Public Health England

Protecting and improving the nation's health

NHS Health Check
Best practice guidance

March 2016

About Public Health England

Public Health England exists to protect and improve the nation's health and wellbeing, and reduce health inequalities. It does this through world-class science, knowledge and intelligence, advocacy, partnerships and the delivery of specialist public health services. PHE is an operationally autonomous executive agency of the Department of Health.

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Chapter 1. Background

This section provides an overview of and background to the NHS Health Check programme.

1.0 Introduction

The delivery of the NHS Health Check programme was extremely successful in 2014-15. Investment in the programme increased from £56m to £62m and more people than ever before had a check. PHE recognises this as a great achievement and would like to thank local authority commissioners and providers for their continued support in delivering the programme.

The NHS Health Check programme aims to prevent heart disease, stroke, type 2 diabetes and kidney disease, and raise awareness of dementia both across the population and within high risk and vulnerable groups. In April 2013 the NHS Health Check became a statutory public health service in England. Local authorities are responsible for making provision to offer an NHS Health Check to eligible individuals aged 40-74 years once every five years as set out in regulations 4 and 5 of the Local Authorities (Public Health Functions and Entry to Premises by Local Healthwatch Representatives) Regulations 2013, S.I. 2013/351.

The NHS Health Check is made up of three key components: risk assessment, risk awareness and risk management. During the risk assessment standardised tests are used to measure key risk factors and establish the individual's risk of developing cardiovascular disease. The outcome of the assessment is then used to raise awareness of cardiovascular risk factors, as well as inform a discussion on, and agreement of, the lifestyle and medical approaches best suited to managing the individual's health risk.

The original Department of Health (DH) modelling showed the average annual cost of the programme as £332m each year at full roll out[1] and the benefit as £3.7bn with a cost per quality adjusted life year (QALY) of around £3000. This modelling also suggests that it is cost effective with potential savings to the NHS of around £57m per year after four years, rising to £176m per year after 15 years.

[1] Defined as 75% of the total five year eligible population receiving an NHS Health Check once every five years

The modelling shows that the NHS Health Check could, on average, prevent 1,600 heart attacks and strokes, saving at least 650 lives each year. As well as preventing over 4,000 people a year from developing diabetes and detecting at least 20,000 cases of diabetes or kidney disease earlier, allowing individuals to be better managed and improve their quality of life.

Achieving these health outcomes is dependent on close working between local authorities and their partners across the health care system, including primary care. This will help ensure the existence of robust referral pathways so that any additional testing and clinical follow up is undertaken, for example, where someone is identified in the risk assessment as being at high risk of having or developing a vascular disease.

This update to the programme's best practice guidance helps local commissioners and providers to understand the legal requirements underpinning the programme's delivery. It identifies where there is scope for local flexibility and innovation in delivery. It also signposts to a wide range of tools and resources that will support the delivery of a high quality local NHS Health Check programme.

This guidance updates and replaces the previous NHS Health Check best practice guidance[2] published in February 2015. Key changes from the previous edition are listed in table 1.

Table 1. Key changes from the previous best practice guidance edition

Change	**Section**
The inclusion of a table summarising the quality and outcome framework indicators that the NHS Health Check aligns with.	1.3
New advice for considering familial hypercholesterolaemia where an individual's cholesterol level is found to be above 7.5mmol/l	3.1
Supplimentary information on managing familial hypercholestorlaemia, cholesterol, irregular pulse, abnormal fasting blood glucose or HbA1c	5
Updated dementia leaflet available to use with people between 65 and 74 years	6
The addition of information from the single data item list guidance in to the quarterly data return chapter.	9 and 10

[2] NHS Health Check Best practice guidance. Department of Health. Febraury 2015. Gateway reference: 2014747

1.1 The NHS Health Check programme

Reducing avoidable premature mortality is a government priority. Through early identification and management of risk factors and early detection of disease the NHS Health Check will help achieve the ambitions set out in 'A call to action to reduce premature mortality',[3] and the 'Cardiovascular disease outcome strategy.'[4]

For males 28% of the gap in life expectancy between the most and least deprived fifth of areas in England is due to excess deaths from circulatory diseases, and for females this figure is 24%. If diabetes and kidney conditions are added to circulatory diseases, then excess deaths from these conditions together contribute to 31% of the gap between the most and least deprived fifth in England for males and 28% for females. Additionally, the cost of social and health care from the rise in levels of obesity, type 2 diabetes and dementia makes the prevention and risk reduction of these conditions key drivers of the programme[5].

The NHS Health Check programme offers a fantastic opportunity to help people to live longer, healthier lives. It aims to improve health and wellbeing of adults aged 40-74 years through the promotion of earlier awareness, assessment, and management of the major risk factors and conditions driving premature death, disability and health inequalities in England.

The programme will achieve this by:

- promoting and improving the early identification and management of the individual behavioural and physiological risk factors for vascular disease and the other conditions associated with these risk factors
- supporting individuals to effectively manage and reduce behavioural risks and associated conditions through information, behavioural and evidence based clinical interventions
- helping to reduce inequalities in the distribution and burden of behavioural risks, related conditions and multiple morbidities
- promoting and supporting appropriate operational research and evaluation to optimise programme delivery and impact, nationally and locally

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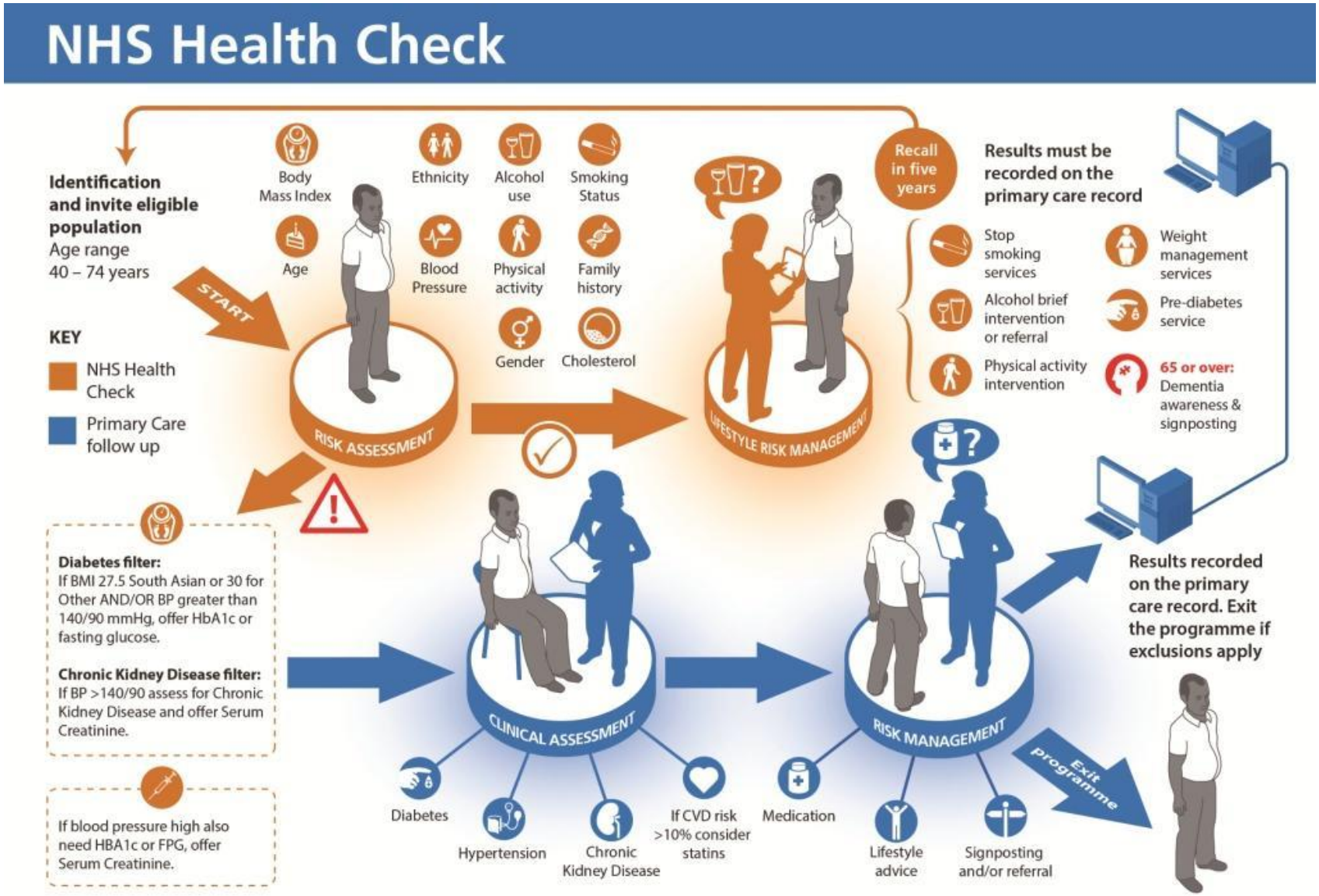
[3] Living Well for Longer: a call to action to reduce premature mortality. Department of Health. 5 March 2013. Gateway reference: 18716

[4] Cardiovascular Disease Outcomes Strategy: Improving outcomes for people with or at risk of cardiovascular disease. Department of Health. 5 March. Gateway reference: 18747.

[5] The Segment Tool 2015 - Segmenting life expectancy gaps by cause of deathhttp://www.lho.org.uk/LHO_Topics/Analytic_Tools/Segment/TheSegmentTool.aspx

Figure 1. NHS Health Check pathway



1.2 Funding and working across the health care system

On 1 April 2013 local authorities became responsible for the risk assessment and life style interventions for the NHS Health Check programme, funded through the public health ring fenced budget. The risk assessment element of the check is a statutory function which local authorities are required to commission or provide.

Additional testing and clinical follow up, for example, where someone is identified as being at high risk of having or developing vascular disease, remains the responsibility of primary care and will be funded through NHS England. Local authorities will need to work closely with their partners across the health care system, including through health and wellbeing boards, to ensure these different elements of the programme link together.

As part of the financial accountability arrangements, local authorities will have to provide DH with a revenue outturn form detailing public health expenditure. This will include reporting expenditure against set public health categories including the NHS Health Check programme, more guidance can be found here.

1.3 Quality and Outcome Framework indicators

The Quality and Outcomes Framework (QOF) is a voluntary incentive scheme for GP practices in the UK. The QOF contains groups of indicators, against which practices score points according to their level of achievement, rewarding contractors for the provision of quality care.[6]

The NHS Health Check aligns strongly with QOF, supporting the achievement of a number of assessment and clinical management indicators. These are summarised in annex A.

1.4 Equality and Health Inequalities

One of the programme's objectives is to reduce health inequalities. Local authorities may tailor the delivery of the programme in a number of ways to achieve this. Although local authorities have a duty to offer the NHS Health Check to all eligible people, PHE supports approaches that prioritise invitations to those with the greatest health risk. For example, by prioritising invitations to people with an estimated ten-year CVD risk score greater than 10% or those living in their most deprived areas.

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[6] British Medical Association. QOF guidance 2015-16. Accessed 7 February 2016 www.bma.org.uk/qofguidance

The programme has also been designed so that the majority of the check, including the tests and measurements required for the risk assessment, can be delivered in different settings. This will help ensure the programme is accessible to a wide range of people. A broad selection of case studies that demonstrate how local authorities have targeted groups with the greatest health need can be found on the NHS Health Check website.

In addition, local areas will wish to ensure that the NHS Health Check programme they offer is in keeping with the Equality Act 2010. A quick start guide[7] is available to help public sector organisations understand a key measure in the Equality Act, the public sector equality duty, which came into force on 5 April 2011. Local areas will be familiar with the purpose and provisions of the Act and understand, for example, that reasonable adjustments need to be made for disabled people when providing services and exercising public functions.

This duty recognises that equality of opportunity cannot be achieved simply by treating everyone the same. 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. For example, the way that wheelchair users access their NHS Health Check, as well as how their risk assessment is undertaken and how they are supported to improve their lifestyle will require specific consideration and action.

[7] Public sector: quick start guide to the public sector Equality Duty. www.gov.uk/government/publications/public-sector-quick-start-guide-to-the-public-sector-equality-duty

Chapter 2. Legal requirements for local authorities

This section sets out local authorities' statutory duties for delivering the NHS Health Check and returning data to PHE.

2.0 Summary of statutory requirements

The Local Authorities (Public Health Functions and Entry to Premises by Local Healthwatch Representatives) Regulations 2013 S.I. 2013/351 set out a number of statutory public health functions for local authorities from 1 April 2013. These Regulations have been made by the Secretary of State for Health under powers conferred by the National Health Service Act 2006[8] and the Local Government and Public Involvement in Health Act 2007.[9] This document provides guidance on what local authorities need to do to comply with the regulations and where there is flexibility. Legal duties exist on offering NHS Health Checks (referred to as 'health check' in the regulations), the content of the risk assessment, communication of results, data recording, transfer and take up rates. It is important that local authorities are satisfied that they are fulfilling their legal duties.

Legal duties exist for local authorities to make arrangements:

- for each eligible individual aged 40-74 to be offered an NHS Health Check once in every five years and for each individual to be recalled every five years if they remain eligible
- for the risk assessment to include specific tests and measurements
- to ensure the individual having their NHS Health Check is told their cardiovascular risk score, and other results are communicated to them
- 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

[8] Sections 6C (1) to (3), 186A (4) (b) and 272(7) and (8) of the National Health Service Act 2006.

[9] Sections 225(1) to (3) and (7) (e), 229(2) and 240(10) of the Local Government and Public Involvement in Health Act 2007.

Local authorities are also required to continuously improve the percentage of eligible individuals having an NHS Health Check. Further information on these provisions is set out in this document.

Local authorities are **not** responsible for offering eligible prisoners or people in detained settings an NHS Health Check. Section 7A of the National Health Service Act 2006, as amended by the Health and Social Care Act 2012, requires NHS England to provide public health services in prisons and detained settings, this includes offering all detainees aged between 40 and 74 an NHS Health Check. PHE recommends that the NHS and local government work closely together to ensure that those people released from custody are able to access services in the community.

2.1 Offering the NHS Health Check to those eligible

Local authorities have a legal duty to make arrangements for everyone eligible aged 40 to 74 to be offered an NHS Health Check once in every five years and for them to be recalled for another check every five years after that, while they remain eligible.

As the NHS Health Check is a public health programme aimed at preventing disease, people with previously diagnosed vascular disease or who meet the criteria set out below are excluded from the programme. These individuals should already be receiving appropriate management and monitoring through existing care pathways.

Exclusion criteria:

- coronary heart disease
- chronic kidney disease (CKD) which has been classified as stage 3, 4 or 5 within the meaning of the National Institute for Health and Care Excellence (NICE) clinical guideline 182 on Chronic Kidney Disease
- diabetes
- hypertension
- atrial fibrillation
- transient ischaemic attack
- hypercholesterolemia
- heart failure
- peripheral arterial disease
- stroke
- prescribed statins
- people who have previously had an 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

NOTE: Where someone has a CVD risk of 10-19%, they would not be excluded from recall unless they meet one of the other exclusion criteria, e.g., being prescribed a statin.

Local authorities may choose to extend the programme to cover a wider age range of people or to include additional tests to the risk assessment according to the needs of their local population but they will need to consider the cost and benefits of doing so. Additional people who do not form part of the eligible population as stipulated in the regulations should be excluded from the quarterly data returns.

2.2 The risk assessment

Everyone receiving an NHS Health Check will have a risk assessment which will look at individual risk factors as well as their risk of having, or developing, vascular disease in the next ten years.

Tests and measures

Local authorities have a legal duty to ensure that the specific tests and measures listed below are completed during the risk assessment and that the results are recorded. Where the risk assessment is conducted outside the individual's GP practice, there is also a legal duty for the following information to be forwarded to the individuals GP:

- age
- gender
- smoking status
- family history of coronary heart disease
- ethnicity
- body mass index (BMI)
- cholesterol level
- blood pressure
- physical activity level
- alcohol use disorders identification test (AUDIT) score
- cardiovascular risk score

In addition, those aged 65-74 should be made aware of the signs and symptoms of dementia and sign posted to memory services if this is appropriate.

Local authorities can decide on the delivery setting for the risk assessment as long as the staff who carry them out are appropriately trained and qualified. For example, they may wish to use a combination of pharmacies and other community settings, as well as GP practices to help ensure the programme is as accessible to as many people as possible. The tests, measurements and risk calculations that make up the risk

assessment part of the NHS Health Check are stipulated in legislation to ensure a uniform, quality offer is delivered across England.

Communication of results

The individual having an NHS Health Check must be told their BMI, cholesterol level, blood pressure and AUDIT score as well as their cardiovascular risk score.

A note on safety and quality

Although local areas can determine where and who delivers the risk assessment, local authorities will wish to consider how the tests and measurements are standardised and quality assured.

This is not a legal requirement of the regulations but equally this is key to providing a high quality and safe service.

It is pivotal that the actions taken at certain thresholds are the same and in line with national guidelines, including those issued by NICE, so that people receive the necessary and appropriate care. Further information and guidance on providing a high quality and safe service can be found in the NHS Health Check programme standards**.**

2.3 Continuous improvement

As well as offering the NHS Health Check to 100% of eligible people over five years local authorities have a legal duty to seek continuous improvement in people having an NHS Health Check.

PHE aspires to achieve a national take up rate in the region of 75% of the eligible population having an NHS Health Check once every five years. Ensuring a high percentage of the eligible population have an NHS Health Check 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's and local area's ability to narrow health inequalities.

Local authorities have the flexibility to decide how to secure continuous improvement and to use data published in the public health outcomes framework to help monitor activity.[10] Some areas have adopted the use of social marketing, local champions,

[10] Public Health Outcomes Framework for England, 2013-2016. Department of Health. January 2012. Gateway reference: 16891. www.gov.uk/government/publications/healthy-lives-healthy-people-improving-outcomes-and-supporting-transparency

delivering checks in non-NHS settings and out of hours, or have used a combination of these approaches to reach more of the eligible population. You can find further information in the marketing section of the NHS Health Check website.

2.4 Information governance and data flow

Data flow between parties involved in the NHS Health Check programme is subject to the Data Protection Act and information governance rules, more information is available on the Information Commissioner's Office website. It is lawful and appropriate to move the data in the manner described for the NHS Health Check, so long as all stated processes are complied with. There should be no impediment to moving data safely between parties who require the data.

In all cases, the GP will remain as data controller, a legally defined role with significant responsibilities. Commissioners should continue to recognise this responsibility when negotiating with GP colleagues. Unless explicit consent has been gained from patients, only anonymised information may flow back to the local authority from the GP practice. The actual process and requirements of securing data is subject to change, readers are therefore directed to the NHS Health Check website to review the Information Governance and Data Flows Pack. It is the responsibility of those storing or moving data to ensure that all systems required are in place and up to date.

The level of data required by the commissioner to properly assess the impact of the programme is set in the NHS Health Check minimum data set. The current template can be found on the NHS Health Check national website; this information can also be found on the Health and Social Care Information Centre (HSCIC) national website.

2.5 Collecting and reporting NHS Health Check data

Local authorities must collect information on the number of NHS Health Checks offered and the number of NHS Health Checks received each quarter and return this data to PHE. This data collection requirement is set out in the single data list (ref 254-00), which prescribes the datasets that local government must routinely submit to central government.

PHE manages the NHS Health Check data return process and requires an individual from every local authority, nominated by the Director of Public Health, to submit data each quarter via the programme website. More information on recording, collecting and quality assuring data before submitting it to PHE can be found in Chapter 9 Quarterly data return or by contacting PHE.

Chapter 3. The risk assessment

3.0 Introduction

This section provides information on how to assess someone's cardiovascular risk and defines what information and measurements are required for the NHS Health Check risk assessment, see figure 2.

3.1 Cardiovascular risk assessment

The NHS Health Check risk assessment requires the use of a risk engine to calculate the individual's risk of developing cardiovascular disease in the next ten years. The National Institute for Health and Care Excellence (NICE) now advises that QRISK® 2 should be the engine used.[11] The following information explains what data is required for the QRISK® 2 risk engine, and the best practice for obtaining it.

Age

Data required: age recorded in years.

Thresholds: the age of the individual should be 40-74 years (inclusive).

Gender

Data required: the gender should be recorded as reported by the individual. If the individual discloses gender reassignment, they should be provided with CVD risk calculations based on both genders and advised to discuss with their GP which calculation is most appropriate for them as an individual.

Ethnicity

Data required: self-assigned ethnicity using one of the following categories: white/not recorded, Indian, Pakistani, Bangladeshi, other Asian, black African, black Caribbean, Chinese, other including mixed.

Key points: ethnicity is needed for the diabetes risk assessment. Ethnicity should be recorded using the Office for National Statistics 2001 census codes.

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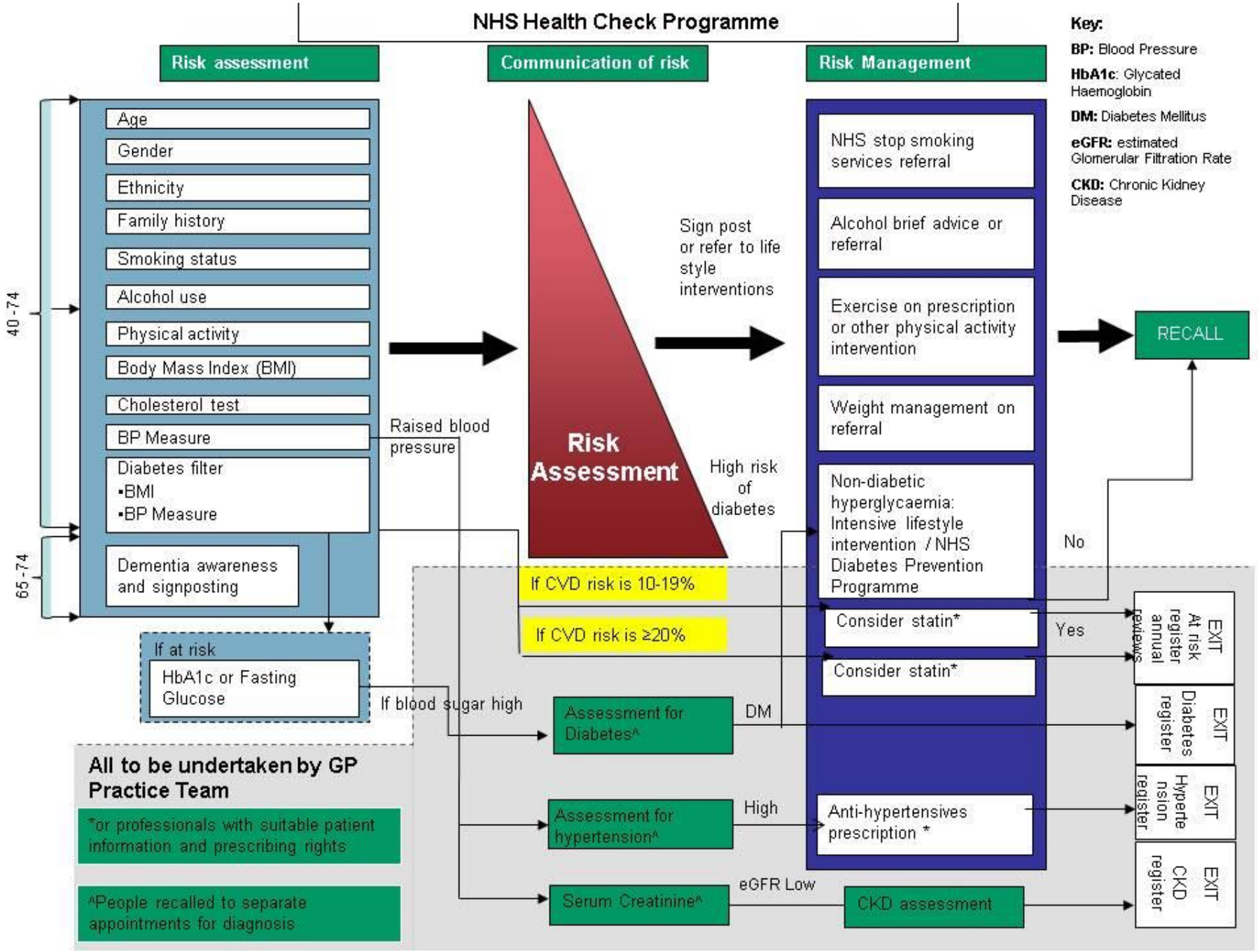
[11] National Institute for Health and Care Excellence (2014) Lipid modification: cardiovascular risk assessment and the modification of blood lipids for the primary and secondary prevention of cardiovascular disease www.nice.org.uk/Guidance/CG181

Figure 2. Overview of the vascular risk assessment and management programme



Smoking status

Data required: non smoker, ex-smoker, light smoker (fewer than 10 a day), moderate smoker (11-19 a day), heavy smoker (≥ 20 a day).

Related stages of the check: local authorities may wish to ensure processes are in place so a smoker who wants to quit can be offered a referral to a local stop smoking service.

Family history of coronary heart disease

Data required: information on family history of coronary heart disease in first-degree relative under 60 years.

Key points: first-degree relative means father, mother, brother or sister.

Body mass index (BMI)

Data required: BMI is required for the CVD risk calculation. It also provides one approach to identifying those at high risk of developing diabetes, or those who have existing undiagnosed diabetes, and is required for the diabetes risk assessment.

Thresholds: a blood sugar test is required where the individual's:

- BMI is greater than 27.5 for people from black, Asian and other ethic groups
- BMI is greater than 30 (rest of population)

Note: if the individual cannot have their height and/or weight measured, the individual's estimate of their own height and weight can be used as approximations but these are prone to error. Arm span can also be used as an approximation for height.

Additional guidance

- Body mass index thresholds for intervening to prevent ill health among black, Asian and other minority ethnic groups. NICE advice LGB13. January 2014.

Cholesterol test

Data required: cholesterol must be measured as the ratio of total serum cholesterol to high density lipoprotein cholesterol.

Related stages of the check: cholesterol is a major modifiable risk factor of vascular disease, and can be reduced by dietary change, physical activity and medicines, and local areas will wish to consider what support to offer individuals. If cholesterol is raised the individual should be offered healthy eating advice. If the ten-year CVD risk is 10% or greater treatment with statins may be recommended in addition to lifestyle changes. If the CVD risk is above this threshold, and the NHS Health Check is undertaken outside of general practice the individual should be referred to their GP or nurse for further assessment and management. Individuals whose cholesterol level is found to be above

7.5mmol/l should be referred to their GP for consideration of Familial Hypercholesterolaemia.

Key points: a random cholesterol test should be used for this assessment. A fasting sample is not required.

Additional guidance

- Lipid modification: cardiovascular risk assessment and the modification of blood lipids for the primary and secondary prevention of cardiovascular disease. NICE clinical guideline 181. July 2014.
- Familial hypercholesterolaemia: identification and management**.** NICE clinical guideline 71. August 2008.

Systolic and diastolic blood pressure

Data required: both systolic (SBP) and diastolic blood pressure (DBP) are required for the diabetes filter and for assessment of chronic kidney disease (CKD) and hypertension within primary care.

Threshold: if the individual has a blood pressure at, or above, 140/90mmHg, or where the SBP or DBP exceeds 140mmHg or 90mmHg respectively, the individual requires:

- a non fasting HbA1c test or a fasting plasma glucose (FPG) (see section on diabetes risk assessment). This is part of the risk assessment element of the NHS Health Check and local authorities will need to consider its provision
- an assessment for hypertension. This will take place in primary care and will mean local authorities will need to work closely with their partners to ensure people receive appropriate clinical follow up
- an assessment for CKD (see the section on additional testing and clinical follow up). Again this will take place within a GP setting and links across the system are essential

Key points: **checking the pulse rhythm**

NICE Hypertension clinical guideline 127 (2011) recommends that practitioners should perform a pulse rhythm check prior to taking blood pressure to detect any pulse irregularities. Irregularities can lead to inaccurate blood pressure readings when an automated device is used. Individuals who are found to have an irregular pulse rhythm should be referred to the GP for further investigation of atrial fibrillation.

Additional guidance

- Hypertension: clinical management of primary hypertension in adults. NICE clinical guideline 127. August 2011.

Physical activity assessment

Data required: NICE guidance on physical activity interventions recommends that primary care practitioners should take the opportunity, whenever possible, to identify inactive adults. The UK Chief Medical Officer recommended that all adults should be physically active daily. Over a week, activity should add up to at least 150 minutes. A validated tool is recommended, such as DH's General Practitioner Physical Activity Questionnaire (GPPAQ) to measure the activity levels of individuals.

Key points: GPPAQ as a testing tool is part of Let's Get Moving (LGM): a physical activity care pathway. GPPAQ has been tested and validated for self-completion. It provides a measure of an individual's physical activity levels, which have been shown to correlate with cardiovascular risk, classifying people as: inactive, moderately inactive, moderately active, and active.

Thresholds: a brief intervention on physical activity can help support people to become and remain active and will be appropriate for the majority of people who fall into all GPPAQ classifications other than active. Individuals who are identified as inactive could be considered for exercise referral where local services exist.

Additional guidance

- Let's Get Moving: Commissioning Guidance - a physical activity care pathway. Department of Health. March 2012.
- Everybody Active, Every Day: An evidence-based approach to physical activity. Public Health England. 2014

Alcohol risk assessment

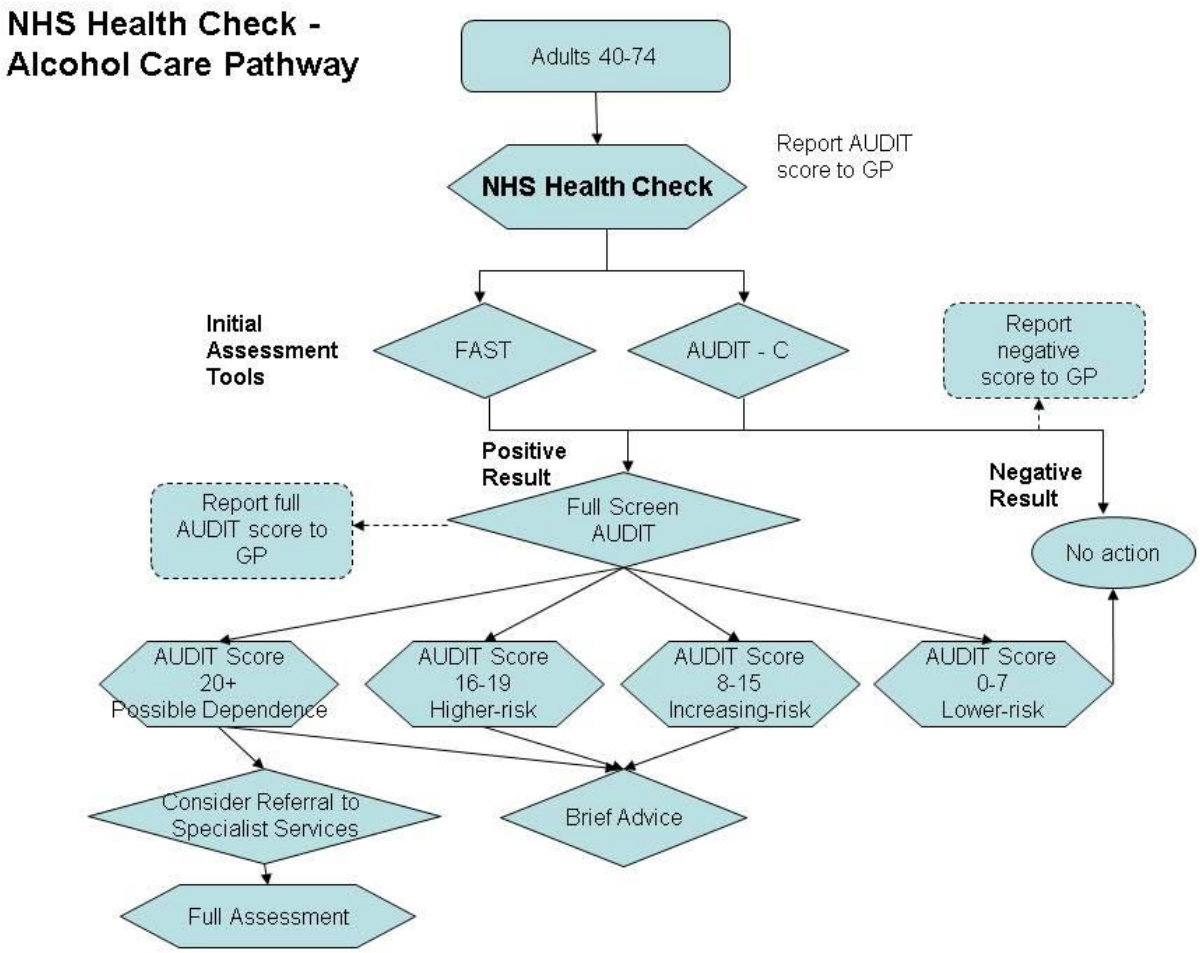
Local authorities need to ensure that everyone having an NHS Health Check has their alcohol consumption assessed. Figure 3 presents the care pathway for alcohol risk assessment.

Key points: to identify the risk of harm from alcohol, the World Health Organisation (WHO) alcohol use disorder identification test (AUDIT) questionnaire should be used. This questionnaire is validated, has been used all over the world and is considered to be the 'gold standard' alcohol risk questionnaire. The AUDIT questionnaire is ten questions long and will take approximately three minutes to complete, not everybody will need to be asked all ten questions. The assessment can be split into two phases:

- an initial assessment to identify those who may be at risk, and
- a second phase to identify the level of risk.

New UK alcohol guidelines were published in January 2016 which recommend a lower threshold of alcohol units for men. As a result, PHE is now consulting on changes to one of the initial AUDIT tool questions to reflect this change in guidance.

Figure 3. Alcohol care pathway



Initial assessment: can be undertaken by using a brief initial questionnaire; a sub-set of the full AUDIT. The two recommended initial assessment questionnaires, AUDIT-C and the fast alcohol screening test (FAST), are both validated and widely used in England. Both can be self-completed by the individual or the questions can be verbally asked of the individual and their response recorded. AUDIT-C consists of the first three questions of AUDIT- the consumption questions. FAST consists of four of the ten questions from AUDIT. These initial assessment questionnaires are about 80% as accurate as the full AUDIT and are enough to rule someone in or out for further investigation concerning their alcohol risk.

Initial assessment threshold: (AUDIT-C $\geq$5 ; FAST $\geq$3) If the individual scores five or more using AUDIT-C, or three or more using FAST the second phase should be undertaken.

Full AUDIT: if the individual scores above the initial assessment threshold then the second phase is to complete the remaining questions of the full AUDIT. It is this full AUDIT score that can identify the risk level of the individual.

AUDIT threshold: ≥ 8. If the total AUDIT score from the full ten questions is eight or more, this indicates the individual's consumption of alcohol might be placing their health at increasing or higher risk of harm. The AUDIT score should be recorded and fed back to both the individual and, where the risk assessment is carried out outside the individual's GP practice, to the individual's GP.

Related stages of the check: although this is not a mandated requirement, if the individual meets or exceeds the AUDIT threshold of eight, the individual should be given brief alcohol advice to reduce their health risk and to help reduce alcohol related harm. A referral to alcohol services should be considered for those individuals scoring 20 or more on AUDIT. Further guidance on this is provided in section 4.

Data required: AUDIT score

Additional guidance

- Alcohol Guidelines Review – Report from the Guidelines development group to the UK Chief Medical Officers. DoH. January 2016
- Alcohol-use disorders: preventing harmful drinking. NICE public health guideline 24. June 2010

3.2 Diabetes risk assessment

This section provides guidance on how to identify people at high risk of developing, or living with undiagnosed diabetes, and to undertake the necessary plasma glucose test – either an HbA1c which is recommended, or a fasting plasma glucose test. Only those identified as at higher risk should have a plasma glucose test as part of their NHS Health Check risk assessment; it is not considered clinically effective or cost effective to test everyone.

There are a number of ways of determining who is at high risk of diabetes and who has undiagnosed diabetes. This guidance describes using BMI (adjusted for ethnicity) and plasma pressure to identify people at high risk that should go on to receive a plasma glucose test. Making arrangements for the plasma glucose test is a local authority responsibility. The outcome of the test will establish how best they can be managed. Figure 4 provides a diagrammatic overview of this approach, as well as additional testing and treatment pathways.

The thresholds specified will not pick up everyone at risk of diabetes, but this approach achieves a balance between sensitivity (ie, finding those people at risk of diabetes as accurately as possible) and feasibility (ie, the practicalities involved in delivering the check).

While the filter remains the current approach for identifying people at high risk of diabetes through the NHS Health Check, NICE guidance recommends that a validated risk engine is used. Therefore, the programme's expert scientific and clinical advisory panel is considering the feasibility of transitioning to a validated risk tool as part of the content review process. You can find further updates on the NHS Health Check website as this process progresses.

Data required: ethnicity, BMI and blood pressure are required for the diabetes risk assessment.

Thresholds:

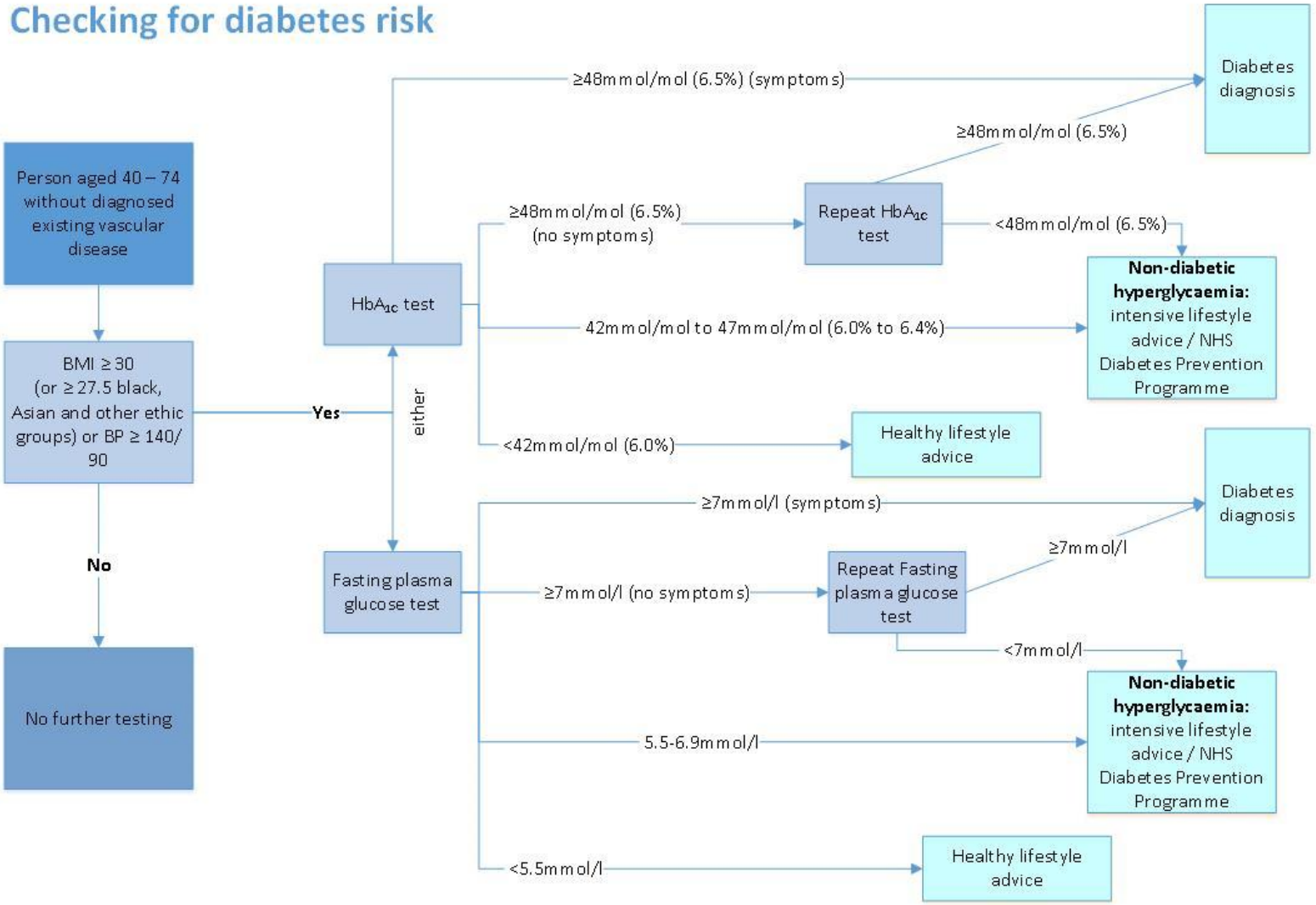
- blood glucose test if an individual's BMI is: greater than 27.5 for people from black, Asian and other ethic groups or or greater than 30 (rest of population)
  or
- blood pressure is at or above 140/90mmHg, or where the SBP or DBP exceeds 140mmHG or 90mmHg respectively

Key points: as with the other tests in the check, it is important that those people who do not go on for further testing understand that everyone has some level of risk. They should also be made aware of the risk factors for diabetes as part of the general lifestyle advice that should be offered to everyone having a check regardless of their risk.

In addition to individuals meeting the high risk filter criteria it is important to consider the situation of the individual individual, as some people who do not fall into the filter categories will still be at significant risk. This includes:

- people with first-degree relatives with type 2 diabetes or heart disease
- people with tissue damage known to be associated with diabetes, such as retinopathy, kidney disease or neuropathy
- women with past gestational diabetes
- those with conditions or illnesses known to be associated with diabetes (eg, polycystic ovarian syndrome or severe mental health disorders)
- those on current medication known to be associated with diabetes (eg, oral corticosteroids)

Figure 4. Checking for diabetes risk



Blood glucose testing

There is no single universally recognised way of testing blood for high risk of diabetes or for diabetes itself. Random (non-fasting) plasma glucose tests are so influenced by food they are not recommended. Fasting plasma glucose tests, while less convenient, are a better method. An HbA1c test can also be used. These two main approaches for testing plasma glucose – fasting plasma glucose and HbA1c – are set out in the following sections.

HbA1c (glycated haemoglobin)

Key points: HbA1c testing does not require fasting so can be more convenient. Blood can be taken venously. HbA1c is formed when glucose binds to haemoglobin in red blood cells. The higher the plasma glucose over the past two or three months, the higher the HbA1c. Even within the non-diabetic range, HbA1c has been shown to be a risk marker for vascular events and can be used to assess the risk of diabetes.

In 2011, the World Health Organisation (WHO) accepted HbA1c as an alternative method in the diagnosis of diabetes provided:

- stringent quality assurance methods are in place
- measurements are standardised
- no conditions exist which contraindicate an accurate HbA1c measurement such as haemolytic anaemia, iron-deficiency anaemia and some variant haemoglobins. HbA1c is not recommended for the diagnosis of diabetes in pregnancy when an oral glucose test is still required. HbA1c reflects glycaemia over the preceding 2-3 months so may not be raised if plasma glucose levels have risen rapidly
- situations where plasma glucose levels have risen rapidly require urgent/same day assessment by a GP, diabetologist or accident and emergency. Examples include:
    - all symptomatic children and young people
    - symptoms suggesting type 1 diabetes (any age)
    - short duration diabetes symptoms
    - patients at high risk of diabetes who are acutely ill
    - patients taking medication that may cause rapid glucose rise, e.g., corticosteroids, anti-psychotics
    - acute pancreatic damage/pancreatic surgery

The WHO did not provide specific guidance on HbA1c criteria for people at increased risk of type 2 diabetes. However, a UK expert group on the implementation of the WHO guidance recommends using HbA1c values between 42 and 47mmol/mol (6.0-6.4%) to indicate that the individual is at high risk of type 2 diabetes. NICE public health guidance 38: Preventing type 2 diabetes: risk identification and interventions for individuals at high risk, supports this recommendation. This advice should be used in conjunction with the programme standards.

Fasting plasma glucose (FPG)

Key points: an FPG test can be used to identify those with potential diabetes or at high risk. It is also used in the presence of conditions that render the HbA1c test inaccurate (see above). To undertake an FPG test, the individual being tested should be informed of the fasting requirement in writing or over the phone and if possible the appointment should be scheduled for 11am or earlier to make fasting easier.

Additional guidance

- Use of Glycated Haemoglobin (HbA1c) in the Diagnosis of Diabetes Mellitus World Health Organization. 2011. Abbreviated Report of a WHO Consultation. WHO/NMH/CHP/CPM/11.1
- Consensus statement: Use of haemoglobin A1c (HbA1c) in the diagnosis of diabetes mellitus**.** The implementation of World Health Organisation (WHO) guidance 2011, Practical Diabetes, 2011, 1, 12a
- Preventing type 2 diabetes: risk identification ande interventions for individuals at high risk. NICE public health guidance 38. July 2012
- NHS Health Check programme standards: a framework for quality improvement**.** Public Health England. February 2014

3.3 Near patient testing and quality control

This section provides guidance and advice on the use of point of care testing (POCT) or near patient testing (NPT) for the blood tests required for the NHS Health Check. It provides advice on training and quality assurance to support the safe use of POCT.

Fasting blood glucose or HbA1c POCT may be suitable for initially filtering out those who are unlikely to have diabetes or non-diabetic hyperglycaemia. However, diagnosis of diabetes or of non-diabetic hyperglycaemia requires a venous blood sample to be tested in the laboratory.

Where the introduction of POCT is being considered the Medicines and Healthcare Products Regulation Agency 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 also be far more likely to support you if there are any challenges 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
- **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
- **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
- **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 satisfy themselves as to whether CQC registration is required for any other service they provide.

Where it is agreed that POCT will be undertaken then local arrangements should also seek to meet the relevant NHS Health Check programme standards.

Additional guidance

- Pathology quality assurance review; NHS England, 2014
- Management and Use of IVD Point of Care Test Devices. Medicines and Healthcare Products Regulatory Authority . December 2013. The report provides extensive guidance, including advice on clinical governance issues relating to the setting up and management of POCT, pathology and laboratory involvement, staff training, health and safety, standard operating procedures and quality issues
- Buyers' guide: Blood glucose systems**.** Purchasing and Supply Agency, Centre for Evidence-based Purchasing. May 2008
- NHS Health Check programme standards: a framework for quality improvement**.** Public Health England. February 2014

3.4 Raising awareness of dementia

The dementia component of the NHS Health Check does not require any formal assessment or memory testing. The purpose of the intervention is to raise awareness of dementia and the availability of memory services which offer further advice and assistance to people who may be experiencing signs and symptoms of dementia.

Everyone who has an NHS Health Check should be made aware that the risk factors for cardiovascular disease are the same as those for dementia. What is good for the heart is good for the brain. In addition, everyone aged 65-74 who has an NHS Health Check should be made aware of the signs and symptoms of dementia and be signposted to memory services if this is appropriate. A leaflet for individuals having their check and training materials for those carrying out the check have been produced to support this. These resources are available to order or to download from our website in a variety of formats and languages.

Chapter 4. Risk management: lifestyle interventions

4.0 Introduction

The NHS Health Check is a preventative programme which is intended to help people live longer healthy lives. Although the risk management element of the programme is not a legal responsibility for local authorities it is essential if the programme is to benefit the public's health.

To maximise these benefits, everyone who has an NHS Health Check, regardless of their risk score, should be given clinically appropriate lifestyle advice, to help them manage and reduce their risk. So, 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 the necessary lifestyle changes to help them manage their risk. 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.

The assumption is that delivering health messages should encourage people to cease or adopt certain behaviours, which in turn is likely to result in health improvement. In the context of cardiovascular disease prevention, behaviour change services are often linked to modifiable cardiovascular disease risk factors that can be managed by changes to a individual's lifestyle. Individual-level behaviour change interventions can be delivered through different methods, including:

- brief advice,
- brief interventions
- motivational interviewing

The approaches are not mutually exclusive, brief interventions may contain brief advice and may use a motivational interviewing approach.[12.]

Depending on the delivery model in place, this advice and the completion of the risk assessment may be completed by different professionals. So it is important that information such as smoking status, blood pressure, levels of physical activity and

[12] as defined by National Institute for Health and Care Excellence (NICE) commissioning guideline 4.2 on Services for the prevention of cardiovascular disease

history of vascular disease in the family is transferred in written form between individuals and within the delivery team as necessary. This will help ensure continuity of care and a positive experience for the individual having the check.

4.1 Local stop smoking services referral

Key points: as with all of the lifestyle interventions which form part of the NHS Health Check, the provision of stop smoking services are funded through the public health ring fenced budget. Although offering these services as part of the programme is not mandated, they provide an essential contribution to its ultimate objective, by helping people who smoke to manage or reduce their risk of developing future disease. Local authorities may therefore like to consider how anyone who smokes, and who wants to stop, is offered the support of a local stop smoking service.

NICE Public Health Intervention Guidance no. 1 'Brief interventions and referral for smoking cessation in primary care and other settings' makes a number of practical recommendations on who should receive advice, as well as on who should advise smokers and how.

The National Centre for Smoking Cessation and Training (NCSCT) local stop smoking service and delivery guidance 2014, illustrates the importance of using every opportunity to systematically identify people who smoke, deliver very brief advice (VBA) and follow up, where appropriate, with a referral into effective support. This very brief advice consists of three steps:

- ASK – establish and record smoking status
- ADVISE – advise that the best way to stop is with a combination of pharmacotherapy and support
- ACT – offer a referral to a specialist service

A free training module on the delivery of VBA is available on the NCSCT website.

Additional guidance

- Brief interventions and referral for smoking cessation in primary care and other settings. NICE Public Health Intervention Guidance no. 1. March 2006
- NCSCT local stop smoking services: service and delivery guidance. NCSCT. 2014. September 2014

4.2 Weight management

Preventing and managing obesity is complex. Where an individual's weight status and/or their waist circumference is a key risk factor, advice or onward referral should be provided in line with the NICE clinical guidelines CG43 on the prevention, identification, assessment and management of overweight and obesity in adults and children. Where

the individual's weight status is not a risk factor, it is still an opportunity to reinforce the benefits of healthy eating and being physically active.

When providing advice around weight management or referring individuals on to more long-term interventions, it will be important to take a individualalised approach, including consideration of an individual's individualal characteristics (age, ethnicity, gender, lifestyle etc). This may require consideration of factors including an individual's:

- willingness and motivation to change
- particular barriers to lifestyle change (for example, lack of time or knowledge)
- self-esteem
- current levels of fitness
- the views of family and community members

Local areas may have their own care pathway for overweight and obesity in adults, involving different tiers of services, in line with NICE guidance.

Any advice or more sustained lifestyle interventions on weight management provided as part of the risk management element of the check should comply with the NICE overweight and obese adults lifestyle weight management guidance.

In addition, the individual's alcohol intake could be considered as part of any discussion about energy intake, and the opportunity used to highlight links between alcohol intake and obesity with liver disease.

Additional guidance

- Obesity: guidance on the prevention, identification, assessment and management of overweight and obesity in adults and children. NICE guideline CG43. December 2006
- BMI: preventing ill health and premature death in black, Asian and other minority ethnic groups. NICE guideline PH46. July 2013
- Overweight and obese adults – lifestyle weight management. NICE guideline PH53. May 2014
- Obesity: identification, assessment and management of overweight and obesity in children, young people and adults . NICE guideline CG189. November 2014
- Lipid modification: Cardiovascular risk assessment and the modification of blood lipids for the primary and secondary prevention of cardiovascular disease. NICE clinical guideline 181. July 2014

4.3 Physical activity interventions

The UK Chief Medical Officers recommend that all adults should aim to be active daily. Activity should add up to at least 150 minutes of moderate intensity activity in bouts of ten minutes or more over a week. One way to approach this is to do 30 minutes at least five days a week. Alternatively, comparable benefits can be achieved through 75 minutes of vigorous intensive activity spread across the week, or a combination of moderate and vigorous intensity activity. They should also do muscle strengthening exercises on two days each week. It should be emphasised that all adults should minimise the amount of time spent being sedentary (sitting) for extended periods.

Key points: if a individual is identified as not achieving these levels, practitioners should offer a brief intervention to increase physical activity as follows:

- provide physical activity advice, taking into account the individual's needs, preferences and circumstances, and agreeing goals
- provide written information about the various types of activities and the local opportunities to be active
- where appropriate, offer a referral to an exercise referral programme
- follow up at appropriate intervals over a three to six-month period

Additional guidance

- Start Active, Stay Active. A report on physical activity for health from the four home countries' Chief Medical Officers. Department of Health. July 2011
- Physical activity benefits for adults and older adults. Department of Health, October 2015
- Exercise referral schemes to promote physical activity. NICE public health guidance 54. PH54 September 2014
- Physical activity: brief advice for adults in primary care. NICE public health guidance 44. May 2013. The recommendations supersede recommendations 1-4 in four commonly used methods to increase physical activity, NICE Public Health Guidance 2
- Four commonly used methods to increase physical activity: brief interventions in primary care, exercise referral schemes, pedometers and community-based exercise programmes for walking and cycling. NICE Public Health Intervention Guidance 2. March 2006
- Let's Get Moving. A physical activity care pathway Commissioning Guidance. March 2012
- Everybody Active, Every Day: An evidence-based approach to physical activity. PHE. 2014

4.4 Alcohol use interventions

The UK Chief Medical Officer recommends that men and women do not drink regularly more than 14 units a week. If a individual is consuming up to 14 units a week, it is best to spread this over three days or more, but also have drink free days.

Key points: local authorities may wish to consider how individuals identified as drinking alcohol above lower risk levels (an AUDIT score at or above eight) can be offered advice to reduce their alcohol use. This would be considered an appropriate measure to improve the health of the people in its area and a way to discharge its general duty to take steps to improve public health.

Advice to reduce alcohol use is an essential part of helping people manage the risk alcohol poses to their health and the risk of developing disease in the future. Evidence suggests this advice is most effective when delivered immediately or as soon as possible after the AUDIT assessment – the 'teachable moment'. This advice can take as little as five minutes and consists of:

- understanding alcohol units – ensuring the individual understands how much they are drinking
- understanding risk levels – explaining the lower-risk guidance and how the health risk rises above this level
- informing them of their level of risk – informing the individual of their AUDIT score (a mandatory requirement), what risk level this indicates and where their risk level compares to the rest of the population
- benefits of cutting down – explain some of the benefits that could come from reducing their alcohol consumption.
- tips for cutting down – providing the individual with a menu of things they could try to cut back on their alcohol consumption

This brief advice could be supported by an information leaflet or booklet given to the individual to reinforce the brief advice given and for future use.

Providing information and brief advice on lower risk drinking is also recommended as part of the guidance on lifestyle interventions within the NICE clinical guideline on hypertension and NICE public health guidance on preventing harmful drinking. It is also a topic likely to be raised in discussing lifestyle issues as part of this programme.

If the individual's AUDIT score is 20 or more, this may indicate alcohol dependence and consideration can be given to referring the individual to more structured alcohol treatment services for a full assessment and any necessary treatment. Those wanting to stop drinking who are experiencing difficulty should be considered for referral to specialist services using locally agreed referral methods. This referral can be made from the NHS Heath Check provider or from the individual's GP.

Additional guidance

- Alcohol Guidelines Review – Report from the Guidelines development group to the UK Chief Medical Officers. DoH. January 2016
- Alcohol-use disorders - preventing harmful drinking. NICE Public Health Guidance 24, June 2010
- Alcohol Identification and Brief Advice e-Learning course
- Primary Care Service Framework: Alcohol Services in Primary Care. NHS. May 2009

Chapter 5. Risk management: secondary prevention in primary care

5.0 Introduction

The NHS Health Check programme is a public health programme aimed at prevention of disease by supporting lifestyle change and by detecting and managing physiological risk factors for disease. It will therefore identify individuals who have undiagnosed conditions such as hypertension or chronic kidney disease and people who are at high risk of developing cardiovascular disease or diabetes. These individuals will require additional clinical assessment and follow up and this is the responsibility of primary care. Figure 5 illustrates the prevention pathway as it flows through primary care.

This section provides advice and guidance on best practice clinical follow up and assessment that may be triggered by the NHS Health Check risk assessment.

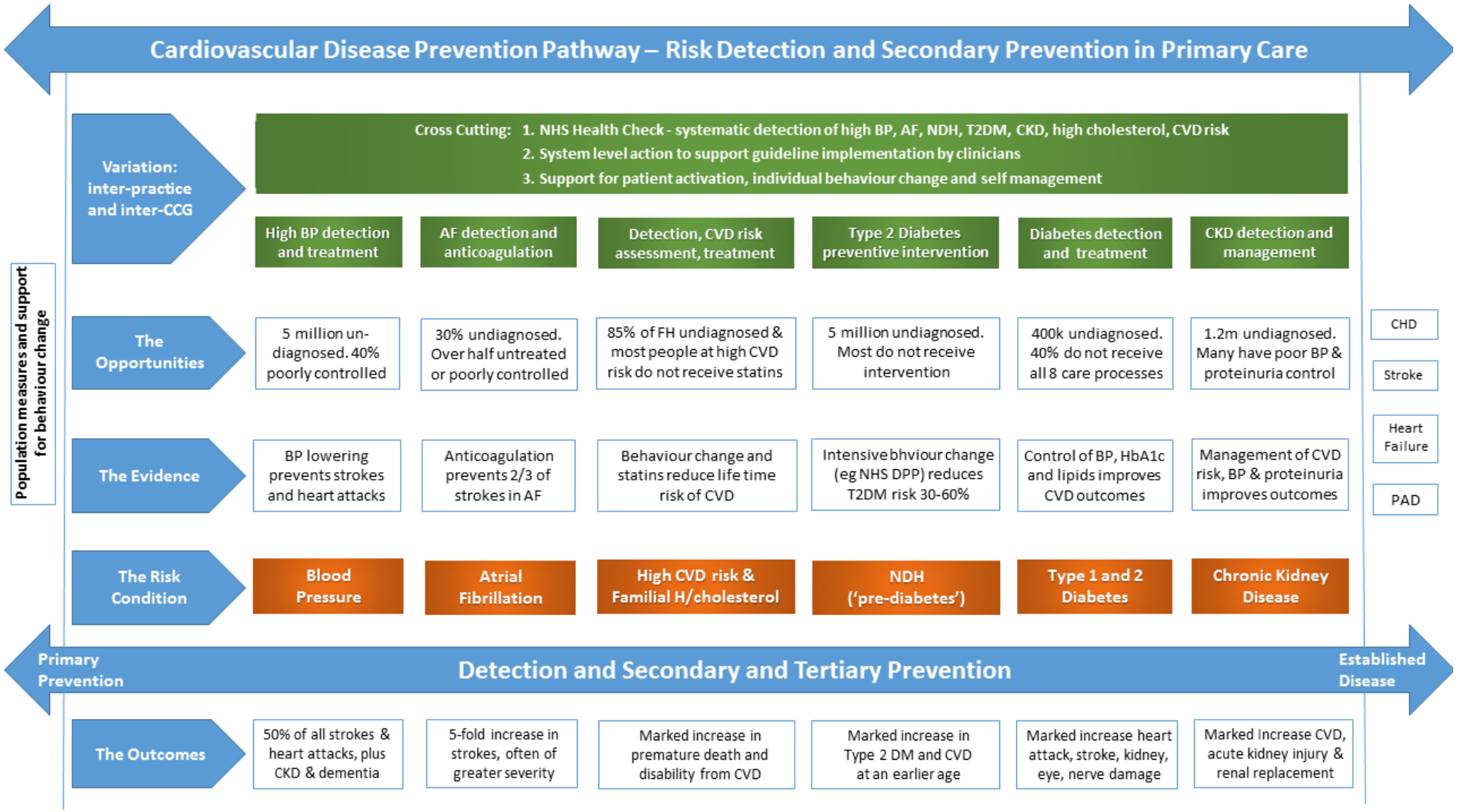
5.1 Managing those with high cardiovascular risk

Cardiovascular disease (CVD) risk should be communicated using everyday, jargon-free language. People should be offered information about their absolute risk of CVD and about the absolute benefits and harms of an intervention over a ten-year period. NICE guidance advises that:

- the decision whether to start statin therapy should be made after an informed discussion between the GP or nurse and the individual about the risks and benefits of statin treatment, taking into account additional factors such as potential benefits from lifestyle modifications, informed patient preference, comorbidities, polypharmacy, general frailty and life expectancy
- people with a 10% or greater ten-year risk of developing CVD should be offered appropriate lifestyle advice and behaviour change support in relation to increasing physical activity, smoking cessation, safe alcohol consumption and healthy diet
- people with high CVD risk should be advised that the potential benefits from lifestyle modifications will also reduce their risk of dementia
- where lifestyle modification has been ineffective or is inappropriate, people with a 10% or greater ten-year risk of developing CVD should be offered statin therapy for the primary prevention of CVD

Key point: individuals that are either prescribed a statin or have a CVD risk score ≥20% should exit on to an at risk register (figure 2).

Figure 5. Cardiovascular disease prevention pathway



5.2 Cholesterol

Risk threshold for primary prevention: Level of risk should be estimated using the QRISK2 assessment tool. Atorvastatin 20 mg should be offered for the primary prevention of CVD to people who have a 10% or greater ten-year risk of developing CVD.

Secondary prevention: The NICE lipid modification guideline recommends commencing statin treatment with atorvastatin 80 mg in people with diagnosed CVD. However, a lower dose of atorvastatin is recommended if any of the following apply: potential drug interactions; high risk of adverse effects; patient preference. NICE recommends measuring total cholesterol, high density lipoprotein (HDL) cholesterol and non HDL cholesterol in people who have been started on high intensity statin treatment at three months of treatment, aiming for > 40% reduction in non HDL cholesterol.

Related stages of the check: Individuals diagnosed with high cholesterol should be treated through appropriate care pathways and measures, as recommended by NICE. The NICE guideline provides recommendations on the management of people diagnosed with high cholesterol, including:

- communication about risk assessment and treatment options
- lifestyle modifications for the primary and secondary prevention of CVD, including advice on:
    - cardioprotective diet
    - physical activity
    - combined interventions of diet and physical activity
    - weight management
    - alcohol consumption
    - smoking cessation
    - lipid modification therapy options

Additional guidance

- Lipid modification: Cardiovascular risk assessment and the modification of blood lipids for the primary and secondary prevention of cardiovascular disease. NICE clinical guideline CG181. July 2014

Familial hypercholesterolaemia

Threshold: NICE recommends that people found to have a total cholesterol of >7.5 mmol/L should be assessed by general practice for familial hypercholesterolaemia (FH).

Related stages of the check: Follow up treatment, including referral for specialist testing and treatment, should be considered in line with the NICE guidance. Further NICE recommendations on diagnosis, identification of people with FH using cascade

testing, management of patients, and information needs and support should also be considered.

Additional guidance

- Identification and management of familial hypercholesteroalemia. NICE clinical guideline CG71. August 2008

5.3 Assessment for hypertension

Threshold: ≥140/90mmHg: if the individual has a blood pressure at, or above,140/90mmHg, or where the SBP or DBP exceeds 140mmHg or 90mmHg respectively, the individual requires an assessment for hypertension by the GP practice team.

Related stages of the check: individuals found to have high blood pressure will need further assessment to diagnose hypertension. This is the responsibility of the GP or primary care nurse. Where diagnosis is confirmed, the individual should be added to the hypertension register and treated in line with NICE guidelines. Once diagnosed with hypertension, individuals should not be recalled as part of the NHS Health Check programme.

When blood pressure is found to be high, discussions about possible hypertension diagnosis and management may raise questions about the relationship between lifestyle and blood pressure management. Such discussion will normally take place as part of the further hypertension assessment or once a patient is placed on the hypertension register. It will however be useful for practitioners to be aware of the lifestyle interventions recommended in the NICE guideline on hypertension:

- ask people about their diet and exercise patterns, and offer guidance and written or audiovisual materials to promote lifestyle changes
- ask people about their alcohol consumption and encourage them to cut down if they drink excessively
- discourage excessive consumption of coffee and other caffeine-rich products
- encourage people to keep their salt intake low or substitute sodium salt
- offer people who smoke advice and help to stop smoking
- tell people about local initiatives (for example, run by healthcare teams or patient organisations) that provide support and promote lifestyle change
- do not offer calcium, magnesium or potassium supplements as a method of reducing blood pressure
- relaxation therapies can reduce blood pressure and people may wish to try them. However, it is not recommended that primary care teams provide them routinely

Additional guidance

- Hypertension: clinical management of primary hypertension in adults. NICE clinical guideline 127. August 2011

5.4 Assessment for chronic kidney disease

If the individual has a blood pressure at or above 140/90mmHg, or where the SBP or DBP exceeds 140mmHg or 90mmHg respectively, the individual requires further assessment to confirm the diagnosis of chronic kidney disease. This is the responsibility of the GP or primary care nurse.

Data required: SBP and DBP.

Threshold: ≥140/90mmHg.

Diagnosing chronic kidney disease

Data required: the results of a serum creatinine test should be used to calculate the estimated glomerular filtration rate (eGFR) in order to assess the level of kidney function, and recorded on the individual's patient record.

Threshold: eGFR<60ml/min/1.73m^2 or ≥60ml/min/1.73m$^{2..}$
Where eGFR is **above or equal to 60ml/min/1.73m^2**, no further assessment is required, unless the individual is diagnosed with hypertension or diabetes mellitus. In this case, their risk of kidney disease will be monitored as part of the management of their hypertension and/or diabetes.

<60ml/min/1.73m^2
Where eGFR is **below 60ml/min/1.73m^2**, further assessment for chronic kidney disease is required in line with NICE clinical guideline 182 on chronic kidney disease. In people with a new finding of reduced eGFR, the eGFR should be repeated within two weeks to confirm that it is abnormal. This is the responsibility of the GP or primary care nurse.

Key points: a venous blood sample is required for this test. NPT is not considered appropriate. A serum creatinine test should be requested from the laboratory. This can be requested at the same time as a cholesterol test from the laboratory (if NPT is not used to assess cholesterol).

Additional guidance

- Chronic kidney disease: early identification and management of chronic kidney disease in adults in primary and secondary care. NICE clinical guideline 182. July 2014

- Hypertension: clinical management of primary hypertension in adults. NICE clinical guideline 127. August 2011
- Lipid modification: Cardiovascular risk assessment and the modification of blood lipids for the primary and secondary prevention of cardiovascular disease. NICE clinical guideline 181. July 2014

5.5 Identifying individuals with an irregular pulse

Individuals found to have an irregular pulse require further assessment to determine if atrial fibrillation is present. This is the responsibility of the GP or primary care nurse and assessment will include an ECG to confirm the rhythm. If atrial fibrillation is diagnosed the individual should be managed in line with NICE guidance.

Additional guidance

- Atrial fibrillation: management. NICE clinical guideline 180. June 2014

5.6 Management of people found to have abnormal fasting blood sugar or HbA1c

Threshold: If the individual's fasting blood glucose (≥7mmol/l) or HbA1c (≥48 mmol/mol) is above the threshold for diabetes and the individual has no symptoms.
Key points: refer the individual non urgently to the GP practice for a repeat blood test and further assessment. They should be told that the results suggest that they may have diabetes but that they require further investigation.

Threshold: If the individual's fasting blood glucose (≥7mmol/l) or HbA1c (≥48 mmol/mol) is above the threshold for diabetes and the individual has symptoms to suggest diabetes.
Key points: refer the individual to the GP practice on the same or next day. They should be told that the results suggest that they may have diabetes but that they require further investigation urgently.

Threshold: If the 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.
Key points: the individual may have non diabetic hyperglycaemia and should be referred to the GP practice non urgently for a repeat blood test and further assessment. They should be told that the results suggest that they may be at increased risk of diabetes and that they require further investigation.

Additional guidance

- Type 2 diabetes: The management of type 2 diabetes. NICE clinical guideline 87. May 2009

- Diabetes in adults quality standard. NICE quality standard 6. March 2011
- Preventing type 2 diabetes: risk identification and interventions for individuals at high risk. National Institute for Health and Care Excellence. 2012
- Chronic kidney disease: early identification and management of chronic kidney disease in adults in primary and secondary care. National Institute for Health and Care Excellence. 2014
- Lipid modification: Cardiovascular risk assessment and the modification of blood lipids for the primary and secondary prevention of cardiovascular disease. NICE clinical guideline 181. July 2014

5.7 Non-diabetic hyperglycaemia (NDH)

Threshold: 42mmol/mol (6%) to 47mmol/mol (6.4%), see figure 2.

Key points: around five million people in England are thought to be at high risk of type 2 diabetes. There is very robust evidence that intensive lifestyle interventions in these individuals substantially reduces the risk of developing diabetes. As it rolls out, the new NHS Diabetes Prevention Programme will offer these intensive interventions that support people to lose weight, to increase physical activity and to eat more healthily.

Chapter 6. Communications, marketing and branding

6.0 Introduction

PHE has developed several means of sharing resources and communicating with commissioners, local councillors and members of the public. We encourage everyone involved in the programme to engage with us and we welcome the opportunity to share and showcase locally developed materials which may help to inspire and drive innovation elsewhere. Some useful tools and resources are described below.

6.1 PHE communications

The programme has a dedicated national website www.healthcheck.nhs.uk which is aimed at commissioners, providers and local government. Content is freely available, registration is required to access the discussion forum. All new information and resources are published on the website to support commissioners and providers with the delivery of the programme.

PHE also sends out an NHS Health Check e-bulletin every two months. The bulletin shares the latest news on the programme, you can subscribe here.

The NHS Health Check team also uses Twitter, Facebook and LinkedIn to promote the programme and respond to stakeholder comments..

6.2 Marketing and branding

In the development of the NHS Health Check branding, market research showed that the NHS brand has a high impact on engagement with the public and provides a fundamental sense of reassurance about the service. It also helps to differentiate it from other commercially available health checks. This research also found no evidence that local authority branding, on its own, encouraged public engagement with the NHS Health Check.

The findings from this work underpin PHEs NHS Health Check marketing and branding resources, which include:

- NHS Health Check identity guidelines designed to provide the information needed to produce effective local NHS Health Check materials
- templates for press advertising, posters, letters, presentations and roller banners

- an image bank which includes photos that are free to use in local NHS Health Check campaigns
- a PR toolkit

These materials are free to use and should be applied within the brand guidelines.

6.3 Patient information

PHE has developed a patient information leaflet that can be used to accompany the invitation letter. This sets out the aims of the NHS Health Check and what a participant can expect at their appointment. It also explains the risk factors associated with vascular disease. It is available to order or download from our website in a variety of languages and accessible formats.

The national NHS Health Check team is working closely with the behavioural insights team within PHE to identify approaches that will help to encourage more people to have a check. Findings from the Medway and Southwark studies show that a shorter invitation letter with a deadline does increase take up. The Southwark study also shows that text message prompts and reminders can enhance take up further. This is why we've changed the national letter template.

PHE also makes available a dementia awareness leaflet that practitioners can use with people between 64 and 75 years. Copies of the recently updated leaflet can be ordered or downloaded.

6.4 NHS Choices

The NHS Choices website provides public facing information on what to expect from an NHS Health Check and what to do after having a check. It also includes a service directory that provides information on where individuals can get a check in their area. Commissioners can request that information on their service is listed on the directory or make updates to existing listings by contacting nhshealthchecks.mailbox@phe.gov.uk

A heart age calculator is also available on NHS Choices and, where appropriate, will prompt users to have an NHS Health Check. If you encounter a technical error on the service directory page on the NHS Choices website, email the NHS Choices service directory team choicesdirectories@nhschoices.nhs.uk

All NHS Health Check content (including videos, links and apps) on NHS Choices is available to stream onto any website, for free, providing an easy way to keep public information on the programme up to date on your own website. Visit the NHS Health Check website to find out more or complete the registration form and a member of the NHS Choices team will contact you to talk through the process.

Chapter 7. Delivering a high quality service

7.0 Raising delivery standards

Programme standards have been developed with extensive input from local authorities to support local commissioners in assuring themselves of the quality of the service(s) they commission. They will also be of help to providers of the NHS Health Check programme in order to monitor service delivery and ensure continuous improvement in quality.

Building on this work the NHS Health Check team 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 adopts a systems approach involving key internal and external partners and so 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

If you are interested in attending a one day introduction to the framework, please email nhshealthchecks.mailbox@phe.gov.uk

7.1 Workforce competencies

The NHS Health Check competence framework outlines the core and technical competences required of people carrying out NHS Health Checks. The competence framework makes use of National Occupational Standards (NOS) which describe the skills, knowledge and understanding needed to undertake a particular task or job to a nationally recognised level.

The competence framework provides a template for minimum standards when commissioning or creating training packages for people who deliver the NHS Health Check. The competences and their underpinning criteria should be used to identify the training requirements for people involved in delivering the NHS Health Check

programme. Free e-learning courses on how to conduct an NHS Health Check and support behaviour change are available here.

Competence workbooks

The learner workbook guides people who are delivering the NHS Health Check on the learning outcomes and the types of assessments required to progress towards full competence against the competence framework. It can be used as a way of keeping record of the learning undertaken in each unit and for gathering evidence to demonstrate full competence of delivering an NHS Health Check.

The assessor workbook describes the role of the assessor, working with the learner to review existing competences and assessment principles. It can also act as a tool to identify potential gaps in internal assessments and existing training. The assessment is usually done in-house, by the employing organisation but could be carried out via a college or other programme of study.

7.2 Dementia training tool

The dementia training tool is for individuals providing the NHS Health Check and includes a self-assessment section, which will then provide a certificate of completion.

Providers must complete each module in its entirety before progressing to the next one and it is not possible to skip through the video. With this in mind, providers should plan to complete the training in one session. The module may not work on older internet browsers, so an up to date browser is required to ensure full functionality.

7.3 Alcohol resources

The Alcohol Learning Centre provides online resources and learning for commissioners, planners and practitioners working to reduce alcohol-related harm. It contains alcohol specific documents, guidance and tools, examples of alcohol harm reduction initiatives across England and provides training resources to support frontline practitioners and commissioners.

Links to the AUDIT and FAST risk assessment tools and to information leaflets are provided on the NHS Health Check website to support the risk assessment and delivery of brief advice on alcohol consumption. There are also short, free E-learning modules on alcohol identification and brief advice.

7.4 Conference, case studies and webinars

A national NHS Health Check conference is held every year. The conference is an opportunity to hear about latest developments with both workshops and a marketplace showcasing services that are helping to deliver successful local programmes. Details on all NHS Health Check events can be found here.

PHE, in partnership with NHS England, publishes a number of case studies each year. The aim of these case studies is to share learning between local authorities on different delivery models and to encourage commissioners to think creatively about engagement with key segments of the population.

PHE runs a regular programme of webinars which complement the suite of case studies, as well as addressing key topics of interest to commissioners and providers of the programme. More information is available here.

Chapter 8. Programme governance

8.0 Introduction

As part of its leadership function PHE has established a governance structure for the programme. In the interests of transparency, this structure and the functions and key responsibilities of each committee and sub-group, how frequently they meet and the deliverables they are responsible for, are all published on the national website**.** For convenience, they are detailed below.

8.1 Governance structure

NHS Health Check national advisory committee
The NHS Health Check national advisory committee (NAC) is responsible to Secretary of State for Health and has been established to oversee the implementation of the NHS Health Check programme which is set-out in The Local Authorities Public Health Functions and Entry to Premises by Local Healthwatch Representatives Regulations 2013**.**

This committee provides a national executive forum for the NHS Health Check programme, acting in an advisory capacity to oversee successful roll-out, maintenance, evaluation and continued improvement based on emerging evidence

NHS Health Check national steering group

The NHS Health Check national steering group (NSG) is accountable to the NHS Health Check national advisory committee (NAC). The group has been established to advise the NAC on the progress and performance on the delivery of PHE's annual NHS Health Check work plan and that of the sub groups.

The NSG is responsible for monitoring performance and progress against PHE's national delivery plan. The group provides a robust check and challenge function to support the sub-groups in delivering key commitments to time, quality and cost.

Expert scientific and clinical advisory panel

The expert scientific and clinical advisory panel (ESCAP) is an expert forum for the NHS Health Check programme, acting in an advisory capacity to keep the content and evidence underpinning the programme under review.

Data, intelligence and information governance subgroup

The data, intelligence and information governance (DIIG) subgroup ensures robust information governance processes are in place to support effective implementation of the NHS Health Check programme.

PHE regional and centre leads NHS Health Check sub-group

The PHE regional and centre leads NHS Health Check sub-group ensures effective matrix working and communication on the NHS Health Check programme by PHE's national, regional and centre teams to support programme delivery.

Local implementer national forum

The local implementer national forum brings together groups of local authority implementers delivering the NHS Health Check programme and relevant PHE teams to ensure effective and frequent dialogue and communication on key priorities for the programme.

8.2 Content review process

As the NHS Health Check programme has become established it is recognised that the benefits of the programme might be extended to other areas. This has led to requests for removing, amending or introducing new elements to the programme.

PHE recognises the importance of considering proposals to change the NHS Health Check programme and the need to have a robust case underpinning any such request. In 2014 ESCAP agreed a robust content review process which will support them in making evidence-based recommendations to the Department of Health and ministers on possible changes to the programme. You can find more information and guidance here.

Chapter 9. Quarterly data return

9.0 Overview

The NHS Health Check is one of the components of the single data list (ref 254-00) which is a list of all the datasets that local government must submit to central government. As a result, local authorities have a statutory duty to provide data for each financial quarter on:

a. the number of NHS Health Checks **offered**
b. the number of NHS Health Checks **received**

PHE manages the NHS Health Check data return process via the NHS Health Check website. The data return portal opens a month before the submission deadline and the nominated individual in each local authority is required to make the data return. Annex B details exactly how to input the data into the reporting tool.

The data returned is treated as an official statistic and is quality assured following submission. It is then published every three months according to the timetable set out on the official statistics website and on the NHS Health Check website. Data is also published on Fingertips, Healthier Lives and as three indicators on the Public Health Outcome Framework to allow national and local comparisons.

Information governance and data flow

Data flow between parties involved in the NHS Health Check programme is subject to the Data Protection Act and information governance rules, more information is available on the Information Commissioner's Office website. It is lawful and appropriate to move the data in the manner described for the NHS Health Check, so long as all stated processes are complied with. There should be no impediment to moving data safely between parties who require the data.

In all cases, the GP will remain as the or joint data controller, a legally defined role with significant responsibilities. Commissioners should continue to recognise this responsibility when negotiating with GP colleagues. Unless explicit consent has been gained from patients, only anonymised information may flow back to the local authority from the GP practice.

The actual process and requirements of securing data is subject to change, readers are therefore directed to the NHS Health Check website to review the Information Governance and Data Flows Pack. It is the responsibility of those storing or moving data to ensure that all systems required are in place and up to date.

9.1 Data return timetable

For Quarter 1, 2 and 3, data returns need to be submitted via the reporting tool by **midday** of the last working day of the month following the quarter to be reported; to allow reconciliation of discrepancies at the end of the financial year, more time is allowed for the submission of Quarter 4 data (Table 2).

Table 2. Access to the data portal

Financial quarter:	Q1 Apr–Jun	Q2 Jul–Sept	Q3 Oct–Dec	Q4 Jan–Mar
Portal opens on the first working day of:	July	October	January	April
Data return required on:	Last working day of July	Last working day of October	Last working day of January	Mid-May

9.2 Before submitting the data

Nominated individual

The individual submitting data on behalf of a local authority must be formally nominated by the director of public health (DPH) of the local authority. To nominate an individual a request must be sent to nhshealthchecks.mailbox@phe.gov.uk, the DPH must return a signed form confirming the change to the nominated individual. If public health functions are shared across several local authorities, a named individual may submit data on behalf of more than one local authority. Where there is a change to the nominated individual returning the data the local authority must contact PHE well in advance of the deadline to request a change in nominee form.

Data definitions

An NHS Health Check offer is defined as the number of offers or invitations made for an NHS Health Check within a single quarter. Include in the count:

- the first written or telephone invitation made in the five-year cycle to an eligible individual
- NHS Health Checks which have been requested by the patient, ie, no formal ‘offer’ was made, but the patient was eligible, had not been offered a NHS Health Check in the five-year cycle and had requested a NHS Health Check
- NHS Health Checks which have been delivered after having been offered opportunistically, where the individual was eligible and had not been offered a NHS Health Check in the five-year cycle

Any subsequent invitations, prompts or reminders within the five year cycle should **not** be counted as part of the data return to PHE.

NHS Health Checks received is defined as the number NHS Health Checks delivered by providers in a single quarter. Include in the count the:

- people meeting the eligibility criteria that had a NHS Health Check within the five-year cycle

People who have had an NHS Health Check but do not meet the eligibility criteria set out in the best practice guidance should **not** be included in the count. Eligible people that have had more than one check in a five-year cycle should only be counted as having received an NHS Health Check once in that period.

Quality assuring local data

To help ensure that the data submitted to PHE is accurate and of a good quality, commissioners can implement local data quality assurance processes. This should include introducing standard codes for providers to record activity against when they deliver the service.

On receipt of the data from the provider local authority officials can also use the following prompts and questions to help identify any errors or problems with the data before submitting it to PHE.

Are the numbers of offers and/or received NHS Health Checks very different from previous data?
Have all the providers returned their data?
Has the number of providers changed? Has a provider ceased to deliver the programme?
Is there a planned change to the way the programme is being delivered?
Do the providers routinely concentrate their activity in one quarter? Or in one part of the year?
Are values similar to the same quarter last financial year? Do providers tend to concentrate their activity at the beginning/end of the year?

Is the number of offers higher than expected; number received is as expected?
Have repeated offers been wrongly counted as ‘offers’? (see FAQs)
Do providers routinely send all offers in one quarter?

Is the number of NHS Health Checks received higher than the number of offers?
Have the numbers for offers and received been mixed up?
Have the number of NHS Health Checks received opportunistically been counted towards the total number of offers?

Is the number of offers and received higher than expected?
Are non-eligible individuals being offered an NHS Health Check?
Are the different assessments completed as part of the check being counted as individual NHS Health Checks, eg, taking blood pressure without the other elements of the check being completed?
Are people who have already received a NHS Health Check being offered another check before the end of the five-year cycle?
Have providers returned data for activity done in more than one quarter?

Is the number of offers and received lower than expected?
Have all providers returned their activity data for the quarter?
Have the number of providers changed? Has one provider ceased to deliver the programme?
Has there been a planned change to the way the programme is delivered?
Do the providers concentrate their activity in one quarter or in one part of the year?
Are values similar to the same quarter last financial year? Do providers tend to concentrate their activity at the beginning/end of the year?

Local authorities who still have concerns about the data after having done the above checks might want to discuss with the quality assurance (QA) lead in the clinical commissioning group (CCG). CCG QA leads might be able to support local primary care providers of NHS Health Checks for example by providing advice on the best way to carry an audit of their data.

9.3 Submitting the data

To facilitate the return of data PHE provide a secure data portal. Data must be submitted by the nominated individual in the local authority, see section 9.2. To log-in, the nominated individual will need to enter their email address, username (local authority name) and password.

Once logged in click on ‘Submit data’ link under Quarterly NHS Health Check Data submission type. The webpage will then show two input boxes, one for NHS Health Checks offered and one for NHS Health Checks received. To eliminate the risk of typing error, each number must be entered into the relevant input box twice. For a step by step guide on how to do this include screenshots see annex B.

9.4 After the data has been submitted

The data that PHE receives from local authorities goes through five stages of quality assurance:

Stage 1: the data portal performs an automated validation to ensure that the data entered is in the correct format. To eliminate the risk of a data entry error, each number must be entered twice.
Stage 2: routine quality checks are undertaken on the data set by PHE analysts
Stage 3: local authority level data are plotted using Spiegelhalter control chart methodology (modified by Laney to handle the effect of over dispersion) and statistically significant variation is identified.
Stage 4: other checks on local authority data include comparing it to: the expected values, the England average and previously submitted data. These thresholds have been agreed by the NHS Health Check Data Intelligence and information governance group. Unexpected trend or changes are also identified and explored.
Stage 5: All outputs, ie, calculations, graphs, and reports are reviewed by a second analyst.

Local authorities that have submitted data which does not comply with the data quality checks will be contacted by PHE analysts. PHE analysts will:

- liaise with the local authority to try and resolve any data query prior to the publication deadline
- retain a record of local authority data quality issues
- review and reference local authority data quality issues raised in previous quarters if necessary

Data publication

As an official statistic, the exact dates of NHS Health Check quarterly data publication must be publicly announced in advance on the UK national statistics publication hub. Publication dates are also announced on the online portal.

The data will be published four weeks after the portal has closed. Once data is published, the formulae in the reporting tool calculate the percentage of invitations offered and received, and the take-up rate for each quarter. As the year progresses, the quarterly data are aggregated to show cumulative data and this will be shown as annual and five yearly totals.

Below is a worked example of the calculations behind the data returns:

A	C	D	E	F = D/C*100	G = E/C*100	H = E/D*100
Total population aged 40-74	Eligible population (see table 3)	Number of NHS Health Checks offered	Number of NHS Health Checks receive d	% of NHS Health Checks offered	% of NHS Health Checks received	% Uptake of NHS Health Checks
22,413	15,494	7,000	4,000	45.18%	25.8%	57.1%

The full dataset can also be downloaded from the online portal.

Other online tools displaying the data are listed below:

fingertips.phe.org.uk/profile/nhs-health-check-detailed/data
Activity data by quarter, by year as well as cumulative figures are presented on this tool. Trend (graph) over time and benchmarking options are also available.

www.phoutcomes.info/public-health-outcomes-framework
Section 'Health Improvement' of the Public Health Outcomes Framework (PHOF): updated annually
Cumulative activity data over five years

www.nhs.uk/Service-Search/performance/Results?ResultsViewId=1016
Take up of NHS Health check by those eligible

10. Calculating the eligible population

Directors of public health will be sent details of their total eligible population in the last quarter of each financial year for the following year.

To identify the total eligible population PHE use the most recent Office for National Statistics mid-year population estimates, minus the estimated ineligible population.

The ineligible population is calculated by estimating the numbers of people already on a disease register. It is important to note that the eligible *population* is independent from the number of invitations already made during the five-year cycle. When estimating the total eligible population, a *individual* who has received a NHS Health Check in the last five years - although not eligible for re-call until 5 years after their first NHS Health Check - remains in the total eligible *population*.

The Department of Health's original modelling work estimated that 30% of the 40 – 74 year old population would not be eligible for a check, and this was applied to eligible population calculations up until 2015-16. For 2016-17 the same modelling for England will be used but the estimate will be refined to reflect the actual age-sex specific population profile of each local authority, as shown in table 3. These adjustments are identical to those used in the NHS Health Check ready reckoner.

Table 3. Proportion of ineligible individuals in each age/sex group in England

Sex	Age group	Ineligible for NHS Health Check due to pre-existing conditions
Males	40-44	8.50%
	45-49	15.08%
	50-54	23.58%
	55-59	33.29%
	60-64	44.53%
	65-69	56.69%
	70-74	66.36%
Females	40-44	8.77%
	45-49	14.04%
	50-54	21.67%
	55-59	30.60%
	60-64	40.93%
	65-69	52.76%
	70-74	62.67%

An example of how this will be applied to a local authority population is shown in annex C.

Some areas are able to identify the local eligible population by running specific searches on clinical systems. Therefore, at the time of sending out the estimated eligible population figures, PHE will invite local authorities to submit alternative eligible population numbers calculated using a local clinical system search.

Alternative eligible population figures submitted to PHE will be considered by the NHS Health Check Data Intelligence and Information Governance group. They will be evaluated against the following criteria. The:

- population selected covers the local authority geographical footprint
- clinical system search approach is clearly defined
- criteria searched for match the inclusion/exclusion criteria set up in the Public Health Functions Regulations

Alternative population figures must be submitted to nhshealthchecks.mailbox@phe.gov.uk by the **31 May** each year using the standard form sent to directors of public health by the NHS Health Check team.

Annex A. QOF indicators 2015-16

Table 4 shows where the NHS Health Check provides a mechanism for supporting primary chare in achieving 2015-16 QOF indicators.

Table 4.

Clinical area	**QOF indicator**	**QOF ID code**
Atrial fibrilation	The contractor establishes and maintains a register of patients with atrial fibrillation	AF001
Hypertension	The contractor establishes and maintains a register of patients with established hypertension	HYP001
	The percentage of patients with hypertension in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90mmHg or under	HYP006
Diabetes mellitus	The contractor establishes and maintains a register of all patients aged 17 or over with diabetes mellitus, which specifies the type of diabetes where a diagnosis has been confirmed	DM017
	The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90	DM002
	The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80mmHg or less	DM003
	The percentage of patients with diabetes, on the register, whose last measured total cholesterol (measured within the preceding 12 months) is 5mmol/l or less	DM004
	The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 59mmol/mol or less in the preceding 12 months	DM007
	The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 64mmol/mol or less in the preceding 12 months	DM008
	The percentage of patients with diabetes, on the register, whom the last IFCC-HbA1c is 75mmol/mol or less in the preceding 12 months	DM009

	The percentage of patients newly diagnosed with diabetes, on the register, in the preceding 1 April to 31 March who have a record of being referred to a structured education programme within nine months after entry on to the diabetes register	DM014
Dementia	The contractor establishes and maintains a register of patients diagnosed with dementia	DEM001
Mental health	The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of blood pressure in the preceding 12 months	MH003
	The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of alcohol consumption in the preceding 12 months	MH007
Chronic kidney disease	The contractor establishes and maintains a register of patients aged 18 or over with CKD stage 3 to 5.	CKD001
Cardiovascular disease – primary prevention	In those patients with a new diagnosis of hypertension aged 30 or over and who have not attained the age of 75, recorded betrween the preceding 1 April to 31 March (excluding those with pre-existing CHD, diabetes, stroke and/or TIA), who have a recorded CVD risk assessment score (using an assessment tool agreed with the NHS CB) of ≥20% in the preceding 12 months: the percentage who are currently treated with statins	CVD-PP001
Blood pressure	The percentage of patients aged 45 or over who have a record of blood pressure in the preceding five years	BP002
Obesity	The contractor establishes and maintains a register of patients aged 18 or over with a BMI ≥ 30 in the preceding 12 months	OB001
Smoking	The percentage of patients with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses whose notes record smoking status in the preceding 12 months	SMOK002
	The contractor supports patients who smoke in stopping smoking by a strategy which includes	SMOK003

	providing literature and offering appropriate therapy	
	The percentage of patients aged 15 or over who are recorded as current smokers who have a record of an offer of support and treatment within the preceding 24 months	SMOK004
	The percentage of patients with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses who are recorded as current smokers who have a record of an offer of support and treatment within the preceding 12 months	SMOK005

Annex B. Submitting quartly data

Step by step guide available including screenshots on the NHS Health Check website.

FAQs

Q. What if I am reporting no activity this quarter?
A. You should still log in to the data returns section of the website and enter ‘0’ in both the offered and received fields.

Q. I have incomplete data for this quarter. Should I not submit at all?
A. You should submit whatever data you have as not reporting will be recorded as a nil return.

Q. Why is the data collected prior to 2013-14 not included in the overall figures?
A. PHE have provided a link above the interactive map to historical data which is held and published by NHS England. As you are aware, local authorities have mandated statutory obligation to offer 100% of their eligible population an NHS Health Check over five years. The first reporting period for this in the Public Health Outcomes Framework is 2013-14 – 2018-19 so we have presented the data in such a way so as to reflect this.

Q. In some areas, the number of NHS Health Checks received is greater than the number of those offered? How can this be?
A. This can occasionally happen if a large number of people were invited in the previous quarter and the invites were not taken up until the next or subsequent quarters. However, we would ask all local authorities to ensure that where an NHS Health Check has been requested or offered opportunistically, it is being counted as ‘offered’. Not doing so will also affect the figures.

Q. Do we include people we have sent a second invite or employed different methods of following up such as SMS/telephone call as being offered a check in the five-year period?
A. Reminders, prompts and follow up invites to people that have already been invited for a check should not be included. An invite is ‘per individual every five years’ and second and third invites to the same individual within that time should not be included in quarterly returns. Nevertheless, PHE recommends that local authorities continue to engage and encourage people to take up the offer by whatever means they deem appropriate as it will affect overall uptake.

Q.I have received further data on checks offered and received but the data for the quarter has now been published. Do I include this in the data return for the next quarter?

A. NHS Health Checks data on appointments offered and received are published as Official Statistics, which means our process to make changes to already published data must comply with the “Code of Practice for Official Statistics”. Therefore, if inaccuracies in the data or new data is identified after the data publication will correct that data at the time of the next data publication.

To request a revision of quarter 1, quarter 2 or quarter 3 data, please present your case formally in writing to nhshealthchecks.mailbox@phe.gov.uk detailing why a complete return was not possible and clearly state both your previously submitted and newly revised figures. Following an internal approval process, PHE will amend the figures on the website when the next quarter data is formally published.

Q. I can’t log in to the data returns section. How do I reset my password?
A. As long as you are registered as the nominated individual you can click on ‘password reset’ to change the password on the log in page. If you are not the nominated individual you will need to email: nhshealthchecks.mailbox@phe.gov.uk

Q. My eligible population is wrong. How do I change it?
A. Prior to quarter 1 data submission each year, PHE will revise the estimated eligible population based on the latest ONS data. Local authorities can request that their figure is revised if they are able to evidence that a search of local clinical systems has been undertaken. This request needs to be completed and returned for review by the national team no later than the end of May. The total eligible population cannot be changed once quarter 1 data has been submitted.

Q. When are the dates for each quarterly return?

Please data return timetable in this document or the NHS Health Check website.

Annex C. Eligible individuals

Local authorities have a statutory obligation to make arrangements for everyone eligible aged 40 to 74 to be offered a NHS Health Check once in every five years and, where people remain eligible, for them to be recalled for another check every five years after that.

Those diagnosed with the following are excluded from the programme:

- coronary heart disease
- chronic kidney disease (CKD)[13]
- diabetes
- hypertension
- atrial fibrillation
- transient ischaemic attack
- hypercholesterolaemia
- heart failure
- peripheral arterial disease
- stroke

Are also excluded from the programme:

- people being prescribed statins
- people who have previously been found by the health service in England to have a 20% or higher risk of developing cardiovascular disease over the next ten years, are excluded from the programme. This is because these patients' condition is presumed to be being managed via other routes.

The read codes corresponding to these criteria are available here and on the NHS Health and Social Care Information Centre website

Using dummy data in column (iii) in table 4 below demonstrates step by step how the total eligible population will be calculated. The final figure sent by PHE to the director of public health of this hypothetical local authority would be: 15,494

[13] Stage 3, 4 or 5 of CKD within the meaning of the National Institute for Health and Clinical clinical guideline 73 on Chronic Kidney Disease, published in September 2008.

Table 4.

Sex	**Age group**	**(iii) Estimated number of individuals in the age/sex group** (based on latest ONS mid-year estimate)	**(iv) Estimated number ineligible for NHS Health Check** due to pre-exisiting conditions
Male	40-44	1,878	=1,878 x 0.085 = 159.6
	45-49	1,940	=1,940 x 0.1508 = 292.6
	50-54	1,793	=1,793 x 0.2358 = 422.8
	55-59	1,540	=1,540 x 0.3329 = 512.7
	60-64	1,440	=1,440 x 0.4453 = 641.2
	65-69	1,420	=1,420 x 0.5669 = 805.0
	70-74	999	=999 x 0.6636 = 662.9
Female	40-44	1,912	=1,912 x 0.0877 = 167.7
	45-49	1,986	=1,986 x 0.1404 = 278.8
	50-54	1,825	=1,825 x 0.2167 = 395.5
	55-59	1,575	=1,575 x 0.306 = 482.0
	60-64	1,500	=1,500 x 0.4093 = 614.0
	65-69	1,498	=1,498 x 0.5276 = 790.3
	70-74	1,107	=1,107 x 0.6267 = 693.8
TOTAL		**22,413**	**6,919**
Estimated total eligible population = 22,413 - 6,919 = 15,494			

Annex D. NHS Health Check guidance and resources

Programme standards

- NHS Health Check programme standards **–** Feb 2014

Training, development and learning

- NHS Health Check competence framework – June 2014
- case studies
- dementia training tool
- e-learning

Information governance and data

- **NHS Health Check IG and data flows pack** – Feb 2014
- NHS Health Check single data list returns guide – Oct 13 refresh – Oct 2013

Background and evidence

- ready reckoner tool – V.9 28th May 2014
- **NHS Health Check: our approach to the evidence** – July 2013
- **Living well for longer: a call to action to reduce avoidable premature mortality** – March 2013
- NHS Health Check programme impact assessment
- economic modelling for the NHS Health Check programme
- costs and benefits of implementing the NHS Health Check programme
- NICE guidelines on prevention of CVD

Communications, marketing and branding

- Department of Health order line for hard copies of patient information leaflets
- download NHS Health Check patient information leaflets
- download NHS Health Check dementia patient information leaflets
- national invitation letter template

Annex E. Relevant guidance

BMI

- Body mass index thresholds for intervening to prevent ill health among black, Asian and other minority ethnic groups. NICE advice LGB13. January 2014

Cholesterol test

- Lipid modification: cardiovascular risk assessment and the modification of blood lipids for the primary and secondary prevention of cardiovascular disease. NICE clinical guideline 181. July 2014
- Familial hypercholesterolaemia: identification and management**.** NICE clinical guideline 71. August 2008

Systolic and diastolic blood pressure

- Hypertension: clinical management of primary hypertension in adults. NICE clinical guideline 127. August 2011

Physical activity assessment

- Let's Get Moving: Commissioning Guidance - a physical activity care pathway. Department of Health. March 2012
- Everybody Active, Every Day: An evidence-based approach to physical activity. Public Health England. 2014

Alcohol risk assessment

- Alcohol Guidelines Review – Report from the Guidelines development group to the UK Chief Medical Officers. DoH. January 2016
- Alcohol-use disorders: preventing harmful drinking. NICE public health guideline 24. June 2010

Fasting plasma glucose (FPG)

- Use of Glycated Haemoglobin (HbA1c) in the Diagnosis of Diabetes Mellitus World Health Organization. 2011. Abbreviated Report of a WHO Consultation. WHO/NMH/CHP/CPM/11.1
- Consensus statement: Use of haemoglobin A1c (HbA1c) in the diagnosis of diabetes mellitus**.** The implementation of World Health Organisation (WHO) guidance 2011, Practical Diabetes, 2011, 1, 12a
- Preventing type 2 diabetes: risk identification and interventions for individuals at high risk. NICE public health guidance 38. July 2012
- NHS Health Check programme standards: a framework for quality improvement**.** Public Health England. February, 2014

Local stop smoking services referral

- Brief interventions and referral for smoking cessation in primary care and other settings. NICE Public Health Intervention Guidance no. 1. March 2006.
- NCSCT local stop smoking services: service and delivery guidance. NCSCT. 2014. September 2014

Weight management

- Obesity: guidance on the prevention, identification, assessment and management of overweight and obesity in adults and children. NICE guideline CG43. December 2006
- BMI: preventing ill health and premature death in black, Asian and other minority ethnic groups. NICE guideline PH46. July 2013
- Overweight and obese adults – lifestyle weight management. NICE guideline PH53. May 2014
- Obesity: identification, assessment and management of overweight and obesity in children, young people and adults . NICE guideline CG189. November 2014
- Lipid modification: Cardiovascular risk assessment and the modification of blood lipids for the primary and secondary prevention of cardiovascular disease. NICE clinical guideline 181. July 2014

Physical activity interventions

- Start Active, Stay Active. A report on physical activity for health from the four home countries' Chief Medical Officers. Department of Health. July 2011
- Physical activity benefits for adults and older adults. Department of Health, October 2015
- Exercise referral schemes to promote physical activity. NICE public health guidance 54. PH54 September 2014
- Physical activity: brief advice for adults in primary care. NICE public health guidance 44. May 2013. The recommendations supersede recommendations 1-4 in four commonly used methods to increase physical activity, NICE Public Health Guidance 2
- Four commonly used methods to increase physical activity: brief interventions in primary care, exercise referral schemes, pedometers and community-based exercise programmes for walking and cycling. NICE Public Health Intervention Guidance 2. March 2006
- Let's Get Moving. A physical activity care pathway Commissioning Guidance. March 2012
- Everybody Active, Every Day: An evidence-based approach to physical activity. Public Health England. 2014

Alcohol use interventions

- Alcohol-use disorders - preventing harmful drinking. NICE Public Health Guidance 24, June 2010

- Alcohol Identification and Brief Advice e-Learning course
- Primary Care Service Framework: Alcohol Services in Primary Care. NHS. May 2009

Cholesterol

- Lipid modification: Cardiovascular risk assessment and the modification of blood lipids for the primary and secondary prevention of cardiovascular disease. NICE clinical guideline CG181. July 2014

Familial hypercholesterolaemia

- Identification and management of familial hypercholesteroalemia. NICE clinical guideline CG71. August 2008

Assessment for hypertension

- Hypertension: clinical management of primary hypertension in adults. NICE clinical guideline 127. August 2011

Assessment for chronic kidney disease

- Chronic kidney disease: early identification and management of chronic kidney disease in adults in primary and secondary care. NICE clinical guideline 182. July 2014
- Hypertension: clinical management of primary hypertension in adults. NICE clinical guideline 127. August 2011
- Lipid modification: Cardiovascular risk assessment and the modification of blood lipids for the primary and secondary prevention of cardiovascular disease. NICE clinical guideline 181. July 2014

Management of people found to have abnormal fasting blood sugar or HbA1c

- Type 2 diabetes: The management of type 2 diabetes. NICE clinical guideline 87. May 2009
- Diabetes in adults quality standard. NICE quality standard 6. March 2011
- Preventing type 2 diabetes: risk identification and interventions for individuals at high risk. National Institute for Health and Care Excellence. 2012
- Chronic kidney disease: early identification and management of chronic kidney disease in adults in primary and secondary care. National Institute for Health and Care Excellence. 2014
- Lipid modification: Cardiovascular risk assessment and the modification of blood lipids for the primary and secondary prevention of cardiovascular disease. NICE clinical guideline 181. July 2014