Health and Wellbeing Board
North Yorkshire

NORTH YORKSHIRE COUNTY COUNCIL

HEALTH AND WELLBEING BOARD

July 2013

NHS Health Checks programme and premature mortality

1.0 PURPOSE OF PAPER

1.1 The purpose of the paper is to highlight the importance of a sustained and co-ordinated action to prevent, identify and manage cardiovascular disease (CVD) which is a key contributor to premature mortality in North Yorkshire. The paper also presents an update on the local position of the NHS Health Check Programme and highlights the contributions the programme makes, as part of a wider public health approach, to the prevention and management of CVD.

2.0 BACKGROUND

2.1 CVD in practice represents a single family of diseases and conditions linked by common risk factors and the direct effect they have on CVD mortality and morbidity. These include coronary heart disease, stroke, hypertension, hypercholesterolemia, diabetes, chronic kidney disease, peripheral arterial disease and vascular dementia (Department of Health, 2013)

2.2 Public Health England has recently produced an interactive map, as part of their Longer Lives project, showing the variation in premature death rates across England. Data for 2009- 2011 reports North Yorkshire County Council:

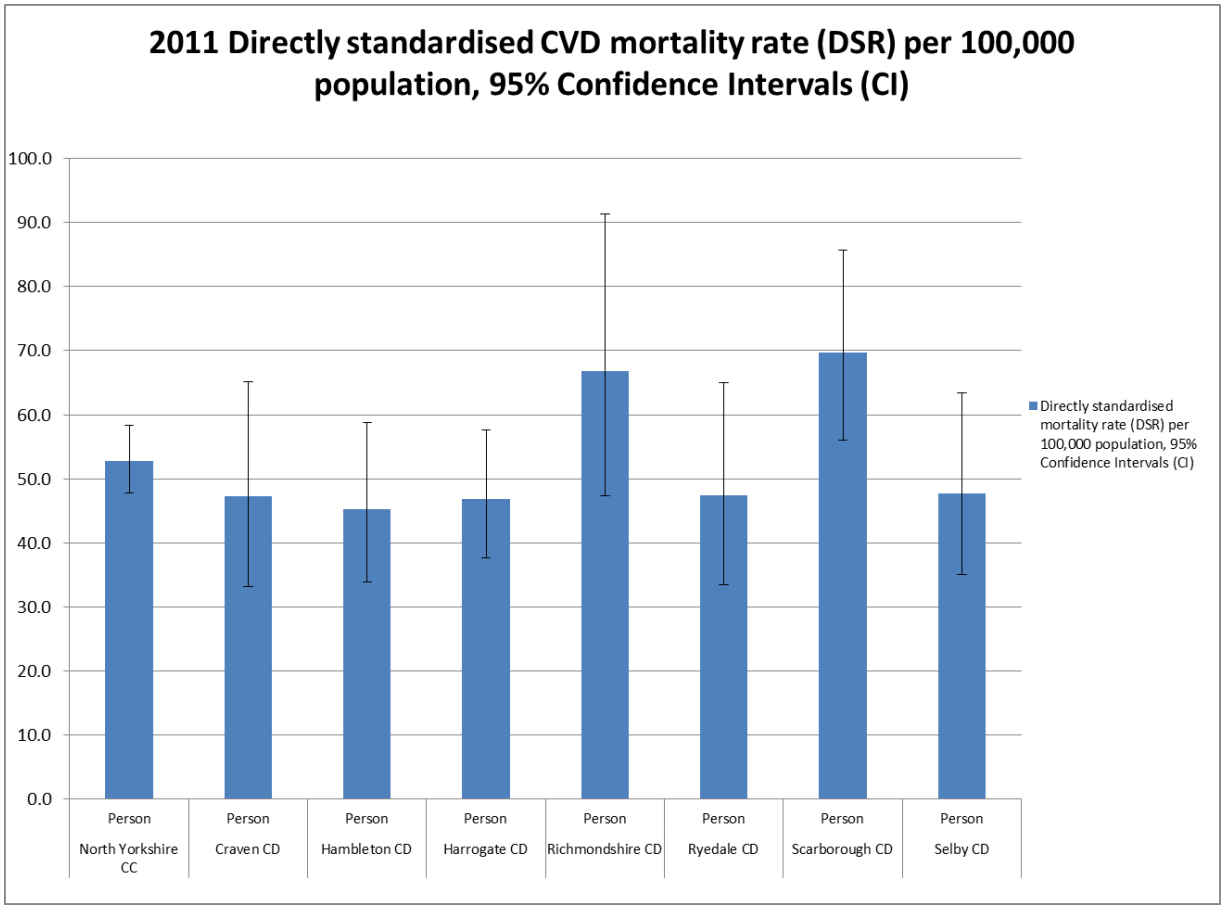
- as ranking 34th out of 150 local authorities for overall premature deaths (including cancer, heart disease and stroke, lung disease and liver disease); this is 9th when compared with 15 statistical neighbours,
- having 237 deaths per 100,000.

To put this into context, the local authority ranked 1st, Wokingham, had 200 deaths per 100,000 and the highest ranking (150th), Manchester, has 455 premature deaths per 100,000.

2.3 When breaking down the data in to specific early mortality diseases, cancer, heart disease and stroke, and lung disease were the highest ranking within North Yorkshire; 37th, 43rd, and 36th out of the 150 local authorities, respectively. When compared with 15 statistical neighbours North Yorkshires rankings were 8th, 13th, and 10th respectively.

2.4 As noted in North Yorkshire's Joint Strategic Needs Assessment (2012) circulatory diseases are the leading cause of death amongst residents of North Yorkshire accounting for 37% of all deaths. The Public Health England Longer Lives data highlights that there were 56 deaths per 100,000 in North Yorkshire, during 2009 and 2011, which were as a result of heart disease and stroke. This equates to 1,347 premature deaths over three years.

2.5 The overall picture for North Yorkshire does mask variation across the patch with regards to early mortality from CVD. CVD is one of the conditions most strongly associated with health inequalities with the burden of mortality and morbidity from CVD disproportionately falling on groups with the lowest socioeconomic status. The graph below illustrates how early mortality from CVD varies across the districts of North Yorkshire (using 2011 data from the Health and Social Care Information Centre).



2.6 The comprehensive nature of the Health Checks programme with its focus on early risk assessment, early intervention and referral to effective risk management services can clearly contribute to the reduction in avoidable premature mortality for the people of North Yorkshire. The key to success will be the ability to engage communities that are disadvantaged and/ or suffer from poor access to primary care services.

3.0 HEALTH CHECKS TO SUPPORT THE REDUCTION IN PREMATURE MORTALITY

3.1 The changes in the NHS under the Health and Social Care Act 2012 present new opportunities to improve CVD outcomes. As from 1 April 2013, North Yorkshire County Council is mandated to commission the risk assessment element of the Health Check Programme, monitor the offers made to the eligible population* across North Yorkshire, and work towards continuous improvement in uptake of Health Check appointments. Local Authorities will work closely with primary care providers and other NHS services to promote prevention and to ensure that the Health Check can deliver the maximum possible benefits.

**Health Checks are aimed at everyone between 40 and 74 years of age excluding those who have been previously diagnosed with a cardiovascular condition or are being treated for certain risk factors such as high blood pressure or high cholesterol.*

3.2 The Health Check programme was fully rolled out across North Yorkshire at the start of October 2011, having earlier been piloted in Scarborough.

3.3 The Health Check programme is a national risk assessment and prevention programme that identifies people at risk of developing heart disease, stroke, diabetes, kidney disease or certain types of dementia, and helps people take action to avoid, reduce or manage their health.

3.4 The Health Check programme has considerable potential to prevent CVD through early identification and management of risk factors. The key to the programme success however, is consistency in implementation and follow up management, which includes lifestyle interventions as well as medical interventions.

3.5 As part of the transfer of the Health Check programme into local authority, North Yorkshire County Council invited GP practices to sign up to the delivery of the Health Check Programme. To date 74 GP practices have entered a contract to provide the Health Check programme, with 3 practices actively opting out.

3.6 The Public Health team are currently reviewing the local implementation of the Health Check programme, visiting a small sample of GP practice to gather feedback on successes and challenges with inviting patients for a Health Check, uptake of Health Checks, and the modification of risk. A process of mapping invites and uptake of Health Checks against deprivation profiles is also underway. This will inform any further development of the current Health Check programme model, identifying any need for a more targeted or outreach approach to increase engagement with those at risk.

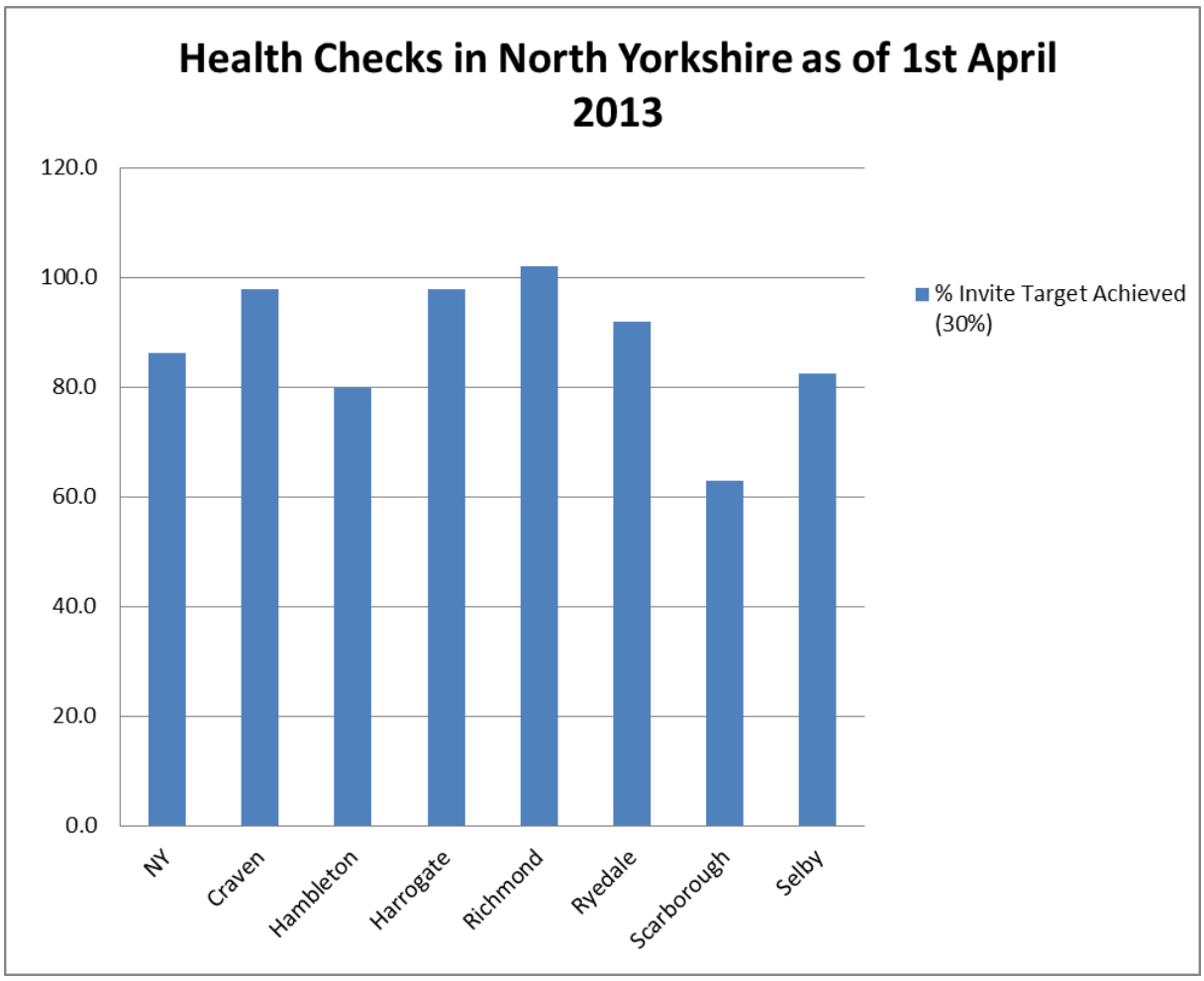
3.7 Appendix 1 provides an illustration of how the Health Check programme is delivered in practice. The illustration highlights what this may look like for two hypothetical patient profiles.

4.0 THE CURRENT STATUS OF LOCAL IMPLEMENTATION

4.1 As noted in 2.5, 74 GP practices have actively opted in to implementing the Health Check programme within their general practice. Three practices have opted out at this stage.

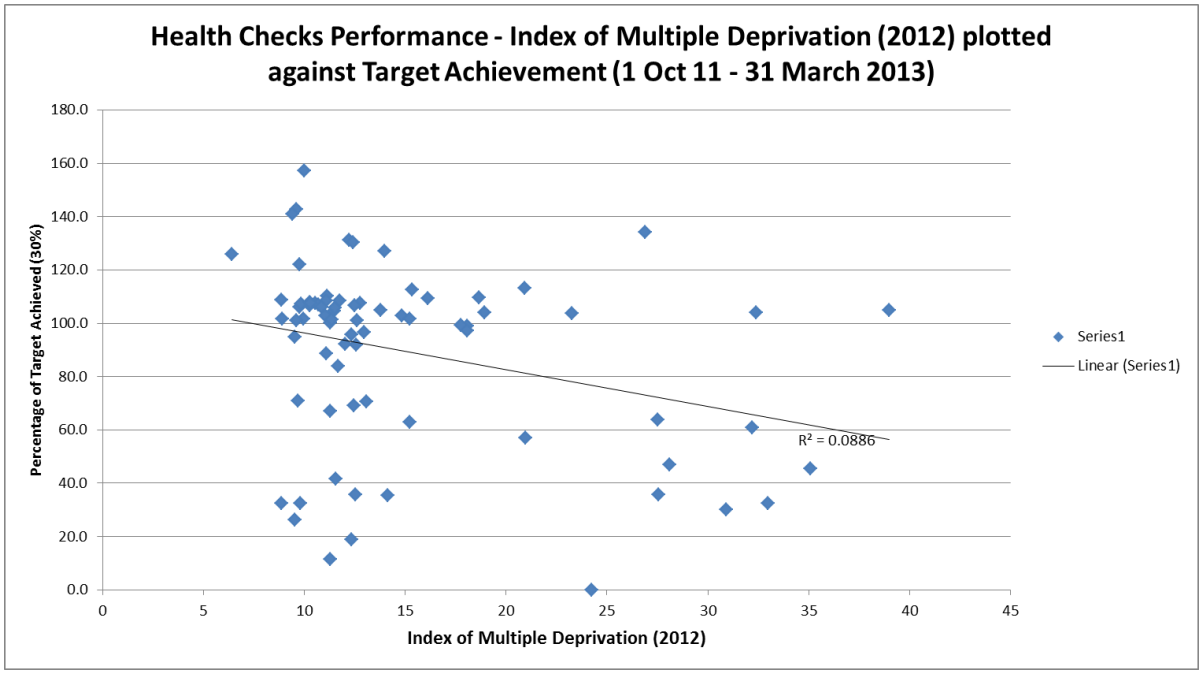
4.2 At the start of the Health Check programme (October 2011) the total eligible population was 193,000. We had a target of inviting 30% of the eligible population by 1st April 2013, working towards 100% of the population being invited by 1st April 2016.

4.3 From 1st October 2011 to 31st March 2013 there have been 49,864 Health Check invites sent out, resulting in 23,922 checks being completed (see appendix one for a more detailed breakdown of performance). Of the total eligible population for Health Checks in North Yorkshire, 25.8% have been invited meaning that 86.1% of the 30% target was accomplished. The graph below illustrates how well each district is performing against the current 30% target.



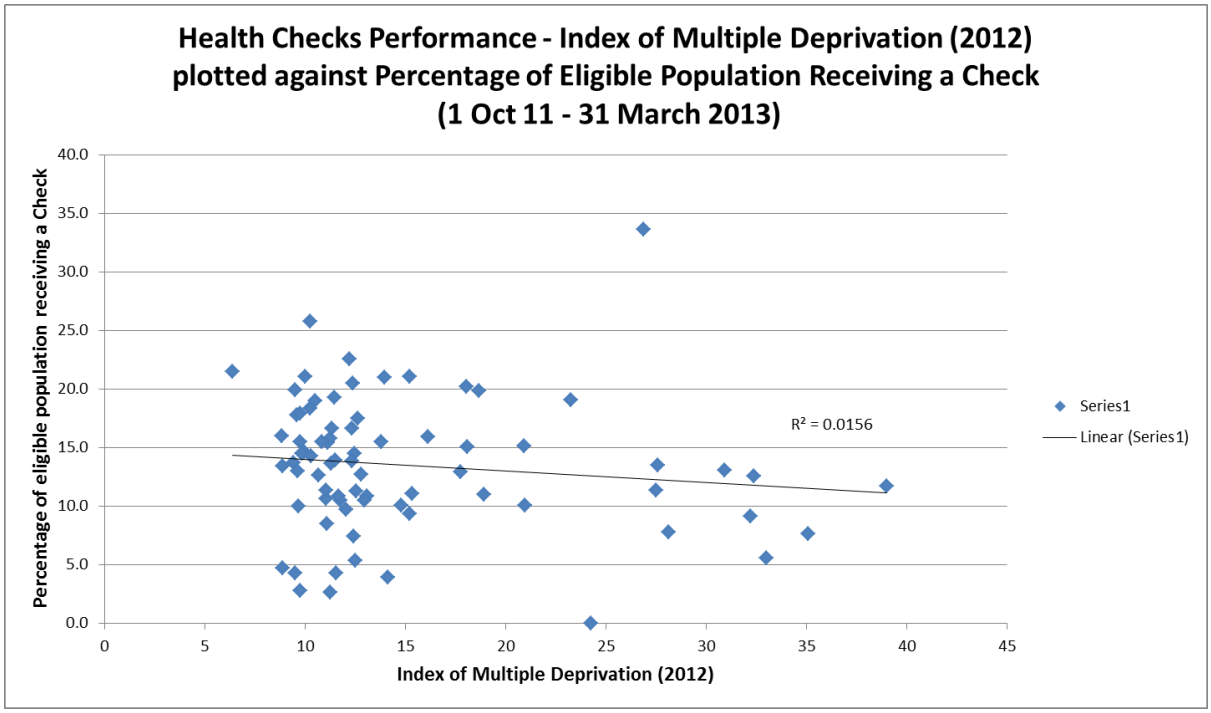
The graph illustrates that only GPs in Richmondshire are reaching the desired invitation target with GPs in Scarborough and Hambleton are performing poorly against this indicator.

4.4 It is known that areas with low socioeconomic status may have lower uptake of Public Health programmes and Health Checks appears to be following this pattern. The graph below illustrates the relationship between socioeconomic status (as measure by the Index of Multiple Deprivation 2012) and the percentage of the 30% target achieved by each GP practice.



As a GP practice's deprivation score increases then the progress against the 30% invitation target decreases. More needs to be done with practices who are not achieving their invitation target, and this is a focus of the current practice visits.

4.5 Importantly however, when GP practice deprivation score is plotted against the percentage of the eligible population who actually receive a Health Check then the gradient of the inequality is not as steep. This could be for a number of reasons such as more specific targeting of invites in deprived areas or better use of opportunistic checks i.e. when a patient attends the practice for another reason and they fulfil the Health Checks criteria.



4.6 Early findings from GP practice visits to date indicate that there is clearly a need to better engage with the eligible population to increase the uptake of invitation to Health Check appointments; more targeted work will be necessary. It is also clear that although practices appear to fully support patients to modify risks post Health Check, the procedures and on-going support for patients to make lifestyle behaviour changes needs strengthening further in line with the current public health evidence-base.

5.0 ASPIRATIONS FOR FUTURE DEVELOPMENT

5.1 To ensure the Health Checks programme contributes to reduction in avoidable premature mortality, specifically relating to CVD, across North Yorkshire, there are some clear aspirations for the coming year, which include:

- The implementation of an effective and high quality Health Check programme that supports the early identification and risk factor management and on-going treatment of cardiovascular disease across the whole pathway, ensuring that the programme interfaces with broader prevention activities,
- A strong emphasis on access and targeting those from most disadvantaged communities – review the current service provision at the patient-level within GP practices and generate evidence-based proposals to increase uptake in the most deprived groups in North Yorkshire,
- Strengthened lifestyle intervention pathways and options to support lifestyle behaviour change – we must ensure that when patients receive a Health Check there are strong, evidence-based programmes to refer into that can provide additional support to individuals seeking to reduce their CVD risk,
- Review the current Health Check implementation model and identify alternative options, and share good practice across GP practices to reduce the levels of variation in invitations and uptake.

5.2 There is a clear opportunity to make improvements in prevention, early identification, and management of CVD risk across North Yorkshire. To ensure this is achieved and sustained, there is a real need for a partnership approach to tackling CVD and reducing the inequalities that exist within the local community.

6.0 RECOMMENDATION

6.1 The Health and Wellbeing Board are asked:

- To note the contents of the paper,
- To support a review of CVD prevention, identification and management activities across North Yorkshire to explore the existing variations in activity and outcomes,
- To encourage adopting best practice for the Health Check programme to ensure reduction in avoidable premature mortality across the County.

7.0 FURTHER DETAILS

7.1 For further details on the Health Check programme, please contact:

Ruth Everson
Health Improvement Manager
ruth.everson@northyorks.gov.uk
01609 79 7027

Tom Hall
Consultant in Public Health
tom.hall@northyorks.gov.uk
01609 53 5963

8.0 REFERENCES

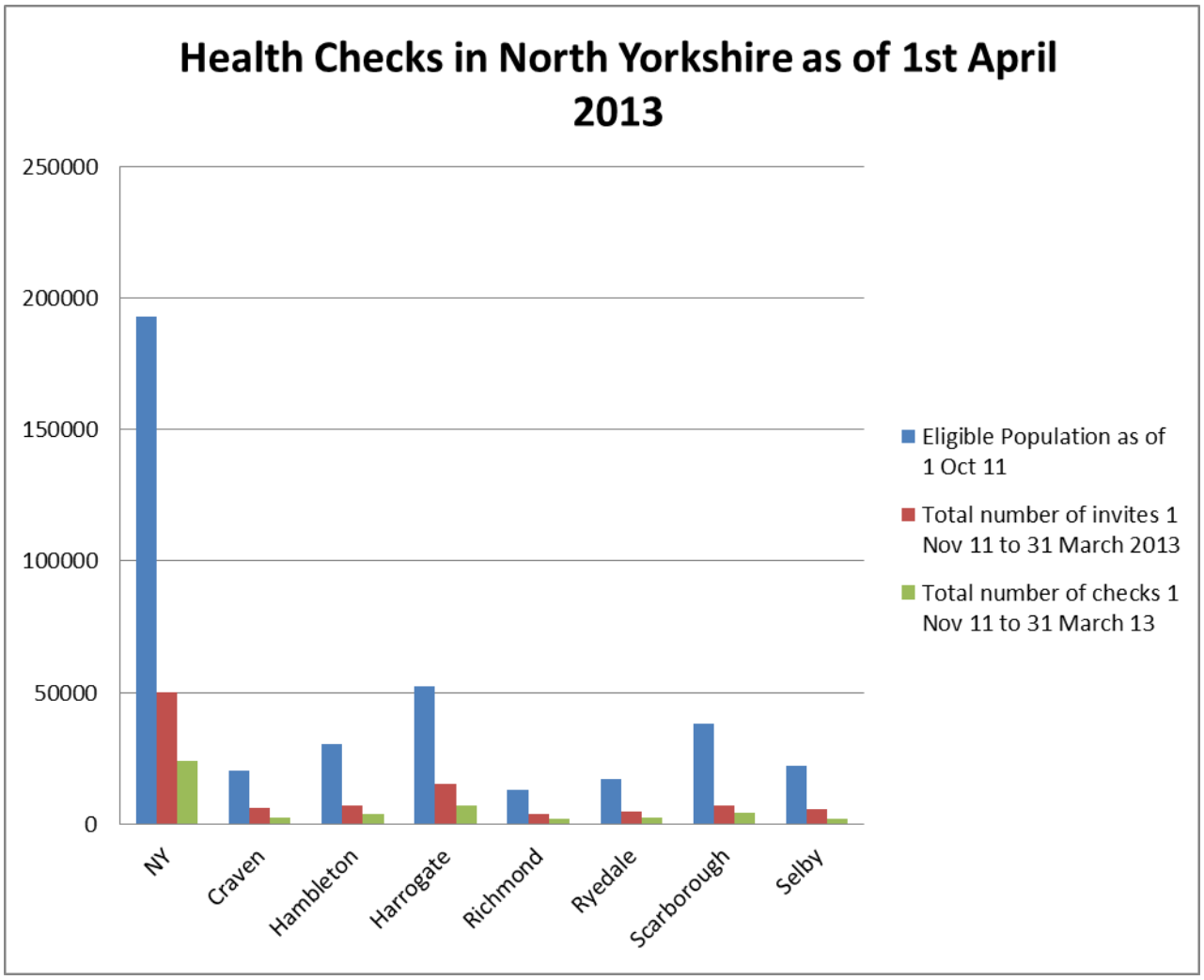
8.1 Department of Health (2013) Cardiovascular Outcomes Strategy: Improving outcomes for people with or at risk of cardiovascular disease

8.2 Department of Health (2012) Health and Social Care Act

APPENDIX ONE – Health Checks Performance

From 1st October 2011 to 31st March 2013 there have been 49,864 Health Check invites sent out, resulting in 23,922 checks being completed. Therefore 12.4% of the total North Yorkshire eligible population have received a health check, resulting in 5,925 (24.8%) new diagnoses of CKD, diabetes or hypertension, which are all high risk patients. Of those invited for a Health Check 48% attended and were checked.

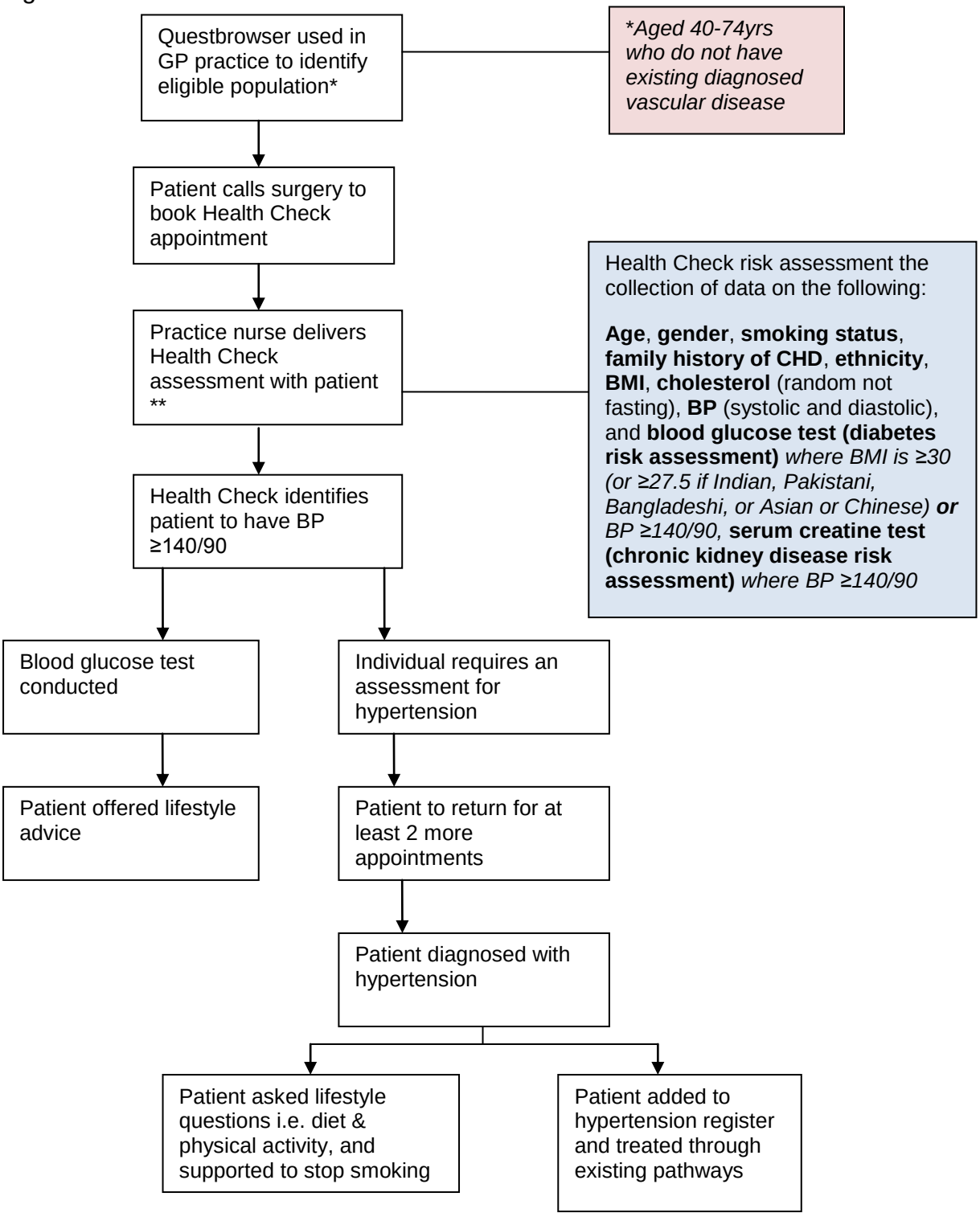
The graph below illustrates the numbers of eligible patients, the number of invites and the number of Health Checks across North Yorkshire.



APPENDIX TWO – Health Check implementation for three individual profiles

Patient profile 1: Frank is aged 56 and lives in Scarborough. Frank currently runs a bed and breakfast, which proves to be very stressful due to the current economic climate affecting tourism in the area. Frank currently smokes 20 cigarettes per day and does very little physical activity.
Frank received a letter of invitation to attend a Health Check appointment within his GP practice. Frank decided it would be a good opportunity to check on his current health and so accepted the invitation and booked an appointment with the practice nurse.

The flow chart below highlights the Health Check pathway that Frank was supported through:



Patient profile 2: Mohammed is aged 65 and lives in Skipton. Mohammed currently works as a senior manager within a small business and plans to retire within the next 5 years. Mohammed tries to eat a balanced diet but often struggles to achieve this.

Mohammed attended an appointment with his GP to discuss a pain he had been experiencing in his stomach and after further discussion with his GP is was agreed that Mohammed would benefit from receiving a Health Check. Mohammed booked straight in to a Health Check appointment at the practice reception. Mohammed isn't currently on any vascular disease registers.

The flow chart below highlights the Health Check pathway that Mohammed was supported through: