

Appendix 2 - Development of an NHS Health Check model for Leeds

Vision.

What are we trying to achieve?

All eligible people in Leeds are offered an NHS Health Check. Those who receive an NHS Health Check, do so in a timely, quality, person-centred way with high uptake from population groups most likely to benefit, helping to increase accessibility and reduce health inequalities.

Key Outcomes (not exhaustive list at this stage)

The primary expected outcomes of the NHS Health Check service are to:

- Reduce the incidence of heart disease, stroke, type 2 diabetes, and kidney disease.
- Reduce premature mortality from CVD.
- Early identify high risk of CVD, high risk of diabetes, presence of diabetes, hypertension, atrial fibrillation, high cholesterol and early chronic kidney disease (CKD)
- Narrow the health inequalities relating to CVD
- Reduce individuals' risk factors
- Raise awareness of the signs and symptoms of dementia.

How do we measure success?

- Number and % of people offered and receiving an NHS Health Check
- Uptake of key most at risk groups is maximised/prioritised - number and % of those people invited and receiving an NHS health checks from key most at risk groups
- Self reported quality person-centred NHS Health Check has been offered and received
- Number and % of people receiving behaviour change support and offer of/uptake to appropriate services/clinical intervention where necessary

- Number and % of people identified as high risk of CVD, or diagnosis of a LTC following NHS Health Check

| Draft Key Principles | Model Feature |
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| Mixed Model Delivery of NHS Health Checks predominantly through GP practice with some testing of community outreach delivery for some key at risk groups | Ensure all eligible people receive an invite to the NHS Health Check. 20% of all those eligible should be invited for an NHS Health Check within each given financial year to meet OHID's target. |
| | Target and maximise uptake from key at risk groups, which includes those from both ethnically diverse and most deprived communities but those most likely to be high risk of CVD. |
| | The service should be delivered across the city with a proportional universalism approach, accessible and inclusive to everyone but will have elements to encourage targeting key at risk groups within communities. |
| | Tailor invitations and methods to suit the local population |
| | Provide accessible (including evenings/weekends), high quality NHS Health Checks in accordance with Best Practice guidance and Standards in GP practices and community settings |
| | Continue programme of catch-up activity where invites/uptake was significantly impacted during the period 2020-22 |
| | Appointments must be offered from a variety of locations in order to increase the uptake rate, and in a manner that meets the needs of the people. The service must ensure the service has city wide provision in order to be accessible by the eligible population. |
| | Provide individuals with a high quality NHS Health Check, including specified tests and measurements by appropriately qualified staff. |
| | Ensure all individuals attending an NHS Health Check are able to gain a good understanding of their results and personal CVD risk |
| | The service should motivate individuals to reduce their risk through self-driven changes to their lifestyle, take up of community opportunities, attendance at appropriate services and/or engagement with ongoing primary care support |
| | Provide quality healthy behaviour change support adopting a 'better conversations' approach including referrals & signposting to relevant services and support available. |
| | The service must have access to clinical system to assess eligibility criteria and ensure appropriately coded NHS Health Checks delivery and results are embedded into individual patient records on GP systems to support ongoing GP follow up as appropriate |
| | The Contractor must ensure a recall system is in place, in line with NHS Health Checks best practice guidance |
| Work with third sector organisations to raise awareness and increase uptake of key at risk groups and ensure the service enhancing local assets. | |

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| | <p>The service provider is expected to provide a community engagement aspect of the NHS Health Checks. This will raise the profile of NHS Health Checks within communities of low uptake</p> <p>Community awareness raising aims to:</p> <ul style="list-style-type: none"> - increase uptake of the NHS Health Check - improve local health aspiration - develop community awareness of early signs and symptoms of CVD - improve uptake of prevention activities relating to improved CVD outcomes <p>The service may explore digital developments and build/progress on the existing digital pilot that has been implemented in the current contract for delivery of the NHS Health Check programme - the use of digital solutions could help improve accessibility and delivery boosting uptake and scale. This could include pre-appointment questionnaires and sharing of results post NHS Health Check.</p> |
| <p>Workforce – skills, development and training</p> | <p>The service shall ensure that staff delivering the NHS Health Checks or communicating the outcomes are demonstrably competent to the standards outlined within the NHS Health Check competency framework.</p> |
| | <p>Staff delivering the NHS Health Check should be trained in communicating, capturing and recording the risk score and results, and understand the variables the risk calculators use to equate the risk.</p> |
| | <p>When communicating individual risks, staff should be trained to:</p> <ul style="list-style-type: none"> - communicate risk in everyday, jargon-free language so that the person understands their level of risk and what changes they can make to reduce their risk - use communication methods that are appropriate, acceptable and effective for the person, taking into account and addressing any communication needs or barriers - use behaviour change techniques (such as Better Conversations) to deliver appropriate lifestyle advice - establish a professional relationship where the individual’s values and beliefs are identified and incorporated into a client-centred plan to achieve sustainable health improvement |
| <p>Effective Monitoring and evaluation of the service</p> | <p>The service provider of the model shall provide quarterly reporting for all quality outcomes and key performance indicators. In addition, and as agreed/required, provide evaluation, feedback, and insight.</p> |