



NHS Health Check: Restart Preparation

Version 9: 14 January 2021

This document aims to assist commissioners and providers with NHS Health Check restart planning and preparation.

1. When to restart

The Government remains committed to the implementation of the NHS Health Check. The [COVID-19 Recovery Strategy](#) highlights the NHS Health Check's clear role in delivering preventative and personalised solutions to ill-health, and empowering individuals to live healthier and more active lives.

Responsibility for commissioning the NHS Health Check lies with local authorities (LA). The decision on when to restart is one for LAs to take, informed by NHS Health Check and ancillary providers, and national guidance:

- On 4th January 2021 the government announced a national lockdown and [corresponding restrictions](#).
- On 7th January 2021 National Health Service England and Improvement (NHSE/I) wrote to all CCGs regarding the COVID-19 response. The [letter](#) directs all CCGs to immediately suspend any locally commissioned services and reporting requirements, except where these are specifically in support of the vaccination or other COVID-19 related support to the local system.
- On 24th December 2020 NHSE/I updated their [standard operating procedure](#) for general practice in the context of COVID-19. The guidance confirms that, as capacity allows, general practice should continue routine activity where clinically appropriate, whilst ensuring that care is clinically prioritised for those most in need of support, including those with urgent healthcare.
- On 11th January 2021 the British Medical Association (BMA) and Royal College of General Practitioners (RCGP) published [COVID-19 Workload Prioritisation Unified Guidance](#). It includes current guidance on COVID-19 Response Levels and a corresponding rating system for services, and suggests that most General Practices are now operating at a response level of 4 or 5. The RCGP and BMA advise that any decisions on reprioritisation of clinical and non-clinical workload should be taken at a local level, based on clinical judgement, experience from responding to the first wave and informed by a shared understanding of the [response level](#) faced in local areas.

2. Regulatory requirements

The [Local Authorities \(Public Health Functions and Entry to Premises by Local Healthwatch Representatives\) Regulations 2013](#), set out that each LA must make provision to offer an NHS Health Check to all eligible people every five years (see Chapter 2, [Best Practice Guidance](#) (BPG)). By virtue of having a rolling indicator on offers and people having a check, PHE recognises that the impact of COVID-19 will be seen in the NHS Health Check data for the next five-years. Given the current need for General Practice to prioritise the COVID-19 response and vaccination work, Public Health England will not be scrutinising LA NHS Health Check delivery activity at this time. However, as General Practice is the dominant provider of NHS Health Checks, LAs are encouraged to consider alternative models of delivery (section 5 and 8) when making local decisions on the future provision of the service.

3. Funding and provider payments

Cabinet Office issued [guidance](#) and [FAQs](#), which apply to local authorities, on managing contracts and supplier payments during the COVID-19 response up until **31 October 2020**. [Guidance](#) on emergency procurement has also been published by Cabinet Office.

On 11th January the Government updated the [COVID-19 funding for local government in 2021-22: consultative policy paper](#). The document now details of the Local Government COVID-19 Support Packages for 2021-22, following up on the commitments made at Spending Review 2020 on 25 November 2020.

4. Workforce, workplace and patient risk

Staff and patient safety are paramount, therefore before restarting the NHS Health Check an assessment of and action to reduce workforce, workplace and patient risk should be undertaken. NHS England have published a [letter](#) highlighting the importance of risk assessments for at-risk staff groups. Guidance produced by the [Health and Safety Executive](#) can help identify who is at risk of harm. It includes templates and examples, along with specific guidance. NHS employers have also produced [guidance](#) on how to enhance existing staff risk assessments.

To minimise workplace risk NHSE/I have produced a [standard operating procedure](#) for general practice and the Royal Pharmaceutical Society has published [guidance](#) for pharmacies. Public Health England has produced guidance on [infection control](#) and [Personal Protective Equipment \(PPE\)](#). Additional PPE guidance has been developed specifically for [community and social care settings](#).

Information on how to access PPE in community and primary care settings is provided on NHS England's [website](#). Due to the costs involved in adapting workplaces and protective equipment, NHS E/I have produced [guidance](#) which sets out finance reporting and an approval process for COVID-19 spending in relation to adapting workplaces and PPE. The British Medical Association have also created a [template](#) reimbursement claim form.

5. Workforce capacity

General Practice workforce capacity may be a limiting factor in restarting the programme. Therefore, commissioners should consider making adaptations to the way the service is delivered and/or using alternative delivery methods. Any provision will continue to need to meet the **regulatory requirement** (see Chapter 2, **Best Practice Guidance**) for eligibility and content as well as the **programme standards**.

In December 2020 PHE delivered a **webinar** 'Developing new NHS Health Check implementation models during COVID-19: local examples' which shared local examples of how different areas are delivering NHS Health Checks during the COVID-19 response. PHE's Top Tips for **Maximising the impact of the NHS Health Check** and **Increasing the Uptake of the NHS Health Check** may also provide helpful insights. Where the implementation approach does deviate from the historical service provision approach, it will be important to evaluate the impact of the changes on take up, completion and outcomes.

6. Workforce competence and confidence

All staff delivering checks should meet the requirements set out in the **NHS Health Check Competency Framework**. If adaptations and/or alternative modes of delivery are being used, consider how that will impact on staff training requirements. For example, commissioners may want to ensure staff are familiar with the NHS E/I guidance on the **principles of safe video consulting in general practice during COVID-19**. Further **training resources** can be found on the NHS Health Check website.

7. Availability of follow-up service provision

To maximise impact, it is essential that individuals having a NHS Health Check can also access appropriate follow-up interventions. This includes timely access to behaviour change services e.g. weight management, stop smoking and, where indicated, clinical management to ensure that they get the right support to reduce their cardiovascular (CVD) risk (see Chapter 5 and 6 of the **BPG**).

8. Equity

When restarting the NHS Health Check, providers should continue to apply the principle of proportionate universalism, delivering checks in a way that prioritises resources and effort to inviting and engaging those who are most likely to be at higher risk of CVD (see Chapter 3 of the **BPG**).

PHE's **review of disparities in the risks and outcomes from COVID-19** confirms that the impact of the disease has replicated existing health inequalities, and in some cases exacerbated them. The evidence and **stakeholder review** recommends that efforts to target culturally competent health promotion and disease prevention programmes' are accelerated. There is a specific reference to prioritising the NHS Health Check to improve identification and management of multiple long-term conditions in Black, Asian and Minority Ethnic (BAME) groups.

PHE has published and advocates the use of a **health equity audit** tool and **local data** to inform local commissioning decisions in support of prioritising groups most likely to benefit from a check. **PHE's Local Health** and **SHAPE** tools can be used to identify distribution of sociodemographic determinants of CVD risk such as age, gender, ethnic group and socio-economic status.

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