

Unmet Needs Pilot Projects –
Recommendations for
Future Service Design

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Unmet Needs Pilot Projects – Recommendations for Future Service Design

Executive Summary

1. The aim of the unmet needs pilot projects was to provide evidence as to whether supplying increased resources to Health Boards with deprived areas would lead to an improvement in access to NHS services in these areas.
2. They were announced in 2004, following research on unmet needs that was conducted for the Standing Committee on Resource Allocation (SCRA). Established in 2001, the Committee sought to consider alternative methods of adjusting the health funding formula, the Arbutnott Formula, for inequalities.
3. The announcement recognised that there was evidence that those in the most deprived areas were not accessing healthcare services at the same rate as their more affluent neighbours.
4. A total of 19 unmet needs pilots were implemented across three Health Board areas (Argyll & Clyde, Greater Glasgow and Tayside) with funding typically granted for two years.
5. The pilots covered a wide range of perceived unmet health needs from mental health and stress, to the treatment of the causes of much ill health (smoking, addiction), to services aimed at specific hard to reach groups (e.g. homeless people, ethnic minority groups).
6. In terms of providing evidence for alternative methods of adjusting the Arbutnott Formula, differences in implementation, monitoring and evaluation across Health Boards made it difficult to directly assess the impact of all the pilots. However, in the main, there was general support for the proposal that targeted funding could address areas of unmet need.
7. Tayside Health Board subjected all their unmet needs pilots to independent evaluation and the results of a cross-cutting evaluation of all the Tayside studies identified five service characteristics that facilitated the likelihood of service uptake. These were:
 1. Proximity
 2. Responsiveness
 3. Convenience
 4. Timing
 5. Continuity
8. Consideration of the findings from all 19 unmet need pilot projects enabled these five service characteristics to be further developed and refined. As a result, a set of recommendations has been developed for future service planners and providers which can be used when developing services designed to improve access by those in deprived areas who have unmet needs.

9. The recommendations consist of eight points:

1. Shape and adapt services to fit users
2. Deliver services at appropriate times
3. Deliver services in the community
4. Integrate with other services
5. Provide patient pathway support
6. Use a personal approach
7. Be persistent
8. Provide services that users value

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Aims

The unmet needs pilot projects were established to provide evidence concerning whether supplying increased resources to Health Boards with deprived areas would lead to an improvement in access to NHS services in these areas.

The purpose of this report is to identify the lessons learned from the unmet needs pilot projects that ran in Argyll & Clyde, Greater Glasgow and Tayside Health Boards and develop a set of guidelines that can be used to inform future service planners and providers.

What is Unmet Need?

Unmet need for health services can be general or specific. General unmet need occurs if there are insufficient resources to meet the entire needs of the population. Specific unmet need occurs when one population group does not use the same level of resources as other population groups with the same level of need.

Background

The unmet needs pilot studies were announced in 2004, following research on unmet need that was conducted for Sir John Arbutnott's Standing Committee on Resource Allocation (SCRA). The announcement recognised that there was evidence that those in the most deprived areas were not accessing healthcare services at the same rate as their more affluent neighbours. SCRA recommended an adjustment to the Arbutnott formula to take account of unmet need in accessing hospital services in the most deprived areas.

However, it was decided that before any adjustment was made, the pilots should be established to "examine how additional funding can be used to improve access to health services by people from the most deprived areas." The announcement asked for "innovative ideas for addressing unmet health needs and an improvement in access to NHS services by people living in our most deprived areas." Examples of the type of unmet need that the pilots could cover were given as follows:-

- Access by people with coronary heart disease living in deprived areas to a range of services
- Attendance rates at breast screening clinics
- Uptake of winter flu vaccination

Aim of the unmet needs pilots

The aim of the unmet needs pilots was to provide evidence as to whether supplying increased resources to Health Boards with deprived areas would lead to an improvement in access to NHS services in these areas. Their purpose was not to establish the extent of unmet need or prove the existence of unmet need.

The unmet needs pilots

A total of 19 pilots were developed in three Health Board areas (Argyll and Clyde, Greater Glasgow and Tayside). The pilots covered a wide range of perceived unmet health needs from mental health and stress to the treatment of the causes of much ill health e.g. smoking and addiction, to services aimed at specific hard to reach groups e.g. the homeless and ethnic minority groups.

Argyll and Clyde Health Board pilots

A total of five unmet need pilots were developed for implementation by Argyll and Clyde Health Board, costing £1.5 million. Brief summaries of all the Argyll & Clyde Health Board pilots can be found in Appendices A to E.

Following the dissolution of the Health Board, the responsibility for evaluating and reporting on these pilots fell to Greater Glasgow. Four of the pilots developed by Argyll and Clyde took a different approach to the projects developed in the other Health Boards. These pilots were set up as research projects, resulting in significant delays in gaining both ethical approval and recruiting temporary staff.

The other pilot, concerning coronary heart disease and improvement of access within the patient journey, experienced significant delays and did not start until 2007. This pilot more closely followed the model of the pilot projects in other Health Boards and rather than a stand-alone research project, was developed to supplement a national implementation programme.

Results from the former Argyll and Clyde unmet needs pilots have been mixed. Two pilots reported notable successes. The pilot that addressed the provision of a nursing service for looked after and accommodated children reported significant improvements in health service access and high client approval. Similarly, the pilot that addressed coronary heart disease and the improvement of access within the patient journey reported a significantly higher number of clients had attended screening than had been originally planned for.

However, other projects were less successful. These projects typically identified a variety of problems that impinged upon successful service delivery and subsequent improved access. For example, results from the implementation of a volunteer-staffed patient transportation scheme found that whilst there may be a demand for the service, the setting for the intervention may have been inappropriate, resulting in a struggle to reach the desired number of referrals per week to the service.

Greater Glasgow Health Board pilots

There were eight unmet needs projects run in Greater Glasgow, costing £12 million. Brief summaries of all the Greater Glasgow Health Board projects can be found in Appendices F to M.

Greater Glasgow has the greatest concentration of deprivation in any of the Health Board areas. Therefore, a variety of services already existed, aimed at tackling the causes of poor

health in these areas. As a result of this, Greater Glasgow Health Board took the approach of using the unmet need funding to further develop services that were already mainstream and long term in which it was known that there was traditionally unmet need.

For example, in the “Starting Fresh” smoking cessation pilot, the funding was used to make smoking cessation services available in twenty-seven pharmacies in deprived areas. Similarly, the funding for addiction services was used to establish the North and West Community Addiction teams and the Stress Centre pilot involved extending the stress centre provision in five social inclusion partnership areas.

The interim reports from Greater Glasgow highlight that, as a result of the integration of the unmet needs funding into already established services, reporting procedures and evaluation of the pilots separately from the services themselves was difficult to do. Therefore, this made it difficult to assess the extent to which the pilot funding successfully addressed unmet need.

However, overall, the Greater Glasgow pilots appeared to have made progress towards their own targets for improving health and findings from the reports suggested that with additional funding to develop services, unmet needs can be addressed.

Tayside Health Board pilots

NHS Tayside received an allocation of £1.78 million to support six pilot studies. Brief summaries of all the Tayside Health Board pilots can be found in Appendices N to S.

Using the most deprived deciles of postcode sectors as a broad guide for targeting resources, the Tayside pilots covered a variety of topics including homelessness, mental health, respiratory disease and diet/child health. The Social Dimensions of Health Institute (SDHI) was commissioned to lead on the summary cross-pilot evaluation and advise on other aspects of pilot specific evaluations.

Tayside reported that all the reports showed an increase in uptake of services offered and that patient satisfaction was high. For example, the pilot to increase breastfeeding rates in deprived areas resulted in a 9% increase in the breastfeeding rate in the intervention areas and the service offered was highly rated by participants. Similarly, the uptake in cardiology services pilot achieved considerable success in engaging hard to reach populations, including ethnic minority participants who are known to be at an increased risk of coronary heart disease.

Therefore, the Tayside pilots, by adopting a proactive, targeting approach to identifying unmet needs, achieved notable success with all pilots reporting increased uptake of services.

The SDHI Tayside evaluation – Key service characteristics

The SDHI Tayside evaluation, using evidence from staff and client interviews and focus groups, identified five service characteristics that were believed to facilitate the likelihood of service uptake among populations with unmet needs. These were Proximity, Responsiveness, Convenience, Timing and Continuity and together form the “PRaCTiCe” mnemonic.

1. Proximity

Proximity refers to the degree to which interventions intended and/or managed to make the approach personal to the individual and can be thought of in terms of:

- focus – whether the approach was to an individual or to a wider social group;
- place – how close the approach was to the personal and/or social world inhabited by the individual;
- relationship – how personal and “deep” the relationship was between the individual care provider and the client.

2. Responsiveness

Responsiveness refers to the client’s expectation that the service will produce tangible benefit for them. Therefore, the service must not only deliver and be seen to deliver; but also it must deliver on outcomes that are valued by the client.

3. Convenience

Three factors can be identified as contributing to convenience. These are:

- accessibility – how easy it is for the client to visit the service;
- frequency – how often the client might visit the location irrespective of the service being located there;
- availability – whether the client is free and therefore available to engage with the service at that location.

4. Timing

Timing could refer to either when the service approaches the individuals or when the service makes itself available for clients to approach it. In addition, it may also be related to how the provision of a service coincides with the provision of other services.

5. Continuity

Continuity refers to three subcomponents:

- persistence – the degree to which the service continued to make its service available to the person;
- person – seeing the same individual over time and this developing a relationship;
- place – the location of service provision.

Recommendations for service planners and providers

The “PRaCTiCe” mnemonic developed by SDHI provides an extremely useful framework in which to consider the findings from the other pilot studies. Taken together, the Tayside Health Board pilots and the pilots conducted by Greater Glasgow Health Board and the former Argyll and Clyde Health Board not only support many of the characteristics identified by the SDHI evaluation, but also allow this framework to be further developed and refined.

The outcome of this further development and refinement is a set of eight recommendations which can be used when developing services designed to improve access by those in the most deprived areas who have unmet needs.

1. **Shape and adapt services to fit users** – the services provided should be shaped by the communities and populations that are to receive the service. This point is highlighted by the observation made by one of the unmet needs project managers, Heather Sloan, who stated “People are not hard to engage; rather it is the process of engagement which is not suited to the target population”.

For example, the coronary heart disease patient journey project in Paisley utilised a range of creative methods to engage potential clients such as attendance at local social activities, slots on community radio and attendance at bookmakers and public houses. These methods were all part of a unique targeted community approach which was developed following the failure of the “Have a Heart Paisley” initiative to engage with the most deprived sections of the population in Paisley.

2. **Deliver services at appropriate times** – Issues of childcare, finances and often chaotic lifestyles mean that the timing of service delivery needs to be flexible.

The “Health Inequalities in the Homeless” unmet needs pilot in Tayside sought to provide an outreach primary care service to homeless people living in hostels. In its efforts to adopt a preventative approach, timing of the service delivery was crucial in order to engage with clients, especially given their often chaotic lifestyles. Therefore, by providing a range of contact options such as drop-in clinics, one-to-one contracts and informal attendance at hostels, the service was able to be flexible in the timing of its services.

In Greater Glasgow, the “Stress Centres” unmet needs pilot operated with a ‘refer or self-refer’ contact option, thereby increasing the flexibility of its service delivery times for clients. In addition, by locating the centres in the local community, this increased their accessibility and allowed clients to visit more regularly than might have been the case had they been located more centrally.

3. **Deliver services in the community** – services should be prepared to be mobile to reach their intended recipients. This may mean moving out of the buildings and places where they are traditionally delivered.

In Tayside, the methodology used by the “Uptake of Cardiology Services” unmet needs pilot had two key features, both concerned with the delivery of services in the community. Firstly, the specialist cardiology clinic was delivered in a community venue or the clinical mobile

unit. Secondly, opportunistic cardiology assessment was used whereby the identification of potential patients was made through attendance at local events such as gala day, bingo halls and mosques.

In Greater Glasgow, the West of Scotland breast screening service implemented a variety of interventions that evidence suggested might be of benefit in increasing attendance. For example, they utilised a personally directed intervention method, using letters to personally invite clients to participate. In addition, they used community seminars to engage with clients and tailored their other information material to suit clients, for example by producing a DVD aimed at ethnic minority populations.

4. **Integrate with other services** – service delivery should be integrated as should access to services at the point of delivery.

In Greater Glasgow, the “Primary Care Mental Health Teams” unmet needs pilot project utilised a ‘stepped’ or ‘matched’ care model which, in practice, meant that a range of interventions were offered to clients such as advice, information, group and individual therapies. Through the use of both standard GP referral and self-referral, the service was able to match the needs of clients to an appropriate and timely intervention.

In Argyll and Clyde, the “Health Advocacy” unmet needs pilot, in seeking to utilise the services of an advocate worker to facilitate access to appropriate health services for people with learning disabilities, relied on the availability of the appropriate health services at the time of contact to measure improvements in service use.

5. **Provide patient pathway support** – services should provide consistent support along the whole patient pathway.

In Tayside, the “Breastfeeding” unmet needs pilot, by seeking to provide women on low incomes with additional information and support to improve breastfeeding initiation and duration, sought to deliver outcomes that evidence showed were valued by clients. In this case, an infant feeding survey carried out in 2000 found that while most women stopped breastfeeding in the first six weeks, 90% of those who stopped in the first week wished that they had continued for longer. Results from the pilot showed a 9% increase in intervention areas and the service received high ratings of satisfaction by those who used it, further supporting the suggestion that the outcomes were valued by clients.

6. **Use a personal approach** – services should support and facilitate links and relationships between specific workers and specific service users so that their needs are met in a way that is personal, respectful and non-judgemental.

For example, the “Health of Homelessness People” unmet need pilot in Argyll and Clyde identified that the crucial factor in the success of the pilot were the relationships that nurses built with colleagues in other services and clients that were potentially vulnerable. These relationships allowed the development of trust with clients, greatly facilitated the timeous access to services and enabled nurses to work co-operatively with officers from other services.

In Argyll and Clyde, the “Improving Looked After and Accommodated Children’s (LAAC) Access to Services” pilot sought to establish a specialised nursing service for LAAC in residential care. The importance of seeing the same individual over time was highlighted by results of a service analysis questionnaire that showed that the opportunities to build up relationships between the nurses and young people was seen as a real strength of the intervention. In addition, the suggestions to improve the service drop-in opportunities and increase the amount of group-work and interactive learning again highlight the importance of aspects of continuity in successful service provision.

7. **Be persistent** – in order to overcome the significant barriers to engagement with services, those services should have an incrementally stepped approach to engagement, doing whatever is necessary to overcome barriers such as illiteracy and poor organisational skills. It is therefore important that to support staff with models of practice/ training around how to engage recipients.

In Tayside, the “Improved Access to COPD Services” unmet needs pilot involved the use of personal contact methods to engage with potential clients. In the case of the pilot, project nurses wrote letters, telephoned and visited patients in deprived areas to attempt to increase access to Chronic Obstructive Pulmonary Disease (COPD) services. The success of this proximity approach was evidenced by the increase in COPD clinic attendance following contact.

Similarly, another Tayside project, the “Outreach Service for Gypsy Travellers” unmet needs pilot found that initially, a lack of trust by potential service users proved a significant barrier to identifying needs and accessing services. This had led to a lack of continuity of care experienced by this population in accessing healthcare. However, as a result of the persistent approach of the project manager in attempting to build relationships, the project encouraged use of the patient held record of personal health, which acts as a transportable medical record and can be used when contacting healthcare services across Scotland. In this way, a degree of continuity of care was developed to allow health professionals access to healthcare information about the individual and identify gaps in provision.

8. **Provide services that users value** – services should adopt intervention models and approaches that involve working with service recipients to identify goals.

The importance of this is evidenced by the “Oral Health Promotion for Vulnerable Children” project in Greater Glasgow. This delivered clear benefits with its aim of improving the oral health practice of children in this group. By undertaking a variety of activities, from providing additional services to nurseries, to increasing support to parents and carers of 0-3 year olds through a range of local initiatives such as weaning fairs and cooking classes and by establishing clear links with primary schools through the enhanced provision of fruit in schools, the service was able to not only deliver dental benefits for those who participated, but deliver a range of health benefits that were valued by those who participated.

In Argyll and Clyde, one of the key factors cited as reason for the lack of referrals to the “Lomond Volunteer Transport” unmet needs pilot was reported to be the result of a failure to deliver an outcome that was valued by clients. In the case of the project, which sought to provide a volunteer run transportation service to a local podiatry clinic, the clinic in question was already well served by a good public transport system. In addition, the stigma associated

with receiving volunteer transport as opposed to being able to utilise personal transport and wariness of accepting transport from unknown volunteers were also thought to contribute to a lack of service uptake and again points to a lack of value attached to the service by clients.

Conclusions

The unmet needs pilots covered a wide range of healthcare services and populations, utilising a variety of methods to engage with potential clients and adopting a range of monitoring and evaluation methods. However, despite these differences, it has been possible to identify a number of shared characteristics among the pilots that appear to play a crucial role in their success in improving access to NHS services in deprived areas.

Applying the service characteristics of proximity, responsiveness, convenience, timing and continuity, identified as the “PRaCTiCe” acronym, by the Social Dimensions of Health Institute as part of the Tayside cross project evaluation, to all the unmet needs pilot projects has highlighted the important of these service characteristics.

This, in turn, has enabled the production of the recommendations for planners and service providers described in the previous section.

As has been highlighted, many of unmet needs pilot projects provide concrete examples of how the direct application of the guidelines has facilitated the successful implementation of a service and subsequent uptake. In some cases, where a service was less successfully implemented or uptake did not meet its specified targets, the reasons given often refer to the failure to implement a guideline, thereby further highlighting their importance.

The recommendations will, of course, require testing and evaluation and, as a result, may be subject to further refinement. Therefore some caution should be employed before using them uncritically. However the evidence presented in the unmet needs pilot projects suggests that they do provide a promising framework which should be taken account of in the planning and implementation of future interventions for populations with unmet healthcare needs. Future designers of a range of healthcare services may therefore benefit from drawing on this work, in order to enable the targeted populations to make use of and gain benefit from the full range of services available.

Appendices

The summaries of the individual unmet needs pilots are based on documents and information sent to Health Analytical Services from Greater Glasgow Health Board and Tayside Health Board and also from the individual project managers. These documents included the SDHI evaluation report of the Tayside project, final reports, interim reports and overheads from conference presentations.

The pilots are presented in the appendices according to which Health Board originally received unmet needs funding.

Across all Health Boards, the majority of pilots focussed on 5 key topics. These were:

Child and Maternal Health

Hard to Reach Groups

Mental Health

Primary Care

Substance Misuse

The topics that each pilot focuses on are highlighted at the start of each pilot summary and coloured as above.

One pilot covered additional topics that could not be categorised. This was the Lomond Volunteer Transport Project.

Appendix A. Coronary Heart Disease – Improving access across the patient journey to CHD services for those living in deprived areas

Topics: **Hard to Reach Groups**

Background

The unmet needs pilot was developed as part of the Have a Heart Paisley national demonstration project. Have a Heart Paisley was aimed at 45-60 year olds living in Paisley and offered one-to-one guidance and support for clients who wanted to make health behaviour changes. Phase two of the programme, was specifically aimed at those most at risk of developing heart disease and those already diagnosed with heart problems was delivered.

However, it was found that individuals living in the most deprived areas of Paisley faced significant barriers in accessing services. Data showed that for example, there was an extremely low uptake of health check screening from people in the target group who lived in areas of higher deprivation such as the Ferguslie Park area.

The unmet need project was developed with the aim of targeting eligible residents of Ferguslie Park who did not participate in the original Have a Heart Paisley project.

Funding allocation

The pilot was allocated £150,000 for 12 months

Aim(s)

The project had a number of aims. The key aims in relation to the provision of funding for the unmet needs pilot projects were:

To determine whether intensive outreach and support encourages people from deprived communities to access primary prevention services

To determine whether intensive outreach and support encourages uptake of health checks for CHD risk in deprived communities

Methodology

The unmet needs team, which included community development officers and a research support officer, used a variety of community engagement techniques. These included on-street interviewing, attendance at local social activities, post office queues during benefit collection times and opportunistic recruitment on local buses.

Those who were approached were given a leaflet highlighting the service offered and encouraged to come forward.

Key Results

The project set out to screen 133 clients. By May 2008, the number of actual screenings was 247 (159 women and 88 men).

A second screening six months after the initial screening was also implemented and has achieved a 75% success rate.

An unmet needs steering group, which includes academics from the University of Glasgow, are undertaking a quantitative and qualitative evaluation of the operational strand of the unmet needs project.

Conclusions

The project has successfully engaged with those living in the most deprived area of Paisley. The success of its range of engagement initiatives suggests that rather than considering groups as being “hard to engage”, flexibility in approaches to engagement appear to be required that have a particular focus on community engagement techniques. Therefore, other agencies need to consider how best to develop engagement techniques that are best suited to their various target populations.

Appendix B. Argyll & Clyde Health Board - Health Advocacy Research Project

Topics: **Hard to Reach Groups**; **Primary Care**

Background

The health needs of people with learning disabilities are characteristically different to that of the general population and there is strong evidence of a higher level of unmet need. For example, the learning disabled population show a higher prevalence of sensory deficit, epilepsy and behavioural and psychological disturbance. In addition, health professionals lack adequate knowledge of the complex factors involved and services designed for the general population present access difficulties.

The Health Advocacy Research Project (HARP) was designed to investigate the effects of using the health assessment “C21st Health Check” and the employment of a health advocate.

Adults living in Inverclyde and Renfrewshire areas who had been diagnosed as having a moderate to severe learning disability were identified for potential participation in the study.

Funding allocation

The pilot was allocated £262,998

Aim(s)

To improve access and uptake of health services, specifically dental, ophthalmic and breast screening (where appropriate) to people with learning disabilities and to investigate barriers to uptake of these services by people with learning disabilities.

Methodology

An intervention group of 116 adults with learning disabilities living in a relatively deprived area was taken from the Inverclyde area. The control group of 102 adults with learning disabilities living in a relatively deprived area was taken from the Renfrewshire area.

All participants firstly received a face to face interview that focussed on their experience of the three stated health service areas of dental, ophthalmic and breast screening. All participants then received a health check using the “C21st Health Check”.

Following this, the intervention group were offered the services of the advocate worker who facilitated access to appropriate services. The control group was only offered the interview and the health assessment.

All participants were then interviewed 12 months after the initial interview.

Key results

There was a general improvement in service use after the intervention. However, given that similar effects were seen across the intervention and control locations on most issues, it is likely that the effect was due to the impact of the health assessment, which may have served as a reminder and a spur to patients and carers, rather than the advocacy work with service providers. There may also have been some carry-over advocacy effects as professionals in the intervention condition may have been in contact with professionals in the control condition.

The only exception to the general finding of improvement in service use for both intervention and control groups came when looking at the pattern of eyesight tests. This showed a notable shift in the intervention area only which saw a higher number of participants reporting recent testing and fewer people whose most recent eyesight test was more than one year ago. Therefore, it is possible that advocacy work with ophthalmologists in the intervention area helped encourage opticians to invite more people with learning disabilities for regular check-ups.

Conclusions

Results suggest that the project helped people with learning disabilities to access routine services appropriately but it is difficult to attribute this to advocacy intervention. The use of the health assessment is more likely to have operated as a reminder to participants rather than the advocacy work providers in Inverclyde.

Appendix C. Argyll & Clyde Health Board - Health of Homeless People

Topics: **Hard to Reach Groups**; **Mental Health**; **Substance Misuse**

Background

The project had three key objectives. These were;

1. To have a dedicated homeless person's nurse working in conjunction with local authority homeless officers in the project area
2. To increase numbers accessing drugs misuse and mental health services
3. To facilitate access to drugs misuse and mental health services

The project period covered January 2006 to March 2007.

Funding allocation

The pilot was allocated £454,000

Aim(s)

To co-ordinate improved access to services needed for increased well-being by homeless people in the project area.

Methodology

Six project nurses were located across the project areas in a variety of settings including offices of local authority Homeless Persons Officers, NHS offices and voluntary sector offices.

Eligible people, defined according the "Improving Health and Homelessness in Partnership: The Way Forward" action plan, were offered a referral to a project nurse or self-referred.

Those who were referred were invited to undergo a health assessment. This recorded a range of health details including general health/ health history and use of services relating to drug misuse and mental health. A summary and action plan was then created for each participant and where appropriate, participants were directed to relevant healthcare services.

Key results

The total number of people who completed a health assessment form with a project nurse during the project period was 356.

Conclusions

The project allowed nurses to meet the unmet needs of homeless people by improving their access to healthcare. This was achieved by first agreeing on the problems with the clients and then achieving their support, advocacy and co-operation with an enormous range of services required to meet those needs.

Therefore, in this sense, it can be deemed to be a success. However, while beyond the scope of the evaluation, questions remain as to its cost-effectiveness and whether it may be better to co-ordinate existing services, rather than establish a specialist team.

Appendix D. Argyll & Clyde Health Board - Improving Looked After and Accommodated Children's Access to Services

Topics: **Child and Maternal Health**; **Primary Care**

Background

NHS Argyll & Clyde successfully bid for unmet needs funding in 2005 and used this to create and evaluate a looked after and accommodated children (LAAC) nursing service. LAAC typically suffer poor health outcomes in both absolute and health inequalities relative to others and they access services disproportionately less than the level of need they have.

Funding allocation

The pilot was allocated £342,000

Aim(s)

To investigate the change in access to health services for (LAAC) in residential care through the establishment of a specialised nursing service.

Methodology

A service evaluation took place and involved data collected before and after the introduction of the nursing service. Originally, it had been planned to carry out a comparison study using control areas but the dissolution of NHS Argyll and Clyde, problems with staff recruitment and the time taken to receive ethical approval for the study to commence were some of the drivers that resulted in the adoption of a service evaluation focus.

The experiences of 168 LAAC domiciled in residential units in Renfrewshire, West Dunbartonshire and Argyll & Bute between August 2006 and March 2007 were studied during the evaluation.

A number of outcome measures were used. These were the proportion of LAAC:

- with completed health records
- pre-admission and comprehensive medicals
- with up-to-date immunisations
- with outstanding medical or dental issues
- registered with a dentist
- whose medical needs had been communicated by a key worker

These were supplemented by a thematically analysed LAAC nurse journal, a service evaluation questionnaire, participant feedback exercise and a qualitative study that investigated the views of residential care workers embedded in the pilot study

Key results

Results were positive for all the key outcome measures.

For example:

- The proportion of LAAC with completed health records increased from 3% to 77%
- Pre-admission and comprehensive medicals increased from 39% to 48%
- LAAC with up-to-date immunisations increased from 9% to 56%
- LAAC with outstanding medical or dental issues decreased by at least 4%
- LAAC registered with a dentist increased from 14% to 62.5%
- LAAC whose medical needs had been communicated by a key worker increased from 23% to 58.5%

In addition, the service evaluation questionnaire and participant feedback both provided positive feedback for the service, highlighting the availability of medical attention and advice and the building of relationships between nurses and young people as the most useful aspects of the service.

However, the study did note a number of systematic and cultural barriers that exist to LAAC accessing universal health services. For example, results from the thematic analysis of the LAAC nurse journals highlighted problems with the procedures relating to the practice of recording and sharing health information between agencies, areas and different parts of the NHS.

Conclusions

The provision of the LAAC nurse service in Renfrewshire, West Dunbartonshire and Argyll & Bute improved access of LAAC in these areas to health services. This was welcomed by both care staff and children.

Appendix E. Argyll & Clyde Health Board - Lomond Volunteer Transport Project

Background

The project operated in Dumbarton and to a lesser extent, in Clydebank. It was primarily available to individuals who were over 65, without their own transport and who were resident in homes with a Health Board Scottish Index of Multiple Deprivation rating of 6-10. However, owing to a lack of referrals, the eligibility criteria was slackened to include frail clients who may not have been resident in the eligible postcode areas and some who may have been under 65.

The project intended to recruit 20 volunteer drivers and achieve 20 interventions a week.

Funding allocation

The pilot was allocated £35,100

Aim(s)

To determine whether a volunteer-staffed patient transportation scheme improved access to healthcare services for socially isolated older people.

Methodology

The project used a mixed design assessing pre and post intervention DNA (did not attend) rates for a podiatry department compared with a control (Alexandria) podiatry department.

A number of qualitative measures were also taken. These were: perceived value of the volunteer transportation service to the users, perceived merit of service to health professionals and experience of volunteering.

Key results

Podiatry DNA rates in the control clinic(s) rose by 1% during the intervention period but declined by 1% in the intervention clinic (Dumbarton).

However, all health professionals who took part in the evaluation of the service felt that it had made it easier for clients to attend appointments. In addition, two further positive outcomes were commented on. These were the reduction in domiciliary visits and the positive effect that verification of transport arrangements had on reminding patients of their impending appointment.

Service users commented that they found the service invaluable as it resulted in financial savings as taxi journeys were no longer required, reduced waiting times when compared with

organised patient transport and increased the confidence of service users with mobility problems owing to the assistance provided by volunteers and reduced return waiting time.

The project experienced a number of problems. These included:

- Driver recruitment was problematic as a result of potential driver concerns about insurance costs and wear and tear on their cars. In addition, a similar scheme that ran in Dumbarton experienced problems with the reimbursement of expenses to drivers
- Lack of referrals, possibly as a result of the number of bank staff used being unaware of the service
- Seasonal commitments such as school holiday childcare can affect driver availability
- Inappropriateness of Clydebank as a project site. For example, no control clinic was available for comparison
- Potential beneficiaries were often reluctant to take up the offer. Reasons for this include the existence of alternatives transport for them, stigma associated with receiving the volunteer transport as opposed to using personal transport and wariness of accepting transport from unknown volunteers

Conclusions

The project continually struggled to reach the desired number of referrals per week, indicating that whilst there may be a demand for this form of transportation, the setting for the intervention may have been inappropriate.

Appendix F. Greater Glasgow Health Board - Chronic Disease Management Programme in Primary Care

Topics: **Mental Health**; **Primary Care**;

Background

Coronary Heart Disease (CHD) is the leading cause of death and morbidity in Glasgow and is associated with high levels of risk factors and increasing levels of deprivation. Secondary prevention can substantially reduce the risk of myocardial infarction and progression of CHD once it is diagnosed.

Funding allocation

The pilot was allocated £2,130,000

Aim(s)

To reduce coronary heart disease (CHD) through a systematic approach to secondary prevention that focuses, not only on using the medical model, but also gives attention to other risk factors that can contribute to risk reduction.

Methodology

The Locally Enhanced Services (LES) in Greater Glasgow ensures a systematic approach to secondary prevention, not only using the medical model but also attention to other health risks that can contribute to risk reduction. Depression or other mental health problems which limit a person's ability to make lifestyle changes are also addressed within the programme.

The programme includes provision of training and resources for practice staff, development of patient pathways, cardiac rehabilitation, liaison with mental health services and robust monitoring systems.

Key results

Some of the key findings from the evaluation of the programme include:

- The analysis of LES data shows that there is a relatively shallow **social gradient** of CHD prevalence when all ages are combined but there is a much steeper gradient in younger age groups in which the main burden of premature CHD mortality and morbidity is found
- There is a 29% excess caseload of CHD patients per WTE GP working in the most deprived fifth of the population

- Although data were only available for a quarter of patients with CHD, there is strong socio-economic patterning in the prevalence of anxiety and depression suggesting that CHD diagnoses in patients in deprived areas are associated with increased psychological morbidity

Therefore, both the increased caseload and associated co-morbidity are likely to affect the quality of care that is provided for CHD patients in deprived areas.

Conclusions

Further work is required to describe the implications of the findings on the quality and outcome of care provided for CHD patients in different settings.

Appendix G. Greater Glasgow Health Board - Looked After and Accommodated Children Mental Health Team

Topics: **Child and Maternal Health**; **Mental Health**

Background

A multi-disciplinary team, the Looked After and Accommodated Mental Health Team (LAA MHT) was established to provide a mental health service to looked after and accommodated children and young people aged less than 18 years.

Funding allocation

The pilot was allocated £930,000

Aim(s)

The service offered by the multi-disciplinary team has three themes:

1. To provide a system for providing mental health support to those involved in the systems of care.
2. To provide an early intervention service routinely to all children entering care.
3. Focussed interventions for individuals, foster families and carers.

Methodology

A variety of activities that related to the three themes of the team took place. These included:

1. To provide a system for providing mental health support to those involved in the systems of care.

Considerable activity took place, including establishing links with children's panel reporters, establishing links with educational psychology and training with foster carers, child health nursing staff and social work students.

2. To provide an early intervention service routinely to all children entering care.

This part of the service provided a routine psychological assessment for all children entering care and provides recommendation regarding their social, emotional and cognitive development.

3. Focussed interventions for individuals, foster families and carers

This was the focus of much work and involved advancing a best fit model. Key features of the model include community CAMHS teams being the entry point for mental health referrals for LAA children and young people; case management and intervention decided according to a number of rules of thumb including continuity, stability of placement and complexity and

an evaluation of views from key stakeholders concerning the care pathway and service provision.

Key Results

- For children and young people aged 0-18 years old, the introduction of the service witnessed a two-fold increase in referrals accepted between 2003-4 and 2004-5 and a three-fold increase in the number of returns. This reflected an increase in staffing and the service plan extending to move beyond service provision for the east sector of Glasgow and Dumbarton
- For under 12s, there was an increase in the number of new notifications between 2004-5 and 2005-6 of 22 children.
- For over 12s, it was noted that the early interventions service development has been limited and consultation with young people was scheduled to take place to facilitate development of the model.

Conclusions

The introduction of the service has seen large increases in both the number of referrals and the number of returns, highlighting the effectiveness of service provision to looked after and accommodated children in Greater Glasgow.

In addition, the team was continually engaged in a process of service evaluation, development and improvement. For example, in developing a foster care intervention package and consolidating links with other services.

For some groups, such as the over 12s, service development has been more limited. However, this had been noted and subsequent actions were scheduled to take place to attempt to address this.

Appendix H. Greater Glasgow Health Board - North and North West Community Addiction teams

Topics: **Mental Health**; **Substance Misuse**

Background

Unmet needs funding was received for two Community Addiction Teams (CATs) from Greater Glasgow Health Board; North and North West.

Funding allocation

The pilot was allocated £2,800,000

Aim(s)

The aim was to assess whether the North and West CATs were meeting unmet need to a greater degree than before. In order to do this, access to treatment and care was measured.

Although beyond the scope of the general aim of the unmet needs pilots to improve access, the pilot also sought to look at depth of engagement by considering usage of the service i.e. actual attendance, assessment, appropriateness of treatment and reassessment prior to discharge.

Methodology

The pilot adopted a case study approach that saw two unmet needs funded CATs that served more deprived catchment areas (North and North West) compared with two CATs with less deprived catchment areas outside Glasgow City (East Dunbartonshire and the Substance Misuse team in East Renfrewshire). These comparisons were chosen as to eliminate as many confounding variables as possible.

Therefore, the evaluation sought to measure whether the North and North West CATs had increased access to treatment and care for people with the greatest unmet need to a proportionately greater extent than they had increased access by other groups.

Specifically:

1. Proportions accessing the service by deprivation category within each CAT area were compared with the proportions of the population within each Deprivation Category in each area, to see if the amount of service usage by Deprivation Category reflected the population by Deprivation Category.
2. Access by Deprivation Category within CAT areas was compared between separate CATs with overall richer and poorer catchments.

Multiple sources of data were used to measure access. These were Social Work Carefirst systems, NHS Standard Morbidity records and single shared assessments.

Key results

During the evaluation period, the number of clients increased across Glasgow city as a whole. However, the two unmet needs funded CATs saw the biggest percentage increase in total number of clients.

In the North West CAT, clients from the more deprived areas contributed disproportionately to the increase. In the North CAT, any substantial increase in the proportion of clients from more deprived areas was difficult to observe, owing to the already high proportions (over 90%) of clients attending who were from DepCat 7. However, here, a general increase in the volume of new clients was also noted.

In contrast, the East Dunbartonshire CAT saw no increasing trend in the population rate of new clients. Any fluctuations noted were the result of staff changing over to using a different information system to record client access.

In the East Renfrewshire CAT, again no increase in new service users among more deprived groups was noted. In fact, the data showed that the more deprived groups decreased quite sharply as a proportion of new clients, while less deprived groups increased.

The number of types of interventions was higher for the unmet needs funded CATs (38 for North and 33 for North West) compared to the comparison Cats (14 for East Renfrewshire and 22 for East Dunbartonshire). In addition, the unmet needs funded CATs gave more interventions to each client (8.5 for North and 5.6 for North West) than the comparison sites (East Renfrewshire 1.8 and East Dunbartonshire 2.6).

In terms of the variety of interventions, there was more emphasis on cognitive and psychosocial interventions in the unmet needs pilot sites than the comparison sites.

Conclusions

The two unmet needs funded CATs managed to reach more deeply into more deprived parts of their populations which are known to have unmet needs, especially in the area of addictions than the comparison sites.

The evaluation did not investigate the effect of the unmet needs funded CATs in delivering better outcomes for clients. However, it was noted that they did deliver a greater variety of interventions and appeared to focus more on evidence-based cognitive and psychosocial interventions than the comparison teams. They also assessed clients for more individual interventions on average than each of the comparison sites, suggesting a greater input into each client. Therefore, this suggests that the unmet needs funded CAT teams were able to channel additional resources into each individual client.

Appendix I. Greater Glasgow Health Board - Oral Health Promotion for Vulnerable Children

Topics: **Child and Maternal Health**; **Primary Care**

Background

The project outline was submitted in the context of the Greater Glasgow Oral Health Strategy and reflected a range of actions required to improve health, reduce inequalities and improve health services.

Funding allocation

The pilot was allocated £1,390,000

Aim(s)

To improve health, reduce inequalities and improve health services in the context of oral health.

Methodology

A number of specific developments related to the unmet needs programme were identified:

- Additional services to nurseries – The “Smile Too” nursery programme and the “Get Brushing Club” initiative are two examples of vehicles used to develop extended oral health practices within nurseries, including those in areas of deprivation.
- Increased support to parents and carers of 0-3 year olds – A considerable range of local initiatives, increasingly targeting the parents of children under 3 years in areas of deprivation have been undertaken, including weaning fairs, Get Cooking, Dental Play boxes and oral health training for health visitors and assistants.
- Links to primary schools – A number of initiatives have been implemented e.g. “Hungry for Success” has seen extensive implementation across GCC primary schools; fruit in schools has seen enhanced provision to all primaries and nurseries and breakfast clubs with extended programmes have provided a range of oral health activities.
- Targeted activity for children with special needs – A specialist oral health promotion and oral hygiene service was developed and work to identify the needs of staff and carers in SEN schools and child health development centres was undertaken.

Key results

There were statistically significant improvements in 5 year olds' dental health indices in pilot districts.

There were also statistically significant improvements across Deprat 7 districts in Greater Glasgow following the introduction of OHAT activities with no similar improvement noted in Depcats 1-6.

Conclusions

The impact on the oral health of five year old children living in areas of deprivation has been significant and the unmet need programme has facilitated the continuing development of efforts to promote oral health across Greater Glasgow and in particular, vulnerable children. It has supported the continuing development of the Oral Health Programme in Greater Glasgow and in conjunction with additional funding, has supported the development of a comprehensive approach to oral health on an area-wide and local basis.

Appendix J. Greater Glasgow Health Board - Primary Care Mental Health Teams

Topics: **Mental Health**; **Primary Care**

Background

Each year, around 170,000 people experience common mental health problems, from relationship problems to anxiety and depression. In addition, rates of distress are twice as high in the most deprived areas. Despite this, few services exist that can adequately meet the needs of those experiencing problems and the services that do exist are characterised by access difficulties and long waiting lists.

Unmet need funding was invested in an existing planned programme to provide primary care mental health (PCMH) services. The unmet needs money facilitated completion of the roll-out of this programme to fund services in the south and east of Glasgow.

Funding allocation

The pilot was allocated £2,332,000

Aim(s)

To roll-out a planned programme to provide primary care mental health (PCMH) services in the south and east of Glasgow.

Methodology

Both PCMH teams have been designed around a 'stepped' or 'matched' care model which, in practice, means that a range of interventions are offered from advice, information and signposting through to self help, group and individual therapies.

One of the key features of this model is that it directly aims to address the issues of easy access and addressing a large volume of clients. It does this by allowing self-referral in addition to standard GP referral and is able to match individual's need to an appropriate and timely intervention.

Key results

In both areas, a high volume of referrals, contacts and interventions have been recorded and there is evidence of clinical effectiveness and client satisfaction.

For example, a Stress Control psycho-educational group was held over six evenings and there is clinical outcome data to show its effectiveness. The first session of the most recent course was attended by 120 people, a figure that far outweighs the number of clients that get help

through a traditional one-to-one therapist model in a single year. Additionally, up to 85% of clients had not used mental health services before.

In terms of unmet need, both teams reported high proportions of clients from the most deprived postcode areas then the more affluent areas. However, as this information is from referrals only, there is also evidence that DNA (Did Not Attend) rates from these areas are higher than more affluent areas.

Additionally, there is a continuing lack of uptake amongst young men, ethnic minorities and older people.

Conclusions

The services provided as part of the programme have been used by an increased number of people in the two areas and have proved to be effective and popular. There has also been increased uptake of services from the most deprived areas when compared with more affluent areas.

However, there remains a need to target certain population types in deprived communities such as old people, young men and ethnic minorities.

Appendix K. Greater Glasgow Health Board - Stress Centres

Topics: **Mental Health**

Background

Unmet needs funding was allocated to five stress centres within Greater Glasgow. The funding was used mainly to either supplement existing services which were already being supported by the NHS and other partners, or to develop new centres.

All the stress centres are located within former Social Exclusion Partnership areas (some of the worst Deprat areas in Scotland). Therefore, they target geographic populations who are amongst the most socially excluded in Scotland.

Funding allocation

The pilot was allocated £880,000

Aim(s)

To support existing stress centres or allow the development of new stress centres in Greater Glasgow.

Methodology

5 stress centres benefitted from unmet needs funding. The stress centres have utilised unmet needs funding in a variety of ways:

- South West Stress Centre (Govan and Pollock) – A stress centre service has been brought in to Govan and Pollock. This operated 3 days a week at two local customised venues
- West – part of the funding received was redistributed to support core funding of the Royston Stress Centre. The rest of the funding was used to support counselling services provided by Caring Over People's Emotions (COPE) in Drumchapel and to train local volunteers and staff in mental health issues
- East – Funding was used to support core funding for an Alternative Stress Centre
- West Dunbartonshire – A stress network was established
- North – The majority of funding was allocated to Lifelink, a service aimed at people at risk of suicide or self-harm. Lifelink provided a number of services including: drop-in; counselling and massage therapy; one-to-one support and assessment and onward referrals. Unmet needs funding allowed Lifelink to create a more comprehensive service

Key Results

The unmet needs funding has enabled existing stress centres to continue to operate and in some cases, extend their service provision.

During 2005/6, the south-west centre saw 279 clients referred to the service. Of these 279 clients, 46 were already attending the service and 233 were new clients who had entered the service for treatment.

The Royston Centre provided outreach to 546 clients, group programmes for 183 clients and stress management plans for a further 300 clients.

Conclusions

Unmet needs funding allowed existing stress centres, all of which were based in areas with populations who have multiple and complex needs to continue to operate and in some cases, extend their service provision.

Appendix L. Greater Glasgow Health Board - Starting Fresh (Smoking Cessation)

Topics: **Substance Misuse**

Background

Unmet needs funding was used, along with additional resources that became available concurrently, to support the development of the “Starting Fresh” (smoking cessation) Programme. This meant that the unmet needs funding was mainstreamed into a comprehensive smoking cessation service.

The unmet needs bid identified 4 principle areas of development for smoking cessation services and the two key areas of development are summarised below.

Funding allocation

The pilot was allocated £400,000

Aim(s)

To support the ongoing development of the smoking cessation service within Greater Glasgow, ensuring developments were targeted to both areas of deprivation and vulnerable client groups.

Methodology

Two key areas of development for smoking cessation services were identified. These were:

- Extension of the “Starting Fresh” pharmacy network within areas of deprivation

A key feature of the Starting Fresh pharmacy programme is the support offered to community pharmacists by the Community Pharmacy Health Promotion Facilitator Network. Pharmacy advisers undertake a number of roles including providing a link between the community pharmacies, acute smoking cessation advisors/pharmacist and smoking cessation advisors in primary care.

Evidence shows that pharmacy services have succeeded in creating a high volume of access to smoking cessation services in Greater Glasgow. However, cessation rates for clients within the pharmacy service are lower than those achieved within more intensive smoking cessation interventions.

- Development of secondary care in-patient services

Unmet needs funding was used to further develop the existing integrated stop smoking services and to accommodate patients who had been given intensive support and prescribed NRT (nicotine replacement therapy) in the acute hospital setting. This was done by funding two of five hospital cessation adviser posts in Glasgow. The advisers were used as part of a smoking cessation protocol that was devised for

hospital in-patients. This protocol included those wanting to make a quit attempt receiving intensive support from a smoking cessation advisor, the provision of NRT on discharge and additional support and NRT from a preferred “Starting Fresh” pharmacy.

Key results

- Extension of the “Starting Fresh” pharmacy network within areas of deprivation

Of the additional 52 pharmacies recruited, 60% were located in areas of deprivation (Deprat 5-7). There is clear evidence that users are being drawn into the service from the most deprived parts of Glasgow’s population, with 57% residing in the two quintiles that are associated with higher areas of deprivation. However, the impact of reducing inequalities is limited as it was found that smokers living in more deprived areas had lower levels of cessation than smokers living in more affluent areas. Therefore, more intensive support achieving higher cessation rates is required.

- Development of secondary care in-patient services

The service reached the target group of heavily addicted smokers from socially deprived areas. 212 patients accessed the service and 48% were not smoking at a one month follow-up. Of the 212 patients, 61% were from Depcats 5-7.

Conclusions

The unmet needs programme supported the ongoing development of the smoking cessation service with Greater Glasgow ensuring that developments were targeted at areas of deprivation and vulnerable client groups.

Appendix M. Greater Glasgow Health Board - West of Scotland Breast Screening Service

Topics: **Hard to Reach Groups**

Background

In the Glasgow area, uptake rates for breast screening varied from 45% to 85%. Many factors can influence uptake rates. However, statistics from 2001/2 showed large attendance differences between deprivation categories with uptake in Deprat 7 below 65%, whereas uptake at Deprat 1 was 85%. In particular, uptake was low in certain areas such as Easterhouse and Gorbals, both Deprat 7 and both with an uptake of less than 45%.

Funding allocation

The pilot was allocated £610,000

Aim(s)

To increase overall attendance at breast screening clinics and to target attendance by ethnic minority groups.

Methodology

An evaluation by NHS Greater Glasgow in 2004 suggested that a variety of types of intervention can lead to a possible increase in uptake of breast screening. These included Personally Directed Intervention e.g. personal invitation letters, reminder letters and contact by phone, second invitations with fixed appointments and the introduction of local initiatives.

Therefore, the West of Scotland Breast Screening Service decided to use unmet needs funding to finance three activities aimed at increasing the uptake for breast screening. These were: community seminars, confirmation of intention to attend contact and information material specifically aimed at ethnic minority women.

- Community seminars

These were held in Castlemilk, Parkhead and Bridgeton and attendees included GPs, practice managers, practice nurses and health visitors.

- Intention to attend

A successful initiative had previously been undertaken in Bridgeton where members of the practice staff had contacted women to confirm their intention to attend. The uptake improved from 55% to 70% as a result of this contact. This idea was introduced at the community seminars and generated some interest.

- Information material

Typically, uptake is low for ethnic minority groups. It was therefore decided to produce a DVD demonstrating the screening procedure for women that addressed general questions that women ask during the process. The DVD was subtitled in three languages and had subtitles in English provided for the deaf community.

Key results

Pre and post community seminar questionnaires were distributed and preliminary results demonstrated a substantial increase in knowledge of the attendees following the seminar. In addition, respondents indicated increased confidence in discussing breast screening and some respondents indicated a desire to initiate activities to raise awareness.

Conclusions

Initial work suggests that the initiatives introduced are having a positive effect in increasing knowledge and there exists the possibility of increasing service uptake through a personal contact initiative used to confirm intention to attend for screening.

Appendix N. Tayside Health Board - Breastfeeding

Topics: **Child and Maternal Health**

Background

The objectives of the project were to recruit and train breastfeeding support workers who would provide additional support, information and practical skills in the antenatal and postnatal periods for mothers living in deprived areas as identified by postcode area.

Funding allocation

The pilot was allocated £190,500

Aim(s)

To provide women on low incomes in Dundee with additional information and support by breastfeeding support workers to improve breastfeeding initiation and duration rates.

Methodology

The project employed a non-randomised (quasi) experimental design involving mothers in Depts 5, 6 and 7 living in Dundee as the intervention group. Two control groups were also recruited for comparison. One group, "Similarly deprived" comprised mothers in two postcode sectors in Angus and one postcode sector in Dundee and the other group, "Affluent" comprised mothers living in Depts 1 and 2 in Dundee. The breastfeeding support workers recruited mothers at 28 weeks gestation.

The primary outcomes of the project were the uptake in services defined as two or more accepted home visits and breastfeeding rates at birth, discharge, first visit and 6/8 weeks.

In addition, a number of secondary outcomes were stated. These were the numbers and socio-demographic distribution of: patients contacted; patients who were contacted and offered follow-up services; patients who attended follow-up services and patients views regarding acceptability.

Key results

In the intervention areas, the breastfeeding rate at 6-8 week review increased by 9%, compared with an increase of 1.8% in the "Similarly Deprived" control group and a decrease of 11.7% in the "Affluent" control group.

Pre and post intervention, the intervention group showed significantly higher increases in breastfeeding rates than the other two groups at each of the points of comparison.

Results from focus groups with breastfeeding support workers, midwives and health visitors and in-depth interviews with 12 mothers indicated that the service was highly valued by both service users and professionals.

Conclusions

The project demonstrated an effective and highly valued model of working that can improve breastfeeding rates for those living in deprived communities and can be used to inform future practice.

Appendix O. Tayside Health Board - Early Intervention in Mental Health

Topics: **Mental Health**

Background

The intervention offered a direct referral to counsellors in primary care and therefore provided an alternative to mainstream treatment of patients identified as having problems best resolved by counselling.

Funding allocation

The pilot was allocated £172,500

Aim(s)

To increase uptake of counselling services for clients in Depcats 6 and 7 by targeting resources for these clients.

Methodology

The project was a descriptive pilot/ impact assessment. This involved patients from 5 GP practices all living in Depcats 6 and 7 presenting with mental health problems best resolved by counselling.

Primary outcomes were the uptake of counselling sessions with successful uptake defined as attendance at at least 2 sessions.

There were also a number of secondary outcomes. These were the numbers and socio-demographic distribution of: patients contacted; patients who were contacted and offered follow-up services; patients who attended follow-up services and patient views regarding acceptability.

Key results

Main findings for the project were that 77% of clients who were offered the counselling service attended at least 2 counselling sessions. Of those accessing the service, 80% lived in Depcats 6 and 7, with majority of referrals for female clients. Significant clinical outcomes were reported although these were less than those of other more generic counselling services. In addition, self-report satisfaction levels from returned client satisfaction questionnaire were high.

Conclusions

Results showed that uptake increased and the service has provided high levels of satisfaction from clients.

Appendix P. Tayside Health Board - Health Inequalities in the Homeless

Topics: **Hard to Reach Groups**; **Mental Health**; **Primary Care**; **Substance Misuse**

Background

The homeless population have a complex set of unmet needs with, for example, high rates of physical illness, chronic disease or mental health problems, poor nutrition and drug misuse. In addition, they often have difficulty accessing services partly due to their lack of permanent residency in one location and partly due to attitudes of service providers. The project therefore sought to pilot a proactive preventative outreach model of care to homeless people.

Funding allocation

The pilot was allocated £358,692

Aim(s)

To provide an outreach primary care service to homeless people living in hostels in Dundee, taking a proactive preventative approach to enable clients to make informed choices about their health and wellbeing.

Methodology

The project utilised a pre-post comparison and recruited two groups of clients – the intervention group and the control group. The intervention group comprised homeless people from selected hostels in Dundee City. The control group comprised homeless people from other hostels and homeless accommodation in Dundee City.

The intervention was delivered in a number of ways. For example, nurses provided twice weekly open access clinics within a variety of suitable locations; GPs offered outreach clinics in two hostels once a month; an advocacy service was provided and some preventative work e.g. dental services were provided in hostels.

In contrast, those in the control group received an existing named health link only in line with standard practice.

The primary outcome of the project was to measure the increase in self-reported use of health services pre and post contact with the service.

There were also a number of secondary outcomes. These were the numbers and demographic distribution of: patients contacted; patients who were contacted and offered follow-up services; patients who attended follow-up services; and patients views regarding acceptability.

Key results

Results of a post intervention follow-up showed that there was an increase in service use for both intervention and control groups. In addition, the intervention group recorded significantly higher access to drug services and open access drop-in. The intervention group also recorded increased contact with primary care services and a significant increase in social work contact.

Conclusions

The project successfully increased service use through the use of the outreach service proposed a number of recommendations. A number of elements of the intervention package were identified as being responsible for changes in service usage. These included the ability of the project team to identify the gaps in services for particular groups or from certain health services and the lack of intimidation in dealing with homeless people compared to that which is often felt by statutory service providers.

Appendix Q. Tayside Health Board - Improved Access to COPD Services

Topics: **Mental Health**; **Primary Care**; **Substance Misuse**

Background

Chronic Obstructive Pulmonary Disease (COPD) is joint fourth leading cause of death in the world, with 32% of respiratory admissions due to COPD. At present it is under-diagnosed and under-treated and given that one of the primary causes for COPD is smoking, the burden of COPD is significant, especially in Dundee which has rates of smoking higher than the national average.

In Dundee, attendance rates at practice based COPD clinics varied, with areas of high affluence achieving rates of +80%, whereas areas of high deprivation are less than 50%.

Funding allocation

The pilot was allocated £45,000

Aim(s)

To increase uptake of COPD services in areas of high deprivation in Dundee.

Methodology

A respiratory project nurse appointed for study period. A quasi-experimental design used in which people from 16 practices in Dundee who had not attended a COPD assessment were identified. Clients were then put into one of three groups –

- Deprived intervention (Depcat 5-7) = 106
- Deprived non-intervention (Depcat 5-7) = 48
- Non-deprived non-intervention (Depcat 1-3) = 24

The primary outcome for the project measured uptake in services defined as meeting for assessment and attendance at 6 month follow-up.

The secondary outcomes of the project were the number and socio-demographic distribution of: patients contacted; patients who were contacted and offered follow-up services; patients who attended follow-up services and patient views regarding acceptability.

Key results

Dedicated nurse telephoning and visiting patients in deprived areas allowed approximately half of identified patients in the deprived intervention group to be contacted and a third to take part in a COPD assessment and treatment programme at home.

The proportion of patients attending their general practice COPD clinic following the above COPD assessment and treatment programme at home was 59% which was 20% greater than a comparable deprived control group who were contacted by letter only.

Conclusions

The project highlights that taking small steps to make contact with persistent non-attenders may be a productive approach.

However, in considering reasons for non-attendance, the project noted the variety of complex health issues associated with condition e.g. 54% of identified patients had mental health problems and 23% had alcohol dependency syndrome.

Appendix R. Tayside Health Board - Outreach Services for Gypsy Travellers

Topics: **Hard to Reach Groups**

Background

Gypsy travellers suffer significant health inequalities, even when compared with other socially deprived or excluded groups. This is most marked in terms of self reported anxiety, respiratory problems and chest pain. A number of key issues in accessing healthcare are prevalent for this group including lack of continuity of care, difficulties in registering with a doctor and high levels of anxiety and stress.

Funding allocation

The pilot was allocated £60,000

Aim(s)

To provide an outreach health screening and surveillance service to gypsy travellers in Angus.

Methodology

The project was a descriptive pilot/ impact assessment and sought to contact travellers living either on one of two council run sites which housed up to 38 families in total or on unauthorised sites ranging from houses to disused land.

The health worker visited two days a week and worked to determine health issues and signpost clients to local services. The health worker was also a member of the Gypsy Traveller Liaison group.

Primary outcomes were the number of successful contacts between Outreach service and clients and the number of service contacts made on behalf of clients.

The secondary outcomes were the numbers and socio-demographic distribution of: patients contacted; patients who were contacted and offered follow-up services; patients who attended follow-up services and patients views regarding acceptability.

Key results

The health worker saw 160 people between January and September during the project run.

It was noted that it took quite a while to build trust with clients and the health worker felt that they were only really beginning to engage with people near the end of the project.

A number of health related issues were identified including lack of knowledge about services, lack of information concerning how to contact them and discrimination at some health centres.

The project encouraged use of the Patient Record of Personal Health – developed by the National Resource Centre for Ethnic Minority Health in consultation with the gypsy traveller community and health professionals. In addition, the project also saw the development of an information leaflet highlighting healthcare services in Angus.

Conclusions

While it was felt to take time to build up trust the health worker managed to begin to address health issues through the project.

However, it is suggested that owing to the complexities involved in addressing health inequalities, a sustainable commitment in funding is required. Also a successful approach requires the various agencies to work together as health is multi-faceted and is affected by accommodation, environment, life experiences and education.

Appendix S. Tayside Health Board - Uptake of Cardiology Services

Topics: **Hard to Reach Groups**

Background

People living in deprived communities have lower uptake of specialist cardiac services than patients from more affluent areas. This means that some patients are missing out on effective cardiological care with resultant poorer outcomes, higher morbidity and reduced survival.

Funding allocation

The pilot was allocated £692,708

Aim(s)

To improve access to modern evidence-based cardiology services for those people most at risk from coronary heart disease (CHD). Therefore all services, which can feasibly be delivered away from the main cardiology department, were to be provided in deprived communities where the prevalence, morbidity and mortality of CHD is highest.

Methodology

The project was a descriptive pilot/ impact assessment. The methodology used in the project had two key features. Firstly, the specialist cardiology clinic was delivered in a community venue or clinical mobile unit. Secondly, 'opportunistic cardiology assessment' was used. This involved the identification of potential patients through attendance at local events e.g. gala days, bingo halls and mosques.

The primary outcomes of the project was to measure the numbers taking up the service, clinical need identified and numbers attending a subsequent referral appointment.

A number of secondary outcomes were also measured. These were the numbers and socio-demographic distribution of: patients contacted; patients who were contacted and offered follow-up services; patients who attended follow-up services and patients views regarding acceptability.

Key Results

1781 people have engaged with clinical project activity and of this number, 10% are of South Asian ethnicity, a group known to have an increased risk of coronary heart disease. The majority of people who have engaged are from the poorest areas of Tayside. In addition, taking clinical services to places of worship has increased engagement with ethnic groups.

Of the total number engaging with the service, 161 have had a consultation at the specialist cardiology clinic and of this number, 82 had no known CHD but described significant symptoms.

Conclusions

The project successfully improved access to modern cardiology services to those in deprived communities and ethnic minorities. The project has produced a variety of service design and delivery information that can inform future service design related to the feasibility, acceptability and popularity of the service in this format.

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