Reducing the rate of premature deaths from CVD and other smoking-related diseases: finding and supporting those most at risk and improving access to services

Report on Fieldwork

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MANAGEMENT SUMMARY

1. Background and objectives

This report presents findings from fieldwork to test draft NICE CPHE guidance on: *reducing the rate of premature deaths from CVD and other smoking-related diseases: finding and supporting those most at risk and improving access to services*.

The fieldwork aimed to test the draft recommendations within the guidance with the different professional groups for which they were developed. It aimed to test the recommendations for perceived clarity, relevance, usefulness and effectiveness, as well as any perceived barriers to implementation.

2. Approach

A qualitative methodology was adopted for the study to enable the research team to explore the response to the draft recommendations in depth and in detail.

Fieldwork was carried out with 95 professionals (see table below):

Type of respondent	Projected sample	No. of focus groups	No. of paired depth interviews	No. of individual depth interviews	**Total no. of interviewees**
SHA DPHs and teams	8	1		1	**7**
PCT DPHs, commissioning directors & performance managers	8	1		1	**7**
PCT teams, health clinicians, specialists and smoking cessation advisors	16	1		7	**10**
GPs	16	2			**13**
Community pharmacists	16	2			**10**
Primary care nurses	16	2			**16**
Other (voluntary, statutory, local authority and NDC)	16	1	2	3	**11**

Health trainers and managers	16	2			**21**
Totals	**112**	**12**	**2**	**12**	**95**

Fieldwork was carried out between 23 April and 23 May in London, Coventry, Liverpool and Northampton.

3. Key findings

Overall, the recommendations and guidelines were very well received across all the groups who took part in the study. The recommendations highlighted the importance of a proactive recruitment of disadvantaged adults at risk of CVD and similar related diseases. The recommendations supported the work currently being conducted in the areas in which these respondents worked and was relevant to them in their professional roles. Recommendations 1, 2, 5 and 6 were considered to be particularly important in reducing health inequalities. Recommendations 3 and 4 received mixed responses.

Respondents found the definition of the 'target population' was clear and represented the appropriate sector to target. They all thought that it would be useful to list the risk factors for CVD and to specify those who are most at risk of CVD. However, the guidance should make it clear that localities should carry out profiling of their populations in order to identify (segment) and plan action to reduce health inequalities within their localities.

Clarification of the age that someone is classed as an 'adult' would be helpful. The category 'lone parents' within the term 'disadvantage adults' was considered to be judgemental.

Although 'who should take action' was clear, respondents considered it helpful if examples of organisations are provided within each category. This will ensure that all groups being asked to take action were clear that they were supposed to take action. Respondents also wanted to know which group(s) should take overall responsibility for the implementation of each recommendation and of action points within recommendations.

Commissioners of healthcare were considered to be particularly important in ensuring that recommended actions were included in service specifications and contracts. This would enable professionals to successfully implement this set of guidelines.

Each recommendation and guidance was discussed for its relevance, usefulness, clarity, effectiveness/appropriateness of the actions and to determine whether there were any potential barriers to their implementation. A summary of these particular aspects for each recommendation and guidance has been detailed below.

Recommendation 1

This recommendation provided evidence-based support for respondents' work and, for those working in the voluntary sector, it was considered to be useful in securing funding for continued proactive recruitment.

Although clear and easy to understand, it would be helpful to have clarification on the following:

- 'Culturally sensitive education sessions' and 'religious settings'
- Which organisations were responsible for completing actions points
- Whether or not 'cold calling' was an appropriate method to use and the reason for using this method
- Specific methods of targeting audiences

Overall, respondents considered that the recommended actions would be effective in identifying and recruiting the target population. However, some GPs and PCT smoking cessation professionals were concerned that the QOF data may not effectively identify those at risk of CVD and other smoking-related diseases.

Barriers to implementation are:

- Lack of contact time between target audience and those working within the NHS
- Insufficient staff time to implement all the actions
- The failure to get commissioners on board to include the recommended actions in their contracts and service specifications
- Smoking cessation services being insufficiently 'geared up' to receive referrals
- Negative responses to cold calling
- Inaccurate QOF data and under-reporting
- Language barriers to implement these recommendations
- Lack of funding and resources to implement the recommendations.

Suggestions for improvement are:

- To specifically mention referrals to smoking cessation services
- To include quality standards for vascular testing
- To include cholesterol testing
- To include examples of settings for community outreach work
- To include case studies and 'gold standard' initiatives (i.e. examples of best practice)

- To raise the awareness of risk amongst disadvantaged groups through role models and support groups.

Recommendation 2

In terms of the target population and who should take action, respondents made the same points as for Recommendation 1.

The main points arising for Recommendation 2 include the importance of highlighting the fact that effective health promotion work has to be carried out over a long period of time.

Barriers to implementation are:

- The use of interpreting services, as this appears to be going against the national trend not to translate but to encourage people to learn to speak, read and write English instead

- Because of limited resources professional services may not be able to offer home visits to clients who were unable to leave their houses

- Ensuring the balance is right between informing service users about healthy lifestyles and then enabling service users to take responsibility for their own health. This balance is important in making disadvantaged service users part of the solution to health inequalities

Suggestions for improvement are:

- Words and phrases such as ‘proactive’, ‘social marketing techniques’, ‘problem solving’ and ‘non judgemental programmes’ may not be understood fully by those implementing the recommendations and would therefore not be particularly helpful to them

- ‘Developmental client-centred services’ could be misinterpreted and be confused with ‘person centred’ services (as used in counselling). An alternative suggestion was ‘client led’

- To ensure standardisation in the training of smoking cessation so that there is transferability of skills (and accreditation) from one PCT to another.

Recommendation 3

Reference to those who were included in the practice based commissioning (PBC) groups should be clarified or expanded. Although a range of people are expected to take action, it was considered helpful if one organisation had overall responsibility for implementing the recommendations and guidance. One suggestion was that primary care trusts (PCTs) should be the organisations who had overall responsibility for implementation. Some considered that the recommendation would only be of use to them if the PCTs made sure that all professional groups who would be effective were clear about the targets and how they would be measured.

System based incentives to recruit and retain target populations were an issue for all respondents. Their concerns included the equation of incentives with funding and the effects on the quality of services. Many believed that the system incentives need to be driven by national policy. There were concerns about the prospects of individual incentives for service providers because they thought that bonus schemes can put too much pressure on individuals. However, they did think that incentives to help motivate staff to reach targets were useful so long as the targets are realistic.

Barriers to implementation are:

- the impact of system based incentives (and penalties for not achieving targets) on the provision and quality of services
- lack of public funding to provide system incentives
- concerns about the sustainability of incentive schemes and the effect on the behaviour of service providers
- professionals' concerns over the corporate culture of targets and incentives contradicting their humanistic approach to healthcare
- lack of support from commissioners
- concerns about how to monitor 'soft' outcomes that are not included in a national data set.

Suggestions for improvement are:

- the term 'policy makers' was associated with national level policy making. 'Strategic planners' may be a better term to use at local level
- clarify what is meant by 'relevant indicators' in the action point '*using relevant indicators and ensuring target-setting and exception-reporting do not increase health inequalities'*

Recommendation 4

As with recommendations 1 and 2, some respondents thought it would be helpful to include further information on the specific groups of disadvantaged adults most likely to be affected by CVD. Many thought that it would be helpful to include the risk factors for CVD and to identify the specific groups most at risk. Smoking cessation professionals in particular felt that this recommendation was relevant to them.

There were particular concerns about the use of individual incentives. Concerns fell into four categories: (i) concerns about the evidence base for individual incentives; (ii) doubts about the effectiveness of individual incentives in recruiting disadvantaged adults into health services; (iii) concerns about the type of incentive that would be used; (iv) concerns about the potential for corruption.

Barriers to implementation are:

- The moral fairness of providing individual incentives in order to effect behaviour change and the potential adverse impact on those who are on low incomes who genuinely try hard to stay healthy
- The effectiveness of incentives in terms of encouraging disadvantaged adults to access smoking cessation and CVD prevention services. However, there were concerns about the abuse of this system and the potential for corruption. This was of particular concern if cash incentives were to be introduced
- Lack of funding for the provision of incentives
- Lack of trained individuals to deliver these interventions
- Lack of evidence to support the effectiveness of individual incentives.

Suggestions for improvement are:

- Clarification on the type of incentive they should use, with specific examples of good practice with disadvantaged groups
- The promotion of public education rather than incentives was needed in order to reduce health inequality.

Recommendation 5

Overall the recommendations are clear and easy to understand and are thought to be relevant to organisations. In some areas partnership and multi-agency working are already part of their agenda for monitoring, proactively recruiting and retaining the target populations. Many thought it was crucial to stress the importance of partnership working and this recommendation and guidance was useful in highlighting this as good practice.

Barriers to implementation are:

- The sustainability of partnership working
- Inappropriate representation (i.e. people who lack the seniority to make decisions) within partnerships
- Disparity in the goals and motivations of organisations working in partnership or in multi agency
- Lack of time and resources to implement this recommendation
- The non-existence of any centralised system for coordinating records and no one available to carry out any such role.

Suggestions for improvement are:

- Clarify what is meant by ‘planners’ and which professions (if any) are included in this category

- Clarify who should take overall responsibility for implementing this recommendation and who should allocate responsibility for each action point
- The term ‘community leaders’ would be a more appropriate term to use than ‘activists’
- Clarify who is responsible for compiling and maintaining the database referred to in action point 4 and exactly what information should be included in the database
- Clearer emphasis on primary care trusts (PCTs) and local authorities (LAs) to identify the challenges for effective partnership working
- Emphasise the importance of partnerships for designated link workers
- More effective channels of communication between community service professionals and primary care trusts (PCTs).

Recommendation 6

Overall, respondents thought that this recommendation and guidance was relevant to them and welcomed it because it provides evidence-based support. They thought that ensuring appropriate training and capacity was essential to the successful implementation of these recommendations. This recommendation is useful to professionals in terms of giving them the skills and the capacity to proactively recruit and retain disadvantaged adults who are at risk of CVD and other smoking-related illnesses. This guidance complemented NICE guidance on smoking cessation.

Barriers to implementation are:

- time for professionals to complete the training
- funding and resources to implement the recommendations
- lack of availability of appropriate training organisations.

Suggestions for improvement are:

- Funding should be made available to provide appropriate training to professionals in order to implement this recommendation and guidance
- Clarify who is a ‘practitioner’
- Expand action point 1 ‘….ensure there are enough of them to meet local needs’ to include specific quality measures
- Standardise accreditation training across all areas

Key considerations for the Public Health Interventions Advisory Committee (PHIAC):

- It is important to clarify which specific organisations or professional groups should implement action points and who (or which organisation) has overall responsibility for implementing the recommendations and guidance.

- It is considered essential that commissioners are on board with the implementation of these recommendations and guidance and the actions are included in their contracts and service specifications

- Training and the funding thereof are considered to be key to the implementation of these recommendations. The standardisation of training and recognition between primary care trusts (PCTs) (transferability of training) is also important. Accreditation of the training therefore needs to be given consideration.

- Sustained funding and the provision of adequate resources were considered essential to the effective implementation of all the recommendations. It was also considered important to allow enough contact time between health professionals and disadvantaged adults. This would require more funding and extra resources.

- Respondents considered that premature mortality as a result of CVD and smoking-related diseases needs to be tackled holistically and that social care issues such as poor housing, unemployment and crime are integral to its solution.

- Emphasis should be given to public education and the promotion of healthy lifestyles as a way of addressing long-term health inequalities. Respondents thought that this was essential. Many respondents, across different professional groups, thought incentives could also play a role. However some, in particular PCT commissioners, wanted clearer evidence that they work.

- A number of concerns were raised about system incentives and individual incentives to implement the advice, particularly on cultural and moral grounds and on allocation of resources. Most notably the need for system incentives should be driven by national policy. Individual incentives may put too much pressure on individuals and may not achieve short-term improvements in healthcare.

- Importance was given to which outcomes are included in the monitoring for system incentives and how they are monitored. There are concerns that ‘soft’ outcomes are not included in national data sets and are more difficult indicators to track.

- Partnership working was considered essential to reducing premature mortality in disadvantaged adults due CVD and other smoking-related illnesses. However, more detail in the recommendation about how to form effective partnerships would be welcomed.

- QOF data may not prove to be a reliable guide to finding disadvantaged adults who have been specified in the target populations. Other social marketing tools such as segmentation of population may be more effective in profiling target populations.

- It was considered very important to take account of cultural variations and actively target minority ethnic and disadvantaged groups. However, some respondents thought the terminology used in the recommendations (e.g. ‘proactive’, ‘social

marketing' and 'non judgemental programmes' might not mean a lot to front-line workers and therefore may not be very useful.

A. BACKGROUND

The Department of Health (DH) has commissioned the Centre for Public Health Excellence (CPHE) at the National Institute of Clinical Excellence (NICE) to develop guidance on the following topic: *reducing the rate of premature deaths from CVD and other smoking-related diseases: finding and supporting those most at risk and improving access to services*.

The guidance has been developed for smoking cessation and the provision of statins and is targeted at disadvantaged adults who are at risk of CVD and other smoking-related diseases.

The guidance has been developed 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 professionals working in local authorities, the wider public sector, and community and voluntary groups.

Following consultation with the Public Health Interventions Advisory Committee (PHIAC), NICE has developed draft guidance on the topic of reducing the rate of premature deaths from CVD and other smoking-related diseases.

B. OBJECTIVES

NICE CPHE commissioned Dr Foster Intelligence to carry out qualitative fieldwork to test the draft recommendations within the guidance with representatives of all the professional groups (including statutory, charitable and voluntary) for which they have been developed.

The main fieldwork objectives were to establish:

- how clear and easy each draft recommendation is to understand
- the relevance of each draft recommendation to the respondents in their professional role/ the respondents' organisations and how they could be made more relevant
- how effective respondents think each draft recommendation will be in terms of reducing premature mortality rates amongst disadvantaged adults who are at risk of CVD and other smoking-related diseases
- how useful each draft recommendation is to the respondents in their professional role/the respondents' organisations and how they could be made more useful
- any barriers to implementation of each draft recommendation and how they could be overcome
- the perceived impact of each draft recommendation
- an overall perspective on how respondents perceive the recommendations, which recommendation(s) they think will have the most or least impact and which recommendations they think should be given the highest priority and why.

C. OUR APPROACH

Fieldwork was carried out using a mixture of group discussions and depth interviews. Discussion groups and interviews followed a discussion guide that included a number of questions and tasks designed to explore responses to each individual recommendation and to gain overall perspectives on the recommendations.

In summary, we conducted 12 group discussions, two paired depth interviews and 12 individual depth interviews. All professional groups (including statutory, voluntary and charitable groups) that were asked to take action by the draft guidance were included in the fieldwork. In summary, these were:

- SHA directors of public health and their teams involved in ensuring commissioning and provision of services to recruit and retain smokers/people with or at risk of CVD
- PCT directors of public health and commissioning directors responsible for commissioning and performance-managing services to recruit and retain smokers/people with or at risk of CVD
- PCT teams (e.g. public health clinicians, specialists, health promotion staff, smoking cessation advisors) involved in designing, working with and/or providing smoking cessation and CVD prevention services
- GPs, community pharmacists, practice nurses, community nurses and other community care team staff involved in recruiting smokers/people at risk of CVD to services and retaining them
- Health trainers involved in the recruitment and retention of people with or at risk of CVD
- Other professionals involved in recruiting smokers/people at risk of CVD to services and retaining them. This included those working in the statutory sector (such as local authority/ New Deal for Communities) and voluntary sector.

Group discussions were carried out with homogenous groups to allow us to compare and contrast responses across different professional groups.

Full details of the fieldwork methods and sample groups included in the fieldwork are appended (appendix 1).

D. MAIN FINDINGS

1. Recommendation 1

Recommendation 1: finding clients

Who is the target population?
Adults who are disadvantaged and:

- *who smoke*
- *who are at high risk of CVD due to other factors*
- *who are eligible for statins.*

Who should take action?
Service providers and commissioners (for example, general practices, primary care trusts, 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 clients including:

- *the use of primary care and general practice registers (for example, to identify people who smoke or who are from particular minority ethnic groups)*
- *opportunistic identification during primary care appointments (for example, during routine visits, prenatal appointments and screening for other conditions such as sexually transmitted infections)*
- *cold-calling in pre-identified areas or with specific populations (for example by direct mail, mobile phones and random-digit dialling)*
- *offering prevention advice to the families of patients who have premature coronary heart disease (CHD)*
- *analysis of quality outcomes framework (QOF) data.*

Those working with communities should use a range of methods to identify clients including:

- *opportunistic identification (for example, using lifestyle factors such as smoking or other indicators such as blood pressure) during health sessions held at a range of community and public sites. These could include post offices, charity shops, supermarkets, homeless centres, workplaces, prisons and long-stay psychiatric institutions*
- *running culturally sensitive educational sessions which include a CVD risk assessment and take place in black and minority ethnic community settings (including places of worship)*
- *using community health workers (including health trainers) and outreach activities.*

Monitor these methods and adjust them according to local needs.

Recommendation 1: Key points

This recommendation provided evidence-based support for respondents' work and, for those working in the voluntary sector; it was considered to be useful in securing funding for continued proactive recruitment.

Although clear and easy to understand, it would be helpful to have clarification on the following:

- 'Culturally sensitive education sessions' and 'religious settings'
- Which organisations were responsible for completing actions points
- Whether or not 'cold calling' was an appropriate method to use and the reason for using this method
- Specific methods of targeting audiences.

Overall, respondents considered that the recommended actions would be effective in identifying and recruiting the target population. However, some GPs and PCT smoking cessation professionals were concerned that the QOF data may not effectively identify those at risk of CVD and other smoking-related diseases.

Barriers to implementation are:

- Lack of contact time between target audience and those working within the NHS
- Insufficient staff time to implement all the actions
- The failure to get commissioners on board to include the recommended actions in their contracts and service specifications
- Smoking cessation services being insufficiently 'geared up' to receive referrals
- Negative responses to cold calling
- Inaccurate QOF data and under-reporting
- Language barriers affecting the implementation of these recommendations
- Lack of funding and resources to implement the recommendations.

Suggestions for improvement are to:

- Specifically mention referrals to smoking cessation services
- Include quality standards for vascular testing
- Include cholesterol testing
- Include examples of settings for community outreach work
- Include case studies and 'gold standard' organisations
- Raise the awareness of risk amongst disadvantaged groups through role models and support groups.

1.1. Target population

Overall, respondents found it clear and easy to understand who is the target population for this recommendation and they thought that the target population was appropriate. They welcomed the emphasis on targeting disadvantaged adults and thought that it was important to proactively recruit them.

Respondents from a range of different professional groups, including managers in primary care trusts (PCTs), commissioners, GPs, community nurses, health visitors and commissioners, thought that it would be useful to include the risk factors for CVD and to pick out the specific groups most at risk. They thought the recommendation should include information on:

- The ethnic groups most at risk of CVD and other smoking-related diseases
- The age ranges most at risk of CVD.

SHA public health professionals in Knowsley said that they rely on segmentation in planning any action to reduce health inequalities.

"It should also be looking at people in deprived communities – people who smoke or have family histories. Also, nothing said here about particular populations but we know that middle aged men, some BME communities are at higher risk. No discussion of age – certain age ranges are at most risk."
Depth interview, SHA director, North West SHA

GPs in Northampton thought that, in addition to mentioning people who are eligible for statins, people who take aspirin or would benefit from taking aspirin for CVD should be explicitly referenced. GPs in Fulham thought that adults with diabetes should be explicitly referenced as adults who are at risk of CVD.

"Why doesn't this apply to people who are on aspirin? It should."
Focus groups, GPs, Northampton

Some PCT staff involved in designing, working with or providing smoking cessation or CVD prevention services thought that it was unclear who would count as an adult. They queried whether 'adults' means people over 15, 16 or 18. They wanted a specific age range to be given.

"Age should be defined. The skeleton is there but [there's] no flesh."
Depth interview, commissioner, Coventry PCT

Community nurses and health visitors from Liverpool questioned the inclusion of lone parents in "disadvantaged adults". They thought that this could be perceived as judgemental and said that many lone parents do not fall into the category of "disadvantaged adults".

1.2. Who should take action?

Overall, respondents thought it was clear and easy to understand who this draft recommendation is addressing and asking to take action. Some respondents suggested that further groups should be either added to or specified in the section on who should take action to make it clear which types of organisation and which specific organisations should take action.

A general point made by many respondents was that it would be helpful to give examples of the organisations that fall under the different categories in the "who should take action?" section. This would help make sure that the organisations that do fall into these categories know that they are being asked to take action.

"Other agencies who should be included: voluntary agencies; agencies involved in delivering the third party model of health trainer interventions such as Merseyside Fire and Rescue Services, staff in Boots, staff in Citizens Advice; secondary care; health and social care professionals."
Focus group, health trainers, Liverpool

The following suggestions were made:

- *Voluntary and community sector groups and professionals* – many respondents appreciated that the voluntary and community sector might fall under "community services" or "others with a remit for tackling health inequalities" but thought that they should be specifically picked out here to make it clear that they should be taking action.

"It should refer specifically to voluntary and community organisations."
Depth interview, healthcare manager, New Deal for Communities (NDC), Coventry

- *Pharmacists* – GPs in Northampton appreciated that pharmacists might be included under "primary care trusts" or "community services" but thought that pharmacists should be specifically picked out here so that it was clear that they should take action.

"Now, amongst the list of who should take action, pharmacists aren't there, are they? I think they would know."
Depth interview, smoking cessation manager, charitable sector, Liverpool

- *Social services* – practice nurses and health visitors in Coventry thought that social services should be explicitly mentioned here to make it clear that they should take action.

- *Further/higher education providers* – practice nurses and health visitors thought that further/higher education providers should be explicitly referenced under "local agencies".

- *Employers* – several respondents thought that employers would be a useful addition to this group, since it was felt that they could identify any at-risk disadvantaged adults who are in work.

"Nothing said about the role of employers – the workplace is a great place to identify people at risk."
Depth interview, SHA director, North West SHA

- *The acute sector* – one SHA director for public health thought that the acute sector should be included in the "who should take action?" section of this recommendation.

- *Health trainers* – several smoking cessation professionals, working in both the public and charitable sectors, thought that health trainers should be explicitly included here.

It's clear but health trainers should be included."
Depth interview, smoking cessation professional, Liverpool PCT

1.3. What action should they take?

1.3.1. Relevance

Overall, respondents responded very positively to this recommendation. All thought that it was very important to proactively recruit disadvantaged adults at risk of CVD and other smoking-related diseases.

The majority of respondents, including community pharmacists, practice nurses, smoking cessation professional, PCT managers and commissioners and SHA public health managers, said that this recommendation fits with the aims and goals of their organisation perfectly. They see themselves as having a role to play in the reduction of health inequalities and think that this recommendation supports that aim. They think that this recommendation is asking them to take action.

"This is relevant to us. In our team we might run campaigns to focus on certain groups of patients, we are looking at patients with high risk of CVD."
Depth interview, commissioner, Liverpool PCT

"It's relevant to us because we target these people. Any other work that went along with this would bring a lot more people into the service."
Focus group, smoking cessation professional**s, charitable sector, Liverpool**

"It's relevant to me within the scope of the smoking cessation project. It's directly relevant to our outreach work in terms of that."
Depth interview, public health manager, New Deal for Communities (NDC) Hammersmith

"Very relevant, smoking cessation rates are not high in these groups in Coventry. It tends to be the more affluent people who use the smoking cessation service. It is a concern that disadvantaged people don't use these services."
Depth interview, commissioning public health consultant, Coventry PCT

SHA public health managers thought that this recommendation was relevant to them in the sense that they hold influence over the people who would be responsible for commissioning these services. However, they said that it could be made even more relevant to them by including specific examples that have worked in practice.

Health visitors, community nurses, health trainers and smoking cessation professionals said that they already carry out most of the recommended actions. They said that they are currently engaged in proactive case-finding, at a 'grass-roots' level amongst disadvantaged groups. However, they said that they felt a lot was being asked of them in this recommendation if it is expected to be carried out in a formal, measured way. They mentioned time and resourcing constraints which would make it difficult to do all that was being asked of them by the recommendation.

There was a mixed response to this recommendation from GPs. GPs in Northampton did not feel that it was their role to play a part in reducing health inequalities. By contrast, GPs in Fulham were enthusiastic about playing a role in proactively recruiting disadvantaged adults who are at risk of CVD and other smoking-related diseases. However, GPs in Fulham thought that they were and should be responsible for the proactive recruitment of disadvantaged adults at risk of CVD and other smoking-related diseases. Therefore they welcomed this recommendation.

1.3.2. Usefulness

Overall, respondents, including SHA public health managers, PCT managers and commissioners, smoking cessation professionals, community nurses, practice nurses, health visitors and health trainers thought that this recommendation was very useful to them, in terms of:

- Suggesting ways of proactively identifying at-risk disadvantaged adults
- Raising the profile of the importance of proactive recruitment
- Providing evidence-based support for the work that they already do.

"Very [useful], well, this organisation, as the performance organisation for the North West, has identified that a key part of reaching national mortality improvement targets and reducing health inequalities gaps is the identification and support to people either already diagnosed or at high risk of CVD."

Depth interview, SHA director, North West SHA

Different professional groups had different reasons for finding this recommendation useful:

- Smoking cessation professionals working in the voluntary sector thought that this recommendation would be useful in securing funding for outreach work.
- One PCT community engagement lead said that this recommendation was particularly useful because it put vascular screening clearly on the agenda.
- Health trainers in Lambeth and Southwark said that this recommendation is very useful to them because it gives them confidence that they will be taken seriously both by the community (and their leaders) and more senior health workers, such as GPs, etc.

Some participants, including those working for New Deal for Communities projects (NDCs), GPs in Northampton and health trainers, felt that there was a lack of substance in terms of how to implement the suggested actions. They thought that this made the recommendation less useful than it could be, from a practical point of view. They would welcome case studies and 'gold standard' examples in any implementation documents to help them put the recommended actions in place.

1.3.3. Clarity

Overall, respondents thought that it was clear and easy to understand what action people are being asked to take. However, there were some suggestions for improving the clarity of this recommendation:

- Many respondents, thought action points were slightly too generalised:

    a) They thought that there should be more substance to the recommendation in terms of how to implement the suggested actions (e.g. through inclusion of more examples and identification of existing projects)

    b) They wanted case studies, and 'gold standard initiatives' (i.e. examples of best practice). They accepted that these could be included in an implementation document.

- Some smoking cessation professionals working in the public sector thought that it would be helpful to specify which organisations were responsible for carrying out each of the action points.

- One respondent thought that it could be made clearer what "culturally sensitive educational sessions" are and what is involved in making them culturally sensitive.

- Health trainers in Lambeth and Southwark thought that "religious settings" would be a better term to use than "places of worship" because it is more inclusive of all faith-based settings.

- Some smoking cessation workers were unsure whether "cold calling" was intended to bring people into smoking cessation services or to follow up on people who have relapsed.

1.3.4. Effectiveness/ appropriateness of recommended actions

On the whole, respondents welcomed the recommended actions and thought that, if implemented, they would be effective in the identification and recruitment of disadvantaged adults at risk of CVD and other smoking-related diseases.

One community engagement lead for Liverpool PCT said that, whilst she thought this recommendation would have a drastic impact, it was important to tackle the issue holistically. She said that poor housing, unemployment and crime all play a part in health inequalities.

There were mixed responses to the recommendation for "cold calling".

- Some welcomed the suggestion

- Others worried that it might breach confidentiality (e.g. if calling a relapsed smoker, whose family don't know they smoke). Some feared intruding too far into people's lives and becoming 'the health police'.

- GPs in Northampton were cynical about the effectiveness of cold calling in terms of recruiting disadvantaged adults at risk of CVD and other smoking-related diseases.

- Practice nurses and health visitors in Coventry were opposed to random digit dialling and cold calling in general, believing that, most people dislike receiving uninvited phone calls in their own homes.

"Cold calling...people get fed up being phoned up"
Focus group, practice nurses practice nurses and health visitors, Coventry

"People don't routinely go to their GP for health check-up. If that's your population to start with, then the uptake from cold calling in that population will probably be extremely low."
Focus group, GPs, Northampton

There were also mixed responses to the recommendation for use of QOF data:

- Some GPs and PCT smoking cessation professionals worried that QOF data might not be reliable as a guide to finding disadvantaged adults at risk of CVD and other smoking-related diseases. They thought that under-reporting could be an issue.

- However, some GPs and pharmacists thought that QOF data was the best available means of identifying disadvantaged adults at risk of CVD and other smoking-related diseases.

Dieticians in Coventry questioned the viability of engaging prisoners or the homeless in a way that was likely to lead to change. They said that, for example, even if prisoners with poor diets were identified, there would be little that could be done to change their diet. They thought that homeless people and prisoners would be unlikely to prioritise a healthy diet.

"If you identify that someone in prison has a poor diet – what are you going to do about it? You can't change their diet. The actions are premised on the basis that identification can lead to the individuals taking up opportunities for health changes. For people who are homeless or in prison this may not be top of their agenda."
Focus group, dieticians, Liverpool PCT

The following suggestions for improvement or change to Recommendation 1 were made.

- Many respondents thought that it would be useful to include examples and case studies of proactive case finding in the implementation document. They would like to see 'gold standard' organisations.

- Some smoking cessation professionals working in the charitable sector thought that it was important to explicitly mention referral to smoking cessation services in this recommendation

- One community development lead for Liverpool PCT thought that it was important to bring in quality standards for actions taken at the grass-roots level, in particular regarding vascular testing:

    a) This individual stressed the need for uniform training in using BP machines

    b) This individual said that BP machines themselves should be standardised and that there should be regular checks on machines to ensure that they are not malfunctioning.

- Community pharmacists in Liverpool thought that cholesterol testing should be included in the recommended actions.

- Health trainers in Lambeth and Southwark thought that the recommendation could be made more effective by including further examples of settings for community outreach work. They suggested including libraries, community centres, youth clubs, and colleges. They said that health promotion is all about awareness and as many places as possible need to offer one-to-one contact.

Respondents made the following suggestions for further ways of engaging with disadvantaged adults at risk of CVD and other smoking-related diseases:

- Using role models such as footballers to engage disadvantaged adults at risk of CVD and other smoking-related diseases (PCT community engagement lead)

- Using patient support groups to reach disadvantaged adults at risk of CVD and other smoking-related diseases (PCT community engagement lead)

- Using community health workers and health trainers to engage at-risk disadvantaged adults (Liverpool PCT practice-based commissioning managers)

- Using cardiac rehab to reach people within the target population who are not reached by other means (dieticians in Coventry).

2. Recommendation 2

Recommendation 2: improving services and retaining people

Who is the target population?
Adults who are disadvantaged and:

- *who smoke*
- *who are at high risk of CVD due to other factors*
- *who are eligible for statins.*

Who should take action?
Service providers (for example, PCTs, general practices, community services, local authorities and others with a remit for tackling health inequalities).

What action should they take?

- *Ensure services are sensitive to cultural and gender issues. For example, provide multi-lingual literature in a culturally acceptable style and involve community, religious and lay groups. Where appropriate, offer translation and interpretation facilities. Promote services using culturally relevant local and national media as well as representatives of different ethnic groups.*
- *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 they can attend appointments (for example, this may include help with transport, postal prompts and offering home visits).*
- *Encourage and support them to comply with treatment, for example by using self-management techniques based on an individual assessment and involving problem solving, goal setting and follow-up. (For recommendations on the principles of behaviour change, see 'Behaviour change at population, community and individual levels' [NICE public health guidance 6].)*
- *Provide flexible services that meet the level of need and understanding of individuals who are disadvantaged. For example, this includes providing community-based services on a drop-in or rolling basis, proactive outreach work, out-of-hours services, workplace services and single-sex sessions.*
- *Offer 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 client-centred, non-judgemental programmes (using, for example, social marketing techniques) to tackle social and psychological barriers to change.*
- *Address factors that prevent people from using the 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 proven local activities.*
- *Use health equity audits to determine how well services are reaching people who are disadvantaged (for example, by matching the postcodes of service users to deprivation indicators and smoking prevalence). In addition, seek feedback from the target populations on whether the services are accessible, appropriate and meeting their needs.*

Recommendation 2: Key points

In terms of the target population and who should take action, respondents made the same points as for Recommendation 1.

The main points arising for Recommendation 2 include the importance of highlighting the fact that effective health promotion work has to be carried out over a long period of time.

Barriers to implementation are:

- The use of interpreting services as this appears to be going against the national trend not to translate but to encourage people to learn to speak, read and write English instead
- Because of limited resources professional services may not be able to offer home visits to clients who were unable to leave their houses
- Ensuring the balance is right between informing service users about healthy lifestyles and enabling service users to take responsibility for their own health. This balance is important in making disadvantaged service users part of the solution to health inequalities.

Suggestions for improvement are:

- Words and phrases such as ‘proactive’, ‘social marketing techniques’, ‘problem solving’ and ‘non judgemental programmes’ may not be understood fully by those implementing the recommendations and would therefore would not be particularly helpful to them.
- ‘Developmental client-centred services’ could be misinterpreted and be confused with ‘person centred’ services (as used in counselling). An alternative suggestion was ‘client led’
- To ensure standardisation in the training of smoking cessation so that there is transferability of skills (and accreditation) from one PCT to another.

2.1. Target population

All respondents found it clear and easy to understand who the target population for this recommendation is and thought that the target population was appropriate. They welcomed the emphasis on targeting disadvantaged adults and thought that it was important to proactively target them.

As with Recommendation 1, some respondents thought that it would be helpful to include further information on the specific groups of disadvantaged adults most likely to be affected by CVD. Respondents from a range of different professional groups, including GPs, community nurses, health visitors and commissioners, thought that it would be useful to include the risk factors for CVD and to pick out the specific groups (including ethnic groups, age ranges and genders) most at risk of CVD.

As with Recommendation 1:

- GPs wanted people who would benefit from aspirin to be included
- Smoking cessation professionals working for primary care trusts (PCTs) wanted to be given a minimum age-limit for adults.

It may be necessary to make clearer in the guidance that localities need to carry out their own profiling of their population.

"I still have a problem with this target population. I don't know why they've made it [just people who are eligible for] statins. Why can't you have aspirin in it?"
Focus group, GPs, Northampton

2.2. Who should take action?

All respondents thought that it was clear and easy to understand who should take action. However, as with recommendation 1, some respondents suggested that further groups should be either added to or specified in the "who should take action?" section to make it clear which types of organisation and which specific organisations should take action.

Suggestions for changes to the "who should take action?" section for Recommendation 2 were in line with the suggestions for Recommendation 1:

- Voluntary and community sector groups and professionals
- Social services
- Health visitors
- Employers
- The acute sector
- Commissioners

GPs in Fulham thought that it should be made clear which of the groups included in the "who should take action?" section should take overall responsibility for ensuring

that the recommendation is implemented. They thought there was a danger of each group relying on the others to take action.

"In who should take action, you've got to have the commissioners in there, because, as I was saying, the commissioners don't commission if providers won't do it; can't even do it. Commissioners need to be commissioning improved services."
Depth interview, SHA assistant director, North West SHA

2.3. What action they should take

2.3.1. Relevance

Respondents across all professional groups said that the recommendation is relevant to them in their professional role and to their organisation. They said that retention of disadvantaged clients is high on their professional agenda. Health trainers, health visitors, community nurses, smoking cessation professionals said that they already carry out many of the recommended actions.

"Very, well, this organisation, as the performance organisation for the North West, has identified that a key part of reaching national mortality improvement targets and reducing health inequalities gaps is the identification and support to people either already diagnosed or at high risk of CVD."
Depth interview, SHA assistant director, Northwest SHA

"We have a very multilingual team support that are devised around the development form, which is the initial bid on which they agree to pay the money, so if you don't hit figures, it can affect your financial allocation, year on year. So there are lots of milestones and outputs that projects have to reach. A lot of this I find, I think we're possibly doing anyway. It all seems to fit around what we are aiming to do anyway."
Depth interview, public health professional, New Deal for Communities (NDC), Coventry

2.3.2. Usefulness

Many respondents – in particular smoking cessation professionals, health trainers and practice nurses – said that this recommendation was useful to them in their professional role or to their organisation. Smoking cessation professionals working in the charitable sector and public health practitioners working for New Deal for Communities (NDC) teams said that this recommendation was particularly useful because it provides evidence-based support for the work that they already carry out.

Respondents across all professional groups welcomed this recommendation and thought that it would be useful in terms of:

- Providing evidence-based support for the work that they already carry out

- Raising the profile of the importance of cultural sensitivity in provision of health services
- Providing a framework for retaining disadvantaged adults in health services
- Strategic planning (particularly for SHA public health managers)
- Supporting calls to sustain health promotion work over a long period of time (health trainers in Lambeth and Southwark, in particular made this point).

"I think it possibly strengthens the framework perhaps in which we're currently operating"
Focus group, SHA Public Health Managers, Knowsley

SHA public health managers in Knowsley suggested that the recommendation could be made even more useful by prioritising action points in terms of importance. They thought that this would give added weight to the recommended actions and improve compliance.

GPs in Northampton welcomed the recommendation in general. In particular they thought that action point 1 was very useful because they thought it was vital to take account of cultural issues in the delivery of smoking cessation and CVD prevention services. However, they were concerned about how useful the recommendation would be to front-line workers. They thought that the terms used in the recommendation might not be fully understood by the professional groups being asked to take action:

- For example, they thought that terms "proactive", "social marketing techniques" and "non judgemental programmes" might not mean a lot and therefore not be that useful to 'people on the ground'.

"Words like proactive and social marketing techniques, non-judgemental programmes. There's a lot lingo, jargon in there. I'm sure it's very well meant, but I'm not sure how helpful it is to people on the ground, if they're going to try to deliver this."
Focus group, GPs, Northampton

Community nurses and health visitors in Liverpool thought that the recommendation could be made more useful to them by making clear the need for extra funding and resources to support the recommended actions.

Smoking cessation professionals thought that this recommendation could be made even more useful by including an action point on referring disadvantaged adults on to stop smoking services.

"I think, perhaps, if you added something about referring them to the stop smoking services would be useful. And, as I say, perhaps adding pharmacists because I think pharmacists will be very important."
Depth interview, smoking cessation manager, charitable sector, Liverpool

2.3.3. Clarity

Overall, respondents thought that it was clear and easy to understand what this recommendation is asking people to do. However:

- One respondent thought it needs to be spelled out what involvement community and religious groups should have

- Some smoking cessation professionals working in the charitable sector thought that "develop client-centred services" could be misinterpreted. They thought it could be confused with "person centred" in counselling terms. They suggested "client-led" as an alternative

- Health trainers in Liverpool thought that Action point 4 could be made clearer. They thought that "problem solving" could be interpreted in different ways and that this could cause problems where, for example a health trainer interpreted "problem solving" in a different way to primary care professionals

- GPs in Northampton thought that some terms ("proactive", "social marketing techniques", "non-judgemental programmes") might not mean much to people on the ground and thought that the recommendation should be more specific. They also thought that it was unclear whether "targeted measures" meant "measures targeted at a particular area" or "measures targeted at a particular community"

- Smoking cessation and public health practitioners for New Deal for Communities (NDC) teams in Hammersmith and Fulham thought that "proven" in action point 9 is unclear. They thought that there need to be clear standards for measuring the effectiveness of initiatives.

2.3.4. Effectiveness / appropriateness of recommended actions

Overall, respondents welcomed the recommended actions and thought that they would be effective in terms of retaining disadvantaged adults who are at risk of CVD and other smoking-related diseases.

One community engagement lead for Liverpool PCT said that a more individual service, which engaged with the target audience, would be effective in terms of improving their long-term health prospects. Therefore, this individual thought that, if implemented, this recommendation would be effective in reducing rates of premature mortality amongst disadvantaged adults due to CVD and other smoking-related diseases.

There were mixed responses to the recommendation for "self-management":

- Amongst Liverpool PCT practice-based commissioning managers, the 'self-management' action point was particularly well received. They thought that it was very important to focus on social factors that contribute to cardio-vascular health.

- Dieticians in Coventry thought that there could be a role for expert patients in peer education.

- However, a minority of Liverpool PCT practice-based commissioning managers doubted the effectiveness of 'self-management'.

Liverpool PCT practice-based commissioning managers thought that the idea of interpreting services went against the national trend not to translate but to encourage people to learn to speak, read and write English instead.

The following comments on changes/improvements to the draft recommendation were made:

- Several respondents thought it was important to stress the need for engagement with and understanding of the target population, e.g. through social marketing techniques and collection of feedback from service users.

- SHA public health managers thought that it should be stressed that commissioners need to include these action points in their contracts and service specifications.

- Health trainers in Lambeth and Southwark thought that, due to a lack of funding and resources, home visits should only be offered in extreme cases, for example, where clients were unable to leave their homes. They thought that this should be made clear in the recommendation. GPs in Northampton were also concerned about who would be asked to carry out home visits. They said that they do not have the time.

- One consultant for public health, responsible for commissioning services, thought that it would be useful to refer to "gold-standard" services as a guide to aid implementation of the recommendation.

- Community pharmacists in Liverpool said that they are not equipped to deliver face-to-face services requiring interpreters. They suggested that this should be done in one or two central locations. Another suggestion was that there could be "roving" healthcare consultants, employed by the PCT who would move around different community pharmacies to deliver services.

- Practice nurses and health visitors in Coventry all welcomed the recommended actions. However, they were concerned about the practicalities of implementing the recommendation. For example, they wondered who would be responsible for the different elements of the recommendation and who would provide funding (e.g. who would pay for postal prompts?).

- One SHA assistant director thought that reference should be made to social marketing because she thought that this was important in terms of understanding the needs of disadvantaged adults at risk of CVD and other smoking-related diseases. This suggests that they may have missed the recommendation for social marketing activities in the text.

"Again, what's missing is talking about social marketing and the need to understand what motivates people, what their value systems are so that the messages and the settings, everything is provided in a way that will reach the objective."

Depth interview, SHA assistant director, North West SHA

- Smoking cessation and public health practitioners working for New Deal for Communities (NDC) teams in Hammersmith and Fulham said that they no longer carry out health equity audits and that this happens at a PCT level. They thought that it should be made clear which particular organisations should carry out each of the action points.

- Community nurses and health visitors from Liverpool were also concerned about home visits. They said that, given under-staffing, it would be difficult to fit this into their agenda unless it was part of an already agreed policy, for example visits by health visitors for babies/children or visits by district nurses to people who are unwell.

2.3.5. Barriers to implementation

There were a number of perceived barriers to the implementation of this recommendation:

- Getting commissioners on board and ensuring that they include the recommended actions in their contracts and service specifications. Some respondents (including the PCT commissioner and the SHA director for public health) stressed that unless commissioners do this, the recommendation will not be implemented.

- Managing tension between informing service users about healthy lifestyles and promoting empowerment of service users. Smoking cessation professionals working in the charitable and statutory sectors said that it was difficult to get the right balance between giving people responsibility for their own health by making them part of the solution to health inequality and health services taking responsibility for informing people about health risks. That is, the balance between "doing to" and "doing with". They said that many smoking cessation professionals want to "do with", rather than "do to" but worried that Recommendations 1 and 2 might lean more towards "doing to" unless they stressed the importance of social marketing and involving the target audience in the design of services.

- Lack of clarity in terms of who should take overall responsibility for ensuring the implementation of this recommendation – GPs in Northampton were concerned that without it being made clear who was responsible overall, the different groups included in the "who should take action?" might all leave it to each other to act. This concern was mirrored by community nurses and health visitors in Liverpool.

- Lack of appropriate skills and training within the NHS – for example, practice nurses and health visitors in Coventry felt that they were willing to contribute to the implementation of this recommendation but that they lacked the relevant smoking cessation training. community nurses and health visitors in Liverpool said that they would need training in self-management techniques in order to implement this recommendation.

"To some extent we have a very good health promotion agency across Lambeth, Southwark and Lewisham which, apparently is in the process of being decommissioned. So for the next few months, yes we do. But past June, July there isn't really any suitable training available. "
Depth interview, public health manager, New Deal for Communities (NDC), Hammersmith & Fulham

"I'd probably say we'd need more training to make sure that everyone was using the same information and a similar service."
Focus group, pharmacists, Northampton

- Non-standardised training – community pharmacists in Liverpool noted problems of transferring accreditation from one PCT to another, which resulted in pharmacists who underwent training by one PCT could not go on to work as smoking cessation professionals in other PCT areas, but would have to re-train. They said that this put some pharmacists off training as smoking cessation advisors.

- Many respondents thought that there is currently a reactive, rather than proactive culture in the NHS – i.e. NHS services respond to people who come to them, rather than proactively seeking out those at risk of CVD and other smoking-related diseases and trying to prevent future problems. They felt that this may be a barrier to the implementation of this recommendation

- Lack of evidence from the UK to support the recommendation (this was particularly important to the consultant for public health).

- Lack of multilingual literature and difficulties in accessing interpretation services (this was raised as a concern by smoking cessation professionals working in the voluntary sector).

"But, there are pockets of places where there are lots of people who can't speak English, Fulham is one of them. Say, for instance, near Heathrow, there is a Polish community who don't speak English, there is another one in East Ham or West Ham. Talking about leaflets and things, there are only so many leaflets you can have in a surgery, and they all get chucked. Children pick them and throw them across, if you're in an area where there's a specific ethnic minority, where you can have leaflets for that group, that's fine, but we've got a few patients that are Bangladeshi, and a few that are…and there's no point in us having lots of leaflets for each, so those people will be discontent, because we can't really provide that service, we can't have every leaflet in every language for everyone we service. They expect you to offer translation and interpretation facilities. You think in practice that's actually quite difficult to do?"
Focus group, GPs, Fulham

- Lack of translation facilities: health trainers in Lambeth and Southwark said that provision of translation facilities in their area was patchy. They thought that this could be a barrier to the effective implementation of this recommendation.

- National trend to integrate and encourage people to speak English, rather than translate: some respondents thought this might be a barrier to providing multi-lingual literature.

- Poor and unappealing facilities for the provision of services – e.g. public health practitioners working for a New Deal for Communities (NDC) team in Northampton said that the buildings for providing smoking cessation services in Northampton are

run down and shabby. They said that this is a barrier to the retention of at-risk disadvantaged adults.

- Lack of funding and resources:

    a) Community nurses and health visitors in Liverpool said that they would need more staff and funding in order to be able to implement this recommendation. In particular, they said that they would need extra staff and funding for transport in order to carry out further home visits. They thought that it was important to highlight this need for funding and resources.

    b) Community pharmacists in Liverpool said that they do not have the time and resources to provide a drop-in smoking cessation service or cholesterol tests for patients as and when they want it. They said that they have a heavy workload and are often unable to spare the time.

    "Our workload is fairly chaotic. We can't spare the time to provide cholesterol checks if we're involved in dispensing at the same time"
    Focus group, community pharmacists, Liverpool

    "I think some of the actions on here are quite resource-intensive as well"
    Focus group, SHA public health managers, Knowsley

- Challenges faced by target population in staying within the system:

    a) One community engagement lead for Liverpool PCT thought that the main barrier to the successful implementation of this recommendation was the fact that at-risk disadvantaged adults would find it a challenge to stay within the system. This individual said that primary care services are not always very good at tailoring their service to individual needs – e.g. at providing appointments at times when people are able to attend them. This individual said that the system needs "hard space" for open access to all.

    b) Dieticians in Coventry said that many people who are obese fear going to see their GP because they fear that they will be judged and do not like being weighed.

    c) Community pharmacists in Liverpool said that many patients who are prescribed statins by their GP end up returning them to the pharmacy because they no longer want to take them. This is rarely reported to the GP because pharmacists do not want to lose business by annoying GPs.

    d) Respondents from across professional groups thought that waiting times for appointments could put the target population off making and keeping appointments.

3. Recommendation 3

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?

- *Provide incentives for implementing strategies that improve proactive case finding, retention and access to services. The strategies should have clear and measurable objectives. The incentives may be positive (for example, performance bonuses) or negative (penalties if targets are not met).*
- *Support and sustain activities aimed at improving the health of people who are disadvantaged by:*
    - *a) using relevant indicators and ensuring target setting and exception reporting do not increase health inequalities*
    - *b) using local enhanced services to encourage the identification and continued support of those who are at risk of premature death from CVD and other smoking-related diseases*
    - *c) ensuring there are incentives for targeting people who are disadvantaged (for example, bonus payments).*
- *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 3: Key Points

Reference to who was included in the practice-based commissioning (PBC) groups should be clarified or expanded. Although a range of people are expected to take action, it was considered helpful if one organisation had overall responsibility for implementing the recommendations and guidance. One suggestion was that primary care trusts (PCTs) should be the organisations who had overall responsibility for implementation. Some considered that the recommendation would only be of use to them if the PCTs made sure that all professional groups who would be effective were clear about the targets and how they would be measured.

System-based incentives to recruit and retain target populations were an issue for all respondents. Their concerns included the equation of incentives with funding and the effects on the quality of services. Many believed that the system incentives need to be driven by national policy. There were concerns about the prospects of individual incentives for service providers because they thought that incentive schemes can put too much pressure on individuals. However, they did think that incentives to help motivate staff to reach targets were useful so long as they are realistic targets.

Barriers to implementation are:

- the impact of system-based incentives (and penalties for not achieving targets) on the provision and quality of services
- lack of public funding to provide system incentives
- concerns about the sustainability of incentive schemes and the effect on the behaviour of service providers
- professionals' concerns over the corporate culture of targets and incentives contradicting their humanistic approach to healthcare
- lack of support from commissioners
- concerns about how to monitor 'soft' outcomes that are not included in a national data set.

Suggestions for improvement are:

- adopting the term 'strategic planners' for use at local level. The term 'policy makers' was associated with national level policy making.
- clarifying the term 'relevant indicators' and what is considered to be 'reasonable'.

3.1. Target population

On the whole, respondents thought that the target population was clear and easy to understand in draft Recommendation 3 and thought that the appropriate groups have been included. However, some respondents were unclear about who was included in the target population and there were some suggestions for improvement and/or change:

o Many participants across professional groups were unclear about whether the system incentives were aimed at provider organisations or individuals within provider organisations. SHA public health managers in Knowsley suggested editing the title of the recommendation to "system incentives for providers" if provider organisations are the intended target.

"The target population of service providers, that's not specific enough in terms of getting incentives"
Mini group, health trainers, Liverpool

- Health trainers in Liverpool thought that "service providers" wasn't specific enough and that it should be expanded on to make clear exactly who was supposed to take action
- Some respondents thought that "practice-based commissioning (PBC) groups" was unclear:
    - Community pharmacists were unclear about whether they were included in the practice-based commissioning (PBC) groups.
    - Community nurses and health visitors in Liverpool and smoking cessation professionals working in the charitable sector thought that "PBC groups" should be expanded in the guidance for clarity (i.e. they thought groups falling under "practice-based commissioning (PBC) groups" should be listed).
- GPs in Northampton thought that PBC groups should not be included in the target population.
- Practice nurses and health visitors in Coventry and health trainers in Liverpool thought that employers should be included in the target population. They thought that employers should be incentivised to arrange workplace-based health checks.

3.2. Who should take action?

Overall, respondents thought that it was clear and easy to understand who this recommendation is asking to take action and thought that the appropriate groups have been included in the "who should take action?" section. However, there were some suggestions for improvement and/or change:

- GPs in Northampton thought that one group (primary care trusts) should be given overall responsibility for implementing this recommendation. They thought the danger was that otherwise no one would end up taking action

"So again, in my system I would say this has to be given to one group. It must be given to the PCTs, which if it's your job you have to do, or you can give it to the local authorities. Your councils."
Focus group, GPs, Northampton

- One SHA assistant director for public health thought that "strategic planners" would be a more appropriate term than "policy makers", as "policy makers" tends to be associated with national-level policy making, rather than local-level strategic planning.

"I think the, who should take action, are probably the correct people; policy makers, that always seems to equate with national level, whereas, at the

local level one's normally talking much more about strategic planning. Right, so strategic planners rather than policy makers are included."
Depth interview, SHA assistant director, North West SHA

- SHA public health managers thought that practice-based commissioning (PBC) groups should be included in the "who should take action?" section because they are included in the target population.

"In terms of staff, you've got PBC groups in the target population, who should take action presumably, they should have PBC groups in there as well."
Focus group, SHA public health managers, Knowsley

- Health trainers in Liverpool thought that workplace development leads should be included in the "who should take action?" section.

"I think the other people who I thought should take action, I mean for us, are health trainers. We've got community services in there, but I think health trainers need to be identified."
Depth interview, smoking cessation professional, Liverpool PCT

- One Liverpool PCT manager questioned the evidence base for the usefulness of including practice-based commissioning groups in the "who should take action?" section of this recommendation.

- Practice nurses and health visitors in Coventry thought that employers should be included in the "who should take action?" section.

"What about giving employers incentives to make them want to encourage their employees to get a health check and they get some incentive to make sure that happens?"
Depth interview, practice nurse, Coventry

- One smoking cessation professional in Liverpool PCT thought that health trainers should be included in the "who should take action?" section. This could be due to confusion about the type of incentive referred to in this recommendation.

3.3. What action they should take

3.3.1. Relevance

Overall, most respondents thought that this recommendation was relevant to them, either because they saw themselves as being involved in the planning or provision of system incentives or because they thought that they or their organisation might receive system incentives.

Community nurses and health visitors in Liverpool thought that the recommendation might impact upon them because they would be required to meet quotas in order for GPs to get incentives, rather than personal incentives.

Primary Care Trust (PCT) managers and commissioners thought that, whilst this recommendation is useful to them, system incentives need to be driven by national policy. They said that, as PCTs, they are driven by targets, as set by national policy. Health trainers in Lambeth and Southwark did not feel that this recommendation was relevant to them because they did not expect to receive incentives for carrying out their work.

3.3.2. Usefulness

Respondents' opinions varied in terms of how useful they perceived this recommendation to be to them in their professional role and their organisation. Views on how useful the recommendation was were linked to views on how effective it would be. Those respondents who thought that system incentives would be effective in improving services for disadvantaged adults at risk of CVD and other smoking-related illnesses were more likely to see the recommendation as useful. Those who worried that the recommendation would be ineffective or that it could lead to a decline in the quality of services were less likely to see it as useful.

- Some SHA public health managers thought that system incentives could be effective in terms of encouraging service providers to tackle health inequalities. They thought that this recommendation was useful because it set out a framework for providing system incentives.

- Community pharmacists and GPs thought that incentives would be effective in getting them involved in tackling health inequalities. They stressed that they needed extra funding for this. They said that the recommendation was useful because it might encourage primary care trusts (PCTs) to provide system incentives

One Liverpool PCT manager said that this recommendation would be more useful at a national level than at the local level. This individual said that national policy makers have "more clout" than local policy makers.

Community pharmacists welcomed this recommendation because they felt that they needed financial incentives to carry out work to recruit and retain disadvantaged adults who are at risk of CVD and other smoking-related illnesses. They equated "incentives" with funding.

GPs in Fulham thought that this recommendation was more useful to primary care trusts (PCTs) and local authorities (LAs) than to GPs themselves, since they thought it would be the PCTs and LAs who would provide the funding for system incentives.

Community nurses and health visitors said that this recommendation would only be of use to them if primary care trusts (PCTs) made sure that all professional groups who would be effective were clear about the targets and how they would be measured.

3.3.3. Clarity

Overall, all thought that it was clear and easy to understand what action should be taken. However:

- Many respondents, from all sample groups, thought it should be made clear whether system incentives were intended for whole systems or for individuals within systems (i.e. would there be bonus-style incentives for individual service providers?)

> *"I think, my confusion before about were these incentives aimed at providers or were these incentives aimed at individuals and I can see there, the first bullet point down, third line, that they're aimed at providers but it's not explicit, so that might need a little bit of work there. It should just say System Incentives for Providers."*
> **Focus group, SHA public health managers, Knowsley**

- Some wanted clarification on the types of system incentive that should be used.

- Some wanted clarification on the indicators that they should use in system incentives. For example, GPs in Northampton thought that the wording of the recommendation was ambiguous. In particular, they did not understand what "relevant indicators" means and thought that this should be clarified. In action point 3, they wanted clarification of what counts as "reasonable".

> *"This is uncomfortable for me. What are you expecting to penalise? How do you measure this?"*
> **Focus group, practice-based commissioning managers, Liverpool PCT**

- Some thought that there was a cross-over between recommendations 3 and 4 and wanted clarification on the difference between system incentives and individual incentives

- One medicines management lead at Liverpool PCT was unclear about what "exception reporting" means.

3.3.4. Effectiveness/appropriateness of recommended actions

There was a mixed response to the recommendation for system incentives:

- Some participants (including community pharmacists and one SHA assistant director for public health) welcomed the recommendation for system incentives and thought that they would improve the quality of service. They thought that this would lead to more effective recruitment and retention of disadvantaged adults at risk of CVD and other smoking-related diseases

- Some PCT managers and commissioners doubted the long-term effectiveness of system incentives. They said that incentive schemes tend to run for a fixed period

and that, beyond that period, the behaviour of service providers often reverts to how it was before the incentive scheme was put in place.

"We used to have a prescribing incentive scheme to meet targets. They did seem to work for the time when the incentives were in place but the target is not sustained when the incentives are withdrawn. Behaviour change is not sustained. For example, incentivising the prescribing of one drug instead of another works for the periods of the incentives. When the incentives are withdrawn, some practices will continue to prescribe the preferred drug, others will go back to the drugs they were previously prescribing"

Depth interview, medicines management lead, Liverpool PCT

- Community pharmacists wanted system incentives to apply to them. They thought that system incentives would be effective in engaging community pharmacists in efforts to proactively recruit and retain disadvantaged adults who are at risk of CVD and other smoking-related diseases.

- Some PCT managers and commissioners had concerns about the difficulty of getting the right balance between incentives and first class care.

- Some smoking cessation professionals working in the charitable sector had reservations about "system incentives". A number of them:

    a) were concerned about the prospect of individual performance bonuses. They thought that professionals working within the statutory sector should not be given extra money for doing their jobs

    b) were concerned that if services did not meet targets, money might be taken away from them and then they would decline further in their effectiveness

    c) thought that the Healthcare Commission annual reports should be sufficient as a system incentive

    d) suggested a scheme whereby services with ideas for innovation could apply for extra funding, as an alternative to system incentives.

- Smoking cessation and public health practitioners working for New Deal for Communities (NDC) teams mirrored the concerns of smoking cessation professionals in the public sector. They were concerned about the prospect of individual incentives for service providers because they thought that bonus schemes can put too much pressure on individuals. However, they did think that incentives can help motivate staff to reach targets if they are realistic.

- GPs in Northampton were concerned that if negative incentives were allowed, it could lead to ineffective services getting worse due to a lack of funding.

- GPs in Fulham said that they had experienced system incentives in the past for other initiatives and that they had not been effective. They therefore had doubts about the effectiveness of this recommendation in terms of recruiting and retaining disadvantaged adults who are at risk of CVD and other smoking-related diseases.

They felt that more research needed to be carried out into the effects of incentives and “the target driven culture”.

- Practice nurses and health visitors in Coventry also had concerns about how effective system incentives would be in achieving the desired goal of reducing premature mortality amongst disadvantaged adults from CVD and other smoking-related illnesses. They thought that without effective auditing, the system would be open to abuse. They reported incidents in which GPs had received incentives for carrying out actions that met the letter but not the spirit of targets.

- Community nurses and health visitors in Liverpool thought that it was important to have systems for evaluating initiatives to proactively recruit and retain disadvantaged adults who are at risk of CVD and other smoking-related illnesses. However, they had concerns about a culture of targets and incentives. They said that it does not fit with their humanistic approach and worried that it would lead to a corporate, “number-crunching” healthcare system, rather than one that was responsive to service users as individuals. They also worried about short-term targets, which might prevent important initiatives that would have long-term results from going ahead.

- SHA public health managers thought that this recommendation would be more effective if system incentives were based on a lifestyle-focussed approach to tackling health inequalities

3.3.5. Barriers to implementation

Perceived barriers to the implementation of this recommendation include:

- A lack of public funding to provide system incentives

> *“No, the only thing that I would think, again from a personal objective, is we're coming to the end of the project. We were unable to roll over any money this year, so financially some projects have had spend cut. We're not in a position to develop new ones yet, so if we were to implement these guidelines, this would be something that this target may not have much impact on, or be able to implement, really, but again that's literally just because of financial constraints.”*
>
> **Paired depth interview, public health manager and stop smoking outreach worker, New Deal for Communities (NDC), Hammersmith**

- Lack of support from commissioners

- Opposition to a culture of incentives for service provision (particularly within the statutory sector)

- Concerns about the sustainability of incentives schemes and effect on the behaviour of service providers: some PCT commissioners thought that incentive systems always end up running for a fixed period. They thought that there is little evidence to show that behaviour of service providers will continue beyond the period of incentivisation. They saw this as an argument against putting system incentive schemes in place.

- Concerns about how to monitor “soft” outcomes: dieticians in Coventry were concerned about how to monitor “soft” outcomes that are not included in the national data set. They said that statins are easy to monitor but that, by contrast, other indicators such as getting people to be more active, which they saw as important in preventing CVD, etc, are harder to monitor.

- National policy: community pharmacists thought that changes in government policy could be a barrier to the long-term implementation of this recommendation.

- Doubts about the effectiveness of incentives and the “target culture”.

Community nurses and health visitors in Liverpool thought that system incentives were already endemic in GP primary care services and that, therefore, there would be few barriers to the implementation of this recommendation.

4. Recommendation 4

Recommendation 4: individual incentives

Who is the target population?
Adults who are disadvantaged and:

- *who smoke*
- *who are at high risk of CVD due to other factors*
- *who are eligible for statins.*

Who should take action?
Service providers (for example, PCTs, general practices, community services, employers, local authorities and others with a remit for tackling health inequalities) and PBC groups.

What action should they take?

- *Provide people who are disadvantaged with incentives to use services to prevent ill health and improve their health.*
- *Provide people who are disadvantaged with incentives to improve their health by changing their behaviour. For example, offer them incentives to complete a treatment programme. (For recommendations on the broader principles of behaviour change, see 'Behaviour change at population, community and individual levels' [NICE public health guidance 6].)*

Recommendation 4: Key points

As with recommendations 1 and 2, some respondents thought it would be helpful to include further information on specific groups of disadvantaged adults most likely to be affected by CVD. Many thought that it would be helpful to include the risk factors for CVD and to identify the specific groups most at risk of CVD. Smoking cessation professionals in particular felt that this recommendation was relevant to them.

There were particular concerns about the use of individual incentives. Concerns fell into four categories: (i) concerns about the evidence base for individual incentives; (ii) doubts about the effectiveness of individual incentives in recruiting disadvantaged adults into health services; (iii) concerns about the type of incentive that would be used; (iv) concerns about the potential for corruption.

Barriers to implementation are:

- the moral fairness of providing individual incentives in order to effect behaviour change and the impact on those who are on low incomes who genuinely try hard to stay healthy
- the effectiveness of incentives in terms of encouraging disadvantaged adults to access smoking cessation and CVD prevention services. However, there were concerns about the abuse of this system and the potential for corruption. This was of particular concern if cash incentives were to be introduced
- lack of funding for the provision of incentives
- lack of trained individuals to deliver these interventions
- lack of evidence to support the effectiveness of individual incentives

Suggestions for improvement are:

- clarification on the type of incentive they should use with specific examples of good practice with disadvantaged groups
- the promotion of public education rather than incentives was needed in order to reduce health inequality

4.1. Target population

All respondents found it clear and easy to understand who the target population for this recommendation is and thought that the target population was appropriate. They welcomed the emphasis on targeting disadvantaged adults and thought that it was important to proactively target them.

As with recommendations 1 and 2, some respondents thought that it would be helpful to include further information on the specific groups of disadvantaged adults most likely to be affected by CVD. Respondents from a range of different professional groups, including GPs, community nurses, health visitors and commissioners, thought that it would be useful to include the risk factors for CVD and to pick out the specific groups (including ethnic groups, age ranges and genders) most at risk of CVD.

As with recommendation 1:

o GPs wanted people who would benefit from aspirin to be included

- Smoking cessation professionals working for primary care trusts (PCTs) wanted to be given a minimum age-limit for adults.

It may be necessary to make clearer in the guidance that localities need to carry out their own profiling of their population.

4.2. Who should take action?

Overall, respondents thought that it was clear and easy to understand who should take action. However:

- SHA public health managers thought that commissioners should be explicitly included in the "who should take action?" section
- Smoking cessation professionals thought that health trainers should be explicitly referenced here
- Health trainers in Lambeth and Southwark thought that health trainers should be included here. They said that they currently use incentives as a means of engaging with the community.

4.3. What action should they take?

4.3.1. Relevance

Overall, respondents felt that this recommendation was relevant to them. However some were uncertain as to what role they would play in giving out individual incentives and some had reservations as to how useful and effective individual incentives would be.

Smoking cessation professionals in particular felt that this recommendation was relevant to them. Some reported that they have already been using or considering incentives, including:

- Health vouchers
- Free access to local gyms
- Free gym kits (including towel, water bottle, etc.)
- Fruit/ other healthy foods

"Well, it is relevant, because obviously we help people from disadvantaged groups stop smoking"
Depth interview, smoking cessation manager, charitable sector, Liverpool

Health trainers in Lambeth and Southwark said that this recommendation is particularly relevant to them because giving out incentives is part of their strategy for engaging the public in health issues. For example, they give out stress balls, tape measures and

pedometers as a way of communicating health messages to the public. They focus on incentives that can help them go on to achieve their health goals.

Community nurses and health visitors in Liverpool said that this recommendation was relevant to them insofar as they could imagine that they might be involved in giving out individual incentives. However, they did not welcome the recommendation, saying that it does not fit with their professional goals. They said that they do not like giving things away in order to effect behaviour change because they think that it is unfair on those who try hard to stay healthy on low incomes.

4.3.2. Usefulness

There was a mixed reception to this recommendation:

- Smoking cessation professionals working in the charitable sector said that this recommendation was useful to them in terms of providing evidence-based support for work that they have already been carrying out or are planning to carry out in the future.

- Health trainers said that the recommendation would be more useful to them in their work if it referenced the health training guidance produced by the British Psychological Society. The reference would give them greater power within their organisations to set up incentives schemes.

- Some public health and smoking cessation practitioners working for New Deal for Communities (NDC) teams had a moral issue with the provision of financial incentives if these included money. To this extent, they were uncertain about how useful the recommendation would be to them in their work. They thought that incentives could be useful in terms of encouraging disadvantaged adults to access smoking cessation and CVD prevention services but were concerned about abuses of the system and corruption.

- Community nurses and health visitors in Liverpool thought that some individual incentives might be useful to them in their work in preventing CVD and other smoking-related diseases. For example, they thought that the offer of free statins might help them in improving the health of people with CVD. However, they thought that if individual incentives were free prescriptions, they would only have a limited effect because they would not provide an incentive for disadvantaged adults to, for example, improve their diet or take more exercise. They thought that the sorts of incentives given would have to be carefully thought out.

4.3.3. Clarity

Overall, respondents thought that it was clear and easy to understand what action this draft recommendation is asking people to take.

However, respondents from all groups in the sample wanted clarification on the types of incentives that they should use. They wanted to be given specific examples.

SHA public health managers in Knowsley said that they found the cross-referencing to other NICE guidance unhelpful. They said that they were interested in this area and that they wanted to find out more about other relevant NICE guidelines. However, they would prefer to have the relevant passages of other NICE guidelines appended, rather than just being signposted to them because they thought it unlikely that people would have all other NICE guidance to hand.

4.3.4. Effectiveness/appropriateness of recommended action

There was a mixed response to this recommendation in terms of how effective respondents thought it would be in reducing rates of premature mortality amongst disadvantaged adults at risk of CVD and other smoking-related illnesses.

Many respondents, from across all the sample groups, thought that public education, rather than incentives, was needed in order to reduce health inequality. They thought that the approach should be more about promoting wellness, healthy behaviour and personal responsibility for health, and believed that incentives could be perceived as "gimmicky".

Whilst they thought that public education and the promotion of healthy lifestyles were essential to long-term reduction of health inequalities, many respondents, across all sample groups, accepted that individual incentives could have a role to play in recruiting and retaining disadvantaged adults who are at risk of CVD and other smoking-related diseases.

However, there were reservations about individual incentives. Concerns fell into four categories: (i) concerns about the evidence base for individual incentives; (ii) doubts about the effectiveness of individual incentives in recruiting disadvantaged adults into health services; (iii) concerns about the type of incentive that would be used; and (iv) concerns about the potential for corruption.

a) *Evidence base for effectiveness of individual incentives:*

- PCT managers and commissioners wanted clearer references to supporting evidence about the effectiveness of incentives. Some also called for a clearer system for grading evidence that supports the effectiveness of individual incentives. They did not feel in a position to say whether individual incentives would be effective and said they practice evidence-based commissioning.

b) *Effectiveness of individual incentives in recruiting disadvantaged adults:*

- Some smoking cessation professionals working in the charitable sector had doubts about the effectiveness of incentives in terms of drawing people into smoking cessation services in the first place. However, they thought that they could be effective in keeping people in the system for short periods after initial contact.

- GPs in Northampton had doubts about the effectiveness of individual incentives in terms of either recruiting or retaining disadvantaged adults who are at risk of CVD or other smoking-related illnesses.

"Long term I wouldn't be sure. And there are very mixed messages as well. I mean, I'm of the opinion that freebies will only work a couple of times, but that's my opinion, I don't know. You need people to put value and take pride in stuff. Sometimes these things are based on that short term, aren't they? And that's a problem that has got to be addressed."
Depth interview, public health manager, New Deal for Communities (NDC), Hammersmith & Fulham

c) *Type of incentive to be used:*

- There was resistance to cash incentives across the board – respondents from all professional groups thought that these had a potential for corruption. Health trainers from Lambeth and Southwark said that they have used £10 cash incentives as a means of encouraging people to use stop smoking services, but they had doubts about the long-term efficacy of this.

- Health trainers in Liverpool thought that the recommendation would be most effective if it called for incentives that were given out over a long period of time – e.g. 10 visits to a gym, spread out over time, which people are only entitled to if they keep coming along to smoking cessation services, for example.

- Health trainers in Lambeth and Southwark said that they currently give out incentives. They said that they focus on incentives that can go on to help people achieve their health goals, for example tape measures, pedometers and stress balls. They said they think incentives help by engaging the client and offering a support to a programme – for example, a pedometer may encourage clients to take walking more seriously.

- Practice nurses and health visitors in Coventry thought that individual incentives would only be effective if there was flexibility in the types of incentives that could be offered. They also thought that even with individual incentives, lack of transport in Coventry would still prevent disadvantaged adults from accessing smoking cessation and CVD prevention services.

- Public health and smoking cessation practitioners working for New Deal for Communities (NDC) teams thought that free prescriptions would be effective in helping to stop smoking and lower cholesterol. They thought that anything further would be "stepping on stony ground".

- SHA public health managers in Knowsley thought that, in keeping with their preferred emphasis on the promotion of healthy living, incentives could include subsidised fruit and vegetables at local supermarkets.

- A community engagement lead for Liverpool PCT thought that activities would be more effective incentives long term than either cash or other gifts. For example, this individual thought that healthy-eating cookery courses would be more effective in improving long-term health than giving away free fruit.

d) *Potential for corruption:*

- GPs in Fulham had concerns about who would "police" the provision of individual incentives to avoid corruption. However, they thought that free

prescriptions could be effective in terms of encouraging disadvantaged adults to take steps towards avoiding premature mortality due to CVD and other smoking-related illnesses. This would require the support of national policy.

- Community nurses and health visitors in Liverpool also had concerns that individual incentives, in particular cash incentives, would be open to exploitation. They said that this would need to be closely policed.

"Who is going to do the policing? Let's say you go to the gym three times, do I have to hang on your tail to see that you are going to the gym?"
Group, GPs Fulham

4.3.5. Barriers to implementation of recommendation

There are a number of potential barriers to the implementation of this recommendation. Perceived barriers included:

- Lack of funding for the provision of incentives (this was a concern across the board)

- Lack of trained individuals to deliver these interventions (this concern was raised by practice nurses in Coventry and GPs in Northampton in particular)

- Lack of clarity around the sorts of incentives that should be offered (this was an across-the-board concern)

- Lack of evidence in support of the effectiveness of individual incentive: PCT commissioners and managers thought that it was particularly important to reference all evidence in the guidance. For example, Liverpool PCT practice-based commissioning managers said that opinions were divided in their team over how effective individual incentives are. They said that securing agreement from all commissioners to implement this recommendation would require clearer supporting evidence. SHA public health managers pointed out that the support of commissioners is key to the implementation of any initiative.

"Even our public health team are split on the efficacy of using incentives"
Focus group, practice-based commissioning managers, Liverpool PCT

- Concerns about the fairness of the system (i.e. providing incentives for disadvantaged service users only, rather than all service users, when using public money).

- Doubts about the long-term effectiveness of individual incentives in retaining disadvantaged adults in the system.

- Practical difficulties with the implementation of the scheme: GPs in Fulham had concerns about whether it would be possible to implement a system of individual incentives in practice.

- The view that incentives will not overcome some other barriers to disadvantaged adults accessing health services – e.g. transport issues, waiting times.

"Transport, if they aren't able to get there this is going to happen."
Depth interview, practice nurse, Coventry

In addition to the issues that respondents themselves perceived to be barriers to the implementation of this recommendation, the attitudes of respondents revealed further potential barriers:

- It was clear that a vocal minority of participants, from a range of different professional groups, had ethical objections to giving out individual incentives.

- Many participants were concerned that it was unfair to single out at-risk disadvantaged adults for incentives. For example, community nurses and health visitors in Liverpool said that they would be reluctant to give out individual incentives because they thought that it would be unfair to people on low incomes who try hard to lead health lifestyles and therefore are not themselves at risk of CVD and other smoking-related illnesses.

" I think one of the problems you might have is that if you've got groups that have got a mixture of people - from disadvantaged groups and people from not disadvantaged groups - you might actually get some discontent at the fact that, just because I go out to work, my tax is paying for this and I can't have it. So I don't know whether that would cause tensions on the ground organising - oh yes, you're unemployed, or, you're in the routine manual, you're in this group you only earn so much so you can have a voucher because you've come along to give up smoking, or, you're at risk of this so you can have a voucher - whereas, in actual fact it's quite difficult. So I think the people that would have a better opinion of that would be the stop smoking advisors, in particular on the ground, that will be saying, well, it will be really difficult for me to be giving this person a voucher and that person not. That doesn't mean to say that I don't think we should do it, but I think the implementation needs to look at the how, and the practicalities of doing that, and how you assess whether somebody's disadvantaged or not, because there's lots of ways of being disadvantaged."
Depth interview, smoking cessation manager, charitable sector, Liverpool

- Many respondents feared that there would be a negative response from the general public. They worried that people would see the giving away of incentives as a reward for "bad" behaviour and thought that "the media would have a field day". Fears about the response to giving out individual incentives could therefore also be a potential barrier to the implementation of this recommendation.

    - One SHA public health manager said that, in a previous job for Manchester PCT, he had been involved in a competition for smokers to win a holiday to encourage them to quit smoking. He reported a very negative response from non-smokers, angry that they had not been allowed to enter the competition. He said that there would need to be very clear guidance on best practice if he were to encourage individual incentive schemes in the future.

“When I was in Manchester, we did the Quit and Win with a holiday and the amount of complaints we got from people that weren’t smokers saying, ‘well, why can’t I enter this competition? Why are you giving it for smokers? It was unbelievable. So I do think there needs to be some sort of best practice on what sort of things you should do”

Focus group, SHA public health managers, Knowsley

5. Recommendation 5

Recommendation 5: partnership working

Who is the target population?
Adults who are disadvantaged and:

- *who smoke*
- *who are at high risk of CVD due to other factors*
- *who are eligible for statins*

Who should take action?
Planners, commissioners and service providers with a remit for tackling health inequalities. These include 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 activists who are in contact with people who are disadvantaged. (For recommendations on community engagement see 'Community engagement to improve health' [NICE public health guidance 9].)*
- *Establish links between practices and the community to identify how best to provide resources to improve the lifestyle of adults who are disadvantaged, specifically those who smoke, or who are at high risk of CVD from other causes, or who are eligible for statins. For example, support delivery of health initiatives as part of local neighbourhood renewal strategies.*
- *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.*

Recommendation 5: Key points

In terms of the target population, respondents raised the same issues as for recommendations 1, 2 and 4.

Overall the recommendation is clear and easy to understand and is thought to be relevant to organisations. In some areas partnership and multi-agency working are already part of their agenda for monitoring, proactively recruiting and retaining the target populations. Many thought it was crucial to stress the importance of partnership working, and this recommendation and guidance were useful in highlighting this as good practice.

Barriers to implementation are:

- the sustainability of partnership working
- inappropriate representation (i.e. people who lack the seniority to make decisions) on partnerships
- disparity in the goals and motivations of organisations working in partnership or in multi agency
- lack of time and resources to implement this recommendation
- the non-existence of any centralised system for coordinating records and no one available to carry out any such role

Suggestions for improvement are:

- clarify what is meant by 'planners' and which professions (if any) are included in this category
- clarify who should take overall responsibility for implementing this recommendation and who should allocate responsibility for each action point
- the term 'community leaders' would be a more appropriate term to use than 'activists' because only a small number of community leaders would want to be called activists
- clarify who is responsible for compiling and maintaining the database referred to in action point 4 and exactly what information should be included in the database
- clearer emphasis on primary care trusts (PCTs) and local authorities (LAs) to identify the challenges for effective partnership working
- emphasise the importance of partnerships for designated link workers
- more effective channels of communication between community service professionals and PCTs

5.1. Target population

All respondents found it clear and easy to understand who the target population for this recommendation is and thought that the target population was appropriate. They welcomed the emphasis on targeting disadvantaged adults and thought that it was important to proactively target them.

As with recommendations 1, 2 and 4, some respondents thought that it would be helpful to include further information on the specific groups of disadvantaged adults most likely to be affected by CVD. Respondents from a range of different professional groups, including GPs, community nurses, health visitors and commissioners, thought

that it would be useful to include the risk factors for CVD and to pick out the specific groups (including ethnic groups, age ranges and genders) most at risk of CVD.

As with recommendations 1, 2 and 4:

- GPs wanted people who would benefit from aspirin to be included
- Smoking cessation professionals working for primary care trusts (PCTs) wanted to be given a minimum age-limit for adults.

It may be necessary to make clearer in the guidance that localities need to carry out their own profiling of their population.

5.2. Who should take action?

Overall, respondents thought that it was clear and easy to understand who is being asked to take action by this recommendation. However:

- GPs in Northampton were unclear about what is meant by "planners" and whether GPs are included in this category. They did not see themselves as having responsibility for tackling health inequalities.

> *"Who the hell are the planners? Obviously it's not very clear there.. It's pedantic. It's not in our contract to take on health inequalities."*
> **Focus group, GPs, Northampton**

- Liverpool PCT practice-based commissioning managers and SHA public health managers in Knowsley thought that greater emphasis should be placed on the need for local authorities (LAs) to work with primary care trusts (PCTs).
- SHA public health managers in Knowsley thought that local businesses should be included as key partners in terms of delivering on health inequalities.
- Practice nurses and health visitors in Coventry thought that health action groups and community pharmacists should be explicitly included in the "who should take action?" section. They welcomed the fact that education and social services are included here.

> *"It is good that education and social services have been put in there as the people that should take action, and local authorities. You don't see pharmacists here and that should definitely be in there."*
> **Focus Group, Practices nurse and health visitors, Coventry**

- Health trainers in Liverpool thought that 'third sector agencies' should be explicitly included here. They thought that voluntary organisations have a crucial role to play in forging partnerships.
- Health trainers in Lambeth and Southwark thought that health trainers should be explicitly included here, rather than "just being lost in community services".
- Dieticians in Coventry thought that peer health researchers should be included here because they felt that they could contribute positively to partnership working on this issue.

- One community engagement lead for Liverpool PCT suggested that job centres should be included in the "who should take action?" section of this recommendation.

- Community pharmacists were unsure whether they were being asked to take action. They said that they do not currently get involved much in partnership working, but there was a very strong sense that they would like to be more involved. Community pharmacists in Liverpool said that they would like to be involved in partnership working – particularly in planning approaches to reducing health inequalities – rather than being told what to do at the end of the process.

5.3. What action should they take?

5.3.1. Relevance

Overall, respondents welcomed this recommendation and felt that it was relevant to their organisation. Most, including SHA public health managers, community nurses, health visitors, PCT managers and commissioners and health trainers said that partnership working at a local level is central to the aims and goals of their organisation.

> *"It's relevant to the SHA because we are very much trying to take a partnership approach to, for instance, working with the government officers around the local area agreement."*
> **Depth interview, assistant director, North West SHA**

> *"It's very relevant. I mean this is all around how we engage with the community, and we're trying to implement a NICE guidance around that."*
> **Depth interview, commissioning consultant in public health, Coventry PCT**

Some respondents felt that this recommendation was less relevant to them:

- Community pharmacists were unsure whether or not this recommendation was relevant to them. They said they are not currently involved in much partnership working. However, they were receptive to the idea of becoming more involved in partnership working in order to address health inequalities. GPs in Northampton felt that this recommendation was less relevant to them because they thought that it was not their role to tackle health inequalities.

5.3.2. Usefulness

Overall, there was a very positive response to this recommendation. They thought that it was crucial to stress the importance of partnership working and thought that this recommendation would be useful to them in doing so.

SHA public health managers in Knowsley said that this recommendation resonates very strongly with them because they are in a partnership with the local authority. They said that there is a very clear opening for further partnership work – e.g. with GPs,

community pharmacists and community activists, to ensure that there is buy-in on follow-up actions.

> *"We do a lot of partner work anyway. A lot of the projects that we fund are external. But I think there are improvements that could be made in the way that we work together, and I think having something like this would be a good starting point from the word go."*
> **Depth interview, public health practitioner, New Deal For Communities (NDC), Coventry**

Smoking cessation professionals thought that this recommendation could be made even more useful if it pointed out the resources currently available for engaging in partnership work. For example, they said that in Health Action Zone areas there should already be link workers to lead on forming partnerships. Not all respondents saw themselves as being directly involved in the implementation of the recommendation. GPs in Northampton did not see themselves as having a role to play here.

5.3.3. Clarity

Overall, respondents thought that it is clear and easy to understand what action this recommendation is asking people to take. However:

- Respondents from across the sample groups said that they would like clarification on who should take overall responsibility for the implementation of this recommendation and of who should allocate responsibility for each action point.

- GPs in Fulham thought that it should be clarified which individuals and organisations should play which roles in the establishment of partnership working.

- Some (including a local authority area public health manager working on a New Deal for Communities (NDC) project) thought that "community leaders" would be a better term to use than "community activists" because they thought only a small proportion of community leaders would want to be called activists.

> *"You could have activists included alongside other things, but I think community leaders is probably a better term. Community activists is one small section. There's a relatively small proportion of people who are community leaders, or who are very engaged with the local community. Leaders is, probably, just a more generic term."*
> **Depth interview, public health manager, New Deal for Communities, Hammersmith**

- One SHA public health director thought that it should be made clearer what local and national networks in particular should be developed and sustained. They thought that examples, such as the CVD network should be included.

- Some respondents wanted clarification on whether "establishing links between practices in the community" meant establishing links between GP practices or establishing links between health development practices.

- GPs in Northampton felt that action point 3 was difficult to understand because they thought that it was a multi-step action.

"It does make sense, but 'established links to identify to provide resources to prove disadvantage in the following group'... It's such a multi-step concept that it's a little difficult to know what they mean by that."
Focus group, GPs, Northampton

- Health trainers and smoking cessation professionals in Liverpool thought that it should be clarified who is responsible for compiling and maintaining the database mentioned in action point 4. Dieticians in Coventry thought it needed to be made clearer what exactly should be covered by the database.

"Develop and maintain a database of local initiatives - that needs to be a bit clearer. Who would do that? Would it be somebody in the public health? Would it be someone who deals totally with CVD?"
Depth interview, smoking cessation professional, Liverpool PCT

5.3.4. Effectiveness / appropriateness of recommended actions

Overall, respondents welcomed the recommended actions and thought that they were necessary for and would be effective in achieving the goal of reducing premature mortality amongst disadvantaged adults due to CVD and other smoking-related illnesses.

Several welcomed the development of a database to support partnership working.

"There is a main database so you can go in, see what services are there and what's happening. That would be good."
Focus group, practice nurses and health visitors, Coventry

I think it's a database that actually enables networks to develop that can tackle health inequalities across the different sectors."
Paired depth interview, public health manager and stop smoking outreach worker, New Deal for Communities (NDC), Hammersmith

There were some suggestions for improvement/change:

- SHA public health managers in Knowsley and PCT managers and commissioners thought that there should be a clearer emphasis on primary care trusts (PCTs) and local authorities (LAs) to identify the challenges for effective partnership working.

"I think it is a good idea to have a local initiative. There is good stuff in that, but it has to be a combined strategy followed by actions plans as to what would the local health community and local authority does."
Depth interview, practice-based commissioning (PBC) manager, Liverpool

- Some smoking cessation professionals working in the charitable sector suggested that it would be useful for services to have a designated link worker to form partnerships between local services because they saw communication between services as very important.

- One local authority area public health manager thought that it is crucial for the guidance to emphasise the value of working with the voluntary and community sector because they feel that it is a culture change for the NHS.

- GPs in Northampton thought that this recommendation was a good idea because partnership working is the only way to implement the other recommendations. However, they thought that it would be difficult to implement because different organisations have different motivations.

- Community pharmacists thought that it needed to be stressed that partnership working should be sustained. They thought that this was necessary in order for it to be effective in achieving desired goals.

- Practice nurses and health visitors in Coventry thought that this recommendation would be effective if implemented as stated. They saw it as an ideal for everyone to work towards. However, they thought that it would be difficult to implement the recommendation as stated.

- Community nurses and health visitors in Liverpool thought that care would need to be taken in terms of data protection. They stressed that patient confidentiality needs to be kept in mind when sharing information between different professional or community groups and agencies.

- Smoking cessation professionals suggested that the recommendation would be more effective if it suggested link workers to aid communication between different partner organisations:

> *"Communication is huge. So, one way might be by having a link person in each of those agencies so if you've got a contact name and number and if you need to update anything or they want to update anything, they can email or feed back to you. I think sometimes you need to coordinate them together a bit more. So, like if we do want to refer them on to someone else, they're not waiting weeks and weeks and weeks. It's not just about establishing those links but it's also about coordinating the sequencing and provision."*
>
> **Focus group, smoking cessation professionals, charitable sector, Liverpool**

5.3.5. Barriers to implementation of recommendation

Perceived barriers to the implementation of this recommendation included:

- Lack of clarity in terms of who should take overall responsibility for implementing this recommendation. As with other recommendations, respondents across different professional groups thought that the danger was that each organisation would leave it up to the others to take action.

> *"It is not clear who is responsible for this."*
>
> **Focus group, dieticians and rehabilitation nurse, Coventry**

- Non-existence of any centralised system for coordinating records and no one available to carry out any such role: practice nurses and health visitors in Coventry said that there is currently no coordinated system in their area. They said that, for example, a practice nurse would have no idea if patient had been to see a community pharmacist for advice on smoking cessation.

- Lack of time and resources (e.g. because smoking cessation services have to work towards targets and so do not always have time to develop and maintain links with outside agencies/organisations. GPs in Fulham raised this as a particular concern.

- Organisations not prioritising the development of partnerships and so sending people who lack the seniority to make decisions.

- Organisations having different goals and motivations.

- Practice nurses and health visitors in Coventry said that it can be difficult to get multi-disciplinary team meetings together. They said that it is hard to link professionals from different organisations and that, as a consequence, MDT **[multi-disciplinary team]** meetings rarely happen.

  "It is so hard to link up with other professional people. MDT meetings just don't happen."
  Focus group, practice nurses and health visitors, Coventry

- Lack of effective communication between different organisations.

- Negative attitudes towards health trainers: health trainers in Lambeth and Southwark thought that negative attitudes towards them (in particular from GPs, who were sceptical about the work they do) could lead to them being left out of local partnerships. However, they said that they felt this situation is improving over time. They thought that it would help to explicitly include health trainers in the "who should take action?" section of this recommendation.

- Logistical difficulties in terms of coordinating so many different stakeholder organisations so that they can be part of central theme (community engagement lead for Liverpool PCT).

Community nurses and health visitors in Liverpool said that they thought that undervaluing of the voluntary sector might be a barrier to them being open to working in partnership with statutory agencies. They said that a lack of funding for voluntary organisations might affect their ability to form effective partnerships.

Community nurses and health visitors in Liverpool reported that barriers between them and the PCT were increasing. They said that there is often a lack of effective communication and dialogue. This could be a potential barrier to effective implementation of this recommendation.

Some respondents reported that they could see no barriers to their organisation implementing recommendation 5.

6. Recommendation 6

Recommendation 6: training and capacity

Who is the target population?
Service providers (for example, PCTs, general practices, local authorities 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 practitioners have the necessary skills to help prevent ill health among people who are disadvantaged and ensure there are enough of them to meet local need. (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.)*
- *Ensure practitioners have the skills to identify and monitor people who are disadvantaged and can tailor interventions to meet their needs. (For examples of the skills needed see: 'Community engagement to improve health' [NICE public health guidance 9]; 'Behaviour change at population, community and individual levels' [NICE public health guidance 6]; 'Brief interventions and referral for smoking cessation in primary care and other settings' [NICE public health guidance 1]; '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 'Statins for the prevention of cardiovascular events' [NICE technology appraisal 94].)*
- *Ensure service providers and practitioners are capable of making services highly responsive to the needs of disadvantaged individuals and ensure there are enough of them to meet local need. 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 6: Key points

Overall, respondents thought that this recommendation was relevant to them and welcomed it because it provides evidence-based support. They thought that ensuring appropriate training and capacity was essential to the successful implementation of this guidance. The recommendation is useful to professionals in terms of giving them the skills and the capacity to proactively recruit and retain disadvantaged adults who are at risk of CVD and other smoking-related illnesses. This guidance complemented NICE guidance on smoking cessation.

Barriers to implementation are:

- time for professionals to complete the training
- funding and resources to implement the recommendations
- lack of availability of appropriate training organisations

Suggestions for improvement are:

- funding should be made available to provide appropriate training to professionals in order to implement this recommendation and guidance
- clarify who is a 'practitioner'
- expand action point 1 '….ensure there are enough of them to meet local needs' to include specific quality measures
- standardise accreditation training across all areas

6.1. Target population

All thought it was clear and easy to understand who the target population is. They thought that the appropriate groups were included in the target population.

6.2. Who should take action?

All thought that it was clear and easy to understand who is being asked to take action by this recommendation. However:

o One SHA director for public health thought that commissioners should be explicitly included in the "who should take action?" section

o Several respondents, including health trainers and public health practitioners working for NDCs, thought that voluntary and community groups should be explicitly included here

o Liverpool PCT practice-based commissioning managers thought that health trainers should be included here

o Health trainers in Liverpool thought that higher education establishments should be included

o A common view across all types of respondents was that one organisation should be given overall responsibility for ensuring that this recommendation is implemented because, with so many different organisations included in the "who

should take action?" section, there is a danger of each group leaving it up to the others.

"All these sections start with who should take action, right, 17 different groups. What should they do/speak to the groups about… So it's a little difficult to know who's doing what. They're not identifying who's got responsibility of making sure it's happened."
Focus group, GPs, Northampton

6.3. What action should they take?

6.3.1. Relevance

Overall, respondents thought that this recommendation was relevant to them and welcomed it. They thought that ensuring appropriate training and capacity was essential to the successful implementation of the other recommendations.

"Underpinning any of these lifestyle management issues with training of the workforce, and identifying a range of practitioners, is just core to what we're trying to achieve."
Focus group practice nurses and health visitors, Coventry

"If staff have the skills and are well trained to deliver, it's obviously going to reflect in the success of the programme."
Depth interview, public health practitioner, New Deal for Communities (NDC), Coventry

PCT managers and commissioners said that this recommendation is very useful to them because they look to NICE for evidence to support the commissioning of training. They stressed that they practice evidence-based commissioning. They said that the recommendation could be made more relevant to them by being a bit more specific about what types of training are effective and what evidence there is to support this.

6.3.2. Usefulness

All sample groups welcomed this recommendation and said that it would be useful to them in highlighting the importance of training and capacity for tackling health inequalities in general.

"Training in smoking cessation advice should be part of induction for anyone working for the PCT – like manual handling"
Depth interview, smoking cessation professional, Liverpool PCT

Practice nurses and health visitors believe if they had the appropriate training and resources in relation to smoking cessation they could provide an on-the-spot intervention, which would not require the person to either return to the surgery or to attend a centralised smoking cessation service.

Some practice nurses in Coventry felt that due to the centralised smoking cessation service local GPs have become less skilled at smoking cessation and that, as a result,

they miss key signs that should prompt them to take action. Therefore they thought that training was very important and thought that this recommendation would be useful in highlighting this.

"GPs ignore 'flags' that prompt them to take action."
Focus group, practice nurses and health visitors, Coventry

6.3.3. Clarity

Overall, participants thought that it is clear and easy to understand what action this recommendation is asking people to take. Smoking cessation professionals said that this guidance goes "hand in hand" with NICE guidance on smoking cessation. However:

- One local authority area public health manager felt that there was too much cross-referencing in this recommendation and that this might make it difficult for people to understand

- Health trainers from Liverpool thought that in action point 1 "...ensure there are enough of them to meet local needs" requires expansion. They thought that quality measures should be specified.

- Some respondents working for New Deal for Communities (NDC) teams thought that "practitioner" required clarification. They were unsure who would count as a practitioner.

  "Well, I would like to say what is a practitioner in this context, because a lot of areas are training up local people. And then you can have practice in community organisations that are practising around the issue of smoking and case finding. I think practitioners implies an individual; a professional, doesn't it? Whereas we are interested in getting people from the community to train up as smoking cessation advisors."
  Paired depth interview, public health manager and stop smoking outreach worker, New Deal for Communities (NDC), Hammersmith

- Health trainers from Liverpool thought that it would be clearer if there were separate recommendations for training and capacity.

6.3.4. Effectiveness / appropriateness of recommended actions

All participants welcomed this recommendation. They thought that there was appropriate training and that the capacity to recruit and retain disadvantaged adults at risk of CVD and other smoking-related diseases is crucial to the successful implementation of the other recommendations.

Community nurses and health visitors in Liverpool said that they thought that, if implemented, this recommendation would be effective in reducing premature mortality amongst those at risk of CVD and other smoking-related diseases. They said that ensuring that people have the necessary skills and training to engage with disadvantaged adults who are at risk could only help to decrease premature mortality.

There were some comments and suggestions for improvement:

- Practice nurses and health visitors thought that training would have to be unified across all professional groups in order for it to be effective. They thought that otherwise there would be pockets of success but failing areas alongside them.

- Many respondents, across professional groups thought that there should be standardised training across all areas, to avoid difficulties with some primary care trusts (PCTs) not accepting the accreditation standards of other PCTs.

Training will have to be unified across disciplines. If not, you will get pockets of successful areas and others will not be successful. There will not be the uniformity of service that is planned."
Focus group, practice nurses and health visitors, Coventry

"Training needs to be consistent and updated at regular intervals. Because you can start off in year one doing that and then four years down the line it's something different."
Focus group, smoking cessation professionals, charitable sector, Liverpool

- Dieticians in Coventry thought that the recommendation for training should include training for Pharmacists on providing medicines management advice to patients because they thought that patients value getting advice from community pharmacists.

"Work that we have done demonstrates that the public love that time they have with a pharmacist who can advise them on how to get the best from their medication in terms of what to take and when. Helping people manage their medication better can be effective and beneficial for the person and cost effective for the NHS."
Focus group, dieticians, Coventry

- Health trainers in Liverpool thought that action point 2 should reference the need for core skills regardless of practitioner group. They suggested a scheme modelled on the core competencies for all practitioners covered by Every Child Matters. They thought that this would help to make draft recommendation 6 more effective.

- One local authority area public health manager felt that it was crucial to include the need for training in public and patient involvement, in the development of services. They thought that understanding the needs of the target audience should be an important part of training in this area.

- Some smoking cessation professionals working in the charitable sector thought that refresher courses should be included in this recommendation, including refresher courses for pharmacists and GPS who have undergone basic two-day training.

- One community engagement lead for Liverpool PCT thought that the recommendation could be made even more effective by including training on raising awareness about healthy eating, since poor diet is a contributing factor to CVD.

6.3.5. Barriers to implementation of this recommendation

The main perceived barriers to implementation for this recommendation were:

- Time for professionals to take part in training:

    a) Some (in particular the SHA director for public health) felt that it was necessary for commissioners to stipulate a requirement for training in their contracts and service specifications.

    b) Community nurses and health visitors in Liverpool said that they were already having to undertake training courses unpaid and in their own time. They said that some GPs will not allow community nurses and health visitors to go on training courses during work hours. They thought that this was a potential barrier to the implementation of this recommendation.

    c) Community pharmacists in Liverpool said that locum pharmacists are often not allowed out for training courses and that they end up having to train in their own time. They said that this acts as a barrier to locum pharmacists attending training courses.

- Funding:

> *"In theory it's very good. But we've had the public health training thing before, it cost the NHS a lot of money, it cost the PCT a lot of money and then it was all shelved because of lack of funding and lack of resources. It cost thousands to roll it out, and then they shelved it. So, that was a big opportunity that was lost there."*
> **Focus group, practice nurses and health visitors, Coventry**

- Lack of availability of appropriate training organisations:

> *"It will be getting the staff to be released from their work, be it hospitals, or whatever; getting the time to be able to attend the training."*
> **Depth interview, smoking cessation professional, Liverpool PCT**

CONCLUSIONS AND RECOMMENDATIONS

- Overall, the recommendations were well received across all the groups who took part in the study.
- Respondents welcomed the fact that they highlight the importance of proactive case finding and retention in reducing premature mortality from CVD and other smoking-related illnesses.
- They thought it was useful to have evidence-based recommendations to support work that is already being carried out in this area.
- Most thought that recommendations 1, 2, 5 and 6 were particularly important in reducing health inequalities.
- Respondents thought that, in order for these recommendations to be put into practice, commissioners would need to be on board.
- Overall, respondents found it clear and easy to understand who the target population was, who should take action and what action should be taken for each recommendation.
- There were, however, some points that respondents thought should be clarified:
    - They thought it would be useful to list the risk factors for CVD and to specify which types of people (e.g. which ethnic groups, which gender, which age ranges) are most at risk of CVD. The guidance may need to make it clearer that localities should carry out profiling of their populations in order to identify (segment) their target population and plan action.
    - They wanted clarification of who counts as an adult.
    - They wanted all groups who were being asked to take action to be explicitly mentioned, rather than being grouped together under headings such as “community services”. This would ensure that all groups who are being asked to take action are clear that they are being asked to take action.

Key considerations for Public Health Interventions Advisory Committee (PHIAC)

The following issues for consideration by PHIAC have been drawn from overall analysis of responses to the recommendations:

1. It is important to clarify specific organisations or professional groups who should implement action points and who or which organisation has overall responsibility for implementing the recommendations and guidance.
2. It is considered essential that commissioners are on board with the implementation of these recommendations and guidance and the actions are included in their contracts and service specifications.
3. Training and the funding thereof is considered to be key to the implementation of these recommendations. The standardisation of training and recognition between

PCTs (transferability of training) is also important. Accreditation of the training therefore needs to be given consideration.

4. Sustained funding and the provision of adequate resources were considered essential to the effective implementation of all the recommendations. It was also considered important to allow enough contact time between health professionals and disadvantaged adults. This would require more funding and extra resources.

5. Respondents considered that premature mortality as a result of CVD and smoking-related diseases needs to be tackled holistically and that social care issues such as poor housing, unemployment and crime are integral to its solution.

6. Emphasis should be given to public education and the promotion of healthy lifestyles as a way of addressing long-term health inequalities. Respondents thought that this was essential. Many respondents, across different professional groups, thought incentives could also play a role. However some, in particular PCT commissioners, wanted clearer evidence that they work.

7. System and individual incentives to implement the advice raised a number of concerns, particularly on cultural and moral grounds and on allocation of resources. Most notably the need for system incentives needs to be driven by national policy. Individual incentives may put too much pressure on individuals and may not achieve short-term improvements in healthcare.

8. Which outcomes are included in the monitoring for system incentives and how they were collected was important. There are concerns that “soft” outcomes are not included in national data sets and are more difficult indicators to track.

9. Partnership working was considered essential to reducing premature mortality in disadvantaged adults due CVD and other smoking-related illnesses. However, more detail in the recommendation about how to form effective partnerships would be welcomed.

10. QOF data may not prove to be a reliable guide to finding disadvantaged adults who have been specified in the target populations. Other social marketing tools such as segmentation of population may be more effective in profiling target populations.

11. Taking account of cultural variations and actively targeting minority ethnic and disadvantaged groups was considered very important. However, some respondents thought the terminology used in the recommendations (e.g. “proactive”, “social marketing” and “non judgemental programmes”) might not mean a lot to front-line workers and therefore may not be very useful.

APPENDICES

1. Method and sample

1. Qualitative methods

Qualitative methods were selected as most appropriate for this study. The iterative nature of qualitative enquiry enables researchers to scope out in depth and detail the response across audiences to the main research questions. We wanted to understand what people thought of the recommendations and why they contributed particular views rather than to count how many people held particular views. We also wanted to make sure that participants were clear about the role of NICE CPHE and the status of the draft guidance and associated recommendations. Care was taken to check comprehension of the draft recommendations and consider their detail, complexity and implications thoroughly.

2. Group discussions and depth interviews

Where possible, group discussions were convened. Group interaction enables participants to trade views and experience, and to formulate more informed viewpoints in the process. It enables them to explore any positive and / or negative issues associated with the draft recommendations and their implementation. It also enables them to work more creatively, e.g. to develop solutions to any issues identified.

A group discussion would usually comprise four to eight participants and would last for 90 minutes. Group discussions would usually comprise homogenous participants (e.g. in terms of professional group, role and responsibilities) to ensure a group dynamic develops. Therefore, we generally aimed to convene group discussions with participants from similar professional backgrounds.

Of course, busy professionals can find it difficult to attend a group discussion at a fixed venue and time. However, given tight timescales for recruitment it was not always possible to conduct group discussions. Where it proved impossible to recruit a group we aimed to conduct individual depth interviews in its place. Depth interviews can be arranged at a time and venue of the participants' choosing. Depth interviews usually lasted around one hour.

In summary, we conducted 12 group discussions, two paired depth interviews and 12 individual depth interviews (see Section 3, Sample, below).

Where possible, NICE CPHE team members attended fieldwork to enable them to hear participants' views first hand.

3. Sample

The sample for this fieldwork included all professional groups (including statutory, voluntary and charitable) for which the draft guidance was developed.

The table below shows the number of respondents for each sample group that took part in the fieldwork. The table also shows the projected sample; that is the number of participants from each sample group that we aimed to recruit. The final sample is slightly lower than the projected sample. The primary reasons for this were the shortened recruitment period and difficulties in convening groups with busy professionals.

Type of respondent	Projected Sample	No. of Focus Groups	No. of Paired Depth Interviews	No. of Individual Depth Interviews	**Total No. of Interviewees**
SHA DPHs and Teams	8	1		1	**7**
PCT DPHs, Commissioning Directors & Performance Managers	8	1		1	**7**
PCT Teams, Health Clinicians, Specialists and Smoking Cessation Advisers	16	1		7	**10**
GPs	16	2			**13**
Community Pharmacists	16	2			**10**
Primary Care Nurses	16	2			**16**
Other (Voluntary, Statutory, Local Authority and NDC)	16	1	2	3	**11**
Health Trainers and Managers	16	2			**21**
Totals	**112**	**12**	**2**	**12**	**95**

4. Developing discussion guides

Researchers used an agreed discussion guide to structure interviews (see Appendix 1). Given the length and detail of the recommendations it was not always possible to cover both the context and the recommendations within the interview. We ensured that moderators covered each recommendation. Length of time spent on each recommendation by each respondent varied according to professional interests and

how much individual respondents had to say about each recommendation. We worked through the recommendations sequentially.

We pre-placed the recommendations with respondents to give them time to consider them in depth and detail in advance of fieldwork. Participants were also sent a “pre-task”, with questions about each recommendation, to encourage consideration of the recommendations prior to the focus group or interview. The pre-task also helped ensure that we had feedback from each participant on each recommendation and, therefore, acted as a safety net in case of time constraints.

5. Recruitment

We used an agreed sample and contact lists to ensure we got the right mix of participants in the study. We sent participants a letter of bona fides from NICE to convey the authenticity of the research (see Appendix 2).

6. Data collection, analysis and reporting, openness and transparency

All fieldwork was audio-taped and transcribed verbatim. Transcripts have been anonymised and stored securely. Researchers completed field notes to supplement transcripts.

Grid Analysis was used to ensure openness and transparency. In summary, Grid Analysis plots the response from each group in a specific row and groups the main themes in an individual column on the grid. Where there are different views within one group, this is marked. Findings recorded in the grid are referred back to the transcript to ensure transparency.

2. Discussion guide

NATIONAL INSTITUTE FOR HEALTH AND CLINICAL EXCELLENCE

Reducing the rate of premature deaths from CVD and other smoking-related diseases: finding and supporting those most at risk and improving access to services

A. INTRODUCTION

Timing	Topic Guide
5 minutes	*Welcome:* o introduce Dr Foster Intelligence, moderator and any observers *Introduce the consultation:* o The National Institute for Health and Clinical Excellence (NICE) have produced draft public health guidance on reducing the rate of premature deaths from CVD and other smoking-related diseases with particular reference to proactive case finding and retention. The focus of this guidance is on smoking cessation services and the provision of statins o NICE are now holding a consultation period in which Dr Foster Intelligence will test the draft recommendations within the guidance with the professionals who will have responsibility for implementing them. o The guidance is aimed at a wide range of professionals from the public, private and voluntary sectors. During the consultation period, the recommendations will be tested with representatives from each of the different professional groups who should take action *Let them know what impact their input will have:* o This is a very important stage in the development of the guidance. o NICE takes the views of professionals and the public very seriously and will consider them very carefully when revising the draft guidance. This is your opportunity to influence what the final guidance says. *Outline rules/taping/confidentiality:* o Please be open and honest – all views will be strictly anonymous o Ask permission to audio-tape fieldwork. Explain confidentiality and anonymity. Participating organisation names will appear in the final NICE report but individuals will not be identified.

B. WARM-UP

Timing	Topic Guide
5 minutes	Respondent(s) to introduce self, role & responsibilities

C. CONTEXT – *Explore what Individuals/Organisations are doing already*

Timing	Topic Guide
	In terms of the terminology you would use, would you talk about *compliance* with the recommendations or *concordance* with the recommendations? Why? Is there a different term that you would use to describe doing what the recommendations ask? If so, what? Why?
15 minutes	o What methods do you currently use to identify adults who are disadvantaged and have a higher than average risk of premature death from avoidable causes (in particular smoking/ factors contributing to CVD)?
	o To what extent and in what ways do you ensure that the services you offer (in particular those relating to smoking cessation/ CVD) are sensitive to cultural/gender issues?
	o Where and when do you currently provide health-related services for people from disadvantaged groups? o *Prompt: do you provide any drop-in/out of hours services? Do you do any home visits? To what extent are your services community-based?*
	o What, if any, support (e.g. transport, postal prompts) do you offer to help ensure that people from disadvantaged groups are able to use your services and/or comply with treatment?
	o What, if any, proactive support do you offer people from disadvantaged groups at greatest risk of premature mortality? o *Prompt: helplines? Brochures? Invitations to attend services? Providing GPs with postal prompts to remind them to monitor people who are disadvantaged and who have had an acute coronary event?*
	o Do you carry out health equity audits to determine how well your services are reaching people who are disadvantaged? How often?
	o What, if any, incentives (including financial) are you/your organisation provided with to implement strategies that improve proactive case finding, retention and access to services?
	o What, if any, incentives (including cheaper treatments/services,

	coupons or cash) do you/your organisation offer to people form disadvantaged groups to use services to prevent ill health and improve their health?
	o To what extent do you/ your organisation develop and sustain partnerships with professionals/ community activists who are in contact with people from disadvantaged groups?
	o What training is available to you/ people working within your organisation to ensure that you have the necessary skills to help prevent ill health among people from disadvantaged groups? o What training is available to you/others working within your organisation to ensure that you are capable of making services highly responsive to the needs of disadvantaged individuals?

D. EXPLORING RESPONSE TO EACH INDIVIDUAL RECOMMENDATION

Timing	**Topic Guide**
45 minutes	*Explore how clear and easy the recommendation is to understand:*
	o To what extent is it clear who the target population for this recommendation is? o Could this be made any clearer? If so, how?
	o To what extent is it clear who is being asked to take action? o Could this be made any clearer? If so, how?
	o To what extent is it clear what the recommendation is asking people to do? o Could this be made any clearer? If so, how?
	Explore relevance of recommendation to respondent/respondent's organisation:
	o Is this recommendation asking you/ your organisation to take action? o Should it be? Why?
	o Does the target population of the recommendation cover population groups with which you work?
	o If implemented, would the recommendation impact on you/ your professional group/ your organisation? o How? Why?
	o How could the recommendation be made more relevant to you in your professional role/ your organisation?
	Explore whether respondents think the draft recommendation will be effective/useful & what could be done to make it more so:
	Thinking in terms of smoking cessation services and the provision of statins: o If implemented, to what extent do you think that the interventions suggested in this draft recommendation would help to reduce the

	rate of premature mortality amongst people who are disadvantaged through proactive case finding and retention?
	o What, if anything, do you think could be done to make the recommendation more effective in terms of achieving the goal of reducing the rate of premature mortality?
	Thinking in terms of smoking cessation services and the provision of statins: o How useful is this recommendation to you in your professional role/ your organisation in terms of reducing the mortality rate amongst adults who are disadvantaged through proactive case finding and retention?
	o How, if at all, could the recommendation be made more useful to you in terms of reducing the mortality rate of adults who are disadvantaged through proactive case finding and retention?
	Explore barriers to implementation and factors that might help implementation of draft recommendation:
	o Do you/ individuals in your organisation feel that you have the training/ confidence to implement/ play a part in implementing this recommendation?
	o Does implementing/ playing a part in implementing this recommendation fit with the goals of your professional role/ your organisation?
	o What, if any, organisational or resourcing barriers are there to you/ your organisation implementing this recommendation? *Probe: Funding? Staffing? Time constraints? Organisational policies/structures/processes?*
	o What, if any, factors external to your organisation (e.g. national policy/ input from other organisations) could help or hinder the implementation of this recommendation? Why?
	o What different professionals/organisations do you think should play a role in implementing this recommendation? What roles should they be? Why?
	o How do you think the draft recommendation could be made more feasible (or do-able)?

E: OVERVIEW

Timing	**Topic Guide**
5-10 minutes	o Overall, which of the draft recommendations will have the most or least impact and why?
	o Which of the draft recommendations do you think should take the highest priority and why?
	o What three things could NICE CPHE do to make sure you/ your organisation implements the recommendations and why?
	o Any other thoughts on how the draft recommendations could be improved? Why?

3. Letter of Approach and Bona Fides

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NICE CPHE PROACTIVE CASE FINDING AND RETENTION GUIDANCE

I am writing to ask for your help with an important stage in the development of guidance by the National Institute of Clinical Excellence Centre (NICE). Our Centre for Public Health Excellence (NICE CPHE) is developing guidance aimed at locating, recruiting and supporting people at risk of health inequalities.

We want to consult with people who work with or are responsible for recruiting those at risk of health inequalities. We need your input to help us make sure that our recommendations are relevant, useful, feasible and implementable. Therefore your feedback is extremely important to us. We are especially keen to involve professionals working with those at risk of health inequalities to make sure that our recommendations work for you. Anything you tell us will be treated in the strictest confidence. No individuals will be identified and no quotes will be attributed to any individuals or organisations. However, a list of participating organisations will be published as an appendix to the report.

NICE CPHE is an independent organisation, created by central government, to be responsible for providing national guidance on promoting good health and preventing and treating ill health. The objective of NICE's public health guidance is to bring about social, economic, organisational, community and individual change to improve health and reduce inequalities in health.

I do hope you will be able to take part in this important project. If you have any queries about the research, please contact James Jagroo, Analyst for the CPHE

at NICE on 0161 870 3116 or Nigel Jackson, Head of Research Services at Dr Foster Intelligence on 0207 332 8800.

Yours faithfully

Anthony Morgan

National Institute for Health and Clinical Excellence