

# NHS Health Checks

Assessment of the early stages  
of implementation

**CARERS** UK  
the voice of carers



Supported by a grant from



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# NHS Health Checks

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## **Carers UK**

Carers UK is the voice of carers. Carers provide unpaid care by looking after an ill, frail or disabled family member, friend or partner. Carers give so much to society yet as a consequence of caring, they experience ill health, poverty and discrimination. Carers UK is an organisation of carers fighting to end this injustice. We will not stop until people recognise the true value of carers' contribution to society and carers get the practical, financial and emotional support they need.

## **HEART UK**

HEART UK – The Cholesterol Charity – promotes healthy hearts and better lives by helping and supporting individuals, families and health professionals to understand and control cholesterol conditions and other heart risks. In addition, HEART UK promotes education and research to improve identification, prevention, treatment and care; and promotes best practice in addressing inherited and other cholesterol problems including familial hyperlipidaemia.

## **Primary Care Cardiovascular Society**

The Primary Care Cardiovascular Society aims to improve the care and outcome of patients with cardiovascular disease in the primary care setting and to provide a general practice perspective on cardiovascular disease management to policy makers. PCCS was represented on the working group which has revised the Joint British Societies Guidelines for Cardiovascular Disease Prevention in Clinical Practice (JBS2). Following on from this PCCS campaigned hard for the implementation of comprehensive vascular risk assessment across the UK and its members are heavily involved in the roll-out of NHS Health Checks nationwide.

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# Executive summary

Imelda Redmond, Chief Executive, Carers UK

Michael Livingston, Director, HEART UK

Fran Sivers, Executive Director, PCCS



Imelda Redmond  
Chief Executive, Carers UK



Michael Livingston  
Director, HEART UK



Fran Sivers  
Executive Director, PCCS

Carers UK, HEART UK and PCCS have a long history of promotion work including promoting the benefits of vascular risk assessment. We are committed to the successful roll-out of the NHS Health Check programme as an essential step in reducing deaths from cardiovascular disease, and reducing the burden placed on the National Health Service by obesity, poor diet and unhealthy lifestyles. As organisations, we represent many clinicians involved in the implementation of the programme, as well as members of the public who will benefit most from the scheme once it is introduced.

## Importance of delivering a 'bespoke' local service

Our organisations support the way in which NHS Health Checks are being implemented by individual Primary Care Trusts (PCTs) based on national guidelines and standards\*. We believe that this method of implementation is the most appropriate way of ensuring that the programme takes account of local needs and addresses health inequalities.

*It should be for PCTs to decide the pace of implementation in line with national guidance and priorities set out in the NHS Operating Framework.*

## Challenges

While this implementation model for NHS Health Checks is essential to the success of the programme there are, of course, challenges which apply to any scheme where roll-out is led by local decision makers. Indeed, some concerns have already been raised from some quarters about 'patchwork provision' as well as duplication of effort and resources. While HEART UK, PCCS and Carers UK believe that these concerns have often been overstated, this research shows that problems do exist, with some areas being left a long way behind others. However, it should be acknowledged that the impressive work of NHS Improvements, and the National Learning Network, is playing a big role in addressing these concerns and joining up implementation.

## Project aims

The aim of this project is therefore to assess – privately – the progress being made by individual PCTs against a number of markers which are essential to the successful implementation of this vital national programme. We have sought to highlight common challenges, uncover and share best practice and highlight places which are lagging behind.

However, we are not looking to criticise or embarrass PCTs. We will therefore be making the full results available only to the Department of Health, and communicating regional results to SHA Chief Executives and individual results to each PCT in confidence.

The review has utilised Freedom of Information (FoI) requests to produce an analysis to show the progress individual PCTs are making implementing the NHS Health Checks programme. PCTs have been scored on preparedness using a sliding scale (Red, Amber, and Green) which assesses progress made on seven important indicators. An overall grade is given to PCTs by compiling the scores for each of the seven indicators.

\*NHS Health Check: Vascular Risk Assessment and Management Best Practice Guidance: Department of Health: 3 April 2009.

# Executive summary

continued

## Headline findings

- > The project achieved an 82% response rate, and therefore includes 124 of England's 153 PCTs.
- > There has generally been a very high standard of implementation in England with 83% of PCTs judged to have taken the initial steps necessary to be on target for full implementation in the timescale set by the Department of Health. However, worryingly, 20 PCTs achieved a 'red' rating which meant that progress was deemed to be behind where it should be at this stage of the implementation process.
- > In total, the 124 PCTs who responded estimate they will undertake a total of 881,615 checks in 2009/10, which means we are well on course to meet the target of 1 million checks set out in Building Britain's Future.
- > As would be expected, there are big variations in the approaches being taken around the assessment of health inequalities, the impact on existing services, and the method by which information is transferred back to the GP-held patient record.
- > Many PCTs are taking a one dimensional approach to targeting 'hard to engage' groups. In general there is an over-reliance on the use of 'tried and trusted' methods of delivery. Not enough PCTs are looking at innovative ways of engaging with populations who are outside GP practice databases, or from groups who find it hard to access services which are not better tailored to their lifestyle.
- > At present it is not possible for information obtained during the checks to be automatically fed back into the GP system. PCTs are, however, developing robust systems for communicating results back to the relevant GP.
- > There is a small but significant number of PCTs who have yet to attempt even the basic first steps, such as assessing the impact of the scheme on health inequalities, or on the capacity of other related services provided in their area.

## Recommendations

- > While the majority of PCTs have made very good progress implementing NHS Health Checks there is a small number who are lagging behind and, to date, have made alarmingly slow progress. Those PCTs who have been given a 'Red' rating in this report – but particularly, Bury, Coventry, Portsmouth, Redbridge, Shropshire, West Essex, Cornwall and the Isles of Scilly, Isle of Wight, Stoke on Trent, West Sussex, Wiltshire, Calderdale and Halton and St Helens – could benefit from being partnered with nearby PCTs who have made better progress.
- > All PCTs should by this stage have a written plan which has been signed off by their board. PCTs should be able to include details for the introduction of NHS checks in their commissioning strategy and operational planning for 2010/11.
- > Every PCT should be able to name an individual who has day-to-day responsibility for the implementation of NHS Health Checks. In addition PCTs should be encouraged to have a designated programme manager to implement the NHS Health Checks programme in post for 2010/11.
- > We do have concerns that some of the numbers quoted for this year are possibly unrealistic, or perhaps include vascular checks which are being carried out already by GP practices but are not equivalent to the full NHS Health Check specification. PCTs in this position should be reminded of what constitutes a 'Health Check' under this scheme.
- > It is worrying that some PCTs are not planning to implement any vascular checks in 2009/10. PCTs in this position should be contacted and plans for 2010/11 assessed.
- > A multiplicity of methods for identifying and targeting patients is required to make the scheme successful. GP case-finding models, where you identify people from existing records, are excellent as a central plank achieving solid numbers of patients. However, it is not thought that this will reach all populations so PCTs will, therefore, need to provide population-based and opportunistic schemes to target 'hard-to-reach' populations.
- > Each PCT should undertake an 'Equalities Impact Assessment' looking at what impact health checks will have on health inequalities and identifying strategies to ensure that the programme targets inequalities effectively. A toolkit should be developed to help PCTs undertake these assessments and more guidance should be given on the types of activity which will be effective in reducing health inequalities.
- > In the future PCTs should be discouraged from developing their own expensive local IT solutions for transferring data onto the records by GPs because ONE secure IT standard mechanism would be more cost effective, productive and user friendly so that accredited producers would also access this one standard mechanism.

# Findings

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We have divided the results of the survey into seven sections, reflecting the different questions we asked PCTs to reflect on:

1. Planning
2. Roll-out
3. Identifying target populations
4. Health inequalities
5. Transferring information
6. Provision of interventions
7. Providers
8. Overall results

The following chapter looks at each of these issues in turn; outlining the survey responses we received and analysing what they tell us about service provision.

## 1. Planning

The formulation of an implementation strategy, preferably agreed at board level, along with the appointment of an individual responsible for delivery, is a fundamental starting point to enable commissioning bodies to roll-out NHS Health Checks effectively.

The survey asked PCTs to publish their plans for the implementation of NHS Health Checks and to indicate whether there was an individual in their organisation with day-to-day responsibility for the implementation of the programme.

### Findings

- > The survey revealed a wide variation in the detail of planning undertaken by PCTs. Some PCTs already have detailed strategies embedded within their operational plan or commissioning strategy. Many other PCTs have detailed stand alone action plans, service specifications or Local Enhanced Service specifications in place. However, 51% of PCTs have yet to produce a written plan for their area which is a worryingly high proportion.
- > 90% of PCTs have already named a lead within the organisation that has day-to-day responsibility for the roll-out of NHS Health Checks. In many organisations this lead is a specific NHS Health Check programme manager, although often the responsibility lies with an individual who has wider public health responsibilities.
- > Only 7.5% (9 PCTs) reported that they have neither a written plan nor a day-to-day lead in position.

### Recommendations

- > All PCTs should by this stage have a written plan which has been signed off by their board. PCTs should be required to include details for the introduction of NHS checks in their commissioning strategy and operational planning for 2010/11.
- > Every PCT should be able to name an individual who has day-to-day responsibility for the implementation of NHS Health Checks. In addition PCTs should be encouraged to have a designated programme manager to implement the NHS Health Checks programme in post for 2010/11.

# Findings

continued

## 2. Roll-out

The NHS Health Check programme is in tier three of the NHS Operating Framework 'Vital Signs'. It is therefore important for PCTs to decide the pace of implementation in line with other national and local priorities. We acknowledge that some PCTs will be able to do this faster than others.

However, all PCTs are expected to begin implementing and delivering NHS Health Checks in 2009/10, and the economic modelling underpinning the NHS Health Check is based on the assumption that PCTs will complete roll-out by 2012/13. This means that by this time, PCTs will be inviting at least a fifth of their population every year as part of a 5 year rolling programme. According to the Department of Health 'Vascular Checks and Interventions Toolkit', this equates to 11% of a PCT's 40-74 age group attending every year.

PCTs were asked to publish the number of NHS Health Checks they estimated would be provided in the period April 2009 to April 2010. The figure provided was compared to the number of checks per year estimated for that PCT by the 'Vascular Checks and Interventions Toolkit'.

### Findings

- > A great deal of progress has been made in the first year roll-out of NHS Health Checks, with around 900,000 people due to receive a check in 2009/2010.
- > 36% of PCTs estimate that in 2009/2010 they will already provide more than half the number of checks needed for full coverage.
- > 13.5% of PCTs estimate that they will provide between 30 and 50% of a full service.

### Recommendations

- > We do have concerns that some of the numbers quoted for this year are possibly unrealistic, or perhaps include vascular checks which are being carried out already by GP practices but are not equivalent to the full NHS Health Check specification. PCTs in this position should be reminded of what constitutes a 'Health Check' under this scheme.
- > It is worrying that some PCTs are not planning to implement any vascular checks in 2009/10. PCTs in this position should be contacted and plans for 2010/11 assessed.

### 3. Identifying target populations

The best mechanism for identifying target populations will depend upon the needs of the local area and should, therefore, be decided by each PCT. Department of Health advice, however, is that the mechanisms undertaken need to take account of health inequalities within the area to ensure that the activity narrows these gaps rather than widens them. This would involve targeting the most deprived communities and should include efforts to reach people who are not currently on NHS registers.

We asked PCTs which methods they currently used to identify individuals to take part in NHS Health Checks: (1) Searches of practice records (2) Birthday based population-wide screening (3) Opportunistic approaches at workplaces or local centres or (4) Other.

#### Findings

- > The evidence indicates that the majority of PCTs are not moving beyond small opportunistic searches, or are sticking to limited searches of GP practice databases. The reason for this might be that they wish to avoid unearthing large numbers of hard to manage patients with entrenched problems, who would overwhelm risk management services. 49 PCTs are currently utilising only one recruitment technique. Of these, 85% are using practice records, 8% population based and 7% opportunistic screening as their sole method of identification.
- > However, 44% of PCTs are already reaching out to their target populations using 2 or more screening methods.
- > Some PCTs are already using 3 or more methods of patient identification. These best practice PCTs are:

● Barnsley PCT	● Kirklees PCT
● Bexley PCT	● Norfolk PCT
● Blackburn with Darwen PCT	● Sandwell PCT
● Central Lancashire PCT	● South West Essex PCT
● East Riding of Yorkshire PCT	● Swindon PCT
● Hartlepool, Middlesborough, Stockton on Tees and Redcar & Cleveland PCTs	● Telford and Wrekin PCT
	● Walsall PCT

Question rating: ● Good ● Average ● Poor      Overall rating: ● Good ● Average ● Poor

#### Recommendations

- > A multiplicity of methods for identifying and targeting patients is required to make the scheme successful. GP case-finding models, where you identify people from existing records, are excellent as a central plank achieving solid numbers of patients. However, it is not thought that this will reach some populations so PCTs will, therefore, need to provide population-based and opportunistic schemes to target 'hard-to-reach' populations.

# Findings

continued

## 4. Health inequalities

Providers will be expected to demonstrate that NHS Health Checks in their area are targeted appropriately so that they reduce, rather than widen, health inequalities. To achieve this, a detailed summary of local health and social care service needs should be drawn from a joint strategic needs assessment, done with Local Authority partners and other stakeholders.

### Findings

- > 42% of PCTs have made some form of assessment of health inequalities in their area before deciding how to target their NHS Health Checks service. These assessments vary in sophistication with best practice being the commissioning of a full 'Equalities Impact Assessment' looking at what potential impact health checks will have on health inequalities and identifying strategies to ensure that the programme's full potential is achieved in addressing this priority.
- > A number of PCTs mention the use of mosaic software to profile their population according to lifestyle factors and socio-economic status.
- > Sefton, Bristol and Ashton, Leigh and Wigan PCT have each undertaken detailed impact assessments in partnership with their local University.

#### 'Best Practice' examples:

##### **Kirklees PCT**

*"The Joint Strategic Needs Assessment has identified localities and population groups who are most likely to suffer inequalities. The service model for NHS Health Checks included an outreach service which is specifically designed to ensure deprived sectors of the population access NHS health checks. A social marketing approach is also being considered and has been written into the business case. The social marketing process particularly the INSIGHT will help inform how the outreach service operates."*

##### **Sutton and Merton PCT**

*"A full Equality Impact Assessment has been carried out, highlighting potential impact on the local population, with particular consideration for specific demographic groups (e.g people in lower socio-economic groups). An EIA Action Plan has been produced, identifying areas for attention to prevent a negative impact on health inequalities. For example, requirements have been built into the Service Specification to ensure that the Health Checks are accessible by people with physical disabilities and/or mental health problems."*

##### **Luton PCT**

*"A series of detailed needs assessments have been carried out which are being used to inform the programme. NHS Luton is undertaking focused work on the five most deprived wards in the borough with the lowest life expectancy. Our work with the Blood Pressure Association targeted these wards and further work this year will also target marginalised and 'hard to engage' groups."*

#### **Ashton Leigh and Wigan PCT**

*“A major evaluation is being conducted by Salford University, under the leadership of Professor Deborah Baker, who has published previous studies relating to inequalities in the Stockport CVD screening programme. This is a 3 year study which will examine factors related to risk, non-attendance, and outcome by deprivation.”*

- > The message that PCTs need to be proactive to ensure that their programmes do not widen inequalities seems to have been heard. 73.5% of PCTs can provide evidence of some form of action they have taken to ensure that NHS Health Checks reduce health inequalities.
- > However, many PCTs are taking a one dimensional approach to targeting ‘hard to engage’ groups. For example for 27% of the 86 PCTs who are taking action to ensure that their schemes reduce health inequalities this involves nothing more than piloting a standard GP record based scheme in their most deprived wards. This is not enough to ensure that health inequalities are narrowed.
- > Some PCTs are providing incentive payments for providers to tackle “hard to reach” groups.

#### **‘Best Practice’ examples:**

##### **North Yorkshire and York PCT**

*“We are setting up a health equity audit so that areas with poor uptake are quickly identified. Multiplicity of providers will be sought in areas of high need, mixed with social marketing and liking to health trainers.”*

##### **Swindon PCT**

*“A full health impact assessment has been undertaken and we have identified the following groups to target a) South Asians b) those in areas of high deprivation and other BME groups c) those without any risk factors previously recorded by GPs and d) carers. These groups will be targeted through checks being offered in the community in areas of deprivation.”*

##### **Wirral PCT**

*“A social marketing campaign is currently being developed to ensure any communications and media is targeted to this population to increase uptake. Additional community screening has been commissioned in the most deprived areas of Wirral and focusing on older men, BME groups, substance misusers and people with mental health problems.”*

## **Recommendations**

- > Each PCT should undertake an ‘Equalities Impact Assessment’ looking at what impact health checks will have on health inequalities and identifying strategies to ensure that the programme targets inequalities effectively. A toolkit should be developed to help PCTs undertake these assessments and more guidance should be given on the types of activity which will be effective in reducing health inequalities.

# Findings

continued

## 5. Transferring information

All information needs to be transferred from the providers' contemporaneous record and recorded in the GP held patient record. Where services are provided by non-GP providers, systems will need to be put in place to enable this to be carried out in a secure and timely manner.

### Findings

- > The fact that NHS IT systems are not compatible with those of other organisations involved in healthcare provision means that there is no PCT with a perfect system. At present it is not possible for information obtained during the checks to be automatically fed back into the GP system.
- > PCTs are, however, developing robust systems for communicating results back to the relevant GP. While there is no way of bypassing the need for someone at the GP practice to manually enter results onto the patient record, the best systems make this process as easy as possible, and provide the information in a form that GPs trust. A number of PCTs have made provision in LES specifications or in QOF+ programmes which ensure GP practices are paid for inputting data onto the patient record.
- > To date 31% have not had to develop a robust system for transferring information from providers to the patient record because their checks are currently only being delivered in GP practices. However, as these PCTs roll-out the full service they will need to look at viable systems.
- > 19% are using a paper based system to transfer information from providers to patient records. This is acceptable as long as systems are in place to ensure that information is processed safely, efficiently and fully.
- > Only 4% of PCTs have employed external IT providers to create a system for transferring patient information.

#### 'Best Practice' examples:

##### *Birmingham East and North PCT*

*"Birmingham East and North have been developing an informatics solution with an independent IT company which allows the NHS Health Check to be conducted outside of the registered GP surgery. Using touch screen monitor the NHS Health Check Facilitator is guided through a standardised assessment. The clinic metrics such as blood pressure and cholesterol are automatically entered onto the system via a USB connect which reduces the risk of data transcribing inaccuracy. This solution also uses standardised interpretation thresholds which provide important quality assurance and clinical governance."*

#### **Bristol PCT**

*“In the first year, it is expected that contactors undertaking checks outside GP practice will be able to securely send completed checks back to the relevant GP practices, using existing locally developed web based tools. However, this will depend on a certain amount of data inputting at the GP practice end, and it is recognised that this should not be a final long term solution.”*

#### **Swindon PCT**

*“At present we propose that all checks provided in the community include completion of a proforma which will be sent to GPs for input into their systems. This will form part of the LES agreement with practices.”*

#### **Kingston PCT**

*“All pharmacies will be linked to GP Practices by the NHS-Net email and similarly all checks undertaken in the community will be encrypted and sent to the PCT and relevant GP using the NHS-Net email.”*

#### **Kirklees PCT**

*“The primary prevention nurses who will be delivering the outreach service have access to system 1 which is one of the main IT systems our GPs use. They will work with ‘clusters’ of GP practices to ensure data is transferred and also provide clinical advice and support to these practices.”*

#### **Richmond PCT**

*“Checks carried out by Pharmacists are recorded by the pharmacist in software purchased by the PCT. The patient information is printed out and sent to the patient’s GP. Care has been taken to ensure that the data is recorded in such a way that it can be readily translated into terminology that is used in the GP clinical system (i.e. cross-mapped to Read codes).”*

#### **Tameside and Glossop PCT**

*“Integrated Care Pilot Sites will be utilising an information-sharing system which will allow direct sharing with practices of information derived in non-practice settings.”*

#### **Wandsworth PCT**

*“Data from NHS Health Checks provided during community outreach events is emailed over a secure network to the appropriate practice and the practice lead should ensure that this information is inputted in to the GP patient record system.”*

### **Recommendation**

➤ PCTs should be discouraged from developing their own expensive local IT solutions for transferring data onto the GP record. Instead, they should be encouraged to implement the secure web-based model which is already in use in some PCTs. GPs need to be adequately incentivised to input data onto the patient record.

# Findings

continued

## 6. Provision of interventions

PCTs will need to consider how best to deal with the demand created for risk management services and the impact this may have on those providing lifestyle interventions. As this is a preventative programme, many of the benefits of the programme rely on these services being available. The inadequate provision of these services is therefore perhaps the biggest threat to the successful implementation of NHS Health Checks.

### Findings

- > The majority of PCTs (60%) have used the implementation toolkit provided by the Department of Health, or a similar method, to estimate prevalence rates in their area and assess the demand for smoking cessation services, lifestyle advice, obesity interventions, prescription of medicines and diabetes support services.
- > In fact 25% of PCTs report that they have already increased capacity in services to cope with the increased demand caused by the introduction of NHS Health Checks.
- > There is, however, still 15% of PCTs who have not yet considered where increased demand for services will fall, and have not considered steps to expand capacity.

#### 'Best Practice' examples:

##### **Brighton & Hove PCT**

*"Assessment has been made using the Department of Health capacity planning tool. Additional capacity in local weight management service has been commissioned in 2009/10."*

##### **Bristol PCT**

*"Operational Planning Process bids were aligned and funding requested in light of the fact that this programme would be coming into being in this financial year. Capacity has been greatly increased in smoking cessation in recent months, with over 1000 practitioners trained in delivering these brief interventions. Dietician capacity will be greatly expanded in this coming financial year, whilst an expanded tier 2 weight management service is due to be procured this year also. This consists of one-to-one support with dietician plus Cognitive Behavioural Therapy. Tier 1 (slimming on referral) is well within capacity and has recently been promoted with GP practices again."*

##### **East Lancashire PCT**

*"A provisional assessment has been made recognising this will impact on not only the range of lifestyle interventions required but also interventions to support the diagnosis of new cases of Atrial Fibrillation, Diabetes, Hypertension, and Chronic Kidney Disease. Indicative budgets have been drawn up for 2010/11 to allow expansion of exercise referral/weight management schemes."*

**Greenwich PCT**

*“The NHS London tool has been used to calculate expected increased demand for stop smoking, weight management and physical activity related support services and for our Health Trainer programme, generated by the Health Checks programme. We already commission a range of services in each of these areas of lifestyle support and are currently planning how we will provide increased capacity needed to support rollout of the programme.”*

**Recommendations**

- > It is unacceptable that a significant minority of PCTs are yet to use one of the tools that have been provided to calculate expected increase in the demand for intervention services. Further investigation is required of the assessment that has been made in this area by PCTs.

# Findings

continued

## 7. Providers

Some commentators have expressed the opinion that many PCTs outside of the Department of Health funded test-bed sites have started in too piecemeal a fashion, and are simply amplifying the work that they have been doing for some time, using GPs to deliver opportunistic risk assessment. In the operating framework 2009/10, commissioning for well being and prevention identifies specific measures for vascular checks which could be achieved through effective tendering or local enhanced service contracts to additional providers. PCTs are, therefore, missing an opportunity to reach out to 'hard-to-reach' groups and tackle health inequalities.

In some ways, of course, this is understandable. The programme needs to be phased in to allow the capacity of risk management interventions to grow so they can meet the increased demand created by risk testing. However, if NHS Health checks are going to reduce health inequalities PCTs need to be utilising a variety of providers who can access those groups who do not regularly engage with the NHS.

### Findings

- > 20% of providers are not yet using any providers to deliver NHS Health Checks.
- > 52% of PCTs have started delivering NHS Health Checks using a single type of provider. Of these the vast majority (85%) are using GP practices.
- > Overall 72% of PCTs use GP practices to deliver NHS Health Checks. 25% are using community pharmacy. 5% use other (none pharmacy) private sector providers. 6% use a third sector provider (Blood Pressure Association).

## 8. Overall results

34 PCTs achieved a ‘green’ rating overall from HEART UK, Carers UK and PCCS. This means progress is rated as ‘excellent’ and the PCT is ‘leading the way and will deliver early on targets set by the Department of Health’.

> The top PCTs in England are judged to be:

● Central Lancashire PCT	● Wandsworth PCT
● Blackburn with Darwen PCT*	● Warrington PCT
● Brighton & Hove City PCT	● Wirral PCT*
● Greenwich Teaching PCT	● Camden PCT*
● Islington PCT	● Joint grouping of Hartlepool, Middlesbrough, Stockton on Tees and Redcar & Cleveland PCTs*
● Newham PCT*	

Overall rating: ● Good ● Average ● Poor

\*Test-bed PCTs – NB. of 15 test beds that responded 11 were given ‘green’ status

> 63 PCTs achieved an ‘amber’ rating which means progress is judged as ‘adequate’ and that the ‘PCT is likely to hit implementation targets’.

> Only 20 PCTs have achieved a ‘red’ rating which means that progress is deemed to be ‘behind where it should be’ and that without improvements the PCT will ‘miss implementation targets’.

## Recommendations

> While the majority of PCTs have made very good progress implementing NHS Health Checks there are a small number who are lagging behind and, to date, have made alarmingly slow progress. More PCTs could benefit from being partnered with nearby PCTs who have made better progress.

# Conclusion

It is important to remember that vascular disease – heart disease, stroke, diabetes and kidney disease – is the biggest cause of death in the UK. It also makes up approximately a third of the difference in life expectancy between spearhead areas and the rest of England. The NHS Health Checks programme offers a real opportunity to cut deaths from vascular disease, help people stay well for longer and make significant inroads in health inequalities.

It is essential that NHS Health Checks are implemented by individual Primary Care Trusts (PCTs) in a way that addresses local needs and priorities. However, we must ensure that national guidelines and standards are upheld and support those PCTs who do not have the expertise or resources to deliver the service adequately in their area. The achievements of the Department of Health and NHS Improvements in tackling this must be commended, however we cannot be complacent and there are still a number of PCTs who have yet to get started on the basics. For example, too many PCTs have yet to undertake assessments of health inequalities, or of the impact on the smoking cessation, weight management, lifestyle advice and diabetes services they provide. Greater intervention is required to ensure that no areas are left behind at this early stage. As organisations with expertise in this area, we are looking to help provide the necessary support and assistance as required.

It is also essential that PCTs look at providers of NHS Health Checks in addition to GP practices. These additional providers can add capacity in identifying and targeting hard to reach groups and improving access especially in ‘spearhead’ and ‘under-doctored’ areas.



**Andrew Hobson**

Insight PA

The Garden House

6 Eccleston Place

London SW1W 9NE

Tel: 020 7824 1850

Email: [andrew@insightpa.com](mailto:andrew@insightpa.com)