

## **CVD Health Checks: Are you ready?**

*Ruth Westerby, Education For Health*

**Set up to help prevent and manage growth of key diseases in the UK, Health Checks benefit from a multidisciplinary approach. Ruth Westerby, Clinical Lead CVD Risk & Stroke, explains the key issues Health Professionals need to appreciate for best practice in order to maximise the potential of the scheme.**

### **Health Checks: What are they?**

'Health Check' is the descriptor adopted by the Department of Health (DH) as a result of work undertaken by the Central Office of Information (2009). It describes the process of an individual being checked in terms of their risk of developing vascular disease; heart attack, stroke, chronic kidney disease and diabetes (Department of Health (DH) 2008). Results are provided as a 'score', indicating the risk of an individual having a cardiovascular event over the next 10 years.

A Health Check is available to all adults aged between 40 and 74 years who do not have an existing diagnosed vascular disease – approximately 15 million people in England. Based on an uptake of around 75% of those invited, the benefit proposed per year are;

- to save 650 lives
- to prevent 1,600 heart attacks and strokes
- to prevent 4,000 people developing diabetes
- earlier identification of 20,000 new cases of diabetes (DH 2010).

Similar work is being undertaken in Scotland via the Keep Well and Well North public health initiatives, with Wales set to follow suit very shortly.

### **Model of success**

The success of the program is dependent upon the ability of Primary Care Trusts (PCTs) to work with their providers to plan and implement the provision of Health Checks in such a way as to reach those who are eligible and most likely to benefit. Reaching those most at risk is only the beginning of the journey. Once a risk assessment has been completed, both the effective communication of that risk and the adherence to a programme of risk reduction are as important in achieving the desired end result.

The model suggested for Health Checks to reach those who are eligible, is for a variety of people in a variety of settings to work together (see Figure 1). This must be underpinned by acknowledgement and understanding of different types of clinical and non-clinical expertise that will support the individual from assessment through to the management of risk. A second model of the detail of the process of vascular risk assessment provides a helpful diagrammatic overview with articulation of the main stages; risk assessment, communication of risk and management of risk (see Figure 2).

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Figure 1: The Proposed Approach to Vascular Checks (DH 2008)

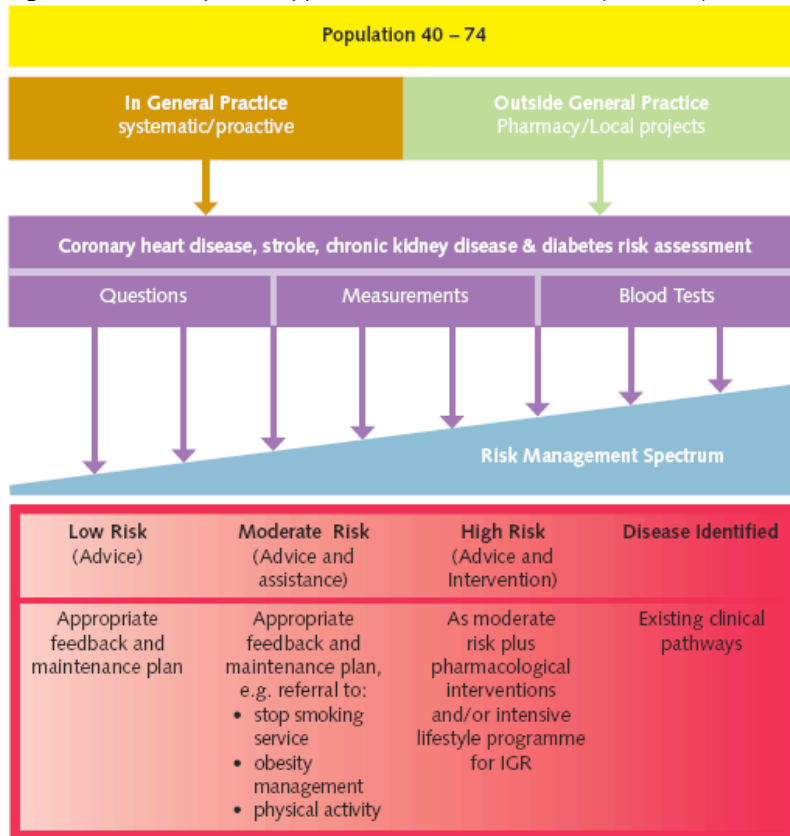
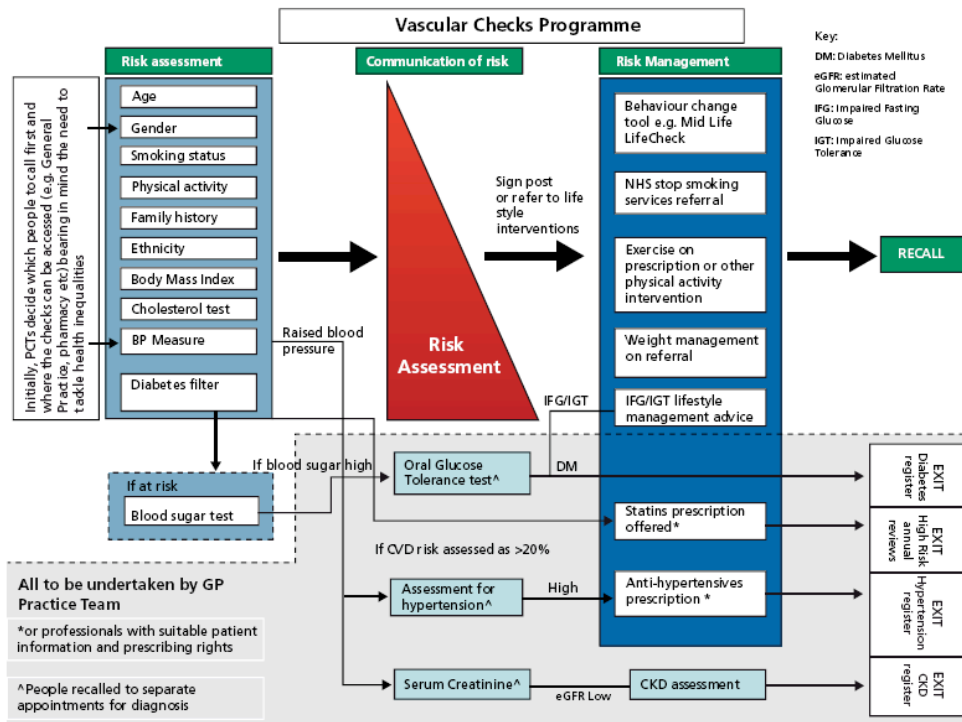


Figure 2: A diagrammatic overview of the detail of the process of vascular risk assessment (DH 2009)



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## Where to start?

A key question to ask when preparing to undertake Health Checks is about *the demographics of the local population*. Cardiovascular disease (CVD) kills 1 in 4 people in the UK but the distribution of death from CVD is not even, particularly that of premature death. It would seem logical to establish who and where those most at risk are, and to start the process in a targeted fashion.

## Who is most at risk?

Risk factors for vascular disease are traditionally described as modifiable or non modifiable where modifiable risk factors are those that can be changed either through change in behaviour or via treatment (see table 1). Patterns of behaviour and demographics of an area are observable.

Table 1: Examples of modifiable and non modifiable risk factors

Modifiable risk factors	Non modifiable risk factors
Obesity, physical inactivity, smoking, high blood pressure, high levels of cholesterol & dyslipidaemia, impaired glucose regulation	Gender, ethnicity, family history

Data in each public health department will help you determine who is most at risk. There is also evidence that people who are disadvantaged are more at risk of CVD and have higher levels of premature death (see table 2, NICE 2008a). The National Institute for Health and Clinical Excellence (NICE 2010) and Quality Care Commission (2009) both write extensively and persuasively about the need to engage people in their own assessment of risk, assessing levels of knowledge, cultural perceptions and beliefs, and using their cultural context to plan and deliver services in order to improve uptake.

Table 2: Definitions of disadvantage (NICE 2008a)

<ul style="list-style-type: none"><li>• Adults who are disadvantaged include (but are not limited to) those:<ul style="list-style-type: none"><li>- on low income or benefits (or who are members of a low-income family)</li><li>- living in public or social housing</li><li>- with a mental health problem or learning disability</li><li>- institutionalised (including in custodial sentence) or homeless</li><li>- some members of black and minority ethnic groups</li></ul></li><li>• Local agencies (such as local authorities and PCTs) define disadvantaged areas in a variety of ways. For example, the Index of Multiple Deprivation 2007 (Social Disadvantage Research Centre 2007) combines indicators on economic, social and housing issues to produce a single deprivation score</li><li>• According to NICE guidance, someone with a 20% or higher risk of a first cardiovascular event in the next 10 years is deemed at high risk of CVD (NICE 2008b)</li></ul>
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### Engaging with a population at risk

An examination of your practice data will help you prioritise your list when inviting people into general practice. Making contact with providers outside your practice will help establish working relationships and protocols so that they can confidently refer people where clinical input and/or prescription are necessary. Understanding the choices available in your area for people who need support is important; building a relationship with these services will increase awareness of the Health Check and may increase uptake within the surgery. Wherever you are working you will need to make time to agree referral routes and protocol as well as procedures for sharing and consenting to share information safely.

### Assessing risk or 'getting a score'?

The NICE guidelines (2008 – revised 2010) indicated a number of risk calculation methods for generating a risk 'score'. Whichever you select, ensure all those undertaking Health Checks agree both on *how to use the methods in practice* and the *actions based on the results*.

This means that;

- people whose risk is determined as being high, medium or low will receive *consistent messages and advice* wherever their risk assessment is undertaken.
- when an overall score is 'medium' or 'low', *important risk factors are not ignored*; for example it is possible to achieve a medium or low score but still have an abnormal cholesterol profile, or raised blood pressure that might benefit from clinical review.

### Communicating and managing risk

Once the measurement of CVD risk has been undertaken, the next stage is to communicate and manage that risk. The National Screening Committee (2008) suggests a two-way process of communication, allowing for the individual's perceptions and beliefs to be explored and understood and for action planning to be underpinned with appropriate information.

This is another action point for those about to undertake Health Checks; *do you have an appropriate range of information, and have you thought about how you can share the information about CVD risk in an understandable and personalised way?* Some risk assessment tools include visual displays colour-coded for ease of understanding the 'what-if?' scenarios attached to taking medication or changing a health-related behaviour.

Behaviour change should not be left to chance. Resources and models used should be made explicit, so that evaluation about their success can be made. The challenges of behaviour change can be reduced if those providing supportive services work with the target population (NICE 2007 & 2010).

### The competency framework

This can be used to prepare yourself or a team to undertake Health Checks (Skills for Health 2008). It permits you to ascertain the *skills and knowledge*

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you already have as well as *those you still require* to contribute to undertaking Health Checks. It also provides *performance criteria* against which an individual or team can be measured.

The competences are available via [www.skillsforhealth.org](http://www.skillsforhealth.org) and include;

- CVD EF3: Assessing individuals at risk of developing CVD
- CVD ED2: Provide information and advice on reducing risk of CVD
- CHS 131: Obtain and test capillary blood samples
- CHS 132: Obtain venous blood samples
- CHS 19: Undertake physiological measurement
- CM A7: Prescribe medication for individuals with a long term condition

### Conclusion

The key elements for successful Health Checks are;

- Careful planning
- Systematic identification of those at increased risk
- Coordinated multidisciplinary delivery of preventative measures, both pharmacological and behavioural (Segrott 2009).

### References

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