NHS HEALTH CHECK FOCUS GROUPS REPORT 2025

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Birmingham City University

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PREFACE

With respect to national guidance and changing practice, this report uses the terms racially marginalised communities instead of the outdated acronym BME or BAME. In some contexts, alternate terms, such as Global Majority, have come to prominence to highlight the fact that people racialised as minorities in some regions represent the majority of the global population. Although such terminology has its advantages, there are debates surrounding it—particularly in relation to the risks of homogenisation and antagonistic regard for distinct identities and experiences. This report prefers a more consistent and neutral approach by using clearer, more specific language to capture all groups. To represent the different perceptions of participants in this study, effort has been made to cite specific global majority groups so as to capture as many points of view as possible.

Moreover, there have been major changes in the public health system in the UK. Public Health England (PHE) has been dissolved and partitions to form two new organisations: the Office for Health Improvement and Health Disparities (OHID) and the United Kingdom Health Security Agency (UKHSA). Each of them has distinct responsibilities; OHID manages health improvement and addressing health disparities while UKHSA deals with health protection and emergency preparedness services. In respect to NHS Health Checks, OHID is the steering or leading organisation focused on illness prevention and reduction of health inequalities. It works along with the NHS and local authorities to enable people to live longer and healthier lives, focusing on cutting down preventable health risks and improving service access within disadvantaged populations.

This report details the findings of the NHS Health Check Focus Group project. We hope it will serve as a valuable resource not only for Birmingham City Council and Office for Health Improvement and Disparities (OHID) but also for academics, healthcare professionals, policymakers, commissioners, and those involved in delivering or planning similar preventive health initiatives.

After a competitive bidding process, Birmingham City Council commissioned the Public Health team at Birmingham City University on 1st July 2024 to conduct an independent evaluation of the NHS Health Check programme. This project was carried out in collaboration with various focus group providers across Birmingham. The council's brief emphasised key areas such as attendance, delivery, and health outcomes, with five specific objectives outlined for the study.

The Public Health team at Birmingham City University operates within the Faculty of Health, Education, and Life Sciences. Birmingham City University plays a vital role in supporting the front-line workforce of health, education, and social care services, both locally and nationally. The university provides state-of-the-art facilities that enable students to gain hands-on experience using professional-standard equipment across its health, sport, and education programme. The faculty comprises four academic colleges: the College of Education and Social Work, the College of Health and Care Professions, the College of Life Sciences, and the College of Nursing and Midwifery.

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THE BIRMINGHAM CONTEXT: HEALTH CHALLENGES AND INEQUALITIES

Birmingham, one of the most diverse and populous cities in the United Kingdom, faces significant health challenges and inequalities that make NHS Health Checks a crucial intervention for improving public health. With over 50% of its population from global majority backgrounds and 88% of its wards more deprived than the England average (Brown et al., 2007), Birmingham's unique demographic and socioeconomic profile highlights the need for targeted, preventative healthcare interventions to reduce health inequalities and tackle the burden of preventable diseases (Department of Health, 2010).

Demographics and Deprivation in Birmingham

According to the latest population estimates Birmingham, UK is home to approximately 1.144 million people (Office for National Statistics, 2021). In relation to other cities, Birmingham has the largest population outside of London in the UK. Birmingham is ethnically diverse, though the population suffers from high levels of deprivation. The 2021 Census registered that more than 50 percent of the residents from Birmingham belong to a global majority community, including large South Asian, Black African and Black Caribbean populations. The city is also a centre of 8 percent of the total African and Caribbean population of England, which raises major concerns to tackle the health inequalities existing in these populations. Among other social issues in the UK, Birmingham is considered to be one of the most deprived cities. Around 88 percent of its wards are ranked below the UK average by deprivation and health inequalities are highly influenced by deprivation (Marmot et al., 2020). People living in the most deprived areas are three times more likely to develop cardiovascular disease (CVD) than those living in richer areas (Diez-Roux et al., 1997; Stafford & Marmot, 2003; Timmis et al., 2022).

Key Health Challenges and Statistics

Birmingham, particularly for global majority populations and individuals residing in deprived neighbourhoods, suffers from preventable cardiovascular disease, diabetes, and obesity (Department of Health, 2010; Sidhu et al., 2016). This description does not fully encapsulate the reality of the city, where cardiovascular disease claim lives more than any other disease, resulting in a higher-than-average reduced mortality rate. In England, about 66 percent of deaths before the age of 75 are classified as preventable (Office for National Statistics, 2024) and deprivation in Birmingham only makes these numbers worse. Certain members of the South Asian, Black African and Black Caribbean communities have been shown to be at greater risk of suffering from hypertension, stroke, and diabetes which are commonly diagnosed during NHS Health Checks.

Diabetes is equally concerning for the health of Birmingham residents and is as prevalent as hypertension in the city. Currently, 9.3 percent of Birmingham's adult population has diabetes, far exceeding the UK average of 6.8 percent (British Dietetic Association, 2018). Among South Asian, Black African and Black Caribbean communities, Type 2 diabetes is particularly prevalent due to genetic factors combined with socio-economic hurdles to obtaining good healthcare services (Diabetes UK, 2025). Obesity is a major contributor to diabetes and heart disease with 68 percent of adults in Birmingham listed at being overweight or already into obesity, which is above the Great Britain average of 63 percent (Bhaskaran et al., 2014; Birmingham City Council, 2023).

NHS Health Checks: Addressing Local Needs

The NHS Health Check programme will make a significant contribution to achieving the health objectives in Birmingham. In national estimates, the programme saves about 650 lives each year, prevents over 1600 heart attacks and strokes, and stops about 4000 people from developing diabetes (Chattopadhyay et al., 2020). In the West Midlands region, Birmingham City Council purchases NHS Health Check services from GP surgeries for approximately £885,000 a year, at a rate of £25 per completed check (Birmingham City Council, 2024). In 2023/2024, over 30,000 NHS Health Checks were provided to residents of Birmingham. This shows the substantive headway made towards the implementation of preventative healthcare. In spite of this, the British Bangladeshi, Black African and Black Caribbean groups continue to have low participation rates for appointments which is disproportionate to the aforementioned groups' higher likelihood of having certain health conditions.

The challenges related to accessing the NHS Health Checks for Birmingham residents are quite intricate. Socio economic deprivation remains a prominent feature of the local population, who might not be able to afford to take time out of work to attend the appointment. In addition to that, a portion of the population is not signed up with a GP practice, which serves as a barrier to access the programme. Certain women might also have additional structural barriers, such as limited childcare support, which make it challenging to attend the health check appointments.

Local Initiatives and the Role of BLACHIR

To overcome these hurdles, Birmingham has implemented a number of initiatives to combat health disparities and increase the availability of preventative healthcare services. One of these initiatives is the Birmingham and Lewisham African and Caribbean Health Inequalities Review (BLACHIR) a joint venture between Birmingham City Council and Lewisham Council (BLACHIR, 2024). This pioneering review seeks to understand and address health inequalities affecting African and Caribbean communities which constitute a sizeable portion of Birmingham's population. In one of its activities, BLACHIR has declared NHS Health Checks as to be of much importance and recommended augmenting its promotion through public advertising and conducting them in easily reachable venues.

However, NHS Health Check delivery was impacted by the COVID-19 pandemic. Estimates showed that between March and December 2020 there were over seven million fewer NHS processes carried out (Carr et al., 2022). The effect of this interruption is a build-up of undiagnosed illnesses, hence the need to improve uptake of diagnosis after the pandemic is even greater. Nevertheless, Birmingham has experienced a remarkable increase in the uptake of NHS Health Checks post-pandemic. However, there is still a lot to be done to ensure everyone accesses this service equitably.

Focus on Community Engagement and Research

Understanding the need for a more nuanced approach, Birmingham City Council tasked Birmingham City University with convening focus groups with prominent Birmingham based ethnic communities to better comprehend the impediments to NHS Health Check utilisation. These focus group participants comprised members from South Asian, Black African and Black Caribbean and other global majority groups, as well White British working-class communities. The findings stressed the importance of culturally appropriate planning and

the necessity for more detailed ethno-specific granularity for purposeful outreach. For example, present data bases tend to categorise distinct communities, like all South Asians or all Black Africans, as one entity which makes it difficult to develop tailored interventions. The participants also discussed the scope of some organisational barriers, such as poor communication channels and suspicion of the healthcare system, which might lead to apathy towards the programme.

Among the recommendations was the need to organise more focus groups, make attempts for targeted outreach, and to enhance the detail of the diversity data capture in the Birmingham enumeration. These recommendations will shape subsequent NHS Health Check commissioning to make the service more pertinent to the needs of the people of Birmingham.

Conclusion

Birmingham's distinct demographic and socioeconomic profile poses challenges and opportunities in the domain of public health. The city is characterised by high deprivation and great ethnic diversity, which requires a focused approach to preventative healthcare services, with NHS Health Checks being paramount in reducing health gaps. Local programmes such as BLACHIR and the focus group study are significant attempts to understand and try to resolve barriers that restrict access so that all communities can benefit from this essential programme. Having more focused efforts and interventions that address cultural sensitivities will help the city further reduce preventable diseases and improve health outcomes among a more diverse population.

EXECUTIVE SUMMARY

The report is the result of a number of focus group discussions conducted to investigate the community's experiences and perceptions of the NHS Health Check programme in Birmingham. It is part of a collaborative endeavour between Birmingham City Council, Birmingham City University, and local community organisations to try and resolve health services access issues resulting from service-user-defined factors of NHS Health Checks.

The NHS Health Check is an essential preventative measure designed to mitigate the risk of heart disease, diabetes, stroke, and kidney disease. NHS Health Checks are necessary for early detection and prevention of disease for the people living in Birmingham. Nonetheless, despite its significance, uptake within the diverse communities of Birmingham is less than optimal. This study seeks to comprehend the uptake influences and the factors that can be changed to make it possible.

A co-production approach formed the foundation of this project by collaborating with community partners to strategize, implement, and evaluate the engagement activities. Co-production was implemented in this case to ensure approaches that were culturally appropriate and accessible and that could build trust and support racially marginalised communities to engage more meaningfully.

The research therefore employed focus groups to explore the following key areas:

- **Awareness and Understanding:** To assess community knowledge and expectations regarding NHS Health Checks.
- **Experiences:** To gather insights into previous experiences with NHS Health Checks, including both positive and negative aspects.
- **Barriers and Facilitators:** To identify factors that hinder or encourage participation in NHS Health Checks.
- **Customer Journey:** To examine the entire process, from invitation to delivery, identifying areas for potential optimisation.
- **Cultural Relevance:** To determine how NHS Health Checks can be made more appropriate and accessible for diverse communities, considering factors such as communication, location, language, and cultural awareness.

The research specifically considered the perspectives of individuals with varying levels of experience with NHS Health Checks, including:

- Eligible individuals who have previously attended a check.
- Eligible individuals who have not previously attended a check.
- Individuals approaching the eligible age.
- NHS Staff who deliver the Health Check (for specific focus group)

The findings of this research will inform recommendations for Public Health, NHS Health Check providers, and other stakeholders, with the ultimate goal of increasing uptake and improving the effectiveness of this vital preventative service. The demographic analysis has been conducted, and the findings have been presented below.

Key Findings:

To better understand this issue, the study engaged a total of 193 participants, including 13 NHS Health Check professionals, through focus groups representing a wide range of ethnic backgrounds. These sessions provided rich qualitative data on both user experiences and the perspectives of healthcare providers. Participants represented 10 distinct global majority groups: Arabs, Bangladeshi, Black Caribbean, Chinese, Ghanaian, Indian, Nigerian, Pakistani, Somali, and White British. The average age of all participants was 52.1 years. Of the total participants, 153 were within the NHS Health Check eligible age range (40-74 years). Total 45 participants reported having had an NHS Health Check. This figure includes only members of the public who were eligible for and attended the checks and does not include NHS Health Check staff who participated in the study. Only 5 participants had some form of disability.

Gender Distribution Across Global Majority Groups

The dataset reveals notable variations in gender representation across different global majority groups. Some ethnicities, Bangladeshi and Black Caribbean, exhibit a nearly equal distribution of male and female participants. In contrast, Chinese and Nigerian communities have a slightly higher proportion of female participants. In the interest of fostering inclusivity, public health campaigns should promote equally active participation of both males and females during the NHS Health Checks.

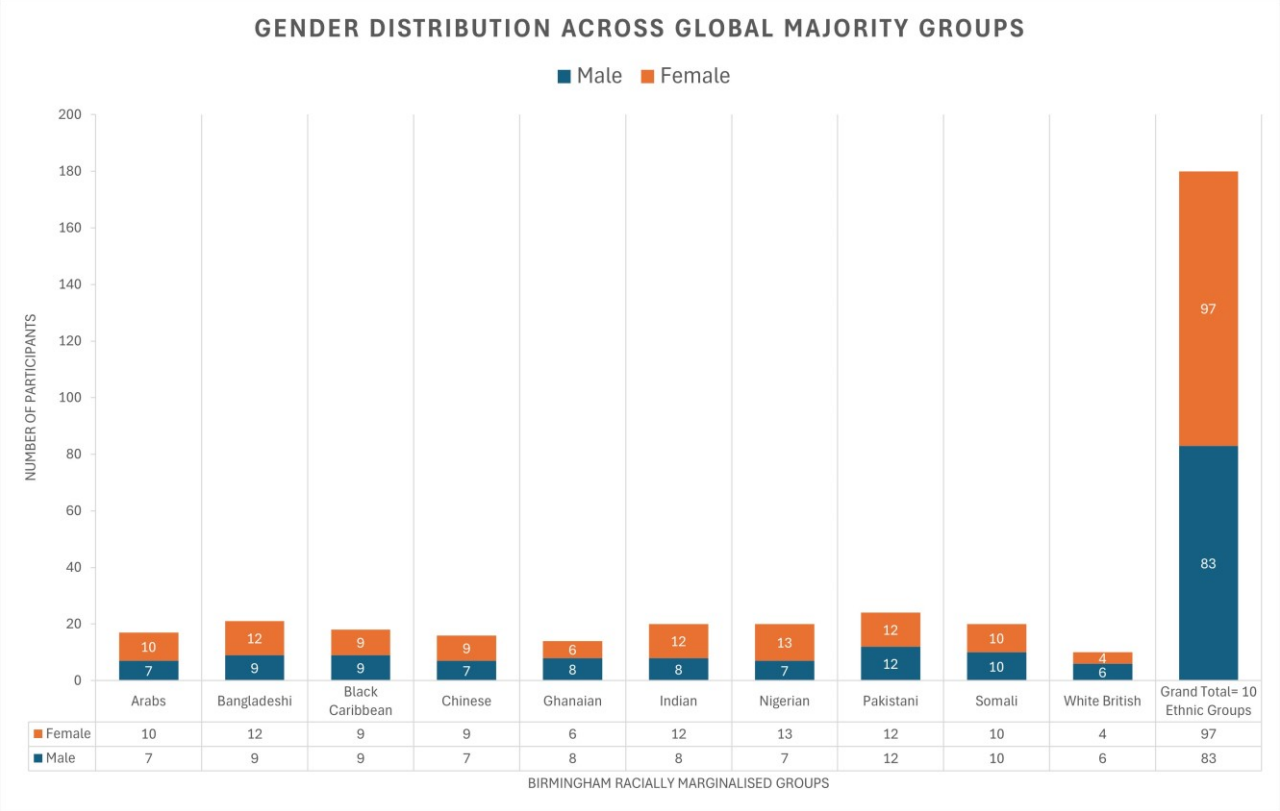

Figure 1: Gender Distribution Across Global Majority Groups - Focus Groups Participants (Birmingham)

NHS Health Check Uptake by Global Majority Group and Gender

This gender imbalance was also evident in the participation of various global majority groups where most women than men attended the NHS Health checks. Chinese and Nigerian groups reported the highest participation rates, while Arabs and White British groups the lowest potentially indicating a lack of accessibility or awareness of these services. There was a particularly striking difference with Ghanaians where women clearly predominated. After a more in-depth analysis of other groups, the study found that eligible Arabs and White British men had no participation in NHS Health Check programme, demonstrating a need for more focused outreach in these populations.

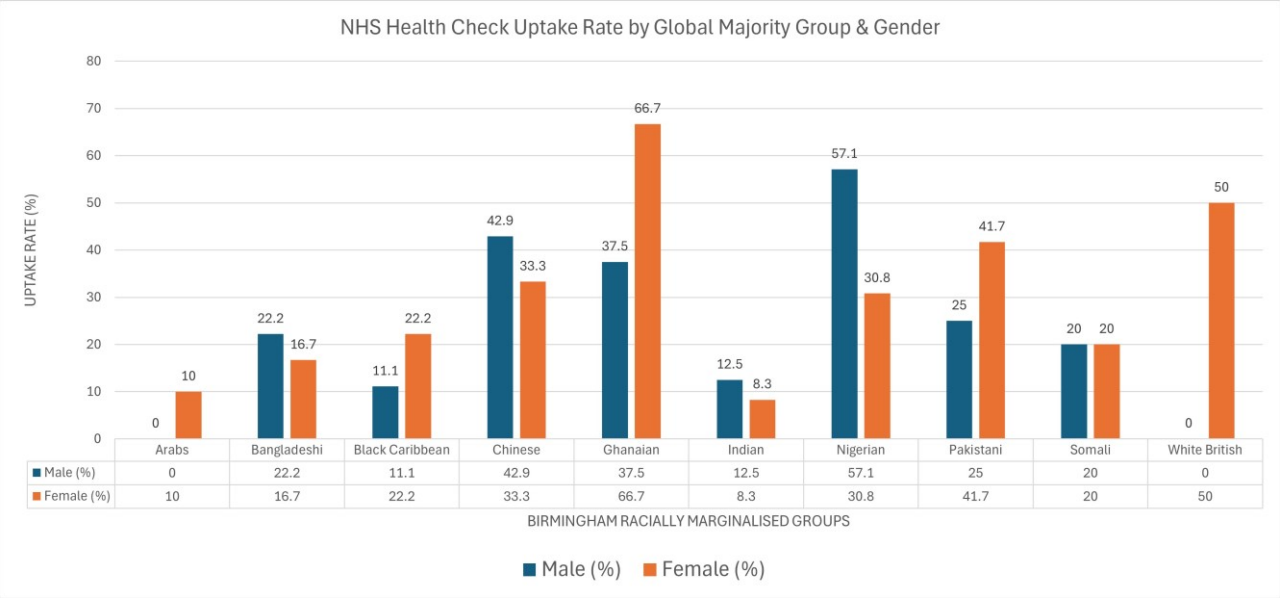

Figure 2: NHS Health Check Uptake Rate Global Majority Group & Gender - Focus Groups Participants (Birmingham)

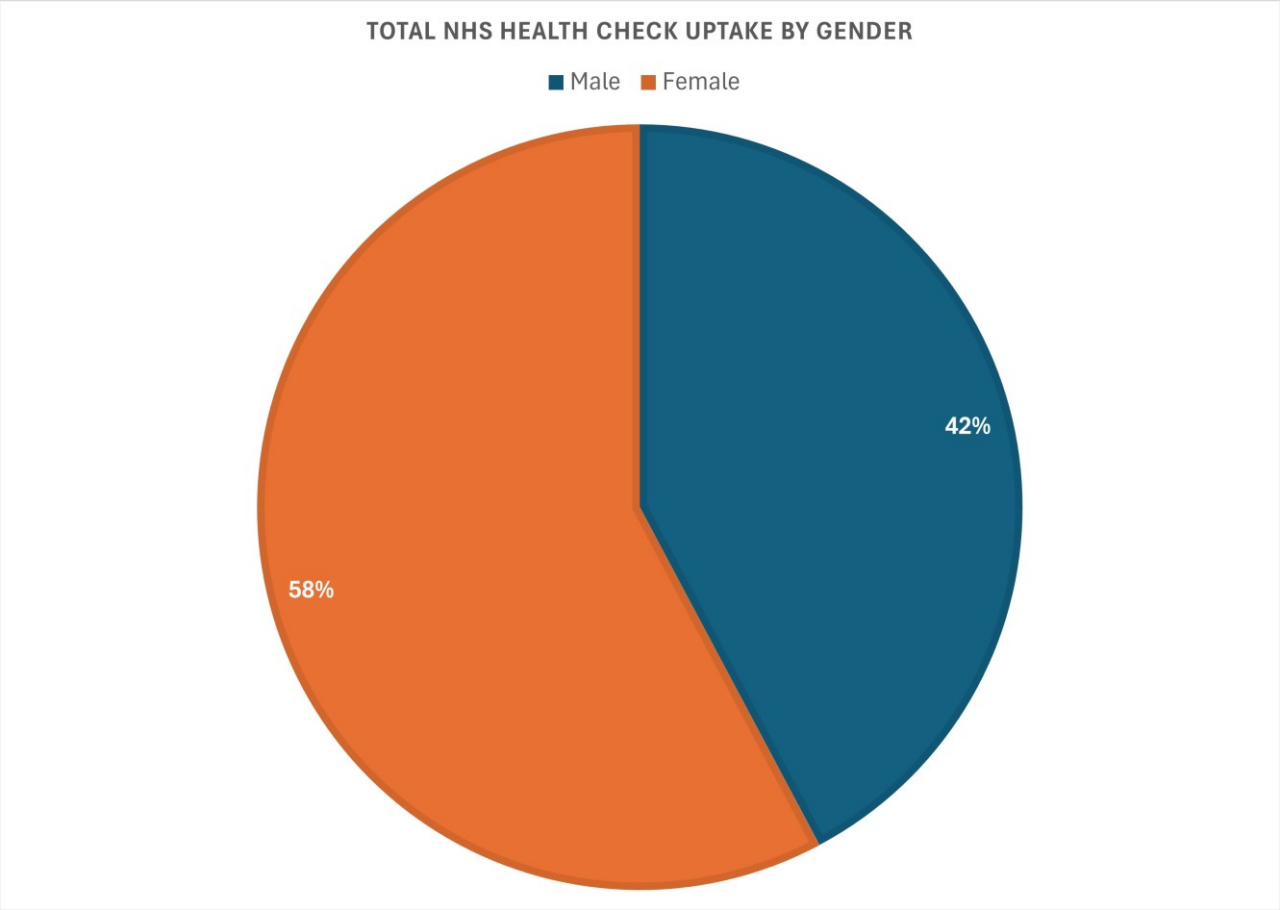

Figure 3: NHS Health Check Uptake by Gender – Focus Groups Participants (Birmingham)

This data reflects responses collected from focus group participants as part of this research project and may not be representative of NHS Health Check uptake across the broader Birmingham population or the national NHS Health Check programme.

Observing the overall uptake of NHS health checks among different participants, it was noted that females used the services more than males with the exception of some global majority groups. This indicates that women might be more in need of preventive health care services than their male counterparts. Male participation, however, lags behind in various global majority groups and that points to a substantial lack of engagement that needs to be addressed. Targeting more men to participate in health check programmes will assist in meeting this gap and tending to the overall health status in communities where men's uptake is considerably low would be beneficial.

NHS Health Check Eligibility vs. Uptake

In all global majority groups, there is a wide gap between eligibility for the NHS health checks and attendance. Many people are able to qualify, yet, so many barriers exist that do not allow the checks to be completed.

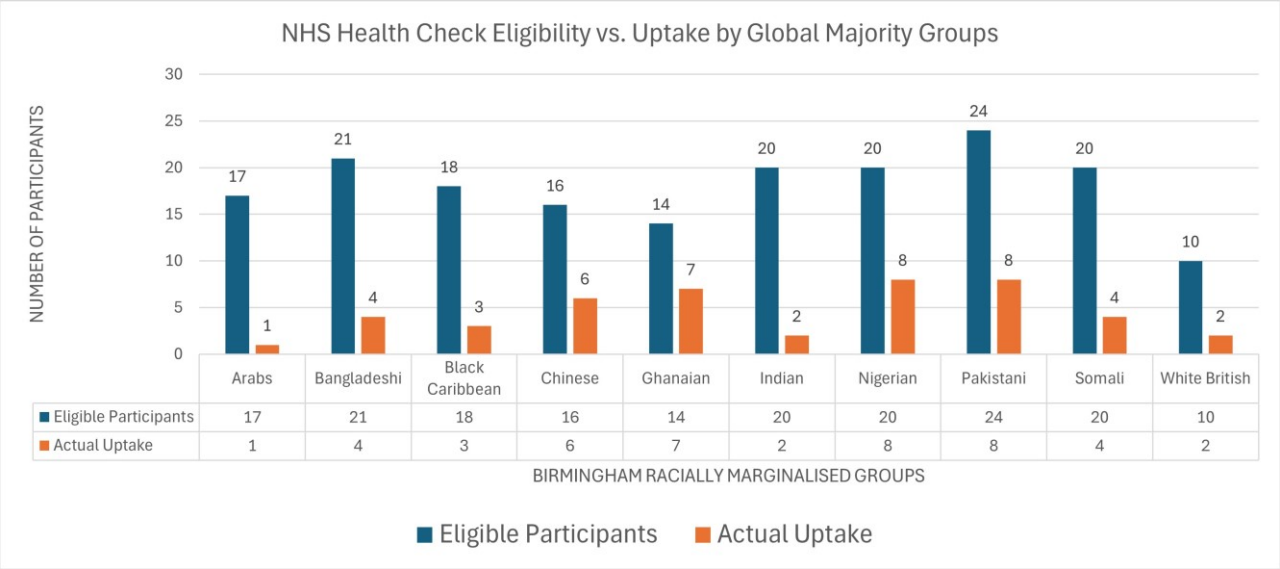

Figure 4: NHS Health Check Eligibility versus Uptake by Global Majority Groups – Focus Groups Participants (Birmingham)

Chinese and Nigerian participants display higher relative uptake rates when compared to other global majority groups demonstrating greater engagement with the programme. However, Arabs and White British eligible groups are less engaged, revealing some barriers such as lack of knowledge, poor access to facilities, or negative views towards preventive health care.

This gap highlights the need for more effective outreach, improved accessibility, and targeted campaigns aimed at motivating participation in their NHS health checks. Overcoming these barriers may assist in minimising the differences between qualifying for health care services and utilising them, which will in turn improve the population's health.

We also found that

The following key findings synthesise the overall insights and themes from the project and portray, in abstract form, the most significant obstacles, enabling factors, and the possibilities pertaining to the NHS Health Check programme.

Barriers to Uptake and Engagement

Cultural and Linguistic Barriers: Insufficient cultural empathy and poor language assistance was one of the greatest barriers for Birmingham racially marginalised groups which resulted in alienation and distrust of the NHS Health Check programme.

Health Literacy Challenges: The lack of knowledge about the aims, value, and steps in getting NHS Health Checks, especially among people with low health literacy was clearly evident and a significant barrier.

Mistrust in Healthcare Systems: Historical and institutional scepticism towards health care, especially when combined with negative personal experiences, kept some participants from attending the NHS Health Check Ups.

Access and Convenience: Practical barriers such as inflexible schedules, lack of childcare, transportation issues, and limited appointment availability during non-standard working hours were very discouraging for many people.

Perceived Lack of Follow-Up: Participants were disappointed by the lack of follow-up care after their health checks leading to distrusting the programme.

Facilitators of Engagement and Participation

Community-Based Delivery Models: Conducting NHS Health Checks in faith centres, schools or workplaces was viewed as an effective way of improving trust and enhancing participation among these populations.

Culturally Competent Care: Participants stressed the need for healthcare staff to show understanding and acknowledgement of the culture of the patients because this was important in gaining their trust and facilitating further participation.

Language Support and Clear Communication: The introduction of interpreters, translated documents, and outreach materials in other languages was pointed out as a solution to enhance poor health literacy as a result of language barriers.

Personalised and Holistic Approaches: Participants appreciated NHS health checks that were tailored to their specific needs, provided with appropriate guidance, or some simpler lifestyle changes and means of follow-up care.

Specific Challenges for Underserved Populations

NHS - Public Health Relationship/Statutory Services: The NHS Health Checks programme is a statutory service under the Birmingham City Council Public Health (BCC PH) division and is provided by NHS providers. The implementation of the programme is subject to the protocols and funding conditions of the Office for Health Improvement and Disparities (OHID). Therefore, any modifications to the delivery model must be kept within these legal boundaries, categorical restrictions and framework of the underlying contracts.

Intersectional Barriers: Individuals with multiple, overlapping identifiers like ethnicity, socioeconomic class, gender, and immigration status experienced significant barriers to accessing and hence benefiting from NHS Health Checks.

Hard-to-Reach Groups: People with disabilities (sub-population group) are particularly in need of health check and require special attention to access such.

Digital Exclusion: Elderly people, the digitally illiterate, and those without stable internet connections faced difficulties due to the increased dependence on technology for appointment scheduling and communication.

Opportunities for Improvement

Cultural Competency Training: Staff members involved in service delivery were said to require training on culture, implicit bias, and effective communication in order to gain the trust of diverse communities and ensure effective delivery.

Enhanced Follow-Up Support: Participants were in favour of continuity of care and sustained health improvement through structured follow-up mechanisms including personalised care plans, scheduled check-ins, as well as referrals to lifestyle support services.

Flexible and Accessible Services: Essential for improving accessibility to NHS Health Checks was the need to expand appointment availability to include evenings and weekends, as well as offering NHS Health Checks in community-based locations.

Targeted Outreach Campaigns: Participants highlighted the need for tailored outreach efforts, including culturally relevant messaging and partnerships with trusted community leaders, to raise awareness and encourage participation in NHS Health Checks.

Recommendations for Future Research

Evaluation of Interventions: Further research is needed to identify which specific interventions (e.g., cultural competency training, community-based delivery) are most effective in improving engagement and outcomes for the most affected populations in terms of health disparities.

Exploration of Long-Term Impact: Longitudinal studies could assess the sustained impact of NHS Health Checks on reducing chronic disease prevalence and improving health equity.

Focus on Underrepresented Groups: Future research should prioritise hard-to-reach populations, such as people with disabilities, to ensure that their unique barriers are addressed.

Refinement of Methodologies: Mixed-methods and participatory research approaches could provide deeper insights into the experiences of diverse communities and enhance the relevance of future studies.

These key findings provide a comprehensive snapshot of the project's overall insights, highlighting the challenges, opportunities, and pathways for improving the accessibility, inclusivity, and effectiveness of NHS Health Checks. They serve as a foundation for actionable recommendations aimed at reducing health inequalities and promoting preventative healthcare for all communities.

GLOSSARY

BCC:	Birmingham City Council
BCC PH:	Birmingham City Council Public Health
BCU:	Birmingham City University
BLACHIR:	Birmingham and Lewisham African Caribbean Health Inequalities Review
BME:	Black and Minority Ethnic Groups
CVD:	Cardiovascular Disease
FGD:	Focus Group Discussion
FGP:	Focus Group Provider
GP:	General Practice
NHS:	National Health Service
NHS-HC:	National Health Service Health Check
OHID:	Office for Health Improvement and Disparities
PAR:	Participatory Action Research
PHE:	Public Health England

ACKNOWLEDGEMENTS

Many individuals have contributed to this project and deserve our sincere gratitude. Across Birmingham, both academics and non-academics have provided valuable resources that have helped identify suitable strategies and materials for our project and data collection.

In particular, we would like to extend our heartfelt thanks to the members of the focus group providers, representing Birmingham City Council, who generously provided data from the 'NHS Health Check' focus groups.

Community Groups and Focus Group Providers:

1. Chinese Community Centre
2. Community Connexions
3. Desi Diabetes
4. DOR Romanian Diaspora
5. Mindseye Development
6. SAHELI
7. SOS Education Organisation
8. The Revival City Church Birmingham

The Project Team as Academic Providers:

We are also deeply grateful for the invaluable assistance provided by our colleagues from the Public Health Department within the Faculty of Health, Education, and Life Sciences at Birmingham City University.

BACKGROUND AND INTRODUCTION

Cardiovascular disease (CVD) remains the leading cause of death and illness in the UK, responsible for 25% of all fatalities (Anis et al., 2022). To combat this, the National Health Service Health Check (NHS-HC) programme was launched in 2009 as part of England's CVD prevention efforts (Tanner et al., 2022). This five-yearly health check also aims to identify diabetes, chronic kidney disease, and raise dementia awareness. The programme assesses individuals' risk of developing CVD and provides tailored interventions for high-risk individuals, including lifestyle changes, statins for high cholesterol, and antihypertensive medication for high blood pressure. It plays a significant role in the NHS Long Term Plan and broader strategies to address health inequalities. One of its primary goals is to reduce disparities in premature CVD deaths, though the specific methods for achieving this are not clearly defined. Research shows that NHS-HC attendees are generally older and more likely to be women, with similar ethnic and socioeconomic profiles to non-attendees. To meet the programme's goal of reducing inequalities in CVD outcomes, it is vital to identify and address any inequities in access and results. Since 2013, Local Authorities have been legally responsible for commissioning the programme under the Health and Social Care Act. Although it is a nationwide initiative, its implementation and delivery vary significantly between and within Local Authorities. The programme is mainly run by General Practices (GPs) but is also offered through community pharmacies and leisure centres. Outreach efforts have included unconventional settings like pubs and libraries. While data on invitations and attendance are consistently collected, other important metrics, such as diagnoses and treatments, are not routinely tracked.

Birmingham and Lewisham African and Caribbean Health Inequalities Review (BLACHIR) is a partnership between Lewisham Council and Birmingham City Council. Work has begun on this ground-breaking review to gather insights on health inequalities specifically within African and Caribbean communities in Birmingham and Lewisham. Birmingham is home to 8% of the overall African and Caribbean population of England, and in Lewisham, African and those of Caribbean descent represent the largest population groups among those of Black and Asian Minority Ethnicities (BLACHIR, 2024). Both Birmingham and Lewisham Public Health Divisions share a joint aspiration to address and improve minority ethnic health inequalities through an increased understanding, appreciation, and engagement with African and Caribbean groups. This shared ambition has resulted in a collaboration between the two local authorities to share knowledge and resources through a robust review process. From the Review, there were 7 developed key priority areas. One of those, NHS Health Checks and Campaigns called for the Health and Wellbeing Board to act across their partnerships to promote NHS health checks through public campaigns to increase the uptake of 8 community-based health checks in easy to access locations. During the COVID-19 pandemic there was a reduction of the number of NHS health checks delivered in the UK with there being an estimated 7.4 million fewer care processes undertaken from March to December 2020 (Carr et al., 2022). This has led to a backlog of testing and prescribing, resulting in more people to be unknowingly living with undiagnosed health conditions that would have been discovered within health checks. However, in Birmingham uptake of NHS health checks has significantly improved since the pandemic.

A rapid evidence review has been completed to collect insight into different ethnic communities and health checks. The evidence review gave 5 recommendations to make NHS Health Checks more specific and applicable to Birmingham's diverse communities.

One of these was to obtain data on specific ethnicities and to conduct focus groups. The recommendation outlined “Data on ethnic background can be difficult to parse through as different databases group global majority communities differently. In some cases, data groups together all South Asians, often Black Africans are grouped together and sometimes even with Black Caribbeans. Occasionally data only talks about minorities born abroad, rather than second, third, fourth or later generation immigrants. Extrapolation without data makes any intervention less sound and evidence driven. It may be worthwhile to conduct focus groups within Birmingham to understand the barriers to NHS Health Checks and consider targeted pilot programmes to address the outcomes from the focus groups.”

Brief Scoping Review of NHS Health Checks Among Racially Marginalised Communities

The NHS Health Check programme was initiated in England in 2009 as a means to curb and manage non-communicable diseases such as cardiovascular disease (CVD), type 2 diabetes, stroke, and kidney disease for individuals aged 40 to 74 years (McCracken et al., 2024). However, there is an increasing body of evidence indicating that the uptake of NHS Health Checks is low across diverse population groups, especially for racially marginalised communities, which contradicts the goal of reducing health inequities.

Different studies have looked at differences in participation. Artac et al. (2013) and Robson et al. (2016) found differences in uptake by South Asian and Black Caribbean ethnicities, where some contexts had both higher and lower participation rates. Robson et al. (2016) conducted a population-based cohort study in five London boroughs and found some minority group participants were more engaged with the programme when outreach was tailored to their culture and background. However, due to socio-economic stresses, language capabilities, and trust in health systems, gaps still exist (Gidlow et al., 2014).

The study by Cook et al. (2016) conducted in Luton also helps understand gaps in participation. They investigated the effect of ethnicity and gender, as well as invitation type, on NHS Health Check uptake. They found that White British, Black Caribbean, and Indian patients had relatively high uptake, while patients identified as ‘Any Other White Background’ and Black African were significantly less likely to participate. Also important, this study found face-to-face personalised culturally and linguistically tailored invitations yielded the most uptake among all groups. In fulfilling these findings, the study illustrates the need for culturally responsive methods to invitation and service delivery.

Comprehensive qualitative research has been conducted to analyse these barriers. Brangan et al. (2019) examined an outreach via telephone for deprived communities and global majority groups in Bristol. The intervention utilised community health workers to call patients in the languages of their preference. This resulted in better understanding of the NHS Health Check and better attendance. Participants appreciated the tailored approach, the ability to communicate in their preferred language, and the option to schedule the appointment over the phone. However, the study also highlighted the logistical challenges of scaling such interventions and the need for improved data quality on ethnicity to better target services.

Further ethnographic research by Riley et al. (2015) examined the delivery of NHS Health Checks in community settings, targeting Afro-Caribbean populations in inner-city Bristol. The study demonstrated the effectiveness of using community assets such as churches, community centres, and engagement workers to promote uptake. Attendees appreciated

the familiar and informal settings, which fostered trust and reduced perceived barriers to participation. Nevertheless, concerns were raised about maintaining confidentiality in community venues and ensuring staff were adequately trained to deliver culturally sensitive lifestyle advice.

Despite these positive examples, several gaps remain within the existing literature. There is a lack of robust, large-scale evaluations of culturally tailored NHS Health Check interventions across different global majority groups and regions. Much of the current evidence derives from small-scale studies or pilot projects with limited generalisability. Additionally, the categorisation and recording of ethnicity in primary care data systems remain inconsistent, hindering efforts to evaluate equity of access and outcomes (O'Brien et al., 2022).

There remains a gap in understanding the views of non-responders to the NHS Health Checks, especially among racially marginalised groups. Knowing the reasons for non-participation is very significant in informing subsequent service design. Although there is promise with community-based approaches, more work remains to be done regarding their long-term sustainability, cost-effectiveness, and overall scalability. Subsequent works should focus on designing the NHS Health Check interventions alongside racially marginalised communities to ensure these services are culturally relevant and easy to use. This means developing detailed protocols for writing invitations, providing sufficient linguistic assistance, and training personnel on appropriate cultural communication. Also, primary care needs to standardise the recording of ethnicity data to enhance monitoring and evaluation. To summarise, although there is some evidence that culturally adapted NHS Health Check programme interventions may increase participation in racially marginalised communities, much remains to be understood and applied. Filling in these gaps requires multidisciplinary attention from policy makers, practitioners, and researchers so that the NHS Health Check programme provides adequate equity in health resources to all communities serviced.

Rationale for Commissioning the Project

The evidence from the scoping review highlights persistent disparities in the uptake of NHS Health Checks among racially marginalised communities. Birmingham City Council therefore decided to commission focus groups for Black African and Black Caribbean communities, and other ethnic communities to further understand and inform current provision and future commissioning of NHS Health Checks. It was proposed that the focus groups must include the following global majority groups, based on 2021 Census data: Pakistani, Indian, Bangladeshi, Caribbean, Arab, Chinese, Somali, Nigerian, Eritrean, Ghanaian. People of mixed heritage that identify with one of the above global majority groups might also be invited to the focus groups. The Council also commissioned some additional focus groups to further support understanding and data analysis. It was proposed that focus groups also include: 1x White British Males and 1x White British Females (in a ward with IMD score of 1 or 2), 2x focus group for NHS Healthcare professionals who deliver NHS Health Checks within these communities in Birmingham.

This project directly supported Birmingham City Council's goals of creating:

- An aspirational city to grow up in: By improving access to preventative healthcare, we contribute to the long-term health and well-being of younger residents.

- A fulfilling city to age well in: By addressing barriers to NHS Health Checks, we help older residents maintain their health and independence.

The project also contributed to the Public Health Outcome Framework by working to reduce differences in life expectancy and healthy life expectancy between communities. This report details the findings of a community-based participatory research project undertaken to understand these barriers and inform strategies to increase NHS Health Check uptake in Birmingham.

ABOUT THE NATIONAL HEALTH CHECK PROGRAMME

Plain English Summary

The NHS Health Check is a free health check-up for adults aged 40 to 74. It helps people find out how likely they are to get serious health problems, like heart disease, stroke, type 2 diabetes, kidney disease, or dementia. The check-up also gives advice and support to help people stay healthy and lower their chances of getting these conditions.

Who Can Have an NHS Health Check?

NHS checks are offered to adults aged 40 to 74 years without any diagnosed long-term diseases such as heart issues, diabetes, high blood pressure, or high cholesterol. Individuals diagnosed with these diseases do not need to undergo this assessment since they are already being monitored on a regular basis.

Those who qualify are sent an invitation from their GP or council every 5 years. Alternatively, if someone did not receive the invitation they can simply reach out to their GP's surgery, local council, or a participating pharmacy to obtain a check.

What Happens During the NHS Health Check?

A healthcare professional, like a nurse, doctor, or pharmacist, conducts the check that lasts between twenty to thirty minutes. It consists of the following processes:

- Height, weight, waist size, and blood pressure are all examined.
- A cholesterol test as well as a blood sugar test if needed (typically a finger prick test.).
- Questions regarding diet and exercise, smoking, and drinking habits.
- Review of personal and family health information.

Results and Risk Assessment

During the check, the following results will be given to you:

- A cardiovascular risk score that estimates the chance of experiencing heart or blood circulation issues within the next decade. This score can be low, moderate, or high.
- Additional health assessments such as body mass index (BMI), cholesterol, blood pressure, risk of diabetes, and alcohol intake.

The healthcare provider presents the results alongside recommendations to help in improving one's health. While age, ethnicity, and family history is unchangeable, one's smoking, diet, and physical activity can greatly be improved.

Follow-Up and Support

Health risks may be mitigated by implementing the following recommendations:

- Improving dietary choices.
- Engaging in more exercise.

- Shedding excess weight.
- Contentiously tracking and limiting alcohol intake.
- Quitting smoking.
- Controlling cholesterol or blood pressure.

Advice may also refer clients to local services to help them with weight loss or to assist in stopping smoking.

Importance of the NHS Health Check

The programme conducts preventive analysis before symptoms appear. It is beneficial in identifying health risks early. High blood pressure and cholesterol are two common conditions that do not have visible indicators but can lead to complicated health issues if untreated.

The NHS Health Check aims to mitigate these risks to heart disease, stroke, type 2 diabetes, and kidney disease. It also increases awareness about risk factors associated with dementia, especially in people over 65 years, and evaluates common risk factors for other preventable illnesses like certain cancers and respiratory diseases.

Summary

For people aged 40 to 74 years, NHS Health Check is non-invasive, cost-free, and straightforward providing there are no underlying health issues. It enables immediate action to be taken in response to serious, preventable health conditions, thereby improving overall long-term health and wellness. Health and wellness is vital at all ages.

AIM AND OBJECTIVES

Aim:

To explore the barriers and facilitators to adopt NHS Health Check among different ethnic communities in Birmingham.

Objectives:

1. **Assess Awareness and Understanding**

To understand the existing level of awareness and knowledge around the NHS Health Check in terms of perception, purpose, benefits, and eligibility.

2. **Evaluate Experiences and Expectations**

To explore participants past experiences with NHS Health Checks and their expectations regarding accessibility, quality, and delivery, identifying barriers and areas for improvement.

3. **Optimise the Customer Journey**

To analyse the full customer journey–from awareness to follow-up care–highlighting challenges and opportunities to enhance the user experience and increase uptake.

4. **Enhance Cultural Relevance and Sensitivity**

To ensure NHS Health Checks are culturally appropriate by understanding community-specific needs, addressing language barriers, and tailoring services to foster trust and inclusivity.

5. **Empower NHS Staff**

To gather NHS staff perspectives on delivering Health Checks, identifying training needs and strategies to improve cultural competence, operational efficiency, and engagement with diverse populations.

PROJECT METHODOLOGY: A COLLABORATIVE AND CO-PRODUCED APPROACH

For this project, we designed it with a collaborative, multi-layered research framework guided by Participatory Action Research (PAR) and Co-Production. Data was collected and analysed using a double-layer sampling strategy, focus group discussions, and framework analysis. Ensuring that racially marginalised communities were not just participants but true partners in the research was essential to this approach.

Participatory Action Research (PAR) and Co-Production

The investigation was based on Participatory Action Research (PAR), which strives to create equitable partnerships between researchers and communities by involving relevant stakeholders in every aspect of the research (Ingram et al., 2020). Co-Production was incorporated throughout the project to promote shared decision making, respect, and ownership for the entire process and results. By integrating these two approaches, the project sought to overcome challenges experienced by racially marginalised populations in relation to NHS Health Checks, considering their experience and expertise for the research design as well as the implementation (Pettican et al., 2023).

Community-Led Focus Groups

The community organisations functioning as Focus Group Providers (FGPs) were engaged as equal partners for the design and implementation of the focus groups. FGPs were selected because of the trust, credibility, and reach within their communities. FGPs were responsible for the recruitment of participants, moderating sessions, and collecting data with cultural and linguistic sensitivity. In order for these goals to be achieved, researchers from Birmingham City University partnered with Focus Group Providers (FGPs) to tailor the preparations for the focus group protocols and topic guides to their specifications. These were intended to achieve the research objectives developed in collaboration with the commissioning partners alongside available evidence from literature on the NHS Health Check and its use. They also contributed and were shaped by FGPs' lived experiences to make them more useful and accurate. FGP facilitators attended pre-research workshops which trained them on several important topics. These ethics, including confidentiality and demographic data collection, was only one part of the workshop. There were measures outlined to ensure uniformity and rigor during data collection as well. The training recapped facilitation techniques that foster respect and inclusive discussions as well as debriefing techniques signposting participants toward supportive information about NHS Health Checks that they might need. This approach was aimed at ensuring confidence among FGP facilitators regarding delivering community-based participatory research sessions while balancing the scientific rigour of the research.

Collaborative Roles and Responsibilities

With respect to focus group implementation, academic researchers offered FGPs mentor support on methodologies, frameworks, and project oversight. In supporting roles during the focus groups with FGPs, the researchers trained FGPs on data collection, developed

research questions, and obtained ethics approval. The project placed a priority on empowerment and building the capacities of the participants. By enabling the community FGPs to take ownership of the entire research process, we cultivated greater community organisational longitudinal research capabilities. This model of collaboration sought to improve local capacity so that the value of the research would transcend the project's lifespan.

Building Trust and Strengthening Relationships

Developing and maintaining trust among researchers, community organisations and participants was the focal point of the co-production approach (Fledderus, 2015). This was important because of the systemic discrimination and historical neglect many of the participating communities have endured from healthcare services. Trust was built by empowering community organisations to facilitate for these communities in safe settings where their cultural practices are respected and where the community is given primacy in the interpretation of findings.

Towards Social Action

With the project's adoption of PAR and co-production, there was a concerted effort towards social action rather than just data collection (Darby, 2017). These activities are expected to stimulate the development of new collaborative models for the delivery and public engagement of the NHS Health Check. Through these results, the project intends to create long-term sustainable solutions to tackle health inequalities with particular attention to the longitudinal gaps faced by ethnically marginalised populations.

Double-Layered Sampling Design:

To study the diversity in the population of Birmingham, and the possible differences in perception and comprehension of the barriers to NHS Health Checks, a double-layered design sampling approach was utilised (Penafiel et al., 2022).

Layer 1 (Ethnicity): The first layer concentrated on obtaining participants from the different global majority groups in Birmingham. This guaranteed adequate coverage for the identification of ethnicity-specific barriers, particularly on the representation of the barriers.

Layer 2 (Demographics): The second layer used demographic characteristics, that are gender and age range, in combination with each identified global majority group to form more homogeneous focus groups. This provided an understanding of the influence of ethnicity, gender, and age on the experiences and perceptions of the participants.

With the aid of this double-layered design approach, it was possible to understand the common and unique barriers different demographic groups face. These findings were significant in the design of the targeted intervention strategies and guidance for the recommended stepwise pilot programmes.

Framework Analysis:

Due to the project's timeline and the requirement of timely analysis, framework analysis was used as the main method of analysis (Ritchie et al., 2013). This technique utilised established themes from the Research Capacity Development (RCD) framework and customised it together with the FGPs to facilitate the analysis and ensure that it met the requirements of the project (Cooke, 2005).

The framework analysis was both effective and efficient. It ensured that there was a comprehensive methodical scrutiny of the data and helped in uncovering important themes, patterns, and relationships linked to the barriers to NHS Health Check uptake. The analysis received guidance from predefined themes, but it was flexible enough to capture new and surprising findings in the data.

Focus Group Design Workshops:

The research team created and implemented workshops with the FGPs that were designed to be highly participative. These workshops were foundational to the quality and reliability of the focus group data collection. The workshops were able to achieve the following goals:

Building a Shared Understanding: All participants, irrespective of their background, came to agree that focus group methodology was suitable for this project and that there was no methodological problem.

Establishing Focus Group Objectives: Each focus group was accompanied by a clear and detailed objective in order to keep the discussions in line with the research goals of the project.

Developing Thematic Questions: Thematic questions aimed at providing detailed information on barriers to participating in NHS Health Checks were crafted to ensure that they would enrich the discussions. The process was consultative to ensure that sensitive cultural issues were taken into account.

Creating Guidelines for The Focus Groups: These guidelines, which were crafted in line with accepted standards of focus group research, gave particular attention to the encouragement of open and frank discussion, the setting of ground rules for constructive talk, and the guaranteeing of ethical behaviour during the research.

Robust Discussion: The workshops enabled participants to have detailed conversations around each topic, considering the purpose of the question and the best possible way to phrase it in order to get meaningful answers.

Role Playing Exercises: FGPs were prepared to deal with different group contexts and problems that may occur during the focus groups through practical role playing activities. These were formulated from the experiences of academic researchers, thereby making the exercises realistic and useful.

The workshops proved exceptionally useful in improving the capacity of the FGPs, achieving the data collection goals, and promoting very active cooperation between the academic researchers and the representatives of the community.

Language and Data Considerations

It is important to note that the data analysed in this report were derived from reporting templates provided by the community groups that facilitated the focus group discussions (FGDs). Also, some of the FGDs were conducted in the indigenous languages of global majority community members and translated into English as needed. Clarity and coherence were maintained during the analysis by removing extraneous filler phrases such as “mmh” and “okay” from both focus groups’ facilitators and participants. Moreover, and in order to maintain accuracy, participant answers were edited to remove unnecessary detail while retaining essential meaning. The responses that were given had to be compacted along with

fragmented sentences and grammatical errors to fit the academic style of the report. Emphasis should be made, however, that these changes were made carefully in a manner that seeks to uphold the accurately capturing the participants' voices alongside their contributions.

Despite all attempts to honour the authenticity of participants' viewpoints, it is acknowledged that some individuals may feel ambivalent or self-conscious about the report because of its formal academic language (Kvale, 1996). All participants were made aware beforehand that any excerpts from their speech or mother-tongue would be rendered in English so that they would be accurately understood by all. This strategy respects the participants and all the other stakeholders of the research by ensuring that their voices are predominant in the study whilst fulfilling the expectations of academic reporting.

Ethics and Confidentiality

Ethics clearance was sought and received from the Health, Education and Life Sciences Faculty Academic Ethics Committee of Birmingham City University **(Ref: Hossain /#13344 /sub2 /R(A) /2024 /Sep /HELS FAEC)** before data collection began. The research maintained all ethical standards to ensure the safety of the participants as well as the study. Participants were given a detailed Participant Information Sheet which outlined the objectives of the research, what participation would entail, and the ways their data would be utilised. This information ensured that participants knew all relevant details before making a decision to partake. Written Informed Consent was collected from all participants prior to focusing on the group discussions. It was made clear in the consent form that participants would take part voluntarily, could leave without having to explain, and would remain confidential and anonymous.

The confidentiality of participants was safeguarded during the study. Data captured in the focus groups was anonymised, and personal identifiers were stripped off in the course of transcription and analysis. Wherever participant's experiences are rendered or their testimonial passages are quoted in the report, due care has been taken to mask their identity. In these cases, pseudonyms or vague descriptors (e.g., "a participant from X community") were chosen to conceal identity and at the same time, allow the participants to have their voices heard.

In addition, data were stored in accordance with the Data Protection Act of 2018 and GDPR regulations (Vlahou et al., 2021). Handwritten notes and interviews were stored in encrypted files on a need-to-know basis within the research team and were not available to the public. After the completion of the study, data will be kept for the specified time in the ethics application before destruction.

The research team was dedicated to making sure all participants were treated with respect and dignity during the entirety of the process. Focused attention was directed towards ensuring participants felt safe and included during the focus group conversations, so participants were able to voice their feelings and experiences without fear of being judged. Such actions made sure that the research was ethically and openly respectful.

Focus Group Discussions (FGDs)

This project used focus group discussions (FGDs) as a method to assess the barriers and facilitators in accessing NHS Health Checks for Black African and Black Caribbean, and

other ethnic communities. The purpose was to explore these issues and enable the current provision and future commissioning of NHS Health Checks.

FGDs are a qualitative research technique often employed for focusing participant discussions around a selected topic (Krueger & Casey, 2000). They stimulate the production of responses with the help of behavioural group activities, where participants' remarks are either accepted or countered by others on the spot. This results in a dialogue and an exchange of ideas which is usually uncontrolled and free within the group members that can facilitate free expression of thoughts and opinions (Beck et al., 1986).

Focus group discussants were recruited through community-based organisations called focus group providers, which enables access to different community networks and confidence among respondents. The study aimed to generate a more representative sample that incorporated proportions of males, females, different age groups, and ethnicities. Although these requirements could not be met in each study region, a sufficient amount of diversity was incorporated into the sample in order to achieve the objectives of the research.

This project's FGDs had members from the following ethnicities as per 2021 Census: Pakistani, Indian, Bangladeshi, Black Caribbean, Arab, White British, Chinese, Somali, Nigerian, and Ghanaian. People with mixed backgrounds who associate themselves with any of these ethnicities were also asked to join. Furthermore, two FGDs were held with NHS staff who were delivering NHS Health Checks to understand their experiences, perceptions of the work, and any issues they faced.

A total of 22 FGDs were held, with 193 people taking part, 13 of whom were NHS health professionals. Apart from this, there were 9 participants for one-to-one interviews, but these interviews are not reported in the results or analysis of this report, because they were outside the scope of the primary research which was focused on the FGDs.

Rationale for Including NHS Staff

Also, having NHS staff was vital to obtaining frontline views on possible gaps in the NHS Health Checks. The discussions were similar to those conducted in the community FGDs in relation to the scope of the inclusiveness, culture, communication, and operations. The study sought to incorporate the perspectives of NHS health professionals in order to understand all the factors affecting the provision and acceptance of NHS Health Checks.

In this way, the approach was effective in capturing most if not all the voices from different ethnic communities and NHS health professionals. The absence of the one-to-one interview data from analysis and findings ensured that the report only dealt with the results of the group discussions while adhering to FGD methodology. These strategies enabled the study to determine important cultural, systemic, and operational factors that influence participation in NHS Health Checks, and devise appropriate evidence-informed strategies to improve service delivery and uptake.

Conclusion

Participatory Action Research, combined with double-layered sampling design, efficient framework analysis, and collaborative focus group design workshops constituted a strong and flexible methodology. This approach ensured the project's goals were achieved, delivering valuable and actionable insights into improving NHS Health Check uptake for the diverse communities within Birmingham. The collaborative nature of the project, particularly

the empowerment of community representatives, has created a lasting legacy of research capacity and a strong foundation for future initiatives.

PROJECT APPROACH: WORKING TOGETHER FOR BETTER HEALTH CHECKS

Focus Group Provider – Who Are They?

Focus group providers were representatives from various Birmingham community organisations who had direct links with their respective communities. The Council therefore commissioned focus groups for Black African and Black Caribbean communities, as well as other ethnic communities, to further understand and inform the current provision and future commissioning of NHS Health Checks. There were about ten focus group providers involved in this project, who have been acknowledged with big thanks and also in the acknowledgements section towards the end of this report.

Academic Partner – Who Are We?

We were the Academic Provider—a pool of academic staff from the Public Health Department of Birmingham City University. Whilst this approach ensured communities were well represented, they needed to be supported by us to ensure that focus groups were well delivered and well documented. Therefore, we were commissioned by the Council to support the smooth delivery of the focus groups, improve the academic rigour of findings and conclusions, ensure that the focus group Providers reported the findings in a standardised way, and produce a final report that explored the differences within age groups and ethnic communities.

Final Report: Improving Access to NHS Health Checks in Birmingham

We are pleased to report that this project has been completed successfully, which sought to understand and mitigate the barriers for certain communities in Birmingham accessing the NHS Health Checks. Our collaboration centred approach worked with the community and the latter implemented actions to achieve the aims of the project efficiently.

Engaging the Community

Right from the start, we collaborated with community representatives and organisations in order to gain the perspectives of the actual participants of the project. We worked with Focus Group Providers (FGPs) who facilitated our contact with the communities, helped in conducting the dialogues, and aided in extracting the needed information. These partnerships were essential for establishing confidence among the participants and guaranteeing the credibility of the research among the residents of Birmingham.

To equip the FGPs, we organised orientation sessions and explained what was expected of them so that they could actively participate in achieving our goals. This approach enabled community members to take responsibility for defining the problems and formulating possible solutions.

Understanding the Barriers

In order to reflect the multicultural nature of Birmingham, we tried our best to incorporate individuals of differing ethnicities, sexes, and ages. This also enabled us to analyse how an individual's cultural or age-related background may affect their understanding of and access to NHS Health Checks. With focus group discussions, we uncovered deeper barriers that people experience. These ranged from not knowing about the checks, to cultural barriers, to practical ones, like the inability to spare time for the appointment.

Turning Insights into Action

The focus groups provided us with clear actionable steps that could make NHS Health Checks more accessible. As an example, we noticed that certain communities could be made more aware through targeted communication campaigns, or that flexible appointment slots could solve some of the practical issues. Such considerations are helpful for creating pilot projects in Birmingham, which would serve the city's diverse population.

Collaborative Workshops

In preparation for the focus groups, we scheduled workshops with the FGPs for us to plan and prepare with them. As a team, we set specific goals, crafted discussion questions, and developed strategies for fostering candid and useful dialogues. Further, we included a couple of practice sessions so that the FGPs would feel confident about directing the group discussions.

What We Achieved

Engagement with local communities has helped us gain important understanding of the obstacles that hinder people's participation in the NHS Health Checks. This project not only described the problems, but it also offered realistic suggestions for dealing with them. We hope this work will help support better health for the people of Birmingham and tackle health inequities in the city.

Next Steps

We expect this project's findings to help inform subsequent efforts, as well as pilot activities, to facilitate participation in the NHS Health Checks. We are sure that the joint approach we took will provide a basis for future similar initiatives.

RESULTS

This Section presents the findings of the research study and uses the parallel reporting format to describe the experiences and perceptions of two primary stakeholder groups; service user and service provider. They separate these perspectives with the aim of providing a complete description of the barriers, facilitators, and opportunities regarding the NHS Health Check programme from both sides of the service delivery.

The participants responses to the follow up FGDs were clustered into major themes that surfaced during the analysis and so each of them is treated independently as for service users and service providers. This enables each groups' challenges and insights to be captured while addressing the extent to which both groups experienced the same and different issues.

The results are structured as follows:

Service Users' Perspectives: This subsection centres on the experiences, views, and issues confronted by candidates of or participants in the NHS Health Check programme.

Service Providers' Perspectives: This subhead aims on the insights, issues, and tactics that healthcare providers engaged in undertaking the NHS Health Check Programme had.

The findings are presented this way because our intention is to target main goals that capture the scope of the issues of implementation, levels of accessibility, inclusiveness, and effectiveness of the health check programme.

Focus Group Discussions with NHS Health Check Service Users

This part provides an in-depth analysis of the findings from 20 focus group interviews conducted with different global majority groups in the city of Birmingham, England. These FGDs investigated participants' levels of knowledge, encounters, and challenges towards the NHS Health Check programme. The analysis's results reflect the following overarching themes: community awareness and anticipations on NHS Health Checks, past encounters with the programme, the patient experience attending the NHS Health Checks, the concern of its appropriateness for the intended community, and important factors like how information is communicated, the building's location, language of the staff, and the healthcare provider's culture sensitivity. All the themes are examined further with supporting quotes from participants and an ethnic, gender, and age analysis.

1. Community Knowledge and Expectations of NHS Health Checks

1.1 Awareness and Understanding

One of the points raised in all the focus group discussions is the startling low awareness of the NHS Health Check programme. Many participants from Somali, Bangladeshi, Nigerian and Chinese communities seemed to know very little about what the programme entailed and who was eligible to participate. For a lot of participants, the NHS Health Check appeared to be synonymous with a general visit to a GP, causing lack of understanding of its role as a preventive measure in health service delivery. This misconception was captured in comments like, "I thought it was just part of my GP appointment, not something separate," which a Pakistani woman noted and, "Do not know, never heard about, 'NHS Health Check,'" articulated by a Somali man. In the remarks, it is clear that there are no adequate strategies

geared towards addressing the communication gap and low public awareness as it relates to the intended purpose and benefits of the programme.

The objective of NHS Health Check's participants was to determine whether they can prevent the chances of acquiring cardiovascular disease or its variants. Unfortunately, this goal was not met as participants had a distorted understanding of its purpose. A significant number of people, especially those below the age of 50, failed to see their risk factors. One of the respondents belonging to the Black Caribbean community said, "I'm young and healthy, so I don't think I need it". This is an example of the general view towards preventative health checks, which seem to be useful solely for elderly or unhealthy individuals. This shows that health campaigns need to shift their focus and promote the idea of preventative medicine for people of all age groups and health conditions.

In addition to age differences, other factors such as gender and culture had an effect on awareness levels. In focus groups, Pakistani, Somali, and Bangladeshi women drew on informal sources such as family, friends, or community groups to gather health-related information. Use of informal networks often contributed to incomplete or fragmented knowledge of the NHS Health Check programme. On the other hand, men tended to rely more on communication from health professionals and NHS brochures. But even among men, there was general agreement that the NHS communication was not interesting or relevant enough for the target audience.

Many respondents outlined the language and format of NHS communication materials as barriers to understanding. Participants from Somali, Bangladeshi, and Chinese non-English speaking communities offered multilingual participation in the programme but their capacity to engage with it was largely limited. For example, one Bangladeshi woman recounted, "I couldn't understand the letter, so I ignored it," whereas a Somali man recounted, "The letter was in English, and I don't read English well, so I didn't know what it was about." These cases call for more focus on culturally and linguistically responsive communication strategies to enhance understanding for everyone in the community about the programme.

1.2 Expectations of the Programme

Outcomes that participants anticipate from the NHS Health Check programme derives from varying degrees of knowledge, health literacy, and cultural perceptions towards preventative healthcare. Some, notably Nigerian and Pakistani men, tended to regard the programme as a "full body MOT" expecting detailed examination and advice on every aspect of their health. This was oftentimes based on the misunderstanding, or more correctly, the assumption that the programme was not exclusively focused on cardiovascular risk factors. As one of the Nigerian participants noted, "I thought they would check every part of my body… but it was just a few basic tests." His remarks succinctly reveal the disparity between the expectations of participants and the provisions of the programme.

On the other hand, some participants, particularly ones belonging to the Chinese and Bangladeshi communities, had very low or no expectations of the programme due to being less informed. For this group, absence of effective information regarding the goal and advantages of the health check led to lack of interest. Some participants appeared to be doubtful about the usefulness of the programme and wondered why it was not advertised more if it was really important. One White British participant added, "If it's important, why doesn't the NHS make it automatic and book me in?" This quotation illustrates a point that

programme which are well thought out and well informed, there is no reason for any issue with communication.

Participants' perceptions of the programme were significantly influenced by cultural norms. For instance, the women from South Asian and Somali communities highlighted the necessity of advice that is culturally relevant. A number of women were keen on receiving nutrition recommendations that were in their native cuisine and cooking style. A Pakistani woman explained, saying, "We need advice that fits our traditional diet, not just generic tips," implying that there needs to be more focus on the context within which health education is provided. Men, in contrast, appeared to be more interested in the details of the health check and the provision of individual feedback. Overall, men and women in all groups expressed a need for more information regarding the process and usefulness of the health check, suggesting that many unmet expectations could greatly hinder participation.

2. Previous Experiences with NHS Health Checks

2.1 Positive Experiences

NHS Health Checks had positive experiences, albeit in a few and rare cases. However, these experiences were largely based on the interaction with the healthcare staff. Participants who reported positive experiences during their appointments mentioned being professionally attended, as well as given comprehensive explanations regarding the checks. A participant from the Caribbean community explained, "The staff were extremely professional and explained everything well. After the check, I was really reassured." In the same manner, a Chinese participant said, "The professionalism was appreciated, and the results were explained in a very clear manner." These experiences are mostly reported when healthcare staff attend to patients and state the objectives of the check, the implications of the results, and the steps to be taken to mitigate the risks.

Those who were referred to specific services performed better on the NHS Health Check than those who were simply given generic advice. For these participants, the NHS Health Check presented a useful chance to prevent some health problems from escalating. Interestingly, respondents who described having good experiences tended to focus on the fact that they were listened to and respected during the appointment, something which is important for the interpersonal dimension of care delivery.

2.2 Negative Experiences

Conversely, negative experiences were more widespread and often eroded the programme's trust. Common complaints were lack of adequate time during appointments, unsatisfactory explanations, and insufficient follow-up care. Many participants perceived the health checks as "skin deep" and impersonated, thus undermining their trust in the programme's efficacy. A Somali woman, for instance, pointed out, "They lost my blood test results two times. It made me feel like I was not helped in any way," which underlines administrative burdens that trust will only be eroded further. A Bangladeshi man similarly said, "The appointment gave me the impression that it was a rush appointment, and I did not get an explanation as to what the results meant," general sentiments of how poor the service was.

There were also other causes for negative experiences such as language barriers from participants who did not speak English in Somali, Bangladeshi, and Chinese groups.

Problems in getting interpreter services left participants to depend on family and friends which was largely viewed as highly inadequate. Women tend to emphasise the absence of female healthcare providers as great concern due to cultural reasons. For example, a Pakistani woman said, “I would feel more comfortable with a female doctor who understands my history,” in relation to understanding gender-sensitive service delivery. Difficulties posed by scheduling appointments and being unavailable during typical working times worsened these negative experiences. Frustration with the overall access to the programme was common among these subjects, which points to how these factors can lead to low uptake in some communities.

3. The Customer Journey of Attending NHS Health Checks

Attending NHS Health Checks requires going through a customer journey with various steps that must be undertaken in order for an individual to successfully complete the process. These steps range from receiving the invitation, deciding whether or not to attend, attending the appointment, and finally, follow-up on provided results and recommendations. Each of these steps has its own challenges and facilitators that can greatly modify a person’s experience with and engagement in the programme.

3.1 Receiving the Invitation

For the customer journey, the receiving and understanding the invitation to the NHS Health Check is marked as the first step. This section of the process was riddled with confusion, miscommunication, and misunderstandings. The methods of communication employed towards these individuals were ineffective. The letters of the invitation, which is the primary method of outreach employed by the NHS, were often described as unclear, overly technical, and not culturally relevant. Non-English speakers from different ethnic and cultural backgrounds like the Somali, Bangladeshi, and Chinese communities suffered from the lack of English resources.

As an illustration, a Somali participant said, “The letter was in English and I cannot read English well so I didn't know what it was talking about” and a Bangladeshi participant noted, “I thought it was junk mail and just discarded it.” These quotations underscore the importance of considering formats that are both simple and culturally appropriate. Many respondents proposed using alternative approaches such as making phone calls, sending text messages, or organising events geared toward educating people on the purpose and significance of the programme. Comments made by one participant from the Nigerian community highlighted this when he said, “A phone call would make it feel more personal and important. A letter doesn’t grab attention.”

Apart from communication barriers, how the invitations were designed and phrased was identified as a problem. Participants observed that the letters did not adequately convey the purpose and the perceived advantages of the NHS Health Check which led to scepticism or disinterest. One White British participant noted, “The letter doesn’t make it sound like it is time sensitive or important. It is simply another piece of NHS paperwork.” This statement articulates the need to proactively changing the narrative to ensure the health check is understood and valued as a crucial supplementary action instead of forward sedentary bureaucratic processes.

3.2 Deciding to Attend

Attendance at the NHS Health Check is influenced by a multitude of personal, socio-cultural and logistical factors. Most respondents noted that the usefulness of the health check in relation to their own health needs was central to their choice. Most younger respondents, especially those younger than 50, did not consider themselves likely to suffer from the programme's target conditions, such as cardiovascular disease. Illustrating this point, one Caribbean participant stated, "I'm young and healthy, so I don't think I need it." This perception was further buttressed by a misunderstanding regarding the focus of the health check, in that, many participants assumed that the health check was only applicable to people with existing health problems.

Attitudes towards culture and health influenced participants' culturally shaped decisions. In some communities, there seemed to be a lens focused and optimistic towards reactive health, bringing attention to it only when symptoms manifest, rather than towards preventative healthcare measures. One Somali participant stated this quite well, "In our culture, we go to the doctor when we are sick. Proactive health checkups are not something we consider." Furthermore, a Bangladeshi respondent also mentioned, "If I fine, there is no need for me to check." These sentiments unfold indicate the gap that exists in terms of understanding the value of preventative healthcare and the need to focus on structured outreach programmes in these communities.

Some logistical challenges like appointment scheduling also discouraged a good many participants from turning up. For several participants who have 9-5 jobs or caregiving responsibilities, booking an appointment seemed to be a burdening and endlessly complicated task. A White British participant put it succinctly, "Appointments are only during work hours which is impossible for me," while a Pakistani woman explained her experience, "The phone system at the GP has a lot of issues so I find it hard to get through." These difficulties reveal that taking on an online appointment system could greatly help resolve these issues.

3.3 Accessing and Navigating the Appointment

For such participants who chose to go for the appointment were subject to several issues regarding the accessibility and manoeuvrability of the venue. Some of these issues include the NHS health check's geographical location, the presence of interpreter services, and the overall cultural competence of the health professionals attending to them. A vast number of respondents reported that the NHS health checks should be conducted in more community friendly places like mosques, community centres, or schools located within the vicinity. As one of the Bangladeshi respondents provided an example, "If it's held in a community centre, people will feel more comfortable and more likely to attend," for such individuals having a centre health care facility is extremely convenient. This is another example that shows how anxiety or alienation is controlled through having a welcoming and culturally sensitive environment.

For those who did not speak English, a primary barrier was with communication with staff during the appointments. The lack of sufficient interpreter resources was inadequate for a lot of people which led to feelings of exclusion. A Somali participant explained the difficulty they had: "I couldn't understand what the nurse was saying, and I felt embarrassed to ask for help." Such information calls attention to the fact that there are numerous reasons for the

NHS to integrate interpreter services for multicultural health check regions: border requirements.

One other major issue in participants' experiences was the cultural sensitivity of the healthcare staff. Some South Asian and Somali women reported a preference for female health care providers because of cultural and religious reasons. As one Pakistani woman put it, "I would feel more comfortable with a female doctor who understands my background." Participants also stressed that the health care staff should be respectful and avoid being judgmental, especially when dealing with sensitive issues such as obesity or behavioural modification. As a Caribbean participant noted, "The nurse was very kind and didn't make me feel bad about my weight. That made a big difference."

3.4 Following Up on Results and Recommendations

The final stage of the customer journey- following results and recommendations was noted as an important area to improve on. Many participants reported being bewildered or at a loss over what the subsequent steps were after their health check, more so when there was a referral made for further tests or specialist attention. A Bangladeshi participant shared, "They told me I needed more tests, but they didn't explain why or what would happen next." Such ambiguities often left people feeling excessively worried and withdrawn.

Furthermore, participants displayed increased frustration due to a lack of communication from healthcare professionals. Several individuals reported that their GP or the NHS was increasingly unavailable or impossible to contact when it came to updating them on their pending test results. A Somali participant provided, "I had to call the GP several times to get my results. It felt like they didn't care." These examples serve to depict how critical it is to provide timely communication regarding results and next steps including ongoing support to help individuals implement lifestyle changes or further services.

4. The Appropriateness of NHS Health Checks for the Target Community

In assessing the effectiveness and engagement of the programme, the most vital factor is whether the participants' needs are met. As participants in the focus group discussions revealed, the programme seemed to meet their cultural expectations. This part then discusses the appropriateness of the programme in regard to Formats and modes of communication, Location and accessibility, Appointment timing and allocations, literacy and language, and the culture of the staff serving the patients.

4.1 Communication Formats

From the above information, it is clear that the scope of community outreach faced a considerable limitation through the inability to issue anything other than written notifications as the predominant means of broadcast. This is especially true for those participants who did not speak English. Yet communication encompasses the language of the communication materials alone but also the style, design, and call to action within the messages. Participants believed that communication must also be able to capture the attention of specific community groups and therefore should be designed in a culturally appropriate manner.

An example includes the Somali and Bangladeshi participants preferring to communicate over the phone or using face-to-face methods because they feel it is more effective. As one

Somali participant noted, “In our community, people are more likely to trust information coming from an authoritative figure such as a leader. A letter does not have the same effect.” In the same way, a Bangladeshi participant provided the following suggestion: “If someone from the mosque or a community group explains it to us, we will listen and take it seriously.” These quotations are a clear example of the need to use the network within the community’s boundaries for successful communication regarding the programme.

Apart from oral communication, participants also suggested other presenting modes including videos, infographics, and even social media. These types of formats are more appealing and comprehensible, especially for the youth and the undereducated. A Nigerian participant stated, “A short video in my language that explains the health check process would be helpful. It would really encourage a lot of people to attend.” This suggestion reflects the importance of multimedia tools in the health check process and the need to overcome fears and misconceptions surrounding the procedure.

4.2 Location and Accessibility

The placement of NHS Health Checks was another important aspect determining their fitness for purpose within the target community. Many respondents preferred to have health checks conducted at accessible and culturally appropriate venues, such as mosques, community centres, and local schools. Compared to GP surgeries and hospitals, these settings were less hostile and much more friendly.

For instance, one Bangladeshi respondent illustrated this by saying, “If it’s held in a community centre, people will feel more comfortable and more likely to attend.” Likewise, one Somali respondent said, “Going to the GP feels formal and stressful. If the checks were done in a place we know, it would be easier for us.” These quotes are a reminder that people are aware of the importance of shields that mitigate environmental factors that enhance anxiety or alienation.

Participants stressed the necessity of ensuring that health check sites are accessible, especially for aging and physically challenged individuals. “Some elderly people can’t travel far or climb stairs. The location needs to be easy for them to get to,” said a participant from the Caribbean. This highlights the importance of ensuring that venue selections for health checks give emphasis to physical accessibility.

4.3 Appointment Availability

Limited availability of appointments was problematic for all focus groups. Participants often reported challenges with getting an appointment because of excessive waiting periods, restrictive booking hours, and limited options-outside standard working hours. For many participants with full-time employment, caregiving, or other time-sensitive responsibilities, these logistical issues caused the most difficulty.

As one white British participant said, “Appointments are only during work hours, which makes it impossible for me to attend without taking time off.” Also, a Pakistani woman stated, “I look after my children all day, so I can’t go to an appointment unless it’s in the evening or on the weekend.” These responses suggest that there can be adjusted working patterns to make appointments convenient by offering evening and weekend times.

Users voiced their frustrations regarding the procedures involved in booking an appointment, particularly for users who had to depend on GP surgeries for the bookings.

Several participants labelled the phone system employed in their GP practices “a nightmare,” citing long waiting periods and constant disconnections. A Bangladeshi participant pointed out, “It’s so hard to get through on the phone. I gave up after trying three times.” These accounts demonstrate that offering online booking or walk-in appointments would greatly simplify access to the programme and thus improve the overall experience with the system.

4.4 Language and Literacy

Communications problems were among the major difficulties that the respondents reported, especially in the case of the Somali, Bangladeshi and Chinese groups. The lack of multilingual resources and interpreters meant that many participants who spoke other languages other than English felt isolated and neglected. A participant from Somalia put it this way, “During the appointment with the nurse, I could neither comprehend what the letter nor what she was saying. It was so irritating.” The same phenomenon was noted by a Bangladeshi participant, "I ended up needing to take my son so that he could help me, which was humiliating."

Such experiences indicate that there is no doubt that the NHS should proactively include language support in health checks. This includes providing interpreters during consultations, translating documents into relevant languages, and providing illustrations to explain important issues. At the same time, participants underlined the need to cater communication to people with different levels of understanding literacy. For instance, a Chinese participant said, “People who have poor reading skills can benefit from simple diagrams or pictures. Those would be very helpful.”

4.5 Cultural Awareness of Healthcare Staff

The programme featured a comprehensive overview of the issues, including key consideration of the cultural knowledge and attitudes of health personnel regarding the appropriateness of the NHS Health Check programme. In regard to this topic, the respondents stressed that the respect, nonjudgmental attitude, and sufficient knowledge of multi-cultural and multi-religion settings is crucial for any health provider working with a diverse population.

Take, for example, the case of South Asian and Somali women, who preferred female healthcare providers due to socio-cultural and religious reasons. A participant from the Somali community stated, "It is respectful for the staff to take into account our faith so that we are not judged." Likewise, a Pakistani woman recounted, "A female doctor who understands my background would be more appropriate." These comments reflect the necessity of addressing gender issues in service provision as well as cultural diversity in competence training for health care personnel.

Focus group participants further suggested that healthcare practitioners should provide advice that considers the specific cultural practices of the people, especially in diet and lifestyle issues. A Bangladeshi participant stated, "We need advice that fits our traditional diet, not just generic tips that don't apply to us." As one of the Nigerian participants put it, "In as much as you people are saying be eating salad, it does not help me. I need advice that is realistic with the food I know." All these observations emphasise the need to ensure that culturally appropriate recommendations are made in order to enable the patients to adhere to the guidelines provided.

5. Recommendations for Improving the NHS Health Check Programme

These recommendations do not serve only as a pointer to where operational improvements can be instituted, but also as a guide to correcting fundamental issues that pose obstacles to equitable distribution of accessibility to NHS Health Checks. The inclusion of the recommendation's objective serves to make the programme enhance the health outcomes of ethnically diverse communities. Below, each recommendation category is discussed further, detailing how they are connected to focus group findings and analysing the possible outcomes they can achieve.

5.1 Communication Strategies

There is a necessity for effective communication because it helps create awareness and motivation towards the participation of the targeted audiences in the NHS Health Check programme. The findings, however, suggest that various participants either did not receive the invitation or the invitation was not adequately explained to them. Therefore, communication needs to be made multi-dimensional and designed to meet the different needs of the various communities.

One key recommendation would be the incorporation of multilingual components which has the potential to enhance the scope and interest of the programme. For instance, translating invitation letters, brochures, and instructions to other widely spoken languages such as Bengali, Somali, Urdu, and Chinese would enable greater participation by non-English speakers. However, participants are likely to get more involved with the programme if there is a greater focus on verbal and non-verbal creative communication. As indicated by participants, methods such as telephone calls, videos, and community outreach tend to engage a more diverse audience, especially those who are less literate or unfamiliar with established healthcare systems.

Moreover, younger sectors of the participants tend to be digitally active and thus, social media and messaging platforms like WhatsApp can be utilised. For example, a short and engaging video revealing the aim and the method behind an NHS Health Check can easily increases get widespread circulation through these platforms. This not only results in greater reach but also helps tip the balance towards acceptance and routine of having health checks, especially among communities where this is not the norm.

Trust is one of the most important considerations in communication. Participants mentioned the importance of community leaders, faith-based organisations, and local charities as sources of credible information. Working together with these organisations to promote the NHS Health Check programme could help build its credibility and increase participation. A Somali participant provided this example: "If the imam at the mosque talks about it, people will listen and take it seriously." This illustrates how trust can build from community partnerships to help reduce scepticism.

5.2 Location and Accessibility

The receptiveness and motivation of individuals towards attending NHS Health Checks is largely influenced by it's location. The results showed strong indications of preference towards community settings, which included mosques, churches, temples, community centres, and schools rather than healthcare institutions.

Conducting health checks in the community has some notable advantages. Firstly, it eliminates some logistical challenges like mobility issues, as services are brought closer to people's homes or workplaces. Secondly, it fosters a certain degree of trust and security – something that is very crucial for people who tend to feel discomfort or nervousness within clinical settings. For instance, one of the participants from Pakistan said, 'If the health check is in a place we know, like the community centre, it feels less formal and more friendly.'

Apart from picking the right setting, attention must be paid to the actual accessibility of the sites. These include health check locations being wheelchair accessible, proper parking space, and accessibility via public transportation. These aspects can make a huge impact for elderly and other people having mobility difficulties.

Moreover, mobile health units can be used for populations that are hard to reach, for instance, people living in farming communities or in housing estates that lack nearby healthcare services. Mobile vans with medical equipment and primary health care providers trained in the local culture can come to the people and deliver the health checks, thus beating the logistically and culturally challenging problems.

5.3 Appointment Availability

Issues surrounding appointment booking system were a key topic across the focus group sessions, with a good proportion of respondents complaining about challenges in scheduling within the current model. In relation to this, the NHS Health Check programme should be more proactive towards the needs of clients when it comes to appointment booking. One of the most basic and yet effective solutions is to include evening and Saturday appointments. This was particularly the case for several respondents, respondents who are indeed full time employed or those who had caregiving duties. A Nigerian participant while expressing the difficulty noted, "Evening or Saturday appointments would make it so much easier for people like me who work long hours." Such an action would lead to improved attendance as there would be more flexible times for appointments. Another suggestion is that the restriction of needing to book clinics in advance be removed. This would help with the call congestion that many GP surgeries experience during the day. Many respondents were mentioned the tedious and burning nature of waiting to contact someone to book an appointment. It was especially disheartening for people who were on the phone and who were frequently disconnected. Community walk-in clinics may serve a useful purpose and pay for themselves by cutting costs for these disorganized, and for some, aged methods of booking appointments.

Furthermore, the systems of online appointment booking need to be extended and improved in terms of usability. For instance, there should be a straightforward, multilingual website that would permit people to determine whether they are eligible, see what appointments are open, as well as when and where they could make the health check at their convenience. This would make it easier for younger users, who are more inclined to work with devices, to do so.

5.4 Language Support

The focus group discussions have revealed that one of the most defining areas of inhibition is "language" especially with regard to the Somali, Bangladeshi, and Chinese communities. So as to ensure that the NHS Health Check programme reaches its objectives, language support has to be provided at every level.

All appointments, whether conducted in person or via telephone or video conferencing, should incorporate the option of interpreter services. This would enable non-English speaking participants to effectively communicate with the health care provider and appreciate the objectives of the health check. As one Somali participant cited, "It would make me feel less shy and more assured if there is someone who can speak my language."

Besides providing an interpreter, it is important to translate written materials into different languages and use visual aids to provide summaries. For instance, pictorial infographics or pictorial guides could be used to portray the steps of checking the health status of the body for low literate persons. One of the Chinese participants noted “Pictures and diagrams are a great help for people who do not read.”

Additionally, healthcare workers must be trained in cultural and linguistic competency to communicate with people from different backgrounds. For example, using a few key terms from frequently spoken languages, or knowing some cultural norms of communication would help in establishing a good doctor patient relationship.

5.5 Cultural Competency

Culture competence is a crucial component for the successful provision of healthcare to different communities. Its significance was stressed continuously by responders in the course of the group discussions. The findings indicated that in as much as the healthcare services were provided in a professional manner, many were used to being treated with more courtesy and dignity as their culture and religion was acknowledged.

An important component of ensuring cultural diversity is the integration of gender perspectives into service provision. For instance, some South Asian and Somali women specifically preferred to be served by female health care personnel because of cultural and religious reasons. One of the Pakistani respondents said, “It is very important to me seeing a nurse who is a woman and comes from my culture and believes in what I do.” Allowing patients to select the gender of the clinician they wish to serve them is an effective way of advancing the inclusiveness of the programme.

Also very significant is the provision of culturally appropriate guidance on nutrition, physical activity, and other lifestyle choices. Many ethnic health experts were shocked to hear such advice as “eat more salads” or “hit the gym” as such advice did was not practical, and was irrelevant. In her own words, one Bangladeshi participant remarked, “We want advise that is targeting our traditional diet and not broad strokes.” In a similar way, one Nigerian participant commented, “What is helpful is not being told to eat things I am unfamiliar with or do not have the capacity to purchase.” There should be such training for the health care service providers on the cultural practices of different communities so as to advise them on the most appropriate health practices for those cultures.

Healthcare staff are supposed to be trained to identify and deal with potential implicit biases that can affect their relations with patients. They also reported that they needed to be treated with respect and dignity regardless of their background. One of the participants from the Caribbean reported, “The nurse was very kind, and did not judge me, and that made a lot of difference.” These short narratives emphasise the necessity of creating an environment where patients feel safe to share their issues without fear of being judged.

6. The Broader Implications of Optimising the NHS Health Check Programme

The analysis and the series of recommendations done so far proves this point: Public health programmes need to be specially customised to fit the targets that they are supposed to serve. The NHS Health Check programme is one of the public health initiatives aimed as the preventative healthcare in England and if implemented correctly, could treat the cardiovascular disease (CVD) and other associated conditions that have an ever increasing prevalence. However, the effectiveness of the programme relies on its capacity to reach and retain participants from all global majority groups and particularly those who are underserved or in high health risk categories. This section details the broad scope of optimizing the NHS Health Check programme in regards to its capacity to close health gaps, build community confidence in the healthcare system, and serve as a case study for other healthcare endeavours.

6.1 Addressing Health Inequalities

The health concerns within global majority and socioeconomically disadvantaged populations – CVD, diabetes, and other chronic conditions – have been particularly severe in the UK. The NHS Health Check programme has the potential to mitigate these discrepancies by assisting the majority of individuals aged 40-74 that are at high risk of developing these conditions. But as the results of this study show, systemic issues such as lack of language support, sensitivity to culture, and other logistical problems are barriers for these at-risk groups to access the programme.

The broader strategy goes far beyond just embracing multilingual materials and providing health checks within the community, as well as training cultural sensitivity to health workers. Doing so is bound to make the NHS provisions more inclusive. The potential is there to reduce substantially the differentials in health outcomes of various demographic groups. Take Bangladeshi and Somali communities who suffer more incidences of type 2 diabetes and hypertension. Ensuring better health services participation in these groups would result in proactive dealing with these conditions, reducing the risk of severe complications like strokes or heart attacks.

Furthermore, solving health disparities entails outreach and engagement that is both thorough and direct. Members from multiple focus groups raised the need to pay greater attention to outreach initiatives focusing on the engagement of communities that have historically low participation rates. For example, one Caribbean participant stated, ‘The NHS should attend our activities like church services or cultural celebrations to speak to us about the health check. That way, more people will be informed.’ Using this outreach strategy centre on communities, the NHS can slowly earn the trust of these groups and somehow increase their chances of subscribing to health services which might otherwise not be the case.

6.2 Building Community Trust in Healthcare Systems

Trust, or the lack thereof, is a powerful indicator for effective health engagement and can hinder participation in public health interventions. This study's findings elucidate a number of reasons why participants showed high levels of mistrust including their past experiences

with healthcare providers, perceived discrimination, and any other factors that suggest a lack of awareness of the reasons for the NHS Health Check programme acuity.

Improving the customer journey for NHS Health Checks offers an opportunity for revitalisation and establishing community faith in the healthcare system. For instance, preparation of health personnel on cultural sensitivity and covert discrimination can assist in making every healthcare consumer feel appreciated and respected. A Somali participant shared, “When the nurse is listening to me and is able to capture my concerns, I would like to come back more.” These positive interactions, over time, encourage people to invite their friends and relatives resulting in improved trust in the programme.

Moreover, engagement of community gatekeepers and institutions in the execution of NHS Health Checks can increase the programme’s trustworthiness and acceptability. There was a general emphasis in focus groups from different participants that they need to be informed by someone well known in the community. For instance, a Nigerian participant said, “If the pastor or a community leader says it, people will believe it.” Through these recommended community leaders, the NHS will be able to fully engage with these communities rather than work with the abstraction of the community, thus fostering a spirit of partnership and responsibility.

6.3 Enhancing Preventative Healthcare Outcomes

The goal of the NHS Health Check programme is improving preventative healthcare outcomes by addressing risk factors for CVD and related conditions before they progress to an advanced stage. Nonetheless, effectiveness of the programme is determined by participation rates as well as the interventions carried out during and after the health check.

The study also uncovered the need for culturally specific diet, exercise, and other lifestyle advice. Many participants from a global majority background found suggestions like “eat more vegetables” and “exercise more” to be entirely useless. For instance, a Bangladeshi said, “Our traditional food is very different, so we need very specific advice that fits our culture.” Likewise, a Caribbean participant said, “Instruction to go to the gym doesn’t work for me if I can’t afford it or don’t feel comfortable there.”

To improve the results of pre-emptive healthcare, providers must render advice that is both personal and appropriate to a patient’s unique situation and background. For example, rather than recommending salads in the Western style, they can suggest that traditional dishes be cooked in a healthier manner, including less oil and salt. Moreover, providers could suggest walking or dancing as forms of exercise that may be more suitable for the patient.

Another area of concern in pre-emptive healthcare is the follow-up care. Some participants voiced their disappointment towards the absence of follow-up post the health check, which unfortunately left them confused on the steps to take towards the management of risk factors. One Somali participant recounted, “I did not hear anything after the health check, I did not know what I was expected to do next." One of the ways the NHS could deal with this is by implementing a more active follow-up system like scheduled phone calls, text messages, or in many community places to enable patients to attend groups that can motivate the patients to make positive changes.

6.4 Serving as a Model for Other Public Health Interventions

The investigation's issues and answers are important for understanding public health efforts beyond the NHS Health Check programme. Many of the participation barriers, like language and culture, and even logistics, are challenges common to all cancer-related health care services, including screening and vaccination efforts. Addressing these obstacles under NHS Health Checks, however, will enable the NHS to design other programme with established guidelines and tested methods.

For instance, community-based approaches, multilingual materials, and culturally tailored efforts may enhance utilisation of other preventive health services, including cervical and breast cancer screening. Likewise, the focus on trust building through community partnerships and caring may enhance the culture of vaccination, especially in the hard-to-reach populations.

Also, the experience gained from perfecting the NHS Health Check programme can enhance future initiatives in public health, like those concerning the newly developed areas of health care, including mental health, or the effects of social changes, like climate change, on health. If the programme focuses on inclusivity, accessibility, and cultural sensitivity, it can ensure that everyone's health outcomes can be improved.

7. Conclusion

To summarise, the most important consideration from this study is that the NHS Health Check programme needs to be adapted to better services specific communities. Dealing with communication, geographical, appointment scheduling, linguistic, and cultural barriers is important to achieve increased participation in the programme and, ultimately, better health outcomes.

The suggestions made in this report serve as a business improvement plan for the NHS Health Check programme customer journey and for the programme overall. The changes suggested can alleviate the health inequalities, foster confidence to the community on the healthcare system, and set a precedent for other public health programmes. Nonetheless, it is important to note that to achieve these objectives, the NHS has to embrace equity, innovativeness, and collaborative action at all levels of organisation on a continuous basis.

As the needs of the population shift, the NHS is adapting accordingly. The insights provided by this study are essential to maintaining preventative healthcare as an integral part of the public health policy in the United Kingdom. The NHS has an opportunity to motivate self-care and assist in constructing healthier communities by being more inclusive and culturally aware, for current and future generations.

Focus Group Discussions with NHS Health Check Providers

The focus group discussions (FGDs) with the participants who utilise the NHS Health Check programme presented a great deal of information concerning programme delivery, implementation problems, and potential improvements of the NHS Health Check programme. This section also offers a full exploration of the findings from two focus group discussions undertaken with NHS healthcare professionals in Birmingham England involved with the NHS Health Check programme. Healthcare professionals of varying ethnicities,

including general practitioners, nurses, and practice managers, participated in these discussions as they all have essential roles in the success of this programme. This extension synthesised data from two focus groups and reports at once. The findings are framed in a way that serves in to achieve NHS staff empowerment and greater cultural sensitivity and enhances the appropriateness of NHS Health Checks for various communities.

1. Participant Demographics and Context

The participants of the focus group discussions were health professionals between the ages of 30 and 50 with ethnic diversity that cut across the Black / African and British Asian communities. They included GPs, practice managers and nurses, all of whom undertook NHS Health Checks within and outside the clinics in Birmingham. Including these professionals was crucial to understanding the frontline delivery of NHS Health Checks and how they sought to address the gaps in service provision for hard-to-reach communities.

The aim of the discussions was to address issues surrounding access, culture, communication, and operation. These themes the FGDs focused on tried to pinpoint effective ways to enhance the uptake of the NHS Health Checks, especially among the ethnic, minority, and high-risk groups. The varying experiences of participants offered a wide range of perspectives on how NHS Health Checks are offered and utilised. For instance, one nurse gave this insight, “From my vantage point, I have witnessed the effect of culture on whether a client utilises their health check. For a health check to be done, it goes beyond just ringing someone up; an effort must be made to ensure that a person connects with that invitation.” So, too, a GP added, “Our patient population is very diverse. This diversity presents a lot of challenges, but it also presents a lot of opportunities too.”

The discussion was enriched by the diversity of participants’ experiences and roles. Practice managers were able to shed light on operational difficulties around booking and staffing, while the nurses and HCAs provided their frontline perspectives. GPs emphasised the clinical relevance of NHS Health Checks and how they can help avert significant healthcare expenditure in the future by addressing weaknesses at the onset.

This variety of viewpoints enriched the discussions and provided a comprehensive analysis of the programmes benefits and the limitations. One notable finding was that even the composition of the health staff seemed to reflect the demographic characteristics of the patients themselves. This shared cultural context enabled certain providers to connect with their patients better. One nurse shared that, “Being able to relate to patients on a cultural level makes a huge difference in how they perceive the NHS Health Check. With an NHS Health Check, patients are more willing to engage.” Participants, however, emphasised that all healthcare staff, irrespective of their background, need to undergo cultural competence training in order to work with different communities.

2. Awareness and Understanding of NHS Health Checks

All respondents explained when they are to participate in NHS Health Checks and spoke about the activities that are performed during these checks, including taking blood samples, measuring blood pressure, and cholesterol levels. As caution GPs said, “NHS Health Checks are a background mechanism to conduct preventive measures against diabetes and heart diseases by monitoring risk factors on time.” Participants have always believed that such measures help to avert the overwhelming majority of medical conditions in the first place, especially in patients with risk factors.

Participants pointed out the high awareness levels among healthcare professionals, but they pointed out that patients' awareness and engagement levels were much lower and difficult to deal with. Many patients misinterpreted the NHS Health Checks or did not understand their significant value. A nurse shared, "Some patients think it's just another routine test and don't realise how important it is for their long-term health." Unfamiliarity with the purpose of the checks often led to poor uptake, especially among ethnically diverse, working aged adults.

As one participant shared, "NHS Health Checks need to be reframed as a tool of prevention rather than restriction, for if it is seen as diagnostic will evoke fear. The reasons people did not want to attend is because they were scared a certain health problem will be diagnosed." Others pointed out the fact that people are scared of checking their health because the narrative is that checks only result is bad news. Shifting the mindset behind such tests can allow for an increase in life expectancy and decrease in mortality rate. One participant explained, "There's a misconception that if you go for a health check, you'll only hear bad news. We need to shift that narrative and focus on the positives—how these checks can help people live longer, healthier lives."

Younger patients in particular tend to have health concerns that are very specific like cholesterol and vitamin deficiency which is why they turn up for the health checks even if they do not qualify for the more comprehensive NHS offering. With more advertising, specific and targeted toward age groups, understanding of health issues can be improved. To increase participation and engagement in healthcare, appropriate communication channels addressing the most important issues need to be implemented.

Some participants mentioned that terminologies used in certain communication materials posed a challenge to comprehension. For example, concepts such as 'cardiovascular risk' or 'lifestyle intervention' may not be understood by patients who have little understanding of medical terms. As one GP said, "We need to use simple, clear, and relatable language. If patients don't understand what is being offered, they will be less likely to accept it." This reinforces the need for health communication strategies that are focused on patients as clients and prioritise accessibility.

3. Delivery of NHS Health Checks

The account of the NHS health checks given by the Healthcare Assistants (HCAs), practice nurses, and physician associates seemed to be one of teamwork, with the GPs overseeing the work. GPs rarely performed the checks due to their lack of time and, thus, most of the work was offloaded onto other team members. Some participants noted that the ARDENS software system was used to target at-risk patients by sending invitations through SMS or letters.

Participants highlighted some issues with the delivery of the programme despite achieving defined targets. Healthcare workers experienced recurrent time constraints, with many individuals finding it challenging to fit NHS Health Checks within their routines or put it together with their other responsibilities. One participant explained, saying, "When it comes to health checks, my allocated time is often lacking, especially when you attempt to do several risk assessments in a single appointment slot."

Using ARDENS and other programmes could be viewed as risky or helpful. While the system was able to flag patients who were due for follow up appointments, its success was conditional to whether the patient's information had been logged correctly and if there was essential follow up action taken. One practice manager commented, saying, "I think ARDENS is very helpful, but it's not speaking for the patient. There are elements that need to be addressed face to face."

Participants equally pointed out that the implementation of NHS Health Checks seemed to differ markedly between approaches to clinical and community practices. Whereas nurses performed health checks in primary settings like Community mosques and Community Centres, there appeared to be greater patient participation than among nurses working in the clinics. To quote one nurse, "People are much more at ease and willing to talk about their health problems. In Community, they are in closer proximity to those who are supposed to offer service. It's a completely different dynamic from the clinical setting."

Another point on implementation was the combination of NHS Health Checks with other services. Participants in the study remarked that the effectiveness and turnout for the health checks could be better if they were aligned with the flu vaccination clinics or chronic disease reviews. A GP further elaborated, "It is an opportunity for us to provide a health check when patients have already come in for something else. It's about proactive healthcare." Making Every Contact Count (MECC), as this approach is called, was popular among the respondents as a strategy to increase the effectiveness of NHS Health Checks.

4. Barriers to Patient Engagement and Accessibility

4.1 Cultural and Psychological Barriers

These barriers were along the most significant ones that inhibited patients from attending the NHS Health Checks. Some participants explained that a number of communities, especially the ones with roots in Afro-Caribbean and South Asian cultures, were reluctant to undertake health checks for fear of the health conditions they may have that would interfere with their insurance status or lead to stigma.

A GP shared, "There's a lot of fear among patients- fear of the unknown, fear of not being accepted, and fear of what their future diagnosis may entail." Distrust in the healthcare system also contributed towards low attendance rates, particularly in communities that have had historically bad experiences with healthcare providers. As one nurse explains: "Some patients tend to believe that the NHS does not cater to their needs, and most of all, does not revere their cultural ethos, which makes people reluctant to participate."

4.2 Practical Barriers

Practical barriers worsened the problem of ease of access. Mid-aged adults commonly did not find Thursday appointments feasible, especially due to the long commute and relative childcare duties. Participants were more vocal than passive and wanted flexible appointments, including the possibility of a mid-week slot. A participant shared, "Even when we offer Saturday phlebotomy sessions, attendance from certain groups is still low. Making these checks more accessible will require some creativity on our part."

4.3 Language Barriers

Another notable barrier emerged from patients coming from a South Asian, Somali or indeed Eastern European background. Many patients actually depended on their relatives to translate for them, which comes with the risk of inaccurate communication or violations of privacy. While online interpreters such as Word 360 are available, their availability presented challenges.

A nurse noted: “Language is a huge barrier. We have translated material, but not all patients can read it. There need to be greater numbers of primary face-to-face interpreters and community health workers that can talk to the patients.” Participants still stressed the need for the translations to be culturally appropriate. A GP noted, “It’s not enough to translate the materials. We must ensure that, at the very least, the wording used is what the intended audience will understand it to mean. Translations in a literal sense can be very inaccurate.”

5. Strategies for Improvement

A number of participants suggested that patient engagement and accessibility can be increased through community partnership, culture focused approaches, and communication improvement.

5.1 Community Partnerships

The outreach approach was guided by strategic collaborations with community leaders and organisations to enhance awareness and participation. Participants reported success working with mosques, churches, and local charity organisations towards the promotion of NHS Health Checks. As one participant noted, “great success was reported in working with imams and other faith leaders because when they talk about the importance of health checks people pay attention and actually do it.”

5.2 Culturally Tailored Approaches

Building trust and enhancing inclusivity in services was associated with the adoption of culturally responsive approaches. Participants recommended the availability of female staff for female patients, postponing appointments during fasting periods, and culturally appropriate dietary recommendations. As a GP explained, “we need to meet the patients where they are, which is in their local environment and culture that is respecting their traditions.”

5.3 Enhanced Communication

The need for effective communication remained the constant theme in all discussions. Participants had proposals concerning the combination of information and communication technology (ICT) with interpersonal communication and graphic communication for different groups.

As one nurse stated, “Local radio stations and community events can be used to popularize NHS Health checks since people tend to believe such information as it is from a trusted source”. Participants had previously highlighted the necessity to mitigate false information considering the aftermath of the COVID-19 Pandemic. A single participant spoke, pointing out “Social media has created a lot of distrust because of false narratives. We should wrestle that with correct information and custom-made decent information.”

6. Process Efficiency and Operational Challenges

The main operational challenges identified were the lack of adequate staffing and time constraints. Participants suggested that more resources should be allocated for NHS Health checks, as well as mobile health units to serve areas that are often overlooked. “Addressing all these issues puts us in a very tough spot. Improving such a programme comes with needing more people,” stated one participant. Limiting patients to a confined schedule of appointments was yet another matter. Participants believed that patients have diverse needs and therefore scheduling should be more flexible for their convenience.

7. Follow-Up and Outcome Support

Participants raised concerns regarding lack of adequate follow up. Some of them voiced their opinions regarding the distinct leave of patients who after health check-up done needed lifestyle modification or higher level of medical treatment. A nurse remarked, “We inform patients regarding their risk factors but what happens next? Patients require comprehensive aid in order to make those changes.” Participants made suggestions about the incorporation of periodic follow up appointments, wellness clinics in patients' locality, and motivational interviews as means of modifying lifestyle.

8. Recommendations for Improvement

An important recommendation was how staff in healthcare facilities are trained on cultural competence. Again, participants emphasised that healthcare practitioners should be trained to attend to the details of various social groups –including, their cultures, religions, and ethnospecific health problems. A nurse for instance stressed, “Cultural competency isn’t just about knowing what to say; rather it is knowing how to listen and how to foster trusting relationships.” Such training could assist staff to uncover and manage unintended biases that they might have and which can affect the manner in which they interact with patients.

Increasing the availability of language services was another important recommendation. Participants suggested that there should be more face-to-face interpreters and that multilingual materials for health education should be crafted. These materials must also be considered for the specific audience to whom they are intended. A GP explained: “It’s not just about translating the words; but rather relaying the information in a manner that is accurate and applicable to the patient.” It was also proposed that community health workers with language competency and cultural understanding of the population they serve should be hired.

The participants regarded community partnerships as one of the most important areas of focus so that trust and involvement can be enhanced. They suggested that NHS Health Checks be done in collaboration with clergy, community groups, and charity organisations. It was suggested that health check activities are best carried out in trusted community locations like mosques, churches, and community centres. One of the participants stated, “The community leaders are not only service providers; when you engage them in your work, they are actually important stakeholders.”

Ensuring professional services are accessible was also of great significance. To accommodate patients with professional obligations, participants proposed that appointments be offered during evenings and weekends. The use of mobile health units to address the needs of remote or underserved locations was equally noted. One nurse stated,

“We will have to go to them because not everyone can come to us. Mobile units are a brilliant idea for bringing NHS Health Checks to the community.”

Participants acknowledged the need to have organised systems of follow up care as an essential strategy to aid and empower patients to achieve basic lifestyle changes. These strategies may include follow-up consultations, group health educational meetings, and access to a dietitian and trainer. A GP commented, “The initial health check is simply the first step. Patients should be provided with supportive measures and self-help tools to empower them to make effective changes.”

9. Conclusion

Focus Group consultations with the NHS Health Check proprietors uncovered essential information regarding the challenges and scope in enhancing the programme. If implemented, these recommendations would address cultural, psychological and practical barriers and enable the NHS to offer a more accessible and efficient preventative health care service. Such initiatives will not only increase engagement levels but will also enhance the health status of many different communities in Birmingham. This broader analysis provides a significant outline intended for the improvement of NHS Health Checks in regard to its effectiveness, sustainability and impact.

DISCUSSION

Discussion and Synthesis

Users from the studied global majority groups provided their perspectives on the NHS Health Check, as well as health service providers' comments about the programme, and these two accounts will illuminate the strengths and weaknesses. As the programme was set up to serve two key stakeholder groups, that is health service users and service providers, it is important to find out areas of convergence, where both groups agree, and points of divergence, where they do not share identical views. This analysis articulates the data by showing how an NHS Health Check programme ought to operate to address the needs of different communities and the obstacles that service providers encounter.

Areas of Alignment

After reviewing the data that was collected, this has stood out as an area of ongoing implementation to enhance the NHS Health Checks programme. The relevant cultural nuances which govern the way specific groups regard and interact with health care services is something that both groups underscored in their discussions. Service users stressed the necessity of a more culturally sensitive approach when seeking engagement as well as interaction with health care service providers. Women from those cultures, for example, were more likely to participate in the programme if female health care workers were employed, which demonstrates that participants have distinct cultural and religious perspectives that dictate their willingness to use the service.

Similarly, service providers emphasised the need of delivering culturally competent care to win trust from patients and engage them meaningfully. Providers understood that their ignorance to some cultural aspects may result in conflict or disaffection, especially in global majority groups where there is a history of marginalization in health systems. For instance, one provider said, "Our failure to appreciate the cultural contexts of our patients can result in their alienation from us and therefore, eliminate any chances we can have of helping them with their health." This alignment reveals the gaps in the application of cultural sensitivity during the NHS Health Check programme, from training staff to communicating with patients, and delivering health services.

Another area of alignment is pinpointing the practical obstacles to accessing NHS Health checks. Users and providers cited inconvenient participants, such as in bedding appointment times, distance between work and place of service, and family or work commitments. Service users expressed anger about the number of booths on calls, saying that for full working people or primary caretakers, voicing out concern was almost impossible. Many suggested that they should be provided with evening or holiday slots so that attendance is not problematic. Providers accepted the shortcomings of the current booking system but said they wanted to be able to do more at their practices to help them. They jointly understood that these service users are not well served, and operational changes need to be put in place so that the range of people who would benefit from NHS Health Checks could be broadened.

A new major point of convergence was noted to be in communication. Both groups appreciated that awareness creation and participation in NHS Health Checks requires proper communication. The service users stressed the need to use community champions,

including faith leaders, community-based organisations and local celebrities, to reach out to different sections of the population. They also asked for more communication materials to be translated into simple English and other languages so that all patients, irrespective of their language or educational qualifications, will understand what the programme is about and its impact. The service providers acknowledged that communication that is clear, simple, and deals with issues such as culture and ethnicity, is necessary in order to establish trust and engagement. They raised concerns regarding the use of digital tools, such as SMS reminders and internet enabled booking systems, to increase coverage. They said that these tools would have to be supplemented with personal consultations to meet the specific needs of various patient groups.

In the end, participants recognised the importance of prevention as a way to enhance current long term health outcomes and the possible benefits of NHS Health Checks. Users appreciated steps that, in their opinion, give them a chance to mitigate health risks. Providers, on the other hand, underscored the importance of the programme in relation to managing diabetes, hypertension and cardiovascular diseases as chronic clinical burdens. Regardless of their focus, both groups needed follow-up assistance for the patients to properly use the results of their health checks to transform specific aspects of their lives. In the words of one service user, “It’s not enough to tell us what our risk factors are. What comes next?” Providers also expressed the same feeling and placed emphasis on the need to incorporate such elements into the programme that would facilitate continuous support to the patients to enable them to alter their health and wellbeing in a more permanent manner.

Areas of Divergence

NHS Health Checks present unique challenges and opportunities for service users and service providers, a fact that highlights both overlap and divergence. One of the main areas of divergence pertains to trust. Global majority group users have often reported a general mistrust towards the healthcare system due to historical issues, negative experiences or the fear of stigmatisation. Such mistrust hampers the ability of patients to engage with health checks. For instance, certain service users worried about the use of their personal health data, or their cultural practices being disregarded. On the other hand, service providers have oftentimes claimed that their culturally sensitive care and community outreach efforts helped to establish trust, although they accepted that there was room for improvement in trust building. More focused steps are required to erode this trust barrier and build respect and safety for service users more intervening on such issues more clearly.

Another reason for the disagreement lies in the accuracy of communication. While service providers thought that they have employed different ways of communicating, such as SMS reminders, posters, and translated documents, service users, in most cases, considered these methods inadequate or not reachable. A language barrier kept cropping and users of the service stressed the need for personal interpreters alongside appropriate ethnic translations. However, the providers focused on the difficulties in offering such resources, like funding restrictions, insufficient staffing, and the time needed to prepare adequate resources. This gap highlights the necessity for a more responsive approach to communication which encompasses the diverse needs of service users.

Differing perspectives were uncovered with the delivery of NHS Health Checks. Providers indicated that health assessments done in mosque and in churches or community centres

have better patient participation than regular clinical settings. Such venues were viewed as more approachable, friendly and less threatening especially for people who are anxious about going to a formal health setting. Providers regarded these venues as a way through which they could target neglected populations and enhance community relations. Nonetheless, even with this community-based approach, service users have criticised of feelings of being rushed and undervalued in the interactions. Others reported lack of attention as a source of dissatisfaction alongside the so called “health checks” which they think are not clinically informed as per their concerns or guidance. Some details are suggested that location of NHS Health Checks is important but so is the degree to which a patient feels he or she is treated reasonably during those interactions.

Another divergence has to do with the follow-up intervention after the NHS Health Checks. Service providers treated the health check as a standalone intervention whereas service users wanted more support in acting on its results. Users, it seems, were most concerned about the perceived discontinuity of the health checks, which left them unsure about how lifestyle changes or further resources could be accessed. But the providers pointed to lack of resources and time constraints as barriers to more comprehensive follow up services. It also captures the split between the service users and the service providers, which is how patients are connected after the initial intervention to care services, such as the referrals to dietetic and exercise and chronic disease management programmes.

Resource allocation became a problem at the point of divergence. Operational issues such as insufficient employees, insufficient funding, and administrative competing priorities within the healthcare system were common problems highlighted by the service providers. Because of the limitations imposed by these factors, they are unable to implement changes that permit greater flexibility with regards to appointment times, language support, or availability of culturally appropriate materials. Nonetheless service users, on the other hand, seemed to be less cognizant of these systemic barriers and tend to focus on their immediate realities and requirements. This divergence illustrates the complexities associated with patient-centred changes versus service deliver practicality.

Informing Strategies for Improvement

Both group members have made it clear that there needed to be a change in the NHS Health Checks programme and the insightful information provided by them can help meet those goals. Service users and providers have both presented solutions that can make the programme more inclusive, accessible, and effective and those solutions can easily resolve the dividing areas of conflict. For instance, cultural training of healthcare staff can aid in building trust, and the use of community partnerships to aid in language support can help. Furthermore, adding an integrated follow-up mechanism to the programme would guarantee consistent support for lifestyle change among patients. With the input and acceptance of both users and providers, these changes can easily turn the NHS Health Checks into a benchmark of efficiency and equity in preventative health care.

Recommendations for Improvement

The suggestions for changes serve as a means to integrate modern evidence-based practice by solving the barriers and questions faced by both service users and service providers as detailed by the study.

Service Users' Recommendations

From their perspective, service users provided actionable recommendations which were of the utmost importance. Flexibility in NHS Health Check appointment slots was highlighted on many occasions, as more evening and weekend appointments could be provided for those with more caregiving or work responsibilities. An example of this entitlement was provided by one service user, "It's difficult to take time off work for an appointment during the day. Evening slots would make things much easier".

Moreover, the last recommendation focused on the provision of the culturally specific advice and interactions. Service users expressed a keen willingness towards healthcare professionals that appreciate their culture or religion, like having prescribing dietary restrictions or fasting periods. Additionally, they also recommended providing female healthcare staff to female patients and vice versa. These changes would limit cultural barriers and enhance the acceptability of the programme for several communities.

Enhancing outreach and engagement was another important area identified by participants. They suggested using local community approach by collaborating with religious leaders, different community organisations, or local celebrities to promote the NHS Health Checks. Moreover, the use of simplified English, as well as adding additional languages to the promotional materials, emerged as vital steps towards ensuring that all patients with different educational and language skills are able to appreciate the programme and its benefits. As one participant put it, "It would help if they had someone from our community explaining the importance of these checks."

Additionally, service users expressed that there is a need for more follow-up support after their health checks. They recommended that there be the possibility of accessing dietitians, fitness trainers, or even community-based wellness workshops to assist with making sustainable changes. Some participants felt that there is no clear system for guidance on acting on the results of their health checks. One participant expressed, "It's not enough to tell us our risk factors, but we also need guidance on what to do next."

Service Providers' Recommendations

Service Providers tended to agree with many of the points made by service users, but also raised some other issues that should be emphasised in order to solve operational issues. These include, but are not limited to, setting aside measures and resources for cultural competency training. Providers indicated that there is a need for healthcare staff to be trained appropriately for service delivery to various cultural groups, such as understanding cultural sensitivities and addressing "hidden" biases.

The enhancement of language assistance was yet another important recommendation. Providers requested the availability of more multilingual interpreters, both in person and virtually, and wished for the creation of culturally appropriate health education materials. "We need materials and interpreters in other languages to make sure everyone can follow the health check process." This was as one GP put it.

Providers proposed increasing outreach and engagement through enhanced community collaborations. Collaborating with clergy, local community groups, and other charitable organisations will facilitate trust regarding NHS Health Checks. Some participants

recommended the use of clinics located in community facilities like mosques or churches to provide services as these facilities have better reception in the community.

In relation to some practical barriers, providers suggested using mobile clinics to target those areas where services are lacking and ensuring there are more flexible appointment times. The recommendation also included combining NHS Health Checks with other activities like flu vaccinations or chronic care consultations to increase productivity and attendance.

Lastly, providers pointed out that follow-up systems should be in place to assist patients following their health assessments. This may comprise of follow-up visits, motivational interviewing, and referrals to community-based wellness programmes. As one nurse put it, 'The initial health check is just the first step. We need to provide patients with the tools and support they need to make changes that last.'

Conclusion

This project's results demonstrate the multifaceted nature of offering and receiving NHS Health Checks within the Birmingham racially marginalised groups and other community settings. In terms of service users, there are barriers of lack of trust, cultural ignorance, and other practical issues that need to be overcome in order to enhance attendance and satisfaction. On the other hand, service providers have resource issues, time constraints, and lack of cultural knowledge as their operational challenges.

While there are challenges, it is appreciated by both parties the importance of NHS Health Checks for preventative healthcare and improving access and effectiveness of the programme. There is a considerable possibility for progress from the convergence of service user's wishes for culturally appropriate care and the provider's need for cultural competence. The NHS can close the gaps of trust and communication to build a more inclusive and patient focused model to cater for health checks.

The NHS Health Checks will succeed as long as the patients, healthcare providers, and community organisations work together. By implementing the combined recommendations outlined from above, the programme can eliminate its current barriers and meet the objective of reducing health disparities and achieving better long-term health for everyone. With the right and continuous integration of these culturally responsive, patient focused innovations, NHS Health Checks can stand as the ideal approach to preventative healthcare for a growing diverse population.

Limitations of the study

When constructing insights around the perspectives of NHS Health Check service users and service providers, it is critical to note the limitations that may have impacted the overall findings. There are some methodological, logistical, and practical limitations that highlight the difficulties in gathering research in heterogeneous and under-researched contexts. To improve the overall comprehension of factors that impact NHS Health Check programme, these limitations will be important for future studies.

Limited Direct Contact with Focus Group Participants

One consideration in this study was the academic partner had to focus on the concerning issue where they did not directly facilitate the focus groups. The academic partner relied on

the community trained facilitators to prepare reports and transcripts that were later analysed collectively for data. This approach was purposive as the focus groups' participants needed to feel safe and comfortable speaking with someone from their own community. This overcomes some bias in the data collection. However, this structure limited opportunities for the academic team to explore emerging themes or seek clarification on nuanced responses in real time. For future projects, closer collaboration between academic teams and community facilitators—while maintaining the trust and comfort of participants—could enhance opportunities for co-analysis or joint reflection on findings. Such an approach could enrich the depth of insights, particularly regarding sensitive issues like culture, trust, and healthcare experiences, while continuing to respect and prioritise community ownership and participant confidence in the process.

Variability in Focus Group Delivery

Variability in focus group delivery is attributable to differences in the quality of service provided due to varied exposure and expertise. Some focus group facilitators reported challenges in meeting the required standards in data collection. For instance, certain facilitators were not able to draw robust discussions from participants or deal with sensitive issues which exhibited a high level of chance factors. In addition, some of the focus groups altered the format guidelines and were not able to comply with the target numbers required which took away the validity and reliability of the discussions. Small focus groups may have low range reticulation, whereas large focus groups tend to restrict the involvement of each participant in the discussion making it difficult for each facilitator to guide the focus group. These discrepancies in the focus group delivery emphasise the need for more comprehensive training and guidance for facilitators in subsequent research projects.

Time Constraints and Project Scope

The limited time available for this study directly impacted the depth of the analysis. Certain practical considerations needed to be made as far as which groups to focus further research on, meaning some communities or subgroups were most likely left out of the research. While there was an attempt to represent a wide array of racially marginalised communities, the time limitations faced would have certainly acted as a barrier towards smaller or more difficult to access populations, whose experience would have also added value. There were also issues surrounding the time allowed for coordination between academic providers and facilitators of the focus groups, which lacked sufficient time, leading to communication problems that may have hindered the quality and depth of data collected and analysed. The timeline constraints also did not allow for any follow-up interviews or any longitudinal studies, restricting the analysis to what participants' needs and experiences at the time of the interview were.

Cultural and Linguistic Barriers

Another challenge encountered during data collection were cultural and linguistic barriers. Despite attempts to provide language assistance through interpreters or translated documents, these efforts may not have been sufficient to accommodate the varying communication needs of the participants. As an example, some participants may have had difficulty expressing themselves because they could not speak the language used in the focus group effectively, or they might have been restrained by cultural norms which do not encourage self or health related discussions. These impediments could have resulted in

insufficient representation of some perspectives or loss of vital details in the participants' responses. Furthermore, such participants may have had differing cultural concepts of health and wellness and therefore, have been reluctant to participate in the focus group discussions which further clouded the interpretation of the results.

Inconsistencies in Demographic Data

The limitations made by the participants and their birth dates is another hurdle to the limitations of the study. Some participants, for instance, were unable to provide their actual date of birth owing to private purposes, security measures, or simply for the fact that they were not willing to share. Such vague non-partisan demographic data can greatly impact the possibility of inferencing patterns based on age, gender, and other crucial underlying factors. Additionally, vague or graphed out identifying details also factor in why the resultant findings will most likely be ineffective to the general public as the sample picked may not suffice to the general population.

Surface-Level Exploration of Needs

The study lacked a profound understanding of certain participant issues raised because of the time constraints, indirect engagement with participants, and the focus group challenges. Regarding the findings, it offers a high-level view of the barriers and obstacles that the racially marginalised population is likely to have experienced while trying to utilise the NHS Health Check services – but not the fragmentation or multi-layered nature of these issues. For example, participants may have listed barriers which, as mistrust or cultural insensitivity, but did not provide further explanations regarding the causes or the ways to address them. The limitations of this report call for more comprehensive and qualitative work to compliment the findings generated from this report and to make sure that the concerns of the excluded communities are properly addressed.

Potential Bias in Participant Selection

While conducting the focus group, participants were chosen who were more willing or interested in using NHS health check services. Thus, it can be said that there is self-selection bias which makes it difficult to generalise the findings as under-engaged or reach relieve sceptical populations may not have been focused on. For instance, focus group participants may be underrepresented because socially isolated individuals with severe access barriers, such as poor ability to communicate in the English language, lack of trust in healthcare institutions, and poor logistical arrangements, simply feel apathetic towards looking for services. In other words, it appears that more focus has been laid on the participants who claim to be active users of healthcare services, yet the situation might be different at the other end.

Methodological Constraints in Data Collection

The use of focus group discussions as the main method of data collection posed certain methodological limitations. Focus groups are useful for collecting rich qualitative information but are often subject to group effects where quieter group members may be overshadowed by more domineering participants or members feeling compelled to go along with group views. These effects could have impaired the diversity, and the genuineness of the views expressed during the discussions. Moreover, the lack of triangulation with other sources of

data such as individual interviews or surveys could have further limited the study in validating and contextualising its findings.

Conclusion on Limitations

The NHS health check service and its users, especially from racially marginalised communities, undergo challenges, yet the value of the study remains high. Despite the obstacles the study did manage to offer important perspectives and insights, which are of considerable valuable importance. It is necessary to conduct another form of research that could examine in-depth the barriers and aids racially marginalised communities face. The additional suggestions cover more direct outreach to participants and engagement with them, ensuring more moderated focus group discussions, improving timelines, and increasing the scope of data collection, all of which greatly enhance the reliability and validity of the findings. These changes to limitations will allow for the next investigation to address barriers in more culturally acceptable and effective ways for diverse communities.

PRACTICAL CONSIDERATIONS FOR THESE FINDINGS

This particular study results showcase the practicality of performing other numbers of tasks to improve the quality of NHS Health Checks. These considerations have been made to again apply more focus on the barriers addressed in the study, which will allow greatly aid in serving the racially marginalised communities as well as other alienated societies within the region. Presented below is a more point by point and easy to act upon strategy for improving the basic structure and form of the programme which achieves tackling these barriers.

- ## Enhancing Cultural Competency and Building Trust

Action: Provide universal cultural competency training for all staff involved in NHS Health Checks. The training should have modules on the identification of the basic social, cultural, and language needs of communities, combating implicit bias, and enhancing interaction with patients from different cultures.

Rationale: Mistrust and perceived cultural insensitivity were recurring themes in the findings, with many participants reporting that healthcare providers lacked understanding of their cultural contexts. Training staff to engage with diverse populations respectfully and empathetically will help the programme build greater trust and uptake among racially marginalised communities.

Priority: High – Trust and cultural sensitivity is key to improving service uptake and making sure that patients feel respected and valued.

Implementation: Engage cultural and community leaders and advocacy organisations to develop and implement training workshops. Use case studies, role-playing, and evaluation activities to ensure the training is practical. Evaluation on patient satisfaction and staff performance should be conducted regularly.

- ## Improving Communication and Language Support

Action: Increase the number of interpreters available as well as translated materials and multilingual campaigns in order to eliminate language barriers that prevent people from accessing NHS Health Checks.

Rationale: In particular, language was a major barrier for many respondents which made it very difficult to understand the goal or advantages of the NHS health checks and to interact with the providers of the health services. Solving this problem is important for provision of services in a fair manner.

Priority: High – Communication makes the maintenance of health information and participation in preventative healthcare programmes more effective and increases their coverage.

Implementation: Set up a centralised booking system for interpreters to attend patient appointments. Transform informational materials such as leaflets, posters, and digital resources into the prevalent languages spoken within the target communities. Collaborate

with local radio stations and newspapers that cater to non-English speaking populations and disseminate information regarding NHS Health Checks in such languages.

- ## Strengthening Follow-Up Support for Participants

Action: Incorporate systematic follow up measures in the NHS Health Check programme to provide greater support for lifestyle modification and chronic disease care. This may include dietary and fitness training referrals, psychiatry, smoking cessation programmes, and routine visits for health monitoring.

Rationale: Participants seemed particularly frustrated with the inconsistency that followed their checks, with little to no information regarding the next steps to take, and how to act on the results. Actionable follow up referrals are a critical part of translating health checks into health outcomes.

Priority: High – The health checks are rendered useless without actionable care, and some forms of proactive measures could certainly be taken advantage of.

Implementation: Create a digital referral system that links patients to available local services and monitors their progress over time. Instruct health care personnel to offer tailored advice during the health check, and make sure that patients always receive printed or digital summaries of their results and how to act on them. Consider follow up calls, or text reminders to aid in adherence.

- ## Increasing Accessibility Through Community-Based Delivery

Action: Broaden the scope of dispensing NHS Health Checks to Community such as faith-based organisations, educational institutions, workplaces, and other local service delivery points.

Rationale: A lot of participants would prefer these services to be offered in a less intimidating environment that is well familiar to them. Furthermore, this approach would also capture those who seldom come into contact with medical services.

Priority: Medium - Although location remains a critical factor, the quality of care delivered, and follow-up activities should be prioritised over the location. It must be noted that NHS Health Checks can only be conducted by appropriately qualified healthcare professionals, including nurses, GPs, pharmacists, and healthcare assistants, in line with national delivery guidelines.

Implementation: Establish strategic partnerships with community and faith-based organisations to provide accessible venues for NHS health checks as well as advertise them in local health centres and schools. Use mobile health units to serve areas that are poorly served with healthcare facilities such as rural areas and urban slums. Plan community health check events in advance and ensure that the dates are covered in local newspapers, along with social media campaigns and community gatherings.

- ## Addressing Resource Constraints

Action: Push for more resources in terms of money and personnel to carry out NHS Health Check services in regions with greater levels of health disadvantage.

Rationale: Providers often cited the lack of resources as a challenge in improving the quality of service offered, such as the ability to offer more appropriate appointment times, follow-up appointments, and serve culturally diverse patients. Resources have to be made available for scaling up and sustaining improvements.

Priority: Medium – Even though resource distribution is an institutional challenge, the potential benefits of these changes, namely increased language assistance and delivery to the community, make them necessary.

Implementation: Engage with the government representatives, commissioners, and funding organisations and show them the value of preventative healthcare in regard to its long-term cost effectiveness and the reduction of chronic diseases. Utilise the results from this and related studies to justify the need for increased spending on the programme.

- ## Standardising Focus Group Practices for Future Research

Action: Create and distribute a document with set guidelines for implementing focus groups which includes steps for recruiting participants, training facilitators, and processing collected information.

Rationale: Focus group execution variations during this study compromised the findings' validity and reliability. In order to facilitate more advanced research, researchers need to be able to replicate certain procedures which is only plausible with well-defined standard operating procedures.

Priority: Medium – While this is not service delivery relevant, better research enables stronger evidence for deeper decisions in the future.

Implementation: Provide focus group facilitators with all necessary training and guidance, which includes recommendations regarding preferred group size, discussion strategies, and other ethical issues. Introduce peer review procedures that will check focus group data before they are analysed and processed to guarantee focus group discussion quality.

- ## Designing Tailored Outreach Strategies

Action: Design specific outreach campaigns suitable for different population segments with a history of low participation.

Rationale: Participants highlighted the need for communications that are culturally specific to enhance their awareness and uptake of NHS Health Checks. Limitations such as fears and misconceptions can be mitigated through customized outreach, which can facilitate participation.

Priority: Medium - Marketing efforts to target groups at greater risk of being ignored requires more investment, although outreach is central to addressing these gaps, it has to come along with other strategies to create a system that works.

Implementation: Use community ambassadors, social media, and local events to promote the benefits of NHS Health Checks. Design communication with assistance from cultural and faith-based leaders for specific segments. Use stories and testimonials of willing participants to create confidence for broad participation in the programme.

- ## Leveraging Technology to Enhance Engagement

Action: Adopt mobile applications, SMS reminders, and online booking tools to engage patients more in the NHS health check processes to make it easier for them to participate.

Rationale: Technology can help when patients have scheduling challenges, difficulty remembering head appointments, securing results, and other logistical challenges.

Priority: Medium – While access may be improved through the use of technology, it should not be the sole method of engagement for patients who have limited access and reliance on these devices.

Implementation: Constructing a general-narrative-ready interface to set appointments, display results, and provide personalised health suggestions. This comprises features like tutoring, appointment reminders, educational materials, and links for local support. It also includes a training and support system for low-literacy users.

- ## Promoting Flexibility in Appointment Scheduling

Action: Providing additional options regarding when patients can set appointments, like evenings and weekends, for those who work or are caregivers.

Rationale: Service users usually mentioned lack of flexibility as a major obstacle when trying to use NHS Health Checks. By providing NHS Health Checks with advanced booking systems, we can remove this obstacle and increase the chances of people participating.

Priority: Low – While people are already prioritising this, they have different systemic problems that are more pardoning such as: follow up care and cultural sensitivity.

Implementation: Offering these on a trial basis in places marked high demand for these services or where Health Checks can be expected to be more frequent than average. Use the data from these trial areas, where these services are expected to have an above average hit rate, to define optimum appointment times for these facilities.

- ## Building Long-Term Community Partnerships

Action: Creating permanent agreements with trusted community-based organisations, leaders, and faith groups that can design NHS Health Check systems.

Rationale: Tension, specifically the mistrust of healthcare institutions, was evident particularly among racially marginalised groups and communities. Building partnerships over a long time will help in this gap bridging and in ensuring that services are provided in a manner that is sensitive to the local populations' needs.

Priority: Low – While building trust is sensitive, it is a low priority activity because it takes considerable time to earn trust.

Implementation: Active community engagement can be done by conducting regular community forums where feedback, concerns, and suggestions can be collected and demonstrate transparency in the changes that are being made. Work with local organisations to develop culturally appropriate materials and events for health promotion.

Conclusion on Practical Considerations

The concerns must be met to make sure that all these groups are spearheaded for the practical step important to meet stakeholder inclusiveness, allowing for a more inclusive, patient-centred NHS Health Check programme. These actions are prioritisation focused to make sure that the ethnocultural diversity is features of the service reflects the needs of its constituents, in terms of communication to them, follow up aspects, and community involvement. These, too, will require the adequate funding, evaluation of the processes, and collaborative working with the service users and service providers in order to help sustain these changes. The more variety is put into these practices, the better changes the NHS Health Check programme will be able to undertake in the matter of health equity and health outcomes for all communities.

FUTURE RESEARCH CONSIDERATIONS

The findings identified from this analysis denote barriers and facilitators to the uptake and effectiveness of NHS Health Checks, especially in the context of racially marginalised communities. However, there are areas that still need further exploration and improvement in the research technique employed within this analysis. More research is needed in order to expand on these findings, answer the uncovered questions, and create more effective, inclusive, and sustainable healthcare interventions. Below, we outline key areas for future research that remains draws on, including gaps within the study, groups that deserve additional focus, and improvements to the methods used.

- ## Unanswered Questions and Emerging Areas of Inquiry

Although this study attempts to provide insights into the factors that pose barriers to the utilisation of NHS Health Checks, there are core components that need additional investigation. These are:

Effectiveness of Interventions: What interventions improve the uptake of NHS Health Checks amongst the purposely underserved groups? Some of these interventions might include multicultural outreach, community-based delivery, or even cultural competency training. There is a need for more thorough research that seeks these answers.

Long-Term Impact: What effect do NHS Health Checks have on health outcomes over time, especially in racially marginalised groups? For instance, are there quantifiable positive changes in chronic disease indicators or health equity, like in diabetes and hypertension? These NHS Health Checks will likely benefit from the assistance of longitudinal studies which can investigate the sustained impact over time.

Role of Trust: Engagement with NHS Health Checks was largely influenced by Trust and thus, trust is a major factor. Further studies should look at how best to trust healthcare systems in communities with deep rooted misconceptions towards healthcare providers. This may include the use of community ambassadors, co-designed interventions, or different forms of tailored communication.

Systemic and Structural Barriers: Even beyond this study's context, more elaborate macro systemic aspects like socio-economic disparities, residential instability, immigration context, and internet access could intersect with the identified barriers. These considerations require further research to understand more fully how they impact NHS Health Checks access and utilisation. This particular set of questions has the potential to be extremely impactful, not only for academia, but also in practice- reminding us the possibility of translating research into concrete policies and actions aimed at making NHS Health Checks more beneficial in elevating public health within the population.

- ## Building on Current Findings

This study explores the specific parts that are key to making NHS Health Checks more accessible and efficient. The findings provide a pathway for additional analysis of these specific parts of focus. Some of these areas to further focus include:

Tailored Interventions for racially marginalised Communities: This study has underlined the need for cultural competence, future research is required to see how the NHS Health Checks can be sub-grouped for different racially marginalised subgroups. Cultural norms around health, illness and preventive care for example how do they impact NHS Health Check? How do family structure, beliefs and community networks drive healthcare decision making?

Follow-Up Care and Continuity: Participants expressed a need for continuous care, yet the absence of any follow up support was an issue of major concern. Further studies may assess the effectiveness of various follow up strategies, for example, active care plans, health technology, community health coaches, or periodic visits to a physician. To bridge the gap between patients and physical activity, nutrition, or mental health support, further research could look into social prescribing.

Community-Based Delivery Models: Extending NHS Health Checks into community centres, faith-based organisations, schools, and workplaces is one model that was put forth to increase access. Further studies may look into these modes of delivery in regard to their feasibility, cost-effectiveness, and overall impact. In particular, comparative studies could determine whether community-centred approaches yield higher engagement, satisfaction, and health metrics than those achieved in conventional clinical settings.

Technology and Digital Inclusion: The ever-expanding digital scope of healthcare provision raises the question of how best to improve the scope and effectiveness of NHS Health Checks. For instance, in what ways do mobile applications, online appointment booking interfaces, and text reminders increase patient participation and compliance with suggested follow-up activities? On a different note, there is also a need to address the risk of exclusion created by such technological advances, especially among older age groups with low digital literacy and poor internet connectivity.

Within these investigations, other recommendations can also be put forward when trying to adapt NHS Health Checks to the varying complexities of its user base.

- ## Specific Groups and Issues Warranting Further Investigation

Some groups and issues were not adequately represented or were omitted from the scope of this study but should be investigated further to ensure that NHS Health Checks are fair and cover everyone.

Hard-to-Reach Populations or Underserved Groups: Future studies should pay attention to the hard-to-reach segments of society, like undocumented migrants, the homeless, disabled persons, and the rural and remote dwelling populations. These groups have specific difficulties in accessing NHS health check services and may need more specialised approaches.

Intersecting Factors: A combination of things such as race, sex, age, class, and even immigration status may hinder the ability to access NHS health check services. Future studies should seek to understand these intersecting factors in their relation to NHS Health Check experiences. For instance, in the racially marginalised communities, what are the differences in challenges faced by older adults versus younger adults?

Mental Health and Social Stigmas: In particular, the interplay between mental health difficulties, social stigma and participating in preventive health care services has received little attention. Investigations could focus on whether mental health problems such as

anxiety and depression obstruct the participation in NHS Health Checks and whether there is need for greater support to remove those barriers.

Health Literacy: A health literacy gap has surfaced as a hindrance to understanding the proper aim and use of NHS Health Checks. Future studies could look at whether bespoke health education initiatives or simplified materials can help raise health literacy levels and increase participation rates.

Research should focus on these under-represented groups and issues so that NHS Health Checks can be made available to all segments of the population, especially those who are most disadvantaged.

- ## Methodological Improvements and Adaptations

Interaction with Participants: This project utilised focus groups; however, future studies should prefer greater interaction between the researcher and the subjects for in-depth inquiry into the respondents' answers and for clarifying ambiguities and discovering new ones. In addition to focus groups, participants should be able to provide interviews for more thorough responses to questions.

Focus Group Procedure: Future studies should increase the quantitative and qualitative accuracy of data used in the study by developing focus group and interview protocols.

That is, participants and facilitators must be restricted by clear instructions covering

participants number, discussion engagement style, and data capturing policies. Facilitators

also need training sessions.

Longitudinal Strategies: For example, how do individual's attitudes towards NHS Health Checks shift after follow-up interventions? What are the outcome health changes per individuals' long term? Within this study participants' experience was collected at a single point of time, but a longitudinal study would help in understanding how perceptions and outcomes progress through time.

Mixed-Methods Approach: One way to identify the obstacles and motivators surrounding the NHS Health Checks is through integrating qualitative and quantitative methods. With the focus groups, surveys could be administered with statistical analysis capturing larger diverse sample which would provide information that correlates but would often be missed in qualitative studies.

Community Based Participatory Research (CBPR): Including community members as active partners in the research has the potential to enhance the value of future studies. In CBPR, researchers work with community members to formulate and design the research and interventions, empowering the community members and volunteers to express the needs of the target population.

Adopt a Co-Production Model:

We recommend that future NHS Health Checks initiatives continue to adopt a co-production model, involving community organisations in all stages of the process—from design to delivery and evaluation. To address capacity challenges, additional training for community facilitators and greater involvement in data analysis could enhance the richness of insights gathered. Establishing formal partnerships and shared leadership models between public health authorities and community organisations may also support sustainable and culturally

competent service delivery. To ensure effective and applicable outcomes for NHS Health Checks, more precise and helpful information needs to be captured, so the methodology of future studies needs to be planned carefully.

Conclusion

Future studies should enhance this research by answering pending questions, utilising overlooked perspectives, and improving methods for sampling. Some of the main areas of focus include looking into the impact of tailored interventions, determining the effectiveness of NHS Health Checks after a longer duration, and the specific needs of certain demographics like hard-to-reach or those facing multiple barriers. Adopting longitudinal and mixed-methods designs and using community-based participatory approaches are some of the methodological changes that will improve the quality and relevance of future work. Providing insights into these critical issues will enable more comprehensive, effective, inclusive, and accessible NHS Health Checks aiding in reducing health inequalities and improving the overall health outcomes of all populations.

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APPENDICES

Appendix 1: Original Bid Contract

QUOTATION DOCUMENT

Contract Title:	Academic Partner: NHS Health Checks Focus Groups
Contract Reference(s):	ED006
Date/Time for Quotation Return:	17:00 (5pm) on Friday 22nd of March 2024
Address for Quotation Return:	Quotations should be submitted by email to the following address: CommunitiesTeam@birmingham.gov.uk

Birmingham City Council

Finance and Governance Directorate

Corporate Procurement Services

PO Box 10680

Birmingham

B4 7WB

www.birmingham.gov.uk/procurement

CONTENTS

Part 1 – REQUIREMENTS

We are committed to being accessible. If you experience or anticipate any barriers within the application process or require support to make an application or accessing services and information, please contact us.

Instructions for Submitting Quotations

You are invited to submit a Quotation for the services as detailed in section •• in accordance with Birmingham City Council's standard terms and conditions.

Quotation suppliers are advised to ensure that they are fully familiar with the nature and extent of the contract. It is the responsibility of the Quotation supplier to obtain for themselves, at their own expense, all information necessary for the preparation of their Quotation.

Quotations must be submitted for the entire requirement as detailed in section •• below, otherwise they may be rejected. No Quotation shall be considered unless it is submitted in accordance with the requirements described in these instructions and no Quotation received after the closing date shall be accepted or considered.

Quotation suppliers' responses and information MUST be submitted as part of the Quotation response. Failure to provide such information may result in the submission being rejected.

The Council may at its own absolute discretion extend the closing date and time specified for the receipt of Quotations or invite variations to the terms of the contract.

Suppliers are asked to demonstrate that the services offered fully comply with section •• of this document. This will be evaluated on a Pass/Fail basis. Only suppliers which pass this quality will have their price evaluated for consideration. Note that all pricing will be fixed for the duration of the agreement. No costs, other than those included in section •• of the Quotation response form will be allowed.

All prices shall in all cases be exclusive of VAT, which will be applied in accordance with legislation. Discounts, trade allowances of any kind must be shown separately.

Birmingham City Council does not bind itself to accept the lowest or any Quotation.

Suppliers should be aware that, should they be awarded a Contract, the contents of the Contract may be published by the Council to the general public in line with transparency requirements.

Before publishing any information, the Council will consult with the supplier on any potential exemptions that may be applicable. The Supplier should note that the final decision on what information is published will rest with the Council.

Indicative Timetable:

Stages following Quotation submission	Date
Advertised on FIIB	9th February 2024
Clarification period	19th February to the 18th March
Deadline for Submission	22nd March
Evaluation period	March 2024
Award approval	April 2024
Anticipated Award notification	April 2024
Anticipated Contract Commencement Date	13th May 2024
Contract Completion Date	TBC – Defined by focus group Provider(s)

This contract will be commencing approximately on the **13th of May 2024.** The start date is variable and will be discussed before contract is awarded. An attached project plan should outline the appropriate timelines for delivering this project.

Specification

Background and Introduction

Birmingham and Lewisham African and Caribbean Health Inequalities Review (BLACHIR) is a partnership between Lewisham Council and Birmingham City Council. Work has begun on this ground-breaking review to gather insights on health inequalities specifically within African and Caribbean communities in Birmingham and Lewisham.

Birmingham is home to 8% of the overall African and Caribbean population of England, and in Lewisham, African and those of Caribbean descent represent the largest population groups among those of Black and Asian Minority Ethnicities. Both Birmingham and Lewisham Public Health Divisions share a joint aspiration to address and improve minority ethnic health inequalities through an increased understanding, appreciation, and engagement with African and Caribbean groups. This shared ambition has resulted in a collaboration between the two local authorities to share knowledge and resources through a robust review process.

From the Review, there were 7 developed key priority areas. One of those, NHS Health Checks and Campaigns called for the Health and Wellbeing Board to act across their partnerships to promote NHS health checks through public campaigns to increase the uptake of 8 community-based health checks in easy to access locations. During the

COVID-19 pandemic there was a reduction of the number of NHS health checks delivered in the UK with there being an estimated 7.4 million fewer care processes undertaken from March to December 2020 (Carr et al., 2022). This has led to a backlog of testing and prescribing, resulting in more people to be unknowingly living with undiagnosed health conditions that would have been discovered within health checks. However, in Birmingham uptake of NHS health checks has significantly improved since the pandemic.

A rapid evidence review has been completed to collect insight into different ethnic communities and health checks. The evidence review gave 5 recommendations to make NHS Health Checks more specific and applicable to Birmingham's diverse communities. One of these was to obtain data on specific ethnicities and to conduct focus groups. The recommendation outlined "Data on ethnic background can be difficult to parse through as different databases group global majority communities differently. In some cases, data groups together all South Asians, often Black Africans are grouped together and sometimes even with Black Caribbeans. Occasionally data only talks about minorities born abroad, rather than second, third, fourth or later generation immigrants. Extrapolation without data makes any intervention less sound and evidence driven. It may be worthwhile to conduct focus groups within Birmingham to understand the barriers to NHS Health Checks and consider targeted pilot programmes to address the outcomes from the focus groups."

The Council would therefore like to commission focus groups for Black African and Black Caribbean communities, and other ethnic communities to further understand and inform current provision and future commissioning of NHS Health Checks. It is proposed that the focus groups must include the following global majority groups, based on 2021 Census data: Pakistani, Indian, Bangladeshi, Caribbean, Arab, Chinese, Somali, Nigerian, Eritrean, Ghanaian. People of mixed heritage that identify with one of the above global majority groups may also be invited to the focus groups.

The Council would also like to commission some additional focus groups to further support understanding and data analysis. It is proposed that focus groups also include: 1x White British Males and 1x White British Females (in a ward with IMD score of 1 or 2), 2x focus group for people who deliver NHS Health Checks.

Academic Partner

Whilst this approach will ensure communities are well represented, they will need to be supported by an academic Provider to ensure that focus group are well delivered and well documented. Therefore, the Council is looking to commission an academic Provider to support smooth delivery of the focus groups, improve the academic rigor of findings and conclusions, ensure that the focus group Providers report the findings in a way that is standardized, and produce a final report which explores the difference within age groups and ethnic communities.

This proposal aligns with both Birmingham City Council corporate goals:

Birmingham, an aspirational city to grow up in

Birmingham, a fulfilling city to age well in

and the Public Health Outcome Framework (1&2): Reduced differences in life expectancy and healthy life expectancy between communities.

Project Requirements

No.	Activity	Outputs	Additional Information
PM1	Planning of Focus Groups	1x planning workshop with focus group Provider(s). Upskill focus group Provider(s).	The partner should agree a suitable workshop date, captured into a calendar and shared with the Council. Work to capacity build the organisation(s) for focus group delivery, including successful recruiting participants and delivery of co-facilitated sessions. Provide any necessary training and support to the organisation(s) for focus group delivery to ensure robust execution of project.
PM2	Delivery of Focus Groups	Standardise focus group delivery Creation of standardised template Develop feedback methodology	Co-facilitate a standardised format for the focus groups with the community facilitators, providing a seamless transition between the different components on the day. Work with the focus group Provider to ensure the focus group format, venue and delivery is tailored to be culturally appropriate and relevant to the target groups. Produce a standardised template that can be used to capture responses to the questions listed in section •••. Ensure that a variety of methods are used to contemporaneously capture

			the discussions and feedback during the workshops.
PM3	Reporting and Evaluation	Support focus group Provider with reporting Support attendee feedback Produce final project report Create a PowerPoint slide set for focus group Provider to use at the 'Creating a City Without Inequality Forum'. Involvement in BLACHIR steering group with existing engagement partners.	The academic partner will be required to work with the focus group Provider(s) to produce a maximum 2000-word report from each focus group. Ensure that attendees evaluate the workshop and this feedback is captured in the summary report. Produce a final report that summarises the responses from each focus group Provider report. The report must include: Report clearly on opinions that differ between age groups Report clearly on opinions that differ between ethnic groups. Report clearly on opinions that differ between gender Extract the key themes from the focus groups, including any differences between age, gender **and** ethnicity To analyse and present the data using a systematic approach Reporting should also include recommendations and implications for Public Health, NHS Health Check deliverers and other systems partners to be included. A draft of the final reports must be sent to Public Health to be reviewed by Senior Management.

Additional Requirements

The academic Provider should work with the focus group Provider to ensure the following topics are captured within the focus groups (Information captured in [box brackets] is applicable only to attendees who are approaching Health Check age):

What do you understand about NHS Health Checks? Are you aware of them and how?

Have you had an NHS Health Check [Do you plan on having an NHS Health Check once eligible]? What was your experience? (include what was easy/difficult).

If you haven't had an NHS Health Check, why? What would make it easier for you to go?

What do you expect from an NHS Health Check? Are these expectations being met and how? If they are not meeting expectations, what could be improved?

The focus groups should also capture discussions surrounding the customer journey, from receiving the invitation, through to the delivery. This **may** include (but is not limited to), discussions surrounding the following:

How did you receive an invite to your NHS Health Check (e.g., letter, digital communication, language of invitation)? How would you prefer to be contacted?

How clear was your communication with the NHS around your Health Check? What other information or resources would you find helpful?

This may include discussions surrounding communications being responsive, in relevant community languages, participants feeling they received enough information to make informed decisions.

What was your experience with the available appointments and locations to receive an NHS Health Check (e.g., was the location accessible, were appointments at appropriate times)? What would improve this experience?

How can the Health Checks be delivered in a way which is more relevant to your community (include who delivers the session and their cultural awareness)

The specific questions may be decided by the academic engagement partner, but should help develop the Council's understanding in:

Community knowledge and expectations of NHS Health Checks

Previous experiences with NHS Health Checks

The customer journey of attending an NHS Health Check

How appropriate NHS Health Checks are for the target community

Including communication format(s), location, availability of appointment, language(s), cultural awareness of healthcare staff

The academic Partner should ensure that discussions/topic questions are made relevant to participants who:

Are of eligible age and **have** attended an NHS Health Check previously

Are of eligible age and **have not** attended an NHS Health Check previously

Are approaching NHS Health Check eligible age category

Are NHS staff who deliver Health Checks

The focus groups **must** use the attached monitoring demographic questionnaire (Appendix 1). All identifiable information must be anonymised before sending back to the Council.

Financial Value

The **maximum** funding available for this project is **£15,000.** This will be paid in two equal instalments of £7,500 (Payment 1 at the mid-point of the contract, Payment 2 on completion of the contracted work). Providers should outline the detailed costs for delivering this research in the quotation document below.

Real Living Wage

Please note that clause 4.6 of the Conditions of Contract – payment of the RLW will apply throughout the contract period. This will require employees of the supplier engaged on this contract to be paid the RLW.

Insurances Required

Public Liability Insurance	Minimum Cover: **£1M**
Employers' Liability Insurance	Minimum statutory limit as laid down by legislation

Electronic Tendering

Quotations must be submitted by email to the following authorised recipient email address: CommunitiesTeam@birmingham.gov.uk and submission by any other means will not be considered. Access to the Quotations will only be made available to those employees of the Council who are responsible for the procurement process.

Communications and Clarifications

All formal communications (including, but not limited to, clarifications and the submission of Quotations to the Council) are to be made by email to the above-named authorised recipient.

If a potential supplier is in doubt as to the interpretation of any part of this document; or if they consider that any of its requirements are ambiguous or conflict with any other requirements, they should contact the Council.

Submission Instructions

You are asked to note that whilst the authorised recipient does have visibility of the names of suppliers, that have responded via email, the details and documents that have been submitted in relation to the ITT are not opened until the closing date/time for submission of Quotations has passes.

Only one Quotation submission is permitted for each potential supplier. In the event that more than one is submitted by a potential supplier, the one with the latest time of submission will be evaluated and the other(s) disregarded.

The Quotation submission must be fully completed and signed by the potential supplier. All Quotations **must** be submitted by potential suppliers by the date and time detailed in section 2 (Quotation response form).

Any submissions received after the deadline (based on the system clock) will not be considered.

The Council accepts no liability for any losses suffered by the supplier as a result of computer viruses. It is the potential supplier's responsibility to ensure that files submitted to the Council are free from viruses. The Council may reject a submission which is submitted in a file or files which are, or the Council reasonable suspects are infected with a virus and may also delete such file or files.

It is the potential supplier's responsibility to ensure that files delivered to the Council are complete and fully accessible by the Council and are not corrupted. The Council accepts no liability for corrupted files or data and may reject a Quotation submission which consists of or contains corrupted or inaccessible files.

If and to the extent that the delivery of a Quotation submission to the Council is prevented or delayed as a result of problems with the Council's service, the Assistant Director, Procurement and or their nominated representative will ensure the integrity of the procurement process and in his or her sole discretion may allow applications to be re-submitted.

Documents submitted must be compatible with all Microsoft Office 2010 or Adobe Acrobat pdf packages. Note that drawings/graphs etc. submitted that cannot be read as determined by the Evaluation Team will be discounted. Note that the Council reserves the right to retain all and any of the information supplied to it by the potential supplier.

Quotation documents should be named in the following format: **Number – Project Reference – Document Name – Supplier Name**

Furthermore, the following formatting styles must also be followed:

It should be presented on size A4 paper;

11pt Arial, or equivalence must be used;

All pages must be clearly numbered, including the total number (i.e. Page 1 of 10)

Confidentiality

All information supplied by the Council in connection with this Quotation shall be regarded as confidential by the potential supplier (except that such information may as is necessary be disclosed for the purpose of obtaining guarantees and Quotations necessary for the preparation of the submission).

Data Protection

Tenderers should note that following the award of the contract, the Council will determine any additional data protection provision that may be required, as well as considering the proposed processing of personal data and drafting the relevant agreements such as data sharing/data processing. The successful tendered will be advised of the requirements as part of the contract mobilisation.

Part 2 - QUOTATION RESPONSE ACADEMIC PARTNER (please complete in FULL & return by specified deadline)

Selection and Evaluation (*for information only)*

Please submit your completed Quotation response to the Communities Team inbox (communitiesteam@birmingham.gov.uk) no later than **22/03/2024 at 5:00pm**. You are required to detail how you intend to deliver the above requirements in your proposal/quote.

The evaluation of Stage 1 of this Quotation will be based on a pass/fail basis (section ••) and Stage 2 being Value Assessment approach (section ••• and ••) that enables the Council to assess a Quotation on **Price (20%) and Quality (80%)**. The assessment of Quality will consider written information provided by the Quotation provider in relation to the specific requirements as set out in the Quotation document. All relevant evidence submitted will be assessed/merit rated against pre-determined criteria. The assessment on price would be scored on ab absolute figure, but Providers will be asked to outline how they are going to be allocating their total project spend each year.

Breakdown of Assessment Stages

A breakdown of the assessment stages is shown in the tables below:

Stage	**Criteria**
Stage 1 (General Information)	Pass/Fail
Stage 2 (Quality Response)	**80% overall weighting**. Minimum threshold of 60% for quality is required to proceed to next step (i.e. 60 marks out of 100 marks)

Stage 2 (Price)	**20% overall weighting**. No minimum threshold, budgets which propose maximum Council savings will be prioritised.

Stage 1 – General Information

No.	Pass/Fail Selection Criteria	Outcome
1	Company Information	Not Scored
2	Birmingham Living Wage	Pass/Fail
3	Delivery of Programme	Pass/Fail

Stage 2 – Price and Quality Responses

Price

Price Criteria 20%	Sub-Weighting
Submitted budget proposal	100%

Quality

Quality Criteria 80%	Sub-Weighting
A Planned Methodology	40%
B Experience	40%
C Risk Management	20%
Total	**100%**

The scoring system to be applied to the assessment of the Quotation proposals will be as follows:

Score	Definition	Assessment
5	An excellent response submitted in terms of detail and relevance and clearly meets or exceeds requirements with no negative implications or inconsistencies. Demonstrates exceptional understanding and evidence in their ability/proposed methodology to deliver the project.	**Excellent**
4	A good response submitted in terms of detail and relevance and clearly meets requirements without significant negative indications or inconsistencies. Above average demonstration by the Tenderer of the understanding and evidence in their ability/proposed methodology to deliver	**Good**

	the project. The requirements would be met to a good standard without intervention or significant ongoing issues.	
3	A satisfactory response submitted in terms of the level of detail, accuracy and relevance, and evidence in their ability/proposed methodology to deliver the project. Aspects of the response may be good but there are either some omissions of important factors or negative indications that reduce the extent to which the requirements will be met.	Satisfactory
2	Satisfies the requirement with minor reservations. Some minor reservations of the Tenderer's understanding and proposed methodology, with limited evidence to support the response. The Council may be concerned that services would require intervention or ongoing management.	Unsatisfactory
1	Limited response provided, or a response that is inadequate, inaccurate or only partially addresses the question. Major reservations of the Tenderer's understanding and proposed methodology, with little or no evidence to support the response.	Poor
0	Does not meet the requirement. Does not comply and/or insufficient information provided to demonstrate that the Tenderer has the understanding or suitable methodology, with little or no evidence to support the response. No response to the question or a response that is significantly irrelevant or inaccurate.	Unacceptable

Quality Assessment

Quality will account for **80%** of the Quotation evaluation. The quality assessment will be carried out on the quality questions/method statements. After rejecting bids that in the opinion of the Council are unrealistically low (in terms of Quality), the highest Quality score will be given 100% for Quality. Other Quality scores will then be expressed as a proportion of the highest score.

Bids which score in excess of **60%** of the quality marks (i.e. 60 marks out of 100 marks) ***may*** be invited to attend a clarification interview in order to discuss points included in the written proposals. The points discussed may result in scores being adjusted either up or down.

The Council reserves the right to disqualify any potential supplier which:

Fails to achieve a ‘Pass’ in respect of a ‘Pass/Fail’ criteria question.

Achieves a score below a **60%** threshold in terms of quality (60 marks out of 100 marks)

Zero in any one section

Zero / no response in any one scored question

Is submitted in whole or in part after the deadline.

Is submitted in part only by the deadline

Overall Assessment

The Weighted Quality Score for each Quotation will produce a total score. The scores for each Quotation will be compared and (Subject to a final risk assessment) the Quotation Provider(s) with the highest score offering the most economically advantageous bid will be recommended for acceptance.

Company Information (for information only)

Name of Organisation	
Trading Name of Applicant	
Address of Registered Office	*Address 1* *Address 2* *Address 3* *City/Town* *Country*
Postcode	
Company Registration No. *(if applicable)*	
Date of Registration	
Certificate of Incorporation, and all certificates of change of name issues by the Company Registrar (Or include reasons if not applicable)	☐ Yes ☐ No
Is the applicant a consortium joint venture or other arrangement? If so, please provide details of the constitution	☐ Yes ☐ No

Contact Name for enquiries about this application	
Telephone Number	
Fax Number	
Email	

The Quotation Provider must inform the Council if they are receiving funding to undertake similar or related activities to that defined in this procurement exercise. Please provide details with your quotation in the table below.

Funder	
Funding Activities	
Date	
Period of Funding	

Have you worked with the Public Health Division previously? If yes, fill below

	Reference
Organisation (Name):	
Customer Contact Name	
Customer Telephone No:	
Customer Email Address:	
Date Contract Awarded:	
Contract Completion Date:	
Contract Reference and Brief Description:	
Contract Value:	
Contract Outcomes:	

Have you had any contracts terminated for poor performance in the last three years, or any contracts where damages have been claimed by the contracting authority?	☐ Yes ☐ No
If **"Yes"** please give details:	

Offer Details

Real Living Wage (Pass/Fail)

You are required to pay employees the Real Living Wage in accordance with Real Living Wage Policy. The Real Living Wage is not the same as the National Living Wage which is a legal requirement. The Real Living Wage is the same as that set out by the Living Wage Foundation and independently determined on an annual basis by the Centre for Research in Social Policy at Loughborough University.

Please confirm you will pay the Real Living Wage in accordance with the Real Living Wage Policy.

Please confirm you will pay the Real Living Wage in accordance with the Real Living Wage Policy.

£ Yes ☐

£ No ☐

Offer Details (Pass/Fail)

Compliance with the Council's requirements - Please indicate by selecting either option **YES** or **NO,** that in the event you are awarded a contract if all goods and services supplied will or will not, unreservedly deliver in full, all the Council's requirements/specification as set out in section •• above.	☐ **Yes -** all goods/services supplied will unreservedly meet all the Council's requirements set out in •• above (Specification) ☐ **No - we** will not, or cannot supply Goods/services that meet all the Council's requirements set out •• in above (Specification)

Quotation Responses (Quality 80%)

Planned Methodology (*40% weighting)*

Please tell us how you plan to work with the focus group Provider(s) to fulfil the requirements of the academic partner. Your response should refer to the deliverables listed in section •• of this Quotation document. To support your answer, the specification for the focus group Provider has been provided in **Appendix 2.**

(Maximum 1 side of A4, any information included over the page count will not be scored).

Our proposed approach utilises a collaborative and multi-layered strategy to achieve the project's objectives.

Participatory Action Research (PAR): We will employ participatory action research (PAR), a collaborative methodology in which researchers and community members directly impacted by the issue collaborate throughout the research process. We understand, engaging **Focus Group Providers (FGPs)**, representatives from community organisations, is crucial for this project and our expertise ensures the effectiveness of FGPs from community organisations. We guide the articulation of research inquiries and the crafting of methodological frameworks, enhancing data quality. Our involvement in focus group sessions will ensure rigorous data collection. The use of Participatory Action Research (PAR) in this project is crucial as it places providers in a unique position to recruit for these focus groups. Their close connection with the community and understanding of its needs provide valuable insights for piloting questions. We will empower FGPs through training and support, fostering community empowerment. By incorporating community perspectives, we catalyse social action to address barriers to accessing NHS Health Checks.

Double-Layered Sampling Design: We propose a double-layered sampling design. The first layer will focus on capturing Birmingham's diverse ethnicities. Within each ethnicity, participants will be segmented by gender, age range, and socioeconomic status (SES) to create homogenous groups. This approach ensures a comprehensive representation of perspectives, allowing for a nuanced exploration of how SES intersects with ethnicity, gender, and age in shaping perceptions of NHS Health Checks. This design enables us to recognise that different demographic groups may perceive NHS Health Checks differently and encounter varying barriers and facilitators to accessing them. By examining how ethnicity, gender, age and SES intersect with individuals' perceptions and understanding of NHS Health Checks, we can uncover nuanced insights into the diverse experiences and needs within the target communities. The insights gained will inform the potential development of targeted pilot programmes to address the specific needs identified in the focus groups.

Framework Analysis with Efficiency: We will employ Framework Analysis, an efficient method, for data analysis. This structured approach allows for thorough exploration of qualitative data, facilitating evidence-based decision-making. Considering the project's anticipated time constraints associated with the funding cycle, framework analysis will be a suitable and efficient methodological approach. This method

leverages pre-defined themes, facilitating a streamlined process for deriving thematic insights. The Research Capacity Development (RCD) framework will inform the chosen framework, ensuring alignment with the study's objectives.

Focus Group Design Workshops: We, the academic researchers, will design and facilitate workshops with the FGPs. These workshops will address several key objectives: **Building a Shared Understanding:** Establish a common understanding of focus group methodology and its appropriateness for this project.

Establishing Focus Group Objectives: Collaboratively develop clear and focused objectives for each focus group.

Developing Thematic Questions: We will develop thematic questions that guide discussions and meet research aims. These questions will be piloted to ensure shared understanding and accessible language, as specified in the tender.

Creating Focus Group Guidelines: Formulate guidelines that align with the chosen research method, emphasising techniques to encourage rich conversation and establish ground rules for productive discussions. During these workshops, robust discussions will be encouraged to explore what information needs to be gathered from each question and how to formulate the most effective wording.

Lastly, we will facilitate interactive workshops where FGPs can pilot and explore the running of focus groups. This hands-on approach provides opportunities for experiential learning and enables FGPs to navigate diverse group dynamics effectively. By combining participatory action research, a double-layered sampling design, efficient framework analysis, and collaborative focus group design workshops, we propose a comprehensive and well-rounded methodology to achieve the project's goals and deliver valuable insights on improving NHS Health Checks for the diverse communities within Birmingham.

Experience (*40% weighting)*

Please summarise your understanding of the overall requirements, your knowledge of evidence-based community approaches and qualitative data collection and analysis. Your response should be supported with relevant examples of where you have provided a similar services and achieved the expected outcomes.

(Maximum 1 side of A4, any information included over the page count will not be scored).

Our team's extensive experience in conducting interviews and focus group qualitative studies, particularly within the context of working with Black, Asian, and Minority Ethnic (BAME) communities across the UK, aligns seamlessly with the comprehensive grasp of evidence-based community approaches and qualitative data collection and analysis methodologies required for the project. We recognise the paramount importance of collaborative engagement with community stakeholders, particularly Focus Group

Providers (FGPs) from diverse community organisations, to ensure the efficacy and relevance of the research endeavour. For example, Paula Smith and Muhammad Hossain have extensive experience collaborating with community partners to conduct focus groups as part of various evaluations. Paula specialises in mental health services within African and African Caribbean communities in Birmingham, while Muhammad has expertise in South Asian communities in Birmingham, Portsmouth, and London, particularly in mental health and dementia services evaluations. Their expertise highlights our commitment to engaging with community stakeholders effectively.

Evidence-Based Community Approaches: Our proficiency in evidence-based community approaches exemplifies our successful execution of similar projects to address public health challenges within diverse communities. For example, Muhammad adopted a community-based participatory research approach in a recent endeavour focused on increasing awareness and uptake of preventive healthcare services among underserved populations. Through strategic collaboration with community leaders and organisations, we facilitated the development and implementation of tailored interventions, resulting in a significant increase in service utilisation rates within the target communities. Additionally, as mentioned above, our team conducted studies in London, Portsmouth, and Birmingham among various global majority groups to explore barriers to accessing dementia and mental health services. Subsequently, based on the study results, we devised tailored interventions that were successfully implemented within these communities.

Qualitative Data Collection and Analysis: Our proficiency in qualitative data collection and analysis is underscored by our extensive portfolio of published research in reputable peer-reviewed journals (please see some selected articles below). These publications reflect the methodological rigour of our work and highlight our commitment to disseminating research findings that contribute to evidence-based practice and policy development. For instance, our team has worked closely with various Patient and Public Involvement and Engagement (PPIE) groups across the UK, drawing on their invaluable insights to shape our research initiatives. Additionally, we have taken a proactive role in providing training for community partners, focusing on co-research methodologies within mental health services in Birmingham. This training equips community groups with the necessary expertise to contribute effectively to funding bids aimed at addressing health inequalities, particularly in the Ladywood area.

Achieved Outcomes: Our collaborative and community-centred approach has consistently achieved tangible outcomes that address identified health disparities and promote health equity within diverse communities. By engaging with community stakeholders and leveraging our expertise in qualitative research methodologies, we have facilitated the implementation of tailored interventions that have had a meaningful

impact on improving access to essential healthcare services. Our commitment to methodological rigour and community engagement consistently yields tangible outcomes that directly impact stakeholders and foster positive health outcomes within diverse communities. For instance, we conducted focus groups to inform the development of a three-year strategy and action plan for North Sparkbrook and Farm Park. These initiatives exemplify our dedication to translating research insights into actionable strategies that address community needs and promote health equity.

In conclusion, our team's extensive experience conducting co-research, interviews and focus group qualitative studies, coupled with our profound understanding of evidence-based community approaches and qualitative data collection and analysis methodologies, positions us as a proficient and reliable partner for the current project. Our proven track record of achieving tangible outcomes through collaborative engagement with diverse stakeholders underscores our capacity to effectively address healthcare disparities and contribute to positive health outcomes within target communities.

Some selected publications:

Rabiee, F., & Smith, P. (2013). Being understood, being respected: an evaluation of mental health service provision from service providers and users' perspectives in Birmingham, UK. International Journal of Mental Health Promotion, 15(3), 162-177.

Rabiee, F., & Smith, P. (2014). Understanding mental health and experience of accessing services among African and African Caribbean Service users and carers in Birmingham, UK. Diversity & Equality in Health & Care, 11(2).

Hossain, M. Z., Tarafdar, S. A., Kingstone, T., Campbell, P., & Chew-Graham, C. A. (2022). From detection to preparing for the end-of-life: A qualitative exploration of the South Asian family carers' experiences of the journey with dementia. Health & Social Care in the Community, 30(6), e5135-e5144.

Hossain, M.Z., Stores, R., Hakak, Y., Dewey, A. (2020). Traditional gender roles and effects of the dementia caregiving within a South Asian ethnic group in England. *Dementia and Geriatric Cognitive Disorders*. doi: 10.1159/000506363

Hossain, M.Z., Stores, R., Hakak, D., Crossland, J., & Dewey, A. (2020). Dementia knowledge and attitudes of the general public among the Bangladeshi community in England: a focus group study. *Dementia and Geriatric Cognitive Disorders*. doi: 10.1159/000506123

Hossain, M.Z., Khan, H.T.A. (2020). Barriers to access and ways to improve dementia services for a minority ethnic group in England. J Eval Clin Pract. 2020;1-9. https:// doi.org/10.1111/jep.13361

Risk Management (20 *% weighting)*

Please identify any risks you foresee and how you plan on managing and mitigating any risks that you may experience during your delivery of the project. This response should include but is not limited to plans for recruiting staff members, engaging with community engagement partners, GDPR considerations, and any disturbances to the project and its delivery.

(Please fill in the table in Appendix 3 – do not delete the table. We would expect to see at least 5 rows completed).

Please see Appendix 3

Budget (Price 20%)

Please outline how you will spend a **maximum of £15,000** for this project, using the table below. The headings/subheadings are not fixed and can be altered to ensure

suitability for this project. Please ensure the table provides **specific** details on the area of expenditure/description of costs for the proposed project.

Please ensure that all proposed prices included in the table below are inclusive of all costs and discounts, but excluding VAT.

The budget will be monitored throughout the duration of the project and any discrepancy larger than 10% must be informed to the project manager.

Item No.	Area of Expenditure/Description	Quantity/Unit Price/ Unit of Measure	Cost (£)
	Salaries including NI & Pension		
1	Pool of academic staff – Muhammad Hossain Salim Khan Paula Smith Natalie Quinn-Walker Sara Zarti Ayazullah Safi	28 days of academic delivery time across the team (allocated internally) at £500 per day +VAT	£14,000
2			
	Delivery of activity		
3	Research Design and Methodology Development	5 days	
4	Focus Group Recruitment and Management	7 days	
5	Data Collection and Analysis	8 days	
6	Report Writing and Dissemination	8 days	
7	Training Day at City Centre Campus		£500 (This includes venue hire and refreshments)
8	Community Venue Hire for Focus Groups		£500 (This is an estimate and will be adjusted based on actual costs)
9			
10			
11			
	Support costs		
12	Finance, HR, admin, governance		

13	IT costs (e.g., connectivity, phones, call costs, MS Teams, etc)		
14			

Total cost of project:

Quotation Supplier's Offer Confirmation

[*Name of Organisation*] confirm that we understand and accept that this offer is made in accordance with the Council's Standard terms and conditions.

[*Name of Organisation*] confirm that this Quotation is on the basis as set out in this document and that it is not subject to any negotiation.

If for any reason following the submission of our Quotation we seek to propose any changes to the Specification, Terms and Conditions or to put forward any proposal which conflicts and we do not withdraw that change following a written request to do so by the Council then [*Name of Organisation*] agrees that the Council may determine not to evaluate our submission any further.

I/We confirm that the insurances required in section ••• will be provided under the Contract and I/We agree that if our offer is accepted that I/We agree to arrange, with the insurers the provision of a Statement to Birmingham City Council: -

that valid Insurance is held in accordance with the requirements of Conditions of Contract;

that all premiums due to the Insurer have been paid including instalment payments;

that the Insurer agrees to give notice forthwith to Birmingham City Council of withdrawal or intention to withdraw insurance cover in connection with the project.

This document is to be signed by such persons:-

where the Quotation supplier is an individual, by that individual;

where the Quotation supplier is a partnership, by one duly authorised partner;

where the Quotation supplier is a company by one director or by a director and the secretary of the Company, such persons being duly authorised for that purpose.

Date	
Signature(s) of Quotation Supplier	

Address *(if different from Section 2.2)*	
Telephone No. *(if different from Section 2.2)*	
Email *(if different from Section 2.2)*	

Thank you for taking the time to respond to this QuotationAppendix 1: BCC Standard Demographic Questions

V1.8 BCC Standard Demographic Questio

Appendix 2: Focus Group Provider Specification

No.	Activity	Outputs	Additional Information
PM1	Ethnicity Focus Groups	2x focus group per identified ethnic community	The focus groups can include people who have mixed heritage, such as people of Mixed White British and Black Caribbean ethnicity. Each focus group must have a minimum of 10 participants. The focus groups must have an appropriate representation within the following criteria: People who are approaching NHS Health Check age (35-39) Those aged 40-64 Each focus group should have a minimum of 5 people aged 50 and over. Minimum of 5 males and 5 females in each focus group (ex. White British gendered focus groups) You may wish to have 1 focus group for those approaching NHS Health Check age and 1 for those who are age-eligible, or 2 focus groups for each community that features a mixture of ages. Your quotation response should outline which approach you have chosen and why.
PM2	Healthcare Professionals Focus Groups	2x focus groups for people who deliver NHS Health Checks	This focus group will focus on gathering frontline staff perspectives of potential barriers to NHS Health Checks, including similar topic discussions as in the community focus groups.
PM3	Reporting and Evaluation	1x project report per focus group Present findings at Birmingham City Council forums Involvement in BLACHIR steering group with existing engagement partners.	The focus group Provider will work with the academic to produce a maximum 2000-word report from each focus group. Report clearly on opinions that differ between age groups Report clearly on opinions that differ within an ethnic group Report clearly on opinions that differ between gender Extract the key themes from the focus groups The focus group Provider will work with the academic to ensure that attendees evaluate the workshop, and this feedback is captured in the summary report. Recommendations and implications for Public Health, NHS Health Checks deliverers and other systems partners to be included. A draft of the final report must be sent to Public Health to be reviewed by Senior Management.

Appendix 3: Project Risks

Risk	Impact (1-5, with 1 being low and 5 being high)	Probability (1-5, with 1 being not likely and 5 being very likely)	Priority level (Impact multiplied by probability) to highlight the biggest risk	How will you mitigate against this risk to lower the impact or probability of the risk occurring?	Impact after mitigation (1-5)	Probability after mitigation (1-5)	Priority level after mitigation (impact multiplied by probability)
Difficulty recruiting participants (esp. specific demographics)	3	3	9	Collaborate with Focus Group Providers (FGPs), utilise diverse recruitment methods (online, community centres, faith-based organisations), offer incentives (refreshments, travel vouchers).	2	2	4
Limited availability of qualified Focus Group Providers (FGPs)	3	2	6	Advertise through relevant networks, thorough selection process focusing on experience and cultural competency, competitive compensation and training opportunities.	2	1	2
GDPR compliance issues (data breaches, non-compliance)	4	3	12	GDPR awareness training for all personnel (including FGPs), robust data security measures (passwords, encryption), informed consent with clear data collection/storage/usage procedures, partnership with university's data protection office.	2	2	4
Disruptions to focus	2	3	6	Develop backup plans (substitute	1	2	

group sessions (illness, weather)				participants, alternative venues), clear communication channels with participants, utilise technology (online conferencing or offering remote focus group discussions) if appropriate.			2
Challenges with participant dynamics (experts, dominant talkers, shy participants, ramblers)	3	4	12	Leverage team's moderation expertise, train FGPs in facilitation techniques (expert management, redirection, active listening), utilise group activities, establish ground rules, use break-out groups for specific questions.	2	3	6

Appendix 2: Focus Group Topic Guides

BIRMINGHAM CITY COUNCIL & BIRMINGHAM CITY UNIVERSITY NHS HEALTH CHECKS RESEARCH

Focus Group Topic Guides

Remember:

Use simple language and short questions.

Explain any medical terms.

Make sure everyone feels comfortable sharing

For All Groups:

Icebreaker:

- What comes to mind when you hear "NHS Health Check"?

General Awareness:

- How did you learn about NHS Health Checks?
- What was your first impression?

For Eligible Adults (Attended/Not Attended):

Knowledge:

- What do you think happens at an NHS Health Check?

Expectations (Attended):

- Did the Health Check meet your expectations?

Expectations (Not Attended):

- Any thoughts about getting a Health Check in the future?

For Approaching Eligible Age:

Anticipation:

- How do you feel about being eligible for a Health Check soon?

Information Needs:

- What information would help you decide about getting a Health Check?

For Eligible Adults (Attended):

Experience:

- What was your Health Check experience like?
- What went well, what could be better?

Outcomes:

- Did you get helpful advice? Did you make any changes?

Follow-up:

- Was there any follow-up? Did you feel supported?

For All Groups:

Ideal Experience:

- What would the perfect Health Check be like?

Communication Preferences:

- How would you like to get information about Health Checks?

For Eligible Adults (Attended/Not Attended):

Invitation:

- How did you get the invitation? Was it clear?

Booking:

- Was it easy to book an appointment?

At the Appointment:

- How was the experience? Did you feel comfortable?

For All Groups:

Cultural Relevance:

- Does the Health Check programme fit the needs of your community?

Language and Accessibility:

- Are the materials easy to understand?

Staff Awareness:

- Do staff understand and respect different cultures?

For Eligible Adults (Attended/Not Attended):

Barriers:

- What makes it hard for people to get Health Checks?

Suggestions:

- How can we make Health Checks more accessible?

Appendix 3: Focus Group Topic Guides for NHS Staff

BIRMINGHAM CITY COUNCIL & BIRMINGHAM CITY UNIVERSITY

NHS HEALTH CHECKS RESEARCH

Focus Group Topic Guides for NHS Staff

Focus: NHS Health Checks on Global Majority **Communities**

Delivery Insights:

- What questions do patients from these communities have?
- Any cultural or religious beleifs affecting their views on health?
- Any communication challenges during Health Checks?

Barriers:

- What makes it hard to get these patients to attend?
- Any cultural or language barriers?
- Any trust issues or concerns?
- Any practical barriers, like transport or childcare?

Successes:

- What works well to get them to come?
- Worked with any community groups?
- Any culturally sensitive approaches that worked?
- Any positive stories to share?

Process Efficiency:

- Any issues in the process affecting these communities?
- Are appointments convenient?
- Is the process flesible enough for their needs?
- Can it be more steamlined and culturally sensitive?

Communication Improvement:

- How can we communicate better with these patients?
- Are materials in languages they understand?
- How to best explain Health Checks and address concerns?
- How can staff communicate effectively with diverse patients?

Additional Considerations:

- Need for more diverse staff or interpreters?
- Any training or resources needed?
- How to involve community leaders in Health Checks?

Appendix 4: Participant Information Sheet

NHS Health Checks within Birmingham Communities. Participant Information Sheet

(To be read individually or verbally translated by Focus Group Leaders prior to participants signing the Consent Form)

You are being invited to take part in a focus group to explore your experience of NHS Health Checks in Birmingham. This project is a partnership between your community, Birmingham City Council and Birmingham City University.

Study title: *NHS Health Checks within Birmingham Communities*.

This information sheet will tell you about the study, why it is being carried out and what the partnership hopes the achieve. It is important that you read this sheet and take the time to decide if you would like to consent to being involved in this focus group. Please ask your focus group leader if you have any unanswered questions.

Purpose of the Study

NHS Health Checks are run across the whole of the country. It is a free service that aims to provide people between 40 and 70 with a checkup of their overall health. These can help to ascertain whether you are at risk of certain conditions such as heart disease, stroke, diabetes or kidney disease.

Birmingham City Council are concerned about the numbers of people that are taking up this opportunity so want to speak to the different community groups to see how this service can be improved for them. The way that the information is being gathered is by focus groups within each community.

Dates and timescale

Between October and December community groups across Birmingham will be conducting focus groups within their communities to explore their experiences of NHS Health Checks.

What will the focus group involve?

Focus groups will be held within each community group, bringing together between 8 and 10 people for approximately 1 hour. You will be asked for your opinion on a number of issues related to NHS Health Checks; this will be in your own language. The Focus Group will be recorded if necessary, and notes will be taken during the focus group. However, individuals will not be identified, so your comments will remain anonymous.

What will happen to the results?

The notes from the Focus Groups will be pulled together to identify themes. This will be written as a report for Birmingham City Council and presented back to communities. Birmingham City University will publish research articles so that other areas can learn from the approach taken to review NHS Health Checks across the country.

Who is funding the study?

The study is being funded by Birmingham City Council.

Who has reviewed the study?

The Ethics Committee at Birmingham City University reviews the research plan to ensure ethical standards are upheld.

How will confidentiality be maintained?

The anonymity of participants will be maintained throughout. No personal data will be collected. No individual notes will be taken that will identify individuals.

What are the benefits to you of taking part?

The study will be used to inform how NHS Health Checks are run in communities across Birmingham.

What are the disadvantages of taking part in the study?

The study is considered low risk as you are discussing your knowledge of a local service.

Do you have to take part?

This information sheet is to help you decide if you think this study is something you would like to be part of. You do not have to agree to take part.

Right to withdraw

If you agree to take part in the study, you can withdraw your consent at any point.

Who can I speak to if I want to discuss this further?

Should you have any questions or concerns, you can contact the focus group leader or the Study Leader Dr Muhammad Hossain at Birmingham City University muhammad.hossain@bcu.ac.uk

What to do if you want to take part in the study?.

If you want to take part in this study, please sign the consent form.

Thank you for reading this information.

Your Community, Birmingham City Council, Birmingham City University

Appendix 5: Consent Form

Consent Form

Research title: *NHS Health Checks in Birmingham Communities - Community Focus Groups*

Name of Community Focus Group .....

Date of Focus Group .....

Name of Focus Group Leader .....

Email address: .....

Contact number: .....

Please initial the boxes below

I confirm that I have read and understand the research project information sheet for the NHS Health Checks study. I have had the opportunity to consider the information and ask questions. ☐

I understand that I will be taking part in a focus group meeting and I understand that my attendance is voluntary and that I am free to withdraw at any time without giving any reason. ☐

I understand that no personal data is being collected. ☐

I understand the focus group leader will record the focus group and take notes from this but that I will not be identified in the notes. I understand that after the study these notes and the recording will be deleted. ☐

Name of Focus Group Leader	Signature of Focus Group Leader	Date

Name of Participant	Signature of Participant	Date

Appendix 6: Focus Group Discussion Reporting Template

BIRMINGHAM CITY COUNCIL & BIRMINGHAM CITY UNIVERSITY NHS HEALTH CHECKS RESEARCH

Focus Group Reporting Template

Please complete the sections below to summarise your focus group discussions.

Focus Group Details

Date of Focus Group:	
Location:	
Number of Participants:	
Facilitator Name(s):	

Participant Demographics

Age Range:	
Gender:	
Ethnic Background:	
Any other relevant details:	

Icebreaker

- What comes to mind when you hear "NHS Health Check"?

(Summarise participants' responses)

Please expand if needed

General Awareness

- How did you learn about NHS Health Checks?

(Summarise how participants became aware of NHS Health Checks)

- What was your first impression?

(Provide a summary of initial thoughts and reactions)

Please expand if needed

Eligible Adults (Attended/Not Attended)

Knowledge

- What do you think happens at an NHS Health Check?

(Summarse participants' knowledge of what an NHS Check involves)

Please expand if needed

Expectations (Attended)

- Did the NHS Health Checks meet your expectation?

(Note whether participants felt the check met their expectations)

Please expand if needed

Expectations (Not Attended)

- Any thoughts about getting a Health Check in the future?

(Capture participants' thoughts or concerns if they haven't yet attended)

Please expand if needed

Approaching Eligible Age

Anticipation

- How do you feel about being eligible for a Health Check soon?

(Summarise feelings or expectations about upcoming eligibility)

Please expand if needed

Information Needs

- What information would help you decide about getting a Health Check?

(Note the types of information participants feel they need)

Please expand if needed

Eligible Adults (Attended)

- Experience: What was your Health Check experience like?

(Provide a summary of what went well and what could be improvied)

Please expand if needed

Allocated Time

- Please summarise whether the appointment times and locations were convenient for eligible adults.

(Please summarise if eligible adults felt they had enough time during the NHS Health Check to discuss their concerns or health information)

Please expand if needed

Outcomes

- Did you get helpful advice? Did you make any changes?

(Summarise any actions participants took based on the advice they received)

Please expand if needed

Follow-up

- Was there any follow-up? Did you feel supported?

(Capture participants' feedback on whether they received follow-up support)

Please expand if needed

For All Groups

- What would the perfect NHS Health Check be like?

(Summarise suggestions for creating an ideal experience)

Please expand if needed

Communication Preferences

- How would you like to receive information about NHS Health Checks?

(Capture preferred communication methods like phone, text, email, etc.)

Please expand if needed

Eligible Adults (Attended/Not Attended)

Invitiation

- How did you receive the invitation? Was it clear?

(Summarise how participants were invited and their impressions of the clarity of the message)

Please expand if needed

Booking

- Was it easy to book an appointment?

(Capture feedback on the ease of booking an appointment)

Please expand if needed

At the appointment

- How was the experience at the appointment? Did you feel comfortable?

(Summarise the overall experience during the appointment, focusing on comfort and interactions)

Please expand if needed

For All Groups

Cultural Relevnce

- Does the NHS Health Check programme meet the needs of your community?

(Summarise how well participants feel the programme caters to their cultural needs)

Please expand if needed

Language and Accessibility

- Are the materials easy to understand?

(Provide feedback on the clarity and accessibility of materials)

Please expand if needed

Staff Awareness

- Do staff understand and respect different cultures?

(Summarise participants' of staff's cultural understanding and sensitivity)

Please expand if needed

Eligible Adults (Attended/Not Attended)

Barriers

- What makes it hard for people to attend Health Checks?

(Sumamrise specific barriers, such as language, transport, or cultural concerns)

Please expand if needed

Suggestions

- How can we make NHS Health Checks more accessible?

(Capture participants' ideas for improving accessibility and relevance)

Please expand if needed

Additional Comments

(Include any additional observations, reflections, or noteworthy comments from the focus group)

Please expand if needed

Facilitator's Notes

(Add any personal reflections or observations on group dynamics, challenges, or opportunities during the focus group)

Please expand if needed

Attachments

(Attach additional documentation to this report and send it to Birmingham City University via your named Buddy. You will find your Buddy details in the community information pack. If you are unsure of who your Buddy is please email Bhawna Solanki. Bhawna's email address is Bhawna.solanki@bcu.ac.uk

Information that you should attach to this report:

NHS Checks consent letter in English completed with all signatures

Individual consent form in English completed with signatures

Revised Checklist for Community organisation completed with information required.

Raw notes – these can be hand-written and in another language. You must not include any names of participants in your notes. Please refer to your participants by giving each participant a number. The raw notes will be returned to you once we have made copies to keep as raw data.

This report template

Thank you for taking the time to support this research project and completing all the necessary documents.

On behalf of Birmingham City University and Birmingham City Council

Dr Muhammad Hossain

Principle Investigator