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
Introduction

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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 NHSGGC 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 Framework\(^1\). 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 practices 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 particular. \(^4\)

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

*Table 1: Approaches to engage previously un-engaged patients*
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)

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 Fund 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 diseases.

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**

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.
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 Cooper\(^9\) have further highlighted what they term as demand side barriers and suggest a range of issues can affect whether an individual uses available services suggesting 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

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

<table>
<thead>
<tr>
<th>Item</th>
<th>Ideas for improvement</th>
<th>Where are we now</th>
</tr>
</thead>
</table>
| **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>| 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 | |</p>
<table>
<thead>
<tr>
<th>Item</th>
<th>Ideas for improvement</th>
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</thead>
<tbody>
<tr>
<td>High Impact Change 2: Delivering person centred consultations</td>
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<tr>
<td>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</td>
<td></td>
</tr>
<tr>
<td>2.1</td>
<td>All staff responsible for delivering the health review (all or in part) understand the aims and purpose of the CDM annual review consultation</td>
</tr>
<tr>
<td>2.2</td>
<td>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</td>
</tr>
<tr>
<td>2.3</td>
<td>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).</td>
</tr>
<tr>
<td>2.4</td>
<td>All relevant staff are familiar with NHS GGC Interpreting Policy and good practice guidelines for working face to face with interpreters and act accordingly</td>
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<tr>
<td>2.5</td>
<td>All staff responsible for delivering CDM annual reviews have completed equalities / inequalities sensitive practice training (e.g. NHS GGC training modules, RCGP)</td>
</tr>
<tr>
<td>2.6</td>
<td>All staff delivering CDM annual reviews have had an induction programme appropriate to their role and are adequately mentored/ supported by practice team</td>
</tr>
<tr>
<td>2.7</td>
<td>We ensure that appointment system is working well and appointment length supports high quality consultations for patients and staff</td>
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<tr>
<td>2.8</td>
<td>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</td>
</tr>
<tr>
<td>2.9</td>
<td>We use learning from any significant events arising from the delivery of CDM annual review consultations</td>
</tr>
<tr>
<td>2.10</td>
<td>We obtain and use patient feedback / experience</td>
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<tr>
<td>Item</td>
<td>Ideas for improvement</td>
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<tr>
<td>3.1</td>
<td>All practice staff have a working knowledge of the NHSGGC Health Improvement Service Directory <a href="http://www.nhsggc.org.uk/infodir">www.nhsggc.org.uk/infodir</a></td>
</tr>
<tr>
<td>3.2</td>
<td>All relevant staff are aware of health improvement and patient education programme service referral pathways</td>
</tr>
<tr>
<td>3.3</td>
<td>We create/participate in opportunities to maintain relationships with local service providers</td>
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<tr>
<td>3.4</td>
<td>We work collaboratively with patients to set and record goals within the patient notes to enable practice staff to have access during future consultations</td>
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<tr>
<td>3.5</td>
<td>We follow up CDM patients referred to health improvement services at future encounters with the patient</td>
</tr>
<tr>
<td>3.6</td>
<td>We have up to date written information on local health improvement services available to our patients</td>
</tr>
<tr>
<td>3.7</td>
<td>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</td>
</tr>
<tr>
<td>Item</td>
<td>What we are going to do</td>
</tr>
<tr>
<td>-----------------------</td>
<td>----------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>High Impact Change 1:</strong> Maximising patient engagement &amp; reducing DNA’s</td>
<td>Change Principle: Our practice delivers flexible engagement approaches to meet the needs of individual patients in order to maximise uptake of CDM Consultations</td>
</tr>
<tr>
<td><strong>High Impact Change 2:</strong> Delivering person centred consultations</td>
<td>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</td>
</tr>
<tr>
<td><strong>High Impact Change 3:</strong> Supporting ongoing patient behaviour change &amp; self-management</td>
<td>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.</td>
</tr>
</tbody>
</table>
References

1. NHS GGC Board Paper No.12/35: Integrated prevention for long term conditions, August 2012
   http://library.nhsggc.org.uk/mediaAssets/Board%20Papers/12-35.pdf
   [Accessed March 2014]

   http://library.nhsgg.org.uk/mediaAssets/Keep%20Well/KW_FINAL%20REPORT_Evaluation%20Wave%201-4_060512.pdf
   [Accessed March 2014]

   (incorporated within Board Paper No.12/35
   http://library.nhsggc.org.uk/mediaAssets/Board%20Papers/12-35.pdf
   [Accessed March 2014]

   [Accessed March 2014]

5. Institute of Medicine, 2001, Crossing the Quality Chasm: A new health system for the 21st century
   www.iom.edu/.../2001/Crossing-the-Quality-Chasm/Quality%20Chasm%.
   [Accessed March 2014]

   [Accessed March 2014]


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

[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
[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

<table>
<thead>
<tr>
<th>CHCP Health Improvement Teams</th>
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| **East Dunbartonshire CHCP** | Telephone: 0141 355 2356  
Web: [www.chps.org.uk/eastdunbartonshire/](http://www.chps.org.uk/eastdunbartonshire/) |
| **East Renfrewshire CHCP** | Telephone: 0141 577 8436  
Web: [http://www.eastrenfrewshire.gov.uk](http://www.eastrenfrewshire.gov.uk)  
Email: HITeam@eastrenfrewshire.gov.uk |
| **Inverclyde CHCP** | Telephone: **01475 506 029**  
Web: [www.chps.org.uk/inverclyde](http://www.chps.org.uk/inverclyde) |
| **Glasgow City CHP – North East Sector** | Telephone: 0141 232 0185  
Web: [www.chps.org.uk](http://www.chps.org.uk) |
| **Glasgow City CHP – North West Sector** | Telephone: 0141 211 0614  
Web: [www.chps.org.uk](http://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](http://www.chps.org.uk/renfrewshirehealthimprovement) |
| **West Dunbartonshire CHCP** | Telephone: 01389 744 650  
Web: [www.wdchcp.org.uk](http://www.wdchcp.org.uk) |

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<thead>
<tr>
<th>Practice Nurse Support Team</th>
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| 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](http://www.staffnet.ggc.scot.nhs.uk/Partnerships/Greater%20Glasgow%20and%20Clyde%20Services/Primary%20Care%20Support/Practice%20Nurses/Pages/default.aspx) |

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<thead>
<tr>
<th>Public Health Keep Well / CDM Team</th>
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| Telephone: 0141 201 4538  
Email: Keepwell1@ggc.scot.nhs.uk  
Web: [http://www.nhsggc.org.uk/content/default.asp?page=home_keepwell](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

Review date – April 2015