NHS Greater Glasgow and Clyde

Keep Well Toolkit: Supporting delivery of primary prevention and early intervention in General Practice

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Keep well

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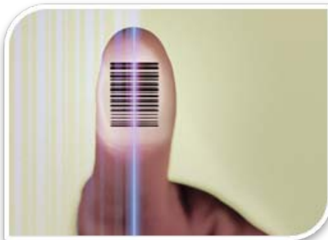

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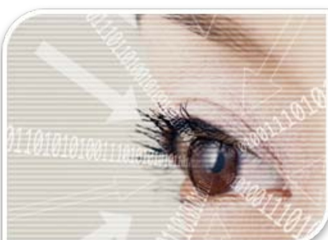

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> “The NHS should work with other public services and with patients and carers to provide continuous, anticipatory care to ensure that, as far as possible, health crises are prevented”
>
> *Delivering for Health, 2005*

INTRODUCTION

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.

Data from the Scottish Health Survey show that the prevalence of various combinations of cardiovascular disease (CVD) risk factors (smoking, alcohol, diet, overweight/obesity, and physical inactivity) is exceptionally high in the Scottish adult population, nearly all of whom (97.5%) have at least one behavioural risk factor for CVD. 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.

ANTICIPATORY CARE IN SCOTLAND

Keep well was established in 2006 by the Scottish Government to deliver anticipatory care in disadvantaged areas across Scotland, with the aim of reducing cardiovascular disease and its risk factors. The programme focuses on identifying, engaging with, and offering health checks to individuals at the greatest risk of preventable ill health, by strengthening primary care and health improvement services in the most deprived areas of Scotland.

ANTICIPATORY CARE IN NHS GREATER GLASGOW & CLYDE

NHSGGC Anticipatory Care Framework (2011) 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*

NHSGGC continues to prioritise delivery of Keep Well from GP practice based settings to facilitate sustainable coverage of our most deprived neighbourhoods. The Keep Well health checks are an integral part of the programme, acting as a catalyst for GP practice engagement and providing an opportunity to engage patients in their own health improvement. However, more importantly, the Keep Well programme aims to strengthen and support area level Health Improvement through integrated working across General Practices, Health Improvement teams / services and Community / Voluntary sector services.

PURPOSE OF THE KEEP WELL TOOLKIT

Building on learning from evaluation of Keep Well programme in NHS GGC, this toolkit provides information and resources to support identification and delivery of improvement activities across 3 areas of high impact change:

i) High impact change 1: Optimising patient engagement & reducing DNAs
ii) High impact change 2: Delivering patient centred consultations
iii) High impact change 3: Supporting patient behaviour change & self-management

Practices are asked to undertake the following:

i) Complete a self assessment against all of the ideas of improvement
ii) Develop an improvement action plan for idea of improvement for each of the high impact changes

Each of these sections provides a summary of key programme learning, and a “Red Amber Green” self assessment approach to help practices to identify & prioritise actions to support programme delivery and improvement.
The final section of the toolkit aims to serve as an initial reference guide to 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 programme of improvement.

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HIGH IMPACT CHANGE 1: OPTIMISING PATIENT ENGAGEMENT & REDUCING DNAs

UNDERSTANDING PATIENT ENGAGEMENT BARRIERS AND MOTIVATIONS

Research exploring facilitators and barriers to engagement with Keep Well indicated three broad characteristics of patients based on their general attitudes towards health and their perceived value of Keep Well health checks in particular [(1)] and clearly demonstrated that no single approach will engage all three groups

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 Keep Well. 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.

PRACTICE FACTORS

Although there is widespread intuitive knowledge of strategies that can increase attendance at Keep Well consultations among primary care professionals, there is 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 a Keep Well health check can still be engaged through a non-judgmental, empathetic approach and appointment flexibility (Table 1).

ROLE OF OUTREACH WORKERS

The NHSGGC Keep Well evaluation showed that appropriately trained outreach workers have potential to engage patients even when GP practice engagement efforts have not been successful. The outreach programme aims to encourage those who are hardest to engage to attend a Keep Well health check using a range of techniques including telephone calls and face-to-face home visits. Outreach workers can also provide support to patients who have been referred to other services and agencies, where appropriate.

In addition to supporting patient engagement, Outreach home visits also aim to confirm the patient's contact details, whether the person is still living at the given address, and whether they are housebound. The role of Outreach workers has continued to evolve to provide support to Practices to engage patients within target group sub-populations.

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"I think when you go to their door it gives them [patient] a wee bit of self-worth - that we have come all the way out to see them....."

Community Outreach Worker

Table 1: Adopting different engagement approaches for different patients

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

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DEFINITIONS OF PERSON- CENTRED CONSULTATIONS

Person-centred care is defined by the Institute of Medicine (IOM) [2] 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).

KEY ELEMENTS OF PERSON- CENTRED CONSULTATIONS

There is now powerful evidence that person centred care improves clinical outcomes; accordingly, and it is at the heart of NHS Scotland's Quality Strategy. Person-centred dialogue between patients and professionals on health related behaviours must become the norm.

Significant cultural change, however, is needed to ensure that healthcare professionals more widely are able to make the transition to person-centred practice. Achieving consistency in the highest quality of a Keep Well person- centred consultation will require:

- a coherent evidence-based theory/framework to underpin all consultations
- a purposeful strategy containing auditable outcomes and process indicators
- dissemination of knowledge and skills via effective professional mentoring and support
- appropriate consultation support tools that allow individualised goal setting
- clinical templates tailored to each patient's priorities and needs
- professional skills that are sufficiently well developed to allow flexibility in consultations
- professional skills that use a range of strategies to promote the confidence, motivation and ability of patients to develop resilience, health literacy and healthy lifestyle choices
- efficient systems to familiarise patients and professionals with the range of available follow-up services and support

SUPPORTING DELIVERY OF A PERSON-CENTRED CONSULTATIONS WITIHN KEEP WELL

The Keep well consultation includes clinical and lifestyle elements which address the reduction of CVD risk. Focus is also given to wider factors contributing to social determinants of health; including financial capacity, employability, caring and health literacy. Practices are strongly advised to provide at least 30 minutes for Keep Well health check appointments, based upon the experience of over 6 years of health checks in many practices.

NHSGGC evaluation of Keep Well identified a need to ensure that Keep Well consultation supports a process of change, rather than simply recording patient status and provision of advice. To facilitate this, the evaluation recommended that further support was required to enable ensure that all Practitioners delivering Keep Well have:

- an overall understanding of principles of anticipatory care and health inequalities
- opportunities to develop confidence and skills for sensitive social enquiry relating to the patients wider circumstances
- opportunities to develop approaches to support patient health behaviour change skills. .

Effective communication skills, brief interventions, motivational interviewing strategies 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 diseases [3].

In April 2013, NHSGGC implemented new clinical support templates to electronic templates is to provide a structured evidence-based approach

" [I was] very reluctant to begin with because to me that [money issues] was none of my business..... It's different now as I understand now why the question is there"

Practice Nurse

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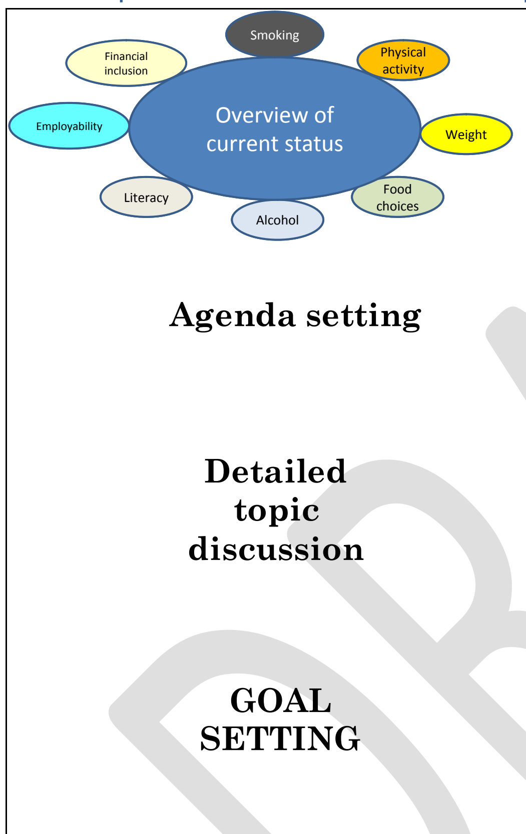
to patient management, providing easy, 'one stop' access to guidelines, protocols, care pathways and decision support to the clinician. The health related behaviour templates were been fundamentally redesigned, providing a tool to enable a rapid overview of the patient's current behaviours and life circumstances, followed by a more in-depth discussion around just one (or, at the most, two) topics, which are then covered in depth. The templates will support clinicians through four key phases of the consultation (Figure 1).

Figure 1: Keep Well health determinants template



Motivational interviewing is a collaborative conversation about change. The Health foundations Co-creating Health [5] model recognises three key processes which enable a collaborative approach to patient consultations.

Agenda setting - supports patients and clinicians to jointly agree the aims of each meeting they have. The evidence shows that when this does not happen effectively, patients feel dissatisfied with their experience. In addition, they are less likely to become 'active patients' and adhere to treatment or advice, act on the lifestyle change advice or even attend their next appointment. Establishing the patient's perspective at the start helps clinicians to work with the patient's own motivations and interests and improves both patient experience and outcome

Goal setting - The evidence shows that the most effective way for someone with a long-term condition to begin to make health-improving changes is by choosing their own small and achievable goals. These goals do not need to be clinical in nature – but achieving them must be important to the patient and something they will be proud of. Achieving these goals builds confidence and momentum.

Follow-up - The ability to keep up health-improving changes diminishes without regular reinforcement. Our existing health system is poorly designed to do this. Proactive 'follow-up' fairly soon after a goal has been collaboratively agreed is needed to provide encouragement, advice and support.

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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 needs of patients identified 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[4]. 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

They suggest that barriers which prevent people from using services can be categorised as personal, financial and organisational. Work within NHSGGC 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 Cooper (2004) 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

NHSGGC 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 NHGSSC 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 directly accessed via directly accessed via the Keep Well templates or via the following address: www.nhsggc.org.uk/infodir

BUILDING RELTATIONSHIPS 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 knowledge of services available in local area and to share experiences to shape future service delivery.

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Anticipatory Care Self-Assessment Tool

This tool uses the Red/Amber/Green system to assess the current situation for each point.
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
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 Keep Well Consultations					
1.1	All Practice staff have been briefed on the aims and purpose of the Keep Well 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 out 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 work collaboratively with community outreach workers to reach previously unengaged patients				
1.12	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
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					
2.1	All staff responsible for delivering the health review (all or in part) understand the aims and purpose of the Keep Well consultation				
2.2	All staff responsible for delivering the Keep Well consultation 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 the Keep Well consultation have completed training in motivational interviewing and health behaviour change (e.g. NHSGGC half day Introduction to Health Behaviour Change)				
2.4	All relevant staff are familiar with NHSGGC Interpreting Policy and good practice guidelines for working face to face with interpreters and act accordingly				
2.5	All staff responsible for delivering the Keep Well consultation have completed equalities / inequalities sensitive practice training (e.g. NHSGGC training modules, RCGP)				
2.6	All staff delivering the Keep Well consultation 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 (recommended time 30-40 minutes) allocated to a Keep Well consultation to allow the practitioner time to review patient history in advance of the Keep Well consultation				
2.9	We use learning from any significant events arising from the delivery of the Keep Well consultation				
2.10	We obtain and use patient feedback / experience				

Item	Ideas for improvement	R	A	G	Where are we now
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.					
3.1	All practice staff are aware of NHSGGC Health Improvement service directory www.nhsggc.org.uk/infodir				
3.2	All relevant staff are aware of HI 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 collaboratively set and record goals within the patient notes to enable practice staff to have access during future consultations				
3.5	We follow-up patients referred to HI services				
3.6	The Ethos of the practice is to reinforce behaviour change messages at all clinical encounters and provide ongoing support to help patients make/ maintain behaviour change				

ACTION PLAN TEMPLATE

Item	Action Plan	Evidence of Achievement (How we achieved)	Who was involved	When did we achieve

USEFUL SUPPORTING RESOURCES / REFERENCES

Healthcare Support Workers (HCSW) Competency Framework ... the role of Healthcare Support Workers delivering National Anticipatory Care.

NHSGGC Interpreting Policy and guidelines
http://library.nhsggc.org.uk/mediaAssets/Procedures/nhsggc_policy_interpreting.pdf

NHSGGC Equalities Toolbox
http://www.equalitiesinhealth.org/public_html/toolbox.html