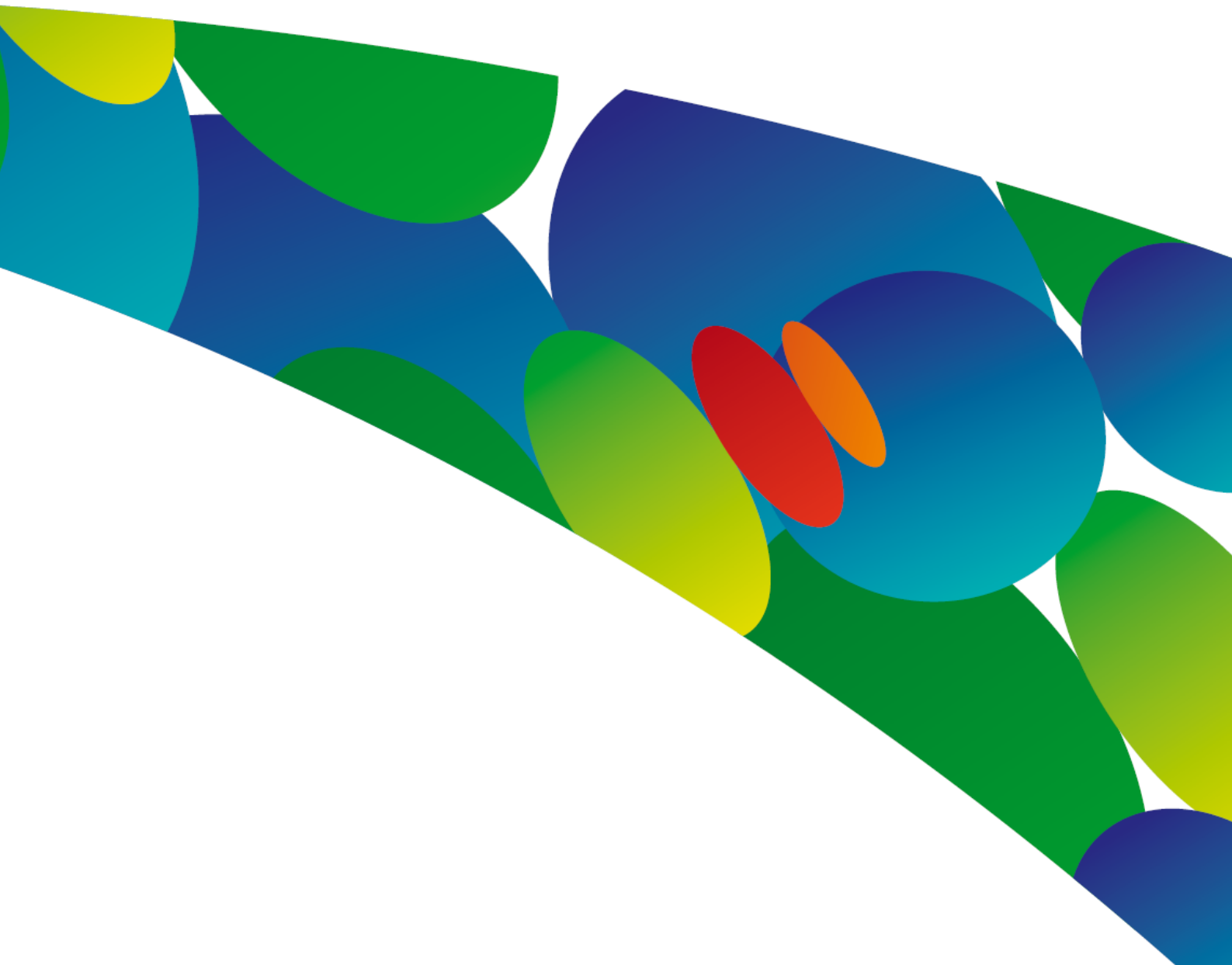


Health Inequalities National Support Team

**Priority actions based upon best practice
that could impact inequalities in mortality and
life expectancy in the short term**



DH INFORMATION READER BOX

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Description	This workbook was developed by the Health Inequalities National Support Teams (HINST) with 70 local authorities covering populations in England. Local areas could use this approach when analysing whether a population level improvements could be achieved from a set of best-practice and established interventions. This is offered as useful resource for commissioners: use is NOT mandatory. It is a diagnostic to analyse the approach to stroke prevention and management in a local area. Through a series of questions and reference to evidence based interventions, it allows a group of local partners involved in delivering services for people with CVD, to determine what would need to be done to achieve a population level outcome through the delivery of these evidence based interventions.
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Contact Details	Health Inequalities National Support Team East Midlands Directorate of Health and Social Care Government Office East Midlands Belgrave Centre, Nottingham 0115 9714746 (Ann Goodwin)
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Foreword

National Support Teams (NSTs) were established by the Department of Health from 2006 to support local areas – including Local Authorities, Primary Care Trusts (PCTs) and their partners – to tackle complex public health issues more effectively, using the best available evidence. By undertaking intensive, ‘diagnostic’ visits to local areas, spending time with key leaders (commissioners and providers) including clinicians and front-line staff, the ten NSTs provided intelligence, support and challenge to local areas to assist in their achieving better public health outcomes. The programme finished in March 2011.

The ten subject specific teams (Sexual Health, Tobacco Control, Health Inequalities, Teenage Pregnancy, Childhood Obesity, Alcohol Harm Reduction, Infant Mortality, Response to Sexual Violence, Vaccination and Immunisation and Children and Young People’s Emotional Wellbeing and Mental Health) were commissioned and established with a focus on improving health and reducing health inequalities.

The ten teams undertook more than 480 visits to local partnerships during the course of the programme and their findings and successes have been documented in Knowledge Management and Evaluation reports. Each team also produced reports setting out and consolidating the learning from their work. A further report that captures best practice identified by each team is planned to enable local areas to continue using the expertise and lessons learnt from the NST model.

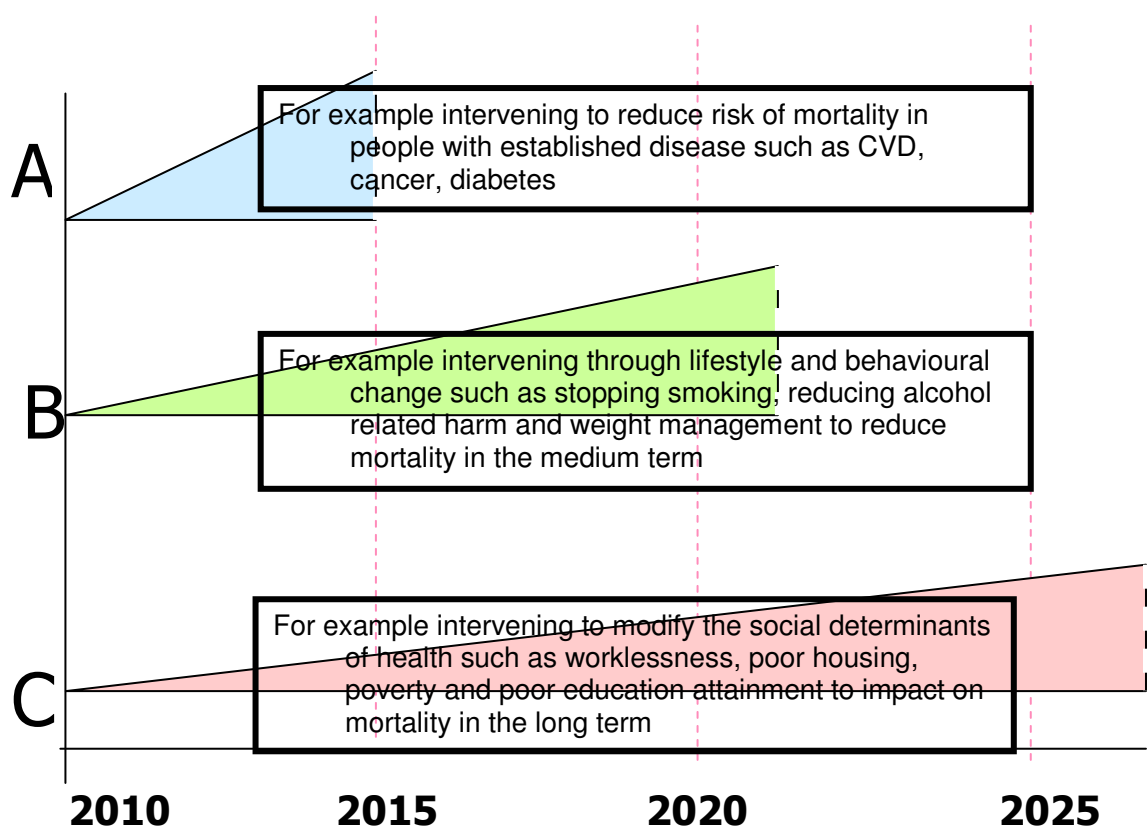
The NST process involved a desk review of key documentation and data-based intelligence, and interviews with key informants, often in combination with a series of workshops or focus groups. Collation and analysis of findings was immediate, and the findings, including strengths and recommendations, were fed back straight away and on site to the key local players and leadership. Recommendations were accompanied by offers of support, either at the time of reporting, or as part of follow-up activity. The Department is publishing a number of reports which distil the learning from the programme, and exemplify the methodology employed. This document (Priority actions based upon best practice that could impact inequalities in mortality and life expectancy in the short term) is a summary of local views on good practice. The suggested approaches are not mandatory, and reflect learnings from a snapshot in time. Where there is clear established evidence to support interventions, this has been signposted in the footnote. This is offered as useful resource for commissioners: use is NOT mandatory.

The Health Inequalities National Support Team (HINST)

The Health Inequalities National Support Team (HINST) has worked in the ways described above with the 70 local authorities covering populations in England with the highest levels of deprivation and poorest health. An area of focus was on how areas could reduce inequalities in life expectancy and mortality within a short timescale (while also working on interventions which would have an impact within medium and longer timescales). This is demonstrated in the diagram below.

The NHS White Papers *Equity and Excellence: Liberating the NHS*¹ and *Healthy Lives, Healthy People: Our strategy for public health in England*² and the *Health and Social Care Bill 2010 - 2011*³ all make clear that tackling health inequalities will be a priority for the NHS Commissioning Board, GP Commissioning Groups, the local authority-led Health and Wellbeing Boards and the new Public Health Service.

Health Inequalities Different Gestation Times for Interventions



[Figure 1: Health inequalities: different gestation times for intervention

¹

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_117353

² <http://www.dh.gov.uk/en/PublicHealth/Healthyliveshealthypeople/index.htm>

³ <http://healthandcare.dh.gov.uk/bill/>

Introduction

As a result of their work HINST has developed a set of priority actions based upon best practice to support areas in implementing interventions that will reduce the health inequalities of their populations. The priority actions are a consolidated list of the essential components that can be expected to impact on mortality in a short timescale (see 'A' – figure 1). The list of eight actions outlined below is expanded on the pages that follow.

HINST has also developed a set of resources to support areas with best practice examples and guidance on implementation of many of these priority actions. These are available at <http://www.dh.gov.uk/HINST> and signposted throughout this document. The resources are designed to help areas identify and address those factors that are important in the systematic and equitable delivery of health improvement. They should, therefore, provide a good framework for early identification of local solutions driven by the new perspectives being brought to bear.

The NHS also faces a challenging financial environment during the transition. Through the Spending Review, the Government protected the NHS, with cash funding growth of £10.6bn (over 10%) by 2014/15. Nevertheless, by historical standards this remains extremely challenging and the NHS has been developing proposals to meet the Quality, Innovation, Productivity and Prevention (QIPP) challenge of efficiency savings of £20bn by 2014/15 for re-investment. This means that considerations of affordability and evidence on the cost-effectiveness and cost-benefit of suggested interventions should be central. Where possible, priority should be given to interventions that are likely to lead to cash-releasing savings that can be re-invested in other services, based on a sound evidence base.

HINST priority actions – Summary

Priority Action 1 – Strategy and governance

Do strategic and operational planning processes support planning to meet local outcomes set to tackle health inequalities?

Priority Action 2 – Setting appropriate outcome goals

Have outcomes been defined according to the range of parameters most appropriate for the local area?

Priority Action 3 – Modelling the numbers

Has the number of deaths that need to be deferred, if outcomes are to be met locally, been modelled?

Priority Action 4 – Driving up primary care quality and capacity

Are primary care quality and capacity sufficient?

Priority Action 5 – Proactive chronic disease management

Is the optimum use being made of primary care registers to manage chronic disease for:

- secondary prevention of cardiovascular disease (CVD) and acute CVD
- management of diabetes

- management of chronic obstructive pulmonary disease

Priority Action 6 – Frontline service engagement

Are systematic and scaled-up processes in place to support frontline staff to make health gain everyone’s business?

Priority Action 7 – Community engagement

Are structures to engage communities fully harnessed to support short-term health improvement?

Priority Action 8 – Delivery plans

Do delivery plans include all items from Priority Action checklists for:

- cancer
- tobacco and smoking cessation
- seasonal excess deaths
- infant mortality

Priority Action – Details

Priority Action 1 – Strategy and governance

Inclusion of outcomes with a credible set of delivery plans in local strategic plans

Do strategic and operational plans for GP commissioning and the Health and Wellbeing Board strategic plans include detailed actions, demystifying how the locally agreed health inequalities outcomes will be achieved?

- 1.1 Is there coherence within plans that ‘demystifies’ how each locally agreed health inequality outcome is to be reached?
- 1.2 Do these plans identify other causes of death that will be addressed as part of the planning process (e.g. chronic obstructive pulmonary disease [COPD], stroke, alcohol, and seasonal excess deaths)?
- 1.3 Is there a clear plan for resourcing the programme to address outcomes, taking into account the breadth of actions and scale needed?
- 1.4 Are the inequalities outcomes and the practical plans to hit them agreed as partnership priorities?
- 1.5 Is there appropriate, specific, assigned leadership with responsibility across partnership organisations for delivery on each of the local outcomes? Is there authority to act across all component pathways?
- 1.6 Are leadership responsibilities for delivery on health inequality outcomes appropriately shared across the partnership (including GP commissioners), and not automatically assigned to public health?

- 1.7 Are there structures and resources for, and a culture of, performance management to drive and ensure timely delivery at a local level?
- 1.8 Is there a process to engage in detail around health inequalities outcomes with:
- Emerging GP commissioners
 - Overview and Scrutiny Committee
 - Current Health and Wellbeing Boards

Priority action 2 – Setting appropriate outcome goals

Have outcomes been defined according to the range of parameters most appropriate for the local area?

- 2.1 Have the following parameters been considered and the most appropriate chosen to set local outcome goals?
- Inequality from the national average:
 - wards in worst national decile/quintile
 - super-output areas (SOA) in worst national decile/quintile
 - Worst quintile by ward of each local authority, compared with:
 - best local quintile
 - local average
 - national average
 - Pockets of deprivation - sometimes aggregated (e.g. using natural neighbourhoods/ SOAs) into quintile of most deprived population for comparison and monitoring
 - Worst population decile measured against the best – Slope Index⁴
 - Communities of interest (e.g. Black and minority ethnic groups) compared with local averages
 - Diffusely spread families and individuals of interest (e.g. people with learning disability, enduring mental illness, low IQ, chaotic families)

Priority action 3 – Modelling the numbers

Has the number of deaths that need to be deferred - if outcomes are to be met locally - been modelled?

- 3.1 Has the current number of deaths been charted:
- by primary cause
 - by age cohort
 - and preferably by secondary cause, particularly:
 - diabetes
 - tobacco
 - alcohol
 - seasonal excess deaths
- 3.2 Have the number of deaths that must be deferred - if local outcomes are to be achieved - been modelled?

⁴ <http://www.apho.org.uk/resource/item.aspx?RID=99033>

- Have they been broken down by cause, geography and, as appropriate, the “protected” population groups/characteristics (*age; disability; gender reassignment; marriage and civil partnership; pregnancy and maternity; race; religion or belief; sex; sexual orientation*) to enable action to be targeted?
- Has an evidence-based approach been used to explore which interventions can have necessary impact on numbers of deaths

For more details, see *How-to guide 1 - Modelling the numbers*⁵

- 3.3 Has there been good use made of this modelling to establish a feasible plan of action encompassing a full portfolio of contributory interventions?
- 3.4 Has the modelling of the numbers been extended to establish the potential cost-effectiveness of intervention options to determine priorities and incorporation into the mainstream planning process?
- 3.5 Have the modelled numbers and outline plan been used as the basis of a communication plan, targeted at:
- Health and Wellbeing Board members
 - GP commissioners/ PCT clusters
 - NHS staff
 - independent practitioners, including GPs
 - local strategic partners
 - elected members of the local authority
 - the public (using a segmented approach)

Priority action 4 – Driving up primary care quality and capacity

Are primary care quality and capacity sufficient?

- 4.1 As an indicator of organisational capability, do all GP practices currently draw down more than 90% of total non-clinical Quality and Outcomes Framework (QOF) points available?
- 4.2 Is there a primary care strategy for quality improvement that includes:
- a ‘balanced scorecard’
 - taxonomy of practices for purpose of ‘like-with-like’ comparison?
- 4.3 Does the strategy include a multi-disciplinary visiting team to support performance development covering at least:
- clinical governance
 - medicines management
 - peer GP
 - public health

⁵http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_115106.pdf

- patient/lay input
 - good information analysis and interpretation support?
- 4.4 Does the strategy address a performance development process that includes:
- integrated analysis and reporting of data
 - multi-disciplinary performance development team
 - a range of development support for recovery plans
- 4.5 Is there a local strategy aimed at ‘raising the bar’ on standards of achieved for GP practice outcomes over and above maximum QOF achievement (taking into account value for money to avoid unnecessary duplication of funding), such as:
- For example Local Enhanced Service agreements (If yes, what mechanisms are in place to ensure that patients of GP practices that do not sign up are not left behind?)
 - QOF Plus, focused on improved outcomes
 - renegotiation of personal medical services contracts
- 4.6 Is the pattern of primary care provision such that under-capacity of staff with key competencies is impacting on patient outcomes, in particular:
- GPs
 - practice nursing
 - practice management?
- 4.7 If yes, is there a process to support practices to develop business models to overcome this and work towards improved outcomes?

For more details, see HINST How-to Guides:

- ***How to Guide 2 - How to Develop and Implement a Balanced Scorecard to Support Primary Care Development*⁶**
- ***How to Guide 3 - How to Develop a Taxonomy of General Medical Practices to Support and Encourage Performance Development*⁷**
- ***HINST Masterclass Guide⁸: Systematic Approaches to ‘Raising the Bar’ on Primary Care Quality and Outcomes***

Priority action 5 – Proactive chronic disease management

Is the optimum use being made of primary care registers to manage chronic disease?

Each action below (5.1–5.12) applies to the registers for secondary prevention of CVD, diabetes and COPD

⁶http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_115107.pdf

⁷http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_115108.pdf

⁸http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_115102.pdf

- 5.1 Is there a systematic and ongoing strategy to include as many people as possible with established disease onto registers, including:
- actual numbers compared against estimates of expected numbers by practice
 - systematic strategies to make full use of the practice records to identify patients with chronic diseases
 - a variety of segmented options to identify patients in the community, scaled up appropriately
- 5.2 With regard to the NHS Health Check programme:⁹
- Is there a current implementation plan?
 - How is the commissioner identifying the cohort to invite first?
 - Does it include assessing the risk of diabetes and kidney disease?
 - Is the programme being commissioned from providers that can access people who are not regular users of health services? Are these services/interventions sensitive to ethnic and cultural preferences?
 - Are commissioners ensuring that everyone receives lifestyle management advice as a result of their check?
 - What services/lifestyle interventions have they commissioned/put in place to ensure that there is sufficient capacity to meet likely demand? Are they using the national tool developed to help with this?

For more details, see the Masterclass Report 2 on closing the gap¹⁰

- 5.3 Has a mortality audit been carried out?

For more details, see How-to guide 4 on how to conduct a retrospective CVD mortality audit¹¹

- 5.4 Is there support to practices in developing a sustainable workforce, with appropriate skills mix to maintain effective, efficient and affordable register management, recognising the industrial scale of activity, through the use of:
- modelling of person-hours of activity necessary by practice per annum
 - modelling of necessary workforce, with skills mix review
 - commissioned training (e.g. of NVQ3 Care Technicians) for subsequent employment by a practice/ practice cluster

For more details, see How-to guide 4 on how to develop a workforce plan to manage chronic disease¹²

⁹ There is a NHS Health Check Ready Reckoner Tool which identifies the potential service implications, benefits and cost savings resulting from implementing the NHS Health Check programme available on the NHS Checks Website. <http://www.healthcheck.nhs.uk/>

¹⁰ http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_115103.pdf

¹¹ http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_115109.pdf

¹² http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_115110.pdf

- 5.5 Is there a condition-specific QOF exception strategy based on national guidance but with clear, transparent interpretation of criteria, regular monitoring of outlier levels and a strongly enforced validation process, including notes audit?
- 5.6 Is there a strong focus on local performance management of QOF outcomes, with verification sampling where maximum points are claimed and recovery plans where outcomes are sub-optimal?
- 5.7 Is there a local mechanism to 'raise the bar' beyond the QOF maximum for target outcomes? Where extra incentives are used, do they recognise the disproportionate effort/ resource needed to achieve outcomes in disadvantaged elements of the register population (e.g. using exponential incentives)?
- 5.8 Are there teams of specialist professionals working in the community to support improved management by primary care; maintaining updated manuals, guidelines and protocols; ongoing induction and professional development training; action planning support; evaluation and audit; and assistance with procurement, maintenance and effective use of equipment?
- 5.9 Is the provision of self-management training scaled up so as to be able to offer support to **all** newly diagnosed patients? Is there a menu of quality assured options, designed with insight into the preferences of the main range of segmental groups?¹³
- 5.10 Has there been prescribing cost-versus-QOF outcomes analysis by practice followed by tailored support for poor performers?

For more details, see How-to guide 6 on prescribing costs against QOF outcomes¹⁴

- 5.11 Is there a 'dashboard' of key information by practice bringing together actual versus expected register numbers, QOF outcomes data, prescribing data and selected hospital admission data, all compared with the district averages (z-score), which is seen to be an effective tool for change?

For more details, see How-to guide 7 on developing a chronic disease dashboard¹⁵

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- This suggested area of work is based on the DH Generic Model for Long Term Conditions which puts supporting self management at the centre of effective management of long term conditions.

http://www.dh.gov.uk/en/Healthcare/Longtermconditions/DH_120915

- The Long Term Conditions QIPP team have also collected examples of cost effectiveness of supporting self management in the Long Term Conditions Commissioning Tool Kit

<http://www.networks.nhs.uk/nhs-networks/commissioning-for-long-term-conditions/resources-1/commissioning-support-for-ltc/LTC%20QIPP%20COMMISSIONING%20TOOLKIT.doc/view>

¹⁴http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_115095.pdf

¹⁵http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_115096.pdf

5.12 Are chronic disease registers being used to identify the potential for multiplicative risk reduction in relation to:

- smoking cessation support
- alcohol harm reduction
- physical activity
- cold/damp housing and fuel poverty in the elderly

Is there a focus on outcome rather than referral? Is professional support assertive? Is there a menu of support options based on social marketing/insight research?

Specific Chronic Disease Areas

- **Best management of acute cardiovascular events**
Are there systematic and scaled up approaches to key pathways: cardiac and pulmonary rehabilitation; transient ischaemic attacks (TIAs); atrial fibrillation (AF)?

In addition to the general actions in relation to chronic disease management above, there are details of priority actions for best management of acute cardiovascular events in the two HINST workbooks on CHD and stroke.

For more details, see Workbooks 2 and 3 on CHD and stroke

- **Tackling diabetes care at population level**
Is there a systematic approach to achieving effective and comprehensive care for patients with diabetes?
In addition to the general actions in relation to chronic disease management above there are details of priority actions for best management of diabetes in the HINST workbook *Assessment of Services to Reduce Diabetes-related Mortality*.

For more details, see Workbook 4 – *Assessment of Services to Reduce Diabetes-related Mortality*

For more details, see Masterclass Report 3 *Achieving effective and comprehensive care for patients with diabetes*

- **Tackling chronic obstructive pulmonary disease (COPD) care at population level**
Is there a systematic approach to delivering management of COPD to have a population level impact?
In addition to the general actions in relation to chronic disease management above there are details of priority actions for best management of COPD in the HINST workbook, *A systematic approach to delivering management of Chronic Obstructive Pulmonary Disease (COPD) to have a population level impact*

For more details, see Workbook 5 on COPD

Priority action 6 – Frontline engagement

Are systematic and scaled-up processes in place to support frontline staff to make health gain everyone's business?

- 6.1 Are commissioners and providers collaborating to ensure that the opportunities for health improvement offered by frontline staff contacts with patients, families and carers are fully capitalised upon?
- Is this done with system and scale and captured within CQUIN (Commissioning for Quality and Innovation) or a health gain schedule to address at least some components of stopping smoking, reducing alcohol-related harm and obesity management?
 - Do programmes include:
 - systematic training on strategies and key screening questions for frontline staff to use
 - application of evidence to support improvements in health and wellbeing of the staff themselves
 - brief intervention training and updates
 - specific referral pathways from all major sites and departments
 - a monitoring system with referrals to specialist support
- 6.2 In particular, are risk assessment and risk management opportunities being used to acutely address behavioural risks (e.g. pre-operatively, antenatal booking)?
- Are they supported by protocols and guidelines and in partnership with specialist behavioural support (e.g. smoking cessation, weight management)?
- 6.3 Is there a corresponding health and wellbeing schedule that could also be used by the local authority commissioners with respect to their providers in relation to the contribution that can be made by frontline staff?

For more details, see *How to Guide How to Develop a Health Gain Programme (HGP) for Frontline Staff to Address Lifestyle Issues*

Priority action 7 – Community engagement

Are structures to engage communities fully harnessed to support short-term health improvement?

- 7.1 Does the local partnership have an infrastructure and processes in place to work systematically with **all** vulnerable and deprived communities (neighbourhoods and communities of interest)? Does this extend beyond consultation to partnership and empowerment to help communities take more control of factors affecting their health?
- 7.2 If a partnership community engagement infrastructure exists, how do the health service commissioners systematically harness it to address short-term, as well as medium- and long-term health goals? If no such infrastructure exists, how does the NHS compensate to achieve necessary penetration and impact?

- 7.3 Do the health service commissioners have arrangements to draw community engagement into the mainstream of its operations, using organisational development approaches to broaden understanding and impact?

For more details, see How-to guide 8 on the ‘Five Elements’ model¹⁶

- 7.1 Does the partnership have an ongoing strategy to develop the community and voluntary sector as a strategic entity, with investment in supportive infrastructure, and market development to expand capacity and capability to meet need?
- 7.2 Does the partnership harness the unique position of the local voluntary and community sector to be able to access ‘seldom seen, seldom heard’ members of communities, including those least likely to access health services appropriately, and whose health prospects are poorest?
- 7.3 To what extent are community engagement approaches being harnessed to improve local healthcare outcomes, in particular to address chronic disease management (e.g. diabetes, CVD, COPD and cancer), with regard to:
- a social marketing approach to targeting key health messages about prevention and early identification
 - a cross-sector partnership approach to case finding and linking to lifestyle change support initiatives and primary care services
 - removing barriers, improving access to clinical care and improving quality of services
 - supporting self-management and addressing identified reasons for non-engagement with services
- 7.1 As part of the needs assessment process, has a ‘bespoke’ mapping of social preference groups (e.g. Mosaic/Experion) been developed and agreed, preferably across the partnership?
- 7.2 If so, is this being combined with other forms of intelligence, including softer inputs from community and frontline staff, to develop and capture ‘corporate’ insight into distinct population segments of differing behaviours and preferences?
- 7.3 Is developing insight and segmentation being used to develop customer access strategies? These should move away from a ‘one-size-fits-all’ approach to service delivery, to a menu of ‘insight’-driven options. The aim should be a monitored improvement of engagement and adherence to care pathways, with adjustments based on user uptake and inputs.

For more details, see How-to guide , How to Develop Voluntary Organisations, Community Groups, Charities and Social Enterprises as Strategic Partners

For more details, see Masterclass Report 4, *Customer access strategies: developing targeted services to increase accessibility*¹⁷

¹⁶http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_115097.pdf

Priority action 8 – Delivery plans

Do delivery plans include all items from Priority Action checklists for:

- cancer
- seasonal excess deaths
- tobacco control and smoking cessation
- infant mortality (if applicable)

Guidance on the development of delivery plans, which include the key priority actions, is provided for each of these areas in the HINST workbooks. They provide a diagnostic tool to help areas ensure each delivery plan defines a systematic and scaled up approach to delivery which will have a population level impact.

Workbook 1 - *Cancer: Systematic Delivery of Interventions to Reduce Cancer Mortality and Increase Cancer Survival at Population Level*

Workbook 6 - *The Systematic Delivery of Population Interventions to Protect Vulnerable Older People from Preventable Seasonal Excess Deaths (SED)*

Workbook 8 - *Tobacco Control Strategies to Reduce Inequalities in Mortality*

Workbook 7 - *Systematic management of programmes to address high infant mortality rates*

For more details also see: How-to guide 10, *How to reduce the risk of seasonal excess deaths systematically in vulnerable older people to impact at population level*¹⁸

How-to guide 11 ‘How to develop tobacco control plans to have optimal impact on health inequalities in mortality in the short term’¹⁹

¹⁷http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_115104.pdf

¹⁸http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_115098.pdf

¹⁹http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_115099.pdf

Appendix 1: Acronyms and abbreviations

AF	Atrial fibrillation
COPD	Chronic obstructive pulmonary disease
CVD	Cardiovascular disease
HINST	Health Inequalities National Support Team
NST	National Support Team
QIPP	Quality, Innovation, Productivity and Prevention
QOF	Quality and Outcomes Framework
SOA	Super output area
TIA	Transient ischaemic attack