

Keep Well Informed

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Anticipatory Care Conference 2009:

Moving Forward Across Scotland

Around 400 delegates, including representatives from NHS Boards, community and voluntary organisations, educational institutions and the Scottish Government attended the second national conference, **Anticipatory Care: Moving Forward Across Scotland**, on 2-3 June in Glasgow.

The event was launched by Shona Robison MSP, Minister for Public Health and Sport, who provided an overview of the policy landscape while reiterating the importance of the anticipatory care agenda and a commitment to reducing health inequalities. Dr David Dorward, a Tayside GP delivering Keep Well, outlined his thoughts on moving towards mainstreaming the approach.

A panel debate on whether anticipatory care programmes can reduce health inequalities prompted lively discussion on wider causes of inequalities, new programmes and the economic recession.

The evening dinner provided a unique opportunity to hear Dr Julian Tudor Hart's views on efficiency and continuity in the NHS.

Day two offered an inspiring presentation on the prevention of cardiovascular disease from Professor Lewis Ritchie, University of Aberdeen. A DVD highlighting practitioner and patient

experiences in NHS Lanarkshire was followed by some of those featured taking to the stage to elaborate on their roles. Professor Craig White, Clinical Lead for Self Management at the Scottish Government, ended the conference by illustrating the links with the long-term conditions agenda.

The event featured 28 parallel sessions, including interactive workshops and presentations which showcased the range of ground-based initiatives. Exhibition stands and posters assisted in the sharing of learning and best practice, while the marketplace hosted the popular 'Smoothie Bike' and taster therapy sessions in reflexology, and head and neck massage.

Helen Hassall,
Senior Programme Officer Keep Well
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Minister for Public Health & Sport Shona Robison MSP addresses the conference

Newsbites



One-stop access at the heart of the Dufftown Project

Since its January launch, Well North's Dufftown Project has demonstrated the benefits of working with an established community-planning ethos. Located within the remote Speyside area of Moray, the town can now access a range of anticipatory care support services from within the co-located Stephen Community Hospital, Health Centre and the Shand Centre.

The advantage of locating services under one roof was highlighted by Margaret Burns, Chair of NHS Health Scotland: 'The joint provision of NHS, local government and voluntary sector services is exactly the vision we would strongly encourage. Dufftown has shown that this model can be delivered effectively and provide people with easy access to a variety of health improving services within the one local setting.'

For further information, please contact **Jan Short, Health Improvement Officer** at jan.short@nhs.net

Dr Julian Tudor Hart on YouTube

Dr Julian Tudor Hart appeared in person at this year's Anticipatory Care: Moving Forward Across Scotland Conference 2009. As he was unable to attend the event last year, NHS Health Scotland commissioned a short interview film with him instead. His inspiring words are now available on YouTube via the links below.

www.youtube.com/watch?v=eHhCpQPJzXY (Part 1)

www.youtube.com/watch?v=FOnValBetpl (Part 2)

Alcohol Brief Interventions - new practitioner and patient resources available

New resources have been developed to assist in the delivery of alcohol brief interventions.

The *Alcohol Brief Interventions Professional Pack* comprises briefing papers, handouts and patient materials for practitioners, trainers and individuals with strategic and operational responsibility for the implementation of this HEAT target.

The pack is designed to complement information already available. The practitioner can select from two patient booklets following a screening that involves an assessment of their readiness to change.

The first, *A Fresh Approach*, encourages the individual to think about their drinking and provides up-to-date information on the benefits of consuming less alcohol, while *Making a Change* offers practical advice on altering habits.

Resources can be ordered directly from local NHS Board health promotion departments.



Anticipatory Care Practitioners' Network - Learning and Workforce Development

The latest event for the Anticipatory Care Practitioners' Network took learning and workforce development as its theme, attracting a wide range of participants. Practitioners came together to share information, experience and learning on topics including telephone engagement training and health behaviour change skills. The new Anticipatory Care training database was also launched - visit elearning.healthscotland.com/mod/data/view.php?id=808 to see it in action.

Delegates were inspired by the experiences of Runima Kakati, who spoke on 'distributed leadership', with at least one practitioner pledging to 'look at leadership differently'.

The overall feedback from the event was very positive. Comments included: 'I learned a lot about the training that is available and how to access it', and 'I now realise that I need to adapt training and learning to better meet needs'.

For more information on the Anticipatory Care Learning and Development Programme, please contact vibha.pankaj@health.scot.nhs.uk

How best to engage with local Keep Well populations remains a critical question for anticipatory care. Last year, the team responsible for evaluating Wave 1 Keep Well projects conducted interviews to examine how it has been reaching out to local communities. While measuring the success of different approaches is challenging, key players were able to share their views on what appears to work.

The findings included:

Different methods

Projects have used a variety of ways to reach local communities, including practice and non-practice based methods, local authority and private sector partnerships, wider NHS schemes (e.g. NHS 24, community pharmacy), community-

based initiatives and outreach approaches.

No single method of engagement is being used exclusively in any one area. Practice-based approaches are understood to have been largely successful in reaching a sizeable proportion of the Keep Well population, while the use of non-practice settings to provide patient contact and initial engagement services is also effective. In particular, telephone contact and open, flexible appointments are more successful in encouraging participation in health checks.

Reaching the vulnerable

It has become increasingly difficult to engage with certain segments of the target population. While approaches such as outreach are believed to be showing early promise in reaching more vulnerable groups, projects also have concerns about the possibility of harassing patients who repeatedly do not attend.



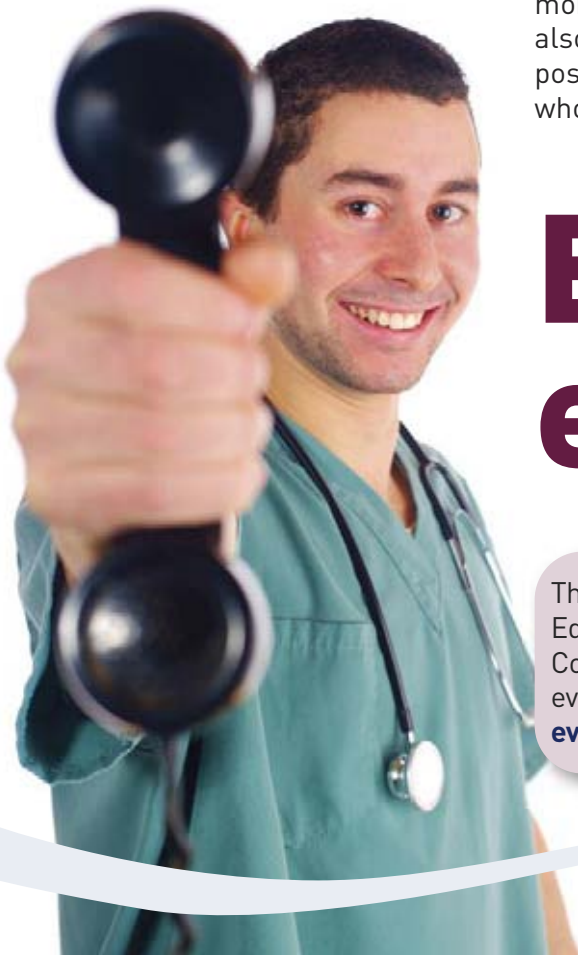
‘No single method of engagement is being used exclusively in any one area’

There remains much to uncover in terms of how best to reach these groups. A priority in the year ahead is to identify those who have attended a health check – and ascertain whether Keep Well is reaching the most vulnerable with regards to deprivation and cardiovascular risk factors.

For further information about evaluation and anticipatory care, please contact **Emma Halliday** at emma.halliday@health.scot.nhs.uk

Evaluating engagement

The research, conducted by teams at the Universities of Glasgow and Edinburgh, was recently presented at the national Anticipatory Care Conference. The report is now available via NHS Health Scotland's evaluation pages at www.healthscotland.com/understanding/evaluation/index.aspx



Updates from Wave 1 and Wave 2 areas

WAVE 2: Glasgow

New ways to spread the message

Within Greater Glasgow & Clyde, Keep Well enables the development of innovative approaches to enhance and promote health improvement services for patients.

In April, Keep Well South West held a Healthy Eating and Active Living taster event at the Palace of Art, in conjunction with the Health Improvement Team. This was an opportunity for people to find out about healthier eating, and active living opportunities and services in the area. A free bus was provided with around 85 people attending. There were cooking demonstrations and gentle physical activity sessions which proved very popular. A number of people signed up for subsequent courses, including Get Cooking, Get Shopping.

Within Inverclyde, Keep Well has funded a new 'Community Coach and Shape Up Coordinator' who is now in post. Free walking groups have been established, and volunteer motivators to assist

'An opportunity for people to find out about healthier eating, and active living opportunities and services in the area'



Milestone

More than half the population of West Dunbartonshire have attended a Keep Well health check

Innovation

Piloting a new approach to showcase health improvement services

Focus

Supporting participating practices and services, and encouraging onward referral where required

in their delivery and development are being recruited and encouraged to attend a walk leader's course.

In West Dunbartonshire, we continue to pilot the health counsellor model, but over the coming year will incorporate an alcohol brief intervention component into the consultation. This has led to the recruitment of a third health counsellor to deliver appointments for patients.

Lauren McCormick, Health Improvement Senior, West Dunbartonshire CHP
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WAVE 2: Aberdeen

Training to change health behaviour

The Keep Well programme continues to develop new methods of delivery, including the 'Healthy Hoose' – a multi-disciplinary team offering health checks from a flat in the Middlefield area. This innovative approach will allow Northfield/Mastrick medical practice patients to access a health check in a local setting.



Milestone

A further two practices commenced delivery of health checks

Innovation

Collaborative delivery of health checks

Focus

Building capability and capacity through developing health behaviour change training, health literacy and understanding of health inequalities

Working with practice staff allows us to recognise the health behaviour change training required to support the delivery of Keep Well. The need and capacity for developing this training has been identified thanks to a needs assessment questionnaire.

Keep Well staff reported different levels of experience, with lack of time and work cover identified as the biggest barriers. Possible solutions, including in-practice instruction and shorter sessions, underline the approach required to meet the needs of both practitioners and practices. A more flexible programme is now in development.

'This will allow the identification of training requirements beyond the immediate Keep Well context'

The needs assessment questionnaire will also be distributed to physiotherapy staff in Aberdeen City and pharmacy employees in NHS Grampian. This will allow the identification of training requirements beyond the immediate Keep Well context, demonstrating the relevance and sustainability of our programme-related initiatives.

A successful Health Literacy Information awareness session was held recently for staff delivering health checks. Invitation to the



The 'Healthy Hoose' in Middlefield

session was extended to other NHS Grampian staff from the Condition Management Programme, Public Health Team and the Health Promotion Team. The session content included an emphasis on:

- clear communication approaches, including Plain English
- how to recognise and respond to literacy issues
- where to refer people locally.

Supporting staff in understanding the nature, location and extent of inequality in NHS Grampian, and specifically within Aberdeen City, is a key factor in securing commitment to an evidence-based approach to service delivery. The newly published Traffic Lights (NHSG 2009) available at www.nhsgrampian.org will help pinpoint areas within the city where community-based (in addition to GP-based) health checks could be delivered.

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WAVE 2: Ayrshire

No one left behind

People with learning disabilities have greater health needs than the general population, and these needs often go unrecognised and unmet. This group can face significant barriers to accessing mainstream healthcare. More individuals now live within communities, often without support, which increases health risks from lifestyle choices. People with learning disabilities are less likely to use preventative screening services and have limited access to easily-understood health promotion literature. In short, we still have a lot to do to adequately address the inequalities they face.

Currently, those aged 16 and above have their physical healthcare needs reviewed in general practice or by the Specialist Learning Disability Service every three years. The publication *The Same as You* (2000), anticipates that this will lead to a higher standard of care and better outcomes.

However, these reviews do not necessarily address cardiovascular disease (CVD) risk factors, despite evidence that this group may develop CVD earlier in life.

Keep Well acknowledges this increased risk and, with the support of the Learning Disability Service, will soon begin to offer health checks to patients aged between 30 and 64. By combining the learning disability review and Keep Well



Milestone

Recognising the increased risk of early development of CVD for people with learning disabilities

Innovation

Offering a comprehensive health check and disability review appointment

Focus

Tackling health inequalities across all groups in society

'The challenge for Keep Well is to tackle unmet health needs wherever they may exist'

health check, a comprehensive appointment, initially offered by GPs, will be provided.

We are developing picture-based appointment letters and considering a photographic resource to help patients have a better understanding of what will happen during and after the health check.

Guidance for staff to allow them to engage effectively with those with a learning difficulty will also be available. We need to recognise that these

appointments may require additional time, and ensure that practitioners have the necessary knowledge and skills. Learning disability awareness training is currently being offered and this will be extended to include staff from referral agencies.

The challenge for Keep Well is to tackle unmet health needs wherever they may exist – inequalities affect not only people living in deprived areas, but many other marginalised groups within society too.

**Carolyn Wyper, Project Manager Keep Well,
NHS Ayrshire and Arran
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WAVE 2: Fife

Pharmacies take the weight

Obesity and obesity related co-morbidity significantly affect cardiovascular risk. The Keep Well programme includes the option for referral to appropriate weight management intervention services. Counterweight is an evidence-based weight management programme which previously has only been delivered by health care staff in primary care. NHS Fife is undertaking the first pilot of Counterweight delivery via pharmacies.

It was agreed by the Keep Well Steering Group (KWSG) that where practices were unable to deliver Counterweight, pharmacies would be approached as a suitable alternative, given their location, private consultation rooms and accessibility.

Initially, a Counterweight recruitment event was held whereby pharmacy managers were invited to learn more. On commitment to the programme, pharmacy staff received two 4-hour specialised obesity management training sessions. They then continue to be supported with on-site mentoring from Fife's Weight Management Adviser and a buddy clinician.

To date, staff from 11 pharmacies and five GP practices across Fife have been trained. Patients are referred directly from Keep Well health checks to Counterweight pharmacies. Criteria are a Body Mass Index (BMI) of 30 or above, or a BMI of 28 with co-morbidity. A consent form, referral letter and pharmacy record card were developed and agreed by the KWSG.

'NHS Fife is currently undertaking the first pilot of delivery via pharmacies'

Measures have also been put in place to collect data from participating pharmacies. This will provide the information to evaluate the outcomes of the pilot.

As the Keep Well programme proceeds, Counterweight referrals continue to increase, with patients currently being seen in five practices and six pharmacies. Feedback from practitioners and the public has been very positive.

This pilot will ascertain the effectiveness of delivering the Counterweight programme in this way. If results are supportive it is anticipated that it could be rolled out to pharmacies across the UK.

**Naomi Brosnahan, Weight Management Adviser,
Counterweight Project, NHS Fife**
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Milestone

Increase in referrals to the Counterweight programme

Innovation

Delivering the weight management initiative via pharmacies

Focus

Evaluating the outcomes of the pilot



WAVE 1: Lothian

Piloting programme innovation

NHS Lothian is currently in the process of recruiting a new project manager to replace Katie Edwards, and an early task for the appointee will be to revise and expand upon the existing project infrastructure.

We are pleased to report that all 14 Edinburgh practices delivering Keep Well will continue to do so in the expansion. In addition, five new practices in West Lothian will come on board, and teams are being established to offer the programme to gypsy travellers, ethnic minorities and prisoners. All practices are now using ASSIGN to assess cardiovascular risk, and all new areas of work have been subject to a rapid equality impact assessment.

The doorstep engagement pilot has been completed with a total of 160 visits made:

- 72 people opened the door to Keep Well
- 88 doors were leafleted
- 15 bookings made on the day
- 5 home assessments completed
- 8 requests made for out-of-hours assessments.



Doorstep engagement has now commenced in Wester Hailes, with a number of other practices due to come on board.

Rollout of comprehensive telephone engagement through NHS24 is proceeding, following the success of the initial pilot. Figures show there have been 712 booked appointments from a total of 1,379 contacts.

Margaret Douglas,
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Milestone

Completion of doorstep engagement pilot and rollout of telephone engagement scheme

Innovation

Teams to be established to deliver Keep Well to travellers, prisoners and minorities

Focus

Revision and expansion of existing infrastructure

WAVE 1: Lanarkshire

Taking Keep Well to our targets

The Equally Well report highlighted the need for health services, including Keep Well, to respond to inequality and diversity in a range of ways including ensuring services are culturally sensitive and accessible.

In Lanarkshire we have around 3,000 patients classed as homeless, and in South Lanarkshire there is an established gypsy traveller population. Many of these people are not registered with a GP, and are therefore ineligible for a Keep Well health check under our current delivery model.

We would like to expand our services to include these groups, and are progressing plans for a flexible delivery model that will be community-based to



Milestone

Developing expanded services to target specific populations

Innovation

Collaborating with service providers to develop a bespoke, holistic anticipatory care service

Focus

Addressing the health needs of hard to reach groups

actively take services to them. We are working collaboratively with those service providers who are currently engaged in these areas. These providers are keen to support us, and work in partnership to develop a holistic anticipatory care service designed to meet the specific requirements of all communities.

There have been a number of health and social needs identified in these populations that should be addressed. In order to offer a holistic service we plan to develop a case management approach to our work – once we have engaged with a patient they will be supported through the Keep Well journey by a single key case worker.

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WAVE 1: Dundee

Taking stock and looking ahead

Looking back over the past two years in Dundee, it is interesting to reflect on how much has been achieved and how much has changed. We have 17 practices delivering Keep Well - between them, they have carried out around 6,000 assessments - with another three practices keen to join. In addition, one community pharmacy is assessing patients with a number of others hoping to join.

Some 12 staff are working within communities providing health coach support as part of their role, including one specifically covering mental health. Three community-based nurses are delivering assessments to those who haven't attended their practice and the homeless. Finally, we've developed a number of

information systems and processes to evaluate and improve our work.

Soon Keep Well will no longer just be in Dundee, but in key areas of Perth and Kinross, and Angus CHPs. We are examining ways to provide more accessible information about the services in these areas, as community planning work and Keep Well findings show that local residents are not always aware of what's available. We are also now working with the British Heart Foundation, through its Hearty Lives programme, to build on the learning from Keep Well.

**Shona Hyman, Project Coordinator
Keep Well and Hearty Lives, Dundee CHP
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Milestone

Around 6,000 assessments delivered in the last two years

Innovation

Staff in communities providing health coach support

Focus

Raising awareness of Keep Well services in new regions

WAVE 1: Glasgow

Possibilities for greater engagement



Milestone

Homeless practice being accessed by registered and non-registered patients from across Glasgow

Innovation

Possible acquisition of new premises within the Forge Shopping Centre

Focus

Continuing to deliver Heartstart and seeking new ways to work

Keepp Well in East Glasgow is going from strength to strength, and as we move into our third year, we've taken this opportunity to examine future development and innovative ways to work.

Greater engagement has been enjoyed with the Homeless Practice, situated within East Glasgow CHCP, now being accessed by both registered and non-registered people from all over the city, thanks to a daily drop-in service.

This is an excellent chance to connect with the most hard-to-reach group, and we are hopeful that the information gathered will be of benefit to other Keep Well sites too. A part-time nursing post will be created to pilot this venture.

Negotiations are underway to acquire premises within the Forge Shopping Centre in Parkhead. This will raise awareness by taking information and

services directly to the community.

The new site will allow outreach workers to better identify those who meet the Keep Well criteria. Members of the public will be able to access guidance, information, taster sessions and referrals, including money advice, stress management, smoking cessation and employability. Services will be provided outside core working hours, including during the weekend, with the potential for further development including screenings within the practices.

Keep Well in East Glasgow continues to offer Heartstart to the local community. The project has trained 272 people, including 31 instructors, with 35 classes being delivered to partnership organisations and members of the public.

**Carol McDougall, Keep Well Project Officer, East Glasgow CHCP
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Strengthening the links

Is better partnership working the way to engage elusive patients and improve the range of services available?

NHS Health Scotland's Community and Voluntary Sector Programme is working together with the Anticipatory Care Programme team in 2009/10 to support the development of partnerships between anticipatory care programmes and community and voluntary groups.

The need for, and value of, advancing this area of practice was enforced by representatives from all

sides during discussions with NHS Health Scotland earlier this year. It was recognised that partnerships could enhance the outcomes of anticipatory care in reaching and addressing the health needs of people within the target population group. As well as supporting existing projects, the work will be especially timely in enabling newly developing anticipatory initiatives to have a flying start in this respect.

Developing and strengthening partnerships with other

organisations is seen as having considerable potential to improve the reach and uptake of anticipatory care among people from harder-to-engage segments of the community. In addition, referrals and links to voluntary groups can improve access to a broader range of health and wellbeing services such as counselling, food cooperatives, smoking cessation and alcohol support and mental wellbeing groups, among others.



Workplan

Initial discussions identified issues to be considered to support partnership development. NHS Health Scotland has drafted a workplan based on these issues, including the need to:



- identify and draw from current partnership networks and learning
- jointly agree referral pathways, evaluation criteria and forms
- increase awareness of the range and nature of services available
- increase knowledge of the strengths of each partner organisation
- agree process for evaluation and collecting outcome evidence
- jointly develop partnership-working protocol and understand accountability frameworks.



Case studies



NHS Health Scotland has commissioned a series of case studies to share good practice from existing partnerships. To be launched this autumn, they will illustrate and analyse examples of initiatives to support uptake with hard-to-reach clients, and develop referrals to other services and programmes. The studies will highlight both positive outcomes and aspects that remain challenging or undeveloped, and identify factors that support or impede successful partnership-building.

Anticipatory care conference

The Anticipatory Care: Moving Forward Across Scotland Conference 2009 provided an opportunity for further discussion on this subject. NHS Health Scotland, in conjunction with the Community Health Exchange, led a workshop during which delegates were informed of the key themes and issues related to partnerships between community and voluntary organisations and anticipatory care. The rationale for working together and existing examples were examined from various perspectives.



Consultation on partnership-building and strengthening



In order to develop the support infrastructure for partnerships, NHS Health Scotland conducted a consultation on its proposals in April. Responses were received from different sectors across Scotland. Both the consultation process and the work itself were enthusiastically received. This feedback has been used to finalise the programme which NHS Health Scotland will lead, including the convening of cross-sector working groups to develop and pilot projects exploring effective partnership-building. Details are available on the NHS Health Scotland website at www.healthscotland.com/topics/settings/community-voluntary.aspx

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Learning and workforce development

Courses get results

Keep Well training courses are helping practitioners gain the skills and confidence to help change the health-related behaviour of targeted populations.



NHS Health Scotland has delivered numerous Behaviour Change and Health Inequalities, and Alcohol and Brief Interventions courses over the past few years. The interim findings of an independent evaluation suggest that the training has benefited participants.

David Henderson from Insight Collective agrees that to use health behaviour change strategies is a 'challenging concept' and some staff 'may not feel it is something they ought to be doing'. However, the study shows that attitudes are boosted by completing the course:

- 92% felt confident in their ability to deliver brief interventions after training, compared to around two-thirds before the course.
- Delegates felt greater sympathy for people with poor health behaviours.
- Participants displayed increased understanding of the role staff can play in altering behaviour.

The evaluation is due to be completed early next year.

If you need further information on the workforce development plan for anticipatory care, please contact vibha.pankaj@health.scot.nhs.uk

Dissemination

Now at the end of its first year, the Anticipatory Care Dissemination Programme is busier than ever. While the programme initially focused on Have a Heart Paisley (HaHP), this has now widened to ensure that learning emerging from other programmes, such as Keep Well, is distributed effectively to ensure the adoption of good practice.

With this broader focus in mind, and in a bid to complement the range of activities undertaken to date, an event was held in March aimed at sharing key experiences from HaHP and identifying common areas of understanding across anticipatory care programmes. Those in attendance, including representatives from Keep Well and Well North, participated in discussions on how knowledge from HaHP could be used. This also enabled the sharing of early learning and skills from across local areas.

A new DVD in which the Keep Well team from Lanarkshire share their experiences of providing an outreach service was showcased at the recent Anticipatory Care Conference. The production features contributions from key individuals and valuable insights from those involved.

For further information, please contact **Theresa King, Senior Programme Officer – Anticipatory Care (Dissemination)**, email: theresa.king@health.scot.nhs.uk

Training and development opportunities in 2009/10 include:

- Behaviour Change and Health Inequalities (Accredited at SCQF Level 7)
- Improving Communication Skills with Hard to Reach Groups
- Alcohol and Brief Interventions.

Training for Trainer (T4T) courses are also scheduled throughout the year, including:

- Alcohol Brief Interventions T4T
- A newly developed Behaviour Change and Health Inequalities T4T which will train trainers to deliver and assess at SCQF Level 7.

NHS Health Scotland's Learning and Workforce Development Team are also delivering the following upcoming events:

- Creating Imaginative Learning – Refresher day (7 July 2009)
- Health Behaviour Change Training for Trainers – Refresher day (8 July 2009)

For more information on the above courses, please contact **Tania Cousin (Training Coordinator)** at tania.cousin@health.scot.nhs.uk or **Vibha Pankaj (Learning and Development Adviser)** at vibha.pankaj@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

