



Public Health England (PHE)

***NHS Health Checks: Stocktake, Deep Dive Qualitative, and
Online Research***

Qualitative Research Report

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1. BACKGROUND AND RESEARCH REQUIREMENT

Public Health England (PHE) commissioned research to update and evaluate the experiences and engagement of all parties involved in implementing the NHS Health Checks programme. This research was required by PHE, NHS Health Checks Leads, Clinical Commissioning Groups (CCGs) and Local Government Associations to help shape the direction of national and local programmes of work.

The specific aims of the research were to:

- aid understanding of how actions by PHE have been received by local authorities and what impact they have had on them
- ascertain which factors contribute to higher uptake of NHS Health Checks in some Local Authority (LA) areas and why other LAs are unable to improve
- assess and identify new priorities for PHE when considering how to support LAs in future

The principal elements of the research consisted of: a 'stocktake' of the impact of the NHS Health Checks Implementation Review and Action Plan, and; qualitative 'deep dive' research to explore and evaluate different LAs.

1.1 Stocktake

In 2012/2013, Research Works Limited conducted a qualitative 'stocktake' comprising 26 qualitative depth interviews (14 commissioners, 12 providers). The objective of the current stocktake was to revisit the 2012/2013 study and identify where PHE is in terms of supporting implementation, specifically in terms of the 10 action points developed after the research in 2012/2013.

The specific aims of the stocktake were to:

- Identify where PHE is in terms of supporting LA implementation
- Determine if LAs feel that PHE has responded to the 10 action points
- Understand emerging issues from a LA point of view
- Help to shape PHE's future work priorities in supporting LAs with the implementation of the programme

1.2 Qualitative deep dive research to explore and evaluate different LAs

The principal aims of the deep dive research were to explore and evaluate different LAs that were either: performing well on their NHS Health Checks targets and/or exceeding them, or; were underperforming.

In particular, the objectives of the deep dive were to:

- Understand in more detail what drives successful implementation
- Describe and illuminate the context, strategic approach and delivery approach to implementing the NHS Health Checks programme
- Understand whether there are factors/conditions common to areas where take up and reach is high

2. RESEARCH METHODOLOGY AND SAMPLE

The qualitative methodology and sample structure employed for the research are set out in detail below. All fieldwork was undertaken between December 2015 and February 2016.

2.1 Methodology

2.1.1 Stocktake

The stocktake comprised two elements:

- depth interviews with commissioners and providers as well as
- an online feedback form.

As with the 2012/13 study, qualitative depth interviews lasting 45 minutes were conducted among commissioners and providers. Research stimulus was preplaced with commissioners, comprising a summary of the action plan recommendations developed by PHE.

In addition, feedback was sought from a wider range of LA commissioners since delegates at the Local Implementer National Forum (LINF) had suggested that all LA commissioners should have the opportunity to participate in the 'stocktake' exercise. To facilitate involvement, an online feedback form was developed, which asked participants to respond to a number of questions via an online portal. The questions covered the following issues:

- If and how the Action Plan had helped them implement NHS Health Checks locally
- Future challenges and their solutions
- Suggested PHE priorities

2.1.2 Deep dive

For the deep dive qualitative research, LA areas were recruited from a PHE list. The ten LA areas were selected from the top ten and bottom ten performing areas. ('Performance' was measured in terms of the uptake of NHS Health Checks). In each area, interviews were completed with both the commissioner and providers.

2.2 Recruitment and Sample Structure

For the stocktake, 27 qualitative depth interviews were conducted; 17 of these among commissioners from a range of LAs in terms of geographic location and population mix. The remaining 10 depths were conducted among providers which included:

- GPs
- pharmacists,
- health trainers,
- primary care champions,
- outreach workers,
- healthcare assistants,
- practice managers,
- health development managers,
- practice nurses.

For the online feedback, 152 Local Authority commissioners were invited to contribute. A total of 50 commissioners completed the online feedback form.

For the deep dive qualitative research, a total of 28 interviews were conducted. These comprised: 11 depth interviews with commissioners, and; 17 with providers. The depth interviews were conducted across 11 LA areas, sampled from PHE lists indicating the top ten and bottom ten LA areas in terms of uptake of NHS Health Checks.

2.3 Limitations of the sample

It should be emphasised that qualitative research samples are purposive and quota-driven in nature; they have no statistical validity or reliability. The purpose of qualitative research is to give generalisable indications of the drivers underlying

behaviour and attitudes, by exploring responses in greater detail and depth. Qualitative research does not have quantitative accuracy in terms of identifying proportions of populations holding stated views.

3. EXECUTIVE SUMMARY

3.1 Stocktake

PHE is overwhelmingly seen as an enthusiastic and effective advocate for NHS Health Checks. The most positively received aspects of PHE involvement are around networks at a national and regional level, and the majority of points on the PHE 10-point action plan.

The qualitative feedback from the online feedback form indicates that LA commissioners feel that PHE actions have supported local implementation, particularly the national conference, regional networks, behavioural insight and marketing interventions, provider competence framework, best practice guidance and guidance about information governance.

Where there were issues with PHE support, these were mainly focused on: the need for evidence about the impact of NHS Health Checks, and; the need for any support to be accessible to, and applicable for, local implementation.

3.2 Deep dive

Findings from the stocktake research illustrated that, similarly to the 2013 research, GPs were still the focus for delivery; success was based on the number of GP practices engaged with NHS Health Checks, and the level of GP buy-in – and the subsequent reported uptake of NHS Health Checks. However, softer measures, such as boosting the profile of NHS Health Checks, and incentivising providers to sign up, were also perceived to be indicators of success.

The challenges for implementing NHS Health Checks remained focussed on GPs. These included: GP perception that they lack time and resources to administer and administrate NHS Health Checks; perceived low remuneration; a perceived lack of outcome evidence, and; GP focus on treatment and a perceived lack of engagement with prevention.

In addition, a lack of LA funding, as well as limited public health capacity to successfully manage the NHS Health Checks workload, were cited as challenges, as were data issues, engaging target populations and the variable quality of the intervention.

However, a range of positive ways of engaging GPs emerged from the findings, as well as progressive and innovative ways of addressing other challenges; although it was clear that there was some uncertainty regarding the future of NHS Health Checks.

A number of key findings emerged from the deep dive interviews, indicating a range of factors driving success or failure in LA areas. For higher performing LA areas, the success factors included:

- The strength of relationships with GPs, CCG and Local Medical Committees
- Funding and stakeholder support
- Delivery model including an emphasis on primary care, but also including third party providers
- Integrated software systems
- Support for 'less engaged' GPs e.g. delivering training to skill up delivery teams
- Dedicated admin staff using text and phone platforms with patients
- Targeted marketing campaigns with consistent branding

For LAs where performance was poor, the driving factors included:

- Problems associated with the transition to LA

- Funding issues
- Poor GP engagement, and a consequent reliance on other providers to achieve take-up
- Poor relationships with CCGs
- Contractual issues

Views on future priorities for PHE typically included: assurance on future funding for NHS Health Checks; providing a nationally available, and locally relevant, evidence base; raising public awareness of NHS Health Checks, and the health benefits of attending NHS Health Checks; ensuring strong stakeholder support for NHS Health Checks at a national and regional level; and providing support in terms of strengthening relationships with LAs and CCGs.

3.3 Checklist of factors that will improve the take up/reach of NHS Health Checks

1. Develop good relationships with LAs, CCGs and LMCs, and secure stakeholder support (e.g. councillors, Directors of Public Health)
 - ➔ This provides multiple strategic perspectives for the locality, which achieves a more focussed and efficient momentum to the programme
2. Initiate and maintain good communication with, and proactive support for, GP practices and primary care providers
 - ➔ This helps by improving engagement, 'buy in' and can help with subsequent data quality
3. Ensure good data collection and subsequent data quality
 - ➔ This is achieved through the implementation of clear data recording protocols and effective IT systems (e.g. BMJ Informatica). **Note:** data collection methods were widely varied across areas
4. Consider models other than GP delivery to reach the NHS Health Checks population, particularly hard-to-reach groups

- ➔ This can involve Outreach/pharmacy/other community bodies that gain more exposure to hard-to-reach groups to help communicate and/or deliver the programme
- 5. *Persist* in trying to engage the NHS Health Checks audience as well as potential providers
 - ➔ Where engagement is low, strategic marketing that is consistent with wider marketing style help to boost uptake
- 6. Consider alternative methods of marketing NHS Health Checks locally e.g. using texts, face-to-face marketing and workplace promotional activity to engage the target audience or different ways of remunerating GPs to maximise appeal
 - ➔ A wider variety of administrative techniques proved successful in terms of engaging, reminding and informing eligible people of HC – it was also more cost effective than simply sending out letters

3.4 Summary of the most common factors that will impede/limit take up and reach of NHS Health Checks

- **The transition to LA oversight has been a major challenge for some areas.** Lack of commitment from LAs and CCGs, and funding issues, have created problems. As a result, some areas are still in the process of setting up new contracts and procurement protocols, therefore delaying progress.
- **The strength of relationships with LAs and CCGs was perceived to be integral to a successful NHS Health Checks programme.** In more successful areas, this has generally been achieved. In less successful areas, this was still perceived to be a challenge.
- **Scepticism and a lack of commitment from GPs was perceived to be an ongoing challenge in some areas,** and GPs were still seen by a majority of participants as the main factor driving successful implementation.

- **Funding and resource issues are an important feature of the local landscape.** Trying to achieve results without the investment or resource perceived to be required to do so was perceived to be a major barriers.
- **Data issues were a common theme amongst less successful areas.** Access to patient data is seen by many as key to effective targeting among the eligible population, particularly harder-to-reach groups.

4. MAIN FINDINGS – STOCK TAKE

4.1 Stock take: the PHE 10-point Action Plan (online feedback)

The PHE 10-point action plan emerged from previous research into the relative success of NHS Health Checks up to 2012/13. The 10 points of action are:

1. Establish collaborative national leadership
2. Test the impact of behavioural insight and marketing interventions
3. Support the provision of the NHS Health Check
4. Support information governance
5. Support delivery
6. Programme governance
7. Provider competency
8. Consistency
9. Proving the case
10. Expected roll-out

A clear majority of the online sample stated: ‘yes, PHE actions have supported local implementation’. However, participants in the online feedback tended to comment more positively on some action areas more than others. The following actions were most valued. (These points are ordered in terms of frequency of mention in the online feedback).

No 10 (expected rollout) and No 5 (support delivery)

Participants indicated that the National Conference was considered important and valuable as a resource on a number of levels: firstly because it reaffirms the importance of NHS Health Checks as a national programme; and secondly because it offers an opportunity to learn and share experiences.

“It has been useful to meet regularly to hear what is going on and feel part of the whole and support from region has been great. LINF (Local Implementer National Forum) representation allows for two-way communication between local operational/strategic experience and PHE nationally.”

Regional Networks were also perceived as offering much needed ‘local area’ support through sharing experiences and ‘how to’ tips that work locally; these forums were definitely valued for the practical support provided.

“The networks are the most useful support really as we can discuss specifics of our areas with neighbouring LAs.”

“Our PHE network lead has been amazing, dealing with our issues as well as feeding us edited updates on developments.”

No 2 (behavioural insight and marketing interventions)

This was seen by participants as an action area with a lot to offer for commissioners in particular. It was perceived as offering a range of useful and practical resource and support for implementation.

“We have used the new branding and developed posters based on nationally developed resources. Also reviewed our invite letter – templates are very helpful.”

“I find the webinars useful as they provide information on a range of aspects. Both these resources have been used during development of our new service specification.”

“We have used some of the examples of social marketing interventions and delivery models to improve uptake and find high risk individuals.”

“I regularly get contacted by residents who found my contact details on NHS Choices.”

No 7 (provider competency)

This action point was particularly valued among participants for its ‘usability’, specifically with on-going work: service specification, contracts and training.

“We now use the current competency training with practices as part of their annual training.”

“The competency framework has been excellent and very useful in helping to improve the quality and consistency of service.”

No 8 (consistency)

Strong support emerged among participants for this action area. It was felt that the best practice guidance helps frame the implementation approach; in addition, the comparison data helps guide thinking on implementation. Again, this action point was perceived to be practical and accessible.

“Implementation is informed by best practice guidance as well as information on NHS Health Checks website.”

“The update to Best Practice Guidance was useful in highlighting the issues to current providers that could be addressed in order to improve service quality.”

No 4 (support information governance)

It was clear from the online feedback that data handling is a crucial issue; consequently, this area is very important for commissioners. It was generally felt that the PHE guidance helps navigate a dense and technical area with greater confidence and ease.

“Very helpful – used to support commissioning of software.”

“We have developed our information sharing agreements based on national guidance.”

Action points 1, 3, 6 and 9 did not appear consistently in the online feedback.

- The National Advisory Committee was established in 2014. It meets twice a year and includes director or chief executive representation from NHS England, NHS Improving Quality (NHS IQ), Department of Health (DH), Local Government Association and others
- Worked with NHS IQ to produce a series of case studies on delivery models that aim to engage people at high risk of CVD or individuals that don't use primary care. Worked with the Centre for Public Scrutiny to publish guidance and case studies on how to get the most from the scrutiny process
- Expert Scientific and Clinical Advisory Panel (ESCAP) was established in 2014. It meets four times a year, is chaired by PHE's chief knowledge officer and its membership includes academics and national clinical directors. ESCAP have responded to emerging issues by publishing responses to editorials and scientific papers in the BMJ, Journal of Public Health and newspapers where relevant. ESCAP published, in

consultation with a wide range of stakeholders, the NHS Health Check priorities for research.

- In 2015 PHE published the NHS Health Check priorities for research. Disseminated the findings of the first national research study published in 2015

It is worth noting that the action areas covered by some of these points (No 9 proving the case in particular) emerged as perceived challenges for commissioners and providers.

A minority of participants felt that ‘no PHE action areas have supported implementation’ of NHS Health Checks. For these participants, issues with PHE support were typically focused on the need for evidence to convince GPs & LAs, as well as the accessibility/applicability of information to implementation in a specific locality.

Some of these participants felt that the guidance offered by PHE was over-complicated; some felt there was simply too much material on offer, and that what was on offer did not necessarily address local conditions and challenges.

“My concern is lack of ‘cut through’ with local authorities – support needs to be relevant to LA priorities.”

“Scepticism about NHS Health Checks and the value of PHE is strong amongst GPs and CCG colleagues in my area; evidence of effectiveness of NHS Health Checks is desperately needed.”

“There are some helpful initiatives but there is a tendency to over complicate guidelines.”

“Most of it is lots of ‘stuff’ – there isn’t time to read and does not address the issue of local engagement and adequate funding.”

4.2 Stock take: experience of implementation for commissioners (stocktake depth interview feedback)

Previous research in 2012/13 had indicated that commissioners were struggling to reach their NHS Health Checks targets; and that the overall appetite for NHS Health Checks was variable. A number of ongoing challenges were clear from this phase of the research.

Overall, NHS Health Checks were viewed differently across the spectrum of LA commissioners; some were more able than others to identify positive impacts (e.g. amongst specific communities). It was clear that a majority of commissioners had encountered significant challenges at some point when rolling out the NHS Health Checks programme in their area.

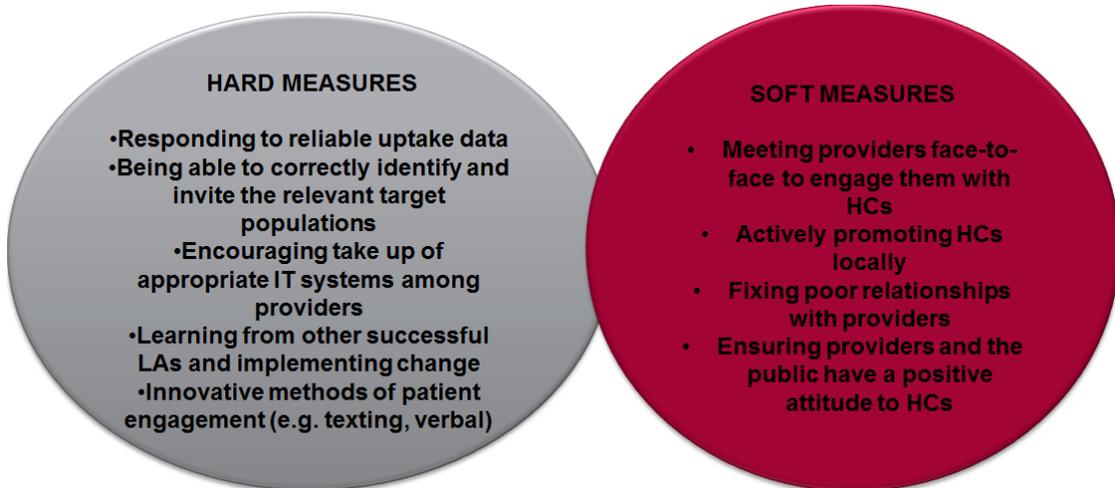
Some commissioners were better placed to assess the uptake and overall success of their NHS Health Checks programme than others. This was dependent upon: their relationships and level of engagement with providers, and; good data collection and subsequent data quality.

Some commissioners who were relatively new to their role (typically 1-2 years) described having to overcome a series of barriers (e.g. poor relationships with certain practices) in order to get closer to meeting their targets. Other challenges were linked to the locality. These included: wide geographical spread of services; low uptake with hard to reach communities, and; poor cooperation (among GPs in particular).

4.2.1 *Perceived indicators of success 2012/2013*

Previous research indicated that a number of factors were key to delivering a successful programme. These included: GP sign-ups (seen by a majority of participants as the main factor driving successful implementation); overcoming perceived GP cynicism; meeting delivery targets; and implementing suitable IT systems. Taken together, these factors were seen as hard indicators for success.

Previous research had also illustrated that softer measures (such as ensuring appropriate follow-up lifestyle services, on-the-day testing and engagement with the public to increase recognition of NHS Health Checks) were perceived to be ‘soft indicators’ of success.



Previous research indicated that success was often driven by adoption of a mixed model approach, with GPs acting as the hub for delivery, with a combination of pharmacies, dentist/opticians, private providers, community teams and health buses offering ‘surrounding roles’ for uptake and delivery.

Key successes for commissioners



4.2.2 Measures of success

Once again, it was clear that success was measured by a mix of hard metrics and perceived (i.e. soft) outcomes. In this phase of research, commissioners again based success on the number of GP practices engaged; and this metric was linked to subsequent reported take-up of NHS Health Checks. The number of invitations issued and the subsequent number of completed NHS Health Checks was cited as a key measure of success.

Once again, softer evaluation methods were also employed as metrics of success. From this phase of research, it emerged that ongoing efforts were geared towards boosting the profile of the programme and incentivising providers for sign up and full cooperation.

Commissioners also assessed what services were available for those who had taken up the service (that is, for subsequent treatment). Clarity of signposting for patients once they have had their health check was also prioritised in some areas.

4.2.3 A mixed model for delivery

Previous research had indicated that success was often driven by the adoption of a mixed model approach, with GPs acting as the hub for delivery and a combination of pharmacies, dentist/opticians, private providers, community teams and health buses offering 'surrounding roles' for uptake and delivery.

In this phase of research, the GP was still the focus for delivery; and the involvement and influence of surrounding providers and teams was inconsistent. In some locations, where unsuccessful pilots had been held (e.g. with pharmacies) this type of provider had been abandoned; it had not even been considered in others.

After five years of contacting target audiences for NHS Health Checks, some commissioners felt that most of the eligible audiences had probably been reached.

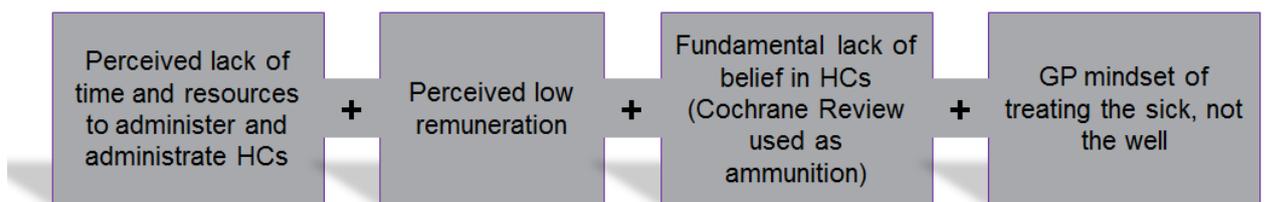
They also felt it was unlikely that many of the patients already contacted would undergo the check again.

However, harder-to-reach groups and those living in more deprived communities were recognised as an ongoing priority for prompting and encouraging uptake (because a significant proportion had not responded, or had failed to attend their check).

Persistence was seen as vital: take up of the NHS Health Check sometimes followed after the first, second or third letter (some target audiences only responded after the third letter). Efforts were ongoing to engage with the public through a variety of channels, in order to encourage them to consider NHS Health Checks. Some commissioners had employed independent external agencies to support delivery by increasing engagement with NHS Health Checks (e.g. Halo, To health).

4.2.4 Challenges to implementation – GP engagement

From the previous research, the challenges set out in the graphic below were encountered by commissioners in trying to engage GPs.



In this phase of research, the challenges were perceived to be much the same, but were felt to be more acute. It was also felt that a lack of emphasis on outcomes for NHS Health Checks was a perceptual issue for GPs – in essence, without data capture for outcomes there is limited evidence to illustrate the impact of HCs for GPs.

Once again, many commissioners reported experience of GPs being reluctant to engage with the NHS Health Checks programme due to a perceived lack of time, or

cynicism about NHS Health Checks (this was typically a perception that NHS Health Checks is not an 'evidence-based' programme). As with previous research, there was also some resistance among GPs to signing up to the Local Enhanced Services (LES) framework.

Further efforts had been made to engage with GPs and ensure that NHS Health Checks were more financially motivating; however, reductions in LA funding under a new Government – and trying to achieve results without the investment required to do so, were perceived as major barriers to GP engagement.

“We have been told that there is no money and that there will not be any provision of further money to provide a statutory mandated programme. We will have to get rid of anything that is not statutory or mandated.”

4.2.5 Challenges to implementation - data quality issues

Previous research indicated that lack of a clear, national solution for data collection and data reporting was a stress point and ongoing challenge. In this phase of research, data quality was an area that was still perceived to be a major issue for commissioners.

Where data solutions were in place, vital information was available. Stakeholders could access information such as the age range of participating patients. It was possible to see if participating patients had a family history of coronary heart disease or diabetes.

“We could see that yes they were inviting the right people. A proportion of them did have family histories.”

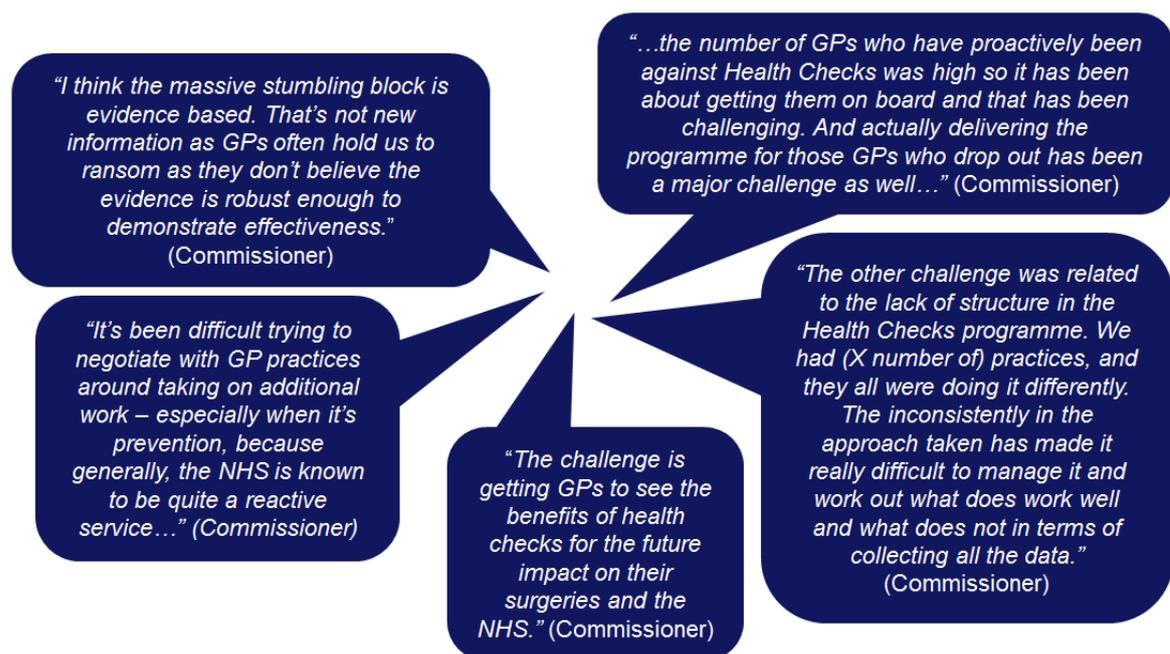
Some commissioners established new software designed for NHS Health Checks data collection and collation (e.g. BMJ Informatica); however, this was not always a complete solution for all data issues experienced. Data collection methods were

inconsistent; it was felt that some GP surgeries were less compliant than others in relation to how they collected and submitted their data.

“Some practices are choosing not to have the software as a way of punishing us. They think that the software won’t do anything additional for them that their clinical systems can’t already do.”

Where more efficient IT systems had been implemented, some practices were reluctant to take them on. Crucially, data about NHS Health Checks *outcomes* was not available; instead, individual stories from practices were used to generate a perception of successful outcomes.

Key challenges for commissioners



4.2.6 Positive approaches

Overcoming challenges and achieving success were seen by commissioners as depending on positive approaches. As previous research had indicated, successful engagement with NHS Health Checks relied more on the ‘carrot’, rather than the ‘stick’.

Communication and early engagement to build relationships with GPs from the outset was seen as a critical factor in developing a collaborative approach to meeting challenges. Some commissioners employed support teams to work directly with practices and their data quality teams; equally, some worked with the Commissioning Support Units (CSU) to achieve results. Training and working groups, which were noted as useful activity in the previous phase, appeared to be less prevalent; this was possibly due to budgetary restraints.

Advertising and promotional communications were commissioned to boost the profile and uptake of NHS Health Checks; the impact of these measures was monitored using uptake data. There were some examples of hard-to-reach groups, or low take-up groups generally (such as middle-aged working men, ethnic minorities and those in very rural areas) being targeted with texts, f2f, marketing and raising awareness within the workplace.

4.2.7 Other strategies for success

Similar strategies to encourage success were found to be applied as with the previous phase of research. These included:

- Investment in IT systems to manage and record data effectively
- Structuring the remuneration package to maximise appeal
- Commissioning external agencies to provide delivery support
- Promoting and marketing NHS Health Checks locally

However, ‘badgering’ the less compliant GPs (i.e. using the stick) to complete their duties in relation to NHS Health Checks, was still seen as necessary by some commissioners to get things done. Equally, some successful commissioners have approached GPs with offers of support and training.

4.3 **Stock take: experience of implementation for providers (stocktake depth interview feedback)**

The providers interviewed for this phase of the research were from a variety of backgrounds. Similarly to the previous phase, we included: GPs, Practice Directors/Managers, HCAs, Nurse Practitioners and Pharmacists. However, for this phase some additional providers were also included: deputy patient services manager, health trainer, Outreach Programme lead, a Health Promotion Manager and a community provider (healthy living team).

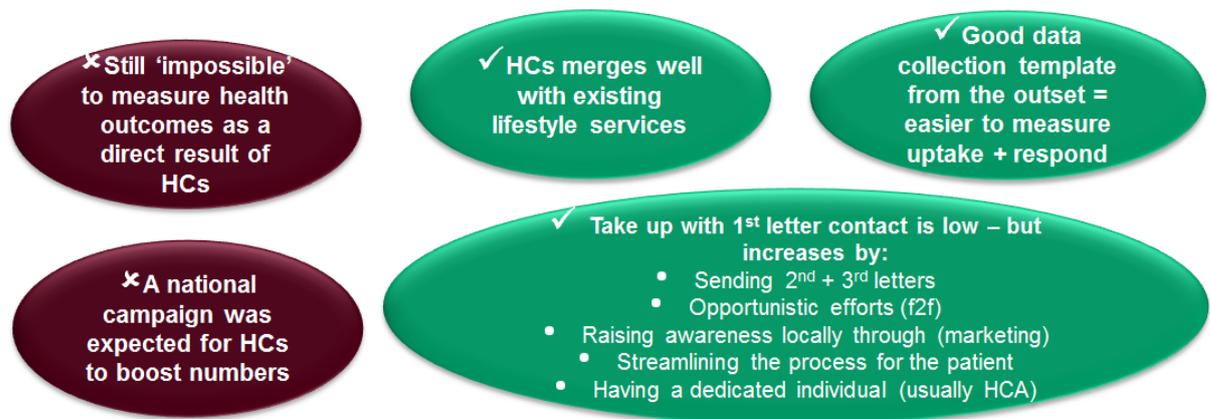
Those delivering the NHS Health Checks programme were immersed in issues such as the time, resource, and administrative aspects of delivery. This was especially evident among those in purely patient-facing roles (HCA, Nurses, etc.). Uptake was generally quite low, and the majority of providers were finding it difficult to motivate target audiences into having NHS Health Checks, given they did not feel unwell and were not presenting any symptoms.

GPs interviewed felt engaged with the NHS Health Checks programme and felt they were 'doing their bit'. Where this was the case, the NHS Health Checks were typically well established, with tasks spread appropriately across the team (typically the GP had a policing role). However, progress was slow and it was felt that further assistance to boost the profile of NHS Health Checks would be beneficial.

“Success is difficult to measure – and it’s hard to gauge outcomes. It’s not tangible.”

“We are motivating and communicating with patients to get them in. We’re also getting their blood tests before the check, which helps to speed things up.”

GP involvement: positives and negatives



It was clear from this phase of research that GPs felt frustrated. Due to funding cuts, in some cases trust had been lost with the commissioner. Equally, the relationship with the commissioner was sometimes “*limited to a contract*”. This, combined with lack of evidence for outcomes, had led to uncertainty regarding the NHS Health Checks programme and its future.

“We need better communication from the commissioner. We should be working as a team. We also need better media coverage. A national media campaign would help.”

“It’s mid-February and I’m still unsure of what’s happening with NHS Health Checks. We need more certainty. If they halve the funding, that has an impact on the practice because our expenses remain the same.”

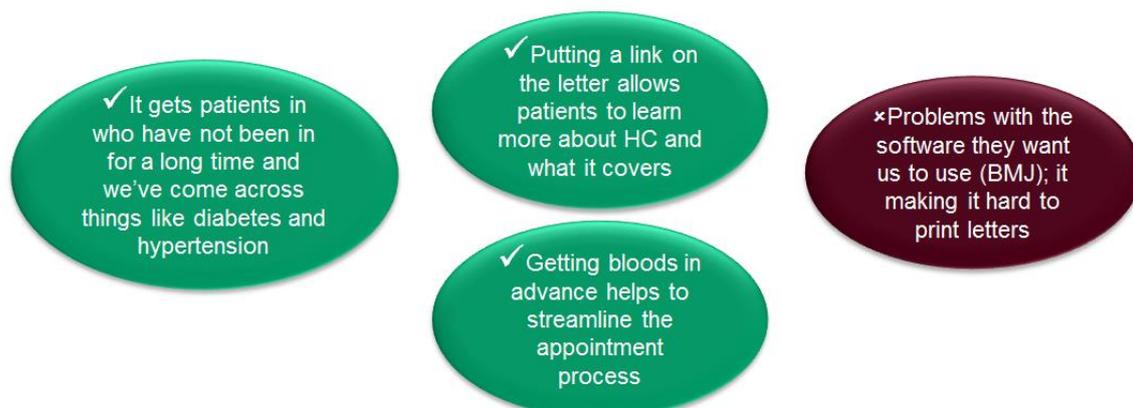
Barriers to trust for GPs



Case studies

4.3.1 Healthcare assistant

One HCA was attempting to overcome the challenges faced in delivering NHS Health Checks.



4.3.2 Practice nurse

One practice nurse respondent was operating in a fairly unique, small island setting. Overall she felt positive about HCs, although uptake was necessarily low.



4.3.3 Pharmacist

One pharmacist respondent was very positive about NHS Health Checks conceptually, and felt that the potential of NHS Health Checks is being limited by practical, data and funding issues.



4.4 Stock take: implementation challenges and solutions (online feedback and stocktake depth interview feedback)

Summary of perceived challenges

- A lack of evidence to encourage LAs that NHS Health Checks programme is worth budget spend and to encourage GPs to engage with NHS Health Checks.
- Lack of funding
- Lack of GP engagement
- Difficulty in reaching target populations
- Variable quality of intervention
- Data issues (e.g. access to patients from GPs who refuse to carry out NHS Health Checks, access to credible outcomes data to assist with evaluation)
- LA public health capacity to successfully manage NHS Health Checks
- Engaging the general public

4.4.1 *Lack of evidence*

Evidence was seen as a core requirement to persuade LAs and GPs that engagement and support were justified. For LAs, this needs to include evidence that NHS Health Checks are worth the budget spend. They needed to see evidence that the NHS Health Checks outcomes were likely to save councils money. There was some concern among commissioners and providers that regional discussion between Directors of public health and LAs would lead to the conclusion that NHS Health Checks were not a priority and were not 'here to stay'.

Evidence was also felt to be necessary to challenge GP scepticism and convince them that NHS Health Checks are effective and worthwhile in a time of resource and budget cuts. Typically it was felt that being able to demonstrate positive health outcomes as a result of NHS Health Checks was key. Evidence was required that patients in 'at risk' categories (smokers, alcohol users, those on unhealthy diets) had

implemented lifestyle changes that would lead to positive outcomes: they had stopped smoking or drinking, had lost weight, or taken exercise.

It was felt that solutions to these challenges were possible. For LAs, it was necessary to be able to present a business case for NHS Health Checks, perhaps in terms of potential savings for social care services. Evidence needs to be both national and local in scope for LAs and GPs; LAs were seen to be focused on savings and costs in the short term, while GPs were perceived as sceptical and hard-pressed. It was also felt that maintaining a consistent flow of evidence was vital.

“I understand that articles about the positive impact of NHS Health Checks planned to be published in the BMJ are delayed. If the evaluation is positive we must ensure a consistent message is disseminated.”

4.4.2 Lack of funding

Lack of funding emerged as a consistently articulated concern among participants. There were concerns about a potential loss of existing funding; some reported being aware of signs that funding will be dramatically cut next year. Others felt that justifying the cost of NHS Health Checks was becoming increasingly difficult. Others pointed to financial, commissioning and procurement constraints.

Many participants were concerned by the reduced capacity of public health due to funding cuts. Others noted the competing priorities in primary care, and felt that the fees currently offered for NHS Health Checks were not sufficiently attractive to encourage engagement.

In terms of LAs, financial challenges were a consistent issue. Public health and social care were seen as a price-constrained environment. Persuading LAs that NHS Health Checks were worth the cost was seen as problematic; this was exacerbated by the perception that NHS Health Checks are a NHS programme, and thus there are issues around ownership for LAs.

A number of solutions to these challenges were suggested.

- an improved business case for LAs, focussed on ROI (return on investment)
- additional NHS funding to support LAs in delivering NHS Health Checks
- cost savings may be possible through contract specifications
- ensuring that the NHS Health Checks budget remains ring-fenced

More broadly, it was consistently felt by participants that there was a need for strong messaging from PHE, the DH and NHS England that NHS Health Checks are 'here to stay'.

“HC has got to a point where it might disappear unless we give it more momentum nationally; this is a crucial point. Whenever we have a national meeting, I feel the only good thing I get from it is networking; otherwise nothing good really comes out of it.

Every time we ask for a national campaign and nothing moves forward.”

4.4.3 Lack of GP engagement

Participants consistently reported a range of challenges related to GP engagement with the NHS Health Checks programme. These challenges can be grouped into three main areas: attitudinal challenges; problems in partnership working, and; problems around data and access to data.

Both previous research and this phase of research have noted a common theme of scepticism among GPs as to the efficacy of NHS Health Checks. This scepticism, which is often linked to a lack of evidence around NHS Health Checks outcomes, is shared by many GPs and other primary care staff. Participants felt that this attitude also drove the distinct lack of enthusiasm among some GPs to drive uptake of NHS Health Checks.

“You can’t always maintain such high outcomes. We still have challenges from GPs; they don’t think there is any strong evidence on HC outcomes. So quite a few practices are not doing health checks, and I don’t have much time to follow up on HC because I have a huge area to cover.”

In addition, respondents reported that many GPs feel they do not have sufficient time to get involved in NHS Health Checks. This creates challenges in terms of maintaining the interest of participating GP practices, and generating commitments from non-participating practices.

The attitudinal challenges compounded the problem of effective partnership working with GP practices. Many participants felt that it was difficult to work constructively with GPs in their areas. This in turn led to a challenge in working with GPs to identify the eligible target population for HCs. This challenge was part of a broader feeling among participants that there were significant data handling and privacy issues involved in the NHS Health Checks programme.

Finally, many felt that GPs were resistant to the idea of third-party providers delivering NHS Health Checks.

GP engagement is clearly a central concern for many participants. However, a number of solutions to the problem of GP engagement were suggested. The solutions offered focused on contractual, evidential, and partnership initiatives.

- Participants consistently felt that evidence for NHS Health Checks outcomes was crucial, and that this would be best delivered by influential local and national stakeholders.
- Many participants were keen to see NHS Health Checks requirements written into GP contracts (e.g. Quality Contract, Quality Outcomes Framework and General Medical Services contract). It was also felt that data sharing guidance should be a feature of contractual arrangements.

- Many participants suggested that maintaining engagement with, and support for, GPs who feel overburdened, or feel that they lack the resources to successfully deliver NHS Health Checks, would be beneficial.

Many also felt that there ought to be more focus on ensuring that GPs follow up on referrals from third-party providers. This idea is clearly linked to the perceived need for a robust evidence base as a tool for enhanced take-up and delivery of NHS Health Checks.

The issue of exploring how outreach data can be uploaded on to GP systems direct and how clinical follow up can be more joined up was seen as very resource intense.

4.4.4 Further challenges

Reaching the target population

Increasing the uptake of NHS Health Checks, and maintaining a consistently high uptake, were seen as linked to the challenge of reaching the eligible target population. Identifying high-risk groups, and accessing hard to reach groups are integral to the task of maintaining and growing the NHS Health Checks programme.

“Now we have 37 (providers), including a new community outreach provider who’s been working with us since 2014 – they have really made a difference in the uptake”

Many participants felt that: ensuring that NHS Health Checks are targeted properly (and that eligibility is adhered to); encouraging eligible people to attend; a focus on ensuring that non-participants attend; ensuring that people take up their five-year recall appointment; and supporting hard to reach groups so that they understand the benefits of attending NHS Health Checks were central to the future survival and success of the programme.

It was felt that maintaining the commitment of participating GP practices, and getting commitment and buy-in from currently non-participating GPs, were central to facing and overcoming the challenge of efficient targeting.

“This is our stumbling point – because a lot of GP practices will say they are not prepared to buy the point of care testing equipment”

Variable quality of intervention

Consistent challenges with quality of intervention were identified. These included: variation in the overall quality of intervention; consistency issues around implementing quality control (this was particularly highlighted where there was a mixed delivery model with a range of providers); and maintaining consistency between providers.

It was felt that the cost of providing staff training, and the perceived lack of time for training, were barriers to achieving a consistent level of quality in NHS Health Checks interventions.

“The areas that are doing well like [removed] for example, the resources and staff are very good there. They have a DPH who believes in the program and they are allowed to go out to GP practices and talk about the program and put on training events, they take the program very seriously.”

Data specific issues

Data issues were consistently identified in terms of both access and quality recording. In terms of access, participants felt that gaining access to GP patient records, and persuading GPs to share that data, presented a challenge. This was seen as a particular problem in the case of non-participating GP practices, despite the existence of Information Governance best practice guidance.

Many participants were concerned about their lack of access to credible outcomes data (on both a local and a national level). This created challenges not only in terms of proper evaluation, but also with persuading sceptical GPs, and hard-pressed LAs, of the value of NHS Health Checks.

“We had to make sure that they were doing the NHS Health Checks, containing the CVD Risk Assessments – which was not necessary happening before. Sometimes some of the wrong data might have been filled in – we might have lots of respiratory and nothing on CVD risk assessments.”

LA public health capacity

Consistent challenges were identified with the capacity of LA public health professionals to manage the NHS Health Checks workload. Resource and time constraints impacted on the ability to communicate with and manage large numbers of GPs. It also presented a problem with having to chase take-up rates; some participants pointed out that this was particularly a problem for LAs when large numbers of invites were leading to low uptake rates.

Competing priorities, and the significant conflicting views on NHS Health Checks, were felt to impact political and clinical buy-in. It was also felt that variable relationships with CCGs and GPs meant both a larger investment of time and resources and a challenge in terms of buy-in. GP and CCG capacity and engagement were consistently reported as challenges.

“Our CCG is on side but it has huge capacity issues; our model is completely provided by primary care; if that falls who knows what would happen with this.”

Engaging the general public

Consistent challenges emerged from this phase of research in terms of engaging the public. Firstly, it was felt that it was essential to increase public awareness of the NHS

Health Checks programme at both a local and a national level. Equally, it was seen as important that the public perception of the value and importance of the NHS Health Checks programme be improved; many felt the public needed to be reminded of the benefits of NHS Health Checks. It was also felt by some participants that the role of GPs in the NHS Health Checks programme needed clarification, and that this would help in terms of public perceptions of the programme.

“If there is more of a push on advertising to raise awareness and profile it would be good. It could point people to their local public health team as well as GPs. We have to do a lot of work to push the programme, and because there is no national push, it’s hard.”

4.4.6 Broader solutions

Introducing more progressive and innovative ways of working emerged as a strong overall theme, though different priorities emerged across the sample. More targeting of delivery at those most at risk and/or less engaged was felt by many to maximise impact for the money spent; the universality of NHS Health Checks was questioned by some in light of current budget/resource constraints.

“If the service was not mandated, we could decide for our own population and GPs would not be swamped with the worried well. Also local councillors can justify the spend on a targeted service, they cannot when it is universal.”

Participants were keen to look at different delivery models, such as workplace or opportunistic testing through outreach work. Additionally, many wanted to see improved collaborative working with providers, for instance in terms of improving the invitation process from GPs.

Some participants were keen to see co-commissioning, with NHS Health Checks as part of diabetes screening or other lifestyle programmes. This was seen as resource

efficient and a persuasive argument in favour of NHS Health Checks for LAs and CCGs. Some felt it would also serve to make NHS Health Checks less of a ‘medical’ intervention and more part of a healthy living programme.

“It is no longer helpful to think of NHS Health Checks as a medical test but a proactive health improvement programme, linking to the reduction of negative lifestyle behaviours.”

In respect to data, some wanted to see better data flow and IT systems used in common with GPs; this point was seen as a common area of focus going forward. There were also suggestions for a national data collection approach, to be achieved through a standard client management system.

Finally, many participants were eager to see public marketing campaigns; these were largely perceived as local in nature, but there were also calls for a national campaign to raise the profile and public understanding of the programme.

5. MAIN FINDINGS – DEEP DIVE

5.1 Deep dive: success factors common to more successful LAs

Overall, more successful areas tended to have a longer implementation history than less successful areas (an average of 6 years compared to an average of 2 years). On average, less successful areas tended to have a larger eligible population see table 1. There were examples of both more and less successful areas with higher levels of deprivation and high, average and low levels of ethnic diversity.

Table 1. proportion of eligible population having a check and total eligible population (TEP) by local authority

% of eligible people having received a NHS Health Check (Q1 2013-14 to Q3 2015-16)			
Local authority with highest %	TEP 2015-16	Local authority with lowest %	TEP 2015-16

Leicester	53.0%	83,992	Surrey	9.5%	349,798
Bolton	49.5%	81,526	Wokingham	10.3%	48,948
Wandsworth	46.6%	66,104	Wakefield	11.4%	103,328
Ealing	45.7%	74,591	Croydon	11.8%	99,940
Newham	43.7%	62,961	Cornwall	13.3%	180,226
Tower Hamlets	42.2%	45,835	East Riding of Yorkshire	13.7%	115,410
Rochdale	42.1%	51,740	St. Helens	15.3%	55,659
Walsall	41.9%	50,947	South Tyneside	15.4%	46,654
Kingston upon Thames	41.7%	43,580	Doncaster	15.5%	91,758
Blackpool	41.2%	44,337	Plymouth	16.5%	72,680
Islington	40.3%	46,937	Bexley	17.0%	67,509
Stockport	39.6%	88,614	Bradford	17.0%	136,935
Thurrock	38.1%	38,138	Sunderland	17.1%	85,571
Hounslow	37.2%	59,788	Dorset	17.3%	126,991
Bury	36.8%	56,440	Somerset	17.5%	175,547

Overview of success factors from case studies

The following factors helped, fairly consistently, to generate effective outcomes in the successful case study areas:

- The strength of relationships with GPs, CCG and Local Medical Committees
- Funding and stakeholder support
- Delivery model including an emphasis on primary care, but also including third party providers
- Integrated software systems
- Support for 'less engaged' GPs e.g. delivering training to skill up delivery teams
- Dedicated admin staff using text and phone platforms with patients

"If we send an invite and some doesn't respond, we do 2 phone calls and a letter; there needs to be more follow-up if people don't respond. I think if GPs did that they would get more people through the programme."

"One of our practices does have a very high rate of health checks. They don't send invites; they just do texting."

- Targeted marketing campaigns with consistent branding

“We’re putting HC on our FB page and Twitter we have ads in reception and patient note alerts. Texts will have a respond/decline code included. We are going to discuss improving uptake at our next practice meeting.”

Strength of relationships

Consistency of personnel dealing with NHS Health Checks was clearly important; in higher-performing LAs, all these participants were clearly committed and knowledgeable, and had worked effectively on NHS Health Checks in their PCT before moving to LAs.

The strength of relationships with GPs, CCG and Local Medical Committees are crucial success factors. Where this factor was evident, there was evidence of:

- ongoing engagement and relationship building
 - This was achieved through face-to-face meetings with the commissioning team, strategic discussions in relation to administration, evaluation data and marketing opportunities
- ensuring engagement with GPs in more deprived areas of LA
 - This was achieved via face-to-face visits by the commissioning team, employing Outreach and working with community organisations to raise awareness/overcome barriers to engagement e.g. funding for equipment, attitudinal barriers in relation to HC and lack of outcome data, etc
- strong tie with the CCG
 - e.g. by making NHS HC part of the CCG quality contract with GPs, therefore addressing another part of the CCG’s agenda

In higher performing LAs, other key success factors included: integrated software systems to minimise data handling issues between GPs and third party providers; and clear evidence that NHS Health Checks professionals were working with GPs who are not meeting targets through training and support, communications and updates.

“When they think about software it’s essential to get integrated systems from the outset; then it’s easier to move data. They need to make sure the outreach can provide quality outreach rather than just numbers.”

“GPs are very important – we have 100% engagement from GPs but great variation in terms of how much they do.”

Funding and stakeholder support

Funding is clearly a critical success factor. For instance, one area was previously performing badly and had funding increased significantly in 2014; this had resulted in significant improvement in performance (however, all participants caveated this point - with cuts happening and more to come, NHS Health Checks performance will inevitably be affected).

“We have good councillors as advocates for NHS Health Checks but it’s all slowly dropping away. The LA is having to make so many cuts. They have to prioritise high need areas and NHS Health Checks doesn’t compete. And we don’t have enough evidence for NHS Health Checks to persuade the LA to allocate more resources.”

Good stakeholder support is also clearly an important success factor: from LA councillors, Directors of Public Health, CCG and LMC. Good support typically involved exchanging information/data, finding solutions to increase uptake or streamline local delivery, and help with promoting HC locally. There was some variation in the level of support from different bodies, and this was partly due to the ownership challenge in delivering an ‘NHS’ service under the auspices of LA public health.

“We report to LA on NHS Health Checks including the Health and Wellbeing Board but CCG is central. For other stakeholders, the word ‘NHS Health Checks’ is off-putting, and a problem of ownership for the LA.”

“The director of public health is on board and information is fed back from the health and wellbeing board. I think the CCG have slightly bigger fish to fry. Internally we have an agreement with our LA leisure services.”

Choice of model

A majority of participants prioritised primary care as the main delivery provider for NHS Health Checks, as this was seen to be the most effective route to achieving high numbers; although there was a recognition that any delivery model ideally needs other providers to successfully target ‘hard-to-reach’ audiences.

“If there is no capacity in primary care, then how do we work together if GP has the list to get the best outcomes? If I was starting again I would spend more time talking to primary care, raising the HC profile and getting primary care on board and getting some ownership of it.”

Some participants in this group had evolved to a mixed model due to a lack of GP support or the perceived gap in reaching hard to reach audiences who are often also high risk audiences; they were using pharmacies (with mixed results), workplace intervention (giving positive indications) and community outreach (this gave positive indications in terms of reaching the right audiences although there were concerns over numbers and value).

Overall, all successful LAs expressed real concerns about the future; the likelihood of maintaining/improving on performance was seen as very much in doubt, largely due to anticipated funding cuts and, for some, a perception that the NHS Health Checks had ‘run out of steam’.

“NHS Health Checks has got to a point where it might disappear unless we give it more momentum nationally; this is a crucial point.”

5.2 Case studies – more successful

Case study 6 Successful

Context	Strategic approach	Delivery
<ul style="list-style-type: none"> • Challenges: • Limited budget; • GP participation (not all GPs very 'active' with HCs); • Getting the right admin staff. • Success areas: • Very close to meeting targets; • Training with GPs + pharmacies about risk scores; • Getting patients to sign up for their HC. 	<ul style="list-style-type: none"> • Considered a 7 day service via pharmacies, piloted this but unsuccessful; • Use public health tools like MOSAIC to look at data and adopt a more targeted approach to their HC offer; • Linking to other initiatives e.g. flu jab marketing (get both done in one setting); • Texting and phoning patients using dedicated admin staff; • In GP surgeries there is an admin team available for following up patients, making contacts and sending out appointments 	<ul style="list-style-type: none"> • Better data evaluation which assesses impact by identifying whether referrals are a consequence of HC; • Money is a driver for GPs – “one practice was able to generate £30k with us paying £15 per HC”; • Pharmacy uptake = low, and most uptake a result of active marketing; • Traveling to people's places of work helps to improve uptake, however, this is expensive

Key learnings:

1. Linking to other initiatives has contributed to success, as has ongoing evaluation of effective vs less effective methods (using good data)
2. A focus on administrative efficiency has contributed to success

6

Case study 7 Successful

Context	Strategic approach	Delivery
<ul style="list-style-type: none"> • Challenges: • Public health budget cuts and “more cuts to come” • Increased data collection demands (many more data fields need to be completed, otherwise not paid) has been a test of relationships • Working with patients that can't see the benefit of a HC (GP helps to facilitate this) • Success areas: • Solid relationships with CCG + providers, which drives programme • PHE education/training support + comms templates useful resource • ‘Study days’ have helped to engage practices 	<ul style="list-style-type: none"> • Offer rates 20% target; take up rates 60%, but intelligence needed to see who is coming and if targeting people that need HC • Close relationship with CCG which helps to access GPs • Use CCG lead nurse's connections with GP clinical staff and practice managers to drive HC programme • Refreshed local specification to align with recent national guidance • Set up a number of ‘study days’ to help providers with updated spec and updates • Marketing exercises were undertaken to tackle the demographic challenge e.g. adverts on buses 	<ul style="list-style-type: none"> • GPs very important. 100% engagement but great variation – some see 100s of patients, others do as little as possible • GP variation driven by lack of capacity or lack of buy in (i.e. doesn't generate enough money) • Piloted a different way of sending invitations i.e. postcards instead of letters in envelopes “people are more likely to read a postcard than open a letter” • New data provider has a web based tool for practices to access information on how many patients have been invited in a month. <u>This also helps to target higher risk patients</u>

Key learnings:

1. Building on positive relationships, communications and proactive engagement with providers (especially GPs) provides a sound foundation
2. Use audits to assess model and whether other providers are needed

7

Case study 8 Successful

Context	Strategic approach	Delivery
<ul style="list-style-type: none"> • Challenges: • Offer rate 22% and 55% uptake, but expected to drop due to budget cuts • LA see potential savings from HC, since HC viewed as an ‘NHS thing’ rather than social care, so less of a priority than other frontline services • Of 79 GP practices 50% want to scrap HC due to perceived lack of evidence base • Success areas: • Have engaged GPs in high-risk communities and low performing surgeries. • Have also engaged outreach provider, which accounts for 10% of figures 	<ul style="list-style-type: none"> • In next 2 years, will be offering HC to more high-risk parts of population • Have a comms team and use their publications to market HC – also link with smoking/drinking messages • Held a large campaign on 200 buses which impacted well on response rates 	<ul style="list-style-type: none"> • Conflict between GPs + pharmacies on data sharing, so unable to use pharmacies for delivery • One organisation working directly with Somali community – holding events. Outreach provider utilises events • Follow up data needed, rather than uptake numbers only – would help to measure outcomes and provide crucial evidence base

Key learning:

1. Targeted approach has engaged key GP providers and outreach has helped to boost figures among key/high risk audiences

8

Case study 9 Successful

Context	Strategic approach	Delivery
<ul style="list-style-type: none"> • Challenges: • Working with patients that can't see the benefit of a HC (GP helps to facilitate this) • LA engagement with HC programme reportedly "low" • Success areas: • Strong local branding of HCs (alongside NHS branding) • Getting all 50 GP practices on board – this means figures are available across the whole area for comparability • Data presents good uptake in both affluent and less-affluent areas • PHE website very helpful for uploading and comparing data with other areas 	<ul style="list-style-type: none"> • Developed HC programme in 2009 – combined local programme with national NHS programme • All 50 practices involved in the programme • Constantly updating skills of HC delivery staff with training • Strong branding developed pre-LA, well recognised in local area and boosts uptake of HC 	<ul style="list-style-type: none"> • 82% target for check completion • Skilling up delivery teams has boosted engagement in HCs and increased uptake figures • Calling and texting patients instead of sending letters

Key learnings:

1. Has learnt what is required in order to encourage GPs to deliver HCs – without a good relationship it is very hard to engage practices

9

Case study 10 Successful

Context	Strategic approach	Delivery
<ul style="list-style-type: none"> • Challenges: • Main providers are sceptical about HC; without their buy in its hard to succeed. • GPs are not entering data into the system or following up; • GPs don't want other providers, because they want the income, but don't actually believe in HC; • Difficulty getting a good outreach company to raise awareness in the community and get high risk people to attend (they are all commercial companies). • Success areas: • Pharmacy HCs = good quality, but low take up means poor VFM 	<ul style="list-style-type: none"> • Employed a project manager to link with GPs and get them on board; <i>"this will improve the quality of HC if it gets GPs on board"</i> • Steering group in place with a large number of people from GP practices – however, lack HC 'champions' in primary care; <i>"there's no drive for following up and interventions"</i> • Hard to get stakeholders on board and outreach in wider areas has been 'disappointing' 	<ul style="list-style-type: none"> • All 5 GP surgeries in area take part; two pharmacies (down from 6); no outreach programmes this or next year. • Over 70% uptake; it's the uptake from deprived areas that proves difficult as the invitations often get ignored in these areas

Key learnings:

1. Commercial companies can tend to go for numbers vs targeted approach
2. Difficult to effectively target deprived areas and high risk groups
3. Also difficult to combat scepticism regarding HCs

10

5.3 Deep dive: barriers to implementation common to less successful LAs

Overview of challenges from case studies

- Problems associated with the transition to LA
- Funding issues
- Poor GP engagement, and a consequent reliance on other providers to achieve take-up
- Poor relationships with CCGs
- Contractual issues

Transition to LA

The transition to LA control has been very challenging, affecting development of the programme. In many cases LAs are perceived as sceptical about public health's role in local government.

“At the beginning, 2013, we had to work very hard within the LA because they were very sceptical about public health.”

Previously, the PCT had typically been managing invites directly in partnership with primary care, and the transition had a significant impact on the invitation programme. Some reported challenges in terms of taking over the invite section of the programme.

“The current uptake is low because of low number of invites, we don't have a systematic programme of calling people in, and having to work with individual practices is very time consuming.”

“We did not get that involved in the programme in the PCT, specifically the logistics, so it was a steep learning curve.”

Funding

Funding and cutbacks have clearly led to a loss of public health resources, as well as a decline in focus and support for NHS Health Checks. This has also created an additional challenge of lack of continuity, as cuts impact on personnel and departmental relationships.

“We’ve had cuts to public health funds and the LA has a challenge of saving £100 million pounds.”

Half of the public health team has disappeared and we’ve lost continuity just as we were starting to work together.”

Provider issues

Poor GP engagement was seen as a significant factor in poorer NHS Health Checks performance. A lack of goodwill and/or scepticism on the part of many GPs was perceived as an issue before 2013, and has hardened even further with budget cuts. In addition, many GPs are unhappy with the incentive offered, and may look for more lucrative work streams.

“NHS Health Checks are worth £20 a shot. Even big practices are going to get only 10 or 12 thousand pounds out of it. The quality contract for some practices is worth nearly a hundred thousand pounds. I can’t compete with that.”

In some areas, there is simply a physical lack of GPs or other healthcare professional to undertake the test. Consequently, some NHS Health Checks commissioners are having to rely largely on other providers to achieve the required take-up of the eligible population, which can be problematic. The opportunistic approach through

pharmacies has had very mixed results (without invitations directing people to the pharmacy, a poor footfall has been achieved).

However, there has been more success in the use of outreach professionals. Outreach providers are typically effective at reaching specific audiences (e.g. ethnic minority communities or outdoor workers in rural areas).

CCG issues

In poorer performing LAs, the team relationship with its CCG was often not as strong. CCGs were perceived as having little interest in, or being sceptical about NHS Health Checks. Additionally, it was felt that the incentive provided for the NHS Health Checks programme is regularly weighed up by CCGs against other opportunities.

“They have bigger fish to fry.”

Many felt that public health does not seem to be ‘part of the loop’ (for CCGs in particular); consequently there is a lack of opportunity to engage and advocate for NHS Health Checks. However, some felt that persevering in relationship building with CCGs could produce results.

“Currently we are doing more work with the CCG, the CCG wanted to focus on their priorities and were not receptive to NHS Health Checks initially.”

One CCG had set up quality contracts with GPs which included different types of NHS Health Checks for over 75s which essentially impacted on GP focus on NHS Health Checks.

“The CCG decided to implement the quality contract, which included a type of Health Check for over 75 year olds – it was expensive and took an hour for the practice to do it. The CCG insisted that practices invite over 50% of the patients

in year one and 50% in year two – which meant that the NHS Health Checks programme has taken a big hit in primary care.”

Contractual issues

In poorer performing LAs, setting up new contracts and procurement protocols seems to be taking a considerable amount of time to get up and running.

“We went out with procurement to an IT provider to get the robust information from primary care. It took until the beginning of this year to get the procurement done.”

One LA team had moved from a Health Check Plus programme (which included a number of other assessments for mental health, cancer, respiratory and men’s health, and an appointment of 45 minutes, which was considered unsustainable).

“So we had a review and moved to CVD assessment using NHS Health Checks guidance. This required a change in contract specification for GPs and other providers which has taken time to bed in with impact on activity. We spent a lot of time in 2013/14 implementing the new NHS Health Checks.”

Overall, despite the many challenges, however, many thought they were performing well given the circumstances and were hopeful of achieving better performance in the future.

“We’re working on a collaborative GP contract which should significantly improve our invitation programme.”

“I have spent a lot of my time on promoting NHS Health Checks, so it’s beginning to change. I think I’ll see a change in our data half way through the year as a result.”

“I’m in meetings now with the CCG and I have a number of GPs who did not previously support NHS Health Checks working on it.”

“The CCG is reviewing the quality contract and it looks like they will include NHS Health Checks as part of the new contract.”

5.3 Case studies – less successful areas

Case study 1 Unsuccessful

Context	Strategic approach	Delivery
<ul style="list-style-type: none"> Challenges: Change of culture to LA (commissioning + procurement now less flexible); Limited funding in general; Challenge of where to send patients once checked; Inability to measure <u>outcomes</u>. Success areas: Mixed group of providers who work well together (e.g. health trainers + leisure services). 	<ul style="list-style-type: none"> Health trainers working in deprived areas, within workplaces and local gyms, targeting manual labourers; 3 large pharmacy chains on board, some situated in deprived areas; Leaflets used to promote HC – and starting a campaign which uses additional marketing materials – providers to use same branding for consistency; Leaflets to promote HC at events – and will be using PHE campaign material provided on the website (formalised branding across region) 	<ul style="list-style-type: none"> Only have 4/53 GP practices delivering HCs in the area Were sending letters to 40-45; 50-55; 60-65 year olds, as well as opportunistic invitations; However, GPs don't feel HC is sufficiently incentivised Crucially, contract for sending letters has ended, therefore HCs are only being carried out opportunistically at present; Offer rates and subsequent take up has being "going down significantly".

Key learnings:

1. Even within a mix of providers, need a good number of GPs involved
2. Opportunistic invitations are not sufficient to maintain up take
3. Maintaining contracts critical to success

1

Case study 2 Unsuccessful

Context	Strategic approach	Delivery
<ul style="list-style-type: none"> Challenges: Budget cuts (nearly £1.5 million); Low GP capacity / engagement therefore poor access to GP lists; HC not prioritised (HC evidence base also questioned) Success areas: Targeted approach reaching high-risk audiences; Voucher incentive to attend HC (distributed via agencies working with vulnerable communities e.g. after Xmas for New Year's resolutions) 	<ul style="list-style-type: none"> Providers include: GPs; Small outreach provider to capture hard-to-reach (farmers + fishermen); Mobile team for workplaces + other venues; HC steering group has "fallen by wayside" Also have pharmacy provider, which has the Living Well agenda and looking to forge more links with GPs 	<ul style="list-style-type: none"> Mostly GP providers with some pharmacy However, take up rate below 50% (annual offer rate = 20%) due to lack of GP engagement GPs stating "if paid more will do more" and "capacity is main barrier" Trying to establish a universal offer, but in a targeted way – difficult with the budget cuts

Key learnings:

1. Once again, GP involvement essential to support a mixed provider approach, not only in terms of delivering HCs, but also in terms of sharing data
2. Budget cuts have increased the implementation challenges

2

Case study 3

Unsuccessful

Context	Strategic approach	Delivery
<ul style="list-style-type: none"> • Challenges: • Logistical i.e. setting up providers, accessing the right equipment, training people to deliver HCs; • Devising a clear specification; • Budget being reviewed; • Marketing to providers. • Success areas: • Rapid implementation and increasing take up numbers; • Good relationships + communication across providers. 	<ul style="list-style-type: none"> • Mixed group of providers: GPs, pharmacists, outreach team • Comms team provide promotional support • LA supports CCGs to address prevention + protection agenda • Outreach programme: approaching large employers. Also reaching companies, schools + colleges that are close to leisure centre (where all activities are run) 	<ul style="list-style-type: none"> • In GP settings HCA's complete HCs • Community pharmacists also complete HCs (booked/ opportunistic) • Outreach team for targeted populations • Competency framework challenging to implement across providers • Trying to boost numbers without targeting HCs populations

Key learnings:

1. HCs challenging logistically for those starting out e.g. getting providers set up, ready and helping them to understand the programme
2. Mixed model approach needs to be targeted to relevant HCs populations
3. Strategic planning is required from the start i.e. when setting up range of providers, comms planning and developing outreach programme

3

Case study 4

Unsuccessful

Context	Strategic approach	Delivery
<ul style="list-style-type: none"> • Challenges: LA were 'sceptical' about public health, needed time to adjust and to recognise where HC would 'fit'; • Take up and response to invitation letter = low; • Difficult to measure outcomes. • Success areas: experience is that face-to-face workplace HC have been more successful than sending letters 	<ul style="list-style-type: none"> • CCG decided to implement their quality contract which was 'expensive' and 'time consuming'; • Visited practices to understand what was going wrong – streamlined their payments + IT systems to systematically call and recall patients, but "still not working"; • Starting to text patients with a respond/decline code included; • Also offering cancer HCs and looking to expand capacity by doing more outreach work; • Community provider conducted leaflet drops which had some impact – try to link to existing events to boost numbers. 	<ul style="list-style-type: none"> • £2 for invite, £18 for completion (therefore completion = essential); • Writing to all practices about improvement plan - 5/36 have delivered HCs; • Trying to get hard-to-reach groups in deprived areas to take up HCs'; • Community providers don't have access to patient data so evaluation difficult to conduct.

Key learnings:

1. Even within a mix of providers, need a good number of GPs involved, not only in terms of delivering HCs, but also in terms of sharing data
2. Contract changes can affect development of HC implementation e.g. CCG implemented quality contract to include HCs for 75 year olds

4

Case study 5 Unsuccessful

Context	Strategic approach	Delivery
<ul style="list-style-type: none"> • Challenges: • Local council trying to save £100 million – subsequent cuts to public health funding; • Opportunistic invitations = hard to control the number of people coming in and GPs are not prepared to buy point-of-care testing equipment if numbers are low • 61 GP practices in local area • Success areas: • Outreach programme working very well; • Increasing number of providers; • Data model facilitated data capture: data sent back from external HCs provider to GP practice as an electronic message 	<ul style="list-style-type: none"> • Have not yet agreed on the contracting framework for invitations; • Looking at commissioning a GP collaborative to deliver HCs (could send invitations to the whole Borough including on behalf of less engaged GPs) • Primary care champion needed: HCs still happening, but <i>“have lost strategic direction”</i> • Targeting people from high-risk groups (stroke, hypertension, diabetes) and considering reducing age from 35 to 30 	<ul style="list-style-type: none"> • Initially only had 22 GP practices and pharmacies, now have 37 including a community outreach provider (targeting specific groups); • 25% uptake and increasing, but invitation levels have not increased; • Since moving to the LA, activity in pharmacies has decreased: <i>“The pharmacies are not that engaged because they don’t have enough people at the door pitch up for HCs and spending money for the point of care machines.”</i> • Need a systematic programme of calling people in for HCs

Key learnings:

1. A robust invitation programme is essential e.g. GP collaborative could send invitations on behalf of nearly all practices in area (including less engaged)
2. A degree of HCs ‘traffic’ is required for providers to invest in equipment;
3. Require planning on a strategic level i.e. collaborative and targeted approach

5

6. MAIN FINDINGS – THE FUTURE

A range of future priorities for PHE and local authorities emerged as consistent themes in the feedback from all participants. These suggested priorities closely reflect the concerns and challenges reported by participants in this phase of the research.

- Evidence and national leadership: a majority focussed on the continued need for evidence to enhance engagement, make a convincing case for support to LAs and GPs and assist implementation through studies on models that increase uptake.

- Adopt a strong system leader role at the highest level: PHE, NHS England, Local Government Association, CCGs, Local Medical Committees, Royal College of GPs, Directors of Public Health.
- Ensure that funding is secured for the NHS Health Checks programme going forward and that funding is ring-fenced or dedicated for the delivery of NHS Health Checks. For example:
 - by encouraging local leadership to ‘buy in’ the HC programme
 - by preserving existing funding by promoting HCs alongside other campaigns
- PHE Support: PHE should continue to support commissioners through regional networks, PHE centre leads’, national conference and updates (case studies, webinars and training).
- Consider the focus of evaluation and indicators of success; it may be beneficial to change focus from uptake to outcomes (such as the number of attendees diagnosed with diabetes) and the quality of interventions offered and evaluated.
- Data management: PHE should provide clear direction on the existing information guidance issues. Provide examples on data sharing best practice, and indicate how providers can work collaboratively and share data.
- Consistency in data capture: PHE should provide clarity and consistency on data recording; for instance, record uptake as a percentage of those eligible and not as a percentage of those invited. Local authorities should follow this through, by ensuring that data consistency recommendations are followed up by providers.

- PHE should provide leadership on GP engagement; for instance, PHE could work to make NHS Health Checks mandatory for GPs by persuading national leadership to include them in the Quality Outcomes Framework. Local authorities must be willing to commit themselves to face-to-face interaction with their providers, especially GPs.
- Marketing to the public: there were calls for a national campaign to increase public understanding of NHS Health Checks; it was also felt that this would help to convince GPs and LAs that it is a priority. Local authorities must ensure that there is consistency in the marketing style adopted by all that promote HCs at a local level.

7. SUMMARY AND CONCLUSIONS

The realities of working within LAs have been challenging (as was expected in the 2013 research): different systems, data governance, procurement and style of working have all impacted on participants. The LA culture has been a big change, with commissioners having to present a business case for NHS Health Checks. Some commissioners clearly have adapted and engaged with the challenges of this new environment, while others have not been so effective or comfortable.

The future of the NHS Health Checks programme was clearly a concern to many participants; many, besides worrying about budget cuts, are also thinking about the future role of NHS Health Checks. Some are wondering whether NHS Health Checks is just a medical testing programme for the worried well. Others are beginning to question the outcome value of the NHS Health Checks programme, particularly without intervention and follow up by GPs and other healthcare professionals.

There was a consistent and important perception (this was found across the sample) that the future of the NHS Health Checks programme was not assured, given the budgetary pressures faced by local government and the potential for NHS Health Checks funding to be diverted elsewhere. This sense that the NHS Health Checks

programme might be imminently discontinued or downgraded was clearly affecting the commitment and determination of some involved with NHS Health Checks.

As indicated by previous research, PHE's role is clearly vital and perhaps even more so at this time. PHE is recognised for being enthusiastic, passionate and motivated about NHS Health Checks. Many respondents were keen to see 'much needed leadership' from PHE in taking on LAs and GPs in relation to their perceived resistance to making the NHS Health Checks programme effective. Some commissioners were now openly hostile to GPs and wanted strong action in relation to recalcitrant GPs, especially those reluctant to give patient lists. Commissioners recognised that GPs increasingly lack resources, but also saw budgets as an issue for GP engagement.

Commissioners were also concerned that the mandate is not strong enough to keep LAs engaged other than at a basic level. Also, the NHS Health Checks budget is not ring fenced and many saw a danger of it being diverted to other public health programmes, which might be considered a greater priority for some LAs.

"What's to stop my council just doing an advert with no real effort, and they'd have fulfilled their mandate?"

Localism is presenting challenges and is seen by some to be leading to a very fragmented picture for NHS Health Checks, with some wondering whether there is actually scope for a national programme. Commissioners pointed out that some LAs are still not sure what public health has to do with them.

There was, however, consistency around the perceived success factors for implementation of the NHS Health Checks programme. The most important factor of all was perceived to be funding: both in terms of the availability of central funding (seen as impossible to guarantee going forward) and local government/CCG prioritisation of the NHS Health Checks programme (which was clearly variable). Evidence was seen as a critical component in creating a business case for NHS Health

Checks and protecting the programme as a priority. Strong support from important stakeholders such as LAs was seen as vital for successful implementation.

Another important success factor was engagement amongst key provider groups (GPs in particular), which was felt to be linked to a proactive approach in tackling barriers to participation. This was mainly seen as a challenge in relation to GPs, who were seen as both cynical about the value of NHS Health Checks and as inclined to claim lack of capacity, even where remuneration seemed more likely to be a key factor. This is linked to the perception that an effective relationship with primary care was essential for the successful implementation of the NHS Health Checks programme.

Effective methods for communicating the purpose and benefits of the NHS Health Checks programme to local at-risk populations (preferably in some targeted manner), was also seen as crucial to success. There was an ongoing call for national advertising and campaign templates for local activity. It was seen as important to educate the public about NHS Health Checks and create some level of demand from the user base.

“NHS Health Checks is not a well-understood programme, which makes it harder to sell to patients, GPs and LAs.”

Data collection, quality of data, software set up and evidence of positive outcomes were all seen as vital components in making NHS Health Checks work, as well as in establishing a process of evaluation to support the future role of NHS Health Checks.

“We need to collect and collate meaningful outcomes data, not just number of invites and checks carried out – that’s just activity, not impact.”

Population profile, needs and types of services, as well as a definition of good outcomes, were also seen as growing in importance. Commissioners are becoming more experienced with providers and are now more focussed on targeting the most at-risk population groups. Many are building a knowledge base of what works and what does not.

Research Report Appendices

APPENDIX A

NHS Health Checks: Review 2015/2016 Qualitative Online Feedback Form

Between January and May 2013, PHE conducted a review of the lessons learned about the implementation of the NHS Health Checks programme. The implementation review and action plan summary identified **ten key areas which would be the focus of PHE's support**.

Public Health England (PHE) is now undertaking a review of the progress made against the 2013 Implementation Review Action Plan. The aim of this work is to understand how the actions PHE have taken so far have supported the local delivery of the NHS Health Check programme.

PHE has commissioned Research Works Limited, an independent market research agency, to conduct the review.

We invite you to contribute to this review by sharing your valuable feedback and experiences through this short online form. The deadline for completing the form is January 15th 2016.

In addition, we will be conducting follow up in-depth qualitative interviews with a range of stakeholders. You may be contacted by Research Works and asked to participate in an interview (either by telephone or face-to-face) during November or December.

Your views, whether expressed via the online feedback or via a face-to-face or telephone interview, will remain confidential (as stipulated by the Market Research Society Code of Conduct¹).

If you have any questions about the review, please do not hesitate to call either Katherine Thompson at PHE 0207654 8305/Katherine.thompson@phe.gov.uk, or Amy Smith at Research Works Limited 01727 893159/ all@researchworks.co.uk.

Q1 Please review table 1.

Have these actions supported you to implement NHS Health Checks locally?

If yes, how?

¹ https://www.mrs.org.uk/standards/code_of_conduct/

If not, why not?

Q2 What are the main three challenges when implementing NHS Health Checks in your local area in future?

1. _____

2. _____

3. _____

Q3. What do you see as the potential solutions to each of these challenges in your local area?

Q4 In future, what should PHE prioritise in terms of supporting LAs to implement the programme?

Please note that these questions are for analysis purposes ONLY and will remain confidential

Q5 What is your role?

- Commissioner
Provider
Other

Q6 Which local authority areas do you work in?

Table 1 a summary of the action plan recommendations and actions undertaken by PHE

	Recommendation	Action taken by PHE
1	Establish collaborative	<ul style="list-style-type: none">The National Advisory Committee was established in 2014. It

	national leadership	meets twice a year and includes director or chief executive representation from NHS England, NHS Improving Quality (NHS IQ), Department of Health (DH), Local Government Association and others
2	Test the impact of behavioural insight and marketing interventions	<ul style="list-style-type: none"> • Established a directory of NHS Health Check services across England on NHS Choices • Published new branding and updated the patient information leaflets • Established a behavioural insight network to share learning • Delivered webinars on social marketing, social media and on the findings of behavioural insight studies. • Shared the findings of trials testing different invite and have changed the national letter template. • Funded two behavioural insight studies due to report at the end of 2015 and 2016
3	Support the provision of the NHS Health Check	<ul style="list-style-type: none"> • Worked with NHS IQ to produce a series of case studies on delivery models that aim to engage people at high risk of CVD or individuals that don't use primary care • Worked with the Centre for Public Scrutiny to publish guidance and case studies on how to get the most from the scrutiny process
4	Support information governance	<ul style="list-style-type: none"> • Published guidance on information governance and data flows
5	Support delivery	<ul style="list-style-type: none"> • The local implementer national forum, which has local representation from every PHE centre area, has met quarterly. The group has identified issues such as the quality assuring of POCT, incident reporting and equality impact assessments that have informed PHE's national programme of work • PHE published the NHS Health Check programme standards in 2014. • PHE have developed the Systematic Approach to Raising Standards (StARS) framework which is currently being used by 24 areas to support improvements in delivery
6	Programme governance	<ul style="list-style-type: none"> • Expert Scientific and Clinical Advisory Panel (ESCAP) was established in 2014. It meets four times a year, is chaired by PHE's chief knowledge officer and its membership includes academics and national clinical directors • ESCAP have responded to emerging issues by publishing responses to editorials and scientific papers in the BMJ, Journal of Public Health and newspapers where relevant • ESCAP published, in consultation with a wide range of stakeholders, the NHS Health Check priorities for research
7	Provider competency	<ul style="list-style-type: none"> • PHE published a NHS Health Check competence framework in 2015

		<ul style="list-style-type: none"> • PHE published learner and assessor competence framework workbooks • PHE delivered introductory training to the competence framework across 14 PHE centres in England
8	Consistency	<ul style="list-style-type: none"> • PHE published an update to the best practice guidance in 2015 • PHE has been sharing best practice on a range of topics through a regular programme of webinars • Publish the NHS Health Check data on PHOF so that local areas can see how they are doing compared to similar areas
9	Proving the case	<ul style="list-style-type: none"> • In 2015 PHE published the NHS Health Check priorities for research • Disseminated the findings of the first national research study published in 2015
10	Expected roll-out	<ul style="list-style-type: none"> • Delivered an annual conference to highlight good practice and share learning • Have provided expert advice in response to local questions and queries and have attended centre network meetings across England • Facilitated NHS Health Check networks

APPENDIX B

NHS Health Checks Review 2015 'Stocktake' qualitative topic guide

Research Objectives for the 'stocktake' of the NHS Health Check Implementation review and Action Plan (July 2013)

The requirement is to conduct a 'stocktake' by replicating a qualitative review exercise conducted by RWL in late 2012/early 2013. The aims are to:

- Identify where PHE is in terms of supporting LA implementation;
- Determine if LAs feel that PHE has responded to the 10 action points;
- Understand emerging issues from a LA point of view;
- Shape PHEs future work priorities in supporting LAs with the implementation of the programme.

1. Introductions and explanations (5 minutes)

- Introduce self and Research Works Limited, an independent market research agency
- Just to re-confirm the purpose of this study: *to discuss how LAs feel PHE has supported implementation, specifically looking at their 10 point plan and understand emerging issues which will help PHEs future work priorities and support*
- Ask permission to record interview - explain confidentiality requirements (DPA and MRS code of conduct).

2. Respondent Background (5 minutes)

- What is your current role and area of responsibility?

- How long have you been in post?
- Discuss specific involvement in, and responsibility for, NHS Health Checks
- How long have you had responsibility for NHS Health Checks? Who else is involved?
- Discuss their LA public health focus; challenges and an overview of their future plans.

3. Key learning from implementing NHS Health Checks (10 minutes)

- Broadly outline experiences with NHS Health Checks – having implemented NHS Health Checks for X years, what have been your overall experiences? What have been key learnings? Why are they important?
- If a Local Authority was starting out on delivering the programme what would be your top three tips?
- What methods of evaluation, if any, have you used? What have you learnt from evaluating your programme? How has evaluation shape the way the programme is delivered?
- What have been specific areas of success? *Probe: what factors contributed to this success? Ask respondent to provide specific detail/examples of what success is for their local authority. What has helped increase uptake?*
- What have been specific areas of challenge(s)? *Probe: what factors contributed to the challenge(s)? Ask respondent to provide specific detail/examples of what are challenges for their local authority. What has hindered uptake?*
- What solutions were (or could be) undertaken in order to overcome these challenges?

4. Views on PHE action plan (30 minutes)

- What sources of guidance and support have you accessed to help inform local delivery of the NHS Health Check programme? *Discuss: which more/less helpful and why?*

- Respondents will be pre-placed with the summary of the PHE action plan.
Moderator for explanation: Between January and May 2013, PHE conducted a review of the lessons learned about the implementation of the NHS Health Checks programme. The implementation review and action plan summary identified ten key areas which would be the focus of PHE's support.
- Discuss whether aware of any of these PHE actions taken to support delivery of NHS Health Checks?
- To what extent have these actions supported you to implement NHS Health Checks locally?
- **Review each point/actions and discuss:**
 - Awareness of this action
 - Perceived usefulness of this action
 - Whether this action has been of value to their implementation approach
 - If yes, why?
 - If not, why not?

5. Future challenges (5 minutes)

- What do you see as key challenges for the future? Why do you say that?
- What do you see as potential solutions to these challenges? Why do you say that?
- What are future plans for NHS Health Checks? *Probe: rationale for these plans, any concerns, what support would/could help in implementing these plans?*

6. Thinking of future support from PHE (5 minutes)

- What do you see as new or emerging issues where support from PHE would be beneficial?
- Discuss how PHE could best support on each of the issues raised?

APPENDIX C

NHS Health Checks Review 2015 'Deep Dive' qualitative topic guide Follow-up interview with provider or stakeholder

Introductions and explanations

- Introduce self and Research Works Limited, an independent market research agency
- Just to re-confirm the purpose of this study: *PHE are proceeding with a programme of work to help local authorities understand the factors that do or don't support increases in the uptake of NHS Health Checks. As part of this PHE are undertaking this qualitative work to explore and identify factors that will maximise, or limit, the programme's reach and impact.*
- Ask permission to record interview - explain confidentiality requirements (DPA and MRS code of conduct).

Respondent Background

- Discuss organisation and role: Outline detail of your organisation and your current role and area of responsibility?
- Discuss specific involvement in, and area of responsibility for NHS Health Checks?
Note if a frontline provider or stakeholder
- How long have you been involved with NHS Health Checks? Who else is involved?

Update on experiences implementing NHS Health Checks

Summarise experiences and progress to date with implementing the programme:

The questions will be amended for stakeholder organisations whose role may not be frontline delivery

- How do you approach the implementation of NHS Health Checks? Probe in detail: what commissioned to do and how they do it?

- Broadly outline experiences with NHS Health Checks – what have been your overall experiences working on the NHS Health Checks programme? What have been key learnings? Why are they important?
- What have been specific areas of success? Probe: what factors contributed to this success? Ask respondent to provide specific detail/examples of what success is for their local authority
- What have been specific areas of challenge(s)? Probe: what factors contributed to the challenge(s)? Ask respondent to provide specific detail/examples of what are challenges for their local authority
- What solutions were (or could be) undertaken in order to overcome these challenges?
- What do you see as key challenges for the future? Why do you say that?
- What do you see as potential solutions to these challenges? Why do you say that?
- What are future plans for NHS Health Checks? Probe: rationale for these plans, any concerns, what support would/could help in implementing these plans?

Thinking of future support from your Local Authority and PHE

- What do you see as new or emerging issues where support would be beneficial?
- Discuss how best support on each of the issues raised?

Sum up

- Summarise key points/thoughts from the discussion
- Any other thoughts or suggestions to help improve implementation of NHS Health Checks going forward?
- Any specific comments or feedback for PHE regarding NHS Health Checks which have not been covered?

APPENDIX D

NHS Health Checks Review 2015

'Deep Dive' qualitative topic guide

Initial interview with Local Authority contact who received email invitation

7. Introductions and explanations

- Introduce self and Research Works Limited, an independent market research agency
- Just to re-confirm the purpose of this study:
 - *PHE are proceeding with a programme of work to help local authorities understand the factors that do or do not support uptake of NHS Health Checks.*
 - *As part of this programme of work, PHE are undertaking this qualitative work to explore and identify factors that will maximise, or limit, the programme's reach and impact e.g developing top tips guide to share across England and presenting findings at the NHS Health Check conference on March 1st*
- Ask permission to record interview - explain confidentiality requirements (DPA and MRS code of conduct).

8. Respondent Background

- What is your current role and area of responsibility?
- How long have you been in post?
- Discuss specific involvement in, and responsibility for, NHS Health Checks
- How long have you had responsibility for NHS Health Checks? Who else is involved?
- Discuss their LA public health focus; challenges and an overview of their future plans.

9. Update on experience of implementing NHS Health Checks

Summarise experiences and progress to date with implementing the programme:

- How long have NHS Health Checks been offered in this area? Include length of
- time PCTs may have been involved in the delivery before transition to local authority
- How are NHS Health Checks delivered in your area?
- **Delivery** who is involved in the implementation of NHS Health Checks in your local authority – delivery and support for NHS Health Checks? *Probe: frontline providers (discuss who and range of different providers)*
 - Why do you think these providers got involved with the programme?
 - What role do you think funding has played in encouraging providers to engage with the programme?
 - What have you done to try to increase the proportion of the eligible population having a check?
 - Have you used communications and marketing to raise awareness of the programme? If so, what and how? Has it been beneficial?
 - Have you considered or taking a targeted approach to try to reach the people with highest risk of CVD? What was your thinking behind this? What was your experience in implementing this.
- **Strategic approach:** other stakeholders/organisations (e.g CCG, Health and Wellbeing Board, Director of Public Health)
 - Which stakeholders have been on board and supportive? Why?
 - What role have they played? How challenging have they been to engage? Why is that?
 - What do you thinking puts stakeholders off getting involved with the programme?
- Why do you think given your offer rates are X that your take up is Y?? What key areas do you feel you need to prioritise in the delivery of the programme?

10. Key learning from implementing NHS Health Checks

- Broadly outline experiences with NHS Health Checks – having implemented NHS Health Checks for X years, what have been your overall experiences? What have been key learnings? Why are they important?
- What have been specific areas of success? *Probe: what factors contributed to this success? Ask respondent to provide specific detail/examples of what success is for their local authority What has helped increase uptake?*
- What methods of evaluation, if any, have you used? What have you learnt from evaluating your programme? How has evaluation shape the way the programme is delivered?
- If a Local Authority was starting out on delivering the programme what would be your top three tips?
- What have been specific areas of challenge(s)? *Probe: what factors contributed to the challenge(s)? Ask respondent to provide specific detail/examples of what are challenges for their local authority What has hindered uptake?*
- What solutions were (or could be) undertaken in order to overcome these challenges?

11. Future challenges

- What do you see as key challenges for the future? Why do you say that?
- What do you see as potential solutions to these challenges? Why do you say that?
- What are future plans for NHS Health Checks? *Probe: rationale for these plans, any concerns, what support would/could help in implementing these plans?*

12. Views on PHE action plan

- What sources of guidance and support have you accessed to help inform local delivery of the NHS Health Check programme? *Discuss: which more/less helpful and why?*
- *We suggest preplacing respondents with the summary of the PHE action plan. Moderator for explanation: Between January and May 2013, PHE conducted a review of the lessons learned about the implementation of the NHS Health Checks programme. The implementation review and action plan summary identified ten key areas which would be the focus of PHE's support.*

- Discuss whether aware of any of these PHE actions taken to support delivery of NHS Health Checks?
- To what extent have these actions supported you to implement NHS Health Checks locally?
- Review each point/actions and discuss:
 - Awareness, has PHE delivered
 - usefulness of this action
 - value to their implementation approach

13. Thinking of future support from PHE

- What do you see as new or emerging issues where support from PHE would be beneficial?
- Discuss how PHE could best support on each of the issues raised?

14. Sum up

- Summarise key points/thoughts from the discussion
- Any other thoughts or suggestions as to how PHE can support the successful implementation of NHS Health Checks going forward?
- Any specific comments or feedback for PHE regarding NHS Health Checks which have not been covered?

- *Following on from this interview we are aiming to interview other parties involved in the delivery of NHS Health Checks in your area, such as providers and stakeholders.*
- *We would like to gather their views as part of this research as well. Would you be able to supply contacts we could interview?*
- *PHE would like to generate more in-depth case studies that highlight different themes i.e GP engagement, marketing, strategic leadership. We would need your permission to become a named local authority case study area purely for PHE internal strategic planning. In addition, generalisable learning from the case studies would be part of feedback at the 1st March conference. Your case study would be published with other case studies undertaken by PHE on the NHS Health Check website.*
- *Agree next steps.*