ROTHERHAM BOROUGH COUNCIL

1.	**Meeting:**	**Cabinet**
2.	**Date:**	**6th February 2013**
3.	**Title:**	**Public Health Responsibilities in relation to NHS Health Checks: Commissioning options for the NHS Health Check Programme April 2013**
4.	**Directorate:**	**Public Health**

5. Summary

This paper summarises the NHS Health Check commissioning responsibilities of Local Authorities in relation to the expected delivery measures as outlined in the Public Health outcomes framework for England, 2013-2016. The paper also outlines the options reviewed for commissioning the programme from April 2013.

6. Recommendations

That for 2013 – 2014 the Mandatory Public Health NHS Health Check programme continues to be provided through Rotherham General Practices.

Cabinet note that this will be via direct commissioning with each General Practice through a Public Health Contract. Contract performance monitoring will require data transfer from the Clinical Commissioning Group.

7. Background

The NHS Health Checks is to be one of the **mandated** areas of work transferring to Local Authorities from April 2013.

NHS Health Checks is a systematic case finding programme targeted at all 40 – 74 year olds, designed to calculate and inform the individual of their 10 year risk of a CVD. The Check providers will work with client to develop risk management strategies.

The programme has been operating since April 2009 via a GP Locally Enhanced Service (LES), it is a well-developed programme; the NHS Health Checks will include a 5 year recall from April 2017. NHS North of England has issued a quality assurance specification for the Health Check programme.

Lifestyle advice and support is provided through the Health Trainer Service but is not exclusive to Public Health providers. Lifestyle pathways have been set up to allow

referral to smoking, obesity and alcohol services. Links have been made with community exercise programmes. There is currently no charge for lifestyle intervention. The Health trainer Service operates predominantly in the most deprived areas and for those with disabilities or in ethnic minority groups.

What does a NHS Health Check involve?

Vascular checks MUST include the following for 40-74 year olds:

Age	Ethnicity
Gender	Body Mass Index (BMI)
Smoking Status	Cholesterol
Physical Activity	Blood pressure (BP)
Diabetes Risk	Pulse (for Arial Fibrillation)
Alcohol Audit C	Dementia Awareness

Dementia

From April 2013, Dementia awareness is now included in the Health Check. This element only applies to those invited for a Health Check within the 65 – 74 year cohort.

It will require the provision of raising awareness of dementia signs and symptoms and signposting people to local memory clinics if necessary, no formal assessment is required in the NHS Health Check.Full guidance to be published early 2013. This will require negotiation with Rotherham General Practices to include this in the check.

8. Proposals and Detail

From 1st April 2013 Local Authorities are mandated to ensure that their local eligible populations receive an invitation to attend a Health Check.

Expectations are that 90% of the eligible population will be screened over 5 years (18% of the 20% of the eligible population annually.

A successful program requires 3 key elements;

1. A population register;
2. Access to the test
3. Results handling and follow up or referral for identified problems or conditions.

1 and 2 are the responsibility of Public Health. 3 above requires Public Health to ensure results are transmitted to both the participants and their GP. It is the GP's responsibility to ensure appropriate follow up and treatment. Cost issues in relation to payment of additional elements are the responsibility of the GP these include further investigation, treatment drug and pharmaceutical costs. Custom and practice over the last five years has been that GP testing in relation to the health check is included in the hospital block contract for chemical pathology. The behaviour change services are commissioned separately – there is no additional cost to the GP (in fact they can deliver smoking cessation and get paid more).

Many patients are screened annually in general practice for CVD risk as part of their care. Taking testing out of general practice would mean that many patients would be tested twice. GP computer systems automatically gather existing data to calculate a risk score.

The cost of the existing service, including blood tests is almost certainly much higher than the current budgeted amount.

Failing to ensure proper arrangements for the treatment of identified conditions would have very significant medico legal risks for the Council. Testing at the GPs means that the GP is then directly responsible for taking treatment action.

Options for Health Check delivery

The recommended option:
(1) Direct commissioning by RMBC with General Practice.
Public Health contract manage the programme in its entirety, managing the budget, payments and data analysis 'in house'. It would create a robust management process and ensure rigorous contract management. This would be part of a Public Health Contract with each General Practice. This approach will also create a stronger relationship with other services commissioned via Public Health such as the Health Trainer service, weight management, alcohol and smoking cessation provision.

Other options considered:
(2) The Commissioning Support Unit (CSU) contract the service with General Practice Public Health may be required to pay management fees under the new NHS structures. Assuming these are between 17% – 20% this could equate to approximately £60,000; leaving a programme budget of £240,000. The CSU will be commissioning services across the NHS Commissioning Board local area. It is unlikely that they can maintain the close working relationships required to deliver the performance required from General Practices. The majority of GP contracts and services will be commissioned by the NHS CB.

(3) Mixed Model of Delivery
This combines option (2) and (4).
General Practice is commissioned to establish and be responsible for a call / recall register and the clinical assessments for the Health Check programme. A Public Health nurse team (Band 6) are responsible for the follow up, risk / lifestyle management, counselling, support and signposting.

(4) Community Nurse Team

Public Health Nurse administers health check using the Exeter system for call and re-call and near patient testing. This would require access to system one and GP venues. The Check results are communicated in situ and a letter is issued to the Health Check recipients GP. General Practice then manages the Health Check yield appropriately.

An indicative cost based on the top of a Nurse band 6, management costs at 17%, travel and sundries equates to approximately £ 47,621.56 per post plus equipment costs.

Additional expenditure to be factored in:
A venue budget of approximately £42,000 (indicative cost per annum for a team of four based on £25 per hour rates).A marketing and communications budget of £1,500 per annum.

A team of 4 should provide enough Borough wide coverage for the programme. This approach will also create a stronger relationship with other services commissioned via Public Health such as the Health Trainer service, weight management and smoking cessation provision.

(5) Initiate a procurement process and test the market for other providers.

Testing the market and initiating a procurement process could provide us with scope for stronger performance management over the providers to include penalty clauses if performance and quality is not as per contract. This approach could also provide us with the opportunity to run a contract for longer than one year (as per the current LES process) and, include a charging schedule if appropriate. Due to the contract value being in excess of 90k, the OJEU procurement process will have to be adhered to. Most schemes have omitted any systematic call and re-call provision and are based on a "venue" approach.

Such schemes would need to include testing costs.

(6) Pharmacy Locally Enhanced Service (LES) Using the Exeter system for call and re-call and near patient testing community Pharmacy have previously expressed an interest in delivering this programme. A LES could be developed to permit Pharmacies to 'volunteer' to deliver this. This would require secure transmission of results to the GP.

(7) A Web based programme – commission the development of a web based Health Check programme based on best practice guidance with three levels of filtering. First level, self-completed vascular risk assessment, utilising existing examples and a computer generated risk response and/or face to face assessment which includes physical measures(e.g weight, central circumference) – 'filters out a lot of the worried well'; smaller groups identified requiring further assessment. The higher risk patients remaining are recommended to contact their GP for further

investigations and online template letter could be generated at this point with the results.

Performance Management of Recall.
5 year Recall (repeat checks) is not currently funded. We will continue to fund first checks only as this optimises health gain.
The 90% annual uptake target (18/20% eligeable population) is to enable the volume of recalls to be managed post 2017.
The recall registers will be activated April 2017.

9. Finance

The finance schedule is per screen and explanation of risk and is a dual tier payment system based on a practice's 45% threshold. This is a Rotherham scheme threshold and will remain for 2013/14.

< 45 % of the practice eligible population = £10.00 (Does not include dementia awareness).
> 45 % of the practice eligible population = £24.20 (Does not include dementia awareness).

Custom and practice denotes that testing costs are included in the Block contract with The Rotherham Foundation Trust.

10. Risks and Uncertainties

Following contract review and tendering processes there is the possibility that some poor performing practices may not want to sign the contract. Should this be the case, there are mechanisms which can ensure the eligible population are not excluded from the scheme, through the creation of a private list.

11. Policy and Performance Agenda Implications?

If Rotherham does not continue to implement the NHS Health Check programme it will fail to deliver on the following strategic priorities:

- Public Health Outcomes Framework – Mandated programme.
- Health and Wellbeing Board – Strategic priority. Obesity, smoking, alcohol and dementia
- Reduction in Health Inequalities – National Indicator and Corporate Plan priority.
- All age all cause mortality rate per 100,000 population – Early Intervention

Currently Health Check data is collated by the Primary Care Trust. Contract and performance management will be coordinated in house from April 2013.

12. Background Papers and Consultation

Public Health outcomes framework for England, 2013-2016.
Public Health in Local Government, 2011
Putting Prevention First: NHS Health Check Vascular Risk Assessment and Management Best Practice Guidance, DH 2009.
Next Steps Guidance for Primary Care Trusts, Department of Health, 2008,
Service Specification for NHS Health Check (CVD Risk Assessment), 2009,
Service Specification for NHS Health Check (CVD Risk Assessment), 2011,

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Appendix 1 – Health Check Model Analysis

Model	Call / Recall process	Test element	Advice and Support	Check Test Outcome Management	Advantages	Disadvantage
GP Delivery	Systematic Register Based Eligible Population invited	Lab based (not funded)	Included in the Check Signposting to other services for additional support	In house Relevant Disease registers	Entire registered population coverage. Systematic risk management. Systematic disease management. Coordination of invite system. Management of throughput.	Differing interpretation of the Best Practice Guidance. Differing levels of staff delivering the Check. Differing commitment to the scheme.
PH Nurse	Systematic Based on Exeter Eligible population invited	Near Patient Testing	Included in the Check	Referral onto GP Signposting to other relevant providers (eg lifestyle services)	Robust in house performance management Target in on communities of need (if required) Opportunity to pick up the unregistered via outreach	Staffing and operational costs Smaller population covered Lack of systematic risk management structure. Sourcing and funding Venue's
Private Sector Other provider	Systematic Based on Exeter Eligible population invited	Near Patient Testing	Included in the Check	Referral onto GP Signposting to other relevant providers (eg lifestyle services	Ability to engage a range of providers including smaller providers GP practices could undertake activity on behalf of	Difficult and time-consuming to manage and QA multiple contracts Difficult to manage a call-recall list External providers

					neighbouring practices Reduced risk of underperformance Open contracting process	will rely heavily on opportunistic invitations Risk of over performance Potentially no systematic invite structure in place. Thus difficult to record no. of invites