Author's response to reviews

**Title:** Postcode lotteries in public health - The NHS Health Checks Programme

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**Author's response to reviews:** see over
Dear Editor,

MS: 9241398235385169 Postcode lotteries in public health - The NHS Health Checks Programme

Many thanks for the feedback that we received on our paper. We have made all the changes related to grammar, spelling and punctuation. Mike Kelly did not make any requests for revisions. Please find below our responses to the comments and suggestions of Linda Marks.

Major compulsory revisions

1. The results section in the abstract refers to PCT budgets varying from 69k to 1.4 million per 100,000 population but, as Table 2 makes clear, these figures do not refer to actual budgets but estimated spend (per 100,000 ) for the population aged 40-74. As this target population is less than 100,000 in the majority of PCTs in the study, the total 2010/11 budget for NHS Health Checks for these PCTs is substantially less than the estimated spend per 100,000 for the target group. The difference between actual and estimated spend should be clarified in the abstract and the text (as in the first line of the section headed ‘Funding and payment structures’ where estimated funding is described as ‘made available’): size of the target population could be included in Table 2 as could percentage of the eligible cohort who have received a check.

Thank you – we have corrected the sentence in the abstract. As you say, there is variation in the size of the eligible population and we have therefore standardised the budgets per 100,000 for the eligible population. We have now also added a column to table 2 (now 3) showing the size of the eligible population per PCT.

2. Methods are described very briefly and the article is based on 8 questionnaires, completed over a two week period by the Health Check lead for each of the 8 PCTs. It is a small and geographically limited study and limitations of the data could be discussed in more detail. The questionnaire would be of interest to those implementing health checks and could be made available.

We are aware that our study is small and geographically limited. We have therefore further developed the limitations section of the paper. We are happy to make the questionnaire available, and have attached this as an additional document.

3. Possible reasons for such large differences in spend could be enlarged upon in the discussion. Contextual information could include overlapping initiatives, if any, and the extent to which these may have been rationalised under the NHS Health Checks scheme; degree of development of a risk management infrastructure and decisions over how the programme was to be rolled out over time. NW London has been a comparatively high performer compared with the rest of London in implementing the NHS Health Checks programme: some national context would be useful to put the findings in perspective.

We haven’t been able to respond specifically to this point. We did not collect any data that would help us to explain the reasons behind the variations described in this paper. However, implicit in the discussion is the view that a lack of clear and detailed guidance contributes to the variation.

Variation in overlapping initiatives is also now discussed in the findings section and we follow this in the Discussion with a note that the success of the programme is ultimately dependant not just on achieving high and targeted population coverage but also on the quality of CVD risk management and the quality of CVD risk management including behaviour change interventions.

4. As discussed in the article addressing health inequalities is an important part of the programme and there is scope for more detailed discussion of how Health checks are being targeted in disadvantaged groups/areas/practices in disadvantaged areas in the 8 PCTs, whether
any equity audits were carried out as part of monitoring and evaluation processes or whether there is a systematic approach to addressing health inequalities through health checks.

We note that 7 PCTs are targeting parts of their health checks programmes at deprived groups. The main limitation of our study is the lack of data on the quality and impact of the programme it is therefore not possible to identify how effective these methods have been with regards to there impact on equity.

5. Local flexibility is described in the conclusions as essential to the programme but Table 5 (which expands on mandatory standards, expected elements and those left to local discretion) only includes method of invitation and setting of health check as areas to be left to local discretion. Are there others that could be included in relation to reaching disadvantaged groups and areas, for example?

Thank you. We have added further detail to table 7 with specific focus on programmatic elements that are left to local discretion. This includes the setting, the method of invitation, method of targeting, POCT used, additional screening added to the test, POCT used, additional screening, methods of evaluation used locally and the design of services available locally.

Discretionary revisions

Thank you for this useful suggestion. – We have included directly standardised rates of CHD Mortality in persons aged under 75 per PCT into table 3 as variable to describe differences in budget. This has been discussed in the discussion.

2. Information from the 8 PCTs drawing on the mandatory data set itemised in Box 2 would provide useful context for the differences in spend.

Thank you for this suggestion. Although this data was collected as part of our survey at the time of collection it was not complete and therefore the data does not provide any accurate indication of differences in spend.

3. Information on levels of deprivation in the 8 PCTs would also provide useful context, especially given that reducing health inequalities is one aim of the NHS Health Checks. This could be included as part of Table 2.

We have added a new column to table 2 (now 3) showing the rank of deprivation based on IMD 2010 scores.

4. The role of PCTs as commissioning organisations could be explained for an International audience.

Thank you – we have done this.

5. The consultation on the funding and commissioning routes for public health (DH 2010) indicates that arrangements for commissioning NHS health checks in England are likely to change. Conclusions could refer to funding (and other) Implications of local authorities becoming lead commissioners of health checks as currently proposed, as well as possible impact of the economic climate on Preventive services.

We have discussed this however we have decided not to include this as it is likely to be confusing to an international audience. We also feel that the future arrangements for public health are still unclear.

Best Regards,

Clare Graley, Kate May, David McCoy