

Keep Well Informed

www.keepwellscotland.com

In this issue

WINTER 2008/09

Newsbites



Practitioners



Anticipatory care



Training



Welcome

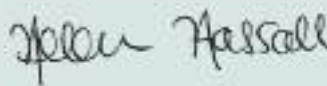
to the Winter 2008/09 edition of Keep Well Informed.

As well as a timely update on the number of Keep Well health checks completed across Scotland to date, you will find a report from the anticipatory care practitioners' network event which took place in Dundee recently. We also take a look at the work of the NHS screening

programmes and how they are linking with Keep Well.

Finally, this issue also contains our regular newsbites, and updates on progress in Keep Well Wave 1 and Wave 2 areas.

Happy reading, and a happy new year!



Helen Hassall
Senior Programme Officer, Keep Well



A significant milestone for the Keep Well programme was recently reached, as Helen Hassall reports.

New year sees renewed focus

On 16 October 2006, NHS Lanarkshire undertook the first Keep Well health check in Airdrie. Almost two years later, the Keep Well Programme Board reports that 38,788 health checks were completed by 30 September 2008.

Health checks have been available in all Wave 1 areas since spring 2007. Since then we have witnessed a predicted curve of activity as illustrated overleaf. As the programme progresses, however, more time is required to engage with individuals

continued on page 3...

Newsbites

Anticipatory care: Moving Forward Across Scotland Conference 2009

The date for the next national Anticipatory Care Conference has been confirmed as 2 and 3 June 2009, at the Hilton Hotel in Glasgow. The conference organisers would like to invite you to submit abstracts for parallel session workshops, presentations and speed presentations, poster displays and exhibition stands. The closing date for submissions is **30 January 2009**. Please visit www.healthscotland.com/anticipatory-care-conference.aspx for more information about how to submit abstracts and register your interest in attending the conference.



The new Active Scotland website

Where can I go to be active?

NHS Health Scotland has launched a new website called Active Scotland. Visit www.activescotland.org.uk to see it for yourself. It has been designed to help you find places to go to be physically active – for you, your patients and your clients. Active Scotland brings together thousands of places, from parks, pools, community centres and climbing walls, to tens of thousands of activities, from archery to yoga, in one easy-to-use website. Just put your postcode or town in the search box and find activities – both easy and extreme.

If you have any involvement in health-enhancing physical activity and helping people get and stay active, Active Scotland is a tool that can help support your work.

New team member for Better Health

Peter King has taken up the new post of Programme Manager in the Better Health team at NHS Health Scotland. His role is centred around supporting the expanding anticipatory care agenda. Peter has a wealth of health improvement and promotion experience, and joins the team from South Lanarkshire CHP where he worked as a Service Development Manager. The Better Health team would like to extend a warm welcome to Peter.

We ask

During the recent practitioners' network event, what did you find most useful about the opportunity to share practice?

Angus MacKiggan, Well North Project Coordinator, NHS Highland

'I have not been in my current role for long, therefore I found the opportunity to learn about the challenges faced in other areas



and how they set about tackling them extremely useful. The beauty of the practitioners' event is that it provides the opportunity for sharing of learning and practice. This is especially important as it allows other areas such as Well North to adapt this knowledge to suit our needs. I'm already looking forward to the next event.'

Marie Williamson, Keep Well Public Health Nurse, NHS Ayrshire & Arran

'As I am just recently in post, it was very useful for me to attend the event. The workshops gave me the opportunity to learn from other people and find out what was working or not working well. I also swapped contact details with

some of the other attendees who were happy to forward me information I was looking for. The presentations gave me an update of what has been happening with the Keep Well programme.'

May Richmond, Braveheart Development Officer, NHS Forth Valley

'I thought the event was excellent and very informative. I was especially interested in the Unmet Need Project as I am working in a regeneration area in Clackmannanshire. I was delighted to hear everyone's input at the group sessions and have taken away a lot of good contact numbers. Well-done on a very worthwhile event.'

Feedback from the anticipatory care practitioners' network events continues to be positive.



Delegates enjoyed sharing best practice

Sharing a common goal

The anticipatory care practitioners' network was established over a year ago, and meets on a six-monthly basis. The network's objectives are to provide:

- a forum to share practice and learning
- opportunities for networking
- support dissemination of learning and experiences
- peer support for practitioners
- an opportunity to reflect on practice and develop new approaches.

The most recent practitioners' network event took place in November in Dundee. The event was very well attended by practitioners from across Scotland who are involved in a range of different anticipatory care projects.

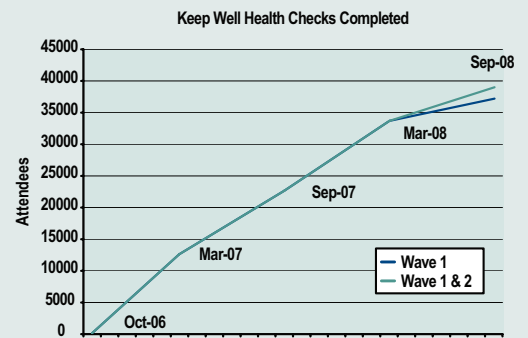
The themes for this event were 'health inequalities' and 'engaging with target audiences'. There was a mix of plenary sessions, break-out workshops and, for the first time, speed presentations. The workshops provided an opportunity to find out more about a specific project, and also to discuss relevant learning and experiences.

The final session involved group discussion about the key learning points identified during the day, which are outlined below.

Visit www.healthscotland.com/anticipatory-care-practitionersnetwork.aspx for details of all the presentations.

The next event, to be held in April 2009, will be themed around learning & workforce development. For more information, please email: keepwell@health.scot.nhs.uk

...continued from page 1



Keep Well's curve of activity

through phone calls and/or home visits.

One of the aims of the Wave 1 extension, announced in March 2007, was to further test the methods required to engage with target populations, particularly those with a range of complex needs that may prevent easy access to the Keep Well health check.

Some of the highlights include engaging with the homeless, people with learning disabilities and travelling populations. There will also be the inclusion of additional geographic areas, re-screening, and workplace and community pharmacy-based assessments. Additions to the health check will include anxiety and depression, and signposting individuals to relevant screening programmes, as detailed on pages 10 and 11.

All Wave 2 areas have now commenced health checks, and we expect a similar pattern of activity to Wave 1.

In addition, the proposed new interim HEAT targets which focus on the NHS Boards completing a number of inequalities-targeted cardiovascular health checks during 2009/10, reinforces the commitment to this approach. However, the number of health checks in each area will vary, reflecting their stage in engagement with the target audience.

Key learning points identified

- The importance of celebrating success and not underestimating the impact of current activities.
- The commonality of barriers and potential solutions across different projects.
- To consider moving away from just a GP practice model of delivery.
- The importance of local and flexible services.
- The benefits of face-to-face communication.
- The need for diversity and innovation in engagement and service delivery.
- The importance of inclusive communication and being aware of the range of potential communication barriers.
- Consideration of all methods of nicotine intake, and how to ask patients about this.
- To consider the use of local champions to support engagement.
- The benefits of focusing on solutions as well as barriers.
- Consider long-term savings of preventative care instead of only short-term costs.

Progress in the Wave 2 areas has been going from strength to strength.

**Dorothy Ross-Archer,
Keep Well Programme
Manager**



Wave 2 Aberdeen

'I think this is a great idea as I haven't had a proper health check for a long time'

Delivery of health checks in Aberdeen commenced at the beginning of September in three of our phase 1 GP practices.

This significant milestone has been achieved through collaboration and teamwork across health and partner organisations.

Initial feedback from patients being offered a health check included the following comments:

'I think this is a great idea as I haven't had a proper health check for a long time.'

'More than willing to take part.'

The range of people contributing towards this milestone included practice staff, and staff from Aberdeen City Community Health Partnership and Public Health, Aberdeen Healthy Living Network, Aberdeen Council of Voluntary Organisations and Grampian Credit Union.

A further two practices are now working towards offering and delivering health checks.

Health, lifestyle and health-related behaviours are all key focus areas of the Keep Well health check. As the Keep Well programme provides a unique opportunity to engage with a specific population, staff have the opportunity to raise the issue of health-related behaviour with patients and assist in helping them to make a change.

We are also working with practice staff to identify the types of training they might require, in order to enhance the delivery of the health checks and better support clients with health-related behaviour change.

Our Health Psychologist in Training has developed a needs assessment questionnaire, which will inform the development of a theory and evidence-based staff training programme around health behaviour change.



In addition, a poster detailing the work of the Grampian Weight Management Integrated Care Pathway was presented at the Public Health Conference in 2008, 'Forging New Collaborations'. The work included demand and capacity modelling to support the development of referral criteria and services.

We are planning to pilot an element of the Integrated Care Pathway in Keep Well practices, to help staff signpost clients through a structured pathway offering specific support according to need.

Milestone
Delivery of the health checks in three GP practices

Innovation
Piloting an element of the Weight Management Integrated Care Pathway

Focus
Supporting staff in the delivery of health checks through tailored training

email: dorothy.ross-archer@nhs.net

**Carolyn Wyper,
Project Manager,
Keep Well**



Wave 2 Ayrshire

It's well-known that Keep Well's target communities are less likely to engage with health services. Therefore, our aim is to make that sometimes-limited engagement as effective as possible.

Ayrshire & Arran has decided on a social marketing approach, and has commissioned a piece of research among the communities with which Keep Well is trying to engage.

Campaigns Officer Fiona McKie says Ayrshire & Arran wants to deliver Keep Well in the most effective way possible: 'We're aiming to meet the information needs of our target population. We want to be able to communicate and engage with them by their preferred method.'

Social marketing is increasingly being used in health promotion. It applies the same techniques and theories as commercial marketing, but uses these approaches to support initiatives that improve health and reduce inequalities.

Ayrshire & Arran commissioned the Scottish Poverty Information Unit (SPIU) to engage with Keep Well's target population. The unit's brief was

to ask people how best we could encourage them to take advantage of the Keep Well programme – and ultimately improve their health. The SPIU targeted six locations from the 15% most deprived areas across North and East Ayrshire (figures taken from the Scottish Index of Multiple Deprivation). The targeted locations were:

to ask people how best we could encourage them to take advantage of the Keep Well programme – and ultimately improve their health.

The SPIU targeted six locations from the 15% most deprived areas across North and East Ayrshire (figures taken from the Scottish Index of Multiple Deprivation). The targeted locations were:

- Saltcoats
- Irvine
- Kilwinning
- Dalmellington
- Auchinleck
- Shortlees.

The research team carried out 180 doorstep surveys and six focus groups. Already, the information gathered has enhanced our communications and community engagement plans.

The information reveals people are willing to take part in health checks, but need more information about local services and the support they would receive after the health check.

Telling people about the long-term benefits to their heart isn't enough. People said they would be more encouraged to attend a health check if they were aware of the short-term benefits to their quality of life, such as weight loss or increased energy.

We aim to take a tailored approach, focusing on individuals' needs. As an example, we have produced a patient-held record card (left), which gives information on the individual and their specific needs, aims and feelings.

To see a full copy of the report, please contact Carolyn Wyper, Project Manager, at the email address below.

email: carolyn.wyper@aapct.scot.nhs.uk



Milestone

Completing a successful social marketing campaign

Innovation

180 doorstep surveys and six focus groups

Focus

A more tailored approach to focusing on the individual's needs



NHS Ayrshire & Arran has produced a patient-held record card

Wave 2 Fife



Milestone

Increase in attendance at health assessments due to patient call reminders

Innovation

Service directory developed with Job Centre Plus for referrals

Focus

Engage with eligible patients and introduce smooth running of Keep Well with the help of the new central team

levels of engagement by early 2009.

Early implementation sites have been working hard to engage with eligible patients, and Keep Well is seeing a steady flow of patients

responding to health assessment invitations. A reduction in failures to attend has resulted from some practices telephoning patients the day before a planned Keep Well appointment.

Lessons are being learned and good practice passed on to other sites. A service directory developed with Job Centre Plus has been piloted and is a useful resource for supporting the referral or signposting of patients to local services and support groups.

We are delighted that stories of health and wellbeing improvement are being reported. One participant, Brian, attended his health check in August, and was referred for smoking cessation and physical exercise support.

He says attending a Keep Well health check made sense to him. 'It's like an MOT for the body, it's vital for my health.'

Brian is now looking forward to his daughter's wedding next year and adds: 'I want to be in the best shape I can be for walking her down the aisle.'

Now that he has stopped smoking, Brian feels fitter and healthier than he has done for years. He is certainly well on the way to meeting his personal goal.

There is a sense of anticipation and excitement in the central team with the appointment of six new staff.

Central team Nurse Case Manager, Anne McNaughton, welcomes Emma Cunningham and Vicky Lawson as Clinical Support Workers. Kay Webster joins as an Administration Assistant and Fiona Duff joins as a Keep Well Nurse. Two more nurses due to start soon will complete the team.

In addition, Margaret Bell has replaced Lynsay Anderson as Programme Manager, and Val Hatch has taken over operational management from Shirley Dempsey who has retired from the NHS.

Now the team is in place, Keep Well is building momentum in the three Community Health Partnerships.

Nine practices are already delivering health checks and many more are ready to go live over the winter period. It is expected all 50 GP practices targeted will have signed up to one of three possible

'A steady flow of patients are responding to health assessment invitations'

email: margaret.bell3@nhs.net

**Marion O'Neill,
Keep Well Coordinator,
South West Glasgow CHCP**



Wave 2 Glasgow

Within Greater Glasgow & Clyde, practices can access interpreters via the Glasgow Interpretation and Translation Service (GTIS). The Keep Well external service has not been able to access the same level of support.

However, via Keep Well in **South West Glasgow**, and as an introduction to the Equality Impact Assessment which will be carried out over the coming months, access to GTIS has been extended to include all the service providers. This ensures non English-speaking patients have equal access to the health check and benefit from the other services available to them.

Our employability service has also been keen to promote its role to asylum seekers. Opportunities available include volunteering, attending language classes and training.

Within **West Dunbartonshire**, efforts are focused on supporting practices which have commenced engaging with patients.

This support has been important for the 11 practices within the Clyde end of West Dunbartonshire and which were unfamiliar with the IT tool adopted to deliver the Keep Well health check.

The introduction of the new screening mechanism has made the initial stages of delivery challenging. However, through the practitioners' forums, staff have access to peer support and are able to share best practice.

A significant milestone during the autumn period was the formation of the Keep Well Services Steering Group, which allowed all the local services involved with Keep Well to network and highlight early learning.

Each service was asked to provide a synopsis of the provisions they offer, including how patients can access the service.



Milestone

Formation of the Keep Well Services Steering Group

Innovation

Liaison with Stepwell and the pilot literacy project for Inverclyde and North Ayrshire – LARHS

Focus

Continue the growing momentum of reviewing clients with existing heart disease

'Non-English speaking patients have equal access to the health check'



Members of the public attend a Keep Well promotional event in Inverclyde

This exercise provided information about each of the services available to patients, and allowed services to signpost patients to other services where appropriate. Future actions for the group will be to look at training needs, data collection and the sharing of good practice.

In **Inverclyde**, the focus will be to support all practices involved with Keep Well and to continue the growing momentum of reviewing clients with existing heart disease. Training requirements are being reviewed in order that further support for practices and external service providers can be offered.

Inverclyde continues to develop excellent partnership working. Working together improves sharing of good practice and facilitates the development of sideways referrals. One successful partnership is Stepwell, which offers coping strategies for smoke-free client groups.

Inverclyde and North Ayrshire were also selected by the Scottish Government's Directive for Adult Learning and Literacies, called Learning Connections, to participate in a pilot project aimed at developing a literacy awareness-raising resource.

Learning Connections will collate the feedback from the two areas to develop the final Literacies Awareness Raising for the Health Sector resource (LARHS), which will be rolled out nationally to all Scottish local authority areas.

email: yvonne.neilson@ggc.scot.nhs.uk
marion.o'neill@ggc.scot.nhs.uk

Wave 1 Dundee

Mental health and wellbeing is an important issue for services and individual patients.

It's a topic which has received increasing press coverage both nationally and locally, and underpins the Scottish Government's vision for a healthier, more successful Scotland.

Keep Well in Dundee identified early on that those with severe and enduring mental illness have a significantly increased risk of metabolic syndrome and cardiovascular disease.

There is already a lot of good practice in Dundee to provide proactive care for this group of patients. However, not all patients in this key group are accessing services for health screening and lifestyle intervention.

'Keep Well – Mental Health' was launched with the help of a multi-agency group last September. It will highlight this issue by looking at current practice in Dundee and supporting further developments in the area of physical wellbeing for the mentally ill.

The work has continued with general practice teams addressing similar issues within their protected learning events. Deirdre McGarvey, facilitator for this work, notes there is a wide range of services

assessing cardiovascular risk and supporting patients. However, she explains not all the needs of the patients are being met.

'It is important we look at inclusion opportunities for these patients. Over the next few months we plan to identify where we can further improve care.'

She adds: 'We are working with the Dundee Healthy Living Initiative to test out the role of health coaching for this group of patients.'

Consultant Psychiatrist Dr Helen Millar says with proper education regarding dietary advice and exercise, Keep Well Dundee can impact on the quality of lives of people with severe mental illness.

'As healthcare professionals, we must ensure this population has equal access to physical health monitoring,' she adds.

Shona Hyman, Keep Well Project Coordinator
email: shona.hyman@nhs.net



Milestone

The launch of 'Keep Well – Mental Health'

Innovation

Testing the role of health coaching for this group of patients

Focus

To look at inclusion and how to further improve care

Wave 1 Glasgow

The importance of partnership working in East Glasgow has been underlined with the success of initiatives by Glasgow East Regeneration Agency (GERA) and Celtic Football Club.

Lack of employment within the East End of Glasgow and the high number of people on incapacity benefit continues to be a concern.

Keep Well has established links with GERA and the Celtic Foundation to develop an eight-week health and employability programme. The course aims to improve the health, wellbeing and employability skills of a group of unemployed people in the East End.

Around 40 local adults took part in the programme at Celtic Park. Similar to a Keep Well health check but without the blood tests, Keep Well provided a Healthcare Assistant to screen attendees. The Healthcare Assistant also delivered sessions on smoking cessation and Heartstart.

Feedback has been very positive and discussions are in place to continue the model.

Early indicators from the evaluation undertaken by GERA show that of the 24 clients who completed the programme, four commenced full-time employment, two began part-time employment and one person undertook voluntary work.

The remainder of the group are working with GERA advisers to help them achieve their employment goals.

Irene McPhail, Social Referral Coordinator, Keep Well East
email: irene.macphail@ggc.scot.nhs.uk



Milestone

Third of attendees who finished Keep Well partnership programme either in employment or voluntary work

Innovation

Success of cross-agency partnership working

Focus

Future development of employability skills programmes

Wave 1 Lanarkshire

The Keep Well programme in Lanarkshire is expanding. Our aim is to offer the benefits of Keep Well to a wider population.

To do this, we've used the latest data in order to identify another locality that fits the Keep Well criteria.

As a result of the research, we've chosen Bellshill, which has a population of 12,331.

We're currently in the planning process and will use the learning from the current Keep Well programme to support the delivery of the project in Bellshill.

Practices in Bellshill are keen to embrace Keep Well. We plan to use a phased approach for its implementation, starting with one large practice and a small single-handed practice.

We're also keen to improve on the continued engagement of clients from initial screening to the onward referral to agencies supporting the Keep Well programme.

To help us, we have taken learning from the Have a Heart Paisley Unmet Needs Project. Although not

all the strategies implemented by the Unmet Needs Project will meet the needs of Keep Well in Lanarkshire, we plan to adapt the learning to ensure we focus on the patients less likely to engage. We have already tried and tested a number of strategies including the Health and Leisure Bus. The evaluation of this project highlighted the benefits of being able to take the service to the clients.

Jill Madden, Project Manager, Keep Well
email: jill.madden@lanarkshire.scot.nhs.uk



Milestone

Expanding Keep Well in Lanarkshire to deliver the project in Bellshill

Innovation

Adapting learning from the Have a Heart Paisley Unmet Needs Project

Focus

Continued engagement with clients

Wave 1 Lothian

The Keep Well team in Edinburgh Community Health Partnership (CHP) is working hard to develop and test new methods of engaging with eligible patients.

Last autumn, the team coordinated three health improvement roadshows at Cameron Toll Shopping Centre, Westside Plaza Shopping Centre and Craigmoynton Community Centre.

Each event offered members of the public access to mini and full Keep Well health checks, and information about a range of health improvement themes and local community services.

The NHS, City of Edinburgh Council, Edinburgh Leisure and voluntary sector staff manning the stalls were kept busy at each of the roadshows. Hundreds of people stopped to complete a health check, and to collect information about health and wellbeing issues – from diet and exercise to sexual health.

In addition to planning and delivering events in local communities, the Keep Well team is planning to undertake doorstep engagement with eligible patients.

The pilot will last for around six to eight weeks

and will initially be in partnership with one general practice in south-east Edinburgh.

During the visit, the team will make the patient aware of their entitlement to a health check and answer any questions the patient may have about the check. If the patient is in agreement, the team will be able to undertake a health check or an initial consultation, right there and then.

The team will feed back health check information to the practice or confirm the patient's wish not to participate in Keep Well. If the pilot is successful, this form of engagement will be rolled out to other Keep Well practices.

Katie Edwards, Project Manager, Keep Well
email: katie.x.edwards@nhslothian.scot.nhs.uk



Milestone

Coordinating three successful roadshows

Innovation

Doorstep engagement pilot

Focus

Developing new methods of engaging with patients

Keep one step ahead

The Keep Well programme has plans to further strengthen its links with Scotland's screening programmes.

Awareness raising and encouraging uptake of screening is an element of anticipatory care the Keep Well programme is keen to promote and strengthen.

Those qualifying for a Keep Well health check are between the ages of 45 and 64, which means many are also eligible for routine screening.

As part of the Keep Well Wave 1 extension, local areas are planning to signpost individuals during the Keep Well health check to relevant screening programmes.

The screening programmes relevant for the Keep Well target audience are detailed below.

Bowel screening

Men and women across Scotland between the ages of 50 and 74 will be invited to take part in the Scottish bowel screening programme.

Following a pilot phase which began in 2000, the roll-out of the national programme commenced in June 2007 when Tayside, Grampian and Fife NHS Boards invited all eligible men and women to be screened every two years.

Over the last 15 months, Ayrshire & Arran, Orkney, Forth Valley, Lothian and Western Isles have come on board, with the remaining health boards due to join in a phased roll-out by the end of 2009.

NHS Health Scotland is currently developing materials to address low uptake among some populations highlighted by the pilot board areas. So far, the programme has demonstrated:

- uptake was higher in women than in men
- uptake was lowest in deprived areas
- men were more likely than women to have a positive FOBt result



- more cancers were detected in men than in women. *Source: ISD Scotland, 2008.*

Eye-catching posters and flyers will aim to raise awareness of bowel cancer and encourage those in the target age group – particularly men, ethnic minorities and people in lower socio-economic groups – to take the test.

NHS Tayside asked Bill Torrance of Beechgrove Garden fame to record a radio advert highlighting the benefits of taking the test. A short DVD was also developed for health professionals to use with community groups.

Keep Well practitioners in Tayside have recently started to include bowel screening questions as a routine element of the health check. If relevant to the individual, a reminder pops up on the screen to encourage staff to discuss the test.

Breast screening

The Scottish breast screening programme invites women aged between 50 and 70 for screening every three years.

Women aged 71 and over are encouraged to attend through self-referral to their local screening centres.

NHS Health Scotland has developed leaflets to support and encourage women through the screening process:

- **Breast Screening Explained** is a reassuring and informative booklet aimed at encouraging women to have routine breast screenings.
- **Your Breast Screening Appointment Explained** provides further detail on mammograms and answers frequently asked questions.





People in the Keep Well target population are also eligible for routine screening

Statistics show that:

- 75.7% of women aged 50 to 64 resident in Scotland had been screened once in the previous three years, compared with 76.4% at 31 March 2006.
- Looking at three-year rolling attendance figures, uptake continues to rise, from 76.2% at 31 March 2006 to 76.5% at 31 March 2007.
- All NHS Boards met the minimum attendance standard of > 70% of women invited during the previous three years.
- The proportion of cancers diagnosed pre-operatively has increased from 67.7% to 94.7% in the last ten years.

Source: ISD Scotland, 2008.

Cervical screening

All women aged between 20 and 60, who have ever had sex, should have regular cervical smear tests.

Of eligible women, 69.7% had been screened for cervical cancer in the previous 3.5 years and 77.9% in the previous 5.5 years. These rates have declined over the last 10 years from 81.7% and 87.0% respectively at 31 March 2003.

In 2007/08:

- Over 373,300 cervical smears were processed within the programme, a drop of approximately 30,000 from the previous year. Of these, 97.2% were satisfactory. Approximately 92% had a negative result and just over 3% had some degree of pre-cancerous change.

- The percentage of unsatisfactory smears has fallen from 7.4% five years ago to 2.8%. The main reason for this is the introduction of Liquid Based Cytology (LBC) as a method of taking samples.
- Uptake rates continued to fall in almost all age groups, with the lowest uptake in the youngest age bands.

Source: ISD Scotland, 2008.

NHS Health Scotland has commissioned research to identify and explore attitudes to uptake of cervical screening services, with particular focus on how to improve uptake and address inequalities. Findings are expected in March 2009.

The publication **The cervical smear test explained** has recently been revised to include information on the HPV vaccine, and to reinforce the message that targeted individuals should have regular cervical screening even if they have been immunised against HPV.

Screening leaflets are available in alternative languages from the NHS Health Scotland website:

www.healthscotland.com/screening.aspx or by emailing: publications@health.scot.nhs.uk

For further information on the screening programmes, contact **Ruth Peebles, Programme Officer, Screening & Immunisation Programme, NHS Health Scotland** email: ruth.peebles@health.scot.nhs.uk



Time for training

Looking to network on healthcare matters, or expand your skills and expertise? Check out the list of events, courses and training being planned over the next few months.

Generic Health Behaviour Change Training for Trainers

March 24-26

To support practitioners to design and deliver their local training courses using a toolkit of resources. Health behaviour change theory, models and ways of supporting change will be explored through active engagement with the content of the toolkit.

Who should apply: Experienced trainers with knowledge and skills in health behaviour change approaches and health

behaviour change practitioners who are in a position to deliver training locally.

Health Improvement Trainers Scotland Network event

February 3

Who should apply: This course is open to trainers who deliver health improvement courses in Scotland.

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.



What is Keep Well?

Keep Well is a programme which aims to increase the rate of health improvement in 45 to 64 year-olds living in areas of greatest need. Keep Well has a particular focus on early intervention for those at high risk of coronary heart disease and diabetes. Individuals in the target population receive a letter or a phone call inviting them to attend a Keep Well health check. The health check is a risk assessment to identify intermediate clinical risk factors and lifestyle risk factors. Based on this assessment, individuals will be offered or directed to appropriate services and support.

Caring and sharing

The wealth of learning which continues to be generated by anticipatory care projects has led to the establishment of a three-year anticipatory care dissemination programme.

The aim of the programme is to encourage and enable action around the learning to help ensure the adoption of effective anticipatory care practices.

Currently, the focus of the dissemination programme is on Have a Heart Paisley – the national demonstration project for coronary heart disease which concluded in March 2008.

The project generated a wealth of learning both via the external evaluation, which was published in October 2008, and from the internal project team who

were keen to share their practical experiences of delivering a complex project.

Although the focus has been on Have a Heart Paisley, emerging lessons from other anticipatory care projects have also been included. These projects are embedded within the dissemination programme, and strong working links with Keep Well pilots have been established to facilitate the sharing of their learning.

A number of dissemination activities have also taken place, allowing learning to be shared with a diverse range of stakeholders, and plans are in place to ensure lessons learned continue to be shared widely.

‘The project generated a wealth of learning’

For details on dissemination, please contact **Theresa King, Senior Programme Officer – Anticipatory Care (Dissemination)** email: theresa.king@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 7534 email: helen.hassall@health.scot.nhs.uk

