

[www.keepwellscotland.com](http://www.keepwellscotland.com)

## Welcome

Welcome to the Spring 2008 Edition of Keep Well Informed. We have refreshed the newsletter so hope you all enjoy the updated look.

It has been a busy few months for the team with the first Anticipatory Care: Keep Well and Beyond conference taking place in March. If you attended the conference, I hope you found the event useful. If you weren't able to attend, the conference report (right) gives details about how you can still view the presentations.

Also in this edition are a selection of newsbites and the regular updates on progress in Wave 1 and Wave 2 areas. As usual, there are many innovations happening on the ground which make for an interesting read. In addition, on page 7, we feature a report on the national evaluation of Keep Well which provides an overview of plans and early findings. We also feature an overview of another anticipatory care project, Have a Heart Paisley. Last but not least, on page 12 we focus on a patient experience of Keep Well.

Enjoy!



**Helen Hassall**  
Senior Programme Officer  
Keep Well

# Conference leads the way



Minister for Public Health, Shona Robison MSP

The recent two-day Keep Well conference proved to be a highly successful event, as Helen Hassall reports.

**A** wide range of representatives from local government, NHS boards, voluntary and community organisations and the Scottish Government attended the action-packed Anticipatory Care: Keep Well and Beyond conference in early March at the Beardmore Hotel and Conference Centre.

The conference was opened by Dr Kevin Woods, Director-General Health and Chief Executive of NHS Scotland, who outlined the origins of anticipatory care.

One of the highlights of the first day was a live videoconference link to Copenhagen. Agis Tsouros, who leads the World Health Organization (WHO) Healthy Cities Programme, spoke about the importance of partnership working, healthy urban planning and using 'health impact assessment' to ensure this. There was also the chance to see the Keep Well Journey DVD which featured patient and professional testimonials.

The evening dinner provided a chance to network. There was also a unique opportunity to listen to Dr Julian Tudor Hart via a pre-recorded DVD interview discussing the need to be proactive in today's primary care.

Minister for Public Health, Shona Robison

MSP, opened the second day and announced a new wave of financial support to extend Keep Well Wave 1 for a further year.

There was also an opportunity to find out more about the local Keep Well experience in NHS Greater Glasgow & Clyde from Chief Executive Tom Divers and North Lanarkshire Council's Mary Castles. Chief Medical Officer, Dr Harry Burns, closed the conference. He stated he believed the climate for tackling health inequalities in Scotland has never been better and was keen to consider how the Keep Well approach can be developed into other areas.

The conference also featured 27 different parallel sessions ranging from Defining Anticipatory Care to Keep Well in a Pharmacy Setting. These provided an opportunity to discover the wide range of work underway both at a local and national level.

The event was streamed live on the web for those unable to attend. If you are interested in viewing the conference online, please register at <http://keepwell.electern.co.uk>

Further details of Shona Robison's announcement can be viewed at [www.scotland.gov.uk/News/Releases/2008/03/06094444](http://www.scotland.gov.uk/News/Releases/2008/03/06094444)

The Minister announced a new wave of financial support to extend Wave 1 for a further year

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SPRING 2008

# Newsbites

## Keep Well website

The new public-facing website for Keep Well, [www.keepwellscotland.com](http://www.keepwellscotland.com), has now been launched. The website provides information for patients and the public about the Keep Well health check. The website also contains patient testimonials, an overview of all the Keep Well areas as well as a Guide to Keeping Well section. The website will also act as a central information point for the public and support wider marketing and awareness raising.

If you have any comments on the website, please email: [keepwell@health.scot.nhs.uk](mailto:keepwell@health.scot.nhs.uk)

## Date for the diary - practitioner's network event

The next practitioner's network event will be held on Wednesday 14 May in Edinburgh from 10am until 4pm. If you are interested in attending, please email [keepwell@health.scot.nhs.uk](mailto:keepwell@health.scot.nhs.uk) to receive a booking form.

## Innovative training has designs on the UK's health

A new MSc in Health Improvement and Health Promotion has been launched by the Robert Gordon University in Aberdeen. The course has been developed in conjunction with stakeholders from across the health sector and is entirely flexible with material being delivered in class, part-time, online or a mixture of the two.

For further information, please contact

**Gil Strachan** on tel: **01224 263274**  
or email: [g.strachan@rgu.ac.uk](mailto:g.strachan@rgu.ac.uk)

## Meeting with Dr Julian Tudor Hart

As part of preparations for the recent Keep Well conference, the Keep Well team had a unique opportunity to meet Dr Julian Tudor Hart (second from left) and hear his thoughts on anticipatory care. Dr Julian Tudor Hart is a retired family doctor but continues to work as a research fellow at the new medical school in Swansea. He also lectures about health policy research in primary care as well as the social functions of healthcare. The visit to Wales was set up to enable filming of pre-recorded footage of Julian for the conference which he was unfortunately unable to attend in person. He spoke about what drove him to focus on communities of greatest need in rural Wales, the Inverse Care Law, the importance of being proactive in primary care, his thoughts on anticipatory care in the present day and, of course, the Keep Well programme. We are currently working to make the recorded footage more widely available.



## We ask What are your personal highlights from the Keep Well conference?

### Grace Christie, Public Health Practitioner Clackmannanshire CHP, NHS Forth Valley

'It was an excellent conference and provided me with useful learning and contacts to bring back to Clackmannanshire. The wide variety of interactive, parallel sessions were particularly good. I enjoyed watching Dr Julian Tudor Hart and it was useful to discuss his thoughts in that arena. I also enjoyed Mary Castle's presentation as her thinking is progressive. The conference certainly gave me time to reflect and to hear great ideas which are pertinent to what we are doing here.'

### Andy Carver, Prevention and Care Adviser, British Heart Foundation Scotland

'I enjoyed everything about the conference but in particular, the parallel sessions and the opportunity to debate ideas. I also enjoyed the networking. The Dr Julian Tudor Hart DVD was very powerful and I'm now keen to share his thoughts with my colleagues. It was also fascinating to hear the innovative ways health professionals are targeting the Keep Well audience.'

### Shona Hyman, Project Coordinator, Keep Well, Dundee

'The conference had many components which worked very well together. I thought Dr Julian Tudor Hart's DVD was very inspiring. He highlighted how difficult the challenges are that we face but it is a very worthwhile exercise. I also thought Chief Medical Officer Dr Harry Burns' presentation was excellent and it gave food for thought. I liked how there was a focus on the individual deprivation rather than area deprivation. The conference highlighted how crucial joint working is and of course I really appreciated the networking element.'



The conference was well attended



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

# Wave 1 Glasgow

The NHS boards involved in Wave 1 of Keep Well have been making good progress, as highlighted in the local reports.



#### Milestone

Employing outreach workers

#### Innovation

Long Term Medicines and Smoking Cessation services

#### Focus

Capturing useful feedback from patients

**The Glasgow Wave 1 team have recently employed outreach workers to visit the homes of patients who have not yet engaged with the Keep Well project.**

These new, dynamic staff members work across a number of practices and target the truly hard-to-engage patients. If a patient has been contacted three or more times without responding, a letter is sent out informing the patient an outreach worker will be dropping by. The patient can opt out of a visit by contacting their practice.

Early indications show that this post is proving highly successful in both promoting the Keep Well project to patients and convincing them to sign up with the services offered.

Another success to date has been the contribution of the Keep Well Pharmacy Long Term Medicines and the Keep Well Pharmacy Smoking Cessation services. Through these initiatives, community pharmacies in North and East Glasgow are supporting hard-to-engage patients from our Keep Well practices.



The pharmacist offers individual patient assessments examining their medicine adherence and smoking. The pharmacists also concentrate on educating patients about the health benefits of their medication.

In addition, they help to address other social and healthcare issues by referring patients to Keep Well services as required. Pharmacists and their support staff are well placed to offer this service as they are easily accessible in the community. The Long Term Medicines service also aims to minimise dropout from Keep Well health checks and other appointments within practices.

Finally and perhaps most importantly, we have been able to capture some useful feedback from patients who have participated in the Keep Well initiative. One patient believes the project has changed her life. Matilda Horner from Sandyhills attended her health check despite feeling there was not much to gain.

She told us how she suffered from chronic pain due to dislocated ribs and had been told she would always be in pain. She thought she had nothing to lose by going along to the Keep Well health check and she is glad she did. She added that before Keep Well, she wasn't a very active person but now she is, thanks to Keep Well.

Patient feedback is very important to us and one of the challenges we face is to turn the wealth of technical information gathered by practices and external services into shared learning regarding the future of Keep Well.

We hope that the data collected by practices and services will inform the future of anticipatory care.

email: [irene.macphail@ggc.scot.nhs.uk](mailto:irene.macphail@ggc.scot.nhs.uk)  
[kevin.hutchison@ggc.scot.nhs.uk](mailto:kevin.hutchison@ggc.scot.nhs.uk)



Jill Madden, Project Manager, Keep Well

# Wave 1 Lanarkshire

**Keep Well in NHS Lanarkshire has now produced its interim evaluation report. The report highlights the successful implementation of Keep Well.**

What we are now interested in is the ‘so what?’ question. We have had over 8,000 patients in for screening, so what difference has this made? Many of the questions will not be able to be answered in the short-term.

It may take several years before the full impact of what Keep Well has achieved is evident. Because of this, Lanarkshire has tagged all their Keep Well patients to allow for long-term follow up.

In the short-term, our evaluation has shown that broadly similar numbers of males and females have attended a screening. Evidence from other pilots has indicated that males may be less likely than females to engage in health programmes. Further data analysis will be needed at a later stage in order to determine if males in North Lanarkshire are sustaining contact.

Our initial model of engagement was by letter, either fixed or open. From this we had an average attendance of around 40 per cent. Data from our interim evaluation has shown that using this model of engagement gave a slight over-representation in our most affluent population. To address this, we have developed our model of engagement to include phone calls using North Lanarkshire’s call centre Keep Well freephone helpline along with home visits from our outreach workers.

This combined resource has allowed us to target our most deprived data zones and to use the personal approach of skilled communicators to engage with our target population.

Data extraction has been tested in six practices to determine the impact Keep Well has had on prescribing and on additions to the disease registers. The data extraction requires rigorous exploration. However, early analysis shows that in the 6 practices, 46 per cent of patients were found to have a cardiovascular risk of 20 per cent or more. A total of 617 prescriptions were required for cardiovascular-related illness. The highest number of prescriptions (237) was for lipid lowering drugs. 190 patients were put on disease registers. This early data is encouraging, but further data analysis will be carried out to ensure patients are taking the drugs prescribed.



**‘Our evaluation has shown that broadly similar numbers of males and females have attended a screening’**

**Milestone**  
Publication of interim evaluation report

**Innovation**  
Development of engagement model

**Focus**  
Fully established Keep Well workforce

We now have a fully established multi-disciplinary workforce working together to deliver high-quality, evidence-based anticipatory care. Our plans for the future are to build on and expand our links with our partner agencies in both the statutory and voluntary sector to ensure we have a comprehensive, sustainable model of anticipatory care. This will form part of Lanarkshire’s long-term condition’s strategy.

.....  
**email: [jill.madden@lanarkshire.scot.nhs.uk](mailto:jill.madden@lanarkshire.scot.nhs.uk)**



Katie Edwards, Project Manager, Keep Well

# Wave 1 Lothian

**We are delighted that due to the ongoing hard work and commitment of participating practices and project team, our 7,000th health check took place in January.**

Over the next few months, we aim to build on this and to ensure as many eligible patients who wish to access a Keep Well health check can do so. Since the last edition of Keep Well Informed, we have been working hard to develop a number of initiatives to support this objective.

From this month, we will be piloting a six-week block of out-of-hours health checks. These checks will be delivered in four NHS sites across Edinburgh - Edinburgh Royal Infirmary, Western General Hospital, Leith Community Treatment Centre and Sighthill Health Centre.



#### Milestone

Celebrating 7,000th health check

#### Innovation

Phone engagement in partnership with NHS24 and piloting of a six-week block of out-of-hours health checks

#### Focus

Developing closer partnership working with community pharmacies

Each participating practice will be able to make appointments for patients via an online booking system. Those individuals who previously indicated they could only participate in Keep Well outside normal practice working hours will also be contacted and offered one of these appointments. If the pilot is successful, we plan to run further blocks of appointments over the summer and winter.

We have also been working in partnership with NHS24 to develop a mechanism to increase our use of the telephone during the day, early evening and at weekends. It is hoped this will support participating practices to inform eligible patients about Keep Well, invite them to make a health check appointment and remind them about their booked appointment.

This support service will be available to practices from late April and it's anticipated those taking part will phase start up over a three-month period. The service should run throughout 2008 and will assist engagement with eligible patients as well as providing a clearer understanding of the numbers of eligible patients who cannot be contacted by phone or do not wish to participate in Keep Well and giving their reasons why.

Finally, we are seeking to develop closer partnership working with our community pharmacy colleagues who have kindly been advertising the project. We are now exploring, with a small number of community pharmacies, more active involvement in engaging eligible patients and increasing the accessibility of Keep Well health checks and services.

email: [katie.x.edwards@nhslothian.scot.nhs.uk](mailto:katie.x.edwards@nhslothian.scot.nhs.uk)

**'We will be piloting a six-week block of out-of-hours health checks'**



Shona Hyman, Project Coordinator, Keep Well

# Wave 1 Dundee



## Milestone

16 practices have assessed over 2,500 patients

## Innovation

Broadening forms of engagement

## Focus

Building on current good practice and enthusiasm

**A**s Keep Well in Dundee moves into its second year, a huge amount has been achieved and next year is already looking like a busy one.

Staff in 16 practices have assessed over 2,500 patients, offering them advice, with referral to agencies and medical treatment where necessary. Patient feedback from these assessments has been very positive.

The health coaching service being delivered by Dundee Healthy Living Initiative (HLI) continues to provide valuable support to individuals who appreciate the time and flexibility offered by the team. This one-to-one support is seen as invaluable by many clients.

Weight management remains the number one reason for referral to Dundee HLI. Practice staff carrying out a 'health coach' role are also providing counterweight support.

The Winning Weigh groups also remain popular. A review of the content and delivery of the Winning Weigh programme is almost completed and we hope the recommendations will improve the service even further.

Most practices in Dundee only began the Keep Well initiative after April 2007 and so have not yet contacted all patients.

**'Under Keep Well, we plan for a nurse to visit certain patients in their home and consider how further care is most appropriately delivered'**



Margaret Burns CBE, Chair of Health Scotland (right), recently paid a visit to Dundee. [picture courtesy of The Courier]

However, many practices are planning to broaden their initial written approach to include invitations to patients while in the practice for other reasons and by phone calls.

Practices which have already been carrying out these forms of engagement report good feedback.

Community pharmacies in Dundee are also enthusiastic about becoming involved in Keep Well. Plans are well underway in a small number of pharmacies located in key communities to start Keep Well health checks from April.

As reported in the last issue of Keep Well Informed, Dundee is also working with colleagues within mental health services and the homeless health outreach team to consider how to deliver Keep Well to these high-risk groups.

There will be specific, funded projects within both teams, building on current good practice and enthusiasm.

We also plan to build on work previously undertaken by two unmet needs pilot projects in Dundee.

The first project deals with patients who have chronic lung disease and who receive a home visit if they are unable to attend their practice.

Under Keep Well, we plan for a nurse to visit certain patients in their home and consider how further care is most appropriately delivered.

We are also developing stronger links with the Community Heart team who have been working in local communities to identify those with undiagnosed or undertreated heart disease.

There has been, and will continue to be, a lot of learning around Keep Well. This includes the wider agendas linked to anticipatory care including self-management of long-term conditions.

Challenges continue around health inequalities but we are continuing to develop ways of engaging with those patients not yet assessed.

For further information about the work of community pharmacies in Dundee, contact **Jackie Duncan, Public Health Pharmacist**, email: [jackie.duncan@nhs.net](mailto:jackie.duncan@nhs.net)

email: [shona.hyman@nhs.net](mailto:shona.hyman@nhs.net)

# Working it out

We report on Keep Well's national evaluation, currently being carried out by the Universities of Glasgow and Edinburgh.

## Highlights so far...

- developing a more detailed understanding about the different approaches to Keep Well
- providing advice to local areas about evaluation issues and hosting local and national meetings to share ideas
- presenting at the national Keep Well conference.

## Recap

Health Scotland commissioned an independent national evaluation into the Keep Well programme which got underway last year and will continue until March 2010.

## Overview

In the evaluation's first phase (2007-2009), the team is focusing on developing a more detailed understanding about the different approaches to Keep Well. Vital information will be captured about the challenges and benefits of providing health checks to deprived and hard-to-reach populations within the policy context for primary care.

The evaluation team's Dr Kate O'Donnell explains that a phased approach is important for a national evaluation, such as Keep Well, as they can be complex.

She adds: 'Evaluations need to be rooted in settings in which they are taking place. There is little opportunity for evaluators to control approaches taken locally as there will be variation across sites. In addition, stakeholders, including policymakers, patients and healthcare professionals, will have different ideas of what "success" is.'

Keep Well is continuing to evolve across pilot sites so it is still difficult to reliably identify measures of long-term efficacy or cost effectiveness. Kate adds, the team is looking at building knowledge about the

feasibility and challenges of delivering Keep Well: 'There will be an emphasis on the effectiveness of different approaches to engagement and to service re-design.'

The evaluation, Kate says, is using a mix of approaches including national and local interviews, observation, and documentary review. The evaluation team is also analysing a range of existing routine data collected nationally from primary care - such as Quality and Outcomes Framework (QoF) data and prescribing data - as well as the Keep Well core data sets.

'This will determine the extent to which the Keep Well Wave 1 areas and the programme as a whole are successfully identifying, screening and appropriately treating target groups,' she adds.

During the first phase, early patient and practice experiences of Keep Well will be captured. This research will explore how Keep Well has had an impact on practices involved including patients and staff receiving and delivering Keep Well. In addition, information will be gathered from community members who have not engaged with Keep Well, to find out their views on health improvement in general.

The work of the team is being complemented by local evaluation studies across Keep Well sites. Examples of local evaluation studies include an economic study in Glasgow and studies of specific approaches, including the use of outreach

workers and health coaching models.

The team is also providing advice to local areas about evaluation issues and is hosting local and national meetings in order to share ideas. The Information Services Division (ISD) and the programme board's information steering group lead the ongoing monitoring of Keep Well. This group has established a set of Keep Well reach indicators which are gathered by local Keep Well areas and reported on a three-monthly basis.

The team also presented at the national Keep Well conference in early March and interim reports of phase one of the evaluation will be available in Spring 2008.

## Direction

The next step for the team is to focus efforts on completing the final stages of data collection for phase one and agreeing how the evaluation should channel its efforts in the final year. The final stage of work will involve undertaking case studies of the most promising approaches identified through learning generated in phase one.

Contact **Dr Kate O'Donnell**, tel: 0141 330 8329; email: [kate.o'donnell@clinmed.gla.ac.uk](mailto:kate.o'donnell@clinmed.gla.ac.uk) or **Dr Mhairi Mackenzie**, tel: 0141 330 4352; email: [m.mackenzie@lbss.gla.ac.uk](mailto:m.mackenzie@lbss.gla.ac.uk)

**We look at how the Keep Well Wave 2 local areas are progressing since our last update.**

## Wave 2 Aberdeen

**D**uring December, we carried out data screening at five practices in Aberdeen with high numbers of eligible Keep Well patients.

The aim was to gain a better understanding of the health status of the Keep Well population. These findings have now been shared with the practices.

Since the completion of the data screening, we have met with the practices to discuss implementation of Keep Well and have had a very positive response. We anticipate that most, if not all, of the five practices will start offering Keep Well health checks from this month onwards.

Later this month, we also propose to offer data screening to a further five practices, and we will continue with this phased process of engagement throughout the year.

The Interventions Implementation sub-group is developing a range of interventions and services that will be available to

**'The Keep Well weight management group has benefited the wider Grampian weight management strategy'**

patients following their Keep Well health checks.

Ultimately, these will form part of a coordinated pathway for Keep Well interventions. The information from the data screening exercise has helped give us a better idea of the numbers of referrals we might expect from each of the participating practices.

We are excited that the work we initiated for the Keep Well weight management group has benefited the wider Grampian weight management strategy. We anticipate the methods used will be transferable to other areas.

We hope many practices will participate in Keep Well in the future, but we recognise this may be difficult in some cases. Therefore we are actively exploring the potential for delivering health checks in other settings, such as the pharmacy service.

**Jackie Fleming, Keep Well Information Analyst**  
email: [jackie.fleming@nhs.net](mailto:jackie.fleming@nhs.net)

**Linda Leighton-Beck, Programme Director**  
email: [linda.leighton-beck@ghb.grampian.scot.nhs.uk](mailto:linda.leighton-beck@ghb.grampian.scot.nhs.uk)



### Milestone

Data screening at five practices

### Innovation

Range of interventions and services

### Focus

How to deliver health checks in other settings

## Wave 2 Fife

**E**nthusiasm for Keep Well continues to grow within NHS Fife and we are looking forward to our first patients coming through the door.

There has been significant progress already this year, with practices in each of the Fife Community Health Partnerships (CHPs) being targeted to engage with the Keep Well project.

The model of delivery we have developed is unique. Fifty practices have a Keep Well population but we wanted to allow for the differences which exist between these practices across the Fife CHPs.

Practices have the option to engage with key stages of the Keep Well initiative depending on the circumstances of each of them. We defined the key stages as follows:

- **commitment to the project / patient identification**
- **reach (contacting patient)**
- **the Keep Well health check.**

We have encouraged commitment to all three stages in order to maximise sustainability beyond the two-year pilot period. However, the model recognises constraints on some practices. For example, there may be limited consulting room space in which to deliver health checks. In addition, clinical and

administrative staff may already be working at full capacity with no scope to implement Keep Well.

Practices opting to deliver only part of the project will be supported by Keep Well staff employed within each CHP to assist with the reach and/or health check stages.

Ten practices within Dunfermline & West Fife CHP have so far committed to the Keep Well programme with eight indicating they will complete all key stages. Work is underway to recruit staff to support other practices where required.

A phased approach to roll-out has always been planned. The remaining practices within Dunfermline & West Fife CHP and practices within Kirkcaldy & Levenmouth CHP and Glenrothes & North East Fife CHP will sign up to the project over the coming weeks.

**Lynsay Anderson, Project Manager, Keep Well**  
email: [lynsayanderson@fife-pct.scot.nhs.uk](mailto:lynsayanderson@fife-pct.scot.nhs.uk)



### Milestone

Practices in each of the Fife CHPs targeted

### Innovation

Model of delivery developed

### Focus

Recruiting staff to support practices where required

## Wave 2 Glasgow

**O**ur plans in Glasgow are progressing well across all three participating areas. For example, practices now have IT systems in place and all Keep Well staff are receiving information and training to support their role.

Areas have also delivered awareness sessions to external service providers and further training is planned.

All external service providers have been proactive in ensuring Keep Well patients can access services locally. Local structures have also been established to support the delivery of the programme.

In all three Keep Well areas in Glasgow, practices have already begun sending out invitations for health assessments.

The Keep Well programme in South West Glasgow Community Health Care Partnership (CHCP) will initially be available in five practices and discussions with additional practices are underway.

We plan to target the most deprived 45-64 year olds registered. Community Health outreach workers will be working alongside the practices to encourage eligible patients to attend the screening and to access the range of health improvement interventions on offer. For patients requiring additional support, a healthcare manager will also be available to provide ongoing,

one-to-one support.

Unlike other Keep Well areas, CHPs in Inverclyde and West Dunbartonshire will target patients who already have a diagnosis of Coronary Heart Disease (CHD).

All practices there have been given the opportunity to participate in a local, enhanced Keep Well service for CHD patients. This will include additional assessments and referrals to other services such as help with money matters.

Patients' engagement will also be monitored in both the initial Keep Well Health assessment and any other service which they are referred onto. Finally, the wider community can access all of the services within the Keep Well programme and practices will be encouraged to refer other patients to these services.

**Heather Jarvie, Principal Health Promotion Officer**  
email: [heather.jarvie@ggc.scot.nhs.uk](mailto:heather.jarvie@ggc.scot.nhs.uk)



### Milestone

Delivery of training and awareness sessions

### Innovation

Targeting patients with CHD

### Focus

Monitoring patients' engagement

## Wave 2 Ayrshire

**T**o make the most of Keep Well, we need to ensure we are engaging with the target group for health checks as well as other services communities need through the patient journey.

The recent Keep Well conference often referred to 'hard-to-reach' groups. We believe it's not so much these groups, more that we often adopt top-down approaches to engagement which do not meet community needs. We expect people who live in challenging life circumstances to have high levels of motivation to do what we, as health professionals, want them to do.

Evidence from Have a Heart Paisley and other public health programmes indicates a one-size-fits-all approach to communication will not yield the best results.

Letters and telephone calls work but do not engage everyone. Health professionals are learning to listen more.

Research and evaluation form the very cornerstone of the social marketing process which recognises our population needs to be broken down into sub-groups.

Many public health programmes show men and women respond to different communication methods and may have different constraints on their ability to attend programmes.

Even in geographically close communities, we must not assume a venue which may be acceptable for one community is acceptable or accessible to neighbouring communities.

A range of engagement methods need to be designed to reflect sensory impairment, learning disabilities, low levels of literacy

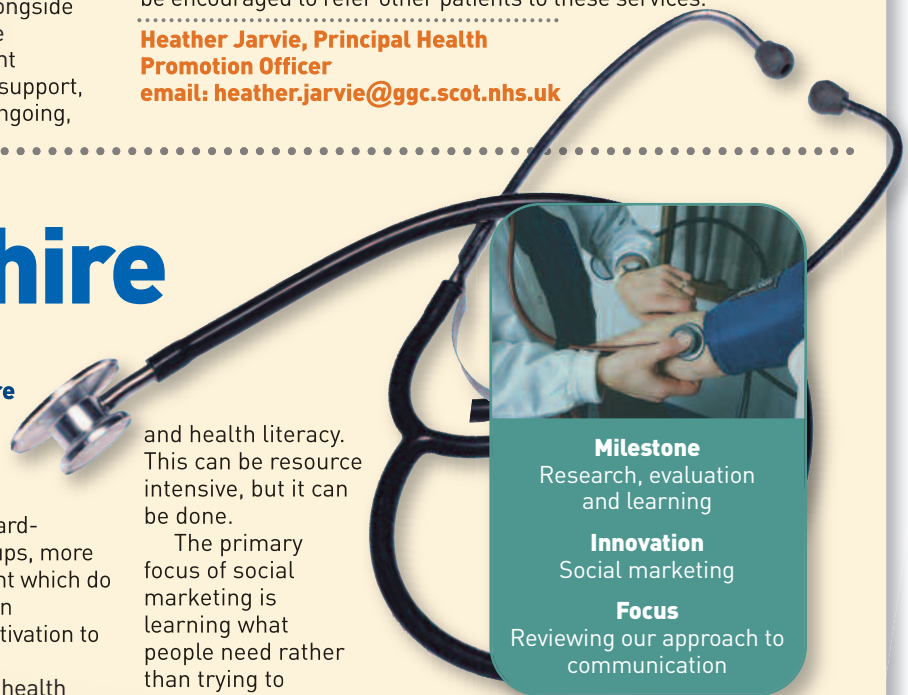
and health literacy. This can be resource intensive, but it can be done.

The primary focus of social marketing is learning what people need rather than trying to persuade them to buy what we are producing.

Ayrshire & Arran implemented a programme in North Ayrshire similar to Keep Well. Much learning has emerged about how to effectively engage with communities. We plan to build on this by considering what we offer, how we offer it and where we offer it. The focus is on creating and sustaining demand for the service.

Our approach is currently in the design stage, but we hope to work with the community over the next few months to gauge needs, and by Autumn, we plan to review our approach to communication.

**Grace Moore, Associate Director of Health Promotion**  
email: [grace.moore@aapct.scot.nhs.uk](mailto:grace.moore@aapct.scot.nhs.uk)



### Milestone

Research, evaluation and learning

### Innovation

Social marketing

### Focus

Reviewing our approach to communication

# Big steps forward



**H**ave a Heart Paisley (HaHP), the national demonstration project for coronary heart disease, ended in February. Throughout its lifespan, the project produced a wealth of learning. Now the project is complete, the lessons learned during its planning and delivery will continue to be disseminated to ensure they become embedded in policy, practice and service development and so contribute to the wider anticipatory care agenda.

One of four national demonstration projects established as a result of Towards a Healthier Scotland, HaHP was launched in 2000 for an initial period of three years.

Following a successful bid, the Scottish Government granted further funding for a second phase of the project and Paisley was seen as its natural home.

Not only does the town have one of the worst heart disease records in Scotland, the population and its geographical spread was ideal in that it could accurately reflect general nationwide trends.

Phase 1 of HaHP targeted the entire population of Paisley with a view to engaging them in a variety of health interventions aimed at improving the heart health of every resident. Phase 2 meanwhile adopted a narrower focus where local residents most at risk were targeted.

#### **The three main strands of Phase 2 were:**

**Primary Prevention:** An anticipatory care intervention for Paisley residents aged 45-60 years aimed at effectively reducing the targeted population's risk of cardiovascular disease.

**Secondary Prevention:** A programme which sought to improve the health of Paisley residents who already have identified coronary heart disease and who are currently maintained in primary care.

**Cardiac Rehabilitation:** A strand that saw the delivery of effective 'phase III' cardiac rehabilitation comprising structured exercise and other risk factor modification in a community setting. At the same time, an effective cardiac rehabilitation service was designed for the highest risk CHD patients who are referred back to the cardiac rehabilitation programme at the Royal Alexandra Hospital in Paisley.

#### **Overview of HaHP**

Health coaching played a major part in the delivery of both the primary and secondary prevention programmes. Primary prevention clients would meet with their health coach to create a personal regime with advice on topics such as healthy eating, giving up smoking and suitable levels of physical activity.

Those clients participating in the secondary prevention programme were supported to increase their levels of physical activity and reduce their risk of recurring health problems.

**Paisley's population and its geographical spread was ideal in that it could accurately reflect general nationwide trends**

## The national demonstration project for coronary heart disease, Have a Heart Paisley, came to an end earlier this year.



### The Have a Heart Paisley evaluation reports can be found at:

[www.chs.med.ed.ac.uk/ruhbc/evaluation/hahp/eag/](http://www.chs.med.ed.ac.uk/ruhbc/evaluation/hahp/eag/)

The site also contains policy reports and other research findings for widespread dissemination.

The cardiac rehabilitation service developed in Phase 1 of HaHP continued to be delivered. At the same time, an innovative study was launched to discover if the service could be delivered in the community as well as the hospital setting.

This work was complemented by the development of a series of health interventions including a marketing programme to promote awareness of the Have a Heart Paisley Phase 2. This work focused on encouraging uptake of the various initiatives as well as highlighting the skills required by the Keep Well workforce.

Whilst secondary prevention clients were engaged via GPs' surgeries, the primary prevention client's journey would begin with them responding to an intensive marketing campaign. These clients would then undergo a health check, delivered by a HaHP nurse, to establish their personal risk of developing CHD and to discuss what action they might take to prevent CHD.

Those clients identified as being suitable to participate were assigned a personal health coach. The health coach would help identify health behaviour changes the client needed to make and then support them through those changes.

Focus was placed on healthy eating, giving up smoking and taking up a suitable level of exercise. Additionally, through health coaching, clients could be signposted to existing services and those set up specifically by the project.

#### Generating learning

There are three areas of learning from HaHP: the external evaluation of the project (which was carried out by the Research Unit for Health Behaviour Change), the work produced by the

internal evaluator and the anecdotal learning from staff involved in the planning and delivery of HaHP.

The external evaluation of the project will be published in mid-2008 whilst the internal evaluator will continue to produce learning until later in the year. To ensure the knowledge is made available throughout the NHS, a range of outputs has been prepared. These include final reports that examine specific programmes of work, practical work packs on healthy eating and a series of summary documents that aim to make as much of the 'bite-sized' learning as accessible as possible. All HaHP outputs will be available from the Heart Health Learning Network:

[www.healthscotland.com/resources/networks/Heart-Health-Network.aspx](http://www.healthscotland.com/resources/networks/Heart-Health-Network.aspx)

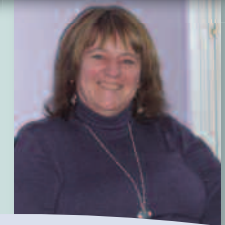
#### Pro-active dissemination

The findings from HaHP will continue to be disseminated throughout 2008 and beyond. Based within Health Scotland, a Dissemination Officer will be responsible for ensuring lessons learned within HaHP are made available to practitioners and policymakers throughout Scotland.

The purpose of the role will be to embed learning generated in emerging policy and practice. As programmes of work around anticipatory care develop, the focus of the Dissemination Officer's work will shift away from HaHP towards other elements of anticipatory care such as Keep Well and Well North.

If you would like further information, please contact:

**Marjorie Gaughan, Have a Heart Paisley** on  
email: [mgaughan@nhs.net](mailto:mgaughan@nhs.net) or **Lynda Brown, Health Scotland**  
on email: [lynda.brown@health.scot.nhs.uk](mailto:lynda.brown@health.scot.nhs.uk)



# Eileen from Airdrie talks about her Keep Well experience

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

I wasn't sure if I wanted to bother with it. I had a check in the workplace a couple of years ago though, which showed my cholesterol was quite high. There's also heart disease on my father's side. My father had this thought in his head when he got to 55 that 'I'm not going to be here' and I thought I don't want to be like that. I thought if these tests were going to show there was something that could be sorted, what harm can it do?

## What happened when you made your appointment?

The letter asked you to phone to make an appointment. When I phoned and explained I worked, they were very amenable. They had appointments that were later on in the day. I went about half past five, which was ideal.

**'She also told me my risk of having heart disease had lowered from 15 per cent to 9 per cent, and said that was really significant in such a small period'**

## When you went along was it what you were expecting?

I expected it would be very quick. But I didn't feel there was a restriction as to how long you could have chatted, and I think that is quite good if you have questions. I was asked a set of questions and some of these triggered questions in my mind. But I spoke to her about family issues and personal anxieties and she made me feel quite comfortable.

## How did you feel when you walked out?

When I came out I actually felt quite pleased with myself. The nurse put my mind at ease and she also said to keep doing what I was doing in terms of weight loss and the gym. The one thing I was amazed by was that she gave me this list of foods and how often I should eat them. Before fruit was a big 'no no' for me, but she explained that fruits and vegetables could be tinned or frozen, not just fresh. So I manage to have the five portions most days now, even if they're out of a tin. I came out with a knowledge I didn't have.

## Did the nurse make any recommendations?

She said to continue with the gym and dieting. My blood pressure was fine but my cholesterol was high. I went for a fasting blood test and the first time I went it was 6.4, which had come down 1 point from the initial test only 3 weeks before. But I felt the changes to my diet weren't going to be huge to do.

## What has the longer term impact of Keep Well been?

I feel it has given me that little bit of oomph to say that I'm definitely going to keep going. When I got the results from the second fasting blood test, my cholesterol had gone down to 5. The good and the bad cholesterols had gone the right way, and she told there was nothing there that was showing heart disease was heredity. She also told me my risk of having heart disease had lowered from 15 per cent to 9 per cent, and said that was really significant in such a small period. Having achieved that, there's no way that I would go back. I think if I did have health concerns in the future I certainly would go the practice now. It's something I probably would have done in the past, but I suddenly realise there is a network of nurses in the practices as well that I would certainly go and see.

## What is Keep Well?

Keep Well is a programme which aims to increase the rate of health improvement in 45-64 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.

## Competition...

Tell us what you think of this new-look Keep Well Informed newsletter and

## Win a goodie bag

Just email your comments to Helen Hassall, Senior Programme Officer at Keep Well, email: [helen.hassall@health.scot.nhs.uk](mailto:helen.hassall@health.scot.nhs.uk)

**The most original comments win!**



## 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 537 4754**  
**email: [helen.hassall@health.scot.nhs.uk](mailto:helen.hassall@health.scot.nhs.uk)**

