NMAHP
Inequalities and Anticipatory Care Education

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## CONTENTS

Part A: Introduction and Literature Review .................................................4

1. Introduction ..............................................................................................4
2. Policy Context ..........................................................................................5
3. Literature Review .....................................................................................7
4. Definitions and Understandings ...............................................................7
5. Educational support for the workforce .................................................8
6. Educational issues from the literature ..................................................9
   6.1. Skills .................................................................................................9
   6.2. Mentoring .......................................................................................10
   6.3. Reflection .......................................................................................11
   6.4. Inequalities Imagination .................................................................12

Part B: Project Methodology.......................................................................14

7. Aim of project ..........................................................................................14
8. Scope .......................................................................................................14
9. Justification ............................................................................................14
10. Questionnaire Methodology .................................................................14

Part C: Questionnaire analysis ...................................................................16

11. Definitions and Understandings ..........................................................16
12. Curriculum philosophy, aims and learning outcomes .......................17
13. Practice placements as opportunities for learning .............................17
14. Contributors to curriculum delivery .....................................................18
15. Discussion .............................................................................................19

Part D: A stakeholder workshop .................................................................20

16. The workshop .......................................................................................20
17. Context for the meeting .........................................................................21
   17.1. Inequalities Sensitive Practice Initiative .........................................21
   17.2. Information support ......................................................................21
   17.3. Discussion topics ..........................................................................22
18. Conclusions ...........................................................................................24
19. Next steps ..............................................................................................25

Appendices ..................................................................................................26
Summary

The aim of the NMAHP (nursing, midwifery and allied health professions) inequalities and anticipatory care project is to contribute to the scoping, designing and commissioning of educational initiatives related to inequalities and anticipatory care to support NMAHPs pre-registration with the overall aim of giving newly qualified practitioners the knowledge and skills to support their patients/clients experiencing inequalities in health.

This is the report of the exploration of what current educational provision related to health inequalities and anticipatory care is currently available within NMAHP pre and post-registration education. The key policies and literature associated with this initiative are highlighted, followed by the analysis from a scoping questionnaire exercise of all relevant courses. Health inequalities and anticipatory care was found to be embedded in all pre-registration/pre-qualifying curricula although was rarely explicitly mentioned. Similarly, anticipatory care was only mentioned specifically by two out of the twelve respondents.

The results of the scoping exercise were fed back to 35 representatives from HEIs (Higher Education Institutions) and services at an information sharing day, to explore what is required to help ensure the future NMAHP workforce have an appropriate awareness of Health Inequalities and Anticipatory Care, and identify key aspects of educational initiatives related to Health Inequalities and Anticipatory Care to support NMAHPs pre and post registration/qualification.

Following on from this report and input from the steering group, the project team wishes to make the following recommendation:

NES will explore the possible commissioning of a learning resource focussing on health inequalities, for NMAHP academic staff, pre and post-reg students and NMAHPs in practice, backed up by appropriate resources and materials, as a tool to support the integration of health inequalities within pre and/ or post registration programmes.

The commissioning and development of a similar resource on anticipatory care, to be embedded within the health inequalities virtual learning resource, needs to be given further consideration by NES and project stakeholders before progressing.
Part A: Introduction and Literature Review

1. Introduction

“Inequalities in health are widening...the health of Glasgow’s populations, as measured by a variety of indicators, is still amongst the worst in Scotland, and indeed in the UK, and that position does not appear to be improving” (Hanlon et al, 2006)

Health inequalities are increasingly recognised as an important public health issue (Judge et al, 2006). Graham and Kelly (2004) comment that the heart of Public Health in contemporary Britain is a Paradox: Britain is now healthier than it has ever been, however while the collective health of the population is improving, the health of the least and less well off either improves more slowly or gets worse in absolute terms. Therefore addressing inequalities must be integral to the health improvement agenda (Dahlgren and Whitehead, 2006b).

As a result, many NHS organisations are responding by developing new projects and methods of working. This particular project has been established to ensure the nursing, midwifery and allied health professions (NMAHP) workforce has the requisite skills and knowledge to support and respond to this important health improvement agenda.

The first part of this report identifies the key policies and literature associated with this initiative, and will offer an overview of the current theories and writings relating to this project. It will allow for a greater understanding of the project, and further attempt to link research studies in the same area to the current literature, and suggest their relevance, if any, to this project.

The second part of this paper offers an analysis of questionnaires sent out to, and interviews with, members of staff from Scotland’s NMAHP courses, to identify the current NMAHP pre and post registration curriculum content, in relation to Inequalities and Anticipatory Care.

Following on from the questionnaire we invited representatives from all pre and post-registration/qualifying NMAHP courses to take part in an information sharing day to further explore curriculum issues related to health inequalities and anticipatory care. The outcomes from the day are discussed in the third part of this report.
This report accepts the many and varied complexities of health inequalities and anticipatory care, and is not meant to act as a comprehensive overview of all the issues, but offer a brief insight into the literature available related to the education of health inequalities and anticipatory care to NMAHPs.

2. Policy Context

Issues around inequalities in health have arisen in various reports over the past 25 years or so. The Black Report (1979) and The Health Divide (1992) were early examples, as was Improving Health in Scotland – The Challenge (1992). Closing the gap (2005) was an important, but less cited, report that set 10 key targets around deprivation, attainment in schools, looked-after children and other areas relating to inequalities. Similarly, Delivering a Healthier Scotland – meeting the challenge (2006) more recently addressed issues relating to inequalities.

There are a number of policy drivers that have led to the development of this NMAHP health inequalities and anticipatory care project. Delivering for Health (SEHD 2005) calls for a greater emphasis to be given to preventative health care and early intervention, particularly in areas where health is at its poorest, and this in turn is reflected in ‘Delivering Care, Enabling Health’ the NMAHP response to Delivering for Health.

In Delivering for Health (2005) the Scottish Executive declares that:

‘We believe the most significant thing we can do to tackle inequalities is to target and enhance primary care services in deprived areas. Strengthening primary care teams and promoting anticipatory care in disadvantaged areas will reduce inequalities by:

- Targeting health improvement action and resources at the most disadvantaged areas
- Building capacity in primary care to deliver proactive, preventative care
- Providing early intervention to prevent escalation of health care needs.’

Delivering Care, Enabling Health is the fundamental strategic policy driver for this project as its focus is the NMAHP workforce. Launched in 2006 it builds on the national strategy for nursing and midwifery, Caring For Scotland, and the strategy for AHPs, Building on Success, to show how NMAHPs will work to enable continuing improvements in the experiences and outcomes of care for patients, the public, families and carers. Although no specific goals for inequalities were set out in these reports, Delivering Care, Enabling Health did refer to the attitudes and values within pre- and post-registration NMAHP education and training. Health improvement has become a key driver in Scotland as evidenced by its presence during keynotes at a recent high profile NHS Scotland event and a workshop held for NHS Scotland CEOs.
Delivering Care, Enabling Health describes the cultural, capability and capacity issues that will underpin the NMAHP contribution to implementing Delivering for Health, and concludes by setting out actions and deliverables across a range of key issues. It states that NMAHP pre-registration programmes should have a strong focus on health inequalities, and that NES and HEIs have a lead responsibility to ensure that appropriate anticipatory care education programmes are in place (see key message 11 and key message 20).

In terms of anticipatory care, a key message from Delivering Care, Enabling Health was that Delivering for Health's identification of anticipatory care as a central element of NHS services '...opens the door to NMAHPs carrying out more of this vital work...'. It also called for the commissioning of educational support to promote anticipatory care services, with appropriate education programmes to be in place by September 2008. This, then, is an action for both NES and HEIs.

Delivering Care, Enabling Health acknowledges this as the essence of anticipatory care, and observes that it is the agenda NMAHPs have sought to address since the launch of Nursing for Health – a Review of the Contribution of Nurses, Midwives and Health Visitors to improving the Public's Health in Scotland in 2001 and from the publication of Building on Success.

The Scottish Executive’s Delivering a Healthy Scotland –meeting the challenge (2006) provides details of a whole government approach to health improvement in Scotland, and commits the Scottish Executive to extending the keep well approach and considering more ways in which to apply the principles of anticipatory care to tackle health inequalities.

Visible, Accessible and Integrated Care (Scottish Executive, 2006) forms a complementary partner document to this, regarding the overall aim of anticipatory care as to helping individuals identify early, any circumstances which may have a negative impact on their long-term conditions and support them in developing strategies to avoid these or reduce their effects. To help support the health improvement agenda it is acknowledged that nurses’ work needs to have a strong emphasis on assessing risk, promoting health, preventing illness and understanding and addressing health inequalities.

The Executive’s approach to closing the opportunity gap by tackling poverty and disadvantage in Scotland can also be seen as part of this same agenda by also addressing aspects of poverty for people living in the most deprived communities, such as improving people’s employability, increasing young people’s confidence and skills and regenerating the most disadvantaged neighbourhoods.
3. Literature Review

Much of the literature analysed for this report focuses on the practitioner’s skills and knowledge, and pays little attention to the context in which the practitioners work. This section will commence with an overview of the wider context in which NMAHPs tackle health inequalities and provide anticipatory care, followed by a discussion of the role and influence practitioners have in tackling inequalities in health. As this is a project to support the education of NMAHPs in relation to health inequalities articles relating to the education of public health to NMAHPs and other health professionals have been selectively included.

4. Definitions and Understandings

Although, there is a vast amount of literature available on health inequalities, it is emerging that there are important conceptual problems associated with discussions of health inequality; particularly in regard to the gap between evidence and practice, and the surprisingly limited conceptual apparatus to describe inequalities in health (Graham and Kelly, 2004, Bream 2006).

The definitions that were most in line with thinking behind the project included that of the World Health Organisation and the Department of Health (DOH) which defines Health Inequalities as:

“…differences in health status or in the distribution of health determinants between different population groups…” (WHO, 2007)

“Health is profoundly unequal. Health inequality...exists between social classes, different areas of the country, between men and women and between people from different ethnic groups. The story of health inequality is clear: the poorer you are, the more likely you are to be ill and to die younger. That is true for almost every health problem”. (DOH, 1999)

This wide range of definitions for health inequalities in policies and in the literature has been heavily informed by epidemiology, thereby favouring geographical and socio-economic understanding of health inequalities (e.g. Bartley et al. 1998). Defining health inequalities as the poor health of poor people has policy advantages, but it also creates limitations by conflating inequality and disadvantage. It turns socio-economic inequality from a structure which impacts on everyone into a condition which only those at the bottom are exposed (Graham and Kelly 2004). Whilst Wilkinson’s (1996) work on the psychosocial concept of Social Capital has become relatively influential in the policy arena it has also been criticised for it’s geographical area-based approaches to tackling inequalities. Hall and Freeman (2006) also point out that Wilkinson’s work only tangentially addresses the nature of the relationship between clients and health care professionals such as health visitors, midwives and nurses.
5. Educational support for the workforce


“…the evidence base for what works is either lacking or difficult to implement for political, social or cultural reasons. It has not yet been shown that improvements in current social conditions, desirable as these are in their own right, can be translated into improved health for the most disadvantaged.” Gruer (2007) p. 5

There are many texts in the health and social care field which practitioners and students can draw on to help them understand the complexities of inequalities in health (Robinson & Elkan, 1996). However, there are few studies which give a framework for exploring inequalities as part of an educational process, both within classroom teaching settings and in practice. Hall et al’s (2003) model of the Inequalities Imagination does however offer such a framework, within which the substantive debates may be explored. This framework will be discussed later in the review.

Similarly, within the plentiful literature on the psychosocial aspects of inequalities in health care provision, the impact of intrapsychic and professional cultural elements have not been explored. Moreover, the body of work which does explore these elements in relation to health care work does not address how they might impact on health inequalities (Hart and Freeman, 2005).

There is general agreement within the literature and health policy that the NHS and medical and nursing education should be continually developing in response to the needs of the population and those at greatest risk, particularly in regard to prevention (Gruer 2007, Dovey et al 2000, Scottish Executive 2003b).

“In the 21st century, health services are expected to be characterized not by the ‘fix-up-when-things-go-wrong’ type of care that 20th century physicians have become so good at, but by preventive care that can obviate much of the need for these fix-up services. Enabling doctors to deal with the different health care needs of future patients will require a values shift in medical education.” (Dovey et al, 2000, p.307)

Such a task requires resources to be directed towards those at greatest risk, with careful attention to service design and staffing (Gruer 2007). However many have argued that insufficient resources have been devoted to the preparation of the workforce as to the complexity of the challenges facing the public’s health, including its leaders (Ansari et al, 2003). If the vision is to ensure the general improvement in the health of the population, Ansari et al (2003) argues it will be necessary for those who are not specialists to understand the underlying principles of population health constructs and values. Similarly, the South Yorkshire Education Training Consortia (1999) and Chapman et al (2000)
identified that nurses lacked clarity about public health and their potential contribution within a broader vision of health improvement.

There is general agreement that in the wake of recent education policy recommendations which recognise nurses as key contributors to the public health function, changes are occurring within nursing pre- and post-registration education. However, it is debated whether the educational issues involved, have been systematically charted, and the adequacy of nurse education’s response to the recent policy emphasis on public health remains largely unexplored (Latter et al, 2003). Ansari et al (2003) noted that besides including public health principles as multiple ‘add-on’ fragments to the continuing professional development of senior professionals, public health concepts will need to be incorporated early and systematically in the health professions’ educational process. Qualified nurses have been found to be lacking public health skills through skill audits and training needs analysis, and schools of health care and medicine are increasingly aware of the need for competencies in public health. For this reason, committed leadership will be critical to setting the change process in motion.

“There are no educational solutions… need to be considered in the context of workforce planning to identify public health capacity needed and service delivery and organisational changes to allow nurses to relinquish traditional roles and role boundaries and to fulfil their public health potential.” (Latter et al, 2003) p.218

There is a lack of appropriate evidence to give a framework for exploring inequalities as part of an educational process, both within classroom teaching settings and in practice. This needs to be redressed if the NMAHPs are to acquire an understanding of what their role entails, to improve not only the health of the population but also for their own professional development.

6. Educational issues from the literature

6.1. Skills

There was a particular dearth of literature regarding education and anticipatory care. The key issues identified from the available literature relating to anticipatory care, highlighted the need for specific skills:

“…an anticipatory attitude requires a physician to think ahead to what might occur. The physician must then convince the patient that it is worthwhile to initiate certain precautions or modify certain types of behaviour. Such patient motivation, especially in the absence of symptoms, calls for the best of physician-patient communication and rapport.” (Crebolder et al, 1996)

Pridham’s (1979) paper proposes that anticipatory care be approached:
“... both in research and clinical settings, as a problem solving process with conceptually distinct phases and problem solving operations specific to each stage... we propose that the paradigm of interpersonal clinical problem solving can provide an effective framework for critical analysis of existing models...” (p.177)

Skills deficits have also been identified in qualified nurses’ ability to deliver public health in practice, and a range of strategies to deliver CPD were recommended by Latter et al (2003), including: emphasising the need for flexible and practice-based learning, and requiring HEIs to consider innovation in education delivery, as well as partnership working with those delivering training in practice.

### 6.2. Mentoring

“A key educational issue to emerge from the review is the opportunity for students on specialist practitioner programmes to learn about and engage in public health work on practice placements under the supervision of a practice educator and/or mentor/assessor.” (Latter et al, 2003, p.215)

However, a number of UK articles reported having insufficient appropriate practice placements, and mentors to cover practice placements, and students were concerned about inadequate support in practice (Hart et al, 2001, Latter et al, 2003, Pearson et al, 2000 and Roffe, undated). Latter et al (2003) noted their concern for this limited exposure as:

“CPD is clearly necessary to enable qualified practitioners to meet the policy agenda, and to provide role modelling for those nurses currently preparing for specialist practice. These educational issues and their implications need to be considered together with discussion and debate about workforce planning to meet public health needs.” (p.217)

A number of solutions were offered by key informants in Latter et al’s (2003, p.215) review to ensure students learn about and engage in public health under the supervision of a practice educator. Some of these could act as a useful potential for this project e.g.: Trusts and HEIs should systematically develop databases of public health practitioners and experiences locally that could act as role models and resources for student placement experiences.

Professional educators face a difficult task in preparing practitioners to work in a way that takes account of differences. Hart and Freeman (2005) recognised that dealing with equality issues is challenging for many practitioners, and use the term ‘professional self-preservation’ to describe how practitioners attempt to maintain their own emotional health when dealing with difficult and challenging practice situations. Some of the ways in which this is achieved include labelling and stereotyping, the creation and maintenance of boundaries in professional client contact, and the dispersal of professional responsibility. Interestingly,
Peckover and Chidlaw (2007) found similar characteristics were visible in their study of district nurses working with clients who misuse substances:

“Clients who misuse substances often face difficulties in accessing appropriate and timely health services such as primary care, and despite having complex health and social care needs that increase their vulnerability, many face prejudice and discrimination from health professionals.” (Peckover and Chidlaw, 2007)

These self preservation methods can have adverse effects upon the patient’s health, resulting in inequalities in access to healthcare provision being exacerbated, often impacting the population groups which are most likely to experience health inequalities in the first instance (Hart and Freeman, 2005).

### 6.3. Reflection

In order to prevent the above occurring Hart et al (2003) and Hart and Freeman (2005) respectively recommend that:

“Acknowledging how one’s practice might develop effectively in the light of these issues requires systematic self-reflection on the part of the professionals”

“[this] would be a valuable contribution to the development of professional practice. This applies particularly to conceptualizing the links between the actions of service providers and the adverse health of clients.”

Whilst acknowledging that self-reflection in nursing and midwifery education is encouraged, through their own research and practice experience, Hart et al (2003) argue it rarely occurs. However, they go on to recommend a number of models in the literature which could be of use in dealing with the subject of self reflection (Brechin et al, 2000, Burns & Bulman 2000, Taylor & White 2000, Rolfe et al. 2001, Hart et al. 2003, Hall & Hart 2004).

Jones et al (1994) found in their research that fostering the process of reflection helped teachers guide the students to link the theory and practice element of their education. A general model of teaching approaches was derived from observations of teaching sessions in which students reflected on their practical placement experiences. There were differences in two main dimensions:

“…the depth to which a topic was pursued; and the degree to which students’ own feelings and values were involved.” (Jones et al, 1994, p.3)

The teachers generally used teaching modes with final year, and post graduate students which explored in more depth the cognitive and behavioural aspect of placement experiences.
6.4. Inequalities Imagination

“Addressing ‘inequalities’ is not a straightforward concept or problem that can simply be taught about/learned about via the acquisition of ‘facts’, or be ‘straitjacketed’ into a guideline. It involves a complex interaction between facts, theory, experience, beliefs, values and resources. We see this as a long-term, on-going process of knowledge acquisition, experience via practice and reflection that occurs through processes of both formal and informal learning.” (Hart et al, 2003, p.488)

The most appropriate, significant model identified by the literature review is the Inequalities imagination model by Hart et al (2003). Originating from their own research which assessed how qualified and pre-qualified midwives are educationally prepared to work with disadvantaged women, Hart et al’s (2003) model (adapted and expanded from Campinha-Bacote, 1999) makes explicit a process that enables practitioners to think about their current practice and move toward a greater understanding and awareness of the way they work with disadvantaged clients, and ways in which they prepare others to do so. The article suggests professionals develop an ‘inequalities imagination’ which would enable them to bridge the gap between challenges in day-to-day practice and what they need to provide equality of care for all.

The model encourages thinking beyond a very limited sense of individualised care (wants and needs) to a much more analytical and creative approach that recognises both structural and individual factors that determine and define needs. The most important component of the model is the ‘Equalities Desire’, which represents the will to develop competence based on caring which ‘begins
in the heart not the mouth’. Without this desire, the other parts of the framework may result in politically correct behaviour alone, rather than genuine attempt to value and respect clients as people and demonstrating a commitment to reducing inequality (Hart et al, 2003).

NMAHP students are taught to practice in anti-discriminatory or anti-oppressive ways, which are often an unrealistic expectation for pre-registration students who are coming to terms with basic clinical competencies and feel powerless in practice (Jones et al, 1994, Hart et al, 2003). Therefore developing an inequalities imagination is more realistic than asking them to implement anti-discriminatory or anti-oppressive practice. The Inequalities imagination is a positive concept that recognises that such change is gradual, on-going and developmental, offering opportunities for success, reflection and future changes.

This type of learning experience seems key to Barnet’s (1997) notion of a ‘critical being’, which in his view, should be the aspiration of a higher education system but also in Hall and Hart’s (2004) view to the development of a competent practitioner.

Similarly, it has been argued that guidelines and protocols may inhibit professionals from realising such imaginative ways of working (Jones et al, 1994, Hart et al, 2003).
Part B: Project Methodology

7. Aim of project
To scope, design and where appropriate commission educational initiatives related to inequalities and anticipatory care to support NMAHP pre-registration/pre-registration education. The overall aim for the pre-registration initiative is to give newly qualified NMAHP practitioners the knowledge and skills to support their patients/clients experiencing inequalities in health.

8. Scope
This project was initiated by NES’s Health Improvement Team, and the project steering group, and adheres to all NES’s business processes. Scoping took place of the NMAHP, pre- and post-registration courses, and will support educational work that will be required for other professional groups.

9. Justification
The project was initiated by Delivering Care, Enabling Health (see introduction) and is supported by current evidence in the literature.

10. Questionnaire Methodology
To support decisions that need to be made with regard to this initiative it was decided to scope what was currently being provided in terms of input to NMAHP curricula in terms of inequalities and anticipatory care. To acquire this information it was decided to use a questionnaire, adapted from colleagues in Brighton focusing on midwifery courses.

The focus of the questionnaires was to look at the current curriculum content for Nursing, Midwifery and the Allied Health Professionals pre and post registration/qualifying courses.

As a basis for the answers to the pre-registration/qualifying questionnaire, we asked respondents to focus on one representative curriculum only, for each selected Nursing, Midwifery or AHP programme. This could be a degree or diploma programme. For example, if the University has both Nursing and AHP programmes, they could choose to complete one questionnaire for ‘child nursing’ to represent the nursing programmes, and one for ‘Dietetics’ to represent Allied Health Professional programmes. Due to current educational developments for Review of Mental Health Nursing – respondents were asked not to include this
pathway in Nursing responses. The post-qualifying questionnaire was more general and did not require restricting answers to one particular curriculum.

We tried to come up with a format which was suitable for most institutions. Some of the questions asked to make direct reference to the curriculum documents, however we acknowledge that not all questions would be applicable to every curriculum.

It was decided to give the opportunity for photocopies and additional supplements of any relevant documentation if it made it easier to provide the information required.

It was noted that any information which respondents provided would be held in the strictest confidence and only accessed by members of the NES Health Improvement Team. Any comments/data reported has been anonymised and every effort has been taken to ensure that individuals and organisations cannot be identified from these written reports.

The questionnaire was sent to all of the 11 HEIs in Scotland running a Nursing, Midwifery or Allied Health Professional pre or post registration programme, including:

- University of Abertay
- Bell College
- University of Dundee
- Edinburgh University
- Glasgow Caledonian University
- Napier University
- University of Paisley
- Queen Margaret University
- The Robert Gordon University
- Stirling University
- University of Strathclyde

The questionnaires were disseminated to all the Heads and/or Deans of the above school’s with the instruction to forward it to the most relevant member of staff for completion. Respondents were given a month’s turnaround for completion and return was by mid May 2007. However, as the return rate was slow and not as successful as initially hoped for, a number of follow up phone calls were made to the departments to ensure the correct person had received the questionnaire. Applicants were also offered the opportunity to complete the questionnaire via interview. Only 2 programmes took up this offer.

A total of 12 questionnaires were returned including: 8 pre-registration/ qualifying (1 midwifery, 2 AHP, 6 nursing) and 3 post-registration/qualifying (2 AHP, 1 Nursing). Not all NMAHP Institutions were represented within these responses.

Programmes are updated every 5 years, therefore the inclusion of health inequalities and anticipatory care, language and priorities will be different depending on where the HEI is in that cycle. Course writers focus on top priorities of NMC (Nursing Midwifery Council) or NES to gain approval.
Part C: Questionnaire analysis

11. Definitions and Understandings

The terms, ‘Health Inequalities’ and ‘Anticipatory Care’ were deliberately left undefined to enable the project to ascertain how the departments/academic schools defined their own curriculum in these broad areas.

Respondents made very different interpretations of what was required from them in their questionnaire responses. Respondent’s interpretation of health inequalities focussed on three main themes: the relationship between socioeconomic status and health, access to services and the level of care received.

Most direct references to inequalities were to be found in the aims of individual modules rather than overall programme philosophy. In some cases, there may have been an under-representation of inequalities provision on offer overall due to the failure to recognise the wider possible range and diversity of coverage of this issue. It may be that the current curricula includes the broader perspective, but the respondent’s, or report writer’s, interpretation does not decipher this.

Some institutions commented that as educators of the future NMAHP workforce they “could not afford to avoid” both the intrinsic and explicit inclusion of health inequalities on their curricula, and interpreted the topic of inequalities very broadly.

Others felt that the inclusion of health inequalities on the curriculum should be more for post graduate programmes. This was particularly mentioned in regard to practice placements where participants we perceived not to be relating the theory they gain to the practice, and vice versa.

Anticipatory care was a term only directly used in two of the programme’s curriculum aims, learning outcomes or within teaching sessions, units or modules. Instead respondents acknowledged and interpreted it as: assessment, planning of services, early intervention, preventative care, and reducing hospital admissions.

This lack of consistency in the interpretation of health inequalities and anticipatory care needs to be addressed, to ensure that all students recognise
the broader understanding of health inequalities required to practice through an ‘inequalities lens’.

12. Curriculum philosophy, aims and learning outcomes

The majority of respondents identified statements from their curriculum philosophy, and/or learning outcomes as either directly or indirectly related to inequalities in health or anticipatory care.

Despite this, the word ‘inequality’ was only used in one of the institutions’ philosophy statements. Others made more indirect references to inequalities and anticipatory care.

Much more common however are references to social/cultural diversity but without reference (direct or indirect) to the inequalities that might arise from those diversities.

Analysis of the curriculum aims and outcomes suggested that for some institutions; inequality issues became compartmentalised into specific modules, rather than being embedded throughout the curriculum. One institution offered two statements from their module aims as direct references to inequalities.

Another institution offered a statement from their programme and course aims as examples of direct references to inequalities. However, they may have been better understood as indirect, rather than a direct, reference to inequalities; in that they employ the concept of ‘diversity’ which implies difference but not necessarily disadvantage, a central aspect of inequality.

In two instances, reflection was mentioned as an example of indirect reference to inequalities, in relation to general attitudes and values of the individual practitioner, and their impact on the provision of care. In addition, being able to practice in different settings and being flexible were identified in curriculum aims and outcomes, as necessary qualities to be developed.

13. Practice placements as opportunities for learning

Respondents were asked about their clinical placements and the opportunities such placements provided to expose students to disadvantaged clients and thereby enable them to acquire relevant knowledge and skills to meet such clients’ needs.
All students experience a variety of practice placements which give them access to a variety of client groups in acute and community settings e.g. areas of deprivation or homeless practices and working with ‘vulnerable groups’ such as elderly and those with learning disability and mental health problems. These ‘rôle emerging’ placements with a range of individuals experiencing inequalities in health, are an essential dimension of developing the ‘inequalities imagination’ as described by Hart et al (2003).

A couple of respondents specifically noted that within their concept, every patient experiences health inequality/ies to some extent, and an attempt to define these inequalities would offer too narrow a perspective of the patient.

There were a number of issues of concern raised by the institutions in regard to placements. Some of these may be able to be addressed by the educational initiative following this scoping. One institution mentioned that students were reported to have limited access to diverse, well mentored placements, particularly in regard to the mentor’s lack of understanding of health inequalities. This was reported to be due to the confusion created by the diverse range of definitions of health inequalities within the workforce practitioners, as the multiplicity of terms [public health, health improvement, health promotion, health education, health inequalities and anticipatory care can often make for confusion (Meerabeau, 1998).

A number of lecturers noted that the initial enthusiasm, understanding and creative thinking that students had in regard to tackling health inequalities was often suppressed during the students’ time in practice placements. This was thought to be due to the lack of investment in the education of the current workforce to tackle health inequalities, and excessive workloads.

14. Contributors to curriculum delivery

One way in which issues relating to inequalities in health and anticipatory care have been reflected in educational programmes, is through the background and expertise of members contributing to teaching and learning.

Many of the sessions or modules are led by NMAHP lecturers or lecturers from other disciplines, such as Health & Social Care lecturers, Public Health and Health Improvement lecturers. The majority of respondents also reported other professionals (e.g. Public Health Nurses, Substance misuse professionals, Domestic violence support workers), representatives from the voluntary sector or members of the community (patient representatives), as leading sessions or modules, often conducted with a lecturer present.

One mental health module was entirely delivered by people who have experienced MH issues.
15. Discussion

A fundamental issue would appear to be that of understanding the meaning of inequalities and anticipatory care. Many activities which are being undertaken in some institutions may not be perceived as addressing health inequalities or anticipatory care, as they may be labelled under other headings. It is important to value the endeavours and accomplishments of what is currently being undertaken in terms of public health concepts at various universities.

Appropriate curriculum philosophy, aims and learning outcomes is an important step towards students developing an understanding of health inequalities. The planning teams and NMAHP educators are made up of individuals from very different disciplinary contexts who do not necessarily share the same philosophical frameworks. It is unlikely that all members of planning teams will embrace the acquisition of the type of model explored in the literature review. Furthermore, the problems associated with attempting to include more subjects in an already crowded curriculum needs to be acknowledged.

Inequalities as a theme/topic perhaps lends itself particularly well at post-registration/post qualifying level to multidisciplinary education. It is unrealistic to expect students to practice in anti-discriminatory/anti-oppressive ways when still at early stages of learning and feeling powerless within their practice settings. In such regard the inequalities imagination model is useful in recognising the gradual process of professional development. A chance to ‘get something right’ and reflect on how to do things differently.

There appears to be a theory/practice divide in education where participants may be given the theory but don’t relate this to the practice that they see or vice versa where there is good mentorship but little or no explicit teaching in this area. However, this is not an issue for all programme/courses across Scotland. Educationalists fostering the process of reflection (Jones et al, 1994) may help in guiding the students to link the theory and practice element of their education.
Part D: A stakeholder workshop

The results of the scoping exercise highlighted a confusing range of definitions and approaches. It was therefore felt that early engagement with stakeholders might prove of benefit to tease out the issues and to explore the potential for developing educational initiatives related to Health Inequalities and Anticipatory Care to support NMAHPs (Nursing, Midwifery and Allied Health Professional) pre and post registration/qualification education. NES therefore organised a one day workshop in July 2007 to engage with representatives from HEIs and services.

The objectives of the day were:

- To share the key issues arising from the scoping exercise
- To share good practice examples of Inequalities education
- To explore what is required to help ensure the future NMAHP workforce have an appropriate awareness of Health Inequalities and Anticipatory Care
- To bring NMAHP educators together to identify key aspects of educational initiatives

16. The workshop

Representatives from all pre and post-registration/qualifying NMAHP courses were invited to take part in the information sharing day to further explore curriculum issues of Health Inequalities and Anticipatory Care.

Jane Cantrell, NMAHP Programme Director at NES welcomed everyone to the event and reminded participants that the idea of the day was to share learning so far and potential ideas for educational initiatives, at this early stage of the project. Participants were to hear presentations from Sally Beautyman, Health Improvement Project Officer at NES and Cath Krawczyk, Project Co-ordinator at the Inequalities Sensitive Practice Initiative (ISPI) in Glasgow. With this context in mind, working in small groups, they were then to discuss and feed back thoughts on specific questions.
17. Context for the meeting

17.1. Inequalities Sensitive Practice Initiative

Participants heard that the impact of inequalities on health in Scotland has prompted the development of a number of initiatives, one of which is the Inequalities Sensitive Practice Initiative (ISPI). It aims to act as a tool for NHS Greater Glasgow and Clyde to find out what will support practice improvement and to define the type of planning and policy structures that are required for achieving and sustaining change.

A broader understanding of inequalities in the health and social care setting is required, particularly as inequality gaps appear to be widening in some areas. The impact of Inequalities tends to be considered from a point of view of poverty. ISPI considers a more holistic view of the individual, including gender, race and sexual orientation to assess how this impacts on their lives, and how issues such as power imbalances, can affect health.

ISPI is also looking at how health practitioners can make an impact in this area and what organisations can do differently to address the determinants of health inequalities. One of the outcomes of this work will be to describe the practical realities of inequalities sensitive practice. What does an inequalities-sensitive practitioner do that is different to one that is not? And how can the effects of that inequalities-sensitive practice be measured?

Participants were then presented with the work which forms the earlier part of this document.

17.2. Information support

Participants heard about the NES e-library project - Equality in Care (www.elib.scot.nhs.uk) - to create a portal to bring together resources around equality in care. This was organised so that users can browse or search for resources in areas such as advocacy, disability, ethnicity/ race, belief, gender, homelessness, improving health, poverty and deprivation.
17.3. Discussion topics

Participants were asked to consider three questions working in small groups and to feed back key points.

Question 1: What do we want every student to leave with in regard to Health Inequalities?
The comments broadly fit into a number of emerging themes:

Understanding Inequalities
Participants suggested that a population approach be taken, ensuring that students understand a context for, and causes of, inequalities. This could only be achieved by considering the wider context of the patient journey. Some suggested the need for measurable and explicit competencies and standards against which students can be measured. Recognition that understanding inequalities requires ongoing development and learning was emphasised, highlighting the idea that appreciating inequalities is a process of 'becoming' not 'accomplishing'. Inequalities as a concept should be introduced by academic staff early in the curriculum and continue throughout, to avoid being seen as an 'add on'.

The importance of multidisciplinary teaching
Students would need to understand the importance of organisational development and multi-disciplinary working in order to make the necessary connections between disciplines. Crucially, multi-agency learning should be used to make the necessary connections between agencies. Education should include existing staff and perhaps placements should be organised outside of an NHS setting. Ultimately, a consistent approach was the goal.

Skills in health behaviour change
Students should receive education in areas such as motivational interviewing, self control diaries, and coaching.

Awareness and reflection
Participants suggested that students should leave their initial education with an awareness of their own values and attitudes regarding equity – and a sense of how their own values and attitudes can influence their practice. An ability to continually reflect upon this would be important. It would also be important for students to understand and appreciate the social model of health in addition to the medical model.

The transition from learning to practice
Discussion indicated that it was important for students to be able to put their own learning, as well as the political and policy background around inequalities into a
care delivery context. An understanding of the organization in which the student moves into after education would be important in order for them to maintain their beliefs and attitudes in situations where practice may not support this.

But what does practice that is sensitive to inequalities look like? It would be important to give students a clear view of how particular roles or tasks (such as handling patient discharge) would change practically in the light of education around issues in inequalities.

**Support through mentoring**

New practitioners would require support through mentoring to develop further learning in post.

Other comments indicated that organisations did not recognise that students or qualified practitioners have undertaken learning or put something into practice related to inequalities. It was low on the agenda of attitudes and skills that were currently measured by NHS Scotland. Participants also noted the importance of reaching those already in practice.

There was also debate about the role of HEIs in teaching about inequalities. Some thought that this was an issue for work-based learning, a issue of awareness rather than teaching a set of values.

**Question 2: How do we join Health Inequalities and Anticipatory Care within the Curricula?**

Participants struggled with a satisfactory definition of anticipatory care as they considered how it could be integrated with health inequalities in a curriculum. Some suggested that a core element of AC could be summarised as working with individuals to understand their lives. Some aspects of AC are covered in prevention topics at primary, secondary and tertiary levels, but there are still gaps. There was general agreement however that Health Inequalities should be the overarching topic with Anticipatory Care integrated as a key element. In practice, it was noted, anticipatory care should be part of a treatment plan.

In order to explore these two areas in depth there was need to focus education at postgraduate level. Although Health inequalities and anticipatory care are 'inextricably linked' the relationship between the two is too complex to explore at undergraduate level. Since educators can't have all the answers in a complex area such as health inequalities, participants suggested using the imagination model to help to fill 'educational gaps' and identify areas in the current curriculum where seeds could be planted regarding health inequalities.

Once again the issue of staff currently in post and the need for in-service training was raised.
Question 3: What do we need pre and post reg, to support students, lecturing staff and mentors to include HI & AC on the curricula?

There was a range of opinions around whether education should be focussed at pre-reg or post-reg level. Overall, there appeared to be agreement that it could be at both although perhaps initially it should be focussed at post-registration since there is currently no explicit NMC requirement to include it at undergraduate level. Participants suggested that the NMC be lobbied to require Health Inequalities and Anticipatory Care education otherwise it would continue to be an option. Similarly, raising awareness of the importance of HI in practice at organisational level would be required in order to ensure that training wasn't seen as an end in itself.

In general there was agreement for the need for multi-professional team learning, with 'continuous' professional development opportunities, using examples of good, local practice, to explore what HI and AC means in real situations. Greater links would be required between practitioners and HEIs - 'inreach' and 'outreach' – along with mentorship support, through Practice Education Facilitators, and training for lecturing staff.

There was a suggestion that NES could help by creating more events and other opportunities to network such as the development of communities of practice. The further development of resources such as the e-library portal would also be welcomed.

18. Conclusions

Health Inequalities and Anticipatory Care are complex areas of health care that are becoming increasingly important areas for NHS Scotland to understand and address. Although health inequalities is a responsibility of current teaching, it is currently only perceived as an option in terms of education, it will need to be integrated within practice, and at all levels of education, if the nation's health is to be improved.

A uniform understanding of what terms such as health inequalities and anticipatory care mean will help to determine merits against which students and staff can be measured, although these are areas of ongoing learning, not a series of right or wrong answers. Although difficult to define, the many dilemmas and creative tension associated with the dimensions of inequalities, offers potential for creative debate and solutions.
**Multidisciplinary, multi-agency teaching** will help to give students the bigger picture, as will an ability to reflect upon values and attitudes and how they can influence their own practice. The application of these values and attitudes in practice will however, ultimately determine the successful tackling of Health Inequalities. An appreciation of the social model of health in addition to the medical model, as well as support from mentors, will be needed for a transition from theory and learning to practice.

An understanding of the organization in which the student moves into after education is important in order for them to maintain their beliefs and attitudes in situations where practice may not support this. Linking the theory to practice shift with reflection has potential to make this transition a more affirming process for students.

The picture for related education in the future began to emerge as multidisciplinary, focused at postgraduate level, along with a need to include staff already in service, and awareness raising of inequalities issues throughout NHS Scotland organisations. However the initial instinctive understanding of health inequalities that students start out with needs to be maintained and not necessarily compartmentalised.

This event had debated some key questions but raised yet more. Importantly, it had provided a forum for discussion and networking welcomed by participants who expressed a need for other such opportunities.

### 19. Next steps

The NES Steering group reviewed the project findings and has decided to progress by further exploring the potential to:

1. Support the structures surrounding curricula, by creating an NMAHP health inequalities and anticipatory care area on NHS e-library
2. Develop a webpage for virtual learning, and; distance learning resources and materials for academic staff, pre and post-reg students and current NHS staff as a tool to support the integration of health inequalities within pre and/ or post registration courses.
3. Support the structures surrounding curricula, by encouraging and facilitating the inclusion of Inequalities and reflection within mentorship programmes, practice placements and the placement teams.
Appendices


Dahlgren, G. and Whitehead, M (2006a) Levelling up (part 1): a discussion paper on concepts and principles for tackling social inequities in health, WHO www.euro.who.int


Hanlon, Walsh and White (2006) Let Glasgow Flourish, Glasgow Centre for Population Health, Glasgow


Scottish Executive Health Department (2001a) Nursing for Health - a Review of the Contribution of Nurses, Midwives and Health Visitors to Improving the Public’s Health in Scotland, Scottish Executive, Edinburgh


