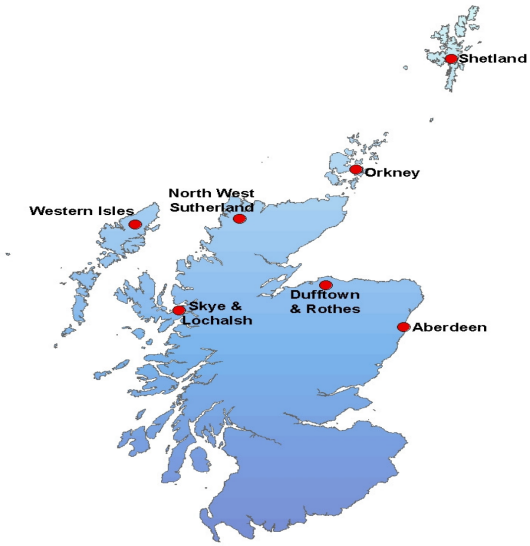
Well North Evaluation Newsletter

Background

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 programme was planned and supported by the North of Scotland Public Health Network (a collaboration between the five North of Scotland Health Boards which aims to link groups of health professionals, to work in a coordinated manner, to contribute to improving health and reducing inequalities).

Well North was evaluated by ODS Consulting between September 2010 and January 2011. This Newsletter includes some of the main findings from the evaluation. The purpose of the evaluation was to learn the lessons from the pilot programmes – including the identification and engagement of target populations; the interventions and approaches used; and the changes brought about.

The methodology included sixty five interviews with stakeholders in the local programme areas; data gathering and a workshop to allow NoSPHN and the local programmes to reflect on the draft report.



Well North is made up of seven local programmes:

- Dufftown and Rothes
- North West Sutherland
- Orkney
- Shetland
- Western Isles
- Grampian Healthy Weight (Aberdeenshire and Moray)
- Highland Healthy Weight (Skye and Lochalsh)

Interventions

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).

Other important features were community consultation and engagement (most notably in Dufftown and Skye and Lochalsh) and training (most notably for nurses and other staff in North West Sutherland and Western Isles and for community members in Dufftown).

Engaging target populations

Well North has had considerable success in engaging the target populations in health checks. Methods used include:

- all programmes using both letters and phone calls for the initial invitation
- use of community venues (in the Western Isles, where a bus also provided a mobile health check venue)
- out of hours service – providing health checks in evenings and weekends
- raising awareness through newsletters and use of local press.

It was recognised that additional methods would be required to attract more people – including greater use of non-surgery settings (like community venues; workplaces; or auction markets); increased use of social marketing; and joint work with other public agencies and voluntary organisations.

Lessons for the Future

Generally:

- **Local autonomy is important.** Local decision making allows programmes to build on previous work done in the area and existing relationships between health professionals. It can draw on knowledge of patients and the local community.
- **Focus on health inequalities in rural and remote areas.** Using national indicators allied to local intelligence can help identify areas which are likely to benefit from anticipatory care.
- **Allow time for planning.** Set aside sufficient time to make sure that staff and resources are in place at the start. Building in time for training is also valuable.
- **Maximise the engagement of GPs.** GPs play a crucial role in delivering health care. It is important to ensure their increased commitment to anticipatory care over time, through ongoing awareness raising and a sound evidence base.
- **Share common resources 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:

- **Delivery by a dedicated team or by existing staff?** A dedicated team of staff undertaking health checks can develop specialist skills. Building anticipatory care into the work of existing nurses was seen to be motivational and provides a rounded work experience. Both approaches are relevant.
- **Use a range of approaches to engagement.** High levels of engagement have been achieved by using contact with patients by letter;

follow up phone calls; and general awareness raising. To maximise engagement levels will need a widening of engagement methods. These might include greater use of health checks out of normal hours; non – surgery settings for checks; increased use of social marketing; and joint work with other public agencies and voluntary organisations.

- **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.

- **Gather standard core data.** Any future programmes should gather standard core data about the target population and engagement. The requirements should be proportionate to the size of programmes. In the longer term, information on changes in health and lifestyle would be valuable. This information could be gathered through follow up health checks (as in Dufftown) or by analysing a sample of GP records.

In relation to long term conditions:

- **Consider long term conditions** One Well North 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 and voluntary organisations.

In relation to community engagement:

- **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.

Significant Changes

Changes for Service Users

The main changes for patients which were observed by those involved in Well North were:

- a significant number of patients following up referrals
- greater awareness of health checks and their benefits
- greater general and personal awareness of health
- provision of new or additional services
- more likelihood of service providers considering the needs of the patient 'in the round'
- some evidence of behavioural change.

Changes for the NHS

- Nurses have been the key resource in delivering Well North and they spoke very positively of the programme in relation to the changes for patients and in broadening their work.
- The involvement of GPs was seen as extremely valuable - however many GPs had not given priority to anticipatory care (among a wide range of initiatives they were asked to support).
- There were indications of Health Boards embracing anticipatory care more fully – but there were some lessons to be learned about the effective planning and resourcing of new programmes.

Facts and Figures

Health checks

The target population for Well North is 10,939 (excluding Phase 2 of Shetland where health checks only began in November 2010).

6,200 people had attended a health check by January 2011 – 57% of the target population. It was estimated that this number would have grown to almost 6,700 by the end of March 2011 (61% of the target population).

Over 2,200 people have been identified as having a previously undiagnosed health risk, for which a referral was required. This is 35% of all those attending a health check. Most referrals were to GPs or practice nurses – referrals were also made to dieticians; weight management programmes; smoking cessation; and physical activity classes.

Programme	Number of health checks (by January 2011)	Health checks as a proportion of total population
Dufftown and Rothes	632	52%
North West Sutherland	375	26%
Orkney	41	33%
Shetland (Phase 1)	39	65%
Western Isles	5,113	63%
Total	**6,200**	**57%**

Other activities

- Forty-nine (49) people have attended 'Healthy Helpings' weight management courses in Aberdeenshire and Moray.
- Nearly 30 community organisations are represented on the Steering Group for Skye and Lochalsh Healthy Weight Programme.
- Eighty (80) patients are included in the multi-agency approach to reducing hospital readmissions in North West Sutherland

Further information

The full evaluation is available at **http://www.nosphn.scot.nhs.uk/?page_id=578**
For more information about Well North contact **angus.mackiggan@nhs.net**