Reducing Inequalities Alliance

Improvement Academy

UNIVERSITY of BRADFORD

Community based NHS health check guidance

(Supporting the planning and delivery of health checks in community settings)

Bradford District and Craven Health and Care Partnership

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This guidance has been created with thanks to a partnership of colleagues from Bradford and Craven representing: West Yorkshire ICB, Public Health, VCS, University of Bradford, Improvement academy, General practice. The intention is for the guidance to be used by all those currently delivering and planning to deliver community-based NHS health checks to complement and enhance the NHS health checks carried out in primary care settings.

1. Community health check model

Background

Community health checks in various forms have been taking place in pilot form in Bradford District and Craven since 2021. Originally part of the Healthy Hearts programme and initiated in South Bradford and Keighley with the support of a Voluntary and Community Sector (VCS) partner's, anchor General Practice's (GP) or PCN's and Community partnership's (CP) in 2022. Then later developed in East Bradford with the support of a city Primary Care Network (PCN) and the Improvement Academy at Bradford institute of Health Research (BIHR). The original model's objectives were to: increase visibility of primary care in local communities; to identify those at risk of cardiovascular disease (CVD) and diabetes and to work with communities and individuals through social prescribing to promote behaviour change.

In the first wave of community health checks in South Bradford 231 people were seen with 79% of the blood tests for Full blood count and kidney function tests receiving an abnormal result and 20% of testing for lipids being abnormal. In the initial Improvement Academy (IA) event 103 people were seen 90% of whom were between 30-69yrs and 61% were identified with an abnormal blood pressure. Monitoring and qualitative feedback from both models has shown the success that can be gained from community-based health checks both in engaging with the public that otherwise would not have attended their health check at their general practice and ultimately identifying those at risk of CVD.

The pilots so far have adopted improvement science and plan, do, study, act methodology that has harnessed learning and allowed for rapid changes to be made within the pilot phase. This has provided invaluable intelligence to allow for this guidance to be created with prior testing and learning. More can be found on reporting on lessons learned from the Improvement Academy pilot can be found in **Appendix 9.**

With the clear success' of pilot work so far there is an increased interest in widening the work to make community health checks part of the universal offer across the district and therefore this guidance is being produced to ensure consistency of delivery and provide assurance that the model is in line with the NHS health check requirements.

Why should community health checks be made universal?

NHS health checks allow the potential for the NHS, public health, and partners to achieve better outcomes across many public health indicators including smoking prevalence, healthy weight, admissions for alcohol conditions, diabetes diagnosis, to support people to have better cardiovascular health and have liver and renal disease identified earlier. In addition, they are an important tool to assist in meeting our cardiovascular disease ambition.

The NHS health checks are currently made available for those over 40 years old and there are eligibility criteria excluding those that are already in receipt of care for some long-term conditions. The community health check model will be unique in that there will be an opportunity alongside the full NHS health check to offer health checks outside of these criteria to communities at higher risk irrespective of age and exclusion criteria.

A recent calculation by public health in Bradford Council describes the impact of an increase of 10% in the uptake of the NHS health check:
If a 10% improvement in uptake to 55% was achieved, the Ready Reckoner tool estimates that in the Bradford district this would equate to an additional:

- 110 individuals completing a weight loss programme.
- 60 additional people starting statins.
- 28 people modifying and regulating their glucose.
- 15 additional people being diagnosed with diabetes.
- 45 starting hypertensive medication.
- 36 people diagnosed with chronic kidney disease.
- 28 people would increase physical activity.

- Unmet need in hypertension annual reviews post covid. More than 50,000 people in Bradford District and Craven HCP have not had Blood Pressure (BP) check and other health advice as part of the NHS health check.
- High levels of unplanned hospital admissions for CVD related illness in inner-city Bradford
- Covid has prevented NHS health checks to be offered and so there is a backlog of forty to seventy-four-year-olds who have not been offered or received an NHS health check.
- Health inequalities data shows in the most deprived areas cardiovascular disease and diabetes remained two of leading causes of premature death in Bradford District and Craven.
- 27% of the gap in life expectancy for men and 23% of the gap for women between most and least deprived populations in Bradford is due to cardiovascular disease (2020/21).

What constitutes a community health check?

- A community health check as a minimum should replicate a full NHS health check completed with the support of a community partner in a central community-based location.

The health check therefore must include the following to classify as a community health check:

- Recording of the following as well as health advice relating to:
  - age
  - gender
  - smoking status
  - family history of coronary heart disease
  - ethnicity
  - body mass index (BMI)
  - cholesterol level
  - blood pressure
  - physical activity level
  - alcohol use disorders identification test (AUDIT) score
  - cardiovascular risk score (QRISK)

- Those aged 65-74 should be made aware of the signs and symptoms of dementia and signposted to memory services if this is appropriate.
- For those not eligible for a community health check on attendance at the event an alternative offer should be made available to allow for Living Well advice and social prescribing to be readily available. Those participating that partake in this should be recorded and reported separately. More information on the district wide offer from Living Well can be found in **Appendix 10**
- PCN's and General Practice working in collaboration with community partnerships could agree to extend the community health check model to younger at-risk population groups, especially in inner city areas where long term conditions are prevalent at younger age.
- A community health check is fundamentally different from the health checks carried out in clinical settings and the intention is for the events to be relaxed, welcoming and include elements of health promotion and associated conversations that may not be possible in a clinical environment. The addition of refreshments, health promotion stands and activities, goody bags and opportunities to engage in community assets should be included as a priority.

See **Appendix 1** for NHS health check guidance.

What should the patient expect from the community health check?

- A clean clinically suitable space which allows for confidentiality and privacy.
- To understand what tests have happened (a patient cannot consent if they do not know)
- To understand what happens next.
- A clear understanding of who is advising them (registered nurse / health care assistant/other).
- Written information where required.
- Patient prioritised lifestyle advice linking to partners from Living Well.
- Clinical triage if urgent care is needed.

2. Getting started: preparing for a community health check event.

Planning

- Ensure there is full clinical governance available for the community health check event. This should be in the form of a senior clinician available throughout for supervision and consultation.
- Carefully consider the date for delivery of the 4-hour event. At least 6 weeks' notice is required for rostering of staff and planning processes.
- Times for delivery need to consider the collection of blood samples within the current system.
- Consider the target group and population and if inclusion health groups are to be specifically targeted consider how the check will need to be set up to include such groups. Liaise where necessary with VCS/faith setting partners supporting these communities.
- Liaison with Living Well team to negotiate time and commitment to the event.
- Allocation of primary care staff and/or students to the health check delivery using planned time or overtime
- Consideration of availability of social prescribers acknowledging there are differing roles and responsibilities for social prescribers between PCN.
- Inform all local GPs of planning and anticipated tasks associated with follow up practice.

See **Appendix 2** for template for communication with GP's.

Staffing

There are two potential models of staffing currently tried and tested in the delivery of community health checks:

- PCN/General Practice staffing model
- PCN/General practice and health care student model

Provision of distinct elements are vital to the success of the event and therefore the task, staffing, numbers of staff and possible source of staff has been considered in and estimated cost has also been suggested however this would need local consideration and is an estimation only. A possible student staffing model and opportunities for funding from the University of Bradford. Further information can be found in **Appendix 7.**

Core staff required will be:

- Administration and PCN/GP leadership support: registration; printing blood forms; co-ordination; follow up.
- Health care assistants: height and weight checks; blood pressure monitoring and QRISK
- Phlebotomy: Lipids; U&E's; FBC; HbA1c
- Living Well advisors: smoking; weight; alcohol advice (AUDIT)
- Social prescribers: Wider health advice and booking of additional social prescribing sessions where appropriate.

See **appendix 3** for links to training and skills of delivery staff and the NHS health check training hub.

VCS/Faith setting venue.

- Central community-based location which offers:
    - Good ventilation
    - Good lighting
    - Space for up to 100 attendees
    - Good Wi-Fi connection
    - Availability of caretaker and opportunity for prior access
    - Opportunity to offer refreshments.

- Although there are relationships in place with many community venues and some have been hosts in the previously described pilots it is anticipated that future checks will incur costs of approximately £300-500 to secure the venue and associated support of the community organisation.

Partnership and engagement

- A local VCS/faith setting partner able to offer at least 5 volunteers to support the event to:
    - Meet and greet attendees, supervising process for turn taking.
    - Support attendees through the event
    - Help serve refreshments.
    - Support to distribute information in the lead up to the event.
    - Circulation of event information to partners including ward officers, local VCS organisations.

- PCN/GP pre-engagement activity to include:
    - Review of patient register for outstanding NHS health check.
    - Review of patient register for outstanding BP review.
    - Personal invite via SMS/other to the community health check

See **Appendix 4** for template marketing materials.

Equipment and training

- Training/briefing on the protocol for use of the community health check
- Clinical equipment for completion of health check model
- Printing equipment
- Wi-Fi connection “dongle” for in case of issues with building Wi-Fi
- “Goody” bag if funding available/leaflets

See **Appendix 5** for details and costings of equipment.

Recording/Systm1 planning

- Consider options for registering attendance at health check.
    - Temporary registration of all attendees to one host GP with prior agreement of host GP and recognition of tasks relating to review of blood results and follow up actions as required.
    - Registration of all attendees to the enhanced access module (cost incurred to Bradford care alliance for review of blood results) see **Appendix 8** for related guidance.

3. Delivery: carrying out the community health check

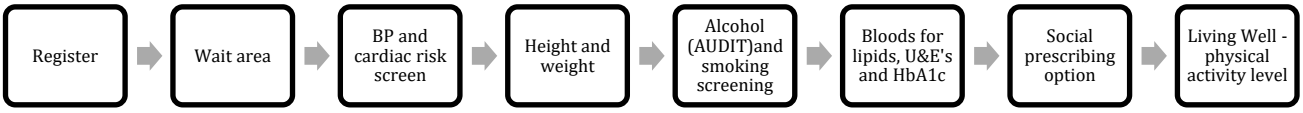
Risk assessment

- The hosting practice manager or lead clinician will be responsible for completion of the risk assessment prior to the event.

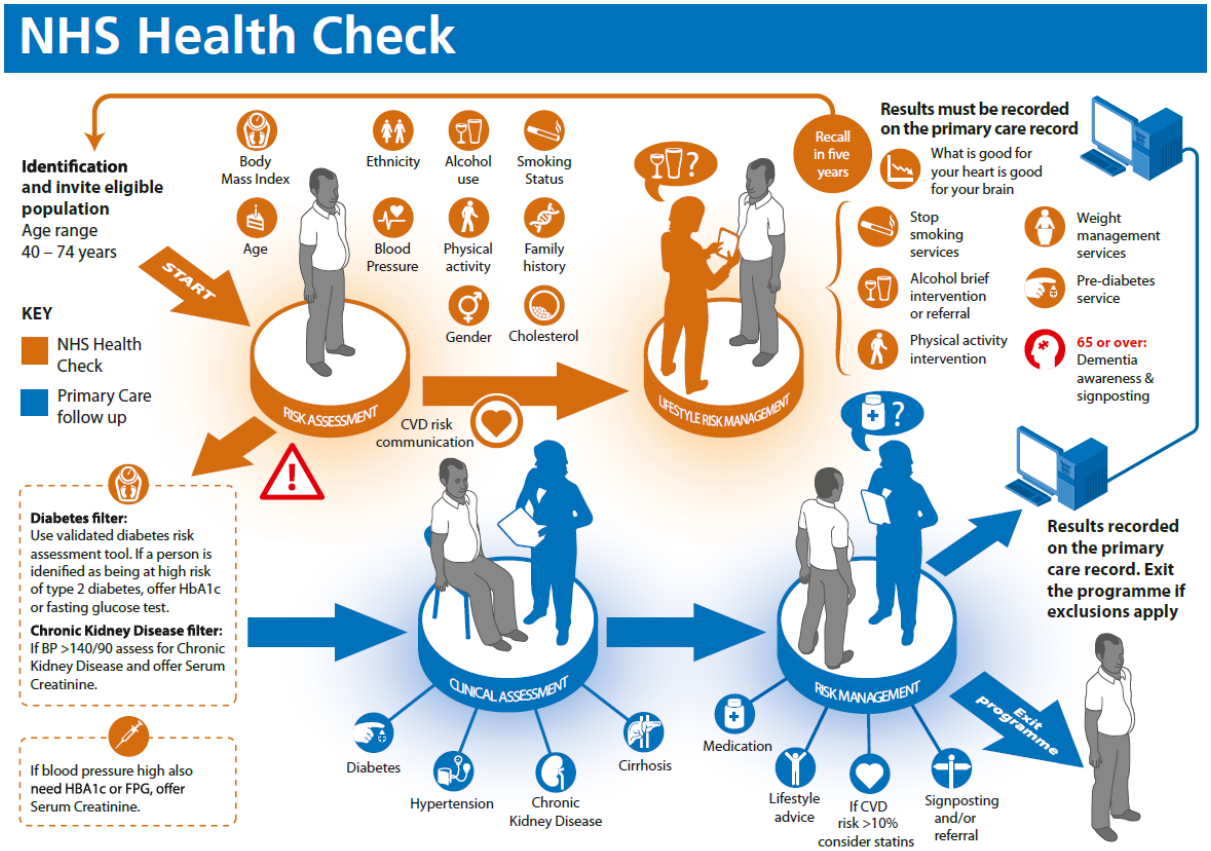
See **Appendix 6** – Template/example risk assessment.

Preliminary venue check

- Hosting practice and co-ordinator to visit venue in preparation to plan stations and create planning document.
- Co-Ordinator and lead practice to attend 90 minutes before event start time to:
  - Co-ordinate volunteers and staff
  - Delegate roles and responsibilities
  - Set up admin stations (2 at entry, 1 at phlebotomy stations for blood forms and BP recording)
- Flow of attendees for best results:



- The community health check co-ordination should consider the below best practice guidance for the NHS health check to provide assurance that full NHS health check has been completed for eligible attendees. This can be reviewed further in **Appendix 1**.



Closing event

- Co-ordination of cleaning and storing equipment
- Collection of blood samples and transporting to host GP for onward collection.
- De-brief with all team members

4. Follow up: ensuring intervention is effective.

Phlebotomy follow-up

- Host practice or Bradford care alliance (if enhanced access module utilised) to review blood results.
- Attendees GP tasked with action as required.
- Attendees GP to communicate and follow up with attendee.

Monitoring and data collection

- Monitoring data (attendance information) to be shared with hosting organisation (PCN/CP/RI manager)
- Hosting GP/PCN practice manager to arrange for reporting on Snomed coded patients at 3-month, 6 month and 12-month intervals to monitor for increases in numbers on hypertension register/lipid management/diabetes pathway, active pathway management, and removal from pathways.
- Hosting GP/PCN to consider further reporting from Snomed coded patients on smoking status, alcohol use, diet changes because of intervention.

Useful Contacts

Reducing Inequalities Alliance – RIA@bradford.nhs.uk
University of Bradford – V.Carter@bradford.ac.uk
Improvement Academy at Bradford institute of health research – academy@yhia.nhs.uk
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Appendices

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Community NHS health check guidance
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