Report author: Carl Mackie/
Lucy Jackson Tel: 07891279692

Restart and prioritisation plans for the delivery of the NHS Health programme.

Date: 7th September 2021

Report of: Director of Public Health

Report to: Scrutiny Board (Adults, Health and Active Lifestyles)

Will the decision be open for call in?	☐Yes ☒No
Does the report contain confidential or exempt information?	☐Yes ☒No

What is this report about?

Including how it contributes to the city's and council's ambitions

- This paper provides an overview and update on the NHS Health Check programme within Leeds. It includes the impact of Covid-19 on service delivery and an overview of the planning being undertaken to support a programme of recovery with a focus on those most at risk of cardiovascular disease.

- The NHS Health Check is one of the nationally Public Health-mandated services for Local Authorities within the 2012 Health and Social Care Act. It is for adults in England aged 40 to 74, who do not have any cardiovascular disease. It's designed to identify early signs of stroke, kidney disease, heart disease, type 2 diabetes, or dementia, and either prevent people developing them through healthy living support, and/ or ensure people have effective support and medication to manage any medical condition identified. The programme directly contributes to Leeds Health and Wellbeing Strategy outcome of 'People will live longer and have healthier lives', and the priority of 'a stronger focus on prevention' and the measure of a reduction in premature mortality from cardiovascular disease (see Appendix 1 for what is included within a NHS Health Check); and also the Best Council Plan Health and Well-being priority.

- The report focuses on the impact of Covid-19 on NHS Health Check programme delivery throughout 2020/21 and the steps being taken to plan for the restart and recovery of this programme. The report is for information and to provide assurance that there is awareness of the impact of Covid-19 on this programme, and that this impact is being actively responded to. A detailed

restart and recovery plan for NHS Health Checks, is in the process of being developed by the GP Confederation. This will be informed by the attached options paper (Appendix 2), which has been produced in partnership by Leeds City Council Public Health, Leeds NHS Clinical Commissioning Group (CCG) and Leeds GP Confederation.

Recommendations

a) It is recommended that the Board consider and comment on the information contained in the report and appendices, noting the assurance provided and considering if any additional information or further scrutiny work would be of benefit.

b) Specific comments on options for restart.

Why is the proposal being put forward?

1 This report provides an overview and update of the NHS Health Check programme, including the impact of Covid-19 on the delivery. It also provides an overview of the planning being undertaken to support the recovery of this programme. It is intended as an overview of the impact, providing assurance that this is being proactively responded to and to seek comments on the options for recovery.

Background

2 The NHS Health Check is for people who are aged 40 to 74 who do not have any of the following pre-existing conditions:

- heart disease
- chronic kidney disease
- diabetes
- high blood pressure (hypertension)
- atrial fibrillation
- transient ischaemic attack
- inherited high cholesterol (familial hypercholesterolemia)
- heart failure
- peripheral arterial disease
- stroke
- currently being prescribed statins to lower cholesterol
- previous checks have found that you have a 20% or higher risk of getting cardiovascular disease over the next 10 years

3 The NHS Health Check is one of the nationally mandated public health functions for Local Authorities within the 2012 Health and Social Care Act. The ‘mandation’ is that all the eligible population are offered the NHS Health Check every 5 years. Appendix 1 outlines what is included within an NHS Health Check. Data on both invitations and completed NHS Health Checks are required by Public Health England quarterly from each Local Authority.

4 Leeds has been delivering NHS Health Checks since 2009. The programme started within the most deprived communities in Leeds and those already identified as at highest risk and then rolled out across the whole city to achieve the national requirements. In Leeds, the programme has always been delivered through GPs, due to the recognition that there is a need to ensure that the correct eligible population are invited each year and that their results are entered onto the primary care system for continuation of patient care. This was also supported by several insights and community engagement programmes asking people from different communities, ages and gender how they would want to take part in the NHS Health Check. These overwhelmingly supported the delivery within primary care. Trials have also taken place in Leeds with pharmacies (e.g ASDA working with Public Health England), however issues of IT and also the low uptake from people meant this was stopped.

5 The contract was recently reviewed with a full health needs assessment and consideration of how to increase uptake in communities most at risk of cardiovascular disease. This led to a revised contract being reprocured which takes a 'proportionate universalism' approach offering the NHS Health Check to everyone who is eligible but incentivising GPs to target and make it more accessible to key communities most at risk of cardiovascular conditions.

6 The present provider in Leeds is the Leeds GP Confederation (Confederation) who were awarded the contract in 2019 for 3 years with the possibility of extension for up to a further two years. The total contract value is £1,560,000with an annual contract value of £520,000. The contract relates to the delivery of NHS Health Check via Primary Care (GPs) to the eligible population of Leeds, ensuring 20% of those eligible are invited for an NHS Health Check within the given financial year. The Provider is required to promote NHS Health Checks and encourage uptake, particularly focusing on increasing uptake amongst groups identified as most likely to benefit:

- (i) Deprived populations (people living in the 10% most deprived communities nationally)
- (ii) Current smokers
- (iii) Obese (BMI 30+)
- (iv) People from Black, Asian and minority ethnic communities

Performance

7 Nationally PHE have set a target uptake rate of 75% of the eligible population In the first year of the new contract (2019/20):
19,880 NHS Health Checks were carried out during 2019-20, with 75,222 invites sent out.
43.5% (19,880) of the eligible population (45,642) received an NHS Health Check.
41.0% (8,100) NHS Health Checks completed were with people in one or more key *'most likely to benefit'* groups. Of these:
- 50.9% were people who had a Body Mass Index (BMI)>30;
- 32.3% were smokers;
- 36.2% were people living in the 10% most deprived communities nationally.

Table 1. Comparison of NHS Health Check performance with other core cities and other areas in our region

Ares	Q4- 20/21	Q3 19/20	% of eligible pop invited in the last 5 years	% of eligible pop received a NHS health check in the last 5 years
England	485	2,057	71.8%	33.4%
Yorkshire and Humber	485	2,057	63.8%	29.6%
Birmingham	3,605	6,721	100%	47.7%
Bristol	9	1,224	73.7%	27.6%
Kirklees	1,292	3,245	83.8%	41.5%
North Yorkshire	1,181	4,127	78.5%	37.9%
Leeds	1,211	4,972	64.1%	43.4%
Liverpool	0	1,908	60.1%	29.7%
Manchester	999	5,297	79.1%	35.7%
Newcastle	0	494	51.6%	16%
Nottingham	331	1,008	56.3%	18.7%
Sheffield	329	2,272	61.1%	19.5%

Table 1 shows that the percentage uptake of eligible population over the last 5 years for NHS Health Checks in Leeds, although under the national requirement, it is higher than the majority of other core cities, some other regional areas and the England average. Only Birmingham had a higher percentage uptake rate.

See Appendix 3 for breakdown of key demographic data taken from 2019/20 annual report.

2020-21

8 As with a many other health care services, NHS Health Check activity across Leeds has been significantly reduced as a result of the Covid-19 pandemic throughout 2020-21. This has also been the case nationally as NHSE wrote to GP Practices at various points throughout the pandemic asking them to stop or prioritise other specific activity.

9 In 2020-21, 3,611 NHS Health Checks were completed from 19,398 invitations sent out (18% of the total number of NHS Health Checks delivered in 2019/20). In 2020/21 a cumulative total of 3,611 NHS Health Checks were completed from an eligible population of 47,435. This equates to 7.6% against the PHE target and compares to 43.5% achieved in 2019/20.

35.7% (1,511) of all NHS Health Checks completed were with people in one or more key *'most likely to benefit'* groups.

10 This means a significant number of people who were eligible did not receive an NHS Health Check during 2020/21 as a result of the wider impact of the pandemic.

NHS Health Check 'restart and recovery' planning

11 Public Health has been working with the GP Confederation to plan for restarting and catching up in 2021-22, working alongside Leeds CCG colleagues, who are co-commissioners of Primary Care. This is in the context of reduced staff capacity in primary care with the prioritisation of the COVID-19 vaccination programme, and other primary care restart priorities. An options paper has been produced to inform these conversations. The Leeds GP Confederation have also issued a short survey to GP practices to gauge capacity to deliver NHS Health Checks, now, and over the next 6-12 months. This will inform a detailed Restart and Recovery Plan currently being developed by the GP Confederation.

Public Health England review of NHS Health Checks

12 Public Health England are currently undertaking a national review of the NHS Health Check programme, and their finding and consequential implications were due in Spring 2021 but have since been delayed to late Summer 2021. The implications will need to be considered and incorporated into the Leeds restart and recovery plan when known, but initial insights are that the age group and potentially the scope might increase. It is clear this will continue to be a Local Authority Public Health function.

Extension of NHS Health Checks Contract

13 The NHS Health Check contract with the Leeds GP Confederation commenced on 1st April 2019 for a period of three years with the option to extend up to a further two. The Public Health Programme Board approved a recommendation on the 22nd April 2021 to extend the contract from 31st March 2022 invoking a two-year extension subject to approval from Delegated Decision Panel (DDP). This decision is supported by the Executive Member for Public Health. The rationale for this decision was based on the following:

- the original decision of primary care being the most appropriate place for delivery of the programme still stands
- the extension will avoid disruption for practices, the GP Confederation and partnership working across city at a time of significant pressure;
- It will enable the focus to be on Covid restart and recovery;
- the potential implications from the national PHE review on NHS Health Checks are not yet known;

- the need for time for in depth discussions and consultation to take place about the long-term future needs of the city are with regards to NHS Health Check programme

Wards Affected: All		
Have ward members been consulted?	☐Yes	☒No

What impact will this proposal have?

14 NHS Health Check is a check-up for adults in England aged 40-74. It's designed to identify early signs of stroke, kidney disease, heart disease or type 2 diabetes. It is recognised that cardiovascular disease is the largest contributor to the gap in life expectancy in Leeds (contributing 25.4 % for men and 23.4 % for women). Positively, this gap has started to see a narrowing over the last few years.

15 NHS Health Checks do not only identify people at high risk of developing cardiovascular disease but through brief advice, they empower people to make more informed choices about their health and wellbeing. This can not only support people to live a healthier life, reducing future healthcare requirements, and can also create a more resilient and independent society.

16 A large proportion of the eligible population have missed out on an NHS Health Check due to Covid-19. Evidence states that people with cardiovascular disease, diabetes and obesity are more likely to experience severe outcomes from Covid-19. This highlights the importance of systematically identifying people at risk of such conditions through the NHS Health Checks programme thereby avoiding further exacerbation of health inequalities. The low completed rate in the current financial year means that significantly fewer people have been identified as high risk of developing cardiovascular disease.

17 Therefore, it is imperative that the restart and recovery of NHS Health Checks, including a programme of catch up, is implemented as soon as practically possible in order to mitigate an increase in cardiovascular disease risk at both an individual and population level as well as avoiding the exacerbation of existing health inequalities.

What consultation and engagement has taken place?

18 Significant engagement with the public and stakeholders previously took place within the re-procurement of the present contract, which was used to inform the current service model.

19 Engagement has taken place with Clinical Commissioning Group (CCG) colleagues. An options paper (Appendix 2) was shared with CCG colleagues for their views on potential options for the Leeds GP Confederation to consider and inform their restart and recovery plan.

20 The Leeds GP Confederation has, and will, continue to engage with GP Practices on their proposals. In particular, the Leeds GP Confederation have recently issued a short survey to GP Practices to gauge capacity to deliver NHS Health Checks, now, and over the next 6-12 months. Findings suggest that a significant proportion of GP Practices are forecasting a reduced capacity to deliver NHS Health Checks over the next 6 months.

What are the resource implications?

21 The contract value is £1,560,000 with an annual contract value of £520,000. This sum is from the Public Health ring-fenced budget.

22 The payment structure of the contract is a combination of fixed management costs and ‘activity-based payment’ (e.g. each NHS Health Check delivered receives a payment of £20. An additional incentive payment of £8 is provided for NHS Health Checks completed with people from groups most likely to benefit, as listed above). This enables value for money as payment is only made for activity received. Commissioning and delivery models vary across the country. Some areas commission the NHS Health Check delivery outside of primary care using community based providers and pay as a ‘block’ contract (payment regardless of activity). Delivery through primary care is the most common approach.

23 The total annual budget for NHS Health Check programme is £520,000 and is funded from the ring fenced Public Health budget. Any underspend from 2020/21, due to the impact of Covid-19, has been mandated to support catching up on those who missed an NHS Health Check during 2020/21.

What are the legal implications?

24 The NHS Health Check is one of the mandated public health functions for Local Authorities within the 2012 Health and Social Care Act. The ‘mandation’ is that all the eligible population are offered the NHS Health Check every 5 years. Due to Covid this has not been the case during 2020-21. This is acknowledged by Public Health England, however working with the GP confederation we are committed to ensure that people in Leeds who did not have their NHS Health Check, specifically targeting those most at risk of cardiovascular disease.

What are the key risks and how are they being managed?

25 The key risk is primary care continuing to not have the capacity to deliver NHS Health Checks to pre-pandemic levels and also not be able to catch up on eligible people who missed their Health Check in 20/21. This is in the context of reduced staff capacity in primary care with the prioritisation of the Covid-19 vaccination programme and other primary care restart priorities. Winter pressures alongside phase 3 of the vaccination programme may also impact in the coming months. This risk is being managed through the Public Health risk register.

26 Public Health and the GP Confederation have been working together to plan for restarting and a catch up programme in 2021-22, along with Leeds CCG colleagues. An options paper (Appendix 2) has been produced to inform these conversations and is being used to inform a detailed GP Confederation Restart and Recovery Plan.

27 One option was to prioritise NHS Health Checks to key ‘at risk’ groups whilst GP Practices have limited capacity and competing pressures. Other options are also being considered to mitigate reduced capacity in Practices, including use of extended access; increased use of digital and delivery on a PCN footprint.

28 Financial underspend (within the Public Health ring fenced grant) as a result of reduced activity in 2020/21 has been carried forward to ensure NHS Health Checks delivery in 2021/22 is able to fulfil the mandated requirements.

Does this proposal support the council’s 3 Key Pillars?

☐Inclusive Growth ☒Health and Wellbeing ☐Climate Emergency

29 The NHS Health Check is for adults in England aged 40 to 74, who do not have any cardiovascular disease. It's designed to identify early signs of stroke, kidney disease, heart disease, type 2 diabetes or dementia, and either prevent developing them through healthy living support, or ensure people have effective support and medication to manage any condition identified. Therefore, it directly contributes to Leeds Health and Wellbeing strategy outcome of ‘People will live longer and have healthier lives’, and the priority of a stronger focus on prevention and the measure of a reduction in premature mortality from cardiovascular disease; and also the Best Council Plan Health and Well-being priority.

Options, timescales and measuring success

a) What other options were considered?

30 Option within options paper (Appendix 2) are currently being considered to inform a detailed Restart and Recovery Plan currently being developed the Leeds GP Confederation.

b) How will success be measured?

31 Quarterly monitoring information shows a consistent increased trajectory on the number of NHS Health Checks completed with the eventual return to pre-pandemic figures. Annual report will demonstrate outcome measure.

c) What is the timetable for implementation?

32 An agreed restart and recovery plan will be agreed by the end of quarter 2 between Leeds City Council and the GP Confederation

Appendices

Appendix 1

What happens at the NHS Health Check?

An NHS Health Check takes about 20 to 30 minutes.

The health professional – often a nurse or healthcare assistant – will ask you some questions about your lifestyle and family history, measure your height and weight, and take your blood pressure and do a blood test. The blood test will be done either before the check with a blood sample from your arm, or at the check.

Your blood test results can show your chances of getting heart disease, stroke, kidney disease and diabetes.

If you're over 65, you will also be told the signs and symptoms of dementia to look out for.

You will then receive personalised advice and provided support to improve your risk. This could include talking about:

- how to improve your diet and the amount of physical activity you do
- taking medicines to lower your blood pressure or cholesterol
- how to lose weight or stop smoking

You may be referred on to specific support services to help improve your risk.

Appendix 2

NHS Health Checks re-start options

Background

The NHS Health Checks is one of the mandated public health functions for Local Authorities within the 2013 Health and Social care Act. The 'mandation' is that all the eligible population are offered the NHS Health Check every 5 years.

NHS Health Check is check-up for adults in England aged 40-74. It's designed to spot early signs of stroke, kidney disease, heart disease or type 2 diabetes. Age is one of the risk factors of developing these conditions and the Health Check has been developed to help lower this risk. During the 'check', brief healthy living advice and signposting is also offered to the patient based on the information they provide, thereby giving them access to other wellbeing services and support within Leeds.

In January 2021, The National Health Service England and Improvement (NHSE/I) wrote to all CCGs to immediately suspend any locally commissioned services and reporting requirements as the Covid-19 vaccination programme was rolled out. However, people living in the most deprived communities have poorer health outcomes and further delaying their NHS Health Checks means that the risk of developing a long term condition will increase. The intention of the re-start model is to scale up activity as the lockdown restrictions ease and to tackle health inequalities that have been highlighted through the Covid-19 pandemic.

NHS Health Checks do not only identify people at high risk of developing CVD but through brief advice, empower people to make better and more informed choices about their health and wellbeing. This can not only support people to live a healthier life reduce the burden on the primary and secondary care services but also create more resilient and independent society.

This paper provides a brief description of the current NHS Health Checks position in Leeds and the options to re-start the programme as the restriction and the pressures on primary care ease.

Current position:

NHS Health Check activity across Leeds remains significantly reduced as a result of the pandemic.

Overall, 4227 NHS Health Checks were completed from 19,400 invites sent out in 2020-21 (uptake of 21%). This compares to 19,880 NHS Health Checks carried out during 2019-20 from 75,222 invites (uptake of 26.5%). This means a significant number of people who were eligible did not receive a NHS Health Check during 2020/21 as a result of the impact of the pandemic.

NHS Health Check delivery was officially paused during quarter 1 of 2020/21 as a result of the first wave of the pandemic and lockdown (245 HCs completed in Q1). During quarter 2, the Leeds GP Confederation sent a communication out to GP Practices and an offer of support to encourage the gradual restart of NHS Health Check where practically possible. This also included a revised payment structure that included extra incentive payments for key target groups (£8 per check for people from one or more of the key target groups) along with the addition of BAME as a key target group. This was in recognition of the key link between serious illness from COVID and underlying cardio vascular conditions.

Surprisingly, in q4, the activity increased despite the roll-out of covid-19 vaccine and pressures on primary care. There were 1,827 checks completed in q4, taking the full year activity to 9.3% when compared to the eligible population. This means a significant number of people who were eligible did not receive a NHS Health Check during 2020/21.

Performance against PHE uptake target

The PHE target number of invites for 2020/21 was 45,436 (based on extracted eligible population Oct 2020).

In 2019/20, a total of 19,880 checks were completed. However, in 2020/21 there were only 4,227 checks completed which equates to 9.3% of the eligible population (4227/45,436*100). This compares to 43% over the same period in 2019/20.

It is concerning that a large proportion of the eligible population have missed out on a NHS Health Check due to Covid-19. Evidence states that people with CVD, diabetes and obesity are more likely to experience severe outcomes from covid-19. This highlights the importance of identifying people at risk of such conditions through the NHS health checks programme thereby avoiding further exacerbation of health inequalities. The low completed rate in current financial year means that significantly fewer people have been identified as high risk of developing CVD. In short term this could mean that more people require emergency treatment thereby, increasing the burden on primary and secondary care services.

Our ambition remains to offer invitations to the eligible population, especially in the at risk groups (Deprived, smokers, BAME and BMI >30) throughout this pandemic, to help reduce health inequalities.

Areas of high eligible population 2020/21

The eligible population for 2020/21 was estimated at 45,436. However, some Primary Care Networks (PCN) have a much higher proportion of eligible population (not the most deprived). These include:

1. Central North 5131
2. Pudsey 4169
3. Morley & Dist 3903
4. Woodsley 3326

Areas of Leeds with higher prevalence of at risk groups

Evidence indicates that the prevalence of obesity and smoking is much higher in the most deprived areas of Leeds. It also suggests that there is a higher proportion of Black, Asian and Minority Ethnic groups within Chapeltown, Beeston and Burmantofts, Harehills and Richmond Hill Primary Care Networks. Further analysis of the risk groups/factors outlined in the NHS Health Checks specification shows that:

- Adult obesity levels (not including overweight) in Leeds show far higher levels in deprived areas than the city as a whole,
- Beeston, Chapeltown, Armley, Seacroft, Middleton, Kippax and Morley wards have the highest rates of obesity (2015)
- Chapeltown and Beeston have the highest rates of diabetes (2015)
- Chapeltown, Beeston and Middleton have the highest rates of Cardiovascular Disease (2015)
- Chapeltown, Beeston, Armley and Seacroft have the highest prevalence of smoking in 16 year olds and above category (2015)

Furthermore, analysis of the performance report for Q1-3 2020/21 highlights that the PCNs in the above wards have had a low uptake of the health checks when compared to the number of people who are eligible. The highest percentage uptake, when compared to the eligible population was at Bramley, Middleton & Wortley PCN (14.6%). In comparison, the table below shows the NHS health checks completion rate for PCNs in wards with high at risk groups.

Table 1. Uptake of NHS Health Checks in Q1-3 2020/21

Primary Care Network	Percentage uptake Q1-3 2020/21
Beeston	1.6%
Chapeltown	8.6%
Armley	6.2%
Middleton	8.7%
Seacroft	1.9%
Pudsey	4.2%

Future planning and considerations

From a LCC Public Health perspective we are keen to attempt a programme of catch up in order to mitigate an increase in cardiovascular disease risk at both an individual and population level as well as avoiding the exacerbation of existing health inequalities. The figure 1 below highlights the importance of a NHS health check as it provides early identification of risks associated with long term conditions and mortality. Figure 2.

Figure 1- risk factors that contribute to death in England

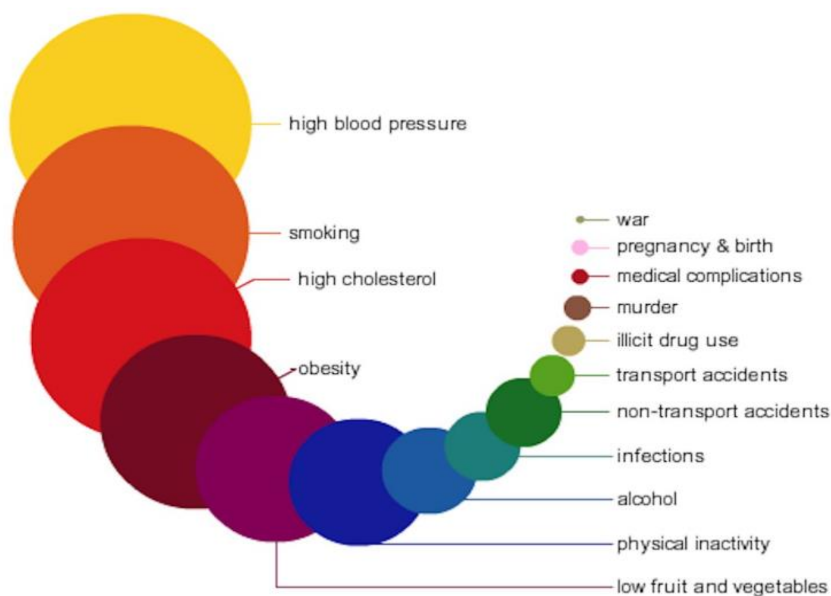
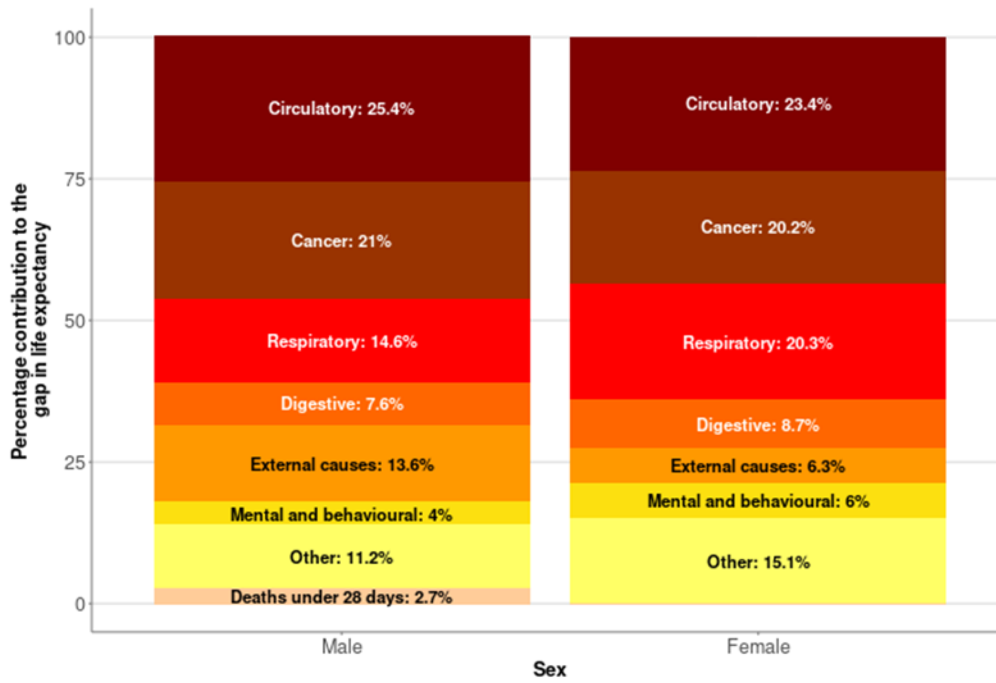


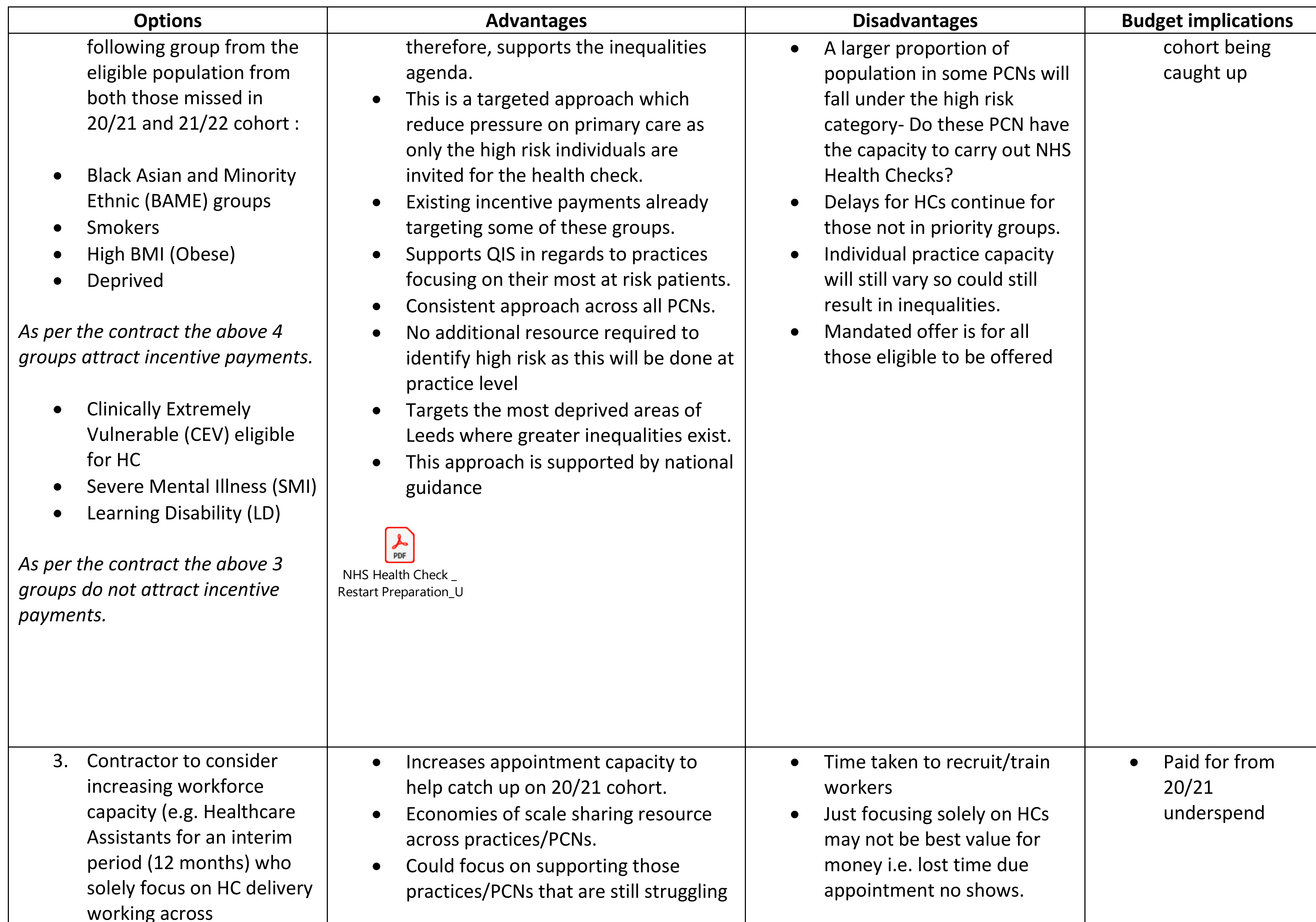
Figure 2 - Scarf chart showing the breakdown of the life expectancy gap between the most deprived quintile and least deprived quintile of Leeds, by broad cause of death, 2015-17.

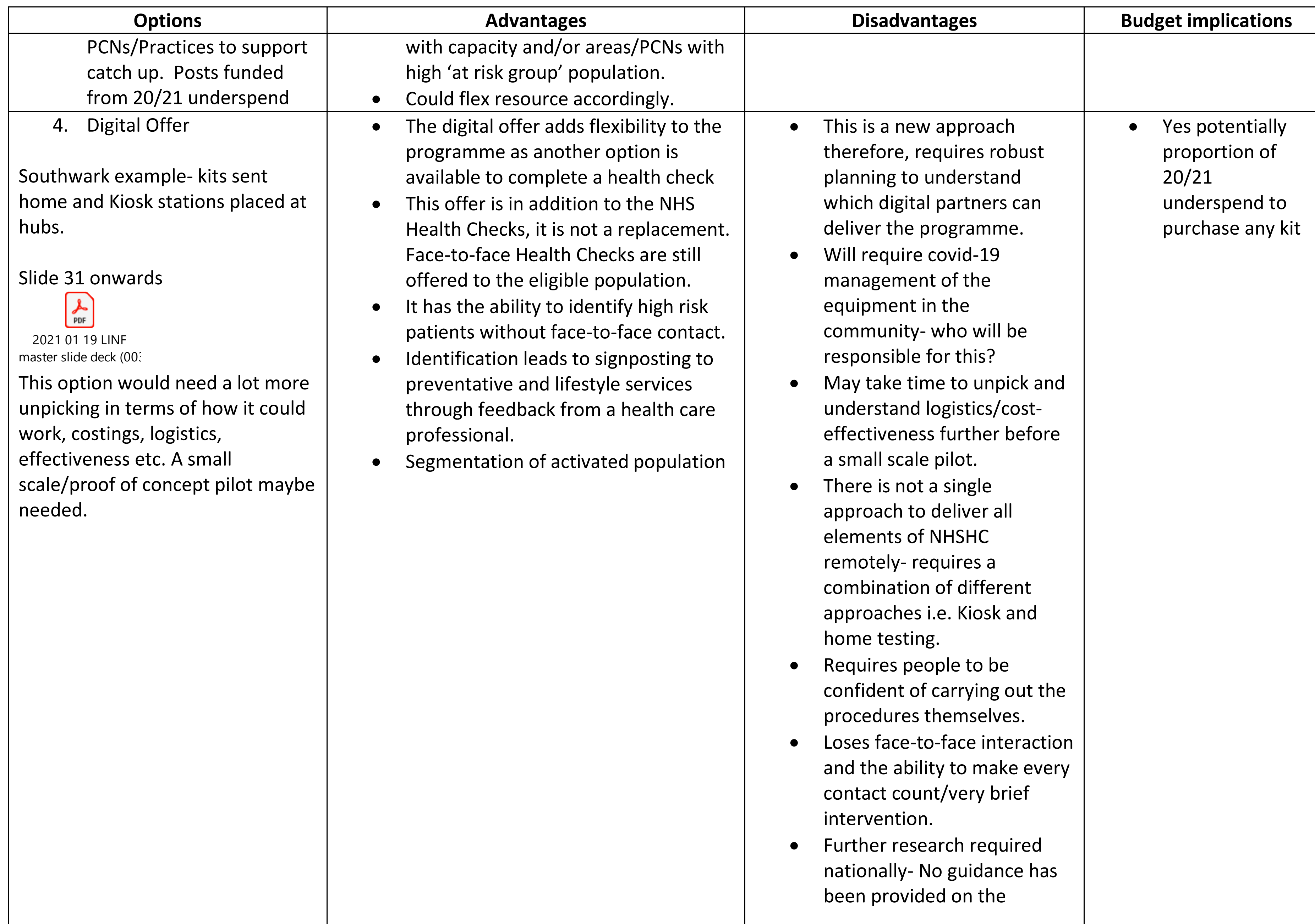


Considering the impact of further delaying the NHS health checks on the most deprived communities in Leeds, several re-start options are proposed in the table below.

Table 2- Options to support re-start and catch up of the NHS Health Checks programme (note not exclusive)

Options	Advantages	Disadvantages	Budget implications
1. Carry on with the current arrangements whereby GP Practices gradually restart activity as and when pressures in primary care ease but with prioritisation. This includes: • Prioritising those eligible in 2020/21 • Increase use of Digital Questionnaire • Maximise use of extended access hubs. • Practices sharing staff capacity/appointments across PCNs	• Releases pressure on Primary Care as the covid-19 vaccination programme is rolled out across the city. • Prioritises those eligible in 20/21 to catch up. • Flexibility to relax or push KPI's as demonstrated since the start of the pandemic. • Provides greater flexibility to respond to the changing government announcements on the pandemic. • Allows to book appointments through extended access hubs including in evenings and weekends and maximise available capacity. • Digital questionnaire will save time for practitioners as lifestyle information is completed prior to the testing appointment.	• As finite workforce capacity, prioritising last year's eligible cohort may cause significant numbers of people eligible in 21/22 to be delayed until 22/23. People at risk of developing a LTC then maybe missed. May widen inequalities as high number of eligible population are not being offered a Health Check. • Currently, there are a low number of completed Health Checks- falling further behind on annual target. • Inconsistency across PCNs- some are more active than others in offering health checks. • Extended access hubs not utilised- low number of HCs completed via the Hubs. • Digital questionnaires has not been used by all practices. Rollout of the questionnaire requires development of a comprehensive comms plan.	• May need to use 20/21 budget to pay for 20/21 cohort being caught up
2. Prioritise and target high risk groups. As per option one but prioritising the	• This approach requires identification of high risk individuals at each practice	• Numbers will be low at some PCNs where the target pop is low.	• May need to use 20/21 budget to pay for 20/21

Options	Advantages	Disadvantages	Budget implications
following group from the eligible population from both those missed in 20/21 and 21/22 cohort : • Black Asian and Minority Ethnic (BAME) groups • Smokers • High BMI (Obese) • Deprived *As per the contract the above 4 groups attract incentive payments.* • Clinically Extremely Vulnerable (CEV) eligible for HC • Severe Mental Illness (SMI) • Learning Disability (LD) *As per the contract the above 3 groups do not attract incentive payments.*	therefore, supports the inequalities agenda. • This is a targeted approach which reduce pressure on primary care as only the high risk individuals are invited for the health check. • Existing incentive payments already targeting some of these groups. • Supports QIS in regards to practices focusing on their most at risk patients. • Consistent approach across all PCNs. • No additional resource required to identify high risk as this will be done at practice level • Targets the most deprived areas of Leeds where greater inequalities exist. • This approach is supported by national guidance  NHS Health Check _ Restart Preparation_U	• A larger proportion of population in some PCNs will fall under the high risk category- Do these PCN have the capacity to carry out NHS Health Checks? • Delays for HCs continue for those not in priority groups. • Individual practice capacity will still vary so could still result in inequalities. • Mandated offer is for all those eligible to be offered	cohort being caught up
3. Contractor to consider increasing workforce capacity (e.g. Healthcare Assistants for an interim period (12 months) who solely focus on HC delivery working across	• Increases appointment capacity to help catch up on 20/21 cohort. • Economies of scale sharing resource across practices/PCNs. • Could focus on supporting those practices/PCNs that are still struggling	• Time taken to recruit/train workers • Just focusing solely on HCs may not be best value for money i.e. lost time due appointment no shows.	• Paid for from 20/21 underspend



Options	Advantages	Disadvantages	Budget implications
PCNs/Practices to support catch up. Posts funded from 20/21 underspend	with capacity and/or areas/PCNs with high 'at risk group' population. • Could flex resource accordingly.		
4. Digital Offer Southwark example- kits sent home and Kiosk stations placed at hubs. Slide 31 onwards 2021 01 19 LINF master slide deck (00: This option would need a lot more unpicking in terms of how it could work, costings, logistics, effectiveness etc. A small scale/proof of concept pilot maybe needed.	• The digital offer adds flexibility to the programme as another option is available to complete a health check • This offer is in addition to the NHS Health Checks, it is not a replacement. Face-to-face Health Checks are still offered to the eligible population. • It has the ability to identify high risk patients without face-to-face contact. • Identification leads to signposting to preventative and lifestyle services through feedback from a health care professional. • Segmentation of activated population	• This is a new approach therefore, requires robust planning to understand which digital partners can deliver the programme. • Will require covid-19 management of the equipment in the community- who will be responsible for this? • May take time to unpick and understand logistics/cost-effectiveness further before a small scale pilot. • There is not a single approach to deliver all elements of NHSHC remotely- requires a combination of different approaches i.e. Kiosk and home testing. • Requires people to be confident of carrying out the procedures themselves. • Loses face-to-face interaction and the ability to make every contact count/very brief intervention. • Further research required nationally- No guidance has been provided on the	• Yes potentially proportion of 20/21 underspend to purchase any kit

Options	Advantages	Disadvantages	Budget implications
		recommended suppliers and procedure. • Additional funding required to purchase equipment. • Remote solution not accessible 'anytime and anywhere' under covid guidelines. • Further research required on this product.	
5. Phone consultations- followed by face-to-face testing for high risk	• This approach gives an opportunity to identify and target the most at risk first. • Flexible for primary care • Telephone consultation identifies high risk and low risk individuals. The low risk individuals can be invited for testing as the lockdown eases- no immediate pressure. • Less time will be allocated for the testing appointment.	• The full NHS Health Check is dependent on easing of lockdown. • Potentially have a high number of cases to follow up at later date. • Potentially- extended length of time between first and second appointment for people not at high risk.	•
6. Contractor to consider subcontracting- an additional community provider to support the programme.	• Opportunistic and attracts people who may not have had an invite. • The GP/Community provider model is currently used by various LA. • Funding is available to explore other providers. • Some providers are joined up to GP clinical system and do send out GP invites. This would allow for a targeted approach and avoid considering an opportunistic delivery model.	• Not enough footfall in community settings in the current climate. • Two providers which could cause confusion. • Would need to join up to GP clinical system • Will require careful relationship management with GP's as historically HCs in Leeds have been provided by GP Practices.	Funded through 20/21 underspend.

Options	Advantages	Disadvantages	Budget implications
		• Contracting issues as current expires in March 2022 (although looking to extend for two years) and along with the uncertainties surrounding the Confed. • Potentially a lengthy process as may require providers to bid for the contract	
7. Pilot 1- NHS Health Checks through Pharmacies in High Risk areas	• Patients do not have to be registered to a particular practice. • Pharmacies are a trusted community setting • Pharmacies have been used to deliver NHS HC in other areas which allows us to gather learning and insight. • Across the country there were 25 Pharmacy providers. • Additional resource to help achieve local and national target/catch up. • Shared care records can help identify and complete checks.	• Will need to manage relationship with primary care. • Capacity- some pharmacies may not have the staff capacity to carry out the checks • Interest- possibility of pharmacies in the most deprived areas not being interested in additional work. • Time taken to get pharmacies on board, set up systems, training of staff etc. • Consideration of any procurement, contractual. Governance implications and sign off – may all take considerable amount of time to resolve. • Have done before and didn't work both with Asda and also through the BP programme	• Yes potential payment of additional activity.
8. As per option 7 but only with Pharmacies attached to PCNs	• May overcome any procurement/contractual/governance	• Not utilising broader potential pharmacy capacity	• Yes for payment of additional activity – could be

Options	Advantages	Disadvantages	Budget implications
	implications as could link into existing arrangements. • May enable quicker set up in terms of training, systems etc.		paid for from 20/21 underspend
9. Point of care testing (POCT) within practices	• Enables HCs to be completed in one appointment potentially increasing capacity (Nationally – majority of those practices that use POCT do HCs over one appointment	• Less validity in test results • Might not be able to fund all practice but could prioritise/pilot	• Equipment paid for from 20/21 underspend.
10. Pilot 2- walk/drive/drop-in Cornwall model- Drive thru testing. This can also be a walk-in/drop-in testing pilot with the same processes. There are three parts to the health check: 1. telephone- gain lifestyle info and offer brief intervention 10-15 mins 2. testing on site- 5-10 mins 3. follow up call to give results 5-10 mins	• Allows practices to identify people at high risk from the eligible pop thereby reducing inequalities. • Gives public more confidence to attend a PC setting. • Less time spent at PC setting for patients	• Works well in summer months as learnt from Cornwall PH. • Need to be accessible for people who do not have their own transport. • 3 part programme may be too excessive for the patients.	

Background Papers

Appendix 3

NHS Health Check Data by key Demographics taken from 2019/20 Leeds GP Confederation Annual Report

No.& % of NHS Health Checks invited and undertaken broken down by:

Age Band & Gender & Quarter of Delivery (Charts)

Invites:

Age Group	Male	Female		Unknown	Total
Under 50	8,950	8,201		855	**18,006**
50-60	4,481	5,158			**9,639**
Over 60	1,862	3,206			**5,068**
Total	**15,293**	**16,565**		**855**	**32,713**

No. of Health Checks:

Age Group	Male	Female	Unknown	Total
Under 50	3,897 (43.5%)	4,536 (55.3%)	349 (40.8%)	**8,782 (48.8%)**
50-60	2,936 (65.5%)	3,754 (72.8%)		**6,690 (69.4%)**
Over 60	1,396 (75.0%)	2,465 (76.9%)		**3,861 (76.2%)**
Total	**8,229 (53.8%)**	**10,755 (64.9%)**	**349 (40.8%)**	**19,333 (59.1%)**

Ethnicity:

Ethnicity	Invited	Completed	Percentage Completed
White Background	**25,330**	**15,835**	**62.51%**
Asian Background	**2,362**	**1,331**	**56.35%**
Black Background	**1,368**	**790**	**57.75%**
Mixed Background	**535**	**291**	**54.39%**
Chinese & Other Background	**899**	**504**	**56.06%**
Ethnicity Not Known/Not Recorded	**2,219**	**582**	**26.23%**
Total	**32,713**	**19,333**	**59.10%**

Total Invites & Completed Health Checks (Actual and Percentages) by MSOA

MSOA Quintile	MSOA Quintile (1 – Most Deprived)	Invited	Completed	Percentage Completed
1	1	5,110	2,739	53.60%
2	2	5,687	3,532	62.11%
3	3	6,061	3,510	57.91%
4	4	6,777	4,198	61.94%
5	5	6,998	4,168	59.56%
Non-Leeds Resident	Non-Leeds Resident	2,080	1,186	57.02%
	Total	32,713	19,333	59.10%

Total Invites & Completed Health Checks (Actual and Percentages) for LD Cohort of Population

	Total	Not LD	LD	LD %
All Invites	32,713	32,577	136	0.42%
Health Check Completed	19,333	19,232	101	0.52%
Uptake % of all Invites	59.10%	59.04%	74.26%	

Total Invites & Completed Health Checks (Actual and Percentages) for SMI Cohort of Population

	Total	Not SMI	SMI	SMI %
All Invites	32,713	32,309	404	1.23%
Health Check Completed	19,333	19,076	257	1.33%
Uptake % of all Invites	59.10%	59.04%	63.61%	