Well North anticipatory care project: Evaluation

Final report
March 2011

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Acknowledgements

We thank all the members of the Well North Evaluation Sub-Group for their input to this report. They helped hugely both in helping our understanding of the hopes and expectations of Well North and in making constructive comments on drafts of the report.

We also thank all of those we met in the seven local programmes throughout our work. We were greatly impressed by their enthusiasm, commitment, knowledge and willingness to share their learning. Several of those we interviewed took the time to comment on the draft report. And a group of people from the local programmes took part in a reflective workshop to consider the draft report. All this input was extremely welcome.

This is an evaluation of the regional programme rather than individual programmes. But to understand the regional programme, we needed to learn about each programme. We hope that we have done justice to the work of all those involved.

Executive Summary

Introduction

Well North is a pilot anticipatory care programme to improve the health of people experiencing health inequalities in remote and rural areas in the north of Scotland. The Well North programme was planned, and is supported, by the North of Scotland Public Health Network (NoSPHN)[1].

Well North is made up of seven local programmes. Two are Healthy Weight programmes (Aberdeenshire and Moray and Skye and Lochalsh). The other five programmes are in Dufftown and Rothes; North West Sutherland; Orkney; Shetland (Unst; Fair Isle and Lerwick); and Western Isles.

Well North is the north of Scotland's contribution to the national Keep Well programme, which was initially developed in 2006 as part of plans to tackle health inequalities in Scotland.

In September 2010, NoSPHN appointed us (ODS Consulting) to carry out an evaluation of Well North. This focused on the identification of target populations; interventions; engagement; changes for patients and the NHS; and lessons learned.

Our methodology included:

- a literature and context review
- sixty five interviews with stakeholders in the local programme areas
- data gathering – including plans, reports, promotional materials and a 'Performance Story' prepared by the local programmes
- a workshop to allow NoSPHN and the local programmes to reflect on the draft report.

Target areas and populations

We looked at three aspects of targeting:

- the influence of inequalities on the targeting of local programmes – targeting inequalities
- how the geographical areas for the local programmes were selected – the target areas
- the criteria guiding the people who were to be encouraged to participate in the local programmes – the target population.

In relation to **targeting inequalities**, indicators used by similar programmes in urban areas (for example the Scottish Index of Multiple Deprivation) are of limited value in remote and rural areas because of the dispersed nature of households experiencing poverty. When we looked at four relevant indicators in the Quality and Outcomes Framework (QOF) we found that in the practices that were involved, 83% of their indicators showed a higher risk than the Scottish average.

[1] The North of Scotland Public Health Network is a collaboration between NHS Grampian, NHS Highland, NHS Orkney, NHS Shetland and NHS Western Isles. The network aims to link groups of public health and health improvement professionals, to work in a coordinated manner where this adds value, to contribute to improving health and reducing inequalities.

There was no one approach to the selection of **target areas.** Decisions were made using local intelligence. The advantages of decision making based on sound local knowledge were stressed at the reflective workshop. The advantages included:

- the ability to build on previous work carried out in the area
- knowledge of patients and the local community (particularly in more remote rural areas)
- the opportunity to build on existing local relationships between health professionals.

Reasons for local programmes selecting particular areas were varied:

- health inequalities – using evidence from the QOF and other sources
- rurality – targeting remote and rural areas
- relationships with local practices – and interest from GPs in participation
- priorities of senior NHS staff – with existing knowledge and experience influencing geographical targeting.

Within the target areas, programmes used a mixture of locally determined methods to decide on the **target population**. The main criteria related to age; existing conditions; risks; family history; and lack of recent contact with the local GP.

Generally, it was felt that Well North programmes had targeted people at risk of health inequalities and had improved access to health services and anticipatory care.

Overall, the Well North programme (excluding Aberdeenshire and Moray, for which figures were not available) targeted over 15,700 individuals across the five Health Board areas. Over half of these were in the Western Isles.

Interventions and approaches

Three main interventions have been used in the Well North programme:

- health checks and appropriate lifestyle advice and referrals (Dufftown and Rothes; North West Sutherland; Orkney; Shetland and Western Isles)
- healthy weight programmes (in Aberdeenshire and Moray and Skye and Lochalsh)
- multi-agency casework to reduce hospitalisation (North West Sutherland).

In addition substantial training programmes have underpinned the development of some programmes, particularly in North West Sutherland. Community engagement was an important part of the approach in Skye and Lochalsh and Dufftown and Rothes.

The **health checks** were generally based on the national Keep Well model where a health check is carried out to identify the risk of heart disease and other serious health problems. They involve an assessment of risk factors and the provision of lifestyle advice. Generally, the health checks took at least 40 minutes, and in some local programmes up to an hour was allowed.

The engagement level (in other words those attending a health check as a proportion of those within the target population who had been contacted) for Phase 1 of Keep

Well between 2006 and December 2009 was 58.5%.[2] For Well North we have calculated engagement slightly differently - using the total number attending for a health check as a proportion of the target population (including those who have not yet been contacted). Nonetheless, the engagement figure at January 2011 for Well North was 57% - and by the end of March 2011, it is expected that this will have risen to 61%. All the Well North programmes expect further substantial engagement of additional people from the target population in the coming year.

It is difficult to identify the impact that the **Healthy Weight** programmes in Aberdeenshire and Moray and Skye and Lochalsh have had. In the case of Aberdeenshire and Moray, this is because the programme is not gathering information about its inputs and outputs. In the case of Skye and Lochalsh this is because the programme faced difficulties and delays in making staff appointments. Work is now underway to link community organisations with public and voluntary agencies in tackling weight issues in the area. Any outcomes will therefore take some time to achieve.

North West Sutherland had a focus on **long term conditions** (with a particular emphasis on preventing hospital admissions). We heard very positive stories from nurses that demonstrated that this had encouraged them to take a more anticipatory approach to all that they did. But it has proved difficult to get all practices to introduce formal multi-agency approaches to reducing hospital re-admission. Some practices have made substantial progress: others found the paperwork off-putting.

Community consultation and engagement has been an important part of the approach in Dufftown. Early involvement of a well respected local social enterprise to work with the community was seen as an important step. Both staff and community organisations believe that the approach has had an impact on health awareness and participation in the area.

Giving priority to **training** brought great benefits in North West Sutherland – increasing skills and confidence; and building opportunities to share skills through peer support across practices. Ensuring that there is time for training (and the associated travel, which can be significant) built into programmes has been valuable.

Engaging the target populations

A range of different approaches to contacting patients were used. Initially, a combination of letters and phone contact worked well, with the phone contact being seen as an important element of this. At the same time, it was important to make it easy for people to attend the health checks – whether by extending the times when health checks were provided (to weekends or evenings) or bringing the health checks to people (for example through the use of community venues or the delivery of workplace health checks). No one mix of methods has been identified as being right – some of the approaches have worked well in some programmes and less well

[2] National Evaluation of Keep Well Policy & Practice Paper No. 4: Keep Well Reach and Engagement NHS Health Scotland, 2010

in other programmes. Consulting the community and learning (and adapting) on the basis of local experience were seen to be effective.

Programmes highlighted that additional techniques were also likely to be required to reach the maximum number of people. The main additional routes that were being considered were:

- greater use of community or workplace venues
- greater joint work with other public agencies or voluntary sector organisations
- the use of social marketing techniques.

A number of programmes had explored the reasons for people not attending health checks. They found that generally the barriers to participation were:

- people forgetting to respond to the invitation or attend their appointment
- people who are well (or think they are) and do not feel a health check is a good use of their time (or staff time)
- people not wanting to be 'told off' about their lifestyle
- people being worried about learning that they are ill
- people who gave their health a low priority.

Changes for patients

The focus of the Well North pilot was to identify target populations and to maximise their engagement in anticipatory care programmes. At this relatively early stage, there have been changes for patients as a result of this approach. We know:

- that more than 6,200 people had attended a Well North health check by January 2011 (82% of these were in the Western Isles)
- that a health risk, requiring referral, was identified for 35% of those attending a health check (over 2,200 patients)
- that many of those being referred have followed this up
- nurses have reported an increasing awareness of health checks and their benefits; greater awareness of personal health; and some changes in diet and lifestyle.

We compared the Western Isles programme to the initial Keep Well programme. A substantially greater proportion of those receiving health checks in Western Isles had a CVD risk of ≥ 20%. The Western Isles figures may be up to 5% higher as a result of the different methods used to calculate the risk. Nonetheless, their figure of 32.4% is substantially higher than those found in Glasgow, Lanarkshire and Dundee, where about 21% of those attending a health check had a CVD risk of ≥ 20%.

Changes for the NHS

Nurses have been the key resource in delivering Well North. They spoke positively about:

- the benefits of the programme for patients in terms of the provision of lifestyle advice and referrals
- anecdotal evidence of emerging changes in patient behaviours
- how appropriate an anticipatory care approach was for their work
- the training and development of skills that the programmes had encouraged.

The involvement of GPs in the initiative has been seen as extremely valuable, where this happened. GPs appeared generally to be more likely to be supportive in smaller, more remote practices. However, stakeholders acknowledged that many GPs were not particularly engaged in the programme. Given the crucial local role that GPs play in delivering health care, it is important to explore ways to increase their commitment to anticipatory care over time. This will require ongoing awareness raising as well as a sound evidence base about the benefits of anticipatory care.

There are some lessons for Health Boards about the effective planning of new programmes. A number of programmes found that the set up time was longer than they had originally planned because of a range of issues including identifying appropriate staff; resolving local governance arrangements; reaching agreements with practices; and clarifying roles and responsibilities. For two of the programmes (Orkney and Skye and Lochalsh) the delays were particularly significant and had a serious impact on the early delivery of outcomes. Any future programmes should make sure that sufficient time is allowed to make sure that staff and resources are in place in advance of planned start dates for delivery.

Collaborative work and learning

The seven Well North programmes have been coordinated by the North of Scotland Public Health Network. Programmes have been able to learn from one another, and share practice. Innovative approaches adopted in some areas, have already been taken up in others. Programmes have trained one another, shared skills and provided peer support. Joint training has been organised – for example support on evaluation has been provided by NHS Health Scotland. This has been a real strength in the Well North approach. Not all programmes took advantage of the opportunities that were available – and there was a tendency for the programmes that had greatest problems in establishing the delivery of their programmes to have less involvement in joint learning.

Given the learning to date from Well North there are some basic support tools (such as standard protocols; model Local Enhanced Service agreements; data gathering and reporting formats; and some elements of IT) which might usefully be developed and shared across the programmes.

Joint work across practices was less common – but was highly effective in North West Sutherland where it was built on from the training programme for nurses. Joint working with other agencies was increasing and was seen as an important part of extending engagement in the future.

Lessons for the future

Given the variety of local approaches; the different scales and timescales of each of the programmes; and the absence of comparable data for all the programmes, it is not possible to set out simply what worked and what did not work. This section therefore highlights the lessons from the seven programmes, and sets out a number of factors that should be considered in the development of future approaches to anticipatory care in rural and remote areas.

1. **Local autonomy is important.** The advantages of local decision making include the ability to build on previous work done in the area; knowledge of patients and the local community; and the opportunity to build on existing relationships between health professionals.

2. **Carefully consider all the options at the start.** When local programmes are asked to submit proposals for the allocation of resources, the proposal document could usefully begin with a short options section to ensure that a range of approaches had been considered.

3. **Focus on health inequalities in rural and remote areas.** Using indicators (such as the QOF indicators) allied to local intelligence can help identify areas which are likely to benefit from anticipatory care.

4. **Maximise the engagement of GPs.** Given the crucial local role that GPs play in delivering health care, it is important to explore ways to increase their commitment to anticipatory care over time. This will require ongoing awareness raising as well as a sound evidence base about the benefits of anticipatory care.

5. **Allow time for planning and getting staff and resources in place.** It is important to allow sufficient time to make sure that staff and resources are in place in advance of planned start dates for delivery. Building in time for training (and the associated travel, which can be significant) built into programmes is also valuable.

6. **Consider whether there are common resources that could be used across regional programmes**. There may be basic support tools (such as standard protocols; model Local Enhanced Service agreements; data gathering and reporting formats; and some elements of IT) which might usefully be developed and shared across the programmes.

In relation to health checks:

7. **Consider whether health checks are delivered by a dedicated team or by existing staff.** A dedicated team of staff undertaking health checks can develop specialist skills and save on management and co-ordination time. Building anticipatory care into the work of existing nurses was seen to be motivational and provides a more rounded work experience. Both approaches are relevant.

8. **Develop a range of approaches for engaging patients in health checks.** High levels of engagement have been achieved by using contact with patients by letter; follow up phone calls; some element of awareness raising through, for example, the local press and newsletters; the provision of health checks out of office hours; and the delivery of health checks in community venues.

9. **Additional methods of engagement are likely to be needed.** To maximise engagement levels will need not only a continuation of the present approaches but also a widening of engagement methods. These might include greater use of non – surgery settings for checks; increased use of social marketing; and joint work with other public agencies and voluntary organisations.

10. **Allow sufficient time for the health checks.** The Well North health checks took at least 40 minutes and, in some cases, an hour was allowed. This length of time was important to carry out the tests and provide lifestyle advice.

11. **Programmes involved in health checks should all gather standard core data.** Although minimum data for each of the local programmes was agreed, this was not always collected and collated. In any future programmes there should be a commitment to gathering standard core data. The requirements should be proportionate to the size of programmes.

12. **It would be useful to gather information on changes in health and lifestyle**. The Well North programme was intended to identify target populations and increase engagement. As a result, there is limited evidence of the changes that occur for patients following the health check. This information could be gathered through follow up health checks (as in Dufftown and Rothes) or by analysing a sample of GP records.

In relation to long term conditions:

13. **Anticipatory care programmes should consider the value of including long term conditions in local programme development.** One programme included this – and it has had a positive impact on the way that nurses and others go about their work and improved joint work with other public agencies and voluntary organisations.

In relation to community engagement:

14. **Consider partnering with existing voluntary organisations or social enterprises.** Working with an established local voluntary organisation may have benefits over employing a dedicated member of staff to work with the community. Identifying a dedicated staff member can take time and it may be hard, particularly in remote areas, to identify people with the right skill set and local knowledge.

1. Introduction and methodology

1.1 Introduction

Well North is a pilot anticipatory care programme to improve the health of people experiencing health inequalities in remote and rural areas in the north of Scotland. The Well North programme was planned, and is supported, by the North of Scotland Public Health Network (NoSPHN)[3].

Well North is made up of seven local programmes involving five Health Boards:

- NHS Grampian (2 programmes – Dufftown and Rothes; and Aberdeenshire and Moray Healthy Weight)
- NHS Highland (2 programmes - North West Sutherland; and Skye and Lochalsh Healthy Weight)
- NHS Orkney (Orkney)
- NHS Shetland (Phase 1 – Unst and Fair Isle; Phase 2 – Lerwick)
- NHS Western Isles (Western Isles).

A profile of each of the local programmes is contained in Appendices 1 – 7.

The project particularly focuses on early intervention with adults at higher risk of coronary heart disease and diabetes. It aims to increase the rate of health improvement in remote and rural communities by enhancing primary care or community services to deliver anticipatory care. Well North is the north of Scotland's contribution to the national Keep Well programme, which was initially developed in 2006 as part of plans to tackle health inequalities in Scotland.

Initial funding from the Scottish Government was provided to Well North for two financial years (April 2008- March 2010), and additional funding was allocated to allow the project to continue until March 2011.

In September 2010, NoSPHN appointed us to carry out an evaluation of Well North. This was to focus on:

- identification of target populations
- the interventions and approaches used
- the engagement of the target populations in the project
- changes for service users, staff and organisations
- lessons learned by individual programmes and through collaborative working
- lessons learned about anticipatory care in rural and remote areas.

1.2 Methodology

The methodology involved five main stages which provided contextual, qualitative and quantitative information for this report.

[3] The North of Scotland Public Health Network is a collaboration between NHS Grampian, NHS Highland, NHS Orkney, NHS Shetland and NHS Western Isles. The network aims to link groups of public health and health improvement professionals, to work in a coordinated manner where this adds value, to contribute to improving health and reducing inequalities.

1.2.1 Literature and context review

We carried out a literature review to provide a context for the work of Well North. This focused mainly on Scottish literature and considered:

- approaches to anticipatory care
- the experience of delivering services in rural and remote areas
- health inequalities
- identifying and engaging hard to reach individuals.

The Literature and Context Review has been submitted to NoSPHN as a separate supporting document. This can be found at:
http://www.nosphn.scot.nhs.uk/?page_id=154

1.2.2 Interviews

We liaised with the leads for each of the seven programmes to identify the people that we should interview in their area as part of our evaluation. The numbers to be interviewed varied depending on the scale and history of each of the programmes. The visits took place over a two or three day period. This helped us to familiarise ourselves with the 'geography' of the area.

The visits took place on the following dates:

- 25-27 October – Shetland (6 interviews – 1 GP; 2 nurses; 3 project staff and managers)
- 1-3 November – Western Isles (15 interviews – 2 GPs; 5 nurses; 7 project staff and managers; and Sports Facility Manager)
- 2-4 November – Dufftown and Rothes (13 interviews – 2 GPs; 2 practice managers; 2 nurses; 2 project staff and managers; 1 researcher; and 4 community organisations)
- 8-9 November – Aberdeenshire and Moray Healthy Weight (5 interviews - 4 project staff and managers and 1 dietician)
- 9-10 November – Orkney (4 interviews – 1 GP; 1 nurse; and 2 project staff and managers)
- 15–17 November – North West Sutherland (8 interviews – 1 GP; 2 nurses; 1 practice manager; 3 project staff and managers; and 1 community organisation)
- 17-19 November – Skye and Lochalsh Healthy Weight (14 interviews – 3 GPs; 2 health partners; 4 project staff and managers; and 5 community organisations).

We prepared a discussion guide for the interviews which was agreed with the Well North Evaluation Steering Group. It was sent to interviewees in advance of the interview.

A total of 65 interviews took place. Most of the interviews were face to face, one-to-one depth interviews. Seven of the individual interviews were carried out by telephone. This occurred where a key individual was not available during our visits or (in two cases) where it was agreed that the amount of travel required was not justified for a single interview.

Two of the interviews with nurses were conducted as group discussions (one for six people and one for two), following the same discussion guide.

1.2.3 Data gathering

We gathered data and other information, including reports, promotional materials and plans from the programmes, including:

- the size and characteristics of the target population
- the numbers involved in the Well North interventions
- the numbers of referrals
- finance and budgets.

The quality of the monitoring data produced by the programmes varied considerably. Western Isles had a sophisticated database which allowed easy analysis of the data. The other programmes had basic systems for gathering and managing data. It had been agreed that standard core information would be gathered by all programmes, but not all programmes gathered this. The information from the Aberdeenshire and Moray Healthy Weight programme is incomplete. The other programmes have been helpful in providing the information that we requested and we are confident in the figures we have used for target populations; engagement and health risks identified. We do not have information on the characteristics of those attending health checks (other than from the Western Isles).

Each of the programmes received training and support from NHS Health Scotland to prepare a Performance Story. These tell, in a concise way, the story of each programme from the perspectives of a number of people who have been involved in the programme. For six of the programmes we received a copy of their Performance Story. No Performance Story was available for Aberdeenshire and Moray as a result of a period of staff illness and other priorities for local staff.

We have incorporated material from the Performance Stories in appropriate sections of this evaluation report.

1.2.4 Analysis

We sorted all of the quantitative and qualitative information we gathered, based on the evaluation questions specified by the Evaluation Steering Group. We recorded the information which would help us to answer each question, using a matrix on an Excel spreadsheet. We reviewed the qualitative information using manual thematic coding. This involved reading the responses, and identifying key themes, trends or divergences in opinion and experience. We did this both by local programme area and for each evaluation question across all seven programme areas.

1.2.5 Reflective workshop

Our draft report was sent to all those who were interviewed as part of the evaluation. We have amended this final report to take account of the comments received (most of which were positive). We also held a reflective workshop on 9 February 2011 in Nairn (with video conferencing from three of the programme areas) to allow the local programmes to consider the report together. This discussion was productive and informed the final evaluation report.

2. Well North

Well North is a response to a complex web of issues which lead to health inequalities. In this section we outline a number of current policy strands which have influenced the development of Well North.

2.1 Equally Well

The '*Equally Well: Report of the Ministerial Task Force on Health Inequalities'* was produced by the Scottish Government and COSLA in June 2008. Although there have been considerable general improvements in health in Scotland, there are still significant differences in health and wellbeing between rich and poor.

The Equally Well Report sets out a wide range of actions to reduce health inequalities in Scotland.

2.2 Keep Well

The then Scottish Executive launched Keep Well in 2006 (initially under the title Prevention 2010). The national Keep Well model aims to increase the rate of health improvement in 45-64 year olds in areas of greatest need. It focuses on cardiovascular disease and the main associated risk factors, in particular blood pressure, cholesterol, smoking and diabetes. It encourages those in the target population to undertake a health check. Treatments and referral to community and other NHS and voluntary services are offered, with regular monitoring and proactive follow-up. The Keep Well pilot programme was rolled out across Scotland's Health Boards between 2006 and 2009.

2.3 Delivering services in rural and remote areas

Many programmes that seek to tackle inequalities focus on the areas that contain the greatest deprivation (usually as measured by the Scottish Index of Multiple Deprivation). Keep Well has generally taken this approach. The model aims to increase the rate of health improvement in 45-64 year olds **in areas of greatest need.** This approach is based on the fact that in many urban areas deprivation is geographically concentrated.

But in rural areas, deprivation does not normally show the same geographic concentrations, and inequalities are dispersed much more evenly. For example, research carried out in Shetland[4] showed that individuals and households experiencing deprivation are fairly evenly distributed throughout Shetland.

In addition, the low population densities mean that it is more expensive to deliver local services – and that service users are likely to have to travel further for services than in urban areas.

In 2007, the Scottish Government Remote and Rural Steering Group produced their report: *Delivering for remote and rural health care*. Amongst its suggested commitments for rural health were:

[4] Perring, *Deprivation and social exclusion in Shetland*, Shetland Islands Council, Spring 2006

- health care provision in remote and rural communities should support self-care
- health and social care within remote and rural areas should be organised as integrated teams with priority given to anticipatory care and the prevention of disease escalation
- action plans are developed for implementing long-term condition management
- the focus of mental health services in remote and rural communities must be upon early detection and prevention of disease escalation.

2.4 Well North

Well North relates to each of these policy areas. It is a pilot anticipatory care project to improve the health of people experiencing health inequalities in remote and rural areas in the north of Scotland.

The Health Boards in Grampian, Highland, Orkney, Shetland and Western Isles are working together through the North of Scotland Public Health Network (NoSPHN) to deliver Well North. In 2007, a proposal encompassing a range of rural anticipatory care approaches was discussed among NoSPHN, the Scottish Government and NHS Health Scotland. In October 2007, a final proposal was submitted to, and approved by, the Scottish Government. Initial funding from the Scottish Government was provided to Well North for two financial years (April 2008 to March 2010), and additional funding was allocated to allow the project to continue until March 2011.

There are seven separate anticipatory care programmes including two healthy weight programmes within the overall Well North programme:

- Dufftown and Rothes (Phase 1 – Dufftown Practice; Phase 2 – Rothes Practice)
- North West Sutherland (involving 5 practices)
- Orkney (involving 3 mainland practices and community nurses on the isles)
- Shetland (Phase 1 – Unst and Fair Isle; Phase 2 – Lerwick Health Centre)
- Western Isles (involving all 12 practices in the Western Isles).
- Aberdeenshire and Moray Healthy Weight (involving 4 general practices in Aberdeenshire and 2 in Moray)
- Skye and Lochalsh Healthy Weight (involving 4 practices).

The Well North approach is to:

- test approaches to address the relationship between rural social deprivation and health inequalities
- identify and target those at particular risk of preventable serious ill-health (including those with undetected chronic disease)
- offer appropriate interventions and services to them.

3. Target areas and populations

In this section we consider three aspects of targeting:

- the influence of inequalities on the targeting of local programmes – targeting inequalities
- how the geographical areas for the local programmes were selected – the target areas
- the criteria guiding the people who were to be encouraged to participate in the local programmes – the target population.

3.1 Targeting inequalities

The North of Scotland Public Health Network (NoSPHN) agreed a number of aims for the Well North pilot. The main aim was to increase the reach of anticipatory care for people experiencing health inequalities in remote and rural areas. NoSPHN agreed that an important aspect of Well North would be to explore how best to identify and engage hard to reach[5] individuals and households in remote and rural areas.

3.1.1 Health inequalities

All of the programmes aimed to reduce health inequalities.

The Quality and Outcomes Framework (QOF) gives an indication of the health conditions in different practices across Scotland. We selected four QOF indicators which relate to the health inequalities that Well North is seeking to influence – heart disease (CHD); hypertension; obesity; and smoking. This information provides a useful picture of health inequalities, but does need to be treated with caution, because the data is not standardised for age and other factors.

Nonetheless, using these indicators, of the 25 practices involved in health checks:

- in 18 of the practices (72%) the indicator for CHD was higher than the Scottish average
- in 23 of the practices (92%) the indicator for hypertension was higher than the Scottish average
- in 20 of the practices (80%) the indicator for obesity was higher than the Scottish average
- in 22 of the practices (88%) the indicator for smoking was higher than the Scottish average.

In addition, in the Dufftown and Rothes practices, seven out of eight indicators were higher than the Grampian averages and in the North West Sutherland practices, 16 out of 20 indicators were higher than the Highland averages. In the other programmes about half the indicators were higher than the Health Board averages.

The comparison to national (and local) indicators suggests that there is considerable potential for reducing health inequalities in the practices involved.

[5] The term 'hard to reach' is used in the Vision for Well North and by those involved. In doing so they do not imply a failure on the part of the individual – rather the need for services to improve their engagement with and relevance to those who have not participated in the past.

More information on the QOF indicators (including a table showing the 2010 health indicators for the practices involved in Well North and making clear the reasons why the information should be treated with some caution) is contained in Appendix 8.

3.1.2 Other inequalities

Three of the programmes originally considered how to target individuals and households experiencing other inequalities:

- The Western Isles considered targeting specific areas based on inequality, but felt that there were no appropriate data sources to enable this. The Scottish Index of Multiple Deprivation did not provide information to enable geographic targeting. Stakeholders in the Western Isles also felt that there was evidence of poor health across the general population. The Western Isles have, however, taken the opportunity to gather socio economic data from those that have been engaged in the programme. This will inform future targeted approaches in the Western Isles (and possibly other remote and rural areas).
- In Dufftown the programme initially intended to target individuals who were in poor housing conditions or in receipt of benefits. However, it was not possible to match this information with patient records, and these criteria had to be dropped.
- The Scottish Index of Multiple Deprivation (SIMD) 2009 was used to identify the most deprived data zones in Shetland. Three areas were identified (in Lerwick) and the second phase of the programme targets these areas. Lerwick is a larger town, which allowed concentrations of deprivation to be more easily identified using the SIMD.

Conversely, some practices in remote and rural communities – for example, Rothes and Skye – raised concerns about the concept of targeting individuals based on inequality. There was some concern that individuals would feel stigmatised if offered a service because they are classed as 'deprived'.

3.2 Identifying the target areas

The Well North approach has been to ensure that local decisions are made by each of the seven programmes regarding the target areas, based on local intelligence. The target areas were set out in the applications put forward by each programme in December 2007. In some cases, the areas have been amended after the local programmes were approved – either because of changes in local circumstances or because of learning during the life of the programme.

Table 3.1 sets out the target areas for each programme. It demonstrates the variety of reasons for selecting target areas and the changes that have been made since the start of the programmes.

Table 3.1: Target areas

Health Board	Initial target area	Reasons	Change	Reason for change
NHS Grampian	Dufftown	• Health inequalities identified through QOF data and Scottish Neighbourhood Statistics • Remote and rural area • Good links between NHS Grampian and the local GP • Complemented existing activity on hypertension	Addition of Rothes	Health visitor valued the lessons from Dufftown
NHS Highland	5 practices North West Sutherland	• Remote area • Promotion by Public Health manager • To invest in areas where deprivation is dispersed		
NHS Shetland	Unst and Fair Isle	• Very remote areas with potential access issues • Promotion by NHS managers • Agreement to participate by willing practices	Addition of Lerwick	3 most deprived data zones in Shetland
NHS Orkney	All of Orkney	• Initial plan to focus on long term conditions (since overtaken)	3 practices	Willing practices following change of programme emphasis to health checks
NHS Western Isles	All of Western Isles	• Universal approach because of lack of information to target inequalities and generally high levels of CVD • Learning from this approach		
Healthy Weight				
NHS Grampian	10 rural practices in Aberdeenshire and Moray	• Areas were in very rural areas • Areas brought challenges for people accessing services • To invest in areas where deprivation is dispersed	6 communities in Aberdeenshire and Moray	As a result of local intelligence
NHS Highland	5-8 practices in a remote rural area	• Rural, small community • Cluster of interested GP practices	4 practices in Skye and Lochalsh	Willing GPs identified

There was no one approach to decisions about selecting target areas – other than that they were based on local intelligence. Reasons for local programmes selecting particular areas were varied, including:

- health inequalities – using evidence from the QOF and other sources
- rurality – targeting remote and rural areas
- relationships with local practices – and interest from GPs in participation
- priorities of senior NHS staff – with existing knowledge and experience influencing geographical targeting.

One implication of working with 'willing' GPs was the creation of unusual geographical areas of operation. For example, in Skye and Lochalsh the programme focused on the south but not the north of the island. Stakeholders recognised that this produced a geographical area which did not relate to local needs, which may have made it harder to get community commitment to the programme.

3.3 Selecting the target populations

Keep Well focuses on health improvements and anticipatory care for the 45 to 64 year age group in areas of greatest need. Well North local programmes each developed different approaches to the selection of target populations, and used different methods to do so. Often, the approach used varied within the local programme – due to discussions with each GP practice. This was helpful in gaining the GPs' support as the programme could focus on the priorities for that practice (for example, smokers or those who had not visited the practice for some time).

Three of the programmes were particularly different in their approach to their target populations. The two healthy weight programmes were both open to people over 16 years old. But, in the case of Aberdeenshire and Moray, the focus was on those diagnosed as obese.

In North West Sutherland, Well North included a focus on long term conditions. This was targeted at those with a 30% risk of readmission to hospital in the next 12 months, using the SPARRA (Scottish Patients at Risk of Readmission and Admission) system.

Some programmes adapted their approach to targeting during the pilot process. For example:

- in Shetland the decision to target the three most deprived areas in Lerwick came part way through the process, when new evidence (from the SIMD 2009) became available
- in some of the programmes, the target group was phased – with an initial high priority target group followed by a wider group
- in Rothes the target group was deliberately smaller than the Dufftown target group, as the pilot began in Rothes considerably later than in Dufftown.

The criteria for access to health checks for each of the programmes delivering health checks (and for different practices within each local programme, where appropriate) are set out in Table 3.2. These cover age, conditions, risks, family history and GP links, each of which is discussed below.

Table 3.2: Target populations for Well North programmes (health checks)

Programme	Age Group	Conditions	Risks	Family History	GP Links
Dufftown	16 to 65	Diagnosed with COPD, depression, hypertension, asthma, rheumatoid arthritis	Smoker BMI ≥ 30 Children likely to develop health needs	Family history of COPD, depression, hypertension, asthma, rheumatoid arthritis	
Rothes	40 to 65	Diagnosed with mental health problems	Smoker Overweight Alcohol problems		Poor attendance at clinic
North West Sutherland	40 to 65				Prioritising people who have not seen GP in 12 months
Orkney	40 to 64		Initial priority if smoker	Initial priority if family history of CHD	Initial priority if not visited GP in last 3 years
Shetland – Unst	No age limit				No record of smoking status or blood pressure in past two years
Shetland – Fair Isle	No age limit				GP has incomplete health records
Shetland – Lerwick	No age limit		In three most deprived data zones in Shetland, with incomplete health records		
Western Isles	40 to 69	*A universal approach for the age group, but with some initial priority targeting at practice level*			

- **Age range** – The target age range varied significantly. While some programmes had no age limit, others focused on a specific age range. Often programmes began by giving initial priority to a specific age range, and then extended this to a wider target group.
- **Existing conditions** – One programme targeted patients with existing conditions.

- **Risks** - Two programmes targeted patients who were known smokers and another targeted patients where there was no record of smoking status.
- **Family history** - Two programmes targeted patients with a family history of certain conditions.
- **GP links** - Four programmes targeted patients whose GP records were incomplete, or had not attended the GP practice for some time.

Generally, consultees felt that the Well North programme had targeted people at risk of health inequalities. Many mentioned that Well North provided a positive balance of targeting health inequalities, while also working with the wider community – through health promotion activity, or a wider target group beyond the immediate priority. It also allowed the introduction of services to improve access to health services and anticipatory care. The advantage of programmes having autonomy to make decisions based on sound local knowledge was stressed at the Reflective Workshop held to discuss the Draft Report. The advantages included:

- the ability to build on previous work carried out in the area
- knowledge of patients and the local community (particularly in more remote rural areas)
- the opportunity to build on existing local relationships between health professionals.

3.4 Size of the target population

Overall, the Well North programme (excluding Aberdeenshire and Moray) targeted more than 15,700 individuals across the five Health Board areas. Over half of these were in the Western Isles. The figures of the target populations are estimates.

The practices and NHS managers worked together to identify individuals within the target populations. In some cases, this took a considerable amount of time. Generally, practices reviewed their records to establish whether individuals could be identified electronically, or required a manual search. In some cases, practice staff invested considerable time in undertaking a manual search of records to identify patients within the target groups. Some mentioned that this was only possible due to the relatively small size of the practice. For example, in Fair Isle, the practice nurse re-organised the way in which records were kept to make it easier to identify the target population.

As well as using practice records, many practices used local knowledge to identify individuals within the target group. Practice staff often knew local families well, and could establish whether they fell into the target group. In addition, in some cases nurses approached individuals on the street if they identified that people fell into the target group (for example, observing someone smoking). 'Local knowledge of people who may need support is extremely important'.

Table 3.3 includes the estimated size of the target population for each programme and indicates where there were different approaches used within individual programmes.

Table 3.3: Size of target population by programme (n)

Programme	Target population	Total
Dufftown and Rothes		
Dufftown	16 plus – and with a family history of certain conditions (414)	**1,085**
	16 plus and diagnosed with certain conditions (671)	
	16 plus and in good health (1,192) – not targeted for health checks but included in community development activity	**1,192**
Rothes	Aged 40 to 65 with risk factors around clinic attendance, weight, smoking, alcohol or mental health	**141**
	Total	**2,418**
North West Sutherland		
North West Sutherland	At risk of hospital re-admission	**80**
	40 to 65 not visited GP in last year	**1,380**
	Total	**1,460**
Orkney		
Orkney	40 to 64 – prioritising those not seen by GP in past 3 years, smokers and family history of CHD	**125**
Shetland		
Shetland	Unst and Fair Isle residents with incomplete health records	**60**
	People from three most deprived data zones in Shetland with incomplete health records	**655**
	Total	**715**
Western Isles		
Western Isles	40 to 69 year olds	**8,068**
Aberdeenshire and Moray Healthy Weight		
Aberdeenshire and Moray	People who are overweight in target areas	**Unknown**
Skye and Lochalsh Healthy Weight		
Skye and Lochalsh	16 plus and overweight or obese	**2,980**
	Total for All Programmes (excluding Aberdeenshire)	**15,766**

3.5 Summary: target areas and populations

3.5.1 Wider inequalities

While Keep Well focuses on 45-64 year olds living in the most deprived areas of Scotland, most of the Well North programme has not generally focused on geographic areas of deprivation. This is because households experiencing deprivation in rural areas tend to be relatively evenly spread throughout the community rather than being concentrated in particular geographic areas. Choosing not to focus on geographical deprivation may avoid the stigma associated with poverty. However, it is important that information is gathered about the socio-economic position of people who become engaged in Well North. This would allow analysis of those attending, to gauge whether the programme is reaching the people who may benefit most from advice on health and wellbeing. This would in turn inform future targeting of anticipatory care. The Western Isles has gathered extensive information about those engaged on a database. It is hoped that this can be used to develop a method for identifying deprivation in rural areas. But the other programmes were smaller. They either did not collect this information or had no method for easily collating and analysing any information collected. Given the

relatively small numbers involved in some programmes, it is unlikely that any substantial investment in data management systems can be justified. Existing performance management systems may need to be adapted to make sure that at least basic information is gathered and analysed.

3.5.2 Targeting health inequalities

The comparison of the QOF indicators at Section 3.1.2 and, in more detail, in Appendix 8 suggests that the programmes are focused on areas where the indicators suggest that health risks are higher than the average for Scotland.

3.5.3 Target populations

Unlike Keep Well, where the target group is 45-64 year olds (with some degree of variation on the extent of targeting in relation to areas of deprivation), the Well North programmes have used a very diverse range of criteria to determine the target populations. This has been decided locally – with different practices within some of the programmes taking different approaches. This has led to appropriate local practice, but means that the Well North approach is harder to capture than the Keep Well approach. The main lesson from stakeholders is that in rural and remote areas it is particularly important to take account of local issues in determining priorities. This, allied to a willingness to share experiences and to transfer approaches that work, can help to embed an anticipatory approach across very diverse communities.

3.5.4 Local autonomy

Local decision making has meant that the seven programmes were based on local intelligence – both in relation to the anticipatory care approaches already delivered and also the local priority areas and targets. The range of different approaches has been a strength of the regional programme. But the wide variety of target areas and target populations makes comparison across programmes more difficult. This makes it important that local programmes do gather and collate information about progress to achieving their local outcomes. The effort put into gathering and collating the information needs to be proportionate to the size of the target population. Smaller programmes were not likely to develop as sophisticated data management systems as larger programmes, based on the relatively high proportionate cost of introducing the system.

4. Interventions and approaches

4.1 Inputs: funding and other support

The Well North programme is funded by the Scottish Government. The resources allocated were agreed on the basis of an application submitted by the North of Scotland Public Health Network (NoSPHN) in October 2007. This was based on proposals from each of the local programmes. These proposals were well argued and provided considerable detail about the proposed approach and the benefits that were expected. However, they took as a starting point that the approach proposed was appropriate and did not set out any alternative approaches that had been considered. This means that it is not clear why the selected approach (rather than an alternative approach) was taken.

Initial funding was provided by the Scottish Government over two financial years (April 2008 to March 2010) and, subsequently, additional funding was allocated to extend the programme until 31 March 2011.

Over £1.5 million has been made available over the three years to the Well North programme by the Scottish Government. Additional amounts have been allocated by individual NHS Boards either through direct support (for example, through payments from CHD and Stroke Management Clinical Networks) or through 'in-kind' support (for example the time and overheads of staff or managers in planning and delivering programmes).

Of the total provided by the Scottish Government, £247,000 has been allocated to a regional fund to:

- support the overall development and coordination of the regional programme
- promote and support regional training
- enable attendance at relevant national or local meetings
- evaluate the regional impact of the programme.

The allocation to the local programmes amounts to £1,315,388 over three years. In most of the programmes, expenditure has not followed the planned profile, with expenditure in the first year in particular being affected by delays in appointments and longer lead-in times than planned. Where appropriate, arrangements have been made either by the relevant NHS Board or through the Scottish Government to re-allocate any resources not spent in one financial year to the next financial year. Over the three years of the programme the total allocation by the Scottish Government to each programme is shown in Table 4.1.

With the exception of the Western Isles, where health checks commenced in May 2008, the initial year (2008-09) was used for preparation, identifying staff, planning, engaging with local stakeholders and training. The health checks commenced in these other areas between January 2009 and August 2010.

Table 4.1: Scottish Government allocation by programme – 2008 to 2011

Programme Area	2008-09 (£)	2009-10 (£)	2010-2011 (£)	Total (£)
Dufftown	63,500	63,500	65,000	192,000
NW Sutherland	27,150	45,150	60,000	132,300
Orkney	16,450	21,050	45,000	82,500
Shetland	17,000	30,000	100,000	147,000
Western Isles	101,696	177,092	220,000	498,788
Highland Healthy Weight	Nil	33,900	67,000	100,900
Grampian Healthy Weight	59,200	62,700	40,000	161,900
Regional fund	22,000	85,000	140,000	247,000
Total	**306,996**	**518,392**	**737,000**	**1,562,388**

4.2 Activities undertaken

Three main interventions have been used in the Well North programme:

- health checks and appropriate lifestyle advice and referrals (Dufftown and Rothes; North West Sutherland; Orkney; Shetland and Western Isles)
- healthy weight programmes (in Aberdeenshire and Moray and Skye and Lochalsh)
- multi-agency casework to reduce hospitalisation (North West Sutherland).

In addition, substantial training programmes have underpinned the development of some programmes, particularly in North West Sutherland. And community engagement was an important part of the approach in Skye and Lochalsh; and Dufftown and Rothes.

Table 4.2: Summary of the main interventions undertaken in each programme

Programme Area	Main interventions
Dufftown and Rothes	Health checks (with regular follow up), lifestyle advice and referrals
	Telecare home monitoring
	Community development and social marketing
North West Sutherland	Staff training
	Health checks, lifestyle advice and referrals
	Multi agency case work to reduce the risk of re-admission to hospital
Orkney	Health checks, lifestyle advice and referrals
Shetland	Health checks, lifestyle advice and referrals
Western Isles	Health checks, lifestyle advice and referrals
Aberdeenshire and Moray Healthy Weight	Integrated weight management pathway
	Weight management classes
Skye and Lochalsh Healthy Weight	Community engagement
	Adult healthy weight pathway

4.2.1 Health checks

Health checks have been the main intervention in five of the local programmes. In Dufftown and Rothes and North West Sutherland, these have been complemented by other interventions. The health checks were generally modelled on the national Keep Well model where a health check is carried out to identify the risk of heart disease and other serious health problems. The checks involve:

- an assessment of intermediate clinical risk factors (such as high BMI or cholesterol)
- an assessment of lifestyle risk factors (such as smoking, drinking and exercise)
- an assessment of life circumstances risk factors (such as employment status)
- provision of lifestyle advice.

Where a risk is identified, patients may be referred to:

- GP practices for advice, care and support (such as the treatment of high blood pressure)
- other health related services (such as smoking cessation or weight management)
- other services (such as benefits advice).

Generally, the health checks take at least 40 minutes, and in some local programmes up to an hour is allowed. They involve physical measurement of height and weight; pulse rate and rhythm; smoking status; alcohol consumption (including the opportunity for a Brief Alcohol Intervention where appropriate); exercise; diet; blood tests; cholesterol check; and mental wellbeing check. Some of the programmes have considered increasing the range of tests undertaken – for example Western Isles has added a 'spirometry' (lung function) test to the health check. The rationale being that, having got 'harder to reach' patients engaged, it is useful to check as many risks as possible. However, there was a general view that the tests should not become too long (as this may be off-putting to patients) and should continue to remain focused. We did, however, hear regularly from nurses and others about the value of the time available which allowed the patient to raise issues that were concerning them, which they were much less likely to do in a short 10 minute appointment with a nurse or GP.

Table 4.3 shows the total number of health checks which had been carried out by January 2011; the projected number of health checks which are expected to have been undertaken by 31 March 2011; and the percentage of the total target group in each area receiving a health check.

The engagement level (in other words those attending a health check as a proportion of those within the target population who had been contacted) for Phase 1 of Keep Well between 2006 and December 2009 was 58.5%.[6] For Well North we have calculated engagement slightly differently - using the total number attending for a health check as a proportion of the total population. This measure of engagement is

[6] National Evaluation of Keep Well Policy & Practice Paper No. 4: Keep Well Reach and Engagement NHS Health Scotland, 2010

likely to give lower percentages – as we have not made allowance for those that have not yet been contacted or could not be contacted. Nonetheless, the engagement figure at January 2011 for Well North was 57% - and by the end of March 2011, it is expected that this will have risen to 61%. We are aware that all the Well North programmes would expect further substantial engagement of additional people from the target population in the coming year. In making a comparison between the two programmes, it is important to note that, with the exception of the Western Isles, all the Well North programmes had been delivering health checks for no more than 2 years – and Orkney and Shetland Phase 2 will have been delivering health checks for six months or less by the end of March 2011.

The highest percentage for engagement achieved was in Western Isles, which started the health checks earlier than the other programmes; used a dedicated team; and targeted the whole of the Western Isles. In Shetland Phase 1, the target population was small – and the individuals were well known to the practice (in Unst) and the community nurse (in Fair Isle). In Dufftown and Rothes, bank nurses were used to provide dedicated support to the programme and awareness of the programme was raised through community engagement. In Orkney the programme only commenced late in 2010 and was focused on a small target group, which would provide the number of health checks required to achieve the HEAT 8 target. The Orkney figures include a number of health checks carried out by the paramedic operating through the Scottish Ambulance Service anticipatory care programme. In North West Sutherland the approach has been to build the health checks into the day-to-day work of the practice and community nurses. The relatively smaller proportion of checks carried out reflect the fact that the checks are built into existing workloads and the determination to build a steady, sustainable approach to the delivery of health checks in the area.

Table 4.3: Number of health checks by programme (to January 2011)

Programme Area	Target population for health checks	Number of health checks (by 31 January 2011)	Health checks as a proportion of target population (%)	Number of health checks expected by March 2011	Health checks as a proportion of target population (%)
Dufftown and Rothes	1,226	632*	52	704	57
North West Sutherland	Up to 1,460	375	26	395	27
Orkney	125 (est)	41	33	55	44
Shetland (Phase 1)	60	39	65	39	65
Western Isles	8,068	5,113	63	5,500	68
Total	**10,939**	**6,200**	**57**	**6,693**	**61**
Shetland (Phase 2)	*655*	*39*	*6*	*81*	*12*
Health Checks Total		**6,239**		**6,774**	

*195 (31%) of the people receiving a health check have also received a follow up check.

We have excluded Phase 2 of the Shetland programme from the proportions, as it has only been underway since November 2010. However, the figures for Shetland Phase 2 and the total number of health checks are included below the totals for completeness.

In most areas health checks took place in surgeries (either in practices or community nurses' surgeries). In the Western Isles suitable alternative community venues (like community and church halls or workplaces) were used to conduct health checks and this was well received by both patients and nursing staff. Also in the Western Isles a bus (which had previously been used to deliver Men's Health Services) provided a suitable mobile health check facility which was particularly useful in remote areas. The bus reached the end of its useful life in early 2010 and is now being replaced with a new vehicle. A number of programmes were considering offering health checks at larger workplaces and other places where people gathered (such as the auction markets). However, the practicality of ensuring appropriate venues (in terms of privacy and facilities) for conducting health checks in these locations was still being investigated.

In all the programmes (with the exception of Orkney and Rothes), health checks were offered 'out of hours' – including evenings and at weekends. This encouraged take up by people who worked during weekdays – and people who worked away from their home area during the week. Dufftown, in particular, saw a rapid growth in the numbers attending for health checks as a result of providing an 'out of hours' service.

In Western Isles 'Point of Care' testing is now being used. The programme has purchased two Abaxis Piccolo Testers (including LIPID test) and one Siemens HbA1c tester. The cost of this equipment, along with all associated IT equipment and links, and the initial consumables to carry out the health checks was £70,000. The Western Isles was the first Health Board in Scotland to use this equipment. This approach is seen by staff to have had substantial advantages, including:

- the provision of an immediate print out of health check results (including bloods) – which allows the lifestyle advice to be tailored to the test results
- ease of use for non technically trained staff
- greater interest from many patients in the check process
- a large reduction in the numbers identified as having high glucose levels – saving patient worry; fasting for second tests; and follow up testing.

In Dufftown, the programme provided funding for equipment to pilot a new approach to monitoring blood pressure. This funding helped to encourage the GP practice to participate in the Well North initiative. Fifty people between 40 to 60 years old with established hypertension took part in a 'telehealth' pilot using electronic blood pressure machines, rather than attending the GP practice. Of the 33 people still participating in the project, 70% have improved or maintained their blood pressure.

4.2.2 Healthy weight programmes

Two of the programmes (Aberdeenshire and Moray and Skye and Lochalsh) focused on weight management programmes. It was intended that the two areas would be part of a single programme, but from the start, they have taken very different

approaches. There has been no significant interaction or shared learning between the two sites.

In Aberdeenshire and Moray, the programme forms part of a Grampian wide integrated care pathway for weight management. It is delivered through the Healthy Helpings programme which also operates in a number of other areas in Grampian. Healthy Helpings is an eight week group support programme for obese or overweight adults. Clients are initially referred by a health professional or can self-refer. Clients attend one session a week in a local venue where they learn about healthy eating and develop skills to lose weight and maintain weight loss.

The programme does not monitor or report Well North data separately from the wider Grampian Healthy Helpings programme. It is therefore not possible to identify precisely the number of individuals who have taken part in the Aberdeenshire and Moray Well North programme. The programme estimates that 26 people accessed the sessions in 2010 – 2011 and 23 people in 2011 – 2012.

In Skye and Lochalsh, the programme is focused on community engagement – with the community taking a leading involvement in healthy weight related initiatives (such as weight management, exercise and healthy eating). After initial engagement of community organisations and some GPs, the programme had a long period while they appointed staff (eventually a dietician and a community worker). This has led to the project still not being fully operational. Nonetheless, there is a bedrock of community support for the programme which can now be built on. And the idea of community engagement in health promotion seems to have great potential.

4.2.3 Multi agency casework with high risk patients

Initially Orkney intended to include multi agency casework with high risk patients as part of their programme. However, the requirement to achieve their HEAT 8 target (which they failed to meet in 2009/10) has led to the programme re-focusing on health checks.

North West Sutherland have retained a focus on those identified by SPARRA as being at 30% risk or higher of re-admission to hospital within the next 12 months as part of their response to long term condition management. The intention was that all five practices involved in the Well North programme would formalise multi-agency working in relation to high risk patients. However, this has led to some tensions over the paperwork required and only two of the five practices are fully engaged in this part of the programme in North West Sutherland. Nonetheless, there is evidence of a reduction in bedspaces required at Raigmore hospital from North West Sutherland, which may be attributable to the multi-agency work.

In addition, North West Sutherland has, through training and a change in culture, encouraged staff (particularly nurses) to plan for, and anticipate issues for, patients with long term conditions. In feedback from nurses, we got a strong sense that forward planning for long term conditions and sharing information with other relevant agencies is now becoming embedded in working practices.

The recent involvement of a housing support worker in Phase 2 of work in Shetland

is a further example of a multi agency approach. This work is just underway, but aims to use housing outreach work to engage people who may not have considered undertaking a health check.

4.2.4 Community engagement

Two of the programmes (Dufftown and Rothes and Skye and Lochalsh) incorporated community engagement at the heart of their programmes.

In Skye and Lochalsh, the intention is to engage community organisations and individuals in a 'health at any weight' project to create an environment where the community has a leading involvement in healthy weight related initiatives like weight management, exercise and healthy eating. The idea was that the community initiatives should form part of a healthy weight pathway. Although the GPs were first contacted in late December 2008, the first member of staff (a dietician who split their work between Well North and Counterweight®[7]) was not appointed until December 2009 (by which time it was clear that the GPs were not committed to the programme and there was no community Steering Group). The second member of staff (a community development worker) was not appointed until May 2010. The delays were as a result of a number of factors including the length of time taken to prepare a job description and its supporting documents (including the amalgamation of responsibilities to create a full time post); attracting a suitable candidate to a fixed period post in a remote rural area; uncertainty about line management; and limitations of office space. The delays in appointment have reduced the impact of the programme to date.

Positively, there is now a Steering Group which involves about 30 representatives of community organisations and individuals. The Group has met three times and has begun to make progress in linking members of the community to relevant services. For example, one of the Steering Group meetings discussed walking and pathways – and was attended by members of the community and NHS Highland; the National Trust for Scotland; the Forestry Commission; the John Muir Trust; and Paths for All.

There is not yet community ownership of the idea and this has led to a range of views about the purpose (and value) of the project. It is important that community led initiatives are led by the community. For a number of reasons (including the substantial delays between Steering Group meetings involving community organisations) some community representatives felt that the programme was 'top down' and there was a feeling that the programme had only been introduced because it had 'worked somewhere else'. Others felt that focusing on weight (rather than wellbeing) might be a 'turn off for the community'.

In Dufftown, there has also been a community focused approach. The Dufftown programme involved extensive awareness raising and consultation from February 2008 onwards. A local social enterprise organisation (REAP) was appointed to lead community consultation activity, working on a sessional basis.

[7] Counterweight® promotes behavioural strategies which seek to change eating habits, activity levels, sedentary behaviours and thinking processes that contribute to a person being overweight or obese. The programme provides a range of options which promote active weight loss for 3 to 6 months followed by long term weight loss maintenance.

This consultation involved exploring views on health, and awareness and interest in Well North. It included public meetings to launch the initiative and establish interest in community participation in a Stakeholder Group, and questionnaires in venues like pubs and shops.

The consultation focused on capturing the views of the public, including 'hard to reach' individuals and helped to influence the programme. For example, REAP found that clinic hours during the day were only suitable for around a third of consultees – so evening appointments were introduced.

A stakeholder group of interested community members was also established. This group influenced how the programme developed. For example group members pressed hard for a cholesterol check to be included in the health check - and it was. It also contributed to awareness raising activities and event organisation.

The programme undertook a mapping exercise of existing groups, services and resources in and around Dufftown, and produced a Dufftown Directory. This publication includes health services, as well as wider services such as housing and financial advice. The directory was produced by a partnership between NHS Highland, Moray Council and REAP and was later expanded to cover the whole of Moray.

A new Patient Information Centre was set up in Dufftown Health Centre, where people can access free leaflets on health issues and use the free Healthline number. Well North also ran wider events and activities, including:

- a community ceilidh, linked to healthy eating and active lifestyles
- tasters of local activities, such as jogging, cooking, dance and cycling
- school competitions to design logos and bookmarks with healthy messages
- Well North stalls at other events to raise awareness of health
- a quarterly newsletter – raising awareness and promoting health.

In Rothes the health checks began in April 2010, before community consultation. The consultation took place at a later date (October 2010) but was not complete at the time of this research.

4.2.5 Training

In addition to the interventions for patients, another important activity has been the provision of training for staff and communities. This has been a major focus of the work in North West Sutherland. The approach here is based on Motivational Interviewing. Large numbers of staff have received training in Health Behaviour Change (25 staff); Alcohol Brief Interventions (26); Counterweight® (14); CVD risk assessment (28); and smoking cessation (in each practice). The training will also be provided to new staff (and has been provided to the paramedic involved in the Scottish Ambulance Service anticipatory care project). The provision of training for new staff was seen as important, because it will ensure that the motivational approach is used consistently in North West Sutherland and will help to support the teamwork across the five practices, which is already well established.

In the Western Isles, 31 nurses received initial training on health screening. Smaller numbers of staff have received training in other areas. Training for community members was included in the Dufftown programme.4.3

4.3 Summary: interventions

4.3.1 Decisions about the approach

The template that was used for proposals from potential local programmes (quite reasonably) asked for details of the programme that was proposed. It did not ask the local areas to set out the rationale for determining that this was the most appropriate approach.

In future, when there is a similar approach to the allocation of resources to local programmes, it would be helpful if any proposal document started with a short options section. This would ensure that a range of approaches had been considered, before deciding on the approach which was felt to be the most appropriate to the local situation.

4.3.2 Health checks

Given the dispersed populations and the fact that most programmes have been undertaking health checks for two years or less, the proportion of the target population that has attended a health check is a significant achievement. The engagement rate was 57% on 31 January 2011, and this is expected to grow to 61% by 31 March 2011 – with over 6,500 health checks achieved. Local programmes have used different approaches which are seen as appropriate. We believe that in taking forward a programme of health checks the following factors should be considered:

- **Use of community venues** – in the Western Isles community venues were used and this was welcomed by patients and nurses. It attracted people who had not visited their GP for some time. The use of the bus in the Western Isles was also helpful in taking health checks to people (rather than getting people to come to the health check) – although this does require a considerable investment. Other programmes had considered using community venues including locations like auction markets or workplaces, but had not yet used this approach. As the numbers engaged in the health checks grow, it is likely that it will become more difficult to engage those who have not attended a health check. The use of appropriate community venues may be one way of continuing to attract as many from the target population as possible.
- **Out of hours service** – most of the local programmes undertook health checks at weekends and/or evenings. Dufftown consulted the community about the timing of health checks and, because of the response in favour of an out-of-hours service, introduced evening and weekend checks. As a result, the programme saw a rapid growth in the numbers attending for health checks. Flexible timing of services can be particularly important for people who are working during the day – or who work away from home during the week.
- **Dedicated team or part of the workload** – Western Isles has a small team dedicated to Well North. This approach has allowed a health check service to

be offered to GPs. It has allowed expertise to be developed; provided a concentrated effort over a period of time (with large volumes of health checks undertaken); given a clear management focus; and is less affected by seasonal and other pressures (like flu jabs). Dufftown has used bank nurses to allow time to be dedicated to the health checks. Conversely, in North West Sutherland, the approach has been to include health checks as part of the work of practice and community nurses. This fits well with the wider approach to anticipatory care and long term conditions in North West Sutherland and helps to embed anticipatory care into the day to day work of practices and nurses. Embedding work also provides a varied job and uses (and builds) local knowledge. This working pattern was seen to empower nurses and to be sustainable, as it uses existing resources. Shetland Phase 1 and Orkney have also used existing practice staff. Both approaches have merits. Programmes should individually decide the best approach for them.

The focus of Well North was on targeting and engaging people in local anticipatory care activities. The start of health checks in Orkney was considerably later than in other areas as a result of changes to the proposed approach in Orkney, along with early planning and programming difficulties. Nonetheless, taken together, the five programmes delivering health checks have made a significant contribution to targeting and engaging people in anticipatory care.

4.3.3 Healthy weight programmes

It is difficult to identify the impact that the Healthy Weight programmes in Aberdeenshire and Moray and Skye and Lochalsh have had. In the case of Aberdeenshire and Moray, this is because the programme is not gathering information about its inputs and outputs. Any information about the Well North supported programme is not separated from Grampian wide figures. The programme estimates that the Well North programme allowed 26 people to access Healthy Helpings sessions in 2009 – 2010 and 23 people in 2010 – 2011.

In the case of Skye and Lochalsh the assessment of impact is problematic because the programme engaged GPs and the community before the staff resources were in place. Difficulties and delays in staff appointments meant that any initial interest had been reduced by the time that staff were in post. There is now a community focused Steering Group and work is underway to link community organisations and public and voluntary agencies in tackling weight issues in the area. Any outcomes will take some time to achieve.

4.3.4 Long term conditions

Although Orkney originally planned to focus on long term conditions, the staff decided to change the approach to focus only on health checks. This left only North West Sutherland with a focus on long term conditions (with a particular emphasis on preventing hospital admissions). On the one hand, we heard very positive stories from nurses that demonstrated that this had encouraged them to take a more anticipatory approach to all that they did. On the other hand, it has proved difficult to get all five practices to introduce formal multi-agency approaches to reducing hospital re-admission. Some practices have made substantial progress. But others found the paperwork off-putting.

Long term conditions and reducing hospital admissions could play an important role in anticipatory care in other areas.

4.3.5 Community engagement

Community consultation and engagement has been an important part of the approach in Dufftown. The early involvement of a well respected local social enterprise to work with the community was seen as an important step. Both staff and community organisations believe that the approach has had an impact on health awareness and participation in the area (shown, for example, in an increase in physical activity and the community volunteers' involvement in sustaining the local gym, which was under threat due to reduced Council resources).

In the Skye and Lochalsh programme, the approach to community engagement and development is currently less advanced. Although it seemed appropriate to appoint an individual member of the Well North team to carry out community development, it may have been more effective to have partnered with an established community organisation or social enterprise to undertake community consultation and development. This may also have reduced the concern which some community organisations have that they are not able to influence key decisions.

4.3.6 Training

Giving priority to training brought great benefits in North West Sutherland – by increasing skills and confidence; and building opportunities to share skills through peer support across the five practices. Ensuring that there is time for training (and the associated travel, which can be significant) built into programmes is important. It is also necessary to consider training for new members of staff.

5. Engaging the target populations

5.1 Methods of engagement

5.1.1 Attracting people to health checks

In all programme areas (other than the Healthy Weight programmes), there was a strong focus on attracting people to health checks. Practices identified individuals through practice records, and invited them to attend a health check using a range of different methods.

Table 5.1: Methods of inviting people to health checks by programme

Programme	Methods
Dufftown and Rothes	1. Letter with appointment time and date
	2. Letter with appointment, and follow up phone call from health visitor
	3. Phone call from bank nurse
	4. Follow up with non attendees
	5. Feedback gathered from non attendees
Orkney	1. Letter offering health check
	2. Phone call from community nurse
Shetland	1. Letter offering health check (two letters issued)
	2. Letter with appointment time and date
	3. Text message reminder of appointment
	4. Follow up phone call (with offer of home visit)
	5. Letter with home visit appointment time and date
	6. Home visit by GP, practice nurse or outreach worker
	7. Feedback gathered by non-attendees
North West Sutherland	1. Letter – some with appointment time and date; some offering health check
	2. Follow up phone call
	3. Opportunistic health checks
	4. Home visit by nurse
Western Isles	1. Letter from practice or Well North offering health check
	2. Follow up phone call from practice or Well North staff
	3. Second round of invitations

In all areas, nurses confirmed that letters, coupled with reminder phone calls were much more effective than letters alone. For example, Dufftown switched from using letters to using phone and face to face contact wherever possible, due to the increased level of engagement with this approach.

Many programmes found that contact from nurses helped to increase engagement levels. For example, one programme originally sent letters from 'Well North'. Due to low uptake it switched to a letter sent from the practice nurse, and this increased uptake. Telephone calls from a nurse, rather than other practice staff, were also seen as more effective. Two practices specifically mentioned that a nurse could discuss the benefits of a health check, explain it fully, and address any initial

concerns over the phone. Often the phone numbers held by practices were out of date, and this approach could not be used. However, the use of direct contact was so important that a number of programmes set aside time to search out phone numbers (this allowed the practices to bring their records up to date).

In Unst in Shetland, the GP (or practice nurse) made home visits to patients who did not respond to initial engagement attempts - with patients alerted in advance of the time and date. By this stage only 11 of the target population had not responded to other approaches and, therefore, this was seen to be a proportionate approach. While this was seen as an effective way of making contact with patients who did not respond to letters and achieved a further six health checks, some consultees were concerned that this may be seen as intrusive and verged on 'hounding people'. Feedback from patients indicated that many were surprised that the GP had dedicated time to visiting them, and some were apologetic at having 'wasted' GP time. 'I'll come to the doctor's when there is something wrong with me. I'm fine just now'.

North West Sutherland offered health checks to patients who visited the practice for another reason, allowing them to speak face to face and encourage participation. This has been a very successful way of engaging with patients who had not responded to invitations for a health check. Other practices mentioned that they felt this was a positive approach.

Programmes found that wider awareness raising activity about Well North and the health checks helped to increase participation. For example, in Dufftown, there was a programme of community consultation, events and publicity to raise awareness. This helped to encourage people to participate, but also provided valuable information about patients' views on access to healthcare information and health checks – resulting in some changes to programme design, which increased participation levels. In Shetland (Fair Isle), the programme was advertised through a public event, helping to encourage participation, and in Western Isles and North West Sutherland press releases and wider publicity were used.

Word of mouth was seen as one of the most important factors in encouraging engagement, and activity like this could enhance community discussions about the programmes.

Some programmes also found that the way in which the health checks were delivered influenced participation levels. For example, the health checks in community venues in the Western Isles appeared to increase the number of participants. In Dufftown, introducing an evening session for health checks significantly increased participation levels.

In Shetland, the second phase of the programme included a housing and health improvement outreach worker to raise awareness and encourage engagement of those who were not likely to attend for a health check. Some other programmes were working (or planned to work) with voluntary sector organisations to improve awareness and uptake of the programme.

Most programmes had produced information sheets about what to expect from a health check. Some practices found that patients were concerned about what the health check would involve, and that basic information could put people's minds at rest and encourage participation.

None of the programmes specifically targeted people from equalities groups such as ethnic minority or faith communities, women or men, or disabled people. However, equalities issues were often considered when developing interventions and planning activities. In the future, if the level of engagement by particular equality groups is lower than for the population as a whole, programmes may wish to target information (or provide services) tailored to those groups that have not been so likely to engage.

Overall, the programmes agreed that there was no one right engagement method. People respond to different methods of engagement, and a variety of different approaches are required.

5.2 Wider health awareness raising activity

The healthy weight programmes focused on much wider awareness raising around weight. The Skye programme undertook networking activity with public and voluntary organisations, through email, phone calls and visits – to raise awareness of the initiative. It also set up a large local Steering Group to bring together relevant public, voluntary and community organisations interested in promoting Well North. The aim was to create a sustainable, community led initiative which would remain beyond the life of Well North.

An initial community consultation exercise was undertaken in 2008, which identified the priorities for Well North in Skye and Lochalsh. However, the delays in staff coming into post meant that, limited community development or engagement work has occurred since. Stakeholders felt that the community in Skye and Lochalsh was largely unaware of Well North. 'People on the street won't know what Well North is'.

In Aberdeenshire and Moray, the programme has worked closely with existing services to raise awareness and engage communities. Initially, a survey was undertaken with GPs – to explore needs, perceptions and referral routes in relation to healthy weight. A small survey of ten service users also took place, but no information on this was available. Letters and events were used to raise awareness of the initiative, and promote services to assist with healthy weight. GPs were also encouraged to refer to healthy weight services. Although uptake and awareness of some services (Healthy Helpings) appears to have increased, for others (Counterweight®) uptake remains poor. Stakeholders report barriers to increasing engagement, particularly in relation to the different priorities of services, and challenges in co-ordination.

Other programmes also undertook wider awareness raising activities. Most significantly, the Dufftown programme focused strongly on community awareness raising and consultation, with a core aim of building 'a self caring community' (for more on this, see Section 4.2.4). Community consultation and engagement, which was undertaken by a respected local social enterprise, was seen by stakeholders to have widened participation and raised the profile of Well North in Dufftown.

5.3 Characteristics of those engaged

In most programme areas, there is limited information on the characteristics of patients who engaged in the programmes. The Western Isles, which has the largest programme of health checks, has high quality monitoring information about patient characteristics. However, in other areas information on the characteristics of those engaged is very limited – it is either not gathered or not collated. This is an important issue. Western Isles developed a database to ensure that data was relatively easily collated and reported. The smaller programmes found it hard to justify the expenditure and resource commitment to this level of information management. As a result, there has been less of a focus on gathering and collating information in programmes other than Western Isles.

The information from Western Isles shows that of those undertaking health checks:

- 65% were employed; 10% unemployed and 25% retired
- 54% were women and 46% men
- 21% were smokers
- 18% were engaged in hazardous drinking
- 26% had not visited the GP in the last year
- 34% lived in the 20% most deprived data zones.

Anecdotal evidence about the characteristics of those engaged in the programmes suggests that all the programmes offering health checks have engaged many individuals who would not normally have visited their GP. Consultees involved in all the programmes delivering health checks indicated that Well North had involved people who may not have been aware of their health, and rarely or never visited their GP. 'The checks have clearly attracted people who were not aware of the state of their health'.

A number of programmes had explored the reasons for people not attending health checks. They found that generally the barriers to participation were:

- people forgetting to respond to the invitation or attend their appointment
- people who are well (or think they are) and don't feel a health check is a good use of their time (or staff time)
- people not wanting to be 'told off' about their lifestyle
- people being worried about learning that they are ill.

The programmes identified people who felt unable to fit either a health check or healthy activities (like cooking healthy food or exercising) into their lives.

Generally, programmes felt that there were some people who could relatively easily be encouraged to participate – there were a number of people who had not yet been invited to participate, and there were others who may respond to a further approach. The programmes had already significantly extended the numbers engaging with services. But it was acknowledged that additional methods would have to be used to continue to engage more of those who were least likely to use services. Ideas included taking health checks to people at workplaces, auction markets and similar venues and working more closely with public and voluntary sector partners.

5.4 Summary: engaging target populations

5.4.1 Range of different methods

The main learning point from engaging target populations is that a range of different approaches to contacting patients should be used. Initially, a combination of letters and phone contact works well, with the phone contact being seen as an important element of this. At the same time, it is important to make it easy for people to attend the health checks – whether by extending the times when health checks are provided (to weekends or evenings) or bringing the health checks to people (for example through the use of community venues or the delivery of workplace health checks). No one mix of methods is right – some approaches have worked well in some programmes and less well in other programmes. By consulting the community and by learning (and adapting) on the basis of local experience, an effective balance can be reached.

5.4.2 Extending the range of methods over time

All of the programmes expect to continue to attract additional people within the target population to a health check. But programmes were aware that additional techniques are also likely to be required to reach the maximum number of people.

The main additional routes that were being considered were:

- greater use of community or workplace venues
- greater joint work with other public agencies or voluntary sector organisations
- use of social marketing techniques.

Although the programmes have achieved high rates of engagement and hope to improve this further, it was acknowledged that 100% engagement was not an achievable goal. For example, Unst, has a small target population; a local practice that was accessible and had promoted health awareness for many years; and an extremely active GP and practice nurse. They achieved an excellent engagement rate (86%). But the five people who declined a health check (having been spoken to directly by either the GP or the nurse) were clear that they did not wish to have a health check undertaken at this time – normally because they felt well.

6. Changes for patients and the NHS

6.1 Changes for patients and communities

It was not the intention of Well North to systematically gather information on longer term changes for patients and communities (not least because of the capacity and the time lapse required to measure outcomes). Dufftown and Rothes, however, are conducting follow up health checks – six months and one year after the initial health check. Of the 632 people who have received an initial health check, 195 (31%) have had their first follow- up check. Once the information from the follow-up checks is consolidated and analysed by the programme, it will give an indication of short-term changes to lifestyle and health risks.

We have no information at this stage about weight loss (or any other changes for patients) in the Healthy Weight programmes.

The remaining information about change for patients relates to:

- referrals following the health checks
- qualitative information drawn from our interviews and from the Performance Stories.

6.1.1 Referrals following health checks

Three programmes (Dufftown, North West Sutherland and Western Isles) have undertaken 98 per cent of the health checks. It is possible to review the number and type of referrals made as a result of the health checks carried out in these three areas.

Western Isles

In January 2011, more than one third of those participating in the health check (1,889 people) have had a health risk needing an intervention. Specifically, the programme found that 32.4% of those getting a health check had a CVD risk of ≥ 20% (using JBS2 guidelines). This compares to figures from the First Phase of Keep Well showing that between 20.7% and 21.4% of those receiving a health check in Glasgow, Lanarkshire and Dundee had a CVD risk of ≥ 20% (using ASSIGN guidelines).[8] The prevalence of Coronary Heart Disease and Hypertension in the Western Isles are amongst the highest in the UK.[9] The Western Isles programme has estimated that using JBS2 could account for approximately 5% of the difference, when compared to programmes using the ASSIGN guidelines. It is natural that the high levels of prevalence in the Western Isles mean that there will be more people at risk (as not all at increased risk will get CVD). The number of patients with a risk identified through the universal health check appear substantial when compared to the more targeted approaches used in Keep Well Phase 1.

Information produced by the programme for the period up to September 2010, shows that in 68% of the cases, the referral has been to the GP or practice nurse. Other

[8] National Evaluation of Keep Well:Policy & Practice Paper No. 5:Who are reached by Keep Well?: Characteristics of attendees by cardiovascular risk factors, NHS Health Scotland, 2010

[9] Draft Well North Outer Hebrides Annual Report, 2008 – 2010, NHS Western Isles, 2011

referrals were to a dietician (16%); smoking cessation (13%) and the physical activity programme (3%).

One in five of those at risk are likely to have an event, if untreated, in the next ten years. They estimate that, if intervention cut that risk in half, there would be 171 less events which could equate to 46 less early deaths, 79 less heart attacks and 46 less strokes as a result.

North West Sutherland
By September 2010, 303 health checks had been undertaken resulting in 72 referrals (24% of completed health checks). Of these, 38 were to the GP or practice nurse; 17 to Counterweight®; 12 to smoking cessation and five to others.

Dufftown
Between January 2009 and December 2010, 514 checks were undertaken in Dufftown. Thirty (16%) were found to have high blood pressure, and were referred to the practice nurse. Seventy-eight (24%) were found to have a BMI of greater than 30. Twenty nine had high cholesterol and were referred to the GP. Seventeen were referred for other risks. It was not always possible to make a referral for weight management support, as there were limited sources of support locally. One local programme (Healthy Helpings) had been discontinued.

In addition, 25 people in Dufftown - identified through the community consultation which was undertaken - were signposted to groups covering activities like walking, cycling, cooking classes or tennis. For example, membership of the local Jog Scotland group increased from 14 to 23 as a result of a community 'taster' event as part of Well North.

All programmes delivering health checks
A high proportion of those engaged in the Well North programmes have been identified as having a health risk – ranging from 20% of those attending a health check in North West Sutherland to 37% in Western Isles. The risk figures for the programmes that had undertaken health checks are shown in Table 6.1.

Table 6.1: Number of health risks identified per programme (to January 2011)

Programme Area	Number of health checks	Number of people identified as having a health risk	Proportion of health checks where a risk is identified (%)
Dufftown and Rothes	632	212	34
North West Sutherland	375	74	20
Orkney	41	14	34
Shetland	78	20	26
Western Isles	5,113	1,889	37
Total	**6,239**	**2,209**	**35**

The programmes did not all gather information on the take up of referrals, but were aware that a large number of those did follow up the referral. For example we heard from a practice nurse in Stornoway that appointments being made with GPs and practice nurses, as a result of referrals following the health checks, had reached over 100 in just a few weeks. There is also evidence of a growth in attendances at healthy weight initiatives; physical activity classes and smoking cessation classes.

6.1.2 Qualitative information

A large number of those that we interviewed spoke positively about the changes that had been brought about for patients. The main themes raised were:

- patients' greater awareness of health checks and better understanding of their benefits
- greater general awareness of health (for example, as a result of being involved in the health checks a group of people in Durness successfully put pressure on the local shop to improve their provision of fresh fruit and other fresh produce)
- greater awareness of personal health – including the identification of previously undiagnosed health problems (in a number of different areas, interviewees told us of more discussion among friends, families and neighbours about health)
- the provision of additional or new services (such as exercise classes in Western Isles)
- services greater awareness of and focus on the patient 'in the round' and the wide range of issues which impact on health and wellbeing
- some evidence of patients taking greater responsibility for their health and lifestyle – including changes in diet and exercise
- greater local delivery of services (mentioned particularly in Aberdeenshire and Moray – with additional Healthy Helpings classes being provided and in Western Isles – with the use of a range of community locations for carrying out the health checks, including the use of the bus).

But, it was noted that bringing about changing attitudes to health and lifestyle can be a slow process. And, ironically, some patients in a number of different programme areas 'blamed' Well North, on the basis that they had been 'well' before they came for a health check – and 'as a result of' the health check they now knew that they were not well.

6.2 Changes for the NHS

Generally, services have responded positively to the changes required to deliver anticipatory care. For example:

- patient information has been improved (to assist the process of inviting patients to health checks)
- methods of engaging patients in health checks have developed (with the use of both letter and telephone contact)
- service delivery times have been extended (to offer health checks in the evening and at weekends)
- services have responded to local needs identified through community consultation.

6.2.1 GPs

A small number of GPs have wholeheartedly embraced and promoted the Well North concept. We found that this was most likely in more remote practices (which tend to have smaller populations and a more community centred approach). But most GPs have not played any major role beyond entering into Local Enhanced Service agreements relating to the administration or delivery of health checks and enabling nurses to take responsibility for delivering Well North. In one or two cases there is some evidence that GPs were considering lifestyle along with medical issues. And (particularly mentioned in Dufftown) practices have developed more links with other organisations and services and made sure that they have information more readily available for patients.

In Orkney the reluctance of GPs to participate was said to be because some were sceptical about the added value of the programme compared to the amount of administration involved - and some did not wish to become involved because there is so much else going on. In Skye and Lochalsh, we spoke to GPs who felt that Well North had not delivered anything in their area. Some GPs also commented on increased workloads arising from the referral of people who had undertaken a health check. We heard that, in Aberdeenshire, many GPs did not see weight management as a priority.

On the other hand, in Western Isles, GPs appeared to welcome the support that the dedicated Well North team had been able to provide.

6.2.2 Nurses

The nurses who had been involved (whether in the dedicated team in Western Isles or practice or community nurses elsewhere) spoke very positively about Well North. For example, in North West Sutherland, nurses saw the Well North programme (both health checks and long term conditions management) as:

- empowering and motivational
- providing a variety of interesting work
- leading to problem solving and a more creative approach
- encouraging joint work with other organisations to plan for anticipatory care for high risk groups
- something that they could 'take ownership' of
- really making a difference.

Also in North West Sutherland, the importance of training for all nurses for the programme helped to bring people together and to make people realise that there were a lot of similarities between the different practices – and this has resulted in peer support.

In Dufftown the nurses believed that the amount of time allowed for a health check (up to one hour) gave plenty of time for people to talk about issues. This has resulted in some increased trust and willingness to attend GP appointments. They found that often people attending a health check have a concern about their health, which they have not raised this with the GP.

In Western Isles, the dedicated team of nurses has a very clear sense of purpose and achievement. They (and their managers) are convinced of the benefits of a dedicated team that provides expertise and support around health checks to the practices. In addition, some practice and community nurses told us that they were moving away from a purely medical model and drawing on other approaches (including conversation and information provision). This was aided by the training that was provided for 31 nurses across the island at the start of the programme. Nurses from the dedicated team said that it had been good in terms of Continuous Professional Development to be involved in this programme.

6.2.3 Managers and boards

Three of the projects have taken some time to get established – because of difficulties in recruiting suitable staff or because of insufficient planning in the early stages. In Orkney, for example, those interviewed acknowledged that more effective planning for any new programmes, with proper consideration of the role and responsibilities of those running programmes and the identification of the resources required would be beneficial in future. In addition, those in Orkney stressed the advantage of corporate (rather than individual) ownership of new programmes. In Skye and Lochalsh, there were substantial delays in the appointment of each of the two members of staff and poor preparation and planning for the arrival of the staff – for example in not having a desk available.

In Shetland we heard that there is growing support for the Well North approach. This is because it is 'seen to be the right thing to be doing – working towards early intervention and removing barriers to access'. Senior managers and the Board were said to see the importance of sustaining a preventative approach.

However, we heard from a number of programmes that the day-to-day pressures of reacting to poor health made it difficult for prevention and early intervention to be given priority in terms of financial and staff resources.

In Western Isles, the Board and the relevant Management Clinical Networks have been supportive of the approach, including the allocation of resources to augment the Scottish Government funds.

6.2.4 New approaches

In Dufftown, an interim evaluation of the hypertension pilot (which is part of Well North) found that the cost of supporting patients with hypertension can be reduced through patients monitoring their own blood pressure at home. The pilot has saved money on regular blood pressure monitoring for patients with hypertension, which is usually undertaken by a nurse.

The pilot has now been incorporated into routine practice for diagnosing hypertension. Normally, a nurse would do three separate blood pressure measures. Now, the patients do this at home.

In Western Isles, the purchase and use of 'Point of Care' equipment has made a big difference for staff in terms of ease of delivering the check and giving immediate feedback to patients. It has provided an improved test for diabetes (although this is

still undergoing testing in Scotland) and has engaged patients as a result of the immediate feedback.

6.3 Summary: changes for patients and the NHS

6.3.1 Changes for patients

The focus of the Well North pilot was to identify target populations and to maximise the engagement of the target population in anticipatory care programmes. These themes are explored in Sections 3 and 4 of the report. We were interested in whether, at this relatively early stage, there had been any changes for patients as a result of this approach. We know:

- that 6,239 people had attended a Well North health check by January 2011
- that a health risk, requiring referral, was identified for 35% of those attending a health check (2,209 people)
- that many of those being referred have followed this up nurses have reported an increasing awareness of health checks and their benefits; greater awareness of personal health; and some changes in diet and lifestyle.

Using the model reported by the Western Isles programme, one in five of those at risk will have an event, if untreated, in the next ten years. The programmes estimate that 6,774 health checks will be completed by 31 March 2011 in the five areas delivering health checks.

It will be important that, in the future, information is gathered about health and lifestyle changes for patients attending a health check. This would provide information on the health benefits of conducting health checks.

6.3.2 Changes for the NHS

Nurses have been the key resource in delivering Well North. They spoke positively about the benefits of the programme for patients in terms of the provision of lifestyle advice and referrals – and some emerging changes in behaviours. Nurses also spoke positively about how an anticipatory care approach was appropriate for their work – and about the training and development of skills that the programmes had encouraged.

The involvement of GPs in the initiative has been seen as extremely valuable, where it happens. GPs were generally more likely to be strongly supportive in smaller, more remote practices. For example, in North West Sutherland and Western Isles, having a GP chair the Steering Group is seen as very positive. However, stakeholders acknowledged that many other GPs were not particularly engaged in the programme.

Most GPs supported the involvement of nurses in the programmes. But there was evident difficulty in encouraging a number of GPs that anticipatory care should be a priority – among a wide range of initiatives that GPs may be asked to support. Given the crucial local role that GPs play in delivering health care, it is important to increase their commitment to anticipatory care over time. This will require ongoing awareness raising as well as the development of a sound evidence base about the benefits of anticipatory care.

There are some lessons for Health Boards about the effective planning of new programmes. A number of programmes found that the set up time was longer than they had originally planned because of a range of issues including identifying appropriate staff; resolving local governance arrangements; reaching agreements with practices; and clarifying roles and responsibilities. For two of the programmes (Orkney and Skye and Lochalsh) the delays were particularly significant and had a serious impact on the early delivery of outcomes. Any future programmes should make sure that sufficient time is allowed to make sure that the staff and resources are in place in advance of planned start dates for delivery.

And there are decisions to be taken about the prioritisation of resources. Moving resources from reactive approaches to early intervention have proved difficult generally in public services. But this will be required to deliver a fully effective anticipatory care programme.

7. Collaborative working

7.1 Joint working

This section explores the lessons learned in relation to joint working as part of the Well North programmes.

7.1.1 Joint working across Health Boards in the North of Scotland

The programmes identified two main advantages of working across five Health Board areas:

- the opportunities for joint training and development (for example, evaluation support provided to all the local programmes by NHS Health Scotland)
- the opportunities of learning from other programmes.

The opportunity of learning together and learning from other projects in Well North was warmly welcomed – although some projects were less engaged in learning than others. Stakeholders in Orkney, Shetland, North West Sutherland and Western Isles indicated that they benefited from regularly sharing experiences and learning. This has included visits to and from other programme areas and joint training sessions.

The Well North network was seen to be useful, with appropriate and timely meetings and support. Video conferencing was used to overcome difficulties in travelling to meetings. The network was seen to have provided an opportunity for peer support – allowing those involved in programmes in different areas to share experience with those who are doing similar things, and working through the same issues and problems. It also built relationships so that programme staff felt that they could contact one another by phone or email between meetings.

The evaluation support for local programmes from NHS Health Scotland was valued by programmes, although this did not always translate into the delivery of effective monitoring and evaluation.

Early agreement to the gathering of standard core data has not always been delivered. This has made it relatively difficult to make comparisons across the programmes.

While welcoming the joint work through Well North, a number of stakeholders mentioned that the Scottish Government and NHS often introduced new ideas and initiatives, as do the Community Health Partnerships at a local level. Many felt that there was a need for improved communication, and co-ordination of similar initiatives at a national level. 'There is a need to join the dots. There are lots of isolated projects.'

7.1.2 Joint working between practices

In many cases, practices participating in Well North have worked independently. There has often been limited contact between practices – although collaborative work and joint training across nurses in the five practices in North West Sutherland has been particularly strong. NHS staff have worked with practices individually to agree the way in which programmes will work, in a way which best suits the practice. This has meant that programmes have been flexible to meet the needs of local

communities. However, it has also been a pragmatic approach to encouraging GPs to participate, as many were initially reluctant.

The key delivery staff have been community, practice and bank nurses and health visitors, who have taken on the role of championing and delivering Well North programmes. The motivation for participating in Well North has often come from nurses or health visitors. For example in Dufftown and Rothes, the programme has expanded from one practice to another due to the enthusiasm of a health visitor from one practice helping out with health checks at another practice and seeing the value of this approach.

7.1.3 Joint working with other agencies

Many practices have established clearer and wider ranging signposting and referral systems as a result of Well North. This includes health related services – such as smoking cessation or healthy weight – as well as wider services such as citizens' advice bureaux, adult literacy services and victim support. However, in some areas, there were problems with a lack of suitable referral sources. In Dufftown and Rothes, patients identified as requiring support with weight management had to travel and/ or pay to access suitable support.

In Shetland, the programme in Lerwick involves joint working with housing services, to address health inequalities related to housing issues.

In North West Sutherland, Well North resulted in improvements in case management between GPs, community nurses, social work services and the voluntary sector. Well North had provided the impetus for a number of GP practices to set up multi disciplinary meetings to review high risk cases on a more formal basis than before. This was viewed very positively by many stakeholders, but it was acknowledged that there were issues around paperwork and bureaucracy.

In the Western Isles, Well North has set up a partnership with the local authority sports facility department. People who have high BMI and blood pressure are referred to a group activity programme, and also receive six weeks free access to sports facilities and four directed sessions at the gym. This approach has worked very well in Stornoway, where there are modern facilities. In more remote areas (in the Western Isles and elsewhere) the lack of accessible facilities reduces the potential of this approach.

There were particular problems in co-ordination between Well North and the Scottish Ambulance Service anticipatory programme in Orkney and North West Sutherland. The Ambulance Service programme was initially seen as a distraction. There were challenges in joint working, and concerns that an already stretched service was introducing a new programme of work. It was felt that there should have been better co-ordination in advance of the introduction of this new service, given the similarities with Well North. Nonetheless a satisfactory way of working has now been agreed.

7.2 Consideration of joint working

The strongest element of joint working was the opportunity for peer support across the programmes. It was disappointing that not all programmes took advantage of the

opportunities that were available – and there was a tendency for the programmes that had greatest problems in establishing the delivery of their programmes to have less involvement in joint learning.

Although programmes agreed to gather standard core data, not all did. This was often because the data management systems were not in place and were seen to be disproportionately expensive to introduce for smaller programmes. This has made comparisons across the programmes difficult on occasion. It would be helpful for programmes to re-commit to gathering a basic range of standard data.

Joint work across practices was less common – but was highly effective in North West Sutherland where it was built on from the training programme for nurses.

Joint working with other agencies was increasing and was seen as an important part of extending engagement in the future.

8. Conclusions

8.1 Planning anticipatory care in rural and remote areas

Well North has encouraged seven very different programmes to test approaches to the delivery of anticipatory care services in rural and remote areas. The approaches have had to be developed to take account of:

- the more dispersed nature of deprivation in rural areas
- the likelihood of greater distances from services
- difficulties in attracting staff to work in rural and remote areas for some programmes (most notably Skye and Lochalsh).

With the exception of the Western Isles, where health checks commenced in May 2008, local programmes generally used the initial year (2008-09) for preparation; identifying staff; planning; engaging with local stakeholders; and training. In Orkney and Skye and Lochalsh there were significant delays in implementing the programme. In Orkney this was as a result of a change in the planned outcomes – with the focus moving from long term conditions to health checks. In Skye and Lochalsh it was principally as a result of delays in staff appointments.

It is important that new programmes do allow a realistic time for setting up – particularly if specialist staff are required, as it can take time to attract specialist staff to work in rural and remote areas. Equally new programmes should ensure that roles and responsibilities are clear and sufficient resources are allocated to make sure that the set up period is not over-extended.

8.2 Targeting

Initially none of the programmes focused on areas of deprivation, because households experiencing deprivation in rural and remote areas tend to be relatively evenly spread rather than being concentrated in particular geographic areas. It will be important in the future to gather and analyse data about the socio-economic and other characteristics of those engaging in programmes. This could inform future approaches to tackling health inequality in remote and rural areas.

Each of the programmes identified the target areas in different ways. One programme (Western Isles) decided to target the whole of the Health Board area. The other programmes selected particular areas (normally based on areas covered by GP practices) within the Board area. These areas were selected for a variety of reasons:

- agreement from GPs to participate in the programme (Orkney; Skye and Lochalsh; and Shetland Phase 1)
- remoteness (North West Sutherland; and Aberdeenshire and Moray)
- QOF or SIMD data (Dufftown and Shetland Phase 2)
- Transfer of approach to a neighbouring area (Rothes).

Comparing the target areas to the QOF indicators suggests that the local programmes are generally focused on areas where the indicators show that the health risk is higher than the average for Scotland.

Local programmes also used a range of criteria used in determining the target populations in each local area. In relation to **age**, the two Healthy Weight programmes; the North West Sutherland long term conditions programme; and the Shetland programmes were for people over sixteen. Dufftown targeted 16 to 65 year olds, while Rothes targeted 40 to 65 year olds – as did North West Sutherland and Orkney. Western Isles targeted 40 to 69 year olds.

In relation to other criteria for selecting target populations:

- Dufftown and Rothes targeted those with existing conditions
- Dufftown and Rothes and Orkney targeted smokers
- Dufftown and Orkney targeted those with a family risk history
- four programmes targeted those with no recent contact with the GP
- within Western Isles individual GPs prioritised particular groups within their practice for the initial round of checks.

Local programmes had a high degree of autonomy in selecting the most appropriate approaches. Decisions were made using local intelligence – both in relation to the anticipatory care approaches already delivered and also the local priority areas and targets. The range of different approaches has been a strength of the regional programme. The local reasons for coming to decisions about targeting were not always captured, which could give the impression that decisions were not strategic. Also the wide variety of target areas and target populations makes comparison across programmes more difficult.

This makes it important that local programmes do gather and collate information about progress to achieving their local outcomes. The effort put into gathering and collating the information needs to be proportionate to the size of the target population. Smaller programmes are not likely to develop as sophisticated data management systems as larger programmes.

8.3 Activities undertaken

The main focus of the Well North programme has been the delivery of **health checks**. Over 6,200 health checks have been delivered. Given the dispersed populations and the fact that most programmes have been undertaking health checks for two years or less, the number of people that has attended a health check is a significant achievement.

Using a dedicated team to carry out the health checks allowed expertise to be developed; provided a concentrated effort over a period of time (with large volumes of health checks undertaken); given a clear management focus; and is less affected by seasonal and other pressures (like flu jabs). Building health checks into the work of existing practice and community nurses engages nurses in anticipatory care; provides a varied job and uses (and builds) local knowledge. It was seen to empower nurses and to be sustainable as it uses existing resources. Both these approaches have worked well – and either could be used in future programmes.

Taken together, the five programmes delivering health checks have made a significant contribution to targeting and engaging people in anticipatory care. One of

the main benefits of the health check was the time allocated – ranging from 40 minutes to an hour for each check.

Two of the programmes focused on **healthy weight**. It is difficult to identify the impact that the Healthy Weight programmes in Aberdeenshire and Moray and Skye and Lochalsh have had. In the case of Aberdeenshire and Moray, this is because the programme is not gathering information about its inputs and outputs and any information about the Well North supported programme has not been separated from Grampian wide figures. In the case of Skye and Lochalsh this is because the programme engaged GPs and the community before the staff resources were in place. Difficulties and delays in staff appointments meant that any initial interest had been reduced by the time that staff were in post. There is now a community focused Steering Group and work is underway to link community organisations and public and voluntary agencies in tackling weight issues in the area. Any outcomes will take some time to achieve.

One programme (North West Sutherland) included a focus on **long term conditions** (and particularly reducing re-admissions to hospital). This incorporated a significant programme of training for the nurses involved. In our discussions with stakeholders in North West Sutherland we got a sense that anticipatory care was becoming embedded in the thinking of staff throughout their work, much more so than in other areas.

There appears to us to be scope for considering long term conditions as part of anticipatory care programmes in other areas.

Community consultation and engagement was a feature of the Dufftown and Skye and Lochalsh programmes. In Dufftown, the early involvement of a well-respected local social enterprise to work with the community was seen as an important step. Both staff and community organisations believe that the approach has had an impact on health awareness and participation in the area (shown, for example, in an increase in physical activity and the community volunteers becoming involved in sustaining the local gym, which was under threat due to reduced Council resources). They also believe that the increased health awareness has led to a greater uptake of health checks.

In Skye and Lochalsh, community engagement and development are currently less advanced. The approach here was for the local Well North programme to employ a dedicated community worker. There were delays in achieving this and in attracting staff with the relevant skill set.

From the experience of these two programmes it appears that partnering with an established community organisation or social enterprise to undertake community consultation and development has significant advantages in terms of making an early start and in building community confidence in the approach.

Giving priority to **training** brought benefits in North West Sutherland – by increasing skills and confidence; and building opportunities to share skills through peer support across the five practices. Ensuring that there is time for training (and the associated

travel, which can be significant) built into programmes is important. It is also necessary to consider training for new members of staff.

8.4 Engaging service users

All the programmes delivering health checks used more than one approach to encouraging service users to engage. The most common approaches were letters followed up by telephone calls. In addition, some programmes used additional techniques – press articles and newsletters to raise awareness; community events and community development activities; working with other public agencies and voluntary organisations; extending appointments into evenings or weekends; and, in one case, direct visits from practice staff to encourage attendance.

Local programmes have used different approaches to encourage engagement which are seen locally to have been appropriate.

The use of community venues to undertake health checks; the provision of health checks in evenings and at weekends; and the use of community consultation and engagement were all seen to be effective approaches.

At the end of January, 6,239 health checks had been undertaken (57% of the target population). By March 2011 it is estimated that 61% of the target group in Well North will have received a health check. Given the stage of the programmes this compares well with the 58.5% engagement figure reported in Phase 1 of Keep Well.

The current approaches, if continued, will further increase the engagement level in Well North. But stakeholders made clear to us that additional approaches would be required as the numbers remaining to be engaged became smaller. Consideration was being given to organising health checks at the workplaces of larger employers; at locations where people gathered (for example the auction markets); and in conjunction with voluntary sector organisations. And consideration was being given to new approaches to awareness raising, including the use of social marketing.

Stakeholders were clear that the current phase of activity around health checks had engaged many people who would not have been involved otherwise. And 35% of those undertaking a health check (2,209 people) were identified as having a risk – and referred for further support and advice.

We believe that the programmes will need to extend their current approaches to make sure that significant numbers of those who have not been engaged so far are to be encouraged to take part. Sharing information among the programmes about approaches to engagement would be valuable.

Feedback from service users who had not taken part in the health checks gave two main reasons for not engaging. The first was working patterns and lack of time for taking care of health generally. The second was the view that as they felt well, there was no value in having a health check. Transport was only rarely mentioned as a barrier. Childcare was not seen as a barrier.

Stakeholders also suggested that if people know that the health checks are targeted at the communities suffering the greatest deprivation, people may feel stigmatised about being invited to or attending a health check.

It will be important that, in the future, information is gathered about health and lifestyle changes for patients attending a health check. This would provide information on the health benefits of conducting health checks. The follow-up health checks being carried out in Dufftown and Rothes will provide useful information.

8.5 Engaging the NHS

Nurses have been the key resource in delivering Well North. They spoke positively about the benefits of the programme for patients in terms of the provision of lifestyle advice and referrals – and some emerging changes in behaviours. They also spoke positively about how an anticipatory care approach was appropriate for their work – and about the training and development of skills that the programmes had encouraged.

The involvement of GPs in the initiative has been seen as extremely valuable, where it happens. GPs were generally more likely to be strongly supportive in smaller, more remote practices. However, stakeholders acknowledged that many other GPs were not particularly engaged in the programme.

It had proved difficult to persuade some GPs that anticipatory care should be a priority – among a wide range of initiatives that GPs are asked to support. Given the crucial local role that GPs play in delivering health care, it is important to increase their commitment to anticipatory care over time. This will require ongoing awareness raising as well as a sound evidence base about the benefits of anticipatory care.

More generally, we heard from a number of programmes that the day-to-day pressures of reacting to poor health made it difficult for prevention and early intervention to be given priority in terms of financial and staff resources. Moving resources from reactive approaches to early intervention proved difficult generally. But this will be required to deliver a fully effective anticipatory care programme.

There are some lessons for Health Boards about the effective planning of new programmes. A number of programmes found that the set-up time was longer than they had originally planned because of a range of issues including identifying appropriate staff; resolving local governance arrangements; reaching agreements with practices; and clarifying roles and responsibilities. Any future programmes should make sure that sufficient time is allowed to make sure that the staff and resources are in place in advance of planned start dates for delivery.

In raising awareness, it is important that the level of health risks identified through this approach is made clear. Over time, it will be necessary to demonstrate that the identification of health risks does lead to a change in lifestyle for a significant number of service users. This was not intended to be a focus of this stage of the Well North programme, which focused on targeting and engagement. But it will be important in informing future strategic decisions about health strategies.

8.6 Learning

The seven Well North programmes have been coordinated through the North of Scotland Public Health Network. Programmes have been able to learn from one another, and share practice as a result of the collaboration across the five Health Board areas. Innovative approaches adopted in some areas, have already been taken up in others. Programmes have trained one another, shared skills and provided peer support. This has been a real strength in the Well North approach.

There are particular challenges as a result of the large, rural and remote areas that these Health Boards cover. Travel to face to face meetings is challenging, particularly in the current financial climate. Video conferencing has been used to make sure that ongoing communication and learning was maintained.

Some programmes have been more actively involved in learning than others. Those that have been less involved have, we believe, missed opportunities and should be encouraged to maintain contact.

Given the learning to date from Well North there are some basic support tools (such as standard protocols; model Local Enhanced Service agreements; reporting formats and some elements of IT) which might usefully be developed and shared across the programmes.

A lot of information has been gathered by programmes – although this has not always been gathered and collated on a similar basis. It seems to us to be essential to consolidate and develop consistent data about the programme.

In addition, this phase of the Well North programme has focused on targeting and engagement. In our view, any future phase should also begin to gather data about the changes for service users. In Dufftown, follow up health checks are being carried out after six months and a year. This should provide evidence of the short-term changes brought about by involvement in health checks. It may also be possible in other areas over time to gather data from GP records, at least for a sample of those who have attended health checks.

9. Lessons for the future

Given the variety of local approaches; the different scales and timescales of each of the programmes; and the absence of comparable data for all the programmes, it is not possible to set out simply what worked and what did not work. This section is based on the lessons from the seven programmes, and sets out a number of factors that should be considered in the development of future approaches to anticipatory care in rural and remote areas.

Generally:

1. **Local autonomy is important.** The advantages of local decision making based on local intelligence include the ability to build on previous work done in the area; knowledge of patients and the local community; and the opportunity to build on existing relationships between health professionals.

2. **Carefully consider all the options at the start.** When local programmes are asked to submit proposals for the allocation of resources, the proposal document could usefully begin with a short options section. This would ensure that a range of approaches had been considered, before deciding on the approach which was felt to be the most appropriate to the local situation.

3. **Focus on health inequalities in rural and remote areas.** At present there is not enough information about deprivation in rural and remote areas to allow targeting by geographic area. Using indicators (such as the QOF indicators) allied to local intelligence can help identify areas which are likely to benefit from anticipatory care. As data is gathered about those who are engaged, this should inform future approaches to tackling health inequalities in rural and remote areas.

4. **Maximise the engagement of GPs.** Where GPs were committed to the approach, considerable progress could be made. Some GPs had not been convinced of the benefits and their lack of involvement had an effect on the delivery of the programme. Given the crucial local role that GPs play in delivering health care, it is important to explore ways to increase their commitment to anticipatory care over time. This will require ongoing awareness raising as well as a sound evidence base about the benefits of anticipatory care.

5. **Allow time for planning and getting staff and resources in place.** There were some unanticipated delays in staff appointments (related to attracting appropriate staff to work in remote rural areas). It is important to allow sufficient time to make sure that the staff and resources are in place in advance of planned start dates for delivery. Ensuring that there is time for training (and the associated travel, which can be significant) built into programmes is also important.

6. **Consider whether there are common resources that could be used across regional programmes**. Given the learning to date from Well North there are some basic support tools (such as standard protocols; model Local Enhanced Service agreements; data gathering and reporting formats; and some elements of IT) which might usefully be developed and shared across the programmes, without detracting from their autonomy.

In relation to health checks:

7. **Consider whether health checks are delivered by a dedicated team or by exiting staff.** A dedicated team of staff undertaking health checks can develop specialist skills and save on management and co-ordination time. Building anticipatory care into the work of existing nurses was seen to be motivational and provides a more rounded work experience. Both approaches are relevant.

8. **Develop a range of approaches for engaging patients in health checks.** There have been high levels of engagement – over 6,200 health checks (57% of the target population) had been carried out by January 2011. Over 2,200 individuals with health risks have been identified and referred for advice or support. This level of engagement has involved initial contact with patients by letter; follow up phone calls; some element of awareness raising through, for example, the local press and newsletters; in most areas, the provision of health checks out of office hours; and, in one programme, the delivery of health checks in community venues.

9. **Additional methods of engagement are likely to be needed.** To move forward from the very good engagement levels achieved so far will need not only a continuation of the present approaches but also a widening of engagement methods. These might include greater use of non – surgery settings for checks (like community venues; workplaces; or markets); increased use of social marketing; and joint work with other public agencies and voluntary organisations.

10. **Allow sufficient time for the health checks.** The Well North health checks took at least 40 minutes, and in some cases, an hour was allowed. This length of time was important to carry out the tests and provide lifestyle advice. The time allowed for the health check was significantly longer than a 'typical' appointment at a practice. This meant that patients often were able to talk about issues that had been worrying them.

11. **Programmes involved in health checks should all gather standard core data.** Although minimum data for each of the local programmes was agreed, this was not always collected and collated. In any future programmes there should be a commitment to gathering standard core data. The requirements should be proportionate to the size of programmes.

12. **It would be useful to gather information on changes in health and lifestyle**. The Well North programme was intended to identify target populations and increase engagement. As a result, there is limited evidence of the short-term changes to health risks and lifestyles that occur for patients following the health check. This information could in future usefully be gathered through follow up health checks (as in Dufftown) or by analysing a sample of GP records.

In relation to long term conditions:

13. **Anticipatory care programmes should consider long term conditions.** Only one of the local programmes included a focus on long term conditions (and the reduction in hospital re-admissions). This has had a positive impact on the way that nurses and others go about their work and improved joint work with other public agencies and voluntary organisations.

In relation to community engagement:

14. **Consider partnering with existing voluntary organisations or social enterprises.** The programme in Dufftown has worked with a local social enterprise to consult with and engage the community. Local stakeholders have seen significant increases in awareness and engagement as a result of this approach. Working with an established local voluntary organisation may have benefits over employing a dedicated member of staff to work with the community. This can take time and it may be hard to identify people with the right skill set.

Appendix 1
Aberdeenshire and Moray Healthy Weight: Profile

Target population – reason for choice	**Overweight or obese adults living (or working) in four communities in Aberdeenshire and two in Moray.** The geographic communities were chosen because they experience significant challenges accessing services – due to geography or a lack of services: • **Huntly, Aberdeenshire –** has a new community kitchen • **Rothes, (Moray) -** a remote community • **Lhanbryde (Moray) –** has no GP practice • **Cruden Bay, Peterhead (Aberdeenshire) -** a coastal community • **Mintlaw, Peterhead (Aberdeenshire) –** inland community with a monthly visit by dieticians • **Hatton, Peterhead (Aberdeenshire)** – a community with few referrals to dietetics service.
Target population – size and characteristics	Not known
Inputs	**The programme received a total of £59,200 in 2008/09; £62,700 in 2009/10 and £40,000 in 2010/11**. Funds from previous years have been carried over. In kind support has been provided by the Band 7 Weight Management Dietician.
Interventions and approaches used	**Healthy Helpings – a group support programme already delivered in communities across NHS Grampian – has been the main intervention funded as part of the programme.** As part of wider work within NHS Grampian, an Adult Integrated Care Weight Management Pathway in Grampian has been developed and is being implemented. Healthy Helpings is viewed as a key intervention which should be offered to clients before referring to community dieticians. As a result, the community dieticians have changed their role and now intervene later and use a behavioural change model. **Healthy Helpings** Healthy Helpings is an eight week support programme for obese or overweight adults. Clients are initially referred by a GP, health professional or self-refer. Clients attend one session a week in a local venue where they learn about healthy eating and develop skills to lose weight and maintain weight loss.

	Clients are weighed at the start and the end of the programme. **Community Pharmacy Pilot** A pilot project within community pharmacies has begun as part of Well North for the weight maintenance strand of weight management interventions. As data was in short supply for the first part of the pilot, a no cost extension has recently been agreed. **Further Support** As part of the Integrated Care Pathway, clients can receive further one-to-one support from a community dietician. By first referring clients to Healthy Helpings it is hoped that this will release resources from the community dietetic services and improve support to clients who really need more intensive support.
Number of people from target group engaged (invitations and acceptances)	**We have been advised by the Coordinator that it is not possible to extract accurate Well North data from the wider Healthy Helpings data.** However, they estimate that 26 people accessed the sessions in 2009 – 2010 and 23 in 2010 – 2011. In October 2010 Healthy Helpings had a two month waiting list. As a result, they have stopped actively promoting the service but will send information out to GPs when asked. As an interim measure, the Community dietetics service has agreed to deliver some Healthy Helpings sessions.
Risks identified	Not applicable
Changes for patients	**We have been advised by the coordinator that it is not possible to extract Well North data from the wider Healthy Helpings because of immature data collection systems.**
Changes for staff	There is anecdotal evidence that Healthy Helpings has reduced pressure on community dietician services. This means waiting times can be reduced and dietician time is used more effectively. In the areas where Healthy Helpings is being delivered, GPs have increased referral options. Counterweight® is another integral component of Practice weight management. The recent involvement of the community dieticians in delivering Healthy Helpings has improved their knowledge and understanding of the programme.

Lessons learned	Developing a project or programme like this requires time and resources – with hindsight, it would have been helpful to have a dedicated coordinator. Delivering the project requires skilled and dedicated staff and there have been real challenges recruiting staff because of a recruitment freeze within NHS Grampian. There are practical issues in organising and delivering services in community settings – finding suitable venues has been a real challenge in these areas. Some health professionals do not see healthy weight as a key responsibility for them. This impacts on how an integrated programme can be developed. This may be due to a lack of targets within their performance management frameworks, and a lack of reward for engagement. Delivering the project in areas where the population is quite dispersed means that uptake can be much lower than in a more intensely populated area. As a result, group work has not been feasible in some areas. It may have been beneficial to have a wider and more strategic discussion about the 'fit' of the project and potential strategic links. In particular, it may have been beneficial to explore at a strategic level how anticipatory care should be delivered across Grampian and how a range of health care professionals could be involved in delivery. More thought could have been given to how best to adapt a universal service for a rural area, and how to engage the most disadvantaged people in the target communities.

Appendix 2
Dufftown and Rothes: Profile

Target population – reason for choice	**In Dufftown - people aged 16 or over who have a family history of, or have been diagnosed with, the following:** • BMI of more than 30 • smoking • COPD • mild to moderate depression • hypertension, asthma or rheumatoid arthritis • children under 10 and likely to develop health needs. The wider community engagement and health promotion work targets all members of the community aged 16 and over. The aim was to create 'A Self Caring Community'. **In Rothes - people aged 40 to 65 who:** • have poor attendance at the practice • smoke • are overweight • have alcohol or mental health problems. The initiative began in Dufftown. Data from the Quality and Outcomes Framework (QOF) showed that there was a higher incidence of high blood pressure, obesity, diabetes, smoking and cardiovascular disease in the Dufftown and Rothes area compared with local and national averages. Scottish Neighbourhood Statistics also indicated that average for suicide rates and deaths from stroke were higher than average in the Dufftown area. The area is remote and rural. Dufftown was also chosen because NHS Moray staff had good links with the GP in Dufftown, with positive working relationships. The GP surgery was already piloting a 'telecare' initiative for people with high blood pressure, and Well North was seen as complementing this activity. Initially, the Dufftown project aimed to target people who were on benefits, unemployed or living in inadequate or poor housing. However, the surgery was not able to identify a way of targeting these households. In early 2010, the project was set up in Rothes. The health visitor was very keen on the approach. She had undertaken a small number of health checks for the project

	in Dufftown, and also already ran similar 'Well Person' health checks at the Rothes practice. The target group in Rothes is smaller than in Dufftown because this was set up later and there was only a relatively short period of time before the end of the project. The practice also felt that if they targeted under 40s it would be difficult to get people to attend, as they would be at work. The detailed targeting was developed through joint working with both GPs.
Target population – size and characteristics	**In Dufftown, 1,085 people fell into the two target groups.** The practice population is 2,444. The practice identified 414 people at risk of poor health, and a further 671 people in the target group with diagnosed poor health. There are 996 cases of diagnosed COPD, depression, hypertension, asthma or rheumatoid arthritis. Four hundred and fifty six patients have diagnosed hypertension, 268 have depression and 231 have asthma. However, all people aged 16 and over were considered part of the target group for wider community activity. **In Rothes, 141 people fell into the four priority categories.** Individuals in both practices were identified using the general practice VISION data collection tool, practice population information and local knowledge. Some information could be extracted easily, but some involved more manual counts (for example to identify families with young children). In Dufftown, temporary administrative support was needed to undertake this manual (paper) search. Both practices indicated that local knowledge was very helpful in identifying potentially at risk patients. One practice indicated that its new management system (introduced in 2007) helped greatly in identifying patients to target.
Inputs	**The programme has cost £192,000 over three years.** The main costs of the programme were initially intended to relate to: • patient information centre (£28,500) • community consultation (£17,500)

	• equipment for monitoring blood pressure (£10,000) • Health Improvement Officer (£20,000) • Community nurse (£11,000) • GP costs (£4,000) The community consultation element of the work was undertaken by REAP (Rural Environmental Action Project), a local social enterprise and community partner in North Well. Some funding has been diverted to appoint two bank nurses since September 2009. This was required to provide dedicated staff to undertake and co-ordinate the health checks. At each practice, the GP, practice manager, and practice and bank nurses have dedicated time to participating in a project Steering Group. There have also been in kind contributions. Interested and dedicated members of the local community have invested their time in attending the wider stakeholder group for the programme.
Interventions and approaches used	**The programme has taken a community development approach to the health checks and wider health promotion activity.** The programme aimed to raise awareness of health issues, deliver health checks, bring the community together in a sustainable way and inform primary care redesign. Partners developed a logic model, explaining the activities and short, medium and longer term outcomes that these should lead to. The programme has involved key elements of work, including: **Community Consultation** – The Dufftown programme involved extensive awareness raising and consultation from February 2008 onwards. This consultation involved exploring views on health, and awareness and interest in Well North. It included public meetings to launch the initiative and establish interest in community participation in a Stakeholder Group, and questionnaires in venues like pubs and shops. The consultation focused on capturing the views of the public, including 'hard to reach' individuals. This consultation helped to influence the programme. For example, it found that clinic hours during the day were only

	suitable for around a third of consultees – so evening appointments were introduced. A stakeholder group of interested community members was also established in Dufftown. This group influenced how the programme developed. For example it pressed hard for a cholesterol check to be included in the health check, and it was. It also contributed to awareness raising activity and event organisation. In Rothes the health checks began in April 2010, before community consultation. The consultation took place at a later date (October 2010) and involved face to face interviews or paper surveys with 76 people. **Mapping and Signposting** – Well North undertook a mapping exercise of existing groups, services and resources in and around Dufftown, and produced a Dufftown Directory. This includes health services, as well as wider services such as housing and financial advice. This was produced by a partnership between NHS Highland, Moray Council and REAP. It was later expanded to cover the whole of Moray. **Health Promotion** - A new Patient Information Centre was set up in Dufftown Health Centre, where people can access free leaflets on health issues and use the free Healthline number. Well North also ran wider events and activities, including: • a community ceilidh, linked to healthy eating and active lifestyles; • tasters of local activities, such as jogging, cooking, dance and cycling; • school competitions to design logos and bookmarks with healthy messages; • Well North stalls at other events to raise awareness of health; and • a quarterly newsletter – raising awareness and promoting health. **Health Checks** – Since January 2009, health checks have been offered in Dufftown. Originally the Dufftown clinic ran once a week (during the day) but since September 2009 it has run six times a week - in the mornings, afternoons and evenings. Since April 2010, health checks have been offered in Rothes. The Rothes clinic runs one afternoon a week. **Skills Development** – Practice and bank nurses have

	been offered training on topics such as behaviour change, health inequalities, engaging hard to reach groups and motivational interviewing. Well North has also funded training opportunities for local groups, such as walking and running groups. It has also committed to funding training opportunities for volunteers who are getting involved in sustaining the local gym, which was under threat due to reduced council resources. **Piloting New Approaches** - The Well North initiative provided funding for equipment to pilot a new approach to monitoring blood pressure. Fifty people aged 40 to 60 with established hypertension took part in a 'telehealth' pilot using electronic blood pressure machines, rather than attending the GP practice. This funding helped to encourage the GP practice to participate in the Well North initiative. **Encouraging Wider Activity** – In 2009 the Well North programme informed the development of the Anticipatory Care in Community Pharmacies health check initiative covering five pharmacies in Elgin, Lhanbryde and Buckie. This initiative is targeted at areas in the 20% most deprived according to the Scottish Index of Multiple Deprivation.
Number of people from target group engaged (invitations and acceptances)	**At the end of January 2011, a total of 533 people had received an initial health check in Dufftown, and 99 in Rothes.** **This is 49% of the target group in Dufftown and 70% in Rothes. In addition, 195 people in Dufftown have received follow up health checks.** Since January 2009, the Dufftown clinic has undertaken 728 health checks. Of these, 533 were initial health checks, and 195 were follow up checks undertaken after 6 months and a year, to explore progress. The project aims to undertake a second follow up check after a further six months, but has not yet reached this stage in the project. Originally the number of people invited for health checks was recorded. Between January and September 2009, 161 were invited, of which 125 accepted and attended (78%). The Rothes clinic has undertaken 99 checks since April 2010. Information on the number of people invited for a health check is not available. It has not undertaken – or intended to undertake - any follow up health checks.

	In Dufftown, the health checks began in January 2009. The practice initially sent letters to invite people to attend a health check. However, there was a relatively poor response. Many patients did not call to cancel their allocated appointment, causing frustration for the nurses who had very limited capacity to undertake health checks. It was difficult to encourage people to attend as all health checks took place during the day, and patients could only be contacted by phone during the day, therefore missing much of the working population. In the first two months, only 11 health checks were undertaken. Since September 2009, dedicated bank nurses have phoned people to invite them to attend a health check, or spoken with them face to face (when in the practice). This has worked much more effectively. There is real value in a nurse calling, as she can address any immediate questions over the phone. In Dufftown, more than 70 per cent of people agreed to come along for the first health check. Around 50 per cent came back for the second health check, six months to a year later. Uptake has also increased since (in September 2009) the clinic hours were changed from afternoon sessions, to morning, afternoon and evening appointments. This resulted in significantly increased demand, and a waiting list for evening appointments. The introduction of flexible bank nurses, able to work in the evening, has been a key success factor in Dufftown. Before this, the sessions only ran on a Wednesday afternoon, but not every week. Now, the bank nurses are dedicated to the health checks, and have more time to prepare, follow up and encourage people to attend appointments. Initially, the bank nurses were intended to supplement existing nurse time. However, community nurses have had to withdraw from the health checks due to other priorities – including flu jabs. In Dufftown, a number of patients were un-contactable as their phone number had changed. Letters were sent, but few responded to these. In Rothes, the health checks are offered during the day, one afternoon a week. The health visitor issues a letter inviting people to attend at a specific time slot. She calls round two days before, to encourage people to attend. This helped to significantly increase attendance rates.

	Older people are slightly more likely to attend, but some people who work arrange to come in for a health check on their holidays.
Risks identified	**Health Checks** Between January 2009 and December 2010, 514 checks were undertaken in Dufftown. Of these, 29 (6%) were found to have high cholesterol and were referred to the GP. Twelve (2%) smokers were referred to the GP for smoking cessation support. Thirty (6%) were found to have raised blood pressure, and were referred to the practice nurse. Five (1%) had glucose in their urine sample and were referred to the practice nurse. At least 78 (24%) were found to have a BMI of greater than 30. There was an issue about referrals for weight management, with limited referral sources. So: • 27 were referred to Healthy Helpings, but this programme was discontinued • two were referred to Jog Scotland • four were referred to Walk Moray • three were advised to join the gym • eight were referred to Slimmer's World. In addition, 16 (3%) were made aware of the adult literacy service, 4 (1%) were made aware of Living Life to the Full, and one was referred to Victim Support. This information is not available for Rothes. **Identifying Risk** In Dufftown, initially, patients with certain risk factors – such as high cholesterol or high blood pressure – were all referred to the GP or practice nurse for further tests. However, the practice has started using the patient's 'assigned score' to gauge cumulative risk. This takes account of a range of factors, including postcode, to assign a risk score. Scores over 20 are referred to the GP. This practice believes that this method of referral is a bit more scientific. **Signposting to Other Services** It can be challenging in remote, rural communities to identify suitable sources of support. In some cases services don't exist, have ceased to operate, have a waiting list, or charge. There is not always good communication – for example Healthy Helpings stopped, but the nurses were not told until a patient (who had been signposted to the service) alerted them. There are also barriers around transport, as having to travel to other

	areas puts people off and is an additional cost. North Well has resulted in some more local sources of signposting. For example, it has supported Jog Scotland groups (for walking, jogging and running) in Dufftown, and is helping to establish a group in Rothes. **Community Consultation** Twenty-five people in Dufftown - identified by community consultation - were signposted to groups covering activities like walking, cycling, cooking classes or tennis. Membership of the local Jog Scotland group increased from 14 to 23 as a result of a community 'taster' event as part of Well North.
Changes for patients	**Health Check Outcomes** The health outcomes for patients are not systematically recorded. However, in Dufftown the health checks have resulted in at least: • five patients beginning to take drugs to manage their cholesterol and 18 are managing their condition through diet and exercise; • twelve patients considered reducing their smoking - three are known to have stopped smoking and one has reduced use of nicotine replacement • nine patients are attending physical activity regularly as a result of referrals • eight patients are attending classes to get support with weight management. This information is not available for Rothes. **Patient Feedback** Patients attending the second health check in Dufftown generally say that they have increased exercise levels, changed their diet, reduced alcohol consumption or stopped smoking. However, the nurses recognise that it is difficult to establish whether people are just talking about these changes, or if they have actually made them. About half of those receiving an initial health check return for their second check. Anecdotal evidence from four patients, who wrote to the GP practices, suggests that the health checks have helped people to: • gain confidence to attended routine check-ups • lose weight (attending slimming classes or the gym) • reduce alcohol intake • eat more healthily and reduce salt and portion sizes • become more aware of their health.

	Monitoring and Managing Blood Pressure As part of Well North, 50 people took part in a hypertension pilot project. Of the 33 still participating in the project, 70% had improved or maintained their blood pressure. All felt more responsible for their blood pressure and felt that this method of measuring their blood pressure was more convenient. The pilot also increased patient awareness of their health more generally. The pilot has also found that many people are not hypertensive – their blood pressure increases because they are scared or worried by the GP surgery. This has saved individuals money on life insurance. **Wider Health Promotion** Well North has supported local groups, like the local Jog Scotland group – through training, advice and equipment. The volunteer coordinator of the group feels that 'it wouldn't exist without Well North'. The group now has 25 to 30 members, who attend on a weekly basis. The Stakeholder Group felt that Well North had resulted in people becoming more interested in health, healthy eating and exercise. People appear to be walking, jogging and cycling more – although there may be wider factors such as employers encouraging cycling to work.
Changes for staff	**Health Checks** The health checks have a minimal impact on the GPs. However, both practices have developed more links with other organisations and services, and have information more readily available for patients. Nurses suggest that the health checks have resulted in some increased trust and willingness to attend GP appointments. People open up to the nurses who have plenty of time (an hour) to talk about issues. Often people have come for a health check because they are worried about something which is not to do with the check itself, but is a specific health issue. There have also been referrals of patients attending for health checks to the GPs. This has increased workloads slightly, but not significantly. **Hypertension Pilot** An interim evaluation of the hypertension pilot found that the cost of supporting patients with hypertension can be reduced through patients monitoring their own blood pressure at home. The pilot has saved money on regular

	blood pressure monitoring for patients with hypertension, which is usually undertaken by a nurse. The pilot has now been incorporated into routine practice for diagnosing hypertension. Normally, a nurse would do three separate blood pressure measures. Now, the patients do this at home.
Lessons learned	**Getting Started** • It has been challenging to engage GPs in the initiative, as they were worried about additional workload. To encourage GPs, the NHS emphasised the potential long term savings in primary care input. It was also flexible in how financial support was used – for example to assist with a pilot that the GP surgery wanted to run. • Involving a senior and respected GP, who is seen as a role model, has helped to encourage other GPs to become involved. • In the future, GPs could be encouraged through robust evidence about the long term impact of anticipatory care, and key outcomes at each stage. • After nine months of planning, GP practices realised that the time dedicated to Well North would replace core services. This caused significant concerns, and negotiations had to take place about the amount of nurse time dedicated to the initiative. This highlighted lessons around effective communication. **Targeting** • In Dufftown, there don't appear to have been negative reactions to a targeted health check. People were generally positive about the initiative, and pleased to see funding going into the Dufftown area. However, although health checks have been targeted at priority groups, the initiative does cover everyone aged 16 and over in the community. • In Rothes, there is concern that targeting may be viewed negatively. The targeting is much tighter in Rothes, partly because the programme launched later. The practice does not tell people about how the health checks are targeted, as there is an issue of anonymity and people don't think of themselves as deprived. • Sometimes the information held in GP databases has not been accurate (or up to date). Local knowledge can really help in identifying at risk patients. **Encouraging Attendance** • Many people in Moray work shifts, and have busy working lives. Evening appointments made the health checks more accessible to a wide range of people.

	Consultation found that around two thirds could not attend appointments during the day. • It was challenging to free up nurse time to undertake health checks, and clinics initially could only take place once a week (irregularly). • Dedicated staff – who can manage and coordinate the process – resulted in an increase in attendance, and increased availability of health checks. • Phone calls have been the most effective method of encouraging people to attend health checks. Letters alone result in a lower response rate. • It is worth following up those who do not attend. Often a reminder phone call will encourage them to attend. • An information leaflet, to inform people about the health check process, has helped people to feel clearer about what to expect. • One practice has found that often NHS staff – who should set a good example – do not come for health checks. • It can be useful to encourage people face to face – for example when they attend the GP or register. **Health Checks** • Many people do not know about the personal benefits of leading a healthy lifestyle, and the personal consequences of not doing so. • In a nurse's words – 'nurses tend to be bossy'. The motivational interviewing training has helped those doing the health checks to change their approach, and assist people to come up with their own solutions. • There is potential to do other tests as part of the health check – such as considering oral health, testing urine for infections, etc. But this needs to be balanced with the resources available. • There have been challenges identifying suitable signposting and referral sources – with particular gaps around weight management and smoking services. • There is potential for enhanced referral, rather than signposting. Nurses could book people in for appointments, which may encourage them to follow through on recommendations. • In one practice the survey on mental health is anonymised, and never reviewed. Patients may think nurses are aware of mental health issues as they fill the survey in, but the nurses never get to see it. **Community Engagement** • Community engagement has widened participation and

	raised the profile of Well North. It has influenced how the programme is delivered – particularly the timing of health check sessions. • Well North has been able to adapt to findings from community consultation, appointing bank nurses to allow for flexible working hours and evening appointments. **Learning from Experience** • Sometimes decisions have been made centrally, rather than by the Steering or Stakeholder Groups. For example the decision to hold two local events wasn't taken locally. Local people felt that if everyone had been involved in the decision, they would have felt differently about the events. • Some approaches to community engagement haven't worked. For example, they tried to run a Wii Challenge, to encourage activity, but very few people were interested. • There was some concern about including a step test in the health check. Nurses felt that they did not have the skills to do this test, and that it was very time consuming. This element was removed in mid 2009. • Initially, the Friday clinic hours did not fit with the deadline for samples to be collected for analysis. These had to be adapted, as samples could not remain in the clinic over the weekend. **Sustainability** • Stakeholders have seen the inequalities gap in Moray increasing, rather than reducing. There will be ongoing demand for initiatives like this. • However, with inequalities increasing, people will be worried about other issues besides their health. It may be difficult to encourage people to prioritise health. **Success Factors** • New IT systems within GP practices made it much easier to get the data for targeting. 'The quality of data is essential'. • The Dufftown practice couldn't have absorbed the project within the practice. The bank nurses could be flexible in working hours, and could dedicate the time to organising and undertaking the checks. • The project manager has communicated very effectively with GP practices and other stakeholders.

Appendix 3
North West Sutherland: Profile

Target population – reason for choice	**The target population is patients in the five practices in North West Sutherland Local Health Partnership who are either:** • **identified by SPARRA as being 30% risk or higher of re-admission to hospital within the next 12 months** • **people aged between 40 and 65.** Initial priority is being given to those aged 45 – 65 who have not visited their GP in the last year.
Target population – size and characteristics	**There are 80 people who have been identified as a high risk of hospital admission and 1,380 people aged between 40 and 65.** The number of those in the target group aged 40 – 65 will be reduced to take account of those receiving palliative care and those on the Chronic Disease Register as the health position of these people is already well known.
Inputs	**The programme has been allocated £132,200 from the Scottish Government over three years.**
Interventions and approaches used	**The main approaches have been:** • **a formalised multi agency approach to avoiding hospital re-admissions** • **health checks for people aged between 40 and 65.** **Multi agency meetings** The aim is to bring together GPs; community nurses; social work; voluntary sector; physiotherapists and occupational therapists to discuss the highest risk cases, where if there was no intervention, the person was 30% more likely to end up in hospital. There are small numbers of people involved – probably between 5 and 15 in each practice. Not all the practices are yet using the formal approach. The system is fully bedded down in two practices. There is a disinclination to formalise the arrangements and to keep formal reports. One reason for this is that there are similarities between the SPARRA approach and the Single Shared Assessment, which some practices were involved in with social work. And shortly after they started promoting SPARRA in North West Sutherland, Highland NHS rolled out Anticipatory Care Patient Alert across the

	Board area. Again this was similar – but each approach used different forms and reporting arrangements. Understandably, this has created some confusion and resistance in the surgeries. **Health Checks** The health check comprises measurements of height and weight, a calculation of Body Mass Index (BMI), blood pressure reading, blood tests (for identification of Diabetes or raised cholesterol) and dietary/physical activity questionnaires. ABI is given if appropriate. A CVD risk score is assessed, and lifestyle advice is offered. Appropriate referrals are made, for example, to the GP, Counterweight®, smoking cessation, literacy support or for employment and benefits advice. The health checks are carried out by practice nurses or community nurses in surgeries. Health checks can be undertaken at weekends (which is seen as helpful for those who were working) – with times offered on both Saturdays and Sundays. There were still some people who it was difficult to engage – but here, word of mouth from family, neighbours and friends had proved to be important. Carrying out the health checks was an additional task for hard pressed nurses – but one where they could see real benefits as the use of existing staff: • embedding anticipatory care into the day to day work of practices and community nurses • providing a more varied job • helping to empower nurses. Although the target group is all people between 40 and 65, checks are being carried out in the following order of priority: • People between the ages of 45-65, who have not been seen by their GP in the past 12 months. • The remainder of people in this age group. • People between the ages of 40 – 44 years. The approach to the health checks is to send an introductory letter and to follow this up with a phone call to those who do not respond. In the initial letter, some practices invited people to contact the surgery to make an appointment – others set a time for the appointment.

Number of people from target group engaged (invitations and acceptances)	**375 health checks had been undertaken by January 2011.** This amounts to at least 27% of the target population.
Risks identified	**Using figures from September 2010, 72 referrals have been made as a result of the 303 health checks that have been undertaken.** This means that a referral has been made in 24% of cases. Of these, 38 were to the GP or practice nurse; 17 to Counterweight®; 12 to smoking cessation and 5 to others. Uptake rates for onward referrals have been high. The Counterweight® Programme in particular has seen a large uptake with 96 people having been inducted onto the programme to date.
Changes for patients	Those that have had a health check will have learned about their health and lifestyle. And in some cases, they will have been alerted to potentially serious (and previously undiagnosed health problems). The signposting to other services (like smoking cessation and Counterweight®) has increased awareness of and access to services. We were told that many individuals (and some communities) now understood the benefits of the health check – and, more generally, of modifying behaviours to improve health. People in Durness had put pressure on the local shop to improve their provision of fresh fruit and other fresh produce. This has been successful – although people do understand the difficulties of transporting fresh food to remote areas. In Assynt there is evidence of the community taking a greater interest in health. It was felt that patients should be starting to see a more rounded approach to their health, based on the broader needs of individuals. Patients involved in long term condition management should have seen improvements in 'joined up' working to support them in the community.
Changes for staff	GPs have not all embraced the approach – although there is evidence of a greater focus on anticipatory care in some cases.

	But the nurses who have been involved (both practice nurses and community nurses) reported very positively on the benefits of the approach. One nurse said, 'The best thing from a nursing point of view has been the training. It brought people together and helped people realise that there were a lot of similarities between the different practices'. The training and change in culture has encouraged nurses to plan and anticipate issues for patients with long term conditions. For example, nurses were planning in October in case there was another very hard winter and were arranging for 'just in case' supplies of drugs and medicines to be delivered (for use if the person can't get out the house for a period of time). They were also working with other public agencies and voluntary organisations to make sure that contingency plans were in place to support vulnerable people over the winter. Nurses have seen the programme as: • empowering and motivational • providing a variety of interesting work • leading to problem solving and a more creative approach • something that they could 'take ownership' of • really making a difference. In relation to long term conditions management, North West Sutherland was seen to be 'ahead of its time', having preceded recent wider developments. The issue of case management has now been developed at regional (and national) level. However, the fact that new initiatives (from elsewhere) have been brought in has confused the situation.
Lessons learned	• The training has been extremely successful. Importantly, it was delivered locally – limiting the amount of travel that was required. It got staff (particularly nurses) involved; brought people together and helped people realise that there were a lot of similarities between the different practices. It is now used in inducting new staff (and has been used with the Scottish Ambulance Service paramedic who is delivering health checks in two neighbouring practices). • The programme has led to a sense of growing confidence and empowerment among the nurses. In part this is because it has allowed the nurses to make a difference to the health of people in their communities. This had led to anticipatory care being increasingly embedded into all aspects of nurses' work.

	• It has been difficult to engage GPs in the work – although a GP chairs the Steering Group and this is seen as very positive. One of the reasons for the difficulty in engagement was seen to be 'change fatigue'. 'With the QOF there is endless change, new initiatives to meet, new targets imposed and so on. There is a need to slow down and let initiatives become established'. • It would have been an advantage to the nurses involved if certain basic support materials (such as IT/ literature reviews/ pro formas) had been provided regionally as part of a standard support package – as the nurses did not have the technical skills to easily produce these. • Offering health checks outwith 'normal hours' has increased uptake. • Visits to other areas (particularly Western Isles and Lanarkshire) were helpful in sharing learning. • Social marketing has the potential to increase awareness of health issues. The programme has not done as much as some might have wanted. But the use of local media did help to 'prepare the ground' for the health checks. • The support provided from NHS Health Scotland on evaluation was welcomed – as local staff felt that they did not have the necessary expertise to evaluate without this support. • The approach is seen to be sustainable – as it is carried out from within existing staff resources. The approach has been taken forward steadily at a pace that could be managed, yet outputs have been good. On the other hand, nurses can be taken off doing health checks at particularly busy times for practices. • It has been difficult to get some practices to formalise multi agency work – with some seen as being 'undisciplined about paperwork'. • As additional health problems are being identified, this is putting pressure on 'secondary' support. • It is important not to underestimate set up time. Staff recruitment can be difficult and take time. It can take time to establish a Steering Group and make sure that it is working effectively. • Although exercise referral is identified in the Health Check guidelines, there is no effective system in place locally to do this, given the scarcity of facilities and the large travelling distances involved. • The approaches taken by nurses were seen to fit

	well with 'Modernising Community Nursing'. • Travel and transport are barriers for some people. In hindsight, it would have been good to apply for resources to allow the provision of a bus to take the health checks to where people were. But this would have required dedicated staff and it was felt that this would not have been sustainable. • Patients generally were happy with the health check process and are open to receiving health improvement advice and referrals. Some, however, who went for their health check thinking that they were in good physical condition were diagnosed with conditions such as hypertension, or a significantly raised cholesterol or CVD risk score, and subsequently prescribed medication which they may need to take for the rest of their lives. This information came as a shock, and a minority showed considerable anger which they vented on the nurse giving the outcome. For nurses on the receiving end of the person's anger or distress, it was a stressful and unexpected experience.

Appendix 4
Orkney: Profile

Target population – reason for choice	**People aged 40 - 64 in 3 practices in Orkney**. Initially, priority will be given to those who have not been seen by their GP in the last 3 years, are known to smoke and who have a family history of CHD. This target differs from the initial aims of the programme, which related to: • Understanding and reducing inequality for people with long term conditions in a rural setting (using a multi-agency approach based on SPARRA). • Developing primary and secondary prevention, self care and education in a rural setting (through access to existing facilities and the development of new approaches, such as telecare and self care packages). • Enhancing prevention and self care aspects of anticipatory care assessment (by developing SPARRA to assess risk and target anticipatory acre to those at greatest risk). However, Orkney NHS responded to their failure to meet the HEAT 8 target by moving away from the initial aims and focusing on the delivery of health checks. All seven practices on the mainland were offered the opportunity to deliver health checks under a Local Enhanced Service. Initially four practices agreed to provide health checks. Subsequently one of the practices has withdrawn. The practices were selected only on the basis of their willingness to participate. We heard of some reluctance by practices to become involved in anticipatory care. It was explained that this was because some GPs were sceptical about the value added compared to the amount of administration involved and some GPs did not wish to become involved because there is so much else going on. In addition, where opportunities arise elsewhere, health checks will be carried out by the community nurses.
Target population – size and characteristics	**The target population is estimated to be between 100 and 150 people.** When four practices were involved their target (supported by the Local Enhanced Service) was for each to achieve a minimum of 15 health checks by March 2011 and up to a maximum of 18 checks. With the withdrawal of one practice, the remaining three practices have been asked

	whether they are prepared to increase their target.
Inputs	**The programme has been allocated £82,500 from the Scottish Government over three years.**
Interventions and approaches used	**The main intervention now is health checks for people from the target population.** Despite the initial broad ambitions for the programme, little was achieved until a change in management in the spring of 2010. An Action Plan has been produced, focusing clearly on health checks and setting out how the HEAT 8 target will be delivered this year. The health checks contain all the required elements of the Well North programme.
Number of people from target group engaged (invitations and acceptances)	**41 health checks had been undertaken by January 2011.** The first health checks were undertaken in August 2010 and it is planned that the HEAT target of 51 health checks will have been achieved by March 2011.
Risks identified	**Health checks had only just begun when we visited Orkney and no information on referrals was available.**
Changes for patients	**It is too early to say.**
Changes for staff	**It is too early to say** – although it is hoped that health checks will become a routine part of the work of community and practice nurses in the future. For the Board the experience of implementing Well North has been a significant learning curve for all involved and re-emphasised the need for effective planning.
Lessons learned	• The main lesson learned has been the importance of planning and corporate ownership of programmes. The Well North bid was prepared by an individual rather than corporately. The initial plans to use Well North to support long term care and avoid hospitalisation through multi agency work came to nothing. The decision to switch Well North to health checks, following the introduction of the HEAT 8 target was initially poorly handled. As a result nothing was achieved in the first two years of the programme. Clear responsibilities and an agreed action plan are now in place and delivery is underway. • The importance of effective co-ordination of the programme is evident – along with the ability to work across the NHS (not only in one sector). • They have learned from the other programmes – particularly the Western Isles and Shetland. This

	relates particularly to data gathering and monitoring. • It would have been helpful if there had been a regional approach to some issues – including IT and reporting *'to save each programme re-inventing the wheel'*.

Appendix 5
Shetland: Profile

Target population – reason for choice	**Phase 1 – Unst and Fair Isle** The intention was to identify two remote communities. Interest in participating was expressed by the GP practice in Unst, a single handed GP practice with a practice population of 620 and the most northerly island in Shetland. In addition Fair Isle (part of the Levenwick GP practice area) was included. It has a practice population of 62 and is a non-doctor island with a GP flying in for a surgery approximately eight times a year. It is covered by a community nurse on twenty four hour call. **Phase 2 – Lerwick** There are 9,000 people living in Lerwick. Using the Scottish Index of Multiple Deprivation, it was agreed that the three poorest data zones in Shetland (which were all located in Lerwick) should be targeted.
Target population – size and characteristics	**Phase 1 – Unst and Fair Isle** **The target population in Unst was 36.** This figure was the number of people for whom there was no blood pressure or smoking status data held. **The target population in Fair Isle was 24.** This figure was the number of people who had not seen by their GP or nurse in the past two years and/or who had had incomplete CVD screening apart from height, weight, blood pressure and smoking status. **Phase 2 – Lerwick** The 3 targeted data zones have a population of 2,000. Of these 655 have incomplete health records in relation to blood pressure and/or smoking and will be the focus of the Well North work.
Inputs	**The programme has been allocated £147,000 from the Scottish Government over three years.**
Interventions and approaches used	**The main intervention is health checks.** In Unst, the checks were carried out by the GP or practice nurse in the surgery. In Fair Isle they were carried out by the community nurse in the surgery. They were full 40 minute checks, including lifestyle advice following the Keep Well/ Well North approach. The health checks include a 'social history' section, gathering information on wider determinants of health like housing conditions and

	income levels to allow signposting to other relevant service and support provision. The health checks are just getting underway in Lerwick. A Health Care assistant has been appointed to carry out the health checks. The checks are to be carried out in Lerwick Health Centre during 'normal' hours. However, if it is evident that offering appointments at different times or at different venues (such as community halls) would increase uptake this could be considered in the future. A joint post has been created with Housing Services – a Housing/Health Improvement outreach worker. Those in the target area who do not respond to three invitations to attend a health check will be contacted through the outreach worker service. Much of the outreach work will be aimed at providing support for the most disadvantaged and vulnerable members of the community. The post holder will support individuals to attend appointments and sustain lifestyle changes, signposting and accompanying individuals to other services (such as benefits appointments). They will also make recommendations about how best to involve and include these hardest to reach individuals and groups in health promoting activities on a much wider basis.
Number of people from target group engaged (invitations and acceptances)	**Phase 1 – Unst and Fair Isle** **39 health checks have been completed – representing 65% of the target group.** **Phase 2 – Lerwick** **The programme started in December 2010. By January 2011, 39 health checks were completed.**
Risks identified	**Based on the Unst and Fair Isle information only, eleven patients were identified as having health risks.** This represents 28% of the patients receiving health checks. A number of the patients had multiple risks. The main risks were hypertension and elevated lipid ratios. Two patients were referred to (and took up) nicotine replacement therapy (and, as a bonus, one of their friends who had not had a health check also undertook NRT).
Changes for patients	There has been a good follow through by people in Phase 1 in Unst and Fair Isle who have been identified through the health check as having health problems like high blood pressure or diabetes. Anecdotally, a number of those receiving health checks have stated that they intend to take more steps to improve their own health. But the

	numbers involved are very small in Phase1. Greater evidence of change for patients is likely once the larger volume of health checks is underway in Lerwick.
Changes for staff	There is growing support for the Well North approach. It is 'seen to be the right thing to be doing – working towards early intervention and removing barriers to access'. Senior managers and the Board were said to see the absolute importance of sustaining a preventative approach.
Lessons learned	• There are different issues to be considered in every local area. **Unst** is a small community focused practice, with a history of targeted health checks (based on regular Well Man and Well Woman Clinics). The Well North programme has allowed the practice to reach out to the small number of patients who had not recently been involved with the practice. As a result, of the promotion of health checks, the practice has now made contact with more than 99% of all patients. Even though relatively few health checks were undertaken, the programme has picked up a relatively high proportion of serious health problems. **Fair Isle** is a non-doctor island with occasional (weather dependent) visits from a GP – or a complicated and time consuming travel route for patients to go to the practice in Levenwick. The community nurse has engaged the community in a number of ways to encourage the take up of health checks. **Lerwick** is a larger town and the practice is very busy already with 'routine cases'. The appointment of a health care assistant and a housing and health improvement outreach worker is a different approach from the other areas and reflects the different scale and characteristics of the area. • Providing health checks on a Saturday morning allowed those who worked (or were away from home during the week) better opportunities to have a health check. • There is a need to make sure that more primary health staff are receptive to anticipatory care (or indeed receptive to change) – at present this was seen to be a barrier. There were seen to be difficulties in trying to drive essential change in primary health through Health Improvement. • In some cases practice records are not as good as they could be – the tidying up and verification stage is seen to be a very important stage. • Care needs to be taken in weighing up the cost and benefits of being involved in regional approaches.

	On the one hand, there is the benefit of learning from other areas and peer support. On the other hand regional work can lead to more paperwork and routine meetings. • On balance it was felt that Well North does provide a useful network – giving immediate access to others who are doing the same things – and trying to solve the same problems.

Appendix 6
Skye and Lochalsh Healthy Weight: Profile

Target population – reason for choice	**The population covered by the four GPs practices of Broadford, Glenelg, Kyle and Sleat.** The programme is based on 'health at any weight', taking a community rather than an individual approach. This was seen to be particularly appropriate in a rural setting. The aim was to identify a small community and seek to create an environment where the community has a leading involvement in healthy weight related initiatives (such as weight management, exercise and healthy eating). The community initiatives are intended to form part of a healthy weight pathway. The community selected was an appropriate size and location and the GPs were interested in the approach.
Target population – size and characteristics	**There are 4,641 people in the target area, who are aged over 16 years and registered with a GP.** Using national prevalence rates the programme estimates that this includes 1,860 (40%) who are overweight and 1,120 (24%) who are obese. A community health profile (which will provide more detailed information is currently being compiled.
Inputs	**The programme has been allocated £100,900 funding from the Scottish Government over three years.** There was no expenditure in 2008/09 – and the resources were carried forward. There is a request to carry forward £35,000 from the allocation to 2011/12, to allow the work of the dietician to continue.
Interventions and approaches used	**The programme uses an asset based community development approach.** However, as the idea has come from professionals rather than the community, it has taken time to explain the approach to the community and to engage them in the work. A large number of local community organisations are involved in a steering committee. This has met three times and focuses on different topics – for example one was based on walking and involved representatives of the council's road services and other services. In addition, more formal approaches (particularly Counterweight®) have been offered. But this has proved hard to sustain as small numbers and large travel distances have led to groups dwindling in numbers.

Number of people from target group engaged (invitations and acceptances)	**More than 25 community organisations are involved in the Steering Group.**
Risks identified	**The approach is based on a community rather than an individual model.**
Changes for patients	Too early to say.
Changes for staff	As yet, there has not been any change. It is recognised that change takes time. But it was felt that the process had been slower than if there were more people and resources.
Lessons learned	• It is essential to be clear about the purpose of the programme – stakeholders have significantly different expectations of what will be delivered and this may lead to frustration. • Planning and specifications for posts are extremely important. The programme has suffered considerable delays as a result of difficulties in making appointments. This has led some stakeholders to lose the initial enthusiasm that they may have expressed for the programme. • It is important that community led initiatives are led by the community. For a number of reasons (including the substantial delays between Steering Group meetings involving community organisations) some felt that the programme was 'definitely top down' and there was a feeling that the programme had only been introduced because it had 'worked somewhere else'. Others felt that focusing on weight (rather than wellbeing) might be a 'turn off for the community'.

Appendix 7
Western Isles: Profile

Target population – reason for choice	**All people in the Western Isles aged 40 - 69.** This was decided because deprivation is spread throughout the Western Isles - and the fact that Western Isles has the highest prevalence of CHD and hypertension in the UK. A 'traditional' CVD risk assessment tool, such as ASSIGN, based on geographically concentrated deprivation was felt not to be useful in this rural and remote area. The programme is using the JBS2 CVD too, which does not include a deprivation measure. This allows the programme to identify those at high risk in every community. And the information gathered about people's circumstances during the health check allows a data base to be developed which may help identify an appropriate CVD risk assessment tool for use in rural and remote areas in future. As a result of a Local Enhanced Service with general practices, those aged 70 -79 can also be included.
Target population – size and characteristics	**The target population is the 8,068 people aged between 40 and 69 living in the Western Isles.**
Inputs	**The programme has been allocated £498,788 from the Scottish Government funding over 3 years.** In addition, £65,000 has been allocated through payments from the CHD and Stroke Management Clinical Networks in recent years.
Interventions and approaches used	**The main approach is the offer of a health check to everyone in the target population.** The health checks are carried out in a range of community settings (such as community halls and church halls) as well as in surgeries. Initially a bus, which had been used in a Men's Health Project, was used to carry out health checks in remote areas. The bus ceased to be roadworthy not long after the programme began. A new bus is due for delivery by early 2011 – and this will further diversify the range of venues. Almost all checks are carried out during 'normal' working hours – following a poor response to Saturday morning health checks.

	There is a specialist team of experienced nurses (some dedicated and some bank nurses – all Band 6 and above) who undertake the health checks on behalf of the general practices. The advantages of this approach are that it: • allows expertise to be developed • provides a concentrated effort over a period of time • gives a clear management focus • is less susceptible to seasonal and other pressures – like flu jabs. Generally, the health checks take about 40 minutes and involve the basics of physical condition (including BMI and waist circumference); pulse rate and rhythm; smoking status; alcohol consumption (including the opportunity for a Brief Alcohol Intervention where appropriate); exercise; diet; blood tests; cholesterol check; mental wellbeing check and so on. Spirometry (lung function) tests have been introduced to the health check. However, the general view is that the tests should not become too long (as this may be off putting to patients) and should continue to be remain focused. Lifestyle advice is offered to all patients attending the health checks. And where health or wellbeing problems are identified in the check, the patient is referred either to the GP or (as appropriate) to support such as smoking cessation classes or weight management programmes. 'Point of Care' testing (which gives immediate results) is now being used in Lewis and Harris. It is hoped that it will be available in the Uists once the new bus is available. They have purchased two Abaxis Piccolo Testers (including LIPID test) and one Siemens HbA1c tester. The cost for these was £70,000. In addition the 'consumables' for each test are more expensive than 'traditional' methods. The Western Isles is leading the way in the use of this equipment. The advantages are: • immediate print out of health check results (including bloods) – which allows lifestyle advice to be tailored to the test results • ease of use for non technically trained staff • zero maintenance • greater interest from many patients in the check process

	• huge reduction in level of concerns about glucose levels – saving patient worry; fasting for second tests; and follow up testing.
Number of people from target group engaged (invitations and acceptances)	**5,113 health checks have been undertaken.** The dedicated Well North team work extremely closely with general practices to identify those patients who should be invited for a health check. In some of the larger practices, initial priority has been given to those with a history of smoking or those that had not attended the practice for more than a year. Letters are sent to patients in the target population inviting them to attend a health check. If required, these are followed up by telephone. So far, all patients in the rural practices have been invited. Invitations in the larger Stornoway practices continue to be issued. So far, 63% of the target population have undertaken a health check – and this figure is expected to rise close to 70% by March 2011. The ongoing priorities will be: • the people that have not yet been engaged • those just reaching 40 years old • a range of issues related to mental health and learning disabilities • identifying useful places to offer the service which will reach those that the current service has not yet reached (like the Salvation Army's Breakfast Club).
Risks identified	**Over one third of those participating in the health check (1,889 people) have had a health risk needing an intervention.** Based on the 1,395 health checks undertaken by September 2010, 68% of referrals have been to the GP or practice nurse. Other referrals were to a dietician (16%); smoking cessation (13%) and the physical activity programme (3%). The programme notes that one in five of those at risk will have an event, if untreated, in the next ten years. They state that, even if intervention cuts that in half, there would be 126 less events which could equate to 46 less deaths, 79 less heart attacks and 46 less strokes.
Changes for patients	Well North was seen to have: • made people more aware of the range of services available • built inter disciplinary relationships and partnerships focused on patients • put CVD on the same footing as breast cancer

	• increased understanding of 'undiscussed' illnesses (like prostate and testicular cancer) • encouraged people to talk about health and lifestyle with less inhibition • identified a lot of unknown health problems – saving patients future distress and saving costs to the NHS through early intervention.
Changes for staff	The approach in Western Isles has been based on a dedicated team undertaking health checks on behalf of practices across Western Isles. Nonetheless, initial training covered 31 nursing staff, so there is a good general understanding of the programme. There are signs that GPs are now more likely to be looking at lifestyle – not just medical issues. A rounded approach can lead to alternative prescriptions – for example statins can replace rather than add to other drug based treatments and physical activity is now more likely to be prescribed. Some practice and community nurses are moving away from the purely medical model and drawing on other approaches (including conversation and information provision). The specialist service involves experienced and knowledgeable nurses. For them it has been good in terms of Continuous Professional Development to be involved in this programme. The 'Point of Care' equipment has made a big difference for staff in terms of ease of delivering the check and giving immediate feedback to the patient. The use of a specialist service has been strongly managed; made targeting checks in particular areas (including the use of community venues and the bus, while it was running) much easier – and has avoided staff from being regularly drawn into other urgent work in practices.
Lessons learned	• The use of a specialist team is unique to the Western Isles. It is seen to be effective because it is managed from a single point in Health Improvement – rather than 31 nurses managed by a wide range of GPs with other priorities. This encourages consistency and effective targeting and has allowed a sophisticated database to be established (significantly improving monitoring information). It is also seen to be attractive to GPs who are getting an additional service. The nurse

	coordinator has played a particularly important role. There was a view that a stand-alone population screening approach should (like breast cancer) be the responsibility of the Health Board rather than individual GPs. • The use of community venues has been very well received by patients and by nurses – more than 80% of people are attending their appointments. • The use of 'Point of Care' technology has been very helpful in allowing immediate feedback to patients. It has also introduced a new glucose check (HBAIC). This is much more accurate in taking glucose readings without the need for fasting – and it has also cut to a fraction the number of people identified as potentially diabetic. This has reduced the pressure on nurse time for second tests. • Referrals for physical activity are easier in Stornoway – where there is a new sports centre than in some more remote areas that do not have facilities. But although capital has been made available for the new sports centre, it is much harder to get revenue funding for staff to effectively support referrals for physical activity. • There is a need to learn more about whether people really do make lifestyle changes as a result of the check – and whether these are temporary or permanent. • With some very important exceptions, GPs have generally not fully bought into primary prevention. 'An example of the lack of understanding from GPs is the number of times that they are referred high risk cases through the checks and they say 'We can't find anything wrong with them'. This is because they are looking at the present position – not the future risk'. • The larger urban practices are generally more difficult to engage than the more rural practices. They are less community based and are seeing larger numbers of patients. • There has been little use of out of hours services – for example an intention to run health checks on a Saturday was stopped as a result of very high levels of 'did not shows' at the early appointments.

	• The scale of the health checks has reached a critical mass and there is now high public awareness. • There has been good communication between the Well North team and the practices. 'There is now a sense that people are working better together as part of a properly joined up NHS. The approach puts patients back in control of their health and wellbeing'. • Western Isles has run training in two other programme areas. This support is ongoing with regular communication and sharing of information which is seen to be mutually beneficial. • Board and senior management support is key – and has been in place throughout. This is not least on account of the project's contribution to the HEAT 8 target.

Appendix 8
QOF indicators

We summarise a number of the QOF indicators in Section 3.2.

The table below outlines the non-standardised prevalence rates of different conditions at each practice involved in Well North (for the programmes undertaking health checks). It is important to note that this information is simply the proportion of patients who are recorded as having a certain condition. The age profile of the practice population can have a significant impact on prevalence rates, and is not taken into account. In addition, the way in which conditions are recorded by GPs influences how they appear in this data. And, importantly, the data is not complete – it does not include information about those who have not visited their GP for some time (often the group that Well North has targeted). However, it provides a useful comparison and broad indication of health inequalities across the Well North areas. We have highlighted the indicators which are higher than the Scottish average in bold. It is clear that many of the practices had much higher rates than the Scottish average – notably in those areas prioritised by Well North – heart disease; hypertension; obesity and smoking.

Finally, each indicator is more complex than the short heading we have given it would imply. For example the smoking figure relates to:

> 'The percentage of patients with any or any combination of the following conditions: coronary heart disease, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses whose notes record smoking status in the previous 15 months (except those who have never smoked where smoking status need only be recorded once since diagnosis)'. ISD Scotland

Table A9.1: Health indicators for practices included in Well North (Source QOF 2010) (%)

Practice	Heart Disease (CHD) (%)	Hyper-tension (%)	Obesity (%)	Smoking (%)
NHS Grampian – Dufftown and Rothes				
Dufftown	**5.27**	**18.24**	**15.00**	**27.77**
Rothes	4.16	13.19	6.12	22.90
Grampian Average	3.99	12.76	**9.43**	22.43
NHS Highland – Skye and Lochalsh Healthy Weight				
Broadford	**5.07**	**14.84**	**11.62**	**25.42**
Glenelg	**4.84**	**14.19**	**8.30**	**24.91**
Kyle	3.62	11.77	**7.54**	21.36
Sleat	**4.49**	**14.34**	**7.23**	22.69
Highland Average	**4.53**	**14.72**	**7.24**	**25.18**
NHS Highland – North West Sutherland				
Armadale	**5.37**	**16.34**	**11.55**	**27.19**
Assynt	3.36	**16.68**	2.95	**27.47**
Durness	**4.40**	**20.75**	**19.50**	**31.45**
Scourie/ Kinlochbervie	3.95	**16.24**	**16.54**	**26.86**
Tongue	**5.71**	**18.23**	**14.36**	**25.78**
Highland Average	**4.53**	**14.72**	**7.24**	**25.18**
NHS Shetland – Unst, Fair Isle and Lerwick				
Unst	2.58	**23.59**	**11.63**	**32.96**
Levenwick	3.32	**13.75**	**16.09**	**24.67**
Lerwick Health Centre	3.23	12.46	4.11	21.2
Shetland Average	3.58	**15.05**	**7.31**	**24.55**
NHS Orkney - Mainland				
Skerryvore	3.38	**13.68**	**7.77**	22.84
Dounby	4.02	**15.31**	**13.80**	**26.17**
St Margaret's Hope	**6.12**	**19.05**	**15.27**	**29.48**
Orkney Average	4.15	**15.95**	**10.53**	**25.2**
NHS Western Isles				
Barra	**5.47**	**18.56**	**12.43**	**29.99**
Benbecula	**4.47**	**15.35**	**13.59**	**24.00**
Broadbay	**6.37**	**17.66**	**12.14**	**28.23**
North Harris	**6.96**	**23.50**	**7.59**	**35.68**
North Lochs	**5.70**	**23.08**	**9.27**	**32.26**
North Uist	**5.51**	**28.31**	**13.04**	**36.68**
Pairc	**11.05**	**29.56**	**9.67**	**40.06**
South Harris	**5. 47**	**14.99**	**10.58**	**29.28**

South Uist	**4.76**	**21.18**	**8.08**	**28.64**
The Group Practice	**6.52**	**17.89**	4.26	**29.00**
Uig and Bernera	**5.25**	**19.60**	6.94	**29.48**
Westside	**6.83**	**21.33**	**16.80**	**32.07**
Western Isles Average	**6.14**	**19.39**	**9.89**	**29.79**
Scotland Average	**4.38**	**13.35**	**7.03**	**23.65**