Editorial

A Model to Support Health Promotion in UK Settings for Urgent Care

In 1978, the first International Conference for Primary Care saw the emergence of the World Health Organisation (WHO) Alma Ata Declaration, subsequently 'Health for All' became a central theme of international healthcare policy. In response, United Kingdom (UK) healthcare policy placed greater responsibility on healthcare professionals working in the community to embed principles of health promotion into practice. Therefore, the launch of community-based Walk-in-Centres, now referred to as Urgent Care Centre's (UCC), was not only designed to improve access to healthcare but to improve overall health and wellbeing and 'offer health promotion, supporting people in caring for themselves' (Salisbury et al, 2002). While those working in UCC's are well placed to deliver health promotion - acute patient presentation coupled with competing organisational priorities and differing levels of practitioner autonomy make it challenging to identify a single best practice approach to health promotion in this setting. Despite an abundance of health promotion theories, the core principles of health promotion including patient participation, partnership and empowerment take time to establish. Consequently, it could be argued that many health promotion models may be unsuitable for application in an urgent care setting.

The Extended Parallel Processing Model (EPMM) does not necessarily fully adopt the core principles of health promotion; a factor that could offer an explanation as to its under-representation in key health promotion text. Yet, its success in raising awareness and behaviour change is proven (Rashmi et al, 2022). The EPPM relies on the combination of perceived threat and self-efficacy following a health 'threat' message thus making it suitably aligned to the acute nature of the UCC and the brief interventions approach documented to be a common practice within this healthcare environment (Adams et al, 2023). The EPMM suggests that when people experience a 'threat message' this invokes a level of fear, in the UCC setting this could be in the form of an acute event e.g. an episode of chest pain. These messages invariably invoke an internal 2- step assessment. Initially, people will determine if they are 'susceptible' to the identified threat and to what degree (Witte, 1992). For example, they may ask themselves how likely is it that the chest pain is to be cardiac? If they deem themselves as being 'susceptible' of developing cardiac disease, they are more likely to be open to receiving health promotive information. However, self-efficacy determines how much a person engages with health promotion. If the recommended behaviour change, such as cutting down on fatty foods, is not considered to be achievable due to perceiving they cannot change or external factors beyond their control, the

proposed strategy will be rejected. Consequently, resulting in fear control and denial and permitting a person to justify their adverse behaviour choices.

Whilst the EPMM does not fully embrace the core values of health promotion, it does have the potential to support those in the UCC setting to deliver health promotion by capitalising on the acute nature of those attending the UCC. And, when supported with a simple SMART goal structure it also has the potential to influence individual behaviour change.

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