REPORT TO
DUNFERMLINE & WEST FIFE CHP COMMITTEE

THURSDAY 10TH JULY 2014

KEEP WELL MAINSTREAMING UPDATE

MARGARET BELL, KEEP WELL MANAGER
BELINDA MORGAN, HEAD OF HEALTH IMPROVEMENT
1. **PURPOSE**

1.1 The purpose of this paper is:-

i. To inform the CHP Committee of the second year progress towards mainstreaming of the Keep Well service and third year plans

ii. To give an indication of the results achieved during the period 2013-14

iii. To inform of the Scottish Government decision to disinvest in Keep Well over the next few years

iv. To support a request to review sustainable funding for Keep Well from 2017.

2. **INTRODUCTION**

2.1 Keep Well continues to be delivered throughout Fife, delivering on its aims and objectives which are; to increase the rate of health improvement in deprived communities by enhancing primary care to deliver anticipatory care.

2.2 This is achieved by:

- Identifying and targeting those at particular risk of preventable serious ill-health including those with undetected chronic disease
- Offering appropriate interventions and services to them
- Providing monitoring and follow-up.

2.3 NHS Fife Keep Well met the agreed 2013-14 target of 2,100 inequalities focussed cardiovascular health checks with 4% delivered to marginalised populations or groups. Marginalised groups for the purpose of the check were defined as South Asian, Black & African Caribbean, Gypsy Traveller and Homeless populations; Offenders and Substance misusers.

2.4 Keep Well uses a person centred targeted model to deliver anticipatory care, using best practice guidelines and screening criteria to provide a holistic health check to the most at risk individuals of chronic ill health and disease. It has also become an enabler for wider work on the reduction of health inequalities working both at the individual and community level and this has been further enhanced by our close working with third sector organisations and community planning partners.

2.5 By developing and sustaining these successful partnerships we have often been able to develop local and responsive support for chronic and long term conditions such as mental health, alcoholism and addictions.

2.6 The programme has evaluated well and results demonstrate that it has the potential to impact on the reduction of health inequalities in Fife with clients showing health benefits such as weight loss, reduced BP, improved mental health and increased opportunities for carers support and financial assistance. The previous HEAT target had a specific Cardio-Vascular outcome, reflecting both the role of CVD (Cardio-Vascular Disease) in contributing to premature morbidity and mortality in deprived communities, but also the common risk factors shared by CVD and other causes of premature morbidity/mortality. The systematic and planned pro-active targeted approach leading to clinical review and treatment where required warranted the Keep Well model being cited within The Audit Committee of Cardiology 2012, as an effective model to reduce coronary heart disease within the most deprived communities.

2.8 In November 2013 the Scottish Government reversed its decision to continue funding Keep Well from 2016 onwards and informed Health Boards of its decision asking Boards to consider their local solutions for sustainable long term funding. There is an anticipated shortfall of funding for the programme from 2015/16 with sustainable funding required to continue the service from 2017.

3. **DELIVERY**

3.1 Keep Well proactively targets those at risk by inviting those eligible for a health check using letters, telephone calls and community outreach. Health checks are offered from local venues such as community and church halls, libraries, fire stations, Fife Council and NHS premises within SIMD quintile 1 areas and close to where the target population live or work. Engagement is further supported by outreach events and mobile clinics with regular evening and weekend appointments available.

3.2 In line with SIGN 97 guidance, cardiovascular risk is assessed using the ASSIGN score (Assessing cardiovascular risk using SIGN guidelines to ASSIGN preventative treatment). This score has been developed to include social deprivation assessed on the basis of postcode of residence as a risk factor, and includes an adjustment for family history and a quantitative estimation of cigarettes smoked.

3.3 Following assessment clients are referred where appropriate for further clinical assessment and/or to a range of services designed to help them achieve their personal goals, such as emotional health, physical activity, smoking cessation, alcohol, drug, financial or employment advice or carer support.

3.4 Services have been commissioned for exclusive use of Keep Well clients; Fife Sport & Leisure Trust provide exercise opportunities and Link Living provide guided self-help for those experiencing mild to moderate anxiety or depression. These interventions can contribute to reducing the risk of CVD and can improve a wide range of health and wellbeing issues.

4. **OUTPUT**

4.1 In the financial year 2013-14 the Keep Well team saw 2244 people for a health check. 1258 (56%) female and 986 (44%) male.
5. **ALL REFERRALS**

5.1 Chart 2 below shows referrals and attendance for community based and preventative services.

5.2 **NHS Fife | Keep Well | Number of Referrals with Attendance Outcome | For all those attended in response to an invite during year ending 31 March 2014**

Chart 2

Note: Excludes data where outcome is unknown
CLINICAL IMPACT: CORONARY HEART DISEASE MORBIDITY/MORTALITY

6.1 To assess Keep Well’s impact on mortality, an analysis of mortality outcomes of the eligible 2008/9 Keep Well cohort was conducted, comparing the survival of those who attended to the survival of those who did not attend a Keep Well Health check. The identified cohort for 2008/09 was 19,166, with 48% (n=9,143) attending a health check between 1 June 2008 and 31 March 2013 and 52% (n=10,023) not attending. 54% (n=4,907) of attendees were female and 46% (n=4,236) were male.

6.2 From 1 June 2008 until 31 March 2013 3.4% (n=658) people died from all causes of death. Survival for those who attended a health check is 98.5% at 31 March 2013 and 95.6% for those who did not attend a Keep Well health check. Cox regression indicated that those who attended their Keep Well check were almost 3 times more likely to survive (ORa 2.9; 95% CI = 2.4-3.5; p <0.0001) from all causes of death compared to those who did not attend their health check.

6.3 Chart 3 shows the Cox regression produced using time to death where the primary cause of death was cardiovascular disease; the regression was adjusted for age and gender.

NHS Fife | Keep Well Cohort 2008/09Survival at 31 March 2013 Comparing Those Attending Keep Well Health Check v Non

6.4 The percentage of deaths where the primary cause was attributed to cardiovascular disease between 1 June 2008 and 31 March 2013 within the cohort was 0.6% (n=106). Survival from death due to cardiovascular disease within those who attended a Keep Well health check is just under 99.8% and about 99.3% within the group that did not attend the Keep Well health check. Cox regression indicated that those who attended their Keep Well check were more than 3 times more likely to survive (ORa 3.1; 95% CI = 2.0-4.9; p <0.0001) a death attributed to Cardiovascular disease compared to those who did not attend their health check.

6.5 Analysis of CHD morbidity shows CHD admissions have been declining for those in the most deprived quintile reducing from 1400 to 900 per 100,000 population. For the least deprived quintile admissions have fallen from 590 to 410 per 100,000 population, confirming that admissions for CHD are falling in NHS Fife across all quintiles.

6.6 The absolute range has fallen from 827 to 473, demonstrating that the gap between the most deprived quintile and the least deprived quintile is narrowing. The relative range overall has also reduced from 2.44 to 2.12 meaning that the population of the most deprived quintile was previously 2.44 more times likely to have a CHD admission than the population of the least deprived quintile and that has now reduced to 2.12 times.
Chart 4 below shows the results for the Keep Well cohort referred to the GP in 2013-14 with raised blood pressure, cholesterol or glucose. The percentage of those referred with a follow-up measurement recorded within general practice. The percentage of those followed up with an optimal improvement in lowering the risk of a CHD or stroke event, those prescribed a first or new medication and those added to a chronic disease register.

**NHS Fife | Keep well | Referrals to GP and Follow up | Attendees Invited during year ending 31 March 2014**

Chart 4

Notes: 1. For blood pressure and cholesterol, improvement is in line with optimal from cited research 2. Blood pressure prescriptions are from BNF chapter 12, cholesterol from BNF chapter 12.2 and glucose from BNF chapter 6.1. 3. Blood pressure relates to hypertension register, cholesterol relates to CHD register and glucose relates to diabetes register.

7. **EARLY INTERVENTION/PREVENTION – GENERAL DEVELOPMENTS**

7.1 The Keep Well team continue to implement a systematic approach to reach at risk individuals who do not normally access health care. NHS Health Scotland in the Policy Review for The Ministerial Task Force on Health Inequalities (June 2013) underlined that actions to reduce health inequalities had to include targeting high risk individuals and the provision of tailored often intensive support. Keep Well continue to look at innovative ways of increasing engagement with the target population in addition to the comprehensive data base and direct approach. Wider communication within local communities is deployed in the way of flyers, leaflet drops and walkabouts.

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7.2 The Keep Well health check itself continues to evolve with screening for the wider determinants of health that compromise an individual’s health & wellbeing now being incorporated. These include personal, social, cultural, economic and environmental elements. Increasingly these social and wider wellbeing factors are being identified and work continues with Fife Council and the Health and Wellbeing Alliance to address such wider structural influences.

7.3 As Keep Well has developed a good knowledge and understanding of the needs of its target population(s) in relation to behaviour change and self management a health coaching more strength-based approach is being implemented to support more sustained health behaviour changes and reductions of generalised cardio-vascular risk factors. The Keep Well health coaching approach is now an integral part of the follow up model and recruitment is underway for a full time health coach.

7.4 This approach was evidenced in the longitudinal cohort study assessing lifestyle change. Impact results demonstrated that 59% were smoking less, 52% were drinking less, 35% were more physically active, 37% were eating more fruit and vegetables and 49% were eating less fat than reported at their initial health check 12 months previously.

7.5 Keep Well’s ‘Heads Up’ programme operated by Link Living continues to evaluate well. In the period 2013-14, 289 individuals were contacted by the service with a 62% uptake. 837 appointments were attended. Post HADS results for Anxiety improved (reduced) by 50% and for depression by 33%. Participants received onward referral or signposting to a range of services including Alcohol/Drugs counselling, bereavement support, carer support, relationship counselling, tenancy support, sexual abuse support and Women’s Aid. The service was valued by clients and received high satisfaction scores.

7.6 Referral to Keep Well Active the physical activity programme operated for Keep Well by Fife Sport & Leisure Trust (FSLT) continued at a high level as over 60% of attendees reported low activity levels and interest in becoming more active.

7.7 In the session 2013-14 Active Options was modified to provide circuit classes in an effort to encourage attendance and long term adherence. 276 referrals were received by FSLT with a known uptake of 61 people. Most participants attended classes two or three times with a small number attending between 20-50 times.

8. MAINSTREAMING PROGRESS – YEAR 2

8.1 50 General Practitioners practices are engaged with Keep Well through a three year Local Enhanced Service Agreement (LES). This facilitates Keep Well access to GP management systems, to assess clients on behalf of GPs and for GPs to accept referrals for further clinical assessment, diagnosis and future management.

8.2 The Keep Well Information System has been further developed to support the administration, clinical data recording and evaluation of Keep Well. GP and partner agency referrals are also generated from the system. 55% of GP practices allow Keep Well to conduct READ coding and data input remotely with the remainder requiring on-site visits.

8.3 The nurse electronic record has been further enhanced to allow clinic details to be downloaded daily from KWIS to an encrypted notebook, where patient details are captured and uploaded at the end of the day back into the KWIS. This has resulted in a more efficient

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and effective service due to improvements in clinical recording, early identification of missing outcomes and facilitation of timely transmission of results to General Practice via email the following day.

8.4 Referrals from Keep Well to partner agencies are carried out via the Fife Online Referral & Tracking System (FORT). FORT has proven to be a secure and efficient electronic method of transferring and tracking all information regarding referral to our partner agencies.

8.5 Five year review health checks commenced in June 2013 for those first screened in 2008. 427 five year review health checks were completed which was 42% above expectation. This dispelled any fear that clients would not engage with Keep Well for a second time.

8.6 Using local knowledge of communities and of the dispersed nature of health and social deprivation in Fife a few additional postcode areas were introduced in 2013-14 this added some postcodes from SIMD Quintile 2 to the Keep Well cohort. The impact will be evaluated in 2014-15.

8.7 A more pro-active through care model has been commenced to support and encourage those referred to follow on services to take up the opportunities open to them. A nurse contacts the client at an appropriate stage to review action taken by the client and to encourage engagement with follow on services if this is outstanding. The impact on uptake of referrals and of behaviour change will be reviewed.

8.8 Keep Well commenced a staff health programme via Well at Work working with NHS Fife Healthy Working Lives Steering Group. Three sessions of health checks were offered across Fife hospital sites with each session well attended. More are planned for 2014.

8.9 Keep Well participated in the Annual Public Health Conference with an oral presentation entitled ‘Heads Up – Pilot of a joint initiative between Keep Well within NHS Fife and Link Living a Voluntary sector Agency’. Two posters were also presented on Keep Well’s work with the Food Banks and Engaging with Islamic Populations. The poster on Islamic Populations was awarded a prize.

8.10 Keep Well released a member of staff for 3 days per week to lead on the Detect Cancer Early – Lung Cancer strand pilot programme across NHS Fife. In collaboration with the Respiratory MCN, lung cancer specialists and radiologists, are piloting an early screening tool, and have developed a fast track pathway which includes a direct referral for chest x-ray. Early results are proving the process to be robust. The number of “good quality” early referrals from Keep Well is already being seen as very positive for patient outcomes. The pilot has been extended for a further 12 months.

9. MAINSTREAMING ACTIONS – YEAR 3

9.1 A Keep Well Annual Report focussing on key achievements and mainstreaming is required by Scottish Government by August 2014.

9.2 NHS Fife SMT will require a paper from the Committee on the sustainability of Keep Well. Partners including those within primary care will be included in discussions.

9.3 The impact of the Health Coach post will be evaluated to measure its contribution. The post holder will proactively develop and deliver one-one support and coaching sessions on an accessible basis to individuals, groups and communities to help them achieve better health outcomes and reduce risk taking behaviour.
9.4 Through care support will continue to be offered by Keep Well nurses to further improve the uptake of referrals to ongoing services. This support will link with the Keep Well Health Coach to encourage sustained health behaviour change in clients.

9.5 To improve the uptake of weight management support the Keep Well Dietitians will offer more group and individual support opportunities for weight management.

9.6 Link Living will introduce group support/education sessions for guided self-help, to encourage those who are unsure of or are not yet ready for one to one support to engage with the Heads Up service.

9.7 A Keep Well Link Nurse will help develop and implement a Social Prescribing Pilot with a GP practice based in Lochgelly with a view to improve mental health and wellbeing by linking patients with non-clinical sources of support within their community and to reduce the use of benzodiazepine medication. Approaches will include addressing the determinants of poor mental wellbeing and addressing the consequences of poor mental wellbeing. Opportunities for physical activity, volunteering and self help, as well as support with employment, benefits, housing, debt, advocacy or parenting will be offered.

9.8 Ongoing patient feedback continues with a survey planned for quarter 3 to review satisfaction levels with the health check experience, including the relevance of health check items. This will allow us to further improve the content and quality of the Keep Well health check in line with National expectations through the Healthcare Quality Strategy (2010) and the Patients Rights (Scotland) Act 2011.

9.9 The nurses have been trained to complete testing for Blood Borne Viruses and this service will be offered to anyone wishing to be tested.

9.10 There will be further development of the Keep Well Information System to allow recording of interventions with people who did not meet the original Keep Well eligibility criteria. This will support Keep Well outreach work with vulnerable people and populations and planned Pilot work in 2014-15.

9.11 Due to relatively poor uptake and adherence to the Keep Well Active programme, run in partnership with FSLT, it will be decommissioned at end of 2013-14 financial year. Alternative physical activity opportunities will be looked for through walking and community based groups and through Community Use Schools.

10. **FINANCIAL IMPACT**

10.1 As part of the mainstreaming plan Keep Well has begun to look at the economic case for investing in an adult anticipatory approach, by modelling the outcomes against the potential financial contribution it can make for NHS Fife’s financial plan.

10.2 This simple economic analysis assumes the potential costs savings are made per person, where an abnormality was found and where an evidence based intervention was available.
10.3 **Table 1 NHS Fife Estimates of Potential Maximum Emergency Admissions Avoided and Associated Costs of Emergency Admissions due to Keep Well, Year ending 31 March 2014**

<table>
<thead>
<tr>
<th>Emergency Admission for:</th>
<th>Estimated Cost Per Emergency Admission¹</th>
<th>Maximum Potential Admissions Avoided²</th>
<th>Maximum Potential Costs Avoided</th>
</tr>
</thead>
<tbody>
<tr>
<td>Uncontrolled Hypertension³</td>
<td>£2,384</td>
<td>330</td>
<td>£786,720</td>
</tr>
<tr>
<td>Undiagnosed Hyperglycaemic Episode⁴</td>
<td>£2,129</td>
<td>25</td>
<td>£53,225</td>
</tr>
<tr>
<td>Chest Pain⁵</td>
<td>£952</td>
<td>137</td>
<td>£130,710</td>
</tr>
<tr>
<td>Stroke/CVA⁶</td>
<td>£4,932</td>
<td>200</td>
<td>£986,400</td>
</tr>
<tr>
<td>Myocardial Infarction⁵</td>
<td>£7,336</td>
<td>137</td>
<td>£1,007,233</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>[ ]</td>
<td><strong>830</strong></td>
<td><strong>£2,964,287</strong></td>
</tr>
</tbody>
</table>

**Notes:**

1. F. Duff, NHS Fife 2011
2. Includes people detected with chronic disease post Keep Well attendance, not detected but provided a new/change of relevant prescription and those improved without the need for new/change of prescription for specific condition
3. Includes people diagnosed hypertensive, or prescribed a new or changed prescription from BNF chapter 2 or with at least 5mm Hg diastolic reduction or 10mm Hg systolic reduction in most recent blood pressure.
4. Includes people detected with diabetes post Keep Well attendance or not detected but provided with a new/change of prescription from BNF 6.1 or those with reduced glucose measurement since Keep Well check.
5. Includes 22% of those with at least 5mm Hg diastolic reduction or 10mm Hg systolic reduction in most recent blood pressure and 50% of those aged < 50, 40% of those aged 50 to 59 and 30% of those aged 60 to 65 showing at least a 10% in reduction in most recent cholesterol measurement.
6. Includes 41% of those with at least 5mm Hg diastolic reduction or 10mm Hg systolic reduction in most recent blood pressure and 50% of those aged < 50, 40% of those aged 50 to 59 and 30% of those aged 60 to 65 showing at least a 10% in reduction in most recent cholesterol measurement.

11. **FINANCIAL POSITION**

11.1 The funding allocation for 2014-15 for Fife NHS Board has been confirmed by the Scottish Government. Thereafter there will be a reduction in the funding available to Keep Well reducing from 2015-16 until its cessation in 2016-17 subject to Parliamentary approval.

12.1 The Dunfermline & West Fife CHP Committee are asked to:

12.2 - **Note** successes to date and ongoing mainstreaming plans for Keep Well Year 3.

- **Note** a potential shortfall in funding from April 2015 and the requirement for sustainable funding from April 2017.

Margaret Bell  Belinda Morgan
Keep Well Manager  Head of Health Improvement
30th June 2014  30th June 2014