HOUSE OF COMMONS

Health and Social Care Committee

Oral evidence: Progress in preventing cardiovascular disease, HC 561

Wednesday 22 January 2025

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Watch the meeting

Health and Social Care Committee members present: Danny Beales; Dr Beccy Cooper; Deirdre Costigan; Andrew George; Paulette Hamilton; Joe Robertson; Gregory Stafford.

Public Accounts Committee members present: Anna Dixon.

In the absence of the Chair, Paulette Hamilton took the Chair.

Questions 1-71

Witnesses

I: Professor Dr Sir Anthony (Sam) Everington, Former Chair, NHS Tower Hamlets Clinical Commissioning Group; and Dr David Wrigley, Deputy Chair, BMA General Practice Committee.

II: Dr Jeanelle de Gruchy, Deputy Chief Medical Officer and Co-Director of Office for Health Improvement and Disparities, Department of Health and Social Care; and Jonathan Marron, Director General for Primary Care and Prevention, Department of Health and Social Care.

Written evidence from witnesses:

– [Add names of witnesses and hyperlink to submissions]

Examination of witnesses

Witnesses: Professor Everington and Dr Wrigley.

Q1 **Chair:** Welcome to this morning's meeting of the Health and Social Care Committee. Our evidence today focuses on the important issue of progressing on the prevention of cardiovascular disease, based on a recent report from the National Audit Office. We are joined today by Anna Dixon from the Public Accounts Committee; I welcome you to our Committee, Anna. We will be hearing from two panels of witnesses. The first focuses on local delivery and the NHS Health Check programme, and the second is with departmental officials. Welcome to you all. Could I invite our witnesses to briefly introduce themselves for the record?

Dr Wrigley: Good morning. I am Dr David Wrigley. I am a GP partner in north Lancashire in a town called Carnforth. We have about 26,000 patients, five branch surgeries in the local villages—it is quite unusual to have so many practices—and over 100 staff, so it is a large GP surgery. I am also deputy chair of the BMA's GP committee, which oversees the national contract negotiations that we are undergoing at the present time.

Professor Everington: I am Professor Sir Sam Everington. I am a GP in the east end of London with 50,000 patients, as well as the flagship Bromley by Bow Centre that has 100 different projects under the roof, dealing with social prescribing—the wider determinants of health. I am also a professor at Queen Mary University.

Chair: Can I start with you Professor Everington?

Professor Everington: Just Sam is fine.

Q2 **Chair:** Okay. Can you briefly set out your experience delivering the Health Check in the communities you serve?

Professor Everington: Let me start by setting out the context for you. In Tower Hamlets, there are 150 ethnic groups and it is one of the most challenging communities in the country. You might say, "Well, how have you managed to achieve it, despite that?" There are some secrets that I am going to give you about how this has happened, but the overarching theme is consistency and persistency.

We have had primary care networks for over 10 years—in fact, that is where the Government got the idea from. We have done social prescribing at the Bromley by Bow Centre for over 30 years, and as the CCG chair 10 years ago, I put it in every single practice. We have a local contract—we are one of the few areas in the country that has a local contract—with the ICB to the tune of 2% of that NHS budget. The contract delivers a whole raft of different things, because it is not just the Health Check that you need to look at in isolation, but all the add-ons that are absolutely critical to getting the delivery. For example, we finance every practice to close for half a day a month and team train, so the receptionist will train with the

GP. It is that team training that makes sure that every member of the team is working to the same goals and in the same direction.

We have a big focus on quality improvement—we invest about £600,000 in quality improvement in primary care—to try to redress the balance between mass regulation and not enough focus on quality improvement.

We have contracts with targets that are manageable but create a certain level of pressure in primary care. For example, one of the things we have done is shifted virtually all type 2 diabetes, on the back of this £11 million local contract with the ICB. City and Hackney have it, by the way, but very few other parts of the country do. We have a contract with a PCN that gives 70% up-front funding and 30% dependent on delivery. We set a target that is stretched but deliverable. We want people to deliver it, so we do not make it impossible, and we keep on changing the goalposts all the time to drive up health and drive out health inequalities.

We have IT systems, and everyone has the same IT system across the whole front. We have a clinical effectiveness group, led by GPs based at Queen Mary University, that collects all the data from the 2 million population in primary care in City in north-east London. They crunch the data and then feed that back in real time to primary care to say what is happening. We create a whole raft of dashboards so that any general practice primary care unit can see where it is delivering on a whole raft of measures compared to local GPs. That is powerful stuff. It is not performance management, by the way, but it plays to people's professional drive. If you see you are not doing as well as your neighbour, guess what? You will talk to your neighbour within the PCN and say, "What's going on? What's the secret?" That professional drive is really powerful.

Things like social prescribing are absolutely critical, because you can do the Health Check, isolate what the problem is and what the matter is, but if you move to a social prescribing approach, you focus on what matters to you as a patient. I could sit there as a GP and say, "You've got heart disease, you need a statin prescribing," but I know that will not motivate most people. What you have to do is drill down to what matters to an individual. What is going to motivate them?

The social prescribers in Tower Hamlets have been working for many years to be expert coaches and focus on this personalised approach. That is completely the opposite of what we were trained to do at medical school, where you would diagnose something, say what the matter is and prescribe a drug—hence the problem we face now: the utter focus on prescribing, of which we are now seeing increasing dangers. One in five adults are on antidepressants. Something like between 10% and 20% of hospital admissions in over-65s is because of the side effects of drugs. I am ranging to give you an idea of this holistic approach, which we take over a period of years.

Q3 **Chair:** Professor Everington, do you believe that because of this holistic approach, you have been able to bring on board some of the diverse

communities that you have in Tower Hamlets, and as I have in areas like Birmingham? Have you managed to get this uptake because of the way you have done things?

Professor Everington: Yes, absolutely. Most importantly, it is about that personalised approach. You are seeing the person in front of you as an individual—not as somebody with heart disease, but very much as an individual. You are working on what will motivate them, depending on their background, family and community—a whole raft of things.

Q4 **Chair:** We will be hearing lots more from you, but I want to move over to Dr David Wrigley.

Dr Wrigley: We offer a more traditional Health Check model. My community is not as diverse as Sam's community; we are across north Lancashire and south Cumbria, with a very rural population, as I have said.

We offer the Health Check, as it is prescribed, with the 20-minute appointment with a nurse. We search our computer system and call people in and take their tests—checking their pulse and blood pressure, and taking blood tests for cholesterol and blood sugars. We follow up afterwards in a system that is very well regulated and ensure that we pick up all the patients. If they need a follow-up because their blood pressure is high or their pulse is not right, we will undertake further tests.

The Health and Social Care Act 2012 outsourced public health, as you know, and handed it over to county councils. It is an area you should focus on, because public health has been absolutely decimated; the budgets were meant to be ringfenced, but they were not. We used to have fantastic public health teams in our localities, but now they are all remote and distant. They would have done a lot of work around Health Checks, looking at populations and targeting disadvantaged communities. It is a real shame that that has been lost, but we are trying. Our integrated care system—Lancashire and South Cumbria—has undertaken additional work, as compared with other ICSs, in targeting areas with additional budgets.

Q5 **Chair:** I am going to ask you a similar question. Your area of South Cumbria and Lancashire is a unique area, and you have managed to get above the average. What two or three things—you will get to know me; I love numbers—has your team in Lancashire and South Cumbria done to help with that increased uptake?

Dr Wrigley: I looked into this. As I mentioned, the ICS focused on population health, which is a particular Department within the ICS, and it set aside some funding, despite very difficult financial challenges, to do what is called an enhanced Health Check. That looked not just at the things I mentioned earlier, but at disadvantaged populations. It targeted them through the primary care networks that we have in place across the ICS and looked at additional factors around cancer risks, mental health, suicide risk and additional health education.

That targeting has shown improved results around better treatment of high blood pressure, picking up cancers better and earlier in deprived populations, and treating irregular heartbeats, which can lead to strokes and heart attacks. That has happened in our area. It is led by a very good GP called Dr Andy Knox, who has led the population health team, and it has been a real success despite the challenges it has faced in the financial climate that we have now.

Chair: I will stop you there. We will move on to the first Member who will be questioning you.

Q6 **Joe Robertson:** What was your experience in the provision of follow-up care for those who were identified as being high risk following a Health Check?

Dr Wrigley: The magic of general practice is that we offer personalised care. We know our communities and they know us, and we have obviously been there for decades. We are trusted, too: patients trust us as GPs in their local surgery, and they know the staff really well. Contacting patients and following them up is made easier, because they know us and trust us, and want to come and see us.

If we identify patients who have a high cholesterol level, high blood pressure or high blood sugar levels, we will call them back and ensure that we treat them. That is done through a computerised system. General practice is way ahead in the NHS on IT. We have been computerised for decades, and our systems are full of all the health information that many external organisations and other companies would love to get their hands on, but we are very careful that we treasure and maintain that confidentiality.

We do follow them up, but with the outsourcing that has occurred, I know that in my particular area of Lancashire and South Cumbria other organisations are undertaking Health Checks, and it is rather disjointed. It is done often with a finger prick blood test, which is not as accurate, and that does cause us concern. I have had patients come to me asking for an urgent appointment because they were told that their blood cholesterol was really high based on a finger prick. Because that is not as accurate, we then have to undertake a repeat test. If the level is not high, the patient has undergone a lot of anxiety and concern, and obviously there is duplication of work and tests. That is not a good way of utilising resources.

As I say, I think it needs to be focused down into the communities, the PCNs and the practices to undertake these tests. There is an ability to do that within the GP contract through what are called enhanced services. You could ask NHS England to produce one across the country, which would be funded through general practice and audited and undertaken by the local surgery.

Q7 **Joe Robertson:** Are there any specific gaps in follow-up pathways that you think might hinder the prevention of CVD?

Dr Wrigley: I think the gaps are around the outsourcing, which I mentioned. I asked colleagues on our committee, which covers the whole country—it represents GPs across the country and has 60 members—and the answers I got back and the differences across the country were mind-boggling. There are so many different things happening that are disjointed and not joined up. Patients will fall through the net if that happens. It is about having national co-ordination; things like this need national co-ordination and a national directive. They need not to allow areas to do things differently and to undertake them with these outsourcing models, which lead to very disjointed care. The NHS is far better to do that in a locality with that national direction.

Q8 **Joe Robertson:** How do you see that national co-ordination being rolled out and embedded in practice? If it was easy, presumably it would just happen organically.

Dr Wrigley: It would require a contractual model, but that is fine; that is very easily done through what are called the directed enhanced services, through the GP contract that every GP surgery across the country works under. NHS England will then provide that and offer an uptake, and then that is audited and measured, and you can extract the figures and show the improvement. That would be a good way of ensuring that the model is rolled out in a way across the country that does not leave a postcode lottery, in effect.

Chair: Sam, do you have any thoughts on this?

Professor Everington: I have three thoughts. First, the local contracts are really important. If the Government are going to be successful in this shifting into the community in the prevention of illness, you have to set a target for each ICB to increase the funding for this by 1% every year for the next five years. You have to be disciplined. At the moment, our ICB and many ICBs are not controlling the acute sector budget, which is actually the least productive part of the system. Primary care is the most productive.

The last month of records saw 40 million consultations in primary care. That is over double the population of this country seen in primary care over the year, which, by the way, gives a fantastic opportunity. It is what Tesco or any other business would die for—that footfall and that opportunity to say, "While you're here, I notice that—". This is the power of primary care.

We also need support services for patients. In Tower Hamlets, swimming is now free for all women over the age of 16 and all men over the age of 55. You might say, why is it better for women than men? The answer is that life expectancy is now lower in women in Tower Hamlets than in men. But why could this not happen in every swimming pool in the country, which, on the whole, are substantially empty for quite a lot of the day? It is the added services that are really important and the holistic approach that I talked about—the social prescribing.

One of the things that can really help somebody with heart disease is to have a job. The worst thing you can do is to sign them off sick. We are now the sick note capital of Europe, with 2.8 million people on sick notes. My longest consultations are with people who are asking for a sick note, because I know that if they get into that sick culture—a deconditioning culture similar to what happens in the elderly—it is a disaster. I know that the best thing somebody with diabetes and heart disease can do is activity and to have good finances within the family so that they can buy healthy food. These sorts of things are really important.

In terms of what you can do nationally—and this might be something you can challenge the people from the Department of Health and Social Care on later—if you are serious about making these changes and these shifts, you need to set a very simple target for the ICBs and ensure that the acute sector is kept within budget like primary care is. We have a fixed budget, to the point that seven years ago, I had no pay for five months because we had not set our budget correctly. That is how powerful it is in primary care.

My overarching message—and not just because I am a GP—is about the potential in primary care and the increase in productivity since covid, which is up 20% with less GPs and less money. There is a key message here. There has been far more investment in acute, with far more consultants and specialists being created, and yet virtually no change in productivity.

The final thing is that our ICB is very innovative. It has given us a population health budget for 50,000 patients of a quarter of a million in our APMS contract. It is the only APMS contract in the country that has that. This should be the norm across the country.

Q9 **Danny Beales:** The NAO report, which is the focus of today's meeting and is the motivation behind today's session, particularly highlighted failings around the patient journey and data-sharing arrangements. Dr Wrigley, you talked about providers not being able to connect with the broader system and about data, once checks have been carried out, not flowing back into primary care records and necessarily leading to effective follow-up for those at increased risk. I want to understand more about your experience.

Sir Sam, the NAO report highlights Tower Hamlets as an example of good practice on data sharing, and you touched on some of the underlying principles of data analysis and sharing in your piece. I would like to get both your perspectives on how the principle of data sharing and enabling an effective patient journey works in your system. I will go to Dr Wrigley first, and then Sir Sam.

Dr Wrigley: The NAO did raise concerns that these checks are not working effectively, and they questioned whether local authorities are the best providers for this, but that is in the context of public health spending falling, particularly since 2015. I spoke earlier about the need to focus on public health.

It is important that data is used properly, effectively and safely. There has to be good governance around the use of data and how it is shared. It is easy for NHS organisations external to the practice to view the GP record. The software is in place—it is called GP Connect: Access Record. In effect, it opens up a window. If you are in A&E or an out-patient department, your clinician can open up that window on the GP record and look at your figures and stats, and that allows them to take the care forward.

There is a move to try to take Health Checks into a digital world. You can go on the NHS App and undertake a Health Check now. We have been approached by NHS England and the Department of Health and Social Care. At the BMA, we have committee called the Joint GP IT Committee, full of experts from the Royal College of General Practitioners and the BMA. We have concerns about the digital Health Check. It does what I mentioned before—the home blood check, with a finger prick. There are concerns about accuracy and how that can further cause anxiety to patients and lead to the duplication of work.

It comes back to what Sir Sam was talking about: personalised care in your local community, with a practice team you trust and recognise. It is about ensuring it takes place in the community. We need to do more of them. We called in about 2,000 patients last year, and we had about a 25% uptake. That is in the context of general practice really struggling, which is obviously in the news at the present time.

Q10 **Danny Beales:** I just want to challenge that assumption. I am picking up from your previous comments, and from what you just said, a hesitancy about other providers being involved—you called it outsourcing—and a concern about a digital version of Health Check through the app. As you highlighted, capacity in general practice is limited, and you are reaching only 25% of the 2,000. There is an aspiration over five years to reach 100% of the population, but we are far off that. Wouldn't the only way to move towards that be to widen the range of providers that work with the broader primary care infrastructure? For example, pharmacies can work with community-led organisations to reach people not registered at GP practices.

Dr Wrigley: In this context, there is no sense that the home tests and checks are accurate enough at the present time. If it were other aspects that did not involve blood tests, that could possibly be a way forward, but you need to take a blood sample from the vein in the arm to get an accurate test.

We are not luddites; we are not saying, "This shouldn't happen." It is about ensuring it is done correctly and accurately so the patient gets the right treatment and the right results, and we do not have duplication of effort. It is about using the funds in the best way possible too. It does come down to funding: we have to pay staff and pay for all the equipment required. If the checks were funded in a better way, there would be better uptake because there would be more staff to call the patients in, ensure they turn up and make sure the follow-up occurs.

We are trying very hard to do that in the context of a very strained system due to difficult finances and a lack of staff. We have lost 1,200 GPs in the last 10 years, so we are doing more with less. That is why the actions that we are currently undertaking are about improving patient care, getting more GPs, bringing the family GP back and improving general practice. We used to be the jewel in the crown of the NHS, but that is no longer the case.

Q11 **Danny Beales:** From a patient perspective, the GP is important, but they are not the only part of the system. Many people unfortunately do not access GP care, so perhaps a range of providers would be helpful to reach beyond those you already reach. You mentioned the GP Connect app, which other clinicians can view. Can community providers use GP Connect? On the data flow issue, is it possible for them to enter data on GP Connect, or can they just view it?

Dr Wrigley: It is a piece of software that attaches to the system. Pharmacies can see that and view the record. There is another aspect called GP Connect: Update Record, which allows others to add to the GP record, but there are further concerns about that. As a GP, you have only limited time with a patient, and if lots of information is being pushed in from other areas, you cannot see the wood for the trees.

It could lead to complexities that you do not want to see within a consultation, such as diagnoses or prescriptions added externally by perhaps a private provider. Once that happens, the GP is responsible and it leads to all sorts of concerns around governance and who is responsible for overtaking the care going forward, when someone else has added in to the GP record. That is not GPs being paternalistic and saying, "We don't want others involved." It is about protecting the patient's record, ensuring confidentiality and accuracy, and ensuring they get the best care possible, without other things clogging the system.

Q12 **Danny Beales:** How does your system currently work if that is not used? When those external providers carry out checks, how does the data flow back to primary care records?

Dr Wrigley: At present, it can come back electronically, or it can be by email as well. That then has to be transferred into the system.

Q13 **Danny Beales:** Are there issues with people's records not being updated, so they may be at higher risk of cardiovascular issues that are not followed up?

Dr Wrigley: When information comes into the practice, we do not miss putting it on to the record. Whether the provider is sending it or whether that information is sent through is obviously not our responsibility because it is done externally. We do not know that it is being done.

Q14 **Danny Beales:** Sir Sam, Tower Hamlets was mentioned in the NAO report as somewhere where data-sharing arrangements are in a good place. Do you have any reflections on that?

Professor Everington: Probably for about 10 years, we have had the east London care record. In practical reality, that means that when a patient is in front of me, I can see everything that is going on in the hospital that is important for their care. If they had an MRI done yesterday, I can give them the result. Hospitals often say, "We'll tell you in two weeks' time."

We have all that information—all their blood tests—and it is downloadable into their records. Tied in and added on to that is something called the Discovery project done by Queen Mary University, which mines all the other information, adds it in and creates a fantastic academic knowledge base, which feeds back information and advice to the system.

There is a second IT thing that is really important. We have been heavily involved in the development of a system called Accurx, which most general practices in the country now have. It is a tag on to the EMIS system that all our practices use. What does Accurx do? One of the best ways to motivate and involve people is to engage the patient, obviously by using the NHS App to access their information, but also to input information.

Any patient with our Accurx system can go online and brief us. There are simple questions. What is the problem? What have you tried? What is your expectation? Who do you want to see? They often write half a page for us, which is fantastic. That should be universal across the country.

That does two things. First, it briefs us properly about what the issue is, and it encourages patients to think more deeply about what it is they want, what it is they are worried about and what matters to them, rather than sitting on the phone at 8 o'clock in the morning in a long queue to get an appointment. It is a completely different approach. We can then send a text to a patient.

All our patients are now measuring their own blood pressure, which is much more accurate. If you come to see the doctor, your blood pressure is going to be up. If you measure it at home when you are chilled, it is much more accurate. We can send a text to the patient. For example, something called a Florey allows them to send their blood pressure reading, coded, into their notes every day for seven days. That is just one example of what can be done within the system.

Engaging patients in managing their own care is absolutely critical. One example that I will give you is that if patients have a blood pressure machine and measure their blood pressure, research shows their blood pressure is 5 mm lower. It does not matter where you look, but engaging patients and supporting them to manage their healthcare will give you far better outcomes.

Q15 **Danny Beales:** That sounds really positive, but I am wondering why that is not common practice. You have highlighted data-sharing arrangements as overcoming some of the barriers to the Health Check system. How have you been able to navigate those barriers locally that other people

face, where there are not data-sharing arrangements in place between Health Check providers and primary care or between the local authority and primary care?

Professor Everington: It is a lot of what I mentioned before. It is a cultural shift over many years. It is a bit like the 10-year plan: this does not happen overnight and you nudge it in all sorts of different ways, such as the group training, which I talked about, over a period of time. So there is not a simple solution to it, but if you want drivers to it centrally, there is a whole raft of drivers around IT, for example. I mean the Accurx system—people should be incentivised.

There has been a great focus, for example, on the pressure at 8 o'clock and people not being able to get through on the phones. So, centrally, people have said, "We have got to improve the phone system." No—that is a bit like going back to faxes. If you get 85%, as we do, to go online and brief us, actually that gives fantastic support to the 15% who are not digitally very good, and they can get through on the phone at 8 o'clock and throughout the day.

The other thing that is really important is the centrality of primary care in delivering on these outcomes. Really interestingly, we had some of the best flu vaccination rates in the country, but that has slipped. Scotland has got even worse. Why? Interestingly, it is because they gave more opportunities to get vaccinations elsewhere, which diluted that population responsibility, so you have to be really careful.

On the one hand, you can argue that what we need is a lot of different mechanisms for getting these checks. But it is really interesting that if you take away the key responsibility from general practice—I am not just talking about GPs; we have pharmacists, physiotherapists and an incredibly wide and amazing team in primary care now—there is a risk that your targets drop. That is counterintuitive.

But the incentives from the centre are absolutely important—sometimes even very minor financial incentives. General practice is very fleet of foot. You give a financial incentive and—guess what?—they'll deliver, as was shown in 2004 in the contract, and as I can guarantee will be shown now with the £20 for advice and guidance. That money will be spent very, very quickly. So there are incentives there, and then, exactly as you said, getting the sharing of this information within systems is absolutely critical.

Dr Wrigley: May I quickly add on the IT, that is happening across the country—the Accurx—the ability for patients to SMS us. We also use the NHS App and they can send us blood pressure or other measurements. To reassure you, that is in use widely—since the pandemic, actually.

Q16 **Danny Beales:** Just to challenge you on a point, you had concerns about healthcare providers entering patient data and the accuracy, but the system is moving to allowing patients to enter blood pressure measurements. I just point out that if a community healthcare provider, a voluntary sector organisation, a nurse or a pharmacist has more

medical training, surely they should be able to enter that.

Dr Wrigley: My point was about the accuracy of the finger prick and how that can cause undue anxiety because it is not accurate.

Danny Beales: I do not want to revisit that, but I think you were suggesting that you were concerned about the accuracy of data from other providers feeding back into the primary care system. I am just pointing out that the system is moving to allow patients to enter their own data, and I support that personally, but it seems kind of counter-logical that other trained healthcare professionals—

Dr Wrigley: It does not drop straight into the GP record. It comes in as a pop-up on the screen and then we interact and save it to the system.

Q17 **Danny Beales:** It might be possible, then, to allow other providers to enter data?

Dr Wrigley: Yes, it could be possible. There is another final point that is really important. We assess patients on a system called QRISK2. That takes information around blood pressure, age and cholesterol, and gives you a risk score for a stroke and heart attacks. Eight million of those are done every year. There is a new one called QRISK3 that has not been rolled out, but it has been around for seven years and is highly respected for academic rigour. We have written to Amanda Doyle at NHS England to say, "We need this in our GP systems to offer better ability to assess patients." So QRISK3 is something that we really need to see rolling out.

Q18 **Chair:** To come back to you on that, has she made a statement as to why it has not been rolled out? Is it because of finances? Has she said what needs to happen for it to be rolled out?

Dr Wrigley: It is almost like a stand-off at the moment. The IT specialists—the health informaticians—know that it needs to be in there. The computer systems across the country are mostly run by two large companies, and they need to put it into their systems. It needs people to come together and get it sorted. We know it is the right thing to do, but it needs something—maybe pressure from this Committee would be helpful.

Chair: Thank you for that. I will bring in Dr Beccy Cooper, who wants to ask an additional question in this area.

Q19 **Dr Cooper:** Thank you, Chair, and thank you both for coming. I should declare that I am a public health consultant, so I have commissioned NHS Health Checks. I just wanted to ask for your thoughts.

It is interesting to hear you talk about GPs—I am a big fan of GPs; they're fantastic—but when I tried to commission Health Checks, there were issues around capacity in general practice, and around how many GPs I could get interested in actually commissioning Health Checks.

I am a medical doctor and I understand the pressures of primary care, so while I am all for allowing primary care to be the real heart of the community, with family doctors and so on, I am concerned that, if we put too much onus on primary care, we may miss out on other opportunities,

with pharmacies and so on. After listening to what you were saying, I just wondered whether you could respond to that.

Chair: Before you respond, I apologise because I should really have brought in Mr Greg Stafford. Do you want to ask an additional point to that, because that was the area you were going to ask on?

Gregory Stafford: I think I will let the witnesses answer first.

Dr Wrigley: It comes down to the resources and the ability for general practice to undertake this work. As I have already stated, we have fewer GPs now. There is a new scheme in place from the Secretary of State around having more GPs in general practice, but the scheme is quite inflexible—it has issues that we need to deal with.

We also need to get more nurses. It is not just about GPs, of course; the whole team is important here—nurses, primary healthcare workers, social prescribers and others. It is about boosting general practice and getting the staff in there so we can do more.

As Sam said, we are very fleet of foot; we have a very flat management structure. We are the only part of the NHS that does not have a deficit. We do not run deficits. We cannot do that because, if we are bankrupt, we cannot hold our contracts. That is why general practice absolutely needs to be focused on and invested in. We will do more and more if we are given the opportunity to do so.

It follows on that, if you provide the funding and the staffing to do these Health Checks, more of them will be done and undertaken, and more diseases will be prevented. But it is about getting that staffing into the community. If it is a trusted practice in the community, known by patients, they will be more willing to engage with that, perhaps, than with an external provider.

Q20 **Gregory Stafford:** My questions are around some of the stuff you have already touched on, but, to bring it together, could you briefly explain how your systems were commissioned and managed? What impact did the way that they were commissioned have on the service delivery in your area?

Dr Wrigley: It is commissioned through the local authority—so Lancashire county council. They offered the package, and, obviously, they have also outsourced it to other providers. As I say, we use our system to find the patients; we call them in; and they get a 20-minute appointment with a nurse, where all of the health advice is given, blood tests are taken, and their blood pressure and pulse are checked—

Q21 **Gregory Stafford:** Sorry, my question is really about there being lots of different commissioners within the NHS for these checks, and yours was commissioned through the local authority. What impact, negative or positive, did that have on the way that you were able to deliver the service, as opposed to it being commissioned in some other way?

Dr Wrigley: It is so disjointed. As I said, I have asked the committee around the country, and there are so many different systems in place and

contracts being offered. It is a real mess—what is going on is a complete mess.

That is why I talked about having a national contract offered for this. That would allow it to be undertaken across the board without that postcode lottery, because people are falling through the net here. In the north-east, a colleague said that it is really difficult to get people on board, because the funding is not adequate. If you provide that national contract with adequate funding, you will prevent more illness—prevent more strokes and heart attacks. It is about encouraging, nurturing and boosting general practice.

Professor Everington: The key to our success, I think, is clinicians, managers and patients working together on the commissioning process. That is absolutely vital. When I think of all the things we have achieved over the last 15 years, the clinician engagement is absolutely critical. One of the first things that we did 15 years ago, rather than sit there as commissioners and say, "This is what you've got to do and we're going to put money behind it," was go to general practice and say, "What's worrying you? What's your biggest concern?" They said that it was actually diabetes, which is a massive problem particularly in our Asian community in east London, so we focused there.

It is about that engagement. When you have those three groups working together on commissioning, that is when you will get the highest success rate. If I see anywhere in the system that is not working well, what I see is clinician disengagement—in population health, in managing finances and in managing the system. Therein lies the secret. It has been quite organic. Yes, there are drivers that you can set centrally, but it is that sense of ownership by the local systems that will actually make it happen.

Q22 **Gregory Stafford:** Am I sensing a disagreement between you two on the commissioning? Sir Sam, you seem very focused on the local element, whereas you, Dr Wrigley, seem to want a national system.

Dr Wrigley: I think you can do both; the national obviously then goes down to the local area, and where there is a national contract to offer the Health Checks, the localities take ownership through the ICBs. Focusing back on public health which, as I say, has been completely eviscerated in localities, you would have had public health teams focusing on this issue in their localities. They know the areas and they can focus on the deprived populations, but they are just not there any more. That national directive, with local input from the practices, the clinicians and the staff who know them best, works perfectly well.

Professor Everington: There is something about a national contract to give stability in primary care, but I think if you are going to get the extra traction that we all want, there has to be a local contract. Otherwise, there is a risk that the ICBs just say, "Well, primary care is not our responsibility. It's done centrally." Then you do not get the creative transformation, where an ICB will say, "Here's our very specific problem we have got locally"—whether that is type 2 diabetes or whatever—"how

do we shift funding from the acute to primary and community to make a real difference with much better value for money?"

Let me give you one example of the value for money that I am talking about. Roughly, to see a GP, for the complete episode with all the back office costs, it is about £25. That is peanuts. I used to be a lawyer and I could tell you what I used to charge—it is a big difference. When I was chair of the CCG 10 years ago, I asked my finance director, "Can you please tell me, what is the equivalence if somebody lands in out-patients?" At that time, he said £628.

Anything you can do to keep things out of hospital and to focus on prevention is going to be much better value for money, but if you have an ICB that is traditionally just bailing out the acute sector all the time, and is not using its creative muscle to think about value for money and the taxpayer pound consistently, you will not get the change. Yes, a central contract gives that stability and means that you do not have to duplicate—you do not want ICBs to duplicate most of the stuff that is in the national contract—but that sense of local ownership and responsibility is vital.

Q23 **Gregory Stafford:** That is very helpful. Finally from me, you have talked about the incentives and the barriers, but would you suggest any changes to the incentivisation or reward schemes for providers of the Health Checks to encourage a higher uptake?

Dr Wrigley: The funding that we get at the present time is £30 per Health Check. As I say, that is for all the work of finding the patients and calling them in, the 20 minutes of nurse time and the follow-up. It is not a lot of funding, and we need to look at that and address it to increase the uptake. What the other providers get—

Q24 **Gregory Stafford:** How much would you like?

Dr Wrigley: I would not want to put a figure on that. We would need to have a discussion and negotiation around it.

Gregory Stafford: I will not make you do contract negotiations in public.

Dr Wrigley: There needs to be a balance between the amount of illness you are preventing and the amount of work needs that to be done. That is where public health and the economists come in. I am happy to have a discussion about that, but it is clearly inadequate at the moment.

Professor Everington: I would like more funding for social prescribing. The determinants of health are about 80% social and 20% are the traditional biomedical determinants. In this sort of territory, where you have to provide a very personalised service to individuals depending on what matters to them and what motivates them, social prescribers are absolutely key. They are not just link workers or connectors. I have described them as highly emotionally intelligent. They like people. They are motivational coaches. They know what is available in the local system, and they know about it in a real way, not in a Google way. You can Google the swimming pool. I swim every day, so I can advise my patients on that,

and the social prescriber can do the same. A patient might say, "Look, if you are not body beautiful, when is the time to go when there are not going to be many people there?" They might say, "Who do you talk to when you go through the door?", and I would say, "Talk to Jane." It is that personalised approach that is important in all of this, and that is where the social prescriber comes in with that unique personalised knowledge.

Gregory Stafford: I would never describe myself as body beautiful, but it is a phrase I will take home with me.

Chair: I will take ownership of the phrase, if you don't want it.

Q25 **Anna Dixon:** Thank you to both the witnesses. I declare a conflict of interest: I have known Professor Everington in a professional capacity for some years.

Something we have not touched on is the fact that NHS England is spending a lot of money on some national programmes, such as weight management diabetes prevention programmes. We have also seen, through the public health grant, a reduction in the amount of money being spent on smoking cessation services. Key to the success of the Health Check programme is not only attendance but follow-up and the detection of those who are at higher risk through that follow-up. Some of that follow-up sits with doctors. You can write a prescription for statins or hypertensives, but as Professor Everington was describing, for a lot of people, the follow-up is about behaviour change, whether that is to diet or physical activity and so on.

How are you connecting Health Checks into the money being spent by NHS England on these centrally commissioned programmes? Could we be getting better value for money in terms of the support available for follow-up, whether that be an increase in the public health grant for smoking cessation, for example, or something else? Perhaps you could answer first, Professor Everington, and then we will hear from Dr Wrigley.

Professor Everington: The public health grant is really important and should be ringfenced. It is well worth looking at because it is completely variable across the country. When we became a CCG and the local authority took over the public health grant, we gave it the top grant in the country. There is something about actually looking at that grant but also looking at what it is spent on and then protecting it. Local authorities, like ICBs, are under massive pressure in all sorts of directions, and it is very easy to take money out of these areas, because most people see them as low-hanging fruit. The temptation is always the winter crisis or the immediacy of any crisis, unless you do ringfence this. It is a bit like ringfencing social prescribing; I would say you need to do that in primary care. It is really important because it is a new and developmental area. That is crucial.

The national schemes are helpful—don't get me wrong—and I think they have driven a change, but I think that is about taking local ownership. My final point is to be cautious about the biomedical approach. The drive now for everyone to have Mounjaro and these injections is enormous, but we

have no idea of the long-term effects. Yet again we are seeing a drive towards biomedicalisation, whereas we should go back to what I am talking about all the time: that personalised approach to an individual. It might be that what somebody needs is a dog to walk every day; that is the thing that is going to get their weight down and get them motivated to change their lifestyle.

There is a key issue with the local supermarkets. I live in social housing locally. I shop in the local supermarket. You see what people have in their trolleys. It is just appalling. Most of what you see in supermarkets is not food. They call it ultra-processed food. No, it is not food, full stop. Supporting patients in managing their finances is really important. There is a widely held belief that healthy food is more expensive. Well, if you see the trolley full of Coke, cakes and biscuits—I could spend the same money and provide a really healthy diet for the whole family.

We need to pay attention also to schools. This is really important. We would like to see a school nurse in every school, not just doing heights and weights but managing proactively social, physical and mental health. Children often get forgotten in this whole process, but that is where the ticking time bomb sits. When I trained as a doctor all those years ago, type 2 diabetes was a disease of the elderly; now I see teenagers with type 2 diabetes. This is the ticking time bomb. This is not just about adult Health Checks. There has to be in every school—like in Norway, where I come from—healthy food every day for lunch, exercise, and a complete focus on health. It is the case that 15% are overweight in Norway; it is 60% in this country. So go back to the prevention and go back to schools. Ask yourself why there is only one nurse in every six schools. Shouldn't there be one in every school, and shouldn't they be on every governing body?

Chair: I am going to have to stop you there; sorry about that. Thank you very much for giving evidence today.

Dr Wrigley: Can I add something?

Chair: No, we are going to swap the panels quite quickly, so thank you, you were both excellent. We will speak to you soon. Thank you.

Examination of Witnesses

Witnesses: Dr de Gruchy and Jonathan Marron.

Chair: Thank you for appearing before us today. I would like to ask you to briefly introduce yourselves—perhaps ladies first?

Dr de Gruchy: Thanks, Chair. I am Jeanelle de Gruchy. I am the deputy chief medical officer for England and the professional lead for the Office for Health Improvement and Disparities in the Department of Health and Social Care.

Jonathan Marron: Good morning. I am Jonathan Marron, the director general for primary care and prevention at the Department of Health and Social Care.

Q26 **Chair:** Thank you. I will start by just asking you about a few points. The NAO report compares Health Check attendance against eligibility. Public Health England said that local authorities should aim for 75% of the eligible population to attend over five years. My question is, what is the Department's target for Health Checks?

Dr de Gruchy: Chair, could I take a slight step back and talk about Health Checks within the programme—

Chair: What you can do—without me reading the question—is give us an update, tell us where you are at, and tell us where you are hoping to get to. Is that simple enough?

Dr de Gruchy: Yes—thanks. I did want to situate the Health Checks programme, which is an excellent, evidence-based programme, and talk about why it is important, if that is all right. Cardiovascular disease has a huge health impact. It is the second biggest cause of mortality in England; one in four of our deaths are through cardiovascular disease. It is a real disease of inequality as well. Those in the most deprived areas are more likely to die young from cardiovascular disease—four times more likely than those in the least deprived areas. It is a really important driver of the gap in life expectancy. We also know that a third of new cases are in working-age people.

We have a huge issue, but, at the same time, we know that we can do something about it. We have seen the trend in cardiovascular disease come down from the 1960s—we have about five times less under-75 cardiovascular disease—but we also know that it has stalled within the last 10 years. That is a real concern if it is preventable; about 70% of risk factors are modifiable. The question, which goes to your point, is: what more can and should we be doing?

Q27 **Chair:** Could you also put into that why less than half the population are actually attending these checks?

Dr de Gruchy: We will come to that. We have a lot, and I heard the previous witness talk about all the primary prevention efforts. Those are really important in terms of having brought that premature mortality—that early death—from cardiovascular disease down over time within the country, but, at the same time, we need to do that secondary prevention.

We need to find people who are at higher risk, and we need to engage with and talk to them and invite them in. They need to understand why it is important for them to attend. They need to actually be able to come and take up the opportunity to have that conversation, and the conversation and the way in which we engage need to enable and empower them to actually do something about those modifiable risk factors. The Health Check programme is really important in doing that—it is evidence-based,

at scale and systematic—but there are clearly issues in terms of who is being invited and having that systematic invitation.

There are also issues with the uptake. Who is taking it up, and how are they consequently modifying those risk factors I talked about, which are preventable and modifiable? I will turn to Jonathan to look at why we see that there are issues in terms of the invites and then translating those into uptake.

Jonathan Marron: Maybe we should look at invites and uptake. We started measuring the programme when it moved to local government in 2013, so we have data from then. We—or, rather, local government—have issued 29 million updates, and some 13 million people have had a Health Check. About 40% of people who are invited actually come through. We have two things that we really care about in trying to drive more people getting a Health Check and more people being followed up. As the NAO has talked about, one is if we can get sufficient offers out to people.

You will have spotted that we measure this in a really confused way. Some 20% of the eligible population should be called each year so that 100% is called over a five-year period. That makes it very confusing to have these conversations, because all the numbers sound wrong. Last year, 22% of the eligible population were offered an appointment, so local government last year were doing a good job of getting out the sort of numbers that they want. Of those, about 40% took up their appointment offers, so I think 8.8% of the eligible population had a Health Check in 2023-24. If that was the same over the five years, we would get to 44% coverage. Those are the numbers that the NAO has.

We—or local government—are doing a reasonable job on offering to people. The real challenge is: can we get people to take it up? As Jeanelle says, it is really valuable for people, and it really helps them to understand their risk. Of the people who have a Health Check, 95% have one modifiable risk factor, and something like 70% have two. If we look at the 1.4 million that we do a year, some 70% of people then have a brief intervention to help them to think about what they could do to reduce their risk. That may be helping them with their weight, alcohol or smoking. A very significant proportion then get referred on to primary care for further clinical investigation, which is about 40% of people. Of those, 10% actually get clinical management. We know that it is important, but the question is: can we get people to really think about if they will take it up?

Q28 **Chair:** But Jonathan, the National Audit Office report stated that out of the six recommendations, you were able to meet two of them adequately, but on the other four, you were not meeting the recommendations.

Jonathan Marron: Are these the recommendations from the 2021 review—our own review?

Chair: Yes.

Jonathan Marron: We commissioned the review of Health Check to understand if it is working. It is a really important piece of work. We took

12 million records out of primary care longitudinally and looked to see if there was any impact from the Health Check.

That has shown that the Health Check is effective: it reduces the number of heart attacks and deaths, and there is some suggestion that wider risk factors are also reduced over that period. It is a really detailed piece of work.

Its six recommendations were broadly about making Health Checks more available and available in ways that people will find more attractive. Those are the things that we have prioritised.

We have done two things. We are working on a digital Health Check, so that people can do it at home at their convenience, including having much of the cholesterol and blood testing sent to them at home. That is quite an innovative programme.

First, we will be working with three local authorities over the beginning of this year to try and pilot that: Norfolk, Lambeth and Medway. We are looking at three different areas and asking, does that make people more likely to carry out the Health Check and would it be a way that we can make it easier for people to take up?

The other thing we have done is look at an alternative to asking people to come and see their GP or pharmacist, where we instead arrange for the Health Checks to happen at their work. We have worked with 48 local authorities and are aiming to do 130,000 checks by the end of this March. We have an evaluation in place in the summer to see whether this has been effective. We are really trying to look at the ways of reaching more people with the Health Checks.

Looking at local government practice, local authorities are responsible for the Health Check, and they make their own decisions. There is a real variety of practice. Learning from the best of local government as to how they have managed to up the numbers of people having a check, and reach communities that are most at risk, is the next big piece of work that we need to do.

Chair: Great stuff. The people around the table will dig deeper into what you have just said and there is a lot to unpack.

Q29 **Deirdre Costigan:** Thank you both very much for coming today. We have heard some really interesting evidence from Tower Hamlets and Cumbria, which has given us some good background about how this works in practice.

Dr de Gruchy, you said that cardiovascular disease is a disease of inequality. You said it yourself, and it is mentioned in the NAO report, that more deprived populations are four times more likely to die prematurely of cardiovascular disease.

It is also a disease that some communities, from particular ethnic backgrounds, are more likely to die of, such as the south Asian

community. My constituency of Ealing Southall has a very high proportion of south Asian constituents, and diabetes is another issue there. It is also another factor in cardiovascular disease.

Looking at the NAO report, do you think we are reaching enough of the people who are more likely to die prematurely of cardiovascular disease?

Dr de Gruchy: We agree we could do more. Working with local government could do more to achieve that.

I was a director of public health for 14 years. I and other directors of public health would absolutely be cognisant of those inequalities and the question of how we ensure that we provide both universal service and that uptake is greater among those who have the greatest need.

There are different ways in which different authorities have tried to do that. Sharing learning between different authorities is really important. OHID regional teams and directors of public health are able to provide a lot of support in encouraging and enabling local authorities to look at who is taking up the Health Check and then doing something different as a consequence. The whole process of that challenge and support is really important.

Then in terms of OHID, Jonathan has talked about the review, and we did a huge segmentation piece of work looking at who are the different communities and why—in segments of the population—and whether they understand, are interested in and think they can do something about the modifiable risk factors. Then we looked at how the programme is delivered, the way in which we try to engage those communities, and how we should adapt it in a way that makes sense to particular groups who are less likely to take up the offer and do something as a consequence. That is really important.

There is starting to emerge a diverse way in which the programme might be delivered. Local authorities are increasingly using GPs and primary care as well as pharmacists, and that is an important way to engage with communities, as pharmacies are perhaps easier to access and less threatening. They are using pharmacists and other community and voluntary sector organisations to reach in and have conversations with people in particular communities who might not want to come forward and take up the offer.

Deirdre Costigan: Did you want to add anything?

Jonathan Marron: Just a couple of broad points. This is a real balance. CVD risk is broadly spread in the population, which is why we started with a process of trying to call all people who were not currently being managed for CVD to capture as much as possible.

Q30 **Deirdre Costigan:** Just to interrupt you briefly, that seems to go against what we have just heard—that it is more likely to be a disease of inequality.

Jonathan Marron: It is broadly spread, but in some of our most disadvantaged communities there is a much higher level. So the risk is higher, but it is not that all the risk is in those communities. This is the tension in the programme. The original set-up was, "Let's call everybody in as they reach 40 and see if we can change behaviour across the whole population." I think that is a legitimate thing to try to do. But we have also thought, "How do we make sure we are targeting our efforts on those who will benefit most and who have the greatest need?" The balance in how we deal with those elements is important.

One of the things we have seen is that quite a lot of the opportunistic testing is really helpful for targeting communities. If you turn up in the shopping centre and ask people to have a Health Check, they will do it there and then, and you can find a reach that is different from if you were to send them a text message or a letter. It is not just targeting or not targeting, but what approaches we use—how much of it is writing to people and inviting them in and how much of it is being in the place that people are in? Frankly, will our digital process allow us to be present wherever people are and are interested in their health and motivated to have a check? We have to think about how we are getting to people and giving them a chance to engage on their terms, and we must not have a one-size-fits-all programme.

Q31 **Deirdre Costigan:** I understand the point you are making, but the hard fact is that even though we are saying that it is a disease of inequality and there are particular ethnic groups who are more at risk, you are more likely to get a Health Check right now if you are more affluent. Basically, the most deprived people are least likely to get a Health Check, whereas the more affluent are more likely to get one.

Jonathan Marron: That goes back to the point about how we offer them. I don't think it is true that you are more likely to get the letter if you are more affluent, but there is higher take-up in more affluent communities. This comes back to thinking about how we make that offer and whether we are making it easy for people to take it up.

Q32 **Deirdre Costigan:** What is the driver for that? At the moment, as you say, the target you have is everybody over 45, so it is an age-based programme. Is there not only a health reason but a value-for-money case for using the limited resources you have to target people who are more at risk?

Jonathan Marron: Over 40 was chosen because that is when your risk starts to increase. One of the things that the review in 2021 looked at was offering it earlier in some communities. The CVD risk in the south Asian community, as you said, is much higher. It starts to manifest itself earlier in life as well. So there are questions around whether for some communities we should go earlier than 40.

Q33 **Deirdre Costigan:** What is the thinking on that at the moment? Is that being assessed actively?

Jonathan Marron: We have really started on trying to broaden our access. Can we do it through work? Can we do it through digital? That is where we have put our focus in the last few years. We now have the NAO report. The Minister is very taken with it. He has asked us to look at all the recommendations, so we will be looking back at these. And of course the Government have already made their commitment to reduce CVD mortality by 25% over 10 years as part of their shift to prevention rather than treatment. I would expect that to be a significant part of the ten-year plan as we get to that in the summer. So I think this is a real focus for how we reduce CVD risk. As Jeanelle says, 70% of it is due to modifiable risk factors. Our real challenge is exactly how we spend our money and how we make sure that all of our communities benefit from it.

Q34 **Deirdre Costigan:** Let us move on to how the service is commissioned. One of the issues that we heard about from Professor Everington and Dr Wrigley, whom we spoke to previously, was the tension that we have between some health-related, prevention-related stuff that is commissioned nationally and stuff that is focused on locally. We had a slight difference of opinion as to what would be the best approach. One issue is that there are not the levers currently with the funding coming through the public health grant, which has been much reduced and which local authorities are in control of. We need to consider whether they might need to spend that money on—I don't know—temporary accommodation because the system is breaking at the moment. So there is not the national targeting or push to sometimes allow that focus locally.

How do you think the current commissioning system is working? Do you think it is fit for purpose and will help us to achieve the targeting and get to the people who are most likely to be helped by Health Checks?

Jonathan Marron: Jeanelle will have views, not least because she has been a DPH for so long. Again, I think this is a real challenge because we are trying to balance different things. We would like everybody to benefit and for there to be a sense of more national consistency. Also, we really want to be able to tailor locally. We are talking about reaching the communities that do not really engage with our services. The best chance is to do that locally. There is lots of advantage to having a locally commissioned service for the Health Check. Clearly, it needs to dock in with the NHS services and we need to make sure that the GP contract, which pays for the follow-up care and incentivises it through the QOF, is fully aligned with CVD prevention. If you think about what we have done in the last few years, we have added new measures on CVD prevention and taken other things out. So the GP contract will be much more focused on this, and I expect that to continue over time.

In terms of local government commissioning it, I think it brings real advantages with the DPH being close to their local communities. They can think about different ways to do it. Obviously they then have to work with the NHS, so there is complexity. But if you swapped over and said that the NHS commissioned it, they would still need to work with the DPH and local communities. This is something that needs to be worked out locally, in partnership between health and local authority services.

Local government has lots of levers to make it happen. The real question is prioritisation and spend.

Q35 **Deirdre Costigan:** Could you give us an example of what those levers are?

Jonathan Marron: The way that they secure the Health Check programme with GPs and pharmacists is by buying the activity, so they have the most direct lever: they pay for it. I know there are bits in the NAO report saying that they have no formal leaders to tell GPs to do things, but the vast majority of GPs are small businesses. You can have a conversation about doing work; I think that is perfectly reasonable. The question is: are we collectively prioritising the Health Check, and are people making the same decisions? Again, the report is very clear that different local authorities have taken different views on how much they prioritise this. Indeed, we have seen some authorities really change their performance. Salford is a great example, which until very recently was quite a low-performing local authority. It has put in place a new package of public health interventions through GPs with the incentivisation of getting paid more the more they do, and that has seen their performance massively improve. There is quite a lot we could do about, not the system and the broad architecture, but what is the practice, what works, and can we learn from people who have been successful?

Q36 **Deirdre Costigan:** The NAO report did recommend reviewing the value of commissioning Health Checks through local authorities compared with the NHS, or a different system. Will you be doing that review, or have you already decided that you are going to stick with what you have got?

Jonathan Marron: No. Mr Gwynne has asked us to look at all the recommendations. He is very open-minded about it, so we will do this work. I was simply trying to reflect that I don't think it is a straightforward question, and there are advantages that come from local authority commissioning as well as from NHS, which I am not sure quite comes over in the NAO report.

Deirdre Costigan: I am sorry; could you say that—

Jonathan Marron: I think the NAO report suggests that this would be a very simple thing to do, and there are obvious benefits from having NHS commissioning. I do not think it really talks about the advantages of local authorities and the DPH in this process. We will look at it. We will need to make a decision, and there are arguments for both ways of doing it. I think there are very clear arguments for improving practice in how we deliver Health Checks, as opposed to necessarily changing the architecture of the system.

Q37 **Deirdre Costigan:** Is there a timeline for that, because in the meantime there are still concerns of a postcode lottery?

Jonathan Marron: We are getting on with that work now.

Deirdre Costigan: But what is the timeline for that?

Jonathan Marron: The teams have started. I have not got a clear date for the finish.

Deirdre Costigan: Would it be useful, Chair, if perhaps you could get back to us on what the timeline is for that?

Chair: Yes.

Q38 **Deirdre Costigan:** I will ask you about the operational considerations for changing how they are commissioned if you do this review. Do you have any feel right now? You have said that the NAO might have—I suppose—a slightly simplistic view of how it might happen. What would the operational, logistic barriers be if you were to change that?

Jonathan Marron: If you actually want to change it, the first thing you have to do is take the money off local government and give it to the NHS. I think the amount of money spent is around £60 million, so it is not a significantly large number. There will need to be instructions to the NHS to do it. The bit that I am more worried about than those practical things is that it is really important that the directors of public health—the people thinking about health inequalities in their communities—are part of this programme. Even if you were to change who was the lead commissioner, you would still end up with the same people around the table trying to work out what the right answers are.

Q39 **Deirdre Costigan:** Was this ICBs rather than local authorities?

Jonathan Marron: Currently the local authority holds the money and buys it from local NHS providers largely. I think 50% of all local authorities only buy Health Checks from GPs—70% or so are buying the majority of theirs from GPs. It is not as if this is a local authority service that is somehow running away from the NHS with no co-ordination; this is something done jointly in practice. That would need to stay.

Again, we will look at the NAO's recommendation and we will talk to local authorities and to the NHS and see what they think. If we come back with a proposal for the Minister because they think making the form will change who the lead commissioner is—obviously we can do that on top of that. I think we will find lots of operational things about how it works being easier to do and quicker to drive success, so I think we will look at that as well. I'm still prejudging the work now, which is difficult.

Chair: May I stop the conversation at this point? Before I bring Andrew in, Danny and Dr Beccy Cooper wanted to ask two quick follow-up questions.

Q40 **Danny Beales:** This is just a follow-up question, because I do not think I heard a clear answer about dealing with failures in the programme. I use the word "failure" because the NAO report shows that in some former CCG areas, 0.1% of the eligible population took up the check, compared with 22.6% in the best areas. I cannot think why local reasons or localism would be an acceptable justification for why only 0.1% would need the Health Check in certain areas.

What are the mechanisms, centrally, that you in the DHSC or colleagues in

NHS England have to address that unacceptable variation? Conversely, if local commissioners are unable to change their system, what mechanisms do they have at the moment to bring about change?

Jonathan Marron: I think the example of the very lowest performance are the Isles of Scilly, where they had been relying on one GP practice that then had some challenges.

Q41 **Danny Beales:** We will ignore the Isles of Scilly—no offence to them—but a large amount are below 5%, compared with 22%.

Jonathan Marron: First of all, it is a duty of local government. The responsibility in law to provide the Health Check is with local authorities. It is also a required service under the public health grant: they are expected to provide a service. We have worked, through our regional offices and our regional directors, with local authorities to improve their performance, to challenge very low levels of performance, where we see them, and to see what can be brought on. The support of the local authority and the DPH for the programme is significant in driving whether they are successful.

I am not sure that this came out in the NAO report, but the programme was deeply controversial when it was launched back in 2009, and I think some of that is still there. One of our challenges is "Do we all believe this is the right thing to do?", which I am hoping the current NAO report will help with. It is very clear that we could do more, but it is not questioning the basis of the programme itself, which was the case in the late 2000s.

There is a question of how we work with others. We have been trying to set standards for what the Health Check should look like and to provide good practice guidance. Technical guidance has been produced. The DPH and our regional directors have been trying to foster relationships and build what works in practice. Where we get the worst sense that we really do not think anyone is doing them, obviously conversations are had: "Actually, this is one of your statutory duties." Could we do more on these things? Almost certainly.

Q42 **Danny Beales:** Are those standards mandatory or are they advisory guidance?

Jonathan Marron: It is guidance. The legal requirement is there on local government to provide—

Q43 **Danny Beales:** Should they be a mandatory part of the programme?

Jonathan Marron: Again, I think what we are really interested in is how we have the most effective programme. We are still learning about how we reach communities. Some level of variation in how that is done is helpful as long as we are using it to learn and drive. That is important.

Q44 **Danny Beales:** To finish up, because time is short: the amount of variation in the programme is not currently acceptable. It is not about localism, from what I am seeing. As my colleague Deirdre said, we are not reaching the right people. The variation in performance is unacceptable, I would say.

Jonathan Marron: Yes. Again, Andrew Gwynne, our Minister, is very clear that he agrees with the recommendations of the NAO report and wants us to look at how we do this. The whole question of how we address that variation is at the forefront of our mind.

Chair: We will stop there and go straight on to Dr Beccy Cooper. Thank you for that, Danny.

Q45 **Dr Cooper:** Do you think that this should continue to be a universal offer?

Jonathan Marron: I think there is a balance. There is advantage in getting as many people as possible. We are not, as a country, a healthy population. As I say, of the people who have had a Health Check, 95% have at least one risk factor, 70% have a brief intervention to try to improve their behaviour, and 11% of them actually need clinical management. There is significant risk, so I am keen to find ways for as many members of our population as possible to understand their risk and to take care of themselves. That is important. That said, we must try to focus our attention on reaching those in most need. We need to do both things.

Q46 **Dr Cooper:** That was a beautiful political answer—thank you so much—but on balance, if you have a limited pot of money, which you do, would you favour making this a targeted programme?

Jonathan Marron: To answer that question, I would want to be very clear about what we thought the benefits were and about the evidence for them. Jeanelle might want to give a public health view at this point.

Dr de Gruchy: It is a good challenge. One needs to keep on going back to the evidence base. I suppose there is a trade-off between universal and targeted, and that is something that we will look at again. At the moment, it is not clearcut. Figure 6 in the NAO report is really good: it shows the mortality rate across all deciles. One in four people die from cardiovascular disease, so it is not that it is not in particular communities.

We need to reach into all communities and have those conversations about their level of risk and what we can do about it. We also know that if we are not reaching into and prioritising energy and effort in those communities that will benefit the most, it is a problem. We need to do both/and.

One of the issues, which might come up in a subsequent question, is about using the data to understand who exactly we are reaching and what the assumptions are about who we are reaching and who we are not reaching. Local areas will have some of that information and may well already, within their universal offers, be targeting in a particular way. For instance, they might be contracting particular community pharmacists in particular communities, doing opportunistic screening events or contracting community champions or VCSE to work with particular communities. Within the delivery of the programme in local areas, I think you will find that there is a universal offer but that effort is also put into getting to those communities that would most benefit.

Dr Cooper: That is interesting. The GPs who were here previously were very much of the opinion that GPs should be delivering the Health Checks, so it is interesting to hear a different perspective.

Q47 **Chair:** I have to admit this: you started the conversation by saying that the way in which it was measured was really quite awkward: it is 20% each year over a five-year period. You then said that it is a universal offer; you then said that within that universal offer there is a limited pot of money. It all makes the point that Dr Cooper has raised: if we have a pot of money, should there be a universal offer or a more targeted service? You have given some very interesting answers, but to be honest you have not answered the question, in my humble opinion.

Jonathan Marron: The reason for that is that we have not got to our answer. We are doing work on this to try to conclude—

Q48 **Chair:** So at the moment you are working it through, and an answer will be delivered at a future date.

Jonathan Marron: Yes. What I would just try to reflect is that actually it is quite a difficult question.

Chair: Excellent. On that lovely note, I will hand straight over to Andrew George.

Q49 **Andrew George:** I speak as the MP for the Isles of Scilly, which have a population of approximately 2,500. There are a number of anomalies that often apply to the Isles of Scilly.

Jonathan Marron: They are doing much better on Health Checks, I must say.

Andrew George: Exactly. I suspect that there is probably something within the methodology of the reporting that might explain it, but I will raise it with the GP when I am over there.

Jonathan Marron: I think it is very simple. There is a very small population with a small healthcare service; I think that issues with primary care not having enough capacity meant that this fell by the wayside for a bit, but it has now been fixed. That is the short story.

Q50 **Andrew George:** Coming back to the wider geographic view, I would be interested to know, given the difficulties—I am not saying that you are fully responsible, but I know that you are not proud of the Health Check response rate or take-up levels—what lessons can be learned from health programmes that have been a success. I do not have the figures before me, but I am thinking of things like the roll-out of the covid vaccine or bowel cancer tests. Can any lessons be learned? Are there health programmes of which the Department is proud or of which you can say "We've had a great success here"? Can you not apply the lessons from them to the roll-out of these tests?

Jonathan Marron: That is an excellent question, and I am sure that Jeanelle will want to come in, but let me have the first go.

First of all, I am proud of the Health Check programme, albeit that I think we could do more to get more take-up.

The real difference between Health Check and vaccinations or our screening programmes is that Health Check is really about helping people to understand their risk. We are not finding an existing disease and treating you for it; we are finding that you have a higher risk of CVD developing over the next 10 years. At some levels, that risk is for you to do something about, like changing your diet, losing some weight or stopping smoking or drinking. For some people, however, the risk is sufficiently high that the health service would like to do something about it, like managing your hypertension or your cholesterol.

In some ways, it is a more difficult pitch to the public. Coming in for a Health Check or for some behaviour change is more difficult than coming in for a screening programme for breast cancer, say, where it is very clear what you are there for. There is a challenge in the communication and what it means.

More broadly, that leads us to think about how we can get people to engage. As Jeanelle said earlier, we have done some work to find out what people think about health, whether different people in our community think differently and whether that means that we have to engage with them differently. That raises questions for us. It comes back to trying to have a broader way of offering the Health Check.

Q51 **Andrew George:** But in each case, with a successful programme, you get them through a door or you get them to try something to get the process started. I think the problem that you are having is that you are not even getting any kind of response.

Jonathan Marron: The original set-up of the Health Check, where we send you a letter and ask you to come in, is very like a screening programme. But we have a 44% uptake, whereas with our screening programmes it is more like 70% or 80%—I would need to confirm that. So that simple process is not getting the same results in the Health Check as it is in screening. I think it is because it is not as clear why you are coming in.

Q52 **Andrew George:** So it is a communication issue.

Jonathan Marron: I think it is partly a communication issue.

Q53 **Andrew George:** Are you not expressing it clearly enough? What is happening?

Jonathan Marron: It is deeper than a communication issue. The member of the public receiving the letter has to understand why it is important to them. That is more difficult to do than simply saying, "We are screening you for a particular disease," so there is a challenge there.

We have seen success with local authorities organising pop-up opportunistic sessions, where they just go to places where people are and ask them whether they would like a Health Check. That seems to be

successful. We are hoping that the programme on workplace testing will also be successful: you go to work, people are there and they just take it on. The range of options for how we can get hold of people, rather than just writing a letter and hoping that they respond, is quite an important part of our process.

Jeanelle is itching to come in. I am sure she has much more sensible things to say, so I am going to shut up.

Dr de Gruchy: I think there are two things, and this is true of any screening programme. I agree with Jonathan that it is more complex, because what we are trying to convey to someone is not whether they have a cancer that they did not know about; it is more like "You've got an increased risk of getting, in the next two years, this thing called cardiovascular disease or having a heart attack or stroke, and you can do something about it—but you are the one who needs to do something about it."

So the first thing is that people do not understand, as Jonathan mentioned. The 2021 review articulated that and went into a lot more detail. People think they do not need it. They do not want any bad news. They do not want to be told off: "Look, I smoke and I'm a bit overweight. Why would I go to the GP to be told that? I just don't want to."

It is quite difficult with those elements. There is something about people's understanding of what it is. That is where the segmentation was important, because it broke down different groups of people. It said, "These are the people who are going to come anyway—fine, they'll come. This is thinking that goes on in groups of people who are not going to come. This is how you might want to communicate differently and encourage people in a different way." That is the first thing.

The second thing is about access. Cornwall, for instance, will have a big issue because there is much more rurality. For people to actually bother to get in the car or leave work and go for a Health Check, they need to be really invested in going, having that conversation and then doing something about it. There is something about accessibility: the supermarket example is about how we can break down some of those pure accessibility issues. We know that screening programmes where you get something through the post and send it back have a bigger uptake than the ones where you actually have to go to a breast screening, for instance. There is definitely something about that physical access.

That is why we are hopeful that the digital element will enable people to do it at home, which will increase the accessibility. That is why the digital programme is really important. It will also encourage, over time, a bit more engagement with one's sense of their level of risk of getting cardiovascular disease. With the digital programme, we need to make sure—this is built into the way we will evaluate it—that it actually gets to those communities so that it increases people's access. That is a really important part of it.

Q54 **Andrew George:** So when will you know? You are rolling it out in three areas at present: Norfolk, Lambeth and Medway. It is well known that the most digitally enabled are in your high take-up groups and not in the target groups that are most at risk, is it not? Are you not fearful that pursuing a digital methodology will actually just reinforce a much higher take-up—not that that is a bad thing—among the group that is perhaps at less risk, but a lower take-up among those who are at higher risk?

Dr de Gruchy: It definitely needs to be evaluated, and I think that is the idea. Equally, it could increase access for people. We know that, over time, people are increasingly digitally savvy. I think it will also enable us to be more bespoke in the messaging and the nudging. That links through to actually thinking about the ways in which people might be able to change their behaviours. I think it provides much more opportunity for that: certainly, over time, one can much more quickly adapt and change based on the feedback.

We will have better data about who is taking it up. As you say, we will therefore be alert to who is and is not taking it up. It is not a replacement for the face-to-face check; it is just an additional option. It might help, on the point about the universal or targeted, with the ability to put more money, energy and effort into ensuring uptake.

Q55 **Andrew George:** Will those who receive an invitation to undertake a digital check-up be invited to undertake a face-to-face check as an alternative?

Dr de Gruchy: I think it is additional. Because it is in three pilot areas, I think we will be exploring the ways in which it is delivered.

Jonathan Marron: The aim is to make a digital one available to expand access so that more people can take it up and people who are interested in their health can look for a Health Check. I think we have something in the background to make sure that you are not getting endless face-to-face Health Checks through the process, so everybody gets it rather than just a few people.

As Jeanelle says, the aim is to open up access to more people. That could indeed mean that the local authority-commissioned local services could become more targeted if we get lots of people coming through digital, but we do not know yet. There are three authorities being piloted and the NIHR is doing a formal evaluation, so we will really get a sense of whether this works.

Q56 **Andrew George:** When will you know?

Jonathan Marron: I believe that that is coming this year as well. We will be doing the pilot into early next year.

Chair: Thank you very much, Andrew. I will bring Dr Anna Dixon straight in. Anna, you have about 12 minutes. Let's see what we can do in 12 minutes.

Anna Dixon: Okay. I will encourage our witnesses to be brief in their

answers.

Chair: We will speed them up if they are going around the bushes a bit. Over to you.

Q57 **Anna Dixon:** Thank you very much, Chair. Before I get into questioning, I will declare a potential conflict of interest: I worked at the Department of Health with Jonathan earlier in my career, before coming to this place.

I will pick up on the issues of the data and the evidence base. As you might have envisaged, as I am guesting from the Public Accounts Committee, there will be quite an emphasis on value for money.

The NAO report says: "The lack of data prevents DHSC from having a national understanding of whether people who are most at risk of CVD are those attending Health Checks and whether people are accessing services or clinical support to help them reduce that risk." Without data such as age, gender, ethnicity and socioeconomic status being routinely collected and shared, what information have you relied on to ensure that the programme is delivering value for money? I guess that that includes reaching the people who can most benefit, as we have discussed.

Jonathan Marron: The data we have most relied on is the data that was collected for the 2021 review, which basically pulled 12 million records out of primary care and looked longitudinally at the experiences of those people.

Anna Dixon: But you are not routinely—

Jonathan Marron: That establishes a very clear evidence base for its effectiveness. That gives us great evidence that this does behave as we expected. You are right, we do not have routine data to that level.

We are currently working with our national advisory group, with local government and with the NHS on what improvements we can make to the data, particularly about getting more information on who is receiving it and ethnic group, the kind of data you would expect to have and that type of thing.

That is something that we are actively working on. As the Committee will fully appreciate, the wider set of information-sharing challenges between local government, the NHS, primary care and the DHSC continues to be something that we work on broadly.

We do not have routine access to the GP record in the way that some might expect. When we try and do in-depth research, it tends to be these one-off projects rather than a meaningful look all the time. There is a much bigger question about data there.

Q58 **Anna Dixon:** It would be useful to understand whether that is going to be part of this review you are talking about in response to the NAO and what the timelines would be. It seems very difficult for you to drill into best practice if you do not actually have data on who is performing well on a real-time basis, as opposed to these one-off studies.

You talked about the evidence base in the 2021 review. What were you able to establish about the cost-effectiveness of the programme?

Jonathan Marron: We established the return on investment of the programme is that for every £1 we spend; it pays back £2.93.

Q59 **Anna Dixon:** Does that include all the costs of the follow-up?

Jonathan Marron: Yes.

Q60 **Anna Dixon:** Coming to some of the data around integration. You talked about the lack of collection of data but also the sharing of that data. That needs to be on who are you inviting, who has then subsequently attended and what follow-up they receive.

Will you be able to track that right through to what the outcomes are as a result of that follow-up? For example, you talked about 70% brief intervention. Do we know whether, having received a brief intervention, people actually change those modifiable risk factors?

Jonathan Marron: The detail of our understanding comes from that study where we looked at 12 million records. That is our best evidence base. In terms of following things locally, wherever a third party is providing the Health Checks—so not the GP—there is a requirement for them to share information so the GP can continue to track and understand what is happening to their patients in order to avoid risk.

We have done lots of work with local government. PHE has published guidance on data sharing regarding what information can be shared for management purposes. We have done lots of work with anonymised information, which is obviously much easier to share across the boundaries of organisations.

Some of the questions we have started getting into would require patient identifiable information, and that makes it much more difficult. These are some of the things we are going to have to think about as we address those recommendations.

Q61 **Anna Dixon:** In the NAO report, it specifically mentions this data set from CVDPREVENT. In addition, we heard from our earlier witnesses about the potential for patients to input data through Accurx, which I believe is quite prevalent within general practice.

We also heard about other tools that would help primary care to target either Health Checks or subsequent interventions by embedding QRISK3, which is an academically developed risk scoring system.

What are you doing around these sorts of opportunities for better data to help support the prevention of CVD?

Jonathan Marron: CVDPREVENT is really exciting. It is a national-level clinical audit of primary care. It is using the primary care data to look at CVD risk and levels of treatment and under-treatment, so really getting at who is being treated. It gives us a chance to understand what is

happening in practice. That will be a very powerful data source and I am really looking forward to working with that.

Q62 **Anna Dixon:** Can we link any information on Health Checks into it, so the sort of thing that you had to commission in 2021, and was very laborious, could be embedded within that audit? Then we would be able to understand, on an ongoing basis, the value of people having had or not had a Health Check.

Jonathan Marron: This is one of the things the NAO has recommended, so it would be one thing that we could look at. It is not included currently. Really it is looking at the management of CVD in primary care, and remember it is not only Health Checks that find people with CVD risk, but GPs will also do that themselves. If we can make the connection to the front end, I am sure we will add further information on the effectiveness of the Health Check programme.

As you said at the beginning, really, we are trying to prevent CVD. The Health Check is just one part of helping people understand their risk and some people being funnelled into primary care services.

Q63 **Anna Dixon:** To come to Dr de Gruchy, you have talked a lot about what more could be done to understand uptake and the different approaches, and about workplace and digital as new areas. I encourage you to think about jobcentres to reach some of these people. But there is no point identifying the risk factors if nothing happens as a result. The data here on treatment seems to be largely more biomedical. We heard from previous witnesses about the need for a more holistic approach: for example, the use of health coaches or social prescribers in primary care, rather than just a GP patronisingly telling people—sometimes, I am afraid, a brief intervention is just that, which we know is not very effective.

Alongside that, NHS England is spending a large amount of money on national diabetes prevention, on various things around tobacco and alcohol dependency, and on weight management programmes. Given this point about evidence and data, how are you assuring yourself that—even where you are getting attendance and detection—you are getting improved management? I know you mentioned that briefly, but I would like to hear a little more. How do we know that the follow-through is effective?

Dr de Gruchy: That is an important question. By the way, I wanted to pick up briefly on QRISK3, which is the programme that is fundamental to the NHS Health Check. That is how the risk is determined. It is a bit different from some of the other programmes that might have been mentioned. I just wanted to clarify that.

We take your six modifiable risk factors and, through QRISK, develop your score, your most likely level of risk of developing cardiovascular disease in the next 10 years. It is then down to that interaction to motivate you to seek help to modify those risk factors. It goes back to what I was saying about people's understanding of that level of risk and their tolerance of where they are—their belief system, whether they think that will happen inevitably anyway, and so on. A lot goes into whether they will take up a

smoking cessation or weight management service, or will become more physically active.

If those services are available and accessible, the referral process is easier: the person is much more likely to take that up, because it is about what they think—their belief—and how they are spoken to, encouraged and supported. There is also the accessibility. That follow-through is very important. The link to GPs is also important, in terms of the clinical risk factors. If you have high blood pressure, it is about checking whether you have hypertension and need treatment. If your QRISK score is over 10%, you would be offered a statin. That is important.

Also, the follow-up of those clinical interventions is itself important. I do not have the figure to hand, but we know that there is a big drop-off between someone being prescribed a hypertensive or a statin, and how long they actually stay on the medication. There is a question about the effectiveness of that secondary prevention through primary care—people's understanding that they might not have a visible symptomatic condition, but they have to take a drug for a lifetime. There is a lot about how we engage with people and support them to be the healthiest they can be to reduce those risks.

Jonathan Marron: We do well in understanding the clinical management of the risk factors, so where we have hypertension, atrial fibrillation or high cholesterol, we have great data through GPs, and we are driving improvements. That is good. Your questions are about what we are doing on much earlier primary prevention, helping with behaviour, where I think there is much more to do.

The diabetes prevention programme, which you mentioned, is a real highlight of what we have done over the past few years. Basically, it identifies people who are at risk of developing diabetes—they are not diabetic yet—and puts them through a behaviour, weight management, eating and exercise programme. The reduction in the risk of diabetes among people doing it has fallen by 37%, so it has been really effective. Some 1.6 million people have benefited from it to date. It is one of the things that, I think, shows we can really make a difference.

Q64 **Anna Dixon:** Is there any link between those effective programmes, which you are spending money on and which are demonstrating benefit, and getting people whose risks are identified through Health Checks on to them? I am concerned that those things—

Jonathan Marron: The Health Check programme is undoubtedly driving people into that programme.

Q65 **Anna Dixon:** So that is one of the referrals. If there is data on the numbers going out of Health Checks into some of those programmes, or on what percentage of people on those programmes have come from Health Checks, it would be useful for the Committee to understand the relationship between them.

We are looking at a 10-year plan. The Government are committed to the

shift to prevention. It is absolutely key that things such as NHS Health Checks, which come under the public health grant at the moment, and lots of things that sit within NHS budgets, are prioritised. That means integrated care leaders saying they have the capacity to invest in prevention. Again, we heard from one of our earlier witnesses that they felt that, for example, you in the Department of Health and Social Care and NHS England should be requiring 1% or some other part of an ICB's budget to be protected for prevention so that we do not continue to bail out the acute sector as we have seen many times in the past, where overspend in the acute sector has raided prevention budgets. Briefly, can you say what discussions you have had with ICB leaders, alongside the DPH, to ensure that prevention activity, such as Health Checks, is protected as we go into the 10-year plan?

Jonathan Marron: The Secretary of State has been very clear that he sees a shift from treatment to prevention. The Government are clear that they want to see a 25% reduction in CVD early mortality over the next 10 years. The 10-year plan process is in place—talking to the public and members of NHS staff—and expert groups are working on what we might do. All of that is happening now and, I am sure, as we get the 10-year plan, we will be able to explain the decisions that the Secretary of State and the ministerial team have made to meet those targets. That work is all live.

Chair: Thank you, and thank you, Anna, for the excellent questions. We are running out of time, but Danny wanted to ask a brief question.

Q66 **Danny Beales:** Building on Anna's point, you have touched on the value you see in there being a variety of providers and new routes into the Health Check system to reach those who are not reached. We heard slightly different views earlier from general practice colleagues. The NAO report highlights the lack of consistent data-sharing arrangements as a major barrier to the programme. That seems to be quite a significant tension going forward if you diversify to further providers and bring in a digital version. As Anna has mentioned, the direction of travel for the 10-year plan is to involve more community-based provision and to push services out to the community away from general practice. How do you overcome the challenges of data sharing? The NAO report specifically points out that at the moment, a lot relies on informal arrangements or locally derived decisions. Does there need to be more direction from the centre about data sharing between the constituent parts of the health and public health system?

Dr de Gruchy: If you are a provider—a community provider or pharmacist—the data has to go to the GP, so it is integrated in that way.

Danny Beales: That is not what the NAO said. At the moment, a lot of it is manual letters being sent that may or may not be entered, or there might be data error.

Dr de Gruchy: We would have to look at how that is done, but it is a requirement that it has to go back to the GPs. Perhaps you are asking

about the quality of that data. When we refer to the negotiation, that is the local authorities needing to get the data from the GPs as providers to look at. That is where I think a lot of that—

Q67 **Danny Beales:** I think it is both. Sorry to labour the point, but if you are in a roadshow delivering a check in a supermarket, I imagine that you would not necessarily have access to GP-level patient data to enter that live into the system. That is certainly what I have seen in my experience; that is what I think the NAO report is indicating; and that is what one of the colleagues earlier said was the case—and, in his view, rightly so, because he wants to protect the integrity of GP data. It seems to me that a big tension in locally derived provision and the variety of providers is the point about a lack of consistent access to data systems.

Jonathan Marron: I do think that, as with many of the questions about this programme, it is about balance. Yes, we need to make sure that the data is consistent. As Jeanelle said, there are rules in place to make sure that data travels around the local system safely. Clearly, making that administratively easier is important, and we have done lots of work on trying to give broader access to the GP system so that other providers can write data directly into the programme that is currently live.

Our other question is, as well as the data, are we actually getting to the people we need to get to? If that means that sometimes our data flows are not quite up to date, or not quite as slick as they might be, but we are getting people through the Health Check, and getting them back into primary care where they need it, I think that is worth doing. It is a balance, always, of maintaining the data flows but getting to the people.

Q68 **Chair:** Just to end it, you are, at the moment, looking at the processes and you are evaluating it—

Jonathan Marron: We are.

Chair: And you will feed back to the Committee the results of that.

Jonathan Marron: Of course.

Chair: On that note, I will swiftly hand over to Beccy to ask a question.

Q69 **Dr Cooper:** I was going to ask about the broader public health agenda, but I am going to stick with a couple of things that I think are quite important. On the NHS Health Check, do you think that you have a branding problem? Because, ultimately, what you are telling us is that this is CVD screening, albeit picking up dementia and so on. Have you considered not calling it a "Health Check"? Have you considered calling it a "heart disease screen" or something? Because I think—and this is from 20 years in the public health business—that "an NHS Health Check" says nothing to people, and it can be easily dismissed. Have you considered that? Have you thought about, "Actually, we need to be much more effective in telling people what we are doing here"?

Dr de Gruchy: It is not a screening programme—

Dr Cooper: I know the "screening" thing is tricky, Jeanelle—I understand that—but there is something more specific that could be said about what you are doing here.

Dr de Gruchy: Just to check, is your point about what it is called, and then how it speaks to people?

Dr Cooper: Yes, and how it speaks to people. Have you considered that there might be a blocker there—that "Health Check" says nothing, essentially?

Dr de Gruchy: I mean, we could look at that communication. It has not come out specifically, but it is certainly something worth looking at. That is more in terms of what it is called on the package as opposed to how it lands with people.

Jonathan Marron: Just to add, one of the six recommendations from that 2021 review was actually that we should think of a broader range of conditions to be in the Health Check. We have two things here. If it is really about CVD, and that is all it will be, could we communicate that better and would that reach more people? Or, actually, is the long-run that this will become a broader health check looking at a wider range of risks? I think that is a big question.

Q70 **Dr Cooper:** But I would recommend having a think about the branding. The other issue that I wanted to bring up is about funding. It is £60 million; is that right?

Jonathan Marron: I have written it down somewhere; it is something of that order—actually, it is £62 million.

Dr Cooper: So, that is ultimately a drop in the ocean compared with acute care funding and so on.

Jonathan Marron: Sorry, that is £62 million for the Health Check, so not any of the follow-up that happens after that.

Dr Cooper: Fine, so £62 million for the commissioning of Health Checks. Clearly you believe in this programme and you think that it is worth while. There is an NIHR report that says this is actually doing some good stuff. Do you believe that this should be funded more substantively, because £62 million will clearly only get you so far?

Jonathan Marron: Clearly it is a local government responsibility; so they make the decisions on this. They are provided with £3.6 billion, in the public health grant from the Government, to meet their local public health requirements.

I think we would like to see greater take up of the Health Check, yes. I personally would like that. The questions that my Minister has asked me, after the NAO report, are about how we can drive more take-up, so I think, you know, that is the work we are doing.

Dr Cooper: Okay, so you think there should be more funding allocated to

this?

Jonathan Marron: I would like to see it have more take-up, and I think we should be looking at how we do that. That work is ongoing.

Q71 **Dr Cooper:** I have one more question around funding, about prevention. This is perhaps for both of you. Prevention obviously has multiple benefits across society. We could argue that it is primarily in health, but, of course, it is also around economic growth and so on. Do you think that prevention funding should primarily come from the Department of Health and Social Care, or do you think that other Departments should have a prevention fund?

Jonathan Marron: Jeanelle will probably give a more technically advanced answer, but I think that prevention—in that broader sense of, "How do we get the best possible health for our population?"—really is a cross-Government effort. Do we have great housing? Is our education system working?

Exactly what of that you would call "prevention" is a more difficult challenge, but I do think that we are thinking much more—through the various missions that this Government adopted—about whether we are spending our money well to drive that. The opportunities mission looks particularly at early years and whether children are ready to learn. That is a set of both education and health interventions, and we are starting to do that much more broadly.

Within the Department of Health, in the Secretary of State's shift from treatment to prevention, we are looking at, "Are we prioritising the things the NHS can do itself, in secondary prevention and other areas?" to really prioritise this work and ensure that we are getting the best possible health outcomes for people—and hopefully reducing the cost of the NHS over time.

Chair: On that very positive note, I would like to thank you both for coming. You have answered some really quite difficult questions, so thank you. And I would like to thank all the people around the table; they have asked some brilliant questions today.