

Keep Well in Scotland – Inequalities Targeted High Risk Primary Prevention

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18th International HPH Conference,
April 16, 2010

The Keep Well *Vision*

“To increase the rate of health improvement in deprived communities by enhancing primary care services to deliver anticipatory care by...”

- identifying and targeting those at particular risk of preventable serious ill-health (including those with undetected chronic disease)
- offering appropriate interventions and services
- providing monitoring and follow-up

Planned Outcomes

- Year 1 – Increased Engagement, Support, Treatment & Compliance
- Year 2 – Reductions in CVD Risk & Improved User Satisfaction
- Years 5-10 – Positive Impact on Morbidity and Mortality

Programme Features

- GP practice-based
- Targeted at **45 to 64 year old** individuals living in specific postcode areas
- Increased **engagement** with target population
- ***Keep Well Health Check*** - Identifies risk factors for **Coronary Vascular Disease**
- **Care and support services** (treatment, smoking cessation, weight management, alcohol counselling etc.)
- **ALSO** identifies **other needs** (e.g. literacy, employment and income)

Key Findings (success?)

- Practice approaches (telephone contacts and open, flexible appointments viewed as more successful than letters and fixed appointments)
- Outreach and community-based approaches (showing early promise in reaching a more difficult to engage group)
- Tackling health inequalities?

Key Lessons (learning)

- Challenges of multi-layered variation
- Consistency in routine data that are collected and the difficulty in accessing these data
- Balancing experiential learning with ‘evaluability’ of programmes/policies

Keep Well Screening to date:

- 67,712 patients screened by 31 December 2009
- 139,192 total eligible population at 31 December 2009

What's Next?

- Further evaluation results
- Mainstreaming of programme
- Piloting universal screening

Keep well

Thank you

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