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This document proposes an approach to reducing the impact of heart disease in one town, Paisley, which if successful could be applied throughout Scotland.

A multi-agency group with high community involvement has put together a proposal based on the following principles:

We will:

- Demonstrate successful action to improve heart disease
- Involve the community to shape the response of the agencies involved
- Work in partnership
- Build the capacity of the community in a sustainable way to reduce inequalities in health
- Harness community spirit
- Ensure *Designed to Care* is implemented through adopting the ethos inherent in *Towards a Healthier Scotland*
- Share the learning from this project with other parts of Scotland and abroad
- Be willing to consider both evidence-based and innovative approaches

The approach has at its heart four Locality Networks that will be the focus of activity for the populations involved. Primary care will be an integral part of these networks.

Concurrent to this the fifth Locality Network – for high risk individuals – will be developed, together with an integrated secondary prevention model linking primary and secondary care. It is likely through this that early indicators of success can be evaluated.

A model using the dimensions of different target groups, settings, topics and methods has been adopted for work within the Locality Networks.

The model relies on total community involvement and commitment from all key partner organisations.

Collaborating organisations include:

- Paisley Local Healthcare Co-operative
- Paisley Partnership
- Renfrewshire Community Health Initiative
- Renfrewshire Partnership Forum
- Renfrewshire Council
- Argyll and Clyde NHS Acute Trust
- Argyll and Clyde Health Board
- Argyll and Clyde Local Health Council
EXECUTIVE SUMMARY

University of Paisley
• Reid Kerr College
• University of Glasgow

It builds on the opportunities given by the new organisation of the health service, in particular the creation of local healthcare co-operatives with a new focus on population health. It will also build on the community planning process and partnerships between health and local authorities.

The project has looked specifically at evaliability, as the ability to demonstrate the value of this approach to Scotland as a whole and further afield is crucial.

For further information, contact:

Dr David C. Davidson
Lead Individual
The Consulting Rooms
21 Neilston Road
PAISLEY PA2 6EW

Tele: 0141 889 5277
Fax: 0141 848 5300
Email: davidlynthemoorings@btinternet.com

Grace Moore
Project Co-ordinator
Department of Public Health
Argyll and Clyde Health Board
Ross House
Hawkhead Road
PAISLEY PA2 7BN

Tele: 0141 842 7289
Fax: 0141 842 1414
Email: grace.moore@achb.scot.nhs.uk

website: haveaheart.org.uk
## GLOSSARY

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
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<tbody>
<tr>
<td>ACE</td>
<td>Angiotensin converting enzyme</td>
</tr>
<tr>
<td>ACHB</td>
<td>Argyll and Clyde Health Board</td>
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<tr>
<td>ASH</td>
<td>Action on Smoking and Health</td>
</tr>
<tr>
<td>CABG</td>
<td>Coronary artery bypass graft</td>
</tr>
<tr>
<td>CARENET</td>
<td>A shared care intranet system for clinicians to share information across professional and organisational boundaries</td>
</tr>
<tr>
<td>CCF</td>
<td>Congestive cardiac failure</td>
</tr>
<tr>
<td>CDSS</td>
<td>Clinical decision support system</td>
</tr>
<tr>
<td>CHD</td>
<td>Coronary heart disease</td>
</tr>
<tr>
<td>CHI</td>
<td>Community health index</td>
</tr>
<tr>
<td>CVD</td>
<td>Cardiovascular disease</td>
</tr>
<tr>
<td>DSS</td>
<td>Department of Social Security</td>
</tr>
<tr>
<td>GP</td>
<td>General practitioner</td>
</tr>
<tr>
<td>GPASS</td>
<td>General Practice Administration System, Scotland</td>
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<tr>
<td>HEBS</td>
<td>Health Education Board for Scotland</td>
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<tr>
<td>IT</td>
<td>Information technology</td>
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<tr>
<td>ISD</td>
<td>Information and Statistics Division</td>
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<tr>
<td>LHCC</td>
<td>Local healthcare co-operative</td>
</tr>
<tr>
<td>NHS-Net</td>
<td>The National Health Service computer network</td>
</tr>
<tr>
<td>NRT</td>
<td>Nicotine replacement therapy</td>
</tr>
<tr>
<td>OP</td>
<td>Outpatients</td>
</tr>
<tr>
<td>PAMs</td>
<td>Professions allied to medicine</td>
</tr>
<tr>
<td>PHD</td>
<td>Paisley Heart Diploma</td>
</tr>
<tr>
<td>RACHEL</td>
<td>Royal Alexandra Cardiovascular Health Electronic Links</td>
</tr>
<tr>
<td>RAH</td>
<td>Royal Alexandra Hospital, Paisley</td>
</tr>
<tr>
<td>RAMH</td>
<td>Renfrewshire Association for Mental Health</td>
</tr>
<tr>
<td>RCHI</td>
<td>Renfrewshire Community Health Initiative</td>
</tr>
<tr>
<td>SHAH</td>
<td>Scottish Health at Work</td>
</tr>
<tr>
<td>SIGN</td>
<td>Scottish Intercollegiate Guidelines Network</td>
</tr>
<tr>
<td>SIP</td>
<td>Social Inclusion Partnership</td>
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<tr>
<td>SMR</td>
<td>Standardised Mortality Ratio</td>
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PREFACE

Sweet Ferguslie, hail! thou’rt the dear sacred grove,
Where first my young Muse spread her wing;
Here Nature first wakened me to capture and love,
And taught me her beauties to sing.

Robert Tannahill, September 1807

When the most celebrated of Paisley’s weaver-poets penned these words at the turn of the 19th Century, our town was clearly very different to now.

Yet Paisley was changing.

Within three or four decades of Tannahill writing so lyrically of his beloved bonnie wood o’ Craggelee or meeting his lover Among the brume bushes by Stanely green shaw, the wood had been cut down to make way for the town’s new gas works and the land around Stanely castle had been flooded to provide a reservoir for the town.

The weaving industry that had brought the town, if not many of its townsfolk, initial prosperity was destined to decline. New industrialisation would follow.

By the beginning of the 20th Century the town had established itself as the thread manufacturing capital of the world. Eventually in the 1960’s even this seemingly impregnable industry was lost to Paisley.

Innumerable great buildings and monuments echo the heady days of Clarks and Coats. They watch as Scotland’s largest town has been gripped by post-industrial decline.

Once again Paisley finds itself on the threshold of a new Century and faced with change.

New hope has replaced despondency.

Communities are taking the lead in renewing the town. Governments are addressing issues of social exclusion, poverty, worklessness and the resulting health inequalities faced by many of Paisley’s townfolk.

The White Papers Designed to Care and Towards a Healthier Scotland set the agenda for the renewal of Paisley’s health.

In funding a major health demonstration project aimed at the prevention of heart disease, the Scottish Executive recognises that Scotland suffers from unacceptably high rates of cardiovascular morbidity and mortality.

Paisley, the largest town in Scotland with a population of some 85,000, has high rates of heart disease even by Scottish standards. About a quarter of its folk live in designated Social Inclusion Partnership areas and the highest levels of cardiovascular disease are found there. For example Ferguslie Park has a Standardised Mortality Ratio (SMR) of 152.

However, the town as a whole has a social mix incorporating some relatively affluent areas that reduces the overall SMR to 115.
Paisley could well be described as “Scotland in Microcosm”. It has the advantage of being self-contained and possesses a strong sense of community identity.

The town has a proven record of community involvement with already well-established and widespread participation of local people in community development. There is a considerable experience of multiple agencies working successfully in partnership. Networks already exist that are ready and willing to link in to a major heart disease prevention programme.

Our town has in its day exported shawls and thread throughout the country and throughout the world. Now, at the dawn of a new Century and a new Millennium, Paisley is ready to demonstrate to Scotland a campaign of heart disease prevention – a programme that will reach and involve all of its people – a programme that will make a significant, necessary, achievable and sustainable difference within the defined timescale.

It’s time for a new Paisley Pattern – a pattern of heart health that we can all take pride in.

Have a Heart Paisley!

Have a Heart Scotland!
SECTION 1

OUTLINE

Name of Lead Individual

Dr David C Davidson
GP and Representative of Paisley Local Healthcare Co-operative

Name of Lead Organisation

Paisley Local Healthcare Co-operative

Our Vision

Our vision is for the people of Paisley and future generations to have reduced heart disease, healthier, longer lives and hope for the future.

Underlying Principles

The approaches taken to reduce heart disease are underpinned by the following principles:

We will:

• Demonstrate successful action to improve heart disease
• Involve the community to shape the response of the agencies involved
• Work in partnership
• Build the capacity of the community in a sustainable way to reduce inequalities in health
• Harness community spirit
• Ensure Designed to Care is implemented through adopting the ethos inherent in Towards a Healthier Scotland
• Share the learning from this project with other parts of Scotland and abroad
• Be willing to consider both evidence based and innovative approaches.
Aims and Objectives

The aims and objectives of *Have a Heart Paisley* are:

**Aims:**

To change the lives and perceptions of every citizen of Paisley by impacting on life circumstances, lifestyles and specific cardiovascular issues

To prevent heart disease from developing

To delay the progression of existing heart disease

To ensure access to appropriate care once the symptoms of heart disease are present and to prevent them from getting worse.

**Objectives:**

To reduce inequalities in health by weighting resources to more socially excluded communities

To demonstrate environmental change through the implementation of appropriate policies by a range of agencies

To increase awareness, knowledge and skills in relation to coronary heart disease risk factors in the Paisley population

To increase the number of people adopting healthy lifestyles

To increase the number of people, (professionals, volunteers and the community) accessing appropriate training

To establish a risk factor database and disease register for CHD

To establish risk factor profiles for people at risk from coronary heart disease

To improve delivery of coronary heart disease prevention by effective implementation of national clinical guidelines

To ensure effective evaluation of programme components through defining intermediate indicators as well as appropriate outcomes measures.
SECTION 1

Collaborating Organisations Include:

- Paisley LHCC
- Paisley Partnership
- Renfrewshire Community Health Initiative
- Renfrewshire Partnership Forum
- Renfrewshire Council
- Argyll and Clyde NHS Acute Trust
- Argyll and Clyde Health Board
- Argyll and Clyde Local Health Council
- University of Paisley
- Reid Kerr College
- University of Glasgow.

From its earliest days the Have a Heart Paisley Steering Group has sought to involve any and every organisation which could have a part to play in developing and implementing the project. There will be no exclusions or barriers to involvement.

Our emphasis throughout has focussed on networking concepts and the ultimate success of this project largely hinges on functional multi-agency co-operation. Appendix 1 lists some of the principal collaborators to date but is neither comprehensive nor exclusive.

A description of the roles of the key collaborating organisations is shown in Appendix 1.
SECTION 2

PREPARING THE HAVE A HEART PAISLEY BID

From the publication of the Green Paper Working Together for a Healthier Scotland, a whole community approach to the major health problems was possible. When the White Paper followed, our aim was to obtain one of the demonstration projects for our local population. A small group consisting initially of health promotion, public health, cardiology and academic public health met to formulate a possible project. The group decided to focus on the town of Paisley for a number of cogent reasons: its record of heart disease; the challenges of social exclusion; the clinical networks which were well advanced; the partnership working already in place and its very visible position as an identifiable town with significant loyalties.

A steering group was then formed, involving key partners. Crucially the newly formed Paisley Local Healthcare Co-operative (LHCC) was beginning to look at the possibilities of addressing public health issues. Paisley Partnership was enthusiastic and they helped with real involvement of the community. Community members saw this as a real opportunity to change things in Paisley for the better. Renfrewshire Council also was keen to be part of the bid.

The bid from the LHCC was submitted, signed by the representative of the LHCC, the Director of Public Health and the Chief Executive of Paisley Partnership. Other applicants from elsewhere also expressed their willingness to be part of the process. A crucial step was the appointment of a senior manager as project co-ordinator whose role was to ensure that targets for completion of the document were met. In addition a writing/editing sub-group was set up to complete production of the final bid. The steering group continued its work refining the bid and networking with key partners including the community. Bids for possible projects were requested, with additional help being given to the community to put together bids from Paisley Partnership, RPF and the Community Health Project. The steering group built on these projects, the majority coming from the community, to finalise the whole bid. Efforts have been made throughout to make the process inclusive and innovative whilst retaining clear goals.

Defining the Project

Definition of the project included consultation with the local community and all other partners. To enable the partners to achieve a consistent approach we used the familiar health promotion planning compass. Two examples from our draft plan are provided overleaf.

TARGET GROUP

TOPIC

SETTING

METHOD
CHILDREN
Pre-school infants, Primary and secondary school

INCREASED PHYSICAL ACTIVITY LEVELS

Mothers and toddlers groups primary and secondary schools nurseries

- Locality Network liaison with educational authorities to develop physical activity facilities and services
- Exercise education
- Menu based approach
- Increase physical activity levels using novel approaches not just sport (e.g. aerobics)
- Teacher and parent education and training
- Purchase of exercise equipment based on needs assessment
- Develop quality of life model
- After school physical activity facilities for children and the local community
- School exercise co-ordinators
- Family Fitness at St Mirren Football Club
- Facilitate active commuting
SECTION 2

WOMEN'S GROUPS
Single parents
Asian women
Pregnant women

INCREASED PHYSICAL ACTIVITY LEVELS

COMMUNITY

- Locality Network liaison with Local Authority to develop physical activity facilities and services
- Exercise education and training
- Menu based approach
- Exercise consultation
- Home based exercise
- Leisure Centre based activities
- Locality based exercise
- Creche co-ops
- Family fitness
SECTION 2

We used this tool to work with communities to develop a range of proposals. These were then summarised and the result was a matrix of action focused on topics, target groups, settings and methods. Examples of these are provided below.

Some of this activity addresses 'life circumstances' and this will be part of the work of many of the community projects as well as the role of the Local Authority and the Paisley Partnership SIP. This will be more fully developed during implementation of the project.

For the 'lifestyle' aspects of heart disease and to ensure effective co-ordination we have developed the concept of Locality Networks.

<table>
<thead>
<tr>
<th>TOPIC</th>
<th>METHOD</th>
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<tbody>
<tr>
<td>Poverty</td>
<td>Community development</td>
</tr>
<tr>
<td>Active living</td>
<td>Service provision</td>
</tr>
<tr>
<td>Healthy eating</td>
<td>Media and marketing</td>
</tr>
<tr>
<td>Tobacco</td>
<td>Training and skills development</td>
</tr>
<tr>
<td>Mental well-being</td>
<td>Policy development</td>
</tr>
<tr>
<td>Sensible drinking</td>
<td>Demonstrations</td>
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<table>
<thead>
<tr>
<th>TARGET GROUP</th>
<th>SETTING</th>
</tr>
</thead>
<tbody>
<tr>
<td>Young people</td>
<td>Community and community groups</td>
</tr>
<tr>
<td>People with pre-existing coronary heart disease</td>
<td>Schools and school boards</td>
</tr>
<tr>
<td>Inactive adults</td>
<td>Youth clubs</td>
</tr>
<tr>
<td>People with risk factors</td>
<td>Licensed premises</td>
</tr>
<tr>
<td>All secondary care patients</td>
<td>Leisure centres</td>
</tr>
<tr>
<td>People recovering from heart disease</td>
<td>Football clubs</td>
</tr>
<tr>
<td>Whole Paisley population</td>
<td>Benefits agency</td>
</tr>
<tr>
<td>SIP area residents and families</td>
<td>Workplaces</td>
</tr>
<tr>
<td>Inactive school children/nursery schools (SIP/Area Wide</td>
<td>Primary and secondary care</td>
</tr>
<tr>
<td>Local authority employees</td>
<td>Local cinema</td>
</tr>
<tr>
<td>Women from SIP areas</td>
<td>Retail establishments</td>
</tr>
<tr>
<td>All smokers</td>
<td>Health service employees</td>
</tr>
<tr>
<td>Parents of school children</td>
<td>Residents with severe or enduring mental illness</td>
</tr>
<tr>
<td>Unemployed men</td>
<td>Community groups</td>
</tr>
<tr>
<td>Health service employees</td>
<td>Community workers</td>
</tr>
<tr>
<td>Residents with severe or enduring mental illness</td>
<td>Men aged 35-55</td>
</tr>
<tr>
<td>Community groups</td>
<td>Women 45+</td>
</tr>
<tr>
<td>Community workers</td>
<td>Private sector employees</td>
</tr>
<tr>
<td>Men aged 35-55</td>
<td></td>
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</table>
THE CONCEPT OF LOCALITY NETWORKS

Locality Networks are the substance of the Have a Heart Paisley campaign. They are an innovative mechanism that will afford each individual within the community of Paisley the opportunity to take charge of his or her health and to reduce their risk of heart disease.

Traditionally the model of healthcare has been one of delivering services to a target population. This tends to be service orientated and generally fails to involve or engage the target population. By contrast, the network concept is a vision of multiple linked strands that begin and end in the community but carry information to and from all partner agencies. It affords individuals the facility to participate actively in developing a healthier lifestyle — not so much being told or advised, but instead developing knowledge and understanding that will foster a desire to change. In turn each individual will have a sense of ownership of this heart disease prevention project and will be empowered to make the vital changes:

- Understand risk factor modification
- Select the risk factor(s) that will make a difference to you and that you want to change
- Know your risk
- Use the network to support and facilitate that change
- Reduce your risk.

It is our belief that the success of Have a Heart Paisley is very largely dependent on our ability to reach each and every citizen of Paisley and to make a difference to that individual. This will be no mean achievement but is nevertheless an attainable goal.

Central to the pursuit of this aim is the knowledge that there will have to be a cultural shift amongst the townsfolk. They will have to want their circumstances to change and in particular they will have to develop aspirations to a better standard of health.

Such expectation cannot be imposed. It must come from within the individual. Our task therefore is to cultivate these seeds through education, community development and a changed environment.

The Paisley-wide Network

The Have a Heart Paisley project will operate through an area-wide network linking all elements of activity. Intrinsic to this will be our core support team with links to the principal elements of local authority, community, schools and the health service. There will be a web with cross-linkage between all of these elements.
Locality Networks

Based around the Paisley-wide network will be five sub-networks. Four of these will collectively serve the whole town, with each covering one geographical sector – the Locality Networks. The fifth will provide for a “high risk” group drawn from all the Locality Networks. See the map below.

While in one sense each Locality Network will have a degree of autonomy to meet the particular needs of a community, each will be working within the context of the overarching strategies for the project. Interplay between Locality Networks as well as with the area-wide network will be essential.

The Locality Networks will be composed of health professionals (from many disciplines), community representatives, lay workers, carers and patients. In many cases they will extend the role of an existing network and add value to existing activities by linking these into the Paisley-wide network.
Aims of Locality Networks

The essence of Locality Networks rests in their ability to engage individuals within communities in a range of activities that will make a positive difference to the health of their hearts. The networks will provide a framework within which risk factor modifying activities can be supported, co-ordinated and appropriately targeted. These activities will be chosen by the communities themselves, with support from the locality professionals. They will go some way to solving the existing problems of access that face socially excluded communities and will address health inequalities by favouring these communities.

Locality Networks will provide multiple interfaces but will be imbued with a uniform message – the Have a Heart Paisley “brand”. The approach of all partners will be to adopt a holistic and comprehensive approach to heart disease risk factor modification. The “top-down” element of this can be perceived as an extension of the concept of the “Health promoting health service” (as advocated in the White Paper towards a Healthier Scotland). The aim will be to work through a wide range of settings accessible to the community. These will include general practices, dental surgeries, pharmacies and community health clinics, but will extend beyond the health service to DSS benefits offices and job centres; workplaces; schools; shops; post offices and banks; libraries; community centres; cinemas and sports & leisure facilities; and churches – simply preface any from this list with “health promoting,” e.g. health promoting workplace.

There will also be some specific targeting, however, e.g. children, inactive adults, women of childbearing years.

The Locality Networks will aim to support local change in life circumstances and deliver both primary and secondary prevention of heart disease. In all cases the guiding principle will be to reduce heart disease. Where appropriate the networks will aim to develop care pathways and support individual case management. As part of the role of health professionals, the Locality Networks will aim to establish risk factors for individuals whenever possible with a view to offering modifying activities from a menu.

Through community capacity building the beneficial effects of the Locality Networks will continue to manifest themselves well beyond the lifetime of the project, resulting in a permanent sustainable improvement in health.
How Locality Networks Would Work

Each Locality Network will have a Co-ordinator:Facilitator appointed by the Project Support Team. This post will ideally be filled by an individual drawn from the relevant locality and who has a range of experience that includes working in partnership in communities together with some knowledge of community development. Health promoting skills will be essential together with a specific knowledge of heart disease prevention. The most important aspect of this work is to ensure full community involvement in the delivery of the programme.

Some of the tasks undertaken by the locality network team might be:

- Mapping existing activities within locality
- Assessing strengths and needs of locality
- Developing the ability of the community to take control
- Linking existing activities into network with particular emphasis on risk factor modification consistent with a menu approach
- Establishing a range of activities which respond to the heart health needs identified by the community and ensuring a participating approach for local people
- Allocating resources to risk modifying activities
- Optimising use of all activities
- Matching people to the most appropriate activity
- Undertaking risk factor assessment to a uniform template and pre-participation screening where appropriate
- Conducting motivational interviews
- Improving self-confidence and self-esteem
- Liaising with other team members within and beyond the Locality Network
- Identifying training and educational needs
- Facilitating training and education.

Successful initiatives in one area will be duplicated in others. Locality Networks will thus provide a means of identifying existing activities and adding value to these by linking them to a matrix that will represent all aspects of heart disease prevention.

The concept of a locality based network hinges on the active participation of townsfolk in the development of heart disease prevention and in particular, risk factor modification. Integral to this lies the concept of community support focusing on areas such as healthy eating, active lifestyle and smoking. This aspect of the network will initially involve the collaboration of health and other professionals - education, social work, community and church - in working with community based lay people to develop skills. As a result, community capacity will build to the point where these networks may become largely self-sustaining.
There will be the need for professional support. This will be intrinsic to the network. A wide range of health professionals will be linked and could be involved wherever and whenever required. Physiotherapists, dietitians, community nurses, practice nurses, health visitors, general practitioners and the cardiologists will all play their part.

Educational professionals including school and nursery teachers and health promotion officers will integrate with the matrix, as will social workers, benefits officers and community project leaders. The list is neither exhaustive nor exclusive. The principle is, however, clear.

Fundamental to the Locality Networks and indeed to the area-wide network will be an information and education strategy. This will comprise two elements: a modular flexible training package adaptable to meet the educational needs of every partner, whether professional or lay, and an information strategy that will provide the means of effectively communicating backwards and forwards throughout the network.

Training and Development

A training pack will be developed and will be made available through various media including interactive training on the project web site. Educational establishments within the town, including Paisley University and Reid Kerr College, will be involved together with other resources such as HEBs. Existing trainers within professions will be used to disseminate the material and provide teaching according to identified need. An approved certificate of learning will be validated and while the emphasis would be on training lay members of the community, the flexibility of the package will ensure that professionals will also aspire to attain their Paisley Heart Diploma (PHD). The training and development component will be more fully discussed in section 5.

Making it Work Together

It will be essential to have effective means of communication within the Locality Networks and extending into the area-wide network. Every opportunity will be taken to collect data with individuals being encouraged to "Know Your Risk" as part of a changing culture. A uniform template will be used and data will be fed back to a central risk factor database. General practices will provide the obvious relay for this. The means of collating such data into a central electronic database from General practices has already been developed within Paisley by the LHCC. Computerisation of Paisley practices is advanced. Each will have a fully operational network installed by the launch date of the campaign. Furthermore, the electronic axis between the Royal Alexandra Hospital Cardiology Department and Paisley general practices is probably the most advanced of any in Scotland as a result of the successful CARENET project.

The development of the project website and the use of a telephone helpline will further enhance the propagation of information.

It is this combination of effective training and information strategies that will give the networks their tensile strength.
SECTION 2

Community Involvement within Locality Networks

It has already been stated that Locality Networks will begin and end in the community. The network will be there to provide support for those who are at risk of developing heart disease or who have already developed symptomatic disease. It will also form part of the wider network that will, through education and social marketing, prevent heart disease from occurring in many cases.

Numerous worthwhile health-promoting activities with relevance to heart disease prevention already exist within the community of Paisley and their inclusion within strategic plans has already been established. Many projects have been in existence over a lengthy period during which they have been evaluated and have a proven record of success. We want to see these continue and would wish to offer our support to them. This desire to link into and to learn from existing activity has provided much of the impetus to develop networking and in particular, the innovative concept of Locality Networks.

The contribution of community projects and the many community volunteers and community activists will be vital to the success of Locality Networks.

Through the intrinsic training programme that pervades the entire network, a team of local people will be formed. This will comprise as many community-based lay members as possible. These members will have developed a knowledge of heart disease and its prevention. In many cases this would have arisen from the personal experience of being a sufferer or of having family and friends who are victims.

This local team will prove invaluable in backing up the work being done by formally trained community volunteers and health professionals. Its purpose will be to support neighbours, friends and family members who have, or are at risk of developing heart disease. Members will promote, advise and inform the wider work in the community aimed at risk factor reduction and modification, e.g., food and diet initiatives, smoking issues and cessation groups, and active living and exercise opportunities.

The hope would be that through the Have a Heart Paisley training strategy, many of these lay volunteers will develop their skills further and be rewarded with a certificate of learning - the Paisley Heart Diploma (PHD).

Primary Prevention within Locality Networks

We see risk factor modification as the central theme of heart disease prevention. This implies the need to establish existing risk factors for individuals. We therefore intend to develop a “Know Your Risk” culture with individuals providing information on lifestyle and seeking measurement of modifiable parameters such as weight (or perhaps abdominal girth) and blood pressure. By using a simple uniform template, most information can be gathered within the community and then fed back to general practices in the first instance.

By providing all local pharmacies with digital sphygmomanometers we will create the means for many more individuals to have their blood pressures measured. A minority will have significantly elevated readings necessitating referral to their General practitioner, while most will have normal pressures or mild to moderate elevations. Here risk factor modification using a menu-based approach should be the preferred initial management.
SECTION 2

General practices will be offered ready access to 24-hour blood pressure monitoring. This will allow better assessment of individuals found to have significantly elevated pressures on screening. It will also afford the opportunity to review the need for treatment in existing hypertensives. A recent study suggested that about one fifth of this latter group could safely have their medication discontinued. Any increase in prescribing generated by screening would therefore be offset.

Secondary Prevention within Locality Networks

Most individuals presenting for the first time with symptomatic heart disease either to general practitioners or to the hospital will be offered appropriate advice in relation to risk factor modification. The majority will also be prescribed a number of drugs including aspirin, β-blockers, ACE inhibitors and statins.

Unfortunately, however, there is a large number who have a history of heart disease but who presented before the evidence base for such drug intervention was established, or who have been lost to follow up and have ceased to comply with recommendations made some time ago. There is compelling evidence to support intervention for this group to prevent morbidity and mortality.

We therefore propose to establish a disease register of coronary heart disease within each of the Paisley general practices. This will identify a target population in which intervention will have a major impact. We will develop a secondary prevention protocol that can be applied to this group either opportunistically or by an organised recall initiative. This will be adapted from national guidelines on prevention and will apply both in primary and secondary care settings. Individual practices will vary in their intentions in this respect but many would wish to establish a clinic, perhaps nurse-led, that would tackle the target group.

The protocol will ensure not only prescription of appropriate drugs but also some revision of risk factor modification. Patients could then be referred to their Locality Network for an exercise plan or help with smoking cessation.

Some may require assessment by a cardiologist, following referral by their GP. This may lead to their inclusion in the "high risk" network. In addition individuals with symptomatic disease will in many cases have contact with the Royal Alexandra Hospital.

Secondary prevention for this group will encompass rehabilitation and we have renamed this combination "heart renewal." They will be assessed by a consultant cardiologist and undergo pre-participation screening. Where appropriate they will in turn be assigned to the "high risk" network. This network will be based at the hospital where there will be some development to provide adequate exercise facilities in as safe an environment as possible.

The Locality Networks will offer a valuable role in providing the means of delivering integrated care for patients following a cardiac event. They could also manage cases and address some health inequalities, particularly in areas of social exclusion where there is evidence of high rates of default from follow up and low rates of angioplasty or coronary artery bypass grafting.
Prescribing Costs

One fear is that there will be a significant increase in prescribing costs incurred as a result of this initiative. While this is a realistic concern, there will be a significant benefit in terms of reduced morbidity and mortality to offset this. In addition, the Primary Care Trust intends to introduce prescribing advisors in 2000/01 who will undertake medication reviews. While primarily a quality initiative, this has been shown to result in significant savings in prescribing budgets so that the overall effect of our initiative should be cushioned.

Anticipated Effects of Locality Networks

It is our belief that Locality Networks will both prevent heart disease from occurring in some individuals and stop the progression of existing disease in many. Furthermore, the concept is so intrinsically community based and linked to community capacity building that we believe the effect will be sustainable. We believe that there will be a real and lasting culture change.

SECONDARY PREVENTION

Heart Renewal Programme for Patients with Established Coronary Heart Disease at High Risk

This "Locality Network" will focus on the following target groups:

♥ Patients admitted to the RAH with a diagnosis of myocardial infarction, unstable angina, established coronary heart disease and heart failure

♥ High risk out-patients attending the RAH following a myocardial infarction, coronary angioplasty, coronary artery bypass surgery, coronary angiography or with lifestyle limiting stable angina

♥ Patients referred by the community Locality Network through the General Practitioner for pre-participation screening and who are found to be at risk on the basis of exercise test result or clinical symptoms.

Aims for the Target Groups

♥ To provide a menu based cardiac rehabilitation programme encompassing: patient education, training, risk factor modification, stress management and secondary prevention. This will be called the Heart Renewal Programme

♥ To increase physical activity levels and reduce obesity

♥ To optimise control of blood pressure and blood cholesterol levels

♥ To network with a designed healthcare initiative on diabetes
 SECTION 2

• To reduce levels of anxiety, depression and stress
• To improve self-efficacy and self-esteem
• To increase the percentage of patients attending the programme who stop smoking
• To increase knowledge of coronary heart disease, healthy eating and improve healthy cooking skills
• To encourage people to be more motivated to maintain healthy lifestyles.

Process Objectives (compared to existing cardiac rehabilitation programme)

• To effectively implement national SIGN guidelines on secondary prevention
• To increase the number of patients being offered the hospital based heart renewal programme by targeting socially excluded patients and the elderly, and overcoming barriers to participation
• To improve the programme uptake and reduce drop-out rates
• To establish pre-participation exercise screening service for community based high risk patients with established heart disease or multiple risk factors.

Methods

Secondary prevention can be defined as limiting future occurrence of cardiac events in patients with established coronary heart disease. It involves risk factor modification by lifestyle change and appropriate pharmacological therapy. This innovative heart renewal programme will provide menu based cardiac rehabilitation encompassing secondary prevention in a hospital setting. The national SIGN guidelines for secondary prevention will be adapted to produce local protocols and integrated care pathways and then implemented in primary and secondary care. The present traditional cardiac rehabilitation programme is oversubscribed and provides a basic service for those patients who have sustained a major cardiac event (350 per year from the Paisley area; 85,000 inhabitants) i.e., myocardial infarction, angioplasty or CABG. This is the tip of the CHD iceberg with a further 2000 patients with established disease (unstable angina, chest pain and heart failure) admitted to the RAH from Paisley each year. Expansion of the existing programme is required to deliver a comprehensive heart renewal programme to this large group of high risk patients. The heart renewal programme will include:

• Smoking cessation
• Exercise consultation
• Individualised exercise prescription
• Multi-media expansion of the education programme
• Cooking skills for healthy eating
Clinical psychology including counselling, focus groups and stress management

Secondary prevention clinics facilitating fast-track consultation with a cardiologist

A randomised controlled trial of the Heart Renewal Programme compared to traditional cardiac rehabilitation.

In the Paisley community there are an estimated further 6,500 patients with coronary heart disease who do not attend secondary care. The present programme excludes these patients who are either asymptomatic or have mild to moderate stable angina. It is recognised that most of these patients are at low risk and can be managed in community programmes through the Locality Network. However, a small, but significant percentage of this group will initially require a hospital based supervised programme to ensure safe exercise. Risk stratification will be on the basis of the exercise test result and clinical symptoms. A pre-participation screening service including stress exercise testing is therefore required for these patients who are potentially at high risk.

It is anticipated that numbers attending the Heart Renewal Programme will approximate 2,500 per year.

Computerised audit of risk factor modification and prescription of appropriate pharmacological therapy will be performed by the heart renewal team in keeping with the ASPIRE study published in 1994. A secondary prevention module of our existing cardiology database (CARENET) is being developed to facilitate collection of data, record interventions and note outcomes. This will reflect the new menu based approach allowing the multi-disciplinary heart renewal team to record data relevant to their own speciality.

Agencies

The Royal Alexandra Hospital Heart Renewal Team will deliver the innovative programme and provide a pre-participation exercise screening service. A locality co-ordinator will be appointed who has a remit to deliver part of the hospital programme but will also ensure seamless care in the community through the general practitioner. Volunteer community members who have established heart disease will be trained to deliver aspects of the hospital based programme and secondary prevention as part of the Locality Networks in the community.

Anticipated Effects

Improved delivery of secondary prevention to high risk coronary heart disease patients

Significant reduction in short-term morbidity and long-term reduction in mortality

Reduced hospital re-admission rates in CHD patients.
SECTION 2

Evidence Based Secondary Prevention

There is an extensive literature detailing randomised controlled trials in various aspects of secondary prevention. Patients who stop smoking following a myocardial infarction reduced their mortality rate by 50%. Treating patients with average or raised cholesterol levels with established coronary heart disease reduced mortality due to coronary heart disease deaths by approximately 40%. The evidence for dietary modification in CHD patients is less convincing. However, the use of fish oils and a Mediterranean type diet has been shown to reduce cardiovascular mortality and recurrent myocardial infarction. A diet high in fruit and vegetables, nuts and grains has also been shown to reduce cardiac events following myocardial infarction. Although there is no single randomised control trial a meta-analysis of exercise based cardiac rehabilitation post-myocardial infarction has been shown to reduce mortality by approximately 25%. Optimised control of diabetes, hypertension and hyperlipidemia significantly improved longterm survival. Appropriate prescription of aspirin, β-blockers, ACE inhibitors and statins have proven mortality benefits in patients with established coronary heart disease.

There is no evidence to suggest that a menu based approach improves the outcome from cardiac rehabilitation compared to a traditional model. We propose to investigate this as part of our innovative programme. We anticipate improved morbidity and improved process outcomes from secondary prevention.

Summarising our Concept

We have defined a vision of Paisley with healthier people, living longer lives and with hope for the future. The process of defining and agreeing this vision has involved discussion among all partners and with the Paisley community as to how this vision can be achieved.

In defining a concept on which to base action, the following points were agreed:

- We will adopt a community-centred approach focused on localities
- This will feature integration of primary care with the community
- We will develop action to improve intersectoral interfaces e.g. patient risk registers, the health promoting school
- There will be a number of over-arching strategies developed by all partners e.g. training and development, information technology and public relations
- Risk factor networks will be developed e.g. active living, healthy eating, smoking, mental well-being
- Risk factor strategies will be developed for exercise, healthy eating, smoking and stress
- These strategies will be implemented following a local decision making process
- We will link closely with the Social Inclusion Partnership and ensure that steps to improve life circumstances are linked to the social inclusion agenda
- We will ensure that all actions will develop sustainable elements
- We will develop practice derived from the project into mainstream work
SECTION 2

- We will ensure equitable and appropriate targeting of resources to each element of the project.
- We will ensure the implementation of effective monitoring and evaluation procedures.
- We will collaborate with others who had submitted notes of interest, e.g., ASH Scotland.

Our final concept involves placing the community at the centre of action and ensuring that they are adequately supported by various agencies. In addition, we wish to ensure action which is primarily focussed upstream and aims to prevent coronary heart disease from ever happening. However, to ensure an inclusive approach we recognise the need to address issues in relation to secondary prevention and have developed a continuum of action from primary to secondary prevention as in Diagram 3 (below).

The following examples illustrate the pathway to a healthier life through a series of signposts from different parts of the network.
SECTION 2: PATHWAYS TO A HEALTHY HEART

Health Promoting School* → Setting for → ‘We’re on the Move’ Movement and Music Project

<table>
<thead>
<tr>
<th>Links to</th>
<th>Attends</th>
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<tbody>
<tr>
<td>Health Promoting School*</td>
<td>Youth Clubs</td>
<td>Child Y Glenburn Resident Family on Low Income Lacking in Confidence</td>
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Child Y Glenburn Resident Family on Low Income Lacking in Confidence

‘We’re on the Move’ Movement and Music Project

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<tr>
<td>‘We’re on the Move’ Movement and Music Project</td>
<td>“Parents at Play’ Community Project</td>
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“Parents at Play’ Community Project → Links to

*Health Promoting Schools
Curriculum
- Spiral curriculum
- Health education appropriate to age and stage
- Opportunities to develop strengths
- Activities to build self esteem

Hidden Curriculum
- Anti-bullying policies
- Policies to promote healthy lifestyle
- Positive relationship building
  - Staff to Pupil
  - Pupil to Pupil
  - Staff to Home

Role of health caregiving staff
- Support from educational psychologists
- One to one support from school health service
Exercise Preparticipation Screening

Mr C
45 years old
Resident of Ferguslie Park
Existing CHD
Smoker
Overweight

Breathing Space Project

Discharged from Hospital

Successful

Phase III Supervised Exercise at Royal Alexandra Hospital

Completed

Locality Network
- Risk Factor Monitoring
- Information and Advice on Healthier Lifestyle
- Referral to Community Groups

Dietary Support

Renfrewshire Community Food Initiative

Smoking Cessation Support
SPECIFIC DETAILS OF WORK PROPOSED

In defining the specific programme components consultation took place with all partners. This process was aided by the existence of a strong community development base, already owned and managed by the community. As a result of this, wide consultation plans were proposed for projects which are:

- Locality based and defined by the community
- Area based and defined by community
- Area based professional support to the community defined projects
- Networks based on the application of health promotion frameworks.

Some of these are new proposals, and some build on existing work.

Proposals have been collated in two ways. First, actions defined in relation to risk factors were collated and presented as outline strategies that will be further developed as the project rolls out. Strategies will be implemented on a settings and locality basis. Secondly, to ensure a holistic approach, settings based activity is further outlined in relation to the frameworks of the health promoting school, NHS and workplace.

HEALTHY EATING

Target Groups:

- All residents
- Families
- Adults
- Children and young people
- Women on low incomes
- People with established risk factors
- Obese adults
- Housebound.

Settings:

- Community
- Schools
- NHS – primary and secondary care
- Workplaces.
SECTION 3

Aims:

• To encourage healthier eating in localities
• To provide training to residents and staff from participating organisations on a settings basis
• Work in partnership with the local community in developing approaches to healthy eating taking a community development approach
• Integrate healthy eating with the concept of the health promoting school, health service and workplace
• Increase the number of people eating fresh fruit and vegetables daily
• Work with local retailers to increase availability of healthy choices and reduce costs
• Raise awareness of food issues in all settings and localities
• Develop services to enable greater access to healthy food e.g. delivery service to housebound people
• Develop a range of food initiatives e.g. community café
• Identify and seek solutions to problems faced by low income households
• Identify practical ways that communities, relevant agencies and the food industry can work together
• Identify opportunities for job creation through the development of local food economies
• Develop local support centres and support groups for those with diet related problems
• Provide information and advice in all settings
• Provide screening in community settings e.g. pharmacies
• Link primary care support with support in local communities
• Provide low stress healthy cooking and healthy eating activities
• Link healthy eating to physical activity programmes
• Link healthy eating to stress management programmes
• Reduce obesity levels in a range of target groups
• Ensure co-ordination of action on healthy eating
• Ensure that healthy eating programmes are developed in all settings.
SECTION 3

Methods:
The above aims would be accomplished through the development of a healthy eating strategy to be rolled out on a network basis determined by local communities.

- Agencies involved
- Community groups – Glenburn, Foxbar, Millarston, Blackhall, Ferguslie
- Community dietitians
- Primary care staff
- Education department staff
- Health promotion staff
- Retailers.

Anticipated Effects:

- Effective co-ordination of action on healthy eating
- Health eating programmes are implemented in all settings
- Increase in range, quality and amount of information on healthy eating available to the community
- Greater awareness of issues related to healthy eating in communities
- Increased skills in community
- Increased availability of healthy foods
- Greater access to healthy food for those on a low income and those who are housebound by easing accessibility
- Increase in number of jobs available locally in the food economy
- Identification of population who need to change eating habits to maintain health
- Increase in numbers of people participating in exercise programmes
- Reduced obesity in general population and at risk groups.
Tobacco

Target Groups

It is important that the resources are maximised, so that the activity will be targeted at those mentioned specifically in *Towards a Healthier Scotland*.

- Young people who smoke and those who are at risk of smoking – all settings
- Pregnant women (and partners)
- Patients with heart disease, respiratory disease, diabetes.

In addition, those people who influence or have a role in the lives of these target groups, such as:

- Education staff who specifically cover smoking in their curriculum
- Health co-ordinators in school
- School nurses and doctors
- Staff who smoke
- Health service staff.

Settings:

Tobacco work must be done where it is both convenient for people and also in places where they are ready to receive information. Within the localities, the Locality Network will work in the:

- Community
- Schools
- Workplace
- Health Service.

Aims:

- To reduce the numbers of people smoking and being exposed to smoke in Paisley in line with the national target
- To help smokers to reduce or stop smoking
- To prevent non-smokers or ex-smokers from starting
- To reduce exposure to passive smoking.
Tackling smoking is a complex and difficult area for many people for any number of deeply rooted factors. Although this document sets out a number of approaches to this, it is worth recording that the groups which will be targeted by this programme are the same groups for which giving up smoking is most difficult. All work to tackle smoking must go along with a supportive approach, by supplementing that which is being taken away (i.e. the pleasure of cigarettes) with some other equally enjoyable activity. In short, this programme must be delivered sensitively if it is to have any impact. It is therefore imperative that the smoking programme is delivered in conjunction with the other activities being undertaken by the Have a Heart Paisley project.

Community setting

As with the other programmes, the tobacco programme will employ a range of methods, ranging from policy development, training and development, skills development and information sharing.

We will:

• Negotiate policy on smoking with smoke-free areas in community premises
• Ensure at least one high profile event in the community (e.g. NSD, World No Tobacco Day) per year in each locality in Paisley
• Provide resources to community groups to support the smoking programme
• Provide smoking cessation services in the community to supplement those in the other settings (linking into the Tobacco White Paper activity)
• Provide NRT patches to communities via community pharmacies
• Review the No Puffin award and consider re-introducing it (or similar)
• Involve the local press in dealing with smoking initiatives
• The local authority will consider how to deal with contravention of the voluntary code on advertising
• Undertake work with the local transport services e.g. buses/taxis on reviewing their smoking policies
• Provide training for staff who work with local communities.

Similar approaches will be developed in all settings with setting specific activity where appropriate.
Agencies Involved

All agencies will be involved in the smoking programme at some point in the process. The facilitator for the smoking programme will develop the overall plan in more detail regarding which target group and method. Much of this will depend on the readiness of certain groups to make a start on this issue.

Overall Outcome

The overall outcome is expected to be a reduction in the numbers of smokers in the Paisley area.

Evidence Base

Research shows that stopping smoking is the most effective health promotion intervention. Research also supports the perception that this is not a significant issue for many community members and also that it is a multi-faceted and complex problem.

MENTAL WELL-BEING

Community Setting

Stress has been highlighted as a major issue in deprived communities of Paisley by a number of community groups who have submitted project ideas for *Have a Heart Paisley*. The relationship between stress and poverty/unemployment are well known. Paisley has high levels of all of these.

In addition, the Acheson Report, *Inequalities in Health* produced earlier this year stated the following:

"For the majority (unemployment) tends to have a significant adverse effect on both physical and mental health"

"In relation to physical health, unemployment carries a higher risk of morbidity and premature mortality"

Paisley has eight areas designated as eligible for SIP regeneration funding. Each of these areas has high levels of unemployment, often two to three times the national average, and those who do have jobs often exist on very low wages.

Lack of income restricts a household's capacity to make healthier choices, but also results in increased stress, anxiety and depression.

By increasing the community's capacity to cope with stress, linking in with expert assistance from voluntary and statutory agencies, levels of physical illness including heart disease will be reduced.
Mental Well-Being in the Workplace

The Acheson Report states that while people in higher socio-economic groups tend to report higher levels of work pressure, health related harm is more associated with an imbalance between demands at work and control at work, and this is more likely to be evident in lower socio-economic groups (see below).

"A number of studies show that an imbalance between psychological demands and control, and lack of control at work are associated with increased risk of coronary heart disease."

Renfrewshire Council is a key partner in Have a Heart Paisley, and is an employer of 7,500 people, most of whom live in Paisley. Given the low paid status of many council posts, it is an ideal venue to demonstrate how to improve the ability to cope with stress among the workforce.

Target Groups:

- Young people
- People resident in SIP areas
- People with mental health difficulties
- Women
- Women over the age of 55
- Unemployed men.

Aims

To reduce levels of anxiety, stress and depression among vulnerable sectors of the community via the following objectives:

- To provide group stress reduction activities to build self esteem, confidence and mental well-being among group members, enabling them to choose healthy lifestyle options
- To provide a variety of enjoyable physical activities
- To provide blood pressure monitoring in a variety of primary care and community settings
- To develop confidence, self esteem and a sense of security among children through taking part in physical activity
- To establish a range of activities easily accessible to the local community, including those with severe and enduring mental health problems
- To increasing understanding of the links between emotional and physical health
SECTION 3

• To set up a community based family stress centre as a focus for activities aimed at improving mental well-being among families living in areas of poverty and deprivation

• To further develop workplace health promotion activity aimed at coping with work induced stress

• To develop approaches to mental well-being through activities within the health promoting school and health promoting health service programmes.

Methods

The above aims will be accomplished through development of a mental well-being strategy rolled out on a network basis and determined by communities. *Have a Heart Paisley* sees community development and capacity building as key methods to address the problems of mental ill health and other illness. By providing community based volunteer groups with the resources, training and support they need, we plan to develop sustainable projects located in deprived communities that are attractive and economically viable to involve vulnerable people.

Agencies Involved

The following agencies and groups have submitted project ideas related to the links between mental wellbeing and heart disease/physical illness:

• Renfrewshire Association for Mental Health

• Renfrewshire Women’s Centre

• Blackhall Millennium Women’s Group

• Millarston Community Forum

• Renfrewshire Council (including education and leisure services)

• Health promotion service

• Primary care staff.

For details of the specific projects that will be developed to address this issue see Appendix 2.
SECTION 3

Anticipated Effects

When the 3 year project period is complete we expect the following to be in place:

• Support groups within communities for local people, particularly those living in poverty within SIP areas, to improve self esteem and confidence through positive activities such as exercise

• Improved mental wellbeing and reduced levels of anxiety and depression in families and individuals accessing community group work

• Increased awareness of the links between emotional and physical health

• Widespread availability of healthy activities to improve mental well-being

• Increased confidence within the population to seek out information and demand high quality services to support their desire to improve life styles and life circumstances

• Physical activity available for residents with severe and enduring mental health difficulties

• Improved self-esteem and self-awareness in nursery/primary school children

• Increased awareness of (and access to) the benefits of relaxation and complimentary therapies.

ACTIVE LIVING

Target Groups:

• Sedentary adults

• Unemployed

• Obese individuals

• Women over the age of 55

• Parents

• Children and young people

• Low risk CHD patients

• Patients with multiple risk factors for CHD.
SECTION 3

Settings:

- Community
- Education establishments
- Argyll and Clyde Acute Trust
- Primary care
- Workplaces.

Aims:

To increase physical activity levels of sedentary adults in Paisley to reduce the incidence of CHD

Methods:

- Establish a multi-agency steering group and develop three year strategy with exit plan (including community bids)
- Develop settings-based approach based on concept of health promoting school, NHS and workplace
- Develop Living Plus (A GP referral for health programme): widen target group and venues to include e.g. St Mirren Football Club – using exercise consultation
- Provide range and diversity of activity options i.e. venue and type of activity
- Establish web site to profile exercise facilities in Paisley and relevant services
- Incorporate and develop community projects such as those proposed:
  - Heartfelt Activities in Glenburn
  - Community Support Programme
  - Heart Matters in Foxbar
  - Charleston Healthy Habits
  - Lifeline Blackhall
- Develop IT links to improve awareness and access using sites in the community such as employment agencies, GP surgeries or pharmacies
- Local events and marketing of Paisley on the Move (including local employers and St Mirren – our local football team).
SECTION 3

- Provide training to health professionals, community workers and the community to expand their knowledge of the benefits of exercise and its safe delivery
- Establish pre-participation screening service for potentially high risk clients
- Establish links with the Renfrewshire Council Department of Leisure and Recreation who will develop physical activity programmes for infants, toddlers and school children linking to community initiatives:
  
  *We're on the move*
  
  *Play till your heart's content*
  
  *Parents at play*

- They will adopt the concept of health promoting schools encompassing the existing *Quality of Life Project*.

**Agencies Involved:**

- ACHB Health Promotion Unit
- RAH
- Renfrewshire Council
- Paisley community groups
- Living Plus steering group
- Reid Kerr College.

**Anticipated Effects:**

- Increased physical activity levels
- Reduced obesity levels
- Improved blood pressure control
- Improved knowledge of coronary heart disease
- Reduced levels of anxiety and depression
- Reduced stress
- Improved self efficacy and self esteem
SECTION 3

- Increased numbers of clients referred for exercise prescription from Locality Networks
- Increased numbers of exercise consultations
- Improved adherence to exercise/increased physical activity level.

Evidence Base

There is an extensive literature on the health benefits of exercise and inactivity as an independent risk factor in the development of CHD. The use of exercise consultation in promoting physical activity and the benefits of motivational interviewing in raising physical activity levels in a primary care setting have been recognised.

SETTINGS BASED PROGRAMMES

Health Promoting School

Education is an important health determinant and therefore has a key role in reducing inequalities in health. Educational qualifications provide a route out of poverty. In addition, schools prepare children and young people for life through their work on developing a range of skills to achieve full and healthy lives. The culture of a school has important effects in relation to the development of confidence and self-esteem, as well as health-related behaviours.

Cohort studies indicate that those with low levels of educational achievement have poorer adult health (Acheson Report). The Acheson Report recommends a number of actions in relation to the development of the health promoting school, particularly related to nutrition, that will be considered in this Have a Heart Paisley demonstration project.

A health promoting school is one in which health is considered as part of the curriculum, hidden/informal curriculum and as part of the role of health and caring services staff. In addition, the school considers its role in relation to the wider community. Recent developments around the concept of new community schools encompass attempts to develop the concept further.

Argyll and Clyde Health Board has a sound and successful history in developing the concept of the health promoting school. Pioneering work in the early 90’s resulted in the implementation of the health promoting school as a vehicle to prevent HIV/AIDS. This programme focussed on a number of schools in Paisley – particularly Merksworlth High and its associated primary schools. Later, a range of topics was the focus for health promoting schools interventions and in implementing work focusing on the role of the school in its wider community, strong links were established with the then Ferguslie Community Health Project.

Therefore, in developing the concept of the health promoting school in the context of coronary heart disease prevention, we have a sound base on which to build. Elements of the Coronary Heart Disease Programme are already in place as roll-out of the Quality of Life Project (an evidence based exercise programme) has commenced in two of the clusters*.

*
SECTION 3

The health promoting school programme will result in a network of health promoting schools in Paisley integral to all other elements of Have a Heart Paisley.

*A cluster is composed of a secondary school and its associated primary schools.

Target Groups:

♥ Young people
♥ Parents
♥ All staff (including non-teaching staff such as caterers and janitorial staff)
♥ Community projects (e.g. Renfrew Association for Mental Health).

Settings:

♥ Pre-5
♥ Primary and secondary schools.

Aim:

♥ To develop further the concept of the health promoting school as a vehicle for coronary heart disease prevention.

Objectives:

♥ To co-ordinate and improve health promotion across cluster groups of schools
♥ To focus on issues in relation to health education, health protection and disease prevention (particularly risk factors of smoking, poor diet and inactivity)
♥ To develop appropriate approaches for the key target groups (including smoking cessation)
♥ To promote and further develop links with primary care services
♥ To develop workplace health promotion activities for all staff
♥ To inform and support a process of change.
SECTION 3

Methods:

- Creation of a network of health promoting schools in Paisley
- Develop schools as health promoting environments
- Develop and implement a staff training programme
- Develop the curriculum on a cluster group, whole school, cross-curricular and special focus approach
- Strengthen links between schools and other agencies through integration with the Locality Networks
- Develop approaches to improve access to appropriate support services e.g. smoking cessation
- Develop appropriate policies to promote heart health e.g. healthy eating.

Agencies Involved:

- Children, young people, parents and staff from all Paisley schools
- Educational development service
- Primary care staff
- Local Healthcare Co-operative
- Smoking cessation services
- Health promotion service
- Community health projects
- Renfrewshire Association for Mental Health
- Other local authority departments e.g. social work.

Anticipated Effects:

- Further development of a spiral curriculum in relation to heart health
- Develop policies to promote heart health
- Increase in health promoting skills of staff
- Reduced smoking rates in all groups in the school community
- Increase in number participating in regular exercise
- Increase in number of people eating a healthy diet
- Further development of the role of primary care staff in health promotion programmes
Health Promoting Workplace

Taking action to prevent ill health and promote good health makes sound business sense for employers. Sickness absence costs employers dearly and is one of the biggest loss factors in industry. A motivated, healthy workforce is more likely to perform to a higher level than one that is not. Both the employers and the employees can benefit from action to promote health in the workplace. These benefits should include:

- improved morale
- reduced absenteeism
- improved productivity.

The health promoting workplace is one in which all aspects that affect health are considered. Such a workplace should provide an environment which protects health through:

- health and safety legislation
- health policies or set procedures such as those for smoking and alcohol
- provision of occupational health and screening programmes.

Such a workplace should provide opportunities and support for the promotion of healthy lifestyles by:

- supporting activities such as smoking cessation, participation in physical activity and healthy eating
- providing information on key health issues
- organising work to promote good health as well as maximising efficiency.

With the ever-changing world of work, the increasing pressures and challenges for both the workforce and management have implications for both physical and mental well-being. Initiatives such as Investors in People address organisation and culture and simultaneously indirectly promote health. Scotland’s Health at Work Award Scheme is an initiative that provides workplaces of all types with a structured but flexible framework for developing workplace health promotion.

A range of workplace initiatives will be developed as part of the Have a Heart Paisley Project. In particular the local authority has agreed to participate in work aimed at improving employee health.
SECTION 3

Target Groups:

- Local authority employees
- NHS employees
- Private sector employees.

Aims:

- To support employers in adopting practice to reduce coronary heart disease
- To enable employees to participate in programmes to promote heart health.

Methods:

The above aims would be accomplished through the development of a workplace strategy. The role of community capacity building will be developed to provide support to workplaces, for example referring workplaces to locality based counselling facilities.

Agencies Involved:

- Locality Networks
- Local authority
- Health service
- Private companies
- Local volunteers.

Anticipated Effects:

- Healthier choices available in the workplace e.g. healthy eating choices
- Increase in number of workplace health promotion policies
- Reduced absenteeism
- Increase in number of local companies registered for SHAW award
- Establishment of a network of companies participating in Have a Heart Paisley.
Health Promoting Health Service

Towards a Healthier Scotland advocates the importance of adopting a comprehensive and holistic approach. This can be developed by the application of the health promoting health service framework. A national pilot project has provided an evidence base to assist in further developing the concept. In the case of the Have a Heart Paisley project the framework will be used as a vehicle to ensure that risk factors for heart disease can be addressed in a holistic and comprehensive manner. The planning compass is presented to indicate how the framework can initially be discussed.

TARGET GROUP
Staff
Patients with risk factors

TOPIC
Risk factors for CHD

SETTING
Primary care
Secondary Care

METHOD
Implement concept of health promoting health service
What is the Health Promoting Health Service Framework?

Programmes to promote and improve health require careful thought and planning if we are to achieve successful outcomes. The health promoting health service framework comprises eight components, consideration of which helps us to ensure that key issues are addressed. By using the components, not only can we address key issues, but also we can identify key personnel who should be involved.

The components of the health promoting health service framework are listed below, with examples of the questions that may be asked in addressing the issue of promoting heart health.

<table>
<thead>
<tr>
<th>Component</th>
<th>Possible questions you might ask in the early planning stages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policy Development</td>
<td>Do we have policies relating to key risk factors e.g. smoking, healthy eating? What would be the purpose of such policies? What are the key components of such holistic policies? How does our environment facilitate the provision of support for risk factor modification? What are the components of an optimal environment? What standards should we aim to achieve? Who in the wider community should we involve? Is there a role for them? What should that role be?</td>
</tr>
<tr>
<td>Environment</td>
<td></td>
</tr>
<tr>
<td>Community participation</td>
<td></td>
</tr>
<tr>
<td>Staff Health</td>
<td></td>
</tr>
<tr>
<td>Skills/Training</td>
<td>Have staff had recent training on risk factors? What training is available? How can we ensure that staff have the skills they need to deal with this issue effectively? Have staff received training in motivational interviewing?</td>
</tr>
<tr>
<td>Communication/Co-ordination</td>
<td></td>
</tr>
<tr>
<td>Patient Programmes</td>
<td>What information do patients need? How accessible is that information? What needs to be highlighted in the patient's care plan? What is the role of the carer?</td>
</tr>
<tr>
<td>Research and Evaluation</td>
<td>What are the gaps in our knowledge? What are the research priorities? How will we measure any improvements made because of implementing this programme?</td>
</tr>
</tbody>
</table>

A detailed example of the framework is shown in Appendix 3.
SECTION 4

TRAINING AND EDUCATION

The importance of a training and education strategy was discussed in the section on Locality Networks. What follows is a more detailed description of the key elements.

It is essential that members of the community and professionals involved in the prevention and treatment of coronary heart disease are equipped with the appropriate knowledge and skills to participate fully in the programme.

A Training and Development Officer will be employed with a key role in developing an appropriate training and education strategy. This strategy will reflect the identified needs of specific groups. The post holder will also be responsible for the planning, co-ordination, and delivery of training and educational events. This will require multi-disciplinary, multi-professional and multi-agency working, in order to meet identified needs.

Provision of Training and Education

The following broadly outlines initiatives to be undertaken in the provision of training and educational activities to support this bid:

- Identify the training, development and educational needs for specific groups (as detailed later) by undertaking a training needs analysis
- Develop a strategy which sets out the training and educational needs that have been identified and includes an action plan
- Co-ordinate training and educational activities to meet the needs of a wide range of people (as described in the target groups) to address issues in relation to life circumstances and lifestyles
- Develop and implement education programmes for the general public, patients and their families to raise awareness of coronary heart disease and the benefits of adopting a healthier lifestyle
- Collaborate with other agencies to deliver programmes that will provide healthcare professionals with the necessary knowledge and skills to support patients and the community
- Collaborate with other agencies to provide a variety of programmes to meet the needs of the target groups e.g. health promotion, dietetics, leisure staff
- Educate and train the public and professionals on effective interventions that include self-assessment components
- Promote training and educational activities to ensure full involvement of the community and professional groups
- Collaborate with educational establishments to develop CD ROM interactive training programmes, Paisley Heart Diploma and other training materials for future use
- Evaluate training and educational activities.
SECTION 4

Initial Suggested Programme Topics:

- Coronary heart disease and prevention
- Programmes to equip those at risk to manage and cope effectively with stress
- Counselling skills for staff to increase their awareness of appropriate strategies which will be used in their role as health promoters
- Risk factor assessment for individuals
- Adopting a healthier lifestyle
- Motivational interviewing techniques
- Foundation level health promotion
- Applying the concept of the health promoting health service
- Applying the concept of the health promoting school
- Applying the concept of the health promoting workplace
- Healthy eating and cooking skills
- One to one counselling
- Group work skills
- Applied group work skills
- GP exercise and referral programme
- Individual skills building to enable development of policies to create a healthier environment
- Basic life support skills/resuscitation especially for family members of high risk patients.

Target Groups:

- Public
- Patients and their families
- Healthcare professionals in both the primary and secondary care settings
- Teachers
- Volunteers
- Community workers
- Social services
- Health promotion staff
- Leisure staff.

Methods implemented will be appropriate to proposed learning outcomes.
SECTION 5

INFORMATION TECHNOLOGY

Aims:

♥ To create a database of all 45-70 year old patients and to calculate their annual CHD risk
♥ To create a database to enable accurate identification of 90%+ of prevalent CHD
♥ To integrate the database within RACHEL Carenet project that is about to be implemented locally
♥ To develop a web site providing information on cardiac health and risks supporting the Have a Heart Paisley project.

Objectives:

♥ To enable accurate risk factor profiling to be undertaken
♥ To develop a tool to import the relevant data to GPASS and other GP systems
♥ To improve the interface between primary and secondary care
♥ To enable effective tracking of CHD risk factors and appropriate intervention
♥ To develop common datasets and links between related clinical areas e.g. diabetes & CHD to support effective clinical management
♥ To develop a web based audit tool to enable local comparisons between general practices of risk factor identification and uptake of effective CHD interventions.

Desired Outcomes:

♥ Accurate recording of prevalent CHD
♥ Accurate identification of key target groups
♥ Accurate targeting of interventions
♥ Improved equity of access to local services
♥ Reduction in health inequality improved consistency and adherence to locally agreed care management protocols
♥ More appropriate risk factor screening (with less duplication of tests)
♥ Improved clinical management - (with more effective and targeted intervention)
♥ Increased number of practitioners reaching agreed targets
♥ Reduced screening costs
SECTION 5

- Improved identification of at risk population (with children of people with known risk factors)
- Information to assist in planning for end stage CHD (CCF).

Evaluation

A case control method would be employed, with controls coming from a matched population outwith the Paisley area (details have yet to be worked up). Links will be developed with an academic institution. (This institution cannot be identified until we know which institution has been awarded the contract for evaluation).

There are four major areas that may be evaluated:

- Access to health information
- Data collection to evaluate the project
- Creation of a cardiovascular risk register using GPASS or its equivalents
- Innovation in IT with respect to health care.

Further details are shown in Appendix 4.
MANAGEMENT OF THE PROJECT

The project will require a management support team to provide day to day support and co-ordination over the three-year time scale.

The Have a Heart Paisley project comprises several components. These form a core with dispersed locality elements. All of these will be carefully co-ordinated to ensure that their work is integrated and synergistic. This will be the responsibility of the support team who will provide continuous assistance.

The project office will form the hub of Have a Heart Paisley. All project components will be networked, co-ordinated and integrated from the hub. Each Locality Network will be serviced by a locality co-ordinator who will facilitate linkage of these component parts.

This is represented diagrammatically below:
Responsibilities of the Project Team Will Include:

Programme Management:
- Ensuring links between the programme areas
- Maintaining an overview of programme development
- Monitoring of all programme areas
- Providing regular written reports to the management team
- Servicing the management team
- Development of exit strategy and ensuring this remains on target.

Project Support:
- Providing specialist support to the individual projects
- Identifying and addressing common training needs across all project areas
- Monitoring all projects for community participation.

Budget Management:
- Monitoring of budget spends from individual projects
- Ensuring the programme remains on budget and to required timescales.

Evaluation:
- Developing and implementing internal evaluation of the programme
- Establishing the baseline necessary for a robust evaluation framework
- Developing intermediate indicators
- Developing sustainability indicators
- Ensuring that projects respond to iterative evaluation.
SECTION 6

Communication, PR and Marketing:
- Ensuring implementation of the PR and marketing strategy
- Ensuring good communication between all partners
- Provision of written reports for the Scottish Executive
- Further development of teamwork to facilitate effective partnership work throughout the life of the programme.

Programme Dissemination:
- Developing and implementing the dissemination strategy
- Planning and implementing seminars for local dissemination
- Preparing and presenting papers at conferences and seminars and for publication as part of the dissemination process.

Resource Development:
- Development of programme specific resources
- Marketing resources with the purpose of income generation.

Proposed Structure for Support Team

ORGANISATIONAL CHART

Steering Group
Management Team

Director of Clinical Development
Renfrew and Inverclyde Primary Care NHS trust

Have a Heart Paisley Co-ordinator

New Deal Employee
Grade 5

Finance
Grade 5/6

Training
Grade 7

Locality Officer x 3
Grade 6

Research
Monitoring
Evaluation
Grade 7

Clerical
Administration
2.5 x Grade 3
EVALUATION

The team working on Have a Heart Paisley understands that there will be an independent evaluation. However it was considered important that outcome measures should be incorporated into the project design. This will enable the project to have internal monitoring of process and intermediate outcomes. It would therefore appear sensible to ensure that internal monitoring uses at least some of the same data thereby reducing duplication. While this might simplify external evaluation of the project, we do not wish to influence the final evaluation, which must retain independence.

Outcome Measures

Have a Heart Paisley has robust outcome measures. These relate both to coronary heart disease outcomes and reduction of risk factors.

A delay between the time when a population’s risk factors are altered and the point at which measurable changes in the population’s mortality and morbidity would be found is inevitable. Therefore both short term and long term outcome measures have been identified enabling the assessment of the effectiveness of this risk factor reduction programme. Discussion with the external evaluation team will enable these to be modified and improved. In essence, these short-term measures focus on health related behaviour changes and environmental changes facilitating healthy choices.

It is important that intermediate outcomes do not focus only on the provision of information and the pros and cons of particular behaviours but also consider factors such as helping people to feel good about themselves, to value themselves, and to acquire the skills to assert themselves. These have incidental benefits in being transferable to other areas of life, in turn promoting well being. The emphasis on the influence of self-esteem on behaviour devised as a model of behaviour change has been developed further within this project picking up on the model of stages of change. Evaluation should determine whether staff have been trained to assess where clients are in the stages of change and whether interventions on offer provide a sufficient menu of choices to engage the people of Paisley according to their needs.

Long-term Outcome Measures

Mortality and morbidity are the most appropriate outcome measures for a risk factor modification programme. For the Have a Heart Paisley project, morbidity would be the number of people with heart disease living in Paisley at one time. Mortality will be the number of Paisley residents who die from heart disease.

Morbidity and mortality would be best measured as part of the overall evaluation of the whole Have a Heart Paisley project, rather than for any specific component. These will require longer term, external monitoring of cardiac mortality and morbidity, which should continue for a substantial time after the project has been concluded.

Mortality should be measured using routine datasets before and after the commencement of the project. Longer-term follow-up of current residents of Paisley might also be considered. Central tagging of death records could enable follow-up of people currently resident in Paisley who had participated in Have a Heart Paisley.
Changes in morbidity could be evaluated through cross-sectional surveys of the two study populations and the control population prior to and following the project interventions.

In addition to the time lag between intervention and measurable effect on morbidity and mortality, it is known that health education interventions to modify risk factors in asymptomatic individuals only produce small beneficial changes in measurable coronary risk. Those at higher risk of CHD benefit the most. However, through the opportunities of access to the population of Paisley afforded particularly in the primary care setting, data on changes in smoking, high blood pressure, obesity, levels of physical activity and cholesterol levels will be recorded and an accurate risk factor profile of the population constructed.

Short-term Outcome Measures

As mentioned above the short-term measures focus on health-related behaviour changes and environmental changes that facilitate making healthy choices on an individual level. It is the project team’s belief that the people of Paisley will be offered the right blend of personal and environmental interventions that best address the current barriers to healthy living. Some of the short-term evaluation measures are best applied to single parts of the project while others may be better suited to evaluation of the complete project (e.g. the range and gaps identified in the interventions offered). Importantly, in conjunction with the evaluation team, there is a need to evaluate the synergy created by the mix of personal and environmental interventions once some of the shorter-term outcomes have been measured.

Evaluation could be directed at the measurement of how the project interventions are helping people to move through the stages of changes in the model mentioned above. For example, it will be necessary to determine the effectiveness of interventions focussing on behaviour change strategies for those in the ‘action’ or ‘maintenance’ stages. Assessment of the effectiveness of education and awareness-raising would be carried out for those in the ‘pre-contemplation’ phase. Working for client self-empowerment is appropriate for someone in the ‘contemplation’ stage and evaluation of these intervention programmes will be undertaken along with assessment of the strategies to help people make decisions for those in the ‘contemplation’ stage.

These measurements could include changes in people’s risk behaviour as a result of the project e.g. dietary modification, smoking cessation/reduction, exercise etc. Changes in people’s knowledge of risk factors and attitudes towards such risk behaviours will also be assessed.

These aspects could be evaluated as individual project schemes, and for the entire Have a Heart Paisley project. In terms of evaluating the effect of the complete project it may be useful for the evaluation team to consider carrying out a systematic review of instruments already designed for the measurement of needs and outcomes e.g. Quality of Wellbeing Scale.

The qualitative measures of satisfaction and accessibility would be measured for each component. As a demonstration site it is important to ascertain whether the interventions are acceptable to the population. There is little point in extending Have a Heart Paisley to Scotland as a whole if it is not acceptable to the population.
SECTION 7

Study Design

The evaluation of many of the measures discussed above requires comparison groups that have not been exposed to Have a Heart Paisley.

Firstly, there could be a comparison of selected measures such as risk knowledge and behaviours, morbidity and mortality with another area. The Inverclyde residents will be used for this. The advantage will be that both groups having been assessed simultaneously, will have been subject to the same external influences. (This would control for confounding in a situation where HEBs, for example, might have run a major Scottish heart disease risks campaign on TV.)

Secondly, a comparison of Paisley residents before Have a Heart Paisley with the same population after the project is over would show local changes. Both these comparisons will be made on a cross-sectional basis.

Key Evaluation Questions:

- Does the intervention reach the appropriate target population?
- Who were the key target groups?
- Is it being implemented in the way specified?
- Is it effective?
- How much does it cost?
- What are its costs relative to its effectiveness?
- What are the critical success processes?
- How have the determinants of health altered?
- How have lifestyles altered?
- What policy changes were implemented?
- What environmental changes have taken place?
- How have communication channels between agencies been affected?
- What have been the training/educational components of the programme and how effective have these been?
- What are the sustainability indicators that have been identified?
- What has been the impact of community involvement/participation in the programme?
- How have changes in health status been monitored?
- Have there been any changes in health status?
COMMUNICATION, PR AND MARKETING STRATEGY

It is essential that throughout the life of the project we maintain a focus on effective communication with the following parties:

- The Paisley community, including retail, business, commerce and leisure
- Locality Networks
- Members of the steering/management groups
- The Scottish Executive
- Other interested parties in Scotland and the rest of the UK
- Other interested parties abroad.

The support team will have the main responsibility for ensuring that this happens. However, to ensure a professional approach we will develop a Communication, PR and Marketing Strategy. This will be developed further by a company who will implement this element on our behalf. In addition, we will work with them to develop training and education materials for further use and to support project dissemination.

They will also assist with wide dissemination of the project.
<table>
<thead>
<tr>
<th>DATE</th>
<th>ACTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>March 2000</td>
<td>Advertise support team posts</td>
</tr>
<tr>
<td>April 2000</td>
<td>Public launch of project</td>
</tr>
<tr>
<td>April 2000</td>
<td>Recruit support team</td>
</tr>
<tr>
<td>April 2000</td>
<td>Develop evaluation protocol</td>
</tr>
<tr>
<td>April 2000</td>
<td>Collate baseline measures/commence gathering of new data</td>
</tr>
<tr>
<td>April 2000</td>
<td>Agree implementation plan with local authority</td>
</tr>
<tr>
<td>April 2000</td>
<td>PR out to tender</td>
</tr>
<tr>
<td>May 2000</td>
<td>Set up Locality Networks</td>
</tr>
<tr>
<td>May 2000</td>
<td>Agree PR tender</td>
</tr>
<tr>
<td>May 2000</td>
<td>Develop detailed area-wide risk factors, settings, IT and exit strategies</td>
</tr>
<tr>
<td>June 2000</td>
<td>Set up projects within localities/primary and secondary care</td>
</tr>
<tr>
<td>June 2000</td>
<td>Agree detail of PR for next 6 months and commence implementation</td>
</tr>
<tr>
<td>July 2000</td>
<td>Agree intermediate and sustainability indicators for individual project elements</td>
</tr>
<tr>
<td>July 2000</td>
<td>Commence training needs assessment</td>
</tr>
<tr>
<td>September 2000</td>
<td>Complete training needs assessment</td>
</tr>
<tr>
<td>October 2000</td>
<td>Develop training and development plan and agree components of Paisley Heart Diploma</td>
</tr>
<tr>
<td>November 2000</td>
<td>Commence implementation of training plan</td>
</tr>
<tr>
<td>December 2000</td>
<td>Trained voluntary support to projects commences</td>
</tr>
<tr>
<td>December 2000</td>
<td>Assess impact of all strategies to date and adjust for next 6 months</td>
</tr>
<tr>
<td>January 2001</td>
<td>Interim seminar for Locality Networks and volunteers to assess progress and agree project plans for next 6 months</td>
</tr>
<tr>
<td>DATE</td>
<td>ACTION</td>
</tr>
<tr>
<td>------------</td>
<td>------------------------------------------------------------------------</td>
</tr>
<tr>
<td>February 2001</td>
<td>Continue 6 month project plans</td>
</tr>
<tr>
<td>March 2001</td>
<td>Commence commercial development of training and education materials for future use, pilot and adjust</td>
</tr>
<tr>
<td>March 2001</td>
<td>Ceremony for award of first Paisley Heart Diplomas</td>
</tr>
<tr>
<td>April 2001</td>
<td>First Year appraisal and annual report prepared</td>
</tr>
<tr>
<td>May 2001</td>
<td>Dissemination of first annual report</td>
</tr>
<tr>
<td>June 2001</td>
<td>Adjust project based on results of first year appraisal</td>
</tr>
<tr>
<td>June 2001</td>
<td>Assess impact of all strategies to date and adjust for next 6 months</td>
</tr>
<tr>
<td>July 2001</td>
<td>Commence preparation of interim evaluation report – Assess impact on lifestyle and life circumstances to date based on intermediate indicators</td>
</tr>
<tr>
<td>September 2001</td>
<td>Interim evaluation report produced and disseminated</td>
</tr>
<tr>
<td>October 2001</td>
<td>Respond to results of interim evaluation and adjust project plans to reflect requirements</td>
</tr>
</tbody>
</table>
### Second phase

<table>
<thead>
<tr>
<th>DATE</th>
<th>ACTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>November 2001</td>
<td>Assess sustainability indicators and adjust to ensure on track</td>
</tr>
<tr>
<td>November 2001</td>
<td>Seminar to disseminate learning to date - Scotland-wide and the UK</td>
</tr>
<tr>
<td>November 2001</td>
<td>First learning materials ready for dissemination</td>
</tr>
<tr>
<td>December 2001</td>
<td>Agree learning materials to be developed during the following year</td>
</tr>
<tr>
<td>December 2001</td>
<td>Assess impact of all strategies and adjust for next 6 months</td>
</tr>
<tr>
<td>March 2002</td>
<td>Appraise project and adjust plans depending on results</td>
</tr>
<tr>
<td>April 2002</td>
<td>Second year appraisal and production of second annual report</td>
</tr>
<tr>
<td>May 2002</td>
<td>Seminar for Locality Networks and volunteers</td>
</tr>
<tr>
<td>June 2002</td>
<td>Local celebration event for Paisley people</td>
</tr>
<tr>
<td>July 2002</td>
<td>Assess impact of all strategies and adjust for next 6 months</td>
</tr>
<tr>
<td>August 2002</td>
<td>Assess and agree exit process and incorporate into project plans</td>
</tr>
<tr>
<td>September 2002</td>
<td>Seminar for Locality Networks and volunteers to agree final exit plans</td>
</tr>
<tr>
<td>October 2002</td>
<td>Ceremony for award of Paisley Heart Diplomas</td>
</tr>
<tr>
<td>November 2002</td>
<td>Agree learning materials to be developed during remainder of project and commence production</td>
</tr>
<tr>
<td>January 2003</td>
<td>Commence final stages of evaluation</td>
</tr>
<tr>
<td>February 2003</td>
<td>National dissemination seminar</td>
</tr>
<tr>
<td>March 2003</td>
<td>Prepare third annual report, final evaluation and complete exit strategy</td>
</tr>
</tbody>
</table>

A number of regular activities/events/meetings co-ordinated by the support team will take place over the life of the project. These include:

- Steering group meetings
- Reports to participating agencies e.g. local authority
- Liaison with existing agencies.
SECTION 10

PROPOSALS FOR OPTIMISING THE BENEFITS OF THE PROJECT FOR SCOTLAND AS A WHOLE

In designing the Have a Heart Paisley project we have carefully considered dissemination as a crucial and integral part of project implementation. Dissemination of findings has been planned at:

♥ key points during the three year life of the project
♥ the end of three years and
♥ for certain elements dissemination will continue beyond the three year span of the project.

We have also considered:

♥ Local dissemination within the Paisley community
♥ Dissemination to key agencies e.g. Scottish Executive
♥ National dissemination
♥ Dissemination abroad.

How We Intend to Disseminate:

Local and National Seminars

See programme plan for details of timing.

Literature/Journal Articles/Papers

This will be incorporated into project implementation plans with key partners producing articles/papers. It will be the responsibility of the project researcher to co-ordinate this aspect of dissemination (see section on project management).

Internet/Web Site

A web site has been specially designed for the project and will contain information for easy dissemination.
SECTION 10

Professional Networks

One of the roles of the steering group will be to ensure that findings from the project form agenda items for key professional networks. These include:

- Institute of Public Health
- Health promotion managers
- Directors of Public Health
- Dietitians networks
- Cardiologists networks
- Community development networks
- Primary care networks.

A key task will be to identify all relevant networks in the early stages of project implementation.

Conferences of Professional Organisations

This will be a regular agenda item at steering group meetings where decisions will be taken on where and when to propose papers for appropriate conferences.

Clinical Guidelines Agenda

Steering group members will liaise with various clinical guideline groups e.g. CRAG, SNAP.

Input to Future White Papers on Health/Influence National Agenda

Steering group members will work with the Scottish Executive to identify key elements required to influence the future White Papers and Planning and Priorities Guidance.

Community Planning

It has already been agreed that elements from the Have a Heart Paisley project will be incorporated into the community planning process. This includes both implementation and dissemination.
Social Inclusion Strategy

It has already been agreed that elements from the *Have a Heart Paisley* project will be incorporated into the social inclusion strategy. This includes both implementation and dissemination.

Key features that will be actively considered for dissemination in Scotland and the rest of the UK during implementation of the project include:

- Analysis of individual disease approach
- How we influence patterns of working and joined up thinking
- Training (particularly the Paisley Heart Diploma)
- Impact of the model of primary care/community development - Locality Networks
- Impact of CARENET
- Community capacity building
- Social marketing
- Impact of the disease risk factor database
- Twinning
- Replicability – the project will adopt a pathfinder approach.

A key challenge will be to demonstrate the synergy created as a result of carefully integrating all project elements.
SECTION 11

FINANCIAL SUPPORT REQUESTED

*Have a Heart Paisley* – Financial Projection

Notes:

It is anticipated the commitment to PR will require to be greater in the first year.

The training element in Year 3 includes supporting the exit strategy.

The secondary health care costs in Year One include £170K for refurbishment and accommodation. This element will remain constant in the three costing models. The resource input will increase in Years 2 and 3 as the new facility becomes available.

There is an element of funding not committed in Years Two and Three. Monitoring of the Project during Year One will identify any under/overspend. Any slippage will be used to fund as yet unidentified locality based projects.
## SECTION 11

<table>
<thead>
<tr>
<th>OPTION 1</th>
<th>YEAR 1 £'000</th>
<th>YEAR 2 £'000</th>
<th>YEAR 3 £'000</th>
</tr>
</thead>
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APPENDIX 1

Have a Heart Paisley

Steering Group Members

Ms Clare Beeston, Senior Health Promotion Officer, Argyll & Clyde Health Board
Dr Oliver Blatchford, Consultant in Public Health Medicine, Argyll and Clyde Health Board and Honorary Clinical Senior Lecturer, University of Glasgow
Ms Sadie Brisbane, Community Member, Renfrewshire Partnership Forum, Paisley
Ms Jackie Britton, LHCC Manager, Renfrewshire & Inverclyde Primary Care NHS Trust, Dykebar Hospital
Andrew Broadfoot, Co-ordinator, Renfrewshire Partnership Forum
Mrs Anne Clarke, Health Promotion Commissioner, Argyll & Clyde Health Board
Dr Graham Dalrymple, Chairman, Paisley LHCC
Dr David C Davidson, General Practitioner and LHCC Representative
Dr Iain Findlay, Consultant Cardiologist, Royal Alexandra Hospital
Ms Elaine Garman, Director of Clinical Development, Renfrewshire & Inverclyde Primary Care NHS Trust, Dykebar Hospital
Ms Jan Henderson, Co-ordinator, Renfrewshire Community Health Initiative, Paisley
Ann Kerr, Acting Health Promotion Unit Manager (until November 1999)
Mr George Laird, Health Support Officer, Paisley Partnership, 10 Falcon Crescent, Paisley
Ms Ann Lees, Health Economist, Argyll and Clyde Health Board
Mr Gordon McAlonan, Renfrewshire Partnership Forum, Paisley
Mr Charlie MacGregor, Head of Regeneration Strategy & Communication, Renfrewshire Council, Cotton Street, Paisley
Annie McIntyre, Information Officer, Renfrewshire Partnership Forum
Dr Paul McIntyre, Consultant Cardiologist, Royal Alexandra Hospital and Honorary Senior Lecturer in Sport’s Medicine, University of Glasgow
Ms Vivienne Middleton, Vice-chair, Renfrewshire Partnership Forum, Paisley
Mrs Grace F Moore, Have a Heart Paisley Co-ordinator
Charles Russell, Renfrewshire Partnership Executive
Mr Jimmy Vipond, 15 Ballater Drive, Inchinnan
Ms Jane Walker, Renfrewshire Partnership Forum, Paisley
Dr Lesley Wilkie, Director of Public Health, Argyll & Clyde Health Board
APPENDIX 1

The Partners

The following organisations have been recognised to be principally involved in the *Have a Heart Paisley* project to date. While each is committed to continue as a key collaborator, this in no way excludes the many others whom we are confident will link with the network as our project develops.

PAISLEY LOCAL HEALTHCARE CO-OPERATIVE

Following publication of the White Paper *Designed to Care*, Paisley Local Healthcare Co-operative (LHCC) was formed. Although the initial impetus was from general medical practitioners, the organisation quickly evolved into a multi-agency body promoting joint working and service development. Soon it had brought together all professionals responsible for service delivery forming an executive team composed of representatives from general medical and dental practices, pharmacists, community nurses, PAMs, social workers and the local health council.

Paisley LHCC also supports a wider forum aimed at involving all stakeholders – in fact everyone with an interest in health in the town of Paisley. This carries involvement beyond the professional service providers to include patients, carers and representatives of the community.

Though it is less than two years since our LHCC was conceived, unprecedented energy and enthusiasm have driven its development. It has become identified as the focus of a real opportunity for change in Paisley. The major success factor has been the overriding desire to work together in improving the health status of the population of Paisley.

The appointment of a General Manager has strengthened operational links with Renfrewshire and Inverclyde Primary Care Trust. Consequently our LHCC has prepared an outline local implementation plan which seeks to:

- Establish an effective communications strategy within and outwith the LHCC
- Develop a training plan, identifying professional needs and personal development plans for clinical support staff and others
- Continue development of multi-professional needs assessment to establish local healthcare priorities
- Address the key priority areas identified as impacting on the health of the population of Paisley
- Begin to address issues of inequality.

General medical services are provided from 13 geographically distinct sites throughout Paisley (GP surgeries). Each practice is an existing focus for the surrounding community and acts as a hub for the delivery of healthcare and social services in that locality. The community pharmacists within Paisley are again geographically spread throughout the town and there is overwhelming support for continuing involvement in the development of the LHCC.
APPENDIX 1

The characteristics of Paisley LHCC, which will lead to its success include:

- Critical mass of size to make a difference in the delivery of healthcare
- Ability of participants to work together
- Common purpose
- Enthusiasm.

Paisley LHCC has emerged as the obvious lead organisation for the *Have a Heart Paisley* campaign. Although only a fledgling organisation it has already established networks and has a proven track record of partnership working. Its arena of interest is conterminous with that of the project.

Paisley LHCC embodies the realisation of the vision in *Designed to Care* and the enactment of that vision through *Towards a Healthier Scotland*.

**PAISLEY PARTNERSHIP**

Paisley Partnership is the Social Inclusion Partnership (SIP) for Renfrewshire that was set up to tackle social exclusion in its most deprived communities.

The partnership consists of a multitude of agencies crossing the community, public and private sectors. The SIP represents 11 separate communities, 8 of which are within Paisley itself:

- Blackhall
- Cart Corridor
- Ferguslie Park
- Foxbar
- Glenburn
- Millarston
- Thruscroigs
- West End.

These communities are characterised by the highest incidences of deprivation factors in the town. Indeed they compare unfavourably with most other parts of Scotland.

The Partnership’s role in *Have a Heart Paisley* is basically two-fold:

- To ensure that the project retains its heavy community focus throughout its three year lifespan and beyond
- To effect changes in life circumstances as a long term tool to reduce the incidence of heart disease.
Community Focus

The Partnership aim is to tackle social exclusion via four thematic action groups that consist of representatives from partner agencies along with strong community representation:

♥ Health and social issues
♥ Education
♥ Housing, environment and transport
♥ Economic development, employment and training.

The main aim of the Health and Social Issues Action Group is to tackle health inequalities, primarily through community development and capacity building. By providing support to community groups we help them to:

♥ Access funding to develop their own health solutions
♥ Raise awareness of health issues
♥ Facilitate uptake of healthier lifestyles by the community.

Much of the community health activity supported by the Partnership is focused on reducing risk factors in heart disease. We strongly believe that the community development approach is at the core of the Have a Heart Paisley project, and will continue to ensure that communities are fully involved and well informed on the progress of the project.

Changing Life Circumstances

To effect a long-term sustainable reduction in the incidence of heart disease in Paisley, we need to change the life circumstances of the town's residents. Through the mechanisms of the Paisley Partnership, we can influence the policy decisions of partner agencies which affect life circumstances such as housing, physical environment, education, training, employment, income levels etc.

Members of the Partnership include:

♥ Renfrewshire Council (social work, income maximisation, planning, chief executives, roads, housing, environmental services)
♥ Scottish Homes
♥ Renfrewshire Enterprise
♥ Paisley Chamber of Commerce
♥ University of Paisley
♥ Reid Kerr College
♥ Benefits Agency
♥ Employment Service.
APPENDIX 1

The most effective way to effect changes in aggregate life circumstances in the town is to target activity and resources towards the most deprived communities, which is what Paisley Partnership has been set up to do.

All of the above agencies are aware of, or have been involved in, the Have a Heart Paisley project. Using the Paisley Partnership structure it will be possible to influence the partners as to the strong relationship between serious enduring physical illness such as heart disease and other life circumstances.

Paisley Partnership will facilitate continued communication between the Have a Heart Paisley project and local partner agencies/community groups.

RENFREWSHIRE COMMUNITY HEALTH INITIATIVE

Renfrewshire Community Health Initiative (RCHI) is an amalgam of three community health projects: Renfrewshire Community Health Initiative; Drugs Development Project; and Ferguslie Health Project.

The organisation utilises a community development approach to advance its two main objectives – empowering people and raising their quality of life.

RCHI addresses the underlying determinants of poor health by raising awareness, encouraging empowerment and increasing skills to take on new challenges in health. While the resulting impact of this approach may not be immediately felt, it will ultimately bring about a real and demonstrable difference in community involvement and cohesion.

In relation to Have a Heart Paisley RCHI plans to:

♥ Further develop community ownership and quality of life through a structured approach to community development

♥ Continue to meet the health targets set by agencies and develop new targets based on the Partnership’s action group development plan (derived from the current health needs assessment)

♥ Ensure that health information is available and accessible to all and that there is equal access to resources and support

♥ Create an empowered community

♥ Ensure that communities identify for themselves the health issues that affect them and address those needs appropriately.
RAISE AWARENESS
Providing information and training on the issues of lifestyle and ensuring access and availability of resources and facilities.

INFORMATION
Ensuring communities are updated on progress and proposed change.

COMMUNITY HEALTH

PLANNING
Contributing to the planning process by ensuring the needs and views of local people in areas of disadvantage are heard and represented. Ensuring a community development process is maintained.

REVIEW
Ensuring monitoring processes are in place to meet the needs of communities and that their needs are upheld.

ACTION
Ensure health worker outreach activity to support volunteers in making plans and meeting aims. Add value by increasing confidence and skills in communities to facilitate effective action. Co-ordinate a consistent approach to e.g. diet and food issues across the SIP areas. To ensure health development in the most appropriate way takes place in communities.

In short, RCHI aims to address inequalities in health through information, involvement and innovation.
APPENDIX 1

RENFREWSHIRE COUNCIL

The support of the local authority is key to the success of this project. As providers of a large range of services, local authority policies and actions directly affect people’s life circumstances. These policies and actions include access to formal and informal education, housing and social services.

In addition, the local authority can support actions designed to improve lifestyles, for example through improved access to leisure facilities and by promoting lifestyle interventions.

Developing the role of the local authority

It has been agreed that the most effective way of supporting actions to improve heart health in Paisley is to ensure that the aims and objectives of the project be integrated with current and future council policy. In doing so we will ensure long term sustainability of actions to improve heart health.

This will happen in a number of ways:

• Discrete programmes designed to change practice and ensure improved communication and access to services e.g. health promoting schools programme

• Integration with current and future planning e.g. community planning, social inclusion strategy

• Discrete programme aimed at promoting health of the 7,500 employees by further development of workplace health promotion programmes and occupational health services

• Linking with business partners to enable them to consider their role and opportunities for action

• Developing existing projects where heart health has not been an integral component e.g. sustainable communities

• Further developing programmes where heart health is already an integral feature or that is focused on heart health e.g. GP Exercise on Referral

• Ensuring effective use of existing communication links with the community and developing new links where appropriate e.g. Renfrewshire newsletters, Chamber of Commerce, Community Planning web site

• Expanding opportunities for action in existing council-owned community facilities.

The input of the local authority will be co-ordinated by the Chief Executive’s Office.

Finally, the Have a Heart Paisley project will pilot health impact assessment by selecting community planning and the social inclusion strategy to perform prospective health impact assessment.
ROLE OF LOCAL AUTHORITY

Action to integrate with new/existing policies and enhance current programmes

Projects to promote staff health

Projects to change practice

Action to improve internal and external communication
ROYAL ALEXANDRA HOSPITAL

The role of the RAH will be to:

♥ Provide a consultant opinion on all aspects of coronary heart disease for the general practitioner
♥ Train hospital staff, primary care staff and the community in the delivery of secondary prevention
♥ Deliver the heart renewal programme encompassing cardiac rehabilitation and secondary prevention to high risk CHD patients
♥ Adopt the ethos of the health promoting health service to reduce risk factors for cardiovascular disease in staff and patients admitted with no evidence of CHD
♥ Develop an electronic network to facilitate shared care, communication of patient information, national guidelines and local protocols
♥ Demonstrate by audit that secondary prevention targets have been achieved.

ARGYLL AND CLYDE HEALTH BOARD PUBLIC HEALTH DEPARTMENT

The Public Health Directorate is made up of two departments – Public Health Medicine and Health Promotion.

Having supported the development of this bid, Argyll and Clyde Health Board’s Department of Public Health will be actively involved in many aspects of this project. These will involve the provision of advice on the population health aspects of Have a Heart Paisley including its sub-programmes. The department will also be responsible for the internal evaluation and monitoring of the sub-programmes, liaising with the external evaluators to facilitate the gathering and collation of appropriate population baseline data.

The Public Health Directorate will also ensure that the principles of Have a Heart Paisley are embedded in the Health Improvement Programme, Community Plans and Trust Implementation Plans. Links to other areas of the UK and abroad will be sought to share results and learn from others’ experiences, especially of public health and primary care.

The Health Promotion Unit delivers its service through four locality teams, one of which covers the Renfrewshire area. The unit has responsibility for health promotion in the Argyll and Clyde Health Board area. The key functions are:

♥ Advice and consultancy
♥ Resource development and provision
♥ Evaluation and research
♥ Media campaigns and events
♥ Training
♥ Policy development.
The Health Promotion Unit will provide the professional health promotion input to the project and work in partnership with the project in delivering these functions. The unit will support the implementation of Have a Heart Paisley through dovetailing operational plans to provide synergy and ensuring the project is consistent with both Boardwide and Renfrewshire wide developments. The unit will have a key role enhancing “the halo effect” of the project by building on existing partnerships to roll out the sustainable achievements to other areas outwith Paisley.

RENFREWSHIRE PARTNERSHIP FORUM

The RPF is a community organisation and a member of the Paisley Partnership. It aims to coordinate and represent the interests of community and voluntary sector organisations from within the priority areas of the Paisley Partnership.

There are two distinctive elements which form the basis of its activity:

- Creating an environment through which meaningful community representation and involvement can take place
- Building capacity within the community to enable full participation within the partnership by developing skills and providing access to information.

RPF and Have a Heart Paisley

The RPF seeks to enable communities to design, implement and participate in services relating to them.

It seeks to address inequalities within and between communities.

The RPF seeks to link communities through information, access to services and shared vision.

If the health of communities is to improve, then the communities must own that change. The RPF would ensure that:

- Communities are informed of available services and are able to access them
- Communities are aided to identify their own needs and priorities and are supported in designing appropriate services
- Participate in creating a climate of understanding about the social issues surrounding quality of life and its relationship to coronary heart disease and the requirement of a holistic approach to tackling it.
RENFREWSHIRE AND INVERCLYDE PRIMARY CARE TRUST

Renfrewshire & Inverclyde Primary Care Trust was established in April 1999, providing a range of health services to the local population. The primary care agenda seeks to encourage the development of new partnership arrangements and strategic alliances.

While still in the developmental stage, the Trust's vision for the future is an organisation with a strong primary care focus and the Trust seeks to develop clinical services in five localities, conterminous with the LHCCs within its area – one of which is Paisley. The Trust employs a wide range of highly skilled primary care staff including community nursing, professions allied to medicine and community medical staff. Establishing LHCCs has presented Renfrewshire & Inverclyde Primary Care NHS Trust with a real opportunity to work closely with other key clinicians in Primary Care – not least general medical practitioners and pharmacists. The *Have a Heart Paisley* project is a welcome opportunity to demonstrate the extent to which the joint working has developed within Paisley.

The Trust's role in the *Have a Heart Paisley* Project has five main strands:

- Working in partnership with others to build on the capacity of the community of Paisley in a sustainable way to reduce inequalities in health;
- Seek to reduce the incidence of CHD by effective implementation of national clinical guidelines;
- Adopt the principles of the demonstration project and implement good practices developed from the experience in other areas throughout the Trust;
- As a major employer within the NHS – adopt the principles of a Health Promoting Health Service and in this regard the Trust has registered for the SHAW scheme;
- Continue to develop training opportunities, ensuring staff are equipped to deliver a high quality service in a multi-agency community environment.

Whilst the following organisations are not core members of the steering group they are key partners and will be co-opted when appropriate.

- University of Paisley
- Local Health Council
- Reid Kerr College
- University of Glasgow Departments of Public Health and Primary Care
APPENDIX 2

EXAMPLES OF PROJECTS DEFINED BY LOCAL COMMUNITIES

Activities:

Charleston Healthy Habits

The links between physical and mental wellbeing are well established. However, as part of the area-wide stress strategy, it is proposed to set up a project to establish a range of physical activities for people with severe and enduring mental health problems. This would be coordinated by the Renfrewshire Association for Mental Health (RAMH) who recognise this as a gap in provision for a group of people considered to experience high levels of social exclusion. The activities would be sited in a number of community settings, and will also incorporate advice on healthier diets and smoking cessation.

RAMH is a locally recognised expert agency on mental wellbeing and stress, and as such will be heavily involved in most of the community and work based projects on stress (see below).

Community Support

Local volunteers in Foxbar propose development of a drop in centre to provide access to a range of activities including exercise.

Ferguslie Parents at Play

Ferguslie parents plan to work with other parents to develop skills in relation to active play.

Heartfelt Activities

Glenburn Health Forum proposes a community development approach to active living using a resource centre and linking with other local activities on healthy eating.

Heart Matters

Renfrewshire Women’s Centre proposes to set up a family stress centre at their headquarters in Foxbar aimed at improving mental wellbeing in disadvantaged households. Activity will mostly be aimed around relaxation techniques, the provision of complimentary therapies and stress counselling using the skills and experience of RAMH. Physical activities and healthy eating classes will also take place focused at raising self esteem and mental well-being therefore facilitating the selection of healthier lifestyle choices.
APPENDIX 2

Lifeline Blackhall & Time Out for Health

Women-only health groups are proposed in Millarston and Blackhall. These two SIP areas have high levels of deprivation and social isolation. The aim is to provide a group for women to participate in healthy eating classes, physical activity and stress reduction activities. This will improve their self esteem, mental well-being, giving them a focus away from their families. Creche facilities will be provided.

Play Till Your Heart’s Content

Glenburn Health Forum proposes linking with the local primary school to encourage exercise through structured play. Local volunteers will be trained and will provide outreach work to other schools as the project develops.

We’re On the Move

It is aimed to target the youngest members of our community (up to 8 years) with the “We’re on the Move” project which is aimed at developing confidence, self-esteem and a sense of security, as well as reducing obesity, through physical activity based around music and movement. This would be an area-wide project delivered by the Renfrewshire Dance Project (Education and Leisure Services). The programme would be delivered in nurseries and primary schools by trained workers, but parents would also be encouraged to become involved.

Wellbeing in the Workplace

Renfrewshire Council has offered to act as a pilot venue for mental wellbeing at work activities as part of an overall programme of health promotion on the main risk factors of heart disease. Feedback on the success of this programme, including the effect on the numbers of absences due to illness will be used as a basis for rolling the programme out to private sector businesses via Paisley Chamber of Commerce.

In addition to the above projects with specific aims regarding mental well-being and self esteem, many of the other community-based projects proposed under Have a Heart Paisley will also have a residual effect on these areas via the mechanism of community involvement, training and development. This is exemplified by the work currently undertaken by Renfrewshire Community Health Initiative who continue to support the development of community groups which address the concerns of communities on the management and understanding of stress and mental wellbeing. Groups such as Stressdance Glenburn have a peripatetic remit to train local people in hand, neck and face massage skills, as well as providing therapeutic massage directly. These existing groups will be fully engaged in the planning process for delivery of services, and will bring added value to the network principle.

Involving residents from deprived communities in positive activity will provide a focus and a sense of achievement which increases their ability to cope with stresses and strains in what are often quite difficult personal and family circumstances.
APPENDIX 3

HEALTH PROMOTING HEALTH SERVICE – ILLUSTRATIVE EXAMPLE

The following steps should be implemented to ensure a systematic approach.

Step 1

Set up a steering group – this should comprise key individuals who can help to drive the programme forward. At trust/ward level this could include:

- Health promotion officer
- Nursing officer
- Dietitian
- Hotel services manager
- Catering staff
- Ward manager.

Step 2

Assess the current situation – select each of the components and assess – where are we now?

This can be accomplished through variety of means e.g. focus groups, questionnaires, observation.

Step 3

Define the task – highlight key issues in relation to each of the components and agree the task.

Consider – where do we want to be? From the answers to this question you should be able to clearly define your objectives.

Step 4

Decide – how will we get there? At this stage you need to use your objectives to develop your action plan. This should include clear milestones, timescales and intended impacts/outcomes. It may also help you at this stage to identify possible opportunities which could arise from implementing this project. This can help motivate staff and give them a sense of purpose. Equally important is the need to identify possible constraints. These should be raised with managers and the steering group should develop a plan to deal with these constraints. This will help prevent staff becoming disheartened when difficulties arise, and can provide a sense of accomplishment when barriers are overcome.
APPENDIX 3

Step 5

Decide – how will we know that we’ve arrived? Agree evaluation and monitoring procedure at the outset.

Step 6

Action

Experience has indicated that reaching step 6 may take around six meetings, each lasting two hours. In addition, it may be useful to perform a worked hypothetical example to get people familiar with the framework.

The proposal in relation to staff health is outlined below.
APPENDIX 3

Health Promoting Health Service

Target Groups:

- Staff working in the NHS in primary and secondary care.

Aims for the Target Groups:

- To improve physical and mental well being
- To reduce stress
- To improve quality of life
- To reduce cardiovascular risk factors
- To provide a range of services in the workplace to promote health
- To create a better working environment
- To provide healthier food for staff and patients.

Process Outcomes:

- Number of staff stopping smoking
- Increased physical activity levels in staff
- Reduced obesity
- Reduced absenteeism.

Methods

All branches of the health promoting health service framework will be utilised.

Environment

The expansion of physiotherapy including the purchase of exercise equipment will create a modern exercise facility within the hospital. This will function as a healthy living centre. Primary and secondary care staff will be invited to join the centre paying affordable membership fees. The centre will be non-profit making and all income generated will be reinvested in provision of services.
Skills/Training/Patient Programmes

Exercise consultation led by exercise specialists will be offered free to all staff. This is a one-to-one motivational interview discussing the benefits of and barriers to physical activity and defining realistic goals for the individual.

Professional dietitians working from the healthy living centre will offer dietary advice for healthy eating, weight reduction and cooking skills. A smoking cessation unit will be established offering a full range of available methods. Blood pressure and sugar levels will be checked as part of the exercise consultation and (if necessary) the patient advised to see their general practitioner. The healthy living centre will work closely with the Department of Human Resources, the Occupational Health Service and the hospital's health promotion committee.

Communication/Co-ordination

The active living message will be promoted using the electronic physical activity network to establish details of community facilities in line with clients' interests. If clients choose to join the exercise facility they will receive an individualised exercise prescription. The centres will provide safe cycle lockups and shower facilities to promote active commuting. Interest groups will be established in activity areas such as walking. The centre will be the focus of all health promotion activity in the hospital. It will have responsibility for disseminating national health promotion material and use multimedia methods of communication.

Policy Development

The hospital will be asked to contribute from its endowment funds to assist in staff membership and subsidise activities within the centre. Stress management, relaxation and a staff physiotherapy service will be offered.

Research and Evaluation

The healthy living centre will improve the physical and mental health of the workforce with an anticipated reduction in absenteeism.

Agencies:

- Argyll and Clyde Acute NHS Trust
- Primary Care Trust
- Paisley Local Healthcare Co-operative
- Local authority
- Private sector.
Anticipated Effects:

- Healthier happier staff
- Reduced absenteeism
- Reduction in staff cardiovascular risk.

Evidence Base

The NHS is the largest employer in the UK but sadly neglects the health of its own staff. Provision of exercise facilities are scarce and usually of poor quality. Corporate memberships of leisure centres are occasionally offered but usually only to a select few. The NHS workforce includes a large percentage of socially excluded people from local communities who are at highest risk from cardiovascular disease and who would benefit most from lifestyle change. A questionnaire survey of staff in the RAH and primary care sector in 1999 showed that they are predominantly sedentary. However more than 900 employees favoured a staff healthy living centre, being willing to pay between £10-£20 per month for its use.
Where Do Standards Fit into this Process?

In attempting to promote health it is important to identify key standards. Standards should be developed and owned by staff and other stakeholders.

The following illustrative example further develops the concept of the health promoting health service and incorporates the development of standards with a focus on healthy eating. Similar action plans would be produced for other risk factors.

HEALTHY EATING

Action Plan for Policy Development

Rationale:

The development of a food and health policy for staff and patients will help create an environment where healthier choices are easier to make.

Objectives:

❤️ Produce a policy which promotes patient and staff health
❤️ Increase awareness of policy among staff, patients and families
❤️ Support all those concerned in making health related changes.

Standard:

❤️ The Trust will implement a food and health policy.

Intended Outcomes:

❤️ The policy and review systems are in place
❤️ Staff and patients are aware of the policy
❤️ The Trust is eligible to apply for a Healthy Choices award.

Milestones:

❤️ A Food and Health Policy Group is set up
❤️ Awareness raising seminars are implemented.
Action Plan for Improving the Eating Environment

Rationale:

The establishment should ensure that the eating environment impacts positively on the nutritional status the patient, reflecting health promoting aims.

Objectives:

- To assess the eating environment through implementation of a survey of staff, patients and relatives/carers
- To identify environmental issues that promote/constrain healthy eating in patients/staff
- To identify resource implications in improving the environment
- To request support of senior management in developing an action plan to improve the environment.

Standard:

Issues identified in the survey will be reflected in a written action plan to improve the environment. Effective monitoring procedures should be established to ensure maintenance of an environment to promote optimum nutritional status in patients.

Raising staff awareness of an optimal environment should be a topic for regular discussion.

Intended Outcomes:

- Environmental improvements are implemented
- Schemes/structures are in place to enable staff/patients/relatives/carers to suggest environmental improvements.

Milestones:

- Survey to identify environmental issues is designed and implemented
- Action plan for addressing environmental issues is produced.
Action Plan for Community Participation

Rationale:

NHS establishments are in a unique position to promote the health of the communities they serve, as well as caring for the sick.

Objectives:

- To ensure that patients/staff and visitors are aware of the role of the hospital in promoting optimum nutritional care
- To ensure that staff are aware of the factors influencing nutrition in the community
- To involve the hospital in promoting events/situations to raise awareness of nutritional issues
- To identify individuals/groups in the community who can support the hospital in improving nutritional status of patients.

Standard:

A written statement on community involvement in relation to nutrition will be provided. This will identify:

- Which groups/individuals are involved?
- The type of support they provide
- How the hospital maintains and monitors community involvement.

Intended Outcomes:

- Awareness of nutritional issues is raised in staff/patients/visitors/local community
- Appropriate involvement of key individuals/groups in improving nutritional status of patients.

Milestones:

Identification of key groups/individuals in the community who can work in partnership to improve nutritional status of patients.
Action Plan to Address Issues in Relation to Staff Health

Rationale:

A motivated healthy workforce is more likely to perform to a higher level than one that is not.

Objectives:

- To ensure that information on occupational health and safety is available to all staff
- To ensure that training appropriate to the issues of staff health is provided.

Standard:

- Uptake of information by staff on staff health issues is monitored at ward level. Activities to promote staff health are implemented at least on an annual basis.

Intended Outcomes:

- Reduction in staff absenteeism
- Healthier staff.

Milestones:

A reference portfolio of staff health information is provided and accessible in each ward area.
Action Plan to address Skills/Training Issues

Rationale:

Staff training/development are essential in ensuring that staff are using current evidence based practice. A recent audit indicated that 50% of nursing staff have not received training in nutrition.

Objectives:

♥ To improve skills of staff in relation to nutrition in key target groups
♥ To identify appropriate training/development opportunities
♥ To ensure that staff have access to appropriate training/development.

Standard:

Training is provided to a range of staff in relation to nutrition in key target groups. A training needs assessment in relation to nutrition should be implemented at ward level every two years.

Intended Outcomes:

♥ Increased knowledge and skills in all levels of staff in relation to nutrition
♥ Opportunities for relevant staff training are available to all members of staff.

Milestones:

Results of training needs assessment to inform action to address staff skills/training needs.
Action Plan to address Communication/Co-ordination Issues

Rationale:
Co-ordination and effective communication should lead to greater efficiency and effectiveness in promoting optimal nutritional status in patients.

Objectives:
- To identify a senior manager to take responsibility for ensuring effective communication and co-ordination in relation to nutritional issues
- To identify effective communication channels at every level in the organisation
- To ensure effective use of communication channels.

Standard:
The means of communication should be clearly stated and accessible for staff/patients/visitors. Hospitals should have a statement that clearly defines mechanisms to monitor effective communication.

Intended Outcomes:
- Improved communication
- Staff/relatives/patients make effective use of communication channels.

Milestones:
- Senior manager appointed to take lead role in relation to communication/co-ordination of action to improve nutritional status.
APPENDIX 4

INFORMATION TECHNOLOGY DETAILS

Access to Health Information

During the lifetime of the Have a Heart Paisley project our lives will be changed by the new technological revolution that is upon us. It is likely that we will under-estimate rather than over-estimate the potential health gains from the use of the Internet. It is quite likely that this will happen quicker than we can envisage. A good example is the use of NHS Direct (www.nhsdirect.nhs.uk) which cost £750,000 to develop and had 1.3 million visitors on its first day. It is likely to exceed its yearly-anticipated visits in less than one month. Thus there is immense potential to improve the knowledge of CHD in our community and to provide access for them to health improving information. A concern would be that those who would benefit most from such knowledge would find this information least accessible, i.e. the socially disadvantaged and the elderly who do not have home computers. This project must address this issue and ensure that ready Internet access is available to such groups.

Data Collection to Evaluate the Project

Evaluation and accountability of the project will be continuous. We shall require a means of monitoring progress and achieving deadlines. We propose to use NHS-Net as our means of communication between primary and secondary care. We should define a dataset based upon the repository model conforming to web technology standards. We should establish a means of access to that repository for each of the project participants. This would be through a firewall for security. Project participants would dial in to this facility from their principal workplace. If this was in a school gym or community centre then we should establish computer facilities with internet access and e-mail facility. Workers in the community would be provided with hand held computers for basic data collection.

Creation of a Cardiovascular Risk Register using GPASS or other GP Systems

We shall create a cardiovascular risk register of all 45 to 70 year old patients. This would enable calculation of their annual CHD risk, facilitating rational prescribing.

In order to enable basic risk factor profiling of the Paisley population the following variables are required: age, sex, blood pressure, cigarette smoking status and diabetic status. These basic patient descriptors will have been recorded in almost all practices and where not, are readily obtainable. Data need not be collected in GP surgeries but can be collected at any place where the community gathers. Pharmacy premises, football grounds, community centres, schools and the local hospital can all act as sources for data collection. A unique identifier is required but most patients would not know their CHI numbers, therefore date of birth, postal code and registered GP should be recorded. This data can subsequently be correlated with CHI.

A basic risk profile can be constructed to suggest whether it is necessary for patients to have their cholesterol checked. Such a register can be used to show patients the effects of lifestyle behaviour change (principality cigarette smoking) on their risk profile. It can be used to identify patients for smoking cessation strategies and avoid the need for expensive medication. We should set up basic cardiac risk assessors in pharmacies, schools, community centres etc.
Automatic blood pressure recorders should be available and the person screened should be able to enter this data into a basic risk assessor or have help to do so. This will require training of staff in these areas. The hand held computers and the desktop computers used for internet access will have the necessary software to do these calculations and store and transmit data back to the central repositories. This will enable the effective tracking of CHD risk factors and appropriateness of intervention.

In order to improve the interface between the community, primary and secondary care it will be necessary to develop tools required for the importing and exporting of data to GPASS and its equivalents. We will also develop the IT infrastructure to exchange clinical information and deliver services to patients suffering from CHD.

CARENET is a shared care Intranet information system that enables this exchange of clinical information and provides such structure to a Scottish Office funded Telemedicine project (RACHEL/CARENET) that is about to be implemented locally. The CARENET tool has been designed to assist clinicians in exchanging information across professional and organisational boundaries. It supports the clinical team in delivering healthcare to specific target groups. Information will be shared across the primary/secondary care interface. It supports an integrated approach to health care delivery through adherence to the same treatment regime based on latest evidence of effective medical practice. Considerable work is required to agree and implement a common dataset. The coronary risk profile could provide an example of this and act as a stimulus to more sophisticated data exchange.

The recording of information from all sources on a common system should achieve improved communication and implementation of agreed treatment and care protocols by all practitioners involved in patient care. We propose to develop a web based audit tool to evaluate this. This will enable comparisons of risk factor identification and uptake of effective evidence based therapeutic interventions between general practices. These data will be anonymised though each practice will be able to identity itself for purposes of comparison. In this way primary care physicians and other interested parties will be able to monitor their progress in this aspect of the project. Initial steps have already been taken in this area in forthcoming versions of GPASS within an add-on system known as CDSS (clinical decision support system). This system is being developed by clinicians in conjunction with the pharmaceutical companies, MSD and AstraZeneca. CDSS has created the environment for data entry into GPASS from external databases and could form a gateway to GPASS. In addition to this and to the development of audit tools CDSS, provides healthcare workers with the appropriate clinical trial data and management advice for specified conditions. There is potential for using and developing this system within this project.

We propose to create a database which identifies more than 90% of patients with existing CHD.

We will scan a range of different information sources to identify patients with CHD. Sources will include: ISD, Hospital databases, Coronary Care Unit, Diabetic registrations, Thrombolytic studies carried out locally, previous population studies such as Midspan, WOSCOPS, Heart Protection, Search, Prosper. Information gleaned will enable this database to provide an accurate picture of established CHD. Once the register is set up a risk factor modification programme will be obtained for each patient. This will be implemented under the supervision of the patient’s GP with input from a cardiologist and other relevant healthcare staff as required. Included within this programme would be linkage of laboratory results with a call-recall system. The laboratory database will be linked to the central register and patients who have not had a cholesterol level recorded on the laboratory system will be identified. The GP will automatically be notified and the practice will contact the patient to have this done. Patients with a satisfactory cholesterol level will be recalled annually.
This programme will be linked to locally agreed protocols and SIGN guidelines. GPASS and its equivalents will form the repository for this data and information will be shared using the CARENET shared care information system. As with primary prevention the development of an audit tool will enable local comparison of adherence to agreed protocols.

Innovation in IT with Respect to Health Care

The IT subgroup will have a commitment to embracing innovative techniques to facilitate the collection and dissemination of information with a view to improving healthcare.

We will consider the development of a patient smart card with relevant cardiovascular risk profile. We will explore the possibility of using supermarket loyalty cards.
THE EVIDENCE BASE

Community-based Programmes for Cardiovascular Disease Prevention

Cardiovascular disease (CVD) is the leading cause of death and disability in the developed world. Coronary heart disease and stroke together account for about 40% of all deaths. It has been shown that the major risk factors for CVD include unhealthy lifestyles (including smoking, poor diet and lack of exercise) as well as an unfavourable physical, economic and social environment. MacLean commented that “These [environmental] conditions produce circumstances in which known but modifiable [CVD] risk factors, such as cigarette smoking, high blood pressure, high blood cholesterol level, obesity and sedentary lifestyle, become commonplace in the population as a whole”.

The commonest approach to treating most diseases, including cardiovascular disease, is on an individual basis. This results in health professionals delivering health care services to single patients in an institutional setting (e.g. a hospital or general practitioner’s surgery).

The ability of such an approach to deliver an improvement in health status at a population level is debatable. Community-based interventions have been used to reduce entire populations’ CVD death rates. These interventions have included both primary and secondary CVD prevention strategies.

The North Karelia Project

In the early 1970’s, Finland had the world’s highest rates of death from CVD. Within Finland, CVD was commonest in the province of North Karelia. A comprehensive community-based CVD prevention programme was launched in North Karelia in 1972.

The North Karelia Project was established as a national demonstration project which was designed to test the feasibility of a community-based approach to CVD prevention. It was also designed to establish whether such an intervention would reduce the burden of CVD in a population.

Between 1972 and 1977, these community-based interventions were limited to North Karelia. Thereafter, the successful North Karelia interventions were extended nationally across Finland.

The North Karelia Project’s main objective was to reduce CVD mortality among the middle-aged population, especially among middle-aged men. Evaluation of the project against its main objective was based on a comparison of North Karelia’s CVD mortality rates with Finland as a whole.

The intermediate objective of the North Karelia Project was to reduce the prevalence of the known CVD risk factors in the population of North Karelia. These included smoking, high serum cholesterol and high blood pressure. The prevalence of these risk factors was assessed using cross-sectional surveys repeated at five-year intervals. These surveys were carried out in North Karelia and in the neighbouring province of Kuopio, which acted as a control area. Kuopio was chosen as the control area because of its similarity to North Karelia in terms of CVD mortality and morbidity and its similar socio-economic characteristics. Baseline surveys were carried out in 1972.
There were several components of the project which were aimed at both primary and secondary prevention of CVD.

The public was provided with information on known CVD risk factors and how to reduce their exposure to these. This was done using local news media, leaflets and posters, and at health education meetings held at schools and workplaces.

Public policy was used to support the objectives of the project, e.g. anti-smoking legislation.

Key personnel, including health professionals, teachers, voluntary workers and community leaders, were trained in practical aspects of the project.

Information systems were set up to support the activities of the project, including hypertension, infarction and stroke registers.

Sub-programmes were set up relating to specific risk factors including smoking, diet, hypertension, coronary heart disease and screening.

**Evaluation of the Project’s Intermediate Objectives**

Puska et al (1979) compared the changes in the levels of the target risk factors among the middle-aged population in North Karelia with the control area over the first five years of the project (1972 to 1977). They found significant changes in risk factors.

In 1972 the average number of cigarettes smoked per day by middle-aged men was significantly higher in North Karelia (9.9) than in the control area (8.9). By 1977 the number was the same in both areas (8.1). Although there had been a reduction in the average amount smoked in both areas, there had been a significantly greater reduction in North Karelia than in the control area. For women, the average amount smoked per day was similar in North Karelia and in the control area in 1972 and remained at about the same level in 1977.

In 1972 the mean serum cholesterol levels of both middle-aged men and women were significantly higher in North Karelia than in the control area. By 1977, they had reduced by significantly more in North Karelia, such that the levels were similar in North Karelia and in the control area for both men and women.

In 1972 the percentage of middle-aged men with high blood pressure diagnosed was similar in the two areas, at around 26%. By 1977, this percentage had fallen to 19% in North Karelia while in the control area it increased to 30%. Among middle-aged women, in 1972 the percentage with high blood pressure was significantly higher in North Karelia (30%) than in the control area (23%). By 1977, this percentage had fallen to 15% in North Karelia but remained constant in the control area (23%).

Puska et al concluded that at the start of the project in 1972, North Karelia had similar or higher risk factor levels than the control area. The 1977 survey showed that this situation had largely been reversed. The authors concluded that this was a result of the project and highlighted, in particular, cholesterol lowering dietary changes in North Karelia and the success of the hypertension programme as playing a major role in the greater reduction in risk factor levels in North Karelia. The project was successful in achieving its intermediate objectives.
APPENDIX 5

Vartiainen et al (1994) subsequently examined changes in the levels of these risk factors during the twenty years from 1972 to 1992.

They found that the percentage of middle-aged men who smoked had fallen by more in North Karelia (52% to 32%) than in the control area (50% to 37%) during this period. In contrast, smoking prevalence among middle-aged women actually increased in both areas over this period, from around 10% to just under 20%. The authors suggest that the greater reduction in smoking prevalence among men in North Karelia was associated with particular programmes in North Karelia.

They showed that during these twenty years, middle-aged men’s average cholesterol levels fell by 16% in North Karelia and 12% in the control area. During the first five years, blood cholesterol levels fell more rapidly in North Karelia than in the control area. Thereafter, cholesterol levels fell at similar rates in both areas. Middle-aged women’s average cholesterol levels fell by about the same amount in both areas (17% – 18%) between 1972 and 1992. The authors believed that dietary changes, which included reduced saturated fat consumption, substitution of low fat for full fat milk and of margarine for butter, were responsible for these cholesterol reductions.

They observed that middle-aged men’s average systolic blood pressure fell during these twenty years by 4.8% in North Karelia and 4.1% in the control area. Again, the fall in North Karelia was greatest in the first five years, with similar reductions in both areas thereafter. Middle-aged women’s average systolic blood pressure fell by 11.3% in North Karelia compared with 8% in the control area over these twenty years. From 1977 onwards, women had similar blood pressure levels in the two areas.

Vartiainen et al suggested that risk factor reductions in North Karelia and the control area were similar after 1977 because the local community-based actions had been extended to a national level.

Evaluation of the Project’s Main Objectives

The North Karelia Project’s main objective was to reduce CVD mortality, particularly among the middle-aged population, especially among middle-aged men. Puska et al (1998) compared the mortality data for North Karelia with Finland as a whole for the period 1969 to 1995.

They showed that between 1969 and 1978, there was a significantly greater reduction in the coronary heart disease mortality of middle-aged men in North Karelia (-2.9% pa) than Finland as a whole (-1.0% pa). The downward trend in mortality was similar in North Karelia and Finland as a whole thereafter. Between 1969 and 1995 the coronary heart disease mortality rate of middle-aged men decreased by more than 60% in both North Karelia and Finland as a whole.

During the 1970s the decrease in middle-aged men’s cancer mortality was similar in North Karelia and Finland as a whole. Thereafter, North Karelia saw a substantially greater decline in cancer mortality, particularly for lung cancer. Between 1969 and 1995 the cancer mortality rate of middle-aged men decreased by 43.5% in North Karelia compared with 39.9% in Finland as a whole. For lung cancer, the decrease in North Karelia was 71.4% and in Finland as a whole it was 57.1%.

In summary, following the launch of the North Karelia Project in 1972, there was a fall both in the levels of the major CVD risk factors and in CVD mortality among the middle-aged population.
of North Karelia. There is little doubt that these reductions were associated with the community-based CVD prevention activities of the North Karelia Project. Once these interventions were extended nationally, similar downward trends were observed in Finland as a whole. This strongly suggests that community-based action to prevent CVD can successfully reduce risk factors and, in the longer term, reduce cardiovascular (and cancer) mortality.

Other Examples of Primary and Secondary Prevention of CVD

Many other CVD prevention initiatives have been reported.

The Imperial Cancer Research Fund's OXCHECK study investigated the effects of patients' general practice health checks. This was a randomised controlled trial in which patients were randomly allocated to an intervention group where they received health checks, or to a control group. The study lasted four years and showed that the intervention group had significantly lower average cholesterol levels, significantly lower saturated fat intake and took vigorous exercise more often. There was, however, no difference between the groups in terms of smoking and alcohol consumption. They estimated that those attending such health checks could reduce their risk of myocardial infarction by between 5% and 13%.

Cupples and McKnight (1994, 1999) reported the results of a randomised controlled trial of the effectiveness of secondary prevention in a primary care setting. Patients with established angina were randomly allocated to one of two groups. The intervention group received normal NHS care with additional personal health education from a trained nurse over a period of two years while the control group received normal NHS care. After two years, patients in the intervention group were significantly less restricted by their angina, had a healthier diet, a higher proportion took daily physical exercise and a higher proportion took prophylactic drugs for angina. After five years, the differences between the groups was much less, although the intervention group still took more exercise and had better compliance with prophylactic medication.

Steptoe et al. (1999) also showed that primary prevention of coronary heart disease, through providing health education in a general practice setting, can lead to improvement in behaviour related risk factors.

Dunbar et al. (1998) described a primary prevention initiative that was undertaken in a Dundee general practice. They intend to emulate the North Karelia Project in a practice. They have encouraged patients to improve their diet, fitness and lifestyle to reduce risk factors associated with heart disease, stroke and cancer. To achieve this, they have developed information systems for recording their patients' cholesterol levels, weight, blood pressure, smoking, drinking habits and fitness levels.

Summary and Conclusions

The evidence from various community-based programmes for the prevention of CVD suggests that such programmes can be successful in reducing the levels of the known CVD risk factors. In the longer term, this leads to reductions in CVD and cancer mortality. One of the largest and most comprehensive programmes, the North Karelia Project, achieved both reductions in the target risk factors (smoking, serum cholesterol and blood pressure) and reductions in CVD and cancer mortality rates. Other smaller scale and more specific primary and secondary prevention initiatives have also produced improvements in risk factors.
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