1. Keep Well National Policy Context

1.1 Keep well (KW) was launched in 2006 to pilot anticipatory care on a large scale in disadvantaged areas across Scotland, with a primary focus on cardiovascular disease (CVD). Its core element, the KW health check, was intended to identify individuals at particular risk of preventable serious ill-health, offering appropriate interventions and initiate monitoring and follow-up.

1.2 In addition to addressing modifiable risk factors and health behaviours associated with CVD (e.g. high blood pressure, high cholesterol, smoking, overweight etc), the Keep Well health check also incorporates wider social issues including money worries, employability, literacy and mental health & well being.

1.3 In March 2010, the Scottish Government announced its intention to mainstream the KW programme across NHS Scotland from April 2012. In March 2011, the Scottish Government issued implementation guidance which stated that the intended focus of the programme should broaden to include the wider range of modifiable factors that contribute to health inequalities, and target the following population groups.

Core population: Individuals aged between 40 and 64 not already included in practice stroke, diabetes or CVD disease registers and living in the most deprived geographical localities

Specific Vulnerable Populations: South Asian and Black & Afro-Caribbean ethnic subgroups, offenders, gypsy/travellers, homeless individuals, those affected by substance misuse and carers

2. Keep Well in NHS Greater Glasgow & Clyde

2.1 Keep Well primary prevention programme was implemented during 2006 within an initial 18 practices across North and East Glasgow. The primary prevention programme subsequently extended in 2008 to include 6 practices within South West Glasgow, and in 2010 to 22 GP practices within West Dunbartonshire and Inverclyde CHCPs.

2.2 NHS GG&C continues to prioritise delivery of Keep Well from GP practice based settings as its principal delivery method, via Local Enhanced Service (LES) contract arrangements, to ensure sustainable coverage of our most deprived neighbourhoods.
2.3 From 1st April 2012 approximately 100 NHS GG&C GP practices continue to participate within the Keep Well LES across Glasgow City, Inverclyde, West Dunbartonshire and Renfrewshire CH(C)Ps. NHS GG&C aims to extend the programme to all GP practices service our most deprived communities by April 2013.

2.4 In total, over 40,000 primary prevention health checks have been delivered within NHS GG&C since the commencement of the programme in 2006, with 19,466 checks delivered during 2011/12 financial year.

3. **Patient Engagement Approaches within Keep Well**

3.1 Identification and engagement with priority groups (vulnerable populations) will be effected principally through maximisation of coverage of GP practices, supported by appropriately targeted deployment of Outreach Workers and development of partnerships with wider primary/social care services and community based organisations.

3.2 From April 2011, NHS GG&C implemented a patient engagement protocol within the Keep Well LES contract, to build on good practice and reduce barriers to patient engagement. Participating GP practices are required to demonstrate flexible engagement methods including utilisation of telephone, SMS, email, opportunistic contacts and outreach engagement approaches.

3.3 Preliminary findings from programme evaluation, demonstrate successful engagement outcomes from community outreach. Further monitoring and evaluation of outreach model will be undertaken during 2012/13 to inform future delivery model and potential to extend to other programme areas.

4. **South Asian Anticipatory Care Project**

4.1. Glasgow has the largest South Asian population in Scotland. South Asians in the UK are up to six times more likely to get diabetes, develop it earlier, suffer from more severe complications, become high intensity users of unplanned secondary and primary care services and more likely to die prematurely compared with indigenous Anglo-Irish Scots.

4.2. The South Asian Anticipatory Care (SAAC) project commenced in April 2011, and will aim to test approaches to; identifying and engaging with South Asian individuals, delivering culturally & linguistically sensitive primary prevention health review for South Asians aged 35-64 years, and supporting individuals to access a range of community health improvement services. The project is delivered by bilingual specialist pharmacists and community outreach workers working closely with GP practice teams with high concentrations of South Asian patients registered within their practice (within Glasgow City CHP South and North West sectors).
4.3. In addition to delivery of Keep Well health checks interventions, the SAAC project team is delivering a wide range of innovative community engagement interventions, providing an opportunity to deliver health behaviour brief intervention and raise awareness of range of community health improvement services.

4.4. Since commencement of the SAAC project, over 850 health checks have been delivered. In addition, the SAAC project team have worked closely with a range of health improvement service providers to implement service improvements to reduce barriers to accessing services and further develop culturally sensitive approaches within programme delivery.

5. Community Orientated Primary Care Pilot – Drumchapel

5.1. Community Oriented Primary Care (COPC) is an approach to healthcare delivery that combines epidemiological and health improvement interventions with the clinical care of individual patients.

5.2. The Drumchapel COPC project began in October 2011 to compliment the Keep Well programme learning. The partnership comprises a cluster of 6 GP practices serving a deprived community, public health and health improvement staff. The project operated at neighbourhood level and comprised four main elements:

- Bespoke definition and profiling of the local population in response to clinician enquiry
- Definition of community health barriers and needs
- Improving pathways, connections and feedback between preventive services
- Creating a more integrated local public health system

5.3. The Drumchapel COPC resulted in a wide range of practical improvements, e.g. healthy affordable food sales within healthcare settings, new healthy eating materials designed by clinicians, a men’s health needs assessment, connections with local regeneration agencies, increased role of the local voluntary sector in responding to health issues and engagement of clinicians in defining solutions to clear deficiencies in current systems.

5.4. The COPC approach is a promising method for improving both the integration and sustainability of local health systems in response to need identified at ‘grassroots’ community level. It improves the interconnectedness of health promotion and healthcare systems through tangible collaborative work shared by GP practices, public health and health improvement practitioners.
6. **NHS GG&C Anticipatory Care Framework**

6.1 NHS GG&C is committed to establishing 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.

6.2 The anticipatory care framework locates prevention and health promotion within a broader ‘whole system’ strategy across the continuum of care for chronic disease (figure 1). The importance of incorporating a focus on health improvement across the spectrum of care, including tertiary prevention, is vital for conditions such as obesity, Type 2 diabetes and hypertension, where non-pharmacological measures play an important role in health gain.

**Figure 1:** An integrated prevention model for anticipatory care  
*Source: NHS GG&C Anticipatory Care Framework (2011)*

6.3 The core activities common to prevention interventions are effective motivational interviewing and universal inequalities-sensitive practice,
allowing individuals with complex health care needs and/or hidden, underlying issues, to be afforded time and space to engage productively with potentially effective services.

6.4 Evidence from evaluation of Keep Well suggests some practical ways forward in delivering this across the entire health system, and will continue to inform implementation of NHS GG&C anticipatory care framework.

Heather Jarvie
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