The NHS Health Check Practice Based Point (POCT Pilot)

The NHS Health Check is a population wide prevention programme aimed at reducing the impact of vascular disease on health. This article provides a local perspective and focuses on the implementation of a Point of Care Testing (POCT) pilot in primary care, identifying benefits, challenges and improvements. Findings suggest that utilising POCT in primary care has the potential to address population health and reduce inequalities.

by Sue Collins

Phased implementation of the NHS Health Check in England began in April 2009, with NHS Primary Care Trusts (PCTs) encouraged to offer preventative checks to people aged 40 to 74 years without established vascular disease [1]. The aim is to identify individuals at risk of developing heart disease, stroke, diabetes or chronic kidney disease, providing early intervention, treatment and management. The health check may take place over one or multiple appointments and consists of:

- simple questions and measurements such as blood pressure and random blood test for cholesterol
- specific thresholds to trigger additional investigation/tests and
- assessment, communication of risk, tailored advice, appropriate treatment and referrals to support services.

Evidence

The Department of Health identifies that this strategy is both clinical and cost effective; nationally the NHS Health Check programme could:

- prevent 1,600 heart attacks and strokes;
- save up to 650 lives per year;
- prevent 4,000 people from developing diabetes and
- detect at least 20,000 cases of diabetes or kidney disease earlier each year.

Local service

Situated in the North East of England, South of Tyne and Wear (SoTW) includes Gateshead, South Tyneside and Sunderland. We have a total population of approximately 630,000 and around 232,000 people eligible for an NHS Health Check.

In 2009 the main provider of the NHS SoTW vascular risk assessment local enhancement service (LES) were general practitioners (GPs), with 91% (n=105) signing up to deliver the service; however data indicated wide variations between practices. In order to provide checks for unregistered populations and those people finding it difficult to access the service selected pharmacies, a nurse lead Community Delivery Team and Occupational Health were provided with equipment procured by Health Diagnostics to conduct point of care testing (POCT) checks in the community. The kit comprised the Health Options’ instant computerised, one-off POCT analysis, associated consumables, quality testing services and training for community providers.

EXPLAIN Market Research was commissioned to undertake social marketing work to inform the development of the programme. Findings provided insights into barriers to engagement, branding and motivational messages, and market segmentation. The target audience could be classified into three main groups, termed “Proactive”, “Denialists” and “Rejectors” to reflect variations found according to attitudes towards health and lifestyles [Figure 1].

Quality improvement work

The North East Transformation System (NETS) is a model adopted by NHS North East to encourage local organisational quality improvement, incorporating tools and activities from the Virginia Mason Production System (VMPs).

A huge amount of work was undertaken to align the SoTW service to the NHS Health Check best practice guidance [1]. A Rapid Process Improvement Workshop (RPIW) was used to standardise the process, explore ways of maximising uptake and put the patient at the heart of the programme.

Five days of intensive interactive group work allowed practitioners to put aside boundaries and work together to identify problems and practical solutions to redesign the service. Teams generated ideas for improvement and implemented changes immediately, developing testing and re-testing products during the process.

Figure 1. Target audience market segmentation.
Outcomes of the RPIWW

Remarkable progress was made during the five days with the following results:

- Standardised:
  - scUrine (GP and community providers)
  - Data collection and audit process
  - Programme resources
  - Training plan developed
  - POCT a new approach for practices to deliver the check.

Reasons for pilot POCT

Locally the service was delivered over two or three appointments, with all practices taking venous blood samples and sent a full batch of tests from the hospital labs. It became evident that a whole step in the process could be removed if POCT for cholesterol was adopted (Figure 2).

The aim was to pilot POCT in a GP setting to test the feasibility of offering NISE Health Check In a single appointment. Patients would receive instant feedback and results, the time for both patient and staff and improving the patient experience.

A business case was developed with input from GPs, pharmacists, practice nurses, commissioners and the local hospital pathology lead, implementation was agreed by the SoTW CCG strategy group.

Implementation

The proposal was to undertake a 12-month POCT pilot across SoTW with 15 practices who were currently delivering checks. NISE SoTW POCT would provide practices with the same testing equipment as community providers. A communication plan was devised to cascade the information to practices, including the NISE Health Check newsletter, e-mail, group presentations and visits to practices.

Initially GP and practice manager engagement was mixed, some were very enthusiastic and others not interested. Barriers were related not being signed up to the ULS and uncertainty of the accuracy of a fingerstic sample and ULS unit. Other issues included the perception of the need for multiple blood tests, and staff having to record audit data manually due to a lack of read codes.

Activitites to stimulate interest and overcome  barriers included:

- Linking to Quality and Outcomes Framework indicators
- Best practice guidance [13] and POCT buyers guide [14]
- Involved staff in developing quality standards
- Standard operating procedure
- Accredited External Quality Assurance Scheme and Internal Quality Control
- POCT training provided by a certified trainer;
- Working with staff to produce a simple data collection grid to record outcome measures.

Due to the high level of interest generated, the pilot was implemented in a staged approach, phase 1 involved a rolling programme of 18 practices, and phase 2 recruited an additional 19 practices.

Impact of pilot and key outcomes

The impact of the POCT is demonstrated by analysis of practice data, the following a summary from the annual evaluation:

- 3 617 health checks completed
- Risk classification:
  - 27% (n=970) identified as high risk
  - 34% (n=1,235) moderate risk, and
  - 39% (n=1,381) low risk
- 70% (n=2,526) of patients experienced the NISE Health Check in one appointment

Staff feedback was positive and provided valuable learning. Table 6 presents a summary of staff feedback. A total of 1 420 patient questionnaires were received with a 47% response rate, of which 54% were female and 46% males.

Productivity was much improved:

(a) 70% of patient questionnaires were received with a 50% response rate, of which 54% were female and 46% males.

(b) 70% of the responses were received within 24 hours.

(c) 80% of the responses were received within 48 hours.

(d) 80% of the responses were received within 72 hours.

(e) 80% of the responses were received within 1 week.

(f) 80% of the responses were received within 2 weeks.

(g) 80% of the responses were received within 4 weeks.

The response rate was much improved and the time for both patient and staff improved.

Table 6. Summary of staff feedback

<table>
<thead>
<tr>
<th>Outcomes of the POCT</th>
<th>Phase 1</th>
<th>Phase 2</th>
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<tbody>
<tr>
<td>Staff feedback</td>
<td>3 617</td>
<td>70%</td>
</tr>
<tr>
<td>Risk classification</td>
<td>27%</td>
<td>34%</td>
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<tr>
<td>Moderate risk</td>
<td>39%</td>
<td>39%</td>
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<tr>
<td>Low risk</td>
<td>70%</td>
<td>70%</td>
</tr>
<tr>
<td>Patient satisfaction</td>
<td>70%</td>
<td>70%</td>
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Benefits of POCT are depicted in Figure 3. It was felt that on the spot results and advice were key elements in improving the patient experience.

Challenges

Figure 4 illustrates the four difficulties identified from the pilot including the perceived narrow scope of the blood tests, difficulty obtaining a blood sample, equipment fails, and that quality checks of the units are time consuming.

Improvements

The new parameters used in the equipment did not identify any need for improvements. Those who did comment focused on two key areas: problems associated with collecting blood samples and the perception that additional blood tests are required. However, the main barrier identified was the perception that POCT does not allow for a holistic patient check to be completed. Comments included:

- "We do the more 'highly' whole patient care.
- "We prefer to carry out a full check.
- "It doesn't give you the bigger picture - liver function tests and U1 and U2 and full blood count and full blood glucose",
- "We do full blood counts, glucose, lipids, liver and thyroid as well.

Cost

A crude estimate of costs was calculated using the Dr Sheen Gordon 2009 model to identify potential savings. Using timing obtained from the RPIWW, the findings suggest a 16% reduction in cost for those patients experiencing the NISE Health Check in one appointment, a breakdown of costs is presented in Table 2.

Current state

Full roll-out across primary care commenced in January 2013, to date we have 73 (58%) of practices using POCT to deliver NISE Health Checks.

POCT has been a tool to support practices to start delivering the NHS Health Check and to address variation within primary care. Particularly within Sunderland, POCT has been the hook to get practices to start delivering the check and in 100% sign up to the LEX for the first time.

Future

In April 2013, the responsibility for commissioning the NHS Health Check service will shift to South Tyneside Local Authority as part of their new public health duties. Department of Health targets for 2012-2013 are 20% of the eligible population offered an NHS Health Check and 10% of those offered receiving a check.

There are two new additions to the NHS Health Check programme from April 2013. These are in addition to the existing assessment and people aged 65 to 74 years to be given information to raise awareness of dementia and upcoming referrals.

Conclusion

POCT in primary care has the potential to increase the feasibility, acceptability and accessibility of the NHS Health Check, reducing the need for multiple visits or repeat appointments. This flexibility has the potential to reduce inequalities and increase the number of checks delivered.

As a mandatory service, the NISE Health Check will assist South Tyneside LA in reaching its strategic priority of having healthier people. It also provides an opportunity to improve outcomes in other public health programmes related to lifestyle issues, and prevention and early identification of risk across the life span.

References

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