Public Health England

Protecting and improving the nation's health

NHS Health Check programme standards: a framework for quality improvement

July 2020

About Public Health England

Public Health England (PHE) exists to protect and improve the nation's health and wellbeing, and reduce health inequalities. We achieve this through world-leading science, knowledge and intelligence, advocacy, partnerships and the delivery of specialist public health services. We are an executive agency of the Department of Health, and a distinct delivery organisation with operational autonomy to advise and support government, local authorities and the NHS in a professionally independent manner.

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Contents

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This is the third release of the National Standards for the NHS Health Checks programme These standards were originally developed in 2014 by the National NHS Health Checks quality assurance working group. The final set of standards were peer reviewed by a number of individuals and organisations that provided feedback and contributed to the final version.

Review working group (2019/20)

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All previous quality assurance working groups are shown in annex 2.

1. Introduction

The NHS Health Check is a national programme, delivered locally in a way that best suits the needs of local populations. Crucially, this gives Local Authorities (LAs) flexibility on who to commission to provide the service and what locations are used. It is important however, that the tests and measurements themselves are delivered to a high quality to help ensure safety, clinical effectiveness and a good patient experience.

The NHS Health Check programme standards were introduced in 2014 and have been developed for local commissioners and providers. They are not mandatory and do not introduce new targets; however, they do set out minimum programme standards necessary to deliver a safe and effective check.

Changes to the standards

The national standards have been reviewed in line with relevant NHS Health Check national guidance that has been published since the 2017 update.

The same ten standards apply, Table 1 highlights where changes have been made to update supporting materials or in light of changes to the programme's best practice guidance.

Table 1: Key changes from the 2017 Programme Standards

No	Standard	Point on the pathway	Update from 2017 standard
1	Identifying the eligible population and offering an NHS Health Check	Invitation and offer	No change
2	Consistent approach to non-responders and those who do not attend their risk assessment appointment	Invitation and offer	Rationale updated
3	Ensuring a complete NHS Health Check for those who accept the offer is undertaken and recorded	The risk assessment	Further information documents updated.
4	Equipment use	The risk assessment	No change
5	Quality control for point of care testing	The risk assessment	No change
6	Ensuring results are communicated effectively and recorded	Communication of results	Description updated to include: • New advice on using QRISK®3 as part of the NHS Health Check risk assessment. • Risk communication messaging should include what is good for your heart

			is good for your brain. Further information documents updated.
7	High quality clinical and behavioural advice given to all	Risk management	Further information documents updated.
8	Additional testing and clinical follow up	Risk management	Description updated to include: • New advice on the clinical management of people with an AUDIT risk score of 16 or more. • New advice on assessing cirrhosis. Further information documents updated.
9	Appropriate follow up for all if CVD risk assessed as 10% and greater	Risk management	Description updated to highlight that people should be advised that what is good for the heart is good for the brain. Further information documents updated.
10	Confidential and timely transfer of patient identifiable data	Throughout the pathway	No change

It is recognised that these standards only focus on a limited number of points on the pathway and therefore are not themselves sufficient to assess the quality of the totality of the programme. However, they set a foundation and are a starting point for increasingly robust assessment of quality. The Systematic Approach for Raising Standards (StARS) should be used for a more in depth review of local NHS Health Check implementation.

These standards should not be used in isolation. They should be considered in conjunction with other national NHS Health Check guidance including: The NHS Health Check Best Practice Guidance; NHS Health Check Health Equity Audit Guidance; NHS Health Check Information Governance and data flow pack and the NHS Health Check Competency Framework and Learner and Assessor workbook.

2. Definition

The overriding aim of these standards is to describe the basic components required to meet a minimum quality of delivery across the whole NHS Health Check pathway (annex 1). This starts from the identification of an individual as eligible, through to their subsequent care and on to a safe exit from the programme; a process which may involve a range of tests leading to diagnosis and treatment.

The Health and Social Care Act (2012) defines quality in terms of three elements:

- clinical effectiveness: care is delivered to the best evidence of what works
- safety: care is delivered to mitigate all avoidable harm and risks to the individual
- patient experience: care is delivered to give as positive an experience as possible for the individual

3. Principles of the standards

The standards are based on the following principles. They:

1. **Have a clear rationale**: they have been identified following an in-depth risk assessment of the pathway, focus on critical points on the pathway and ensure delivery of the aims and objectives of the NHS Health Check programme.

2. **Are sensitive**: they enable an assessment of the quality of the pathway and can pinpoint suspected performance issues where further investigation is required.

3. **Add value to local providers and commissioners**: not only in identifying potential issues so that mitigating actions can be put in place, but also to aid implementation of quality monitoring, management and improvement. They also support the programme in delivering its population health improvement objective in local communities.

4. **Improve consistency:** and help to reduce national variation.

5. **Are supported by stakeholders**: they have been developed from consensus between stakeholders.

6. **Are realistic and attainable for all:** they set out the expectations for providers in delivering the NHS Health Check programme.

7. **Are applicable:** irrespective of the provider or setting in which they are delivered.

8. **Are cost–effective:** in that implementation costs are proportionate to benefit.

9. **Are measurable and specific**: source data is identified and collected with appropriate frequency and timeliness.

10. **Are simple:** they use terminology that is clear.

4. Format of the standards

The standards are set out using the following format:

- name of the standard and the point on the pathway to which it applies
- description (this could be included in service specifications)
- rationale for inclusion
- quality indicator(s) evidence that could be used to demonstrate standard
- further information

The quality indicators outlined are not targets or mandatory indicators for performance management. The aim is that they help to understand the programme, benchmark it and improve it.

Expected levels of achievement for quality indicators are not specified. These standards are intended to provide local areas with assurance that safety requirements are being met and that improving quality is a core component of the programme.

5. Quality Assurance roles and responsibilities - nationally and locally

National Programme	Commissioner	Provider
• Assess the pathway and identify areas of high risk that require failsafe measures • Set out national guidance and standards • Monitor the overall effectiveness and long-term outcomes against the aims of the programme • Provide economic modelling and evidence base.	• Ensure strong local leadership • Commission a high quality and consistent programme, irrespective of the provider. Applying these standards and achieving universal coverage • Work with the Clinical Commissioning Group, Primary Care Networks, Sustainability and Transformation Partnerships, Integrated Care Network and NHS England Improvement to ensure appropriate integration of the NHS Health Check pathway with primary care. As well as wider wellbeing programmes and integrated wellbeing services, so that individuals undergoing the checks receive appropriate follow up • Through contract management, assess all providers against these national standards, facilitate quality improvement and reduce variations between providers • Publish performance and monitoring reports at defined intervals, including an annual report. This could be part of the annual director of public health report • Ensure systems are in place to support identification and invitation of eligible populations, data transfer back to GP practices and anonymised data extract from GP practices • Ensure systems are in place to identify and manage serious incidents, supporting improvements and disseminating learning.	• To achieve a high standard of care review and risk assess local pathways against national guidance and standards • Work with commissioners to develop, implement and maintain appropriate risk reduction measures • Provide agreed performance data and evidence of quality to the commissioner at agreed intervals • Review implementation on a routine basis through audit and ensure appropriate staff training is in place for delivery of the programme. To audit practice, the service should seek the views of patients who attend for an NHS Health Check; asking their experience of, and satisfaction with the NHS Health Check, together with suggestions for service improvement • Ensure appropriate links are made with internal governance arrangements, such as risk registers • Must ensure they meet the Equality Act 2010 requirements, by ensuring reasonable adjustments are made for everyone, but specifically in respect of those who share one of the nine protected characteristics. Community venues need to be fit for purpose and have the equipment and privacy required to conduct an NHS Health Check.

Through working relationships with the national programme and stakeholders:

- Advise on specific issues to ensure consistency of processes, such as protocols for transfer of electronic data, identifications of potential risks and mitigation of these.
- Sharing good practice and assist with the development of the programme.

6. Data quality

Timely and good quality data is crucial for assessing the quality of provision and will aid reporting. For each standard, quality indicators have been suggested. Some areas will collect and monitor this information already. Nationally published data can also be used, including metrics from the PHE and NHS Digital NHS Health Check dashboard. To achieve continuous service improvement, the aim should be to establish systems where reporting of these indicators can take place. Once data reporting is established, benchmarking may be of help, possibly through peer review or sector led improvement or through the use of a Systematic Approach to Raise Standards (StARS).

To assist local areas improve their data flows, PHE have produced guidance for LAs on the three data flows for the NHS Health Check (identification and invite of eligible people, data transfer from provider to the patient's GP, and data extraction from GP practices for monitoring, evaluation and quality assurance).

7. Self-assessment tools

Should LAs like to assure themselves against these standards, a quality standards self-assessment tool has been developed. Assessment and improvement of quality should be embedded into the delivery of the programme at every level.

Building on this, PHE launched the Systematic Approach to Raising Standards (StARS) framework in the Autumn of 2015. The StARS framework draws on advice and standards from existing national guidance. It goes beyond the programme standards, by setting out a systems approach for involving key internal and external partners in ensuring that all aspects of the programme are delivered to a high quality. In doing so it provides:

- an opportunity to review and reflect on the delivery of the NHS Health Check programme, to identify gaps and recognise achievement
- a baseline against which providers can compare future activity and demonstrate progress
- an opportunity to raise awareness of the programme with both internal and external stakeholders
- a legitimate reason to begin a conversation about the NHS Health Check and establish new relationships

Please email the nhshealthchecks.mailbox@phe.gov.uk to find out more about StARS

8. The standards

1. INVITATION AND OFFER: identifying the eligible population and offering an NHS Health Check	
Description	As outlined in the Local Authorities regulations in 2013, each local authority is to ensure systems are in place to consistently and accurately identify the population, establish eligibility and offer NHS Health Checks to all eligible persons in its area within a five-year period. The eligibility criteria are that the invitee must: • be aged 40 to 74 • must not have been offered an NHS Health Check within the previous five years. Specifically, people already diagnosed with the following are excluded from the programme: • coronary heart disease • chronic kidney disease (CKD) (classified as stage 3, 4 or 5 within NICE CG182) • diabetes • hypertension • atrial fibrillation • transient ischaemic attack • familial hypercholesterolaemia • heart failure • peripheral arterial disease • stroke. In addition, individuals: • must not already have been prescribed statins for the purpose of lowering their cholesterol • must not have been assessed through a NHS Health Check, or any other check undertaken through the health service in England and found to have a 20% or higher risk of developing cardiovascular disease over the next ten years. The national letter template should be used to invite eligible people for a check and made available in other formats (Braille, language, easy read, translation services). Where the NHS Health Check is offered opportunistically, written information should still be provided.
Rationale	Legal duties exist for LAs to: a) make arrangements for each eligible person aged 40 to 74 to be offered a NHS Health Check once in every five-year period, and for each person to be recalled every five years if they remain eligible; b) to seek continuous improvement in the percentage of eligible individuals

	taking up their offer (LAs (Public Health Functions and Entry to Premises by Local Healthwatch Representatives) Regulations 2013). Including or signposting to patient information (on nhs.uk or by using the NHS Health Check patient information leaflet) is important to ensure informed choice. Individuals should be provided with clear information so that they understand the NHS Health Check process and can give informed consent. Ensuring a high percentage of those offered a NHS Health Check actually receive one is key to optimising the clinical and cost effectiveness of the programme. The top tips for increasing the uptake of NHS Health Checks, makes eight recommendations based on research undertaken by PHE. Applying these recommendations is especially important for populations with the greatest health needs and will impact on the programmes and local areas abilities to narrow health inequalities. The higher the take up rates for the programme, the greater its reach and potential impact.
Quality indicator(s)	The number of invitations and the number of NHS Health Checks actually completed must be recorded and monitored by LAs as per the NHS Health Check Single Data List Returns Guide. The information that will need to be submitted on a quarterly basis to PHE is: 1a. the number of NHS Health Checks offered in the quarter 1b. the number of NHS Health Checks received in the quarter These two measures are used to inform NHS Health Check indicators published in the public health outcomes framework (indicators C26a, C26b and C26c in PHOF) for England. The acceptable threshold for these indicators are: • 100% of the eligible population invited every five years • aspiring to ≥75% of eligible people having a check.
Evidence to demonstrate achievement	• Text message prompts and reminders are used in conjunction with the national template invitation letter • Patient information is included or signposted as part of a written invitation for a check or discussed as part of an opportunistic invitation • A protocol setting out how a telephone invite should be undertaken • Evidence that NHS Health Check information is available in other formats (Braille, language, easy read, translation services) • Social marketing plans in place, using top tips for maximising the impact of the NHS Health Check programme research • Local NHS Health Check champions in place, e.g. documentation of job description/reports on activity. A champion acts as an advocate for the programme, encouraging uptake and improving service delivery; they are usually a GP, practice nurse or local leader and may undertake this role formally through paid session(s) or informally and unpaid • Feedback from individuals that NHS Health Checks are held at convenient locations and times

	• Service/process in place to offer NHS Health Checks to those not registered with a GP • Criteria for Service Delivery, under section 4.1 is clearly met within the StARS framework
Further Information	Public Health Outcomes Framework, Public Health England. (As of May 2020) Top tips for maximising the impact of the NHS Health Check Programme, Public Health England. March 2020 Top tips for increasing the uptake of NHS Health Checks, Public Health England. August 2016 NHS Health Check Single Data List Returns Guide, Public Health England. October 2013 The Local Authorities (Public Health Functions and Entry to Premises by Local Healthwatch Representatives) Regulations 2013, Legislation.gov.uk. February 2013 Public sector: quick start guide to the public sector Equality Duty, Government Equalities Office. June 2011

2. INVITATION AND OFFER: consistent approach to non-responders and those who do not attend their risk assessment	
Description	An agreed process should be in place for those eligible for the NHS Health Check who either do not respond to an offer/invitation or do not attend (DNA) their appointment. At least two contacts should be made: a second written invitation letter should be sent if there is no response. Local areas may agree on the most appropriate reminder method for their population (e.g. phone, text, letter, email, in person). Evidence shows that telephone invites or a text message prompt before an invite letter and a follow up text message, are more effective than an invitation letter alone. Research suggests that behaviourally informed messaging i.e. use of social norms and ensuring that messages are clear and simple, will bring benefits to increasing the number of eligible individuals that attend their check. Clear marketing and promotional material is required to ensure that the eligible population in each local area are aware of the opportunity and the purpose of it, as well as understanding the benefits of attending. All PHE NHS Health Check branding and marketing resources should be applied within the brand guidelines and in line with the NHS Health Check Best Practice Guidance.

Rationale	Low uptake and variation may exacerbate inequity of access and health outcomes. Evidence suggests that barriers to attendance can include lack of understanding of CVD risk and the purpose of the NHS Health Check. Ensuring a high percentage of those offered an NHS Health Check actually receive one is key to optimising the clinical and cost effectiveness of the programme. This is especially important for populations with the greatest health needs and will impact on the programme and local areas abilities to narrow health inequalities. The implementation of a proportionate universal approach which prioritises higher risk groups and adopts methods more likely to encourage take up among higher risk groups will help to maximise the programme's potential impact.
Quality indicator(s)	2a. Proportion recorded as do not respond. 2b. Proportion recorded as DNA. 2c. Proportion of these individuals recalled in five years, if they remain eligible. (Please note it is for local determination whether areas wish to invite individuals on a more frequent basis).
Evidence to demonstrate achievement	• Locally agreed protocol in place defining standard approach to non-responders and DNAs. Protocol should detail number and method of reminders sent • Number and method of reminder sent should be recorded • NHS Health Check information available in other formats (Braille, language, easy read, translation services, etc) • If an individual opts out this should be recorded on the person's medical record. An auditable process should be in place to recall in five years, if they remain eligible.
Further information	SNOMED codes used for the recording of attendance can be found on several browsers. These can be accessed here: • www.snomedbrowser.com • www. hscic.kahootz.com/connect Top tips for maximising the impact of the NHS Health Check Programme, Public Health England. March 2020 Top tips for increasing the uptake of NHS Health Checks, Public Health England. August 2016 NHS Health Check marketing and branding resources, Public Health England. March 2014

3. THE RISK ASSESSMENT: ensuring a complete NHS Health Check for those who accept the offer is undertaken and recorded	
Description	A complete NHS Health Check must include **all** the elements outlined in the NHS Health Check Best Practice guidance **all taken at the time of the check** unless specified: a. age b. gender c. ethnicity d. smoking status e. family history of coronary heart disease f. blood pressure, systolic (SBP) and diastolic (DBP) g. body mass index (height and weight) h. General practice physical activity questionnaire (GPPAQ) i. Alcohol use score (AUDIT-C **or** FAST can be used as the initial screen, further guidance is in the best practice guidance) j. cholesterol level: total cholesterol and HDL cholesterol (either point of care **or** venous sample if within the last six months) k. cardiovascular risk score calculated by QRISK©3: a score relating to the person's risk of having a cardiovascular event during the ten years following the NHS Health Check, derived using an appropriate risk engine that will predict cardiovascular risk based on the population mix within the local authority's area l. validated diabetes risk assessment score or, if that is not possible, the diabetes filter (BMI and BP); see standard 8 Active consideration should be given locally with regard to both access to, and delivery of, the NHS Health Check for everyone but specifically in respect of those who share one of the nine protected characteristics. In some circumstances, how these individuals access a complete NHS Health Check, as well as how their risk assessment is undertaken and how they are supported to adopt healthier behaviours will require specific consideration and informed action. The nine protected characteristics are: • age • disability • gender reassignment • marriage and civil partnership • pregnancy and maternity • race – this includes ethnic or national origins, colour or nationality • religion or belief – this includes lack of belief • sex • sexual orientation

Rationale	All NHS Health Check providers should be competent and confident to carry out all elements of the risk assessment. PHE and partners have therefore developed a NHS Health Check competency framework and Learner and Assessor workbook to support LAs to be assured of this. Staff delivering NHS Health Checks must demonstrate that, as a minimum, they meet the core competencies, clinical skills competencies and NHS Health Check programme competencies outlined in the framework. The tests, measurements and risk calculations that make up the risk assessment part of the NHS Health Check are stipulated in legislation because of the importance of a uniform, quality offer. An incomplete risk assessment may lead to an inaccurate calculation of cardiovascular disease risk and therefore have clinical implications, and in turn, reputational implications for the programme. Every local NHS Health Check programme must also be in keeping with the Equality Act 2010. Meaning that every individual who receives an NHS Health Check should receive a check of an equal standard. This means a good quality and complete risk assessment irrespective of where they live, their characteristics or the provider. This duty recognises that equality of opportunity cannot be achieved simply by treating everyone the same. To support LAs to ensure this, PHE has published guidance on undertaking a Health Equity Audit (HEA) on the NHS Health Check programme. Additionally, a quick start guide is also available to help public sector organisations to understand the key measures to consider from the public sector equality duty, which came into force in April 2011.
Quality indicator(s)	3a. Proportion of those who receive a complete NHS Health Check with all indicators listed above recorded at the time of delivery.
Evidence to demonstrate achievement	Provider has a record of the following for each NHS Health Check undertaken: • **all** data items listed in the above description box • 'NHS Health Check complete' recorded • name of health professional delivering the NHS Health Check • date of NHS Health Check Evidenced through the use of the national NHS Health Check data dashboard or regular local electronic data extraction and production of reports, read code audit or if not possible, notes audit. Evidence that equity of access and outcomes have been considered through a health equity audit, with recommendations for action to be taken to address any inequity identified. **GP providers:** evidence they are using, either a national GP system supplier template or a locally devised template; as long as the local template collects information for all of the data items listed. **Alternative service providers**: should record information for all the data items listed and transfer the information to the patient's GP in a timely

	manner as outlined in standard 10.
Further Information	NHS Health Check Best practice guidance, Public Health England. October 2019 NHS Health Check primary care data dashboard, NHS Digital. October 2019 Health Equity Audit guidance. Public Health England. December 2016 NHS Health Check Competence Framework, and it's associated resources; Learner workbook and; Assessor workbook. Public Health England. July 2020 Equality Act 2010: Public Sector Equality Duty. A quick start guide for Public sector organisations, Government Equalities Office. June 2011

4. THE RISK ASSESSMENT: equipment	
Description	Ensure all equipment used for NHS Health Check delivery is: fully functional, used regularly, CE marked, validated, maintained and is recalibrated according to the manufacturer's instructions. This includes height and weight measuring devices, blood pressure monitors and point of care testing equipment. Where appropriate, it should also be checked that devices are compliant with the Medicines and Healthcare products Regulatory Agency (MHRA) requirements. Any adverse incidents involving medical equipment should be reported to the manufacturer as well as the MHRA and managed according to providers' governance arrangements. An adverse incident is an event that causes, or has the potential to cause, unexpected or unwanted effects involving the accuracy and/or safety of device users (including patients) or other persons. For example: • a patient, user, carer or professional is injured as a result of a medical device failure or its misuse • a patient's consultation is interrupted or compromised by a medical device failure • medical device failure leads to inappropriate management and treatment e.g. an individual's CVD risk score is incorrectly calculated • a patient's health deteriorates due to medical device failure (MHRA)

Rationale	If equipment is not used correctly, there is a risk that incorrect readings will be given, affecting the risk score and potentially the clinical management of the individual. Incidents should be reported as soon as possible. Some apparently minor incidents may have greater significance when aggregated with other similar reports.
Quality indicator(s)	To develop locally, as appropriate.
Evidence to demonstrate achievement	• Documentation of equipment checks • Audit • Use of equipment and notification of incidents included within provider's governance arrangements
Further information	Medical devices regulation and safety. Medicines and Healthcare products Regulatory Agency (MHRA). Last visited in May 2020 Blood pressure measurement devices, Medicines and Healthcare products Regulatory Agency (MHRA). December 2013

5. THE RISK ASSESSMENT: quality control for point of care testing	
Description	Point of care testing (POCT) or near patient testing (NPT) are defined as medical testing at or near the site of patient care by healthcare specialists, with the goal of achieving accurate results in a short time period at the location of the patient. In the instance of the NHS Health Check this would include blood tests. Where the introduction of POCT is being considered the MHRA advises that: • the local hospital pathology laboratory is involved as it can play a supportive role in providing advice on a range of issues including the purchase of devices, training, interpretation of results, troubleshooting, quality control, and health and safety. They will be far more likely to support you with any challenges encountered if they have been involved from the outset • **a POCT co-ordinator is identified** to manage the creation, implementation and management of a POCT service and governance structure • **quality assurance must be addressed**, implementing quality control (QC) procedures provides assurance that the system is working correctly. A QC record should be in place for each machine • This should include an appropriate **internal quality control (IQC) process** in accordance with the MHRA guidelines on

POCT, Management and use of IVD point of care test (POCT) devices. This should take the form of at least a daily "go/no go" control sample (use of a liquid sample) on days when the instrument is in use. This may require other procedures, e.g. optical check to be performed in addition to the use of a liquid control sample. All record keeping on this process should be accurate and contemporaneous

- each **POCT location is registered** in and participating in an appropriate external quality assessment (EQA) programme through an accredited (CPA or ISO 17043) provider that reports poor performance to the National Quality Assessment Advisory Panel (NQAAP) for Chemical Pathology. This can be checked on the UKAS website: www.ukas.com/
- **potential hazards** associated with the handling and disposal of bodily fluids, sharps and waste reagents outside of a laboratory setting should be considered
- **staff who use POCT devices must be trained.** Only staff whose training and competence has been established and recorded should be permitted to carry out POCT
- **the equipment instructions should always be read** and staff should be particularly aware of situations when the **device** should not be used
- **standard operating procedures (SOPs),** which must include the manufacturer's instructions for use, are developed. You should pay particular attention to any storage and handling requirements of the machine and cassettes
- **which staff review the results should be considered,** staff should be appropriately qualified and cited on the patient's history
- **record keeping** is essential and must include patient results, test strip lot number and operator identity
- **maintaining devices** according to the manufacturer's guidance is essential to ensure that they continue to perform accurately

Where POCT is used, the Care Quality Commission's (CQC) diagnostic and screening procedure confirms that non-ambulatory blood pressure monitoring and blood tests carried out by means of a pin prick test are excluded from the CQC registration requirement. However, provider organisations are legally required to ensure that they are satisfied as to whether CQC registration is required for any other service they provide.

Additionally, ISO standard ISO15197:2013 defines performance standards for self-testing meters in the absence of a standard for other point-of-care testing devices. This should be considered a minimum performance requirement.

Rationale	Inadequate quality assurance of POCT may lead to potentially inaccurate results, affecting clinical management and clinical risk for the provider, as well as being a threat to the integrity of the programme and to clinical engagement.
Quality indicator(s)	Proportion of providers using POCT that can demonstrate: 5a) Healthcare professionals and staff who have been trained (by a competent trainer) to use the equipment 5b) A named POCT coordinator is in place 5c) An appropriate internal quality control (IQC) process is in place in accordance with the MHRA guidelines on POCT 5d) Each POCT location is registered in and participating in an appropriate External Quality Assurance (EQA) programme through an accredited (CPA or ISO 17043) provider that reports poor performance to the National Quality Assessment Advisory Panel (NQAAP) for Chemical Pathology. This can be checked on UKAS website: www.ukas.com/
Evidence to demonstrate achievement	• up-to-date register of trained/competent operators who have evidence of meeting the minimum standards as outlined in the NHS Health Check Competence Framework • name of POCT coordinator • record of results of quality control performed • evidence of registration and compliance in an accredited EQA scheme reporting to NQAAP.
Further information	NHS Health Check Best Practice Guidance, Public Health England. October 2019 NHS Health Check Competence Framework and its associated resources; Learner workbook and; Assessor workbook. Public Health England. July 2020 Pathology quality assurance review, NHS England. January 2014 Management and use of IVD point of care test, Medicines and Healthcare Products Regulatory Agency (MHRA). December 2013 Buyers' guide: Blood glucose systems, NHS Purchasing and Supply Agency. May 2008 A Practical Guide to Point of Care Testing, NHS Improvement. April 2008

6. COMMUNICATION OF RESULTS: ensuring results are communicated effectively and recorded	
Description	All individuals who undergo a NHS Health Check must have their cardiovascular risk score calculated using QRISK©3 and explained in such a way that they can understand it. This communication should be face to face. When communicating CVD risk all individuals should also be made aware that 'what is good for their heart is good for their brain' as risk factors discussed for the prevention of CVD, are also those that will prevent the onset of dementia. Individuals aged 65 – 74 specifically, should also be made aware of the signs and symptoms of dementia. Staff delivering the NHS Health Check should be trained appropriately in communicating, capturing and recording the risk score and results, and understand the variables that the risk calculators use to equate the risk. When communicating an individual's risks, staff should be trained to: • establish a professional relationship where the individual's values and beliefs are identified and incorporated into a client- centred plan to achieve sustainable health improvement • communicate risk clearly, in everyday, jargon-free language so that individuals understand their level of risk • deliver very brief advice, brief advice, or an extended brief intervention, to support individual behaviour change • frame the risk messages in a way that will motivate the individual to consider what changes they can make, to reduce their risk Practical considerations for communicating risk: • Adequate time should be allocated to deliver the assessment, share and discuss the results with the individual. • Individualised written information should be provided that includes their full results*, bespoke advice on the risks identified and self-referral information for behavioural interventions. *This should include and provide an explanation of their: • BMI • cholesterol level (total cholesterol: HDL cholesterol ratio) • blood pressure • alcohol use score (AUDIT C or FAST) • physical activity level (GPPAQ) • diabetes risk • CVD risk score and what this means • referrals onto behavioural or clinical services (if available) In addition, individuals over the age of 65 must be made aware of the signs and symptoms of dementia and signposted to local services where appropriate.

Rationale	Legal duties exist for LAs to make arrangements to ensure that people having their NHS Health Check are told their cardiovascular risk score, made aware of the signs and symptoms of dementia and that other results are communicated to them. NHS Health Checks is a preventative programme which aims to help people stay healthy for longer. To maximise these benefits, efforts should be made to ensure individuals understand their level of risk and their results. Everyone who has a NHS Health Check, regardless of their risk score, should also be supported to understand what their risk means for them and to consider how and what changes might help them to reduce their risk of ill-health. That means that, unless it is deemed clinically unsafe to do so, everyone having a NHS Health Check should be provided with individually tailored advice that will help motivate them and support the necessary changes to reduce their risk. This includes supporting and encouraging individuals to maintain healthy choices where no change is required.
Quality indicator(s)	6a. Proportion of NHS Health Checks undertaken where cardiovascular risk score, BMI, cholesterol level, blood pressure, alcohol use (AUDIT Cor FAST) score, physical activity level (GPPAQ), diabetes risk and among people aged 65-74) dementia signs and symptoms are communicated face to face. 6b. Proportion of NHS Health Checks undertaken where written, tailored information is provided.
Evidence to demonstrate achievement	• in addition to recording the risk assessment indicators as outlined in standard 3; advice to support individual behaviour change should be recorded • examples of written information used • training and education materials on risk communication available for health professionals • patient survey or other patient feedback mechanism that asks whether patients felt they understood what was communicated • number of patient complaints received
Further Information	Free e-learning courses on how to conduct an NHS Health Check and support behaviour change are available. Last accessed May 2020 Top tips for maximising the impact of the NHS Health Check Programme, Public Health England. March 2020 NHS Health Check Best Practice Guidance, October 2019 NHS Health Check Invitation and results card, Public Health England. July 2017 Cardiovascular disease: risk assessment and reduction, including lipid modification, NICE Clinical guideline CG181. September 2016

	NHS Health Check Competence Framework and its associated resources; Learner workbook and; Assessor workbook. Public Health England. July 2020 Behaviour change: individual approaches. NICE guideline PH49. January 2014

7. RISK MANAGEMENT: high quality and timely advice given to all	
Description	Provision of and timely access to high quality and appropriate risk-management interventions should be in place in line with the NHS Health Check best practice guidance. This includes providing evidence-based and accessible healthy lifestyle services including: • stop-smoking services • physical activity interventions • weight management interventions • alcohol-use interventions • diabetes prevention interventions (Healthier You: NHS diabetes prevention programme). Recent research into maximising behaviour change in follow up from an NHS Health Check has found that all action needs to be **tailored, achievable and social**.
Rationale	NHS Health Checks is a preventative programme which aims to help people stay healthy for longer. To maximise these benefits, all individuals who have a NHS Health Check, regardless of their risk score, should be given advice, where clinically appropriate, to help them manage and reduce their risk. That means that, unless it is deemed clinically unsafe to do so, everyone having the check should be provided with individually tailored advice that will help motivate them and support any necessary behaviour changes to help them to manage their own risk. This includes supporting and encouraging individuals to maintain healthy behaviours where no change is required. It is pivotal that the actions taken at a certain threshold are the same and in line with national guidelines, including those issued by the National Institute for Health and Care Excellence (NICE), so that people receive the necessary and appropriate care. This approach echoes the competencies set out in Making Every Contact Count (MECC). MECC enables the opportunistic delivery of consistent and concise healthy lifestyle information to individuals at scale.

Quality indicator(s)	7a. Proportion of NHS Health Checks undertaken where a record exists that brief advice for smoking, physical activity, weight management and alcohol is provided. 7b. Proportion of NHS Health Checks undertaken where referral to local services to help reduce risk, (e.g. national diabetes prevention programme, stop smoking service) is made, where appropriate. 7c. Proportion of individuals where a record of outcome following intervention is available (e.g. four-week smoking quit/ 5% reduction in body weight)
Evidence to demonstrate achievement	• evidence-based and accessible intervention services in place to support behaviour change on smoking, alcohol, physical activity and weight • agreed patient pathway in place • documentation of: - brief advice, i.e. record of specific advice given - offer of referral made - referred to local provision - referral declined - referral to intervention accepted - outcome • example of written information used • clinical codes or notes audit against indicators outlined above • training and education materials available for health professionals • patient survey or other patient feedback mechanism that asks about behaviour change • number of patient complaints received
Further information	Top tips for maximising the impact of the NHS Health Check Programme, Public Health England. March 2020 <u>Stop smoking</u> • Very Brief Advice on Smoking, National Centre for Smoking Cessation and Training. Online training module. Last accessed May 2020 • Stop smoking interventions and services, NICE guideline NG92. March 2018 • Local Stop Smoking Services: Service and delivery guidance, National Centre for Smoking Cessation and Training. September 2014 • E-cigarettes: an evidence update, PHE. August 2015 • E -cigarette and heated tobacco products: evidence review, PHE. February 2018

- E-cigarette: A briefing for stop smoking services, National Centre for Smoking Cessation and Training. January 2016

Weight management

- Weight management guidance for commissioners and providers, Public Health England. March 2020
- Adult obesity: applying All Our Health, Public Health England. June 2019
- Non-alcoholic fatty liver disease (NAFLD): assessment and management, NICE guidance NG49. July 2016
- Cardiovascular disease: risk assessment and reduction, including lipid modification, NICE Clinical guideline CG181. September 2016
- Preventing excess weight gain, NICE guidance NG7. September 2016
- Obesity prevention, Clinical guideline CG43. March 2015
- Obesity: identification, assessment and management, Clinical guideline CG189. November 2014
- Weight management: lifestyle services for overweight or obese adults, NICE Public health guideline PH53. May 2014
- BMI: preventing ill health and premature death in black, Asian and other minority ethnic groups, NICE Public health guideline PH46. July 2013.

Physical Activity

- Moving medicine is a set of resources to support medical professionals with promoting physical activity to their patients. Faculty of Sport and Exercise Medicine, Public Health England and Sport England. (As of May 2018)
- UK Chief Medical Officers' Physical activity guidelines, UK Chief Medical Officers'. September 2019
- Physical activity: encouraging activity in the community, NICE Quality Standard QS183. June 2019
- Physical activity: for NHS staff, patients and carers, NICE Quality Standard QS84. March 2015
- Physical activity: exercise referral schemes, NICE Public health guideline PH54. September 2014
- Physical activity: brief advice for adults in primary care, NICE Public health guideline PH44. May 2013
- Physical activity: walking and cycling, NICE public health guidance PH41. November 2012
- Let's get moving. A physical activity care pathway commissioning guidance, Department of Health. March 2012

Alcohol

- E-learning programmes for alcohol identification and brief advice. E-learning for healthcare. (As of May 2020)

	• E-learning programme for alcohol and tobacco. E-learning for healthcare. (As of May 2020) • Communicating the UK Chief Medical Officers' low-risk drinking guidelines 2017. Drink aware. (As of May 2020) • Alcohol use screening tests (including AUDIT and FAST) and Brief Advice Leaflet. Public Health England. June 2017 • UK Chief Medical Officers' Low Risk Drinking Guidelines. Department of Health and Social Care. August 2016 • Cirrhosis in over 16s: assessment and management. NICE guideline NG50, July 2016 • Alcohol Guidelines Review – Report from the Guidelines development group to the UK Chief Medical Officers, Department of Health. January 2016 • Alcohol-use disorders – preventing harmful drinking, NICE Public health guideline PH24. June 2010 <u>Diabetes prevention</u> • NHS National Diabetes Prevention Programme, NHS England. (As of May 2020) • Type 2 diabetes: prevention of people at high risk NICE, Public health guideline PH38. September 2017 <u>Additional information</u> • NHS Health Check Competence Framework and associated resources; Learner workbook and; Assessor workbook, Public Health England. July 2020 • NHS Health Check primary care data dashboard. NHS Digital, October 2019

8. RISK MANAGEMENT: additional testing and clinical follow up	
Description	Individuals should not exit the programme until all abnormal parameters have been followed up and a diagnosis has either been made or ruled out. Timely access to further diagnostic testing should take place as outlined in the NHS Health Check best practice guidance at the following thresholds: 1. Assessment for **diabetes** risk It is recommended that a validated diabetes risk tool should be used, and specific thresholds applied to identify people at high risk of diabetes and so eligible for a blood glucose test. Individuals should be considered as being at high risk of diabetes using the following thresholds for the corresponding validated risk assessment tools: • QDiabetes score is greater than 5.6 • Cambridge diabetes risk score is greater than 0.2

- Leicester practice risk score is greater than 4.8
- Leicester risk assessment score is greater than or equal to 16.

Where it is not possible to introduce a validated risk tool then the diabetes filter can still be used. In this case, people at high risk of diabetes, and so eligible for a blood glucose test, include:

- an individual from black, Asian and other ethnic minority groups with BMI greater than or equal to 27.5
  or
- an individual with BMI greater than or equal to 30
  or
- those with blood pressure at or above 140/90mmHg, or where the SBP or DBP exceeds 140mmHG or 90mmHg, respectively.

If the individual is identified as being at risk of developing type 2 diabetes they should go on to receive either a fasting plasma glucose or HbA1c test. If an individual's fasting plasma glucose (5.5 – 6.9 mmol/l) or HbA1c (42 – 47 mmol/mol or 6% – 6.4%) is above the threshold for non-diabetic hyperglycaemia but below the threshold for diabetes, there is very robust evidence that intensive behavioural interventions in these individuals substantially reduces the risk of developing diabetes.

The Healthier You: NHS Diabetes Prevention Programme offers an intensive intervention that supports people to lose weight, to increase physical activity and to eat more healthily. This long-term intervention allows individuals to set and achieve goals and make positive changes. Where the programme is already available individuals should be referred to it in line with the local care pathway. Individuals diagnosed with type 2 diabetes should be treated through appropriate care pathways and measures, as recommended by NICE.

2. Assessment for **hypertension** by GP practice team when indicated by:
   a. BP >140/90 mmHg where either the SBP or DBP exceeds 140mmHg or 90mmHg respectively

Individuals diagnosed with hypertension, after appropriate further assessment should be added to the hypertension register and treated through existing care pathways in line with NICE guidance.

3. Assessment for **chronic kidney disease** by GP practice team when indicated by:
   a. BP >140/90 mmHg where either the SBP or DBP exceeds 140mmHg or 90mmHg respectively.

All who meet these criteria to receive serum creatinine test to estimate glomerular filtration rate (eGFR).

4. Assessment for **familial hypercholesterolemia** by GP practice team should be considered if:
   a. Total cholesterol >7.5 mmol/L

	b. There is a personal or family history of premature coronary heart disease (if a parent of the individual has encountered a CVD event before 60 years of age) 5. **Alcohol risk assessment**, use of full AUDIT when indicated by: a. AUDIT C Score ≥5 b. Or FAST ≥3. If the individual meets or exceeds the AUDIT C or FAST thresholds above, the remaining AUDIT questions should be administered to obtain a full AUDIT score. If the individual meets or exceeds a threshold of 8 on AUDIT, brief advice is given. For individuals scoring 20 or more on AUDIT a referral to alcohol services should be considered. If individuals meet or exceed the alcohol AUDIT score of 16 or above, they should be referred for a transient elastography; a non-invasive test to assess whether the liver has been damaged by their alcohol consumption (assessment for cirrhosis). For all, systems and process should be in place to ensure that follow up test(s) are undertaken and results received.
Rationale	Only through the early detection and management of risk factors can the NHS Health Check maximise its public health impact and reduce premature mortality. It is key that the actions taken at these thresholds are the same to ensure a systematic and uniform offer across England. Systems should be in place to ensure follow up tests are undertaken, and results received in order to provide assurance that appropriate follow up and management is undertaken. Disease management should be undertaken in line with NICE guidance, including provision of appropriate behaviour change intervention.
Quality indicator(s)	Where thresholds met: 8a. Proportion of individuals with investigations undertaken 8b. Proportion of individuals with outcome recorded.
Evidence to demonstrate achievement	• Record of individuals identified with: ○ prediabetes/diabetes ○ hypertension ○ CKD ○ familial hypercholesterolemia ○ Full AUDIT score ○ Cirrhosis ○ BMI ≥ 30, or 27.5 if individuals from the Indian, Pakistani, Bangladeshi, other Asian and Chinese ethnicity categories • Results communicated to patient and recorded using appropriate read code • GP practice has a protocol in place for additional testing and clinical follow up, identifying review timeframes for

	further investigations • Regular electronic data extraction and reporting • Read code audit or if not possible, notes audit.
Further information	NHS Health Check Best Practice Guidance, October 2019 Type 2 diabetes in adults: management, NICE guideline NG28. August 2019 Hypertension in adults: diagnosis and management, NICE guideline NG136. August 2019 Familial hypercholesterolaemia: identification and management, NICE Clinical guideline CG71. October 2019 Preventing type 2 diabetes: risk identification and interventions for individuals at high risk, NICE Public Health Guidance PH38. September 2017 Cirrhosis in over 16s: assessment and management, NICE guideline NG50. July 2016 Chronic kidney disease: national clinical guideline for early identification and management in adults in primary and secondary care, NICE clinical guideline CG182. January 2015 Familial Hypercholesterolaemia, NICE Quality standard QS41. August 2013 Alcohol-use disorders – preventing harmful drinking, NICE Public health guideline PH24. June 2010

9. RISK MANAGEMENT: appropriate follow up for those with high cardiovascular risk	
Description	All individuals with ≥10% CVD risk should be managed according to NICE guidance, including provision of behaviour change advice and intervention, assessment for treatment with statins and an annual review. This may be through maintaining a risk register. Individuals that have a CVD risk score ≥10% (at risk) • people with a 10% or greater, ten-year risk of developing CVD should be offered appropriate behaviour change support in relation to increasing physical activity, smoking cessation, safe alcohol consumption and healthy diet • people should be advised that what is good for the heart is good for the brain and so making behavioural changes to reduce their CVD risk will also reduce their risk of dementia • where behavioural changes have been ineffective or are

	inappropriate, people with a 10% or greater, ten-year risk of developing CVD should be offered statin therapy for the primary prevention of CVD • the decision whether to start statin therapy should be made after an informed discussion between the health professional and the individual about the risks and benefits of statin treatment, taking into account additional factors such as potential benefits from behavioural modifications, informed patient preference, comorbidities, polypharmacy, general frailty and life expectancy • people with a ten-year CVD risk above 10% and diabetes, hypertension or chronic kidney disease, should be managed according to NICE guidance (including provision of lifestyle intervention), recorded on the relevant disease register and will then exit the programme • Where the NHS Health Check is delivered by an alternative service provider, a timely referral back to the GP practice should be made to ensure that appropriate follow up is undertaken (see standard 10). **Key point:** individuals that are either prescribed a statin or have a CVD risk score ≥20% should exit the programme on to a risk register.
Rationale	With appropriate management and follow up, the rate of progression of CVD and risk factors can be reduced.
Quality indicator(s)	9a. Proportion of those identified with a CVD risk of 10% and greater managed according to NICE guidelines.
Evidence to demonstrate achievement	• GP practice has a protocol/clinical pathway in place to outline the process for follow up, which is updated annually • documentation of individuals' transfer to the CVD risk register recorded as a result of the NHS Health Check • record of statin offered, accepted and declined • clinical system audit, or if not possible, notes audit.
Further information	NHS Health Check Best Practice Guidance, October 2019 Cardiovascular disease: risk assessment and reduction, including lipid modification, NICE Clinical guideline CG181. September 2016 Cardiovascular disease prevention optimal value pathway. NHS RightCare Commissioning for value products. September 2016

10. THROUGHOUT THE PATHWAY: confidential and timely transfer of patient identifiable data

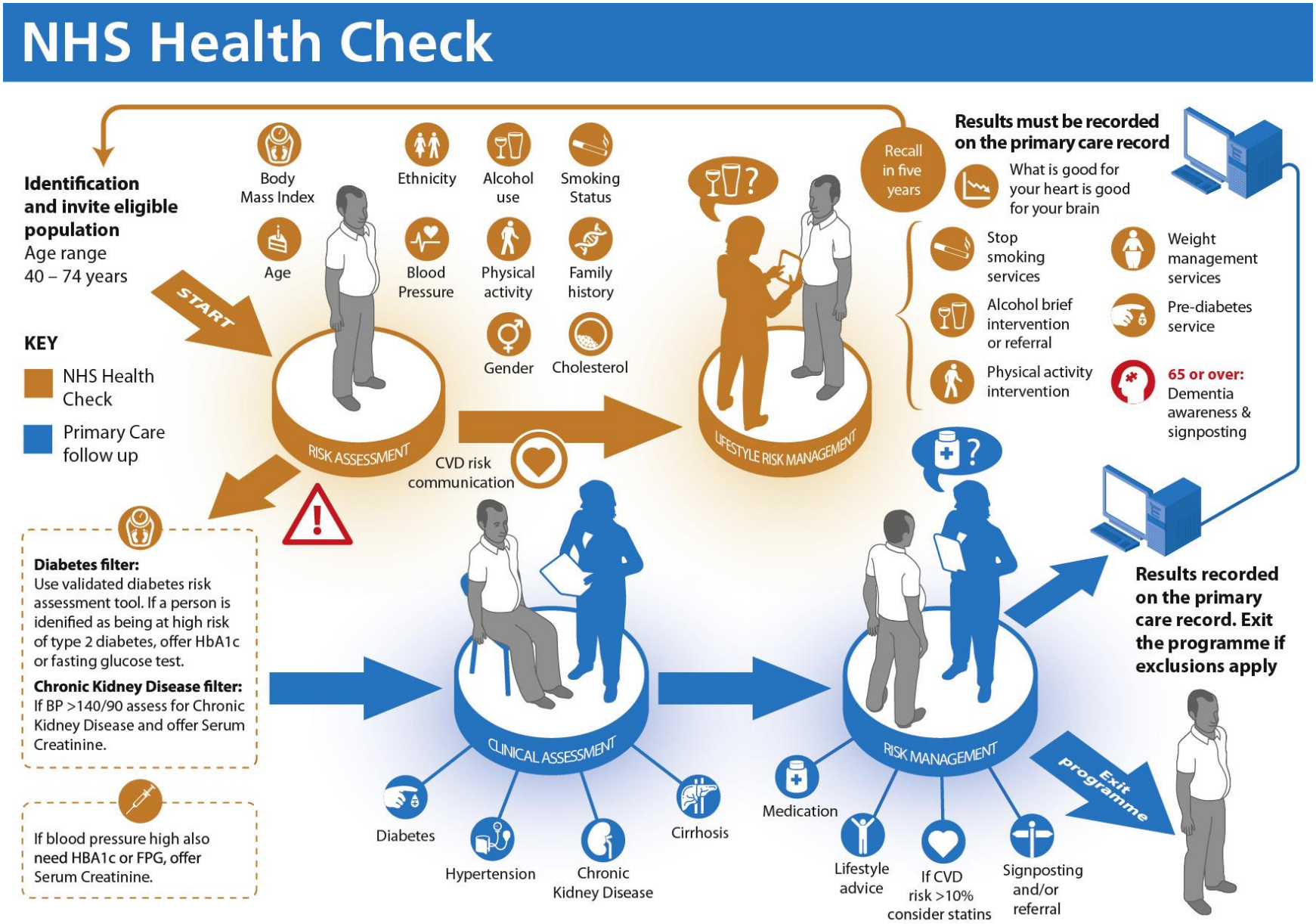
Description	Where the risk assessment is conducted outside the individual's GP practice, LAs have a legal duty to arrange for the provider to send the following information to the person's GP: • age • gender • smoking status • family history of coronary heart disease • ethnicity • body mass index (BMI) • cholesterol level • blood pressure • physical activity level - inactive, moderately inactive, moderately active or active • cardiovascular risk score • alcohol use disorders identification test (AUDIT) score (AUDIT C or FAST). A protocol also needs to be in place for timely referral of patients where abnormal parameters are identified. For all individuals who require additional testing and clinical follow up, GP practices should follow Standards 8 and 9.
Rationale	Legal duties exist for LAs to make arrangements for specific information and data to be recorded and where the risk assessment is conducted outside the individual's GP practice, for that information to be forwarded to the individual's GP. There are a number of potential issues surrounding data flows for example: • if NHS Health Checks are undertaken in a community setting, there may be a delay in the GP practice receiving the information and results • ensuring confidential transfer of patient-identifiable data • errors surrounding accuracy of data inputted • limited QRISK©3. These process failures could lead to a breach in confidentiality and/or inappropriate action undertaken due to inaccurate or delayed information being received. If information is not recorded it is unknown whether appropriate intervention and follow up has been undertaken.
Quality indicator(s)	10a. Proportion of non-GP service providers that send data to the relevant GP practice in a timely way (the suggested expectation is within two working days). 10b. Proportion of GP practices that then record these results on their clinical system results in a timely way (the suggested expectation is within two working days).

Evidence to demonstrate achievement	• electronic data transfer in place between alternative service provider(s) and GP practices • read code or notes audit • agreed protocol for data transfer between alternative service provider and GP practices • protocol in place for timely referral of patients where abnormal parameters identified by the alternative service provider, including outlining action when urgent referral required.
Further information	NHS Health Check primary care data dashboard. NHS Digital, October 2019

9. Next steps

It is recognised that these standards only focus on a limited number of points on the pathway, and so provide assurance that a minimum level of quality is being achieved. They set an important foundation and are a starting point for increasingly robust assessment of quality, such as the StARS framework.

Annex 1. NHS Health Check pathway



Annex 2. How the standards were developed

The NHS Health Check pathway for an individual is complex, involving several providers, data flows between organisations and systems, and a variety of tests, assessments and investigations. This complexity and the interface between the components creates risks that might be clinical, financial or affect the public perception of the programme or the organisational reputation of those delivering or commissioning the service.

To inform this work, extensive stakeholder engagement was undertaken. Stakeholders felt that there were significant risks during the identification of the eligible population, the offer of a health check, the risk assessment, communication of results, subsequent management, follow-up and appropriate recall.

However, most risks and errors in this pathway can be predicted. They often arise from systems failure occurring along the pathway, as opposed to individual error. A failsafe mechanism is a back-up, in addition to usual care, which ensures if something goes wrong in the pathway, processes are in place to identify the error and correct it before any harm occurs.

An in-depth risk assessment of the whole pathway was undertaken by the quality assurance working group to identify the known risks in the pathway. The ten standards outlined here reflect these critical points on the pathway, and describe the processes and monitoring required to mitigate risk, including the implementation of failsafe mechanisms where appropriate.

The pathway is defined here as starting with the identification of the eligible population through to their exit from the programme either by turning 75 years old, dying, moving outside of England, or receiving a diagnosis that means they are no longer eligible for the programme.

Quality assurance working group (2014)

- Medicines and Healthcare products Regulatory Agency (MHRA)
- National Institute for Health and Care Excellence
- National Screening Committee and Programme
- Network of Public Health Observatories

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Louise Cleaver	NHS Health Check support manager, PHE
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Veena De Souza	Public Health Consultant, NHS Health Check lead, Buckinghamshire County Council
Victoria Donnelly	NHS Health Check data quality project manager, PHE
Lucy Holdstock	Screening QA research and development lead, UK National Screening Committee/NHS Screening Programmes, PHE
David James	Deputy chair of the joint working group for quality assessment in pathology, Royal College of Pathology
Eric Keogh	NHS Health Check support manager, PHE
Nada Lemic	Director Public Health, Bromley, London. Association of Directors of Public Health (ADPH) lead for NHS Health Checks
Sue Longden	Public Health Consultant, Manchester City Council

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Sarah Stevens	Quality Assuarance lead, consultant in public health, NHS Health Check programme, PHE
Jamie Waterall	National lead, NHS Health Check programme, PHE (Chair)

Review working group (2017)

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Helen Daly	Support Manager, CVD Prevention team, PHE
Catherine Lagord	Analyst, CVD Prevention team PHE
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Hayley Martin	Health Improvement Principal, Public Health, East Sussex
Dr Matt Kearney	National Clinical Director for Cardiovascular Disease Prevention team, NHS England and National Clinical Advisor, PHE