

## **Deep End Report 4**

### **Experience and views of Keep Well and ASSIGN**

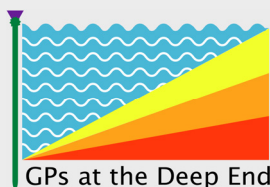
*The fourth meeting of "General  
Practitioners at the Deep End"*

29 January 2010

**Twenty GPs from Glasgow, Edinburgh and Inverclyde met on Friday 29 January 2010 at the Teachers Building in St Enoch Square, Glasgow for a workshop on their experience and views of Keep Well, including their experience of using the new Scottish cardiovascular risk score ASSIGN. The meeting was funded by NHS Health Scotland.**

## SUMMARY

- Keep Well has largely worked well, providing a boost for preventive activities via increased ascertainment and provision of specific health improvement activities.
- Ascertainment is not yet complete and there is uncertainty as to how much effort should be expended in maximising response rates.
- Government commitment is needed to maintain the work that has been started.
- In Keep Well practices, there is a need to provide continuing support as the focus shifts from initial ascertainment to long term support and follow up.
- Keep Well should also be initiated in the large number of severely deprived practices which have not so far taken part in the programme..
- The arrangements required for continued follow-up and support are different from those required for initial ascertainment and need to be more closely integrated within routine practice activity.
- To avoid fragmentation of services, with predictable effects on patient uptake, it is desirable that key health improvement services are provided “in-house”, within practice settings, via staff attached from other agencies.
- There is an urgent need to develop such an approach in response to the increasingly serious and prevalent health effects of alcohol misuse.
- ASSIGN provides a welcome opportunity to increase and improve the targeting of CVD risk in deprived areas, for men and women, but effort is needed to standardise its use across practices.
- Without additional resources, commensurate with changes in caseload, it is likely that ASSIGN will be used opportunistically within consultations, rather than for screening.
- For both Keep Well and ASSIGN, there is concern that Government initiatives are leaving deprived practices with lots to do without the resources to do it.



GPs at the Deep End

“General Practitioners at the Deep End” work in 100 general practices, serving the most socio-economically deprived populations in Scotland. The activities of the group are supported by the Royal College of General Practitioners (Scotland), the Scottish Government Health Department, the Glasgow Centre for Population Health, and the Section of General Practice & Primary Care at the University of Glasgow.

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# ATTENDING

Name	Location	Practice deprivation ranking
<b>Mandy Allison</b>	Craigmillar Health Centre, Edinburgh	29
<b>Albert Burton*</b>	Woodside Health Centre, Glasgow	51
<b>Ronnie Burns*</b>	Parkhead Health Centre, Glasgow	13
<b>Alastair Douglas</b>	Allander Street, Glasgow	9
<b>Jim Ferrell</b>	Health Centre, Port Glasgow	89
<b>Susan Langridge</b>	Possilpark Health Centre, Glasgow	15
<b>Pauline McAlevy</b>	Glenmill Medical Centre, Glasgow	24
<b>Alan McArthur*</b>	Braidcraft Medical Centre, Glasgow	66
<b>Martin McLaughlin</b>	Govan Health Centre, Glasgow	46
<b>William McPhee</b>	Parkhead Health Centre, Glasgow	19
<b>Bob Mandeville</b>	Possilpark Health Centre, Glasgow	1
<b>Jim O'Neil</b>	Lightburn Medical Centre, Glasgow	39
<b>Gerry Spence*</b>	Shettleston Health Centre, Glasgow	72
<b>Andy Townsley</b>	Easterhouse Health Centre, Glasgow	7
<b>Nicholas Treadgold</b>	Pollok Health Centre, Glasgow	53
<b>Marie Wilson</b>	Easterhouse Health Centre, Glasgow	5

\*From practices not yet participating in Keep Well

<b>John Budd</b>	Edinburgh Homeless Practice (Group Facilitator)
<b>Julia Clark</b>	University of Glasgow (Rapporteur)
<b>Andrew Lyon</b>	International Futures Forum (Meeting facilitator)
<b>Michael Norbury</b>	University of Dundee (Group facilitator)
<b>Kate O'Donnell</b>	University of Glasgow (Observer)
<b>Wendy Peacock</b>	NHS Health Scotland (Observer)
<b>Anne Scoular</b>	NHS GG&C (Observer <i>morning only</i> )
<b>Fiona Turner</b>	University of Glasgow (Rapporteur)
<b>Graham Watt</b>	University of Glasgow (Meeting facilitator)

*Equally Well*, the current Scottish Government policy on Health Inequalities, confines its coverage of the contribution of general practice to narrowing health inequalities to Keep Well, the flagship national anticipatory care programme. At the first meeting of general practitioners from the most deprived 100 practices in Scotland, at Erskine in September 2009, it was noteworthy that there was no mention of Keep Well in the plenary sessions or post-it notes of group discussion. Only 37 general practices out of the most deprived 100 practices currently take part in Keep Well (including 25 of the 85 practices from Glasgow and 12 of the 15 practices from outside Glasgow). 19 Keep Well practices were represented at the meeting.

This subsequent meeting aimed to review the experience of practices, specifically asking:

- What had worked well, and not so well in Keep Well.
- What was missing from Keep Well.
- How the effect of Keep Well could be evaluated.
- Whether and how Keep Well is sustainable.
- The practical implications of using ASSIGN in clinical practice.
- How colleagues in general practice and health improvement can work more effectively together.

A draft report was circulated to all participants, to ensure that the report reflected the content and views of discussions at the meeting.

## **KEEP WELL REVIEW OF PROGRESS**

GP experience of KW was positive. The idea and practice of anticipatory care were not new, but KW provided a large boost to this aspect of practice work, via enhanced ascertainment and the provision of specific health improvement programmes.

The initial stage of ascertainment is incomplete, with a significant minority of the target population (sometimes called “hard to reach”) still to take part. A balance needs to be struck between pursuing the very “hard to reach”, or perhaps more accurately “hard to engage”, and focusing on continued engagement with patients whose problems and risks have now been identified.

The lower age threshold of 45 years is considered too high in severely deprived areas, given that many patients have identifiable problems and risks before that age.

The initial focus on cardiovascular risks was too narrow, and practitioners welcomed the broader focus, including mental health, which was incorporated in the initial KW assessment, as the programme developed.

For many practitioners, KW provided the opportunity not only to address cardiovascular risks but also patients’ underlying psychological and behavioural problems and circumstances. Flexibility was required in the order and pace at which these issues could be addressed. When several problems are identified, they usually have to be tackled one at a time.

For many patients, Keep Well is the start of a long journey and key messages may need to be repeated several times. After a gap of six weeks or so, the process may need to re-start at the beginning.

Although the example of Julian Tudor Hart has often been cited as the inspirational force for KW, it was noted that Dr Hart not only had additional resources in his practice, but worked in a time when general practitioners were under less intense pressure. It was also noted that Dr Hart's example involved neither of the two main features of Keep Well – additional resources for ascertainment and linkage to health improvement programmes. His main approach had been an unconditional commitment to the preventive needs of all his patients over a long period of time.

Patients in very deprived areas represent a particular challenge, in terms of readiness to engage with preventive activities. Some practitioners felt that additional training in motivational interviewing would be helpful for doctors and nurses.

Referral to health improvement programmes was highly valued, although it was felt that these should be provided "in house" or in close proximity to the practice. Referral to another agency at another place and time significantly reduced the probability of many patients attending. Within Glasgow, there could be a strong sense of "territory" and unwillingness of patients to attend services elsewhere.

Alcohol problems are a major cause of premature death in severely deprived populations and a substantial barrier to addressing other problems. It was strongly felt that the lack of in-house referral to a mental health worker who could share the burden of addressing alcohol problems, separately from services for drug misusers, was a weakness of the KW arrangements.

## **KEEP WELL THE FUTURE**

A good start had been made, after teething problems, mostly with IT. The challenge within KW practices is to build on the progress that has been made.

It is important to extend KW to the 63 Deep End practices (60 in NHS GGC) which have so far not taken part. Participation in KW has involved 25 of the 85 Deep End practices in Glasgow, and 12 of the 15 Deep End practices outside Glasgow.

Uncertainty concerning the future was encapsulated in the example of one practice whose budget for KW is set to reduce from £40K to £4K in April 2010, with the consequent loss of a valued health care assistant, including the shared knowledge and relationships that have been built up with patients.

It was felt that Keep Well had provided a very substantial boost to preventive activities, principally via increased ascertainment, but also via the provision of additional health improvement programmes. The next step is to provide continuing support for the individuals with high risks who have been identified.

Practices vary in the extent to which the initial process of ascertainment is considered complete, as successful as it is likely to be, or incomplete and needing further effort. Many reported staff having being exhausted by the work of initial ascertainment.

Most agreed that subsequent activity, following ascertainment, and planning for the long term, would need different arrangements, more closely linked to the routine work of the practice and retaining KW staff who know large numbers of patients well.

Planning for the future should involve greater input from practices than was the case in the initial planning of Keep Well.

The group felt that when resources are constrained, Keep Well resources should be targeted where they are most needed in Scotland.

## **ASSIGN IMPLICATIONS FOR PRACTICE**

At the start of this session, there was a short presentation demonstrating the effects on the numbers of patients with high CVD risks of:

- Switching from JBS 2, based on the Framingham Study cohort, to ASSIGN, based on the Scottish Heart Health Extended Cohort and which includes deprivation (based on postcode) and family history as new CVD risk factors. For a given risk threshold, ASSIGN identifies slightly fewer people at high risk, but with a substantial redistribution of the proportions of high risk cases from affluent to deprived areas.
- Switching from a 30% ten year CVD event risk to a 20% threshold for instigating preventive measures. This change approximately doubles the number of people at high CVD risk.

Discussion within the group demonstrated that practices are currently using a variety of risk scores and thresholds. Greater clarity, cohesion and consistency are needed.

ASSIGN was welcomed as a tool providing the opportunity to improve the detection of patients in deprived areas with high cardiovascular risks, but the additional work of processing the increased numbers of such patients through successive stages of ascertainment, discussion, treatment and follow-up was considered to be substantial.

GPs welcomed the opportunity to redress the relative lack of attention that has been given to the detection and management of cardiovascular risks in women.

GPs recognised the limitations of postcodes in attributing socio-economic status to individuals, and planned to apply such information with discretion, using ASSIGN as a guide, rather than a prescription. The group took the pragmatic approach that while using postcodes is not a perfect method of characterising individual socio-economic status, it is the best method available.

This use of postcodes needs to be portrayed as a positive way of addressing inequalities in health, rather than the usual negative media response towards “postcode prescribing”.

In general, ASSIGN was felt to compound the uncertainty concerning the sustainability of KW at a time of resource constraints.

## **HOW CAN GENERAL PRACTICE AND HEALTH IMPROVEMENT WORK BETTER TOGETHER?**

The group was confident that general practice provides the main organisational structure in the NHS capable of delivering personal, holistic, continuing and co-ordinated care for large numbers of people. It is also the main source of personal health advice for most patients.

Routine consultations provide a ready starting point for preventive activity, but to capitalise on this opportunity, GPs and patients need quick and convenient access to other resources.

A major challenge is to increase the range of services available to patients without fragmentation. Services that can only be provided at another location on a different day are least likely to be taken up by patients with multiple problems.

The point was strongly made that alcohol is becoming a greater cause of premature mortality in deprived areas than cardiovascular disease, but this is not reflected in KW priorities. The use of alcohol counselling had been the least acceptable and successful of referral activities. This was felt a prime example of the need to provide such a service "in house", via an attached mental health worker. The added value of this approach would not only accrue to individuals with alcohol problems; it would also release GP time to address the needs of other patients.

GPs commented on how the effect of their advice to smokers on smoking cessation had been enhanced by the Government's action on smoking in public places. Similar consistency of support is needed in relation to alcohol.

It was felt that colleagues in health improvement could work more effectively with general practices in an area, sharing information, educational materials and access to specific services, so that there is greater consistency. Practices also need protected time to work at their relationships with external agencies. It might be helpful if practices identified a lead practitioner for this task.



# ANNEX 1 DETAILED SUMMARY OF SESSIONS

## Session 1

### *Review of Keep Well*

#### WHAT WORKED WELL?

- The group is keen to record that the overall message from implementing Keep Well (KW) thus far is positive, and that there is strong support to continue the work if it is resourced.
- The group valued the holistic and fresh approach that KW has brought.
- The group reported positive feedback from both patients and nurses. There was a feeling that KW had “transformed some people’s lives.”
- The group felt that there had been attitude changes in some patients, with an increased focus on health and wellbeing. Some had almost become community advocates for health.
- KW has provided the necessary time and resources to target problems within practice populations, which are a mixture of newly identified problems and problems already known to practices.
- KW is seen as representing a positive shift towards preventing ill-health, even although there are difficulties and challenges in this way of working.
- KW allows a move away from the traditional medical model of health care and opens up a channel for dealing with psychological and social issues that may impact upon a patient’s health and wellbeing.
- The group valued the fact that KW is based within general practice.
- Having resourced and focused time with patients is particularly valued by both nurses and GPs.
- Due to the short term nature of KW, it was felt it was better to extend existing staff hours rather than to employ new short-term staff, to provide better continuity of care for patients
- The increase in local resources based outside practices was valued, but there was some feeling that these could be better linked with practices, in electronic and other ways.
- There was a feeling that the advertising and general awareness of Keep Well had gone well, even though the targeted approach within practices had prevented blanket advertising.
- Opportunistic invitation was considered the best method to engage patients
- An opportunistic cholesterol check by the doctor was seen by some as the hook to get patients to make a KW appointment with the practice nurse
- Some GPs felt that the outreach worker was working effectively to engage the hard-to-reach, but there were mixed views on this topic with some negative experiences of outreach workers also reported. This appeared to reflect the different models of outreach that are operating across the KW pilots.

- Case finding: there was agreement that KW had clinically identified important cases.
- In addition to CVD, the KW health check picked up other health problems, including diabetes, COPD and anaemia
- Referrals to benefit advice services are popular with patients
- KW has also helped to update patient records.
- One-to-one support and advice services are much better received than group interventions. It was felt that this should direct future planning.

#### **WHAT DIDN'T WORK WELL?**

- There was some feeling of an initial 'culture clashing' between project and practice. More involvement of practices in the planning stages would have been beneficial.
- KW created an additional administrative burden for practices, especially during the set up period, leading to frustration.
- Concern was expressed as to the implications of KW being only a short term project
- A premature end would lower staff morale (via redundancy or reductions in hours) when staff morale may already be low due to working in deprived areas, and where retention of staff is already difficult, with high 'burn out' rates.
- If staff morale is reduced, this may affect the long term care of patients and undermine the service that was previously given.
- There has been a lot of "chasing up" of patients who have not engaged and of patients newly entering the age cohort.
- There was some concern that patients who were engaging were those who were already identified to have health problems, and therefore already closely managed, leading to duplication of work
- There were difficulties in some practices in advertising KW because of the targeted approach. On the other hand, it was felt that people may accept variation in services – raising the question of whether KW could have had wider promotion.
- There was much discussion in the group about whether KW was targeting the right people.
- It was felt that KW might be "missing the boat" in terms of not also capturing a younger cohort.
- It was agreed that other aspects of health than CVD are as important in the target group. Mental health, in particular, was a focus of discussion and it was argued that the late incorporation of mental health screening into the health check had corrected an initial oversight.
- There were difficulties in communication between practices and pharmacies delivering KW. GPs valued pharmacy's contribution to repeat prescribing but were less clear about the role of pharmacists in smoking cessation.
- The splintering of services by time and place generally reduced uptake
- Information technology (IT) was seen as a "necessary evil"
- It was felt that the tracking tool for collating KW information could and should be integrated with GP's own clinical systems rather than being bolted on.

- If IT is to be bolted on to existing clinical systems it is important to have someone to manage this within the practice
- For recording data and search functions, no guiding template had been provided centrally. This caused problems in a number of ways e.g.
- Difficulties with having to back-track when the template changed and evolved over time.
- Challenges to evaluation when practices have different templates; issues of there being “parallel universes”.
- Gaps in engagement data: difficulties in knowing where some patients have come from.
- Questions over accuracy of recording data.

### **WHAT WAS MISSING?**

- Lack of clarity on overall aims of KW
- Lack of clear outcomes to measure the success of KW
- The vital statistics of practices should have been measured at the start so that before/after KW comparisons could be made.
- What happens in the long term for patients after the health check? Will there be systematic follow up?
- KW is broader than CVD risk reduction
- There was some feeling that there needs to be more focus on psychosocial factors and less on risk scores, and more focus on prospects for social change.
- Should the health check be extended to other patient groups including drug users and those under the age of 45?
- Particular groups may represent missed opportunities, e.g. newly registering parents may have a fresh focus on their health.
- Who exactly are the hard to reach population?
- More resources for longer opening hours would have helped engagement.
- For patients with multiple issues a 40 minute health check is insufficient to allow all issues to be identified and targeted
- Alcohol should be a key focus because it is the biggest cause of ill-health in the target group
- There were missed opportunities in other health areas e.g. COPD.
- More dietetic services are required, not only for those overweight but also dietary advice and education
- A referral route to housing services should be included
- There was often a lack of feedback from referral services for social issues
- More one-to-one services are needed
- Local expertise could have been used better: existing services are not always used to their full potential.
- More services are needed ‘in-house’ because of the reluctance of some patients to access services outwith the practice.
- IT issues: it was highlighted that the project should have communicated better from the outset about templates and data recording.

## **WHAT INFORMATION/EVIDENCE WILL TELL US THAT KEEP WELL HAS BEEN EFFECTIVE?**

- The group felt that it was still too early to assess the effectiveness of the KW intervention.
- A longitudinal study could have compared KW and non KW practices to compare long term patient outcomes. It was felt that this opportunity had been missed.
- Lack of uniformity in KW implementation made it very difficult to make useful comparisons between approaches and between practices.
- There is a need for local outcomes as well as national evaluation
- Outcome measures need to include well being as well as clinical indicators and should include:
  - Cardiovascular events
  - Premature death
  - Measuring health rather than illness
  - GP contacts
  - Attitude change (in target group) to anticipatory care
  - Patient empowerment: seeing patients starting to take their own initiative
  - Social mobility (although said with some humour!)
  - Generation effects: the idea that Keep Well has the potential of a knock-on effect if it changes parental attitudes towards health
  - Increased knowledge and education, especially around food habits. The possibility of measuring changes in consumer purchasing
  - Sustained behaviour change
  - A change in the acceptability of certain behaviours, e.g. a similar effect to the smoking ban where it was felt that there was impact on the social acceptability of smoking.
- Finally, it was argued that the effectiveness of interventions should not be all about numbers.

## **Session 2**

### *Whether and in what ways is Keep Well sustainable?*

#### **GENERAL COMMENTS ABOUT THE FUTURE**

- The Government needs to show consistency and commitment.
- The future of Keep Well is entirely resource dependent.
- It was agreed by the group that paramount to keeping Keep Well sustainable is continued funding at the same level.
- It was felt important for the KW model to be sustained to avoid a return to predominantly reactive care.
- Time was seen as a crucial factor.

- Sustainability means acknowledging the multiple and complex social factors that exist amongst patients and understanding social barriers to engagement in KW.
- A loose structure, rather than a rigid template, for KW was seen as important when moving forward
- Sustainability was seen as depending on the ways in which the aims of tackling health inequalities are conceptualized. The question of how far KW should be rolled out is dependent on the level of anticipatory care that is anticipated.
- In order to be sustainable, KW needs to be modifiable in terms of rolling it out to other groups and age ranges. This included discussion about creative use of the existing template.
- If resources are limited there needs to be a focus on existing patients rather than chasing the 'hard-to-reach.'
- The allocation of resources should be based on levels of deprivation. Sustainability should be primarily about sustaining resources in the most deprived practices.
- QOF could be amended to release funding for KW.
- The question was raised 'when should we stop trying to engage the hard to reach?'
- Some felt that a lack of response from the target group (after numerous attempts) should be accepted as the patient's choice of not to participate in KW.
- The counterargument was that a lack of response may not always indicate a lack of willingness to participate in Keep Well (as found by outreach workers)

## **WHAT WILL BE NECESSARY FOR KEEP WELL TO WORK IN THE FUTURE?**

### **■ GP level**

- There was discussion about the role of GPs in KW : whether they are simply gatekeepers to KW services or are GPs' skills of continuity and communication central to KW's long term impact?
- Changing attitudes – KW involves a move away from the medical to the biopsychosocial model of health and health care
- Time and resources are needed for patients with multiple issues
- The current initial 40 minute KW consultation is unsustainable without the current KW funding arrangements
- Time and resources are needed to allow follow up of patients who have had a KW health check, addressing one issue at a time, taking a holistic approach and providing continuing education of patients in self care
- Professionals need additional training, for example in motivational interviewing, as this is crucial to KW

### **■ Practice level**

- Sustainability was seen as linked to the ability to incorporate Keep Well into everyday practice (thereby normalising the KW approach).
- Funding needs to continue at the same level.
- Resources to provide smoking cessation are best provided 'in-house'.
- Referring on to community pharmacy is a barrier for some patients leading to missed opportunities

- Existing practice staff should be used to deliver KW, putting resources into primary care, allowing practices to build relationships between patients and staff and supporting continuity of care
- Easier referral systems would enhance Keep Well: streamlining was seen as an important factor in sustaining the links between practices and services.

#### ■ **Groups of practices**

- KW should be extended to practices not already participating (60 out of 85 GGC practices in the top 100)
- The KW template and format should be kept as it is, but it should be applied to a wider target group, especially to younger age groups
- Improving people skills: relevant to all professions involved in KW.
- IT should be improved : up to date, intelligent IT is needed
- Centrally produced publications (newsletters, leaflets for patients) would be helpful.

## **Session 3**

### *ASSIGN*

#### **GENERAL**

- The use of four different approaches to the use of CVD risk tools was reported in one of the breakout groups (of 8 GPs).
- If KW is a national programme, why are different practices (and even doctors within the same practice) interpreting ASSIGN differently? Some are using 20% and others 30% thresholds.
- It was felt that the focus and effort that went into standardizing the health check now need to be applied to agreeing the use of the risk calculation tool.
- There was issues of IT access to ASSIGN, and awareness of it, with one GP reporting that he was unaware that he was able to use ASSIGN until he actively looked for it (after seeing it on the meeting agenda).
- It was felt that ASSIGN should be used sensibly and with discretion as a tool rather than as a prescription. This includes acknowledgement of the larger context such as other causes of death and ill-health.
- The group argued that ASSIGN should not become a means of penalty if risk scores are not improved.
- ASSIGN needs to be used sensibly, with an acknowledgement that an increase in score (e.g. due to ageing) may not mean much in practice.
- It was agreed that ASSIGN can be a useful tool for communicating with patients and can empower patients to reduce their score. Reducing their cigarette entry could show patients how this impacts upon their risk score
- There was a question over why diabetes is part of the risk calculation when having diabetes already means high CV risk.
- How can practices cope with the increased numbers of high CVD risk cases?

- If KW funding ends there is concern that there will not be enough time for the implications of applying ASSIGN
- The increasing workload that ASSIGN will cause includes time to discuss risks, empower patients (to understand what a 20% risk reduction over 10 years means), initiate statins, monitor risks etc
- Concern was expressed about the implications for statin prescribing. Will resources be taken from elsewhere to fund this? Potentially, savings will be made by secondary care.
- How do we translate the risk score to lifestyle behaviour change in a population that is difficult to educate?
- If resources for Keep Well come to a end, it was agreed that GPs would only use ASSIGN opportunistically, and that its general use in screening would stop.
- Will resources be re-distributed to practices with more cases than others due to ASSIGN?
- Resonating with the call for ASSIGN to be used as a tool rather than a prescription, the group felt that there was a danger of over-prescribing and medicalising. It was felt that ASSIGN should not automatically lead to prescribing and can be used as a before/after comparison in relation to lifestyle interventions.
- Discussion of ASSIGN generated some talk about prescribing decisions. The cost effectiveness of statins was a particular focus, with one GP feeling that there had been a missed opportunity within KW for a large effectiveness study.
- Following discussion about the need for agreed risk calculation tools, the question was raised about the value of having agreed strategies for managing patients. This generated debate, with some GPs arguing that agreed strategies would go against the ethos of individual clinical judgment
- Are there special implications of the large increase in women at high risk?
- Historically CVD risk in women has been underestimated. The group welcomed the opportunity to correct this.
- There was a worry that women may become medicalised
- Given that smoking rates in young women are high, should younger women be targeted?
- If we can reduce other risk factors, statin treatment may not need to be long term.
- Many women in the KW target population are likely to be grandmothers
- This may be an opportunity to educate women about diet which may in turn filter to their daughters and grandchildren
- How do GPs feel about classifying individual deprivation status on the basis of postcode?
- Common sense and discretion will be needed, for example when patients move between postcodes
- Risk is not exclusive to those in poorer postcode areas
- There may be a need to counter media reaction to targeting prevention strategies based on postcode. Rather than a “postcode lottery” ASSIGN is a good thing
- This question quickly generated the answer that using postcodes was fine for the purpose of including deprivation as a factor, but they should be used

sensibly and with acknowledgement that postcode is not a foolproof method of classifying deprivation.

## **Session 4**

### *Conclusions*

#### **POSITIVE AND PRACTICAL CONCLUSIONS FROM THE MEETING:**

- It had been a good opportunity to meet with other GP colleagues and a safe environment in which to share experience and views.
- Participants liked the focused approach and the small size of the meeting
- The group felt that the structure of the day worked well
- GPs valued the opportunity to taking learning points away from the meeting, especially practices not yet involved in Keep Well.
- It was felt that the value of the meeting could have been diluted if other groups
- Some felt that practice nurses' views would be very important to capture, however the general consensus was that the potential for openness would be greater if the process were kept exclusively for GPs.
- There was also feeling that nurses views would already be represented by the GPs and that the different agendas of different professions could make a multi-disciplinary meeting difficult to manage.

#### **HOW CAN GENERAL PRACTICE AND HEALTH IMPROVEMENT WORK BETTER TOGETHER?**

- GPs need protected time to foster relations with other agencies (voluntary, community)
- More health promotion teams(including social work, drugs counselling etc) should be based within practices to deliver "in house" and improve uptakes
- Improving patient access to health improvement services was thought important, particularly subsidized exercise.
- GPs felt it would be useful to have more information about how their practices stood in comparison with other practices
- Creation of a standardized health improvement "shop window" for practices could use common materials such as a unified series of newsletters to patients
- Local health intelligence is needed to explain local needs (e.g. the use of ASSIGN) to local populations
- The experience of the group was that one-to-one services are much better received by the Keep Well cohort than group interventions. More resources are required for one-to-one counselling.
- The call for a focus on alcohol was discussed in terms of interventions. The group felt that it is important for services to differentiate between alcohol and other types of substance abuse. This came from patient feedback, in which there was a lack of willingness for those with alcohol problems to be 'categorized' in the same way as those with drug problems.
- Mental health resources were particularly valued and there were calls for more mental health workers and CPNs working in-practice.



- The group felt that IT and information to support referrals and signposting to local health improvement services was lacking.
- In Lothian, outreach workers act as a 'bridge' between GPs and services; however, in other areas there was a feeling that GPs' knowledge of what is available locally could be better supported.

*Compiled from notes made by **Julia Clark** and **Fiona Turner**, 08/02/2010*

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