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Short Communication

Understanding implementation and uptake in the National Health Service Health Check Programme

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ABSTRACT

Objectives: We present findings from a national online survey of uptake and implementation of the National Health Service Health Check (NHSHC) programme. The research aimed to understand national variation in implementation of NHSHCs and to explore the relationship between uptake and different components of implementation.

Study design: The study design was a descriptive online survey.

Methods: Data were collected via an online survey between November 2015 and August 2016. The survey was distributed nationally to practice managers in the Midlands and East of England, South of England, North of England and London via local NHSHC leads with the help of the national programme manager.

Results: Responses were received from 153 participants, half of who were practice managers (49.7%). Common components of implementation included using postal invitations accompanied by the national leaflet, delivering NHSHCs routinely with other appointments, offering NHSHC outside of working hours and taking blood samples during the consultation. Meaningful exploration of the relationship between uptake and components of implementation was not possible given the inaccuracy of self-reported uptake data, which was confirmed by comparison with public health data in a subsample ($n = 18$). The comparison also found that a number of practices were reporting more completed health checks than the total number of patients invited, which again indicates problems that may have implications for uptake figures locally and nationally.

Conclusions: Overall, our findings showed considerable variation in the implementation of NHSHCs on a national scale and issues with quality of programme uptake data, which has implications for national reporting for NHSHC.

National Health Service Health Check (NHSHC) is a national programme to identify and manage cardiovascular disease (CVD) risk in adults aged 40–74 years in England. All eligible adults should be invited for an NHSHC where CVD risk is assessed based on measurements including blood pressure, cholesterol and other patient information (e.g. age, gender, family history, smoking status). This forms the basis for a discussion around managing risk through lifestyle advice,

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referral back to the general practitioner (GP) or other services, where possible, based on National Institute for Health and Care Excellence (NICE) guidance.

Nationally, uptake of NHSHC remains below 75% on which the original economic model was based.[1] Best practice guidelines have been available to support the implementation of NHSHC since 2009, but local authorities are given autonomy to design and implement the programme in a way that meets the needs of the local population. This has inevitably led to varied implementation throughout the country, both across regions and between individual general practices. Data from eight Primary Care Trust (PCTs) (in 2010)[2] and 99 practices in London[3] and 13 practices in Sefton[4] indicated a number of variations including the budgets for NHSHC; approaches to delivery; payments made to general practices; evaluation and monitoring; tools used to estimate CVD risk and services available for referral postcheck.[2] Training given to staff involved in NHSHC also differed. Some, but not all, general practices included: measurement methods (43%); communicating risk (65%) and advice about lifestyle change (62%).[3] Variation between practices and individual health professionals in the delivery of NHSHC has also been identified in the recording of medical and lifestyle information, advice given to patients, requested tests and lifestyle support referrals.[4] Units of alcohol consumed, body mass index, smoking status, levels of physical activity, blood pressure and cholesterol were only recorded in 45.3% of patients with marked variance in lifestyle advice and referrals between practices and health professionals.[4] Aside from the differences in the consultation, it is also important to understand disparities in the organisation and implementation of NHSHC as this is likely to influence uptake. This article explores uptake, implementation and reporting of uptake data for the programme.

This short report presents findings from an online survey on uptake and implementation of NHSHC. The survey was informed by previous research[4,5] and discussion with public health NHSHC leads. Survey questions focussed on uptake and programme implementation (e.g. invitation method, staffing, advertisement and appointments). Typically, closed questions were used, ending with an open question allowing respondents to leave additional comments and information.

There were two main aims: (i) to understand national variation in NHSHC implementation; and (ii) to explore the relationship between NHSHC uptake and different components of implementation.

National variation in NHSHC implementation

Data were collected through an online survey, which was distributed nationally to practice managers (November 2015–August 2016), with the help of the national programme manager and regional NHSHC leads. A number of NHSHC national lead meetings and steering groups were also attended to encourage participation. Over 10 months, 454 responses were initiated and 112 were completed. Additional responses were received via paper ($n = 17$) and telephone ($n = 26$), giving 153 responses in total. Respondents were most commonly practice managers (49.7%), health care assistants (16.3%) and 'others' (17%), which included administrators and data quality staff. Almost half of the responses received were from the Midlands and East of England ($n = 72$), followed by the South of England ($n = 31$), North of England ($n = 30$) and London ($n = 19$). Mean NHSHC uptake reported by respondents was 47.09%, which was in line with the national average for the corresponding year (48.3%, 15/16 NHS Health Check[6]). Respondents represented a range of practices in terms of practice size (mean 8202, range 1650–36000), patients registered White British (mean 78.91%, range 12.3–99%), GP population aged 40–74 years (mean 41.05%, range 7.86–55.56%) and deprivation of practice location based on the Index of Multiple Deprivation (most deprived to least deprived quintile, Q1 = 27.5%, Q2 = 24.1%, Q3 = 17.4%, Q4 = 17.4%, Q5 = 13.5%).

As reported elsewhere,[7] letters were the most common method of invitation, although most respondents reported use of multiple methods (Table 1). Of those that sent a postal invitation, the majority included the national NHSHC leaflet ($n = 152$). Other methods to invite patients for a NHSHC included telephone (52%) and text messages (22%). Research that has looked at invitation methods has suggested that telephone invitations are associated with higher uptake than postal,[8] and the combination of a postal invitation and text messaging improves uptake.[9]

The average number of practice staff involved in the invitation process was 3 ($n = 147$), most commonly administrative staff ($n = 153$). Sixty-two percent stated that NHSHCs were routinely implemented with other appointments (e.g. prescription review, vaccinations), whereas 33% ran NHSHC-specific clinics and 5% used both. Despite limited investigation of prebooked appointments, which have shown the method to be effective,[10] just 11% of practices adopted this method alone or in combination with a letter requesting a patient to book an appointment (26%; $n = 152$). More respondents in London chose to adopt both methods (58%) instead of leaving it to the patient to book the appointment (21%). Nearly three-quarters of practices offered NHSHC appointments to patients after working hours. Blood sampling varied between practices; half reported taking blood samples during the NHSHC (not in advance) in line with previous research.[7] Although a single appointment method may be more effective for uptake, it precludes the discussion of CVD risk during the health check if the practice does not use point-of-care testing. Eighty-six percent of practices advertised NHSHCs in surgery. Strategies included posters, TV monitors, practice websites, newsletters, on prescriptions, via social media and leaflets in the waiting area ($n = 121$).

Perceptions of the programme were mixed. Respondents from the South of England were less inclined to perceive health checks as 'very' or 'extremely' important compared with those from London. When asked to list three services to which practice gave highest priority, 20% of respondents included NHSHCs, although this varied by region (e.g. lower priority in the South of England). Although other services such as asthma clinics and sexual health are undoubtedly important, the results may indicate a lower perceived importance of preventive services. The findings show a large variation in the perceived importance, effectiveness and priority of NHSHCs nationally, which is in line with the findings of Krska, du Plessis and Chellaswamy,[7] who found

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