Office for Health Improvement & Disparities

Review of the NHS Health Check

Annex D: stakeholder engagement

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Contents

1. Summary

This annex to the report ‘Preventing illness and improving health for all: A review of the NHS Health Check programme and recommendations’ describes the approach and findings of extensive stakeholder engagement. The information gathered through this process has been used to inform the 8 review issues and recommendations.

Stakeholders were identified as professionals working nationally, regionally and locally with an interest in the NHS Health Check as well as the public. They were engaged through a programme of one to one meetings, an online survey, network meetings and workshops (Appendix A). Stakeholder engagement took place between July 2020 and February 2021, in line with the underlying principles stated in the review’s terms of reference.

The main findings from this work related to review issues 1 to 4 and 6 to 8 and are:

Issue 1. The benefits and limitations of the existing service

The 2 most commonly occurring benefits of the programme cited by stakeholders were the opportunity for prevention and the early identification of health conditions.

Issue 2. The eligible population

Stakeholders valued the NHS Health Check’s universal approach but felt that a greater focus should be placed on increasing uptake among those at greatest risk and who have most to benefit.

Stakeholders did not see value in extending the NHS Health Check programme to those who are currently ineligible because of an existing health condition.

Stakeholders were supportive of reducing the age limit for NHS Health Checks for some groups to help address health inequalities. However, the practicality of this was queried.

Issue 3. The potential inclusion of additional physical of mental health conditions

Stakeholders were primarily supportive of including an assessment of mental health within the NHS Health Check.

Issue 4. How the checks are delivered, in particular digital opportunities

Digital follow ups were a key area of interest among stakeholders. While the efficiency and convenience of digital approaches could be of benefit to many, it was recognised that this would not be appropriate for all.

Issue 6. Improving uptake

Stakeholders felt that better marketing of the programme could improve engagement, alongside ensuring it accommodates the needs of the public, such as using different delivery settings and commissioning more providers to carry out NHS Health Checks.

Issue 7. Improving follow-up

Stakeholders recognised that empowering patients to act on their check result depends on the availability of timely, fit for purpose solutions that support behaviour change.

Training was identified as a way of improving quality of delivery of the programme.

Issue 8. How research can support long-term development of the service

Improvements to data quality were recognised as a way of enabling better monitoring and comparisons of activity and outcomes between local areas.

2. Background

NHS Health Checks are an important component of locally led public health prevention services. They are offered to people without pre-existing disease aged between 40 and 74, free of charge, every 5 years. The results are used to raise awareness and support individuals to make behaviour changes and, where appropriate, access clinical management to help them reduce their risk of a heart attack, diabetes, stroke, respiratory disease and some forms of dementia and cancer in the next 10 years.

The government's prevention green paper 'Advancing our Health: Prevention in the 2020s' recognised that the NHS Health Check programme, originally introduced in April 2009, has achieved a lot and continues to do so. A national evaluation of the programme estimates that at current statin prescribing levels, over 5 years, 2,500 people will have avoided a major cardiovascular event, such as heart attack or stroke. (Robson J and others, BMJ)

In their current form, checks also underpin important NHS Long Term Plan commitments to prevent 150,000 heart attacks, strokes and cases of dementia, and are the major conduit for recruitment to the Diabetes Prevention Programme.

However, the green paper also recognised significant variation in uptake and follow-up of health risks identified by the programme, along with the potential that people could benefit from a more tailored service or a particular focus at pivotal changes in the life course. The government therefore announced its intention, building on the gains made over the past 10 years, to consider whether changes to the NHS Health Check programme could help it deliver even greater benefits.

To achieve this, the Department of Health and Social Care (DHSC) commissioned Public Health England (PHE) to undertake an evidence-based review of how NHS Health Checks can evolve in the next decade to maximise the future benefits of the programme. Professor John Deanfield, was appointed to chair the PHE review of the programme. The review work was completed by PHE in September 2021. On 1 October 2021, responsibility for national oversight of the NHS Health Check programme and for publishing the findings of the review transitioned to the Office for Health Improvement and Disparities (OHID).

This annex to 'Preventing illness and improving health for all: A review of the NHS Health Check programme and recommendations' describes the approach and findings of extensive stakeholder engagement. The information gathered informed the review issues and recommendations.

3. Methodology

3.1 Underlying principles for conducting stakeholder engagement

Stakeholder engagement was conducted in accordance with the 5 principles for the review, as stated in the terms of reference. Three of the principles were particularly relevant in underpinning stakeholder engagement activities:

- Principle 2 – the review will proceed in an open and transparent manner, which makes relevant, non-sensitive information publicly available
- Principle 3 – the review will provide opportunities for widespread, meaningful engagement with stakeholders, which allows them to directly inform the work
- Principle 4 – the review team will communicate regularly with all stakeholders, providing appropriately detailed updates on progress and anticipated next steps

Further principles were devised, which were specific to the review engagement work, including:

- ensure awareness of the review among key audiences by making information available in a variety of formats and channels
- use a range of targeted communication channels to direct these audiences to information and how to contribute to the review
- communication should encourage input, while making clear the aims of the review, the criteria against which any proposals for changes will be assessed and the need for evidence to inform this assessment

3.2 Initial identification of stakeholders

The following stakeholders were identified as being important to engage through this process.

Local government

- Association of Directors of Public Health
- Directors of Adult Social Care

- Directors of Public Health
- Local authority chief executives
- Local authority commissioners
- Local authority finance
- Local Government Association
- Solace

Health and professional

- Academy of medical royal colleges
- clinical commissioning groups
- community pharmacy
- diagnostic industry
- Faculty of Public Health
- general practices
- Health Education England
- health insurers, private health care providers
- Healthwatch England
- Integrated Care Systems
- NHS Digital
- NHS England (including Diabetes Prevention Programme)
- NHS England as commissioners of NHS Health Checks for prisons
- NHSX
- Office for Life Sciences
- pharmaceutical industry

- primary care networks
- Richmond Group
- Royal College of General Practitioners
- Royal Pharmaceutical Society.

Other

- Academics
- digital and technology industry
- public
- voluntary and third sector

National government

- Department for Work and Pensions
- devolved administrations
- ministers and central government
- Ministry for Housing, Communities and Local Government
- Public Health England
- UK national screening committee

3.3 Types of engagement

Between July 2020 and February 2021, the following stakeholder engagement activities were undertaken (figure 1).

One to one meetings

These were used to engage stakeholders from local authorities, charities and arms-length bodies. The meetings were conducted virtually, led by senior PHE officials.

Online survey

This provided an opportunity for any stakeholder to comment on the review, as well as answering questions on specific issues and possible solutions (Appendix C). The survey was conducted between 13 November and 18 December 2020. It was publicised through the NHS Health Check ebulletin and circulated to members of the NHS Health Check programme's existing governance groups with the request for them to cascade the information on to their networks.

Network meetings

The review team engaged with stakeholders through existing networks and guest-speaker slots, primarily to an audience of local authority commissioners and PHE internal stakeholders.

Workshops

These enabled stakeholders, including commissioners and providers of the NHS Health Check, to engage with the review and each other, discussing areas for improvement and testing possible solutions. Workshops were conducted virtually and took the format of a main presentation followed by small group discussions with a maximum of 7 participants each. Group discussions were facilitated by a member of the NHS Health Check review team and a scribe. An open invitation, cascaded through members of the NHS Health Check governance groups, was issued and places at the workshop were offered on a first come, first served basis.

Public engagement

Involved discussions with members of the public to understand their approach to healthy living, their opinions on the NHS Health Check and how it can have greater impact with the population it serves. These group conversations were conducted virtually and were facilitated by a member of the review team. Individuals were identified via an expression of interest shared by the PHE communications team to members of PHE's public panel.

The organisations the review engaged are listed in Appendix A.

3.4 Review issues for engagement

Through the different stakeholder engagement mechanisms PHE sought to address a set of 8 issues that form the scope of the review:

1. The benefits and limitations of the existing service.

2. The eligible population.

3. The potential inclusion of additional physical or mental health conditions.

4. How the checks are delivered - in particular digital opportunities.

5. The potential for more personalised risk-focused approaches.

6. How to improve take-up.

7. How to improve follow-up to the checks.

8. How research can support long-term development of the service.

3.5 Iterative engagement process

Stakeholder engagement was delivered iteratively in 3 phases. Phase 1 sought to understand stakeholders' perspectives on the issues relating to the NHS Health Check. During this phase 3 broad questions were used to explore the review issues:

1. What do you value most about the current NHS Health Check programme?

2. Which aspects of the NHS Health Check programme could be improved, and how?

3. How can the NHS Health Check programme reduce health inequalities?

Activity in this phase included one-to-one stakeholder meetings, initial stakeholder engagement workshops, delivery of presentations at network meetings and themed workshops which were used to test and confirm the 7 issues identified from the responses to the 3 broad questions set out above.

Phase 2 built on the findings from phase 1 by exploring and scoping the potential solutions to the issues identified through the phase 1 engagement. This phase sought to understand the impact and feasibility of the tested solutions.

In addition to presentations at network meetings, activity in phase 2 included solution testing workshops, during which the 8 questions that form the scope of the review were explained and stakeholders presented with relevant evidence. Potential solutions were then tested using mentimeter, an online survey tool, to allow workshop attendees to rate each solution's potential impact (including coverage, equity and effectiveness) and how feasible (including affordability and practicality) it would be to enact.

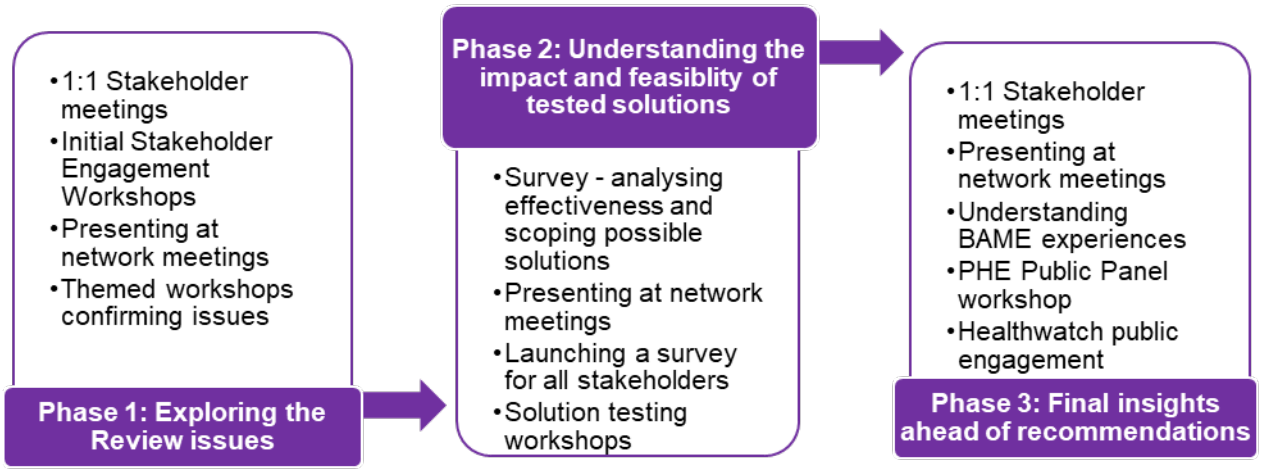
Additionally, phase 2 included the development and deployment of an online was survey. This provided an opportunity for stakeholders to comment on the review, as well as answering questions on specific issues and possible solutions. The survey questions can be found in Appendix C.

Phase 3 sought to gather final stakeholder insights on how the programme can evolve in the next decade to maximise its future benefit.

This phase had a particular focus on gaining insight from members of the public and from local authorities with experience of engaging with black and minority ethnic (BAME) communities. Activity in this phase included one-to-one stakeholder meetings, delivery of presentations at network meetings and 2 public engagement workshops, facilitated through the PHE Public Panel and Healthwatch. These workshops asked questions that assessed participants' attitude towards healthy living and knowledge of an NHS Health Check, and discussing the programme's usefulness to the public.

The outputs of activities from each of the phases were relayed to the review steering group, which advised on areas to explore in subsequent engagement activities. Figure 1 illustrates the phased activity as described.

Figure 1. Iterative engagement process



The schedule of stakeholder engagement was as follows:

On 21 July a presentation was given to local authority commissioners at the Local Implementor National Forum (LINF) to introduce the review.

Between 12 August and 28 September the first series of one-to-one stakeholder meetings were delivered to introduce the review and understand key areas for improvement.

On 1 September a presentation was given to PHE employees who support regional activity on CVD prevention and NHS Health Checks to introduce the review.

Between 25 September and 12 October introductory workshops were held to understand the benefits of the NHS Health Check, areas for improvement and reducing health inequalities.

On 27 October a presentation was given at the Local Implementor National Forum to understand the benefits of the NHS Health Check, areas for improvement and reducing health inequalities.

Between 10 October and 13 November themed workshops on key issues were held. These workshops tested stakeholders views on the analysis of key issues.

On 11 November a presentation on the analysis of key issues was given at the South East regional NHS Health Check network meeting.

On 13 November the online survey was launched to invite general opinion and to understand the effectiveness of the NHS Health Check programme.

On 20 November the first of 2 public engagement workshops was delivered via PHE's Public Panel.

Between 4 and 8 December testing solutions workshops were held to test the impact and feasibility of potential recommendations.

Between 6 and 27 January engagement took place with local authorities through one-to-one meetings to discuss how to reach BAME communities and understanding of BAME experiences.

On 19 January a presentation was given at the Local Implementor National Forum to present themes of recommendations.

On 19 January the second of 2 public engagement workshops was delivered, with members of the public approached via local Healthwatch.

On 25 January a presentation was given at the London regional NHS Health Check network meeting. The themes of recommendations were discussed.

Between 1 February and 31 March a second series of one-to-one stakeholder meetings was delivered.

4. Results

PHE engaged with 114 stakeholders via 12 one-to-one meetings, 8 workshops and 2 network meetings, a further 236 of stakeholders responded to the online survey (Appendix A). A full description of the responses to the online survey can be found in Appendix B.

4.1 Phase 1

The 7 themes uncovered from the responses to the initial 3 questions were:

Service design and links to other programmes: the NHS Health Check is carried out differently in different parts of the country, from its delivery setting to who delivers it. Issues surround onward referrals to other programmes: there isn't always a suitable programme to refer patients to and the referrer doesn't know if someone has successfully enrolled – for example, in the diabetes prevention programme.

Data and evidence: different databases are held by different organisations and there are often significant barriers to data sharing to support the programme, which makes it difficult to identify who is eligible or track someone's follow up. Additionally, some of the electronic templates used to carry out the NHS Health Check don't have mandatory fields, so that data that should be collected through the NHS Health Check can go unrecorded. (Addressing the review issue 8.)

Digitising the NHS Health Check: digital solutions were identified as a way to increase uptake of the NHS Health Check; stakeholders highlighted their surprise at the success of digital solutions to public health during COVID-19. Digital approaches could provide the opportunity for a 'light' NHS Health Check and allow more form-filling elements to take place remotely with more convenience for patients. One local authority workshop attendee said: "using an app or online form to complete an initial assessment would provide more time face-to-face to deal with any issues". However, there are concerns about digital exclusion. (Addressing the review issues 4 and 6.)

Marketing the NHS Health Check: there is low awareness of the NHS Health Check among the public. While there is no national marketing campaign, some areas have created their own marketing campaign with their own materials. There are issues around the name of the NHS Health Check, with different name in different local areas. This allows the development of local branding, but limits the potential for developing a broader national brand and using national marketing campaigns to make people aware of the rationale and benefits of NHS Health Checks. (Addressing the review issue 6.)

Criteria for being offered an NHS Health Check: there have been some questions about how beneficial an NHS Health Check is to those aged between 70 and 74. Expanding the

NHS Health Check to those between 30 and 39 years, either as a blanket offer or targeted based on risk has been suggested as a way of promoting upstream prevention. (Addressing the review issue 2.)

Reaching those most at risk and reducing health inequalities: there is not enough uptake of the NHS Health Check by those who would benefit most – some local authorities have succeeded in increasing uptake in these groups, however others have focussed on increasing uptake more generally. There were suggestions that local authorities could be incentivised to ensure those most at risk are receiving an NHS Health Check. (Addressing the review issue 2.)

Assessing beyond CVD: expanding across physical and mental health – the NHS Health Check does, in some cases, lead to a broader conversation around health issues that are not CVD related. This usually arises because the NHS Health Check assesses risk factors that can be associated with other health issues, such as alcohol intake as a risk for depression. Stakeholders showed some interest in assessing other factors including some wider factors, such as someone's financial situation, to better understand their risk of health issues. (Addressing the review issue 3.)

4.2 Phase 2

Responses on perceptions of effectiveness and what is valued most about the NHS Health Check programme included:

"Provides opportunities for health improvement and behaviour change much earlier than would otherwise be possible."

"Opportunity for positive interaction with the health service for people who do not normally engage."

"Increases agency that people have with their own health."

Survey responses showed that 43% (n=82) of respondents rated the programme as 'very effective' or 'effective' while 25% (n=48) rated as 'ineffective' or 'very ineffective' (see figure 3).

The benefits and limitations of the existing service

The 2 most commonly occurring benefits of the programme cited by stakeholders were the opportunity for prevention and the early identification of health conditions. The opportunity for behaviour change and the universal approach were also frequently recognised as benefits.

Limitations cited included poor communication of the service to the public; and the risk of medicalising people who are at low risk for disease.

The eligible population

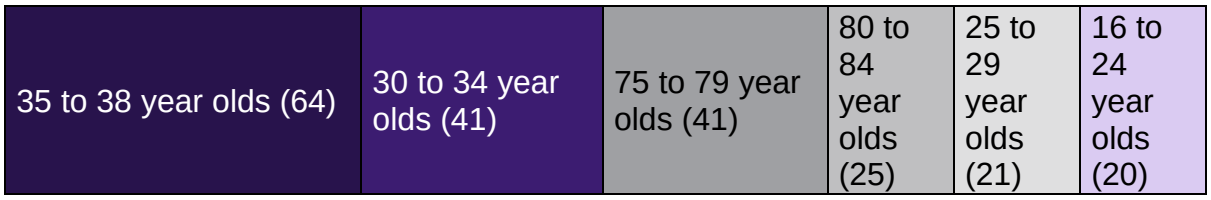
One solution, which suggested strengthening the focus on delivering NHS Health Checks to a higher proportion of disadvantaged and higher risk groups, scored high on impact and low on feasibility. In discussion with participants, building trust and communicating in a person's first language were understood to improve engagement from people that would benefit most from the NHS Health Check.

Solutions which proposed including those who are currently excluded from an NHS Health Check as a result of a diagnosis of cardiovascular disease, scored low on impact and feasibility. In discussion, duplication of services was cited as an issue and the need to ensure the most effective use of resources.

Solutions proposing business as usual or an expansion of the NHS Health Check to all 30 to 39-year olds were seen as having low impact and low feasibility. However, offering the NHS Health Check only to high risk groups before the age of 40 was seen as having high impact but low feasibility.

Figure 4 shows the age groups that stakeholders suggested should be eligible for an NHS Health Check. The most popular category was 35 to 39 year olds and was selected by 38% (n=64) of respondents. The 30 to 34 year olds and 75 to 79 year olds categories were both selected by 24% of respondents (n=41). The 80 to 84 year olds, 25 to 29 year olds and 16 to 24 year olds categories were selected by 14% (n=25), 12% (n=21) and 12% (n=20) respondents respectively.

Figure 4: Stakeholders' perceptions on which age groups should be eligible for the NHS Health Check



The potential inclusion of additional physical or mental health conditions

Continuing to deliver the NHS Health Check as currently defined scored low on impact, but high on feasibility. Solutions suggesting including new assessments of risk factors scored high on impact.

Figure 5 shows that the majority of respondents (48%, n=83) agreed that new assessments for risk factors or disease should be added to the NHS Health Check. For the majority who answered ‘yes’, mental health related assessment was the most cited. One quarter (25%, n=44) of respondents thought that new assessments for risk or disease should not be added to the NHS Health Check and 27% (n=46) were not sure.

Figure 5: Stakeholders’ views on whether new assessments for risk or disease should be added to the NHS Health Check

How the checks are delivered

Asking people to digitally input data for the NHS Health Check before a attending the check scored low on impact and feasibility. Solutions that used digital to support patients’ next steps following a check, such as referrals to a weight management or physical activity service or that directed them to information online, scored highly on impact and feasibility.

Figure 6 shows that 74% (n=122) of respondents thought that digital technology would improve the NHS Health Check. Those who responded ‘yes’ most commonly cited the use of digital technology for data collection prior to consultation, providing results digitally and encouraging follow up actions. Only 7% (n=12) of stakeholders thought digital technology could not improve the NHS Health Check and 19% (n=30) were not sure.

Figure 6: Stakeholders’ views on whether digital technology could improve the NHS Health Check (n=164)

How to improve uptake

The solutions considered included using a range of communication channels to invite individuals for a check as well as increasing the availability of checks by offering them in a variety of settings at a variety of times. These solutions scored higher on impact and feasibility than the business as usual solution.

Figure 7 shows that 69% (n=110) of respondents thought the programme should be delivered in settings other than general practice, 11% (n=18) of respondents thought that settings other than general practice should not be used and 20% (n=32) were not sure.

Figure 7: Stakeholders' views on whether settings other than general practice should be used to deliver the NHS Health Check

How to improve follow-up

Two solutions promoting clear mechanisms for referring patients to the correct programmes, or to appropriate digital follow up to encourage behaviour change, were rated high for impact but low for feasibility.

How research can support long-term development of the service

A range of solutions scored very highly on impact but low on feasibility, including: national arrangement for quality assurance and programme oversight, promoting high quality training for staff, creating a national system to improve the quality of data collection and financial incentives from the Secretary of State for local authorities to conduct high quality NHS Health Checks.

4.3 Phase 3

Further engagement with members of the public and local authorities with experience of engaging with minority ethnic communities provided the following insights:

Attitudes towards healthy living, knowledge of the NHS Health Check and perceptions of its usefulness

Participants were conscious of their health, with some citing efforts to maintain good diet and exercise, using fitness apps and exercising outdoors. They had mixed knowledge of the NHS Health Check. Those who knew of it only did so as they had received an NHS

Health Check themselves. Participants could recognise the benefit of the NHS Health Check, but felt that it was not well advertised. They suggested it could be offered during routine GP appointments or at a flu jab. Participants offered practical advice and emphasised that the NHS Health Check is ultimately reliant on broader public health messages.

“Some people can’t read and don’t understand cholesterol, they don’t even know what it is.”

“Why not tell people at 35 years old that in 5 years’ time they will be eligible for an NHS Health Check to make them more conscious.”

“The NHS can’t make you join a club, that is up to the individual.”

“I was brought up on a farm and we always had big hearty meals and trying to stop that is difficult.”

“You never see buy one tomato and get one free offers.”

“The last couple of week’ work has stopped, and I am not moving about so much so it’s easy to get in a spiral of decline.”

Engaging with minority ethnic communities

One stakeholder advised cultural humility is a way to engage with ethnic communities: to actively listen to those within the community who are able to explain people’s needs and the best ways of communicating. The stakeholder explained how using people within the community who can fully grasp an issue, or promote an appropriate solution, is key to reducing health inequality.

The voluntary sector was cited as having a major role in effecting this change: a ‘navigator’ role was suggested, where someone engages with all the stakeholder groups who are involved in the NHS Health Check programme, from primary care to the community.

Tailoring the NHS Health Check programme and advice to the needs of local communities was seen as important for increasing uptake and producing positive outcomes from the programme.

Examples included:

- conducting the NHS Health Check either in a local language or by members of the community of the same sex

- taking the NHS Health Check to communities, such as conducting blood pressure readings in barber shops to reach black men

- providing realistic advice on changes to diet, from portion sizes to substitution, rather than expecting someone to be able to completely change their food culture

In focusing on accessibility, some local authorities suggested lowering the age limit for some communities at particular risk, such as South Asian men at risk of diabetes. Others suggested using QRISK®3 as a measure of risk factors, and taking family history, ethnicity and age into account, to understand who could benefit most from receiving an NHS Health Check.

4.4 Strengths and limitations

Stakeholder engagement took place during the COVID-19 pandemic, during which time many stakeholders across health and social care had restricted availability owing to their roles in the pandemic response. Additionally, some engagement activities were restricted due to social distancing measures and working from home arrangements. The truncated timeline for the review also limited the type and time available for stakeholder engagement.

While the limitations on travel and social contact put in place to contain the spread of COVID-19 reduced the review's ability to engage with stakeholder in person, the review has engaged widely with stakeholders through virtual methods. Virtual methods have made it easier for the review to engage with stakeholders from a wide range of organisations and from across the country. As a result the views of over 350 stakeholders were captured and used to inform the work of the review through this process.

5. Conclusion

The stakeholder engagement process reached a range of different audiences, from members of the public to chief executives, with good geographical spread across England. Over 450 stakeholders provided their different perspectives to the review, allowing areas of interest, issues and potential solutions to be identified.

The breadth of information gathered in the process has contributed to answering the issues which form the scope of the review, and in informing the review recommendations:

Issue 1. The benefits and limitations of the existing service

The 2 most commonly occurring benefits of the programme cited by stakeholders were the opportunity for prevention and the early identification of health conditions.

Issue 2. The eligible population

There was strong support for reducing the age limit below 40 for those who would benefit most, to help tackle health inequality. Practicality, particularly around resources, was seen as a barrier to offering an NHS Health Checks to all 30 to 39-year olds.

The universal offer of an NHS Health Check to all 40 to 74 year olds was seen as a major success, which should not change. However, stakeholders felt that a greater focus should be placed on engaging with priority groups – minority ethnic communities, men, and the white working class population –- to increase their uptake. As a local authority workshop attendee said: “those within the deprived group category should be a primary target because they are more likely to be left behind.”

Successfully reaching priority groups will require the use of delivery settings other than general practice and clear communication. Using a ‘navigator’ role to understand community needs while working with providers could be a solution.

Stakeholders did not see the need to extend the NHS Health Check to those who are currently ineligible because of an existing health condition. It was felt that elements of the check should be provided to these individuals via their current package of care. As one workshop attendee put it: “offering the NHS Health Check to people with existing conditions could potentially duplicate the same work being done by local surgeries. Basically, these people are already receiving care from their GP surgeries, there is no need to offer them more”.

Issue 3. The potential inclusion of additional physical or mental health conditions

The majority of stakeholders were supportive of including an assessment of mental health within the NHS Health Check.

Issue 4. How the checks are delivered, in particular digital opportunities

Digital follow-ups are a key area of interest, with patients having access to their own results to empower them and act on. Digitising parts of the NHS Health Check would be useful for much of the public, saving time and increasing convenience. However, it was recognised that this was not the case for all – some people may not trust providing information online and some may be excluded from using digital solutions.

Issue 6. Improving uptake

Better marketing of the NHS Health Check could increase awareness and uptake. A national campaign to promote the programme and raise awareness of CVD risk and beyond, similar to the current ‘Every Mind Matters’ campaign, was suggested.

Stakeholders suggested that uptake could be improved by ensuring the NHS Health Check accommodates the needs of the public – by using delivery settings other than general practice, such as community settings, places of worship and workplaces.

Issue 7. Improving follow-up

Empowering patients to act on their health following the NHS Health Check is only possible if timely, fit-for-purpose solutions are provided to patients. This may include digital applications or programmes to support healthy behaviour change.

A standard training offer to those carrying out NHS Health Checks would help to improve the quality of checks.

Issue 8. How research can support long-term development of the service

Creating templates for the NHS Health Check with mandatory fields would improve data quality and allow for better monitoring and comparisons between local areas.

6. Acknowledgements

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PHE would like to thank all those who participated in the stakeholder engagement activities that informed the review of the NHS Health Checks programme. In particular, PHE would like to thank those who completed the online survey or attended workshops, forums or individual meetings.

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National Health Service (NHS). The NHS long term plan’. 2019 (accessed 9 June 2021).

Appendix A. Stakeholders engaged

Engagement through workshops forums and meetings

Academic Health Science Networks (AHSN), Oxford AHSN

Age UK

Alzheimer’s Research UK

Applied Health Research, Staffordshire University

Arthritis

Bath and North East Somerset Council

Bexley Council

Birmingham City Council

Birmingham City Council

Blood Pressure UK

Brighton and Hove City Council

British and Irish Hypertension Society

British and Irish Hypertension Society representative

British Heart Foundation

Calderdale Metropolitan Borough Council

Care Quality Commission

Clinical Commissioning Group representative

Chartered Society of Physiotherapy

City and Hackney GP Confederation

City of Wolverhampton Council

Community Pharmacy Surrey and Sussex

Conexus Healthcare

Consultant in Public Health, Public Health England

Croydon Council

Diabetes UK.

Doncaster Council

East Riding of Yorkshire Council

East Riding of Yorkshire Council (ERYC)

East Sussex County Council

Faculty of Public Health

Friends, Families and Travellers

Hackney Council

Hallcross Medical Services Limited

Hampshire County Council

Haringey Council

Healthcare Assistant Workforce Skills Qualification (HCA, WSQ)

Health Diagnostics

Health Diagnostics Limited

Health Improvement, Leeds City Council

Health Improvement, Oxfordshire County Council

Health Improvement, Southwark Council

HealthWatch Northamptonshire

HealthWatch, National

HEART UK (the cholesterol charity)

Hertfordshire County Council

Hull City Council

Humber Teaching NHS Foundation Trust

Ice Creates

Isle of Wight Council

Kent Community Health NHS Foundation Trust

Kent Council

Lancashire County Council

Leeds City Council

Leicester City Council

Live Well Stay Well

Local Government Association

London Borough of Hounslow

London Borough of Southwark

London Borough of Sutton

Medway Council

Men's Health Forum

Middlesbrough Council

Middlesbrough, Redcar and Cleveland Council

Midlands Partnership Foundation Trust

Milton Keynes Council

Newcastle City Council

NHS England and Improvement

NHS Humber Teaching Foundation Trust

NHS Norfolk and Waveney Clinical Commissioning Group

National Institute of Health Research Clinical Research Network

Norfolk County Council

Norfolk Local Pharmaceutical Committee

Norfolk Public Health

Northants County Council

Nottingham City Council

Nottingham County Council Public Health

Notts County Council

Oxfordshire County Council

Oxfordshire Local Medical Committee

Parkwood Healthcare

PHE National Teams

PHE Regional – East of England

PHE Regional – North East

PHE Regional – North West

PHE Regional – North West

PHE Regional – South West

PHE Regional – West Midlands

PHE Regional – Yorkshire and Humber

Phetalz Limited

Portsmouth City Council

Primary Contracts [NHS Health Checks] – Richmond and Wandsworth Council Public Health

Prospect Medical Practice

Public Health Team, Merton Council

RCGP Midlands Lead Person Centred Care (Birmingham)

Richmond and Wandsworth Council

Richmond Group

Royal Borough of Kensington and Chelsea

Royal Borough of Kingston

Royal Borough of Kingston

Royal College of General Practitioners

Royal College of Nursing – Public Health Forum Committee Member

Sandwell Council

Shropshire Council

Solace, Representative for Community Wellbeing

Stroke Association

Suffolk County Council

Sussex Health and Care Partnership

The Stroke Association

The Wellbeing Leader Limited

Thrive Tribe

UCL Partners (Primary Care Innovation)

Versus Arthritis

Voluntary, Community and Social Enterprise Sector [Health Check Programme] – Alzheimer’s Research UK.

Voluntary, Community and Social Enterprise Sector [Health Check Programme, Stroke Association

Wakefield Council

Warwickshire County Council

West Sussex County Council

Westminster City Council

Wigan Council

Engagement through online survey

Academics

Clinical commissioning groups

Clinicians

Community care providers

Department of Health and Social Care (DHSC)

Digital solution providers

Local authorities

Members of the public

NHS England and Improvement

Pharmacies

Public Health England

Primary care providers

Private healthcare

Professional leadership organisations

Secondary care providers

Service providers

Voluntary Service Overseas (VSO)

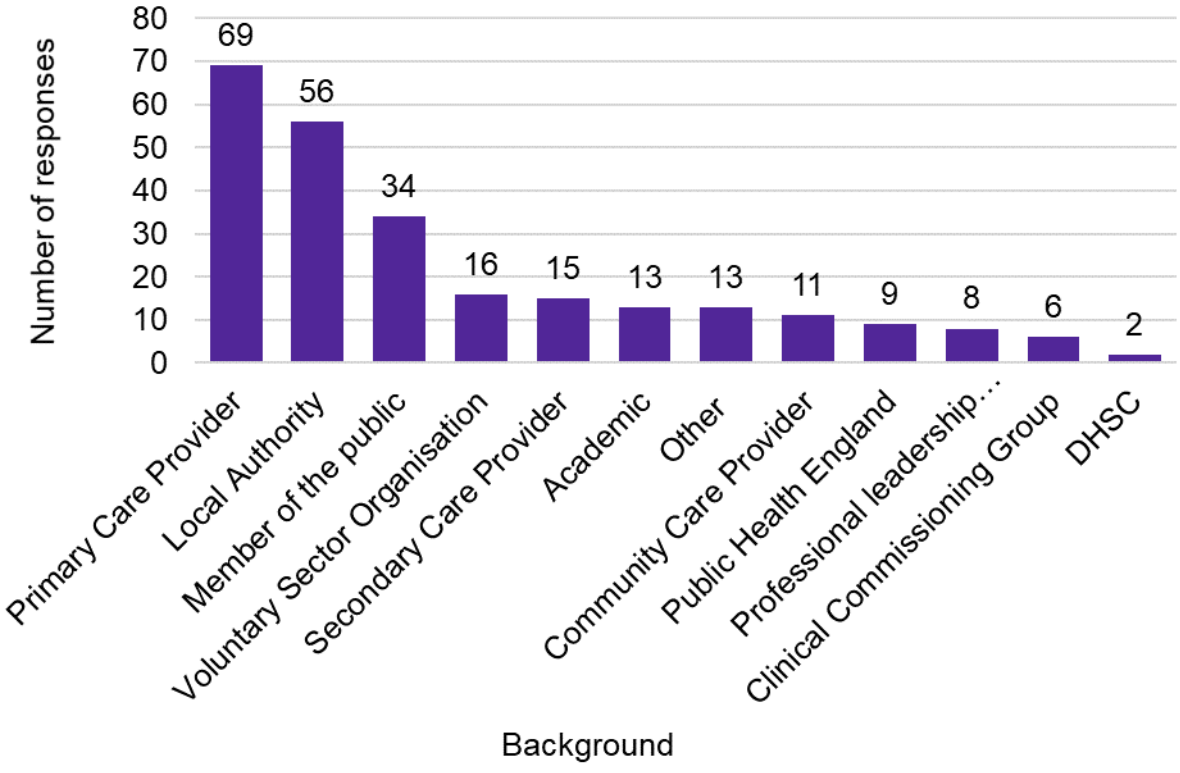
Appendix B. Analysis of responses to online stakeholder survey

Stakeholders engaged

There were 235 respondents to the survey. The information below shows the background of the stakeholders that responded.

Figure 1 shows that the 3 most common backgrounds of respondents were primary care providers (n=69); local authorities (n=56) and members of the public (n=34). Additional backgrounds of respondents included voluntary sector organisation (n=16), secondary care provider (n=15), academic (n=13), community care provider (n=11), Public Health England (n=9), Professional leadership (n=8), Clinical Commissioning Group (n=6) and Department of Health and Social Care (DHSC) (n=2). Respondents who selected 'other' background (n=13) included, for example, digital solutions provider and provider of products used to deliver the NHS Health Check. Respondents could select more than one option.

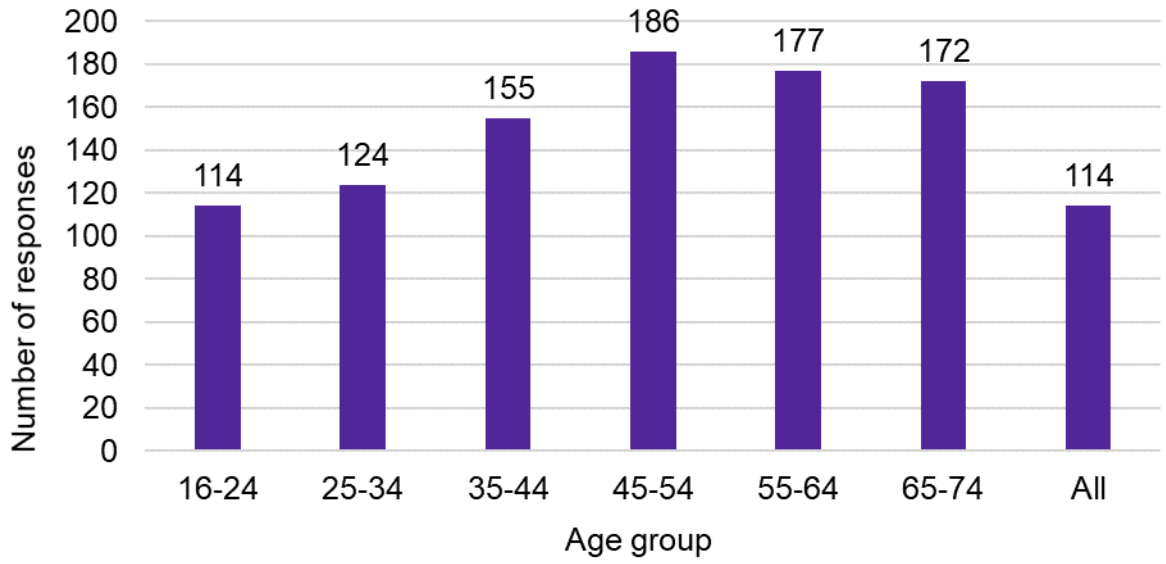
Figure 1. Background of respondents (N=235)



Age groups of interest to respondents

Stakeholders were asked which age groups are of interest to them and were given the option to select multiple categories. Figure 2 shows that the ages of most interest were 45 to 74 years (n=186), followed by 55 to 64 years (n=177), 65 to 74 years (n=172) and 35 to 44 years (n=155). There was less interest in younger age groups; 25 to 34 years (n=124) and 16 to 24 years (n=114). One hundred and fourteen respondents said they were interested in ‘all’ age groups.

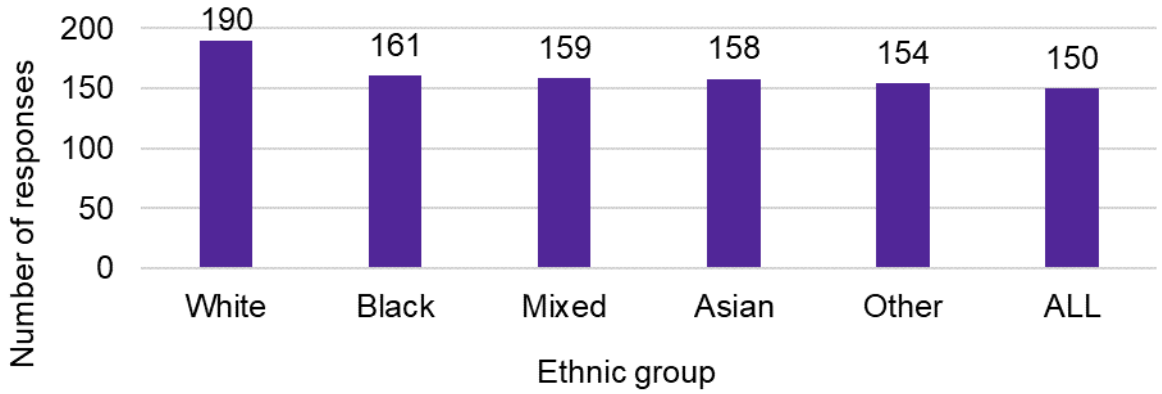
Figure 2. Age group(s) of interest to respondents



Ethnicities of interest to respondents

Stakeholders were asked which ethnic group(s) are of interest to them and were given the option to select multiple categories. Figure 3 shows that White ethnicity was selected by the highest number of respondents (n=190), followed by Black (n=161), Mixed (n=159), Asian (n=158), Other (154) and All (n=150). Responses are summarised in the following figure.

Figure 3. Ethnicities of interest to respondents



Interest in the lesbian, gay, bisexual and transgender community (LGBT)

In all, 151 respondents indicated they had an explicit interest in the LGBT community.

Effectiveness of the NHS Health Check programme

Stakeholders were asked for their view on the effectiveness of the current NHS Health Check programme in reducing the chance of heart attacks, strokes and some cases of dementia among adults. The number of responses totalled 217. Data showed that 37.7% (n=82) of respondents rated the programme as 'very effective' or 'effective' while 22.1% (n=48) rated as 'ineffective' or 'very ineffective'. Some respondents selected neutral (28.6%, n=62) and don’t know (11.5%, n=25).

Table 1. Respondents’ perceptions of the effectiveness of the NHS Health Check (n=217)

Response	Number of responses	Per cent
Very effective	10	4.61
Effective	72	33.1
Neutral	62	28.6
Ineffective	35	16.1
Very ineffective	13	6.0
Don't know	25	11.5

Most valued aspect of the NHS Health Check programme

Stakeholders were asked what they felt was the most valued aspect of the programme. Answers were in free text. Qualitative analysis identified the 2 most common themes as the opportunity for prevention and the early identification of health conditions. The opportunity for behaviour change and the universal approach were also commonly cited benefits of the programme.

Inclusion of additional risks or diseases in the NHS Health Check programme

Stakeholders were asked whether there should be assessments for additional risk factors or diseases as part of the NHS Health Check and, if so, which additional risk factors or diseases should be assessed. The number of responses was 173. Almost half (48%, n=83) respondents thought that additional risks or disease should be included in the programme, while 26.6% (n=46) were not sure and 25.4% (n=44) thought they should not. The responses are summarised in table 2.

Table 2. Respondents' perceptions on inclusion of additional risks or diseases in the NHS Health Check (n =173)

Response	Number of responses	Per cent
Yes	83	48.0
Not sure	46	26.6
No	44	25.4

Stakeholders put forward a large number of ideas on additional risks and conditions to be assessed by the NHS Health Check. The most common suggestion was assessment of mental health.

Age groups eligible for the NHS Health Check programme

Stakeholders were asked which age groups should be eligible for the NHS Health Check. Multiple categories could be selected. Data shows that the most commonly cited priority age groups were: 45 to 54 (n=156); 55 to 64 (n=166); 65 to 74 (n=169). All age groups already included in the programme, including these age groups and 40 to 44, were pre-checked on the survey form. Respondents had to uncheck these options if they did not want them included in their response. One hundred respondents selected 40-44 years. There was less support for inclusion of younger and older age groups.

Clinical (such as prescribing medication, medical procedures) and behavioural (weight management, stop smoking, physical activity, alcohol) follow-up of the NHS Health Check and ensuring people with the greatest health need benefit the most

Stakeholders were asked to feedback on their thoughts on the follow-up to NHS Health Checks. Answers were in free text. Responses were grouped thematically and qualitative analysis identified that the most common themes were focus on holistic approach and integrate behavioural programmes; ensure funding to reach everyone eligible and single digital to access the NHS Health Check and follow-up.

Use of digital technology to improve the NHS Health Check programme

Stakeholders were asked whether digital technology could be used to improve the NHS Health Check. The number of responses was 164. Almost three-quarters (74.4%, n=122) respondents thought that digital technology could improve the programme, while 18.3% (n=30) were not sure and 7.3% (n=12) thought it could not. Responses are summarised in the table 3.

Table 3. Respondents' perceptions on whether digital technology could improve the NHS Health Check (n=164)

Response	Number of responses	Per cent
Yes	122	74.4
Not sure	30	18.3
No	12	7.3

Areas digital technology could help with

Stakeholders were asked to suggest areas that digital technology could support. Answers were in free text. Responses were grouped thematically and qualitative analysis identified that respondents felt that technology could best support the programme by providing results to citizens and collecting data prior to the consultation. Themes such as patient data targeting and virtual appointments were commonly cited.

Settings used to deliver the NHS Health Check

Stakeholders were asked whether other settings could be used to deliver the NHS Health Check. The number of responses totalled 160. Over two-thirds of respondents (68.8%, n=110) thought that other settings should be used to deliver the programme, while 11.3% (n=18) were not sure and 20% (n=32) thought they should not. Responses are summarised in the table 4.

Table 4. Respondents' perceptions on the use of other settings to deliver the NHS Health Check (n=160)

Response	Number of responses	Per cent
Yes	110	68.8
No	18	11.3
Not sure	32	20.0

Other sites that could be used to deliver the NHS Health Checks programme

Stakeholders were asked to name other sites which they felt the NHS Health Check programme could be delivered through. Answers were in free text. Responses were grouped thematically and qualitative analysis identified that respondents named 8 sites which could be used to deliver the programme. The most frequently suggested sites were community outreach, pharmacies and the workplace.

Improving uptake of the NHS Health Check programme

Stakeholders were asked for their thoughts on what the programme needs to do to increase citizens' uptake. Answers were in free text. Responses were grouped thematically and qualitative analysis identified that raising awareness was the most commonly cited response, followed by diversifying the settings and improving the invite.

Appendix C. Online stakeholder survey template

Introduction

Public Health England (PHE) has been commissioned by the Department of Health and Social Care (DHSC) to undertake an evidence-based review of the NHS Health Check programme and we are interested in your views about the current programme and how it could be improved.

This survey is open to anyone who wishes to comment on the NHS Health Check programme. Your feedback will contribute to a stakeholder feedback report and, together with an analysis of data from programme and a review of the academic literature, will inform the review and recommendations. All responses will be anonymised so that no individual person or organisation can be identified.

The survey should take around 10 minutes to complete and will close for responses on Friday 18 December. Further details about the NHS Health Check programme and the background to the review can be found below.

About the NHS Health Check programme

The NHS Health Check was first introduced in April 2009 and aims to prevent 150,000 hearts attacks, stroke and cases of dementia, and to provide onward referral to the diabetes prevention programme. In 2013, responsibility for commissioning the programme moved to local authorities and it is mainly delivered by NHS Primary Care Services. Adults in England aged 40 to 74 are eligible for an NHS Health Check every 5 years.

The check is made up of 3 key components:

- risk assessment
- risk awareness
- risk management

During the risk assessment, standardised tests are used to measure risk factors and to establish the individual's risk of developing cardiovascular risk factors, as well as to inform a discussion about, and agreement on, behaviour changes and medical approaches best suited to reducing the individual's chance of developing cardiovascular diseases. You can find more information at the NHS Health Check Programme review.

Review of the NHS Health Check programme

Last year, the government published ‘Advancing our Health: Prevention in the 2020s’, announcing its intention to review the NHS Health Check programme in order to build on the gains made over the last 10 years and to consider whether changes to the NHS Health Check programme could help it deliver even greater benefits. PHE has been commissioned to deliver the evidence-based review by January 2021.

The survey

To begin the survey, please click ‘next’.

1. Please complete the sentence with options given. You may select more than one option.

'I am interested in the review of the NHS Health Check programme. I am responding to this survey from the perspective of a…'

- Local Authority
- Clinical Commissioning Group
- Community Care Provider
- Primary Care Provider
- Secondary Care Provider
- Department for Health & Social Care
- NHS England Regional / National Team
- Public Health England
- Voluntary Sector Organisation
- No organisation - I am interested as a member of the public
- Other, please specify

2. Please complete the sentence with one or more of the options given. You may select more than one option.

'Through my personal interest or as part of my job, I am answering this survey with the interests of the following groups of people in mind…'

- 16 to 24 year olds
- 25 to 34 year olds
- 35 to 44 year olds
- 45 to 54 year olds
- 55 to 64 year olds
- 65 to 74 year olds
- All of the above
- Other, please specify
- White (Including any white background)
- Black, African, Black British or Caribbean
- Mixed or multiple ethnicity groups
- Asian or Asian British
- Other Ethnic Groups
- Lesbian, Gay, Bisexual and Transgender

Your opinion of the NHS Health Check programme

3. The aim of the NHS Health Check is to reduce the chance of heart attacks, strokes, and cases of dementia among adults (40 to 74 years) without existing cardiovascular diseases.

How effective do you think the NHS Health Check programme is in achieving its aim?

- Very effective
- Effective
- Neutral
- Ineffective
- Very ineffective

- Don't know

4. What do you value most about the current NHS Health Check programme?

Areas for improvement

On this page are a number of questions about how we can improve the NHS Health Check programme. You do not need to answer every question.

5. As part of the review, we are considering whether additional diseases should be assessed in the NHS Health Check, as well as additional risk factors.

Currently, the NHS Health Check assesses an individual’s risk of having a heart attack or stroke in the next 10 years and their risk of developing diabetes. This is underpinned by the assessment of 6 risk factors:

- alcohol consumption
- cholesterol
- blood pressure
- obesity
- physical activity
- smoking

Additionally, 65 to 74 year olds are made aware of the signs and symptoms of dementia.

Do you think that the NHS Health Check should include the assessment of additional diseases or additional risk factors? If Yes, give details about which additional diseases or risk factors you think should be assessed and provide evidence to support these.

- Yes
- No
- Not Sure

6. The NHS Health Check is currently offered to 40 to 74 year olds. As part of the review, we are considering which age range should be eligible to receive an NHS Health Check.

Please select all age ranges that you think should be eligible to receive an NHS Health Check. The age ranges which are ticked are the ones which are currently offered an NHS Health Check. As part of your answer, you may untick them.

- 16 to 24 year olds
- 25 to 29 year olds
- 30 to 34 year olds
- 35 to 39 year olds
- 40 to 44 year olds - ticked
- 45 to 54 year olds - ticked
- 55 to 64 year olds - ticked
- 65 to 74 year olds - ticked
- 75 to 79 year olds
- 80 to 84 year olds
- All of the above

7. How can we improve or expand the clinical and behavioural follow-up of the NHS Health Check and ensure people with the greatest health need benefit the most? (Clinical follow-up includes prescribing medication, medical procedures and behavioural follow-up includes weight management, stop smoking, physical activity, alcohol.)

8. Do you think that digital technology could be used to improve the NHS Health Check programme? If Yes, please use the text box to tell us know.

- Yes
- No
- Don't know

9. Currently, NHS Health Checks are most commonly delivered in general practice. Are there other settings where you think an NHS Health Check could be delivered? If yes, please give further details in the text box below.

10. Around 50% of people who are invited for an NHS Health Check take up the offer, and those who take up the offer are broadly representative of the population in England.

How can we improve the take-up rate while continuing to ensure that people who would benefit most from an NHS Health Check, particularly from disadvantage groups or experiencing barriers to accessing health services, are invited to the NHS Health Check and have access to one?

11. Can you suggest any other areas for improvement of the NHS Health Check programme?

Office for Health Improvement and Disparities