HEALTHY BEHAVIOURS
GMS Quality Improvement project 2024/25

Name of Practice: Brunswick Health Centre
Name of Cluster: City Cluster

PLAN: Understanding the problem

Unhealthy behaviour stems from a multitude of reasons, this could be influenced by mental health, physical, social and economic issues. Read coding of data of unhealthy behaviour not only new patients but our patients with long term conditions. We have a diverse patient population with much socio- economic deprivation. This correlates with high levels of chronic disease and obesity. Unhealthy behaviour habits could be detrimental to patients physical and mental wellbeing, ever since the Covid lockdown patients' health had somewhat deteriorated and they then find it hard to get themselves back on track to a healthy lifestyle. This may be due to social pressures, eating habits, stress, anxiety and gambling.

PLAN: Involving others

We have involved all clinicians, Health Care Support Worker, Cluster pharmacist and the All-Wales Diabetes Prevention Programme. Referring patients to outside services is crucial for patients who would like to quit smoking, stop bad eating habits to lose weight, lowering alcohol consumption and gambling addictions.

PLAN: Aim: What are we trying to accomplish?

We are trying to help patients live healthier lives by reaching their goals of losing weight by eating well (weight management services), stopping smoking (NHS HelpMeQuit), cut down on alcohol intake and general wellbeing improvement. This may be in the form of self-monitoring weight loss, healthy eating goals or exercise regularly and giving patient education leaflets for help and advice. Read-coding correctly gives us a better understanding of unhealthy behaviour with all of our patients.

PLAN: Measures: How will we know a change is an improvement?

We have targeted our chronic disease and newly registered patients; our chronic disease patients are regularly monitored in our CD clinics and intervention such as weight loss smoking cessation and alcohol reduction are followed up. Look for trends in improving weight loss and smoking cessation figures and referrals to outside agencies. Read coding of data for both new patients and existing patients and checking regularly on Informatica.

DO: What changes did we make could result in an improvement?

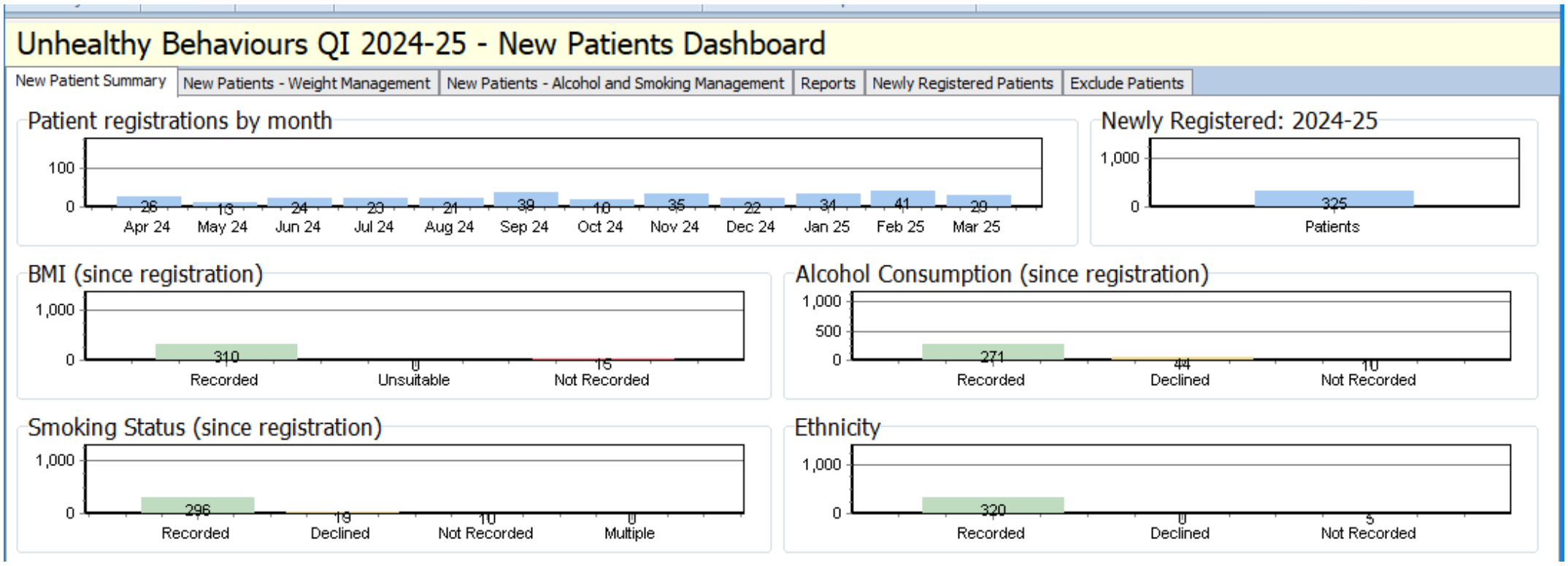
All our new patient checks are done face to face by our HCSW or practice nurse and any problems identified, patients are sign posted to relevant organisation such help me quit, social prescriber, weight loss services or drug/ alcohol and gambling support services. We send follow up SMS messages to patient with links to all the services indicated. On our website we have multiple links for help and support for our patients and we have promotional material in our waiting room. Staff are aware of the importance of sign posting patients to healthy living resources and we have had an increase on referrals to NERS since the beginning if this year.

We have completely redesigned our diabetic clinic and have created a one stop shop in which all patients are brought into the surgery. All lifestyle measures are recoded, and patients are offered interventions as indicated. The diabetic patients are seen by our HCSW, diabetic nurse and clinician and are closely followed up by the diabetic lead GP.

All staff were emailed the correct read codes to use within the Vision system.

STUDY: What did the measure(s) show, and what have you learned?

Patient often accept sign posting to relevant agencies however they are often unwilling to engage to change their behaviours. Patients are frustrated with the waiting times for services such as weight loss interventions and issues with smoking cessation at local pharmacies. Using Informatica data it showed that new patients were being read coded correctly, we are inviting asylum patients in for a new patient check but unfortunately a majority don't accept the invitation. We have a lot of improvement to make on our existing patients under our chronic disease groups, we must make sure the nurses and GPs seeing the patients record their lifestyle within Vision.



ACT: Reflection and the next steps

We will continue to support our patients through our chronic disease clinics and provide opportunistic health promotion wherever possible. We are looking to roll out the model we use for our Diabetic clinic to all other chronic disease registers. We have discussed in practice meetings the importance of read coding lifestyle on all patients for us to have a true reading on unhealthy behaviour within our practice population. All our non-clinical staff are now read coding correctly for all new patient questionnaires that we receive with a patient registration form. Our next steps: We have made changes, but we still have a lot of work to do on our chronic disease registers, tidy ups, The ongoing challenges we face within the NHS is the workload but our main priority is always to deliver patient care.