'Targeted primary prevention: making it happen'

Welcome

&

Well done getting here

Today provides an opportunity to:

- Take stock
- Take account of change
- Share perspectives
- Inform local roll out
- Inform national direction
- Continuously improve performance
  - Identify immediate and longer term actions

Timeline

- Sept 2007- NHSG proposal signed off
- Aug 2008 –Local evaluation procured
- Sept 2008 - First local health checks in KW
- 2008-09-HEAT 8 introduced
- 2008 – Health Psychology - NES
- Dec 2009 – Community Pharmacy (CP) proposal signed off
- Nov 2010- First local health checks in CP
- 2010 - Health Psychology - NES
- March 2010 – target health checks = 1495 (704)
- April 2011 – Preparation to extend KW
- April 2012 – KW extended

Getting started

Maximising Flow

Keep well

NHS Grampian

Keep Well
Data Screening

Jackie Fleming
Keep Well Information Analyst
November 2010

Keep well

The Keep Well vision is ‘to increase the rate of health improvement in deprived communities…..’

It’s for eligible 45 to 64 year olds at participating GP practices in Scotland.

The health check ……. typically takes 30-40 minutes…..

to identify

- **intermediate clinical risk factors**
- **lifestyle risk factors**
- **other issues that may impact on health**

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GPs like to know

How many Keep Well eligible patients are there in this practice?

How much work is involved in providing health checks to those patients?

Keep well

How many Keep Well patients do I have?

‘45-64 year olds in areas of greatest need’

‘areas of greatest need’ – ie among the 15% most deprived datazones in Scottish Index of Multiple Deprivation 2006.

Aberdeen City has 44 datazones among the 15% most deprived.

Patient record does not have SIMD marker, therefore postcode is used.

But…….simple search is not possible, as there are 1897 eligible postcodes.

So…….. extract patient data (including postcode) from GP practice system, cross-match with datazone/postcode file to identify patients within the 15% most deprived datazones.

Then…….use the resulting list of patients to create a patient group on the practice record system.

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How much work is involved?

Data Screening report

220 patients at this practice are eligible for a Keep Well health check.

Number & % of patients whose latest (most recent) record was in 2009/10

	No.	%
Personal contact with practice	165	75%
Serum cholesterol	68	31%
Alcohol	33	15%
Smoking	183	83%
BMI	103	47%

Also, prevalence levels for alcohol, smoking, BMI.

Keep Well patients already on a Disease Register

	No	%
Hypertensive only	29	13
Ischaemic Heart Disease only	7	3
Cerebrovascular Disease only	4	2
Diabetes only	4	2
On more than one register	18	8

Keep well

Points to ponder……..

SIMD identifies areas of greatest need –it's not perfect at identifying individuals.

SIMD is not on the patient record – therefore the patient id process is not self-contained within the practice.

SIMD changes – 2009 version has different datazones in the most deprived 15%.

How can we improve the process?

Keep Well at Calsayseat Medical Group

Dr Stephen Lynch

Calsayseat Medical Group

- 11, 000 patients
- Cover many of the deprived areas of the City
- Total Keep Well population ~ 830
- Early adopted of Keep Well 2008

Organisation of care

- 1 lead GP
- Administrator
- 3 practice nurses with designated slots throughout the working week
- Patients contacted by mail and telephone
- In house CAB, Counterweight and SAS.
- Recent linkage with community pharmacy in the town to help deliver checks

What has gone well

- Patients who attend pleased with service
- Integrated guidelines and referral pathways in Vision
- Most common referral – CAB, SAS and Counterweight
- Disease pick up (Hypertension, diabetes, impaired glucose tolerance and increased CVD risk)
- Support from the Keep Well team

What has gone less well!

- Getting folk to attend
- 611 invited
- 223 seen
- Seeing 3 – 11 per week
- Illness within our nursing team has impacted on our ability to offer assessment
- How do we reach the people who aren't keen to be seen ?

Keep Well Programme

A Manager's perspective

Lorraine McKenna, Business Manager
Carden Medical Centre

The Journey

- Holistic approach to address health inequalities
- Health checks commenced September 2008
- 245 patients qualified
- 4 part-time nurses
- 3 appointments per week
  - Tuesday & Thursday 5.00 p.m.
  - Friday 2.15 p.m.

The Struggle

- Batch letters sent to call patients for a health check
- Difficulties getting patients to make and attend appointments
- High percentage of DNA's (27% March 09)
- ? Target group
- September 2009
  - 69% of patients invited to have a health check
  - 25% attended for health check

The Solution?

- Assigned an Admin person
- Better follow up of letters & patients
- Contacted patients by phone between 6.00 – 8.00 p.m.
- Flexibility re: times of health checks

The Results

- Changes had positive impact
- March 2010
  - 100% of patients invited
  - 41% attended for health check
- September 2010
  - 94% invited (new 45 & 65 year olds)
  - 51% attended for health check
- 3 patients diagnosed with hypertension & 3 with diabetes
- New targets set

The Future

- Look at new ways to engage those most disadvantaged e.g. community level
- Follow on from Health Coach Pilot
- Empowerment
- Transferable skills
- The programme post-March 2011?

Dufftown Well North

Who We Targeted

- **Practice Population** 2498

- **Target Group 1** – Prevention/Hard-to-reach Age 16-45
- Smokers, BMI=>30, FH of chronic disease
- 413 Identified
- 211 Screened (50%)

- **Target Group 2** – Anticipatory Age 16-65
- Asthma, COPD, Hypertension, mild to moderate depression, Rheumatoid Arthritis
- 449 Identified
- 216 Screened (50%)

What We Did

- 1 Hour Consultation
- BMI, BP, Diabetes & Cholesterol Checks
- Lifestyle Advice
- Referral/Signposting as Necessary
- Self Care Directory
- SIGN Guidelines
- ASSIGN Score
- 6 Month Follow-up

Interventions

- 145 Smoking Cessation Advice
- 45 GP Referrals
- 42 ABIs
- 38 PN Referrals
- 27 Healthy Helpings
- 16 Raised Cholesterol
- 10 Literacy Problems
- 6 Exercise Programmes
- 3 New Diabetics

(Ex. Gym, Slimmer's World)

Personal Reflections

- "We are writing to thank you for the advice my husband and I received at Well North. It has been great encouragement to us and we are enjoying the benefits of changes we have made to our diet and lifestyle. Both of us have lost over a stone in weight since April this year. We attend the Shand Centre gym twice a week. Improving our fitness means we are able to walk longer with our dogs and do not feel so tired in the evenings." *Helen & George McDonald*

- " Since taking part in the Well North Project I have managed to lose weight and modify my lifestyle. I am pleased with the positive results and it made me realise that small changes can lead to big results. The second check-up gave me an incentive and also I would rather know now if there is a problem than when it is too late. I would be very happy if I could get an "MOT" like this every 6 months."

  Julian Holder

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Keep Well Programme
The patient view?

Louise Forrest Treatment Room Nurse
Garthdee Medical Group

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- **Feedback from patients:**
-
- *"My father had a heart attack at 52 so I am quite relieved to have this health check."*

- *"Finding out my cholesterol is high may give me the motivation I need to address other issues, like my weight and lack of exercise."*

- *"It's reassuring to think my GP is interested in my health. I wanted to have a a check,however, because I feel well didn't think I should waste people's time."*

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- **Feedback from patients:**
-
- *"I think this is a great idea as I haven't had a proper health check for a long time"*

- *"More than willing to take part"*

- *"Knowing that I could be referred to Community Welfare*
- *Rights is reassuring, I had no idea this type of service was available"*

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Integrated care addressing whole person - How?

-
- **Through a targeted health check**
- Identifying and **targeting those at risk of preventable** serious ill-health;
- Offering appropriate, core, **evidence based interventions** and services;
- Focusing on **cardiovascular disease** and its main risk factors;
- Incorporating **appropriate means of engagement** with different clients groups;
- Providing individual **monitoring and follow up.**
- Addressing mental health issues through **Depression Screening**
-

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People empowered to manage their health – How?

-
- **Menu of interventions offering referral and signposting e.g.**
  - Cash In Your Pocket Partnership
  - Healthwise Aberdeen (health & literacy)
  - Credit Union's – e.g. St Machar, Torry, Grampian
  - Smoking Advice Service
  - Healthy Helpings (healthy eating/healthy lifestyle course)
  - *healthpoint (*NHSG Health information service*)*
  - Wellbeing Circuit Session Classes – Aberdeen Sports Village
  - Counterweight

In conclusion……

-
- Encouraging feedback
- Supports and encourages patients – preventable ill-health.
- Supports delivery of anticipatory care
- Facilitates checks for those concerned about their health but would not see GP/Nurse unless felt clinical need
- Modest changes support the system
- Promotes lifestyle changes

Health Behaviour Change

… in 5 slides taking a MAXIMUM of 10 minutes addressing a MINIMUM of three national priorities…

Stephan Dombrowski

Outline

1. The importance of behaviour change
2. Process of behaviour change
3. Methods of behaviour change
4. Application of behaviour change practice
5. Summary

"Prevention is better than healing because it saves the labour [costs] of being sick", *Thomas Adams, 1618*

(Primary Care contributes to best use of public resources)

"What fits your busy schedule better, exercising one hour a day or being dead 24 hours a day?"

Behaviour = death!!!

Highly beneficial for health

Process and Methods

Two key questions:

1. What influences an individual's behaviour?
2. How can we change an individual's behaviour?

Process:

- Key influences: e.g. Habits, Knowledge, Attitudes, P tion,

Which ones to use?

How to use these?

Methods:

- Behaviour change techniques: e.g. self-monitoring, information provision, verbal persuasion, intention formation, action planning

Behaviour Change Practice

- Keep Well context - Two key projects

1. Health behaviour change training
2. Health Coach Pilot

- Training:
  - For health professionals, focus: health behaviour change practice in the context of health checks
- Health coaching:
  - For patients, focus: health behaviour change support for self-selected behaviour

Summary

- Behaviour influences health
- Primary prevention “works” through changing behaviour
- Behaviour change is a process that behaviour change methods target
- Providing training (for HCPs) and support (for patients) has proven successful for Keep Well in Aberdeen

Health Behaviour Change

Stephan Dombrowski

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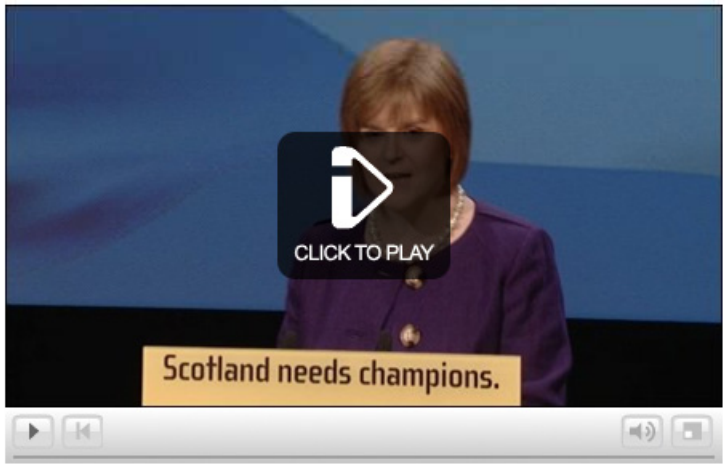
SNP announces plan for universal health checks



SNP conference: Sunday afternoon

People in Scotland over the age of 40 are to get access to universal health checks, Health Secretary Nicola Sturgeon has announced.

And she outlined plans for health workers like GPs to play a greater role in tackling alcohol abuse.

SNP CONFERENCE

LATEST NEWS

- SNP makes health service pledge
- SNP's pledge on cuts protection
- Best of the rest at conference
- SNP conference agenda

BACKGROUND/ANALYSIS

- Nationalists aim to be champions
- In profile: Alex Salmond
- SNP ministers at-a-glance

AUDIO/VIDEO


Webcast with Angus Robertson
Watch

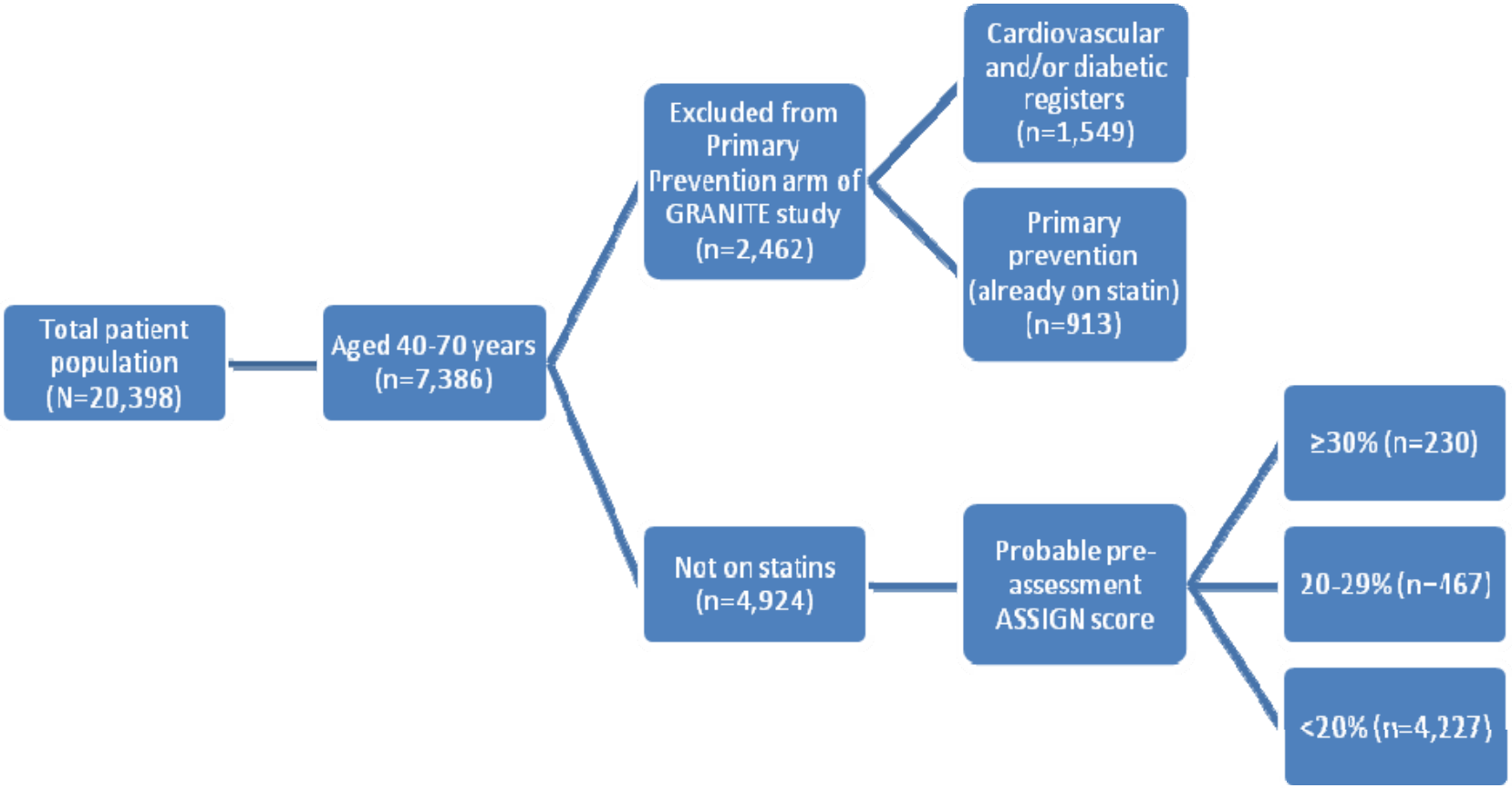

SNP conference: Saturday afternoon

QIS Clinical Standards for Heart Disease April 2010 recommends that :-

There is a mechanism in place for the identification of individuals without confirmed cardiovascular disease in the following high priority groups:

- **- living in deprived circumstances, beginning with the most deprived**
- **- confirmed hypertension**
- **- regular smokers**
- **- first degree relatives with a history of premature cardiovascular disease**
- **- serious and enduring mental health problems**

GRANITE : Peterhead Medical Practice



GRANITE RESULTS : Initial 96/230 with probable risk ≥ 30 % : -

Probable mean risk was 10 % greater than actual mean risk

- 42 % attended the first of 9 GRANITE clinics
- 39 (41 %) had a ≥ 30% actual risk
- 31 (32 %) had a 20-29 % actual risk
- *70 (73 %) had a ≥ 20 % actual risk*
- 26 (27 %) had a < 20 % actual risk
- 47 (67%) patients were prescribed a statin
- 8 men & 2 women exceeded recommended weekly alcohol intake
- 13 patients with < 20 % actual risk had SBP > 140
- 83 (86 %) needed review for risk / BP alone
- 6 men & 6 women with < 20 % risk were obese

GRANITE : targeted screening

Grampian Risk Assessment aNd InTErvention

- Utilises " predictive " software to calculate probable risk
- Uses ASSIGN calculator to estimate the risk including social deprivation factors
- Highlights non-attendees to allow for opportunistic screening at a later date
- Structured clinics with Questionnaires & Near Patient Testing
- Identifies & addresses co-morbidities
- Allows intervention if alcohol excess
- Fulfils QIS standards criteria
- Increases prevalence rates

Keep well

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Keep Well – why community pharmacy?

Wendy Robertson
Development Pharmacist, NHSG
November 2010

Keep Well – why community pharmacy?

"Better Heart Disease and Stroke Care Action Plan" states

"Community pharmacies, located where people live, are well placed to help provide patients and the public with personal care closer to home, including measuring weight, calculating BMI, measuring total and HDL cholesterol, blood pressure and blood glucose monitoring"

Keep Well – why community pharmacy?

- Complementary route for delivery of Keep Well health checks
- Community pharmacies in centre of communities
- Accessible to all
- May be only contact some members of public have with Healthcare professionals
- Initial patient engagement can be planned or opportunistic
- Consultation Rooms

Keep Well – why community pharmacy?

- Partnership working
  - G.P. practices signed up to facilitate pilots by providing cohorts of eligible patients from practice lists
  - Community pharmacists providing health check data to G.P. practices
  - Community pharmacists making referrals to G.P.s, healthcare and social services partners

Keep Well – why community pharmacy?

- Scottish government funded pilots in Grampian – currently until March 2011

- 2 pharmacies in Aberdeen city already delivering
- 4 pharmacies in Fraserburgh
- 6 pharmacies in Moray

Keep Well – why community pharmacy?

Challenges

- Engagement of defined eligible population
- Ensuring health checks delivered in community pharmacies are comparable with KW checks delivered elsewhere
- Validity of ASSIGN using population averages
- Appropriateness of referrals
- IT – transfer of information between Community pharmacy /G.P. practice/patient medical records