

CHOLESTEROL AND A HEALTHIER NATION: SHARED RESPONSIBILITY FOR BETTER PUBLIC HEALTH



HEART UK
THE CHOLESTEROL CHARITY

HEART UK is the nation's cholesterol charity and aims to prevent premature deaths caused by high cholesterol and cardiovascular disease. The charity works to raise awareness of the risks of high cholesterol, campaigns for better detection of those at risk, develops and provides materials and a telephone advice line for the public, and supports health professional training.

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Foreword

Rt Hon Kevin Barron MP, Former Chair of the Health Select Committee

“We have an opportunity to keep improving the nation’s heart health. It is an opportunity we cannot afford to miss.”



We all now accept that, as a nation, most of us are eating, drinking, and smoking too much, and exercising too little. Heart disease is still the country’s number one killer, and all these behaviours contribute to its place at the top.

Sadly, heart disease is often a disease without symptoms – until it’s too late, that is. Without obvious symptoms of ill health, it’s easy for someone to think that there is nothing wrong, and that there’s no need for them to change their lifestyle. For example, a raised cholesterol level, the single biggest risk factor for heart disease, has no outward signs except in the most severe cases, yet most people in this country have above recommended levels.

This excellent report by HEART UK, the Cholesterol Charity, is an important reminder to all involved in the NHS and policy making to keep heart disease as a number one priority. It is also a wake-up call for the new NHS Health Checks programme – a great initiative to help early diagnosis and prevention of cardiovascular disease – despite clear instructions from both the current and the previous government, at least nine PCTs have failed to offer a single health check since roll-out of the programme began in 2009.

This report also identifies other areas where improvements can be made to help the NHS keep pace with the fast changing advances in clinical knowledge on cholesterol, and shares good examples of local public health initiatives that are making a difference to people’s lives.

Over the past decade, the NHS has made huge advances in the treatment of heart disease. But the growing problems of unhealthy lifestyles mean efforts must be redoubled to help people identify the condition earlier, manage it better, and where possible prevent it developing altogether. And the responsibility rests with all of us, not just the NHS.

We have an opportunity to keep improving the nation’s heart health. It is an opportunity we cannot afford to miss. I welcome this report and urge all who read it to heed its recommendations and support HEART UK’s important work.

**Rt Hon Kevin Barron MP,
Former Chair, Health Select Committee**



Chapter 1

CVD: The number one health priority



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Despite major improvements in the management and treatment of cardiovascular disease (CVD) over the last 10 years, heart disease remains the number one killer in the UK¹.

The most recent data from 2008 show that 191,000 people died from heart and circulatory diseases, including 88,000 deaths attributed to coronary heart disease (CHD). Of these, 50,000 people died prematurely (under the age of 75) as a result of CVD, accounting for more than one in four deaths in men and one in five deaths in women². 30% of all premature deaths in 2008 in Europe were caused by CVD³. 21% of all male deaths and 22% of all female deaths in Europe were caused by CHD⁴.

For people already living with some form of CVD, and in particular those who have already suffered an event such as a heart attack or stroke, their chances of suffering a further event increase significantly. Of the 250,000 people in the UK admitted to hospital every year with a heart attack or unstable angina, around 30% will have another heart attack, be re-admitted to hospital for a second time, or will die

within six months⁵. The costs of continued care increase with readmission and rehabilitation, which is reflected in rising fiscal pressures.

Despite these figures, public awareness and understanding of the dangers of heart disease appears to remain at a low level.

In a recent survey of 1,034 people conducted by ICM and funded by MSD, more than two thirds (69%) of those questioned were not worried about their heart health despite the fact that 14% of these individuals knew that they had high cholesterol, 19% knew they had high blood pressure, and 5% had an established heart condition. Two thirds of those questioned (66%) were more motivated to exercise to improve their physical appearance rather than improve their heart health⁶.

Heart disease in numbers

- Globally, an estimated **17.3 million** people died from CVD in 2008, accounting for **30%** of all deaths⁷
- In Europe **23%** of the population was affected by CVD in 2008⁸
- In the UK, **191,000** people died from heart and circulatory diseases in 2008⁹
- There are approximately **124,000** heart attacks¹⁰ and **150,000** strokes in the UK every year¹¹
- The cost of CVD to the UK economy is in the region of **£30 billion** a year¹²
- Approximately **six in every ten** adults in England have high cholesterol¹³

- Around **one in three** adults in England and Scotland has high blood pressure; just over half are receiving treatment¹⁴
- In England in 2008, **266 million** prescriptions were issued to help treat CVD¹⁵

The cholesterol factor

One of the most significant risk factors for heart disease is raised cholesterol. NICE guidance recommends that healthy adults should aim for a total cholesterol of 5 mmol/L or less¹⁶. Six out of ten adults in England have cholesterol levels at or above 5mmol/L¹⁷.

The table below explains the difference between the recommendations for total cholesterol, low-density lipoprotein (LDL) and high-density lipoprotein (HDL) levels for healthy adults and high risk adults. High risk adults include those with existing heart disease, high blood pressure, diabetes or with a family history of early heart disease.

LDL 'bad' cholesterol carries cholesterol from the liver, through the bloodstream, to where it is needed. HDL 'good' cholesterol returns cholesterol that is not needed, from the cells and the bloodstream to the liver for recycling, removing excess cholesterol from the bloodstream. This helps prevent cholesterol from being deposited in the arteries where it can lead to atherosclerosis.

	Recommendations for Healthy Adults	Recommendations for High Risk Adults
Total cholesterol	5 mmol/l or less	4 mmol/l or less
LDL cholesterol	3 mmol/l or less	2 mmol/l or less
HDL cholesterol	Men – above 1.0 mmol/l Women – above 1.2 mmol/l	

The term cardiovascular disease encapsulates diseases of the heart and blood vessels. The two main types of CVD are coronary heart disease (CHD) and stroke, but CVD also includes congenital heart disease and other diseases of the heart and blood vessels.



For many people raised cholesterol is relatively easy to manage once diagnosed. For a proportion of the population (around 1 in 500 people¹⁸), high cholesterol can be as a result of the inheritance of the condition Familial Hypercholesterolemia (FH). In these cases, it is important that patients are diagnosed with the condition as early as possible, and that family members are also tested. Cholesterol lowering drugs that can significantly lower cholesterol are required for people with inherited high cholesterol to make sure that their levels are reduced as much as possible.

For non-inherited high cholesterol, some individuals may require medicines prescribed by their doctor, but for others, adopting a healthier lifestyle, increasing their exercise and improving their diet, can naturally reduce cholesterol levels. For example, this can be achieved by reducing the consumption of foods that are high in saturated fat such as fatty meats, pastries, cream and cheese. In addition, there are a number of food products such as soya, nuts and oats, as well as those containing plant stanols or sterols, which are readily available in supermarkets and which can help lower a person's cholesterol when used in conjunction with a healthier lifestyle.

A number of other lifestyle choices can significantly impact on an individual's risk of developing heart disease. In England, about 21% of adults smoke¹⁹, whilst across Britain two-thirds of adults do not consume the recommended five portions of fruit and vegetables a day²⁰. Amongst younger people aged five to fifteen, this figure increases to four out of five²¹.

More than a third of men and nearly a third of women exceed the government recommended level of alcohol intake on a regular basis²².

These findings are not new and compound what has long been recognised. However, progress in tackling these problems remains slow and patchy.

There have been a number of initiatives aimed at raising awareness of the dangers of poor lifestyle choices and the measures that can be taken by the general public to make healthier choices. A critical challenge facing healthcare professionals and policymakers is the delivery of suitable information, advice and messages.

The risk factors for heart disease

As well as raised cholesterol levels, patients are at risk of developing heart disease if they have one or more of the following clinical risk factors:

- Previous history of heart attack or stroke
- Type one or two diabetes
- High blood pressure
- A family history of heart disease, including forms of inherited high cholesterol
- Erectile dysfunction
- Inflammatory conditions that include psoriasis, rheumatoid arthritis and ankylosing spondylitis

Ethnic origin also plays a role in determining risk. People from South Asia or of African-Caribbean descent have been found to be at higher risk of developing heart disease than the rest of the population.

In addition, there are a series of lifestyle factors that can impact on the risk of developing heart disease, including:

- Age over 50 years
- Poor physical fitness and generally inactive
- Being overweight
- A poor and unbalanced diet
- Smoking
- Increased levels of personal stress

NHS Health Checks

In 2007, a report by HEART UK issued a warning that by 2020, heart disease will be the leading cause of disability in the UK as people with the condition are forced to leave the workforce prematurely²³. Although measures have been taken since the report was published to improve understanding of the risks of heart disease, the message has not encompassed all levels of society. For this reason, the focus on heart disease must remain a priority health issue for healthcare professionals, government and health policymakers.

The NHS Health Checks programme, announced in 2008 with implementation beginning in April 2009, represents a major step forward in adopting a preventative approach to CVD. In a recent report in the London Journal of Primary Care, Dr Martin Dachsel and Dr Eugenia Lee note that 2009 NHS Comparator data suggested an average rate of 50% under-diagnosis of major cardiovascular risk factors²⁴.

An explanation of the NHS Health Checks and how they work is explained in figure 1.

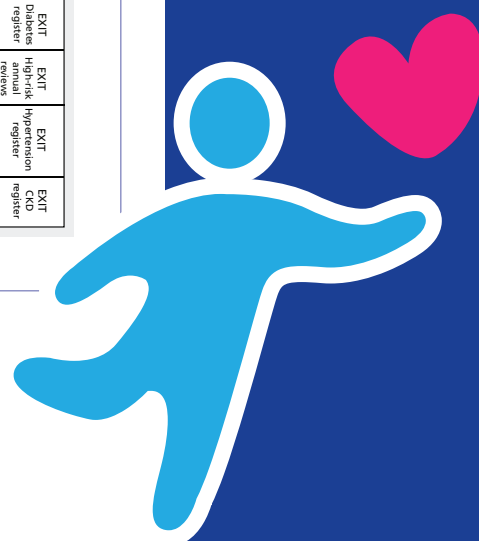
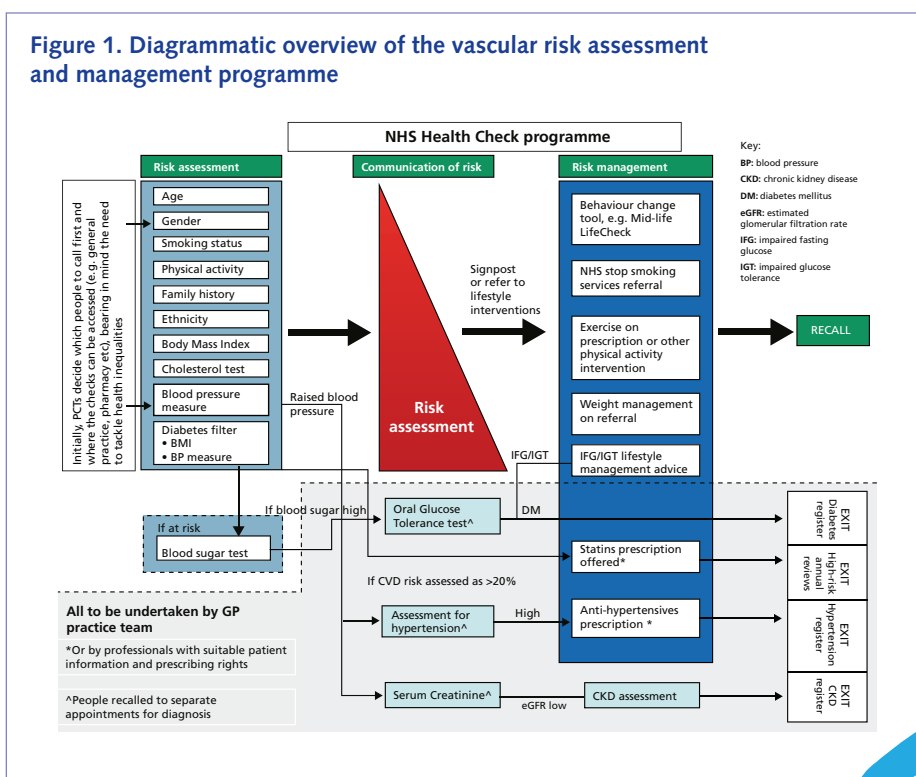
The age old divide

This report uniquely maps the uptake of NHS Health Checks against the prevalence of CHD mortality across England. The results highlight that the subjective view of a north-south divide in CHD mortality is objectively correct.

These data show the South West, South Central, East of England, London and South East coastal regions all have lower than average mortality from CHD per 100,000 people²⁵. Conversely, the West Midlands, East Midlands, North West, Yorkshire and the Humber and the North East all have higher than average mortality from CHD²⁶. Amongst these, the South Central region has the lowest rates and the North West has the highest²⁷.

In 2007, a report by HEART UK issued a warning that by 2020, heart disease will be the leading cause of disability in the UK

as people with the condition are forced to leave the workforce prematurely.



The inequalities are emphasised by a more detailed review of specific areas. For example these data show that the CHD rate for people living in Tameside and Glossop near Manchester is almost four times higher than those living in Kensington and Chelsea in London²⁸.

Mapping this against HEART UK's Freedom of Information survey scrutinising NHS Health Check implementation across England, Kensington and Chelsea is adopting one of the most innovative approaches to NHS Health Checks in the country by providing the service in a variety of settings outside of the standard GP surgery, including pharmacies, youth hostels, supermarkets, parks and town halls. By contrast, Tameside and Glossop failed to submit a response.

HEART UK's research mirrors the findings of the British Heart Foundation's Coronary Heart Disease Statistics showing that the relative difference between the numbers of people dying from heart disease in the most deprived and the most affluent areas of the country has hardly changed since the mid-1990s²⁹.

Making England a world leader in preventative health

HEART UK believes that the NHS Health Checks, if universally pursued throughout the country, engage the public in health prevention by:

- identifying potential risk factors for vascular disease
- providing individuals with information to reduce their risk of CVD through lifestyle changes
- reducing their risk of CVD through treatment where necessary.

The charity calls on PCTs to fulfil the requirements placed upon them by the NHS to ensure that the Health Checks programme is made available to all people at a local level aged between 40 and 74, and that a key target is to prioritise the most effective ways of targeting the harder to reach groups.

In the same way that the smoking ban has led to a reduction in the number of heart attacks³⁰, NHS Health Checks have the potential to positively impact on long term health. They can influence behavioural change amongst patients, who can be encouraged by their GP or healthcare professional to adopt healthier practices following the identification of raised cholesterol, high blood pressure, high BMI, or multiple risk factors.

Using a holistic approach to risk factors associated with CVD can act as a catalyst to encourage change in individuals to adopt a healthier lifestyle. At the same time, GPs and healthcare practitioners have a systematic approach to measuring the patients' progress, rather than monitoring stand-alone risk factors individually.

A study published in 2008 showed that patients diagnosed with the inherited high cholesterol condition FH not only reduced their risk of developing CVD as a result of the diagnosis and subsequent treatment, but also reduced their risk of cancer³¹. The promotion of a healthy life style encourages actions beyond those that specifically help in reducing risk for CVD and simultaneously reduces their risk of developing other conditions associated with unhealthy living.

The study showed that all-cause mortality was reduced by a third in patients with known heart disease, primarily as a result of a significantly lower risk of developing cancer. The authors concluded that this was because patients adhered closely to advice from their doctors to be more physically active, adjust their diet, remain at a healthy weight and stop smoking³².

There are approximately 16 million people eligible for an NHS Health Check in England³³, many of whom are of a working age. This is a significant proportion of the population. Making even half of this number of people more aware of their risk of developing heart disease by presenting them with the results of their NHS Health Check and encouraging them to act could make significant progress towards delivering on public health objectives. This in turn would be associated with savings for

the NHS by preventing patients having a cardiovascular event, as well as protection from other diseases caused by poor lifestyle choices. Simultaneously, this would benefit the economy by improving the health of individuals and ensuring they can work longer. Finally, a comprehensive rollout of the Health Check programme can help encourage individuals to take greater responsibility for their own heart health.



Chapter 2

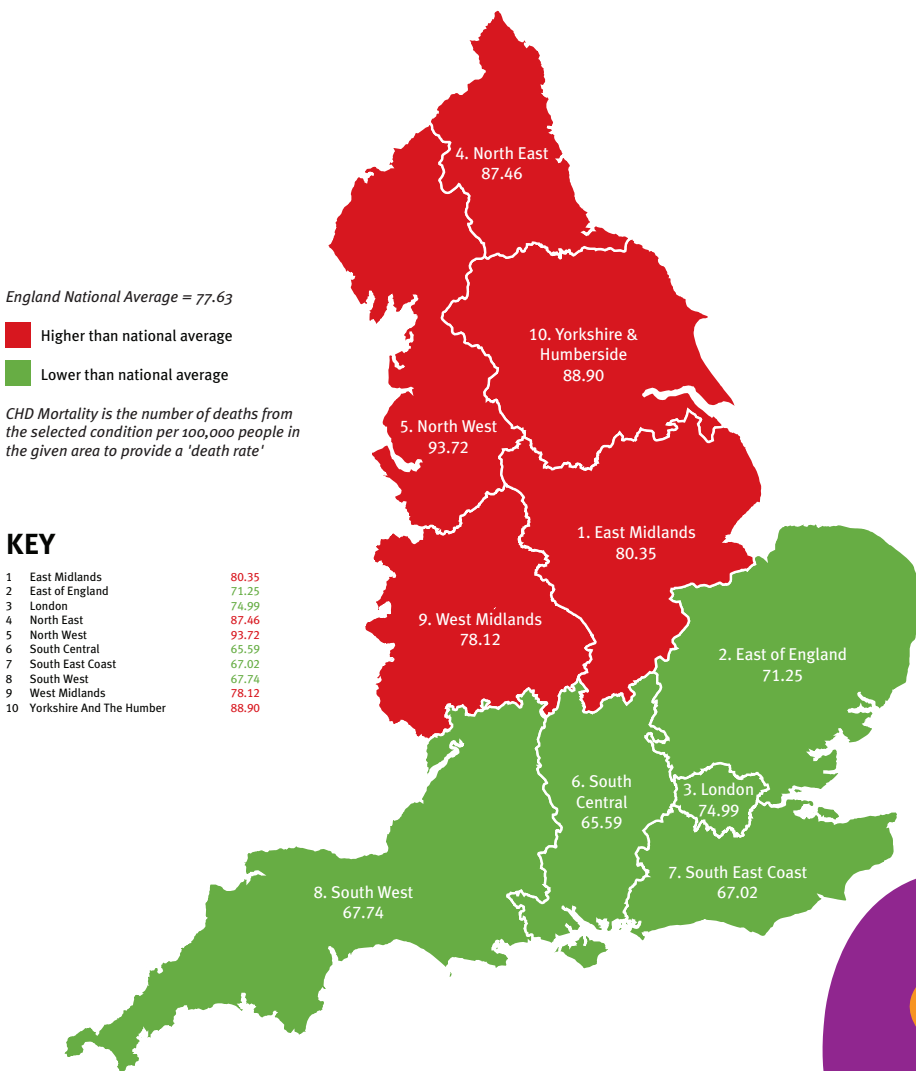
Mapping heart disease

HEART UK commissioned a Freedom of Information (FOI) request of 152 Primary Care Trusts (PCTs) across England in September 2011 in order to collate information about the local provision and implementation of NHS Health Checks.

We received a total of 112 response, which represents a response rate of 74%.

HEART UK's findings demonstrate that the NHS Health Checks programme has made a rather slow and patchy start. Whilst some regions appear to have seized the opportunity with both hands, others are yet to implement the programme locally.

Map of National Average Mortality Rate for Coronary Heart Disease in 2009 by Strategic Health Authority



Map re-used with the permission of MSD

HEART UK FOI Request Questions: NHS Health Checks

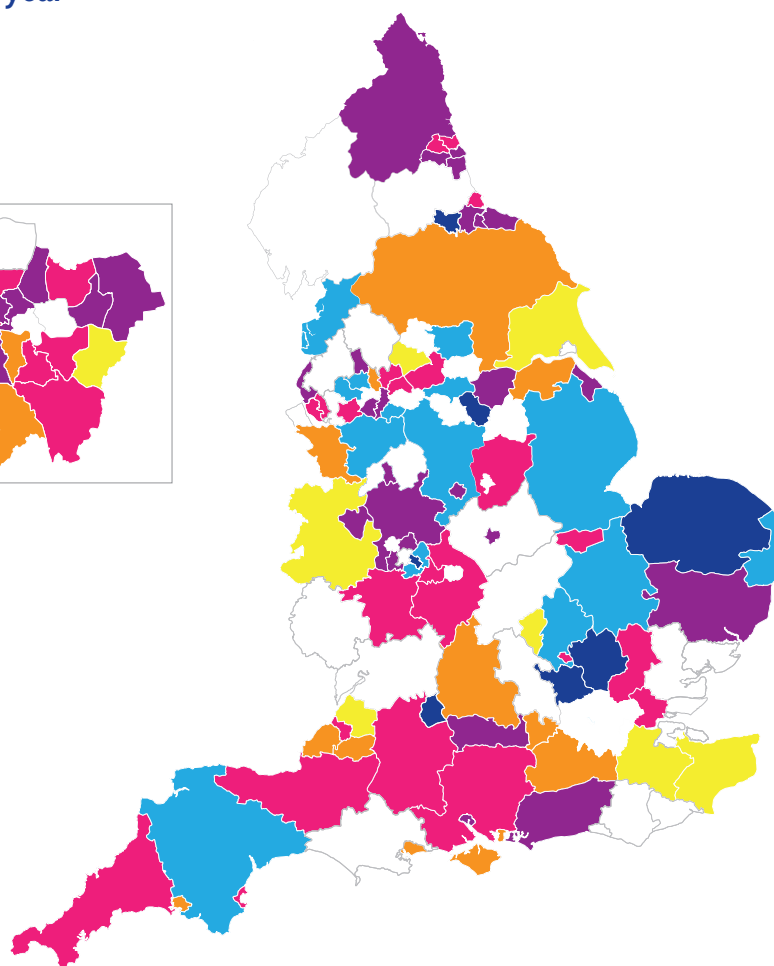
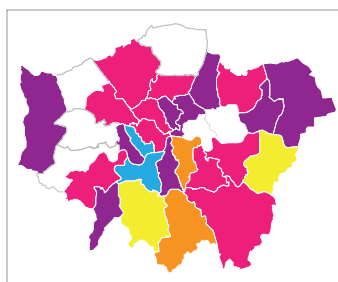
1. Are you rolling out the NHS Health Checks programme locally? (yes/no/in part)
2. If yes to question 1 above, how many NHS Health Checks were provided in the year 2010-2011?
3. Does your Trust have targets for the number of NHS Health Checks provided to patients in 2011/2012? (yes/no)
4. If yes to question 3 above, what targets have been set?
5. Where have your PCT-commissioned NHS Health Checks been provided? (e.g. GP surgeries, pharmacies, community centres etc).
6. Does your PCT have plans to commission NHS Health Checks from other providers? (If yes, please specify which providers)



Map of NHS Health Checks offered in the year 2010 - 2011 per PCT



London



NB: See Appendix for table showing number of health checks offered per PCT.

Analysis of the figures

The best and worst performers

HEART UK's results suggest that the best performing Strategic Health Authority is the East of England, where PCTs provided an average of 8,946 NHS Health Checks in the year 2010-2011.

The worst performing region is the South East Coast, where local PCTs provided an average of just 732 NHS Health Checks in the same time period.

The average number of NHS Health Checks provided nationally in 2010-2011 was 6,112. The highest number was 35,104 checks – provided across Hertfordshire PCT. Nine PCTs who responded to the FOI were yet to provide a single Health Check. These included Bexley Care Trust, Calderdale PCT, East Riding Of Yorkshire PCT, Eastern and Coastal Kent PCT, Milton Keynes PCT, Shropshire County PCT, South Gloucestershire PCT, Sutton and Merton PCT and West Kent PCT.

Encouragingly, four out of the five regions with the highest rates of CHD mortality per 100,000 of the population were among the top five regions for providing Health Checks, indicating that these regions are recognising the benefits that can be gained from the programme, and are working hard to make sure that patients are accessing the service.

Average number of NHS Health Checks provided per SHA

SHA	Average number of NHS Health Checks provided by local PCTs	CHD Mortality (number of deaths from CHD per 100,000 of the population)*
East of England	8,946	71.25
West Midlands	6,633	78.12
East Midlands	4,882	80.35
North West	4,645	93.72
Yorkshire and Humberside	4,211	88.90
London	3,863	74.99
North East	4,859	87.46
South Central	2,390	65.59
South West	2,161	67.74
South East Coast	732	67.02

* Green denotes lower than national average for CHD mortality (77.63), Red denotes higher than national average

Where NHS Health Checks are being delivered

Access to a number of locations delivering NHS Health Checks is important for men and women aged 40 to 74 to ensure health equality. However the results for the numbers of PCTs commissioning the service outside of the GP surgery do not reflect this. The Government's 2010 White Paper for Public Health, *Healthy Lives, Healthy People*, stated:

"NHS Health Checks will continue to be offered to men and women aged 40 to 74. Everyone receiving an NHS Health Check will receive individually tailored advice and support to help manage their risk of heart disease, stroke and diabetes. The assessment can be carried out in a variety of settings, including pharmacy and community settings and the workplace, to help ensure that the service is accessible to all those eligible, including those in groups at highest risk of these diseases³⁴."

However, our results show that half of PCTs that responded to our survey were still providing the Health Checks in GP surgeries only, with 5% providing the checks in pharmacy settings only. The remaining PCTs provided the checks in a number of more innovative locations, including:

- workplaces
- walk-in centres
- traveller sites
- prisons
- mental health centres
- pubs
- town centres
- football grounds
- youth hostels
- supermarkets
- public parks
- town halls
- public libraries
- village halls

The majority of those PCTs commissioning NHS Health Checks outside of the traditional GP surgery, or even pharmacy setting, were located in the South of the country where CHD mortality is lower than national average.

In total, 15 PCTs responded to say that their NHS Health Checks were provided in more than just GP surgeries or pharmacies. 27 PCTs also stated that they had plans to commission the NHS Health Checks from other providers.

Across the PCTs in the Northern SHAs – North East, North West and Yorkshire and Humberside, only 8 were commissioning NHS Health Checks from providers other than GP surgeries and pharmacies, and 19 responded that their PCTs had plans in place to commission NHS Health Checks from other providers.

HEART UK congratulates those PCTs that have already commissioned services from alternative settings to make the NHS Health Checks as accessible as possible, and calls on the remaining PCTs to consider where the Checks can be provided to ensure they are accessed by the hard-to-reach – and potentially highest risk – groups.

NHS Health Check Settings



- GP surgeries
- Pharmacies
- Community Centres
- Workplace
- Other

PCT Health Check delivery targets for 2011/2012



- 11%-20%
- 1%-10%
- 21%-30%
- 100%
- 40%

Meeting the targets

NHS Health Checks are intended to be fully rolled-out across the country by 2012/2013. The programme is designed to roll out in a five year cycle, meaning that 20% of the eligible population aged 40-74 should receive the offer of a test every year. PCTs should therefore be setting annual targets to offer 20% of their eligible population an NHS Health Check in order to deliver the programme as intended.

The 2011/12 Operating Framework set a target of offering an NHS Health Check to 90% of one fifth of the eligible cohort of individuals aged 40-74³⁵. For PCTs, this meant providing 18% of their eligible population with a Health Check every year.

The results of HEART UK's FOI survey appear to support recent reports that a number of PCTs will fall short of this target³⁶. Only 36 PCTs had set a target of 18%. 21 PCTs had set a more ambitious target, including four PCTs aiming to provide the testing to everyone within a fifth of their eligible population. However, a sizable number – 42 PCTs – responded that they had targets in place for less than 18%.

Overall, HEART UK's findings demonstrate that the NHS Health Checks programme has made a rather slow and patchy start. Whilst some regions appear to have seized the opportunity with both hands, others are yet to implement the programme locally.

As the NHS moves to a new model of commissioning care, it is imperative that all PCTs make good progress towards delivering the NHS Health Checks programme in full by the 2012/13 target. Otherwise the benefits of the programme will not be realised for patients or the NHS.

Under the new commissioning structures, CVD must be identified as a priority across the country, but particularly in the North where CHD mortality is consistently higher than national average. The NHS Health Checks programme should be seen as a means of addressing this divide.

Chapter 3

How to identify and manage high cholesterol at a local level



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**Former Chair of HEART UK's
Healthcare Committee**



Role of NHS Health Checks and importance of rolling them out

As already outlined, NHS Health Checks play an important role in identifying those most at risk of heart disease, raising awareness of the dangers of cardiovascular disease (CVD) and helping patients to manage their conditions more effectively.

This report could not come at a more important time. While HEART UK's research reveals progress in the roll out of NHS Health Checks, there are growing concerns that momentum may be lost in the face of budgetary restrictions³⁷.

HEART UK's FOI results reflect the Department of Health figures for the first quarter of 2011/12, which exposed a disappointing performance by many PCTs, raising doubts about whether the target of providing 18% of their eligible population with a Health Check every year, as set out in the 2011-12 Operating Framework, would be met³⁸.

For example, NHS West Midlands noted in September 2011 that only five out of 17 PCTs achieved or exceeded their targets³⁹, while 20 other PCTs in England had failed to offer a single person a health check in the first quarter of 2011/12⁴⁰ (the three months from April to June 2011).

Given the scale of the burden of CVD, the need to focus on prevention cannot be overstated. While the delivery of new services may be challenging in the current financial climate, there is no doubt that poor identification of at-risk patients will prove more expensive in the long-term⁴¹. It is therefore necessary to continue to build on the progress made by some PCTs since the Health Checks were first announced in 2008.

HEART UK's research has uncovered evidence of good practice in a number of PCTs and it is hoped that, by drawing attention to these, others will follow their example.

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Hammersmith and Fulham: What's happening in my PCT?

Within my PCT Hammersmith and Fulham, there is a high prevalence of patients at risk of CVD, including high incidences of obesity and diabetes. Even before the NHS Health Checks programme was announced, it was recognised that we needed to take action to address this issue locally. Our practice is fortunate to benefit from the PCT's innovative approach to developing services for at-risk patients, including lifestyle management clinics and "drop-in to weigh in" services.

Since 2010 we have implemented a number of simple steps to identify at-risk patients from the earliest possible stage and to help monitor their progress on a continual basis. New patients are given a written registration check form which is designed to flag risk factors for CVD. Within our computer system we also have a basic CVD risk calculator that appears onscreen for every patient. The system posts a flag on all patients' notes to review their CVD risk factors, which is updated every three months.

For patients with a risk greater than 20%, we are reminded to check their treatment programmes and ensure that they are comfortable with their plan. There are a number of services available to those requiring further treatment, including access to dieticians, exercise facilities and education programmes. These are all designed to suit individual need.

Delivering NHS Health Checks in the community

NHS Health Checks are designed to be preventative and there is a particular need to make them accessible to those most at risk. High-risk individuals often come from the more hard-to-reach groups which are less likely to engage with their GP practice.

The Men's Health Forum suggests that men are 20% less likely to visit their GP than women⁴². A 2008 report by the Department of Health also showed that black and minority ethnic (BME) individuals, especially Bangladeshi individuals, were on average significantly less satisfied with all aspects of access to primary care⁴³.

A number of PCTs have adopted innovative approaches by commissioning NHS Health Checks from a range of alternative community locations. While GP surgeries remain the most common setting, followed by pharmacies, some PCTs are delivering Health Checks from innovative locations such as community centres, supermarkets, town halls, football grounds and parks.

The accessibility and informality of non-surgery locations make it easier for people to "drop in" and have a Health Check. There are even examples of some supermarket pharmacies developing convenient programmes in store, whereby a person can have a Health Check before shopping and receive the results by the time they finish, although in most cases these have not yet been linked-up to the NHS Health Checks programme.

Of those questioned, 28 PCTs currently offering Health Checks from just one setting said they had plans to commission from other providers. Telford and Wrekin PCT, which currently provides Health Checks from a number of non-surgery sites including football grounds and town centre locations, is also planning to commission from other providers.

Critics of the NHS Health Check programme argue that its impacts will be limited to the "worried well"⁴⁴. While this argument fails to recognise the wider benefits of the Programme, it does correctly allude to the need to engage with hard-to-reach groups if the Health Checks are to deliver maximum benefit. Greater accessibility is the best way to do this.

Examples of different locations for proving NHS Health Checks

Kensington and Chelsea

- GP surgeries
- pharmacies
- supermarkets
- youth hostels
- parks
- town halls

Cambridgeshire PCT

- GP surgeries
- workplace
- traveller sites

Telford and Wrekin PCT

- GP surgeries
- pharmacies
- pubs
- workplace
- town centre
- football ground



The importance of lifestyle advice



It is widely recognised that many of the barriers to the implementation of CVD prevention strategies arise with patients themselves. People often either overestimate their health or simply don't have the inclination to improve it on their own⁴⁵. GPs, nurses and the wider community have a role to play in encouraging at-risk patients to adopt healthier lifestyles. Their advice ought to focus on helping patients to stop smoking, eat a healthy diet, take sufficient amounts of exercise, achieve a healthy weight and reduce alcohol intake.

There are a number of innovative ways in which to help patients act upon this advice. For example, Rotherham PCT has partnered with DC Leisure Management Ltd, an organisation which manages leisure facilities in partnership with local authorities, to offer a six-week gym membership trial to people identified through the NHS Health Checks as requiring lifestyle improvements.

Good lifestyle advice plays an integral role in best practice service delivery at a local level. However, as the King's Fund highlighted in its inquiry into the Quality of General Practice in England, many GPs feel that they do not have the

skills to deliver effective health promotion⁴⁶. Public health is now moving to new commissioning arrangements with local authorities taking the lead for delivering on this area, meaning it is important that there is sufficient link up between GPs and public health leads so that the patients who stand to benefit the most from public health interventions have access to these services. Examples such as the Rotherham partnership referenced above highlight how local authorities and GPs can work effectively together to promote healthier lifestyles.

Role of QOF and the case for lowering targets

While NHS Health Checks help to identify at-risk patients in the first place, there are further initiatives aimed at improving secondary prevention. This relates to measures taken to prevent patients who have already suffered a cardiovascular event, such as a heart attack or stroke, from experiencing another one.

The Quality and Outcomes Framework (QOF) is an annual reward and incentive programme for all GP surgeries in England. Introduced in 2004 as part of the GMS contract, the QOF rewards GP practices financially, depending on their achievements against specific quality indicators. These indicators are organised into four main domains: Clinical, Organisational, Patient Experience and Additional Services⁴⁷.

Since 2009, NICE has overseen the development of the QOF clinical indicators, making recommendations about whether any of the existing indicators need to be reviewed, or new indicators should be added. Part of the reason NICE took on this role was to ensure that the recommendations from its other guidance were reflected in the QOF indicators.

The cholesterol target for secondary prevention of coronary heart disease (CHD) included in the QOF, (indicator CHD08) awards points for the percentage of

individuals with CHD whose last measured total cholesterol is 5 mmol/l or less⁴⁸, with no targets for low-density lipoprotein (LDL) cholesterol. NICE guidance and the Joint British Society's second set of guidance (JBS 2) both call for a target of below 4 mmol/l for total cholesterol and below 2mmol/l for LDL cholesterol. The GMS Contract is not reflective of clinical best practice guidelines.

NICE's own clinical guideline on lipid modification recognises that it is clinically effective to achieve total cholesterol of 4mmol/l for patients with CHD⁴⁹. Similarly, JBS 2 on prevention of CVD in clinical practice recommends that, for patients with established CHD and other major atherosclerotic disease, the total cholesterol level should be no higher than 4 mmol/l and the LDL cholesterol should be below 2 mmol/l⁵⁰.

While there has been some inconsistency in the association between QOF scores and clinical outcomes, research in 2010 found that GP practices that better meet evidence-based quality targets related to CVD and risk factor management have lower hospital admission and death rates from CHD⁵¹. To maximise the potential impact of QOF, the indicators should be reflective of best practice guidance, and therefore GPs should be aiming for more ambitious targets for cholesterol. Although it may not be clinically possible to get all patients with established CHD to a total cholesterol of 4mmol/L, GPs should be encouraged to get as near to this figure as possible.

In light of the proven correlation between better primary care and lower health inequalities, and the role of the QOF in improving primary care, there are genuine opportunities through QOF to encourage better management of CVD and prevention of secondary events.

Local Initiatives outside of the NHS Health Checks Programme

HEART UK has identified a number of innovative approaches to addressing CVD at a local level that are separate to the NHS Health Checks Programme. Just a few examples are included below.

These projects demonstrate that it is possible to engage with all parts of society; even those commonly referred to as 'hard-to-reach'.

As these projects already target a number of people eligible for an NHS Health Check, there could be opportunities for PCTs and commissioners to try and engage directly with the projects and consider how link up with the NHS programme could help to deliver on local objectives for full roll-out.



CASE STUDY 1

Get Walking Keep Walking

Get Walking Keep Walking (GWKW) is the flagship project of the Ramblers, Britain's walking charity, aimed at helping inactive people improve their health and well-being by walking regularly and locally. GWKW encourages everyday walking as a way of reducing health inequalities and risks.

The project has developed a 12-week plan for people to increase their level of walking until they meet the recommended government target of 150 minutes' weekly exercise. Guided walks are delivered using the plan, a log book and step counter over 12 weeks. These materials are also in "Get Walking Packs" for others not on the walks, across England.

Walking programmes are organised with a range of partners, especially for those at risk of health inequalities, including black and minority ethnic communities and those living in deprived areas. BIG-funded programmes are in Sheffield, Manchester, Birmingham, and London, and others in Durham and now Swindon. The launch of Get Walking Durham in February 2011 was specifically aimed at people who have, or are at risk of, CVD.

By September 2011, over 14,000 people had participated in a local programme and 73,000 had received a Get Walking Pack.



An evaluation in October 2011 showed that 68% of people engaging face to face were inactive or insufficiently active, compared with an average of 55% in the control group. Of those interviewed three months later, 43% had increased their activity, rising to 70% amongst the least active. People also on average increased their regular walking activity by over one day per week.

CASE STUDY 2

Premier League Health

Launched in 2009, Premier League Health is a partnership between football clubs and local authorities designed to help improve the state of men's health. With a focus on deprived regions, the £1.63m programme, funded by The Football Pools, sees a number of Premier League clubs working with local PCTs to engage over 4,000 men.

The Everton example: Premier League Health activities are based at Everton's football stadium. The initiative is run from a specialised facility operated in partnership with Liverpool John Moores University, School of Sport and Exercise Sciences, and Everton in the Community. The Everton project targets 18-35 year old men, a demographic inherently reluctant to engage with health services.

The project tackles six key regional health themes:

- Alcohol and Substance abuse
- Cancer
- Mental Health
- Obesity and CVD
- Stopping Smoking
- Sexual Health

By offering a range of weekly sporting opportunities including football, circuit training, boxing and access to gym facilities, the project encourages men to make healthy lifestyle choices. The initiative also offers regular health checks, one-to-one mentoring support to achieve targeted health and lifestyle goals, and access to education, training and employment through a range of sporting and non-sporting qualifications.

Since its inception in 2009, Premier League Health has run a series of health themed match day engagement events at Everton FC aimed at promoting disease awareness and reducing risk factors.



CASE STUDY 3

Delivering health checks in a religious setting

South Asians in the UK have a higher than average CVD mortality rate⁵². Furthermore, as outlined previously, there is evidence that ethnic minority groups are less engaged with primary care services in the UK when compared to the wider population, thus contributing to health inequalities⁵³.

In an attempt to reach out to the at-risk South Asian community, a joint collaboration was established in 2008 between HEART UK, The Royal Free Hampstead NHS Trust and Hindu temples. Through this initiative, NHS Health Checks have been delivered in both the B.A.P.S Sri Swaminarayan Mandir Temple in Neasden and the Sri Swaminarayan Temple in Willesden, as well as other linked Temples in Birmingham and Leicester.

By the summer of 2011, 1,027 individuals had been tested; 527 men and 500 women. The tests identified at least one modifiable CVD risk factor in 92% of those tested.

As shown by the significant number of tests carried out, the project has proven that religious locations can provide an effective setting for delivering NHS Health Checks to members of the South Asian population.

CASE STUDY 4

GP referral schemes at DC Leisure Management Ltd

DC Leisure Centre sites in the UK are working in partnership with local GPs to offer a six week course to individuals who are overweight and/or at risk of CVD or type 2 diabetes.

Rotherham's three DC Leisure Centres were pioneers of this project, developing a partnership model that has been adapted by most of the 90 DC Leisure Centres in the UK to foster greater participation in their respective communities to help heart health. Each scheme works slightly differently in order to support the needs of the Local Authority and the local NHS.

In Rotherham, cardiovascular risk screening referrals are offered Cardiovascular Lifestyle Sessions on a weekly basis to support them throughout their six week membership. These are run by the fitness team and are designed to be educational, interactive and light-hearted!

All participants referred by their GP attend half hour appointments on a one-to-one basis, during which goals are set, an exercise programme is written, motivation and health education are discussed and a high level of customer interaction is achieved.

The sessions focus on the following themes:

- Understanding heart conditions – how the heart works
- Living with a heart condition – what happens when it doesn't work as it should?
- Reducing the risk of CHD
- The importance of a healthy diet – how to manage weight gain
- How to reduce cholesterol – cutting down on saturated fat
- How to reduce salt intake – understanding food labels
- Being aware of dangers – stress, smoking and alcohol
- Managing high blood pressure
- Controlling blood glucose – diabetes
- Healthy recipes – eating healthily on a budget
- The importance of being physically active – at home, work, shopping

DC Leisure operates a tracking system whereby all referrals receive a confirmation call the day before their next appointment and if appointments are not kept, they receive further telephone calls or letters to ensure that they stay on track.

All participants referred by their GP attend half hour appointments on a one-to-one basis, during which goals are set.

Chapter 4

Cholesterol and CVD in the new NHS



Jules Payne
Chief Executive of Heart UK

HEART UK's call to action

This report highlights the progress that has been made in tackling the onset of cardiovascular disease (CVD) in some parts of society. However, there is still some way to go before this progress reaches – and benefits – all levels of society.

In the current economic climate, this country cannot afford to undo the progress that has been made towards tackling heart disease. The number of individuals with and at risk of coronary heart disease (CHD) is increasing, putting pressure on their families and often their livelihoods. The costs of treating people with CHD are mounting at a time when the NHS is looking for opportunities to make significant efficiency savings.

The good news is that these issues can be addressed, particularly through heart disease prevention, leading to better health and cost savings.

Opportunities in primary prevention: stopping an event

The NHS Health Checks programme is a cost effective and evidence based programme⁵⁴ that can deliver on a number of major Government objectives for health.

This includes delivering cost efficiencies for the NHS, by saving the money that would be spent if individuals go unchecked resulting in a cardiovascular event that requires treatment and rehabilitation. The Health Checks can also play a role in preventing other lifestyle-associated conditions, like some types of cancer, through encouraging healthier lifestyle choices.

The preventative aspects also benefit the wider economy, as people stay healthier and in work for longer, enabling them to continue to actively contribute to society.

In line with the Government's *Big Society* agenda, and one of the main drivers behind the *Change4Life* campaign and the *Public Health Responsibility Deal*, people can also be encouraged to take greater responsibility for their own health.

HEART UK supports the view that NHS Health Checks need to be accessible to the most vulnerable and at-risk individuals, and should be seen as a major opportunity to tackle health inequalities. However, it is up to the local PCTs and eventually the local commissioning groups, to establish exactly where and how Health Checks can be delivered to reach the people who would benefit the most.

Our survey findings highlight both encouraging results, and areas for concern. It is encouraging to see that a number of PCTs have explored ways of providing the checks to reach all parts of

the target population. However, it remains a major concern that half of those PCTs that responded are only providing the service out of local GP surgeries, which are viewed as less accessible than other community based settings.

As our case studies show, in some local areas, groups and organisations such as Premier League Health are themselves taking the initiative to help raise awareness of the dangers of CVD amongst their target population.

The next stage for success is to help foster involvement of local projects in the delivery of the NHS Health Checks programme. This will help facilitate the transfer of valuable clinical data to GPs when tests are conducted, and where necessary, trigger further action.

Where PCTs are not already doing so, HEART UK calls on Public Health Directors to conduct an audit of all CVD related prevention programmes taking place within their local area, and explore the possibility of linking these up to the roll-out of NHS Health Checks. This could be particularly beneficial for those areas only providing Health Checks in a minimal range of settings, such as GP surgeries.

RECOMMENDATION 1: Where PCTs are not already doing so, consideration should be given to where the NHS Health Checks programme can be provided to reach the most at-risk groups of society

RECOMMENDATION 2: PCTs should audit local CVD services to consider how local initiatives can be joined-up with local NHS Health Check services

Our survey findings highlight both encouraging results, and areas for concern. It is encouraging to see that a number of PCTs have explored ways of providing the checks to reach all parts of the target population.



Holding commissioners to account

Reports that the NHS Health Checks programme is under threat in some areas due to lack of funding and waning support from GPs⁵⁵ are worrying, particularly as the NHS undergoes significant reforms to its commissioning structures.

HEART UK is concerned that the NHS Health Checks programme will fall through the gaps of the new arrangements, particularly in those areas where the programme is yet to get off the ground.

HEART UK supports suggestions that the new NHS Commissioning Board will be responsible for monitoring uptake of the NHS Health Checks programme⁵⁶, and will hold commissioning consortia to account for poor uptake and performance.

The charity calls on the Government to ensure that this safeguard is put in place. A regular update on the numbers of Health Checks provided, broken down by clinical commissioning group, should be made publicly available so that the best and worst performing areas can be identified.

RECOMMENDATION 3:

The Government must ensure that the NHS Commissioning Board oversees the continued delivery of the NHS Health Checks programme and monitors local implementation rigorously

Aiming for success

The 2011/12 Operating Framework sets a target of 90% of a fifth of the eligible cohort of individuals aged 40-74 to have an NHS Health Check⁵⁷. For PCTs, this meant providing 18% of their eligible population with a Health Check each year.

The results of HEART UK's survey support recent reports that a significant number of PCTs will fall short of this target. Only 35 PCTs had set a target of 18%. 20 PCTs had set a more ambitious target, including

4 PCTs aiming to provide the testing to 100% of their eligible population. However, over a quarter of all PCTs – 40 PCTs – responded that they had targets in place for less than 18%.

More support is needed to ensure that the PCTs struggling to implement the programme can benefit from shared best practice from those PCTs that have successfully rolled it out.

In addition, specific targets like those contained within the NHS Operating Framework need to be retained until they are delivered in full.

RECOMMENDATION 4:

The Department of Health and the new NHS Commissioning Board should devise a system for sharing best practice across PCTs to help with the roll out of the NHS Health Checks programme

RECOMMENDATION 5:

Targets for delivering the NHS Health Checks programme should continue to be specified in the NHS Operating Framework until such time as the programme is fully rolled out across England

Preventing individuals with CVD from having a second event

The Quality and Outcomes Framework (QOF) incentive scheme also provides a real opportunity for improvements in heart disease, particularly in secondary prevention. This is aimed at helping individuals who have already had a cardiovascular event such as a heart attack or stroke from suffering a further one.

As outlined earlier in this report, for people already living with some form of CVD, and particularly those individuals who have already had an event, their chances of suffering a further heart attack or stroke increase significantly compared to the rest of the population.

However, the existing QOF indicators regarding cholesterol targets for secondary prevention of coronary heart disease (CHD) are not reflective of clinical best practice guidelines, including JBS 2⁵⁸ and NICE's (National Institute for Health and Clinical Excellence) own guidance on lipid modification⁵⁹.

At present, the QOF indicator (CHD08) rewards points for the percentage of individuals with CHD whose last measured total cholesterol is 5 mmol/l or less⁶⁰. NICE guidance and JBS 2 guidance both call for a target of 4 mmol/l.

NICE assumed the responsibility for developing and reviewing QOF indicators in part to ensure that "the principles behind [NICE's] recommendations are reflected in the indicators⁶¹." HEART UK calls on NICE to ensure that this principle is applied to all indicators for CVD related conditions, particularly raised cholesterol, by making all QOF indicators reflective of NICE and other best practice guidance.

RECOMMENDATION 6: NICE should review QOF indicators for secondary prevention of CHD and ensure that all existing targets reflect best practice guidelines and are ambitious enough to help individuals achieve the best possible outcomes

Public Health and lifestyle advice

As the case studies in this report and many others around the country demonstrate, there is much that public health leads can learn from local independent projects about how best to engage with target populations and encourage healthier practices. A link up between some of these local projects and the NHS Health Checks programme would help in the short-term to reap the benefits of this innovative thinking at a local level.

HEART UK also calls on the Government and Royal Colleges to ensure that GPs and other healthcare professionals are encouraged, and feel able, to provide

lifestyle advice to their patients. This is particularly important at a time when NHS budgets are under pressure. The more patients can do to help themselves the better.

Longer term, Government proposals mean that local authorities will take greater responsibility for delivering public health initiatives for their populations. Examples like DC Leisure's agreement with Rotherham PCT are an innovative approach to encouraging healthier living practices amongst the population, which could easily be replicated elsewhere.

RECOMMENDATION 7: The Government and Royal Colleges should consider how best to support GPs and other healthcare professionals to provide lifestyle advice and support to patients

RECOMMENDATION 8: Local authorities should consider adopting innovative best practice examples for promoting public health locally

Opportunity for change

The NHS Health Checks programme could be this country's once in a generation opportunity to have a major impact on CVD – Britain's major cause of disability, ill-health and mortality.

Despite the budgetary pressures on the NHS, and the continuing demands on healthcare professionals, it is imperative to ensure that the NHS Health Checks Programme is fully rolled out and accessible throughout the country, and for those at highest risk of CVD.

This programme is not about medicalising the population. It is about empowering people to take greater responsibility for their own health. In cases where patients would benefit from treatment, healthier lifestyle choices should also be encouraged to help patients reduce their risks as much as possible.

For those patients who have already suffered an event such as a heart attack or stroke, the focus should be on preventing this from happening again. As well as encouraging lifestyle changes and treatment adherence, GPs and healthcare professionals should be incentivised through the QOF on the basis of clinical best practice guidance, to enable patients to reach their optimal clinical targets.

Finally, as the NHS undergoes significant changes, CVD must remain the number one priority in healthcare and public health. Within this, cholesterol must be recognised as a key risk factor, and in cases where individuals have raised cholesterol as a result of non-inherited conditions, an area where both patients and their healthcare professionals can focus on simple changes to gain significant benefits.



Appendix: NHS Health Checks offered in the year 2010-2011

	2011: Are you rolling out the NHS Health Checks programme locally? (yes/no/ in part)	How many NHS Health Checks were provided in the year 2010-2011?	Number of people eligible for HealthCheck	Does your Trust have targets for the number of NHS Health Checks provided to patients in 2011/2012? (yes/no)	What targets have been set?	Where have your PCT-commissioned NHS Health Checks been provided? (e.g. GP surgeries, pharmacies, community centres etc).	Does your PCT have plans to commission NHS Health Checks from other providers? (yes/no)
Hertfordshire PCT	Yes	35104	328615	Yes	55400 (17%)	GP Surgeries	No
Norfolk PCT	Yes	30353	227924	Yes	42901 (19%)	GP Surgeries, Pharmacies, Workplaces, Walk-in Centre	Yes
Heart of Birmingham Teaching PCT	Yes	20632	57000	Yes	10260 (18%)	GP Surgeries	Yes
Rotherham PCT	Yes	20244	77569	Yes		GP Surgeries	No
Blackpool PCT	Yes	17232	45336	Yes	5621 (12%)	GP Surgeries	No
Devon PCT	In part	16821	294195	No		GP Surgeries, pharmacies and community centres	No
South Birmingham PCT	Yes	16520	104766	Yes	18858 (18%)	GP Surgeries	Yes
Leeds PCT	Yes	16461	206570	Yes	37183 (18%)	GP Surgeries	No
North Lancashire PCT	Yes	14100	110000	Yes	6753	GP Surgeries	Yes
Ashton, Leigh and Wigan PCT	Yes	14037	109053	Yes	9000 (8%)	GP Surgeries, workplaces and community centres	Yes
Barnsley PCT	Yes	13943	65085	Yes	18%	GP Surgeries	No
Birmingham East and North PCT	Yes	13931	124000	Yes	22500 (18%)	GP Surgeries	Yes
Derbyshire County PCT	Yes	13873	233512	Yes	18%	GP Surgeries	No
Central and Eastern Cheshire PCT	Yes	13322	196102	Yes	18718 (10%)	GP Surgeries	No
Bolton PCT	Yes	12888	110100	Yes	4990 (5%)	GP Surgeries	No
Lincolnshire Teaching PCT	Yes	12886	222506	Yes	32840 (15%)	GP Surgeries	No
Kensington and Chelsea PCT	Yes	11992	50475	Yes	11600 (23%)	GP Surgeries, pharmacies, hostels, supermarkets, park and town hall	Yes
Great Yarmouth and Waveney PCT	Yes	10970	74000	Yes	12450 (17%)	GP Surgeries	Yes
Bedfordshire PCT	Yes	10711	124,000	Yes	22500 (18%)	GP Surgeries	No
Wandsworth Teaching PCT	Yes	10319	82000	Yes	12000 (15%)	GP Surgeries	Yes
Cambridgeshire PCT	Yes	10070	177000	Yes	31861 (18%)	GP Surgeries, workplace, Traveller sites	No
Stockport PCT	Yes	10000	100260	Yes	16000 (16%)	GP Surgeries	No
Stockton-on-Tees Teaching PCT	Yes	9862	41549	Yes	40%	GP Surgeries, pharmacies, community centres and workplaces	No
Dudley PCT	Yes	9587	90000	Yes	7200 (8%)	GP Surgeries	Yes
Sunderland Teaching PCT	Yes	9561	101700	Yes	9153 (9%)	GP Surgeries, pharmacies, workplaces and community centres	No
Telford and Wrekin PCT	Yes	9517	46662	Yes	8400 (18%)	GP surgeries, pharmacies, pubs,workplaces, town centre and football ground	Yes
Trafford PCT	Yes	9314	69907	Yes	12600 (18%)	GP Surgeries	No
Stoke On Trent PCT	Yes	8853	85000	Yes	15000 (18%)	GP Surgeries	No
Walsall Teaching PCT	Yes	8615	86900	Yes	9656 (11%)	GP Surgeries, pharmacies, workplaces and community centres	Yes
Southampton City PCT	Yes	8158	58321	Yes	11664 (20%)	GP Surgeries	No
Havering PCT	Yes	8066	86000	Yes	15480 (18%)	GP Surgeries	Yes

Barking and Dagenham PCT	Yes	7997	41328	Yes	6500 (16%)	GP Surgeries, walk in centres and community centres	No
Berkshire West PCT	Yes	7715	121296	Yes	21836 (18%)	GP Surgeries	Yes
City and Hackney Teaching PCT	Yes	7500	55561	Yes	10,000	GP Surgeries	Yes
Leicester City PCT	Yes	7408	77520	Yes	13954 (5.4%)	GP Surgeries and pharmacies	No
Hammersmith and Fulham PCT	Yes	7374	40050	Yes	10000 (25%)	GP Surgeries, pharmacies and community centres	Yes
Northumberland Care Trust	Yes	7204	112282	Yes	112282 (2.1%)	GP Surgeries	Yes
North East Lincolnshire Care Trust Plus	Yes	7056	48502	Yes	10080 (18%)	GP Surgeries	No
Sefton PCT	Yes	7000	87300	Yes	15750 (18%)	GP Surgeries	No
Waltham Forest PCT	Yes	6900	70155	Yes	12588 (18%)	GP Surgeries	No
Derby City PCT	Yes	6732	78650	Yes	8567 (11%)	GP Surgeries	No
Gateshead PCT	Yes	6719	74452	Yes	6700 (9%)	GP Surgeries, pharmacies and community centres	No
Islington PCT	Yes	6661	52778	Yes	9500 (18%)	GP Surgeries	No
Lambeth PCT	Yes	6110	91009	Yes	4450 (5%)	GP Surgeries	Yes
Hillingdon PCT	Yes	5999	74000	Yes	14747 (20%)	GP Surgeries and pharmacies	No
Middlesbrough PCT	Yes	5887	28181	Yes	40%	GP Surgeries, pharmacies, community centres and workplaces	No
Blackburn with Darwen	Yes	5760	89900	Yes	18%	GP Surgeries and pharmacies	Yes
South Tyneside PCT	Yes	5687	55841	Yes	9160 (16%)	Pharmacies	No
Redcar and Cleveland PCT	Yes	5545	28232	Yes	40%	GP Surgeries, pharmacies, community centres and workplaces	No
Doncaster PCT	Yes	5337	54522	Yes	8000 (26%)	Independent provider	No
West Sussex PCT	Yes	5247	264696	Yes	47650 (18%)	GP Surgeries, pharmacies, workplaces and community centres	Yes
Suffolk PCT	Yes	5183	185233	Yes	21648 (12%)	GP Surgeries, pharmacies, workplaces and community centres	Yes
South Staffordshire PCT	Yes	5038	185510	Yes	33400 (18%)	GP Surgeries	No
Kingston PCT	Yes	5000	50573	Yes	10.90%	Pharmacies	Yes
Oldham PCT	Yes	4926	64489	Yes	11948 (19%)	GP Surgeries	No
Peterborough PCT	Yes	4914	48105	Yes	5160	GP Surgeries	No
Greenwich Teaching PCT	Yes	4905	73531	Yes	11164 (15%)	GP Surgeries and community centres	Yes
Lewisham PCT	Yes	4651	72646	Yes	7103 (10%)	GP Surgeries and pharmacies	No
Warwickshire PCT	Yes	4131	165000	Yes	11200 (7%)	GP Surgeries	Yes
Solihull PCT	Yes	4021	62968	Yes	12420 (20%)	GP Surgeries	No
Westminster PCT	Yes	3971	61800	Yes	14000 (23%)	GP Surgeries and pharmacies	Yes
Hartlepool PCT	Yes	3960	17473	Yes	40%	GP Surgeries, pharmacies, community centres and workplaces	No
Liverpool PCT	Yes	3806	90683	Yes	16324 (18%)	GP Surgeries	No
Luton PCT	Yes	3710	42484	Yes	5458 (13%)	GP Surgeries	No
Worcestershire PCT	Yes	3700	190348	Yes	12000 (6%)	GP Surgeries	Yes
Newcastle PCT	Yes	3580	75206	Yes	75206 (100%)	GP Surgeries	Yes
Brent Teaching PCT	Yes	3565	83194	Yes	20%	GP Surgeries	No
Bromley PCT	Yes	3150	98548	Yes	7%	GP surgeries, pharmacies, community centres	Yes
Haringey Teaching PCT	Yes	3145	65705	Yes	11827 (18%)	GP Surgeries and community centres	Yes
Nottinghamshire County PCT	Yes	3044	199022	Yes	14006 (7%)	GP Surgeries and pharmacies	Yes

Wiltshire PCT	Yes	3000	168160	Yes	20%	GP Surgeries	Yes
Heywood, Middleton and Rochdale PCT	Yes	2946	54795	Yes	9864 (18%)	GP Surgeries	No
Knowsley PCT	Yes	2688	44379	Yes	2405 (5%)	GP Surgeries, pharmacies and community centres	Yes
North Tyneside PCT	Yes	2652	68394	Yes	63894 (100%)	GP Surgeries	Yes
South West Essex PCT	Yes	2647	115528	Yes	15084 (13%)	GP Surgeries	Yes
West Essex PCT	Yes	2647	83800	Yes	15084	GP Surgeries	Yes
Richmond and Twickenham PCT	Yes	2600	65234	Yes	18%	GP Surgeries and pharmacies	No
Somerset PCT	Yes	2590	179635	Yes	179600 (100%)	GP Surgeries, pharmacies and community centres	No
Camden PCT	Yes	2548	64916	Yes	10000 (15%)	Pharmacies	Yes
Torbay Care Trust	Yes	2301	46261	Yes	3867	GP Surgeries	No
Kirklees PCT	In part	1912	100945	Yes	4542 (4%)	GP Surgeries	No
Bristol PCT	In part	1553	108263	Yes	20%	GP Surgeries and community centres	Yes
Warrington PCT	Yes	1540	65123	Yes	3820 (6%)	GP Surgeries and community centres	No
Redbridge PCT	Yes	1400	71800	Yes	30%	GP Surgeries	No
Hampshire PCT	Yes	1331	410130	Yes	73824 (18%)	GP Surgeries	Yes
Barnet PCT	Yes	1180	132049	Yes	20%	GP Surgeries	No
Cornwall and Isles Of Scilly PCT	Yes	1177	191254	Yes	18%	GP surgeries, pharmacies, community centres	No
Bath and North East Somerset PCT	Yes	924	52994	Yes	4768 (9%)	GP Surgeries	No
Plymouth Teaching PCT	Yes	827	73382	No	0	GP Surgeries	Yes
North Yorkshire and York PCT	Yes	805	244652	Yes	18%	GP Surgeries and pharmacies	No
Southwark PCT	Yes	800	79294	Yes	16000 (20%)	GP Surgeries	Yes
Berkshire East PCT	In part	629	109760	Yes	4939 (4%)	GP Surgeries	No
Isle Of Wight NHS PCT	Yes	628	67421	Yes	17214 (26%)	GP Surgeries and pharmacies	Yes
Surrey PCT	In part	544	353242	Yes	6430 (2%)	Prisons, community centres and mental health centres	No
Portsmouth City Teaching PCT	Yes	361	49490	Yes	2821 (6%)	GP Surgeries and pharmacies	No
Bournemouth and Poole Teaching PCT	Yes	300	91858	Yes	18%	GP Surgeries	Yes
Oxfordshire PCT	Yes	300	183717	Yes	33000 (18%)	GP Surgeries	Yes
North Lincolnshire PCT	In part	260	56166	Yes	18%	Community centers, public libraries, village halls and workplaces	Yes
North Somerset PCT	In part	199	72840	Yes	5120 (7%)	GP Surgeries and pharmacies	No
Western Cheshire PCT	In part	132	69108	Yes	12440 (18%)	GP Surgeries	No
Croydon PCT	Yes	77	97848	Yes	97848 (100%)	Pharmacies	No
Bury PCT	Yes	55	54870	Yes	18%	GP Surgeries	No
Bexley Care Trust	Yes	0	82095	Yes	12%	GP Surgeries	No
Calderdale PCT	In part	0	51250	Yes	18%	GP Surgeries	Yes
East Riding Of Yorkshire PCT	No	0	116970	Yes	14036 (12%)	Pharmacies	Yes
Eastern and Coastal Kent PCT	Yes	0	239000	Yes	26665 (11%)	GP Surgeries	Yes
Milton Keynes PCT	No	0	76050	Yes	18%	GP Surgeries	No
Shropshire County PCT	Yes	0	92170	Yes	4155 (5%)	GP Surgeries	Yes
South Gloucestershire PCT	Yes	0	73459	Yes	18%	GP Surgeries	No
Sutton and Merton PCT	No	0	111398	Yes	20385 (18%)	GP Surgeries	Yes
West Kent PCT	Yes	0	223406	Yes	24575 (11%)	GP Surgeries	Yes

Bassetlaw PCT	38368
Bradford and Airedale Teaching PCT	136760
Brighton and Hove City Teaching PCT	69614
Buckinghamshire PCT	180327
Central Lancashire PCT	126977
County Durham PCT.	183360
Coventry Teaching PCT	86880
Cumbria Teaching PCT	174358
Darlington PCT	37436
Dorset PCT	149648
Ealing PCT	70181
East Lancashire Teaching PCT	138043
East Sussex Downs and Weald PCT	117427
Enfield PCT	82880
Gloucestershire PCT	195353
Halton and St Helens PCT	91551
Harrow PCT	76840
Hastings and Rother PCT	61687
Herefordshire PCT	63942
Hounslow PCT	62366
Hull Teaching PCT	83022
Leicestershire County and Rutland PCT	257767
Medway PCT	79030
Mid Essex PCT	113800
Newham PCT	74000
North East Essex PCT	98000
North Staffordshire PCT	64511
Northamptonshire Teaching PCT	225387
Nottingham City PCT	63000
Salford PCT	63300
Sandwell PCT	80654
Sheffield PCT	147753
South East Essex PCT	101700
Swindon PCT	61213
Tameside and Glossop PCT	76998
Tower Hamlets PCT	44335
Wakefield District PCT	105712
Wirral PCT	109770
Wolverhampton City PCT	78420

References

1. Scarborough *et al* (2010), Coronary Heart Disease Statistics 2010 edition; British Heart Foundation Health Promotion Research Group and Department of Public Health, University of Oxford
2. *ibid*
3. Scarborough *et al* (2008), European Cardiovascular Disease Statistics 2008 edition; British Heart Foundation Health Promotion Research Group and Department of Public Health, University of Oxford
4. Scarborough *et al* (2008), European Cardiovascular Disease Statistics 2008 edition; British Heart Foundation Health Promotion Research Group and Department of Public Health, University of Oxford
5. AH Gershlick *et al* (2001), Ischaemic heart disease: therapeutic issues; British Medical Bulletin, October 2001
6. ICM Research (2011), Physical Health Survey; MSD, June 2011
7. World Health Organisation (2011), Cardiovascular Diseases; www.who.int/cardiovascular_diseases/en/ last accessed 24 October 2011
8. Scarborough *et al* (2008), European Cardiovascular Disease Statistics 2008 edition; British Heart Foundation Health Promotion Research Group and Department of Public Health, University of Oxford
9. Scarborough *et al* (2010), Coronary Heart Disease Statistics 2010 edition; British Heart Foundation Health Promotion Research Group and Department of Public Health, University of Oxford
10. The British Heart Foundation (2011), Our Heart Disease Facts; www.bhf.org.uk/media/news-from-the-bhf/bhf-facts.aspx last accessed 2 November 2011
11. The Stroke Association (2011), www.stroke.org.uk/information/about_stroke/who_does_stroke_affect/ last accessed 24 October 2011
12. Scarborough *et al* (2010), Coronary Heart Disease Statistics 2010 edition; British Heart Foundation Health Promotion Research Group and Department of Public Health, University of Oxford
13. *ibid*
14. *ibid*
15. *ibid*
16. National Institute for Health and Clinical Excellence (2008), Lipid Modification: Cardiovascular risk assessment and the modification of blood lipids for the primary and secondary prevention of cardiovascular disease [CG67]; NICE
17. Scarborough *et al* (2010), Coronary Heart Disease Statistics 2010 edition; British Heart Foundation Health Promotion Research Group and Department of Public Health, University of Oxford
18. National Institute for Health and Clinical Excellence (2008) Identification and management of familial hypercholesterolaemia (FH) clinical guideline [CG71]; NICE
19. Scarborough *et al* (2010), Coronary Heart Disease Statistics 2010 edition; British Heart Foundation Health Promotion Research Group and Department of Public Health, University of Oxford
20. *ibid*
21. *ibid*
22. *ibid*
23. Murray CJ and Lopez AD (1997), Alternative projections of mortality and disability by cause 1990-2020: Global Burden of Disease Study; The Lancet, volume 349, pages 1498-504, 24 May 1997
24. Dachsal D and Lee E (2011), Opportunistic Health Checks in a Retail Environment; London Journal of Primary Care, Issue 1, pages 5-10, May 2011
25. NHS Information Centre for Health and Social Care (2011), Life Expectancy at birth 1991-93 to 2007-09. 2011. Available from www.nchod.nhs.uk
26. *ibid*
27. *ibid*
28. *ibid*
29. Scarborough *et al* (2010), Coronary Heart Disease Statistics 2010 edition; British Heart Foundation Health Promotion Research Group and Department of Public Health, University of Oxford
30. Meyers D *et al* (2009), Cardiovascular Effect of Bans on Smoking in Public Places: A Systematic Review and Meta-Analysis; Journal of the American College of Cardiology, volume 54, pages 1249-1255, September 2009
31. Neil Andrew *et al* (2008), Reductions in all-cause, cancer, and coronary mortality in statin-treated patients with heterozygous familial hypercholesterolaemia: a prospective registry study; European Heart Journal, volume 29, issue 21, pages 2625-2633, August 2008
32. *ibid*
33. Department of Health (2011), Number of eligible people that have been offered and received NHS Health Checks www.dh.gov.uk/en/Publicationsandstatistics/Statistics/Perfomancedataandstatistics/Integratedperformancemeasuresmonitoring/DH_129481, last accessed 13/10/2011. NB: Actual number is 15,967,356.
34. Department of Health (2010), Healthy Lives, Healthy People: Our strategy for public health in England; November 2010
35. Department of Health (2011), Technical Guidance for the 2011/12 Operating Framework, January 2011; page 183
36. Santry Charlotte (2011), Health inequalities scheme flagging as GPs shun 'charity work'; Health Service Journal, 12 October 2011 Available at www.hsj.co.uk/health-inequalities-scheme-flagging-as-gps-shun-charity-work/5036300.article
37. *ibid*
38. Department of Health (2011), Number of eligible people that have been offered and received NHS Health Checks; www.dh.gov.uk/en/Publicationsandstatistics/Statistics/Perfomancedataandstatistics/Integratedperformancemeasuresmonitoring/DH_129481, last accessed 13 October 2011
39. Santry Charlotte (2011), Health inequalities scheme flagging as GPs shun 'charity work'; Health Service Journal, 12 October 2011 Available at www.hsj.co.uk/health-inequalities-scheme-flagging-as-gps-shun-charity-work/5036300.article
40. Pulse (2011), PCTs falling behind on vascular screening; Pulse, 18 October 2011. Available at www.pulsetoday.co.uk/newsarticle-content/-/article_display_list/12905725/pcts-falling-behind-on-vascular-screening
41. Lungo-Fernández, R *et al* (2006), Cost of cardiovascular diseases in the United Kingdom; Heart, volume 92, pages 1384-1389. Available at <http://heart.bmj.com/content/92/10/1384.abstract>
42. Men's Health Forum (2011), Memorandum to the Department of Health in response to the Health and Social Care Bill, March 2011
43. Department of Health (2008), Report of the National Improvement Team for Primary Care Access and Responsiveness; February 2008, page 8
44. Santry Charlotte (2011), Health inequalities scheme flagging as GPs shun 'charity work'; Health Service Journal, 12 October 2011. Available at www.hsj.co.uk/health-inequalities-scheme-flagging-as-gps-shun-charity-work/5036300.article
45. Morrell J (2009), Implementing Better Identification and Treatment; HEART UK insert into RCGP Journal, 2009
46. Boyce *et al* (2011), A proactive approach. Health Promotion and Ill Health; The King's Fund, page 3
47. National Institute of Health and Clinical Excellence (2011), About the Quality and Outcomes Framework; NICE www.nice.org.uk/aboutnice/qof/qof.jsp#Involved, last accessed 18 October 2011
48. BMA (2011), Quality and Outcomes Framework guidance for GMS contract 2011/12: Delivering investment in general practice; page 35, April 2011
49. National Institute for Health and Clinical Excellence (2008), Lipid Modification: Cardiovascular risk assessment and the modification of blood lipids for the primary and secondary prevention of cardiovascular disease [CG67]; NICE page 10
50. British Cardiac Society *et al* (2005), JBS 2: Joint British Societies' Guidelines on prevention of cardiovascular disease in clinical practice, Heart, volume 9, supplement V, page 34, December 2005,
51. Kiran T *et al* (2010), The association between quality of primary care, deprivation and cardiovascular outcomes: a cross-sectional study using data from the UK Quality and Outcomes Framework; Journal of Epidemiology & Community Health, volume 64, pages 927-934
52. British Heart Foundation (2011), South Asians and Heart Disease; www.bhf.org.uk/publications/south-asian-publications.aspx last accessed 30 November 2011
53. Department of Health (2008), Report of the National Improvement Team for Primary Care Access and Responsiveness; page 8, February 2008
54. Department of Health (2008), Putting Prevention First, Vascular Checks: risk assessment and management; page 9, April 2008
55. Santry Charlotte (2011), Health inequalities scheme flagging as GPs shun 'charity work'; Health Service Journal, 12 October 2011. Available at www.hsj.co.uk/health-inequalities-scheme-flagging-as-gps-shun-charity-work/5036300.article
56. Anweke Lilian (2011), Commissioning board to police GPs on vascular screening uptake; Pulse, 6 May 2011
57. Department of Health (2011), Technical Guidance for the 2011/12 Operating Framework; January 2011, page 183
58. British Cardiac Society *et al* (2005), JBS 2: Joint British Societies' Guidelines on prevention of cardiovascular disease in clinical practice; Heart, volume 9: supplement V, page 34, December 2005
59. National Institute for Health and Clinical Excellence (2008), Lipid Modification: Cardiovascular risk assessment and the modification of blood lipids for the primary and secondary prevention of cardiovascular disease [CG67]; NICE, page 10
60. BMA (2011), Quality and Outcomes Framework guidance for GMS contract 2011/12: Delivering investment in general practice; page 35, April 2011
61. National Institute of Health and Clinical Excellence (2011), About the Quality and Outcomes Framework, NICE, www.nice.org.uk/aboutnice/qof/qof.jsp#Involved, last accessed 18 October 2011





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