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Title: Local authority commissioning of NHS Health Checks: a regression analysis of the first three years

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Abstract: In April 2013, the public health function was transferred from the NHS to local government, making local authorities (LAs) responsible for commissioning the NHS Health Check programme. The programme aims to reduce preventable mortality and morbidity in people aged 40 to 74.

The national five-year ambition is to invite all eligible individuals and to achieve an uptake of 75%. This study evaluates the effects of LA expenditure on the programme's invitation rates (the proportion of the eligible population invited to a health check), coverage rates (the proportion of the eligible population who received a health check) and uptake rates (attendance by those who received a formal invitation letter) in the first three years of the reforms. We ran negative binomial panel models and controlled for a range of confounders.

Over 2013/14 to 2015/16, the invitation rate, coverage rate and uptake rate were 57% 28% and 49% respectively. Higher per capita spend on the programme was associated with increases in both the invitation rate and coverage rate, but had no effect on the uptake rate. When we controlled for the LA invitation rate, the association between spend and coverage rate was smaller but remained statistically significant. This suggests that alternatives to formal invitation, such as opportunistic approaches in work places or sports centres, may be effective in influencing attendance.

Highlights

- The English NHS health check programme aims to prevent morbidity and mortality
- In 2013, local authorities became responsible for health checks
- Higher expenditure is linked to higher invitation and coverage rates
- The amount spent does not influence uptake rates
- Opportunistic approaches may help improve uptake

Local authority commissioning of NHS Health Checks: a regression analysis of the first three years

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Conflicts of interest

Conflicts of interest: none

1 **Abstract**
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4 making local authorities (LAs) responsible for commissioning the NHS Health Check
5 programme. The programme aims to reduce preventable mortality and morbidity in people
6 aged 40 to 74.
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12 The national five-year ambition is to invite all eligible individuals and to achieve an uptake of
13 75%. This study evaluates the effects of LA expenditure on the programme’s invitation rates
14 (the proportion of the eligible population invited to a health check), coverage rates (the
15 proportion of the eligible population who received a health check) and uptake rates
16 (attendance by those who received a formal invitation letter) in the first three years of the
17 reforms. We ran negative binomial panel models and controlled for a range of confounders.
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28 increases in both the invitation rate and coverage rate, but had no effect on the uptake rate.
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30 rate was smaller but remained statistically significant. This suggests that alternatives to
31 formal invitation, such as opportunistic approaches in work places or sports centres, may be
32 effective in influencing attendance.
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43 **Key words**
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45 Cardiovascular Diseases; Preventative Care; Primary Prevention; NHS Health Check
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1 Introduction

The overarching aim of the national NHS Health Check (NHS HC) programme is to reduce cardiovascular disease (CVD) risks and events by addressing behavioural and physiological risk factors driving premature mortality and preventable morbidity [1, 2]. Considered to be the largest and most ambitious programme of its type worldwide [3], it targets people aged 40 to 74 who have no diagnosed vascular disease such as CVD, diabetes or other cardio-metabolic condition [4].

The programme was introduced in 2009. As part of the April 2013 reforms, responsibility for commissioning health checks was transferred from the NHS to 152 local authorities (LAs) as part of the transfer of the public health function to local government. LAs were given ring-fenced public health grants “to improve significantly” the health and wellbeing of their local populations and to reduce health inequalities by addressing the needs of under-served groups [5]. CVD is strongly associated with health inequalities [6].

Over a five year period, Public Health England’s (PHE) ambition is that 100% of eligible individuals are invited for a health check [1], with uptake reaching 75% [6]. The health check begins with a structured assessment of CVD risk, followed by individually tailored risk management advice and/or further clinical assessments, and then by appropriate interventions such as medication, signposting or referral [6-8]. Most of the check can be delivered in settings other than GP practices, but data from these risk assessments must be forwarded to the attendee’s registered practice [6].

LAs have a statutory duty to submit annual revenue outturn forms detailing how their public health budget was spent [6]. The risk assessment element of the NHS HC is a mandatory function that LAs are required to commission or provide, and there is a bespoke category in the revenue form to capture this expenditure. It is important to recognise that this category of expenditure excludes the cost of follow-up health care: NHS England funds the costs of additional testing and prevention in primary care, whereas local healthy lifestyle services, such as for smoking cessation and promoting healthy weight, are commissioned by LAs [6].

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2 Therefore, LAs have only limited ability to influence health outcomes arising from risk
3 identification.
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6 While the health benefits of general – untargeted – health checks have been questioned [9],
7 both the viability and impact of the programme on health outcomes depend upon uptake
8 rates being sufficiently high [10]. Moreover, significant health benefits, such as reduced
9 morbidity or mortality, are unlikely to arise in the short term. For these reasons, our
10 evaluation of the impact of the 2013 reforms on the NSHC programme focuses on the
11 relationship between LA spend on the programme and its intermediate outcomes –
12 invitation rates, coverage rates, and uptake rates. This forms part of a wider study on the
13 impact of the public health reforms on commissioning public health services [11].
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23 The expected causal pathway between LA expenditure on the NSHC programme and its
24 intermediate outcomes merits consideration. Invitational activity is funded directly from
25 this category of the public health budget, with GP practices typically subcontracted to invite
26 patients and provide health checks, although other providers may also be commissioned.
27 The link between spend and coverage rate, defined as count of attendees as a proportion of
28 the eligible population, is also intuitive: practices are paid (partly) according to the number
29 of checks provided which is in turn mediated by invitational activity. However, opportunistic
30 settings, such as workplace checks, also affect coverage and these checks are typically
31 outside of the formal invitation process but are (or should be) captured in counts of
32 attendees. The causal pathway between uptake rates (attendance by those invited) and
33 level of spend is more complicated. The decision to attend for a health check is complex
34 and reasons are not fully understood, but are likely to include personal beliefs [12],
35 invitational level and approach [13, 14], venue [15] and socio-economic factors [15-17]. It is
36 plausible that LAs with a higher per capita spend on the NSHC programme are offering
37 additional approaches to the formal invitation, such as locally relevant opportunistic
38 screening, and are, therefore, more successful in engaging with their local populations.
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55 By definition, the coverage and uptake rates become equivalent when all the eligible
56 population has been invited.
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2 Materials and methods

We used count panel models, with LAs as the unit of analysis and ran a series of robustness checks. National data on counts of individuals eligible for, invited to, and attending a health check are reported annually for each LA. For our key explanatory variables, we used annual expenditure returns. LAs submit these returns for each of 18 public health categories (20 categories in 2015/16) and for total public health spend.

The selection of control variables was informed by a literature review and categorised using Andersen's Behavioral Model of Health Services Use [18].

2.1 Outcomes

We tested the effect of LA expenditure on the NHSHC programme on three outcomes.

First, the invitation rate is defined as the proportion of the eligible population invited for an NHS health check (the eligible population is defined as people aged 40 to 74 who have no known vascular disease). This captures 'formal' invitational activity by LAs, but excludes opportunistic invitational approaches, e.g. outreach in shopping malls. Second, the coverage rate is the proportion of the eligible population attending for a health check. Lastly, the uptake rate is defined as the proportion of those who received a formal invitation and then attended a health check. This outcome is considered a measure of the effectiveness of the formal screening programme than the coverage rate [4]. The coverage rate measure may be better than the uptake rate for assessing public health impact [4].

2.2 Key explanatory variables

The principal explanatory variable of interest is annual expenditure by LAs on the NHSHC programme. These data are reported as part of the annual financial returns. They are freely available to download from the website detailed in Appendix Table 1. We used the variable for net current expenditure to match the approach used by Public Health England in its performance assessment framework.

As the composition and size of LA populations vary considerably, total spend is not a useful measure. Instead, we derived per capita values of spend on the NHSHC programme based

1 on the eligible population of people aged 40 to 74 and converted these to terciles (thirds).
2 In the sensitivity analyses, we tested two alternative measures of programme spend.
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5 **2.3 Control variables**

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7 To quantify the relationship between expenditure on the NHC programme and outcomes,
8 other factors potentially affecting uptake of the programme need to be taken into account.
9 Many of these influences occur at the level of the individual: for example, a person's age,
10 employment status, or the distance from home to their GP practice, could all potentially
11 affect the attendance decision. However, there are no national datasets detailing uptake by
12 individuals, only summary data by LA. Therefore, we used LA characteristics instead of
13 person-level characteristics: for example, LA rurality was used in place of travel distance.
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23 To overcome this limitation, previous studies have used primary care databases [3, 16, 19-
24 22]. However, these databases have drawbacks that make them unsuitable for evaluating
25 the 2013 reforms. First, they cannot give a national picture of performance on the NHC
26 programme: they typically cover only a fraction of the English population; participating
27 practices may be unrepresentative of their local areas; and health checks done in other local
28 practices are missed. Second, the databases are expensive to access, and coding of NHCs
29 in primary care records has historically been poor [19, 23]. Lastly, linking detailed data on
30 LA characteristics to GP practices increases the risk of identity disclosure: this means that
31 linkage would likely be permitted only for a small number of aggregated LA factors.
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42 We reviewed the literature to identify factors predicting uptake of health check
43 programmes in high income countries (details of the inclusion and exclusion criteria are
44 available on request from the authors). We identified 31 relevant studies [3, 4, 12, 16, 19-
45 45] and grouped factors using Andersen's Behavioral Model of Health Services Use [18].
46 Predisposing factors included age group, proportion of males, proportion of white ethnicity,
47 and deprivation level (terciles). Enabling factors included rurality, density of GPs and
48 measures of expenditure on the NHC programme. We also included a binary variable
49 capturing whether the LA chose the default NHC option in the 2014/15 Health Premium
50 Incentive Scheme (HPIS) [46], and adjusted for class (type) of local authority. Need factors
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1 included measures of morbidity, physical activity levels, adult obesity levels and smoking
2 rates. We also included year effects with 2013/14 as the reference. Due to data limitations,
3 measures of need mostly related to the whole adult population, not specifically to people
4 aged 40-74. Some potentially relevant predictors, for example, past consulting behaviour
5 [31, 47], were not included in our analyses because data were unavailable.
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11 We checked the covariates for pairwise correlations and tested significance at the 5% level
12 using Bonferroni adjustments to counteract the problem of multiple comparisons.
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16 **2.4 Modelling**

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18 For the base case analyses, we used random effects negative binomial models For cases
19 where the outcome is a count variable (i.e. non-negative integer), these statistical models
20 offer a flexible approach for analysing the relationship between the outcome and
21 explanatory variables whilst allowing for unobserved LA characteristics that persist over
22 time [48]. We ran three models to test the effects of spend on health checks on each of the
23 three outcome variables:
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- 31 1. Model 1: Invitation rate: count of NHSHC invitees (exposure: eligible population)
- 32 2. Model 2: Coverage rate: count of NHSHC attendees (exposure: eligible population)
- 33 3. Model 3: Uptake rate: count of NHSHC attendees (exposure: count of NHSHC
34 invitees)

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42 The size of the eligible population is reported in the annual NHSHC datasets (Appendix Table
43 1). It comprises the LA population aged 40-74 without an existing diagnosis of vascular
44 disease, diabetes or chronic kidney disease. The 'exposure' is the pool of individuals from
45 which an outcome is observed, and its inclusion in the model effectively converts the count
46 variable into a rate.
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53 The effects of expenditure may not be linear, i.e. the impact of an increase in per capita
54 spend of £1 may vary depending on the level of baseline expenditure. For example, the
55 effect of a £1 increase in spend may be different in an LA with a per capita spend of £0.24 to
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1 the effect in another authority with spend of £24. Similarly, the effects of deprivation may
2 be non-linear, and previous studies have used deprivation terciles [4, 21-23, 26, 27, 33]. In
3
4 the base case, we used terciles both for each type of spend, and for deprivation.
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6 7 **2.5 Sensitivity analyses**

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9 For each of the three outcome measures, we tested three sets of control variables that
10 differed in terms of how deprivation and expenditure were measured.
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15 In the first sensitivity analysis, we tested continuous measures of spend (i.e. per capita
16 values) and deprivation scores (range: 0 to 100). In the second sensitivity analysis, we used
17 total programme spend as a proportion of the public health budget and measured
18 deprivation in terciles. In the third sensitivity analysis, to identify the influence of
19 invitational activity on coverage, we re-ran Model 2 but also controlled for the LA invitation
20 rate.
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28 By way of robustness checks, we tested linear models with the dependent variables
29 converted to rates; Poisson models (a special case of the negative binomial model); and
30 fixed effects models. In all checks, only the base case model was explored. Analyses were
31 run in a statistical software package (Stata 14.2).
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37 38 **2.6 Data sources**

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40 All our data were sourced from publicly available datasets (Appendix Table 1), with one
41 exception: details of LA participation in the Health Premium Incentive Scheme (HPIS) [46]
42 were provided by the Department of Health and Social Care. We merged the datasets using
43 LA codes and (for time-varying variables) the year to which data related. Estimations were
44 based on a balanced panel of data from 150 LAs: data for City of London and the Isles of
45 Scilly are incomplete so these LAs were excluded. In 2015/16, one LA did not report
46 expenditure outturn data and we instead used revenue account budget data (planned
47 spend) for this organisation.
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3 Results

Over the first three years of the public health reform, the cumulative number of individuals invited to and attending a health check increased (Figure 1). When converted to rates, these cumulative totals translate into increasing invitation and coverage rates but the national uptake rate – the proportion of invitees who attend a health check – remained stable at slightly under 50% over the study period (Figure 2).

INSERT FIG 1 AND FIG 2 HERE

As the invitation rate, coverage rate and uptake rate were heavily skewed, we report results as medians. Across LAs, the median annual invitation rate was 19.6% (range: 0.8% to 74.6%). The median coverage rate was 9.1% (0.9% to 29.1%) and the median uptake rate was 49.1% (7.6% to 234.9%). Uptake rates above 100% may be due to opportunistic checks of local and/or transient populations – this activity is recorded in attendance numbers (numerator) but is not captured in counts of invitees (denominator). There was remarkably little variation by class of LA, and the extreme outliers in uptake rate are mostly London boroughs.

3.1 Explanatory variables

In the unadjusted data, per capita spend on the NHSHC programme was positively correlated with higher proportions of the eligible population aged 40 to 50 and negatively associated with larger proportions of people 65 to 74. Spend was negatively correlated with white ethnicity (rho: -0.261) and positively associated with greater deprivation (0.199). There were small but significant correlations between per capita spend on the NHSHC programme and spend on wider tobacco control (0.245) and adult physical activity (0.161).

Descriptive statistics for the explanatory variables in the analysis are presented in Table 1.

INSERT TABLE 1 HERE

3.2 Regression results

Table 2 shows results from the base case regressions. Compared with LAs in the lowest tercile of per capita expenditure on the NHC programme, authorities with medium or high levels of expenditure had significantly higher invitation rates and significantly higher coverage rates. However, programme spend was not significantly associated with uptake rate. These findings were consistent: the direction and significance of the effect was independent of whether expenditure was measured in monetary per capita values, terciles or as a proportion of total public health spend, and results were also robust to model specification. In addition, the impact of programme spend on coverage rate remained statistically significant after controlling for the LA invitation rate (Appendix Table 2), although its magnitude was smaller: a one percentage point increase in NHC programme spend per head was associated with an increase in the coverage rate of 3.7% before controlling for invitation activity, and an increase of 2.0% after this was taken into account. This suggests that factors other than invitation are effective in increasing the attendance rate for a health check.

INSERT TABLE 2 HERE

Most of the predisposing factors, such as the age distribution of the local population, gender, ethnicity and deprivation, did not explain variations in outcome rates (Table 2). Compared with the reference group (aged 40-44), coverage rates were significantly lower in LAs with a higher percentage of people aged 65-69, and uptake rates were significantly lower in LAs with a higher percentage of 50-54 year olds. Of the 'enabling' factors, rurality, LA class, GPs per head of population, and participation in the NHC part of the Health Premium Incentive Scheme (HPIS) [46] were not statistically significant predictors. Compared with LAs within the lowest tercile of expenditure on adult obesity, those in the highest tercile achieved significantly higher invitation rates but also significantly lower uptake rates.

With regard to need factors, in the base case model LAs with a higher prevalence of smokers had a higher invitation rate but findings from the robustness checks were mixed. LAs with a

1 higher percentage of the population on the GP disease registers for obesity had significantly
2 higher invitation rates, coverage rates and uptake rates.
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4 **4 Discussion**

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7 In 2013, responsibility for commissioning the NLSHC programme was transferred from the
8 NHS to upper tier and single tier LAs. Our evaluation covered the first three years of these
9 reforms and included all upper tier and single tier English local authorities except for the
10 City of London and Isles of Scilly. Findings on the impact of programme expenditure are
11 consistent: higher spend by LAs is associated with both higher invitation rates and higher
12 coverage rates. When controlling for invitation rate, the magnitude of the association
13 between spend and coverage rate is reduced but remains statistically significant. As formal
14 invitation only partly explains attendance, this means that LAs expenditure on non-
15 invitational activity is, by definition, associated with higher attendance rates. One possible
16 explanation is that alternative approaches, such as opportunistic invitations, are driving this
17 observed effect.
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30 Uptake rates – the proportion of invitees who attend a health check – appear unrelated to
31 the level of programme spend. Uptake depends primarily on individuals’ responses to the
32 invitation, although LAs can influence uptake, for example by follow up of non-responders
33 or by careful framing of the invitation letter. Gidlow and colleagues (2015) analysed patient
34 records from five GP practices in Stoke-on-Trent and found that telephone or verbal
35 invitations were associated with a higher uptake rate than postal invitations [16].
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38 Qualitative research suggests that community venues may offer greater convenience [15].
39 Uptake also depends on actual and perceived access to local services[18], and LA
40 commissioners can facilitate access, for example through innovation in terms of venues or
41 providers. For example, the high uptake rate observed in some London boroughs may
42 represent commuters attending checks in venues other than GP practices (e.g. workplaces,
43 sports centres or pharmacies). There are no national data on the types, location and
44 providers of lifestyle services commissioned by LAs, nor on how budgets are used across
45 directorates or pooled with other agencies. As part of the broader evaluation, we
46 conducted national surveys to try to address these evidence gaps, but response rates were
47 insufficient to be used in the analyses [11].
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2 Compared with previous evaluations [19], our study found less regional variation in
3 coverage rates. We identified one study with a similar unit of analysis: Artac and colleagues
4 (2013) explored variation in coverage rates amongst local health authorities (Primary Care
5 Trusts (PCTs)) in 2011 [4] and found higher coverage in PCTs with greater levels of
6 deprivation. This contrasts with our finding that deprivation is not associated with
7 coverage; a possible explanation for the discrepancy is that mandatory commissioning of
8 the NHSHC programme following the 2013 reforms has made programme performance
9 more geographically consistent.
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19 The NHSHC programme has been criticised for differential uptake, favouring the least
20 disadvantaged groups, although evidence is mixed [1, 15, 49]. PHE has emphasised the
21 importance of supporting approaches that prioritise invitations to those at highest risk [50]
22 and that address equity and health inequalities [51]. LAs have several options for
23 addressing these challenges: for instance, they could extend training for carrying out health
24 checks to a wider workforce, provide health checks through community-based services and
25 work across different LA directorates to target outreach to vulnerable groups. They could
26 also capitalise on their voluntary sector and community networks, and on their public
27 profile, making use of these to advertise opportunities to local populations [11].
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38 Interviews from the case study component of our broader evaluation demonstrated a
39 spectrum of engagement with the NHSHC programme [11]. At one extreme was a
40 combination of GP provision, extensive outreach programmes (sometimes provided through
41 social enterprises), and integration with healthy lifestyle services. At the other was
42 scepticism about the programme's value for money and potential to reduce inequalities,
43 combined with implementation challenges due to attrition from GPs and rationing of follow-
44 on lifestyle services in response to budgetary cuts. Outreach activities were widespread
45 across our 10 case study sites, covering locations such as supermarkets, town centres,
46 leisure centres, roadshows, farmers' markets, well-point kiosks and mobile health checks
47 around estates, workplaces and through a health check bus.
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There were initiatives targeted at underserved groups, such as traveller communities, examples of collaboration with providers of mental health services to improve uptake and targeting of younger people within the eligible population who were thought less likely to respond to invitations. However, whilst LAs appear to be moving towards a more targeted approach, a robust evaluation of its impact on health and health inequalities requires national data to be collected at ward-level.

5 Conclusions

In the first three years since LAs became responsible for the NHS Health Checks programme, invitational activity has risen, but uptake has remained static and appears unresponsive to higher levels of spend. Our study suggests that approaches other than formal invitation, such as opportunistic offers of checks, may be effective in increasing attendance rates and that assessment of the NHSHC requires evaluation of all three outcomes described in this study if effective local action is to be further developed by LAs. The extent of unidentified need revealed through the health check is also an important consideration in assessing the benefits of different approaches to invitation and outreach, coverage and uptake, and further research is needed to address this gap in the evidence base.

6 References

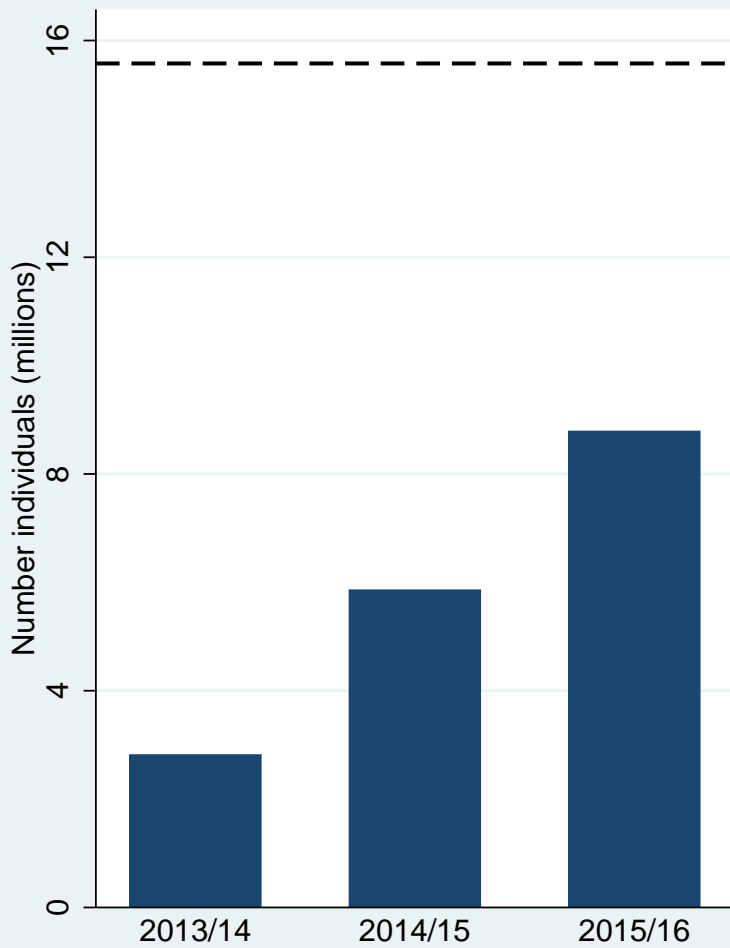
- [1] Robson J, Dostal I, Sheikh A, Eldridge S, Madurasinghe V, Griffiths C, Coupland C, Hippisley-Cox J. The NHS Health Check in England: an evaluation of the first 4 years. *BMJ Open* 2016; 6:e008840.
- [2] Waterall J, Greaves F, Kearney M, Fenton KA. NHS Health Check: an innovative component of local adult health improvement and well-being programmes in England. *J Public Health (Oxf)* 2015; 37:177-84.
- [3] Chang KC, Lee JT, Vamos EP, Soljak M, Johnston D, Khunti K, Majeed A, Millett C. Impact of the National Health Service Health Check on cardiovascular disease risk: a difference-in-differences matching analysis. *CMAJ* 2016; 188:E228-38.
- [4] Artac M, Dalton ARH, Babu H, Bates S, Millett C, Majeed A. Primary care and population factors associated with NHS Health Check coverage: a national cross-sectional study. *J Public Health (Oxf)* 2013; 35:431-9.
- [5] Hunter D, Marks L. Health inequalities in England's changing public health system. In: Smith K, Hill S, Bambra C, editors. *Health Inequalities: Critical perspectives*. Oxford: Oxford University Press, 2016.
- [6] Public Health England. NHS Health Check: Best practice guidance. PHE publications gateway number: 2016609. London: PHE, 2017:70.
- [7] Dalton ARH, Soljak M, Samarasinghe E, Millett C, Majeed A. Prevalence of cardiovascular disease risk amongst the population eligible for the NHS Health Check Programme. *European Journal of Preventive Cardiology* 2013; 20:142-50.
- [8] Syed AM, Talbot-Smith A, Gemmell I. The use of epidemiological measures to estimate the impact of primary prevention interventions on CHD, stroke and cancer outcomes: experiences from Herefordshire, UK. *J Epidemiol Glob Health* 2012; 2:111-24.
- [9] Krogsbøll LT, Jørgensen KJ, Grønhøj Larsen C, Gøtzsche PC. General health checks in adults for reducing morbidity and mortality from disease. *Cochrane Database of Systematic Reviews* 2012.
- [10] Gidlow CJ, Ellis NJ. Opportunistic community-based health checks. *Public Health* 2014; 128:582-4.
- [11] Marks L, Jehu LM, Visram S, Mason A, Liu D, Davis H, Hunter D, Smithson J, Melvin K. Commissioning public health services: the impact of the health reforms on access, health inequalities and innovation in service provision. Final Report. York: University of York, 2017:173.
- [12] Petter J, Reitsma-van Rooijen MM, Korevaar JC, Nielen MMJ. Willingness to participate in prevention programs for cardiometabolic diseases. *BMC Public Health* 2015; 15:44.
- [13] Sallis A, Bunten A, Bonus A, James A, Chadborn T, Berry D. The effectiveness of an enhanced invitation letter on uptake of National Health Service Health Checks in primary care: a pragmatic quasi-randomised controlled trial. *BMC Fam Pract* 2016; 17:35.
- [14] Public Health England, Department of Health, Southwark Council. Low cost ways to increase NHS Health Check attendance: results from a randomised controlled trial. 2015:6.
- [15] Usher-Smith J, Mant J, Martin A, Harte E, MacLure C, Meads C, Saunders C, Griffin S, Walter F, Lawrence K, Robertson C. NHS Health Check Programme - rapid evidence synthesis. Cambridge: University of Cambridge, 2017:140.
- [16] Gidlow C, Ellis N, Randall J, Cowap L, Smith G, Iqbal Z, Kumar J. Method of invitation and geographical proximity as predictors of NHS Health Check uptake. *J Public Health (Oxf)* 2015; 37:195-201.
- [17] McDermott L, Wright AJ, Cornelius V, Burgess C, Forster AS, Ashworth M, Khoshaba B, Clery P, Fuller F, Miller J, Dodhia H, Rudisill C, Conner MT, Gulliford MC. Enhanced invitation methods and uptake of health checks in primary care: randomised controlled trial and cohort study using electronic health records. *Health Technol Assess* 2016; 20:1-92.
- [18] Andersen RM. Revisiting the behavioral model and access to medical care: does it matter? *J Health Soc Behav* 1995; 36:1-10.

- 1 [19] Chang KC, Soljak M, Lee JT, Woringer M, Johnston D, Khunti K, Majeed A, Millett C. Coverage
2 of a national cardiovascular risk assessment and management programme (NHS Health Check):
3 Retrospective database study. *Prev Med* 2015; 78:1-8.
- 4 [20] Cochrane T, Gidlow CJ, Kumar J, Mawby Y, Iqbal Z, Chambers RM. Cross-sectional review of
5 the response and treatment uptake from the NHS Health Checks programme in Stoke on Trent. *J*
6 *Public Health (Oxf)* 2013; 35:92-8.
- 7 [21] Dalton ARH, Bottle A, Okoro C, Majeed A, Millett C. Uptake of the NHS Health Checks
8 programme in a deprived, culturally diverse setting: cross-sectional study. *J Public Health (Oxf)* 2011;
9 33:422-9.
- 10 [22] Artac M, Dalton AR, Majeed A, Car J, Huckvale K, Millett C. Uptake of the NHS Health Check
11 programme in an urban setting. *Fam Pract* 2013; 30:426-35.
- 12 [23] Artac M, Dalton ARH, Majeed A, Car J, Millett C. Effectiveness of a national cardiovascular
13 disease risk assessment program (NHS Health Check): results after one year. *Prev Med* 2013; 57:129-
14 34.
- 15 [24] Bekwelem W, Vanwormer JJ, Boucher JL, Pereira RF. Cardiovascular risk factor screening
16 satisfaction in the heart of New Ulm project. *Clinical Medicine and Research* 2012; 10:1-6.
- 17 [25] Caley M, Chohan P, Hooper J, Wright N. The impact of NHS Health Checks on the prevalence
18 of disease in general practices: a controlled study. *Br J Gen Pract* 2014; 64:e516-21.
- 19 [26] Cochrane T, Davey R, Iqbal Z, Gidlow C, Kumar J, Chambers R, Mawby Y. NHS health checks
20 through general practice: randomised trial of population cardiovascular risk reduction. *BMC Public*
21 *Health* 2012; 12:944.
- 22 [27] Dalton ARH, Bottle A, Okoro C, Majeed A, Millett C. Implementation of the NHS Health
23 Checks programme: baseline assessment of risk factor recording in an urban culturally diverse
24 setting. *Fam Pract* 2011; 28:34-40.
- 25 [28] Forster AS, Burgess C, Dodhia H, Fuller F, Miller J, McDermott L, Gulliford MC. Do health
26 checks improve risk factor detection in primary care? Matched cohort study using electronic health
27 records. *J Public Health (Oxf)* 2015.
- 28 [29] Hoebel J, Starker A, Jordan S, Richter M, Lampert T. Determinants of health check
29 attendance in adults: findings from the cross-sectional German Health Update (GEDA) study. *BMC*
30 *Public Health* 2014; 14:913.
- 31 [30] Hooper J, Chohan P, Caley M. Case detection of disease by NHS Health Checks in
32 Warwickshire, England and comparison with predicted performance. *Public Health* 2014; 128:475-7.
- 33 [31] Labeit A, Peinemann F, Baker R. Utilisation of preventative health check-ups in the UK:
34 Findings from individual-level repeated cross-sectional data from 1992 to 2008. *BMJ Open* 2013; 3
35 (12) (no pagination).
- 36 [32] Lambert MF. Assessing potential local routine monitoring indicators of reach for the NHS
37 health checks programme. *Public Health* 2016; 131:92-8.
- 38 [33] Laws RA, Fanaian M, Jayasinghe UW, McKenzie S, Passey M, Davies GP, Lyle D, Harris MF.
39 Factors influencing participation in a vascular disease prevention lifestyle program among
40 participants in a cluster randomized trial. *BMC Health Serv Res* 2013; 13:12.
- 41 [34] Liao Y, Tucker P, Siegel P, Liburd L, Giles W. Decreasing disparity in cholesterol screening in
42 minority communities-Findings from the Racial and Ethnic Approaches to Community Health 2010. *J*
43 *Epidemiol Community Health* 2010; 64:292-9.
- 44 [35] Lin CC, Ko CY, Liu JP, Lee YL, Chie WC. Nationwide periodic health examinations promote
45 early treatment of hypertension, diabetes and hyperlipidemia in adults: Experience from Taiwan.
46 *Public Health* 2011; 125:187-95.
- 47 [36] Murray KA, Murphy DJ, Clements S-J, Brown A, Connolly SB. Comparison of uptake and
48 predictors of adherence in primary and secondary prevention of cardiovascular disease in a
49 community-based cardiovascular prevention programme (MyAction Westminster). *J Public Health*
50 *(Oxf)* 2014; 36:644-50.

- 1 [37] Naderi S, Johnson CE, Rodriguez F, Wang Y, Pollin I, Foody JM. Characteristics of women lost
2 to follow-up in cardiovascular community health interventions: findings from the Sister to Sister
3 campaign. *J Community Health* 2013; 38:458-62.
- 4 [38] Norberg M, Blomstedt Y, Lonnberg G, Nystrom L, Stenlund H, Wall S, Weinehall L.
5 Community participation and sustainability--evidence over 25 years in the Vasterbotten Intervention
6 Programme. *Glob Health Action* 2012; 5:1-9.
- 7 [39] Rodin D, Stirbu I, Ekholm O, Dzurova D, Costa G, Mackenbach JP, Kunst AE. Educational
8 inequalities in blood pressure and cholesterol screening in nine European countries. *J Epidemiol
9 Community Health* 2012; 66:1050-5.
- 10 [40] Rosell-Murphy M, Rodriguez-Blanco T, Moran J, Pons-Vigues M, Elorza-Ricart JM, Rodriguez
11 J, Pareja C, Nuin MA, Bolibar B. Variability in screening prevention activities in primary care in Spain:
12 a multilevel analysis. *BMC Public Health* 2015; 15:473.
- 13 [41] Saffar D, Perkins DW, Williams V, Kapke A, Mahan M, Milberger S, Brady M, Wisdom K.
14 Screening for diabetes in an African American community: identifying characteristics associated with
15 abnormal blood glucose readings. *J Natl Med Assoc* 2011; 103:190-3.
- 16 [42] Si S, Moss JR, Sullivan TR, Newton SS, Stocks NP. Effectiveness of general practice-based
17 health checks: a systematic review and meta-analysis. *Br J Gen Pract* 2014; 64:E47-E53.
- 18 [43] Thorpe RJ, Bowie JV, Wilson-Frederick SM, Coa KI, LaVeist TA. Association Between Race,
19 Place, and Preventive Health Screenings Among Men: Findings From the Exploring Health Disparities
20 in Integrated Communities Study. *American Journal of Mens Health* 2013; 7:220-7.
- 21 [44] Weaver A, Gjesfjeld C. Barriers to Preventive Services Use for Rural Women in the
22 Southeastern United States. *Soc Work Res* 2014; 38:225-34.
- 23 [45] Willis A, Rivers P, Gray LJ, Davies M, Khunti K. The effectiveness of screening for diabetes
24 and cardiovascular disease risk factors in a community pharmacy setting. *PLoS One* 2014; 9:e91157.
- 25 [46] Department of Health. Public health ring-fenced grant conditions: 2015/16. LAC:
26 (DH)(2014)2. London: Department of Health, 2014:20.
- 27 [47] Kumar J, Chambers R, Mawby Y, Leese C, Iqbal Z, Picariello L, Richardson D. Delivering more
28 with less? Making the NHS Health Check work in financially hard times: real time learning from
29 Stoke-on-Trent. *Qual Prim Care* 2011; 19:193-9.
- 30 [48] Hausman J, Hall BH, Griliches Z. Econometric Models for Count Data with an Application to
31 the Patents-R & D Relationship. *Econometrica* 1984; 52:909-38.
- 32 [49] Baker C, Loughren EA, Crone D, Kallfa N. A process evaluation of the NHS Health Check care
33 pathway in a primary care setting. *J Public Health (Oxf)* 2015; 37:202-9.
- 34 [50] Public Health England. NHS Health Check: Best practice guidance. London: PHE, 2017:70.
- 35 [51] Public Health England. NHS Health Check Programme: Health Equity Audit Guidance.
36 London: PHE, 2016:37.
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Figure 1

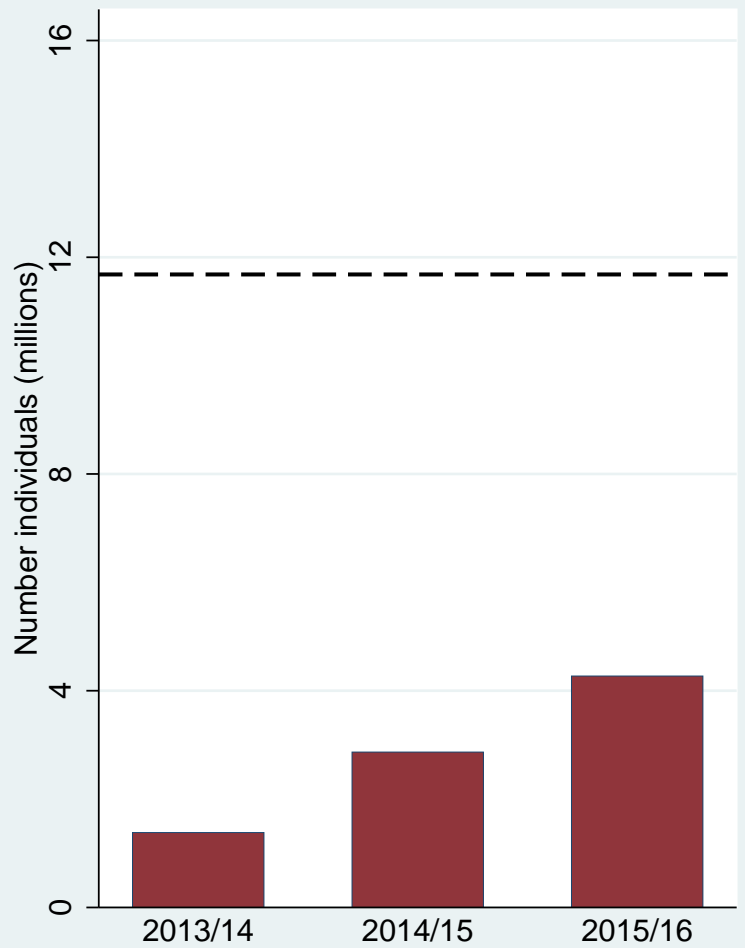
Invitees



Bars show cumulative totals

Dotted line: PHE 5-year ambition – 100% invitees

Attendees



Bars show cumulative totals

Dotted line: PHE 5-year ambition – 75% uptake

Figure 2

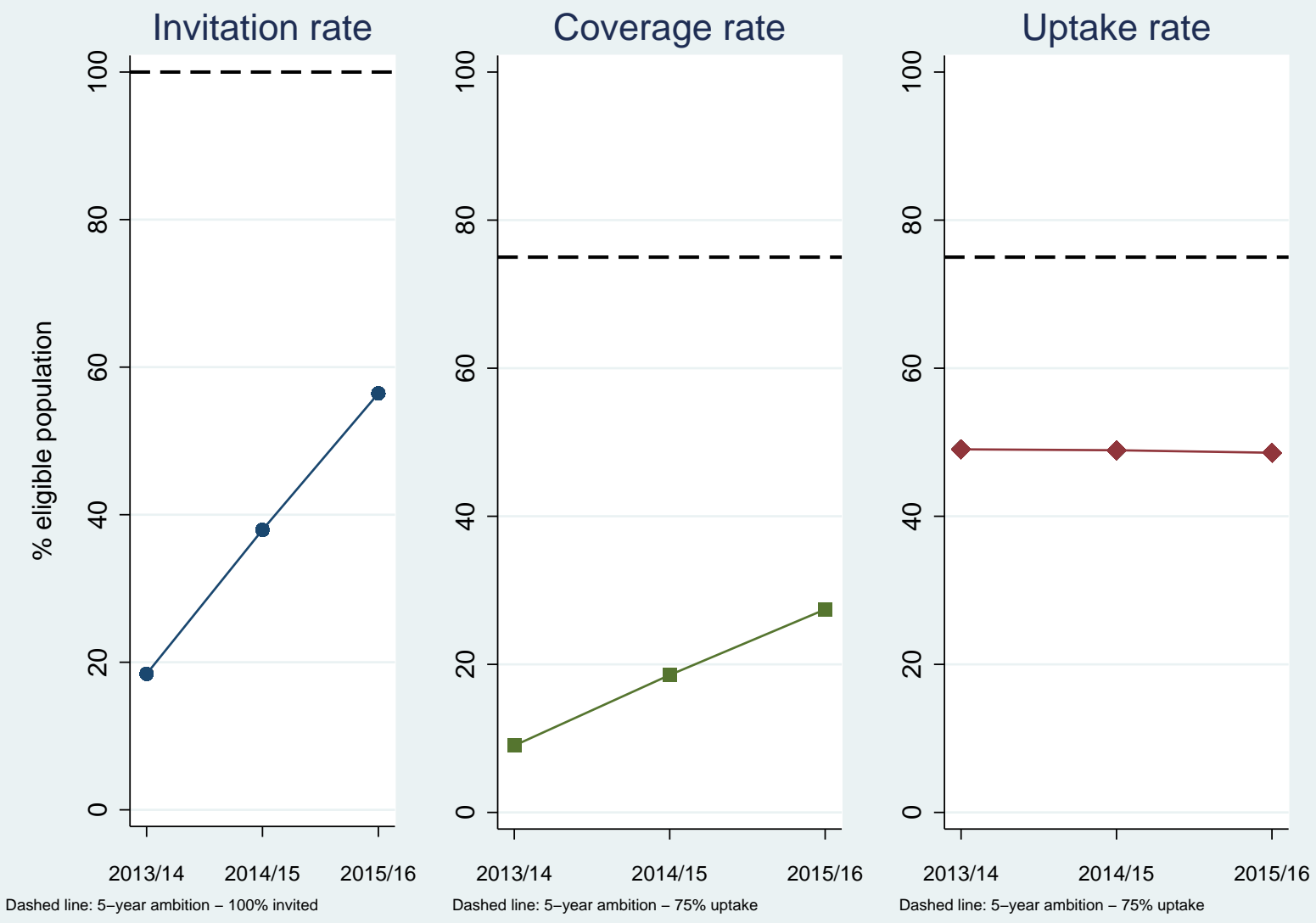


Table 1

Table 1: Covariates: summary statistics, 2013/14 to 2015/16

	2013/14			2014/15			2015/16			All years		
	mean	sd	N	mean	sd	N	mean	sd	N	mean	sd	N
<i>Predisposing factors</i>												
Age 40 to 44 (ref)	17.58	2.70	150	17.09	2.80	150	16.64	2.94	150	17.10	2.84	450
Age 45 to 49	17.87	1.44	150	17.67	1.45	150	17.39	1.47	150	17.64	1.46	450
Age 50 to 54	16.33	0.73	150	16.62	0.71	150	16.87	0.69	150	16.61	0.74	450
Age 55 to 59	13.90	0.55	150	14.11	0.58	150	14.40	0.60	150	14.14	0.61	450
Age 60 to 64	12.85	1.14	150	12.66	1.07	150	12.54	1.01	150	12.68	1.08	450
Age 65 to 69	12.44	1.98	150	12.60	2.00	150	12.69	1.99	150	12.57	1.99	450
Age 70 to 74	9.03	1.36	150	9.25	1.53	150	9.47	1.71	150	9.25	1.55	450
% male (40-74)	49.21	0.77	150	49.22	0.78	150	49.22	0.80	150	49.22	0.78	450
% white (2011) *										77.27	20.74	450
% living in 20% most deprived LSOAs (2015) *										24.85	18.98	450
<i>Enabling factors</i>												
%LA rural pop (2011) *										17.51	24.49	450
FTE GPs per 10,000 pop **	6.59	0.95	150	6.62	0.98	150	5.13	0.76	150	6.11	1.14	450
Per capita spend on NHSHC (£)	£4.17	£2.97	150	£4.46	£2.51	150	£4.16	£2.36	150	£4.26	£2.62	450
Per capita spend on adult obesity (£)	£1.65	£2.04	150	£1.67	£1.79	150	£1.60	£1.62	150	£1.64	£1.82	450
Per capita spend on adult physical activity (£)	£1.37	£1.92	150	£1.89	£2.49	150	£1.95	£2.47	150	£1.73	£2.32	450
Per capita spend: stop smoking services (£)	£2.74	£1.56	150	£2.53	£1.31	150	£2.33	£1.25	150	£2.53	£1.39	450
Per capita spend: wider tobacco control (£)	£0.40	£0.78	150	£0.34	£0.50	150	£0.31	£0.44	150	£0.35	£0.59	450
Spend on NHSHC as % PH budget	2.37%	1.50%	150	2.45%	1.37%	150	1.98%	1.08%	150	2.27%	1.34%	450
Spend on adult obesity as % PH budget	2.31%	2.38%	150	2.21%	2.08%	150	1.86%	1.57%	150	2.13%	2.04%	450
Spend on adult physical activity as % PH budget	1.84%	2.24%	150	2.36%	2.47%	150	2.18%	2.21%	150	2.12%	2.32%	450
Spend on stop smoking services as % PH budget	5.30%	2.84%	150	4.53%	2.10%	150	3.60%	1.62%	150	4.47%	2.34%	450
Spend on wider tobacco control as % PH budget	0.75%	1.24%	150	0.60%	0.89%	150	0.45%	0.53%	150	0.60%	0.94%	450
Spend on lifestyle interventions as % PH budget	10.19%	4.45%	150	9.69%	4.09%	150	8.09%	3.59%	150	9.32%	4.15%	450
Participated in NHSHC HPIS ***				70.67%	45.68%	150				70.67%	45.68%	150
<i>Need factors</i>												
Adult obesity: % LA population (QOF registers)	10.46	2.28	150	10.00	2.26	150	10.23	2.32	150	10.23	2.29	450
PHOF 2.14: smoking prevalence (%)	18.78	3.27	150	18.20	3.32	150	17.33	3.12	150	18.10	3.29	450

	2013/14			2014/15			2015/16			All years		
	mean	sd	N	mean	sd	N	mean	sd	N	mean	sd	N
PHOF 2.13ii: % physically inactive adults	28.88	4.54	150	28.34	4.51	150	29.21	4.78	150	28.81	4.62	450
PHOF 4.04ii: preventable CVD deaths / 100,000 in <75s	54.10	11.83	150	52.61	11.85	150	51.44	11.93	150	52.72	11.89	450
CVD prevalence, 2011*										0.12	0.02	450

* time-invariant;

** excludes GPs employed by CCGs

*** HPIS: health premium incentive scheme (operated in 2014/15 only)

Table 2

Table 2: Regression results – base case models, 2013/14 to 2015/16

Factor type	Explanatory variables	Model 1: Invitation rate		Model 2: Coverage rate		Model 3: Uptake rate	
		IRR	95%CI	IRR	95%CI	IRR	95%CI
Predisposing	% aged 45-49	0.814*	[0.694,0.955]	0.831*	[0.716,0.964]	1.029	[0.898,1.179]
	% aged 50-54	0.947	[0.828,1.083]	0.853*	[0.754,0.965]	0.845**	[0.753,0.947]
	% aged 55-59	0.783**	[0.668,0.917]	0.854*	[0.740,0.985]	1.098	[0.968,1.245]
	% aged 60-64	0.921	[0.785,1.081]	0.939	[0.810,1.090]	1.039	[0.904,1.194]
	% aged 65-69	0.918	[0.804,1.049]	0.848**	[0.750,0.958]	0.864**	[0.774,0.964]
	% aged 70-74	0.952	[0.853,1.062]	0.992	[0.897,1.097]	1.060	[0.968,1.162]
	% male	0.982	[0.909,1.062]	1.001	[0.931,1.077]	1.035	[0.971,1.104]
	% white	1.001	[0.995,1.007]	0.999	[0.993,1.005]	1.000	[0.995,1.006]
	Deprivation level: medium (IMD 2015)	1.009	[0.887,1.148]	0.941	[0.832,1.065]	0.966	[0.865,1.078]
	Deprivation level: high (IMD 2015)	0.957	[0.788,1.162]	0.868	[0.724,1.041]	0.892	[0.758,1.050]
Enabling	% rural (incl. hub towns), 2011	0.999	[0.996,1.002]	1.000	[0.997,1.002]	0.998	[0.995,1.000]
	FTE GPs per 10,000 pop (excl CCGs)	0.999	[0.957,1.042]	0.993	[0.954,1.033]	1.015	[0.979,1.052]
	Per capita spend, NHSHC: medium	1.168***	[1.087,1.255]	1.198***	[1.123,1.278]	1.044	[0.985,1.106]
	Per capita spend, NHSHC: high	1.288***	[1.182,1.404]	1.260***	[1.166,1.362]	1.003	[0.935,1.077]
	Per capita spend, adult physical activity: medium	1.140**	[1.050,1.237]	1.083*	[1.005,1.168]	0.942	[0.881,1.008]
	Per capita spend, adult physical activity: high	1.127*	[1.017,1.250]	1.011	[0.921,1.110]	0.866***	[0.795,0.943]
	Per capita spend, adult obesity: medium	0.951	[0.881,1.026]	0.971	[0.906,1.041]	0.982	[0.922,1.046]
	Per capita spend, adult obesity: high	0.928	[0.846,1.018]	0.973	[0.895,1.059]	1.057	[0.980,1.139]
	Per capita spend, stop smoking services: medium	1.054	[0.975,1.139]	1.034	[0.964,1.109]	0.990	[0.932,1.053]
	Per capita spend, stop smoking services: high	1.034	[0.940,1.138]	1.044	[0.959,1.138]	0.997	[0.922,1.077]
	Per capita spend, wider tobacco control: medium	1.014	[0.939,1.094]	1.055	[0.984,1.130]	1.064	[0.998,1.135]
	Per capita spend, wider tobacco control: high	1.051	[0.963,1.146]	1.041	[0.962,1.127]	1.033	[0.960,1.112]
	Participated in NHSHC Health Premium Incentive Scheme	1.000	[0.906,1.103]	1.054	[0.964,1.151]	1.044	[0.963,1.132]
	Class: County	0.963	[0.847,1.095]	0.966	[0.849,1.100]	1.070	[0.954,1.199]
	Class: London Borough	1.111	[0.892,1.384]	1.077	[0.873,1.329]	0.937	[0.771,1.138]
Class: Metropolitan District	0.909	[0.794,1.042]	0.962	[0.846,1.094]	0.996	[0.886,1.120]	

Factor type	Explanatory variables	Model 1: Invitation rate		Model 2: Coverage rate		Model 3: Uptake rate	
		IRR	95%CI	IRR	95%CI	IRR	95%CI
Need	Adult obesity: % LA population (QOF registers)	1.062 ^{***}	[1.027,1.099]	1.096 ^{***}	[1.062,1.130]	1.036 [*]	[1.007,1.067]
	PHOF 2.14: smoking prevalence	0.999	[0.981,1.017]	0.995	[0.979,1.012]	0.993	[0.979,1.007]
	PHOF 2.13ii: physically inactive adults	0.988	[0.975,1.001]	0.985 ^{**}	[0.973,0.996]	0.999	[0.989,1.009]
	PHOF 4.04ii: preventable CVD deaths per 100,000 (<75s)	1.000	[0.993,1.007]	1.001	[0.995,1.008]	1.000	[0.994,1.006]
	Cardiovascular disease prevalence, 2011	0.045	[0.000,36.905]	0.167	[0.000,94.501]	17.917	[0.054,5962.981]
	2014/15	1.120 [*]	[1.004,1.251]	1.092	[0.988,1.208]	1.023	[0.934,1.120]
	2015/16	1.095	[0.946,1.268]	1.091	[0.953,1.250]	1.064	[0.935,1.211]
	Observations	450		450		450	
	Likelihood ratio test (Chi-squared)	56.548		74.279		75.436	

IRR, Incidence rate ratio: exponentiated coefficients; 95% confidence intervals in brackets; * p < 0.05, ** p < 0.01, *** p < 0.001

Base case (A): spend as terciles; deprivation as terciles

Reference groups: % aged 40-44; Deprivation level (tercile): low; Per capita spend (tercile): low; Class: unitary authority; Year: 2013/14

Appendix Table 1

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Appendix Table 2

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Data Statement

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