

# **Learning from Salford's NHS Health Check Improvement Journey: A document review**

**Part A – Executive Summary**

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## **Introduction**

The National Health Service (NHS) Health Check (HC) programme began in 2009 and is aimed at preventing cardiovascular disease (CVD) through early identification and management of risk factors, or early detection of disease. Since April 2013, the programme has been the responsibility of Local Authorities<sup>1</sup>, and it is a legal requirement to ensure that systems are put in place to correctly identify the eligible population and offer this population HCs within a five-year period.

In Salford total CVD mortality rates are higher when compared to the National average, and to Greater Manchester, Lancashire and South Cumbria Clinical Network as a whole. At the same time, modifiable, lifestyle-related behaviours such as diet and smoking are estimated to be worse in Salford compared to the England average, with higher rates of obesity reported, although alcohol consumption is not significantly different.

In 2013 a collaborative was formed between many of the stakeholders involved in the NHS HC collaboration (Salford CCG, Salford City Council, Salford Royal Foundation Trust, and the University of Salford). At the same time Haelo was commissioned by the Salford City Council Public Health Team to lead projects around improving HC uptake in Salford. The aim of the collaborative was to improve the uptake of HCs from 30% to 75% by the end of the commissioned period. The aim was to do this through involving a number GP practices to work intensively with Haelo to support them with achieving greater uptake in HCs, alongside involving a number of community stakeholders to help raise awareness of HCs and working with a range of key stakeholders to deliver HCs within non-GP settings.

## **Project aims**

The aim of this review was to:

- Explore the outcomes of the 2014-2016 collaboration between Salford City Council (SCC), Haelo and other Salford Partners with respect to improving the uptake of NHS Health Checks.

## **Methodology**

This project is a secondary data analysis of documentation from a range of key stakeholders involved in the provision and delivery of Health Checks between 2014 and 2016. The documents for analysis include: reports; minutes of meetings; research (including successful

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<sup>1</sup> The NHS Health Check programme had previously been the responsibility of Primary Care Trusts

and unsuccessful bids), posters, a rapid review of the literature, research bids and best practice guidance from PHE.

## **Data Analysis**

To ensure consistency in respect of the data captured, a data extraction form (see Part B, Technical Report) was used. The form was designed to identify, the key features of the range of programmes/interventions designed to increase the uptake of HCs.

## **Overall Summary, Recommendations and Conclusions**

The aim of this review was to explore the outcomes of the 2014-2016 collaboration between Salford City Council, Haelo and other Salford Partners with respect to improving the uptake of NHS HCs. The review has shown that there have been a huge variety of different activities under this collaboration, separated out into 4 key activity-themes, namely:

- Non-traditional settings/ partnerships - Community Engagement
- Practice Engagement/GPs
- Research
- Management/governance of the Health Check processes

The delivery of these activities involved a considerable number of partners, including those from traditional medical settings and community focused organisations, the Health Improvement Service, and SHCC. Partnership working has been previously identified as having a key role in tackling 'wicked issues' in local communities (Hunter, 2009; Glasby, Dickenson & Miller, 2011). The co-ordination of activities began in earnest in 2014 when the collaborative was formed, a clear governance structure was established, and a HC budget agreed with the Assistant Mayor. This led to the appointment of designated staff, both within SCC and in Haelo with responsibility for improving uptake of HCs across Salford.

Part of Haelo's role involved working with individual practices to implement 'Plan, Do, Study, Act' methods in order to improve their uptake. To facilitate this, they organised a number of engagement activities, which allowed the sharing of information and communication of best practice. Haelo also worked across Salford to help facilitate increasing the uptake of HCs, supporting existing service deliverers, and engaging new ones, including GP practices who were not signed up to deliver HCs. This was a challenging aspect of the programme, involving the need for a diverse range of activities, such as face-to-face meetings, and persistence to get some of the more reluctant practices/partners on board.

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Throughout the collaboration period one of the ongoing challenges was recognised as accurately being able to capture necessary data, as illustrated through the FARSITE report, and required by PHE. Specifically, it has been highlighted that there are challenges for practice staff using Read codes consistently and capturing data in non-traditional settings. Of note, referral data to onward services is virtually absent, making it impossible to track long-term outcomes of the HC, e.g. behaviour change. In recognition of the challenges with data collection BMJi was introduced (funded by the CCG) to replace the MIQUEST query. This new system, which practice staff have been trained and supported on is anticipated to lead to improved data quality moving forward.

There have been some challenges delivering HCs in non-traditional settings, e.g. ineligibility of patients due to their age, or postcode. However, there have also been some wins, e.g. the Jewish Orthodox Community, providing flexible ways of getting a HC, upskilling a number of providers, and potentially accessing those people who would not have attended their GP. Although a more thorough evaluation of these activities is needed to definitively ascertain the potential for HC delivery in this way, in particular to identify which facets of the process are key facilitators or barriers.

A number of media campaigns were undertaken to improve public knowledge about HCs, and encourage people to have one. These were seen as facilitative and included radio broadcasts, a video played in GP practices, articles in 'Life in Salford', and advertisements in local newspapers. In addition, a website that could be used by service delivery staff to signpost patients to a range of services was developed. Evaluating the impact of these campaigns is difficult. Hit rates, where measured, did indicate spikes in hits – however, there did not appear to be a corresponding surge in uptake levels.

Throughout the period a number of research activities were undertaken to investigate aspects of the HC journey, e.g. the invitation process. Efforts were also made to secure additional funding to enable more thorough evaluation and explore processes around the HC, e.g. training and experiences of patients. This resulted in a number of collaborations, including those between PHE Behavioural Insights, the University of Manchester, Manchester Metropolitan University, Huddersfield University, Haelo, The University of Salford, and Salford City Council. Disappointingly additional funding was not forthcoming for the larger research projects, limiting the ability to address these questions, however some of the research questions were answered through smaller projects, include those undertaken by two students.

Throughout the collaborative period there were a number of iterations of the drivers for the programme. These were informed primarily by those delivering the service through learning

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events, operational and steering group meetings. Patients, or those for whom the HC is intended, have had limited involvement in the collaborative learning processes. One of the challenges identified is the focus on quantitative outcomes (i.e. the numbers of people taking up HCs) with less of a focus on evaluating the processes and determining the effectiveness and acceptability of the range of activities undertaken. In this regard, the key barriers and facilitators to engaging people in a HC remain largely unknown, although the two student projects are anticipated to shed some light on this.

Overall, the key aim of the collaborative, i.e. to increase uptake rates to 75% was not consistently met, which mirrors national trends; see for example the recent review by Chang et al (2016). Data indicated peaks and troughs of activity (both invites and attendance), with Quarter 1 consistently showing higher rates of invites, and Quarter 2 correspondingly showing higher rates of attendance for the first two years.

Although it is not possible to map discrete activities against uptake, PHE (2016b) data shows that offers taken up between Q1 2013/14 and Q4 2015/16 (which reflects the period of the collaborative) were 55.4% and met the PHE target. Although during the same period, PHE targets were not met for appointments offered, or NHS HCs received. Looking at the Salford NHS Health Checks Workstream Dashboard and the quarterly returns to PHE, whilst the goals set around increasing uptake and number of invites was not consistently met across the collaborative period, it can be seen that at points during the collaborative activity, levels of activity were above the median (most notable during the first quarter of each year).

Lack of uptake may be reflective of difficulties in accurately measuring uptake in relation to invitations, for example if only opportunistic screening occurs uptake will appear high. This review has shown the breadth of work undertaken by the collaborative, facilitated by Haelo, to raise the profile of HCs in Salford, and the wealth of partnerships currently in existence, which should facilitate long-term sustainability. The work around HCs and the learning from this has provided the foundations for translating these processes into the 'Long Term Conditions' agenda. However, there is an imperative to integrate evaluation and participatory approaches more fully into future programmes i.e. involving *all* key stakeholders, including those who are the target of the intervention, in designing and developing future strategies.

### Recommendations

Under each theme in the main report (Part B) specific recommendations have been made, the following recommendations are designed to provide key overall messages identified from the review.

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1. Good practice guidance states that evaluation needs to be built into future programmes more consistently from the outset to effectively capture information (both quantitative and qualitative) about why some initiatives are more or less successful than others. In this regard, there is potential for some of the initiatives identified in this review to be scaled up across other areas and their impact evaluated.
2. All key stakeholders, including those that are the intervention target, should be involved in the design, development and evaluation of future initiatives.
3. Efforts should be made to manage and maintain the range of partnerships that have been developed to help facilitate the continued work around long term conditions.
4. The 'Model for Improvement' (Langley et al, 2009) incorporating PDSA cycles should be incorporated into practice in a way that helps to test and reflect on new initiatives, and inform process evaluation.
5. Face-to-face contact with the range of providers should be maintained, to enable ongoing support and the identification of training needs.
6. Learning events were shown to be beneficial, although it was difficult for staff to be released for a whole day. It is recommended that these be continued, but that potentially they should be shorter. It is also recommended that participants include those who are the target of the intervention at some events.
7. It is important that the data is used effectively to track onward referral, so that the impact of this can be ascertained.
8. Ensure that the learning from previous initiatives, e.g. Jewish Orthodox Community project is captured and used to inform future initiatives.
9. Explore methods of improving data quality and transfer from HCs done in community settings.
10. Explore alternative ways for GPs to provide health checks, which could be facilitated through the new Salford Standard.
11. Continue to use innovative mixed-method delivery of HCs, with built in evaluation.