimated that from 20% to 40% of all health spending was wasted through inefficiency.

Despite the empirical difficulties in applying efficiency concepts to health systems, there is a considerable body of evidence at both the macro and micro levels on the pervasiveness of inefficiency in the health sector. Many findings of wasteful use of resources have been reported in the empirical literature, inter alia: i) sub-optimal setups for delivery of care; ii) inefficient provision of acute hospital care; iii) fraud and corruption in health care systems; and iv) a sub-optimal mix of preventative versus curative care. Consequently, reducing inefficiencies can lead to substantial gains. OECD (2010) estimates that average life expectancy could increase by about 2 years for the OECD as a whole, if resources were used more efficiently. Conversely, holding health outcomes at current levels, while increasing efficiency to the level of the best performing countries, would free-up a considerable amount of resources. This could help reducing the long-term growth rate of health expenditure without compromising access to (quality) care, which is a major concern for European policy makers<sup>5</sup> and, of course, for patients.

Raising sufficient money for health is imperative, but just having the money will not ensure universal coverage. Nor will removing financial barriers to access through prepayment and pooling. The final

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<sup>3</sup> “Efficiency estimates of health care systems in the EU” - European Commission Directorate-General for Economic and Financial Affairs.

<sup>4</sup> The world health report: health systems financing: the path to universal coverage. - World Health Organization 2010

<sup>5</sup> “Efficiency estimates of health care systems in the EU” - European Commission Directorate-General for Economic and Financial Affairs.



requirement is to ensure resources are used efficiently. Opportunities to achieve more with the same resources exist in all countries.<sup>6</sup>

Patients, institutions, professionals and companies must work together to address this problem and this is why Active Citizenship Network has decided to dedicate the conference of the 10<sup>th</sup> European Patients' Rights Day (held on 4 May 2016 at the European Parliament) to the issue of waste and inefficiency in healthcare.

## **2. Waste definitions**

There are many definitions and classifications of healthcare waste, that is a clever container concept for a whole series of phenomena causing financial losses in healthcare.

From a first research the definitions and reflections on this issue come moreover from English - speaking countries, UK and USA. The same applies to the examples of good practices: most of the experiences we have found come from these countries, even though in this report only those coming from European countries are included.

According to the US Institute of Medicine of the National Academies<sup>7</sup> there are multiple driving factors for all areas of healthcare waste. They listed the following six categories, with the driving factors of each one:

### **1. Unnecessary Services**

- ✓ Defensive Medicine
- ✓ Use of high-cost services instead of low cost alternatives
- ✓ Frequent use

### **2. Excessive Administrative Costs**

- ✓ Duplicated efforts to meet various payer protocols
- ✓ Unproductive documentation

### **3. Inefficiently Delivered Services**

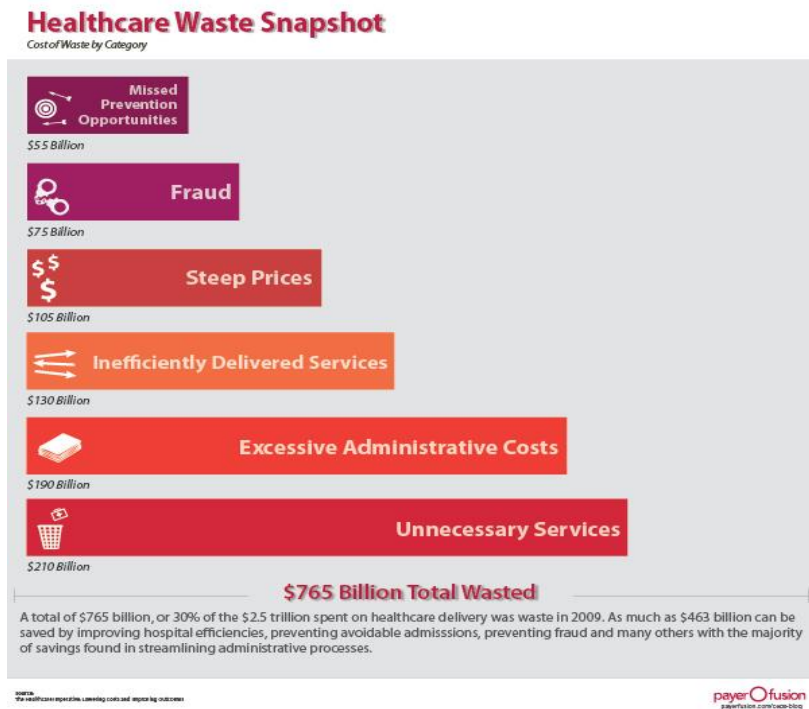
- ✓ Medical Errors
- ✓ Uncoordinated Care

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<sup>6</sup> The world health report: health systems financing: the path to universal coverage. - World Health Organization 2010

<sup>7</sup> <http://www.nap.edu/read/13444/chapter/1>

- ✓ Inefficient operations
- 4. **Prices Set Too High**
- ✓ Excessive price variation
- ✓ Uncompetitive prices
- 5. **Fraud**
- ✓ Fraudulent Medicare and Medicaid claims
- ✓ Insufficient detection budgets
- 6. **Missed Prevention Opportunities**



As showed in the above graphic, the Payer Fusion<sup>8</sup>, research company, taking into account these categories, has estimated that in

<sup>8</sup> <https://payerfusion.com/ceos-blog/healthcare-waste-by-category/>

the USA the amount of healthcare waste totaled \$765 billion and 30% of the \$2.5 trillion spent on healthcare delivery in 2009.

The New England Healthcare Institute<sup>9</sup> defined waste as “Healthcare spending that can be eliminated without reducing the quality of care.”

According to Thomson Reuters,<sup>10</sup> “waste” can be distinguished in different categories of which fraud, abuse and unwarranted use or overconsumption account for more than 59% aside from administrative system inefficiencies, medical errors, lack of care coordination and avoidable care.

The European Healthcare Fraud & Corruption Network drafted a lexicon of infringements by healthcare providers in healthcare provision considered to be “WASTE” and suggested enforcement actions. Generic definitions of infringements, in a scale with an increasing degree of “intention”, are:

- *Errors* : unjustly obtaining a benefit of any nature by unintentionally breaking a rule or a guideline
- *Abuses* : unjustly obtaining a benefit of any nature by knowingly stretching a rule or guideline or by taking advantage of an absence of rule or guideline
- *Fraud* : illegally obtaining a benefit of any nature by intentionally breaking a rule
- *Corruption* :illegally obtaining a benefit of any nature by abuse of power with third party involvement.

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<sup>9</sup> [www.nehi.net/](http://www.nehi.net/)

<sup>10</sup> <http://thomsonreuters.com/en.html>

WASTE					
TYPES					
Incorrect billing of services			Unwarrented services/Overconsumption		
Rules			Guidelines EBM/BFF		
NATURE	Compliance / Formal checks	Reality/ Material check	Overutilization of services/Medical Check	Overly expensive services/Financial Check	
Errors	Unintentionally billing a night time consult instead of a daytime consult	Unintentionally billing a radiography that has not been rendered	Prescription of antibiotics "out of ignorance" for simple rhinitis	Prescription of the most expensive antibiotics "out of ignorance" for a simple infection	O u t l i e r
F1		E2	E3	E4	
Enforcement	information/warning/(reimbursement claim)/( admin fine)	information/warning/reimbursement claim/( admin fine)	information/warning	information/warning	
Abuses	Assimilation of non insured care by use of a code for insured care	A hospital "optimizes" the default % of errors permitted in their invoicing system	Knowingly taking and billing an electrocardiogram without GMP indication	A supplier makes and bills knowingly a tailor made orthesis for profit only, while a cheaper prefab equivalent product exists	O u t l i e r
A1		A2	A3	A4	
Enforcement	adapt or create rules	adapt or create rules	focused information/warning/(reimbursement claim)/( admin fine)/( disciplinary sentence) Monitoring/ correctve incentives	focused information/warning/(reimbursement claim)/( admin fine)/(disciplinary sentence) Monitoring/ correctve incentives	
Fraud	Intentionally billing a night time consult instead of a day time consult	Intentionally billing a night time consult that has not been rendered	Intentionally taking and billing an electrocardiogram without GMP indication after being informed and warned	A supplier makes and bills intentionally a tailor-made orthesis for profit only, while a cheaper prefab equivalent product exists, after being informed and warned	r e s p o n s i v e
F1		F2	F3	F4	
Enforcement	reimbursement daim/ (admin fine)/(penal fine)/(prison sentence)/(disciplinary sanction)	reimbursement claim/admin fine/(penal fine)/(prison sentence)/(disciplinary sanction)	(reimbursement claim)/( admin fine)/( penal fine)/(prison sentence)/ disciplinary sentence	(reimbursement claim)/ admin fine/(penal sentence)/(prison sentence)/disciplinary sentence	
Corruption (third party involved)	Implant of a singular pacemaker while billing for a quadrapal and receiving a kickback from the hospital or the industry	Paying for car petrol with a certificate for a night time consult that has not been rendered	Prescribing unnecessary bloodtests and receiving a kickback from the lab	A supplier makes and bills intentionally a tailor-made orthesis for profit only, while a cheaper prefab equivalent with a kickback from the industry	
C1		C2	C3	C4	
Enforcement	reimbursement daim/admin fine/tax claim/damage claim/ tax fine/penal fine/prison sentence/ disciplinary sanction	reimbursement claim/admin fine/tax claim/damage claim/ tax fine/penal fine/prison sentence/ disciplinary sanction	reimbursement daim/admin fine/tax claim/damage claim/ tax fine/penal fine/prison sentence/ disciplinary sanction	reimbursement claim/admin fine/tax claim/damage claim/ tax fine/penal fine/prison sentence/ disciplinary sanction	

The classification used by the World Health Organization in the report “Improving health system efficiency as a means of moving towards universal coverage”<sup>11</sup> is also very interesting:

<sup>11</sup> Chisholm D, Evans DB. *Improving health system efficiency as a means of moving towards universal coverage*. World health report 2010 background paper, no. 28. [www.who.int/healthsystems/topics/financing/healthreport/whr\\_background/en](http://www.who.int/healthsystems/topics/financing/healthreport/whr_background/en).

**Table 4.1. Ten leading sources of inefficiency**

Source of inefficiency	Common reasons for inefficiency	Ways to address inefficiency
<b>1. Medicines: underuse of generics and higher than necessary prices for medicines</b>	Inadequate controls on supply-chain agents, prescribers and dispensers; lower perceived efficacy/safety of generic medicines; historical prescribing patterns and inefficient procurement/distribution systems; taxes and duties on medicines; excessive mark-ups.	Improve prescribing guidance, information, training and practice. Require, permit or offer incentives for generic substitution. Develop active purchasing based on assessment of costs and benefits of alternatives. Ensure transparency in purchasing and tenders. Remove taxes and duties. Control excessive mark-ups. Monitor and publicize medicine prices.
<b>2. Medicines: use of substandard and counterfeit medicines</b>	Inadequate pharmaceutical regulatory structures/mechanisms; weak procurement systems.	Strengthen enforcement of quality standards in the manufacture of medicines; carry out product testing; enhance procurement systems with pre-qualification of suppliers.
<b>3. Medicines: inappropriate and ineffective use</b>	Inappropriate prescriber incentives and unethical promotion practices; consumer demand/expectations; limited knowledge about therapeutic effects; inadequate regulatory frameworks.	Separate prescribing and dispensing functions; regulate promotional activities; improve prescribing guidance, information, training and practice; disseminate public information.
<b>4. Health-care products and services: overuse or supply of equipment, investigations and procedures</b>	Supplier-induced demand; fee-for-service payment mechanisms; fear of litigation (defensive medicine).	Reform incentive and payment structures (e.g. capitation or diagnosis-related group); develop and implement clinical guidelines.
<b>5. Health workers: inappropriate or costly staff mix, unmotivated workers</b>	Conformity with pre-determined human resource policies and procedures; resistance by medical profession; fixed/inflexible contracts; inadequate salaries; recruitment based on favouritism.	Undertake needs-based assessment and training; revise remuneration policies; introduce flexible contracts and/or performance-related pay; implement task-shifting and other ways of matching skills to needs.
<b>6. Health-care services: inappropriate hospital admissions and length of stay</b>	Lack of alternative care arrangements; insufficient incentives to discharge; limited knowledge of best practice.	Provide alternative care (e.g. day care); alter incentives to hospital providers; raise knowledge about efficient admission practice.
<b>7. Health-care services: inappropriate hospital size (low use of infrastructure)</b>	Inappropriate level of managerial resources for coordination and control; too many hospitals and inpatient beds in some areas, not enough in others. Often this reflects a lack of planning for health service infrastructure development.	Incorporate inputs and output estimation into hospital planning; match managerial capacity to size; reduce excess capacity to raise occupancy rate to 80–90% (while controlling length of stay).
<b>8. Health-care services: medical errors and suboptimal quality of care</b>	Insufficient knowledge or application of clinical-care standards and protocols; lack of guidelines; inadequate supervision.	Improve hygiene standards in hospitals; provide more continuity of care; undertake more clinical audits; monitor hospital performance.
<b>9. Health system leakages: waste, corruption and fraud</b>	Unclear resource allocation guidance; lack of transparency; poor accountability and governance mechanisms; low salaries.	Improve regulation/governance, including strong sanction mechanisms; assess transparency/vulnerability to corruption; undertake public spending tracking surveys; promote codes of conduct.
<b>10. Health interventions: inefficient mix/ inappropriate level of strategies</b>	Funding high-cost, low-effect interventions when low-cost, high-impact options are unfunded. Inappropriate balance between levels of care, and/or between prevention, promotion and treatment.	Regular evaluation and incorporation into policy of evidence on the costs and impact of interventions, technologies, medicines, and policy options.

In the next chapter another definition of waste, from a civic point of view, will be showed.

## CHAPTER 2 - The active role of citizens in the fight against inefficiencies

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### 1. Foreword

*"Cittadinanzattiva believes that citizens have the power, by organizing themselves, to overcome conditions of subordination and violation of their rights, to build a world where no human being is excluded and no common good is wasted."*

As explained in the above mentioned corporate vision, dealing with waste and inefficiencies in all areas of the public spending is for Cittadinanzattiva an essential part of its mission , and it is the same for its European dimension represented by Active Citizenship Network. Not surprisingly, Article n.1 of its Charter says:

*"Cittadinanzattiva is a laic/nonreligious movement of civic participation that works for the protection of human rights, the promotion and the practical exercise of social and political civil rights of citizens at national, European and international level; It fights against waste and corruption, and fosters protection and preservation of the environment, territory, health, individual and public security, but also of economy and transparency of legal actions and of public faith ... ".*

Undoubtedly, the issue of waste is at the heart of the public debate, but it is often treated in an incomplete way and referred to single areas (water, waste, energy, health, etc.). For us, however, waste is a cross-cutting issue, which refers to the way in which common goods are used and, more specifically, to their selfish and inappropriate use: this happens when economic, environmental, landscape or human resources they are misused, abandoned, deprived of value and planning skills.

Having a negative impact on those resources, waste - of whatever type - damage common goods and limit the scope of the rights, which will especially affect future generations.

In this sense, to fight waste in an effective and permanent way, the joint efforts of all the social stakeholders (institutions, businesses, experts, media, civic organizations and individuals) are crucial.

## **2. The active role of citizens in the fight against inefficiencies**

There are many actions that citizens can undertake to fight waste. For example, with regard to **food waste**, they can plan a better spending, pay attention to deadlines, reuse leftovers; but also detect and report waste, produce and disseminate information, participate actively in all programming and verification places already planned (such as the school canteen commissions), undertaking joint initiatives with all the actors in the supply chain. The power and responsibility of the individual are fundamental even for the **environmental waste**. There are many possible daily actions to undertake, such as recycling, an appropriate use of available resources, choosing local and seasonal food, preferring products free from non-renewable or bulky packaging, buying energy-efficient appliances and taking care about their proper disposal when they are no longer functional.

Citizens can also play a key role in the fight against **waste in healthcare**: on one hand, by acting as sentinels to track and report corruption, irregularities and inefficiency. On the other hand, they can contribute directly to the reduction of waste, for example through the adoption of responsible behaviors aimed at preventive measures and an effective lifestyle, respecting the rules of access to services and health services, adhering to therapeutic paths and consciously using drugs. In this regard, in particular, the issue of the adherence of the patient to drug therapies is crucial, as compliance can affect the outcome of treatment and, therefore, the health of the person and the welfare costs borne by the government. Thus, it is obvious how raising awareness on this issue among all the actors of the society and promote communication campaigns and projects addressed to citizens is a priority.

Today, being committed to the quality of expenditure, to the proper allocation of all resources, to the promotion of real and non-formal transparency of public administration while contrasting at the same

time inefficiencies, corruption, ensuring that "savings actually remain in health" means protecting the right to health and each National Health Service as a common good.

### **3. Our commitment against Waste at national level**

Health, food, environment. Every day, without realizing it, we use more resources than necessary. A wrong approach damages everyone, but everyone can do their part to defeat waste. With small, daily actions. In Italy, since 2014, Cittadinanzattiva has been promoting "Sprek.o", a three-day national celebration to raise awareness on the fight against waste and collect best practices through meetings, workshops, laboratories, seminars, exhibitions and performances (for more information: [www.spreko.it](http://www.spreko.it)).



The approach is extremely practical, being finalized - on one hand - to learn to recognize misconducts and - on the other hand- to share ideas, practices and projects promoted in the various areas of Italy, to meet the demand of the fight against food, environmental and healthcare waste. For each of them, specific initiatives are promoted and undertaken with the direct involvement of citizens and in partnership with other civic associations actually sensitive to the issue. Here are some examples:





## FOOD WASTE

- **“Italia, sveglia! Diritto al cibo e ristorazione a scuola”** (Italy, wake up! Right to school "food and catering), with the presentation of the survey conducted by Cittadinanzattiva in the school cafeterias of 13 Italian regions.  
Apparently, the survey revealed that food waste is estimated to around 13%. Among the most wasted foods, vegetables (23%), pasta (19%) and bread (16%).
- **“La mensa che vorrei”**, (The canteen that I would like to have), a project against waste in school canteens, with the purpose to increase the quality, sustainability and safety in 30 school canteens, involving more than 4,000 students and teachers, 1800 parents, 25,000 visitors to Expo. Read more (IT language): [www.cittadinanzainfesta.it/news/alimentazione/](http://www.cittadinanzainfesta.it/news/alimentazione/)



## ENVIRONMENTAL WASTE

- **“Disponibile! L’attivismo civico per la riqualificazione dei territori”**, (Available! The civic activism for the riqualification of the territory), a campaign on citizens' right to reuse abandoned places. It was promoted to embrace the widespread desire for a greater well-being, which may also be achieved through the recovery and reuse of abandoned buildings, unused areas, and/or public use of the spaces. This initiative took inspiration from two specific legal articles, both promoted by Cittadinanzattiva (Art. 118 of the Italian Constitution, and Art. 24 of the National Law 164/2014). Read more (IT language): [www.cittadinanzainfesta.it/news/ambiente](http://www.cittadinanzainfesta.it/news/ambiente)
- Publication of a free ebook: **“Dal recupero degli sprechi un nuovo assetto insediativo”**, (A new arrangement, starting from the recovery of wastage), which features photos and stories of 37 experiences of re-appropriation of abandoned areas and buildings converted to places and projects for activities of general interest. To download it: [http://freebook.edizioniambiente.it/libro/105/Dal\\_recupero\\_degli\\_sprechi\\_un\\_nuovo\\_assetto\\_insediativo](http://freebook.edizioniambiente.it/libro/105/Dal_recupero_degli_sprechi_un_nuovo_assetto_insediativo)



## HEALTH WASTE

- **“Accesso alle cure e aderenza terapeutica”** (Access to care and therapeutic adherence), with the presentation of the survey conducted by Cittadinanzattiva, which involved 619 patients affected by chronic diseases. It shows that roughly one in five patients sometimes forget to follow the therapy, and one out of seven takes a wrong dosage of the drug. Read more (IT language): [www.cittadinanzainfesta.it/news/salute](http://www.cittadinanzainfesta.it/news/salute)
- Report **“I due volti della sanità. Tra sprechi e buone pratiche, la road map per la sostenibilità vista dai cittadini”** (The Two Faces of Health. Between waste and good practices, the road map towards sustainability from the citizens’ perspective), which depicts lights and shadows of the National Health Service and was led by Cittadinanzattiva-Tribunal for Patients' Rights. Read more (IT language): [www.cittadinanzattiva.it/primo-piano/salute/8761-presentato-il-rapporto-su-sprechi-e-buone-pratiche-in-sanita-i-dati.html](http://www.cittadinanzattiva.it/primo-piano/salute/8761-presentato-il-rapporto-su-sprechi-e-buone-pratiche-in-sanita-i-dati.html)

#### **4. Waste and best practices in healthcare: the Italian case**

Equipment not used or underused, closed wards - although recently renovated or underused- due to lack of staff, tools and devices that are not suitable to the needs of patients, health personnel forced to exhausting shifts or away with additional costs for health care companies, expensive bureaucracy that hinders the patient care pathway. These are the main areas of waste in health reported in the Report "The Two Faces of Health. Between waste and good practices, the road map towards sustainability from the citizens' points of view", which depict lights and shadows of the National Health Service and was led by Cittadinanzattiva-Tribunal for Patients' Rights. The report examines 104 wasting situations identified in Italy by citizens, associations and health professionals that in June 2015 were still unsolved, but also 55 good practices.

In one case out of two, to eliminate waste should intervene a local healthcare provider, in one in three cases the region, in one of ten national institution, that is basically the Ministry of Health.

Based on the reports of citizens, the following list shows the main causes of waste in healthcare:

<b>The main causes of waste in health according to citizens</b>	<b>%</b>
Lack or surplus of staff	9,1
Allocation of resources	8,6
Ineffective organization of services	8,6
Purchases of goods/services not used	8,6
Lack of planning	8,2
Unused costly equipment	7,3
Inappropriate use of resources	6,5
User/underutilized facilities	6
Unnecessary bureaucracy	4,3
Call for tenders	3,4
Coordination of services	3
Assessment/supervisions	2,6
Hospitalizations	2,6

Conditions/maintenance of facilities	2,6
Job positions and recruitment of head physicians	2,6
Lack of Assistential Diagnostic-Therapeutic Paths	2,2
Difficulty to access to services	2,2
Information/reports	1,7
Lack of computerization	1,7
Administrative Services	1,7
Drugs	1,3
Other	1,3
Investments	1,3
Lack of participation	1,3
Lack of access to documentation	0,9
Health mobility	0,4
TOTAL	100

*I due volti della sanità, tra sprechi e buone pratiche, la road map per la sostenibilità vista dai cittadini, Cittadinanzattiva, 2016*

Waste damage patients' rights, in particular those more frequently violated, according to the experience of citizens: the right to the respect of quality standards (14.7%), the right to respect of the time (14%), the right to security of care (11.6%) and access to health services (10.9%). Hence the definition of Cittadinanzattiva: **Waste in the National Health Service is any activity, behavior, good and service that uses resources, without producing results in terms of health, wellness and quality of life as established by the European Charter of Patients' Rights.**

<b>Classification of waste in healthcare from the perspective of citizens</b>
<b>Use of Equipment and Medical Information</b>
• Unused or underused diagnostic and therapeutic equipment
• Unused or underused wards/departments
• Internal condition of the facilities (common areas, furniture, medical equipment, various equipment etc.)

<b>Services And Performance</b>
• Diagnostic services, pre-surgery exams, inappropriate hospital admissions
• Dispensing aids, aids, principals and procurement tenders
• Structural equipment and provision of services
• Excessive bureaucracy and lack of coordination between offices
<b>Human Resources Management</b>
• Lack or reduction of health personnel
• Consulting, health care workers fees
• Redundant staff accompanied by failure to ensure the delivery of services and adequate performance
• Staff assigned to another job or jobs
• Lack of control of objectives and activities

*I due volti della sanità, tra sprechi e buone pratiche, la road map per la sostenibilità vista dai cittadini, Cittadinanzattiva, 2016*

Based on reports gathered and evidence made by citizens of what and how much is wasted in health, Cittadinanzattiva has developed a road map, which is a rich recipe (34 actions) with ingredients for the sustainability of the NHS, with the purpose to move from a sustainability understood as compatible with the resources allocated in accordance with a hierarchy of priorities set by the government, towards a sustainability based on the results that it can produce in terms of health and maintaining quality of life. Read more (IT language): [www.cittadinanzattiva.it/primo-piano/salute/8761-presentato-il-rapporto-su-sprechi-e-buone-pratiche-in-sanita-i-dati.html](http://www.cittadinanzattiva.it/primo-piano/salute/8761-presentato-il-rapporto-su-sprechi-e-buone-pratiche-in-sanita-i-dati.html)

## **5. Our commitment against waste at European level**

So far, the European Network of Cittadinanzattiva, Active Citizenship Network, rather than dealing with waste in the strict sense, has been committed, among other things, to the sustainability

of mobility, energy and health systems. It works in parallel for research and promotion of best practices.

On the other hand, limited to the health issues, we are fully aware that sustainable Healthcare Systems are probably the main challenge we face in the coming years at European level, together with the need to achieve higher efficiency standards and a better use of the available resources, with the main objective to ensure comprehensive health coverage for all the citizens of the European countries.

During the IX Edition of the European Patients' Rights Day (May 2015), among others, emerged the need to improve the level of awareness about the importance of the common commitment to reduce the waste in healthcare.

For this reason, and because we are convinced of the power that each of us has to change things, Active Citizenship Network decided to dedicate to the X edition of the European Patients' Rights Day to this topic, trying to answer to the following questions:

- What has been done and what is being done to fight the waste in Healthcare Systems all around Europe?
- What are the best practices to be shared in this field at local, national and European level?
- What is the role and the contribution of public and private sectors on it, as well as the ones of the civic society and patient organizations?

In particular, we believe that many (institutions, public and private companies, professional groups, individual citizens, patient organizations, civic activism organizations), acting in their own framework, are already doing their part to fight against waste: there are professionals who are committed, and strive to re-organize services more rationally and close to citizens.

We therefore believe that these experiences should be enhanced through the story-telling, the networking, the trust in their reproducibility and their impact.

The second part of this report will therefore be dedicated to the presentation of best practices in the fight against waste, experiences that we believe should be valued.



## CHAPTER 3 – Good Practices

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### **1. Good practice: the policy of Cittadinanzattiva at National and European level**

The commitment of Cittadinanzattiva – and of its European branch Active Citizenship Network - to promote and provide incentives for service improvement, innovative experiences and community oriented policies has deep roots going back to 1988 and to the journey of the “Minibus rights”, when operators were rewarded (in this case within the healthcare services) for having favored the protection of citizens' rights. These improvements in the services lead to the sharing of experiences among policymakers, patient organizations, and, most importantly, to the improvement of the lives of those suffering from chronic pain. Over the years we have refined assessment tools, and have found a proper definition of good practices, identified their key features and instituted awards dedicated to their public acknowledgement as well as real databases; in the meantime, the Good Practices have begun to have a real impact on many and varied contexts, with the consequent increase in the number of awards and recognitions. Therefore, the questions: is the contribution given by Cittadinanzattiva on this front a positive factor, and do they have the expected results been achieved? The answer, of course, cannot be negative, because the process of seeking, encouraging, rewarding and promoting good practices answers, now more than ever, to one of the imperatives of the mission of Cittadinanzattiva, that is to contribute to turn the individual experiences into a “system” and place citizens at the centre of services. It is therefore important to acknowledge the spirit of human research in contributing to the service and the promotion of actions of individual citizens, with the view of creating a network of “good operators” which will bring about a change “from below” in the relationship between citizens and Public Healthcare providers in a framework of subsidiarity. Cittadinanzattiva has developed over the time a unified strategy in the definition and identification of good practices that goes beyond the scope of specific

areas of reference (healthcare, education, etc.) and uses the same evaluation criteria. Even the goal and the tools used to pursue it are in the same common: press, network, databases, juries of experts to evaluate the projects reported on the basis of the above four criteria.

## **2. Definition of Good Practice**

The collection and dissemination of good practices have a key role in the protection of citizens and patients' rights since they allow to:

- bring to light the possibility of immediate change in the organisation of services without new laws or particular investments;
- valorise the action of those who strive to improve their work and “draw them to one’s own side” stigmatizing, conversely, negative behaviors unjustifiable in front of good practices;
- introduce incentives in the organization of services in order to empower those involved;
- promote the spirit of emulation.

Given the difficulty of collecting good practices through occasional initiatives and actions, the best way to deal with this issue is promoting specific programs aimed at this purpose. Among the most useful and most effective is certainly the promotion of awards and competitions. But what is a good practice? Good practices are actions whose very nature lies in the impact on the quality of services, the protection of citizens' rights, the promotion of civic participation and the enhancement of human resources. In particular, they are very successful initiatives aimed at improving the efficiency (cost) and the effectiveness (as a way to meet, in an appropriate manner, the needs and expectations of citizens) of the management and provision of services.

## **3. The 2016 collection**

In 2016, in the framework of the celebrations for the X European Patients' Rights Day, Active Citizenship Network has carried out a research in order to gather good practices: concrete examples of

actions aimed at reducing waste and inefficiencies in healthcare (waste caused, for example, by: unnecessary services; excessive administrative costs; inefficiently delivered services; prices set too high; fraud; missed prevention opportunities etc.. ) experienced in EU and no EU countries.

In our collection, the identified initiative in order to be defined Good Practice should be concluded or ongoing and meet the following criteria:

- **Reproducibility** (possibility of its transfer and application in places and situations other than those in which it was developed);
- **Innovativeness** (ability to produce new and creative solutions in order to improve the quality of services and the protection of citizens' rights);
- **Added value** (the capacity of the identified practice to produce a greater impact on the situation);
- **Appropriateness** (a practice enabling an efficient and effective management of an issue).

In order to collect information, it has been necessary to write a form, divided into the following parts:

- **contact details** (name and surname, organization, country, email and phone number) with a short description of the person/organization
- **description** of the good practice: title, source of waste or inefficiency to fight, actors involved, location (where the initiative took place), duration (start and ending dates), brief description of its objectives, outcomes/impact on participants (explaining which benefits have been identified as a result of the good practice), indispensable resources to carry out the initiative (human and financial resources, logistic facilities, information, experiences, etc.);
- **analysis**: development of the good practice (brief description of the main activities), obstacles faced (economical, cultural,

managerial, etc.) and means used to overcome or remove them, factors enabling the process;

- **evaluation:** reproducibility (is it possible to reproduce and implement the good practice in other situations and places?), innovation (did the good practice produce any innovative solutions?), added value (was the use of the good practice more helpful than the solutions previously used?), appropriateness (did the good practice produce an efficient problem management?);
- **next steps:** answering to these questions: if another country/organisation was attempting to implement your good practice, what advice would you give them regarding lessons learned? What are the two key ‘take away messages’ about your good practice that you want to convey?  
If applicable, what are your organisation’s next steps for your good practice?
- **other information:** to add any other relevant information not mentioned on the form (i.e. links to web pages, etc.).

#### 4. Good practices list:

<b>Number</b>	1
<b>CONTACT DETAILS</b>	
<b>Name and Surname</b>	Project Innovating care for people with multiple chronic conditions in Europe (ICARE4EU)
<b>Countruy</b>	Cyprus
<b>Short description of the person submitting this project</b>	
The ICARE4EU project aims to identify, describe, and analyse innovative integrated care practices for people with multimorbidity in European countries, and to disseminate knowledge and experiences from these practices to all European countries in order to support further implementation of effective and sustainable care approaches for European citizens with multimorbidity ( <a href="http://www.icare4eu.org">www.icare4eu.org</a> ).	

<b>DESCRIPTION</b>	
<b>Title</b>	TeleRehabilitation programme
<b>Source of waste or inefficiency</b>	<ul style="list-style-type: none"> <li>inefficiently delivered services</li> </ul>
<b>Actors</b>	<p><b>Helthcare Organisation(s)</b> Intensive care unit (ICU) of the Nicosia General Hospital ICU of the Heraklion General Hospital in Crete (Greece); Hellenic Society of Ergospirometry Exercise and Rehabilitation.</p> <p><b>Universities</b> Department of Computer Science of the University of Cyprus Medical School of the University of Nicosia</p>

	<b>Health Professionals</b> Cypriot non-profit organisation Intensive Care Forum <b>Other</b> Patients
<b>Location</b>	Cyprus
<b>Term</b>	<b>Ongoing:</b> after the initial research project had proved its viability, the TeleRehabilitation programme was included into annual budget of ICU of the Nicosia General Hospital and became a standard service offered to patients.
<b>Objectives</b>	The TeleRehabilitation programme is a home-based rehabilitation service that applies advanced telemedicine for intensive care unit (ICU) patients after discharge from hospital. – In Cyprus living in remote areas impedes access to health care, rehabilitation and care provision. – The target population often experiences both financial and mobility-related limitations preventing them to attend in-hospital rehabilitation services.
<b>Outcomes Impact on participants</b>	The programme improves adherence to rehabilitation, the health status of patients and reduces the possibility of a return to the ICU. – It proved to be cost-effective and satisfactory for both users and health professionals. It seems to have reached the goal of patient satisfaction: results show that all patients enrolled in the TeleRehabilitation programme were enthusiastic and thankful for this opportunity. The use of video-communication and remote monitoring systems have a positive impact on quality of life as it overcomes the aforementioned logistic and financial barriers

	<p>which would otherwise lead to high rates of non-attendance of an in-hospital rehabilitation programme.</p> <p>Health professionals working in the TeleRehabilitation programme state that it can contribute to avoiding re-hospitalisation of patients.</p>
<b>Resources</b>	<p>The programme started as part of a research project running from 2012 to 2014 which was cofunded by the European Commission under the European Cross-border Cooperation Programme “Greece-Cyprus 2007-2013”.</p> <p>It provided 1,200,000 Euros overall for research and development activities in the two sites of Nicosia (Cyprus) and Heraklion (Greece). The costs for technical equipment (including video-communication system, wearable sensors, IT infrastructure, central and patient stations, web applications, exercise equipment) amounted to 600,000 Euros. The expenditure for human resources involved (clinical, IT and home care staff) was approximately 150,000 Euros.</p> <p>The cost for the programme per patient is approximately 2,100 Euros, which is the same cost of a single patient staying one-day in the ICU. This means that, assuming that a patient discharged without doing any rehabilitation will at least have two extra hospital days after re-admission to the ICU, the programme saves cost.</p>

<b>ANALYSIS</b>	
<b>Development</b>	<p>The TeleRehabilitation provides a “tower kiosk”, which is installed at patients’ homes, enabling the interaction with a physiotherapist</p>

	at distance. This latter one can monitor the patient's exercises, as well as vital signs from wearable devices in real time.
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<b>EVALUATION</b>	
<b>Reproducibility</b>	The programme would be interesting for other areas/countries where rehabilitation services are underdeveloped or not easily accessible as in remote areas. The potential of the programme for expansion to other fields of medicine lies in its flexible design. The telemedicine service could easily be transferred and adapted for rehabilitation, monitoring and training that are required for other (chronic) health problems and diseases.
<b>Innovativeness</b>	The TeleRehabilitation programme is an innovative home-based rehabilitation service provided as part of ICU care for patients with complex health problems that often suffer from multiple chronic conditions. It fills a gap in the provision and continuity of out-of-hospital services. The introduction of a telemedicine service in a country with limited experience in e-health is a challenge, but it has been successful according to both professionals and users.
<b>Added value</b>	TeleRehabilitation has added value for those patients who are unable or cannot afford travelling to the Nicosia General Hospital for rehabilitation sessions. With the introduction of this home-based rehabilitation service, patients can stay at home and schedule rehabilitation sessions with physiotherapist at designated times. This enables them following an adequate



	rehabilitation plan while safety is secured through the wearable vital sign monitoring.
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NEXT STEPS	
<b>Lessons Learned</b>	One of the major strengths of the programme is the fruitful partnership between a clinical unit – the ICU of the Nicosia General Hospital – and a non-profit organisation – the Intensive Care Forum. These two entities act in a complementary way, with the Intensive Care Forum working on those aspects, which the public ICU cannot offer because of budget and time constraints. The integration of additional professionals as part of the ICU team such as informatics, engineers, physiotherapists and psychologists, in addition to traditional ones (intensivists, nurses, other ICU staff), leads to a multidisciplinary team with well-designed roles that can provide tailored care services.
<b>Next Steps</b>	Currently, the programme has the capacity for enrolment of 75-96 patients annually, while there is a potential number of 250-350 patients in the ICU with a moderate need for rehabilitation, who would benefit from the service.  The acceptance of the new technology by the users was considered positive. The frailest target group of older people however did report drop-outs and resistance towards this technology. This is a challenge which should be addressed in order to allow the inclusion of older patients.

## OTHER INFORMATION

[http://www.icare4eu.org/pdf/TeleRehabilitation\\_programme\\_Case%20Report.pdf](http://www.icare4eu.org/pdf/TeleRehabilitation_programme_Case%20Report.pdf)

<b>Number</b>	2
<b>CONTACT DETAILS</b>	
<b>Name and Surname</b>	Project Innovating care for people with multiple chronic conditions in Europe (ICARE4EU)
<b>Country</b>	Germany
<b>Short description of the person submitting this project</b>	
The ICARE4EU project aims to identify, describe, and analyse innovative integrated care practices for people with multimorbidity in European countries, and to disseminate knowledge and experiences from these practices to all European countries in order to support further implementation of effective and sustainable care approaches for European citizens with multimorbidity ( <a href="http://www.icare4eu.org">www.icare4eu.org</a> ).	

<b>DESCRIPTION</b>	
<b>Title</b>	The ‘Gesundes Kinzigtal’ (GK) programme
<b>Source of waste or inefficiency</b>	<ul style="list-style-type: none"> <li>• prices set too high</li> <li>• inefficiently delivered services</li> </ul>
<b>Actors</b>	<p><b>Helthcare Organisation</b></p> <ul style="list-style-type: none"> <li>- local physicians network (Ärztendorf – MQNK)</li> <li>- 52% of all health care providers in the Kinzigtal region</li> </ul> <p><b>Civic Organisations</b></p> <ul style="list-style-type: none"> <li>- community groups and associations are involved, such as sport clubs, gyms, education centres, self-help groups</li> </ul> <p><b>Other</b></p> <ul style="list-style-type: none"> <li>- sickness funds, the AOK Baden-Württemberg and the LKK</li> <li>- health management company (OptiMedis AG)</li> </ul>

<b>Location</b>	State of BadenWürttemberg, in the rural Black Forest area of south-western Germany
<b>Term</b>	Start date: 2005 Ongoing
<b>Objectives</b>	The guiding principle of the integrated care system GK is the triple aim concept: improving the health of the population in the Kinzigtal region, improving the individuals experience of care and at the same time reducing the per capita costs of care.
<b>Outcomes Impact on participants</b>	<p>Already seven years after the start of the project, it turned out that the mix of curative and preventive interventions resulted in better health outcomes among GK members. In addition an increase in life expectancy of 1,5 years compared to a propensity matched pair control group of not participating inhabitants in the region of Kinzigtal, has been achieved.</p> <p>GK has achieved savings compared to usual care, particularly from lower pharmaceutical costs, hospital costs and rehabilitation/ home care costs (17). In 2010 the per-capita expenditures of an LKK 12 policy holder in the GK programme vs. those in the control group have decreased about 16, 9% compared with 2005 (7; 18). Results of an internal evaluation of the AOK and GK over the period of 2006-2013 show that the programme has led to a net annual saving for the sickness funds (AOK and LKK) of close to 3% (after having shared the 6,5% surplus difference with GK).</p>

<b>ANALYSIS</b>	
<b>Development</b>	GK`s main elements are: self-management support, prevention, patient-centred care, electronic networking system.

<b>Factors enabling the process</b>	The way shared decision making among patients/members and health care providers has been formalised and organised in the routines of the programme is another difference to usual health care.
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<b>EVALUATION</b>	
<b>Reproducibility</b>	The programme's transferability has not been evaluated yet, but a pre-existing physician network would be helpful for the implementation within another region. Nevertheless a similar programme is planned to be implemented in Billstedt-Horn, a part of the city of Hamburg having a population with a low social status.
<b>Innovativeness</b>	The GK programme is one of the few programmes in Germany with a population based integrated care approach. The programme has a holistic public health approach, enabling health- and social care professionals and other partners involved to offer a comprehensive package of services to people across indications and health service sectors. Another innovative aspect is the programme's financing, as their shared savings arrangement is still an uncommon business model in Europe. It includes both incentives for sickness funds and providers and integrates actors which usually operate separately.
<b>Added value</b>	The GK programme is a positive exception, as it is distinct due to its comprehensive population based approach, its orientation on public health and its long- term horizon. Instead of producing care services, as usual in health care systems,

	the GK programme focusses on producing better health.
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NEXT STEPS	
<b>Next Steps</b>	The programme is continuously internally and externally evaluated since the beginning with an overall positive trend. Thus the two participating sickness funds and Gesundes Kinzigtal intend to continue the contract for an unlimited period and transfer the Kinzigtal-approach to three other regions in Baden-Württemberg.

OTHER INFORMATION
<a href="http://www.icare4eu.org/pdf/Gesundes_Kinzigtal.pdf">http://www.icare4eu.org/pdf/Gesundes_Kinzigtal.pdf</a>

<b>Number</b>	3
<b>CONTACT DETAILS</b>	
<b>Name and Surname</b>	Agron Bytyqi
<b>Position</b>	General Hospital “Prim.Dr.Daut Mustafa”, Prizren, Kosovo
<b>Organization</b>	Coordinator of Centre for Continuing Nursing Education
<b>Country</b>	Kosovo
<b>Email</b>	agron_bytyqi@hotmail.com
<b>Short description of the person submitting this project</b>	
Agron Bytyqi is coordinator of Centre for Continuing Nursing Education at General Hospital of Prizren and coordinator of intra-hospital infection council since 2012.	

<b>DESCRIPTION</b>	
<b>Title</b>	Change the developers of X-ray films
<b>Source of waste or inefficiency</b>	<ul style="list-style-type: none"> <li>missed prevention opportunities</li> <li>inefficiently delivered services</li> </ul>
<b>Actors</b>	<b>Civic Organisation(s)</b> Prak & Pha <b>Helthcare Organisation(s)</b> General Hospitalof Prizren, Kosovo
<b>Location</b>	Region of Prizren
<b>Objectives</b>	Since Kosovo is experiencing a slow economic development, good clinical practices have been stagnant for a while. X ray films were developed

	through classical methods, that is the X ray film was immersed into a solution containing the chemical necessary to develop the film. For this solution there wasn't any special disposal. It was just run down the drains, so that the chances of poisoning and radiation sickness of the population were high likely. On the contrary, the quality of films and digital storage were very poor. During the evaluation phase, we discussed the possibility of replacing the developers of X-ray films in digital.
<b>Outcomes Impact on participants</b>	Better X-ray quality, the possibility of digital storage of the films, preventing poisoning and radiation sickness of technicians that work in radiology and of population, because the chemical waste (fixer) will not contaminate urban drains.
<b>Resources</b>	All members of intra-hospital infection council were involved, as well as head of Radiology dept. and the executive board of the hospital. The executive board of the hospital has found the financial resources to buy the digital developer of X-ray films.

<b>ANALYSIS</b>	
<b>Development</b>	The team for infection control during routine investigation noticed that x-ray developer solution (fixer) and contaminated blood were not having good waste management. Then the council for intra-hospital infection and executive board of General Hospital were informed. After four months, the hospital found the financial resources to buy a digital



	developer. We are still trying to find the best disposal for blood.
<b>Obstacles</b>	We did not encounter obstacles, but the hospital struggled a bit to find the financial resources needed.
<b>Means used to overcome or remove the obstacles</b>	Support from Ministry of Health and Government.

<b>EVALUATION</b>	
<b>Reproducibility</b>	It is reproducible in any other hospital or healthcare centre.
<b>Innovativeness</b>	This GP is not innovative, but has the merit to have enhanced management of chemical and hazardous waste.
<b>Added value</b>	For this kind of waste this GP was the best option.
<b>Appropriateness</b>	It works effectively. It is faster, accurate and storable.

<b>NEXT STEPS</b>	
<b>Lessons Learned</b>	The fixer should be changed as it is hazardous for healthcare of professionals and population.
<b>Key Take Aways</b>	<ol style="list-style-type: none"> <li>1. Prevent hazardous practices as much as you can</li> <li>2. Control regularly accuracy of waste management following protocols.</li> </ol>

<b>Next Steps</b>	Check if other healthcare centres in Kosovo have the X-ray developer with fixer. Find a good practice for waste management of contaminated blood and samples
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<b>Number</b>	4
<b>CONTACT DETAILS</b>	
<b>Name and Surname</b>	Eileen Nolan
<b>Position</b>	National Programme Manager Electronic Cancer Referral and Urological Cancers
<b>Organization</b>	National Cancer Control Programme (NCCP)
<b>Country</b>	Ireland
<b>Email</b>	<a href="mailto:Eileen.nolan@cancercontrol.ie">Eileen.nolan@cancercontrol.ie</a>
<b>Short description of the person submitting this project</b>	
<p>Programme Manager, NCCP, she is responsible for the project management of this project. She qualified as general nurse and midwife, and has a Business Degree, MBA and a Diploma in Cancer Prevention in the National Cancer Institute, US. Eileen works in the National Cancer Control Programme and is responsible for the development of electronic cancer referral which has won an eGovernment Award.</p>	

<b>DESCRIPTION</b>	
<b>Title</b>	National Development of Electronic Cancer Referral System in the Republic of Ireland
<b>Source of waste or inefficiency</b>	<ul style="list-style-type: none"> <li>• excessive administrative costs</li> <li>• inefficiently delivered services</li> <li>• other: patient pathway and communication between primary care and the cancer teams at the designated cancer centres</li> </ul>
<b>Actors</b>	<p><b>Healthcare Organisation(s)</b>  National Cancer Control Programme (NCCP), Dublin  The National Healthlink Project  Portfolio Manager, Acute Hospitals  Office of the Chief Information Officer, Health Service</p>

	<p>Executive (HSE)</p> <p><b>Health Professionals</b></p> <p>E Nolan, M Laffoy, R Codd, J. Coffey, M Lalor, V. Jordan</p>
<b>Location</b>	<p>This project took place nationally in the Republic of Ireland in any GP / Primary Care Physician Practice that registered for the service. It was co-ordinated by the National Cancer Control Programme in conjunction with the National Healthcare Messaging System called The National Healthlink Project (<a href="http://www.healthlink.ie">www.healthlink.ie</a>). All referrals could be sent to each of the following eight designated cancer centres plus one satellite breast cancer centre:</p> <ol style="list-style-type: none"> <li>1. Beaumont University Hospital, Dublin</li> <li>2. Cork University Hospital, Limerick</li> <li>3. Galway University Hospital, Galway</li> <li>4. Letterkenny General Hospital, Donegal</li> <li>5. Limerick University Hospital, Limerick</li> <li>6. Mater Misericordiae University Hospital, Dublin</li> <li>7. St. James's University Hospital, Dublin</li> <li>8. St. Vincent's University Hospital, Dublin</li> <li>9. Waterford University Hospital. Waterford</li> </ol>
<b>Term</b>	<p>Start date: 2009</p> <p>Ongoing: Rolling out phase three, project ongoing.</p>
<b>Objectives</b>	<p>The National Cancer Strategy 2006 recognised that information systems should be developed to manage cancer services. The National Cancer Control Programme (NCCP), in collaboration with a broad range of stakeholders, has developed electronic cancer referral for breast, prostate and lung cancer. The objective was to develop an</p>

	<p>online system so that patients can be referred by their GP directly to the cancer centre. This ensures rapid referral of patients with suspected cancer in a secure manner. Once the GP sends an electronic cancer referral, an immediate acknowledgment is given. In addition the cancer teams will send a response to the GP, with the date of the patient's appointment within five working days. The project builds on utilising existing technologies already deployed in GP's surgeries and the wider Health Service. These technologies included the Healthlink infrastructure (<a href="http://www.healthlink.ie">www.healthlink.ie</a>) and the accredited GP practice management systems. .</p> <p>This is a multi-agency project involving the following organisations:</p> <p>The National Cancer Control Programme, Parnell Street, D 1 <a href="http://www.hse.ie">www.hse.ie</a></p> <p>The National Healthlink Project, Eccles Street, D 7 <a href="http://www.healthlink.ie">www.healthlink.ie</a></p> <p>The ICT Directorate, HSE, Parkgate Street, D 1 <a href="http://www.hse.ie">www.hse.ie</a></p> <p>The GPIT group (made up of representatives of the HSE and ICGP)</p> <p>Irish College of General Practitioners, D 2 <a href="http://www.icgp.ie">www.icgp.ie</a></p>
<p><b>Outcomes Impact on participants</b></p>	<p>47% of all breast, prostate and lung cancer referrals were sent electronically in 2015. The target for 2016 is 50%.</p> <p><b>Benefits:</b> There are many benefits to this project which include the following:</p> <ol style="list-style-type: none"> <li>1. Streamline the cancer referral process.</li> <li>2. Rapid access for patients who are being referred with a suspected cancer.</li> <li>3. Provide automatic confirmation of receipt of</li> </ol>

	<p>GP referral.</p> <ol style="list-style-type: none"> <li>4. Provision of direct access for GPs to the cancer teams at the eight designated cancer centres.</li> <li>5. Reduce communication difficulties.</li> <li>6. Reduced costs for GP and HSE.</li> <li>7. Introduces a greater degree of safety into the referral process.</li> <li>8. Electronic cancer referral reduces stress for patients as it provides reassurance that the referral has been received by the cancer teams.</li> <li>9. The GP often completes the electronic cancer referral with the help of the patient.</li> <li>10. Reduced DNA (Do Not Attend) Rate with electronic referrals of approximately 3% versus posted/faxed referrals of 11%.</li> </ol> <p>Further information is available via the following weblink: <a href="http://www.ehealthireland.ie/Strategic-Programmes/eReferral/Statistics%20NCCP/">http://www.ehealthireland.ie/Strategic-Programmes/eReferral/Statistics%20NCCP/</a></p>
<b>Resources</b>	<p>The NCCP have spent approximately €250,000. This covered the cost of the electronic general referral message, which is a national priority. The NCCP have invested a large amount of time and resources into making this project a success. The NCCP electronic cancer referral project provides useful lessons for future development of electronic referrals for other diseases and health services.</p>

<b>ANALYSIS</b>	
<b>Development</b>	<p>To develop GP electronic referral systems and prompt specialist triage that follow evidence-based clinical pathways. The electronic referral process takes place via The National</p>

	<p>Healthlink Project (<a href="http://www.healthlink.ie">www.healthlink.ie</a>).</p> <p><u>Phase one</u> was the development of site-specific cancer referral forms in Healthlink. This enabled the GP to complete the referral often with the help of the patient. This provides reassurance for patients that their referral has been sent, The immediate acknowledgment that the referral has been successfully sent also provides another level of comfort. Clinical referral guidelines and paper referral forms (breast, prostate, lung and pigmented lesion) have been developed by the relevant clinical specialists. These paper referral forms were adapted for online use by Healthlink. The online forms were refined after piloting. Copies of forms are available via the following link:</p> <p><a href="http://www.hse.ie/nccpgpinfo/">http://www.hse.ie/nccpgpinfo/</a></p> <p><u>Phase two</u> involved the development of direct referral to the cancer service in four ICGP accredited GP practice management software systems below:</p> <ul style="list-style-type: none"> <li>• Complete GP</li> <li>• Helix Practice Manager</li> <li>• Health One</li> <li>• Socrates</li> </ul> <p><u>Phase three</u> is the development of an integrated web services browser using the NCCP Pigmented Lesion GP Referral Form. This form has been piloted and is in the process of being rolled out nationally. A video demonstrating this NCCP initiative is available at:</p>
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	<a href="http://www.hse.ie/eng/services/list/5/cancer/pr&lt;br/&gt;ofinfo/resources/gpelectronic/Electronic Canc&lt;br/&gt;er Referral .html">http://www.hse.ie/eng/services/list/5/cancer/pr ofinfo/resources/gpelectronic/Electronic Canc er Referral .html</a>
<b>Obstacles</b>	<p>The development of standardised national GP referral Forms and guidelines was time consuming. It also involved engagement with multiple stakeholders to get national agreement on the data items that were required and which fields should be mandatory. This has required a change in practice for the cancer teams.</p>
<b>Means used to overcome or remove the obstacles</b>	<p>Prior to go live with electronic cancer referral in one of the designated cancer centres, a project meeting takes place with representatives from the following:</p> <ul style="list-style-type: none"> <li>• Corporate Function</li> <li>• Lead Clinician</li> <li>• Administration Function</li> <li>• Nurse Specialist</li> <li>• Healthlink Representative</li> <li>• NCCP Project Manager and Project Sponsor</li> </ul> <p>At this project meeting, Service Level Agreements are discussed and signed off, and other topics such as who is responsible for opening and responding to the electronic referrals are agreed.</p>
<b>Factors enabling the process</b>	<p>The NCCP was set up in 2007 and was given the national mandate to restructure cancer services. As part of this work, eight designated cancer centres were agreed and rapid access clinics were developed for breast,</p>



	<p>prostate and lung cancer. The restructuring of these clinics has made it easier to develop standardised referral forms in paper and now electronically. The National Healthlink Team provide a Helpdesk service for all users at hospital and primary care level. They are open Monday to Friday 9am to 5pm. They can resolve most issues in this way, and feedback has been very positive. Further information is available via the following link: <a href="http://www.hse.ie/eng/services/list/5/cancer/about/">http://www.hse.ie/eng/services/list/5/cancer/about/</a></p>
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EVALUATION	
<b>Reproducibility</b>	<p>The recent HIQA report ‘Report and Recommendations on Patient Referrals from General Practice to Outpatient and Radiology Services including the National Standard for Patient Referral Information 2011’ states that implementation of electronic referrals will improve patient referral pathway in Ireland. The NCCP referral model is being used to develop a platform for a National General Electronic Referral Form. The NCCP Electronic Cancer Referral Project is a good example of how different agencies can work together to pool their resources to achieve innovation and better quality healthcare for all, especially in these recessionary times. The general electronic referral form has been developed at no extra cost, as the NCCP shared their spare capacity to enable this development. The general electronic referral form is now available in all 32 public</p>

	hospitals nationwide. Further information is available via the following link: <a href="http://www.ehealthireland.ie/Strategic-Programmes/eReferral/">http://www.ehealthireland.ie/Strategic-Programmes/eReferral/</a>
<b>Innovativeness</b>	The innovation was to integrate the NCCP breast, prostate and lung cancer referral forms into the GP Practice Management Software Systems. Using the paper based referral forms, a technical specification was devised to apply the content of the form to the messaging standard in use in Ireland for healthcare which is HL7 (Health Level 7). This specification outlined each discreet data item, what was required for that field to be populated, whether it was mandatory or not and the corresponding HL7 segment. Also, clearly outlined was the detail of the corresponding referral response message to be delivered back to the GP and the acknowledgement message to indicate that the referral had been received by Healthlink. This process meant that the GP had in their local system a record of the referral, the acknowledgement and the response of the patient encounter with the hospital, all now included in one location.
<b>Added value</b>	The electronic cancer referral project reduces costs for the GP and HSE. The direct costs incurred by GPs to prepare and send a cancer referral are avoided. These are in the form of stationary, post and printing material. However a much greater saving is achieved by avoiding the time-consuming work of following-up a referral to ensure it was received by the specialist team; reassuring the patient the

	referral is being assessed; and ensuring a specialist appointment is given to the patient. As well as these cost savings, patient anxiety is reduced by using a proven and assured referral mechanism. We have discovered that there is reduced DNA (Do Not Attend) Rate with electronic referrals of approximately 3% versus posted/faxed referrals of 11%. This has many implications for improved efficiencies within our national cancer services. We hope to further explore this in 2016.
<b>Appropriateness</b>	The NCCP Electronic Cancer Referral Project, saves time and reduces communications difficulties. As soon as the referral is received at the destination, an acknowledgment message is given, which is very reassuring for the GP. There is also a response from the designated cancer centres within five working days, confirming the triage status of the patient, and the date and time of the patients appointment if available.

<b>NEXT STEPS</b>	
<b>Lessons Learned</b>	Development of standardised electronic GP referral has lead to improved efficiencies in the GP referral process. It is a large project and requires resources and a dedicated project team with a national mandate to deliver. Early and ongoing engagement with relevant stakeholders is essential for the success of a large national project.
<b>Key Take Aways</b>	1. Development of standardised electronic GP referral can lead to improved efficiencies in the GP referral process. It is a large project and

	<p>requires resources and a dedicated project team with a national mandate to deliver.</p> <p>2. Early and ongoing engagement with relevant stakeholders is essential for the success of a large national project.</p>
<b>Next Steps</b>	<p>The National Cancer Control Programme is working with the Office of the Chief Information Office on a project to implement a Medical Oncology Clinical Information solution which will enable clinicians to focus on their direct patient centric activities throughout the oncology and haematology care pathways.</p> <p>The solution is expected to deliver a portal providing a holistic view of the patient's cancer treatment which will help reduce risks associated with chemotherapy prescribing and administration whilst accommodating the complex rules and clinical requirements of specialist cancer care treatment protocols. Please go to the following weblink for further information:</p> <p><a href="http://www.ehealthireland.ie/Strategic-Programmes/Cancer-Care-eHealth-Programme/">http://www.ehealthireland.ie/Strategic-Programmes/Cancer-Care-eHealth-Programme/</a></p>

<b>OTHER INFORMATION</b>	
<p>Links to additional information</p> <p><a href="http://www.hse.ie/eng/services/list/5/cancer/about/">http://www.hse.ie/eng/services/list/5/cancer/about/</a></p> <p><a href="http://www.ehealthireland.ie/Strategic-Programmes/Cancer-Care-eHealth-Programme/">http://www.ehealthireland.ie/Strategic-Programmes/Cancer-Care-eHealth-Programme/</a></p> <p><a href="http://www.ehealthireland.ie/Strategic-Programmes/eReferral/">http://www.ehealthireland.ie/Strategic-Programmes/eReferral/</a></p> <p><a href="http://www.healthlink.ie">www.healthlink.ie</a></p> <p><a href="http://www.icgp.ie">www.icgp.ie</a></p>	

<b>Number</b>	5
<b>CONTACT DETAILS</b>	
<b>Name and Surname</b>	Fernanda Anna Maria Ventura
<b>Position</b>	Deputy chief medical officer
<b>Organization</b>	Santa Viola Hospital
<b>Country</b>	Italy
<b>Email</b>	anna.ventura@consorziocolibri.com
<b>Short description of the person submitting this project</b>	
Dr. Fernanda Anna Maria Ventura, medical doctor, specialist in preventive and community medicine. She is deputy chief medical officer of Santa Viola Hospital in Bologna (Italy) and continuing education project manager.	

<b>DESCRIPTION</b>	
<b>Title</b>	Clinical and assistential strategies in a dedicated ward for patients with Disorders of Consciousness
<b>Source of waste or inefficiency</b>	<ul style="list-style-type: none"> <li>missed prevention opportunities</li> <li>excessive administrative costs</li> <li>inefficiently delivered services</li> </ul>
<b>Actors</b>	<b>Health Professionals</b> Medical Doctors, nurses, health care assistants, physiotherapists, Psychologists, Psychiatrists <b>Other</b> Caregivers of patients with Disorders of Consciousness
<b>Location</b>	Bologna, Italy
<b>Term</b>	Start date: 22/01/2014 Ongoing
<b>Objectives</b>	1) The improvement of a multi-disciplinary approach to the care of patients with Disorders of

	<p>Consciousness (DOCs) ;</p> <p>2) the improvement of clinical and assistential practices: reduction of medical complications/ hospital infections and consequent reduction of costs for their management;</p> <p>3) the reduction of discharge to inpatient acute wards (emergency room, intensive care unit) and consequent reduction of costs for the National Health Service;</p> <p>4) the enhancement of professionals' quality of life, the prevention of their work related stress and the reduction of costs related to the burnout;</p> <p>5) the prevention of burden for caregivers of patients with DOCs.</p>
<b>Outcomes Impact on participants</b>	<p>1) From descriptive statistics of epidemiological data, a reduction of mortality rates, a reduction of discharges to emergency room and a better management of infections were detected;</p> <p>2) A good management of work related stress was found: the rates of sickness absence is quite normal and stable;</p> <p>3) From a qualitative point of view, a better relationship between healthcare professionals and caregivers was found.</p> <p>Furthermore, the establishment of reciprocal help between caregivers was noticed.</p>
<b>Resources</b>	<p>1) Human resources: the healthcare workers and the group's conductors (the chief of the ward and a psychiatrist) participate in monthly meetings without remuneration.</p> <p>2) Logistic resources: a common room with tables and chairs, situated inside the ward, usually employed from caregivers to take a break, receive other relatives/friends, and converse.</p> <p>3) Information and experiences: they usually come</p>

	from previous structured and periodic meetings among the professionals of the ward (nurses, medical doctors, healthcare assistants, physiotherapists), and previous meetings between caregivers and medical doctors.
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ANALYSIS	
Development	<p>The present good practice consists in structured and formalized monthly meetings between healthcare workers and caregivers of patients with Disorders of Consciousness, conducted by the chief of the ward and a psychiatrist, specialist in group dynamics. In Santa Viola Hospital, caregivers are considered an important part of the care network and they are in a constant connection with professionals, who are the same in DOCs dedicated ward.</p> <p>The meetings are aimed to share criticalities related to patients and caregivers, to spread information and last scientific research, and to support each other. Sharing the clinical and assistential strategies to take care of fragile patients, as DOCs patients, is helpful to train participants in the right procedures for avoiding infections and complications. At the same time, the group climate permits reinforcement of the relationships between caregivers themselves and professionals and caregivers.</p> <p>The stages are:</p> <ol style="list-style-type: none"> <li>1) Educational project by the continuing education project manager.</li> <li>2) Structured and permanent meetings between professionals and Balint groups</li> <li>3) Monthly meeting between professionals and</li> </ol>

	caregivers
<b>Obstacles</b>	The major obstacle was the resistance to change from both healthcare workers and caregivers and the difficulty to adopt newer and better procedures.
<b>Means used to overcome or remove the obstacles</b>	The obstacles detailed above were opposed by information, vocational training and practical verification.
<b>Factors enabling the process</b>	The group climate, the relationship between professionals and caregivers, and the active participation positively influenced the good practice.

<b>EVALUATION</b>	
<b>Reproducibility</b>	This good practice is feasible in other rehabilitation or hospital contexts, especially in those settings in which caregivers are often present and patients have a long length of stay.
<b>Innovativeness</b>	This good practice produced the need to better understand some features of patients with DOCs and their caregivers, both still understudied in the literature. Indeed, a research project was launched and a part of it was published in an international scientific journal (Romaniello, C., Farinelli, M., Matera, N., Bertoletti, E., Pedone, V., & Northoff, G. (2015). Anxious attachment style and hopelessness as predictors of burden in caregivers of patients with disorders of consciousness: A pilot study. <i>Brain injury</i> , 29(4), 466-472.)
<b>Added value</b>	This good practice was helpful in terms of cost-



	effectiveness. Since it has distinctive features, no comparison with other good practices could be carried out.
<b>Appropriateness</b>	This good practice and the good climate group enable the possibility to show criticalities and to manage the needs of caregivers and healthcare professionals first by listening.

<b>NEXT STEPS</b>	
<b>Lessons Learned</b>	<ol style="list-style-type: none"> <li>1) To structure well-defined moments of encounter.</li> <li>2) To refer to internal and external psychologists for conducting groups and managing their dynamics.</li> <li>3) Have a dedicated team, composed by the same professionals.</li> </ol>
<b>Key Take Aways</b>	<ol style="list-style-type: none"> <li>1. The work group is its strength</li> <li>2. A good relationship with caregivers permits a good sharing of clinical and assistential procedures.</li> </ol>
<b>Next Steps</b>	<p>The next steps expected are:</p> <ol style="list-style-type: none"> <li>1) An help desk for psychological support addressed to caregivers and healthcare workers who wish for it.</li> <li>2) An improvement of research projects</li> <li>3) An improvement of information and training through conferences and workshops.</li> </ol>

<b>Number</b>	6
<b>CONTACT DETAILS</b>	
<b>Name and Surname</b>	Giuseppe Banfi
<b>Position</b>	IRCCS Galeazzi
<b>Organization</b>	Scientific Director
<b>Country</b>	Italy
<b>Email</b>	<a href="mailto:banfi.giuseppe@univr.it">banfi.giuseppe@univr.it</a>
<b>Short description of the person submitting this project</b>	
<p>MD, Full professor of Clinical Biochemistry in Vita e Salute San Raffaele University in Milano. Scientific Director from 2007 of the IRCCS Galeazzi, orthopedic hospital accredited by Ministry of Health for research programmes. General Director of Fondazione Centro San Raffaele in Milano, a foundation supporting the San Raffaele (the first research center in Italy) research programmes. Scientific Director of Gruppo San Donato (the first private healthcare group in Italy) Foundation, a foundation supporting the research programmes of different leading and teaching hospitals. He has long experience in management and direction of assistance and hospital organization; he has experience in Health Technology Assessment, and participates in Regional Group of experts in evaluation and assessment of technologies.</p>	

<b>DESCRIPTION</b>	
<b>Title</b>	Use of a software to optimize the surgical process and to assure traceability of procedures in a high throughput orthopaedic hospital
<b>Source of waste or inefficiency</b>	<ul style="list-style-type: none"> <li>• missed prevention opportunities</li> <li>• excessive administrative costs</li> <li>• inefficiently delivered services</li> </ul>
<b>Actors</b>	<b>Healthcare Organisation</b>

	IRCCS <b>Health Professionals</b> Nurses, Medical Doctors <b>Institution</b> Ministry of Health
<b>Location</b>	Milan Italy
<b>Term</b>	Start date: November 2015 Ongoing
<b>Objectives</b>	<p>The software of HCS, already implemented in different hospitals in USA, was installed in IRCCS Galeazzi. It is the first application of the software in Europe and in an healthcare system based on universality. The principal aim is the optimization of times elapsed from the ward to the theater and return to the ward of patients. The optimization is cost-effective, saving times and expensive procedures, usually driven by personnel, mainly nurses, but it is also crucial to assure traceability of all the procedures performed on (and around) the patient. All the procedures and correspondent times are registered, and they could be useful to improve efficiency, even by using internal and external benchmarking, to improve safety of patients, to assure correct informations to caregivers, and to minimize incidents and legal troubles. The recorded data are also useful for defining efficacy, not only efficiency, of the medical staff and of the hospital.</p> <p>The whole process is easily followed by nurses and doctors by computer-assisted programme, which is available on big interactive displays in ward and surgical theatres. The interaction is driven through a hierarchy of responsibilities, even recorded and monitored, from nurses, to anesthesiologists and surgeons, and, finally, to hospital management.</p>
<b>Outcomes</b>	-improvement of throughput (by times, i.e. decrease

<b>Impact on participants</b>	<p>of times between transfers and procedures, decrease of overall time of process)</p> <ul style="list-style-type: none"> <li>-improvement of traceability (by record of all procedures)</li> <li>-improvement of motivation of personnel (by monitoring of compliance of nurses and doctors)</li> <li>-improvement of patients and their caregivers satisfaction (by monitoring their agreement to the services)</li> <li>-improvement of costs (by comparison with previous processes)</li> <li>-improvement of management (by comparison with previous processes, through the possible exchange of theatres or modification of patients list allowed by new system)</li> <li>-decrease of incidents (by incident reporting)</li> </ul>
<b>Resources</b>	<ul style="list-style-type: none"> <li>-Material resources: financial resources for purchasing software and hardware, and for training personnel</li> <li>-Immaterial resources: quality-driven decision of hospital managers, involvement of personnel through proper training, involvement of all hospital personnel for supporting the organization modifications</li> </ul>

<b>ANALYSIS</b>	
<b>Development</b>	<ul style="list-style-type: none"> <li>- Phase #1: Deployment pre-go-live (3 to 5 months)- appointment of facility steering committee, detailed site survey, process workflow analysis, IT set up and hardware procurement, software initial process configuration, hardware installation and data verification, training documentation, configuration testing, key users training, assess historical process KPI and establish</li> </ul>

	<p>short, medium and long term process benchmark objectives to be achieved</p> <ul style="list-style-type: none"> <li>- Phase #2: Deployment post go-live (2 months) – intensive on the job coaching of staff, hardware infrastructure alignment, refinement of process initial configuration; as staff becomes more familiar with the technology, leverage system flexibility for configuration of additional functionalities to scale the scope of process activities supported by the systems.</li> </ul> <p>Ongoing:</p> <ul style="list-style-type: none"> <li>-monitor staff adoption of the systems for an effective real time management of the process on the system;</li> <li>-monitor and periodically review with operating staff process improvements;</li> <li>-adjust system configuration for new previously unidentified process efficiency issues;</li> <li>-periodically evaluate quantitative and quality performance improvements against pre-established benchmarks objectives;</li> </ul> <p>Improving efficiency and effectiveness of a complex operating area is an iterative process that changes over time, and therefore needs to be adapted to the evolution of the operational processes of the structure.</p>
<b>Obstacles</b>	<p>Being first adopter in Europe, the organization had an initial difficulty in properly understanding scope, functionality, deployment process and potential of such an innovative technology, substantially different from traditional and more familiar IT projects previously handled. End-users natural</p>

	resistance to the use of new technology and devices. End-users resistance to replace traditional communication means (paper, phone calls, etc.) with technology introducing a more intuitive and easy to access way of communicating and interacting.
<b>Means used to overcome or remove the obstacles</b>	Appointment of a hospital management Active involvement of the management and of key users in each phase of the deployment. Ongoing training and on the job coaching to overcome end users resistance, and make them realize that technology is easy to use and for their own daily use, which raises interest and active participation by all staff involved.
<b>Factors enabling the process</b>	Hospital management did a strong commitment and leadership to ensure adoption and proper implementation of the project. Improvement of results induced the recruitment of skeptic persons

<b>EVALUATION</b>	
<b>Reproducibility</b>	Technology is flexible and scalable, can be reproduced and implemented in any complex area of an healthcare facility configuring the system to the process needs of the specific area to be managed. Technology could be applied in all hospitals.
<b>Innovativeness</b>	Technology introduces innovative solutions now made available also for healthcare. Four components make the technology effective:  The technology allows real time independent tracking and measuring of all critical factors of the operating process: patients, locations, staff,

	<p>assets, status. Staff is not distracted from their primary function to input data in the system. Specifically designed control system elaborates data, updating in real time or schedule of the day of surgery, providing actionable information directly to each individual across the organization to help continuously coordinate and direct their activities. Dynamic OR schedule is made available to all staff involved in the process inside and outside the OR, through intuitive, easy to access display. System automatically sends Alert messages to prevent delay of single activities that might hamper the efficiency and effectiveness of the process.</p>
<p><b>Added value</b></p>	<p>The adopted technology substitutes for significant amount of costly traditional paperwork, telephone calls, email messages, fax. RTLS technology provides automatic, objective process data collection, much more reliable than previously used barcode readings left to the initiative of the individual staff.</p> <p>Systems provide actionable information for an ongoing real time management of the OR process; it is fundamentally different than traditional IT, focused on data entry and retrieval that, aside from distracting staff from their primary clinical functions, are meant to be for an after-the-fact measurement and management reporting. Transparency across the facility in an intuitive, easy to access mode, of the information related to real-time status of procedures, patients, rooms, staff assignments, and critical equipment, Patients and their</p>

	caregivers, makes end-users acceptance and satisfaction a real value, contributing to improve productivity, efficiency and effectiveness the OR operating process.
<b>Appropriateness</b>	<p>After fourteen months since go-live date:</p> <ul style="list-style-type: none"> <li>- there is always a larger number of staff actively using the system with enthusiasm and personal satisfaction;</li> <li>- most of the prior costly process practices have been replaced with significant improvements in terms of productivity, efficiency and effectiveness of the operating process;</li> <li>- new opportunities for further process improvement have emerged, clearly identified and are under ongoing management attention;</li> </ul>

<b>NEXT STEPS</b>	
<b>Key Take Aways</b>	<ol style="list-style-type: none"> <li>1. Efficiency could be improved by technology even in a well-organized and high-throughput hospital</li> <li>2. Technology should be a tool for improving the efficiency and appropriateness of assistance</li> <li>3. Technology could improve the work of staff, especially of nurses, decreasing workload, and stressful relationships with colleagues and doctors</li> <li>4. The increase of efficiency could mean an increase of transparency, especially for caregivers accompanying patients into the hospital</li> <li>5. Better information mean better</li> </ol>



	motivation for the staff
<b>Next Steps</b>	<p>Leverage the investment made to scale the technology:</p> <ul style="list-style-type: none"> <li>- with additional functionality to support other activities that can contribute to the ongoing continuous improvement of the OR operating process;</li> <li>- extend the technology for further adoption in managing process of other operating area of the healthcare facility, especially for the front-end activities, like ambulatory services, where the information are crucial to define a correct relationship with patients</li> </ul>

<b>Number</b>	7
<b>CONTACT DETAILS</b>	
<b>Name and Surname</b>	Tonino Aceti
<b>Position</b>	National Coordinator
<b>Organization</b>	Cittadinanzattiva/CnAMC, ANMAR e AMICI
<b>Country</b>	Italy
<b>Email</b>	mail@cittadinanzattiva.it

<b>DESCRIPTION</b>	
<b>Title</b>	Assistential Diagnostic-Therapeutic Paths (PDTA) for rheumatic diseases and for inflammatory bowel diseases (Crohn's disease and ulcerative colitis) become "Agreements among the State-Regions-Autonomous Provinces".
<b>Source of waste or inefficiency</b>	<ul style="list-style-type: none"> <li>inefficiently delivered services</li> </ul>
<b>Actors</b>	<b>Civic Organisation(s)</b> - National Board of Associations for Chronic Patients-Cittadinanzattiva - National Association of Rheumatic Patients (ANMAR) - AMICI Onlus
<b>Location</b>	Italy
<b>Term</b>	2015
<b>Objectives</b>	Improvement, applicability, uniformity and equity of assistance in Italy for patients affected by autoimmune inflammatory rheumatic diseases and chronic inflammatory diseases

<b>Outcomes Impact on participants</b>	<p>Assistential Diagnostic-Therapeutic Paths for autoimmune inflammatory rheumatic diseases and for inflammatory bowel diseases (Crohn's disease and ulcerative colitis) developed by the National Board of Associations for Chronic Patients-Cittadinanzattiva along with the NGOs ANMAR FRIENDS and AMICI, officially became part of an agreement among the State-Regions and Autonomous provinces.</p> <p>This allows to structure health networks and treatment pathways as best as possible, improving and harmonizing responsiveness to patients' needs and achieving, with a proper implementation, even a containment of public and individual health spending</p>
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ANALYSIS	
<b>Development</b>	<p>The PDTA were developed by the associations from the citizens' point of view, integrating the contributions of the main professionals involved in helping to ensure a real taking charge of patient's care, appropriateness and well-timed interventions, and so quality of care and a more rational use of resources.</p>

EVALUATION	
<b>Innovativeness</b>	<p>The agreements stand for the first two PDTA at national level approved by the Institutions; It is therefore a remarkable and innovative achievement</p>

OTHER INFORMATION	
<a href="http://www.cittadinanzattiva.it/notizie/salute/8270-i-pdta-approvati-da-conferenza-stato-regioni-i-testi-degli-accordi.html">http://www.cittadinanzattiva.it/notizie/salute/8270-i-pdta-approvati-da-conferenza-stato-regioni-i-testi-degli-accordi.html</a>	

<b>Number</b>	8
<b>CONTACT DETAILS</b>	
<b>Organization</b>	Dutch Association of Medical Specialists (OMS) and ZonMw
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<b>DESCRIPTION</b>	
<b>Title</b>	Choosing Wisely Netherlands Campaign
<b>Source of waste or inefficiency</b>	<ul style="list-style-type: none"> <li>inefficiently delivered services</li> </ul>
<b>Actors</b>	<p><b>Health Professionals</b> The Dutch Association of Medical Specialists (OMS), scientific associations and ZonMw</p> <p><b>Civic Organisation</b> The Federation of Patients and Consumer Organizations in the Netherlands (NPCF)</p>
<b>Location</b>	Netherlands
<b>Term</b>	Ongoing
<b>Objectives</b>	The goal is for care professionals and patients to work together to realize quality improvement in care, while keeping costs under control. The campaign is meant to answer the question of how we can spend the ‘care euro’ as efficiently and practically as possible, especially as the cost of care continues to rise. This must not detract from the high quality of care we offer in the Netherlands.
<b>Outcomes Impact on</b>	Patients have more clarity about the different treatment options and can make choices more easily, together with their doctor. In addition,

<b>participants</b>	they help the medical specialists to provide the same high quality of care, while making an important contribution to a future-proof healthcare system. Medical specialists receive supportive material for conversations with patients to help them give a good explanation of the treatment options and whether treatment is useful or not. More information about the cause of variations in practice and the effects of certain treatments helps doctors to gain insight, and eventually improve their own working method.
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<b>ANALYSIS</b>	
<b>Development</b>	<p>Choosing Wisely Netherlands supports medical specialists and their patients to make joint decisions about <i>the suitable use of care</i>. The doctor discusses in greater depth with the patient the best treatment at the right moment.</p> <p>Choosing Wisely Netherlands is a coherent whole of activities that systematically lead to quality improvement and, as a result, cost savings. The campaign consists of several components that have areas of overlap:</p> <ol style="list-style-type: none"> <li>1. Wise Choices:</li> </ol> <p>Wise Choices are proven recommendations (evidence) for a particular treatment. They are meant to stimulate doctors and patients to talk about what the most suitable treatment is at the right moment. These conversations about the benefit and necessity of certain medical tests and treatments can significantly contribute to improving the quality of care. This can lead naturally to cost management. It does not mean searching for the cheapest treatment method but deciding jointly on the most suitable treatment for</p>

the individual patient. Wise Choices is published by the scientific associations of medical specialists. The NPCF helps to distribute the materials.

## 2. Shared decisions

Research has shown that patients who decide options together with their caregiver are not only more satisfied, they make wiser choices in medical terms. Conscious choices reached after consultation by the patients can lead to cost savings because the chosen options are often less invasive or diagnostics or treatment options are refused. To arrive at these wise choices, it is necessary that the patient:

- is conscious of the fact that there is more than one treatment option and that the patient can be consulted about the choice;
- is clearly informed about all possible options, with doing nothing also being a possibility;
- is presented with the advantages and disadvantages of the different options;
- is explicitly asked what he thinks about the advantages and disadvantages and what he finds important;
- comes to the most suitable choice in consultation with the doctor.

The NPCF and OMS have made it their aim to ensure that Shared Decisions will become standard in every doctor's office. A joint program is currently being organized to support this aim.

## 3. Care evaluation

Guidelines provide the knowledge base for medical measures and must improve the quality and efficiency of the care. Not all care is described in the guidelines, however, and there is a lack of proof for much of the care provided. This is not surprising: 'medicine' has existed for

	<p>thousands of years, while the principles of ‘evidence-based medicine’ were only developed a few decades ago. The consequences are: variations in practice, potentially less worthwhile care, and even unsafe situations are possible. Care evaluation in the form of effectiveness studies leads not only to evident quality improvement but also to considerable efficiency gains. Scientific associations of medical specialists therefore developed knowledge agendas: overviews of treatments whose effectiveness has not been confirmed and must be examined.</p> <p>2. Variations in practice</p> <p>By making variations in practice evident and pointing them out, understanding their causes and initiating improvements where necessary, the appropriate use of care is encouraged. The activities should supplement the existing activities or bundle them. For example, several scientific associations conducted research in the past few years into variations in practice and developed improvement activities, including the development of ‘Wise Choices’. This year a general conceptual framework for appropriate use was developed. The NPCF also highlighted variations in practice with the ‘Care Atlas’ (Zorgatlas). Joint interpretation of variations in practice is the focus of pilots started in collaboration with the National Health Care Institute (ZINL).</p>
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EVALUATION	
<b>Reproducibility</b>	The campaign is based on the American ‘Choosing Wisely’ campaign. In other countries like Canada, Germany, Australia and New Zealand, campaigns have been started to stimulate appropriate use of care.

OTHER INFORMATION
<a href="http://www.choosingwisely.org/">http://www.choosingwisely.org/</a> <a href="http://www.kwaliteitskoepel.nl/verstandig-kiezen/english/">http://www.kwaliteitskoepel.nl/verstandig-kiezen/english/</a>



<b>Number</b>	9
<b>CONTACT DETAILS</b>	
<b>Name and Surname</b>	Maarten de Wit, PhD
<b>Position</b>	Convenor of the PARE network of patient research partners
<b>Organization</b>	EULAR Standing Committee of People with Arthritis/Rheumatism in Europe (PARE)
<b>Country</b>	Netherlands
<b>Email</b>	martinusdewit@hotmail.com
<b>Short description of the person submitting this project</b>	
<p>Maarten de Wit is a person with psoriatic arthritis who was the EULAR vice president of PARE (representing the national arthritis patient organizations in Europe) between 2005-2009. He led the EULAR task force that formulated the ‘EULAR recommendations for the involvement of patient representatives in scientific projects’ and established thereafter the PARE network of patient research partners. This network of over 40 trained patient research partners are participating in the development of European management recommendations for a great variety of rheumatic conditions, review of lay summaries of recommendations, in the design and assessment of scientific research proposals and in the implementation of research findings on a national level. They also participate as collaborating partners in research consortia such as IMI projects, and in EMA committees. Their main objective is to ensure that the patient perspective is not lost throughout the research process.</p>	

<b>DESCRIPTION</b>	
<b>Title</b>	Patient research partners ensure research proposals target outcomes that matter to patients. A good practice from the field of rheumatology.
<b>Source of</b>	<ul style="list-style-type: none"> <li>• <b>inefficiently delivered services</b></li> </ul>

<b>waste or inefficiency</b>	<p>suboptimal quality of care  <b>other:</b> improving quality of care across Europe and access to up-to-date and high quality health information for patients.</p> <ul style="list-style-type: none"> <li>• <b>unnecessary services</b></li> </ul>
<b>Actors</b>	<p><b>Healthcare Organisation</b>  EULAR: European League Against Rheumatism  <b>Health Professionals</b>  EULAR standing committees of health professionals, standing committee of epidemiology, standing committee of international clinical research and the standing committee of investigative research  <b>University</b>  Our research partners collaborate with many researchers from all over Europe, in particular the centres of Excellence as indicated on the EULAR website (<a href="http://www.eular.org">www.eular.org</a>)</p>
<b>Location</b>	<p>Members of the PARE network of patient research partners come from all over Europe: Denmark, Bulgaria, Cyprus, Ireland, Estonia, Netherlands, Belgium, Germany, France, Switzerland, Portugal, Italy, Slovakia, Serbia, Sweden, Romania and UK.</p>
<b>Term</b>	<p>2010  Ongoing</p>
<b>Objectives</b>	<p>The aims of the Patient research partners are to improve methodology and research outcomes by providing the patient perspective in the context of health research. Incorporating the experiential knowledge of patients, gives credibility to the results and acknowledges that for moral reasons patients should have a say in health care and health research when it is expected that decisions in these areas will have an impact on</p>

	<p>their daily life.</p> <p>Patient involvement in research is increasing. EULAR has supported the integration of the patient perspective in its vision, procedures and practices for a long time. EULAR initiated the development of recommendations (2009) and established a network of educated patient research partners (2010). EULAR facilitated a follow-up project (2012) to promote the implementation and evaluation of the network over the period 2011-2013 and its integration into the EULAR secretariat core activities (2013-2015). Supportive materials such as reference cards and a background brochure for researchers and PRP have been developed.</p>
<p><b>Outcomes</b> <b>Impact on participants</b></p>	<p>Impact of patient involvement has been internally evaluated in 2012/3 and has led to the development of supportive materials for researchers and patient research partners to improve and intensify collaboration in research. The benefits of patient involvement has been demonstrated in a PhD study published in 2014 (M. de Wit, “Patient participation in rheumatology research. A four level responsive evaluation”)</p>
<p><b>Resources</b></p>	<p>EULAR facilitates the network for already more than 6 year. One staff member at the EULAR secretariat in Zurich supports and coordinates the recruitment, selection, education, matching and acknowledgement of the network members. 6 Members of the network have or are still participating in the EUPATI online training course on innovative medicine development. Annual network meetings are organized to evaluate and to provide additional training.</p>

ANALYSIS	
Development	<p>Patient research partners from the PARE network are currently involved in the following patient roles and activities in scientific research:</p> <p>Membership of the EULAR task forces for management recommendations and classification criteria</p> <p>To assess research grant applications from a patient perspective for EULAR calls.</p> <p>Membership of Forum committees (Exec Committee, Scientific Committee)</p> <p>Review the ARD lay summaries of articles of Annals of Rheumatic Diseases</p> <p>Review the EULAR lay summaries of recommendations, including translation and dissemination.</p> <p>Membership of EMA committees.</p> <p>Membership of EULAR research initiative.</p> <p>Membership of external, international research initiative.</p> <p>Membership of mono-pharmaceutical research initiative.</p>
Obstacles	<p>Implementing principles of participatory research and establishing new partnerships between patients and researchers/health professionals requires time. The support of the leadership, presence of ‘ambassadors’ or ‘change-agents’ and sufficient resources for support and training have been crucial success factors. Lack of time for researchers, strict deadlines and legal concerns for patient involvement and lack of knowledge of “how to do”, are still important barriers. In</p>

	particular appropriate acknowledgement or compensation of the work that patient research partners do, is still challenging.
<b>Means used to overcome or remove the obstacles</b>	Learning along the way and training-on-the-job are important principles to go ahead. EULAR has ensured sustainability of the network by continues support to evaluate and to provide resources that were needed to resolve problems or to develop materials. Support is time consuming and by having a designated network coordinator many problems can be identified early and resolved. We have produced ‘reference cards’ and a ‘background brochure’ for both researchers and patient research partners to make them aware of the opportunities for collaboration and potential pitfalls for each stage in the research.
<b>Factors enabling the process</b>	See the success factors mentioned above.

<b>EVALUATION</b>	
<b>Reproducibility</b>	<p>There are now also new initiatives, based on the PARE network, to establish patient research partners on national and regional level (Belgium, Germany, Norway, Sweden, UK and Netherlands).</p> <p>The EULAR network will also be presented at the first patient engagement workshop organized by IMI to inform other disease areas about the lessons learnt in our network.</p>
<b>Innovativeness</b>	Involvement of patient research partners has directly influences and increased the dissemination of EULAR disease management

	recommendations to patients. Patient research partners did take the initiative to develop lay summaries and produced the PARE guide for disseminating EULAR recommendations to patients. This would not have been happened without direct involvement of patient research partners.
<b>Appropriateness</b>	Tailor made support, developed over the years, has been pivotal. Regular evaluations have helped to identify concerns and needs of both researchers and patient research partners. This has in an iterative way steered the development of the network and the quality of the collaboration in EULAR and outside EULAR.

<b>NEXT STEPS</b>	
<b>Lessons Learned</b>	Take time, start small, keep it simple, discuss mutual expectations, look for meaningful opportunities for involvement, and evaluate lessons learned during and after the project.
<b>Key Take Aways</b>	<ol style="list-style-type: none"> <li>1. Collaboration between patient and researchers/health professionals is challenging but improves better health care.</li> <li>2. Appropriate support and education of all stakeholders involved, combined with the financial and unconditional support of the leadership have been important factors of success.</li> </ol>
<b>Next Steps</b>	Next steps will be to explore opportunities for further involvement of patient research partners in research initiatives of third parties. For this we need to develop new guidelines, standardized operational procedures and formats for appropriate acknowledgement and

	compensation for patient research partners.
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<b>Number</b>	10
<b>CONTACT DETAILS</b>	
<b>Name and Surname</b>	Karolina Laskowska
<b>Position</b>	Bureau of the Commissioner for Patients' Rights Institution
<b>Organization</b>	Inspector, Social Dialogue and Communication Department
<b>Country</b>	Poland
<b>Email</b>	promocja@bpp.gov.pl
<b>Short description of the person submitting this project</b>	
The Commissioner for Patients' Rights is a central body of governmental administration in Poland and it is directly subordinated to the Prime Minister. Our main aim is to guard and protect patients' rights. October 2, 2009 the Prime Minister has appointed Mrs. Krystyna Barbara Kozłowska to the post. The Act on patients' rights and the Commissioner for Patients' Rights came into force in 2009.	

<b>DESCRIPTION</b>	
<b>Title</b>	Effective access to information related to health, thanks to the actions of the Bureau of the Commissioner for Patients' Rights.
<b>Source of waste or inefficiency</b>	<ul style="list-style-type: none"> <li>• <b>missed prevention opportunities</b></li> </ul> <p>Receiving medical benefits successfully in the public healthcare system often requires extensive knowledge in the field of patients' rights and obligations of medical entities. Patients often do not know what they are entitled to, and, moreover, healthcare institutions are not aware of the procedures they are obliged to and their responsibilities towards the patient. Accordingly, when the waiting time for health services is elongated, there are unnecessary charges generated by the long procedures which</p>



	<p>leads to an inefficient use of public funds.</p> <ul style="list-style-type: none"> <li>• <b>inefficiently delivered services</b> Low efficiency in the provision of medical services, often due to lack of knowledge of the patients about their rights and the consequences of not using the entitlements</li> <li>• <b>prices set too high</b> Lack of awareness among patients about the possibility of using the majority of health services covered by health insurance, in effect, patients often incur additional costs for treatment in a commercial system</li> <li>• <b>other</b> Bureau undertakes a number of activities and initiatives aimed at preventing pathologies. The Commissioner applies to the competent organs for legislative initiative or the issuance or amendment of legislation for the protection of patients' rights, including the above mentioned examples of waste or inefficiency. The Commissioner also seeks to change the relationship between the patient and the medical entity in terms of perception and embracing problems of patients, even in situations that are not related to the granting of benefits.</li> </ul>
<b>Actors</b>	<p><b>Civic Organisations</b> working in the field of protection of patients' rights Healthcare Organisations Health Professionals Universities Institutions Other Patients</p>
<b>Location</b>	Poland

<b>Term</b>	<p>Start date: 2009</p> <p>Ongoing</p>
<b>Objectives</b>	<p>Protecting the interests of patients in terms of access to treatment, improve treatment efficiency, attention to the complexity of medical services and to avoid returning patients to other entities, improvement of access to medical services by transparent rules for determining the order of the benefits and minimize the waiting period for benefits, popularization of good practice in a treatment and adequately inform patients on how to implement the recommendations and guidance of medical. Creating the doctor-patient partnership. Specific support and assistance for the disabled, the elderly, children and socially helpless.</p> <p>Achievement of the objectives through the following:</p> <ul style="list-style-type: none"> <li>- Increase the awareness of patients' rights in the society (in all age groups);</li> <li>- Support and assistance to people in therapeutic entities providing psychiatric care and rehab facilities through actions of Commissioners of Psychiatric Patients' Rights;</li> <li>- Dissemination of knowledge about patients' rights by, among others, Bureau hotline, educational programs, informational visitations and promotional publications (leaflets, books);</li> <li>- Identification of hazards and areas in the health care system that need the repair and corrective actions;</li> <li>- if necessary, take action to defend the patients'</li> </ul>

	<p>rights by intervention (inquiries);</p> <ul style="list-style-type: none"> <li>- Consideration of any applications regardless of the manner of their submission (electronically, in writing). After reviewing the application, depending on the issue presented, the employee sets the most effective way of dealing with the case. Requests made by patients are free of charge.</li> </ul>
<b>Outcomes Impact on participants</b>	Wide access to the Patient Ombudsman, lack of administrative barriers, restricted formalism.
<b>Resources</b>	<p>The resources needed to carry out the project are: information obtained directly from patients through the hotline, applications of patients submitted to the Bureau, health-related information from the mass media and non-governmental organizations working in the field of health care. Statistical analysis and qualitative internal and external information. An analysis requires people with experience in the preparation of statements and draw conclusions, the communication of social projects and organization of the events and management of the whole project.</p>

<b>ANALYSIS</b>	
<b>Development</b>	<p>The project brings the institutions of the health system to the citizen-patient, allowing an individual approach through:</p> <ul style="list-style-type: none"> <li>- Proactive informing about the possibility to benefit from the aid (handouts, promotional films on the Internet and Bureau's website);</li> <li>- Organizing meetings of experts of the Commissioner with stakeholders during the local events, long-range, eg. during events</li> </ul>

	<p>organized by local governments;</p> <ul style="list-style-type: none"> <li>- Actions of Commissioners of Psychiatric Patients' Rights - providing assistance in the investigation by the rights of patients in psychiatric hospitals and their families;</li> <li>- Preparing own publications, ie. Information about the rights of the patient in publications targeted at a specific group of patients / age group (eg. Novel about patients' rights for children aged 7-10 years, also issued in the form of audio book titled "Kuba and Buba in hospital - almost everything about child-patients' rights");</li> <li>- Information and promotion of patients' rights (television, radio, press, online media) and educational campaigns for the protection of patients' rights (lessons for primary schools, lectures for seniors);</li> <li>- Proactive cooperation with NGOs (web communication platform, thematic meetings with NGOs), including the proposing of legislative activities;</li> <li>- Free nationwide helpline open from Mon-Fri 9 a.m.-9 p.m. (experts on the rights of the patient, the health care system, medical law and psychiatric care);</li> <li>- Different ways of communicating and reaching out to the Commissioner (helpline, written submissions, ePUAP- e-platform for communication with the Bureau, daily shifts expert in the Bureau);</li> <li>- Enabling contact for people with disabilities (sign language translators, on-line translators);</li> <li>- Services adapted to the needs of the clients</li> </ul>
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	with impaired vision and hearing (SKOGN);
<b>Obstacles</b>	<ul style="list-style-type: none"> <li>- Prejudices and the lack of ability to build appropriate interpersonal relationships;</li> <li>- An act or omission of the person that is obliged to take care of patients' problems in a proper way;</li> <li>- Obstacles of financial nature, in particular the limited resources for the implementation of custom actions that require broad presence in the media;</li> <li>- The lack of willingness to cooperate from other institutions or media organizations with a broad range of opportunities for communication and for the promotion of patients' rights;</li> <li>- Lack of interest of other bodies and institutions concerning the protection of patients' rights;</li> <li>- Limited abilities of the Commissioner regarding the possibility of making changes to the system and legislation for the protection of patients' rights in the health system;</li> <li>- Low activity of patients in the use of the possibility of asserting their rights;</li> <li>- Inefficient human resources.</li> </ul>
<b>Means used to overcome or remove the obstacles</b>	Optimization of financing by reducing costs, proactively seeking of partners for the project, searching for ways of improving cooperation with external entities by increasing awareness on the importance of a social mission of the project, the search for non-standard methods of reaching out to the community, promotional actions.
<b>Factors enabling the process</b>	Involvement of all employees of the Bureau. The positive internal and external image of

	the project. Social utility, an important social mission.
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<b>EVALUATION</b>	
<b>Reproducibility</b>	The strategy of open office for its visitors is possible to implement in each institution. The practice can be used in other places, in particular in other institutions and countries where there are problems with the availability of medical services, as well as problems with access to comprehensive information about patients' rights. The project has a wide impact on the process of providing health care services regardless of time and place. It applies to any entity performing public duties and private, commercial and using public funds, in the hospital and in the individual doctor's office.
<b>Innovativeness</b>	Innovation in this solution is to combine a number of known and used methods in a consistent mechanism of broad social impact, in particular through the use of a wide range of opportunities offered by cooperation with partners, to reach communities at many levels, from small children (eg. through books) to adults and especially elderly people (eg. by giving lectures on patients' rights specifically dedicated to seniors). Reaching innovation manifests itself in the widest possible usage of different channels of communication and synergy between public and private partners.
<b>Added value</b>	Before the creation of the Bureau there was no institution entirely responsible for protecting the rights of patients and their education in this

	<p>field. These tasks were performed by the department of Ministry of Health, but the limited powers of these activities were insufficient in comparison to the needs of the patients. Establishment of the Commissioner allowed patients to receive the necessary help and support in pursuing their rights.</p> <p>Focusing our internal structures around the main goal triggered creativity and ingenuity in finding and creating custom methods. All these activities enable more effective assistance to all interested parties and the new projects give new capabilities and open another door. Social actions of the Commissioner are very popular and have increased interest in patients' rights.</p> <p>Undoubtedly, another added value is also an increased confidence in the state institutions and health institutions, systematically restoring the essence of the mission, which is to serve patients.</p>
<b>Appropriateness</b>	<p>The practice has allowed to increase the efficiency of management the needs connected with patients' rights. In particular, the institution has been focused on the implementation of the basic needs of patients in obtaining information. Implemented practices allowed to increase the efficiency of used resources and to reduce the resources involved. A creative approach, where the unconventional methods are being sought, gave the opportunity to a much more effective management of the needs. The project is still being developed and at this very moment we can say that it is being successful.</p>

<b>NEXT STEPS</b>	
<b>Lessons Learned</b>	The key to success is appropriate defining of the project recipients, involving own teams and building a positive attitude to the needs in the entire organization. Working with a team focused on the goal, convinced of the rightness of the validity of the action, gives extra motivation to other employees which is much more important than financial incentives.
<b>Key Take Aways</b>	<ol style="list-style-type: none"> <li>1. The creativity and commitment of employees is the basis of proper implementation of the project.</li> <li>2. Creating a positive image of the project makes it easier to gain partners and reduce costs.</li> <li>3. Raising awareness of patients' rights allows better and more efficient use of scarce resources in health care.</li> <li>4. An aware and well-informed patient is safe, able to take care of his/her interests.</li> <li>5. Healthcare entities and other institutions are obliged not only to do their statutory tasks but also to fulfill the mission for which they have been established.</li> </ol>
<b>Next Steps</b>	<ol style="list-style-type: none"> <li>1. Strengthening effective methods of building a correct relationship between patients and medical entities.</li> <li>2. The cooperation with the social partners, financing and supporting next projects.</li> <li>3. Promotion of good practices among other organizations.</li> <li>4. Increasing the involvement of NGOs that are working with specific groups of patients, in narrow, specialized and demanding support</li> </ol>



	<p>areas / departments of medicine.</p> <p>5. Popularize and modernization of additional communication channels, eg. Social media (new audiences), educational materials for primary schools (classes about the patients' rights).</p>
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OTHER INFORMATION	
Total number of submissions to the Commissioner	
Year	Number of submissions
2011	38206
2012	63913
2013	69045
2014	65339
2015	71366
Number of applications submitted via the Helpline	
Year	Number of submissions
2011	22725
2012	35887
2013	36563
2014	37868
2015	49308
Number of patient visits in the Bureau	
Year	Number of visits
2011	445
2012	731
2013	485
2014	420
2015	519

<b>Number</b>	11
<b>CONTACT DETAILS</b>	
<b>Name and Surname</b>	Karolina Laskowska
<b>Position</b>	Bureau of the Commissioner for Patients' Rights Institution
<b>Organization</b>	Inspector, Social Dialogue and Communication Department
<b>Country</b>	Poland
<b>Email</b>	promocja@bpp.gov.pl
<b>Short description of the person submitting this project</b>	
The Commissioner for Patients' Rights is a central body of governmental administration in Poland and it is directly subordinated to the Prime Minister. Our main aim is to guard and protect patients' rights. October 2, 2009 the Prime Minister has appointed Mrs. Krystyna Barbara Kozłowska to the post. The Act on patients' rights and the Commissioner for Patients' Rights came into force in 2009.	

<b>DESCRIPTION</b>	
<b>Title</b>	Commissioners of Psychiatric Patients' Rights as a unique institution that helps patients with mental disorders
<b>Actors</b>	<b>Institution</b> Bureau of the Commissioner for Patients' Rights <b>Other</b> Patients with mental disorders and their families
<b>Location</b>	Poland
<b>Term</b>	Start date: January 2006 Ongoing
<b>Objectives</b>	Helping people with mental disorders in hospitals, their families, legal and actual representatives through: 1) receiving oral and written complaints, 2) providing patient access to legal information,

	<p>3) help in preparing and filing a complaint to the head of the psychiatric hospital,</p> <p>4) informational and educational tasks,</p> <p>5) own actions towards patients admitted to the hospital and requiring assistance.</p>
<b>Outcomes Impact on participants</b>	Increasing the knowledge of patients in a psychiatric hospital about their rights and raise of their legal awareness. Ongoing work of Commissioners affect respect for the rights of patients by the medical staff.
<b>Resources</b>	Commissioners of Psychiatric Patients' Rights are the employees of the Bureau. They have the knowledge of human rights and the experience in working with people with mental disorders.

<b>ANALYSIS</b>	
<b>Development</b>	<p>The institution of the Commissioner of Psychiatric Patients' Rights was established in 2006 to protect the rights of patients with mental disorders in mental hospitals/wards. Currently, there are 49 Commissioners who fulfil their duties throughout the country. Their activity is mainly focused on direct contact with the patient, his family, or legal representative. They perform their tasks in therapeutic entities – their contact with patients is continuous and direct. Most of the time they spend on the hospital wards. In case of violation of patients' rights Commissioners undertake interventions in the hospital / psychiatric ward, particularly in the head of entity and medical staff.</p>
<b>Obstacles</b>	Sporadic cases of lack of understanding of the activities of Commissioners from the head of the entity or the medical staff.

<b>Means used to overcome or remove the obstacles</b>	Petitions of the Commissioner for Patients' Rights directed to medical entities concerning cooperation with the Commissioners of Psychiatric Patients' Rights or improvement of already established relationship.
<b>Factors enabling the process</b>	<p>1) establishing a good relationship with the manager and the medical staff of the hospital,</p> <p>2) constant improvement of qualifications of the Commissioners through internal and external training and participation in conferences organized by other institutions of state administration.</p> <p>3) ongoing exchange of experience and knowledge between the Commissioners.</p>

<b>EVALUATION</b>	
<b>Reproducibility</b>	Such an institution can be developed in the other country.
<b>Innovativeness</b>	The institution of Commissioner of Psychiatric Patients' Rights contributed to reducing the number of violations of patient's rights in psychiatric hospitals throughout the country. Patients are the subject of constant care of Commissioners in the hospitals and receive help even after leaving it.
<b>Added value</b>	Such a function did not exist in Poland until 2006. The appointment of Commissioners had a positive impact on the patients' rights in psychiatric hospitals.
<b>Appropriateness</b>	Commissioners perform their function in the hospitals where previously violations of patients' rights have occurred. As a prevention

	they work also in other psychiatric hospitals.
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NEXT STEPS	
<b>Lessons Learned</b>	Effective implementation of the project largely depends on properly conducted recruitment process of employees. Employees performing this function must be empathic and must combine the ability to establish relations with patients with mental disorders, knowing being aware the rights of the person hospitalized in a psychiatric hospital.
<b>Key Take Aways</b>	<ol style="list-style-type: none"> <li>1. The implemented solutions have significantly contributed to raising the awareness of patients' rights among patients and their families.</li> <li>2. The result of activities of Commissioners was a change in attitude of medical staff to the mentally ill. These people came to be seen as legitimate patients, which directly resulted in a decrease in the number of complaints made by the patients.</li> </ol>
<b>Next Steps</b>	Increasing the number of Commissioners, who will supervise the next hospitals.

OTHER INFORMATION		
The number of patients visits to the Commissioners for Psychiatric Pateints Rights		
Year	Number of visits	
2011	5287	
2012	10763	
2013	15889	
2014	11334	

2015	13369
The number of investigations initiated by the Commissioner	
Year	Number of investigations
2013	536
2014	607
2015	1196
The number of cases in which indicated legal solutions	
Year	Number of cases
2011	2824
2012	3647
2013	4395
2014	3594
2015	4627

<b>Number</b>	12
<b>CONTACT DETAILS</b>	
<b>Name and Surname</b>	Project Innovating care for people with multiple chronic conditions in Europe (ICARE4EU)
<b>Country</b>	Spain
<b>Short description of the person submitting this project</b>	
The ICARE4EU project aims to identify, describe, and analyse innovative integrated care practices for people with multimorbidity in European countries, and to disseminate knowledge and experiences from these practices to all European countries in order to support further implementation of effective and sustainable care approaches for European citizens with multimorbidity ( <a href="http://www.icare4eu.org">www.icare4eu.org</a> ).	

<b>DESCRIPTION</b>	
<b>Title</b>	The Strategy for Chronic Care in Valencia Region
<b>Source of waste or inefficiency</b>	<ul style="list-style-type: none"> <li>• inefficiently delivered services</li> <li>• medicines use</li> </ul>
<b>Actors</b>	<b>Institution</b> Regional Ministry of Health of the Valencia Region <b>Health Professionals</b> Case managers, Nurses, Medical doctors <b>Other</b> Patients
<b>Location</b>	Valencia, Spagna
<b>Term</b>	2014
<b>Objectives</b>	The goal of this policy programme is to develop

	a comprehensive framework for an integrated care model for patients with chronic diseases and multimorbidity in need of highly complex care.
<b>Outcomes Impact on participants</b>	The integrated care model is successfully implemented, with benefits for patients, professionals and the health sector. The drug monitoring system allowed saving over 35 million Euros by reviewing drug therapies in the period 2012-14: more than 200,000 patients with polypharmacy were reviewed and over 99,000 drug treatments were changed, leading to an impressive reduction of public expenditure in drugs from 19.5 million Euros in 2012 to 7.3 million in 2014. Between 2011 and 2013 there was also a significant decrease (-10%, -34,300 patients) of older people treated with polypharmacy (defined as more than 5 drugs prescribed).
<b>Resources</b>	The Strategy is implemented by the Valencia Region mainly through ordinary funds of the regional health system, which is financed mostly by general taxation (94%). Some technical projects within the Strategy benefited from funding from the regional, national or European sources or by ad hoc resource allocation of single health departments.

<b>ANALYSIS</b>	
<b>Development</b>	The programme implements an integrated care model that allows continuity of care thanks to the joint collaboration of hospital nurse case managers and community nurse case managers, in charge of monitoring and supporting patients and mobilizing primary or



	<p>specialized resources according to their needs.</p> <ul style="list-style-type: none"> <li>– Information systems are used for stratifying population according to patient' morbidity profile and monitoring their drug therapies.</li> </ul> <p>The care process includes a continuous monitoring of the case. The case managers are thus always aware of the situation of the particular patient and receive an alert from their information system if changes take place. All the information (patients' clinical documents, diagnoses, analytical tests) is shared through EHRs and is used by all actors involved in the process. The work and cooperation of the case managers is supported by additional ICTs, such as tablets to monitor patients both in a hospital and at their homes.</p>
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EVALUATION	
<b>Reproducibility</b>	The integrated care model and the information systems developed for stratifying the population are promising instruments that can be exploited by professionals working at hospitals, health centres and other community facilities for proactive interventions in complex patients.
<b>Innovativeness</b>	There are two main innovative aspects which deserve attention within the Strategy implementation. The first one concerns the integrated care model which relies on a strong collaboration and integration of actors in the regional health system. In particular, the case management approach, with the availability of nurse case managers in hospitals and in the community, supports the idea of care services designed for and around the patient,

	<p>guaranteeing the continuity and quality of longterm care. This model is carried out through a deep involvement of health professionals in training and re-organising care processes with new tasks and tools. The second driver of innovation is constituted by ICTs and, in particular, information systems developed for stratifying the population according to their morbidity profiles and monitoring their conditions and drug use.</p>
<b>Added value</b>	<p>The model is clearly patient-centred: it introduces the roles of two nurses acting as hospital nurse case manager (HNCM) or community nurse case manager (CNCM). They are jointly responsible for monitoring the patient and interacting with professionals as well as checking the appropriateness of care received. The two nurses are in constant communication to ensure seamless coordination if a patient switches from living in the community to accessed hospital services.</p>

<b>NEXT STEPS</b>	
<b>Lessons Learned</b>	<p>The possibility to find new ways of collaboration between health facilities (where health social workers are employed) and municipalities and regional authorities (offering proper social services through their own social workers) should be further discussed, in order to improve the link between the needs assessment of patients (including social needs) and the provision of social services.</p>
<b>Key Take Aways</b>	<p>The Strategy for Chronic Care gave specific</p>

	<p>guidelines how chronic care should be addressed within the regional health system, based on previous policies and actions implemented by the Valencia Region. This framework provided a solid basis for achieving ambitious objectives</p>
<p><b>Next Steps</b></p>	<p>Some health departments and hospitals are implementing additional ICT tools for targeting specific issues and tasks, which work well with the general information systems (e.g., SIP, SIA-ABUCASIS, SCP-CV) but are not connected with other facilities. If the development of information systems is not monitored and guided at higher lever, there might the risk of fragmentation of some patient data, collected by some health facilities and not by others within the same Region. Efforts in strengthening interoperability and transferability of these additional information systems could be put in place.</p>

## OTHER INFORMATION

[http://www.icare4eu.org/pdf/Case\\_report\\_%20Valencia\\_final.pdf](http://www.icare4eu.org/pdf/Case_report_%20Valencia_final.pdf)

<b>Number</b>	13
CONTACT DETAILS	
<b>Name and Surname</b>	Cari Almazán
<b>Position</b>	Agency for Health Quality and Assessment of Catalonia. A public agency of evaluation of Catalan Ministry of Health
<b>Organization</b>	In charge of “Essencial” Project
<b>Country</b>	Spain
<b>Email</b>	calmazan@gencat.cat
Short description of the person submitting this project	
MD (University of Barcelona), specialist in Preventive Medicine and Public Health, master in Management and Health Technology Assessment (Autonomous University of Barcelona). She was a senior researcher and responsible of the Health Technology Assessment Department in the AQuAS. With over 20 years’ experience at the health sector, developing and recommending strategies and policies in the planning and evaluation related to access to health care of medical and surgical procedures, imaging diagnostic technologies and telemedicine, using the evaluation of health technologies in these areas. Currently is in charge of the strategic project of the AquAS: ‘Essencial. Adding value to the clinical practice.	

DESCRIPTION	
<b>Title</b>	Essencial. Adding Value To The Clinical Practice
<b>Source of waste or inefficiency</b>	<ul style="list-style-type: none"> <li>• inefficiently delivered services</li> <li>• medicines use</li> <li>• unnecessary services</li> </ul>

<b>Actors</b>	<p><b>Healthcare Organisation</b> Department of Health, Public Healthcare Providers</p> <p><b>Health Professionals</b> Primary care and hospital health professionals</p> <p><b>Institution</b> Catalan Scientific Societies of Health Professionals</p> <p><b>Other</b> Catalan patient council (Consell Consultiu de Pacients de Catalunya)</p>
<b>Location</b>	Barcelona. Catalonia
<b>Term</b>	<p>Start date:7/03/2013</p> <p>Ongoing</p>
<b>Objectives</b>	<p>Essencial is a public policy initiative to identify low-value practices and which elaborates clinical recommendations to avoid these practices reducing unnecessary care. The quality of health care is directly related to the effectiveness and efficiency of health care services provided to achieve the maximum possible value for the available resources. Nowadays there is enough evidence to show that, alongside clinical practices which have been proven effective, there are other low-value practices as well as some, which the evidence tells us, add no value whatsoever. Avoiding clinical practices which do not add value can help improve healthcare quality, innovation and sustainability of the health system, insomuch as it frees up resources which may then be allocated to processes that do add value to clinical practice.</p> <p>Main objective</p> <p>Promoting clinical practices aimed at avoiding practices classified as adding low or no value for the general public. This in turn will contribute to improving healthcare quality.</p>

	<p>Specific objectives</p> <ul style="list-style-type: none"> <li>• To inform the professional community and the general public of procedures which, according to the scientific evidence and expert opinion, fail to provide benefits to patients' health.</li> <li>• To encourage health professionals to contribute to identifying practices which are of little value.</li> <li>• To assess the impact of the recommendations on the health system, both from the point of view of the process as well as the end result.</li> </ul>
<p><b>Outcomes Impact on participants</b></p>	<p>Main outcomes of the project:</p> <p>1) In the short time:</p> <ul style="list-style-type: none"> <li>• Currently, 45 recommendations to avoid low-value practices about prevention, diagnosis, treatment and rehabilitations has been elaborated in collaboration with Catalan Scientific Societies</li> <li>• 100 primary care teams of 369 of the Catalan Public Primary Care System are implementing the Essencial recommendations</li> <li>• Reduction of use rates of practices recommended as of "low-value"</li> <li>• Resources spent in low value practices should be reallocated in promoting appropriate added value clinical practices (opportunity cost) and to reduce waste</li> </ul> <p>2) In the long term</p> <ul style="list-style-type: none"> <li>• To improve the quality of care of patients by reducing the harm due to the overdiagnosis, overtreatment and overuse</li> <li>• To maintain the sustainability of the</li> </ul>

	healthcare services
<b>Resources</b>	<p>AQuAS: a team of 6 professionals are involved in the Essencial project. The main activities are: coordination of identifications of low-value practices and the implementations of recommendations in a pilot experience, adaptation of recommendations addressed to the patients and citizens, dissemination of recommendations and measurement of impact of recommendations in clinical practice.</p> <p>Close collaboration with Catalan Scientific Societies and Healthcare Providers is needed. And a multichannel communication strategy is implemented to reach as much as possible healthcare professionals.</p>

<b>ANALYSIS</b>	
<b>Development</b>	<p>“Essencial” project includes the following steps:</p> <p>Identifying practices of low-value Clinical practices that contribute little value in the catalan healthcare system are identified. AQuAS coordinates this process in collaboration with scientific societies, the Department of Health master plans and the professional community. Recommendations to avoid these low-value practices are elaborated.</p> <p>Active communication A specific communication strategy is designed for each prioritized recommendation which is tailored to the particular stakeholders involved using the most suitable communication and distribution channels in each case (social media communication tools, press releases, scientific</p>

	<p>communication, etc.).</p> <p>Assessing the impact</p> <p>In this final stage, and whenever possible, an impact assessment study is carried out by measuring the degree of knowledge of prioritized recommendations and their adoption by medical professionals, as well as any changes in healthcare provision attributable to the implementation of the recommendation.</p>
<b>Obstacles</b>	<p>The most relevant obstacles regarding the identification of low-value practices are the current values and culture of clinical practice of Scientific Societies ('more is better', 'innovation is better'). Also, some Scientific Societies perceive the project as a measure to cut healthcare costs and finally, pharmaceutical and medical devices companies and its incentives influence professional behaviors.</p> <p>In the implementation stage, physicians identified as most relevant obstacles to implement the project: lack of visiting time to explain the patient why to avoid a clinical practice and existing clinical uncertainty. The lack of support and commitment of organization and managers when a patient makes a complaint is considered relevant, too.</p>
<b>Means used to overcome or remove the obstacles</b>	<p>To overcome the obstacles in the first step of the project, we began to collaborate with Scientific Societies aligned with the principles of Essencial. Also, the project has been presented to all health care providers of Catalonia, in hospitals and primary care centers. At implementation level, clinical leaders of primary care teams are</p>



	developing their specific strategies to overcome their obstacles. Some primary care teams focus their activities on reducing the variability of the clinical practices, others on improving communication with patients or achieving a better coordination within the organization.
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EVALUATION	
<b>Reproducibility</b>	Essential recommendations are based on scientific evidence included in Clinical Practice Guidelines (CPG), systematic review and supported by Scientific Societies. In that sense knowledge of recommendations and communication strategy can be shared between countries. An implementation model is more difficult to share because it is more context and organization-dependent (culture, mindset, incentives, predisposition for change, healthcare system, etc)
<b>Innovativeness</b>	The innovativeness of the project is not only the identification of low-value practices, but also the idea to identify those low-practices relevant to the Catalan healthcare system and to promote an implementation button-up with the commitment of physicians and the help of health managers.
<b>Added value</b>	Essencial project is still at the beginning of the project. Cultural and behavior changes take long time and there is no similar experience to compare

NEXT STEPS	
<b>Lessons Learned</b>	<p>The need of establishing a fluent relationship with Scientific Societies and to encourage the participation in identification of relevant low-value practices (high prevalence, important burden of disease). Also, to promote and to plan an active communication strategy.</p> <p>Before implementing Essencial recommendations a process of barriers and enablers identification should be developed. Each healthcare organization is different and tailoring interventions of implementation are needed. A multifactorial strategy is needed to reduce low-value practices, including: 1) organizational aspects, 2) information materials for patients and GPs and 3) use of ICT.</p>
<b>Key Take Aways</b>	<p>1. Identifying low-value clinical practices is so crucial as implementing recommendations to avoid them and to assess its impact.</p> <p>2. Essencial is committed to health of population and to health benefits of patients and citizens</p>
<b>Next Steps</b>	<p>Next steps of the project are:</p> <p>1) To explore the perception of patients and citizens about low-value practices</p> <p>2) To improve communication strategies addressed to patients about avoiding low-value practices.</p> <p>3) To implement Essencial recommendations in hospitals.</p>

OTHER INFORMATION
<a href="http://essencialsalut.gencat.cat/en/que_es_essencial/">http://essencialsalut.gencat.cat/en/que_es_essencial/</a>

<b>Number</b>	14
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<b>Short description of the person submitting this project</b>	
Pamela Mazzocato has a background in economics and management, specifically public management. Her core competence lies in the field of Quality Improvement and Operations Management.	

<b>DESCRIPTION</b>	
<b>Title</b>	Unpacking the key components of a programme to improve the timeliness of hip-fracture care: a mixed-methods case study
<b>Source of waste or inefficiency</b>	<ul style="list-style-type: none"> <li>• inefficiently delivered services</li> <li>• missed prevention opportunities</li> <li>• unnecessary services</li> </ul>
<b>Location</b>	Sweden
<b>Term</b>	2015
<b>Objectives</b>	Delay to surgery for patients with hip fracture is associated with higher incidence of post-operative complications, prolonged recovery and length of stay, and increased mortality. Therefore, many health care organisations launch improvement programmes to reduce the wait for surgery. The heterogeneous application of similar methods, and the multifaceted nature of the interventions, constrain the understanding of which method works, when, and how. In

	<p>complex acute care settings, another concern is how changes for one patient group influence the care for other groups. We therefore set out to analyse how multiple components of hip-fracture improvement efforts aimed to reduce the time to surgery influenced that time both for hip-fracture patients and for other acute surgical orthopaedic inpatients.</p>
<p><b>Outcomes Impact on participants</b></p>	<p>The improvement efforts led to an increase in the monthly percentage of hip-fracture patients operated within 24 h of admission from an average of 47 % to 83 %, with performance predictably ranging between 67 % and 98 % if the process continues unchanged. Meanwhile, no significant changes in lead time to surgery for other acute surgical orthopaedic inpatients were observed. Interview data indicated that multiple intervention components contributed to making the process more reliable. The triangulation of qualitative and quantitative data, however, indicated that key changes that improved performance were the creation of a process improvement team and having an experienced clinician coordinate demand and supply of surgical services daily and enhance pre-operative patient preparation.</p>

ANALYSIS	
<p><b>Development</b></p>	<p>This study is an observational mixed-methods single case study of improvement efforts at a Swedish acute care hospital, which triangulates control chart analysis of process performance data over a five year period with interview, document, and non-participant observation data.</p>

NEXT STEPS	
<b>Lessons Learned</b>	Timeliness of surgery for patients with hip fracture in a complex hospital setting can be substantially improved without displacing other patient groups, by involving staff in improvement efforts and actively managing acute surgical procedures.

OTHER INFORMATION
Mazzocato et al. Scandinavian Journal of Trauma, Resuscitation and Emergency Medicine (2015) 23:93

<b>Number</b>	15
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<b>Short description of the person submitting this project</b>	
Pamela Mazzocato has a background in economics and management, specifically public management. Her core competence lies in the field of Quality Improvement and Operations Management.	

<b>DESCRIPTION</b>	
<b>Title</b>	How does lean work in emergency care? A case study of a lean-inspired intervention.
<b>Source of waste or inefficiency</b>	<ul style="list-style-type: none"> <li>• inefficiently delivered services</li> </ul>
<b>Location</b>	Swedish pediatric Accident and Emergency department of Astrid Lindgren Children's Hospital.
<b>Term</b>	2011
<b>Objectives</b>	<p>There is growing interest in applying lean thinking in healthcare, yet, there is still limited knowledge of how and why lean* interventions succeed (or fail). To address this gap, this in-depth case study examines a lean-inspired intervention in a Swedish pediatric Accident and Emergency department.</p> <p>(* The term lean thinking is based on a production philosophy originally developed by Toyota Motor Corporation. It consists of principles and practices that focus on</p>

	<p>minimizing the total time and resources needed to produce and supply goods or services to a customer, thus increasing efficiency. Reductions in time and resource use are achieved by focusing on value-adding steps and eliminating non-value-adding steps in the production process. To summarize the literature on lean applications regarding process capability, lean is a strategy for how to plan, design, and manage operations to achieve continuous patient flow and thereby improve operational performance e.g. reduce lead and waiting times.)</p>
<p><b>Outcomes Impact on participants</b></p>	<p>Improvements in waiting and lead times (19-24%) were achieved and sustained in the two years following lean-inspired changes to employee roles, staffing and scheduling, communication and coordination, expertise, workspace layout, and problem solving. These changes resulted in improvement because they: (a) standardized work and reduced ambiguity, (b) connected people who were dependent on one another, (c) enhanced seamless, uninterrupted flow through the process, and (d) empowered staff to investigate problems and to develop countermeasures using a “scientific method”. Contextual factors that may explain why not even greater improvement was achieved included: a mismatch between job tasks, licensing constraints, and competence; a perception of being monitored, and discomfort with inter-professional collaboration.</p>

ANALYSIS	
Development	We used a mixed methods explanatory single case study design. Hospital performance data

	<p>were analyzed using analysis of variance (ANOVA) and statistical process control techniques to assess changes in performance one year before and two years after the intervention. We collected qualitative data through non-participant observations, semi-structured interviews, and internal documents to describe the process and content of the lean intervention. We then analyzed empirical findings using four theoretical lean principles (Spear and Bowen 1999) to understand how and why the intervention worked in its local context as well as to identify its strengths and weaknesses.</p>
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NEXT STEPS	
<p><b>Lessons Learned</b></p>	<p>Drawing on Spear and Bowen's theoretical propositions, this study explains how a package of leanlike changes translated into better care process management. It adds new knowledge regarding how lean principles can be beneficially applied in healthcare and identifies changes to professional roles as a potential challenge when introducing lean thinking there. This knowledge may enable health care organizations and managers in other settings to configure their own lean program and to better understand the reasons behind lean's success (or failure).</p>

OTHER INFORMATION
<p>Mazzocato et al. BMC Health Services Research 2012, 12:28  <a href="http://www.biomedcentral.com/1472-6963/12/28">http://www.biomedcentral.com/1472-6963/12/28</a></p>



<b>Number</b>	16
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<b>Short description of the person submitting this project</b>	
Pamela Mazzocato has a background in economics and management, specifically public management. Her core competence lies in the field of Quality Improvement and Operations Management.	

<b>DESCRIPTION</b>	
<b>Title</b>	Complexity complicates lean: lessons from seven emergency services
<b>Source of waste or inefficiency</b>	<ul style="list-style-type: none"> <li>• inefficiently delivered services</li> </ul>
<b>Location</b>	Swedish University Hospital
<b>Term</b>	2014
<b>Objectives</b>	<p>Explain how different emergency services adopt and adapt the same hospital-wide lean*-inspired intervention and how this is reflected in hospital process performance data.</p> <p>(* The term lean thinking is based on a production philosophy originally developed by Toyota Motor Corporation. It consists of principles and practices that focus on minimizing the total time and resources needed to produce and supply goods or services to a customer, thus increasing efficiency. Reductions</p>

	in time and resource use are achieved by focusing on value-adding steps and eliminating non-value-adding steps in the production process. To summarize the literature on lean applications regarding process capability, lean is a strategy for how to plan, design, and manage operations to achieve continuous patient flow and thereby improve operational performance e.g. reduce lead and waiting times.)
<b>Outcomes Impact on participants</b>	The complexity of the care process influenced how improvement in access to care was achieved. For less complex care processes (ENT and gynecology), large and sustained improvement was mainly the result of a better match between capacity and demand. For medicine, surgery, and pediatrics, which exhibit greater care process complexity, sustainable, or continual improvement were constrained because the changes implemented were insufficient in addressing the higher degree of complexity.

<b>ANALYSIS</b>	
<b>Development</b>	A multiple case study based on a realistic evaluation approach to identify mechanisms for how lean impacts process performance and services' capability to learn and continually improve. Four years of process performance data were collected from seven emergency services at a Swedish University Hospital: ear, nose and throat (ENT) (two), pediatrics (two), gynecology, internal medicine, and surgery. Performance patterns were linked with qualitative data collected through realist interviews.

EVALUATION	
<b>Reproducibility</b>	The variation in process performance and sustainability of results indicate that lean efforts should be carefully adapted to the complexity of the care process and to the educational commitment of healthcare organizations. Ultimately, the ability to adapt lean to a particular context of application depends on the development of routines that effectively support learning from daily practices

OTHER INFORMATION
<p>Pamela Mazzocato Johan Thor Ulrika Bäckman Mats Brommels Jan Carlsson Fredrik Jonsson Magnus Hagmar Carl Savage , (2014), "Complexity complicates lean: lessons from seven emergency services", Journal of Health Organization and Management, Vol. 28 Iss 2 pp. 266 – 288</p> <p>Permanent link to this document:  <a href="http://dx.doi.org/10.1108/JHOM-03-2013-0060">http://dx.doi.org/10.1108/JHOM-03-2013-0060</a></p>

<b>Number</b>	17
<b>CONTACT DETAILS</b>	
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<b>Position</b>	School of Nursing and Midwifery, Plymouth University
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<b>Short description of the person submitting this project</b>	
<p>Professor Janet Richardson BSc., PhD., PGCE., RN., DN., CPsychol is a nurse with clinical experience in cancer and supportive care. Following a psychology degree she began to research patients' views of healthcare, and health service effectiveness. Much of this work focused on engaging staff and users in the development, commissioning and evaluation of services using participatory approaches. She teaches research methods, evidence-based practice, and health and sustainability. Her current research engages healthcare providers in finding solutions to the challenges that climate change and resource depletion could impact on health and healthcare delivery. She leads the Sustainability, Society and Health Research Cluster at Plymouth University, her work on embedding sustainability in the healthcare curricula won a Green Gown Award in the 2014 courses and learning category.</p>	

<b>DESCRIPTION</b>	
<b>Title</b>	Embedding sustainability in healthcare education and practice
<b>Actors</b>	<b>Health Professionals</b> Nurses and midwives, dentists (and others) <b>University</b> Plymouth University, UK

<b>Location</b>	Devon and Cornwall, UK
<b>Term</b>	Start date: 2013 Ongoing
<b>Objectives</b>	Embedding sustainability into the curriculum ( <a href="http://www6.plymouth.ac.uk/pages/view.asp?page=32809">http://www6.plymouth.ac.uk/pages/view.asp?page=32809</a> ) and raising sustainability consciousness within the student population is crucial as the challenges we face impact on all aspects of health promotion/healthcare delivery. Our European funded NurSusTOOLKIT ( <a href="http://nursus.eu/">http://nursus.eu/</a> ) project will contribute to the availability of a sound learning offer in Sustainability Literacy and Competency in nurse education by developing innovative teaching and learning approaches and materials.
<b>Outcomes Impact on participants</b>	We have developed an evidence-based ( <a href="http://www.eauc.org.uk/shop/mms_single_event.php?event_id=4154">http://www.eauc.org.uk/shop/mms_single_event.php?event_id=4154</a> ) Health Environment and Resources Toolkit HEaRT ( <a href="http://heart-tools.com/">http://heart-tools.com/</a> ) designed to raise awareness (and support decision-making) about the possible threats to supply of key items used in healthcare due to scarce natural resources, geopolitical issues and the impact of climate change.

<b>ANALYSIS</b>	
<b>Development</b>	Development of evidence-based education on sustainability and waste management for healthcare professionals and students and waste audit approach Sustainability, Society and health: <a href="http://www6.plymouth.ac.uk/pages/view.asp?page=32806">http://www6.plymouth.ac.uk/pages/view.asp?page=32806</a> Evaluated a range of practices to assess for

	<p>sustainable practice.</p> <p>Delivered sustainability education sessions (and evaluated these) to over 700 students. Won National Green Gown Award on 2014.</p> <p>Designed and developed online training tool <a href="http://www.heart-etools.com">www.heart-etools.com</a></p> <p>Developed EU sustainability education project <a href="http://www.nursus.eu">www.nursus.eu</a></p>
<b>Obstacles</b>	Lack of understanding of sustainability issues and assumptions that this is not relevant for healthcare
<b>Means used to overcome or remove the obstacles</b>	By using an evidence based approach and by evaluating the process and effects on practice and education.
<b>Factors enabling the process</b>	Evaluation and evidence.

EVALUATION	
<b>Reproducibility</b>	<p>Is it possible to reproduce and implement the <b>good practice</b> in other situations and places?</p> <p>Yes, by using our training tool <a href="http://www.heart-etools.com">www.heart-etools.com</a> and audit approach.</p>
<b>Innovativeness</b>	<p>Did the <b>good practice</b> produce any innovative solution? Yes and this resulted in us winning a national award.</p>

NEXT STEPS	
<b>Key Take Aways</b>	<p>1. Use evidence to develop the intervention</p> <p>2. Evaluate the process and outcome to demonstrate success</p>

## OTHER INFORMATION

Richardson J., Grose J., Manzi S., Mills I., Moles D. Mukonoweshuro R. Nasser M., Nichols A. (2016) What's in a bin: A case study of dental clinical waste composition and potential greenhouse emission savings. *British Dental Journal* 220:61-66 <http://www.nature.com/bdj/journal/v220/n2/full/sj.bdj.2016.55.html>

Richardson J, Heidenreich T, Álvarez-Nieto C, Fasseur F, Grose J, Huss N, Huynen M, López-Medina I, Schweizer A. (online pre-publication 2015) Including sustainability issues in nurse education: a comparative study of first year student nurses' attitudes in four European countries. *Nurse Education Today* [http://www.nurseeducationtoday.com/article/S0260-6917\(15\)00462-1/pdf](http://www.nurseeducationtoday.com/article/S0260-6917(15)00462-1/pdf)

Grose J and Richardson J. (2015) Can a sustainability and health scenario provide a realistic challenge to student nurses and lead to a commitment to making changes in practice? *Nursing and Health Sciences* doi: 10.1111/nhs.12241

Richardson J., Grose G., O'Connor A., Bradbury M., Kelsey J., Doman M. (2015) Nursing students' attitudes towards sustainability and health care. *Nursing Standard* 29(42):36-41

Grose J., Doman M., Kelsey J., Richardson J., Woods M. (2015) Integrating sustainability education into nursing using an interdisciplinary approach. *Local Economy* DOI: 10.1177/0269094215578224

<b>Number</b>	18
<b>CONTACT DETAILS</b>	
<b>Name and Surname</b>	Jamie Hogg
<b>Position</b>	NHS Grampian (CHAIN member)
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<b>Short description of the person submitting this project</b>	
Clinical Lead and Innovation Champion for Modernisation, NHS Grampian. Developed the concept and takes a lead role in all clinical aspects of the innovation.	

<b>DESCRIPTION</b>	
<b>Title</b>	No Delays, transforming delivery of health services and reducing reliance on traditional clinical interactions
<b>Source of waste or inefficiency</b>	<ul style="list-style-type: none"> <li>• missed prevention opportunities</li> <li>• excessive administrative costs</li> <li>• inefficiently delivered services</li> <li>• medicines use</li> <li>• unnecessary services</li> </ul>
<b>Actors</b>	<b>Healthcare Organisation(s)</b> NHS Grampian <b>Institution</b> Scottish Government Health Department <b>Health Professionals</b> Consultants, GPs, AHPs, Specialist Nurses,



	Practice Nurses <b>University</b> University of Glasgow, University of Highlands & Islands, University of Newcastle
<b>Location</b>	The Scottish Health Board areas of Grampian, Tayside, Lanarkshire and Ayrshire and Arran
<b>Term</b>	Start date: November 2013 Ongoing
<b>Objectives</b>	<p>The objective was to review and redesign care pathways to release clinical time by offering alternatives to traditional clinical appointments. The No Delays project team worked directly with clinicians and patients to understand key contact points in the patient pathway and the information exchanged during these interactions. The outcome was confirmation that patients retain minimal amounts of the complex information they receive from clinicians in traditional appointments and forget important points about their condition or treatment. The team went on to design a methodology that allow the clinical team to review their pathway and identify opportunities to develop digital resources to either reinforce the information given to the patient or prepare the patient for making a decision about care or treatment. The first pathway subjected to this process was Chronic Obstructive Pulmonary disease. The whole clinical team from consultant to physiotherapist came together to review how this group of patients was managed and develop digital information including short video-clips to support patients with self-management, appropriate use of medication, access to rehab and adoption of a healthy lifestyle. Digital postcards are ‘prescribed’ directly to individual patients via a secure email link. The success of this</p>

	project has resulted in the process being replicated in 10 other clinical specialities.
<b>Outcomes Impact on participants</b>	<p>Measures are agreed at the start of each pathway review.</p> <p>The digital platform allows the clinical team to check if the patient has accessed the personalised material prescribed to them. This allows the clinician to judge how best to support that patient at their next interaction.</p> <p>Examples:</p> <p>COPD – increased uptake and completion of pulmonary rehabilitation classes (recorded attendance).</p> <p>Diabetes – increased update and completion of type 2 education programme (recorded attendance)</p> <p>Pediatric Constipation - reduction in emergency admissions for management of constipation and return appointments for repeat the treatments (recorded attendance)</p> <p>Dermatology – reduction return appointments for management of eczema (new to return ratio)</p> <p>Coeliac - reduction in new to return ratio</p> <p>Patient reported benefits: better understanding of medicines and how to use them properly, better understanding of roles healthcare team. Use of patient stories is highly valued.</p> <p>Impact on staff of implementing No Delays was evaluated by University of Newcastle</p>
<b>Resources</b>	<p>The success of this project has been dependent on the drive of individuals and clinical teams to innovate to improve service delivery and outcomes for patients. In practical terms, the inherent resources are as follows:</p> <p>Human Resources: Project team experienced in</p>

	<p>improvement methodology and working with clinical teams. Team comprises clinical lead, project manager and admin support of: £10,000 per pathway</p> <p>Film production team comprising experienced cameraman, editor, content director and associated kit: £6,000 per pathway</p> <p>Platform team - help desk, web developer: £3,000 per pathway</p> <p>Facilities: Digital platform to host resources and create vehicle for secure communication with patient - £100k</p>
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ANALYSIS	
Development	<p>The project team has developed a methodology to support clinical teams through the process of discovery, redesign, creation of digital resource, implementation and benefits realisation. The team arranges a series of meetings involving clinical stakeholders and patients. First step is to define the clinical opportunity, i.e. the constraint that is limiting the capacity of the clinical team to maximise reach and access for patients. It is important that all stakeholders in the pathway are involved in this discussion. The stakeholders develop a clear understanding of how the pathway works and how it can be improved. Critically, they also conclude whether a digital approach is part of the solution. If this is the case the clinical team is then guided through a process to develop the digital resource including scripting and filming. A key part of this step is working out how the new way of working and use of the digital resource will be introduced. This focuses</p>

	<p>the team on changing practice and how best to deploy the digital resource rather than the novelty of creating it. If other solutions are more likely to be successful then the project team will also facilitate this work or make the links to other sources of help.</p>
<p><b>Obstacles</b></p>	<p>The project team has taken a collaborative approach to this work and once the prototype was developed and demonstrated clinical teams signaled their interest. Clinical teams have managed to carve out time to work within the project through careful planning. There has been minimal promotion of No Delays but word of mouth has resulted in the generation of a considerable pipeline of activity from all over Scotland, the UK and beyond. The main obstacle has been access to a sustainable funding source. The Scottish Government Health Department provided a small amount of starter funding and has also supported the dermatology pathway. Beyond that, clinical teams have managed to come up with funds to film their content. NHS Grampian has now secured funds to host and develop the digital platform and is now working on a business plan to ensure a sustainable future for the work of the No Delays team.</p>
<p><b>Means used to overcome or remove the obstacles</b></p>	<p>NHS Grampian is committed to transforming the delivery of health services through innovative means. By actively pursuing innovation forums and communicating with external partners, it has managed to secure sufficient funding the sustain this way of working. The approach has been to</p>

	grow the work from small beginnings and test and refine along the way. The innovative culture permeates throughout the organisation which has made it easy to engage colleagues in new ways of working.
<b>Factors enabling the process</b>	Necessity is the mother of invention and the health service in Scotland faces massive pressures in terms of changing demographics and limited financial resources. This has created a culture of innovation and willingness to change. This has been key to the success of the project.

<b>EVALUATION</b>	
<b>Reproducibility</b>	No Delays is now a tried and tested methodology and can be used with any clinical team seeking to transform service delivery.
<b>Innovativeness</b>	Every clinical team that becomes aware of No Delays and what it can do immediately sees opportunities for its own service. Clinical teams who don't usually work together have been able to share video resources to support their own patients. The video resource is now also being used by junior staff members as an educational resource to improve their knowledge of clinical services.
<b>Added value</b>	Clinical teams developed a better understanding of what each member contributes to the patient journey and therefore were able to adapt their ways of working to improve the overall pathway. Working towards developing video based advice meant team members were jointly

	reviewing the information and messages given to patients leading to a more consistent approach.
<b>Appropriateness</b>	Clinical teams have released capacity to see both new patients and urgent return patients more quickly.

<b>NEXT STEPS</b>	
<b>Lessons Learned</b>	It is important to give clinical teams the time and space to reflect on practice as a group.
<b>Key Take Aways</b>	<ol style="list-style-type: none"> <li>1. Whole team engagement is the only way to achieve transformational change</li> <li>2. Patients must be at the centre of everything we do</li> </ol>
<b>Next Steps</b>	There are plans to roll out the process with key clinical teams to transform service delivery.

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<b>Country</b>	UK
<b>Email</b>	<a href="mailto:Katy.morris@sssft.nhs.uk">Katy.morris@sssft.nhs.uk</a>
Short description of the person submitting this project	
<p>Dr Katy Morris is the Head of Quality Improvement for South Staffordshire and Shropshire NHS Foundation Trust (SSSFT), managing the implementation of the Virginia Mason Production System methodology for the organization, which aims to optimize quality, efficiency and safety for processes throughout the trust. SSSFT provides mental health, learning disability and specialist children's services across South Staffordshire and mental health and learning disability services in Shropshire, Telford &amp; Wrekin and Powys. SSSFT also provide some services on a wider regional, or national basis.</p>	

DESCRIPTION	
<b>Title</b>	Use of Rapid Process Improvement Workshops in a Mental Health and Learning Disability Trust
<b>Source of waste or inefficiency</b>	<ul style="list-style-type: none"> <li>• excessive administrative costs</li> <li>• inefficiently delivered services</li> </ul>
<b>Actors</b>	<b>Healthcare Organisation</b> South Staffordshire and Shropshire NHS Foundation Trust

<b>Location</b>	Staffordshire, UK
<b>Term</b>	Start date: 2013 Ongoing
<b>Objectives</b>	<p>Rapid Process Improvement Workshops (RPIW) are events which take place as part of the quality improvement programme across the organisation. These take a particular process which staff and service users want to improve and place them under scrutiny to enable sustainable changes to be made, impacting on experience, efficiency, quality and safety. The objective of an RPIW is to eliminate waste – time, resources and money, so allowing staff to spend more time providing valued added activities to service users and carers. RPIWs have been held in inpatient wards, community teams and support functions. Each event has its own objectives, set by consensus by the very people who know the processes the best, i.e. the staff who deliver them. This provides a sense of ownership and empowerment to the staff and leads to more sustainable change. Objectives include: reducing waiting times for service users, eliminating wasteful practices, improving service user experience of care, increasing staff engagement and improving team working, reducing quality defects, saving resources and time, and improving the efficiency of services. Inevitably, there are further objectives, such as sharing the achievements of one team across the organisation, and increasing the application of the learned tools and techniques within the team</p>



	to other processes once the event has finished.
<b>Outcomes Impact on participants</b>	Benefits include time of clinical staff saved engaged in wasteful activities which add no value to service user experience, such as unnecessary processing of forms, repeated searches for information, duplicated data work and setting up clinical spaces. The time service users have to wait has been reduced, for appointments, for outcomes and for information. All outcomes are measured against a baseline and repeatedly measured over 12 months to ensure sustainability of outcomes. All outcomes are based on direct observations of the processes as they occur. Benefits also include improved experience and satisfaction of all participants, measured before and after events.
<b>Resources</b>	Resources include two or three facilitators of the events, engaged in measuring the baseline, facilitating the weeklong event, and supporting teams in implementation, over a period of twelve weeks per event. Each event involves a team of clinical and non-clinical staff taking part, accompanied by a service user or customer. The events take place close to the team's base, so changes and improvements can be tested during the week, so changes can be implemented as soon as possible. Information is gathered from direct observations and supported by data collected by the organisation's systems. All this information is supported by service user feedback and experience information.

ANALYSIS	
<b>Development</b>	<p>During the week-long event, the team are presented with the ‘current state’ information collected by the facilitators, which shows in detail, what the current process consists of, the service users’ experience, how long it takes, what wasteful activities are inherent within these processes. The team are then taught a series of tools and techniques from the lean methodology which they consider in turn on their application to the process under scrutiny. This results in a large number of ideas for change, which are then systematically considered during the week in how they may eliminate the waste from the process. Ultimately by the end of the week, a new future state is designed which has achieved the objectives set prior to the event, eliminated all the waste and suggests itself to be the best way of performing this process. This is tested and goes live as soon as possible, being reviewed, re-measured and revised across 3 months, supported by all levels of the organisation.</p>
<b>Obstacles</b>	<p>Some changes required by the team are not within their immediate gift, and require support from other teams, such as support functions across the organisation. Post event, the team may encounter barriers to progress, the presence of a ‘sponsor’ supports this.</p>
<b>Means used to overcome or</b>	<p>The presence of an ‘advisory group’ provides the additional expertise and work often</p>

<b>remove the obstacles</b>	required. All teams across the organisation are aware of the event in progress and are 'on standby' to support the immediate implementation of the new processes. The 'sponsor' is cognisant of the barriers being encountered and, being of at least service manager or director level, can assist in removing these barriers to change. The sponsor is also aware of the potential impact of the changes on other teams, and can prepare other teams accordingly.
<b>Factors enabling the process</b>	Having a 'process owner' who knows the process intimately supports the team to make the changes. Also, the ideas for changes come from the staff and service users themselves, they are not imposed by 'experts'. The knowledge gained by the participants during the event carries on to other processes long after the event has finished.

<b>EVALUATION</b>	
<b>Reproducibility</b>	Yes, a new process is tested with one team and a standard way of delivering this process is produced and tested up to 90 days post event. It can then be shared with other teams when sustainability has been measured.
<b>Innovativeness</b>	Yes, the changes to processes are developed by the very people who know the processes the best, the staff and service users. They are asked to develop 'the perfect patient experience' and often the ideas produced would not have been forthcoming had they not had the time,

	information and opportunity to consider how services are currently being delivered.
<b>Added value</b>	All steps in the future process add value to the service user. If they do not add value, they do not go forward. This is the essence of the event. Outcomes of the events can be large scale, for example, weeks saved off a process. Or they can be smaller in quantity, but add a huge amount to the service user's experience of the process.
<b>Appropriateness</b>	Each event presents a range of metrics which have been improved upon, for example, resources saved, clinical saved time, removal of the need to travel, removal of waiting for appointments. All time saved is directly used by the team in the improvement of delivery of services.

<b>NEXT STEPS</b>	
<b>Lessons Learned</b>	To consider one small aspect of a process, which impacts on the service users' experience of your services, such as the first hour of arrival on a ward, or the experience of waiting for an appointment. Drill down into that process to ensure that it is as value added to your service user as it can be. Eliminate every aspect which does not add value to your service users.
<b>Key Take Aways</b>	1. This methodology can be applied to every facet of the organization. By concentrating on one process at a time. It may feel like a considerable effort for a small process, but we

	<p>cannot underestimate the impact that individual processes in our organizations have on our service users.</p> <p>2. The methodology works if everyone respects the knowledge and experience of the staff and service users who work with these processes every day. They have the solutions to improving the quality of their services, and need to be supported to effect those changes.</p>
<b>Next Steps</b>	<p>To continue to work towards perfection, with more teams, and more deeply with teams who are already engaged. To train more staff to use the lean tools with their own teams.</p>

### OTHER INFORMATION

There have been over thirty of these events across the organisation, some of the quantitative outcomes include:

- 84% reduction in clinical staff unnecessarily walking around wards due to changes to room set up
- 88% time saving for staff setting up clinic rooms for exams
- 19 hours per week of clinician time saved by inputting information into systems
- 94% reduction in nurses walking around the wards completing paperwork
- 30 minutes saved for every appointment undertaken, meaning increased capacity to see more people
- Reduced wait for managers from 12 days to 4 days in part of the recruitment process
- Time to appoint an investigating officer reduced to 2 days from 10 days
- 64% reduction in time service users were waiting for an appointment

- 89% improvement in the time service users were waiting for an assessment
- 14 days waiting saved by streamlining administrative processes.

<b>Number</b>	20
<b>CONTACT DETAILS</b>	
<b>Name and Surname</b>	Dr Virginia Minogue
<b>Position</b>	Research lead/ Research, evidence and knowledge lead for the NHS Future Focused Finance programme
<b>Organization</b>	NHS England
<b>Country</b>	UK
<b>Email</b>	Virginia.minogue1@nhs.net
<b>Short description of the person submitting this project</b>	
<p>Virginia Minogue is the Research, evidence and knowledge lead for the NHS Future Focused Finance programme. This programme is a five year vision for NHS finance professionals, clinicians and patients. One work stream, Close Partnering, specifically focuses on increasing effective working between clinicians and finance staff. The work stream has undertaken a scoping project on reducing waste entitled 'Re-thinking Berwick'. Dr Minogue presented this work at the EBH Conference in Sicily in October 2015. This outlined the difficulty of replicating the methodology in the NHS and how many different initiatives were seeking to address this area but were not joined up. She also led a theme group looking at patient engagement in reducing waste.</p> <p>Close Partnering has also undertaken discussions with patients looking at NHS finances.</p> <p>The recent Carter review has identified examples of waste reduction, see: <a href="https://www.gov.uk/government/publications/productivity-in-nhs-hospitals">https://www.gov.uk/government/publications/productivity-in-nhs-hospitals</a></p> <p>The Academy of Medical Royal Colleges has also undertaken work in this area: <a href="http://www.aomrc.org.uk/general-news/protecting-resources-promoting-value.html">http://www.aomrc.org.uk/general-news/protecting-resources-promoting-value.html</a></p>	

DESCRIPTION	
<b>Title</b>	Adding value - the challenges of reducing waste in the National Health Service (NHS)

OTHER INFORMATION
<a href="http://www.futurefocusedfinance.nhs.uk/">http://www.futurefocusedfinance.nhs.uk/</a> <a href="http://www.futurefocusedfinance.nhs.uk/page/close-partnering">http://www.futurefocusedfinance.nhs.uk/page/close-partnering</a> <a href="https://www.researchgate.net/publication/289220356">https://www.researchgate.net/publication/289220356</a> <u>Re-thinking Berwick Reducing Waste in Health Service Commissioning and Delivery in England</u>



<b>Number</b>	21
<b>CONTACT DETAILS</b>	
<b>Name and Surname</b>	Diana Dalglish

<b>DESCRIPTION</b>	
<b>Title</b>	Follow-up imaging of breast symptomatic patients: a waste of radiologist time?
<b>Source of waste or inefficiency</b>	<ul style="list-style-type: none"> <li>inefficiently delivered services</li> </ul>
<b>Location</b>	UK
<b>Term</b>	2013
<b>Objectives</b>	The NHSBSP does not recommend early recall following assessment of screen-detected abnormalities. Symptomatic patients in our breast clinic may be invited to return for repeat imaging. A survey of repeat imaging in our symptomatic breast clinic was undertaken to understand whether we can justify reducing the number of patients recalled and to gauge associated anxiety levels.
<b>Outcomes Impact on participants</b>	One patient did not attend. Mean interval between initial and repeat imaging: 4–16 weeks. Fifty-five episodes classified R1/R2 at initial imaging; 11 R3; four R4. Outcomes: 68 % were discharged; 11 % were invited for a third imaging appointment and all were then discharged; 13 % had a benign biopsy; 7 % returned to the surgical clinic for management of their benign symptom. Twenty-three questionnaires were completed – one patient

	was 'very anxious' about repeat imaging, seven patients were 'mildly anxious', 10 were 'relieved', six were 'not bothered'.
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ANALYSIS	
<b>Development</b>	We identified 71 consecutive patients attending an imaging appointment from 1 February 2013 who had a repeat imaging recommendation. Patients were asked to complete a questionnaire. We recorded reason for recall, imaging interval, imaging outcome, and feedback from questionnaires.

NEXT STEPS	
<b>Lessons Learned</b>	<p>Conclusion</p> <p>Repeat imaging did not yield any diagnoses of malignancy. All patients were eventually discharged with a benign outcome. We can justify reducing follow-up imaging of our symptomatic patients in line with guidelines for screening assessments. Radiologist time may be better directed towards meeting the symptomatic breast 2-week wait standard.</p>

OTHER INFORMATION
<a href="http://breast-cancer-research.biomedcentral.com/articles/10.1186/bcr3806">http://breast-cancer-research.biomedcentral.com/articles/10.1186/bcr3806</a>

<b>Number</b>	22
CONTACT DETAILS	
<b>Organization</b>	Royal College of Nursing
<b>Country</b>	UK

DESCRIPTION	
<b>Title</b>	Frontline First campaign
<b>Source of waste or inefficiency</b>	<ul style="list-style-type: none"> <li>inefficiently delivered services</li> </ul>
<b>Actors</b>	<b>University</b> Royal College of Nursing <b>Health Professionals</b> Nurses
<b>Location</b>	Uk
<b>Term</b>	2010
<b>Objectives</b>	In July 2010 the RCN launched the Frontline First campaign with the aim of monitoring the impact of efficiency savings on frontline services.
<b>Outcomes Impact on participants</b>	Over the last five years the RCN has published nine reports that have provided a snapshot of the current state of the NHS and the challenges that lie ahead. A summary of these various reports is provided in the appendix. The reports demonstrated that thousands of frontline posts had been lost, with deeper cuts set out in cost improvement plans, and proposals to cut thousands more nursing posts across Trusts in the long term. Our figures were regularly

	disputed by the Government with some going as far as accusing us of scaremongering (Boffey D, 2011). Our view is and will always be that the public needs to know what is going on in their NHS.
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ANALYSIS	
<b>Development</b>	The campaign provided nurses with the opportunity to talk about their experience of the cuts and the impact on their patients and working lives. This real time information has become a credible barometer for how the frontline is feeling and coping.

OTHER INFORMATION	
<a href="http://royalnursing.3cdn.net/9808b89b8bfd137533_krm6b9wz7.pdf">http://royalnursing.3cdn.net/9808b89b8bfd137533_krm6b9wz7.pdf</a>	

## CHAPTER 4 – Good practices from Italian Alesini Award

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On the subject of Good Practices, Cittadinanzattiva has established specific awards: for the health sector the main is the Prize Alesini, since 1997:

<http://www.cittadinanzattiva.it/progetti-e-campagne/salute/politiche-sanitarie/1949-premio-buone-pratiche-in-sanita.html>

## CHAPTER 5 - Conclusions

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### 1. Geographical impact

This collection allowed us to receive 22 Good Practices.

They come from 10 different countries: Cyprus (1); Germany (1); Kosovo (1); Ireland (1); Italy (3); Netherlands (2); Poland (2); Spain (2); Sweden (3); United Kingdom (6).

### 2. Source of waste or inefficiency

Most of the reported good practices (19/22) cited as the main source of waste and inefficiency to fight the “inefficiently delivered services”. The “missed prevention opportunities” and the “excessive administrative costs” are reported in 6 cases.

Three times has been cited the inappropriate “medicines use” and the “prices set too high” (for medicines, products, services, workers, etc).

Only three good practices reported about “unnecessary services” and no one about “fraud”.

### 3. Actors and promoters

The principal actors of the gathered good practices are the “health professional”(14/22), followed by the “health care organizations” (12/22) and “Institution” directly involved in the development of healthcare services. An important role is also played by the universities, patients’ organizations and patients.

The secret of their success often lies in the ability to collaborate among private and public sector.

### 4. Final comments

This report will be presented during the conference of the 10th European Patients’ Rights Day (4<sup>th</sup> of May 2016) through a multi-stakeholder conference titled “Reducing waste and inefficiency in the Healthcare Systems, increasing quality of patient care” at the presence of the European Health & Food Safety Commissioner.

It will be the base of the discussion and an intense and effective reflection of the all involved stakeholders.

Our hope is that our work can contribute to raise the public awareness on the topic, foster active actions at local, national and European level by disseminating successful concrete examples to face the waste and create an informal network of operators of good practices.

## **Back cover**

### **The research was conducted by the Active Citizenship Network project staff:**

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### **Acknowledgements**

Active Citizenship Network project staff wishes to thank all the civic and patient associations, professionals, good practice operators, network partners, private and public stakeholders for their support in the collection of good practices.

### **About Active Citizenship Network (ACN)**

ACN was established in December 2001 as the European and international representative of the Italian organization for civic participation Cittadinanzattiva (Active Citizenship). ACN is a flexible network of European civic organizations which are involved as partners in its projects addressed to encourage active participation of citizens in European policy-making.

ACN mirrors Cittadinanzattiva's Italian policies, such as healthcare, consumer protection, corporate social responsibility, education and training at global level. ACN's mission is to promote and support the construction of European citizenship as an "active citizenship" meaning the exercise of citizens' powers and responsibilities in policy-making. The European Charter of Patients' Rights and the promotion of the European Patients' Rights Day are its main initiatives.