Keep Well Anticipatory Care Programme
NHS Greater Glasgow and Clyde

A Qualitative Exploration of Primary Care Practitioners use of Inequalities Sensitive Practice Skills in the Keep Well Health Check
Report Author: Jane Beresford, Inequalities Development Lead (Keep Well)
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## Glossary

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>CDM</td>
<td>Chronic Disease Management</td>
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<tr>
<td>CIT</td>
<td>Corporate Inequalities Team</td>
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<td>CHD</td>
<td>Coronary Heart Disease</td>
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<tr>
<td>CHP</td>
<td>Community Health Partnership</td>
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<td>CHCP</td>
<td>Community Health and Care Partnership</td>
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<td>CVD</td>
<td>Cardio Vascular Disease</td>
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<tr>
<td>DNA</td>
<td>Did Not Attend</td>
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<tr>
<td>GCPH</td>
<td>Glasgow Centre for Population Health</td>
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<tr>
<td>GP</td>
<td>General Practitioner</td>
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<tr>
<td>GWMS</td>
<td>Glasgow Weight Management Service</td>
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<tr>
<td>HCSW</td>
<td>Health Care Support Worker</td>
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<td>HI Services</td>
<td>Health Improvement Services</td>
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<td>ISP</td>
<td>Inequalities Sensitive Practice</td>
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<td>ISPI</td>
<td>Inequalities Sensitive Practice Initiative</td>
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<td>KW</td>
<td>Keep Well</td>
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<td>LES</td>
<td>Local Enhanced Service</td>
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<td>NHSGGC</td>
<td>NHS Greater Glasgow and Clyde</td>
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<tr>
<td>PDSA</td>
<td>Plan Do Study Act Audit Cycle</td>
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<tr>
<td>PM</td>
<td>Practice Manager</td>
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<td>PN</td>
<td>Practice Nurse</td>
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<td>QIS</td>
<td>Quality Improvement Scotland</td>
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<tr>
<td>REC</td>
<td>Research Ethics Committees</td>
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<td>SG</td>
<td>Scottish Government</td>
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<tr>
<td>SIMD</td>
<td>Scottish Index of Multiple Deprivation</td>
</tr>
</tbody>
</table>
Contents

Executive Summary ........................................................... 6
Introduction ........................................................................... 13
Methods .............................................................................. 18
Findings and Discussion .................................................... 20
Conclusion ............................................................................ 47
Appendices ........................................................................... 52

(a) Copy of ISP Quantitative Survey
(b) The Ten Goals for an Inequalities Sensitive Health Service
(c) Copy of Ethics Letter
(d) Copy of Participant Invite Letter
(e) Copy of Participant Interview Schedule
(f) Copy of Hard to Reach Project Findings
(g) Copy of Literature Search

References ............................................................................. 69
Executive Summary

Keep Well was launched by the Scottish Government in 2006 as a pilot project to implement anticipatory care in the most deprived areas. The aim was to decrease inequalities in health by focusing health screening (the health screening included clinical assessment of blood pressure, hypercholesterolemia, diabetes, family history; health behaviours such as diet, exercise, alcohol and social circumstances such as financial inclusion, employability and literacy) on those most likely to experience ill health.

The Scottish Government has made a commitment to mainstream the project by April 2012 by continuing to target patients 40 – 64 years of age without established CHD, Stroke or Diabetes who reside in the 15% most deprived data zones. Additional target populations have also been identified such as those with severe and enduring mental health problems.

Alongside Keep Well, NHSGGC developed an Inequalities Sensitive Practice Initiative. This project identified common characteristics of practice which promotes person centered care – for a full report on the project, click on the following link:

http://www.equalitiesinhealth.org/inequalities_sensitive_practice_initiative.html

ISPI identified that person centred care should include an understanding of the impact of social inequalities on health; sensitive enquiry should be used to identify individual life circumstances and experiences, such as poverty or discrimination which present barriers to wellbeing. The practitioner should provide empathetic support and act in partnership with the individual to ascertain related health and social care needs and to negotiate a plan of care to meet those needs. The characteristics of an ISP approach to care include being pro-
active, non judgemental, empathetic, involving, affirming, encouraging and honest.

The aim of this study is to discover if and how Keep Well practitioners are using Inequalities Sensitive Practice skills during the health screening. The study was completed in two phases. Phase one focused on a quantitative survey administered through survey monkey to each Keep Well practice. This generated 22 responses from 58 practices including responses from GPs, Practice Nurses, Health Care Support Workers and Practice Managers. The full report from phase one is available at http://teams.staffnet.ggc.scot.nhs.uk/teams/CorpSvc/HIT/IKMHR/PublicHealth/keepwell/. The key findings from phase one include issues around engagement, sensitive enquiry and inequalities in health.

Overview of findings from Phase 1

**Patient Engagement**

Practices are using a range of methods to engage patients. These included open letters (where patients are required to make their own appointment); closed letters (where the patient received an appointment time in the letter); telephone calls (although practices reported time constraints in using this method). A minority had used text messaging, however, results from other projects, such as the hard to reach project in pharmacy suggests texting had lead to positive results in engaging patients. For a full report on the project, click on the following link [http://www.nhsggc.org.uk/content/default.asp?page=s1846](http://www.nhsggc.org.uk/content/default.asp?page=s1846). All practices had used opportunistic methods i.e. inviting patients to attend a Keep Well check when they approached the practice for other issues. Some practices managed this by “tagging” patient records when patients were eligible for the Keep Well check. This acted as a reminder to staff to invite the patient to attend. None of the practices reported approaching patients through email.
**Sensitive Enquiry**

Many respondents felt more comfortable with the medical aspects of the health check, e.g. Blood Pressure. The areas where respondents were most unsure were aspects of social enquiry including employability, financial inclusion, mental health and literacy.

**Inequalities in Health**

Most respondents felt that Keep Well has been somewhat successful in tackling inequalities in health as it had targeted resources at those in greatest need. It was also recognised the project had been successful in engaging hard to reach groups. The role of the outreach workers was mentioned as useful in engaging these groups.

**Phase Two**

The purpose of the second phase of research was to explore some of the issues raised in phase one using in-depth qualitative interviews. Phase two is the focus of this report.

**Methods**

All Practitioners involved within Keep Well received a letter inviting them to take part in the study. Keep Well co-ordinators encouraged practitioners to take part. This generated 16 volunteers including GPs, Practice Nurses and Practice Managers. From these volunteers, 15 interviews took place.
Findings

The key themes emerging from the qualitative interviews were:

- Variations in conceptualisation of inequalities in health and how understanding of inequalities in health influences practice
- Limitations and opportunities that the Keep Well Programme presents for reducing inequalities in health
- Staff perceptions of skills and training required to deliver the Keep Well Programme
- The range of learning from Keep Well and its application to wider practice in primary care.

Each of the above themes will be explored in turn.

**Variations in conceptualisation of inequalities**

Many participants struggled to describe what inequality meant to them. Some felt they treated everyone the same so the term did not apply. Others felt the term related to “unfairness” or “divide” but could not describe how this related to health care. Whilst others felt it applied to variations in health care provision, such as the “post code lottery”, whereby those in poorer areas have less access to services. Some recognised that patients from more deprived backgrounds may struggle to access services that are offered and recognised they had a role in improving access. Others acknowledged the extent to which inequality affected practice was related to the definition of health applied by practitioners. If health was defined using a medical model then inequality did not apply to the recording and treatment of blood pressure, cholesterol or weight, however, when broader social influences on health are taken into account the influence of inequality becomes more apparent. A few respondents described how they altered their
practice for patients with additional health care needs as a result of the inequality they faced.

Overall, there were differences across all professional groups in their understanding of inequalities; however, there was greater clarity and understanding amongst General Practitioners.

**How conceptualisation of inequalities influences practice**

Some practitioners talked about ways in which they altered their practice to offer different support for people with extra needs. For example, some increased the support they offered to patients with drug problems due to the challenges they faced in accessing services; others followed up patients who did not attend in order to address barriers. Some mentioned how the Keep Well programme had changed their view of inequality in health. One participant mentioned how they came to recognise literacy issues are a major barrier to accessing health care services, whereas, others reported that they treated “everyone the same” regardless of need.

**Limitations and opportunities offered by the Keep Well Programme**

Keep Well offered a number of opportunities and challenges to practices. For example, some welcomed the targeting of resources in areas of greatest need. The additional resources allowed practices to employ staff for more hours which enabled them to open in the evening and at weekends. Some used the resources to test out more time consuming methods of engagement such as telephone calls. Others took the time to match up practice staff with patients they knew in the community as a way of encouraging attendance. Overall, practices value the opportunity to adapt the project to their own needs.
In terms of limitations, some practices felt the competing demands in the practice restricted the time they could devote to the health check. This was particularly true in practices where delivery of Keep Well was focused on one or two members of staff to deliver. Some noted that to become truly anticipatory the age limit should be lowered to 35 as many were already symptomatic by the time they were 40 years of age. Practices that did not extend their opening hours noted that routine opening hours were a barrier to patients who worked. Some expressed discomfort in tackling social issues such as literacy, in the health check. Whereas, others pointed to the social issues in the check acting as an incentive to attend. This was particularly true of the financial inclusion element of the check.

Some respondents felt the screen templates were a barrier to motivational interviewing, whereas, others noted the strict referral criteria and operating procedures of some of the health improvement services as a barrier to access.

**Staff perceptions of skills and training required to deliver Keep Well**

Some respondents mentioned the need to “sell” the concept of anticipatory care to practices. Others mentioned the need for discussion and training regarding the social aspects of the health check as it was an area in which they felt unfamiliar. Many reported inconsistent approaches within and between practices in this area. It was noted that it was a cultural change to refer on to social support agencies rather than being equipped to solve these issues for patients.

Some were concerned about the role and practice of Health Care Support Workers due to the unregistered nature of their roles. Some mentioned inadequate training offered to people in these posts; whereas, others mentioned a lack of training to all roles prior to the implementation of Keep Well.

Practitioners were asked about the disclosure of sensitive issues such as suicidal ideation, gender based violence or childhood sexual abuse. Some felt that just
listening to the patient was therapy in itself and might be all some require. Whereas, others felt unprepared to deal with these issues. There was some concern regarding the emotional impact of issues being disclosed to staff and the support networks available for different professional groups. Consideration should be given on how to support staff.

**The range of learning from Keep Well and its application to wider Practice**

Many practitioners struggled to identify learning from Keep Well and its application to wider practice. For some, this was because they had a role only for Keep Well in the practice and therefore did not have an opportunity to use their learning elsewhere. Others recognised how some of the new services that were tested in Keep Well could be used elsewhere. For example, the outreach worker role could be extended to chronic disease management services. Some mentioned specific cases where the full health assessment offered through Keep Well had uncovered surprising findings in apparently healthy people. This experience led practitioners to never pre-judge the health and social experience of patients. Some went further and mentioned how working on Keep Well had enhanced their experience and response to the inequalities their patients experienced. A minority reported they had not learnt from the Keep Well project.

**Conclusions**

Phase two provided a deeper understanding of the implementation and legacy of Keep Well within practices. For some, Keep Well had confirmed and strengthened their understanding of inequality and health and improved practice response to this. Whereas, others continued to struggle to see the connection between health and social circumstances. Many practices welcomed the additional resources offered by Keep Well within the practice and the range of support services which enhance the programme. The findings from this work and
phase one will be used to enhance practice development and response to Keep Well as it is mainstreamed in 2012.
Final Report

1.0 Introduction

Keep Well was launched by the Scottish Government in 2006 as a pilot project to implement anticipatory care in the most deprived practices serving the most deprived populations. The aim was to decrease inequalities in health by focusing health screening on those most likely to experience ill health. The health screening included clinical assessment of blood pressure, hypercholesterolemia, diabetes, family history; health behaviours such as diet, exercise, alcohol and social circumstances such as financial inclusion, employability and literacy.

The Scottish Government has made a commitment to mainstream the project by April 2012 by continuing to target patients 40-64 years of age without established CHD, Stroke or Diabetes and who reside in the 15% most deprived data zones. Additional target populations have also been identified such as those with severe and enduring mental health problems.

The aim of this study is to discover if and how Keep Well practitioners are using Inequalities Sensitive Practice skills during the health screening. The study was completed in two phases. Phase one focussed on a quantitative study (see appendix A) administered through Survey Monkey to each Keep Well Practice. This generated 22 responses from a possible 58 practices including responses from GPs, Practice Nurses and Health Care Support Workers. The full report from phase one is available at: http://teams.staffnet.ggc.scot.nhs.uk/teams/CorpSvc/HIT/IKMHR/PublicHealth/keepwell/. The key findings from phase one include issues around engagement, sensitive enquiry and inequalities in health.
2.0 Context

Scotland overall experiences worse health than the rest of the United Kingdom (Gray et al 2010). Health in NHS Greater Glasgow and Clyde shows the greatest variation, with some neighbourhoods experiencing life expectancy on a par with developing nations, whereas, other areas have levels of life expectancy one would expect from a developed nation. (Wilkinson R, Pickett K, 2009). In short, the population of Glasgow experiences vast differences in health and life experience. For example, Glasgow City contains more of the most deprived areas listed in the Scottish Index of Multiple Deprivation than any other local authority area in Scotland (SIMD 2009, Scottish Health Survey, 2010). Further, it experiences poorer health outcomes than deprivation alone can account for. This has been termed the “Glasgow Effect.” While some aspects of health in the Glasgow area are improving, the gap in life expectancy between the most affluent and deprived areas has increased over the past decade.

The effect of power differentials, discrimination and socialisation acts as a pathway into poor health. This can limit access to health and social care and can affect the quality of response by both individual practitioners and care systems. The Commission on Social Determinants of Health concluded that social inequalities in health arise because of inequalities in the conditions of daily life and the fundamental drivers that give rise to them; inequalities in power, money and resources.

There is strong evidence about the links between social determinants and poor health outcomes but little evidence around what works in reducing health inequalities and improving health outcomes. Despite many health policies in recent years aimed at tackling inequalities it appears that, for those most marginalised and with the poorest health the gap seems to be widening.
"The Government is faced with the dispiriting fact that not only have health inequalities not improved, they have got worse... Not only are lower socio-economic groups less healthy, but the relative gap is growing... it is increasingly clear that the NHS does little to combat inequality and may even make it worse, by providing an inequitable service." (Civitas Report, 2007, p80)

Despite the plethora of work which describes inequality in health there are few examples how inequality influences practice in the NHS. Tsuchiya A et al., (2007) noted that there was assumption made that all staff working for the NHS were committed to a reduction in inequalities in health. This research demonstrated key differences between both the public and professional perspective in targeting NHS resources in those who have greatest need. The example given in this paper highlights two models. One targets resources at those in greatest need, for example, areas experiencing lowest life expectancy receive more resources than other areas. The other distributes resources equally. Professional and public views were sought through a survey to gauge opinion regarding each approach. The findings suggest that just under 50% of NHS clinicians chose not to target resources at greatest need compared with 58% of members of the public. Hanlon P et al (2008) focussed on inequalities within primary care mental health. This found that policies related to inequalities were not driving practice to reduce inequalities in mental health within primary care. For example, the mental health needs assessment did not incorporate discussion about inequalities in mental health. Yet some individual steering group members had expressed concerns about inequalities in mental health. Frontline professionals defined inequalities as being linked to access to health services rather than social factors and were often uncomfortable about discussing inequalities in mental health.

One way of tackling poor health in Glasgow has been to invest more resources in primary care practices which cover the most deprived areas. NHSGGC used this approach in the Keep Well model. A total of 100 GP practices across 5 CH(C)Ps
currently participate in the programme. More practices serving NHSGGC’s most deprived communities will be identified and invited to participate in the programme from April 2012 via a Local Enhanced Service (LES) agreement.

Alongside Keep Well, NHSGGC developed an Inequalities Sensitive Practice Initiative (ISPI) (see: http://www.equalitiesinhealth.org/inequalities_sensitive_practice_initiative.html) This project identified common characteristics of practice which promote person centred care. The ISPI project was funded through the Scottish Government Complex and Multiple Needs Initiative and was delivered by NHSGGC working in partnership with four key services Mental Health Services, Addictions Services, Maternity Services and Children’s Services.

ISPI identified that person centred care should include an understanding of the impact of social inequalities on health; sensitive enquiry should be used to identify individual life circumstances and experiences, such as poverty or discrimination which present barriers to wellbeing. The practitioner should provide empathetic support and act in partnership with the individual to ascertain related health and social care needs and to negotiate a plan of care to meet those needs.

The characteristics of an inequalities sensitive practice approach to care include being proactive, non-judgemental, empathetic, involving, affirming, encouraging and honest. The key elements of sensitive enquiry include the quality of the relationship with the practitioner; sensitive enquiry in wider issues; working in partnership with the client to identify needs; facilitating access to agencies; enhanced availability and accessibility of staff; and agencies communicating and working together. According to ISPI, for consultations with patients to be effective and bring about change, the practitioner needs to understand the social determinants of health and its relationship to health behaviours and health outcomes. Specifically they need to know:
• their community and its demographic profile
• the resources available to them and how to access them
• their role and responsibilities

Practitioners need to be able to build trusting relationships with patients/clients; undertake sensitive enquiry; contain distress and build resilience; provide responsive care; offer information and advocacy; and work as part of a multi-agency/disciplinary team where appropriate.

The term inequalities sensitive practice is solely related to work undertaken within NHSGGC. Few of the published papers on health inequalities describe this from a practical point of view i.e. the relationship and impact of practice, or what practice should look like in order to tackle health inequalities in the primary care setting. As such, NHSGGC is innovative in linking their work on inequalities sensitive practice with Keep Well.

NHSGGC developed 10 goals (Appendix B) for an Inequalities Sensitive Health Service. The goals are formed around 3 themes:

(1) Engaging with Populations and Patients
(2) Developing the Workforce
(3) The Health Services role in society

The aim of the goals is to drive forward a health service that is sensitive to inequalities in every aspect of its work.
3.0 Overview of findings from Phase 1

**Patient engagement**

3.1 Practices used a number of methods to engage patients. These included open letters (where patients are required to make their own appointment); closed letters (where the patient received an appointment time in the letter); and telephone calls (practices report time constraints in using this method). A minority had used text messaging. Findings from other projects, such as a hard to reach project in pharmacy, suggest text messaging led to positive results in engaging patients. All practices had used opportunistic methods i.e. inviting patients to attend a Keep Well check when they approached the practice for other issues. Some practices managed this by tagging patient records when patients were eligible for the Keep Well check. This acted as a reminder to staff to invite the patient to attend. None of the practices reported approaching patients through email. See [http://www.nhsggc.org.uk/content/default.asp?page=s1846](http://www.nhsggc.org.uk/content/default.asp?page=s1846) for more information on the hard to reach project.

**Sensitive enquiry**

3.2 Many respondents felt more comfortable with the medical aspects of the health check. The areas where respondents were most unsure were aspects of social enquiry including employability, financial inclusion, mental health and literacy.

**Inequalities in health**

3.3 Most respondents felt that Keep Well has been somewhat successful in tackling inequalities in health as it had targeted resources at those in greatest need. It was also recognised that the project had been successful
in engaging hard to reach groups. The role of the outreach workers was mentioned as useful in engaging these groups.

**Phase Two**

3.4 Phase two of the research is the focus of this report. Its aim was to explore some of the issues raised in phase one in more depth by using qualitative interviews.

This work seeks to understand the responses of practitioners in relation to practice and to make recommendations for the way forward.

**4.0 Methods**

Ethics advice was sought from the West of Scotland Research Ethics Service Office on the project. The Scientific Officer advised that the research did not need ethical review under the terms of Governance Arrangements for REC in the United Kingdom. A copy of the response from the West of Scotland Research Ethics Service Officer can be viewed in Appendix B.

Approximately 58 General Practices in NHSGGC were involved with the pilot delivery of Keep Well in 2010. All practitioners involved within Keep Well received a letter informing them about this research with a reply slip to complete and return if they were willing to participate in an interview. A copy of the invite letter can be found in Appendix C. This was distributed both electronically and by hand. Local Keep Well Co-ordinators also encouraged participation in the interviews.

This approach generated 16 volunteers including General Practitioners, Practice Nurses and Practice Managers. The researcher contacted each volunteer and arranged an interview appointment at a time and place convenient to the
respondent (usually the practice). Of the 16 volunteers, 15 took part in interviews. A breakdown of professional groups participating in interviews is as follows:

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<tr>
<th>Role</th>
<th>No. participating</th>
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<tr>
<td>General Practitioners</td>
<td>5</td>
</tr>
<tr>
<td>Practice Nurses</td>
<td>9</td>
</tr>
<tr>
<td>Health Care Support Workers</td>
<td>0</td>
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<tr>
<td>Practice Managers</td>
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The interviews focused on the following themes:

- Aims of Keep Well – description of how these may or may not have been met and how the aims may be met more effectively during the transition and mainstreaming process
- How inequalities influences primary care practice
- The barriers and opportunities that the Keep Well programme offers for addressing inequalities in health
- Workforce development including information on competencies and skills that clinical practitioners need in order to deliver the health check using an inequalities sensitive approach with a particular focus around the social prescribing elements of the health check
- Use and development of sensitive enquiry
- Learning from the Keep Well anticipatory care programme in NHSGGC and how this has been applied to wider primary care practice

The interview schedule can be viewed in Appendix E.

All respondents agreed to allow interviews to be recorded using an encrypted digital voice recorder. Interviews were transcribed. The content of transcripts were analysed by the researcher and key themes will be discussed in the findings.
5.0 Findings

5.1 The key themes emerging from the qualitative interviews were:

- Variation in the conceptualisation of inequalities in health and how this influences practice
- Limitations and opportunities that the Keep Well programme presents for reducing inequalities in health
- Skills and training required to deliver the programme
- The range of learning and application to wider practice

Each of the themes will be explored in turn.

5.2 Variations in the conceptualisation of inequalities in health

For some respondents the word inequalities caused confusion. There was a lack of understanding as to what was meant by the term. There was a perception that the term meant "unfairness" or "divide" but this understanding was not directly related to health. Many respondents said they offered the same services to all patients accessing Keep Well.

“It is the word inequalities that I am not managing to get. What do you mean?....I just treat everybody the exact same and they get offered exactly the same service.” (PN4)

Others noted variation in access to services depending on the geographical area lived in:

“Inequality – some kind of postcode lottery, some people have…where will I start? Some people in poorer areas have less access to services and don’t know about services.” (PN7)
Some respondents felt inequality related to inadequate service provision in the most deprived areas. However, others acknowledged that sometimes an individual’s knowledge of how to access services that were available was an issue. Some respondents considered themselves to be in a primary position to help people to access services.

“Some people don’t know how to go about accessing services so we can hopefully help them with that.” (PN1)

Others were unsure about links between inequalities and health

“This is one question I would probably just say the same. I am not quite sure maybe it is a lack of equal opportunities for everyone” (PN5)

And others saw inequality to be linked to poverty:

“Inequalities em a lot of patients don’t have very much so that is what I say to inequalities.” (PN7)

Some respondents felt their understanding of inequality developed over the course of delivering the Keep Well programme.

“It depends on how narrowly you define health so if health is just blood pressure, weight and cholesterol then all that is irrelevant so why should I bother with an unnecessary additional part of the job that I could really do without but as the programme evolved I began to shift my thinking.”(PN3)

Some saw the link between poor health and lack of resources clearly

“I see inequalities as more ill health so lower life expectancy and more ill health and fewer personal resources to deal with it. Some people are willing to come for help just because they don’t know what else to do. There are
far fewer resources that they have as an individual or family. They experience more inequalities, have more health needs and fewer means of dealing with it.” (GP2)

“It is the inverse care law – primarily. The patients who often have the most need often get the least care and they have the worst outcomes. It’s something I feel quite strongly about.” (GP4)

There was a general recognition that patients experiencing inequalities consulted more frequently. This made particular demands on the practice and on appointments.

Poor housing was suggested by a number of respondents as missing from the Keep Well health check. There are no specific questions on housing yet the links between poor housing and health are well understood. Respondents mentioned stresses caused by rogue landlords, anti-social behaviour and noisy neighbours.

“People who have got complex health issues who have got social issues, housing issues, that kind of long standing stress it is actually very difficult in practice to do anything about these issues. There was no systematic question around housing or referral options” (PN6)

Overall there was a difference across all professional groups in their understanding of inequalities and what this means.

In conclusion there was quite varied understanding of inequalities and it was clear that many struggled to fully understand the complexity and the links between power, discrimination and socialisation and how these may lead to poor health. There was some mention of specific determinants of health such as housing in a small number of interviews. Although there was
variation across the professional groups, there was greater clarity and understanding amongst General Practitioners.

5.2 How conceptualisations of Inequalities influence practice

Respondents were asked how their understanding of inequalities influenced their professional practice. For some respondents, it was clear that they did not adjust their practice based on need.

“I don’t think it affects my practice. All my patients are all my patients – I just treat them all the same.” (PN4)

Interestingly, the same respondent later mentioned how she treated everyone as an individual

“I treat each person as an individual. I don’t change the way I do anything. I treat everybody exactly the same and they all get offered the same. Obviously they get offered it and not everybody needs all the services but I do offer them anyway.” (PN4)

It is interesting that the belief that treating someone as an individual can sit comfortably with the practice of treating everyone the same. This has ramifications for the way in which competency based training is offered in the future.

The view that treating patients equally meant treating everyone the same was widespread.

“I admit I don’t think it influences me at all because I tend to treat everybody the exact same and I more or less offer everybody the same services regardless of what problems they might have had when they came in the door.” (PN5)
There was little or no understanding from some respondents around how the possibility of treating everyone the same might increase the health gap. Whereas, altering practice response to need was seen as normal part of everyday work by a few respondents.

“There have been quite a few different incidences which have required a different approach to liaison especially in relation to our patients with drug problems. It doesn’t matter to me what they are or who they are do you know what I mean? I do know a lot of our methadone patients for instance don’t like going to hospitals. They probably aren’t the best patients. So there have been quite a few incidences that we have had to do quite a bit of liaison work around sorting things out for them. I do follow up when they haven’t gone for their appointments, chasing things up, catching up with them if I haven’t seen them for a while…that is just normal to me. It’s my normal way of working.” (PN2)

Some mentioned that their involvement with Keep Well had altered the way they view the impact of social inequality and health.

“I guess it didn’t influence my practice much before I was doing Keep Well. I think Keep Well has really opened my eyes to it. Although we always knew there were some patients who didn’t get down to the practice much or just had poorer health because of various social reasons. I think Keep Well has highlighted things like people can’t read and write and therefore you need to take a different approach to engagement.” (PN6)

In summary, there were many examples of respondents who believed treating people the same was an adequate response to inequality. This should be reviewed in training offered in the future. There was also evidence of respondents who practised sensitively and who adjusted
practice as part of normal everyday activities. Some respondents reported
changing their thinking as a result of working on Keep Well.

5.3 Opportunities and limitations of the Keep Well Programme to reduce
inequalities in health

Respondents reported a range of opportunities and limitations offered by the
Keep Well programme. Opportunities were around targeted resources; testing
out new methods of engagement; being able to adapt the programme to fit in with
the practice; and longer consultation times. Limitations related to time; capacity;
age range; organisational factors; perception of social enquiry; templates; and
onward referral. Each of these issues will be discussed in turn.

Opportunities

Targeted Resources

The targeted resources for Keep Well were welcome. Indeed one respondent
reflected on the benefit of targeting at the most need and contrasted this with
alternative models of resourcing developments.

“I think Keep Well has been enormously successful. I think it offers great
advantages in the fact that it was a targeted resource and that is very important.
Too often in the past this kind of resource would have been thrown out nationally.
Targeting areas in where it is going to bring about the greatest health
benefit/health outcome was enormously beneficial” (GP3)

Engagement Methodologies

Respondents had contrasting views on the range of engagement methods used
in Keep Well. For example many practitioners acknowledged that letters did not
generally work with the target group.
“People don’t turn up for appointments because they have been sent a letter and they can’t read and write.” (PN6)

However, proactive use of telephone as a means to engage had resulted in success.

“I think the way we call people up for Keep Well is different from the way we called up people in the past. We are phoning them you know and it’s much more successful.” (PN6)

**Adapting Practice Factors**

Additional resources available within Keep Well had enabled practices to adapt including employing staff for extra hours, offering evening and Saturday morning appointments.

“Our Practice Nurse increased her hours. We also offered appointments outwith normal hours and developed our own invite letters.” (GP3)

One practice gave a practical example of adaptations they had made by identifying patients and matching them with reception staff who knew them and then asked those staff to do the telephone calls. This resulted in increased engagement and lower DNA rates. The practices valued the flexibility that the Keep Well programme offered.

“The big plus was giving individual practices the ability to adapt the programme to their own individual circumstances. So it wasn’t prescriptive like you will do Keep Well and you will deliver it this way. It was here is the coverage that we are looking for, here is the resource in the best way that you see fit to bring about coverage. Again I think this is something you are building on the strength of the
practice and by definition general practice is a diverse organisation and this approach allows you to play to the strengths of that.” (GP3)

**Longer Consultations**

Respondents reported that patients welcomed the longer consultations offered by Keep Well.

“I think once they are here they really feel that they have benefited from it and they are really impressed by the fact that they get a good opportunity to be able to sit, it is not a 5 or 10 minute consultation, we obviously have to warn them that it takes a reasonable length of time. And I think patients do appreciate this and it does often give them the opportunity to discuss other issues.” (PN4)

**Social referral**

One respondent noted that some aspects of social enquiry were seen as a carrot to get the patient in the door and it was a quick win for patients who often saw a very quick return and gained great benefit from this.

“The money one generally that’s been a driving force for patients to engage with Keep Well. I have asked patients to come and see the nurse for 45 minutes and she would even ask you if you were getting enough benefits. This usually brings a positive response.” (GP1)

**Limitations**

**Time and Capacity**

Time was considered a limitation. Respondents reported that competing demands in the practice restricted the time that could be devoted to the health check. Time was also mentioned in relation to the burden of the programme
being the responsibility of one individual within a practice. In many cases, this fell to the Practice Nurse rather than taking a whole team approach.

“It is just me doing it – the GPs have not been involved at all. Not at all” (PN9)

Evidence from the Hard to Reach Pharmacy Service noted that, where practices took a whole team approach to the delivery of the programme, they were more likely to be successful in engaging with hard to reach groups. A summary of practice organisational factors which can positively influence engagement outcomes can be viewed in Appendix G.

**Age Range**

Primary care practitioners suggested that, in order to maximise the benefits of the programme to those living in the most disadvantaged areas, the age range should be lowered to at least 30 years. By the age of 40, many people are already symptomatic.

“I think one issue was the age range. Part of the problem is that people in their 60’s have ill health problems for people who would be in their 80s elsewhere. So by the time you get to 45 you have got quite a lot of established ill health problems and so to make significant changes to people’s lifestyles we should be targeting an earlier group of patients. I am not sure how early, but 30 would not be ridiculous when they are starting to have families and perhaps be a little more health aware and see if we can make changes at that stage. It might have a great impact. I think the age banding has been quite restrictive.” (GP2)
**Practice Organisational Factors**

Practice opening hours were a barrier to patients in employment.

“The surgery hours have been a bit of an issue especially for people who work in the area. Although we can be flexible people struggle to get time off work – at least not for a routine appointment you know that they don’t really need.” (PN5)

**Social Enquiry**

It was acknowledged that some topic areas within the consultation were either more difficult for practitioners to broach or that patients often told the healthcare professional what they wanted to hear. Alcohol was cited as an example of an issue for which people were either unwilling to accept that they may have a problem or unwilling to consider accessing a service for help. Some topic areas were new to practitioners. There was at least an initial resistance in seeing this as part of their role. The following respondent discusses difficulties with financial inclusion and literacy issues:

“Putting a leaflet on money advice in with a letter would be better and then they can contact them directly rather than me doing it. I don’t know anything about benefits so what’s the point of me mentioning it. I think even if we supplied leaflets and said away you go….The likes of the learning one (literacy) what do we do with the learning thing because we don’t often tick the box as having discussed learning. I do em well ask but I don’t actually. I kind of assume that if they bring in their forms and they have read and filled them in then they can read. I don’t think it’s particularly relevant.” (PN9)

Some respondents mentioned the lack of training on social enquiry as a barrier to implementing Keep Well in the practice.
**Templates**

There was significant dissatisfaction with the screen templates and this is common to other Local Enhanced Services screen templates. Some found them time consuming:

“The template is hugely involved and you need time to complete it.” (PN1)

Whereas others found them cumbersome to operate:

“The big limitation was the IT – I found it a total headache. It’s cumbersome, time consuming – I felt like throwing the computer out of the door.”(PN8)

And others found them a barrier to motivational interviewing:

“Plus there is a huge amount of motivational stuff asking them if they are eating the right amount of fruit and vegetables, we all know they don’t so there is a kind of façade of a conversation in order to tick the box. Given also the view that the ticking of the box is the emphasis that the conversation has happened in an effective way. Now the conversation may have happened but whether it has been in an effective way is a different thing.” (GP1)

Others made general comments about dissatisfaction with the templates:

“I have a great admiration for the Practice Nurses who do this but they are getting a lot of things coming at them and you know there is quite a lot of anger and dissatisfaction about this Keep Well template and everything.” (GP1)
Onward Referrals to Services

There were some limitations in making onward service referrals. This was particularly marked in the case of services with an opt-in policy. Respondents reported that it is difficult for patients with complex or chaotic lifestyles to opt into services. The Glasgow Weight Management Service was highlighted as one service with an unhelpful policy regarding access.

“The Glasgow Weight Management Service in particular are very strict you know one strike and you’re out and then you have to wait a year before you can re-register. This sort of model is totally useless for an area with deprivation. It is tailored to suit people who have mobiles and diaries and keep a tight schedule but people who are chaotic and disorganised and lacking motivation to begin with then it’s just not going to happen.” (GP2)

Short Term funding of Support Services

Practitioners in South West Glasgow highlighted the benefits of the Health Case Manager Service and were concerned that this may no longer be funded in future and felt that the service was very beneficial to patients with complex needs.

“I think if things like the Health Case Manager don’t continue then that will be a real blow to the whole equalities thing because it has been such a great thing for these people who have got complex health issues, who have got social issues, housing issues and that kind of thing. Long standing depression and problems with stress levels then that was something positive as a Nurse that I could do as actually it is very difficult in practice to do anything when they have got these big issues.” (PN6)
Summary

This section highlighted both significant opportunities that the Keep Well programme offers and limitations to the delivery of the programme. The opportunities included targeted resources; different engagement methodologies; the ability to adapt practice organisational factors; and the opportunity to have longer consultation times with patients. Limitations of the programme included constraints of time and capacity of staff and the age range and presentation of patients living in deprived communities with chronic diseases at much younger ages. Other limitations included the design of templates practice organisation factors, and difficulties with services to which patients were referred.

5.4 Skills and training required to deliver the Keep Well programme

There was some discussion around the need to sell a broad concept of health to general practices. Historically, general practices have been designed to deliver a reactive service i.e. when someone becomes unwell, they go to the General Practice where their immediate problem is dealt with.

“Yeah, I think it’s a bit of a selling job. I think it’s sort of that practices have been very much the medical model. In selling health and inequalities has been a much wider thing and it’s a bit of me “Why should you bother?” so it is a bit of me to overcome that in terms of the health professional. It’s a skill that some have and some don’t but I am sure we can all learn better on how to modify and change behaviour.” (GP2)

This suggests the need to engage in dialogue with General Practice around the need for inclusion of social issues and the relationship to health.

In phase one we found that practitioners were less confident in dealing with social circumstances, alcohol, mental health and sensitive enquiry within the
health check. This was explored in more detail during the qualitative interviews for phase two.

**Financial Inclusion**

Financial Inclusion is a key aspect of social enquiry delivered as part of the Keep Well Health Check. This was a new issue for many practitioners. Many initially felt uncomfortable at raising an area of such sensitivity with patients.

“Very reluctant to begin with because to me that was none of my business do you know what I mean? It’s different now as I understand now why the question is there. This depends on understanding why you should ask the question and how widely or narrowly you view health.” (PN3)

Some Practice Nurses suggested they didn’t necessarily see it as part of their role. Sometimes this reflected concerns that they would be required to have expertise in financial inclusion.

“Maybe this financial inclusion is an area where some practitioners don’t feel this is a part of their remit because it’s very non medical” (GP1)

There was some discomfort in being unable to fix all the social referral issues and the need to refer onwards.

“Basically as nurses I think they think (patients) think that we are going to fix things for them.” (PN7)

However, an alternative position was expressed by others:

“I am only screening the patient and referring on and I don’t need to be an expert.” (PN8)
Other practices developed organisational systems to support staff to ask the questions by informing patients by letter to expect these aspects in the course of the consultation.

“The questions around literacy, money advice and employment were mentioned in our invite letter so patients expected to be asked so it wasn’t an issue in our practice” (GP3)

**Alcohol**

Alcohol was found to be a very sensitive subject and not all patients were willing to look at their intake or be in a place to accept that they may have a problem.

“I think the biggest area is alcohol issues. A lot of people, me I don’t think they tell the whole truth and even those who have issues will categorically say I am not wishing any intervention at all.” (PN5)

**Literacy**

There were specific issues raised in the interviews in relation to literacy and this was often a topic area that staff felt uncertain and even embarrassed around.

“Literacy is quite different, it is difficult for the patient too, but we picked up quite a few people with literacy problems. What I learned was that the patient isn’t always embarrassed – it’s you who has to get over the barrier.” (PN6)

Practitioners who were interviewed said that asking about financial inclusion, literacy, employability and mental health got easier the longer they delivered the programme. This was because their confidence increased, they had practiced
the question and most importantly patients perceived being asked as important and valuable.

**Employability**

Employability was also a new area for practitioners delivering the Keep Well health check. In particular, staff found some areas of employability challenging with reference to the issue of sick lines.

“We have a third generation of unemployed. [Practice Nurses] don’t want to address it because they feel it is dodgy ground and they don’t want to be seen as somebody making them go to work because God forbid that we should make people work.” (GP1)

One respondent remarked on the lack of uniformity in approach to employability and providing sick lines.

“There is no uniformity in approach to employability so it’s very risky for practitioners….Historically if you were seen as somebody [GP] who would give patients the sick lines that they felt they should have then it is very easy for patients to go and register with a practice that did that. What this means is that patients then register with the Practice prepared to sign off sick lines. You could argue that we should all risk that but the problem is then you would have all patients registered with one or two practices. There is a need to engage practitioners and give education around work being good for your health” (GP1)

In their report “Is work good for your health and wellbeing?”, Waddell and Burton, 2006 acknowledge that

“Increasing employment and supporting people to work are key elements of the United Kingdom (UK) Government public health and welfare reform agendas.
There are economic social and moral arguments that work us the most effective way to improve the wellbeing of individuals, their families and communities. There is also growing awareness that (long term) worthlessness is harmful to physical and mental health so the collary might be assumed that work is beneficial to health. However that does not necessarily follow”

They conclude that work generally does impact beneficially on health but note this depends on the nature and quality of the work. There is a lack of evidence to define the physical and psychosocial characteristics of jobs and workplaces that are good for health.

**Sensitive Enquiry**

Practitioners were also asked about the disclosure of sensitive issues Keep Well during the health check. Issues disclosed included suicidal ideation, gender based violence and a history of childhood sexual abuse. As part of the qualitative interview process, practitioners were asked how prepared they were for such disclosures and what would help to make them feel more prepared.

Staff also acknowledged that sometimes just listening to the patient was therapy in itself.

“Other patients who are not part of the Keep Well programme have confided about personal issues during a consultation so this can be something that happens in everyday practice.”(PN2)

Other respondents acknowledged that, although it can be challenging in responding to issues of sensitivity, there is always other team members at hand to help or offer support.
“Anything you can’t deal with, you need to refer on and get someone else to deal with. I don’t see where the problem lies if you are not confident you refer onto a GP. I mean in nursing you are learning all the time so there are things that I will go and ask the doctor” (PN2)

Some staff felt very unprepared and wanted further development in these areas.

“Unless practitioners are from a mental health background then they will not feel prepared at all for these issues.” (PN8)

Taking these issues into account, it is important to consider the context of the working environment and what practitioners are being asked to do. Many practitioners mentioned that they feel overwhelmed with what they are being asked to take on: there were concerns about workload demands and how to deal with the emotional fallout of this.

"I suspect that the underlying problem is that Practice Nurses are continually getting more and more workloads from all areas because of the position we are in, because we can deal with things for patients. I think that is the issue. It is that it’s a bit of extra work that we need to do and where do we fit it in?” (PN2)

Many practitioners mentioned the significant changes in practice nursing over the years and the ever evolving role of the Practice Nurse. As new programmes are added to the practice this responsibility often falls onto that of the Practice Nurse.

“Practice Nursing has evolved and the role has been extended and extended to take on more work for the Practice. I think it’s time constraints in nurse hours that is probably a hinder to developing Practice Nursing.” (PN7)
There was also concern about the emotional impact of issues being disclosed, where staff can take this, and the differing support networks available for different professional groups e.g. GPs, PNs and HCSWs

“At Practice Nurse level, for want of a better word, find it extremely difficult to deal with listening to these issues without having somewhere to take it themselves – they can’t” (GP1)

There was concern for some respondents about the cost of allowing patients to open up and the impact this may have on the individual practitioner.

“Mental health issues also take time and capacity and it can be consuming not just on your time but personally consuming. If you are prepared to open the can of worms then you run the risk of being the only person who has been prepared to do this as well as it being massively laborious both in time and emotion… You get practitioners who are at various levels of burnout because of the emotional impact [can of worms] of it who will make conscious or unconscious choices not to raise these difficult issues.” (GP1)

There needs to be consideration of how to support staff better. If staff are dealing with the disclosure of sensitive issues then there needs to be a support mechanism in place to deal with the emotional impact of what patients disclose. If you were working as a Psychologist, for example, clinical supervision would be built in to that role. It is not something that is routinely available for primary care practitioners.

**Differing staff groups and development needs**

There were some general concerns about the training and development of staff undertaking the health check, in particular, the Health Care Support Workers (HCSW). These posts are filled by unregistered practitioners who may not have
Social and Vocational (SVQ) level qualifications. Staff in these roles who carry out some or all of the Keep Well check may require intensive training and development.

“More training and development opportunities are needed for HCSWs” (PN9)

There was also discussion around inadequate preparation before undertaking the delivery of the programme for other staff groups. Many respondents indicated they received only one day’s training which consisted of information about services as opposed to how to undertake the health check.

“We only had 1 day of training. I can't remember having any specific training just mainly an overview of the template and we were all thinking this is a bit out of my comfort zone being a nurse.” (PN1)

However some staff were proactive in supplementing the training and development on offer.

“Staff often arranged their own inputs i.e. getting services to come and speak to them in practices.” (PN5)

Staff themselves had ideas about the type of support that would be useful. This included formal induction training with a focus on consultation skills and the rationale for social enquiry questions.

“More training please than we had at the beginning – all we had was people from services speaking.” (PN5)

“Behaviour change training – Practice Nurses need to know how to approach these things.” (PN3)
There was a degree of frustration when discussing risks with patients. Some patients were unwilling to recognise their risk, whilst others carried on with their risk taking behaviour and refused any onward referral.

“It’s quite surprising, some patients will come back, you know their risk score is very high and they are right okay thanks very much but I am not going to stop smoking or well I know my risks and will take my chances. It’s hard to understand that mentality and you wonder why they come in the first place.” (PN9)

Staff also raised that, whilst e-learning may be beneficial, it is difficult to get away from practice. It is not always the best delivery mode and staff generally favoured face to face training.

“I think probably e-learning has a place but I think for a lot of these issues [sensitive enquiry, social enquiry] then face to face would be better.” (PN1)

Shadowing or mentoring opportunities would be welcomed.

“Sometimes it is really helpful if you can speak to someone with experience in certain areas [gender based violence] who can offer mentoring, shadowing.” (PN8)

Staff would welcome the opportunity to potentially be a mentor and be mentored. Mentors would need significant experience and training to fulfill the role successfully.

**Summary**

In summary, practitioners said that there was insufficient training to enable them to feel confident when addressing social enquiry and sensitive enquiry areas with the Keep Well Health Check. All practitioners who were interviewed said they would welcome more training and professional development. Many would
welcome the opportunity to shadow more experienced practitioners or to be mentored in their role.

5.5 Links with health improvement services – onward referral mechanisms

The Keep Well programme has invested into Health Improvement Services to increase capacity, provide local services and improve access. Variation has emerged across the areas as each CHCP and each sector has been given the opportunity to make investments in support agencies that they feel most effectively meets their needs. Services range from weight management to local stress centres to money advice services

**Enablers to onward referral**

There was a general view that Keep Well had helped facilitate links between health improvement services and primary care. For some practitioners, these were new. Others already had an awareness of local services.

Practitioners valued the efficiency of some services such as Live Active, Waist Winners and Smoking Cessation. Live Active was viewed very highly because of its systematic communication processes.

“Live Active is extremely efficient and we do see patients back they have told us they’ve had their consultation and then we get the paperwork which is great for updating our practice records.” (PN5)

Those localities with access to stress centres highlighted this as a very useful and effective service. Several practitioners mentioned the innovative approach taken in South West Glasgow through the development of “Maintaining Mental Wellbeing Sessions” which was a collaboration between the local Lifelink Stress Centre and the Primary Care Mental Health Team.
“Maintaining mental wellbeing has been really good. It’s been a great service to refer people to.” (PN6)

**General communication with services**

Other health improvement services logged on the tracking tool when patients had attended or failed to attend. There was a strong feeling amongst practitioners that they would have valued much fuller communication from services around patient progress. However, practitioners did under utilise the information on the tracking tool. Many reported that they did not use it to monitor progress and would prefer a paper record which could be included in patient records.

**Barriers to onward referral**

Waiting lists were an issue for some health improvement services. The Primary Care Mental Health Teams and Glasgow Weight Management Service were mentioned specifically, for example:

“I stopped referring to the Glasgow Weight Management Service because the patients that I had referred had their initial review and were considered suitable and then received a letter saying that they were advised to contact the service again in six months if they were still interested. And I thought well that is rubbish because they are interested now and these people are morbidly obese so after that I just referred to Waist Winners.” (PN4)

The strict referral criteria meant the intervention was offered only for the obese and morbidly obese. Other issues with Glasgow Weight Management Service included location. For example, patients in Alexandria had to travel to Gartnavel or the Western Infirmary – some 20 miles away.
“They have to go to Gartnavel or the Western which is just too far its an impossibility for these patients who have got this weight problem anyway to then get transport that sort of distance.” (PM1)

The challenges with Primary Care Mental Health Teams (PCMHT) were due to waiting lists and patients being sent leaflets in the post without being assessed.

“Mental Health has not been particularly good. We were referring to the Primary Care Mental Health Team and the patients were then coming back to the Practice and saying that they had never been seen and they just got leaflets sent to them” (PM1)

This has been discussed with the service and the problem has now been resolved.

There was some concern regarding the length of the referral form from Lifelink.

“A lot of the information I am not filling in. I understand why they are doing it because they have got lottery funding and they obviously have to collect information. We have already collected this information and if they want that information then they are going to have to collect it for themselves.” (PN7)

Practitioners welcomed the openness and degree of dialogue with services. Health Improvement Services were valued by practitioners. They were keen to see the capacity increase to enable services to maintain accessibility following mainstreaming of Keep Well.

“It is something about the big unknown about what is going to happen now with this pot of Scottish Government funding [Keep Well monies]. Will they try to spread this more thinly and some of the key components like extra Nurse time just won’t be there and we really need that extra resource for quite a long time."
Just having it for a few years is not enough; there is huge unmet need out there. We have only scratched the surface.” (GP2)

Summary

Overall, the relationship between primary care and health improvement services was viewed positively. Practitioners welcomed the opportunity to refer onto a wide range of services. Relationships were particularly successful where Practitioners had existing relationships with local service providers where some services were provided locally within the health centre. There were barriers to engaging with services due to waiting lists, eligibility criteria and opt-in services which do not necessarily work well for patients with complex needs.

5.6 The range of learning and application to wider practice

Many Practitioners struggled to identify learning or applicability to wider practice. In many cases, this was related specifically to the role of Practitioners within General Practices. In some practices, Practice Nurses had been given extra hours. This gave Practitioners time to identify learning and to transfer this to wider practice. Where staff were appointed as Keep Well Nurses, then identifying learning that could be applied to wider practice was a barrier. In these practices, the Keep Well Programme had been devolved to the Keep Well Nurse and did not take a whole team approach. Thus organisational factors limited the learning and transfer to wider practice. This was also found in earlier work during the Hard to Reach project (See appendix G).

Some saw the potential for Keep Well Services to be developed into other areas.

“One of the major strengths of Keep Well has been the use of Outreach Workers. The Outreach Workers have been phenomenally successful in getting patients into Keep Well. I am interested to see if we can now apply this to other areas, in
particular non-attendees at Diabetic Clinic and this is now being tested by taking the principle of Keep Well and applying this to other areas.” (GP3)

Other examples which could be applied to chronic disease management include use of telephone calls to reduce “Do Not Attends”.

“You could see how it [telephone reminders] could all be applied to Chronic Disease that’s the principle. There is no point in doing something just because it’s a good idea you have got to prove it works.”(GP3)

One respondent gave an example of the importance of enquiring about all aspects of health even in the apparently healthy:

“People are amazing. There are some people who have been dealt the most awful hand of cards and have just raised themselves above it. I had one person who filled in a HADS questionnaire – a man I had seen maybe twice a year since I started working here 6 years ago and he always seemed sort of larger than life. Not full of the joys but quite chatty when I saw his HADS Score and I said to him did you understand you know what the questions were about and he looked at me and said this is how I am inside. I could have cried as I thought my God you have been coming in here and you know being positive and jolly and you have not been great inside and he was actually seen by the GP and referred onto formal services but is doing well. It has made me realise that sometimes what you see is not always the real person.” (PN7)

There was also an increased awareness of inequalities in health amongst a minority of practitioners who felt they had better established relationships with their patients and a greater understanding of how patients live their lives.

“IT has highlighted more things, highlighted inequalities; it really has that exist in a small area. And the fact that people who probably don’t need to come will jump
at the first invite and people that really do [need the health check], I have to make phone calls and somebody has to go out to them before they come long. I have learned that the ones who are hard to reach are the ones that need the most and that kind of social issues that whole thing and how it impacts on health.” (PN6)

Most practitioners admitted that delivering Keep Well had been harder work but had led to benefits to patients and practice alike.

“I have worked in this area for a long time and know there is lots of stuff out there but I think now we see more clearly and I feel a bit better equipped to deal with it” (GP2)

A minority of practitioners did not see any particular learning or transfer to wider practice.

“I don’t think it is really benefiting the practice or patients at all. It may be developing things in NHSGGC and data collection but I don’t think it is actually helping patients in this practice.” (PM1)

Some practitioners also felt there was no difference between delivering Keep Well and what they currently do as part of the Chronic Disease Management programme.

“I think it was really just much em the same as you know the kind of LES programmes that we do for heart disease, diabetes and things. I think we managed it pretty much the same as that. Possibly we have learnt that maybe we need to get a bit more creative at getting people in the door.” (PN9)

Another felt their professional skills had enhanced Keep Well.
“I would say Keep Well has benefited from my previous experience rather than the other way round.” (GP5)

**Summary**

Most practitioners viewed the programme positively and wanted it to continue. In summary there was some evidence of learning applied to wider practice by a minority of practitioners, but many practitioners did not see a difference between Keep Well and other programmes. Wider learning was more likely to be noted in practices that had taken a whole team approach to the implementation of Keep Well and was less likely amongst practices that have devolved Keep Well to specific posts in the practice.

**6.0 Conclusion and Summary of Progress**

This work has assisted in identifying key areas of development for the Keep Well Programme in NHS Greater Glasgow and Clyde. Structures are currently being put in place to address a number of the issues raised within this piece of research.

**Variations on the conceptualisation of inequalities in health**

It was clear that there was limited understanding around the effect of power differentials, discrimination and socialisation on health and wellbeing. There was little understanding of how this acts as a pathway into poor health. For a minority of practitioners, their understanding had increased as the programme had developed over a period of time. There is a need to develop practitioners’ knowledge, understanding and skills in relation to inequalities in health.
How conceptualisation of inequalities influences practice

There was evidence of respondents who practised sensitively and who adjusted practice as part of normal everyday activities. There was also evidence that Keep Well had influenced individual practitioners thinking in relation to inequalities sensitive practice. However, there were a significant amount of practitioners who had limited knowledge and understanding of health inequalities and this prevented them from adjusting their practice to take a more inequalities sensitive approach to the delivery of care. The social enquiry approach adopted within Keep Well was completely new to practitioners and more work needs to be undertaken to increase understanding around the rationale for the inclusion of social enquiry questions within the check and how this might influence health and health related outcomes.

Limitations and opportunities offered by the Keep Well programme

Practitioners were able to clearly demonstrate some of the limitations and opportunities within the Keep Well programme. In summary, the limitations were staff capacity and time, the target age range of patients as patients living in deprived communities presented with chronic diseases at much younger ages, design of the templates for the delivery of the programme, practice organisational factors, onward service referrals and role perceptions. However, the programme did offer the opportunity to have access to targeted resources, apply different engagement methodologies, the ability to adapt practice organisational factors and the opportunity to have longer consultation times with patients. There is an opportunity to consider as part of the continued delivery of the programme how we can be more creative in our delivery through the redesign and piloting of templates, the application of engagement methodologies as part of mainstream practice and the use of patient and practitioner experience tools as a method for consultation development.
Skills and training required to deliver the Keep Well programme

There were significant concerns that the training delivered at the beginning of the pilot programmes was not sufficient to meet the needs of practitioners. There was evidence that some practitioners had made their own links to services and had attended training. Practitioners also raised the need for differing levels of training depending on who was delivering the Keep Well Health Check in particular the role of Health Care Support Workers. Many Practitioners felt unprepared for the social enquiry and sensitive enquiry aspects of the Health Check and would value more professional development opportunities in these areas. Practitioners also asked for opportunities for shadowing and mentoring many saying that they would find this particularly useful as part of ongoing professional development approaches. In summary there is a need to review the competencies required to deliver the Keep Well Health Check and the skills and training required to reach that level of competency. Further developments need to include an induction training programme for new practices participating in Keep Well which provides practitioners with the knowledge and understanding required together with a clear rationale for the inclusion of social enquiry within the check.

Links with health improvement services – onward referral mechanisms

There were clear enablers and barriers to onward referral within the Keep Well Health Check. Many Practitioners welcomed the wide range of services to refer patients to as part of their Keep Well Health Check. The barriers identified included waiting lists, opt-in criteria, the need to travel considerable distances to some services and tracking tool information supplied by services. In summary, work needs to be undertaken to ensure quality standards as part of the commissioning process and to ensure the services to which onward referrals are made are inequalities sensitive and do not create barriers to patients with complex needs.
The range of learning and application to wider practice

It was clear that some Practitioners had taken practice from Keep Well and applied this within the Primary Care setting. Clear examples of this were seen in the transfer of different engagement methodologies to other areas of chronic disease management. For example, telephone calls and the use of outreach workers for non-attendees at Diabetic Clinic. However, some Practitioners were either unable to identify specific learning or could identify learning but not its application to wider practice. This was primarily related to the specific role of Practitioners. For example, some Practices had employed Nurses to specifically deliver Keep Well and not to deliver other services within the Practice. There is a need to support staff with learning tools which will help them identify learning and its applicability to practice.

7.0 Summary of progress

Since this research has been completed a number of actions have taken place which address some of the issues raised. These include the development of induction training; establishment of a Consultations Development Group and Mental Health Short Life Working Group; mentoring, shadowing and learning support.

Keep Well Induction Training

From April 2011 the Keep Well Programme has been delivered via a LES contract arrangement. A further 42 General Practices have opted in to deliver the programme. As part of this process it was compulsory for all staff involved in the delivery of the health check to attend a two day induction programme. The training programme includes overviews of the policy context, inequalities in health, IT tracking tool, engagement methodologies and outreach, the Keep Well Template, input from peers around their experience of delivering the programme health behaviour change, social enquiry, sensitive enquiry and patient centred
goal planning. The training was delivered to a total of 92 staff at 3 sessions during the months of May and June 2011. Further training is planned in October 2011.

**Consultations Development Group**

A Consultations Development Group has been formed with the primary aim of identifying core components to optimise delivery of the Keep Well Health Check. This programme of work will include training and development, development of consultation decision support tools and strategies to enhance person centered approaches, oversee medical informatics development including template screens, and evaluate patient and practitioner experience within Keep Well to inform consultation development.

**Keep Well Mental Health Short Life Working Group**

A short life working group has been established to review the current mental health context within the Keep Well Health Check. Currently, within NHSGGC the HADS tool is used across Keep Well and Chronic Disease Management. The HADS tool, however, is not validated for use within a primary prevention approach and therefore not appropriate for use within Keep Well. The work of this group aims to make recommendations with regard to the content of Mental Health and Well being components within mainstreaming delivery of Keep Well programme.

**Mentoring and Shadowing Support**

Additional capacity has been added to the Primary Care Support Nurse Team within NHSGGC to provide mentoring support to Practice Staff delivering the Keep Well Health Check. An additional 1.0 wte Primary Care Support Nurse and
an additional 1.0wte Health Care Support Worker have been recruited and are expected to be in post from 1st November 2011.

**Learning support and application to wider practice**

As part of the LES contract arrangements for 2011 Practices have been asked to use the PDSA model (Plan, Do, Study, Act) to identify areas of learning and application to wider practice. The practices have been given a number of options including patient access to/uptake of Keep Well health checks, patient experience, tailoring consultations to individual need, practitioner knowledge and skill development, health improvement referral patterns and outcomes, collaborative systems for closer working with health improvement services, systems for ongoing management of patients after Keep Well health checks, application of programme learning to wider practice activity. The learning from this will not only support individual practices but inform the wider development of the Keep Well programme within NHSGGC.
Keep Well Primary Care Practitioners Survey

1. Primary Care Keep Well Survey – Introduction
We are seeking your views on the Keep Well programme in NHS Greater Glasgow and Clyde to help inform the mainstreaming/delivery from 2011/12. Please take time to let us know your thoughts. It will only take 10 minutes to complete this short survey. All information will be anonymised so that the respondent’s identity is fully protected. Following completion of the survey you will be directed to a web page which will give you the opportunity to take part in a 1-2-1 interview at a time and location convenient for you. This page is not connected to the responses you have made and therefore no data from the questionnaire can be linked to your identity. Thank you for your help. If you have any questions or queries please feel free to contact me.

Jane Beresford
Inequalities Development Lead – Keep Well
North Glasgow CHCP Headquarters
Stobhill Campus
300 Balgrayhill Road
Glasgow G21 3 UR
0141 201 9795
Jane.Beresford@nhs.net

2. Demographics
1. Are you…
   □ Male
   □ Female

2. What is your role within the primary care team?
   □ General Practitioner
   □ Practice Nurse
   □ Health Care Support Worker

3. For how long have you worked within General Practice?
   □ Less than 1 year
   □ 1 – 5 years
   □ 5 – 10 years
   □ More than 10 years

4. Which Keep Well area do you work in?
   □ East Glasgow
   □ Inverclyde
   □ North Glasgow
   □ South West Glasgow
   □ West Dunbartonshire

5. How long have you been involved in delivering the Keep Well programme?
   □ Less than 1 year
   □ 1 – 2 years
   □ 3 – 4 years
3. Patient Engagement
   1. Has your practice used any of the following engagement methods? Please tick the appropriate box for each engagement method

<table>
<thead>
<tr>
<th>Engagement Method</th>
<th>Never</th>
<th>Occasionally</th>
<th>Frequently</th>
</tr>
</thead>
<tbody>
<tr>
<td>Telephone calls</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Text Messaging</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outreach workers (Contacting the patient at home address when other methods have failed)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Email</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Please describe any difficulties or challenges you have had with any of the above engagement methods


2. Has your practice used opportunistic contact as an engagement method?
   □ Yes
   □ No

Please describe if you have encountered any difficulties with this method


4. Sensitive Enquiry
   1. How confident do you feel about discussing each of the following elements of the health check?

<table>
<thead>
<tr>
<th>Element</th>
<th>I feel confident</th>
<th>I feel neither confident nor unconfident</th>
<th>I feel unconfident</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood Pressure</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family History</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cholesterol Levels</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Discussing risk of a CVD event with patients</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Smoking habits</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alcohol</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Healthy Weight and Diet</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical Activity</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental Health and Wellbeing</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employability</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Money Advice</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Literacy</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Please feel free to provide any further information in relation to your response above

2. Below are examples of sensitive issues that may have been disclosed by Keep Well patients. Please indicate how frequently these issues have been disclosed.

* Please note gender based violence can include domestic abuse, financial control, child sexual abuse, rape and sexual assault, sexual harassment, female genital mutilation, forced marriage and involvement in prostitution.

<table>
<thead>
<tr>
<th>Issues</th>
<th>Frequently</th>
<th>Sometimes</th>
<th>Never</th>
</tr>
</thead>
<tbody>
<tr>
<td>Suicidal Thoughts</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gender Based Violence*</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bullying &amp; Harassment</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Racial Harassment</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Please describe any other sensitive issues that have been disclosed as part of the health check

5. Inequalities in Health

1. The Keep Well programme aims to reduce inequalities in health. How successful do you think Keep Well has been in achieving this?
   □ Very Successful
   □ Successful
   □ Somewhat Successful
   □ Not at all Successful

Please give the reason for your response above

2. The Keep Well programme aims to reach those who are described as “Hard to Reach” groups. How successful do you think Keep Well has been in achieving this?
   □ Very Successful
   □ Successful
   □ Somewhat Successful
   □ Not at all Successful

Please give the reason for your response above
3. How successful do you think the Keep Well programme has been in supporting you to update your practice list?

☐ Very Successful
☐ Successful
☐ Somewhat Successful
☐ Not at all Successful

Please describe the reason for your response above

4. The Keep Well programme is an anticipatory care model. How successful do you think Keep Well has been in delivering anticipatory care?

☐ Very Successful
☐ Successful
☐ Somewhat Successful
☐ Not at all Successful

Please describe the reason for your response above

5. Do you have any other comments or points that you wish to make which have not been covered by the previous questions?
Appendix B – The 10 Goals for an Inequalities Sensitive Health Service

<table>
<thead>
<tr>
<th>GOALS</th>
<th>EXAMPLES OF HOW THIS AFFECTS THE WAY WE WORK</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Engaging with populations &amp; patients</strong>&lt;br&gt;The health service:</td>
<td>Engaging with populations &amp; patients&lt;br&gt;The health service:</td>
</tr>
<tr>
<td>1. knows and understands the inequalities &amp; discrimination faced by its patients and population</td>
<td>1. gathers evidence on men and women’s poverty levels and uses to plan services which will reduce inequality and discrimination</td>
</tr>
<tr>
<td>2. engages with those experiencing inequality &amp; discrimination</td>
<td>2. uses the information gathered to change and improve services to reduce the effects of poverty on disabled people</td>
</tr>
<tr>
<td>3. knows that people’s experience of inequality affects the health choices they make</td>
<td>3. takes into account the reasons for differences in quit rates between men and women when delivering services to help people stop smoking</td>
</tr>
<tr>
<td>4. removes obstacles to services and health information caused by inequality</td>
<td>4. assesses patients’ communication and language needs before referral to outpatients, e.g. need for an interpreter or visual aids</td>
</tr>
<tr>
<td>5. uses an understanding of inequality and discrimination when devising treatment and care</td>
<td>5. Routinely and sensitively asks mental health patients whether issues such as poverty, racism, gender-based violence or homophobia affect their current problem.</td>
</tr>
<tr>
<td>6. uses its core budget and staff resources differently to tackle inequality</td>
<td>6. allocates staff time to work specifically with minority ethnic patients with diabetes to ensure appropriate medication for this high risk group in the long term</td>
</tr>
<tr>
<td><strong>Developing the workforce</strong>&lt;br&gt;The Health Service:</td>
<td>Developing the workforce&lt;br&gt;The Health Service:</td>
</tr>
<tr>
<td>7. has a workforce which represents our diverse population</td>
<td>7. Has senior management teams which represent the population in terms of sex, ethnic background and disability.</td>
</tr>
<tr>
<td>8. creates a non-discriminatory working environment and a workforce which has the skills to tackle inequality</td>
<td>8. provides a training programme for managers on the implications of prejudice and discrimination</td>
</tr>
<tr>
<td><strong>Health Service’s role in society</strong>&lt;br&gt;The Health Service:</td>
<td>Health Service’s role in society&lt;br&gt;The Health Service:</td>
</tr>
<tr>
<td>9. spends the money being invested in buildings, goods and services in a way which tackles poverty</td>
<td>9. sources hospital food and catering from local suppliers</td>
</tr>
<tr>
<td>10. Works with partners to reduce health inequality by addressing issues such as income inequality, social class inequality, gender inequality, racism, disability discrimination and homophobia.</td>
<td>10. Identifies and works with local and national partnerships which make decisions about economic and social policy.</td>
</tr>
</tbody>
</table>
Appendix C – West of Scotland Research Ethics Committee Letter
Dear Dr Beresford

Full title of project: Inequalities Sensitive Practice within Keep Well

You have sought advice from the West of Scotland Research Ethics Service Office on the above project. This has been considered by the Scientific Officer and you are advised that it does not need ethical review under the terms of the Governance Arrangements for Research Ethics Committees (REC) in the UK. The advice is based on the following:

- The project is an opinion survey seeking the views of NHS staff on service delivery.
- Recruitment is invitational and the transcripts from the focus/discussion groups will be irreversibly anonymised so that the respondent’s identity is fully protected.
- It is not possible to identify the individual from any direct quotation used in the reporting of your project.

If during the course of your project the nature of the study changes and starts to generate new knowledge and thereby inadvertently becoming research then the changing nature of the study would necessitate REC review at that point, before any further work was undertaken. A REC opinion would be required for the new use of the data collected.

Note that this advice is issued on behalf of the West of Scotland Research Ethics Service Office and does not constitute a favourable opinion from a REC. It is intended to satisfy journal editors and conference organisers and others who may require evidence of consideration of the need for ethical review prior to publication or presentation of your results.

However, if you, your sponsor/funder or any NHS organisation feels that the project should be managed as research and/or that ethical review by a NHS REC is essential, please write setting out your reasons and we will be pleased to consider further.

Where NHS organisations have clarified that a project is not to be managed as research, the Research Governance Framework states that it should not be presented as research within the NHS. This letter has been copied to NHS Greater Glasgow & Clyde R&D Department for their information.

Kind regards

Dr Judith Godden
WoSRES Scientific Officer/Manager

Delivering better health

www.nhsggc.org.uk
Appendix D – Participants Invite Letter
Dear Colleague

Keep Well Research – Request for participants in a key research project that will inform the development of anticipatory care in NHSGGC

I am writing to invite you to participate in an important piece of research that will explore your experience and learning within Keep Well. The work aims to better understand how Keep Well delivers accessible services to people who may otherwise experience difficulties, and record the broad range of skills and knowledge of practice staff in helping this happen. The work will inform future anticipatory care approaches across NHS Greater Glasgow and Clyde.

The research will take place in two stages. Firstly a survey monkey questionnaire (survey monkey is a tool for administering a questionnaire by email) will be sent to primary care staff (GPs, Practice Nurses, Health Care Support Workers). The questionnaire will be sent to your practice mailbox on Monday 18th October 2010. Please complete the questionnaire - your views will provide a valuable insight and inform future anticipatory care approaches. Where survey monkey is unavailable to practices electronically a paper copy will be provided.

The second stage of the research will take place during a one hour face to face interview. The purpose is to gain a better understanding of the key lessons learnt from implementing Keep Well at practice level. This will focus on your views and experience of working with patients in structured Keep Well consultations and how you have managed to respond to some of the challenges.
this can present. This is an opportunity to share experience of working in Keep Well and influence the mechanisms and support that will be put into place for the roll out programme.

All information from each stage of the research will be anonymised. No individual will be identified in the reports and presentations emerging from this work.

To take part in the interview stage of the research please complete the attached Interview Form and email the completed slip to Jane.Beresford@nhs.net. Alternatively, please feel free to contact me directly on 0141 201 9795.

Yours sincerely,

Jane A. Beresford
Inequalities Development Lead – Keep Well
Interview Form

I am interested in participating in an interview which will explore my views of Keep Well and the lessons I have learnt from participating in this project.

I confirm I have received a letter about the project. I understand that all data from the interview will be anonymised and that any information given will not identify me as an individual.

I give consent for the researcher to use the details I have provided below to contact me to arrange to participate in an interview.

<table>
<thead>
<tr>
<th>Name:</th>
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<tbody>
<tr>
<td>Address 1:</td>
<td></td>
</tr>
<tr>
<td>Address 2:</td>
<td></td>
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<tr>
<td>City:</td>
<td></td>
</tr>
<tr>
<td>Postcode:</td>
<td></td>
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<tr>
<td>Contact Telephone Number:</td>
<td></td>
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<td>Contact Fax Number:</td>
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<tr>
<td>Contact E Mail:</td>
<td></td>
</tr>
<tr>
<td>Locality:</td>
<td></td>
</tr>
</tbody>
</table>

Please return this form to:
Jane Beresford
Inequalities Development Lead – Keep Well
North Glasgow CHCP Headquarters
Stobhill Campus
300 Balgrayhill Road
Glasgow
G21 3UR
Appendix E – Interview Topic Guide
Interview Schedule for Keep Well

Section 1 – Introduction

My name is Jane Beresford and I have recently taken up post as Inequalities Development Lead for Keep Well. As part of my role I am keen to explore the views of staff involved in the delivery of Keep Well to help inform the delivery of inequalities sensitive practice within the extension of Keep Well and wider anticipatory care practice.

The original aim of the Keep Well programme was to “reduce inequalities in Cardiovascular Disease (CVD) by increasing the rate of health improvement among high risk, hard to reach groups living in the most deprived communities.”

Question 1

How did your practice become involved with the Keep Well programme?

Prompt: approached by CHCP/clinical director, practice approached CHCP, who in practice took lead role in decision (whole practice decision/GP/practice manager), attended the briefing session

Section 2 – Access to Services and Engaging with Populations and Patients

Question 2

(a) What does the term ‘inequalities’ mean to you?

Prompt: Social model of Health, discrimination, equalities, and relevance to practice population

(b) How does this understanding (your response to above) influence the way you work?

Prompt: design and delivery of services, approaches to patient engagement and patient care/has your understanding changed since Keep Well

Question 3

(a) What role do you think Keep Well has in reducing inequalities?

Prompt: limitations/opportunities relating to
(1) Inverse care law
(2) Engaging with patients
(3) Knowing more about patients needs/identifying unmet need and complex case management

(b) How could the limitations be overcome at:
   (1) individual level
   (2) Practice level
   (3) Organisational level (NHSGGC)

**Section 3 – Developing the Workforce and the Keep Well Health Check**

**Question 4**

From the recent Keep Well Primary Care Practitioners Survey respondents highlighted that many practitioners did not feel confident in raising the following issues:
(1) Money Advice
(2) Employability
(3) Literacy
(4) Mental Health and Wellbeing

What needs to change to enable practitioners to confidently address each of those elements of the Keep Well Health Check?

*Prompt: knowledge and skills/information and relationships with service providers/time*

**Question 5**

We know from the results of the questionnaire that during the Keep Well Health Check some patients disclosed sensitive issues that can have an impact on their health and experience of inequalities. E.g. sexual abuse, gender based violence, suicidal thoughts

(a) How prepared do you feel to raise, discuss and work with patients on such issues?

*Prompt: respond/support. Sensitive enquiry/training*

(b) How prepared do you think practitioners are generally?
(c) What would make you feel prepared?
Prompt: Competencies/skills development/training/mentoring/shadowing/e-learning/wider issues eg.GBV

Section 4: Health Service Role in Society and Programme Learning

Question 6

The results from the questionnaire suggested that Keep Well has facilitated links between health improvement services and primary care.

(a) What is your perception of this?
(b) What has helped?
(c) What could be further improved?

Question 7

What have you learnt from delivering the Keep Well programme?

Question 8

Have you applied any learning from Keep Well to your wider role/approaches with your/the practice?
Appendix F – Hard to Reach Project Findings – Whole practice Approach for Successful Engagement

GG&C H2R INTERVENTION “PICK ‘N MIX”

- Written, personalised letters with provisional appointment
- Telephone invitation calls
- Telephone counselling
- Text messaging (to and from patient)
- Mobile phones for appointments & cancellations
- Emailing
- Tailored interventions based on contact history
- Medical (nurse) + Social (OW) model
- Outreach home visits
- Opportunistic (practice-based)
- Early/late hours
- Welcoming late-/early-comers
- Alternative GP venues
- Maintaining accurate and updated registers
- Build rapport, empathise
- Not wearing a uniform
- Asking direct & honest questions to break down barriers
Appendix G - Literature Review
Literature Search Results for Jane Beresford: Looking for evidence on how to change health professional practice in relation to Inequalities Sensitive Practice in Primary Care. Looking at Studies about staff attitude to ISP and any barriers to healthcare when staff Screening patients about inequality topics.

Databases searched:

Internet: Yes Listed at back of document

Limits applied: English, (2007-2010), human(s),

Subject Headings: health inequality, socioeconomic factors, social care, social care models, primary health care, health personnel attitude, staff attitudes, health care access, treatment outcomes, health care delivery, health care quality, health care utilization, and screening

Keywords: Inequalit$, social determinants, inequality$ sensitive practice, inequality$ sensitive approach

Key: A1 = Author

T1 = Title

YR = Year / Publication details

AB = Abstract

JF = Journal

UR = Ovid Link
Internet Results:

Search Strategy (Google advanced):

barriers attitudes screening evidence OR success ("inequality$ sensitive practice" and “Primary Care”)

Only two results, both documents are the ones that Jane has passed to Library to assist in search.

Search Strategy (Google advanced)

“Inequalit$ sensitive practice” and “Primary Care”

Brought up a number of results, however many of the results are documentation from either the PHRU site or from NHSGGC site, which I have not listed nor are any dated prior to 2007:

Scottish Government Mental Health Division & Equalities and Planning Directorate
http://www.vhscotland.org.uk/library/nhs/MH_race_equality_prog_March08.doc
Voluntary Health Scotland

Quality Improvement Scotland Local Report for NHSGGC April 2007
Clinical Governance & Risk Management: Achieving safe, effective, patient-focused care and services.

Health Inequalities and Hard to Reach Groups: A framework for CH/CP’s to review and evaluate action on inequalities.
Pauline Craig (Centre for Population Health) – presentation
http://www.evaluationsummerschool.com/handouts/D3Ess09_PaulineCraig/D3Ess09_PaulineCraig.ppt

Good Practice Examples in Mental Health Equal Access to Employment in Glasgow: Employability Training for Health and Social Care Workers.
Scottish Development Centre (SDC) 2009
References

ADAMS R.J., STOCKS N.P., WILSON D.H., HILL C. L., GRAVIER S., KICKBUSCH I., BEILBY J.J., “Health Literacy – A New Concept for General practice?” *Australian Family Physician*


BOYLE P.J., NORMAN P., POPHAM F., 2009, “Social mobility: Evidence that it can widen inequalities,” *Social Science and Medicine*, May, 68, 10


Cluster randomised trial of a telephone delivered physical activity and dietary behaviour intervention for primary care patients with type 2 Diabetes or Hypertension from a socially disadvantaged community – rationale, design and recruitment,” Contemporary Clinical Trials, May 29^{th}, 3.


GOLINKOFF M., 2007., “Managed Care Best Practices: The Road from Diagnosis to recovery: Access to Appropriate Care,” Journal of Managed Care Pharmacy, November 13, 9, Supplement A


MCHARG L., 2008, “We can’t afford to be shocked,” Nursing Times, 16 December, 104, pp17


POPAY J., KOWARZIK U., MALLINSON S., MACKIAN S., BARKER J., 2007., “Social problems, Primary Care and pathways to help and support: Addressing health inequalities at the individual
level. Part 11: lay perspectives,” *Journal of Epidemiology and Community Health*, November 6,11 pp972-977


SCHWARTZMANN L., 2009, “Research and Action: Toward good Quality of Life and Equity in Health,” *Expert Review of Pharmacoeconomics and Outcomes Research*, April 9, 2, pp143-147


TSUCHIYA A., DOLAN P., 2007., “Do NHS Clinicians and members of the public share the same views about reducing inequalities in health?” *Social Science and Medicine*, June, 64, 12, pp2499-2503

