

Keep Well Informed

www.keepwellscotland.com

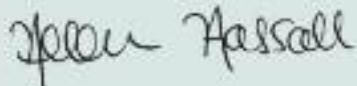
AUTUMN 2008

Welcome

Welcome to the Autumn 2008 edition of Keep Well Informed. This issue looks at the recently launched Scottish Government report of the Ministerial Taskforce on Health Inequalities called **Equally Well** and its implications for anticipatory care.

We also take a closer look on page 3 at one of the Equally Well recommendations that Keep Well should identify people with depression and anxiety, and make sure they get the necessary treatment and support.

As usual, Keep Well Informed contains its variety of newsbites in addition to regular progress updates in the Keep Well Wave 1 and Wave 2 areas. The newsletter also features the Community Heart Project in NHS Tayside on page 10, which is part of the Cardiology Unmet Needs Project. The service aims to improve access to hospital-based cardiology services by offering clinics in deprived areas. Finally, on page 12, we can read about Bronka's Keep Well experience and there is another Keep Well goodie bag to be won. Hope you enjoy another full and informative issue of the newsletter.



Helen Hassall
Senior Programme Officer
Keep Well

Reducing health inequalities top priority



Equally Well. A focus on reducing health inequalities in Scotland

A recent report confirms good health for all should be at the top of the agenda and as Helen Hassall explains, that doesn't just mean physical good health.

On 19 June, the Minister for Public Health, Ms Shona Robison MSP, announced **Equally Well – the report of the Ministerial Task Force on Health Inequalities. The document signals a commitment to a renewed focus on reducing inequalities in health across Scotland.**

In total, the report sets out 78 recommendations to deliver on a range of priorities focused on families and young people, mental health and wellbeing, poverty and employment, physical environments, and alcohol, drugs and violence. In terms of anticipatory care there are three key recommendations of particular note.

Recommendation 45 - Keep Well health checks in deprived areas should identify people with depression and anxiety and make sure they get treatment and support.

Recommendation 46 - The government commitment to health checks for all at age 40 should be implemented in ways that build on the Keep Well programme.

Recommendation 47 - The government should create and fund new evidence-based anticipatory care programmes for other groups at high risk of health problems.

So far, work is already in progress to develop recommendation 45 and equality sensitive options continue to be considered for health checks at age 40. In relation to new anticipatory care programmes, NHS Borders, Dumfries & Galloway and Forth Valley are currently working on proposals.

A commitment to a renewed focus on reducing inequalities in health

Details of additional programmes are still to be finalised, however a focus on prisoner populations is at an advanced stage. The Equally Well implementation plan should be published in December.

NHS Health Scotland is delighted to extend its support to these new developments and will do so via the Board's Better Health Team.

Visit the **Equally Well** report at www.scotland.gov.uk/Resource/Doc/229649/0062206.pdf

The report containing the supporting papers can also be accessed at www.scotland.gov.uk

Newsbites

Interventions Resource

The second version of the Keep Well Interventions Resource has been signed off by the Scottish Government. Visit www.healthscotland.com/anticipatory-care.aspx to access the resource and for further information. Plans for dissemination and future revisions are in the process of being agreed.

Anticipatory care training

The delivery of Keep Well and other anticipatory care programmes requires a multi-professional workforce which has the knowledge and skills to deliver on a range of anticipatory care interventions.

NHS Health Scotland has delivered training to over 400 practitioners supporting Keep Well in a range of courses to hone their skills in areas which include health behaviour change, communication with hard to reach groups and community engagement.

To see some of the courses on offer this year go to page 12. Contact Vibha Pankaj for further information by either email: vibha.pankaj@health.scot.nhs.uk or phone 0131 313 7500.

Overwhelming response to heart health initiative

All but two area health boards have taken up the invitation from the British Heart Foundation (BHF) Scotland to submit initial applications for a share in up to £1m of heart health funding for their community.

Claire Fraser, the charity's Heart Health Coordinator, says: "It was an overwhelming response. There were some fantastic ideas for ways to use additional resources for people already living with heart disease or at risk of developing it."

NHS Lanarkshire, Tayside and Ayrshire & Arran have been short-listed for the Localities Programme funding and will submit detailed proposals to a selection panel in October. The charity also hopes to work with four other health boards on a smaller scale. For more information, contact Claire on 01651 843767 or email: fraserc@bhf.org.uk

Pilot training course for breast awareness

Breast Cancer Care (BCC) promotes the importance of early detection of breast cancer as an anticipatory service. BCC provides Breast Awareness Workshops to those women who may not readily access services e.g. BME women, older women and women in socially disadvantaged areas.

BCC are launching a free pilot training course targeting individuals who would like to promote breast awareness to their clients.

Train the Trainer will help participants gain the knowledge they need to provide support in local communities or workplaces. Training dates are 14, 21 and 28 October in Glasgow. For further information email: lucyw@breastcancercare.org.uk. For more information about other BCC services phone 0141 353 8330 or email: sco@breastcancercare.org.uk



We ask

What are NHS Health Scotland's views on the launch of the government's Equally Well report?

"At NHS Health Scotland, we warmly welcome Equally Well as a clear demonstration of the joint commitment of government at both national and local level to tackle health inequalities and its causes. As the causes of health inequalities are complex and multi-factorial, a wide range of mutually interactive measures are required across partner agencies at policy, strategy and service delivery levels to address them."

"We think there is scope for further development of the analysis and response to inequalities over and above those relating to socioeconomic status by including the seven major equality strands of gender, transgender, sexual orientation, disability, race, age and faith and belief."

"One of the main new ideas is the emerging concept of local test sites. Given our dissemination responsibilities for

Have A Heart Paisley, Starting Well and Healthy Respect and other initiatives aimed at tackling health inequalities, such as the Smoking Cessation for Young People pilots, we wish to offer our support in the development of these test sites to help avoid the mistakes of the past."

"We welcome the emphasis on continuous improvement whilst recognising that improvement tools and methods on service redesign for health improvement and patient experience work are still in their infancy. While we have had relatively limited engagement with improvement methods to date, we see this as a major area for development by us in the future. By working together with the improvement and support team, as well as on the local test sites, we believe we can move significantly towards a key objective of providing improved health outcomes for priority groups."

"As an organisation whose purpose includes reducing health inequalities, NHS Health Scotland is committed to supporting this complex agenda in collaboration with others."



The recently published Equally Well report



Mental health and wellbeing take centre stage

We look at the plans to include mental health questions in the Keep Well health check

Improving physical health can help to improve mental health and wellbeing and vice versa. Mental health improvement is an essential part of achieving the government's social, health, economic and cultural objectives and for addressing health and social inequalities. This commitment to improving mental health and wellbeing is clearly apparent in Equally Well.

This is underlined by one of the report's recommendations relating to Keep Well: 'Keep Well health checks in deprived areas should identify people with depression and anxiety and make sure they get treatment and support'.

This recommendation is welcome as it now provides an opportunity to explicitly cover mental health and wellbeing as part of the Keep Well health check. Keep Well projects are committed to implementing this recommendation and areas such as Glasgow already include the Hospital Anxiety & Depression Scale (HADS) questionnaire.

There are, however, many factors and implications to be considered and discussions are taking place to progress

the issues. The first step is determining the most appropriate method of identifying individuals who have depression and anxiety. Various other issues need to be taken into account, including training implications for staff, what questions to add to the core data set and evaluation considerations.

Another key element for consideration is the second part of the recommendation which refers to ensuring treatment and support is available for identified individuals. It is likely that including depression and anxiety in the health check will result in increased identification of individuals with mental health needs and therefore it is essential there are appropriate local services in place to provide the necessary support. This will be a key consideration during implementation discussions.

Progress on delivering this recommendation will be outlined in the Equally Well implementation plan, when it is published at the end of the year, and updates on progress will appear in future editions of Keep Well Informed.

Course offers First Aid on mental health

Mental Health problems affect more than one in four people in Scotland at some point in their life. Chances are you know someone who may need help – whether it is a colleague, friend or a patient.

Scotland's Mental Health First Aid is a 12 hour course which will teach you the skills to help someone who is developing a mental health problem or is experiencing a mental health crisis.

While attending the course will not make you a therapist, participants will gain an awareness and understanding of mental health problems, including depression, anxiety, panic attacks, psychosis, self-harm and suicide. Participants will learn how to recognise the signs of a mental health problem and learn the appropriate skills needed to help and support someone in distress before professional help can be accessed.

Over 20,000 participants have attended the course in Scotland. A significant proportion of these have been frontline staff working with people at high risk of developing mental health problems e.g. nurses, community services and prison staff.



For more information, please visit the website, www.SMHFA.com or contact **Kirsty Robertson, SMHFA National Coordinator**, tel: 0131 3137500.

We look at the progress made in the Wave 1 areas

Jill Madden,
Keep Well
Project Manager



Wave 1 Lanarkshire

Following a great start by Keep Well in Lanarkshire with 10,000 patients given a health check, the team is developing plans to extend funding of the project.

With more than 22,000 patients already invited to attend a health check, the team is continuing to ensure it is delivering a quality service meeting the needs and expectations of our service users.

Keep Well staff ensure patients are consulted to improve the flexibility of appointment times, and that feedback on the Keep Well customer experience is also being sought. A market research campaign targeting 100 patients will soon be rolled-out and the results of the questionnaires will be used to support the development plan and general service improvements.

As screening numbers increase, the team are picking up more patients with cardio-vascular disease risks. Many of these patients are not aware they are at risk as they often don't have obvious physical symptoms. Because Keep Well is detecting risks at an early stage, the Lanarkshire team is able to offer treatment in order to prevent their condition worsening.

But medical treatment is not the only service offered. Some patients have a multitude of issues impacting on their physical wellbeing. This can include money worries, stress, pain or unemployment. The team is able to offer direct referral to a large number of agencies, and with no waiting lists patients are seen almost immediately.

The ongoing success of Keep Well in Lanarkshire means it is becoming a brand name. Many patients who did not attend their first appointment are now attending their second appointment because they have heard about the benefits of Keep Well from family and friends. No eligible patient is discriminated against. If patients cannot come to the team, the team visits the patient. This includes home visits for housebound patients.

Keep Well in Lanarkshire will continue to strive to meet the needs of the patients and to develop a flexible user-friendly service.

email: jill.madden@lanarkshire.scot.nhs.uk



Milestone

10,000 patients given Keep Well health check

Innovation

Market research campaign targeting 100 patients

Focus

Continuing huge success of Keep Well in Lanarkshire

'If patients cannot come to the team, the team visits the patient'

**Katie Edwards,
Keep Well
Project Manager**



Wave 1 Lothian

In the life of an outreach worker, no two days are ever the same. While inevitably there are set routines and processes, variety is most definitely the spice of life – according to North East Edinburgh outreach worker, Elaine Farris.

The daily routine includes checking and responding to mail, after which Elaine can see as many as three clients, while liaising with the voluntary sector.

She points out: "I have a lot of contact with the voluntary sector as I signpost and refer people on to specialist agencies. The work is rewarding as I often see people making huge changes in their lives."

South East Edinburgh's Pat MacKinnon agrees that issues raised in client meetings can cover a whole range of worries and concerns, including benefit advice, support for carers, literacy, depression and phobias. However, with ongoing support and access to a range of local services, progress is being made by many clients.

Nick Bernie (South West Edinburgh) adds: "I often accompany clients with low confidence to local resources such as Wester Hailes Health Agency or West Edinburgh Action and introduce them to service providers. Often, health choices aren't the main priority but become more important for individuals after they have addressed their more immediate worries."

Lynne Simpson (North West Edinburgh) agrees each working day tends to encompass a diverse range of tasks and activities. However, working in partnership is a common thread.

"I see establishing allies to working across a range of services and organisations as integral to being able to carry out our roles," Lynne says. "Working in partnership ideally requires mutual respect and an understanding of the tensions of competing priorities, constraints and levels of accountability which we face daily in our work practice."

With work underway to review various elements of the Outreach Worker role, Lynne believes a positive opportunity is being provided to reflect on current functions and consider how these can be developed and expanded.

"For example," Lynne explains, "it demonstrates how we may be able to contribute to meeting the aims and objectives of the local health action plan, as well as national policy directives such as Equally Well, at both a local and citywide level."

A key challenge for outreach workers, and the rest of the Keep Well team, is to engage with the 'hard to reach' clients who have still to respond to their Keep Well health check invite.

However, progress is being made, with ongoing support and intervention being provided

Nick Bernie (South West Edinburgh) believes the imminent arrival of the 'doorstep engagement' pilot will boost awareness of Keep Well in the communities and help gain a clearer understanding of what individuals want from the service.

A pilot is planned within a Keep Well 'cluster' area within the next few months and it is envisaged that Keep Well outreach workers will be a central part of this pilot.

email: katie.x.edwards@nhslothian.scot.nhs.uk

'With ongoing support and access to a range of local services, progress is being made by many clients'



Milestone

Effectiveness of working in partnership

Innovation

Introduction of doorstep engagement pilot

Focus

Engaging with hard to reach clients



Outreach workers Nick, Elaine, Lynne & Pat (from left) are kept busy

**Shona Hyman,
Project Coordinator
Keep Well**



Wave 1 Dundee

'All those who attended the focus groups were positive about the service'



Jim Creighton attends a health coaching session with health coach Catriona Boal

Over the past few months we have been continuing to develop opportunities for patients to access Keep Well through community pharmacy and community nurse Keep Well assessments.

IT system development is progressing and will allow the various innovative approaches taken to delivering assessments to be evaluated. We are currently piloting systems in six practices and hope to make fast progress. We also have the database for health coaching in operation in addition to a system in development to help manage the Winning Weigh weight management groups.

Feedback from patients is key so we have also held focus groups. All those who attended were positive about the service and felt it had been worthwhile, especially the opportunity to have cholesterol measured or to find out if they might be diabetic.

A number of those who attended did so because they had family members who had attended and had felt the benefits. Others commented that the supporting programmes had improved their quality of life and were grateful.



Milestone

Continuing hard work, flexibility and enthusiasm

Innovation

New approaches through community pharmacy and nurses

Focus

Improving information patients receive after health check

A key comment was, 'if anyone receives a letter for Keep Well they should definitely go'. It was felt the programme should be more widely promoted with some participants feeling they would have benefited from clearer feedback and information on their results. The project team had already identified this issue and work is underway to improve this.

Recent feedback on a new approach to physical activity (using pedometers and the Paths to Health Counting Steps literature) has been popular.

We have several new team members. Deirdre McGarvey has just taken up the post of Keep Well Mental Health Facilitator to support the work within mental health. Anne Winks and Tracey McKay have also joined the team within the HLI and are leading on community and home-based assessment work.

We also have a new practice – Broughty Ferry Health Centre – which is starting Keep Well and we would like to welcome them to the team.

.....
email: shona.hyman@nhs.net

Left: Irene MacPhail,
Social Referral Coordinator, Keep Well East
Right: Kevin Hutchison,
Social Referral Coordinator, Keep Well North



Wave 1 Glasgow

**'Patients liked consultations
in their practice'**

In Glasgow North, East and South West, Keep Well is battling poor levels of health literacy and is adopting a new, varied pathway to care.

In Glasgow, Keep Well pilots are GP led, with a systematic and targeted approach to anticipatory care for patients between the ages of 45-64, focusing on those at risk of preventable serious (cardiovascular) ill health and on engaging with hard to reach patients who have established disease.

Although in Scotland there is a general increase in patients taking medicine that prevents heart attacks, strokes and other preventable disease, with more people being referred for social and other health-related support. This is not the case in the most deprived areas of Glasgow.

Poor health literacy means the expected benefits of medicines are less likely in our Keep Well patient group.

To support patients in a way that addresses poor adherence, Glasgow pharmacies have worked within a new, integrated pathway that involves identification of patients with established cardiovascular disease who are not in a routine with their prescriptions. It provides repeated, one-to-one support in the pharmacy during prescription collection.

Structured discussion enables the pharmacist and patient to understand the concerns that arise from having to take medicines every day for life. As the patient and community pharmacist relationship grows, opportunities to make behaviour change interventions also arise. This is resulting in more patients being referred onwards to services – such as money advice, smoking cessation and weight management.

An innovative process for contacting patients underpins this work, and all contacts are recorded on a shared tracking tool. Formal evaluation is underway to inform sustainability. More than 700 'hard to reach' patients have agreed to the service and in North and East Glasgow at least 500 people have received support. Staff from 66 pharmacies in the Community Health and Care Partnership (CHCP) have received training and are delivering the service.

For further information, please contact
Richard Lowrie, Community Pharmacy Clinical Services Lead,
tel: 0141 201 5317.

In order to find out how Keep Well is perceived and experienced by patients, North Glasgow held a patient focus group which included the following feedback:



Milestone

Systematic and targeted approach to anticipatory care

Innovation

Glasgow pharmacies working with a new, integrated pathway

Focus

Further patient focus groups

- Length of consultation was satisfactory at an average of 45 minutes.
- Patients liked consultations in their practice and that the nurse knew their medical history.
- It was important to trace the root of the problems and not just diagnose and medicate.
- All would strongly advise others to take advantage of the project.
- Monday-Friday is no good for those who work (applicable for both services and practices).
- Overall the patients thought that the project was 'very worthwhile' and a 'good opportunity' for those 'getting on a bit'.

For more information or a copy of the minutes of the focus group, contact:

**Karen McCafferty, Keep Well Project Officer,
North Glasgow**

tel: 0141 201 9782,

email: karen.mccafferty@ggc.scot.nhs.uk



Wave 2 Ayrshire

Staff at two of Ayrshire's early implementer Keep Well practices have been impressed by the response from patients to the tangible benefits achieved since they introduced Keep Well health checks.

"Keep Well is all about making patients' lives a bit better," says Pauline Young, Practice Development Manager at the Ballochmyle practice in East Ayrshire.

Since starting Keep Well health checks earlier this summer, Pauline and her colleagues are discovering that one of the main rewards is the knowledge they are giving hope to patients with problems. Pauline explains: "Help may be through a referral to the Benefits Agency or help with literacy, a weight problem or alcohol misuse."

Across Ayrshire, in Kilwinning Medical Practice, Eileen Singleton, Practice Manager, and her team are reaping similar rewards.

Eileen adds: "Many more referral pathways are available to them. To be able to tell patients there's so much out there to help them is really rewarding."

Both Pauline and Eileen have been involved in setting up training and protocols for the introduction of Keep Well in their practices, focusing on the needs of clinical and administrative staff.

While staff at the Ballochmyle practice were already using the Bluebay system to record patient information, it was new to staff at Kilwinning. Where both practices benefited, however, was in their already innovative approach to patient care. Patients at both practices can already access special clinics, including a primary cardiac clinic at Ballochmyle,

ensuring health care staff are already very highly trained.

The challenge both practices now face is engaging with patients from their first contact to ensure they can reach and help as many people as possible.

Both practices have chosen to make first contact by telephone to explain the aims of the Keep Well project and why they have been contacted.

Eileen says the response so far has been encouraging, despite initial reservations in some cases.

Pauline adds: "If you send someone a letter and they can't read it they won't come in for the Keep Well check, but they can ask questions in a phone call."

"The next challenges," Eileen points out, "will be getting the next wave of patients in, while hoping existing patients will follow up their referrals."

Carolyn Wyper, Project Manager, Keep Well
email: carolyn.wyper@aapct.scot.nhs.uk



Milestone

Making first contact with patients and preparing staff for Keep Well checks

Innovation

Bluebay system to record patient information

Focus

Giving hope to patients with problems and making their lives better.



Wave 2 Fife

Keeper Well in Fife has continued to make progress over the summer, with 40 GP practices across each of the Kingdom's three Community Health Partnerships (CHPs) now committed to delivering the project.

The flexible model of delivery devised for Keep Well in Fife has been the key factor in practices successfully engaging with the project.

It has provided an alternative option for practices where consulting room space is already at a premium or where GP staff are already at full capacity. Discussions with the remaining ten eligible

practices are ongoing and it is hoped each practice will engage with Keep Well.

So far, four practices within Dunfermline & West Fife CHP are currently delivering health checks. Early indications are that patients have welcomed the opportunity of the health check and have valued the dedicated time spent with the practitioner. The project team are keen to document all

aspects of learning from Keep Well and will be gathering both formal and informal feedback from practitioners and patients.

In order to share learning and experiences from practices across Fife, CHP-based networking events will become a feature of Keep Well.

The project team has identified the next group of practices ready to commence the health checks. Additional practices within Dunfermline & West Fife CHP and the first cohort of practices from both Kirkcaldy & Levenmouth CHP and Glenrothes & North East Fife CHP commenced delivery of health checks in September 2008.

The focus for the project teams during the forthcoming autumn period will be on maintaining the momentum within the practices already actively screening patients and supporting those that have engaged with the project to commence delivery.

Lynsay Anderson, Project Manager, Keep Well
email: lynsaysanderson@fife-pct.scot.nhs.uk

Milestone
40 GP practices committed to delivering Keep Well

Innovation
Flexible model of delivery developed in Fife

Focus
Next group of practices starting health checks

Wave 2 Glasgow

A holistic approach to health has been a major contributor to the success of Keep Well in Glasgow Wave 2.

As well as tackling clinical and lifestyle risk factors, Keep Well is exploring life circumstances such as employment, literacy and financial inclusion.

Within all three of the Glasgow Wave 2 areas training has been offered to practice staff around these life circumstances to increase confidence in raising these issues during the Keep Well health check.

If patients are interested in accessing learning support, they are assisted in accessing a range of services within their local area.

In South West Glasgow, the Keep Well team and Learning on Prescription Service are commissioning research that will explore primary care's response to literacy issues.

In Inverclyde, a milestone has been reached following the IT team's successful roll-out of Keep Well screens to the majority of local practices. Onward referrals are now increasing in these practices.

Smoke Free Service advisors within Inverclyde have all undergone Maudsley training to facilitate groups. This has



Milestone

IT successful roll-out of Keep Well screens

Innovation

Commissioning research exploring literacy issues

Focus

Continuing with holistic approach to Keep Well

shown to be four times more effective in supporting clients to quit. Marketing of the service commenced in September and Smoking Cessation staff are being recruited to ensure flexibility of attendance for clients.

Weight management within Inverclyde is also to be supported with additional services in Glasgow and Clyde.

Within West Dunbartonshire health checks are well underway and engagement with patients continues. Efforts are continuing to ensure the target group, patients with established heart disease, understand what is involved in their new Keep Well appointment. The introduction of the local enhanced service means each patient receives a structured and consistent health check. As a result of Keep Well, participating practices now have access to a number of new health improvement services which have been well received.

With the appointment of the Keep Well Welfare Rights Officer in West Dunbartonshire, patients now have the opportunity to receive advice on money, debt issues and benefit entitlement.

Yvonne Neilson, Health Improvement Senior, Keep Well
email: yvonne.neilson@ggc.scot.nhs.uk

Wave 2 Aberdeen

Keepp Well in NHS Grampian is moving towards integrating and embedding services which will support the health checks and ensure sustainability.

A significant milestone has been gaining agreement to pilot the use of Scottish Care Information [SCI] Gateway referrals from GP practices participating in the programme to specific health promotion services, including Healthy Helpings Courses and Health Walks. This supports the eHealth Strategy, which is designed to reduce paper referrals by using IT systems to receive and process information.

The Keep Well team is focussing on continuing to develop the network of services it offers, and expand the pathway for lifestyle interventions working with third sector organisations, including Aberdeen Healthy Living Network.

Staff skills are also being developed through national training programmes. Key staff from Practice Nursing, Pharmacy, Public Health Team, Substance Misuse Team, and our Trainee Health Psychologist participated in the recent successful alcohol and brief interventions training workshop to build capacity to deliver on the associated HEAT target.

Trainee Health Psychologists, funded in partnership with NHS Education for Scotland (NES) and Health Boards in

Scotland, will also be exploring the contribution health psychology can make in supporting NHS Scotland to meet its health improvement targets. We anticipate that our Trainee Health Psychologist will make a contribution to the Keep Well programme in working with clients on changing health related behaviours. Alongside the development of direct interventions, this will support Keep Well patients' wellbeing.

Dorothy Ross-Archer, Keep Well Programme Manager
email: dorothy.ross-archer@nhs.net



Milestone

Establishing referral processes using SCI Gateway system

Innovation

Using SCI Gateway to pilot referral from GP Practices participating in the programme.

Focus

Continuing to develop and build on the client pathway and the network of services to support this.

Heartening response

Collaboration proves key to success for NHS Tayside's Unmet Needs project.



Ashley Daily measuring cholesterol in a capillary filler at the Kirton Festival in Dundee

Affectionately known as “Community Heart”, the project has been described as ‘the ultimate in anticipatory care’.

Our aim is to improve access to hospital-based cardiology services among people from deprived areas. From the outset we recognised that many initiatives that have attempted to do this have resulted in disproportionate take-up by people from more affluent backgrounds. As a result increases in overall health have been achieved, but at the expense of a widening in health inequalities.

At Community Heart we began by admitting that we did not have all the answers to this problem. Instead we experimented with a variety of ways and means of engaging with people in deprived areas, and through ongoing evaluation we listened to what they said, examined how readily they engaged with us and remodelled the service accordingly. We soon realised that uptake might be increased by ensuring ease of access, making people feel welcome and valued and highlighting the importance of the service and its ability to help them. Our next question was how these qualities could be translated into practice!

Our experience and evaluation to date (carried out in collaboration with the Social Dimensions of Health Institute, Universities of Dundee & St Andrews) suggests that these underlying values can be achieved by thinking about place, timing and staffing. In other words providing the service in the right place, at the right time and by staff who are approachable and who make people feel valued. In practice we have delivered the service by using a variety of venues including a mobile clinical unit, non NHS anti-poverty centres and places of worship such as the Mosque. When provided in the right way we have found that significant numbers of ‘potential patients’ self-present opportunistically for a heart health check. It may seem “opportunistic” but with careful thought and consideration, visiting many different locations at many different times can cause an “opportunistic” approach to achieve quite systematic coverage.



to cardiology initiative



Tricia Byres and Alison Hume at Baxter Park in Dundee



Some of the team with the mobile clinical unit

Opportunistic cardiology assessment: the key to our success

Our sandwich board seems to be a 'draw'. It is the first piece of 'equipment' to be set up at an event. Often we do not get the chance to set up when the queue forms and once a queue forms people like to join it! Our admin team give people information on Community Heart and about the 'health check'. The person is then directed to a phlebotomist who takes a capillary blood sample for glucose, total and HDL cholesterol and is then directed to the specialist nurse who undertakes the health-check, advises on clinical findings, gives brief intervention on modifiable risk factors and then summarises the consultation. People who describe symptoms of CHD or if the nurse has concerns regarding a cardiac condition, he/she is offered an appointment with the cardiologists at a community clinic. However, if they have a risk factor that may require further monitoring or management, the person is asked to visit their GP practice.

Results

We are successful in engaging with deprived communities. Between April 06 and July 08, 2715 people engaged with clinical activity. The team focus their activity in local areas of deprivation, religious venues, parks and the bingo. The team continues to look for innovative ways

of identifying the most 'at risk' people in the hope of engaging with them and supporting their access to health services for their longer term health gain.

Links with Keep Well

There is no doubt that the work done within this project overlaps with that of Keep Well in Tayside. The projects have embraced this collaboratively, developing a shared protocol to ensure continuity of clinical advice, parameters, management and service, regardless of where a person presents for a cardiovascular assessment.

We have learned from each other's experience, recognising that people will engage in different ways, some responding to a letter of invitation to the GP practice, whilst others require the convenience of self presenting while out shopping.

The opportunities for anticipatory care in NHS Tayside are enhanced as a result of mutual respect for each other's approach.

For further information please contact:

Alison Hume, NHS Tayside. Co clinical lead for the Cardiology Unmet Needs Project.

email: ahume@nhs.net

Shona Hyman, NHS Tayside. Keep well project co-ordinator. email: shona.hyman@nhs.net

Time for training

Looking to network on healthcare matters or expand your skills or expertise? Check out the list of events, courses and training being planned up until the end of the year.

Anticipatory Care Practitioners' Network Event

Tuesday, 18 November 2008

Hilton Hotel, Dundee

Themes include "Health Inequalities" and "Engaging with Target Populations", with plenary and parallel sessions focusing on these topics. Plenary presentations are confirmed on Equally Well and the evaluation of Have a Heart Paisley.

- Stop Press - Places for this event are now full but if you are interested in learning more about the network or would like to be kept informed of future events email: keepwell@health.scot.nhs.uk

Anticipatory Approaches in HealthCare Module

September 2008 onwards

This module has been developed by Robert Gordon's University for experienced nurses, midwives and allied health professionals as part of an initiative by NHS Education for Scotland. For more details, please see the Module Flyer.

Training courses

These training course are free at the point of delivery and practitioners from Keep Well and Well North areas providing anticipatory care will be given preference.

Developing Communication Skills with Hard-to-Reach Groups

Glasgow: 27 November 2008

Aberdeen: 2 December 2008

Inverness: 3 December 2008

Stirling: 11 December 2008.

A one-day training course for frontline staff.

For more details email:

ldwteam@health.scot.nhs.uk

or go to

<http://elearning.healthscotland.com/course/view.php?id=21>

to access a booking form.

Behaviour Change and Health Inequalities Training

Glasgow, 28 - 29 September 2008,

follow-up day 3 October 2008

Glasgow, 2 - 3 September; 2008,

follow-up day 3 October 2008

Stirling, 23 - 24 September 2008,

follow-up day 31 October 2008

Aberdeen, 23 - 24 October 2008,

follow-up day 5 December 2008

Inverness, 6 - 7 November 2008,

follow-up day 8 December 2008

A three-day training course for staff undertaking health checks.

For more details email:

ldwteam@health.scot.nhs.uk

or go to

<http://elearning.healthscotland.com/course/view.php?id=21>

to access a booking form.

Bronka from Dundee talks about her Keep Well experience



How did you feel when you were invited to attend the Keep Well Project?

I got a letter saying, as I was aged between 45 and 64, I was to come and have a health check. There was nothing to it.

What happened at the health check?

I got my weight taken and my height and blood pressure checked and they also checked my cholesterol and measured my waist.

Do you feel better?

I feel a lot better. When I started my waist measured 40 inches and I've now lost four inches. That's because of the exercise classes, one on a Tuesday night and one after the weight-management class on Thursday mornings.

How has your lifestyle changed?

I had resigned myself to being overweight, thinking I could never lose it. But that's a myth. I've got much more energy, I can climb a hill near to where I live without stopping. I also couldn't pull myself up out of the bath because of my weight, but I can now!

What would you say to someone who has got a letter like you did but is a bit nervous about going along?

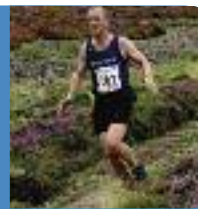
There's absolutely nothing to fear and it's changed my life completely!

Competition... Where in the world?

Alastair Pringle, Patient Focus Manager at the Scottish Government and proudly wearing his Keep Well T-shirt, coming down Dumyat, the eleventh peak of the Ochil's 2000 race. The route was 20 miles long and had over 10 x 2000ft peaks with Dumyat at the end.

Do you have a picture of yourself or a friend in an exotic location with your Keep Well bag or other Keep Well materials by your side? If so, more Keep Well goodies could be yours!

Email your photographs to Helen Hassall, Senior Programme Officer for Keep Well, email: helen.hassall@health.scot.nhs.uk



Get in touch. If you would like more information about any of the content of this newsletter or to be added to the distribution list, please contact: **Helen Hassall**, Senior Programme Officer, Keep Well,

Tel: 0131 313 7500 email: helen.hassall@health.scot.nhs.uk

