School *for* Health

Guidance for the NHS and other sectors on interventions that reduce the rates of premature death in disadvantaged areas: proactive case finding and retention and improving access to services

Mapping review

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Executive Summary

Background
In August 2006 the Centre for Public Health Excellence (CPHE) at the National Institute for Health and Clinical Excellence (NICE) was asked by the Department of Health to develop intervention guidance for the NHS and other sectors on interventions that reduce the rates of premature death in disadvantaged areas through proactive case finding, retention and improvement of access to services. This review, one of four commissioned to inform the guidance, maps relevant projects, service developments and other initiatives and was carried out between May and August 2007 by a team based at Durham University.

Aims
This review aimed to identify and describe interventions on smoking cessation and the use of statins for under-served areas and disadvantaged groups in relation to three areas:

- proactive case finding;
- retention;
- improvement of access to services.

Methods
Projects and interventions for both topic areas were identified using four methods:

- telephone interviews
- documentary analysis
- questionnaires
- scanning of selected conference archives and databases (where these were available online).

Work was carried out in two phases over a three month period: an initial exploratory phase; and a second phase that focused on mapping local interventions.

In phase 1, 54 semi-structured exploratory telephone interviews were carried out with representatives from a wide range of organisations at national and regional levels, in order to identify contacts at local level, interventions and key approaches. Selected conference archives and project databases were also scanned. During phase 1, categories of interventions were identified that were subsequently used to structure results in phase 2.

In phase 2,, interventions were identified through completed questionnaires from local stakeholders, and through analysis of local documents. Questionnaires were sent to regional/national leads for distribution to NHS stop smoking service managers and the All Wales Tobacco Forum, tobacco control coordinators (Northern Ireland), cardiovascular disease nurse leads, PCT pharmacy advisers, and PCT CHD leads. In addition, documentary analysis of PCT Local Delivery Plans and Local Area Agreements for the Spearhead areas (62 PCTs and 70 local authorities), where these were available, was carried out and other relevant documents were searched opportunistically. Less detailed searches were carried out for a sample of 60 non-Spearhead PCTs.

Results

Local priorities (including how interventions are combined) are influenced by national targets and the way in which they translate into local targets and priorities. Both areas of this mapping review - smoking cessation and the use of statins - are located within this policy context. Different activities seem to be required for achieving the 'quick wins' needed to meet 2010 national inequalities targets, than are needed for health improvement over the longer term .

Tackling disadvantage by increasing the numbers from disadvantaged groups and areas who successfully give up smoking, or who are treated with statin therapy to reduce their risk of cardiovascular disease (CVD), is, in part, a function of the effective targeting of services. Our review provides examples of the different approaches that are currently being used to identify target populations. These include:

- ward-based (or Super Output Area) based approaches
- the use of GP practice registers
- health equity audits (for both heart disease and for smoking)
- lifestyle surveys
- client databases.

This review also documents the use of new geo-demographic tools such as Mosaic.

Reaching these target populations is more complex. Social marketing techniques and other approaches based on understanding the needs and motivations of different groups of smokers are being used to increase awareness and use of mainstream services. The use of ex-smokers as advisers, and the recent introduction of health trainers to provide lifestyle support, are also examples of a more client-centred approach.

This review identifies many interventions designed to make services more accessible. However, these interventions do not fit neatly into categories of 'proactive case finding' and 'improving access to services' as, for both smoking cessation and statins, the two areas are closely related and providing community-based accessible services also enables proactive case finding.

Many smoking cessation services identified in this review were adopting client-centred approaches including more flexible times and locations for clinics, drop-in models and rolling programmes (the mainstream service in some areas). Services may be provided in community-based locations in disadvantaged wards, or via a wide range of leisure and work locations, including pubs, clubs and bingo halls, and through other initiatives such as Sure Start. They can be targeted at specific groups (e.g. pregnant women in disadvantaged areas, or black and minority ethnic groups). A number of areas reported success with drop-ins, free NRT, social marketing techniques, stop smoking shops, and widespread availability of level 2 advisers..

This review also illustrates several different approaches to identifying those at risk from cardiovascular disease, from city-wide proactive case finding across practice populations, to interventions targeted at practices in disadvantaged areas, or combinations of practice and community-based proactive approaches targeted at specific groups. Pharmacies, one stop shops and roving clinics are among the options for community-based proactive case finding. Practice-based approaches to identifying target populations fall into two main areas: Those related to better performance against the Quality and Outcomes Framework (QOF) and NSF standards; and those which build on practice registers to develop proactive approaches to case finding. Software development is key to identifying practice

populations at risk, given current difficulties. This review took place at a time where there is a lack of alignment between QOF incentives and national guidance and while this gap informs local incentive schemes currently being developed, the situation is also subject to change.

Incentives provided through the local enhanced service element (LES) of the GP and pharmacy contracts are also being used in innovative ways to target disadvantaged groups and areas for both smoking cessation and screening for statins. Many PCTs are adopting the local enhanced service element of the nGMS contract to improve stop smoking services in primary care, and there is local evidence that this is effective. The use of pharmacies to help target specific areas is evident in a number of PCTs, and activities include proactive case finding (through, for example, Heart MOTs) and involvement in NRT voucher systems. There are also examples of promoting concordance with statin therapy and providing on-going support for quitters. Pharmacy-based approaches have many advantages, such as high street locations, commercial marketing experience, and long opening hours.

Follow up by text, phone (including telephone consultations) or letters are used for relapse prevention in smokers, but it is also suggested that flexible drop in services and support from others (who could be at different stages of the quit process) are also helpful. Service level agreements may be implemented to help reduce drop out rates.

In relation to concordance with statin therapy, as well as working through the QOF, or through concordance structured medication and medicines use reviews, the review found examples of statin audits carried out through community pharmacies. There was also evidence of more targeted approaches in development, including prompts for compliance through text messaging or inclusion in local incentive schemes.

Discussion

This mapping review is a snapshot in time, and its content is influenced by those who responded to our requests for information and the availability of relevant documents. In spite of these limitations, this review presents a good overview of the range of interventions being adopted, providing a framework within which to consider the range of activities being developed. It also highlights gaps in knowledge and practice.

This review identified a large number of interventions targeted at disadvantaged groups and areas, and a broad range of ways in which national targets are translated into local interventions. These interpretations of national priorities reflect local contexts, needs and population groups. With a range of different models emerging for flexible outreach and proactive case finding, there is a case for carrying out further research into the costs and benefits of different approaches to providing smoking cessation services (such as drop-ins), and the impact on inequalities of different models of community-based opportunistic screening for cardiovascular disease. There is also scope for applying what has been learnt from outreach methods in smoking cessation to other areas, including screening for cardiovascular disease, and work to develop joint approaches.

Few examples of evaluation were identified, partly because many of the activities associated with evaluation are locally considered to be part of mainstream service provision (rather than separate initiatives) and are therefore less likely to have been written up or reported.. However, the wealth of examples here provides fertile ground for further comparative analysis, recognising that certain outreach activities are dependent on the local context. Smoking cessation services are often eclectic and opportunistic in their choice of locations, and in the ways in which they capitalize on

national campaigns. Furthermore, smoking cessation activities do not occur in isolation. They are often combined with keep fit activities, other community or work-based healthy lifestyle initiatives, incorporated into a wide range of community development initiatives or form part of wider tobacco control strategies.

While the local enhanced service element of pharmacy contracts and GP contracts can provide a vehicle for PCTs through to target disadvantaged groups, more research on differential uptake is needed. There are also concerns that GP registers may under-record prevalence. Monitoring the implementation of a local enhanced service will allow uptake to be evaluated, which could inform the future development of this incentive.

This review considers interventions separately for both topic areas. Yet in practice, different kinds of approaches are often combined. For example, some stop smoking services may use a social marketing approach inform messages that are used to target priority groups in order to promote client-centred services that reflect the communities in which they are located.

Strategies to address inequalities in health combine and prioritise interventions in different ways. The effectiveness of specific interventions in reducing rates of premature morality may therefore need to be considered in the context of broader local strategies for narrowing the health gap.