

TEES VASCULAR ASSESSMENT PROGRAMME

**Evaluation commissioned by the Tees Primary Care
Trusts (PCT) from the Centre for Translational
Research in Public Health**

September 2009 to August 2010

MAIN PROJECT REPORT

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Contents

Executive summary.....1

Main Report

Background, commissioning and aims.....5

Research design and methods.....9

Report on main evaluation themes11

 The initiation of Healthy Heart Checks in community pharmacies.....11

 Implementation of HHC in community pharmacies.....12

 General Practice action plans14

 General Practice team interviews.....17

 Workplace Interviews (clients).....18

 Client interviews20

 Quantitative aspects of HHC in general practice.....21

Conclusions..... 23

References.....25

Appendices:

 A. Pharmacy Phase 1 report.....A1

 B. Pharmacy implementation report.....B1

 C. General Practice action plans report.....C1

 D. GP Team interviews.....D1

 E. Workplace interviews report.....E1

 F. Client interviews.....F1

 G. Some quantitative aspects of HHC in general practice.....G1

Please note that reports included as appendices have their own contents pages.

Glossary

AP	Action Plan
BMI	Body Mass Index
CHD	Coronary Heart Disease
CVD	Cardiovascular Disease
DH	Department of Health
DNA	Did Not Attend
GP	General Practitioner
GPT	General Practice Team
HCA	Health Care Assistant
HHC	Healthy Heart Checks
IT	Information Technology
LES	Local Enhanced Service
LPC	Local Pharmaceutical Committee
NEPHO	North East Public Health Observatory
NICE	National Institute for Clinical Excellence
NHS HC	NHS Health Check
PCI / TPCI	Primary Care Informatics/ Tees Primary Care Informatics
PCT	Primary Care Trust
PN	Practice Nurse
QA	Quality Assurance
SLA	Service Level Agreement
TVAP	Tees Vascular Assessment Programme

An Evaluation of the Tees Vascular Assessment Programme 2009-10

Executive Summary

Background, commissioning and aims

The Tees Vascular Assessment Programme (TVAP) is the NHS Tees response to the Department of Health 'NHS Health Checks' programme. It is designed to provide primary prevention for cardiovascular disease to the whole Tees population aged 40-74, under the local banner 'Healthy Heart Checks' (HHC). Because of the extent of the programme, an evaluation of early aspects of TVAP (September 2009 to August 2010) was commissioned. The tender for this evaluation was won by FUSE, the Centre for Translational Research in Public Health in the North East of England.

The aims for the evaluation were to explore aspects of TVAP relating to:

- The initiation and progress of HHC in community pharmacies
- The content of 'Action Plans' (AP) provided by participating general practices, and opinions about how the plans worked when implemented
- Evidence about HHC assessments carried out in workplaces
- The opinions of clients and members of the public about HHC
- Some quantitative aspects of the programme, in partnership with Tees Primary Care Informatics (TPCI).

Research design and methods

The research uses a 'Theory of Change' model, which involves a thorough grounding in the logic of the programme being evaluated, followed by a process of continuing feedback to the organisation so that the programme may be modified in the light of developing experience.

The methods of the research were primarily qualitative, involving interviews with those with experience of TVAP (PCT staff, primary care professionals and clients). Some interviews were carried out with members of the public who did not have knowledge of TVAP, and there was a small amount of quantitative work making use of aggregated and practice data prepared by TPCI.

Main messages for the PCTs

Bringing together the information from all the strands of our evaluation, we believe there are some overarching messages for NHS Tees:

- Between October 2008 and June 2010 TVAP achieved an outstanding level of acceptance in general practices and workplaces, which resulted in well over 34,000 vascular risk assessments
- More than 12,000 people were identified as at high risk of CVD and offered support and treatment. These are impressive achievements
- Overall, up to March 2010, general practices carried out more assessments than they had aspired to do in their response to the original TVAP Local Enhanced Service (LES) agreement
- In order to understand better the service and activity it can expect from GPs and pharmacies, NHS Tees could scrutinise more carefully, and against criteria, responses relating to aspirational targets and facilities which it receives from contractors
- NHS Tees is providing improved feedback to contractors, but there is room for additional sharing of good practice
- Good practice guidance (for example on recall of non-attenders), and better knowledge of PCT expectations, would be valuable to practices
- NHS Tees commissioners need fully to understand the businesses and commitments of contractors in order to be able to set secure budgets for the programme
- There are persisting problems with information transfer between community providers and general practices, leading to significant amounts of missing data
- This information gap between community assessment data and GP practice data is a major concern because it puts people at risk
- The low levels of referral of high and medium risk clients to lifestyle support pathways, is not accounted for. Should these referrals rise, capacity within the support systems will need review
- Further development of the scheme for involving employers in offering HHC in workplaces is desirable
- Knowledge of HHC in the general population is low. Social marketing could raise awareness of the availability of checks, but also of the purpose of prevention and the potential benefits of taking action to reduce risk.

Main themes

The main themes are each addressed in appendices A-G. The headline findings for each report are:

The initiation of HHC in community pharmacies (Appendix A)

- The initiation of the pharmacy programme was subject to severe delay
- IT difficulties were hard and time consuming to resolve
- The full costs of HHC in community pharmacies are still not known.

Further experience of HHC in community pharmacies (Appendix B)

- The number of assessments carried out is much lower than expected
- There are still difficulties with the IT system
- Social marketing may help to increase activity in community pharmacies
- The longer term viability of HHC in community pharmacies is not known.

The implementation of GP action plans (Appendix C)

- Action plans submitted are often not complete enough to provide NHS Tees with assurance about practice processes, and this persists in LES 2010
- The TPCI prioritisation lists are effective in directing practices to higher risk people
- There is major variability in practice activity in TVAP
- There are important discrepancies between data recorded in community assessments and in GP records.

HHC assessments in general practices (Appendix D)

- The TVAP LES is flexible enough that practices of widely differing size and composition have been able to adapt it to their existing circumstances. This has led to universal uptake of the LES
- Nurses are very supportive of TVAP and they and their clients consider it worthwhile
- There are no criteria or support for how to engage clients who do not attend invitations to assessment.

HHC assessments in workplaces (Appendix E)

- There are many opportunities to deliver HHC in workplaces
- Where HHC is delivered, reaching the whole workforce is a challenge
- Employees find workplace assessments convenient and nearly always attend if they have made an appointment.

Client perceptions of HHC (Appendix F)

- Among the public, knowledge of healthy heart checks is low
- Among the public, knowledge of prevention of illness is low
- There is minority, but widespread, resistance or apathy to assessment
- Social marketing may have an important role in raising awareness of the benefits of prevention.

Quantitative aspects of HHC activity Appendix G)

- There are people who have been identified as high risk in the community who have not received the care they require
- The fact that workplace/community data does not match GP information is a matter of great concern.

TVAP EVALUATION MAIN SUMMARY

Background, Commissioning and Aims

Background

In April 2008 the Department of Health announced plans to introduce a national vascular assessment programme, which was launched on 1 April 2009 as 'NHS Health Checks'. The Tees Vascular Assessment Programme (TVAP), which has been in development since 2007, is consistent with the national programme. Following a period of market research across Tees a local brand (logo, images and text) was developed with the title 'Healthy Heart Checks' (HHC). The programme as initiated is often referred to in this way in the report.

HHC focuses on cardiovascular disease (CVD), represented by heart attack, stroke and the vascular (blood vessel) complications of high blood pressure, high cholesterol and diabetes mellitus.

NHS HC is presented as primary prevention (the identification of individuals at increased risk of CVD, of which they are unaware, and the offer of intervention to reduce that risk), for the whole UK population aged 40-74. The screening process is planned as a five year rolling programme for this population, with yearly review for all those identified as 'high risk'. High risk is defined as having a greater than 20% risk of a cardiovascular event within the next 10 years.

The NHS HC programme was initiated in 2009, with planned national rollout by 2012. Some areas were early adopters and some, including NHS Tees, were planning for more than a year before the initial launch in April 2009.

The programme is matched with substantial resources, and underpinned by an imperative that its introduction should not result in an increase in health inequality. As such it was recognised by NHS Tees that evaluation of the introduction of the programme would be valuable and could provide lessons, through networks and/or publications, for other members of the NHS family.

TVAP is offered in general practitioners' premises, community pharmacies, workplaces and other community venues, with the majority of assessments expected to take place in GP premises. Each GP practice has an 'eligible' list of registered patients (all those aged 40-74), and an 'indicative' list (a subset of the eligible list who are believed to be likely to be at increased risk of CVD). This 'indicative' list is generated by Tees Primary Care Informatics (TPCI), based on individual patient values acquired through information supplied under the GP 'Quality and Outcomes Framework' (QOF), and through normative data.

Within NHS Tees there is wide variation in general practice size, demography and health profile. The impact this has on the workload, organisation and activity required of practices under TVAP is referred to through the report and its appendices.

In April 2009, the numbers falling within the scope of TVAP were:

Total Tees Population: 574,255

Total eligible population, eligible for HHC every five years: 243,217

Range of eligible list size between practices (excluding known CVD): 80 - 7315

Total estimated 'high risk' population as identified by TPCI: 30,826

Range of estimated 'high risk' population between practices: 4 - 1401

Commissioning of the evaluation

The evaluation was commissioned through a formal invitation to quote on behalf of the Tees PCTs. The Centre for Translational Research in Public Health (CTRPH/FUSE), a collaboration between the five Universities in the North East of England, submitted a formal tender, with Teesside University's Centre for Health and Social Evaluation (CHASE) as the lead partner. This competitive tender was selected.

The invitation to quote specified that the evaluation proposal was to cover a maximum of 12 months from September 2009. By making this stipulation the PCTs limited themselves to an evaluation of the early implementation phase of TVAP, and ruled out any investigation of the outcomes of the programme and any 'value for money' assessment. This was reflected in the tender submitted, and the aims chosen for the evaluation.

Aims

The overall aims of the evaluation of TVAP are to:

- identify barriers and levers to successful implementation
- highlight best practice
- inform service improvements and/or redesign if appropriate
- shape future commissioning strategies to inform full rollout.

More specific aims set out in the tender document were:

- To undertake a quantitative and qualitative assessment of the GP Action Plans against aspirations and actual levels of activity achieved
- To undertake empirical inquiry which allows understanding of the various factors that promote effective delivery of the Action Plans (and aspiration targets) and of the structural and procedural barriers that prevent or impede delivery

- To explore the factors within General Practice that allow staff to positively identify and engage with individuals at high risk of CVD (>20% 10 year risk of CVD event) and to derive suggestions for ways to improve future delivery of the service
- To examine the issues related to establishing the first cohort of pharmacies to provide open access assessments and to derive suggestions for ways to improve future delivery of this arm of the service
- To understand and describe the perceived effectiveness and acceptability of the Tees Vascular Assessment Programme amongst professionals and agency stakeholders taking part across the different settings (general practices, pharmacies, workplaces and community settings)
- To understand and describe the perceived effectiveness and acceptability of the Tees Vascular Assessment Programme amongst clients taking part across the different settings (general practices, pharmacies, workplaces and community settings). This is understood to include both those who accessed the service and also those who were identified through screening of records as appropriate candidates for TVAP, but who chose not to take up the offer of screening and/or further treatment.

Research Design and Methods

Our overall evaluation design uses Theory of Change (ToC) perspectives and framing (Fulbright-Anderson et al 1998). Theory of Change is widely used in the evaluation of complex interventions. It requires a thorough understanding of the 'logic' behind the processes being evaluated. It takes a perspective in which early findings in the evaluation are fed back to commissioners, with the intention of enabling modification to the evolving process under study, and aiming to maximise efficiency and responsiveness.

Within this overall design, and a 12 month maximum length for the evaluation, we identified four principal strands of work: investigation of general practitioner (GP) Action Plans; analysis of the implementation of phase 1 of the Pharmacy Project; exploration of staff and client experiences of the assessment process; and exploration of the operation of assessments in workplaces.

Methods

The chief method has been to establish the views of individuals through personal interview. In the majority of cases, these individuals have had direct experience of TVAP.

In our tender we stated that approximately 50 client interviews would be undertaken, and this aspiration has been exceeded. The interview profile of clients includes those who have experienced assessment in both GP or community settings, and we have testimony from individuals found to be at higher and lower risk. Our plan was to include views from members of the public who have either not heard of the HHC initiative, or who have chosen not to take part in assessment. We were successful in this and have identified a range of attitudes and beliefs which will be of value in preparing for the further marketing of HHC, designed to avoid any increase in health inequality as a result of TVAP (reported in Appendix F).

We undertook interviews with professional staff administering the assessments in different settings (i.e. GP surgery, pharmacy and workplace settings), giving a focus on the quality of the assessment experience, client motivation to continue within TVAP, and indications of whether barriers to assessment are being overcome (reported in Appendix B, D and E).

Because of the emphasis on initiating the Pharmacy Programme, and the delays associated with this, and the issues in administration of the workplace assessments, interviews were also conducted with PCT staff who have experience of these aspects of TVAP (reported in Appendices A, E).

Analytic work was carried out on the Action Plans (AP) submitted by participating general practices, and there has been sufficient time to report on the further development of these plans for 2010/11 (Appendix C). Some quantitative work was also carried out in collaboration with Tees Primary Care Informatics (TPCI), and the Strategic Intelligence Directorate (SID). This work was partly focussed on the activity and geographical spread of HHC activity, and partly on the activity of GP practice teams as set out in their Action Plans. In both cases the purpose of

quantitative analysis was to offer early insight into the likely effect of TVAP on inequity in the availability and uptake of HHC assessments (reported in Appendix G).

Report of the Main Themes of the Evaluation

The initiation of HHC in community pharmacies (Full report: Appendix A)

Delivery of HHC through community pharmacies was planned from the start of TVAP as a way of increasing access and convenience for those wishing to be assessed. This was to be linked with a social marketing programme and involvement of a high proportion of pharmacies. A 'Phase 1' group of eight suitable pharmacies was identified, as a preliminary to further roll out.

In practice, the process of enabling these pharmacies proved more challenging than expected. This was caused partly by the length of time taken to negotiate the Service Level Agreement (SLA) under which pharmacies would provide the service. In addition unanticipated difficulties arose about training of pharmacy staff, Information Technology (IT), (specifically secure connectivity to the NHS network), and issues of NHS standards, such as infection control, privacy and waste disposal. The training issues were addressed, and the training provided was highly regarded by those who took part. There was great interest in developing pharmacy staff, and a feeling of enthusiasm in pharmacies that opportunities for staff would be increased by the initiative. However, the time delay between training and implementation caused difficulties. Practical barriers, such as the provision of hand washing facilities, could not be overcome for some pharmacies.

Whether to extend provision of HHC in more pharmacies is under review. The evaluation team is aware that the pharmacies selected so far are able to provide a high level of facilities, meeting NHS standards. If NHS Tees aims to provide equitable access to HHC in community pharmacies across the patch, it may be necessary to invest significantly in pharmacies with poorer existing facilities.

Good practice and levers to implementation

- NHS Tees has responded positively to NHS HC to ensure wide access to risk assessment, and has supported pharmacies as a site for HHC assessments
- A social marketing programme was planned and initiated
- Motivation to deliver HHC in pharmacies is high among pharmacy staff
- The training provided by the PCTs was appreciated by pharmacy staff and considered to be of high standard.

Barriers to implementation and service improvement

- The initiation of the pharmacy programme was subject to severe delay
- Some of this delay resulted from insufficient appreciation of the realities of pharmacy business

- Some delay resulted from lack of co-ordination between PCT directorates, and from the temporary absence of key individuals
- Details of service delivery, such as the disposal of contaminated 'sharps', proved a challenge to resolve, and caused delay to the programme
- The delays between training and implementation of the service resulted in loss of staff skills and enthusiasm
- IT connectivity between pharmacies and the NHS network is still not fully resolved (e.g. because of firewalls belonging to national pharmacy chains)
- Data transfer between pharmacies, GPs and PCTs is still not robust
- Separate templates are used for pharmacy and GP risk assessments.

Commissioning to inform rollout

- The full costs and implications of the 'Phase 1' pharmacy programme were not set out in advance. This should be corrected in any future rollout
- In any future rollout, the existing facilities and capabilities of intending pharmacies must be rigorously reviewed in advance
- Some pharmacies are constrained by belonging to national chains, and this needs to be taken into account in pharmacy selection
- The commissioners of further rollout should have a thorough understanding of pharmacy business and working practices
- It is the evaluation team's impression that in order to preserve equity of access, further rollout will involve investing in less well developed pharmacies.

Further experience of HHC in community pharmacies (Appendix B)

Following the prolonged period for introduction of HHC in community pharmacies, follow-up interviews were arranged. This was because of PCT concerns that HHC assessment numbers in pharmacies were low, and statements from the CVD support nurses that there continued to be a need for them to provide significant input to pharmacies to ensure the competence of staff.

Our interviews confirmed the low levels of activity, for which a number of reasons were advanced. The slow development of the programme had resulted in few opportunities for staff to maintain or develop their skills, and the number of customers asking for an assessment was low.

All pharmacies were offering appointments for assessments rather than operating a 'drop-in' service. A drop-in service requires sufficient demand and a pharmacist always able to provide the risk assessment and advice.

Pharmacists wished to see more advertising of the service, which they hoped would increase uptake. Such advertising is now going ahead, and the response will be reviewed by the Public Health Directorate in November 2010.

Initial problems with the IT system persisted. Some of this related to connectivity to the NHS, some to a malfunction of the provided risk calculator, and some to the system making it difficult for the pharmacist providing advice to see results from earlier stages in the assessment appointment.

Pharmacists use varied methods to transfer patient information to GP surgeries, and this is a matter of concern as data from community settings is not reliably reaching GP clinical systems (although this problem is more widespread than just from pharmacy – see Appendix C,D,G)

Pharmacists themselves reported that the service was worthwhile, and was also thought to be valuable by clients who had used it.

Good practice and levers to implementation

- The presence of CVD nurses employed by the PCTs to support community pharmacies has been essential to achieving competence among pharmacy staff
- The PCTs have enabled pharmacies to begin to carry out assessments in ways which suit them as individual businesses.

Barriers to implementation and service improvement

- Implementing CVD risk assessments in community pharmacies has taken much more time than expected, and the number of assessments carried out is much lower than planned
- The systems which pharmacies have used to return data from their assessments to GP practices are not robust. There is no assurance that information, including that on high risk patients, has not gone missing between pharmacies and practices.
- The IT system has caused problems in the 'flow' of each consultation and further updating is needed because the consultation is split between pharmacy assistant and pharmacist
- Problems with the miscalculation of risk scores which were identified with the IT system have now been rectified, but have impacted on some pharmacists' confidence in the programme and hindered them at some points in developing the service more fully
- The input in time from CVD support nurses has been a cost to the system and has created some logistical problems when pharmacy staff are unable to operate without nurse supervision

- The pharmacies reported that there was insufficient public awareness of the service, and believe that additional marketing of HHC would be valuable.

Commissioning to inform roll out

- Value for money calculations were not within the remit of this evaluation, and we are not able to report whether delivery of HHC in community pharmacies represents value for money
- Should further roll out be contemplated, the importance of social marketing must be carefully considered
- Should further roll out be contemplated, the selection and support of pharmacies to ensure equity of access to the service would be important
- It is essential that the PCTs have assurance that the transfer of data between pharmacies and general practices is secure and complete.

The implementation of GP action plans (Appendix C)

The original Local Enhanced Service (LES) agreement (October 2008- March 2010) was successful in engaging almost all Tees GP practices, and must be accounted a success, since it was followed up by very large numbers of completed assessments (34,980 by end June 2010), and identification of many individuals at high risk of a CVD event (12,293 = 35% of the number tested). It also resulted in many new diagnoses of unrecognised hypertension and diabetes mellitus. It should be emphasised here that the Tees intervention asked GP practices to prioritise those at highest risk and aided them in so doing by providing an indicative list of high risk patients. This is somewhat different from the national Health Checks programme which merely requires practices to cover all the eligible population within five years and does not require practices to prioritise patients according to estimated risk.

Originally the LES was planned to run for one year (to October 2009), but while some practices started assessment activity immediately, many others did not undertake assessments until January – March 2009. The LES was extended to run to March 2010, at which point a new LES was introduced.

The initial LES required each practice to provide an 'Action Plan' (AP) of how its primary care team would meet the LES requirements. The planning team recognised that with practices of very different sizes, population age structures and existing ways of working, the method of implementation of the LES could not be uniform. The PCTs wanted to know how many people the practices expected to assess in the first year of the LES. This was to enable a budget-setting exercise to be carried out, and to provide an early indication of whether the target to risk-assess the whole 40-74 population within five years was likely to be achieved.

Each practice was asked to provide an 'aspiration' for its activity in the first year, and it was recognised that this could provide a yardstick for practice performance (set by the practice itself). No sanction was included in the LES for either exceeding or failing to reach this aspiration, but variation in performance was expected.

The AP also asked practices to identify who was likely to be carrying out the assessments, whether extra staff would be required, and how information reaching the practice from community assessments would be handled.

Detailed evaluation of these aspects is included in Appendix C, but the headline findings were:

- Nearly all general practices signed up to the LES and carried out HHC assessments
- The variable size of practices and the demographics of the registered population made for very wide variation in the work required from individual practices to sustain TVAP
- Nearly all practices planned their service to be run by practice administrative staff, and delivered by practice nurses and health care assistants (HCA)
- Many practices planned to increase nursing hours, and some planned to appoint new posts, meaning that at least some of the financial benefit to practices of TVAP was ploughed back into making the service work
- The request to provide an 'aspiration' figure for the first year's activity was not understood uniformly by practices, making the aspiration difficult to interpret
- Although some practices persist with low levels of activity, some 'slow starters' eventually reached or exceeded their aspiration targets
- By the end of the calendar year 2009, the number of assessments carried out and submitted to the PCTs broadly matched the total number of assessments aspired to by practices in October 2008
- The extent to which practices targeted patients identified as likely to be at high risk varied, but overall about 35% of patients assessed by June 2010 had been identified as having high risk of a CVD event in the next 10 years, significantly above the population average of approximately 11%
- Practices were often unclear how they would handle, or even identify, data being received from community or workplace assessments. This aspect is dealt with in greater detail in Appendix C but is a concern which has been considered in the second LES (from April 2010).

The LES 2010/11: 'the second LES'

A new LES was created for 2010/11, in response to the first year's experience of TVAP, and in order to obtain new action plans from the practices. There was some delay in initiating the new LES, and at the time of final data collection within the evaluation (mid August 2010), 42 action plans were available for analysis (48% of participating practices).

The new APs asked for information from practices about the number of patients they intended to review from their 'high prioritisation' list of expected higher risk patients, and the number from their CVD recall register. In response to concerns raised earlier in the year, further questions were asked about how the practices handle and act on data when HHC assessments have taken place in community settings or workplaces. Practices were also asked about their approach to engaging people who have failed to attend an invitation for a HHC risk assessment.

The findings are reported in detail in Appendix C. They indicate that:

- The returned APs are of variable quality and many do not provide clear details of how community data is handled or acted upon within the practice
- The PCTs do not have criteria for what constitutes an acceptable AP
- Practices do not have failsafe mechanisms for dealing effectively with community-generated data, and there are probably identified high risk patients who have not been reviewed in their practice
- The 2010 APs ask for figures to indicate some aspects of practice assessment aspiration, but do not cover all the assessments a practice may be planning to carry out, e.g. opportunistic assessment of lower risk individuals on its list
- As a result the PCTs do not know whether practice HHC activity will remain on track to cover all the eligible population by the end of the five year TVAP cycle
- The system for engaging non-attenders is variable, and it seems likely that a group of the population will not engage with TVAP. The consequences of this for health inequality are not part of this evaluation, but would be a valuable subject for future work.

Good practice and levers to implementation

- The TPCI prioritisation list is effective in directing practices to those most at risk on their list
- Assessment activity is high, and more than matches the initial aspiration at an aggregate level
- The LES agreement was effective in engaging nearly all Tees practices (in contrast to experience in other areas of the country).

Barriers to implementation and service improvement

- There is no assurance that data from assessments carried out outside general practices is reaching practice clinical systems
- There is no unified system for recording and transferring data between external providers, the PCT and GPs

- There is no assurance that individuals identified as at high risk by outside providers have been identified and managed in general practices
- There are no robust criteria for the actions to be taken (if any), when individuals do not attend invitations to assessment
- APs often do not provide sufficient detail to provide assurance of the robustness of practice processes, and the PCTs do not have criteria specifying what constitutes a complete and acceptable AP
- There is no clear mechanism within the current LES for holding practices to account for low aspirations in identifying high risk patients or in following up those on CVD risk registers
- There is no strategic intervention to review practice aspirations so that five year targets are met uniformly across Tees.

Shape of future commissioning to support rollout

- The aspiration figure plus the high risk recall figure asked for in the AP 2010 do not give a complete picture of likely practice activity, and are not sufficient to set the budget
- The intention to focus TVAP first on people at highest risk is being only partly achieved.

HHC assessments in general practices (Appendix D)

Interviews were carried out with general practice teams from 13 practices. There were practices from all four Tees PCTs and they included larger and smaller practices, and those demonstrating higher and lower levels of activity.

HHC in practices is largely delivered by nurses, and most interviews were with practice managers and nurses. Most practices were delivering HHC in a way which suited their existing practice structure, and were therefore reasonably satisfied with how it was running. There were many variations on the details of programmes, and the impact HHC had had on nurses' work, and these are reported in detail in Appendix D.

Nurses were positive about the programme, and felt that prevention was an important part of the nursing role. They appreciated the extra time for assessment offered by HHC appointments, and reported that patients appreciated this too.

Nurse described a variety of patient reactions to the advice they received after their risk had been assessed. Some patients were shocked, some were resigned, and their willingness to engage with risk reduction varied.

How practices decided on their LES Action Plan, and set their aspiration target, was often obscure. Practices did not report a wish for greater direction from the PCT, but

some would have appreciated greater understanding of what was expected of them in committing themselves to the LES, and to a precise practice aspiration figure. The identification and handling of patient data from assessments carried out outside the practice is an area about which the staff appeared to have little knowledge.

Practices respond to patients who do not attend invitations for HHC assessments in very different ways.

Good practice and levers to implementation

- The practices found the LES flexible enough to be able to deliver HHC in a way which suited their existing organization
- This variation in approach allows a high level of involvement of practices. We believe a more prescriptive approach would have been unhelpful
- Successful practices appeared to combine a focus on their indicative list with opportunistic screening
- HHC is a nurse-led programme. The nurses involved with the programme thought it was worthwhile, and reported that patients felt the same way
- Nurses felt that they were well equipped to deal with patient queries and to support patients to make informed decisions about their healthcare.

Barriers to implementation and service improvement

- Approaches to constructing APs and aspirational targets varied between practices. Additional support may be helpful, especially in practices where aspirations are low
- Information derived from assessments undertaken outside practices has not been easily recognised or handled consistently. Practices confirmed what is reported elsewhere, that community data remains a challenge.

Shape of future commissioning to support roll out

- Practices are adopting different approaches to patients who do not attend HHC appointments. Some criteria set in the LES may be necessary to limit the number of those who may be disadvantaged by being removed from recall registers.

HHC assessments in workplaces (Appendix E)

Interviews were carried out in workplaces where employees were receiving HHC assessments. We explored people's attitudes to being assessed, their motivation and their opinions about the place of employment as a venue for carrying out CVD prevention.

The programme was well received by local employers who took part. Employers took responsibility for promoting the programme among their employees, although with varying degrees of success.

Workplaces were generally considered as suitable for the assessments, and a number of clients commented on the advantages of being able to be assessed while at work.

Most clients perceived the programme positively, although overall uptake was relatively low. Among those advised to make lifestyle changes, there was usually an intention to respond to the advice they had been given.

PCT figures show that the workplace assessments so far have identified more than 200 people at high risk of CVD. Concerns remain that not all these people have subsequently been identified in their general practice and offered the management plan they require.

Good Practice and levers to implementation

- Recruitment and ongoing training of bank nurses to provide the HHC service has been successful, and is a model likely to be adopted elsewhere in the Region
- Links with employers have been promoted, and many have taken on responsibilities to advertise HHC and to recruit clients among their staff
- Systems are in place to facilitate provision of a service in the workplace. These systems are being strengthened, and a more active and a more diverse approach is being taken
- Clients were generally positive about the service and the opportunity to be assessed at work
- Very few workplace clients did not attend appointments they had made.

Barriers to implementation and service improvement

- So far the programme has not achieved its aim to engage people with mental health problems, minority ethnic groups and travellers and provide them with access to HHC. A new staff appointment has been made to address these issues
- The use of public nurse facilitators has been successful but there is a need for more proactive engagement with a wider range of employers
- Employers need support in finding ways to promote HHC to all employees, to ensure equity and engage those more likely to be at risk
- There is a lack of awareness of the programme among the public, and a failure to promote HCC in local communities

- Because of the separation of those identifying suitable community sites or workplaces from those delivering the service, effective and continuous communication between them is essential
- There is no robust facility to track patients from workplace assessments through to follow-up with their GP and agreement of a management plan when required.

Shape of future commissioning to support roll out

- Workplace assessments require improved technology systems that link with the wider HHC dataset
- The value for money aspects of workplace and community assessments are not within the scope of this evaluation.

Client perceptions of HHC (Appendix F)

Interviews were carried out with members of the public to gauge their awareness of and involvement in TVAP. Interviews took place with higher and lower risk clients, who had received an HHC assessment, and particular efforts were made to speak to individuals who had not received assessments or were unaware of the programme. Client responses are reported in detail in Appendix F.

Interviews revealed a wide variety of client responses. For those who had had an assessment carried out at their GP surgery, their reactions generally mirrored those reported by nurses in the practice and reported in Appendix D.

Perhaps of most interest to the PCT are the responses from those with low levels of awareness of the programme. Many people reported being unaware of HHC, and a proportion of those who were known to have had an assessment reported not being able to remember this. Many people thought the idea of the checks was worthwhile, but especially for giving ‘peace of mind’, rather than for action to be taken. Interviewees had many reasons for thinking that HHC was not important for them, or that they would rather not know about any risks that they had. Some people were clear that they would not change, whatever they were advised, and there were a variety of attitudes to taking medication. The idea of prevention and a risk reduction programme was poorly understood.

It was clear to the interviewing team that among the public the TVAP message has not penetrated, and that the reasons for being assessed and the potential benefits in improved health have not been persuasively presented.

Good practice and levers to implementation

- Where clients had experience of HHC assessment they generally reported the service as good
- Some clients recognised prevention as a good thing, and that it helped identify unrecognised problems

- Clients reported that information spread by word of mouth would encourage them to seek assessment.

Barriers to implementation and service improvement

- Awareness of HHC in communities is low
- Understanding of prevention is poor, and many clients are not interested in it
- Clients expressed many fears about, and resistance to, assessment when they did not feel unwell
- GPs are not using the HHC branding uniformly when sending for patients for assessment, undermining the impact of the campaign.

Shape of future commissioning to inform future rollout

- A stronger advertising campaign appears to be necessary to engage people who do not attend their GP surgery
- Public education about prevention and its potential benefits is lacking
- Use of a wider range of community venues could be further explored.

Quantitative aspects of HHC activity (Appendix G)

A large amount of data has been collected within the PCT about clients who have presented themselves for assessment. This data is being linked to already known data held by the intelligence unit regarding deprivation and health outcomes in Tees.

We have concentrated on three quantitative aspects of TVAP:

- The numbers of assessments carried out by individual practices in relation to the aspirations set out late in 2008
- The pattern of assessments geographically across Tees, to consider whether this could give an early indication of the likely impact of TVAP on health inequality
- What can be understood about the further progress of people identified as at high risk in community and workplace settings.

These are all reported on in detail in Appendix G.

The headline findings are:

Good practice and levers to implementation

- The information provided by TPCI to identify individuals likely to be at high risk is helpful to practices in focusing on those most likely to experience an event
- 24% coverage of the eligible population by June 2010 indicates Tees PCTs appear to be making good progress to cover their eligible population within five years
- The use of accumulating data to inform planning while the programme is still evolving is good practice and should be encouraged
- CVD support nurses are already employed by the PCTs to work in both practice and community/workplace settings. They are a resource to encourage change where appropriate assessment activity is not occurring.

Barriers to implementation and service improvement

- The fact that workplace/community information does not match with practice information is a matter of great concern which should be urgently addressed
- The probability that there are people identified as high risk in the community who have not been identified as such by their GP teams is a matter of great concern which should be urgently addressed
- The low level of referral to existing services of people who would be likely to benefit from lifestyle change is not explained and should be evaluated.

Commissioning to inform roll out

- Practice systems for handling and acting on community data should be made more rigorous, and this should not wait for a further version of the LES
- Information available from TPCI should inform any further social marketing carried out for TVAP
- The PCTs could choose to pilot an 'aspiration predictor' system with willing practices
- Within the context of high achievement there continue to be widespread variations in practice assessment activity. These would need to be understood in more detail if an attempt was made to establish the cost effectiveness of TVAP.

Conclusions: main messages for the PCTs

Bringing together the information from all the strands of our evaluation, we believe there are some overarching messages for NHS Tees.

The TVAP programme has achieved a very high level of acceptance among Tees general practices and workplaces, and has delivered over 34,000 vascular risk assessments. Through it more than 12,000 people at high risk of a premature CVD event have been identified, and they have been offered the chance to reduce their risk of disease and premature death. This is an outstanding achievement.

In order to improve the service further, we believe there are some key areas which the PCTs can address to maximise good practice and to minimise the potential for health inequity.

The ways that some providers have planned their internal processes may disadvantage some people. For example, some practices plan to remove from future recall individuals who have failed three calls to attend a HHC assessment, and some employers have not employed recruitment methods which reach all of their employees. We believe that the PCTs could take additional action to scrutinise such issues, and in particular to ensure that the descriptions NHS Tees receives about the processes contractors intend to use have been rigorously scrutinised and, where necessary, challenged. Further, there has only been partial success in reaching out to 'hard to engage' groups, such as those with enduring mental illness, ethnic minorities, men at work and travellers.

There are many examples of good practice among the reports we have received, and we think that the PCTs could do more to promote these, especially while substantial variations in activity exist among practices, and while there is a range of local employers who have not yet become engaged in TVAP. At the same time NHS Tees will want to be assured that the rate of assessments generally will meet the requirement for population coverage over a five year cycle. We believe that TVAP is now sufficiently well established that the PCTs can challenge practices which are below target in their aspiration to risk assess their registered population, and support them to greater activity.

We have identified important concerns with the compatibility of IT systems used by practices, pharmacies and in workplaces. We believe that there are difficulties with the different templates being used and we are certain (as is TPCI in its latest quarterly report) that there are people identified as at high risk from community assessments who are not so recorded on their GP practice registers. This is a matter for urgent action.

The feedback general practices are now receiving from TPCI is of high quality and is viewed as helpful. This area could be further developed, along with the dissemination of good practice

In general, referrals of high and medium risk clients from assessments to lifestyle support pathways are low. The reason for this is unclear, but many people who could reduce their risk are not being supported to do so. Should the rate of referrals

rise, existing support pathways appear likely to be overwhelmed, and NHS Tees may wish to further consider this issue.

We have identified that knowledge of HHC and knowledge of illness prevention is low among many of the people we interviewed. In some, attitudes to prevention are misinformed. We believe that to engage as many people as possible in TVAP, public education, perhaps through social marketing strategies, will be needed.

Future evaluation

The evaluation we have undertaken has achieved its aims but is necessarily time limited. The further development, rollout and impact of TVAP lies in the future. We now know that HHC can be delivered at high volume in general practices and workplaces. We know that the public is generally willing to attend assessments and in many cases to accept medication and listen to health advice.

To obtain the maximum benefit from the programme, and to be able to quantify its impact and cost, we recommend that further evaluation be carried out, in the form of:

- An exploration of the impact of the TVAP programme in improving health outcomes for the Tees population, with a particular emphasis on value for money
- The collection and analysis of data from individuals who have received HHC assessments, and from the recall of individuals from the CVD prevention registers. This is of vital importance as this data on individual patient progress in terms of adherence to medical advice, if fed back to individual practices, would be a powerful tool for sustaining the TVAP programme.

Presentations

Presentations of aspects of the evaluation have been made on two occasions to meetings of Tees GP teams convened to discuss modifications to the Tees LES. Other dissemination of information from TVAP, and NHS TEES HHC activity has taken place on:

21 October 2009: to the ESRC Troika meeting at Fuse, including DH representatives, Newcastle upon Tyne

23rd February 2010: to the Department of Health NHS Health Checks national learning network, Manchester

24-25th March 2010: to the United Kingdom Public Health Association (UKPHA) Conference, Bournemouth

12th May 2010: to the Royal College of Nursing (RCN) International Research Conference, Gateshead

9th June 2010: to the North East England HHC cardiac network.

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Appendix A

AN EVALUATION OF THE IMPLEMENTATION OF THE TEES VALLEY CARDIOVASCULAR ASSESSMENT PROGRAMME

Introduction into community pharmacies

Acknowledgements

The evaluation team would like to thank all the Pharmacists, members of the Primary Care Trust, and members of the Local Pharmaceutical Committee who agreed to give their time and views.

Table of Contents

Purpose.....	A5
Research methods	A5
Findings.....	A7
Management of phase 1 pharmacy set up process	A7
Community pharmacies: recruitment and selection	A9
Service Level Agreement (SLA).....	A10
Information Technology (IT).....	A12
Pharmacy accommodation and equipment.....	A14
Training and competency.....	A14
Summary.....	A19
Strengths and good practice	A21
Recommendations to facilitate rollout of community pharmacy involvement in HHC in NHS Tees and other PCTs.....	A23

Purpose

The purpose of this report is to feed back on interviews with stakeholders within the PCTs, community pharmacists and the Local Pharmaceutical Committee (LPC) to understand the processes which took place in the early stages of setting up Healthy Heart Checks in community pharmacy settings. This evaluation looks at the barriers, facilitators and good practice which all played a part in preparing to implement HHCs in community pharmacies.

Research methods

A qualitative research design was employed to collect data in relation to the first phase of setting up the TVAP intervention in community pharmacies. Stakeholders from the PCT, community pharmacies and representatives from the LPC were invited to take part in semi-structured interviews to give their views and ideas about implementing TVAP.

Stakeholders (n=8) within the PCT were identified by the project manager for the TVAP project. These stakeholders were contacted by letter and invited to take part in the evaluation. All pharmacies (n=9) that had been selected to take part in the Phase 1 intervention were contacted by letter and invited to propose a representative to take part in the evaluation. Eight put forward suggestions of people who agreed to be interviewed. Members of the LPC (n=2) were also invited by letter to take part in the evaluation.

All interviews lasted between 20 and 60 minutes and followed a semi-structured format. Interviews were recorded and subsequently transcribed. Data analysis was carried out thematically, with two researchers reviewing material and working to establish themes which could be supported by the evidence.

The study protocol was approved by the School of Health and Social Care Research Governance and Ethics Committee at Teesside University.

Limitations of Study

Eight of the nine pharmacy representatives taking part in the HHC programme were interviewed. Whilst their views could be said to represent the voice of Tees pharmacies delivering the programme, this is still a small sample and one must be mindful when trying to generalise these findings to a wider population.

Findings

In this section we present the data from interviews with PCT staff, pharmacists and the LPC. The data presented here is organised under the following themes: the management of the phase one pharmacy set-up process, recruitment and selection of the community pharmacies, the Service Level Agreement (SLA), Information Technology (IT), pharmacy accommodation and equipment, and training and competency.

Management of phase 1 pharmacy set-up process

Across the Tees Valley it was decided to deliver HHCs in community pharmacies, as they seemed to be ideally placed locations to deliver this service to hard-to-reach populations, thus linking with improved access to healthcare and reducing health inequalities. It was felt that many people might not access their GP surgeries to have their HHC, yet might use a kind of 'drop in' service at their local pharmacy:

I originally thought taking the community pharmacy on was a good idea because I thought that it would improve the access for patients who we know don't all go to GP surgeries to have their checks. Going to a community pharmacy where, if you like, they could just go whenever they wanted, it's more accessible for them. (PCT staff member)

The DH had said they wanted us to look at other providers, and community pharmacies they thought would be a good venue, and there had been a lot of projects around the country like the big one from [pharmacy name] in [English city] that was very successful, fantastic results, doing CVD assessments. (PCT staff member)

Not only was it believed that community pharmacies could deliver interventions to people who might otherwise not access their GP, but pharmacies have their own 'naturally occurring' populations which access their other services (such as smoking cessation) regularly. Anecdotally, they have become trusted sources of information for many patients, which makes them ideal candidate venues for reaching out to those populations otherwise hard to reach from general practice. The combination of offering this programme through multiple health providers also addressed the matter of trying to improve access to services and reduce health inequalities. It is not clear, however, if people will travel to community pharmacies outside their area just to receive the assessment. This impacts on the placement of the pharmacies delivering the assessments within areas of deprivation, and suggests the need for careful monitoring of the pharmacies which were selected to deliver the service:

From my experience of working in a deprived area, as a health visitor, people do access pharmacies like they would access their GP at times. They trust their pharmacy, and from being in the pharmacy [names pharmacy] that is very evident. It's 'Hi John. I need this, I need that. What can I do about this? Can I try that?' They know their population very well. (PCT staff member)

We do focus on the services, because we do a lot of the morning after pills. We have started doing the flu vaccinations and the cervical cancer vaccinations. So in this store we like doing the services, because it brings people into the store. (Pharmacy 1 rep)

The feedback that we have [from pharmacists] is that pharmacies seem to have a natural community of people who come into the store, and whether you will get people travelling to the pharmacy just for the check is the question really. If you have somewhere that is within [large chain pharmacies], I would guess they have a lot more people going through the door who are from different areas because of where they tend to be located. But with an independent pharmacy that is very much based within a small community, whether you will get other people travelling from outside [the area] that will come in, I don't know. (PCT staff member)

However, whilst all evidence was pointing towards pharmacies being a suitable place to deliver HHCs in a community setting, the costs of delivering the service were not fully assessed before the intervention. There was some concern expressed in interviews, that delivering the service in community pharmacies might not be viable in the longer term due to the costs involved, many of which were hidden at first:

So when we costed the service up and looked at the training, the equipment and resources we have to provide for the payment of the Healthy Heart Check, and the amount of money we are going to spend on advertising to direct people into the pharmacies it's quite an expensive intervention per patient. (PCT staff member)

If I was looking at it with my PCT commissioning hat on I would be thinking about the amount of time for [PCT staff named], nurses, and buying in extra pharmacy support and Hepatitis B [vaccinations for pharmacy staff] - costing up properly it would never have got past a commissioning process because it would be far too expensive. It was costed up on the basis of how much they [pharmacies] were getting paid. They [pharmacists] get paid per assessment plus an annual retainer fee to make sure they keep their equipment maintained, and their set up costs which were supposed to allow for them to be released for training. (PCT staff member)

With this in mind, some concern was raised as the Tees intervention rolled forward. Data was starting to filter in from other areas in the Country that had rolled out HHCs in community pharmacies, but then withdrawn the service from many locations due to the small volume of activity making the service non viable:

- R What they [other PCTs] are finding is that it is not delivering the service they wanted, [English PCT] in particular. They took on 30 pharmacies, set them up with the training, equipment, IT and have taken the stuff off 15 of them already, because they weren't ...*
- I Not meeting the targets?*
- R Not only that. For me, you need to be performing a service like that on a regular basis in order to keep your competencies up, and they*

just weren't doing any assessments. So they withdrew the contracts from 15 of them. (PCT staff member)

Additional challenges were faced in the early stages of implementation of the programme due to this being a Tees-wide initiative. PCT staff raised the issue of inter-PCT working being a barrier to setting up the pharmacy side of things and adding to the time delays experienced by the teams. These issues were, however, eventually overcome:

So what I tried to do was to say to [Local Director of Public Health] that he needs to be influencing the directors of those other directorates [across the Tees Valley], that this piece of work is part of the core responsibilities of their team. But I am not sure that that is embedded at the minute – that cross working. People have got other competing priorities. (PCT staff member)

Changes within the PCTs during the initial phase of setting up the programme and staffing changes impacted on the process of getting the pharmacies off the ground with the initiative. Those people involved in the early management of the programme did not see it through to completion. This caused delays in matters such as training, but also confusion about the audit trail of the programme regarding things such as the rationale for choosing each of the pharmacies. This is discussed in the next section.

Community pharmacies: recruitment and selection

At an early stage all pharmacies in the Tees area were contacted and invited to express an interest in delivering the HHCs in their pharmacy. Those which expressed an interest were then assessed against a list of inclusion criteria set out by the PCT. A selection of those which fitted the criteria were then invited to take part in the phase one roll out of the HHCs. Whilst the PCT aimed to choose pharmacies which were both interested in delivering the TVAP and fulfilled the inclusion criteria, some members of staff felt that this process should have been more stringent. For example, had there been a site visit prior to offering the pharmacies an opportunity to take part in the HHCs, PCT staff could have made an assessment as to the suitability of the premises and provision of essential equipment for delivering the service:

With hindsight there should have been an expression of interest [from the pharmacies], selection criteria and a visit [to the pharmacy premises]. (PCT Staff member)

Those pharmacies involved in the first phase roll- out of the intervention saw the selection process as a simple one by which they expressed an interest and were offered the opportunity to deliver the service. Some pharmacies were aware that they had been chosen because they served a population in an area of deprivation and because they had previously delivered some other services such as testing for diabetes and smoking cessation. Some pharmacies seemed unaware of any other selection criteria which were applied to them.

Whilst it had initially been intended to include large pharmacy chains in the first roll-out of the programme, issues specific to their internal management have hindered their participation. Unlike independent or pharmacist-owned pharmacies, some large chains have layers of management which need to be consulted in order to get requests actioned:

Yes, because we are [large pharmacy chain]. Nothing gets done in store – it is all from Head Office and they send the engineers out. And they won't do anything that is not safe, so if it means doing something here and if something is going to go wrong to the structure they won't do it. So there is nothing we can do. (Pharmacy 1 rep)

Service Level Agreement (SLA)

As this service was brand new, and bearing in mind nothing of this scale had ever previously been rolled out in community pharmacy, a new SLA document had to be drafted. Issues quickly arose as there was no template on which to base the document. Members of the PCT took the lead on its construction. Part way through this process, the DH released a template for PCTs to work with, and this was incorporated into the final document:

I think the initial SLA that came out was not really applicable to pharmacies. It didn't really go into what we do and how things would work and what we would get paid. It wasn't really what I have become used to the PCT producing for pharmacy SLAs. It was just something that looked like an alien document. (LPC member)

Restructuring of certain departments into what is now a 'Contracting and Procurement Directorate' also had an impact on the development of the SLA:

What we did was not get them involved early enough in the day, although I thought we had. Changes in the roles in that directorate impacted on the SLA development. (PCT staff member)

As the PCT wanted community pharmacies to implement the service as quickly as possible, many strands of the process were running concurrently (for example expressions of interest and drafting of the SLA), something neither the PCT, pharmacies or LPC were used to:

The SLA took a year and a half to finally produce, so they were asking pharmacies to make decisions on something they had no idea about. Like how much work it would involve and how much they would get paid for it. (LPC member)

This was exacerbated by the confusion of roles and input of PCT staff and the LPC. Some PCT staff felt that the role of the LPC was to keep the pharmacies informed of the proposed service. In contrast, the LPC saw its role as being to liaise with the PCT and negotiate with them about the terms and conditions within the SLA document:

There was this issue of taking things through the LPC. I could see that that made some sense. However, I never saw this as a board that I had to get agreement from to get things passed. I just saw them as a way to keep the pharmacies involved in what we were doing, informed. (PCT staff member)

It's our role [LPC] to negotiate on their behalf [pharmacies]; agree what we consider to be fair terms and reasonable prices and to ensure that what is being described, what is being commissioned, is reasonable, equitable and legal. (LPC member)

During the process of drafting the SLA many issues arose around the responsibilities of both the commissioner and provider. The collection and disposal of 'sharps' became an issue. As previously stated, the commissioner felt it unreasonable to be responsible for the collection and disposal of waste, yet some smaller pharmacies did not have this provision in place:

As a commissioner do we really want to be handling the contract for our providers' waste? It just seems silly for us to do that. It should have been part of the agreement. (PCT staff member)

The LPC saw its role here as being to negotiate with the commissioner and this was overcome by including a set fee for the pharmacies to then buy in this service themselves:

Originally the PCTs were going to deal with sharps disposal, the way they do with medicines disposal – it just happens. But suddenly the vascular team said they didn't want to do that. So we had to find someone who was going to take away the sharps and agree a price. To be fair the bigger companies have got their own arrangements anyway. It's more for the smaller pharmacies. Originally the PCTs were going to refund the cost, but then they decided it would be simpler just to pay a grant. (LPC member)

Another issue that arose during the drafting of the SLA was around the payments that pharmacies were to receive per patient screened. It became clear that, unlike GPs, pharmacies pay VAT on each service they provide. The LPC negotiated with the PCT to pay the VAT price on top of the flat fee that was suggested for both GPs and pharmacies:

We realised that the price that was suggested originally was completely unachievable. So we then had to go away and create prices that actually would work; a set up fee, an annual fee and then a small fee for actually doing the services. (LPC member)

One of the bones of contention has been the pay, because apparently pharmacies have to pay VAT on any services they deliver and GPs don't, and so we are paying them both the same so it does not work quite right. So we have negotiated now that we will pay the basic price plus VAT,

otherwise they would have been doing it for quite a bit less. (PCT staff member)

Another unexpected issue that came to light as part of the agreement between commissioner and provider, was that in order to deal with blood and bodily fluids the provider is required to have up-to-date Hepatitis B vaccinations, something many of the pharmacy staff did not have:

We have actually paid a lot of the pharmacies to have Hepatitis B vaccinations which is a requirement for nurses and GPs who deal with body fluids. And we have actually paid for that out of our CVD budget. To me some of those pharmacies should have already had Hepatitis B vaccinations because of the work they are doing with needle exchange and other things. (PCT staff member)

However once all of these issues had been negotiated, it was felt that the final SLA was acceptable to all parties:

It is not bad actually, because we do a lot of services anyway, and it is quite similar to other SLAs that we do. (Pharmacy 6 rep)

Information Technology (IT)

Access to IT was raised as an issue by both PCT staff and pharmacists. The magnitude of this problem was unforeseen. Unlike GP practices, many pharmacies do not have secure access to the internet or NHS email accounts. Part of the SLA describes how the service is to be delivered and requires there to be internet access in the consulting room, as the person delivering the HHC follows a proforma which was developed by the PCT. Many of the pharmacies did not have the required N3 connection which would allow secure transfer of data across the internet. In order to connect to the PCT server securely, the IT team had to install software onto the pharmacy's computers and provide a 'RAS token'. This randomly generates numbers to increase security when logging onto the server that holds the HHC assessment tool. In many cases this was rectified simply by pharmacies having the correct internet connection installed:

There were a lot of phone calls to our IT provider so that we could have an extension of the N3 connection or whatever, and there was a lot of to-ing and fro-ing getting that to work. But we have got our own laptop and our own printer now – we can connect. There are still a few little teething issues I think – there is only one password that works. (Pharmacy 3 rep)

Some of the larger chain pharmacies encountered additional problems with connecting to the PCT server, as their company firewalls would not allow external access to the internet or would not allow the software that runs the database to be installed onto their systems. To date this issue had not been resolved, stopping some larger chains taking part in the initial phase of the HHC programme:

They [large chain pharmacy] won't let us put any of our IT software onto their systems, so they have asked if they can have another system of

doing it. The nurses [who go out into workplaces] have a database on a laptop that they take out with them and then they bring it back to the PCT at the end of the day and upload the data they have collected. All the information then goes onto the server [at the PCT]. And they [large chain pharmacy] have asked why they cannot do that. There is no reason why not, but they wanted us to give them the laptops and be responsible for the taking in and out of the laptops, and we have said that we cannot do that because it is unfair advantage and we cannot start buying laptops for every pharmacy. (PCT staff member)

Whilst internet connections and data security issues caused the PCT a headache, the pharmacies were happy with the system for recording data. All were happy that they were able to access the NHS server utilising their RAS token, though some were a little apprehensive about remembering their passwords and entering the correct data into the database:

It's the computer and remembering the passwords and how to log on and what to put in. It is different and it is like a scroll down for certain criteria and you can't just type in ones, you have to scroll down and choose a specific one, and sometimes there is a few and it is quite confusing. (Pharmacy 6 rep)

However, the majority of pharmacies felt that the database tool they were required to use to carry out the assessments was user friendly and fairly self-explanatory. The only issue raised was that there could be unforeseen 'teething troubles' once they actually went 'live':

That is the other thing that the PCT have provided. They have provided us with the database that we use. We have had a play around with it and we have had no problems. It is quite self explanatory. We have been through it. So yes, I don't think that there will be a problem. We are used to using computers and things so it is not anything new. (Pharmacy 5 rep)

It is nice that the computer system leads you through step-by-step what you have to do, but it is remembering what advice to pass on. I am sure that once they have done a few each they will be fine – but it is the time that has lapsed that they are worried about. (Pharmacy 7 rep)

Until we actually 'go live' and then you actually come across problems then when you try and do it. I haven't actually physically inputted data, and printed out forms or getting on the forms, or tried to save the data and send it off. So we might have a few problems there. (Pharmacy 4 rep)

As a precautionary measure, the system which has been developed to capture patient information and generate a risk score has a checking system built in. Patient demographic information is automatically checked to ensure that each patient only receives the assessment once in a two-year period. This provides a guard against the possibility of 'double counting' patients, or patients shopping around different pharmacies receiving multiple assessments:

There is a check on it, but you can only check so much. It checks the patient's name, first line of address and date of birth. If they [pharmacist/pharmacy assistant] put that in, it goes into the database and looks to see if these details have been put in, in the last two years. So if they tried to do that it would flag up an error. (PCT staff member)

Pharmacy accommodation and equipment

As a requirement of the SLA each pharmacy needed to have a private consultation room with internet access, hand washing equipment and the clinical machinery to carry out the HHC. Aside from the issues outlined previously, pharmacies felt that the PCT had provided everything they needed to implement the service, from stationery to money for buying equipment that was not provided under the SLA:

R Everything was provided by the PCT, other than folders and stationery and things. We didn't need to buy anything.

I What exactly did they provide?

R They provided a cholesterol machine, all the things that go with it, they provided folders and information about to refer to, and sample leaflets. (Pharmacy 5 rep)

We had to buy a colour printer because that is part of the process. When you do an assessment for a patient you go through everything and then you fill in all the boxes. And then what it does, the computer works out, based on the data you have fed in, whether the patient is low, medium or high risk. And then there is the BMI chart and they are different colours so that is why we need a colour printer, so you can actually identify what colour you fall into, what category. But that was provided, money was given by the PCT to [pharmacy name], so that came out of that. (Pharmacy 6 rep)

Aside from the provision of equipment, the actual consulting rooms in some cases were not felt to be appropriate as locations in which to deliver the service:

Some are brilliant... whereas some were an old broom cupboard. So I would have liked to visit them myself beforehand and assess the training needs before I started. (PCT staff member)

Training and competency

From the point of view of the PCT staff who were involved in setting up and delivering training to the pharmacy staff, the training need turned out to be much higher than initially envisaged.

Originally it had been expected that pharmacists themselves would deliver the HHC, but it soon became apparent that this would be impractical. For a pharmacist to take 30 minutes to deliver a check would mean that other day-to-day business within the pharmacy could not be completed without cover from a locum.

It was decided therefore that pharmacy assistants could deliver the check, but that the pharmacist would be required to deliver the overall risk assessment to the patient at the end of the assessment. This meant that pharmacy assistants would need to be trained to use the equipment and database. This then increased the training load in order to ensure that all pharmacy staff were competent to deliver their part of the check:

The pharmacists are highly skilled and highly trained. The people they have working for them who are normally dispensing assistants, haven't got any background in care knowledge or expertise. So it wasn't like a GP surgery where you have got HCAs and practice nurses, who on a day-to-day basis take blood pressures, take pulses, take blood and give advice on health. And so the starting point for pharmacies was very much lower than a GP setting. (PCT staff member)

The training package which was developed by the PCT was well received by the pharmacy staff. It was felt that it was good staff development for the pharmacy assistants. Indeed, some were excited by the idea of increased responsibility and a new dimension to their job role:

One of our counter staff at [names pharmacy], she is a middle-aged woman and said 'I never thought I would be doing this!' She's quite excited and it is a huge jump from their [counter staff] present role in some cases. (PCT staff member)

It was really good. Nice and hands-on, practical stuff. It was great. We practised on each other. We haven't done that for a while because it has sort-of been shelved for a while. (Pharmacy 7 rep)

It has been really good – hands-on, so you did role plays and things like that. Even when we did the assessment we did it on each other and they were there watching us and saying, 'Do it like this or that.' So it was really good. (Pharmacy 1 rep)

However, delivery of the training package was not without its difficulties. Due to the nature of pharmacy businesses it soon became apparent that delivery of training would have to take place outside office hours. The PCT took a flexible approach to delivery of the training by providing it at these unusual times. This was appreciated by pharmacy staff, as their needs had clearly been taken into consideration:

I offered to do some weekend training where we could have a Sunday where we could get all that training done in one day – like a workshop. But they didn't want to come on a Sunday. So then (I had to) to do in the evenings – we did do brief training for the brief motivational interviewing and for the equipment, and for some communication risk training. But for the CVD and going through the data base, learning how to use all our databases and things like that, I had to go and do in-house training round each pharmacy. And I would turn up with all my equipment in the trolley ready to spend 2 ½ -3 hours out of my afternoon to do the training, and

what happened on several occasions was that they were far too busy and I would have to come back and do it another day. (PCT staff member)

Once the training had been delivered, both PCT staff and pharmacy staff became aware that the time delay between training and 'going live' was increasing. Worries were expressed that, due to lack of real world practice, the level of competency to deliver the HHCs would be compromised:

I think it is literally because of the swine flu that the cardiovascular is so far behind. Otherwise this would be up and running months ago. Like we got the training months and months ago and since all of us had the training, me personally I can't remember half of the stuff I was being told, because it has been that long, and we haven't had a chance either to practice or anything. In that sense it was a waste of time, because we are having to get the whole training back to refresh again. (Pharmacy 6 rep)

I know that is my staff's concern, because one of them said to me yesterday 'I am worried that I can't remember everything.' I said I am sure that it will all come back to you once you get started, because it was a good training session that we did. I think that is the main concern. (Pharmacy 7 rep)

However this issue was addressed by the PCT in the form of refresher training, and also the provision of a nurse to each pharmacy who would oversee the initial consultations with patients and ensure that any queries or difficulties experienced by the pharmacy staff were dealt with. This would satisfy both parties, that the staff delivering the HHC were fully competent to do so, thus addressing quality assurance (QA) issues too:

What is going to happen is, after they have signed the SLA off and they 'go live', they can 'go live' in a protected environment up until Christmas. So that they will be able to do risk assessments on the public or on family and friends, it is up to them, that meet the criteria, and without the spotlight on them. The relevant nurse will go in and mentor them. Then in January there will be a big media push and advertise it. (PCT staff member)

Pharmacy staff that were interviewed felt confident that once they had 'gone live' they would be able to deliver a high class service to patients, as the training they had received and the ongoing support from the PCT were sufficient to enable them to do so.

The mechanism by which the QA of staff performance will be assessed and dealt with is not yet clear. It is not clear how the PCT will address the possibility of keeping competencies at a satisfactory standard, should there not be sufficient throughput of clients:

I have been given a sheet of papers and told, 'You will fill in one of these for all the staff. And it is about ticking boxes about whether they are competent to do this and this, and this will go alongside the start of the

programme. But I thought they should be trained before they do it. They shouldn't be being mentored afterwards. (Pharmacy 3 rep)

We are actually going to be doing a competency thing, and they need to be doing assessments regularly to keep your competency thing. I will be signing them off at the beginning to say yes we are happy that you get going under supervision. But then after three months I will be going out and doing a three-month review and seeing how many assessments they have done and are they happy about it or any issues that they have got. And then give them a competency certificate or something. And then we want to build in updates every time we go. (PCT staff member)

Summary

The semi-structured interviews we carried out provided a large amount of information about the process of Phase 1 pharmacy assessment implementation. They indicated parts of the process which can be considered as areas of good practice, and others where lessons have been learned. These have been set out in the following section. We have made these recommendations with an eye on insights which will be of value to other PCTs, should they also wish to initiate NHS Health Checks in community pharmacies.

In our opinion the most prominent issues are:

1. The initiation of the programme in community pharmacies was much more complex and time-consuming than had originally been anticipated.
2. All elements of the process must be integrated from the start.
3. Fully thought-through costings (for all phases from initial planning to long term quality assurance) are required to establish value for money and cost-per-assessment.
4. Prospective, objective and transparent criteria are required for pharmacy selection.
5. The implications of pharmacy selection for population access and equity of outcome must be fully considered.
6. The Service Level Agreement presented to pharmacies must fully comprehend the reality of the business and professional sides of pharmacy practice.
7. The IT solutions selected must be robust and fully costed.
8. The training issues must be fully understood and planned to cover initial training, support and continuing development.

Strengths and good practice

- The Primary Care Trusts (PCTs) are early adopters of NHS Health Checks, and have locally established 'Healthy Heart Checks' (HHC)
- The PCTs have responded actively to the objectives to ensure wide access to HHC, and to avoid widening health inequalities
- The PCTs have driven this complex intervention forward in a context of substantial changes within the organisations
- The PCTs adopted an inclusive process in inviting community pharmacies to express an interest in delivering HHC, and attempted to link this to pharmacy selection for inclusion in Phase 1 of the process
- This process generated widespread interest and support among community pharmacies
- The standard of many pharmacy premises has been established as high
- Motivation to deliver HHC in pharmacies is high among pharmacy staff, and has been maintained over a long preparation period
- The process shows evidence of involving and developing pharmacy staff at all levels
- A Steering Group (later an Operational Group) which included broad representation was established to oversee the establishment of HHC, including delivery in community pharmacies
- The training provided by the PCTs was widely appreciated by pharmacy staff, and considered to be of high standard
- The training was delivered in a flexible way, recognising the needs and constraints affecting pharmacy teams
- The IT team responded innovatively and actively to pharmacy difficulties with IT equipment and connections
- The IT team have developed an electronic database which is unified between all community sites for HHC
- Electronic data from pharmacies will be securely transferred to the PCTs, in line with NHS data policies
- The database is capable of recognising duplication of data when HHC assessments are being processed for payment.

Recommendations to facilitate roll-out of community pharmacy involvement in HHC in NHS Tees and other PCTs

Processes and leadership grounded in the PCT:

- Recognise that in such a complex initiative, governance issues, clinical expertise, training and support issues are all essential components, and are closely inter-related
- Recognise that PCT Directorates must be fully engaged in such a programme from the start
- Recognise that direction of such a programme must be in the hands of an individual or a group empowered to see this role through to completion
- Set out in advance a complete sequence of outcomes, aspirations, criteria and selection processes to ensure a robust model (logic model) for implementation of HHC in community pharmacies
- Ensure that true costs are reflected in budgets and in the pricing of the service, including training, information technology (IT) and its support, equipment and its supply and maintenance, the quality assurance (QA) of processes and competence and VAT
- Recognise that modelling of the number and distribution of community assessments will significantly affect ultimate cost-per-person, and the impact of HHC in individual pharmacies
- Recognise that the absence of key individuals may disrupt and delay the whole process, and plan in advance for this eventuality.

Selection of pharmacies:

- Recognise the characteristics of individual pharmacies from the point of view of staff training, clinical engagement, premises, equipment and services provided
- Criteria for pharmacy selection might include geographical (socio-demographic) location, size, skills, facilities and existing services, and potential capacity, taking into account the target population
- Ensure that requests for information from pharmacies about their facilities and existing services and capacities are explicit, and the responses are detailed
- Ensure that the pharmacy selection process is explicit within the PCT and in pharmacies
- Recognise the implications for pharmacies of belonging to national or local chains, in terms of their ability to make autonomous decisions, and the length of time to obtain permissions in some large organisations
- Consider, in the context of providing equitable access to HHC, the position of pharmacies where the premises or facilities require development
- Consider carefully any assumptions made about the clientele likely to access individual pharmacies
- Ensure that detailed processes, such as for disposal of 'sharps' and clinical waste, are explicitly addressed, and the responsibilities clearly allocated.

Service Level Agreement (SLA):

- Ensure that commissioner – provider responsibilities are clearly set out in the relevant SLA
- Ensure that those charged with creating any SLA have the requisite skills and advice, and that the work is sufficiently prioritised
- In the interests of equity for clients, ensure that the acceptable range of service provision (quantity, timing, walk-in/appointment, staff involved and their respective roles) are set out clearly in any agreement
- Ensure that, notwithstanding the above, it is possible for smaller pharmacies and those in less advantaged areas, to provide a service acceptable to the commissioner
- Assess pharmacies in their own context, and recognise differences from other providers (such as GP teams) from the start.

Information Technology:

- Recognise the current variable level of pharmacy connectivity with the NHS network
- Ensure the integrity and continuity of data transfer between community pharmacies, the PCT and GP practices
- Recognise governance issues in access to databases/the internet for pharmacy staff
- Recognise privacy and confidentiality issues in the siting of computers within the area in which HHC are carried out, and where health risks will be discussed and plans formulated
- Recognise the 'in-house' IT systems of large chains may contain restrictions and firewalls which make NHS connectivity problematic.

Training and competency:

- Ensure that training comes after agreement of the relevant SLA, and closely precedes the start of the service
- Recognise the need for, and burden of, training for pharmacy staff
- Recognise the full costs, in money and time, of training (initial, continuing and QA)
- Ensure competence and continuing compliance of pharmacy staff with legal requirements (eg Health and Safety, Data Protection) and patient safety requirements (eg Infection Control)
- Recognise the full costs of IT development, installation and training.

Appendix B

An evaluation of the implementation of the Tees Valley cardiovascular assessment programme

Community pharmacies: update report

Acknowledgements

The evaluation team would like to thank all the pharmacists and nurses who agreed to give their time and views for the purposes of this follow-up report.

Table of Contents

Purpose	B5
Research methods	B5
Findings.....	B7
'Going live': the mechanics of delivering a service.....	B7
Ongoing staff support.....	B9
Information technology.....	B10
Uptake	B12
Advertising	B14
Sustainability of the programme	B15
Patient reactions to the programme	B15
Summary.....	B19
Recommendations	B21

Table of Figures

Table 1: Number of completed assessments in each pharmacy	B12
Table 2: Number of completed assessments broken down by risk score.....	B12

Purpose

The purpose of this report is to feed back on a second round of interviews with community pharmacists about their views and experiences of delivering the Healthy Heart Checks to members of the public. We did not, in this piece of follow-up work aim to revisit PCT stakeholders' experiences, as these were included within the first Pharmacy report.

Research methods

As with the prior Pharmacy study (McNaughton, Oswald and Shucksmith, 2010), a qualitative research design was utilised to collect data about the experience of pharmacies since they had gone 'live' and had begun delivering the HHC intervention to members of the public. The pharmacists who took part in the first pharmacy study were invited to take part in a second round of semi-structured interviews, as were nurses with responsibility for liaising between the PCT and pharmacy.

Of the nine pharmacies that were selected to take part in the Phase 1 intervention (see previous Pharmacy report), only seven went 'live' and began delivering the HHCs. Six of these pharmacists were re-interviewed for the purposes of this report. In one interview one of the pharmacy assistants joined the interview to give her views of conducting assessments. Pharmacists were contacted by telephone and asked to take part in another interview, this time about their experiences since going 'live'. Interviews were also held with three nurses employed to liaise with pharmacy, deliver training and assess competence of counter staff.

All interviews followed a semi-structured format and lasted between 20 and 40 minutes. These interviews were, with the permission of participants, digitally recorded and later transcribed. The transcripts were then subjected to analysis whereby emergent themes were identified and verified between researchers.

The School of Health and Social Care Research Governance and Ethics Committee reviewed and approved this study protocol prior to commencement of fieldwork.

Limitations of Study

Six of the seven pharmacies that 'went live' and began to deliver the HHCs were interviewed. Whilst their views could be said to represent the voice of Tees pharmacies delivering the programme, this is still a small sample of all pharmacies in the area, and one must be mindful of this when trying to generalise these findings to a wider population.

Findings

In the section which follows, we present data from the interviews with pharmacists and nurses grouped and presented by the following themes:

- 'Going live': the mechanics of delivering a service
- Ongoing staff support
- Information technology (IT)
- Uptake
- Advertising
- Sustainability of the programme
- Patient reactions to the programme.

'Going live': the mechanics of delivering a service

At the time of writing the last Pharmacy report it was expected that the HHCs would begin to be delivered from around December 2009, and that there would be a big 'push' in the New Year of 2010 to market the HHCs in pharmacy settings. However, with the exception of one pharmacy, implementation of the HHCs was met with further delays and all pharmacies finally went live only around February and March of 2010. These further delays caused frustrations for pharmacists:

Well, we started doing them just before December. Although the [agreement] hadn't been properly signed we were under the impression it would go ahead, and then in January they said, "Oh you've started." They said, "Oh, you're not supposed to." So that was a bit ambiguous.
(Pharmacy F representative)

All pharmacies are offering the HHC on an appointment based system. This, however, raises some challenges. Some pharmacies are still waiting for their staff to be signed off as competent, so are trying to make any appointments they get at a time when they think a nurse from the PCT will be available to sit in and assess the appointment. As the nurse comes in only once per week this impacts on how many appointments they can do per week:

If somebody comes in and approaches us we will try and do it on the day we think that the nurse is going to come. She usually comes on a Wednesday. Or we will just fit them in when we have got a gap and just make sure that [names pharmacist] or myself are going to be there to be able to spare the time to nip in. (Pharmacy B representative)

Another commented:

R: Yeah, so in the meantime, we were told now, when we get someone, to ring [names nurse], and she comes and watches, which has changed the goalposts a little bit again.

I: I suppose that makes it awkward if, say for instance, [names nurse] can't attend the appointment that you've set up with somebody?

R: Well she says we've got to work it round her. [It] isn't ideal for the patient. (Pharmacy F representative)

Other pharmacies would be happy to also deliver the service on a drop-in basis if they had the space and staff free at the time:

We have only got the two rooms in the front to do the actual consultations and [it] obviously depends on your staff levels as well. Sometimes we would do a walk-in, but the only problem is with walk-in is that the cassettes that are used for the Healthy Heart Check machines need to be left at room temperature for half an hour. (Pharmacy C representative)

Another commented:

What we try and do if somebody comes in, and says I'm interested in a Healthy Heart Check - if the room is free and there's a member of staff in that's qualified to do it - we'll say, "We can do it now if you've got half an hour." But mainly it's appointment based. (Pharmacy E representative)

Each pharmacy has a different method of returning patient results to the relevant GP practices. Some allow the patient to take their printed out results to their GP themselves, whilst others either post them or deliver them when they send a van to pick up the prescriptions from surgeries:

We give them the option of whether the patient wants to take that to the GP. I mean sometimes it's easier for them to take it themselves, if it's like a surgery that's further away. Or if they say, "No, I am not passing," we will say, "That's fine, we will send it to them." (Pharmacy C representative)

We do a collection and delivery service. We go round all the surgeries every morning anyway, so the longest it would ever be is from one morning to the next morning. (Pharmacy E representative)

We do a collection service from a lot of doctors, so we hand them in then or, if it's not a surgery that we go to, we post it. (Pharmacy D representative)

Two pharmacists raised an issue of payment for the service, stating that the system of payment for this particular enhanced service differed from the others they deliver. This caused problems in knowing when and from whom the payment was coming:

With the Healthy Heart Checks it's a completely different system because it's going to the Stockton part of the PCT, and - apart from a few blips - they've just paid us directly by BACs into our bank. So, from a system point of view, there's different things going on and we're [asking] "Why are you doing it like that? It's an enhanced service: it should be dealt with in the same way [as other enhanced service payments]." (Pharmacy E representative)

Ongoing staff support

Whilst all seven of the pharmacies are delivering the HHC programme now, not all of the counter staff have been signed off as competent. One pharmacist spoke of how this seemed to be 'back to front' in relation to all other enhanced services they deliver as, based on her previous experience, staff would be signed off as competent before the SLA was signed:

I know we had a couple of visitations - well, a visitation - when we were assessed, to make sure that everything was in place that they wanted, which was done pretty quickly. Then we were told right here, "Sign the SLA and then you will be signed off." Well I think I said before that, you know, you normally get your competencies in place before you get signed off on an SLA. (Pharmacy B representative)

Another pharmacist felt that the decision to sign off the counter staff as competent was simply a 'judgement call' by the nurse assessing them, and that it was not based on an objective measure (e.g. once ten assessments had been successfully completed):

So that's another little issue that we just found out last week. So that was a little spanner in the works. I don't know how many they think we will have to do to become competent - I don't know. It just depends on her [the visiting nurse], whether she thinks the girls are competent or not. (Pharmacy E representative)

As uptake by customers of the HHC programme has been very low, this has had a knock-on effect on staff being signed off as competent. There has not been an influx of people coming through the doors for staff to develop their skills with, and the nurses from the PCT have not been able to sit and watch many assessments taking place. This delay to certifying competence was becoming increasingly frustrating for pharmacy staff:

That was the initial issue in the first place - that they [the visiting nurses] had left it almost a year before they came back to do it [testing for competence] all again. And we haven't had enough people through the door for the others to get up to speed with it and to do the practice on. (Pharmacy B representative)

[names nurse] was wanting to come and see everyone do like three or four [assessments] in a row and then sign them off, but we have never really managed to, after that first week, get as many as three or four in one sitting. I think we are gradually getting on with training things, but ... if you do it regularly it does help the staff, because they get used to doing it. Whereas, if you don't do it for three or four weeks you sort of forget how to do it and you lose your flow a little bit. (Pharmacy A representative)

Another pharmacist felt that giving a little extra time to some staff before trying to sign them off was good, as one of her counter staff was still a little nervous about

some aspects of the assessment. They tried to rectify this by giving her more assessments to do to build her confidence:

R: They are finding it good. One girl has already been signed off, she is that competent. The other lady is just waiting to be signed off. She is still a bit nervous about getting bloods from people at the moment.

I: Right.

R: So it's giving her more tests to do and obviously trying to increase her confidence. (Pharmacy C representative)

Information technology

There had been a few teething problems with the IT system once the pharmacies went live. The flow of the system has caused some issues, since the agreed procedure is that, once the pharmacy assistants have completed all of the measurements and taken the patient's history, the pharmacist will come into the treatment room to deliver and interpret the results for the patient. Some pharmacists, however, felt as if they were going into the consultation 'blind'. They would have liked a print-out of the measurement details and the prior patient discussions to be given to them outside the treatment room by the pharmacy assistant, so that they would have a chance to review them, enabling them to deliver the risk score to patients more effectively:

It didn't tend to flow, and also what we found was when I came in at the end to communicate the results, I was either going in completely blind, not knowing and just sitting down and looking at the results in front of the patient, which wasn't ideal. What would have been ideal was to be able to print out the results, because we do print out the results at the end, but you can only print out everything all in one go. (Pharmacy E representative)

Another commented:

But I think the flow of the process is quite important from the patient perspective. If someone does the actual testing, then the pharmacist comes in, communicates the risk, goes out and then the first person prints everything out and then they [the patient] go - that's fine. It's just making sure that happens as smoothly as possible, but the way we're having to do it, it doesn't quite flow right. (Pharmacy E representative)

This issue was addressed by the PCT. However, the remedy was not deemed to be acceptable by pharmacy staff:

You are going in blank and so they designed this little flimsy bit of paper for the girl to bring out and show you, which I don't think is right. (Pharmacy B representative)

Moreover, once the pharmacies had begun delivering the programme it became apparent that the IT system they were using was not giving true readings. All of the

pharmacists highlighted that the IT system they were using was taken off-line whilst the PCT investigated the apparent miscalculations of patient risk scores. One pharmacist discussed how they were surprised such a mistake had happened since there are standardised software packages available to purchase 'off the shelf':

Well there's that many set packages that are available off the shelf to buy that you could have used. To try and design one yourself, you're leaving yourself open to risk because, while you can do something and it runs smoothly, there are that many different parameters that you're putting into it. All it takes is one to be slightly out and you won't pick up false results all the time. You'll pick them up now and again, which is really hard to detect, and I was sort of suspicious for a while. (Pharmacy E representative)

Another pharmacist commented about the inconvenience of calculating risk scores by hand:

R: Yes. Everything is up and running, um...we did have a bit of a hiccup a few weeks ago, whereby the computer system wasn't working. That was more so to do with the NHS than ourselves.

I: Right. Was that everybody?

R: Yeah, everybody yeah, so we had to go through a few weeks of writing every paper down, all the details, because its quite a...a depth consultation anyway and that just kind of put extra time on. But, other than that though, everything is back on track and everything is going well.

I: Do you know what had actually gone wrong with the computer system?

R: They don't know. It was some kind of um...form that they had where you put...you input data, like people's personal details of their weight or whatever. Something had gone wrong and it wasn't giving the right information. So we weren't able to do that. (Pharmacy C representative)

It happened up in [names pharmacy] whereby they put certain patients in and the risk that came back was, like, enormously high and there was nothing wrong with the patient in terms of what information was given. (Pharmacy C representative)

This problem with the IT system diminished the pharmacies' faith in the system and prevented some of them really pushing the HHC until a solution had been found:

But in terms of sort of getting people to come into the service... obviously that put us off really giving a big advertising push, because when it's paper based it's so time consuming and awkward as well, and it doesn't look very good in this day and age. You want it all to be computerised. So we have sort of hung back from pushing it until all these things are ironed out, because we have got plans to push it further. (Pharmacy E representative)

Uptake

Across all seven pharmacies uptake of the HHC programme has been low. Figures range from as little as nine completed assessments to 49 in the highest performing pharmacy. Table 1 below shows the spread of completed assessments across all active pharmacies.

Table 1: Number of completed assessments in each pharmacy

Pharmacy	Number of assessments*
Pharmacy one	9
Pharmacy two	12
Pharmacy three	17
Pharmacy four	18
Pharmacy five	19
Pharmacy six	32
Pharmacy seven	49
Total	156

*Figures taken from 1st January – 20th July 2010

Although uptake has been low, pharmacists have identified 31 patients with an increased risk of developing CVD as can be seen in table 2 below.

Table 2: Number of completed assessments broken down by risk score

Risk score	Number of assessments*
Less than 10% (Low Risk)	86
Between 10-19% (Medium Risk)	39
20% and greater (High Risk)	31
Total	156

*Figures taken from 1st January – 20th July 2010

All pharmacies were disappointed by the lack of uptake of the HHC programme. After an initial flurry of patients coming through the doors, business has died down somewhat for most pharmacies:

We are disappointed unfortunately in the response that we have had from the public for it. It just seems to be not that much demand from people coming in the shop in terms of actually wanting it done, which we are a little bit surprised with. I felt we were the only pharmacy doing the service, so I thought for that reason a lot of people would want to use it, but for some reason it hasn't really gone. We had a really good first day when we went live. We had about ten on that day, all booked in the same day and it went really well. They were coming in and everything was kind of going well...we had [names nurse] on that day to help us as well. It did go really well that day...but for some reason, after that, it has sort of died down.
(Pharmacy A representative)

One pharmacist felt that the size and location of his pharmacy could be one explanation of why uptake had been so poor in his particular instance. This suspicion was backed up by the nurses overseeing this pharmacy too:

For us I don't really know to be honest with you. I don't know if it's our location, that there is maybe not enough people going through or ...the fact that...in terms of pharmacies we have maybe got a small pharmacy. You know yourself, when you come in, it's a fairly small shop area, so we don't have a lot of people coming in who are not on medication. Most people who are coming in are already bringing prescriptions in for things and I guess that rules 95% of them out anyway on that score. (Pharmacy A representative)

Another commented:

I think in some cases it has turned out not so well because of their locations. Some are really struggling because they are out of town and in locations close to GP practices which is where the pharmacies get a lot of their customers from. So a lot of them already have chronic diseases. (PCT Nurse)

Another pharmacist felt that competition with GP practices in their catchment area could have been an explanation for the poor uptake:

Actually there's another problem capturing the people because everyone is out to capture them. The surgeries are getting a lot in, so I think the expectations of the ones who are running it, thought we would get loads in but that's not the case, and, again, some people just don't want to know. But it's very hard if you see someone coming in and say, "Oh you could be candidate," and they say, "The surgery has approached me and I'm going there." (Pharmacy E representative)

Some pharmacies found it challenging identifying patients who, for example, met the eligibility criteria, fell into the right age bracket and who were not already on medications for blood pressure or cholesterol. Even when pharmacy personnel thought they had identified the right people, once the assessment began they sometimes found that patients were ineligible:

They have to say they are not taking any medications, they are between 40 and 70. They go, "Yeah, yeah, yeah." But then, when you book the appointment, they come in, do the tests, and you set up everything and then you do the blood tests and everything, and then you go through the system. "Oh, by the way, actually I am taking X, Y and Z." You are like, "Oh...!" And then, straight away, you know you can't do it, because it's not part of the protocol you know? (Pharmacy C representative)

The PCT nurses also acknowledged that due to the populations that the pharmacies are attracting, they may continue to have problems with uptake of the HHC service. They felt that perhaps the criteria by which the pharmacists identify possible patients could be relaxed to improve uptake:

R1: I don't know what will happen in the future for the ones [pharmacies] that don't seem to be able to get the business?

R2: I think they will stay struggling, because a lot of their clients are already taking medication for heart disease or hypertension or other things. But we are looking to reassess the eligibility criteria because of the statements on the system is that the patient must not have had their blood pressure checked within the last year. This means that pharmacists are having to turn lots of people away! (PCT Nurses)

Advertising

All pharmacists felt that an advertising campaign was needed to promote the work going on in pharmacy. Some forms of advertising had taken place; however, it was felt that more was needed. Pharmacists were all under the impression that once the HHCs had gone live in their pharmacy, then the PCT were going to undertake a mass advertising campaign to promote the service and raise awareness in the community:

I think the only problem is we're relying on drawing in people into the service from people coming into pharmacy. There's no external advertising and what would have been good is if we could have had some personalised posters with our name and address on. You know, you can get this at [names pharmacy]. Then we could have put them out in the local community centres, the local pubs where people go, and it might catch their eye and they might think, "Oh I'll go for that." (Pharmacy E representative)

I thought that they were going to do a publicity campaign eventually. But I think they are waiting for people to be...up and running. It's a bit of a 'catch 22', isn't it? Because...we are not...because it's not being advertised and...then yes we really all need to be signed off before they blitz it I suppose. (Pharmacy B representative)

All pharmacies had been provided with materials so that they could promote the service in-store:

The PCT got this marketing company to come and visit us and we bounced round a few ideas of things that we thought would be good - like a big banner stand that we could take out and about, a banner for the railings outside, posters, fliers, all this type of thing and you know they did deliver on that and they brought it to us direct. (Pharmacy E representative)

An advert had been put in the local paper for one pharmacy to raise awareness of the service, but this had limited success:

We put an advert in the [local newspaper]. We have done that three times now and I thought that would really help, because everyone reads [local newspaper]. As I say, it did happen that first day, we got the first ad out and we did get about nine or ten calls that next day, people wanting to book up. But it's never really sort of followed on from that. I think the second advert, I think we had like two calls after but both of them they

weren't eligible anyway, so we never even got one! (Pharmacy A representative)

Other pharmacies had sought to raise awareness of this new service by dropping leaflets into the prescription bags of people they thought were eligible, or had stood outside the pharmacy handing out leaflets and promoting the service that way:

I have leaflets inside, so when I get acute prescriptions across I also pop a leaflet into their bag. (Pharmacy C representative)

We did do a session with [names nurse] at the front door. We just stood for an hour handing out leaflets, and we booked quite a lot of people in that way. (Pharmacy D representative)

This proactive approach seemed to work well for these pharmacies.

Sustainability of the programme

Questions were raised by some pharmacists about the possible sustainability of such a programme in pharmacy. For the most part the customers they serve have a pre-existing health concern:

Most people who come in the shop are already on blood pressure medication anyway so they will get reviewed by the doctor, so that kind of rules out people who come in the shop. But I did expect maybe more demand, outside people coming in. (Pharmacy A representative).

Moreover pharmacies have a finite number of people coming into the store, people who use the services regularly. So it is possible that they will reach saturation of their populations quickly and, unless they can find new ways of generating new business, such a programme may not survive in the long term:

We're seeing the same people, month in, month out, with the same script so, and you've still got the local population. It's not as if it's a through population of different bods all the time, whereas in the supermarket maybe it's all different. But how many would be willing to spend half an hour just there? So you've got that problem as well. Whether they'd do that, I don't know, people reading the [posters], going by and a bit of advertising... Would it work? I suppose. I don't know when it goes on the radio what influence that'll have, but it's even gone off the boil from the Government. (Pharmacy E representative)

Patient reactions to the programme

In this section we present data from pharmacists about their interpretation of how patients have responded to the service. Generally, pharmacists believe that reactions from the public have been good and that the public believe this is a high quality service which they are delivering. Pharmacists have found that the people they have approached to see whether they would like to have the HHC, are interested to find out whether they are healthy or not. However, in some cases, a

little coaxing is needed to get them to have the assessment actually carried out, as one pharmacist describes:

There are a couple [of patients] who just said, "No I'm quite happy going along", but you tell them what it entails. I think people are quite happy to have an MoT you know. And, just out of interest as well, and if they're sound, you know, and got a low percent, they're as happy as Larry.
(Pharmacy F representative)

Once they have had the assessment carried out, patients' reactions are varied. Some find it to have been a positive experience which has highlighted, in good time, changes they need to make to their lifestyle in order to remain fit and well:

Really positive, a lot of people when they do it, say, "Oh you know this is really good. We didn't know what our blood pressure was and we didn't know what our cholesterol was", and things like that. And most of them seem quite motivated at the end of it to make the changes that they need to. Yeah, it's been really positive so far. (Pharmacy D representative)

Other patients are already quite motivated before they attend the assessment and use it as a method of confirming what they already suspected:

I had one woman that was over 20% and her husband had just had a heart attack, so she was quite, "Oh, this is what I've got to do. I know I've to stop smoking; I know what to do with my diet; I know not to eat so late", so she was quite sort-of motivated. (Pharmacy D representative)

For some patients, pharmacists have found that if the patient is shocked by the news that they are at an increased risk of a CVD event, this can act as a motivating factor to make changes to their lifestyle or seek further medical help:

It gets them thinking and it does make them alarmed and obviously it's a good thing because then it actually makes them to do something about it. You know we explain to them, it can make a difference to them. (Pharmacy C representative)

To be honest they're quite shocked, so you just advise them to go and see their GPs to get checked out. Depending on what it is - whether it's their blood pressure, cholesterol or whatever - I advise them to go and see their GP. (Pharmacy D representative)

Generally, however, if this information is delivered to the patient in such a way that they feel it is something that they can take control of and make small changes which will add up to a big difference to their risk of CVD problems, the patient can see it as a positive experience:

The way we've put it across is: the bad news is they're high risk; the good news is we've picked it up now instead of in ten years' time when you're waking up in hospital having had a heart attack or stroke. So, you're able

to make minor lifestyle modifications now. We put it across in a very positive way. (Pharmacy E representative)

The fellow yesterday was really grateful. He said, "That's really helped", and I think he did actually say, "Potentially you've just saved my life by giving me this information so I can do something about it now." And it was like he was really motivated and shook my hand and said, "Thanks very much." (Pharmacy E representative)

Summary

Findings from interviews with pharmacists and pharmacy assistants suggest that they found the length of time it took to implement the programme and complete the training was, at times, frustrating. They were met with many delays (see pharmacy report, Appendix A) and these delays continued well into 2010. Since 'going live' with the service, pharmacists faced further difficulties in having their staff signed off as competent to deliver the HHCs. They found themselves in a situation where their staff had been trained many months previous, and since they had not had the opportunity to practice their new skills they felt they were not competent to deliver the service to the public. When they did begin delivering the service there was a lack of custom which further exacerbated the competency issue. They did, however, appreciate the time and resource provided to them by the PCT nursing staff, who oversaw initial consultations and offered support and advice to the pharmacy staff. Availability of the PCT nurses to oversee assessments did impact on the speed at which counter staff could practice their skills and be deemed as competent to deliver the service alone. Poor interest of patients in the service also slowed down this process somewhat. At the time of writing this report not all counter staff had been signed off as competent.

All pharmacies were offering the HHC on an appointment based system, which they felt was the best way to deliver the service – as opposed to a drop-in based system. However, had there been demand for the service some pharmacies would be willing to provide this as a drop-in service.

Uptake of the service has been very low across all pharmacies. This had been disheartening for pharmacists, especially those running small, single-handed pharmacies. All pharmacists had tried some measures to drum up business and in some cases they had limited success. This caused some pharmacists to evaluate the sustainability of the programme within their own pharmacy. All pharmacists acknowledged that the PCT had provided some advertising at the start of the programme, but some felt the need for sustained advertising campaigns to keep public interest, perhaps through the local press and radio stations.

However, some pharmacists were reluctant to have an advertising drive within their pharmacy due to complications with the IT system. It became apparent, some time after they began delivering the service, that the IT system provided by the PCT was not giving accurate risk calculations for some patients. This issue was raised with the PCT and the online tool was removed whilst investigations took place. Pharmacists were assured that the issue had been resolved and they continued to use the online tool.

The methods pharmacists used to inform patients' GPs that they had attended pharmacy for a HHC varied and this was not dependant on the patients' calculated risk score. Some pharmacists took it upon themselves to ensure that the relevant documentation was delivered to the GP practice either by post delivered by the vans they use to collect prescriptions, or by leaving the patient to deliver the documents to their GP practice themselves. This raises implications for losing patients between service locations and suggests that some patients that have a risk calculation of over 20% may not be seen by their GP for a full assessment and to be prescribed the

relevant medication or given appropriate lifestyle advice. It also provides insight into why GP practices are not always aware if their patients have had an assessment elsewhere (see GP report Appendix D).

Overall, pharmacists believed they were delivering a worthwhile service which had the potential to make a real difference to their local population and they felt that those patients who had come in for an assessment felt the same.

Recommendations

Good practice and levers to implementation

- The presence of CVD nurses employed by the PCTs to support community pharmacies has been essential to achieving competence among pharmacy staff.
- The PCTs have enabled pharmacies to begin to carry out assessments in ways which suit them as individual businesses.

Barriers to implementation and service improvement

- Implementing CVD risk assessments in community pharmacies has taken much more time than expected, and the number of assessments carried out is much lower than planned.
- The systems which pharmacies have used to return data from their assessments to GP practices are not robust. There is no assurance that information, including that on high risk patients, has not gone missing between pharmacies and practices.
- The IT system has caused problems in the 'flow' of each consultation and further updating is needed because the consultation is split between pharmacy assistant and pharmacist.
- Problems with the miscalculation of risk scores which were identified with the IT system have now been rectified, but have impacted on some pharmacists' confidence in the programme and hindered them at some points in developing the service more fully.
- The input in time from CVD support nurses has been a cost to the system and has created some logistical problems when pharmacy staff are unable to operate without nurse supervision. Demand for nurse support had been much higher than anticipated, meaning capacity was stretched and it was hard to meet demand from pharmacy staff.
- The pharmacies reported that there was insufficient public awareness of the service, and believe that additional marketing of HHC would be valuable.

Commissioning to inform roll out

- Value for money calculations were not within the remit of this evaluation, and we are not able to report whether delivery of HHC in community pharmacies represents value for money.
- Should further roll out be contemplated, the importance of social marketing should be carefully considered

- Should further roll out be contemplated, the selection and support of pharmacies to ensure equity of access to the service would be important
- Should further rollout be contemplated, it is essential that the PCTs have assurance that the transfer of data between pharmacies and general practices is secure and complete.
- The 'value for money' aspects of HHC in community pharmacies, is a suitable area for further evaluation.

Appendix C

An evaluation of the implementation of the Tees Valley cardiovascular assessment programme

GP Action Plans

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Table of Contents

Purpose.....	C5
Purpose of the Action Plans (AP)	C5
Rationale for evaluating the Action Plans	C5
Action Plans from the first Local Enhanced Service Agreement (October 2008 – March 2010) (LES 2008).....	C5
Research methods	C9
Limitations of the method.....	C9
The LES 2008 Protocol	C11
Content of the action plan.....	C11
Responses by general practice teams to the request for an action plan.....	C11
Findings from analysis of LES 2008 Action Plans.....	C13
The LES 2010 Protocol	C19
Action Plans from the second LES Agreement	C19
Background/ findings relevant to APs submitted for LES 2010.....	C20
Recommendations	C25

Purpose

The purpose of this report is to provide analysis of the GP action plans (AP) submitted under the Local Enhanced Service (LES) 2008 and LES 2010.

Purpose of the Action Plans (AP)

Delivering Healthy Heart Checks (HHC) through general practices is a key element of TVAP. The service involved is delivered as a Local Enhanced Service (LES), the contract for which was developed by a sub-group of the Tees CVD Prevention Programme Steering Group.

In order to understand the likely development of TVAP, while allowing for the widely different size and circumstances of individual general practices, part of the LES 2008 (para 4.2) required that each practice should submit to the PCT, and have agreed, a proposal for how it would meet the conditions and standards set out in the LES. Specifically the plans would:

- Mean that each practice had provided its own measure of performance (in contrast to having one set by the PCT)
- Allow the PCTs to set a budget for TVAP
- Allow for a process of monitoring practice activity against plan
- Indicate areas suitable for development in future versions of the LES.

Rationale for evaluating the Action Plans

The APs are a tool for PCT management of TVAP. At the start of the process it was unknown how many practices would sign up to the LES, how actively practices would carry out the programme, and how much variation there would be between the processes adopted by different practices. Underlying this was an anxiety as to how to ensure that TVAP did not increase health inequality.

Tees was an early adopter of the NHS Health Checks programme, and it was hoped that lessons would be learned of value to others adopting the programme as it rolled out nationally between 2009 and 2012. For all these reasons, evaluation of the APs was included as an element in the programme commissioned by the Tees PCTs.

Action Plans from the first Local Enhanced Service Agreement (October 2008 – March 2010) (LES 2008)

Important context in the LES document:

- The LES is explicit that TVAP is intended to take a targeted approach, allowing 'practices to prioritise for assessment those with the highest estimated risk' (LES 2008 para 4.1) and 'ensuring that the highest risk patients are identified as soon as possible' (para 11.3)
- This was further emphasised by the statement (para 4.3) that '*Patients from the prioritised list*' (our italics) should be systematically targeted for a full vascular risk assessment

- This prioritised list of named, registered individuals was provided to each practice as part of TVAP by staff of Tees Primary Care Informatics (TPCI). It identified a list of named individuals with an *estimated* high risk of CVD based on information already held about CVD risk factors, and inserting default values based on normative data where a measurement was missing (para 16.1)
- The prioritised list, or ‘indicative’ list, is thus a subset of each practice’s population of individuals aged 40-74 who make up the whole list of those eligible for CVD risk assessment during a five year period
- It was estimated by TPCI, (and subsequently proved correct) that approximately 70% of those in the prioritised list would convert to ‘high risk’ when fully assessed by the practice, providing a strong rationale for approaching these individuals first.

The importance of the ‘aspiration’ which practices set for the LES 2008

Appendix 6 to the LES, which suggested suitable content for each practice’s AP, asked *‘Please provide information on the estimated number of patients that the practice aspires to assess within the first 12 months’*.

The level of aspiration provided some evidence about the practice’s enthusiasm for TVAP, and its interpretation of the likely future of the programme. Its importance is that it underpins the practice budget, the PCT budget, the initial payment made to practices, and thus has a bearing on the geography of the development, and possibly the equity, of TVAP.

Taken with the rest of the LES the aspiration allowed practices to calculate the likely income associated with the LES in the first year, and thus the funds available to pay for the additional staff hours required to deliver the projected assessments. This in turn had an influence on the process the practice planned to adopt – for example how to identify people to be assessed, and how much of the assessment should be delivered by practice nurses/nurse practitioners, and how much by health care assistants or GPs.

The meaning of the aspiration to practices

The words used in LES 2008 to enquire about practices’ aspirations are subject to interpretation. They do not:

- specify the meaning of ‘the first 12 months’ (unclear because practices began assessments at different times, and the LES was extended from 12 to 18 months)
- require the prioritisation of patients set out elsewhere in the document
- suggest any expectation of an upper or lower limit to the aspiration
- clarify some ambiguities about who could legitimately be assessed, as opposed to those who should be prioritised for assessment.

While these differences may seem merely semantic, the different interpretation by practices (set out in more detail below) explains some of the very wide variation in aspiration between practices, and how this variation had practical consequences for both process and budgets. Some of this variation is explicit in the content of APs submitted by practices, and some must be inferred.

Research methods

The evaluation of APs involved a three stage process:

1. Scrutiny of the submitted practice APs. In April 2009, 85 practices were identified in the Tees PCTs, of which four were in the process of merging into two practices. Six of these practices had not submitted an AP, and in three APs no definite aspiration figure was included. All submitted APs (79, 93% of all practices) were reviewed for their completeness, proposed practice HHC process and 76 for their aspiration
2. Reflection on practices' intentions contained in APs, taking into account the size and demography of practices, and their expressed aspirations
3. A further scrutiny of a sample of APs submitted as a response to the second LES (LES 2010), current from June 2010.

As quarterly activity data accumulated, practice activity was reviewed against the initial aspiration. During the period of the evaluation the PCT's own systems for analysing data and reporting it back to practices became much more detailed. Quantitative aspects of the data which continued to be reviewed under this FUSE evaluation are reported in Appendix G.

Limitations of the method

- The original LES was intended to last for 12 months (1 October 2008 to 30 September 2009). In the event, the differing rate at which practices adopted and began to submit assessments under TVAP resulted in the original LES being extended by 6 months to 31 March 2010. This made a difference in terms of what practices understood by the term 'the first 12 months' in the AP request, and it influenced the aspiration figure depending on how quickly or actively each practice intended to initiate their process.
- Three practices did not submit an aspiration figure.
- It was difficult to establish the number of practices existing in Tees (and thus the denominator for AP responses) at different times during the process, due to practice mergers and the establishment of new practices.
- Some practices in Middlesbrough and Stockton-on-Tees are small and provide a specialist service for substance misusers and asylum seekers and their families. Their inclusion was liable to provide outliers within the analysis of practice activity.
- Several practices also moved or significantly upgraded their premises during the period of study. When the evaluation team was requesting to interview practices it was reported on at least one occasion that the disruption had resulted in lower priority being given to TVAP activity.

- Seven new practices which had not submitted APs under LES 2008 were in existence and providing assessments by April 2010.

Initial uptake of the TVAP LES by practices was very high, and 79 (93%) practices had submitted assessments by April 2009. By April 2010, 87 practices had submitted completed assessments so, despite these confounders, a reliable picture of practice activity and process has been obtained.

The School of Health and Social Care Research Governance and Ethics Committee reviewed and approved this study protocol prior to commencement of the study.

The LES 2008 Protocol

The aim of the LES 2008 is to *‘facilitate General Practices to adopt a systematic approach to primary prevention of cardiovascular disease by identifying, managing and monitoring patients who are at high risk of developing cardiovascular disease aged between 40 to 74 (>20% risk of CVD over 10 years)’* (Paragraph 2).

Paragraph 11.3 states *‘This LES is intended to deliver prioritised, targeted vascular risk assessments, thereby ensuring that the highest risk patients are identified as soon as possible, managed appropriately and population health maximised’*.

This confirms that the LES 2008 had a more focused aim for general practices than the generic NHS Health Checks programme (Department of Health 2009) which aims to cover the whole 40-74 population over a period of five years, but without identifying priority cases or suggesting sequencing.

Within the LES it was made clear that subsequent management of identified high risk patients should comply with NICE guidance (Para 4.5, 5.1), and this guidance was included in appendices.

Content of the action plan

The AP requires practices to:

1. Estimate accurately the number of patients at high risk, using the TPCI prioritisation tool
2. Specify the operational procedure they intended to adopt for inviting patients with an estimated high risk for vascular risk assessment, and also indicate which staff would undertake the assessments
3. Indicate whether the specified plans would require the recruitment of additional staff, and identify any training needs that might occur
4. Produce a description of the procedure to manage referrals and deal with data from assessments carried out in community settings
5. Determine the estimated number of patients that the practice aspired to assess within the first 12 months.

Responses by general practice teams to the request for an action plan

Number

By April 2009, 79 practices had submitted an AP and 76 of these contained a clear aspiration figure.

Completeness

Approximately 50% of the original APs were incomplete in the sense that either some of the questions asked by the PCT were not answered, or that, to the evaluator, the responses were insufficiently clear to allow an adequate understanding of the practice’s plans. Although some APs were sketchy, this

contrasted with a number of practices which provided comprehensive and detailed descriptions of the planned operation of their programme.

Where practice plans were incomplete this chiefly related to descriptions of the responsibilities of individual staff members, including doctors, within the process of assessment, and to the ways in which the practice planned to identify and then incorporate into their system the results from assessments carried out at workplaces, pharmacies and other community settings. Any information which was given has been included in this analysis.

Contrasts in understanding of the 'aspiration' figure

In reporting their aspiration for the first 12 months of the LES, practices evidently used different assumptions. Sometimes these were made explicit within the AP itself, and sometimes motivations and calculations were reported either in interviews with practice teams (see Appendix D), or in conversation, for example at meetings to promote the LES. It is certain that if the PCTs hoped to obtain an answer to the question 'What proportion of the prioritised list provided by TPCI will have received an assessment by 12 months from October 2008?', they did not receive it.

The chief variations introduced by practices were:

- An aspiration to assess more than 100% of the prioritised list in the first year. This was in part sanctioned by the LES itself because paragraph 16.2 stated that people with known hypertension but no previous CVD risk assessment should be 'considered to be at estimated high risk and included in the indicative number of assessments to be undertaken'
- Some practices recognised that although prioritisation is desirable, NHS Health Checks are planned to cover the whole eligible population in five years. The assessment of people at lower risk contributes to this aim, and would help to smooth the flow of patients coming back for review
- Some practices believed that to carry out CVD risk assessments on newly registered patients within the age range, (whose risk would be unknown), would be efficient and effective, given existing procedures for offering new patients a health check before admitting them to the practice register
- Some practices, believing that TVAP would be a short term programme, aspired to cover as many of the eligible population as they could in one year
- Some practices calculated an aspirational figure, but then reduced it to about 70% of the starting number, on the basis that this was the likely proportion of patients who, if invited, would attend an assessment appointment
- Some practices expected their involvement in the TVAP to be limited, aspiring to cover less than 70% of their prioritised list in the first year. The lowest aspiration was just over 20% of the prioritised list.

Despite these variations in approaches to developing their aspirational plans, it was possible to make an estimate of the number of assessments planned across the Tees Valley, and to judge whether there was sufficient momentum in the programme to ensure eventual coverage of the population as envisaged by Department of Health. More details of actual performance are given in Appendix G.

There remained very widespread variations in the aspiration offered by practices, ranging from 20% to 470% of the practice's prioritised list. The value of the aspiration figure must remain in doubt unless it is attached to management of performance for which the practice is accountable.

Scrutiny of the responses

A review of the action plan files held by the PCTs makes it clear that some action plans were referred back to practices for clarification. However, given the incompleteness of many action plans, the process of scrutiny was not rigorous, and did not result in the PCTs being in a position to be sure what many practices intended. The TVAP process had great momentum at the time action plans were submitted for LES 2008, and practices were keen to sign up, so it is understandable that there should be no wish to delay the process. It was also the case that answers to certain questions, such as the intended procedures for the handling of community data, were theoretical in that community assessments had not yet started in any number.

Findings from analysis of LES 2008 Action Plans

The quality of responses

The clarity with which practices described their proposed process varied from the comprehensive to the incomplete. There was no discernible relationship between the size of the practice and the quality of its AP.

Acceptance/divergence from the LES protocol

Most practices planned an assessment pathway in accordance with the LES protocol and the underpinning NICE documents. A few practices were not explicit about this, and two referred to following their own 'existing' protocols, although without clarifying whether these met the LES and NICE criteria.

The great majority of practices provided evidence in their AP that they intended to follow LES guidance in advising and managing patients at high risk. Practices provided less information about their planned use of the lifestyle pathways available to support risk factor reduction (obesity, smoking, exercise, alcohol), and this will be discussed in more detail in Appendix D on GP team activity.

How the plans were decided

The content of a practice's AP was decided in different ways. Most often this was done by discussion between the practice manager and the nurses who would be responsible for delivering HHC. Sometimes GPs were involved, and sometimes the

whole clinical team. In one case an extended team including a pharmacist made the decisions. This is reported in more detail in Appendix D.

Administration of Healthy Heart Checks (HHC) in general practices

Practice managers generally organised the administration of the practice's AP. Details of the administration depended to some extent on the practice's existing organisation and size. Generally all administrative staff were aware of the programme and contributing to it. In one large practice a single dedicated member of the administrative staff took on responsibility for the whole scheme, and this was reported to work very well. In smaller practices with fewer resources, administrators would have had to undertake whatever work was entailed within the agreed AP alongside their other tasks.

Calling patients for assessment

Practices' initial action plans mostly suggested that practices would identify first patients on the provided 'indicative list', using the materials (written and visual) provided by TVAP. It was suggested to us during later interviews that many practices adopted alternative strategies to attract and encourage patients to attend assessments. This included letters with altered wording felt to be more in tune with the practice's approach, posters in waiting rooms, telephone calls in advance of the letters being sent (to encourage people to read them), and follow up telephone calls to those who had failed to attend an assessment.

Few practices specified how they would approach people who did not attend. The LES suggests three attempts to contact those who did not attend, but this was rarely indicated in the AP, nor what method would be used to make the three contacts. During the first year of the LES, practices planned for initial invitations to eligible patients, and did not generally address the issue of non-attenders. This matter is dealt with in more detail in the section on LES 2010 (see below).

Entering data

Initial APs generally took it for granted that when patients had attended for assessment at the practice's request, the results and measurement required to calculate the CVD risk would be entered on the practice's clinical system using the routines for all patient data. It was usually specified that the HHC data would be passed to one of the practice nurses for scrutiny before being entered, and less often that the data would be scrutinised by a doctor. Most APs, while specifying that this would be the pathway, did not provide evidence of any fail-safe system to ensure that such scrutiny had taken place before data entry. This provides a loop hole through which data could enter the clinical system without it being recognised that this was a HHC patient, and possibly one at high risk.

There was uncertainty about how practices would handle the arrival of data from assessments carried out by nurses or pharmacists in the community or workplaces. In spite of a question about this in the AP return, 40% of APs did not include such a process. Among those that did, it was generally along the line that this data would be dealt with 'according to our existing procedures for data entry'. It was not clear

that administrative staff would necessarily be aware of the origin of such data, and that the results should be scrutinised by a nurse or doctor as for a patient called for HHC by the practice. It was also unclear, should such data be brought to the attention of a nurse or doctor, how they would be aware of its origin.

At the time the first APs were submitted, community assessments were few, and practices may have been unaware of the processes by which such data would reach them. Nevertheless a robust process was necessary in that at that time community assessments were not 'full' assessments (for example in not requiring fasting blood tests). Therefore there was a responsibility on practices to further assess patients found to have $\geq 20\%$ risk to calculate a definitive risk score, and act to agree a management plan with the individual, as well as enter high risk patients on the CVD recall register.

There is a risk that individuals who have been told that they have a suspected high risk after testing in a community or workplace setting, have not contacted their doctor of their own volition, have not been recognised by the practice as having had such an assessment, or have not been contacted by GP practices even after notification of the community assessment.

Delivery of HHC in the practices

Almost universally the early parts of the assessment process were planned to involve health care assistants and practice nurses, with reliance on reception staff to ensure that invited patients followed the correct procedures (which in LES 2008 involved the taking of fasting blood tests). In only 40% of APs are doctors explicitly indicated as playing a part in the process.

Most APs indicated a two-stage process for assessments, with a first visit for measurements and blood tests, and a second visit for the assessed risk to be communicated to them, and a management plan agreed or lifestyle change advised.

APs varied in specifying how assessments would be offered. Some planned for 'clinics' at which several people would be booked for assessments. Others included assessments in general clinics, and at least one provided a dedicated nurse who carried out all the assessments.

The additional length of time required for HHC meant that it was difficult to incorporate these within general clinics, or required unusual alertness from reception staff. Responses indicated that the holding of specialist HHC clinics was the preferred plan, but this is an instance of when the plans of a large practice (carrying out perhaps 12 assessments per week) might reasonably differ from those of a small practice doing two per week.

Most practices expected to increase staff hours to cover the increased work generated by HHC. Approximately 20% of practices planned to employ additional staff from the start, but the majority indicated that they would wait to see their process in action before deciding what action was necessary.

Aspirations

Practice aspirations and how they were set have been referred to above. In general, aspirations were achieved, provided a generous interpretation is made of the term 'the first 12 months', and subject to the limitations described above. So far as it has been possible to ascertain, total aspirations across Tees in LES 2008 were 25,458 assessments, with an actual record of completed assessments containing correct values of 28,162 by 31 March 2010. At this aggregate level the practices met their aspirations and the PCTs overachieved on the completed assessments for which they had budgeted.

At the level of individual practices the picture is much more variable. Timing was important, and snapshots of practice activity are misleading. Some practices began slowly and developed their assessment system, so that by the end of the period they were overachieving on their aspiration. Others began very strongly, but activity fell away later. Some practices experienced much more difficulty than others in collecting and submitting intelligible data to the PCT.

Some practices were extremely active and achieved their aspirations, while others set a low aspiration, and did not manage to achieve even this. From PCT data to end of March 2010 it is possible to identify, across the Tees PCTs, nine practices which achieved less than 50% of their aspiration, while 15 practices achieved 200% or more of their initial aspiration. There is no clear pattern to the type of practice falling into either group, and there are low and high performers in each of the four PCTs. The aspect of variable performance could be further explored by PCTs and could be the subject of future evaluation.

Training

Practice APs indicated that additional training in management of CVD and in motivational interviewing would be required by staff. Training was available in planned sessions from the PCTs, but many practices indicated that they would, or already had, provided in-house training for staff using expertise within the practice. It is not possible to assess the relative importance of these training methods since APs were often imprecise, and several practices indicated that staff were waiting for PCT training because existing training slots were full. Many practices recognised that administrative staff, as well as HCAs, nurses and doctors would take part in training.

Community assessments

It was expected that TVAP would generate large amounts of data from HHC carried out in community pharmacies, workplaces and other community settings such as day centres. It is an essential part of TVAP that such data be promptly and accurately entered on practice clinical databases, and that it be acted upon according to the LES protocol. In LES 2008 community assessments were not 'complete', for example in not including fasting blood tests, and thus required that higher risk patients should have their assessment completed in the practice, followed by an agreed management plan and entry on the CVD high risk register if the assessed risk was $\geq 20\%$. People assessed in the community at lower risk should still have their data entered, and be scheduled for 5-year recall.

At the time, practices had little experience of the process of receiving community data, and both electronic and paper based data transfer was in operation. The level of community assessments was low.

Practices were rarely specific about their community data handling in their APs, usually stating, where a description was given, that high risk patients would be reviewed in the same way as for high risk patients identified in the practice. There was much less assurance about data from individuals at lower risk, and only 60% of responding practices provided assurance that the community data would be entered on their clinical system.

The LES 2010 Protocol

Action Plans from the second LES Agreement

Rationale

In the light of experience and developments in the roll out of NHS Health Checks, a second Local Enhanced Service for the TVAP was introduced, to run from 1 April 2010. In the event, the LES was not received by practices until June 2010. The LES required an updated practice Action Plan (AP). At the time of analysis (mid August 2010), 42 out of 87 (48%) APs had been received. This rate of response is sufficient to report on the aspects of 2010 APs of particular interest to the PCTs.

Changes in emphasis in the new Action Plan

Part of the reason for a new LES was that some aspects of practices' original APs had been unclear or neglected, making for challenges in the governance of TVAP. The continuation of TVAP meant that some new information was required from practices. Questions in the second AP included:

1. How many patients from the High Prioritisation List do you aspire to assess during the 12 months duration of this LES?
2. How many patients do you estimate will be due for recall from your Primary Prevention Register during the 12 month duration of this LES?
3. Describe how you are going to integrate patient results received from assessments delivered by other providers in the community with your practice records
4. What will you do about those invited for assessments who do not attend?

In a spreadsheet seen by the evaluation team, the numbers provided in answer to questions 1 and 2 above have been used to provide an 'estimated cost' of each practice's activity, based on the direct cost of each presumed assessment. These costs form part of the whole TVAP budget (which also includes other elements such as payments to community providers, cost of blood tests and cost of medications supplied as part of the management of CVD risk).

It is not clear from the figures which we have seen whether the sum of the figures provided in answer to questions 1 and 2 has been taken by the PCTs as the total practice aspiration for LES 2010. If this is the case, the practice aspiration will be an underestimate, as will the PCT budget. The reason for this is that in order to meet the overall NHS HC aspiration to risk assess the whole of the 40-74 population within five years, each practice needs to aspire to invite and assess a proportion of its eligible list who are neither believed to be high risk, nor on its CVD high risk register. This issue is considered in more detail in Appendix G.

It is not possible to tell from submitted APs whether practices have understood, and will respond to, this additional population due for assessment. They have not been

asked for an aspiration figure beyond their responses to the two specific figures requested in questions 1 & 2. In none of the APs reviewed by the evaluation team is such an additional figure included.

Background to and findings relevant to APs submitted for LES 2010

These reported findings are based on the returned APs from 42 (48%) of the participating 87 general practices in Tees.

How many patients from the High Prioritisation List do you aspire to assess during the 12 months duration of this LES?

Patients on the high prioritisation list now exclude those who have been assessed at an earlier stage of the TVAP cycle. Twenty one out of 42 practices (50%) aspired to assess at least 90% of their remaining high risk patients during this year. Twenty one practices (50%) suggested figures lower than this, the lowest being only 14%. The PCTs may wish to follow this up with practices. Four practices aspired to review more than 120% of their whole high risk list. This suggests a misunderstanding of the question.

How many patients do you estimate will be due for recall from your Primary Prevention Register during the 12 month duration of this LES?

Now that HHCs have been delivered for more than one year, the high risk patients originally identified would be expected to be recalled for review from the Register, reassessed and further data submitted, prior to a claim under the LES 2010. The PCT would expect that this number would be close to the number of patients previously identified by the practice as high risk: because of yearly recall, any high risk patient identified at any time and remaining on the register would be expected to be recalled in every 12 month period.

This face-to-face consultation at recall attracts a payment, although less than an initial assessment, and will form part of the TVAP budget.

The number of people assessed by the practice and found to be at >20% risk of an event is known to the PCT, and each of these people should be reviewed each year. It would be expected that the number estimated for recall would be the same as the number identified as at high risk. This is not the case. Only 4/42 practices planned to review 100% of their recorded high risk patients. 30/42 practices planned to review less than 100% of their high risk list, with the lowest estimate being 25%. The reason for this is unknown, the AP question simply asking for a number without any qualifying information. Follow-up of those on the high risk list annually is a LES requirement.

By contrast, seven practices stated they would recall more than 125% of the known number of patients on their high risk register. Three of these practices are very small or new, but the PCTs may wish to check with the other practices to identify whether there are inaccuracies in their CVD recall recording system.

Describe how you are going to integrate patient results received from assessments delivered by other providers in the community with your practice records

This question is included because of a need to ensure that community assessments are being entered into practice clinical systems. This is to ensure that those identified as high risk have entered the correct pathways according to the LES, and that duplication of payment for assessments of the same patient are minimised.

The LES 2008 specified that a community assessment gave a provisional CVD risk which, when $\geq 20\%$, should be confirmed in practice, and involving additional measurement. In the LES 2010, due to some changes in procedure and advice (including, for example, removal of the need for fasting blood tests), it is expected that a community assessment will be considered to be a 'full' assessment, and the risk result will therefore be accepted without additional testing and acted upon.

The management of patient data transfer between community/workplace settings and general practices is one of the most contentious areas of TVAP. There has been no simple, unified and consistent process for doing this. Some records have been received in electronic form and some on paper. There has been difficulty in matching assessments reported as carried out in community/workplace settings with data received in the PCT and in practices. There is the possibility that individuals identified as at high risk have not received further management in their general practice, and may not be identified in practice high risk registers. In LES 2008 the practices' responses as to how they would handle such data were generally unclear.

As a result, LES 2010 asked a more precise question (above) about handling of data received from other providers. For the system to be effective it would require fail-safe systems for the following steps of the process:

- recognition of HHC data received from other providers
- accurate data entry onto practice clinical systems (using the separate template and Read codes for community providers)
- notification of data to a professional tasked with taking follow-up action
- a call system for those at high risk
- a mechanism to identify non-attenders
- entry onto the relevant practice recall system.

All 42 practice APs evaluated responded to the question about handling external data. Generally they did not provide reassurance that failsafe mechanisms are in place to avoid unrecognised community data or high risk patients who have been overlooked. Some responses were extremely brief, for example one entire response was 'Code onto clinical system':

- 40/42 practices stated that data from community assessments would be entered on their system. Twelve of these practices explicitly stated that they would use the community rather than the practice template
- No practice (0/42) described a failsafe process to ensure that HHC results from community sources were recognised as such by data entry staff
- 19/42 practices stated that data would be passed to a responsible professional (usually a practice nurse)
- 10/42 practices specifically stated that this person would have a responsibility to take action on the patient's behalf
- 25/42 practices stated that data on high risk patients would result in entry on the high risk recall system
- 1/42 practice described a system for identifying individuals at high risk who had been invited for review after a community assessment but who had not attended.

The overall impression from these responses is that practices generally do not have robust processes for dealing with HHC data which has originated outside the practice, and the possibility remains that high risk individuals have been identified but are not receiving the follow-up and management they require.

What will you do about those invited for assessments who do not attend?

During the period of LES 2008 increasing concerns have been raised about non-attenders, from the point of view of maintaining equity and also in terms of seeking to understand how people can be encouraged to participate in the programme. The LES indicates that three invitations to a named patient should be issued.

Individuals potentially not attending come from populations of different risk, for example:

1. People who are already on the high risk register, who are being recalled
2. People known to be at high risk from a community assessment
3. People who have made an appointment, but who did not attend
4. People who have not responded to one or more invitations
5. People whose registration or address is uncertain, who may have no fixed abode, or who cannot read
6. Those who have explicitly refused to be assessed or to be followed up.

Each of these groups represents a different level of risk to themselves or to the PCTs' aspiration to avoid increasing health inequalities.

Nearly all practices indicated that they would provide three invitations to those who did not attend an assessment. A majority indicated that they would attempt this by a variety of methods (e.g. telephone or texts as well as letters), or through tagging the patient's records with computer screen prompts and alerts. About a quarter indicated that they would recall any such non-attenders annually, but about an equal number indicated that they would 'exempt' such defaulters, and did not indicate whether they would be permanently excluded from recall. Some practices indicated they would recall non-attenders after five years.

No practices specifically indicated they would use different processes for different categories of non-attenders, and none provided additional explanations about what they would do when a patient already on the high risk list failed to attend.

Recommendations

Good practice and levers to implementation

- The TPCI prioritisation list is effective in directing practices to those most at risk on their list
- Assessment activity is high, and more than matches the initial aspiration at an aggregate level
- The LES agreement was effective in engaging all Tees practices (in contrast to experience in other areas of the country).

Barriers to implementation and service improvement

- There is no assurance that data from assessments carried out outside general practices is reaching practice clinical systems
- There is no unified system for recording and transferring data between external providers, the PCT and GPs
- There is no assurance that individuals identified as at high risk by outside providers have been identified and managed in general practices
- There are no robust criteria for the actions to be taken (if any), when individuals do not attend invitations to assessment
- APs often do not provide sufficient detail to provide assurance of the robustness of practice processes
- The PCTs do not have a robust process specifying what constitutes a complete and acceptable AP
- There is no clear mechanism within the current LES for holding practices to account for low aspirations in identifying high risk patients or in following up those on CVD risk registers
- There is no strategic intervention to review practice aspirations so that five year targets are met uniformly across Tees.

Shape of future commissioning to support rollout

- The aspiration figure plus the high risk recall figure asked for in the AP do not give a robust picture of likely practice activity, and are not sufficient to set the budget
- The intention to focus TVAP on highest risk people first is being only partly achieved.

Appendix D

An evaluation of the implementation of the Tees Valley cardiovascular assessment programme

General Practice Interviews

Acknowledgements

The evaluation team would like to thank all the General Practice Teams, members of the public and members of the Primary Care Trust who agreed to give their time and views.

Table of Contents

Purpose.....	D5
Research methods	D5
Findings.....	D5
How practices worked out their aspirational targets.....	D7
How practices deliver the service	D8
How practices chose which patients to focus on.....	D9
Uptake of the programme	D11
Patient reactions and management plans.....	D12
Referrals from workplaces and pharmacy.....	D14
Summary.....	D17
Recommendations.....	D19

Purpose

The purpose of this report is to feed back on interviews with General Practice Teams (GPT) about their views and experiences of the HHC programme. This report makes up one part of a much wider evaluation of the TVAP Programme, which includes an evaluation of the implementation of TVAP in community pharmacy, community settings and workplaces.

Research methods

A qualitative research design was employed to collect data from GPTs in relation to their experiences of setting up and implementing the TVAP intervention in General Practice.

A target sample of four practices per Tees locality (Hartlepool, Middlesbrough, Stockton on Tees and Redcar and Cleveland) was identified initially, covering practices of differing sizes and levels of HHC activity in the first half of 2010.

For each practice identified, the practice manager was contacted via a letter which invited their practice to take part in the service evaluation. A member of the evaluation team then contacted the practice by telephone to answer any questions they may have had and to ascertain if the practice would be happy to take part. If a practice refused to take part, another was selected using the above criteria.

In total 13 practices agreed to take part in the evaluation. Appointments were made with these practices at times convenient to them and the evaluation team. The evaluator asked if she could interview all those staff involved with the HHC programme, either on a one-to-one basis or as a group interview. Altogether eight practice managers, fourteen nurses, one GP, one health care assistant and one pharmacist took part in the interviews. Interviews lasted between 30 and 80 minutes and followed a semi-structured format. Interviews were recorded and subsequently transcribed. Data analysis was carried out thematically with two researchers reviewing material and working to establish themes which could be supported by the evidence.

The study protocol was approved by the School of Health and Social Care Research Governance and Ethics Committee at Teesside University.

Limitations of the study

Difficulties in GP recruitment impacted on the sampling strategy devised. It had been hoped to recruit equal numbers of high performing and low performing practices. However, low performing practices were more reluctant to take part in the evaluation. This should be taken into consideration when interpreting and generalising findings from this report .

Findings

How practices worked out their aspirational targets

Each practice was asked, as part of the Local Enhanced Service Agreement (LES), to provide an 'aspirational target' of how many patients they thought they would assess within the first 12 months of delivering the service. These decisions were normally made by the practice manager in consultation with the practice nurses who would be delivering the service, or solely by the practice nurse herself. However, in some cases the whole GPT were involved and discussions took place in practice meetings about how best to deliver the service. The way that practices arrived at this aspirational figure differed greatly. Some practices made an educated guess, whilst others applied a more structured approach:

We just picked a figure! I did put it on the action plan, that we could not give a number because it will depend how many patients would come out on our list and they were not happy with that, so we had to give a number and despite that we said the majority of our screening would probably just be opportunistic and we could not put a figure on it. But, they wanted a figure, so we just plucked a figure out for them. (Practice 10 representative)

However this practice manager went on to state that they would take a much more structured approach to the next LES:

It will be much more structured. I think the problem last year was they rolled the LES out... well certainly I felt that the LES was rolled out and then we got this list and, sort of, well what are we supposed to do with it? Despite the fact that we had been to meetings [about the LES]. It was kind of, like, they wanted the action plan, possibly before we got the list or before the nurses even got the training. (Practice 10 representative)

Another respondent stated:

I think developing aspiration figures was the hardest thing in the whole project. Because we don't have a set clinic...and because we do it opportunistically... that's the hardest part... I mean I did it last time. I'm sure I just made it up. (Practice 11 representative)

Other practices tried to base their aspirational target on what they felt was a realistic workload for the nurses:

We do it on really a number of factors, and I think the main factor, if I am honest, is what target we could realistically achieve and between the three of us. It would be no good us saying we could do four per week each, because we couldn't. (Practice 3 representative)

Others worked on the assumption that they would choose a 'reasonable' percentage of their patients.

I found it very easy actually, because there wasn't a lot of guidance in how to write the action plan. So we just presented it in a way, a little bit of background about the practice and what population we had, which would help us to work out the numbers of high risk patients, and again we looked at the appointments we could offer, and then we worked it out on that we thought 50 % of people would actually attend, and that is the number we gave. And actually we surpassed it, the aspirational number. We met it, I think, within about 6 months, and passed it really quickly. (Practice 9 representative)

How practices deliver the service

From visiting the thirteen practices participating in the evaluation, it became clear that five very different models of delivery were being used in the practices:

- A nurse led programme: this was the most popular method of delivery
- A HCA and GP led programme
- A HCA and nurse led programme
- A HCA, nurse and GP led programme
- A 'whole practice approach', where the whole clinical team, including a pharmacist, identified patients and delivered the service.

Practices made the decisions about how to deliver the programme based on their particular staffing levels and also the specific interests within their teams.

The PCT nurses commented that:

Nurses do seem to be more bothered about doing their bit. They can see how it [the HHC programme] is so important. The GPs, the ones who are involved in the programme, would rather the nurses were doing it. But not all practices have a nurse prescriber, so they need to see a GP for their prescription. (PCT nurse representative)

The way in which each practice decided to deliver the service had an impact on the patient experience, affecting how many professionals a patient saw through the process and how many appointments each person had to attend.

In some cases, where there was one nurse employed solely to deliver the HHC programme or the practice nurses had adopted HHCs as part of their overall role, the patient only needed to attend two appointments. In these cases either the nurse was able to prescribe relevant medications to the patient or an agreement had been made between the GP and nurse that the GP would sign any relevant prescriptions without seeing the patient:

We are lucky, because it's basically that's all [names nurse] does. We employed [names nurse] solely to do this because the other practice nurses felt that they don't have any more time to do something else... That gave us the opportunity to make sure that it was all carried out by one person. We also gave [names nurse] a receptionist to work on the

paperwork side of it, organising the appointments, organising the blood tests etc... (Practice 12 representative)

In other cases HCAs were responsible for taking the bloods and lifestyle information before making a second appointment to see either the GP or nurse, who would then deliver the risk score and prescribe any medications:

R She does everything (HCA). She follows the template as it has been set out by Informatics. So she does everything. The blood results are already there, because the patient has had the blood taken about two weeks before, because that [request for bloods] is sent out with the invitation, the blood form is sent out, and asking for the urine sample and that sort of thing. So they come in and everything is there for [HCA] to do the assessment and run the calculator, and it is a half-hour appointment they get for the first healthy heart check.

I what happens if they have a risk of over 20%?

R If the risk is 20 or greater, then the HCA gives them very little information apart from 'you have been highlighted as high risk and what we do now is we organise an appointment for you to see the doctor'. (Practice 9 representative)

In only one case were there three layers of staffing for patients to navigate through. HCAs would take the bloods, nurses would deliver the risk and then - should the patient be at high risk - then an appointment with the GP would be made in order for the patient to receive a prescription.

How practices chose which patients to focus on

It became clear that practices were using different approaches to identify patients for screening; either using the indicative list provided by Primary care Informatics (PCI) or identifying patients opportunistically whilst they attended for other types of appointments.

Some respondents felt that whilst they focussed on the indicative list provided by PCI, this method had not been fruitful. One practice that approached patients by periodically 'blanket mailing' all of the patients on their list stated that:

R: It's a lot of work for picking up hardly anybody.

I: So you haven't had very many high risks from your list?

R: We targeted them first.

I: Right. From the list that you were provided?

R: Yeah. We worked down from the highest predicted risk to the lowest. So we dealt with those first but they weren't really high.

I: Were they not?

R: We hardly had any...if you look at our figures over the last year there might be half a dozen. (Practice 8 representative)

The majority of practices, however, were using their indicative list alongside identifying patients opportunistically; they found that this method worked best for their practice. One nurse felt that if you have a patient with you already it is easier to broach the subject of a HHC and the patient is more likely to be responsive than they are to a letter:

You get a better response from people when you are one to one, if they are already in the surgery and we can say, "We are offering this service." They are more likely to come back than sending a letter out. (Practice 1 representative)

Some practices chose opportunistic screening as their main focus of identifying patients and found it had worked well for them:

The list came in when we had already prioritised what were going to do [for the coming year]. But what we were going to do was start opportunistic screening, which has gone down well. The patients have given no complaints, which is good, and we are now starting, we have started looking at the reports that we get from PCI. But what we found is we have found a lot of the patients on the list, you know, seen them opportunistically. (Practice 10 representative)

Some practices have begun adding the HHC to their routine check for new patients, as a matter of routine for those within the right age bracket, as well as using a more focussed approach:

We are also - as of this week - starting with any new patients who are registering, instead of doing any run-of-the-mill patient check. If they are in the age group of 40-74 and they have not got any family history of heart disease we are actually going to send them to [names nurse] instead of the HCAs to do the new patient check and combine both. (Practice 12 representative)

Other practices identified patients during other consultations:

The doctors will often view a cholesterol and put on it 'write out to the patient - please make an appointment to see the nurse to have a CVD risk assessment done', and of course they will come back and go, 'What's this?' So we will do a lot of random ones, and we will often pick ones out, won't we? If they are in the age group and we will happen to see that they are not on anything and they have had cholesterol done recently. We will bring them back to do a risk assessment on them. (Practice 2 representative)

Uptake of the programme

Each practice sends for patients by letter. However, the number of times each patient is contacted differs between practices. Some practices contact each patient once and - if there is no response - then this patient is either moved to the bottom of the list or not contacted again. Other practices are using the same method they use for other chronic disease patients. This involves sending three letters, and then, in the event of continued non-response, either moving the patient to the bottom of the list or not contacting them again:

[We contact them] by letter three times and if there is no response we just move on to the next cohort. Otherwise you would spend forever trying to contact them. (Practice 12 representative)

Another respondent stated:

We've just been sending them one letter because there has been such a list to work through. (Practice 3 representative)

One practice raised concerns that, even though they had sent out the appropriate literature with the letter of invitation, patients were still unsure what the screening was for at the time of appointment, perhaps because this is a very new programme:

I am not convinced that despite the fact we have sent all the appropriate literature out with it [letter], I am not convinced that they really have known what it was for. And certainly as I embarked on the consultation I have said, 'Do you know why we have called you in?' It is difficult to give a percentage, but quite a few people have said, 'No I am not really sure'. And as far as I am aware we have sent the appropriate leaflets and things. So, they have all been reasonably happy to turn up and be here, but I am not convinced that they have been 100% informed of what it was all about. (Practice 7 representative)

Some practices have found that it is becoming easier to get people in now that the programme has been running a while and people have begun to hear about it:

It is becoming a bit easier as they now know what's happening because they have spoken to others [people who have been screened]. They may just turn up if I have sent them the letter out two days ago so it is a little easier. I think with it being a new initiative. I also think the NHS envelopes with heart check puts them off also, I think that they may just chuck it, whereas I always use headed letter paper from the surgery so it makes it a little more personal to them. (Practice 4 representative)

Some practices felt that, despite sending out letters, patient interest and uptake was very low:

R1 We maybe haven't had quite as much of a response from patients themselves as we would have hoped. I think the process, from the

invitation, having the bloods done, and being appointed, has worked reasonably well. It is just that the uptake hasn't been tremendous.

R2 *We sent out 563 letters and we have done 137 assessments.*
(Practice 7 representative)

Other practices, however, felt that interest and uptake of the programme was good:

We did actually a little audit not so long ago, because we did a presentation about this after the first year of doing it, and we actually found the numbers were much better than any other general clinic actually, but we think it's because the ages were slightly up or older. These tended to be the people in late 50s, late 60s, who may not be working. So the turnout was quite good, it was better than we'd imagined. (Practice 9 representative)

Practice nurses all felt that, once a patient had arrived for screening, they were generally happy with the service they had received. They felt that patients appreciated having a professional take the time to screen them and explain lifestyle advice:

They are absolutely delighted and they think it is marvellous that someone is taking any notice of them. In general they think it is great that someone is giving them that time, because usually with the doctor it's 10 minutes and they just feel rushed. They come and see me and I'm not very good at getting them out really! Once they're in, the time just flies. (Practice 12 representative)

Patient reactions and management plans

Nurses reported a range of reactions from patients when they were told that they are at a high risk of a CVD event. Many patients were shocked that they were at high risk. Others were, at the back of their mind, expecting it:

I would say most of the men are shocked. They step back. Although they are coming in for a Healthy Heart, they don't want to be told that they are at a greater risk. I think shocked in quite a few cases and usually if it is a good result it is happy! (Practice 1 representative)

Another stated:

There are people who see it in writing that they already knew that they were smoking/overweight and they kind of acknowledge, "Oh yeah I knew". Then you get other people who are... well it's like anything. They're in denial. It's like, "Oh I'm shocked at that." It's quite hard to explain to people sometimes what it means and to get them to understand. (Practice 11 representative)

One nurse described how it was sometimes a struggle to get her patients to understand the implications of being high risk:

It's a long assessment and most people... we are in a deprived area. Making people understand they can improve themselves, if they want to.... Some people are not bothered. Once they have got the figure, the figures don't mean anything. Percentages they don't understand. You have got to do it in more simple terms. That is the biggest problem sometimes, I think. It's talking to them. You can feel the way through the conversation, they are really not getting the gist. (Practice13 representative)

Nurses found that those patients who had an estimated risk of over 20% were, for the most part, happy to take a statin to reduce their overall risk. Some patients did need a little extra coaxing, as some had taken on board the bad press associated with this particular medication. Patients realise this will be a medication for life and that is sometimes off-putting for them. However, nursing staff are equipped to deal with these situations:

R There are always one of two [patients] that say, "Oh! I don't want to be on those for life." But once you go through the pros and cons they are usually quite happy

R2 I would say that we must put people on statins every day of the week; a couple of times a day, every day of the week. We have the occasional person who has watched a television programme or read an article in the Daily Mail. But, other than that, I think we have very good success with it. (Practice 1 representative)

Some patients would much rather take medication than take ownership of the problem and make positive lifestyle changes.

R2 They are ok if it is tablets to take. But if it's a lifestyle change it is a totally different scenario!

RT They are quite happy taking statins, but if you say, "Stop eating this, do some more exercise or stop smoking"...

R2 Then it's not the answer for them. They don't want that to be the answer. They would rather pop a pill. (Practice 1 representative)

One possible barrier for patients taking statins as a preventative measure (rather than as a treatment for a condition) was raised by many nurses. Whilst many people identified by the HHC programme will no longer pay for prescriptions because of their age, some still do. Nurses felt that this could stop patients from continuing with the medications:

The other problem I think is if people have to pay for a prescription and they don't feel ill I think they will tend to fall by the wayside. They may not want to pay £7.20 every month for 2 boxes of cholesterol tablets. I don't think it is a lot of money, but it might be – you don't know what their income is, and if they are paying for that prescription. It might be a lot of money and that could fall by the wayside. I think the statins should be free. (Practice 2 representative)

Another stated:

R3 You're fighting a losing battle sometimes, because they've already had all this [negative feedback about statin], or they've read it in the Daily Mail and already made their mind up. The other issue is the cost. They are going to have to pay for this [statins] every month.

R2 And that's frightening because we are talking about young people, with a high risk.

R3 They say, "I have got to take this for the rest of my life and I've got to pay". That is an issue. (Practice 6 representative)

Once patients have been prescribed a statin it is difficult to predict if they will continue to take it. Once practices begin to recall patients for their annual review it will be possible to better assess this situation. One respondent stated:

Not everybody will have continued to take a statin, that is absolutely true. It's difficult to put a figure on it but an awful lot of people will have developed some sort of side effect. In some areas statin still has some strange rumours attached to it. You know, neighbours and friends will say, 'You shouldn't be taking that'. So certainly a lot of people fall by the wayside, and it is at the annual review that we will pick this up and say, 'Actually why did you stop it?' (Practice 8 representative)

Some patients however, feel that rather than taking medications for the rest of their lives they would prefer to tackle the problem with lifestyle changes. Some patients make an immediate start and attend their second appointment, having lost weight in an attempt to reduce their calculated risk score:

Don't get us wrong some are, some of them are quite willing [to change their lifestyles]. Some of them have lost some weight between having their bloods done and coming back to see me. But, quite a lot just want to pop pills. (Practice 1 representative)

However nursing staff are well aware that these small lifestyle changes may not be enough to make a big enough impact on patients' risk:

Some [patients] have wanted to do it by themselves [tackle risk without medication] but I do go through, and get them back on the calculator and explain that if we can get you to stop smoking your risk will drop by whatever percent. At the end of the day it's often, even if they have given up smoking, due to family history they are still going to be high risk. (Practice 4 representative)

Referrals from workplaces and pharmacy

Most of the practices recalled having seen patients who had received assessments through pharmacy or community settings. In some cases these came in erratically. It had, in some cases, been a case of trial and error. For some time letters had been arriving into practice without the HHC branding on

them and this had caused the letters to be scanned into records without the appropriate follow up. This had been raised with nurses at the PCT and now all letters coming in from workplace assessments carry the HHC logo for easy identification:

Yes we do [receive letters about patients from workplace assessments]. Actually we have been getting them for a long time, about a year. When they first started to come through, and I was speaking to [PCT nurse] about this, it [letter] didn't have the 'Healthy Hearts' logo. It said something like 'cardio-metabolic assessment'...so it wasn't going in the right place... So for ages we missed them completely. Then we found out accidentally that we had been getting them. We had to scroll back and find all the people to make sure that the 20% plus were brought in. But then once it started having the logo, and as Informatics have sent the template to every practice, and so every practice should have this template which is for the community assessments, and as they are re-coding there for 'carried out in the community'. So every GP practice will have had that sent to them. (Practice 9 representative)

One nurse recalled having patients arrive at the practice after being assessed in a local pharmacy. The pharmacist had not sent the letters to the practice directly, as would be protocol from workplace assessments. This nurse felt that it would be better to have a consistent approach to ensure that patients with a high risk are not slipping through the system:

It would be better if the pharmacies sent it [patient documentation] direct to us, wouldn't it? Then it would be our choice to invite the patient or even [admin assistant] to phone them and say, "We've had a form from the pharmacy and can you come in and we just need to do a few more tests on you". But it's just disturbing because the patients, like [names nurse] said, are they going to come into practice or decide, 'I won't bother'. (Practice 5 representative)

Summary

The findings from interviews with GPTs found that practices took different approaches to completing the action plans that were required of them. In some cases the whole team were included in the decision making process and helped shape how the programme would be delivered in their particular practice. Most often these decisions were made between the practice manager and the nurses who would be responsible for delivering the service, and in some cases this decision was left to the nurse who would head up the programme.

Practices found it difficult to estimate the number of patients they would aspire to assess within the first 12 months of programme roll out. Whilst many practices used structured methods of trying to estimate how many assessments would be completed, based on their indicative list, workload and staff availability or a percentage of their 'at risk' patients, it seems that some practices took an 'educated guess'. However, some did state that they would be better placed for the second round of the LES to make more appropriate estimates.

Practices seemed to adopt a model of delivery which suited their individual needs and staffing levels. The most popular method of delivery was a nurse-led programme, whereby a single nurse would see the patient through multiple appointments (to take bloods and to carry out the lifestyle assessment). This seemed to be the most successful of the models, as nurses felt that they were best placed to give the lifestyle advice because they had more time allocated for each appointment than GPs. In most cases these nurses were able to prescribe medications or had come to an agreement with the GPs in their practice that they would be provided with prescriptions for the patients to take away from the consultations. It seemed that GPs did not play a large role in HHC delivery in the majority of practices, preferring to leave this to the other staff. One practice that had assessed and identified many patients with high risk attributed this to having whole practice involvement. Every clinician was involved in identifying patients opportunistically and ensuring they had a HHC. They found this approach worked for all interventions they delivered.

Practices not only focussed on the list of potential high risk patients which were provided to them by PCI. Many also identified patients opportunistically from other consultations, if they met the eligibility criteria for age and other chronic conditions. Some practices had taken the initiative and were also providing HHCs when they delivered their new patient check or well person clinics. They found that this was an ideal way to identify patients at increased risk, whilst also having an impact on screening the whole eligible population within five years as recommended by the Department of Health. Even though practices are employing these different methods of identifying patients, some felt the return on the effort they were expending was not sufficient.

All practices were inviting patients in by letter, for those identified through the indicative list. The number of letters sent to each patient varied across practices with some only sending out one letter and others repeat mailing three times. Those who did not respond were then either moved to the bottom of the list to be contacted again periodically or they were removed from the list altogether. Removal from the

list has implications for targeting those estimated to be at a high risk of CVD, and perhaps other methods should be employed to contact them if the programme is to meet its aims.

Nurses felt that where patients attended for screening, they were happy with the service provided and thought that it was worthwhile. Patient reactions to being made aware that they were at high risk of CVD varied from shock to relief. This was in keeping with nurses' experiences of other interventions. Most patients who were offered a statin were happy to accept it, though some were resistant and had heard bad press about the drug. These patients took a little extra convincing, and in many cases the patient decided to try and alter the risk factors by making positive changes to their lifestyle. It is impossible to say at this stage if patients prescribed a statin have continued with their management plans and this should be monitored once annual reviews are under way.

Referrals from workplaces and pharmacy do seem to be making their way into GP practices. However, they have not always been identified as such initially, and have in some cases been missed. Workplace assessments now arrive in practice in a standardised way on letter-headed paper that is identifiable. This process, however, is not the same from pharmacies. It is possible that patient referrals are being lost because in some cases patients themselves are left with the responsibility of informing their practice that they have been screened in the community (see appendix F).

Recommendations

Good practice and levers to implementation

- The practices found the LES flexible enough to be able to deliver HHC in a way which suited their existing organisation
- This variation in approach allows a high level of involvement of practices. We believe a more prescriptive approach would have been unhelpful
- Successful practices appeared to combine a focus on their indicative list with opportunistic screening
- HHC is a nurse-led programme. The nurses involved with the programme thought it was worthwhile, and reported that patients felt the same way
- Nurses felt that they were well equipped to deal with patient queries and to support patients to make informed decisions about their healthcare.

Barriers to implementation and service improvement

- Approaches to constructing APs and aspirational targets varied between practices. Additional support may be helpful, especially in practices where aspirations are low
- Information derived from assessments carried on outside practices have not been easily recognised or handled consistently. Practices confirmed what is reported elsewhere, that community data remains a challenge.

Shape of future commissioning to support roll out

- Practices are adopting different approaches to patients who do not attend HHC appointments. Some criteria set in the LES may be necessary to limit the number of those who may be disadvantaged by being removed from recall registers.

Appendix E

AN EVALUATION OF THE IMPLEMENTATION OF THE TEES VALLEY CARDIOVASCULAR ASSESSMENT PROGRAMME

Workplace assessments

Table of Contents

Introduction	E5
Methodology	E7
Limitations of Study	E7
Findings	E9
Management Structure.....	E9
Participant recruitment.....	E9
TVAP Database (Quantitative).....	E10
Qualitative Findings.....	E12
Summary	E17
Recommendations	E19

Introduction

The purpose of this report is to provide analysis of the workplace aspect of the Tees Valley vascular assessment programme (TVAP) that will feed into future development.

The workplace assessment aspect of TVAP follows on from an earlier CVD in the Workplace Programme. (Watson & Shucksmith 2008) The earlier study showed that such a programme had been successful in identifying people at risk of developing CVD that were previously undiagnosed. In that study over 20% of participants were identified as being at high risk of a heart attack or stroke within ten years and a further 20% identified at moderate risk. The previous study included only two local authorities (Redcar & Cleveland and Middlesbrough) in the Tees Valley.

This report includes an explanation of methods used and the limitations of this study. We report on both quantitative and qualitative findings, the processes evident within this programme of work and peoples' perceptions of the healthy heart checks in their workplace. Conclusions are drawn as to the advantages of workplace assessments in reaching people with previously undiagnosed cardiovascular risk.

Methodology

A qualitative research design was employed to collect data in relation to the workplace assessments. People who have been assessed within their workplace were invited to take part in a short interview following their assessment to give their views on the process.

A wide range of employers have now offered the assessments to their employees. For the purposes of this evaluation, three venues were selected. This selection was opportunistic as they fit in with the fieldwork timescale. The organisations involved in this evaluation were:

- James Cook University Hospital (n=16)
- Police Headquarters (n=4)
- Corus (n=8).

A total of 28 interviews were carried out across the 3 sites. These included a mix of staffing levels from managerial through to manual workers.

All interviews lasted 10-20 minutes and followed a semi-structured format. Notes were taken throughout the interviews and these were later typed up. Data analysis was carried out using a grounded theory approach, identifying key themes. Nvivo (a qualitative data analysis package) was used as a way of managing the data, and ensuring that the themes were supported by the evidence gathered.

The study protocol was approved by the School of Health and Social Care Research Governance and Ethics Committee at Teesside University.

Limitations of Study

This evaluation forms a small part of a much wider evaluation brief. It is estimated that to date approx 1,800 participants have undergone the assessment within their place of work. Our sample size is therefore less than 2% of the overall sample size. This means that it will not be feasible to generalise the findings from this study across the whole of the population. However, a range of employees working at different levels are included.

Findings

Management Structure

The processes for deciding which employers are to be included for Healthy Heart Check (HHC) assessments appear varied. Each PCT has Workplace Leads in post, linked to the “How Healthy is your Business” Campaign. Their role is to work with employers to promote health and wellbeing within the staff. This includes things like establishing smoking policies, mental health services, gyms etc. The Workplace Leads have been tasked with promoting the HHC Programme to the employers. All have been briefed on the remit of TVAP and have achieved some measure of success in encouraging employers to be included in the workplace assessments. To date these have included Corus, Boulby Potash, Cleveland Police, Coast & Country Housing and James Cook University Hospital.

In addition to this the CVD Team also target employers based on current policy and/or NHS drivers (Interview – Delivery team). An example of this is the JCUH Acute Trust and North Tees & Hartlepool Foundation Trust who were targeted as a result of the Boorman Review which focused on the health of NHS staff (Boorman 2009). This report found high rates of sickness absence, obesity and smokers within the NHS. As a response, the HHC Programme was targeted towards NHS staff.

TVAP is managed by Public Health Workforce Development in Middlesbrough/Stockton PCT. However, the workplace aspect of TVAP is managed within Specialist Services in Redcar & Cleveland. In effect this separates the management of the programme. The strategic management in terms of recruiting nursing staff and identifying employers remains with the team in Middlesbrough. Redcar & Cleveland have been commissioned to take responsibility for the operational management of the workplace programme in terms of linking with employers, arranging venues, publicity materials and ensuring nursing staff are available to provide the sessions. Payment is dependent on number of assessments carried out. In order to ensure value for money, it is essential that sessions are staffed in accordance with the number of appointments allocated. Employers are responsible for raising awareness of the programme to their staff and also for setting up the appointments. Systems are now in place for appointment information to be passed to the provider of the service. (Participant Interview)

Nurses and Healthcare Assistants are employed on a sessional basis to the CVD Nursing Bank. They are provided with comprehensive CVD training. In essence they provide a reactive service based on identified need. Systems are now in place to record availability in advance.

Participant Recruitment

Employers were responsible for advertising of the programme. There was no recruitment strategy in place. Participation was purely voluntary. A target number of 4,000 HHC in the first year was agreed in the first instance.

However, to date 1,756 assessments have been carried out so it would seem that this target will not be achieved. The advertising strategy for CCH was varied across the employers involved. A full evaluation of these strategies has not been carried out as it falls outside the remit of the evaluation. However, participant interviews indicate that full coverage of all staff is not currently being achieved.

TVAP Database (Quantitative)

Uptake from employers has been reasonably high. Contact has primarily been achieved through the Public Health Nurse Facilitators and known contacts of the CVD team.

A total of 36 employers have been involved so far across all four boroughs - Hartlepool, Stockton, Middlesbrough and Redcar & Cleveland. There has been a mix of large scale employers and small employers.

Employers involved to date include:

<ul style="list-style-type: none"> • Teesside Park • Lifestore, Middlesbrough • Stockton Borough Council • Durham University • KP Foods • Cleveland Fire Brigade • Job Centres – various locations • Dickenson Dees and Endeavour House • Cleveland Police • HBC Foggy Furze Library • HBC Civic Centre • Middlesbrough Teaching and Learning Centre • HBC AND EDC • Avandale Dyke House • Boro Taxis • Coast and Country Housing • Wilton – ICI 	<ul style="list-style-type: none"> • George Hardwick Foundation • Liberate • Fine Organics • Bio Fuels • Cleveland Potash • Health Bus • Hartlepool Carers • Vopac • Holme House Prison • Middlesbrough Riverside College • Stockton Riverside College • James Cook University Hospital • Billingham College • Barclaycard – Stockton • Corus • Middlesbrough Football Club • Amec • Tristar Homes • Geoban - Santander
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CVD Report May 2010

This highlights good employer engagement in the programme. Also new contacts continue to be established indicating continued interest in the programme by employers and some commitment to the health of their workforce.

To date a total of 1,756 people have had a HHC done within their workplaces. It is noted that there is a discrepancy between total numbers inputted to dataset and reported numbers of assessments carried out. This matter is

under consideration. However, it does reiterate a problem identified in the earlier CVD in the Workplace report that the IT system was not robust enough for us to ensure absolute accuracy and means that we have to place a caveat on the following quantitative data.

Of the 1,756, 64% (n=1125) were female and 36% (n=631) male. According to Fleming (2005), the CHD mortality rate in County Durham and Tees Valley is three times higher in men than women. It could therefore be argued that this programme attracted a significant number of people at lower risk (e.g. females) and that more specific targeting of males is necessary. However, the programme as a whole aims to have the whole eligible population screened within a five year period. Therefore, workplace assessments are engaging people in the programme earlier.

It is also notable that 96% (n=1689) of participants classified themselves as white British. This shows that the take up of assessments from minority ethnic groups was 4% (n=67). According to One North East, the north east of England has a lower percentage (2.4%) of ethnic minority groups than other parts of England and Wales. However, both Middlesbrough (6.2%) and Stockton (3.8%) have a higher than average ethnic minority group presence.

Smoking is also regarded as a key factor in CVD. Of those people assessed, only 9% (n = 163) disclosed that they were current smokers. These figures are far below the local prevalence of smoking. According to NEPHO (North East Public Health Observatory), the North East region has 29% smokers compared to a national average of 24%. (NEPHO, 2008) A further 24% (n = 417) were ex-smokers and 64% (n = 1129) reported as having never smoked.

BMI measurements form a major part of the assessment. This consists of height and weight and waist measurement and provides a full body mass measure. According to NHS Choices, a BMI measurement under 25 is regarded as normal (NHS Choices: Conditions and Treatments). Of the 1,756 people assessed 43% (n = 754) were classified as overweight with a BMI of 25-29 and 22% (n=392) classified as obese with a BMI of 30+.

According to the British Heart Foundation Statistics website, obesity in males and females has continued to rise steadily since 1993. In 2006, 38% of adults were overweight and 24% classified as obese with a BMI of over 30. More men (43%) than women (32%) were overweight although there was no significant gender difference for the obese. However, women (3%) are more likely to be morbidly obese than men (1%) (The Information Centre 2008)

It was not possible to do a gender breakdown on the HHC data at this time as access to the dataset is limited. The Health Profiles 2008 show that whilst obesity is an issue, it is not significantly different to the England average. However, there were a significantly higher proportion of participants with a BMI of 26-30 who were classified overweight.

Diet and exercise are often regarded as a key intervention for addressing a high BMI as are close monitoring of blood pressure, cholesterol and glucose levels.

Using the JSB2 Risk Assessment Formula which is based on the Framlington model, each participant was provided with a risk assessment of them suffering CVD in the next 10 years. Results showed:

Less than 10% risk	10-19% risk	Over 20% risk
1065 (60%)	468 (27%)	223 (13%)

It could be argued that these figures indicate that a significant proportion of participants fall into the “worried well” category as opposed to the “at risk” category. However, it could also be argued that these people took up the opportunity because it was available rather than due to health concerns.

Those people assessed as at medium to high risk (including high blood pressure and cholesterol) were referred to either the GP, Practice Nurse or other relevant agency eg Smoking Cessation service. More general advice on diet and exercise, including leaflets and in some cases referrals to weight management programmes, was also provided as part of the assessment. Suggested timescales for referral depended on severity of assessed risk.

These figures show substantial numbers of people assessed as high risk. This suggests that the aims of this programme, to identify employees at risk of developing CVD and also those with established but undiagnosed CVD, have been met through this programme.

It is also noted that although TVAP is one programme with three strands, not all the data is collected in the same way. GP surgeries feed directly into the PCT where the information is included on to a dataset developed for this programme. However, workplace and pharmacy assessments data needs to be uploaded from the laptops and this data does not appear to link with the main dataset so a separate dataset is in place. This second database is managed through the IT department and any queries or statistical analysis must be done through them.

Qualitative Findings

This section includes the analysis of information collected within the interviews of participants who have undergone the HHCs.

In total 28 participants were interviewed across three employer venues. This provides a snapshot of the workplace programme that can inform future development.

A number of key themes emerged from the data collection. These were:

- Awareness of HHC in the workplace
- Practical issues
- Perceptions of HHC.

Publicising HHC in the Workplace

Although posters advertising the programme are provided, it became clear that the level of awareness of the programme and how the programme was advertised to staff was very mixed. Informing staff of the HHCs and providing information about the planned sessions were also mixed. In one organisation, the staff intranet was used. However, it is noted that not all staff have access and the use of intranet served to restrict uptake. There was also some indication that all managers were informed and tasked with cascading the information to their teams. However, the evidence suggests that this was not entirely successful as some managers did this and others did not.

One participant commented:

I heard about it from a colleague from another department whose manager had told her about it. My manager never mentioned it to us. (Participant No 4)

Employers A and B highlighted the programme to their staff through briefing papers, meetings and by posters. However, staff intranet was the most common method for spreading the word. This appears to have worked very well for those staff who have instant access to the intranet in their workplace.

However, not all manual staff eg cleaners, kitchen staff and laundry staff do not have access to intranet. For these staff, alternative methods are needed to ensure that all staff have equal access to the programme.

Employer C used a different method of publicising the programme. The Health & Safety Representative was tasked with ensuring everyone knew. He primarily achieved this through word of mouth and sending notes to staff. Posters were also put up. It is noted that bearing in mind the timing of the HHC, the take up was good and attracted both management and manual level workers.

It must be recognised that if we are to ensure that **all** staff are aware of and can access the HHC, then a range of methods and tools should be used to raise awareness. There is no one method that will work effectively in all venues. There may be need for mixed methods. What is clear is that this issue should be raised with employers in the early discussions and agreement reached as to how **all** employees are informed.

Process – Practical Issues

As mentioned earlier, employers were responsible for organising suitable venues and setting up appointments. The HHC sessions within the three venues covered as part of the evaluation were fully booked and well attended. The number of “did not attend” (DNA) were minimal. This is a similar picture across the wider programme (Interview – Delivery Team). Therefore it seems fair to say that this system is working effectively.

In terms of venues, some concerns were raised by a small number of participants (n=4) about the lack of privacy. Generally, a number of checks will be carried out simultaneously in the one room.

However, on some occasions more than one room is used. Some respondents commented that moving from room to room for different tests, consultations and seeing different nurses did not always work well. For some this created some confusion; for others, the interruptions were seen as an invasion of privacy. Whilst the majority of participants did not feel this was an issue, a minority would prefer their checks to be done in private.

Watson, Shucksmith (2008) also highlighted this as an issue. However, in many organisations, space is at a premium and while efforts were made to ensure that rooms were large enough to ensure participants were not sat closely together and that nurses adapted each venue to take account of this, this could not be guaranteed. As this is an issue that continues to arise, it may be necessary to make a statement on the publicity materials that privacy cannot be assumed and if they require absolute privacy provide other options such as the GP for the checks. This way, people can make a more informed decision as to whether to attend in the workplace.

Perceptions of Healthy Heart Checks in the Workplace

Respondents from the interviews following the assessments reported that this type of assessment in the workplace was a “good idea”. Reasons for this included:

- Convenience
- Prevention
- Raising awareness of own health.

The reasons why people attended for the HHC was varied but generally fell into 4 categories. These were:

- Family history (n=7)
- Age milestones eg 40, 50 (n=5)
- Not seen GP for a long time (n=5)
- Prevention/Convenience. (n=11)

Of the 28 respondents interviewed, 3% (n=1) was reported at high risk, 18% (n=5) were reported at moderate risk and 79% (n=22) at low risk. Although only one respondent reported being at high during the interview process, indications from the database are that 22% of participants overall have been identified as high risk. Our sample was purely opportunistic – people who had their assessments the day evaluators were present and were willing to participate in the evaluation. This provides some explanation for the low number of high risk patients interviewed. However, efforts to include high risk patients in the evaluation through the GP surgeries and pharmacies are underway. Any participants assessed as high risk in the workplace or the pharmacies are referred to their GP surgery for follow up and are then included in the GP dataset.

Most respondents received some form of healthy living advice, e.g. dietary, exercise, and were happy with the information they were given. Generally there was a view that even those assessed at very low risk were happy to have this confirmed and that they welcomed advice on how to maintain that level of risk in future years. Those participants reporting that no action was needed reported feeling reassured, were happy to have confirmation of their health status and more aware of potential risk factors.

One respondent stated:

I feel really good and pleased that what I have been doing is right.
(Participant Interview 13)

Another commented:

I feel really good and righteous. I have tried to get into good habits in terms of diet and exercise and it's really good to have this reaffirmed. (Participant Interview 8)

Some respondents reported that primarily due to family history, they had had some concerns and had used the HHC as a way of confirming to them that they needed to begin to take better care of themselves. Others knew they were overweight and took the opportunity to obtain advice.

The one respondent classified as high risk reported that, although shocked at being of high risk, they had had some concerns, which was why they had opted to have the check done.

Of those respondents classified as moderate risk, only one reported that they were surprised at the result as they had had no earlier concerns. However, the results meant that they would now take a follow up appointment with their GP. For some, the confirmation of moderate risk, although not totally unexpected would encourage them to take a more active role in their own health. Some reported they would be taking more exercise, others already exploring weight management opportunities after their discussions with the nursing staff. One respondent reported:

I knew I was overweight but my cholesterol was a bit high so I now need to take on more exercise and am going to have a go. (Participant Interview 6)

Many respondents interviewed reported they would be actively taking on board the advice given. Given the timeframe for this evaluation it has not been possible to provide any follow up as to whether these changes in lifestyle actually materialised, but the evidence does support a willingness to do so at the time of the HHC.

Respondents reported that the service they received was very high quality, that the staff were friendly, knowledgeable and able to put people at ease. There was a view that the tests carried out were relevant and non-invasive. However, some respondents felt that the HHC should have included tests for diabetes as this was also an indicator for cardiovascular disease. Glucose testing was included in the original CVD in the Workplace programme, but this raised some issues about the accuracy of the tests in terms of non-fasting samples and they were removed from the HHC programme.

Some respondents reported that in addition to leaflets to supplement dietary and exercise advice, contact details for support services should also be provided in order to further encourage people to move forward and make the lifestyle changes necessary.

A small number of respondents (n=3) also commented that the HHC would benefit from further expansion to include tests for other chronic long term conditions. There was also a view that such testing should be regularly available every 2 years.

Overall the perception of the value of the HHC in the workplace was very positive. Generally respondents felt it was very beneficial to have the opportunity during work times, that they were unlikely to have made an appointment to have the HCC at their GP's and that they were very happy with the level of service they had received.

Summary

The evidence of this evaluation supports the view that the HHC in the Workplace is a feasible way of addressing CVD issues and is showing some success in identifying those most at risk.

The programme was well received by local employers who have played an active role in its success. Although a number of methods were adopted to raise awareness of the programme with employees, these were not wholly successful and additional methods need to be explored and adopted to ensure that **all** staff have equal access to the assessments. More care must be taken to ensure that staff at all levels are fully aware of the programme and are able to access it if they wish to do so. The publicising of the scheme needs to be more uniform both across and within the organisations.

The target number for HHC is 4,000 in the first year. It is unlikely that this target will be met for year 1. However, it is accepted that there have been some recruitment issues and that the administration and management of the workplace aspect changed resulting in the need for new systems and procedures to be put into place.

Venues were generally acceptable in terms of space although privacy was an issue for some participants. In future all potential venues should be fully vetted for suitability prior to the assessment sessions. This will ensure that the space is adequate and offers some element of privacy for those who require it.

Findings also show that access to such a service within the workplace during work time was a key incentive to participation. Accessibility and opportunity served to promote the programme well. Perceptions of the programme and the assessment process were positive. However, the uptake by the workforce remains relatively low. This means there is scope to revisit and provide additional sessions as a way of improving overall uptake.

Over 22% of those assessed at high risk and were referred to GP/Practice Nurses for further intervention. Results from the workplace assessments are sent directly to the GP. However, participants have responsibility on making appointments for any follow up. Over 40% of participants received lifestyle advice to help them reduce their risk factor and there were clear indications that the majority of these participants would be taking some kind of action as a result of the assessments.

In conclusion the evidence supports the view that this programme has been successful in identifying employees at risk of developing CVD, has identified employees with established but undiagnosed CVD and as a result has referred 223 people to their GP as at 20% or greater risk of CVD. In addition to this a further 468 people were referred as being at 10-19% risk. These figures illustrate a significant success in meeting the aims of this programme.

More work is required to attract higher numbers of males to the programme. Another high risk group is those from ethnic minorities and additional work is needed to further increase the participation of this group.

Although there were some earlier problems in terms of developing networks and systems and processes, it would seem that the workplace strand of the wider TVAP programme is showing some success and the evidence supports the potential for higher levels of success in the future.

Recommendations

Good Practice and levers to implementation

- Recruitment and ongoing training of bank nurses to provide the HHC service has been successful, and is a model likely to be adopted elsewhere in the Region.
- Links with employers have been promoted, and many have taken on responsibilities to advertise HHC and to recruit clients among their staff.
- Systems are in place to facilitate provision of a service in the workplace. These systems are being strengthened, and a more active and a more diverse approach is being taken.
- Clients were generally positive about the service and the opportunity to be assessed at work.
- Very few workplace clients did not attend appointments they had made.

Barriers to implementation and service improvement

- So far the programme has not achieved its aim to engage people with mental health problems, minority ethnic groups and travellers and provide them with access to HHC. A new staff appointment has been made to address these issues.
- The use of public nurse facilitators has been successful but there is a need for more proactive engagement with a wider range of employers in order to expand the number and type of workplaces involved.
- Employers need support in finding ways to promote HHC to all employees, to ensure equity and engage those more likely to be at risk.
- It is acknowledged that a mass marketing campaign to raise awareness across the general population was the intention of the programme. However, there appears to be a lack of awareness of the programme among the public, which may need to be addressed in order to increase uptake.
- The separation of those identifying suitable community sites or workplaces from those delivering the service requires effective and continuous communication between them.
- There is no robust facility to track patients from workplace assessments through to follow up with their GP and agreement of a management plan when required.

Shape of future commissioning to support roll out

- Workplace assessments require improved technology systems that link with the wider HHC dataset.
- The value for money aspects of workplace and community assessments are not within the scope of this evaluation.

Appendix F

An evaluation of the implementation of the Tees Valley cardiovascular assessment programme

Community Interviews

Acknowledgements

The evaluation team would like to thank all the members of the public across the Tees area for taking their time to give their views for the purposes of this report.

Table of Contents

Purpose.....	F5
Research Methods.....	F5
Findings.....	F9
GP and pharmacy interviews.....	F9
Community -based interviews	F12
Summary.....	F17
Conclusions.....	F19

Table of Figures

Table 1: Number of respondents interviewed and included in analysis.....	F5
Table 2: Number of respondents in each locality broken down by gender.....	F6
Table 3: Localities.....	F6

Purpose

The purpose of this report is to feed back on interviews with members of the public about their views and experiences of the HHC programme. This report makes up one part of a much wider evaluation of the TVAP Programme, which includes an evaluation of the implementation of TVAP in community pharmacy, GP practices and workplaces.

Research Methods

The following report is based on analysis of qualitative interview data from a range of respondents and is split into two sections:

Section one – Patients who had received a HHC assessment:

Semi-structured telephone interviews were conducted with patients who had received a HHC assessment in GP practices or pharmacy settings. These patients were identified in three different ways:

- Four GP practices which took part in the GP phase of the wider evaluation (Appendix D to main evaluation report) agreed to ask patients if they would be happy to be contacted by the research team to give their views about the HHC. One GP practice provided a list of patients happy to be contacted
- Three pharmacists from the pharmacy phase of the wider evaluation (Appendix B to main report) also agreed to ask patients if they were happy to be contacted by the research team. Again, only one pharmacist provided a list of patients happy to be contacted
- A third list of patients was supplied by the PCT of patients who had received an assessment in community locations and had already agreed to take part in the service evaluation

The table below shows the number of interviews carried out with patients from each location. A further nine patients who were identified from the PCT community list also agreed to be interviewed. However, seven of these could not recall having the HHC assessment done and the quality of this data was poor, so it was decided to exclude this from the main analysis.

Table 1: Number of respondents interviewed and included in analysis

	GP	Pharmacy
Number interviewed	6	2

Each patient was telephoned by a member of the research team and asked if they were still happy to take part in a short telephone interview. Interviews lasted between five and fifteen minutes and followed a semi-structured format. Notes were taken by the researcher during the interview; these were later analysed for emerging themes and verified between researchers.

Section two – Community interviews with members of the public:

Two members of the research team went out into community locations to ask members of the general public if they had heard of the HHC programme, if they intended to attend a HHC assessment and what, in their view, would make this programme worthwhile.

The research team went to job centres, working mens' clubs and libraries in Hartlepool, Middlesbrough, Redcar and Cleveland and Stockton on Tees to gather data. Table 2 shows how many people were interviewed in each area, broken down by gender:

Table 2: Number of respondents in each locality broken down by gender

	Hartlepool	Middlesbrough	Redcar and Cleveland	Stockton on Tees
Male	3	8	11	5
Female	9	5	4	6
Total	12	13	15	13

A range of localities within each local authority areas were targeted. These included:

Table 3: Localities

Hartlepool	Middlesbrough	Redcar & Cleveland	Stockton-on-Tees
<ul style="list-style-type: none"> • Town Centre • Owton Manor • The Headland • Seaton Carew 	<ul style="list-style-type: none"> • Town Centre • Coulby Newham • Marton • Berwick Hills • Grove Hill 	<ul style="list-style-type: none"> • Redcar • Loftus • Marske • Eston 	<ul style="list-style-type: none"> • Town Centre • Roseworth • Norton

The research team approached people who had been pre-selected based on estimated age. An interview guide was developed to ensure consistency.

Each interview lasted between five and ten minutes and notes were taken during the interview to record people's opinions. These notes were later transcribed and analysed for emerging themes.

The School of Health and Social Care Research Governance and Ethics Committee reviewed and approved this study protocol prior to commencement of fieldwork.

Limitations of Study

This evaluation forms part of a much wider evaluation brief. An opportunity sample was used and only 53 people were interviewed in the communities. In addition to this a total of 8 people were also interviewed through GP and pharmacy settings. Our overall sample size is therefore very small which

means it is not feasible to generalise the findings from this study across the whole population. The results do, however, start to illuminate some of the main issues which may affect community uptake of the programme.

Findings

This section of the report will focus on the views of people identified as high/medium risk as a result of a HHC assessment and also of people who have not yet participated in the programme.

In the first instance the views and opinions of those people identified as “at risk” by their GP or pharmacist will be explored. These will then be followed by findings from the community-based interviews which were carried out as a way of gathering views of people who had not participated in the HHC programme.

GP and pharmacy interviews

How participants heard of the Healthy Heart Check Programme

All six respondents who had received a HHC assessment in GP practices had been sent for directly. They received letters through the post which invited them to attend an appointment for what they described as an MOT health check. Some respondents were very clear that the letter did not specifically mention the HHC. The two respondents from pharmacies had heard about the service from a press advertisement or publicity material in their pharmacy.

Reasons for participation in the Healthy Heart Check Programme

For those attending at the GP practices all but one respondent (n=5) stated amongst other reasons that they attended the check because they had an interest in their own health. Other reasons that they gave for attending the appointment were more personal. Three respondents stated that as they were getting older, having check-ups of this sort made sense as one respondent stated:

It is good to check that everything is still working as it should.
(Interview 4)

Two other respondents felt that as the GP practice had called for them directly it must be a check-up that was of great importance and they therefore had no reservations about attending promptly. Three respondents were aware they had a family history of CVD and felt they should go to ‘be on the safe side’. One respondent, however, stated he only went along because he thought it was some sort of mandatory assessment.

Both of the respondents from the pharmacy-based assessments saw the adverts and thought ‘it sounded like a good idea’ with one going on to state:

I think at my time of life prevention is most definitely better than cure. (Interview 1)

The pharmacy respondents saw the adverts and actively sought the assessments because they both had a family history of heart disease and

wanted to make sure their families did not suffer loss in that way again.

Reactions to having the Healthy Heart Check

Five respondents from the GP sample were identified as high risk and one was identified as medium risk. Both respondents from the pharmacy were identified as medium risk. People described their reactions very differently.

Below is a selection of short vignettes describing people's reactions to their assessment.

Interview 1; Male, 61+years old, High risk

This person described how he had attended the appointment because he felt that as the doctor had called for him directly it must have been important. He was aware that there was a history of CVD in his family as his father had suffered a stroke when he had been alive. He told of how he was already aware that he was not leading as healthy life as he possibly could, but he prided himself on the fact he was a non-smoker and felt that this was in his favour. When he was told by the nurse that he was at a high risk of developing CVD he was not shocked, as he already knew he needed to make some changes to his lifestyle. He was prescribed a statin to control his cholesterol and given lifestyle advice about diet and exercise. Initially he had been given diet sheets to follow but had found that all of the foods he loved were in the 'bad' column. He said "I tried and failed – I love cheese!" so he had resigned himself to the fact that he would have to rely on the statin to improve his health. He described how he didn't mind having to take tablets for the rest of his life because "I figure that everyone my age is on them or ones for your blood pressure!" He has since had an annual review at the doctors and was surprised at the results. "I am really over the moon that it has worked".

Interview 3; Male, 61+ years old, High risk

This gentleman described how he was "totally shocked" by the news of being at high risk as he felt generally fit and well at the time of assessment. He had attended the appointment as a precautionary measure to check that everything was still working as it should be. The HHC had been presented to him as an MOT which he felt he really responded to, stating "the idea of having an MOT – like a car is great!" The news spurred him on to make positive changes to his lifestyle and get fitter. He now runs three or four times per week and has lost his excess weight. He was prescribed a statin and was really excited by the positive results he had obtained from taking the drug and increasing his exercise. At his annual review, his cholesterol has returned to normal levels and since including this with exercise he feels better than he ever has. He realises that he will be on tablets for the rest of his life but he has seen the positive effects for him. "I find it amazing that such small changes have made such a huge difference in how I feel".

Interview 5; Male, 40-50 years old, High risk

This gentleman had gone along for his HHC because he thought it was a mandatory assessment. He was very shocked at the news that he was at

high risk, as this was something that had never occurred to him before. He was offered lifestyle advice and also a statin to control his risk of having a CVD event. However, he refused the statin as he didn't feel like he needed them. He wanted to make changes to his lifestyle by himself and take ownership of the problem. He has since bought some fitness apparatus and uses this on a regular basis now and tries to watch what he eats. However, he does acknowledge that he could try harder and eat much more healthily but as he feels well in himself it really can be difficult. He is awaiting another check up to see if the changes he has made actually have made a difference.

Interview 8; Female, 51-60 years old, moderate risk

This lady attended the HHC at her GP practice and was told that she was at a medium risk of developing CVD. She had been given lifestyle advice and told she needed to lose some weight. She was referred to a programme called lite 4 life which runs in the Stockton area. The sessions cost £2.20 per week and include an hour of exercise and an hour of nutritional information. She was very happy to have been referred to this service as she felt it was very good value for money when compared to other slimming clubs.

Potential improvements to the Healthy Heart Check programme

When asked how they would rate the service they had received and also if they could make any suggestions for improving the HHC, all but one respondent said that they thought the service was a very good idea, irrespective of whether they had taken on board the advice given to them. Two respondents from the GP sample had already been for their annual follow up review. They felt that as part of this review a reassessment of their cholesterol should have been automatic. This was not offered to them and both had asked for it to be done. The nurses were happy to reassess their cholesterol to reassure them that their treatment was working, but both felt this should have been part of the standard review process.

It is noted that reassessments are not currently part of the LES or the protocol. This decision is based on current evidence that everyone with a risk factor of >20% should be on a statin for life whatever their initial cholesterol count was. However, respondents felt that reassessment was necessary and should be offered.

One gentleman who had been assessed in a pharmacy felt that whilst the service he had received was very professional he felt that the only reason pharmacy was offering the service was "to make extra money" (Pharmacy respondent 2), not because they particularly cared about his wellbeing. He said "I found out after having it done at the pharmacy that I could have gone to my GP for the tests – a little MOT if you like. My mates down the club had been there; I would have preferred to go there too".

Community-based interviews

Awareness of the Healthy Heart Check Programme

Community-based interviews were carried out with people contacted “on the street”. Interviewers had no prior knowledge of their assessment status or their attitudes to prevention. A range of venues were used across the 4 local authority areas.

Generally people were unaware of the HHC. Of the 53 interviews 36 (68%) had never heard of HHC. Only 14 people (26%) interviews reported that they were aware of the HHC programme. The remaining 3 respondents (6%) were not sure if they had heard of HHC. It also appears that although some had heard about it, it was not always under the banner of HHC. Some respondents had been asked to go to the doctor for an MOT or the ‘well man’ clinic and had the tests done but it had never been called HHC, so they were unaware, even though they had had it done.

Of those people interviewed who had received an invitation letter from the doctor, it became clear that not all letters used the HHC branded letterhead or specifically mentioned HHC and some used different terms. Of those interviewed, only four respondents received invitations from the GP to attend for a HHC assessment. A further five respondents were asked to attend for either an MOT or an annual health check. One man had been invited to the ‘well man’ clinic for a health check but a leaflet of HHC was attached to the letter. We understand that this issue is currently being addressed with GPs.

It became obvious in the interviews that some participants had undergone some of the tests included in HHC but not all, and that they had been offered under a different banner. It was also clear that some respondents suffering various other ailments (e.g. asthma, diabetes, hypertension) received annual checks. Nevertheless, these checks did not cover all the HHC checks and no offer had been made to upgrade such checks to incorporate the additional HHC checks. However, it is understood that these would be excluded from HHC. However, it does offer some indication that there is potential for patients developing expectations as the programme progresses as they do not understand the process or criteria for HHC.

It is also noted that only seven respondents (13%) reported having seen the leaflets either in the GP surgery or the local libraries. This indicates that leaflets are not prominently displayed and are therefore failing effectively to raise awareness of the programme in local communities.

In total only one person of those interviewed reported already having had the HHC done at the GP surgery and one other in the workplace.

Overall, it appears that awareness of the HHC programme in the eligible population communities is low.

Peoples' perceptions of the Healthy Heart Check programme

Many interview participants (n=20 – 38%) reported that they believed that the HHC is a worthwhile programme and provided an opportunity for people to get either reassurance of their health status or benefit from early detection of potential risk. The term “prevention” did not appear to be high on the agenda of some participants.

However, one respondent reported:

I think these checks are a really good idea. If I had had it done earlier, they may have caught my condition earlier. (Interview 12 Hartlepool)

Another respondent reported:

Having possible issues highlighted early could be a good thing . . . It's like having your car tested once a year – just go and have your body tested instead. (Interview 6 Middlesbrough)

Whilst on the face of it this highlights a belief that prevention programmes such as the HHC can be beneficial, it could be argued that it also highlights a lack of understanding of risk. For instance when a car has an MOT, you expect it to be fixed until the next year. With risk factors there is a need to work at this yourself continuously and even then it will only reduce the likelihood of an event by approximately 30%.

However, for many, the “need to know”, or “getting reassurance” were regarded as more important factors as opposed to thinking about it in terms of addressing issues earlier.

A higher proportion of female respondents appeared to be more proactive in terms of prevention. One respondent stated:

For me it is just like the smear tests and breast screening – the HHC is just one of those things that you have to do, especially as you get older. (Interview 4 Hartlepool)

Most of the people interviewed reported that they thought the HHC was a good idea although some admitted that they would not be interested in taking part themselves. There was a view that access to such a scheme was beneficial and that it should be available for those who want to participate. Some respondents held a view that HHC should be made compulsory. One respondent stated:

Healthy Heart Checks should be made compulsory. (Interview 3 Redcar & Cleveland)

Many respondents reported either a family history of heart disease or knowing people who have had heart attacks or strokes. They portrayed a knowledge

of the issues and the need for such a programme, although many of them would only have such a check as a reaction to feeling unwell or concerned. It is not clear whether this attitude is attributed to fatalism or 'head in the sand', although indications are that for some respondents it was a mixture of the two and for others it was purely based on the fact that they just did not want to know.

Participants who are now considering engaging with the programme

Following the interview process, some of the respondents who had not heard about HHC were now considering having the tests done. Fourteen respondents (26%) reported that if their GP invited them into the surgery for the tests then they would definitely go and have them done. However, they were unlikely to go in and ask for them specifically. A further eight respondents (15%) reported that, should they be invited, they would consider it but made no commitment to attend. Male respondents generally held the view that they would consider it further if they began to feel unwell or had any health concerns.

Six respondents (11%) reported that they would ask the doctor about HHC at their next visit to the surgery and make an appointment. Two respondents (4%) already had appointments booked with the practice nurse for the HHC. Some respondents felt that, had they known about it earlier, they would have already been in and had it done.

Most respondents felt that the GP practice was the best place to have a HHC. However, some commented on difficulties in getting appointments to suit their lifestyles. One respondent reported:

Time is a big issue for me. I leave the house at 5 am and don't get home until after 6 pm so it's hard to get to the doctor's. (Interview 11 Redcar & Cleveland)

This argument highlights the value of workplace assessments as a way of encouraging employed people into the HHC programme by making it easier and more convenient for them to access HHC.

The interview data clearly indicated that people who are health conscious to start with were more likely to engage than those who are not. For those who are, publicity and invites etc will serve to influence them in participating in the HHC. For those who are not, the current publicity campaign lacks strength and depth. It fails to provide the information as to why prevention is important and is not strong enough to influence their decisions.

Participants who will not engage with the programme

A number of respondents (n=11 – 21%), some of who were aware of HHC and others who were not, reported that they had no intention of undergoing a HHC. Fear of the results appeared to be the main reasons for this. It was

clear that, although some respondents felt that HHC was a good idea, they were not interested for themselves.

Statements included:

I am just the type of person who wouldn't want to know. I would rather things just happen and then deal with it. I worry about the now and not the future. (Interview 2 Stockton)

I would rather leave it alone, it would only come as a shock. Anyhow, there aren't enough hours in the day to be going to the doctor's. (Interview 13 Redcar & Cleveland)

I got a letter from the doctor but I just didn't want to go. I didn't feel it was necessary as I am in good health. I will go if I have a problem, but not now. (Interview 2 Hartlepool)

I just don't like the idea of people telling me how to live my life and, if the tests turned up something, I might have to make changes I don't want to make. (Interview 7 Redcar & Cleveland)

I have no intention of getting the Healthy Heart Check done. Once they have found one thing then they will have you dead and buried before you know it. I feel fit, so there is no point in going to see the doctor. (Interview 9 Hartlepool)

Of those respondents who indicated no interest in participating in the HHC, there was a view that they just “did not want to know”. Their interest was in the present and not the future and for some, the present caused them enough worry, so they felt unable to cope with worrying about “what might happen”. However, some respondents reported being very fearful of what the results may be. It is also noted that some of these respondents reported some family history of cardiovascular disease but, rather than prompting them to look at prevention, this actually influenced their decision not to find out.

Findings indicate that some people are just not willing to engage in prevention programmes of this nature. Fear of the unknown and a lack of understanding of prevention appear to be the major cause for concern.

Some respondents told stories of their friends and family members who had heart problems or strokes, of people dying of heart attacks in working mens' club toilets at young ages and how they were concerned that the same could happen to them. Some also reported knowing that smoking was not good for them or that they were overweight or took little exercise.

One respondent stated:

People know what is bad for them but are too scared of the consequences to face the reality of what they are doing. Having their fears confirmed may not be a good thing, as then you have to

take on the role of an ill person. I call this the 'ostrich syndrome'.
(Interview 10 Stockton)

Improving engagement in Healthy Heart Checks in local communities

The findings indicate that awareness of HHC is generally low. An improved ongoing advertising campaign using TV, radio, local newspapers was reported by some respondents as one way of improving awareness of the programme. There was also a view that any advertising campaign needed to be hard hitting to ensure that people fully understand the purposes of preventative measures. Some respondents felt that GP surgeries and workplaces needed to more actively promote the HHC programme through word of mouth and by more prominently displaying posters.

Other suggestions to improve uptake included:

- A prevention campaign
- More active use of mobile venues such as the Health Bus
- Incorporate HHC with other screening e.g. cervical and breast screening, asthma clinics
- Use neighbourhood management and community activists to spread the word in the more disadvantaged communities
- Provide HHC sessions at community events e.g. Cleveland Show, community fetes
- Provide regular drop in HHC clinics in local venues e.g. libraries, community centres
- GPs to provide HHC clinics during evenings and weekends in order to include people who work
- More workplace assessments.

Summary

Findings from participants assessed through their GP surgeries indicate that the recruitment process through the GPs is progressing, although this appears to be dependent on the patients' views on prevention to some extent or current health status or health concerns. Overall take up of assessments through GPs is provided in a separate report.

Findings from the two participants assessed through the pharmacies provide some indication that publicity materials were well displayed, although the interviews also raised some questions as to the quality of service and support provided within the pharmacy.

It is clear that many of those respondents interviewed through the GP and pharmacies were shocked to be classified as "at risk". Most had reported feeling generally fit and well. Of those identified as high risk, most were now being prescribed medication as a way of managing and reducing those risk factors. This shows that the HHC is showing some success at identifying previously undiagnosed cardio vascular conditions.

Of those respondents interviewed in the community who had already participated in HHC, all had been assessed as low risk. Other respondents reported that, now they were aware of the HHC, they would be requesting an appointment.

The quality of the service provided in the GP surgeries and pharmacies was reported as good, although some potential improvements were identified. These did not relate to the actual testing process but related to follow up arrangements and on successfully engaging increasing numbers out in communities. These ideas should be explored in the future development of the HHC programme of work.

Awareness of HHC in the community sample interviewed was very low. The publicity campaign for HHC does not appear to have been successful in raising awareness of the programme to the specific target groups. Awareness of the benefits of preventative interventions such as the HHC would appear to be necessary if the programme is to continue to engage people, particularly those less likely to engage through GP surgeries.

The community interviews also highlighted the fact that some GPs were sending out letters for people to attend the surgery for an "MOT" or "health check". Other GPs used the HHC branding. This indicates a lack of consistency within the HHC programme. It also became clear that some people attended their GP surgeries for annual health checks but that such checks did not include all of the HHC testing procedures. This highlights a lack of consistency in terms of the use of the HHC brand and also that those on annual reviews are not getting the opportunity for the full range of tests e.g. cholesterol or BMI.

However, early prevention is the key concept of the HHC programme. Responses were mixed among respondents as to the benefits of such a preventative programme. Although many respondents felt the HHC was a good idea, they held a view that the results would give them “peace of mind” as opposed to preventing future problems. There was also a view that going to the doctors without being ill was not essential, and that securing a doctor’s appointments was not easy if you were employed. However, some respondents were very clear that prevention was a good thing.

It was clear that some respondents were clearly not interested in prevention. Reasons for this varied but some were clearly fearful, not of the actual testing process, but of the possible results. Some respondents just did not want to know if anything was wrong and some were really fearful that, if they were identified as at risk, they would have to make lifestyle changes that they did not want to make or take regular medication. This could illustrate a lack of understanding of the benefits of prevention in terms of health care.

Overall, the evidence clearly supports the view that HHC is providing a quality service and is identifying previously undiagnosed cardio vascular risk. There are also indications that the overall awareness of HHC is low in communities. Invitations by GPs for patients to come forward for HHCs has shown some level of success for those interviewed, but overall rates of take-up require further investigation. Although HHC is available through GPs, a number of pharmacies and some workplaces, respondents from some of the communities covered in this study report they have very limited access to such a programme. The use of community venues could be further explored as a way of addressing this problem.

Conclusions

Good Practice and levers to implementation

- Recruitment through the GP surgeries is progressing well.
- Some respondents were shocked at being identified as high risk indicating that HHC is showing some success in identifying previously undiagnosed conditions.
- On raising awareness of the HHC in communities, some respondents reported they would now be requesting an appointment for a HHC.
- The quality of the service provided was reported as good.
- There is some evidence to support that people who respond to GP invitations for a HHC assessment and are identified as 'high risk' have often gone on to make significant lifestyle changes, and this, coupled with medication, can make a substantial measured difference one year on.

Barriers to implementation and service improvement

- Awareness of HHC in local communities is low and a stronger advertising campaign is required to raise awareness of the HHC and the purpose of prevention generally.
- Fear of the outcomes of the testing remains a considerable deterrent for a significant number of people.
- GPs are not consistent in their use of the HHC brand in their letters to patients.
- People in communities highlighted a number of reasons for non-participation. These include
 - 'Things just happen'
 - I live in the present
 - It would shock me
 - I don't have time
 - I would have to have a problem
 - I don't want to change
 - I don't want to be told what to do
 - It would be harmful to me
 - I feel fit
 - There is no point.

These issues should be addressed within either the social marketing strategy or an Awareness Campaign.

Shape of future commissioning to support roll out

- Re-establish the social marketing campaign.
- More work needs to be done in ensuring local people understand the purposes of prevention and what this programme will offer and why. Some of the successful one year on vignettes used in this report could be used to persuade some doubters that the HHC is a good idea.

APPENDIX G

An evaluation of the implementation of the Tees Valley cardiovascular assessment programme

Quantitative aspects of the evaluation

Acknowledgements

The team would like to thank Tees Primary Care Informatics and the Strategic Intelligence Directorate for making available data from TVAP and for their assistance in providing background information and analysis used in this report

Table of Contents

Introduction.....	G5
Scope of Report.....	G5
Practice based data – the geographical and health implications.....	G5
Assessments carried out outside general practice: the fate of data.....	G6
Practice aspirations and actual assessment performance.....	G7
What number of HHC assessments should a practice carry out in each year? – The ‘aspiration predictor’.....	G9
Recommendations.....	G13

Table of Figures

Table 1: Community assessments recorded in community & practice data April – June 2010.....	G7
Table 2: People assessed from April - June 2010 with Body Mass Index (BMI) >30 who were referred to weight management services.....	G9
Table 3: Provisional calculation for annual assessment activity in A single large practice.....	G11

Introduction

Throughout the development of TVAP from late 2008, large amounts of data have accumulated, been analysed and stored with the Tees PCTs. This data has been fed back to practices and scrutinised in the TVAP Operational Group. As time has passed, the quality of the data received has increased and improved, and so has the sophistication and depth of the analysis carried out within the PCT. Datasets being worked on now are different from those in earlier phases, and TVAP itself has developed and evolved. As a result, earlier interpretations of the data have become outdated and this report will rely only on the most recent data, that supplied by Tees Primary Care Informatics (TPCI) for the fourth quarter of the financial year 2009/10 (January to March 2010) and the first quarter of the financial year 2010/11 (April to June 2010).

Scope of this report

Much analysis has been carried out within the PCT itself. Each quarter figures are presented to the TVAP Operational Group including, for example, total assessments carried out, risk profile of those assessed, number of people declining an assessment, new diagnoses of diabetes and high blood pressure, prescriptions of statin medication, levels of obesity, cholesterol and smoking, and referrals to alcohol services. In the last quarter (for the first time) assessments carried out in community services, and numbers recalled from the CVD high risk register, are reported.

Every practice receives information each quarter based on its own activity, so that it may make comparisons with aggregated PCT results.

The PCTs report on TVAP assessment activity and results by electoral ward, allowing analysis of linkage to deprivation data and providing another way of considering the likely impact of TVAP on health equity.

This report will deal only with aspects which were agreed from the beginning of our evaluation programme to lie within its scope, and aspects which have been drawn to our attention by matters arising during other aspects of our study. These aspects are:

- Geographical and health implications of activity data submitted by practices
- The fate of data from assessments carried out outside practices
- General practice assessment aspirations and actual performance
- A discussion of appropriate expectations of practice annual activity.

Practice based data – the geographical and health implications

At an early stage we fed back to the PCTs that there was substantial variation in the rate of HHC assessments being carried out by individual practices, and

that this might have important implications for the imperative that TVAP should not result in an increase in health inequalities.

If it should turn out that low actual assessment activity was concentrated in practices with a registered population predominantly living in more deprived areas, this would be an early warning sign that those with worse health were receiving less information about their risk, with potential adverse consequences for their future health. Equally, if it could be shown that, despite initial variation, activity and assessments were well spread between areas of greater and lesser deprivation, this would be encouraging and an indicator that no systematic inequality was being generated. In either case, early reviews of the data would enable the PCTs to take targeted action to support practices facing challenges, and encourage those demonstrating a high level of performance.

This approach was considered helpful, and with help from the PCT Strategic Intelligence Directorate, maps were constructed showing this variation in a visual form. The information generated was referred to in NHS Health Check National Network meetings, and presented at the national United Kingdom Public Health Association Conference 2010.

With the passage of time more data has enabled the PCTs to understand better the patterns of assessment by different practices and in different areas, and has resulted in improved feedback to practices regarding their performance, and better presented ward-based data. This has led to greater confidence in relating activity data to deprivation data, and should allow greater understanding of likely future outcomes. The information has also highlighted areas where support from the CVD nurses may be most beneficial, and has begun to highlight evidence of population behaviour, for example prevalence of obesity, and the pattern of active refusal of the invitation for assessment, between more and less deprived areas. All this work is already being carried out within the PCT, and is included within the TPCI quarterly reports, providing a secure basis for future planning.

Data is still accumulating on patterns of activity between areas of greater and lesser deprivation. On a single quarter basis there are wide variations in ward data. It is not yet known whether there are systematic longer term differences between wards.

These aspects can be considered in detail should the PCTs plan further social marketing of TVAP, or the extension of assessments in community pharmacies and workplaces.

Assessments carried out outside general practice: the fate of data

Concerns have already been referred to in Appendix B, C, D & E about the handling of data from community and workplace assessments, and a possible adverse health impact on those found to be at high risk in the community. This adverse impact comes about if people who have been told that they are

at higher risk neither approach their GP nor are sent for by their practice. They are effectively 'lost' within the system.

Previously, it had been problematic to identify whether or not people having a community assessment had been recognised as having that assessment in their practice, and had had their data entered on the practice clinical systems.

In the latest set of data from TPCI, this difficulty appears to have been overcome, and each PCT and each practice is now notified about how many of their registered patients have had a community assessment according to **community** data, and how many are recognised according to **practice** data.

This is a substantial step forward, but the findings are not encouraging. Across the Tees PCTs only 22% of those known to have received a community assessment are also recorded as such in practices.

Table 1: Community assessments recorded in community & practice data April – June 2010

PCT	Vascular risk assessments recorded in the community	Community risk assessments also recorded in the practice	% of assessments recorded in practice data
Hartlepool	43	12	28%
Middlesbrough	165	41	25%
Redcar & Cleveland	125	23	18%
Stockton on Tees	226	46	20%
Total	559	122	22%

This is an important area for the PCTs to address. How has such an information gap arisen, and what prevents the use of a single dataset? It emphasises concerns raised in Appendix C that even with the new LES, practices which have a clear pathway for handling community data may not have a failsafe mechanism to ensure that community data is recognised as such in the first place. Latest quarterly figures from TPCI show that of 86 people identified as at high risk in community assessments, only 10 also appear on their practice register, and will thus have entered the TVAP management and recall system.

Practice aspirations and actual assessment performance

There continues to be considerable variation in practices' planned (aspirational) and actual performance in terms of HHC assessments carried out. Some practices have high aspirations and have exceeded them. Some have low aspirations and may or may not have reached them. Overall, the

Department of Health has the aspiration that the whole population aged 40-74 should be assessed over a five year period. Locally the PCTs have an aspiration to assess all those on the priority risk list as soon as possible, and to ensure that those found to be at high risk are registered and recalled for review every year. There are thus general targets to be achieved, but there has been no attempt to insist on practice by practice targets, nor sanctions against those with low aspirations.

Now that TVAP has been running in nearly all practices for over a year it is possible to look at overall achievement as well as individual practice activity. The results are generally reassuring.

Tees PCTs are leaders nationally in NHS HC activity. Fifteen months have elapsed since the official launch of TVAP in April 2009, or a quarter of the planned 5-year assessment cycle. Local figures to June 2010 show that 34,890 assessments have been carried out, covering 24% of the whole eligible population of 145,111 Teesside people aged (TPCI figures). This is an outstanding achievement, and is based on the participation of all Tees practices.

Comparing figures derived from the first aspirations of practice from April 2009, and given the limitations set out in Appendix C, total aspirations to April 2010 were 25,458, and total assessments with correct values carried out were 28,162. This demonstrates that despite the variations, practices in Tees overall exceeded their initial collective aspiration.

Figures from TPCI quarterly reports show that of those who have been assessed, 12,293 (35%) have proved to have a 'high risk' of a CVD event. This contrasts with the general population estimation of 11% high risk and demonstrates that the indicative list system, and the local preference to target these people first, has enabled practices to direct their attention towards those at higher risk.

This finding also shows that 65% of those being assessed are found to be not at high risk. This does not mean that those at lower risk need take no action, and people who have been assessed who would benefit from lifestyle change, whether assessed in the community or in general practice should receive appropriate advice. This may involve referral on to support teams in the community. TPCI figures show that referral for such support lags far behind those who might benefit.

Table 2: People assessed from April - June 2010 with Body Mass Index (BMI) >30 who were referred to weight management services

PCT	Number with BMI >30	Number referred to weight management services	% of obese people referred
Hartlepool	115	5	4.3%
Middlesbrough	123	4	3.3%
Redcar & Cleveland	157	1	0.7%
Stockton on Tees	220	24	11%
Total	615	34	6%

The reasons for these low rates of referral are unclear, but should be of concern to the PCTs. If sufficient resources have been set aside to increase capacity within the lifestyle support pathways, this investment seems not to be being taken up. Alternatively, if there is no additional capacity, any future increased referral to respond more effectively to population need seems likely to overwhelm the services. This is an area in which further evaluation seems likely to provide the PCTs with valuable material for planning and prediction.

By the time TVAP is coming towards the end of its five year cycle, at least 90% of all those assessed would be expected to be found to be not at high risk. Thus the task for practices and community providers is changing: it is moving away from finding those expected to be at the most severe risk to identifying those where the expectation is of lower risk. There will be an increasing emphasis on identifying those who have not yet attended for assessment. Thus the PCTs expectations of practices should gradually change through the five year cycle.

In the first year of TVAP, determining the practice aspiration could be simple, for example by stating that the practice intended to assess 100% of those on its indicative 'high risk' list. Now the programme is rolling forward, and there is a low risk population to assess, as well as the continuing annual recall of those at high risk, it is worth asking what the PCT should expect of practices and what practices will need to offer to reach the five year target. This is a critical exercise for future budgeting for TVAP.

What number of HHC assessments should a practice carry out in each year? – the 'aspiration predictor'

Assuming that the PCTs continue to operate a LES under which it is expected that anyone still unassessed on the practice's 'high risk' list will be invited for assessment in the next 12 months, and the practice intends to continue

providing population prevention through TVAP, the practice annual aspiration should consist of:

1. All unassessed individuals on the indicative list, added to
2. All individuals on the practice's CVD recall register, including all those identified as high risk in community or workplace settings, added to
3. A proportion of the practice's eligible list of people who are not expected to be at high risk, aiming to cover the whole population by April 2014, added to
4. Newly registering individuals aged 40-74, added to
5. From April 2014, a number of people at low risk who had their previous assessment five years before.

Notes:

1. *This number would be expected to fall year on year to reach a level when only those who have declined invitation would be left.*
2. *This number would be expected to rise year on year, with the rate of increase to level off to near steady state by 2014.*
3. *This number would be dependent on how active the practice had been in earlier years (ie how many people are still uninvited from the original 'eligible' list), and on the proportion of people who have not responded to earlier invitations.*
4. *This number will be unknown, but may be inferred from previous registrations. It will make sense to incorporate HHC with the new patient checks for newly registering people in the eligible age range.*
5. *The more active a practice has been in the early years of TVAP, the sooner it will have significant numbers of people in this category.*

Such a scheme for developing 'expected' aspirations could be worked on between each PCT and its practices, giving PCTs a tool to predict budgets, and the practices a tool to predict workload.

An example:

A large, active practice had carried out 1092 assessments to 30 June 2010. Of these, 478 showed an actual risk of >20%. This is 44% of all assessments, which shows that this practice is well above average in targeting the highest risk group first (Teeswide high risk rate 35%). It has 356 patients remaining on its indicative list, and 3534 other eligible patients to be screened. To cover these patients in the next four years it will need to assess 883 of these per year. There were nine patients from its list assessed in community settings during the last three months, and this would be expected to generate four high risk patients for assessment per year if community assessments remain at the same level.

The practice's declared aspiration to the PCT for 2010/11 is 710 assessments, made up of 178 from the indicative list and 532 recalls.

Note that the Action Plan only asked for these two figures, and so the PCT does not know whether the practice also intends to assess people from the other parts of the list.

Table 3: Provisional calculation for annual assessment activity in a single large example practice

Individuals remaining on 'indicative' list	356
Individuals named on the CVD 'recall register'	478
25% of people on the 'eligible' list, to cover population by 2014.....	883
High risk individuals identified in community settings.....	4
Total annual assessments to cover practice population if NHS Health Checks targets are to be achieved	1721
Practice aspiration offered in the Action Plan for 2010-11	710
Apparent shortfall in assessments, for discussion with PCT.....	1011

The practice may calculate on the basis that only 70% of those invited will attend, but this itself poses a problem especially if those known to be at high risk from the CVD register do not attend.

This example illustrates that there is work for the PCTs to do even with the most active practices, to find out whether they have the will or the capacity to increase assessments. This would help the PCT set realistic budgets if they do so intend, and to consider the implications for achieving universal coverage and equity by 2014 if they do not.

Recommendations

Good practice and levers to implementation

- The information provided by TPCI to identify individuals likely to be at high risk is helpful to practices in focusing on those most likely to experience an event.
- 24% coverage of the eligible population by June 2010 indicates Tees PCTs are currently on track to cover their eligible population within five years.
- The use of accumulating data to inform planning while the programme is still evolving is good practice and should be encouraged.
- CVD support nurses are already employed by the PCTs to work with both practice and community/workplace settings. They are a resource to encourage change where appropriate assessment activity is not occurring.

Barriers to implementation and service improvement

- The fact that workplace/community information does not match with practice information is a matter of great concern which should be urgently addressed.
- The probability that there are people identified as high risk in the community who have not been identified as such by their GP teams is a matter of great concern which should be urgently addressed.
- The low level of referral to existing services of people who would be likely to benefit from lifestyle change is not explained and should be evaluated.

Commissioning to inform roll out

- Practice systems for handling and acting on community data should be made more rigorous, and this should not wait for a further version of the LES.
- Information available from TPCI should inform any further social marketing carried out for TVAP.
- The PCTs could choose to pilot an 'aspiration predictor' system with willing practices.
- Within the context of high achievement there continue to be widespread variations in practice assessment activity. These would

need to be understood in more detail if an attempt were made to establish the cost effectiveness of TVAP.