Report to Health Scrutiny Committee

NHS Health Checks Programme – Update

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Purpose of the Report

The Health Scrutiny Committee has requested a report on the NHS Health Checks programme.

Summary of the issue:

This report provides an update on the NHS Health Checks programme in Oldham. This includes previous performance, an outline of our current performance and plans for the future of the programme in Oldham.

1. Background to the NHS Health Check

1.1 NHS Health Checks is a national health risk assessment programme that aims to help prevent vascular disease including heart disease, stroke, diabetes and kidney disease. Patients between the ages of 40 and 74, who have not already been diagnosed with one of these conditions, are invited, once every five years to have a health check to assess their risk of developing one or more of the conditions above.

1.2 The 5-year programme was first introduced in 2013. In 2018, a decision was made to continue with a 'second wave' of the programme for a further five years; 2018-2023

1.3 In its first 5 years, the NHS Health Check is estimated to have prevented 2,500 heart attacks or strokes nationally. This is the result of people receiving intervention after their health check. The latest research suggests that:

- for every 27 people having an NHS Health Check, 1 person is diagnosed with high blood pressure
- for every 110 people having an NHS Health Check, 1 person is diagnosed with type 2 diabetes
- for every 265 people having an NHS Health Check, 1 person is diagnosed with kidney disease

1.4 The NHS Health Check gives a personalised risk of developing a heart or circulation problem in the next 10 years. Tailored advice and management plans are then put in place to lower the risk. This may include:

- Improving physical activity levels
- Diet advice
- Prescribed medicines for cholesterol or blood pressure
- Support to stop smoking

1.5 In Oldham, once the risk assessment has been completed, the individual receiving the health check is given feedback on their results and advice on achieving and maintaining healthy behaviours. If necessary, they are then directed to either a health improvement intervention (e.g. smoking cessation) or referred to their GP for clinical follow up including additional testing, diagnosis, or referral to secondary care.

1.6 Those patients identified as being at high risk of cardiovascular disease are placed on disease registers and clinically managed through their GP practice.

2. Performance to date

2.1 In Oldham we deliver NHS Health Checks using both a primary care and a community model. The community model has been developed through the Early Help service at Positive Steps. Early Help offer a mixed model of health checks and 'Health MOTs' and are targeting areas of the population with the greatest need. A

pharmacy model has also been implemented to support the health checks carried out in GP practices.

2.2 During the first 5-year wave, Oldham moved from one of the lowest performing local authorities nationally in 2013, to being an example of good practice. Between quarter 1 2014/15 and quarter 4 2018/19, 45.4% of Oldham's eligible population had taken up the offer of a health check. This is slightly below the England average of 48.1% but one of the top performances by a Greater Manchester authority.

2.3 The tables below summarise the performance of the programme 2013-2019

People invited for NHS Health Checks year on year

Period	Oldham			North West region	England
		Count	% of eligible population		
2013/14	● (red)	4,106	6.5%	16.6%*	18.4%
2014/15	● (red)	10,768	17.0%	18.1%*	19.7%
2015/16	● (green)	13,105	22.2%	18.0%*	18.8%
2016/17	● (green)	12,245	20.2%	19.0%*	17.0%
2017/18	● (green)	12,782	20.2%	22.3%*	17.3%
2018/19	● (red)	5,808	9.1%	22.1%*	17.6%

**Source:*
Local authorities collect information on the number of NHS Health Checks offered and the number of NHS Health Checks received each quarter and return this data to Public Health England

People receiving NHS Health Checks per year

Period	Oldham			North West region	England
		Count	% of eligible population		
2013/14	● (red)	2,780	4.4%	9.4%	9.0%
2014/15	● (red)	4,892	7.7%	9.6%	9.6%
2015/16	● (amber)	5,353	9.1%	9.1%	9.0%
2016/17	● (green)	5,761	9.5%	9.4%*	8.5%
2017/18	● (amber)	5,270	8.3%	9.9%*	8.3%
2018/19	● (red)	3,584	5.6%	9.7%*	8.1%

**Source:*
Local authorities collect information on the number of NHS Health Checks offered and the number of NHS Health Checks received each quarter and return this data to Public Health England

2.4 During 2018/19, reported performance dipped. However, when interpreting NHS Health Checks data for 2018/19, several factors surrounding the collection and reporting of the data need to be considered.

2.5 A change in data management provider occurred during this period, following the introduction of the GDPR and required compliance levels. As a result, GP practices in Oldham were unable to access reports advising them of patients eligible to receive an NHS Health Check during Q1 and Q2 2018/19.

2.6 This led to a dramatic decrease in the number of invites sent at the start of 2018/19 and also thus a reduction in the number of completed health checks. Once invite lists were made available to practices again (in Q3 2018/19) this led to a large

number of invites being sent to patients in this quarter and the following quarter, health checks being completed. Overall performance improved as a result for the final quarter of 2018/19.

2.7 During the first 2 quarters of 2019/20, invite lists have been fully accessible to GP practices and recorded performance for the full year when published in 2020 should be representative of NHS Health Check activity within Oldham.

2.8 As a result of the improvements seen in the reach and engagement of the programme in Oldham over the 5 years, the following patient findings were reported during last year: the number of patients who were entered onto a disease and/or condition monitoring register as a result of their NHS Health Check was 348. Of those 348:

- 44 patients were diagnosed with diabetes
- 11 patients were diagnosed with chronic kidney disease
- 103 patients were diagnosed with hypertension
- <5[1] patients were diagnosed with coronary heart disease or atrial fibrillation
- 197 patients were diagnosed as morbidly or super-morbidly obese

These numbers may not represent unique patients i.e. there may be some patients with more than one of these conditions found, however, these results demonstrate that a significant number of potentially life-threatening conditions have been uncovered through health checks, which can now be managed in primary care and/or through health improvement services.

2.9 Oldham is recognised in Greater Manchester as having some good practice examples in relation to delivery of the programme in Primary Care. These are:

- The length of appointment time in some Oldham practices for NHS Health Checks exceeds national recommendations of 20 minutes per appointment per patient
- The Q-Risk score[2] is given to the patient by a clinician at a point when the management pathway is already in place to support the patient.

3. Future development of the NHS Health Checks programme in Oldham

3.1 The ambition for the next wave of the programme in Oldham is an NHS Health Check that gives the best possible outcomes for local people. This means an increased focus on quality and outcomes and a more tailored, targeted approach to those who are most at risk.

3.2 Our key focus as we move into the second wave of 5 year roll out of the programme will be on improving the outcomes from the programme including:

- higher numbers of appropriate patients put onto care pathways for diagnosed conditions

[1] Numbers less than 5 have been suppressed for reasons of confidentiality.

[2] The Q-Risk score is found by entering in the patient data and test results, (i.e. family history, height/weight, and cholesterol score) and then using an algorithm to calculates a person's risk of developing a heart attack or stroke over the next 10 years. It presents the average risk of people with the same risk factors as those entered for that person. The algorithm was developed by doctors and academics and accepted by NICE.

- better and earlier condition management

3.3 We will also work to:

- Increase referrals to support services, including social prescribing
- Increase referrals to health improvement services such as smoking cessation, weight management and alcohol support
- Through the NHS Health Check identify common mental health conditions earlier i.e. stress, anxiety and depression and support timely referrals being made

3.4 In addition, Oldham have a community offer ensuring that those most at risk in the population are targeted for proactive invites to attend their health check, specifically: residents who are homeless or veterans.

3.5 We will also be looking to offer and deliver a higher number of Health Checks across the borough during the second five years.

3.6 To reflect our commitment to quality and outcomes for our population, NHS Health Check payments will be structured to reflect the various levels of intervention offered and linked to recorded individual patient outcome data and appropriate onward referrals.

3.7 Continuing Professional Development for clinicians delivering the checks will be ensured through ongoing CVD communications risk training and annual best practice training.

4. Wider public health work with primary care

4.1 The NHS Health Check programme is part of a broader range of public health work with primary care. Other work includes support and advice to each of the 5 primary care networks (PCN's), health literacy, GM working well programme called 'working well early help' and ongoing engagement within the respiratory collaborative.

4.2 A health literacy training programme is being piloted with practice nurses and healthcare assistants to communicate health information that is appropriate to residents understanding. Where residents better understand their health condition, they are better in control; and able to manage their condition and reduce the risk of hospital admissions.

4.3 Oldham have been the front runners embedding the GM programme 'working well early help' ensuring maximum referrals from GPs in the North PCN to a service that ensures people with health conditions who are off work with a fit note are supported back to work through timely and appropriate interventions.

4.4 The Public Health team are members of the Respiratory Collaborative in Oldham West PCN and have been involved in developing the priorities for the cluster to address the prevalence and impact of respiratory diseases, most recently presenting at the Oldham West PCN Respiratory Workshop. The Public Health team are leading the community response to reducing smoking rates as commissioners for stop smoking services, as reduced smoking rates will directly impact the prevalence of respiratory disease, in particular COPD, for which smoking is the biggest preventable risk factor. Work has also been undertaken to share best

practice on oral health for vulnerable older people and resources are being developed to be used in COPD patient education sessions, as poor oral hygiene increases the risk of respiratory infections.

5. Recommendations

5.1 The Health Scrutiny committee are asked to note the performance of the NHS Health Check programme and support the continued work to improve the quality of the programme and ensure it reaches those most at risk of long term conditions.