University of Sheffield | Academic Unit of Primary Medical Care

General Practice at the Deep End
Yorkshire and the Humber

Short report and user guidance

FAIRSTEPS Study:

Framework addressing inequities in primary care using stakeholder perspectives

Ben Jackson, Steven Ariss, Chris Burton, Anna Cantrell, Mark Clowes, Jo Coster, Munira Essat, Caroline Mitchell, Josie Reynolds, Tom Lawy.

FAIRSTEPS STUDY

Guidance for action in primary care to address health inequities

Short report and user guidance

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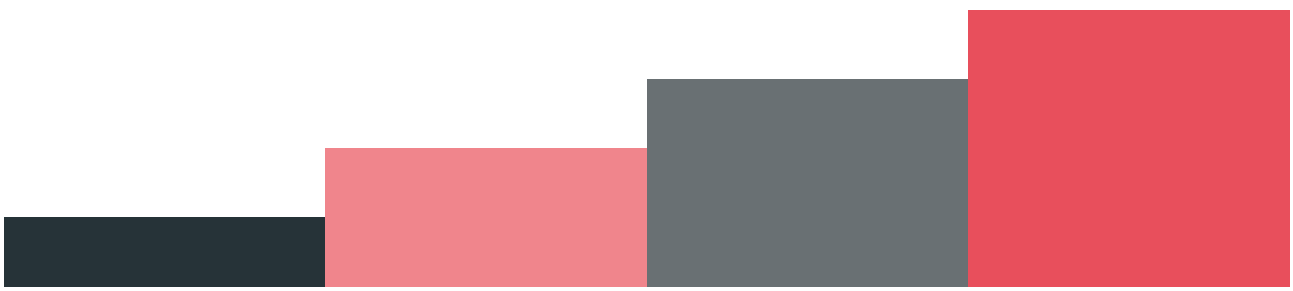
This short report presents the key findings of a mixed-methods study to develop an evidence-informed framework for those wishing to develop actions to address health inequities through primary care in the UK through education, training and primary care service development.

The Academic Unit of Primary Medical Care (AUPMC) and the School of Health and Related Research (ScHARR) at The University of Sheffield have prepared the report under contract to the Health Education England (North East and Yorkshire), through funding from the Primary Care School (Yorkshire and the Humber). The findings and interpretations in this report are those of the authors and do not necessarily represent the views of any services or organisations or funders of the study.



Audience for the report

There are several target audiences for this report, including all local, regional and national organisations whose strategic objectives are to address health inequities through the proportionate provision of primary health care services.

These include:

- **Primary Care Practitioners, Primary Care Networks.**
- **Health Education England; NHS Education for Scotland; Health Education and Improvement Wales;**
- **NHS England, NHS Scotland, NHS Wales, Department of Health Northern Ireland,**
- **Independent policy units**
- **The public: a lay summary has been prepared for service users and carers/family members.**

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David Blane	Clinical Research Fellow, University of Glasgow / Deep End Scotland group / GP
Rebecca Fisher	Senior Policy Fellow, Health Foundation / GP
Nigel Hart	Professor, General Practice and Primary Care, University of Belfast / Deep End Northern Ireland / GP
Chad Hockey	Clinical Director, North Hammersmith and Fulham Primary Care Network / GP,
Margaret Ikpoh	Vice-Chair, Royal College of General Practitioners / GP
Yeyenta Osasu	Regional Health Equity Lead (NHS North East and North Yorkshire) / National Pharmacy Integration Lead (NHS England) / Pharmacist
Dominic Patterson	Director, School of Primary Care (Yorkshire and Humber), Health Education England / Deep End Yorkshire and Humber / CEO FairHealth / GP,
Martin Weatherhead	Clinical Lead, Deep End North East and Cumbria / GP
Johanna White	Deep End Research Group Nurse, South Yorkshire / Practice Nurse

Members of the Deep End Sheffield patient participation panel:

Alan White, Carole Hobson, Linda Jones, Tasleem Aziz, Shabir Aziz, Aneesah Aziz, Jude Beng, Aaisiaah Aslam

Patient participation facilitation:

Kate Fryer	Project Manager Deep End Research Alliance – AUPMC, Sheffield, UK

Study team support:

Harvir Braich	Leadership Fellow, Health Education England
Laura Jones	Leadership Fellow, Health Education England

Executive summary

The reason we carried out the FAIRSTEPS work

Health inequities are unjust and avoidable inequalities in health outcomes within populations[1]. While the largest contributor to health inequalities come from social determinants of health (income, housing etc.), around 20% is amenable to high quality healthcare[2]. However, this is less available to those that need it the most[3]. This 'inverse care law', described over 50 years ago, but persisting today[4], suggests that we need to make significant changes in the way we plan and deliver services to reduce health inequity. The 2010 Marmot report argued that in order to tackle health inequities, services should develop local interventions to fit their setting, informed by a set of guiding principles[5]. A set of evidence informed principles should help ensure additional investment of time and resources into developing interventions has maximal impact.

Our aims

The FAIRSTEPS study aims to provide a set of evidence informed principles to guide the commission, design and delivery of interventions in primary care to address health inequities, along with a set of practical examples, prioritised by practitioners and patients, of interventions that have been tried and tested. The resulting framework is relevant for providers and commissioners of education and training and primary care services.

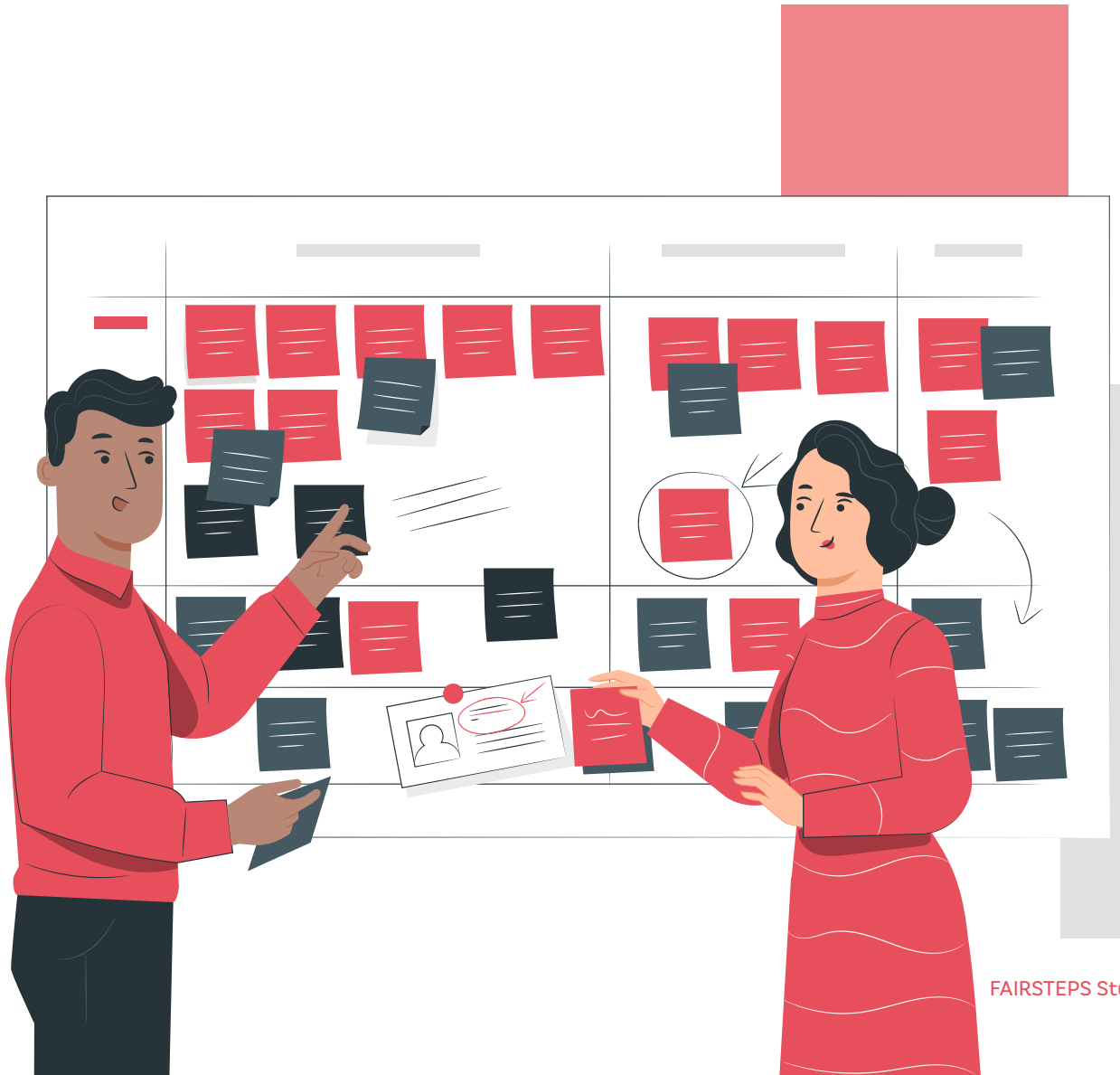
What we did

We developed the FAIRSTEPS framework using a mixed methods approach that had three parts: an integrative review of evidence[6]; a Delphi process for understanding and prioritising interventions with practitioners and experts in the field[7]; and engagement with individuals and communities with lived experience of health inequities to ensure that the work remained relevant to the real world[8].

Integrative review

The review used a systematic search for information about interventions in general practice to reduce health inequities over the last 20 years . It integrated scientific publications with relevant reports and policy documents. The review looked at what interventions contained and how well they worked; it also examined what they tried to do and how they tried to do it. The review had three outputs:

- A description of interventions according to what they contained, what they aimed to do, how they aimed to do it, and why they expected it to work;
- A description of the barriers and facilitators to implementing interventions;
- A set of intervention vignettes. These are short descriptions of interventions to reduce health inequities – either taken directly from one report or composed of typical components from a number of similar reports. These provided the material for both the Delphi process and the iterative discussion with people with lived experience of health inequities.



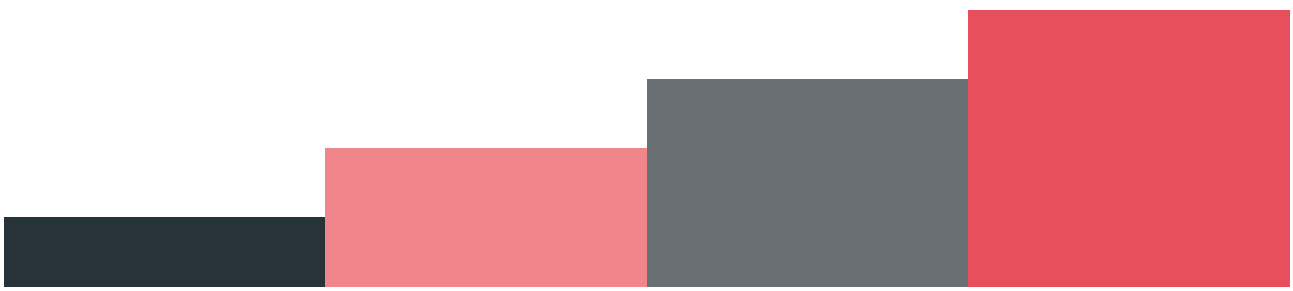
Delphi Process

The Delphi process used a panel of experts to rank the vignettes in terms of usefulness and ease of implementation[7]. The aim of the Delphi was to find those interventions that were most useful to patients and which, with appropriate support and investment, could be most easily implemented in general practice.

We used a three round Delphi process in which participants ranked vignettes of possible interventions. Those completing all three rounds were predominantly general practitioners (76%), but participants included practice management (19%) and other clinical practitioners from urban or mixed urban/rural primary care settings. In the first round, all participants scored each intervention vignette. In the second round, participants re-scored the same vignettes but could see group scores from the first round. After the second round, we removed vignettes that did not reach a consensus threshold on both usefulness and ease of implementation ratings. The third round produced a final prioritised ranking of the highest scoring vignettes. Before the first round of the Delphi, our lived experience group discussed all of the vignettes to ensure they made sense and suggest modifications. They also met to review the results of each round of the Delphi and contribute to decision-making for the following round. We also had the process reviewed by our expert stakeholder panel.

Involving people with lived experience
We worked with 8 individuals from the Deep End Sheffield Patient and Public involvement group at all stages of the project to ensure that the suggestions for the Delphi process and the findings at each stage of our methods were easy to understand and focused on the needs of people in the real world[8].

These methods are summarised in figure 1.



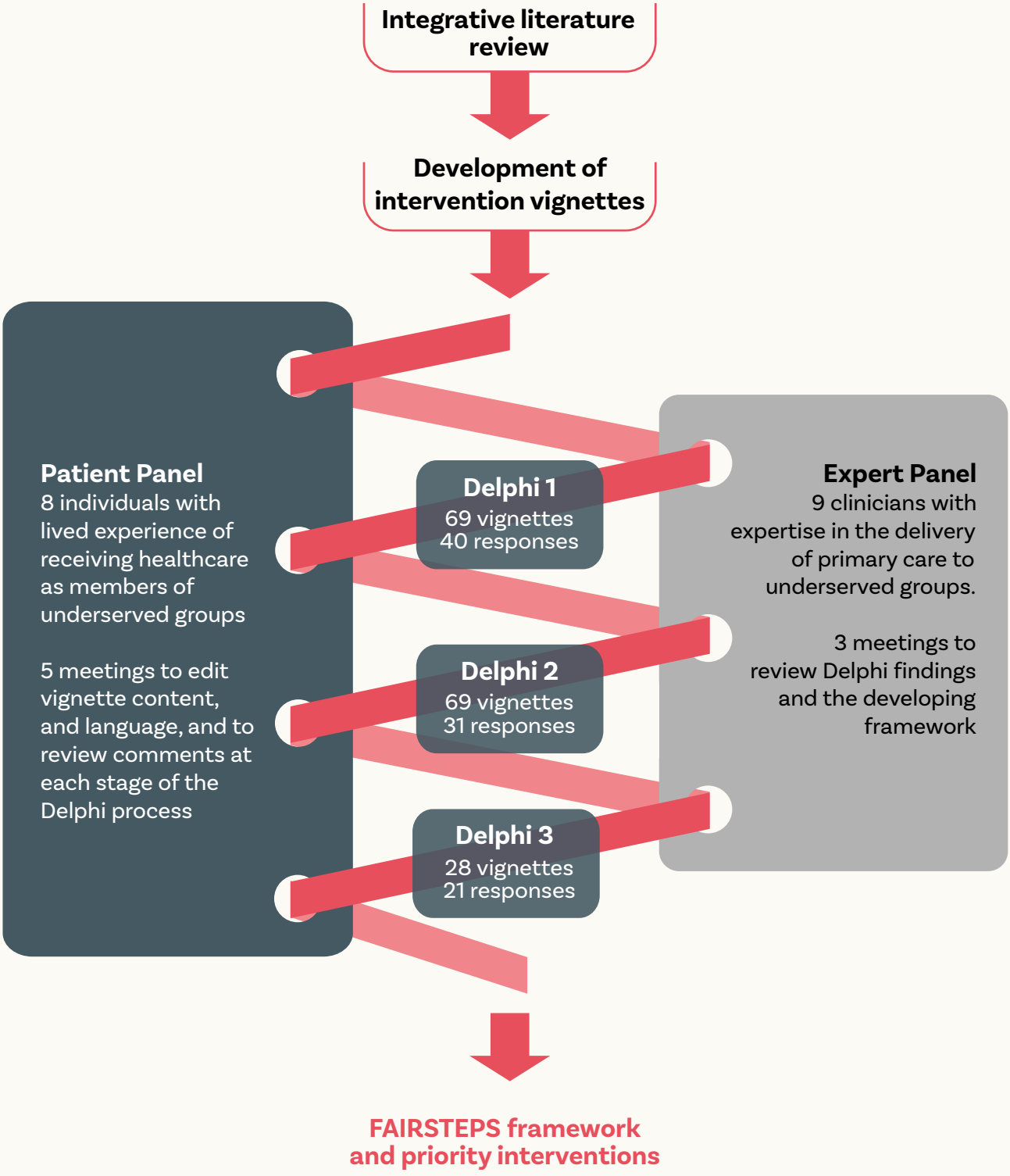


Figure 1. Process of development of the FAIRSTEPS framework

What we found

Review
The review included 68 scientific papers and 20 other forms of report. From these we produced 69 examples of interventions designed to reduce health inequities in general practice. We used these to inform and develop the vignettes for the Delphi process and patient panel. At the end of the Delphi process, 28 of the 69 intervention vignettes had met our standards of usefulness and ease of implementation. These are the FAIRSTEPS prioritised interventions.

Very few of the interventions identified from the review had been tested in rigorous randomised controlled clinical trials. This lack of testing is not surprising as there is historically poor representation of underserved populations and their practitioners in research[9]. As the aim of this research was not to make strong recommendations for particular interventions as a consistent way of reducing health inequities (as assessed by traditional hierarchies and grading of evidence[10]), but rather to map and prioritise different options available, this lack of testing did not prevent us from including studies. The Delphi process and integration of patient perspectives and topic experts were therefore the essential components in developing a credible framework.

Many of the interventions we found included some evidence of effectiveness. Where this was accompanied by clear description of plausible ways that the intervention should work, we were able to recommend key components that should be included and contextualised in any local interventions aiming to reduce health inequities. We were also able to review evidence on the important issues that mean that underserved populations are not able to receive high quality primary healthcare.

We found that many interventions were designed for a specific setting, patient group, or type of service. Rather than recommending that these be used in settings different from those for which they were designed, we recommend that the principles that inform them should be used within a structured framework for building local interventions which reflect local circumstances and local needs.

Examples of interventions

The interventions we found ranged from strengthening or adapting current general practice to developing new services or partnerships with other groups such as charities or businesses. Examples include providing regular targeted, accessible information for underserved groups; 'flagging' individual records using standardised data coding (SNOMED[11]) to highlight a different approach to care is required and developing new out-reach clinics with multidisciplinary teams.

Following the Delphi process, we were able to show how different interventions scored for usefulness and ease of implementation. These 'prioritised interventions' - those interventions that were considered most useful in addressing inequities of care and, with appropriate strategy, support and investment, feasible to implement, from the perspective of practitioners- are provided at the end of the framework with examples and comments about the intervention from the lived experience patient panel.

The FAIRSTEPS framework

The FAIRSTEPS framework is unique in its integration of evidence of theory and both practitioner and patient perspectives.

This builds on both our comprehensive review of primary care interventions and why and how they may work, and our Delphi survey of example interventions scrutinised by practitioners and patients for how useful and easy to implement they would be in practice.

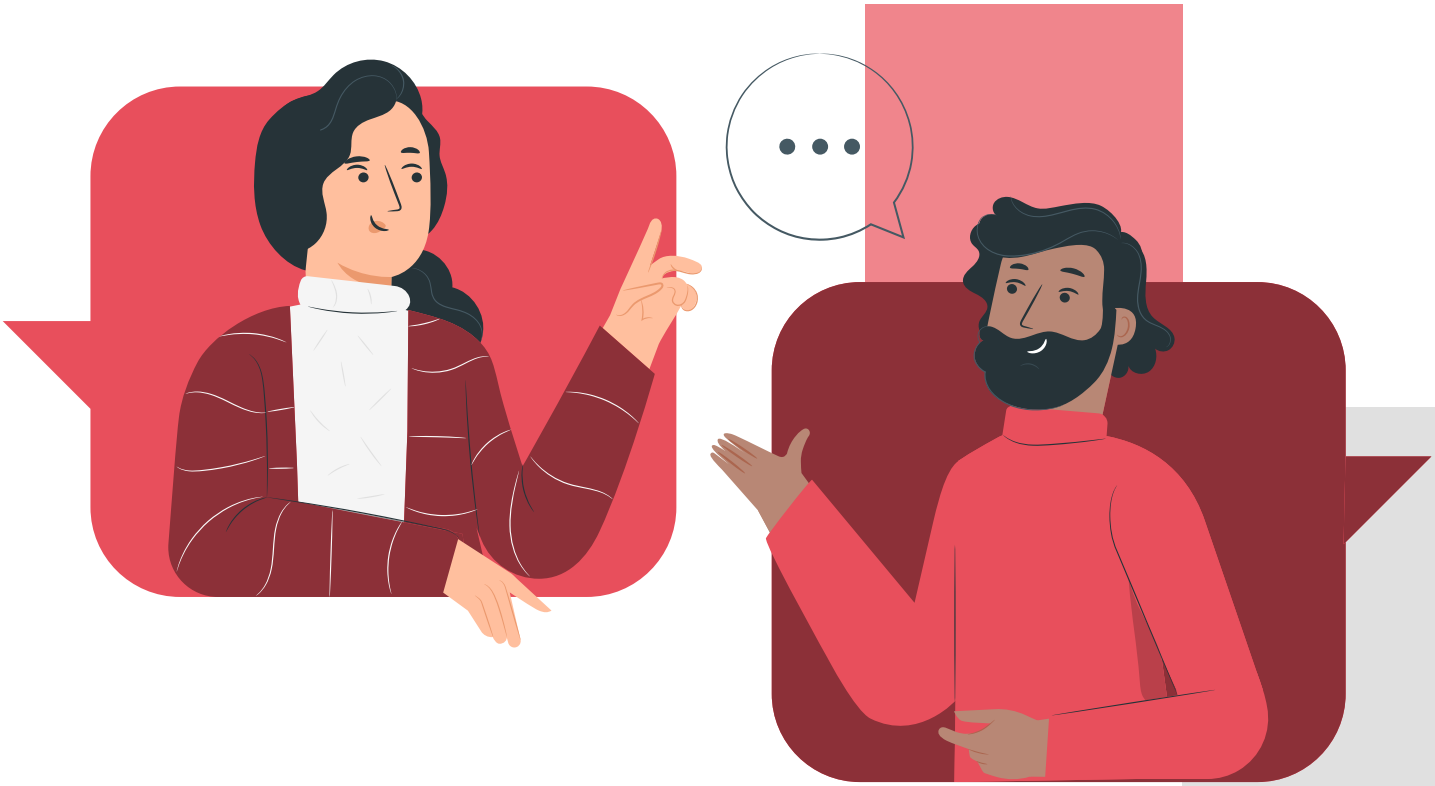
We recommend that developing a local intervention should be a local process, inclusive of as many local stakeholders as possible. This co-creation is an overarching principal within the framework and should ensure that important local factors are incorporated into the service re-design and evaluation, and is an overarching principal within the framework. Who is this service for, who will deliver it and what are the key outcomes of interest? This approach reflects best practice in the iterative development of complex interventions to improve healthcare[12]. The resulting intervention may be a simple change to a structure or process, for instance in one practice. It may also be a more complex intervention involving a wider group of stakeholders, across a network of practices, involving multi-agency working. Whatever its form, plans should be agreed by all stakeholders and specific actions and components clearly described. Being explicit about what is being proposed, and who is responsible for the changes, should make it easier to plan how the intervention (and any associated investment) might be evaluated, through changes in care processes, outcomes, or wider impacts.

A collection of FAIRSTEPS interventions prioritised by practitioners supplement the framework, to signpost to particular interventions to consider adapting to local circumstances. Many of these examples require strategic investment of resources and time, but others are achievable through simpler changes. The examples provide commissioners with examples of the sorts of interventions that, with appropriate investment, might be delivered by existing general practice providers, and those that are better commissioned separately, for example incorporating a multiagency approach .

Developing a FAIRSTEPS intervention.

The framework supports organisations to develop their own FAIRSTEPS intervention for locally identified health inequities and sensitive to local context. The following targeted groups can use the framework:

- **Training and education providers –** to help build the content and form of any education or training regarding health inequities and to inform learning outcomes
- **Networks and practices -** as a tool to co-create more effective primary care interventions with stakeholders to maximise impact on addressing health inequities.
- **Primary Care commissioners –** to develop specifications for primary care or inclusion health services with service users and their practitioners in a way that maximises return on public investment.



Using the framework

The FAIRSTEPS framework has four components, or steps, outlined below and illustrated in figure 2 on page 20.

1

Step one - Define the groups experiencing the inequity.

This describes the nature of the inequity problem that has been identified and the patient group(s) experiencing it. It will often be something identified locally, but could also be something identified more broadly, or something required by healthcare commissioners as a contractual requirement. In the latter case, it will ensure that any subsequent actions taken are evidence informed and sensitive to local circumstances. In all situations, it is best to describe clearly the characteristics of the patient group(s) that are experiencing the inequity and why it is a current priority before going onto step two.

2

Step two - Consider the issues.

This step asks users of the tool to consider each of the four key areas in turn:

- **access and engagement;**
- **structure and processes of services;**
- **patient experience;**
- **staff awareness and capability.**

Though it is not necessary to identify something important in each area, we recommend that users of the framework carefully consider each question together, and that time is taken to hear different perspectives. Taking this time to consider how each area is contributing to the inequity problem for different groups will ensure the intervention developed is holistic and minimise any risk its effect will be limited by a missing ingredient.

The **four areas** are described in more detail below:

- **Access and engagement –** this refers to difficulties people face in accessing services. It can include things like location, scheduling, transport and interpreter availability. It will also relate to service capacity of existing provision.
- **Structures and processes –** this refers to ways in which current ways of providing healthcare might contribute to the inequity. For instance, it may be more difficult for some groups of people to use certain services or require skills and confidence in negotiating phone access and triage systems. Issues identified might relate to the focus and priorities of care delivery (i.e. contractual requirements) or processes of communication.
- **Patient experience –** this refers to public experience, and expectations, of what services provide and how they communicate. It includes how much patients feel able to trust their healthcare providers and how understood they feel when receiving services. One example might be the responsiveness to particular patient circumstances during registration procedures.
- **Staff training and development –** this refers to identifying and addressing specific issues with knowledge, skills or attitudes of staff that may influence inequities. This might include reviewing the skill-mix of multi-disciplinary teams or additional support or supervision. Training might address knowledge gaps relating to single issues or a more general understanding of health inequities. It comes last as, when working through the framework, new development needs maybe identified that were previously unrecognised.

3

Step three – Ensure key ingredients are included.

This step is critical. It incorporates the ingredients into the intervention that are most likely to make it work. A summary of the ingredients found in the FAIRSTEPS study is shown in table 1. Some relate to the issues identified and others relate to how the intervention should be set up. Users will find these are more or less obviously matched to the inequity problem being addressed. Given the issues discussed in step 2, users should reflect on which ingredients should be prioritised for their intervention. They may identify other ingredients not listed. Establishing a shared focus on building these ingredients into the designed intervention should help to ensure that return on any investment is maximised. The converse applies: without tending to these ingredients, the risk increases that resource and investment is wasted.

We recommend users ask themselves the following questions to identify these ingredients.

- ***Which ingredients need prioritising to make it work?***
- ***How should we be implementing the changes to make it work?***

Writing down the answers and keeping them at the heart of any intervention design is a critical step in using the framework.

Table 1 – Examples of key ingredients that help make interventions work.

Active ingredients: general Which need prioritising to make this intervention work?	Active ingredients: implementation How should we implement the intervention?

• Access barriers
• Anti-stigma interventions
• Awareness of patient characteristics
• Building trusting relationships
• Care models
  • Continuity of care
  • Cultural sensitivity, responsiveness & competency
  • Culture and language matching
  • Equity oriented care
  • Holistic care
  • Integrated care
  • Patient-centred care (non-judgemental)
  • Social paediatric care
  • Trauma informed care (i.e. Adverse Childhood Experiences)
• Health literacy
• Income improvement
• Interactions between different groups
• Involvement & empowerment
• Lifestyle questions
• Multi-disciplinary consultations
• Patient group appointments
• Psychosocial interventions
	• Collaboration
	• Context-sensitive
	• Embed into existing processes
	• Using facilitation
	• Flexibility in approach
	• Participatory approach (co-design)
	• Partnership working

3

How and why?

The last part of step three involves considering how and why the intervention is expected to work. Many interventions in the FAIRSTEPS study clearly described how they had been planned in a particular way. These descriptions often referred to common ideas or theory on the ways patients interact with healthcare, taking into account aspects relating to both the patients and the service providers. Most commonly, these ideas were about how individual attitudes and behaviours are shaped by their environment and the ways in which these attitudes and behaviours can be changed. Less often, there were theories about how interventions would change the way organisations worked more generally. The theories we found are described simply in table 2.

We recommend users of the framework reflect on whether any of these ideas or theories are relevant to what they are trying to achieve, and how they relate to the key ingredients they have prioritised. Considering how you expect your intervention to change people's behaviour will also help identify the key ingredients that are likely to make the intervention successful and transformative.

Table 2 – Examples of theories about behaviour changes used in some interventions.

Changing behaviour	Theory description	Theory name
General behaviour change	Behaviour can be altered through exploring a person's thinking and motivation about their behaviour	Motivational interviewing[13]
	A sense of autonomy, competence and connectedness increase people's motivation to change behaviour	Self-determination[14]
	A person's belief that any action will help achieve a desired goal determines their likelihood of taking that action	Self-efficacy[15]
	A persons knowledge and understanding is created through interactions with the world	Social cognitive theory[16]
	A person's behaviour depends on their physical, social and cultural world	Social ecology[17]
Health behaviour change	Characteristics about a person and the way a service is provided affect a person's sense of eligibility for health care	Candidacy theory[18]
	What we think and do affects how we feel; what we feel affects how we think and behave	Cognitive behavioural theory[19]
	A person's sense of threat and their belief they can do something about it drives health behaviour	Health belief theory[20]
	People use unhealthy methods to feel better and reduce stress when other methods are not available	Coping theory[21]
	People perceive their own health in different ways	Self-perceived health status[22]
Team behaviour change	For change to become more permanent, team members need to see sense in the changes, actively participate, work collectively and reflect on the changes together as a team	Normalisation process theory[23]
	Teams learn best when learning together, in a relaxed atmosphere, in small groups	Small group learning[24]
	Stigma and prejudice between groups can be reduced through creating interactions between them	Allport's contact theory[25]

4

Step four – Co-design the intervention

This is a local process, which follows on from the evidence-informed components described above. It should reflect answers to the previous questions, involve service users and all stakeholders. It should address the inequity problem identified. It should reflect local context, resources and investment available. It should ensure key ingredients identified are prioritised in its design. The FAIRSTEPS framework gives stakeholders confidence their intervention is developed through an evidence-informed tool. The FAIRSTEPS framework will also form the basis of an evaluation framework for the intervention. In order to help users to think broadly about the possibilities we have collated a list of the things that we found described in the FAIRSTEPS study review (Table 3).

Table 3 – A catalogue of the types of interventions found in the FAIRSTEPS review that people had tried as interventions to address health inequities

A catalogue of interventions described in the FAIRSTEPS review		
• Additional or longer appointments • Advocacy with patients • Automated reminders • Capacity building • Case management • Community engagement • Counselling and coaching • Employment advisors • Exercise • Extended hours • Financial incentives	• Group-based interventions • Health checks • Housing provision • Income optimisation • Organisational change • Outreach & Transport • Motivational interviewing • Multidisciplinary Team working • Participatory Action Research (PAR) • Patient Education • Plan Do Study Act cycles	• Professional support networks • Screening • Self-management • Signposting • Staff self-care • Staff training • Standardised coding of patients from underserved groups • Survey & Small groups • Translation • Compound activities – more than one intervention

Whatever changes are decided, there should be a clear action plan, with shared agreement of responsibilities and timelines. Being explicit about what is being proposed and how it will address the inequity can inform plans about how the impact of the intervention might be measured by changes in care processes, outcomes and impact. These plans might reflect the issues identified and how the changes will mitigate them, as well as more formal health outcomes (e.g. blood pressure). Ongoing audit and evaluation should be built in from the outset.

The FAIRSTEPS prioritised interventions are those interventions found in the FAIRSTEPS evidence review that were prioritised by practitioners and the public during the FAIRSTEPS Delphi study as most likely to have impact at the frontline. They act as a further signpost to interventions that might be adapted to users' local circumstances and are provided as a supplement to the framework. Table 4 provides an illustration of the framework in action.

Summary

The FAIRSTEPS framework provides an evidence informed tool for developing locally sensitive interventions targeted at addressing health inequity through primary care. The framework takes users through a considered, step-by-step, process of intervention design for primary care service development and training & education. The framework is flexible to employ across a wide range of provider contexts and can be used to develop new interventions or refresh existing services.

It collates evidence available on the sorts of issues that need to be addressed, the key ingredients that will make interventions to address them more likely to be successful, and the types of interventions others have tried.

The FAIRSTEPS framework does not provide the definitive prescription for how to address any particular health inequity identified. Instead, it gives its users an evidence informed tool to develop or commission something that they can be confident should address the issues they have identified in an effective way. As the delivery of any FAIRSTEPS intervention is likely to require additional investment, the framework provides a method to target investment for those who wish to address the inverse care law through primary care.

1

STEP 1 - Define the group(s) experiencing the inequity

- May be more than one group

2

STEP 2 - Consider the issues

- Access and engagement
- Structures and processes of care
- Patient experiences
- Staff training and development

3

STEP 3 - Ensure key ingredients are included

- What ingredients need prioritising to make it work?
- How should we implement any change to make it work?
- How and why do we think this intervention will work?

4

STEP 4 - Co-design the intervention

- Involving service users wherever possible.
- Plan the evaluation of the intervention

Figure 2. The FAIRSTEPS framework map

Table 4 – An illustration of how the FAIRSTEPS framework could work for three contrasting examples from the prioritised interventions

Inequity		Issues to Address				Key Ingredients	New Intervention
Which groups experience the inequity that needs addressing?		**What problems do these groups have accessing services?**	**Which processes of care contribute to the problem?**	**Which patient experiences need to be improved?**	**What staff training and development is needed?**	**Which key ingredients should be included?**	**What changes will we make to address the inequity?**
1	Victims of domestic violence and their families	Integration between health and housing services	Lack of 'safe' places for victims	Resistance to discuss sensitive subjects Listening	Wellbeing workers Trauma informed care Emotional burden	Confidentiality Safety Anti-stigma Integration	**Targeted support for domestic violence victims and their families from trained health and wellbeing workers, including access to support about safe housing, family support and general advice.**
2	People who are homeless	High personal thresholds for seeking healthcare Lack of opportunity to access care and medicines	Lack of capacity for services traditionally carried out by GPs	Easier access for regular routine care, but not necessarily to a GP	Other practitioners: to deliver physical examination; diagnosis; prescribing; onward referral; and clinical follow-up	Access barriers Continuity of care Community engagement	**Increase capacity with pharmacists delivering services for people who are homeless so that the level and intensity of care is appropriate. Awareness & signposting-Promotion to community organisations to encourage equitable access**
3	Trans-patients	Structural discrimination	Services not aligned to gendered health risks	Non-judgemental	Gender and sexual identity	Awareness of Pt characteristics Cultural safety and sensitivity Anti-stigma	**A systematic programme of flagging trans-patients in the practice during cancer screening to identify if need recall or not for cervical and breast screening.**

FAIRSTEPS prioritised interventions

We present below the intervention vignettes that were prioritised in the FAIRSTEPS Delphi survey by primary care practitioners. Out of the 69 descriptions presented in the survey, those shown here met our criteria for being considered most useful and, with the right strategic investment of time and resources, easier to implement.

They are presented according to the three primary audiences for the Delphi findings.

- **Training and education providers –** to help build the content and form of any education or training regarding health inequities and to inform learning outcomes
- **Networks and practices -** as a tool to co-create more effective primary care interventions with stakeholders to maximise impact on addressing health inequities.
- **Primary Care commissioners** – to develop specifications for primary care or inclusion health services with service users in a way that maximises return on public investment.

Training and education providers (figure 3)

FAIRSTEPS training and education interventions can inform strategy for national and regional bodies responsible for training the future NHS workforce (Higher Education Institutions, Health Education England and NHS Education for Scotland) who want to develop socially accountable curricula. These interventions target equipping the future workforce to the particular challenges of working with underserved groups through learning at various stages of their training. In general, earlier is better than later and engaged, experiential learning activities are considered most useful. The prioritised interventions also suggest that, with appropriate resourcing, practitioners serving underserved groups have the appetite to engage with training and supervision.

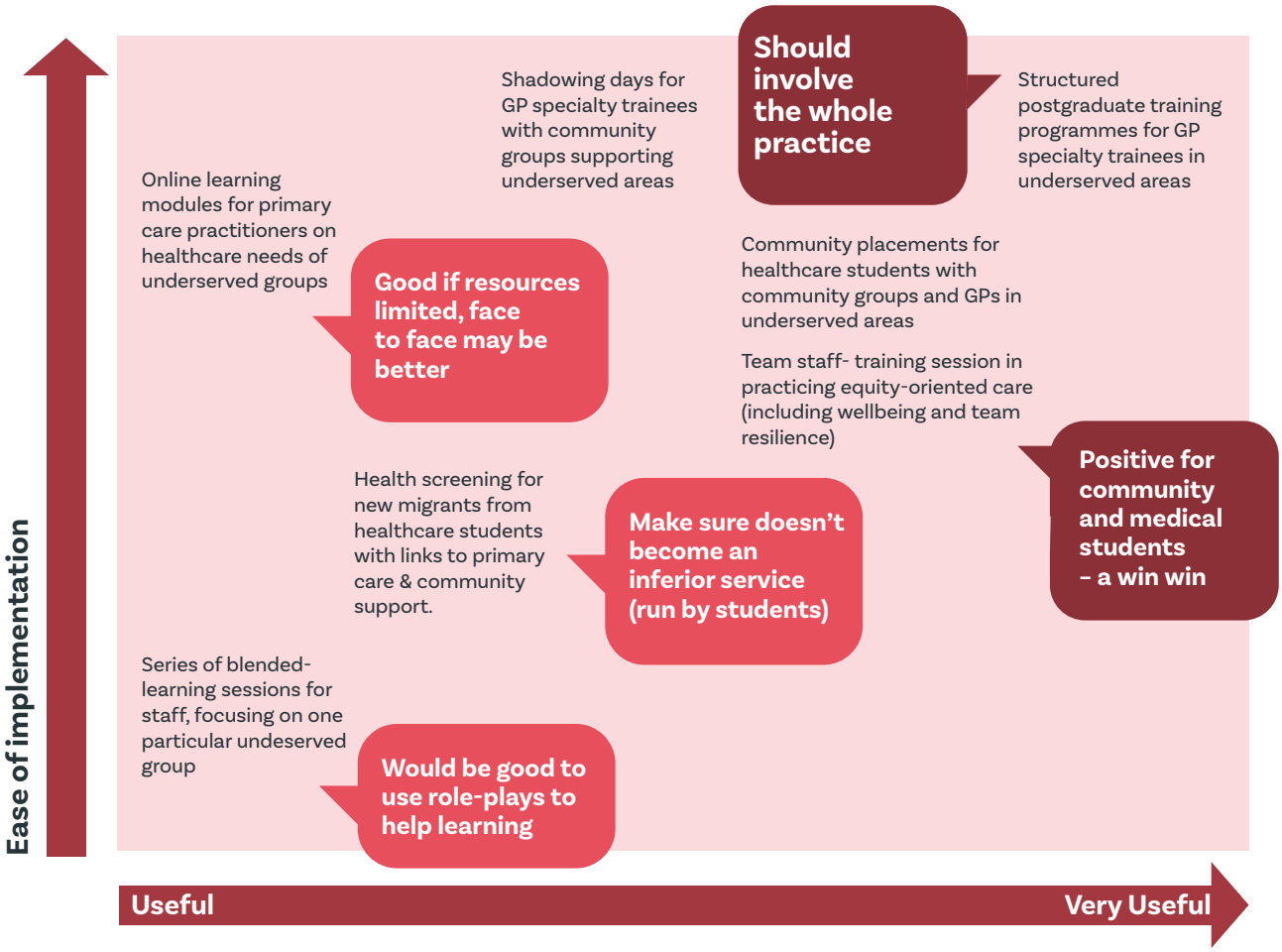


Figure 3. Prioritised examples of actions to address health inequity for training and education providers with summaries of comments from study patient group.

Primary care providers (figure 4)

FAIRSTEPS interventions for primary care providers tend to fall into three groups. There are interventions, which practices could adapt independently, through altering their systems and processes of care. There are more collaborative interventions involving others such as patient groups, charity or community groups (potentially provided across a connected network of practices). There is a smaller group of targeted interventions to help patients support their own wellbeing.

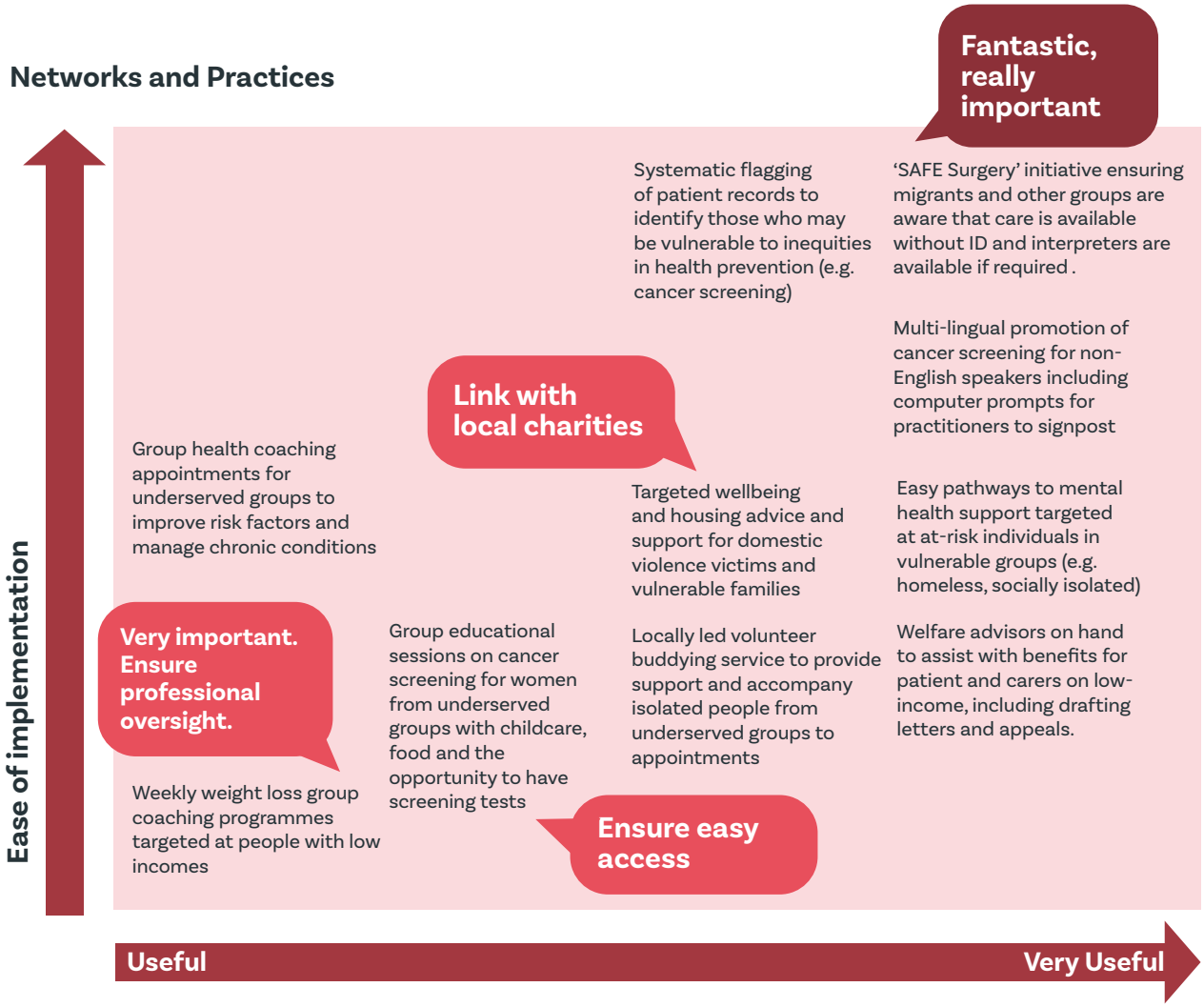


Figure 4. Prioritised examples of actions to address health inequity for primary care providers with summaries of comments from study patient group.

Primary care commissioners (figure 5)

This group of interventions contains the largest number of prioritised interventions. We hope it helps commissioners of primary care services to identify where and when to target investment at networks or practices or at specialised commissioned services. The interventions comprise three main groups. There are interventions that require targeted investment to enhance generalist care through current primary care. There are interventions that make access to current services easier for underserved groups and there are interventions that describe new specialised inclusion health services that would need commissioning separately from general primary medical care services.

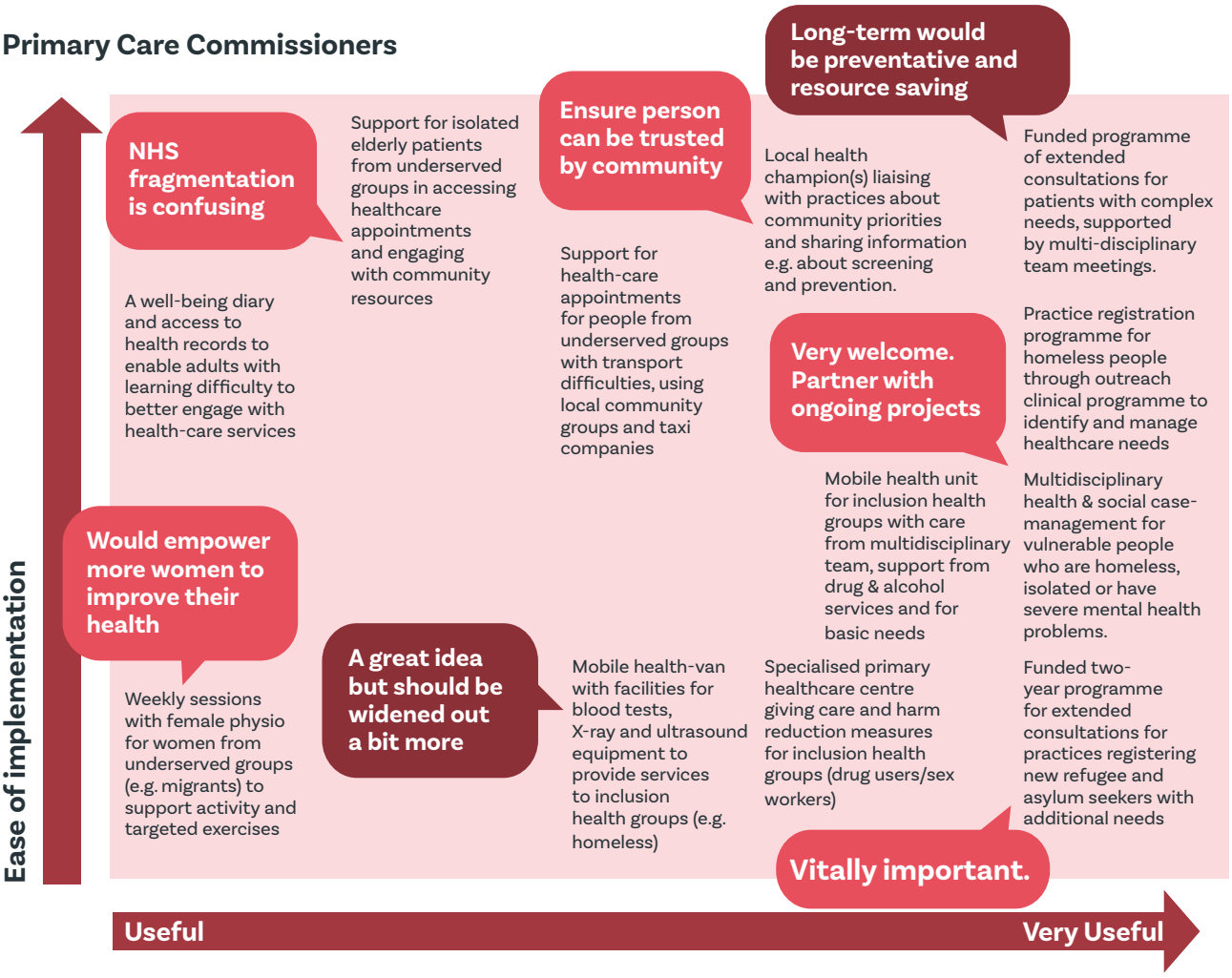


Figure 5. Prioritised examples of actions to address health inequity for primary care commissioners with summaries of comments from study patient group.

This report and more detail about the FAIRSTEPS study, including the results of the integrative review, the Delphi study, the patient participation work-stream and prioritised interventions can be found in the full report at https://figshare.shef.ac.uk/

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