

## HEALTH IMPROVEMENT PERFORMANCE MANAGEMENT REVIEW

### MANAGING FOR SHARED OUTCOMES TOWARDS ACHIEVING A HEALTHIER SCOTLAND

Scottish Ministers are committed to achieving certain outcomes for the Scottish people, including that we live longer, healthier lives and have tackled the significant inequalities in Scottish society. As part of this commitment, the Government is seeking to ensure that the public sector and its partners focus on these priorities and are effective in delivering results in a way that provides value for money. Accountability for delivering actions that will be effective in improving Scotland's health and reducing inequalities needs to be clear and performance monitored and managed.

Work to review health improvement performance management is being taken forward by the Scottish Government (Public Health & Wellbeing Directorate) and NHS Health Scotland working with a high level, cross-Government and cross-sector Steering Group (Annex 1) and short-life working groups to take forward specific pieces of work. The work of the Steering Group is set within the context of *Improving Health in Scotland: The Challenge* (2005) and the principles set out in *Better Health Better Care* (December 2007). It also reflects the broader Scottish Government ambition to develop outcome-focused performance reporting across government impacting on all community planning partners. Current accountability arrangements are outlined in Annex 2.

#### **Re-focusing performance management on the outcomes of service delivery**

In the Scottish Budget (November 2007), the Scottish Government set out a National Performance Framework to guide public reporting on progress towards achieving the five cross-government strategic objectives – Healthier, Wealthier & Fairer, Safer & Stronger, Smarter and Greener. The Scottish Government will report on progress against these national outcomes and indicators (see Annex 3), and public bodies will likewise be accountable for the contributions they make towards these. The national outcomes and indicators form the basis of the Concordat between central and local government in Scotland. This extends the focus of management beyond the delivery of outputs to include the outcomes, or results, of those services or partnership programmes. The learning and feedback on results from performance measurement and/or evaluations are expected to be integrated into reporting and service improvement, as well as forward budgeting and planning.

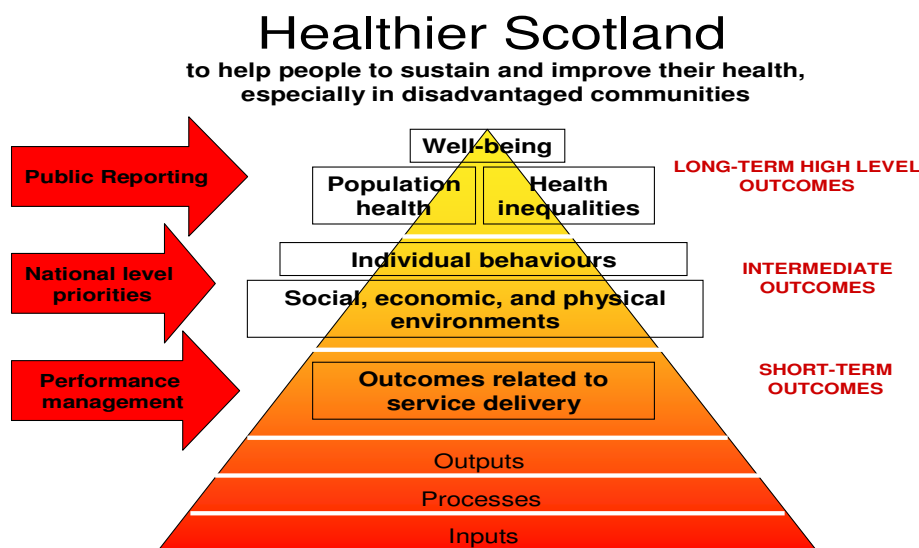
The development of outcome-focused accountability systems for public sector performance is reflected in the development of Single Outcome Agreements with local authorities and their Community Planning Partners and the review of the HEAT performance measures for the NHS. This approach offers a number of potential benefits: It means better alignment between public investment, goals and effective actions and harmonising national level outcomes, targets and performance measurement systems bringing better alignment for local delivery organisations. This should make life easier for partnership planning and delivery and for voluntary organisations that rely on public sector bodies for funding.

#### **An outcomes framework for health improvement**

In keeping with this outcomes approach, and to aid this process at local and national level, the Steering Group have developed an outcomes framework for health improvement (Figure 1) which shows relevant outcome categories for the long-term and intermediate level. The

national indicators used in the Scottish Government's National Performance Framework and related to Healthier Scotland are shown in Annex 4. They are also indicated in bold in the tables below.

**Figure 1: National outcomes framework for health improvement**



The long-term outcomes are concerned with high level indicators of population health and wellbeing status. The intermediate outcome categories focus on the 'determinants' of health and wellbeing: individual health behaviours and the social, economic and physical environments that shape these. At this intermediate level, there are close inter-relationships between health improvement outcomes and those relevant to the other four strategic objectives which are also about the social, economic and physical determinants of health. The high level and intermediate health outcomes should reflect the combined results of delivering a range of actions, programmes and services by statutory bodies, voluntary organisations and partnerships. In other words, these are outcomes of whole system performance combining unique and collaborative contributions. We have therefore defined a set of shared priorities for health improvement at this level and expect these to provide the basis for health improvement planning and performance reporting across the whole system.

The short-term outcomes are about the more immediate results of service delivery and are more appropriate for performance management within service delivery organisations. These outcomes represent the contributions of specific organisations, partnerships, services or programmes and should be effective (or at least plausible) in contributing to intermediate level outcomes. The revised set of NHS performance measures for health improvement in the HEAT targets thus focus on the NHS contribution to delivering on the relevant national outcomes and indicators defined in the National Performance Framework (see Annex 5).

To support the outcome planning process, for each of the health improvement priority areas Health Scotland will develop a series of examples of outcomes-focused performance reporting to illustrate how the outputs and immediate results of key delivery actions/services might be linked to intermediate level outcomes and through to national indicators and outcomes.

## Priorities for health improvement

Achieving a Healthier Scotland relies on the contributions of many partners, in the NHS, local authorities and the community and voluntary sectors. Because there are such a wide range of factors that influence a population's health, it is easy to define everything as being important and spreading our resources and energies too thin and thus dissipating the effects. To achieve maximum impact on population health, we suggest there is a need to focus public resources and efforts on a narrower range of priorities for health improvement and reducing health inequalities, and that these goals are shared across the whole delivery system. Having consulted with community planning partners, presented below are a set of priority outcomes for health improvement that can be shared across national and local levels and that will form the basis of health improvement performance reporting across Scotland.

The following intermediate level outcomes are defined as priorities for health improvement that can be shared across delivery organisations:

- *Inequalities and health.* Reduced inequalities in the wider social, economic and environmental factors that help shape inequalities in physical and mental health, in particular educational achievement, the work environment, unemployment and relative poverty.
- *Mental well-being.* Improved mental wellbeing through improved mental health literacy, resilience, self-confidence and self-esteem and the social, economic and environmental factors that influence mental wellbeing
- *Tobacco.* Reduced tobacco-related disease, disability and premature death through reduced inequalities in current smoking rates, reduced exposure to second-hand tobacco smoke and lower uptake of smoking
- *Alcohol.* Reduced burden of disease, harm, distress and premature death due to excessive alcohol consumption
- *Obesity.* Reduced burden of disease, disability and premature death due to rising levels of overweight and obesity in children and adults
- *Early years.* Improving the healthy development of young children and their families, particularly those children most at risk

By shared priorities we mean those areas that should be (or should continue to be) part of all delivery organisations' set of 'really important' and valued results for the next 3-5 years. It doesn't necessarily mean that all other goals are dropped, but with finite public resources tough decisions are needed about what areas are most important for improving Scotland's health.

## Selection criteria

The selection of priorities was based on the currently available epidemiological information and evidence and using the following criteria:

1. *Importance.* The issue is a large one in absolute terms and/or contributes materially to health improvement and reducing health inequalities.
2. *Potentially effective intervention.* There is potential to intervene effectively via a set of actions with known, or at least plausible, effectiveness with scope to increase their population coverage and/or targeted reach (e.g. smoking cessation services, raising the age of legal tobacco purchase).

3. *Feasibility.* It is feasible to implement these proven or plausible interventions in the Scottish context via public policy measures, mainstream public services or inter-sectoral partnerships.
4. *Performance assessment.* It is possible to monitor and evaluate progress in achieving the desired level of change via performance indicators related to the short-term results of service delivery and that these are unlikely to encourage perverse incentives or unintended consequences.

In the next section we present the case for these priorities and illustrate the sequencing of a 'chain' of outcomes that we might expect to follow from the effective delivery of services and actions on the ground. The outcome categories and indicators listed below are for the purposes of priority setting. More work will be done in 2008 to translate these into local performance indicators and measures. The aim is to rationalise and streamline the range of performance indicators in use, not to create an additional layer.

## **Inequalities and health**

*Why is reducing inequalities in social, economic and environmental determinants of health important for a Healthier Scotland?*

There is a clear social gradient for most physical and mental health problems as well as for mental wellbeing. Poor mental and physical health is both a cause and consequence of social, economic and environmental inequalities; the uneven distribution of health problems in the population both reflects inequalities and contributes to them. Moreover, the mental and physical dimensions of health inequalities are intertwined. For example, CHD risk is directly related to the severity of depression with a 1–2-fold increase in CHD for minor depression and 3–5-fold increase for major depression (Bunker et al 2003). For young people, psycho-social functioning (self determination, closeness to others and school integration) is closely correlated with behaviour problems (arrests, truancy, alcohol, tobacco and marijuana use).

The exact policy goal for tackling health inequalities varies with the analytical perspectives and measures used. Reducing the absolute size of the inequalities between the most/least disadvantaged leads to a focus on heart disease, cancers and respiratory diseases in older age groups (40-65 years). Reducing the relative inequalities (steepness of the gradient) between the most/least disadvantaged leads to a focus on suicide, drug-related disorders and assault at younger ages (16-39 years). While the actual size of the problem and health gain may be small, this measure is an early alert of trends that will feed through into future years.

In terms of the burden of disease, mental illness (including suicide) accounts for 20% of the total burden of disease in the UK, compared with 17.2% for cardiovascular diseases and 15.5% for cancer<sup>1</sup>. The risk factors for poor health in Scotland that are related to individual behaviour (smoking, alcohol, obesity, diet, exercise) are well recognised and extremely important, but they account for less than 40% of morbidity and mortality (measured in Disability Adjusted Life Years). At least a further 10% of the disease burden is attributable to aspects of the wider social, economic and physical environments that shape health, in particular adult literacy and educational achievement, income/relative poverty, the work environment and unemployment.

While the inclusion of 'upstream' factors (the causes of the causes of ill-health) increases the complexity of the 'Healthier' picture and the levels of uncertainty about effective intervention

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<sup>1</sup> World Health Organisation (2006) *Burden of disease statistics*. <http://www.who.int/healthinfo/bod/en/index.html>

and attribution, it also increases the chances of more synergistic action across the Government's five strategic objectives. The establishment of a Ministerial Task Force on Health Inequalities also reflects the Government's commitment to this goal.

*What is the potential to intervene effectively?<sup>2</sup>*

Education, employment and income are often seen as the key factors for reducing social and health inequalities; they also enhance mental and social wellbeing and social inclusion. Education provides literacy, numeracy, analytical and communication skills which increase people's employability and ability to cope with a range of issues including health. Employment builds on these skills and provides income which provides access to health promoting resources such as housing, heating, food etc.

While most of the major drivers of health inequalities lie outside the NHS, the NHS has an important role to play in promoting health and wellbeing, preventing disease and ameliorating the damage to mental and physical health caused by disadvantage. Improving the accessibility of health services (treatment and prevention) and a range of other essential services (e.g. good quality education, housing, welfare, public transport, food retail outlets) to those in greatest need through targeted, tailored and outreach approaches to service provision is a key component of coordinated action to tackle inequalities. Approaches which target disadvantaged individuals and households need to be combined with services and programmes that are area-based.

Given the lack of robust evidence on specific measures that are effective in reducing inequalities in health, Macintyre offers examples of policy measures and intervention approaches that are more likely to be effective in reducing inequalities in health:

- Structural changes in the environment (e.g. area wide traffic calming schemes)
- Legislative and regulatory controls (e.g. drink-driving legislation, speed limits)
- Fiscal measures (e.g. increase price of tobacco and alcohol products)
- Income support (e.g. tax and benefit systems, welfare rights advice)
- Reducing price barriers (e.g. free prescriptions, school meals, fruit and milk)
- Improving accessibility of services (e.g. location and accessibility of primary care)
- Prioritising disadvantaged groups (e.g. multiply deprived families and areas)
- Offering intensive support (e.g. systematic, tailored, intensive approaches)
- Starting young (e.g. pre- and post-natal support and interventions, home visiting)

*How would we assess performance?*

This priority would bring together outcomes across the other four strategic objectives and link them to reducing health inequalities. Further work is needed on the appropriate measures of health inequalities, both in terms of population monitoring and public reporting but also for measuring performance in terms of service delivery outcomes. We suggest that progress could be monitored and assessed using a selection of the following outcomes.

<b>Outcome level</b>	<b>Outcome category</b>	<b>Outcome categories and possible indicators</b>
Long-term	'Healthier'	<p><b>Reduced inequalities in:</b></p> <ul style="list-style-type: none"> <li>• <b>Healthy life expectancy at birth</b></li> <li>• <b>Mental well-being (WEMWBS)</b></li> </ul> <p>Reduced inequalities in age-specific premature</p>

<sup>2</sup> Macintyre, S. (2007) *Inequalities in health in Scotland: what are they and what can be done about them?* Occasional Paper No. 17. October 2007. Available at [www.sphsu.mrc.ac.uk](http://www.sphsu.mrc.ac.uk)

		mortality: <ul style="list-style-type: none"> <li>• Infant mortality</li> <li>• Accidents and cancers (ages 2-15 years)</li> <li>• Suicide, drug-related disorders and assault (ages 16-39 years)</li> <li>• CVD, cancers and chronic lower respiratory diseases (ages 40-65 years)</li> <li>• <b>CHD (under 75s)</b></li> </ul>
Intermediate	Individual behaviours	
	Social, economic, and physical environments	Reduced inequalities in: <ul style="list-style-type: none"> <li><u>Educational environment</u> <ul style="list-style-type: none"> <li>• Educational attainment of school pupils</li> <li>• <b>% school-leavers not in education, training or employment</b></li> <li>• <b>Adult literacy and numeracy rates</b></li> </ul> </li> <li><u>Economic and work environment</u> <ul style="list-style-type: none"> <li>• Nos. of children in workless households</li> <li>• <b>% population living in poverty</b></li> <li>• Nos. of workless people dependent on benefits</li> <li>• Employability of those not in employment</li> <li>• Retention and rehabilitation of those off work due to long-term sickness and in receipt of benefits</li> </ul> </li> <li><u>Accessibility of services</u> <ul style="list-style-type: none"> <li>• Accessibility of health and social services for disadvantaged groups and those with multiple and complex needs</li> </ul> </li> </ul>

## Mental wellbeing

### *Why is improving mental wellbeing important for a Healthier Scotland?*

Positive mental health, or mental wellbeing, is defined as "a state of wellbeing in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community" (Jane-Llopis & Anderson 2006). In Scotland in 2006, 14% of the population were classified as having good mental wellbeing, 73% average mental wellbeing and 14% poor mental wellbeing<sup>3</sup>. Improvements in positive mental wellbeing will help reduce the prevalence of common mental health problems, such as depressions and anxiety, substance use, anti-social behaviour, as well as improving health and social outcomes in clinical populations. While the best outcomes are associated with the absence of mental illness, the presence of positive mental wellbeing brings additional benefits, especially for those with common and chronic health problems who are limited by their condition and/or disabled.

Confidence, self-esteem, positive affect (e.g. hopefulness, optimism), resilience and (mental) health literacy are individual level factors that underpin mental wellbeing and quality of life. In terms of environmental factors, having close and supportive friends and family, social interaction, social participation and engagement within local communities and the extent to which people are satisfied with their residential neighbourhood are all strong positive influences on mental wellbeing. Insecure and inadequate income and working conditions

<sup>3</sup> Brauholtz S, Davidson S et al (2007) Well? What Do You Think? (2006): The Third National Scottish Survey of Public Attitudes to Mental Health, Mental Wellbeing and Mental Health Problems Edinburgh: Scottish Government

characterised by high demand/low control, low support and effort-reward imbalance are the most commonly cited negative influences on mental wellbeing.

*What is the potential to intervene effectively?*

Review level evidence demonstrates that programmes promoting positive mental health are effective in improving multiple areas of functioning and in reducing the risk of mental health problems<sup>4</sup>. The following intervention areas have been identified as ‘best buys’ in a recent economic analysis<sup>5</sup>:

1. Early years: Pre-school education, pre-school child *and* family/parenting support; parenting skills training, parenting group programmes
2. Children and young people: Health promoting schools, life skills training, peer tutoring and cross-age tutoring, emotional literacy programmes.
3. Employment/workplace - early referral to workplace-based support, CBT-based counselling/stress management, organisational change to improve levels of job control; supporting people back to work through primary care; improving ‘mental health literacy’ at work
4. Lifestyle messages and advice on positive mental wellbeing including diet, exercise, sensible drinking and social support
5. Older people: psychotherapeutic interventions; self-help group-based practical, social and emotional support; befriending, intergenerational projects, approved trader schemes, work with providers to promote greater uptake of education, sports and leisure, targeted outreach with those who are most isolated and vulnerable
6. Environmental improvements: places to escape to (e.g. green open spaces in urban areas, cultural facilities in rural areas), places to stop and chat, events to bring people together, community facilities and social and entertainment facilities

*How would we assess performance?*

High level, long-term population trends in positive mental wellbeing and common mental health problems will be monitored via the Scottish Health Survey using the new Warwick-Edinburgh Mental Well-being Scale (WEMWBS) and the GHQ12. Progress in intermediate level outcomes could be monitored using the following outcome categories and indicators.

<b>Outcome level</b>	<b>Outcome category</b>	<b>Outcome categories and possible indicators</b>
Long-term	‘Healthier’	<ul style="list-style-type: none"> <li>• <b>Improved mental well-being (WEMWBS)</b></li> <li>• Reduced prevalence of common mental health problems (GHQ12)</li> </ul>
Intermediate	Individual behaviours	<ul style="list-style-type: none"> <li>• Improved (mental) health literacy</li> <li>• Improved confidence and self-esteem</li> <li>• Improved resilience/problem solving</li> <li>• Reduced substance use</li> </ul>
	Social, economic, and physical environments	<p><u>Social environment</u></p> <ul style="list-style-type: none"> <li>• Social networks, supportive relationships (family and friends)</li> <li>• Social participation (social life, hobbies, recreations, sport, <b>outdoors visits</b>)</li> <li>• Civic and community engagement</li> <li>• Social integration and cohesion</li> </ul>

<sup>4</sup> Jane Llopis et al 2005; WHO 2004a; 2004b; Tilford et al 1997; Taylor et al 2007; Barry and Jenkins 2007

<sup>5</sup> Friedli L and Parsonage M (2007) *Building an economic case for mental health promotion* Belfast: Northern Ireland Association for Mental Health

		<ul style="list-style-type: none"> <li>• <b>Neighbourhood satisfaction</b></li> <li>• Tolerance, non-discriminatory values</li> </ul> <p><u>Economic and work environment</u></p> <ul style="list-style-type: none"> <li>• Economic participation; financial inclusion (those of working age)</li> <li>• Sickness absence (employers)</li> <li>• Job progression/satisfaction (those currently in employment or self-employed)</li> </ul> <p><u>Physical environment</u></p> <ul style="list-style-type: none"> <li>• Safe community and work environment</li> <li>• <b>Fear of crime; exposure to violence, crime and assault; victimisation</b></li> <li>• Exposure to harmful noise levels in workplaces, communities, clubs/leisure venues</li> </ul> <p><u>Access to basic resources and services</u></p> <ul style="list-style-type: none"> <li>• Water, food and fuel security</li> <li>• Access to education and lifelong learning</li> <li>• Access to good standard housing</li> <li>• <b>Unintentionally homeless households</b></li> <li>• Mobility, access to affordable transport</li> <li>• <b>Access to health services</b></li> <li>• Access to natural resources/ greenspace for rest and recreation</li> </ul>
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## Tobacco

*Why is reducing inequalities in smoking important for a Healthier Scotland?*

Differences in smoking rates can explain between half and two-thirds of the differences in mortality between socio-economic groups in industrialised countries. This is reinforced for Scotland by long term follow-up in the Renfrew and Paisley (MIDSPAN) study<sup>6</sup> which shows that smokers of all social classes tend to die younger than never-smokers including those in the lowest social class. The mortality gradient between people of the same smoking status but different social class is much smaller. Even if you could elevate someone from low to high social class, as long as they continued smoking their chances of survival would be little better.

*What is the potential to intervene effectively?*

There is now good evidence for effective interventions in smoking cessation, prevention and protection measures to reduce exposure to second-hand smoke (the smoke-free legislation introduced in March 2006) and to prevent the uptake of smoking by young people. With smoking rates coming down, there is a cast-iron case for further intensifying efforts to reduce smoking across the population but with disproportionate efforts in areas with the highest smoking rates.

*How would we assess performance?*

This priority would contribute primarily to outcomes related to the Healthier strategic objective. We suggest that progress could be monitored and assessed using the following sequence of outcomes

<sup>6</sup> Gruer L, et al. Manuscript in preparation.

<b>Outcome level</b>	<b>Outcome category</b>	<b>Outcome categories and possible indicators</b>
Long-term	'Healthier' outcomes	<b>Reduced inequalities in:</b> <ul style="list-style-type: none"> <li>• <b>Healthy life expectancy at birth</b></li> <li>• <b>CHD (under 75s)</b></li> <li>• Other tobacco-related premature mortality and morbidity</li> </ul>
Intermediate	Individual behaviours	Reduced inequalities in <ul style="list-style-type: none"> <li>• <b>Adult smoking prevalence</b></li> <li>• Sustained quit rate</li> <li>• Uptake of smoking by young people</li> </ul>
	Social, economic, and physical environments	<u>Social environment</u> <ul style="list-style-type: none"> <li>• More people view non-smoking as the norm</li> </ul> <u>Economic environment</u> <ul style="list-style-type: none"> <li>• Reduced availability, affordability, visibility and attractiveness of tobacco to young people</li> </ul> <u>Physical environment</u> <ul style="list-style-type: none"> <li>• Reduced exposure to second-hand tobacco smoke in public places, workplaces, homes</li> </ul> <u>Access to services</u> <ul style="list-style-type: none"> <li>• Improved accessibility and availability of smoking cessation services to smokers who want to quit</li> </ul>

## **Alcohol**

*Why is stemming the rising levels of excessive alcohol consumption important for a Healthier Scotland?*

Excessive alcohol consumption (beyond recommended limits) can result in harmful consequences for an individual's physical and mental health and for community safety due to alcohol-related violence and disorder. Alcohol-related harm impacts on communities and across public services – police, criminal justice, emergency services, health services and social services – but the greatest impact is on people living in the most deprived areas with nearly two-thirds of alcohol-related deaths in SIMD4&5 in 2005. People living in the most deprived areas are 6 times more likely to be admitted to general acute hospitals and almost 8 times more likely to be admitted to psychiatric hospitals due to alcohol-related problems.

The number of alcohol-related deaths has increased by 15% for both men and women between 2001 and 2005 but with twice as many alcohol-related deaths in men. Of greatest concern for Scotland is the exponential rise in mortality rates from liver cirrhosis between 1950 and 2002, an increase that far outstrips the rise also observed in England and Wales.

*What do we know about the causes of the rise in alcohol-related harm?*

While drinking has long been a strong feature in the Scottish way of life, consumption levels and patterns have changed, especially among young people. The evolution of contemporary drinking patterns is complex but consumption levels are likely to be affected by the fall in the relative price of alcohol compared to earnings, the wider availability of alcohol, the active promotion and marketing of alcohol to young people and changing social norms about drinking and drunkenness among younger age groups. Alcohol is increasingly perceived as a problem and as causing more harm than drugs.

*What is the potential to intervene effectively?*

Evidence for effective action falls into three main categories:

- Prevention – community prevention programmes; brief interventions in primary care for people who are not alcohol dependent but drinking at harmful levels (SIGN 74 National Clinical Guideline)
- Protection and controls – alcohol taxation; laws on minimum drinking age and on drink-driving; selective breath-testing, sobriety checkpoints and random-breath-testing; ignition interlock devices; intensive face-to-face server training + management support
- Treatment and support – for those who are alcohol-dependent and/or drinking at hazardous levels, psycho-social interventions, and pharmacological treatments as adjuncts to psycho-social interventions

There is good evidence for the effectiveness of measures to increase cost, reduce availability and increase controls on under-age drinking and on drinking and driving. Recent work in England suggests only 1 in 18 people with an alcohol problem are receiving appropriate treatment and support from services. If the situation is similar in Scotland, this is unacceptably low.

*How would we assess performance?*

This priority would contribute to outcomes related to both the Healthier and Safer & Stronger strategic objectives. We suggest that progress could be monitored and assessed using the following sequence of outcomes:

<b>Outcome level</b>	<b>Outcome category</b>	<b>Outcome categories and possible indicators</b>
Long-term	'Healthier' and 'Safer & Stronger' outcomes	<ul style="list-style-type: none"> <li>• <b>Reduce inequalities in healthy life expectancy at birth</b></li> <li>• <b>Improved mental well-being</b></li> <li>• <b>Reduced alcohol-related hospital admissions</b></li> <li>• Reduced alcohol-related mortality</li> <li>• Reduced alcohol-related road traffic accidents, arrests, imprisonments, injuries</li> <li>• Reduced inequalities in alcohol-related harm</li> </ul>
Intermediate	Individual behaviours	<ul style="list-style-type: none"> <li>• Reduced consumption of alcohol beyond recommended limits</li> </ul>
	Social, economic, and physical environments	<p><u>Social environments</u></p> <ul style="list-style-type: none"> <li>• Reduced acceptability of hazardous drinking and drunkenness</li> <li>• Increased acceptability of sensible drinking and non-drinking</li> </ul> <p><u>Economic environments</u></p> <ul style="list-style-type: none"> <li>• Reduced access to and affordability of alcohol</li> </ul> <p><u>Physical environments</u></p> <ul style="list-style-type: none"> <li>• Reduced alcohol-related incidents on roads, in workplaces and city centres</li> <li>• More premises where alcohol is served that promote sensible drinking and ensure the</li> </ul>

		<p>safety of drinkers and others</p> <p><u>Access to services</u></p> <ul style="list-style-type: none"> <li>• Improved access to timely, sensitive and effective treatment services for those dependent on alcohol and drinking at hazardous levels</li> <li>• Increased access to effective preventive services for those drinking alcohol at harmful levels</li> </ul>
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## Healthy weight and obesity<sup>7</sup>

*Why is stemming the rising levels of obesity important for a Healthier Scotland?*

Scotland now has one of the highest levels of obesity among OECD countries, second only to the USA. The prevalence of obesity (BMI > 30 kg/m<sup>2</sup>) in Scotland has increased over the past two decades, reaching 22% in men and 24% in women in 2003. In children, nearly one in five (18%) boys and over one in ten (14%) girls aged 2–15 years are obese. Obesity levels are patterned by gender in adulthood and by deprivation (SIMD quintile) in childhood.

The rising levels of obesity in Scotland are of serious concern given the levels of morbidity and mortality associated with obesity. Obesity decreases life expectancy and is linked to an increased risk of coronary heart disease, diabetes, cancer, kidney failure, arthritis, back pain and psychological damage. For example, type 2 diabetes is almost 13 times more likely to occur in obese women than in women of normal weight. Obesity in Scotland is linked to nearly 500,000 cases of high blood pressure, 30,000 cases of type 2 diabetes, and similar numbers of cases of osteoarthritis and gout. It is estimated that obese people in Scotland are 18% more likely to be hospitalised than those of normal weight. Obesity and its consequences cost the NHS in Scotland an estimated £171 million in 2001.

*What do we know about the causes of obesity?*

At the individual level obesity results from a sustained imbalance between energy intake (diet) and energy expenditure (physical activity). These are influenced by a complex range of ‘obesogenic’ factors in the wider social, economic and physical environment, for example the abundance and ready availability of energy-dense foods and drinks, the resulting “passive over-consumption” of energy and an environment that limits opportunities for safe physical activity and promotes sedentary lifestyles. Tackling over-consumption and building more physically active living environments will contribute to future sustainability and are goals shared across the Government’s ‘Healthier’ and ‘Greener’ strategic objectives.

*What is the potential to intervene effectively?*

The 2006 NICE Clinical Guideline<sup>8</sup> covers the prevention, identification, assessment and management of overweight and obesity in adults and children (aged 2 years and older) in two main population groups:

1. Those who are already overweight and obese - how staff in GP surgeries and hospitals should assess whether people are overweight or obese, what they should do to help people lose weight and how to care for people whose weight puts their health at risk.

<sup>7</sup> ScotPHO (2007) *Obesity in Scotland: An epidemiological briefing*. Sept 2007.

<sup>8</sup> Health Scotland has produced a commentary on the public health aspects of this NICE Guideline for Scotland

2. Those who are currently a healthy weight - the prevention of overweight and obesity - how people can make sure they and their children stay at a healthy weight and how health professionals, local authorities and communities, childcare providers, schools and employers should make it easier for people to improve their diet and become more active.

The Foresight Report (2007)<sup>9</sup> acknowledged the need to influence a broad set of systems with diverse and well-thought through policies across multiple sectors. It concludes that there are currently no realistic short- or medium-term solutions to curtail the projected rise in obesity and it is therefore necessary to start building the foundations for long-term sustainable change. Building on existing action, a timeline of interventions needs to be constructed with short-term outcomes focused on improving awareness of the problem and its complexities and achieving a mandate for change. Medium- and long-term outcomes should be focused on, for example, changes in the built environment and transport policies.

*How would we assess performance?*

This priority would contribute primarily to outcomes related to the Healthier strategic objective. The measure in the National Performance Framework is the proportion of children whose Body Mass Index is outside the healthy range (i.e. children who are both underweight and overweight). However, the HEAT target is focused on NHS interventions with families of children who are overweight and obese. There are no national performance measures related to adults who are overweight or obese.

We suggest that progress could be monitored and assessed using the following sequence of outcomes:

<b>Outcome level</b>	<b>Outcome category</b>	<b>Outcome categories and possible indicators</b>
Long-term	'Healthier' outcomes	<ul style="list-style-type: none"> <li>• <b>Reduced inequalities in healthy life expectancy at birth</b></li> <li>• <b>Improved mental well-being</b></li> <li>• Reduced obesity-related mortality and morbidity: CHD, diabetes, cancer, kidney failure, arthritis, back pain and psychological distress</li> <li>• Increased % of adults within the healthy weight range</li> <li>• <b>Reduced % of children outwith the healthy weight range</b></li> </ul>
Intermediate	Individual behaviours	<ul style="list-style-type: none"> <li>• Increased physical activity among children and adults who are overweight</li> <li>• Reduced consumption of energy-dense processed foods that are high in fat and/or sugars + soft drinks and fruit juices.</li> <li>• Increased rate of exclusive breastfeeding</li> <li>• Increased confidence, self esteem, and self image among those who have learned to successfully manage their weight</li> </ul>
	Social, economic,	<u>Social environment</u>

<sup>9</sup> Foresight (2007) Tackling Obesity: Future Choices – Project Report. Government Office for Science, October 2007. Available at <http://www.foresight.gov.uk/Obesity/Obesity.html>

	and physical environments	<ul style="list-style-type: none"> <li>• Public awareness of the obesity problem and the need for change</li> <li>• Public recognition of healthy weight as desirable</li> </ul> <p><u>Economic environment</u></p> <ul style="list-style-type: none"> <li>• Access to and affordability of energy-dense processed foods high in fat and/or sugars + sweetened soft drinks and fruit juices</li> <li>• Availability and visibility of 'healthy foods' in public sector catering</li> <li>• <b>Active commuting</b></li> </ul> <p><u>Physical environments</u></p> <ul style="list-style-type: none"> <li>• Opportunities for safe active living, travel and commuting (e.g. no. of journeys to work or school made by public or active transport)</li> </ul> <p><u>Access to services</u></p> <ul style="list-style-type: none"> <li>• Access to timely, sensitive and effective treatment for those who are already obese</li> <li>• Access to effective preventive weight management services for those who are overweight</li> </ul>
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## Early Years

*Why is ensuring the healthy development of young children and their parents/carers important for a Healthier Scotland?*

Having a good start in life provides a strong foundation for health and well-being. Investment in ensuring 'our children have the best start in life and are ready to succeed' including healthy child development (their social, emotional, cognitive and physical development) is a priority national outcome area where health can both contribute and benefit. Improving the life chances for children, young people and families at risk is also a national priority. The first year's results from the *Growing Up in Scotland* study provide strong evidence of the widening divide between high and low income areas with respect to many factors known to be important in the healthy development of children – teenage and single-parenthood, parental substance misuse, smoking and drinking in pregnancy, breast-feeding, oral health, reading books to children etc. These factors will almost inevitably result in even greater health inequalities in the future if not addressed.

*What is the potential to intervene effectively?*

There is plenty of evidence that investing in the early years (young children and their families) can have long term benefits and reduce health inequalities. Areas of effective prevention worthy of attention are:

- Routine enquiry, screening and intervention for maternal depression, domestic violence and harmful drinking (NICE, Chang 2004; Home Office)
- Preventing conduct disorders in those children who are most disturbed

There is less clear evidence about how to address teenage parenthood and maternal health in pregnancy (including smoking) in disadvantaged areas. Interventions with more disadvantaged and vulnerable families may need to be much more intensive, tailored and targeted. There is however good evidence of successful interventions to promote

breastfeeding and improve oral health. General support for parents in these circumstances should also result in better specific health-related behaviours.

*How would we assess performance?*

This priority would link some key intermediate level health outcomes as contributors to child development outcomes within the 'Smarter' strategic objective. The key health-related indicator for early years in the National Performance Framework is reduced dental disease among primary school entrants. We suggest that progress could be monitored and assessed using the following sequence of outcomes:

<b>Outcome level</b>	<b>Outcome category</b>	<b>Outcome categories and possible indicators</b>
Long-term	'Smarter' outcomes	<p>Reduced inequalities in</p> <ul style="list-style-type: none"> <li>• Pre-school child development indicators (physical, social, cognitive, communication, expressive)</li> <li>• Health and wellbeing status of looked after &amp; accommodated children</li> <li>• <b>Dental disease among children (Primary 1)</b></li> </ul>
Intermediate	Individual behaviours	<ul style="list-style-type: none"> <li>• Increased confidence, skills and emotional literacy among parents of young children</li> <li>• Children are more resilient</li> </ul> <p>Reduced inequalities in:</p> <ul style="list-style-type: none"> <li>• Parental substance use</li> <li>• Smoking in pregnancy</li> <li>• Breastfeeding rate at 6-8 weeks</li> <li>• Post-weaning diet (consumption of sugary drinks and fruit juices)</li> <li>• Physical activity levels (ages 2-5)</li> </ul>
	Social, economic, and physical environments	<p>Reduced inequalities in:</p> <p><u>Social and family environment</u></p> <ul style="list-style-type: none"> <li>• Acceptance of pro-health behaviours as the norm among parents (e.g. non-smoking and breastfeeding)</li> </ul> <p><u>Economic environment</u></p> <ul style="list-style-type: none"> <li>• Nos. of children in workless households</li> <li>• % children living in poverty</li> </ul> <p><u>Physical environment</u></p> <ul style="list-style-type: none"> <li>• Safe and stimulating home environments</li> <li>• Safe and active neighbourhood play environments for young children</li> </ul> <p><u>Access to services</u></p> <ul style="list-style-type: none"> <li>• Nursery attendance (ages 3-5)</li> <li>• <b>Improved standards in pre-school centres (positive inspection reports)</b></li> <li>• Uptake of ante-natal care and preventive child health services (e.g. dental health registrations, immunisations)</li> <li>• Improved support for vulnerable families (e.g. homeless, prisoners and looked after children)</li> </ul>

## Next Steps

This is the beginning of a journey towards shifting the focus of public sector performance to improving the outcomes of service delivery so that these contribute effectively to achieving a set of shared priority outcomes, defined nationally and locally. In the area of health improvement, these six priority areas are known to be critical to improving Scotland's health and reducing health inequalities. An outcomes approach to health improvement planning, management and reporting will take time to evolve and we are keen to learn lessons along the way from our own experience in Scotland and that of other countries. The challenges are both technical and organisational – shifting organisational cultures and leadership as well as re-orienting our information and measurement systems.

The Scottish Government's Action Plan, *Better Health Better Care* (December 2007) has set out what NHS Boards will be held accountable for via the HEAT performance management process. The National Performance Framework and the Concordat with local government will inform the priorities and performance targets for Single Outcome Agreements with local authorities and their Community Planning Partners.

The review of Health Improvement Performance Management will move onto a new phase of work in 2008. Feedback from the regional consultation seminars suggests that this work should include:

1. Advise the Ministerial Task Force on Health Inequalities on the most appropriate approaches, measures and performance indicators; the Task Force is due to report in May 2008
2. Further develop the HEAT targets to develop the necessary data collection and reporting infrastructure for the new targets, to review the inequalities dimension of the existing HEAT targets and to take forward the development of any new or revised targets in the priority outcome areas
3. As far as possible, ensure alignment across sectors in the language, approach, frameworks, indicators and methods used for outcome-focused planning, performance management and reporting; for health improvement, we will provide worked examples across the six priority outcomes areas
4. Develop plans for taking forward the leadership and capacity-building implications of an outcomes approach to health improvement. This will be aligned with developments in public sector performance generally, but also build on the learning from the recent pilot work with CPPs on outcomes planning and leadership development with the community and voluntary sector.

We will provide regular updates on progress with and key outputs from this work via the Health Scotland website.

<http://www.healthscotland.com/scotlands-health/evaluation/planning/hi-performancemanagement-nhs.aspx>

## Annexes

Annex 1: HIPM Steering Group members

Annex 2: Current accountability arrangements

Annex 3: National Performance Framework: National Outcomes and Indicators

Annex 4: Healthier Scotland: a Framework for National Indicators

Annex 5: Revised HEAT targets for 2008/09 and National Indicators

## **Annex 1: Health Improvement Performance Management Steering Group members**

### **Members**

Kay Barton (Chair), Health Improvement Strategy Division, Scottish Government

Erica Wimbush, Head of Policy Evaluation & Appraisal, NHS Health Scotland

Graham Robertson, Chief Executive, NHS Health Scotland

Rab Fleming, Public Service Delivery Division, Scottish Government

Fiona Mackenzie, Chief Executive, NHS Forth Valley

Catriona Renfrew, Director of Corporate Planning and Policy, NHS Greater Glasgow & Clyde

Lesley Wilkie, Director of Public Health, NHS Grampian

Mary Castles, Executive Director, Housing and Social Work Services, North Lanarkshire Council and SOLACE

COSLA representative

Eleanor Logan, Chief Executive, Voluntary Action Fund

Angela Canning, Audit Scotland

Mike Palmer, Social Inclusion Division, Scottish Government

Angiolina Foster, Chief Executive, Communities Scotland

Kenneth Hogg, Public Health and Substance Misuse Division, Scottish Government

Alistair Brown, Deputy Director of Delivery (Health), Scottish Government

Peter Donnelly, Deputy Chief Medical Officer, Scottish Government

Kathleen Bessos, Assistant Director, Primary and Community Care Directorate, Scottish Government

Colin Cook, Healthcare Planning Division, Scottish Government

Jill Vickerman, Analytical Services (Health & Wellbeing), Scottish Government

## **Annex 2: Current Accountability Arrangements**

### **Local Government and Community Planning Partnerships**

Local authorities are elected bodies, making them democratically accountable to people in their respective areas. Like other public bodies, local authorities are also accountable to the Scottish Government for the nature and quality of services they provide and the difference these services make to people's lives.

The Scottish Government has stated its intention of working towards the establishment of a new relationship with local government. John Swinney MSP, Cabinet Secretary for Finance & Sustainable Growth, has described this new relationship as "one in which we can work together in partnership and in which we recognise local government's central role in the governance of Scotland, there is less prescription from central Government and local government has greater freedom to exercise its responsibilities"<sup>10</sup>.

Under this new relationship, the interest of the Scottish Government in the work of local government will focus on the outcomes they secure (that is, the effects which local services have on people's lives). Councils will become increasingly accountable to the Scottish Government for their performance against a series of outcome indicators. In return, the volume of additional information which councils are required to submit to the Scottish Government about their performance will be substantially reduced. The Scottish Government will reduce their interest in overseeing how local services are delivered. This means, for example, that councils will have more freedom over how they plan and deliver services, in step with local needs and preferences. Obligations on councils to provide the Scottish Government with plans setting out how they propose to use funding and deliver services will be reduced, and less of the funding given to councils will be ring-fenced for specific purposes.

Importantly, information to be submitted to the Scottish Government will form only a relatively small subset of the performance information which local government collects. Councils will be expected to collect and publish additional information to fulfil the statutory duty upon them to report to their citizens on their performance. They will also have to ensure they have the information they need to manage performance effectively.

Success under an outcomes-based approach requires close working among different agencies with shared objectives. Local authorities already work closely with other agencies (including health boards, as well as enterprise, police and fire bodies) through Community Planning Partnerships (CPPs). These partnerships were set up to provide a vehicle in which organisations can work together to deliver better public services, and to make sure people and communities are genuinely engaged in the decisions made on public services which affect them. Local authorities have a special role in the work of these Partnerships, as they have a statutory duty to initiate and facilitate Community Planning in their respective areas. To date, CPPs have principally been used to facilitate joint planning, resourcing and delivery on services for which Partners are separately accountable to the Scottish Government.

Like other public bodies, the quality of performance and services which councils are responsible for providing are subject to external scrutiny. For local government, this work is principally carried out by the Accounts Commission for Scotland and a number of service-focused inspectorates and regulation bodies.

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<sup>10</sup> *Scottish Parliament Official Report*, 28 June 2007

The Scottish Government is considering recommendations made in the recently published report on public scrutiny by Professor Lorne Crerar<sup>11</sup>. For local government, the report noted that performance indicators and outcome measures for local government are also being developed by the Scottish Government and other stakeholders. It recommended that this focus should continue, with a view to local government being the first sector in which self-assessment becomes the core tool of accountability, with less reliance on external scrutiny required.

## **NHS Boards**

An important function of the Scottish Government's Health Directorate is to performance manage the NHS in Scotland. The current arrangements are intended to:

- Provide focus and clearly set out Ministers' key priorities, and NHS Boards understand what they have to achieve through clearly defined targets and measures.
- Support the scrutiny function because performance can be readily assessed through measures.
- Provide a 'whole systems' view of performance across key outcomes and across NHS Boards through the HEAT performance management system. Targets at risk of not being met, and NHS Boards encountering difficulty across a range of targets are identified early on to allow corporate action to be taken.
- Support the ongoing dialogue between performance managers/policy leads and NHS Boards.
- Reduce the burden on NHS Boards through focussing on key priority outcomes and avoiding asking Boards for wordy delivery plans.
- Allow the Scottish Government and NHS Boards to develop a more coherent approach to delivery and finance, and increasingly workforce.
- HEAT also provides a framework to help NHS Boards understand how intermediate outcomes and targets align with the Government's longer term strategic objectives.

The performance management task includes:

- Establishing agreed performance measures for key outcomes that the NHS is seeking to achieve through key services
- Setting specific, measurable, achievable, realistic (but stretching) and time-bound (SMART) targets for these measures
- Ensuring that the NHS produces local delivery plans (LDPs) showing how each Board will achieve the targets within the set timescale
- Tracking each Board's performance against its LDP profiles for each target
- Discussing performance with Board chief executives and senior staff where accrual performance varies materially from the planned profile
- If necessary, intervening to support Boards in improving performance and meeting targets
- Supporting Ministers in the formal Annual Review of each Board's performance, in public
- At the same time, checking that adequate systems are in place to ensure that quality and service do not suffer in the pursuit of SMART targets.

The performance management process currently works as follows.

Performance measures and targets are set out in what is called the core set of performance measures and targets, also referred to as the HEAT (Health improvement; Efficiency; Access; and Treatment) framework. The framework for 2007-08 sets out 28 targets for the

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<sup>11</sup> *Report of the Independent Review of Regulation, Audit, Inspection and Complaints Handling of Public Services in Scotland*, September 2007

NHS which are performance managed through 31 key measures. Work is underway to review these measures and targets. Boards complete their LDPs in good time for review and agreement before the beginning of each financial year.

As well as providing planned performance trajectories in respect of key measures for the next 3 years, NHS Boards' LDPs include commentary on the key risks to delivery and the actions being taken by Boards to manage these risks. LDPs also include integrated financial plans. Performance managers and policy leads in the Health Directorates negotiate and agree the LDPs with each NHS Board. Once agreed and signed off by the Director-General these form the 'performance contract' with the Boards.

Health Directorates regularly assess Board performance, and when necessary take action on targets at risk of not being delivered. An IT system - to which the Cabinet Secretary, Ministers, Health Directorates staff and NHS Boards have access - provides traffic lights, charts, and tables which compare actual performance against planned performance. The information is updated regularly to ensure that the most up to date information is available.

The Annual Reviews with each Board are supported and informed by performance information extracted from the HEAT framework and the associated IT system. Health Delivery Directorate also uses actual and planned performance to inform in-year dialogue and reviews with each Board.

## **Annex 3: National Performance Framework – National Outcomes and Indicators**

*Source: Scottish Budget Spending Review, Scottish Government, 14 November 2007*

### **National Outcomes**

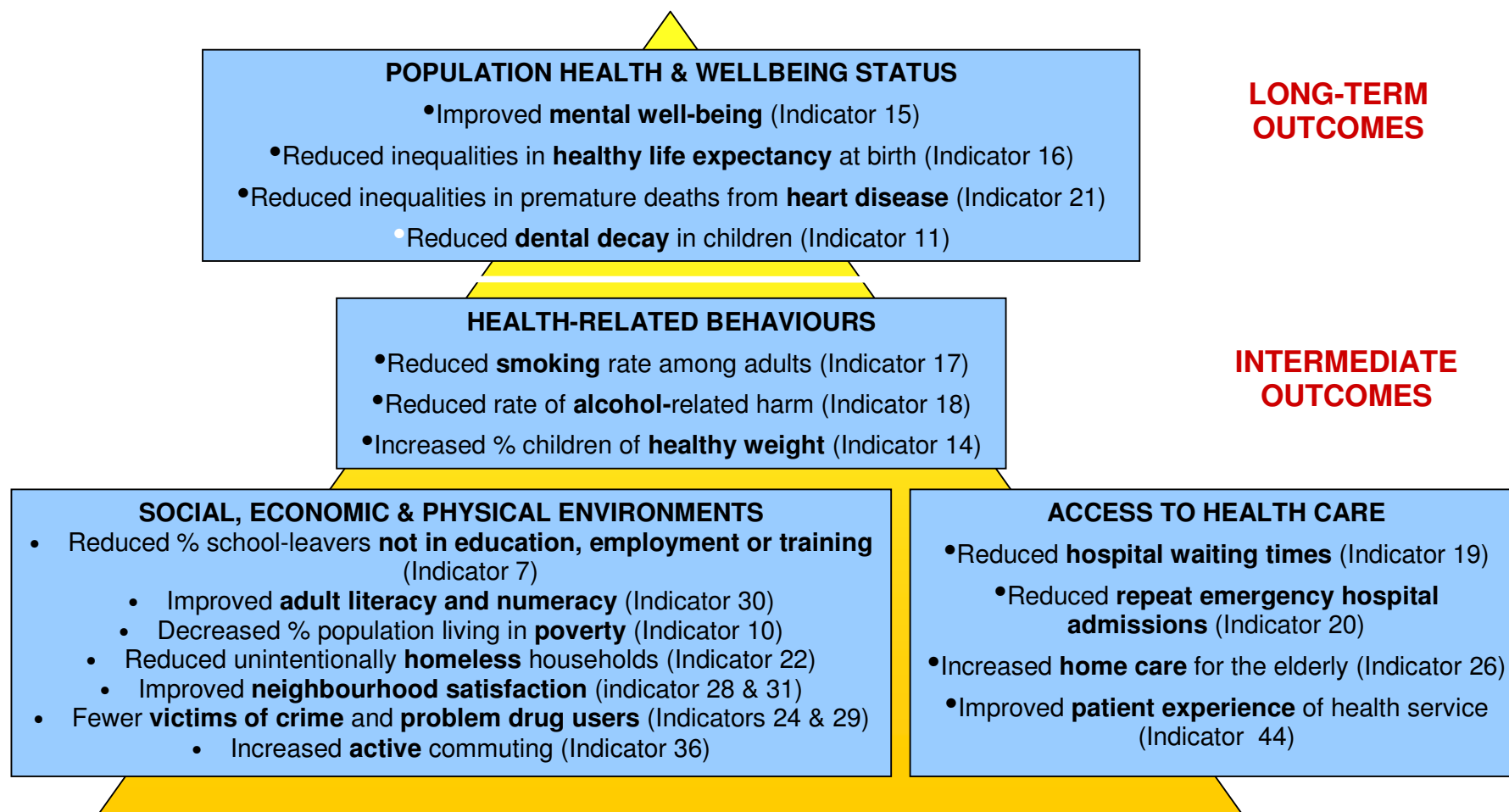
1. We live in a Scotland that is the most attractive place for doing business in Europe.
2. We realise our full economic potential with more and better employment opportunities for our people.
3. We are better educated, more skilled and more successful, renowned for our research and innovation.
4. Our young people are successful learners, confident individuals, effective contributors and responsible citizens.
5. Our children have the best start in life and are ready to succeed.
6. We live longer, healthier lives.
7. We have tackled the significant inequalities in Scottish society.
8. We have improved the life chances for children, young people and families at risk.
9. We live our lives safe from crime, disorder and danger.
10. We live in well-designed, sustainable places where we are able to access the amenities and services we need.
11. We have strong, resilient and supportive communities where people take responsibility for their own actions and how they affect others.
12. We value and enjoy our built and natural environment and protect it and enhance it for future generations.
13. We take pride in a strong, fair and inclusive national identity.
14. We reduce the local and global environmental impact of our consumption and production.
15. Our public services are high quality, continually improving, efficient and responsive to local people's needs.

### **National indicators**

1. Reduce the gap in total research and development spending compared with EU average (by at least 50% by 2011)
2. Increase the business start-up rate
3. Grow exports at a faster average rate than GDP
4. Reduce the proportion of driver journeys delayed due to traffic congestion
5. Increase the percentage of Scottish domiciled graduates from Scottish Higher Education Institutions in positive destinations
6. Improve knowledge transfer from research activity in universities
7. Increase the % of school-leavers (from Scottish publicly funded schools) in positive and sustained destinations (FE, HE, employment or training)
8. Increase the proportion of schools receiving positive inspection reports
9. Increase the overall proportion of area child protection committees receiving positive inspection reports
10. Decrease the proportion of individuals living in poverty
11. Increase the proportion of school children in primary 1 who have no signs of dental disease (60% by 2010)
12. Increase the proportion of pre-school centres receiving positive inspection reports
13. Increase the social economy turnover
14. Reduce the rate of increase in the proportion of children with their Body Mass Index outwith a healthy range by 2011
15. Increase the average score of adults on the Warwick-Edinburgh Mental Well-being Scale by 2011
16. Increase healthy life expectancy at birth in the most deprived areas
17. Reduce the proportion of the adult population who smoke (22% by 2010)
18. Reduce alcohol related hospital admissions by 2011

19. Achieve annual milestones for reducing inpatient or day case waiting times (18 week referral to treatment time by December 2011)
20. Reduce the proportion of people aged 65 and over admitted as emergency inpatients 2 or more times in a single year
21. Reduce mortality from coronary heart disease among the under 75s in deprived areas
22. All unintentionally homeless households will be entitled to settled accommodation by 2012
23. Reduce overall reconviction rates by 2 percentage points by 2011
24. Reduce overall crime victimisation rates by 2 percentage points by 2011
25. Increase the percentage of criminal cases dealt with within 26 weeks by 3 percentage points by 2011
26. Increase the percentage of people aged 65 and over with high levels of care needs who are cared for at home
27. Increase the rate of new house building
28. Increase the percentage of adults who rate their neighbourhood as a good place to live
29. Decrease the estimated number of problem drug users in Scotland by 2011
30. Reduce number of working age people with severe literacy and numeracy problems
31. Increase positive public perception of the general crime rate in local area
32. Reduce overall ecological footprint
33. Increase the proportion of protected nature sites in favourable condition (to 95%)
34. Improve the state of Scotland's Historic Buildings, monuments and environment
35. Biodiversity: increase the index of abundance of terrestrial breeding birds
36. Increase the proportion of journeys to work made by public or active transport
37. Increase the proportion of adults making one or more visits to the outdoors per week
38. Increase the proportion of electricity generated in Scotland from renewable sources (31% by 2011; 50% by 2020)
39. Reduce the amount of waste sent to landfill (1.32 million tonnes by 2010)
40. Increase to the proportion of key commercial fish stocks at full reproductive capacity and harvested sustainably (70% by 2015)
41. Improve people's perceptions, attitudes and awareness of Scotland's reputation
42. Improve public sector efficiency through the generation of 2% cash releasing efficiency savings per annum
43. Improve people's perceptions of the quality of public services delivered
44. Improve the quality of healthcare experience
45. Reduce the number of Scottish public bodies (reduce by 25% by 2011)

## Annex 4: Healthier Scotland: a framework for the National Indicators



## Annex 5: Revised **HEAT targets** for 2008/09 and **National indicators**

	MENTAL HEALTH	ALCOHOL	SMOKING	HEALTHY WEIGHT	EARLY YEARS	EARLY YEARS
<b>Long-term outcomes</b>	<ul style="list-style-type: none"> <li>• Improved mental wellbeing</li> <li>• Reduced inequalities in healthy life expectancy at birth</li> <li>• Reduced inequalities in CHD mortality</li> </ul>					
	Reduced suicide rate	Reduced rate of alcohol-related hospital admissions	Reduced tobacco-related mortality and morbidity		Increased health benefits to mothers and babies	Reduced dental decay in Primary 1 school children
<b>Intermediate outcomes – Indiv. behaviour</b>		Reduced rate of alcohol consumption	Reduced adult smoking rate Sustained quit rate (1 year)	Reduced increase in % children with BMI outwith a healthy range	Increased rate of exclusive breastfeeding at 6 months	
<b>Intermediate outcomes - environments</b>						
<b>Short-term outcomes</b>		Reduced % screening FAST positive at follow up	<b>Increased quit rate at 1 month follow-up</b>	Reduced weight at follow-up	<b>Increased rate of exclusive breastfeeding at 6-8 weeks</b>	Regular attendance at dentist for check-ups
<b>Reach (target population)</b>	Those at risk of suicide	Harmful and hazardous drinkers	Smokers who want to quit	Overweight children aged 7-13 and their families	Mothers with newborn babies	Families with children aged 3-5 years
<b>Outputs</b>	Rate of early intervention – help, advice, support, referral	<b>No. of screenings &amp; brief interventions (SIGN 74)</b>	Uptake of smoking cessation services – advice, support, NRT	<b>Completion rates for child healthy weight intervention)</b>	Uptake of breastfeeding advice, help and support	<b>NHS dental registrations</b>
<b>Inputs</b>	<b>50% frontline staff trained to assess and prevent suicides</b>					