The Improvement Model (Nolan)

Before attempting to implement any change, it is essential to answer the following questions:

1. **What are we trying to accomplish?**
Know exactly what improvements are desired

2. **How will we know that change is an improvement?**
Without measurement, it is impossible to tell whether there has been an improvement

3. **What changes can we make that can lead to an improvement?**
Decide exactly what changes will bring about the improvements

PDSAs

Plan, **D**o, **S**tudy, **A**ct (PDSAs) break down ideas for improvements into small pieces of work allowing you to test changes (eg, trial telephone consultations with one GP for 1 week). Testing allows you to assess the impact of the change and see if it works without compromising existing services to the patient. One PDSA invariably leads on to another and because they are so small, they reduce the anxiety to change. In this way any member of the team can be involved and take ownership of the changes implemented in the practice, thus leading to more sustainable improvements.

Further information is available from:

www.cci.scot.nhs.uk

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NHS SCOTLAND

SCOTTISH PRIMARY CARE COLLABORATIVE

Phase II

A Guide for Health Care Professionals

healthier scotland
SCOTTISH EXECUTIVE

What is the Scottish Primary Care Collaborative?

The Scottish Primary Care Collaborative (SPCC) is one of a number of programmes run by the Improvement and Support function of the Scottish Executive Health Department's Delivery Group. The SPCC uses an improvement methodology based upon small rapid incremental cycles of change (PDSA's) used in conjunction with Langley Nolan's 3 improvement questions (see overleaf).

The methodology has been used successfully in America, England, Sweden and Australia. The programme, in Scotland, is initially concerned with improving access to primary health care professionals and improving quality of care for people with long term conditions. Practices currently involved in the programme, aim to:

- Generate early, demonstrable improvements in management of care of patients with long term conditions and in this instance coronary heart disease (CHD).
- Apply generic quality improvement methods and skills to at least one other topic within the second year of the Collaborative.

Specific Aims of the Scottish Primary Care Collaborative

- 90% of patients can access their primary health care professional, routinely, within one working day (see Advanced Access),
- Practices reduce mortality of patients with established CHD by 10% per year.

Monthly Measures

Monthly data must be submitted via the online reporting system to the Collaborative on the following measures:

Access

- GP 3rd available appointment
- PN 3rd available appointment
- % of patients seen on their day of choice
- Number of GP DNAs (Did Not Attends)
- Number of GP Locum sessions

CHD

- % of people with CHD on aspirin
- % of people with CHD on statins
- % of people with CHD up to 12 months post MI on Beta Blockers
- % of people with CHD with a last recorded BP reading of 140/80 in the last 12 months

Practices must also submit at least one PDSA (see overleaf) per month on both access and CHD

Advanced Access

Advanced Access means that a patient can have an appointment whenever they wish, today, tomorrow, next week or next month.

The first step towards Advanced Access is to understand demand. Once demand has been measured and analysed, work can be undertaken to reshape the handling of demand. This can be managed in a number of ways, for example by introducing telephone consultations, nurse or GP triage, PN minor ailment clinics.

The practice can then take steps to alter their capacity to their reshaped demand e.g. employing or training a current member of staff as a health care assistant. The formulation of robust practice based contingency measures and the continuous monitoring of demand will ensure that the equilibrium between capacity and demand is maintained.

Improvement in the care of people with CHD

CHD is the leading cause of premature death and mortality in the UK and is higher than in most other developed countries. There is a strong body of evidence supporting practical and often simple interventions that can significantly add years to life and life to years. The participating practices will be looking at the care they provide for their CHD population to explore ways in which care can be improved. The measures will be monitored monthly using the online database to track the improvements.