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Weighted financial remuneration for NHS Health Checks in Cornwall

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Brief summary
Cornwall Council use a system of weighted payments for NHS Health Checks with the aim for primary care to target checks to those with a higher likelihood of a medium or high QRisk score. Payments are tiered based upon the outcome of the NHS Health Check (QRisk score), with additional payments for identifying specific previously undiagnosed disease, and for inviting patients with certain risk factors e.g. smoking.

What was the timescale for the project?
A stratified payment system was introduced in the 2016/17, and further refined for the 2017/18 NHS Health Check annual contract.

What was the setting and population covered?
Cornwall and the Isles of Scilly are seen as idyllic places to live, with beautiful beaches, mild weather and a relaxed way of life – all of which makes it a popular holiday destination. The 2011 Census described how 75% of the population identified their health as 'good'; however, healthy life expectancy is below the national average; men on average have poor health from 63.6 years, women from 65.5 years. This inequality is also seen geographically, with life expectancy 6.6 years lower for men and 5.1 years lower for women in the most deprived areas than in the least deprived areas[1].

What were we seeking to achieve?
The introduction of the weighted remuneration into the NHS Health Check contract was intended to encourage primary care to target their NHS Health Checks to those with a greater likelihood of medium (10-19.9%) and high (20%+) QRisk score.

Why did we decide to take action?
Offer rates of NHS Health Checks have historically been low in Cornwall. With the national ambition of offering 20% of the eligible population a check per year; Cornwall were achieving approximately 8-10%, and the average QRisk score was 6-7% (low risk).

Following local update training it was identified that using a weighted payment system based upon patient characteristics was viable and a potentially useful method to encourage primary care to target NHS Health Checks. The budget was set so the option to use weighted payments was an opportunity to get the most value for money from the programme.

What did we do?
As part of the annual contract setting process practices were asked to develop their strategy for NHS Health Checks and forecast throughput of patients based upon the new targeted payment model. The payment model was set up in the following way:

Invite based payment: £1 per individual if they were: on anti-psychotic medication, have poly-cystic ovarian disease, are Asian or other high risk ethnic group, or a smoker.

QRisk stratified payment: Based upon the QRisk score of the check payment was set up as follows:

- Low risk (<10 QRISK2 score) £9.80
- Moderate risk (between 10-19.9% QRISK2 score) £42
- High Risk (20% & above QRISK2 score) £52

Disease identification payment: £10 per review for each individual previously identified >20% but not on a disease register or statin, with previously undiagnosed diabetes, high blood pressure, atrial fibrillation or chronic kidney disease (payment per disease).
£5 per individual identified within the non-diabetic hyperglycaemic range and considered for referral to the National Diabetes Programme programme or weight management

Why did we choose this approach?
Using weighted payments facilitated a more targeted approach to delivery of NHS Health Checks without the need for increased financial investment.

Practices were able to target invites through identifying patients from their electronic patient management systems, however this was time consuming for some.

The data collection and invoice submission process requires more time and resource to be allocated to it than the previously used fixed rate system, resulting in a resource impact for practices.

What was the outcome?
Since introducing the new contract there was high uptake particularly in the first quarter, which levelled out. Offers of checks were lower in first year, with uptake remaining stable at about 50%. Of those receiving checks the average QRisk score has increased from an average of 6-7% to a higher 10-11%

One practice in Penzance demonstrated a change in the demographics receiving checks as a result of the new strategy, with the previous Q1 20% of those receiving checks were high risk, then since introducing the new approach those receiving checks in Q1 were 24% high risk, 37% medium risk and 39% low risk.

The majority of checks have been under 65s, but most of those who are high risk have been over 65. It has been mostly women accessing health checks, although 80% of the high risk patients identified through NHS Health Checks are men.

A cap on the maximum number of checks to be completed was placed upon practices, as some were very enthusiastic and able to invite large numbers of patients based upon this new model.

Table 1: Offers, completed checks and uptake for Cornwall Council NHS Health Checks Q1 16/17 – Q2 17/18

	Offers	Checks	Take up
Q1 16/17	5651	2209	39%
Q2 16/17	2773	1581	57%
Q3 16/17	2000	1598	80%
Q4 16/17	2106	1164	55%
Q1 17/18	2119	1248	59%
Q2 17/18	2252	956	42%

Table 2: QRisk outcomes of NHS Health Checks in Cornwall Q1 15/16 – Q2 17/18

QRisk	Low %	Medium %	High %
Q1 2015/16	67	25	8
Q2 2015/16	Not recorded	Not recorded	7
Q3 2015/16	Not recorded	Not recorded	5
Q4 2015/16	Not recorded	Not recorded	7
Q1 2016/17	64	27	10
Q2 2016/17	60	33	7
Q3 2016/17	55	32	12
Q4 2016/17	60	30	9
Q1 2017/18	50	38	12
Q2 2017/18	61	31	9

What did we learn?
It is important to be realistic and fair in the payment amounts. The original proposal was not to pay anything for low QRisk patients, however to cover staff time and consumables it was decided to change this to a payment of £9.80 to ensure the programme was still viable for practices. Equally, the higher amounts need to be commensurate with the additional effort required to identify, invite and see more high risk patients e.g. likely to be a longer appointment.

The use of a clear strategy was useful to engage practices. By introducing the requirement that practices were to be proactive and fill in a form to document how many patients they were going to target it motivated and committed them to doing so.

Early engagement with the Local Medical Council would be recommended for areas considering using this approach, as setting the payment levels appropriately is a key part of the use of weighted payments in order for it to be attractive to practices.

What is the single most important one line of advice which we can give to others starting a similar project?

Weighted payments can be used to target NHS Health Checks and change the demographics of people receiving a check; however when designing the payment structure keep it simple!

What is happening next with this work?
It is likely that the contract will be amended at the next annual review point to change the payment structure in response to feedback. It was felt that the payment system introduced is too complicated, so a more simple structure will be used going forward. Although practices will be encouraged to have a targeted strategy for targeting high risk, it is hitherto undecided if there will be a stratified payment structure.

Where can people find out more?
Cornwall Council contact: Gareth Walsh, Public Health Practitioner, gwalsh@cornwall.gov.uk

For research on the topic of using weighted financial remuneration for NHS Health Checks: Gemma Brinn, Public Health Specialty Registrar, gemma.brinn@phe.gov.uk

Date: 7th November 2017

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[1] https://www.cornwall.gov.uk/media/17512664/public-health-annual-report-2015-web.pdf