Health Inequalities Inquiry

NHS Greater Glasgow & Clyde Evidence on Keep Well

KEEP WELL - NHS Greater Glasgow and Clyde
This brief provides an outline of the operation of the first pilots of the national Keep Well programme in NHS Greater Glasgow & Clyde (NHSGGC). It includes detailed proposals for an evaluation of the first wave of pilots.

Background to Keep Well Project [formerly known as Prevention 2010]

In October 2005 Delivering for Health was launched by the Minister for Health & Community Care in Scotland. At that time the Scottish Executive announced its intention to pilot anticipatory care in five Community Health Partnerships (CHPs)/Community Health and Care Partnerships (CHCPs) in 2006/07. These CHP/CHCPs would represent four different NHS Boards in Scotland. Each of the participating CHP/CHCPs was to receive £1m per year for two years, together with additional funding of £0.4m per annum to support delivery of the smoking cessation strategy (this to cover a wider CHP/CHCP population than that of the core project).

Focusing on coronary heart disease (CHD) the aim of Keep Well is to broaden the health improvement role of primary health care services in communities with multiple complex needs. This entails four key objectives:

- to enhance primary care services to deliver anticipatory care
- to identify and target those at particular risk of preventable serious ill health (including those with undetected chronic disease)
- to offer appropriate interventions and services to those identified
- to provide monitoring of Keep Well referrals to external services.

Criteria for success have been identified at a national level as follows:

- the project will be supported at a senior level by Board and CHP/CHCP partners
- support will be given to primary care for the redesign of services to improve
- the project will provide access to preventative primary care for the target group
- the project should reflect local partnership priorities
- the project should be developed and led by GP practices
• the project should identify, contact and engage all those in the target population

• the project should refer those in the population to other NHS and community services as required

• the project should track patients in the target population in order to monitor progress and enhance compliance with treatment

• the project should generate evidence of successful, evaluated approaches to identifying and engaging with those at particular risk

• the project should be sustainable

**Organisational Context in NHS Greater Glasgow & Clyde:**

The White Paper *Partnership for Care* published by the Scottish Executive outlined the principles and framework for the establishment of Community Health and Care Partnerships (CHCPs). The NHS Board’s Delivery Plan sets out the framework in which CHCPs and other parts of the system operate. The model for CHCPs developed in Glasgow supports the full integration of health and local authority social care services into single organizational and service delivery frameworks. The key purposes of CHCPs include:

- improving the health and wellbeing of its population and close the health inequalities gap;

- integrating (joining up) primary, secondary health care with social care services to create person centered services that offer seamless journeys for patients.

For management purposes Wave I of *Keep Well* is hosted by the north Glasgow CHCP and the project is being delivered in north and east Glasgow CHCPs.

NHS GG&C has embarked on an attempt to bring about institutional change in order to maximize its contribution to addressing the causes and health consequences of the different forms of inequality and discrimination. There is a recognition of the challenges, including conflict between medical and social models of health and roles as drivers for change. In line with legislative requirements, the NHS Board’s Equality Scheme 2006 - 2009 sets out the goals for the organisation (and its partners).

Responsible to the Director of North Glasgow CHCP, the role of the Project Manager is to lead the establishment and implementation of the project across the two CHCPs. A Project Team has been identified - supported by sub-groups
leading on training/development; communications; information technology & information and local evaluation & learning. There is also a delivery group in each of the CHCPs - with responsibility for taking forward implementation at a local level. The Project Manager participates in each of these.

Operation of Keep Well in NHS Greater Glasgow & Clyde

The first wave of pilots in 18 GP practices in Glasgow began operating Keep Well in late 2006. A second wave of pilot practices is due to begin in the autumn of 2007.

Keep Well activities involve 5 key steps. All practices have been asked to:

1. contact all patients within the 45-64 age group
2. modify contact strategies where necessary to engage the ‘hard-to-reach’ patients
3. provide a CVD risk assessment for all eligible Keep Well patients who attend a Keep Well appointment
4. where indicated, refer or signpost patients to other services
5. monitor activities around Keep Well patients.

Contact

For the purposes of this brief, patients who are registered with a GP but who have not had contact with or been to their practice for a number of years are referred to as ‘hard-to-reach’. Patients who visit their GP practice regularly, have visited it within the last two years, or who are known to respond positively to contact from the practice, are referred to as ‘easy-to-reach’. Some practices have made a strategic decision to contact easy-to-reach patients first and hard-to-reach patients later; some are approaching both at once; some are going through their patient list alphabetically, and some are using opportunistic approaches.

The method of contact can be crucial to engaging with patients. Practices are being asked to employ a range of approaches to ensure success in contacting hard-to-reach patients. These include letters, tear-off slips, pre-made appointments, follow-up letters, telephone calls, opportunistic screening and house-calls. It is expected that over the course of the Keep Well project, practices will use a number of these approaches in combination for individual patients.

Health assessment

A core data set for the screening/assessment for Keep Well has been developed at national level. Further data sets have been added to this locally (by agreement).

The health assessment conforms to an agreed protocol and is available on-screen to Keep Well practitioners. Completion of the on-screen assessment
takes approximately 45 minutes. Assessments are carried out in practices by Practice Nurses, Health Care Assistants, and in some instances, by GPs. A completed assessment allows a CVD risk score to be calculated and given to the patient. If the patient has no previous, recent blood test results on record, the risk score cannot be calculated until results from blood tests taken at the assessment are received (usually 2-3 weeks).

**Referral/signposting and other services**

A range of local services, mostly community based, are involved in Keep Well. These include smoking cessation; weight management; exercise programmes; debt management; literacy support; selected pharmacies, etc. (a comprehensive list can be provided).

The Keep Well practitioner will inform patients of the relevant services available to them. Patients will be supplied with literature on the services available. If the patient is agreeable, the Keep Well practitioner will make a referral to a service. The Keep Well practitioner will enter details of their encounter with the patient onto the patient’s clinical record and the Keep Well tracking tool.

**Inequalities sensitive practice**

The ‘inequalities sensitive’ nature of the assessment, treatment and referral is likely to impact on the success of the Keep Well intervention. The ability of practitioners to reflect in their approach an understanding of individual life circumstances, experience of discrimination, power imbalance and socialization because of race, gender, disability, sexual orientation, poverty, etc will be of significant impact on the success of Keep Well.

**Monitoring**

NHSGGC has developed a web-based tracking tool for Keep Well based on one already in use to deliver annual reviews for those with CHD, stroke and diabetes. This is available to all pilot practices. Referrals/signpostings are logged on the tracking tool by the Keep Well practitioner. The tracking tool can also be accessed by participating community services. This allows services to identify whether new attendees have been informed of the service through the Keep Well assessment and whether those referred by the practice follow-up the referral by attending the service. Where appropriate, outcome (success criteria) are also recorded.

**Recording**

Individual patient information held on the assessment screen and the tracking tool is collated by NHS GG&C IT Development. All cases are anonymised. Statistical reporting by individual practice will be available on a monthly basis.