

Quick reference guide

Identifying and supporting people most at risk of dying prematurely

This quick reference guide presents the recommendations made in 'Reducing the rate of premature deaths from cardiovascular disease and other smoking-related diseases: finding and supporting those most at risk and improving access to services'. The guidance aims to identify what works in driving down population mortality rates in disadvantaged areas, where risk of early death is higher than average, with particular reference to proactive case finding and retention and access to services.

The recommendations have been developed for smoking cessation services and the provision of statins. Although the referral specified a focus on people in disadvantaged areas, the recommendations are relevant for all those who are disadvantaged, regardless of where they live.

The guidance is for NHS and other professionals who have a direct or indirect role in, and responsibility for, services aimed at people who are disadvantaged. This includes those working in local authorities and the wider public, voluntary and community sectors. It may also be of interest to members of the public.

NICE guidance on community engagement, behaviour change, smoking cessation, statins and lipid modification complements and supports this guidance (see related NICE guidance on page 8 for a list of publications).

NICE public health guidance 15

This guidance was developed using the NICE public health intervention process.

NICE public health guidance makes recommendations on the promotion of good health and the prevention of ill health. This guidance represents the views of the Institute and was arrived at after careful consideration of the evidence available. Implementation of this guidance is the responsibility of local commissioners and/or providers. Commissioners and providers are reminded that it is their responsibility to implement the guidance, in their local context, in light of their duties to avoid unlawful discrimination and to have regard to promoting equality of opportunity. Nothing in this guidance should be interpreted in a way which would be inconsistent with compliance with those duties.

Recommendations

Definitions of adults who are disadvantaged and of what constitutes a disadvantaged area and a high risk of cardiovascular disease (CVD) are given below, along with a brief description of the interventions covered.

Definitions

- Adults who are disadvantaged include (but are not limited to):
 - those on a low income (or who are members of a low-income family)
 - those on benefits
 - those living in public or social housing
 - some members of black and minority ethnic groups
 - those with a mental health problem
 - those with a learning disability
 - those who are institutionalised (including those serving a custodial sentence)
 - those who are homeless.
- Local agencies (such as local authorities and primary care trusts [PCTs]) define disadvantaged areas in a variety of ways. An example is the Index of Multiple Deprivation 2007¹. This combines indicators on economic, social and housing issues to produce a single deprivation score.
- According to NICE guidance, if someone has a 20% or higher risk of a first cardiovascular event in the next 10 years they are deemed at high risk of CVD (see NICE clinical guideline 67 on lipid modification at www.nice.org.uk/CG067).

Smoking cessation and statins

Statin provision and smoking cessation services were used as the basis of the recommendations because:

- Methods of identifying and supporting adults and improving their access to services need to be assessed using interventions which have already been established as effective and cost effective. Smoking cessation services and the provision of statins are both generally agreed to be effective and cost effective.
- Epidemiological data show a clear socioeconomic gradient for smoking and CVD. Tackling smoking and providing statins, as recommended, should make a significant contribution to reducing health inequalities.

This guidance should be used alongside NICE guidance on smoking cessation, lipids and statins (see related NICE guidance on page 8 for a list of publications).

¹ Indices of Deprivation 2007 [online]. Available from: www.communities.gov.uk/communities/neighbourhoodrenewal/deprivation/deprivation07

Cost effectiveness

Smoking cessation interventions are generally cost effective, irrespective of the target audience, the methods used to identify and recruit adults or the type of service offered. It is also cost effective to identify adults in secondary care who are disadvantaged and need statins (and then prescribe these drugs). Similarly, it is cost effective to identify these adults in primary care, if at least 14% of the population is at high risk of CVD. It is highly likely that within any disadvantaged population at least 14% will be at high risk of CVD.

Tackling health inequalities

Health inequalities are so deeply entrenched that providing disadvantaged groups or areas with better services – and better access to those services – can only be one element of a broader strategy to address the distribution of the wider determinants of health. All activities need to be developed and sustained on a long-term basis.

The recommendations below focus on system and structural changes to ensure effective clinical and public health practice can take place. This requires a comprehensive approach at all levels of the health system (for example, involving both practitioners and commissioners) and in partnership with others in the wider public, community and voluntary sectors. The recommendations are not aimed at clinical practice itself as the relevant advice is found in other NICE guidance (see above).

Effective implementation of the recommendations will require:

- an appropriate infrastructure and resources for commissioners, planners and service providers
- policy initiatives which prioritise health inequalities and ensure action to tackle them are included in PCT plans and local area agreements.

Recommendation 1: identifying adults at risk

Who is the target population?

- Adults who are disadvantaged:
 - who smoke and/or
 - who are eligible for statins and/or
 - who are at high risk of CVD due to other factors.

Who should take action?

- Service providers and commissioners (for example, general practices, PCTs, community services, local authorities and others with a remit for tackling health inequalities).

What action should they take?

- Primary care professionals should use a range of methods to identify adults who are disadvantaged and at high risk of premature death from CVD. These include:
 - primary care and general practice registers (for example, to identify adults who smoke; who are from particular minority ethnic groups; or who have family members who have had premature coronary heart disease)
 - primary care appointments (for example, during routine visits and screening)
 - systematic searches in pre-identified areas or with specific populations (for example, using direct mail or telephone)
 - analyses of quality outcomes framework (QOF) data.
- Those working with communities should use a range of methods to identify adults who are disadvantaged and at high risk of CVD. Methods to use include:
 - health sessions run at a range of community and public sites, including post offices, charity shops, supermarkets, community pharmacies, homeless centres, workplaces, prisons and long-stay psychiatric institutions. (Lifestyle factors such as smoking or other indicators, such as blood pressure, could be used to identify those at risk)

- culturally sensitive education sessions that include a CVD risk assessment and which take place in black and minority ethnic community settings (including places of worship)
- outreach activities provided by community health workers (including health trainers).
- Service providers should monitor these methods and adjust them according to local needs.
- Service providers should encourage everyone who is disadvantaged to register with a general practice.

Recommendation 2: improving services for adults and retaining them

Who is the target population?

- Adults who are disadvantaged:
 - who smoke and/or
 - who are eligible for statins and/or
 - who are at high risk of CVD due to other factors.

Who should take action?

- Service providers (for example, PCTs, general practices, community services, local authorities and other organisations with a remit for tackling health inequalities).

What action should they take?

- Provide flexible, coordinated services that meet the needs of individuals who are disadvantaged. For example, this could include providing drop-in or community-based services, outreach and out-of-hours services, advice and help in the workplace and single-sex sessions.
- Involve people who are disadvantaged in the planning and development of services. Seek feedback from the target groups on whether the services are accessible, appropriate and meeting their needs.

- Gain the trust of adults who are disadvantaged. Offer them proactive support. This could include helplines, brochures and invitations to attend services. It could also include providing GPs with postal prompts to remind them to monitor people who are disadvantaged and who have had an acute coronary event.
- Develop and deliver non-judgemental programmes to tackle social and psychological barriers to change. These should be tailored to people's needs. For example, they could make use of social marketing techniques. (Social marketing involves using marketing and related techniques to achieve specific behavioural goals.)
- Ensure services are sensitive to culture, gender and age. For example, provide multi-lingual literature in a culturally acceptable style and involve community, religious and lay groups in its production. Where appropriate, offer translation and interpretation facilities. Promote services using culturally relevant local and national media, as well as representatives of different ethnic groups. Consider providing information in video or web-based format.
- Provide services in places that are easily accessible to people who are disadvantaged (such as community pharmacies and shopping centres) and at times to suit them.
- Provide support to ensure people who are disadvantaged can attend appointments (for example, this may include help with transport, postal prompts and offering home visits).
- Encourage and support people who are disadvantaged to follow the treatment that they have agreed to. For example, encourage them to use self-management techniques (based on an individual assessment) to solve problems and set goals. It could also involve providing vouchers for treatments (such as nicotine replacement therapy [NRT]). (For recommendations on the principles of behaviour change, see 'Behaviour change at population, community and individual levels' [NICE public health guidance 6].)
- Routinely search GP databases (and other electronic medical records) to generate lists of patients who have not collected repeat prescriptions or attended follow-up appointments. Make contact with them.
- Address factors that prevent people who are disadvantaged from using services (for example, they may have a fear of failure or of being judged, or they might not know what services and treatments are available).
- Support the development and implementation of regional and national strategies to tackle health inequalities by delivering local activities which are proven to be effective.
- Use health equity audits to determine if services are reaching people who are disadvantaged and whether they are effective². (For example, by matching the postcodes of service users to deprivation indicators and smoking prevalence.)

² Health equity audits typically consist of six steps: 1) Agreeing partners and issues for the audit 2) Undertaking an equity profile 3) Identifying high-impact local action to narrow key inequities identified 4) Agreeing priorities for action 5) Securing changes in investment and service delivery 6) Reviewing progress and assessing impact. Department of Health (2004) Health equity audit: a self-assessment tool. London: Department of Health.

Recommendation 3: system incentives

Who is the target population?

- Service providers (for example, PCTs, community services, local authorities and others with a remit for tackling health inequalities) and practice-based commissioning (PBC) groups.

Who should take action?

- Policy makers, planners and commissioners.

What action should they take?

- Support and sustain activities aimed at improving the health of people who are disadvantaged by:
 - using relevant indicators to measure progress and compare performance across areas or organisations
 - ensuring, wherever possible, that all targets aim to tackle health inequalities – and do not increase them
 - ensuring exception-reporting does not increase health inequalities: PCTs should be provided with additional levers and tools to monitor and benchmark exception-reporting and to reduce persistent rates of exception coding
 - considering the provision of comparative performance data to encourage providers to meet targets
 - using local enhanced services to encourage providers and practitioners to identify and continue to support those who are at risk of premature death from CVD and other smoking-related diseases.
- Provide incentives for local projects that improve the health of people who are disadvantaged, specifically those who smoke or are at high risk of CVD from other causes or are eligible for statins. Ensure the projects are evaluated and, if effective, ensure they continue.

Recommendation 4: partnership working

Who is the target population?

- Adults who are disadvantaged:
 - who smoke and/or
 - who are eligible for statins and/or
 - who are at high risk of CVD due to other factors.

Who should take action?

- Planners, commissioners and service providers with a remit for tackling health inequalities. This includes PCTs, general practices, community services, PBC groups, local strategic partnerships, local authorities (including education and social services), the criminal justice system and members of the voluntary and business sectors.

What action should they take?

- Develop and sustain partnerships with professionals and community workers who are in contact with people who are disadvantaged. Use joint strategic needs assessments, local area agreements, local strategic partnerships, the GP contract, world class commissioning and other mechanisms. (For recommendations on community engagement see 'Community engagement to improve health' [NICE public health guidance 9].)
- Establish relationships between primary care practitioners and the community to understand how best to identify and help adults who are disadvantaged to adopt healthier lifestyles. For example, they should jointly determine how best to support health initiatives delivered as part of a local neighbourhood renewal strategy.
- Establish relationships with secondary care professionals (for example, those working in respiratory medicine and CVD clinics) to help identify patients at high risk of further cardiovascular events. Offer these patients support or refer them on, where appropriate.

- Develop and maintain a database of local initiatives that aim to reduce health inequalities by improving the health of people who are disadvantaged.
- Develop and sustain local and national networks for sharing local experiences. Ensure mechanisms are in place to evaluate and learn from these activities on a continuing, systematic basis.
- Ensure those working in the healthcare, community and voluntary sectors coordinate their efforts to identify people who need help.
- Ensure practitioners have the skills to identify people who are disadvantaged and can develop services to meet their needs. (For a set of generic principles to use when planning and delivering activities aimed at changing health-related behaviour see: 'Behaviour change at population, community and individual levels' [NICE public health guidance 6]. For advice on getting communities involved see 'Community engagement to improve health' [NICE public health guidance 9].)
- Ensure service providers and practitioners have the ability to make services responsive to the needs of people who are disadvantaged. For example, they should be able to compare service provision with need, access, use and outcome using health equity audits. (For examples of the training and skills needed, refer to national organisations such as the Faculty of Public Health, British Psychological Society, Skills for Health and the Institute of Environmental Health.)

Recommendation 5: training and capacity

Who is the target population?

- Service providers (for example, general practices, PCTs, local authorities, community and lay workers and others with a remit for tackling health inequalities).

Who should take action?

- Commissioners and service providers (for example, PCTs, community services, local authorities and others with a remit for tackling health inequalities).

What action should they take?

- Ensure there are enough practitioners with the necessary skills to help people who are disadvantaged to adopt healthier lifestyles. (For examples of the skills needed see: 'Brief interventions and referral for smoking cessation in primary care and other settings' [NICE public health guidance 1]; 'Workplace health promotion: how to help employees to stop smoking' [NICE public health guidance 5]; 'Smoking cessation services in primary care, pharmacies, local authorities and workplaces, particularly for manual working groups, pregnant women and hard to reach communities' [NICE public health guidance 10]; and 'Standard for training in smoking cessation treatments' [www.nice.org.uk/502591] or updated versions of this.)

Implementation tools

NICE has developed tools to help organisations implement this guidance. For details see our website at www.nice.org.uk/PH015

Further information

Ordering information

You can download the following documents from www.nice.org.uk/PH015

- A quick reference guide (this document) for professionals and the public.
- The guidance, which includes the recommendations, details of how they were developed and evidence statements.
- Supporting documents, including an evidence review and an economic analysis.

For printed copies of the quick reference guide, phone NICE publications on 0845 003 7783 or email publications@nice.org.uk and quote N1xxx.

Related NICE guidance

Much of NICE guidance, both published and in development, is concerned with tackling heart disease, stroke and cancer – all conditions linked to premature mortality among disadvantaged groups. For details go to www.nice.org.uk/guidance/

The following are particularly relevant:

- Community engagement to improve health. NICE public health guidance 9 (2008). Available from: www.nice.org.uk/PH009

- Lipid modifications: cardiovascular risk assessment and the modification of blood lipids for the primary and secondary prevention of cardiovascular disease. NICE clinical guideline 67 (2008). Available from: www.nice.org.uk/CG067
- Smoking cessation services in primary care, pharmacies, local authorities and workplaces, particularly for manual working groups, pregnant women and hard to reach communities. NICE public health guidance 10 (2008). Available from: www.nice.org.uk/PH010
- Behaviour change at population, community and individual levels. NICE public health guidance 6 (2007). Available from: www.nice.org.uk/PH006
- Workplace health promotion: how to help employees to stop smoking. NICE public health guidance 5 (2007). Available from: www.nice.org.uk/PHI005
- Brief interventions and referral for smoking cessation in primary care and other settings. NICE public health guidance 1 (2006). Available from: www.nice.org.uk/PHI001
- Statins for the prevention of cardiovascular events. NICE technology appraisal 94 (2006). Available from: www.nice.org.uk/TA094

Updating the recommendations

This guidance will be updated as needed and information on the progress of any update will be posted on the NICE website (www.nice.org.uk/PH015).

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