Anticipatory Care Information Report:

Lessons Learnt From Keep well Engagement

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Introduction

Over the past few years a wide variety of reports have been produced in response to the introduction of Keep well. Although there is a small and growing body of work looking at the impact of Keep well upon clinical outcomes, predominantly reports have concentrated on the programme's ability to reach and engage with its target cohort.

Qualitative evaluations have been carried out both nationally by the Keep well National Evaluation Team (NET) from the University of Glasgow and University of Edinburgh; and locally using a range of methods including patient satisfaction questionnaires and interviews. Quantitative reports include scheduled reporting made to NHS Health Scotland through the National Reporting Indicators and HEATH H8 target, and in-depth analysis carried out locally focusing on specific aspects of the Keep well data set.

The Keep well Team in NHS Tayside is continuing to carry out evaluation work on all aspects of the project. The aim of this report is to take stock of the formal evidence produced thus far and highlight the key lessons learnt to date. Anecdotal evidence has not been included in this report although this form of feedback has often contributed to continued delivery of Keep well. It should also be recognised that Keep well is being delivered by a wide variety of stakeholders and a sensitive, pragmatic approach should be adopted when applying the lessons detailed in this report into practice.

Background to Keep well

Keep well was introduced to Dundee CHP in April 2007 and to Angus and Perth & Kinross CHPs in late 2009. It is a Scottish Government initiative that is central to NHS Tayside’s anticipatory care agenda. The key aims of the project are to reach and engage with patients from deprived communities, to screen these patients for cardiovascular risk and provide them with support in establishing or maintaining a healthier lifestyle. Through these objectives, Keep well is seeking to prevent the onset of cardiovascular disease and reduce future incident rates, and through its concentration on deprived communities, to address the health inequalities that exist within NHS Tayside.

Keep well in Tayside is primarily delivered through a general practice model whereby practices identify and invite eligible patients to a Keep well health check. In addition,
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centralised teams of Keep well Outreach Nurses have been established in each of the three CHPs to assist practices delivering Keep well health checks; to develop novel engagement methods for patients where practices have struggled to establish contact; to provide Keep well health checks at a wider variety of venues and times than general practice is able to offer; and to provide Keep well health checks to specific vulnerable communities such as the homeless and prison leavers.

Keep well is targeted at patients aged 45 to 64 years old and living in deprived communities. In Dundee CHP deprivation has been defined as patients living in a postcode sector with a DepCat score of 6 or 7, and in Angus and Perth & Kinross CHPs patients have been considered deprived if they have a postcode that is in the 15% most deprived across Scotland according to SIMD 2006. These parameters may be widened if the patient belongs to a specific vulnerable community such as the homeless. The Keep well health check includes standard measures such as Body Mass Index (BMI), blood tests including cholesterol and blood glucose, and an assessment of the patient’s lifestyle including smoking status and alcohol consumption. The health check also seeks to assess the patient’s wider determinants of health including financial support, literacy screening and mental wellbeing. Through the health check the patient is able to access a range of services aimed at supporting positive health behaviour changes. These include smoking cessation services, employment services and literacy advisors amongst others.

To date, over 10,000 patients have attended a health check across NHS Tayside. In Dundee CHP 22 out of 26 eligible practices are delivering Keep well health checks and a further practice is working with the Keep well Outreach Nurses to make health checks available to its patients. In Angus all 5 eligible practices are delivering health checks and in Perth & Kinross CHP all 11 eligible practices are delivering or about to start delivering health checks. NHS Tayside has exceeded the associated HEAT target during 2009/10 and 2010/11.

There are many shared objectives between Keep well and NHS Tayside’s Health Equity Strategy. Essential to both programmes is their focus on narrowing the health inequalities gap that exists within NHS Tayside through increased screening in deprived areas and increasing access to services in areas of greatest need. In addition both programmes seek to improve primary care’s ability and capacity to tackle health inequalities and to refine the integration between NHS Tayside and its partner agencies including local authorities and voluntary groups.

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Keep well Health Check

Optimum Invitation Strategy

The majority of practices participating in NHS Tayside have lead on the decisions as to the order in which to invite patients in the target cohort, and how. This is important in allowing practices to deliver Keep well with minimal adverse impact on the other services that they provide, but as a result, many different approaches have been adopted. Despite this, recurring lessons have been drawn as to the invitation strategy that reaches and engages with the greatest number of patients: an optimum invitation strategy.
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- There is contradictory evidence over the relative merit of “open” letters, where invited patients are asked to arrange an appointment, compared to “fixed” letters where patients are invited to a health check at a predetermined date and time. It has been reported that the attendance rate after the first round of invitations is higher for fixed letters than for open letters. However, the Did Not Attend (DNA) rate associated with fixed letters is higher. Although the attendance rate after the first round of open letters was lower, it was less likely that patients would DNA. The NET reported that open letters were more successful in engaging patients as they gave patients more flexibility to arrange time for an appointment in the face of their personal competing priorities. Throughout NHS Tayside, practice staff have often demonstrated an innate knowledge of their patient population and have drawn upon this to decide which form of letter invitation would be the most successful. This local knowledge should continue to inform decisions around engagement strategies.

- Telephone invitations made during normal office hours are less successful than those made in the early evening. This is thought to be because many patients are at work.

- Practices have encountered logistical problems in delivering telephone calls including insufficient number of out-going lines with which to make the calls and incomplete or out of date contact details for patients. The contact details held by the practices are reliant on patients informing them of changes of address and telephone numbers as they occur.

- Opportunistic invitations have a high attendance rate and are cost effective. However, practices have experienced problems integrating opportunistic invitations into their existing service delivery. Also, this form of invitation inherently misses those patients who are deemed “hard to reach” as it is reliant on patients attending their practice for reasons other than Keep well. It has been suggested that opportunistic invitations should be adopted where possible but not relied upon as the single mechanism for inviting patients to a Keep well Health Check.

- Diminishing returns have been reported with each round of invitations made. However best attendance rates were found when practices invited patients using a mixture of contact methods. Local analysis suggests that the optimum attendance rate is achieved when patients are invited using a strategy that includes one letter and one phone call as the first two attempted contacts. Both NET and local reports indicate that invitation strategies relying on a single method, such as 3 consecutive letters, yields the lowest attendance rates.

- Local analysis indicates that 81% of patient who attended a Keep well health check did so within 60 days of receiving their most recent invitation. In addition patients who received consecutive invitations within a shorter time frame (less than 60 days) had a higher attendance rate.

- Reminder phone calls/texts 24 to 48 hours ahead of Keep well health check appointment have been shown to increase attendance rates.

Targeting

As described in the background, Keep well is an intervention targeted at deprived communities. Reports have highlighted two key points of learning as described here.
• Geographical indicators of deprivation such as DepCat and SIMD, have their limitations. There will be patients who are less well off living out with locations defined by DepCat or SIMD. Some specific deprived communities may not be included in using a geographical approach. One potential example is the location of a homeless shelter outside the 15% most deprived areas according to SIMD. It has been suggested that a range of targeting approaches is required in order to reach as many patients in deprived circumstances as possible.

• Effective targeting requires staff with skills to search, extract, maintain and audit target population lists. Practices have led on identifying which patients within the target cohort to prioritise and producing lists of patients to work from. This requires specific IT and admin skills amongst the practice staff. At a project level, there is a requirement to ensure that all practices understand which patients are eligible for a Keep well health check and to support practices in managing their patient lists. This may include training staff or providing IT solutions such as the Keep well engagement audit.

Barriers to Engagement

Throughout the reports produced, factors affecting whether or not patients engage with Keep well have been highlighted. Here are listed the key barriers that may prevent the effective delivery of and engagement with Keep well.

• During the early phase of Keep well, concern was highlighted over the “amount of leverage brought to bear” by the NHS on general practices as independent contractors in delivering Keep well. There is a continued and necessary need for dialogue with general practices to foster successful working relationships. The result of this continued effort is seen in the high proportion of eligible practices delivering Keep well health checks in Tayside.

• Infrastructure barriers have been experienced by practices including lack of outgoing phone lines with which to make telephone invitations and insufficient number of consultation rooms to allow Keep well health checks to be booked during certain periods of the working week.

• The ability of practices to reach and engage with target patients is heavily reliant on practices having up to date contact details. In turn this is reliant on patients informing their practice of any change of address or telephone number as they occur. As such, this is not a barrier easily overcome.

• Patients often have competing priorities for their time. In particular these have included work and caring responsibilities. The qualitative evidence produced thus far indicates that patients may be reluctant to prioritise their physical health against a background of adverse social problems and material circumstances.

• The NET’s model of candidacy described the interplay between service providers and patients that results in a patient accessing healthcare. The NET found that patients often view the NHS as a service to make them better as opposed to a service that maintains good health. As a result there is a danger that patients will not engage with anticipatory care interventions as they do not perceive themselves to be a candidate for such a service.
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**Marketing of Keep well**

- The Keep well brand is not widely recognised by patients although many feel that the concept of anticipatory care is worthwhile\(^9,10\).

- Stories in the local press (in rural areas) have been shown to raise awareness of Keep well and produce positive outcomes\(^6\).

**Positive Feedback**

Patients have reported that they would not have attended their general practice if they had not been invited for a Keep well health check\(^10\).

The increased appointment length afforded by the Keep well health check has been viewed favourably by patients\(^4,9\).

Patients have reported the identification of previously un-recognised cardiovascular risk factors and the optimisation of existing treatment\(^10\).

**Follow-on Services**

**Health Coaching**

- Staff delivering Health Coaching are on the whole positive about Keep well and there is a willingness to maintain or increase their role. Staff view Keep well as having the potential to influence wider service delivery and they perceive that some of the patients engaged would not otherwise have attended their general practice\(^11\).

- There is a heavy emphasis on weight management and this reflects the needs of the patients. However, it has been suggested that this may lead to a reduced appreciation of the variety of issues that can be addressed by Health Coaching amongst practice staff\(^10\).

- Health Coaching embedded within the Dundee Healthy Living Initiative is viewed by patients positively as it has allowed them to access a wide skill base and a variety of support mechanisms, such as activity groups, in addition to their one-to-one health coaching support\(^11\).

- There are many, often inter-related, factors specific to individual patients that impact on their ability to instigate positive health behaviour changes. These include work commitments, caring responsibilities and the ability to prioritise their physical health within adverse circumstances\(^10,11\).

- Often small positive changes achieved by a patient is significant to that patient but may not be recognised by quantitative evaluation\(^10\).

- Health Coaching is a time-intensive service\(^10\). There is considerable effort required in maintaining contact with patients and supporting them to make lifestyle changes often against a complex social background. This limits the number of patients that can be supported during any given period.
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• The rapport established between the Health Coaches and their patients has been highlighted by both staff and patients as key to supporting positive health behaviour changes\textsuperscript{10}.

• The patient-centred approach integral to the Health Coaching model has been viewed positively by patients\textsuperscript{10}.

Summary

This report has collated the key lessons learnt from an extensive body of evaluation evidence that has built up since the start of Keep well. These lessons have largely concerned the reach and engagement aspects of the Keep well project. There are a number of central themes that have emerged from this evidence.

As a result of the evaluation work and the lessons highlighted here, Keep well is now able to establish a coherent evidence based engagement strategy for general practice. By using the evidence produced it should be possible to implement a strategy that will engage with a high proportion of the target population and be time and cost effective.

The lessons highlighted here also indicate that there are many, often inter-related, factors that affect a patient's ability to attend and engage with the Keep well health check and the follow-on services. The Keep well Outreach Nurses have been instrumental in helping practices to overcome these barriers and engage with patients as they have provided a flexibility and increased capacity that otherwise would not have existed within the primary care setting. The increased flexibility has enabled patients to schedule a Keep well health check at a time and venue to suit them thus allowing them to give time to their physical health often against a background of competing demands.

The lessons learnt highlighted in this report are transferable to other health interventions and programmes looking to reduce health inequalities. Many of the barriers identified through the Keep well evaluation will not just be stopping patients from accessing a health check but also stopping them from accessing other services offered by the NHS. In addition, the evidence concerning invitation strategies could be applied by other services to optimise the number of patients from deprived communities they are able to engage with. These lessons not only provide an occasion to refine the Keep well programme in Tayside but also an opportunity for other services to further develop as they work towards narrowing health inequalities.

Bibliography

1. Cardiovascular Anticipatory Care Screening; ISD Scotland 2010

2. Health Equity Strategy 2010: Communities in Control; NHS Tayside 2010


5. Noakes G. Retrospective Analysis of the General Practice Model of Engagement and Different Invitation Strategies, NHS Tayside 2010


