



## The South Asian Anticipatory Care Project

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Final Evaluation Report: October 2013

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## Executive summary

Glasgow's large South Asian population experiences a substantially higher incidence and mortality from diabetes and cardiovascular disease (CVD) compared with indigenous Anglo-Irish Scots. Accordingly, the Keep Well programme in NHS Greater Glasgow & Clyde (NHSGGC) established a pilot project (the South Asian Anticipatory Care (SAAC) project) in May 2011 as a culturally appropriate response to these issues within general practice settings, targeting South Asian individuals aged 35-64 in the South and North West sectors of Glasgow City. This paper reports the findings of the SAAC project's evaluation.

Six 'hot spot' GP practices where a high proportion of the practice list was of South Asian ethnicity were identified, within which 4,578 eligible patients were identified by local searches. These patients were subsequently contacted by a bilingual administrator, who arranged a practice based appointment. A further 238 people were engaged at community events, including the Glasgow Mela, religious & cultural centres, pharmacies and community halls; 124 were eligible and contacted after the event; 85 (69%) subsequently booked appointments for a Keep Well consultation and 71 (84%) subsequently attended.

Keep Well consultations were delivered by a bilingual pharmacist, using a modified Keep Well consultation template, followed by an individualised action plan which included onward referral to relevant services when appropriate. By November 2012, 1,136 Keep Well consultations had been delivered; 1,032 initial consultations and 104 follow-up consultations. Of 973 patients who underwent initial Keep Well consultations prior to 31 July 2012, the vast majority described themselves as Pakistani; only 304 (31%) stated that their preferred language for communication was English, the vast majority preferring to converse in Punjabi or Urdu. A significant minority were unable to speak English at all, although there were clear age and sex variations in this characteristic. Clinical assessment demonstrated a high prevalence of risk factors for vascular disease and metabolic syndrome, including overweight and obesity (78%), elevated systolic blood pressure (>140mmHg) (20%), a family history of diabetes (38%), elevated (> 5.0 mmol/L) plasma cholesterol (57%) and random plasma glucose values of 7.0mmol/L and above (10%).

The clinical impact of the SAAC consultations on intermediate health outcomes associated with long term risk of diabetes and vascular disease was evaluated in a sample (n=104) of patients. This showed were statistically significant improvements in physical activity and healthy eating behaviours between the first and second reviews. For systolic blood pressure and waist circumference, there were small improvements in average values and confidence intervals included the possibility of a positive effect, but this did not reach statistical significance. High levels of need were identified, yet South Asian patients often perceived that they had little control over their own health destiny. Social isolation, low self esteem and poor mental health were identified as key issues.

After using the service, patients became powerful advocates for change. Group interventions were well received and patients valued opportunities to share experiences with peers. Food-based interventions also appeared to function particularly well. For some individuals, there was clearly a need for more in-depth support with making lifestyle or other changes to improve health and wellbeing. Patients, the SAAC team and other stakeholders all shared a common view that the SAAC service had achieved a great deal during its short lifespan, largely as a result of its ability to connect, influence and bridge cultural divides. However, there were complaints about the fact that there had been too many similar short term projects and longer term effort was required.

Recommendations for future service provision are proposed, underpinned by these evaluation findings.

## Introduction

1. This paper reports the findings of an evaluation of a pilot project (the South Asian Anticipatory Care (SAAC) project) established in Glasgow in May 2011 with the explicit purpose of defining and meeting the anticipatory care needs of NHSGGC's South Asian individuals, among whom prevalence, morbidity and mortality from CVD and diabetes are substantially higher than the indigenous white Caucasian UK population. The SAAC project targeted South Asian individuals aged 35-64 predominantly within general practice settings in the South and North West sectors of Glasgow City, complemented by a wider set of community activities. This paper reports the findings of the SAAC project's evaluation in mid 2012.

## Definition

2. 'South Asia' is an extensive geographical area spanning India, Pakistan, Bangladesh, Nepal, Bhutan, Maldives and Sri Lanka. In this report, the 'South Asian' subpopulation is defined by UK census ethnicity categories (ie Pakistani, Indian, Bangladeshi and 'Other South Asian' descent). However, this is acknowledged to be a gross oversimplification, because of the diverse linguistic and cultural sub-groups, castes and tribes subsumed within this region. Although beyond the scope of this report, it should be fully acknowledged that there is no single 'South Asian community' in NHSGGC; more accurately, the South Asian subpopulations in Glasgow represent an amalgam of several distinct identities, with common origins, historical experiences and ties to geographic places arising from migration patterns, particularly in the late 20<sup>th</sup> century.

3. The definition of anticipatory care in NHSGGC's anticipatory care framework is: "An integrated programme of defined preventive interventions delivered to individuals, operating across the continuum of primary, secondary and tertiary prevention. Its overall aim is to shift the focus of service provision from reactive to preventive care, by adopting a whole population perspective across all aspects of service planning and delivery."

## Policy Context

### National

4. The SAAC project was established within the Keep Well programme, a large scale anticipatory care programme launched in 2006, initially in Scotland's most disadvantaged areas. The Keep Well programme subsequently became mainstreamed across the whole of Scotland and now takes many different forms; however, in NHSGGC its core elements continue to involve i) identification of individuals at particular risk of preventable serious ill-health (including those with undetected chronic disease); ii) an individualised Keep Well consultation in general practice; and iii) a systematic approach to providing appropriate interventions in response to identified needs.

5. In March 2011, the Scottish Government announced that the intended focus of the programme should broaden to additional population subgroups, including South Asian, Black and Afro-Caribbean ethnic subgroups; however, there was acknowledgement that evidence was scarce concerning how best to characterise and systematically engage these different populations.

### Local

6. By late 2009, three years' experience of the Keep Well programme had created an expanded and sustained portfolio of engagement methods. Nevertheless, it was becoming increasingly clear that the South Asian community was one of several population subgroups who required a more targeted type of approach, as well as a clearer understanding of their anticipatory care needs.

## **Anticipatory care needs of the South Asian population**

7. The City of Glasgow has the largest South Asian population in Scotland, among whom CVD remains a leading cause of death and a major driver of our health inequalities. In the UK as a whole, South Asians are up to six times more likely to get diabetes, develop it significantly earlier, more likely to suffer from more severe complications, become high intensity users of unplanned secondary and primary care services and much more likely to die prematurely. South Asians consequently have a 40-50% greater mortality from cardiovascular disease, compared with white Caucasians.<sup>1</sup>

8. Equitable provision of effective health and social care in response to need is a governing principle of all NHS services. The UK literature examining ethnic variations in processes and intermediate outcomes of healthcare is sparse and there is conflicting evidence about the extent to which BME subpopulations experience systematic inequity in quality of clinical care.<sup>1,2</sup> However, key intermediate outcomes from healthcare do appear consistently poorer among some BME subgroups (eg disproportionately higher HbA1c and retinopathy in South Asian diabetics compared with non-South Asians). In addition, ethnic minority groups often experience communication and language barriers, with different needs and expectations compared with the wider UK population.

## **The SAAC Project**

### Funding and project initiation

9. A funding proposal for an anticipatory care pilot targeting the South Asian population in NHSGGC was submitted to the Scottish Government in 2010, building on the approaches and learning from a smaller pharmacy-led initiative known as the Minority Ethnic Long Term Medicines Service (MELTS), a community development, engagement and advocacy model which had been established in Glasgow in 2002. Funding was granted in early 2011 and the project became operational in June 2011. NHSGGC then continued to fund SAAC locally from April 2012 onwards.

### Aims & objectives

10. The aim of the SAAC project was to develop, optimise and test the effectiveness, efficiency and reach of an anticipatory care programme which aimed to decrease risk factors for CVD and associated health problems in the South Asian population.

11. The project identified the following objectives:

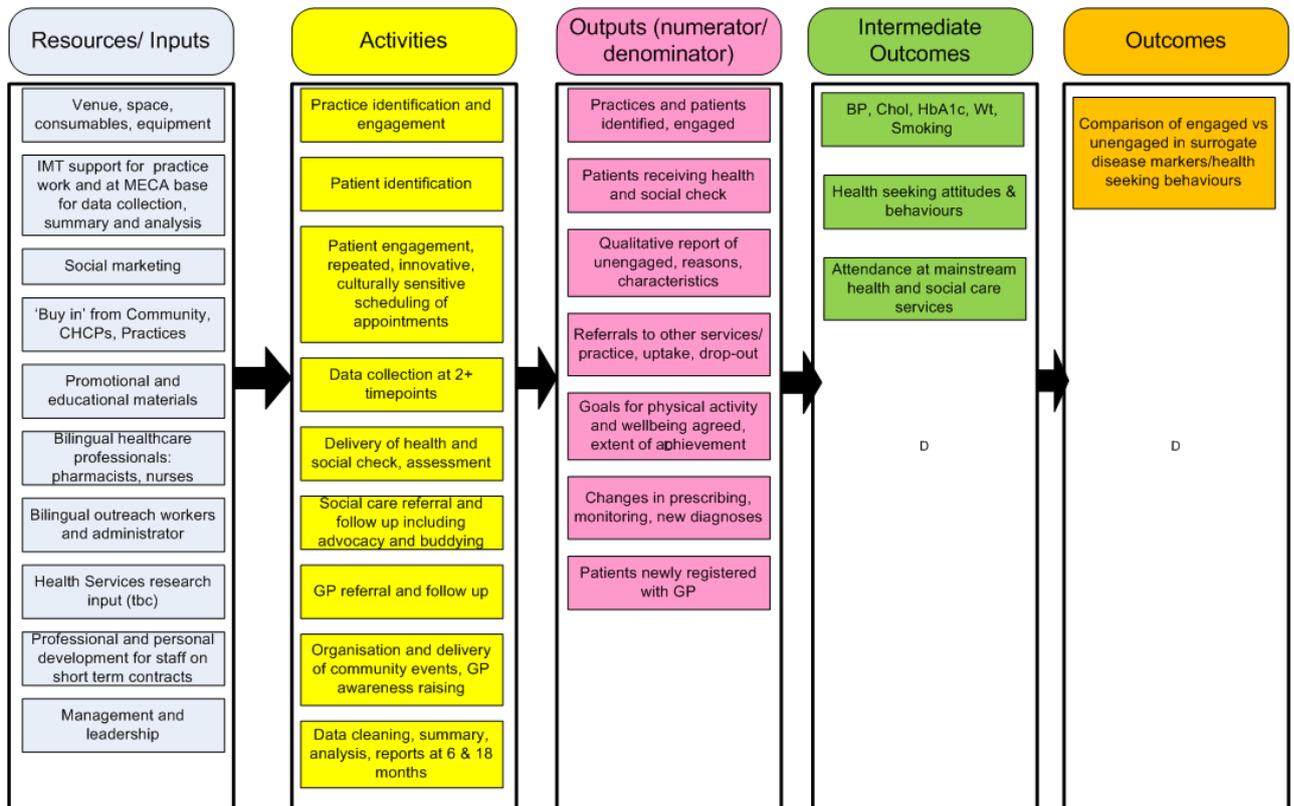
- i. Systematically identify from general practice information systems South Asian patients aged 35-64 eligible for primary prevention
- ii. Engage minority ethnic patients in a range of community venues used by minority ethnic communities, including mosques, community halls, pharmacies, workplaces employing a high proportion of South Asian people and other appropriate locations

- iii. Develop and deliver culturally appropriate cardiovascular health checks to the target population
- iv. Engage and empower targeted individuals to improve their health seeking behaviour
- v. Engage targeted individuals, their wider families and their social networks in health improvement
- vi. Increase access and utilisation to health advice and prescriptions for appropriate preventative medicines
- vii. Systematically collect information on barriers limiting engagement
- viii. Improve the quality and quantity of relevant clinical, physical, demographic and engagement data to enrich the long term relationship between patient and general practitioners
- ix. For those with established disease, limit worsening disease control and reduce the use of unplanned health care

Original SAAC Planning Model

12. Figure 1 summarises the original planning assumptions around the project’s inputs, change mechanisms and outputs.

**Figure 1: Original SAAC Logic Model**



## Description of SAAC Project

13. SAAC was designed to deliver targeted, culturally appropriate anticipatory care via a set of engagement approaches based on shared language, familiarity, trust and cultural understanding. The SAAC management team recruited a South Asian administrator, South Asian outreach worker and five South Asian Four multilingual pharmacists (1.2wte) and delivered received a programme of training (vascular screening and consultation skills). SAAC management pharmacists developed a computerised eligibility query in order to identify the eligible population from general practices which were known to have a high proportion of South Asian patients on their lists. SAAC clinical staff worked with General Practitioners (GPs) to case find South Asian people, without CVD or diabetes, aged 35-64 years, who were eligible for the project. Six 'hot spot' GP practices where a high proportion of the practice list was of South Asian ethnicity were identified. Lists of eligible patients together with their contact details, were agreed with practices and taken back to the SAAC team base (Pharmacy Long Term Conditions Team in Queens Park House).

14. The multilingual administrator invited eligible South Asian people, by telephone, to attend a SAAC pharmacist-led Keep Well consultation in their general practice at a time of their choosing, on a day agreed between the pharmacist and practice. Family members were frequently involved in telephone conversations leading up to arrangement of an appointment and repeated phone calls were often required to engage some patients. Empathetic phone calls generated excellent engagement results, and overcame the burden of explanation, with most calls involving a thorough explanation of the service, alignment of SAAC team to practices, and the nature and merits of a health check. Translated letters were used to supplement phone invitations for a trial period. As the team worked through different patient lists and built up their repertoire of approaches to explain and book patients, a significant amount of tacit learning was developed and used to inform subsequent contacts. For example, reminder phone calls were offered in some cases, or family members recruited opportunistically during the flow of the conversation if they fell within the target group. In some cases, the administrator and/or pharmacists were known to individuals in the community, which established trust and helped overcome barriers arising from cold calling. Non-attendees were generally found to be those patients who could not be contacted by phone.

## Target population

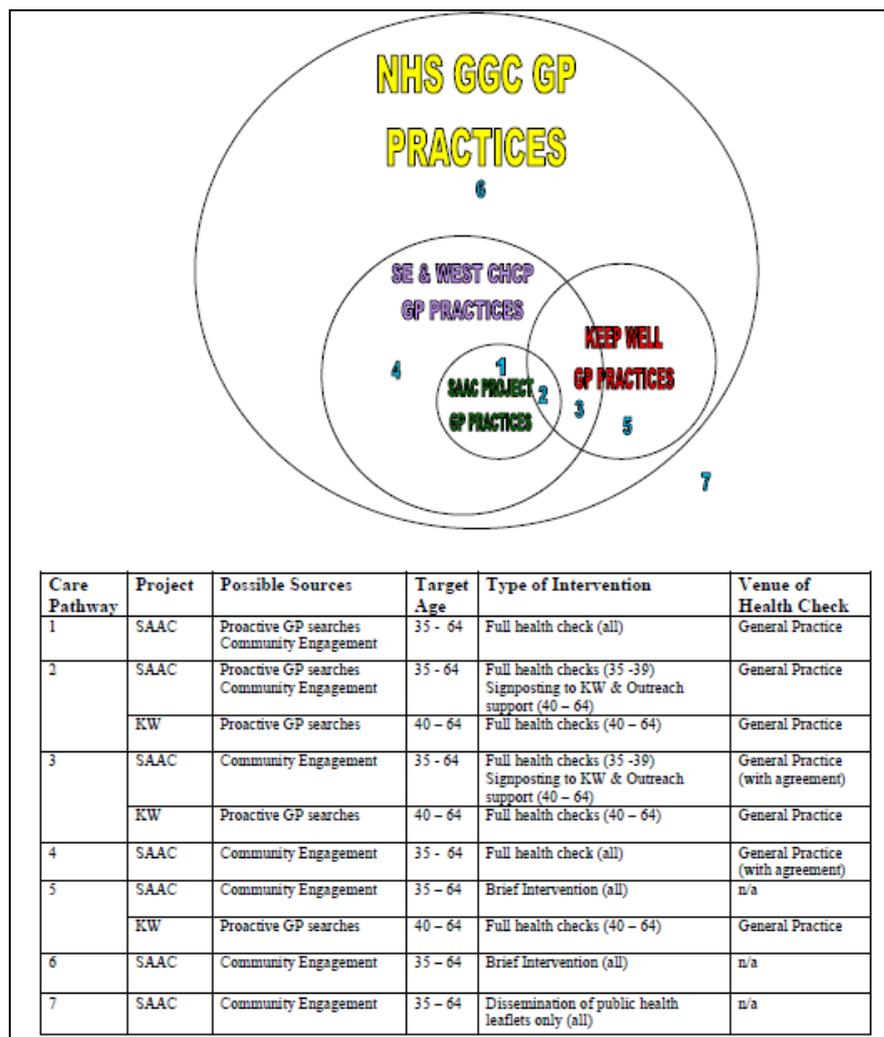
15. In the initial group of six target practices, the SAAC team systematically identified and invited South Asian patients to their practice for a health check, using up to three telephone calls, followed by a letter (in Urdu and English); patients who did not engage as a result of these contact methods were visited by a bilingual outreach worker. Patients who were successfully contacted by the bilingual administrator were booked into the practice at designated appointment slots on the day when the bilingual pharmacist was based in the practice. Patients were booked into their practice at hourly intervals throughout the day on which the pharmacist was in the practice. Anticipating a high attendance rate as a result of telephone engagement, the one hour appointment slot was found to be necessary for completion of the paper based consultation form, ensuring that the first contact was culturally appropriate and thus more likely to lead to subsequent engagement with health improvement services and health behaviour change. The vast majority of patients had not previously encountered the concept of proactive anticipatory care; this appeared to be a new way of thinking about health and wellbeing for most targeted patients. Home based health checks were undertaken in a very small number of patients. At a later date, the practice based intervention was extended to a further three practices.

16. The SAAC project also recruited patients from local community venues known to South Asians within respective communities. Although initiated and organised by the SAAC

team, community members were involved in the organisation of these events, as were charities and other voluntary organisations. The events were advertised through word of mouth, or by letter to patients from practices in these areas who had not attended appointments. The purpose of these events was to identify eligible patients who may not be reached through the traditional practice route and also to raise awareness of vascular health and diabetes among the community. All Pakistani, Indian, Bangladeshi or Sri Lankan patients resident within the original boundaries of the SE & West CHCPs aged 35 to 64 years, excluding those with pre-existing coronary heart disease (CHD), stroke or diabetes, were eligible for a full SAAC health check. Before SAAC outreach support became available, open appointments at local venues were offered as an alternative to non-attendees at practice based appointments were sent a letter inviting their attendance.

17. Appointments arising from community engagement events differed from those in the group of six non-Keep Well practices with a high concentration of South Asian patients, because patients' registered practices were dispersed across Greater Glasgow and Clyde and not all were involved in Keep Well. Following General Practice engagement, this led to arranging of a date and time for the pharmacist to visit the practice to access the patient's medical records, obtain consulting room space and arrange a mutually suitable time for the patient's consultation. The precise type of Keep Well intervention delivered was dependent on the patient's area of residence, location of their general practitioner and whether or not their own practice was already delivering Keep Well (Figure 2).

**Figure 2: SAAC pathway variations dependent on status of registered practice**



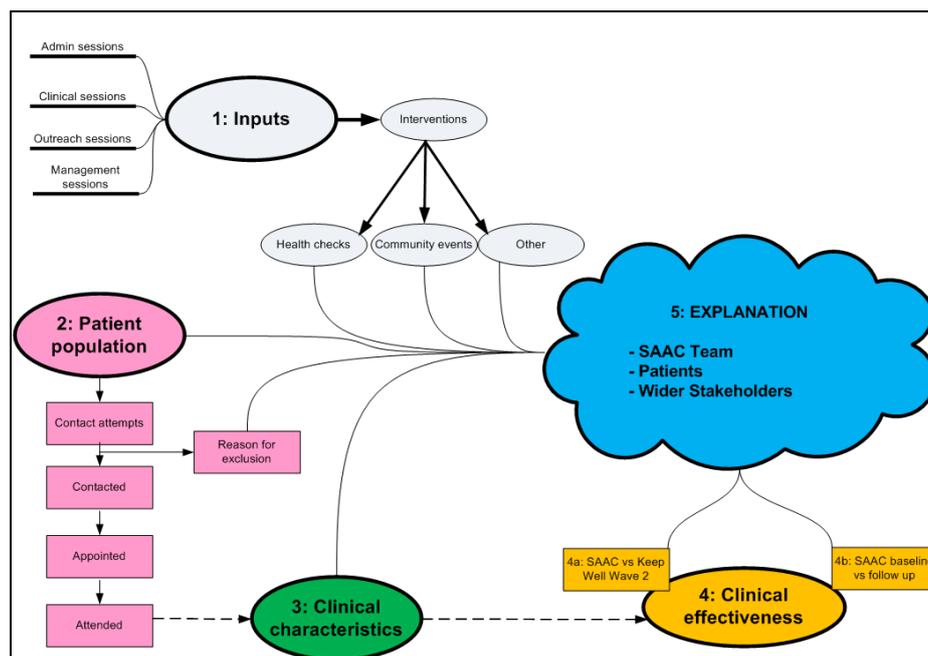
18. The content of the SAAC consultation followed the standard generic Keep Well model, augmented with two additional variables (waist circumference and other tobacco options; hooka and betel leaves). The standard Keep Well core dataset includes BP, Pulse, BMI, Random Glucose, Cholesterol, ASSIGN cardiovascular risk score, behavioural attributes (eg smoking, alcohol, diet & exercise) and aspects of life circumstances (eg literacy, employment, financial issues). An action plan was agreed between the pharmacist and the patient, including onward referral or signposting to relevant services when appropriate. SAAC pharmacists and GPs worked collaboratively to follow up clinical results reported as being outwith reference ranges. All data were recorded by the pharmacists during or immediately after the consultation by hand, onto paper based records because the time required for IMT development was considered prohibitive at the time of the SAAC project's initiation and also because of the flexibility required in conducting SAAC consultations in more diverse settings compared with the generic practice based Keep Well model. On completion of all consultations on each working day, the pharmacist annotated the patients' records on practice's computer systems, confirming those patients who had received a SAAC consultation. All clinical measurements were entered onto practices' computer systems. The pharmacist made the initial referral on to the GP or to health improvement services, arranging an appointment for follow up by the SAAC project if necessary.

## Evaluation methods

19. An evaluation framework was developed at the outset, in order to generate a clear understanding of the extent to which the programme achieved these stated aims and objectives. The methodology used a combination of quantitative and qualitative methodologies, both to define key outcomes and also to elicit as clearly as possible some insight into how these were achieved and understood by the project team, its service users and wider stakeholders.

20. The schematic map below shows the components of the evaluation, the results of which are presented in the sections to follow (Figure 3).

**Figure 3: Schematic map of SAAC Evaluation Framework**



21. All descriptive numerical data were summarised and stratified into appropriate subgroups. Given the absence of a formal interventional study design, two comparative analyses were conducted as a proxy for estimating the effect size of the SAAC model of care:

- Historical comparison of the SAAC model with the South Asian patient population targeted within the SW Glasgow Wave 2 programme in 2008-10, focusing on engagement, the proportion of patients who underwent relevant clinical interventions and measurements at the consultation and the proportion of patients who had appropriate referrals to health improvement services
- A paired analysis of clinical and behavioural status pre and post SAAC consultation in a statistically powered sample of 104 first attendees, based on the hypothesis that the SAAC intervention resulted in a clinically detectable reduction in BMI

22. Explanation of these findings by the SAAC project team, its service users and wider stakeholders was obtained by qualitative analysis of documentary material and transcribed focus group discussions, as follows:

- Semi-structured reflective notes made by all nine team members (including sessional workers) from project implementation onwards, at a minimum of monthly intervals (Appendix 1).
- Four semi-structured focus group discussions held between May and November 2012;
  - One with SAAC team members, which explored the SAAC project's ethos and perceptions on where it adds greatest value to population health (Appendix 2);
  - Two with service users (one with male and the second with female patients who had personally used the SAAC service); these discussions were designed to elicit male and female South Asian patients' understanding of the SAAC project and to explore their perceptions of any change which occurred as a result of their being involved (Appendix 3).
  - The final focus group discussion involved other individuals who had developed working relationships with the SAAC project (including general practitioners, CHP staff and health improvement services). This discussion explored the nature of these partners' working relationships with the SAAC team and where the SAAC team were perceived to add value (Appendix 4).
- A semi-structured interview was conducted with a Live Active Advisor who was in post for one year (January 2012 – January 2013) to capture their perspectives of need.

All audio material was transcribed verbatim. Transcripts and written diary material was then thematically analysed, deriving initial categories from the data themselves, which were then analysed and summarised in role-defined matrices.

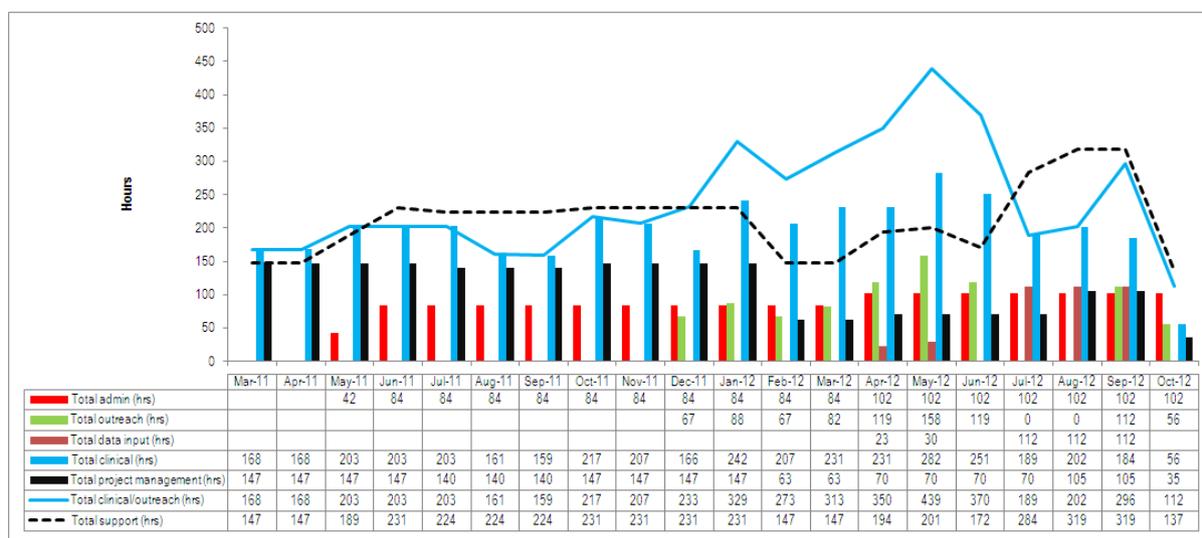
## Evaluation findings

### 1: Project inputs & reach

23. Clinical inputs remained steady at an average of 190 hours per month for the first nine months (Figure 4). After recruitment of an outreach worker in December 2011, clinical activity increased, peaking in May 2012 at 282 hours; the combined input of outreach and clinical staff also peaked at 439 hours in the month of May 2012, falling sharply in July and August (during Ramadan, when no outreach worker sessions took place), rising temporarily thereafter, only to decline again due to reduced pharmacy capacity.

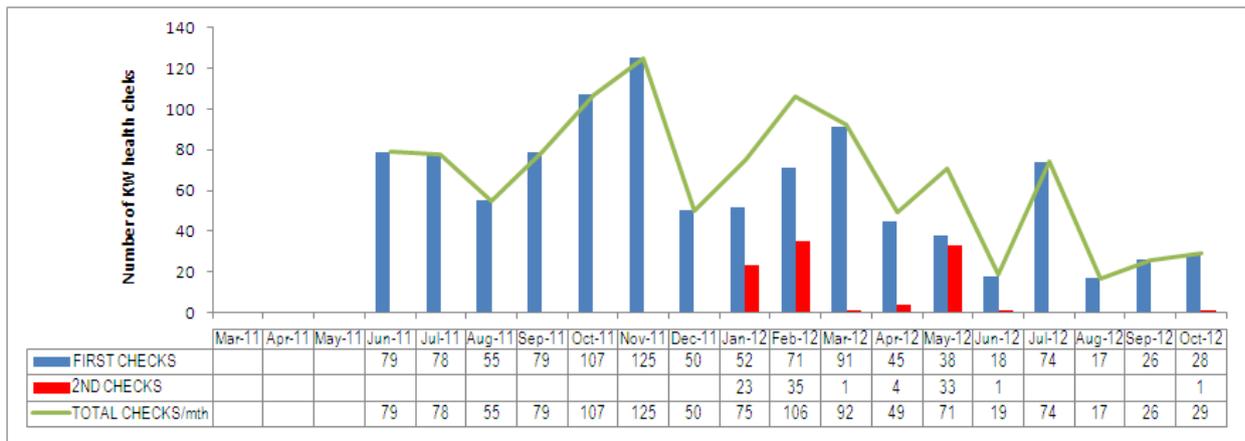
During Ramadan, the number of attempted contacts was reduced out of respect for individuals' priorities during this holy period. As many Muslims fast during Ramadan, hence prefer to avoid venipuncture, staff focused instead on patients not thought to be Muslim, using surname and forename as a proxy. During Ramadan, the SAAC team devoted more time to data input and cleaning, together with organisation of community events.

**Figure 4: Inputs of staff time, by type**



24. By early November 2012, a total of 1,136 Keep Well consultations had been delivered; 1,033 of these were first time consultations and a further 103 were follow-up consultations (Figure 5).

**Figure 5: Keep Well consultations delivered by SAAC team, by month**



25. SAAC’s community engagement work developed rapidly and has continued to gain pace, with a particularly high uptake of Keep Well appointments following the Glasgow Mela in June 2011 (Table 1). Overall, community events involved individual level interactions with 238 people, of whom 124 were subsequently contacted after the event; 85 (69%) subsequently booked appointments for a Keep Well consultation, a high proportion of whom (71;84%) attended a Keep Well consultation.

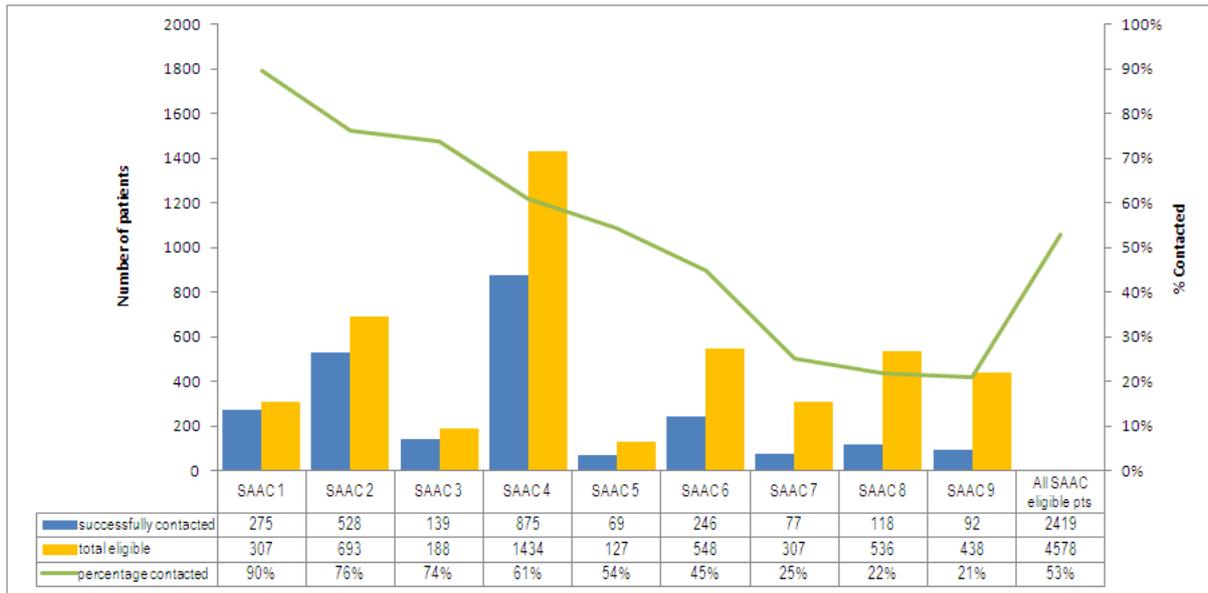
**Table 1: SAAC Community engagement activity and outcomes**

Date	Event	Signed for Health checks	People contacted	KW health checks booked	Number of KW appointments attended
June 2011	Mel Milaap	2	2	1	1
June 2011	KRK Continental Grocers	2	6	6	6
18/19 June 2011	Mela 2011	75	69	43	36
July 2011	Central Mosque Health Fair	11	11	8	4
14 June 2012	Islamic Relief Event	2	0	0	0
14 June 2012	Central Mosque	9	1	1	1
23/24 June 2012	Mela 2012	47	6	6	6
25 August 2012	Al Meezan	32	11	11	8
29 August 2012	Glendale School Event	3	3	2	1
8 September 2012	Woodfarm Education Centre	22	4	3	3
14 September 2012	Hajj Health Event	10	3	3	2
15 September 2012	Carmichael Hall	11	5	2	1
17 September 2012	Diabetes UK	12	3	2	2
<b>TOTAL</b>		<b>238</b>	<b>124</b>	<b>85</b>	<b>71</b>

26. Reach is defined as the extent to which a programme attracts its intended participants. It has two components: the ability of the programme to contact its participants and the uptake of the programme by those who are contacted.

27. The proportion of SAAC eligible patients who were successfully contacted varied from 21 to 90% in the nine target practices. This compares with an overall proportion of 108/158 (68%) in the South Asian Wave 2 Keep Well population in SW Glasgow (Figure 6).

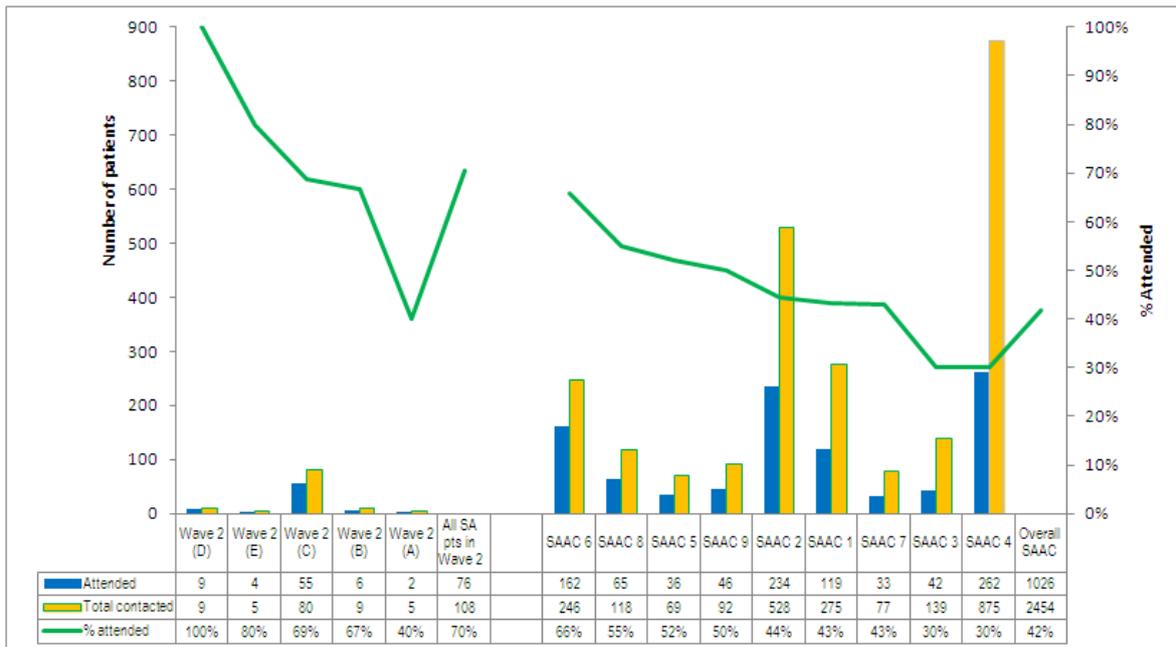
**Figure 6: Numbers (%) of SAAC eligible patients successfully contacted, by practice**



The success of engagement by telephone and outreach was highly conditional on the accuracy and completeness of the contact details recorded by the practice. This is particularly important where there are significant numbers of patients registered temporarily. This led to considerable between-practice variation in the proportion of patients who were successfully contacted.

28. By 31<sup>st</sup> October 2012, the uptake of Keep Well consultations in patients who had received one or more contact attempts by the SAAC team was 1026/2454 (42%) in the nine SAAC practices, which compares with 76/108 (70%) in the South Asian Wave 2 population in South West Glasgow (Figure 7).

**Figure 7: Uptake of Keep Well Consultations: SAAC vs SW Glasgow Wave 2**



However there are limitations in the validity of this comparison, renders these results difficult to interpret:

- as the total number of South Asian patients involved in Keep Well Wave 2 was much smaller, representing only a small proportion of the overall target Keep Well population subgroup
- both staff and time capacity were considerably smaller in the SAAC programme
- the practice with the largest number of South Asian patients refused to participate in this comparison, with resultant potential for bias
- opportunistic health checks were not possible in the SAAC model because of the peripatetic nature of the pharmacists' attachment to practices
- the SAAC team had substantially less time to engage with targeted patients from targeted practices, as compared with KW Wave 2 practices
- the SAAC team hypothesised that there are fundamental differences in the social characteristics of patients who were registered (by choice) with practices where the majority of patients are South Asian, compared with patients who were registered in practices where there were in a very small minority
- a significant yet unknown number of patients identified (through name recognition) as South Asian in Wave 2 comparator practices were asylum seekers or refugees, who received the Keep Well health check within their practice registration process.

29. As with the generic Keep Well programme, uptake was comparatively lower in men, younger age groups and resident of more deprived neighbourhoods (Table 2). It is noteworthy that the male:female ratio of contacted patients was extremely high (1.6:1) in the SAAC practices; although this was also a feature in the South Asian Wave 2 population the ratio was smaller, at 1.2:1.

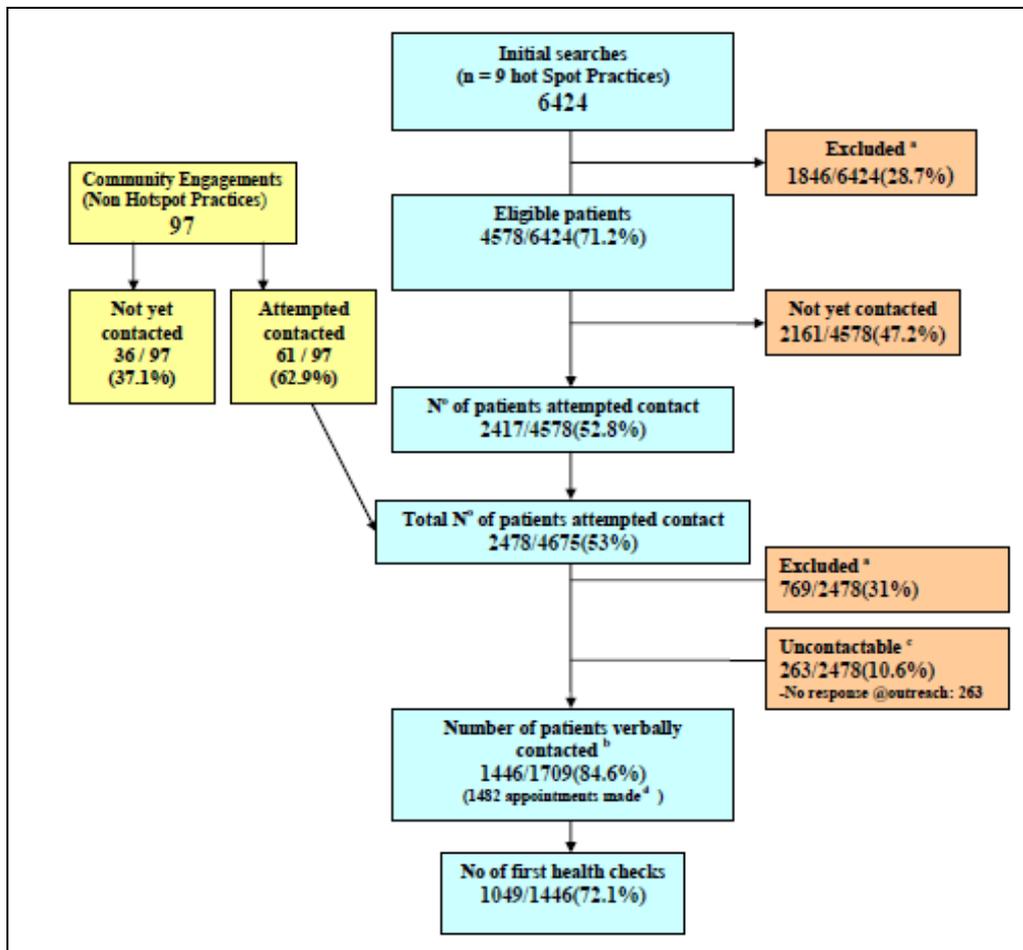
**Table 2: Uptake of Keep Well within SAAC Programme to 31/10/12**

Attribute	Attended/Total invited	% Uptake
<u>Gender</u>		
Male	494/1491	33%
Female	532/959	56%
<u>Age group</u>		
35-39	190/495	38%
40-44	268/686	39%
45-49	202/478	42%
50-54	169/354	48%
55-59	121/262	46%
60-65	62/139	45%
<u>SIMD Quintile</u>		
Q1 (Most Deprived)	142/377	38%
Q2	378/980	39%
Q3	154/361	43%
Q4	206/447	46%
Q5 (Least Deprived)	121/236	51%

30. The above analyses all use the agreed generic Keep Well data definitions, which define 'contact' as any documented contact attempt. However, the SAAC team learned at an

early stage that direct communication with the patient could not be assumed using standard administrative methods; accordingly, individual patients were only classified as ‘contacted’ when direct telephone or verbal contact was successfully achieved. Using this definition, the overall uptake of appointments among patients who had been successfully contacted was 1049/1446 (72%), as at 21 January 2013 (Figure 8).

**Figure 8: Uptake of Keep Well consultations among eligible patients in SAAC**



<sup>a</sup> Exclusion criteria - non South Asians/ any long term conditions (diabetes/Ischaemic heart disease/stroke), no longer at practice, deceased or other outcome indicating practice list not up to date.

<sup>b</sup> Verbal contact-If contact outcome is one of the following: Appt made, patient declined, agreed to contact later, dates does not suit, already had recent health check, left the practice, interested but house bound, written consent given

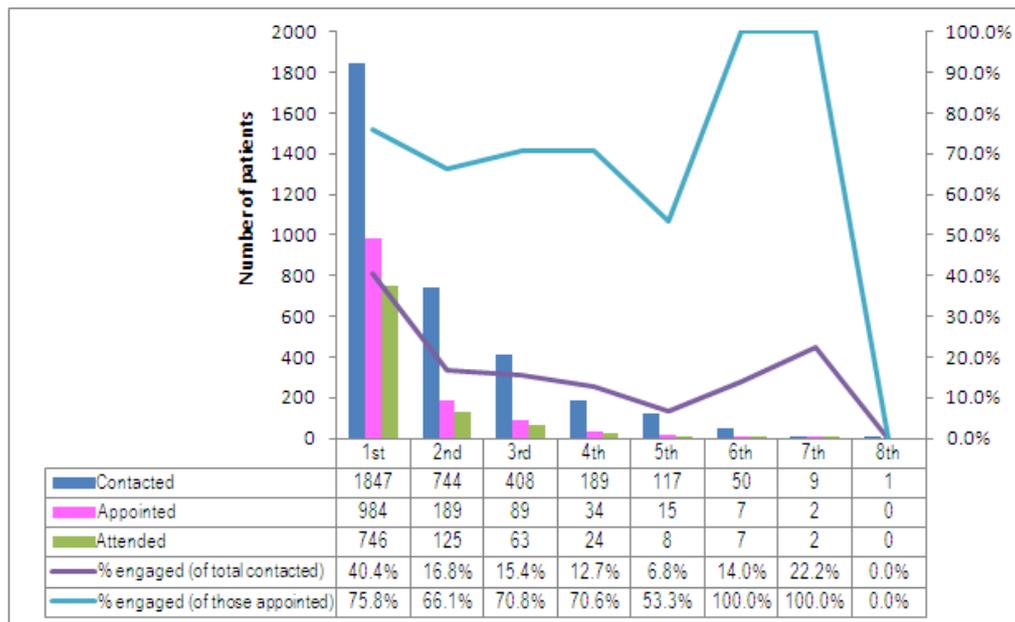
<sup>c</sup> uncontactable - If no contact made despite outreach visit

<sup>d</sup> total number of appointments made: includes some patients who had more than one appointment made because of failure to attend or cancellation.

31. Of the 2,478 patients in whom a contact attempt was made, 769 (31%) were excluded for the reasons given above. A further 263 (11%) were defined as uncontactable; in these cases, it was not possible to make contact with the person at an outreach visit. In most of these cases, individuals were not known at the address, had died or had left the UK. In some cases, the address did not exist.

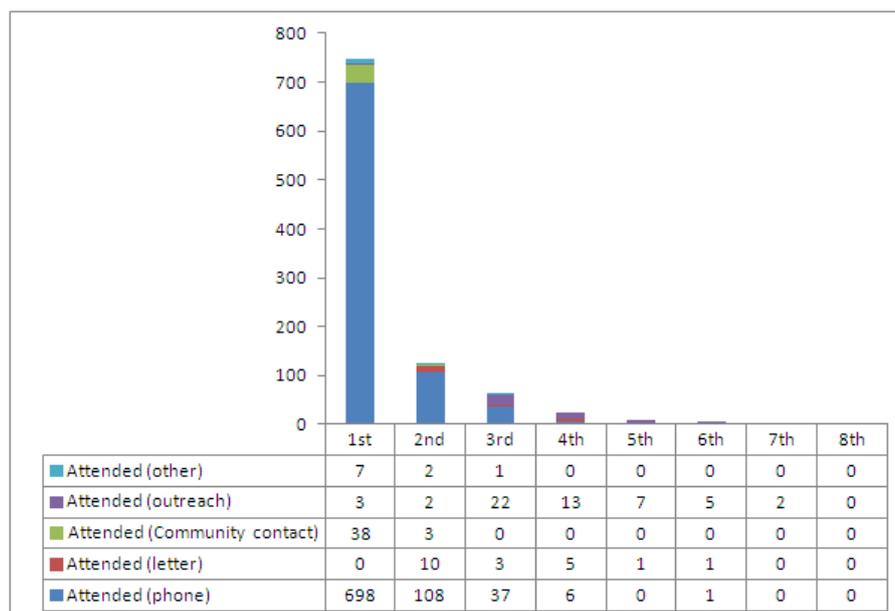
32. A total of 3,364 contacts were made among patients who had telephone numbers on file. Of those who ultimately engaged, the vast majority did so at the first attempt, with a steep attrition of engagement success rates thereafter (Figure 9).

**Figure 9: Cumulative SAAC contact attempts and their outcomes to September 2012 (Patients with telephone contact details on file)**



33. Among patients who engaged after only one or two contacts from SAAC, telephone contact was the predominant method used. However outreach methods assumed greater predominance in patients who had three or more contact attempts prior to their attendance (Figure 10)

**Figure 10: Successful contact attempts, by number and method, to September 2012 (Patients with telephone contact details on file)**

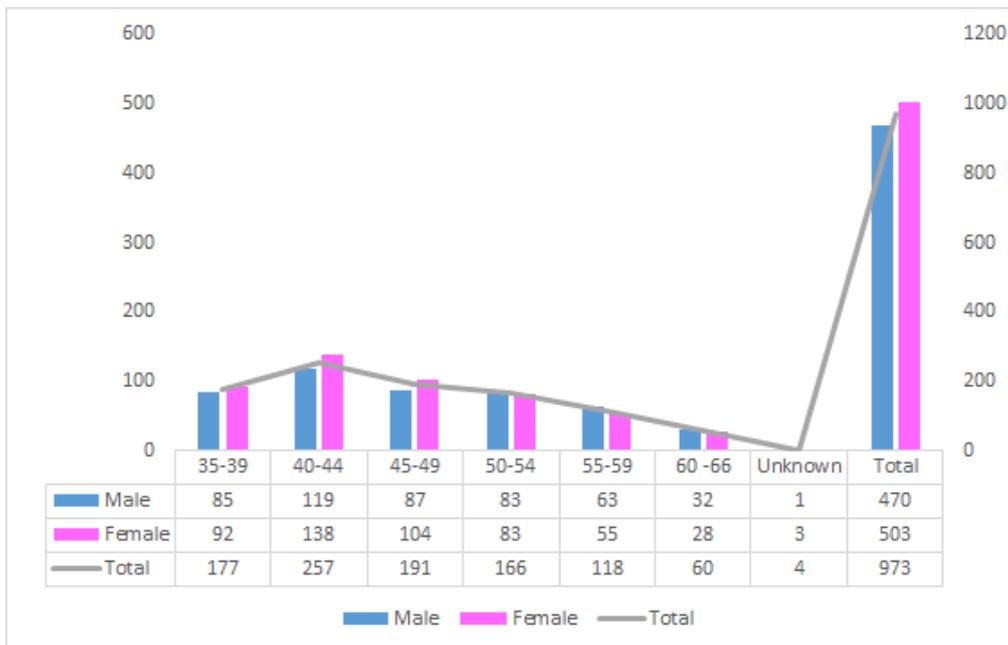


34. A further 476 contacts were made among those patients who did not have contact telephone details on file (71 by letter, 404 by the outreach worker and one by community contact), however only four (0.8%) of these resulted in attendance, all after outreach worker engagement. This highlights the crucial importance of current telephone numbers within GP record systems.

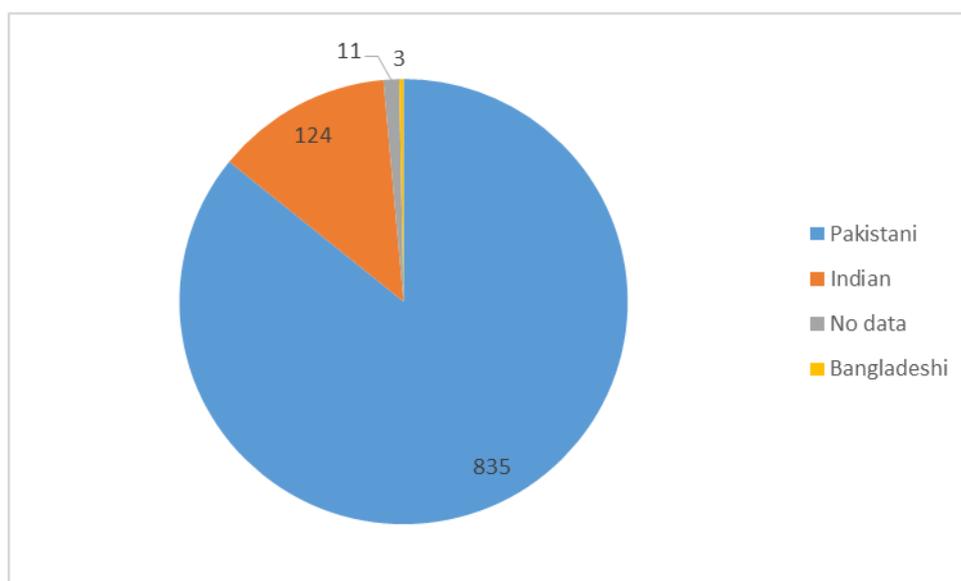
## 2: Patient population

35. Demographic and clinical data were analysed on the 973 patients who underwent first Keep Well consultations prior to 31 July 2012. The basic demography and linguistic preferences of patients are summarised below.

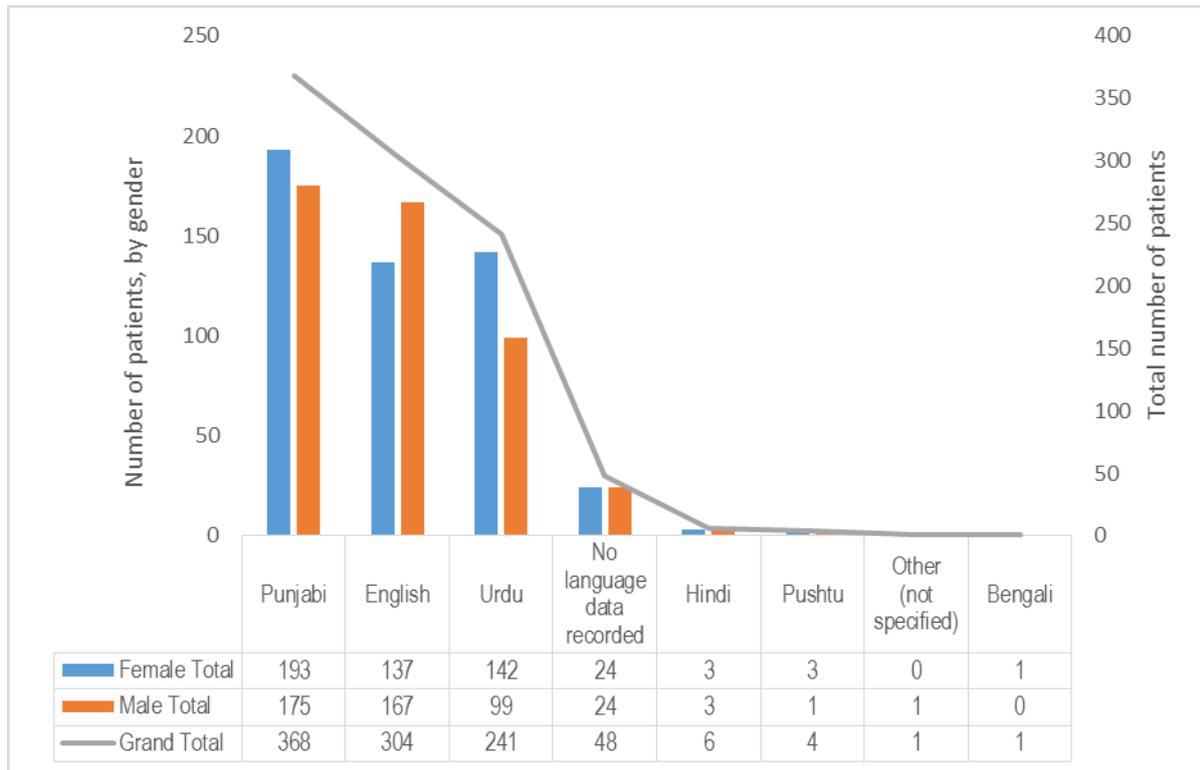
**Figure 11: Age and sex profile (n=973)**



**Figure 12: Ethnic profile of engaged patients (n=973)**

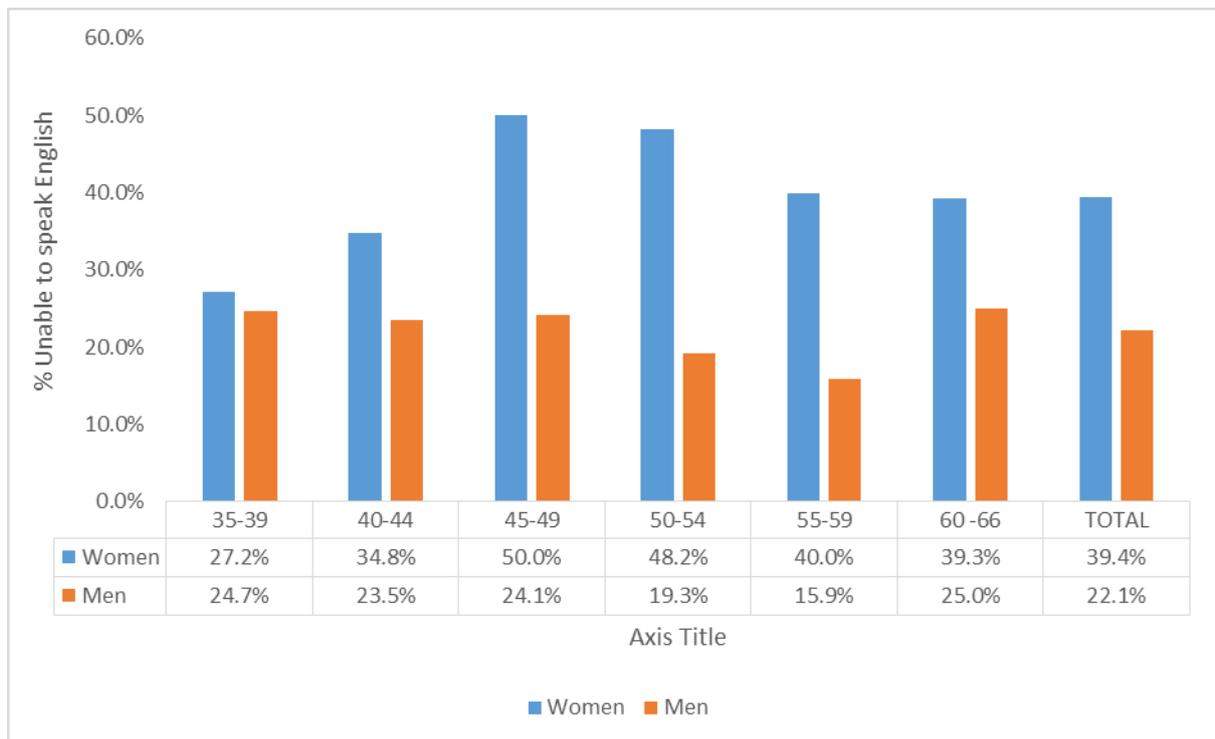


**Figure 13: Preferred language of engaged patients (n=973)**



Among the 410 patients in whom data were available, 39% of women and 22% of men declared themselves unable to speak English at all for the purposes of a clinical consultation (Figure 14).

**Figure 14: Inability to speak English (n=410)**



### 3: Clinical characteristics

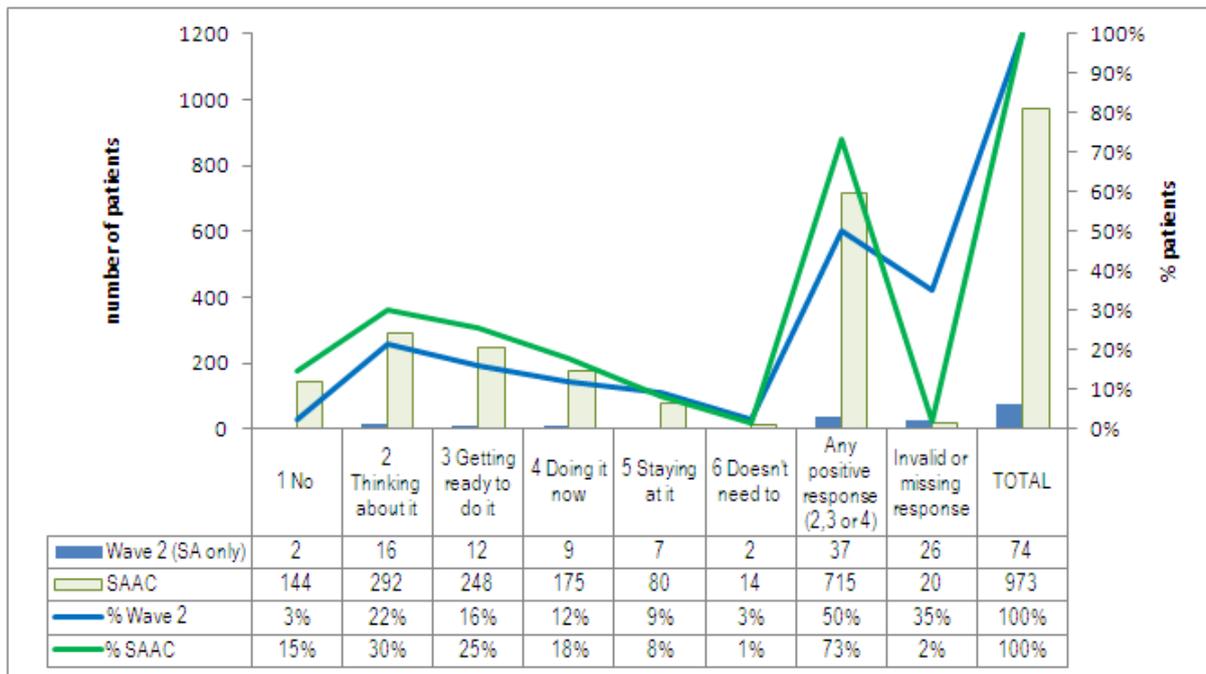
36. Clinical data were analysed on 973 patients who underwent first Keep Well consultations prior to 31 October 2012. This demonstrated a high prevalence of risk factors for vascular disease and metabolic syndrome (Table 3).

**Table 3: Clinical characteristics of engaged patients**

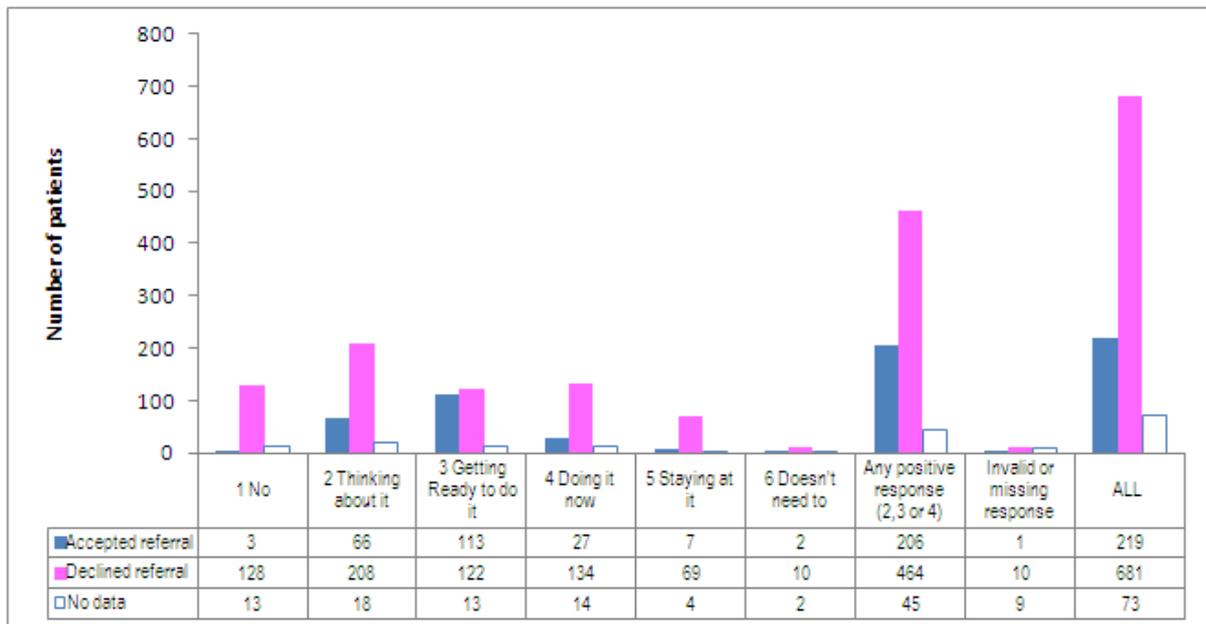
	Male	Female	All patients
<b>Family history of CHD</b>	113/470 (24%)	155/503 (31%)	268/973 (28%)
<b>Family history of diabetes</b>	155/470 (33%)	217/503 (43%)	372/973 (38%)
<b>Plasma cholesterol (mmol/L)</b>			
<5.0	173/470 (38%)	208/503 (41%)	381/973 (39%)
5.0-5.9	178/470 (38%)	176/503 (35%)	354/973 (37%)
6.0 and above	104/470(22%)	95/503 (19%)	199/973 (20%)
<b>Plasma glucose (mmol/L)</b>			
<7.0	368/470 (78%)	410/503 (82%)	778/973 (80%)
7.0-9.9	37/470 (8%)	39/503 (8%)	76/973 (8%)
10.0 and above	17/470 (4%)	4/503 (1%)	21/973 (2%)
<b>Systolic BP (mmHg)</b>			
<140	362/470 (77%)	415/503 (83%)	777/973 (80%)
140 and above	106/470 (23%)	85/503 (17%)	191/973 (20%)
<b>BMI (kg/m<sup>2</sup>)</b>			
<20	11/470 (2%)	15/503 (3%)	26/973 (3%)
20-24.9	104/470 (22%)	76/503 (15%)	180 (18%)
25-29.9	225/470 (48%)	179 (36%)	404 (42%)
30.0 and above	125/470 (27%)	221 (44%)	346 (36%)
<b>ASSIGN 10 year CVD risk score</b>			
<20%	410 (87%)	459 (91%)	869 (89%)
20% or more	39 (8%)	13 (3%)	52 (5%)

37. Health associated behaviour indicators were analysed on 973 patients who underwent first Keep Well consultations within the SAAC programme prior to 31 October 2012. For the purposes of comparison, cumulative data were analysed for the South Asian Wave 2 Keep Well population in SW Glasgow (Figure 15). This highlights the high proportion of invalid or missing responses in the generic Keep Well programme, which contrasted markedly with the more differentiated responses documented in SAAC clinical assessments. Around one third of patients classified as 'ready to change' were referred to Live Active (n=206) (Figure 16).

**Figure 15: Physical Activity Readiness to Change: SAAC vs SW Glasgow**



**Figure 16: Referral to Live Active, by readiness to change (SAAC only)**



Of the 219 patients who accepted referral to Live Active, more detailed demographic data were available in 215; in contrast to the patterns of uptake of weight and physical activity interventions seen in the generic Live Active service, 123 (57%) patients who accepted a referral were male and 92 (43%) female. 39 (19%) of the patients referred required communication support. 26 spoke primarily Urdu (67%) and the remaining 13 (33%) Punjabi. Only 13 (33%) of the 39 patients who required communication support attended their baseline Live Active appointment and only 78/215 (36%) engaged into the scheme.

38. Further information was derived from analysis of Live Active referrals from the SAAC team.

**Table 4: Further information from Live Active service (to end August 2012)**

Referrals From SAAC Team	215	%	Comments
Engaged	78	36%	Lower than non BME engagement (68%)
Booked Baseline and Still to attend	2	1%	
Baseline Booked and DNA	28	14%	
Still to Engage (contacted 1-2x)	50	23%	11 need communication support
Still to Engage (contacted x3)	17	8%	1 needed communication support
Drop out – Not interested	19	9%	
Discharge – uncontactable	44	20%	Have had all 3 contacts (Mixture of calls letters)
Inappropriate(eg BP too high/still active)	5	2%	2 still active, 1 BP too high, 2 do not require support.

Of the 78 SAAC patients who engaged into the scheme, 40 (51%) participants were still physically active at the end of August 2012, 6 (8%) participants had initially become more active, but subsequently returned to their previously sedentary lifestyle, although stated that they intended to return to a more physically active routine; 23 (29%) participants were no longer contactable, one hadn't started at all and eight had only recently been engaged so had not yet started the scheme.

The identified activity goals were very similar in content to those of the standard Live Active programme:

- 52 participants (67%) identified gym attendance as part of their goals
- 5 participants (6%) required supervised gym sessions
- 37 participants (47%) of people identified walking as part of their goals
- 27 participants (35%) identified swimming as part of their goals
- 9 participants (12%) identified home based exercises in their goals
- 9 participants (12%) requested women only sessions
- 7 participants (9%) identified classes as part of their goals (yoga/zumba)
- 5 participants (6%) identified 'Vitality' classes as part of their goals
- 4 participants (5%) identified community exercise schemes as part of their goals
- 4 participants (5%) identified racket sports as part of their goals
- 1 participant 1% identified cycling outside as part of their goals

## 4: Clinical effectiveness

### 4.1 Comparison of clinical characteristics at first and second reviews

39. In the sample of 104 patients who underwent second reviews, analyses of paired data were conducted to assess the extent of change in the following characteristics:

- Systolic blood pressure
- Body mass index (BMI)
- Waist circumference
- Number of times/week undertakes at least 30 minutes of physical activity\*
- Number of portions of fruit & vegetables per week\*

NB: the latter two measures (proxies for physical activity and healthy eating behaviours) were previously in the core Keep Well dataset, however these were subsequently discontinued in the light of updated guidance and improved data recording methodologies.

There were statistically significant improvements in both physical activity and healthy eating behaviours between the first and second reviews. For systolic blood pressure and waist circumference, there were small improvements in average values and confidence intervals around the mean paired difference included the possibility of a positive effect, but this did not reach statistical significance.

**Table 5: Comparison of clinical characteristics at first and second reviews (n=104)**

Measure	Mean (1st Review)	Mean (2nd Review)	Mean paired difference (95% ci)	Significance (Paired t test)
Systolic blood pressure	124.4	120.4	-3.990 (-8.4 to 0.4)	0.077
Body mass index (BMI)	28.5	28.7	0.135 (-0.2 to 0.5)	0.422
Waist circumference	90.7	86.9	-3.777 (-9.4 to 1.9)	0.187
Physical activity >30' occasions >30'	1.2	1.8	0.596 (0.2 to 1.0)	0.003
Portions of fruit & vegetables/week	2.2	2.5	0.356 (0.1 to 0.6)	0.016

## 5: Explanation of SAAC processes & outcomes

40. Exploration into the fundamental nature of SAAC, its achievements and the mechanisms through which these were created, as understood by the project team, its service users and wider stakeholders, identified six main themes:

- Extent & intensity of unmet need
- SAAC team's community profile & legitimacy
- SAAC team as a 'boundary spanner' for cultural competency
- The challenge of the post-health check 'vacuum'

- Food as a catalyst for change
- Mainstreaming & ensuring sustainability

### 5.1 **Extensive unmet need for health improvement in Glasgow South Asian adults**

41. Although the qualitative component of the evaluation was not designed to explore the nature of need among the target population, the extent, intensity and specific nature of South Asians' preventive health needs was one of the most dominant themes identified (Table 6).

42. Scale of challenge: the range and intensity of adverse social and behavioural risk factors for chronic disease was a striking feature and professionals delivering the SAAC service clearly recognised the limitations of a single encounter in responding to this challenge:

SAAC team member's reflective note: *The nature of the change which we want people to implement is pretty massive, given that many of these clients may have previously never considered a more active lifestyle or ideal weight. To change a mindset will require frequent reinforcement of advice and peer pressure. Maybe an Indian keep fit/healthy living movie....! Motivational interviewing could certainly go a long way towards this. But I feel that one-off checks or even six monthly checks may not be effective. But reinforcement of advice could make the difference. I don't think we've got the resources for this. Health costs in the future could be massive though.*

43. Health beliefs of South Asian patients: although patients had some awareness of poor health in their community, this was mostly attributed to getting old and/or a lifetime of hard work. South Asian patients often perceived that they had little control over their own health destiny. Accordingly, the idea of influencing this through lifestyle change, such as physical activity or diet, appeared quite a revelatory and sometimes alien notion when suggested by the SAAC team. Many people had significant risk factors for chronic disease, but lacked knowledge on how to address these:

Male focus group participant: *Some people have not got the need to go to the doctor yet, but may have in the future. They need to be targeted as well. How can they be targeted?*

Interpreter: *You can't target them, because you don't know who is going to develop a condition, it is only when you go to your GP.*

SAAC Team Member's Reflective Notes (following consultation with a SAAC patient): *He had put on 5 kilos over a period of 6 months. The reason being that someone had told him that since he was claiming disability allowance as result of an injury sustained when coming off the bus, he should not be seen out walking as this would affect his claims. Previously he walked everywhere. He could not speak English. I explained that it was important for him to keep walking if he could manage it and if he was unable to work the system would still help him. Again the importance of being able to communicate was very important in this case.*

Interpreter: *Through our discussion have some thoughts come in your mind that you can have health problems too? Like - to avoid diabetes, what you should do?*

Male focus group participant 1: *Yes, I did think I will take care. And God willing I will try.*

Male focus group participant 2: *Yes we all say we will try. But it never happens.*

Male focus group participant: *I have worked for 27 or 28 years at the same place. I did it alone as well. But when we develop any illnesses or health problems in old age, the wealth we accumulated will count for nothing.*

**Table 6: Unmet health needs in SAAC target population in Glasgow**

Informant Group	Theme		
	Extensive need	Poor mental health & social isolation	Unmet community needs for promoting health
<b>Patients</b>	<p>South Asian adults have prioritised economic success for their families – so preventive health not been a priority</p> <p>Opportunities for physical activity are few, reasons differ across subgroups of Asian men &amp; women</p>	<p>Social isolation is a real issue – causal factors differ in different subgroups of South Asian people</p>	<p>Feel distant from NHS – do not see NHS as a preventive service</p> <p>Referrals &amp; signposting disappear into the ether</p>
<b>SAAC Team</b>	<p>Scale of change needed to transform health is 'massive'</p>	<p>Much stigma around mental health – adequate consultation length, conducted in native language, enable free dialogue and 'opening up'</p>	<p>Many services are not responsive to South Asians people's needs</p> <p>Continuity of support required to help South Asian patients</p>
<b>Other stakeholders</b>	<p>South Asian patients often have multiple needs – little room in short GP consultations for holistic primary prevention</p>	<p>Many South Asian patients suffer from low self esteem and lack confidence</p>	<p>Traditional top down 'community engagement' events for South Asian people do not work</p> <p>No time to explore fully in reactive consultations in general practice</p>

44. Social isolation: this was also quite profound, with differentiated underlying reasons which varied by subgroup. For recent migrants, social isolation was attributed to loss of support systems, distance from family networks and low educational and language skills. For women, social expectations of their role in attending to domestic matters and lack of access to transport compounded these factors. South Asian men reported a different type of social isolation: in the pressure for economic survival, the life of a South Asian shopkeeper was seen as taxing and isolated, with no time for personal needs or meaningful social activities; this was a pattern which people explicitly wanted to change for the next generation:

Female focus group participant: *Those women who have come from back home in Pakistan or India - transport is the biggest issue for them. They can't go anywhere. They don't go anywhere because of the transport issues. They can't come and learn - so they lose out.*

Male focus group participant: *Us Asians - we don't have time, we work hard, come home in the evening, eat and go to sleep. This is a big problem. We only realise when problem starts..... What mistakes had been made, they are done, but I don't want that to happen to younger generation.*

45. Poor mental health: there was a clear recognition by both the SAAC team and also other services that poor self esteem and low confidence were significant barriers to health improvement among many South Asian people. Although social isolation was a major topic of concern in the two patient focus groups, its impact on mental health was implicit rather than stated. Related issues of domestic abuse and gender-defined roles were raised, but not developed as a theme:

SAAC team focus group participant: *And also we were talking about mental health and domestic issues and things like that as well and really kind of trying to set out a more appropriate referral system for the patients because it is a very taboo subject and you would be surprised what 35/45 minutes could do with patients where you really set a lot of information and really develop good links with the person and even women who are sort of older than you, you know, and they do confide in you and you are able to actually just give them, not just general advice but - help them - at a social level.*

46. NHS perceived as an illness service: Patients and professionals alike saw preventive healthcare for South Asian patients as virtually non-existent, until their engagement by SAAC. Patients viewed their GP as relevant only for symptomatic health problems; consistent with this observation, GP stakeholders experienced their consultations with South Asian patients as often complex, leaving little time for systematic primary prevention:

Female focus group participant: *We don't go and see doctor unless we got a personal problem. I have not been to my doctor for a year. Now you have invited me and that gave me the chance to have a check-up. Otherwise I would not have bothered especially to arrange an appointment for check-up because I have not got a problem.*

GP (stakeholder focus group participant): *I think the other thing is - in the consultation you are so busy trying to deal with the multiple symptoms that it is quite difficult to get on to primary prevention. So it is quite good to have it as a "stand alone" kind of thing. And say - right, this is what we are focusing on, not the kind of - aches and pains.*

47. Current services respond poorly to South Asian people's needs: As the first step in the process, professional stakeholders acknowledged the limitations of (albeit well intended) top down 'community engagement' events, because they are almost always the main strategy used by statutory organisations such as the NHS:

GP (stakeholder focus group participant): *But one thing that I would like to say, because I have been working in health for so many years now, and go to all the care centres etc. When people are holding events - health care professionals, they hold it in one place - community organisations - people come there year after years, you know, reaching out to give you a message. There are people who really need that. But we need to just change the delivery style to benefit those people. And this has happened for years and years - money just gets wasted giving the same talk.*

For women in particular, there was a dearth of opportunities for taking physical activity; for younger women, this was attributed to long working hours; and for older women, to unavailability of women-only sessions:

Female focus group participant: *There is nothing for women here. There is only swimming on Sunday for women. There is nothing else for women. There is not a swimming day for ladies - only at the weekend - in whole of Glasgow. Last year I used to go with my friend who used to take me somewhere outside Glasgow.*

Even when dedicated funding was invested in additional capacity within the Live Active exercise referral scheme to enhance responsiveness to South Asian individuals' physical activity needs, significant barriers remained. In January 2012, SAAC phoned a sample of 131 patients who had been referred to Live Active to determine engagement rates. The vast majority of these patients reported that they had not received a telephone call from Live Active. As reported by the SAAC team:

SAAC team focus group participant: *As an example back in January we realised that we had a core of patients - 130 odd - who had a referral to Live Active and the old excuse trying to contact these patients and the vast majority of the hadn't been seen.*

Interviewer: *I remember that, yeah*

SAAC team focus group participant: *Same sort of stuff coming up, February, March, April, May - and we realised that we really needed to sort of - DO something about this. So by May it still hadn't ....it was still much the same.*

Interviewer: *What were the bits that didn't work?*

SAAC team focus group participant: *Well engagements attempts by someone who wasn't fluent in Punjabi. So we tried to call them again and some of them said they had got one invitation. The rest said they'd never had anything from them. Because the number of venues is quite different and they never knew which venue they were given or were given a venue in the West End. So that is not HAPPENING.*

Whilst there are many likely practical administrative explanations for this, it is consistent with the reported experience of the male focus group participants:

Interpreter: *So if there was a group, like today we have come here, and if tomorrow there is an invitation for exercise, we will go there as well. There are many services but you want to find what is available? And what you can access for yourself and others also?*

Male focus group participant 1: *Yes. I was told I will be sent letter regarding gym, but now it has been a year.*

Interpreter: *They saw you a year ago? Was check up done a year ago?*

Male focus group participant 1: *Yes, they have not written anything, where I have to go for gym, just said they will arrange for me to join, but where?*

Interpreter: *So, it was not followed up?*

Male focus group participant 1: *No. It's same for him as well.*

Interpreting services were also viewed as often posing challenges, for professionals and patients alike; one South Asian woman reported that her trust in the interpreting service had broken down completely:

Interpreter: *How do you feel when you can talk freely without an interpreter?*

Female focus group participant: *You feel better. We can tell everything ourselves.*

Interpreter: *You have used the word 'better'; tell me more on this that you can talk to somebody about your health freely?*

Female focus group participant: *It is like here I tell something to this person who tells you, there it is better you are telling yourselves. Other person can also understand you better. Sometimes doctor gets confused and sometimes the listener. It has happened with me once or twice with the council. My English is bit better now. Before I did not know at all. I had to go to Council for something. They sent somebody with me there. I could understand but was unable to explain myself so the lady they had arranged for me did a little wrong to me. She was telling them wrong things about me. I really felt that she should not have done this. Later on when I questioned her outside what she is being paid for. She said if I could understand why get an interpreter? I said my understanding is not very good - especially big words..... I cannot trust anybody after the way she talked there, that was quite an experience, for these days I kept thinking about that.*

However, despite the enormity of these significant 'real world' barriers, they are not always visible to service providers, even those who have everyday client contact at an operational level:

Other stakeholder: *At the time I was in post for the BME groups, there was no discussion around cultural awareness. Maybe that is something to be raised within practices? This could be included in the Keep Well induction day – just a small section to go through language barriers, language line, and education on cultural differences. There is no need to do separate training.*

## 5.2 SAAC team's legitimacy & community profile

48. SAAC team's powerful team ethos & purpose: despite the fact that the SAAC team was fixed term, assembled in an incremental fashion and comprising a substantial number of sessional pharmacy workers in its first year, it shared a clear sense of purpose which was strongly driven and motivated by communitarian values, which was also valued by patients:

SAAC team focus group participant: *On my, you know, whatever experiences and skills I think the SAAC Team I am honoured to be part of this team. It is a great opportunity to work for my own people the community is very close to my heart I am part of it and can relate to them. So every day is a mission.*

Interviewer: *And is that quite hard - to give them that em... feeling that you know what you are doing and that you are a professional adult and not just a junior - to somebody who is a community elder? That you are professional in your own right even although you are very young?*

SAAC team focus group participant 1: *I think they actually respect you.*

SAAC team focus group participant 2: *I think they are actually proud of you*

SAAC team focus group participant 3: *Yeah*

SAAC team focus group participant 1: *Oh you are a pharmacist you must be so proud and all the rest of it. They are quite proud that somebody from the community wants to do something more in the community.*

49. Power of informal community networks: the SAAC team began to establish relationships with community members which meaningfully involved both parties on the common objective of improving health for South Asians. For the SAAC team, this was greatly facilitated by having an NHS identity which was distinct from the patient's own practice. These informal relationships contributed powerfully to acceptance and validation of the SAAC project; the personal nature of the SAAC telephone engagement approach (often involving several conversations) was highly valued, both by patients and by the team themselves:

Female focus group participant: *Yes we were talking in Urdu and Punjabi. I went for fun. I had a bet with my husband. He thought my cholesterol was high because I was overweight, but I said no. So when I did it I proved to him it was not high. So I came along to prove this point.*

(LAUGHTER)

Interpreter: *So you came to get checked up?*

Female focus group participant: *Yes, so I told [SAAC worker] that I will come along. So at least I found out all about it, before I did not know of it.*

Interpreter: *OK - so was the whole consultation in your language?*

Female focus group participant: *Yes.*

SAAC team focus group participant 1: *No matter who was there., em... the Religious Leader was waiting at the practice it would not have happened if [SAAC team member] had not been able to break the ice, so many times there is a frosty response when Fiaza say I am phoning from the NHS and you use their own language and then all of a sudden things change the conversation goes on and it widens out.*

SAAC team focus group participant 2: *It is such an - I don't know which words to use, it is such a nice experience - you know - I go and tell my family what people are like – oh it is so lovely to hear somebody in our own language - you know, explaining the whole thing to us. So you know they feel - quite IMPORTANT, you know - CARED FOR - by NHS. It takes longer, it takes more effort but I think it is worth it.*

#### Extract from SAAC team reflective diary

Week commencing 7th May: *Positive response of people contacted, convincing them to get their health checks done and then booking appointments for health checks, is a very exciting and rewarding process for me. When I contact people more than once, sometimes when they hear my voice they recognise me and are very happy to be re-contacted and appreciate it.*

Week commencing 14th May: *Attendance at our clinics has always been really good. Reminding people on the day of health checks has played an important role. This week two clinics with 100% attendance-GREAT. Contacting patients on phone create different situations every day. A small child picked up the phone, I greeted him in Urdu and asked for his parents. I heard him saying to his parents "There is a call from Pakistan!!"*

Week commencing 28th May: *Continuous hard work and dedication resulting in high standards of service provided*

Word of mouth (usually at a community event or with a family member) was thus very influential in attracting patients into the SAAC service, although there did not appear to be many examples of this occurring more widely in the community beyond the immediate

relationships established around the invitation for the SAAC consultation itself, The SAAC team attributed this partly to their lack of a community base which would allow them to have a physical presence in the areas where there are a large concentration of South Asian residents:

SAAC team focus group participant 1: *As regards community events I think having premises is very important because we actually include patients in community events so yeah ////*

SAAC team focus group participant 2: *[talking over one another] I was recruiting some new patients at the event and trying to explain the way we do the Health Check and things. The lady we had seen - she quickly said "It is a very good service I had a Health Check with XXX - it is very effective". Soon after, the person I was talking to signed the form.*

SAAC team focus group participant 1: *So it is kind of - word of mouth in the community*

For patients, word of mouth in the community also legitimised SAAC as a high quality service in the eyes of new service users:

Interpreter: *But how did you find out about this?*

Female focus group participant: *Yes I found out from some of my friends who were told by the doctor that some people who are from Pakistan and they don't know English, can go there as they can speak in Punjabi.*

Interpreter: *OK so you friends found out from somewhere else?*

Female focus group participant: *Yes. No, no - they were with Dr XXX themselves. Then they took me into his surgery.*

Thus, for South Asian people who have used the service, the SAAC project quickly became legitimised and valued partly as a consequence of immediate community and family networks. However its overall profile at neighbourhood level still appears relatively low; patients attending the focus groups seemed very unclear and confused about the respective roles of the SAAC team, their practice and other community services, with a sense of passivity around how they had ended up at the SAAC service and no real working familiarity with the NHS, beyond their own GP.

Interpreter: *OK. Mr XXXX, what was your experience? You probably saw them in the practice?*

Male focus group participant: *Yes. I don't know the name, there was a girl who spoke to me and said a letter will be sent out.*

Interpreter: *OK that's fine, so you were phoned and a letter was also sent to confirm?*

Male focus group participant: *Yes. Both letter and phone.*

Interpreter: *OK, the girl who saw you there, did she explain who she was and what was her objective?*

After using the service, however, patients clearly powerfully advocated for wider provision of preventive action at a personal level, wanted to see it extended for a wider subset of their community, expressing anger that for them it was "too late", were very keen to suggest enhancements to the service and wanted to see it more actively promoted:

Male focus group participant: As I have said before, you should just get literature printed in Urdu or maybe do a programme or two on Radio Awaz, because people listen to it. Maybe around Friday prayers. GP could be asked to refer people if he is concerned about someone and if he has the time to do it.

Interpreter: So, the information should be available in our language through the channels which people of our culture use, like television or radio or magazines?

Male focus group participant 1: She was just saying that we talk and discuss why you have problems.

50. Language & culture both matter: the SAAC project team was clear that their effectiveness in promotion of health among the South Asian communities was not just a simple matter of language. Rather, their cultural roots enable genuine community engagement and mutual understanding:

SAAC team focus group participant: You know the people don't even want to engage if they can't communicate. So it is quite a big, you know big barrier because em... especially with women South Asian women, older women you know because if they can't communicate - what can they say?

Interviewer: So sort of dissecting out that reluctance to engage, with somebody doesn't speak Urdu, what do you think that is?

SAAC team focus group participant: There could be lots of different reasons - people almost make the assumption that there is not going to be a cultural understanding, there is not going to be a meeting of minds.... So they know we will respect their boundaries. We know what to ask, what not to ask, how to ask things. So I think - we are in a lot better - you know, much better position - than a person who is not aware of these.

51. Community mobilisation: in a short space of time, the SAAC project managed to fulfil several diverse functions beyond a simplistic service delivery model, with varying degrees of success. These included advocacy on behalf of the South Asian community, community development, needs assessment, practice development support and influencing service change:

SAAC Team Member's Reflective Notes: Week commencing 14th May: Was at local park earlier this week and saw a few SAAC patients power walking! One patient asked if it was fast enough! So definitely taking our advice on board!?

SAAC Team Member's Reflective Notes (following consultation with a SAAC patient): Many clients are unwilling to enlist for live active gym referrals due to lack of segregated facilities. The most I can offer them is to walk regularly and watch their diet. However the Scottish weather is always the excuse that gets in the way of their resolve to get fitter. Many of the women I have seen would like to lose weight but struggle with the concept of a gym. At Al-Meezan we ran a keep fit class a couple of years ago. We recognised that although we had the opportunity to influence women in many aspects of their lives we always came up against a wall when it came to keep fit. So we asked an Asian physiotherapist to come in and tried to sell the keep fit sessions by promoting the fact that there would be someone there to help them with their sore knees and backs etc. This seemed to work and the classes attracted a few more women. We are now intending to have yoga classes rather than keep fit to see if this might be a more attractive option for them. I think this may be a more culturally accepted way forward.

**Table 7: SAAC's legitimacy & community profile**

Informant Group	Theme		
	SAAC's cultural and linguistic assets are both vital	SAAC's community profile	Community mobilisation role
<b>Patients</b>	<p>Initial bilingual telephone contact initiates trusting relationship</p> <p>Perceive service to understand their needs, provide safe environment &amp; enhance mutual understanding</p>	<p>Low awareness of SAAC prior to personal use of service</p> <p>'Bespoke' South Asian service is highly valued and seen as important after being used</p>	<p>After attending service, patients become powerful advocates for health improvement in the South Asian community</p> <p>Want more ongoing support from SAAC team</p>
<b>SAAC Team</b>	<p>Team's cultural &amp; social understanding opens doors</p> <p>SAAC team understands and respects boundaries</p> <p>Enable patients to feel more confident about using mainstream services</p>	<p>After attending SAAC service, patients actively seek out further contacts with SAAC team in community settings</p> <p>Patients advocate actively for the service (but only after using it!)</p>	<p>Powerfully driven by motive 'to give something back' to their own community</p> <p>SAAC team brings needs of their patients into sharper focus</p> <p>SAAC team advocates for and shapes changes in service delivery to better meet the needs of South Asians</p>
<b>Other stakeholders</b>	<p>GPs value support of SAAC team with more complex patients for whom systematic preventive healthcare has never been easy</p>	<p>Value SAAC's 'specialist' focus on issues relevant to South Asians</p>	<p>SAAC team has worked with services to improve engagement</p>

### 5.3 SAAC as a 'boundary spanner'

52. Building connections across many divides: The SAAC team effectively bridged the gaps across several interfaces:

- Between the targeted community and the local NHS
- Between the targeted community and general medical practices
- Between the local NHS and services attempting to meet South Asian patients' needs
- Within consultations, the SAAC model offers an opportunity to speak openly about health in a mutually understood cultural context

SAAC team focus group participant 1: Networking – you are networking with the patient, and the patient is networking with you as well as the GP practice and other health care professionals as well so you are building a bridge between all of the services [talking over one another] yeah. And then building it for the patient as well. Where they will become confident themselves - in their self esteem - and be able to access it any time they want and build up themselves as well.

SAAC team focus group participant 2: I think there is a benefit to all parties. So services, GPs to patients that we actually approach and - I think it is working - so it is a good benefit generally speaking.

SAAC team focus group participant 3: I don't think you can quantify that the real value of it. The folk that we have seen, they are in the practice they have been invited in for their Health Check I think they feel they have been part of something that they weren't previously - that is very difficult to quantify. It is intangible but it is a big thing. You know?

53. Desire for more family based approach: As previously observed, patients valued their community and family networks and thus struggled to understand why SAAC was a service targeting individuals, rather than the whole family particularly as traditional gender roles are quite distinct within some Asian families:

Male focus group participant: No one, wife does the cooking but I am a cook myself. Yes, usually wife cooks. Mr XXXX [referring to himself] does the cooking. And then I asked if I could bring my wife. She is diabetic and it is quite high and she is on insulin, but I was not given the permission, don't know why.

**Table 8: SAAC as a 'boundary spanner'**

<b>Informant Group</b>	<b>Theme: Integration and building connections</b>
<b>Patients</b>	Limited understanding of how all these services connect  Desire for family based interventions
<b>SAAC Team</b>	Patient 'becomes part of something that they weren't previously'  Helps patient understand and navigate through the wide range of preventive opportunities available for them
<b>Other stakeholders</b>	'Bringing patients back in from the cold' in general practice  Helping services to respond better to South Asian community needs  Helping South Asian patients to navigate mainstream services

54. Bringing patients 'in from the cold': For patients, the SAAC project was perceived as signal that 'someone cares about my health at last'; many had previously felt distant from NHS services and appeared to have only the vaguest notion about how these are organised beyond their GP, whom they only consulted for solving (rather than preventing) problems. SAAC was also perceived by other stakeholders as a powerful way of reaching patients that they had failed to do. For GPs in particular, the SAAC project was valued as a way of finding time and capacity to change the focus of care towards preventive, anticipatory care and demonstrating that this was something the practice valued:

External stakeholder: I mean one of the strongest things that the SAAC project could do. I mean if it is possible you know, some patients are isolated within the practice and if we can bring them back into the fold of the practice that is probably more important than a lot of other things that we do with them. Sometimes getting them through the door, appreciate what health care means and stuff, getting that relationship back up and running is more important or as important as anything else that we do, taking a blood pressure or cholesterol you know.

SAAC team focus group participant: The thing is not just but with our service is getting them to engage with a mixture of community services, a mixture of people, a diverse range of people, all ages. Different ethnicity is an important factor for all of us because it helps them as well build up their confidence and actually get to know that although there might not be some things in common, they build up their relationships and from that progress themselves as well.

#### 5.4 Post health check 'vacuum'

55. Need for follow up after the SAAC consultation: it was clear from the observations of both patients and the SAAC team that a 'one off' consultation sometimes left patients feeling uncertain and unsupported, particularly when they had been referred to a service. There were several accounts of patients who expected something to happen after the consultation, but who then felt disappointed because they had no further contact and they lacked the knowledge and confidence to pursue this themselves:

Interpreter: Were you referred for further services or informed about it?

Male focus group participant: That's what the forms were filled for, that if there were any further services, we will get in touch, but we did not find anything out after that.

Interpreter: OK, you were saying that you will be sent for some exercise, but you did not hear anything. Did they send you for anything apart from exercise?

Male focus group participant: No.

SAAC Team Member's Reflective Notes (following consultation with a SAAC patient): Second health checks highlighted patients falling through net in terms of referral. Maybe increased involvement in time after referrals and health check till second health check would help.

56. Need for more sustained support in some patients: for some individuals, there was also a need for more in-depth support with making lifestyle or other changes to improve their health and wellbeing. For these patients, they required help with reinforcing their behavioural changes. Group interventions were well received and patients valued opportunities to share experiences with peers:

Female focus group participant 1: Those who can't come, you should tell them as well so they could benefit from it. You should bring them along. The more we tell as people ourselves, more successful it will be and these facilities will continue. OK.

Female focus group participant 2: Sorry, if I can say something.

Interpreter: Yes, OK

Female focus group participant 1: As that auntie has said like when we do something for one day, two days or ten days it stays with us. So these sessions should not end. The continuity should carry on. The benefit of this will be as if you are being told something repeatedly. Your brain will retain this and it will become a part of your routine, and then this practice will continue. So you see she is saying that these sessions should continue and you all saying that these have raised awareness

Stakeholder focus group participant 1: *It is interesting what you were saying about Walking Groups as well because certainly I am conscious that the Asian em... that it is walking that you can generally get people to do and it is probably quite good to have almost like a mentoring that if you have got other folk doing it, and folk are a bit anxious about it there is obviously [talking over one another]*

Stakeholder focus group participant 2: *Well that is something that we are certainly exploring at the moment is having em.... peers or mentors within the scheme. .... To have people who have been through the system who are South Asian and are able to kind of engage with family members as well - is one of things that we have come across quite em... a lot through conversations with us.*

**Table 9: Post health check ‘vacuum’**

Informant Group	Theme: Post health check ‘vacuum’
Patients	Report ‘hearing nothing’ after referral to physical activity interventions  Some individuals want sustained support after initial Keep Well consultation  Group interventions highly evaluated for opportunities to share experiences with peers
SAAC Team	Need deeper understanding of individual patients’ beliefs about health  Patients too often ‘fall through the net’ after a great consultation
Other stakeholders	Value of family & community networks in sustaining support

57. Need deeper understanding of individual patients’ beliefs about health: The SAAC team frequently identified profound misconceptions held by patients about the cause and course of their disease, however were wary of attempting to correct these without a deeper exploration of patients’ beliefs:

SAAC Team Member’s Reflective Notes (following consultation with a SAAC patient): *I think I need training on motivational skills. Some patients say they take on board the advice given them, however I wonder whether by more probing I might be able to get insight to their thinking about their beliefs about the changes they could make. I have attended such sessions with Lloyds as part of CMS. I’ll brush up on this. Pulses were fine.*

58. Value of family & other close community networks in sustaining support: It was clear that patients explicitly valued support from both family and other community members, which enhanced the additional attributes of SAAC as an ‘expert’ source of advice:

Interpreter: *This whole thing, what we are trying to do here, your own opinion on this, is - if you tell your friends about it.*

Male focus group participant: *Yes, my opinion is that it is very, very beneficial and useful for Asian people. It is very important because lot of Asians including me are not aware, even if there is some literature is available, but that is in English. Even if there is programme on television, we won’t know, because that will be in English as well. Here we all get together take advice from SAAC experts and we can also discuss our experiences with each other - which is very good.*

SAAC Team Member’s Reflective Notes: *Family members seem to be the important thing because the kind of word of mouth seems to be quite important, especially with the activity level it is walking with a sister, walking with a parent, it could be anything like that.*

## 5.5 Food as a catalyst for individual & community level change

59. Food as a catalyst in individual consultations: the SAAC team’s work with individuals was enhanced by their understanding of cultural significance of South Asian food, which established mutual understanding and legitimacy with patients, facilitated by a shared interest in Asian food:

*SAAC Team Member’s Reflective Notes (following consultation with a SAAC patient): Here’s a good question: What IS a healthy curry? Here the value of understanding the cultural background is important. A good curry must be balanced in its flavours, look rich and be eaten with mounds of rice or several chapattis at around 9pm! Lots to talk about around this topic. But first I have to make a good curry myself - with just three dessertspoonfuls of sunflower oil to serve six people.*

*(1 WEEK LATER): Curry was good. I used a lot more vegetables and intensified the flavours. Served with a huge bowl of salad of brilliant colours. Great! This helped to reduce the number of chapattis eaten. Followed by fruit salad. Shared this with the patient from last week.*

**Table 10: Food as a catalyst**

Informant Group	Theme: Food as a catalyst for health improvement
<b>Patients</b>	<p>Valued South Asian specific cooking classes: “now at least we should save our children”</p> <p>Food created focus for social interaction</p> <p>Food as catalyst for other change</p>
<b>SAAC Team</b>	<p>Food readily engages patients in discussions about health behaviours in individual consultations</p> <p>SAAC team display understanding of cultural significance of South Asian food</p> <p>Gain legitimacy with patients via shared interest in Asian food</p>
<b>Other stakeholders</b>	<p>Community based cooking &amp; exercise classes highly successful initially, but high rate of attrition poses threat to sustainability</p>

60. Food as a catalyst in wider community interventions: As a result of the SAAC team’s observations about the need for food and physical activity interventions which were more customised to the needs of South Asian patients, joint work with the local SE CHCP (at that time) health improvement team resulted in the decision to a pilot a more culturally sensitive healthy eating and physical activity programme for South Asian clients in south Glasgow (fully described in Appendix 5). The programme incorporated a ‘Get Cooking, Get Shopping’ type 6-week course with some physical activity input more tailored to the needs of South Asian food cultures. This appears to have been very well received; patients valued its relevance to their own cultural traditions, as well as its appropriate location, conversation in their native language and gender-specific exercise classes.

Female focus group participant 1: *I have only come once or twice I have not been much, but it is very good. Your project is very good. It is healthy, it very good for health. The more we learn and move forward, more it will be beneficial for us.*

Interpreter: *OK which thing you found beneficial?*

Female focus group participant 1: *Like when we cook at home we use more oil, more salt, more chilli powder which are harmful for our health. So if we use less salt, chilli powder as advised it will be good for our health.*

Interpreter: *OK, you said you have been here twice, so what was your experience here?*

Female focus group participant 2: *My experience is been that less oil, less salt, less chilli powder should be used, we should not overcook the food they way we do. We overcook the food, nearly burn it that's not good. It is better the way they are telling us which is good for health.*

Interpreter: *So you came twice?*

Female focus group participant 2: *Yes I tried that, that was fine and my children liked it as well.*

Interpreter: *And then many times you have cooked like that?*

Female focus group participant 2: *Yes I cook that way from time to time. It will take time for children to get used.*

However, there were challenges too; although the tailored community based cooking & exercise classes were highly successful initially, they had very high rates of attrition which would require to be investigated and addressed to enable their future sustainability.

61. Food as catalyst for more fundamental change: Food was seen as an 'easy' entry point to the more fundamental health issues facing the South Asian community and patients saw engaging with the food agenda as a first step in beginning to mobilise their community more widely on other aspects of health improvement:

Male focus group participant: *See, actually it is all for our health. It is our fault if we don't come or don't do it. You asked about an experience at the start. We were told just only treatment wont work, if we don't exercise or watch our diet. That's what we were advise here what type of food and how should it be cooked. This is a good programme and if it is continued long term, only then it will have some effect. Our community particularly should be targeted.*

## 5.6 Continuity and sustainability

62. Continuity & strengthening of some functions required: Patients, the SAAC team and other stakeholders all shared a common view that the SAAC service had achieved a great deal during its short lifespan, largely as a result of its ability to connect, influence and bridge cultural divides. However, there were complaints about the fact that there had been too many similar short term projects and longer term effort was required, as well as the areas highlighted for strengthening in Section 5.4.

SAAC team focus group participant 1: *I would definitely say - that it is very important that we do extend the service - and it seems as if the South Asian population - at least in the practices we are operating in - we are giving them back something. Second benefit I think is we actually are improving the relationship between the surgery and the patient - that sort of - Lost Relationship. We have actually brought back that confidence that should have perhaps been there now but I appreciate that not all practices are like this. And separate perhaps talking to some of the patients they are actually getting in touch with other services that already exist that are in the community.*

SAAC team focus group participant 2: *Just making them aware of things that are actually present in the community and helping to access it, so improving access for the patients*

**Table 11: Continuity and sustainability**

Informant Group	Theme: areas for strengthening
<b>Patients</b>	<p>Programmes like SAAC must be sustained over a longer period</p> <p>SAAC must be more clearly adopted by South Asian community itself</p>
<b>SAAC Team</b>	<p>Expand role in raising awareness of long term diseases and the community's knowledge of them</p> <p>Empower community - these services are there for them, so use them!</p> <p>Influence health improvement services more</p>
<b>Other stakeholders</b>	<p>There have been too many short term projects</p>

*SAAC team focus group participant 1: I would definitely say - that it is very important that we do extend the service - and it seems as if the South Asian population - at least in the practices we are operating in – we are giving them back something. Second benefit I think is we actually are improving the relationship between the surgery and the patient that sort of lost relationship. We have actually brought back that confidence that should have perhaps been there now but I appreciate that not all practices are like this. And separate perhaps talking to some of the patients they are actually getting in touch with other services that already exist that are in the community.*

*SAAC team focus group participant 2: Just making them aware of things that are actually present in the community and helping to access it, so improving access for the patients*

*SAAC team focus group participant 1: Stakeholder focus group participant: And I think the reason this has worked is because it is well integrated. When you put these models out on their own and just kind of let them “fish for themselves” they often perform quite poorly and basically if we are going to ever go outwith general practice for kind niche patient it kind of proves we just have to make sure that the communication part looking at the integration of practice is there. Whereas we have gone to the GPs and then said – OK we know this is a problem, let’s work together, we will come and do searches we will do it in your place. I think it is all those things together.*

## Conclusions

The SAAC project has been highly effective as both a clinical and health improvement intervention, serving a population with demonstrably low levels of health literacy and a very high prevalence of risk factors for vascular disease, including overweight and obesity (78%), elevated systolic blood pressure (>140mmHg) (20%), a family history of diabetes (38%), elevated (> 5.0 mmol/L) plasma cholesterol (57%) and random plasma glucose values of 7.0mmol/L and above (10%). The small bilingual team worked productively with patients following an initial verbal (usually telephone) contact, which was followed by attendance for Keep Well consultations in around 72% of cases. Word of mouth (usually at a community event or with a family member) was very influential in attracting patients into the SAAC service, although its overall profile at neighbourhood level appeared relatively low; the absence of a physical base suitable for seeing patients was given as a reason for this. However, after using the service, patients became powerful advocates for strengthened preventive action and wanted to see the service extended and more actively promoted.

The benefits of bilingual staff were clear; the vast majority of patients preferred to converse in Punjabi or Urdu and 39% of women and 22% of men were unable to speak English at all. The team also possessed extensive cultural knowledge which they used in many different ways at community level, including advocacy on behalf of the South Asian community, community development, needs assessment and influencing service change. At a second follow-up review in a subset of 104 patients, statistically significant improvements were documented in both physical activity and healthy eating behaviours. For systolic blood pressure and waist circumference, there were small improvements in average values and confidence intervals around the mean paired difference included the possibility of a positive effect, but this did not reach statistical significance.

The extent, intensity and specific nature of South Asians' preventive health needs was striking. Moreover, South Asian patients often perceived that they had little control over their own health destiny. Social isolation, low self esteem and poor mental health were frequently described. Professionals delivering the SAAC service clearly recognised the limitations of a single encounter in addressing these overwhelming needs. GPs described their consultations with South Asian patients as typically complex and crowded, with little time for preventive interventions, compounded by the fact that South Asian patients (in the SAAC target age groups, at least) have limited understanding of health services and largely use their GPs as an illness service.

Services were found, generally, to face challenges in responding to South Asian people's needs and even when dedicated funding was invested in additional capacity for specific services, significant barriers persisted and patients still appeared to 'get lost' in the system. For significant numbers, there was a need for more in-depth support with making lifestyle or other changes to improve their health and wellbeing. Group interventions were well received and patients valued opportunities to share experiences with peers. Food-based interventions also appeared to function particularly well, both in consultations with individual patients and also in mobilising the South Asian community more widely in health improvement. Patients, the SAAC team and other stakeholders all shared a common view that the SAAC service had achieved a great deal during its short lifespan, largely as a result of its ability to connect, influence and bridge cultural divides. However, there were complaints about the fact that there had been too many similar short term projects and longer term effort was required.

The profound needs identified here accord with other studies in South Asian communities, which report significant practical and structural barriers to healthy lifestyles in this subpopulation (lack of time or money, difficulties with childcare, poor housing, fear of crime, reduced access options and limited fluency in English).<sup>3-5</sup> However, cultural factors are likely

to play the major role. A review of the qualitative literature published by Lucas et al in 2013 reviewed ten studies of the perceptions around lifestyle disease and health behaviours among UK South Asian populations, investigating awareness, knowledge, perceptions, and misconceptions about living a healthy lifestyle for UK South Asians. The review provides additional insight into possible reasons why South Asian perceptions may be at odds with current models of behaviour change.<sup>3</sup>

A survey of 188,572 individuals using the General Practice Assessment Questionnaire examined differences in white and ethnic minority patients' evaluations of primary care, adjusting for demographic factors, health need and variation in reported standards of received care. This found negative evaluations of waiting times to see general practitioners and of continuity of care, which was largely explained by actual experiences of these aspects of care, but was also partly attributed to communication problems and different expectations.<sup>4</sup>

Fatalistic and episodic approaches to health and illness have long been highlighted by health professionals as being characteristic of South Asian patients, with South Asian people cited as great believers in destiny and fate, often quoting 'this is God's will' or 'what is written in my destiny no-one can change'. Such an approach to health often results in patients being less proactive in their pursuit of health, with a propensity to shift readily into a dependent role. However, some researchers question the extent to which this is an oversimplification.<sup>5</sup>

Grace et al explored the attitudes of British Bangladeshis without diabetes to the risk of developing diabetes and the opportunities for preventing it.<sup>5</sup> They concluded that the main barrier to positive lifestyle change in this community was not lack of knowledge, but rather a complex value hierarchy in which what is accepted to be healthy was seen as less important than the social norms of hospitality, religious requirement for modesty, a larger body size and cultural rejection of a 'sporting' identity or dress (especially for women, older people, and senior members of society). This led these researchers to question the transferability of standard behavioural change theory and current self management approaches to South Asians, for whom individualism and self investment may be seen as less relevant to societies with a collectivist history.

Many studies highlight the important role played by food in social networks, the social significance of cooking for guests and of celebratory meals. A positive approach is needed to promote the benefits and advantages of a healthy and traditional South Asian diet. Delivering education, advice, and support to the whole family given the broader role that the shared consumption of South Asian food plays in community life is important.<sup>5</sup>

The continuing unmet needs identified by this evaluation accord with previous observations made in the process of developing culturally sensitive cardiac rehabilitation services in NHS GGC in 2004.<sup>6</sup> Many similar small projects, tailored services and opportunities across the UK have attempted to address these issues, however they have generally been narrow in focus, located either in health services or in community settings, with few and have thus shown no convincing evidence of impact at a population level. Despite the multiple determinants of health in this disadvantaged population, there appears to be dearth of multifaceted or sustained initiatives addressing prevention agenda for this population.

Finally, although the SAAC project focused on the anticipatory care and prevention needs of South Asians in mid adult life, the research on social exclusion among young second and third generation South Asians in Britain points to a pressing need for a continuum of preventive interventions starting much earlier in the lifecourse.<sup>7,8</sup>

## Recommendations

The SAAC should be developed into a fully integrated clinical and health improvement programme operating at strategic and operational levels, supported by high quality community development. Its core activities, target population, settings, potential structural arrangements and delivery model are outlined below as a starting point for future discussion and ratification by the Keep Well Management Group and NHSGGC Partnership Directors. .

### Core activities

#### 1. Strategic

- Coordinate systems to promote health in the South Asian community
- Improve and increase access to culturally sensitive healthcare across NHSGGC
- Use of a range of public health data & information sources to:
  - i. identify & characterise local South Asian communities across NHSGGC
  - ii. assess their knowledge, awareness, attitudes and beliefs about health
  - iii. assess their specific cultural, language and literacy needs.
- Development of tailored preventive interventions targeting South Asian patients and their immediate families
- Identification of successful local interventions serving South Asian patients
- Address gaps in service provision.
- Creating local environments that encourage people to be more physically active and to adopt a healthier diet
- Development of effective, collaborative linkages between the NHS, local practices and existing community projects using a Community Orientated Primary Care approach
- Influencing & supporting existing statutory and third sector services in responding to the needs of South Asian adults

#### 2. Operational

- Direct service provision to practices, to support them with engaging individual patients
- Proactively support service attendance after referral
- Individual support to patients with making and sustaining change
- Support local CHCPs/sectors and practices with developing culturally relevant preventive services
- Act as a conduit between primary care, local NHS partnerships, third sector organisations and faith communities and help to strengthen these connections

#### 3. Community development

- Identification of relevant skills, capacities and experiences in community
- Working in partnership with local health improvement teams, help community members to recognise and articulate areas of concern and their causes
- Work in partnership with third sector organisations and relevant faith communities to identify issues and contribute to addressing them via practical solutions
- Establish a 'vehicle for change'
- Develop an action plan

- Training of lay and peer workers in how to plan, design and deliver community based health promotion activities

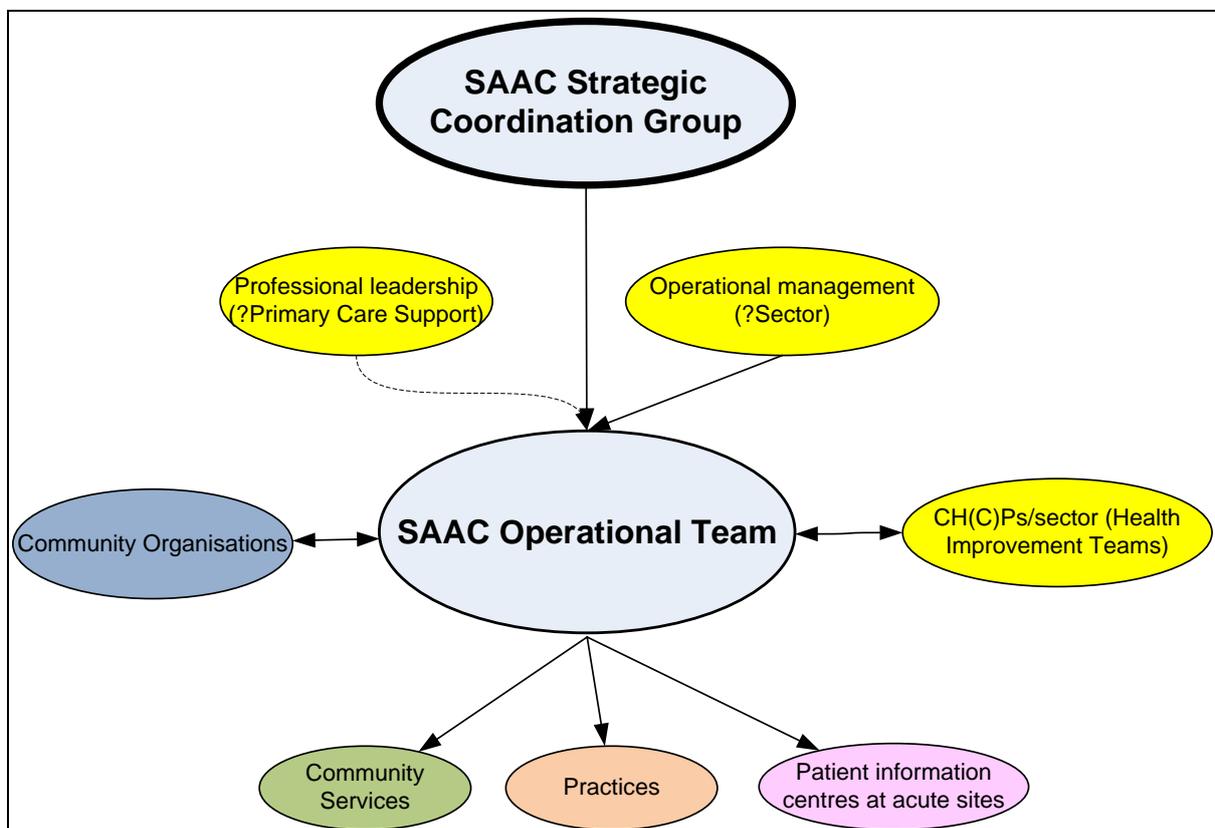
### **Target population**

The target population should continue to focus on adults of South Asian ethnic origin aged 35-64 who are resident in NHSGGC, however the service should explicitly extend to work with their immediate family and develop working links with preventive and other healthcare services serving older and younger age groups of South Asians in each local area.

### **Settings for operational activities**

- General practices
- Community settings (eg mosques, community halls etc)
- CHCP/sector premises (eg health shops, etc)
- Acute ambulatory settings (eg patient information centres)

**Figure 17: Potential future structural arrangements for Integrated SAAC Programme**



### **Proposed structural arrangements (Figure 17)**

- For the strategic components, a ‘hub & spokes’ model is recommended to promote effective participation of all partnerships in promoting health in the South Asian community, coordinated by a senior manager with leadership responsibility for the programme. This could be delivered by the Public Health Directorate.
- Given the findings of the process evaluation on how the SAAC team achieved its outcomes, it is essential that the operational SAAC team operates as an integral unit, with bilingual clinical, outreach and administrative functions and a clear brand and

identity. Consideration should be given to recruiting a bilingual nurse for delivery of bilingual clinical consultations and mentorship of practice nurses, as the majority of primary care consultations for chronic disease prevention and management are nurse-led.

- Existing Keep Well practices who do not achieve acceptable levels of Keep Well uptake in eligible South Asian patients should be offered support from the SAAC team and/or additional support from the primary care support functions when required
- Each of the disciplines subsumed within the operational team should have appropriate professional leadership
- The SAAC operational team should ideally be located at an accessible community location to allow walk-in appointments, increase the profile of the project and function as a base for community development work. As the team's activity is likely to be concentrated in South Glasgow, there are advantages in locating it there, with management and professional support from the South Sector health improvement team. However, as its role is a pan-GGC support function, careful consideration would need to be given to how to share this resource equitably with other CHCPs/sectors; there would also be a strong case for management within the primary care support team.

### **Leadership**

Given the size and range of challenges highlighted, the limited capacity available and the interagency partnerships which are required, the SAAC programme will require effective senior leadership to ensure that all available resources are identified and used to maximum benefit. Advocacy, application of knowledge, evidence and insight, together with clear governance and accountability arrangements are all important components of the leadership role.

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## **Appendices**

### **Appendix 1: SAAC Team Reflective Notes**

1. What has gone well in SAAC to date?
2. What has not gone well in SAAC?
3. How do you think SAAC has helped its patients?
4. What are the biggest achievements of the SAAC project to date?
5. What changes would you like to see happen to the SAAC project / Keep Well / current practice / HI services?
6. GENERAL POINTS --- (you can share thoughts on unique situations, any concerns, your experience of interacting with patients in checks, and feedback on blood training/shadowing in practice)

## **Appendix 2: SAAC team focus group discussion schedule, May 2012**

### **1. The job role and function**

- i. Describe your job role and how you approach the task of the SAAC team when you started.
- ii. How did you get into this type of work?
- iii. What skills and experience did you bring from any previous roles which you feel were important for the task of the SAAC team

### **2. The essence of the SAAC team work**

- i. How would you sum up the essence of the SAAC team role?
- ii. What is unique – where do you think the SAAC team adds unique value?
- iii. Which client groups really need your input?
- iv. Tell us about the types of encounters with clients in which you feel you achieved real change.
- v. Tell us about fears and barriers to engagement in the SAAC project

### **3. Project History**

- i. What were the SAAC teams main challenges at the beginning?
- ii. How were these overcome?
- iii. What aspect of the service still need to be improved

### **4. The future**

- i. What are the benefits to patients as a result of working with the SAAC team?
- ii. To what degree do you think the SAAC team adds unique value to the Keep Well programme?

## **Appendix 3: Patient Focus Group Discussion Schedule**

### **I: Introductions**

### **II: Initial contact with SAAC**

- 1.Had you ever heard of the project before you received your own invitation?
- 2.How were you invited to attend SAAC?
- 3.Can you tell us a bit about your experiences of that initial invitation?
- 4.Could we improve on the way we invite patients to SAAC?

#### **Prompts:**

*Were you at all unsure about whether to attend or not?  
What was communicated? Was it clear? In your own language?  
Did you understand what you were attending and why?*

### **III: The Keep Well Consultation**

- 1.Tell us about your experience of the Keep Well Consultation (health check)
- 2.What were the personal benefits to you ?
- 3.Could we improve on the Keep Well Consultation approach? If so, how?

#### **Prompts:**

*Was anything unique about the Keep Well Consultation (health check)?  
Where do you think this project adds value to healthcare?*

### **IV: After the consultation – what changed?**

- 1.During the consultation, were you offered referral to any other services?
- 2.What made you decide whether to take this offer up (or not?)
- 3.What was your experience of that onward referral?
- 4.As a result of the SAAC consultation, would you be any more likely to use other NHS Services in the future?
- 5.As a result of the SAAC consultation, will you have a different understanding of your own health? In what ways?

#### **Prompts:**

*Services referred to, language issues if any, barriers, ease of access, experience of the service, communication and engagement*

### **V: Closing Questions**

1. In just a few words, how would you sum up the 'essence' of SAAC?
- 2.Any areas where you feel there is potential for improvement?
- 3.Finally, is there anything else that we have not asked this evening but which you feel is important to share?

**CLOSE BY THANKING ALL PARTICIPANTS AND RETURN TO MAIN GROUP**

## **Appendix 4: Focus group discussion involving wider partners**

### **1. Engaging with South Asian clients/patients**

- i. Before the SAAC team was established, how would you describe your previous level and types of engagements with South Asian patients?
- ii. Did you identify any particular barriers in your attempts to engage with South Asian patients?
- iii. Can you think of any examples of successful models of engaging with South Asian patients for health promotion of health care delivery in this client/patient group?

### **2. Your current understanding of the role of SAAC**

- i. How would you sum up the essence of the South Asian Anticipatory Care project?
- ii. What is unique? Where do you think the SAAC team adds unique value?
- iii. Are there any particular client groups who really need the SAAC team input?
- iv. Tell us about the types of encounters with the SAAC team in which you feel they achieved real change.
- v. Tell us about any aspects of the SAAC team role where you feel there is potential for improvement.

### **3. Your connections with the SAAC team**

- i. What types of interactions have you had with the SAAC team?
- ii. In what context?
- iii. Since inception of the SAAC team, what has changed in your ability to engage and promote health among the South Asian population?
- iv. If nothing has changed, why not?

### **4. The future**

- i. What are the benefits to patients as a result of working with the SAAC team?
- ii. To what degree do you think the SAAC team adds unique value to the Keep Well programme?

## **Appendix 5: Report from Glasgow City CHP (South Sector) on Culturally Sensitive Healthy Eating and Physical Activity Pilot Programme**

