

# Inclusion Health Action in General Practice: Early Evaluation Report



**HEALTH AND SOCIAL CARE**

# Executive Summary

In March 2023, the Scottish Government developed the Inclusion Health Action in General Practice (IHAGP) programme in response to a [recommendation from the Short Life Working Group on Health Inequalities in Primary Care](#) to create a new 'enhanced service' to provide increased resources for general practices in disadvantaged areas specifically targeted at activities to address health inequalities.

IHAGP provided funding to 66 individual general practices within NHS Greater Glasgow and Clyde. The funding was intended to support work to prevent health outcomes worsening for people with greatest need, and proactively engage those who are 'lost' to the system but need support to manage their health and social circumstances. Three themes for IHAGP activity were established:

- **Developing connections with the local community** - implementing inclusive patient engagement/community participation approaches to create or enhance existing patient/community participation capacity.
- **Enhancing workforce knowledge and skills** - practice staff to access education, knowledge resources or training on health inequality and health equity.
- **Proactive outreach and extended consultations** - enabling proactive outreach and extended consultations with patients who are at high risk of physical or mental ill health due to poverty and inequality.

The Scottish Government commissioned a social research agency, The Lines Between (TLB), to carry out a rapid evaluation to explore how general practices used the funding, the impacts of IHAGP-funded activity and lessons learned. The findings drew on monitoring data from participating practices submitted in September 2023 and January 2024. Interviews with a self-selecting sample of 23 staff from 15 practices were conducted between January and March 2024. Interviews with patients were outside of the scope of the study, so findings reflect the views of primary care staff only.

## **IHAGP activity**

Eighty practices were invited to participate in IHAGP, and 66 had opted in by December 2023. The majority (47) were delivering activity under one theme, 16 were delivering against two, and three practices were delivering activity across all three themes.

Activity delivered in theme one (patient engagement and community participation), has largely centred on the creation of new, or enhancement of existing, patient participation groups, resulting in direct support for 200 patients. Furthermore, 800 patients have been given the opportunity to provide feedback to inform service development and improvement activity.

The use of IHAGP funding by practices under theme two (enhancing workforce knowledge and skills) enabled over 200 staff to undertake training related to health inequalities including trauma-informed practice; suicide prevention; gender-based violence; abusive behaviour; conflict negotiation; signposting; and medical coding.

Activity relating to theme three (proactive outreach and extended consultations) has resulted in the delivery of approximately 7,000 extended consultations and outreach

appointments. This activity has focussed on patients identified as vulnerable, high risk or having the greatest needs due to medical conditions or social issues.

## **Achievements**

Practice staff described improved morale, less stress and pressure, and increased job satisfaction. Some observed increased collaborative working through whole practice approaches, with staff feeling better supported in their role. Improved understanding of health inequalities, patient populations and needs was also reported.

Several examples were provided by staff of patients experiencing improved health and wellbeing as a result of IHAGP activity. Staff also reported that some patients had developed a greater understanding of their health condition and the various lifestyle factors and changes they were in control of. IHAGP activity was perceived by practice staff to improve access to healthcare and provide patients with greater care continuity, with this delivered in a more welcoming, accommodating and tolerant environment.

At a practice and system level, IHAGP activity has resulted in operational efficiencies for some practices, as well as improved systems and record keeping. There has been reduced demand and need from some patients, alongside fewer missed and repeat appointments. More widely, targeted work with some patients has resulted in reduced attendance at out-of-hours and accident and emergency services.

## **Enablers**

The programme was viewed as a driver for action; with the three IHAGP themes helping to focus activity while providing flexibility in what could be delivered. Funding through IHAGP was highlighted as critical to secure the protected time required to plan and deliver IHAGP activity.

Willingness among general practice staff to work in new ways, take on new responsibilities, and work collaboratively were also critical enablers. The use of data and digital tools enabled new ways of communicating with patients, improved record keeping, and informed the identification of patients to target. Some practices had a foundation and momentum to build on, due to engagement in previous programmes to address health inequalities, or activity that was already underway.

## **Challenges**

A range of wider system challenges were experienced by practices, including capacity in the system, limited availability of temporary staff, issues with staff recruitment and retention, a shortage of practice space, and limitations in IT systems. These affected the pace of progress, the interventions that could be delivered, and the impact on their patient populations.

Practice staff also acknowledged the wider social factors and systemic inequalities and injustice that influenced population health such as poverty, job instability, poor nutrition, isolation and trauma.

The relatively small sums and short-term nature of funding was described as limiting the scale of activity, and a barrier to introducing longer-term interventions, particularly those that required ongoing funding and resource. Staff were wary of introducing unsustainable changes. Practices also experienced a variety of specific challenges related to different themes and activities and noted that communication from the Scottish Government could be improved.

## **Learning**

Practice staff expressed that IHAGP-funded activities have improved services, reached target populations, and improved access to healthcare. Almost all described their usual day-to-day work as reactive and demand-driven, and many believed IHAGP demonstrated the potential for practices to have a greater impact on health inequalities and on improving patients' quality of life, given more capacity to upskill their teams and deliver proactive preventative work.

However, some noted that a proactive approach might trigger an increase in workload by identifying unmet needs and demand among missing patients. Gaps in support for staff implementing trauma-informed practice into their day-to-day work were also identified.

While positive about experiences with IHAGP, many staff reflected on the scale of the challenge around health inequalities, feeling that activity delivered through IHAGP should already be resourced and embedded within primary care.

## **Conclusions and Recommendations**

There is a clear appetite for continuation of IHAGP with calls for increased, recurring and longer term funding. Without this, the sustainability of some activity and development is at risk. The IHAGP programme themes are generally seen as spanning the areas thought most critical by practices, while offering sufficient flexibility to adapt to local contexts. Several expressed a desire to learn from what other practices have delivered, and would like greater access to examples of other approaches or uses of IHAGP funding.

Early lessons include the need for practices to have protected time to plan and identify priorities and delivery mechanisms, increased capacity for delivery, and access to examples of approaches and good practice.

Clear successes have been captured relating to patient care and support, changes in working culture and improved connection with, and health outcomes for, patients. Positive impacts on staff morale and satisfaction have been identified, including validation of their efforts to address health inequalities.

There is an appetite for the continuation of IHAGP among participating practices, particularly as some developments are unlikely to be sustained without it. Constraints within the primary healthcare system remain a challenge, as does the nature of the issues facing communities and individuals which were identified as needing more targeted, focussed and sustained support.

The overarching recommendation is for continuation funding to be sought for IHAGP as an enabler of person-centred and equitable care.

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# Chapter One: Introduction

## Background to the IHAGP programme

In March 2022, the [Short Life Working Group on Health Inequalities in Primary Care published a report](#) that recommended that the Scottish Government create a new 'enhanced service' to provide general practices with increased resources targeted at addressing health inequalities in disadvantaged areas. The intent of the recommendation was to:

1. Address a gap between existing demand-led funding allocation processes and patient needs associated with inequality.
2. Act as a bridging mechanism between the current general practice funding formula and any future funding model/approach which takes fuller account of deprivation.

In response to this recommendation, the Scottish Government worked with the Primary Care Health Inequalities Development Group and other stakeholders to develop the Inclusion Health Action in General Practice (IHAGP) programme. The development of IHAGP was informed by the existing evidence generated from previous local initiatives, which included the evaluation of [Govan Social and Health Integration Project](#), the [Deep End Pioneer Scheme](#), the [Chance 2 Change](#) project, the [CarePlus study](#) and research on "[missingness](#)".

IHAGP provided funding for individual general practices during 2022/23 and 2023/24. This was targeted at general practices within NHS Greater Glasgow and Clyde, which operate in areas of blanket deprivation. 80 of the 100 "Deep End" practices<sup>1</sup> are in Glasgow and were invited to take part in the IHAGP programme.

Funding allocations to each practice varied, and were formulated based on each practice's patient list size and the proportion of their list living in an area of high disadvantage as classified by the [Scottish Index of Multiple Deprivation](#) (SIMD). A total of £1,300,000 was allocated to the programme, with £300,000 in the financial year 2022/23, and a further £1,000,000 in 2023/24.

In the financial year 2022/23, 66 practices participated in the programme, with initial funding allocated in March 2023 for activity until August 2023. In the financial year 2023/24, the same number of practices participated in the programme, with funding allocated in two tranches: the first in September 2023 and the second in March 2024. Over the duration of the programme the allocation of funding to participating practices ranged from £3,446 to £49,415.

The funding was intended to support work which helps to prevent health outcomes worsening for people with greatest need and/or proactively engage those who need support to manage their health and social circumstances. The funding provided through the programme could be used to support activity under one of the three IHAGP themes:

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<sup>1</sup> 'Deep End' practices are 100 General Practices that are serving the most socio-economically deprived population in Scotland, where 44-88% of patients live in the 15% most deprived data zones as classified by the Scottish Index of Multiple Deprivation.

1. Developing connections with the local community - implementing inclusive patient engagement/community participation approaches to create or enhance existing patient/community participation capacity.
2. Enhancing workforce knowledge and skills - practice staff access education, knowledge resources or training on health inequality and health equity.
3. Proactive outreach and extended consultations - enabling proactive outreach and extended consultations with patients who are at high risk of physical or mental ill health due to poverty and inequality.

## **Purpose and approach of the evaluation**

In November 2023, the Scottish Government commissioned social research agency The Lines Between (TLB) to carry out a rapid evaluation of IHAGP. This report sets out the evaluation findings on how different general practices used IHAGP funding; the impacts of IHAGP-funded activity; and lessons learned from the programme. The findings will be used to inform decisions about IHAGP's future.

This report draws together a range of evidence. The main source of evidence is qualitative interviews with practice staff participating in the IHAGP programme between January and March 2024. A diverse sample of practices were initially invited to participate in interviews (See Appendix Three for further details of sampling approach and characteristics). However, due to low uptake, all 66 practices participating in the programme were later invited to take part in the research. The 9 practices who declined to participate in the programme also declined to participate in the research. A total of 23 staff members across 15 practices were interviewed for the research (16 GPs, 5 practice managers, 1 community link worker (CLW) and 1 pharmacist). In addition, 3 senior strategic stakeholders were interviewed to inform the background and recommendations of the report and to explore alignment with practice perceptions. Most of the interviews were individual and took place over video call, however there were also 2 paired interviews, 4 face to face and 2 over the phone. Overall, the heterogeneity of data collection approaches did not create any limitations or affect the analysis or reporting process. See Appendix Three for further details.

In addition to the interviews, the report is informed by a review of programme documentation and observation at IHAGP webinars, network and steering group meetings. All practices participating in the IHAGP programme were required to submit two monitoring forms to the Scottish Government (see Appendix Four) in September 2023 and January 2024, though many submissions were delayed. Where consent was given, these forms were shared directly with TLB and provided background to staff interviews. The Scottish Government also provided two anonymised summaries of the quantitative data and thematic analysis of free-text response from the monitoring returns which were drawn into the overall analysis.

Analysis and reporting took place during March and April 2024. The analytical team developed a collaborative and robust coding framework and the analysis was peer-reviewed. The report presents key themes reported commonly across practices, as well as views shared by individual or small numbers of general practice staff, to ensure all views are represented. When discussing findings specifically related to an individual IHAGP theme, the total number of participants varies across each theme. Therefore, phrases such



as most and many do not relate to a specific number, but a proportion of participants that are delivering activity under that theme. Where findings are not related to a specific IHAGP delivery theme, such as wider learning, phrases such as most and many account for the proportion of views across the population of staff that participated in the evaluation. Quotes have been edited for readability; some content has been removed or changed to shorten quotes or protect anonymity but the meaning has been retained.

In addition to the main report, eight case studies have been produced to highlight key themes and lessons in more detail at the practice and activity level (Appendix One). Appendix Two provides a breakdown of the acronyms and abbreviations used in the report. Further details of the methodology are also included in Appendix Three and evaluation materials in Appendix Four.

## **Data limitations**

Participation in the research among general practices was lower than hoped due to a lack of capacity within practices and the short timescale for the evaluation. Interviews were conducted with a self-selecting sample and likely reflect the views of practices with the highest capacity to engage with the programme and may not be representative of all practices' experiences. The extent to which changes reported are attributable to IHAGP (especially as some practices have invested additional funding from other sources into their projects) is not always clear.

Additionally, non participating practices did not take part in the research. They had been invited to take part- to explore barriers to engagement, and whether any changes could be made to the programme that would enable or encourage participation. However, no practices took up the offer and the report therefore does not present any findings in relation to this.

Furthermore, the evaluation was not able to directly engage with patients or staff outside primary care, due to the time constraints for delivery of the evaluation, and the timeline involved in gaining the required ethical approval. Therefore, findings presented in this report relating to outcomes for patients and the healthcare system are based on perceptions of general practice staff.

## Chapter Two: IHAGP engagement and activity

This chapter provides an overview of programme engagement and activity. It covers practices' aspirations and motivations for engaging with the programme, the number of participating practices, types of activity, and rationale for delivery against specific themes.

### Aspirations and motivations for practices

Reflecting on their motivations for involvement with the IHAGP programme, practice staff expressed a personal interest in addressing health inequalities. Many noted that they see daily manifestations of inequalities, which have widened since the pandemic.

At a broad level, many welcomed the opportunity to explore the impact of enhanced preventative and inclusive healthcare approaches, and how they might contribute to wider change. For example, some hoped to test new approaches and expected the learning within practices would inform others; one hoped that the programme would demonstrate the cost and resource implications of activities such as extended consultations and make the case for additional funding to be allocated to GPs in deprived areas to allow more time with patients who have complex unmet needs.

Some viewed the programme as an opportunity to validate, resource and build on work they had already begun, either through involvement in programmes such as the Deep End GP Pioneer Scheme, the Govan SHIP Project or work by the Scottish School of Primary Care. Others described it as a way to continue self-instigated approaches to shift from reactive to more preventative models of care.

“I suppose a lot of it is about capturing what we're doing, but also kind of validating what we're doing as well. So I suppose I always felt a little bit worried, you know, externally it would be seen as not a good use of time that I was spending all this time with just one person. But actually what this programme allowed me to say is, oh, actually what I'm doing is a thing that you're meant to do. It just kind of validated a little bit that it was OK to do that and it was the right thing to do that as well”

A few mentioned local leaders and inspirational colleagues who championed the opportunity and motivated others. While many reflected on the programme's potential as a catalyst for change within practices, linked to enhanced capacity, better understanding, improved approaches and upskilling through training, others focused on the direct impacts on patients. They viewed the resource as an opportunity to offer enhanced services, identify patients' needs, and widen their reach within communities.

“We have such a big population of people where language [and] cultural differences are a real barrier. Our receptionists... don't necessarily understand some of the cultural barriers that, I'm going to say particularly women coming into general practice will face, so that was something that we had a bit of a focus on.”

While participants were highly motivated, many expressed caution about what could be achieved through IHAGP due to the limited funding and timescales; one interviewee described the need for realistic expectations. Another reflected that IHAGP might not make a significant difference for existing patients, but it could deliver and inform approaches that prevent worse outcomes for patients in the future.

“It's a small first start. I think our health service does not reflect needs. It's very demand-driven, very reactive and very failure-driven. We spend huge amounts of money downstream when we should be investing much further upstream... It doesn't fill the gaps at all, but at least it's the first step in recognising there is a gap and recognising the GP practices can help to bridge that.”

### **Number of participating practices and breakdown of delivery**

The majority (66 of the 80) of practices invited to take part had opted in by December 2023. Most practices (46) were delivering activity under one theme, 16 were delivering against two, and three practices were delivering activity across all three themes.

Monitoring data as at December 2023 demonstrates that eight practices were working on theme one (patient engagement and community participation), 24 practices were delivering activities related to theme two (enhancing workforce knowledge and skills), a decrease from 35 in August 2023, and 52 practices were delivering against theme three, (proactive outreach and extended consultations), an increase from 32 in August 2023.

Some intersections between themes emerged; for example, one practice which had received funding for theme two delivered training for their admin staff around signposting for wider needs. This activity is expected to encourage patients to join some of their patient groups and therefore contribute under theme one. Similarly, another practice reported that staff attendance at a patient participation group enabled staff to identify and address unmet need in certain groups and arrange follow up appointments that otherwise might have been delayed or not happened. This activity also aligns with and contributes to theme three. Another practice combined themes one and three by engaging with their local women's group to understand why people often do not attend smears and breast screening appointments, particularly for women who use drugs and/or alcohol, do not speak English as a first language or have trauma/mental health issues. The surgery and women's group hope to work together to offer further information, engagement and open surgeries to encourage attendance.

### **Theme One: Building inclusive patient engagement and community participation.**

Over 200 patients have been supported with engagement and participation. Funding has been used for room hire and refreshments, activities and resources, and practice staff time to support community groups. Examples span walking groups, groups for men and women, peer support and practice-led patient participation groups. The funding has largely been used to support existing groups to reinstate, maintain or increase their activities. This is the least commonly chosen theme; practices which selected this were typically building on existing work in this area.

Furthermore, approximately 800 patients have been given the opportunity to provide feedback to help inform service development and improvement. In one example, a practice has used the feedback they received from patients to make improvements to their appointment system.

## **Theme Two: Enhancing workforce knowledge and skills for health inequalities**

Over 200 staff members, including a range of clinical and non-clinical roles, have been trained in health inequality and trauma-informed practice themes. Topics include suicide prevention; gender-based violence; drugs and alcohol; chronic pain; long-term disease monitoring and management; abusive behaviour; data management; conflict negotiation; and medical coding. This includes practice-wide sessions and protected individual learning time with funded backfill, with examples of training being developed and delivered internally, as well as the use of external organisations. This is the second most commonly chosen theme; motivations included recognition of the scope to improve the practice culture so that staff are more accommodating and understand patient needs and experiences, and for upskilling to encourage changes in practice, policy and processes, and to create efficiencies and capacity within practices.

## **Theme Three: Enabling proactive outreach and extended consultations**

This was the most commonly chosen theme for IHAGP activity; practices described motivations such as awareness of missing patient groups and additional challenges and barriers for specific patient groups that cannot be addressed in standard consultation slots.

Approximately 7,000 extended consultations and outreach appointments have been conducted through IHAGP, with interventions involving staff across the practice. This is likely an underestimate of the number of extended consultations and outreach appointments as not all practices consistently record or report this data. Activity under this theme varies, spanning extended appointments, home visits, improved resources and navigation, and proactively contacting patients.

This activity has largely been targeted at specific patient groups including older people, those living in the most deprived areas, people with multiple or specific conditions, patients with multiple medications, those with a history of substance misuse, frequent attenders, and individuals who do not speak English as a first language.

# Chapter Three: Achievements and Outcomes

This chapter presents IHAGP's achievements and impacts on staff, patients and practices, based on the perceptions of practice staff interviewed for the evaluation.

## Achievements

A huge range of activity has been delivered through the IHAGP programme, as described in Chapter 2. When asked about achievements, practice staff focused on the changes they attributed to this activity; many described positive feedback from their colleagues about the practice's participation in IHAGP and felt it had contributed to a boost in morale and increased job satisfaction for some staff.

"Making it a whole practice project is really useful. Getting everybody involved, and letting them know what it is and enjoying it as well. Getting a bit of satisfaction out of it. For the doctors to be able to start enjoying their jobs, you know, enjoying what they like to do. Spending time with their patients, making their patients better, has been really good for them. So being able to enjoy it as well has been quite good for us. Otherwise, I don't think we would have kept going with it as long as we have."

Staff delivering patient engagement activities reflected that these groups create a forum for peer support, promote self-management, tackle isolation, and can reduce the demand for appointments which stem from loneliness and factors other than clinical need (see Case Study 2: Extending and strengthening activity to address health inequalities). Staff valued the time they were able to spend with community groups, finding it provided an informal environment to gather feedback and interact with patients.

Some of those working on skills and knowledge described changes in culture; for example, noting that staff were more tolerant and compassionate after training, or that practitioners had developed greater skills, leading to more efficient and effective patient care (see Case Study 3: Training). Examples of changes to policies and new approaches to patient contact and engagement were shared. Across several practices, a whole-team shift was attributed to shared training and a practice-wide commitment to new approaches.

"Health inequality is just not something [we talked] about with reception staff before. They would come and say, '[patient] just gave me an absolute mouthful; they've been rude and they told me to f\*\*\* off'. And I would always say, 'Right, OK, that person's got really significant mental health problems, I don't think that they meant that at you personally'. And [before] they would have probably said, 'you're not supporting us, you should have put that person off the list'. And now this is giving them a bit of insight as to why we respond the way we do."

Under the outreach and extended consultation theme, achievements included breakthroughs with patients linked to greater time, rapport, trust, and improved understanding by patients of the healthcare system and their own healthcare needs. Staff described contact with people with a history of non-engagement with the practice, or progress for those with complex health conditions or those new to the NHS, leading to changed behaviour or better treatment and care.

“They're just maybe not used to the NHS because they've never had an NHS. So they sometimes don't know what some of your role is actually. Or they're used to a system that's more privatized. You need more than a double appointment because it's actually explaining, ‘no, that's not how it works. This is my role and here's what happens next. You see the specialist after me if I think it's appropriate’. I mean, there's a cultural difference but there's a sort of health literacy difference of how the systems work. Like I saw someone who's not a perfect English speaker, and they had no idea that out of hours services existed. So those sort of things can lead to poorer health outcomes because they might have waited until Monday, you know? There's a cultural difference. And a slightly subgroup of that is the asylum group, they definitely have complex health needs. More than just their language, they are a complex group that require more time.”

One explained that through closer contact with patients they had become aware of, and helped patients overcome, barriers to accessing other medical services with opt-in models. Opt-in models could act as a particular barrier for their practice population.

“We've referred patients onto mental health services or other things where they've got an opt-in. We phone the patients to say, ‘listen, you still want to be seen; you need to opt in to the service. I would do it now’. We give them a phone number because we've also found that sometimes the patients haven't received the letter and then they're discharged from the service. Or they're told to respond in seven days [on a letter] dated the 6th. They received the letter say on the 8th. That's not giving a lot of time for somebody to respond back. So it's good that we get an electronic copy sent to us for us to be able to help improve patients' engagement.”

Several staff noted changes to systems and processes that the practice introduced, enabling them to better understand and accommodate those with access barriers, and identifying who to offer extended consultation to. A number of practices reported changes to their ‘did not attend’ policies, shifting from a punitive approach to one which was more considerate of their patients' circumstances.

“It's definitely impacted on how we send letters. Instead of saying ‘this is your second DNA [Did Not Attend] - the next one you'll have to find another practice’, we're adding a comment around, ‘if you're having issues in coming in at certain times of the day please call us and let us know’. It's not as harsh as it was before... we're trying to get a better understanding. Because there are patients that regularly DNA we want to try and find out what's going on with them, is there support that can be put in in another area, does the link worker need to get involved, you know this sort of thing.”

Examples of wider achievements include greater use of outside resources, such as specialists, other health partners, and universities, to access additional capacity, resource and expertise. One staff member noted that IHAGP activity had provided further justification for continuing funding for community link workers, stressing the integral role that this resource played in supporting proactive outreach and community engagement activity. Another highlighted the contribution of IHAGP in supporting students' learning about working with patients in areas with high levels of health inequalities and social challenges such as poverty.

“Our pharmacist has started getting dietetic students to talk about diabetes [at patient groups]. And it's been really eye-opening for the students. I'm not sure the kind of dietary stuff they talk about with our patients is quite what they get taught at Glasgow University. So I think it's been more an education for them than it has for the patients”

Several mentioned the value of IHAGP seminars in developing knowledge, sharing resources, and building relationships with other practices working to support similar patient populations. One believed their work might influence activity at a senior level in the Health and Social Care Partnership (HSCP).

“A lot of what we see comes down to how poorly nourished our patient groups are. And GPs have probably got a big role to play in shouting about that. I've been banging my drum about that for a long time. Finally, there's going to be an HSCP meeting in a couple of weeks' time about changing things. Now, I don't know if it's going to make any difference. But I suppose [there is] that bit about GPs having leadership roles within communities and being listened to at leadership level.”

### **Outcomes for staff, patients and practices**

Practice staff noted that participation in the IHAGP programme had contributed to a boost in morale for some staff and had increased GPs' time with patients targeted through their activity. Some staff reflected that additional staff capacity had reduced the guilt and anxiety they experienced, as they could now provide patients with the time they needed. Before the IHAGP funding, unsustainable workloads and the need to work additional hours to catch up were described. Some practices also reported greater satisfaction for administrative staff as they felt they were making a more direct contribution to improving health outcomes. Some described observing a shift in patient behaviour when they were able to feel heard and had their needs met.

“We have more GPs on over the week and it's better. The workload is better. I don't feel guilty about offering [extended appointments] - this person does need doubles because they're really complicated and it takes time. I don't feel guilty about that because I'm doing a better job, but I don't now feel like I'm depriving other people of appointments too. You know, it's, it's that balance.”

Some noted that training other staff to carry out a wider range of tasks reduced stress and created greater job satisfaction because they could focus on activities that delivered the most value to patients. Some practices also reported more efficient multi-disciplinary team (MDT) working, and increased team-working and collaboration through discussing and implementing the work together.

A small number of practices described changes to roles and responsibilities following training and development of new skills. One example of this is where healthcare assistants (HCA) in one practice have taken on clinical responsibilities that would normally be provided by the practice nurse. This involved the practice nurse writing new protocols, which were approved by the GPs in the practice. Training was provided for the HCAs, which has enabled them to assist the practice nurse with aspects of chronic disease management reviews and to undertake new patient medicals, for those first registering.

A few staff reflected that their colleagues had developed greater insight and understanding of patient experiences, which motivated them and helped them to feel supported in their role. For example, trauma-informed training supported a shift in thinking about patients' needs and helped staff to understand why an aggressive patient might not be struck off. Suicide prevention training reduced stress and anxiety when dealing with patients in crisis. Without training, these factors contribute to dissatisfaction and high turnover among those in patient-facing roles.

“Some of the trauma-informed stuff that we've done with the administrative staff is starting to filter through. You know like women coming into practice, being aligned with a female GP so that they can talk openly and there's not the same issues around chaperones and things. So, it is starting to filter through slowly.”

Several highlighted the impact of training on health inequalities, such as improving understanding and motivating staff.

“That statistic that people who miss appointments are eight times more likely to die is really powerful. And it's really changing how people see missed appointments. So people are now really much more proactive at coding them and are following people up and phoning them. And often they're not waiting for a protected clinic time - we each have a little bit protected admin time every week. So I regularly see people coding it as an outreach clinic, but they're doing it in their admin time to follow people up who haven't been to see them or what have you.”

Most practice staff were able to share examples of improved patient experiences and outcomes based on changes they observed and direct feedback they received from patients (see Case Study 5: Extended Consultation).

Views among those delivering patient engagement activities included feedback that patients are enthusiastic about the approach, more informed and empowered to make decisions about their healthcare, and feel valued and listened to. Staff also described improved uptake of a greater range of support, such as physiotherapy, other clinics, attendance for various tests, and information and resources. Engagement with the groups by practice staff provided opportunities for practices to identify and address unmet needs in certain groups and arrange follow-up appointments that otherwise might have been delayed or not happened.

Under the skills and knowledge theme, practice staff highlighted that some patients demonstrate a higher level of trust with staff who have participated in training; for example, more engagement with staff and fewer patient confrontations and complaints after staff completed trauma-informed training.

Among practices engaged in outreach and extended consultation activities, staff highlighted that patients generally found the proactive contact from practice staff important, and that successful engagement with a patient considered 'missing' or unlikely to attend often resulted in an appointment. However, some staff reflected that when they called patients as part of proactive outreach activity, they could initially be concerned or suspicious. Staff explained that patients were not used to being contacted in this way by their GP and described their efforts to put patients at ease, by explaining that the contact



was nothing to worry about and it was a call to check in and discuss their needs, (as illustrated in Case Study 8: Staff Reflections on Patient Care).

Staff in two practices noted that the extended consultation had allowed them to build relationships with patients with complex needs, resulting in improved engagement, better care continuity, reduced presentation at accident and emergency (A&E) and lack of escalation in health issues (see Case Study 1: Fernbank).

In monitoring reports, some staff noted impacts including increased patient understanding of their condition, positive lifestyle changes, better engagement with services, improved trust between practices and patients, increased uptake of screening services, and reduced hostility and aggression. Such shifts resulted in a “noticeable difference in many patients’ health and wellbeing”.

“Particularly things like chronic disease management, you know, they’re much more likely to engage in it if they do feel that it’s not just, you know, just us ticking boxes or whatever. When they feel that it’s individualised and that we’re looking on them as individuals and reaching out to them and wanting to help them, wanting to know what they feel, you know, wanting to hear their views, you know, I think that makes a big difference to them too.”

With better information, communication and planning, patients have more time to prepare for and engage with appointments. Stress and anxiety about interactions with the practice are less fraught because patients are able to access the care they need, and have faster access to test results, prescriptions and other information in accessible formats. Health professionals are less rushed, which can also contribute to better patient experiences.

“I would hope the patient will have a better relationship because they don’t feel rushed either. You know, when I feel rushed, they’ll feel rushed, we’re both stressed, it’s a bad combination. You’re only human, your temper will probably get a bit shorter with them or, you know, not as compassionate as you’d like to be.”

Some practices reported fewer missed and repeat appointments, reduced waiting times, and a decrease in A&E and out-of-hours attendance among some patients. Increased efficiency, capacity and continuity of care were also described as positive outcomes of the programme by some staff. The programme monitoring report noted that one practice has reduced its wait time for a routine appointment from two to three weeks to two to three days (though this may not be entirely due to IHAGP).

Overall, practice staff perceived the activity they have delivered to be contributing to increased accessibility to care and support, and to instances of improved health and wellbeing among those patient populations targeted by work supported by IHAGP.

# Chapter Four: Learning

This chapter sets out the findings on learning, identifying enablers and what worked well, challenges and barriers, and wider lessons about work to address health inequalities.

## What worked well?

Monitoring returns showed that many practices were already working on health inequalities, but that the IHAGP resources and support helped them to have a greater focus on, or expand work, in this area. This has resulted in resources being better targeted towards those with higher or complex health and social care needs.

“This programme has allowed me from time to time just to see how we step back and do things, I know they have to be done. But there's a list, 100 miles long, that comes up before it. And it's just brought it up to the top of the list.”

Across conversations, funding for protected time to plan and deliver IHAGP activity was identified as crucial. Staff also noted that willingness among team members to work in new ways was an important enabler. The programme monitoring report notes that practices are putting additional funding into this work from their main budget allocation, to enhance this resource.

Some staff emphasised the enabling role of the IHAGP programme. Many stressed the programme's significance as a driver for action. Some specifically valued the focus on three themes that shaped their ideas and activities. In these discussions some staff stressed that they felt the IHAGP steering group contributed knowledge, networks and impetus which they felt had encouraged participation in the programme and driven it forward.

“What I think is quite good is that we are given boundaries as in, these are what you can look at. I even asked, can we get an idea of what we can and what we can't spend it on?”

Several highlighted the value of data and digital tools. One described using tools to reinforce activity and encourage shifts in culture, for example, by sending daily reminders to follow up with patients who had not attended (see Case Study 1: Fernbank). Another described the role of technology in improved contact; reaching patients by phone and email instead of letter. They described this as a faster and more effective form of communication, and better use of resources (see Case Study 2: Extending and strengthening activity to address health inequalities). In another example a practice updated its text messaging system to give non-English speaking patients time to translate the message, and this has led to decreased missed and repeat appointments and time spent on the phone.

“We've also introduced kind of digital ‘asynchronous consulting’, I think is the formal term. So basically things like e-consult or online consulting where patients can send in the details of what's wrong with them and then we can decide what the best way of dealing with it is.”

Others used patient data to inform targeted outreach, either by self-directed review or deploying resources such as the Scottish Therapeutics Utilities tool<sup>2</sup>, or the CarePlus model (described in the introduction section of the report) to try and identify specific patient groups or those with the greatest need. One described using data to inform a multi-disciplinary approach, making better use of resource by having the right professionals present at the right time.

“We've started the coding process of marking these patients so that the data could be extracted and have set up our multi-disciplinary team meeting in a smaller scale on a monthly basis with these targeted patients, having a practice discussion about what we can do to intervene. [Using] the categories that we had in SHIP [Social and Health Integration Partnership] for example vulnerable children and families, the frail elderly, palliative care, impending crisis - that helps when we're having a structured meeting, for example our health visitors will be there when we're discussing the vulnerable children but there's no need for them to be there when we're talking about frail elderly.”

On recording and monitoring, one noted that IHAGP provided an opportunity to capture aspects of work that they had not recorded before. For example, they had previously met patients with complex needs outwith surgery hours because they would not fit in the booking system. Now, they have introduced a code to capture these appointments and gather evidence of the extent and nature of this work. Another noted the value of this data for planning and managing capacity during clinics.

“We wouldn't necessarily have coded our interpreter consultations before, and even though there are a lot of these patients who are in interpreter consultations, there are a lot of white British English-speaking patients who take a lot of time just because they have other deprivation needs. So that's been quite helpful to sort of to quantify that...it's good for say visiting doctors, or new trainees, or new doctors to come in and if they see that there's been a previous extended consultation they know then that they can book a double appointment so that it's not impacting on the rest of your surgery.”

Group development and facilitation by knowledgeable and passionate staff with excellent interpersonal skills was highlighted as an important enabler of patient engagement, and some practices brought in visiting staff for this expertise. One staff member suggested groups had the greatest chance of success if they built on existing networks.

Under the training theme, practices emphasised the importance of protected time for planning and review, identifying and prioritising training topics, identifying materials and trainers, booking the training and creating staff capacity to attend.

On extended consultation, staff in one practice described creating additional resource by involving medical students in data review, and working with partners in community and recovery services to identify missing patients. An interviewee from another practice described work to address language barriers that could restrict access to medication. They had started providing interpreters with information about pharmacy opening times and addresses, to inform patients where and when to go, and how to get there.

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<sup>2</sup> [Overview of the Scottish Therapeutic Utility tool](#)

## Challenges and barriers

Some practices were unable to create the additional capacity they needed to deliver their IHAGP-funded activity. In a few practices, reflecting their commitment to the programme, staff were working additional unpaid hours to deliver the IHAGP activity. The Scottish Government programme monitoring summary notes that two practices reported a reduction in capacity to support other patients in the practice, suggesting that resourcing is still not sufficient to meet need in some areas.

In some practices, staff highlighted difficulties in finding cover for training, noting a lack of available locums, and an inability to make a 'buddy' system for GPs work, due to overall lack of capacity in the wider primary care system. They reflected that this hampered their practice's ability to engage in outreach or whole-staff training events. This reduced the volume of activity or impact of training, because delivery in smaller groups restricted opportunities to learn from peers and took longer, stalling momentum. In these cases, training and other activity was often done on personal time, despite additional funding to cover this.

"We can't get locums. So it's just basically extra hours for ourselves and most of us don't have the extra hours to give. But obviously we did short term because we all recognised that this project was important."

Signposting to various training resources and organisations was provided to participating practices, however some staff still described difficulties in finding specific training on health inequalities. In these cases, staff had undertaken their own research and delivered the training themselves. However, they noted that the quality and impact may have been greater if they could have sourced something tailor-made, with specialist input.

"Being able to source good material for training has been quite difficult. I think actually having it delivered and having that opportunity for discussion would be great, absolutely great. I think people get so much more out of that. And then being challenged on how you put that into practice, how do you make this happen in your practice, how can you make a difference as a receptionist?"

Many highlighted challenges linked to IHAGP funding amounts and processes (see Case Study 6: Challenges and Barriers). The relatively small sums and short-term nature of funding was described as limiting the scale of activity, and a barrier to introducing longer-term interventions such as hiring new staff. One felt the programme was limited by restricting the number of practices invited to participate, noting that not all had taken up the funding. They felt that participation should not have been optional, and that other practices across Glasgow and further afield needed and could have taken up the opportunity.

"The way in which these things are funded, which is kind of short term with possibly longer is detrimental in its own right. We wouldn't run an accident emergency department like that or some of these big services with little bits here and there."

Some felt that time-limited funding discouraged participation in the programme or prevented investment in development activity, due to the unsustainability of any changes introduced.

“I suppose it was just trying to be realistic, because, the amount of money wasn't enough to really you know, you couldn't employ somebody off that. You couldn't. It's non-recurring. So you can't change a system. It had to be something that was going to be a sort of short term intervention. And so a lot of that I could tell was going to be around cultural change really more than anything else.”

One described difficulties with the new NHS Greater Glasgow and Clyde interpreter service. While this is not attributable to IHAGP, it impacted on the activity they were delivering.

“This newer service (interpreter) is more problematic. Sometimes you can get an interpreter, sometimes you can't. I was in a meeting with other Glasgow practice managers yesterday, and we're all having the same issues, and in fact one had an interpreter hang up just a couple of minutes into a consultation saying they weren't going to do it. So it creates huge problems and huge barriers for the patient which obviously is not good and not what we're trying to do.”

There was some negative feedback about IHAGP coordination. A few participants reported that clearer communication from the Scottish Government about IHAGP from the outset, and more information and suggestions about how funding could be used would have improved their understanding and enabled them to make better use of the resource. However, many stressed that this has improved as the programme has been embedded.

Practices also experienced wider system challenges. These included staff recruitment and retention, limited practice space, IT difficulties, and sustainability concerns, including short timescales and uncertainty around funding, with many practices investing additional funding from their main budget. The programme monitoring report notes that some practices described limitations in IT systems' capacity and flexibility.

One staff member reflected that complex areas of work, such as the introduction of trauma-informed approaches, require additional changes and resources that practices do not have the funding to provide. For example, staff may require access to clinical supervision and reflection sessions or further training on boundaries, stress management and safeguarding.

Some reflected on the particular challenges associated with the patient engagement theme, which were linked to the limited IHAGP timeframes. Another noted that buy-in and understanding were required and that some staff needed help to appreciate the benefits of enabling patients to connect with peers. They feared that some viewed patient groups as a way to disseminate information or consult about operational issues, rather than offering patient benefit. While it was not possible to explore this with all practices, these specific challenges may have contributed to low uptake of theme one activities.

“I think some of the constraints of the short-term limited funding programme are particularly relevant to [the patient engagement theme] because you can't set up something with patients or peer support group for a very short period of time, and it does need proper resourcing and it needs a bit of knowledge and expertise to do some of that.”

Those involved in proactive, targeted outreach stressed that this could take a significant amount of time; an afternoon on the phone might only result in engagement with a small

number of patients. While staff emphasised how resource-intensive this activity is, they noted the significant impacts on patients they successfully engage with (see Case Study 4: Outreach).

Some described frustrations and barriers linked to factors outwith practices' control, such as waiting lists to access different health services.

### **Key learning on implementing activity to address health inequalities**

Building on the enablers and addressing the barriers identified earlier in this chapter is key to implementing activities to address health inequalities. Practice staff reflected that the activities delivered through IHAGP effectively improved services, reached target populations, encouraged engagement with healthcare and prevented patient harm. Almost all described their usual day-to-day work as reactive and demand driven, and many believed IHAGP demonstrated the potential for practices to have a greater impact on health inequalities, given more capacity to upskill their teams and deliver proactive preventative work.

“I think it needs to be addressed from the root. There's no point in putting more and more money into secondary care because if it's not being addressed, you know, dealt with at the root, then you're on a hiding to nothing.”

Many reflected that IHAGP has achieved a broad range of positive impacts, such as improved quality of life leading to an overall reduction in demand for services for patients with better health. However, some noted that a proactive approach might trigger an increase in service demand by identifying unmet needs and demand among missing patients.

“It's probably one of my learnings from Stewart Mercer's work was when he did the CarePlus study. It wasn't that people that went through the CarePlus study got better, it just got worse more slowly than the people who didn't. And to a certain extent, it's I think it's something you have to kind of learn that there aren't any happy endings. You don't solve people's lives at all, but you can support people to keep well longer.”

Practice staff frequently described the health impacts of wider social stressors and systemic inequalities and injustice, such as poverty, job instability, poor nutrition, isolation and trauma. Insufficient funding and the need for preventative, community and population-level health interventions were emphasised. While positive about experiences with IHAGP, many viewed the funding and activity as inadequate in the face of the challenge. They felt these activities should already be resourced and embedded within primary care.

“A lot of what is recommended for doing in the programme is stuff that we know needs to be done and there's just not a moment in the day to do it. We spend our days firefighting and it would be so wonderful to actually really properly do absolutely everything. I mean, the whole approach to [identifying missing patients] you know, I would want to do that all, that's what we should be doing all the time. But we literally firefight the whole time.”

Some reflected that IHAGP activities will have an impact on some patients, but not all. They suggested that proactive and preventative approaches to address inequalities will reduce demand in the long-term, but recognised that a small group of patients absorb a significant amount of practice time due to mental health and trauma. These patients might

not engage with mental health support, or cannot access it because they don't meet the high thresholds for specialist services.

"We're all going to have people who, no matter how many times you see them, and however long you give them, these same people will come and see us twice a week, and we'll run late and we'll never make any progress, we'll never get them to realise the root cause of their issues is their previous trauma and something needs done about it. We can keep trying and keep trying, but nothing really makes a significant difference. So what we're trying to do with [IHAGP] is identify those people at a younger age to try and make the difference to prevent them from becoming these people who have such high need that is essentially always going to be unmet."

# Chapter Five: The future

This chapter sets out the appetite among practices for programme continuation, sustainability considerations, and potential areas of development.

## Continuation

There is a clear appetite for continuation of IHAGP across practices who participated in evaluation interviews. Many called for increased and recurring funding to sustain or further develop and enhance IHAGP activity.

## Sustainability

A common theme across interviews was that the activity delivered through IHAGP could not be sustained without continuation funding. While a small number identified aspects of change that they hoped to be able to resource and continue, many said the activity would stop without funding.

“If the money was to stop next year, basically, everything will go back to business as usual. I don't think it would achieve very much. There might have been a change in attitudes towards people missing appointments and a greater willingness to contact people. But no, this can't be done without resources. A little bit of money [cannot] change the world. This is... To me, this has to be the start of the ship turning round.”

Others noted that continuation without resource would require additional out-of-hours work which they thought would negatively impact staff job satisfaction and morale as well as their wellbeing, and would affect recruitment and retention.

Overall though, the potential for the impact of work already delivered by IHAGP to be sustained is variable. For example:

- In terms of patient engagement, patients participating in IHAGP activities may have experienced some lasting impacts through increased knowledge and connections. However, the value of these groups as a means to address issues such as loneliness, for example, will end if the groups stop. It is unlikely that groups will continue at the same level or scale without ongoing funding; they require facilitation by skilled professionals and resources such as venues and information materials.
- The culture changes attributed to IHAGP may continue while staff are in post, but retention is an issue in the medium to longer term. Without funding, there may not be scope to offer training for new staff, nor access to the shared experience that underpinned much of the commitment that has stemmed from IHAGP activity.
- New systems have been established in some practices. However, without continuation funding, extended consultations and proactive outreach are likely to end, or at best substantially reduce, because they are resource-intensive. As some staff noted, practices often used IHAGP funding to resume an activity which had been proven through the Govan SHIP programme. When that funding ended, the activity stopped.

## Areas for development



There were mixed views on the themes covered by the IHAGP programme. Some reflected that it broadly spans the areas they thought were most critical for their practices and offers sufficient flexibility to implement activities that work best in their context. A few suggested additional potential themes and strands of activity for consideration in any future rounds of the programme, namely:

- stronger links with partners and other professionals, such as pharmacists, social work, health improvement teams and community link workers, given the number of patients with complex conditions and lengthy medical histories.
- patient health literacy and education, noting the potential role of other services in helping people to understand their specific condition or how the health system works.
- patient populations which require intensive support, such as those with multiple comorbidities, chronic pain, refugees and people seeking asylum, or people with diabetes.
- specific missing groups; for example women who have never had a smear test, pre-teens, young people with adverse childhood experiences, or those over 85 with no recent history of contact with the surgery.
- social prescribing, boosting elements of patient engagement, which had the lowest uptake, and considering other ways to meet patients' needs.
- specific training across the programme, such as health inequalities, dealing with aggressive patients, and trauma-informed approaches.

“There's so much more that we could do from a sort of social prescribing, you know, peer support, patient support that would make a huge difference to people.”

Some practice staff reflected on ways to enhance capacity or help to tackle recruitment and retention challenges for practices operating in areas of disadvantage, such as doing more to encourage trainee GPs to consider working in these areas after they qualify.

“In X area we produce every year something like 24 newly qualified young GPs. So if we had the ability to approach them early on in their training to say once you're finished training, here is something that you might want to consider, working in X, and we would then have, particularly the 'Deep End' practices to say to start with, we would have a ready source of young GPs ready to basically give us the GP resource that you need for the protected time.”

A few highlighted that IHAGP could play a role in developing the future workforce, noting that student placements were a core feature of the [Deep End Pioneer Scheme](#), which evaluated positively.

The IHAGP networking webinars were valued by those who attended them and have informed some practice interventions and approaches. However, not all practices engage with this network and there is scope to increase efficiencies and enhance the

dissemination of knowledge developed through the IHAGP programme, including awareness of effective tools, services and resources.

“It's entirely transferable. I just pinched all the graphs off Public Health Scotland, it took quite a long time to put it all together. So [sharing this could] save somebody else doing the same thing.”

Practice staff are keen to learn, and would like greater access to examples of other approaches or uses of IHAGP funding.

“Have the practical examples or expectations all clear before sending out invites and cash. Since it started, there has been some stuff come round, trauma-informed care, [we also need] practical examples of how you can reach out to minority groups to improve their screening uptake... I think it would make a difference to engagement and people really say, right, that is something that resonates with me, we can try that. Rather than having broad themes where you're thinking, 'I'm not really sure what that means, or how are we actually gonna do that?’”

Some requested support for training, with the programme monitoring report highlighting feedback from practices for training to be organised and delivered centrally. However, while the monitoring report highlights the potential efficiency and capacity benefits, it also acknowledges the potential disadvantages of reduced flexibility and choice.

Given the reported impact of training on approaches, culture and patient experiences, there is value in considering wider changes to staff induction processes to ensure that all practice staff benefit from the learning.

While IHAGP is intended to act as a bridging mechanism between the current general practice funding formula and any future funding model which takes a fuller account of deprivation, there were several calls to expand the programme. Some practices also highlighted the potential of IHAGP to gather learning to inform other practices with similar patient profiles both within Glasgow and in other areas of Scotland.

“The government needs to sit down and say right we are going to do this as a national program specifically targeted at deep end practices in the country and it needs to be rolled out on a sustainable basis.”

However, one practice described it as a ‘drop in the ocean’, with limited reach in one area of Glasgow, and argued that it distracted from the wider issues that practices in deprived areas across the country face, including greater demand, widening health inequalities and ever-growing financial pressures.

“It lets people off the hook a bit with thinking this is all sorted, and I mean this at national level and the government level.”

The evaluation has gathered examples of practices capturing new data from activities delivered by IHAGP. There is scope to formalise and enhance this data capture, although this would require additional, dedicated resources. Further consideration is required of the potential for this programme to gather evidence of the value of preventative approaches in the long-term and the wider impact on health inequalities, patient outcomes, and demand

for health services. Any further evaluation of the impact of IHAGP should also address the gap in direct patient feedback.

“I would be keen to understand more about how it could be embedded into mainstream practice, and what the learning from this programme is around how we support, and how we support practices generally with changes around multidisciplinary team working, and what effective practice in areas of high deprivation looks like.”

Several argued that if IHAGP continued, the funding timescales should be lengthened to allow practices to fully commit and invest in the approaches.

“The difficulty I feel with this is how much effort do you put into something when it might disappear? When we only have so much time and effort to put into things, when there's still a lot of competing interest.”

One reflected on the commitment across practices involved in IHAGP, noting that some delivered more activity than others for similar levels of funding. If the programme continues there may be scope to explore this or set clearer expectations for practices.

Finally, there were suggestions that while the IHAGP programme is “better than doing nothing”, there is a need for a more ambitious reconfiguration of primary care funding to deliver transformational change. One suggested that IHAGP could play a role in this. They argued that practices should already be delivering the types of activity encouraged by IHAGP, and felt that the programme had the potential to capture more insight into the challenges and enablers to working in that way.

“What does it take to enable GPs to spend more time with the people who really need it, and how much more time, and what does that look like, and how do we start to track and quantify that, and then what would that take to build this into the way in which practices work every day? Because that's meant to be part of what practices are doing, and so for me there's lessons in there around how you look at the outcomes, and the value for money, and the practice activity as part of the normal GP contract, because that's the billion pounds, that's the bulk of what practices are paid to do and that's where I think the bigger gain comes in. This is how we can use this as a kind of trigger for supporting that change in practice through the rest of the system.”

# Chapter Six: Conclusions and recommendations

This report has considered how different practices have used their IHAGP funding, the impacts of IHAGP, and lessons learned. Much of the delivery during the 14 months of IHAGP has centred on extended consultation and outreach, and training and development activity. While some patient engagement has been delivered, this has been limited and tended to build on existing activity. The different challenges for practices undertaking activity in this specific area have been identified.

The first 14 months of IHAGP have produced important learning on the value of the approaches across all three strands. Each practice has implemented its approach in different ways, depending on their individual contexts, systems, resources, staff and priorities. Early lessons include the need for practices to have protected time to plan, identify priorities and delivery mechanisms, to have capacity for delivery, and to have access to examples of approaches taken by other practices.

Clear successes have been captured. Patient support groups enable peer support, promote self-management, tackle isolation, and reduce the demand for appointments. Enhanced skills and knowledge have contributed to changes in culture and new approaches, processes and working practices. Extended consultation and proactive outreach have led to contact with 'missing' patients and improved health outcomes for many individuals, linked to a deeper understanding of patients' needs and improved patient knowledge of the healthcare system and their own role in health improvement. Positive impacts on staff morale and satisfaction have been identified, including validation of their efforts to address health inequalities.

There is an appetite for the continuation of IHAGP. Consideration of how to build on what has worked well, and maximising the enabling factors while addressing barriers can inform future programme planning. Factors which have supported IHAGP include the resources, support and enabling role of the IHAGP programme, data collection and analysis, the use of digital tools, input by knowledgeable and passionate staff, and creation of additional resources, for example, by involving medical students. The main barriers were difficulties in finding staff cover, lack of access to training providers, limited funding amounts and short-term timescales, IHAGP communication in the early phases, and the time required for activities such as proactive and targeted outreach. There remains a gap in understanding the experiences of practices which did not take part in IHAGP. The evaluation therefore did not capture insights into how the barriers to adopting the programme could have been reduced or overcome.

Some practices were unable to create the additional capacity they needed to deliver their IHAGP-funded activity in full, and staff worked additional unpaid hours to help ensure the delivery of programme activity. A few found that committing resources and time to the delivery of IHAGP activity reduced their capacity to support other patients. There were also some observations that patients could be concerned or suspicious if they were contacted as part of proactive outreach, though these were overcome through subsequent conversations with patients. Through closer contact with patients, some practices identified

barriers to accessing other medical services and found ways to navigate these. There was some negative feedback about IHAGP coordination, particularly in the early phases, and some reflected on IHAGP within the broader context and argued that it distracted from the wider issues that practices in deprived areas across the country face.

Activity delivered through IHAGP is unlikely to be sustained without continuation funding and the potential for the impact of work already delivered by IHAGP to endure is variable. While there were many references to the vast scale of work to address health inequalities, and discussion of the factors outwith practices' control, there is no doubt that more could be achieved if the programme continues. With greater funding and longer timescale commitments, the learning and impacts generated by IHAGP could be significantly enhanced.

Participants indicated that the IHAGP themes are appropriate, although challenges in delivering patient engagement activities were noted. Additional themes for consideration include stronger links with partner agencies, patient health literacy, patient populations that require intensive support, specific missing groups, social prescribing, and the provision of specific training for all practices. Some practices have found ways to enhance capacity, which could be replicated in the future, enabling IHAGP to play a significant role in developing the future workforce. IHAGP networking webinars were valued and there is an appetite for continuation of these to build a community among Deep End practices, for ongoing development, and as a route to access examples of uses of IHAGP funding.

Recommendations for the Scottish Government:

1. As a minimum, for continuation funding to be sought for IHAGP.
2. For acknowledgement that the rapid evaluation findings make a case for greater investment in the programme over longer timescales.
3. To build on the findings about enablers and barriers and use these to shape future iterations of IHAGP.
4. To consider and respond to the suggestions on additional themes and strands of activity in any future iterations of IHAGP.
5. To involve other partners who can play a role in addressing the unmet needs identified through IHAGP; for example, gaps in patient health literacy.
6. For ongoing case study development to capture examples of approaches which can be shared more widely.
7. To disseminate the knowledge to practices working with similar patient populations across Scotland.
8. A focus on longer-term monitoring and evaluation is needed to evidence the impact on practices and patients, and the benefits for the wider healthcare system.

# Acknowledgements

This evaluation has provided valuable insight into ways in which practices have used IHAGP funding, the impact of the funding and the challenges and barriers that practices have experienced.

We would like to thank all the practices and staff who completed monitoring forms and took part in interviews to inform the findings. Without their participation it would not have been possible to capture the valuable learning that has been generated. Furthermore, we would also like to extend our thanks to the members of the IHAGP Steering Group for their input and support throughout the evaluation.

# Appendix One: Case studies

## Introduction

In March 2022, the [Short Life Working Group on Health Inequalities in Primary Care published a report](#) that recommended that the Scottish Government create a new 'enhanced service' to provide general practices with increased resources targeted at deprivation. In response to this recommendation, the Scottish Government worked with stakeholders to develop the Inclusion Health Action in General Practice (IHAGP) programme.

IHAGP provides individual practices in the most deprived areas of Greater Glasgow and Clyde with funding to undertake specific areas of work to help to prevent health outcomes worsening for people with the greatest need and/or proactively engage those who need support to manage their health and social circumstances. The funding provided through the programme can be used to support activity under one of the three IHAGP themes:

- **Developing connections with the local community** –to create or enhance existing patient/community participation capacity.
- **Enhancing workforce knowledge and skills** – whole practice team access to education, knowledge resources or training on health inequality and health equity.
- **Proactive outreach and extended consultations** – enabling proactive outreach and extended consultations with patients who are at high risk of physical and/or mental ill health due to poverty and inequality, and who are frequently 'missing' from services.

The eight case studies in this Appendix illustrate the work carried out as a result of IHAGP funding. Each case study has a different focus:

- Case Study 1 explores a whole team approach to service development.
- Case Study 2 shows IHAGP funding used by a general practice to extend and strengthen activity that aligns with each of the three IHAGP delivery themes.
- Case Study 3 summarises findings from interviews in seven practices that have invested in training and development to enhance workforce knowledge and skills.
- Case Study 4 is based on interviews with staff in three practices that have used funding to encourage proactive engagement with patients.
- Case Study 5 outlines approaches to providing extended consultations for patients with the greatest need, based on interviews with staff in ten practices.
- Case Study 6 presents the challenges and barriers faced by eleven practices.
- Case Study 7 is based on interviews with staff in three practices that have used funding to deliver patient engagement work.
- Case Study 8 presents examples of staff experiences of engaging with patients through IHAGP.

Please note that this work is based on interviews with staff and does not necessarily represent patient experience. Some quotes have been edited to protect anonymity.

## Case Study 1: A whole team approach to equity-informed service development

### Introduction and context

This case study is based on an interview with the Practice Manager at Fernbank Medical Centre. The practice is delivering IHAGP activity under the theme of extended consultation and outreach, taking a whole team approach to make this effective.

Fernbank Medical Centre is based in Springburn, Glasgow and has a patient list of just over 5000. The practice has a young patient population notably young males and young families – from its work with asylum seekers and refugees.

“We do have children and older people, but a big chunk of our practice is aged between 20-40. We have two doctors, one advanced nurse practitioner, two practice nurses, a health care assistant and three receptionists.”

It was explained that the practice tends to have less frequent contact with a younger patient population, compared to an older demographic. Furthermore, asylum seekers and refugees who are not in stable accommodation often live transient lives, moving to different areas, and having to register with a different practice.

“Having the younger patient population, you don't have as much contact with them as you would the elderly population..... So say the average patient contacts a doctor maybe about four times a year, we can have patients that we just never see from one year to the next. Quite a high number of those in that age range, and we had a lot of movement with asylum seekers as well, so they were constantly moving.”

### Motivation to join the programme

Staff at the practice recognised that while they were already working to allocate the right time to the right patients, the programme offered an opportunity to focus on this approach. They sought to formalise this culture within the practice and encourage the whole team to adopt it.

“We felt that we probably already did a little bit of this work without thinking. So we thought it would be good to have the time to build on it and take it a bit further.”

“[Doctors] just want to see their patients. They don't want the admin side of things - they just want to see people and to have the time to spend with them because sometimes they're under enormous pressure. If they've got a queue of people waiting, I think they feel a lot of the time they're basically just fire-fighting.”

### A whole team approach

The IHAGP funding has paid for extra staff hours and allowed the practice to introduce extended consultations for some targeted patients with higher level of unmet needs. While extended consultations are normally provided by a GP in the practice, depending on patient need, sometimes this can be carried out by an Advanced Nurse Practitioner (ANP).

“So we have given [the ANP] an extra session per week....and [the ANP will] either do a normal clinic, and [GP in the practice] will see some for long consultations, or sometimes [the ANP] will, depending on the patient.”



Identifying patients who would benefit most from extended consultations was the responsibility of different roles, with the practice taking a whole team approach to this. One component of this was working alongside medical students who were keen to undertake project work to help in the process of identifying patients who had barriers to health care.

“They identified a lot of patient groups that were DNA’ing [patients who ‘did not attend’ appointments] quite often, and people that we hadn’t thought of that weren’t accessing health care.”

Across the team, the administrative tasks of trying different ways to engage with patients to maximise take-up have been an important enabler in the project’s success. There are clear examples of adopting new approaches to more effectively establish contact with patients.

“Admin, researching what patients have to be called in, taking time to work out things like that, lettering them, contacting them. Sometimes you can spend time having a conversation with one of them first of all, encouraging them to come in, and reassuring them. So all these things will take time... we’ve got that time to spend on these things now. That’s where the bulk of our funding has gone.”

“We’ve been finding different ways of contacting the patients...phone calls, texts, emails...we had a patient who just would not communicate with us at all but we managed to get them by email - somebody we had not had contact with for a long time and were quite worried about - they had a lot of health issues and had suddenly started to depend on A&E. Now we’ve got that managed, and they’ve got a way to contact us that makes them feel comfortable. To have the time to do things like that, it’s been really enjoyable and it’s really benefited the patients.”

The whole staff approach required new ways of working; providing timely electronic reminders was one helpful method of creating and embedding a whole team approach for an evolving culture.

“When we first started, we were just a bit unsure about how to get going with it... I sent wee reminders to our electronic system especially at the start of the clinic: ‘remember anyone that you feel is suitable’ or, ‘refer their name on to me and I can get in contact with them’.... Now I think we’re more into the swing of it and we can remember, so even the admin staff are saying, ‘Mr so and so, he was on the phone, we’ve not seen him for a while - do you think he would be suitable?’”

Work like this has helped to raise awareness of those who are ‘missing’ and embed the new approach across the wider primary care team. For example, community link workers and addiction support workers have also been involved in identifying patients who would benefit from extended consultations.

“It’s also helping us identify more patients for our community link worker. So [the community link worker is] quite heavily involved and [has] been identifying patients that are suitable for it. Our drug worker as well has identified quite a few patients who we weren’t aware of struggling with their health, but were almost afraid to come to the doctors in case their medication changed or stopped.”

Communicating the benefits experienced by patients has also been an important component of the whole practice approach. When staff hear encouraging stories resulting

from the new way of working there is more of a team approach to enabling better patient care.

“If a receptionist refers somebody and it turns out it works quite well and it's a good referral, then speak to the rest of your staff about that - it makes them feel more confident about mentioning it as well. Definitely, making it a whole practice project is really useful.”

#### Deeper insights into patient healthcare needs

The additional time created through IHAGP enables a fuller, more open conversation about a patient's life. With more time there is an increased likelihood of the patient raising the issues that really matter to them, and of the doctor gaining a greater understanding of the patients' wider circumstances to enable the most effective treatments to be identified and agreed.

This new approach has resulted in improved care for many patients, including those referred by reception staff, and positive patient feedback:

“A lot of doctors will tell you that patients don't tell you the most important thing that's going on. You know, they'll start with their sore toe and the mark on their arm and an average consult is about 10 minutes. So you could be in for 15 minutes and then they turn around and tell you this massive thing that's going on with them. When it's an extended consultation, they can relax, [doctors] can talk to them and ask them about other things that are going on in their life, not just medical issues - they can find really out important things that are affecting their health. And they can take time to consider all different options and the best treatment for that patient. It makes the patient feel that they've been listened to and taken seriously.”

“A lot of their health is improving, and it might be that they get a referral to elsewhere, but at least if we're listening to what's going on, we get the time to listen and we can send them to somewhere that can help them.”

“A lot of the patients are giving good feedback and quite a lot of it verbally, you know, coming over and saying, ‘It's been so good’, ‘I've been so well looked after’, ‘I felt I was listened to’, ‘I felt the doctor wasn't rushing me out the door’, and so that's been good.”

“One patient identified by one of our receptionists, hadn't been in for a long time, and was complaining about the practice, but we looked at it. They're not very good on the phone, you know, and we're doing a lot of telephone calls and not a lot of face to face appointments. They weren't sure how the system worked - we've managed to get them in... and they've left very, very happy and praising us.”

#### Benefits for staff

Staff members described feeling encouraged and motivated by the results of the new approach.

“The doctors have been expressing that they're enjoying it as well. They're getting a lot of job satisfaction out of it, and I think with the patients feeding back to them as well, you know, ‘thank you doctor’, ‘thank you for listening to me’, they get a lot of pleasure out of that as well.”

## Challenges and next steps

There are some challenges in measuring success in this area of work, but the practice is considering ways of doing this as well as targeting other groups using the methods already successfully employed across the team.

“Staff record all A&E attendances, so I'm going to look at a select number of patients who were frequently in A&E, and look and see, has there been a reduction?” I get the feeling that it's made a difference.”

“We have come up with more and more groups as we're going on and all the staff are involved in that. They're all in charge with identifying these patients. At the moment we're starting to look at over 45 males who never contact us...working men that just did not want to pursue a doctor...So we're constantly updating, constantly changing, constantly looking at different groups, so our numbers are quite high at the moment for our health inclusion.”

## Case Study 2: Extending and strengthening activity to address health inequalities

This case study outlines the way a general practice in Drumchapel has used funding from the IHAGP programme. The practice has approximately 5,300 patients, of whom about 65% live in an area of high disadvantage, as classified by the [Scottish Index of Multiple Deprivation](#) (SIMD).

The practice was one of the few that utilised funding across all three priority areas: patient engagement, enhancing knowledge and skills, and outreach. This breadth allowed some flexibility; while work to address health inequalities predated the practice's involvement in the IHAGP programme, the funding was used to extend and strengthen this activity.

Funding enabled the practice to pay for:

- Staff time to attend patient support groups and room hire costs.
- Staff training on preventing suicide, attendance at a 'Refresh and Reboot' conference for the Practice Manager.
- Protected time for GPs, allowing appointments to be extended and for proactive outreach calls to targeted patients.
- More time with patients and less reliance on locums

IHAGP funding enabled the practice to spend more time meeting patients' needs. Staff said this meant they could widen their focus and work holistically; moving beyond the immediate health care issue to underlying issues. One GP highlighted:

"I think there's a lot more to helping people with physical and mental problems than just a prescription. Ideally, to do it properly and to be able to really make a difference to them, you need to have the time and be able to look at the psychological, the social, the support. If you've got the time to be able to spend with them and deal with the whole person, not just the one issue, that makes a huge difference."

Another GP noted that the smaller practice size compared to other practices had enabled them to deliver the programme effectively.

"I think it's enabled us not to be so reliant on locums. We have used it to pay for locum sessions, but they are quite hard to get. So, we've been able to provide internal locum sessions or use flexibilities in the system. So, it's definitely been an enabler in that it's removed that bottleneck, which is probably quite a barrier for quite a number of practices that are already feeling that they've got larger list sizes and work in a different way."

### Enhancing early intervention

Practice staff reflected the IHAGP programme enabled them to be creative, and consider the best way to improve patient outcomes and adopt preventative practices:

"There are patients who may have gone too far, and we can keep trying and keep trying, but nothing really makes a significant difference. So, what we're trying to do is identify those people at a younger age to prevent them from becoming these people who have such high needs that are essentially always going to be unmet."

The funding also facilitated more cost-effective ways to deliver preventative support, which included re-starting a patient support group that had been running prior to the COVID-19 pandemic but had stopped.

“The patients who went to [a community] group at the start were very much the people who we would see week in and week out with chronic problems we didn't have an answer to. When they were coming in to see us, it was more just for someone to talk to and a bit of support. And it's incredible how that group has now given them the support that they need. And that's meant that they need fewer appointments with healthcare professionals.”

#### Impact of the IHAGP programme on staff and patients

Protected time to address health inequalities has had a positive impact on staff morale and legitimised their focus on health inequalities.

“It can be the most satisfying job in the world when you've got the time to spend with people, and you feel that you can do it properly and go the extra mile with them. And it gets so frustrating when you've got the pressure of time and people are coming in with four different problems in one consultation and you can't do it properly. Absolutely, it's made such a huge difference.”

“It's good to feel validated, it's something that we've been doing for a while, and it adds to that validation, so that's been a wider positive impact for us.”

While the GPs cautioned the direct impact of IHAGP on patients was limited and perhaps intangible, some benefits were identified, for instance, potential avoidance of health decline, or improved patient engagement with treatment.

“Sometimes you feel you spend a lot of time and don't get anything back in terms of outcomes. And I think to a certain extent, it's an act of faith that there's evidence behind it to say that this type of working has better outcomes....I think it's something you have to learn; that there aren't any happy endings. You don't solve people's lives at all, but you can support people to keep well longer... It's what hasn't happened. That's the improvement rather than what has happened.”

“We can help, to a certain extent, with chronic disease management or mental health issues. But having the time to be able to spend with patients to explain to them and educate them so that they see where we're coming from, they're much more likely to engage with treatment and self-help if they understand the logic behind it. So, it's a case of trying to work with them, but that takes time.”

No negative or unintended consequences for the staff, patients, or practice were identified by those interviewed, and they expressed a desire for continuation funding to sustain the additional activity delivered through the IHAGP programme.

“I think it's been hugely beneficial. And I think it feels as though it's the tip of the iceberg that we've started, and it would be great if we could carry on. But as I say, I think the only way we would be able to do that would be with funding because there's not the time and the resources to do it without, with the demand that we're under on a day-to-day basis.”

#### Changes within the practice

Funding provided by the IHAGP programme enabled the practice to dedicate time to enhance data recording protocols and establish codes to identify patients who did not

attend appointments. This data was used to proactively contact specific groups, such as those considered to be at high risk:

“We could have patients that book for an appointment at 14:30 that don't turn up to their appointment til 16:30 because of something happening in their chaotic lives. So, we've never really recorded those DNAs...whereas now we're going to try and be a bit more proactive with them.”

The practice was also able to make better use of existing information; drawing on welfare benefit reports to identify patients who had not recently seen a GP, for example due to barriers linked to poor mental health. This allowed GPs to contact those patients and link them to other, more relevant, services (including the practice CLW).

“The next step is for me to say, ‘Look, I think you would benefit from this service. I’ll put you in touch with them’. It’s not a mental health problem in terms of what a doctor or a psychiatrist can fix. It’s you know, it’s years of social deprivation and entrenched health beliefs. And the link workers, from a social prescribing perspective, allowing them to maximise their potential, are going to have a much more effective role than I can really.”

An enhanced interface between staff and patients was also highlighted; for example one GP reflected on the value of the training for receptionists on suicide prevention:

“To give them the knowledge and the understanding that they can help the patients and react to them in a way that’s, you know, going to be okay from the patient’s point of view.”

### **Case Study 3: Equipping staff to tackle health inequalities**

This case study presents findings from interviews with staff in seven practices who have used the funding to enhance workforce knowledge and skills, by investing in training and development.

#### Rationale for training and development activity

Practice staff said that health inequalities are evident every day in their work with patients, but understanding of causes and manifestations varies. They viewed the IHAGP programme as an opportunity to develop a consistent foundation of knowledge and understanding about health inequalities, understand the impacts of health inequalities, and identify the range of contributory factors.

"I felt that the education, the training was the most crucial part if we were going to move forward as a practice. There's no point in putting initiatives in without staff having that level of understanding. So the first base had to be education."

A need for development opportunities to underpin improvements to patient experiences and support patients' wider holistic needs, was highlighted by practice staff.

"A lot of our admin staff for example deal with patients who have communication needs or financial needs as part of their day-to-day, but haven't really had any formalised training. So we're looking at improving people's knowledge and comfort in dealing with people with financial or deprivation issues."

#### Upskilling to transfer responsibilities between clinical roles

Staff upskilling has been prioritised by some practices to enable teams to transfer responsibilities between clinical roles and support service development. They noted this enhances skills and knowledge, creates capacity in other clinical roles, and contributes to a seamless and responsive patient service.

"We just wanted to make people more skilled in certain areas that would free up time higher up the hierarchy. It makes you more efficient if the right people are seeing the right people at the right time."

#### Approaches to staff development

Practices have focused on providing development opportunities for clinical and non-clinical staff. In some instances, staff have all undertaken the same training; in others, practices targeted specific areas of development at particular staff, depending on aims and priorities.

"Every so often people present agitated or distressed at the reception desk. So, they've had suicide awareness training and communication skills training, just to try and make it a better interface between the public and the practice, both from the patient's point of view and the receptionist's point of view."

In some cases, a blend of bespoke training has been developed by practice staff in addition to drawing on existing materials and opportunities. There has also been variety in training delivery, including sessions led by practice staff, self-led learning through online modules, and bringing in other individuals and organisations.

“I looked at organisations that delivered health inequalities training across Glasgow, contacted two or three, had no response whatsoever. So I'm no expert in health inequalities but I had to go away and do a lot of training, a lot of reading, a lot of looking at things so I could then deliver with confidence to the team so that's what I had to do.”

“We also got our link worker to do a session with us about what it's like to live on benefits. We had [external organisation] to deliver two workshops on stigmatisation.”

Staff explained that health inequalities are broad, which gives them scope for development activity across a range of areas that align with and contribute to the programme aims. This has been reflected in the wide variety of training and development activities undertaken, which include:

- Suicide awareness
- Conflict de-escalation
- Trauma-informed practice
- Understanding health inequalities
- Chronic pain and pain management
- Active listening
- Mental Health First Aid
- Active signposting and care navigation

The enabling influence of the programme

The main barriers to undertaking training and development activity were reported to be time, capacity and cost. Combined, these prevented practices from:

1. Considering, identifying and prioritising areas of training
2. Identifying and sourcing training materials and/or providers of training
3. Planning, scheduling, booking and coordination activities required to put on development activities
4. Freeing staff to attend training or being able to pay staff to attend on non-working days

“I think the main thing is that it's stuff that we would love to be doing all the time, but just don't have time.”

One practice explained that before the COVID-19 pandemic, practices had two to three afternoons of protected learning time each year where they would effectively close and focus on staff training and development. These stopped during the pandemic and have not been re-introduced which has also reduced the ability and opportunity for staff development.

The IHAGP programme has enabled practices to overcome these barriers in two main ways. Firstly, participation in the programme has acted as a catalyst for focussing and prioritising training and development activity related to health inequalities.



“This programme has allowed me to see how we step back and do things that I know have to be done. But there's just a list 100 miles long that comes up before it. And it's just brought it up to the top of the list.”

Funding is the second core enabling aspect of the IHAGP programme. Practice staff explained this was critical in freeing staff time and creating the capacity for the development of training resources, enabling staff to attend training, and/or planning and organising training and development activities.

“I think the biggest thing is that it enables us to have a different avenue for training the staff and getting the GPs available.”

“We held it last November, the second one through this IHAGP money, and again it was really successful. It's very difficult to get the staff away from work together, and we found that this was really successful. We utilised it to bond, and get the team working together, but also cover lots of different subjects that would enhance the team's skills.”

#### Achievements and the impact of enhanced workforce knowledge and skills

Overall, practices have been encouraged by the response and level of engagement in the training opportunities provided through the IHAGP programme. Staff described positive feedback from colleagues who have taken part in training, and perceive that it has helped to maintain morale, foster autonomy and demonstrate that staff are valued.

“I remember them asking a lot of questions, which is slightly unusual as sometimes these kind of teaching sessions they will all just sit there and go hmmm. You know, there was a lot of questions and they were quite surprised at things.”

In evaluation interviews, staff suggested that the development opportunities have helped to better equip practices with the skills, knowledge and confidence to meet their patients' needs. Some reported having observed changes in colleagues' approaches and practice when interacting with patients, demonstrating greater compassion, understanding and empathy.

“I think when people are coming in and they're feeling unwell or they're stressed or they've got social worries or concerns, understandably they're anxious. And if they don't get the answer that they want or can't get seen immediately or whatever, the receptionists bear the brunt of it. So it has been hugely beneficial to them to have that extra training so that they can see it from the patient's point of view, and they've got a better idea how to manage it. I think that's made a difference.”

A small number of practices shared examples of changes to roles and responsibilities and/or processes because of the training and the implementation of new learning. This included equipping healthcare assistants to take on new clinical duties, and in one practice, the implementation of a new approach to responding to patients who do not attend appointments, those who were ‘missing’.

“This allowed us to give them extra hours to take on this extra workload and extra training, so that they could support the practice nurse a bit better.”

“We're now trying to find out, you know, why can't you make it? Is there anything that we can do? So we're questioning things a little bit more. I think sometimes there was not an understanding of what the patients were going through that had health inequalities issues.”

## Case Study 4: Proactive healthcare in General Practice

This case study presents findings from interviews with staff in three practices who have used the programme funding to support outreach activity which is focussed on proactive engagement of patients.

### Outreach and the opportunity to be proactive

Practice staff reflected that due to capacity, their work is largely demand-driven and reactive; they respond to patients' needs as they present. The IHAGP programme provides an opportunity to be more proactive in identifying and contacting patients with a history of non-attendance who are often 'missing' from services or those who could benefit from a longer consultation or review.

"We spend our days firefighting and it would be so wonderful to actually do absolutely everything. I mean, the whole approach to missingness, I would want to do that, that's what we should be doing all the time."

### Targeting activity

Practices have taken different approaches in identifying patient groups to target through outreach, including patients who:

- Have missed a scheduled smear test
- Receive, or have applied for, Personal Independence Payments or Scottish Disability Payments and have not seen a GP for a period of time
- Are at an increased risk of falls
- Have missed medication reviews

For example, one staff member said:

"Obviously I look in these patients' notes and see when they last saw a doctor and we've got people claiming Universal Credit or Personal Independence Payment who haven't actually spoken to a doctor in a year..... so I've been keeping a record and actively seeking these people out in my outreach clinics because I think that they are really good candidates for this."

Through the development of planned, targeted outreach activity, the IHAGP programme has been a catalyst for more opportunistic outreach work. Practice staff explained they were now more proactive in following up with patients that have not attended appointments on the day, rather than waiting until they are identified through targeted work.

"And it feels like good use of time that I've added to outreach clinic numbers by proactively reaching out to the patient and finding out why they didn't come there and then."

### Enabling quality improvement and process development

One practice reported that the use of the Scottish Therapeutics Utility tool (which searches GP IT systems for patients on multiple, higher-risk medicines) was an example of quality improvement activity in their outreach work and it had enabled them to clearly identify patients that could benefit from targeted engagement because of the medications they are prescribed.

"So that was a good quality improvement activity that I was able to use my outreach time for using this new tool.... that is able to extract data from our prescribing interface to pick people out who are at an increased risk of falls or, anybody who's at potential harm for the combination of their medications, if you're on three or four different things that can thin your blood, that sort of thing."

Another benefit of carrying out the outreach activity, reported by two practices, is the development and introduction of a more consistent approach to recording and coding patients who fail to attend appointments and noting any follow-up undertaken. This was expected to better support future outreach activity and encourage ongoing proactive outreach across staff.

"We already had a system in place, but it's really beefed that system up and what has become systematic is recording. And when people don't come to see us, I think before, on the whole, we would just go 'thank goodness' and go on to the next patient. You can now really clearly see people are recording it and you can also see people are looking and you see little entries saying didn't attend, phoned the patient to find out what was wrong. Just there and then just using that appointment slot to phone them rather than just to say didn't attend. So that's been a change in practice. It's been quite interesting to see. I'm not saying we always do that, but we are systematically recording it anyway."

"The other thing that we started doing was actually being better at coding people when they don't come for appointments, because the evidence is showing that people who don't come for their appointments have higher mortality than other people. So we thought it was really important to start coding these."

#### Overcoming barriers linked to time and capacity

The IHAGP funding has been critical for practices in overcoming the time and capacity issues that prevent outreach activity from taking place. It has enabled practice staff to secure protected time to run outreach clinics or other outreach activities.

"I think time. Time, absolutely. That's the fundamental thing because it's very much been things that we've been keen to do as a practice over the years, but time is of the essence and just with the demand that we have, even without doing extra stuff. So just having that protected time is hugely beneficial."

Two practices reported challenges with carrying out extended outreach activity. For one, the time to achieve even a small number of successes was seen as a challenge. However, practice staff still viewed it as a worthwhile investment of time, and making a positive difference.

"But it's a big time commitment for only a few. I mean, you might in the space of phoning people over two hours, you might only get to speak to maybe six or seven people. And out of those six or seven, you might succeed in getting three in. So it's a lot of time, but for those three people, it's really, really important."

Another challenge stems from the time often required after the contact to address patients' unmet needs and concerns. Aligned to this, GPs may find that aspects of meeting patients' needs is out of their control, for example, if they require access to a different service or form of support, and there is a waiting list for access.

"So it does take on a barrel of work afterwards. It's not just a nice simple have the phone call and things will be rosy."

"I have tried emailing the service to explain the severity of the person's situation. And they simply emailed back and said they're on a waiting list. There's nothing we can do, even though I'd ask them to upgrade it to urgent."

What difference does outreach make?

Practice staff said that proactive contact with patients has been well received. Those involved in outreach work note that patients respond to the contact, are happy to engage in conversation, and consequently become more likely to engage with healthcare services.

"And it's just nice to hear, people in those situations, for the GP just to randomly cold call them. People seem to be very receptive of it, just saying to them, 'We've just done a little review of people who might benefit from a phone call and your name's popped up, do you mind if we have a wee chat about certain things', and they seem to be really keen on it."

"And I think they are more likely to engage, particularly in things like chronic disease management, they're much more likely to engage in it if they do feel that they are important, that it's not just us ticking boxes. When they feel we're looking on them as individuals and reaching out to them and wanting to help them, wanting to know what they feel, to hear their views, I think that makes a big difference."

Practice staff described gaining further insight and understanding into the factors that influence non-attendance, as well as opportunities to address or minimise those barriers where they can. For patients, one of the main perceived benefits is gaining a sense that someone in the healthcare system is interested in them, their health and their wider needs.

Beyond this, staff provided a range of examples where successful outreach had led to patients attending the practice for tests, medicine reviews or general consultation to explore their health and wider needs.

"What was really important was that so many of them had said, but 'now that you're on the phone to me, I'll come'. So our phone call is really, really important."

"And I haven't been able to fix that other than to say somebody cares in the system and is willing to give you time and try and at least be with you in that way, even if I can't solve it."

"I think we've done a lot more in the way of polypharmacy, reviews of elderly people at greater risk and done much more in the way of stopping medications that they've been on for a long time that maybe they don't need now."

## Case Study 5: The role of time in addressing health inequalities

This case study presents findings from interviews with staff in ten practices. Each practice has used programme funding to support approaches to providing access to extended consultations for their patients with the greatest needs.

### Rationale for extended consultation

Staff across the practices described the range of health and wider issues and challenges faced by many of those in their patient populations. They also commented on how this can contribute to higher levels of demand and unmet need, and the importance of those in General Practice being supported and enabled to work in a way that can better meet those needs.

“I suppose it's really just need, there's an unending need for better care for patients and really this funding that we've been provided has been used to provide what we would see as better care, and for some of our more vulnerable patients.”

“I think there's a vast amount of unmet need and I think we're scratching on the surface at the moment, but I think it's definitely helpful because we have such high demand and such pressure on appointments. And realistically, if you're going to deal with the problem properly, you can only deal with a certain amount in one appointment. So to be able to have the time and the capacity to be able to spend a bit longer or, get patients back and focus on specific aspects has been very helpful.”

Staff in General Practice spoke passionately about wanting to do the things, and work in the ways that could have the greatest positive impact on their patients and provide them with the care and support that can help them overcome the various challenges they face.

“It's trying to be proactive in terms of doing things to try and help those whose health is adversely affected by their social demographic.”

“Govan is one of the biggest areas for deprivation in Glasgow. I think trying to enhance the experience for the patients is a key thing.”

### Making it happen

Practices described having extra protected time to plan and deliver extended consultation as being crucial and that partners in a practice were open to change and willing to adopt new models of working. Allocating more time was achieved through funding being used for additional hours for different roles, for example, a practice nurse to do some initial assessment work and medical tests before the doctor saw them, or locum time, which meant that there was an additional complement of GP hours.

“Time, absolutely. That's the fundamental thing - it's very much been things that we've been keen to do as a practice over the years, but time is of the essence and with the demand that we have, even without doing extra stuff, more often than not, we're doing reports and paperwork at home because we don't have time to do it during the day when we're here. So just having that protected time is hugely beneficial.”

Laying the groundwork for this work by identifying people who would benefit from appointments was an important early step. Involving clinical students on placement in the practice, as well as administrative staff in this process, eased the burden and created a

collaborative approach across different team members, in addition to being a valuable learning experience for the students involved.

“We've identified a lot of people that we thought would benefit from it. I would say we were quite lucky but we were actually quite clever. A few medical students are in working for us, well training. And they were looking for a project to hand back in to their tutors, and they asked if there was anything that they could focus on. And we suggested, ‘we've got this new project identifying patients who we find have barriers to health care’. So we tasked them with that, identifying these patients. And the results were quite surprising. I'm glad they did it because they were looking at it from a different view than I would.”

The catalytic influence of the programme, beyond that of additional funding, was also recognised, with it bringing about conversations and creating the space to think about how things can be done differently.

“It was not only funding which was great, but it gave us a reason to have these discussions and a bit of brain space that was almost like it was required of us because there was money given to us but it meant that we were having these conversations.”

Focussing activity where it can be of most benefit

Extended consultation activity has been focused on patients who are most vulnerable, at the highest risk, or would benefit most from having additional time with a healthcare practitioner. This has included:

- Patients living with mental illness
- Patients living with chronic diseases or conditions (e.g. diabetes)
- Patients with multiple co-morbidities
- Patients with drug and/or alcohol-related support needs

For example, staff explained:

“We have a number of patients who would have what we call a ‘personality disorder’. And so with personality disorders, one type is an antisocial personality disorder which basically means that they find it difficult to engage well with other humans just in general... So what we managed to do with the help of this funding is that we understand our patients who are like that. So what we can do is offer extended contact time with them and an increased ease of access for them to our service so that they can effectively be listened to or be heard or feel that they're being heard.”

“I had [someone] who doesn't often come... one of our methadone patients, and just to know that there's a little bit of extra time, when they came I could also do their bloods, for example, because they're just not going to come back...and it just allows you to offer a fuller piece of care.”

Several practices have also utilised extended consultations to support patients, who due to English not being their first language, face barriers to accessing healthcare and require additional support to understand and navigate the health system. This has included refugees and asylum seekers who have arrived in Scotland and been housed in the catchment area of these practices.

“A couple of years ago we tried to figure out how many people spoke different languages and there were 13 different languages spoken. Here is probably the most deprived area in Scotland.”

“So it helps with the translations, it helps to go over and reiterate that and agree that that's what somebody means. And usually you've got another member of the family when they're here as well.”

“We very frequently, several times a day, have to use the phone interpreting service and obviously everything takes double the amount of time for the same quality of consultation instead of it taking 15 minutes it then takes 30 minutes.”

### Benefits and Impacts of Extended Consultations

A number of different benefits and impacts were reported as a result of extended consultation activity for patients and practice staff. Firstly, staff reported an improvement in patient experience, which was reflected in the positive feedback they received from patients.

“So having this additional time which we can afford to give now has been really beneficial... a lot of the patients are giving good feedback and quite a lot of it verbally, coming over and saying, ‘it's been so good’, ‘I've been so well looked after’, ‘I felt I was listened to’, ‘I felt the doctor wasn't rushing me out the door’, so that's been good.”

Staff also explained that extended consultations provided the additional time needed to have more person-centred conversations and explore in greater depth the health needs and wider issues and challenges that their patients face. This included identifying other services or support that patients could be referred to in order to meet their wider needs.

“[Patient] had [multiple] different quite complicated issues to bring up...and I've not seen them for a while, and it just allowed me to have half an hour with them, which I think was quite valuable to be able to go into detail.”

“And it might be that they get a referral to elsewhere, but at least if we're listening to what's going on, we get the time to listen and we can send them to somewhere that can help them. We've been doing a lot of work like that.”

Some staff described positive impacts for staff, which mainly related to reducing pressure and increased satisfaction in the care they are able to provide. It was also reported to have provided valuable learning and experience for training practices that have trainee clinical staff.

“The doctors have been expressing that they're enjoying it as well. They're getting a lot of job satisfaction out of it, and I think with the patients feeding back to them as well, you know, ‘thank you doctor’, ‘thank you for listening to me’, you know, they get a lot of pleasure out of that as well.”

“We have very capable [trainees] in practice just now, so it's meant that their appointments have filled up more readily and so we've been able to backfill some of that and give them experience and supervision.”

Overall, staff perceive that extended consultations are helping to ensure that they can provide the level of care that can have a positive impact on the health and wellbeing of their patients.

“It's been really, really enjoyable and it's really benefited the patients. A lot of their healths are improving.”





## Case Study 6: Challenges and barriers to implementing IHAGP activities

This case study presents some of the challenges and barriers faced by 11 participating practices when implementing IHAGP activities.

### Funding

Most practice staff highlighted challenges linked to IHAGP funding amounts and processes. The low-value, short-term nature of funding was described as limiting what practices were able to achieve or a barrier to introducing longer-term interventions, such as hiring new staff. Some also felt that the non-recurring nature of the funding prevented staff from investing in development activity or taking up funding opportunities in the first place, due to the unsustainability of any changes introduced.

"The amount of money...you couldn't employ somebody, It's non-recurring. ... It had to be something that was going to be short-term... We did a project on looking for our missing smears....but long-term, it's impossible because we can't get locums to work out of the cities. So, it's just basically extra hours for ourselves and most of us don't have the extra hours to give."

"Sometimes GPs don't engage with opportunities... because historically we've had our fingers burnt with investing time and emotion in projects. Only to find that after a year or two, it gets snatched away."

Limitations with primary care funding generally were also raised. In this context, IHAGP funding was described as having minimal impact, used to deliver activity that should be happening anyway, or put towards pre-existing activity that was not adequately funded.

"Our health service does not reflect needs. It's very demand-driven, very reactive and very failure-driven. We spend huge amounts of money downstream when we should be investing much further upstream... (IHAGP) doesn't fill the gaps at all, but at least it's the first step in recognising there is a gap and recognising the GP practices can help to bridge that. It's very early days and it's still very insecure and fragile."

"The sort of stuff that IHAGP is doing...we should be doing it all the time, but there's just not enough resource for it at the moment."

Some explained that the changes they had introduced could not be sustained without further funding or highlighted their continuation at a cost to staff wellbeing, and in turn, recruitment and retention. There were calls for increased and recurring funding to allow practices to sustain or further develop IHAGP activity. Others suggested that although the IHAGP programme is "better than doing nothing", there is a need for a more ambitious reconfiguration of primary care funding to deliver transformational change.

"The GP is squeezed. It's a very perverse business model... It's then expected of us that we will do these things for reasons of compassion. And we do them for reasons of compassion. And then we reach burnout. And that's where you've got GPs hanging up their hats...and you've got a problem with recruitment."

"It feels as though it's the tip of the iceberg that we've started, and it would be great if we could carry on... But the only way we would be able to do that would be with funding - there's not the time and the resources to do it without, with the demand that we're under on a day-to-day basis."

"If we had the time and the resources to be able to deal properly with things in the community... [that would] have a knock-on effect on the number of people needing to attend secondary care... There's no point in putting more and more money into secondary care because if it's not being dealt with at the root, then you're on a hiding to nothing."

### Systemic barriers

Wider social stressors and systemic inequalities and injustice, such as poverty, job instability, poor nutrition, isolation and trauma, were raised as barriers to tackling health inequalities by some practice staff. The need for preventative, community, and population-level health interventions, with GP input, was highlighted.

"The retail sector are making an absolute fortune out of making the population ill... S1s were taught in the school down the road how to add boiling water to dried noodles, that was their cookery. The council are quite happy to let Fish and Chip shops get licenses directly across from school gates. So it's so multifactorial... If you go into supermarkets in the well-to-do areas... you'll have a lovely fruit and veg aisle. And in [our area], the first thing that hits you is chocolate and crisps and full-fat Coke. And they know what they're doing."

"A lot of what we see comes down to how poorly nourished our patient groups are. GPs have probably got a big role to play in shouting about that... I suppose that bit about GPs having leadership roles within communities and being listened to at leadership level... people just leave GPs to see the patients, but don't ever say 'what do you think needs done?'"

A few reflected, however, on the difficulties GPs face focusing on preventative activity in the current climate of high demand and funding and time constraints.

"General Practice has lost that... proactive stuff... maybe never really had it. It doesn't feel like there's a time to do a lot of that stuff. ... [For IHAGP activity, we have noticed the things] that aren't working... Community Treatment and Care's [CTACs] not working.... the struggle for appointments, and that's the things we've tried to fix.... But that's problem-solving, that's not being aspirational to try and improve health generally.... that front end stuff is harder to think about when you think 'that may be a lot of time I put into that'."

### Communication, support, and administration

Challenges linked to IHAGP programme communication, support, and administration were raised. Most commonly, participants felt they would have benefitted from better communication about expectations for participation in the programme and support with idea generation for IHAGP activities. Some shared that while the freedom to decide how to spend funding was appreciated, the parameters were so broad, it was difficult to know what constituted acceptable IHAGP activity or where best to focus their efforts. Others described initially being unaware that the funding could be spent under more than one theme or on an activity that the practice was already delivering.

"Quite a degree of confusion as to what was expected reigned for quite a long time. Maybe still does."

Suggestions to better support practices with idea generation and the practicalities of implementation going forward included:

- Publicising examples in newsletters to spread awareness of different practices' approaches to utilising IHAGP funding.
- Holding more meetings (in person or Teams) to discuss what others are working on.
- Linking practices with existing services that can support them with implementation, such as health improvement teams and community link workers.
- Having GPs in advisory roles able to offer guidance.

Further administrative and communication challenges included some practices not being notified when they had received funding. Communication was, however, described by the participant below as improving with time:

“Communication is improving. In the first half of the year communication was very, very poor. People didn't even know they'd received the money in some cases or didn't even know they were part of the programme. So that's definitely improved.”

Finally, a couple of participants also raised difficulties with forms. One found feedback sheets hard to fill in. Another suggested personalising monitoring forms to avoid repetition for those filling them in and that reviewers offer more feedback from these.

“I don't know if [monitoring forms] can be personalised a little bit for each practice to say, right you've given us this and we now need it for this.. because every email I've had recently...has had a blank monitoring form...and I'm thinking do I need to do that?... [And] I would like a little bit of feedback on what they thought and what I could be doing better.”

## Case Study 7: Patient engagement for peer support and service development

This case study presents findings from interviews with staff in three practices who used IHAGP funding to enhance existing community engagement work or support new activities to connect with their local community.

### Drivers of patient engagement activity

Those with experience in community engagement and facilitating peer support identified benefits for their patient population. IHAGP funding was viewed as a resource to expand or enhance this activity.

"That's something that we very much want to be able to expand because that can do far more than anything that we can give them medication-wise."

"Particularly [a community group] loneliness group, the patients who went to that at the start were very much the people who we would see week in and week out and really with chronic problems that we didn't have an answer to. And when they were coming in to see us, it was more just for someone to talk to and a bit of support."

Practices without direct experience also recognised the potential benefits of this type of activity. One staff member described a long-held desire in their practice to create patient groups, noting that IHAGP funding was the catalyst for them to take it forward.

"That's what I want out of this - just trying to make it, as a whole, a better practice so that we're more part of the community."

"For many years we've been working with social prescribing and trying to be proactive in engaging with patients. So it's very much something that we as a practice have been trying to do for a long time."

### Harnessing what exists or creating something new

Starting community engagement activity can be resource-intensive and daunting; however, one practice manager explained that working with and supporting existing groups made it more feasible and achievable. Another described a need to create something new, due to a lack of suitability of existing groups for specific patient populations.

"We just fed into that, with new patients every week, and we would go with the patient the first time just so that they were feeling they knew somebody. It's reassurance from myself, or from [colleague] or anybody, you're going to be fine when you go there, we'll go with you the first time and they've just all been going back."

"There is a lot of walking groups, some that can walk slow, some that can medium walk, some can fast walk, but the ones that were coming in with infirmities, with sticks and things, even felt when they were going with a slow walking group they were holding everybody back."

One practice reflected that the experience of carrying out community engagement generated awareness of other opportunities and possibilities for patient support.

"The more you do of it, the more you start to see other areas that you could work in. Obviously, the patient groups that we've started recently has been specifically focused on diabetics, but I think patient groups for COPD [Chronic Obstructive Pulmonary Disease] or some mental health issues, there's so many groups.....and again, that's another area that you think people with chronic pain and arthritic conditions. So I think there's so many, the more you start looking, the more you're going to see"

Involving colleagues and partners

Patient engagement has incorporated input from different staff and partner organisations who bring capacity, experience and expertise, achieving mutual benefits for those involved.

"Get community pharmacies on board or, you know, the local church or something like that. I found that far easier to do with that little bit of support. I think it's made a massive impact."

"We now employ some of our receptionists to go and help supervise at these meetings as well."

"Yeah, I think having [community link worker] is invaluable, because without them we wouldn't have that initial person going, 'do you know what, you would really benefit from this', and that trust is there already."

"I hooked up with one of the dietitians who's very enthusiastic and was great and she said if I was really interested in running a group, they would be interested from their side for their students. I could see a lot of benefits from that because they basically ran the group and I just got the patients and went along and it was students, it was a student-led thing. So the way we did it was we got, so I had two groups of patients and each group of patients was invited to two sessions, an initial session where it was a bit more about diabetes, and then the second session was more of a follow up and more about the practicalities and more free flowing..... So I just invited your normal Jo who has diabetes who tends to be, I was just thinking younger people are probably going to gain more from it in the longer term."

Involving or demonstrating the impact to others in the practice was also described as a route to change perceptions and gain wider support for patient engagement activity.

"Yeah, because if you can say to someone, you know, we've seen this person on the walking group, right? And before we've seen them on the walking group and they had that social aspect in their life, they used to come in practice once a month and they used an appointment, right? And I can then say, well, that person hasn't been in here in six months What do you think that says?."

Barriers to starting patient engagement activity

Practice staff shared their thoughts and experiences on the barriers to starting patient engagement activity, and two core themes emerged. The first related to knowledge and confidence in delivering this work. The second was uncertainty about the ability to sustain the activity due to a lack of clarity about continued funding.

"But things like more community connections, and going into the communities, bringing the services which are available in the communities to the health centre, and making patient

groups and getting them involved, sending staff to them, that would require ongoing funding.”

“I would say there's a lot of uncertainty, like what's coming through, whether it's an ongoing thing, I think it is easier to plan if we know. It's really kind of tricky to plan things, and we are not sure whether it's an ongoing thing or not.”

“I was maybe a bit overwhelmed at setting it up myself, you know, in terms of like resources, time, confidence, and you look at all this stuff online, there's lots of stuff online about groups and they talk about having a, let's call it a facilitator and the structuring, like there's stuff in England about all these groups. Well, they're very structured and it's all intimidating. If you're looking at that, you're thinking ‘how am I going to do all of this?’.”

The importance of resources to start and sustain activity

Having the capacity and staff resources to connect with existing groups or establish new activity is critical to enabling this area of work, however, funding is also a key factor in enabling and sustaining patient participation. This could involve providing funding for arts and crafts materials, or for example, paying for refreshments at the end of a walk for patients on low incomes who were taking part in a walking group.

“It really helped because we've got a lot of people who don't work, very low incomes....so we came back to the cafe which was costing them maybe two or three pounds for their tea, so [colleague] said, ‘we've got the funds why don't we use it for that?’, and then that kind of started...they came back more because, they weren't thinking, well it's my turn to buy a cup of tea for everybody this week.”

“So yeah, I mean it's really been a pleasure to watch that actually, and that wee bit of funding, it's not mega money it's just a wee bit of funding that backs these wee groups up, that's what helps the best.

What difference does this activity make?

Practice staff identified the benefits generated by patient engagement activity for:

- Staff members
- The Practice
- Patients

Benefits for staff include enjoying involvement in this type of activity, and observing the positive impacts for patients, which enhanced experiences of their role.

“The people that have all been coming, can now go in different places and the confidence you can see in them. That's where I get the joy of my job when you actually see your job's working, and that's where you see that the results are.”

Patient involvement has also contributed to service improvement, with groups providing valuable feedback on how things can be improved and enhancing patients' views on the practice and staff. Another benefit for the wider practice was shifting internal perceptions of how to support patients.

“And actually, you know, [groups] work as a good sounding board to get a realistic idea of how the patients view the practice and what they think we can improve on.”

"The patients do feel that the surgery's doing something else for them, apart from just giving medication. And this is all about their mental health as well, do you know what I mean? So all these things, you know, it makes a big difference to some of them coming into the surgeries."

"And I think building up the trust that we're here for something other than prescriptions helps us as well."

One practice highlighted that working alongside a university to deliver patient engagement activity provided valuable benefits for students by giving them additional real-life experience with patients that they would not have gained otherwise.

"The university, they're delighted because for their students, it's a real-life experience and the [sessions] went well and our patients who turned up were really engaged and there was a lot of chats and I think on all fronts, it was a very positive experience.

Practice staff described physical and emotional benefits for patients stemming from the activities undertaken in these groups and the crucial peer support that patients can provide one another. This was seen to contribute to a reduction in healthcare service use.

"A lot of them are saying it benefited their physical health but it also benefited their mental health just because they had someone to talk to."

"And, you know, the support that they've given one another and the self-esteem has been hugely beneficial to the people that attend these groups."

"And it's incredible how that group has now given them support that they need. And that's meant that they need fewer appointments for the healthcare professionals."

## Case Study 8: Staff Reflections on Patient Care

This case study presents stories drawn from interviews with staff across five practices. These are examples of the experiences staff have had when engaging with patients through IHAGP activity and do not necessarily reflect patient experience.

Investing time to understand patient history

A key feature of IHAGP activity is identifying patients who could benefit most from proactive outreach and extended consultation. One GP identified patients with a typical long history of repeat presentations at A&E and out-of-hours services due to a combination of physical and psychological symptoms.

"[A patient] has a number of kind of fairly deep-seated post-physical and psychological problems. If you look back at previous notes, hugely present to accident and emergency and out-of-hours services. It was kind of hyper-investigated, you know, for basically lots of what we call somatic symptoms or psychosomatic as in these are real symptoms, but they are augmented or amplified by [the patient's] psychological state."

Before the appointment, the GP spent considerable time reviewing the patient's medical history to fully understand their experiences and potential underlying causes for their frequent use of healthcare services. This allowed the GP to discuss this with the patient and describe what they had observed over the years. This supported the patient's understanding and provided reassurance that nothing was being missed.

"This [patient] has the classic long long history of multiple investigations and health inputs. What I was able to do with them is go through myself [many] years of medical notes which took me probably a day....and try and get to the bottom of why [the patient] is having these types of unmanaged chronic [problems] that's causing them so much anxiety and depression and low mood and dysfunction. So I was able to take a day to go through all that, and go back to [hundreds of] letters, and really gather a good picture in my own brain and then able to reflect that back to them. And I think that was helpful to bring them on the journey, that you are being listened to, you're not being ignored, but we're also not missing like a cancer diagnosis or that there's something sinister going on, but there's something very real to cause your pain so let's try and work at this together."

This approach positively impacted the patient and the broader health system.

"[The patient] almost has no presentation to accident and emergency now, [and] almost has no presentation to out-of-hours services. Now, that's not of particular benefit to us as a practice because it doesn't affect us, but it is of benefit to the wider health service. I think the patient also benefits because they feel listened to and validated and valued rather than 'nobody's interested in me, I feel ignored, I feel like something's been missed'."

Prevention and early intervention

Helping patients better understand their health issues and the range of controllable factors that contribute to them can empower them to make choices and changes that positively impact their health.

Identifying these issues at the right time and taking the necessary steps can mean reduce or prevent more severe and complicated health issues in the future.



"So all of these things, it was just one extended consultation..... it's about prevention and having an early intervention...actually taking the time with them and having the processes in place within the practice, we were able to make a really big difference"

#### Advocating for patients

Proactively contacting patients to check in with them can reveal issues that require an intervention that would not have been known about otherwise.

"In other examples from the outreach, someone who thought [they were] on a waiting list for surgery. But they'd written to say [the patient] hadn't attended an appointment, and [the patient] didn't even know they had an appointment. They hadn't received the letter. They hadn't had any phone calls or what have you. So this is an appointment that they should have had months before.... It could be potentially life-changing if they didn't get treatment.

The GP liaised with other healthcare professionals to advocate on the patient's behalf and request a new appointment for their surgery. The GP also demonstrated their concern for the patient and reassured them that they were there to support them.

"So I was able to contact the service and say that [the patient] was unaware that they had an appointment and asked them to reappoint [the patient] and asked [the patient] to get back in touch if they hadn't heard from them [the service]. And really explained to [the patient]...it was important and I would follow it up on their behalf."

#### Understanding patient fears that act as barriers to engagement

Awareness of why different patient groups might not engage with healthcare services is critical to addressing those barriers. The knowledge and expertise of different professionals can provide those needed insights.

"Our drug worker as well, who runs a drug clinic once a week, [has] identified quite a few patients who we weren't aware of struggling with their health, but were almost afraid to come to the doctors in case their medication changed, or stopped. So that was a group that we never thought of. We just thought, drug users just don't bother coming to the doctors, or don't bother coming to their appointments and DNA."

Addressing patients' concerns and misconceptions can result in improved engagement and ensure they receive the required care, treatment, and medication.

"But it turned out [the patient] was actually quite afraid. [They were] afraid that one of their medications was going to get changed, and we really assured them about that. We got them in, got them their medication, what they needed, and they're doing fantastic now."

One GP described their approach to initiating contact with patients to reduce fear:

"One example was before Christmas. The first time I'd done it, I'd just done the search and I was phoning down my list of people. I wasn't quite sure how to express it because if I was to phone up someone and say I'm phoning you because you missed an appointment, they'd instantly think I was phoning to tell them off. So I decided to say 'I'm just phoning because Christmas is coming and I'm wondering how you're doing. It can be a tough time of year for people'."

Proactive outreach patient to connect with vulnerable patients

One GP described offering proactive outreach to vulnerable patients, and the difficulty of getting access to the right support and the need for ongoing engagement.

"I mean, it hasn't solved their problems. Mental health team, unfortunately, haven't felt they can support them after assessment... So I'm still trying to offer them support. And in fact, they came to see me a couple of times and they stopped coming to see me. So they're still missing."

Managing aggressive behaviour to provide continuity of care

Problematic patient behaviour is a challenge in general practice. This is often borne by receptionists, the first point of contact.

"I think administrative staff carry a huge burden in GP practices because they're usually the front line of everything, so when people at their most anxious or the most upset or the most frustrated or the most aggressive, it's actually the admin guys who get it first."

Rather than remove a patient from the practice list, one practice worked with them to communicate expected standards of behaviour, while acknowledging the individual's health problems as a contributing factor.

"It means that I see [a patient] for double amount of time if they call and I try and call them back the same day and we were able to sit down when [the patient] was being particularly abusive I was able to sit down and work out a plan with them, and the practice manager, so that they understand that there is a minimum standard of behaviour, but we do understand that [they have] personal challenges that our other patients don't."

Finding an effective way to navigate these issues with patients has meant that they have been able to remain with the practice and receive safe and effective care and treatment.

"It provides continuity of care for them, and we've managed to get them off of all these toxic doses and we're managing them on medium strength [medications] that are much safer"

This case study demonstrates how activity delivered under the three IHAGP themes can contribute to meeting the needs of patients. While it is not representative of the experiences and benefits of all patients that have engaged with and been supported through IHAGP activity, it does provide insight into the significant benefits to health and wellbeing that can be generated at an individual level.

## **Final thoughts**

These eight case studies have provided valuable insight into ways in which practices have used IHAGP funding, the impact of the funding and the challenges and barriers that practices have experienced.

We would like to thank all the practices and staff who took part in interviews to inform the case studies. Without their participation, these case studies would not have been possible.

## Appendix Two - Acronyms and abbreviations

The list below provides a breakdown of the acronyms and abbreviations used in the report and what they refer to.

A&E:	Accident and Emergency
ANP:	Advanced Nurse Practitioner
CLW:	Community Link Worker
COPD:	Chronic Obstructive Pulmonary Disease
DNA:	Did Not Attend
CTACs:	Community Treatment and Care Services
GP:	General Practitioner
HCA:	Healthcare Assistant
HSCP:	Health and Social Care Partnership
IHAGP:	Inclusion Health Action in General Practice
MDT:	Multi-Disciplinary Team

# Appendix Three: Technical Methods

This technical annex to the final evaluation report provides further details of the methodology used to deliver the evaluation for a technical audience. The evaluation tools are also included as an Appendix.

## IHAGP evaluation methodology

A description of the methodological approach used to deliver the IHAGP evaluation is detailed in the following sections and covers:

- The tools developed to undertake data collection activity.
- The approach to participant sampling.
- Recruitment of participants and fieldwork undertaken.
- The approach to data analysis.
- Details of the reporting outputs produced.

## Development of evaluation tools

Following an inception meeting with the client team and a review of background documentation, the following tools were developed to support evaluation fieldwork and data collection:

- Participant information form which provided evaluation participants with the information required to make an informed choice about their participation. The information sheet covered the following:
  - The purpose and aims of the evaluation.
  - Why participants were being invited to take part in the evaluation.
  - What participation involved.
  - GDPR, data protection and data storage.
  - Confidentiality and how findings would be used.
  - The voluntary nature of participation.
  - Processes for questions and complaints.
- Privacy notice.
- Discussion guide for semi structured interviews.

Evaluation tools were reviewed by the IHAGP Research Advisory Group and approved prior to any fieldwork and data collection activity commencing.

Copies of the evaluation tools that were developed are included as an appendix.

## Sampling approach

A deliberative sample of 30 General Practices participating in the IHAGP programme was selected to be invited to take part in the evaluation fieldwork. The sample provided proportionate representation across the following criteria:

- Practice list size – small (<3,000 patients), medium (3,001 – 6,000), large (6,001+). The categories for patient list size were developed by identifying the smallest practice list size among participating practices (1,362) and the highest (10,407) and setting categories to reflect roughly a third of the minimum to maximum range.

- % of patients in living in the most deprived areas (as per Scottish Index of Multiple Deprivation classifications) – low (<50% of patients), medium (50-70%), high (70%+).
- Number of IHAGP themes practices were delivering activity under.
- The IHAGP theme chosen by practices to deliver activity under.

Furthermore, 9 practices who did not take up voluntary participation in the programme were also invited to take part in the evaluation. The aim of this was to explore barriers to engagement, and whether any changes could be made to the programme that would enable or encourage participation. However, no practices took up the offer and we are therefore unable to provide any findings in relation to this.

Due to a slow response from the initial sample of 30 practices when inviting them to take part in the evaluation, the decision was taken in conjunction with the client team to open the opportunity to all 66 practices participating in IHAGP. The tables below provide a breakdown of practices that participated in evaluation fieldwork against the sampling criteria.

#### Sample breakdown by practice list size

Practice list size	Number of practices
Large (6001+)	4
Medium (3001-6000)	9
Small (<3000)	2

#### Sample breakdown by percentage of patients in SIMD15

% of patients in SIMD15	Number of practices
High (70%+)	4
Medium (50-70%)	10
Low (<50%)	1

#### Sample breakdown by IHAGP theme chosen to deliver activity

Theme chosen	Number of practices
1 - Patient Engagement	3
2 - Staff Training	8
3 - Extended Consultation and Outreach	9

## Sample breakdown by number of IHAGP themes selected

Number of themes chosen	Number of practices
1	11
2	3
3	1

## Monitoring data

All practices participating in the IHAGP programme were required to submit two monitoring forms (template in Appendix One) over the duration of the programme. The first monitoring forms were to be submitted in August 2023 and the second in December 2024, though many submissions were delayed.

The Scottish Government carried out an analysis of the individual monitoring returns and produced an anonymised summary of the data contained in the monitoring forms. The summary report was shared with the evaluation team so that findings detailed could be drawn into the overall analysis.

When inviting practices to participate in the evaluation fieldwork, consent was sought to share the monitoring returns with the evaluation team. Where consent was given, the forms were accessed by the member of the evaluation team conducting fieldwork with the practice to gain an overview of progress and activity being delivered and any learning shared in the return.

## Fieldwork

### Recruitment of evaluation participants

The following steps were taken to recruit practices for the evaluation:

1. Scottish Government made initial contact with practices via email, providing the information and consent form, and asking practices to provide initial consent:
  - a. To participate in the evaluation.
  - b. For their contact details to be shared with the evaluation team.
  - c. For monitoring data relating to their IHAGP activity to be shared with the evaluation team.
2. Contact details and monitoring returns of consenting practices were shared with the evaluation team.
3. The evaluation team contacted the practice to plan for semi-structured interviews to take place.
4. Semi-structured interviews were then carried out as per the agreed arrangements.

5. Additional reminders and follow-up emails were sent throughout recruitment to improve the sample. This included targeted follow-up with practices less well-represented in the sample (i.e. those with a list size in the 'small' category, and those with a 'low' percentage of patients in SIMD 15). Targeted follow-up was also undertaken with practices who, based on a subjective appraisal of their monitoring forms, had well developed projects and had potentially generated learning that could inform the evaluation.

Over the duration of the evaluation 19 practices provided consent to participate in the evaluation. All 19 were contacted by the evaluation team to plan for the fieldwork to take place, though 3 did not respond to contact attempts and one had to withdraw due to capacity challenges.

### Fieldwork and data collection with IHAGP practices

To minimise barriers to participation, we explored participant preferences and accommodated their availability. This included:

- Giving participants the option to contribute to the evaluation through one-to-one or group discussion.
- Offering face-to-face, telephone and video call as options for participation.
- Being responsive to participant availability, including offering and accommodating times outside of 'normal' working hours including evenings and weekends.

Over the duration of the fieldwork 23 staff from across 15 practices participated in an interview, with the average length of interview being 40 minutes. This included 19 one-to-one interviews and two paired discussions delivered through the following methods of engagement:

- Face-to-face at the participating practice (4)
- Video call (15)
- Phone call (2)

The 23 staff were made up of:

- 16 GPs
- 5 practice managers
- 1 community link worker
- 1 pharmacist

The client team at Scottish Government also identified 4 strategic stakeholders to be interviewed as part of the evaluation to explore their perspectives of the programme. All four stakeholders consented to participate but only 3 responded to contact from the evaluation team to schedule an interview. The 3 stakeholder interviews that went ahead were all carried out through video call. One was from the NHS Greater Glasgow and Clyde Health Board, one from Glasgow City Health and Social Care Partnership, and one from the Scottish Government.

Participation in the evaluation among General Practices was lower than hoped due to a lack of capacity within practices and the short timescale for the evaluation. We highlight that this was a self-selecting sample, and the findings may not represent all practices' experiences. However, evidence from monitoring data suggests that similar types of work

are going on across the programme though they may be at different stages. Furthermore, the evaluation was not able to directly engage with patients due to the time constraints for delivery of the evaluation, and the timeline involved in gaining the required ethical approval. Therefore, findings presented in the main report relating to patient experience and patient outcomes are based on reports from practice staff.

All interviews were recorded with the participant's consent. Recorded interviews were then transcribed to inform the data analysis phase. The transcribing or recorded interviews involves a two-step process:

1. The recording is run through automated transcription software, which produces a typed version of the recording.
2. A member of staff then listens to the recording while reviewing the typed version generated by the transcription software and making any required changes or additions to ensure complete accuracy.

### **Approach to data analysis**

The following sets out the key steps in the analysis process:

- Each team member reviewed a sample of colleagues' transcribed interviews, identifying themes and evidence aligned to the evaluation objectives, key questions, and theory of change/logic model.
- Each team member prepared an individual codification framework to support thematic analysis of the qualitative data.
- All team members participate in a facilitated team workshop, where each individual team member presents their initial analysis which is then discussed and challenged until a consensus is reached.
- When this is completed for each team members initial analysis, the team members work collaboratively to develop a single consistent codification framework.
- Thereafter, each team member is allocated interview transcriptions to analyse and code the qualitative data.
- During the analysis process, quotes from the coded responses that illustrate and support key findings are identified and highlighted for inclusion in the report writing process.
- The anonymised summary of monitoring returns produced by the Scottish Government was reviewed during the analysis process and its findings drawn on to:
  - Provide an overview of delivery and activity across the programme.
  - Provide quantitative data relating to the activity delivered.
  - Support and supplement findings from interviews with practices.

Peer review of colleague's work was an ongoing feature to ensure consistency and accuracy throughout the process. At regular intervals the codification framework was reviewed to identify any areas where sub-themes were emerging or identified, and additional codes were added to the framework to bring further detail and depth to the analysis.

The data captured through stakeholder interviews was analysed in line with the process set out above. The analysis of this data was then used to cross check against the analysed data gathered from engagement with participating practices to explore alignment between stakeholder perceptions and the experiences of practices (e.g. types of activity being delivered, progress, learning, sustainability). This process found that stakeholder



perceptions broadly aligned with the experiences of practices, though feedback from practices was more in-depth and detailed due to their direct involvement in delivery, whereas stakeholder feedback was generalised or based on perceptions.

One stakeholder was also a GP at a practice participating in the IHAGP programme and shared their experiences of delivering activity through IHAGP and drawn into the analysis of responses from other participating practices that had engaged in the evaluation.

### Reflections on the heterogeneity of data collection methods

The following sets out the variation in data collection methods that were applied during engagement with participating practices, and discusses any implications or limitations this presented in the analysis and reporting process:

- **Interview length** – While the average interview lasted 40 minutes, this varied from 30 minutes to 60 minutes. However, the interview length did not reflect any variation in the depth or quality of data, instead it reflected the type and number of activities being planned or delivered by a practice and the number of themes that they were delivering activity under.
- **One-to-one or paired interviews** – Two interviews were paired interviews (all others were one-to-one) which involved a member of the research team and two members of staff from the participating practice. Prior to the interview the researcher checked that each participant was comfortable speaking openly and honestly with their colleague present, and confirmed this was their preferred method of participation. During paired interviews the researcher ensured both participants were given the opportunity to share their experiences and perspectives for each of the questions asked.
- **Mode of interview** – Interviews were conducted using a combination of face-to-face, telephone and video call. The mode of interview was selected by the participant based on their own preferences, which contributes to effective engagement with the evaluation. Again, no differences in depth or quality of data were observed across the different modes of interview.
- **Professional role of participant** – While interviews were conducted with a mix of different roles across different practices, the participants represented those that had taken a lead role in the implementation or delivery of the programme, or a particular activity that had been developed and delivered as part of the programme. Therefore, each participant was able to provide an informed view of their own experiences, learning and perceived achievements based on their own involvement.

It is also worth noting that a single discussion guide was used during all interviews, which ensured consistency in the lines of enquiry that were explored with every participant. This enabled the development of a single, consistent thematic coding framework to support the analysis of each interview.

Furthermore, in presenting findings and to assist the reader in interpreting the findings, the following terms were used to provide an indication of prevalence throughout the report:

Most practices/staff: over half of participants provided feedback relevant to the theme presented

Many practices/staff: a third or more but less than half.

Several/some respondents: more than a few but less than a third.

A few: A view expressed by roughly three individuals

One/two: a singular view or a view identified from two participants.

Overall, the heterogeneity of data collection approaches did not create any limitations or affect the analysis or reporting process.

### Reporting outputs

The following reporting outputs were produced:

- A final evaluation report which detailed the learning generated, and evidence of emerging outcomes.
- A suite of eight thematic case studies.
- A technical annex to the full report.
- A two-page infographic highlighting the key findings.
- A short animation covering key findings.
- Three workshops with stakeholders to reflect on the findings with stakeholders and integrate them into the programme theory and design.
- Two workshops with practice staff to integrate and share learning into the programme implementation.

# Appendix Four: Evaluation tools

## Participant Information form

### Inclusion Health Action in General Practice Evaluation - Participant Information Sheet

#### Introduction

The Scottish Government has commissioned The Lines Between, a social research organisation, to carry out a rapid evaluation of the Inclusion Health Action in General Practice (IHAGP) programme. The evaluation aims to explore how the intervention is being implemented across a range of practices and what early successes and learning can be captured to inform decisions about the future of IHAGP and policies to tackle health inequalities.

You are being invited to take part in the evaluation, but before you decide whether to take part, it is important for you to understand what participation will involve and how findings will be used. Please take time to read the following information. You can contact the study team using the details below if you have any questions or would like more information.

#### What is this study about?

IHAGP was developed by the Scottish Government and other stakeholders from the recommendation for a new 'enhanced service' set out in the [Primary Care Health Inequalities Short Life Working Group report](#). IHAGP provides up to £1.3 million over financial years 22/23 and 23/24 to 80 general practices operating in the most deprived areas of Glasgow.

The aim of this research is to provide the Scottish Government with information on how the IHAGP funding is being used, to learn what is working well and less well and to demonstrate early and emerging outcomes and benefits. Findings from the evaluation will be used to inform decisions about the future of the programme and policies to tackle health inequalities.

#### Why have I been invited to take part?

The evaluation team selected a sample of practices to reflect the diversity of characteristics (e.g. practices of different sizes or with a lot of patients who need help with language interpretation services) across all those taking part in the programme. Your practice has been selected in this sample and we would like to explore your experiences of the programme, and the activities that have been undertaken as part of it. If any of your colleagues have been involved in the programme, we would also like to understand their experiences and perspectives as well.

#### What will taking part involve?

If you are interested in participating, a member of the TLB team will arrange a time to speak with you either one-to-one or in a group with your colleagues, depending on your preferences. The discussion will take place on a date and time (including evenings or weekends) that is convenient for you. It can be over the phone, video call, or in person.

One-to-one discussions will take between 30-45 minutes, and group discussions will last around an hour. The areas that we explore during these discussions will be tailored to reflect your role and how IHAGP funding has been used, but will cover the following themes:

- how IHAGP funding have been used at your practice;
- the progress that has been made, including enablers, challenges, and barriers to this;
- the learning that has been gained,
- and any impacts IHAGP has had;sustainability of actions and activities.

What else do I need to know?

- Taking part is voluntary. It is up to you whether you participate in the study.
- Taking part is confidential. Your participation in the discussion will be confidential, and we won't share any information that could identify you to anyone else.
- There are no right or wrong answers; this research is purely to understand different experiences and views, and you do not need to answer any questions that you do not wish to.
- We might use some things you say in the report that we write for the Scottish Government. While the discussion will inform the findings that we present in the report that we produce, we will not attribute any findings to an individual or organisation.
- You can change your mind about taking part. Even if you are initially happy to have a discussion with us, you can change your mind at any time. If you decide that you want to withdraw from the study after the discussion has taken place, please contact Derek at TLB using the contact details below. We will not be able to exclude the information you have provided after it has been anonymised or used in analysis or the report. In this case, your rights to access, change or move your information will be limited as we need to manage your information in specific ways for the research to be reliable and accurate.
- We will ask to audio record the discussion with you. This is to ensure that we have an accurate account of our discussion and to draw on relevant quotes to include in the final report. Recorded discussions will be transcribed, after which the recording will be deleted. If you do not want us to record the discussion, we will take handwritten notes, which will be typed up without your name. The handwritten notes will be destroyed, and the typed version deleted at the end of the study.
- Any personal information will be held securely. Interview notes and transcripts will be stored securely, in line with UK data protection legislation. [TLB's privacy notice](#) explains your rights in more detail. Any personal information will be deleted at the end of the study. You can ask us to delete any personal data we have about you at

any time. To do this, please speak to us or email [hello@thelinesbetween.co.uk](mailto:hello@thelinesbetween.co.uk), and tell us to delete your data.

- The evaluation report will be published and publicly available. The evaluation report will be published by the Scottish Government and will be shared with all practices that have contributed to the evaluation. There will also be a learning event organised to share the findings.

What next?

If you agree to taking part, a member of the TLB evaluation team will liaise with you to make arrangements for the discussion to take place. Before the start of any one-to-one or group discussion the team member from TLB will ask you to verbally confirm that you have understood the information in this document, and consent:

- To take part in an interview.
- For the interview to be audio recorded.
- For anonymised quotes from you to be used in the report we write.

What if I have a complaint or concern about the evaluation?

If you have any concerns about the evaluation or the conduct of the evaluation team, please contact the Contract Manager at the Scottish Government.

Who can I contact if I have any questions?

If you have any questions or want to discuss this information, please don't hesitate to contact The Lines Between.

Thank you for taking the time to read this information. Please retain a copy for your reference.

## **Privacy Notice**

### **Inclusion Health Action in General Practice Evaluation**

#### **Privacy notice for interviewees**

##### About the project

The Scottish Government has commissioned The Lines Between, a social research organisation, to carry out a rapid evaluation of the Inclusion Health Action in General Practice (IHAGP) programme. The evaluation aims to explore how the intervention is being implemented across a range of practices and what early successes and learning can be captured to inform future planning and delivery.

##### About this privacy notice

This privacy notice is for those taking part in this research. It explains how your personal data will be collected for the purposes of this research are used and handled.

The Scottish Ministers are the “data controller”. The data controller decides what personal data is collected from you as part of this research.

The Lines Between is the “data processor” for this research, which means that The Lines Between is responsible for collecting information from you during an interview or survey, securely storing it, and using it to write a report on behalf of the Scottish Government.

##### About The Lines Between

The Lines Between is a specialist research agency. All research staff have Basic Disclosure and adhere to the Social Research Association Code of Ethics and RESPECT Code of Practice. They revisit these guidelines at the start of each project along with the ESRC's frequently updated Framework for Research Ethics.

##### What happens to the information you provide and how is your privacy protected?

With your consent, The Scottish Government will share your contact details with The Lines Between (name, job role, practice name and your email address at the practice), who will contact you and arrange an interview, if you would like to take part in the research. Sharing your data and participating in the research are both entirely voluntary and can be withdrawn at any time.

With your consent, the Scottish Government will also share your monitoring forms with The Lines Between. These will not form a formal part of the evaluation but will provide background knowledge and context.

The information collected during the interview will be used for research purposes only. The Lines Between will use the information to write a report for the Scottish Government who will publish it, but this report will not contain any personal data.

Personal data can be collected and used in this way under the terms of data protection legislation in the UK on the grounds of “public task”. The data collected as a part of this

evaluation will be used to provide the effective provision of health services in the public interest in accordance with the NHS Act 1978.

The Lines Between will treat the information you give them in the strictest confidence under the Data Protection Act 2018, the UK General Data Protection Regulation (GDPR). Only The Lines Between research team will have access to your personal data and this will be stored securely, in a protected electronic folder that only the immediate research team have access to. The data is stored on a UK server and will not leave the UK. No information that could make a person identifiable will be passed on to the Scottish Government.

Where and how long your information is retained

All personal data and interview responses are stored securely and confidentially under the terms of data protection and in line with international best practice.

The Lines Between will only retain your data in a way that can identify you for as long as is necessary to support the research project and findings and will be deleted at the end of the study or earlier if no longer needed.

Your rights

Data protection legislation gives rights to individuals in respect of the personal data that organisations hold about them. These include the right to:

- access a copy of the information an organisation holds about them;
- rectify any information they think is inaccurate or incomplete;
- restrict the processing of their information in certain circumstances;
- object to processing that is likely to cause or is causing damage or distress;
- complain to a supervisory authority if they are unhappy with the way in which their data has been processed.

Questions or queries

If anything in this privacy notice is not clear or you would like us to talk you through it, please contact the Scottish Government:

By post:

St. Andrews House, 2 Regent Road, Edinburgh EH1 3DG

If you have questions or concerns about how your personal data is being collected or used, or if you believe that The Lines Between have not complied with your data protection rights, you can contact the Data Protection Officer at the Scottish Government. If you have questions about your personal data held by the data controller you can also contact the Data Protection Officer at the Scottish Government:

By email:

[DataProtectionOfficer@gov.scot](mailto:DataProtectionOfficer@gov.scot)

By post:

Victoria Quay, Commercial Street, Edinburgh, EH6 6QQ

Complaints

You have the right to lodge a complaint with the Information Commissioner's Office. If you are unhappy with the way your personal data are being processed, you can report it to the [Information Commissioner's Office](#) (ICO) or by calling the ICO helpline on 0303 123 1113.



## Discussion Guide – Practices participating in IHAGP

### Inclusion Health Action in General Practice Evaluation: discussion guide

#### Role and aspirations

1. Can you give me an overview of your practice? (probe the following):
  - Practice size
  - Staff numbers and roles
  - Patient population characteristics
2. What is your role at the practice?
3. What has been your role in the IHAGP programme and activity that has been delivered?
  - How did you come to be involved in the programme?
  - What were the key drivers and/or motivations for involvement? What were you hoping to achieve?
4. To what extent do you feel that your aspirations for the programme have been met?
  - Why do you say that?
  - Do you think that the IHAGP programme is an effective means of addressing higher levels of unmet need in deprived areas?

#### Aims and progress

5. Which of the three IHAGP themes did your practice decide to implement and why was that/were those the focus?
  - (If not covered in answer to the above) – Why did you decide to deliver activity under more than one theme?
  - To what extent does the activity under each of the different themes complement each other and contribute to what you hoped to achieve?
6. Has IHAGP funding been used to start a new initiative/new activity under one or more of these themes, or used to supplement/enhance activity that was already happening in the practice?
  - If used to supplement/enhance - what has this enabled that wouldn't have happened otherwise
7. Can you tell me about initial delivery plans and intended approach (*Tailor follow-up questions to theme/s implemented*):

##### Theme one (patient engagement)

- What was the starting point for this activity?
- Were you building on any work that had already been undertaken or has this been the catalyst for new patient engagement activity?
- where has/is implementation been/being targeted
- Did you engage with any existing peer support or community groups to support this activity?

- Did this activity involve the Practice Community Link Worker? If so, can you tell me a bit about that?
- How did you recruit patients, how was recruitment done, what type of activities were they asked to participate in?
- What was the rationale for those initial plans and approaches?
- What were you trying to achieve through patient engagement activity?
- Have there been any changes to those initial plans and approaches?
  - i. If so, what were those changes and what influenced them?
  - ii. What difference did they make?

Theme two (enhancing workforce knowledge and skills)

- where has/is implementation been/being targeted,
- What type of training or activity did you introduce
- How did you identify staff to participate?
- What was the rationale for those initial plans and approaches? What were you trying to achieve?
- Have there been any changes to those initial plans and approaches?
  - i. If so, what were those changes and what influenced them?
  - ii. What difference did they make?

Theme three (enabling proactive outreach or extended consultations)

- Where has/is implementation been/being targeted, what type of activity did you introduce, how did you identify patients to target?
- What was the rationale for those initial plans and approaches? What were you trying to achieve?
- Have there been any changes to those initial plans and approaches?
- On reflection, were those the right changes to make? Why is that?
  - i. If so, what were those changes and what influenced them?
  - ii. What difference did they make?

8. How would you describe the progress that has been made? (*Exploring: what has been implemented and delivered to date*)

- What are the key IHAGP activities have been implemented?
- Are you where you'd hoped to be at this point?
  - i. Why do you say that?
- What have been the key successes and achievements so far?
- What have been the enablers of the progress that has been made?
- Which are the elements of the programme that have seen the least progress?
  - i. What factors have influenced this?
  - ii. How are these being tackled?
  - iii. What support would you benefit from to overcome these barriers?

9. Overall, what has worked well with the approach taken?

- Any factors not already mentioned that have been most critical to implementation and delivery success?

10. Overall, what could have worked better?

- Any factors not already mentioned that have presented the most significant challenges?
  - i. What did you do to mitigate or overcome these?
  - ii. What could have been done to avoid these?

### **Learning and good practice**

11. What is the most important learning you are taking away from your involvement in the IHAGP programme?
  - What would you do differently if you were starting again?
  - What would be the most important learning or piece of advice that you would share with other practices that are delivering against the same theme/s?
12. What, if any, examples of good practice have been generated by IHAGP activity?
  - Why do you consider these to be examples of good practice?
13. What has been the main learning for you from your involvement in the programme?
  - What learning have you generated that you feel is important in shaping the future of the programme?
  - Have you learned anything that might be useful to inform efforts to tackle health inequalities more generally?
  - What changes could be made to the programme's design and implementation that would make it more effective?
    - i. What difference would that make?

### **Uptake and Impacts**

14. Can you please describe any patterns of IHAGP support uptake? (Tailor follow up questions to theme/s implemented)

#### Theme one (patient engagement)

- How well have patients/communities engaged in involvement opportunities?
- Has there been variations amongst patient groups/communities and if so, why do you think that is?
- Were you able to recruit the patient population you hoped you would (i.e. diversity, health conditions etc)

#### Theme two (enhancing workforce knowledge and skills)

- Are there variations in the extent to which training/activities have been taken up by staff? (e.g. by profession, level of seniority etc).
- If so, why do you think that is?
- To what extent has the training activities resulted in learning influencing and being embedded in practice, process, and policies?
  - i. Why is that?

#### Theme three (enabling proactive outreach or extended consultations with patients at high risk)

- How well have you managed to engage patients in outreach or extended consultation opportunities?
- What has influenced this?
- Have there been variations amongst patient groups and if so, why do you think that is?

15. What benefits and positive impacts have been generated as a result of IHAGP delivery (exploring impacts, both positive and negative on):
- Patients that have directly accessed IHAGP opportunities (either through accessing opportunities themselves, or, if theme 2, engaging with staff that have engaged in training and support)?
  - The wider patient population?
  - Individual staff that have been directly involved in IHAGP activity or delivery?
  - The wider staff team?
  - The practice's policies, processes, and systems?
  - The practice overall

16. Have there been any unanticipated benefits or wider impacts? (exploring eg development of any communities of practice and/or peer support with other general practices in deprived areas, impacts on morale/motivation/feelings of burnout through opportunities created?)

17. Have there been any negative impacts of IHAGP activity?

18. Are there any alternative activities/themes that could be delivered with a similar budget that you think would still align with the ambitions of the IHAGP programme but with a greater impact?
- To what extent do you feel that the IHAGP is an effective approach to supporting general practice in addressing health inequalities?
  - Why do you say that?

### **Future and sustainability**

19. How sustainable are the developments introduced to-date- as part of the IHAGP programme? (exploring the extent to which they are sustainable without and with future funding)
- Why do you say that, and what are the factors that will influence this positively and negatively?

20. What are the key priorities for future development and delivery of the IHAGP programme at your practice?
- What are the factors that will be critical to achieving this?
  - What are the perceived challenges of this?
    - i. How are these being mitigated/how can these be overcome?

21. Is there anything that we have not covered that you wanted to say about the IHAGP programme?

## Sample Monitoring Form

Theme Two: Enhancing workforce knowledge and skills for health in equalities.

"To provide practices with support to help and enable staff (including administrative and management, clinical and link workers) to access education, knowledge resources or training on health inequality and health equity."

Please complete the form below in full on excel and return to:  
healthinequalitiesprimarycare@gov.scot by 15 December 2023

Question	Response
Spend: please indicate how much of the IHAGP payment received in September 2023 you have used or plan to use for this theme alone.	
Actual spend to 15 Dec 2023 (£)	
Planned spend (£)	
Estimated date to spend all of the Sept payment (if relevant) (£)	
Brief description/breakdown of spend	
Activities: please provide a brief description of the actions you have taken (e.g. learning activities staff have undertaken, resources purchased)	
Reach: provide an approximate numbers of staff that have undertaken training. Please describe your evidence for this.	
<b>Reach: give further details</b> (e.g. role and numbers staff who have accessed relevant education resources or training; length and/or regularity of training) Please describe your evidence for this.	

<p><b>Outcomes: describe how the activity has impacted on the practice.</b>_(E.g what practical changes have happened or will happen as a result of training/learning; impact on staff) Please describe your evidence for this.</p>	
<p>Outcomes: describe how the activity has impacted <u>on the patients involved</u>. Please describe your evidence for this.</p>	
<p><b>Barriers: describe any barriers or challenges you have encountered.</b> Information about what practices may have found difficult is valuable for learning and for the potential development of future resources/support for practices.</p>	
<p><b>Learning: describe key learning to share with other practices</b> (e.g. useful webpages, patient or staff feedback or practical tips)</p>	
<p>Learning: do you have suggestions for additional support or resources which would help practices to deliver actions under this theme</p>	

Note: different forms were completed depending on the theme being undertaken. Each form collected similar information with slightly different wording depending on the theme.



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