

Local Evaluation of the Workplace Cardiovascular Disease Health Checks Pilot (SMBC/JLR)

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Executive Summary

This report represents a local evaluation of the workplace model for cardiovascular disease (CVD) checks. It serves to complement the national evaluation of all the CVD workplace pilots in England due later in 2025.

It draws insights from the data and information received regarding the health status of the JLR employees who participated in this pilot project.

It also captures the observations and learning from partners involved in the pilot in terms of the planning, logistics and implementation of CVD health check model at JLR and what this means for developing a sustainable workplace model moving forward.

One of the main objectives of this workplace pilot was the early identification and intervention of those employees with increased risk of CVD and with no previous diagnosis or treatment.

An important working assumption was reliance on self-reported health status from employees (i.e., those who had previously not had an NHS Check in the past 5 years and were not on any treatment from their GP).

A QRisk3 score higher than 10% represents at least a 1 in 10 chance (moderate risk) of having a stroke or heart attack in the next 10 years. Of the 1,275 JLR staff that attended a health check, 139 (10.9%) had a QRisk3 score $\geq 10\%$. As expected, the prevalence of a moderate risk of cardiovascular disease varied significantly with age and gender.

Were this figure (10.9%) extrapolated to the total workforce, we would expect to identify over 1000 JLR employees with a QRisk3 score of $\geq 10\%$ (earlier caveats apply). Moreover, following the health check, a total of 437 (34.3%) employees required a referral to a GP for follow-up tests, advice and/or treatment for health issues identified. This suggests that the case finding model was effective in identifying unascertained comorbidities in hard-to-reach subjects and warrants further development.

The local objectives shed additional insight into the value of an enhanced health check.

i. Target working-age adults, especially men.

JLR has a predominantly male workforce (94%). It would have been beneficial to have had more employees from the production line; manual workers tend to have a higher risk of CVD.

ii. Extend the local dataset to include: the AUDIT-C alcohol questionnaire and GPPAQ (General practice physical activity questionnaire) for each employee.

The addition of both tools as part of the health check has proved valuable. The AUDIT-C identified that 10.4% of employees (n = 130) had a high or very high-risk score that warranted immediate intervention.

Effectively all employees receiving a health check answered the GPPAQ (n = 1,271/ 1275), The GPPAQ identified 6.6% (n = 84) were physically inactive. One in ten female employees (10.3%, n = 31) were found to be physically inactive, double that of men where 1 in every 20 male employees were inactive (5.4%, n = 53).

- iii. *Extend blood testing to all employees, i.e. HbA1c (glycated haemoglobin) and total cholesterol profile measurements taken (with consent), regardless of eligibility for the NHS Health Check programme, using point of care testing (POCT).***

The value of POCT is well evidenced in terms of efficiency and acceptability. In this model, it facilitated real-time discussions with employees identified as high risk and in need of escalation to a GP.

- iv. *Incorporate referrals into Solihull Lifestyle services as well as to the JLR in-house health support services. Understand uptake into these services.***

The ability to track employees after their health check to lifestyle services is an area that requires further work. Only 40 of the 1275 were registered with Solihull GPs; it is not clear from the data if these employees were referred to lifestyle services. This is not surprising given JLR is a large employer that recruits employees from across the region and nationally.

- v. *Explore the feasibility of electronic data sharing with the employee's general practice (GP), if possible. If not, understand issues with sending letters to GP for high risk / NHS Health Check results.***

One of the longstanding limitations with third party health checks is that there is no electronic transfer of results to the individual's own GP surgery. The onus is on the individual to inform their GP of the results and then on the GP to progress any action.

A solution to data transfer was found, not without some initial logistical issues, however once resolved, provided greater assurance. To this end, the involvement of SiSU provided added value.

Partners have provided some valuable insights into what would be required to support the development of a sustainable model.

It works best as a partnership model, underpinned by a strong collaboration and solution-focused ethos. There are also some helpful practical considerations on data transfer and tracking, contract management and procurement that will be shared locally and regionally with all partners and with the national team.

Early identification of CVD risk factors contributes to long-term reductions in healthcare costs, increased workforce productivity and reduced absenteeism, aligning with national priorities set out in the 'Get Britain Working' white paper (Work and Health Integration Strategy, 2024).

It is hoped that learning from this pilot will influence local decision-making on what is required to build a sustainable working age adult prevention model that informs strategic prevention plans, joint commissioning arrangements and integrated models of delivery.

Introduction

The Government and NHS continue to recognise the importance of cardiovascular disease (CVD) prevention and the opportunity that the NHS Health Check offers to support this. In 2019 NHS England's Long-term plan (NHS, 2025) confirmed its commitment to the broader CVD prevention agenda and within that to:

'work with local authorities and PHE, to improve the effectiveness of approaches such as the NHS Health Check, rapidly treating those identified with high-risk conditions'. Pg. 62 (3.68)

Under the Health and Social Care Act 2012, responsibility for commissioning and monitoring the NHS Health Check programme was conferred to local authorities. Therefore, local authorities have a legal responsibility to offer an NHS Health Check to 100% of their eligible population once every five years.

The NHS Health Check programme is a national initiative aimed at identifying early signs of cardiovascular disease, diabetes, and other preventable health conditions among adults. By offering routine health assessments, the programme seeks to promote early intervention, encourage healthier lifestyles, and reduce the long-term burden on the NHS. In alignment with these objectives, a national cardiovascular workplace pilot was introduced to enhance employee well-being and improve access to preventative care by taking health checks to diverse workplace settings.

This national pilot aimed to deliver up to 150,000 cardiovascular disease checks in workplaces by the end of March 2025. These checks sought to identify the early signs of heart disease and provide people with the information they need to reduce their risk of having a heart attack, stroke or developing diabetes. The pilot was designed to gather evidence on the feasibility and impact of workplace CVD checks. It hoped to encourage employers to support people to stay well in work, by gathering and sharing learning on delivering CVD checks in the workplace (Department of Health & Social Care, 2025).

This pilot complements wider government activity to promote workplace health; this includes the WorkWell service that will link employment and health support at a local level, the expansion of access to NHS talking therapies and the expansion of Musculo-skeletal Hubs (Department of Health & Social Care, 2025).

The Government has set out an ambition to improve the countries productivity in the Get Britain Working white paper with the aim to move the country to 80% employment by reducing Economic Inactivity (Proctor, 2024). A quarter of all people aged 16 to 64 have a long-term health condition that limits their day-to-day activities (therefore classing them as disabled), with disabled people nearly 3 times more likely (than non-disabled people) to be economically inactive (Reeves MP, Kendall MP, Phillipson MP, & Streeting MP, 2024).

The white paper recognises the significant adverse impacts for people, the economy and for public finances when there is this inactivity, and has described 4 priority areas to tackle this challenge:

- improving the health of the population so that more people can stay in and thrive at work
- mobilising local leadership to tackle economic inactivity by better connecting work, health and skills support and increasing engagement with that support
- supporting employers to promote healthy workplaces, and to recruit and retain workers with a health condition or disability
- reforming the system of health and disability benefits to promote and enable employment (Reeves MP, Kendall MP, Phillipson MP, & Streeting MP, 2024).

This report is intended to complement the national workplace evaluation undertaken across the country (national evaluation report expected Autumn/Winter 2025). It provides the opportunity to examine the programme from inception to implementation.

The report explores some of the key themes, challenges and innovation identified by partners as well as the impact of this workplace model.

Background

Cardiovascular Checks in Solihull Metropolitan Borough Council

Launched in 2009, the NHS Health Check aims to reduce cardiovascular disease (CVD) and its associated ill-health in England. CVD, while still a major health concern accounting for 24% of adult deaths (second only to cancer), was the leading cause of death when the programme began. The check is offered every five years to adults aged 40-74 who do not have pre-existing CVD.

CVD is strongly linked to health inequalities, with mortality rates three times higher in the most deprived communities compared to the least deprived. The NHS Health Check programme offers a valuable opportunity to address this disparity and improve health outcomes. This is reflected in the population of Solihull where CVD is one of the leading causes of preventable premature mortality. There are approximately 258 deaths in residents aged under 75 that are considered preventable in Solihull each year, around 50 of these are from CVD.

Since 2013, local authorities have overseen the NHS Health Check, with most checks conducted by healthcare professionals in GP surgeries. Efforts to improve accessibility have included offering appointments outside of working hours, utilising phone calls and existing GP appointments for invitations, and sending text message reminders. Extending access by using community locations such as pharmacies, libraries, community halls and workplaces have been considered and used. The current model in Solihull for NHS Health Check delivery is by invitation from General Practice only.

Jaguar Land Rover Solihull

Located in the Elmdon ward of Solihull, a manufacturing plant has been in operation since the 1930s. Originally manufacturing Bristol Hercules engines for World War II, the factory, now owned by Jaguar Land Rover (JLR), employs over 9,000 people to produce the Range Rover and Jaguar F-Pace.

Approximately 94% of the JLR workforce are male and 65% of employees are aged 40 years or over.

The aspiration was to deliver a workplace model of CVD checks at JLR that would attract employees that are eligible for an NHS health check that may not have taken up the offer with their GP, for example men from socio economic groups (who are more likely to develop CVD at an earlier age) (NHS, 2025), as well as raise awareness of risk factors in all age groups.

Collaboration between Solihull Metropolitan Borough Council and Jaguar Land Rover

One of the key elements of success to this project was the working relationship between SMBC and JLR. This relationship has been a longstanding one but was strengthened through the COVID-19 Pandemic when the Director of Public Health at SMBC and the Chief Medical Officer (CMO) at JLR worked collaboratively to protect the workforce and their families.

The call for expressions of interest and bids for grant funding came to local authorities in March 2024, for workplace CVD checks to take part in a pilot aiming to deliver up to 150,000 CVD checks in workplaces by the end of March 2025.

The previous collaborative working between Solihull Metropolitan Borough Council (SMBC) and JLR prompted the Director of Public Health to initiate conversations with the Chief Medical Officer of JLR to explore if this was a feasible pilot, if it aligned with JLR's priorities and whether the short timelines to complete the bid process were even attainable.

Within a two-week window the initial conversations, completion of the bid and submission were completed between the Public Health team and the Occupational health team at JLR.

All bids had to be signed off and submitted by the local Director of Public Health.

Governance and accountability for this pilot sat with the local authority with the DPH as lead Director. The model agreed locally was that SMBC would commission JLR to deliver an agreed number of workplace CVD health checks in the time period specified by the Department of Health and Social Care (DHSC). JLR subcontracted elements of the work to partners.

The national plan was for pilots to run for 12 months from April 2024 up to the end of March 2025.

The announcement in the early Spring of 2024 of a national general election put a hold on proceedings. The new government agreed to continue with the pilots but it wasn't until September 2024, that a new CVD Memorandum of Understanding was signed and agreed between the Local Authority and the Office for Health Improvement and Disparities (OHID).

This pilot aligned with the All-Age Prevention Strategy outlined in Solihull's ['Living Well in Solihull \(2023–2028\)' framework](#) and was funded by a £160,000 grant from the Department of Health and Social Care (DHSC) via OHID (Perkins, 2024).

Evaluation of the Pilot Programme

National Objectives

The national objectives of this pilot were to:

1. Understand the benefit to business of delivering checks in workplace settings.

2. Test the feasibility of delivering NHS Health Checks or similar in workplaces and identify successful implementation approaches.
3. Detect more people at risk of CVD who are:
 - i) Eligible for an NHS Health Check but less likely to take it up (e.g. men and younger age groups) (Office for Health Improvement & Disparities, 2025).
 - ii) Outside of the 40- to 74-year-old age range for the NHS Health Check Programme.
4. Compare the relative reported experience of different delivery approaches to inform future interventions.

Local Objectives.

It was agreed by all partners from the outset to undertake a local evaluation. There would be valuable local lessons learnt that partners were keen to capture to inform future opportunities, and ways of working.

SMBC used the grant funding to commission JLR to deliver The Workplace Cardiovascular Disease (CVD) Health Checks Pilot in Solihull. This was implemented with the primary aim of delivering over 4,000 comprehensive CVD checks within workplace settings, primarily focusing on employees at Jaguar Land Rover (JLR) in Solihull. The initiative was designed to reach underrepresented and high-risk groups, including working-age men, ethnic minority populations, and individuals from deprived communities—groups that have historically shown lower uptake of NHS Health Checks.

Local Objectives included:

1. Target working-age adults, especially men.
2. Extend the local dataset to include: the AUDIT-C alcohol questionnaire and GPPAQ (General practice physical activity questionnaire) for each employee.
3. Extend blood testing to all employees, i.e. HbA1c (glycated haemoglobin) and total cholesterol profile measurements taken, regardless of eligibility for the NHS Health Check programme, using POCT.
4. Incorporate referrals into Solihull Lifestyle services as well as to the JLR in-house health support services. Understand uptake into these services.
5. Explore the feasibility of electronic data sharing with the employee's general practice (GP), if possible. If not, understand issues with sending letters to GP for high risk / NHS Health Check results.

Project Scope

- 1) The Department of Health and Social Care (DHSC) issued a document in early September 2024 (Appendix 1) which stipulated the data that would need to be collected by the local authority as part of the evaluation pilot into three categories:

- a) **Workplace data** - this is the data that will need to be collected only once for each of the workplaces where checks are delivered as part of the pilot. The data focuses on the characteristics of the workplace and workforce. Local authorities should assign a unique reference number/identifier to each workplace to enable CVD checks to be linked to the workplaces where they were delivered at an aggregated level.
- b) **CVD checks data** - this is the data that will need to be collected by providers for every individual receiving a check as part of this pilot. Data collected at individual employee level will not be shared with DHSC/the evaluator; only aggregated data will be requested as set out below.
- c) **Aggregated and anonymised CVD checks data** - this is the CVD checks data that will be submitted to DHSC by each local authority for evaluation. As noted, DHSC/the evaluator will not be requesting/handling personal identifiable data as part of the evaluation. Therefore, this data must be aggregated and anonymised before it is returned to DHSC.

In October 2024 this was amended to reflect the ONS /UK Standard Industrial Classification (SIC) would be required as part of the data collection, as well as other minor amendments in the data requirements (Appendix 2).

- 2) The CVD health checks were a combination of the NHS Health Check (eligibility is for those aged 40 – 74 years inclusive) (NHS, 2025) and a CVD check for all employees under 40 years or over 75 years. It was agreed locally to enhance this, all employees were offered a full blood check including HbA1c and total cholesterol profile using point of care testing (POCT), blood pressure check, body mass index (BMI) calculated, lifestyle questions asked (smoking status, alcohol consumption (AUDIT), physical activity questionnaire (GPPAQ)). All employees, regardless of age, were offered the same tests.
- 3) Valid and eligible NHS Health Check results sent back to the employee's GP, clearly stating the check had been delivered by a 3rd party.
- 4) Employees under 40 years and more than 75 years who had abnormal results and requiring follow up by a GP were asked to see their own GP and consent taken to inform their GPs via letter.
- 5) 4000 CVD health checks to be completed between the period 1/9/2024 – 31/3/2025.

Implementation

A Workplace CVD Health Checks Task and Finish Group (TFG) was mobilised at the beginning of September 2024 and weekly meetings were in place every Friday afternoon until the end of the pilot. The key stakeholders, SMBC, JLR, and Health Partners (an independent occupational health service contracted by JLR) met weekly for the first month.

The TFG quickly expanded to include representatives from the Birmingham and Solihull Integrated Care Board (ICB), SiSU Health UK (an independent company that provides accessible, self-service health checks, utilising a medical device health check machine, the SiSU Health Station), SoliHealth Ltd (a provider care alliance of local GPs) and the DHSC.

The pilot had 2 phases:

Phase 1 Planning: September – December 2024

Employees were to receive their CVD Health check as part of a wider health and wellbeing programme run by JLR called 'People Love Day' held within JLR. Approximately 4000 CVD checks to be completed within a 12-week period between January – March 2025.

Key Activities in this period included the following:

Data

Ensuring that the data requirements were manageable and attainable in line with the national specification for data reporting. An exploration of how to establish secure data returns to primary care with input from ICB, SoliHealth and DHSC. Expand the data set to include AUDIT and GPPAQ questionnaires on the SiSU health kiosks.

The transfer of information/results from JLR on individuals who had consented to having a CVD health check had been identified early on by the TFG as one of the key challenges. There was a willingness in the group to explore the possibility of finding a digital solution to this problem (as opposed to the fall-back position of explaining to the employee that they needed to take their results home and make an appointment with their GP to discuss them).

The ICB Chief Digital officer offered support whilst SiSU helped identified a solution for data sharing to the GP surgeries in a secure and easy process, while SoliHealth strengthened this, through the provision of a GP on site with a healthcare assistant in the sessions. This would provide assurance to an employee's GP and reduce the number of employees lost to follow up. Additional funding for this work was provided by JLR.

Procurement

The main elements of procurement were undertaken by JLR and included the equipment for POCT and the SiSU Health kiosks.

Process mapping

The design and development of the pathway that incorporated the key elements of the CVD health check in a logical sequence and flow was a collaborative effort by partners.

Logistics

Understanding the logistical requirements of delivering the model on site at JLR included the planning for the transfer of staff from the workplace without disruption to the operational

viability of the plant, the identification of the appropriate facilities at JLR to deliver the model and ensuring easy access to the site for non-JLR partners.

Staff recruitment and training

There was a considerable amount of work undertaken to understand the additional human resource requirements for the delivery of this model and the training requirements of all staff involved in the delivery of the programme.

Communication

From the outset all partners signed up to the development of one communications plan, with the communications leads from all partner organisations working collaboratively to produce it.

Contract management

This required formal agreements between SMBC with JLR and JLR with its subcontractors: Health Partners (HP), SiSU Health and SoliHealth Ltd.

Additional Providers

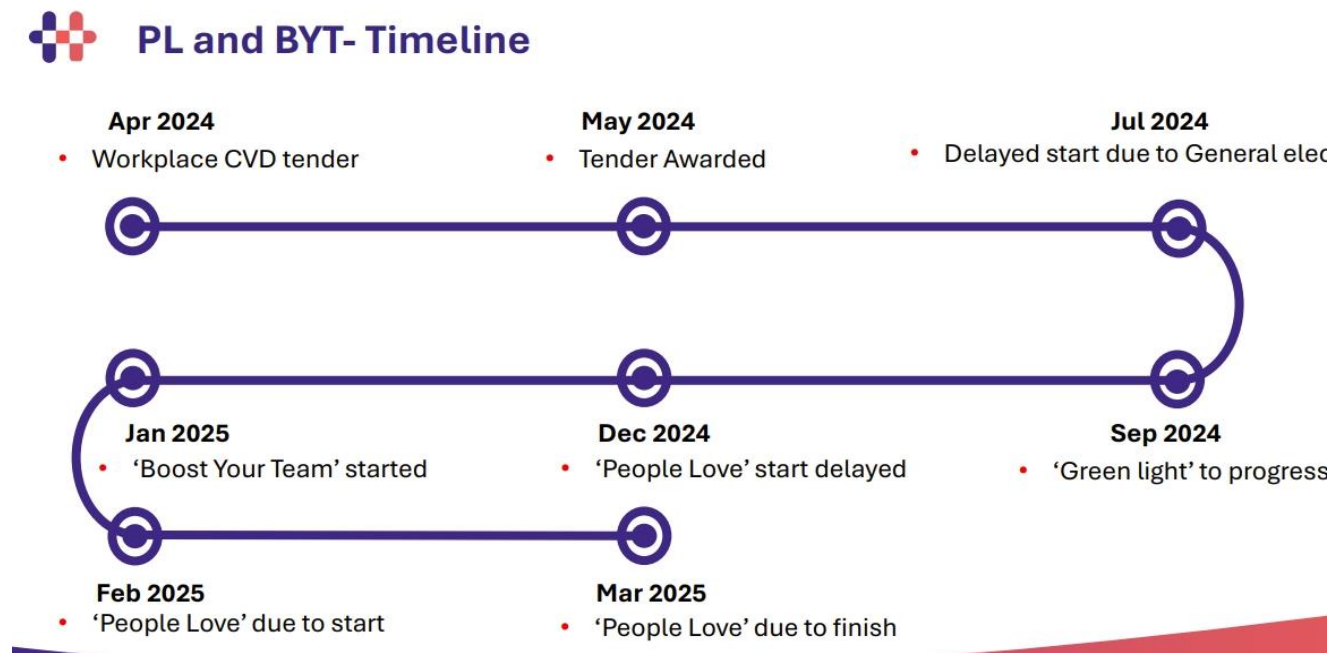
SMBC commissions several lifestyle services e.g. smoking cessation, alcohol and substance misuse services. Access and referral to them were part of our local model. It was agreed that because employees are not Solihull residents, information should be provided to employees about similar services from the neighbouring Local Authorities (Coventry, Warwickshire, Birmingham, Staffordshire) where many of the JLR workforce live.

Phase 2 Implementation January to March 2025

The plan for People Love (PL) Day was to deliver the CVD health checks on-site at JLR's Castle Bromwich site, using a multi-zone approach, which included biometric testing, CPR training and other activities for the employees. Staff would be transported via coach from the Lode Lane site to the Castle Bromwich site when they came on to their shift and returned before the end of the shift.

As the 'People Love' start date was delayed, JLR rapidly planned and implemented a short-term event called, 'Boost Your Team' (BYT) to include office-based staff to attend for their CVD checks and to ensure that the staff who had been recruited, trained and paid were utilised effectively (**Figure 1**).

Figure 1: People Love and Boost Your Team delivery timelines, Health Partners/JLR



'Boost your team'(BYT) was an opportunity to test and trial the model in January 2025 prior to the launch of People Love Day in February. This provided us with helpful detailed feedback that led to some minor adjustments. It remained a 90-minute offering aimed at leaders and their teams. This cohort was used to establish the look and feel of the process. The delivery plan can be seen in **Figure 2**.

Figure 2: People Love and Boost Your Team – Delivery Plan, Health Partners/JLR

PL and BYT- Delivery Plan

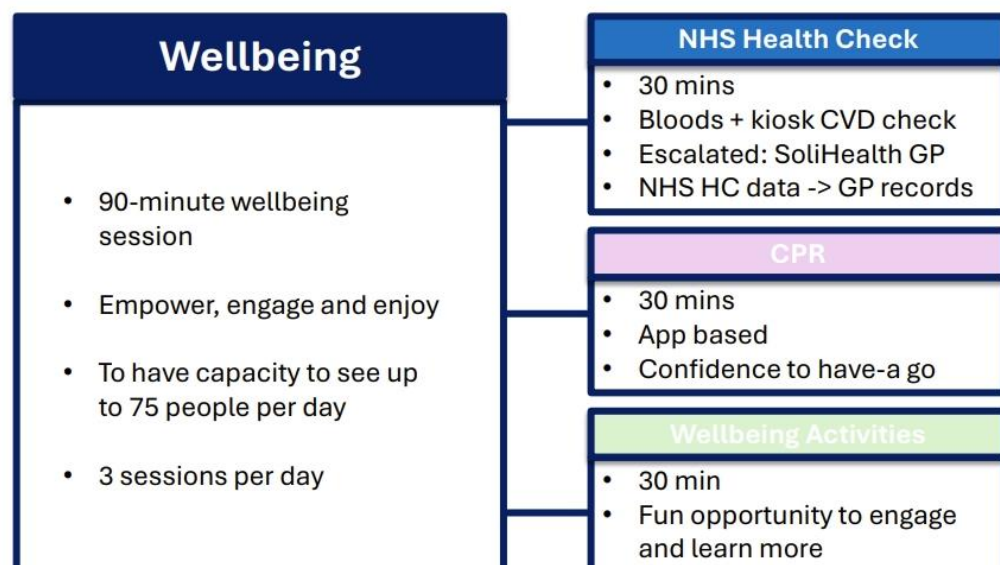


Figure 3: Escalation process for elevated measures to GP appointment



The model: process from start to finish:

Prior to attendance

- Employees were informed about the need to register with a GP, know their NHS number, and create a SiSU account using the app on their telephones
- Appointment scheduling was made available for staff and so that bookings for slots could be made in advance.

People Love Day

- JLR provided a coach from the Lode Lane site that transported employees to the Castle Bromwich visitor site for their experience day.
- Employees involved in BYT and PL days were part of the 90-minute wellbeing sessions, with the intention to see up to 75 employees per day, held over 3 sessions a day.
- Initial Health check undertaken (cholesterol, HbA1c using POCT)
- Move to SiSU health kiosk to measure other health parameters (blood pressure, BMI, lifestyle questions and QRisk3 calculated)
- Risk assessment, Wellbeing physiologist engagement and GP consultations booked (as required). GP consultations included both face-to-face and telephone follow-up sessions
- Engage in wellbeing activities, lifestyle support available
- CPR training available
- Data sharing and follow-up actions
- Employees transported back to Lode Lane site

Findings

JLR began offering NHS health checks on the 9th of January 2025 and operated until the 27th of March 2025 delivering 1,275 health checks. The numbers receiving a health check was less than the 4000 originally planned. This was because operational issues prevented JLR from closing their production which delayed the start of the CVD Health Check programme and reduced the number of production line staff being offered the opportunity to receive a health check though the People Love Day (PL).

To increase participation numbers, JLR offered health checks to their office staff through the Boost Your Team (BYT) initiative, while they rescheduled the release of production line staff.

Attendees (n = 648) at BYT sessions were office-based staff, while attendees at PL sessions (n = 627) were production line staff. There was an approximate 50:50 split between the two groups.

Demographic Data

Of those that attended a JLR health check, the majority were male (n = 979), with just 290 female employees receiving a health check (**Table 1**). Although only 290 females received a health check, this represents approximately 46.2% of the entire female workforce at JLR. It is possible that offering health checks to office workers meant much of the female workforce had the opportunity to attend a health check with the more male dominated production line staff having limited access to the health check. We do not have data on the number of female production line staff employed by JLR however we do know that 231 of the 290 that attended a health check were part of the BYT initiative (office staff). Just 35 of the females that attended a health check gave their occupation as either technical and craft, routine manual and service, semi-routine manual and service or traditional professional occupation. The 979 male employees that attended a health check represents just 10.8% of the total male workforce.

Table 1: Total number and % of JLR workforce, with proportion who have received a CVD health check by gender and age, SiSU health, JLR

Age/Gender	Eligible JLR Workforce		Received Health Check	Workforce Tested	
	Total number	Total Percentage (%)		% of total received a health check	% of eligible population tested
Female <40	232	2.4%	144	11.3%	62.1%
Female 40-59	305	3.1%	140	11.0%	45.9%
Female 60+	91	0.9%	6	0.5%	6.6%
Female Total	628	6.5%	290	22.7%	46.2%
Male <40	3,355	34.6%	459	36.0%	13.7%
Male 40-59	4,401	45.4%	456	35.8%	10.4%
Male 60+	1,316	13.6%	64	5.0%	4.9%
Male Total	9,072	93.5%	979	76.8%	10.8%
Unknown	N/A	N/A	6	0.5%	N/A
Total	9,700		1,275		13.1%

At JLR approximately 61-79% of the workforce describe themselves as white, this is slightly lower than the proportion in the Solihull population (82.2% white, Census 2021), indicating that JLR has a slightly higher representation of ethnic minorities (

Table 2), reflecting the fact that staff come from across the wider region which has a higher ethnic minority population than Solihull.

Table 2: Total number and proportion (%) of JLR workforce, who received a CVD health check by ethnicity, SiSU Health, JLR.

Ethnicity	Eligible JLR Workforce		Workforce Tested		
	Total number	Total Percentage (%)	Received Health Check	% of total received a health check	% of eligible population tested
Asian/Asian British	999	10.3% (13.2%)	202	15.8%	20.2%
Black/black British	301	3.1% (4.0%)	76	6.0%	25.2%
Mixed or multiple ethnic	262	2.7% (3.5%)	39	3.1%	14.9%
Other	29	0.3% (0.4%)	15	1.2%	51.7%
White	5,975	61.6% (79.0%)	943	74.0%	15.8%
Unknown	2,134	22.0% (N/A)	0	0%	N/A
Total	9,700		1,275		

Of those that attended a health check, 74% described themselves as being white. Although the majority attending a health check were white, this represented just 15.8% of the eligible white population. Over half of those tested described their ethnicity as other, this represented over half (51.7%) of the eligible workforce in this ethnic group. A fifth (20.2%) of the Asian/Asian British JLR workforce attended a health check and a quarter of the Black/Black British JLR workforce accepted the offer of a health check. Of those that attended a health check at JLR, those from an Asian/Asian British, black/black British and other ethnic background were over-represented compared to the wider Solihull population.

Uptake of NHS health checks can be low amongst some ethnic minority populations. Mixed or multiple ethnic background and ethnic minority populations living in the most deprived areas are among those with the lowest uptake. Novel avenues to target these groups is of key interest, and these findings suggest that CVD workplace models might be a way of buttressing uptake.

CVD Health Checks Data

QRisk3 cardiovascular risk score

The QRisk3 cardiovascular disease risk score calculates a person's risk of developing a heart attack or stroke over the next 10 years. A QRisk3 score higher than 10% suggests at least a 1 in 10 chance (moderate risk) of having a stroke or heart attack in the next 10 years.

Of the 1,275 JLR staff that attended a health check, 139 (10.9%) had a QRisk3 score $\geq 10\%$. The prevalence of a moderate risk of cardiovascular disease varied significantly with age and gender (Table 3).

Table 3: Percentage of men and women with a QRisk score $\geq 10\%$ by age, SiSU Health

Age Group	Male	Female
<40	0.2%	0.7%
40-59	19.1%	5.0%
60+	62.5%	33.3%
Total	13.1%	3.4%

There were no statistical differences in the prevalence of cardiovascular risk by ethnic group. The highest prevalence was observed in those from an Asian/Asian British background and those from a white background, but as the numbers tested were small, no statistical inferences can be made (Table 4).

Table 4: Prevalence of moderate Cardiovascular disease risk by ethnicity, *low number suppression, SiSU Health2

Ethnic Group	Prevalence of moderate CVD risk % (Number)
Asian/Asian British	11.9% (24)
Black/black British	7.9% (*)
Mixed/Multiple ethnic groups	2.6% (*)
Other ethnic groups	6.7% (*)
White/White British	11.3% (107)

Blood Pressure > 140/90

A clinic blood pressure reading greater than 140 over 90 (140/90mmHg) is suggestive of high blood pressure. A blood pressure above this level is considered high and increases a person's risk of developing serious problems such as heart attacks and strokes if it is not treated. A total of 232 employees receiving a health check registered a high blood pressure, approximately 18.2% of those tested. Prevalence increased significantly in the older age groups with approximately half of those aged 60+ having high blood pressure readings, the prevalence for males and females in this age group were similar.

Table 5: Prevalence of high blood pressure by age, SiSU Health

Age Group	Male, % (Number)	Female, % (Number)
<40	8.9% (41)	6.9%
40-59	29.2% (133)	11.4%
60+	45.3% (29)	50.0%
Total	20.7% (203)	10.0% (29)

Due to the small numbers involved, again no statistical inferences could be made when stratifying by ethnic group. Those from a black/black British background had the highest prevalence of hypertension with 1 in every 4 employees tested (**Table 6**, not statistically significant)).

Table 6: Prevalence of high blood pressure by ethnicity, , SiSU Health. *low number suppression.

Ethnic Group	Prevalence of Hypertension, % (Number)
Asian/Asian British	13.9% (28)
Black/black British	25.0% (19)
Mixed/Multiple ethnic groups	17.9% (*)
Other ethnic groups	13.3% (*)
White/White British	18.7% (176)

Smoking

Smoking prevalence in those that received a health check at JLR is similar to the estimated smoking prevalence in the Solihull population. Current estimates suggest that 8.7 - 12.8% of the Solihull population smoke. At JLR the smoking prevalence in those receiving a health check was 11.4%. Men had a higher prevalence than women, particularly in those aged under 40 and 60+ (**Table 7**).

Table 7: Prevalence of smoking by age, SiSU Health

Age Group	Male, % (Number)	Female, % (Number)
<40	13.9% (64)	4.9% (7)
40-59	11.6% (53)	10.0% (14)

60+	10.9% (7)	0.0% (0)
Total	12.7% (124)	7.2% (21)

Those from the white ethnic group had the lowest smoking prevalence with 9.2% smoking, all other ethnic groups had a smoking prevalence higher than the estimated prevalence in Solihull and JLR. The highest prevalence was observed in those from the other ethnic group and mixed and multiple ethnic background (**Table 8**).

Table 8: Prevalence of smoking by ethnicity, SiSU Health, *low number suppression

Ethnic Group	Prevalence of smoking % (Number)
Asian/Asian British	16.8% (34)
Black/black British	14.5% (11)
Mixed/Multiple ethnic groups	23.1% (*)
Other ethnic groups	26.7% (*)
White/White British	9.2% (87)

Body Mass Index

Body mass index (BMI) is a measure of whether you are a healthy weight for your height. For most adults aged 18 and over, a healthy BMI falls between 18.5 and 24.9. A BMI below 18.5 is considered underweight, a BMI between 25 and 29.9 (BMI 23 to 27.4 for Asian, Chinese, Middle Eastern, Black African or African-Caribbean family background) falls into the unhealthy overweight category and a BMI of 30 or more means you are obese.

Of the 1,275 employees that received a health check, 3 in 4 employees had a BMI of greater than 25. The prevalence was slightly higher in males, particularly in the younger age groups (Table 9).

Table 9: Body mass index by age and gender, SiSU Health

Age Group	Male % (Number)	Female % (Number)
<40	70.6% (324)	54.2% (78)
40-59	85.7% (391)	66.4% (93)
60+	87.5% (56)	100% (6)
Total	78.8% (771)	61.0% (177)

By ethnicity the prevalence of overweight was highest in the other, mixed and multiple ethnic groups with Asian/Asian British employees having the lowest prevalence of >25 BMI (data not statistically significantly different) (Table 10).

Table 10: Prevalence of high BMI (Overweight) by ethnicity, SiSU Health

Ethnic Group	Prevalence of overweight (BMI>25) % (Number)
Asian/Asian British	66.3% (134)
Black/black British	80.3% (61)
Mixed/Multiple ethnic groups	69.2% (27)
Other ethnic groups	80.0% (12)
White/White British	76.2% (719)

It is estimated that 64.2% of the Solihull adult population are overweight, this is lower than the prevalence observed at JLR.

Alcohol Consumption

The Alcohol Use Disorders Identification Test (AUDIT-C) is an alcohol screen that can help identify employees who are hazardous drinkers or who may have an active alcohol use disorder. Generally, the higher the AUDIT-C score, the more likely it is that the patients drinking is affecting their health and safety (Department of Health and Social Care, 2025).

A total of 1,261 JLR employees answered the AUDIT-C questionnaire of which, 10.4% (130 employees) had a high or very high risk score. A total of 8 employees were classified as very high risk (score of 11-12) which could indicate possible dependence. All those with a very high risk were Male, just 3.2% of the female employees had a high risk (including very high) of alcohol use compared with 12.9% of Male employees.

Physical Activity

The general practice physical activity questionnaire (GPPAQ) is a validated screening tool, used in primary care to assess the physical activity levels of adults (16 to 74 years) (National Health Service, 2025).

Table 11: Physical Activity Definitions, General Practice Physical Activity Questionnaire

GPPAQ Result	Definition
Inactive	Sedentary job and no physical exercise or cycling
Moderately inactive	Sedentary job and some but < 1 hour physical exercise and/or cycling per week or standing job and no physical exercise or cycling
Moderately active	Sedentary job and 1-2.9 hours physical exercise and/or cycling per week or standing job and some but < 1 hour physical exercise and/or cycling per week or physical job and no physical exercise or cycling
Active	Sedentary job and ≥3 hours physical exercise and/or cycling per week or standing job and 1-2.9 hours physical exercise and/or cycling per week or physical job and some but < hour physical exercise and/or cycling per week or heavy manual job.

Almost all the employees receiving a health check answered the GPPAQ (1,271), of which 6.6% (84) were physically inactive. One in ten female employees (10.3%, 31) were found to be physically inactive, double that of men where 1 in every 20 male employees (5.4%, 53) were

inactive. Two-thirds of employees were physically active (68.5%, 871) this is similar to the overall Solihull population where 67.5% of adults are estimated to be physically active (Department of Health & Social Care, 2025).

Referrals to Primary Care

Following the health check a total of 437 (34.3%) employees required a referral to a GP for follow-up tests, advice and/or treatment for health issues identified during the health assessment (Table 12).

Table 12: Referrals to primary care by age and gender, SiSU Health

Age Group	Male	Female
<40	22.7%	16.7%
40-59	46.9%	29.3%
60+	75.0%	66.7%
Total	37.4%	23.8%

Half of the Black/Black British JLR employees required a referral to a GP following their health check, this is the highest proportion amongst all ethnic groups (Table 13).

Table 13: Referrals to primary care by ethnicity, SiSU Health

Ethnic Group	Referrals to primary care (%)
Asian/Asian British	32.7%
Black/black British	53.9%
Mixed/Multiple ethnic groups	28.2%
Other ethnic groups	26.7%
White/White British	33.4%

Employees were given the opportunity to see a GP at work through SoliHealth, appointments with a SoliHealth GP were bookable at the time of the health check. Alternatively, employees would need to contact their own GP or wait to hear from their GP practice following notification of their health check. In the first month of the JLR health check service just 24% of those that required an escalation to their GP chose to book with SoliHealth. As a result of the low uptake, the SoliHealth service was changed to an opt-out service, this helped increase

acceptance of the SoliHealth offer to 40% in the final 5 weeks. In total 34% of those requiring escalation to a GP booked with SoliHealth, it is unknown whether the remaining 66% went on to see a GP.

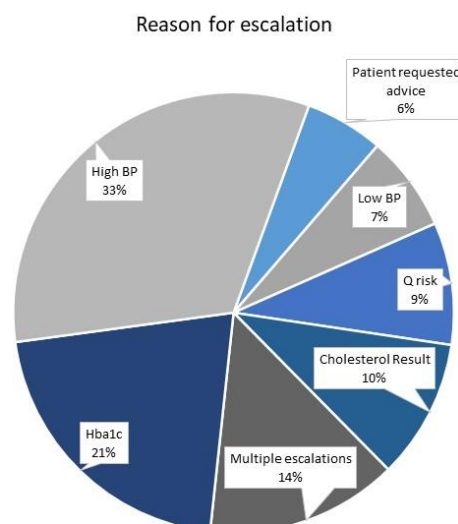
Eligibility for an NHS Health Check

Of the 1,275 employees receiving a health check, just 672 (52.7%) met the age criteria (40-74 years) for a full NHS health check. Many of these employees may also have pre-existing health conditions that would have rendered them ineligible. Only 57 employees receiving a health check could recall receiving an offer of an NHS Health check in the last 5 years but did not take up the offer, this equates to just 8.5% of the employees aged over 40.

GP Referral Case Findings

Following their health check a total of 437 JLR employees required a follow-up with a GP. The reason for the escalation to the GP was not recorded routinely (not part of the DHSC data requirements). SoliHealth were able to provide some data on the 156 of the employees requiring an escalation to their GP. A third of employees required escalation because of high blood pressure (33%, 51), one in 5 (21%, 33) had HbA1c blood sugar levels that required a consultation with a GP (Figure 4).

Figure 4: Reason for Escalation to SoliHealth, SoliHealth

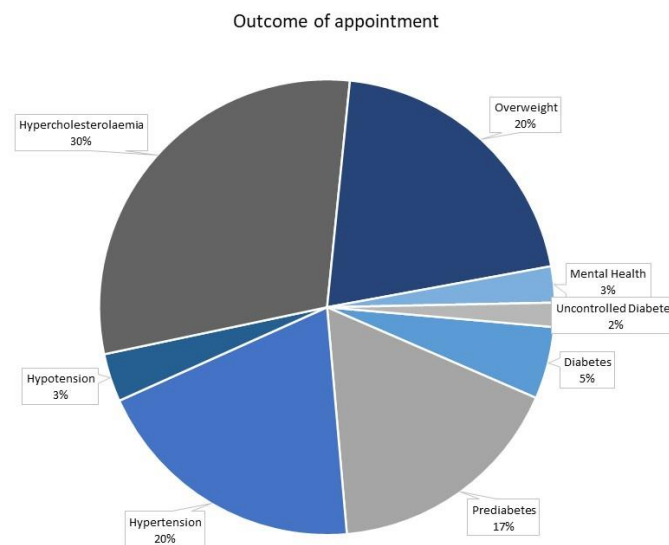


Some patients required further tests, 83 employees received further diagnostic tests from SoliHealth such as Bloods, electrocardiograms (ECGs) and blood pressure monitoring.

Following the Health check and SoliHealth GP consultation, 84 patients had at least 1 new health concern identified. Almost a third were found to have hypercholesterolaemia (30%), one in 5 were overweight (20%) and an equal number were found to have hypertension.

Seventeen percent were found to have non-diabetic hyperglycaemia ('pre-diabetes') (Figure 5).

Figure 5: Outcome of SoliHealth appointment, SoliHealth



Of those with newly identified health conditions, 15 employees required treatment. This included prescriptions for newly diagnosed diabetes, employees with uncontrolled diabetes, hypertension and employees requiring cholesterol-lowering treatment because of high cholesterol.

Onward referrals for specialist support were made for 13 individuals, these included appointments with the familial hypocholesterolaemia clinic, NHS diabetic prevention programme, weight management, hypertension clinic and the mental health charity MIND.

Discussion

The purpose of developing local objectives was to gain additional insight into the value of an enhanced health check. Local Objectives included:

Target working-age adults, especially men.

Over 10% of JLR's workforce were successfully recruited to the pilot and undertook a CVD health check (n = 1,275/9,700). The majority of whom were working-age males (n = 979, 94%), a historically difficult population to recruit to CVD health checks. We were therefore able to achieve this local objective. Manual workers from lower socioeconomic groups have a higher risk of CVD, it would therefore have been beneficial to have had more employees from the production line. However, logistical difficulties meant that a significant proportion of recruited employees were office staff.

Extend the local dataset to include: the AUDIT-C alcohol questionnaire and GPPAQ (General practice physical activity questionnaire) for each employee.

Increasing the granularity of local data points to include the externally-validated AUDIT-C and GPPAQ risk scores as part of the health check has proven valuable. A total of 1,261 JLR employees (98.9%) answered the AUDIT-C questionnaire of which, 10.4% (130 employees) had a high or very-high risk score. Almost all employees receiving a health check answered the GPPAQ (99.7%, n = 1,271), of which 6.6% (84) were physically inactive. One in ten female employees (10.3%, n = 31) were found to be physically inactive, double that of men where 1 in every 20 male employees (5.4%, n = 53) were inactive.

Extend blood testing to all employees, i.e. HbA1c (glycated haemoglobin) and total cholesterol profile measurements taken, regardless of eligibility for the NHS Health Check programme, using POCT.

The value of POCT is well evidenced in terms of efficiency and acceptability. In this model it facilitated real-time discussions with employees identified as high risk and in need of escalation to a GP. A total of 437 (34.3%) JLR employees required a follow-up with a GP. POCT therefore offers a comprehensive, streamlined avenue to diagnose and treat hard-to-reach communities in a single-visit to mitigate loss to follow-up and inequity in accessing healthcare.

Incorporate referrals into Solihull Lifestyle services as well as to the JLR in-house health support services. Understand uptake into these services.

The ability to monitor employees' follow-up referrals to lifestyle services following their health check is an area that requires further work. Only 3.1% of the 1275 employees (n = 40) were registered with a Solihull GP. It is not clear from the data if those registered outside of Solihull were referred to lifestyle services. This is not surprising given JLR is a large employer that recruits employees from across the region and nationally. However, having the ability to track the patient journey across secondary and tertiary services remains a challenge and is an important area of UK public health focus to ensure continuity of care.

Explore the feasibility of electronic data sharing with the employee's general practice (GP), if possible. If not, understand issues with sending letters to GP for high risk / NHS Health Check results.

An important limitation of third-party health checks is the lack of pathways to ensure electronic data sharing with patients' own GP surgeries. The onus is on the participant to self-refer to general practice with their results and then on the GP to progress any action.

A solution for data transfer was identified within the pilot. SiSU developed the technology and facilitated the transfer via Pharma Outcomes [the NHC results letter] from the Kiosk directly to the GP via email including PDS look up for accuracy. Solihull were involved with assessing and checking accuracy etc. There were initial logistical issues however, once resolved, provided greater assurance.

While the initial study protocol aimed to recruit 4000 employees, due to issues with plant closure days at JLR, over 25% of the planned study participants were recruited to the final study. Notwithstanding this, the completed pilot was by all accounts a large study (n = 1275), representing over 13.1 % of the JLR workforce (n = 9700). To this end, the findings are instructive and highlight areas for direct action to facilitate a sustainable workplace CVD model.

One of the main objectives of this workplace pilot was the early identification and intervention of those employees with increased risk of CVD and no previous (self-reported) diagnosis or treatment. Of the 1,275 JLR staff that attended a health check, 139 (10.9%) had a QRisk3 score $\geq 10\%$. As expected, the prevalence of a moderate risk of cardiovascular disease varied significantly with age and gender.

Extrapolating this finding (10.9 %) to the total workforce, we would expect to identify over 1000 employees with a QRisk3 score greater than 10%. An important caveat is the assumption that employees would be asymptomatic and currently not receiving any treatment. The effectiveness of this case-finding model is best demonstrated with the identification of 437

employees (34.3%) requiring onward referral to a GP for follow-up tests, advice and/or treatment for newly-identified health issues.

Additional findings

Age

Globally, age is the single biggest risk factor for cardiovascular and cerebrovascular disease. Employees with a QRisk3 score $\geq 10\%$ below the age of 40 would by definition be statistical outliers. Despite this, in this pilot, $\sim 1\%$ of employees in the under 40 age group ($n = 603$, 47.2%) had a QRisk3 score $\geq 10\%$. For these employees, there is a real value in performing CVD checks early. For these patients, lifetime risk is more important than 10-year risk alone. Given how costly the impact of cardiovascular and cerebrovascular disease is on NHS and social care, it is important to identify these patients early. Previous efforts have supported this finding that CVD checks should be offered at 30 years of age to identify risk and intervene much earlier in a person's life.

Gender

Interestingly, female JLR employees had a higher prevalence of moderate cardiovascular risk under the age of 40 compared to their male colleagues. Historically, women are far more likely to be misdiagnosed with non-cardiac chest pain or have delays in their treatment. This finding is therefore welcomed in potentially identifying those patients most likely to have CVD. In all other age groups, males had a higher prevalence of moderate CVD risk. Men are less likely to respond to the invitation to attend for their health check at their GP and workplace CVD checks may be an effective solution to counter this.

Ethnicity

Uptake of NHS health checks can be low amongst some ethnic minority populations, particularly those from a mixed or multiple ethnic background and ethnic minority populations living in the most deprived areas. Identifying better ways of targeting these groups is of key interest. Half of the Black/Black British JLR employees required a referral to a GP following their health check, this is the highest proportion amongst all ethnic groups. This finding suggests that workplace models could enable increased uptake in these groups.

Undiagnosed hypertension.

A total of 232 (18.2%) employees receiving a health check registered a high blood pressure. Prevalence increased significantly in the older age groups with approximately half of those aged 60+ having high blood pressure readings. Identifying undiagnosed hypertension is a high priority for the NHS and partners across Birmingham as a leading contributor to premature mortality.

Healthy Weight

It is estimated that 64.2% of the Solihull adult population are overweight. One of the most concerning findings was that 75% of workers who participated had a BMI over 25. The prevalence was slightly higher in men, particularly in the younger age groups. This is higher than the estimated prevalence in Solihull.

Smoking

At JLR the smoking prevalence in those receiving a health check was 11.4%. Men had a higher prevalence than women, particularly in those aged under 40 and 60+. This is similar to estimates of prevalence in the wider Solihull population (8.7-12.8%).

Alcohol

The vast majority of JLR participants (n = 1261) answered the AUDIT-C questionnaire of which, 10.4% (130 employees) had a high or very high-risk of having an active alcohol use disorder. A total of 8 employees were classified as very high risk (score of 11-12) which could indicate possible dependence. All those with a very high risk were Male. Only 3.2% of female employees had a high risk (including very high) of alcohol use compared with 12.9% of male employees.

Physical Activity

Almost all employees receiving a health check answered the GPPAQ (1,271). A compelling finding was that one in ten female employees (10.3%, 31) were physically inactive, double that of men where 1 in every 20 male employees (5.4%, 53) were inactive.

GP referrals

Following the health check a total of 437 (34.3%) employees required a referral to a GP for follow-up tests, advice and/or treatment for health issues identified during the health

assessment. Point of care testing contributes to real time risk assessment and negates the need for additional consultations.

Although data completeness was not optimal for the whole of the pilot on this issue, it provided important insights. The common issues identified were: high cholesterol, raised blood glucose, high blood pressure and being overweight (BMI > 25). This led to initiation of treatment and/or referral to specialist services for further investigation and management (for example, familial hypocholesterolaemia clinic).

In summary the findings suggest that this model is acceptable to the workforce with excellent participation. The inclusion of CVD health checks as part of a wider fun and welfare event badged as Boost Your Team and People Love Day where employees were given time to attend with transport proved popular, and a key learning point.

The initial findings also suggest that some subsets of employees might benefit from bespoke support and targeted interventions. For example, women and ethnic groups.

In this pilot, women were found to have a slightly higher prevalence of moderate cardiovascular risk under the age of 40 compared to their male colleagues and one in ten female employees (10.3%, 31) were found to be physically inactive, double that of men.

Half of the Black/Black British JLR employees required a referral to a GP following their health check, this is the highest proportion amongst all ethnic groups.

The model of support for those employees who face challenges regarding achieving healthy weight, moderate alcohol consumption, support to quit smoking needs etc could be strengthened through the development of an integrated disciplinary team model.

Lessons Learned

The pilot ended on 31st March 2025. In support of the local evaluation, partners came together to attend a face-to-face workshop on the 24th April 2025.

The purpose of the workshop was to facilitate cross-functional team discussion and facilitate key take home learning. The below section briefly summarises the key themes from the workshop:

Partnership Working

- The existing positive working relationship between the Chief Medical Officer of JLR and Director of Public Health at Solihull Council meant that approval and turnaround for submission of the bid for the pilot was rapid and timely.
- Having a dedicated project officer was essential to the smooth running of the pilot. The use of project management processes and tools meant there was rigour to the

work, providing assurance to all partners. All members of the TFG were the single point of contact for their organisation which ensured swift responses and timely action.

- All members of the TFG were committed to facilitating the delivery of the pilot. There was a strong 'can do' attitude, for e.g., the collaborative working between the ICB and SiSU that helped resolve data transfer issues between SiSU and primary care.
- Having the structure of the weekly meeting was valued by partners and seen as critical to the success of the pilot. It was well attended and maintained the focus around the effective delivery of the pilot.
- A Microsoft Teams SharePoint was created for internal and external partners so that a central repository of key documents and the action log could be accessed easily.

Operational

- The employees were kept at the heart of this project. The BYT and PL days demonstrated JLRs ongoing commitment to employee wellbeing.
- There was consensus among partners that we were constructing a unique model of delivery. A key component was having the CVD health check hybridised as part of a fully dedicated experience day (BYT/PL) set aside for employees with an opportunity to engage in a variety of other activities e.g. simulator experiences and provision of a healthy lunch.
- Overall satisfaction from employees remained consistently the highest out of all 3 areas of overall JLR project (high Net Promoter Score¹ (NPS)).
- External quality control of the point of care testing equipment provided assurance to the SoliHealth team of the reliability of the results.
- The model fully integrated prevention, risk assessment to treatment on-site.
- There strong collaboration between partners enabled the successful implementation of the pilot within a narrow three-month timescale. The project management structure put in place meant that progress was regularly reviewed, problems addressed, and solutions implemented at pace.

Workforce

- The timely recruitment in advance of the 'go live' date ensured ample time for training, evaluation and assessment of the team.
- Early access to the pilot site facilitated effective planning of the layout, flow and floor plans of each room effectively, especially the clinical spaces.

¹ Net Promoter Score (NPS) is a widely used market research metric that measures customer loyalty. It is based on a single survey question asking respondents how likely they are to recommend a company, product, or service to others.

- Prompt delivery of the health kiosks ensured staff had time to practise and familiarise themselves with the equipment.
- The GP appointment booking process was simple and easy with the laptop provided on site.
- Feedback collected during the pilot (April CVD Workplace Evaluation Feedback, 2024) highlighted employees appreciated the convenience of on-site delivery, the professionalism of staff, and the multi-zonal layout. However, there were calls for improved pre-appointment communication—specifically regarding SiSU registration and escalation pathways.

Challenges

- Delays and uncertainty due to the election of the new government, meant a reduced window of time for implementation and delivery.
- Operation issues with releasing production line staff to attend the health checks meant the planned 4000 health checks could not be reached, however 1275 health checks were performed effectively.
- There was some initial confusion regarding the use of the escalation protocols for those employees identified at risk. This was swiftly resolved.
- Processes for booking employees with HCA instead of GP wasn't followed/known until the last few weeks of pilot – this could potentially serve to reduce GP pressures and streamline patient care.

Data Sharing

The makeup of the Task and Finish Group consisted of people with the right knowledge, skills, and experience with access to an extensive network of expertise to draw on. This included IT and technical skills that enabled alternative solutions to be explored, for example, when transferring an employees' information back to their GP following NHS Health Checks. The aim was to originally send this information by letter, however, during the initial conversations the group felt it would be 'safer' to have a digital solution to communicate effectively with primary care partners.

SiSU played a critical role as they developed the technology and facilitated the transfer via Pharma Outcomes [the NHC results letter] from the Kiosk directly to the GP via email including PDS (Personal Demographics Service) look up for accuracy.

By having SoliHealth working on the pilot, we were able to successfully share data with all the local practices (data sharing agreements already in place). For those employees outside of the area, a discharge letter was emailed to the employees registered GP practice.

SoliHealth Ltd. added quality assurance and credibility which likely lead to better follow up and action from the employees GP.

Fulfilling the extensive national data reporting requirements imposed a significant administrative burden for the staff.

Communications

Internal and external communication has been an important element of this work. Not least internally to the employees in raising awareness of the pilot project.

Across partners too it was acknowledged that a consistent narrative be used when using communications to the employees and stakeholders as well as to the public. It was important to demonstrate that this was a partnership approach.

A small communications team was established with a communications lead from each partner. They were responsible for providing the consistent narrative and promoting the pilot as a cross sectoral partnership. For instance, any internal or external communications were badged with the partners logo.

Delays in upfront communication to JLR employees regarding the health check, what they entailed and how their data would be used, led to confusion for some employees. In one instance it led to a GDPR complaint regarding whether an employee had knowingly consented for their details to be shared. This was swiftly investigated and amendments made to highlight the issue of consent to employees who participated in the pilot.

Once the bid was approved, JLR received ministerial visits to their Solihull site increasing awareness of the workplace CVD health check pilot for their employees but nationally too through multimedia coverage of the work. This raised the profile of the work and of all partners involved, as well as expectations. See Appendix 8 for the links to media coverage.

Procurement / Contracting

Partners acknowledged that the procurement 'language' is very different across all organisations. The different processes for procurement also provided some complexity, however timely deadlines ensured issues were resolved speedily and contracts agreed in a timely fashion.

The national team were clear that the CVD checks pilot would end by 31/3/25 so when they announced that this would be extended to the end of May 2025, JLR were not able to continue as contracts were due to end in March. Earlier notification of this decision may have helped retain those staff recruited for the initial period and supported employee recruitment efforts.

Costs

The total funding allocation for the pilot was £160,000, which supported the delivery of approximately 4,000 health checks at an estimated unit cost of £40 per check. This included £33 for delivery by JLR/Health Partners and £7 for LA support services (Workplace CVD Application, 2024).

In addition to this, JLR also devoted a significant amount of time, effort and resources in making this model viable.

Below is a summary of the key considerations for supporting the development of a sustainable model for workplace CVD health checks

Considerations

Data

1. Improve data integration systems to streamline GP referrals and reduce manual follow-ups.
2. Investment in user-friendly data collection tools to reduce local authority reporting burden.
3. GDPR and Data Governance Templates: need to simplify management of data privacy. JLR used single SiSU platform to de-risk but that may not be available for all organisations.
4. NHS Data Sharing Framework: it should be much simpler for this transfer. Additional costs were incurred by JLR to transfer data back to GP records (SiSU and SoliHealth Ltd). Ideally it would be a secure clinical platform allowing for bidirectional data exchange.
5. Post Programme Outcome Tracking: Our ability to track the employee journey beyond healthcare (SoliHealth) was very limited. It would be helpful to track across primary care and into lifestyle service usage.

Procurement

6. In a sustainable model a Single Procurement Framework would be of benefit. It can be difficult for procurement teams to onboard new suppliers that are not within their normal scope.
7. People and Consumable Discounts: businesses would need more favourable costs to allow scaling up of CVD checks at work. E.g. point of care testing consumables

General

8. Explore how this workplace delivery model can be extended to include other major employers and supply chain SMEs to increase reach.
9. Use insights from the pilot to influence regional strategies such as WorkWell and inform DHSC evaluations on future workplace health models.
10. Pilot Evaluation and Cost Benefit Support: tools and resources to support in-depth evaluation from the data not just quantitatively but also qualitatively.

Conclusion

This local evaluation of the JLR workplace CVD pilot has demonstrated the feasibility and value of delivering comprehensive health checks in the workplace setting. Of the 1,275 employees recruited, 10.9% were found to have a QRisk3 score $\geq 10\%$, and 34.3% required onward referral to their GP. These findings highlight both the extent of undiagnosed cardiovascular risk within the workforce and the effectiveness of the workplace model in reaching individuals who may otherwise have had limited engagement with the NHS Health Check programme.

The pilot incorporated several features that added significant value. Point-of-care testing facilitated real-time clinical decision-making and supported immediate escalation of high-risk cases. The inclusion of validated tools such as the AUDIT-C and GPPAQ provided robust data on lifestyle risk factors, identifying alcohol excess and physical inactivity. Access to on-site GPs further strengthened the model, providing assurance to both employees and their primary care teams and reduced the likelihood of loss to follow-up.

Nevertheless, the evaluation also highlights important limitations. Participation from production line employees was lower than anticipated, despite this group being at higher risk of CVD. Future programmes must prioritise access for these staff to tackle health inequality. Data sharing with general practice, while achieved in this pilot, required considerable resource and bespoke workarounds. Tracking of referrals into lifestyle services was limited, constraining the ability to measure longer-term outcomes.

A further omission was the absence of validated measures of mental health. Psychosocial stress—including financial and occupational stress—represents a recognised risk factor for cardiovascular disease, as evidenced by the INTERHEART study. Considering the cost-of-living crisis and ongoing workplace pressures, the integration of validated mental health instruments such as GAD-7 and PHQ-9 is strongly recommended for future iterations. Their inclusion would allow a more comprehensive and holistic assessment of risk, aligning the pilot more closely with current evidence and best practice in prevention.

In conclusion, this pilot provides important evidence that workplace health checks can deliver early identification of cardiovascular risk, engage populations with historically low uptake of public health services, and support national ambitions to improve health, productivity and workforce participation. With refinements such as improved equity of access, stronger data integration, clearer referral pathways, and the inclusion of validated mental health assessment tools—this approach could form the basis of a sustainable workplace prevention model for working-age adults.

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Appendices

Appendix 1: 05/09/2024 - DHSC Workplace Cardiovascular Health Checks Pilot: Quantitative Data for Evaluation



Department
of Health &
Social Care

Workplace Cardiovascular Disease Health Checks Pilot: Quantitative Data for Evaluation

This document sets out the data that will need to be collected at a local authority level as part of the evaluation of the Workplace Cardiovascular Disease Health Checks Pilot. This data falls into three categories:

1. **Workplace data** - this is the data that will need to be collected only once for each of the workplaces where checks are delivered as part of the pilot. The data focuses on the characteristics of the workplace and workforce. Local authorities should assign a unique reference number/identifier to each workplace to enable CVD checks to be linked to the workplaces where they were delivered at an aggregated level.
2. **CVD checks data** - this is the data that will need to be collected by providers for every individual receiving a check as part of this pilot. Data collected at individual employee level will not be shared with DHSC/the evaluator; only aggregated data will be requested as set out below.
3. **Aggregated and anonymised CVD checks data** - this is the CVD checks data that will be submitted to DHSC by each local authority for evaluation. As noted, DHSC/the evaluator will not be requesting/handling personal identifiable data as part of the evaluation. Therefore, this data must be aggregated and anonymised before it is returned to DHSC.

1. Workplace Data

The following data needs to be collected by providers for each workplace where checks are delivered as part of this pilot:

Data value	Explanation
Industry type	List of industry types adapted from ONS/UK Standard Industrial Classification (SIC)¹ - Agriculture, forestry & fishing - Energy and water - Manufacturing - Construction - Distribution, hotels, and restaurants - Transport and communication - Banking and finance - Public admin, education, and health - Other services
Size of workforce	Value to be selected from: - Public sector <50 - Public sector >= 50 - Charity sector <50 - Charity sector >=50 - Micro private enterprise <10 - Small private enterprise 10-50 - Medium private enterprise <250 - Large private enterprise >250
Number of male employees	Number
Number of female employees	Number
Number of employees from each ethnic group	Value to be selected from: - White British - White Irish - Other White - Mixed or Multiple ethnic groups - Indian - Pakistani - Bangladeshi - Chinese - Any other Asian Background - Black African - Black Caribbean - Black British - Arab

¹ ONS. UK Standard Industrial Classification (SIC) Hierarchy - https://onsdigital.github.io/dp-classification-tools/standard-industrial-classification/ONS_SIC_hierarchy_view.html

	Other ethnic group
Breakdown of workforce by profession (can select more than one)	Values to be selected from the following list (adapted from the National Statistics Socio-economic Classification (NS-SEC²)): - Modern professional - Clerical & Intermediate - Technical and craft occupations - Semi-routine manual and service - Routine manual and service - Middle or junior managers - Traditional professional occupations
Estimated number of employees eligible for a CVD check within this workplace	This will vary per workplace and will be influenced by: - Size of the workplace - Demographics of the workforce - Eligibility criteria for the NHS Health Check or alternative CVD assessment being delivered.
Workplace unique reference	Local authorities are asked to assign a unique reference number/identifier to each of the workplaces in which they are delivering checks. This can be any series of numbers / letters. It will allow linkage between the workplace data and the CVD checks data for evaluation.

2. CVD Checks Data

This is the data that will need to be collected by providers for every individual receiving a check as part of this pilot.

Data value	Explanation
Type of check delivered	Either 'NHS Health Check' or 'alternative CVD assessment'.
Method of delivery	Face-to-face check or kiosk delivery
Workplace unique reference number/identifier	As above, local authorities are asked to assign a unique reference number/identifier to each of the workplaces in which they are delivering checks. This can be any series of numbers / letters. It will allow

² [National Statistics Socio-economic Classification \(NS-SEC\) variable: Census 2021 - Office for National Statistics \(ons.gov.uk\)](https://ons.gov.uk)

	linkage between the workplace data and the CVD checks data for evaluation.
Month and year that assessment was delivered	Month / year
Sex	M/F/prefer not to say
Is the gender you identify with the same as your sex registered at birth?	Y/N/prefer not to say
Age	(In years)
Ethnicity	Value to be selected from: - White British - White Irish - Other White - Mixed or Multiple ethnic groups - Indian - Pakistani - Bangladeshi - Chinese - Any other Asian Background - Black African - Black Caribbean - Black British - Arab - Other ethnic group
Profession	Values to be selected from the following list (adapted from the National Statistics Socio-economic Classification (NS-SEC ³)): - Modern professional - Clerical & Intermediate - Technical and craft occupations - Semi-routine manual and service - Routine manual and service - Middle or junior managers - Traditional professional occupations

³ [National Statistics Socio-economic Classification \(NS-SEC\) variable: Census 2021 - Office for National Statistics \(ons.gov.uk\)](https://ons.gov.uk/methods/classifications-and-statistical_codes/national_statistics_socio-economic_classification/ns-sec)

• GP registration status	Whether or not the individual is registered with a GP.
• Whether the individual can recall receiving an offer of an NHS Health check in the last five years?	Yes/No
• If the individual <u>can</u> recall receiving an offer of an NHS Health Check in the last five years, did they complete the check?	Yes / No
• Q Risk Score of $\geq 10\%$	Yes / No
• Blood pressure $\geq 140/90$	Yes / No
• Smoker	Yes / No
• BMI ≥ 25	Yes / No
• Was the individual referred to their GP for any reason following a check delivered as part of this programme?	Yes / No
• Agreed consent to be contacted for further research.	Yes / No

The following section is **optional** for local authorities to complete if they so wish. This will provide further insight into whether a workplace health check may reach those people less likely to take up the NHS Health Check through the existing programme.

For those who <u>can</u> recall receiving an offer of an NHS Health check in the last five years but <u>did not complete</u> it, what was the main reason behind this?	Value to be selected from: ○ I did not think I was at risk of CVD. ○ I forgot. ○ I could not take time off work to complete the check. ○ I was not able to select a convenient time. ○ I was not able to select a convenient location. ○ I can't remember / don't know.
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3. Aggregated CVD Checks Data

This is the CVD checks data that will be submitted to DHSC by each local authority for evaluation. We will not be collecting or handling personal identifiable data as part of the evaluation. Therefore, this data must be aggregated and anonymised before it is returned to DHSC. We will likely be requesting the following data variables aggregated according to age, ethnicity, sex, occupational group, and GP registration status (whether or not they are registered with a GP).

- Total no. checks carried out.
- No. with QRISK $\geq 10\%$ (where recorded).
- No. with BP over 140/90.
- No. current smoker.
- No. overweight or obese.
- No. of referrals to GP following any check.
- No. of individuals who can recall receiving an offer of an NHSHC in the last 5 years.
- Of those who recall having received an offer of NHSHC, no. who completed a check.

Appendix 2: 15/10/2024 – DHSC Updated Workplace Cardiovascular Disease Health Checks Pilot: Quantitative Data for Evaluation



Department
of Health &
Social Care

Workplace Cardiovascular Disease Health Checks Pilot: Quantitative Data for Evaluation

This document sets out the data that will need to be collected at a local authority level as part of the evaluation of the Workplace Cardiovascular Disease Health Checks Pilot. This data falls into three categories:

1. **Workplace data** - this is the data that will need to be collected only once for each of the workplaces where checks are delivered as part of the pilot. The data focuses on the characteristics of the workplace and workforce. Local authorities should assign a unique reference number/identifier to each workplace to enable CVD checks to be linked to the workplaces where they were delivered at an aggregated level.
2. **CVD checks data** - this is the data that will need to be collected by providers for every individual receiving a check as part of this pilot. Data collected at individual employee level will not be shared with DHSC/the evaluator; only aggregated data will be requested as set out below.
3. **Aggregated and anonymised CVD checks data** - this is the CVD checks data that will be submitted to DHSC by each local authority for evaluation. As noted, DHSC/the evaluator will not be requesting/handling personal identifiable data as part of the evaluation. Therefore, this data must be aggregated and anonymised before it is returned to DHSC.

1. Workplace Data

The following data needs to be collected by providers for each workplace where checks are delivered as part of this pilot:

Data value	Explanation
Industry type	List of industry types adapted from ONS/UK Standard Industrial Classification (SIC)¹ Agriculture, forestry & fishing Energy and water Manufacturing Construction Distribution, hotels, and restaurants Transport and communication Banking and finance Public admin, education, and health Other services - AGRICULTURE, FORESTRY AND FISHING - MINING AND QUARRYING - MANUFACTURING - ELECTRICITY, GAS, STEAM AND AIR CONDITIONING SUPPLY - WATER SUPPLY; SEWERAGE, WASTE MANAGEMENT AND REMEDIATION ACTIVITIES - CONSTRUCTION - WHOLESALE AND RETAIL TRADE; REPAIR OF MOTOR VEHICLES AND MOTORCYCLES - TRANSPORTATION AND STORAGE - ACCOMMODATION AND FOOD SERVICE ACTIVITIES - INFORMATION AND COMMUNICATION - FINANCIAL AND INSURANCE ACTIVITIES - REAL ESTATE ACTIVITIES - PROFESSIONAL, SCIENTIFIC AND TECHNICAL ACTIVITIES - ADMINISTRATIVE AND SUPPORT SERVICE ACTIVITIES - PUBLIC ADMINISTRATION AND DEFENCE; COMPULSORY SOCIAL SECURITY - EDUCATION - HUMAN HEALTH AND SOCIAL WORK ACTIVITIES - ARTS, ENTERTAINMENT AND RECREATION - OTHER SERVICE ACTIVITIES - ACTIVITIES OF HOUSEHOLDS AS EMPLOYERS; UNDIFFERENTIATED GOODS- AND SERVICES-PRODUCING ACTIVITIES OF HOUSEHOLDS FOR OWN USE - ACTIVITIES OF EXTRATERRITORIAL ORGANISATIONS AND BODIES

• Size of workforce	Value to be selected from: ○ Public sector <50 ○ Public sector >= 50 ○ Charity sector <50 ○ Charity sector >=50 ○ Micro private enterprise <10 ○ Small private enterprise 10-50 ○ Medium private enterprise <250 ○ Large private enterprise >250
• Number of male employees	Number
• Number of female employees	Number
• Number of employees from each ethnic group	Value to be selected from: ○ White British ○ White Irish ○ Other White ○ Mixed or Multiple ethnic groups ○ Indian ○ Pakistani ○ Bangladeshi ○ Chinese ○ Any other Asian Background ○ Black African ○ Black Caribbean ○ Black British ○ Arab ○ Other ethnic group

¹ ONS. UK Standard Industrial Classification (SIC) Hierarchy - https://onsdigital.github.io/dp-classification-tools/standard-industrial-classification/ONS_SIC_hierarchy_view.html

Breakdown of workforce by profession (can select more than one)	Values to be selected from the following list (adapted from the National Statistics Socio-economic Classification (NS-SEC²)): - Modern professional - Clerical & Intermediate - Senior managers or administrators - Technical and craft occupations - Semi-routine manual and service - Routine manual and service - Middle or junior managers - Traditional professional occupations
Estimated number of employees eligible for a CVD check within this workplace	This will vary per workplace and will be influenced by: - Size of the workplace - Demographics of the workforce - Eligibility criteria for the NHS Health Check or alternative CVD assessment being delivered.
Workplace unique reference	Local authorities are asked to assign a unique reference number/identifier to each of the workplaces in which they are delivering checks. This can be any series of numbers / letters. It will allow linkage between the workplace data and the CVD checks data for evaluation.

2. CVD Checks Data

This is the data that will need to be collected by providers for every individual receiving a check as part of this pilot.

Data value	Explanation
Type of check delivered	Either 'NHS Health Check' or 'alternative CVD assessment'.
Method of delivery	Face-to-face check or kiosk delivery
Workplace unique reference number/identifier	As above, local authorities are asked to assign a unique reference number/identifier to each of the workplaces in which they are delivering checks. This can be any series of numbers / letters. It will allow

² [National Statistics Socio-economic Classification \(NS-SEC\) variable: Census 2021 - Office for National Statistics \(ons.gov.uk\)](https://ons.gov.uk/methods/classifications-and-standards/national-statistics-socio-economic-classification/ns-sec)

	linkage between the workplace data and the CVD checks data for evaluation.
Month and year that assessment was delivered	Month / year
Sex	M/F/prefer not to say
Is the gender you identify with the same as your sex registered at birth?	Y/N/prefer not to say
Age	(In years)
Ethnicity	Value to be selected from: - White British - White Irish - Other White - Mixed or Multiple ethnic groups - Indian - Pakistani - Bangladeshi - Chinese - Any other Asian Background - Black African - Black Caribbean - Black British - Arab - Other ethnic group
Profession	Values to be selected from the following list (adapted from the National Statistics Socio-economic Classification (NS-SEC ³): - Modern professional - Clerical & Intermediate - Senior managers or administrators - Technical and craft occupations - Semi-routine manual and service - Routine manual and service - Middle or junior managers - Traditional professional occupations - None of the above

³ National Statistics Socio-economic Classification (NS-SEC) variable: Census 2021 - Office for National Statistics (ons.gov.uk)

• GP registration status	Whether or not the individual is registered with a GP.
• Whether the individual can recall receiving an offer of an NHS Health check in the last five years?	Yes/No
• If the individual <u>can</u> recall receiving an offer of an NHS Health Check in the last five years, did they complete the check?	Yes / No
• Q Risk Score of $\geq 10\%$ (where applicable)	Yes / No
• Blood pressure $\geq 140/90$	Yes / No
• Smoker	Yes / No
• BMI ≥ 25	Yes / No
• Was the individual referred to their GP for any reason following a check delivered as part of this programme?	Yes / No
• Agreed consent to be contacted for further research. (As per our email of 09/10/24, this question is no longer required as part of the evaluation of this programme and therefore should not be asked as part of these checks.)	Yes / No

The following section is **optional** for local authorities to complete if they so wish. This will provide further insight into whether a workplace health check may reach those people less likely to take up the NHS Health Check through the existing programme.

For those who <u>can</u> recall receiving an offer of an NHS Health check in the last five years but <u>did not complete</u> it, what was the main reason behind this?	Value to be selected from: ○ I did not think I was at risk of CVD. ○ I forgot. ○ I could not take time off work to complete the check. ○ I was not able to select a convenient time. ○ I was not able to select a convenient location. ○ I can't remember / don't know. ○ I had more immediate priorities other than my health. ○ I was concerned I would be judged. ○ I was afraid of what I could find out about my health risks, and I did not want to know. ○ I did not have the money/time/confidence to make health changes. ○ I did not think a health check would be effective.
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3. Aggregated CVD Checks Data

This is the CVD checks data that will be submitted to DHSC by each local authority for evaluation. We will not be collecting or handling personal identifiable data as part of the evaluation. Therefore, this data must be aggregated and anonymised before it is returned to DHSC. We will likely be requesting the following data variables aggregated according to age, ethnicity, sex, occupational group, and GP registration status (whether or not they are registered with a GP).

- Total no. checks carried out.
- No. with QRISK $\geq 10\%$ (where recorded).
- No. with BP over 140/90.
- No. current smoker.
- No. overweight or obese.
- No. of referrals to GP following any check.
- No. of individuals who can recall receiving an offer of an NHSHC in the last 5 years.
- Of those who recall having received an offer of NHSHC, no. who completed a check.

Appendix 3: 6/12/2024 – DHSC Workplace CVD Health Checks Pilot – Local Authority Data Aggregation Requirements for Programme Evaluation

Workplace CVD Health Checks Pilot – Local Authority Data Aggregation Requirements for Programme Evaluation

This document sets out how data needs to be aggregated and anonymised before it is returned for evaluation of the Workplace CVD Health Checks Pilot.

Contents

Section 1	Overview (Page 1)
Section 2	Minimum data aggregation requirements (Pages 2-4)
Section 3	Additional data aggregation request - to be completed wherever possible (Pages 5-12)

Section 1: Overview

As part of the evaluation of the programme, participating local authorities have been asked to collect a specific minimum data set. This includes data on both the workplaces in which checks were completed, and data as part of the checks themselves.

This data needs to be aggregated and anonymised before it can be returned to DHSC and our independent evaluator. This document sets out how this data needs to be aggregated and anonymised before it is returned for evaluation.

Please note that data tables are provided throughout this document for illustrative purposes. The precise visual format for the return of data will be confirmed once the digital platform for data returns has been finalised.

Section 2: Minimum data aggregation requirements

The following data needs to be returned at a local authority-level, for each workplace where checks were delivered:

- Workplace data - (anonymised using workplace unique reference)
- CVD health checks data - (aggregated and anonymised)

Workplace data

This workplace data table will only ever need completing once for each workplace where checks were delivered.

Please note that no numbers less than 5 should be entered for any of the fields requested below (including zero). This is important to maintain the anonymity of the data. If you have numbers less than 5 for any of the values below (including zero), please enter '0-4' instead of the value.

Mandatory table 1: Workplace data

Industry type	Options listed in data collection requirements document
Size of workforce	Options listed in data collection requirements document
Number of male employees	
Number of female employees	
Number of employees from each ethnic group	• Black ethnic groups • Asian ethnic groups • White ethnic groups • Mixed or multiple ethnic groups • Other ethnic groups
Breakdown of workforce by profession	Options listed in data collection requirements document
Estimated number of employees eligible for a CVD check within this workplace	
Workplace unique reference	

CVD health checks data

The CVD health checks data tables below (mandatory tables 2 & 3) need completing for each workplace where checks are delivered. Please note that mandatory tables 2 & 3 may need completing multiple times for each workplace in which checks are delivered:

- Where local authorities have offered both NHS Health Checks and alternative assessments of CVD in the same workplace, please complete mandatory tables 2 & 3 separately for each of these types of checks.
- Where local authorities have offered both face-to-face checks and kiosk checks in the same workplace, please complete mandatory tables 2 & 3 separately for each of these types of checks. Please note that digital / app-based checks should be included under 'kiosk' checks, as they are not face-to-face checks. (The data returns platform will include an option to specify the type of check completed under 'kiosk' check.)

Please note that no numbers less than 5 should be entered for any of the fields requested below (including zero). This is to maintain the anonymity of the data. If you have numbers less than 5 (including zero) for any of the values below, please enter '0-4' instead of the value.

Mandatory table 2: CVD health checks data

	Total	Female <40	Female 40-59	Female 60+	Male <40	Male 40-59	Male 60+	Sex 'prefer not to say' / sex unknown	Black ethnic groups	Asian ethnic groups	White ethnic groups	Mixed or multiple ethnic groups	Other ethnic groups	Ethnic group not known / not record ed
A: Total number of CVD health checks completed														
B: Number of individuals with QRISK $\geq 10\%$ (where calculated)														
C: Number of individuals with BP over 140/90														
D: Number of individuals who smoke														
E: Number of individuals with BMI >25														
F: No. of referrals to GP														
G: No who received a check who can recall receiving an offer of an NHS Health Check in the last 5 years but who <u>did</u> not take up the check														

Mandatory table 3: Number of CVD health checks delivered by profession

Profession	Male <40	Male 40-59	Male 60+	Female <40	Female 40-59	Female 60+	Sex 'prefer not to say' / sex unknown
Modern professional							
Clerical & Intermediate							
Senior managers or administrators							
Technical and craft occupations							
Semi-routine manual and service							
Routine manual and service							
Middle or junior managers							
Traditional professional occupations							
None of the above							
Not known / not recorded							

Section 3: Additional data aggregation request (to be completed wherever possible)

This section sets out the aggregated data that we request is returned for evaluation wherever possible. We recognise that some local areas will be able to provide this information, while for others this will not be possible. (There is also the option to complete a selection of the tables below, where only some of this information is available.)

Please note that no numbers less than 5 should be entered for any of the fields requested below (including zero). This is to maintain the anonymity of the data. If you have numbers less than 5 (including zero) for any of the values below, please enter '0-4' instead of the value.

Section A: Total number of checks

Table A1: Total number of checks by age, sex, and ethnic group:

Ethnic group	Male <25	Male 25-39	Male 40-59	Male 60+	Female <25	Female 25-39	Female 40-59	Female 60+	Sex 'prefer not to say' / sex unknown
Black ethnic groups									
Asian ethnic groups									
White ethnic groups									
Mixed or multiple ethnic groups									
Other ethnic groups									
Not known / not recorded									

Table A2: Total number of checks by GP registration status and NHS Health Check history

GP registration / previous NHS Health Check status	Male <25	Male 25-39	Male 40-59	Male 60+	Female <25	Female 25-39	Female 40-59	Female 60+	Sex 'prefer not to say' / sex unknown
Total no. of checks									
Total no. of checks delivered to those registered with a GP									
Total no. of checks delivered to those who recall receiving an offer of an NHS Health Check in last 5 years <u>but who did not complete the check.</u>									

Table A3: Total number of checks by sex and gender (supplementary data table)

	Total
Identifies with sex registered at birth	
Does not identify with sex registered at birth	
Chose not to disclose / unknown	

Section B: Total number with QRISK $\geq$ 10% (where applicable)

Table B1: Total number with QRISK $\geq$ 10% by age, sex, and ethnic group

Ethnic group	Male <25	Male 25–39	Male 40–59	Male 60+	Female <25	Female 25–39	Female 40–59	Female 60+	Sex 'prefer not to say' / sex unknown
Black ethnic groups									
Asian ethnic groups									
White ethnic groups									
Mixed or multiple ethnic groups									
Other ethnic groups									
Not known / not recorded									

Table B2: Total number with QRISK $\geq$ 10% by age, sex, and profession

Profession	Male <25	Male 25–39	Male 40–59	Male 60+	Female <25	Female 25–39	Female 40–59	Female 60+	Sex 'prefer not to say' / sex unknown
Modern professional									
Clerical & Intermediate									
Senior managers or administrators									
Technical and craft occupations									
Semi-routine manual and service									
Routine manual and service									
Middle or junior managers									
Traditional professional occupations									
None of the above									
Not known / not recorded									

Section C: Total number with BP over 140/190

Table C1: Total number with BP over 140/190 by age, sex and ethnic group

Ethnic group	Male <25	Male 25-39	Male 40-59	Male 60+	Female <25	Female 25-39	Female 40-59	Female 60+	Sex 'prefer not to say' / sex unknown
Black ethnic groups									
Asian ethnic groups									
White ethnic groups									
Mixed or multiple ethnic groups									
Other ethnic groups									
Not known / not recorded									

Table C2: Total number with BP over 140/190 by age, sex and profession

Profession	Male <25	Male 25-39	Male 40-59	Male 60+	Female <25	Female 25-39	Female 40-59	Female 60+	Sex 'prefer not to say' / sex unknown
Modern professional									
Clerical & Intermediate									
Senior managers or administrators									
Technical and craft occupations									
Semi-routine manual and service									
Routine manual and service									
Middle or junior managers									
Traditional professional occupations									
None of the above									
Not known / not recorded									

Section D: Total number of current smokers

Table D1: Total number of current smokers by age, sex and ethnic group

Ethnic group	Male <25	Male 25–39	Male 40–59	Male 60+	Female <25	Female 25–39	Female 40–59	Female 60+	Sex 'prefer not to say' / sex unknown
Black ethnic groups									
Asian ethnic groups									
White ethnic groups									
Mixed or multiple ethnic groups									
Other ethnic groups									
Not known / not recorded									

Table D2: Total number of current smokers by age, sex and profession

Profession	Male <25	Male 25–39	Male 40–59	Male 60+	Female <25	Female 25–39	Female 40–59	Female 60+	Sex 'prefer not to say' / sex unknown
Modern professional									
Clerical & Intermediate									
Senior managers or administrators									
Technical and craft occupations									
Semi-routine manual and service									
Routine manual and service									
Middle or junior managers									
Traditional professional occupations									
None of the above									
Not known / not recorded									

Section E: Total number with BMI >25

Table E1: Total number with BMI >25 by age, sex and ethnic group

Ethnic group	Male <25	Male 25–39	Male 40–59	Male 60+	Female <25	Female 25–39	Female 40–59	Female 60+	Sex 'prefer not to say' / sex unknown
Black ethnic groups									
Asian ethnic groups									
White ethnic groups									
Mixed or multiple ethnic groups									
Other ethnic groups									
Not known / not recorded									

Table E2: Total number with BMI >25 by age, sex and profession

Profession	Male <25	Male 25–39	Male 40–59	Male 60+	Female <25	Female 25–39	Female 40–59	Female 60+	Sex 'prefer not to say' / sex unknown
Modern professional									
Clerical & Intermediate									
Senior managers or administrators									
Technical and craft occupations									
Semi-routine manual and service									
Routine manual and service									
Middle or junior managers									
Traditional professional occupations									
None of the above									
Not known / not recorded									

Section F: Total number of referrals to GP

Table F1: Total number of referrals to GP by age, sex and ethnic group

Ethnic group	Male <25	Male 25–39	Male 40–59	Male 60+	Female <25	Female 25–39	Female 40–59	Female 60+	Sex 'prefer not to say' / sex unknown
Black ethnic groups									
Asian ethnic groups									
White ethnic groups									
Mixed or multiple ethnic groups									
Other ethnic groups									
Not known / not recorded									

Table F2: Total number of referrals to GP by age, sex and profession

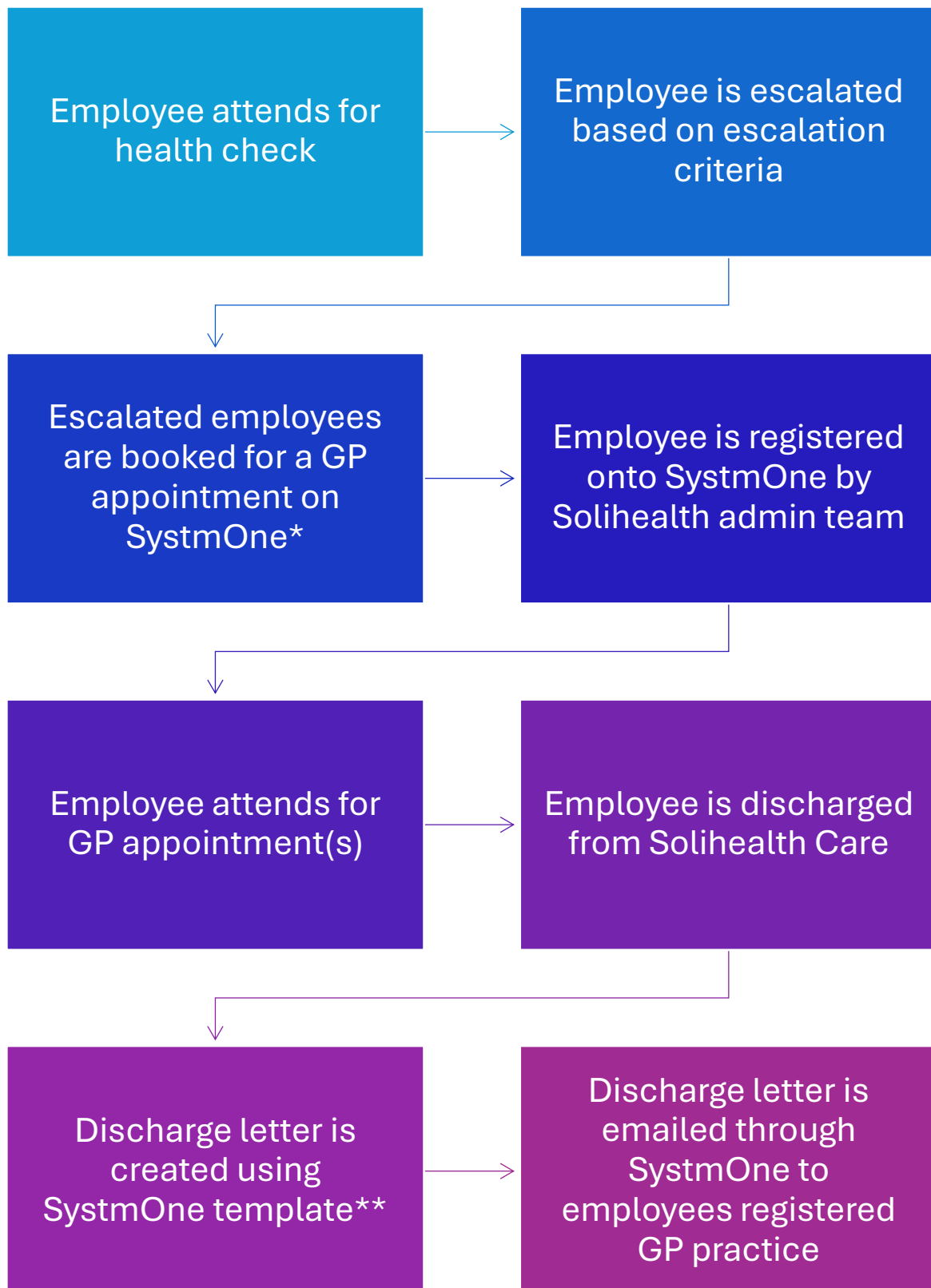
Profession	Male <25	Male 25–39	Male 40–59	Male 60+	Female <25	Female 25–39	Female 40–59	Female 60+	Sex 'prefer not to say' / sex unknown
Modern professional									
Clerical & Intermediate									
Senior managers or administrators									
Technical and craft occupations									
Semi-routine manual and service									
Routine manual and service									
Middle or junior managers									
Traditional professional occupations									
None of the above									
Not known / not recorded									

Section G: Total number who recall being offered an NHS Health Check in the last 5 years but who did not complete the check. (Optional question in data collection requirements)

Table G1: Total number who recall being offered an NHS Health Check in the last 5 years but who did not complete the check by reason for not attending.

Reason for non-attendance	Male <25	Male 25-39	Male 40-59	Male 60+	Female <25	Female 25-39	Female 40-59	Female 60+	Sex 'prefer not to say' / sex unknown
I did not think I was at risk of CVD									
I forgot									
I could not take time off work to complete the check									
I was not able to select a convenient time									
I was not able to select a convenient location									
I had more immediate priorities other than my health									
I was concerned I would be judged									
I was afraid of what I could find out about my health risks – I did not want to know									
I did not have the money/time/confidence to make health changes									
I did not think a health check would be effective									

Appendix 4: SoliHealth JLR Health Check Pathway



Appendix 5: Escalation Process used to refer JLR employee to SoliHealth GP

JLR Health Check Protocols of escalation

BLOOD PRESSURE:

- **140/90 or higher**
 - o Take a second measurement
 - o If second measurement is substantially different from the first, take a third measurement
 - o Record the lower of the last two measurements
- **Between 140/90 mmHg and 180/120 mmHg –**
 - o Refer to SoliHealth HCA for repeat reading/HBPM – persisting raised readings are then escalated to SoliHealth GP for review.
 - o Confirmed new hypertensive patients need:
 - HCA apt for ACR, urine dipstick, bloods (HbA1c, renal, lipids), ECG, lifestyle advice
 - GP review for medication initiation and up-titration (may require more than one contact)
- **180/120 mmHg or higher –**
 - o WP to repeat recording 3x using automated cuff.
 - If average BP reading between 140/90mmHg and 180/120mmHg refer to steps above. Discuss with GP if onsite.
 - If average BP reading is still 180/120mmHg or higher - NEEDS SAME DAY ESCALATION – WP to contact and escalate to Business Protection.
- **<90/60 –**
 - o Same day clinical review and consider referral for same day specialist assessment

HEART RATE:

- Heart rate >110 (repeat recording 3x, 5 minutes apart) if still >100, ECG and same day clinical review
- Heart rate <50 (repeat recording 3x, 5 minutes apart) - if still <60, ECG and same day clinical review

LIPIDS

Refer to SoliHealth GP if:

- QRisk >10% (require lifestyle advice +/- statin)
- TC > 7.5mmol/L and/or LDL-C >4.9mmol/L

HbA1C

- HbA1c level between 42 and 48mmol/mol – prediabetes, refer to HCA
 - o Readcode, referral to NDPP, lifestyle advice, recall for annual bloods
- An HbA1c level of 48mmol/mol or higher indicates diabetes, refer to GP for further management

There may be clinical issues unrelated to the above protocols that arise during health checks. In the event of uncertainty around whether escalation is required – contact SoliHealth service clinical lead via email to clarify (tara.shah@nhs.net).

Appendix 6: SoliHealth Discharge letter Template



<Today's date>

SoliHealth - Hurst Lane North B36 0EY

solihealthlocality@nhs.net

0121 203 2207

<GP Details>

Dear GP

R.E <Patient Name> <NHS number> <Date of Birth>

The above patient attended a workplace health check and had a follow up with our GP to discuss the results. The consultation is attached below. Please update this to the patient records.

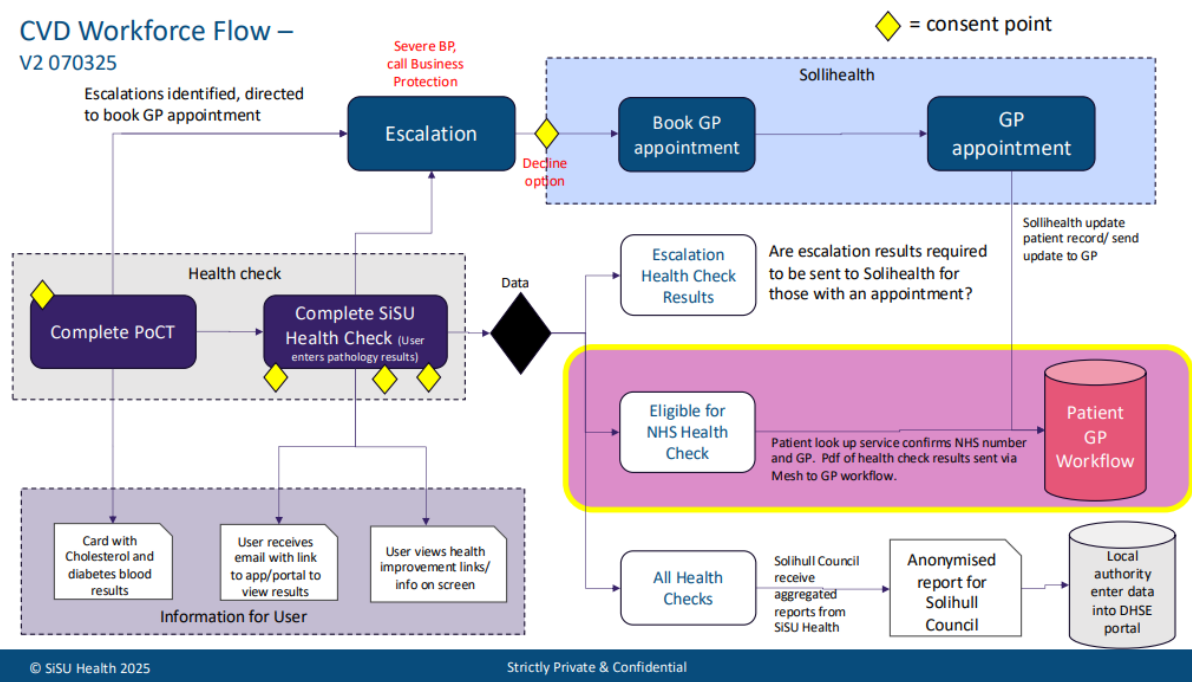
<Event Details>

Many thanks

SoliHealth

Appendix 7: GP Data Transfer

CVD Workforce Flow – V2 070325



Appendix 8: Media Coverage of the JLR CVD workplace Health Check Pilot

[Over 130,000 people to benefit from life-saving health checks - GOV.UK](#)

[Plan for workplace health checks to curb heart disease - BBC News](#)

[JLR OFFERS 4,000 PLANT WORKERS CHECKS TO IDENTIFY HEALTH PROBLEMS EARLY | JLR Corporate Website](#)

[Minister launches workplace health checks programme - The Solihull Observer](#)

[JLR offers 4000 plant workers health checks](#)

[JLR offers health checks to 4,000 Solihull staff | TheBusinessDesk.com](#)

[Jaguar Land Rover 'office GP' as 4,000 employees offered health checks - Birmingham Live](#)

[Solihull Council Report Template](#)