

# Keep Well Informed

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

In this issue

SPRING 2010

Newsbites



p2

Wave 1-3 updates



p5

Practitioners  
network



p10

Long term conditions



p12

## Scottish Government commits to anticipatory care

**T**he Scottish Government has announced its continued support for Keep Well and Well North with new developments planned to commence in April 2012. These include :

- an intention to make it part of normal, permanent practice
- the lowering of the eligible age to 40
- repeating the health check every five years
- extending the programme to all those living in the 15% most deprived areas, with some local flexibility to reach deprived/high risk populations who live outwith those areas.

A transition year in 2011-2012 will support the development and implementation of these new arrangements.

**'Keep Well is successfully tackling health inequalities in our poorest communities.'**

### MOTs piloted

The introduction of universal health checks for everyone in Scotland aged 40-74 was also outlined by Health Secretary Nicola Sturgeon.

In addition to these developments, a

pilot of 'Life Begins', a web-based self assessment for 40 year olds, begins in NHS Grampian in May 2010.

Ms Sturgeon said: 'Prevention is better than cure and we are committed to doing all that we can to identify those at risk from heart disease, diabetes and strokes as early as possible.'

'The new "heart MOT" health check will provide vital research in health prevention. The checks for all individuals aged 40-74 – not just those believed to be at risk – will mean that we will be able to test the success of a general heart check-up for the first time.'

'Keep Well is already successfully tackling health inequalities in our poorest communities. It has made a difference to thousands of people's lives and, with this development, 170,000 Scots will get the extra help and treatment that they need.'

**Tim Warren, Team Leader, Keep Well,  
Scottish Government**  
[Tim.Warren@scotland.gsi.gov.uk](mailto:Tim.Warren@scotland.gsi.gov.uk)



Nicola Sturgeon

# Newsbites

## Learning and workforce development

NHS Health Scotland will be delivering the following training events (April–June 2010):

<b>Behaviour Change and Health Inequalities (3 days)</b>	
Glasgow	22 June 2010
Edinburgh	27 May 2010
Addiewell, West Lothian (Blended Learning Course)	2 June 2010

Three Better Engagement Skills with Hard to Reach Groups courses will also be delivered from May 2010 with dates and course locations still to be confirmed.

For more information please contact:  
**nhs.HealthScotland-ACLWD@nhs.net**  
 or access: <http://elearning.healthscotland.com/course/view.php?id=21&topic=4>

**Tania Cousin, Training Coordinator.**  
**Email: [tania.cousin@nhs.net](mailto:tania.cousin@nhs.net)**

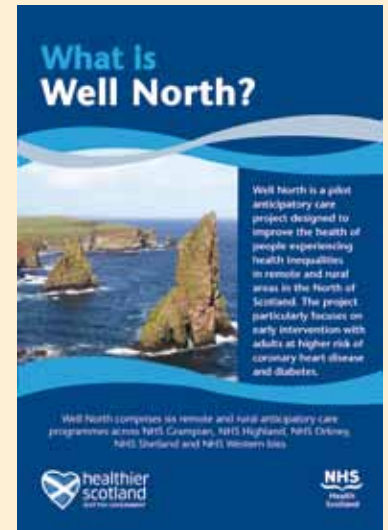
## New publications available now

A revised edition of the 'What is Keep Well?' publication has been produced and is now available. Updated to reflect developments with Wave 3 and 4, the publication is aimed at health professionals and gives a useful overview of the Keep Well programme.

A similar leaflet for Well North, entitled 'What is Well North?', and a Well North patient journey poster have also been published.

To request copies of any of these publications or for further information on available marketing materials for the Anticipatory Care programme, please contact Jo Maclellan.

**Jo Maclellan, Senior Health Improvement Programme Officer – Anticipatory Care.**  
**Email: [jo.maclellan@nhs.net](mailto:jo.maclellan@nhs.net)**



## A fond farewell

The Better Health team bade a fond farewell to Peter King, Health Improvement Programme Manager – Anticipatory Care, at the end of March. Peter has now taken up the post of the West Regional Manager for the National Childsmile Programme. The team would like to say a huge thank you to Peter and wish him well in his new job.



Peter King

## Customer feedback survey

NHS Health Scotland strives to deliver a more locally focused 'customer service' role for the national Anticipatory Care team to support local programme implementation. To help us understand whether we're meeting this aim, the survey asked Keep Well and Well North project managers and other Anticipatory Care staff:

*'How do our customers perceive how effective the National Anticipatory Care Programme Team has been in supporting your delivery of the Anticipatory Care programme?'*

The results will be used to improve the support from NHS Health Scotland. Watch this space for further details!

**Lynne Galloway, Senior Health Improvement Programme Officer – Anticipatory Care.**  
**Email: [lynne.galloway@nhs.net](mailto:lynne.galloway@nhs.net)**



# Developing the role of healthcare support workers delivering anticipatory care

**T**he role of Health Care Support Workers (HCSW) is key to the successful delivery of Keep Well and Well North programmes. A new working group aims to raise the profile of this often overlooked group.

HCSW have played an integral part in the delivery of Keep Well and Well North, undertaking a range of roles and responsibilities, many of which have traditionally been carried out by qualified nursing staff. The HCSW role has been described as:

*'Anyone who has not got a professional qualification as such but is working in a support role with professional colleagues in either delivering some element of Keep Well or Well North. Examples include outreach or development workers and unqualified staff attached to local health projects, including volunteers. What they all have in common is that they engage with target populations in support of anticipatory health care services which are part of Keep Well or Well North.'*

## Working party established

The wide range of duties delivered by HCSW across local areas led to the establishment of a National Anticipatory Care working group set up in June 2009 to address the need for enhancing the HCSW role. The experiences of Anticipatory Care areas which employ



the services of HCSW have informed this programme, raising key issues to be considered by the working group. These included patient safety, confidentiality and the appropriate delegation of tasks traditionally undertaken by qualified staff and now often being delivered by HCSW.

Work is being progressed in three stages:

- **stage I** – scoping study – to identify current status of HCSWs
- **stage II** – development/adaptation of national resources to support role development
- **stage III** – area specific piloting (3-4 areas) for further roll out.

The scoping study was commissioned to map activities and clarify the

HCSW role including existing skills, qualifications and competencies. The study found that HCSW are increasingly becoming case workers providing support at one or many stages of the Keep Well journey, including medium- to long-term support within community and voluntary sector settings. It also highlighted that a wide range of practitioners from a variety of professional backgrounds have been contributing towards the HCSW role.

These findings are being used to progress stages II and III of the programme.

**Vibha Pankaj, Learning and Development Adviser.**  
Email: [vibha.pankaj@nhs.net](mailto:vibha.pankaj@nhs.net)

## Welcome

Welcome to our spring edition of *Keep Well Informed*. As well as updates from local areas involved with the delivery of Keep Well and Well North, you will find information on the latest exciting developments announced by the Health Secretary. There's also an in-depth look at our most recent Practitioners' Network event and two interesting feature articles that offer clear illustrations of the wide contribution being made by learning from the Anticipatory Care programme.

I hope you enjoy the newsletter.

**Theresa King, Senior Health Improvement Programme Officer – Anticipatory Care (Dissemination).**  
Email: [theresaking@nhs.net](mailto:theresaking@nhs.net)

## Well North

# Keeping the North of Scotland's population healthier

**In the past year, over 3,000 health checks have been carried out across the North of Scotland area. Data gathered locally has demonstrated that these checks have been effective in identifying clinical risks and conditions.**

Here's a brief update from each of the local Well North programmes:

### Dufftown

The number of patients attending health checks has increased considerably since the appointment of a dedicated nurse for the programme. Discussions have also taken place with the GP practice in neighbouring Rothes, with a view to commencing health checks there from April 2010.

### Healthy Weight (Grampian / Highland)

Both Grampian and Highland areas are in the process of undertaking a Community Needs Assessment and it is envisaged that the outcome of that piece of work will be instrumental in fully implementing the Healthy Weight programme.

### North West Sutherland

North West Sutherland note that their greatest success story to date has been the number of people participating in the Counterweight weight management programme.

Only a small proportion of these have been referred directly from health checks, with most of them attending because of 'good news stories' and positive outcomes being shared in their communities.

### Orkney

Orkney has recently experienced difficulty with service capacity and this has prevented them from fully implementing their programme to date. However, some discussions have taken place between Orkney and the Scottish Ambulance Service (SAS) around a six-month pilot that would see the SAS support delivery of health checks in the Orkney area.

### Shetland

Health checks in Unst and the Fair Isle have been completed.

Shetland are now commencing Phase 2 of their programme, with three areas of Lerwick having been identified as the most deprived areas to target.

### Western Isles

The programme will implement several new developments in April 2010, including the introduction of Point of Care Testing and Chronic Kidney Disease screening. They are also working in partnership with NHS Greater Glasgow & Clyde toward developing an obligate network for diabetes, in order to enhance service delivery for people in remote and rural areas.

.....  
**Angus MacKiggan,**  
**Well North Coordinator.**  
**Email: [angus.mackiggan@nhs.net](mailto:angus.mackiggan@nhs.net)**



## KEEP WELL: Tayside Reaching out

**T**ayside Keep Well has been targeting one of the most difficult to reach groups in an initiative that has seen them deliver support, advice and coaching to homeless people.

For the past year, Tayside has been piloting a project to reach and engage with homeless groups and has based a Keep Well outreach nurse in the existing Health and Homeless Outreach team in Dundee.

Being part of an existing team has supported and helped the nurse to reach and engage with homeless people. The nurse offers Keep Well health checks to people in hostels, resettlement flats and other venues used by homeless groups.

Health coaching is also offered to support and motivate people wishing to change an aspect of their life to improve their health. This could include improving their diet or increasing physical activity. The nurse also runs a smoking cessation group, which has been particularly successful in engaging people who have traditionally found quitting difficult. The more



The Tayside outreach team: working with homeless groups

informal approach to running this group is proving to be successful.

A local report described the many successes and included positive stories from people who have received Keep Well input. Importantly, the benefits of an anticipatory care approach, complementing the more traditional unscheduled care approach for this group, are highlighted. There is still work to do, and to this end a jointly formulated project plan is being developed to progress Keep Well activities.

**Nicola Stevens, Keep Well Project Implementation Manager. Email: [nicolastevens@nhs.net](mailto:nicolastevens@nhs.net)**

## KEEP WELL: Fife Working together for Fife's homeless groups

**L**inking up with other community groups to deliver advice and support has proved just the key for Fife's Keep Well team.

As part of an ongoing piece of work designed to support relationship and confidence-building between Community and Voluntary Sector and Anticipatory Care programmes, a project grant awarded by NHS Health Scotland enabled Keep Well Fife, in association with Fife Council's Home4Good network, to hold an event in January aimed at improving the health of those living in temporary accommodation across Fife. The event provided attendees with information and access.

The event piggy-backed onto a regular Frontline Fife drop-in lunch for homeless people, with transport arranged by the Tenancy Management Service enabling people from across Fife to attend.

A number of agencies were invited to attend. These included the Community Dental Service, Citizens Advice Bureau, Library and Museum Service, Adam Smith College Guidance Team, Working Links, Fife Credit Union and the Volunteer Centre Fife. Participatory sessions from Adult Basic Education, Fife Community Food Project and Fife Sport and Leisure Trust, as well as the presence of the Revolution Bus, with its games consoles, provided the fun element. A private consultation area for health checks



Supporting homeless people in Fife

was also available.

Well over 60 people attended on the day and there have been subsequent positive outcomes. More support workers are contacting us to arrange health checks for their clients, other agencies have adopted a homeless person reference code and there has been closer working between agencies to support homeless groups.

**Margaret Bell,  
Project Manager – Keep Well.  
Email: [margaretbell3@nhs.net](mailto:margaretbell3@nhs.net)**

## KEEP WELL: Lanarkshire

# Accessing the margins

**The Lanarkshire Keep Well team has been successfully targeting patients traditionally on the fringes of society.**

With the additional Wave 4 funding, Keep Well in Lanarkshire has expanded to reach a wider population. The programme is now offered in six out of the ten localities and a seventh is keen to participate. We have also amended our follow-up model so this is carried out by a patient's GP practice rather than the Keep Well team. This embeds Keep Well into GP practices and increases the partnership between practices

and the Keep Well team.

Work with gypsy/traveller populations, homeless people and ex-offenders has also progressed in partnership with local Councils, restorative justice departments and private/public homecare providers. All agencies have been keen to participate in the Keep Well health checks and, where possible, clinics are provided in-house, on-site, or by the health bus.

Early findings have identified that many people from these marginalised patient groups have

complex social and healthcare needs. The holistic approach of the Keep Well nurse care management service has been key to building relationships with patients. The service also acts as an advocate, making it easier for these patients to register with local GP practices and access services.

It is anticipated that the service will continue to progress and expand over the next couple of months with Keep Well health checks being offered to more of these patient groups in Lanarkshire.

**Jill Madden, Project Manager – Keep Well.**  
Email: [jill.madden@lanarkshire.scot.nhs.uk](mailto:jill.madden@lanarkshire.scot.nhs.uk)

## KEEP WELL: Lothian

# Minority reports

**As well as targeting the prison population, Keep Well Lothian's latest plans aim to engage ethnic minority communities.**

Practices in Edinburgh continue to successfully reach people through out of hours telephone calls and doorstep engagement. Next year's focus is to evaluate, consolidate and mainstream Keep Well. A local evaluation of staff perspectives is underway with similar plans to evaluate the outreach worker role and patient perspectives. Work will take place to build capacity within additional practices



to ensure that they are ready to deliver targeted health checks by March 2011.

Keep Well has now expanded to West Lothian. 119 health checks were completed by four practices in the first seven weeks of the programme. Follow-up appointments with 200 West Lothian patients will be conducted one year on to find out if they have changed their behaviour in terms of diet, exercise, weight loss, smoking or alcohol consumption.

The Edinburgh Access Practice continues to develop Keep Well services for key population groups. A nurse and outreach worker from NHS Lothian Keep Well are jointly working with Scottish Prison Service nursing and health promotion staff within Edinburgh prison to offer Keep Well checks and outreach follow-up to prisoners sentenced to six months or under.

Finally, we will begin piloting a culturally and linguistically enhanced model for ethnic minority communities. Minority ethnic link-workers will contribute to the engagement and assessment process, supported by dedicated minority ethnic outreach support workers and a nurse case manager.

**Ciara Byrne, Project Manager – Keep Well.**  
Email: [ciara.byrne@nhslothian.scot.nhs.uk](mailto:ciara.byrne@nhslothian.scot.nhs.uk)

## KEEP WELL: Borders All work...

**W**ith many of us working longer hours and health care low down the priority list, the Borders Keep Well team is taking its service out to the workplace.

With business targeted initially by letter, a follow-up call gives companies an opportunity to ask questions about the service before opting to book a Keep Well health check session led by one of our three nurses.

Posters advertising the health checks and booking forms are sent out two to three weeks prior to the session. Employees are under no pressure to have the check. They are informed that it is free and confidential. We offer workplace health checks across the Borders and these continue with the Keep Well health checks being offered to employees aged 45-64 years on lower wages.

To date, 15 health checks have been carried out for employees working in a range of businesses, including a bus company and an agricultural engineering business.

'Uptake certainly increases over the day, as employees realise the check is beneficial to them and their employer is happy for them to have time off the shop floor,' says Rachael Forsyth, the lead nurse for workplace health checks.

'Most employees said they would take up the offer of a check again,' continues Rachael. 'I did overhear employees discussing their results. Many felt work was a good place to raise awareness of their health and wanted to know when we were coming back!'

**Pippa Walls, Programme Manager – Keep Well.**  
Email: [pippa.walls@borders.scot.nhs.uk](mailto:pippa.walls@borders.scot.nhs.uk)



Rachael Forsyth at work in the Borders

## KEEP WELL: Forth Valley Breaching the gender gap

**K**eepp Well funding is enabling the Forth Valley team to extend its successful men's health service to women in the region.



Anticipatory care within Forth Valley has been developed in slightly different ways across the 3 CHPs involved with delivery: Clackmannanshire, Falkirk and Stirling.

Within Falkirk CHP the Keep Well investment will be used to build on the work established within the existing men's health service, the

Camelon centre – including developing a women's version.

The core component of the service is a one-to-one assessment involving a range of health checks and an exploration of lifestyle issues. Each patient then plans actions to improve or maintain their health. Following the success of the Camelon centre, established in 2001, the model was adopted in both Clackmannanshire and Stirling.

With Keep Well investment, the challenge has been to expand on this 'gender sensitive' approach.

This will allow us to provide further opportunities for men and also develop a service aimed at women, within the Keep Well ethos.

The plan is to develop and incorporate a women's anticipatory care service similar to the men's service, maintaining the gender sensitive approach that has proved successful. In addition, service provision for both men and women will be increased to cover other areas of Falkirk. These new services would target the hard-to-reach clients within the age groups specified within the Keep Well programme.

**Lynne Galloway,**  
Senior Health Improvement Officer  
– Anticipatory Care.  
Email: [lynne.galloway@nhs.net](mailto:lynne.galloway@nhs.net)

## KEEP WELL: Greater Glasgow & Clyde Brief encounters make a difference

**The Keep Well team in the West Dunbartonshire region has been piloting Alcohol Brief Interventions (ABI) in the fight against alcohol dependency, with amazing results.**

An Alcohol Brief Intervention is an evidence based structured conversation typically lasting 5-10 minutes. It can be as little as raising the issue, listening to the client's response and a brief discussion including the provision of information. The most effective brief interventions use a motivational interviewing style which makes the best use of a short consultation.

In West Dunbartonshire the

piloting of ABIs in a community setting commenced in February 2010. Three health counsellors are in post to deliver within leisure centres across the CHP as part of the lifestyle consultation. After three weeks, 30 ABIs had been completed.

In Inverclyde the Keep Well primary care alcohol nurse has delivered a programme of brief intervention, motivational interviewing and onward referring/signposting. In addition, reviews of patients who previously attended the service have been conducted and evaluations performed.

One male client reduced his alcohol consumption from 80 units/week to 18 units/week and had accessed anxiety management. A female client had remained abstinent for over a year, which her family reported had significantly improved the atmosphere at home.

Keep Well Wave 4 is due to commence in Inverclyde in April. This is an exciting time for the six practices involved, with staff recently attending a full day training event. This venture will develop the health care assistants' role in delivering Wave 4 health care reviews.

**Sandra Moore, Health Improvement Senior – Keep Well.**  
Email: [sandra.moore@renver-pct.scot.nhs.uk](mailto:sandra.moore@renver-pct.scot.nhs.uk)

## Challenge the Big Smoke

**The Keep Well team in North Glasgow is using up-to-date technology to target the smoking population across the region.**

Nine GP practices participated in Wave 1 of Keep Well within North Glasgow Community Health & Care Partnership. The last three years have passed quickly and we are keen to maintain their involvement during 2010/11. As seven new GP practices start the Wave 4 programme, we are negotiating with the Wave 1 practices to offer a health check to the remaining cohort. This would include those patients who have reached 45 years of age, as well as the smoking population.

It is anticipated that engaging patients who smoke could significantly reduce the risk of heart disease in the future. Working closely with the Smoking Cessation team, the Wave 1 practices will use similar engagement methodologies used in Keep Well (texting is also being considered) to encourage patients to make use of the smoking cessation services. Practices are currently developing plans to deliver this part of the programme. As well as exploring ways to engage the whole smoking population, each practice will select an age group to focus on. Plans have still to be finalised but we have been encouraged by the enthusiasm of the practices.

**John Thomson, Health Improvement Lead.**  
Email: [john.thomson@ggc.scot.nhs.uk](mailto:john.thomson@ggc.scot.nhs.uk)



## KEEP WELL: Grampian Partnerships that bring rewards

**J**oining forces with a local partnership has reaped rewards for patients of Keep Well Grampian.

Increasing synergy between local health programmes and partnerships in order to provide improved access to benefit services is paramount to providing anticipatory care aimed at reducing health inequalities.

At the Keep Well health check, patients can access different lifestyle interventions, including a benefits check.

The Aberdeen 'Cash In Your Pocket Partnership', is a partnership of public services and third sector organisations providing a single point of onward referral for benefits advice. The 'Cash In Your

'Pocket Partnership' offers help and referral in a number of core areas:

- benefit advice
- money
- budgeting
- debt legal advice appeals
- housing
- the social fund.

Referral examples:

### Issue raised: Fuel debt

Outcome: Home visit. Full demonstration on safe and efficient operation of central heating system. Programme timer on the wrong setting.

### Issue raised: Savings options

Outcome: Opened a credit union account.

### Issue raised: Benefits review

Outcome: Consultation with Community Welfare Rights Officer identified client was entitled to access additional benefits.

Feedback is provided to the referrer, giving them a brief summary of the issue raised and the outcome.

Working with the 'Cash In Your Pocket Partnership' provides access to a range of services that can benefit patients and their wellbeing.

**Dorothy Ross-Archer,**  
Keep Well Programme Manager.  
Email: [dorothy.ross-archer@nhs.net](mailto:dorothy.ross-archer@nhs.net)

## KEEP WELL: Ayrshire & Arran On the IT path to the right solution

**T**he expansion of the Keep Well programme from GPs to pharmacies and Healthy Living Initiatives presented challenges for data sharing and collation. Ayrshire & Arran's IT team developed a solution.

In Ayrshire & Arran the Keep Well programme started with General Practice and is now expanding to include Pharmacy and Healthy Living Initiatives. The inclusion of additional partners presented challenges in terms of data collection, transfer and storage.

Data from health checks carried out by GPs is recorded directly onto the practice system. However, conducting screening programmes elsewhere is relatively new and

data recording has been primarily paper-based.

The Keep Well team's IT Support Officer, Heather Nelson, researched options that could offer a solution to meet the needs of the programme, and recommended Microsoft Infopath. This is an electronic form, allowing data to be entered and sent by secure email to be stored centrally for analysis. Heather created the form based on the data set used by GPs, with built-in options and calculations to ensure user friendliness. The form was tested by the clinicians and adapted to suit their needs. The aim: a more free-flowing health check.



Heather explains: 'The result is a system which provides comparable data to that collected from the GPs, and a form that is readily adaptable to meet the needs of our partners, as well as some of the marginalised groups being targeted through Keep Well.'

'So far feedback on the Infopath forms from pilot sites has been very positive.'

**Heather Nelson,** Keep Well IT Support Officer.  
Email: [heather.nelson@aapct.scot.nhs.uk](mailto:heather.nelson@aapct.scot.nhs.uk)



Cartoonist Graham Ogilvie captured the day's main themes.

# One size does not fit all

**E**quality and diversity was the thought-provoking theme at this year's Anticipatory Care Practitioners Network event.

Do we meet the needs of each and every one of our patients equally? Would better communication between ourselves and with our patients help give the appropriate level of support, advice and care that patients are fully entitled to, regardless of where they live, what their age is, or what their social or ethnic background is?

These were some of the challenges discussed at the Anticipatory Care Practitioners Network 'Equality and Diversity' event held at Edinburgh's Dynamic Earth in March.

Speakers at the event outlined the challenges faced in tackling health inequalities to an audience made up of 130 anticipatory care practitioners. These practitioners represented all 14 territorial health boards as well as a range of sectors and agencies, including the community and voluntary sector.

Alastair Pringle, Scottish Government, gave the first presentation entitled 'Quality, Equality & Patient Centred Care, are we getting it right for everyone?'. This was followed by NHS Health Scotland's Lynda Brown who discussed the 'Scottish Perspective on NICE Public Health Guidance on identifying and supporting people



Paul Barton, NHS Scotland; Jean Macleod, NHS Highland; Marese O'Reilly, NHS Health Scotland; Lynne Waddell, NHS Forth Valley; and Jo MacLennan, Senior Health Improvement Programme Officer – Anticipatory Care

most at risk of dying prematurely'.

Anne Bryce, NHS Greater Glasgow and Clyde, concluded the morning's presentations by talking about the challenges of health in disadvantaged areas. Anne showed a powerful and emotive training video on how effective communication can make a difference in understanding patients' needs.

Following the morning's plenary sessions, a series of break-out workshops gave attendees the ideal opportunity to tackle specific subjects and share experiences in a more intimate setting. These workshops covered themes such as connecting with travelling communities and exploring the needs of patients with learning disabilities.



The Market Place: The British Heart Foundation, Citizens Advice and agencies working in healthy eating, community support, mental health as well as a Keep Well team were among the organisations manning stalls at the event and were on-hand to give out information and hand out literature.



Alastair Pringle, Head of Patient Focus and Equalities, Scottish Government outlines the Scottish political context and the strategy to ensure NHS Scotland becomes a world leader in its drive for equality and the delivery of excellent patient-centred care.

The pressing issue of equality and diversity affects clinicians' everyday appointments and healthcare planning and delivery throughout the country. This event enabled a number of equality and diversity-related issues to be discussed within the specific context of the Anticipatory Care programme.

The diverse nature of Scotland's population includes hard-to-reach groups such as homeless people, travelling communities and ethnic minority populations. A range of issues can make communicating with these groups difficult, including language barriers and lower levels of literacy, and this event gave solutions on how we can best communicate with them.

Jo Maclennan, Senior Health Improvement Programme Officer – Anticipatory Care, organised the event and opened the day's proceedings. Jo said: 'The practitioners network was established in 2006 and a steady increase in membership means numbers have grown to more than 250. This shows the great appetite for the network.'

'Although we keep in touch with the network via our Virtual Learning Environment and other electronic means, it's vital that practitioners have the opportunity to meet face-to-face at events and share ideas. This brings issues to life and makes learning more likely to be embedded, especially when complemented with hands-on opportunities to adopt good practice ideas. The main message I've taken out of this year's event is that we need to take an adaptable approach to the quality of care we give.'



**Jo Maclennan, Senior Health Improvement Programme Officer – Anticipatory Care.**  
Email: [jo.maclennan@nhs.net](mailto:jo.maclennan@nhs.net)

## Event feedback

Here's what some of the people attending the Anticipatory Care Practitioners Network Event said:

### **Gayle Muir, Community Keep Well nurse, NHS Lanarkshire**

'We need to be able to offer emotional support, take time to listen and not get too caught up in time pressures when we see patients. We need to be able to listen and that's why I found Anne Bryce's presentation so powerful. For me, it made a lot of sense.'

### **Alex Medcalf, Public Health Secretary, NHS Highland**

'The presentations have been inspiring and it's a great way to find out more about anticipatory care. Partly it's all about sharing experiences with colleagues.'

### **Wendy Robertson, Development Pharmacist, NHS Grampian**

'We are piloting a project to deliver community health checks within pharmacies in the Aberdeen and Fraserburgh areas. Other areas such as Ayrshire and Arran have already been doing it so it's been useful understanding and sharing what's been done to date. I found today really beneficial by learning how people are engaging with the hard-to-reach groups and how something as simple as a look or a word can make all the difference. I found Anne Bryce's presentation simple and powerful.'

## Key event messages:

There can be no 'one size fits all' approach to health

We need to adapt care to individual needs regardless of age, gender or background

Effective communication and asking patients the right questions breaks down barriers

We need to embed the equality and diversity message in every part of NHS Scotland

People need to be encouraged to engage more in their own health and healthcare

We still have much work to do in this area to make equality a reality.

# Making Connections – linking up Keep Well and Long Term Conditions

**In Scotland, an estimated two million people live with one or more long-term conditions, with many more at risk. Using Keep Well to target those most at risk will bring huge benefits for patients and healthcare professionals.**

We know only too well that Scotland has a poor record on smoking, alcohol misuse, diet and physical inactivity – key risk factors for cardiovascular disease, chronic lung disease and diabetes. It also has an increasingly ageing population, likely to live with a number of conditions for which they may require care and support.

## Support along the pathway

People with long-term conditions, and those at risk of developing them, are on a common pathway that views health as multi-dimensional, encompassing physical, psychological, social, emotional and financial wellbeing. This pathway needs interventions across all of these dimensions to support people to flourish and to live their lives to the full. At all stages of the continuum it needs approaches that:

- are enabling and anticipatory or 'thinking ahead'
- build community and voluntary sector capacity and develop health improvement services across all sectors



**'Scotland has an increasingly ageing population, likely to live with a number of conditions for which they may require care and support.'**

- understand the distribution of need in terms of inequalities and design services to address this,
- are collaborative across all community planning partners to harness the synergy and to maximise benefits.

Spring 2010 will see the publication of a guidance note to support practitioners to better understand the continuum of health improvement, anticipatory care and self-management

supports and the concept of community-led health. The document highlights the synergy across the Long Term Conditions Collaborative, Keep Well programmes and wider health improvement networks as well as community and voluntary sector, health and local authority supports for health improvement and self-management. The publication will be available on the National Long Term Conditions Collaborative and NHS Health Scotland websites.

**Lynne Galloway, Senior Health Improvement Officer - Anticipatory Care.**  
Email: [lynne.galloway@nhs.net](mailto:lynne.galloway@nhs.net)

**Get in touch.** If you would like more information about any of the content of this newsletter or to be added to the distribution list, please contact: Theresa King Senior Programme Officer, Anticipatory Care (Dissemination)  
tel: 0141 354 2994 email: [theresaking@nhs.net](mailto:theresaking@nhs.net)