

Change Principles and Change Ideas

Change principles and change ideas are key components of the Collaborative methodology. They are the principles and ideas for action that the Expert Reference Panel (ERP) members for each topic area consider would secure the greatest improvement in that particular topic if they were implemented by those responsible for delivery of care.

The change principles are milestones that the practice should aim to achieve while the change ideas are the practical steps the practice will need to take to achieve them.

Topic	Access & Care Re-design		
Change Principle	1. Building the Practice Team	2. Foundation Work 2.1 Know your business	2.2 Change your business 3. Pathways
Change Ideas	<ul style="list-style-type: none"> • Set realistic goals • Communicate with other team members • Engage the practice team • Assign roles and responsibilities • Reflect & review what you are doing 	<ul style="list-style-type: none"> • Know your business <ul style="list-style-type: none"> ○ Understand current capacity of the practice ○ Understand the profile of demand 	<ul style="list-style-type: none"> • Change your business <ul style="list-style-type: none"> ○ Communicate with staff and patients ○ Shape the handling of demand ○ Shape patient behaviour ○ Match the capacity of the team to the reshaped demand ○ Embed and monitor the system ○ Contingency plan • Advanced access • Managing demand • Increasing capacity • Increasing quality

Topic	Diabetes				
Change Principle	1. Building the Practice Team	2. Establish a system for creating, validating and updating a register of people with diabetes	3. Be systematic and proactive in managing care	4. Involve patients in delivering and developing their care	5. Develop effective links with key local partners
Change Ideas	<ul style="list-style-type: none"> Set realistic goals Communicate with other team members Engage the practice team Assign roles & responsibilities around diabetes management Reflect & review what you are doing 	<ul style="list-style-type: none"> Agree on a clear definition of diabetes type 1 and diabetes type 2 Develop a register of people with diabetes Develop systems to maintain a valid register 	<ul style="list-style-type: none"> Establish systems for delivering care to patients with diabetes Establish appropriate care pathways for people with diabetes Establish proactive call and recall arrangements for people with diabetes Use guidelines, protocols and computer templates to support care delivery 	<ul style="list-style-type: none"> Implement a deliberate strategy for self-management Integrate the patient's perspective constantly in the design of services Ensure written and verbal communication is appropriate and understood Pay special attention to the needs of people from hard to reach groups Identify psychosocial factors which may affect patient care 	<ul style="list-style-type: none"> Analyse the patient journey and redesign where necessary Identify and engage local organisations and other sources of care in developing diabetes services Provide integrated care by improving the relationship between primary, secondary and tertiary providers

Topic	Coronary Heart Disease				
Change Principle	1. Building the Practice Team	2. Establish a system for creating, validating and updating a register of people with CHD	3. Be systematic and proactive in managing care	4. Involve patients in delivering and developing their care	5. Develop effective links with key local partners
Change Ideas	<ul style="list-style-type: none"> Set realistic goals Communicate with other team members Engage the practice team Assign roles & responsibilities around CHD management Reflect & review what you are doing 	<ul style="list-style-type: none"> Agree on a clear definition of CHD Develop a register of people with CHD Develop systems to maintain a valid register 	<ul style="list-style-type: none"> Establish systems for delivering care to patients with CHD Establish appropriate care pathways for people with CHD Establish proactive call and recall arrangements for people with CHD Use guidelines, protocols and computer templates to support care delivery 	<ul style="list-style-type: none"> Implement a deliberate strategy for self-management Integrate the patient's perspective constantly in the design of services Ensure written and verbal communication is appropriate and understood Pay special attention to the needs of people from hard to reach groups Identify psychosocial factors which may affect patient care 	<ul style="list-style-type: none"> Analyse the patient journey and redesign where necessary Identify and engage local organisations and other sources of care in developing CHD services Provide integrated care by improving the relationship between primary, secondary and tertiary providers

Topic	Chronic Obstructive Pulmonary Disease				
Change Principle	1. Build and maintain your practice team	2. Establish a system for creating, validating and updating a register of people with COPD	3. Be systematic and proactive in managing the care of people with COPD	4. Involve patients and their families in delivering and developing their care	5. Ensure effective co-ordination through the use of a multi-skilled and multi-agency approach
Change Ideas	<ul style="list-style-type: none"> Set realistic goals Communicate with other team members Engage the practice team Assign roles and responsibilities Reflect and review what you are doing 	<ul style="list-style-type: none"> Agree on a clear definition of COPD Develop a register of people with COPD (confirmed by spirometry and reversibility testing) Maintain an accurate record of smoking status in all patients Identify patients with undiagnosed COPD Develop systems to maintain a valid register 	<ul style="list-style-type: none"> Manage the care delivery provided to people with COPD through an established micro-multidisciplinary team Establish appropriate care pathways for people with COPD Establish proactive call and recall arrangements for people with COPD Use guidelines, protocols and computer templates to support care delivery 	<ul style="list-style-type: none"> Develop and implement deliberate strategies for self-management to allow patients and carers to better understand and manage their condition Integrate the patient's perspective constantly in the design of services Ensure written communication is appropriate and understood Pay special attention to the needs of people from hard to reach groups 	<ul style="list-style-type: none"> Identify and engage local organisations and other sources of care to provide best care to patients with COPD Analyse the patient journey and redesign where necessary Provide integrated care by improving the relationship between primary, secondary and tertiary providers

Topic	Chronic Disease Prevention and Self Management					
Change Principle	1. Build and maintain your practice team	2. Identify those people in your practice for whom risk assessments are recommended	3. Undertake the appropriate risk assessments on those identified	4. Deliver evidence-based and patient-centred interventions and other risk factor reduction strategies	5. Develop self management plans and systems to monitor and review those plans	6. Adopt a multi-skilled and multi-agency approach
Change Ideas	<ul style="list-style-type: none"> Set realistic goals Communicate with other team members Engage the practice team Assign roles and responsibilities Reflect and review what you are doing 	<ul style="list-style-type: none"> Identify individuals for whom risk assessments are recommended, using the evidence guidelines Understand the practice population Establish clear business rules around risk assessment 	<ul style="list-style-type: none"> Administer the appropriate risk assessment tool to those identified in need of risk assessment Develop 'high risk', 'medium risk' and 'low risk' registers for diabetes and cardiovascular disease Determine a system to maintain the 'registers' 	<ul style="list-style-type: none"> Establish appropriate care pathways, using evidence-based guidelines, to implement risk reduction strategies for: <ul style="list-style-type: none"> Individuals on the 'high risk' registers for diabetes and cardiovascular disease Individuals on the 'low risk' and 'medium risk' registers for diabetes and cardiovascular disease Establish a proactive call and reminder arrangement for individuals identified on the 'high risk' registers for diabetes and cardiovascular disease Tailor interventions to suit local needs Use guidelines, protocols and computer templates to support care delivery 	<ul style="list-style-type: none"> Establish clear definitions of self management and what providing self management support implies Organise internal and external resources to provide patient centred self management support Implement a deliberate strategy for self management support to allow patients and carers to better understand and manage their conditions Ensure written and verbal communication is appropriate and understood by the patient 	<ul style="list-style-type: none"> Analyse the patient journey and redesign where necessary Identify and engage local organisations and other sources of care in developing patient centred services Provide integrated care by improving the relationship between primary, secondary and tertiary providers