

PREVENTION 2010 – PILOTS WAVE 1 – SPECIFICATION (19 April version – for development of detailed proposals)

1. THE VISION

To increase the rate of health improvement in deprived communities by enhancing primary care services to deliver anticipatory care: identifying and targeting those at particular risk of preventable serious ill-health (including those with undetected chronic disease); offering appropriate interventions and services to them; and providing monitoring and follow-up.

2. KEY FEATURES

These were outlined in Pam Whittle's letter of 24 November 2005 and are summarised below.

- Extra resources for primary care in deprived areas - primarily for additional staff and/or staff time and services to identify, contact and offer improved access, health checks and risk assessment to those who may be at particular risk.
- Offering effective interventions and referral to community and other NHS services for those found to be at particular risk, with regular monitoring and follow-up.
- Clear targets for reach, outputs and outcomes from the pilots.
- National support for the pilots.

3. THE RATIONALE

Main underpinning points are given below.

- Assists in the delivery of the Executive's **health inequalities** targets in SR2004.
- Part of the overall implementation of *Delivering for Health*. Initial activity through two waves of pilots prior to general application of the principles of **anticipatory care** for those 'at risk through deprivation' wherever they live (see 9). First wave – 2006 - 5 pilots in local authority areas with highest numbers of people in most deprived 15% of population using Scottish Index of Multiple Deprivation. Second wave – 2007 – around 5 further pilots in CHPs with high levels of deprivation.
- Focuses on **cardiovascular disease and its main risk factors, especially blood pressure, cholesterol, smoking and diabetes**; this will have benefit in relation to other serious conditions. Focuses on evidence-based interventions, to make the greatest difference to health outcomes in the short term.
- Seeks to improve reach, access and methods of engagement within primary care services thereby addressing the **inverse care law** (availability of good medical care tends to vary inversely with the need for it in the population served).
- A **systematic and targeted** approach.
- Builds on and augments but does not replicate, the **nGMS contract** and **2006 Directed Enhanced Services** proposal.

4. CRITERIA FOR SUCCESS

Proposals should say how the following success criteria will be evidenced.

- **Supported at senior level** by Board and CHP partners.

- **Reflects local partnership priorities** for action on health inequalities and includes strategies for initial and sustained engagement of target populations. These should include but not be confined to, social marketing approaches.
- **Developed with and led by local GP practices** (and involving community pharmacists and other key health professionals).
- **Generates evidence of successful, evaluated approaches** to identifying and engaging with those who are at particular risk. Applicability for wave 2 pilots and national implementation.
- **Financially sustainable** - approaches which have been seen to be effective and value for money are mainstreamed after initial Executive funding ceases.

5. NATIONAL SUPPORT

5.1 The Scottish Executive (Health Improvement Strategy Division and the Chief Medical Officer), ISD, NHS Health Scotland (HS) and the Managed Public Health Network (MPHN) will be the main sources of national support.

5.2 Lead responsibilities are shown below and lead bodies will work collaboratively with pilots. The following will be the main areas of activity.

- Systems to support patient identification, risk stratification and monitoring patient outcomes (ISD)
- The evidence base for the key interventions (HS, with MPHN, to advise on effective interventions – drafts circulated at meeting with pilots on 21 February. To be finalised by end May.)
- Guidance and support with planning, monitoring and evaluation (HS to develop a logic model for Prevention 2010, a framework for monitoring and evaluation and commission evaluation including economic analysis)
- Development of existing and new skills and roles for primary care teams (HS)
- Development and piloting of a Personal Health Plan approach in pilot areas (HS)
- Communications Strategy (Core Project Team with HS and MPHN)

5.3 More details on the roles of HS and ISD were issued at the meeting with pilots on 21 February and circulated thereafter.

6. EQUALITY CONSIDERATIONS

Pilots should consider and incorporate appropriate means of engagement with different client groups with particular needs, building in Equality Impact Assessment to their proposals and making use of the Executive's Equality and Diversity Impact Assessment Toolkit.

7. KEY INTERVENTIONS, RISK FACTORS AND CORE DATA

7.1 The **target population** is 45-64 year olds (cut-off date 65th birthday) at risk of preventable serious ill-health, including those with undetected chronic disease. Initiatives funded by additional smoking cessation monies may however address the needs of a wider age range.

7.2 Core interventions with this group will be as below.

- Tackling **Intermediate Clinical Risk Factors** – identifying, treating and controlling high cholesterol and high blood pressure.
- Tackling **Lifestyle Risk Factors** through smoking cessation services, *Counterweight* (addressing diet and physical activity), brief interventions on alcohol.

All pilots should deliver the core interventions and generate and report data to evidence what proportion of the target group has been reached, what interventions have been delivered to whom and with what effects. Any unintended consequences for service delivery or patients should also be reported.

7.3 The interventions should be delivered by a **mix of providers** – NHS and voluntary/independent sector.

7.4 Effective management of **existing and detected chronic diseases** – diabetes, CHD, stroke, COPD – should already be taking place under the terms of nGMS, but Prevention 2010 activity is likely to lead to increased numbers on disease registers and to result in more effective management of those with already detected chronic disease.

7.5 In developing planned and tailored interventions for individuals, Prevention 2010 will recognise the importance of co-morbidity involving physical and mental health problems, and the need to take account of **mental health** issues in tackling risk factors for physical diseases.

8. METHODS OF ENGAGEMENT

8.1 To succeed, Prevention 2010 must find effective means of reaching and engaging with those in deprived communities and with particularly ‘hard to reach’ populations. Although all pilots must deliver the core interventions, there is scope for variation and specialisation in methods of engagement.

8.2 We have evidence of effectiveness for a number of interventions (see draft produced by HS for 21 February meeting) but these may be more difficult to deliver in deprived areas. We expect therefore, to see clear plans which include activities to enable pilots to reach and engage with the target group so as to deliver the interventions effectively – e.g. consultation with the target population, making services accessible through more flexible opening times and variety of venues; considering different methods of service delivery and types of service to meet particular needs; addressing human resources and other capacity drivers and barriers; innovative methods of monitoring and follow up.

9. FUNDING AND TIMESCALES

9.1 The Scottish Executive will contribute up to **£1m p.a. per CHP** (or equivalent pilot areas) for 2 years from April 2006 for the first wave of pilots. Support is for 2 years of activity so if projects are operational later than April 2006, Boards will be expected to carry forward financial allocations to ensure 2 full years of activity from the start date. The funding is primarily for additional staffing costs. Other costs e.g. prescribing or IT support, should be borne by Boards from the outset.

9.2 Pilot proposals should identify **budgets and timescales** for full implementation and identify the **timeline for expected change** in key health outcomes.

9.3 An additional £2m for **smoking cessation services** for first wave pilots (£0.4m for each CHP) is available in principle from April 2006. Boards should include plans to spend their share of this additional funding as part of their detailed proposals.

9.4 The Executive will support roll-out of Counterweight, at a cost of £1.2m, in the 4 Board areas with Prevention 2010 wave one pilots. Subsequently, other Health Boards will be expected to adopt Counterweight and resource the programme from within their own budgets.

9.5 Executive funding is for the initial 2 year period only. Service redesign and identification of future resources must take place during the initial period and we expect to see emphasis on this in detailed proposals.

9.6 There will be a budget held centrally by SEHD for the national support commissioned through ISD, NHS Health Scotland and others.

9.7 Prevention 2010 Boards should indicate in their proposals whether they intend to participate in the **Physician Assistant** pilot.

10. NATIONAL POLICY CONTEXT

Pilots should be delivered in the context of the overall framework for health improvement policy and delivery – *Improving Health in Scotland: The Challenge*. The national policies on physical activity, diet, smoking and alcohol and the programmes listed below, are particularly relevant. Pilots should ensure effective contacts, links and integration at local level. SEHD/other policy leads are listed below.

- Health Improvement and Health Inequalities Policy and Strategy (Frances Wood)
- Well Man Pilots, Personal Health Plans, Counterweight, and Physical Activity Policy (Fergus Millan)
- Diet Policy (Maureen Bruce)
- Alcohol Policy and the new National Action Plan (currently in development) (Kevin Hanlon)
- Unmet Needs Pilots (Morag King/Keith MacKenzie)
- Physician Assistant Pilots (Ricky Bhabutta)
- National Health Demonstration Pilots (Cathy Magee)
- nGMS Enhanced Services (David Notman) and link to carers policy (Peter Stapleton) and learning disability policy (John Storey)
- Additional smoking cessation funding and services from April 2006 and Tobacco Policy (Mary Cuthbert)
- Multiple Needs Pilots in Glasgow and Closing the Opportunity Gap Policy (Neil Langhorn)
- Equality Impact Assessment Pilots (Alastair Pringle)
- Health Literacy Strategy development at Learning Connections Scotland (Prue Pullen)
- 21st Century Social Work Review (Michael Proctor)

11. PROGRAMME MANAGEMENT AND NETWORKING

11.1 The **Core Project Team** will work collaboratively with all pilots through development and implementation of their plans. Membership is as follows:

SEHD: Frances Wood (Chair), Cathy Magee, Dr Lesley Wilkie, Fergus Millan, Morag King and Gill Scott (Secretary)

NHS Health Scotland: Andrew Tannahill, Cath Krawczyk, Erica Wimbush, Eleanor Anderson

Managed Public Health Network: Anne Maree Wallace

ISD: Colin Fischbacher

11.2 The Executive aims for learning to be shared throughout the lives of the two waves of pilots prior to application of the general approach across Scotland. Pilots should therefore participate in a **network of pilots** and share learning. (HS to establish mechanism.)

11.3 The Core Project Team will consider the scope for **external support and review** of the programme and pilots, and discuss this with pilots.

Conclusion

Pilots should develop their outline proposals further - on the template already provided - basing them on this revised specification, and taking account of feedback from reviewers. They should submit detailed proposals by 19 May for final approval by end June. Pilots should also ensure that the headings used in the reviewers' feedback are covered in the detailed proposals.

Frances R Wood,
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