

# Prevention 2010/ Keep Well

## The Lanarkshire Approach

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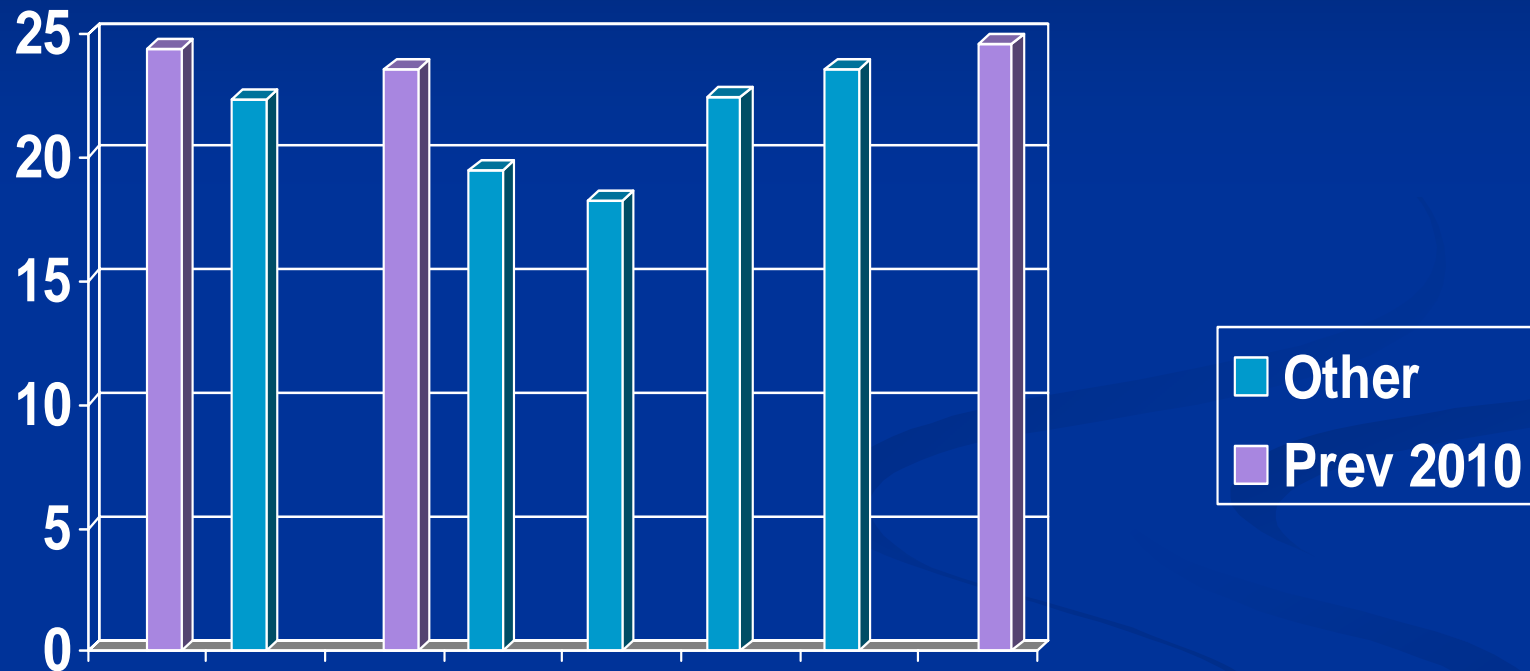
# Summary

- Current Situation
- A “new and additional” approach
- Strengthening Primary Care
- Generating Early Evidence

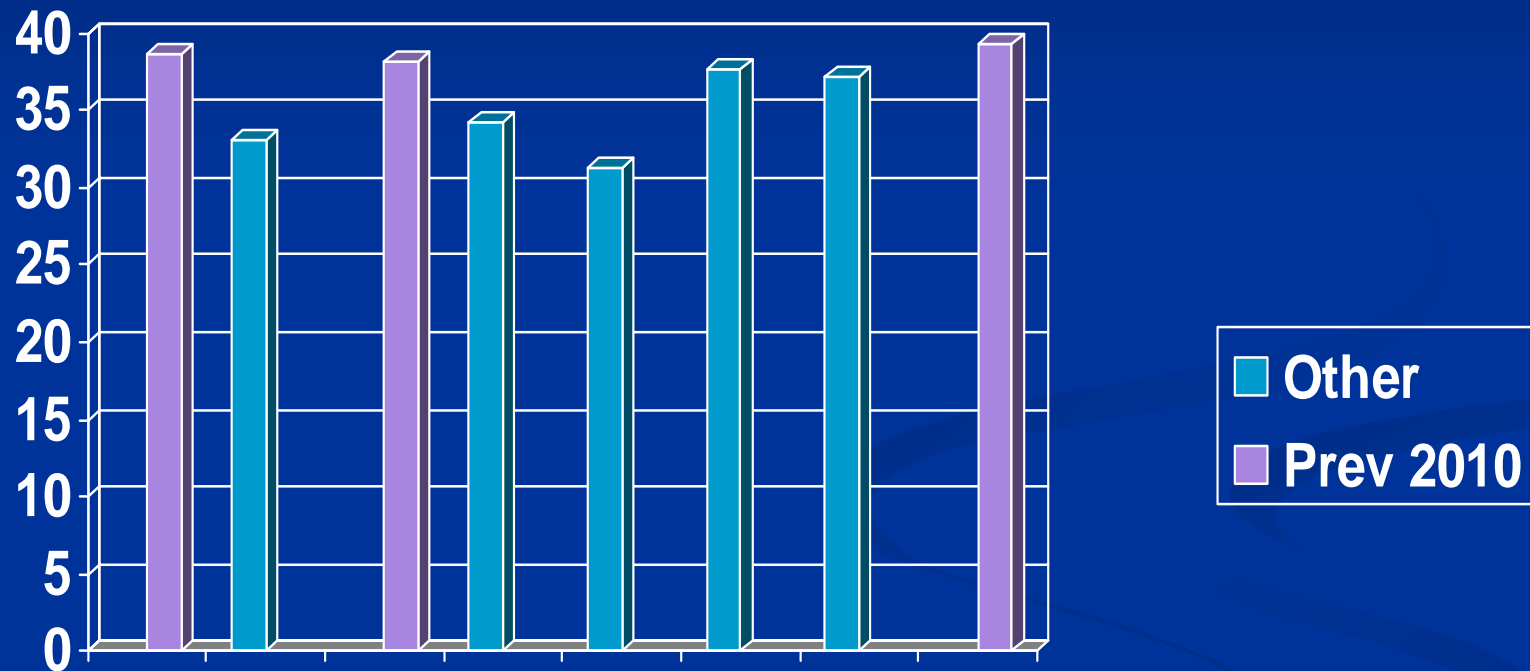
# Situation at October 2005

- Health Burden in Lanarkshire
- QOF and Primary Care Performance
- Lifestyle issues

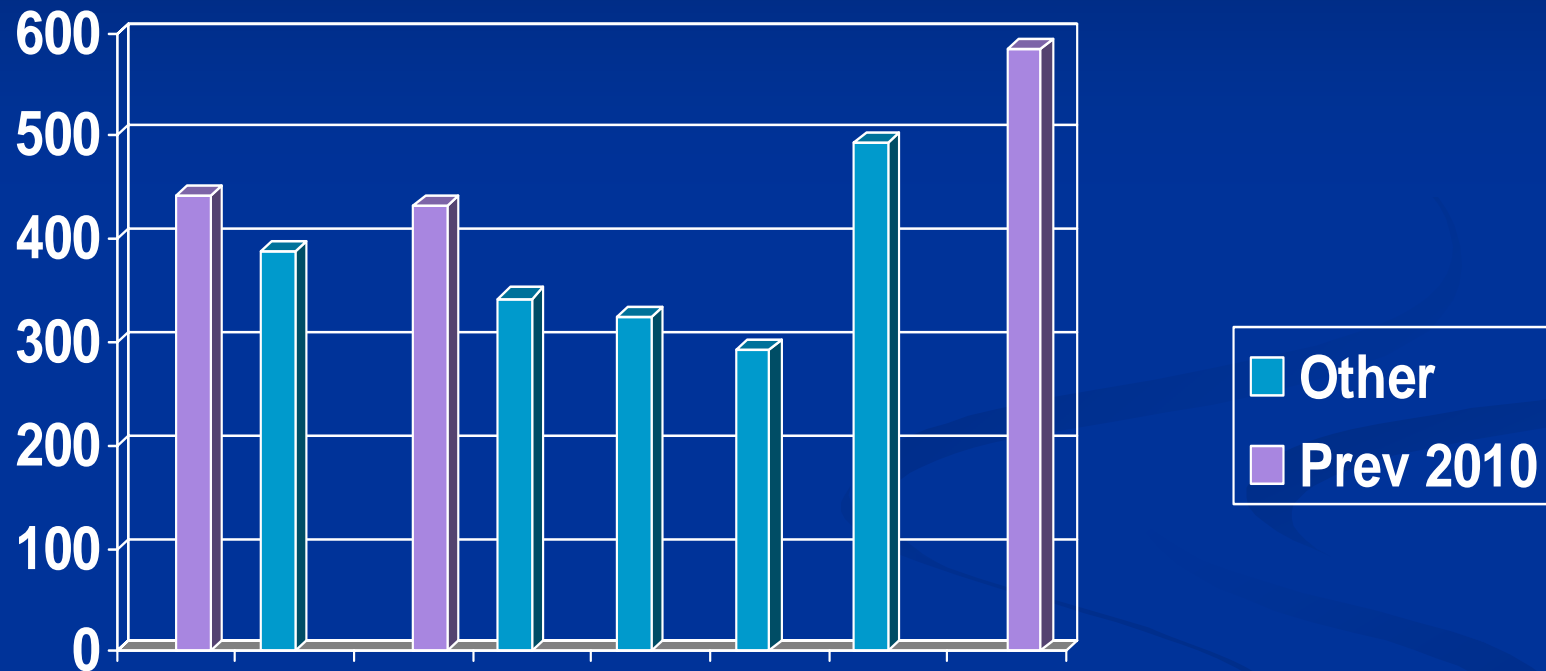
# Long Term Limiting Illness



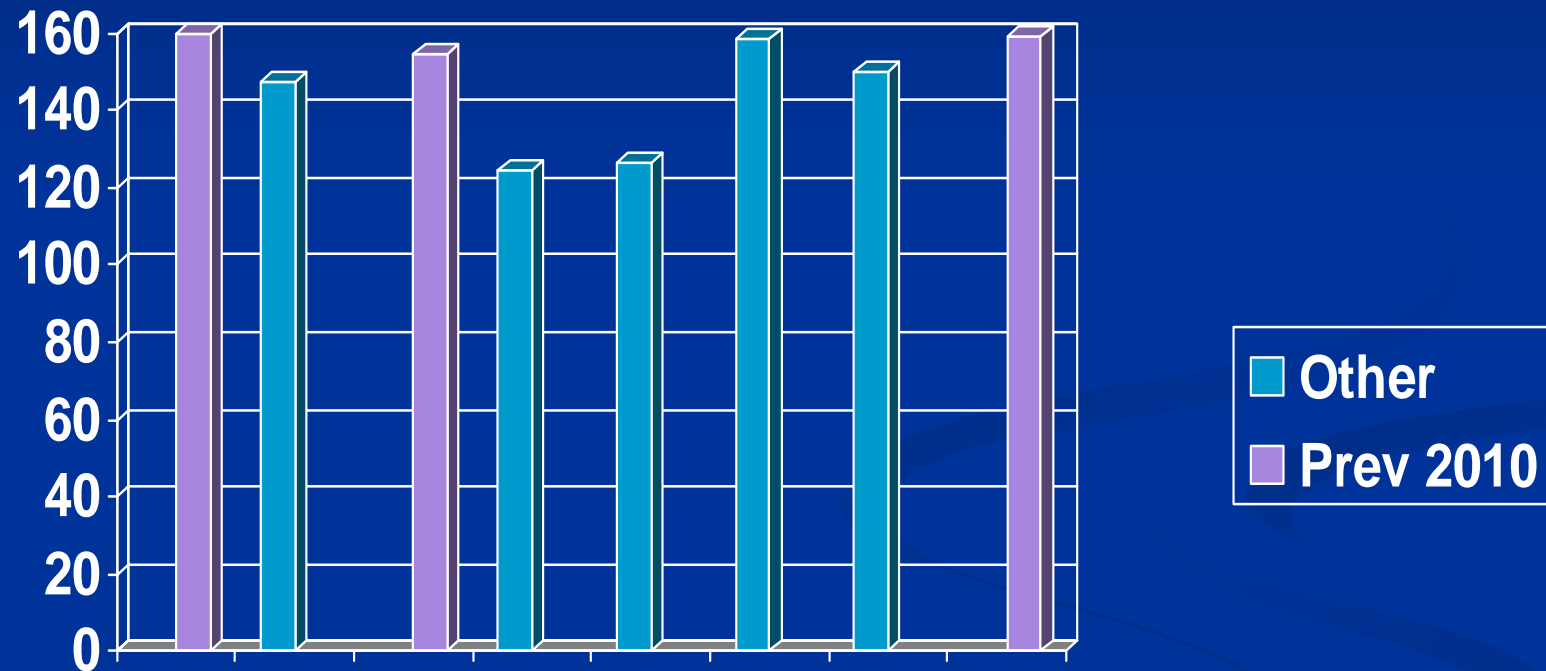
# Percentage Smokers



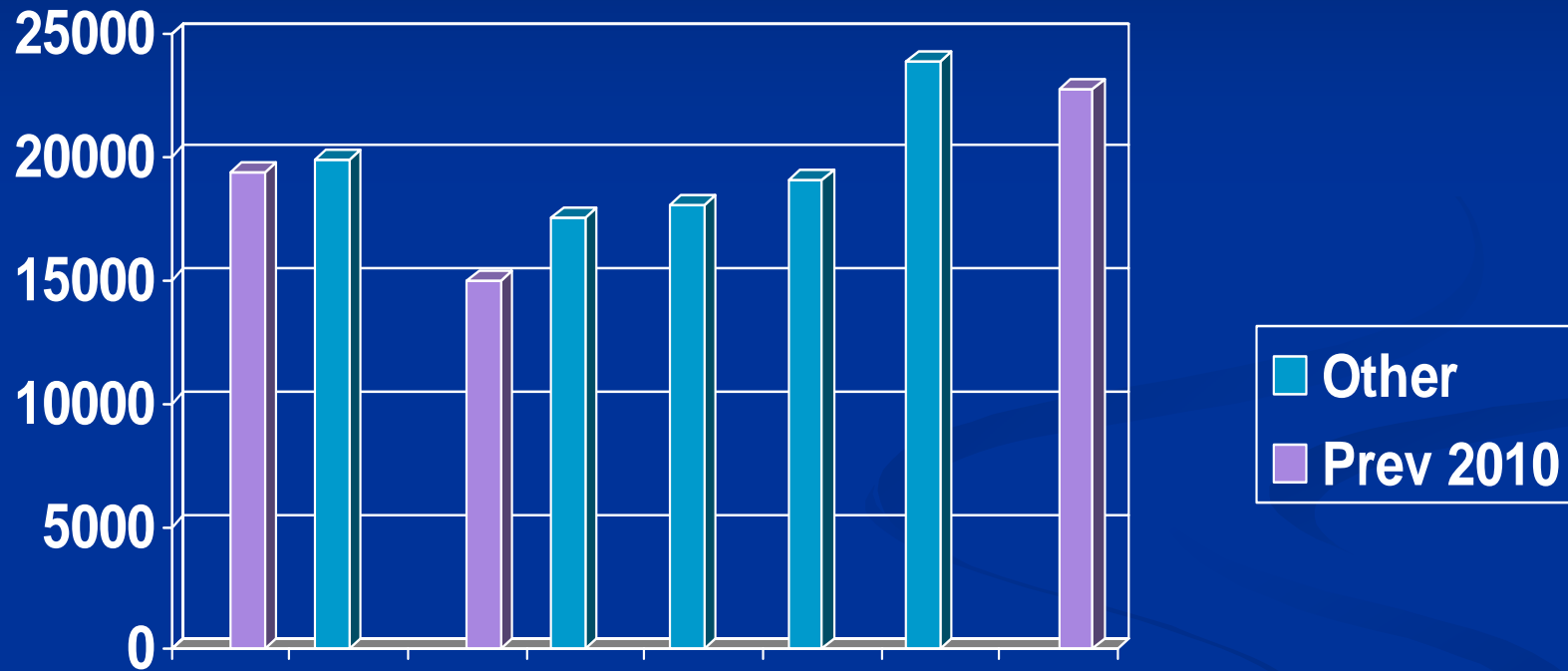
# Smoking Related Mortality



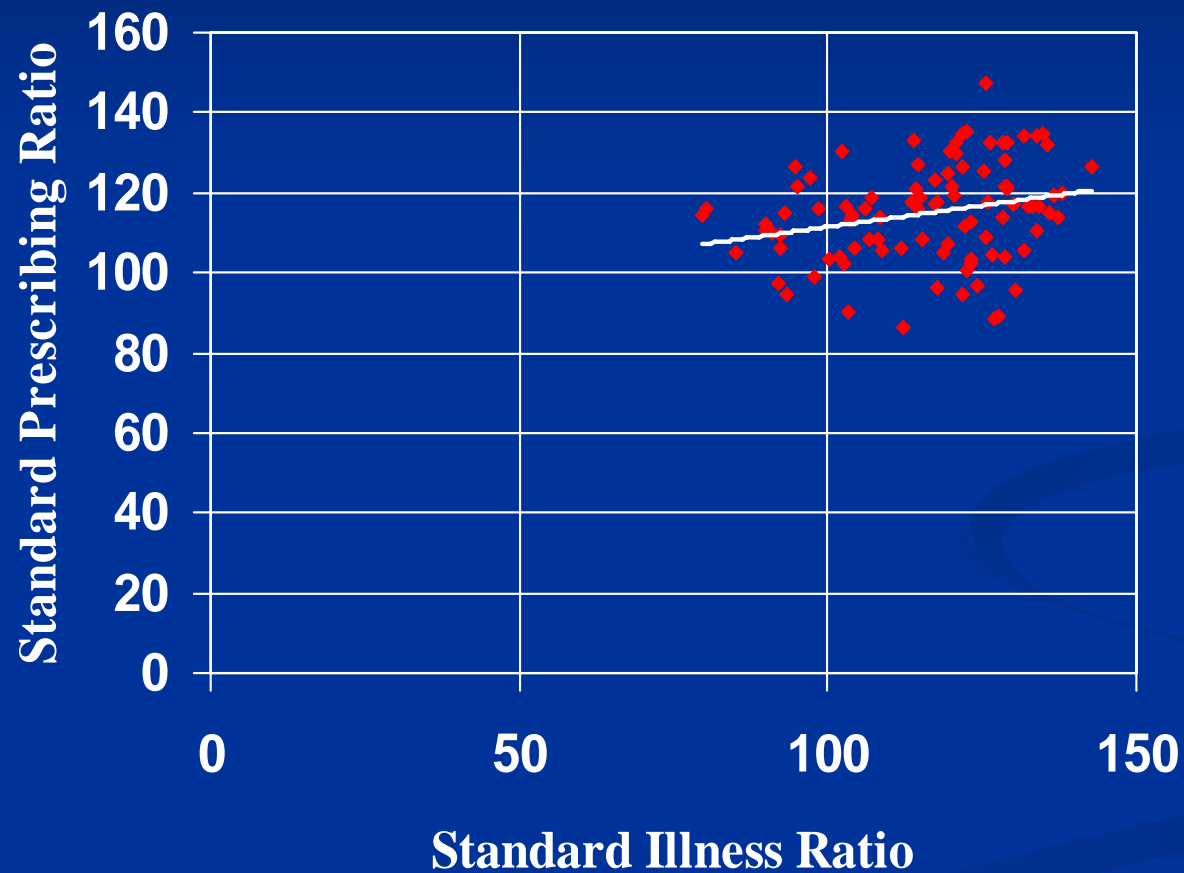
# Heart Disease Mortality



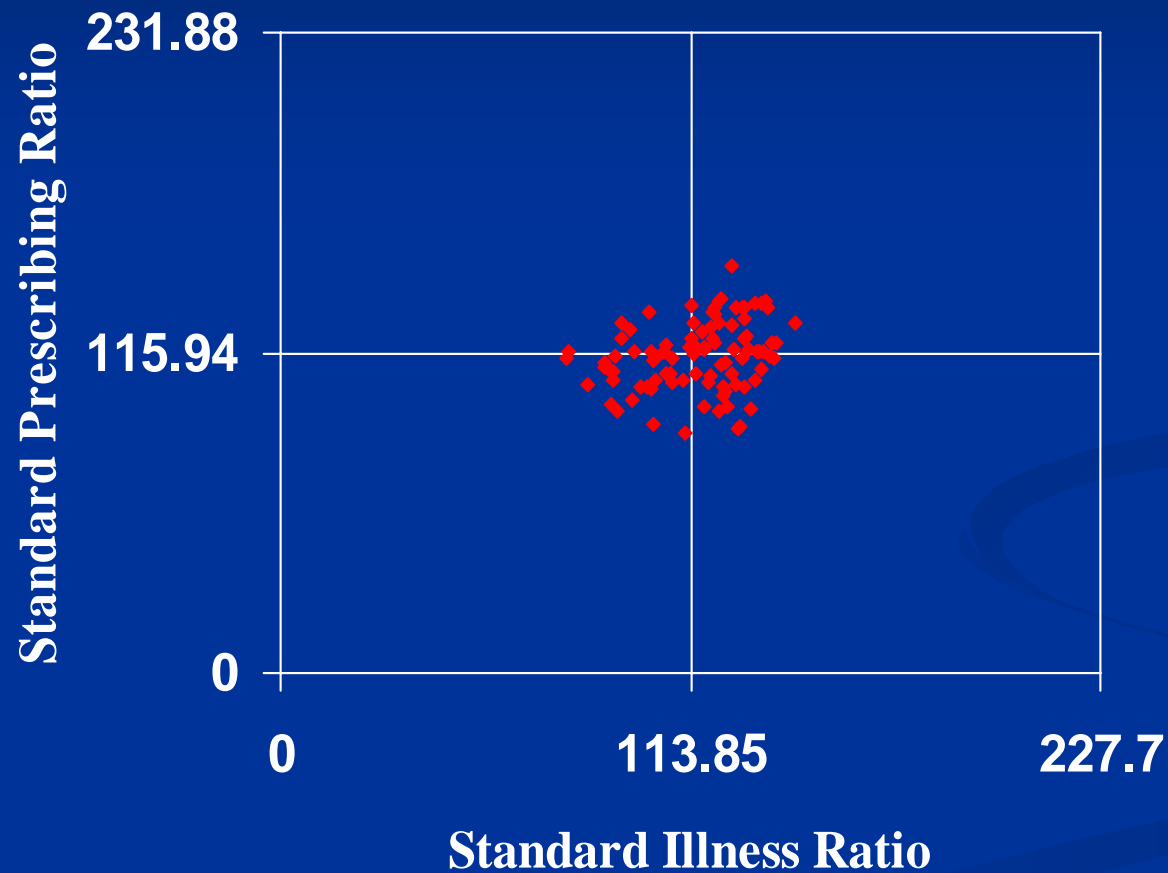
# CVD Drug Prescribing



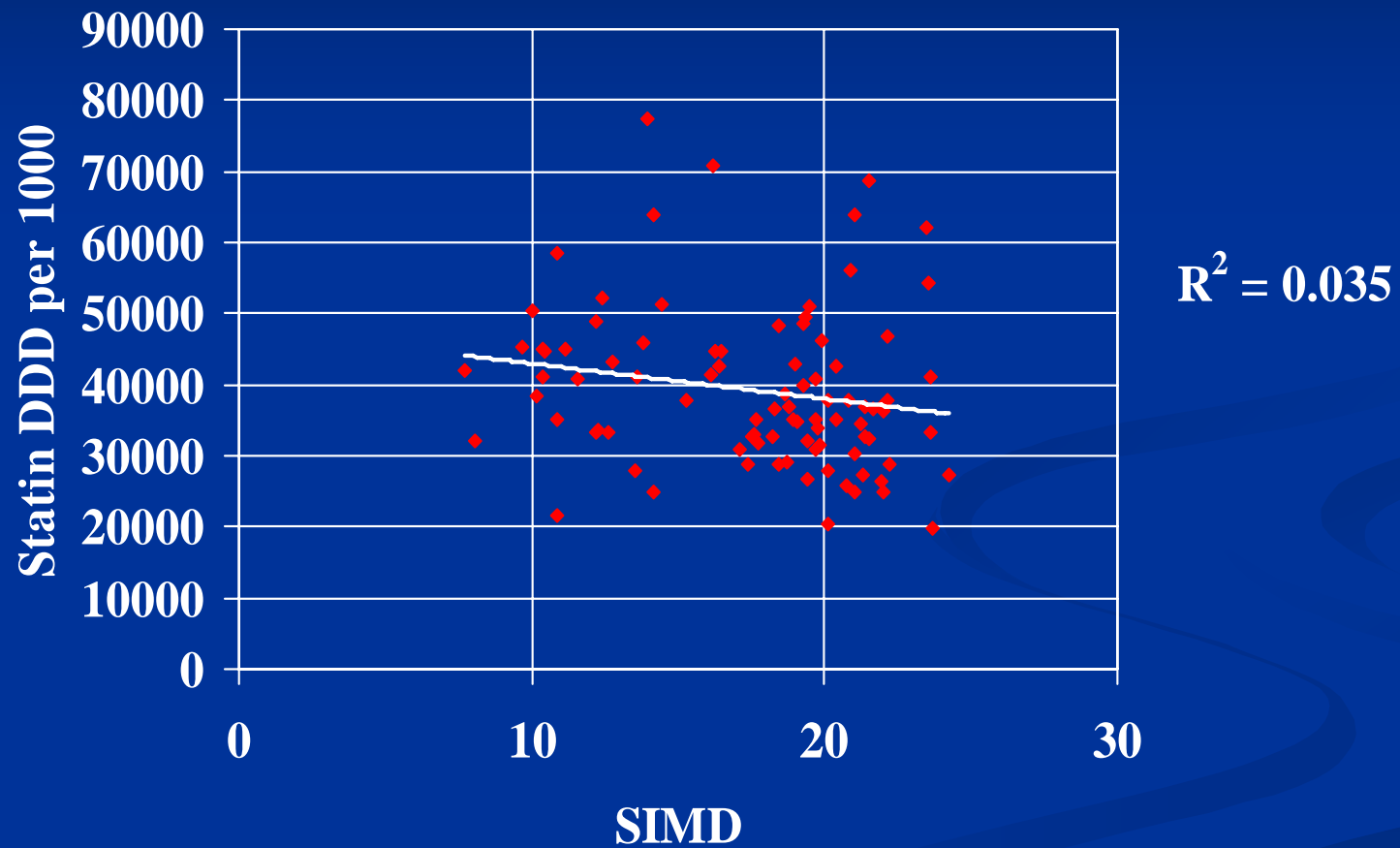
# Illness vs Standardised Prescribing Ratio



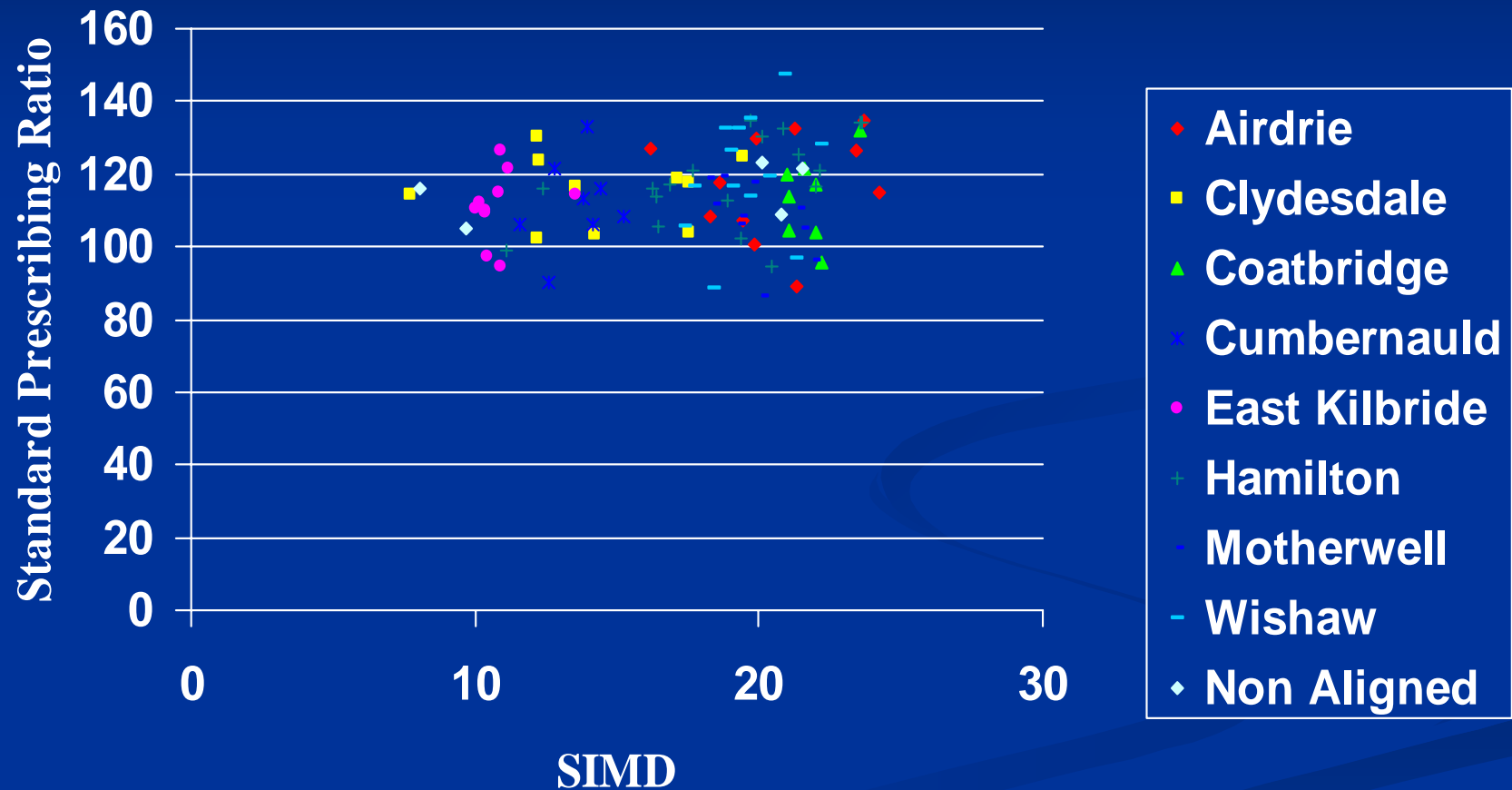
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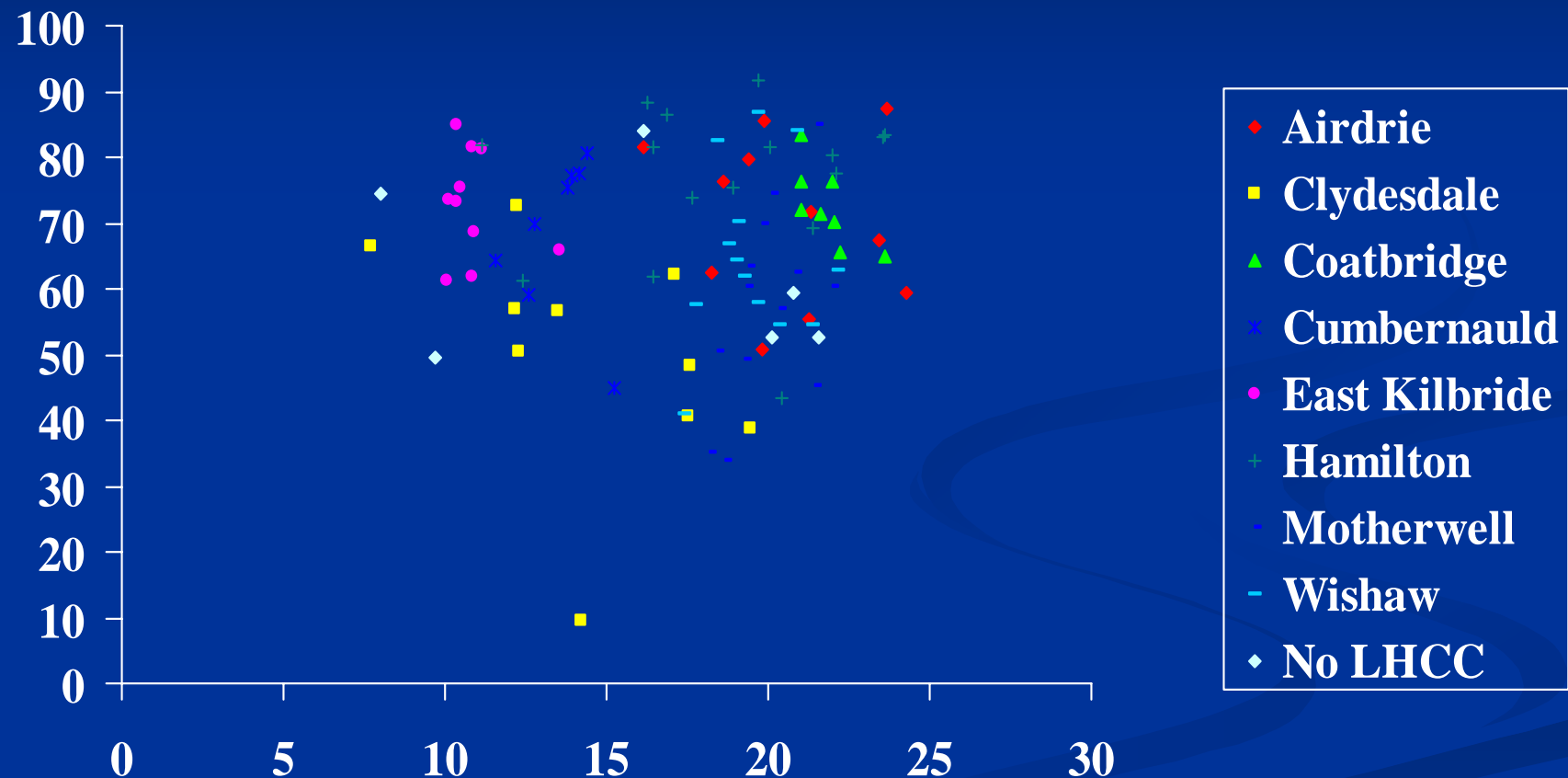
# Deprivation vs Statin Prescribing



# Deprivation vs Standardised Prescribing Ratio



# CHD 08 Performance vs Deprivation by Practice/LHCC (2004/05)



<b>Disease Area</b>	<b>England</b>	<b>Wales</b>	<b>Scotland</b>	<b>Lanarkshire 2005/06</b>	<b>Lanarkshire 2004/05</b>
Coronary Heart Disease	3.6%	4.3%	4.5%	<b>4.74%</b>	4.6%
Stroke	1.5%	1.8%	1.7%	<b>1.82%</b>	1.6%
Hypertension	11.3%	12.5%	11.7%	<b>12.1%</b>	11.1%
Diabetes	3.3%	3.8%	3.3%	<b>3.58%</b>	3.3%
COPD	1.4%	1.9%	1.8%	<b>2.02%</b>	2.4%
Epilepsy	0.6%	0.7%	0.7%	<b>0.73%</b>	0.7%
Hypothyroidism	2.2%	2.6%	2.7%	<b>2.93%</b>	2.7%
Cancer	0.5%	0.6%	0.5%	<b>0.59%</b>	0.4%
Mental Health	0.5%	0.6%	0.6%	<b>0.55%</b>	0.5%
Asthma	5.8%	6.5%	5.3%	<b>5.53%</b>	5.4%

# A “New and Additional” Approach

- Locality based
- Centred on practices
- Help – not more work
- Community outreach
- GP engagement via QOF and DES
- Funding for extra staff – nurses, PA’s
- Information from and for practices
- Links to outcomes & prescribing

# Strengthening Primary Care

- Distribution of GP's by patient number not need.
- Practice resources follow this
- “Running to stand still” - Reactive PHC
- Engagement via extra staff not money
- Positive effect on QOF performance

# Generating Early Evidence

- Sign up by all practices in locality
- Improvement in registers
- Identify those at risk
- Interventions – statins and CVD drugs
- Performance – QOF outcomes
- Effect on Acute Services – modelling and prospective data

# Delivery

- Nurses and PA's into practices and beyond
- Clear guidelines for clinical management
- Engage external agencies
- Robust baseline and audit of change
- Plan roll out in NHS(L)
- Ensure whole system sustainability

# Delivery

- Rebasing of Prescribing Budget
- Congruent with CHP development
- Partnership with NLC
- Involvement of Voluntary Agencies
- Involvement of Industry Partners

# Timescale

- Initial letter Nov 2005
- Funding Available from 01 April 2006
- 2 years from effective start date
- Detailed Proposals 19 May 2006
- Executive leads meeting 14 June 2006
- Approve plans end June/ early July

# Finance

- Funding for 2 years activity
- Timed from effective start date
- NHS (L) - £1.42m per annum
- £1m Prevention 2010
- £0.4m smoking cessation
- £20k dietician funding

# General Principles

- Focus on Health Inequalities
- Deliver Anticipatory Care
- Focus on CVD
- Reverse Inverse Care Law
- Systemic and Targeted Approach
- Builds on nGMS Contract

# Criteria for Success

- Support at Senior Level
- Reflects local partnership priorities
- Developed with and led by GP Practices
- Evidence of successful approaches
- Financially sustainable

# Keep Well - Work Areas

- Target Population 45-64
- Optimise clinical care
- Discover undiagnosed illness
- Tackle intermediate clinical risk factors
- Tackle lifestyle risk factors

# Clinical Risk Factors

- High Blood Pressure
- Cholesterol – Refer-to-Us
- Near patient testing
- Additional resources required

# Lifestyle Risk Factors

- Smoking
- Obesity – Counterweight et al.
- Alcohol – brief interventions

# Chronic Disease Management

- Review practice registers
- Look for patients with sub-optimal therapy
- Invite patients for review
- Propose changes
- Review proposed changes with practice
- Implement changes with approval of patient and practice

# Keep Well Health Check

- Questionnaire
- Discussion with Nurse/HCSW
- Measure BP, weight, waist circumference
- Measure cholesterol, glucose (NPT)
- Assess 10 year CVD risk
- Discuss risk, lifestyle issues
- Signpost and refer

# Partnership Working

- Community Renewal Pilot of a model to “Reach the Hard to Reach”
- North Line (North Lanarkshire Council Call Centre CCC).
- SALUS
- Department of Works and Pensions

# North Line CCC.

- A specialised KW help line has been set up
- Patients requiring to make or change an appointment will phone the KW helpline.
- The CCC staff are phoning the DNA patients to re-appoint them
- The benefit of this is extended opening hours and the direct access to a specific KW telephone operator

# Keep Well in Lanarkshire - The Vision

- To decrease the inequalities in health in our deprived communities
- To identify and target those at particular risk of preventable ill health
- To offer interventions and services tailored to the needs of the patient
- Provision of monitoring and follow up
- To develop a sustainable model of anticipatory care

Data Updated:	17/09/2007								
Practice Name	Church Street Practice	Coatbank MP	C.R.C. Practice	Waverley Practice	Centenary Surgery	Glenboig Surgery	Dr Singh's Practice	Dr Stewart's Practice	All Practices
GP System	GPASS	IPS Vision	IPS Vision	IPS Vision	GPASS	GPASS	GPASS	Exeter	
List Size	6,706	9,200	6,746	17,929	2,092	1,183	2,560	6,500	<b>52,916</b>
Patients aged between 45 and 64	1,662	2,160	1,795	4,338	510	287	633	1,617	<b>13,002</b>
Patients on Registers Sub Optimally Controlled	154	412	284	653	57	62	105	223	<b>1,950</b>
Patients not on Registers for second phase	1,369	1,677	1,455	3,469	425	221	501	1,354	<b>10,471</b>
Appointment Letters Sent to Date	954	1,548	900	3,853	482	281	606	1,368	<b>9,992</b>
Letters Sent to DNA Patients	0	0	0	0	0	0	0	0	<b>0</b>
Appointment Slots	888	1,332	948	2,940	504	300	360	1,368	<b>8,640</b>
Appointments Made	372	398	573	1,297	422	245	142	1,201	<b>4,650</b>
Patients Attended	327	361	415	1,213	249	70	133	617	<b>3,385</b>
Patients DNA	45	37	158	83	173	175	9	594	<b>1,274</b>
Patients Referred to Counterweight	21	36	51	173	29	6	4	42	<b>362</b>
Patients Referred to Smoking Cessation	11	21	16	78	7	3	3	13	<b>152</b>
Referred to Exercise Program	8	27	11	119	5	0	2	44	<b>216</b>
Referred to Alcohol Team	0	2	3	2	0	0	0	0	<b>7</b>
Referred to Literacy	0	0	0	1	0	0	0	0	<b>1</b>
Referred to Phlebotomy	0	0	0	1	0	0	0	0	<b>1</b>
Referred to Social Services	0	0	0	1	0	0	0	0	<b>1</b>
Referred to Carrers Info Line	0	0	0	3	0	0	0	0	<b>3</b>
Big Plus	0	0	1	0	0	0	0	0	<b>1</b>
Referred to GP	2	3	9	27	5	0	0	5	<b>51</b>
Reffered Back to CDMN	105	106	133	502	66	13	13	166	<b>1,104</b>

Data Updated:	17/09/2007											
Practice Name	Dr MacFarlane	Dr Connelly	Dr Majumdar	Dr George	Dr Walimbe	Dr Reddy	Harthill	Dr Maule	Dr Murphy	Dr Logan	Dr McKay	Dr Dear
GP System	GPASS	GPASS	GPASS	GPASS	GPASS	GPASS	GPASS	GPASS	GPASS	GPASS	GPASS	EMIS PCS
List Size	5,500	1,468	2,778	2,600	2,244	2,699	4,086	4,604	6,179	10,936	3,100	2,750
Patients aged between 45 and 64	1,270	349	714	628	594	700	1,134	1,167	1,626	2,832	708	0
Patients on Registers Sub Optimally Controlled	132	25	91	76	32	93	102	122	176	388	72	0
Patients not on Registers for second phase	1,026	304	572	519	562	567	817	751	1,140	1,992	447	0
Appointment Letters Sent to Date	1,008	294	576	595	401	567	420	144	108	24	24	0
Letters Sent to DNA Patients	0	0	0	0	0	0	0	0	0	0	0	0
Appointment Slots	1,053	314	576	636	425	732	506	192	168	12	24	0
Appointments Made	879	225	501	526	357	566	460	180	154	8	19	0
Patients Attended	529	137	254	236	174	315	236	66	60	6	7	0
Patients DNA	350	88	247	288	183	251	224	114	94	2	12	0
Patients Referred to Counterweight	79	10	42	42	18	13	18	6	5	0	1	0
Patients Referred to Smoking Cessation	27	6	11	16	8	7	14	7	1	2	0	0
Patients Referred to Exercise Programme	52	4	28	17	11	10	3	3	1	0	0	0
Patients Referred to Alcohol Team	1	0	0	0	3	0	1	0	0	0	0	0
Referred to Learning Advisor	1	0	0	0	0	0	0	0	0	0	0	0
Patients Referred to	0	0	0	0	0	0	0	0	0	0	0	0
Patients Referred to	0	0	0	0	0	0	0	0	0	0	0	0
Patients Referred to GP	3	6	0	0	2	3	2	0	1	0	0	0
Reffered Back to CDMN	313	52	164	108	73	111	93	29	33	4	5	0

Data Updated:	17/09/2007									
Practice Name	Dr Carlin	Bankhouse M/P	Chapelhall (Dr Brough)	Dr Idrees	Airdrie HC (Dr Lough)	Dr Clements	Dr McInnes	Dr Zaman		All Practices
GP System	GPASS	GPASS	GPASS	GPASS	GPASS	GPASS	GPASS	GPASS		
List Size	2,059	3,755	7,623	1,016	3,667	7,684	0	987		26,791
Patients aged between 45 and 64	486	928	1,809	229	912	2,081	407	182	0	7,034
Patients on Registers Sub Optimally Controlled	75	83	245	33	110	195	0	0	0	741
Patients not on Registers for second phase	385	773	1,462	179	700	1,399	287	98	0	5,283
Appointment Letters Sent to Date	460	384	576	180	593	646	72	96	0	3,007
Letters Sent to DNA Patients	0	0	0	0	0	0	0	0	0	0
Appointment Slots	480	408	624	180	593	708	84	96	0	3,173
Appointments Made	427	390	584	177	550	644	82	97	0	2,951
Patients Attended	174	159	217	39	265	302	25	29	0	1,210
Patients DNA	253	233	367	138	285	342	57	68	0	1,743
Patients Referred to Counterweight	21	27	28	3	34	26	1	0	0	140
Patients Referred to Smoking Cessation	7	8	10	3	10	16	1	0	0	55
Patients Referred to Exercise Programme	12	7	9	0	14	16	0	3	0	61
Patients Referred to Alcohol Team	0	0	0	0	0	0	0	0	0	0
Referred to Phlebotomy	0	0	0	0	0	0	0	0	0	0
Referred to Social Services	0	0	1	0	0	0	0	0	0	1
Referred to Career Info Line	0	0	0	0	0	0	0	0	0	0
Patients Referred to GP	0	0	0	0	0	1	0	0	0	1
Referred Back to CDMN	62	61	65	9	86	130	14	10	0	437

# Department of Work and Pensions

KW in conjunction with the DWP have devised a joint referral form and signposting service for KW clients requiring benefits or employability advice

All referrals are sent to a central point via Routes to Work who sign post the client to the appropriate service

# Early Feedback

- Staff in all localities have actively engaged in supporting the Keep Well Pilot and have Local Implementation Groups who are supporting the ongoing development and engaging with the process of “Reaching the Hard to Reach”
- Service Users are benefiting from screening and onward referrals and many have expressed how much they appreciated having the opportunity of having a health check and the offer of onward referral for example our Chronic disease management nurses, smoking cessation and counterweight

# Onward Steps

- Continued Joined up working with partner agencies to deliver screening in the community and join up services
- Training and development of Keep Well staff
- Evaluation
- Sustainability and Roll Out