Joint Scrutiny Review of Healthchecks

February 2014

Joint Scrutiny Task Group:

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Foreword

We have pleasure in presenting this joint report from Lancashire County Council and South Ribble's Scrutiny Committees. This first collaborative review of the County Council's Health Scrutiny Committee with a district committee shows the value that working across the two-tiers of local government can provide in improving health and wellbeing for our residents.

This is also the first major Scrutiny review involved Public Health since it was transferred to the County Council last year and had been essential to the success of the review and demonstrated that public health is best placed more closely to the communities that it serves.

Our review is part of a number of pilots across England looking at the effectiveness of NHS Healthcheck's and Return on Investment, which has also been a great learning opportunity and one which adds strength to the outcomes of the review. Our work has been used in a national publication 'Checking the Nation's Health produced by the Centre for Public Scrutiny on behalf of NHS England, which will be used to inform national policy on NHS Healthchecks. A copy of this report is included at Appendix 2.

We would like to thank colleagues on the Task Group (all those listed on page 4) for their invaluable help in our review.

We hope you find the report useful and share our commitment to improving the health and wellbeing of our residents in Lancashire and South Ribble.

Councillor Mick Titherington
Chair of South Ribble Borough Council Scrutiny Committee
Chair of the Joint Task Group

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Chair of Lancashire County Council Health Scrutiny Committee
Vice-chair of the Joint Task Group

Acknowledgements

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Centre for Public Scrutiny:

Linn Phipps – Expert Advisor

Lancashire County Council Public Health Team:

Steve Owen, Karen Slade, Peter Lobmeyer

Public Health England Cumbria and Lancashire Centre:

Diane Draper

GP Surgeries:

- Coastal Road Surgery, Morecambe
- Irwell Medical Practice, Bacup
- Owen Street Surgery, Morecambe
- Padiham Group Practice, Burnley
- Ryan Medical Centre, Bamber Bridge
- Worden Medical Centre, Leyland

Clinical Commissioning Groups:

- Chorley & South Ribble/Greater Preston CCGs
- North Lancashire CCG
- East Lancashire CCG

Scrutiny Team:

- Wendy Broadley – Lancashire County Council
- Darren Cranshaw – South Ribble Borough Council

Introduction

In summer 2013, the Centre for Public Scrutiny (CFPS) was commissioned by NHS England to work with six scrutiny development areas to pilot a review on how the NHS Healthcheck Scheme was working at a local level. The pilot was to use the Return on Investment Modelled designed by the Centre for Public Scrutiny.

Following expressions of interest Lancashire County Council and South Ribble Borough Council's Scrutiny Committees were invited to carry out a joint review as part of the pilot.

A joint Scrutiny Task Group was created with four councillors from each Scrutiny Committee. The Centre for Public Scrutiny appointed an Expert Advisor to work with the Joint task Group.

Review Aims

The agreed aims and objectives of the review were:

To enable the County and District Councils to work together and develop joint working methodology from which 2-tier authorities in particular can learn.

- To deliver a scrutiny review which focuses on good practice in the use of Healthchecks and captures both local and general learning as set out in the NHS Healthcheck briefing.

- To use and develop the methodology for calculating the 'rate of return' on scrutiny activity, with reference to the Centre for Public Scrutiny model to measure the return on investment – 'Tipping the Scales!' from targeting groups at greater risk, instead of 20% random targeting.

- To link with the County and District Councils corporate plans.

What are NHS Healthchecks?

NHS Health Check is a national prevention programme to identify people at 'risk' of developing heart disease, stroke, diabetes, kidney disease or vascular dementia. The term that covers all these conditions is 'vascular disease'.

Everyone between the ages of 40 and 74 in England (almost 15 million people) who has not been diagnosed with vascular disease or already being managed for certain risk factors should be offered an NHS Health Check once every five years to assess their risk.

The risk assessment involves a face to face meeting with a trained person such as a nurse, public health worker or pharmacist and uses questions about family health history and checks such as weight, blood pressure and cholesterol.

At the present time there is a legal requirement for councils with responsibility for public health to commission NHS Healthchecks but there is no legal requirement for GP surgeries to provide them.

What is the Return on Investment Model?

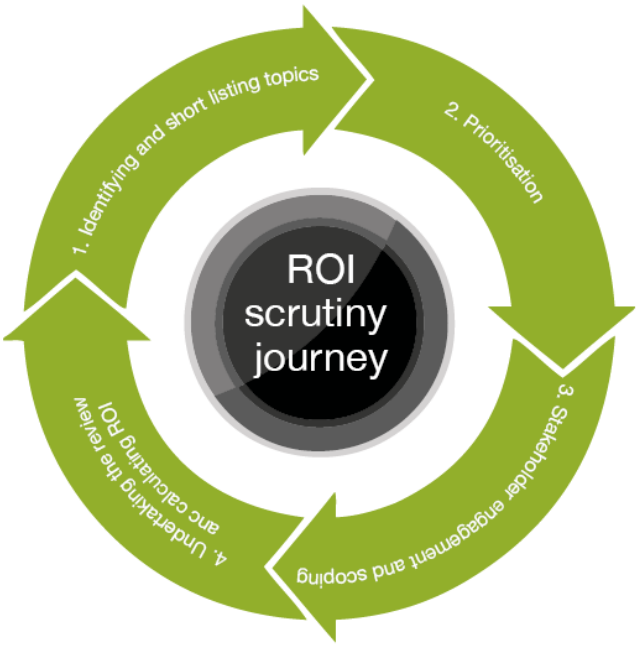
The model is based on 4 stages of a “scrutiny journey”, utilising a variety of tools:

1. Identifying and short listing topics: understanding the health inequalities in your area and knowing what strategies to look to, to source ideas for a review of health inequalities.

2. Prioritisation: to make a good final decision on which topic to choose, using new ‘impact statements’ that are linked to the policy objectives of the Marmot review.

3. Stakeholder engagement and scoping: broadening out the review via a stakeholder event that uses a wider determinants of health approach to produce the ‘Key Lines of Enquiry’ for the review.

4. Undertaking the review - designing measures and measuring impact – processes and outcomes: estimating and evaluating the impact of overview and scrutiny, and testing the ways in which a potential “return on investment” may be calculated – measures of process and outcome impacts.



Review Methodology

As part of carrying out this review, the Scrutiny Task Group undertook the following research methodology:

- The Task Group carried out a desktop review of information on NHS Healthchecks and Return on Investment Model.

- At a scheduled meeting of the County Council's Health Scrutiny Committee, which includes representatives of each of the district councils in Lancashire, the approach taken by Clinical Commissioning Groups in Lancashire with regards Healthchecks was probed in detail.

- A sample of six GP surgeries were selected (2 in South Ribble, 2 in the north of Lancashire and 2 in the east of Lancashire) to explore in detail how the Healthchecks were being delivered and the view of health professionals.

- A questionnaire was developed with Task Group Members visiting each of the GP surgeries to collect consistent data to help with the research for the review.

- The Task Group met with representatives of the County Council's Public Health Lancashire Team to look at their commissioning strategy, performance data and gain views on best practice and potential future approaches to Healthchecks in Lancashire.

- The Task Group Chair and Vice-chair attended an Action Learning event in London with the other 5 Scrutiny Development Areas to share information and approaches.

Interview Results

As mentioned above Members of the Task Group carried out interviews with GP surgeries. A copy of the detailed outcomes of the interviews is included at Appendix 2. A summary of the results, which have informed the findings and recommendations are as follows:

- 5 out of the 6 practices interviewed carried out NHS Healthchecks. The 1 practice that didn't carry them out stated the reason as the benefit of doing it against the cost involved and felt they were being financially squeezed through manpower and resources.

- 2 of the practices randomly contact eligible patients randomly targeted based on their demographic, 2 randomly contact eligible patients on their list. 1 practice only conducts Healthchecks when the opportunity arises and doesn't routinely contact patients as they are small businesses and have to ensure they use their resources effectively, especially as the contracts might not be permanent.

- Those that invite patients for NHS Healthchecks send the standard letter of invitation out, followed by reminders with varying levels of response. There was

general comment that engaging with men in their 40s can be difficult, with practice barriers around accessibility to NHS Healthchecks being an issue.

- None of the practices carried out any outreach services with regards Healthchecks, however one practice had done some general outreach at local community events.

- Where outreach was discussed with GP practices they did not feel that Healthchecks carried out by other providers was appropriate because of issues of whether they had the ability and in how follow-ups were dealt with.

- With regards assessing the impact of NHS Healthchecks those who responded felt that this would be measured by long-term outcomes. Although, short-term measures would be when the NHS Healthchecks identified conditions, with the following example:

- Out of 1,395 NHS Healthchecks undertaken up to 1 April 2013, the number of patients identified as being at risk of developing diabetes was 13, hypertension 27 and heart disease 38.

- When asked, it was felt that men in their 40s and people living in deprivation would benefit from a NHS Healthcheck.

Key Findings

The Task Group found the following key findings from the above research:

- The introduction of NHS Healthchecks is not a statutory requirement and was not effectively launched with GPs with the necessary support, advice and guidance.

- There is varied delivery of NHS Healthchecks by GPs across Lancashire.

- Where random selection of NHS Healthchecks is carried out by GPs the invitations issued use national templates, which are not felt to be user-friendly to encourage take-up.

- There is a feeling from GPs that there is an over-complicated bureaucracy associated with carrying out the NHS Healthchecks.

- Due to the short-term nature of the programme and no ongoing commitment to funding GPs feel that it is not worthwhile to invest in the scheme.

- In the main GPs do not feel that the fee they are paid adequately covers their costs or encourages them to champion the scheme.

- The data collected and monitored on NHS Healthchecks is not robust enough to make decisions.

- Where targeting does take place there is a significant Return on Investment using the following example of target group as opposed to a random sample:

  What is the Return on Investment of targeting 50% middle aged men (40-55) instead of the 20% random targeting?

Invest: Cost of targeting NHS Healthcheck	£552,000
To save: Potential benefits of QALYs and ready reckoner	£575,000
Potential Return on Investment	£23,000

  A **quality-adjusted life-year (QALY)** takes into account both the quantity and quality of life generated by healthcare interventions. It is the arithmetic product of **life expectancy** and a measure of the **quality of the remaining life-years**

  Notes on caveats and assumptions:

  NHS Healthchecks cost £21 whether delivered by GP or outreach: extra costs to reach an extra 26297 more men is therefore £552,000.

  Assuming take up is increased this means 26,297 more men are checked; on average x 0.09 QALYs per person (this underestimates value for particular cohorts), this generates 2331 QALYs. Each QALY costs (is worth) £247, so the value of these QALYs is £575,668 (based on average populations).

- Scrutiny councillors found the experience of working directly with GP surgeries as part of the review extremely useful and felt that Scrutiny had a great deal to offer Clinical Commissioning Groups (CCGs) and GPs in helping to improve the health and wellbeing of communities.

- Councillors found a general lack of awareness and understanding of how local government worked amongst GP surgeries and how the two could work together to champion local health issues.

- Lancashire County Council Public Health team was piloting limited use of outreach services at work places and other community venues using other providers such as Lancashire Care NHS Trust to deliver NHS Healthchecks. An evaluation of the pilot will take place to inform the future commissioning of NHS Healthchecks in the future.

- Both Lancashire County Council and South Ribble Borough Council take employee health and wellbeing very seriously with relatively large workforces that would fall into the target group for NHS Healthchecks.

Conclusions

The Task Group feels that there is evidence that targeting NHS Healthchecks is an effective way to prevent ill-health, but the current commissioning process with GPs is not effective. The way in which the programme is delivered and monitored is not currently fit for purpose.

Further work is needed to understand the Return on Investment to inform improved commissioning decisions with the new arrangements for Public Health in Lancashire and designing a system that Clinical Commissioning Groups and GPs can buy-into and deliver with confidence.

The role of Scrutiny and elected councillors working in partnership with local health providers is also a key tool in improving the health and wellbeing of local people. This is to be encouraged and further work to understand the various roles should be developed further.

Recommendations

1. Lancashire County Council Public Health Team undertakes a more detailed study to generate more robust data and Return on Investment Calculations, which is transferrable to other preventative health models.

2. The detailed study is used to justify the importance of carrying out NHS Healthchecks to Clinical Commissioning Groups and GP practices in Lancashire.

3. Lancashire County Council's Cabinet Member for Health and Well Being take into account the findings of this review when evaluating the success and future direction of commissioning and delivering Healthchecks through pharmacies, community organisations and other trusted partners.

4. Clinical Commissioning Groups look at how the commissioning and process involved with NHS Healthchecks could be improved, to provide GPs with the support and assurance needed to prioritise and target NHS Healthchecks.

5. Clinical Commissioning Groups provide a briefing to GPs on the function and role of Scrutiny and how they work together in partnership to improve health and wellbeing of our communities.

6. As relatively large local employers, Lancashire County Council and South Ribble Borough Council provide NHS Healthchecks to their employees as part of their employee Health and Wellbeing Plans.

Contacts

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Appendix 1 Joint Scrutiny Review of NHS Healthchecks – Results of Interviews with GP Practices

GP Practice	Do you currently carry out Healthchecks?	What constitutes a Healthcheck in your practice?	How do you invite and approach eligible patients for a Healthcheck?	What data do you use to inform the way you target Healthchecks ?	Do you think that targeting in relation to you profile data would improve performance against targets?	What do you do about those patients who are invited for a Healthcheck but don't attend?	What kind of outreach do you do, if any, to encourage take-up of Healthchecks ?	If not already the practice, how could you target your approach to have a greater impact on outcomes for at risk groups?	How do you assess the impact of Healthchecks ?	Which groups do you feel would benefit most from Healthchecks ?	How could you measure the effectiveness of Healthchecks ?
Coastal Road Surgery	Yes	Carried out by Healthcare Assistants in accordance with specification, although HBA1C blood test is used which is more thorough.	Randomly – although some targeting of smoking status groups 70 letters a month sent with leaflets and opportunistically. Take up is about 10-15 of those approached. Problem with younger end of target group as they can only make appointments up to 3.30pm because of time of blood collections and they can't miss work to attend an appointment.	See Q5	-	Practice does not follow up and taken the view that 'you can only do so much' and 'if people don't want to' they won't.	Does not engage in outreach work but sees some advantage to workplace checks etc. but equally raises questions of who deals with the results.	At risk identified patients are give advice on diet, exercise, smoking and alcohol cessation and invited back annually for check-ups	There does not appear to be a formal measurement of effectiveness although there is a recognition of long-term benefits by the prevention of conditions being developed.	-	-
Worden Health Centre	Yes	Blood test, pulse, height, weight, blood pressure, urine test, family history and smoking and alcohol history. Then follow-up accordingly.	Public Health Lancashire put out a specification which suggests practices should attempt to reach all eligible patients within 5 years, 20% of our eligible patients a year. We don't do that. We are a small business and need to ensure we use our resources	At risk patients, those with high cholesterol levels, high alcohol intake and/or strong family history of health risk.	As we don't invite patients to attend for Healthchecks – not applicable.	As we don't invite patients to attend for Healthchecks – not applicable.	We don't employ outreach at the moment but we would be willing to share best practice with partners. But stress we don't see this as our remit. How could we share information? What systems	We could employ a 'plan – do – study' approach and measure the effectiveness of the procedure. We could do them on a 5 years basis but this would require co-ordination. Once a problem is identified, patients go onto a recall schedule and healthchecks are	We monitor outcomes and can do audit searches on clinical systems, but don't routinely do so. As an aside, Dr Kelsall suspects that there will be more emphasis on this aspect	The risk groups include patients with high body mass indices, possibly males, but they tend not to turn up. The way forward is to make Healthchecks collaborative – conducting	

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			effectively. We're also aware that the healthcheck contract might not be permanent so we don't want to invest in resources which would become redundant if the contract was not renewed. Also, we are geared up to handle the unwell. The target cohort for healthchecks generally considers itself to be well, so the response to our approach offering a healthcheck is not high. We of course give healthchecks to anyone who requests one and we conduct opportunistic healthchecks on patients who present with other ailments.				are in place?	no longer relevant for them. We suggest research into demographics be conducted to fin which media patients respond best to – radio, television, billboard, etc. The traditional doctor's letter is perceived as being less effective today. We also have plans for our IT systems to enable the sharing of data. In addition, there are concerns that if another provider performs a Healthcheck on one of their patients, which mechanism exists to treat the problem once identified? They were concerned that under 'any qualified' provider rules, private sector diagnostic services could spring up, services which were likely to generate unnecessary worries amongst patients without offering treatment.	going forward	them on the premises of big employers and at football matches for example – perhaps conducted by nursing staff shared across the district, say a nurse employed by Public Health.	

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Padiham Group Practice	Yes	Personal health & family history information, blood test, blood pressure, pulse, heart rate, weight, BMI, advice on exercise, diet alcohol intake, smoking and healthy lifestyle.	Use of internal records to select different groups on a changing basis, through opportunistic appointments, no specific target, those that are least seen encouraged to attend Healthchecks as opportunity presents itself. Letter, noticeboard, website. Letters only tended to generate a 20% response, the call-in board at the surgery is also used to attract the attention of patients waiting to be seen by the GP. This is the most effective method to encourage take up. Invitation to Healthchecks are also offered at consultations. Texts have been used for the last 6-9 months, but for appointment reminders only. A cautious approach is taken in using	Searches on internal records to identify high risk groups in differing categories e.g. risk of stroke or diabetes. Variable groups depending on age and risk factors are also targeted. The practice nurse selects the target groups for each round of invitations to a Healthcheck on a random basis to cover as wide a range as possible.	Yes. Older people could be targeted. Social factors such as poor housing, asthma and respiratory problems are prevalent in the area. With regards targeting in relation to profile data, the information is not up to date and in some cases incorrect.	Reminders are sent, but some patients do not take up the offer of a Healthcheck. The Practice Manager said in the main it was down to individual choice. Face to face contact was more effective – approx. 80% responded.	No external locations involved. However, this is a practice with 9 GPs so any patient who is unable to visits the surgery because of age or infirmity is home visited, usually on the same day as the request for an appointment is made. Healthchecks are offered on the basis to this high risk group – but these checks would be carried out as part of the consultation visit. The use of pharmacies for Healthchecks is not encourage as the Practice Manager did not have confidence in their ability to identify health issues, which may then go unnoticed	Further target the 'hard to reach' groups, especially those that are known to be high risk.	On the number of picked up cases – particular hypertensions and diabetes.	Smokers, obesity sufferers and drug users. Alcohol is also a 'massive' problem. There are many social issues due to the deprivation of the area, where Healthchecks would be of benefit to promote healthy lifestyles. The groups most likely to benefit from Healthchecks are predominantly men in the 40-50 age range and those who are in their 70s and likely to fall away after they reach the upper limit of 74.	Through the promotion of preventative measures, for example the promotion of screening to identify early indictors or symptoms.

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			text messages to avoid raising any alarm or concern.								
Owen Street Surgery	Yes – the surgery has a positive approach to Healthchecks and has been very proactive. They had under-capacity amongst the nursing staff and saw it as an opportunity to utilise spare capacity effectively.	In accordance with that stipulated in the contract with the exception of an HBA1c blood test which is more effective at identifying symptoms of diabetes. The tests are carried out by a Healthcare Assistant and includes blood test, blood pressure, weight, BMI, smoking, alcohol.	Patients are selected randomly but determined a cross-section by using age, gender and geography as factors The surgery adapted the letter template to make it more inviting. 50/60 letters a month sent out. After six weeks if the patient has not responded a reminder is sent and if still no response a third letter is sent. Also, opportunistically – word of mouth, clinicians, reception staff.	See Q5	The surgery is reasonably happy with its current targeting but is open to considerations. Age is one – it could be argued that the younger the client the Healthcheck is given, the greater the opportunity to take early preventative measures. On the other hand those approaching 74 will fall out of eligibility categories within the year so maybe they should be targeted.	See previous answers, but we did not ascertain if the surgery followed this up in any way.	The GP was unsure what was meant by outreach and the discussion developed into the use of authorised providers and using supermarkets and football matches etc. but this was not well received. It raises the questions 'who takes responsibility for the results?'. Feasible but to complex – did not see it as an opportunity.	Surgeries have limited information in relation to occupation and this practice would find it difficult to target other than randomly.	There is no formal way of determining impact as much of the benefit will be seen in the long-term preventing the development of the debilitating conditions although the practice has been able to present figures that showed 862 Healthchecks had been carried out to 1 April 2012 and 533 since 1 April 2013. From these checks the number of patients identified as being at risk of developing diabetes was 13, hypertension 27, heart disease 38.	Se Q8 response. Although they recognise that people living in areas of deprivation are harder to reach and less likely to engage in preventative programmes.	The surgery takes a proactive approach to the 'prevention is better than cure' believe and believe the effectiveness will be measured less by patients presented themselves for treatment of preventing premature deaths.

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Irwell Medical Practice	Yes	Blood test (no urine test unless BT indicated diabetes), blood pressure, heart rate, weight, height, BMI, lifestyle advice on alcohol, diet and exercise. Dementia checks on over 60s, dementia checks on under 60s where referred on for specific reviews and considered appropriate. The practice manager commented that they were limited in what they could do in relation to dementia cases because of resource capacity, lack of funding and lack of resources for nurses. No investment in primary care!	Targeted monthly search in the 40-74 age range for those without chronic diseases. This is done on a rota basis from 40 years upwards in age stages. Approximately 100 patients a month. All new patients are routinely given a Healthcheck. Invitation letter and explanatory leaflet. 3 letters per patient are sent to try to encourage maximum response. Men in their 40s are not responsive as other groups in the target range. Website used more by younger patients. Text – the response is not good.	Monthly search of the records or opportunistic by patient contact. Clinical database from the service spec. Patients without chronic conditions are identified from the database as these are the ones least likely to visit the practice, but respond well to Healthcheck invitations.	Yes. High COPD, high smoking levels, asthma, CVD and alcohol. Social factors including damp living conditions, unemployment (young unemployed) all contribute to the need to target healthchecks. The data as presented is difficult to understand. Data group meetings do help to explain the data. Sometimes the data does not reflect exactly what is going on in the practice.	Reminder letters are sent out. Men in their 40s less likely to respond.	Use of website. They recently held a Health Day at the Co-op car park to promote healthy lifestyles providing information and advice. The practice promotes health awareness and healthy diets at the local school. They are looking to do more in the community through schools and organisations that support local group e.g clubs for blind people. They refer patients to the Falls Clinic and Baby Clinic and target young mums who lack parenting skills. The Practice Manager pointed out that anyone irrespective of age could request a Healthcheck.	To further target at risk groups, more resources and more time would be needed. The problem is a lack of resources.	By identifying and picking up on conditions like hypertension and blood pressure. Ensuring follow up has an impact on the workload, reflecting the lack of resources.	Those in the age range 50-60 years and men in their 40s. Healthchecks would benefit patients across the board.	It would be 2-5 years before results could be assessed – the Change for Life programme is still on-going. The Practice Manager commented that they were only paid for the initial Healthcheck and not paid for high risk and other categories and 12 monthly reviews. Lack of resources was an issue and funding needs to be reviewed. The practice consisted of 8 partners – 4 full time and 4 part time, 1 registrar, 1 FY02, 1ST2 and always 4 students.

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Ryan Medical Centre	No – and haven't done for 12 months The benefit of doing it against the cost. The target area was 40-74 you had to do three letters for those who didn't attend and the template you had to fill in to assess the percentage risk could take up to 1 hour. The Doctors routinely check for diabetes or cardio-vascular disease as part of their normal doctor/patient relationship. There was a view at that some sort of check on males 45-55 would be beneficial as this was the group that didn't routinely attend surgery and were of an age when something could be done about the symptoms. They felt they were being financially squeezed both manpower and resources and were still awaiting payments from August onwards. Health visitors were no longer based in the practice. Previously this enabled GPs, health visitors and district nurses to discuss informally patient care. As the health visitors and district nurses are no longer areas based they do not now cover the same area as the GP practices. As note – the information requested by NHS England for data regarding flu jabs was only 48 hours notice.										

Checking the Nation's Health

The Value of Council Scrutiny

Centre for Public Scrutiny

accountability, transparency, involvement

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The Centre for Public Scrutiny
The Centre for Public Scrutiny (CfPS), an independent charity, is the leading national organisation for ideas, thinking and the application and development of policy and practice to promote transparent, inclusive and accountable public services. We support individuals, organisations and communities to put our principles into practice in the design, delivery and monitoring of public services in ways that build knowledge, skills and trust so that effective solutions are identified together by decision-makers, practitioners and service users.

Public Health England
Public Health England's (PHE) mission is to protect and improve the nation's health and to address inequalities through working with national and local government, the NHS, industry and the voluntary and community sector. PHE is an operationally autonomous executive agency of the Department of Health.

About NHS Health Check
The Global Burden of Disease 2012 Study highlighted the need to tackle the increasing trend in people dying prematurely from non-communicable disease. The UK is falling behind other countries and we need to take urgent action. The NHS Health Check programme systematically addresses the top seven causes of preventable mortality by assessing the risk factors: high blood pressure, smoking, cholesterol, obesity, poor diet, physical inactivity and alcohol consumption. We know that there is a huge burden of disease associated with conditions such as heart disease, stroke, type 2 diabetes and kidney disease and that many of these long term conditions can be avoided through modifications in people's behaviour and lifestyles.

Commissioning and monitoring the risk assessment element of the NHS Health Check is one of the small number of public health functions that are mandatory and detailed in the Local Authorities Public Health Functions and Entry to Premises by Local Healthwatch Representatives Regulations 2013. Supporting local authorities to implement this programme is one of Public Health England's priorities.

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This publication has been written by Su Turner, Principal Consultant at the Centre, and Rachel Harris Expert Adviser for the Centre. We are very grateful to the councillors, officers, partners and their Expert Advisers from the five Scrutiny Development Areas for their hard work and commitment to the programme.

Foreword

The NHS Health Check programme is a world-leading programme and a key component of this Government's priority to reduce premature mortality. It gives us an unprecedented opportunity to tackle the UK's relatively poor record on premature mortality by focusing on the risk factors that are driving the big killers. We know that high blood pressure and cholesterol, smoking, obesity, poor diet, physical inactivity and excessive alcohol consumption increase the risk of diseases that we can – and should – do more to prevent, such as heart disease, stroke, type 2 diabetes and kidney disease.

The NHS Health Check programme is the first approach this country has taken to address these risk factors at a population level, and in a systematic, integrated way. We believe it could also be a powerful way to reduce health inequalities, because we know that the burden of chronic disease tends to fall more heavily on those who are most deprived.

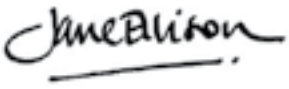
If NHS Health Check is going to realise this potential, it will require highly effective implementation. This report from the Centre for Public Scrutiny marks a valuable contribution to this effort, by providing a process for how local areas can undertake their reviews of local NHS Health Check programmes. The five case studies in this report illustrate local scrutiny in action; namely the opportunity it gives local councillors, commissioners and GPs, among others, to ask tough and practical questions: how will the NHS Health Check programme improve outcomes for those with the worst health? How will NHS Health Check be integrated with the work of health and wellbeing boards? What does best practice look like?

These challenges are the local counterpart to the national challenge set out in last year's NHS Health Check implementation review and action plan, which was led by Public Health England. This plan identified the need for greater consistency of delivery, the need for new governance structures and evaluation as well as the importance of data flows across the health and social care system.

Independent reviews can play an important role in meeting these challenges, by encouraging stakeholders to search for practical solutions that are adapted to local circumstances – how best to collect data, for instance, or how best to explain to users the aims and benefits of the programme. We need to make sure that these insights are shared, and that the questions prompted by these reviews are useful to others, who may be embarking on their own reviews of local NHS Health Check programmes.

Ultimately, though, the power of these reviews is not in coming up with a uniform set of recommendations, but in providing a forum, in which local clinicians, public health professionals and elected officials can develop a shared understanding of how to improve the health and wellbeing of their communities. The hope is that these reviews will help them to find their own way of working together. It is these relationships that will be vital to the success of NHS Health Check implementation.

I am delighted to introduce this report, which I hope will prove a valuable resource to all those who commission, deliver and support the NHS Health Check programme.



Jane Ellison MP
Parliamentary Under Secretary of State for Public Health

Introduction

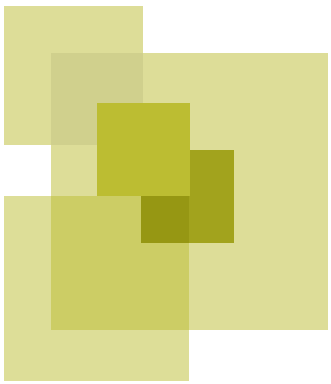
NHS Health Check is a national illness prevention programme to identify people 'at risk' of developing heart disease, stroke, diabetes, kidney disease or vascular dementia. It was introduced on a phased basis in 2009 and at that time Primary Care Trusts were expected to roll it out over five years. However, there was considerable variation across the country which meant that when local authorities took on responsibility for NHS Health Check in April 2013 they took on local programmes at different stages of implementation.

Early in 2013, a review of the lessons learned from the programme's implementation was used to develop a 10 point action plan. The implementation review and action plan set out the work that will be undertaken with key partners to support effective implementation across the country and realise the programme's potential to reduce avoidable deaths, disability and inequalities. The 10 point action plan covers:

- Leadership
- Improving take-up
- Providing the Health Check
- Information governance
- Supporting delivery
- Programme governance
- Provider competency
- Consistency
- Proving the case
- Roll-out

Councillors' scrutiny role can be a powerful lever for improving local health services, alongside other incentives in the system. Recognising this, the Centre for Public Scrutiny (CfPS) was identified as a key partner in delivering the 10 point action plan and was asked to support some local areas to undertake scrutiny reviews of their local NHS Health Check programmes to:

- Understand the benefits of the NHS Health Check programme to local areas (costed and consequential benefits).
- Understand the barriers to take up and how it can be improved.
- Promote the role of scrutiny to all councils and NHS Health Check teams.
- Increase the use of scrutiny reviews to assess NHS Health Check programmes.



CfPS worked with the following five areas to help them to carry out a scrutiny review of their local NHS Health Check Programme:

- Devon County Council
- London Boroughs of Barnet and Harrow
- Lancashire County Council and South Ribble Borough Council
- London Borough of Newham
- Tameside Metropolitan Borough Council

This publication contains the learning gathered from these areas – collectively via the outcomes of a national learning event and individually via short case studies at the end of this publication. It provides useful insight for councils and for NHS and Public Health colleagues.

Public Health England, CfPS and the five areas were aware from the outset that reviewing NHS Health Check was set against a backdrop of structural changes to the health system:

- The new health landscape created by the Health and Social Care Act 2012 was being implemented – including the creation of Public Health England.
- Public health responsibilities, including the commissioning of the NHS Health Check programme, were moving from the NHS to Local Authorities.

Using CfPS' return on investment approach (see details at appendix one) has reinforced the value of scrutiny as a way to build relationships. The case studies in this publication illustrate that there are significant opportunities for improving understanding and working relationships between councillors and primary care practitioners. Reviews of NHS Health Check programmes have led to closer working between GPs and councillors – two groups that are fundamental partners in improving the health and wellbeing of local communities.

The lessons from the five reviews chime really well with the actions that are being taken forward nationally by the NHS Health Check programme. As you will read, opportunities for improved leadership, quality, consistency and integration that are identified within the 10 point action plan have been confirmed by the CfPS support programme.

The five areas found that there were challenges and opportunities around leadership, culture and relationships; and information and communication. This publication looks at these through the lens of CfPS' principles of:

Accountable - improving leadership for whole system pathways.

Inclusive - developing relationships and cultural understanding.

Transparent – understanding information and getting communication right.

The recommendations within this publication are equally applicable to local areas as they seek to improve local population health; or to national health organisations who support and advise (including how councillors and council scrutiny have a valid role in health improvement).

The five areas also suggested questions that other councils may find useful (see appendix two).

Accompanying this publication is a series of briefings for council scrutiny:

- Improving take-up.
- Barriers and solutions to delivery of effective NHS Health Check.
- Understanding data (launched December 2013).

Accountable – Improving leadership and whole system pathways for health

Improving leadership

All five areas reported confusion about responsibility for leading local NHS Health Check arrangements. Although professionals in the system are aware of their responsibilities for delivering a NHS Health Check Programme, it is not clear to the wider health and wellbeing sector or local populations.

All areas were interested in improving take up of the NHS Health Check, however they found that variations in commissioning and the commitment of GPs were local barriers to take up.

They concluded that whilst attention is placed on inviting and carrying out NHS Health Checks, it is important for leaders of local programmes to ensure that there are effective follow-up procedures in place – either to ensure that people attend a NHS Health Check appointment or that if they are identified at risk – follow up action is taken.

Areas also reported a desire to work with NHS England as the commissioner of primary care but were unclear how to best engage local area teams.

Recommendations

- Further clarify roles and responsibilities within the health system (including the NHS Health Check programme - nationally and locally).
- Emphasise the quality of follow-up action to reap the benefits of early interventions.

Whole system pathways – embedding NHS Health Check

What became clear is that the NHS Health Check programme as a health improvement tool needs to be 'plugged in' to a wider 'improving health' pathway. Areas found that some GPs chose not to engage with the programme because the validity of the NHS Health Check as part of the whole system remained an issue of debate.

> *"GPs are geared up to deal with the unwell whereas NHS Health Checks are for people who are apparently well."*
>
> **Quote from programme participant**

Concerns also surfaced about the clarity, consistency and quality of feedback to patients following NHS Health Checks. Questions arose about how NHS Health Check can be used to encourage and support people to make lifestyle changes. Programme participants felt there were opportunities to maximise the impact of NHS Health Checks by embedding them within the work of health and wellbeing boards.

Recommendation

- The NHS Health Check programme needs to be 'plugged in' to the local health system, the preventative agenda and the work of health and wellbeing boards.

What practical steps helped?

Devon's review helped to develop the local approach to NHS Health Checks. Their approach to the review strengthened both their internal and external relationships and flagged up their intent as community leaders to embed public health improvements for their most socially isolated groups. The strong leadership focus of the review also helped to kick start relationships with local area teams.

London Borough of Newham found that whilst public health professionals understood lines of accountability there was not a shared understanding across the wider system. The transfer of public health allowed for clarity of this and the review and its recommendations have gone some way towards plugging this gap. The review took an asset based approach - supporting GPs to improve their NHS Health Check programme via their Clinical Effectiveness Group and using their expertise, adding to the clinical collaboration perspective of the review.

Inclusive – Developing relationships and cultural understanding

Developing relationships

In some areas, the reviews were pivotal to changing and enhancing the relationship between council scrutiny and local public health teams. For many, there had not been the opportunity for councillors and public health teams to work together and scrutiny provided a catalyst.

Focusing together on improving the outcomes and effectiveness of a new area of council commissioning has highlighted how closer working and sharing data and insight can move services forward. All areas reported the positive impact of outcomes and recommendations from scrutiny on commissioning of preventative interventions.

All areas agreed that the approach to identifying and hearing from stakeholders was a very effective element of the CfPS support. The approach leads scrutiny to move beyond its traditional audience and thematic workshops produced a better understanding of issues to be tackled by commissioners. Further details are included within the case studies.

Three areas recognised the need to foster relationships across tiers of local government and between councils to support health improvements. The return on investment approach was a good way to achieve closer working with robust recommendations.

Recognising the contribution of other organisations and partnerships can also help share learning about ideas for future working. The Community Hub model developed by Devon & Cornwall Probation Trust inspired a recommendation about developing a whole person 'one stop' approach for socially isolated and hard to reach groups.

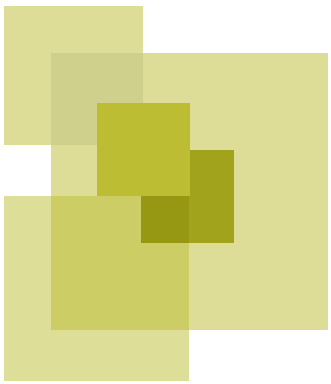
Recommendations

- A commitment to develop relationships constantly and consistently can help local areas achieve better health outcomes.
- Moving beyond traditional stakeholders can strengthen the outcomes and value of scrutiny.

Understanding cultural differences

Evidence emerged in some areas that the cultural differences between the NHS 'clinical model' and councils' 'social model' need to be better understood so that a shared health and care improvement culture can be developed.

Areas found that the natural focus of clinicians and GPs is the patient and the symptoms that present to them (the clinical model); whilst the council and councillors naturally focus on what is impacting on poor health – the causes of the causes and the wider determinants of health (the social model). By blending these skills (as advocated by the Institute of Health Equity's Fair Society, Healthy Lives (Marmot) review on health inequalities) a better understanding of communities can be gained leading to better action to support health.



Scrutiny has been shown to be an effective way to build on the common ambition of GPs and local councillors to improve the health of local people. Scrutiny of the NHS Health Check programme can be a catalyst to strengthen relationships between councillors and primary care.

Recommendations

- Develop a universal language for health locally that all partners can understand.
- The knowledge and experience of councillors can enhance the work of health partners and commissioners to improve health and health services.

What practical steps helped?

Tameside Metropolitan Council's stakeholder event provided the vehicle to get everyone together to look holistically at improving a service. It allowed for open and honest dialogue between public health professionals, GPs and the commissioners – something that wouldn't have taken place without the review. Using the CfPS approach helped scrutiny to move at a pace which led to massive benefits. They will be using the model again within future reviews.

Transparent – Understanding information and getting communication right

Understanding information and data

All areas encountered challenges with the collection, consistency or analysis of data to help them explore issues and support their findings. Inconsistent data collection by different agencies, particularly at general practice level, was highlighted as a barrier to understanding the financial value of care pathways. This translated in to a lack of confidence in some areas about the validity of data.

An important lesson from the programme was that clinicians and health professionals are used to working with absolutes whereas scrutiny is more comfortable with possibilities and insight. For example, public health professionals wanted to provide detailed, statistically accurate information and data (which could take longer to produce) but councillors were happy to receive less academically robust figures, together with strong experiential evidence and public health team insight. The reviews generated considerable learning about which partners held useful information, for example:

- Clinical Commissioning Groups understand and have access to national acute care costing information as well as GP practice information. It is essential that scrutiny develops contacts with their CCGs and general practices so that they work alongside each other.
- Information about public health outcomes is often available from national organisations and charities that hold robust data banks based on specific areas of interest that can be useful for return on investment calculations.

Some areas used particular methods to test performance data. Examples included: commissioning a community researcher; direct questionnaires to GPs to establish take up levels; concentrating on gathering in depth information from a few sources.

All the areas recognised the validity of financial return on investment as a proven and important demonstrator of the effectiveness of the NHS Health Check programme. But they also found 'softer' qualitative return on investment is equally important and gave weight to the potential of the NHS Health Check programme as a key tool to improve public health. For example, the actions that can move people towards recognising their own responsibilities for improving or maintaining their personal health is an essential part of the improvements that the NHS Health Check programme is seeking to make. The drivers for changes in personal behaviour may include improving neighbourhood interactions or bringing services into one place to improve accessibility and outcomes from the NHS Health Check programme.

Recommendations

- The variation in the quality and nature of data held at GP practices needs to be reviewed at a national level alongside consideration of how population statistics could be standardised. There is a need for consistent data collection, particularly around quantifying hard to reach groups and clearer standard measurements of comparable performance and NHS Health Check take up rates. They need to be readily available and usable by local authority commissioners.
- Review and revise local data sharing protocols and consider easily accessible mechanisms to pool partners own knowledge about alternative information sources.
- Commission services from a variety of sources including 'drop-in' services for people unable to attend their GP during working hours and monitor follow-up.

Communication

Communication was a key feature that emerged at the learning event – both with the public about the NHS Health Check programme and within and across stakeholders about how to best incorporate NHS Health Check in to local actions to improve health. Improving communication across the partners in the local health system would allow for a better sharing of information leading to improved services.

Most reviews sought to gather public views on the NHS Health Check programme, and concluded that, despite national publicity, there remains a lack of public awareness about the aims, objectives and benefits of the programme. Feedback from some people indicated an awareness of the NHS Health Check programme but an anxiety that it might identify medical conditions that could not be treated.

Recommendations

- Provide clear public information about the benefits and process of a NHS Health Check and the support available to participants with health issues and consider targeted promotion.
- Consider a NHS Health Check scrutiny review to see who does what, to generate a local understanding of the breadth of the programme.

What practical steps helped?

London Boroughs of Barnet and Harrow tested public opinion about their NHS Health Check programmes by commissioning an engagement specialist and concluded that there was not a great understanding by the public on what NHS Health Check is and how to access it.

Lancashire County Council and South Ribble Borough Council created an effective “drill-down” questionnaire that generated a new set of qualitative information about GPs’ views of their experience with the NHS Health Check, and why many GP practices do not feel it worthwhile to engage with the programme. This review also demonstrated the value of district council scrutiny and the added dimension that district councillors can add to scrutiny.

The value of good scrutiny

Good scrutiny and accountability involves different people in different ways – citizens, patients and service users, elected representatives, service providers and commissioners, inspectors and regulators. Four mutually reinforcing principles, leading to improved public services, need to be embedded at every level:

- Constructive 'critical friend' challenge.
- Amplifing the voice and concerns of the public.
- Led by independent people who take responsibility for their role.
- Drive improvement in public services.

Using these principles, CfPS has again highlighted the benefit that scrutiny can bring to other partners seeking to improve health and health services.

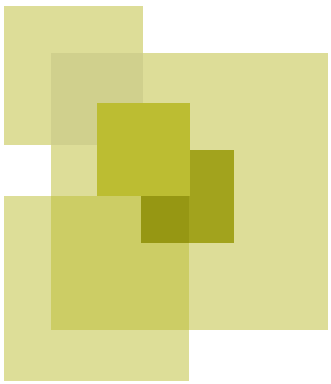
Why scrutiny - what's the added value?

- Scrutiny is independent.
- Scrutiny adds value to councils' corporate leadership and it supports health improvement by taking a proactive approach.
- Can bring the NHS / GPs and councils / councillors together by providing a neutral space to work through issues and identify solutions.
- Uses councillors' unique democratic mandate as a 'conduit between the public and their services', enables them to test whether what is provided meets community needs and aspirations.

The added value of a return on investment approach

In addition to the value described above the return on investment approach:

- Allows areas to move away from a traditional 'committee meeting' approach and explore an 'action learning' approach.
- Involves a wider group of stakeholders from across the whole system bringing more ideas and contributions to the review process.
- Uses quantitative and qualitative outcomes to provide evidence for improving joint working and the pooling of resources.
- Keeps scrutiny focused on outcomes when scoping and undertaking a review.
- Provides an opportunity to use return on investment to demonstrate the value of scrutiny, alongside internal council performance measures.



The added value of scrutiny to public health

All five reviews secured the involvement of their local public health teams, and as you have read contributed to improved understanding and working relationships. Below are quotes from public health professionals involved with the programme.

Tina Henry, Consultant in Public Health and NHS Health Check lead, Devon County Council commented:

> *The work undertaken by scrutiny on NHS Health Checks has been very timely and has raised the profile and understanding of the programme. The process allowed independent engagement with a wide range of stakeholders and providers to determine next steps in rolling out the programme. The intelligence work and feedback from the focused sessions will be used to inform the model of delivery to increase take up.*

Gideon Smith, Consultant in Public Health Medicine, Tameside MBC

> *The Tameside Health Checks Scrutiny Review has been extremely timely and supportive to the process of rethinking the local programme within the context of transition from NHS to local authority commissioning responsibility. The Stakeholder Workshop was particularly helpful in gauging the concerns, commitment and potential contributions of interested parties, and facilitating the development and delivery of a re-invigorated local programme.*

Summary and further recommendations

This programme demonstrates the diversity of good scrutiny to tackle local health inequalities in the best way suited to localities. The reviews have gone some way to overcome some scepticism regarding the validity of the NHS Health Check programme. We believe that council scrutiny has been a valuable way to independently review the roll-out of the NHS Health Check programme – with findings that can be used locally and nationally to inform commissioning decisions.

Specific recommendations have been made throughout this publication. In addition to these, below are some wider final recommendations from our observations:

- Council scrutiny can be an effective public health tool and can help areas to fully understand the health of their population and how services can improve to meet this need.
- Council scrutiny can be the bridge in developing effective working relationships – combining the knowledge of the health community and councillors in developing solutions to improving community health and wellbeing.
- The NHS Health Check programme needs to be accepted as part of a whole system review of the abiding problems of health inequalities, self-responsibility and the prevention agenda. This would enable commissioners to co-operate and to develop improved services that encompass both health and social care and continue to integrate patient pathways at all stages of their interaction with the system.
- Areas need to develop clear lines of accountability to ensure effectiveness across councils' public health role, Clinical Commissioners and general practice.
- There needs to be a continued drive towards integrated working between public health, health and wellbeing boards, council scrutiny and local Healthwatch.

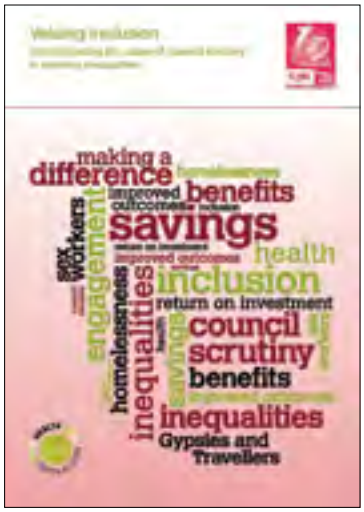
Information flow is critical across all sectors of the health economy (including people who use services), with public health retaining a vital source of data and information. Partners should aspire to transparent data that can be understood by professionals and people who use services.

Appendix one – Case studies

Tipping the Scales

http://cfps.org.uk/health-inequalities

Valuing Inclusion



http://cfps.org.uk/health-inequalities

CfPS' return on investment approach to scrutiny

In 2011 CfPS developed an approach to council scrutiny that captures the potential return on investment of a review and its recommendations. This approach has been published in our previous publications.

Each area that took part in the programme was supported to use the return on investment approach to ensure that their review was outcome focused and realised 'costed and consequential' benefits.

Over the following pages you will find out more about the scrutiny reviews that each of the areas undertook.

The case studies particularly focus on:

- Why the issue was important
- Successes and challenges
- Learning points
- Qualitative benefits
- Measuring return on investment

One of the main benefits of reviewing NHS Health Check using the return on investment approach was the opportunity to involve all stakeholders in designing the review and the key lines of enquiry. Whilst stakeholder engagement is not a new concept, in a return on investment approach it focuses the review on the policy objectives of the Institute of Health Equity's health inequalities review (Marmot) – evidence based objectives to reduce inequalities.

In assessing the potential return on investment, changes in ways of working and a focus on health inequalities will no doubt realise a financial saving both in terms of joined up delivery and less money spent within the health service, however this is difficult to quantify and assign credit to the review alone. Therefore in order to determine the potential return on investment that the review could realise, a number of assumptions need to be made.

CfPS' return on investment approach it is not an exact science. The five areas did not use health economists or finance professionals, but they did use information, data and costings that were either available nationally, provided locally or collected by themselves. The calculations (summarised in the case studies) represent the potential return on investment if the recommendations are accepted and implemented.

The case studies have been provided by the areas themselves.

Case Study: London Boroughs of Barnet and Harrow

The London Boroughs of Barnet and Harrow have had a joint public health service from April 2013 which is hosted by Harrow. The review provided an ideal opportunity to transfer knowledge from the two areas and ensure that the NHS Health Check programme develops appropriately.

Successes and qualitative benefits

- Testing public views of the NHS Health Check programme within specific community groups.
- The review identified differences in how the programme has been commissioned and delivered within the two Boroughs.
- The review helped to develop relationships between scrutiny and public health services, the two scrutiny committees and their communities.

Challenges

- The review highlighted some challenges for public health and the local authorities in dealing with issues relating to a transferred shared service.
- The complexity of the issue and its role within a wider pathway could have caused the review to be unwieldy.
- The financial modelling using the ROI model was difficult with the lack of availability of data.
- Engagement with GPs was difficult.

Learning points

- ROI is an excellent tool for demonstrating the economic benefits that scrutiny can deliver.
- The opportunity to look to other boroughs and alternative delivery models brought useful insight to local discussions.
- Public health faces a new challenge operating in a political environment.
- The scrutiny review highlighted that the public are not aware of NHS health checks.
- A balanced approach needs to be taken – people need to be encouraged to make lifestyle changes.

Key Recommendations

The review has made clear recommendations to influence the future commissioning of the NHS Health Check programme:

- Accessibility, promotion and take up.
- Aligning financial incentives.
- A whole system scrutiny of care pathways.

ROI question and calculation

What would be the return on investment if we improve take up of the Health Check amongst specific groups?

Invest : Cost of additional checks	Harrow – £93,225 Barnet - £81,575 Total - £174,800
To save : Potential savings	Harrow = £1,262,105 Barnet = £2,834,882 Total = £4,096,987
Potential return on investment	**£3,922,187**

Assumptions

Average cost of a NHS Health check = £25 (local data on spend for Barnet) – using this as the basis:

Harrow (12/13) 3729 checks cost £93,225 (Of those 65 cases of those at risk of a heart attack).

Barnet (12/13) 3263 checks cost £81,575 (Of those 146 cases of those at risk of a heart attack)

The British Heart Foundation report cost of treating heart attacks as £19,417 per case.

Calculation uses a doubling of costs and cases to illustrate ROI

For more information use this link to the review report:

http://committeepapers.barnet.gov.uk/documents/s12062/NHS%20Health%20Checks%20Scrutiny%20Review.pdf

Case Study: Devon County Council

The NHS Health Check programme in Devon was in its infancy, and the committee saw the opportunity to actively contribute to policy development using the ROI model. The committee pursued their instinctive observation that the NHS Health Check programme should be of most benefit to people in groups with the poorest health outcomes and framed their review around rural and urban socially isolated groups.

Successes and qualitative benefits

- Raised awareness of the role of scrutiny and the value it can bring.
- Strengthened relationships with public health colleagues, including monthly meetings with the Director of Public Health.
- Had a high response rate to a qualitative GP survey that was developed with assistance from the two Clinical Commissioning Groups in Devon.
- Gained insight in to the take up of NHS Health Checks in rural areas via the Farming Community Network Devon.
- Heard from a range of expert witnesses including local Veterans groups, the Probation Trust, drug and alcohol service providers and outreach health services for homeless people.
- Synthesised all the information in to a template to engage with hard to reach groups across Devon.
- Structured short 'deep dive' reviews can produce locally relevant policy insights.

Challenges

- The availability of comparable local quality data and discrete service costing's to use for measurement. They endeavoured to meet this challenge by balancing and using conflicting or small sample data to widen their understanding of the evidence.

Learning points

- NHS Health Check programme is a gateway to realising the potential of health improvement and ensuring that marginalised groups are included.
- Mental Health should be integral to the consideration of health and wellbeing and included in the Health Check programme.
- There needs to be a whole person approach in considering the health and wellbeing of everyone, particularly vulnerable or hard to reach groups.
- NHS Health Checks need to be accessible - timing, location, information and trust.
- The ROI model gave a framework and a rigour that could be shared with key stakeholders and used to include them and members together from the beginning.

Recommendations:

The task group put forward nine recommendations backed by their findings covering:

- The importance of whole system approaches from all agencies to commissioning strategies.
- Improvements to the understanding and systems approach to the NHS Health Check programme for vulnerable groups.
- The County Council visibly taking up the role of health promotion and Health Check take up.

ROI question and calculation

What would be the ROI of improving the access to NHS Health Checks for our less accessible and most isolated groups?

Invest : Cost of targeting NHS Health Checks (based on 1000 smokers)	£183,000
To save : Potential savings	£323,500
Potential return on investment	**£140,500**

Assumptions and caveats

Review costs calculated 165 hours x £9.81 (Devon median wage) ; In 2013, NHS expenditure on care on smokers will be £39.7 million (122,724 smokers with av. care cost of £323.50 per person per year). **http://www.ash.org.uk/localtoolkit** ; Each NHS Health Check costs £24 ; Smoking cessation costs are £159 **http://www.smokinginengland.info/stop-smoking-services**

Therefore cost of intervention per person is £183.

Calculation based on targeting 1000 smokers with a 100% success rate.

For more information use this link to the review report:

http://www.devon.gov.uk/loadtrimdocument?url=&filename=CS/13/35.CMR&rn=13/WD1206&dg=Public

Case Study: Lancashire County Council and South Ribble Borough Council

The Review sought to identify the value of greater targeting of the NHS Health Check programme on those whose health and wellbeing could benefit most, as opposed to randomly selecting 20%. As data was discussed with the DPH and GPs, it became apparent that increasing the take-up was a factor at least as important as targeting the invitation; and that middle aged men are generally the highest risk group, being the least likely to look after their health or attend a NHS Health Check.

Successes and qualitative benefits

- High involvement of councillors.
- Developed 2-tier collaboration of county and district councils working together on a health scrutiny review - demonstrates districts can influence health.
- Engaging public health created a practical example of the kind of data that health scrutiny wants to use – a model for further projects.
- Created a way to gain engagement of GPs and general practices.
- Developed an effective "drill-down" questionnaire to seek the views of GP's.
- Generated a new set of qualitative information on GPs' views of their experience with the NHS Health Check programme, and why many GP practices do not feel it worthwhile to engage with the programme.

Learning points

- Need to "front load" information more extensively - need to think more at the start about what information is needed and the context.
- Public health teams are used to working to longer timescales and want to provide accurate data.
- This approach to generating data illuminated understanding of the choices that GPs make, and why there are the tensions in aspirations between the GP practice as a small business model versus centrally-chosen NHS policies.
- GPs have interesting and helpful views on the best ways to increase take-up.

Key recommendations

- Undertake a deeper study to generate more robust data and ROI calculation, and a transferrable model.
- Commission the NHS Health Check programme focusing on widening the range of locations for delivery (e.g. football matches) and providers commissioned to deliver.
- NHS England be asked nationally to calculate whether it would be cost-effective to pay GPs more to carry out a NHS Health Check.
- NHS England calculate the benefits of extending the age range to say 35 (perhaps particularly for men) so as to maximize the benefits of early prevention.

ROI question and calculation

What is the ROI of targeting 50% middle aged men (40-55) instead of the 20% random targeting?

Invest : Cost of targeting NHS Health Check	£552,000
To save : Potential benefits est. by QALYs & ready reckoner	£575,000
Potential return on investment	**£23,000**

Notes caveats and assumptions

NHS Health Checks cost £21 whether delivered by GP or outreach: extra costs to reach an extra 26,297 more men is therefore £552k.

Assuming take up is increased this means 26,297 more men are checked; on average x 0.09 QALYs per person (this underestimates value for particular cohorts), this generates 2331 QALYs. Each QALY costs (is worth) £247, so the value of these QALYs is £575,668 (based on average populations). QALY = Quality adjusted life year.

For more information use this link to the review report:

www.southribble.gov.uk/scrutiny.

Case Study: London Borough of Newham

Newham has a high prevalence of preventable illness such as diabetes and had been heavily involved in early stages of the NHS Health Check programme. As a result of this involvement their programme had been front loaded (invested in early), so as the NHS Health Check programme implementation progressed nationally, statistics appeared to show that they were falling behind. Research from the pilot had also identified variations within the GP clusters.

Successes and qualitative benefits

- A strong collaborative approach between scrutiny and public health resulting in excellent support to this project.
- Local Healthwatch enthusiastically engaged with the review and ran own patient forum.
- Engagement with the Clinical Commissioning Group allowed for patient feedback, which correlated the views of the patient forum.
- A short, sharp questionnaire to those who administered the NHS Health Check programme allowed front-line feedback.
- The review has prompted a more detailed cost benefit analysis of health checks to inform future commissioning of the NHS Health Check programme.
- A good example of how scrutiny can add value to health and wellbeing boards and influence commissioning decisions.
- Strengthened partnership relationships.

Challenges

- Discrepancies in how data was collected and reported by the different agencies meant that it was difficult to correlate and gain meaningful conclusions.
- Obtaining clear financial information on the cost of providing health services was a considerable challenge.

Learning points

- Clinicians work with absolutes whereas scrutiny is more comfortable with possibilities and insight. Bridging that gap so that both are comfortable with the outcomes is essential.
- The “softer” qualitative ROIs are equally as important as quantitative ROIs.

Key recommendations

At the time of writing the final conclusions and recommendations had not been determined, but emerging issues include:

- The need to complete a review of options and funding for NHS Health Check as part of the wider preventative agenda.
- The need to reduce practice variation.
- That a collaborative partnership agreement is required.
- Statin prescribing increase in line with Clinical Effectiveness Group guidelines.

ROI question and calculation

What is the ROI of supporting the GP clusters in improving NHS Health Check take up and follow through?

The review also focused on the qualitative nature of ROI which is harder to quantify. This included the benefit of developing new relationships with the commissioners and providers to create a new vision for the future commissioning and delivery of NHS Health Checks locally.

The review did notionally model a potential financial return on investment with a focus on strokes.

Invest : Cost of targeting NHS Health Check		£35,000 (1000 additional checks)
To save:	£75,000	3 people identified at risk
Potential return on investment		**£40,000**

Assumptions and caveats

Cost of treatment for a stroke = £25K (British Heart Foundation average) ; Cost of undertaking a NHS Health Check £35 (excl. admin fees) ; Research shows for every 10,000 checked 30 are identified as having risk factors for stroke (verified by the Clinical Effectiveness Group at Queen Mary University of London). Based on a crude calculation and the cost of acute medical care and rehabilitation will vary depending on the patient and other variables – including other interventions.

For more information use this link to the review report:

https://mgov.newham.gov.uk/ieListMeetings.aspx?CommitteeId=1227

Case Study: Tameside Metropolitan Borough Council

Tameside MBC had already achieved above average take up of NHS Health Check programme across the Borough but wanted to develop its community model of delivery. The public health team were undertaking a series of reviews of their services and through working closely with the Health and Wellbeing Improvement Scrutiny Panel wanted to identify and consider how best to utilise a community or GP based approach for the delivery of NHS Health checks.

Successes and qualitative benefits

- Held a stakeholder event attracting over 40 delegates from 14 organisations connected to NHS Health Checks. The event enabled participants to discuss the benefits, opportunities and challenges in the delivery of integrated GP and community based models.
- The review helped to create new and improve existing partnerships between the Council, CCG and a range of other partners and stakeholders.
- In addition to supporting the review process the stakeholder event also benefitted public health directly in allowing them to make contact and connections with the lead officers from relevant organisations in relation to the delivery in Tameside.
- The review helped to raise the profile of the NHS Health Check programme and identify areas where take-up could be improved, e.g. through publicity and marketing.

Challenges

- A significant challenge identified during the course of the review was the need for further development around communication between partner organisations linked to NHS Health Checks.

Learning Points

- The event required financial and staff resources – but this investment led to a successful outcome.
- The need for data to accurately calculate the ROI.
- The review of NHS Health Checks was undertaken following a level of transition from the Clinical Commissioning Group to the Public Health Team at Tameside Council and this caused some concerns around the sharing of information.

Key recommendations

At the time of writing the final report had not been approved but review recommendations are likely to include:

- A marketing campaign to promote the availability and benefits of NHS Health Checks.
- Utilising community centres and engagement with leaders of hard to reach communities.
- The use of electronic invites and reminders.
- A primary and community based approach to the delivery of NHS Health Checks in the borough.
- Work with local pharmacies to improve the delivery of community based Health Checks in the borough.
- Further work with Tameside Sports Trust to explore further commissioning opportunities.

ROI question and calculation

Identifying and considering how best to utilise a community or GP based approach to the delivery of NHS Health Checks and appropriate targeting?

Invest : Cost of 10% increase in NHS Health Checks	£5,708
To save : Potential savings	£28,500
Potential return on investment	**£22,792**

Assumptions

Total cost of NHS Health check programme 12/13 £567,412 including delivery in community settings

In Q1/Q2 (6 mths) of 2012/13 there were 3,976 delivered assuming therefore 7,952 over 12 mths.

Cost of a NHS Health Check £71.35

Calculation based on 10% increase 80 patients (80 x £71.35 = £5,708). Of 8000, 11.4% identified as being at risk of stroke

Cost of treatment for a stroke = £25K (British Heart Foundation average)

1.14% out of 80 would give a £28,500 saving

Reports once approved will be available at:

http://www.tameside.gov.uk/scrutiny/reports#pers

Appendix two – 10 Questions for council scrutiny about NHS Health Check

Interested in carrying out your own review of NHS Health Check? Here are 10 questions to consider before you start. You will also find additional questions in the supplementary briefings sitting alongside this publication.

1. **How has the NHS Health Check programme been commissioned so far and who measures outputs and outcomes from it?**

2. **What do we understand about the NHS Health Check programme, how and where they happen, and the intended positive benefits for our population?**

3. **How is data about outputs and outcomes collected? Are there local systems for collecting as well as national? Can we learn anything from the experience of NHS Health Checks elsewhere?**

4. **Do we understand which sections of our local population have the poorest health outcomes and how the NHS Health Check programme will improve them? If not, who can tell us about this?**

5. **How is the commissioning of the NHS Health Check programme intended to contribute to improving the content of the Joint Strategic Needs Assessment and how does it contribute to joint health and wellbeing strategic outcomes? How is this aspect monitored and by whom?**

6. **Who has actually taken up the NHS Health Check so far and what impacts have been observed? Do we have evidence to hand about the effectiveness of the current or intended programme from existing providers and clinical commissioners?**

7. **Who provides the NHS Health Check and how does this currently relate to population coverage and the Public Health Outcomes Framework?**

8. **To what extent are clinicians and service users currently involved in commissioning the NHS Health Check programme locally? How is their contribution used?**

9. **Are there any national or local organisations and charities with specific focus on health conditions that the NHS Health Check programme seeks to prevent, that might provide an external critical friend or specialist knowledge that could be useful?**

10. **How does the baseline information we have in front of us compare to other local authorities; and what ideas do they have for taking this programme forward? Have we got comparable best practice examples to consider?**

Notes

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