



Have a Heart Paisley
Phase 2 Plan
May 2005

**HaHP is funded by the Health Improvement Strategy Division of the
Scottish Executive Health Department**

Contents

1. The Vision	Page 3
2. Rationale	Page 3
3. What will HaHP do to achieve its intended outcomes?	Page 6
4. Evaluation Framework	Page 10
5. Structures for Phase 2	Page 11
6. Financial Framework	Page 12
7. Dissemination	Page 12
8. Success Criteria	Page 12
9. Conclusion	Page 14
Glossary	Page 15
Annex 1	Page 16
Annex 2	Page 19
Annex 3	Page 23
Annex 4	Page 27
Annex 5	Page 28
Annex 6	Page 33
Annex 7	Page 36
Annex 8	Page 37

1. The Vision

Through the combined efforts of its partners, Have a Heart Paisley (HaHP) will deliver a targeted programme for the working age population (aged 45-60), and for those with heart disease, in Paisley. The aim is to demonstrate the degree to which primary and secondary preventive measures can improve heart health by tackling risk factors and unmet needs for treatment.

Funded by the Scottish Executive Health Department, HaHP is a partnership between NHS Argyll and Clyde, Renfrewshire Council, voluntary and community organisations and the people of Paisley. The vision for the second phase has been developed through a process of engagement with local and national partners and draws on learning from the evaluation of Phase 1. It has been agreed that having a narrower focus for actions in Phase 2 will improve HaHP's chances of making short-term and measurable gains in heart health for the people of Paisley.

How will the vision be realised?

This Phase 2 vision of HaHP focussing on support for those most at risk of developing heart disease and making services accessible to those most in need, will be delivered through a partnership approach that is committed to delivering through three Dimensions of activity:

Dimension A that helps those aged 45-60 years old who are at risk of cardiovascular disease through delivery of a targeted primary prevention system;

Dimension B that helps those people of any age who already have established coronary heart disease by increasing opportunities available to make improvement to their cardiovascular health and to improve access and adherence to cardiac rehabilitation programmes; and

Dimension C that supports this work through enabling participation, building confidence and increasing skills.

2. Rationale

Have a Heart Paisley was developed in 1999 within a spirit of enthusiasm to see Scotland's largest town enjoy the benefits of aspects of a comprehensive approach in tackling heart disease. Recent evaluation reports have suggested this has been an over-ambitious goal for Scotland in the present day. Experience from HaHP and other complex community health initiatives suggests that positive health improvement changes may only be expected and demonstrated over a longer period, driven by a project that focusses on a high risk population and is supported by wider prevention activities.

Coronary heart disease (CHD) is a major cause of mortality and morbidity in Scotland, responsible for nearly one in four of all deaths. It is a priority area for health improvement in Scotland, with a target of a 60% reduction in CHD mortality between 1995 and 2010 for those under 75 years of age. Despite a substantial decline in the CHD death rate since the 1970s Scotland persistently has higher rates than its Western European neighbours. The overall CHD death rate in Paisley is 8% higher than the Scottish average. Within the town, the CHD death rates for different areas range from 24% less than the overall Scottish rate to 50% more.

In common with many other major preventable health problems CHD shows a gradient across socio-economic groups and deprivation categories, with the toll of illness and

death being greatest among the most disadvantaged people and communities. For people from the most deprived areas of Scotland, the annual risk of dying from CHD is more than two and a half times that of people from the least deprived areas. Many of the influences that impact on the causes and treatment of CHD are beyond an individual's direct control. These are factors such as life circumstances, environments, services and amenities that affect an individual's risk of CHD and access to primary and secondary care treatments.

Health inequalities are starkly apparent within the parliamentary constituencies in which the town of Paisley sits. The recent constituency profiles published by NHS Health Scotland (2004), found that in Paisley North (made up of some of the most deprived wards in Scotland) annual rates of CHD related deaths were 25.5% higher than the Scottish average. Within Paisley South, annual CHD related death rates were 14.6% higher than the Scottish average.

There are eleven postcode areas within Paisley and the table below categorises those which have a DEPCAT score of 4 or above according to the Carstairs and Morris deprivation category (7 being the highest level of deprivation). These data are extracted from work by McLoone (2004) on behalf of the MRC Social Policy and Public Health Unit and uses 2001 Census data.

DEPCAT score	Postcode area
4	Espedair
5	Paisley Central, Glenburn
6	Gallowhill, Laigh Park, Millarston, Foxbar
7	Ferguslie Park

Table 1: Extract of Deprivation Categories in Paisley

It is estimated that a total of 65% (48,210) of the Paisley population falls within DEPCAT 4-7. This is further broken down to reveal approximately 39% of the population (28,926) fall within DEPCAT 4-5 and 26% of the population (19,284) fall within DEPCAT 6-7.

In order to narrow this health inequalities gap the Phase 2 interventions will, where appropriate, focus upon people living in DEPCAT areas 6 and 7 who fall within the target population for Phase 2.

Publication of the Scottish Index of Multiple Deprivation (SIMD) in June 2004 described the development of multiple deprivation scores for data zones in Scotland. The local Community Planning Partnership is currently considering which data zones will be targeted in the three year Regeneration Outcome Agreement.

Policy matters

The policy context in Scotland has evolved substantially from the early stages of Phase 1, with significantly greater funding streams currently being directed at health improvement activity. This plan for Phase 2 has been considered alongside the relevant, key health improvement policy areas (see Table 2). The proposed national Smoking, Health and Social Care (Scotland) Bill along with Renfrewshire Council's Policy and Initiatives to Control Smoking at Work will help in the development of healthy environments and support change in Paisley.

Table 2: Policy Context

Policy links within Dimension A
Local Government in Scotland Act 2003
NHS Reform (Scotland) Bill
Improving Health in Scotland – The Challenge
Eating for Health – A Diet Action Plan
Let’s Make Scotland More Active – A Strategy for Physical Activity
Coronary Heart Disease and Stroke – Strategy for Scotland
A Breath of Fresh Air for Scotland – Tobacco Control Action Plan
Unmet Needs Pilot in NHS Argyll and Clyde
Integrated Community Schools
Policy links within Dimension B
Local Government in Scotland Act 2003
NHS Reform (Scotland) Bill
Improving Health in Scotland – The Challenge
Eating for Health – A Diet Action Plan
Let’s Make Scotland More Active – A Strategy for Physical Activity
Coronary Heart Disease and Stroke – Strategy for Scotland
A Breath of Fresh Air for Scotland – Tobacco Control Action Plan
Unmet Needs Pilot in NHS Argyll and Clyde
Policy links within Dimension C
‘Working and learning together to build stronger communities’ (Scottish Executive, Jan 2004).
Performance Assessment Framework: Improving Health (Using a Capacity Building Framework)
Health Promoting Health Service
Local Government in Scotland Act 2003
NHS Reform (Scotland) Bill
Improving Health in Scotland – The Challenge
Integrated Community Schools

What has been learned?

The many evaluation reports that are now available through the Heart Health Learning Network website, www.healthscotland.com/hearthealth, highlight areas of success as well as providing key lessons about *how* to take forward health improvement in Scotland. Annex 1 summarises the key lessons from Phase 1. HaHP believes that the successes and challenges experienced at the commissioning, implementation and evaluation stages echo the experiences of others involved in improving health. It is essential to ensure that effective ways of working are better understood and that knowledge that is generated is shared with others. The Heart Health Learning Network based at NHS Health Scotland plays an essential role in sharing that knowledge.

How has the evidence base shaped Phase 2 plans?

In developing this plan for Phase 2 HaHP has absorbed best available evidence, both local and national and used a number of planning and evaluation tools, including RE-AIM (Reach, Effectiveness/Efficacy, Adoption, Implementation, Maintenance) see www.RE-AIM.com. The RE-AIM framework assisted in delineating those interventions that are drawn from the existing evidence base and those that seek to generate evidence of effectiveness. Drawing on that evidence HaHP will now move from a broad population approach to an approach that focusses support for those most at risk of developing heart disease and makes services accessible to those most in need.

Guiding principles

The strategic partners of HaHP have agreed to revisit the partnership values and principles, with reference to the Madrid Framework dimensions (Marinker 2005). This framework outlines many dimensions of health policy and governance and the partners consider that work on this area will help to strengthen joint working. Such continued improvements to partnership working are partly achieved through the process of clarifying the cultural beliefs and values that underpin partner organisations. This clarification may identify areas of difference that can be explored and better understood as well as areas of similarity that can be built upon.

3. What will HaHP do to achieve its intended outcomes?

The intended outcomes will either generate new knowledge, or take existing knowledge and develop it further in its application.

Intended outcomes

Dimension A

A1 A Central Data Repository (CDR) that enables implementation of a targeted primary prevention system through primary care.

A2 A primary prevention intervention for Paisley residents aged 45-60 years that effectively reduces the targeted population's risk of cardiovascular disease.

Dimension B

B1 A CDR that enables implementation of a targeted secondary prevention system through primary care.

B2 Improvement of the cardiovascular health of Paisley residents who already have identified coronary heart disease and who are currently maintained in primary care.

B3 Delivery of effective 'phase III' cardiac rehabilitation (comprising structured exercise and other risk factor modification) in a community setting for appropriate patients. At

the same time a safe and effective cardiac rehabilitation service is designed for the highest risk patients (i.e. the most ill CHD patients) who are referred to the cardiac rehabilitation programme at the Royal Alexandra Hospital, Paisley.

Dimension C

C1 Maximum participation of target population in both A and B interventions using a social marketing approach and innovative community planning workforce development.

C2 Influence on wider policy and practice through dissemination of learning/lessons from HaHP.

Central Data Repository (CDR)

The IT based Central Data Repository (CDR), successfully developed in Phase 1 will play an important role in Phase 2. Drawing on population data, services can be directed to those most in need and the CDR will work as a powerful public health tool in helping to address health inequalities relating to life circumstances. The current policy context in Scotland promotes greater responsiveness to patient needs and it is proposed that an equity audit be carried out in Paisley with a view to improving access and services to vulnerable populations and to promote patient involvement. The CDR will enable multi-practice audits to examine equity between population groups as well as between practices. Annex 2 provides further information on the functioning of the CDR.

Dimension A

Evidence

- Recent research suggests that CHD registers in primary care settings can impact positively on patient care and outcomes. In these settings, evidence exists that CHD registers have supported evidence-based practice and favourable health outcomes. However, while some of the potential benefits of CHD registers have been identified, further work is required to determine how the HaHP CDR can support changes in risk factor management and clinical decision-making.
- The 2004 Department of Health (DoH) public health White Paper, *Choosing Health: Making Healthy Choices Easier*, states that:
 - evidence supports a health trainer role in helping people to change and maintain healthier lifestyles
 - the 'self-care' or 'expert patient' approach has been successful with people who are ill and that this approach should be expanded into the prevention field enabling people to take greater control of their own health
 - further inequalities in health can be prevented through identifying people who may be at risk of developing chronic diseases or supporting people with existing chronic conditions. This sort of approach has been shown to be effective in work with people in their 50s - an age at which people often begin to experience illnesses that can develop into chronic disease and is a time when people's motivation to improve their own health increases.
- Much of what the DoH proposes fits with the HaHP Phase 2 approach for Dimensions A and B. HaHP proposed a health coach approach prior to the launch of the White Paper and subsequently used the DoH's description of the health trainer to develop further its own health coach concept.

Intervention

- The Central Data Repository will be used to support the delivery of a targeted primary prevention intervention through primary care. The CDR extracts all relevant data from the GPASS systems.

A primary prevention intervention will be designed and implemented for people aged 45-60, with the intention of reducing that population's risk of cardiovascular disease. For deprived communities staff from an NHS Argyll and Clyde unmet need pilot project, funded by the Scottish Executive, will work with staff from HaHP to increase uptake through the use of community development approaches. Individual participants will have their cardiovascular risk score calculated. Those found to be at increased risk will be offered a service that helps reduce their risk through a model of health coaching. Those whose scores do not indicate increased risk will be given advice to help them maintain their current low level of risk. People whose individual scores do not suggest increased risk but who live in area with Depcats 6 or 7 will be offered a positive mental health promotion intervention. This component will be developed subject to the recommendations of a systematic review of positive psychology literature that will be completed by the Glasgow Centre for Population Health early in 2006.

In the first six months of Phase 2 a mapping exercise and needs assessment will be carried out that will enable identification of current services and opportunities in Paisley in relation to CHD risk factors and identify the service needs of the target population (45-60 year olds). This will subsequently inform the decision process around the development of interventions and services required to strengthen the overall preventive effort in Phase2.

Health coaching will engage those at risk in the target population, help maintain them on their planned lifestyle changes and plan with the individual how they will adhere to this on a long-term basis including sign-posting to other relevant services, as identified by the mapping process. This will include sign-posting to local alcohol services should that be found to be required. Questions around alcohol consumption will be asked as part of the enquiry relating to diet with health coaches having a basic level of knowledge and understanding about alcohol and its impact on health.

A lay mentoring approach will also be used within communities to aid healthy lifestyle promotion in relation to tobacco, physical activity and healthy eating, helping to overcome some of the barriers that this target group faces through empowerment and support. Evaluation of this approach will add to the evidence base in this largely untested area.

Health coaching roles and staff numbers will be clarified by October 2005. A competency framework for health coaching along with innovative workforce development will be developed with NHS Education Scotland, NHS Health Scotland and others. The workforce is likely to be drawn from HaHP development staff, Unmet Need staff, lay mentors, NHS and local authority staff. This training approach will inform any additional recruitment requirements of the health coaching role/function.

In year 1 a computer based Health Behaviour Change Network (HBCN) will be developed that will capture details of all the available services in a web based tool that can be used by the Health Coaches to signpost individuals to suitable services. HaHP will work with the Big Lottery Fund development of the *CHD and Stroke MCNs on the Web* project that is seeking synergies with related health care projects.

Dimension B

Evidence

- The weight of evidence indicates that exercise-only cardiac rehabilitation reduces all cause mortality by 27%, cardiac death by 31% and a combined end-point mortality, non-fatal myocardial infarction and revascularisation by 19%.
- Evidence is being sought as to whether it is possible to create a systematic and integrated programme to improve cardiovascular health for those with existing heart disease.
- It has been found that effective and safe phase III cardiac rehabilitation can be delivered in a community setting. It is recommended for safe practice that cardiac

rehabilitation services for the highest risk patients (i.e. the most ill CHD patients) should be delivered in a hospital setting.

Intervention

- An intervention will be designed and implemented that aims to improve the cardiovascular health of patients who only attend primary care and already have been identified with coronary heart disease. This will engage the patients in comprehensive secondary prevention and rehabilitation through the most appropriate and desired setting using the health coaching model. This rehabilitation will also include support from trained lay mentors to encourage adherence and give added social support.
- The cardiac rehabilitation service will be redesigned to deliver menu-based phase III cardiac rehabilitation in a community setting and provide a safe and effective cardiac rehabilitation service for the highest risk patients (i.e. the most ill CHD patients) in a hospital setting. Successful delivery of this intervention requires ongoing partnership working with the Local Authority and other stakeholders to develop a broad range of sustainable exercise opportunities.

Dimension C

Evidence

- It has been shown that the provision of information and 'persuasive messages' (as in social marketing) can increase individuals' knowledge of health risks and appropriate action.

Intervention

- Dimension C will
 - Help to deliver A and B through social marketing approaches incorporating co-branding of HaHP and the national *Healthy Living* campaign.
 - Facilitate learning and development for the target population and those providing interventions based on lessons from Phase 1 and expanding to include positive mental health and wellbeing.

As Phase 2 of HaHP will concentrate on building the capacity of both the target group identified and that of partners who can help facilitate heart health change, there will be considerable emphasis on education and learning within these distinct areas. The project will work closely with Renfrewshire Council on their developing 'Community Learning and Development Strategy' and in integrating HaHP learning with the local Community Learning Plans. Workforce development activity will be aimed at those working within the direct and wider HaHP field to deliver Phase 2 of the project. The purpose of this area is to build the capacity of community planning partners in relation to heart health promoting needs.

A training needs assessment will take place at the start of Phase 2 and solutions generated to support the capacity of these professionals according to need and setting. This could include topics such as CHD awareness and risk factors for non health related staff, or motivational interviewing for those performing a health coaching role.

- Influence policy and practice through dissemination of learning from Phase 1, the Transition Phase and Phase 2 as it progresses.

The following organisations have been identified as potential agents for enabling capacity building in respect of Dimension C:

a) Social Marketing:

- Local press and media
- Liaison with National Healthy Living Campaign
- ASH Scotland
- Scottish Executive – Press Health Team
- NHS Health Scotland
- Scottish Community Diet Project
- National Physical Activity Co-ordinator

b) Education/Learning:

- Community Learning & Development within Renfrewshire Council
- Integrated Community Schools within Renfrewshire Council
- NHS Argyll and Clyde Learning and Development
- Paisley University and Reid Kerr College
- Local education centres (e.g. adult learning centres, RCVS)
- NHS Health Scotland
- NHS Education Scotland
- Centre for Confidence and Wellbeing

c) Dissemination

- NHS Health Scotland – Heart Health Learning Network
- All local contacts listed above in a) and b)
- National organisations (e.g. BHF, COSLA, CHSA, Diabetes UK, Heart of Mersey, Braveheart)

Annex 3 gives further details on the planned activity for Dimensions A, B and C.

4. Evaluation Framework

Leadership

Lessons from Phase 1 indicate that clearer leadership on evaluation and greater clarity of evaluation and monitoring roles are essential. These issues have been addressed within the new staffing and reporting structures. Building on the proposal set out in Annex 4, progress has been made in the development of the evaluation approach for Phase 2. The Scottish Executive Health Department and NHS Health Scotland have shown further commitment by ensuring that HaHP has support with evaluation. The specific deliverables required of RUHBC (Research Unit in Health, Behaviour and Change) and NHS Health Scotland have been defined as follows:

- Senior academic support in the design and implementation of the Phase 2 evaluation framework, taking account of existing preliminary progress
- Evaluation leadership within the project which would include:
 - performance management of the evaluation plan using a suitable monitoring system and linking with project leads
 - capacity building within the project by means of supporting project leads in developing appropriate monitoring and evaluation plans and by developing report writing expertise across the project
 - lead on a particular research aspect within Phase 2
 - lead on commissioning any external evaluations
 - a research and evaluation networking role with others, both local and national.

The evaluation framework will be firmed up following discussions with the new Head of Evaluation at RUHBC and the Head of Evaluation at NHS Health Scotland in May 2005.

It is proposed that the evaluation in Phase 2 will focus on structure (the attributes of the setting in which the intervention occurred), process (how the intervention was organised, delivered and used) and outcome (the impact of the intervention) (Donabedian 1980) (see Annex 5). The outcome measures represent the evaluation endpoints but qualitative and quantitative descriptive data on structure and process will also be necessary to explore whether, and how, the outcome was caused by the intervention itself, and/or by variations in structure, or the way it was organised or delivered (process). Process measures refer to accessibility of the interventions and the quantity and quality (numbers, type and suitability) of intervention outputs. Both user and health professional perceptions of satisfaction will be sought to explore quality.

Evaluation of structure will involve description of the quantity and quality (numbers, type and suitability) of the inputs, or resources, required to deliver the intervention. Inputs might include the distribution of staff, their mix in relation to level of training, grade and skill, availability, siting and type of buildings, facilities and equipment, numbers and types of services, consumables used and other types of capital and financial resources. Information about these aspects of the intervention is particularly important for learning to be successfully shared in other areas.

Monitoring

Performance frameworks will be established to monitor progress towards achievement of the evaluation endpoints, i.e. outcome measures. This will enable the project to identify and respond to performance issues within its life course thereby optimising capacity to deliver on outcome targets.

Performance management

A variety of methods have been used that enable linkage of planned activities and interventions to high-level outcomes. A grid is in development that will form the basis of an integrated method of performance management where key performance indicators are clearly linked to individual activities and interventions and a performance audit trail created. In this way changes in high-level outcomes can be tracked back to specific initiatives and interventions.

5. Structures for Phase 2

Management and accountability

HaHP will be located within the emerging Renfrewshire Community Health Partnership (CHP). This will maximise benefits to local Community Planning mechanisms (see Annex 6). The CHP structures are currently in development but it is proposed that the Chair of the HaHP Management Group will sit within the general management structure of the CHP. This will allow for direct influence of the local health improvement and community planning agendas.

The HaHP Steering Group, chaired by the Director of Public Health, is responsible for overseeing all governance issues and assuring Renfrewshire CHP and the Scottish Executive that appropriate governance structures and systems are in place, and that these are operating effectively. It is also responsible for the development of policy and practice in line with the agreed strategic direction. The delivery and operation of governance, implementation and evaluation issues will be led by the HaHP Management Group, which will discharge its responsibility through the operating structure of the project. The Project Manager will guide the development of the governance and performance management systems throughout the project. As Renfrewshire CHP becomes established management and accountability arrangements will be reviewed to ensure that the most effective and efficient use of structures are put in place to maximise influence.

Human resources

Following issues raised and recommendations made within evaluation reports a more centralised approach has been taken to the staffing structure for Phase 2. This will provide an opportunity to ensure greater consistency in terms of implementation, monitoring and evaluation co-ordination, and resource expenditure.

For the delivery of Dimension A, emphasis has been placed on developmental posts, with a specific remit to develop activity in partnership in order to achieve the agreed outcomes for Phase 2. Dimension B requires additional staff to move cardiac rehabilitation activities into a community based delivery model, including a key senior level post to oversee the integration of secondary care activities. Additional posts will be required to further support Phase 2 activities including a post that will co-ordinate all evaluation functions and specific IT posts that are central to the implementation and monitoring required across HaHP.

Health coaching is an overarching term used within the plan to describe activities that will take place on a one-to-one basis with individuals from the A and B populations later in the project. Specific skills will be needed to carry out this function and further scoping will be required to define whether this should be a separate role or whether skills could be developed with HaHP or the partner workforce. As stated on page 8, this will be clarified by October 2005.

6. Financial Framework

The figures presented in Annex 7 provide an indication of likely spend in years 1, 2 and 3 of Phase 2, taking account of projected and actual spend in Phase 1 and in Transition Phase. For practical purposes it is assumed that the current premises at Mile End Mill will be retained and salary costs have taken account of a possible 3.225% uplift in salaries in April 2005, 2006 and 2007. The Development budget will be used in support of the activities that will result from the mapping and needs assessment work, including the health coaching activity. Flexibility within and across budget headings will ensure that project spend is targeted in line with key objectives. Funds have also been allocated to support the evaluation and dissemination activities.

Within Phase 2 there will be a taper of staff within the three years of the project. For those existing posts finishing prior to the end of Phase 2 discussions will take place with the Cardiac Services MCN regarding the strategic fit for continuing these posts. The Scottish Executive has indicated that HaHP should be exempt from any local vacancy management procedures that might otherwise delay recruitment processes. The length of contract for any new member of staff will be considered individually in relation to Phase 2 plan requirements.

7. Dissemination

How will learning be shared with others?

In Phase 2, key HaHP staff will have a specific role to play in achieving the dissemination objectives. HaHP's dissemination plans continue to feed into the Heart Health Learning Network work programme (see Annex 8).

8. Success Criteria

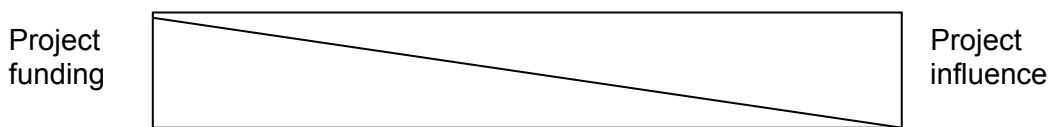
This plan for the second phase of HaHP seeks to address the four Success Criteria identified in the Scottish Executive Health Department's Phase 2 commissioning letter of 13 April 2004 as follows:

i. Financial sustainability and ii. Senior level leadership

The commissioning letter indicates a requirement for Phase 2 of HaHP to be funded by a specified mix of local and Executive funding. The partners remain committed to HaHP as a national health demonstration project guiding future action locally and beyond. It is not, however, possible for the partners to commit to make up for the tapering off of Executive funding during HaHP Phase 2, as might be represented thus:



Instead, our intentions can be represented thus:



This means that specifically identified funding for HaHP will be dependent on SEHD funding, but as this tapers off, the influence of HaHP will be expected to increase progressively through:

- local and national dissemination activities
- the legacy of changes achieved that will be sustainable without funding from the HaHP partners
- informing national policy, and future action locally and beyond.

This approach not only reflects the reality of financial and other challenges and responsibilities facing HaHP partners, but will also aid mainstreaming of HaHP lessons in areas that have not had the benefit of the special funding that has enabled HaHP to be set up and developed.

HaHP partners are committed to ensuring that approaches which have been seen to be effective and value for money will influence local practice and service implementation through the Joint Health Improvement Planning mechanism (see Annex 6). The outcomes of Phase 2 of HaHP will help inform decision-making in NHS Argyll and Clyde in relation to chronic disease management, new models of care and the Cardiac Services MCN. If the model proves successful in increasing numbers, using Local Authority facilities in the medium term, this will also help inform future Council decision-making and community planning processes.

NHS Argyll and Clyde is currently rolling out the CDR through the MCN. Should the targeted primary prevention intervention prove successful, this will be considered for roll out again within the MCN.

iii. Applicability for the rest of Scotland

The selection of the interventions within Phase 2 has been made within the context of an evidence based approach. The new evidence that will be generated through the implementation of those interventions will be captured through the evaluation framework that is being developed with the support of NHS Health Scotland (see Annex 4 and 5). That new learning will highlight what does and does not work, and what may be transferable and will be disseminated nationally and internationally in conjunction with the Heart Health Learning Network (see Annex 8).

iv. Tackling health inequalities

Have a Heart Paisley's activity is underpinned by the need to address the health inequalities gap in Paisley (see page 4) and the Phase 2 interventions will, where appropriate, focus upon people living in DEPCAT areas 6 and 7 who fall within the target population for Phase 2. The use of the CDR as a public health tool, the targeted health coaching, the local community development and unmet need activity, the consideration of deprivation in calculating a risk score for CHD and the promotion of positive mental health will combine to help HaHP tackle the socio-economic, gender and disability inequalities in the target population.

Defining success

The need to track HaHP's progress towards the achievement of success, as defined by these four criteria, will guide the development of the evaluation priorities with NHS Health Scotland along with the intended outcomes listed within the plan (see pages 6 and 7).

9. Conclusion

All involved in Have a Heart Paisley have worked hard to secure this opportunity to build on the knowledge, skills and initiatives developed in Phase 1. We will now work in partnership to ensure that HaHP's Phase 2 interventions will improve the heart health of local people and provide valuable learning for Scotland.

Glossary

Cardiovascular disease:

A classification which encompasses a number of different problems of the heart and circulatory system such as coronary heart disease, stroke, congestive heart failure, peripheral vascular disease, congenital heart disease, and many other conditions.

Myocardial infarction:

Also called a heart attack; occurs when one or more regions of the heart muscle experience a severe or prolonged decrease in oxygen supply caused by an occlusion of the coronary blood vessels. The surrounding heart muscle is damaged and may not work effectively.

Phase 3 cardiac rehabilitation:

Structured exercise programme, lasting an average of 11 weeks, delivered either in a hospital, community or home setting.

Primary care treatments:

Medical care or services received on first contact with the medical system (before being referred elsewhere) and typically provided by a general medical practitioner, a community nurse, midwife or health visitor.

Primary prevention:

Any intervention targeted at people without clinical evidence of a disease to prevent it developing.

Revascularisation:

A broad term that describes surgical and catheter procedures that are used to improve blood flow to the heart. Includes percutaneous transluminal coronary angioplasty (PTCA), with or without stenting, and coronary artery bypass grafting (CABG) surgery.

Secondary care treatments:

Specialist care or services, typically provided in a hospital setting following an emergency admission or referral from a primary or community health professional.

Annex 1

Have a Heart Paisley Learning From Phase 1 - Independent Evaluation

Phase 1 of HaHP was subject to both external, independent evaluation and internal, project based monitoring and evaluation. This section outlines how learning from the independent evaluation is being applied in Phase 2 of the project.

There is much to be learnt from Phase 1 but not all is relevant to the more focussed Phase 2 plans. This section does not therefore detail all Phase 1 lessons. For a detailed description of these (including learning from the internal evaluation), please see the learning templates available from the Heart Health Learning Network website (www.healthscotland.com/hearthealth). Similarly, the section does not try to identify every Phase 1 lesson that may be of relevance as it could be argued that most are being addressed, at least in part, in Phase 2 and given the depth of information available, this would lead to a particularly large section. For the sake of brevity therefore, the section draws on the independent evaluation learning templates and the various independent evaluation reports to identify the main relevant lessons from Phase 1 and outlines how these are being addressed in Phase 2.

Applying Independent Evaluation Lessons from Phase 1

Phase 1 Learning

HaHP activities need to be tailored to the right residents/groups (Blamey et al, 2004)

Phase 2 Action

At the individual level, the Health Coaches will identify specific need and tailor advice and support accordingly. At a more group orientated level, the initial mapping and needs assessment exercise will identify where gaps in services exist. Working with project partners, HaHP will then seek to fill these gaps.

Phase 1 Learning

There were high rates of referrals (for those with identified CHD risk factors) to smoking cessation projects and services, fewer to exercise projects and hardly any to community food projects. Furthermore, the majority of referrals were made to HaHP services as opposed to community run projects. There are seen to be some lost opportunities in developing links with the community projects (and locality network coordinators) that are available (Blamey et al, 2004)

Phase 2 Action

The Health Coaches will act as intermediaries between primary care, HaHP and partner led services and the community. This should lead to higher referral rates for all services based on individual need and should maximise the potential input from partner agencies and community and voluntary groups.

Phase 1 Learning

On the whole HaHP has remained on the periphery of all the key partner agencies work and made little contribution to the wider community planning agenda (Blamey et al, 2004)

Phase 2 Action

In Phase 2, HaHP will be actively engaged in the community planning agenda, designing and delivering services with and for the local community.

Phase 1 Learning

Evidence-based practice (as understood from a medical or health service perspective) was applied to a degree at the conceptual level across most of HaHP. However, there were areas of operational practice where the application of evidence or “best practice” was variable or non-existent (Blamey et al, 2004)

Phase 2 Action

Phase 2 has utilised the RE-AIM planning tool to develop relevant and appropriate programmes. This tool helps to identify and apply the most up-to-date and applicable evidence. In addition, Phase 2 will focus on areas where there is the strongest evidence of effectiveness (i.e. primary prevention in high-risk groups and secondary prevention).

Phase 1 Learning

Many of the problems around the use of evidence, intervention intensity and scope for saturation had their roots in the early planning phases of the project and resulted from a lack of early scrutiny from both the SE and HaHP of the range of plans submitted by different agencies (Blamey et al, 2004)

Phase 2 Action

Phase 2 has utilised a number of planning and evaluation tools (e.g. LEAP For Health and RE-AIM) to develop relevant and appropriate programmes. In addition, the project has employed the services of an external consultant to assist in project planning through the identification of relevant strategy maps and associated targets and performance indicators.

Phase 1 Learning

The internal evaluation of HaHP experienced a range of difficulties. These included: problems in recruiting and retaining staff; the lack of relevant data that can be disaggregated to a local level for use as a baseline, the poor response rate achieved in the external baseline survey, confusion over monitoring and evaluation roles and delays in prioritising the key focus of the internal evaluation (Blamey et al, 2004)

In addition, according to the final independent evaluation report:

it is vital that evaluation is considered from the outset in any future pilot initiatives and that priorities for key areas of evaluation are agreed and monitoring processes subsequently focused towards these priorities. It is also important that internal and external evaluation roles are clearly defined and that monitoring is seen as the responsibility of those running programme. (Blamey et al, 2004)

Phase 2 Action

Phase 2 has utilised a number of planning and evaluation tools (e.g. LEAP For Health and RE-AIM) and employed the services of an external consultant to identify a series of targets and performance indicators that will be used to monitor and evaluate the success of the project.

Phase 1 Learning

The lack of available internal monitoring data makes it impossible to gauge HaHP's success in saturating Paisley with services and opportunities for health improvement or reducing inequalities. Although many areas of HaHP appear to be engaging with their key target groups, the frequency, quality, duration and health impact of this engagement has not been established (Blamey et al, 2004)

Phase 2 Action

As outlined above, Phase 2 of the project will ensure all appropriate monitoring data is captured. In addition, key factors of saturation are reach/coverage (no. participants), intensity (quality and extent of participation), adoption (no. of organisations providing/participating in opportunities) and dose (interaction of intensity, frequency and duration). The RE-AIM framework, applied in Phase 2 planning, addresses many of these issues.

Phase 1 Learning

Short-term population interventions are unlikely to reach enough members of the public, to deliver intense enough interventions or to fully engage enough community members in their design delivery or evaluation, particularly if they fail to allow adequate time for consultation of evidence and effective planning. It appears increasingly evident that dramatic change will not be achieved by such short-term interventions unless they are given feasible timescales and genuine national support to deliver and to fully engage local communities. The types of changes achieved in the more successful of the CHD or chronic disease interventions projects resulted from intense activity with small high-risk sub-groups or from long-term community and advocacy to tackle upstream policy issues with the direct support of central government (Blamey et al, 2004)

Phase 2 Action

Dimension A of Phase 2 will target a high-risk sub-group with an intense range of activities.

References: Blamey, A., Ayana, M., Lawson, L., Mackinnon, J., and Judge, K. Final Report for the Independent Evaluation of HaHP. Glasgow: [Health Promotion Policy Unit, University of Glasgow](#); 2004.

Introduction

This document gives a high level description of the capabilities and functionality of the Central Data Repository (CDR), which has been developed as part of Have a Heart Paisley (HaHP). The CDR has been developed primarily as a tool to facilitate the delivery of health care in relation to coronary heart disease. The paper aims to address the following:

1. Describe the capabilities of the CDR in relation to other Scottish and UK systems
2. Outline the potential gains and risks of the CDR in Phase 2
3. Identify how those risks could be mitigated so that the effectiveness of the project is not undermined
4. Clarify the individuals and staff groups who will have access to identifiable data.

1 HaHP CDR Capability

The CDR acts as a hub collecting and storing data from systems based within primary care and secondary care. It also imports demographic and hospital discharge data from the Information Services Division (ISD) and from the Community Health Index (CHI). Data is transferred on a regular basis from these legacy systems, producing audit and patient reports, which are updated daily and viewable on-line. The CDR provides comprehensive patient information. It provides or has the following features:

- A single system containing all coronary heart disease data to support the care of patients.
- Access to a single patient summary with the latest data values within a core dataset.
- Access to historical data items e.g. all blood pressures, cholesterol levels in the system for an individual patient which can be viewed over time in a graph or report.
- Access to all relevant General Practice Administration System for Scotland (GPASS) information for a specific patient via a web browser.
- Access to all secondary care information, including rehabilitation data via a web browser.
- Area-based comparisons, comparing current GP practice details against the average of all other practices.
- General Medical Services (GMS) Contract indicator reports for individual practices.
- The CDR is a population database and has the capability to be developed through the use of relevant Read codes for any chronic disease management or identification of target groups within the population.
- The CHD dataset was developed in Phase 1 and influenced the national core dataset for CHD. It is compliant with SCI Bronze and has been ratified by ISD as holding national definitions in the dataset and thus is also compliant with Scottish Care Initiative (SCI) diabetes and SCI Store. The CDR IT team is working with the national IT subgroup in cardiology and any further work will be in line with development of SCI Silver and Gold.
- The CDR is currently seeded by a CHI download from the national centre in Dundee and updated daily with a CHI transactional file. When SCI store is ready to seed other NHS Argyll and Clyde systems it will be possible to seed directly from the Store to the CDR as the CHI index is already there.

HaHP has shared CDR development information with other projects, however this has not been reciprocated. To fully compare the functionality of the CDR to other systems in Scotland complete information is required. This is now being addressed by ISD. In the interim it is possible to make comparisons from published articles on other systems and five aspects of the CDR system have been identified as unique:

- A current population demographic database, including deprivation categories
- Availability of CCU (Coronary Care Unit) and general cardiology inpatient data including investigations (once Read Codes are finalised)
- Availability of cardiac rehabilitation data
- Community nursing palmtop data capture system
- Patient lifestyle data.

2 Benefits from the CDR

The CDR has the potential to deliver several gains for stakeholders during Phase 2. The expected benefits to each group are given in the table below.

Stakeholder	Benefits/evidence
NHS Argyll and Clyde (NHSAC)	<p>Provides a platform to enable future evaluation The CDR can be used as a patient tracking database that could facilitate long-term patient outcome assessment at practice or Paisley level. In addition, the CDR can facilitate targeting of HaHP community-based activity on specific groups/individuals and enable ongoing monitoring and ex-post evaluation of HaHP service delivery</p>
	<p>Improves patient care and outcomes Improved information will help enhance healthcare delivery, which will in turn enhance patient health outcomes. 25% of community nurses stated that the CDR had already impacted positively on patient care. With fuller access to the CDR we expect that this impact will be greater.</p>
	<p>Key learning generated through IT development and delivery Learning from the CDR experience can be applied locally and more widely in future, where clinical IT systems are being developed/planned.</p>
GP practices	<p>Information availability In a recent internal evaluation survey 75% of GPs stated that the CDR contained information not available elsewhere. Without the CDR, immediate discharge data and Secondary Care data from CCU would be unavailable electronically.</p>
	<p>New Information The CDR will include patients' lab test results and timeline charts for GPs, which represents new electronic information. All GPs stated that such information would be useful.</p>
	<p>Efficiency savings Electronic CDR information will lead to reduced time and effort expended in GPs seeking patient data, thus increasing GPs' efficiency in treating CHD patients.</p>
	<p>GMS Contract facilitation CDR data is Read Coded then sent to practices. All information is pre-coded and is GMS contract compliant, requiring no administrative coding effort by practice staff and assists data gathering required by the new GMS contract.</p>
	<p>Targeting CHD Helps general practitioners focus services on CHD patients</p>
	<p>Speed of access to patient information Community nursing staff will not have to wait for written communication (e.g. hospital letters)</p>
Community nursing team	<p>Time saving During evaluation community nurses stated that having the CDR would certainly save time in sourcing patient information</p>
	<p>Fuller information The CDR contains information not otherwise available to community nurses.</p>
	<p>Focuses community nursing practitioners on CHD Risk factor and behaviour information will allow nurses to target existing health inequalities.</p>
	<p>Improved care and service All the above benefits will contribute towards more rapid, better-informed care delivery for patients. Patients who are not receiving appropriate therapy, e.g. statins post MI, or whose cholesterol is not ideal, can be identified.</p>
Patients	<p>Improved health outcomes Better outcomes will derive from improved care and service. Through the Rapid Alert System the CDR can alert patients by mailshot to a medicine recall with an explanation to allay anxiety.</p>

3 Potential Risks to the CDR

A number of potential obstacles has been identified by the IT project team that could present threats to achieving the potential benefits of the CDR. The table below shows the identified risks. The potential risks have been considered against the risks that face HaHP in Phase 2 and those that currently face NHSAC Cardiac Services MCN in rolling out Phase 1. Should HaHP CDR be rolled-out nationally it might be expected that similar risks would face other NHS Systems.

Potential risk	Solutions/safeguards	Extent of Risk
1. Insufficient hardware in surgeries. (Relates to roll-out of Phase 1 only.)	An extensive IT upgrade programme was recently carried out in primary care ensuring that all surgeries met a minimum specification. It has been confirmed that all practices in NHSAC meet the required specification.	Risk: Medium Impact: Low
2. GPASS practice but no CDSS installed. (Relates to roll-out of Phase 1 only.)	The IT project team is rewriting the extraction routine which means that the CDR will no longer be dependant on CDSS being installed. This is currently being tested.	Risk: Medium Impact: Low
3. Practices without GPASS or EMIS system. (Relates to roll-out of Phase 1 only.)	A new extraction method would need to be devised. The number of such practices is likely to be very small within NHS Argyll and Clyde. The picture in Scotland as a whole may be different.	Risk: Low Impact: Medium
4. Sufficiency of resources to support the surgeries, given primary care support teams limited resource. (Relates to roll-out of Phase 1 and implementation of Phase 2.)	If the new extraction routine is implemented the transfer of data will take place directly between the HaHP server and the GP server; there will be no program on the surgeries server. This will reduce greatly the need for outside support as most problems that arise could be fixed remotely by the HaHP system administrator. The key resource need therefore is for hardware purchase and installation – this has been tackled through point 1 above.	Risk: Low Impact: Medium
5. Changing working practices – Will the practices support roll-out? (Relates to roll-out of Phase 1 and implementation of Phase 2.)	A key thrust of the CDR roll out is to minimise the required change to working practices, embedding the CDR as seamlessly as possible using existing hardware and communications channels.	Risk: High Impact: Low
6. Staff – if we lost key staff this would be a major risk to the project (Relates to roll-out of Phase 1 and implementation of Phase 2.)	If this was implemented widely it would become a corporate system and be supported by the relevant IT departments. This would mean a greater knowledge of the system among several more staff so that dependency on certain people would be minimised.	Risk: Low Impact: Medium
7. New versions of GPASS are implemented which affect the transfer of data (Relates to roll-out of Phase 1 and implementation of Phase 2.)	GPASS have now registered HaHP as a third party supplier and will supply software updates of GPASS to determine any potential problems before the update goes live. The IT project team now has extensive experience of responding to a changing software environment and know the pitfalls, thereby minimising unanticipated disruption. The impact of new software versions may cause CDR information delay, but no loss of data.	Risk: High Impact: Low
8. Surgeries cannot link to the RENVER network. Are there resources available to implement a new link? (Relates to roll-out of Phase 1 only.)	All surgeries appear to be on BT Healthnet. If they are not on the local network. This means that connections can be easily set up.	Risk: Low Impact: Medium

4 Access to the CDR

Access to the CDR is governed by procedures and standards agreed by partners and set out in the *Security Protocols* document (available on the HaHP Register web-site). Access is broadly structured as follows:

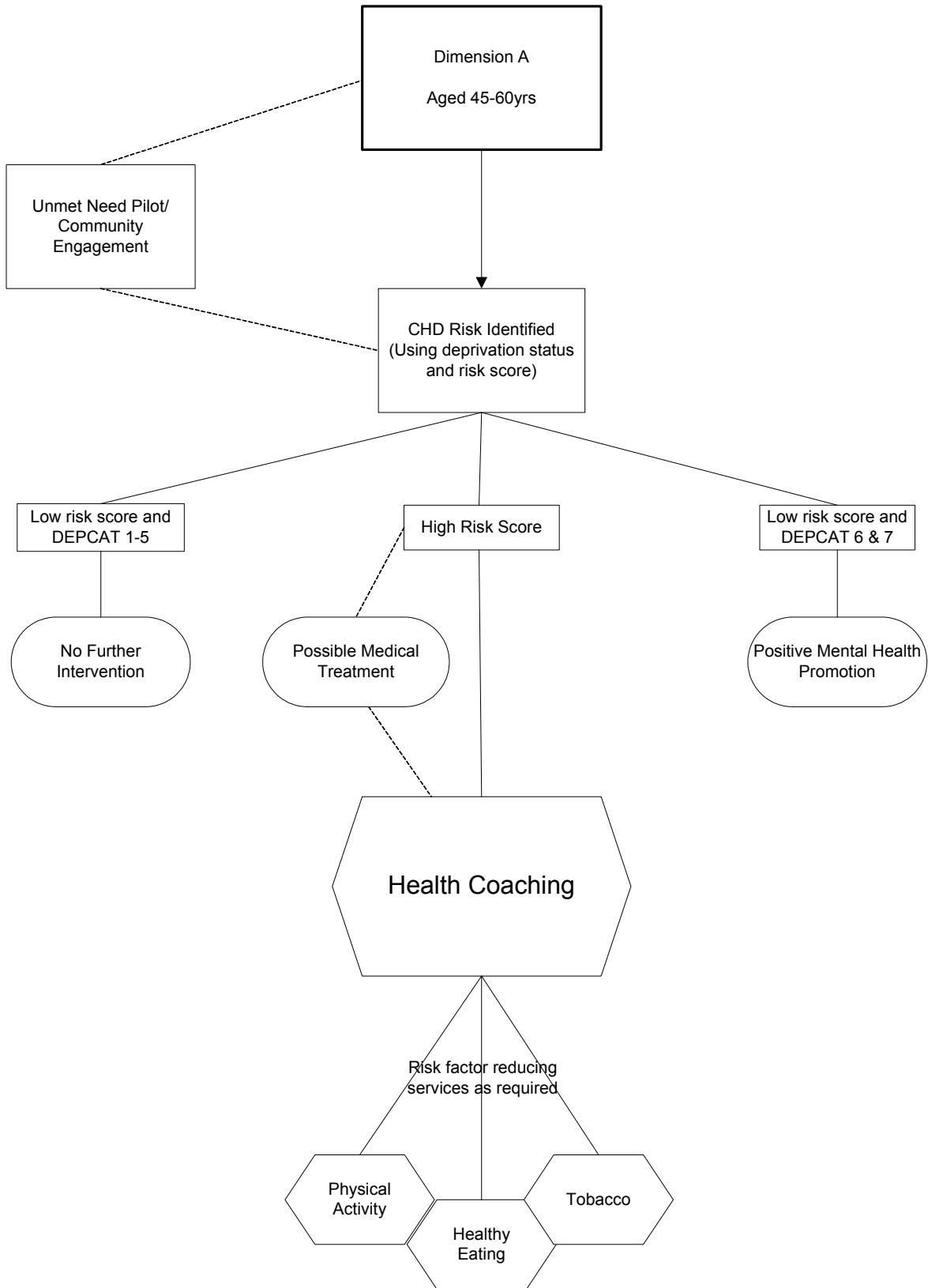
- All primary care health professionals have access to their own patient-identifiable information via the CDR. This is determined by the surgery in which they work. Primary care health professionals can access only their own patients' data
- Secondary care professionals will only have access to patient data for those patients who are currently being cared for in their unit e.g. CCU
- Researchers have access to anonymised data only
- IT project team members have access to patient-identifiable information within a controlled and secure environment
- Other interested parties may apply to have access to CDR data, however, this will be anonymised data only.

Annex 3 Planned Activity

Intended Outcomes	Objectives	2005					2006					2007					2008																		
		M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D
A1	To develop a fully Data Protection compliant, functioning CDR	Develop monitoring system by end Feb 06										Implementation of system										Data Analysis													
		Set threshold for risk April 05																																	
A2	To get people to recognise their risk To connect people with services to enable participation To ensure that the right services are available	Mapping & needs assessment by Sept 05																																	
		HBCN Functioning by end Feb 06										Health Coaching Begins March 06										Eval/ Exit													
												Risk factor Related Interventions begin Oct 05										Eval/ Exit													
B1	To develop a fully Data Protection compliant, functioning CDR that is compatible with CR data management systems	Develop monitoring system by end Feb 06										Implementation of system										Data Analysis													
		Set threshold for risk April 05																																	
B2	To enable people to maximise healthy behaviours To enable people to adopt and maintain recommended physical activity	Chronic stable population engaged by end Feb 06																																	
		Enhanced secondary prevention services in place by end Feb 06										Implementation of secondary prevention system										Eval/Exit													
B3	To enable people to maximise healthy behaviours To enable people to adopt and maintain recommended physical activity	Non hospital based Phase III services in place by end Feb 06										Implementation of services										Eval/Exit													
		Phase IV community services in place by end Feb 06										Implementation of services										Eval/Exit													
		CR for high risk patients in place by end Feb 06										Implementation of services										Eval/Exit													
C1	To build the confidence, skills and awareness of the target population and those providing interventions	Health Coaching Competency Framework developed by Oct 05																																	
												Workforce development activity from Oct 05										Eval/Exit													
C2	To disseminate HaHP Learning	Pilot 'Learning Days' by June 05 and subsequent rollout																				Eval/Exit													
												Publications and conferences from March 05																							

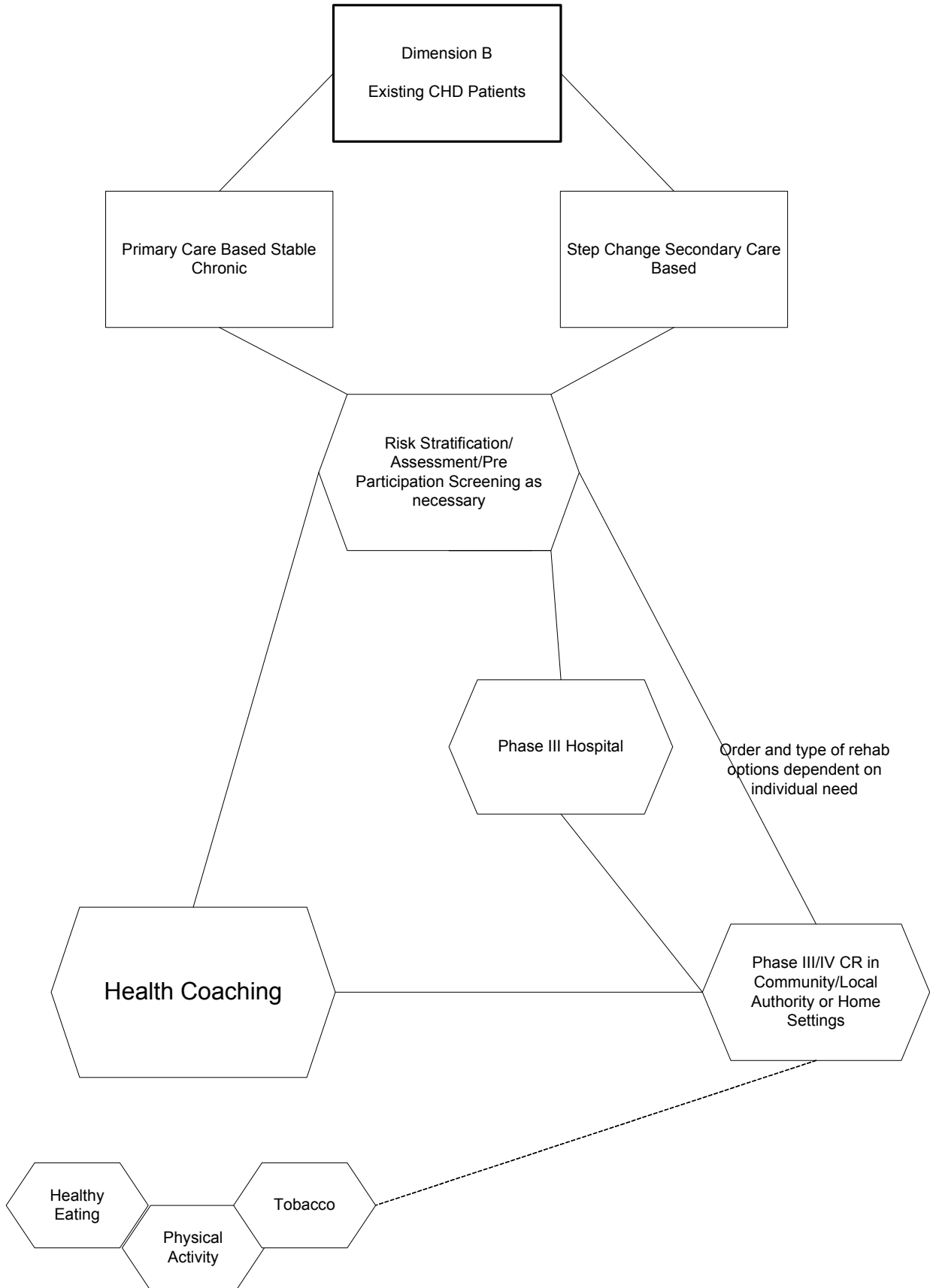
Dimension A

Client Journey Flowchart

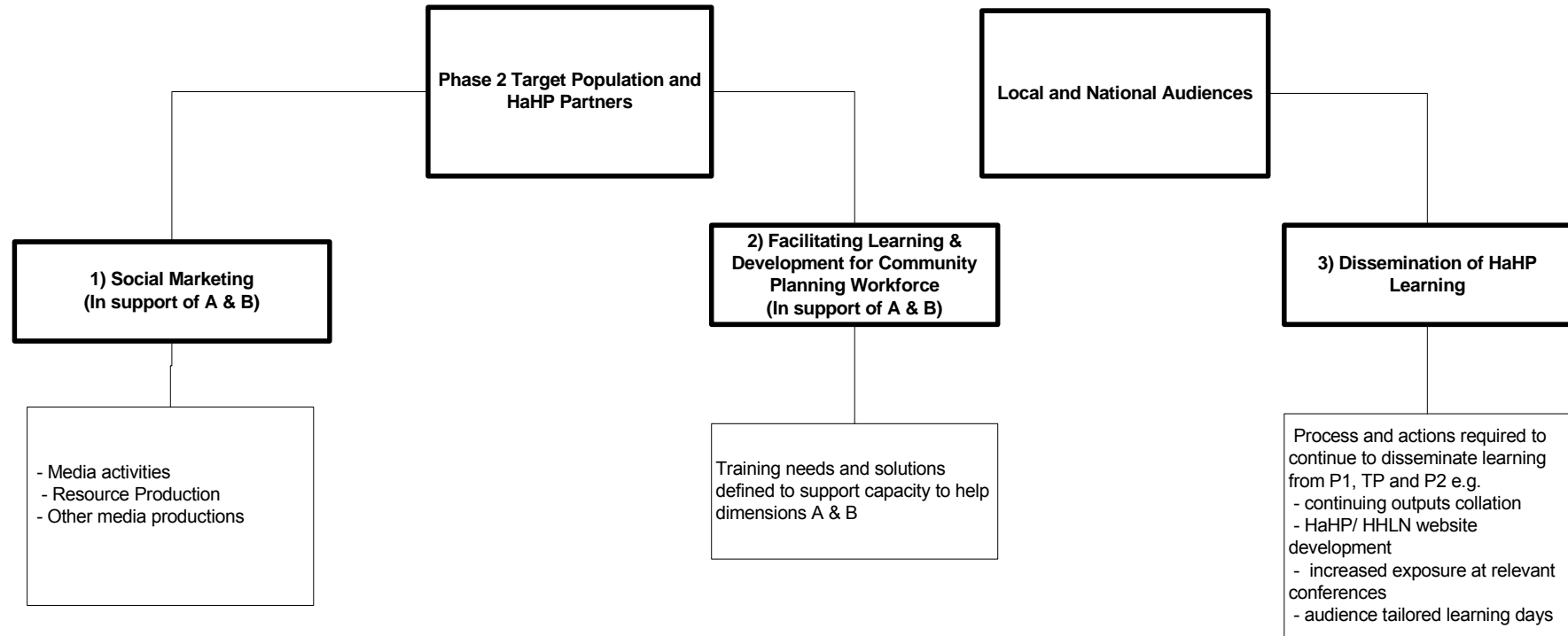


Dimension B

Client Journey Flowchart



Summary of Dimension C



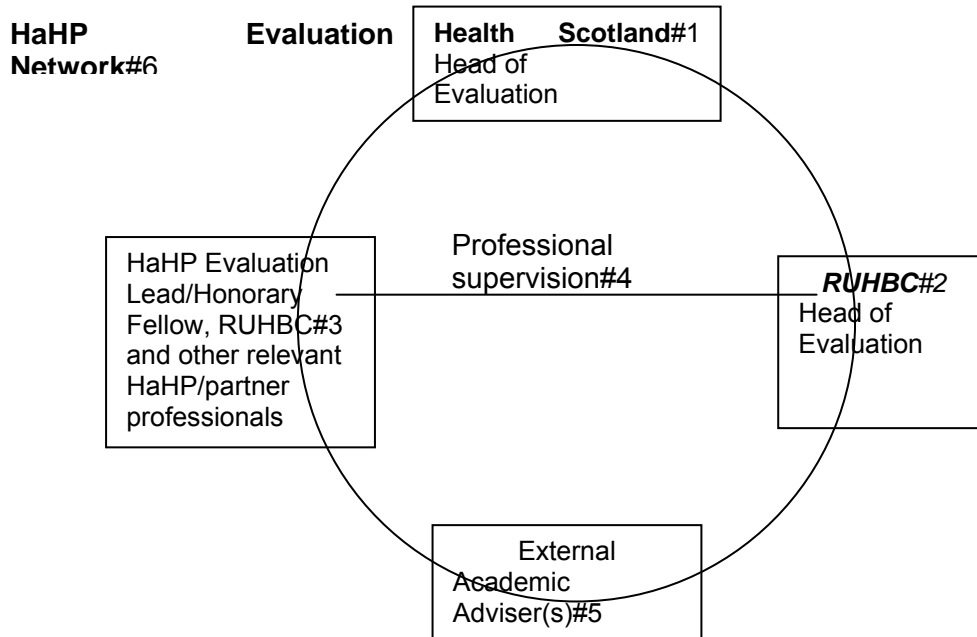
Annex 4

POSSIBLE APPROACH TO EVALUATION

At the meeting of SEHD and HaHP representatives on 14 December 2004 the following points were agreed.

- Evaluation is of crucial importance to HaHP Phase 2 as a national health demonstration project; some outcomes need to be further clarified; and there needs to be clarity over what data are to be collected, when and by whom.
- There are significant limitations to what can reasonably be expected of HaHP in itself as regards designing and delivering the evaluation, especially as there are real concerns as to the likelihood that an NHS evaluation post of the anticipated grade would attract and retain a suitably skilled person. there are also limits to the extent to which HaHP partners' senior staff can be expected to provide ongoing evaluation leadership inputs; moreover, it would be highly desirable for HaHP to have the support of an academic input and/or other high-level specialist evaluation expertise.
- SEHD will support HaHP in the identification and timeous realisation of a practical and suitably streamlined evaluation solution.
- HaHP would explore possibilities with NHS Health Scotland.

Following discussion involving representatives of the Scottish Executive, NHS Health Scotland and NHS Argyll and Clyde the following HaHP evaluation network approach is suggested as a potential solution for exploring further as a matter of high priority



Notes

#1: Health Scotland input highly relevant, given national lead role in health improvement evaluation, sponsorship of RUHBC (see #2) and links with all national demonstration projects

#2: RUHBC (Research Unit in Health, Behaviour and Change, University of Edinburgh) currently seeking to fill new post of Head of Evaluation, viewed by Health Scotland as an important health improvement resource; Erica Wimbush of Health Scotland will discuss possible involvement in HaHP with RUHBC Director, Steve Platt

#3: Post would be in HaHP, but link to RUHBC likely to make it more attractive to individuals with suitable expertise; possibility of Honorary Fellowship would need to be discussed with RUHBC/University of Edinburgh.

#4: See #3. Postholder might work towards PhD.

#5: Inclusion of other academic adviser(s) would widen/deepen expertise, provide in-built peer review at all stages, and facilitate wide engagement in HaHP. Invitations to participate actively could be sent to all relevant university departments/other relevant research institutions, but need to avoid unwieldy arrangements/excessive bureaucracy.

#6: HaHP Evaluation Network would link to other relevant networks, e.g. Heart Health Learning Network and network of national health demonstration projects.

Annex 5 Evaluation Measures

Intended Outcome	Outcome Measure (% figures will be agreed with NHS Health Scotland in May 2005)	Process Measure
<p>A1 A Central Data Repository (CDR) that enables implementation of a targeted primary prevention system through primary care.</p>		<p>% of people aged 45-60 in Paisley with risk data populated within CDR, broken down by deprivation status.</p> <p>% of missing data for each variable.</p> <p>User satisfaction.</p>
<p>A2 A primary prevention intervention for Paisley residents aged 45-60 years that effectively reduces the targeted population's risk of cardiovascular disease.</p>	<p>% of population who meet the standard for CV risk score at exit from intervention.</p> <p>% of population who experience a reduction in their CV risk score between entry to and exit from intervention.</p> <p>% of population who meet the standard for CV risk factors at exit from intervention:</p> <ul style="list-style-type: none"> ▪ Blood pressure status ▪ Total serum cholesterol ▪ Smoking status ▪ Physical activity (compliance with recommendation for active living or regular exercise) ▪ Weight ▪ BMI ▪ Waist circumference ▪ Alcohol intake ▪ Psychological wellbeing <p>% of population who experience positive change in CV risk factor between entry to and exit from intervention:</p> <ul style="list-style-type: none"> ▪ Measures as defined above for standards and including cigarettes per day <p>% of population eligible to be on certain medication receiving appropriate pharmacological therapy at exit from intervention (may be measured within Unmet Need pilot):</p> <ul style="list-style-type: none"> ▪ % eligible on antiplatelet ▪ % eligible on betablocker ▪ % eligible on ACE inhibitor ▪ % eligible on statin <p>% of population are started on appropriate medication between entry to and exit from intervention:</p> <ul style="list-style-type: none"> ▪ Medications as defined above (may be measured within Unmet Need pilot). 	<p>% of eligible population who gain access to intervention, broken down by gender, disability, age, diagnosis, setting and deprivation status:</p> <ul style="list-style-type: none"> ▪ % of those at high risk who are invited to health coaching service ▪ % attended health coaching service ▪ % referred to HaHP and non-HaHP funded micro-interventions ▪ % attended micro-interventions ▪ % adhered to micro-interventions ▪ % referred/prescribed to maintenance services/activities <p>Number and % of people attending community development activities from Depcat 6 & 7.</p> <p>Number, range and adequacy of available services.</p> <p>Number of appropriate services with an agreed Service Level Agreement.</p> <p>% of priority gaps filled, as identified by mapping exercise.</p> <p>% split of investment in new services by HaHP/partners.</p> <p>Satisfaction with Health Behaviour Change Network amongst Health Coaches.</p> <p>Satisfaction with available services amongst Health Coaches and users.</p>

Intended Outcome	Outcome Measure	Process Measure
<p>B1 A CDR that enables implementation of a targeted secondary prevention system through primary care.</p>		<p>% of people in Paisley who are identified by CDR as having CHD compared with LHCC records, broken down by deprivation status.</p> <p>% of missing data for each variable.</p> <p>User satisfaction.</p>
<p>B2 Improvement of the cardiovascular health of Paisley residents who already have identified coronary heart disease and who are currently maintained in primary care.</p>	<p>% of population who meet the standard for CV risk factors at exit from intervention:</p> <ul style="list-style-type: none"> ▪ Blood pressure status (<140/90mmHg, 130/80mmHg in diabetics) ▪ Total serum cholesterol (<5mmol/L) ▪ Smoking status (non/ex smoker) ▪ Physical activity (compliance with recommendation for <i>active living or regular exercise</i>) ▪ Weight ▪ BMI (18.5-24.9) ▪ Waist circumference ▪ Alcohol intake (≤21 men, ≤14 women) ▪ Psychological wellbeing (HADS anxiety and depression scores <11, absence of self-reported stress, mean wellbeing score for population) ▪ Shuttle walking test performance: number of shuttles, peak heart rate, rating of perceived exertion <p>% of population who experience positive change in each CV risk factor between entry to and exit from intervention:</p> <ul style="list-style-type: none"> ▪ Measures as defined above for standards and including cigarettes smoked per day <p>% of population eligible to be on certain medication receiving appropriate pharmacological therapy at exit from intervention:</p> <ul style="list-style-type: none"> ▪ % eligible on antiplatelet ▪ % eligible on betablocker ▪ % eligible on ACE inhibitor ▪ % eligible on statin <p>% of population who are started on the appropriate medication between entry to and exit from intervention:</p> <ul style="list-style-type: none"> ▪ Medications as defined above 	<p>% of eligible population who gain access to intervention, broken down by gender, disability, age, diagnosis and deprivation status:</p> <ul style="list-style-type: none"> ▪ % referred to health coaching service ▪ % attended health coaching service ▪ % referred to non-exercise based services ▪ % referred for exercise tolerance testing ▪ % undertaking exercise screening ▪ % referred to phase III or IV physical activity opportunities ▪ % attended phase III or IV ▪ % adhered to phase III or IV ▪ % referred/prescribed to maintenance physical activity <p>Number, range and adequacy of exercise-based CR services across multiple settings: hospital, community, home, local authority. Including number of additional venues available for exercise, and volume of exercise sessions on offer out with the hospital.</p> <p>Number of instructors qualified to deliver phase IV CR exercise.</p> <p>Number of non-hospital locations at which the CR menu can be accessed.</p> <p>Number of non-hospital locations where any part of the menu is delivered, broken down by setting (community, LA).</p> <p>Satisfaction with available services amongst health professionals and users.</p>

Intended Outcome	Outcome Measure	Process Measure
<p>B3 Delivery of effective phase III cardiac rehabilitation (comprising structured exercise and risk factor modification) in a community setting for appropriate patients. At the same time a safe and effective cardiac rehabilitation service is designed for the highest risk patients (i.e. the most ill CHD patients) who are referred to the cardiac rehabilitation programme at the Royal Alexandra Hospital, Paisley.</p>	<p>% of population who meet the standard for CV risk factors at exit from intervention:</p> <ul style="list-style-type: none"> ▪ Blood pressure status (<140/90mmHg, 130/80mmHg in diabetics) ▪ Total serum cholesterol (<5mmol/L) ▪ Smoking status (non/ex smoker) ▪ Physical activity (compliance with recommendation for <i>active living or regular exercise</i>) ▪ Weight ▪ BMI (18.5-24.9) ▪ Waist circumference ▪ Alcohol intake (≤21 men, ≤14 women) ▪ Psychological wellbeing (HADS anxiety and depression scores <11, absence of self-reported stress, mean wellbeing score for population) ▪ Shuttle walking test performance: number of shuttles, peak heart rate, rating of perceived exertion <p>% of population who experience positive change in each CV risk factor between entry to and exit from intervention:</p> <ul style="list-style-type: none"> ▪ Measures as defined above for standards and including cigarettes smoked per day <p>% of population eligible to be on certain medication receiving appropriate pharmacological therapy at exit from intervention:</p> <ul style="list-style-type: none"> ▪ % eligible on antiplatelet ▪ % eligible on betablocker ▪ % eligible on ACE inhibitor ▪ % eligible on statin <p>% of population who are started on the appropriate medication between entry to and exit from intervention:</p> <ul style="list-style-type: none"> ▪ Medications as defined above <p>Comparison of death and hospital readmission rates amongst different user groups (attenders/non-attenders/adherers/non-adherers etc).</p>	<p>% of eligible population who gain access to intervention, broken down by gender, age, diagnosis and deprivation status:</p> <ul style="list-style-type: none"> ▪ % referred to CR ▪ % referred to part of menu ▪ % referred to phase III ▪ % uptake of phase III ▪ % adherence to phase III ▪ % referred/prescribed to phase IV <p>Output and satisfaction measures as for B2.</p>

Intended Outcome	Outcome Measure	Process Measure
<p>C1 Maximum participation of target population in the A and B interventions using a social marketing approach and innovative community planning workforce development.</p>	<p>% of 45-60 year olds who are aware of their risk level of CHD.</p>	<p>% of eligible population who gain access to intervention, broken down by gender, age, diagnosis and deprivation status:</p> <ul style="list-style-type: none"> ▪ % of those at high risk who are invited to health coaching service ▪ % attended health coaching service ▪ % referred to HaHP and non-HaHP funded micro-interventions ▪ % attended micro-interventions ▪ % adhered to micro-interventions ▪ % referred/prescribed to maintenance services/activities <p>Number and % of people attending community development activities from Depcat 6 & 7.</p> <p>% of priority gaps filled, as identified by mapping exercise.</p> <p>Satisfaction with available services amongst Health Coaches and users.</p> <p>Number of individuals who attend capacity building activities.</p> <p>Number of targeted group events undertaken e.g. per quarter / year.</p> <p>Number of training events offered to partner organisations.</p> <p>% of budget going on capacity building activities</p> <p>% sample of target group who are aware of the services available.</p> <p>Number of media items in public domain</p> <p>Column inches printed and prominence.</p>

Intended Outcome	Outcome Measure	Process Measure
<p>C2 Wider policy and practice is influenced by the dissemination of learning/lessons from HaHP.</p>		<p>HaHP is involved in the Community Health Partnership and is involved in the Joint Health Improvement Plan of the Health and Social Care, Community Planning Partnership.</p> <p>Number of key lessons adopted into policies and services of partner agencies.</p> <p>Number of key lessons adopted into national policy.</p> <p>Number of publications (of all kinds)/ presentations disseminated.</p> <p>HHLN HaHP subsection website hits.</p>

Funding for the development and implementation of the Phase 2 evaluation plans has been included in budget projections. Additional evaluation work may be commissioned outwith HaHP during Phase 2. The following are possible additional areas of enquiry, some of which may require additional funding:

- How can the Central Data Repository help to support implementation of the quality and outcomes framework of the GMS contract?
- Is it feasible to use the CDR to target people for primary prevention?
- How is the CDR used to target people for primary prevention?
- Does the CDR have added value for Primary Care?
- Can increasing levels of confidence, skills and awareness for the target population living in deprivation enable participation in heart health related activities? (It is proposed that HaHP will work with the Glasgow Centre for Population health to gain further understanding of the role of determinants of mental health and wellbeing [such as a sense of control, confidence, hopefulness and self efficacy] in achieving Phase 2 outcomes)
- What is the specific contribution of deprived circumstances to an individual's risk of developing CVD?
- What is the cost effectiveness of the targeted primary prevention intervention?
- Does targeted primary prevention for CHD reduce risk of developing CHD?
- Does the targeted primary prevention for CHD reduce the rate of acute coronary syndrome from developing?
- What is the feasibility and value of incorporating deprivation into a risk score?
- As part of Phase 2 various risk score estimators will be appraised.

A meeting with key local and national stakeholders is planned to discuss the feasibility of taking some of these issues forward.

Annex 6

Implementing Effective Practice in Paisley's Statutory Agencies

Partnership

Renfrewshire Council and NHS Argyll and Clyde (NHSAC) are engaged in joint community planning, integrated children's services and the joint future agenda. Representatives of NHSAC and Renfrewshire Council are members of the Health & Social Care sub-group of the Community Planning Partnership, which drives the Joint Health Improvement Plan. The establishment of Renfrewshire Community Health Partnership will further facilitate such work and relationships.

Developing Influence

The Education and Leisure Service has created a new healthy lifestyles team to integrate the range of physical activity, sport and health initiatives including *Active Schools*, *Hungry for Success*, *Health Promoting Schools* and NOF projects. The local authority has experience of short term funding initiatives and has incorporated successful elements of these projects. For example the Learning Neighbourhood model developed with the Better Neighbourhood Services Fund has been expanded and is integral to the structure for local community learning plans and community planning fora.

Elements of Phase 1 of HaHP have influenced Council policy such as the introduction of the Corporate Policy on Tobacco and the development of the Access Strategy. A healthy lifestyles coordinator post has been created to develop an authority wide framework for *Health Promoting Schools* as part of the new healthy lifestyles team. Other practice has been continued and rolled out across Renfrewshire schools and pre-5 establishments, including the *Eat Well to Play Well* resource.

Phase 1 of HaHP has developed the public health contribution of primary care. The redesign of the interface between primary and secondary care for coronary heart disease (CHD) patients has increased the effectiveness of rehabilitation and secondary prevention. It has made long lasting effects in increasing public health capacity of the community nursing workforce in particular. This is clearly sustainable development using established staff undertaking role development that benefits other aspects of prevention.

Renfrewshire Council's Internal Structure for Health Improvement

The local authority has developed a corporate health improvement group and departmental health improvement groups to feed into the Health & Social Care sub-group. This will enable joint departmental planning across transport, education and leisure, social work and environmental services to drive health improvement initiatives. The group is reviewing health improvement activity within departmental service plans and is planning a programme of capacity building through staff training. The Health & Social Care group has agreed to the development of a Renfrewshire Physical Activity, Sport and Health Strategy. This will be developed as a multi agency partnership and will be cross-referenced to the Community Learning and Development Strategy. It is envisaged that Phase 2 will contribute to both these key strategies.

NHS Argyll and Clyde's Cardiac Services Managed Clinical Network (MCN)

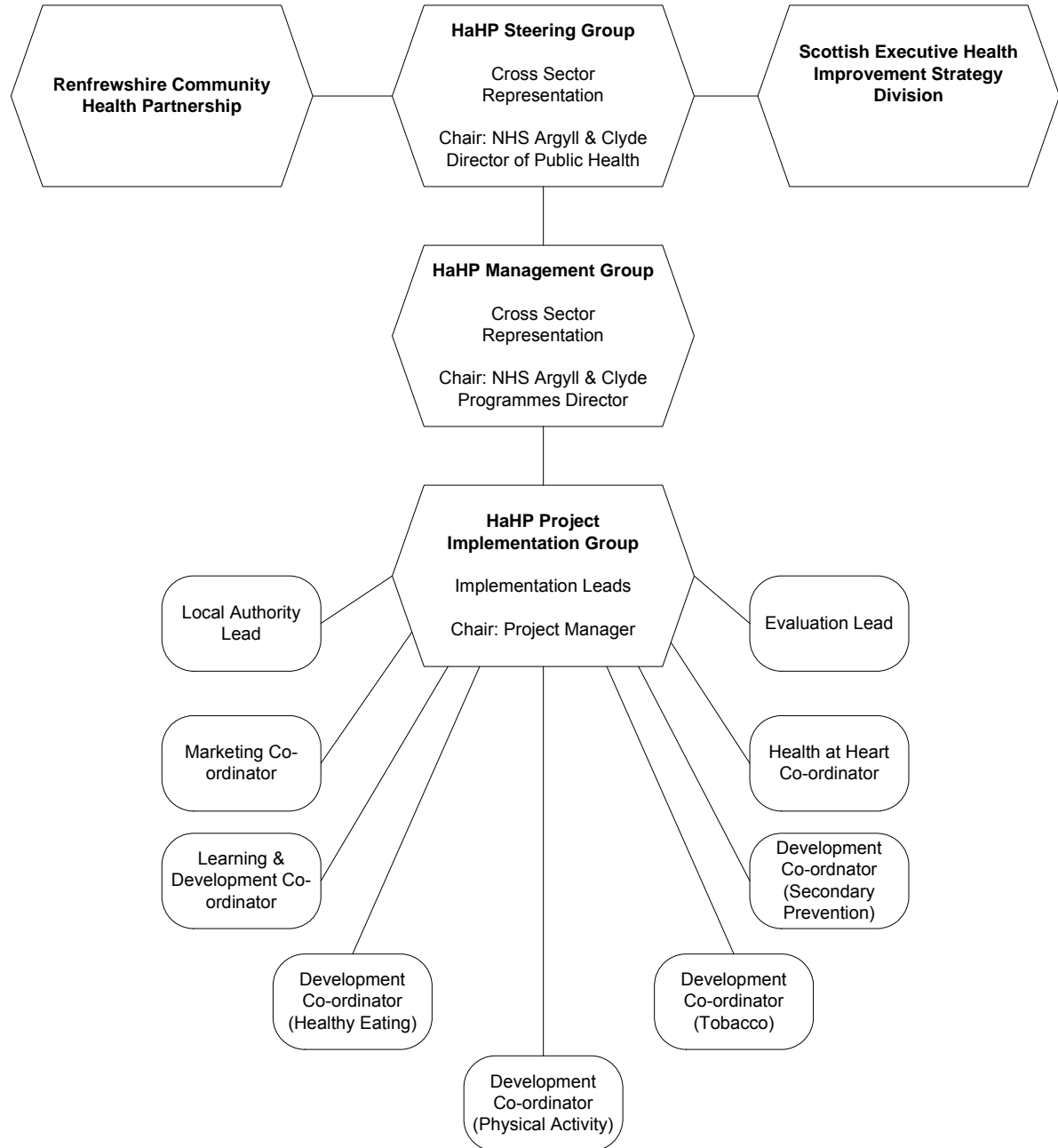
NHSAC, with key input from the MCN, is currently drafting its Primary Prevention Strategy that incorporates the prevention issues from diabetes, cancer, stroke and CHD. The evaluation of Phase 2, like the learning from other prevention projects, will be considered by the MCN. The lessons from Phase 1 are currently informing the redesign of cardiac rehabilitation services across Argyll and Clyde. The redesign intends to create equity of quality cardiac rehabilitation services throughout the patient journey, at a local level.

New services must demonstrate financial viability. As partners in HaHP the local authority and NHSAC will work together to define the capacity of the existing community based exercise programmes for cardiac patients (phase IV rehabilitation i.e. maintenance) and seek to maximise access to these services. The British Association of Cardiac Rehabilitation firmly believes that clients with heart disease involved in ongoing exercise in a community setting should pay a nominal amount to cover costs. HaHP Phase 2 will consider integration of community based phase III cardiac rehabilitation (structured exercise and risk factor modification) for patients with a step change in CHD and phase IV programmes for chronic stable CHD patients. There are existing models in the UK where phase III cardiac rehabilitation is delivered in local authority premises free of charge on the basis that clients will then pay for an ongoing phase IV programme.

Conclusion

Successful elements from Phase 1 of HaHP have influenced and are continuing to influence policy and practice in the local authority and NHSAC. It is anticipated that by framing elements of Phase 2 within current local authority strategy development, the potential influence of successful elements will be enhanced. Similarly dissemination and roll-out of effective practice from Phase 1 into NHS strategies and the continuing close liaison between HaHP and the Cardiac Services MCN will maximise the influence of Phase 2.

Have a Heart Paisley Phase 2 Organisational Structure



Annex 7

Financial Framework

Dimension A	Financial Years					HAHP Years				
	Yr1 1 mths	Yr 2 12 mths	Yr 3 12mths	Yr 4 11 mths	Total	Yr1 1 mths	Yr 2 12 mths	Yr 3 12mths	Total	
(Mid Pt Start)	01/03/05-31/03/05	01/04/05-31/03/06	01/04/06-31/03/07	01/04/07-29/02/08		01/03/05-28/02/06	01/03/06-28/02/07	01/03/07-29/02/08		
Development Officer (Physical Activity)	2,283	29,419	31,647	29,945	93,294	29,251	31,461	32,582	93,294	
Development Co-Ordinator (Physical Activity)	2,783	35,922	38,573	36,498	113,777	35,712	38,352	39,713	113,777	
Development Officer (Healthy Eating)	2,283	29,419	31,647	29,945	93,294	29,251	31,461	32,582	93,294	
Development Co-Ordinator (Healthy Eating)	2,783	35,922	38,573	36,498	113,777	35,712	38,352	39,713	113,777	
Development Officer (Tobacco)	2,283	29,419	31,647	29,945	93,294	29,251	31,461	32,582	93,294	
Development Co-Ordinator (Tobacco)	2,783	35,922	38,573	36,498	113,777	35,712	38,352	39,713	113,777	
GP Sessions	1,667	20,000	20,000	18,333	60,000	20,000	20,000	20,000	60,000	
	16,867	216,024	230,657	217,663	681,212	214,889	229,438	236,885	681,212	

Dimension C	Financial Years					HAHP Years				
	Yr1 1 mths	Yr 2 12 mths	Yr 3 12mths	Yr 4 11 mths	Total	Yr1 1 mths	Yr 2 12 mths	Yr 3 12mths	Total	
(Mid Pt Start)	01/03/05-31/03/05	01/04/05-31/03/06	01/04/06-31/03/07	01/04/07-28/02/08		01/03/05-27/02/06	01/03/06-27/02/07	01/03/07-27/02/08		
Project Manager	3,333	43,767	45,179	42,750	135,029	43,453	45,061	46,514	135,029	
Learning & Development Co-Ordinator	2,783	35,922	38,573	36,498	113,777	35,712	38,352	39,713	113,777	
Marketing Co-Ordinator	2,783	35,922	38,573	36,498	113,777	35,712	38,352	39,713	113,777	
Evaluation Co-Ordinator	2,013	35,922	38,573	36,498	113,777	35,712	38,352	39,713	113,777	
Development Co-ordinator	3,787	37,367	38,573	36,498	115,455	37,270	38,472	39,713	115,455	
Admin	1,917	25,084	26,958	25,509	79,467	24,910	26,802	27,755	79,467	
Admin – Marketing Support	1,575	20,542	22,057	20,871	65,044	20,405	21,930	22,709	65,044	
Admin	1,308	16,826	18,114	17,140	53,388	16,732	18,007	18,650	53,388	
Admin	1,308	16,826	18,114	17,140	53,388	16,732	18,007	18,650	53,388	
CDR										
Programmer (18mths -start 01/03/05)	1,917	25,084	11,233		38,233	24,910	13,323		38,233	
Programmer	1,917	25,084	26,958	25,509	79,467	24,910	26,802	27,755	79,467	
Evaluation Officer	2,283	29,419	31,647	29,945	93,294	29,251	31,461	32,582	93,294	
Technical Implementation Officer	1,575	20,542	22,057	20,871	65,044	20,405	21,930	22,709	65,044	
Admin 0.5 WTE	788	10,271	11,028	10,435	32,522	10,202	10,965	11,354	32,522	
Heart Health Nurse Facilitator	2,633	33,445	35,802	34,482	106,362	33,291	35,606	37,465	106,362	
Cardiologist Sessions	833	10,000	10,000	9,167	30,000	10,000	10,000	10,000	30,000	
	32,754	422,023	433,437	399,811	1,288,025	419,608	433,422	434,995	1,288,025	

Dimension B	Financial Years					HAHP Years				
	Yr1 1 mths	Yr 2 12 mths	Yr 3 12mths	Yr 4 11 mths	Total	Yr1 1 mths	Yr 2 12 mths	Yr 3 12mths	Total	
(Mid Pt Start)	01/03/05-31/03/05	01/04/05-31/03/06	01/04/06-31/03/07	01/04/07-28/02/08		01/03/05-27/02/06	01/03/06-27/02/07	01/03/07-27/02/08		
Cardiac Care Nurse	2,633	33,445	35,802	34,482	106,362	33,291	35,606	37,465	106,362	
Cardiac Care Nurse	2,633	33,445	35,802	34,482	106,362	33,291	35,606	37,465	106,362	
Cardiac Care Nurse (1 year - start 01/03/05)	2,317	27,441			29,757				29,757	
Physiotherapist Senior II	2,258	29,109	31,540	30,550	93,458	28,942	31,337	33,178	93,458	
Physiotherapist Basic Grade (1 year - start 01/03/05)	1,975	23,372			25,347				25,347	
Dietician Senior I (18 mths - start 01/03/05)	2,583	33,445	14,784		50,813	33,241	17,571		50,813	
0.2 WTE Admin Support (1 year - start 01/03/05)	262	3,085			3,346				3,346	
Cardiac Technician MT03 (1 year - start 01/03/05)	2,238	26,451			28,689				28,689	
Cardiac Technician MT02 (1 year - start 01/03/05)	1,760	20,800			22,560				22,560	
Community Based Phase 3 Co-ordinator Senior I (2 years - start 01/03/05)	2,583	33,445	32,526		68,554	33,241	35,313		68,554	
Community Dietician	2,258	29,109	31,540	30,550	93,458	28,942	31,337	33,178	93,458	
Evaluation Officer	2,283	29,419	31,647	29,945	93,294	29,251	31,461	32,582	93,294	
Admin Support	1,308	16,826	18,114	17,140	53,388	16,732	18,007	18,650	53,388	
0.3 WTE Clinical Psychologist (1/2 costs in first year)	610	8,186	15,600	14,761	39,156	8,114	14,982	16,061	39,156	
Clinical Exercise Professional MT03	2,238	28,856	30,977	29,312	91,383	28,689	30,801	31,893	91,383	
Cardiologist Sessions	1,667	20,000	20,000	18,333	60,000	20,000	20,000	20,000	60,000	
	31,608	396,433	298,332	239,554	965,927	403,434	302,020	260,473	965,927	
Current Posts	64,752	827,242	814,564	758,523	2,465,082	827,292	812,619	825,172	2,465,082	
New Posts	16,477	207,238	147,861	98,506	470,081	210,639	152,261	107,181	470,081	
Grand Total	81,229	1,034,480	962,426	857,029	2,935,164	1,037,931	964,880	932,353	2,935,164	

Have A Heart Paisley Phase 2 Costing - Non Staff

	Year 1	Year 2	Year 3	Year 4	Total	Year 1	Year 2	Year 3	Total
Projected Costs									
LA/Community CR Services	8,333	100,000	100,517	97,350	306,200	100,000	100,000	106,200	306,200
Mile End Mill (rent, rates, stationery etc)	6,883	82,890	86,822	87,049	263,645	82,600	86,082	94,963	263,645
CDR Non-staff	3,833	44,667	29,242	19,158	96,900	46,000	30,000	20,900	96,900
CR (Includes funding for development of community phase 3)	7,417	85,375	44,658	32,450	169,900	89,000	45,500	35,400	169,900
Development	12,500	145,833	96,350	51,517	306,200	150,000	100,000	56,200	306,200
Research & Evaluation	3,750	44,167	33,925	20,258	102,100	45,000	35,000	22,100	102,100
Capacity (Soc Marketing, L&D)	7,500	88,333	67,842	40,425	204,100	90,000	70,000	44,100	204,100
Dissemination	2,083	24,167	14,667	10,083	51,000	25,000	15,000	11,000	51,000
Financial Services	1,800	22,100	22,800	21,500	68,200	22,700	22,700	23,400	68,200
Blood Pressure Monitors	0	4,900	4,900	4,600	14,400	4,800	4,800	4,800	14,400
IT Costs	0	18,200	5,500	6,300	30,000	16,700	6,500	6,800	30,000
Total	54,100	660,632	507,222	390,691	1,612,645	671,200	515,582	425,863	1,612,645

Have A Heart Paisley Phase 2 Costing - Summary

	Year 1	Year 2	Year 3	Year 4	Total	Year 1	Year 2	Year 3	Total
Staff Costs	81,229	1,034,480	962,426	857,029	2,935,164	1,037,931	964,880	932,353	2,935,164
Non Staff Costs	54,100	660,632	507,222	390,691	1,612,645	671,200	515,582	425,863	1,612,645
Grand Total	135,329	1,695,111	1,469,648	1,247,720	4,547,809	1,709,131	1,480,462	1,358,216	4,547,809

Project Funded By

Year	New Allocation	Carry Forward Trans Phase	Total Funds
2004/05	£m	0.679	0.681
2005/06	1.081	0.068	1.149
2006/07	1.430	0.040	1.470
2007/08	1.140	0.108	1.248
Total	4.330	0.218	4.548

Annex 8

Dissemination and learning

The National Heart Health Learning Network (HHLN) based at NHS Health Scotland is allied to Have a Heart Paisley and has two key strands of work:

Strand 1. Dissemination of learning from the national demonstration project Have a Heart Paisley (HaHP).

An internal Dissemination Group (containing representatives from HaHP Management and Evaluation teams and the Heart Health Learning Network) steers this strand of the work. The group identifies key outputs and lessons emerging from the project, and coordinates the national dissemination of these through a variety of mechanisms. These include:

- HaHP library of outputs. This collates all of the various outputs from the project. To date this includes 71 reports, 13 peer reviewed journal papers, 61 peer reviewed abstracts, 20 presentations, 2 external learning days (deaf connections and "from the heart"), 43 posters, 6 videos, 3 annual reports and 1 national newsletter.
- HHLN website. The HaHP section of the site allows the user to access all of the outputs given above. In addition, it contains "learning templates" that summarise the key lessons from each of the various project strands and the "cross-cutting" project wide lessons. Plans for Phase 2 are also available through the site.
- A database of over 1000 individuals and organisations. The database is routinely sent information relevant to HaHP and heart health.

The above activities will continue into 2005/2006 and will be updated accordingly. They will also be augmented by the provision of up to six project hosted "Learning Days". Each learning day will consist of presentations by HaHP staff and where relevant its users and will combine site visits with more formal presentations. The days will cover all elements of the project from its commissioning, evaluation and methodology and will combine lessons from Phase 1 with plans and emerging lessons from Phase 2. A "menu" of programmes will be developed, reflecting the projects diversity.

The HHLN is also in the process of commissioning a DVD that will tell the story of the first phase of the project. It will be split into relevant chapters (corresponding to the projects programmes of work) and will combine formal evaluation lessons with softer user experiences.

Strand 2 – Combining learning from HaHP with other local, national and international evidence to inform future Heart Health research, policy and practice in Scotland

An Executive Group, containing representation from a variety of relevant groups and organisations drives this strand of work. It was agreed that the focus of the second strand should be Heart Health primary and secondary prevention through behaviour and lifestyle modification at both an individual and population level. The specific interest therefore lies in public health / health improvement activity rather than clinical intervention.

The Executive Group agreed that an important role of the network was to support the local production of primary prevention strategies, recommended in the recent *CHD and Stroke Strategy for Scotland*. The group initially identified three Heart Health risk factor areas that it deemed were priorities for primary prevention. These were smoking, inactivity and poor diet. Three Expert Groups were formed (one for each topic) to review the evidence, identify areas of current practice in Scotland and make

recommendations for action at a local level. The expert groups drew on the experience and expertise of academics, policy makers and practitioners and produced 37 physical activity recommendations, 20 smoking recommendations and 16 diet and nutrition recommendations. For each recommendation, a summary of the evidence was presented together with any relevant local or national policy and examples of current practice in Scotland. The recommendations were circulated nationally for consultation before being presented at the national Heart Health conference in March 2004 through ten topic-based workshops. Conference participants were able to volunteer for a particular workshop, based on their experience and interests. The workshops explored barriers and subsequent levers for each of the recommendations.

The recommendations and their associated barriers and levers and mapping of current policy and practice have been collated in a central resource and are available on the Heart Health website. They will be published and circulated to HHLN in May 2005.

In 2005/2006 the relevant section of the HHLN website will be expanded. It will focus on primary prevention (although it will overlap with secondary prevention) and will be split into a high-risk section and a population-risk section. For each section, up to date evidence (and where relevant examples of practice) will be presented / signposted demonstrating how to reduce overall risk. The website will be updated regularly to take account of new/emerging evidence, policy and practice.