Health and Wellbeing Board

26 July 2016

Check 4 Life – Improving performance of the NHS Health Check within County Durham

Report of Gill O'Neill, Interim Director of Public Health, Children and Adults Services, Durham County Council

Purpose of the Report

1 This report is to update the Health and Wellbeing Board about the performance of the Health Checks service, benchmarking against other areas and ways in which coverage may be improved. A more detailed report with additional information can be found in the report attached at Appendix 2.

Background

2 The provision of Health Checks is a mandated function of local authorities, the way in which Health Checks are delivered is however not prescribed.

3 The purpose of the Health Check is to identify people with an increased risk of developing cardiovascular disease (CVD).

4 CVD is a leading cause of early death and significant ill health in the UK. The Health Check programme seeks to individually assess everyone in the target group and to meaningfully communicate their risk of disease to them.

5 Performance of the Health Check programme is measured in terms of delivery by the proportion of the eligible population who have received a Health Check in the previous quarter aggregated to give an annual figure.

6 The eligible population is based on the estimated resident population aged 40 to 74 excluding those with CVD and those receiving treatment for its risk factors. Importantly this will include people who have received a Health Check in the previous five years and so will be an over estimation of the true eligible population.

7 The size of the eligible group, and therefore targets based upon it, is an estimate set centrally by Public Health England (PHE). For County Durham this is 163,780 people, however the locally estimated eligible

population in March 2016 based on data recorded on GP practice systems was 115,677.

8 Within County Durham the majority of Health Checks are conducted in a GP setting. There is however variation in activity which is not correlated to practice size. Even where practices exceed their target of providing Health Checks to 20% of their eligible population per year this is not sufficient for the total target for County Durham. To do so practices would have to invite a higher proportion of patients.

9 Within County Durham fewer Health Checks are provided than either the regional or England averages. However the rate at which offered Health Checks are converted into attendances is relatively better.

10 This may be due to the targeted approach (in line with national guidance), centred on those people with higher estimated CVD risk, taken by Health Checks within County Durham. This NICE evidence based approach is predicated upon the CVD framework approved previously by the Health and Wellbeing Board.

11 While this more targeted approach to identify those most at need means that we will tend to fall below national Public Health England targets we can be assured that our Health Check programme is designed to reduce health inequalities.

12 Strict quality controls are applied to the County Durham Health Check programme through the use of Health Diagnostics software. The high proportion of mini health MOTs done in certain settings do not count towards the national target. This is detailed in paragraphs 53 to 55 in Appendix 2.

13 In total 5,028 Mini Health MOTs were carried out between April 2015 and March 2016. This is in excess of the 3,000 Mini Health MOTs expected from contract thresholds.

14 If the locally and not the nationally estimated eligible population was used for performance monitoring and the total number of Health Checks carried out was counted toward the performance figure, the County Durham coverage for Q3 2015/16 would be 2.5% and 3.3% in Q4 2015/16 instead of PHE's 1.6% and 2.0% respectively.

15 Although there has been a slow uptake of NHS Health Checks within County Durham (in line with many areas in England) conversion of Health Check offers to attendances is significantly in excess of the England average. The ongoing review of the Health Check programme seeks to build upon this and other positives locally to develop a resource efficient programme which meets the needs of the local population. This is detailed in paragraphs 94 to 97 in Appendix 2.

16 Going forward the County Durham Health Check programme is being reviewed. In light of budget cuts the programme may become more targeted. This review takes into account learning from high performing local authorities and both stakeholder and public surveys in County Durham. This information is detailed in the full report (Appendix 2).

2015/16 Financial Performance

17 In 2015/16 Check4life services were commissioned from a range of providers; GP practices, DCC Leisure Services, Leisure Works, PCP and Pharmacies.

18 Providers are paid in accordance to the number of verified health checks delivered at a rate of £15 for 'mini MOT' health checks, £25 for a full health check and £35 for a high risk patient health check. Additional contracts exist with County Durham and Darlington NHS Foundation Trust (CDDFT) to provide health checks and Quality Assurance/ mentorship for all service providers (£0.501 million). A contract with Health Diagnostics for ICT licenses and support for the system, including data management (£0.140million). A contract with North of England Commissioning Support (NECS) provides ICT support to GP systems (£40K). The overall 2015/16 Check 4 life revenue budget totalled £1.073million.

19 As noted the uptake for health checks is relatively low and in 2015/16 the service underspent by £79,000. Table 1 below summaries the financial activity in 2015/16.

20 Following a performance/quality assurance review at the end of 2015/16 a number of providers have not been recommissioned to deliver Health Checks in 2016/17.

Table 1 Check 4 life 2015/16 revenue Budget and actual spend

Contract	Full Year budget 15-16 £	Full year actual 15-16 £	15-16 Variance £
CDDFT-Health Improvement service - Health check	501,288	501,288	(0)
GP Practices - various-Health Improvement service - Health check	288,612	217,005	(71,607)
PH039-NECS-Primary Care Informatics & Bus Suppt	40,000	38,500	(1,500)
Various Providers-Community Contract – pharmacies	104,000	62,405	(41,595)
Health Diagnostics -Capital and Consumption	140,000	176,195	36,195
Total	**1,073,900**	**995,394**	**(78,506)**

Recommendations

21 The Health and Wellbeing Board is recommended to:

- Note the content of the report;
- Note the impact that differences between centrally and locally estimated eligible populations have on performance outcomes;
- Note the impact of quality control measures on reported numbers of Health Checks;
- Note the outcomes from the Health Check review and agree that the new delivery model will be presented to a future HWB meeting;
- Note the programme is subject to procurement and the current contractual arrangements end 31 March 2017.

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Appendix 1: Implications

Finance
Funded through public health grant.

Staffing
If the current model does not alter significantly there will be minimal impact to staff. However if the programme were to change significantly this could impact upon staff training and necessary staffing levels in provider organisations.

Risk
As health checks is an ongoing mandatory function there is a reputational risk should the provision of health checks be interrupted.

Equality and Diversity / Public Sector Equality Duty
One of the programme's objectives is to contribute to narrowing health inequalities. It is for local authorities to decide how best to commission the programme in such a way that this objective is achieved. Local authorities have a duty to offer the NHS Health Check to all eligible people, with the expectation that a priority is given to inviting individuals with the greatest health risk.

Accommodation
None

Crime and Disorder
None

Human Rights
None

Consultation
A market engagement was held in January 2016. Additional consultation with service providers was had through questionnaire and face to face meetings. Furthermore an expert panel was set up to provide a sounding board to proposed new models of delivery.

Members of the public have previously also been interviewed on the topic.

Procurement
A procurement exercise is being undertaken on the Health Checks programme currently.

Disability Issues
Health checks must be accessible to all those eligible. The current model makes provision for this. Access will be preserved in any future Health Check model.

Legal Implications
In April 2013 the NHS Health Check became a mandated public health service in England. Local authorities are responsible for making provision to offer an NHS Health Check to eligible individuals aged 40-74 years once every five years. Specifically there are legal duties for local authorities to make arrangements:

- For each eligible person aged 40-74 to be offered a NHS Health Check once in every five years and for each person to be recalled every five years if they remain eligible
- For the risk assessment to include specific tests and measurements
- To ensure the person having their NHS Health Check is told their cardiovascular risk score, and other results are communicated to them (including information designed to raise their awareness of dementia and of
- The availability of memory services)
- For specific information and data to be recorded and, where the risk assessment is conducted outside the person's GP practice, for that information to be forwarded to the person's GP.

Local authorities are also required to continuously improve the percentage of eligible individuals taking up their offer of an NHS Health Check.

Legal duties are set out in Local Authorities (Public Health Functions and Entry to Premises by Local Healthwatch Representatives) Regulations 2013, S.I. 2013/351

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Purpose of the Report

1 This report is to update the Health and Wellbeing Board about the performance of the Health Checks service, benchmarking against other areas and ways in which coverage may be improved.

Background

2 Health Checks is a national risk assessment and management programme for those aged 40 to 74, who do not have an existing cardiovascular disease (CVD), and who are not currently being treated for CVD risk factors. It is a rolling programme offering everyone in the target group a Health Check every 5 years. The programme aims to prevent heart disease, stroke, diabetes and kidney disease, and raise awareness of dementia both across the population and within high risk and vulnerable groups.

3 Health Checks is one of the five mandated Public Health functions in the Health and Social Care Act 2012. Local authorities are responsible for commissioning Health Checks and for monitoring uptake. Local authorities have a statutory obligation to provide the patient's GP with the outcomes of an individual's Health Check.

4 In County Durham Public Health commission two elements, the national NHS Health Check programme, plus a locally developed and enhanced Check4Life scheme.

5 Durham County Council has a number of contracts with various providers to provide the NHS Health Checks and Check4life programmes. These contracts will cease in 2017 and therefore a review is now being undertaken. A procurement exercise is to be undertaken on the Health Checks programme in 2016 to allow sufficient time to prepare the market and develop the programme for April 2017.

6 Key stakeholders such as service users and health professionals will be actively involved in the review of the service.

Current Health Check Performance

7 Figures 1 – 3 show nationally published Health Check data from Quarter 3 2015/16. They compare County Durham to the England and North East averages as well as benchmark against other areas in the North East. In Quarter 3 of 2015/16 significantly fewer Health Checks were offered to the eligible population than the England or regional averages (Figure 1). Within the region only North Tyneside and Sunderland had similar rates. Newcastle upon Tyne showed a significantly lower proportion, whilst all other areas had rates in excess of County Durham's.

8 Figure 2 shows the relative proportions of eligible people who have actually received a Health Check in Quarter 3 (rather than just been offered one). In this chart we can see that the gap between County Durham and the North East and England averages has closed markedly. Additionally approximately half of the other areas locally did not perform as well in this regard within the quarter. Several areas did however do slightly better than County Durham.

9 The reason for the relative narrowing of the gap can be better seen in Figure 3. This demonstrates the success County Durham has had in converting offers of Health Checks into actual checks received. It is notable that County Durham exceeded both the England and North East averages substantially in Quarter 3 and indeed the majority of local areas. Only North Tyneside had a greater percentage success rate and again this was broadly similar to County Durham.

10 While a single quarter's numbers are interesting and paint a picture of what may have been happening at that point they are just a snapshot in time. As the NHS Health Check programme is a long term rolling programme designed to run in five-year cycles performance is better examined over a longer time frame. Therefore Figures 4 to 6 show data from the first quarter of 2013/14 to the second quarter of 2015/16.

Figure 1: Percentage of NHS Health Checks offered to total eligible population in 2015/16 Q3

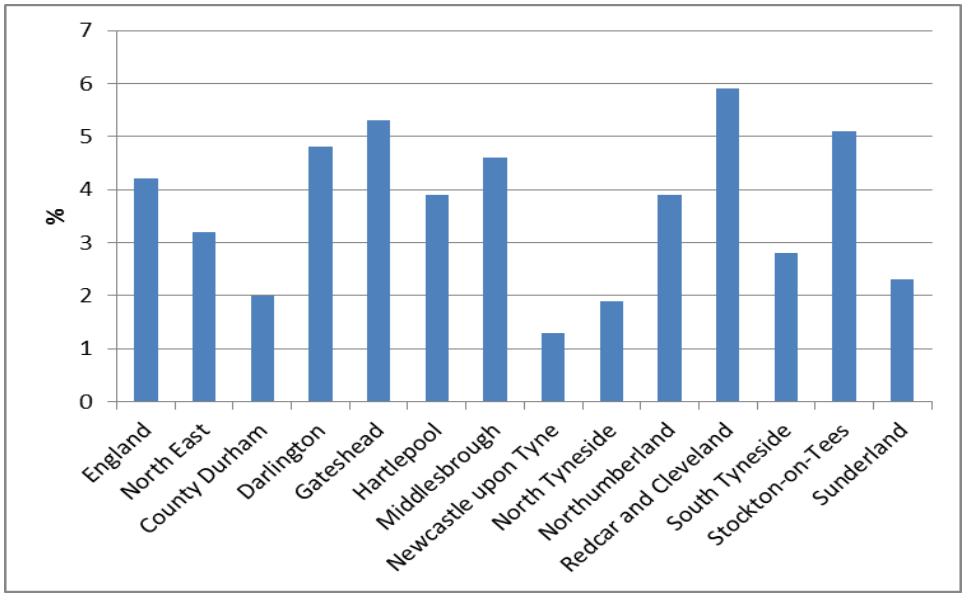


Figure 2: Percentage of NHS Health Checks received by total eligible population in 2015/16 Q3

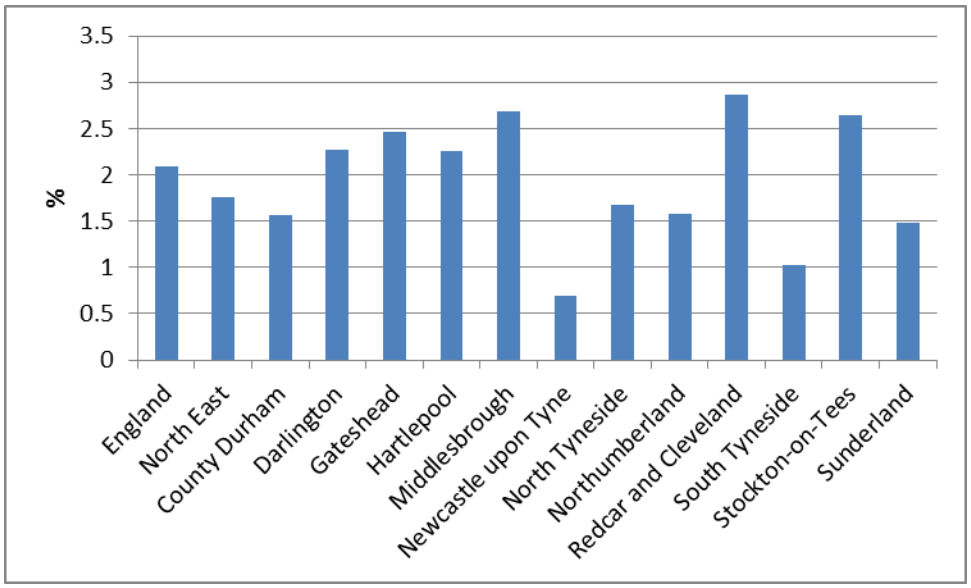
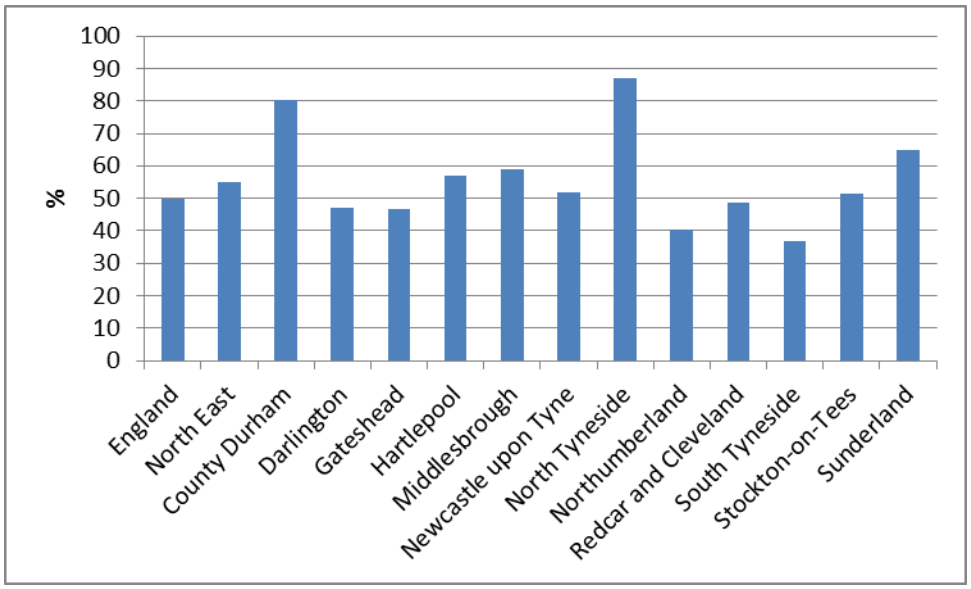


Figure 3 Percentage of offered NHS Health Checks taken up in 2015/16 Q3

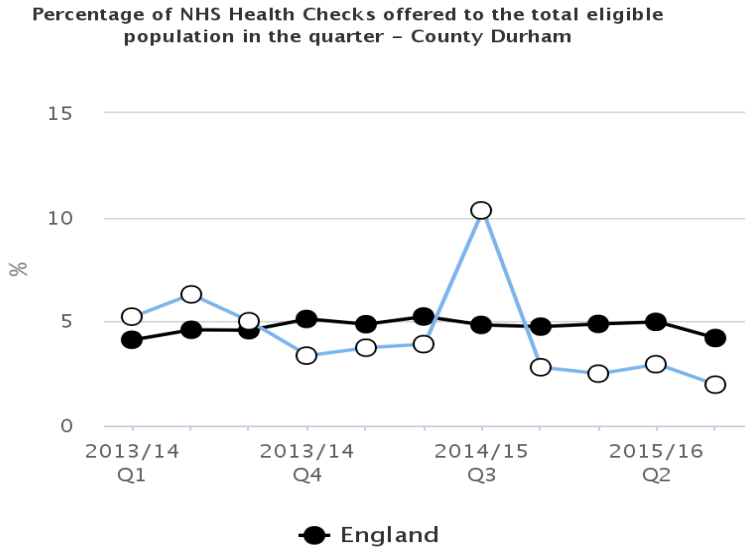


11 The cumulative percentage of the eligible population aged 40 to 74 who were offered a Health Check from 2013/14 to 14/15 in County Durham is 40.6% (95%CI 40.4 to 40.8). While this is slightly lower than the North East regional average of 42.1% for this same period, it is in excess of the England average of 37.9%.

12 Figure 4 demonstrates that the number of Health Checks offered to the eligible population in County Durham has fluctuated around the England average. Whilst it has in the main tracked slightly below the England average it has exceeded it in several quarters, most notably reaching over 10% in Quarter 3 of 2014/15.

13 Similarly Figure 5 shows that eligible Health Checks received have tended to track just below the England average. Figure 6 shows that County Durham tends to be better at converting Health Check offers into actual received Health Checks.

Figure 4



14 In terms of those who were offered a Health Check and receive one, the County Durham value of 43.7% (95%CI 43.2 to 44.2) is not significantly different from the North East average of 44.2% for 2013/14 to 14/15. This is slightly below the England average of 48.9%. In terms of those who receive a Health Check as a proportion of all those eligible the figures are markedly lower being 17.7% (95%CI 17.5 to 17.9) for County Durham and 18.6% for both the North East and England for 2013/14 to 14/15.

Figure 5

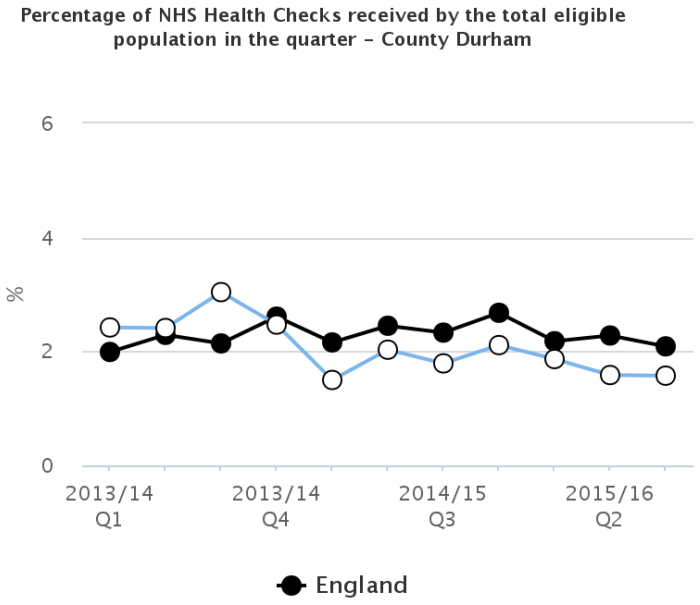
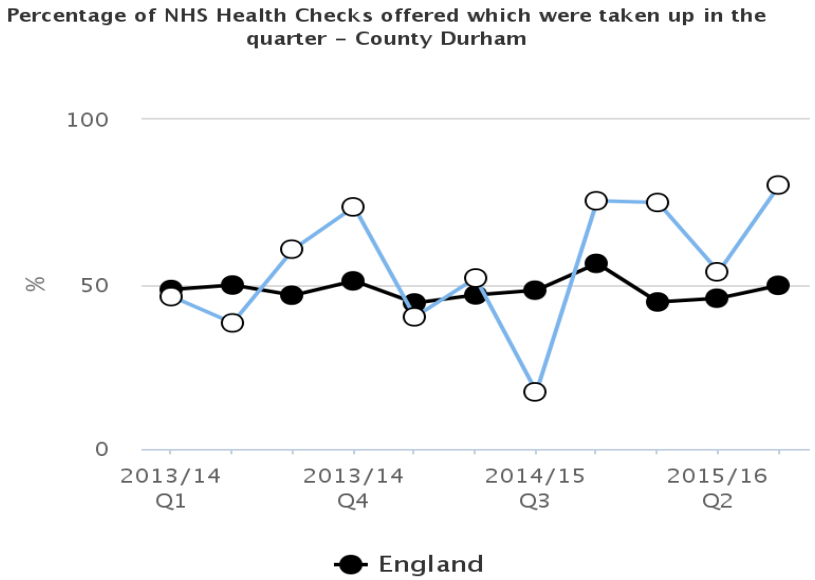


Figure 6



15 Nationally in terms of cumulative percentage of the eligible population aged 40-74 who received an NHS Health check2013/14 - 14/15 County Durham is ranked 83rd out of 152. Bolton has the greatest success rate reported at 44.7%, the poorest being Surrey at 5.7%. County Durham sitting at 17.7%.

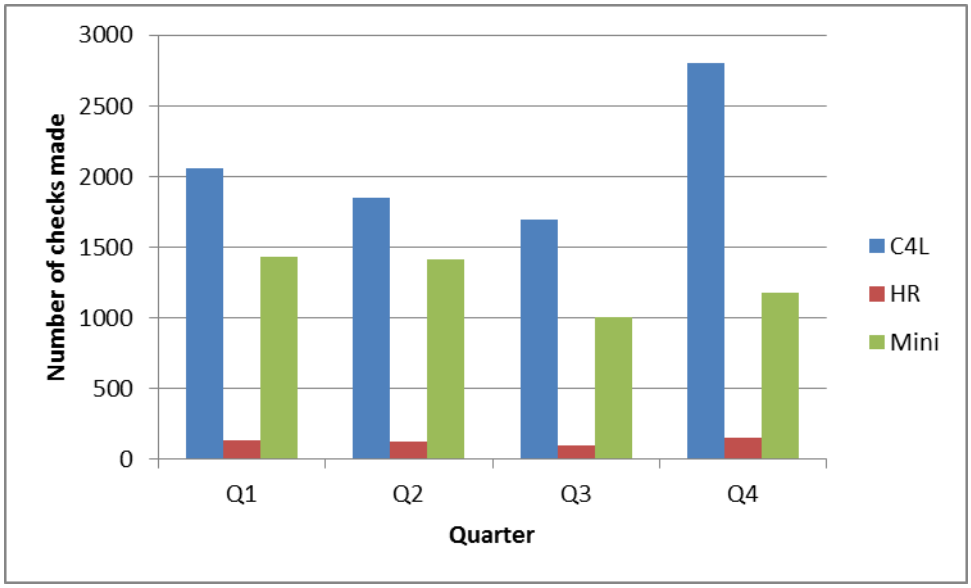
16 Table 2 below shows a breakdown of Health Check and Mini Health MOT activity from April 2015 to March 2016. The total number of Health Checks conducted can be found by summing the Check 4 Life (C4L) and those conducted in individuals thought to be at High Risk of cardiovascular disease. While Mini Health MOTs come under the banner of the C4L / Health Check they do not themselves constitute a full Health Check (blood is not taken to provide a lipid profile and furthermore MOTs are open to a wider age bracket than national Health Checks). Activity levels of Mini Health MOTs are therefore not reported to NHS England and do not form part of the count against the national target. They do however currently represent a significant aspect of activity.

Location	Table 2 Health Check and Mini Health MOT Activity April 2015 to March 2016											
	Quarter 1			Quarter 2			Quarter 3			Quarter 4		
	C4L	High Risk	Mini	C4L	High Risk	Mini	C4L	High Risk	Mini	C4L	High Risk	Mini
GP	1157	129	-	1228	126	-	1091	93	-	1969	155	-
Community	751	-	1420	507	-	1406	539	-	1004	745	-	1169
Pharmacy	149	-	12	114	-	11	68	-	1	86	-	5
Total	2057	129	1432	1849	126	1417	1698	93	1005	2800	155	1174

17 The total activity for April 2015 to March 2016, as reported through Health Diagnostic software, is shown in Figure 7 below. This again displays the relatively high level of Mini Health MOTs conducted. In total 5,028 Mini Health MOTs were carried out between April 2015 and March

2016. This is in excess of the 3,000 Mini Health MOTs expected from contract thresholds (derived by summing the individual provider maximum thresholds).

Figure 7 Total Health Check and Mini Health MOT Activity April 2015 to March 2016



Quality control of Health Checks

18 While comparisons of nationally published Health Check data are broadly informative there are limitations with this methodology. The numbers published are reported by each area quarterly. There is no standardised data validation process used uniformly across England. Within County Durham bespoke software is used to record Health Checks that meet the strict criteria of a Check 4 Life (C4L) Health Check. Comparison of data from this software to that received through RAID-R as well as the identification, through Health Diagnostics, of ineligible health checks being conducted (either a health check done on an ineligible person or one which did not meet the requirement for a C4L Health Check) show that a significant proportion of health checks recorded on practice systems would not be recorded in the national data. It is unclear if other areas would filter in the same way. This may explain a degree of the variation observed. The rate of ineligible Health Checks conducted also vary by site with community outreach tending to have a higher rate than those conducted in GP surgeries.

19 The size of the eligible group, and therefore targets based upon it, is an estimate set centrally by Public Health England. For County Durham this is 163,780 people, however the actual eligible population in March 2016 based on data recorded on GP practice systems was 115,677.

20 If the actual and not the estimated eligible population was used for performance monitoring and the total number of Health Checks carried

out was counted toward the performance figure, the County Durham coverage for Q3 2015/16 would be 2.5%. The figure is higher in Q4 2015/16 being 3.3%. The performance reported by PHE is 1.6% and 2.0% respectively.

National evaluation

21 In 2016 an evaluation of the first four years was published in BMJ Open by Robson et al. It highlighted that programme attendance increased as it became more established rising from 5.8% in 2010 to 30.1% in 2012 nationally. As the programme is to be assessed over five years, coverage was given as the percentage of attendance per fifth of the eligible population. This rose from 5.8% in 2009/10 to 14.6% in 2010/11 to 24.4% in 2011/12 and 30.1% in 2012/13.

22 Over the four years of the study it was noted that individuals taking up an offer of a Health Check tended to be older (19.6% of those aged 60 to 74 who were eligible compared to 9% of those eligible but aged 40 to 59 attended). Those more at risk of cardiovascular disease, including those living in more socially disadvantaged areas were more likely to attend (in the most deprived quintile, 14.9% attended and in the least deprived quintile, 12.3% of those eligible attended). There was also a slight tendency for women to be more likely to take up a health check than men (although more women were eligible than men).

23 The study also presents a number of recorded risk factors comparing health check attendees with non-attendees. Smoking was less common in attendees than non-attendees, with 17.7% of attendees being smokers and 22.4% of non-attendees. There was a lower prevalence of non-drinkers in attendees, additionally heavy drinking (>9 units/ day) was reported by 2.5% of attendees and 2.2% of non-attendees.

24 The QRisk2 and (in a minority of cases) Framingham tools had been used to assess Cardiovascular disease (CVD) risk. In total 27 624 of the 214 295 attendees (12.9%) were recorded as having a high CVD risk (a 20% or greater risk of having a heart attack in the next 10 years).

25 Individuals with high CVD risk who attended a Health Check tended to be older (the majority being 60 to 74 years old) and the majority were men (78.3% of the high risk group cf 47.9% of all attenders).

26 The authors also point to a number of local studies which suggest that the programme has been variably implemented with some areas achieving coverage of 80%. Nationally, uptake in 2011–2012 was reported to be 45%, with better uptake in more deprived areas. They conclude that large organizational change in the NHS will have contributed to the slower than expected start to Health Checks. They also note the possibly deleterious effect of financial cuts on the programme, and conclude that the most efficient ways of delivering the programme are still being researched and debated.

Local evaluation

27 Data from a recently conducted study of five years of NHS Health Check data showed similar results to the national study. This study used data extracted from the information systems of 71 practices in County Durham. The data included a specified data set on everyone registered with these practices, between the ages of 40 and 74 years old at any time in the first 5 completed years of the programme. This was from January 2009 to December 2013. From these records it was possible to see which eligible people had received a Health Check in line with local Check 4 Life (C4L) standards. These were based on the Read Codes set out in the Best Practice Guidance for the programme. The definitions used and the population assessed were therefore robust and representative of the local eligible population.

28 The overall coverage within County Durham was 49% from 2009 to 2013, this is significantly in excess of that published in Robson et al. Again there tended to be more women than men seen at a Health Check. The coverage of the programme increased significantly with age. This increased steadily by 5-10% for every 5 years age gained, starting at 35% at 40-44 years old and reaching 82% at 70-74 years old. This demonstrates the same trend as Robson et al saw nationally but the effect is significantly more pronounced in County Durham. The possible explanation for this difference is that the programme in County Durham gave a greater emphasis to inviting people with an estimated high risk of CVD. This means that older people were more likely to be invited for a Health Check.

29 There was however less of a clear picture around deprivation as the trend seen nationally was not seen in the raw local data.

30 Smokers were again seen to be in the minority of attenders. The coverage for non-smokers was 49%, and for smokers 42%. The group most likely to have a health check were ex-smokers at 59%.

31 There was considerable variation in the coverage of Health Checks by GP practice ranging from 88% to 21%. There is no discernible trend to explain the wide variation by practice size.

32 There was a significantly greater proportion of attendees who had a CVD risk score of 20% or more in County Durham than in the national programme, the figures being 21% and 12.9% respectively.

Learning from other areas

33 Bolton had the highest cumulative proportion of eligible people receiving a Health Check in 2013/14 - 14/15 (44.7%). Their “BIG Bolton Health Check” case study described steps taken to address a situation where those living in the most deprived areas were living 15 years less than those in more affluent areas, often from preventable conditions. A key

aim of their approach to Health Check delivery was to involve a large number of stakeholders with the process.

34 A particular focus was put on those who could influence people to have a Health Check, such as: GPs (all staff); local authority; faith groups; voluntary sector and local press. This latter group was seen as having a major role as weekly stories were published about Health Checks during the first year.

35 As an outcome robust primary prevention registers were created. These recorded findings from Health Checks conducted in a number of settings, not limited to GPs but also including community settings including supermarkets, bingo halls, cafes and barbers. The authors of the case study note that although outreach work did not reach as many people as GPs these sites were seen as being important in marketing the programme. However once this was achieved, Health Checks were only offered through GPs in interest of efficiency.

36 Health trainers were also important to the delivery of the BIG Bolton Health Check. These professionals were trained in venepuncture and in the taking of blood pressure and were embedded within GP surgeries to support the Health Check programme. Additionally the Health Trainers were able to continue to work with people who were motivated to make lifestyle changes who were identified in this setting. However it was noted that in the future the role of the Health Trainer might change from being part of the Health Check into lifestyle modification interventions.

37 In Leicester GP practices were consulted so that they could be efficiently incorporated into the Health Check framework. Each practice was allowed to develop its own model of patient engagement (e.g. some chose to text eligible people others used direct mail outs). Further consultation led to a restructuring of the payment system so that GPs were paid per screen as well as receiving a one-off payment “for each patient entered into the condition management system”.

38 Furthermore the local CCG and local authority were aligned on the programme with the Public Health team being the bridge between both bodies. In addition a project group with representatives from CCG, research and Public Health was established. A common IT system was put in place to collate data and share reports across practices.

39 In 2014 Cooper and Dugdill completed a rapid review of the Evidence of improved uptake of Health Checks (Uptake of Health Check Review link).
This summarised the findings of five studies described in seven papers. The authors drew attention to generic barriers around uptake which include:
“anticipated embarrassment of the screening procedure, perception of pain related to screening or fear/anxiety related to the test results, cultural barriers, fatalism towards health outcomes, low level of

perceived effectiveness of the screening procedure, lack of recommendation by a physician, male staff performing the screening, as well as lack of time, and lack of transport or costs involved in attending screening" (Cooper and Dugdill, 2014, p.3).

40 With regard to specific recommendations to increase uptake of the NHS Health Check the authors concluded that data should be explored to understand the local population (both attenders and non-attenders). Additionally it was recommended that qualitative data (again from both attenders and non-attenders) be used to understand the local barriers and facilitators to attending a health check. The questionnaire survey in County Durham goes some way to contributing to this locally.

41 Importantly they also suggest targeting those thought to be in high-risk groups (already done in County Durham) and draw attention to ensuring that those likely to engage with the programme (e.g. those with a good history of attending their GP as well as older female non-smokers) receive a clear offer.

42 They also suggest that invitation letters be tailored to different population groups. Whilst the relevance of this may be limited in County Durham, as there are fewer minority groups resident, this approach could be used with respect to gender and age group for example.

43 Where GP practices are large Cooper and Dugdill recommend that the invitation comes from their "preferred GP" within the practice in order to counter the effects of reduced continuity of care. From County Durham data this may not be a major driver of NHS Health Check uptake locally as we have shown clinically unexplained variation, which was not seen to be dependent upon practice size.

44 Finally the authors highlight the need for good systems for tracking patient data (including ethnicity and smoking status) as well as the completeness of tests.

The Health Check programme in County Durham

45 The move to using Health Diagnostics software in C4L Health Checks, which has been proceeding over the past several months in order to address these points, has now reached the point where all practices delivering C4L Health Checks have this software in place. The software allows public health to see the number (and proportion) of C4L Health Checks completed to specification. This has allowed Public Health to identify sites that are not reaching the expected numbers of eligible people and services that have been delivering unexpectedly high numbers of mini Health MOTs instead of full Health Checks.

Stakeholder survey

46 As part of the on-going review of the Health Check delivery model a questionnaire was used to gather the opinions of all stakeholders currently providing Health Checks in County Durham.

47 All of the 13 respondents to the Health Checks Stakeholder questionnaire (sent to all GP practices in County Durham) reported currently carrying out Health Checks within their practices. However only ten practices (77% of the sample) stated that they used the Health Options software within their check (therefore only 77% complied with the current Check 4 Life standard in that regard). The majority (55%) of those who use Health Options software saw it as a benefit, however in numbers terms this was only six practices, with five other practices noting that it was a barrier to conducting Health Checks. Two respondents noted that they did not use or could not comment on the software.

48 A clear majority of respondents (77% of the total sample) thought that the programme should be offered to the entire eligible population with 15% (two practices) suggesting it should be offered on a targeted basis. One practice indicated that it should be both. Presumably this was to illustrate the need to apply proportionate universalism. As this was not an explicit option on the questionnaire it is unclear how many respondents would have agreed with the idea of providing the Health Check programme to all eligible people but with additional targeting to at risk or vulnerable groups, or indeed by area deprivation levels. Only one practice indicated that they would not want to have a signed data sharing agreement, compliant with the Data Protection Act, allowing Apollo Medical to access patient data to facilitate a call and recall system. One practice did not answer the question; the remaining 11 indicated that they would be willing to agree to such an arrangement.

49 A number of barriers to the efficient delivery of Health Checks were identified in a free text section of the questionnaire. There was concern around the wasting of consumables if a patient does not attend a with patients around Health Checks and getting them to attend. There were a number of concerns around resources. These ranged from nurses' time and availability to the time pressures put on surgeries. One respondent noted that, "although the appointments take half an hour there is far more preparation involved in getting ready for the appointment, maintain equipment, calibrating testing of equipment and I don't think that this is reflected in the time allocated or payment."

50 The use of IT was an issue raised a number of times. Some practices felt that the software did not "allow for all situations/circumstances" others felt that the software itself wasn't particularly reliable, this lead to users picking the closest alternative, which would introduce errors to the data.

51 The need to support practices in the installation, set-up and training of staff in the use of software was also expressed.

52 There was also concern around the numbers of completed health checks being designated as ineligible. It was felt that better feedback could be given to the practice as to what point made the patient ineligible. There were also concerns around payments associated with this.

53 It was felt that the programme could benefit from increased promotion in order to gain more engagement from eligible people.

54 Conversely a number of benefits were also seen. The main benefit seen was that it provides intervention and information to patients. Health Checks were seen as being an example of “proactive health care" which engages individuals otherwise unlikely to attend a GP. Importantly it was also believed that Health Checks could lead to early detection of risk factors and conditions (allowing for better outcomes than if disease was allowed to progress) and additionally re-assurance for the “worried-well”. Furthermore the Health Check “makes people think about their health and getting older and to consider lifestyle changes”.

55 Referring to the NHS Health Check provision in County Durham, Check 4 Life, is “a more robust system for ensuring the correct patients are offered a health check”. The information pack provided for patients to take away was seen as an important resource.

56 In addition to this Durham County Council commissioned independent research to explore perceptions of NHS Health Checks amongst residents of County Durham. This resulted in 509 on-street surveys being carried out along with 10 in-depth interviews.

57 The majority of respondents (52%) had experienced a Health Check. A larger proportion (66%) had received an invitation for a Health Check from their GP. This was an increase of 14% since 2014. The large majority (89%) received their Health Check at their GPs with 91% reporting that they had received an update of their results.

58 Communication of risk was less good however as only 22% of respondents reported receiving a risk score. Indeed this is a decrease of 18% since 2014. Furthermore 49% of respondents stated that they were given advice on how to improve their lifestyles after receiving a Health Check. The most commonly reported ways that people had improved their lifestyles after a Health Check were through improved diet and greater levels of exercise (46% and 39% respectively).

Health Checks – a new model

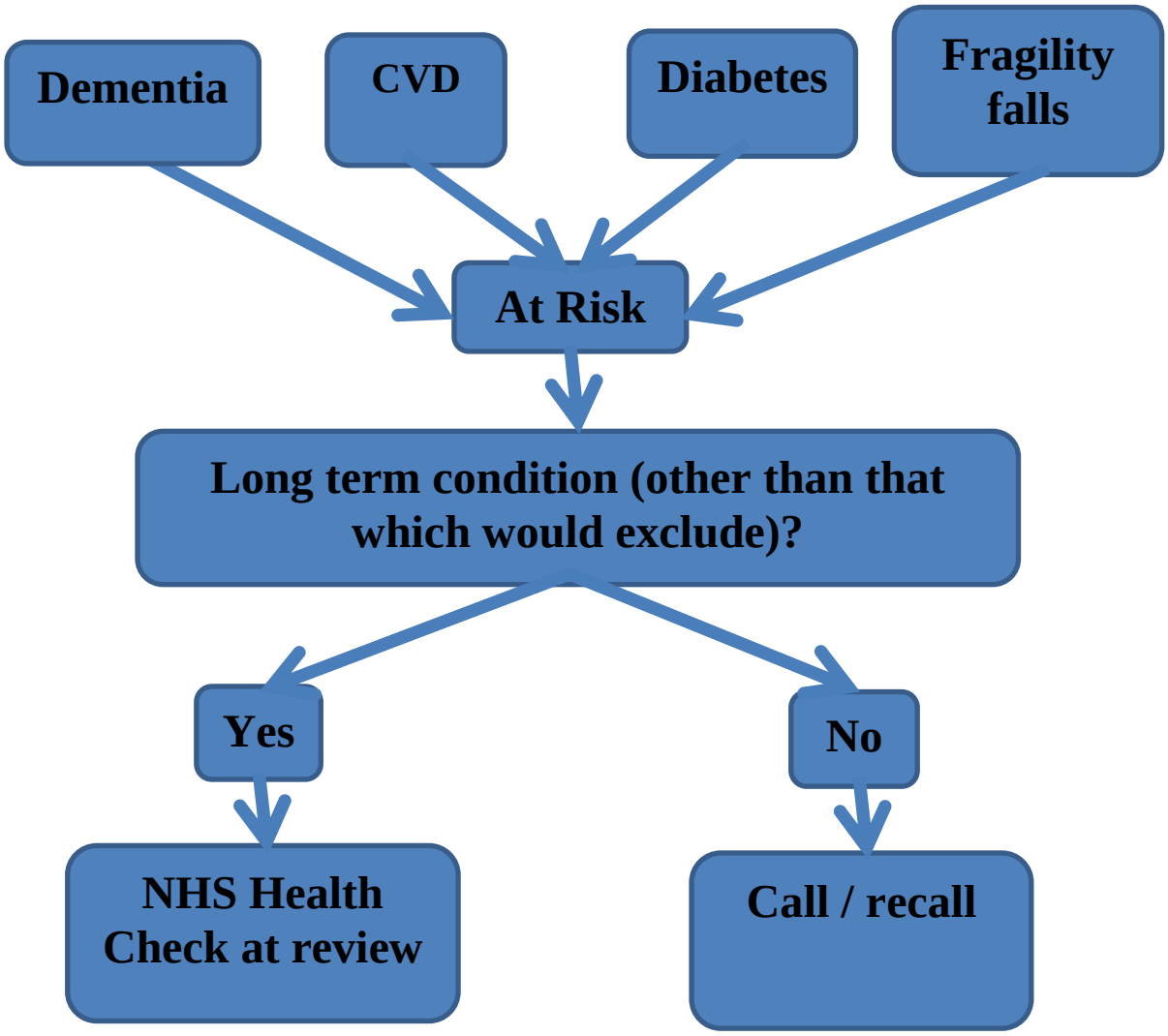
59 An expert reference panel (comprised of primary care, representatives of GP federations and healthcare bodies) was set up to advise on possible models of service delivery. Four potential models were presented to the expert panel. These are described below in Table 3:

Table 3 Possible Future Health Check Models

MODEL	PROS	CONS	NOTES
1. No change – mixture of GP and community providers	• No/little restructuring required	• Variable engagement currently • Ignores possibility of efficiencies • Currently high proportions of ineligible people are seen in community settings. • Those seen are less likely to require a health check (low risk)	
2. Primary care call and recall with targeted community outreach	• Allows good coverage of total population • Allows choice of venue – all patients would have access to a health check at a practice • Promotes patient/GP engagement • Allows for proportional universalism • Infra structure (e.g. IT, Quality Assurance) already exists to	• Requires all primary care to at least allow access to records for call and recall	• By strong consensus within the group this was seen as the favoured model. • A strong standardised QA process needs to be in place. • To be of greatest utility the model could be integrated with others such as diabetes prevention and fragility falls in terms of at risk case finding. • The point was strongly made that the software used also

MODEL	PROS	CONS	NOTES
	meet this • Little disruption from current service • Good quality data		integrates with practice systems so that data do not need to be typed in multiple times to various programs.
3. Procure flat number of Health Checks from provider(s)	• Simple to commission • Knowable costs	• Little ability to target • Possibly less informative data returned (e.g. numbers of checks and risk factors only, health check status unknown at time of testing)	• It was noted that the targeting ability of this model depended largely on what was put around it within contracts.
4. Local Authority only runs community outreach for those not registered with a doctor. All other aspects of Health Checks to be delivered by GPs' routine work	• Potentially cheaper for Local Authority • Allows more resource to target hard to reach groups known to have poorer health outcomes • Recognises GPs may be seeing those at high risk already	• More expensive for GP than current model • Probable increase in health inequalities • It was noted that GP Federations would find it difficult to provide support for this model.	

60 The expert panel agreed that Model 2 is seen as the preferred choice to deliver an effective Health Check service. The model below was mapped out as the Primary Care section of Model 2. It should be noted that to complete this model a community outreach arm, following the principals of proportionate universalism to target areas of relative deprivation / high risk would be necessary. This would allow for inclusion of individuals not registered with a GP.



61 This new model may see a more targeted approach in order to make efficient use of a decreasing budget. Health Checks within County Durham have tended to be conducted on those at a higher risk of heart disease and therefore an older population. This has been incentivised to GPs in order to maximise the potential gain to the patient and therefore efficiency of the programme. It is likely that this targeting will continue into the new model. This targeting is in line with PHE advice (NHS Health Check Implementation Review and Action Plan link) which states that while the programme is a population centred one it may be targeted towards certain groups such as people living in deprivation. This is important as we know that a greater burden of disease falls on these communities.

62 In summary C4L Health Checks is an evidence based programme that, while giving due attention to providing a population level intervention has focussed on identifying those at most risk who potentially have the most to personally gain from early intervention. This is at least in part due to the need to provide a cost efficient service.

Conclusion

63 There has been a slow uptake of NHS Health Checks within County Durham; however this is in line with many areas in England. A clear positive of the local C4L service is that once at risk individuals are identified and offered a Health Check there is a strong tendency for it to be taken up. This is significantly in excess of the England average.

64 Several factors have been seen to affect the success of Health Checks in terms of checks offered to the eligible population. County Durham meets a number of these, including having a robust IT system to follow Health Checks delivered and targeting those most at risk of developing cardiovascular disease.

65 There are however areas that could be considered for improvement however. These could include the rationalisation of the number of mini health MOTs conducted, freeing resources to support full C4L Health Checks. Furthermore which sites deliver Health Checks and which only signpost to the service (e.g., from community settings) could also be altered so that resources can be focused on sites which conduct a greater volume of Health Checks (i.e., GP surgeries).

66 The on-going review of C4L Health Checks seeks to engage with primary care and other stakeholders, in line with case studies seen from other areas, to develop a resource efficient service that also meets the needs of the local population.

Recommendations

67 The Health and Wellbeing Board is recommended to:

- Note the content of the report.
- Note the impact that differences between centrally and locally estimated eligible populations have on performance outcomes.
- Note the impact of quality control measures on reported numbers of Health Checks.
- Note the outcomes from the Health Check review and agree that the new delivery model will be presented to a future HWB meeting;
- Note the programme is subject to procurement and the current contractual arrangements end 31 March 2017.

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