Public Health England

Protecting and improving the nation's health

NHS Health Check programme standards: a framework for quality improvement

About Public Health England

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

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

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1. Introduction

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

The NHS Health Check programme standards were introduced in 2014 and have been developed for local commissioners and providers. They are not mandatory and do not introduce new targets, however they do set out aspirational but achievable programme standards where reducing variation and assessing quality is particularly important. Local application of the standards will help to ensure that local NHS Health Check services are delivered safely and to a consistently high quality at every step of the pathway.

Changes to the standards

The national standards have been reviewed in line with related NHS Health Check national guidance that has been published since the initial publication in 2014. Essentially the same ten standards apply, however within those standards there have been a number of updates and beneficial resources that will support with the implementation of them.

No.	Standard	Point on the pathway	Update
1	Identifying the eligible population and offering an NHS Health Check	Invitation and offer	There have been no changes to the legal requirement on who should be offered an NHS Health Check. Updated resources are now available including; - Patient information leaflet - National invitation letter template - Public Health Outcomes Framework (PHOF) now included
2	Consistent approach to non-responders and those who do not attend their risk assessment appointment	Invitation and offer	Updated resources now available including; - Top tips for increasing uptake
3	Ensuring a complete NHS Health Check for those who accept the offer is undertaken and recorded	The risk assessment	Updated resources now available including; - Best Practice Guidance December 2017 - Links to NHS Health Check competence framework

			- Publication of the Health Equity Audit guidance 2016 - NHS Health Check competence framework - - QRisk calculator - Best Practice Guidance November 2017
4	Equipment use	The risk assessment	No changes
5	Quality control for point of care testing	The risk assessment	No changes
6	Ensuring results are communicated effectively and recorded	Communication of results	Updated resources now available including; - QRisk calculator - Best practice guidance - NHS Health Check Competence Framework. - Training resources for communication of risk
7	High quality and timely lifestyle advice given to all	Risk management	Updated resources now available including; - Alignment to Making Every Contact Count framework. - Updated guidance for associated risk factors
8	Additional testing and clinical follow up	Risk management	Updated resources now available including: - Best Practice Guidance December 2017 - NICE clinical guidance and public health guidance updates. Updated information on: - Diabetes filter assessing individuals risk of diabetes. - NHS National Diabetes Prevention Programme
9	Appropriate follow up for all if CVD risk assessed as 20% and greater	Risk management	Changes to the NICE guidance: - CVD at risk threshold lowered from 20% to to include the revised threshold of 10%.
10	Confidential and timely transfer of patient identifiable data.	Throughout the pathway	No changes

It is recognised that these standards only focus on a limited number of points on the pathway and therefore are not themselves sufficient to assess the quality of the totality of the programme. However, they set a foundation and are a starting point for increasingly robust assessment of quality. It is envisaged that over time quality assurance of the programme will develop. This will start by working closely with LA's to explore options for the way forward.

These standards should not be used in isolation. They should be considered in conjunction with other national NHS Health Check guidance including: The Best Practice Guidance, Health Equiy Audit guidance, Information Governance and data flow pack and the Competence Framework.

2. Definition

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

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

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

A high quality programme must:

- monitor the delivery of national standards that cover the entire pathway, defined here as identification of the eligible population through to their exit from the programme either by turning 75 years old, dying, moving outside of England, or receiving a diagnosis that means they are no longer eligible for the programme
- have robust failsafe procedures to identify problems early thereby minimising harm and error
- support and underpin improvements in delivery by professionals and providers, and through liaison with commissioners
- reduce risks by ensuring that errors are dealt with competently, that lessons are learnt and that there are robust, documented, processes to allow serious incidents to be identified and subsequently managed
- have robust information systems to collect a standard dataset, sufficient for the comparison of programmes and to benchmark performance against agreed national key performance indicators
- ensure a coherent and explicit programme of quality improvement related activities including processes that ensure the effective sharing of lessons learnt.

3. Principles of the standards

The standards are based on the following principles. They:

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

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

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

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

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

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

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

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

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

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

4. Format of the standards

The standards are set out using the following format:

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

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

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

5. Quality Assurance roles and responsibilities nationally and locally

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

Through working relationships with the national programme and stakeholders:

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

6. Data quality

Timely, good quality data is crucial to establishing robust systems to assess quality and will aid reporting. For each standard, quality indicators have been suggested. Some areas will collect and monitor this information already; however, it is acknowledged that not all local areas will have end-to-end electronic data systems in place. To achieve continuous service improvement, the aim should be to establish systems where reporting of these indicators can take place. Once data reporting is established, benchmarking may be of help, possibly through peer review or sector led improvement.

To help local areas improve their data, PHE have produced guidance for LA's on the three data flows for the NHS Health Check (identification and invite of eligible population, data transfer back to GP practices, and anonymised data extract from GP practices). PHE will also review the existing information standard for NHS Health Checks and ensure it is implemented appropriately.

7. Self assessment tools

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

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

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

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

8. The standards

1. INVITATION AND OFFER: identifying the eligible population and offering an NHS Health Check	
Description	As outlined in the 2013 regulations, each local authority is to ensure systems are in place to consistently and accurately identify the population, establish eligibility and offer NHS Health Checks to all eligible persons in its area in a five-year period. The eligibility criteria are that the invitee must: • be aged 40 to 74 • must not have been offered an NHS Health Check within the previous five years Specifically people already diagnosed with the following are excluded from the programme: • coronary heart disease • chronic kidney disease (CKD) (classified as stage 3, 4 or 5 within NICE CG 73) • diabetes • hypertension • atrial fibrillation • transient ischaemic attack • familial hypercholesterolaemia • heart failure • peripheral arterial disease • stroke In addition, individuals: • must not be being prescribed statins for the purpose of lowering cholesterol • must not have been assessed through a NHS Health Check, or any other check undertaken through the health service in England, and found to have a 20% or higher risk of developing cardiovascular disease over the next ten years A clearly written invitation letter, available in other formats (Braille, language, easy read, translation services); outlining the potential benefits and risk of the NHS Health Check process should be provided to all. Where the NHS Health Check is offered opportunistically, written information should still be provided.
Rationale	Legal duties exist for LA's to: a) make arrangements for each eligible person aged 40 to 74 to be offered a NHS Health Check once in every five

	years and for each person to be recalled every five years if they remain eligible; b) to seek continuous improvement in the percentage of eligible individuals taking up their offer (LA's (Public Health Functions and Entry to Premises by Local Healthwatch Representatives) Regulations 2013). Including the patient information leaflet (which is free to order or download) with a written invitation is important to ensuring informed choice. Individuals should be provided with clear information so that they understand the potential benefits and risks of the NHS Health Check process and can give informed consent. Ensuring a high percentage of those offered a NHS Health Check actually receive one is key to optimising the clinical and cost effectiveness of the programme. This is especially important for populations with the greatest health needs and will impact on the programme's and local area's abilities to narrow health inequalities. The higher the take up rates for the programme, the greater its reach and potential impact.
Quality indicator(s)	The number of invitations and the number of NHS Health Checks actually received must be recorded and monitored by LA's as per the 'NHS Health Check single data list returns: a brief guide for LA's'. The information that will need to be submitted on a quarterly basis to PHE is: 1a. the number of NHS Health Checks offered in the quarter 1b. the number of NHS Health Checks received in the quarter These two measures are stated indicators for health improvement within the public health outcomes framework for England. The acceptable threshold for these indicators are: • 100% of the eligible population invited every five years • aspiring to ≥75% of eligible people having a check.
Evidence to demonstrate achievement	• Patient information leaflet is sent out with written invitations for a check • Evidence that NHS Health Check information is available in other formats (Braille, language, easy read, translation services) • Social marketing plans in place • Local NHS Health Check champions in place, eg, documentation of job description/reports on activity. A champion acts as an advocate for the programme encouraging uptake and improving service delivery, they are usually a GP, practice nurse or local leader. They may undertake this role formally through paid session(s) or informally and unpaid • Feedback from individuals that NHS Health Checks are held at convenient locations and times • Service/process in place to offer NHS Health Checks to those not registered with a GP

Further information	Research has shown that adapting invitations to support improved uptake from local population groups is pivotal to success. PHE will work with local authority NHS Health Check teams to test the potential impact of behavioural insight and marketing interventions on uptake and will share information through the NHS Health Check website. Top tips for increasing the uptake of NHS Health Checks, Public Health England. August 2016 Public Health Outcomes Framework, Public Health England. July 2017 The Local Authorities (Public Health Functions and Entry to Premises by Local Healthwatch Representatives) Regulations 2013. Legislation.gov.uk. 2013 Public sector: quick start guide to the public sector Equality Duty, Government Equalities Office. June 2011 NHS Health Check Secondary Use Data Set, NHS Digital. 2011

2. INVITATION AND OFFER: consistent approach to non-responders and those who do not attend their risk assessment	
Description	An agreed process should be in place for those **eligible** for the NHS Health Check who either do not respond to an offer/invitation or do not attend (DNA) their appointment. At least two contacts should be made: a written invitation letter should be followed up by a reminder if there is no response. Local areas may agree on the most appropriate reminder method for their population (eg, phone, text, letter, email, in person). Evidence shows that a text message prompt before an invite letter and a follow up text message can significantly increase take up. All PHE NHS Health Check branding and marketing resources should be applied within the brand guidelines and in line with the Best Practice Guidance.
Rationale	Low uptake and variation lead to some people being given more of a chance to participate than others. Ensuring a high percentage of those offered an NHS Health Check actually receive one is key to optimising the clinical and cost effectiveness of the programme. This is especially important for populations with the greatest health needs and will impact on the programme's and local area's abilities to narrow health inequalities. The higher the take up rates for the programme, the greater its reach and potential impact.

Quality indicator(s)	2a. Proportion recorded as do not respond. 2b. Proportion recorded as DNA. 2c. Proportion of these individuals recalled in five years, if they remain eligible. (Please note it is for local determination whether areas wish to invite individuals on a more frequent basis).
Evidence to demonstrate achievement	• Locally agreed protocol in place defining standard approach to non-responders and DNAs. Protocol should detail number and method of reminders made • Number and method of reminder made should be recorded • NHS Health Check information available in other formats (Braille, language, easy read, translation services, etc) • Individuals who opt out should be read coded. An auditable process should be in place to recall in five years, if they remain eligible
Further information	NHS Health Check Secondary Use Data Set, NHS Digital. 2011 Top tips for increasing the uptake of NHS Health Checks, Public Health England. August 2016 NHS Health Check marketing and branding resources, Public Health England.

3. THE RISK ASSESSMENT: ensuring a complete NHS Health Check for those who accept the offer is undertaken and recorded	
Description	A complete NHS Health Check must include **all** the elements outlined in the best practice guidance **all taken at the time of the check** unless specified: a. age b. gender c. ethnicity d. smoking status e. family history of coronary heart disease f. blood pressure, systolic (SBP) and diastolic (DBP) g. body mass index (height and weight) h. General practice physical activity questionnaire (GPPAQ) i. Alcohol use score (AUDIT-C **or** FAST can be used as the initial screen, further guidance is in the best practice guidance) j. cholesterol level: total cholesterol and HDL cholesterol (either point of care **or** venous sample if within the last six months) k. cardiovascular risk score calculated by QRISK2: a score relating to the person's risk of having a cardiovascular event during the ten years following the NHS Health Check, derived using an appropriate risk engine that will predict cardiovascular risk based on the population mix within the local authority's area l. dementia awareness (for those aged 65 to 74) m. validated diabetes risk assessment score or, if that is not possible,

	the diabetes filter (BMI and BP); see standard 8 Active consideration should be given locally with regard to both access to, and delivery of, the NHS Health Check for everyone but specifically in respect of those who share one of the nine protected characteristics. In some circumstances, how these individuals access a complete NHS Health Check, as well as how their risk assessment is undertaken and supported to improve their lifestyle will require specific consideration and action. The nine protected characteristics are: • age • disability • gender reassignment • marriage and civil partnership • pregnancy and maternity • race – this includes ethnic or national origins, colour or nationality • religion or belief – this includes lack of belief • sex • sexual orientation
Rationale	NHS Health Check providers should be competent and confident to carry out all elements of the risk assessment. PHE and partners have developed a national competence framework. This document describes the core competences and technical competences required to carry out an NHS Health Check. The tests, measurements and risk calculations that make up the risk assessment part of the NHS Health Check are stipulated in legislation because of the importance of a uniform, quality offer. An incomplete risk assessment may lead to an inaccurate calculation of their risk score and therefore have clinical implications and in turn, reputational implications for the programme. Every NHS Health Check programme must be in keeping with the Equality Act 2010. Meaning that every individual who receives an NHS Health Check should receive a check of an equal standard. This means a good quality, complete risk assessment, irrespective of where they live, their characterisics or the provider. This duty recognises that equality of opportunity cannot be achieved simply by treating everyone the same. To support LA's to do this, PHE has published guidance on undertaking a Health Equity Audit (HEA) on the NHS Health Check programme. A quick start guide 10 is also available to help public sector organisations understand a key measure in the Equality Act, the public sector equality duty, which came into force in April 2011.
Quality indicator(s)	3a. Proportion of those who accept the offer that receive a complete NHS Health Check with all indicators listed above recorded at the time of delivery.

Evidence to demonstrate achievement	Provider has a record of the following for each NHS Health Check undertaken: • **all** indicators listed above • 'NHS Health Check complete' recorded • name of health professional delivering the NHS Health Check • date of NHS Health Check Evidenced through regular electronic data extraction and production of reports, read code audit or if not possible, notes audit. Evidence that equity of access and outcomes have been considered through a health equity audit, with recommendations for action to be taken to address any inequity identified. **GP providers:** evidence they are using either a national GP system supplier template or a locally devised template; as long as the local template collects all of the indicators listed. **Alternative service providers**: should record the read codes as set in the information standard and transfer to the GP in a timely manner as outlined in standard 10.
Further Information	NHS Health Check Competence Framework and it's associated resources; Learner workbook and; Assessor workbook. Public Health England. March 2014 Best practice guidance, Public Health England. December 2017 NHS Health Check Secondary Use Data Set, NHS Digital. 2011 Health Equity Audit guidance. Public Health England. December 2016

4. THE RISK ASSESSMENT: equipment	
Description	Ensure all equipment used for the NHS Health Check is: fully functional, used regularly, CE marked, validated, maintained and is recalibrated according to the manufacturer's instructions. This includes height and weight measuring devices, blood pressure monitors and point of care testing equipment. Where appropriate, it should also be checked that devices are compliant with the Medicines and Healthcare products Regulatory Agency (MHRA)requirements. Any adverse incidents involving medical equipment should be reported to the manufacturer as well as the MHRA and managed according to providers' governance arrangements. An adverse incident is an event that causes, or has the potential to cause,

	unexpected or unwanted effects involving the accuracy and/or safety of device users (including patients) or other persons. For example: • a patient, user, carer or professional is injured as a result of a medical device failure or its misuse • a patient's treatment is interrupted or compromised by a medical device failure • a misdiagnosis due to a medical device failure leads to inappropriate management and treatment eg an individuals CVD risk score is incorrectly calculated. • a patient's health deteriorates due to medical device failure (MHRA)
Rationale	If equipment is not used correctly, there is a risk that incorrect readings are given, affecting the risk score and potentially the clinical management of the individual. Incidents should be reported as soon as possible. Some apparently minor incidents may have greater significance when aggregated with other similar reports.
Quality indicator(s)	To develop locally, as appropriate.
Evidence to demonstrate achievement	• Documentation of equipment checks • Audit • Use of equipment and notification of incidents included within provider's governance arrangements
Further information	Medical devices regulation and safety. Medicines and Healthcare products Regulatory Agency (MHRA). March 2017 Blood pressure measurement devices, MHRA. December 2013

5. THE RISK ASSESSMENT: quality control for point of care testing	
Description	A 'Point of Care Test' (POCT) is a device the manufacturer has intended to be used for examining specimens derived from the human body including blood and urine. Where the introduction of POCT is being considered the MHRA advises that: • **the local hospital pathology laboratory is involved** as it can play a supportive role in providing advice on a range of issues including the purchase of devices, training,

	interpretation of results, troubleshooting, quality control, and health and safety. They will 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 • **quality assurance must be addressed**, implementing quality control (QC) procedures provides assurance that the system is working correctly. This should cover both internal quality control and external quality assurance. A QC record should be in place for each machine • This should include an appropriate **internal quality control (IQC) process** in accordance with the MHRA guidelines on POCT, 'Management and use of IVD point of care test (POCT) devices. Device bulletin December 2013. This should take the form of at least a daily "go/no go" control sample (use of a liquid sample) on days when the instrument is in use. This may require other procedures eg optical check to be performed in addition to the use of a liquid control sample. All record keeping on this process should be accurate and contemporaneous. • That each **POCT location is registered** in and participating in an appropriate EQA programme through an accredited (CPA or ISO 17043) provider that reports poor performance to the National Quality Assessment Advisory Panel (NQAAP) for Chemical Pathology. This can be checked on the UKAS website: www.ukas.com/ • 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. • **potential hazards** associated with the handling and disposal of bodily fluids, sharps and waste reagents outside of a laboratory setting should be considered • **staff who use POCT devices must be trained.** Only staff whose training and competence has been established and recorded should be permitted to carry out POCT • **the equipment instructions should always be read** and

	staff should be particularly aware of situations when the device should not be used • **standard operating procedures (SOPs)** which must include the manufacturer's instructions for use, are developed. You should pay particular attention to any storage and handling requirements of the machine and cassettes • **which staff review the results should be considered,** staff should be appropriately qualified and cited on the patient's history • **record keeping** is essential and must include patient results, test strip lot number and operator identity • **maintaining devices** according to the manufacturer's guidance is essential to ensure that they continue to perform accurately
Rationale	Inadequate QA of POCT may lead to potentially inaccurate results affecting clinical management and clinical risk for the provider. As well as being a threat to the integrity of the programme and to clinical engagement.
Quality indicator(s)	Proportion of providers using POCT that can demonstrate 1) Healthcare professionals and staff who have been trained (by a competent trainer) to use the equipment 2) A named POCT coordinator is in place 3) An appropriate internal quality control (IQC) process is in place in accordance with the MHRA guidelines on POCT 4) That each POCT location is registered in and participating in an appropriate EQA programme through an accredited (CPA or ISO 17043) provider that reports poor performance to the National Quality Assessment Advisory Panel (NQAAP) for Chemical Pathology. This can be checked on UKAS website: www.ukas.com/
Evidence to demonstrate achievement	• up-to-date register of trained/competent operators who have evidence of meeting the minimum standards as outlined in the NHS Health Check Competence Framework. • name of POCT coordinator • records of results of quality control performed • evidence of registration and compliance in an accredited EQA scheme reporting to NQAAP
Further information	Best practice guidance, Public Health England. December 2017

	NHS Health Check Competence Framework and it's associated resources; Learner workbook and; Assessor workbook. Public Health England. March 2014 Management and use of IVD point of care test, MHRA. December 2013 A Practical Guide to Point of Care Testing, NHS Improvement. April 2008 The latest buyers' guides from the NHS Purchasing and Supply Agency, Centre for Evidence Based Purchasing: • buyers' guide: blood glucose systems. NHS Purchasing and Supply agency. May 2008 • buyers' guide: point of care testing for cholesterol measurement. NHS Purchasing and Supply agency. September 2009 • buyer's guide: point of care testing for HbA1c. NHS Purchasing and Supply agency. June 2009 [Please note, The Centre for Evidence Based Purchasing has since disbanded on 31 March 2010 so these documents have not been updated.] ISO15197:2013 defines performance standards for self-testing meters. International Organization for Standardization. 2013

6. COMMUNICATION OF RESULTS: ensuring results are communicated effectively and recorded	
Description	All individuals who undergo a NHS Health Check must have their cardiovascular risk score calculated using QRisk2 and explained in such a way that they can understand it. This communication should be face to face. Staff delivering the NHS Health Check should be trained appropriately in communicating, capturing and recording the risk score and results, and understand the variables the risk calculators use to equate the risk. When communicating individual risks, staff should be trained to: • communicate risk in everyday, jargon-free language so that individuals understand their level of risk and what changes they can make to reduce their risk • use behaviour change techniques (such as motivation interviewing) to deliver appropriate lifestyle advice and how it can reduce their risk • establish a professional relationship where the individual's values and beliefs are identified and incorporated into a client- centred plan to achieve sustainable health improvement. Individuals receiving a NHS Health Check should be given adequate time

	to ask questions and obtain further information about their risk and results. Individualised written information should be provided that includes their results*, bespoke advice on the risks identified and self referral information for lifestyle interventions. *This should include and provide an explanation of their: • BMI • cholesterol level (total cholesterol: HDL cholesterol ratio) • blood pressure • alcohol use score (AUDIT C or FAST) • physical activity level (GPPAQ) • diabetes risk • CVD risk score and what this means • referrals onto lifestyle or clinical services (if any)
Rationale	Legal duties exist for LA's to make arrangements to ensure the people having their NHS Health Checks are told their cardiovascular risk score, and other results are communicated to them. NHS Health Checks is a preventative programme to help people stay healthy for longer. To maximise these benefits, efforts should be made to ensure individuals understand their level of risk and their results. Everyone who has a NHS Health Check, regardless of their risk score, should also be given lifestyle advice to help them manage and reduce their risk. That means that, unless it is deemed clinically unsafe to do so, everyone having a NHS Health Check should be provided with individually tailored advice that will help motivate them and support the necessary lifestyle changes to manage their risk. This includes supporting and encouraging individuals to maintain a healthy lifestyle where no change is required.
Quality indicator(s)	6a. Proportion of NHS Health Checks undertaken where cardiovascular risk score, BMI, cholesterol level, blood pressure,alcohol use (AUDIT C or FAST) score, physical activity level (GPPAQ) and diabetes risk is communicated face to face. 6b. Proportion of NHS Health Checks undertaken where written, tailored information is provided.
Evidence to demonstrate achievement	• in addition to record of risk assessment indicators as outlined in standard 3; life style advice should be recorded • examples of written information used • training and education materials on risk communication available for health professionals • patient survey or other patient feedback mechanism that asks whether patients felt they understood what was communicated • number of patient complaints received

Further Information	Best practice guidance, Public Health England. December 2017 NHS Health Check Competence Framework and it's associated resources; Learner workbook and; Assessor workbook. Public Health England. March 2014. 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. Free e-learning courses on how to conduct an NHS Health Check and support behaviour change are available. NHS Health Check Invitation and results card, Public Health England. July 2017 Cardiovascular disease: risk assessment and reduction, including lipid modification, NICE Clinical guideline CG181. September 2016

7. RISK MANAGEMENT: high quality and timely lifestyle advice given to all	
Description	Provision and timely access to high quality and appropriate risk-management interventions should be in place in line with the best practice guidance. This includes providing evidence-based and accessible healthy lifestyle services including: • stop-smoking services • physical activity interventions • weight management interventions • alcohol-use interventions • diabetes prevention interventions (Healthier You: NHS diabetes prevention programme)
Rationale	NHS Health Checks is a preventative programme to help people stay healthy for longer. To maximise these benefits, all individuals who have a NHS Health Check, regardless of their risk score, should be given lifestyle advice, where clinically appropriate, to help them manage and reduce their risk. That means that, unless it is deemed clinically unsafe to do so, everyone having the check should be provided with individually tailored advice that will help motivate them and support the necessary lifestyle changes to manage their risk. This includes supporting and encouraging individuals to maintain a healthy lifestyle where no change is required. It is pivotal that the actions taken at a certain threshold are the same and in line with national guidelines, including those issued by the National Institute for Health and Care Excellence (NICE), so that people receive the necessary and appropriate care.

	This approach echoes the competencies set out in Making Every Contact Count (MECC). MECC enables the opportunistic delivery of consistent and concise healthy lifestyle information to individuals at scale.
Quality indicator(s)	7a. Proportion of NHS Health Checks undertaken where record exists that brief advice for smoking, physical activity, weight management and alcohol are provided. 7b. Proportion of NHS Health Checks undertaken where referral to lifestyle intervention is made, where appropriate. 7c. Proportion of individuals where a record of outcome following lifestyle intervention is available (ie, four-week smoking quit/ 5% reduction in body weight)
Evidence to demonstrate achievement	• evidence-based and accessible lifestyle intervention services in place • agreed patient pathway in place • documentation of: - brief advice, record of specific lifestyle advice given - signposted to local provision - offer of referral made - referral declined - referral to intervention accepted - outcome • example of written information used • clinical codes or notes audit against indicators outlined above • training and education materials available for health professionals • patient survey or other patient feedback mechanism that asks about lifestyle change • number of patient complaints received
Further information	<u>Stop smoking</u> • Local Stop Smoking Services: Service and delivery guidance, National Centre for Smoking Cessation and Training. 2014 • Smoking: brief interventions and referrals, NICE Public health guideline PH1. March 2006 <u>Weight management</u> • Non-alcoholic fatty liver disease (NAFLD): assessment and management, NICE guidance NG49. July 2016 • Cardiovascular disease: risk assessment and reduction, including lipid modification, NICE Clinical guideline CG181.

	September 2016 • Preventing excess weight gain, NICE guidance NG7. September 2016 • Obesity prevention, Clinical guideline CG43. March 2015 • Obesity: identification, assessment and management, Clinical guideline CG189. November 2014 • Weight management: lifestyle services for overweight or obese adults, NICE Public health guideline PH53. May 2014 • BMI: preventing ill health and premature death in black, Asian and other minority ethnic groups, NICE Public health guideline PH46. July 2013 <u>Physical Activity</u> • Physical activity benefits for adults and older adults, Chief Medical Officer. October 2015 • Four commonly used methods to increase physical activity, NICE Public health guideline PH2. March 2015 • Everybody Active Every Day, Public Health England. October 2014 • Physical activity: exercise referral schemes, NICE Public health guideline PH54. September 2014 • Physical activity: brief advice for adults in primary care, NICE Public health guideline PH44. May 2013 • Let's get moving. A physical activity care pathway commissioning guidance, Department of Health. March 2012 • Start Active, Stay Active, Chief Medical Officers. July 2011 <u>Alcohol</u> • Alcohol consumption: advice on low risk drinking, Alcohol consumption: advice on low risk drinking. August 2016 • E-learning / training, Alcohol Learning Centre. 2017 • Identification and Brief Advice Tool, Public Health England. April 2017 • Alcohol Guidelines Review – Report from the Guidelines development group to the UK Chief Medical Officers, Department of Health. January 2016 • Alcohol-use disorders – preventing harmful drinking, NICE Public health guideline PH24. June 2010 <u>Diabetes prevention</u> • NHS National Diabetes Prevention Programme, NHS England. 2016 • Type 2 diabetes: prevention of people at high risk, NICE

	Public health guideline PH38. September 2017 Additional information • NHS Health Check Secondary Use Data Set, NHS Digital. 2011 • NHS Health Check Competence Framework and it's associated resources; Learner workbook and; Assessor workbook. Public Health England. March 2014

8. RISK MANAGEMENT: additional testing and clinical follow up	
Description	Individuals should not exit the programme until all abnormal parameters have been followed up and a diagnosis has either been made or ruled out. Timely access to further diagnostic testing should take place as outlined in the best practice guidance at the following thresholds: 1. Assessment for **diabetes** risk It is recommended that a validated diabetes risk tool should be used and specific thresholds applied to identify people at high risk of diabetes and so eligible for a blood glucose test. Individuals should be considered as being at high risk of diabetes using the following thresholds for the corresponding validated risk assessment tools: • QDiabetes score is greater than 5.6 • Cambridge diabetes risk score is greater than 0.2 • Leicester practice risk score is greater than 4.8 • Leicester risk assessment score is greater than or equal to 16 Where it is not possible to introduce a validated risk tool then the historical diabetes filter can be applied as part of the risk assessment. This includes either: a. BP >140/90 mmHg where either the SBP or DBP exceeds 140mmHg or 90mmHg respectively b. BMI > 30, or 27.5 if individuals from the Indian, Pakistani, Bangladeshi, other Asian and Chinese ethnicity categories If the individual is identified as being at risk of developing type 2 diabetes they should go on to receive either a fasting plasma glucose or HbA1c test. If an individual's fasting plasma glucose (5.5 – 6.9 mmol/l) or HbA1c (42 – 47 mmol/mol or 6% – 6.4%) is above the threshold for non-diabetic hyperglycaemia but below the threshold for diabetes, there is very robust evidence that intensive lifestyle interventions in these individuals substantially reduces the risk of developing diabetes. As it rolls out, the new Healthier You: NHS Diabetes Prevention Programme will offer an intensive intervention that supports people to lose weight, to increase physical activity and to eat more healthily. The long-

	term intervention allows individuals to set and achieve goals and make positive changes to their lifestyle. Where the programme is already available individuals should be referred to it in line with the local care pathway. Individuals diagnosed with type 2 diabetes should be treated through appropriate care pathways and measures, as recommended by NICE. 2. Assessment for **hypertension** by GP practice team when indicated by: a. BP >140/90 mmHg where either the SBP or DBP exceeds 140mmHg or 90mmHg respectively Individuals diagnosed with hypertension, after appropriate further assessment should be added to the hypertension register and treated through existing care pathways in line with NICE guidance. 3. Assessment for **chronic kidney disease** by GP practice team when indicated by: a. BP >140/90 mmHg where either the SBP or DBP exceeds 140mmHg or 90mmHg respectively All who meet these criteria to receive serum creatinine test to estimate glomerular filtration rate (eGFR). 4. Assessment for **familial hypercholesterolemia** by GP practice team should be consideredif: a. Total cholesterol >7.5 mmol/L b. There is a personal or family history of premature coronary heart disease (an event before 60 years in an index individual or first-degree relative) 5. **Alcohol risk assessment**, use of full AUDIT when indicated by: a. AUDIT C Score $\geq$5 b. Or FAST $\geq$3 If the individual meets or exceeds the AUDIT C or FAST thresholds above the remaining questions of AUDIT should be administered to obtain a full AUDIT score. If the individual meet or exceeds a threshold of 8 on AUDIT, brief advice is given. For individuals scoring 20 or more on AUDIT referral to alcohol services should be offered. For all, systems and process should be in place to ensure follow up test(s) undertaken and results received.
Rationale	Only through the early detection and management of risk factors can the NHS Health Check maximise its public health impact and reduce premature mortality. It is key that the actions taken at these thresholds are the same to ensure a systematic and uniform offer across England. Systems should be in place to ensure follow up tests are undertaken and results received in order to

	provide assurance that appropriate follow up and management is undertaken. Disease management should be undertaken in line with NICE guidance including provision of appropriate lifestyle intervention...
Quality indicator(s)	Where thresholds met: 8a. Proportion of individuals with investigations undertaken 8b. Proportion of individuals with outcome recorded

Evidence to demonstrate achievement	• Record of individuals identified as:
	  ○ pre diabetic/diabetic
	  ○ hypertensive
	  ○ CKD
	  ○ familial hypercholesterolemia
	  ○ Audit C ≥5/ FAST ≥3
	  ○ BMI ≥ 30, or 27.5 if individuals from the Indian, Pakistani, Bangladeshi, other Asian and Chinese ethnicity categories
	• Results communicated to patient and recorded using appropriate read code
	• GP practice has in place a protocol for additional testing and clinical follow up identifying review timeframes for further investigations
	• Regular electronic data extraction and reporting
	• Read code audit or if not possible, notes audit

Further information	Best practice guidance, Public Health England. December 2017 Preventing type 2 diabetes: risk identification and interventions for individuals at high risk, NICE Public Health Guidance PH38. September 2017 Estimated detection rates of NDH and type 2 diabetes between validated risk assessment tools. Public Health England. February 2017 Chronic kidney disease: national clinical guideline for early identification and management in adults in primary and secondary care, NICE clinical guideline 182. January 2015 Type 2 diabetes in adults: management, NICE guideline NG28. May 2017 Alcohol-use disorders – preventing harmful drinking, NICE Public health guideline PH24. June 2010 Hypertension in adults: diagnosis and management, Clinical guideline CG127. November 2016 Familial hypercholesterolaemia: identification and management, NICE Clinical guideline CG71. November 2017 Familial Hypercholesterolaemia, NICE Quality standard QS41. August

	2013

9. RISK MANAGEMENT: appropriate follow up for those with high cardiovascular risk	
Description	All individuals with ≥10% CVD risk should be managed according to NICE guidance including provision of lifestyle advice and intervention, assessment for treatment with statins and an annual review this may be through maintaining a high risk register. Individuals that have a CVD risk score ≥10% (at risk) • people with a 10% or greater, ten-year risk of developing CVD should be offered appropriate 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 • the decision whether to start statin therapy should be made after an informed discussion between the health professional and the individual about the risks and benefits of statin treatment, taking into account additional factors such as potential benefits from lifestyle modifications, informed patient preference, comorbidities, polypharmacy, general frailty and life expectancy • People with a ten year CVD risk above 10% and diabetes, hypertension or chronic kidney disease should be managed according to NICE guidance, including provision of lifestyle intervention, recorded on the relevant disease register and will exit the programme. • Where the NHS Health Check is delivered by an alternative service provider, a timely referral back to the GP practice should be made to ensure appropriate follow up undertaken (see standard 10). **Key point:** individuals that are either prescribed a statin or have a CVD risk score ≥20% should exit on to an at risk register.
Rationale	With appropriate management and follow up, the rate of progression of CVD and risk factors can be reduced.

Quality indicator(s)	9a. Proportion of those identified with a CVD risk of 10% and greater managed according to NICE guidelines.
Evidence to demonstrate achievement	• GP practice to have in place protocol/clinical pathway in place to outline process for follow up. Updated annually • Documentation of individuals' transfer to the high-risk register recorded as a result of the NHS Health Check • Record of statin offered, accepted and declined • Read code audit, or if not possible, notes audit
Further information	Best practice guidance, Public Health England. December 2017 Cardiovascular disease: risk assessment and reduction, including lipid modification, NICE Clinical guideline CG181. September 2016

10. THROUGHOUT THE PATHWAY: confidential and timely transfer of patient identifiable data	
Description	Where the risk assessment is conducted outside the individual's GP practice, LA's have a legal duty to arrange for the provider to send the following information to the person's GP: • age • gender • smoking status • family history of coronary heart disease • ethnicity • body mass index (BMI) • cholesterol level • blood pressure • physical activity level - inactive, moderately inactive, moderately active or active • cardiovascular risk score • alcohol use disorders identification test (AUDIT) score (AUDIT C or FAST) A protocol also needs to be in place for timely referral of patients where abnormal parameters identified. For all individuals who require additional testing and clinical follow up, GP practices should follow Standards 8 and 9.
Rationale	Legal duties exist for LA's to make arrangements for specific information and data to be recorded and where the risk assessment is conducted outside the individual's GP practice, for that information to be forwarded to the individual's GP.

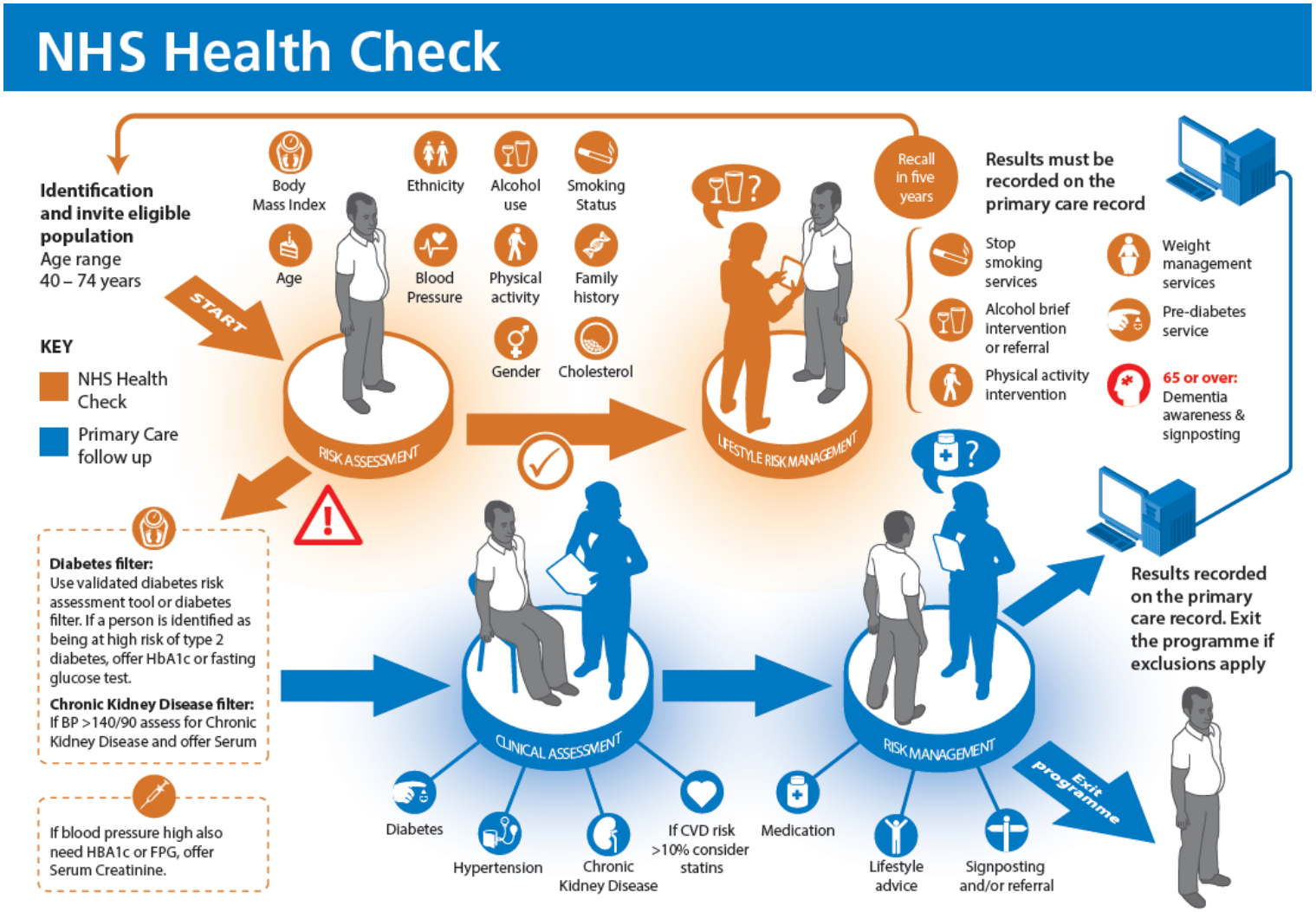
	There are a number of potential issues surrounding data flows for example: • if NHS Health Checks are undertaken in a community setting, there may be delay in the GP practice receiving the information and results • ensuring confidential transfer of patient-identifiable data • errors surrounding accuracy of data inputted These process failures could lead to a breach in confidentiality and/or inappropriate action undertaken due to inaccurate or delayed information being received. If information is not recorded it is unknown whether appropriate intervention and follow up has been undertaken.
Quality indicator(s)	10a. Proportion of non-GP service providers that send data to the relevant GP practice in a timely way (the suggested expectation is within two working days). 10b. Proportion of GP practices that then record these results on their clinical system results in a timely way (the suggested expectation is within two working days).
Evidence to demonstrate achievement	• Electronic data transfer in place between alternative service provider(s) and GP practices • Read code or notes audit • Agreed protocol for data transfer between alternative service provider and GP practices • Protocol in place for timely referral of patients where abnormal parameters identified by the alternative service provider, including outlining action when urgent referral required
Further information	NHS Health Check Secondary Use Data Set, NHS Digital. 2011

9. Next steps

It is recognised that these standards only focus on a limited number of points on the pathway; they are not themselves sufficient to assess the totality of programme quality. They focus on describing what good looks like, and by setting out quality indicators encourage improved data quality and reporting. They set an important foundation and are a starting point for increasingly robust assessment of quality.

It is envisaged that over time quality assurance of the programme will progress. PHE will continue work closely with LA's to explore options and develop mechanisms to support local commissioners. This programme of work will also continue through ongoing discussion and engagement with local commissioners, utilising existing programme networks

Annex 1. NHS Health Check pathway



Annex 2. How the standards were developed

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

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

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

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

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