PEER REVIEW HISTORY

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ARTICLE DETAILS

TITLE (PROVISIONAL)	GPs' perspectives on managing the NHS Health Check in primary care: a qualitative evaluation of implementation in one area of England
AUTHORS	Shaw, Rachel; Lowe, Hellen; Holland, Carol; Pattison, Helen; Cooke, Richard

VERSION 1 - REVIEW

REVIEWER	Suzanne Richards University of Exeter Medical School, UK
REVIEW RETURNED	18-Jan-2016

GENERAL COMMENTS	This paper reports on a small scale qualitative study exploring GPs' views and experiences of implementing the NHS Health Checks. The findings add to this emerging area of research, although there are some issues that need to be resolved in the manuscript. **Comments** **The NHS Health Check (NHSHC) and QOF.** The authors need to clarify the relationship between QOF and NHSHCs – although the participants talk about QOF being a financial incentive for NHSHC this is this is somewhat misleading. NHSHC are commissioned by local government authorities through locally enhanced contracts – the direct funding of NHSHC activities is not through standard PMS service budgets. NHSHC uptake is a Public Health Indicator, but not part of NHS indicator monitoring or QOF. I acknowledge there are some areas assessed in NHSHC have the potential to contribute to QOF points, but in more tangential ways. For example, practices gain QOF points for having an up to date disease registers for certain cardiovascular diseases (e.g. hypertension), but the actual proportion of QOF points is small, with a much greater priority and points allocated to managing patients with established diseases (i.e. those ineligible for NHSHCs). To the contrary, there are concern in primary care that NHSHC are over-diagnosing people with borderline conditions, and that the costs of covering the subsequent diagnosis and management have not been covered adequately. I'm not sure we have a definitive answer for this question – but my point is that there is no simple, direct relationship between QOF funding and NHSHC implementation. In the discussion, and possibly the introduction, this paper would benefit from a clearer description of how NHSHC are commissioned and what financial incentives are directly linked to the NHSHC activity. I would also carefully review your primary data to see if the participants elaborate more on how they see the linkage between QOF and NHSHCs. There is overlap/synergy, but the two aren't explicitly linked.

	Introduction: The review of existing literature is extremely brief. A number of qualitative studies have been published within the last two years that are omitted from the background. Please review the wider literature (the NHS Health Check website holds a list of published research) and provide a wider overview to the existing literature in this area. **Qualitative methods:** Please provide more information on how the qualitative methods – in particular how the GPs were sampled, approached, and recruited (e.g. what was the sampling frame, did any GPs who were approached decline to be interviewed?), and the final sample size was determined to be sufficient for your purposes (e.g is this an IPA project, or did data reach saturation etc). **Limitations:** the authors need to unpack some of the limitations to their approach more explicitly. They don't formally discuss the limitations, except to say it was a small sample in one area

REVIEWER	Janet Krska Medway School of Pharmacy The Universities of Greenwich and Kent UK
REVIEW RETURNED	26-Jan-2016

GENERAL COMMENTS	1. This paper describes a series of interviews conducted with GPs in one locality seeking their views on providing the NHS Health Check in their practices. These interviews were conducted as part of a larger series of interviews which also involved other health professionals and patients. The GP interviews reported here were also included in the previous publication of this work, in which four different themes are described. Hence there appears to be some duplication, albeit involving a different analysis, of data already published. 2. The work makes no mention of other work conducted with health professionals providing Health Checks, indeed suggests that there is none, which is far from being the case. There are a number of issues relating to methodology which require to be addressed. 3. The abstract is not clear, as the themes described do not lead directly to the need for greater transparency in referral processes or resources. 4. The conclusion given in the abstract is not drawn from the data and differs from that in the main text. 5. The date of the study is not given, nor how its timing relates to either national or local implementation of the Health Check programme. no detail is given to allow the reader to assess the context in which the GPs were operating with regards to the implementation (local support/training/expectations etc). 6. No details are given of how practices were selected for the study, how the GP were then selected or GPs invited to take part in interviews and nothing is mentioned about response/refusal rates. 7. The nine interviews were conducted using two different methods (telephone and face-to-face), which is not justified, and by two researchers. Good practice in qualitative research requires consistency in the method of gathering data and ideally the same

	person should gather the data, particularly for such a small number of interviews. 8. The interview schedule should be provided. 9. There is little detail of the method of analysis. 10. It is not made clear whether any of the nine GPs worked in the same practice or if they all came from different practices. Moreover nothing is known about how well the practices in which the GPs worked were delivering NHS Health Checks. 11. The work is limited in scope and reference to the literature and adds little of value to what is already known about implementation of NHS Health Checks, but the strengths and limitations bullet points are poorly drafted. 12. Some corrections for English are required, there are words missing in places. There is inconsistent use of capitals for Health Checks and use of an incorrect term: Care Commissioning Groups. 13. The introduction and discussion need to take account of other work available on this topic: Oswald, N., McNaughton, R., Watson, P., Shucksmith, J. (2010) Evaluation of the Tees Vascular Assessment Programme. Centre for Health and Social Evaluation, Teesside University Graley CEM, May KF, McCoy DC. (2011) Postcode lotteries in public health – the NHS health checks programme in North West London. BMC Public Health 11: 738 Research Works (2013) Understanding the implementation of NHS Health Checks. St Albans Krska J, duPlessis R, Chellaswamy H. Views of practice managers and general practitioners on implementing NHS Health Checks. Primary Health Care Research & Development 2015; 1-8 DOI:10.1017/S1463423615000262 Krska J, duPlessis R, Chellaswamy H. Implementation of a high CV risk approach to NHS Health Checks: variation in processes, recording and immediate outcomes. Primary Health Care Research and Development (2015) doi:10.1017/S1463423615000493 Ismail H, Atkin K. The NHS Health Check programme: insights from a qualitative study of patients. Health Expectations 2015; doi: 10.1111/hex.12358

REVIEWER	Dr Sheila Hardy Northamptonshire Healthcare NHS Foundation Trust, England
REVIEW RETURNED	13-Feb-2016

GENERAL COMMENTS	In your method section it would be helpful to see some reasons provided as to why the authors interviewed GPs only. It would have been useful to have the perspective of the clinicians actually delivering the service. Also views of practice managers who may have made the decision as to which level of clinician are involved. In the discussion it would be helpful to reference similar clinics provided for secondary prevention. If these have more positive outcomes you could make suggestions as to why this may be (delivered by a qualified nurse with further education in that disease area, motivation of pt may differ if have a diagnosis etc). Also more discussion is needed with supporting evidence around the effectiveness of using goal setting alongside some of the barriers that may be present in using this in primary care (e.g. access to appropriate training, no financial reward to see patients over a period of time to review goals etc).

VERSION 1 – AUTHOR RESPONSE

Reviewer 1	Response
The NHS Health Check (NHSHC) and QOF. The authors need to clarify the relationship between QOF and NHSHCs – although the participants talk about QOF being a financial incentive for NHSHC this is this is somewhat misleading. NHSHC are commissioned by local government authorities through locally enhanced contracts – the direct funding of NHSHC activities is not through standard PMS service budgets. NHSHC uptake is a Public Health Indicator, but not part of NHS indicator monitoring or QOF. I acknowledge there are some areas assessed in NHSHC have the potential to contribute to QOF points, but in more tangential ways. For example, practices gain QOF points for having an up to date disease registers for certain cardiovascular diseases (e.g. hypertension), but the actual proportion of QOF points is small, with a much greater priority and points allocated to managing patients with established diseases (i.e. those ineligible for NHSHCs). To the contrary, there are concern in primary care that NHSHC are over-diagnosing people with borderline conditions, and that the costs of covering the subsequent diagnosis and management have not been covered adequately. I'm not sure we have a definitive answer for this question – but my point is that there is no simple, direct relationship between QOF funding and NHSHC implementation. In the discussion, and possibly the introduction, this paper would benefit from a clearer description of how NHSHC are commissioned and what financial incentives are directly linked to the NHSHC activity. I would also carefully review your primary data to see if the participants elaborate more on how they see the linkage between QOF and NHSHCs. There is overlap/synergy, but the two aren't explicitly linked.	Many thanks for this clarification regarding funding issues. We accept that our original presentation of the potential financial gains to offering the NHS Health Check was over simplistic. The GP practices we recruited did indeed function through locally enhanced contracts through the local authority. Participants in our study gave us the impression that there was some financial reward for practices that met their recruitment target but the source was not made clear. Some participants did mention the disease registers related to QOF, which is why we referred to it in our data. Unfortunately, they didn't expand on the issue of possible over-diagnosis or the potential links between health check funding and QOF. We have made some revisions in the introduction (p.3), results (p.4) and discussion to clarify this issue (p.8-9).
Introduction: The review of existing literature is extremely brief. A number of qualitative studies have been published within the last two years that are omitted from the background. Please review the wider literature (the NHS Health Check website holds a list of published research) and provide a wider overview to the existing literature in this area.	Reviewer 2 also suggested we include more literature – please see the response below.
Qualitative methods: Please provide more information on how the qualitative methods – in particular how the GPs were sampled, approached, and recruited (e.g. what was the sampling frame, did any GPs who were approached decline to be interviewed?), and the final sample size was determined to be sufficient	Recruitment to the evaluation was undertaken by the local NHS Trust, in line with the contract we had with them. This means we don't have access to the numbers of refusals. The sampling strategy was negotiated with the Trust to identify practices which represented the demographics of the region and GP recruitment from those practices was

for your purposes (e.g is this an IPA project, or did data reach saturation etc).	opportunistic. We have added in a clarification to this effect (p.3). The final sample size was determined by the exploratory design and availability, and on that basis a target sample of 10 GPs was agreed with the Trust. As a small scale exploratory study we felt this was sufficient. We do not claim generalizability from these data but rather aim to present one set of opinions in one area of England which we hope others will add to in order to build up a wider evidence base.
Limitations: the authors need to unpack some of the limitations to their approach more explicitly. They don't formally discuss the limitations, except to say it was a small sample in one area.	Thank you for highlighting this omission. We have now added a more detailed discussion of limitations in the discussion (p.9).
Reviewer 2	
1. This paper describes a series of interviews conducted with GPs in one locality seeking their views on providing the NHS Health Check in their practices. These interviews were conducted as part of a larger series of interviews which also involved other health professionals and patients. The GP interviews reported here were also included in the previous publication of this work, in which four different themes are described. Hence there appears to be some duplication, albeit involving a different analysis, of data already published.	We are happy that this paper presents novel findings that do not duplicate existing results. Rather our findings add to the growing literature in the area.
2. The work makes no mention of other work conducted with health professionals providing Health Checks, indeed suggests that there is none, which is far from being the case. There are a number of issues relating to methodology which require to be addressed.	We have included reference to the literature you suggested – see below (point 13). The methodological issues will be dealt with in turn below.
3. The abstract is not clear, as the themes described do not lead directly to the need for greater transparency in referral processes or resources.	Thank you for this comment; we have changed the sentence in the abstract so the point made links more clearly with the themes presented (p.2).
4. The conclusion given in the abstract is not drawn from the data and differs from that in the main text.	We have adapted the conclusion in the abstract to fit more closely with the main conclusion (p.2). Many thanks for pointing this out.
5. The date of the study is not given, nor how its timing relates to either national or local implementation of the Health Check programme. No detail is given to allow the reader to assess the context in which the GPs were operating with regards to the implementation (local support/training/expectations etc).	The interviews took place during 2010-11. We have included this in the method (p.3). We have given as much information as we can about the location of the practices recruited without threatening anonymity (see p.4).
6. No details are given of how practices were selected for the study, how the GP were then selected or GPs invited to take part in interviews and nothing is mentioned about response/refusal rates.	The larger evaluation study was conducted under contract with the local Trust. The Trust recruited participating practices (see response to Reviewer 1 above). The GP sample was an opportunistic sample within the practices that volunteered to take part in the evaluation.
7. The nine interviews were conducted using two different methods (telephone and face-to-face), which is not justified, and by two	Practicalities of recruiting GPs and GPs' availability required that some interviews be undertaken via telephone. The same interview schedule was used

researchers. Good practice in qualitative research requires consistency in the method of gathering data and ideally the same person should gather the data, particularly for such a small number of interviews.	for all interviews, regardless of the medium through which they were conducted, and so we would disagree that different methods were employed. Increasingly, studies use a range of media to generate experiential accounts (face-to-face, telephone, Skype, written messaging) so we do not feel that this is a limitation in our design. However, we understand that the nature of data generated through different media may vary. We have added a sentence about this in the method (p.3). While we appreciate that there may be advantages to one interviewer generating all the data, this is not always practicably possible, which was the case here. In larger projects it is quite common for a team of researchers to conduct interviews. What was important for us was that the team discussed the conduct of the interviews and was all involved in the analysis of the data.
8. The interview schedule should be provided.	We have included some examples of the interview questions (p.4). These were the key issues covered and so work well to demonstrate how interviews were conducted.
9. There is little detail of the method of analysis.	We have described the procedures undertaken to carry out the analysis with a reference to thematic analysis. It is difficult to go into too much detail here given the word limit. We have added that the thematic analysis conducted was inductive and included more detail about what this entails (p.4).
10. It is not made clear whether any of the nine GPs worked in the same practice or if they all came from different practices. Moreover nothing is known about how well the practices in which the GPs worked were delivering NHS Health Checks.	The GPs were recruited from different practices (see abstract and p.4 for added clarification). Our contract determined that the nature of this study was to focus on the experiences of delivering the Health Check rather than performance indicators such as patients recruited or lifestyle services deployed, thus we haven't included those data here.
11. The work is limited in scope and reference to the literature and adds little of value to what is already known about implementation of NHS Health Checks, but the strengths and limitations bullet points are poorly drafted.	We thank the reviewer for highlighting the limitations in our strengths and limitations section. We have re-drafted these to make a clearer link to the findings presented and the need for future research to build upon what was only a small scale evaluation in one geographic area of England.
12. Some corrections for English are required, there are words missing in places. There is inconsistent use of capitals for Health Checks and use of an incorrect term: Care Commissioning Groups.	We have made these corrections.
13. The introduction and discussion need to take account of other work available on this topic: Oswald, N., McNaughton, R., Watson, P., Shucksmith, J. (2010) Evaluation of the Tees Vascular Assessment Programme. Centre for Health and Social Evaluation, Teesside University Graley CEM, May KF, McCoy DC. (2011) Postcode lotteries in public health – the NHS health checks programme in North West London. BMC Public Health 11: 738 Research Works (2013) Understanding the	Many thanks indeed for making us aware of these studies. We were delighted to see that some of the work this reviewer and other researchers have been involved in supports the rationale for this study and corroborates some of our findings. We have added in references to this work in the introduction (p.3) and discussion (p.8).

implementation of NHS Health Checks. St Albans Krska J, duPlessis R, Chellaswamy H. Views of practice managers and general practitioners on implementing NHS Health Checks. Primary Health Care Research & Development 2015; 1-8 DOI:10.1017/S1463423615000262 Krska J, duPlessis R, Chellaswamy H. Implementation of a high CV risk approach to NHS Health Checks: variation in processes, recording and immediate outcomes. Primary Health Care Research and Development (2015) doi:10.1017/S1463423615000493 Ismail H, Atkin K. The NHS Health Check programme: insights from a qualitative study of patients. Health Expectations 2015; doi: 10.1111/hex.12358	
Reviewer 3	
In the discussion it would be helpful to reference similar clinics provided for secondary prevention. If these have more positive outcomes you could make suggestions as to why this may be (delivered by a qualified nurse with further education in that disease area, motivation of pt may differ if have a diagnosis etc). Also more discussion is needed with supporting evidence around the effectiveness of using goal setting alongside some of the barriers that may be present in using this in primary care (e.g. access to appropriate training, no financial reward to see patients over a period of time to review goals etc).	We thank the reviewer for raising the issue of secondary prevention. However, we were unable to discuss this issue as the focus of this research was purely the NHS Health Check. The sister paper to this one (Shaw RL, Pattison HM, Holland C, Cooke R. Be SMART: examining the experience of implementing the NHS Health Check in UK primary care. BMC Fam Pract 2015;16:1. Available from: http://www.biomedcentral.com/1471-2296/16/1) examines the implementation of goal setting and the evidence supporting its effectiveness, which is why we haven't gone into it in detail here. However, we have added a reference (p.10) in the discussion.

VERSION 2 – REVIEW

REVIEWER	Dr Sheila Hardy Northamptonshire Healthcare NHS Foundation Trust UK
REVIEW RETURNED	30-Mar-2016

GENERAL COMMENTS	Thank you for making the suggested amendments.