

Greater Glasgow and Clyde NHS Board

**Board Meeting
24 June 2014**

Board Paper No: 14 /36

Director of Public Health

KEEP WELL PROGRAMME UPDATE

RECOMMENDATIONS:

The NHS Board is asked to receive and note the content of the report and in particular:

1. The Scottish Government's decision to disinvest in Keep Well programme from April 2017
2. The on-going programme development and planning to build a lasting legacy from Keep Well
3. The challenges of this financial disinvestment and the impact on delivering system level prevention activities
4. Lessons learned from programme implementation and next steps

1. Keep Well national policy context

1.1. Policy origins and development

Keep Well was launched in 2006 as part of the Scottish Government's 2005 policy 'Delivering for Health' and was then expanded through successive policy developments, including Better Health Better Care (2007), Equally Well (2008) and the Healthcare Quality Strategy (2010). Its initial focus was to pilot anticipatory care on a large scale in disadvantaged areas across Scotland, with a primary focus on cardiovascular disease (CVD). Its core element, the Keep Well health check, targeted individuals residing in Scotland's most deprived areas by offering interventions to address modifiable CVD risk factors, health behaviours and wider social issues, e.g. high blood pressure, high cholesterol, smoking, overweight, mental health and wellbeing, employability, money advice and literacy.

The pilot programme was initially implemented within areas of concentrated multiple deprivation in NHS Greater Glasgow and Clyde (NHSGGC), Lanarkshire and Tayside.

Over the following 4 years the programme expanded in a succession of 'waves' across Scotland, with considerable variation in programme implementation.

1.2. Programme mainstreaming and subsequent disinvestment

In March 2010, in advance of publication of the final national programme evaluation report, the Scottish Government announced its intention to mainstream the programme across NHS Scotland, with programme funding becoming part of NHS Boards' general allocation from April 2014. Implementation guidance issued by the Scottish Government In March 2011 further broadened the focus of the Keep Well programme to specifically defined additional target population groups. These were South Asian and Black and Afro-Caribbean ethnic subgroups, gypsy travellers, offenders, homeless individuals, those affected by substance misuse; and carers. Although this guidance provided a common delivery framework for health boards, programme implementation across Scotland remained largely variable.

Interest shown in Keep Well by both the Parliamentary Public Audit Committee and the Health and Sports Committee, raised the profile of the programme and the requirement to demonstrate that Keep Well delivered value for money through measurable improvements in health outcomes¹. This prompted the Cabinet Secretary for Health and Wellbeing to request a full review of the Keep Well Programme in November 2013, seeking views from Health Boards regarding their commitment to the programme and potential impact of programme disinvestment.

NHSGGC strongly advocated that the Scottish Government continued sustained investment in the Keep Well anticipatory care programme in line with the mainstreaming aims to: *'shift primary care practice and culture towards anticipatory care and, in so doing, enabling primary care to pursue an assets-based approach that takes account of the wider life circumstances and emotional wellbeing of the patient population'*, (Keep Well extension programme guidance for NHS Boards, March 2011). However, NHSGGC did not support the continuation of the current national reliance on the CVD health checks, in line with the evidence amassed over the past four decades on 'heart health' initiatives predicated on screening for high CVD risk individuals. This evidence suggests that they achieve only small reductions in risk factors and thus represent a costly and relatively ineffective strategy.

In December 2013, the Scottish Government announced its decision to discontinue funding for Keep Well, ending in March 2017, with incremental reduction in funding over the intervening period. In light of this decision, NHS boards were encouraged to develop flexible and innovative approaches to delivering anticipatory care and were advised that

health check targets and associated national programme reporting would cease from April 2014.

2. NHSGGC Keep Well programme evolution and legacy

The Keep Well programme in NHSGGC has been extensively evaluatedⁱⁱ ⁱⁱⁱ and as a result of its findings, has explicitly sought to strengthen functioning connections between primary care clinicians and wider stakeholders. Rather than an over-reliance on individualised health checks, the NHSGGC Keep Well programme unequivocally placed emphasis on actions to systematically address health inequalities, in partnership with General Practices, through sustained investment in planned systems for primary prevention to:

- i) build capacity and systems in general practice to proactively engage with and respond to health and social needs of our most deprived neighbourhoods, and
- ii) create sustained, systematic, population level health improvement initiatives.

NHSGGC original Keep Well mainstreaming plans further committed to continue to align these efforts with proposals outlined by *General Practitioners at the Deep End*^{iv}. This included enabling co-production between general practices and area-based services via expansion of COPC approaches, developing infrastructure to support social prescribing via the expansion of our online service directory and providing backfill for general practice staff to participate in local service networking events.

2.1. GP Practice programme

From the outset, NHSGGC prioritised the delivery of Keep Well health checks from GP practice based settings. The pilot programme was implemented in 2006 within an initial 18 GP practices across North and East Glasgow. During the next 7 years, the programme extended to involve 151 GP practices serving our most deprived communities across NHSGGC area and delivered over 70,000 health checks up to 31st March 2014.

NHSGGC deployed **Community Outreach Workers** to support engagement of patients, where GP practice efforts had been unsuccessful, through adoption of both telephone and home visit engagement methods. Preliminary evaluation findings from this approach identified potential of these roles to:

- i) support patient engagement within other public health initiatives (e.g. chronic disease management, immunisation and screening programmes)
- ii) act as a mechanism to influence and support practices to change their patient engagement systems, and

- iii) contribute to community health improvement through family and social networks.

NHSGGC Keep Well Management Group in conjunction with Partnership Health Improvement teams, planned to commission Community Outreach services across NHSGGC from 1st April 2014, and undertake a more detailed service evaluation to establish greater evidence based and build the case for mainstreaming these roles. However, in response to the CMO's announcement, NHSGGC discontinued the delivery of Keep Well health checks from 1st April 2014, and consequently, plans for commissioning outreach services were also withdrawn.

Following this decision, NHSGGC commissioned an amended one year Keep Well Local Enhanced Service (LES) from existing Keep Well practices. The amended LES for 2014/15 has two main aims:

- i) to provide existing Keep Well practices with sufficient time to plan their own practice level arrangements in advance of the March 2015 end date; and
- ii) to support collaborative work with practices to leave a meaningful legacy of transferable learning and innovation following discontinuation of Keep Well.

The main findings from the evaluation of Keep Well in NHSGGC were translated into practical actions for practices and CHPs, in the form of an **Anticipatory Care Toolkit**, (Appendix 2) outlining improvement activities across the following 3 areas:

- i) Optimising patient engagement and reducing DNAs
- ii) Delivering person centred consultations
- iii) Supporting behaviour change and self management

The toolkit was piloted in a number of GP practices in Glasgow City NW sector in 2013, (Appendix 2). Feedback from the pilot practices suggested that the toolkit could also be useful in wider aspects of chronic disease management in primary care. As a result of the discontinuation of Keep Well primary prevention health checks from 1st April 2014, the anticipatory care toolkit was modified to support wider range of practice activity, in particular chronic disease management.

During 2014/15 contract year, participating GP practices are asked to complete a self assessment against all of the suggested areas of good practice described in the toolkit and develop a practice action plan, undertaking innovative improvement activities in ways that best fit practices' local context and systems. In addition, Public Health, Primary Care Support and Partnership Health Improvement teams will facilitate series of rapid improvement sessions to support sharing of learning, knowledge and approaches across participation practices. The programme will be evaluated during 2014/15, with

the hope to extend adoption of practical improvement ideas within wider GP contract arrangements and public health programmes as appropriate.

2.2. Creating a coherent system for Health Improvement in Primary Care

An integral element of NHSGGC Keep Well programme included additional investment in **health improvement services** through commissioning of third sector organisations to deliver services to address wider determinants of health, e.g. financial inclusion, mental health and wellbeing, and employability services. NHSGGC has also worked closely with our local authority leisure providers across all Partnerships to extend and concentrate provisions of our local physical activity programmes, including Live Active health coaching, Health Walks and Vitality programmes, within areas of concentrated deprivation. A **health improvement service directory** was developed to provide Practice staff with a single point of access to local service information and referral pathways. Keep Well also enabled additional **investment in Primary Care Support and Partnership Health Improvement Teams** to develop and strengthen the connectivity of relationships between clinicians and these wide range of support services.

The **Drumchapel Community Oriented Primary Care (COPC)** initiative, a partnership between Drumchapel GP practices, Glasgow City CHP North West Sector, Public Health and local community services and organisations, aims to strengthen the ability of local general practices to function as a coherent local public health programme. It combines the resources available from public health, e.g. local epidemiological profiling, service evaluation etc., and health improvement e.g. tailoring services and interventions to align with patients' needs with practices' own clinical experience and local knowledge.

Following the CMO announcement, a consultation with Partnership Health Improvement, Primary Care Support and Public Health senior management teams unequivocally noted the need to further extend and strengthen efforts to develop connectivity between Primary Care, health and social care and wider stakeholders as a fundamental element of integration.

2.3. Customised approaches for defined population subgroups

In addition to the GP practice based programme, NHSGGC invested additional capacity to support the identification, engagement and delivery of tailored health checks for defined population groups.

The **South Asian Anticipatory Care (SAAC)** project aimed to develop, optimise and test the effectiveness, efficiency and reaches of an anticipatory care programme to decrease the population impact of cardiovascular disease and associated health problems in minority ethnic groups, with a primary strategic focus on the South Asian population. SAAC was designed to deliver targeted, culturally appropriate anticipatory care via a set of engagement approaches based on shared language, familiarity, trust and cultural understanding. The SAAC team included a bi-lingual administrator, outreach worker and South Asian multilingual pharmacists. Following the discontinuation of Keep Well health check from 1st April 2014, the SAAC project concluded on 31st March 2014. Work is ongoing to build on the evaluation findings of the programme and develop sustainable approaches mainstream learning from this project to strengthen chronic disease management and access to wider community health improvement support.

NHSGGC Keep Well in Prisons programme provided dedicated capacity to enable the development and implementation of a comprehensive Offenders and Prisons Health Improvement Action Plan. In addition, funding was provided to manage and deliver Keep Well health checks within HMP Barlinne, Greenock and Low Moss. Like the SAAC project, Keep well health checks were discontinued from 1st April, with clinical staff time re-directed to the delivery of Wellman/women health reviews. A full review of anticipatory care and prevention programmes across all 3 establishments will be progressed during 2014 to further define health needs in relation to prevention and management of long term conditions, and establish delivery models appropriate to the needs of each establishment and population.

Following findings from NHSGGC **Keep Well Carers pilot**, 6 Carers Nursing posts, funded by Glasgow City CHP, have been created to support implementation of Glasgow City CHP Carers Information Strategy. These posts continue to build on lessons learned from the Keep Well carer's pilot and act as a link between NHS and Social Work to systematically support health needs of Carers across Glasgow City CHP via the delivery of holistic health checks.

The evaluation of NHSGGC Keep Well targeted programme demonstrated clearly that there are identifiable subgroups of patients, who have extensive unmet anticipatory care needs. Further focused effort is required to strengthen and coordinate our systems to promote health and increase access to culturally and inequalities sensitive healthcare across NHSGGC.

3. Challenges of programme disinvestment

NHSGGC had planned for, and implemented the mainstreaming of Keep Well on the basis of programme funding becoming part of NHS Boards' general allocation from 2014. The Scottish Government's announcement on the phasing out of Keep Well funding comes at a time of other challenging financial pressures. In addition to recent boundary changes, recent announcements have also been made by Scottish Government on discontinuation of other national ring fenced allocations to further preventive programmes, i.e. healthy weight programmes and Healthy Working Lives. The impact of all of this is a radically shrinking financial envelope for preventive public health services.

3.1. Programme funding 2013-2017

The current level of ring-fenced central funding (£11 million) will be sustained during 2014-15. After this, Scottish Government funding will reduce to £7 million and then to £3 million in 2015/16 and 2016/17 respectively. NHSGGC will receive a *pro rata* reduction proportionate to the above central allocation. Table 1 provides a summary of indicative programme funding. As individual Health Board proportion allocations from April 2015 have yet to be confirmed, figures below relating to 2015-2017 financial years should be considered with caution.

3.2. Current programme investments

NHSGGC explicitly invested in Keep Well as a means of strengthening connections between primary care, health improvement and public health activities. For this reason, the Keep Well programme supported an extensive range of vital preventative and health improvement services and support functions (Table 2).

Table 1: Anticipated Keep Well Programme Funding 2013– 2017

	2013/14 budget	2014/15 indicative budget	2015/16 indicative budget	2016/17 indicative budget	2017 onwards
National Programme Budget	£11,000,000	£11,000,000	£7,000,000	£3,000,000	£0
NHSGGC KW allocation*	£4,191,000	£4,191,000	£2,667,000	£1,143,000	£0
6.25% reduction due to Boundary Changes	-	-£261,938	-£166,688	-£71,438	-
Remaining NHSGGC Allocation	£4,191,000	£3,929,062	£2,500,312	£1,071,562	£0
Overall real % funding reduction	-	6.25%	40.3%	74.4%	100%

* based on NHSGGC 2013/14 allocation of 38.1%

NHSGGC Keep Well programme now funds a sizeable proportion of vital preventative and health improvement services in NHSGGC, although there is considerable variability in this proportion across partnerships. As detailed in Table 2, this includes both centrally and locally services and support functions. Following consultation with Partnerships, Public Health and Primary Care Support, it is clear that disinvestment in prevention activities on this scale will have a detrimental impact on our ability to deliver a coherent, integrated programme of anticipatory care. This would significantly compromise NHSGGC’s ability to ‘turn off the tap’ of chronic disease incidence and progression, both of which are powerful drivers of need and demand for increasingly scarce healthcare resources.

4. Lessons learned and next steps

The Keep Well programme offers a valuable learning opportunity in relation to the public health policy and programme development and implementation by ensuring:

- i) an emphasis on building on existing knowledge and evidence base
- ii) development of a robust transition plan from other similar demonstration projects rather than creation of new initiatives
- iii) the development of a well designed evaluation plan from the outset
- iv) engagement of all relevant stakeholder from the start

- v) sufficiently resourced programme support/infrastructure (including information systems, programme management capacity and workforce development planning)

Table 2: 2013/14 Keep Well programme investments (approximate)

Directly Employed Staff	No WTE staff	Costs (approximate)
Public Health Programme/HI Staff	3.5	£160,000.00
Partnership Health Improvement Staff	8	£341,000.00
Partnership Programme Support Staff	6	£162,000.00
Prisons Keep Well/HI programme staff	3.5	£120,000.00
Primary Care Support / Practice Development Staff	5.5	£161,000.00
South Asian Anticipatory Care Project Staff	2	£62,000.00
HI Service Delivery Contribution (all Partnerships)		
Live Active		£200,000.00
Vitality		£ 25,000.00
Money Advice		£230,000.00
Employability		£60,000.00
Mental Health / Stress Management		£160,000.00
Programme Specific Investments		
GP Practice Payments - Keep Well LES		£1,000,000.00
Patient Outreach (disinvested from April 2014)		£350,000.00
Other		
Local services investment and programme costs		£160,000.00
Contribution to Partnership Savings		£1,000,000.00

Tackling the burden of preventable ill-health and resultant demand on healthcare services requires the balance of spend to be shifted in favour of prevention. However, only 2-3% of total NHS expenditure currently goes toward population-wide prevention and public health programmes, with most spending focused on 'illness care' services. Keep Well programme investment has represented a small but vital step towards rebalancing this position. The Keep Well programme disinvestment poses a real risk of a return to silo based health improvement activities, at the expense of integrated prevention activities across health, social care and 3rd sector partners, aiming to embed health improvement within core service delivery.

The NHSGGC Keep Well Management group will continue to work closely with Partnership Directors to develop a financial disinvestment plan and agree appropriate mechanism to mainstream key elements of programme learning outlined in this paper in advance of funding cessation in 2017. It is imperative however that this takes cognisance of the wider financial pressures, to maximise leverage of our existing investments in health improvement and anticipatory care.

Appendix 1 CMO Letter



Keep Well - Letter
from CMO to Chief Ex

Appendix 2 NHSGGC Anticipatory Care Toolkit



Anticipatory Care
Toolkit 2014.pdf

ⁱ Public Audit Committee. 3rd Report, 2012 (Session 4) Cardiology Services
<http://www.scottish.parliament.uk/parliamentarybusiness/CurrentCommittees/54692.aspx>

ⁱⁱ Scoular A, Evaluation of 'Keep Well' programme in NHS Greater Glasgow & Clyde, May 2012
http://library.nhsgg.org.uk/mediaAssets/Keep%20Well/KW_FINAL%20REPORT_Evaluation%20Wave%201-4_060512.pdf

ⁱⁱⁱ Scoular A, Prevention 2012: Acting on the evaluation findings of 'Keep Well', July 2012
(incorporated within Board Paper No.12/35)
<http://library.nhsggc.org.uk/mediaAssets/Board%20Papers/12-35.pdf>

^{iv} General Practitioners at the Deep End - What can NHS Scotland do to prevent and reduce health inequalities? March 2013.
http://www.gla.ac.uk/media/media_271030_en.pdf

Chief
Medical
Officer
and
Public
Health
Directorate

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Chief
Executive

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Copy:
Directors
of

13 December 2013

Dear Colleague

KEEP WELL ANTICIPATORY CARE HEALTH CHECKS

I wrote to you on the 4th of November requesting some information about the Keep Well programme. My thanks to those who have submitted a reply including the joint response from the Directors of Public Health.

There is clearly some success with Keep Well, particularly when it comes to reaching and engaging with people who are less likely to see their GPs in areas of socio-economic deprivation. Although there is positive work happening as a result of Keep Well locally, the difficulty is gaining a national picture in terms of medium and long term outcomes and effectiveness.

A decision has been made to gradually decrease the current level of central funding provided by the Scottish Government with a view to disinvesting by 2017. The expectation is that NHS Boards will prioritise locally in terms of services to be retained through existing resources.

The current level of central funding at £11 million will be sustained for 2014-15 to give NHS Boards an opportunity to plan ahead. This will be reduced to £7 million in 2015-16 and to £3 million in 2016-17, thereafter the funds will cease. Individual Board allocations will be re-calculated from 2015.

Boards will no longer be required to report centrally on a monthly basis from the next financial year onwards. NHS Health Scotland will continue to provide national

support for the current year and will work with Boards to wind down support in time for the year end.

I would encourage you to consider these changes as an opportunity to take a more flexible and innovative approach to delivering anticipatory care interventions.

Yours faithfully,

Sir Harry Burns
Chief Medical Officer

Anticipatory Care Toolkit: Applying Keep Well learning to chronic disease management in General Practice



“The NHS should work with other public services and with patients and carers to provide continuous, anticipatory care to ensure that, as far as possible, health crises are prevented”

Delivering for Health, 2005



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Health Inequalities

Health inequalities, defined as systematic differences in life expectancy and health problems among different population subgroups, represent a significant challenge in Scotland. Although healthy life expectancy has increased in recent years and the overall health of the Scottish population is improving, stark problems remain, with significant variation among people depending on their age, gender, disability status, residential area, ethnic group and socio-economic deprivation. People from Scotland's most deprived communities are more than three times as likely to have multiple risk factors than those from the least deprived.

Keep Well In Scotland

Keep Well was established in 2006 by the Scottish Government to deliver anticipatory care in disadvantaged areas across Scotland, with a major focus on primary prevention of cardiovascular disease. Although the Scottish Government has recently announced its decision to discontinue funding for Keep Well, in NHS GGC we have explicitly invested in Keep Well as a means of strengthening connections between primary care, health improvement and public health activities; this type of coordinated action is vital for effectively tackling the health challenges we face in the most deprived areas of Scotland.

An Exemplar For Anticipatory Care

Keep Well was part of NHS GGC's Anticipatory Care Framework¹. This defines anticipatory care as:

An integrated programme of defined preventive interventions delivered to individuals, operating across the continuum of primary, secondary and tertiary prevention. Its overall aim is to shift the focus of service provision from reactive to preventive care, by adopting a whole population perspective across all aspects of service planning and delivery.

The evaluation of Keep Well in NHS GGC as much to teach us about wider anticipatory care programmes^{2,3}. In the Keep Well programme, variation at three critical points was shown to be a major factor in the programme's overall effectiveness:

Before engagement (effectiveness of engaging subgroups with greatest need).

At the consultation (effectiveness of initiating changes in health literacy, risk factors, health associated behaviours and use of wider practice systems).

After the consultation (sustained change following the consultation, both at individual patient level and in the overall responsiveness of local health improvement services).

Purpose Of The Anticipatory Care Toolkit

We want to ensure that Keep Well leaves a lasting legacy by applying some of its learning to the wider spectrum of anticipatory care, specifically to chronic disease management, which shares many common activities with Keep Well. This toolkit captures important Keep Well evaluation findings and incorporates these into practical actions for practice activities across three areas of high impact change:

High impact change 1:

Optimising patient engagement and reducing DNAs

High impact change 2:

Delivering person centred consultations

High impact change 3:

Supporting behaviour change & self-management

Each of these sections provides a summary of key programme learning, and practices are asked to undertake the following:

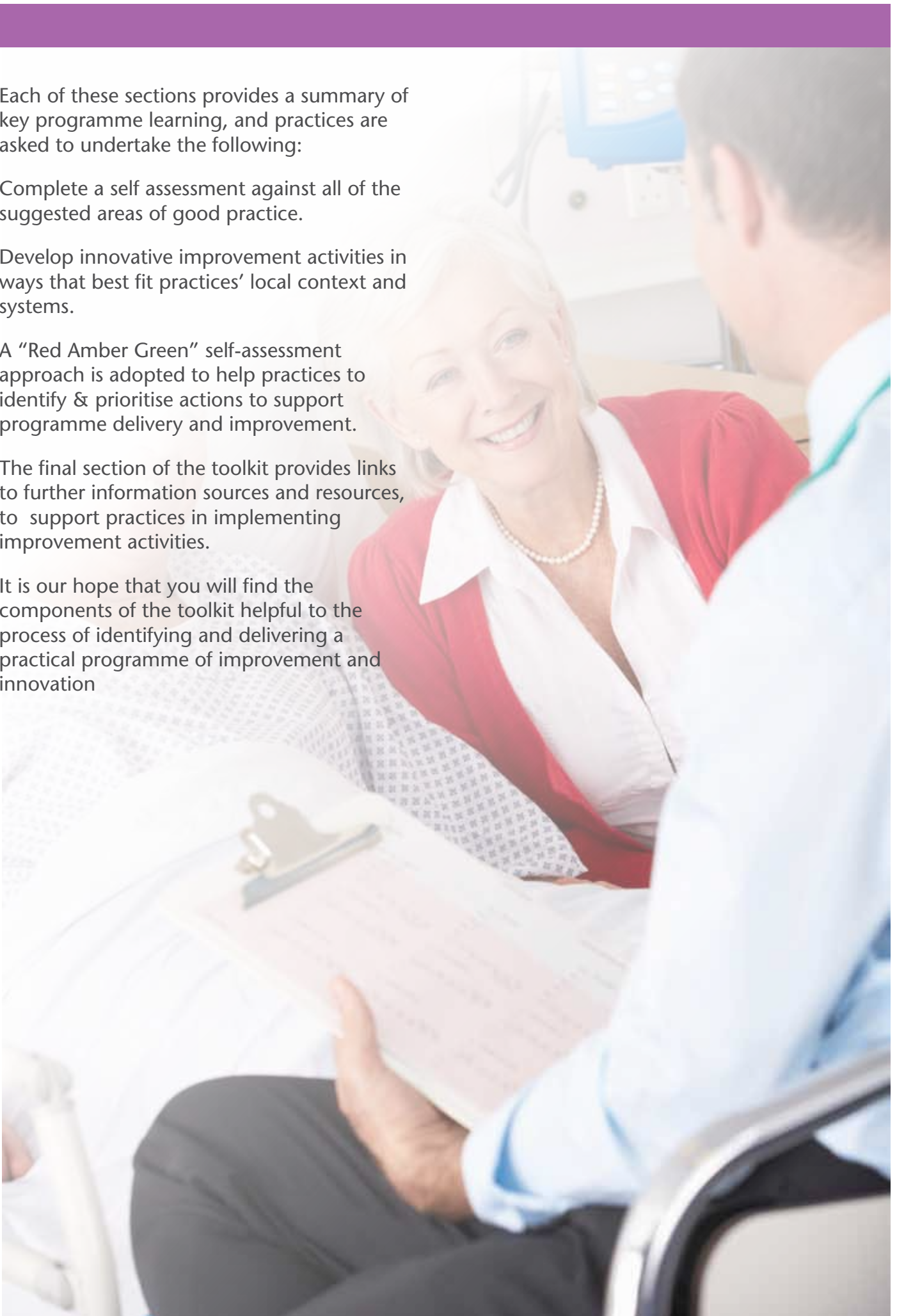
Complete a self assessment against all of the suggested areas of good practice.

Develop innovative improvement activities in ways that best fit practices' local context and systems.

A "Red Amber Green" self-assessment approach is adopted to help practices to identify & prioritise actions to support programme delivery and improvement.

The final section of the toolkit provides links to further information sources and resources, to support practices in implementing improvement activities.

It is our hope that you will find the components of the toolkit helpful to the process of identifying and delivering a practical programme of improvement and innovation



Understanding Patient Engagement Barriers And Motivations

Research exploring the facilitators and barriers to engagement within preventive healthcare care indicated three broad characteristics of patients based on their general attitudes towards health and their perceived value of Keep Well health checks in particular⁴.

Health involved:

- Generally 'early adopters' of preventive healthcare, convinced of the benefits that accrue from making the effort to stay healthy.
- Few if any attitudinal barriers to engagement in preventive healthcare.
- However it is still beneficial to ensure that any potential practical barriers are minimised, e.g. by providing a degree of flexibility in appointment times.

Healthy enough:

- Acknowledge that health is important, but a direct link between an improved life and improved health is not clear to them, and other life issues have priority.
- Feel sufficiently healthy and as such that no additional effort is urgently required.
- Emotional barriers and rational misperceptions, as well as even minimal required effort or inconvenience, mean that an invitation to participate in a health check is likely to be declined or simply ignored.
- Engagement approaches include testimonials of those who have benefited from a health check, focusing on other life priorities as reasons to stay healthy. A phone call following any letters to confirm/rearrange /arrange appointment.

Health Wary:

- Characterised as having significant emotional barriers to attending preventive healthcare.
- These barriers are apparently so profound as to demand face-to-face 'coaxing', directly reassuring the individual of the benefits of participation.

The research clearly demonstrated that no single approach will engage all three groups.

PRACTICE FACTORS

Although there was widespread intuitive knowledge of strategies that can increase attendance at Keep Well consultations among primary care professionals, there was enormous variation in the extent to which it is systematically applied.

During the course of Keep Well, the presumption has been that it is patient-related factors, such as fear, apathy, health service avoidance, and health service over-consultation, which are the major barriers to engagement with the programme, and that the key to improved engagement was to address these factors. However, what seems to be an equally significant indicator of attendance are practice-related factors, such as the engagement approach, patients' previous experiences with primary care and the accuracy of patient data (e.g. up-to-date phone numbers, ethnicity, communication and language needs).

Even patients with significant emotional or practical barriers to attending an anticipatory care health check can still be engaged through a non-judgmental, empathetic approach and appointment flexibility (Table 1).

Types of unengaged patients	Method(s) with limited success	Method(s) with greater success
Patients who work during the day	Daytime phone calls to a home number Open invitation letters (patient must remember/find time to call the practice during working hours)	Evening phone calls Texts Emails Fixed appointment invitations with the option to reschedule
Patients who tend to avoid health services and other establishments	Open invitation letters (which put the onus on the patient to take action) Invitation phone calls made by staff unfamiliar with Keep Well or not confident when phoning	Phone calls made by Keep Well staff Handwritten invitation sent in handwritten envelope, without practice stamp
Patients with literacy issues	Invitation letters	Phone calls Opportunistic appointments
Patients who are hearing impaired	Phone calls	Invitation letters Opportunistic appointments
Patients who are visually impaired	Invitation letters	Phone calls Opportunistic appointments
Patients who speak English as a second language	Phone calls (very often, English is more confidently read than spoken or understood)	Fixed appointment invitation letters
Patients who have refused in the past	Open invitation (no opportunity for further explanation of why the check is important) Invitation phone calls made by staff unfamiliar with Keep Well or not confident when phoning	Phone calls
Patients who have DNA'd in the past	Fixed appointment invitations	Phone calls Reminder letters/calls/texts

Table 1: Approaches to engage previously un-engaged patients

High impact change 2: *Delivering person-centred consultations*

Definition of person-centred consultations

Person-centred care is defined by the Institute of Medicine (IOM) as:

“Healthcare that establishes a partnership among practitioners, patients and their families (when appropriate) to ensure that decisions respect patients’ wants, needs and preferences and that patients have the education and support they need to make decisions and participate in their own care”.
(IOM, 2001)⁵

Key elements of person-centred consultations

There is evidence that Chronic Disease Management (CDM) consultations that include risk factors, education and counselling bring clear patient benefits, including reduced risk of mortality, disease progression and recurrent events. A review by Greenhalgh & Heath for The Kings Fund⁶ concluded that person centred consultations:

- Improve patient satisfaction.
- Improve professional fulfillment.
- Save time.
- Increase compliance with therapy.

A person centred consultation:

- Is a collaborative approach which combines clinical guidance and support with addressing patient’s priorities
- Fits with a patient’s expectation of the consultation, their concerns and information needs.
- Explores the patient’s physical, emotional and social circumstances.
- Establishes if there are any problems and facilitates agreement on their management
- Promotes health.
- Enhances a relationship between the clinician and the patient.

Supporting delivery of person-centred consultations

Important components of CDM delivery systems include structured multidisciplinary team care, integrated decision support via electronic templates and other supportive information technology, provider expertise and skill, education and support to patients. The CDM Local Enhanced Services (LES) templates are designed to support practitioners to deliver a high quality, person centred CDM consultation that helps practitioners make decisions in conjunction with your patient and take the right action in improving their care. These consultations will achieve more successful outcomes when they support a process of change, rather than simply recording patient status and providing advice.

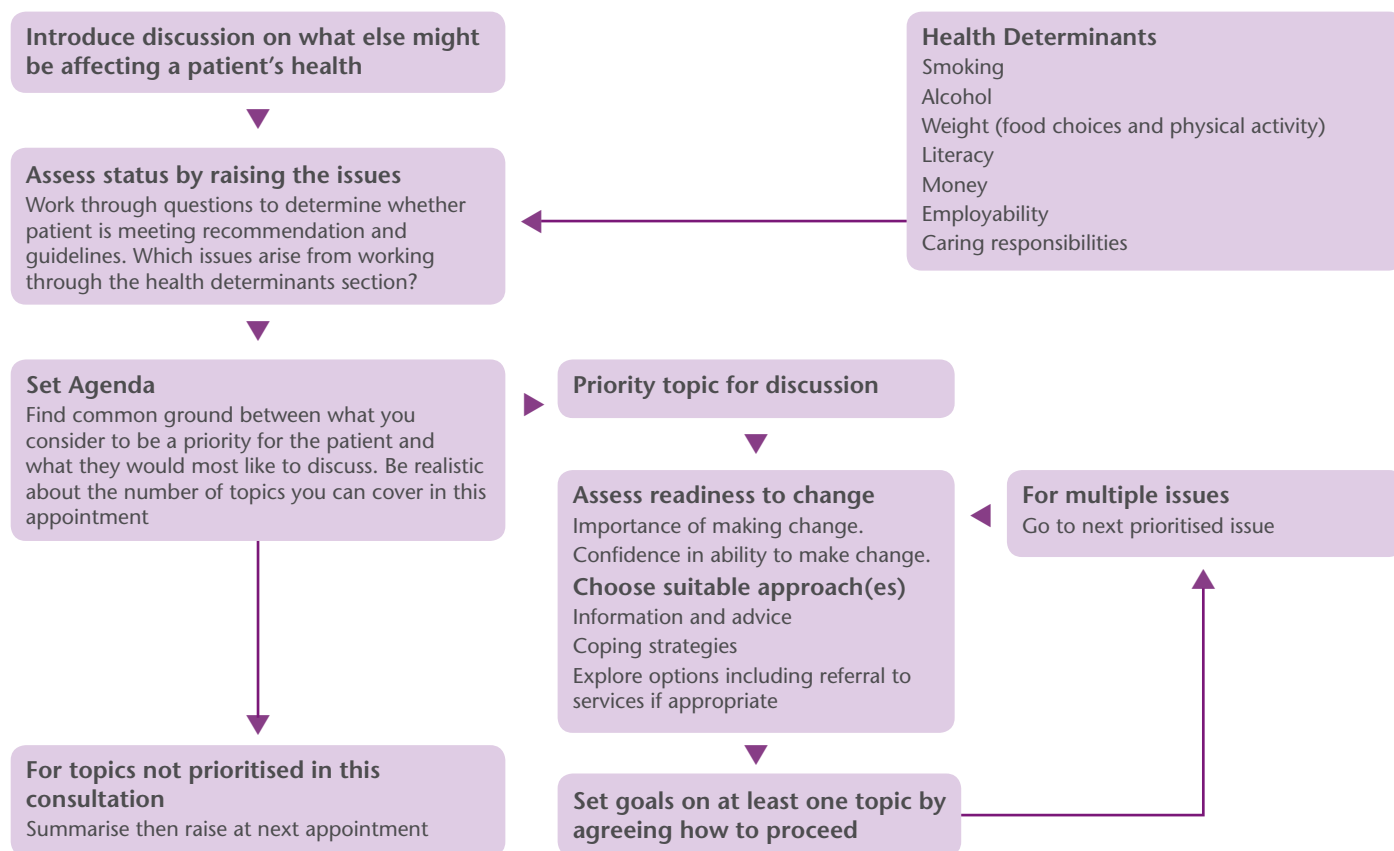
Skills such as effective communication, brief interventions and motivational interviewing can support the practitioner to deliver effective person centred consultations. These skills can encourage a patient to engage, participate and make a personal investment in changing their health behaviours. A systematic review and meta-analysis showed that motivational interviewing outperforms traditional advice giving in the treatment of a broad range of behavioural problems and diseases⁷.

The health determinants section of the CDM template facilitates a person-centred conversation around lifestyle and life circumstances. It helps to:

- **Identify the issues affecting the patient’s health and wellbeing.** By assessing status, the practitioner can identify topics which might be affecting the patient’s ability to manage their long term condition.
- **Provide a framework for addressing priority issues.** By setting an agenda, practitioners will have the time to find common ground between what we recognise as important topics to raise and what the patient would like to discuss further.

The structure of health determinants template is based on the brief intervention framework (figure 1).

Figure 1: Brief intervention framework



Following this brief intervention framework supports practitioners to adopt an evidence-based approach to addressing life style issues. It provides alternative and sensitive strategies to support patients to make changes. The brief intervention allows practitioners to do this while involving patients as partner in managing their own health.

Brief Intervention Framework - a four stage approach

1 Health determinants status check

Through the use of open questions, the practitioner can identify where patients are not meeting recommendations and/or experiencing problems around key lifestyle factors and life circumstances.

2 Agenda setting

This allows patients and practitioners to identify the topics they would like to discuss

further and jointly agree the focus of the consultation. Evidence shows that patients feel dissatisfied with their experience if the practitioner focuses on a topic that is not important to them. Therefore, collaboration is crucial.

3 Readiness to change/topic discussion

Once the topic has been agreed, the next step is to assess the barriers to behaviour change for the patient. This will include how important the change might be for the patient, and how confident they are to make that change.

4 Goal setting

Setting a goal allows the person to take control of their health. Evidence shows that choosing small, achievable goals is most effective as it can build confidence and momentum.

High impact change 3: *supporting behaviour change and self-management*

Access to Services

NHSGGC Keep Well evaluation demonstrated substantial variation in referral activity across participating GP practices relative to identified needs of patients within the Keep Well health check.

Facilitating access to services is about helping people to command appropriate resources in order to preserve or improve their health. Access to services is about more than ensuring that there is adequate service provision. They have proposed four dimensions of accessibility:

- Service availability
- Utilisation of services and barriers
- Relevance and effectiveness
- Equity

Gilford et al (2002)⁸

They suggest that barriers which prevent people from using services can be categorised as personal, financial and organisational. Work within NHS GGC Primary Care Inequalities Project highlights barriers such as embarrassment at being referred to particular services (personal), being offered services out with their geographical area (financial/organisational), long waiting time for some services (organisational).

Ensor and Cooper⁹ have further highlighted what they term as demand side barriers and suggest a range of issues can affect whether an individual uses available services suggest some examples of methods to improve service uptake including:

- Information on service choices/providers
- Information on when to access services and the range of services available
- Accreditation systems to indicate preferred services

- Community and cultural preferences, attitudes and norms
- Culturally sensitive services

Promoting awareness of services

NHS GGC has invested in a range of services, which have been acknowledged as having a key role to improve health outcomes, including stop smoking, mental health & well being, physical activity, weight management, health literacy services, financial inclusion, and employability services.

Within NHS GGC the development of the Health Improvement Service Directory (HISD) has enabled health improvement and self management service details, local service pathways, referral forms etc for all CH(C)Ps to be located at a single point of access.

This directory can be accessed via the CDM templates or via the following address:

www.nhsggc.org.uk/infodir

Building relationships between practices and wider service providers

Community Health (& Care) Partnership Health Improvement Teams provide local opportunities for GP practice staff and local community service to network, with the aim of increasing awareness of services available in the local area. Contacts for local Health Improvement Teams are provided in the useful contacts section.

Anticipatory Care Self-Assessment Tool

This tool uses the Red/Amber/Green system to assess the current situation for each item.

Red: Ambition not achieved

Amber: Ambition is achieved but further work needed to maintain performance

Green: Ambition is achieved and is being maintained or improved

Item	Ideas for improvement	R	A	G	Where are we now
<p>High Impact Change 1: Maximising patient engagement & reducing DNA's</p> <p>Change Principle: Our Practice delivers flexible engagement approaches to meet the needs of individual patients in order to maximise uptake of CDM Consultations</p>					
1.1	All Practice staff have been briefed on the aims and purpose of the CDM programme and recognise their role in patient engagement				
1.2	Our Practice has clear systems in place to ensure patient contact details are up to date including patients who do not regularly attend the practice.				
1.3	Our Practice staff record patients' ethnicity, language and communication needs.				
1.4	All our Practice staff adapt patient engagement approaches to reflect communication and access needs, (e.g. Deaf, Blind, low literacy, English not first language)				
1.5	Before attempting engagement we use our shared knowledge of the patient to tailor approaches (e.g. DNA history)				
1.6	Our Practice has EMIS/Vision alerts in place to support opportunistic engagement with target / high risk patients				
1.7	Our patient invitation letters have been developed in line with NHSGGC Accessible Information Policy and taking into account patient feedback				
1.8	All staff responsible for making appointments via telephone have received training on telephone engagement skills				
1.9	Our patient engagement approaches include contacting patients out of a standard working day				
1.10	Our patient engagement approaches include making use of facility to send SMS messages				
1.11	We have ongoing monitoring process to review effectiveness of our patient engagement approaches and act accordingly				

Item	Ideas for improvement	R	A	G	Where are we now
<p>High Impact Change 2: Delivering person centred consultations Change Principle: All staff understand the effects of health inequalities and social determinants of health and have necessary knowledge and skills to help them support patients to make positive lifestyle change and reduce risk factors</p>					
2.1	All staff responsible for delivering the health review (all or in part) understand the aims and purpose of the CDM annual review consultation				
2.2	All staff responsible for delivering CDM annual reviews are familiar with and confident in using the clinical and health determinants template by attending a training session and understand the principles of the template				
2.3	All staff responsible for delivering CDM annual reviews have completed training in motivational interviewing and health behaviour change (e.g. NHS GGC half day Introduction to Health Behaviour Change).				
2.4	All relevant staff are familiar with NHS GGC Interpreting Policy and good practice guidelines for working face to face with interpreters and act accordingly				
2.5	All staff responsible for delivering CDM annual reviews have completed equalities / inequalities sensitive practice training (e.g. NHS GGC training modules, RCGP)				
2.6	All staff delivering CDM annual reviews have had an induction programme appropriate to their role and are adequately mentored/ supported by practice team				
2.7	We ensure that appointment system is working well and appointment length supports high quality consultations for patients and staff				
2.8	Practitioners have sufficient time allocated to CDM annual review consultations to allow the practitioner time to review patient history in advance of the CDM consultation				
2.9	We use learning from any significant events arising from the delivery of CDM annual review consultations				
2.10	We obtain and use patient feedback / experience				

Item	Ideas for improvement	R	A	G	Where are we now
<p>High Impact Change 3: Supporting ongoing patient behaviour change & self-management</p> <p>Change Principle: We encourage people to enhance their health and well being by supporting self-management and signposting people to the type of services and information they need</p>					
3.1	All practice staff have a working knowledge of the NHSGGC Health Improvement Service Directory www.nhsggc.org.uk/infodir				
3.2	All relevant staff are aware of health improvement and patient education programme service referral pathways				
3.3	We create/participate in opportunities to maintain relationships with local service providers				
3.4	We work collaboratively with patients to set and record goals within the patient notes to enable practice staff to have access during future consultations				
3.5	We follow up CDM patients referred to health improvement services at future encounters with the patient				
3.6	We have up to date written information on local health improvement services available to our patients				
3.7	The ethos of the practice is to reinforce behaviour change messages at all clinical encounters, providing ongoing support and facilitating referrals to local health improvement services where beneficial				

Action Plan Template

Item	What we are going to do	Who will be involved	How will we know if it works	When do we expect to achieve the goal
<p>High Impact Change 1: Maximising patient engagement & reducing DNA's Change Principle: Our practice delivers flexible engagement approaches to meet the needs of individual patients in order to maximise uptake of CDM Consultations</p>				
<p>High Impact Change 2: Delivering person centred consultations Change Principle: All staff understand the effects of health inequalities and social determinants of health and have necessary knowledge and skills to help them support patients to make positive lifestyle change and reduce risk factors</p>				
<p>High Impact Change 3: Supporting ongoing patient behaviour change & self-management Change Principle: We encourage people to enhance their health and well being by supporting self-management and signposting people to the type of services and information they need.</p>				

References

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<http://library.nhsggc.org.uk/mediaAssets/Board%20Papers/12-35.pdf>
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2. Scoular A, Evaluation of 'Keep Well' programme in NHS Greater Glasgow & Clyde, May 2012
http://library.nhsggc.org.uk/mediaAssets/Keep%20Well/KW_FINAL%20REPORT_Evaluation%20Wave%201-4_060512.pdf
[Accessed March 2014]
3. Scoular A, Prevention 2012: Acting on the evaluation findings of 'Keep Well', July 2012 (incorporated within Board Paper No.12/35)
<http://library.nhsggc.org.uk/mediaAssets/Board%20Papers/12-35.pdf>
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4. Reid M, Report of research to explore motivators and barriers to engagement with Health Checks. Health Scotland, January 2009.
http://www.healthscotland.com/uploads/documents/9305Motivators%20and%20%20Barriers%20to%20_Health%20Checks.pdf
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www.iom.edu/.../2001/Crossing-the-Quality-Chasm/Quality%20Chasm%20
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http://www.kingsfund.org.uk/sites/files/kf/field/field_document/quality-therapeutic-relationship-gp-inquiry-discussion-paper-mar11.pdf
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Health Matters - Conversations about Change

Course summary:

Lifestyle choices like what we eat, how active we are, the amount of alcohol we drink, if we smoke and life circumstances e.g. finances etc have a significant impact on the health of individuals and communities. Many of us in our day to day work have the opportunity to talk with our client group about lifestyle choices and how they impact on health and wellbeing. NHS GGC have developed a range of health behaviour change training to support person centred methods of talking about and supporting health behaviour change.

By the end of the course, participants will be able to:

- Identify factors which influence decisions to change and consider health inequalities
- Introduce communication skills including open questioning, reflecting, giving feedback and summarising
- Describe the range of services that can provide support to individuals to enable lifestyle change
- Identify opportunities in your own practice to incorporate conversations about change

This course is aimed at practitioners who:

- Have had little or no health behaviour change training
- Have the opportunity to discuss lifestyle and behaviour issues with individuals.

For further information email HIADMIN@ggc.scot.nhs.uk.



Useful Resources / Links

Healthcare Support Workers (HCSW) Competency Framework, NHS Health Scotland, May 2012

<http://www.healthscotland.com/documents/5881.aspx>
[Accessed March 2014]

NHS GGC Interpreting Policy and guidelines, March 2012

http://library.nhsggc.org.uk/mediaAssets/Procedures/nhsggc_policy_interpreting.pdf
[Accessed March 2014]

NHS GGC Equalities Toolbox

http://www.equalitiesinhealth.org/public_html/toolbox.html
[Accessed March 2014]

NHS GGC Health Improvement Service Directory

http://www.nhsggc.org.uk/content/default.asp?page=home_Health%20Improvement%20Directory
[Accessed March 2014]

NHS GGC Public Health Resources Directory –online resource ordering facility

<http://www.phrd.scot.nhs.uk/HPAC/Index.jsp>
[Accessed March 2014]



Useful Contacts

CHCP Health Improvement Teams	
East Dunbartonshire CHCP	Telephone: : 0141 355 2356 Web: www.chps.org.uk/eastdunbartonshire/
East Renfrewshire CHCP	Telephone: 0141 577 8436 Web: http://www.eastrenfrewshire.gov.uk Email: HITeam@eastrenfrewshire.gov.uk
Inverclyde CHCP	Telephone: 01475 506 029 Web: www.chps.org.uk/inverclyde
Glasgow City CHP – North East Sector	Telephone: 0141 232 0185 Web: www.chps.org.uk
Glasgow City CHP – North West Sector	Telephone: 0141 211 0614 Web: www.chps.org.uk
Glasgow City CHP –South Sector	Telephone: 0141 232 8035 Email: Pollok.HIAdmin@ggc.scot.nhs.uk
Renfrewshire CHP	Telephone: 01505 821 800 Web: www.chps.org.uk/renfrewshirehealthimprovement
West Dunbartonshire CHCP	Telephone: 01389 744 650 Web: www.wdchcp.org.uk
Practice Nurse Support Team	
Telephone: 0141 211 3632 Email: PNATeam@ggc.scot.nhs.uk Web: http://www.staffnet.ggc.scot.nhs.uk/Partnerships/Greater%20Glasgow%20and%20Clyde%20Services/Primary%20Care%20Support/Practice%20Nurses/Pages/default.aspx	
Public Health Keep Well / CDM Team	
Telephone: 0141 201 4538 Email: Keepwell1@ggc.scot.nhs.uk Web: http://www.nhsggc.org.uk/content/default.asp?page=home_keepwell	





CONTACT DETAILS

Public Health Directorate - Health Services Section
Email: Keepwell1@ggc.scot.nhs.uk
Direct Line: 0141 201 4538

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