THE LONDON BOROUGH

The Prevention Journey through NHS Health Checks and Beyond

Annual Public Health Report 2023

Table of contents:

Welcome to Bromley's Annual Public Health Report 2023

This year's report will look at the progress of the NHS Health Checks programme in Bromley looking at their predecessors, inception, achievements to date and beyond.

Dr Nada Lemic
Director of Public Health London Borough of Bromley

Each year, approximately 1.3 million NHS health checks are delivered in England, identifying 315,00 people living with obesity and 33,000 cases of hypertension, preventing over 400 heart attacks and strokes.

The report will span the 23 years of impressive work carried out by GP surgeries and partners in Bromley, in the prevention, early detection and management of risk factors for cardiovascular disease (CVD) and other non-communicable diseases.

Our journey begins in the year 2000 with the Coronary Heart Disease National Service Framework and ends with the current position and a look to the future. The report aims to document the journey of prevention efforts in Bromley, while providing evidence and action for GP surgeries to celebrate successes and to continue to increase the scale and quality of NHS Health Checks, with targeted recommendations which can be implemented now, and in the future.

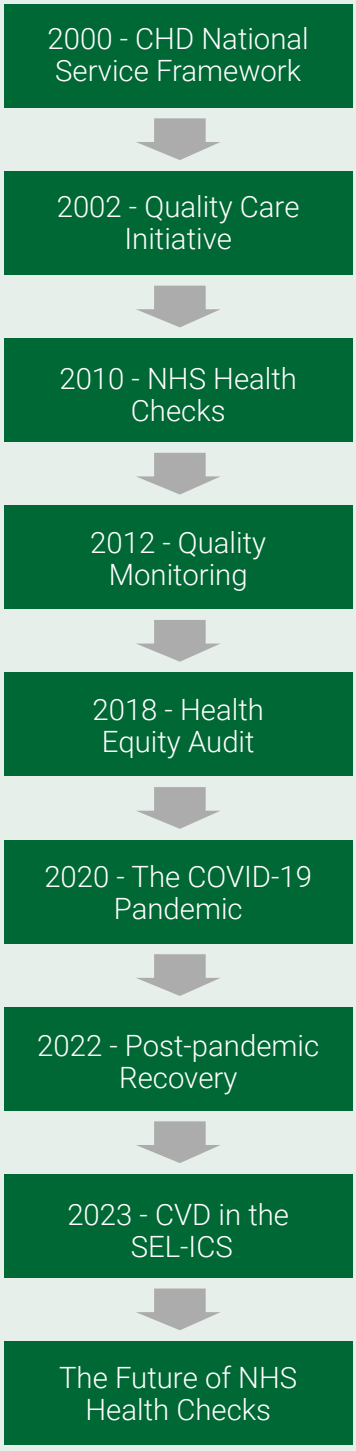


Figure 1: Time line of the prevention journey in Bromley

NHS Health Checks in the last decade: Achieving targets for offers completion and uptake.

Over the last 10 years, Bromley GP practices and the GP Alliance have delivered 56,057 health checks:

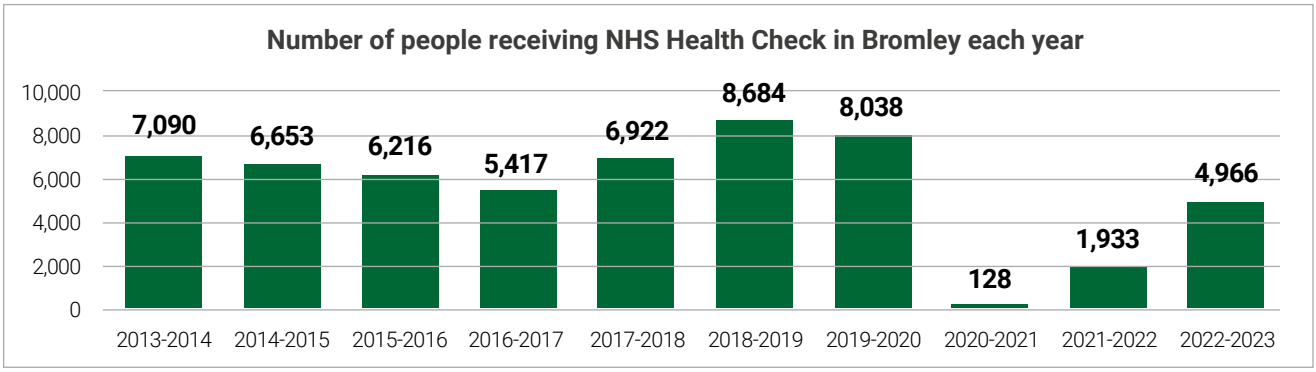


Chart 1: Number of people receiving NHS Health Checks 2013-2023

The annual target is to invite 20% of the eligible population for NHS Health Checks each year. Bromley GPs showed impressive post-pandemic recovery in 2022/23, inviting 4966 people for a Check. **This more than triples the proportion of eligible people invited for Checks, reaching pre-pandemic levels of invitation.**

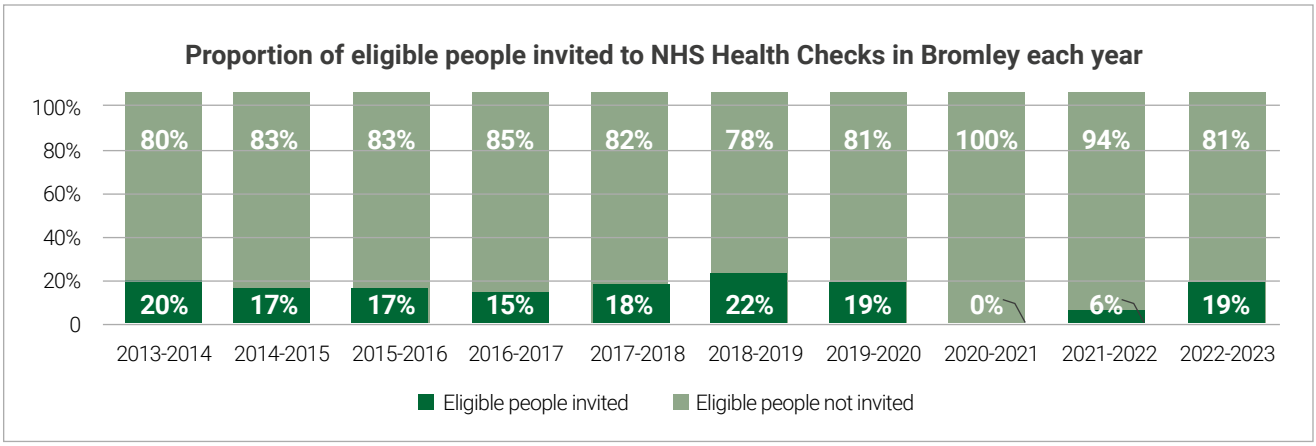


Chart 2: Percentage of eligible population invited each year 2013-2023 compared with annual 20% target.

The aim is that 50% of invited eligible people attend their NHS Health Check each year. Pre-pandemic, Bromley had shown consistent progress to reaching this target.

In 2022/23, one quarter of invited people attended their NHS Health Check.

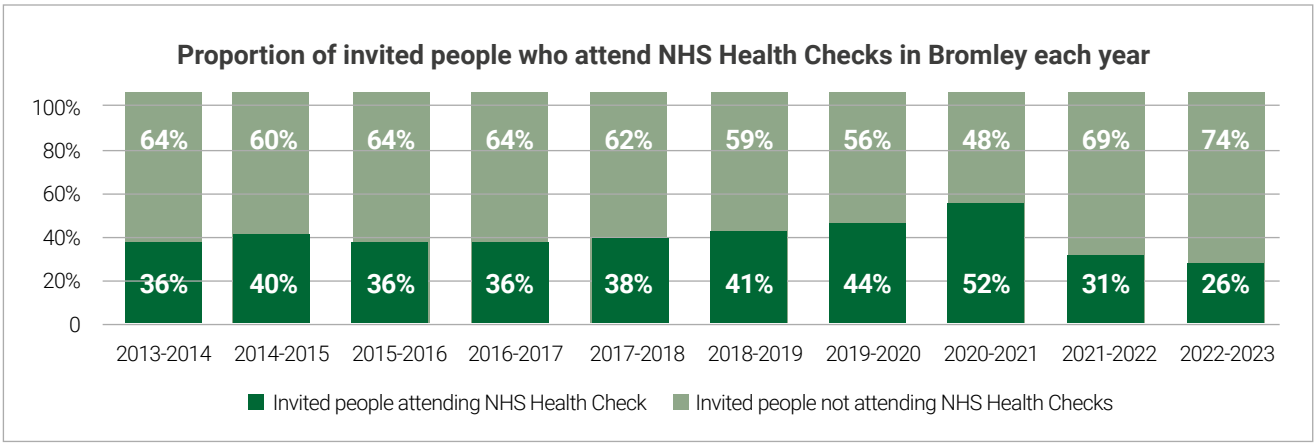


Chart 3: Percentage of eligible population invited each year 2013 -2023 compared with 50% target.

Year 2000 – Back to the beginning with the Coronary Heart Disease National Service Framework (CHD NSF)

To better understand NHS health checks today, we need to look back at how Bromley has tackled health improvement in the past.

The Coronary Heart Disease National Service Framework (CHD NSF) laid out the first national plan to systematically help manage patients with cardiovascular disease to high quality standards. Chapter two of the framework was particularly aimed at primary care, with the inclusion of standards three and four (see Figure 2).

Figure 2: Standards three and four of the Coronary Heart Disease National Service Framework.

The first step was to achieve standard three for people with established disease, through:

- Developing their Coronary Heart Disease National Service Framework (CHD NSF) and stroke registers.
- Establishing clinics for follow up and review, to ensure patients with CVD were on the correct medication, plus given appropriate lifestyle advice.

The next step was to achieve Standard four, through the identification of people without diagnosed CVD who were at increased risk and offer preventative interventions. This standard was the precursor to the NHS Health Check programme.

Other Chapters of the NSF relevant to primary care included quality standards to achieve for the identification and management of atrial fibrillation, heart failure, angina, heart attack, cardiac rehabilitation.

The Coronary Heart Disease National Service Framework (CHD NSF) required some significant system and clinical change in Primary Care. A cardiovascular disease nurse specialist for each Primary Care Group, to support that group of Practices as required.

Bromley GP Practices embraced these standards and worked hard to achieve them. Progress against the Coronary Heart Disease National Service Framework (CHD NSF) was assessed each year through annual audits demonstrating achievements and identifying areas for improvement to focus on.

Year 2002 – Introducing the Quality Care Initiative

In March 2001, Bromley Primary Care Trust (PCT) introduced The Quality Care Initiative (QCI), a framework for "encouraging quality improvement and evidence based clinical practice across General Practice, with the ultimate goal of improving health across key disease areas".
The initiative used small incentive payments to encourage the development of chronic disease registers, and the achievement of quality targets for six health outcomes:

- **hypertension**
- **chronic heart failure**
- **diabetes**
- **secondary prevention of CHD**
- **non-rheumatic atrial fibrillation**
- **adverse reporting**

The methodology included an organisational development approach, with a range of support provided to the three clusters of Practices from the Primary Care Trust (PCT) Practice Educators. Further expert clinical support was provided to GP Practices by three cardiovascular nurse specialists, and three prescribing advisors. Regular meetings and audit were able to target the supportive resources to areas in need of development.

The scheme's effectiveness quickly became clear, through a 2003 evaluation using estimates of attributable risk of the six risk factors to calculate the impact the initiative was having on the incidence of coronary heart disease and stroke.

The results were impressive, with significant estimated reductions in disease incidence.

	ESTIMATED REDUCTION IN CHD INDIDENCE	ESTIMATED REDUCTION IN STROKE INCIDENCE
Hypertension	16%	32%
Cholesterol	25%	-
Diabetes	4%	5%
Atrial Fibrillaton	-	8%

Table 1: Estimated reduction in CHD and stroke incidence in Bromley as a result of QCI, using estimates of attributable risk.

Participating practices continued with the scheme until it was superseded by the Quality and Outcomes Framework. At the time, there was a strong recognition of the success of the scheme, which was **locally developed, flexible and provided significant support** to improve evidence-based practice.

Year 2010 - The NHS Health Checks Programme is Born

In 2009-2010, the Government launched the NHS Health Checks Programme, a national public health programme aimed at helping people live longer healthier lives.

The programme focuses on the prevention early detection and management of risk factors driving **heart disease, stroke, diabetes, chronic kidney disease, some dementia** but will have impact on reducing risk of **cancer** and **wider long-term conditions**. NHS Health Checks look at many aspects of a person's life (Figure 3):

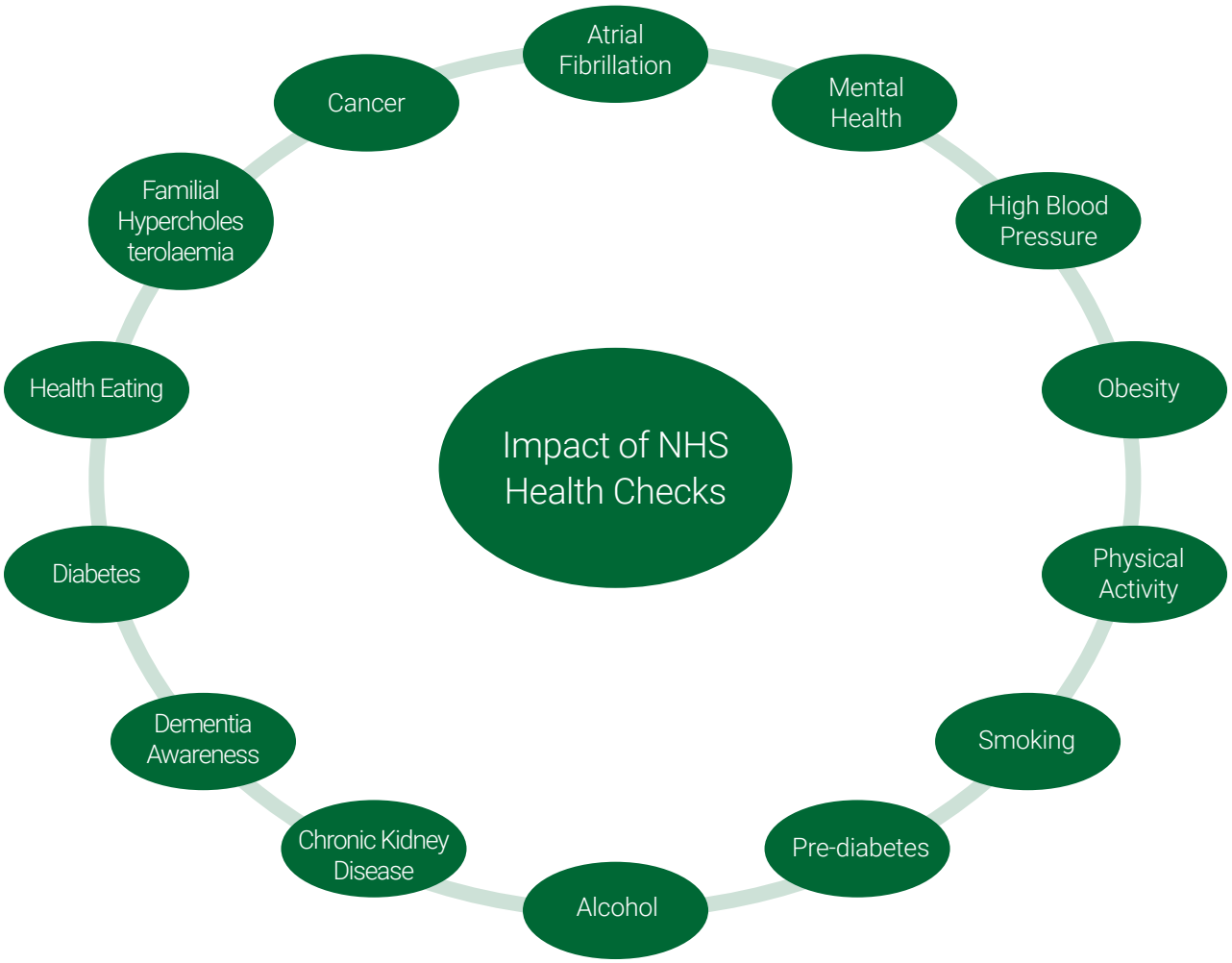


Figure 3: Diagram illustrates the varied aspects of an individual's life that can be impacted as a result of the NHS health check.

Under the Health and Social Care Act 2012, local authorities have a statutory responsibility for making sure that eligible people have an NHS Health Check once every five years. This is a major opportunity to tackle public health issues by helping individuals to take responsibility for their own health and reducing health inequalities arising from the conditions and lifestyle risks covered by the programme.

Our approach in Bromley is for GP Practices to be the main provider of NHS Health Checks. When planning the programme in 2009, our Director of Public Health presented options to GPs at an Academic Half Day.

'Would you like primary care to provide these NHS Health Checks, or would you like Public Health to arrange alternative arrangements?'. There was an overwhelming positive response from GP Practices at the time that they wished to provide the NHS Health Checks.

GP Practices (including those supported by the Bromley GP Alliance) have an important role in the NHS Health Checks programme, as they;

- ✓ hold the register for patient NHS Health Checks.
- ✓ manage the call recall element of the programme.
- ✓ provide, signpost, and refer to appropriate behavioural interventions to support healthy lifestyle change.
- ✓ ensure ongoing management of those at high risk of vascular disease and/or detection of previously undiagnosed conditions.

Ensuring Quality in the NHS Health Checks programme

Completing NHS Health Checks well is so important to us. Quality is at the core of all aspects, and we continue to promote, monitor, and inspire quality in everyone that is involved. We believe excellence should happen at every level and our programme is structured in such a way to achieve this see figure 4.

More detail on the quality of the award-winning Bromley NHS Health Checks programme is still available to read in the Annual Public Health report 2016. It is still very relevant today: NHS Health Checks (bromley.gov.uk). You can also watch our video created for our Annual Public Health Report in 2016.

Figure 4: Structure supporting the quality of Bromley's NHS Health Check Programme

https://www.youtube.com/watch?v=jXvS_VhRJ78

Years 2012 to 2017 – Introducing quality standards Bromley NHS Health Checks

The year of 2013 brought about national changes to the NHS structure with the dissolution of Primary Care Trusts. Public Health responsibilities were split across local authorities, NHS England, and Public Health England. The NHS Health Checks programme became a statutory requirement for Public Health in local authorities to ensure the eligible population were offered and could receive an NHS Health Check. **https://www.legislation.gov.uk/uksi/2013/351/contents/made** This ensured the continuation of this important public health programme within the new structural arrangements. Public Health England reviewed the structure, monitoring and guidance for NHS Health Checks. It developed a new Best Practice Guidance document and provided support to local authority commissioners and providers of NHS Health Checks through regional networks **https://www.healthcheck.nhs.uk/commissioners-and-providers/**

In 2015, when the first five-year cycle of NHS Health Checks were complete, the Bromley Public Health team, together with colleagues from the London NHS Health Check Network, developed and piloted a set of nine quality standards (Appendix 1). This London standards tool was used to perform a quality audit to "assess the follow up outcomes of patients identified through the programme". The audit objectives were to:

1. Identify how well a model practice is meeting the data collection criteria and how successful interventional efforts have been.
2. Identify any areas where the model practice is not meeting requirements.
3. Develop an audit ready for implementing in other practices in the clinical commissioning group (CCG).

The audit tool set out nine standard outcome measures for service specification and quality and measured compliance in a model practice. The results were particularly impressive for outcomes relating to diabetes, as can be seen on example from Table 2.

STANDARD	DEFINITION	COMPLIANCE
1.1	80% of patients identified with a raised BMI at the time of the NHS Health Check should have a documented lifestyle intervention and measurement of HbA1c within 3 months of the NHS Health Check.	79%
1.2	A follow up review should include further monitoring of height, weight and BMI recorded and achieve a weight reduction of 5%.	Data not available
1.3	If BMI ≥35, then 100% patients should be offered a referral to a tier 2 weight management service.	61%
2.1	80% patients identified as meeting the NHS Health Check diabetes filter criteria should have assessment of diabetes risk by measurement of HbA1c or fasting plasma glucose.	83%
2.2	100% of patients with a raised HbA1c of between 42 - 48mmols/mol (6.0-6.4%) or FPG ≥5.5 - ≤6.9 mmol/l, they should be coded with an appropriate READ code indicating level of risk of diabetes and/or diagnostic code of pre diabetic state e.g. At high risk of diabetes.	55%
2.3	Patients identified as 'high risk of diabetes' should have intensive lifestyle intervention and a repeat blood test HbA1c or FPG at 12months achieving a reduction in glucose and therefore diabetes risk.	100%
3.1	At least 80% of patients with sustained systolic blood pressure ≥140 and/or diastolic blood pressure and/or ≥90 should be coded with an appropriate READ code indicating hypertension. This may occur subsequently following the Health Check.	Unable to confirm
3.2	Patients with hypertension should be treated with lifestyle advice and evidence of antihypertensive prescribing and further monitoring and reduction in blood pressure to <140/90mmHg.	Pass
4.1	At least 80% of patients with screening total cholesterol of ≥7.5 mmol/L should have the use of the familial hypercholesterolemia filter.	40%

Table 2: Compliance rate of one audited GP practice against quality standards, 2015

The audit also highlighted several opportunities for improved follow up and management of diagnoses, specifically regarding data coding with hypertension and obesity, and subsequent testing and referral. In addition, the audit highlighted patients with a QRISK2 score over 20% (high risk) 27% were commenced on a statin, an area where there was a significant focus on improvement.

In 2017, a follow up quality audit was conducted to see if the management of those with a very high or high QRISK2 score had been enhanced. All health checks with the relevant data conducted across the borough in 2015/16 period were analysed (n=370). Against, we saw that challenges remained with coding of people at high risk of CVD, and a slight decrease in statin prescribing (Table 3).

STANDARD	DEFINITION	COMPLIANCE
CVD1	Patients with a QRISK2 ≥ 20% should be offered lifestyle advice and interventions where appropriate – 100%	69%
CVD2	Patients with a QRISK2 ≥ 20% should be offered a statin unless contraindicated – 100%	24%
CVD3	Patients with a QRISK2 ≥ 20% should be coded as being at high risk of cardiovascular disease, to enable annual follow up – 100%	0%

Table 3: Compliance rate of NHS health checks against quality standards (n=370)

With a continued emphasis on quality improvement the report suggested that all practices aim for the following standards in the future:

- CVD. 1 – Patients with a QRISK2 ≥ 20% should be offered lifestyle advice and interventions where appropriate – 80%
- CVD. 2 – Patients with a QRISK2 ≥ 20% should be offered a statin unless contraindicated - 100%
- CVD. 3 - Patients with a QRISK2 ≥ 20% should have a date for annual follow up recorded – 90%
- CVD. 4 - Patients with a QRISK2 ≥ 20% should have a lipid profile measured prior to commencement of statin – 100%

- CVD. 5 - Patients with a QRISK2 ≥ 20% should be offered a statin within 6 months of undergoing health check – 80%

The London standards document was superseded by the publication of National Programme Standards a year later **https://www.healthcheck.nhs.uk/commissioners-and-providers/national-guidance/**

Year 2018 - Auditing Health Equity

The NHS Health Checks went from strength to strength throughout the 2010's so as part of the routine audit cycle, a Health Equity Audit was conducted. The Audit examined how health determinants, access to relevant health services, and related outcomes affected point of identification, invitation and take up of the NHS Health Check programme in Bromley.

Despite small variations in invitation across age, gender, ethnicity and deprivation, the commitment of Bromley GPs to health equity shone through, with results showing **largely equitable distribution of invitation and uptake across the Borough.**

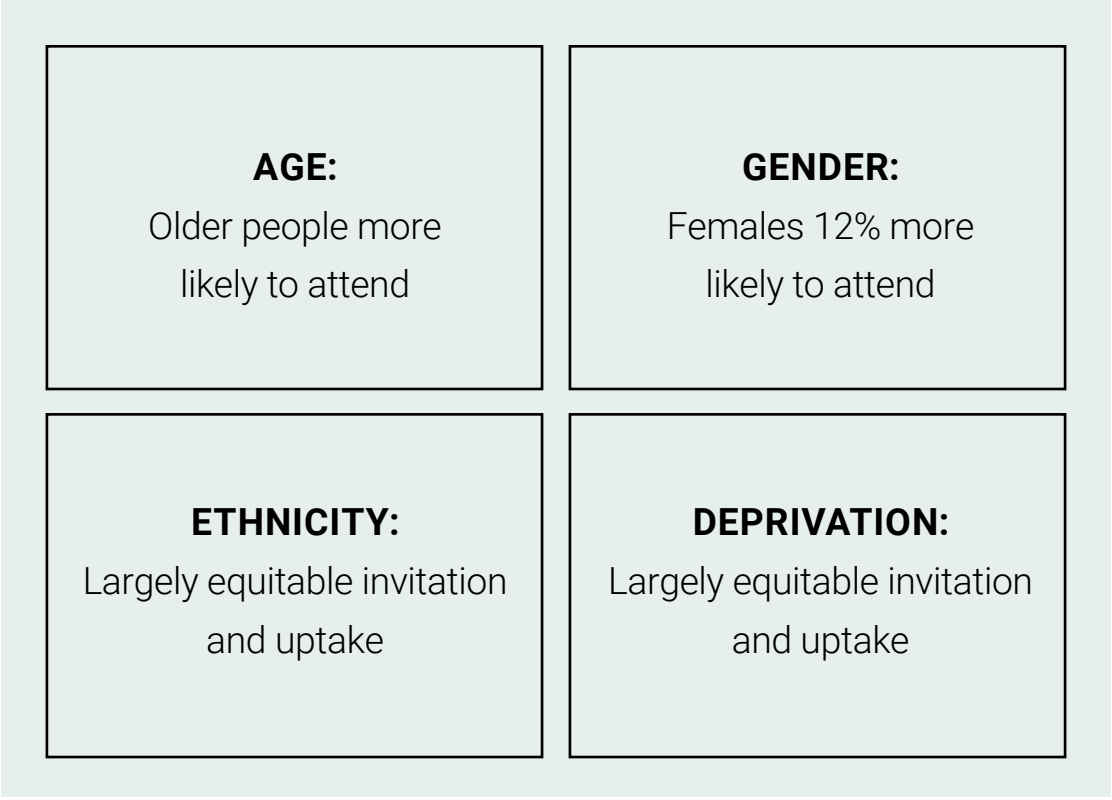


Figure 5: Summary of findings from Bromley NHS Health Checks equity audit

Importantly, the Audit highlighted the key role the GP Practices play in uptake, with the GP practice itself having the greatest influence on the increasing the number of invitations, and the successful conversion of those invited to attending their NHS health check. For example, **60% more invited residents attended their health check in the highest achieving GP Practice.**

	GP WITH LOWEST PROPORTION	GP WITH HIGHEST PROPORTION
Invitation of eligable residents (target 20%)	5%	41%
Uptake of invited residents (target 50%)	22%	80%

Table 4: Comparison of GP surgery with highest and lowest proportion of residents invited to and attending NHS health Checks in 2018.

Year 2020 - 21 – The Impact of Covid-19 on the NHS Health Check programme

Understandably, Covid-19 had a significant impact on the delivery of NHS Health Checks, which reduced from 8038 health checks in 2019/20 to 128 in 2020/21 as Primary Care were instructed by NHS England to stop providing non-essential work.

In 2021/22 against difficult odds, 8 of the 42 GP practices met the target of 20% of eligible population offered a check, and three managed to invite more than 30% of eligible people.

Unfortunately, no practices met the 10% target for NHS Health Checks delivered, though some were close with 9.1% achieved. The report largely mirrored the results from 2018, finding that any inequity in access across the Borough was small and not usually statistically significant.

Nevertheless, the report highlighted key areas of focus, to ensure the burden of cardiovascular disease and diabetes does not increase as a result of inequities which may have been widened by the COVID-19 pandemic.

Focus populations identified from the 2018 and 2022 Health Equity Audits:

- Young: Those aged 40-44 years are most likely to benefit from early detection and prevention advice. Targeting invitations at milestone birthdays can increase uptake.
- Men: Men have a higher risk of cardiovascular disease than women, and therefore additional efforts to encourage their attendance at NHS Health Checks should be made.
- Ethnicity: People of Asian and Black heritage have a higher risk of cardiovascular disease, and therefore targeting this group is appropriate. However other groups should also be encouraged to attend to ensure they are not overlooked.

Year 2022 - Post-Pandemic Recovery of Health Checks

After a few extremely difficult years recovering from the pandemic, it is encouraging to start seeing the first positive signs of recovery of the NHS Health Checks programme.
In the 2022-23 reporting period, increases in delivery were seen each quarter, with the final figures for the period being significantly higher than the previous two years.

NATIONAL TARGETS **Total eligible population** *(PHE estimated Bromley residents)		**BROMLEY 2019-20** **97,495**	**BROMLEY 2020-21** **97,495**	**BROMLEY 2021-22** **99,247**	**BROMLEY 2022-23** **100,074**
	TARGET %				
The number and percentage of eligable population aged 40-74 eligable for an NHS Health Check who were offered an NHS Health Check	20%	18,271 (18.7%)	246 (0.3%)	6,271 (6%)	19,009 (19%)
The number and percentage of eligable population aged 40-74 years who received an NHS Health Check	10%	8,038 (8.2%)	128 (0.1%)	1,933 (2%)	4,966 (5%)
The percentage of eligable population aged 40-74 years offered an NHS Health Check, who received an NHS Check	50%	8,038 (44%)	128 (52%)	1,933 (31%)	4,966 (26%)

Table 5: Trends in invitation to and uptake of NHS health checks from 2019-2023.

The Borough reached 19% of the eligible population with an invitation for a Health Check (almost reaching the 20% target) and 26% uptake from those invited. While this leaves room to continue to grow, it represents a significant recovery towards pre-pandemic levels.

In 2022/23 - 42 GP Practices (11 using the Bromley GP Alliance) provided 4966 NHS Health Checks in Bromley.

Prevention of the onset of long-term conditions such as cardiovascular disease and related conditions is a priority for NHS Health checks. By identifying risk factors for these conditions early, working with individuals to support and refer to services for lifestyle behaviour change and further investigation and treatment where needed to address the risk factors is key to maximising the benefits of the NHS Health Check programme. Bromley's NHS Health Checks programme identified significant numbers of adverse risk factors in 2022-23, as shown in Table 6.

Type, number, and percentage of adverse Risk factors identified through an NHS Health Check	No. Patients	%
Irregular Pulse	78	1.6%
Raised Blood Pressure (BP), greater than or equal to 140/90mmHg	1108	22.3%
Body Mass Index greater than or equal to 30 (27.5 in BAME popultion)	1504	30.3%
Current Smokers	601	12.1%
Alcohol assessment scores AUDIT score 8-15 indicating - Increased Risk AUDIT score 16-19 indicating - Higher Risk AUDIT score 20 or more indicating Dependancy	 463 39 18	 9.3% 0.8% 0.4%
Inactive - GP Physical Activity Questionnaire (GPPAQ)	1088	21.9%
Increased risk of diabetes due to raised Qdiabetes score, raised BMI or raised BP	2347	47.3%
Qrisk 2 cardiovascular raised 10-yearrisk score: 10-19.9% 20% or greater	 976 276	 19.7% 5.6%
Cholesterol greater than 7.5mmol/l	77	1.6%

Table 6: Type, number and percentage of adverse Risk factors identified through an NHS Health Check 2022-23

Ensuring follow up investigation and management of people with adverse risk factors. In Bromley, staff providing the NHS Health Check are trained in when to act supported by a written Clinical Filter Guide (See Appendix 2). In addition, prompts for action are included in the Bromley NHS Health Check template on the computerised EMIS Patients medical record. GP Practices are encouraged to make this pathway as smooth and robust as possible. However, there is an element of patient choice here, so although provided with the information the patient may choose not to attend for further investigation.

Sensitive and appropriate communication of risk is essential to maximise the patient uptake of follow up and the uptake of behavioural lifestyle services. Staff providing NHS Health Checks receive training in how to communicate risk as core training. Additional motivational interviewing training is also recommended. Early diagnosis of the associated high-risk conditions is beneficial in reducing progression to more severe cardiovascular disease, such as heart attacks, stroke, and vascular dementia.

One of the great achievements of last year's checks, is that several individuals were diagnosed with these conditions following their NHS Health Check, patients can now receive treatment to reduce cardiovascular risk, manage their condition and prevent disease progression. Please note due to the timing of data submission for NHS Health Checks, many of those identified with risk factors may still be undergoing further investigation and would be too soon to see the diagnosis on record therefore, the numbers in Table 7, will be an underestimation.

Conditions diagnosed following an NHS Health Check	No. Patients	%
Atrial fibrillation	0	0.0%
Hypertension	126	2.5%
Chronic Kidney Disease	21	0.4%
Non-diabetic Hyperglycaemia (pre-diabetes)	193	3.9%
Type 2 Diabetes	34	0.7%

Table 7: Number of patients diagnosed with key conditions follow NHS health checks, as a percentage of the population of Bromley.

Statin therapy is another important management measure for prevention of cardiovascular disease. South East London Integrated Care System (ICS) has developed comprehensive guidance for primary care regarding statins in the Lipid Management: Medicines Optimisation Pathways (selondonics.org)

Of patients with elevated QRisk2 scores of 10-19.9%, almost 10% are on statin therapy. This number increases for those with a QRisk2 score more than 20%, to 15% on statin therapy. For patients with a cholesterol of 7.5mmol/l, 23% are on statin therapy.

Key Areas of Focus for 2023/24:

- Increasing invitation and uptake numbers: Ensuring an effective call and recall system with consideration to the recommendations from the health equity audit section on age, gender, ethnicity, and deprivation to ensure equitable provision.
- Support training for all staff on the NHS Health Checks Programme, with an emphasis on the complexity of referral pathways (see Figure 7 below).
- Continuing to support improvements in follow up, investigation and appropriate management of those with adverse risk factors Ensure robust Develop closer links between NHS Health Checks and wider CVD prevention work in the SEL ICS, to maximise beneficial patient outcomes.

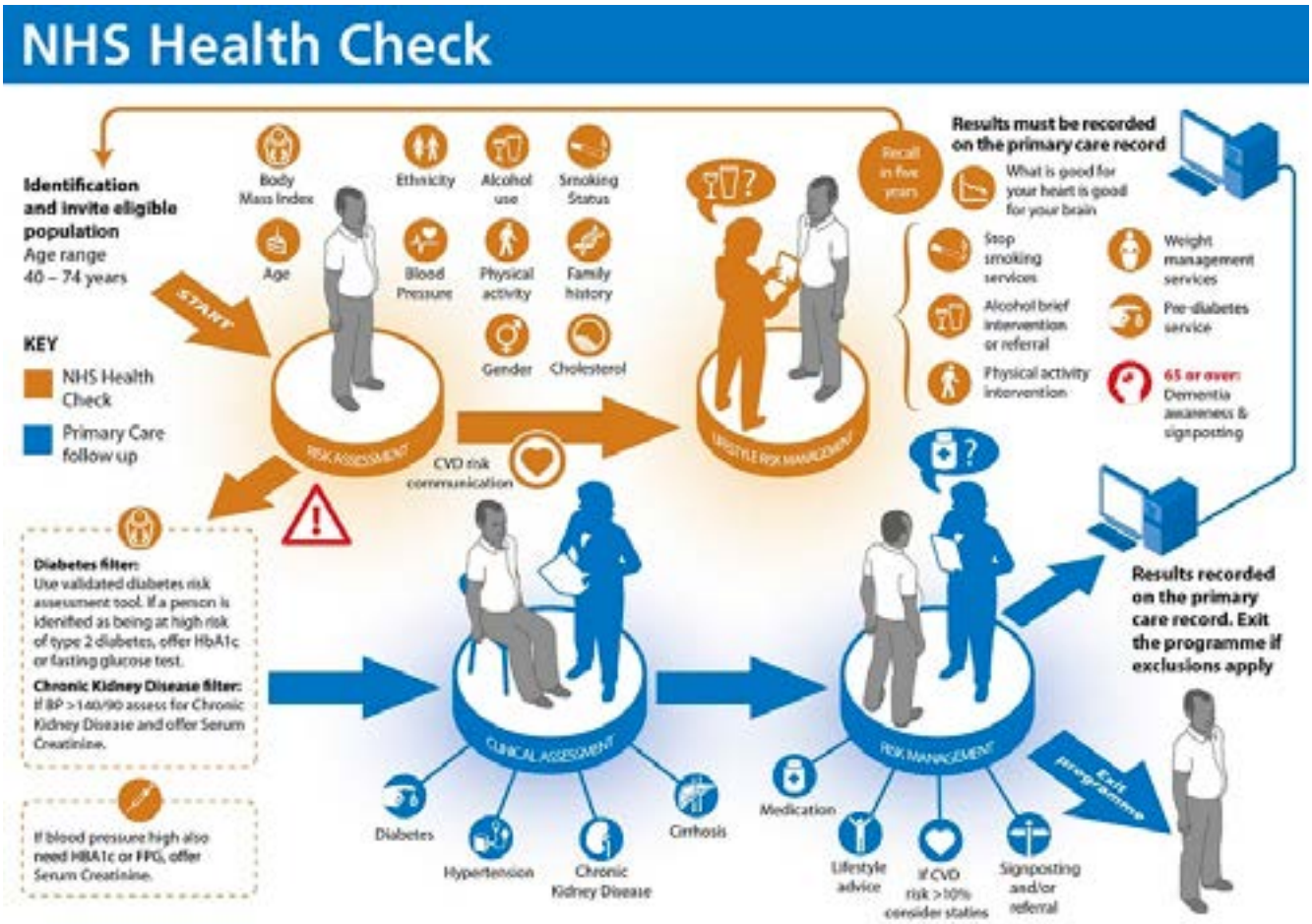


Figure 7: Infographic of care pathway through the NHS Health Check programme

Year 2023 – Linking with wider Cardiovascular Disease Prevention priorities

The NHS Long Term Plan (2019) sets out a roadmap to redesign patient care and future-proof the NHS for the decade ahead. Chapter Two of the Plan sets out how to take action to prevent disease and ensure health equity.

- Cardiovascular disease (CVD) being one of the priority conditions highlighted.
- Improving and increasing early detection and treatment of CVD, in particular **A**trial Fibrillation, High **B**lood Pressure and High **C**holesterol (A, B and C) are key elements of this.

This work has obvious overlaped with the NHS Health Check which will focus on the identification. However, there is of course the wider population including those diagnosed with CVD who need these risk factors managed appropriately. See Figure 8.

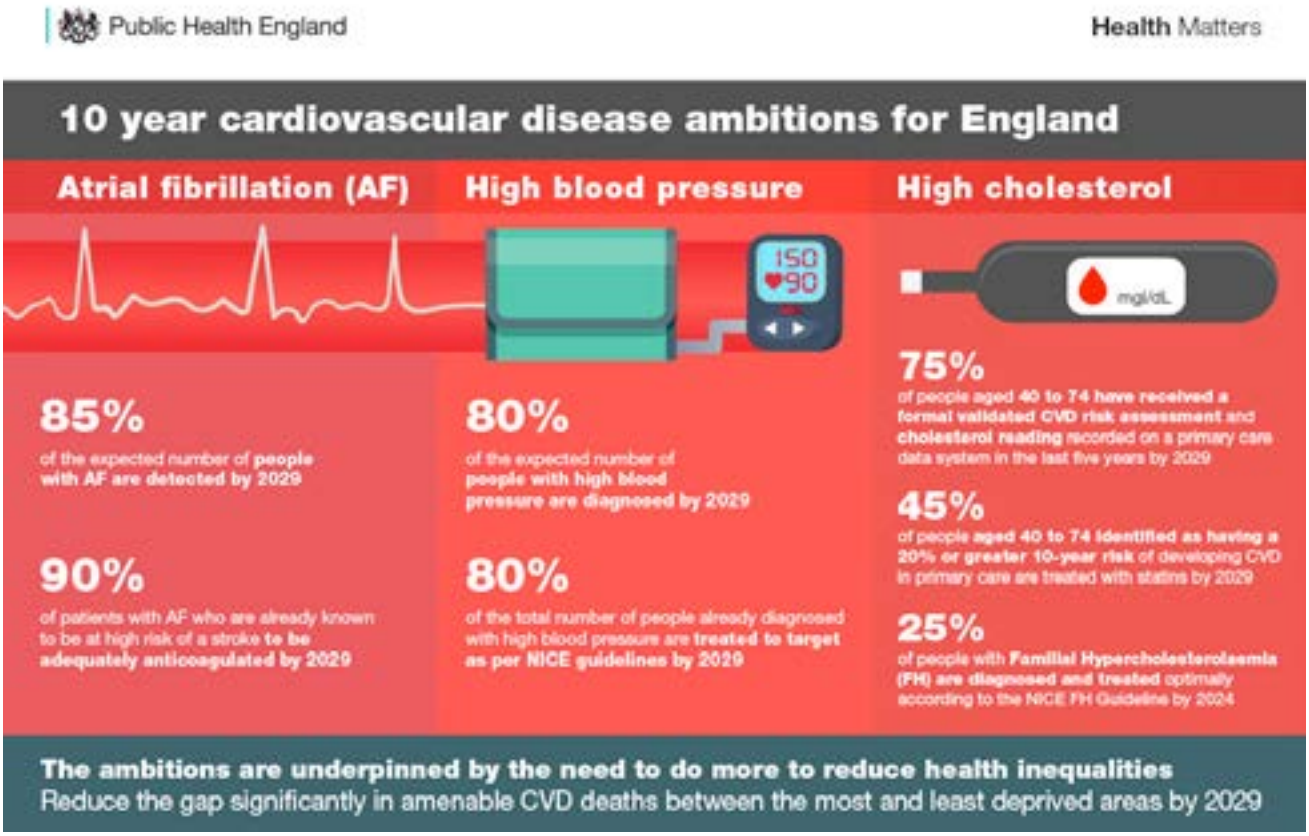


Figure 8: Infographic from PHE England setting out ambitions for the Long-Term Plan

If these ambitions can be achieved, it is estimated that more than 140,000 cardiovascular events can be prevented by 2029.

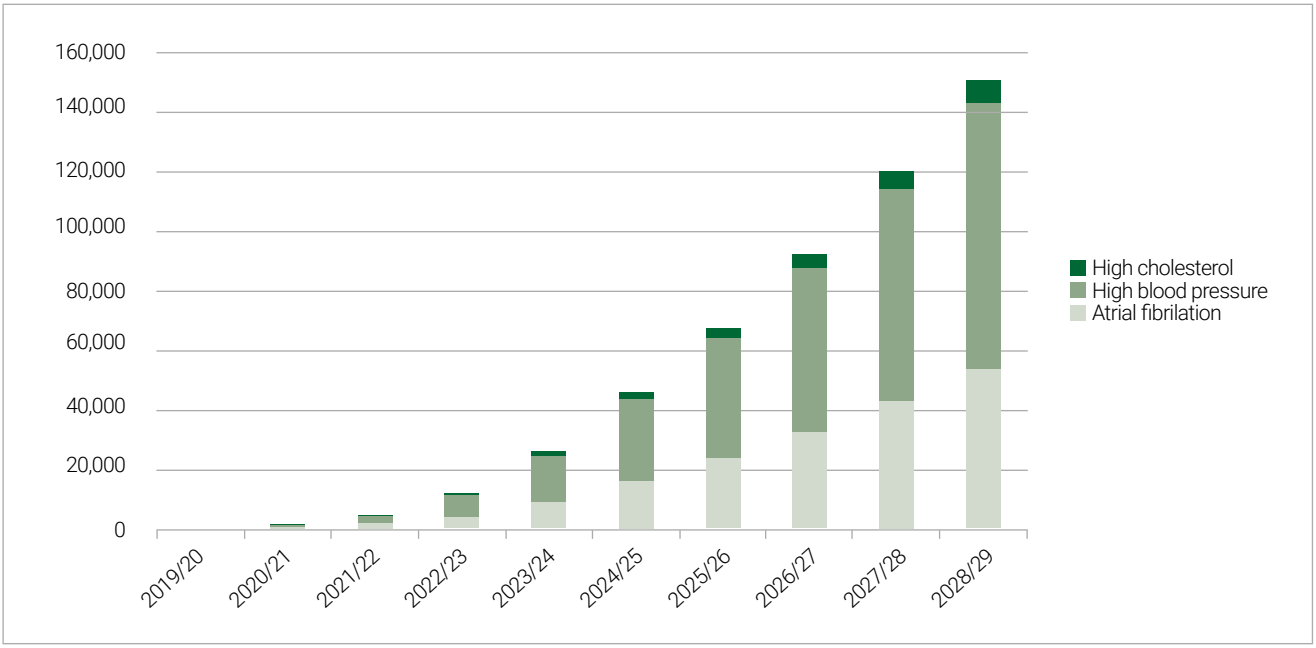
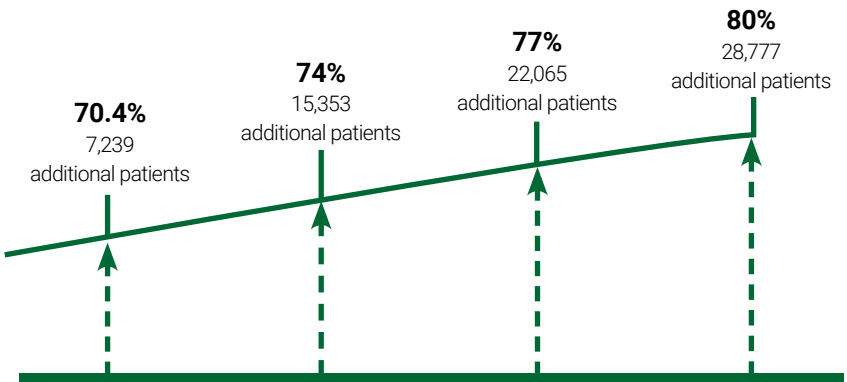


Figure 9: Shows projected cumulative number of heart attacks, strokes and dementia cases in England prevented by 2029.

The priority area being addressed is High Blood Pressure for people diagnosed with hypertension to achieve a blood pressure of 140/90mmHg or less. As part of the plan, NHS England sets out a target to 'increase the percentage of people treated to The National Institute for Health and Care Excellence (NICE) blood pressure targets to 77% by March 2024.

The ambitions of NHS England are for each ICS to work towards achieving the targets represented in Figure 10 below, which illustrate much like QCI in 2002, the significant reduction in cardiovascular events and subsequent savings to be realised from scaling up NHS Health Checks.



Ambition 1	Ambition 2	Ambition 3	Ambition 4
Potential cardiovascular events and deaths prevented in 3 years[1] and estimated savings[2,3]			
43 heart attacks	**92** heart attacks	**132** heart attacks	**173** heart attacks
UP TO £0.3M saved	**UP TO £0.7M** saved	**UP TO £1M** saved	**UP TO £1.3M** saved
65 strokes	**137** strokes	**198** strokes	**258** strokes
UP TO £0.9M saved	**UP TO £1.9M** saved	**UP TO £2.7M** saved	**UP TO £3.6M** saved
35 deaths	**74** deaths	**106** deaths	**138** deaths

Figure 10: Potential number of cardiovascular events and death prevented through scaling up of CVD preventive work including prompt follow up of people post NHS Health Checks.

In addition, key stakeholders across South-East London Health Economy are working together to improve systems for blood pressure management. GP Practices and Community Pharmacies are key to improving patients' blood pressure management and self-management initiatives such as home blood pressure monitoring. In addition to the role of NHS Health Checks in identifying people with undiagnosed hypertension, wider Public Health Campaigns, including Know Your Numbers Blood Pressure Awareness, can successfully increase knowledge and understanding of the risks of high blood pressure in the wider population.

Key Actions recommended by SEL ICS for blood pressure control:

- Appoint a **clinical champion** and **admin lead**

- Embed robust **call and recal**l systems
  - Make every contact count
  - Invite patients early to beat the winter pressures
  - Utilise the community pharmacy BP checks programme
  - Optimise BP@home

- Engage with **Clinical Effectiveness South-East London (CESEL)** for in-practice support

- Follow **CESEL / NICE guidance**
  - Utilise the wider workforce to support lifestyle / behaviour change
  - Intensify medicines in a timely manner
  - Offer early follow up to assess effectiveness
  - Support adherence and persistence to therapy

- **Review progress monthly** and feedback to staff

Looking forward – What comes next?

With such clear benefits to be gained from prevention and early identification of risk factors, the desire to increase access to health checks lends itself well to a digital transformation.

In June 2023, the Government announced the introduction of Digital NHS Health Checks. The new digital check will be commissioned nationally to be delivered alongside the existing in-person NHS Health Check. The digital NHS Health Check has been piloted and developments of the national check are in progress. The detail is yet to be confirmed but it is anticipated the digital NHS Health Check will be accessible via mobile phone, tablet, or computer via an online questionnaire where patients will enter their height, weight, blood pressure and blood test results. It will link with the NHS App. **Digital NHS Health Checks are expected to deliver an additional one million checks over 4 years, while easing pressure on GP surgeries.**

It is estimated that each digital could save 20 minutes of NHS time - potentially freeing up hundreds of thousands of appointments in primary care, relieving pressure on GP surgeries, and helping reduce waiting times. Health and Social Care Secretary Steve Barclay said:

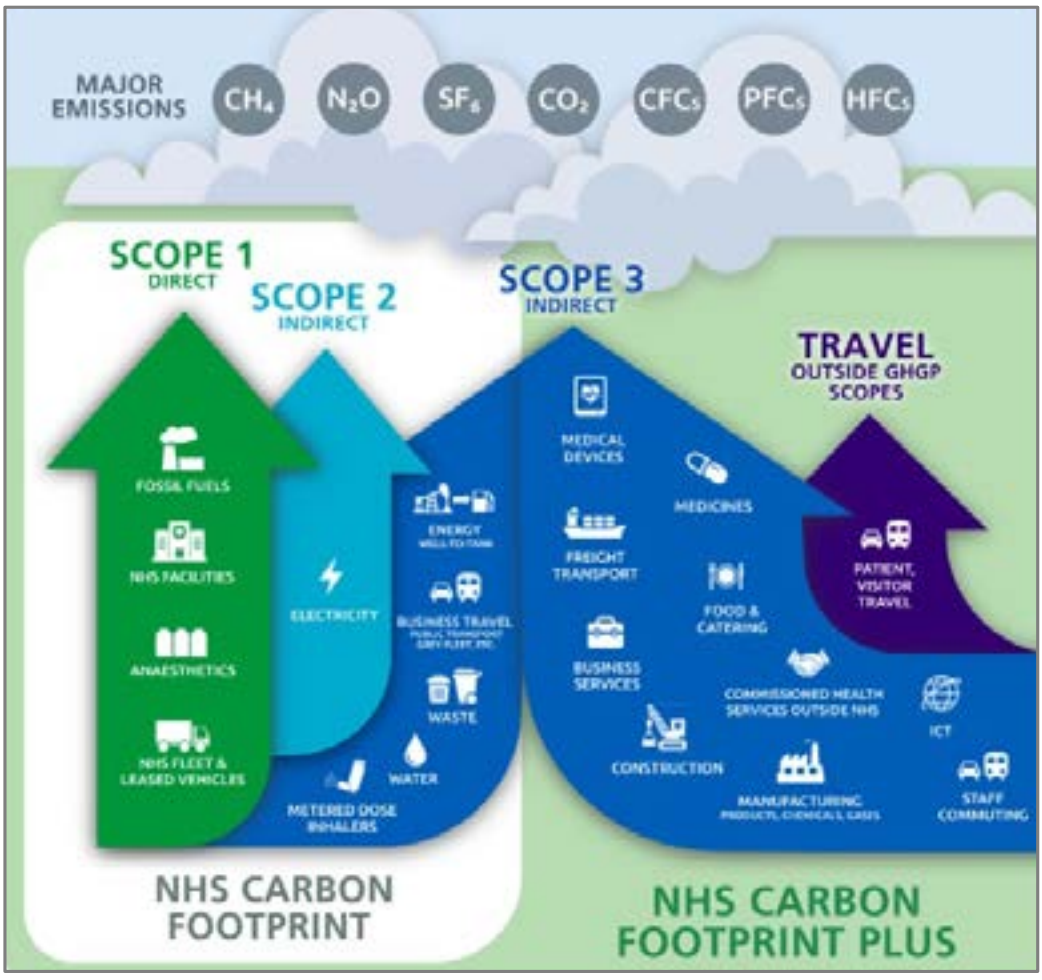
> *"Thousands of heart attacks and strokes could be prevented every year through simple health checks, which would save lives and ease pressure on the NHS... This programme is the latest example of how we are using technology to cut waiting times, one of the government's 5 priorities, improve diagnosis and treatment."*

The development of a new digital NHS Health Check to complement the face-to-face NHS Health Check is excellent news. Whilst it won't be appropriate for all, it will provide the additional capacity needed to reach all those who are eligible. We eagerly await more information to see how this will work in practice, in particular how the digital and

face to face NHS Health Check programmes link together. It is expected this digital NHS Health Check will be available in 2024.

Digital NHS Health Checks: A move towards sustainability

The NHS is responsible for 5% of all UK environmental emissions, with some estimates citing as many as 1 in 20 journeys on UK roads are healthcare related. Patient travel alone makes up about 5% of NHS emissions, with primary healthcare visits being one of the major contributors to this. Green NHS sets out the organisations ambitious target to reach net zero emissions for the care provided by 2040.



Box Figure 1: Shows the NHS carbon footprint, and significant contribution of travel to greenhouse gas emissions.

The Green NHS 'Delivering a 'Net Zero' National Health Service' report sets out a clear path for how to decarbonise the NHS, including specific recommendations for primary healthcare.

The report estimates that by reducing travel through digital care pathway redesign (for example through Digital NHS Health Checks) and prevention of disease and health inequality, the system can reduce carbon by 221 kilo-tonnes CO2 equivalent (ktCO2e) **– together that is the same as reducing travel of petrol cars by more than 566,000 miles in a year.**

This in turn reduces air pollution, supporting further improvement in air quality, to support prevention of respiratory diseases which cause approximately 38,000 premature deaths per year.

Clearly, increasing access to the NHS Health Check through digitisation of the pathway with not only provide protective health effects, but also deliver significant environmental benefits too.

Explore how starting Digital NHS Health Checks can support your practice's Net Zero targets and integrate into decarbonisation planning.

Support for Lifestyle Behaviour Change – keeping up to date with available services

The role of lifestyle behaviour change is incredibly important and is an integral part of the NHS Health Check and wider CVD prevention. However, we do acknowledge that the services available to support patients with lifestyle changes come and ensure quality.

2024 is a good year for behavioural support lifestyle services with newly the commissioned Slimming World programme as an additional Tier 2 weight management programme and Smokefree Bromley which is a new local stop smoking service.

To ensure up to date information, GP Practices should use the ROP on their computer system, there are additional services and information on the Bromley pages of the Make Every Contact Count website for health care professionals **https://www.mecclink.co.uk/location?location=bromley**
General public can find information on the Bromley Council Health and Wellbeing pages. **https://www.bromley.gov.uk/health-wellbeing**

As we all know making and maintaining healthy lifestyle behaviours is often difficult. Using motivational interviewing techniques and making every contact count can help enhance success. There is guidance on speaking to people about weight which can be a very emotive subject Let's Talk About Weight – step by step guide **https://assets.publishing.service.gov.uk/media/5b8d54d2e5274a0bd7d11928/weight_management_toolkit_Let_s_talk_about_weight.pdf**

It is also recommended that everyone in Primary Care and the wider health economy that have the opportunities to speak to Smokers about their smoking undertake at least some Very Brief Advice Training. This is available via the NCSCT website or will be part of some webinars from the new local Stop Smoking Service during 2024. **https://www.ncsct.co.uk/**

Commercial Weight Loss programmes

(meetings and/or online – fees apply)

Further examples of some of the lifestyle support services are shown below.

With so many diet options to choose from, it can be hard to find a weight loss plan to suit you. The following are available in the Bromley area:

Weight Watchers:

Telephone: 0345 345 1500 **https://www.weightwatchers.com/uk/**

Slimming World:

Telephone: 0344 897 8000 **https://www.slimmingworld.co.uk/**

MAN v FAT Football:

Based at Bromley Football Club. For men with BMI of 27.5 or over.

https://manvfatfootball.org

Mytime Active - Healthy Habits course: A 12 week fully supported weight management programme that aims to give the skills to change the way you think and feel and lead to a fitter, healthier, happier you. **https://www.mytimeactive.co.uk/activities/healthy-habits**

For additional commercial weight loss plans endorsed by the NHS visit:

https://www.nhs.uk/better-health/lose-weight

Leisure Centres in Bromley

Mytime Active

run local leisure centres across the borough with activities and classes for all ages and programmes for different types of physical activity ranging from swimming, dance, yoga and aerobic classes to golf, tennis and much more. Fees apply. For more information visit: **www.mytimeactive.co.uk** or call: 07714 077408

Primetime

is a programme of events and exercise sessions for the over 60s run in many of the Mytime Active leisure centres. A buddy system is available for those new to exercise. Email: primetime@mytimeactive.co.uk

Football Activities

Bromley Football Club

have a range of football-based activities for all ages and abilities. Opportunities for men and women – (fees apply).

Walking Football group

@ Bromley FC – Come and be a part of an all-new Walking football group at Bromley FC! Predominantly aimed at over 50s but all are welcome! Fees apply. For more information https://www.bromleyfc.org/walking-football/

Bromley Belles FC

is a women's recreational football team for ladies aged 30 to over 60. No experience required. See link for more information: https://www.bromleyfc.org/womens-over-30s-recreational/

Football for absolute beginners (FAB) for females aged 18+. Have fun while learning to play football https://www.bromleyfc.org/football-for-absolute-beginners/

Palace for Life Foundation

runs a variety of programmes to inspire adults to get fit: Fitter Fans (football), Walking Football (men's and women's opportunities), Some based at Crystal Palace training ground in Beckenham - (fees apply). For further information: https://www.palaceforlife.org/whats-on/family-health-well-being/

Other emotional, practical, and social support

Bromley Well

provide support and activities for local people with specific circumstances to prevent them from falling into a crisis and improve their health, wellbeing, and independence. Website: https://www.bromleywell.org.uk/ Email: spa@bromleywell.org.uk; Telephone: 0808 278 7898

Bromley Mind Recovery Works service

offers bespoke 1:1 support, including physical health to support good mental health wellbeing. Website: www.blgmind.org.uk/bromley/recovery-works/

Key Actions Checklist

Here you can find the key actions from this report summarised in one place.

- [ ] Increase invitation and uptake numbers: In doing so, consider the recommendations from the health equity audit section on age, gender, ethnicity, and deprivation to ensure equitable provision.
- [ ] Support training for all staff on the NHS Health Checks Programme, with an emphasis on the complexity of referral pathways (See below diagram)
- [ ] Continuing to support improvements in follow up, investigation and appropriate management of those with adverse risk factors.
- [ ] Prescription of statin therapy for those at increased CVD risk (Qrisk) and high cholesterol according to South-East London Guidelines
- [ ] Appoint a clinical champion and admin lead.
- [ ] Embed robust call and recall systems.
- [ ] Make every contact count.
- [ ] Invite patients early to beat the winter pressures.
- [ ] Utilise the community pharmacy BP checks programme.
- [ ] Optimise BP@home.
- [ ] Engage with CESEL for in-practice support.
- [ ] Follow CESEL / NICE guidance.
- [ ] Utilise the wider workforce to support lifestyle / behaviour change.
- [ ] Intensify medicines in a timely manner.
- [ ] Offer early follow up to assess effectiveness.
- [ ] Support adherence and persistence to therapy
- [ ] Review progress monthly and feedback to staff
- [ ] Explore how starting Digital NHS Health Checks can support your practice's Net Zero targets and integrate into decarbonisation planning.

Appendix 1

Pan London NHS Health Checks Minimum Standards

These Pan London Consensus NHS Health Checks Minimum Standards are endorsed by HEART UK, and are intended to ensure comparable and robust commissioning and delivery of NHS Health Checks. It is envisaged that these standards will be incorporated into local service specifications as part of the commissioning process. They do not describe the entire process, however they are touch points within the service where quality can be measured to determine a successful programme. Commissioners may want to consider other elements as part of the service specification for example, training and qualifications for staff in the competencies they must have.

These standards are a precursor to National Quality Assurance Standards, currently being developed by Public Health England and due for release early 2014. The London NHS Health Check working group have helped inform this national work. Once released, this national guidance will supersede these standards.

	CRITERIA	MINIMUM STANDARD	ACHIEVABLE STANDARD	HOW TO MEASURE
Objective 1: To ensure NHS Health Checks have local leadership	1. Named person responsible for the commissioning of the NHS Health Check Programme within local authority	To be in post	To be in post	Name and role submitted in Annual Report
Objective 2: To invite all eligible persons to attend a NHS Health Check	1. Percentage of the eligible population invited for an NHS Health Check Eligible population: a. 40-74 Years And does not have a diagnosis or documentation of: b. Coronary heart disease c. Chronic kidney disease (CKD stages 3-5) d. Diabetes e. Previous stroke f. Hypertension g. Atrial Fibrillation h. Transient Ischaemic Attack (TIA) i. Heart Failure j. Peripheral Arterial Disease or k. Prescribed a statin l. Found to have 20% or greater CVD Risk in a previous NHS Health Check	20% of eligible population annually	20% of eligible population annually Eligible age criteria can be extended to 30-74 (or other locally agreed range) years for certain South Asian ethnicities for example: a. Indian b. Pakistani c. Bangladeshi d. Sri Lankan e. Tamil	
Objective 3 Maximise uptake	The proportion of those offered (verbal or written) who have an NHS Health Check	50% of those who receive an offer of an NHS Health Check take up the offer	75% of those who receive an offer of an NHS Health Check take up the offer	Quarterly Data Returns submitted to the Commissioner and PHE
Objective 4 Provision of the NHS Health Check	1. The NHS Health Check/CV risk assessment must include (at least) all elements outlined in the Best Practice Guidance. Using a validated risk engine such as QRisk2 or Framingham based tool a. Blood pressure b. Height/Weight/BMI c. GPPAQ d. Audit C (alcohol) e. TC:HDL (either Point of Care or if venous sample within the last 6 months)	100% of NHS Health Checks have 100% completed data 100% of all NHS Health Checks delivered	100% of NHS Health Checks have 100% completed data. 100% of all NHS Health Checks delivered	Quarterly Data Returns to the Commissioner (Each item should be included within an NHS Health Check template) To be included within NHS Health Check template and captured as part of Quarterly Data Returns

	CRITERIA	MINIMUM STANDARD	ACHIEVABLE STANDARD	HOW TO MEASURE
	f. Smoking status g. Demographics h. Dementia awareness (65-74yrs) i. Diabetes & CKD if filters activated *Agreed data fields must form part of the Commissioning of NHS Health Checks. Completeness of NHS Health Check will be determined through payment process* 2. The results of the NHS Health Check, particularly the 10 year risk must be communicated faceto face and recorded.			
Objective 5 Additional activity following NHS Health Check	1. Use of diabetes filter when indicated by either : a. BP >140/90 mmHg b. BMI > 30 or 27.5 if individuals from the Indian, Pakistani, Bangladeshi, Other Asian and Chinese ethnicity categories 2. Use of hypertension filter when indicated by: a. BP >140/90 mmHg 3. Use of chronic kidney disease filter when indicated by: a. BP >140/90 mmHg 4. Use of Familial Hypercholesterolemia filter when indicated by: a. Total cholesterol >7.5 mmol/L 5. Use of Audit C filter when indicated by: a. Score >=5 6. People with >20% CVD Risk to: a. Be assessed for treatment with statins b. Receive an annual review 7. Referral into lifestyle services for: a. Smoking cessation b. Weight management c. Physical Activity d. Alcohol use	If any filter activated then investigations and outcome recorded in 80% of people 100% of all people with CVD Risk >20% 80% of lifestyle advice offered and referrals made to be recorded (irrespective of level of risk)	If any filter activated then investigations and outcome recorded in 100% of people 100% of all people with CVD Risk >20% 100% of lifestyle advice offered and referrals made to be recorded (irrespective of level of risk)	Quarterly Data Returns to the Commissioner and annual audit reviewing: 1. Any change in disease prevalence and 2. Proportion of people identified as 1. Pre diabetic / Diabetic 2. Hypertensive 3. CKD 4. Familial Hypercholesterolemia 5. Audit C >=5 6. CVD Risk >=20
Objective 6 Monitoring of quality within programme	1. Robust commissioning, contract monitoring and reporting mechanism 2. If used, all point of care devices must demonstrate and comply with Quality Control.	4 monthly monitoring/ reporting 100% of devices have QA programme	Quarterly monthly monitoring/reporting 100% of devices have QA programme	Recorded Quarterly performance reports and issue log sent to Commissioner

NHS Health Check Pan London Leads working group:
Chair: Dr Nada Lemic (Bromley)

Michaela Nuttall (Bromley)
Lindsey Sills (Havering)
Sue Levi (Barking and Dagenham)
Julie Boyd (Enfield)
Chima Olughu (Greenwich)
Rachel Fluke (Croydon)
Imran Choudhury (Brent)
Sundus Hashim (Kingston)
Anne-Marie Liew (Merton)
Dr. Muhammad Usman Khan and team (Richmond)
Yogini Patel (Brent)
Gemma Lyons and Marta Calonge-Contreras (Camden & Islington)
Patroklos Sesis (Hillingdon)

Appendix 2

NHS Health Check Clinical Filter Guide

	NORMAL	RAISED/HIGH	ACTION	VERY HIGH	ACTION
Blood Pressure	Below 140/90 Below 135/85 (HBPM)	140/90 - 179/119 135/85 or higher (HBPM)	blood tests for HbA1c U&E's, eGFR plus Refer for ABPM or Home BP monitoring	180/120 or higher	Recheck x2 if still the same or higher to see GP same day or if out of hours refer to A&E
BMI	18.5-24.9 (White british/Other) Below 23 Black African/ Caribbean South Asian/Chinese	25-29.9 (White British/Other) 23 or higher Black African/ Caribbean South Asian/Chinese	Give weight reduction advice (weblinks on results sheet)	30 or higher (White British/Other) 27.5 or higher Black African/Caribbean South Asian/Chinese	Bloods for HbA1c or Fasting Glucose for patients with haemoglobinopathies. Discuss signposting to weight loss programmes if BMI 30 or higher for White British/Other or if 27.5 or higher for Black African/Caribbean/ Asian/Chinese. Refer to weblinks on results sheet.
Waist Circum-ference * 4 cm less for male Asian patients	Men: Below 94cm (South Asian men: Up to 90cm) All women: below 80cm	Men: 94-101cm (South Asian Men: Over 90cm or higher) All Women: 80-88cm	At risk of developing diabetes and heart problems, give advice on diet & exercise (weblinks on results sheet)	Men: *102cm or higher (South Asian Men: 98cm or higher) All women 88cm or higher	Explain at high risk of diabetes and heart disease. Give advice on diet and exercise and refer to weblinks on results sheet.
	NORMAL	**ABNORMAL**	**ACTION**		
Pulse	Regular beat	Irregular beat *	If pulse irregular, possible Atrial Fibrillation, refer to GP/ANP/PN (Patient may need an ECG) Without symptoms = Standard appointment With symptoms = Same day GP appointment (A&E if out of hours) *Possible symptoms may include dizziness shortness of breath or feeling ill.		
QDiabe-tes Risk Tool	5.6% or less	Greater than 5.6%	Requires blood test for HbA1c		
	NORMAL	**HIGH RISK OF DIABETES**	**ACTION**	**POSSIBLE TYPE 2 DIABETES**	**ACTION**
Hba1C (mmol/ mol)	41 or less	42-47	Give lifestyle advice and lab-test form for Hba1C. 42-47 - Will require referral to NHS Diabetes Prevention Programme.	48 or higher	Repeat test using venous sample Standard appointment if no Symptoms present. Same day appointment if Symptoms of Diabetes Present.

	NORMAL	HIGH	ACTION	VERY HIGH	ACTION
Serum Cholesterol (Total cholesterol)	Below 5	5 – 7.4 mmol/L	Give advice on lowering cholesterol. Provide a diet sheet.	7.5 or higher	Give advice on lowering cholesterol – provide a diet sheet or refer to weblinks on results sheet PLUS bloods for Fasting lipid profile, HbA1c, U&E's & eGFR, Thyroid Function (TFT) Liver Function Test (LFT), and a routine appointment.
	NORMAL	**ABNORMAL**	**ACTION**		
HDL	Women: Above 1.2 mmol/L Men: Above 1.0 mmol/L	Women: Low less than 1.2 Men: Low less than 1.0	Advice on how to improve the HDL (diet and exercise; weblinks on results sheet) NB – a HDL of less than 0.8 may be an inaccurate reading. Repeat test if client willing. If HDL remains less than 0.8 with repeat testing, refer for random lipids blood test.		
TC/HDL Ratio	4.5 mmols/L or below	Greater than 4.5mmols/L	If ratio is 4.5 or higher – below 6 give advice as above about reducing total cholesterol and raising HDL If ratio is 6 or higher Refer for fasting lipids blood test.		
Alcohol 'regularly drinking'**	Up to 1-2 units/day (Max14 units/week)	Above 1-2 units/day (Over 14 units/week)	**'Regularly' means drinking every day or most days of the week. Give Brief Intervention Advice on reducing alcohol intake (weblinks on results sheet).		
Audit-C/Alcohol Audit Score	Score of 4 or less on audit c – lower risk.	Score 5 or more on Audit C - complete full Audit questionnaire adding score from Audit C to full Audit score	Full AUDIT score: 0-7 – Lower risk 8-15 - Increasing risk, 16-20 - Higher risk, 20+ - possible dependence. Give brief intervention on alcohol using brief intervention tool. Refer to GP/ANP/PN if score is16-20 if needed. Refer to GP/ANP/NP and or BDAS (020 8289 1999) for scores 20+ and above.		
	LOW RISK	**MODERATE RISK**	**ACTION**	**HIGH RISK**	**ACTION**
Qrisk2 10 year Cardiovascular Risk Score	Below 10% Recall for NHS Health check: in 5 years	10-19.9% RECALL: 5 years	Advise trial of lifestyle modification for 3-12 months. Request blood test in 5 months for Lipid profile, HbA1c, U&E's, eGFR, Thyroid Function (TFT) & Liver function test (LFT) and re-assessment of Qrisk following lifestyle changes.	20% or higher	Blood test for non-fasting Lipid profile, HbA1c, U&E's, eGFR, Thyroid Function (TFT) & Liver function test (LFT). Set Lifestyle goals and refer to GP/NP or PN for discussion about statin therapy following blood tests. RECALL: No further NHS Health checks – will need annual review of CVD risk.

Appointment Type Routine - To see GP/PN 2-3 weeks for non-urgent appointment,
Standard – To see GP/PN within the next week.

THE LONDON BOROUGH

www.bromley.gov.uk