Public Health England

Supported by: Local Government Association, NHS England

NHS Health Check implementation review and action plan

July 2013

Public Health England

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Public Health England

Executive summary

The NHS Health Check programme offers a fantastic opportunity to tackle avoidable deaths, disability and reduce health inequalities in England. Public Health England (PHE), the Local Government Association (LGA) and NHS England are working closely together to provide consistent, strong support for this important programme.

Key to the review has been talking to people involved in commissioning and delivering local programmes. Qualitative research to understand how the NHS Health Check programme has been implemented since 2009, was combined with a series of stakeholder and expert meetings to explore, in detail, best practice, barriers to implementation, emergent issues and possible actions.

Through the review process and in discussion with our partners in the Local Government Association, NHS England and others, we have identified ten key areas which will be the focus of PHE support.

The review has been an opportunity to take stock of what we have achieved, share what we have learned and start to understand what makes a successful programme. We stand united in our shared ambition to work together for successful implementation and scale-up of the NHS Health Check programme. Colleagues working across health and social care all play a critical role in now making this programme happen. This will help achieve the reductions in avoidable deaths and ill-health across our communities: the people we serve, our neighbours, friends and within our own families.

Professor Kevin Fenton
Director, Health and Wellbeing
Public Health England

Councillor Zoe Patrick
Chair, Community Wellbeing Board
Local Government Association

Professor Sir Mike Richards
Director for Reducing Premature Mortality
NHS England

Public Health England

Local Government Association

NHS England

	Issues	Actions
1	Leadership	PHE fully supports the NHS Health Check programme at all levels. It will lead the development of collaborative national leadership through a clear programme governance structure including an advisory committee, comprising the key stakeholders (NHS England, NHS Improving Quality (NHS IQ), Department of Health (DH), LGA and others) and an expert clinical and scientific advisory panel. PHE will provide timely and authoritative advice on emerging issues and will empower public health leaders locally with the evidence and rationale for the programme.
2	Improving uptake	PHE will work with local authority NHS Health Check teams to test the potential impact of behavioural insight and marketing interventions on uptake. This will include developing options for improving the NHS Health Check brand, establishing the effectiveness of different approaches to recruitment and testing marketing campaigns to support uptake locally and nationally.
3	Providing the Health Check	A. PHE will thoroughly review and collate previous approaches to commissioning and delivering the NHS Health Check programme and so learn from and share promising practice and experience. B. PHE will collaborate with the Centre for Public Scrutiny to work with several test bed sites to explore approaches to effective commissioning the programme.
4	Information governance	PHE will explore long term solutions to free up the system to enable the flow of data, including to and from GP practices, for the best possible delivery of the NHS Health Check programme. It will explore the use of innovation and IT technologies to allow the seamless flow of NHS Health Check data across the health and social care system. This will create an environment that supports local teams to commission and evaluate programmes which aspire for excellence and improved outcomes.
5	Supporting delivery	PHE will build upon and give continued support to established national, regional and local implementation support networks, ensuring equitable access to all organisations across England. PHE will work with the LGA to advance NHS Health Checks through the sector led improvement agenda.
6	Programme governance	PHE will set up clear programme governance arrangements, including an Expert Clinical and Scientific advisory panel to assure that any additional elements of the programme are evidence based. It will keep the programme under review and advise the DH and Ministers accordingly.
7	Provider competency	A. PHE will work with Health Education England (HEE) to build upon existing competency frameworks for use by providers and commissioners to ensure high quality training for those delivering the NHS Health Check. B. PHE will work with local commissioners, training providers and professional bodies to develop a professional development programme of work on NHS Health Checks to enhance the focus on behaviour change for better health outcomes.
8	Consistency	PHE will release and review on a regular basis best practice guidance describing all the elements and standards it would expect of a quality programme such as quality of delivery and robustness of data capture and reporting. It will raise awareness, promote adoption and explore opportunities for quality assurance programmes in local authorities.
9	Proving the case	PHE will work with system partners to facilitate future research and evaluation of the NHS Health Check programme at a national and local level. This will provide the implementation evidence required to ensure effective roll-out and improvement.
10	Expected roll-out	PHE will support those LAs taking on challenging programmes. It will work with local authorities to achieve offers to 20% of the target population annually with a vision to realise at least 75% uptake per year. This will support local authorities to achieve offers to 100% of their eligible population over five years.

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Purpose and scope of the implementation review

This review has determined how PHE will support local authorities in commissioning the NHS Health Check programme

The Secretary of State for Health has prioritised reducing premature mortality and has a focus on improving prevention and early diagnosis; the NHS Health Check programme will be a key deliverable in supporting this ambition.

The Department of Health published *Living well for longer:* a *call to action on avoiding premature mortality* and the *Cardiovascular disease (CVD) outcomes strategy* on 5 March 2013. Both identify the NHS Health Check programme as a vehicle for delivering ambitions.

The *Global burden of disease* report (2013) highlighted the need to reverse the growing trend in the number of people dying prematurely from non-communicable diseases. Since 1990, the number of people dying from ischemic heart disease and diabetes has risen by 30% and a high body-mass has been attributed as the most important cause of premature mortality and disability.

Therefore it is imperative that PHE supports local authorities to commission successful NHS Health Check programmes.

- *The Global burden of disease: Generating evidence, guiding policy* – The Global Burden of Disease (GBD) approach is a systematic, scientific effort to quantify the comparative magnitude of health loss due to diseases, injuries, and risk factors by age, sex and geography for specific points in time [Ref 1]

- Living well for longer: a call to action on avoiding premature mortality – the Government's ambition is for England to have the lowest rates of premature mortality amongst European peers
- CVD outcomes strategy – provides advice to local authority and NHS commissioners and providers about actions to improve cardiovascular disease outcomes. It sets out outcomes for people with or at risk of cardiovascular disease (CVD) [Ref 2, 3]

In winter 2012/2013, PHE led an implementation review with a range of stakeholders to determine how they can best support local authorities to commission the NHS Health Check programme successfully.

The implementation review:

1. reviewed the public health leadership position in support of the implementation of the programme
2. reviewed implementation and uptake across England
3. identified examples of effective practice and lessons learned
4. considered national and local support mechanisms
5. identified awareness and attitudes in key clinical communities
6. considered how local engagement could be strengthened to support future local authority commissioning and DH policy
7. considered NHS Health Check delivery expectations for 2013/14 – 2014/15
8. considered the support PHE will provide
9. identified any difficult issues which require further work

Link to Methodology – Annex A

Public Health England

NHS Health Check: explained

The NHS Health Check programme is a national risk assessment and management programme for those aged 40-74 years

NHS Health Check is a national risk assessment and management programme for those aged 40 to 74 living in England, who do not have an existing vascular disease, and who are not currently being treated for certain risk factors. It is aimed at preventing heart disease, stroke, diabetes and kidney disease and raising awareness of dementia for those aged 65-74 and includes an alcohol risk assessment. An NHS Health Check should be offered every five years.

The programme systematically targets the top seven causes of premature mortality. It incorporates current NICE recommended public health guidance, ensuring it has a robust evidence base. Economic modelling suggests the programme is clinically and cost effective. [Ref 4]

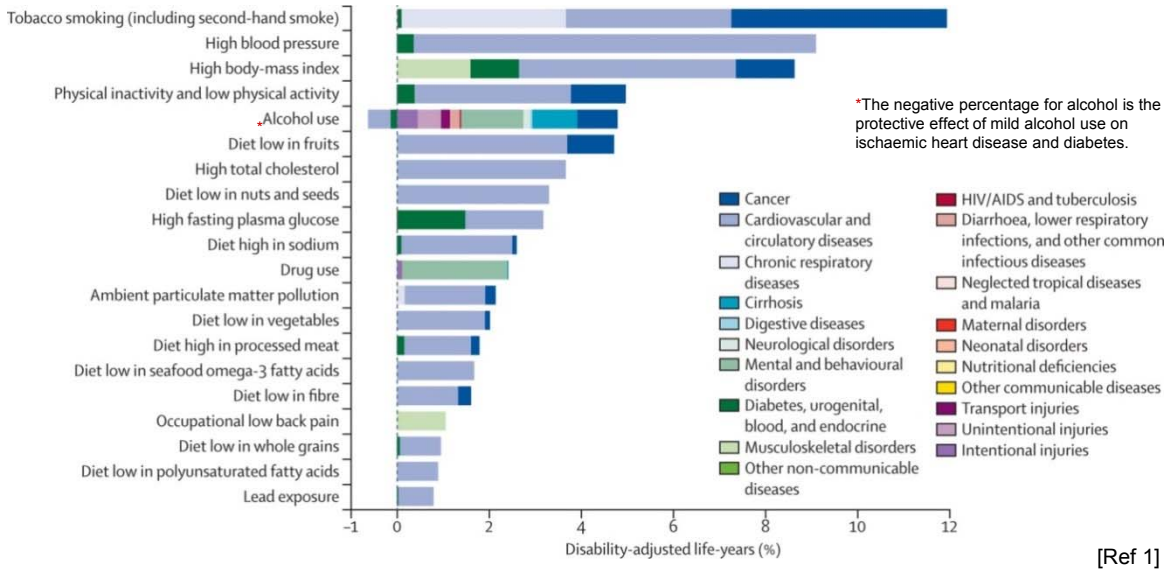
Top seven causes of preventable mortality: high blood pressure, smoking, cholesterol, obesity, poor diet, physical inactivity and alcohol consumption.

Each year NHS Health Check can on average:

- prevent 1,600 heart attacks and save 650 lives
- prevent 4,000 people from developing diabetes
- detect at least 20,000 cases of diabetes or kidney disease earlier

[Ref 5]

Burden of disease attributable to 20 leading risk factors for both sexes in 2010, expressed as a percentage of UK disability-adjusted life-years



[Ref 1]

Public Health England

NHS Health Check: benefits to health

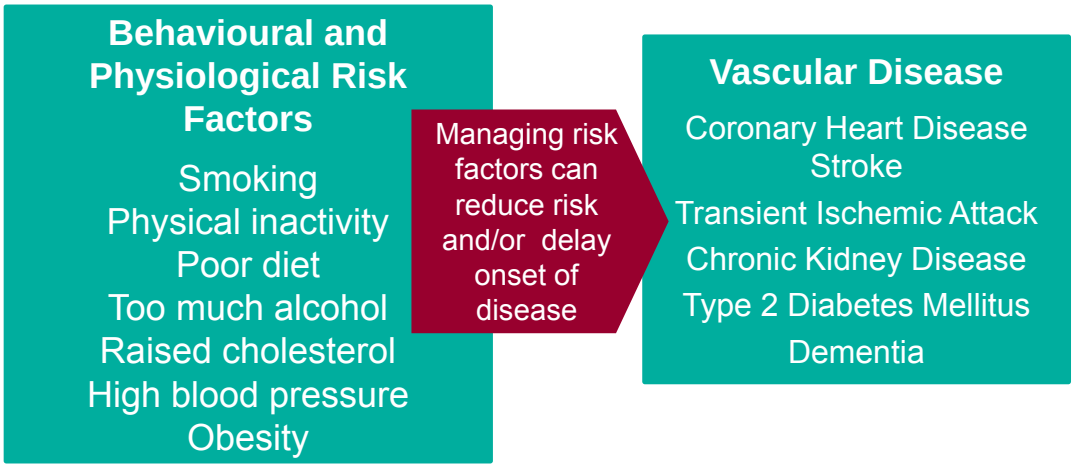
Reducing and managing risk factors will reduce prevalence and effects of disease

Vascular disease: over four million people in England are estimated to have vascular disease, which is recognised as the largest single cause of long term ill-health, disability and death. Vascular diseases are responsible for over a third of deaths and a fifth of hospital admissions in England each year.

Dementia: more common in people as they get older, it is estimated that 670,000 people are living with dementia in England. Over half have Alzheimer's disease and up to a third vascular dementia. In many cases however these conditions coexist and are thus likely to be subject to delay in symptoms if we manage the common risk factors that predispose to them.

Alcohol consumption: over 10 million people in England are drinking at levels which increase their risk of ill-health. [Ref 5-7]

The NHS Health Check programme helps to prevent the onset of vascular disease and vascular dementia by supporting changes to and management of behavioural and physiological risk factors.



- it is estimated that around 850,000 people are unaware that they have type 2 diabetes; half of all people diagnosed have serious complications [Ref 8]
- in more than 90% of cases the first heart attack is related to preventable risk factors [Ref 9]

Public Health England

NHS Health Check: the economic case

Economic modelling suggests the programme is clinically and cost effective

The economic case [Ref 4]

DH established that the NHS Health Check policy was likely to be cost effective, before implementation began.

The cost calculations include two components:

- the cost of the actual assessments plus any follow-on tests or monitoring that are required in terms of staff time and lab costs
- the cost impact of the interventions that are provided as a result of the NHS Health Checks

The estimated savings to the NHS budget nationally are around £57 million over four years, rising to £176 million over a fifteen-year period. It is estimated that the programme will pay for itself after 20 years as well as having delivered substantial health benefits.

The programme is underpinned by cost benefit modelling which considers cost in relation to quality adjusted life year (QALY) and shows that it is extremely cost effective.

Further analysis showed that of all the options considered, the optimal is a starting age of 40 with an NHS Health Check offered every five years.

Further work will be undertaken to:

- refresh the economic modelling for this programme, given the addition of the two new components: alcohol and dementia awareness
- establish the potential savings for local local authority services, including social care and benefits

Quality Adjusted Life Years (QALYs) – gives an idea of how many extra months or years of life of a reasonable quality a person might gain as a result of treatment.

The ready reckoner [Ref 10]

An **interactive ready-reckoner** on the NHS Health Check website identifies the potential service implications, health benefits and cost savings resulting from implementing health checks at council level. It is likely that there will be significant additional social care savings as a result of ill-health prevention, with a reduction in people accessing social care with conditions such as dementia, stroke and heart failures.

Example area results from ready reckoner

local authority: Macclesfield

- Total cost of providing NHS health check for one year based on national estimates - £216,842
- Workforce requirements to undertake NHS health check in this year - 2,234 hours of time to invite people to Health Check and arrange appointments, 2,688 hours of contact time for the health check and 1,862 hours of contact time for feedback of results
- Total lifetime gains for the cohort of people invited for an NHS Health Check this year 879 QALYs at a cost of £1,941 per QALY

Public Health England

NHS Health Check: responsibilities

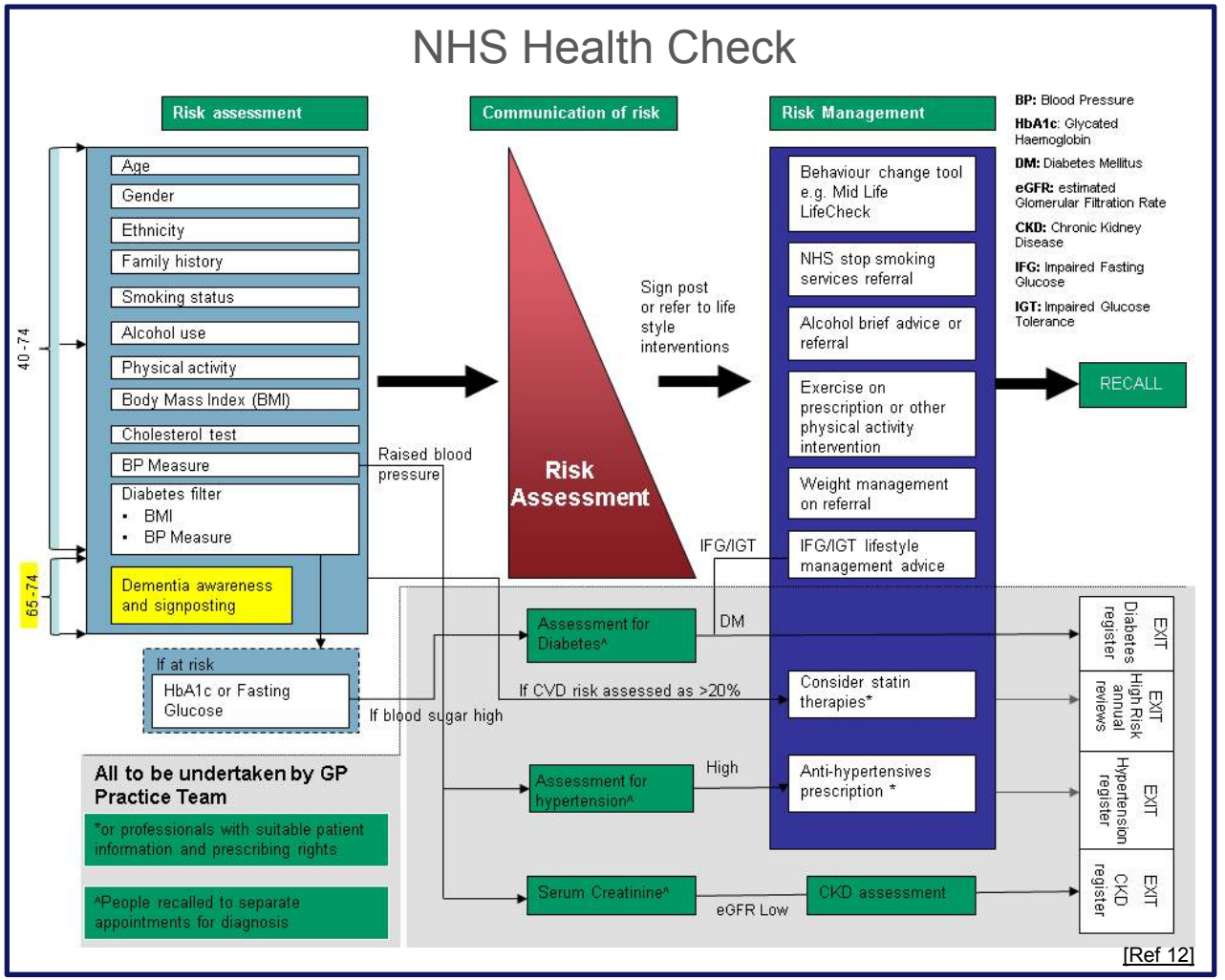
Local authorities are mandated to commission the NHS Health Check and are encouraged to work with the HWBs to commission local interventions

From April 2013 local authorities are mandated to provide the NHS Health Check programme. Money has been allocated as part of the public health ring fence to provide NHS Health Checks for 20% of the eligible population per year.

For benefits to be secured, local authorities will need to ensure the programme is seen as part of a strategic approach to tackling morbidity and mortality from vascular disease and have a clear sense of how it impacts on local priorities.

They will need to provide:

- strong leadership at the health and wellbeing boards (HWBs) and work closely with the clinical commissioning groups (CCGs) to ensure a co-ordinated response
- risk assessment and follow-up interventions, with clear links to commissioned staying healthy initiatives and community development programmes [Ref 11]



[Ref 12]

Public Health England

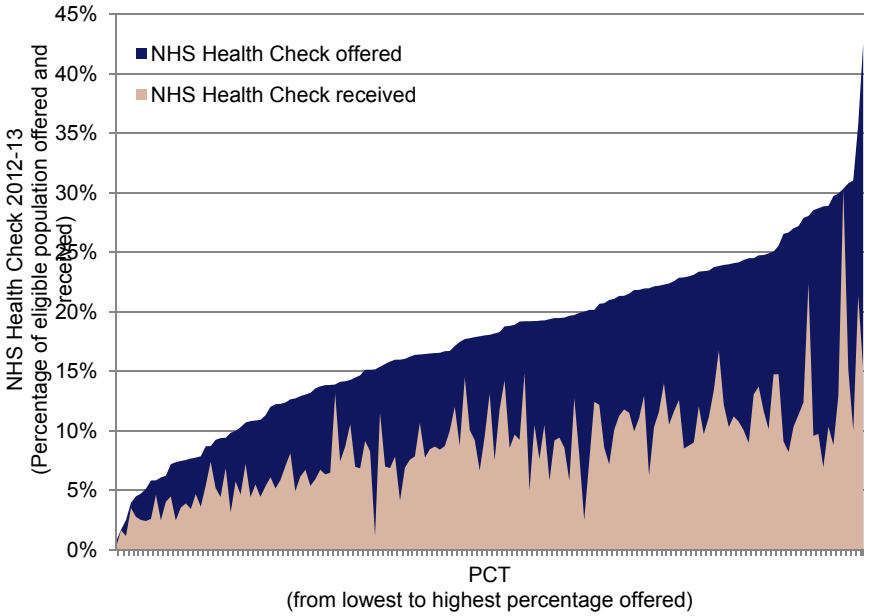
NHS Health Check: varying implementation

Local authorities will be taking on programmes at varying stages of implementation and performance

Before April 2013, primary care trusts (PCTs) had responsibility for commissioning the programme. Phased implementation began in 2009. The number of NHS Health Checks offered and received has varied significantly across England. Therefore local authorities will be taking on programmes in varying stages of implementation and with widely varying performance.

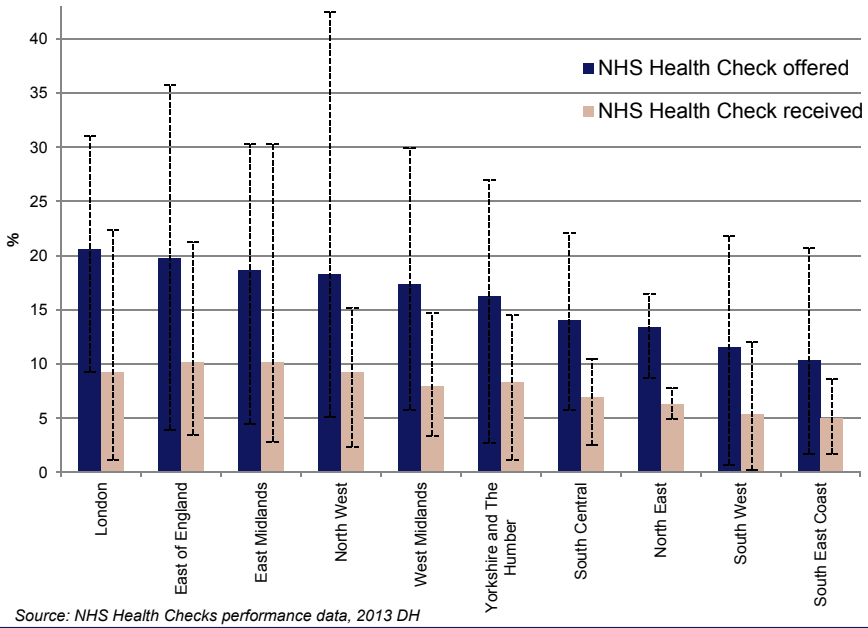
Learning from similar programmes has demonstrated that it takes time to increase uptake rates and with the programme still in its early stages, it is encouraging that the national take-up rate in 2011/2012 was 52% and that during transition, in 2012/13 it was 49%.

A comparison of offered and received NHS Health Checks by PCT (2012/2013)



Source: NHS Health Checks performance data, 2013 DH

Variation in NHS Health Check offers and take-up rates across SHAs (covers all 2012/2013; each year 20% of eligible population should be offered an NHS Health Check)



Source: NHS Health Checks performance data, 2013 DH

Public Health England

Making the case: the rising costs of social care

Current trends suggests that the cost of social care and continuing healthcare will continue to rise

As the number of older people living in England increases and public expenditure becomes more constrained, meeting the need for social care will become more challenging.

The Office for National Statistics (ONS) 2010-based principal population projections for England project that between 2010 and 2022 the number of people aged 65 or over will rise by 27% and the number aged 85 or over will rise by 44%.

Eighty percent of those aged 65 and over will need care in their later years of their life.

Current trends suggest that the cost of social care and continuing healthcare will continue to rise; reasons include:

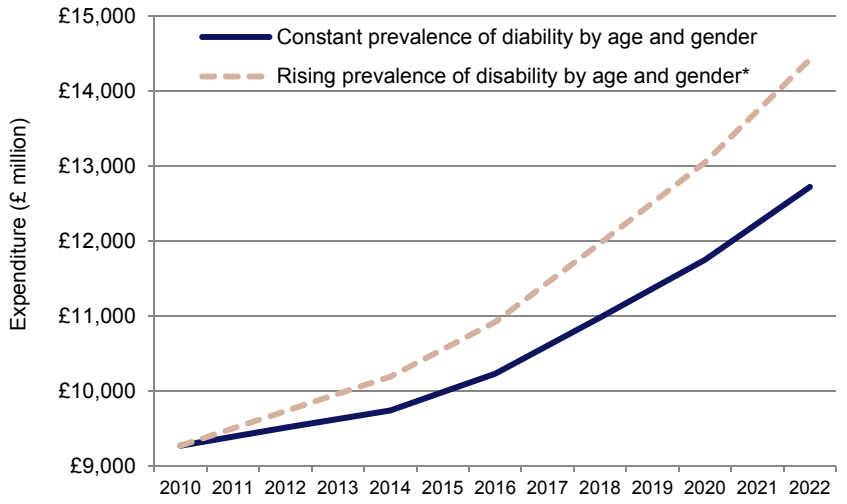
- 2% yearly increase in obesity, increasing prevalence of arthritis, stroke, CHD and vascular dementia
- emergence of minority ethnic groups in significant numbers within the older population adds to prevalence of stroke and CHD
- 2% bi-yearly increase in prevalence of arthritis, stroke, CHD and mild dementia from 2012 (moderate/severe dementia from 2016)
- 10% increase in disabling effects of arthritis, stroke and CHD from 2012 and a reduction in mortality of 5% from mild dementia, stroke and CHD from 2016

The NHS Health Check programme offers us an opportunity to stall some of these trends, and reduce current cost predictions.

[Ref 13]

Personal social services net and continuing health expenditure on over-65s in England under base case (BC) and continued trends assumption (CTA), 2012-2022 [Ref 13]

Scenario	BC	CTA
Rise in number ≥ 65 years with a moderate or severe disability by 2022	32%	54%
Cost of social and continuing healthcare by 2022	£12.7 billion	£14.4 billion



*The rising prevalence of rates of disability reflects continuation of recent trends in prevalence rates of chronic conditions.

Public Health England

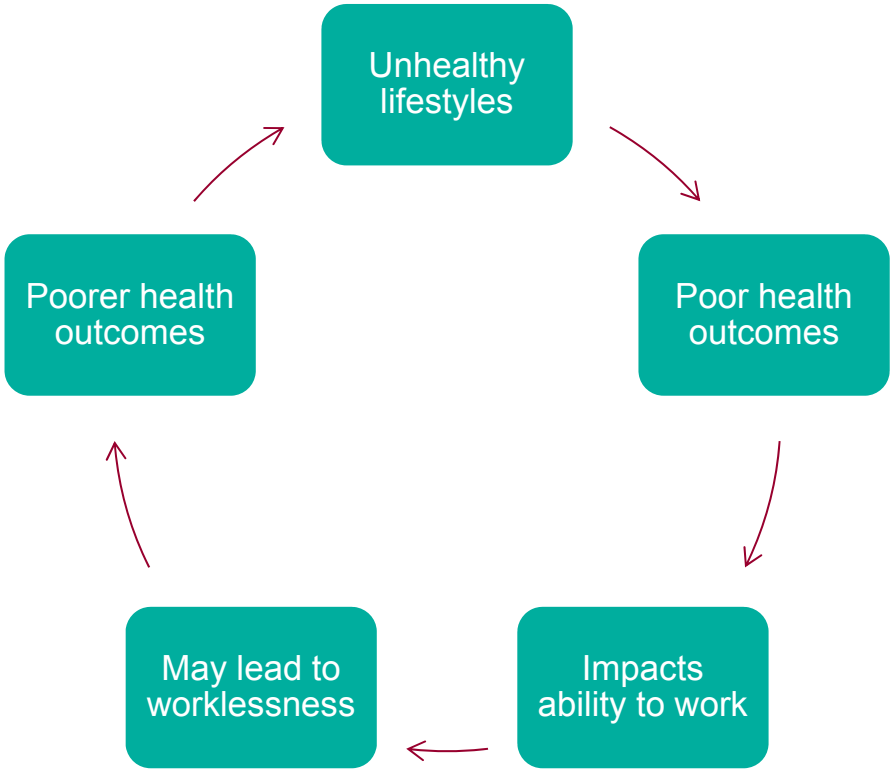
Making the case: keeping the working population healthy

The impact of poor health on the working age population affects everyone: individuals, employers and society

Good health improves an individual's chances of finding and staying in work and enjoying the consequential financial and social advantages. Being in work has a beneficial impact on health. Conversely poor health may impact on an individual's ability to work and lead to poorer health outcomes.

The health of the working age population is important for everyone:

- **individuals and families:** impacts quality and length of life, affects capacity to work and provide for family
- **employers:** a healthier workforce is more productive and inspires greater investment from employers
- **society:** consequences of ill-health include social exclusion, lower output and reduced tax revenues and higher healthcare and social security costs



- 175 million working days were lost in sickness absence in 2006 (7 days per working person)
- 7% of the working age population are workless and receiving benefits [Ref 14]

The NHS Health Check programme is well placed to support people to remain in and return to work and consequently benefit from it.

Public Health England

Making the case: the cost of poor health

There is an economic and social case to act decisively to improve the health of the working age population

The annual costs of sickness absence and worklessness associated with working age ill-health are estimated to be over £100 billion.

The NHS Health Check programme offers an opportunity to target those in work, aged 40 and over to support a reduction in sickness absence and worklessness.

Individuals	Employers	NHS	Government	Whole economy
• loss of income if poor health leads to worklessness • emotional cost of ill-health to themselves and their families • loss of years of life spent in state of poor health • cost of informal care by friends and family (£25-45 billion per year)	• cost of health related productivity losses • associated costs of staff turnover, loss of skill base, downtime, recruitment and re-training	• cost of treating working age people who are sick and out of work, which includes GP consultation through to secondary care (£5-11 billion per year)	• cost to the NHS • cost of benefits related to working age ill-health (£29 billion a year) • increased burden on the tax payer (£30-34 billion per year) • loss of income tax due to loss in productivity (£28-36 billion per year)	• includes forgone taxes (£70 billion per year) and healthcare costs (formal and informal) to Government (~£30 billion per year)

[Ref 14]

Public Health England

Making the case: targeting deprived communities

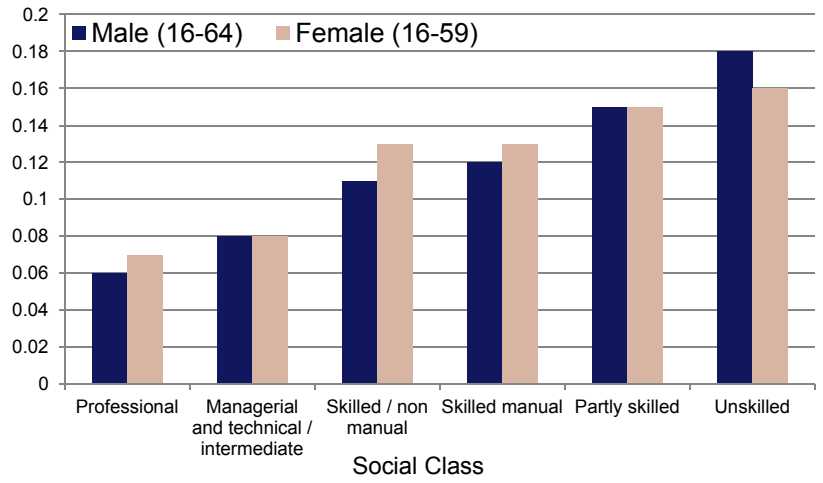
Supporting people in deprived communities to improve their health, will give them the greatest chance to stay in work and remain healthy

Socio-economic status influences health outcomes.

Having a higher income is likely to improve a person's health status, while being in good health increases earnings potential. Conversely a lower income is linked to poorer health outcomes.

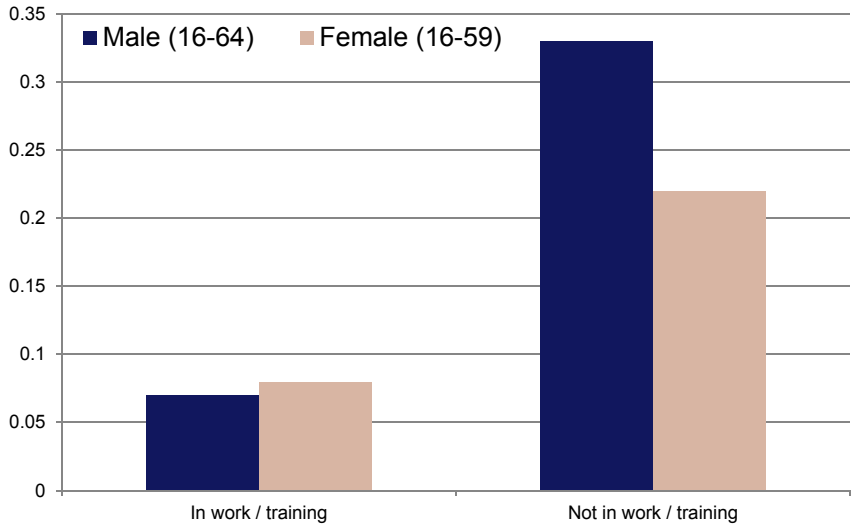
Tackling the risks and managing poor health will lead to lower incidence of health inequalities and a higher number of people staying in work.

Proportion of deviation from perfect health by social class



Note: Based on QALY measure of self-reported health. Does not cover Scotland and Wales
Source: Health Survey for England 2005, age adjusted, analysis by Department of Health

Proportion of deviation from perfect health by work status



Note: Based on QALY measure of self-reported health. Does not cover Scotland and Wales
Source: Health Survey for England 2005, age adjusted, analysis by Department of Health

- a child of a lone parent who does not work is eight times more likely to live in poverty than that of a lone parent who works full time
- children have higher incidence of recurrent health conditions if parents have a low income

[Ref 14]

Public Health England

Making the case: targeting BME groups

There is a strong association between ethnicity and health

General health outcomes

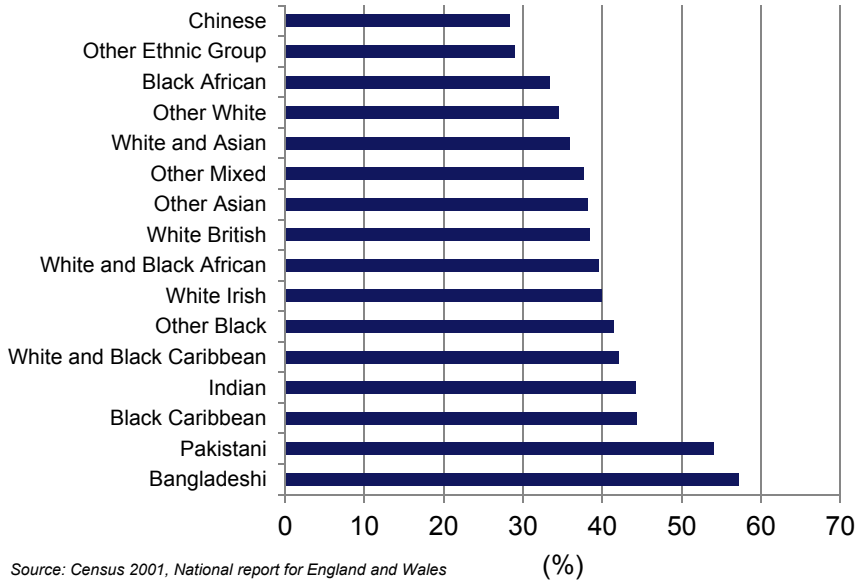
Black British people are 30% more likely to rate their health as fair, poor or very poor.

Pakistani and Bangladeshi people have the worst health of all the ethnic groups and are 50% more likely than white people to report fair, poor or very poor health. [Ref 15]

Diabetes

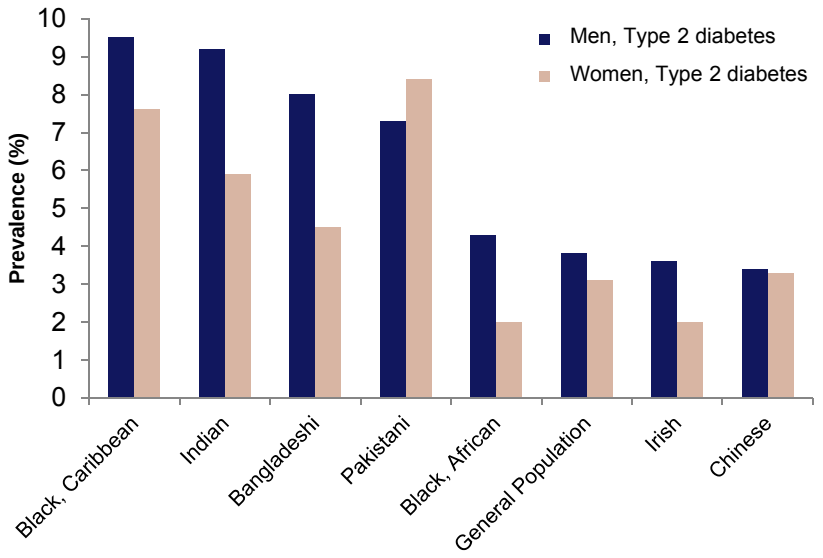
South Asian people who live in the UK are up to six times more likely to have diabetes than the white population. With the prevalence predicted to increase by 47% by 2025 (in England), the condition will continue to have a considerable impact on South Asian communities across the UK. [Ref 16]

All people over 50 years with limiting long-term illness, by ethnic group, 2004, England and Wales



Source: Census 2001, National report for England and Wales

Prevalence of doctor diagnosed diabetes (type 2) by sex and ethnic group, 2004, England



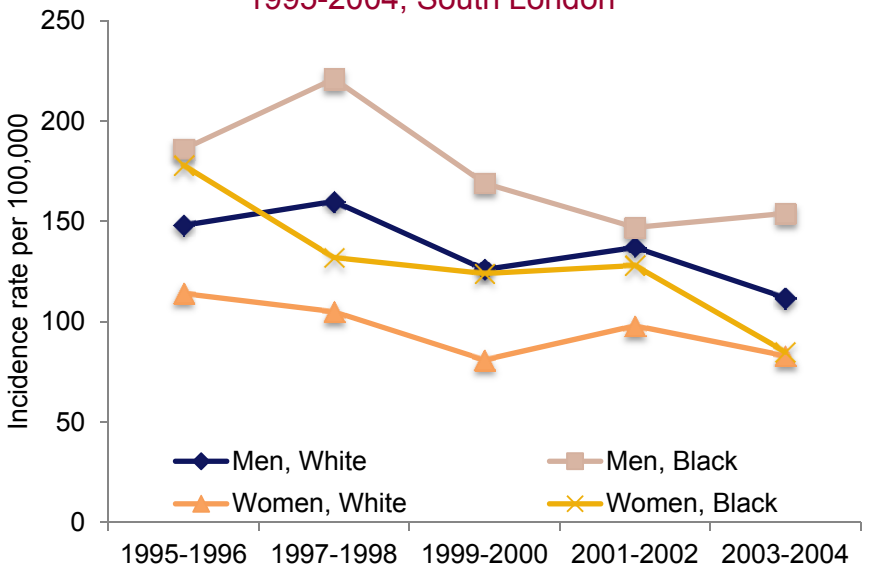
Source: Health Services Unit (2005), Health Survey for England (2004). The health of minority ethnic groups, DH, London.

Public Health England

Making the case: targeting BME groups

Premature mortality rates for CVD are higher in some populations

Incidence of stroke in men and women by ethnic group, 1995-2004, South London



Source: Health Survey for England (2004)

Stroke

The premature mortality rate for stroke in England is higher for those born outside the UK than for those born within. Furthermore stroke mortality rates are falling more slowly in minority ethnic groups than the rest of the population, widening inequality.

[Ref 17]

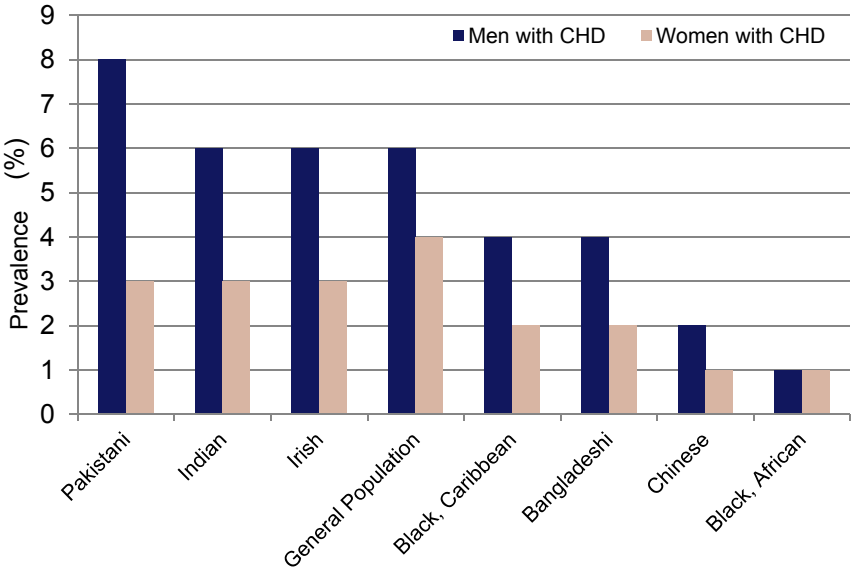
Coronary heart disease (CHD)

South Asian people born in India, Bangladesh, Pakistan and Sri Lanka are approximately 50% more likely to die prematurely from CHD than the general population.

The prevalence of CHD in England is highest in Indian (6%), Irish (6%) and Pakistani (8%) men.

[Ref 18]

Prevalence of CHD in men and women by ethnic group, 2004, England



Source: Health Services Unit (2005), Health Survey for England (2004). The health of minority ethnic groups, DH, London.

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Issue 1: leadership

Disagreement in the public health community has led to inconsistent support for the NHS Health Check programme

The NHS Health Check programme offers a fantastic opportunity to reduce premature mortality and health inequalities in England; PHE is fully supportive of its roll-out.

PHE's role is to lead the public health community in promoting the programme's value. The key to its success lies in collaboration with key partners from all sectors (local authorities/LGA, NHS England, clinical commissioning groups, Health Education England, wider government, other healthcare providers, pharmacists, voluntary organisations).

PHE acknowledges that there are some significant issues to be addressed and reservations from national and local leaders to be overcome in making NHS Health Check a world class public health programme.

The comment boxes on this and following slides illustrate some of the concerns expressed to us [Ref 19].

personal level you're not sure if you've 100% bought into the programme either" (Commissioner)

Action 1

PHE fully supports the NHS Health Check programme at all levels. It will lead the development of collaborative national leadership through a clear programme governance structure including an advisory committee, comprising the key stakeholders (LGA, NHS England, NHS IQ, DH and others) and an expert clinical and scientific advisory panel. PHE will provide timely and authoritative advice on emerging issues and will empower public health leaders locally with the evidence and rationale for the programme.

Public Health England

Issue 2: improving uptake

Low public awareness and engagement are major barriers to the success of the programme

To drive uptake, PHE recognises the need to improve both awareness of the NHS Health Check programme and engagement of those invited so they are willing to take up the offer of an NHS Health Check.

While there have been concerns that local authorities may not want to promote and lead on an 'NHS' product, the LGA is supportive of the continued use of the NHS Health Check brand complemented by local authority joint branding.

Research has shown that adapting invitations to support improved uptake from local population groups is pivotal to success. PHE will work with local authorities to develop a repository of local case studies to support local implementation.

PHE will work with and support its partners (local authorities, LGA, NHS and DH) to co-produce and share advice and good practice to ensure consistency across the programme.

"The biggest thing in being able to increase our uptake. We've had a very big communications campaign" (Commissioner)

Action 2

PHE will work with local authority NHS Health Check teams to test the potential impact of behavioural insight and marketing interventions on uptake. This will include developing options for improving the NHS Health Check brand, establishing the effectiveness of different approaches to recruitment and testing marketing campaigns to support uptake locally and nationally.

Public Health England

Issue 3: providing the NHS Health Check

The landscape is complex and local authorities have different options to choose from; we cannot say yet, the best way to commission the service

PCTs have used different invitation processes; case studies have shown us that using a call-recall system is effective, but that opportunistic approaches also have benefits. We are not yet certain of the best approach to use.

PCTs commissioned the programme from a range of providers (GPs, pharmacists, third sector etc). Case studies suggest that programmes using a mix of providers are most successful at reaching out to local population groups but more evaluation is needed before we can say for certain which approach is best.

NHS Health Checks can and have been provided by a range of health professionals (GPs, nurses, healthcare assistants, volunteers etc). Further work needs to be undertaken to understand the value of using different types of professionals for different populations.

"There's a risk that the GPs will throw their hands up and say 'this is too much work, we're not going to do it,' and then we'll have to commission private providers who are more expensive, then we risk it becoming very expensive programme which will not be cost effective"
(Commissioner)

Action 3a

PHE will thoroughly review and collate previous approaches to commissioning and delivering the NHS Health Check programme and so learn from and share promising practice and experience.

Action 3b

PHE will collaborate with the Centre for Public Scrutiny to work with several test bed sites to explore approaches to effective commissioning of the programme.

Public Health England

Issue 4: information governance

Some commissioners are unclear about NHS Health Check information governance

The transfer of responsibilities brings with it a requirement to continue to meet the highest possible data protection requirements for services users, combined with reaching all eligible residents in the most appropriate manner. Local commissioning arrangements and procedures for identifying and inviting eligible people to their NHS Health Check are extremely varied and it is therefore not possible to provide national guidance to cover every eventuality. Local areas should be familiar with legal requirements for handling sensitive personal data.

In March 2013 a guidance note from PHE and DH was shared with local authorities and other key partners setting out a number of general approaches that local commissioners could consider: a) NHS Health Checks are conducted by GPs only b) invitations are sent by GPs, but health checks are issued by a third party provider or both a GP and a third party provider c) an opportunistic element of the programme is offered, in conjunction with GP delivery d) invitations are sent via the National Health Authority Information System (NHAIS), where people can opt out.

"Recording community practice data on practice systems has been a challenge – this has to be done, in order to count towards targets" (Commissioner)

"It's about understanding the challenges we face and where possible coming up with national solutions, particularly data solutions" (Commissioner)

Action 4

PHE will explore long term solutions to free up the system to enable the flow of data, including to and from GP practices, for the best possible delivery of the NHS Health Check programme. It will explore the use of innovation and IT technologies to allow the seamless flow of NHS Health Check data across the health and social care system. This will create an environment that supports local teams to commission and evaluate programmes which aspire for excellence and improved outcomes.

Public Health England

Issue 5: supporting delivery

There is uncertainty about the future of regional and national networks

National and regional networks play a vital role in supporting roll-out and improving the quality of NHS Health Check programmes across England.

Since April 2010, NHS Diabetes and Kidney Care (NHS DAKC), with the Department of Health supported commissioners and providers to improve NHS Health Check programmes through provision of a national network and targeted local support. Strategic Health Authorities supported improved performance, disseminating national messages through regional networking events to PCT commissioners and encouraging local teams to share their knowledge and work together.

Now that those organisations who provided support have been abolished or integrated into other organisations, some commissioners are worried that networks will no longer be supported. PHE will take on the role of providing support to both clinical and non clinical commissioners of the risk assessment and follow-up services.

"You get an idea of the issues other people are going through. It's good to know it's not just you" (Commissioner)

"I would hope it would be PHE who would provide networking and support. That's the role they should have, combined with the local area teams and Commissioning Boards" (Commissioner)

Action 5

PHE will build upon and give continued support to established national, regional and local implementation support networks, ensuring equitable access to all organisations across England. PHE will work with the LGA to advance NHS Health Checks through the sector led improvement agenda.

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Issue 6: programme governance

The NHS Health Check community is concerned that new elements are added without due concern for the evidence base

Before introducing the policy DH undertook a comprehensive analysis of the evidence and the economic case for the NHS Health Check programme. This suggested that the programme is both clinically and cost effective.

Mindful of transition, PHE will allow the system time to stabilise, while continuing to review existing and potential new elements for the programme, ensuring they are evidence based.

PHE will also ensure governance is in place to review any future proposed changes. Decision makers will be cognisant of concerns raised by commissioners and providers, including the time pressures and practicalities of introducing new elements and their affect on the effectiveness of the NHS Health Check.

NHS Health Check: risk assessment measurements

Age
Gender
Ethnicity
Family history
Smoking status
Alcohol use
Physical activity
Body-mass index
Cholesterol test
Blood pressure measure
Dementia awareness*
Diabetes filter (BMI and BP measure)
If at risk: HbA1c/Fasting Glucose tests

* Awareness and signposting only for those aged 65-74

Action 6

PHE will set up clear programme governance arrangements, including an expert clinical and scientific advisory panel to assure that any additional elements of the programme are evidence based. It will keep the programme under review and advise the DH and ministers accordingly. See Appendix B for programme governance structure.

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Issue 7: provider competency

Some commissioners are worried that providers are not appropriately skilled to deliver behaviour change interventions

PHE recognises that the success of NHS Health Check lies in part with the ability of the chosen provider to inspire behaviour change in those attending.

Through this review, PHE has identified that risk assessment delivery varies nationally, from those that focus on prevention through lifestyle advice to those focusing on early detection of disease and other clinical elements. Some practitioners have suggested that they do not feel equipped to undertake lifestyle discussions. There is therefore a risk that the programme's impact is not fully realised.

PHE has a role in supporting local authorities in commissioning local programmes focused on behaviour change using and building on NICE guidance[ref 20] and in working with its partners (professional bodies and training providers) to support enhanced delivery.

> *"The health check consultation is perceived as a series of clinical tests by attendees; lifestyle discussions are seen as secondary to testing"* (Commissioner)

Action 7a

PHE will work with Health Education England (HEE) to build upon existing competency frameworks for use by providers and commissioners to ensure high quality training for those delivering the NHS Health Check.

Action 7b

PHE will work with local commissioners, training providers and professional bodies to develop a professional development programme of work on NHS Health Checks to enhance the focus on behaviour change for better health outcomes.

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Issue 8: consistency

There is a lack of consistent, quality driven roll-out

Every person eligible for an NHS Health Check should be offered a good quality, consistent risk assessment interview and follow-up, irrespective of where they live, or the provider commissioned to deliver it.

This review has highlighted a desire in some for a national quality assurance process. While PHE may consider this in the future, supporting delivery of a consistent offer is considered the priority at present. The programme is a mandated service in order to help to drive this.

Commissioning and management of the programme has been the responsibility of PCTs and through this review PHE has identified a disparity in approaches and investment.

PHE accepts that some local authorities may wish to add elements to their local NHS Health Check services to reflect local need, but stresses that additional elements should not compromise the quality of the standard offer.

Encouraging consistency will support and further develop local and national evaluation of the NHS Health Check programme.

"The major problem is that there just isn't a QA programme in place, either centrally or regionally, that you see for other programmes" (Commissioner)

Action 8

PHE will release and review on a regular basis best practice guidance describing all the elements and standards it would expect of a quality programme such as quality of delivery and robustness of data capture and reporting. It will raise awareness, promote adoption and explore opportunities for quality assurance programmes in local authorities.

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Issue 9: proving the case

Some of the public health and clinical communities are concerned about the evidence base for the NHS Health Check intervention

Each of the individual elements contained within the NHS Health Check are evidenced by NICE guidance [ref 12] and have a strong economic case, supporting their inclusion in the NHS Health Check programme. However some leading pubic health professionals and clinical providers continue to have questions about the evidence base.

The case for the programme is clear and research is currently underway to provide an early assessment of programme outcomes since phased implementation began in 2009. This work will also highlight a range of implementation and delivery issues for future consideration. See February's e-bulletin for more details.

PHE will work with its partners to develop data collection techniques and research proposals to support evaluation of the NHS Health Check programme.

> *"I would like PHE to highlight the benefits of the programme, as the critical national voice. This will encourage GPs and other organisations to buy into it. There is a debate about the evidence for health checks. PHE should provide clear evidence of their value"*
> (Commissioner)

Action 9

PHE will work with system partners to facilitate future research and evaluation of the NHS Health Check programme at a national and local level. This will provide the implementation evidence required to ensure effective roll-out and improvement.

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Issue 10: expected roll-out

Some local authorities are worried that they will not meet expected delivery targets

NHS Health Check is a mandated service and the regulations state that local authorities must achieve a 100% offer rate in their eligible populations after five years.

Ideally local authorities will offer the NHS Health Check to 20% of their eligible population each year, reaching 100% over five years. Enabling them to commission a programme in steady state and supporting the development of clinical and lifestyle follow-on services.

Funding has been allocated to support this scenario and is modelled on an uptake rate of 75%. Ideally local authorities will want to show annual improvement in uptake rates aiming for and beyond 75%.

PHE is aware that local authorities are taking on programmes in varying stages of implementation and with widely varying performance. Reporting by PHE of delivery and take-up by local authorities will be cognisant of this being a five year rolling programme.

"We'll be lucky if we get anywhere near 10%... Some GPs have really gone for it and smashed their targets, but those with low engagement are bringing the average down." (Commissioner)

"The massive thing is the sheer variability in delivery. You get some star performers and some people just don't engage with it" (Commissioner)

Action 10

PHE will support those local authorities taking on challenging programmes. It will work with LAs to achieve offers to 20% of the target population annually with a vision to realise at least 75% uptake per year. This will support local authorities to achieve offers to 100% of their eligible population over five years.

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Executive summary

Context

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Next steps

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Next steps

2012-13, the first full year of the NHS Health Check programme, saw 2.7 million offers made and 1.26 million NHS Health Check appointments received, during a time of so much transformation across the health system. This provides a solid base on which to build.

Over the coming year and beyond, PHE will work with our key partners to:

- support effective implementation and monitoring
- facilitate the sharing of best practices
- support evaluation and research
- make sure that any new strategic developments are based on the best evidence
- support strong, challenging and robust governance

Our challenge now is to increase national coverage so that all areas are offering access to this mandated public health programme. We must also strive to increase further levels of uptake and referral to appropriate risk management services, particularly in those communities at greatest risk.

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Annex A: methodology

Stage	Information	Dates of Completion
1. Research Works qualitative research: 'Understanding the implementation of NHS Health Checks'	Commissioned by the Public Health England Transition Team to: • assess the experiences of commissioners and providers in delivering the NHS Health Check programme • gain an understanding of the engagement of public health professionals with NHS Health Check and the process of implementing the programme	February 2013
2. Workshops help to establish the views of senior stakeholders	Two workshops held. Stakeholders represented the following organisations: DH, local government (Birmingham, Cheshire & Merseyside, North Lincolnshire, West Midlands, Worcestershire, York), LGA, NHS England, NHS IQ, PHE, Research Works, UK National Screening Committee	January 2013 & February 2013
3. Comments sought via the PHE's engagement mailbox	Comments sought from PHE's National Executive, the project working group and wider stakeholders, with an interest in the NHS Health Check programme: a) after the second stakeholder meeting in February 2013 b) after the launch of our initial findings at the NHS Health Check Learning Network Event in April 2013. • 17 sets of comments were received.	May 2013
4. Meetings held with 'opinion leaders' from across England	Engagement meetings held with: • Members of the Delivering Transition Steering Group (DTSG) • PHE Centre directors • Leading GPs • Association of Directors of Public Health [June 2013]	May 2013
5. Analysis agreed with the PHE Programme Board chaired by the Director General of DH	Final report agreed with the PHE National Executive and Felicity Harvey (Director General – Public Health Directorate, DH)	June 2013

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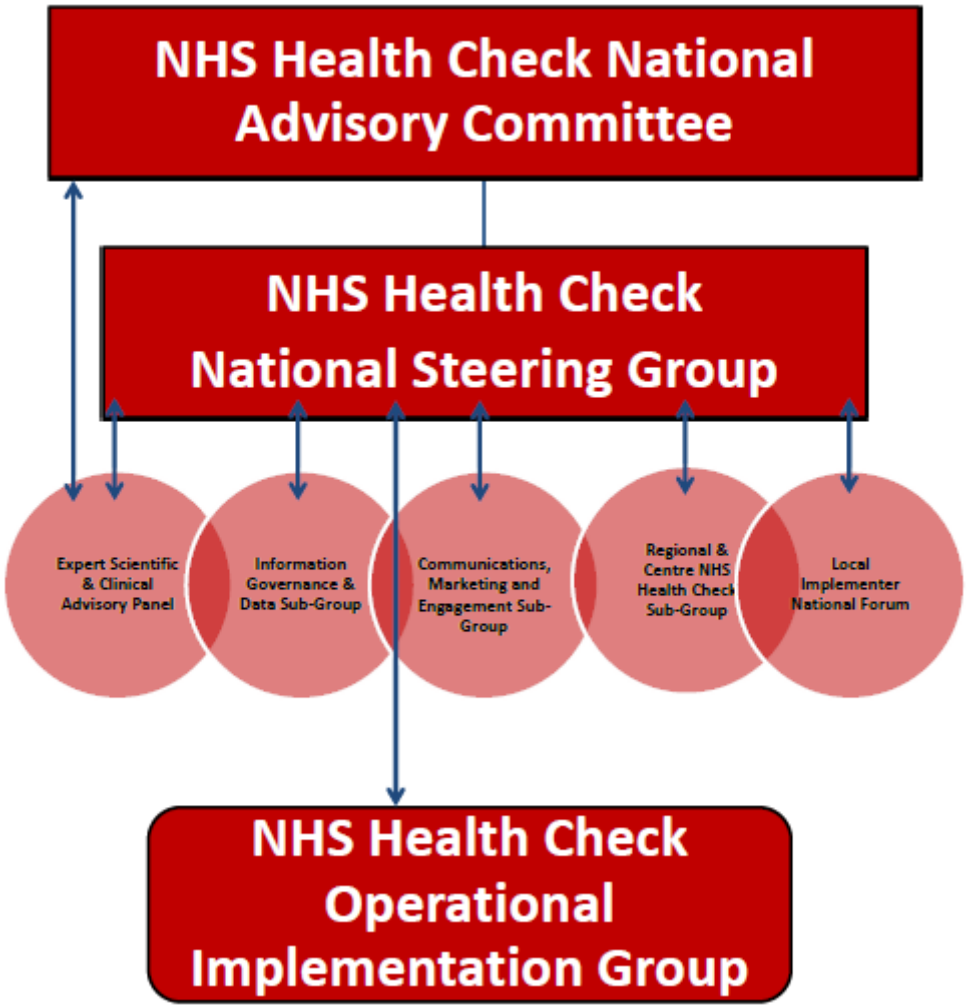
Annex B: NHS Health Check governance



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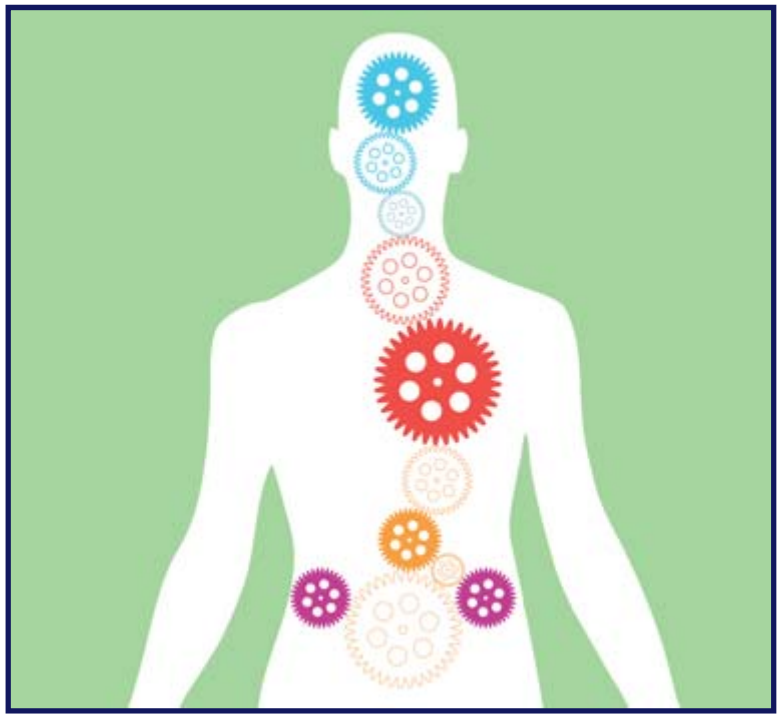
Acronym list



Acronym	Full title
CCG	Clinical Commissioning Group
CHD	Coronary Heart Disease
CVD	Cardiovascular disease
DTSG	Delivering Transition Steering Group
HEE	Health Education England
HWB	Health and Wellbeing Board
LA	Local Authority
LGA	Local Government Association
NHAIS	National Health Authority Information System
NHS CB	NHS Commissioning Board
NHS DAKC	NHS Diabetes and Kidney Care
NHS IQ	NHS Improving Quality
NICE	National Institute for Health and Care Excellence
PCT	Primary Care Trust
PHE	Public Health England
QALY	Quality Adjusted Life Year
RCGP	Royal College of General Practitioners
SHA	Strategic Health Authority

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Useful documents

Local Government Association (2013)
NHS Health Check frequently asked questions

Centre for Public Scrutiny (2013)
NHS Health Check – what council scrutiny needs to know

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