**OUTPUTS**

**OUTCOMES**

##### MEDIUM

##### LONG

##### SHORT

**INPUTS**

Reduced health inequalities

##### LOCAL SERVICE DELIVERY

# PARTICIPATION

# ACTIVITIES

# Reach

No. in target pop

% on risk register

% contacted

# Access

% attended for 'health check'

% new attenders

# Uptake

% fully risk assessed

% received clinical interventions

% referred to other services

**Compliance**

% followed up

% complying

Impacts on GP practices & local services

Increased prescribing and use of GP practices and local services

# CVD risk factor modification

Quit rate

Smoking

BMI

Cholesterol

Blood pressure

Diabetes management

Additional risk factors

PA levels

Healthier diet (F&V, fat, salt)

Alcohol consumption

Patient satisfaction

Health-relatedQoL

Quality of contact with GP

Reduced premature CVD mortality in dep areas

# Target groups

Boards & CHPs

Snr leaders

GP practices/PC teams

Vol & community services

Community

# ISD

Health info & IT

# HS

Planning & evaluation

Evidence

Social marketing

Capacity-building

Learning for roll-out

# Boards/CHPs

Planning

Engagement with GPs & serv

Recruit and train staff

Monitoring and reporting

# Target population

Those aged 46-64 who are registered with a GP

(See flow chart)

# GP practices

Service re-design

Identify population

Invite/reach individuals

Engage

Assess for disease and risk

Provide a range of effective clinical interventions, incl referral to other local services

Maintain, monitor and follow-up

# Other local services

Accommodate additional demand

Resources invested:

SE (£25m over 3 years + Counterweight)

HS (staff tme)

ISD (staff time)

CHPs

NHS Boards

Resources invested:

£1m pa per CHP for 2 years from April 2006

£0.4m per CHP smoking cessn for

Additional staff time

##### IMPLEMENTATION SUPPORT