Health and Wellbeing Board

31 January 2017

Cardiovascular Disease Framework and Prevention Programmes

Report of Gill O'Neill, Interim Director of Public Health, Adult and Health Services, County Durham

Purpose of Report

1 The purpose of this report is to update the Health and Wellbeing Board on the progress made on the Cardio-Vascular Disease (CVD) Framework and associated programmes. The Strategic Framework for the Prevention of Cardiovascular Disease identifies a number of risk factors for heart disease and other related conditions that may, through lifestyle and other forms of intervention, be reduced.

2 There are a number of programmes that Public Health leads or contributes to which are designed to influence these risks. These programmes include:

- NHS Health Checks;
- Smoking cessation programmes;
- National diabetes prevention programme;
- Change4Life.

Summary

3 The CVD Framework – The Strategic Framework for the Prevention of CVD 2014/19 sets out the direction of evidence based CVD prevention initiatives in County Durham. It identifies modifiable risk factors for: CVD risk; diabetes; chronic kidney disease; chronic obstructive pulmonary disease (COPD); and some cancers. These risk factors are: over weight / obesity; high cholesterol; smoking; high blood pressure; failure to meet exercise guidelines; hazardous and harmful drinking; Type 2 diabetes.

4 NHS Health Checks – Health Checks are part of a national risk assessment and management programme for those aged 40 to 74, who do not have an existing CVD and are not being treated for its risk factors. It therefore addresses the points raised within the CVD Prevention Framework. Work is ongoing to ensure equitable access and efficient delivery across the county. The more targeted approach will focus on those at a greater risk of CVD, this will tend to be an older age group and people with risk behaviours such as smoking and obesity.

5 As of September 2014 the local delivery of Health Checks became more targeted towards those at greatest risk of CVD. This has allowed an efficient service delivery and will be reflected in future delivery models (e.g., targeting those with high estimated CVD or Diabetes risk scores).

6 The programme has recently been reviewed and GP federation and community outreach models designed. These will follow national standards and National Institute for Health and Care Excellence (NICE) guidelines to provide a high quality service, with the GP based programme offering broad access on a federation footprint and the community programme supporting those who do not engage with primary care.

7 We are currently seeking additional funding from the British Heart Foundation to compliment the community health check programme with additional capacity to provide an extra 2000 blood pressure measurements per year above those conducted as part of an NHS Health Check.

Diabetes Prevention

8 The local roll out of the national NHS Diabetes Prevention Programme (a joint initiative led by NHS England, Public Health England and Diabetes UK, together the National Programme Team) has been underway since April 2016. This is led by North Durham and Durham, Darlington, Easington and Sedgefield Clinical Commissioning Groups (CCGs) with advice from the Public Health team and replaces the Just Beat It programme. The programme aims to identify people at high risk of developing Type 2 diabetes and offer them a behavioural intervention designed to lower their risk.

9 Diabetes prevention is also crucial not just for the health economy but in the protection of the health of the population. For this reason Durham County Council continues to provide advice to the local CCGs and national providers regarding the roll out of the first wave of the national prevention programme locally.

Smoking Alliance and Data

10 County Durham delivers tobacco control within an evidence based framework via the County Durham tobacco control alliance. Durham County Council is also the lead commissioner of the regional tobacco programme ‘Fresh’. County Durham has experienced a steady drop in smoking prevalence over the last three years, resulting in a 3.2% drop since 2012. However 18.1% of women in County Durham continue to smoke in pregnancy. Whilst data shows a reduction for County Durham since 2009/10, this is not equal across the two CCG areas and further work is needed to address this unwanted variation.

Obesity

11 In County Durham it has been estimated that 72.5% of adults, 24% of children aged four to five years, and 36% of children aged 10 to 11 years have excess

weight. If the significant upward trend is not reversed there will shortly be an untenable cost in terms of population health and economic costs to the NHS and wider economy. If we fail to halt the rise in obesity then 60% of adult men, 50% of adult women, and 25% of children in England will be obese by 2050. A life course approach must be taken to reducing the prevalence of excess weight. As such it is a cross cutting theme in several strategies and plans:

- County Durham Plan;
- County Durham Children Young People and Families Plan;
- County Durham Joint Health and Wellbeing Strategy;
- County Durham Healthy Weight Framework;
- County Durham Physical Activity Framework.

12 These multiagency plans, strategies, and programmes which each address different aspects of CVD must be supported and co-ordinated to efficiently reduce the overall risk. The detailed report can be found at Appendix 2.

Recommendations

13 The Health and Wellbeing Board is requested to:

- Note the multifaceted approach to reducing the risks of CVD and associated conditions as identified in the CVD prevention framework;
- Note the experience of delivering the Health Check programme in County Durham;
- Endorse the changes to the health check programme that will be included in the revised services specifications from April 2017.
- Note the work being undertaken by the CCGs to increase uptake of the diabetes prevention programme;
- Support partners to deliver evidence based tobacco control interventions.
- Note that a bid of £99,200 over two years has been submitted to the British Heart Foundation to complement the community health check programme.

Contact: Dr Mike Lavender, Consultant in Public Health Medicine
Tel: 03000 267681

Appendix 1: Implications

Finance
Smoking cessation and health check programmes are paid for via the Public Health grant. Note bid submission to BHF for £99,200.

Staffing
Not applicable.

Risk
Not applicable.

Equality and Diversity / Public Sector Equality Duty
Public health aims to address health inequalities and narrow the gap in health outcomes.

Accommodation
Not applicable.

Crime and Disorder
Not applicable.

Human Rights
Not applicable.

Consultation
Not applicable.

Procurement
The NHS Health Check programme has been recently reviewed in order to support the current redesign and procurement of new services.

Disability Issues
Reasonable adjustments should be made to allow equity of access to services.

Legal Implications
- Provision of NHS Health Checks is a mandated function.
- A memorandum of understanding has been signed between NDPP partners.

Update of CVD Framework: Health Checks, Diabetes prevention programme, tobacco and obesity

Purpose of the Report

1. The purpose of this report is to summarise activity in the context of The Strategic Framework for the Prevention of Cardiovascular Disease (CVD) 2014 – 19. These early findings will feed into commissioning reviews and inform the revision of specifications and assessment of proposals. This is of particular interest for the review of NHS Health Checks.

Background

2. The Strategic Framework for the Prevention of Cardiovascular Disease (CVD) 2014 – 19 was written to set out the direction of CVD prevention initiatives in County Durham. The framework was consistent with NICE guidance and sought to address modifiable risk factors, through evidence-based interventions at the population, community and individual levels.

3. Although the framework is focused on the prevention of CVD, the overall approach also helps to prevent other non-communicable diseases. Therefore this paper presents ongoing work which addresses: CVD risk; diabetes; chronic kidney disease; chronic obstructive pulmonary disease (COPD); and some cancers.

4. The CVD framework identified and estimated the prevalence of modifiable risk factors for CVD in County Durham, they were: over weight / obesity; high cholesterol; smoking; high blood pressure; failure to meet exercise guidelines; hazardous and harmful drinking; types 2 diabetes. Detailed below are several programmes which address these risks.

Check4Life Health Check programme – interim evaluation report

5. Health Checks are part of a national risk assessment and management programme for those aged 40 to 74, who do not have an existing cardiovascular disease (CVD), and who are not currently being treated for CVD risk factors. It is a rolling programme offering everyone in the target group a Health Check every 5 years. The aim of the programme is to identify anyone in the eligible population who has a high risk of developing CVD.

6. That risk is communicated to the patient and lifestyle advice offered. Other clinical interventions to reduce risk may also be used. By addressing the main risk factors for CVD, this will contribute to the prevention of heart disease, stroke, diabetes, and kidney disease, in line with the CVD prevention framework.

7. In September 2014 the Health and Wellbeing Board endorsement of the Strategic Framework for the prevention of CVD saw the beginning of the a plan to replace the standard NHS Health Check programme in GP practices with a locally developed Check4Life programme. The main changes introduced in the Check4Life programme in GP practices include:

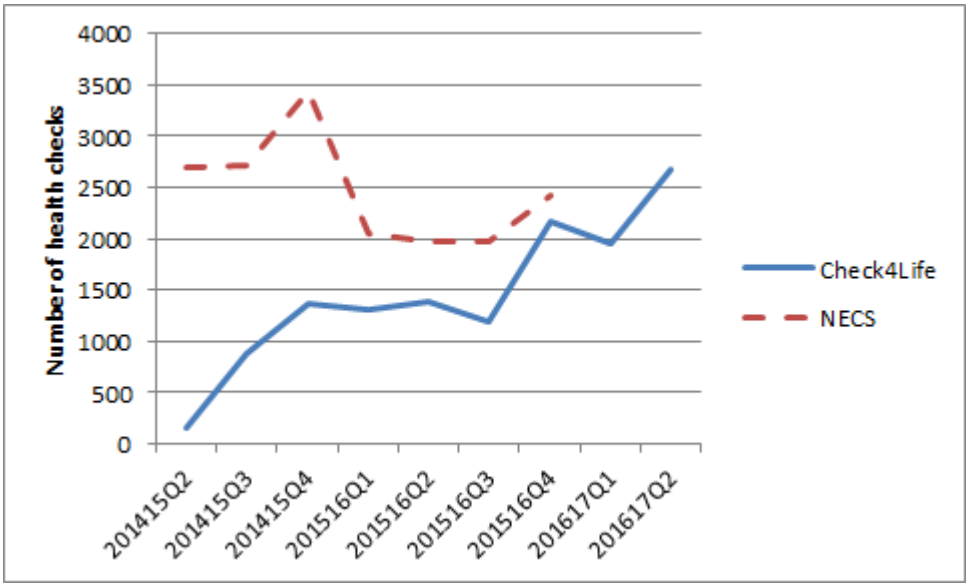
    - Targeting the invitations from GP practices for a Health Check toward those patients with an estimated high risk of CVD
    - Improving the quality of all Health Checks through the Check4Life Quality Assurance programme
    - Health Checks carried out at a single appointment by carrying out blood cholesterol checks using portable equipment in the practice
    - Providing practices with a software package that collects all the information from the Health Check and provides a structured risk communication programme
    - Introducing new risk assessment tools such as the AUDIT-C to assess alcohol intake, the Diabetes UK Risk Score and the QRisk Heart Age calculator.

8. In November 2015 the Health and Wellbeing Board received a report on a review the first five years of the NHS Health Check programme in County Durham. The conclusions in that report highlighted:

    - The wide variation in coverage between practices, practice groups and CCGs.
    - The inconsistency in the data recorded at a Health Check in the GP records.
    - The difficulty in obtaining reliable data on the outcomes following a Health Check.

9. Figure 1 shows the number of Health Checks carried out in GP practices by quarter. The dotted line is quarterly data provided by NECS on all Health Checks carried out combining standard NHS Health Checks and Check4Life health checks. The solid line is the number of Check4Life health checks only provided by Health Diagnostics. It should be noted that the data from NECS is from all 72 practices, and the Check4Life data is from an increasing number of GP practices between July 2014 and March 2016 and a total of 62 practices from then until September 2016. This shows the steady take up of the new Check4Life programme by GP practices.

Figure 1: The number of Health Checks carried out by GP practices by quarter



10. The current GP contracts for health checks ends in March 2017. The service has been reviewed and a new contract with a revised service specification will be commissioned from April 2017 onward. The Check4Life programme has provided Public Health with an almost complete data set on every health check carried out in GP practices. Health Diagnostics provided an anonymised record of each Check4Life health check carried out in GP practices between July 2014 and September 2016, a total of 13,381 records. This report summarises the key findings from the Check4Life data set to inform the recommissioning process.

Findings

CVD risk assessment

11. The primary purpose of the NHS Health Check programme is to identify people with a CVD risk of 20% or more (the risk of a CVD event such as a heart attack or stroke over the next 10 year). In the Check4Life programme this measured by using the recommended QRisk2 calculator. There were 13,080 valid records of a health check carried out among people in the eligible age range of 40 to 74.

12. Table 1 summarises the number and proportion of health checks by age, gender and CVD risk score of 20% or more. It shows that in the eligible population for a health check, 11% of all health checks identified someone with a high risk of CVD, 5% of women and 18% of men. This is strongly age dependent with the proportion of people with a high CVD risk score ranging from 0% among those aged 40 to 44 and 61% among those aged 70 to 74.

13. Table 1 shows that of the 4,715 health checks carried out among people aged 40 to 49, only 27 were found to have a CVD risk of 20% or more. This equates to approximately £4,400 per person with high CVD risk found. In contrast, of the 8,365 health checks carried out among people aged 50 to 74, 1,441 were found to have a CVD risk of 20% or more. This equates to approximately £170 per person with high CVD risk found. This supports the intention to target the health check programme toward people with a higher risk of CVD (via CVD risk score, of which age is a significant factor).

Table 1: Health checks by age, gender and CVD risk score

	All C4L health checks			Number with high CVD risk (QRisk 20% or more)			% high CVD risk		
Age	F	M	All	F	M	All	F	M	All
40-44	1258	1120	2378	0	5	5	0%	0%	0%
45-49	1182	1155	2337	0	22	22	0%	2%	1%
50-54	1153	1110	2263	2	62	64	0%	6%	3%
55-59	1003	914	1917	4	99	103	0%	11%	5%
60-64	904	754	1658	34	187	221	4%	25%	13%
65-69	891	712	1603	104	383	487	12%	54%	30%
70-74	474	450	924	175	391	566	37%	87%	61%
All	6865	6215	13080	319	1149	1468	5%	18%	11%

14. In a Check4Life Health Check CVD risk is also given as 'heart age'. This estimates the age of someone's heart relative to someone of the same age and gender. Table 2 shows the number and proportion that have a high heart age (five years or more than their actual age). This is less dependent on age and gender and highlights the high proportion of younger adults with modifiable lifestyle factors (such as smoking and obesity) that will eventually lead to an increased risk of CVD as they grow older.

Table 2: Health checks by age, gender and 'heart age'

	All C4L health checks			Number with a high heart age (QAge difference of 5y or more)			% high heart age		
Age	F	M	All	F	M	All	F	M	All
40-44	1258	1120	2378	288	311	599	23%	28%	25%
45-49	1182	1155	2337	238	289	527	20%	25%	23%
50-54	1153	1110	2263	246	254	500	21%	23%	22%
55-59	1003	914	1917	151	189	340	15%	21%	18%
60-64	904	754	1658	134	127	261	15%	17%	16%
65-69	891	712	1603	95	102	197	11%	14%	12%
70-74	474	450	924	49	57	106	10%	13%	11%
Total	6865	6215	13080	1201	1329	2530	17%	21%	19%

15. Table 3, appendix 3, (summarising the number of health checks with valid measurements recorded) shows that of the 1468 people identified with a high risk of CVD of 20% or more, only 48% were referred to the GP for further assessment. Similarly, of the 647 people identified as having a very high risk of type 2 diabetes, only 39% were referred to the GP for further assessment. There were similar referral rates for people identified with high blood pressure and high total cholesterol levels. Of particular concern is the low referral rate (16%) to stop smoking services and alcohol brief interventions (2%).

Conclusions

16. The Check4Life programme is quality assured with an enhanced specification for health checks. This has been successfully implemented in most but not all practices in County Durham. As the GP practice staff have been trained and equipped to carry out health checks to this specification, coverage has steadily increased.

17. The Check4Life programme has provided the first comprehensive data set to assess the impact of the programme. The key findings are:

- carrying out health checks among younger adults (under 50) cannot be justified on economic grounds,
- introducing new assessment tools such as the Diabetes UK risk score and QAge heart age tool is possible with appropriate training and supervision,
- more work is needed on the care pathway to ensure that people identified with modifiable risk factors are fully assessed and appropriately referred.

Next steps

18. We are currently undertaking a commissioning process, supported by the Health Checks project board, to provide an efficient programme in place from April 2017. This will be formed of two arms, a GP centred contract and a community based one. While these build on the experience gained and standards set in previous contracts there are a number of key differences.

- The GP centred contract is based on working with GP federations. This will allow us to have a single contract with a lead federation rather than individual contracts with each GP across the county. While we will expect each health check to be done to national standards we will also now require that the provider supply information regarding checks directly to the local authority, rather than Health Option software currently supplied by Health Diagnostics. This will allow efficiencies to be made.
- Working with GP federations should provide equitable access to health checks across the county, as patients will be able to access health checks from their own or other participating practices within the federations.

- The community outreach portion of the programme will address the need of those people who do not engage with primary care to receive a health check, again to ensure equity of access.

19. We are currently seeking additional funding of £99,200 over two years from the British Heart Foundation to complement the community health check programme with additional capacity to provide 2000 blood pressure measurements per year above those conducted as part of an NHS Health Check. This will allow a greater number of at risk individuals to be identified and signposted to primary care.

Diabetes prevention - NHS Diabetes Prevention Programme Background

20. The NHS Diabetes Prevention Programme (DPP) was announced in the NHS Five Year Forward View, published in October 2014, which set out the ambition to become the first country to implement at scale a national evidence-based diabetes prevention programme modelled on proven UK and international models, and linked where appropriate to the new NHS Health Check.

21. In 2014/15 there were 31,056 patients aged 17 years and over with diabetes mellitus (Types 1 and 2), as recorded on practice disease registers. As approximately 90% of diagnosed cases are type 2 this would give approximately 27,950 patients aged 17 years and over with type 2 diabetes mellitus recorded on disease registers.

22. The NHS DPP is a joint initiative led by NHS England, Public Health England ("PHE") and Diabetes UK, together the National Programme Team. The programme aims to deliver services which identify people with non-diabetic hyperglycaemia who are at high risk of developing Type 2 diabetes and offer them a behavioural intervention that is designed to lower their risk. Building on its experience as a demonstrator site Durham County was selected as a first wave site for implementation of the NHS DPP national programme. This lead to several changes in diabetes prevention within the county, whereas previously Durham County Council (DCC) commissioned the intervention "Just Beat It" the implementation of the local NHS DPP is a partnership lead by DDES and ND CCGs with advice given by DCC's Public Health team as necessary. As the national programme was due to provide an intervention to prevent those at risk of diabetes from developing the condition from April 2016 the Just Beat It contract was not renewed at that time. Those referred to the national programme should receive personalised help to reduce their risk of Type 2 diabetes including education on healthy eating and lifestyle, help to lose weight and bespoke physical exercise programmes, all of which together have been proven to reduce the risk of developing the disease.

23. The partnership, consisting of Lead and Partner Organisations committed to deliver referrals in line with table 4, with the understanding that any changes to this profile would be dealt with through an agreed variation process. Table 4 also shows the actual referrals made to date. They reflect a slower than anticipated roll out of the new programme locally.

Table 4:Expected and actual NHS DPP referral levels												
	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Expected 2016/17	0	15	15	25	25	25	40	40	40	50	50	50
Achieved 2016/17	0	0	0	6	20	21	3	71				

24. There are now weekly meetings between CCG leads and the national provider (Living Well Taking Control), supported by Public Health. Furthermore a recruitment plan to increase referrals has recently been agreed within these meetings, with Public Health providing intelligence regarding eligible population. This sees a mix of location based delivery centres as well as GP lead interventions. Currently central delivery venues have been agreed in Derwentside and Chester le Street GP federations with a number of practices signed up to refer into the programme. In Durham Dales and Sedgefield federations a GP practice delivery model has been agreed with the national provider. The provider is also in the process of establishing central venues within Durham, Sedgefield and East Durham GP federations. Furthermore the national provider is identifying which GP practices have maintained a register of at risk of developing diabetes. This latter piece of work is expected to be completed imminently.

Tobacco Control

25. Smoking is the primary cause of preventable illness and premature death and is the single biggest cause of inequality in death rates between rich and poor in the UK.

26. Each year in County Durham smoking is estimated to cost society approximately £155.0m, that's £1,801 per smoker per year. Tobacco is a key contributor to poverty and with roughly 61,279 households in County Durham with at least one smoker. This means 33% of these households fall below the poverty line. If these smokers were to quit, nearly 6,688 households would be lifted out of poverty.

27. County Durham delivers tobacco control within an evidence based framework via the County Durham tobacco control alliance with local partners. Durham County Council is also the lead commissioner (on behalf of all 12 North East councils) of the regional tobacco programme 'Fresh'.

28. County Durham along with Fresh and the North East councils deliver a tobacco control package of eight key strands (building infrastructure, skills and capacity and influencing decision making through advocacy; media and communications; motivating and supporting smokers to stop; reducing exposure to tobacco smoke; tobacco regulation; reducing availability and supply e.g. on illicit tobacco; reducing advertising and promotion; research, monitoring and evaluation).

29. County Durham has experienced a steady drop in smoking prevalence over the last three years, resulting in a 3.2% drop since 2012 (table 5).

Table 5: Smoking prevalence in County Durham 2012 - 2015

All Adult smoking prevalence (APS Survey)	2012	2013	2014	2015	Change since 2014	Change since 2012
County Durham	22.2%	22.1%	20.3%	19.0%	-1.3%	-3.2%

Stop Smoking Services

30. A total of 5,333 clients set a quit date with the service in 2015/16. Of which 54% (n=2,903) were quit at 4 weeks. The number of clients setting a quit date are down by 10% in comparison to 2014/15 and quitters are down by 5% in comparison to last year. This drop in access has been experienced over the years at both the national and regional level. The drop in numbers accessing the Durham service has however been smaller this year (10%) in comparison to previous years (2013/14, 16%) and (2014/15, 27%). The percentage of quitters achieved this year has increased to 54% from 52% last year. This trend has continued over a five year period.

31. Public Health England guidance recommends that in a given year services should aim to treat at least 5% of their smoking population (NICE guidance for smoking cessation 2014). In County Durham this year the service treated 6.2% of the smoking population. The target was also to achieve 2,774 quitters. The service has seen 2,903 quitters, this is 129 above target.

32. A key factor of stop smoking services is to ensure they are having an impact in relation to reducing health inequalities and that services are delivered equitable. Compared to the 2007 stop smoking service Health Equity Audit (HEA), the 2014 HEA demonstrates a higher rate of people setting a quit date and quitting smoking in the more deprived Middle Super Output Areas (MSOAs) of County Durham. This indicates that the County Durham Stop Smoking Service is contributing to a reduction in health inequalities.

Smoking in pregnancy

33. Smoking at Time of Delivery (SATOD) hospital data 2015/16 reported 18.1% of woman in County Durham continue to smoke in pregnancy.

34. SATOD data is showing a reduction for County Durham since 2009/10. However this reduction is not equal across the two CCGs (table 6). There is a noticeable 5.6% difference in SATOD data between North Durham CCG and Durham Dales, Easington and Sedgefield (DDES) CCG (table 7).

Table 6: Smoking at time of delivery over time

	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	Change since 2011/12 (pre-babyClear)
England	14.0%	13.5%	13.2%	12.7%	12.0%	11.4%	10.7%	-2.5%
North East	22.2%	21.1%	20.7%	19.7%	18.8%	18.0%	16.7%	-4.0%
County Durham	22.2%	22.9%	21.3%	19.9%	19.9%	19.0%	18.1%	-3.2%

Table 7: SATOD by CCG

Clinical Commissioning Group	**2015/16**
North Durham	15.1%
DDES	20.7%
Total average	**18.1%**

Pregnant smokers and access to stop smoking services

35. The number of women setting a quit date with the service has fluctuated over the last five years. However since the implementation of the babyClear pathway, which supported training and resources for maternity staff across all eight North East Foundation Trusts to support activity at the initial booking appointment and 12-week dating scan, as well as clarifying referral pathways into stop smoking support, the number of quitters has increased and the percentage of pregnant smokers quitting with the service has increased.

36. Prior to babyClear, the drop off rate in County Durham between referral and attending first appointment was 84%. In 2014/15 this reduced to 66% and in 2015/16 reduced to 57%. Although the funding has now ceased, the legacy of babyClear has become embedded within both maternity and the stop smoking service.

Excess weight

37. Obesity is a priority area for Government. The Government's "Call to Action" on obesity (published Oct 2011) included national ambitions relating to excess weight in adults, which is recognised as a major determinant of premature mortality and avoidable ill health. The World Health Organisation (WHO) regard childhood obesity as one of the most serious global health challenges for the 21st century.

38. If we fail to halt the rise in obesity then by 2050, obesity, in England is predicted to affect 60% of adult men, 50% of adult women and 25% of children. Recently reported modelling suggests that by 2030 41-48% of men and 35-43% of women could be obese, if the trends continue. NHS costs attributable to overweight and obesity are projected to reach £9.7 billion by 2050, with wider costs to society estimated to reach £49.9 billion per year.

39. In County Durham it has been estimated that 72.5% of adults, 24% of children aged 4 to 5 years and 36% of children aged 10 to 11 years have excess weight. County Durham also has an adult obesity rate higher than the England average.

40. Overweight and obesity needs to be tackled by a life course approach from pre-conception through pregnancy, infancy, early years, childhood, adolescence and teenage years, as weight once gained is difficult to lose and health trajectories can be set at an early age. In childhood, excess weight can directly cause mobility problems, hypertension and abnormalities in glucose metabolism (Department for Children Schools and Families and Department of Health, 2009). In addition there may be emotional issues related to low self-esteem.

41. The 2015 County Durham Director of Public Health Annual Report on obesity was clear that tackling obesity requires a focus on multiple projects and levels, in a wide variety of settings settings and for many groups of people. Expecting behaviour change by solely focusing on the individual is unlikely to be successful. There is strong evidence to support that a whole systems approach is the most effective way to tackle obesity.

42. Reducing unhealthy weight and the poor outcomes associated with it is a cross cutting theme which is reflected and referenced in many strategies and plans for County Durham. For example:

- County Durham Plan
- County Durham Children Young People and Families Plan
- County Durham Joint Health and Wellbeing Strategy
- County Durham Healthy Weight Framework
- County Durham Physical Activity Framework

43. Durham County Council has recently started a programme to develop part time 20mph speed limits in areas of County Durham. The purpose of this scheme is to reduce traffic speeds around schools during drop off and pick up times. This will improve road safety for vulnerable road users as well as making walking, cycling and outdoor play more attractive.

44. The Families Initiative in Supporting Children's Health (FISCH) programme provided by Durham County Council, Leisureworks, and Harrogate and District NHS Foundation Trust is effectively operating in schools across County Durham. This has led to a reduction in both excess weight and obesity prevalence in the participating schools. However work is ongoing to reprioritise this resource to achieve a larger impact for a greater number of obese children whilst also attempting to have a longer term impact upon the wider school environment.

45. County Durham's Wellbeing for Life Service also presents a holistic approach to support people to live well which encompasses not only the person but the wider community, including empowering individuals to improve their health through, for example, healthy eating.

46. Change4Life is a national initiative that brings together a range of stakeholders with the shared aims to improve diets and levels of activity. In County Durham this has expanded to not only include marketing programmes but cooking courses, sports clubs in schools, fun runs and other events. Currently the branding is also shared with the NHS Health Check programme, Check4Life.

47. The most recent Director of Public Health Annual Report presents a number of ways of tackling the obesogenic environment at the local level. Subsequently County Durham has become a national pilot site for obesity reduction. The healthy weight strategic framework (2014-2020) was developed through the multi-agency County Durham healthy weight alliance. This is supported through a variety of work in Count Durham, based on NICE guidance that obesity be tackled as a whole system. These programmes include:

    a. **Leading by example** - Durham County Council has a significant workforce and the overwhelming majority live in County Durham. Any efforts to impact the health of Durham County Council's workforce will have the dual benefit of a healthier workforce and residents. This is also an opportunity to work with wider partner organisations who are also interested in improving their workforces and County Durham residents' health. Efforts are underway across County Hall to make the healthy choice the easy choice. This includes access to healthier food choices and supporting physical activity during the day (e.g. Stepjockey).
    b. The food offer has been reviewed within County Hall and branding removed from vending machines.
    c. Holiday hunger was addressed through a programme funded by Public Health in the east of the county in 2015. This was further developed and funded in 2016 through a number of AAPs and saw several holiday schemes across the county incorporate the ethos of holiday hunger into their activities. This programme will be academically evaluated in 2016/2017.
    d. **Best start in life and schools -** This approach focuses on the early years and the potential impact upon the National Child Measurement Programme (NCMP) levels of overweight and obesity.
    e. Breastfeeding remains a priority in County Durham and its impact on obesity is critical. UNICEF accreditation, breastfeeding cafes, and peer supporters are examples of the ongoing efforts to improve rates across the county.
    f. In partnership with Harrogate and District NHS Foundation Trust we are exploring opportunities to improve the distribution and reach of the Healthy Start voucher scheme. A submission has been made to NHS England for County Durham to be a national pilot to increase uptake of the Healthy Start programme.
    g. A new project is being developed with Newcastle University which will assist in understanding the cultural challenges of weight gain in infancy. This programme will aim to develop new ways to assist early year's

health professionals to successfully address the challenges of healthy weight in the first 1001 critical days.

h. Schools are also able to have a significant impact on the health of children, currently the school food plan is being rolled out across the county with 64% uptake of school meals across primary schools. Additionally education and public health colleagues developed a physical activity grant scheme to help further encourage physical activity in our schools. This is targeted towards increasing activity and vulnerable groups.
i. **Play well** – Again a multifaceted approach has been taken to increase safe play within the activity framework. This includes the successful slow to 20 for safer streets programme, supported by several AAPs a number of which have also supported physical activity programmes for their residents.
j. Communities have also been engaged through activities such as Beat the Streets set to be piloted in areas of County Durham in 2017. This will see whereby friends, schools, workplaces or communities take part in a game against each other through levels of physical activity.
k. **Engaging with the system** – In collaboration with Leeds Beckett University (LBU) a workshop was delivered with the healthy weight alliance to begin to explore the working culture of County Durham. Efforts will be made to explore how obesity contributes to a variety of our corporate priorities. A development session is planned with the healthy weight alliance to attempt to develop further approaches to tackle obesity in County Durham.
l. We are also working with partners in primary care to identify and refer clients of community pharmacists to Slimming World, after assessment. Healthy living pharmacies were identified in target communities to deliver this.
m. Obesity and planning
n. Closer working with planning colleagues led to a workshop in July which assessed the County Durham Plan against the Town and Country Planning Association's healthy weight framework. Such collaborations are essential in addressing the obesogenic environment and health inequalities and should include provision to access green space.

References

Capewell S. Graham H Will cardiovascular disease prevention widen health inequalities? PLoS August 2010
http://www.plosmedicine.org/article/info%3Adoi%2F10.1371%2Fjournal.pmed.1000320

Department of Health. The Local Authorities Public Health Functions and Entry to Premises by Local Healthwatch Representatives Regulations 2013
http://www.legislation.gov.uk/uksi/2013/351/contents/made

Department of Health. Cardiovascular disease outcomes strategy: improving outcomes for people with or at risk of cardiovascular disease. Mar 2013.
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/141273/9387-2900853-CVD-Outcomes_web1.pdf.pdf.

Department of Health. Public Health Outcomes Framework. November 2012.
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216161/Improving-outcomes-and-supporting-transparency-part-1B1.pdf

Jørgensen T, Borch-Johnsen K, Thomsen TF, Ibsen H, Glümer C, Pisinger C. A randomized non-pharmacological intervention study for prevention of ischaemic heart disease: baseline results Inter99. Eur J Cardiovasc Prev Rehabil2003;10:377-86.
Medline

Krogsbøll LT, Jørgensen KJ, Larsen CG, Gøtzsche PC. General health checks in adults for reducing morbidity and mortality from disease: Cochrane systematic review and meta-analysis. BMJ2012;345:e7191.
Abstract/FREE Full Text

National Institute for Health and clinical Excellence, Clinical Guideline 65 Lipid modification: Cardiovascular risk assessment and the modification of blood lipids for the primary and secondary prevention of cardiovascular disease. Issued: May 2008 (last modified: March 2010) page 41.
http://www.nice.org.uk/nicemedia/live/11982/40742/40742.pdf

NHS Health Check Ready Reckoner tool
http://www.healthcheck.nhs.uk/commissioners_and_healthcare_professionals/national_resources/ready_reckoner_tools/

Pill R, French J, Harding K, Stott N. Invitation to attend a health check in a general practice setting: comparison of attenders and non-attenders. J R Coll Gen Pract1988;38:53-6.
MedlineWeb of Science
Public Health England. Our priorities for 2013-14. Apr 2013.
https://www.gov.uk/government/publications/public-health-englands-priorities-for-2013-to-2014.

Public Health England. NHS health check implementation review and action plan. Jul 2013.
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/224538/NHS_Health_Check_implementation_review_and_action_plan.pdf

Waller D, Agass M, Mant D, Coulter A, Fuller A, Jones L. Health checks in general practice: another example of inverse care? BMJ1990;300:1115-8.
Abstract/FREE Full Text

Wilhelmsen L, Berglund G, Elmfeldt D, Tibblin G, Wedel H, Pennert K, et al. The multifactor primary prevention trial in Göteborg, Sweden. Eur Heart J1986;7:279-88.
Abstract/FREE Full Text

Appendix 3

Table 3: Key findings and actions following a health check

	Health checks carried out			Referred to GP and other services for further assessment						
All C4L HC	Number of valid readings	Number of cases	%	No	Yes	Declined	Blank	No	Yes	Declined
Absolute CVD Risk Score 20 and above	13080	1468	11%	745	703	20		51%	48%	1%
Diabetes UK risk score 16 - 24	12756	3706	29%	2524	1102	49	31	68%	30%	1%
Diabetes UK risk score 25 and above	12756	647	5%	385	253	5	4	60%	39%	1%
Total Cholesterol 7.5 and above	13114	792	6%	416	365	10	1	53%	46%	1%
BP - Systolic 140 and above	13222	2489	19%	1418	1031	21	19	57%	41%	1%
BP - Systolic 140 and above and CVD Risk Score 20 and above	13222	532	4%	240	289	3	0	45%	54%	1%
Smokers	13248	2140	16%	1531	338	250	21	72%	16%	12%
AUDIT-C 5 and above	13235	4630	35%	4371	93	124	42	94%	2%	3%

Appendix 4 Summary of the County Durham GP Health Check contract 2014/15

These are the key elements of a revised specification for the Health Check component of the public health contract with GP practices:

- Tariff based at £35 per Health Check
- An upper limit for the number of checks carried out by all GP practices combined
- A quarterly lower limit for each practice. If the practice falls below this level then the option is for other practices/providers to be allowed to carry out health checks for the practice population
- Contract limits to be based on a submission of a list of the patients in the target eligible population to NECS.*
- The target population will be those with an estimated CVD risk of 20% or more using QRisk2.*
- The practice will allow NECS to access an agreed minimum data set with a limited amount of patient identifiable information that will be compliant with the data sharing agreement we have for the Health Equity Audit.*
- Practices take part in the Check4Life Quality assurance scheme. This involves:
    - Using the supplied Health Options software to collect information on every Health Check
    - Practices will work toward the quality standards set out in the operating procedures for invitations, conducting the health check, risk communication and follow up
    - The Health Check will be conducted in a single appointment using the supplied LDX machine for cholesterol testing
    - Practice staff take part in the C4L QA audit
    - Practices comply with the external QA for the LDX machine supported by the C4L QA team
    - The Health Option software licence and LDX machine remain the property of Durham County Council Public Health through the C4L QA service and loaned to the practice while they have a Health Check contract
    - The practice uses the consumables supplied by the C4L QA programme in proportion to the number of Health Checks Carried out. This means the practice can use the machine for other patients but will need to pay for the cassettes.
    - The cost of the LDX machine and software is £1900 per practice paid for by the Check4Life programme. In addition the programme will pay for the cholesterol testing cassettes. Practice staff will be able to take part in any of the C4L training sessions run throughout the year in different venues. These are accredited and free.
- Practices will be paid monthly in arrears based on data supplied by Health Diagnostics. There will be no need for invoices or data validation by NECS.
- High performing practices will be invited to carry out health checks in high risk patient from other practices in the area at the same tariff of £35 per check.
- High performing practices in selected areas will be invited to carry out a defined number of health checks in low risk patients at £25 per check.

* We are working with Apollo Medical Systems Ltd to carry out data extraction and risk stratification as part of a call/recall system.

Health Option Software

Key features:

- Supplied by Health Diagnostics, the company that provides a range of support for the Check4Life community health check programme.
- Local experience over 4 years
- Backed up by training, telephone support
- Regularly reviewed and updated to local specification
- Provides a well-structured interface to communicate CVD risk and lifestyle advice
- Incorporates local information on lifestyle programmes
- Collects a standard data set on every health check
- Web based transfer of data to the practice system

Advantages over the current system of GP system templates:

- Ensures complete data collection
- Added value of risk communication (heart age) and lifestyle advice
- Easier to modify and regular updates QRisk2 risk calculator
- Consistency across the whole programme
- Training and support available
- Monthly reporting
- Potential for automatically adding cholesterol/HDL readings from POCT machine
- Includes Type 2 diabetes risk assessment

Possible developments:

- Identifying the cohort of patients among those who are eligible for a health check and have an estimated CVD risk of 20% or more,
- Pre-populating the Health Options software with patient data to avoid unnecessary data entry and avoid errors,
- Link the cohort identification with a standardised way of inviting patients though Docmail or similar.

Disadvantages:

- Cost to the commissioner
- Training needed
- Delay in data transfer to the practice system (up to 24 hours)
- Fitting in with current practice approach to health checks with two appointments

Point of Care Testing

Advantages:

- One appointment for a full CVD risk assessment
- Accurate risk assessment to inform risk communication
- Capillary v venous blood sample

Disadvantages

- Cost to commissioner
- Training
- Full blood test needed in those with risk > 20%

Appendix 5:
Frequently Asked Questions

CVD Risk

Q. Do we only get paid for 20% risk?

A. Practices will be paid £35 for a health check for a patient identified as having a CVD risk 20% or higher. In selected areas practices will be invited to carry out health checks in individuals with an estimated CVD risk below 20%. If the CVD risk is below 20% then the practice will be paid £25 per check.

Q. Can we do health checks on people outside of 20%?

A. For all practices, the new contract will be based on the assumption that you will invite people with an estimated CVD risk of 20% or more. For patients registered with the practice who have not been invited because their estimated risk is below 20% but ask to have a health check, then the practice will be paid the tariff based on the risk score. For some practices in certain areas, we will offer in addition to the standard contract an option to carry out a number of Health Checks in people with a CVD risk below 20%.

Q. The NHS Health Checks only utilises QRISK scores and not Framingham scores. Is this right? Can Framingham not be used?

A. The Health Diagnostic Software can calculate the CVD Risk Score using Framingham, modified Framingham, JBS2, ASSIGN, and QRisk2. NICE does not recommend any particular CVD risk model. We standardised on QRisk on the recommendation of the LMC and it is the best risk engine for our population as it takes into account deprivation based on the Townsend score.

Invitation/Identification/Eligibility

Q. How do we identify people who will be at a greater than 20% risk with the new software?

A. We are looking into the best way of doing this. The ideal solution is to access practice systems and extract the necessary data, apply the QRisk algorithm and identify those with a risk of 20% or more. We are running a pilot to test this approach working with Health Diagnostics and Apollo Medical systems. This includes populating the practice Health Options software with the people identified. The alternative solution is for the practice to run a query using a set of instructions provided by the North of England Commissioning Support Unit.

Q. Will the Practice continue to invite patients for a Health Check?

A. Yes. In the new contract we want practices to limit their invitations to people with an estimated CVD risk of 20% or more. We are also looking at way of standardizing all practice invitations using Docmail.

Q. Will the 20% risk be based on old data, 2008?

A. No. The CVD risk assessment will be based on current clinical records.

Q. Will we still be using RAIDR to identify patients?

A. Practices can still use RAIDR to identify patients. This will not be linked to the Health Options software. The aim is to link the new Apollo system with Health Options software to identify patients and populate the Health Options software with relevant patient data.

Q. Will Practices be conducting mini health checks?

A. No. This is limited to the Check4Life Community Programme.

IG/Data Management/Patient details

Q. Can you confirm that the software is compatible with EMIS and EMIS web?

A. The Health Options software is a standalone programme. It is not the same as the current EMIS templates that are part of the practice system. The data collected by the software is turned into READ codes based on the national minimum data set for health checks and should be the same as the current templates. Any read code conflicts/errors will be addressed during the early implementation process. The data transferred to the practice system by the Health Diagnostics server is compatible with all GP Practice Systems.

Q. How sure do you think this data will be compatible?

A. See response above

Q. How will the patient data transfer from clinical system onto Health Options and back onto clinical system?

A. These are the steps in the data collection and transfer system:

- Apollo create query based on Health Diagnostics/Commissioner specification
- Complex queries run remotely by Apollo on practice list
- Cohort identified and file imported into Health Options®
- Health Options® run risk stratification algorithm
- Client attends GP. Client's details already in Health Options®
- Health Check completed and data automatically uploaded to Health Diagnostics central data repository
- Indigo 4's Keystone Enterprise converts this data into the correct format for the practice system and transfers the information to the practice through an adaptation of existing practice links and pathology messaging
- The data collection and transfer back to the practice occurs within 24 hours.

Q. Regarding the time difference between the data being entered on the Health Diagnostics tool and then being sent back to the practice and put onto the clinical system this may mean that for this period of time there is a prescription issued for a patient where their record doesn't look like this is relevant/necessary, or a chronic disease code may be recorded but the measures that lead to the disease diagnosis (e.g. cholesterol or BP) may not be present straight away in the patient clinical record.

A. The time difference is up to 24 hours between a Health Check recorded on Health Options Software and that record sent to the Practice In-Box (i.e. similar to Lab Links). This assumes that the computer with the Health Options Software is connected to the internet. It is unlikely that the findings at a Health Check would necessitate a prescription for high blood pressure or raised cholesterol without further investigation and assessment. However, it

would be sensible to make an entry on the patients practice record that a Health Check had been carried out and to record anything that needed follow up.

Q. Can the Practices be assured that Health Diagnostics have permission to extract, store and manage patient identifiable information and whether they are then subject to FOI or are able to sell or to share this information with other organisations?

A. Health Diagnostics are a registered ISO 27001:2005 Company; Certification Number ISM7799129. The Company has completed the NHS Connecting for Health Information Governance Statement of Compliance (IGSoC) process. The Company are bound by the provisions of the N3 Code of Connection and NHS Information Governance and Data Protection Act 1988. Details of the IT system and the protocols for confidentiality and data security are available on request.

Q. Will patient confidentiality be protected involving the clinical systems?

A. See response/s above

Q. How does this fit into confidentiality when patients don't want their personal information shared with other data users?

A. A patient's personal information will not be accessed by any other user. The data handling process hosted by Health Diagnostics is compliant with the highest standards for data protection. No-one other than the staff within the practice who have legitimate access to patient records will be able to use this data. Nearly all of the data provided by Health Diagnostics to Public Health will be in the form of summary tables. Once a year Health Diagnostics will provide Public Health anonymised individual records with a limited data in order to audit the programme. This will be carried out under the terms of the information sharing agreement with the practice and Public Health.

Q. Can Practice Managers have administration access to software to check synching for reports

A. Will confirm this as soon as possible.

Q. Can Practices input the patients NHS number into the software to access the patient records/details? Will the software be pre-populated?

A. The aim is to pre-populate the records on the software with a limited set of patient details including NHS number, name, gender and date of birth.

Read Codes

Q. Can the Practices be assured that the Read codes that are held within the Health Diagnostics tool are those that are nationally mandated (e.g. for QOF etc.) to ensure that when the data is uploaded onto the clinical system from Health Diagnostics there won't be anything that affects other areas. I know that there are various screening codes available and only some are accepted for other LES/DES/QOF indicators.

A. As a national company Health Diagnostics have worked closely with the NHS Health Check Data leads to ensure that the Read Codes in the Health Options Software are consistent with the nationally agreed minimum data set. If we identify any inconsistencies, then Health Diagnostics will make the necessary changes.

Q. Will read codes be able to be updated as and when required?

A. See response above

CVD Diagnostic Equipment

Q. If the Practice has more than one site will there be a machine for all sites?

A. Possibly. This will be decided (by the Commissioner) on a case by case basis depending upon the size of the practice and likely number of health checks on each site.

Q. Can Practices have more than one LDX machine?

A. See response above

Q. Who would be responsible for the up-front costs of purchasing the machines? Would they be provided to practices free of charge?

A. The CVD Diagnostic Equipment (POCT LDX machines and Health Options Software) is loaned to the Practices at no cost and remains the property of Durham County Council Public Health managed through the Check4Life Quality Assurance (QA) Programme. Practices can use the equipment as long as they have a contract to provide Check4life Health Checks.

Q. Who is responsible for the maintenance and on-going running cost for the machine? Hope it is not the practices?

A. The C4L QA Programme which oversees the maintenance and replacement of the equipment if required. The practice is responsible for calibrating the LDX Machine every two months.

Q. How is calibrating defined? How is calibration different to maintenance?

A. The C4l QA Scheme includes an agreement with an external laboratory to check that the LDX machines are functioning effectively (calibrated). The laboratory sends serum samples to the Practice every two months and the Practice will be required to run the Quality Control Tests on the LDX machines to ensure that the machine is calibrated and is providing accurate readings/test results. Whilst no formal maintenance is required, Practices will be provided with and expected to abide by specific LDX Equipment standard operating procedures supplied by Health Diagnostics and will be required to apply a ‘duty of care’ in terms of good housekeeping; storage; handling and usage of the LDX Equipment in-line with CDDFT Medical Devices Policy and procedures.

Q. If the machine breaks or is non-functional for a period what is the ‘plan B’? Can practices do lab blood test then? Why can't practices not also use lab cholesterol results to do NHS Health Checks as well?

A. The C4l QA Programme will provide a replacement machine within a day or so. There is no need to cancel appointments. If the LDX machine is not available then carry out a health check as normal and save the results, take a venous sample for blood lipids and complete the health check with the results when they become available. The point of near patient testing is completing the risk assessment and risk communication during the single appointment.

Q. What would be the cost of disposables for near patient tests? Would this cost be met by Practices or would kits be provided/reimbursed?

A. The Practice is not liable for the cost of consumables. The practice will be provided with a phone number of the supplier to request consumables as required. The cost of this is covered by the C4l QA Programme. Consumables will consist of TC/HDL Cassettes; Heparin Tubes/Plungers; Unistick 3 single use Lancets and one Optics Check Cassette. Approx cost per check £7.61.

Q. Will Practices receive colour printers to print out patient results sheets and QRisk Page?

A. No. If the practice does not have a colour printer then the print out will be black and white and then included in the packs provided.

Training

Q. Would there be other training apart from the training provided by Health Diagnostics?

A. Mandatory training will be provided covering the essential knowledge, skills and competencies required to deliver the new C4l Health Check Programme. The training programme has been designed to meet the workforce competency requirements outlaid in DH Putting Prevention First Workforce Competency Framework and is specifically tailored to skill staff to effectively deliver a C4l Health Check, including use of the new C4l Health Options Software. All identified practice staff who will be delivering the C4l Health Check Programme will be required to attend the mandatory training. The training is FREE and will be 2.5-3 hours duration and delivered in a central location to facilitate access for all practices across County Durham.

The C4l QA Programme will also provide a C4l Training Calendar with a range of additional PDP training opportunities, for example, making every contact count (MECC); brief intervention for stop smoking; weight management; physical activity etc. Individual practices and staff will be able to self-select the most appropriate training to meet their individual requirements. The training calendar will provide greater flexibility in terms of choice, accessibility and time management for practice staff to be released at an appropriate time which meets the individual learner and practice capacity demand requirements.

Q. How long will the training take?

A. See response above

Q. Who would need to be at the training? Can it be cascaded to other staff?

A. All identified practice staff who will be delivering the C4l Health Check Programme will be required to attend the mandatory training. The initial mandatory C4l Health Check Training cannot be cascaded as the training is designed to meet the competency outcomes outlaid within DH Putting Prevention First Workforce Competency Framework and in accordance with the C4l QA Programme requirements to ensure all staff delivering C4l Health Checks are delivering standardized, consistent quality assured health checks across County Durham. **5.**

However we actively encourage in-house coaching and mentoring ‘post’ mandatory training as part of your individual practice ‘whole team’ approach to creating a learning environment and supporting each other by sharing practice and lessons learnt. We also recommend that

individual practices assign a 'lead' C4I Practice Champion who will work closely with the C4I QA Support Team to enable practices to achieve the C4I GP QA Mark.

Q. When will the pilots start?

A. The initial C4I Health Check pilot practices will be implemented after approval is confirmed via LMC (4th February 2014) and expressions of interest are received by individual practices wishing to take part in the early adopter pilots following a series of awareness raising engagement briefing events. It is anticipated that pilot implementation will commence March 2014 with a view to inform any additional service improvements prior to full roll out across all GP's in County Durham.

Practices will be invited to sign up to the new C4I GP Contract. The new C4I GP QA Programme will be gradually rolled out and implemented due to the enormity and scale of the programme. The current contract will be extended until Practices are fully recruited; trained and resourced to deliver the new C4I GP QA Programme.

Point of Care Testing (POCT)

Q. With the proposed move to near patient tests for cholesterol, do you have any information on the reliability/accuracy of these tests? Presumably you are happy with the evidence base?

A. POC Testing LDX equipment provides readings that are good enough for estimating cardiovascular risk. For follow up and management of people identified at a high risk of CVD and considered suitable for statins, then the clinician will probably want to have laboratory readings based on a venous sample. This could be taken at the time of the health check based on the CVD risk score and risk management plan agreed with the patient (**please view national guidance on POCT at www.improvement.nhs.uk**).

Q. Will practices need to confirm the blood cholesterol results following a health check using POCT equipment?

A. The POCT LDX machine provided by the programme provides blood cholesterol results that are accurate enough for calculating a CVD risk score. Before making any shared decision about the suitability of statins to reduce CVD risk, the more comprehensive results from a laboratory on a venous blood sample will be needed. Similarly, a venous blood sample to check HbA1c levels in people who are identified as having a high risk of developing diabetes is also appropriate. The venous blood sample can be taken at the time of the Health Check and followed up in accordance with the normal practice protocol. The advantage is that the need for venous blood samples is reduced to patients with a proven high risk of CVD and Diabetes.

Q. How accurate is the POCT test compared to fasting blood results for total cholesterol?

A. A fasting blood test is not necessary for a CVD risk assessment. Non-fasting total cholesterol and HDL from a capillary sample are sufficient to calculate the TC/HDL ratio in CVD Risk Calculators. In addition, we have conducted vast market research to find out what the barriers are for people who do not attend a health check despite numerous invitations. The fear of blood tests and the inconvenience of fasting have been cited as reasons for not taking up the offer.

In terms of accuracy, the external Quality Assurance Scheme ensures that the LDX Equipment produces accurate TC/HDL test results. The machines are calibrated against

laboratory gold standard tests every two months. If there is a wide difference between a fasting venous sample and non-fasting capillary sample then it will not be due to the equipment. The effect of fasting on total cholesterol could be the reason which is why the risk assessment is made on the TC/HDL ratio rather than single result.

Q. Diagnosis of Diabetes.

A. For the Health Check programme the recommendation for identifying those at high risk of developing and having undiagnosed diabetes is to use HbA1c. Only those identified as at higher risk should be tested as part of their NHS Health Check risk assessment and it is not considered clinically effective or cost effective to test everyone. There is no single accepted way of identifying people who are at risk of diabetes or who have existing undiagnosed diabetes. There are a number of ways of determining who is at high risk and the guidance for Health Checks is to use BMI (adjusted for ethnicity) and blood pressure to identify people at high risk. Using these factors as a filter, those at higher risk can be identified and go on to have an HbA1c test.

Q. Why are Practices not doing blood glucose? Can we not do it at the same time as testing cholesterol?

A. It is up to the practice how they want to investigate patients who are at a high risk of diabetes. The recommendation is to follow NICE guidance and use a non-fasting HbA1c test to assess risk.

Implementation of C4L GP Programme

Q. If a practice has only 1 HCA who has other duties to do she/he may not be able to just solely focus on NHS Health Checks using the machine approach only. Has this been considered?

A. The new contract makes no assumption about how much time an HCA is allocated to health checks. The only difference is that each health check will last up to 30 minutes to complete with the near patient testing.