



Public Health
England

Protecting and improving the nation's health

NHS Health Check Health Equity Audit Guidance webinar

23rd March 2017

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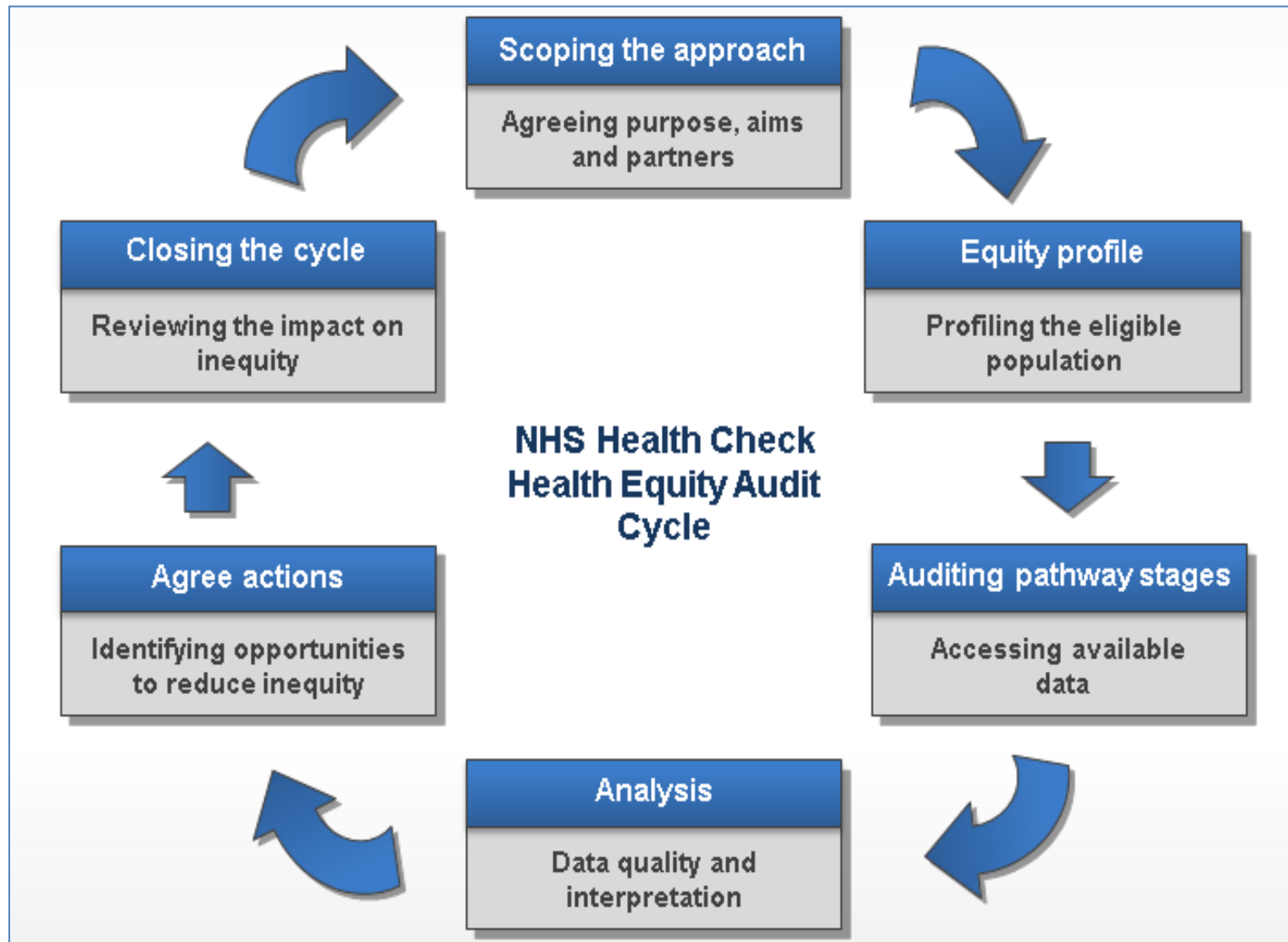
Liz Labrum, Public Health Lead, Surrey County Council

Ellen Bloomer, Public Health Registrar, Brighton & Hove City Council

Gerrard Abi-Aad, Head of Health Intelligence, Kent County Council

Melanie Earlam, Health Improvement Manager, PHE Yorks & Humber

What is a Health Equity Audit (HEA)?



Why prioritise an HEA in your area?

Emerging Evidence (ESCAP Feb 2016) *overall* reaching beyond 'worried well' **BUT do you know what's happening in your patch?**

To maximise programme impact & ensure contributing to reducing health inequalities, need to understand not only equity of *access* to checks but equity of *outcomes*.

Undertaking an HEA can provide a robust mechanism through which to generate local evidence which can be used to:

- Understand who is accessing/benefiting from checks – protected characteristics, seldom heard, greatest CVD risk
- Inform action to improve equity of access and outcomes
- Inform decisions about proportionate resource allocation
- Demonstrate compliance with 2010 Equality Act



How & why was the guidance produced?

- Request from **Local Implementer National Forum** (LINF) for a resource to help undertake comprehensive HEAs
- Produced **collaboratively** through task & finish group
- **Consultation:** x2 LINF & Strategic Partners Group (PHE/DH/NHSE formal mechanism from engaging with 3rd sector)
- Supported **pilots** (3 LAs) & unsupported pilots (4 LAs) lead to extensive revisions
- **Guidance:** supports scoping, design and process of undertaking audits PLUS extensive resources to support recommendations to address inequities identified
- **Data management, extraction & sharing:** the key to effective audits



Who was involved?

Local Implementer National Forum (LINF)	PHE Centres: South East & Yorkshire & Humber
Task & finish group: LAs (Cumbria & Surrey), PHE national CVD prevention & Health Equity Teams, PHE Centres, PHE London	National NHS Health Check (CVD Prevention Team)
Supported pilot sites: Surrey & Kent County Councils and Brighton & Hove City Council	Unsupported pilots: Warrington, Oldham, Thurrock, Blackpool
Medwyn Surgery (GP & Service Redesign Manager)	KSS NHS Health Check Network
Knowledge & intelligence: South East, West Mids & Northern & Yorkshire KITs	National Cardiovascular Intelligence Network
Strategic Partners Group	

Surrey County Council – HEA Objectives:

- Equity of access by age, gender, ethnicity or deprivation of area
- Are providers situated equitable across Surrey geographies?
- Access in Relation to Need – are NHS Health Checks being provided in areas of highest need?
- Are groups with highest CVD Risk receiving a greater proportion of NHS Health Checks?
- Pilot draft PHE HEA guidance & template

Surrey County Council – Key findings:

- Quality of activity data from GPs generally poor
- Uneven spread of commissioned providers across Surrey
- Non-GP providers appear a more equitable access point for residents
- More women and older age group receive NHS Health Checks
- In GP providers more non-deprived residents receiving NHS Health Check
- The highest proportion of NHS HS were in Asian ethnic groups followed by white and mixed ethnic groups, and lowest proportion in those of black ethnicity

Surrey County Council - Recommendations:

- Improve GP activity data
- Optimise outreach provision in areas of deprivation
- Opportunity to incentivise providers to risk stratify for CVD high risk factors



BLOOD PRESSURE (mmHg)						
	Normal SBP 120-139, or DBP 80-84	High-normal SBP 130-139, or DBP 85-89	Grade 1 SBP 140-159, or DBP 90-99	Grade 2 SBP 160-179, or DBP 100-109	Grade 3 SBP ≥180 DBP ≥110	
No other risk factors	2.9 14.3	- 28.0	1.8 26.8	8.3 37.5	- 42.9	2.7 26.5
1-2 risk factors	41.3 59.8	33.0 58.3	32.3 57.3	40.7 62.8	40.7 55.9	36.2 58.8
3 or more risk factors, target organ damage, metabolic syndrome or diabetes	56.3 78.9	67.0 75.2	67.4 79.4	69.2 84.9	69.3 84.3	66.9 80.9
Associated clinical conditions	40.0 51.1	53.3 73.3	59.5 74.1	67.6 81.1	69.0 76.2	58.8 72.7
	39.9 57.7	46.3 64.7	48.4 66.5	57.1 75.0	60.0 74.5	50.2 67.8

■ Low added risk
 ■ Moderate added risk
 ■ High added risk
 ■ Very high added risk

GP practice

Community
health

Mental
health

Out of
hours

Acute
hospital

Public
health

Adult social
care

~~Ambulance
service~~

Hospice

KID minimum dataset: data on activity, cost, service/treatment received, staffing, commissioning and providing organisation, patient diagnosis, demographics and location.

{ Datasets linked on a common patient identifier
(NHS number) and pseudonymised }

And Patient
Master Index

KENT INTEGRATED DATASET

Kent County Council Public Health and HISBI data
warehouse

Arrangements are in progress to link to data covering other services, including:

Health and social care services: Children's social care, child and adolescent mental health, improving access to psychological therapies, and non-SUS-reported acute care.

Non-health and social care services: District council, HM Prisons, Fire and Rescue, Probation, and Education.

Extraction parameters

Extract period 01 April 2015 to November 2016

Invites: '9mC1'

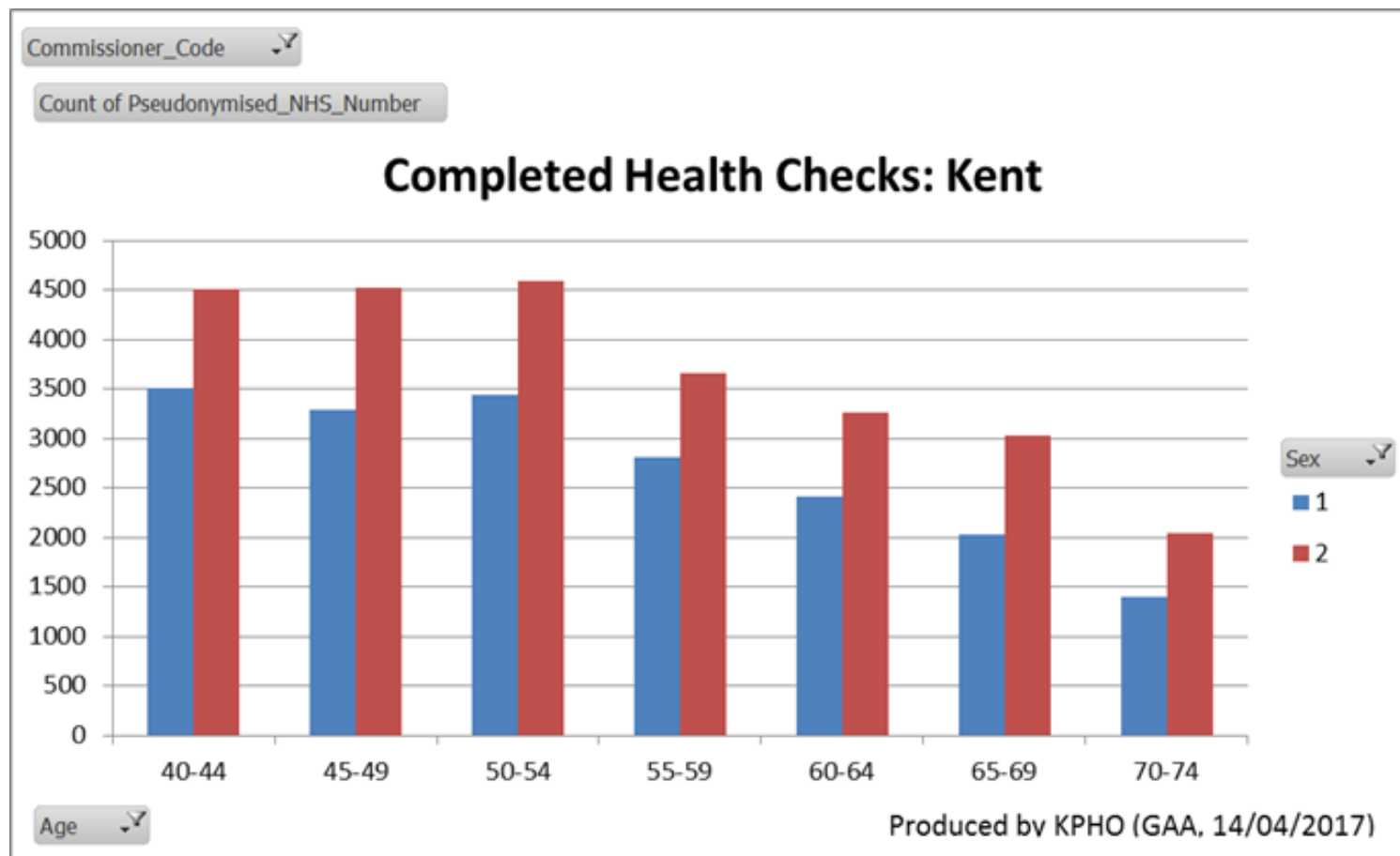
NHS Health Check Completed: '8BAg' and '8BAg0' (third party provider)

Exclusions: duplicate Pseudonymised number, NULL Pseudonymised number,

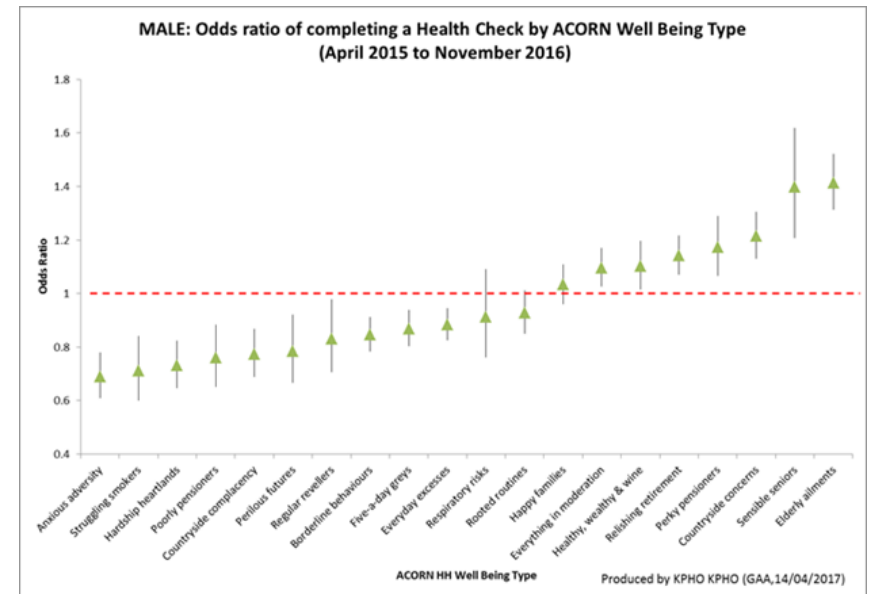
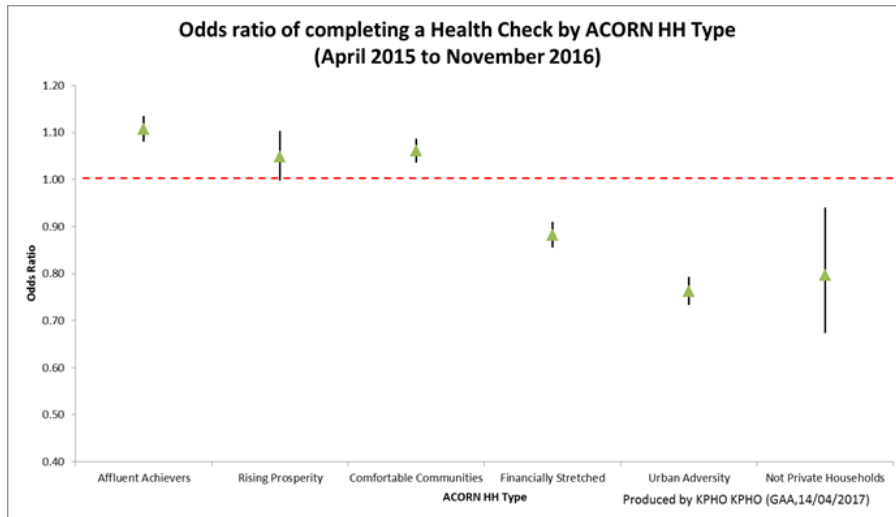
Total Invites: 105,453

Total Health Checks: 44,542 (42.2%)

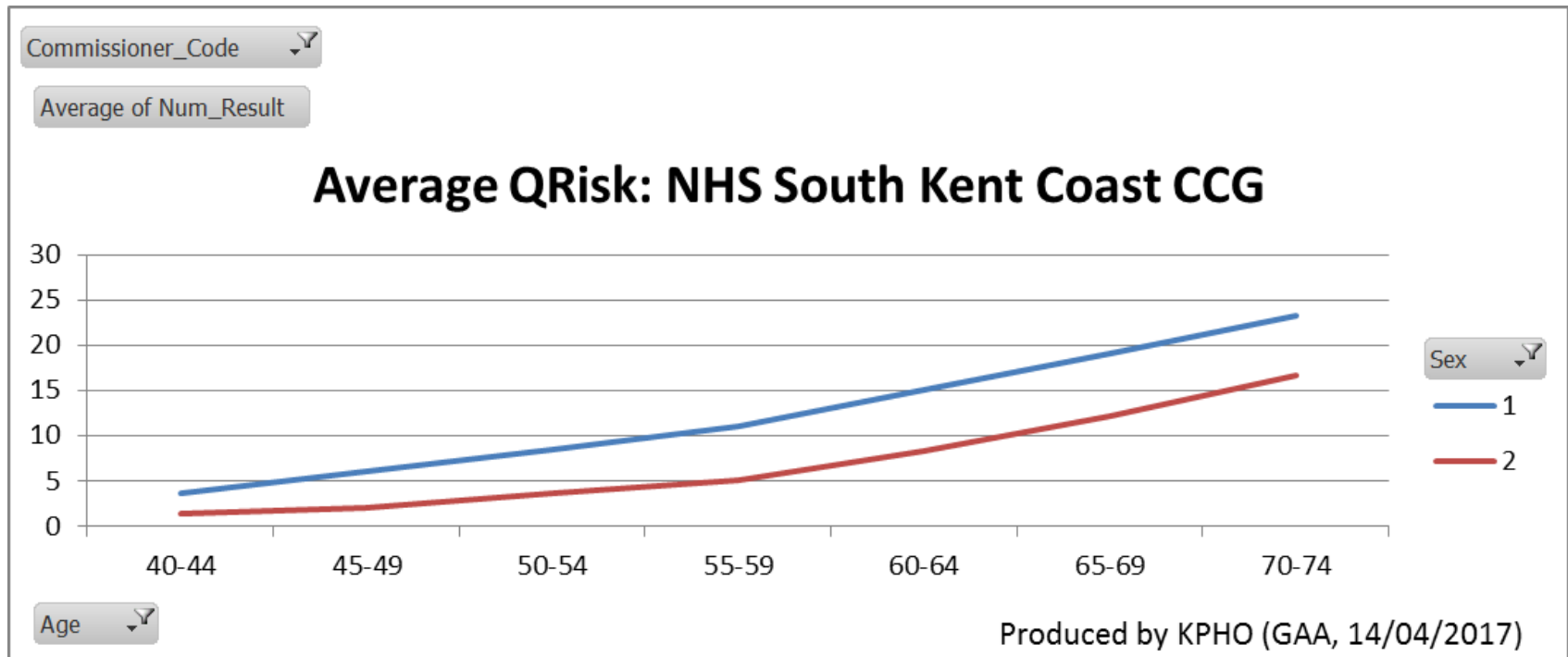
Sample results



Odds ratio of completing a health check k ACORN



Qrisk by gender



Conclusions

Person level linked analyses can provide deep insights when considering equity

Data extraction can be complex and there are significant data quality issues

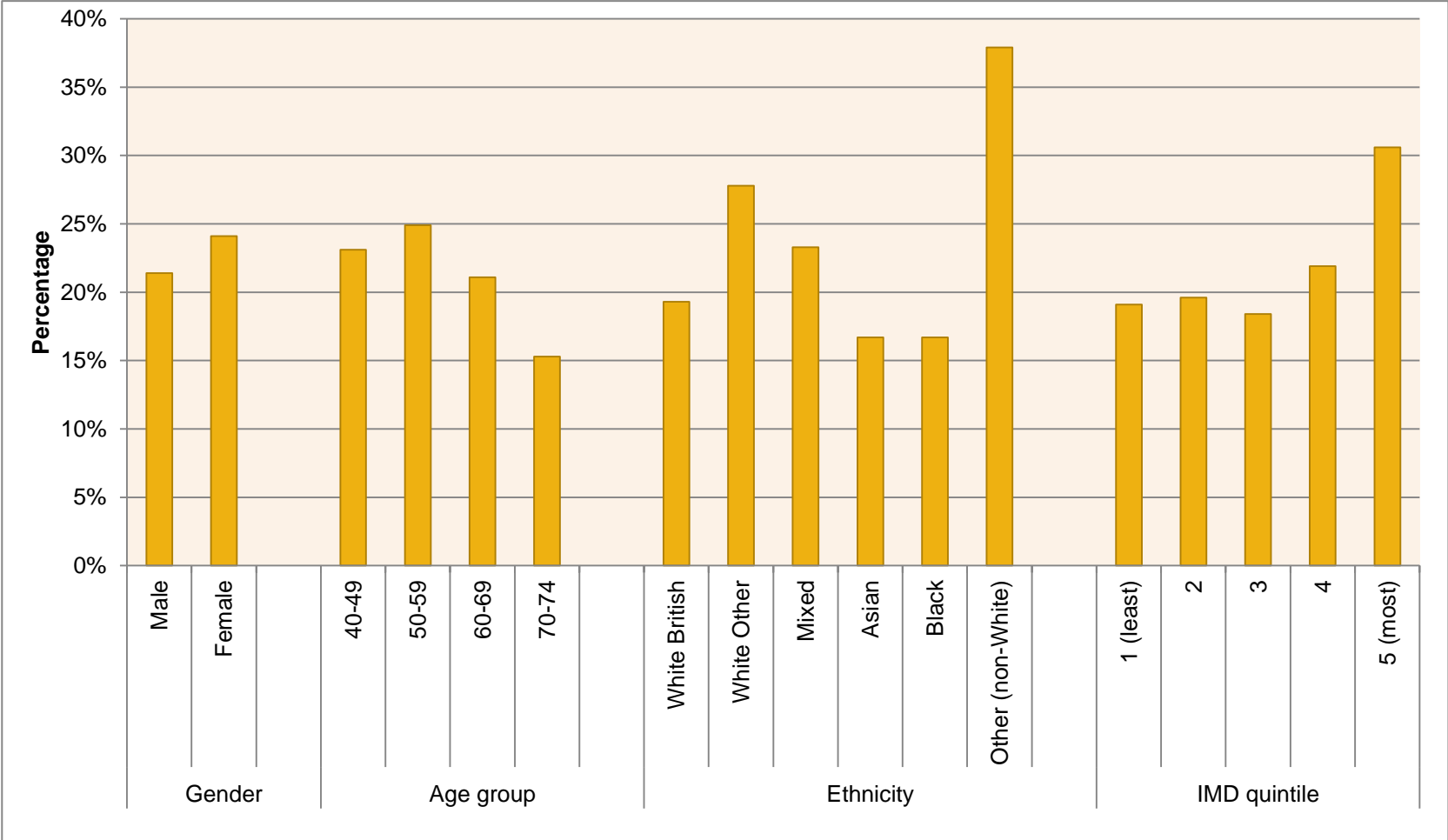
Tracking outcomes (even with linked data) are likely to be complex

Brighton & Hove City Council

- Variation in CVD mortality and hospital admissions
- Action has been taken to target NHS Health Checks at more deprived populations
- Key findings:
 - **Performance:** only 28% of target invitations sent, but 84% take-up; number of referrals to lifestyle services v low
 - **Gender:** more checks delivered to women
 - **Age group:** more checks delivered to younger groups
 - **Ethnicity:** suggestive that more checks should be delivered to Asian & Black ethnic groups (small numbers/missing data)
 - **Deprivation:** 48% checks delivered to 40% most deprived

Brighton & Hove City Council

Proportion of the eligible population receiving an NHS Health Check, by gender, age group, ethnicity and IMD quintile, B&H 2015/16



Brighton & Hove City Council

- How do you envisage using them?
 - Cluster specific data to be produced
 - Further research
 - Stakeholder meeting to develop recommendations
- Key challenges:
 - Data collection: accuracy, completeness
 - Lack of disaggregated data on invitations and referrals
 - Estimating the baseline eligible population
- What insights/learning/opportunities?
 - Understand your data
 - Ideally collect data on equity of outcomes (referrals)

Summary of key messages

- Use process to **generate discussion** & support **review of provision**, to maximise opportunities to improve equity
- Process can also be used to **engage primary care** – an in-depth understanding of **impact on outcomes** can help reposition programme to emphasis it's contribution as an **enabler** of action at scale to prevent CVD
- Be **ambitious** in your aims/scoping – if not got all data required, use process to make **recommendations** to improve future audits (e.g. **outcomes tracking?**)
- Identifying limitations in systems for recording, extracting, managing & sharing data is a **core part of the process** e.g. is data adequate to go beyond access to understand in equity of outcomes?

- ***Local IT systems essential*** – without them:
 - can't know what you are commissioning or what impact it's having
 - data won't be available for national extraction or future research
- ***Pragmatism***: doing what's possible/practical is better than doing nothing!
 - where data limits scope, work with analysts/primary care to make the most of what you've got (e.g. manual sampling of activity data)
 - where previous analysis indicates a need to focus on specific pathway stages, prompts & questions within each section may support a more focused approach
- ***'Developing recommendations' appendix*** – a useful resource in it's own right for developing ideas for improvements across the pathway

We hope that the HEA process is used to identify & close inequity gaps, by providing a robust approach to generating local evidence and insight to inform proportionate allocation and use of resources to improve outcomes of the NHS Health Check programme.