Health and Wellbeing Scrutiny Committee

Health Checks Task Group

November 2013

cfps Centre for Public Scrutiny

accountability, transparency, involvement

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2. Introduction

2.1. Devon County Council Health and Wellbeing Scrutiny Committee was chosen in the summer as one of five Scrutiny Development Area project to examine NHS Health Checks through the lens of the 'Return on Investment' (ROI) scrutiny model developed by CfPS (the Centre for Public Scrutiny). The project itself was initiated by Public Health England who commissioned the support provided to the programme by CfPS. The work was supported through the CfPS with specific time of an expert consultant.

2.2. The Health and Wellbeing Scrutiny Committee established a small task group on the 6th September to examine this work and report back on the 21st November, giving a bit under two months to complete this substantial piece of work

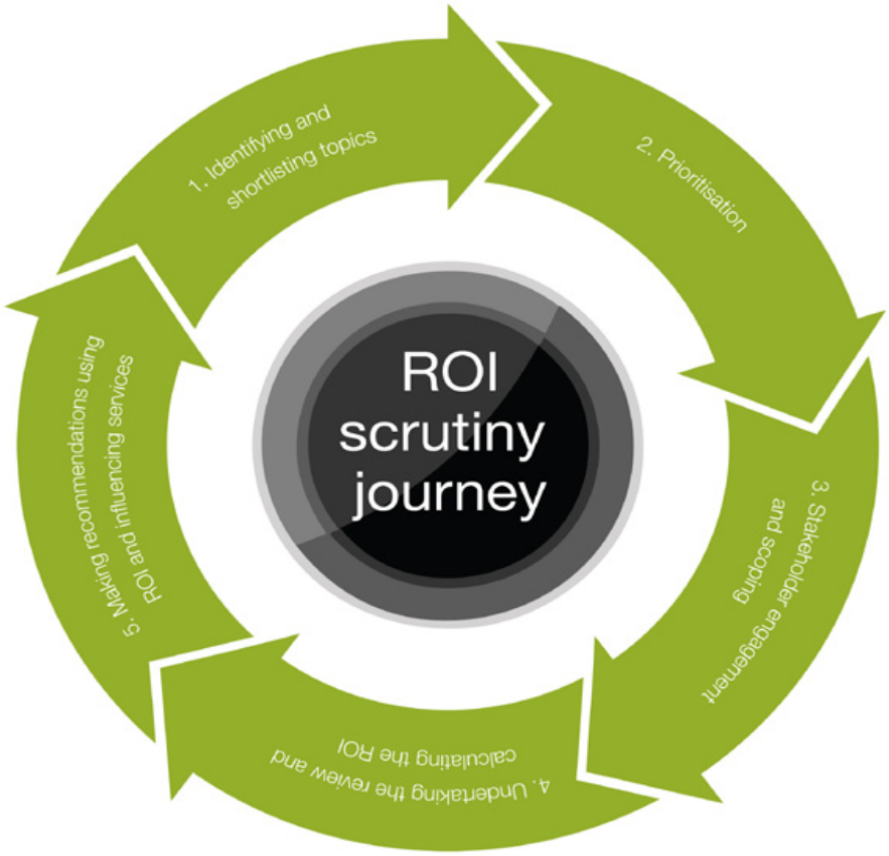
2.3. Due to the need to draw conclusions and recommendations from this work in a very short period of time, the task group determined to focus the scope of the review in order to come up with meaningful contributions and make conclusions about the ROI. Narrowing the focus of the review makes the investigation more achievable within the timeframe as well as increasing the likelihood of reaching well-evidenced conclusions.

2.4. The potential is clear: 'In the two years 2011-13, NHS Health checks were given to approximately 2.4 million people, potentially averting 3,200 heart attacks, 1,300 deaths and 8,000 cases of diabetes'. However there is a significant difference between quantifying the potential and realising it.

2.5. The task group clearly sees the need and potential benefit from the programme. Despite empirical evidence on effectiveness not always being available. However there is not a flat health landscape and the task group would like to see a focus on the quality not just quantity. A goal of 75% take up for those offered health checks may be commended, however if those with the most significant health needs are in the 25% that are not checked the programme is likely to have limited impact.

2.6. The task group is not placed to evaluate the exact quantitative merits of the health checks. The conclusions drawn in this report are taken from modelling data rather than empirical evidence. There is also the separate point that the health check should be one initiative in partnership with other agencies and interventions. **Actually getting someone to think about their health**, **even if the health check does not discover an underlying condition does have merit.**

5.1 The Centre for Public Scrutiny has developed the following tool for analysing and computing the return on investment of investigations. The task group have used it to inform every step of the investigation. Although the broad topic was inspired by the centre for public Scrutiny, the specifics of the question as well as the focus of the investigation was determined and carried out against the backdrop of an appreciation of the local landscape.



3. What are Health Checks?

3.1 The starting point for the task group's work was to understand the nature of the Health Check programme and fully explore the aims of the initiative.

3.2 The Country is facing a significant problem. With the economic climate of recent years there is less public spending. However there is also a significant increase in health need. The burden of non-communicable disease is particularly on the increase, many of which are based on lifestyle choices. Co-ordinated radical action is needed.

The problem

Noncommunicable diseases (NCDs), also known as chronic diseases, are not passed from person to person. They are of long duration and generally slow progression. The four main types of noncommunicable diseases are cardiovascular diseases (like heart attacks and stroke), cancers, chronic respiratory diseases (such as chronic obstructed pulmonary disease and asthma) and diabetes.

The World Health Organisation cites the global impacts as follows:

- Tobacco accounts for almost 6 million deaths every year (including over 600 000 deaths from exposure to second-hand smoke), and is projected to increase to 8 million by 2030.
- About 3.2 million deaths annually can be attributed to insufficient physical activity.
- Approximately 1.7 million deaths are attributable to low fruit and vegetable consumption.
- Half of the 2.3[2] million annual deaths from harmful drinking are from NCDs.

3.3 According to Public Health England, the programme of Health Checks can help to meet this challenge:

'The NHS Health Check programme offers a fantastic opportunity to tackle avoidable deaths, disability and reduce health inequalities in England.' [1]

3.4 A Health Check will offer a series of tests that aim to pick up risk of, or potentially diagnose some of these conditions. These include Coronary Heart disease, diabetes, stoke and kidney failure. They will do this by offering a short check up to everyone over age of 40 and under the age of 74 over a five year rolling programme.

The solution?

For the major non-communicable diseases, studies show that a small number of well-known risk factors contribute to the bulk of the population's attributable risk. These are poor diet, smoking, high blood pressure, obesity, physical inactivity, alcohol use and high cholesterol. Their contribution to ill health and premature mortality in England is so large that unless the numbers in these raised risk categories change substantially, national outcome measures cannot be expected to improve.

It has been estimated that the programme could prevent 1,600 heart attacks and strokes, at least 650 premature deaths, and over 4,000 new cases of diabetes each year. At least 20,000 cases of diabetes or kidney disease could be detected earlier; allowing individuals to be better managed and so improve their quality of life. The estimated cost per quality adjusted life year (QALY) was approximately £3,000, well below the National Institute for Health and Clinical Excellence's (NICE) accepted value for money threshold of £20,000 - £30,000 per QALY.

[1] Public Health England, NHS Health Check implementation review and action plan, July 2013

[2] Public Health Devon

3.5 The task group appreciates that there is scepticism with the introduction of such a wide reaching initiative. However to really have an impact on these major lifestyle related conditions then brave decisions must be taken. The task group understands that the criticisms of the project are firstly about the evidence base for such a programme. Whilst there is much public support for the idea of Health Checking everyone over 40 and under 74, there has not been direct randomised control trials to develop the evidence base for whether or not it actually works. Combined with this a recent Cochrane review was critical about the benefits of previous health check initiatives.

3.6 The Health Check programme is in its infancy in Devon. This has made the work of the task group particularly challenging, as there is not an established data set to analyse. To try to get a sense of possible things that might be successful as well as anticipated concerns the task group ran a very short questionnaire to GP surgeries throughout Devon. The aim of the survey was to get a very quick sense of what GPs think of the initiative, to identify where there may be opportunities to improve the service as well as to gauge whether or not the checks are likely to be value for money. The task group recognise the limitations with this approach.

What do GPs think?

3.7 To begin to ask meaningful questions about the health check programme in Devon the task group sent a very short survey to all GPs in Devon (Appendix 1). With just six questions

3.8 There are 127 GP practices in the NEW Devon CCG area, and 37 in the South Devon and Torbay CCG area. The task group have heard that the overwhelming majority of GP surgeries have signed up to administer health checks. The survey catalogued 80 different responses, giving a response rate of 49%. However, there were a number of technical difficulties and limitations with the survey, which indicate that there could have been a higher response rate. A further complication is that some of the respondents may be from the same GP practice as this was possible. No respondents were required to identify themselves in order to promote more candid answers.

3.9 The numbers are too small to draw statistical conclusions, but the feedback from the survey does suggest that there may be a more positive reaction if surgeries see a positive impact having carried out a number of health checks.

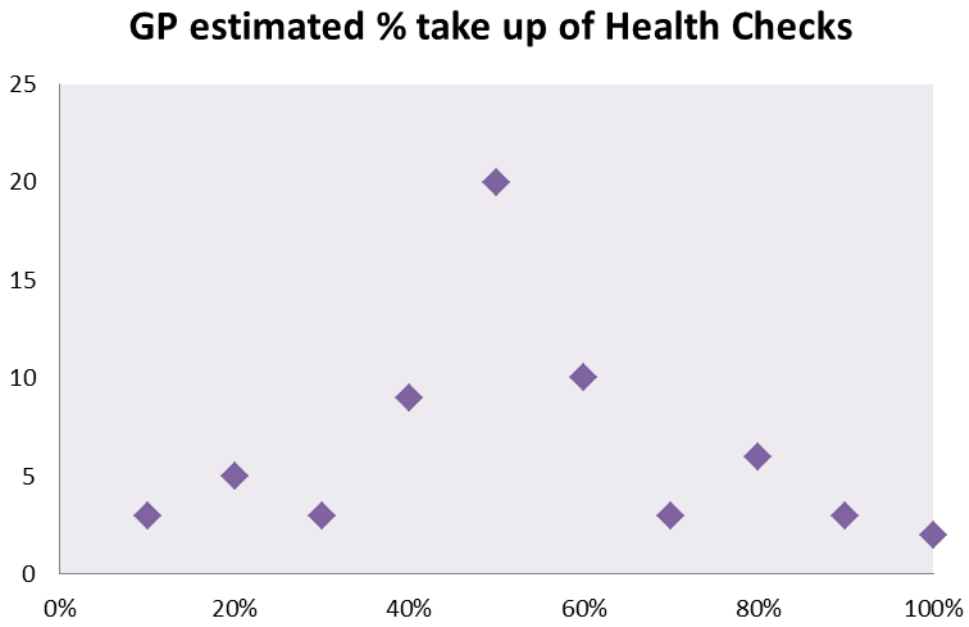
‘Having carried out just over 40 checks, we have referred 7 patients for further tests and 5 to a GP re CVD risk over 20%. We have initially targeted the 40-50 age bracket and I think the checks are beneficial as it targets those patients who don't come to the doctors on a regularly basis.’ Devon GP

3.10 There is a lot of concern regarding the people who will be invited to a Health Check and those that will come in. Harder to reach groups and isolated individuals are likely to be the ones who would benefit more from receiving a Health Check.

‘I feel they will exacerbate health inequalities, the uptake in the difficult to access sections of the population will be minimal whilst more educated motivated individuals will access them. A fair proportion of this population will already have sought advice.’ Devon GP

3.11 Out of respondents the total number of Health checks estimated to be offered is 24407, this represents 10% of the total eligible population in Devon, 2449343 when put with the specific percentage that each respondent estimated the figure anticipated to go to a Health Check is 14749, or 6% of the total eligible.

3.12 There was significant variation over the estimated percentage of people who when offered a health check would turn up. The range was from 10% to 100% and covered everything in between; the spread is demonstrated on the graph below:



3.13 With an average of 51%, the estimated take up is lower than the 75% used to model the benefits of the Health Check by Public Health England. This is significant as the basis for the projecting the benefits of the Health Check programme is on a 75% take up rate. The target is then to increase take up to 100% of those being offered a Health Check taking it up within 5 years. With only one GP surgery estimating 100% take up rate, this seems wildly optimistic.

3.14 Getting individuals to attend a health check is only part of the challenge. In fact the follow up support after the health check is crucial. In part this will rely upon joined-up commissioning to provide evidence-based services to help people make the changes that may be identified in the health check.

[3] NHS Health Check website
http://www.healthcheck.nhs.uk/public/interactive_map/south_of_england/devon_cornwall_and_somerset/?la=Devon&laid=126

4. Isolated groups

4.1 Having established the scope of the programme and the opinion of General Practitioners, the task group needed to determine exactly what areas they might be able to draw meaningful conclusions from in the time allotted. The starting point for this consideration came about through reflection and an iterative process of discussions:

Can Health Checks improve Health Equality?
If so – How?

4.2 The fundamental concept is that the Health Check Programme applies an equal approach and the model of return on investment benefits assumes and equal distribution of treatable conditions. In reality different people, communities and groups have differing levels of need complicated with different ways of getting help or helping themselves.

'Generic health improvement or commissioning policies will be unlikely to need the needs of these groups, unless they recognise how vulnerability impacts upon access to services' [4]

4.3 Local Authorities have a duty to reduce Health Inequality in their areas. The task group considered information from Public Health and discussed the topic within their frame of reference. Working through the logic of the problem they came to the working hypothesis that:

People in groups with the poorest health outcomes are likely to be the ones that will benefit most from receiving a Health Check.

4.4 This is entirely in line with Marmot's concept of proportionate universalism. Where targeted support and initiatives can have a greater impact upon equality. With the support of the CfPS consultant, the task group worked through the considerations for an Return On Investment question. The task group felt that building on the work and considerations that had already been taken into account

What would be the ROI of improving the access to NHS Health Checks for our less accessible and most isolated groups?

4.5 The starting point for the enquiry must be:

In Devon which groups of people have the poorest Health Outcomes?

4.6 To determine the groups to focus upon, the task group undertook an analysis of the Joint Strategic Needs Assessment, Health and Wellbeing priorities as well as information received from the Insight and Impact team at DCC. To identify the groups the task group considered targeted behaviour and physiological risk factors that the health check will try to address. These are as follows:

- Smoking
- Physical activity
- Poor diet
- Too much alcohol
- Raised cholesterol
- High blood pressure
- Obesity

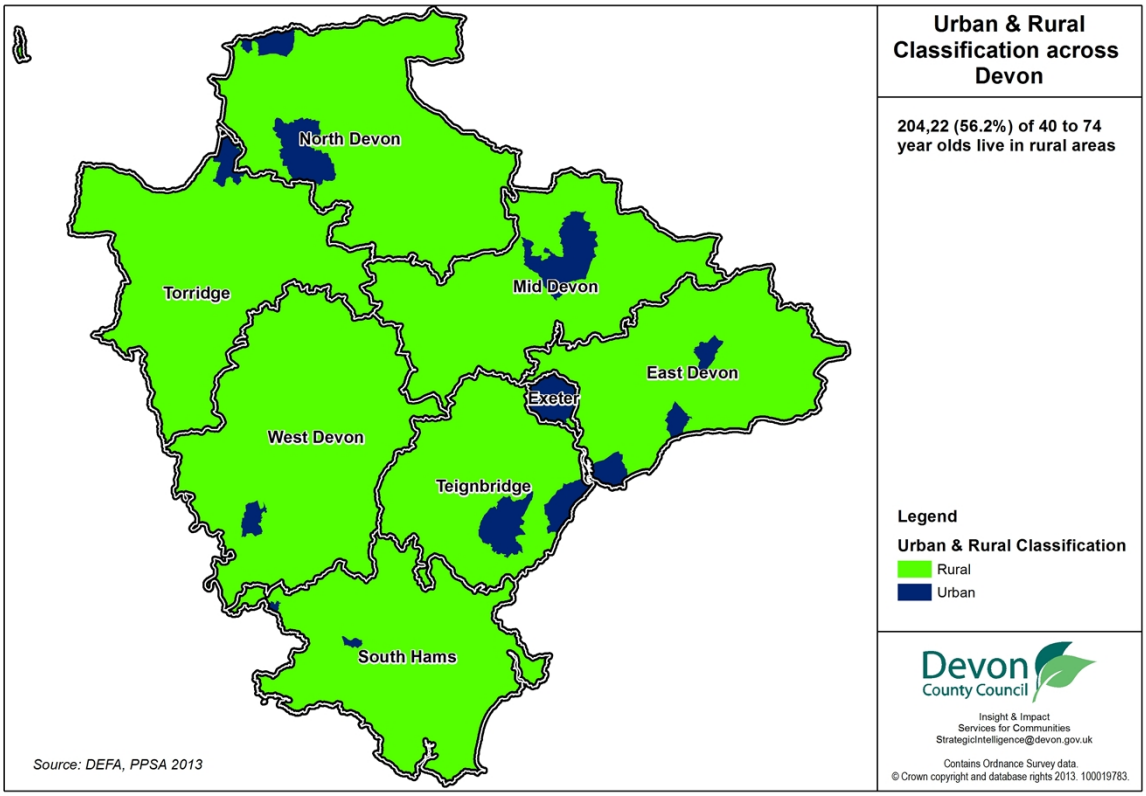
[4] Devon County Council Annual Public Health Report 2012-13 pg 48

4.7 The task group anticipated that taking evidence-based approach would lead to several discrete categories. For illustration, the list may include some or all of the following: Those who are rurally isolated, people claiming benefits, ex-offenders, victims of domestic violence, veterans, gypsies and travellers and many others. Of course the filter will need to include age as only 40 – 74 year olds are offered the health check.

Area for consideration	**How high a priority is this in the JSNA?** High/Medium/Low	**How available are measures and info?** Very/Reasonably/ Scarcely	**How much influence is the scrutiny review likely to have?** High/Medium/Low	**Overall what value will it add to include this area in the review?** High/Medium/Low	
Men 40 -70	Medium	Very – general figs.		Low – too wide	x
Women 40-70	Medium	Very – general figs		Low – too wide	x
People claiming benefits	High – but implicit rather than a separate category	Too fragmented to track			x
Ex-Offenders	High	Reasonable	High	High	✓
Veterans	High	Reasonable	High	High	✓
Rurally Isolated	Medium - implicit	Reasonable (for those we know about)	High	High	✓
Farmers	Medium	Very – general figs	High	High	✓
Homeless People	High	Reasonable	High	High	✓
Gypsies and travellers	Low	Scarcely	Low	Low	x
BME Communities	Medium	Reasonably – general figs	High	Medium – very small disparate population	x

4.8 The task group subsequently determined to focus attentions on two groups – those that are isolated both in a rural settings, and those who are isolated in an Urban setting. The breakdown of geography in the defined categories of 'urban' and 'rural' are displayed on the map over the page.

4.9 The task group then developed this idea further and in conjunction with previously identified isolated communities. This led to looking at rurally isolated farmers and urban isolated group made up of ex-offenders, the homeless and veterans. This was in recognition that it is not uncommon for one person to be in all of these groups. The task group then held two stakeholder sessions structured around each group.



5. Where is the Return on Investment?

Urban Isolation and associated health problems

5.2 The task group overlaid three communities of individuals with the belief that some people will actually be in all three categories. The homeless, ex-offenders and some veterans as discrete communities do have significant health need.

5.3 There are a disproportionate percentage of veterans in the criminal justice system. There are likely to be numerous reasons for this, however there does appear to be a link with young men and a low self worth or self esteem. There is no concrete figure to quantify and many guestimates range, as follows. What remains consistent is that there is likely to be a high degree of under reporting so the correlation is probably higher than the figures indicate:

- Studies conducted by the Home Office between 2000 and 2003 indicated between 4% and 6% of the prison population were veterans which would equate to 5000 prisoners
- The Ministry of Defence (DASA) recently suggested about 3.5% of the prison population are former service personnel which equates to 3,000 prisoners
- The Veterans in Prison Association has suggested it is over 9% = 7,650 prisoners
- **A study in 2007 at HMP Dartmoor suggested 17% of its population were veterans**
- Other individual prisons are quoting approximately 14% [5]

[5] The Veterans Change Partnership Business Plan, March 2011

5.4 There are figures that suggest the return on investment of engaging with these particular groups. For example 52% of the Ex-Service Community report a long term illness, disability or infirmity compared to 35% of the non- Ex-Service Community. They are '…also at risk of cardiovascular and respiratory conditions than their peers nationally.'[6]

5.5 It is unlikely that the standard Health Check will address many of the prevalent health issues for the urban isolated groups. Although these groups are likely to smoke, drink too much and suffer from cardio-vascular diseases, they are also likely to be experiencing a number of other health issues, such as mental health problems and substance misuse, which are not addressed at all in the standard Health Check.

5.6 Because of these particular health issues and risk factors, people in these groups tend to 'age faster' than the general population, and therefore the group did not consider that the 40-74 age range was particularly relevant for urban isolated groups. However it is also worth noting that the average age of services users at EDP Drug and Alcohol Services is going up, with many users over the age of 40, and in prison populations, the highest growing age group is the over 50s.

Rural Isolation and associated health problems

5.7 Benefits of carrying out health checks on farmers were identified as being prevention and management of illness through education and early intervention. This means that not only is the individual farmer healthier, he should be able to carry on working for longer, which will benefit the family, but also the local economy as a whole. The longer that farmers are able to keep on farming, the higher rate of local food production there is, and the group considered the impact that improving farmer health could have on improving or maintaining economic output in the region.

'Agriculture is responsible for about twice as much employment in Devon as it is generally in Great Britain'[7]

5.8 The long term effects on health from the manual nature of farming work and the long working life of farmers, often well past retirement age, was also evident. Although farm work remains a manual job, with modern farming methods and machinery it is now less physically demanding, however many farmers continue to eat the same high fat, high calorie foods as they did in previous years, leading to an increasing threat of obesity related conditions.

5.9 When comparing farmer's health issues to national health issues, the unique nature of farming was highlighted, showing that generally farmers tend to put the health of their animals and their farm before themselves. There is a high prevalence of depression and suicide among farmers. Contributing factors include working alone, having access to the 'means' to take their own life, and even the fact that farmers have put ill animals down themselves, affecting their outlook on sickness, life and death.

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[6] Royal British Legion: 'Profile and Needs of the Ex-Service Community 2005-2020, summary and conclusions of the Welfare Needs Research Programme, September 2006, pg 15

[7] Lobley, Thomson and Barr, 'A review of Devon's food economy'; University of Exeter, centre for rural policy. 2012 http://socialsciences.exeter.ac.uk/media/universityofexeter/research/microsites/centreforruralpolicyresearch/pdfs/researchreports/Devon's_Food_Economy_FINAL.pdf

Mental Health

5.10 The task group feels strongly that mental health should be an integral part of the health check process. The task group have encountered some of the challenges associated with mental health conditions as a result of the urban and rural isolated groups. The stigma attached to having a mental health condition is significant and anecdotally service personnel are less likely to come forward to be diagnosed because of an ethos of not asking for help.

'From a family perspective mental health is the hardest to deal with… you can't put a plaster on it'[8]

5.11 The mental health of veterans is an increasing problem:

- Roughly 1 in 1,000 serving personnel will be diagnosed with PTSD – this is much lower than in the US where it is approximately 20%.
- Reservists are at greater risk than regular serving personnel both suffering with PTSD and presenting at a more developed level.
- 80% of new patients getting help via combat stress have tried to get help from the NHS.
- 69% have a present or past history of drug, alcohol, dependency and abuse.
- Suicide rates for ex-service personnel are two to three times higher than for their civilian counterparts.[9]

5.12 Mental health presents a particular challenge as the symptoms are often not encountered until many years after the damage is sustained. For PTSD it is not uncommon for symptoms to present 13 years after the trauma. At this stage the individual may not relate the mental health condition back to their time in the military, especially if this time was short.

Will Health Checks meet their aims?

'To lessen the impact of non-communicable disease on individuals and society, a comprehensive approach is needed that requires all sectors, including health, finance, foreign affairs, education, agriculture, planning and others, to work together to reduce the risks associated with NCDs, as well as promote the interventions to prevent and control them.'[10]

5.13 Over a third of GP respondents to the task group's survey were unsure about whether or not the programme would achieve its aims. Whilst there are some very negative reactions to the programme from GP practices, there are significant numbers who are quietly optimistic or who are waiting to see any evidence before making up their minds.

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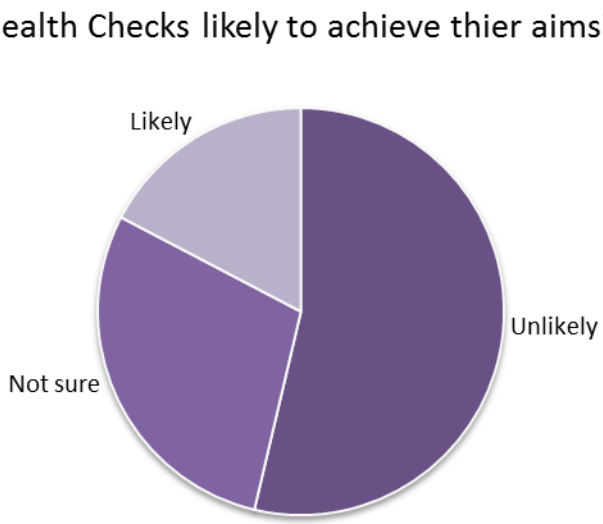
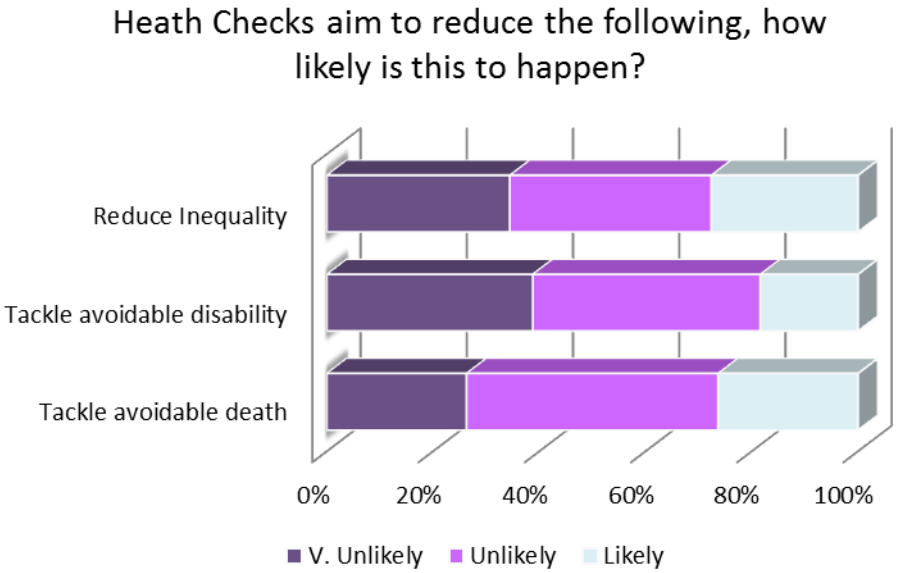
[8] Family member of a soldier diagnosed with PTSD

[9] Royal British Legion magazine, Jan/Feb. 2012

[10] World Health Organisation Prevention and control of NCDs http://www.who.int/mediacentre/factsheets/fs355/en/



5.14 Out of those respondents who did have a view, about 75% are pessimistic about the Health Check programme. Overall between 20% and 30% think that Health Checks are very unlikely to reduce health inequalities, or contribute to avoiding disability or death. The strength of feeling is particularly noticeable with only one respondent saying that Health Checks are very likely to reduce avoidable deaths.



5.15 Public Health England has estimated that the benefits of the Health Check programme on 75% take up of those people offered a health check. However the task group believes that this figure is optimistic at best. The table below is taken from the 'Ready Reckoner' and models the return on investment for a lower take up, with the same assumptions.

	Costs incurred		Savings		Net savings	
	75% take up	50% take up	75% take up	50% take up	75% take up	50% take up
1st year after checks	£1,753,669	£1,169,113	£287,206	£191,471	£1,466,463	£977,642
5th year after checks	£3,635,910	£2,423,940	£1,897,643	£1,265,095	£1,738,267	£1,158,845
10th year after checks	£4,392,126	£2,928,084	£3,925,900	£2,617,267	£466,226	£310,817
15th year after checks	£5,320,645	£3,547,097	£5,320,345	£3,546,897	£300	£200
20th year after checks	£6,040,887	£4,027,258	£6,347,065	£4,231,377	-£306,178	-£204,119

[11]

5.16 Many of the isolated groups are likely to have barriers engaging with GPs and may wait until a problem is so severe that they present at A&E. A visit to a GP's surgery costs approximately £25, compared to an average of £88 for a visit to A&E[12] and an overnight stay can be very expensive with a starting point of £255 a night.

What do GPs really think?

5.17 The two open questions at the end of the survey are perhaps the most illuminating. As these questions were completely free text analysis always presents challenges. However it was felt that allowing unrestricted comments was the best way of gauging exact opinions. For the first question there were a total of sixty seven respondents, almost 85% of all returned surveys. This may be taken to indicate that GP practices are highly interested in these issues. The strength of feeling is quite marked.

5.18 To analyse the data, a summary of comments has been developed from the responses. This enables an overview of recurring comments, even if they are not identical. On the chart below the positivity of the responses is reflected in the colour scheme, the lighter blue columns are broadly positive, whilst the darker blue columns are more negative. This overview shows that the comments are by no means all negative. Many GP surgeries identify that patients like the idea of Health Checks and that recognise the potential to bring people into the surgery that would not normally come. However there are significant concerns over the evidence base to support the initiative with clinicians thinking it is just being done as a political panacea reflected in their concern that it will not reach the individuals who would most benefit and as a result will be a waste of resources for surgeries.

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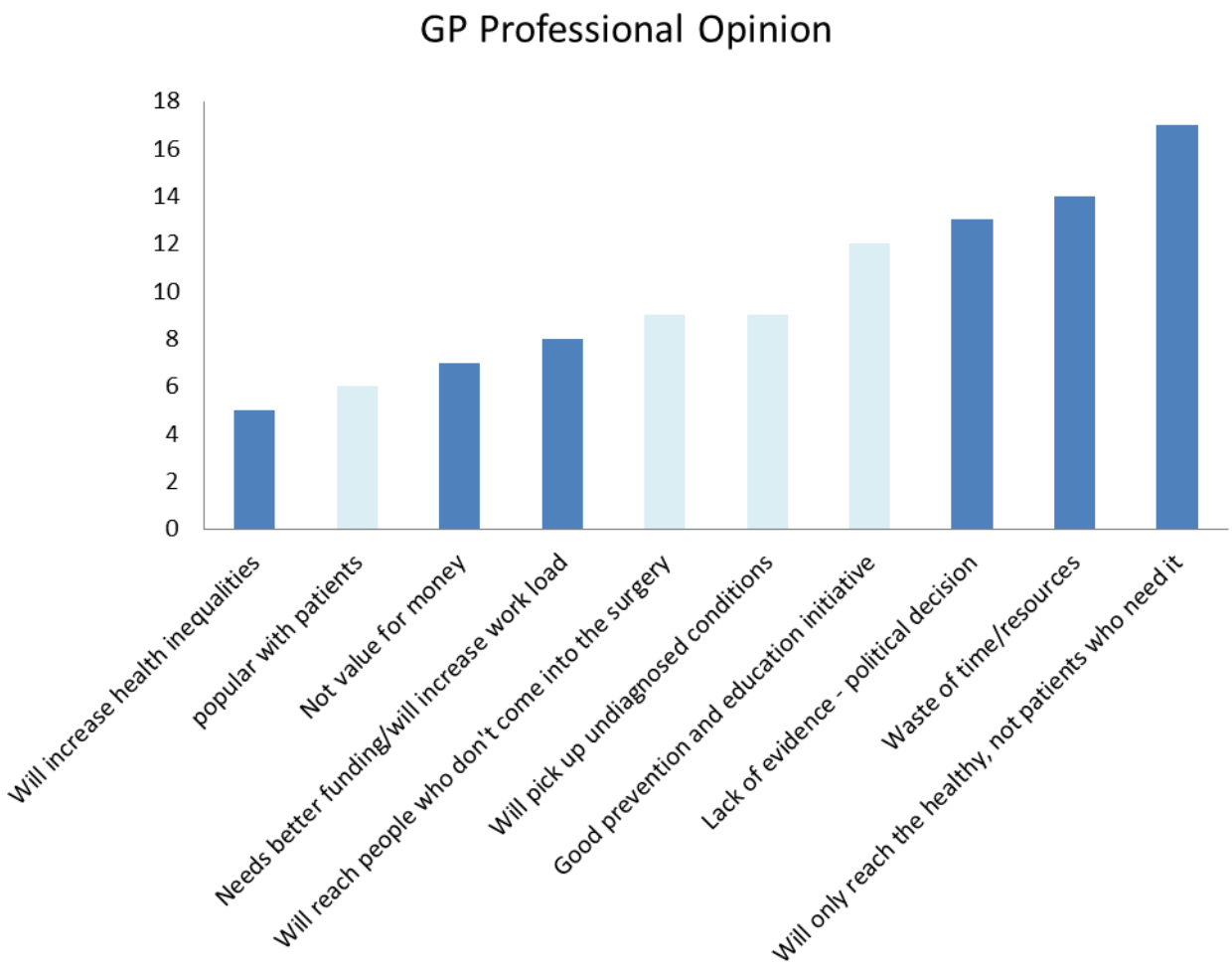
[11] http://www.google.co.uk/url?sa=t&rct=j&q=&esrc=s&frm=1&source=web&cd=2&cad=rja&ved=0CDUQFjAB&url=http%3A%2F%2Fwww.healthcheck.nhs.uk%2Fdocument.php%3Fo%3D287&ei=Y0BBUomgO6bR7AaTn4H4Bg&usg=AFQjCNETjU1hdIDoHAWplLrm2STV3rgDiQ

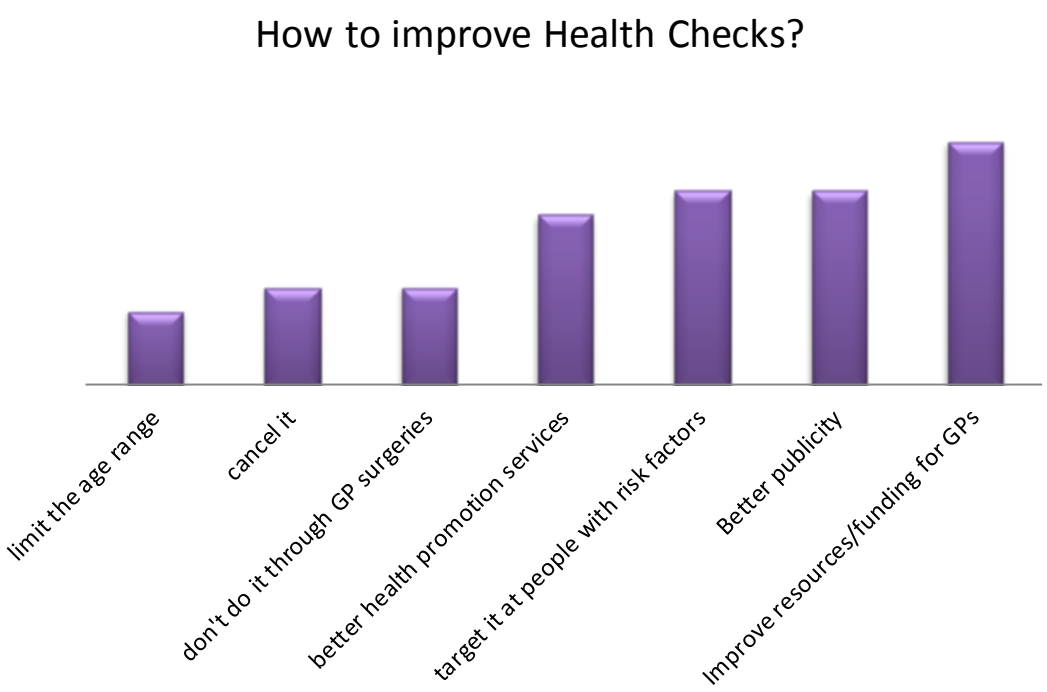
[12] http://www.northwest.nhs.uk/document_uploads/Choose%20Well/A4_feeling_unwell_posters.pdf



'It is a complete waste of money and time. It is politically driven and non- evidence based. It is very likely to cause increases in patient anxiety but will have no effect at all on population morbidity and mortality. As such it will have no beneficial health outcomes but due to its use of resources inappropriately it will divert GP time towards the worried well and away from the sick and needy.' Devon GP

'Great for offering to men as they are the ones who will not make appointments themselves and are not currently encouraged to get wellbeing checks. Very valuable.' Devon GP

5.19 Finally the survey asked for suggestions as to how the Health Check programme could be improved. Again this was an open question, but the results have been synthesised into recurring topics. This is displayed on the graph below:



5.20 Although many GPs highlight a need for greater funding to enable more time to be spend on the initiative, other suggestions such as better, more targeted publicity and very specific targeted support have been spontaneously highlighted:

> *'targeted interventions to pubs / clubs, unemployment offices where tend to be a higher proportion of ill people who may have treatable conditions'* Devon GP

There are also some interesting ideas such as the following:

> *'Fund intelligent 'patient pods' in surgeries that can check height/weight /pulse/BP/chol/glucose while the patient waits in the GP waiting room for their appointment - opportunistic'* Devon GP

5.21 Health Checks may offer the opportunity to inspire individuals to be engaged with the healthcare system in ways that they had previously not been. However the Health Check itself is unlikely to lead to significant change without serious interventions to change ingrained behaviour.

People who were invited to a health check and turn up	People who were invited to a health check and do not turn up	People who were not invited, because they are not registered with GP
Benefit of a HC: Reassurance?	Benefit of a HC: Rectify?	Benefit of a HC: Rehabilitation?

6. How to engage hard to reach groups?

The task group has synthesised the testimonies, experience and evidence shared by witnesses and come up with the following:

1. **Trust** – How the Health check is administered and by whom can be very important on firstly getting the individual into having the check but also in following up the lifestyle advice or support afterwards.

   How?

   This requires an understanding of the community that you are trying to reach. Tapping into existing forms of support is crucial. Different communities will have a range of different contacts and supports within their community, peer-to-peer support can be particularly helpful. This helps to embed the idea of having the check and what lifestyle changes or modifications might be appropriate.

   Example:

   In the rurally isolated group a number of farmers identified vets as their first point of health care advice. They were more likely to listen to their vet and trust their judgement.

> "The Forces Veterans for Veterans group which regularly meets in Exmouth offers a coffee drop-in session, which provides peer to peer support for local veterans and their families, including those who suffer with PTSD and associated mental illnesses. The Veterans themselves are keen to offer support to others with similar issues. They recognize that "speaking the same language" and "having a shared experience" is key to helping people move on in their lives.
> This would enable the Veterans to talk about their issues, be it PTSD, anxiety, depression, anger or alcohol difficulties, with someone that has "been there".
>
> The peer support outreach work is recognized by the Veterans as a very rewarding and positive way of working. It not only helps the new referral, who quite often has bottled up their feelings and emotions for many years, but also helps the outreach workers build their own confidence, self-esteem and pride.
>
> The all-round feeling of sharing their experiences has an almost instant healing effect, with new referrals realizing that, "they are not on their own" and often say, "at last I can speak to someone who understands me".

2. **Ease** of access – it has to be simple and convenient for the individual to get to.

   How?

   Identifying places or events that the person is already familiar with and going to them. This requires an appreciation of the group that is trying to be reached to identify the most appropriate level of engagement. This may require out of hours doctors surgeries and opening weekends.

   Example:

   The Royal Borough of Greenwich targeted specific points for the BME community. The borough worked with local religious leaders to promote the programme.

3. **Whole person approach –** simply inviting people in for a health check is only one very small part of the process. If we are talking about improving health inequality, there are many other faculties that contribute to health and wellbeing.

   How?

Having more than the health check under one roof. Utilising a venue that is also frequented by the individual with other services also available.

Example:

See the box below

Community Hubs

Who?

Devon & Cornwall Probation Trust have been instrumental in facilitating a number of Community Hubs around Devon and Cornwall during 2013/14. They are working with a wide range of partners, mainly from the voluntary and community sector to establish these. In the main they are centres that already exist, offering a wide range of services and opportunities to both offenders and others with complex needs.

Why?

Research shows that reducing re-offending is more likely if the label of 'offender' is removed and people are supported near to where they live. Hubs provide a wide range of people (not just offenders) with opportunities and support to address various issues and difficulties in their lives including: housing, debt, relationships, drug & alcohol, etc. A joined up approach where different problems and blocks can be addresses, in one place, rather than the more familiar siloed approach. This can provide real benefit as well as reducing the risks people face falling between different services. Different staff teams and organisations working together, sharing skills and information is also effective and efficient.

What ?

In different places Community Hubs will look different, as they will grow out of existing projects, where relationship and support is already available and established. As an example in Barnstaple this is at the Freedom Centre, which for many years has provided a range of services and support, including meals, internet access, a gym, and housing advice. Now through the development as a Hub, it has additional services including Drug & Alcohol workers, Probation staff and the North Devon District Council's Local Welfare Support Service.

Where?

Initially eight hubs will be developed throughout Devon and Cornwall, including Barnstaple and Exeter. It is however envisaged that the model of Hubs needs to grow as if establishing a range of services near to where people live is important, then in a mainly rural county, many more would be advantageous. Therefore if there is a need in Barnstaple there is an equal need in Bideford and Ilfracombe. Likewise in East Devon, Mid Devon, West Devon, Teignbridge and the South Hams Hubs are being explored.

When?

The first Community Hub opened in October 2013 at the Freedom Centre Barnstaple, with seven more throughout Devon and Cornwall opening before April 2014.

How?

The Hub model is a simple approach that enables those with complex needs, requiring a range of different services and interventions to access these easily in one place. Experience at the Freedom Centre shows this approach is working and both appreciated by the client and the various workers.

4. **Follow up** – what interventions are required? The success of the programme will stand or fall on the quality of evidence-based initiatives that are available.

5. **Quality** and consistency of Health Checks offered.
   How: The task group has heard that a comprehensive training programme has been implemented across Devon.

6. **Information and communication.** People need to know what the programme is, who might be eligible and who would not be?
   How: There is a large element of this programme that offers reassurance and this should be followed through in clear lines of communication.
   Example:
   Health Checks to carers were promoted directly by support workers and word-of-mouth, this was more effective than generic information through GPs.

5.22 A final point is that the timing of the health check can be quite crucial. For some of the groups the task group has considered there is the opportunity to make a positive intervention in people's lives if it is done in the right way. For veterans and ex-offenders it is at the point of departure from the forces or from the justice system. This offers a time frame when lifestyle interventions are far more likely to have salience.

7. Conclusion

The task group have carried out a short investigation into the programme of NHS Health checks with a particular focus on activity and uptake in Devon. Whilst it is too early to draw conclusions or evaluate the Health Check activity in Devon there do appear to be positive results coming from ones that have been done. However in light of the lack of evidence proving the initiative and the significant concerns of practitioners it is difficult to be entirely positive.

The task group have always believed that there is a greater return on investment by focussing on those with highest need. Whilst a health check is not going to actively support a drug addict, getting individuals to engage with health care professionals may be the start of a rehabilitation programme.

GP opinion is mixed. There is a tendency towards seeing the intervention as a waste of time and not believing that there will be a significant return on investment from it. Most GPs still need to be convinced if there is value in carrying out the Health Checks initiative. In line with the task group's thinking, many GPs highlighted the need to target the people that they struggle to get to attend surgeries and suggest that there could be a higher impact from a project that seeks to do that.

The Health Committee may wish to review the Health Check programme in Devon once it has embedded to identify whether or not the aims are being achieved.

8. Membership

Chairman Councillor Richard Westlake

Councillors Caroline Chugg and Claire Wright

9. Contact

For comments or further information regarding this report please contact

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10. Sources of evidence:

Expert Witnesses

The task group heard testimony from a number of sources and would like to express sincere thanks to the following for their involvement and the information that they have shared as well as to express a desire of continuation of joint work towards the fulfilment of the recommendations in this document.

Name	Job Title	Organisation
Tina Henry	Public Health Specialist	Devon County Council
Jenny McNeil	Associate, delivery Directorate	NEW Devon CCG
Sallie Ecroyd	Head of Communications	South Devon & Torbay CCG
Jacob Dunkley		South Devon & Torbay CCG
Andrew Butler	Devon County Advisor	South West NFU
Joanne Jones	Co-ordinator	Farming Community Network Devon
Mark Lane	Armed Forces Lead	Devon County Council
Mel Hartley	Project Manager	St Petrocks
Mary Greener	Director	EDP Drug & Alcohol Services
John Pattison	Social Worker, Veterans Lead	Devon Partnership NHS Trust
Adrian Thornton	Lead for Forces Veterans for Veterans	Forces Veterans for Veterans (FV2)
Trevor Gardiner	Project Manager	Devon & Cornwall Probation Trust
Bea Knight		Exeter 10'000 Project
Simon Perkins	Partnership and Joint Commissioning Manager	Devon & Cornwall Probation Trust
Dr Philippa Smithson	GP	Clock Tower Surgery

Robin Head	Farmer	Devon Farms

The task group would also like to place on record its appreciation of the time taken by the eighty GPs to complete the survey, and likewise for the fifteen farmers who completed the survey run by the Farming Community Network.

Documents/Links

- 'Our Approach to the Evidence': https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/224537/NHS_Health_Check_our_approach_to_the_evidence_v2.pdf
- 'Press Release – NHS Health Checks': https://www.gov.uk/government/news/nhs-health-checks
- ASH http://www.ash.org.uk/localtoolkit/R9-SW.html
- Devon County Council Annual Public Health Report 2012-13
- Homeless Link; The Health and Wellbeing of People who are Homeless: Evidence from a National Audit' 2010
- Krogsboll, L.T., Jorgensen, K.J., Gronhoj Larsen, C., Gotzsche, P.C. General Health Checks in Adults for Reducing Morbidity and Mortality from Disease: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD009009.pub2/pdf (2013)
- Lobley, Thomson and Barr, 'A review of Devon's food economy'; University of Exeter, centre for rural policy. 2012 http://socialsciences.exeter.ac.uk/media/universityofexeter/research/microsites/centreforruralpolicyresearch/pdfs/researchreports/Devon's_Food_Economy_FINAL.pdf
- Public Health England, knowledge and intelligence team, Offender health http://www.nepho.org.uk/topics/Offender%20Health
- Public Health England, NHS Health Check implementation review and action plan, July 2013 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/224536/NHS_Health_Check_implementation_review_and_action_plan_summary_web.pdf
- Royal British Legion magazine, Jan/Feb. 2012
- Royal British Legion: 'Profile and Needs of the Ex-Service Community 2005-2020, summary and conclusions of the Welfare Needs Research Programme, September 2006
- The Veterans Change Partnership Business Plan, March 2011

Appendix: 1 Health Check Task Group GP Survey

1. **Is your surgery offering Health Checks?**

Yes No

2. **How many people do you anticipate offering Health Checks to in the first 12 months?**

3. **Out of the people who are invited to a Health Check, what percentage would you anticipate taking up the offer?**

4. **Please could you indicate how likely you think the Health Checks Programme will meet the following stated aims?**

4.1 Tackle avoidable deaths

Scale of 1 – 5 where 5 = very likely and 1= very unlikely

4.2 Tackle avoidable disability

Scale of 1 – 5 where 5 = very likely and 1= very unlikely

4.3 Reduce Health Inequalities

Scale of 1 – 5 where 5 = very likely and 1= very unlikely

5. **What is your professional view on the Health Checks programme?**

6. **In your opinion, what could make the local programme more effective?**