

IMPROVEMENT FOUNDATION PROGRAMMES 2000 – TO PRESENT

	CHANGE PRINCIPLES	MEASURES	RESULTS	POPULATION COVERAGE	NUMBER OF PARTICIPANTS
National Primary Care Collaborative: Improving Access	<p>Understand demand</p> <p>Shape the handling of demand</p> <p>Match capacity to reshaped demand</p> <p>Establish contingency plans</p> <p>Ensure effective communication</p>	<p>Third available appointment for GPs</p> <p>Third available appointment for practice nurses</p>	<p>Over 70% improvement in waiting times to see a GP</p> <p>Over 60% improvement in waiting times to see a practice nurse</p> <p>Average patient waits to see a GP down from 5 days to less than 1 day</p>	34,137,769	<p>All PCTs</p> <p>5,442 General Practices</p> <p>Minimum of 5,442 GPs</p> <p>16,326 primary care team members</p>
National Primary Care Collaborative: Coronary Heart Disease	<p>Develop and maintain a valid CHD register</p> <p>Implement agreed protocols of care</p> <p>Use computerised templates for collecting patient information</p> <p>Identify systems for call and recall</p>	<p>% of CHD patients on aspirin</p> <p>% of CHD patients on statins</p> <p>% of post-Myocardial Infarction patients on beta-blockers</p> <p>% of patients with BP < 140/85</p>	<p>Fourfold reduction in mortality for patients with CHD in participating PCTs compared to non-participants</p> <p>3,000 lives from Myocardial Infarctions saved per year</p> <p>Non-fatal</p>	34,137,769	<p>All PCTs</p> <p>5,442 General Practices</p> <p>Minimum of 5,442 GPs</p> <p>16,326 primary care team members</p>

	Develop nurse-led care for CHD patients		Myocardial Infarctions also reduced by 3,000 per year		
Healthy Communities Collaborative: Reducing Falls in Older People	<p>Raise awareness of the need for change in a topic area</p> <p>Enable communities to lead the process supported by 'insulated professionals'</p> <p>Focus energy on common goals</p> <p>Enhance social systems</p> <p>Raise expectations</p>	<p>Falls in over 65 year olds: Number of falls in the team area - from ambulance data.</p> <p>Number of fallers in the identified care home/residential facilities.</p> <p><u>Social Capital</u> Aimed to measure to assess the impact of the HCC intervention relating to social capital in each of the team areas by asking a variety of questions relating to residents' sense of community and also relating to falls</p>	<p>32% decrease in falls handled by the ambulance service</p> <p><u>Social capital</u> 13% increase in general population of people who thought their area was a good place to live</p> <p>48% increase in participants who thought they could change attitudes and improve things in their area</p> <p><u>Sustainability</u> Of 21 HCC sites since 2002, only 1 site has failed to sustain the work in one form or another</p>	570,000 people in most deprived communities	<p>Total team members = 1,140 people</p> <p>Of those 800 were lay people</p> <p>Others: local statutory and non-statutory agency staff</p>
Healthy Communities Collaborative:	Raise awareness of the need for change in a topic area	Shop quality scores based on accessibility, awareness and	87 new initiatives created to widen access to a healthy diet	360,000 people in most deprived communities	Total team members = 720 people

<p>Widening Access to a Healthier Diet</p>	<p>Enable communities to lead the process supported by 'insulated professionals'</p> <p>Focus energy on common goals</p> <p>Enhance social systems</p> <p>Raise expectations</p>	<p>availability.</p> <p>The number of new initiatives in the area.</p> <p>The number attending courses on cooking skills or basic food hygiene. The number of employment opportunities created.</p> <p><i>Social Capital</i> Aimed to measure to assess the impact of the HCC intervention relating to social capital in each of the team areas by asking a variety of questions relating to residents' sense of community and also relating to healthy diet.</p>	<p>315 people given skills-based training</p> <p>10 new job opportunities</p>		<p>Of those 500 were lay people</p> <p>Others: local statutory and non-statutory agency staff</p>
<p>National Primary Care Collaborative: Chronic</p>	<p><u>COPD</u> Establish a system for creating, validating and updating a register of people with</p>	<p><u>COPD</u> % of people who have received spirometry to confirm diagnosis</p>	<p><u>COPD</u> 156% improvement in COPD patients who have received</p>	<p>12,932,575</p>	<p>All PCTs</p> <p>1,931 General Practices</p>

<p>Obstructive Pulmonary Disease and Diabetes</p>	<p>COPD</p> <p>Be systematic and pro-active in managing the care of people with COPD</p> <p>Involve patients in delivering and developing their care</p> <p>Adopt a multi-skilled, multi-agency approach to ensure effective co-ordination of the care of people with COPD</p> <p><u>Diabetes</u></p> <p>Establish a system for creating, validating and updating a register of people with diabetes</p> <p>Be systematic and pro-active in managing the care of people with diabetes</p> <p>Involve patients in delivering and developing their care</p>	<p>% of COPD patients with smoking status recorded within previous 12 months</p> <p>Number of acute admissions for respiratory illness in COPD patients in the previous 12 months</p> <p><u>Diabetes</u></p> <p>% of people with diabetes with a last recorded HbA1c of <7.5 within the previous 12 months</p> <p>% of people with diabetes with a last recorded cholesterol reading of <5 mmol within the previous 12 months</p> <p>% of people with diabetes with a last</p>	<p>spirometry</p> <p>67% improvement in COPD patients with smoking status recorded</p> <p>COPD admissions reduced by 16%</p> <p><u>Diabetes</u></p> <p>17% improvement in diabetic patients with excellent control (HbA1c<7.5)</p> <p>33% improvement in diabetic patients with cholesterol < 5 mmol</p> <p>31% improvement in diabetic patients with BP<140/80</p>	<p>Minimum of 1,931 GPs</p> <p>5,793 primary care team members</p> <p>300 lay/patient representatives as part of improvement teams</p>
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	Adopt a multi-skilled, multi-agency approach to ensure effective co-ordination of the care of people with diabetes	recorded BP reading of <140/80 within the previous 12 months % of people with diabetes with a retinopathy screening recorded within the previous 12 months	80% improvement in digital retinopathy screening 2,000 fewer Myocardial Infarctions and strokes a year		
Unique Care - Integrated Care for People with Complex Needs	<p>Create a <i>Unique Care</i> team between health and social services</p> <p>Create and maintain a practice based register of patients with complex needs</p> <p>Case find patients at risk of admission</p> <p>Establish hospital in-reach</p> <p>Create a bespoke plan with each patient</p>	<p>Number of people per practice identified as requiring proactive case management / care co-ordination (accumulative measure)</p> <p>Number of people receiving case management / care co-ordination, including the inactive cohort who have discharged themselves (accumulative measure)</p> <p>Number of acute medical admissions and bed occupancy</p>	<p>Outcomes include a reduction of 13 - 25% in total admissions for the over 65 population, not just a small cohort of case managed individuals.</p> <p>In addition bed days in entire over 65 practice populations have been reduced by 20 - 40%</p> <p><i>In one practice:</i> 53% reduction in emergency admissions (12% in comparator practice)</p>	2,560,160	<p>35 Unique Care sites</p> <p>Majority of sites are PCT led, others are Local Authority led, GP practice led and GP consortia led.</p> <p>Mix of staff involved in the improvement work ranges from senior executives (health and social care) to frontline staff and service users.</p>

		for the over 65 population within the last 12 months per practice (rolling 12 month figure)	70% bed days reduction (10% in comparator practice) Increases in user and carer satisfaction and quality of life Reduction in GP attendance, GP home visits and A&E attendance		
National Primary Care Mental Health Collaborative First wave	Create and validate an electronic list for proactive care Create alternative care management arrangements Implement directed self care	Rate of consultations with GPs for people on the common mental health disorders electronic list Rate of consultations with other practice staff for people on the common mental health disorders electronic list Rate of referral to Community Mental health Teams and/or consultant psychiatrists for	44% reduction in patients receiving sick notes of over 13 weeks (getting people back to work) 20% reduction in referrals to specialist services Up to 21% reduction in GP consultations across sites	743,465	100 General Practices Minimum of 100 GPs 300 primary care team members 30 lay/patient representatives as part of improvement team

		<p>people on the list</p> <p>% of people on the list issued with sick notes for a continuous period of sickness absence totalling 13 weeks or more</p>			
<p>National Primary Care Contracting Collaborative</p>	<p>Develop strong clinical and managerial leadership to drive improvement</p> <p>Develop information systems and use information to drive forward change</p> <p>Re-design the delivery of services to meet local need</p> <p>Align resources and incentives to support service delivery</p>	<p><u>Commissioning Systems</u></p> <p>% Practices using named benchmarked information on referrals to all providers</p> <p>% Practices participating in an agreed demand management incentive scheme</p> <p><u>Service Areas Management of sexual health services:</u></p> <p>3rd available appointment and waiting times for open access or drop in clinics</p> <p>Number of patients tested for <i>STIs or</i></p>	<p>22% improvement in the number of practices receiving and using information on referrals and use of services</p> <p>13% improvement in the number of practices participating in various demand management incentive schemes</p> <p>54% improvement in scores from the baseline Primary Care Contracting Assessment Framework The improvements have been across all measures.</p>	<p>5,000,000</p>	<p>28 PCTs</p> <p>140 General Practices</p> <p>140 GPs</p> <p>350 practice staff</p>

		<p><i>HIV</i></p> <p><u>Management of common mental health disorders:</u> % patients with a common mental health disorder referred for primary care based interventions (including lifestyle prescriptions) Number and % referrals for patients with a common mental health disorder accepted for management by secondary care</p> <p><u>Unique Care</u> Number of patients with complex needs requiring proactive management Number of acute medical admissions and bed occupancy for the over 65 population within the last 12 months</p>	<p>34% increase in the numbers of patients with a common mental health disorder referred for primary care based interventions (including lifestyle prescriptions).</p> <p>75% improvement in the number of patients identified with complex needs requiring proactive management.</p>		
Practice Based Commissioning	The change principles developed through this work include:		Ongoing Programme:		99% of PCTs engaged (150 out of 151 PCTs)

Development Programme	<p>Develop effective multidisciplinary teams across the whole pathway</p> <p>Process map and analyse the current patient pathway</p> <p>Apply the principles of advanced access at key points where patients wait</p> <p>Engage and involve patients and carers in pathway redesign</p>		<p>Large numbers of redesigned pathway examples being assembled from around the country for a range of priorities, demonstrating reductions in waits, shifting care, delivery of 18 weeks and release of efficiency savings for re-investment.</p>		<p>either in formal PBC programme or separate individual PBC support from IF Centres</p>
West Yorkshire Programme	<p><u>Care pathway redesign</u> Develop effective multidisciplinary teams Process map and analyse the current pathway Apply the principles of improving access Engage and involve patients and carers in pathway redesign</p> <p><u>Systems redesign</u> Create the</p>	<p><u>Systems</u> % of practise receiving benchmarked referral information % of practices involved in referral incentive schemes</p> <p><u>Care pathways</u> Length of wait from referral to first specialist appointment to first definitive treatment</p>	<p>Reduced waiting times of minimum of 50%</p> <p>57% reduction in numbers of patients waiting to access physiotherapy</p> <p>Reduced outpatient appointments by 40%</p> <p>Referral</p>	<p>3,000,000</p>	<p>15 PCTs</p> <p>5 Acute Trusts</p> <p>5 Geographical Sites</p> <p>Site improvement teams consisted of clinicians and managers from participating organisations</p> <p>150 people engaged in the</p>

	<p>environment for change</p> <p>Establish robust data/information systems</p> <p>Establish effective demand/capacity management arrangements within the PCT</p> <p>Align resources to support care pathway redesign and improvement</p> <p>Agree, monitor and manage activity and financial performance</p>		<p>management systems now in majority of PCTs</p>		<p>improvement teams including service users.</p>
<p>Scottish Primary Care Collaborative</p>	<p>Same change principles as for National Primary Care Collaborative</p>	<p>Same measures as for National Primary Care Collaborative</p>	<p>71% improvement in GP 3rd available appointment.</p> <p>59% improvement in Practice nurse 3rd available appointment.</p> <p>67% improvement in diabetic patients with cholesterol < 5 mmol</p>	<p>2,678,535</p>	<p>13 Community Health Partnerships</p> <p>450 practices</p> <p>450 GPs</p>
<p>Australian Primary Care</p>	<p>Same change principles as for National Primary Care</p>	<p>Similar measures as for National Primary Care Collaborative</p>	<p>81% improvement in percentage of patients with</p>	<p>(Non registered population in Australia)</p>	<p>41 Divisions of General Practice</p> <p>500 Practices</p>

Collaborative: Diabetes, CHD and access	Collaborative		diabetes with last recorded BP < or equal to 130/80 (within last 12 months) 63% improvement in CHD patients with last recorded BP < 140/90 41% improvement in Practice Nurse 3 rd available appointment		Now spreading to all divisions
Saskatchewan, Canada Primary care Collaborative: Diabetes, CHD and access	Same change principles as for National Primary Care Collaborative	Very similar measures as for National Primary Care Collaborative	25% improvement in patients with diabetes who received a urine microalbumin screening test (for kidney damage). 11% improvement in patients with diabetes prescribed statins	15,000 people	All Health Regions – 20% of physicians
Leadership for Quality Improvement Programme	<u>Aims</u> To assist public service providers with the capacity for developing Quality Improvement Leaders by delivering the		34% improvement in facilitating local improvement 37% improvement in confidence in leading		309 individuals have been through the Programme so far. Mixture of

	<p>national Leadership for Quality Improvement Programme (LQIP) for front line health and other public service professionals.</p> <p>To target the programme at those clinicians and managers that display leadership traits at the level they operate at (not necessarily those in senior positions)</p> <p>To make academic accreditation available to participants</p>		<p>improvement</p> <p>42% improvement in creating a vision for their organisation</p> <p>39% improvement in confidence in developing their team</p>		<p>managers and clinicians.</p> <p>240 of these have been GPs</p>
<p>Quality Improvement Skills Programme</p>	<p><u>Aims</u> To help front-line service providers develop the quality improvement skills need to improve their services.</p> <p>To provide a training programme for front line teams focusing on</p>		<p>Over 170 teams have participated so far including general practices, hospitals, dentistry, and pharmacy and PCT management.</p> <p>Big improvements in many different</p>		<p>170 Primary care Teams</p> <p>525 front line staff and managers received Quality Improvement Training</p>

	<p>the practical application of quality improvement techniques</p> <p>To help practices, PCTs, hospitals, dentists, prisons and other organisations to make sustainable changes by applying improvement skills to any clinical or organisational challenge.</p> <p>To make academic accreditation for available to participants</p>		<p>areas including disease management, access to services, wait times and operational management of services.</p> <p>86% of participants feel that QuISP training has helped them develop a “can do” approach to change and now regularly use the skills learnt to help them think about change.</p>		
<p>National Education Breakthrough Programme</p>	<p>Use strong leadership to create the environment for change.</p> <p>Focus on teaching and learning.</p> <p>Use targeted interventions including mentoring.</p>	<p>Range of measures assessing:</p> <p>Attainment, Motivation and Attendance in under-achieving boys.</p>	<p>Year 9: 43% at least 1 KS3 grade higher than baseline</p> <p>Year 11: 30% of the boys in the cohorts achieved at least 1 GCSE grade higher than baseline</p>		<p>145 Schools so far, 5 waves</p>

	Create capacity.				
	Use data to drive improvement.				