Service Provider information		
	i. Provider name (use drop downbox in Column I, Row 4):	K1234 - The Surgery
	ii. Oxfordshire Primary Care Network assigned to:	
	iii. Date of Completion (DD/MM/YYYY):	
	iv. Who is completing the QA Tool on behalf of the Provider?	

NHS Health Check Pathway Description		Questions	Response Yes / No	Any Comments
INVITATION AND OFFER	Programme Standard 1: Identify the eligible population and offering an NHS Health Check	1.1. Is a process / plan in place to invite your entire eligible cohort over a 5 year period?		
		1.2. Is the NHS Health Check search within Emis Enterprise software used to identify the eligible patients?		
		1.2a Is there a process/ plan in place to invite missing eligible patients that includes the Community Service Provider as an option for the Service User?		
		1.3. Have staff doing the Invitation and Offer, using the EMIS Search and Report, completed any training (peer-to-peer or face-to-face) in the last two years? (Not scored)		
		1.3b. Are Staff doing the Invitation and Offer, taking a Risk Stratification approach so that those at highest risk are invited first? (Not Scored)		
		1.4. For first invites that are sent by post or email, do you use the suggested invite letter (created by OHID)? (Not scored)		
		1.5. If answered 'Yes' to 1.4, which letter type do you use? (Open, Closed or Standard) (Not scored)		
		1.6. Does the first invite include an offer of an NHS Health Check leaflet, including a link to a web-based version of the leaflet if done so via email or SMS/text, outlining the risks and benefits of the Programme?		
		1.7. Does the invite also include a Dementia NHS Health Check leaflet, including a link to a web-based version of the leaflet if done so via email or SMS/text? (Not scored)		
		1.8. Is the first invitation recorded on the patients clinical record as an offer of a NHS Health Check using the relevant SNOMED code(s)?		
		1.9. Is the NHS Health Check information made available in other formats (i.e. Braille, other languages, easy read) on request or do you know where to source these if requested?		
		1.10. Do you market the NHS Health Checks Programme to your eligible population? (i.e. Social Media, posters in waiting rooms, GP Practice websites, newsletters, digital screens etc.)		
		1.11. Are NHS Health Check appointments available at different times of the day (am/pm) and week?		
		1.12. Do you have an allocated cardiovascular disease (CVD) prevention/NHS Health Check champion for the GP Practice (I.e. someone who oversees the performance of the Programme and acts as an advocate for the Programme encouraging uptake and improving service delivery)?		
		1.13. If answered 'Yes' to 1.12, who is your champion? (Not scored)		
	Programme Standard 2: Consistent approach to non-responders and those who do not attend their risk assessment	2.1. Are at least two further attempts made to follow-up patients who do not respond to the initial/first invitation (either by letter, email, verbal, telephone, or SMS/text)?		
		2.2. Is there a process in place to record on the patient record (using SNOMED codes) those who opt out (decline), do not respond or do not attend?		
		2.3. If a patient opts out, is a process in place to recall them in five years if they remain eligible?		
		2.4. Once a patient books their NHS Health Check, are they sent a reminder about the date and time of check (i.e. SMS/text) to maximise attendance rates?		
		2.5. Are records of number and types of invites sent kept and monitored by the GP Practice? (i.e. through EMIS web searches)		
THE RISK ASSESSMENT	Programme Standard 3: Ensuring a complete NHS Health Check for those who accept the offer is undertaken and recorded	3.1. Are staff allocated a minimum of 20 minutes to complete a NHS Health Check?		
		3.2. Are patients made aware that they are receiving a NHS Health Check before the consultation begins? (i.e. is an overview of its aim discussed, focus on cardiovascular disease (CVD) prevention)		
		3.3. Have staff delivering the Risk Assessment completed any specifc NHS Health Check training (online, peer-to-peer or face-to-face) in last two years? (Not scored)		
		3.4. Are the following elements recorded / measured for all NHS Health Check patients on your clinical system during or after the Risk Assessment?		
		i. Age (recorded in years)		
		ii. Gender (as reported by the patient)		
		iii. Ethnicity (recorded using the Office for National Statistics 2001 census codes)		
		iv. Smoking Status (defined as smoking tobacco, vaping status is excluded from this definition)		
		v. Family history of coronary heart disease - first degree and aged under 60 yrs ('first degree' means mother, father, brother or sister)		
		vi. Physical Activity score (categorised using the General Practice Physical Activity Questionnaire (GPPAQ))		
		vii (a). Initial Alcohol Risk score (categorised using the alcohol use disorder identification test-consumption score (AUDIT-C))		
		vii (b). Full Alcohol Risk Score (If the patient achieves a score of five or more on AUDIT-C categorised using the full alcohol use disorder identification test (Full AUDIT))		
		vi. Body Mass Index (calculated from the weight of the individual, divided by their height squared)		
		vii. Blood Pressure (both systolic (SBP) and diastolic (DBP))		
		viii. Pulse Rhythm Check prior to taking blood pressure (used to detect pulse irregularities)		
		ix. Cholesterol test (measured as the ratio of total serum cholesterol to high density lipoprotein cholesterol) Note that a random non-fasting sample should be used		
		x (a). Raising Awareness of Risk Factors for Dementia (Dementia awareness raising information offered to all patients (within Results Booklets and / or patient leaflet))		
		x (b). Raising Awareness of Risk Factors for Dementia (people aged 65-74 should be made aware of the signs and symptoms of dementia and be signposted to memory services if this is appropriate (within Results Booklets and / or patient leaflet))		
		3.5. Do NHS Health Check patients at higher risk of diabetes (categorised as a BMI ≥ 27.5 if Black, Asian and other ethnic groups or a BMI ≥ 30 rest of the population and/or blood pressure ≥140/90 mmHg or where the SBP or DBP exceeds 140mmHg or 90mmHG respectively) receive an offer of a diabetes risk assessment (via a HbA1c or FPG blood test) by the GP Practice team?		
		3.6. Do NHS Health Check patients with blood pressure ≥140/90 mmHg, or where the SBP or DBP exceeds 140mmHg or 90mmHG respectively, receive an offer for an assessment for hypertension by the GP Practice?		
		3.7. Do NHS Health Check patients with a blood pressure ≥140/90 mmHg, or where the SBP or DBP exceeds 140mmHg or 90mmHG respectively, receive an offer for an assessment for chronic kidney disease (CKD) via a serum creatinine blood test to calculate estimated glomerular filration rate (eGFR)?		
		3.8. Do NHS Health Check patients with an irregular pulse receive an offer for further assessment to determine if atrial fibrillation is present?		
		3.9. Do NHS Health Check patients with an Audit C score ≥16 receive an offer for an assessment for liver fibrosis/cirrhosis via an serum fibrosis markers (ELF) blood test or Fibroscan?		
		3.10. Once the Risk Assessment is completed, is the QRisk calculator used to calculate the patients estimated 10 year risk of developing cardiovascular disease (CVD)? (This may be calculated retrospectively depending on when the blood tests for cholesterol was taken)		
		3.11. When the QRisk score is calculated (this may be calculated retrospectively depending on when the blood tests for cholesterol was taken), is the 'NHS Health Check Completed' SNOMED code inputted into the patients clinical record?		
		3.12. Do you use a template on your clinical system (i.e. EMIS, Systm1) that incorporates all the Risk Assessment information required that is outlined in Question 3.4?		
	Programme Standard 4: Equipment use	4.1. Does the GP Practice have an infection control policy in place?		
		4.2 Are all height and weight measurement devices validated, maintained and recalibrated according to the manufacturing instructions?		
		4.3. Are all blood pressure monitors validated, maintained and recalibrated according to the manufacturing instructions?		
		4.4. Are staff correctly trained on how to use the equipment detailed in Question 4.2?		
		4.5. Are audit processes in place? (Documentation of equipment checks)		
		4.6. Are governance procedures in place to report any adverse incidents involving medical equipment used during a Risk Assessment?		
	Programme Standard 5: Quality control for point of care testing	Number and % of Staff who have been trained (by a competent trainer) to use the POCT equipment.		
		A named POCT coordinator is in place.		
		An appropriate internal quality control (IQC) process is in place in accordance with the MHRA guidelines on POCT		
		Number of adverse incidents involving medical equipment and actions.		

COMMUNICATION OF RISK	Programme Standard 6: Ensuring results are communicated effectively and recorded	**6.1. Are patients offered the NHS Health Check Results Booklet to review their results from the Risk Assessment?**		
		6.2. Are the following outcomes communicated with the patient face-to-face:		
		i. Cardiovascular disease (CVD) risk score and what this means		
		ii. Blood Pressure (both systolic (SBP) and diastolic (DBP))		
		ii. Body Mass Index (calculated from the weight of the individual, divided by their height squared)		
		iv. Cholesterol (displayed as either a ratio of Total:HDL or Total)		
		v. Initial Alcohol Risk score (categorised using the alcohol use disorder identification test-consumption score (AUDIT-C)) or Full Alcohol Risk Score (If the patient achieves a score of five or more on AUDIT-C categorised using the full alcohol use disorder identification test (Full AUDIT))		
		vi. Physical Activity score (categorised using the General Practice Physical Activity Questionnaire (GPPAQ))		
		vii. Diabetes Risk (if applicable)		
		6.3. Do staff Communicating Risk have access to educational materials? i.e. OHID documents such as the current Best Practice Guidelines		
		6.4. Are patients provided with a printed/written summary of their results that, as a minimum, includes the risk factors outlined in Question 6.2? (This would include use of the Results Booklet)		
		6.5. Is a mechanism in place for patients to feedback if they understood what was communicated about their cardiovascular disease (CVD) risk score?		
RISK MANAFGMENT	Programme Standard 7: High quality and timely lifestyle advice given to all	**7.1. Are patients provided with evidence-based lifestyle advice in-line with NICE Guideline PH49 on individual behaviour change that recommends practitioners deliver very brief advice, brief advice, or an extended brief intervention to support individual behaviour change?**		
		7.2. Are agreed processes in place for patients to be given brief lifestyle advice on:		
		i. Stopping smoking if status is a current smoker (i.e. the best way to stop is with a combination of pharmacotherapy and support)		
		ii. Reducing BMI using the key principles of the Eatwell Guide if BMI 25-29.9 or BMI 23-27.5 if from black, Asian and other ethnic groups origin		
		iv. Reduce alcohol use (including understanding alcohol units, understanding risk levels, informing of level of risk, benefits of cutting down tips for cutting down) if Full Audit Score 8-19		
		v. Increasing physical activity levels if patients are not achieving the recommended levels as defined by the UK Chief Medical Officers' Guidelines		
		7.3. Are agreed pathways in place for patients to be referred (if eligible) to the following lifestyle interventions:		
		i. Local Stop Smoking Services (i.e. Stopforlife Oxon) if status is a current smoker		
		ii. Weight Management Interventions (i.e. in-house support, Achieve Oxfordshire, Weight Watchers, Slimming World) if BMI ≥30 or ≥BMI 27.5 if from black, Asian and other ethnic groups origin		
		iii. Healthier You: NHS Diabetes Prevention Programme (NDPP) if the patients 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		
		iv. Alcohol Use Interventions (i.e. Oxfordshire's Road to Recovery) if Full Audit Score ≥20		
		v. Physical Activity Interventions (i.e. Active Oxfordshire, Go Active or Generation Games, other) if patient is not achieving recommended physical activity levels		
		7.4. If answered 'Yes' to any of Question 7.3, are the appropriate SNOMED codes used? (i.e. when brief advice is given, signposted and/or a referral is made or declined)		
		7.5. If answered 'Yes' to any of Question 7.3, is written information on the intervention(s) provided? (i.e. a leaflet on the Local Stop Smoking Services)		
		7.6. Have staff communicating the cardiovascular disease (CVD) risk completed any specifc behaviour change or motivational interviewing training (online or face-to-face) in the last 2 years?		
		7.7. Is a system in place that records the number of patient feedback received to understand whether patients are happy with the service provided, or where improvements are needed? (i.e. NHS Friends and Family Test)		
	Programme Standard 8: Additional testing and clinical follow-up	**8.1. Are clear protocols in place for any additional testing / clinical follow-up following a patients Risk Assessment if the patients:**		
		i. Fasting blood glucose (≥7mmol/l) or HbA1c (≥48 mmol/mol) is above the threshold for diabetes and has no symptoms, do they have a repeat blood test and further assessment (non-urgent)?		
		ii. Fasting blood glucose (≥7mmol/l) or HbA1c (≥48 mmol/mol) is above the threshold for diabetes and has symptoms, do they have a repeat blood test and further assessment (urgent)?		
		iii. Blood pressure is ≥140/90mmHg, or where the SBP or DBP ≥ 140mmHg or 90mmHg, is an assessment for hypertension completed?		
		iv. Identified with an irregular pulse, is an assessment for atrial fibrillation, that includes an ECG to confirm the rhythm, completed?		
		v. Cholesterol is identified as being raised (ratio of total serum cholesterol to high density lipoprotein cholesterol greater than 4) but the patients 10-year cardiovascular disease (CVD) risk is <10%, is the patient offered healthy lifestyle advice?		
		vi. Cholesterol is identified as being raised (ratio of total serum cholesterol to high density lipoprotein cholesterol greater than 4), the 10-year cardiovascular disease (CVD) risk is ≥10% and where lifestyle modification has been ineffective or is inappropriate, is Atorvastatin 20mg offered?		
		vii. Total cholesterol level is found to be above 7.5mmol/l, do they receive an offer of further assessment for consideration of Familial Hypercholesterolemia (FH) and for cascade testing of family members if a FH diagnosis is confirmed?		
		viii. Serum creatinine test results show the estimated glomerular filration rate (eGFR) is <60ml/min/1.73m2, is further assessment for CKD completed?		
		ix. Full Audit score is ≥16, is this flagged with the GP so that an assessment for cirrhosis can be undertaken?		
		8.2. Where the NHS Health Check, and the additional testing / clinical follow-up, has led to a diagnosis, is this outcome recorded (using SNOMED codes) in the patient records? Is the patient added to the appropriate risk registered (if appropriate)? Are they treated in line with NICE Guidelines (if appropriate)? for the following:		
		i. Hypertension		
		ii. Non-diabetic Hyperglycaemia (pre-diabetes) / Diabetes		
		iii. Chronic Kidney Disease (CKD)		
		iv. Atrial Fibrillation		
		v. Full AUDIT score		
		vi. Cirrhosis		
		vi. Obese (BMI≥30 or BMI ≥27.5 if South Asian origin)		
		vii. Familial Hypercholesterolemia		
		8.3. Are patients communicated the diagnosis?		
	Programme Standard 9: Appropriate follow-up for those with high Cardiovascular Risk	**9.1. Is the risk register of patients with 10-year cardiovascular disease (CVD) risk ≥20% maintained?**		
		9.2. Are patients with a 10%-19.9% 10-year risk of developing cardiovascular disease (CVD) offered appropriate lifestyle advice and behaviour change support in relation to increasing physical activity, smoking cessation, safe alcohol consumption and healthy diet?		
		9.3. Where lifestyle modification has been ineffective or is inappropriate, are patients with a 10%-19.9% 10-year risk of developing cardiovascular disease (CVD) offered an appointment with the GP or nurse about the risks and benefits of statin treatment for the primary prevention of CVD?		
		9.4. Are patients with new diagnoses of a 10-year cardiovascular disease (CVD) risk ≥ 20% transferred to the appropriate risk registers and excluded from NHS Health Check eligible list?		
		9.5. Are patients with a 10-year cardiovascular disease (CVD) risk ≥ 20% offered an appointment with the GP or nurse about the risks and benefits of statin treatment?		
		9.6. Is there a SNOMED code record of a statin being offered, accepted and declined for patients with 10-year cardiovascular disease (CVD) risk ≥ 20% or 10-19.9% where lifestyle modification has been ineffective or is inappropriate?		
		9.7. Are pathways in place to ensure these 'high risk' patients with 10-year cardiovascular (CVD) risk ≥10% are followed up on an annual basis?		
THROUGHOUT	Programme Standard 10: Confidential and timely transfer of patient identifiable data	**10.1 Is there electronic data transfer in place between the community provider and GP practices?**		
		10.2. Is there an agreed protocol for data transfer between the community provider and GP Practices?		
		10.3. Is there a protocol in place for timely referral of patients where abnormal parameters identified by the community provider, including outlining action when urgent referral is required?		
FEEDBACK	Feedback	**Please provide any additional feedback on the quality of the NHS Health Check Programme, including any identified serious risks:**		

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