INFORMATION ITEM D

HEALTH AND WELLBEING BOARD				
Report Title	An update on the NHS Health Checks Programme in Lewisham			
Contributors	Frances Fuller, CVD Programme Manager		Information Item No.	7 D
Class	Part 1	Date:	7th July 2015	
Strategic Context	Whilst cardiovascular disease prevention has not been identified as a specific priority outcome within the Lewisham Health and Well Being Strategy, it is addressed by several of the priority outcomes.			
Pathway	A report on Reducing Cardiovascular Disease in Lewisham to the January 2015 Board included information about NHS Health Checks			

1. Purpose

1.1 To update members on progress of the Lewisham NHS Health Check programme.

2. Recommendation/s

Members of the Health and Wellbeing Board are recommended to:

2.1 Note the progress made in the delivery of health checks in Lewisham.

3. Policy Context

3.1 The NHS Health Check programme aims to prevent heart disease, stroke, diabetes and kidney disease, and raise awareness of dementia both across the population and within high risk and vulnerable groups.

3.2 In April 2013 the NHS Health Check became a mandated public health service in England. Local authorities are responsible for making provision to offer an NHS Health Check to eligible individuals aged 40-74 years once every five years.

3.3 Legal duties exist for local authorities to make arrangements:

- For each eligible person aged 40-74 to be offered a NHS Health Check once in every five years and for each person to be recalled every five years if they remain eligible.
- For the risk assessment to include specific tests and measurements.

- To ensure the person having their NHS Health Check is told their cardiovascular risk score, and other results are communicated to them.
- For specific information and data to be recorded and, where the risk assessment is conducted outside the person's GP practice, for that information to be forwarded to the person's GP

3.4 Local authorities are also required to continuously improve the percentage of eligible people taking up the offer of a health check.

4. Background

4.1 Diabetes, heart and kidney disease and stroke make up a third of the difference in life expectancy between the most deprived areas and the rest of the country. Additionally, the cost of social and health care from the rise in levels of obesity, type 2 diabetes and dementia makes the prevention and risk reduction of these conditions key drivers of the programme.

4.2 Lewisham has high premature mortality rates from circulatory disease compared with London and England and CVD is a major contributor to the life expectancy gap between Lewisham and England. However, Lewisham has lower levels of detected disease. In 2013 there were 32,709 people diagnosed with hypertension in Lewisham. This was lower than expected and 10.3% of adults (an estimated 20,000) could have hypertension who have not been diagnosed.

4.3 The Lewisham NHS Health Check programme was launched in March 2011 and is now a well-established programme. Health Checks are provided by general practices, community pharmacies and a community outreach health check team provided by Lewisham and Greenwich Healthcare Trust.

4.4 The total eligible population for the Lewisham programme is 67,250 Twenty percent of the eligible population are invited for a health check annually.

5. Progress of the programme since it was launched:

5.1 A comprehensive call and recall system is in place and over 29,000 health checks have been undertaken

5.2 3,000 people have been identified to be at high risk of developing cardiovascular disease. 5.2Everyone with increased CVD risk factors are also screened for diabetes

5.3 The Lewisham NHS Health Check programme was nationally recognised in November 2014 and was awarded the Heart UK "Team of the Year" award for the Community Pharmacy Health Check Service.

Twenty five percent of all health checks have been undertaken by community pharmacies

5.4 The health check programme is increasingly reaching more men (44% in 2014/15). The majority of people attending are in the younger age group (40-55 years)

5.5 The Lifestyle Referral Hub service was launched in 2012. The service offers a "one-stop shop" for people who have received a health check and identified at increased risk of developing cardiovascular disease. The Lifestyle Hub service offers one to one support using behavioural change techniques as well as onward referral to local lifestyle services. These include stop smoking services, weight management programmes, alcohol services and physical activity programmes. Client follow up takes place at 3, 6 and 12 months

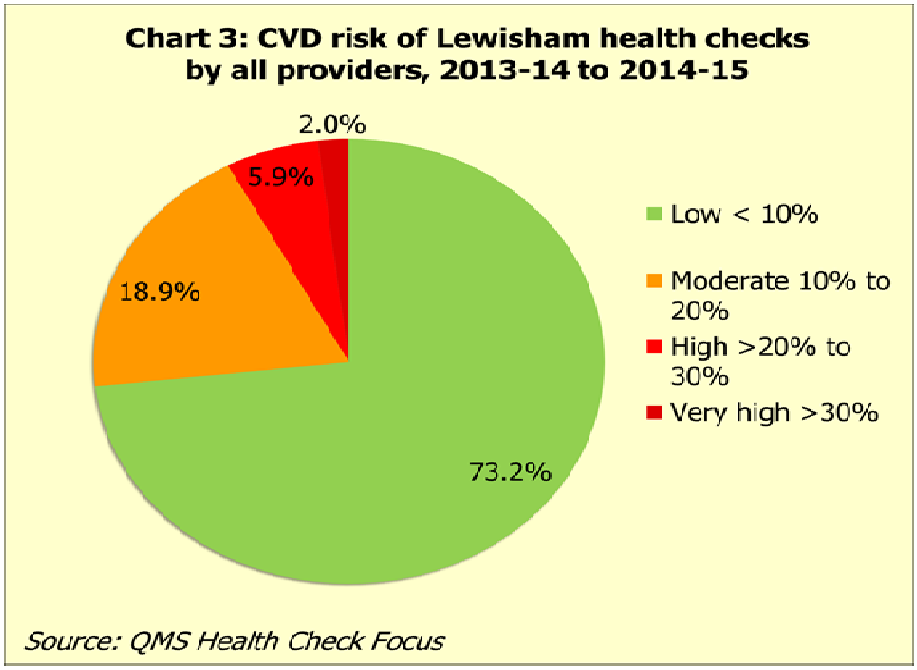
6. Performance

6.1 At least 20 per cent of the eligible population have been offered a health check annually. The annual % uptake rate is increasing and in 2014/15 uptake was 47% in line with the London at 46.6% uptake and England 46.4% uptake.

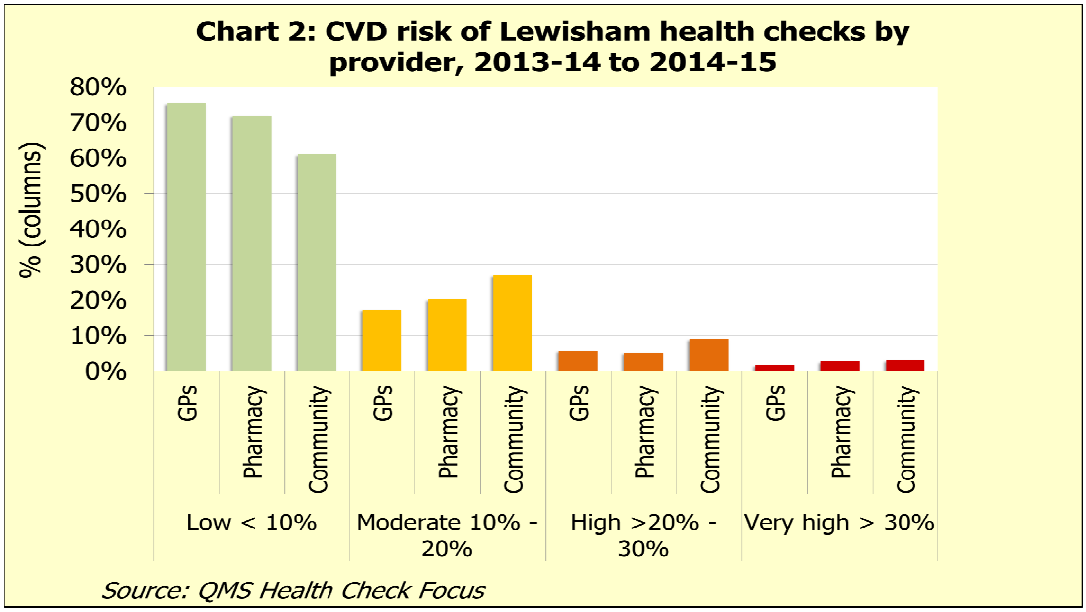
	2013/14	**2014/15**
Number of Health Checks offered	15,543	13,450
Number of health checks received	7075	6346
% uptake	45%	47%

6.2 The health check programme has been very successful at identifying people with a high risk of developing cardiovascular disease.

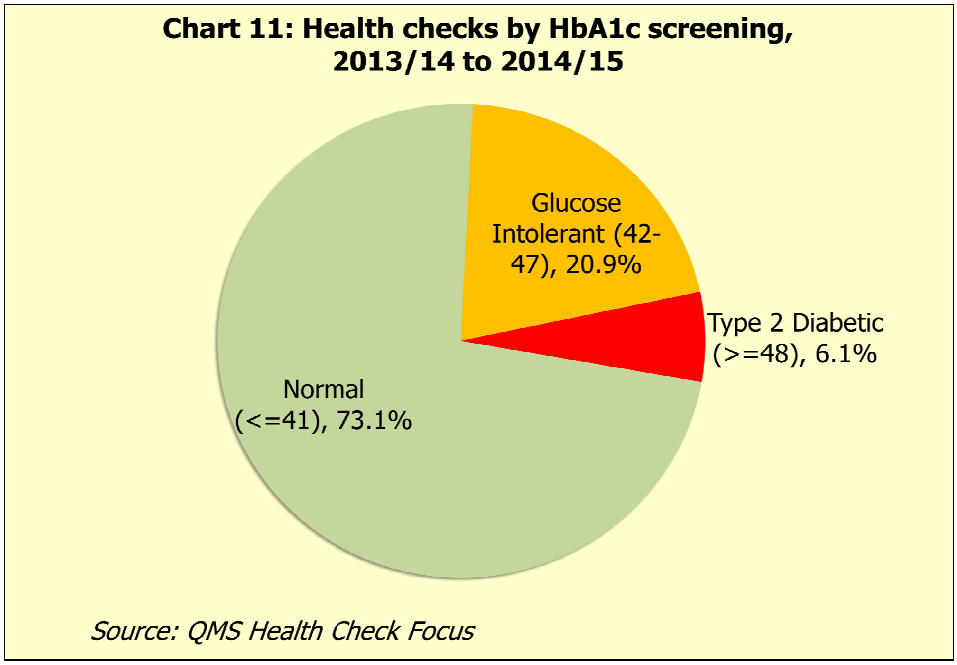
CVD Risk Scores 2011-15 (JBS2)	**Number**	**Percentage**
Very high risk (>30%)	842	3%
High Risk (>20%)	2114	7%
Moderate Risk (>10%)	6407	22%
Low Risk (<10%)	19,739	68%
Total numbers of health checks	29,102	



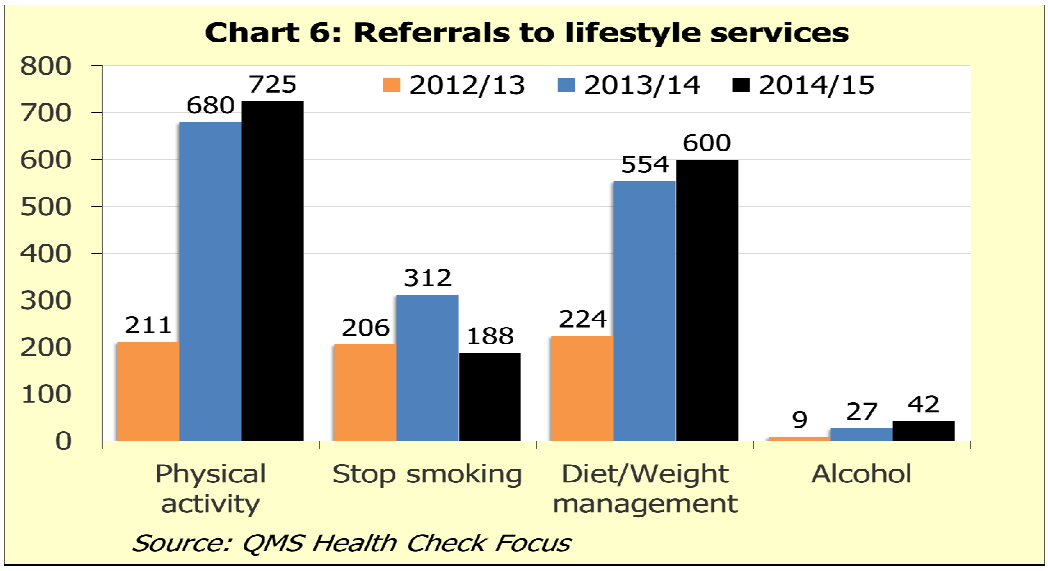
6.3 Community pharmacies and the community outreach service have been successful at identifying a greater number of people at risk of developing CVD. Health Checks have been offered opportunistically at different locations in Lewisham and pharmacy appointments are offered at evenings and weekends.



6.4 The health check programme has identified large numbers of individuals at high risk of developing diabetes and over 6% with established disease. Early identification and diagnosis will lead to better clinical management and long term outcomes.



6.5 Referrals to lifestyle services has steadily increased since the launch of the Lifestyle Hub Service in 2013.



7. Financial implications

7.1 There are no specific financial implications in this report, however, it will be important for the board to be aware of the possible impact of any savings made in the future on the programmes associated with improved CVD outcomes.

8. Legal implications

8.1 Legal duties exist for local authorities to make arrangements:-

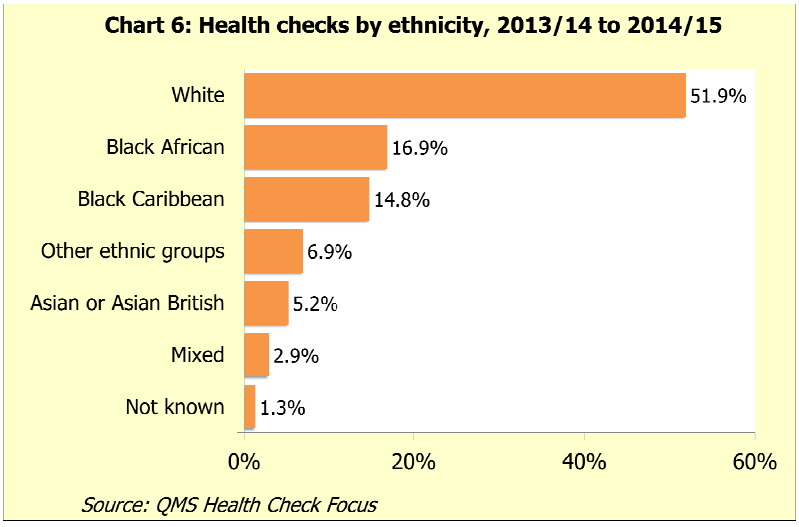
- For each eligible person aged 40-74 to be offered a NHS Health Check once in every five years if they remain eligible
- For the risk assessment to include specific tests and measurements
- To ensure the person having their NHS Health Check is told their cardiovascular risk score, and other results are communicated to them
- For specific information and data to be recorded and, and where the risk assessment is conducted outside the person's GP practice, for that information to be forwarded to the person's GP

9. Crime and Disorder Implications

9.1 There are no Crime and Disorder implications arising from this report.

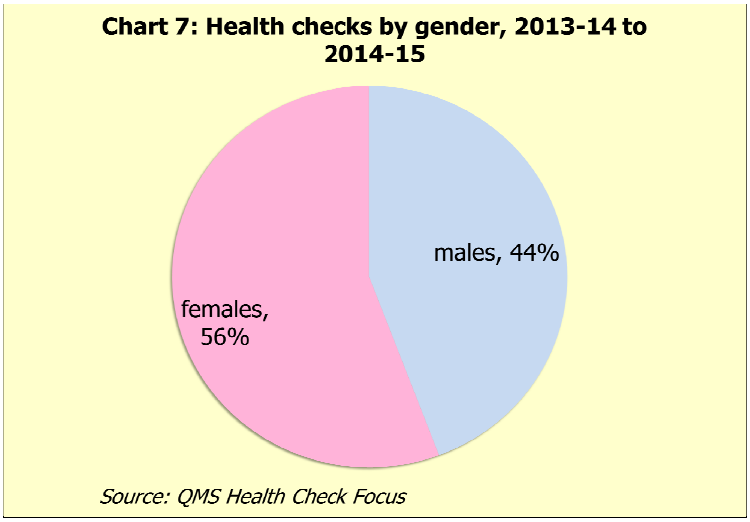
10. Equalities Implications

10.1 The health check programme is successful at reaching the black and minority population. Black African, Black other, Asian or Asian British and other ethnic groups all used the service more than would be expected looking at the demographic make-up of Lewisham.



10.2 The programme reaches a broad range of ages between 40-74.years. As the programme has become more established the age profile of those having health checks has become younger.

10.3 The health check programme has increasingly reached more men as the programme has become more established in Lewisham.



11. Environmental Implications

11.1 There are no Environmental Implications arising from this report.

12. Conclusion

12.1 The NHS Health Check is a mandated public health service.

12.2 The Lewisham NHS Health Check service is now a well-established programme.

12.3 The programme has been successful at identifying people at high risk of developing cardiovascular disease.

12.4 The programme has identified high numbers of Lewisham residents at high risk of developing diabetes and over six per cent with established disease.

12.5 There are plans in place to increase the uptake of health checks in Lewisham and increase the numbers of referrals to lifestyle services.

If there are any queries on this report please contact Frances Fuller, Public Health, Lewisham Council, on *0208 314 7543, or by email at:* ***frances.fuller@lewisham.gov.uk***