Evaluation of Berkshire West

Community Wellness Outreach Health Check

EXECUTIVE SUMMARY

This report describes a clear case for continued expenditure on the CWO programme. The programme is successful at raising awareness of CVD and reaching communities who would not otherwise access a health check (especially global majority communities). There is tentative evidence of improved health and value for money. The report recommends a more focused service, which is closely embedded into a neighbourhood health model, and which puts a greater focus on follow up support (e.g. lifestyle and physical activity interventions).

The programme runs from January 2024 to 30th June 2026. The evaluation covers the period January 2024 – September 2025, with the patient data study (in particular), focused on the early part of the programmes (March 2024-April 2025). **Many of the issues highlighted in the evaluation have already been addressed and improved, prior to this report being finalised.**

Targeting & locations

- 57%[1] of checks have been delivered to target populations. Reading and West Berkshire are more successful at targeting – in Wokingham targeting was initially more challenging, but remedial action was taken.
- All three locations have encouraged a disproportionately high number of people from the global majority to access the health check.
- There are two approaches to encouraging take up which have been especially valuable: (i) West Berkshire's approach to phoning patients (ii) Reading's collaboration with voluntary organisations.
- Feedback regarding locations for health checks is complex: (i) Those who had a health check at a venue they were attending for another reason (e.g. homeless

[1] This figure comes from the running report: a monitoring report which gathers data from the three locations on a monthly basis. A separate patient data study (drawing on connected care data and delivered by Nuffield Department of Primary Care Health Sciences, University of Oxford) states that 89% of checks were delivered to the target cohort - this figure works on the assumption that the target cohort is IMD1-6. In West Berkshire, the target cohort was 1-6 for 18 months from January 2024 – June 2025 (this includes the period covered by the patient data study). In June 2025, the target cohort in West Berkshire revered to IMD 1-4. In Reading and Wokingham the target cohort has been IMD 1-4 throughout.

drop in lunch, community learning centre, Gurkha village hall) indicated that the location was critical: they would not have had a health check elsewhere. (ii) Among those who attended more generic locations (e.g. libraries and church halls), a majority (although not all) were relaxed about where the health check was delivered, as long as it was accessible and offered privacy. In fact some were confused / frustrated that they had not been able to access a health check at their GP surgery.

Patient experience and CVD awareness

- Patient feedback across all three sites is overwhelmingly positive (interviews n=23, focus groups / survey in Reading n=16, free-text responses in the patient survey n=391). People value the thoroughness of the check, the amount of time they have to discuss issues, the attitude, empathy and expertise of the staff.
- Most patients who needed language support were able to access it in a way that suited them.
- The running report suggests that around 85% of patients feel that the health check increased their awareness and understanding, with survey respondents suggesting that their knowledge has increased by about 33 percentage points.

Clinical impact

- The running report shows that nearly 70% of people accessing the checks had a high BMI. Nearly half had high cholesterol and 20-25% had high blood glucose or high blood pressure.
- The running report suggests that around 25% of people were referred to their GP following the health check.
- Data regarding benefits to people aged 18-39 is tentative. However the scoping review makes clear that a focus on these younger adults would be valued.

Behaviour change

The evidence of behaviour change is promising, although not entirely conclusive.

- The running report suggests that weight management is the most common referral for lifestyle support (following by social prescribing and mental health support). Smoking cessation and loneliness referrals are less common.
- 75% of survey respondents (n=391) indicated that they had made a lifestyle change, with 97% of those indicating that they felt the change would be maintained in 2 years' time. The lifestyle changes (listed in order of frequency, with the most common change listed first) were: improved food and nutrition,

increased activity / exercise, reduced alcohol consumption, improved mental wellbeing / reduced stress, reduced smoking.

- However in-depth conversations with the 23 people who took part in interviews suggests that people are finding it hard to make a meaningful change in their health outcomes. They would value more follow up to ensure they can generate and maintain lifestyle changes. The scoping review promotes a focus on lifestyle support (and finds that investment in physical activity services can result in a return of £7.78 for every £1 spent).

Partnership working and comparing the models

Details of the three models are available in the full report. Notable *differences* in delivery are highlighted below:

Figure 1Differences between the models

Differences between the models
Reading • Delivery contracted to voluntary sector and RBH • Higher levels of voluntary sector collaboration to recruit participants + open access to all adults 18+ • Check delivered by nurses • Additional follow up support through social prescribers on site, and 'Give it a go' programme. • Focused on IMD 1-4
West Berkshire: • Delivery contracted to Solutions4Health • Phone call follow up to recruit participants • Check delivered by health care assistants • Focused on IMD 1-6 for the first 18 months, then IMD 1-4
Wokingham: • Delivered in-house • Focused on IMD 1-4

- Stakeholders feel very pleased with the quality of partnership working, and the sustainable working relationships which have been developed. They would value more input from primary care colleagues if possible.
- Whilst is has been challenging to implement a suitable digital solution for transferring data to primary care, stakeholders now feel satisfied with the arrangements. They would however prefer that follow-on referrals and lifestyle support is co-ordinated through the Joy App, across all three sites.
- The evaluation has been unable to uncover strong evidence to justify the use of qualified nurses to deliver the health checks. However there is likely to be value in having clinical oversight (e.g. a nurse-led team of health care assistants, or a nurse 'on-call' during the delivery of health checks).

Areas for improvement

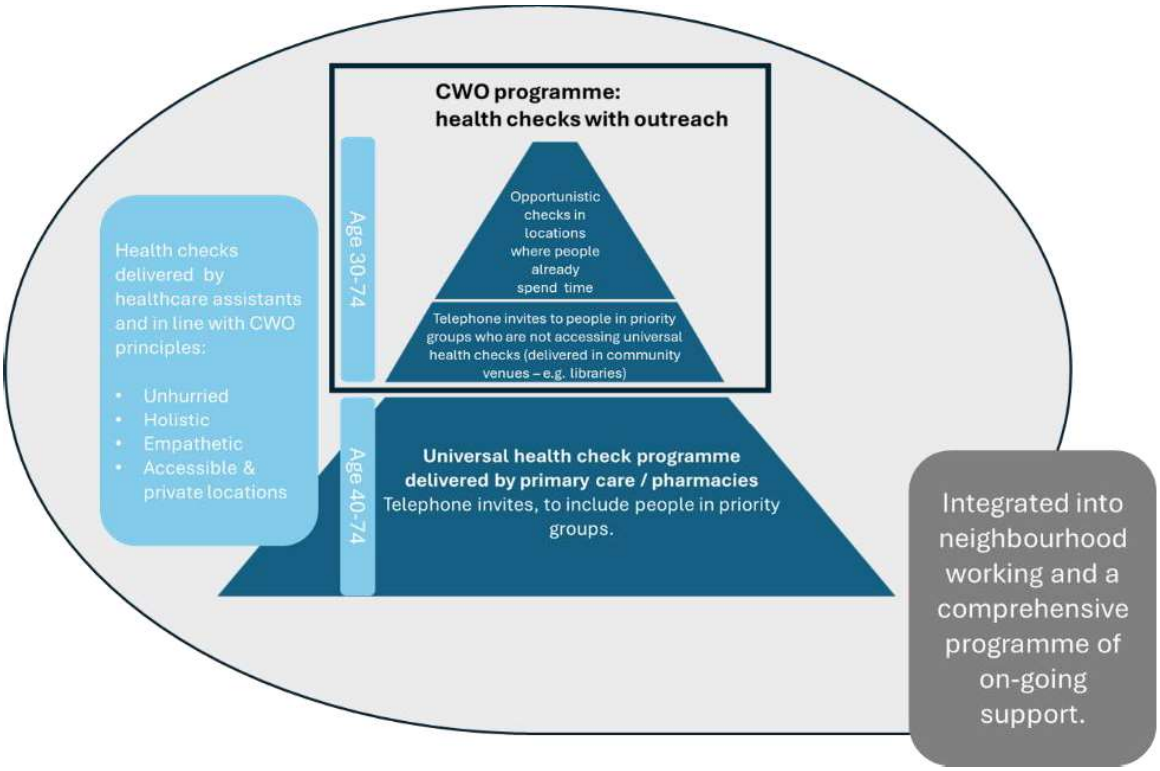
- **High priority:** Improved targeting and risk stratification – this is likely to include more effective / accurate Connected Care lists, combined with community-led engagement and telephoning key cohorts. Even more focus on informal, opportunistic invites, and an overall programme of targeted awareness-raising.
- **High priority:** Improved data recording. The success of the programme relies on accurate recording of blood pressure, HbA1c and patient outcomes. Improvements to point of care testing and accuracy of recording is key. For example, it is important to make sure the full systolic and diastolic readings (rather than simply noting that it falls within the 'normal' range). There may also be value in reviewing the codelist template and ensuring there is an on-going plan to regularly verify data entry and data recall.
- **High priority:** Better follow up support for those who are making lifestyle changes.
- **Medium priority:** Even more flexibility in terms of time slots (e.g. evenings and weekends). Balance the location of deliver to ensure optimum access and value for money. Likely to involve (a) a greater focus on opportunistic checks in locations where the target cohort will be (e.g. work place appointments, support groups and drop-in lunches) (b) a more modest focus on targeted outreach invites (and where these are used, they should be by telephone). It is acceptable for a greater proportion of health checks to be delivered at GP surgeries or pharmacies, as long as they are accessible, offer privacy, are unhurried and empathetic.
- **Low priority**: There may be value in offering follow up support for the small number of people who have trouble interpreting their personalised risk report.

Future service

Overall approach

The future CWO programme would be integrated into neighbourhood working and ideally focus on delivering a smaller programme of opportunistic health check delivery in locations which target communities frequent. This assumes that more checks are moved to primary care and pharmacies, delivered using CWO programme principles (non-judgemental, adequate time, delivered by healthcare assistants). Alongside these two 'extremes' of delivery, there would ideally be a small programme of additional support for those who can travel to a health check location, but are unlikely to attend a 'medical' setting.

Figure 2 Summary of an 'ideal' model



Targeting

The services would ideally improve targeting through even better collaboration between primary care, CWO colleagues and Connected Care. This work would be complemented with a programme of awareness raising, telephone invites and local relationship building, with an especial focus on those groups who will only access a health check when it is delivered in a location which is familiar and routine for them to attend (e.g. Mosque, Community Learning Centre).

Staffing

It would focus on recruiting healthcare assistants with the attitudes and behaviours which patients have valued so strongly (empathy, non-judgemental, patience). This model would reduce the amount of nursing presence (however nursing oversight in some form would ideally be maintained). The role of social prescriber would be maintained and expanded (to support follow up lifestyle and behaviour change activities), and the use of community champions to help recruit patients would be explored, especially where voluntary sector presence is low.

Age

The service would consider lowering the entry age to 30, but pilot this in high-deprivation areas only, due to limited evidence of benefits for those under 40.

Support for lifestyle changes

There would be improvement to the post-health check support to ensure easy / immediate access to social prescribers, consistent availability of lifestyle programmes, tailored gym/swim sessions, informal peer encouragement, and regular progress reviews (cholesterol, blood sugar).

Digital solutions and data recording

All sites would migrate to the Joy App for better referral monitoring and broader patient access to support options.