Greater Glasgow and Clyde NHS Board

Board Meeting
23 June 2015 **Board Paper No: 15/24**

Director of Public Health

Keep Well and Chronic Disease Management Programme Update

RECOMMENDATIONS:

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

1. NHSGGC Keep Well programme disinvestment planning and programme legacy developments

2. NHSGGC Chronic Disease Management (CDM) developments and House of Care early adopter programme

1 Introduction and purpose

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. 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.

This paper has two purposes: to provide an update on NHSGGC Keep Well programme disinvestment planning and programme legacy, and to update on key developments within NHSGGC primary care Chronic Disease Management (CDM) and associated House of Care Early adopter programme.

Previous Board updates in relation to NHSGGC Keep Well and CDM programmes can be accessed via Board Paper No: 14/36 and Board Paper No: 12/35 respectively.

2 Keep Well disinvestment planning

2.1 Programme funding

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 2015/16 allocation letter confirmed a further reduction of £500k in national funding, resulting in circa £190k less funding for NHSGGC for 2015/16 than previously communicated. Table 1 provides a summary of updated funding position from 2013-2017.

Table 1: Keep Well Programme Funding 2013– 2017

	2013/14 budget	2014/15 budget	2015/16 budget	2016/17 indicative budget	2017 onwards
National Programme Budget	£11,000,000	£11,000,000	£6,500,000	£3,000,000	£0
NHSGGC Allocation	£4,191,000	3,927,000	2,437,500	£1,081,750	£0
NHSGGC overall real % funding reduction	-	6.3%[1]	41.8%	75.7%	100%

[1] reduction due to Health Board Boundary Changes

Following the Scottish Government's decision to disinvest in Keep Well, NHSGGC Keep Well Management Group, in consultation with Partnerships, initiated a full review of the programme in order to:

i) Prioritise areas of programme learning applicable to mainstream activities to ensure a lasting legacy from Keep Well, and;
ii) Agree and action a three year financial disinvestments plan to take account of decreasing and eventual withdrawal of programme funding

2.2 2014/15 programme re-orientation and disinvestments

As outlined in Table 1, significant programme budget reductions were not due to take effect until April 2015. However, NHSGGC made the decision to discontinue the delivery of Keep Well Health checks from 1st April 2014. As a consequence, the following programme elements were withdrawn or re-orientated during 2014/15 financial year:

i) Keep Well Local Enhanced Service

Following the decision to discontinue delivery of primary prevention health checks, NHSGGC commissioned an amended one year Keep Well Local Enhanced Service (LES) from existing Keep Well practices. Further details of the amended programme are provided in Section 3.

ii) South Asian Anticipatory Care (SAAC) Programme

Following the completion of the SAAC pilot programme, and the decision to discontinue Keep Well health checks, it was agreed that the learning from the SAAC pilot should be progressed via wider programme legacy developments. Learning from the SAAC programme was integrated into the development of the Anticipatory Care Toolkit (section 3), particularly in relation to; routine recording of patient ethnicity and communication needs; adapting patient engagement

approaches to reflect these needs; application of NHSGGC Interpreting Policy and sensitive practice training.

In addition, this provided Glasgow City South Sector with an opportunity to opportunity to undertake strategic review of BME focused activities to inform practice, for example:

- Development of Community Orientation Primary Care (COPC) model within the new East Pollokshields Health Centre and surrounding GP practices
- Review and adaptation of community health improvement programmes to better meets the needs of BME population, e.g. women's walking groups, South Asian Cookery Classes, and culturally sensitive smoking cessation classes for Roma community
- Continuation of collaborative work with practices to improve access and registration of Roma patients with GP practices

iii) Community Outreach Workers

As noted in previous Board paper, NHSGGC plans for commissioning outreach services were withdrawn. A reduced level of funding to the service provider in order to phase out the service and to facilitate a lasting legacy from the delivery of outreach via the following activities:

- provide outreach service for backlog of patients not yet contacted
- provide practices with advice and support to improve local approaches for better patient engagement
- development and delivery of tailored Telephone Engagement Skills training to practice staff
- development and delivery of Better Engagement Resource providing a framework for improvement for patient engagement approaches (including learning from SAAC project)

iv) Prison Keep Well Programme

As in the case of primary care health checks, Keep Well health checks within HMP Barlinnie, Greenock and Low Moss were also ceased from 1st April 2014. Clinical staff time was re-orientated to deliver Well Man programme and delivery of Prisons Health Improvement Framework.

2.3 Ongoing programme disinvestment planning

Following consultation with Partnership Directors and Health Improvement Managers, it was agreed to manage the 2015/16 and 2016/2017 budget allocation at a programme level, as opposed to applying respective percentage funding reduction across all Partnerships. Budget allocations were prioritised to minimise risks to existing contractual commitments relating to:

i) commissioned health improvement services, principally money advice, employability and mental health and well being service contracts within Glasgow City
ii) Partnerships Health Improvement, Primary Care Development and Practice Nurse Support posts to secure capacity, knowledge and skills developed over

the duration of the programme to enable development and delivery of programme legacy priorities

The 3 year disinvestment period, provides some time for Partnerships to identify other funding sources for service and/or staff by April 2017. However, the discontinuation of funding from April 2017, coupled with wider financial pressures will make this very challenging.

3 2014/15 Keep Well Local Enhanced Service

3.1 Programme overview

The amended one year LES for 2014/15 had 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 in the form of an Anticipatory Care Toolkit outlining improvement activities across the following 3 areas 'high impact change':

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

Each area of high impact change contained a range of practical 'areas of improvement' designed to enable practices to undertake a self-assessment within the context of their chronic disease management (CDM) programmes and to develop a written action plan based on this self-assessment. Public Health, Primary Care Support and Health Improvement teams facilitated a series of collaborative networking opportunities to support sharing of learning, knowledge and approaches across participating practices.

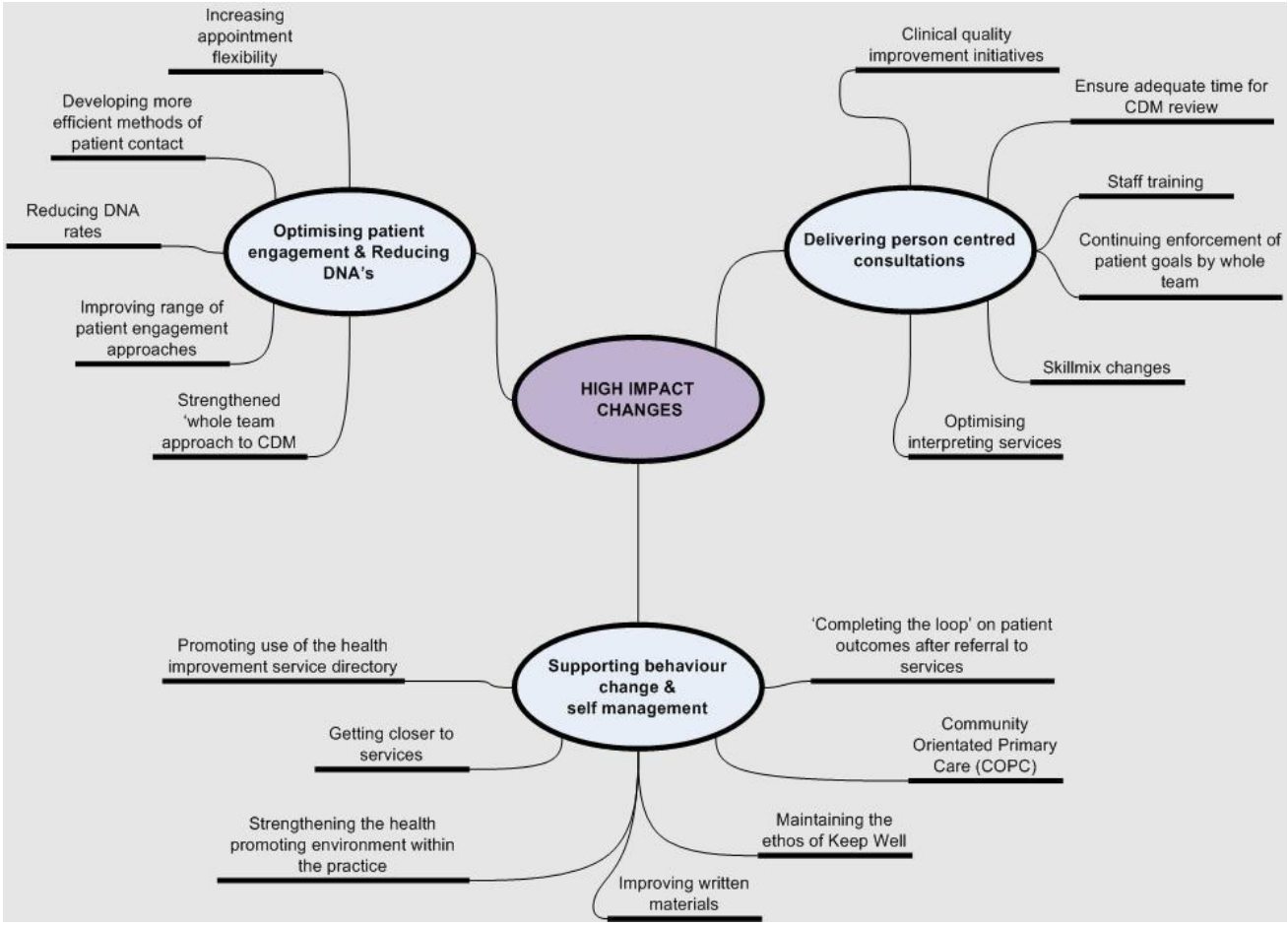
3.2 Learning from Anticipatory Care Toolkit activities

An evaluation of the 2014/15 Keep Well LES by Dr Anne Scoular was conducted to obtain structured insights into practice action plans and improvement activities. A total of 122 practices submitted individual self assessment and actions plans.

Overall, practices generally employed systematic and inclusive approaches to quality improvement and identified a wide range of improvement actions following completion of the self-assessment. This evaluation reviewed information contained within practice action plans and information shared with other practices during practice webinar events. Figure 1 provides a summary of themes identified. A full version of the evaluation report can be found via the following link .

Following completion of practice webinars, a representative from participating practices attended an informal learning & dissemination event to provide further opportunity to share learning from the evaluation of practice action plans, and to provide an opportunity to discuss views of Keep Well programme so far and programme legacy priorities.

Figure 1: Practice Action Plan Themes



Practices were asked to provide one word which best described how they now felt about the toolkit and associated LES activities (Figure 2).

Figure 2: Practice 'after' views of the Anticipatory Care Toolkit

"This has been a beneficial journey"

Practices reported that the toolkit had provided a focus and whole practice approach and that it should be made available to other practices. Undertaking the self-assessment had been seen as a valuable exercise, with examples of where this enabled a greater understanding of;

- the workings of their own practice (roles and remit of colleagues)
- social determinants of health and health inequalities
- local health improvement and community services
- new methods and approaches around patient engagement
- the ethos and practice of holistic patient care.

"All good things come to an end"

Practices however continued to express disappointment over the abrupt discontinuation of Keep Well health checks and overall planned programme disinvestment, in particular the loss of a focus on primary prevention of long-term conditions.

"Keep Well became less about income and more about patients"

Overall, practices spoke positively about their experience within the Keep Well programme, regardless of the duration of their practice involvement. Practices reflected that the programme had had a positive impact at; a practice level, by facilitating a whole team approach and developing better partnership working with other practices, community services, Partnership and Board staff, and; at a patient level, by increasing patient engagement and being better equipped to identify and respond to unmet need. Practices expressed a readiness to continue to embed learning to wider practice activity and spoke of ways to further build on Keep Well learning, for example, adopting elements of the Keep Well health check as part of new patient assessments.

In addition, practices also responded positively to the use of Webinar technology as part of the programme activities, and recognized that it had potential to support networking at a practice / local level as well as for wider communication with the health board, other external services or as a training medium. Within practices the Webinars were viewed as a useful tool for updating staff or for team meetings within busy practices who support large staff groups. In particular, it provides a convenient option for multi-site practices

A full report of the 2014/15 Anticipatory Care Toolkit activities is expected in July 2015, providing further analysis of practice year end reports and case studies of improvement actions.

3.3 Continuing the Keep Well legacy

Following learning from previous Keep Well evaluations and 2014/15 programme learning, Public Health will continue to work closely with Partnerships to progress the following actions/priority developments during 2015/16:

i) Continue to facilitate collaboration within delivery of CDM programme:

Following the positive reception of the Anticipatory Care Toolkit and Webinar sessions, Pubic Health, Primary Care Support and Partnerships Health Improvement teams will continue to support opportunities sharing of learning between all NHSGGC practices in relation to delivery of CDM programme. The Anticipatory Care Toolkit will continue to be used as a framework for improvement, and continue to expand the use of Webinar sessions to engage practices in collaborative discussions.

ii) Dissemination of Better Engagement Approaches resource:

Keep Well has amassed a great deal of learning from of community outreach worker's role, and from practice innovative approaches to patient engagement. This learning has been translated into 'top 'tips' and generic good practice guide to support practices (and wider services) to review current levels of service engagement and DNAs, critically appraise existing patient engagement approaches and consider practical improvements / changes in engagement

approaches . A final version of this *Better Engagement Approaches* resource is expected in August 2015. NHSGGC Public Health Long Term Conditions Team will provide leadership to support the dissemination of this resource, and build capacity within wider Public Health and Partnership teams to support its application.

iii) Increase awareness of and opportunities for closer working relationship between practices and the available services in their area

It was evident from the practice action plans and feedback that there is still a need and appetite to consolidate systems to support health improvement at a local level. Community Oriented Primary Care *(*COPC*)* is a systematic process for identifying and addressing the health problems of a defined population, usually involving a team of health professionals and community members working in partnership over a long period, with primary care very much at its heart. Two successful COPC pilots are operating in NHSGGC, in Drumchapel and in Possilpark, and the planned COPC site in East Pollokshields, have potential to be replicated in other areas. Public Health will continue to support the evaluation and learning of COPC approaches and liaise with Partnership teams to consider sustainable options for model expansion.

Practice staff awareness of *NHSGGC* Health Improvement Service Directory was variable despite the system going live in 2010. Work has been completed to; extend the range of services contained within the directory and; develop an improved user interface to enable the system to meet the need of a wider range of health and social care staff, patients and public. The re-named Health & Wellbeing Directory will be re-branded and launched in Autumn 2015 and supported by a communications plan to raise awareness and utilisation among wide range of staff and patients. This work will also feed into wider national development being undertaken by NHS Inform Health & Well Being Zone and the Alliance ALISS programmes to ensure integration with NHSGGC resource and service information.

4 Chronic Disease Management (CDM) Programme Update

4.1 Background to CDM programme

CDM is a generic term for systematic delivery of coordinated healthcare for populations with established LTCs. NHSGGC invests substantially in an extensive, well established chronic disease management (CDM) programme which delivers practice based CDM care for patients with five major chronic diseases:

- Coronary Heart Disease (CHD)
- Type 2 Diabetes
- Stroke/Transient Ischeamic Attack (TIA)
- Chronic Obstructive Pulmonary Disease (COPD)
- Left Ventricular Systolic Dysfunction (LVSD).

The NHSGGC CDM programme is delivered in primary care, but strongly underpinned by a whole population perspective across all aspects of service planning, coordinated by a multidisciplinary planning group, with input from a

Consultant in Public Health Medicine, a GP Medical Editor, Health Improvement, Primary Care Support Team, four Managed Clinical Networks (Heart, Diabetes, Respiratory & Stroke) and specialists in Information Management & Technology and in Health Improvement. The programme is delivered via a General Medical Services (GMS) Local Enhanced Services (LES) contractual arrangements.

The current NHSGGC CDM programme aims to provide person centred care for patients with any combination of the above co-morbidities. The programme has three distinctive unique assets:

i) decision support technology, which supports and enables efficient delivery of evidence based clinical care and supports the practitioner in creating a workable, person-centred consultation process. This provides a 'roadmap' for brief interventions addressing lifestyle and life circumstances, a brief patient goal-setting tool, a range of other clinical/consultation tools and access health and wellbeing directory
ii) a 'whole system' ongoing development programme to ensure that all of the CDM programme content is fully up to date and reflects best practice in both clinical content and also 'softer' consultation content.
iii) a proactive programme of workforce development which uses a wide range of evidence based knowledge management methods, working with NHS Education for Scotland and NHSGGC's 'Knowledge into Action' team

4.2 Registered diagnoses and disease prevalence

As at 31 March 2014, 146,461 patients were registered on one or more LES CDM disease registers. Among the 146,461 patients in the 2013/14 contract year, a total of 194,714 chronic disease diagnoses were recorded, representing an average of 1.3 conditions per patient.

Of the five disease areas, CHD was the most prevalent, closely followed by Type 2 Diabetes. COPD prevalence which showed a threefold variation across the NHSGGC partnerships

A copy of the full CDM report by Dr Anne Scoular can be accessed using this link. During 2015/16, Public Health will work in collaboration with Information Services to establish an online programme surveillance system, to provide practices, Partnerships and MCNs with real time programme data, to monitor the effectiveness of CDM ES programme through continuous audit.

4.3 'House of Care' early adopter programme

The 'House of Care' model (Figure 3), represents a tangible and proven improvement framework that allows services to embrace care planning to support the self-management of people living with LTCs. Over the past few years, the 'House of Care' approach has been implemented in three successful projects that embedded Care Planning for people living with diabetes in England. This approach has been endorsed by Scottish Government to address the needs of people living with multiple LTCs and is aligned with Scottish Government's Route Map of deliverables to achieving its 2020 vision through developing New Models of Primary Care

NHSGGC along with NHS Lothian and NHS Tayside are participating in a 2 year early adopter programme initiative in partnership with the Scottish Government, Health and Social Care Alliance and British Heart Foundation to apply the model in Scotland during 2015-2017.

Figure 3: House of Care Model – The Care Planning House

The strategic aims, underpinning principles and ethos of House of Care and NHSGGC CDM programme are virtually identical, namely:

- ensuring that people with long-term conditions play an active part in determining their own care and support needs through personalised care planning
- collaborative relationships between patients and professionals
- shared decision making and self management support
- single, holistic care planning process, creating a single care plan that works in the context of multimorbidity

The House of Care model, nevertheless, offer valuable opportunities to build on the learning from the Anticipatory Care Toolkit and Keep Well programme legacy activities to further develop and strengthen the NHSGGC CDM programme.

Nine GP practices across Glasgow City and East Dunbartonshire have volunteered to apply the House of Care approach within their existing CDM programme/service. The programme will initially target population of patients with existing diagnoses of Type 2 Diabetes and/or CHD from disease registers and work collaboratively to define clearly a workable range of care pathway models for these patients, which would have common and variable components to fit with practice systems.

Public Health and Primary Care Support will jointly oversee the planning and implementation of the programme, and the development and delivery of a robust

programme evaluation to ensure learning informs the ongoing development of system wide CDM within primary care.

5 Conclusions

Despite the discontinuation in Keep Well funding, learning from the programme amassed over the last 7 years has been successfully translated into transferable and practical improvement actions for the primary and secondary prevention of Long Term Conditions. It is vital that NHSGGC continues to commit to strengthen system wide integrated prevention activities across health, social care and 3rd sector partners to maximise leverage of our existing investments in health improvement.

APPENDIX 1

2013-2017 Keep Well programme investments (approximate)

Directly Employed Staff	2013/14	2014/15	2015/16	2016/17
Public Health Programme/ Health Improvement Staff	£160,000.00	£160,000.00	£75,800.00	£60,000.00
Partnership Health Improvement & Support Staff	£503,000.00	£433,907.00	£360,220.75	£281,420.50
Prisons/Offenders Keep Well programme staff	£120,000.00	£120,000.00	£72,900.00	£72,900.00
Primary Care Support / Practice Development Staff	£161,000.00	£121,000.00	£95,000.00	£60,000.00
South Asian Anticipatory Care Project Staff	£62,000.00	£0	£0	£0
Health Improvement Service Delivery Contribution (all Partnerships)				
Live Active	£200,000.00	£100,000.00	£15,000	£15,000
Vitality	£ 25,000.00	£25,000	£15,000	£15,000
Money Advice	£200,000.00	£200,000.00	£200,000.00	£200,000.00
Employability	£60,000.00	£60,000.00	£60,000.00	£60,000.00
Mental Health/Stress Management	£160,000.00	£190,000.00	£175,000.00	£175,000.00
Programme Specific Investments				
GP Practice Payments	£1,000,000.00	£1,000,000.00	£112,000.00	£ 55,000.00
Patient Outreach	£350,000.00	£100,000.00	£0	£0
Other				
Local services investment and programme costs	£190,000.00	£190,000.00	£ 90,700.00	£15,000.00
Contribution to Partnerships	£1,000,000.00	£1,000,000.00*	£1,000,000.00*	tbc*

**plus any remaining unallocated sum following final budget approval*