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WINTER 2007/08

Welcome

Welcome to the winter edition of Keep Well Informed. This newsletter is published on a quarterly basis and is also circulated via email. It is also available at www.healthscotland.com. The aim of the newsletter is to inform interested parties of Keep Well programme developments.

Simon from Shotts talks about his Keep Well experience

How did you feel when you were invited to attend a Keep Well health check?

At first I wasn't sure, because it was something new. But I just knew that I had a problem with my weight and the more help I could get the better. I also felt I had a problem with my blood pressure. I don't go to my doctor very often so I thought this was a good opportunity for me to mention this.

What happened at the health check?

When I did go they asked me lots of different questions, some of which were quite difficult for me. I had a good cholesterol level, so I was quite pleased with that. But there was a problem with my blood pressure which was a concern. They also weighed me and they recommended I lose some weight, and I agreed, as this would help my blood pressure.

What happened next?

They explained I would go and see somebody else at Counterweight who would help me to lose weight. Normally you go to the doctor and they just tell you to lose weight, and away you go. But you had somebody to help and I think that is the most important thing for me, there was somebody there that I could go and talk to, without feeling that I'm wasting the doctor's time.

How did Counterweight help you?

They started off weighing me and measuring my waist and they gave me plenty of leaflets. It's difficult for me because I'm a coeliac so a lot of the food which they recommended, I can't eat. But Debbie was really, really good and she listened and never tried to push me.

I brought my wife along, because she does the cooking, and eventually I got my wife to join as well. Through Debbie I got even more support from Helen at Community Renewal, without even asking.

Have you been able to make changes to what you are eating?

We've definitely made a big difference to the way we've been eating. We weren't a family who ate fatty food, but some things like sugar we thought weren't fat. Through all the little leaflets and booklets they give you, they tell you what to watch for and there are hints and tips. If you fall slightly to one side it's not a problem, the next day you just get straight back onto it.

Have you been able to do more exercise?

I've had free gym membership which has been good. I find it really difficult to get into the swimming pool, so I wouldn't go on my own. But because my wife is now with Counterweight they've got her into exercise as well so we go together, it's really good.



“ I think it's a fantastic service, I really, really do. ”

Partnership working – it's more than emails, phone calls and meetings.

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The power of partnership working

John Howie, Keep Well Programme Manager for Health Scotland, reflects on the key achievements of the last 12 months and explains that without the national and local commitment to effective partnership working, many developments in the programme would not have been realised.

The challenges of multi-practitioner and multi-agency working, combined with the ambitions of ensuring user participation, can never be underestimated. However, the positive benefits of effective joint working and the impact this can have on service delivery and user experience are both significant and they are a fitting reward for the drive, patience and stamina of staff who choose to deliver services in this way.

Central to the successful delivery of Keep Well, is an approach that aims to maximise the skills, experience and resources available at a local, regional and national level. Whilst this approach is not unique to Keep Well, the evidence to date (and illustrated in this and previous editions of Keep Well Informed) would indicate that the desire and ability to make this happen is shared across all programme areas.

One of the answers to why there exists such consistency in this way of working, is the Keep Well national planning criteria. Developed in 2006 and later refined in 2007, through feedback by national and local staff, a clear set of planning requirements were laid out for

participating Keep Well Community Health Partnerships. This included the need for senior support and leadership across all leading partner agencies, and planning and delivery infrastructures that involve all participating agencies and user representatives. Furthermore the application of equality impact assessment approaches were identified as essential to ensure the needs of particular populations would be acknowledged and responded to.

Consequently over 300 individual agencies and services have contributed to the programme so far. The opportunity to extend this further continues as confidence increases across partnership staff to work together and access each others services.

How we capture the diversity and effectiveness of partnership approaches will be outlined further in the next edition of Keep Well Informed, with an overview of early findings from the national evaluation team. However, North Lanarkshire CHP arranging Keep Well appointments through the North Lanarkshire Council Call Centre, is just one of many examples of how lateral thinking can work towards the delivery of a more effective and efficient health improvement agenda.

In November last year, the 2007 Spending Review outlined a commitment to extend national screening to detect serious illness early and support this with £41 million over the next three years. This coupled with a three-year investment to reduce harm through alcohol (£85 million) and obesity (£34.5 million), and further action to reduce smoking (£9 million), provides a strong financial platform. Through a partnership approach this foundation will be further strengthened and, if applied



correctly, provide additional opportunities to not only build on programme lessons to date, but extend our thinking to support other critical parts of the anticipatory care jigsaw. For example, the creation and maintenance of safe and healthy living environments without which lifestyle changes will remain a challenge for many.

In early 2008/09 Health Scotland will publish its annual Delivery Plan for Keep Well and Anticipatory Care with input from partner services. This will outline how allocated funds will be spent and will be informed greatly by the hard work of all partner agency staff involved in the process to date. In addition the experiences and suggestions shared by those, such as Simon, who have participated in Keep Well, and others from the Have a Heart Paisley programme, will be taken into consideration. Such contributions are vital and fully recognised by everyone involved in the co-ordination of the programme and deserve a massive thank you. Here's to another productive year of partnership working in 2008/09.

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‘ A number of initiatives aimed at increasing engagement and reducing barriers to access are being explored. ’

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Innovation in Wave 1

We take a closer look at how NHS Boards involved in wave 1 are progressing with Keep Well.

News from NHS Lanarkshire

Keep Well in NHS Lanarkshire has a target population of 28,547. As of November 2007, 19,389 of these patients had been invited to a Keep Well health check and 7,852 patients had attended.

Over 4,500 referrals have been made to a variety of sources, the majority being patients found to have an assumptive cardiovascular disease risk of 20 per cent or more, requiring more in-depth screening and treatment.

Areas of development include pharmacists supporting screening; and flexible appointments including Saturdays and evenings in a variety of venues. There is also joined-up working with Community Renewal (a community-based organisation) and North Line (North Lanarkshire Council's customer contact centre) who Lanarkshire are working in partnership with to target patients who do not attend, through phone calls and home visits.

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News from NHS Lothian

As Keep Well in NHS Lothian approaches its first birthday there has been some taking stock of activity and experience to date.

The 14 participating general practices, supported by the core project team, have been working hard to engage with, and assess, eligible patients. Moving into its second year, the top priority will be to ensure as many of the 23,000 eligible Edinburgh residents yet to engage in Keep Well do so, initially by participating in a Keep Well health check. A number of initiatives aimed at increasing engagement and reducing barriers to access are being explored, in partnership with other statutory services. For example, delivery of health checks out-of-hours at key sites across the city; early evening phone engagement and appointment reminders; and door-step invitations. To complement any new initiatives the project team will continue to advertise and promote the project within local communities through linkage with local community groups, voluntary sector projects and businesses.

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News from NHS Tayside (Dundee CHP)

There has been significant progress in Dundee with 16 general practice teams involved who have now assessed and offered ongoing support, where desired, to around 2,000 people. The Dundee team would like to thank practices for their hard work.

The health coaching service has had a high level of referrals for weight management in particular, often combined with physical activity. The Dundee Healthy Living Initiative groups, which promote cooking skills, walks and other physical activity, remain very popular, with new groups being developed to suit Keep Well clients. The Active for Life exercise programme is very popular with both the two new centres working to full capacity.

Plans are well underway to expand the means of offering Keep Well. As well as continuing to encourage more practices to be involved, Keep Well will be delivered in a small number of community pharmacies, and also in community and workplace settings, by linking more closely with the Community Heart team. It is also hoped to look at groups with particular needs, such as the homeless.

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News from East Glasgow CHCP

Heartstart UK is an initiative co-ordinated by the British Heart Foundation to teach members of the public what to do in a life-threatening emergency.

It aims to facilitate and support emergency life support training in the community to provide simple skills that can save lives.

One of the biggest challenges in Glasgow is how local people perceive themselves and their perception of what is normal, and as a result the impact on the community has to be considered. The Heartstart programme will not only save lives but empower the community to take responsibility for their, and others, own health and wellbeing.

Keep Well is working in partnership with Heartstart to develop systems and procedures to implement the initiative within East Glasgow. There is a lot of enthusiasm about this in the CHCP and it is seen as an excellent way to engage with the local community.

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News from North Glasgow CHCP

Glasgow recently held alcohol awareness training for primary care staff in North and East Glasgow CHCPs.

This looked at the definitions of 'binge', 'harmful' and 'hazardous drinking' and attempted to educate staff regarding the need to explore patients alcohol-related habits. The training was delivered in a practical setting by Glasgow Council on Alcohol with the use of props and mock consultations. The event was well received by all and there is an intention to duplicate this on a smaller scale in GP practices.

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📌 NHS Fife will specifically target the travelling and homeless populations. 📌



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Wave 2 developments

News from NHS Fife

Lynsay Anderson, Project Manager, provides an overview of plans for Keep Well in Fife.

NHS Fife is delivering Keep Well within all three CHPs in the Board area – Dunfermline & West Fife CHP, Kirkcaldy & Levenmouth CHP and Glenrothes & North East Fife CHP. This is reflective of the dispersed nature of the deprived population across Fife, with pockets of deprivation spread across both urban and rural locations.

The Keep Well population cohort is 45–64 year-olds living within Fife's 20 per cent most-deprived datazones, to correspond with regeneration areas in Fife. Across Fife this gives a total target population of approximately 17,200 patients registered with GP practices, including those already on existing disease registers. In addition, NHS Fife will specifically target the travelling and homeless populations and will also engage with people who may not be registered with a GP practice.

Forty-nine GP Practices across Fife will be invited to participate in Keep Well. Using learning from wave 1, core models of delivery have been developed, from which practices will be able to choose the most suitable option. Local variations to these core models will be permitted to allow for individual differences in the set up of practices across the region.

In addition to the variations in the structure of each of the three CHPs, GP practices within each CHP differ greatly in terms of practice size, space available, number and skill-mix of staff, and size of the Keep Well target population. It is therefore anticipated that different models of delivery will exist both across CHPs and across practices within each CHP.

It is recognised that only offering Keep Well within GP practices may exclude some patients. As some Community Pharmacies in Fife successfully delivered health checks as part of a recent men's health project, a Community Pharmacy model of delivery for Keep Well is also being developed.

Keep Well will link patients with local services that will address their particular lifestyle behaviours and/or life circumstances needs. Joint working with Fife Council and the voluntary sector will ensure an efficient referral system is developed for primary care staff delivering the Keep Well health check to enable referral of patients to appropriate services.

A service directory will be developed for each CHP to provide primary care staff with details of all locally available services to which referral or signposting of patients might be appropriate. These services will include those tackling lifestyle behaviour issues such as diet, smoking and physical activity and the services that address other social factors, such as mental health, literacy and employability.

NHS Fife has taken on Keep Well on a particularly large scale and thus expects significant learning outcomes from the project. To help facilitate the extensive work involved, link officer posts will be created in each CHP to drive the project forward at a local level.

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❖ A number of implementation sub-groups have been established in addition to the GP, Pharmacy and IMT groups. These are Communications, Evaluation, Literacy, Learning & Development, and Weight Management. ❏

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News from NHS Grampian

Linda Leighton-Beck, Project Lead, reports on Keep Well planning in Aberdeen.

The Keep Well proposal was agreed at the end of August and since then sub-groups for GP, Pharmacy and IMT implementation have been established. These groups will agree a range of criteria by which the introduction of Keep Well will be phased in within Aberdeen City CHP, in practices which are characterised by deprivation.

There have been negotiations with five practices to initiate data screening at this stage, without prejudice to any subsequent involvement in Keep Well. An Information Analyst has been appointed to progress this work, which will involve negotiation of access with each practice as the work cannot be done remotely. At the conclusion of data screening, there will be an accurate list of all patients eligible for the Keep Well programme. It will be important to manage the communication of this information effectively, given that not all patients in any practice or community, in the 45–64 age band, will be eligible.

Following the data screening for five practices, the next step will be to negotiate with one or more of these practices, the preferred model of operation. Then to begin to work through the logistics of building a transparent network of service delivery for patient support, post health check.

A number of implementation sub-groups have been established in addition to the GP, Pharmacy and IMT groups. These are Communications, Evaluation, Literacy, Learning and Development, and Weight Management.

The Learning and Development Group has met with the co-chairs of the national group and is now progressing with a number of initiatives to try to ensure good use of national activity to support local need.

The Weight Management Group is taking forward modelling around the patient pathway to ensure that Keep Well drives service and referral activity which will support the programme. This is part of the wider NHS Grampian approach to weight management, effectively incorporating preventive support and self-care.

There has also been involvement in two other initiatives that add-value to Keep Well. NHS Grampian, in collaboration with Aberdeen University, successfully bid to NHS Education Scotland for matched-funding for a two year Health Psychology traineeship, the service focus for which will be located within Keep Well. It is hoped to make an appointment early in 2008. Furthermore, Aberdeen University in collaboration with NHS Grampian, was invited to submit a full bid to the Health Technology Assessment Programme for the evaluation of an exercise referral programme built around Keep Well, the outcome of which is expected shortly.

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‘ The specific needs of vulnerable and hard to reach groups within the community will be considered at each stage of the project’s delivery. ’

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News from NHS Ayrshire & Arran

Carolyn Wyper, Project Manager, reports on NHS Ayrshire & Arran’s approach to delivering the Keep Well project.

Keep Well will be delivered in North and East Ayrshire. There is a plan to engage with the target population, including marginalised groups within society, by developing services specific to their needs. Individuals will be identified who could benefit from anticipatory care through a variety of approaches such as GP registers, health visitor contact lists for homeless people, and case lists from community learning disability teams.

A phased approach will be used to deliver the project, to ensure that those involved in the implementation receive appropriate levels of support, particularly in the initial stages.

Initially practices with significant numbers of identified Keep Well patients will be invited to participate in delivering the project. Two practices, Kilwinning Medical Practice and Ballochmyle Practice, have been identified as early implementers and have agreed to begin the engagement process in January 2008. During this time, these practices will provide feedback on the systems and processes which have been put in place to support the practices.

It is recognised that a high number of the project population will be ‘hard to reach’. Therefore from the outset NHS Ayrshire & Arran has proposed to use a combined delivery model, which uses primary care and community development approaches. This will involve enhancing and developing the skills of those individuals within primary care teams and community pharmacies.

By doing so, it is hoped to improve the accessibility of the project and its services. This development will be influenced and informed by the learning and experiences of the Community Pharmacy-based Healthy North Ayrshire project.

Within the project proposal, it is recognised that some individuals living outside the most geographical deprived areas may also be disadvantaged. Evidence has shown that although groups within society such as homeless people, prisoners and people with learning disabilities, exhibit a different pattern of health needs to the general population, they also encounter greater difficulties in accessing services. Therefore the specific needs of vulnerable and hard to reach groups within the community will be considered at each stage of the project’s delivery.

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‘ In South West Glasgow, the Keep Well model will remain similar to all other areas and build on the experiences of North and East Glasgow programmes from wave 1. ’

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News from NHS Greater Glasgow & Clyde

Given that NHS Greater Glasgow and Clyde is host to a high proportion of the national programme target population, it is no great surprise that an investment of £5 million over two years is extended to Glasgow South West, Inverclyde and West Dunbartonshire. However unlike Glasgow wave 1 there is an added dimension.

In South West Glasgow, the Keep Well model will remain similar to all other areas and build on the experiences of North and East Glasgow programmes from wave 1. The overall target population is 7,430 and 12 of the 27 local practices will be taking part. The identification of attendees commenced in December 2007 and the Community Animator role, similar to that developed in Lanarkshire, will be considered as a key component of the engagement process. Other aspects of this programme reflect Glasgow's wave 1 experience with plans for mental health assessment, use of the online tracking tool and weekend health checks.

In Inverclyde and West Dunbartonshire the initial focus will be on optimised secondary prevention and follow current Glasgow CVD Locally Enhanced Service approaches. In other words, services will be created to provide an increased range and intensity of services to individuals of all ages who have already been diagnosed with heart disease.

The combined target population of both areas is 6,930 people and 24 local practices will be taking part. To retain a focus on health inequalities, individuals from this group who live in the most deprived areas of Inverclyde and West Dunbartonshire will be provided with additional support around employability, money advice/welfare benefits and literacy if required.

Inverclyde and West Dunbartonshire will complement these interventions with a structured opportunistic screening programme for other individuals aged 45–64 years not diagnosed with heart disease, but registered with the 24 participating practices.

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More and more people within the health profession are recognising that work is, in general, good for people's health. »



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Health, work and wellbeing

Michael Kennedy, from the Scottish Government, updates on the current work underway in relation to employment and health and wellbeing.

Working Together for a Healthier Scotland Conference

On 1 November 2007 over 150 senior staff from health, social work and employability met at Hampden Park Glasgow to develop closer partnership working between health and employability services. The conference provided an opportunity for delegates to share existing good practice and develop action plans to support the links between the health and employability agendas. Keynote speakers included Nicola Sturgeon MSP, Cabinet Secretary for Health and Wellbeing, who opened the conference. Ms Sturgeon set out the Scottish Government's commitment to tackling health inequalities; outlined the need to improve services offered to local people and emphasised the vital role that work can play in health improvement.

Professor Gordon Waddell presented the results of his evidence review (with Professor A Kim Burton); to show both the benefits of good work and the risk that unemployment poses for people's health.

His report showed that:

- there is a strong evidence base that work is generally good for physical and mental health and wellbeing
- worklessness is associated with poorer physical and mental health and wellbeing
- work can be therapeutic and can reverse the adverse health effects of unemployment and applies to healthy people of working age, for many disabled people, for most people with common health problems and for social security beneficiaries. However obviously the nature and quality of work and its social context must be taken into account
- overall the beneficial effects of work outweigh the risks of work and are greater than the harmful effects of long term unemployment or prolonged sickness absence
- work is generally good for health and wellbeing.

Employability training support pack

More and more people within the health profession are recognising that work is, in general, good for people's health. However, a skills gap has been identified around their knowledge and understanding of employability issues. To help fill this gap the Scottish Government has arranged for Equal Access to develop an awareness raising pack for health professionals. The Equal Access team are working closely with Keep Well colleagues in Glasgow to ensure the product meets the needs of staff and this will be tested soon. Once the training pack has been finalised, further discussions with Keep Well colleagues will take place.

Pathways to Work

Jobcentre Plus has now rolled out their Pathways to Work programme across the whole of Scotland. This will mean people claiming Incapacity Benefit can have access to the following via their Jobcentre Plus Adviser:

- the Condition Management Programme – which delivers short courses on stress/anxiety management, pain management and confidence building
- a Return to Work credit of £40 per week up to 52 weeks for people earning less than £15,000 per year
- in-work support
- job grants.

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‘ The first meeting of the practitioners’ network took place on 23 November in Glasgow and received very positive feedback. ’



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Insight into the Keep Well sub-groups

In this edition there is an overview of the Keep Well Practice and Learning Group, chaired by Lynda Brown, Public Health Advisor, and Vibha Pankaj, Learning & Development Advisor, both from Health Scotland.

The Practice and Learning element of the Keep Well programme is taken forward at a national level by the Practice and Learning (PaL) sub-group. Effective delivery of the programme requires a skilled workforce, relevant knowledge, awareness and confident application of the evidence base, and awareness and refinement of good practice to suit local circumstances. It also supports the development of new and innovative anticipatory care approaches. The PaL group was set up in February 2007 and has representation from all wave 1 areas, NHS Education Scotland and Have a Heart Paisley. It provides a forum for discussion, development and implementation of new approaches within Keep Well, how such approaches can be shared (within Keep Well and nationally) and implications for workforce development.

Learning and development

To support the implementation of Keep Well, Health Scotland has developed a range of programmes to support capacity building of staff involved in the delivery of Keep Well. Behaviour Change and Health Inequalities training was developed to skill staff in delivering effective brief interventions.

The training programme aims to help practitioners embed Health Behaviour Change approaches into their everyday practice. Training for Improving Communication Skills with Hard to Reach Groups was also developed, to provide knowledge and skills required to understand the needs of the hard to reach groups and to encourage take up of Keep Well services. The knowledge and skills required to undertake Effective Community Engagement were supported through provision of one-to-one support to Keep Well areas. The tools used to facilitate this process were the Standards for Effective Community Engagement and LEAP (Learning Evaluation and Planning) for health.

All the above mentioned programmes have been provided to wave 1, and will be available to wave 2 areas to support their implementation. Funded places have been made available to Keep Well staff to attend Health Scotland capacity building programmes such as Health Improvement: Developing Effective Practice; Creative Imaginative Learning (trainer development programme); Health Behaviour Change Training for Trainer programme. Currently, Alcohol-related harm and brief interventions training is also being offered to Keep Well areas.

Evidence-based practice

In 2006, Keep Well Interventions: Overview of Guidelines and Evidence – A Resource for Local Areas was commissioned by the Keep Well Core Project Team. The purpose of this resource was to provide local areas with an easily accessible overview of current guidelines, on action that can be taken by professionals and members of communities when pursuing the vision and focus of Keep Well. The resource also covers evidence on the effectiveness of relevant interventions where this helpfully supplements and complements the guidelines identified. An interim version of the document was produced in August 2006 to support development and implementation of wave 1. The resource is currently in the process of being revised following the launch of the new SIGN Guideline on risk estimation and the prevention of cardiovascular disease. The revised version should be available on the Keep Well website by January 2008. The PaL Group has an ongoing role in updating the resource as new evidence becomes available.

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Practitioners' network

One of the remits of the PaL Group during its first year has been to establish a practitioners' network for staff involved in delivering Keep Well, as well as staff from non Keep Well areas with an interest in anticipatory care. The network aims to provide opportunities through face-to-face events and web resources to provide a forum for sharing practice, support dissemination of learning from Keep Well and give opportunities to reflect on practice and develop new approaches. The first meeting of the practitioners' network took place on 23 November 2007 in Glasgow and received very positive feedback. There were a number of national presentations and the opportunity for wave 1 areas to showcase innovative local practice via workshop sessions. The day also allowed an opportunity to consult with practitioners on what they want from the network on an ongoing basis. Results of the consultation will be used to further develop the network through the PaL Group. Helen Hassall, Senior Project Officer for Keep Well, will be in touch with network members in January to update them on future plans.

PaL group activities

Some examples of activities that the group has been involved in this year include:

- making links with community engagement standards
- making links with NHS Education Scotland's work around health inequalities and anticipatory care in the pre and post-registration nursing curriculum
- seizing opportunities to capture some of the informal learning from Have a Heart Paisley
- consideration of how Keep Well could collaborate with NHS24 to support client engagement.

The way ahead

In the year ahead, the PaL Group has plenty of activities to focus on. Wave 1 have had time to test out approaches and this learning can now be built upon. Wave 2 has come on board and can benefit from the wave 1 experiences of implementation. Have a Heart Paisley comes to an end in February 2008 and a period of extensive dissemination of learning will follow to ensure it is fast tracked to Keep Well areas.

There is also the national conference in March to look forward to!

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Membership of PAHA is free and open to practitioners from a wide range of professional and volunteer backgrounds. »



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There's a lot of activity around physical activity

The Health Scotland Physical Activity Programme update on developments planned for the new year.

First off the starters' block in March 2008 will be a high-profile national campaign from the Scottish Government to promote the benefits of walking. Campaign details were still being finalised as this went to print, but this does represent a unique opportunity for frontline health professionals to talk to patients about walking and its benefits to their physical and mental health. If staff can signpost people to local opportunities for walking, then so much the better. Visit www.pathstohealth.org.uk to get information about led walks in your locality.

Community pharmacists have grasped the walking baton in support of the Pharmaceutical Public Health Service part of their new contract. For a period of six weeks starting in April, all 1,800 Community pharmacists in Scotland will have posters in their windows and in-store leaflet displays to promote walking. In Lothian and Forth Valley, there will be the additional activity of a pedometer pilot, delivered by Paths to Health.

Health Scotland is also developing guidance for the primary care setting to raise awareness of the key messages around physical activity and to support health professionals in translating evidence-based guidelines and recommendations into the every day 'lived reality' of patients. This guidance has drawn on the experience and expertise of a reference group as well as pre-test findings from user focus groups and will be available shortly.

The best place to find out about the latest fixtures is www.paha.org.uk. The Physical Activity and Health Alliance (PAHA) offers exclusive access to hundreds of online resources (including policy documents, images, toolkits, websites and more). Members can also share information about job vacancies, events and projects. Membership of PAHA is free and open to practitioners from a wide range of professional and volunteer backgrounds.

In addition to being a central hub for evidence and practice, PAHA also offers a wide range of networking opportunities. For the past few months, the Alliance has been on the road with a series of regional events in Aberdeen, Peebles, Edinburgh and Glasgow. With a focus on the Schools Act and physical activity and older people, the events have been popular with extremely positive feedback: 'presentations were excellent and relevant to work areas', 'an excellent chance to hear other health professionals' point of view', 'excellent,

informal, open with masses of expert input'.

PAHA plans to build upon the success of the regional events with its annual conference, open to all members and interested parties, on the 27 February 2008. The venue is Murrayfield Stadium in Edinburgh. Registration for this event will be open soon, for further details please visit:

www.paha.org.uk

For more information on any of the above the Health Scotland contacts are:

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Get in touch

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