# Health Checks

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# What are they - History

- Long history – started out as cardiovascular checks – premise being to check peoples CVD risk and then Rx those at high risk with either lifestyle advice or statins / other meds as appropriate.
- Everyone wants to add something though...
  - Alcohol risk screen
  - Dementia risk (Number 10 initiative)
  - Diabetes
  - Renal disease (never really made the cut locally or nationally)
  - Winter Warmth (locally)

# Must dos*

- Offer health checks to eligible persons in the LA area
  - Eligible person is anyone between 40-74 yrs of age, who is not already on a disease register, on statins, or been previously assessed as having a greater than 20% CVD risk
  - Every five years, on a rotating basis
- Have to ask/measure/calculate (if they consent)
  - (a)age, (b)gender, (c)smoking status, (d)family history of coronary heart disease, (e)ethnicity, (f)body mass index, (g)cholesterol level, (h)blood pressure, (i)physical activity levels, (j)cardiovascular risk score, (k)AUDIT score
- Have to communicate
  - BMI, Cholesterol, BP, CVD risk, AUDIT score
  - If not the pts GP, have to send this info to the GP.
- Monitor and act to increase uptake in area

* = as stipulated in The Local Authorities (Public Health Functions and Entry to Premises by Local Healthwatch Representatives) Regulations 2012

# What are our basic aims?

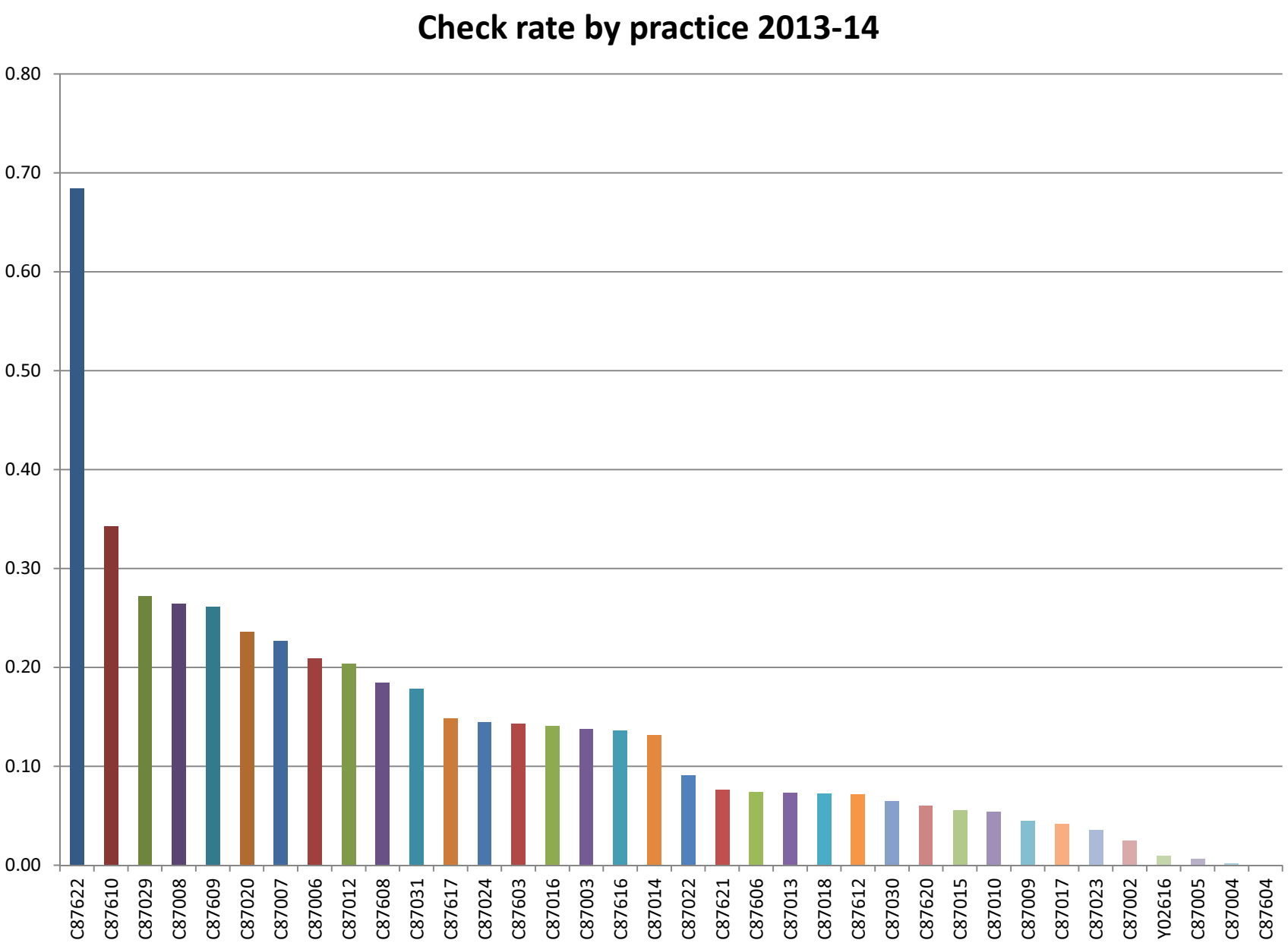
- Identify asymptomatic risk factors / disease and initiate changes
  - Lifestyle modification
  - Treat risk factors (BP, Cholesterol)
- Reduce inequalities in health
  - Identify unmet need in more deprived areas
  - Get people who normally wouldn't present onto treatment

# So we need to...

- Get people to attend
- Ensure we are getting referrals
- Commission appropriate lifestyle services

# Current provision in Rotherham

- Opted for GP based delivery
- Demographics
  - Age, Gender, Ethnicity
- History
  - Smoking history, Alcohol (AUDIT C), Physical activity (GPPAQ), drugs, family hx of CVD in 1st deg relative.
- Examination
  - BP, pulse, BMI
- Ix
  - Serum cholesterol (unless one on file from last 6/12)
- Add-ons
  - “Raising awareness of dementia” – screen? To what end?
  - HotSpots referral is risk >20%


Check rate by practice 2013-14
0.80
0.70
0.60
0.50
0.40
0.30
0.20
0.10
0.00
C87622
C87610
C87029
C87008
C87609
C87020
C87007
C87006
C87012
C87608
C87031
C87617
C87024
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C87015
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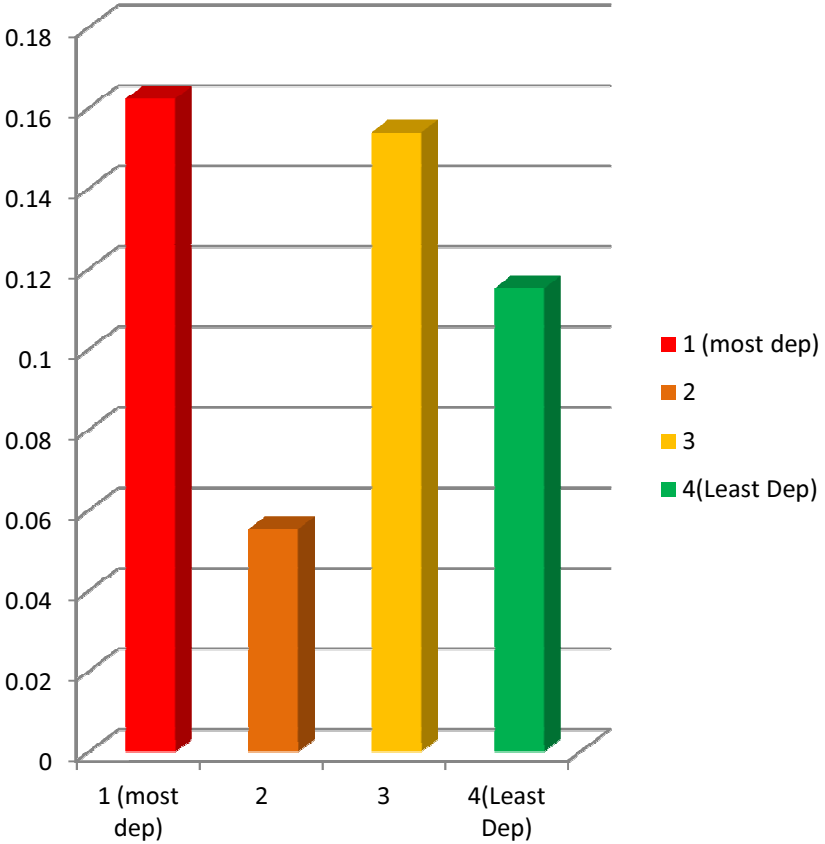
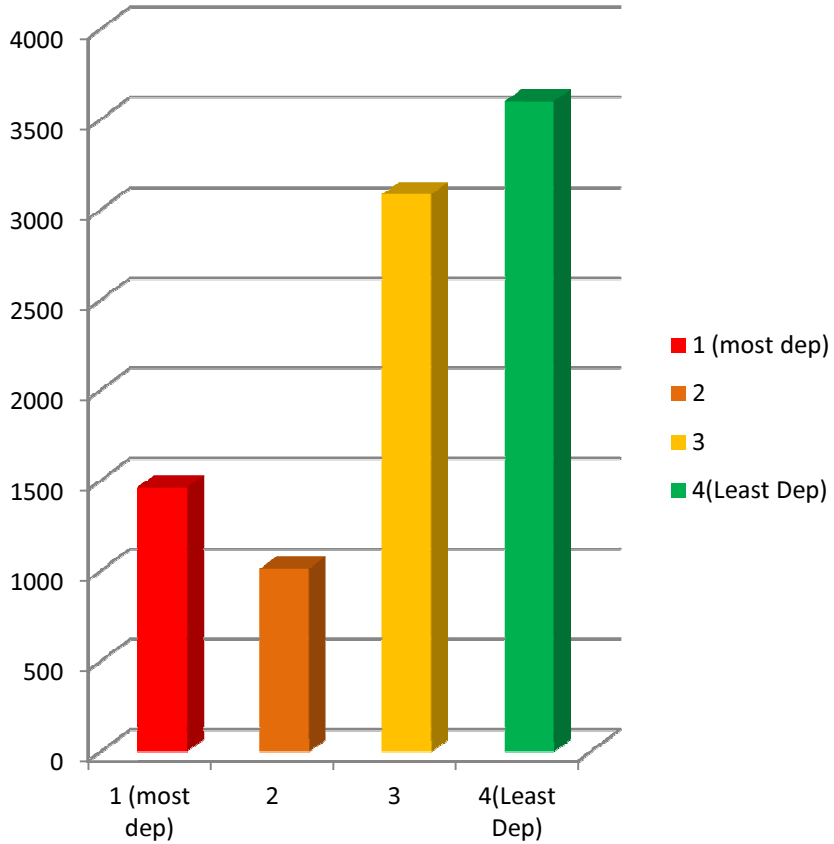
C87002
Y02616
C87005
C87004
C87604

## Rate of health checks by deprivation of practice area for 2013-14




## Number of checks by deprivation of practice area 2013-14



# How are we doing?

- Reasonable balance between deprived and less deprived areas.
  - On absolute count have done nearly 3 times as many in least deprived vs most deprived
    - BUT – most deprived areas have younger populations – less eligible patients
- Great variation between practices performance
- On last years performance
  - 17/36 practices will have checked less than 45% of their population over the five years
  - 25/36 practices will have checked less than the PHE recommendation of 75%

# Benchmarks

- Spending £1.35 per head of population for Rotherham
  - Cf avg £2.27 for our deprivation decile (~40% less)
- Hard to compare with other areas – probably doing better than most but new measures so hard to compare

# Guidance

- Latest guidance
  - DH/PHE – Sept 2013
    - Some clinical recommendations on further testing
  - NHS Health Check programme standards: a framework for quality improvement
    - Results of CVD risk must be communicated "**face to face**"
  - Framework of competencies for those delivering the checks
    - Significant training requirement

# Problems

- Likely to miss targets on current performance
  - Probably still one of the best areas though
- Huge variation in practice
- A lot of the asks are not supported by evidence
- Guidance
  - Aiming to standardise? But without specifying
  - making delivery more onerous
  - Compliance with guidance would cost more
- No demand – not marketed

# What are our options?

- Change delivery model?
  - Likely to cost more to re-commission
  - Other models elsewhere
    - Pharmacies
    - In house teams going to workplaces
    - Private providers in car parks of shopping centres
    - List acquisition
- Simplify current delivery by increasing practitioner freedom
  - Reducing frequency of monitoring
    - Eg currently asking for monthly returns – could be qtrly
  - Removing unnecessary specifications
    - Face-to-Face to be simplified
    - Remove HotSpots referral
    - Practitioner to decide dementia
- Drive demand with marketing locally and push PHE for national campaign
- Practice visits and advice for worst performers