

High impact changes for practice teams



NHS
*Institute for Innovation
and Improvement*



The Improvement Foundation
Improving public services

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Foreword

The first port of call for the majority of patients in the NHS is their general practitioners and nurses in primary care teams. Primary care is at the fulcrum of the NHS. This role is strengthened by the transfer of services closer to patients, and Practice Based Commissioning. It may not be the stuff of drama, but the majority of care in the NHS is carried out by primary care teams.

Maximising the effectiveness and efficiency of general practices is therefore crucial to maximising the effectiveness of the NHS as a whole. The Improvement Foundation and NHS Institute have identified nine High Impact Changes which, if fully implemented, will have a highly beneficial impact on patients, staff and services.

They have been identified by front-line people for front-line people. Many are already being implemented by practices actively engaged in re-shaping services. They reflect both the commissioning and delivery roles. Some changes you will recognise and be implementing already, others may give you new ideas to consider.

The most successful organisations take a systematic approach to all aspects of care they provide, reducing unwanted variation, investing in their most valuable asset – their staff, and building strong teams. This internal development needs to be matched by strong facilitative support from PCTs, that creates opportunities for organisations to grow and develop.

We hope that the ideas and examples we are sharing here will provide your team with an opportunity to excel, and deliver an even better care experience to your patients.



Sir John Oldham,
Head
The Improvement Foundation
(incorporating NPDT)



Professor Bernard Crump
The NHS Institute for
Innovation and Improvement

High impact changes
for **practice teams**

Change No. 1: Promote patient self care and self management



Description

There is evidence that people with long term conditions who are supported to take care of their conditions themselves are more likely to have a better quality of life. Self care support builds on a patient's own knowledge and expertise of living with their condition. In addition there is now good evidence that clinical interventions, and the way they are delivered, can either support or erode the capacity to self manage. This is because people's beliefs and expectations about their condition, and the role of healthcare, are major determinants of health related quality of life and strongly predict healthcare seeking behaviour. Many people develop anxiety as a result of misconceived beliefs leading to fear and avoidance behaviour. 95% of angina patients have distorted health-related beliefs ("angina is a mini heart attack"). 50% improvement in disability in angina patients can be achieved through challenging misconceptions.

There are a range of approaches to promoting and supporting self care. Aspects relevant for general practice include:

- (i) Providing support within the practice for self care e.g. practice based support groups, and group education sessions
- (ii) Signposting the patient to available external support for self care

e.g. Disease specific support programmes such as Breathe Easy courses supported by the British Lung Foundation.

e.g. Generic skills programmes such as the Expert Patients Programme

The NHS Expert Patients Programme (EPP) and other self management skills training provided by voluntary and community groups provide people with long term conditions with the skills to deal with common issues e.g. pain management, stress, low self-image and the need to develop everyday coping skills and confidence.

(ii) Adapting consultation content and style to promote self care

Front-line primary care professionals are well placed to modify the way that people seek help by addressing their beliefs about their health and condition. A motivational style of consultation that identifies beliefs and expectations, and then promotes contemplation of a planned lifestyle change, is most effective in this situation. There is evidence that clinicians predominantly trained in caring for acute diseases will choose the goals, give advice, and tell the patient what to do. To encourage self management, clinicians need to shift to a style in which their communication builds trust, listens to a patient's ideas and invites the patient to make choices about their care.

Impact on patients

- ▲ Better health and well being
- ▲ Better mental health and less depression
- ▲ Reduced perceived severity of symptoms, including pain
- ▲ Greater confidence and sense of control
- ▲ Avoid unnecessary hospital admissions
- ▲ Better planned and co-ordinated care
- ▲ Remain in their own home

Impact on primary care

- ▲ Improved medicines compliance
- ▲ Prevents the need for emergency health and social services
- ▲ Reduced drug expenditure
- ▲ Reduced primary care patient consultations (by up to 40%) and repeat visits
- ▲ Improved patient satisfaction with quality of their healthcare self care can be highly cost effective

Impact on staff

- ▲ Enhanced understanding, skills and confidence in interacting with patients with long term conditions
- ▲ Improved professional/patient relationship
- ▲ Skills development and improved skills mix
- ▲ Increased job satisfaction

How to get going

- ▲ Review, with your patients, what information you already provide for patients and carers, and how it is delivered – is it good enough?
- ▲ Ensure the practice maintains a list of local community contacts and support networks, and is easily available for all practice staff.
- ▲ Identify, and evaluate with your patients, disease/condition-specific education and self management courses (e.g. DAFNE and DESMOND for diabetic patients).
- ▲ Ensure that the options for the EPP are accessible to your patients (GPs are not required to formally refer patients to the EPP but the programme would be more successful if GPs could act as advocates for the programme. Putting notices up in the surgery may not be enough to encourage patient involvement).
- ▲ Provide patients with copies of letters written about them by clinicians. Benefits include better informed patients, better compliance and opportunities to reinforce advice on self care and lifestyles.
- ▲ Ensure that patients contribute as much as possible to their own needs, assessment and care planning.
- ▲ Consider taking up development opportunities to improve specific consultation skills to facilitate meaningful lifestyle change and promote more effective self care support.
- ▲ Training for key staff on implementation of self management plans

Change No. 1 Case studies

- ▲ Derbyshire Dales & South Derbyshire PCT
- ▲ King Edward Road Surgery, Northampton
- ▲ The Milton Abbas Surgery in Dorset



Case study 1

Group patient education sessions for diabetic patients

Derbyshire Dales & South Derbyshire PCT undertook a needs assessment in all the practices within the PCT and found that there was no standardised education for people newly diagnosed with type 2 diabetes. The practice nurse was identified as the main deliverer of education, and varying amounts of time were being spent on this task, from 0.5-3.5hrs per patient. In addition there was no standardised written information given to patients.

Clinicians worked with service users to design a programme which would meet NICE guidance for patient-education (2003). The course, entitled "Diabetes & You" consists of three 2-hour group education sessions delivered over a 6-week period, covering all aspects of diabetes care including what is diabetes, treatment, management, food and diabetes, activity, foot care, what care to expect and the annual review.

Clinicians worked with service users to design a programme which would meet NICE guidance for patient-education (2003).

The courses are held in different accessible locations across the PCT, in a variety of venues including a leisure centre and a community centre, and are delivered by primary care professionals experienced in diabetes, namely practice nurses with expertise in diabetes, a community dietician and a podiatrist. As the courses were held at a leisure centre, staff there were able to input on physical activity.

People attending are involved in the self management of their diabetes by having well managed blood glucose control; being able to manage their weight and diet, and undertaking appropriate physical activity; and having improved psychological well-being and quality of life.

Initial evaluations have been very promising with 93% of people finding the sessions helpful and useful, 96% reporting they understood the sessions and 89% feeling they had ample opportunity to participate. This programme offers people with diabetes an opportunity to improve their knowledge and skills to manage a condition they live with on a daily basis, and enhance their quality of life.

Case study 2

King Edward Road Surgery, Northampton has been participating in the Healthy Communities Collaborative approach to both preventing falls and widening access to a healthier diet. Working with the volunteers in the Healthy Communities Collaborative, they started by holding large events in their surgery promoting falls prevention, writing directly to the patients over 70. The Healthy Communities community members did all the organising and brought in staff from the PCT and the voluntary sector. The success was such that other practices in the town wanted to host similar events.

When the Healthy Communities teams went on to work with widening access to a healthier diet, the practice was again willing and eager to work in partnership with the community members. Using practice data, they wrote to people on their list classed as obese, inviting them to a series of advice and cooking sessions, facilitated by healthy communities volunteers and designed to educate these patients and support them to manage their weight loss. A PCT dietician and one of the practice GPs undertook to be in attendance at all the group sessions. It transpired that of the 20 patients attending, 17 were newly diagnosed Type II diabetics, so the emphasis of the cooking and education sessions became one of directly managing their condition through diet. The partnership works by the GPs and the dietician providing the clinical input, and validating the information, and skills being given by the community members.

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Case study 3

The Milton Abbas Surgery in Dorset offers a range of approaches to the management of patients with chronic diseases from supporting self management by their patients through to disease specific clinics:

- ▲ Patients are able to check their own blood pressure without seeing any clinicians by using the static automatic BP machine installed in the waiting room, which provides a printout that can be entered onto their clinical record
- ▲ The surgery has developed a nurse run "Healthy Pulses Clinic" which provides holistic care to patients with hypertension, CHD or diabetes, whose condition is stable and does not require additional support from GPs
- ▲ Where investigations are returned as 'abnormal' the patient will then be seen by the GP and return to the disease specific monitoring clinic





High impact changes
for **practice teams**

Change No. 2: Improve the management of patients with long term conditions

Description

Long term conditions (or chronic diseases) have a major impact on the lives of patients and on those who care for them. These conditions are common, particularly in the elderly and include ischaemic heart disease, hypertension, asthma, diabetes, chronic obstructive pulmonary disease, arthritis, depression and dementia.

Long term conditions have a major impact on patients, their carers and families. The care of people with these conditions already consumes a large amount of health and social care resources and the incidence is expected to double in the next 25 years as the population ages.

Today, 80% of GP consultations and 60% of hospital bed-days relate to long-term conditions.

Health care systems have traditionally been designed around the care of acute problems, with insufficient emphasis on long term conditions. Poor identification of these conditions means that many patients with LTCs are undiagnosed and so unaware there is anything wrong. The care of those who are diagnosed has been patchy and often uncoordinated, with insufficient involvement of the patient.

Changing the emphasis to structured, proactive care of patients with long term conditions will improve the quality of life of patients and lead to a reduction in hospital admissions and GP appointments. By educating and involving patients more in their own care we can greatly improve their quality of life.

Good chronic disease management is an area with large potential to free up resources under practice based commissioning.

Impact on patients

- ▲ Better informed and more involved in their care
- ▲ Increased confidence to manage their own condition
- ▲ Reduced hospital admission and outpatient attendance
- ▲ Reduced disease complications and exacerbations
- ▲ Improved quality of life and life expectancy

Impact on primary care

- ▲ Accurate disease registers allow identification of patients and risk stratification
- ▲ Reduced drug waste
- ▲ Recall systems allow consistent follow up
- ▲ Better communication with, and involvement of, social services

Impact on staff

- ▲ Greater involvement of the primary health care team with increased skill mix
- ▲ Reduced demand for GP appointments by increased involvement of nurses and health care assistants and better informed patients
- ▲ Reduced home visits by GPs

How to get going

Validate your disease registers

Keep accurate records of your patients with long term conditions using your clinical systems. Validate existing registers by checking that coding of conditions is accurate. Have systems in place to maintain accuracy by coding diseases, hospital admissions, referrals and results of investigations. This will enable:

- ▲ Identification of patients with LTCs
- ▲ Identification of vulnerable LTC patients with complex needs
- ▲ Risk stratification to identify patient need and target care appropriately
- ▲ Systematic monitoring of appropriate interventions (for example, checking that patients with heart failure have had an echocardiogram)

Develop proactive call and recall systems

Use your clinical system to identify patients who need to be seen and reviewed. Ensure patients are invited for regular review and that those that do not reply are followed up. Phone patients who fail to respond and look at different ways of contacting patients, for example by email or text.

Utilise templates for management

Use templates (which are readily available on commonly used clinical systems) when seeing patients. Templates pull together relevant information, such as investigation of results and help ensure that patients' care is consistent and appropriate. Using templates will help to build accurate disease registers.

Identify and give bespoke care to those with complex needs

Patients with complex needs, such as those with multiple long term conditions, can be identified using computer searches. Care can be tailored for individual patients using multidisciplinary teams, for example using specialist nurses and physiotherapists. Close liaison with social services is vital as many of these patients have complex social problems.

Encourage self care and patient education, for example using self management plans. Consider referring patients to an Expert Patients programme

Keep hospital admissions to a minimum – for example using intermediate care teams and admission avoidance programmes.

The following are also recommended:

- ▲ Explore ways to expand the skill mix of staff involved with caring for patients.
- ▲ Develop well trained multi-disciplinary teams
- ▲ Develop closer links with social services and local specialists
- ▲ Provide as much care as possible in the community

Change No. 2 Case study

▲ Drs Sharma and Sharma Practice,
North East Lincolnshire PCT



Drs Sharma and Sharma Practice, North East Lincolnshire PCT

This practice took part in NPDT's Primary Care Collaborative for long term conditions which offered PCTs and individual practices the opportunity to develop systematic approaches to the care of COPD and Diabetes patients. The practice appointed a Nurse Practitioner and have achieved significant improvements in systematising their Long Term Conditions care.

The practice also reviews all patients with emergency admissions to hospital using the discharge information received. Those patients who fit the criteria are visited / seen by the Nurse Practitioner. The other patients are called for a review with the doctor. As a result they have cut the hospital admittance rate for COPD by nearly 87%.

Data is received on a weekly basis from the PCT regarding all patients who are admitted and are due for discharge. On a monthly basis data is received from the PBC data clerks at the PCT. This data is validated and all patients with 2 or more admittances through A&E have their information passed onto the Nurse Practitioner and the Doctors. The patients then go through a case management process.

Acute visits

When a patient contacts the surgery for a home visit, the Nurse Practitioner discusses with the GPs and between them they decide who will cover the visit. The patient is then assessed to determine the problem. In addition the Nurse Practitioner (NP) has access to GP respite beds and Emergency Social Service Assessment. The NP will discuss with the GP and recommend admission to hospital if appropriate. Basically this is a form of 'See and Treat'.

General visits

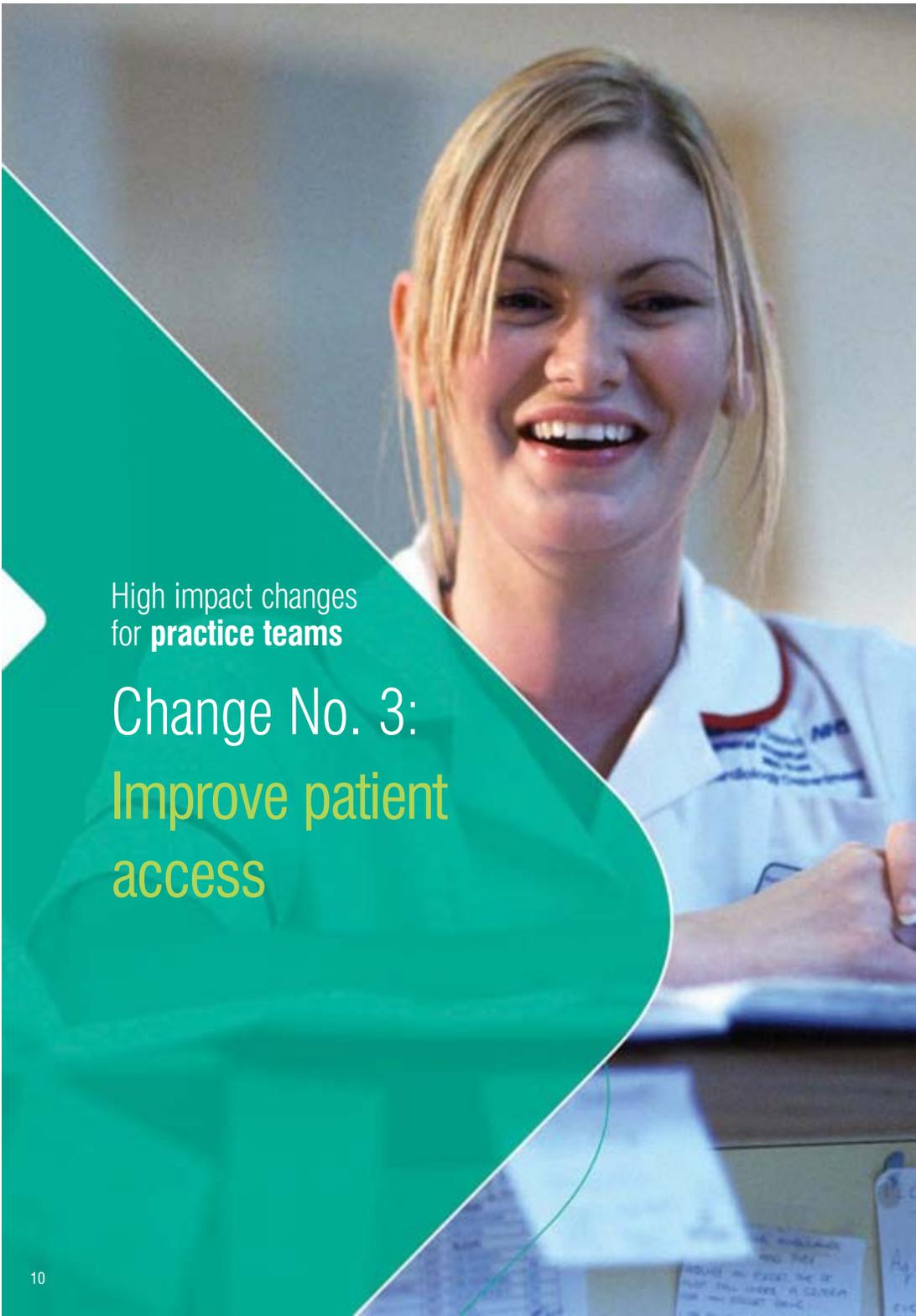
The NP sees all the over 75 housebound patients for their reviews and all the patients on the chronic disease register who are unable to attend surgery.

The practice work alongside the community nursing team and over the last winter period the NP took a backlog of the work from the District Nurses and covered the practice patients herself e.g. for flu jabs etc..

The practice is now achieving 100% of the quality and outcomes framework points on COPD, Asthma, CHD and Diabetes, 30.8 of 31 points for Stroke/TIA, is 37.5% below the admissions target (i.e. a reduction of 37.5% on last year) for Cardiology and all elderly patients have received flu and pneumo vacs.

A photograph showing two men in a professional setting. One man, seen from the side, has a beard and is wearing a dark suit. The other man, facing him, is wearing a blue striped shirt and a lanyard, and is holding a document. They appear to be in a meeting or discussion.

We have become
a smooth running,
multidisciplinary team
which has put us in
a good position for
improving patient care,
achieving QOF targets
and moving forward
with Practice Based
Commissioning.



High impact changes
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Change No. 3: Improve patient access

Description

Good quality health care means that patients get the care they need, at the time they need it, from people who can meet their needs. Waiting too long to access care is a common cause of complaints from patients, and a frequent cause of stress for practices. The key to ensuring good access for patients is to match demand (the number of patients requiring care) with capacity (the number of staff available to give care) on a daily basis.

Many practices have introduced new working systems with the aim of giving patients quicker access to care. However, some of the changes have had the unintended consequence of making patients feel they have less access to care. For instance, some practices have introduced same day only appointment systems and ask all patients to call after 8.30am. Once the 'quota' of appointments is full, no further appointments can be made that day. Patients then have to try again the next day. This is not Advanced Access. Such a system will not have improved access for patients, but in fact have worsened patients' access to timely and convenient healthcare.

Advanced Access is a model for improving patient access to general practice, based on ensuring a balance everyday between patient demand for services and the capacity of the practice to deliver them. Advanced Access has been successfully adopted by many thousands of practices that have participated in the National Primary Care Development Team's National Primary Care Collaborative.

Advanced Access is a step by step process that helps busy practices to:

- ▲ Understand the size and the nature of the needs of patients
- ▲ Successfully predict demand for care
- ▲ Develop services to effectively meet patient needs
- ▲ Feel more in control of the workload within the practice

It is a method of improving access for patients so they can see a GP or other clinical professional at a time and date convenient to them. However, it is also about enabling clinicians and managers to gain a better understanding of their demand, and in that process gain greater control of how they manage and deliver care.

Advanced Access gives patients care when they want it. Practices operating Advanced Access offer both same day appointments and pre-booked appointments for future dates. Advanced Access means significant improvements for patients without additional staff or resources. It is about making better use of existing staff resources by managing and scheduling them better.

Impact on patients

- ▲ Advanced Access allows patients to be seen when they want to be seen, whether it is today or at a specific date in the future
- ▲ More personalised service
- ▲ Less anxiety for patients who perceive they need urgent care
- ▲ Equity in waiting times for all patients with similar levels of need (everyone gets seen quickly)

Impact on primary care

- ▲ Telephone management of same day appointment requests can reduce face to face consultations by up to 50%, with no reduction, or an increase, in patient satisfaction
- ▲ Email and websites can be used successfully for repeat prescribing requests, health queries, self help materials and programmes
- ▲ Over 70% improvement in waiting times to see a GP
- ▲ Over 60% improvement in waiting times to see a practice nurse
- ▲ Average patient waits to see a GP down from 5 days to less than 1.5 days
- ▲ Average patient waits to see a practice nurse down from 5 days to 1 day
- ▲ Less time spent 'fire fighting' and managing patient backlogs
- ▲ It releases more time to spend on service quality and preventative activities

Impact on staff

- ▲ Clinical and administrative staff aligned to provide the best care for patients
- ▲ Increased time spent on positive interactions with patients
- ▲ Staff able to plan and control their work which leads to reduced stress and increased good will
- ▲ Fewer 'hassle factors' due to better planning of schedules
- ▲ Managing activity leads to lower stress in the working environment
- ▲ Reduced duplication and less staff time spent on 'non value adding' activities
- ▲ More timely decision making
- ▲ Reduced time spent on patient complaints
- ▲ Reduction in the clinical, managerial and administrative time dedicated to managing patient backlogs and waiting times
- ▲ Less complexity in the system gives staff an opportunity to achieve consistent standards of care

How to get going

The steps of the Advanced Access Model are:

- ▲ Understand demand (understand how many people wish to be seen)
- ▲ Shape the handling of demand (consider alternatives to face-to-face consultations, e.g. telephone, e-mail etc)
- ▲ Match capacity to meet shaped demand (match capacity to predicted demand and consider skill mix, who is the most appropriate professional to respond to the patient)
- ▲ Develop contingency plans to sustain the system (for both predictable e.g. holidays, and unpredictable events e.g. staff illness)
- ▲ Communicate effectively and continuously with the team and patients about changes (if patients don't know they will still behave as if old system operates)

Change No. 3 Case study

▲ Stockbridge Village Health Centre

Stockbridge Village Health Centre

Stockbridge Village Health Centre is an urban practice, with a population of 8,300 patients and 6 whole-time equivalent GPs and 0.9 whole-time equivalent practice nurses. The practice formerly had an appointment system in place, combined with open access to see the 'duty doctor'. GPs worked a rota to be 'duty doctor' for a day, and this limited each of their available appointments over a week to four days.

There were more patients calling in without prior arrangements than patients booking via the telephone. In June 2004, the practice had an average wait for a routine appointment of 14 days.

The practice worked hard at understanding their demand and re-shaped their appointment system accordingly. Open surgeries have now been incorporated into the daily appointment system, and patients no longer need to request an 'urgent' appointment to see their GP or nurse on the day that they wish to be seen.

They shaped their demand by discouraging follow-up appointments on their busiest day (Monday), and moved Monday clinics to a less busy day in the week. They also looked at pathology results, and whether the patients required face-to-face consultation for results. They used a vacant room for two further sessions per week for the practice nurses, and changed a GP-led diabetic clinic to a nurse-led clinic, freeing up 15 more GP appointments.

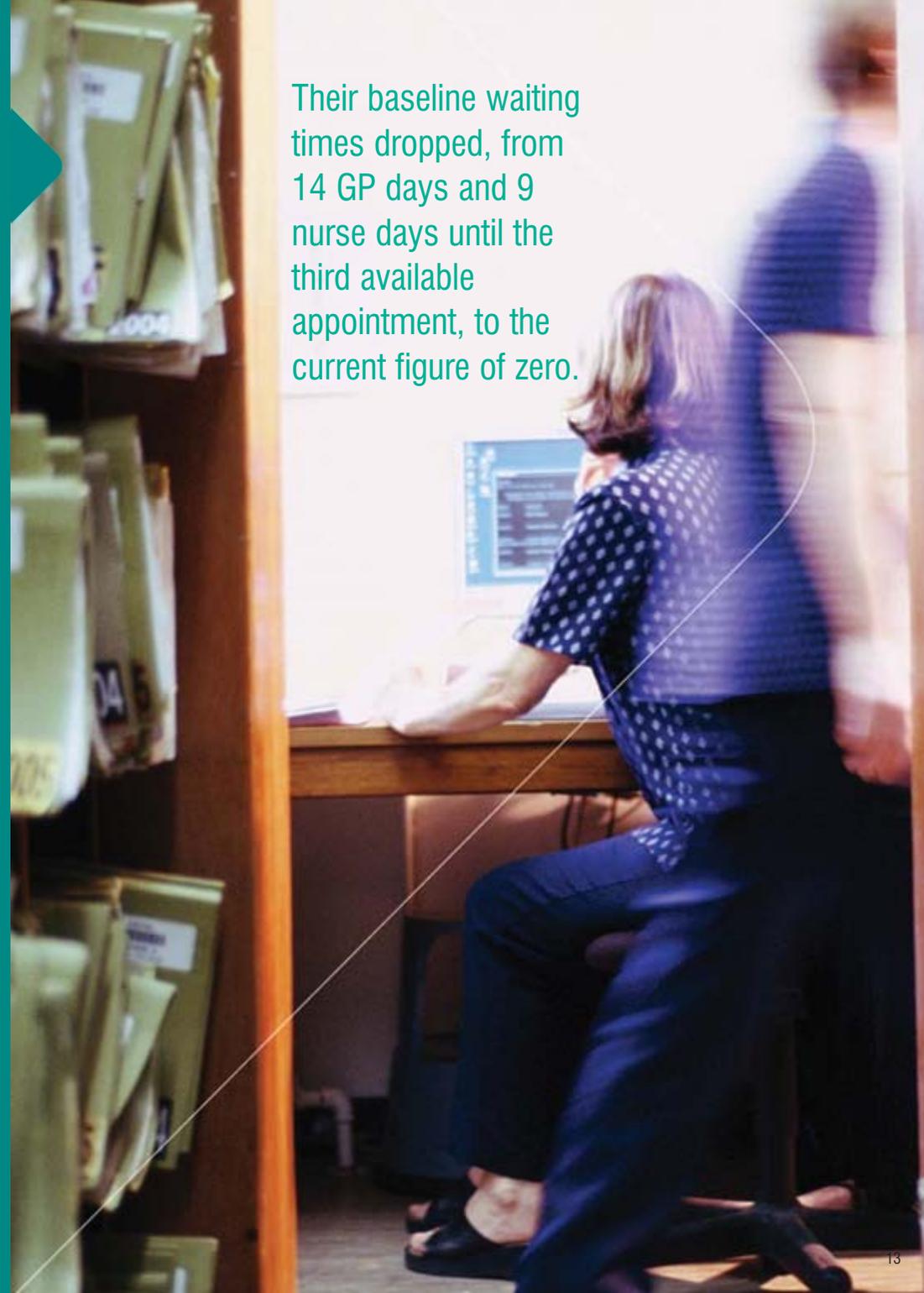
They worked down the backlog by calculating how many extra appointments were needed to clear the excess, and then adding sufficient extra appointments to each day of the week for two weeks. They also capped pre-booking appointments to one week on a short-term basis. Now they have more control over their appointment system, they offer pre-bookable appointments.

They took into account teaching sessions, practice meetings, study sessions and their half-day closure. They agreed to avoid holidays in the busiest months, and not to attend courses or take leave on Mondays without consultation with the other staff. Policies were written to cope with excess demand, and it was agreed that the practice manager and senior receptionists were responsible for deciding to implement contingency plans when necessary.

Their baseline waiting times dropped, from 14 GP days and 9 nurse days until the third available appointment, to the current figure of zero. They have no restrictions for patients, who can pre-book up to four weeks ahead. No-one is asked to phone back the next day for an appointment. They have sustained Advanced Access by constantly keeping tabs on demand, and hold a very detailed analysis of this in a spreadsheet, which is reviewed regularly.

In June 2004, the practice had an average wait for a routine appointment of 14 days.

Their baseline waiting times dropped, from 14 GP days and 9 nurse days until the third available appointment, to the current figure of zero.



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Change No. 4: Improve care for patients by redesigning roles in general practice



Description

Role redesign aims to improve patient services, tackle staff shortages and increase job satisfaction through the development of new and amended roles. It can involve:

- ▲ Increasing the depth of a role e.g. GPsWSI
- ▲ Extending the breadth of a role e.g. Community Paramedic
- ▲ Developing a new role e.g. Health Care Assistant
- ▲ Adding additional skills e.g. Case Managers

Role redesign can be described in many different ways: job design, new ways of working, workforce redesign and skill mix. They all mean very similar things – changing the way a role or the work is done to make improvement for the care and experience of the user. It is not a way of getting staff to do more for less nor is it a cost cutting exercise. It is a response to the widening gap between service demand and delivery, which cannot be filled simply by recruiting more staff.

Role redesign addresses traditional and long-standing barriers to change such as professional boundaries, team structures and hierarchies. It can benefit the entire healthcare team from support workers to the medical workforce.

Many practices have introduced new ways of working and roles which have improved care for patients. It helps if there is an equal focus on both ends of the career framework. Having well designed roles at all levels of the primary care workforce will help meet the needs of a modernised workforce particularly supporting career pathways for skilled but not registered staff to move into.

Some of the delays in the system exist because working practices or patterns are out of date and no longer reflect what is required by the service user. As you redesign your services, roles need to be redesigned to ensure they meet the needs of the user.

Impact on primary care

- ▲ Flexible responsive workforce
- ▲ The chance to work with a range of different staff
- ▲ More responsive management of work load

Impact on patients

- ▲ Improved access to care, diagnosis or treatment
- ▲ Quality care when the patient needs it
- ▲ Less 'faces', more personalised care
- ▲ Reduction in waiting times

Impact on staff

- ▲ Increased job satisfaction
- ▲ More interesting roles with expanded breadth/depth
- ▲ Wider opportunity in career development
- ▲ Reduced vacancies and staff turn over
- ▲ Changes in culture

How to get going

Both role redesign and service redesign go hand in hand. The really important first step is to fully understand what the problems are. If you want to redesign the process by cutting out steps and changing the sequence of things, it is best to do this before commencing the role redesign.

Role redesign should be based on a set of fundamental principles:

- ▲ The changes reflect care pathways
- ▲ Any changes must ensure clarity, accountability and safety for patients and staff
- ▲ Close links are maintained with partner organisations and their human resources (HR) departments when necessary
- ▲ Role design should take account of the need for continuing personal and professional development and lifelong learning. Experience and training from one post should be recognised and accredited and used for development
- ▲ Role design should build on growing evidence and experience of good practice

The first steps include:

- 1. Think about your aim.**
What needs to improve?
- 2. Really understand what currently happens**
Map the current process to really understand who does what at each stage in the patient's journey.
- 3. Understand the causes of any problems**
Get under the problems and identify the ones related to who does what.
- 4. Learn more about the team and the work they do**
Get a clear understanding of the amount of time staff are in clinical settings providing direct patient care.
- 5. Talk it through as a team**
Make sure your team are involved from the very beginning of the process so that members feel that they are contributing to role redesign not having it imposed on them. Get the team involved, by keeping activities diaries so then can make a note of the times they perform a particular activity. Look for mismatch such as a practice nurse spending half of her time completing administrative and relatively simple – although important tasks.
- 6. Build commitment**
Encourage staff to ask questions and to comment, make sure they feel it is a redesign process to improve care for patients and personal job satisfaction.



Change No. 4 Case study

- ▲ Woodlands Health Centre:
Impact of employment of a health care assistant

Woodlands Health Centre: Impact of employment of a health care assistant

Woodlands Health Centre decided to employ a health care assistant (HCA) in 2003 following a review of nursing activity in the practice. The review demonstrated that a significant proportion of nurse time was spent on administration and housekeeping tasks which could be delegated. These tasks were typically cleaning and stocking treatment rooms, sterilising and checking equipment. Following the appointment of the HCA the practice has been able to increase nursing hours spent providing clinical services, this has supported the practice to accommodate one GP moving to part time without the practice seeking additional GP hours.

The impact of the HCA

The HCA undertakes a range of tasks formerly undertaken by the nurses, these include:

- ▲ Blood pressure checks
- ▲ Blood tests (phlebotomy)
- ▲ ECGs
- ▲ Helicobacter tests
- ▲ Doppler tests

The practice was able to demonstrate that the HCA had contributed to:

- ▲ A greater proportion of nursing hours being used to deliver direct patient care
- ▲ A reduction in nursing hours spent on routine housekeeping tasks
- ▲ Quantifiable contribution to the care of patients

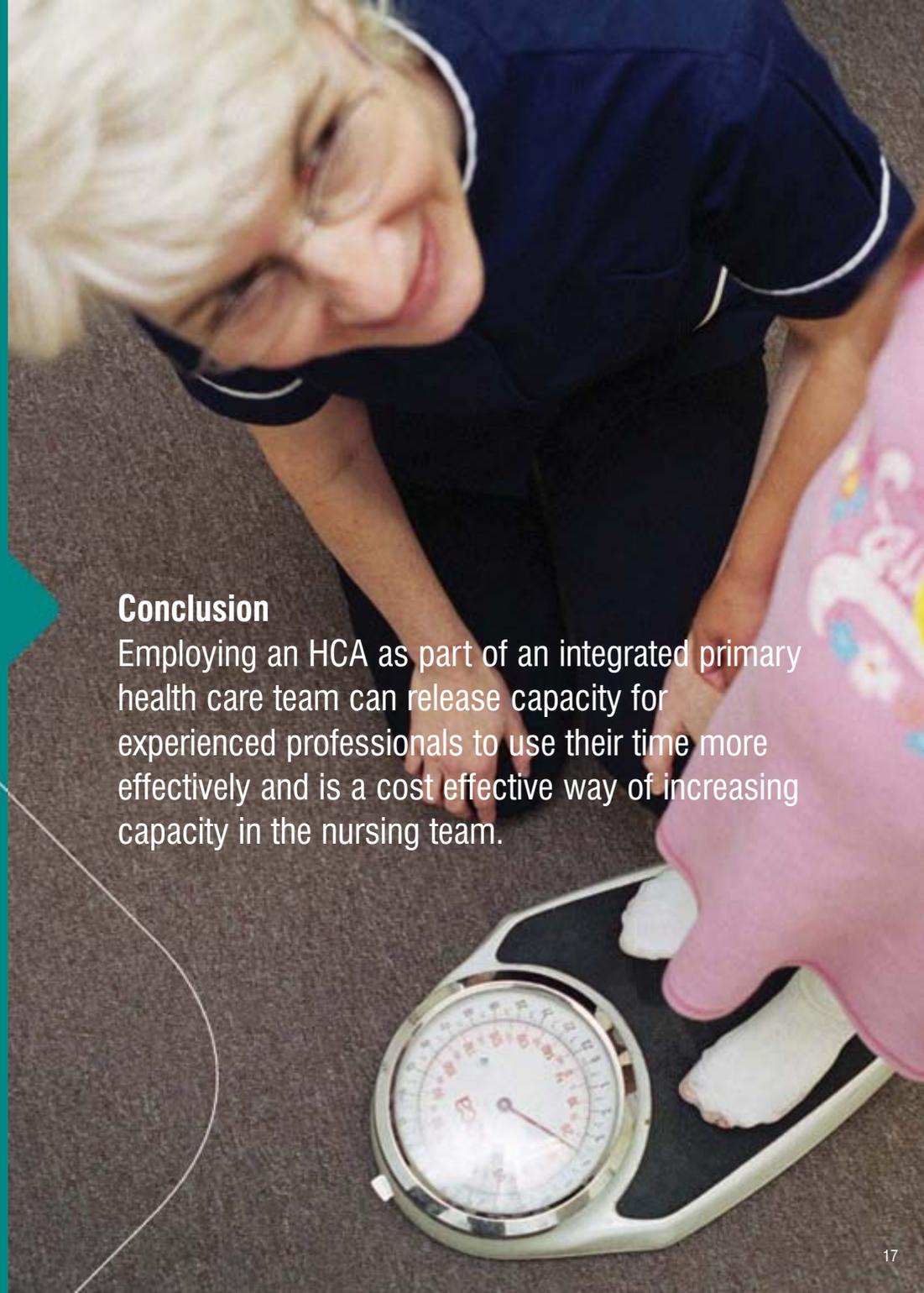
For example the HCA now delivers 60% of all blood pressure tests and 49% of all blood tests. This is likely to grow as the practice extends its HCA team.

The change also demonstrated that increasing the size of the nursing team by appointing an HCA is a cost effective way to increase capacity. The practice has succeeded in increasing clinical hours by 64% with only a 44% increase in the nursing budget. This equates to a "saving" of around £10,000 per year to deliver the same volume of work.

Today the distribution of workload in the practice is more in keeping with the skills and experience of the members of the nursing / HCA team, for example the HCA spends 40% of her time on admin and housekeeping tasks when compared with nurse team members who spend around 15% of their time on admin and housekeeping. This has released more time for patient / clinic activities among the nurse team. Further more the HCAs' remaining time is spent undertaking clinic work, a direct contribution to the clinical workload of the practice.

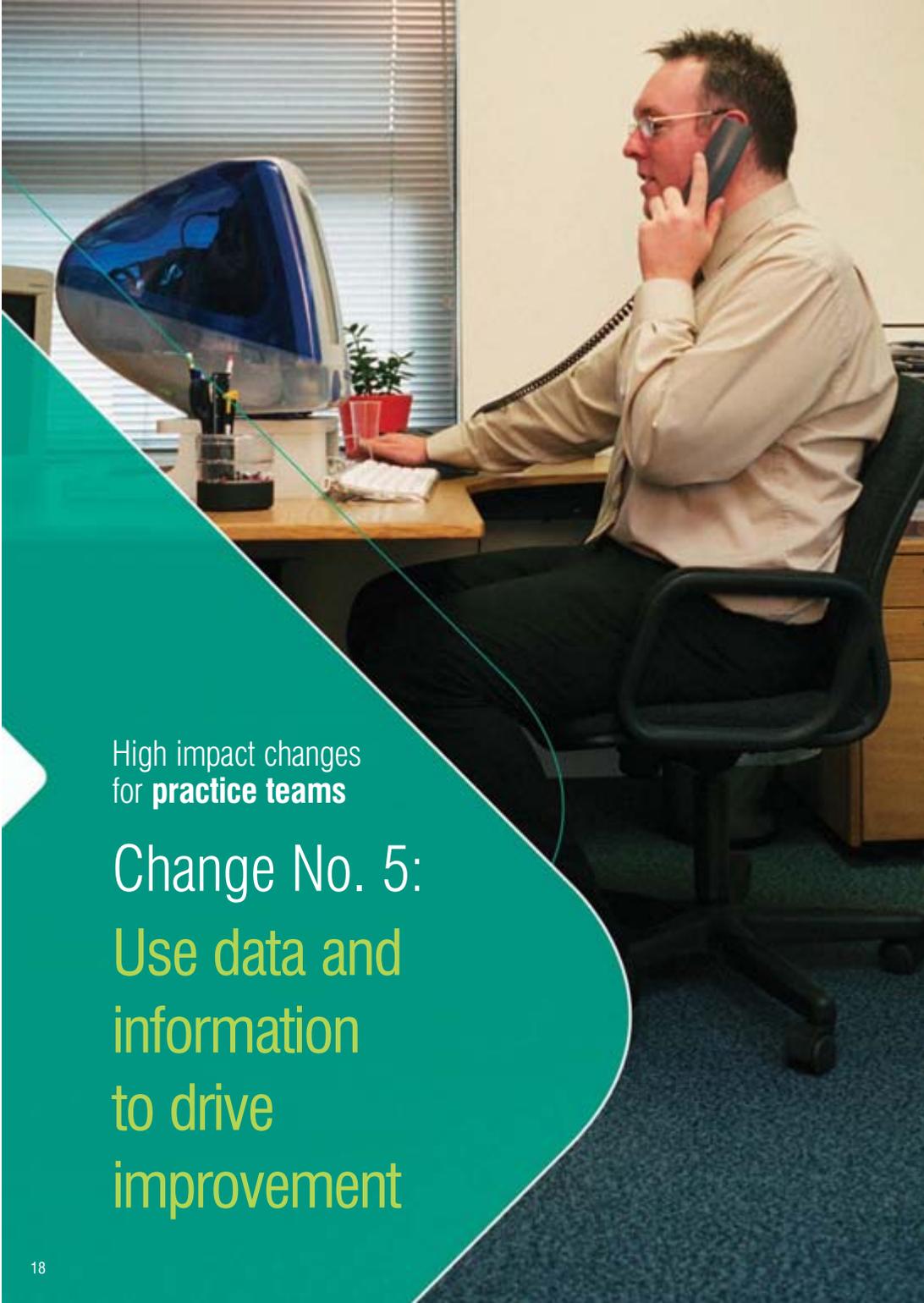
Conclusion

Employing an HCA as part of an integrated primary health care team can release capacity for experienced professionals to use their time more effectively and is a cost effective way of increasing capacity in the nursing team.



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Change No. 5: Use data and information to drive improvement



Description

There is a significant resource of data available to General Practice via mediums such as the QOF, Choose and Book referral data, ePACT prescribing data, and in house practice data accessed via practice clinical systems. With the development of PBC there is an increase in the availability of good quality, validated hospital activity data aimed at practice level. In addition to this, practices have the ability to acquire in house data relating to the effective management and vitality of the practice such as staff turnover rates and profitability. These can be used at a local level to understand our performance, pin-point areas for improvement and optimise organisational development.

Such data offers a valuable tool which GPs can use to review their existing working practice and develop changes in future practice to improve their own working standards and their practice productivity.

With the increasing volume and validity of data available to practices it should now be possible to look at different areas of past and current working within the practice. Using the data as a tool the practice can review its current position and make targeted changes to improve future care and future productivity.

Keeping the data and the way it is dealt with inside the practice will hopefully allow an open culture of sharing such information with colleagues and promoting change in a positive way. For example, a practice that scrutinises its own referral patterns and acts on their own results accordingly is more likely to adopt positive change as a result of this exercise. This contrasts with a PCT that has adopted a referral centre system, "bounces back" referrals the practice has made in good faith and expects the clinicians concerned to change their referral practice as a result.

Impact on primary care

- ▲ Identification of areas where improvement can be made
- ▲ Creating an open culture of sharing information
- ▲ Reduced drug waste/costs
- ▲ Improve prescribing quality
- ▲ Improve referral quality
- ▲ Budget savings via Practice Based Commissioning by reducing outpatient activity
- ▲ Improved awareness of secondary care activity

Impact on patients

- ▲ Reduced unnecessary attendances to secondary care
- ▲ Reduced adverse drug effects
- ▲ Reduced disease complications and exacerbations

Impact on staff

- ▲ Financial savings
- ▲ Open culture of sharing information within the team
- ▲ Highlight areas of best practice and areas of educational need

How to get going

- ▲ Be aware of the avenues available to you for accessing data about your practice
- ▲ Agree an open, no blame approach to data review
- ▲ Involve all the relevant members of the Primary Care Team
- ▲ Review the data regularly and model future change around it
- ▲ Use the data available to you constructively. Don't collect it simply for the sake of collecting it
- ▲ Benchmark against previous practice, individual clinician or national data sets
- ▲ Develop links with other services and encourage data sharing
- ▲ Single-handed or small group practices can "Buddy-Up"

Change No. 5 Case study

▲ Salters Meadow Centre: The use of referral data



Salters Meadow Centre: The use of referral data

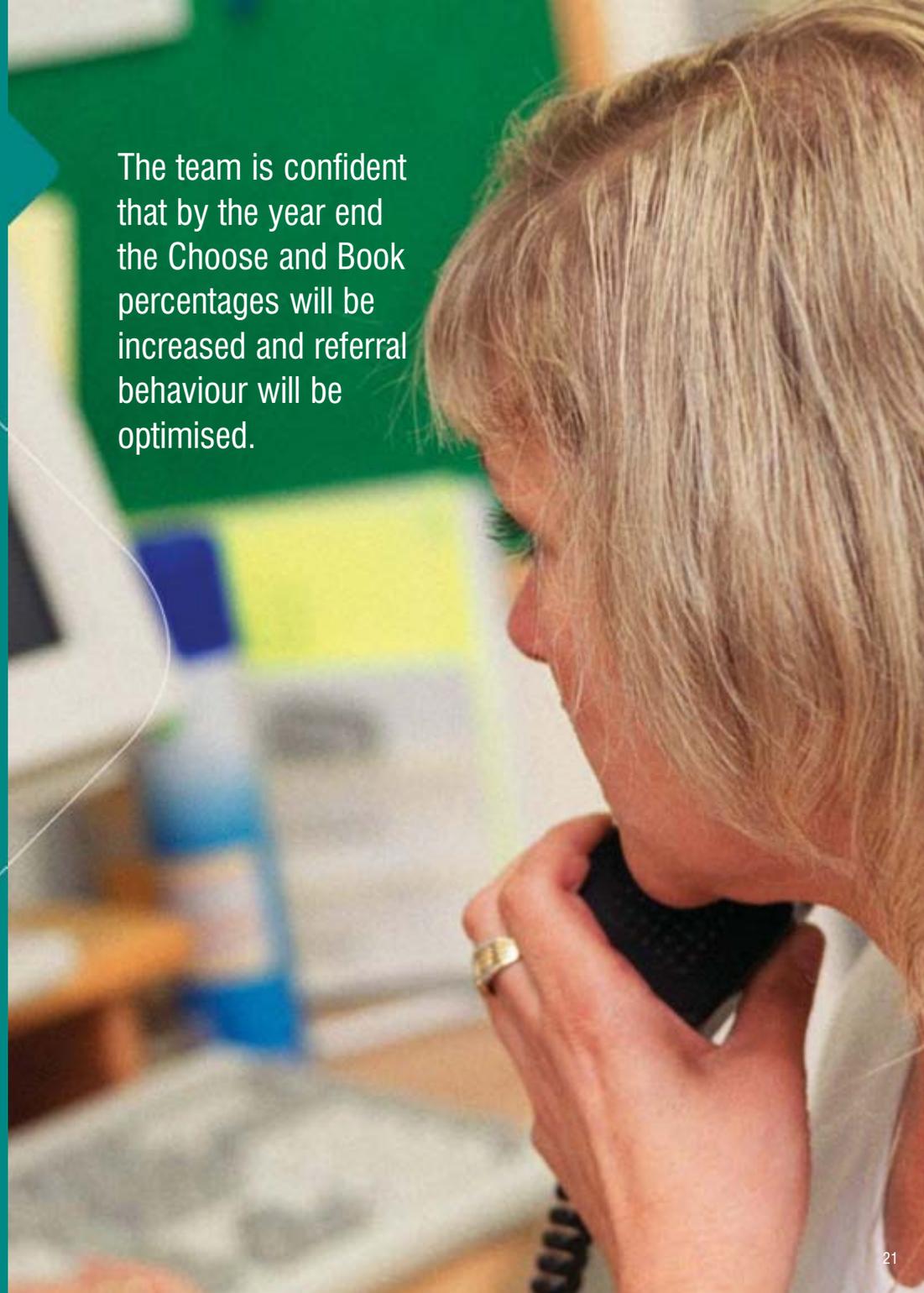
Salters Meadow Centre has 5 WTE partners and 2 WTE salaried GP's. It was agreed at a meeting that they would analyse their referral data to try and streamline and optimise their referrals. They wanted to use the practice directed enhanced services (DES) Plan for Practice Based Commissioning so generating practice income via the DES payment and future savings via reduction in referral activity. All the referring GP's were involved in agreeing this proposal. One partner took on the leadership role and every week was supplied with referral data from the secretaries. Every month the partner was supplied with Choose and Book referral data from the Practice Manager. This was entered onto an Excel spreadsheet with the first month being used as the practice benchmark.

The data collected includes all referrals and is split into specialty and whether the referral was choose and book (and if not the reason why not). On a monthly basis one specialty is chosen to be further analysed. This involves analysing the reason for referral for each case and then reviewing the notes for that patient relevant to the condition and the referral.

At a monthly practice clinical meeting all the data is presented openly. There is no anonymous data. Any patterns are noted and discussed in order to identify areas where the number of referrals could be reduced or areas of clinical uncertainty and educational need might exist within the team.

The practice has been using this system for three months now. The team is confident that by the year end the Choose and Book percentages will be increased and referral behaviour will be optimised. This will benefit the patients, the local health economy and the practice.

The team is confident that by the year end the Choose and Book percentages will be increased and referral behaviour will be optimised.





High impact changes
for **practice teams**

Change No. 6: Improve care through systematic review of patient feedback

Description

Involving patients and seeking their views on the quality of their care is a key theme of the NHS Plan, national service frameworks and clinical governance. The new GMS and PMS contracts through the QOF now incentivise practices to run validated patient surveys. Most of the practices across the UK have now completed at least one cycle of patient surveys and many have put into place improvements based on the findings of these surveys.

Although the QOF requires feedback only at the practice level, the power of patient feedback really comes alive when individual clinicians receive this feedback at the personal and individual levels, and test and implement changes as a result. Such feedback informs our personal and professional development, and is useful for appraisals and possibly future revalidation.

So what do patients value? Patients tend to look for five areas when rating the quality of general practice. These are:

- ▲ Access and waiting
- ▲ Information and choice
- ▲ Clean, comfortable and friendly place
- ▲ Safe, high quality care
- ▲ Good communication and relationships

Evidence shows that healthcare organisations that seek the views of their patients and act on the findings create better outcomes in terms of:

- ▲ More accessible and effective health services
- ▲ Priorities are made which matter to patients
- ▲ Greater participation by marginalised groups

There is a wealth of evidence showing that for those clinicians that seek patients' views on their communication and relationship building skills, and take action as a result, achieve:

- ▲ Better health outcomes, both physiological and psychological
- ▲ Improved diagnostic accuracy
- ▲ Greater compliance or adherence to advice and treatment regimes
- ▲ Improved time management
- ▲ Less complaints and malpractice risk
- ▲ Other benefits of undertaking systematic patient feedback and acting on the results include:

Impact on patients

- ▲ Patients feel they are being listened to
- ▲ They value your service if they feel part of it
- ▲ They experience the practice as being open to suggestions
- ▲ Their evaluation of the service will improve if they feel involved with it
- ▲ Patients can better care for themselves when they feel in partnership with their healthcare staff

Impact on primary care

- ▲ Services become more responsive when patients' views are incorporated into the daily running of the practice
- ▲ Extra strength for commissioning as services are more patient-centred
- ▲ Better communication with patients
- ▲ Greater opportunities for patient and public involvement as the results become a focal point for addressing change eg. critical friends groups or patient participation groups

Impact on staff

- ▲ Staff become more aware of how they can better respond to patients' needs
- ▲ The practice may benefit from patient ideas on changes
- ▲ Staff have the opportunity to get their message across to patients about the practice's services
- ▲ The staff and doctors feel valued as often the feedback is positive

How to get going

A systematic review of patient feedback can occur both at the organisational and clinical level of the practice.

At the organisational level, the key areas include:

- ▲ Patient perceptions of access (including waiting)
- ▲ Information provided on health promotion and prevention of illness
- ▲ Choice issues such as healthcare professional, time of appointment and treatment options
- ▲ The friendliness and approachability of all staff
- ▲ The cleanliness and comfort of the premises
- ▲ The safety and privacy provided by the practice

At the clinical level, the key areas are to do with the clinician/patient relationship that focus mainly on communication, trust and partnership within the consultation. Feedback from patients at this level is particularly useful for:

- ▲ General Practitioners
- ▲ Practice Nurses
- ▲ Nurse Practitioners
- ▲ Health Visitors
- ▲ Community nurses, such as district nurses
- ▲ Visiting Specialists

The key issue is to promote patient centred consultations and involve patients in decision making.

Change No. 6 Case studies

- ▲ Wilmslow Road Medical Centre in Handforth, Cheshire
- ▲ Steyning Health Centre, Horsham and Chanctonbury PCT

An action plan was developed identifying priorities for action and how the practice proposed to address them.

Case study 1

Wilmslow Road Medical Centre in Handforth, Cheshire have undertaken the nationally approved Improving Practice Questionnaire at Practice Level for both their surgery sites, in support of the Patient Experience Domain of the QOF.

The practice team reflected on the results at a clinical governance meeting and put forward proposals for improvements. An action plan was developed identifying priorities for action and how the practice proposed to address them. A written invitation was then sent to 6 patients inviting them to a meeting attended by the Practice Manager, and Doctor, Practice Nurse & Reception staff to discuss their comments and suggestions on the practice proposals to rectify the identified areas of concern. Examples of improvements then implemented include the following:

Improved Access

- ▲ Advanced Access introduced (patients seen on the day of their choice)
- ▲ Additional health care assistant recruited to "free up" practice nurse time
- ▲ Doctor led telephone consultations introduced
- ▲ Installation of IP telephony at both surgery sites. E.g. touch screen self check-in systems installed
- ▲ Flu immunisation clinics were organised on a "drop in" basis at the request of patients. Pneumonia vaccination to patients aged 65 and over also offered at these sessions

Confidentiality

- ▲ Privacy booth installed in the patient reception area
- ▲ Installation of touch screen self check-in systems also offer more privacy

Practice Facilities

- ▲ One designated receptionist responsible for co-ordinating health promotion campaigns on the patient information notice boards at both surgery sites

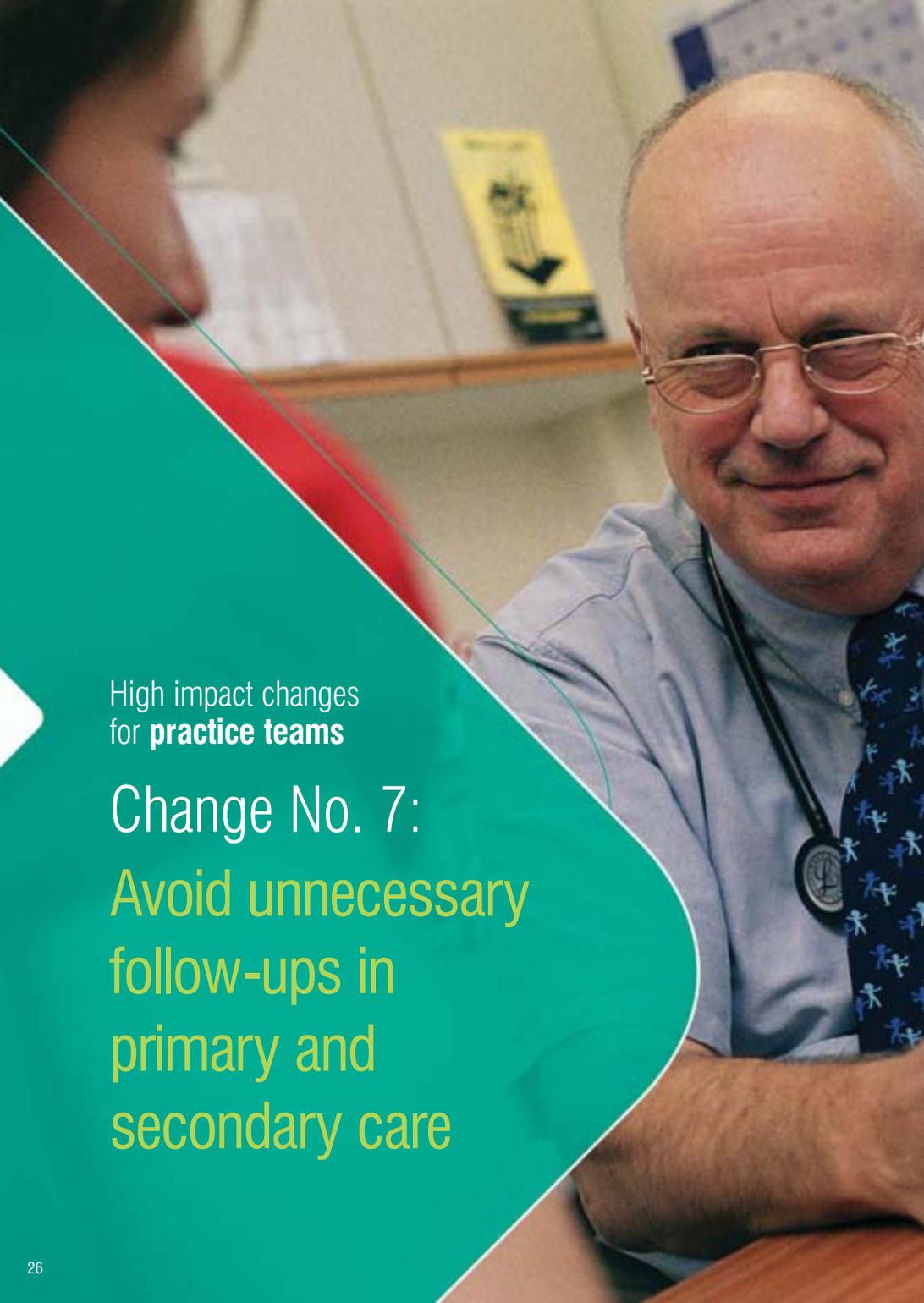
Information

- ▲ Call & recall systems have been set up to ensure all patients on a chronic disease register are reviewed annually
- ▲ Patients aged 65 & over and in "at risk" categories are prioritised and actively targeted
- ▲ New service developments are publicised in the twice yearly produced practice newsletter
- ▲ All services available within the practice are outlined in the recently updated practice leaflet and the practice website currently under development
- ▲ Seasonal campaigns e.g. Flu and seasonal topics e.g. hay fever are publicised through the various media available: practice newsletter, repeat prescriptions, posters and the patient display system
- ▲ A Heart Start Basis Life Support training session is offered to "at risk" patient groups and their families
- ▲ Self treatment of common illnesses and accident information has been included in the recently updated practice leaflet and on the practice website

Case study 2

Steyning Health Centre, Horsham and Chanctonbury PCT, started compiling a falls register by putting an article (written by the senior GP in the practice) and self-assessment questionnaire in their patient participation newsletter. Over 300 questionnaires were returned. The practice developed an information exchange system with the Sussex ambulance service whereby each month, the patients over 65 from the practice who had been attended by the paramedics as a result of a fall, were referred directly to the GPs for a personal risk assessment. High on the list of risks of falling are certain combinations of medicines. Each faller was reviewed for this and other personal risk factors. The practice then designed a referral pathway for patients to have ongoing input appropriate to their circumstances.

The practice designed a referral pathway for patients to have ongoing input appropriate to their circumstances.



High impact changes
for **practice teams**

Change No. 7:

**Avoid unnecessary
follow-ups in
primary and
secondary care**

Description

Every year within secondary care, there are 37 million follow-up appointments. A significant proportion of these follow-ups have been shown to be clinically unnecessary, create inconvenience and anxiety for patients, and waste valuable resources. 75% of all 'Did Not Attend' (DNAs) are for follow-up appointments.

Common practice has been to invite patients for a follow-up 'just in case'. If that practice is changed to 'no follow-ups unless there is a specific reason', i.e. clinical need or patient request, this would reduce the number of unnecessary follow-ups and DNAs. Many local projects have actively involved patients in the redesign of their care. It is often surprising how frequently patients want to redesign follow-ups out of existence. Patients tend to give far less value to follow-ups than staff.

It has been difficult in the past for commissioners to identify the specific costs of follow-ups as the tariff price covers a number of aspects of each procedure in acute care. However, with the advent of Foundation Trusts and Practice Based Commissioning, more work is being done to 'unbundle' the tariff and identify specific resource savings that can be made by individual commissioners. Tariffs for community services are anticipated for 2008.

As general practices move to take on practice based commissioning they will have the opportunity to look at the services they commission and identify opportunities to reduce unnecessary follow-ups. This will improve the quality of care for patients and release resources for investment in local priorities.

Also general practices are beginning to consider ways of reducing follow-ups within their own practices, often as a result of improved management of patients with long term conditions (as illustrated in the case study).

There are different aspects to reducing follow-ups. One aspect is to streamline the service for patients with a 'One-Stop-Shop' approach where the relevant consultation and tests are all booked into one visit. Another aspect is to consider where the follow-up could be delivered, which healthcare professionals, such as nurses, can do the follow-up and how it is delivered. Telephone calls, web-based services and group visits could be used to replace the traditional visit.

Impact on patients

- ▲ Reduced number of unnecessary visits
- ▲ Reduced waits
- ▲ Patient confidence and reduced anxiety because they are formally 'discharged' from an episode of care
- ▲ Reduced anxiety by providing opportunity for tests and results within one visit
- ▲ Nurse-led clinics can offer patients more time

Impact on primary care

- ▲ Reduced follow-up appointments creating increased capacity to see other patients sooner
- ▲ Reduced DNA rates creating increased capacity to see other patients sooner
- ▲ Better use of staff mix and skills
- ▲ Active discharge of patients as appropriate
- ▲ Potential release of resources for use elsewhere

Impact on staff

- ▲ Reduced DNAs not wasting staff time
- ▲ Enhanced nurses/therapists role in outpatient setting and primary care
- ▲ Training opportunities to enhance skills
- ▲ Reduced duplication and non value added time
- ▲ Single or group visits improve timely decision making

How to get going

- ▲ Benchmark services currently provided to your patients and identify number, pattern and variability of follow-ups
- ▲ Avoid unnecessary "duplicate" follow ups in patients with more than one long term conditions. E.g. many patients with diabetes have CHD +/- hypertension and often will be seen in both clinics as they are on both disease registers. Reduce follow ups by offering all the care in the diabetic clinic
- ▲ Talk to your patients about their experiences of follow-ups and whether they think they are needed
- ▲ For secondary care services consider:
 - Getting clinical agreement with consultants on discharge and follow-up protocols through commissioning and service redesign
- ▲ For your own practice consider:
 - Alternatives to face to face follow-ups
 - Introduction of specialist clinics/'one-stop-shops'/group consultations
 - Staff training and skills enhancement needed

Change No. 7 Case studies

- ▲ The Oakley Medical Practice, Leeds: The setting up and implementation of nurse run long term conditions clinics (quality clinics) in primary care.
- ▲ North Bradford Practices



Contingency plans and a robust computer system are essential

Case study 1

The Oakley Medical Practice, Leeds: The setting up and implementation of nurse run long term conditions clinics (quality clinics) in primary care.

Objectives

- 'One stop shop' facility for reviewing patients with multiple chronic diseases
- Reduction in unnecessary follow-ups
- Provision of necessary follow-ups in the right setting
- All relevant tests carried out in a timely and convenient way during 30 minute appointments
- Nurse run telephone follow up appointments
- Functional help towards fulfilment of QOF criteria
- To enable GPs to run ten minute routine appointments
- To facilitate 24/48 hour access for routine appointments

Progress with activity

- Quality clinics are now a permanent service at the practice
- Considering the potential more widely in the PCT
- PCT interest / presentation request
- Presentation at collaborative workshop
- Expressions of interest from other practices

Outcomes to date

- The practice is now into the third year of running quality clinics, proving their sustainability
- Run charts for diabetes / COPD demonstrate high level of goal achievement
- Reduction in unnecessary follow-ups
- The initial doubters at the practice are happy to continue with this service
- Patient feedback has been very positive / quality clinic appointments are in demand
- 24 / 48 hour access has been realised and sustained
- Doctor appointment times have been lengthened
- Since the practice gave a presentation within the locality on setting up and running quality clinics we are aware of two practices who have now adopted this method

Lessons learnt

- Quality clinic DNA rates have been very low, which is a big plus, as to waste a 30 minute appointment is bad news all round
- Contingency plans and a robust computer system are essential

The practices have achieved a 10% reduction in the overall number of referrals to secondary care.



Case study 2

North Bradford Practices are managing demand using the skill mix within the practice, and working with other practices. Approaches include peer review of referrals, changing clinical behaviour, providing alternative routes (including GPwSI) for referrals to secondary care, small system change, and GP direct access for diagnostics. The practices have achieved a 10% reduction in the overall number of referrals to secondary care and a **10% reduction in follow-ups for General Surgery, ENT and Orthopaedics.**



High impact changes
for **practice teams**

Change No. 8: Provide services closer to patients

Description

A theme throughout these High Impact Changes is the right service at the right time by the right people, in the right place. Practice based commissioning gives us the opportunity to think about which services could be provided closer to patients' homes, either by the practice (or group of practices) or within a local community facility. Advances in technology and skills development mean that many services that previously needed the infrastructure and specialist skills of hospitals can now be carried out much closer to patients.

Provided that the practice undertakes an assessment of the benefits of bringing a service closer to home (see "How to Get Going"), such services have been shown to have benefits for patients.

Impact on patients

- ▲ More convenient service
- ▲ Usually less waiting time for the service
- ▲ Improved continuity of care
- ▲ More seamless service (frequently the same organisation that provides other elements of their primary care)
- ▲ Improved patient satisfaction

How to get going

The practice (or group of practices) should carry out a detailed analysis to determine whether a service could or should be relocated closer to patients' homes. These are some of the questions to ask:

- ▲ Are there clear benefits for patients?
- ▲ Is there a sufficient volume of work to make the new service economically and operationally viable?
- ▲ If there is not enough volume in our practice to shift the service, could we partner with other practices?
- ▲ Are the skills and technology available to provide the service locally or can existing staff be trained?
- ▲ Who will provide the new service and have they got the time?
- ▲ How will we ensure clinical quality?
- ▲ Are there opportunities to create new partnerships with hospital based services to ensure training, professional support, staff cover and referral pathways for these local services?

Impact on primary care

- ▲ Allows primary care providers to grow and develop
- ▲ Creates efficiencies which can translate (wider Practice Based Commissioning) into investment
- ▲ High satisfaction approval rating from patients

Impact on staff

- ▲ Personal development of skills and roles
- ▲ Sense of purpose and direction in the new environment
- ▲ High positive feedback from patients

A theme throughout these High Impact Changes is the right service at the right time by the right people, in the right place.

Change No. 8 Case studies

- ▲ Whitstable Medical Practice, Kent
- ▲ Manor House Surgery, Glossop, Derbyshire
- ▲ Birchwood Medical Practice in Norfolk

Case study 1

Whitstable Medical Practice, Kent

Whitstable Medical Practice analysed their referral data and identified a high (and increasing) demand for hearing tests. Many of these had gone to ear nose and throat clinics because of existing referral pathways. The GPs put forward a case that these tests could all be carried out in primary care much more cost-effectively. In their first year of operation they are on target to realise £21,000 efficiency savings, shorter waits and more satisfied patients. They have also commenced dermatology and one-stop urinary flow clinic.

Case study 2

Manor House Surgery, Glossop, Derbyshire

This practice has established under personal medical services plus a number of services which are available not only to their patients, but to patients in the locality also. The starting point for the case put to the PCT was the identified need (previous long wait) convenience for patients and lower cost. The practice has skilled up some of its own personnel to help operate the services, but also has sessional arrangements with other professionals. The services currently include ultrasound scanning, echo cardiography, anticoagulant management (including home testing), extended minor surgery and dermatology. All services are actively monitored for clinical quality and the quality of patient experience. All wait times are 4-6 weeks.

Case study 3

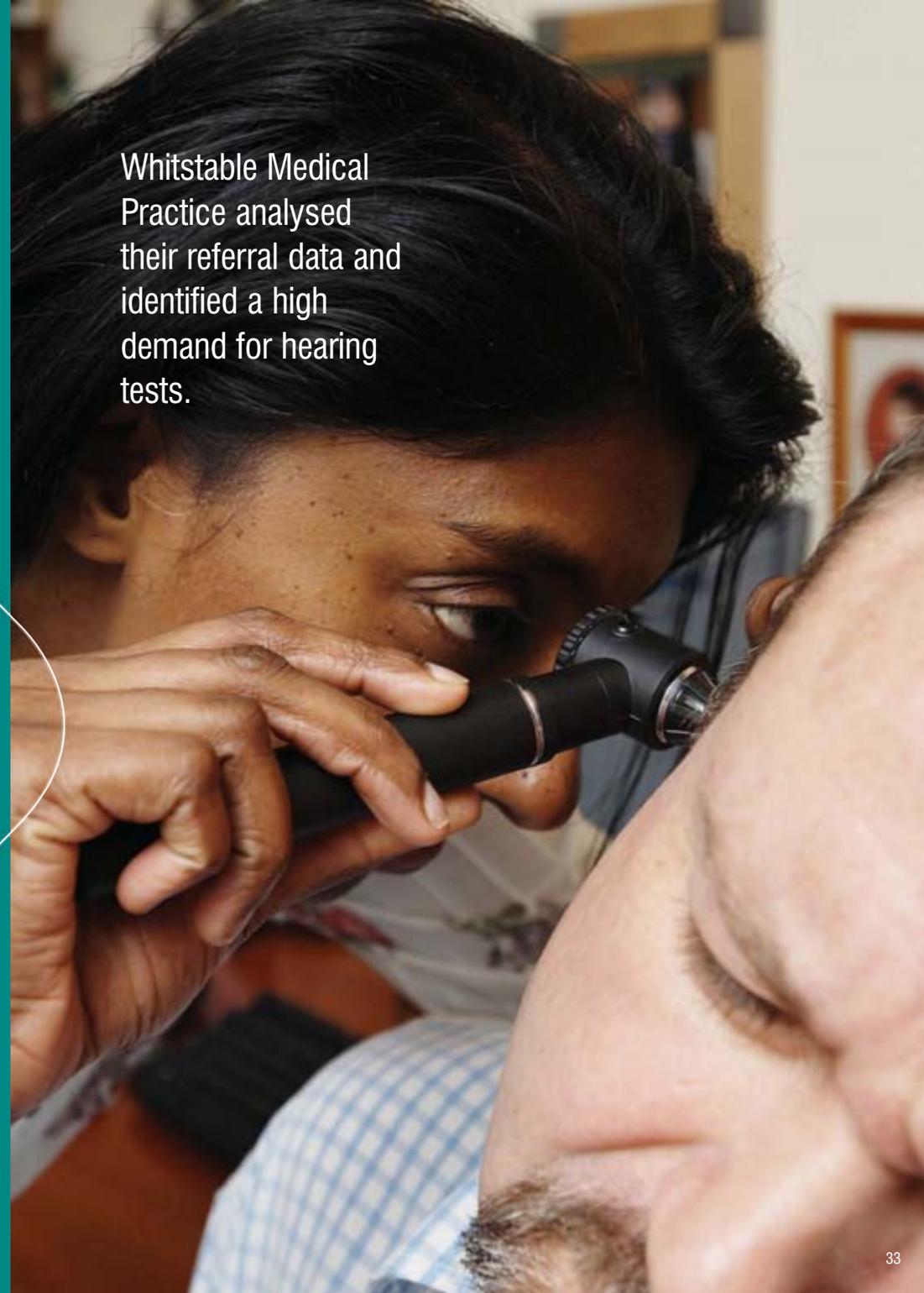
Birchwood Medical Practice in Norfolk

aims to provide urgent healthcare innovatively via primary care as opposed to the occasionally inappropriate emergency care route. A multi-disciplinary team (including a community paramedic) ensures more efficient use of resources, saving time and reducing duplication of work. Started in 2003. A&E transfers have been reduced by 78%; 49% patients have been managed safely in the community; 16% ambulances on red status have been stood down. The practice has only 50% of the emergency admissions compared to demographically similar practices in the same PCT.

Some examples of services that can be brought closer to patients

Diagnostic Test	Treatment and Management	Rehabilitation/ Palliative Care
e.g.	e.g.	e.g.
<ul style="list-style-type: none"> • Blood tests • Audiology • Plain film x-rays • Ultrasound • 75% of pathology (non slide based, non specialist work) • Echo-cardiology • Endoscopy • Colposcopy • INR testing 	<ul style="list-style-type: none"> • Extended minor surgery • Dermatology • Chronic pain • Podiatry • Endoscopy • GUM • Follow-ups of various conditions 	<ul style="list-style-type: none"> • COPD • Cardiac rehabilitation • Orthopaedic • Palliative care • End of life care • Stroke care

Whitstable Medical Practice analysed their referral data and identified a high demand for hearing tests.





High impact changes
for **practice teams**

Change No. 9: Maximise use of practice based commissioning

Description

Practice Based Commissioning creates a mechanism by which practices or consortia of practices can influence service configuration. In doing so they can create efficiencies for the local health economy, provide the means of investment for services for their own population – and assist the NHS as a whole.

Impact on patients

- ▲ Fewer admissions
- ▲ Additional more convenient services
- ▲ Involvement in priorities for commissioning

Impact on primary care

- ▲ Mechanism to create investment
- ▲ Provides for growth and development of organisations
- ▲ Retention of skills in primary care

Impact on staff

- ▲ Opportunity for personal development
- ▲ Retention of staff
- ▲ Growth in skill base

How to get going

- ▲ Analyse activity data and comparative data with other practices in PCT
- ▲ Identify key areas for prioritising effort; useful to do in conjunction with a patient group
- ▲ Construct business case as part of PBC plan

Practice based
commissioning creates
a mechanism by
which practices or
consortia of practices
can influence service
configuration.



Change No. 9 Case studies

- ▲ Claremont Practice in East Devon
- ▲ Hopwood Practice in Oldham as MSK Partnership
- ▲ Probus Surgery, Cornwall



Case study 1

Claremont Practice in East Devon

(population 10,700) have benefited from a pro-active PCT who provided activity and other data in 04/05 that enabled real budget management in 05/06. The practice instituted peer review of referrals and provided dermatology in-house. They instituted the Unique Care means of case management of those with complex needs. They created unified nursing teams across the community and the practice and involved a social worker in assessments and management. This enabled skill synergy and bespoke management of those with complex needs which significantly reduced emergency admissions. In the first year they saved £400,000.

Case study 2

Hopwood Practice in Oldham as MSK Partnership

provide musculoskeletal services for other practices (and the PCT). They utilise specialised personal medical services to deliver rheumatology services involving specialist physiotherapy triage. The service is entirely community based. Waiting times, and surgical procedures, have been reduced. Currently there are around 1500 new referrals per annum.

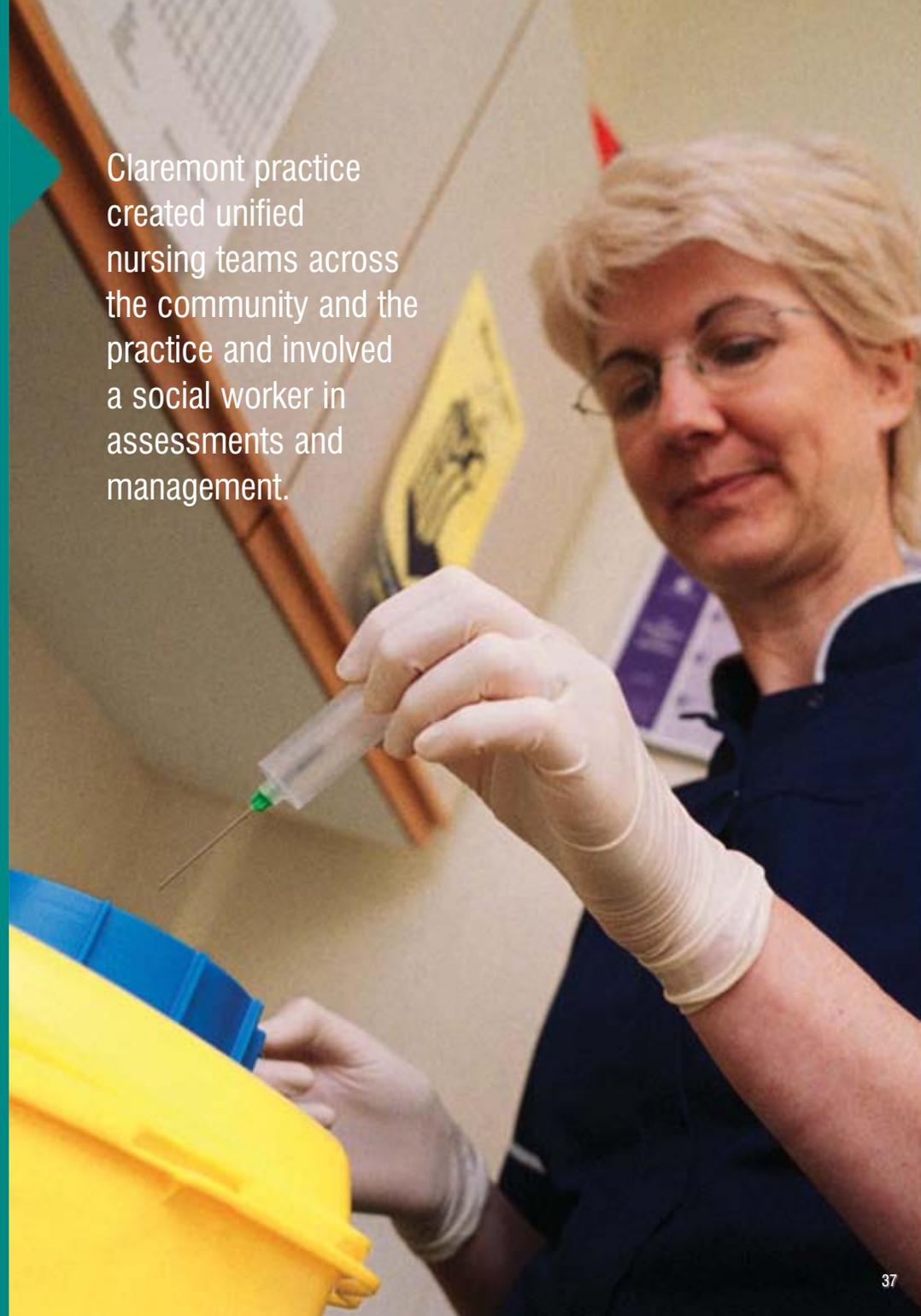
Case study 3

Probus Surgery, Cornwall

have undertaken the redesign of surgical services in primary care including vasectomies, eye procedures, hernia repairs and carpal tunnel release. They have reduced waiting times by 8 weeks, and gained the confidence of GPs, consultants, patients and the PCT. The costs are 70% of the tariff resulting in efficiency gains of £400,000 in 2005

The service is entirely community based. Waiting times, and surgical procedures have been reduced.

Claremont practice created unified nursing teams across the community and the practice and involved a social worker in assessments and management.



High impact changes for practice teams

Additional information

View websites for details of live and interactive 'webcasts' illustrating these changes.

High Impact Change	Additional Information	Web Address
No 1 Promote patient self care and self management	The Expert Patient Programme	www.expertpatients.nhs.uk
	'Promoting Optimal Self Care Consultation Techniques', Dr Stephen Tomkins & Dr Alf Collins, Dorset & Somerset SHA	http://www.southwest.nhs.uk/
	'Self Care' – DH Working in Partnership Programme	www.wipp.nhs.uk
No 2 Improve the management of patients with long term conditions	Improvement Foundation/NPDT LTC work – Primary Care Collaborative, PC Contracting Collaborative, Scottish PCC, Unique Care and additional printed resources, Mental Health Collaborative	www.improvementfoundation.org
	Long Term Conditions Programme, NHS Institute for Innovation and Improvement	www.institute.nhs.uk
No 3 Improve patient access	IF/NPDT Advanced Access work – includes information on contingency planning, pre-bookable appointments, measuring demand, e-mail tips and success stories	www.improvementfoundation.org
No 4 Improve care for patients by redesigning roles in general practice	'Redesigning Roles – an Improvement Leaders' Guide'	www.institute.nhs.uk
	'HCAs – Facilitating the Employment, Training, Development and Integration' – Working in Partnership Programme	www.wipp.nhs.uk
No 5 Use data and information to drive improvement	Measurement for Improvement – an Improvement Leaders' Guide	www.institute.nhs.uk

No 6 Improve care through systematic review of patient feedback

General Practice Assessment Questionnaire (GPAQ)
CFEP – UK Surveys www.cfep.co.uk

'Involving Patients and Carers (including how to do Discovery Interviews) – an Improvement Leaders' Guide' www.institute.nhs.uk

NHS Clinical Governance Support Team work on Patient Experience www.cgsupport.nhs.uk

Support on consultation techniques from RCGP Faculty or local deaneries www.rcgp.org

No 7 Avoid unnecessary follow-ups in primary and secondary care

'Ten High Impact Changes for Service Improvement and Delivery A guide for NHS Leaders' www.institute.nhs.uk

IF/NPDT website commissioning and contracting section – The West Yorkshire Programme, primary care contracting collaborative, CHD success stories www.improvementfoundation.org

'Productivity and Efficiency' – Publication from Delivering Quality and Value work of the NHS Institute www.institute.nhs.uk

No 8 Provide services closer to patients

IF/NPDT website commissioning and contracting section – The West Yorkshire Programme, primary care contracting collaborative, CHD success stories. www.improvementfoundation.org

"Shifting Services" work and 'Productivity and Efficiency' – Publication from Delivering Quality and Value work of the NHS Institute www.institute.nhs.uk

No 9 Maximise use of practice based commissioning

Improvement Foundation National Practice Based Commissioning Programme – website, newsletter, web casts, web forum. Also range of guidance documents and helpful publications from other organisations also on website under Practice Based Commissioning/PBC Resources. www.improvementfoundation.org

Department of Health PBC website www.dh.gov.uk/PolicyAndGuidance/OrganisationPolicy/Commissioning/PracticeBasedCommissioning/ts/en

High impact changes **for practice teams** needs to be read by clinicians and managers working in General Practice who wish to improve patient care. It is clearly written and offers a number of wonderful examples on how staff have brought health benefits to patients and improved job satisfaction for themselves. The document deserves wide dissemination and will, without doubt, help to bring further improvement to General Practice.

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