

# Delivering the NHS Health Check in Islington: Targeting high risk groups

## Introduction

As of 2011, cardiovascular disease (CVD) was responsible for over 20% of the life expectancy gap in women and almost 40% in men in the London borough of Islington when compared to the rest of England. Targeting high risk groups with the NHS Health Check programme was identified as the best way to reduce this health inequality gap.

## Background

The London Borough of Islington is the 14th most deprived in England. There are an estimated 68,200 people aged 40-74 years in Islington, which is equivalent to 31% of the whole population. On average life expectancy in Islington at birth is 78.2 years for males and 83.4 years for females. However, both male and female residents with conditions such as CVD have a lower healthy life expectancy (57.2 years and 58.7 years respectively) compared to the national average (63.3 years and 63.9 years respectively). CVD has had a significant impact on the health of Islington's population and the borough was lagging behind the rest of England in improving its CVD health.

Additionally, there have been longstanding health inequalities in Islington between deprived areas and ethnic groups. This is particularly visible in CVD prevalence and mortality. As of 2011, people living in Islington's most deprived areas were more likely to be diagnosed with coronary heart disease (CHD) than those living in less deprived areas. Within the population, people from Asian and black backgrounds were more likely to be diagnosed with diabetes, high blood pressure, chronic kidney disease (CKD), CHD (Asian people only) and stroke (black people only).

## Why was a programme to target high risk groups developed?

Several underlying issues were identified as causing the life expectancy and health inequalities:

- **Prevalence gap:** In 2010-2011 there was an estimated 40,000 undiagnosed cases of hypertension, diabetes, CHD and CKD in Islington.
- **Differences in access to health care:** In March 2011 people with high risk of CVD from ethnic minority groups were less likely to have received a CVD assessment than their white counterparts. There was also significant variation in the percentage of population that received a NHS Health Check depending on the practice where they were registered.
- **Differences in diagnosis:** People with learning disabilities are less likely to report symptoms than other groups, and are less likely to receive checks for blood pressure or cholesterol compared to the general population. People with learning disabilities are also more likely to have reported symptoms which were overlooked. This is known as diagnostic overshadowing - when a patient's symptoms are over-attributed to an existing condition resulting in key co-morbidities being undiagnosed and untreated.
- **Differences in the prevalence of risk factors:** Obesity and smoking contributed to at least 45% more diagnosed long term conditions in the most deprived parts of Islington compared to the most affluent in 2011. Moreover, people with poor mental health have poorer health outcomes compared with the general population. Islington has a significantly higher proportion of serious mental illness compared with the national average. A local CVD deaths audit in 2004-2006 found that 40% of those who died had poor mental health.

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The 2007 Annual Public Health Report 'Reducing early deaths from CVD in Islington' looked into why premature CVD mortality continued to be higher than other comparable boroughs, such as Camden, and made recommendations on how to reduce CVD death... These recommendations included which groups of people, diseases and risk factors should be targeted for the highest impact on CVD mortality.

An evaluation of the Local Incentive Scheme for Cardiovascular Disease 2009-2010 was carried out in 2010 and highlighted the need for a broader approach to CVD case finding in Islington. This work was used to identify which groups should be targeted for the highest impact on CVD related health inequalities:

- high CVD risk patients
- people from deprived areas
- ethnic minorities (especially south Asian)
- people with mental health and/or learning disabilities
- men.

The analysis also showed that prevalence of high CVD risk was high among young deprived people. This suggested that the check should be extended to people from the age of 35 years.

## How was the programme implemented?

A combination of existing local intelligence and relationships, learning from other boroughs as well as national guidance was used to agree how to approach specific target groups. Local analysis informed the decision to amend the national eligibility criteria and extend the programme to individuals aged 35-39 years locally.

The NHS Health Check programme in Islington is also supported by an active steering group, including representatives of the local commissioners, primary care representatives, pharmacies, medical unions and patients, as well as a consultant biochemist.

The steering group advised the programme leads on key decisions, including the focus of checks in primary care on high risk populations and delivery of the NHS Health Check in community settings.

Local GPs were asked to focus on delivering checks to people with high CVD risk, as well as people on mental health/learning disability registers. Historically good relationships with general practice, as well as access to patient records and mental health/learning disability registers put GPs at the forefront of delivery to these target groups.

Pharmacy (particularly those in the most deprived areas) and community groups were asked to prioritise delivery to Islington residents who were not registered with a GP, or who were registered but did not access primary health care on a regular basis.

Examples from other local authorities suggested that a selection of community settings should be used to target people from deprived areas, ethnic minorities and men. These groups tend not to engage with primary care, for reasons such as cultural, language or belief barriers. A combination of static (pharmacy) and flexible (community) units in areas of high density of target groups were used to maximise the uptake of checks. Good relationships with the community, voluntary and social care sectors allowed for engagement with the public in venues such as community centres, places of worship, libraries, housing estates, local markets and employers, as well as local events.

Improvements in point of care testing (POCT) and increased affordability allowed for quicker, safer and more accurate testing in community and pharmacy venues. Developments of software helped to structure the experience by creating online templates for NHS Health Check, as well as allowing for streamlining of data transfers and sharing the results with GPs.

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## The critical success factors

- **Payment and monitoring schemes:** Delivery of NHS Health Check to target groups in primary care has been incentivised with additional payments. Community provider's performance in targeting is regularly monitored and discussed.
- **Patient pathway:** Aligned to national guidance, the NHS Health Check steering group created a pathway for patients receiving checks in pharmacies. The approach was then re-used by the community provider and updated by commissioners. This assured that all patients received the same clinical and lifestyle intervention referrals regardless of setting.
- **Training:** Staff delivering the NHS Health Check or responsible for delivery of the programme were invited to attend training events to improve the quality of delivery. A new online training programme has also been developed.
- **PR:** A selection of local channels was used to promote the checks, including early use of social media campaigns (2010), local press and mail drops to housing estates.

## Key challenges and barriers

- **Data flows between services:** Due to the incompatibility of existing IT systems and information governance restrictions, the transfer of data between NHS Health Check providers was not possible. To partially solve this problem, bespoke software was developed to match community NHS Health Check data with patient records and automatically upload this to GP systems. However, there is not a data sharing agreement in place to allow data to flow back to community providers. This has been a limitation in terms of identifying potential duplicate checks, as it is not possible to assess whether someone having a community health check has previously had a check in primary care.

- **Data flows back from the behaviour change services:** Despite an official system of referrals to lifestyle services it was hard to track service initiations due to data recording issues. Providers had unique referral forms and different methods of recording referral origin, which made it challenging to identify the source of referrals and to track the referrals that resulted from the NHS Health Check programme. Relationships have now been developed between the NHS Health Check provider and local behaviour change service providers to ensure referral data is captured accurately and the data flow is improved, as well as treatment

## Project outcomes

Islington is currently undertaking a full evaluation of the programme and have so far identified the following outcomes:

- By 2013-2014 (mid-point of the timeframe reviewed) 64% of checks took place in primary care, 33% in the community and 4% in pharmacies. The number of checks delivered in pharmacies has remained stable since.
- 3% of people seen by GPs in 2013/2014 had high CVD risk (QRisk2 $\geq$ 20%), i.e. an estimated 6% of the eligible population of that risk. Another 4% of people seen were people on mental health/ learning disability registers.
- Targeting of minority groups in the community has been successful (40% vs. an estimated 26% in Islington's eligible population) and has reached more people from the most deprived areas (26% vs. 19%).
- Men are under-represented when compared to Islington's eligible population.



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## Key lessons learned

- Pharmacies tend to have static/captive populations. They appear to be very supportive in getting people at early stages of the programme, but with time their effectiveness falls.
- General Practice has proven to be effective at targeting high risk patients, thanks to availability of data and call/recall systems. However, variation between practices, especially lack of capacity in small practices, creates postcode lottery for checks. Targeting areas of underperforming practices by community provider can improve the situation.
- Community checks are an effective and efficient way of engaging with hard to reach groups - 46% of checks carried out in deprived areas took place in supermarkets, and 32% of checks carried out on men took place in leisure centres.
- A lack of time was one of the main reasons people gave for not engaging.
- A lack of knowledge about the programme and the training that the community staff received were also listed as reasons why people may not always engage.
- Small, temporary, not very private spaces that the checks may be delivered in may put some people off.

## Contact

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