Appendix 3 - NHS Health Check Delivery Model Options Appraisal

NHS Health Check Model Options	Strengths	Challenges
	Option 1 GP Practice Delivery - Either Lead Provider or individual contracts	
Option 1 GP Practice Delivery	**IT Infrastructure** • Use of **existing IT infrastructure** (Systm1, EMIS) input, extraction and recall • Current GP Practice model uses existing venous blood testing without additional incurred costs – more **cost effective**, higher quality assurance and referral opportunities • Digital aspect of NHS Health Check can feed directly from and into the clinical system building on the pilot that has been developed in the current model. Some practices already established this. **Data Sharing/Information Governance** • Patient data access ensures that **eligibility** is checked • Trusted information **governance protocols** in place **Accessibility** • Insight from citizen's panel (90ppl) reflected GP Practice as **preferred location** for delivery of NHS H/C • Patients can be **engaged opportunistically** if attending for other checks/appts in practice • GP Practices know their community/registered population and can adapt/tailor their offer and support mechanisms in the local community through their local links and Local Care Partnerships. • **Extended access appointments** are able to offer flexible appointment times across evening and weekends if utilised	**IT Infrastructure** **Data Sharing/Info Governance** • • **Accessibility** • Anecdotally, some hard to reach populations mistrust or do not attend GP Practice so a proportion of **some eligible populations may not be accessing NHS H/C** – who may be more susceptible to being high risk. Some communities and populations are not coded in the clinical system therefore the picture is unknown but this based on research gathered nationally and local anecdotal feedback from local partners. • Unable to reach those that are not registered with GP • **Flexible locations are limited** – people only able to attend their GP Practice and or hubs • Based on the current delivery model, uptake in extended access hubs is not being utilised to fulfil the flexible offer, and often not offered as an option to people and when it is feedback has been received that some are not accessible to people and people unwilling to travel very far to access this kind of appointment. • Reliance of provision – no contingency should the service be impacted and not available if delivered by individual GP Practices. Eligible population may not be offered and be able to access their NHS Health Check for period of time as unable to be offered by another provider – for example pandemic, workforce issues, sickness • Due to venous blood testing approach people are unable to get their results in the same appointment – some form of **follow up is required**, i.e face to face, via phone or letter. This creates more demand/capacity required for the person and workforce to undertake/receive follow up, which can be problematic when pressures are high but also may result

	Engagement • Based on local insight of current delivery model and national market research, NHS Health Checks in GP Practices is perceived as 'NHS' and seen as more **credible** by some people especially when having bloods taken and reassured the results are fed in somewhere for follow up • One pathway for people via GP Practices provides reassurance that following the outcome of the NHS Health Check people will be recalled and managed via the appropriate clinical pathway for high risk/diagnosed conditions **Quality and Capacity** • Data from OHID on overall performance indicates that delivery models in different areas suggests the current Leeds model (GP Practice) is better than other areas that have community approach. • Experienced provider of clinical service and model well established across Leeds • Current GP Practice model has experience of successfully engaging and demonstrating success with reaching 'groups most likely to benefit' • To support General Practice and PCN's the Leeds GP Confed currently has a GP Practice Development Team in place across the city to offer practical support to all practices improve efficiency and support development working to identify and solve any issues and share best practice with others. Through this team, the NHS Health Check implementation is supported and provides extended capacity to embed the programme at practice level. **Finance and Costs** • Supports activity based payment model and payment can modelled to incentivise to influence areas of **prioritised focus** • **Clinical workforce** can offer expertise for clinical elements of the NHS Health Check **Workforce** • Provides citywide coverage and capacity with **existing trained, skilled and trusted workforce** • **Workforce** can be diverse with new models of Primary Care and the investment of new additional roles now in place – i.e ARRS roles, social prescribing, HWB coaches . This can offer opportunity to utilise a broader non clinical workforce to deliver the NHS Health Check whilst	in no follow up occurring as a consequence of these issues based on feedback received. • **Engagement** **Quality and Capacity** • Currently low volume of **referrals and or signposting** to follow up services • Risk that some practices do not sign up to deliver the NHS Health Check contract therefore means that the eligible population from this practice register would not be offered the programme and therefore creating inequity and not fulfilling contract requirements. • If contracting directly with individual Practices, potentially more difficult for commissioners to manage if multiple providers – multiple contracts, meetings, quality assurance, relationship management between providers Could be complex to manage contractually for LCC and the provider. **Finance and Costs** **Workforce** **Evidence Base**

	still being based in GP practice, with access to the clinical system and referrals and follow up pathways in place and accessed easily as seen as one workforce. This allows for flexibility and continuation of service. **Evidence Base**	
	Option 2 - Community Outreach delivery (the provision of NHS Health Checks in a community non GP practice setting)	
Option 2	**IT Infrastructure** • Opportunity to develop digital NHS Health Check **Data Sharing/information Governance** **Accessibility** • Variety and wide range of **locations/**settings could be used for example**,** workplace, leisure centres, places of worship etc and could increase likelihood of engagement • flexible appointment times across evening and weekends and taken to where the people are in community settings which could influenced **increased access** • Point of Care testing (POCT) can be used need to be used and allows for quick patient feedback and results in one appointment • Could work as part of existing service offered in the community • Potential for opportunistic Health Checks in the community – evidence suggests maybe beneficial for some key at risk groups **Engagement** • Through using trusted community assets this delivery **targets** 'hard to reach' groups including those that do not attend GP practices through tailored approaches. Evidence suggests uptake in some groups is better and may increase diagnosis as risk likely to be higher for these people. • **Increases awareness** of NHS Health Checks at the same time as offering them out in the community	**Evidence Base** • **Lack of evidence base** and longitudinal studies on the success of community outreach delivery **IT Infrastructure** **Data Sharing/information Governance** • Some providers may not have **access to the clinical records** and therefore unable to check patient eligibility and invite people for their NHS Health Check • Difficulties with data transfer and IG – NHS Health Check has to be input back onto clinical system – pathway needs to be in place **Accessibility** • There is a risk that the model could be unable to offer **geographical spread** like GP Practice does **Engagement** • Duplication of offers from providers out in the community around Health and Wellbeing could be confusing for people • Research suggests that community outreach approaches may not be trusted by some

	Quality and Capacity • Can offer resilience should GP Practice not be able to deliver – have the ability to maintain service as dedicated provision to NHS Health Check • May offer more person centred holistic discussion and increase referrals and signposting to wider services **Finance and Costs** • Supports activity based payment model and payment can modelled to incentivise to influence areas of **prioritised focus** **Workforce** **Evidence Base**	**Quality and Capacity** • Depending on delivery model of implementation may result in reluctance from GP Practice to undertake follow up for people found to be high risk, ongoing management and or clinical investigation required which could impact on a person's pathway and experience of service. This is based on previous feedback gained from the last review via GP practices and shared learning from the Regional NHS Health Check Network. The reluctance is often associated with the use of POCT for bloods. Although clinical quality assured some GP practices choose not to accept these and would insist on re doing or not undertake the follow up based on the results. • If follow up is required following NHS Health Check – may be challenges re pathway back to GP Practice, could be disjointed and engagement lost through transfer resulting in poor experience for the person and potential for high risk people be missed. • Is there infrastructure for community provision to deliver at scale for Leeds eligible population? **Finance and Costs** • Depending on the provider - may not be as **cost** effective or able to reach large scale eligible population as the financial envelope for activity may be impacted/reduced due to IT solution required to enable clinical system access, and blood testing process • **Cost implication** would need to be considered for **IT solution** – this is expensive and may not accepted by GP Practice **Workforce** •
	Option 3 Pharmacy Delivery – Either Lead Provider or individual contracts	
Option 3 Pharmacy delivery	**IT Infrastructure** • Opportunity to develop digital NHS Health Check • Pharmacies often use Pharmoutcomes (IT system) which can provide operability with the clinical systems and therefore may be an opportunity to utilise in delivery and enable access to the identify the	**IT Infrastructure** • Potential software barriers depending on operability available if not connected with GP Practice and **cost** implication would need to be considered for IT solution **Data Sharing/information Governance**

	eligible population and enable invites to be sent. IG processes to allow integration can offer a strength as already in place. **Data Sharing/information Governance** **Accessibility** • **Access and flexibility** - Out of hours and weekend provision could be offered increasing convenience for the patient which may increase likelihood of engagement. Pharmacies are often at the heart of communities and have open access and therefore may be used more particularly in deprived communities. • Could provide citywide coverage and capacity with **existing workforce** • Estimated 90% of the population make a pharmacy visit once a year • Point of Care testing (POCT) allows for quick patient feedback and results in one appointment if utilised • Could work as part of existing service **Engagement** • Viewed as an extension of GP Practice and provider of a primary care services and seen as more **credible** by some people especially when having bloods taken and reassured the results are fed in somewhere for follow up **Quality and Capacity** • May offer more person centred holistic discussion and increase referrals and signposting to wider services • Can offer resilience should GP Practice not be able to deliver **Finance and Costs** • Supports activity based payment model and payment can modelled to incentivise to influence areas of **prioritised focus** **Workforce** **Evidence Base**	• **Data sharing** could become complex – internal and external management and requirements **Accessibility** • Learning from previous pilot demonstrated challenges – low footfall of eligible people, staff competence not maintained due to irregular delivery are some examples • Not all pharmacies may sign up – so risk that uneven and inequitable offer for NHS Health Checks **Engagement** • Mixed patient attitudes to pharmacy delivery **Quality and Capacity** • Lack of time and resource – often restricted when offered as part of multiple services • May lack facilities to offer NHS Health Checks i.e. consultation room • If contracting directly with individual organisations, potentially more difficult for commissioners to manage if multiple providers – multiple contracts, meetings, quality assurance, relationship management between providers Could be complex to manage contractually for LCC and the provider. • Complexity of mobilisation would need to be considered and the time needed for this **Finance and Costs** • Pharmacy requires Point of care testing for undertaking blood tests – this can be more **costly** taking into account the requirements for consumables, quality assurance and monitoring by commissioners – this could impact reachability given the constraints of the financial envelope • Complexity of financial envelope available – capacity would have to be capped further than it already is (51%) to enable delivery potentially

		Workforce • Learning from previous pilot demonstrated challenges – low footfall of eligible people, staff competence not maintained due to irregular delivery are some examples **Evidence Base** • Limited evidence base and longitudinal studies on the success pharmacy delivery • **Lack of evidence base** from other areas on successfulness – this approach has often been tested but reverts back to GP Practice delivery as pre dominant model
	Option 4 - Mixed model (a combination of predominant GP Practice delivery and some community outreach delivery to key most likely to benefit groups) **Would provide opportunity to maximise the strengths of option 1 and 3 approaches and flexibility to meet the needs of the eligible population, along with weaknesses identifed**	
Option 4	**IT Infrastructure** • Opportunity to develop digital NHS Health Check • Depending on provider and delivery approach there is potential opportunities to utilise connection to clinical system i.e GP Confed having access **Data Sharing/information Governance** **Accessibility** • Options available to service user for where to access NHS Health Check – person centred approach – could choose clinical vs non clinical **setting**. Could offer increased convenience for the patient which may increase likelihood of **engagement.**	**IT Infrastructure** **Data Sharing/information Governance** • Data flow between services – **investment and IG barriers** to work through and permissions from GP Practice required **Accessibility** • How would it work in practical terms for the eligible population – would choice be offered when invited? Could this work or cause confusion for the person and require significant management resource – learning from pharmacy choice when offer presented **Engagement**

	• Could increase **access** to NHS Health Checks from groups not accessing GP Practices • Partnership/consortia arrangement could be beneficial to meet the needs of different populations. • Could be single or multiple provider approach I.e. GP Confederation could potentially employ staff to provide delivery in community • Scope to have predominant delivery still in GP Practice complemented by some targeted community delivery **Engagement** • • Provides opportunity to link in with local community assets/organisations • Increased marketing opportunities out in the community • Potential for some opportunistic Health Checks – evidence suggests maybe beneficial for some key at risk groups **Quality and Capacity** • Can offer continued NHS Health Checks should GP Practice not be able to deliver for any unforeseen reasons i.e pandemic, blood bottle shortage etc • May offer more person centred holistic discussion and increase referrals and signposting to wider services **Finance and Costs** • Depending on model delivery could be cost effective using established blood testing infrastructure, staff skills and economies of scale whilst maintaining reachability for NHS H/C offer whilst providing choice to the person • Supports activity based payment model and payment can modelled to incentivise to influence areas of **prioritised focus** **Workforce** **Evidence Base**	**Quality and Capacity** **Finance and Costs** **Workforce** **Evidence Base**

	• NHS Health Check review highlighted that a 'Mixed Model' approach using different services for uptake/delivery is most successful.	

Chosen Model – Option 4.

Procurement Options Detail need to be outlined for option 4:

The project team are recommending progressing with Model Option 4. This option would enable further testing of and building capacity for community delivery approaches to determine if the approach can yield greater uptake from key 'most likely to benefit groups whilst maintaining the current delivery through General Practice as the predominant delivery mechanism. This would also ensure that the existing links with General Practice infrastructure are maintained, including access to the GP clinical system.

In addition, findings from the review (appendix 1) suggest that the current Leeds approach, using GP Practices, and approaches in other areas generally perform better overall in comparison to community provision but with some evidence suggesting that community settings may yield better NHS Health Check uptake in some most likely to benefit groups e.g. most deprived and South Asian. Also, public insight in Leeds shows that NHS Health Check delivery in General Practice is valued and supported but there is also an ask for greater availability and accessibility. Insight from the stakeholder event suggests potential added value from community approaches and greater working with the third sector in the delivery of NHS Health Checks.

Model Option 4 would also enable additional capacity to deliver more NHS Health Checks to support catch up, if additional funding is provided. The project team recommend that the £550,000 underspend from the existing NHS Health Check contract be used to fund the additional catch up activity and testing of community delivery in addition to the existing service (£520,000) annual budget envelope. This would deliver the outstanding 25,020NHS Health Checks, as part of catch up, highlighted in section 3. Finance colleagues have confirmed that this underspend could be used as part of the new contract but would have to be used within the first two years.