Scottish Directors of Public Health
Response to the Scottish Parliament Health and Sport Committee
Preventative Agenda Inquiry

29 February 2017

The Directors of Public Health (DsPH) Group in Scotland welcome the Health and Sport Committee’s inquiry into preventative spend. This submission is on behalf of the Scottish Directors of Public health. We acknowledge submissions from colleagues in individual Health Boards who have also submitted views to the Committee.

1. Which areas of preventative spending/ the preventative agenda would it be most useful for the Health and Sport Committee to investigate?

Prevention is the best way to improve population health, and helps manage financial pressures on the health and social care systems (as well as other areas of public expenditure) whilst improving health outcomes and tackling persistent inequalities in health. The DsPH wish to draw several themes to the attention of the Committee which we consider warrant investigation in order to develop further the preventative agenda. Our response incorporates key messages from the draft responses from NHS GGC, NHS Health Scotland and NHS Borders’s.

The investigation should consider the ability to reduce inequalities and tackle social determinants as a primary consideration for preventative activity. There are three levels of preventative action:

1. Primary Prevention – action before any health harm has arisen
2. Secondary Prevention – early intervention to catch and reverse or mitigate health harm at an early stage.
3. Tertiary Prevention – once health harm established to prevent further deterioration.

We propose as the most useful areas for attention, based on the important of the problem in public health terms, evidence for benefit and cost-effectiveness of prevention measures are in the following:

a. Integration of policies designed to tackle inequalities and improve health;
b. Interventions for the early years, with an extension of focus on health before conception,
c. Interventions directed towards the wellbeing of young people;
d. Selected important disease and health/risk problems – alcohol, obesity, cancer, and mental health.

2. How can health boards and integrative authorities overcome the (financial and political) pressures that lead to reactive spending/ a focus on fulfilling only statutory duties and targets, to initiate and maintain preventative spend?

We recommend that the Committee examined the following areas:

a. Drawing together and synthesising for policy makers, decision makers and the wider public and professional audiences the most compelling evidence to act in a range of key
areas. Public health economics is providing some vital material to support such preventative approaches and investments, and this can be supplemented by evidence-informed, logic model approaches, coupled with the real-life experiences of families and young people relevant to key areas of interest.

b. Recommending a basket of appropriate outcomes-based targets and success measures, LDP standards and preventative activities, building on current work to review targets and performance measures in the health and other sectors.

c. Coordinating and protecting preventative spend – allowing discretion in allocating resources to prevention whilst taking intelligence-led approaches; preserving worthwhile prevention programmes as well as suggesting alternatives to current treatment spend; being realistic about the potential for savings; and recognizing the need for double running as effective programmes take effect.

d. Encouraging specific projects that prevent serious injury and costly care, such as accident prevention, that are proven ‘winners n a small scale and deserve application on a much larger scale.

e. Blending the views and expectations of the public with knowledge about what works in relation to preventative activity.

3. How could spend that is deemed to be preventative be identified and tracked more effectively? What is required in terms of data, evidence and evaluation to test interventions for producing ‘best value for money’?

The Public Health Review identified approx. 2.6% of the NHS Scotland budget spent on public health (including health visitors / school nursing). This figure should form the basis for future benchmarking of investment specific to this area.

More precise measurement of current spend on prevention would be a positive development in principle but challenging in practice. Much of the spending on preventative activities is not categorised as such because, for example, it takes place in routine primary and secondary health care or because the primary goal is not prevention, in particular for services out with the health sector.

We recommend the Committee should take the following lines of enquiry:

a. Emphasis on using data and evidence to identify the drivers of (inequalities in) preventable mortality and morbidity, then use evidence and evaluation to identify the most effective and cost-effective interventions.

b. Focused study, management information and costing in priority areas and for priority groups – for instance children and young people. In this field, joint approaches with the education sector and specialist agencies would be appropriate.
Scottish Directors of Public Health
Response to the Scottish Parliament Health and Sport Committee
Preventative Agenda Inquiry

29 February 2017

c. an emphasis on using data and evidence to identify what we think are the drivers of (inequalities in) preventable mortality and morbidity, many of which we already know well enough, and then use evidence and evaluation to identify the most effective and cost-effective ways of tackling these. These data require careful interpretation, and expert advice on the limitations of studies that show what works.
d. Any initiatives should be blended with community input and expressed needs.

4. How can the shift of spending from reactive/acute services to primary/preventative services be speeded up and/or incentivised?

The Health and Social Care Delivery Plan sets out the strategic direction for shifting spending from acute to community care. Together with the Christie Commission report as a framework, other policy documents, on Integration, Partnership and community empowerment, we already have an adequate policy environment on which to plan and implement services that have the potential for preventative activity, switching away from reactive and acute services.

The main thrust of the Committee’s attention should be to the proper objective-setting, monitoring and evaluation of policy intentions; paying heed to the main stakeholders, their view and factors that influence the pace of progress.

The key areas for attention in the health and related sectors should be on:

a. Primary care, especially where its mismatch between need and service quality, and resilience is under particular threat.
b. Services that support children, and young people who are vulnerable
c. Political and local leader’s support for service change decisions that aim to enhance community wellbeing but alter (and threaten, in the perception of some) the integrity of acute services.
d. Studying and applying learning from initiatives that deploy incentives in each of these areas.

There follows more detailed notes on each of these key questions.
Scottish Directors of Public Health
Response to the Scottish Parliament Health and Sport Committee
Preventative Agenda Inquiry

29 February 2017

1. Notes on useful areas for prevention

A useful way to consider determinants of health is through the adapted Health Scotland Model below:

![Health Scotland Model](image)

There is evidence\(^1\),\(^2\) that action which is more upstream, more likely to be regulatory and proportionate is the most effective and cost-effective at achieving the above aims. There is also strong evidence for early intervention particularly as it relates to the life-course.

Lifestyle drift refers to the phenomenon of policy starting with an acknowledgement that inequalities in resource and power are the fundamental causes of much ill health and inequalities in health outcomes but then drifting toward action on the more immediate behavioural and lifestyle

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\(^2\) Macintyre S. *Inequalities in health in Scotland: what are they and what can we do about them?*. MRC/CSO Social and Public Health Sciences Unit Occasional Paper no. 17, Glasgow, 2007
Scottish Directors of Public Health
Response to the Scottish Parliament Health and Sport Committee Preventative Agenda Inquiry

29 February 2017

causes. There is much that can still be done at Scottish Government and Local Government levels and within public sector agencies. With respect to the latter, the table below suggests relevant action.

<table>
<thead>
<tr>
<th>Partner role</th>
<th>Employer role</th>
<th>Service Provider role</th>
</tr>
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<tbody>
<tr>
<td>Inform, advocate, monitor</td>
<td>Participative Management and co-determination including good industrial democracy. Equitable recruitment and training policy – e.g. targeting employment opportunities at those further from labour market People orientated terms and conditions Inequalities sensitive training Making health choices easy choices at work</td>
<td>Proportionate universalism Health and inequalities impact assessments Reducing price and access barriers Prioritisation and integration of welfare rights/income maximisation Participatory budgeting Community Benefit clauses in procurement.</td>
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<tr>
<td>Increase availability of good jobs</td>
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<td>Health promoting community planning</td>
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<tr>
<td>Contributing to achievement of place standard(^3)</td>
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<td>Living wage accreditation and advocacy</td>
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It would be useful to look at the balance in spend between primary, secondary and tertiary prevention and, within these levels, the subsequent balance between upstream and downstream action even just for explicit ring-fenced public health budgets.

Integration of Policy

The Health and Social Care Delivery Plan notes that one of the main public health challenges for Scotland is to tackle key health harming behaviours that affect population health outcomes across age groups in Scotland (diet, physical activity, tobacco and alcohol) and that have
significant implications for health and social care needs and for care costs. There is an opportunity to consider the development of a more integrated approach to prevention across these health topics, which have tended to be addressed in isolation. These behaviours are risk factors for a number of preventable diseases including diabetes, heart disease, stroke and some cancers. Many of the health-harming behaviors that characterise the health of the population in Scotland are also associated with poor mental health.

Health literacy is a prerequisite for effective self-management of long term conditions and disability. Realistic Medicine has started to address the importance of health literacy in effective self management. Other opportunities to further develop discussions between the service user and clinician regarding treatment goals should be explored. Health literacy is a prerequisite for the effective self management of long term conditions and disability. Realistic Medicine has started to address the importance of health literacy in effective self management. Other opportunities to further develop discussions between the service user and clinician regarding treatment goals should be explored.

With the exception of the primary immunisation schedule in pre-school children – no most effective preventive measure in medicine, no area should be exempt from scrutiny or regarded as sacred and beyond review, However the DsPH wish to draw several themes to the attention of the Committee which we consider warrant investigation in order to develop further the preventative agenda.

Early years

The importance of early year’s experiences is now well accepted in Scotland as seen in many policies to improve life chances for children. There is growing evidence about the importance of recognising Adverse Experiences in Childhood (ACES) and understanding their impact on future health. The work on this issue being taken forward by Wales, and now Scotland, is to be commended.


Health Scotland has established an ACES expert group which will operate as a Scottish ACES Hub to raise awareness of and learning about ACES and to promote opportunities for prevention and mitigation.

Scottish Directors of Public Health  
Response to the Scottish Parliament Health and Sport Committee  
Preventative Agenda Inquiry  

29 February 2017

It is well evidenced that the health of the mother before or early in pregnancy impacts on the health of the child long after infancy. 

Preconception care would aim to improve health for all women of childbearing age and to target support for women at highest risk of poorer medical or social outcomes. Better preconception health, education and care has great potential in Scotland and has the potential for:

- reducing inequalities;
- promoting social justice across generations;
- preventing harm from happening in the first place (e.g. fetal alcohol harm and some ACEs);
- easing the demands upon health professionals and the NHS; and,
- grasping the opportunity to listen to, and then support, girls and women, boys and men in ways that lead to healthier families and a better society.

http://www.nhsggc.org.uk/media/237841/prepared-for-pregnancy-j-sher-may-2016.pdf

Parenting support and engaging parents in evidence-based programmes also have untapped potential to improve children’s health, well-being and life chances and should be promoted and delivered throughout Scotland. The POPP (Psychology of Parenting Project) led by NHS Education Scotland supports the delivery of two of the most evidence-based parenting programmes (Incredible Years and Triple P) and the committee should review the effectiveness of this programme with a view to sustaining it and encouraging the use of these programmes throughout Scotland.

Health and wellbeing of young people and adults

Coordinated responses to youth health challenges, including a strong focus on mental health and wellbeing of young people, would be a key area for the committee. This is arguably the next most important area of public health policy (after early years) in terms of potential impact, but one of the least joined up in policy terms. One in 10 children and young people experience mental health problems, and this has substantial implications for personal, social, health, educational and economic outcomes. Specifically there should be focus on the teenage to early adult years (partly due to the strong evidence of the drop of support for key health issues as young people “age out” of integrated children’s services. Systematic connection of young people with a range of health; social; educational; vocational opportunities within local communities can improve employability skills and raise attainment.

Of the many pieces of evidence to back up this recommendation, we cite two: the global work of the Lancet Adolescent Health Commission http://adolescentourfuture.com/ and the most recent iteration of the annual Macquarie Index from the Princes Trust, showing a huge level of unmet need amongst young people and young adults, leading of course to a huge burden of adult morbidity at best, and youth suicide at worst: https://www.princes-trust.org.uk/about-the-
Scottish Directors of Public Health
Response to the Scottish Parliament Health and Sport Committee
Preventative Agenda Inquiry

29 February 2017

trust/research-policies-reports/youth-index-2017 . Both of these areas of work demonstrate we need to adopt a social model of health, grounded in the reality of young people’s lives, in contrast to a quasi-medical risk factor reduction approach.

Resilient Communities

As far as preventive action is concerned, building resilient communities will protect against some of the common every day stresses and more significant problems that the community and individuals face. There are examples of where this has been done and where groups have identified assets in their community that offer wellbeing in terms of physical and mental health. This approach is particularly useful in areas of socioeconomic, physical or mental disadvantage. A combined approach with statutory services, third party and voluntary sector providers and on an intergenerational basis is most likely to produce the biggest return. Intergenerational work is valuable in ensuring that older people remain integrated in the community and pass their skills on to the younger generation. It also provides younger people with access to the skills and experience of older people. It would reduce social isolation and loneliness which contribute to morbidity, mortality and more use of expensive services. The evidence base needs to develop in order to determine the best investment blend, but community-level action to build on strengths and empower groups is a worthwhile preventative endeavour.

Identification of communities that face the greatest challenges could be undertaken through use of commonly available data such as SIMD 16, but it may be usefully supplemented by health board or council or other services data to further identify communities of interest.

Alcohol

In the alcohol field further work needs to be taken forward to protect children and young people from exposure to alcohol-related harms.

A review of alcohol deaths has indicated that about a third of those who died first developed problematic alcohol use in their teens. Measures considered in the current review of progressive policy to reduce alcohol-related harms constitute effective prevention; early intervention with children and families to delay the time when alcohol is first consumed would reduce the risk of these children growing up to become problematic drinkers and allow them to complete their education and develop skills for work.

Obesity

In 2015, 65% of Scottish adults aged 16 and over were overweight, including 29% who were obese. There has been an increase in the proportion who are overweight or obese among both sexes (aged 16-64) since 1995, from 52% to 62%. The impact of obesity is being felt across all parts of society including the NHS. The projected increase in the numbers of the population affected by Type 2 diabetes is an area of great concern not least because of the age profile of our
local population in the coming twenty to thirty years. There is therefore an urgent need to look into effective prevention models that would have applicability in rural and urban Scotland to slow down the numbers of people developing the condition and the complications associated with its onset.

Cancer

The role of multidisciplinary teams in developing person centred care based on holistic needs assessment and care planning is growing and innovative practice such as Improving Cancer Journey Partnership Programme in Glasgow (McMillan) or Extensive Care model in Blackpool and Fylde.\(^5\) This provides opportunities for preventative intervention with vulnerable patient groups identified in secondary care with a view to tailored early intervention and community support or social prescribing. Gathering robust evidence to support such approaches is key for transfer to mainstream practice.

Mental health

The fact that 1 in 10 children and young people experience mental health problems has a considerable personal, social and economic impact. Poor mental health in adulthood frequently starts during adolescence. Unidentified and untreated problems lead to poorer health, educational and social outcomes with significant costs to the public sector.

There is now considerable evidence on the life situations and circumstances which increase risk of poor mental health – adverse childhood experiences - ACEs, experience of loss, change, ill health, social isolation and exclusion, prolonged financial stress and insecurity. There are important roles at every level for Governments, community and third sector in supporting families and communities and in building social connectedness and resilience. The education sector has a vital role in creating positive learning environments, recognizing diversity and vulnerability, and preventing bullying. There is also a vital preventative role for public policy in reducing child poverty, promoting attainment, good employment opportunities and thriving communities. The prevention of poor mental health is an area that warrants further attention as part of a wider preventative agenda.

2. Notes on overcoming the (financial and political) pressures ....to initiate and maintain preventative spend

Leadership and vision are required to build a compelling case to act on early years and youth health, at both national and local level. This will require drawing together and synthesising for policy makers, decision makers and the wider public and professional audiences the compelling evidence to act in a range of key areas. Public health economics is providing some vital material

\(^5\) http://www.bbc.co.uk/news/health-38911008
Scottish Directors of Public Health
Response to the Scottish Parliament Health and Sport Committee Preventative Agenda Inquiry

29 February 2017

to support such preventative approaches and investments, and this can be supplemented by evidence-informed, logic model approaches. We also need to be collectively much better at learning from and engaging with the real-life experiences of families and young people as they attempt to navigate through life transitions, adopting an inclusive approach to the diverse needs, particularly of higher risk groups.

A good practice example: The “Not for Play” programme

A good example of tracking spend and savings from NHS Greater Glasgow and Clyde is the “Not for Play” programme in 2013. The initiative was aimed at tackling the growing concern of liquitab ingestion injuries to children in the NHS Greater Glasgow and Clyde Board area. It highlighted that if only one case was prevented, the average costs saved to NHS GGC was £19,500.00. The costing is based on nine cases treated by the ENT department only and excludes other departments and specialties. In the pre-campaign year, there were nine children admitted to the Intensive Care Unit with liquid tab/laundry pod injuries. Hospital costs for these nine children alone, excluding all other A&E or ward attendances, amounted to £175,500 in total with a mean cost of £19,500 (range £4,711-63,890). The cost per cupboard catch safety pack is £0.84, amounting to £13,440 for the 16,000 packs ordered for year three. In year three the suggested costs saved are: £175,500 costs of treating 9 cases, minus the cost of packs at £13,440, equates to £162,060 saved in year 3 alone. On totaling the costs for the three consecutive years of Not for Play, year one and two and three, the total costs saved are estimated at £450,700.00 for NHSGGC alone. The costs of treatment for liquid tab/laundry pod ingestion are significant to the NHS and also to wider society. These costings exclude parental time off from employment, travel to hospital or arrangements to have other children cared for. They also exclude A&E attendances.

LDP standards and preventative activities

We would strongly suggest this is partly about changing or supplementing current targets and performance management processes more generally. The current review of performance measures is relevant here. Many of the National Indicators in the National Performance Indicators make sense in terms of encouraging investment in prevention but some of the Local Delivery Plan (LDP) standards to which local boards are held to account encourage further investment in hospital or other health service-based activity to meet existing needs. Whilst this is clearly important to current patients, it also limits room for manoeuvre in trying to invest in more preventative approaches.

Statutory duties and targets need to be more in line with what we want to achieve with respect to prevention and a shift in the balance of care and we suggest that this would be a useful area for
Scottish Directors of Public Health
Response to the Scottish Parliament Health and Sport Committee
Preventative Agenda Inquiry

29 February 2017

the Committee to explore⁶. We hope that the forthcoming review of NHS targets will signal a move in this direction.

Coordination and protection of preventative spend

The more recent approach to increase the discretion for local NHS Boards to make decisions about the allocation of the public health budgets in bundles is welcome. This approach is proving helpful to develop a coordinated approach to preventative work across funding streams, although this is still at an early stage. We would welcome the opportunity to learn how this is being addressed in other Boards. However the increase in discretion for local NHS Boards to make decisions about the allocation of the public health budgets in bundles has advantages but has the risks of variability and of using the money for other purposes. Given the financial pressures in the NHS, monies for prevention can be at risk if not ring-fenced and in the current situation where there are few national targets attached to their use.

It may also be misleading to assume that prevention will facilitate disinvestment in the medium term. It is more likely to require upfront investment in prevention alongside the continued support for treatment services to address current need. This would lead in the longer term to the alleviation of pressures on acute services. In the short term, it may be as important to protect current preventative services as it is to ‘make the shift’ to preventative spend. There is a risk, particularly in a relatively small organization / partnership that a critical mass of preventative services becomes unviable if these services drop below a critical scale.

The views and expectations of the public are important considerations in relation to preventative activity. The Committee might want to look into how the public can be engaged further in the development of preventative approaches in view of the strong support that came through the recent National Conversation on a Healthier Scotland.

3. Notes on identifying and tracking preventative spend more effectively.

The Public Health Review identified approx. 2.6% of the NHS Scotland budget spent on public health (including health visitors / school nursing). This figure should form the basis for future benchmarking of investment.

It would be worth considering how spending of the pupil equity fund will be monitored. This is a substantial investment and provides a wonderful opportunity for teaching staff to be involved in preventative activity. Reducing socioeconomic inequalities in attainment requires action beyond

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education services. Head-teachers will need support with understanding the evidence base for what will work beyond education and support in monitoring the impact of their actions.

In the case of youth health, one of the approaches can (and should) be much more direct involvement of young people and their advocates in the process of developing, delivering and evaluating services. Lots of good examples of coproduction approaches (including our Aye Mind work, Young Scot’s youth commission on alcohol and also on 5Rights (digital rights), plus also good models for young people as service commissioners. No doubt many other means could be used, various communities of practice and regular sharing of approaches across the country. At the moment, youth health is fragmented across multiple governmental departments, performance targets, funding streams; health board and HSCP level planning is fragmented in many cases (but some good practice in some areas, e.g. working through GIRFEC lens).

The recent (2016) publication by University of Manchester of the factors contributing to youth suicides, shows that we have a very clear handle on many of the risk factors that will put young people at risk – bereavement, trauma and neglect, bullying, exam stress, self harm, long term conditions; yet we struggle to galvanise a coordinated set of responses to these underlying factors – obviously our child and youth mental health framework is an attempt to support this, with some evidence of success, but much more could and should be done in this regard.7

More precise measurement of current spend on prevention would be a positive development in principle but challenging in practice. Much of the spending on preventative activities is not categorised as such because, for example, it takes place in routine primary and secondary care or because the primary goal is not prevention, in particular for services out with the health sector. We would suggest that the emphasis should be on using data and evidence to identify what we think are the drivers of (inequalities in) preventable mortality and morbidity, many of which we already know well enough, and then use evidence and evaluation to identify the most effective and cost-effective ways of tackling these8. However, there is a risk from the application of inappropriate methods of assessing evidence, with an overemphasis on outcomes of individual behaviour change rather than across the breadth of its activities. Systematic review methods need to include a broader range of studies and research methods, including qualitative research. Those who have a direct interest in a health improvement initiative should have the opportunity to participate in all stages of its planning and evaluation. Adequate resources should be devoted to the evaluation and the ‘success’ of health improvement initiatives should be evaluated in terms

7 [Link](http://research.bmh.manchester.ac.uk/cmhs/research/centreforsuicideprevention/nci/reports/cyp_infographics.pdf)

8 NHS Health Scotland draft response to Health and Sport Committee Inquiry into Preventative Spend, February 2017.
Scottish Directors of Public Health
Response to the Scottish Parliament Health and Sport Committee
Preventative Agenda Inquiry

29 February 2017

of processes as well as outcomes. Expertise in the evaluation of health improvement initiatives needs to be developed and sustained. The use of randomised controlled trials (RCTs) to evaluate health improvement initiatives may, in some cases, be inappropriate, misleading and unnecessarily expensive.9

4. How can the shift of spending from reactive/acute services to primary/preventative services be speeded up and/or incentivised?

The Health and Social Care Delivery Plan sets out the strategic direction for shifting spending from acute to community care.10 This states that in 2017, Health and Social Care Partnerships – with NHS Boards, local authorities and other care providers – should make full use of their new powers and responsibilities to shift investment into community provision by reducing inappropriate use of hospital care and redesigning the shape of service provision across hospital, care home and community settings. It would be useful to evaluate the effectiveness of these Partnerships to see if they are indeed able to make these shifts. For example effective clinical involvement and clinical leadership (primary and secondary care) working together with public health professionals are essential components of high-quality commissioning. However it is unclear if the Partnership structures designated in regulations allow this to happen effectively. Other barriers may include the difficulty in giving clinicians and public health professionals the autonomy they need to effectively take decisions about the design of local services.

Emerging themes of Scottish Primary Medical Care contract, currently under negotiation, suggest the recognition of flexibility in application according to the care setting and local characteristics. Primary care services need to be adequately funded and to be trusted to provide the best possible care for the individual patients in front of them.

Incentives to sustain primary medical care in areas of need and low resilience – whether in areas of multiple deprivation or remote and rural settings – are preventive measures in themselves. General practice has already demonstrated itself to be a highly cost-effective service and a leading and vital component of any coherent community based health and social care service. Primary care services need to be adequately resourced, supported and connected, and trusted to apply the art of medicine to the individual patient in front of them.

It is also important to note that some HSCPs include children’s services. Given the small visibility of children in acute service budgets there is a significant risk that early life course intervention and prevention is overshadowed by older people’s issues in these circumstances. The proportion of spend

across the life course should be closely monitored to ensure it reflects need to rebalance care in favour of early life course intervention. One approach could be for there to be a specified minimum proportion of relevant public health budgets allocated to prevention. This would require a clear definition of prevention and perhaps further delineation of spend in terms of greater focus on primary prevention. Boards supported by the Scottish Government will have to make bold, informed and intelligent decisions about acute site closure where this is cost-effective. In doing so, agencies should ensure that resources are reinvested in prevention rather than lost through other acute service pressures that do not affect health outcomes, or in efficiency savings.

Financial pressures may also mean that Partnerships are required to take tough prioritisation decisions but may feel they are not able to keep the public on board as they do this. History tells us that local populations often fiercely resist any changes to local acute service provision. An ongoing evaluation of Partnerships is therefore required if we are to build on the progress Partnerships have made so far and work to spread that learning by embedding clinical and public health professional involvement in planning decisions wherever they happen in the system. This evaluation could also consider the ability of Partnerships to influence and engage with the wider public health agenda; the impact of the Community Planning Partnership locality plans including the new Local Outcome Improvement Plan on preventative objectives and reduction of health inequalities; and whether the new GP contract is supportive of the planned shift from acute to community service provision.