



Public Health
England

NHS Health Check programme standards: a framework for quality improvement

February 2014

About Public Health England

Public Health England's mission is to protect and improve the nation's health and to address inequalities through working with national and local government, the NHS, industry and the voluntary and community sector. PHE is an operationally autonomous executive agency of the Department of Health.

Public Health England
133-155 Waterloo Road
Wellington House
London SE1 8UG
Tel: 020 7654 8000
www.gov.uk/phe
Twitter: @PHE_uk
Facebook: www.facebook.com/PublicHealthEngland

Prepared by: NHS Health Checks quality assurance working group
For queries relating to this document, please contact: the NHS Health Check team on 020 7654 8000 or PHE.enquiries@phe.gov.uk

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Published February 2014
PHE publications gateway number: 2013503

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Acknowledgements

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

These standards were developed by the National NHS Health Checks quality assurance working group:

Andrew Clark	Public health consultant, Yorkshire and Humber PHE Centre
Louise Cleaver	NHS Health Check support manager, PHE
Adrian Davis	Director, population health science, PHE
Veena De Souza	Public health consultant, NHS Health Check lead, Buckinghamshire County Council
Victoria Donnelly	NHS Health Check data quality project manager, PHE
Lucy Holdstock	Screening QA research and development lead, UK National Screening Committee/NHS Screening Programmes, PHE
David James	Deputy chair of the joint working group for quality assessment in pathology, Royal College of Pathology
Eric Keogh	NHS Health Check support manager, PHE
Nada Lemic	Director public health, Bromley, London. DPH lead for NHS Health Checks
Sue Longden	Public health consultant, Manchester City Council
Nicky Saynor	Health improvement manager, Kent, Surrey and Sussex PHE Centre
Sarah Stevens	QA lead, consultant in public health, NHS Health Check programme, PHE
Jamie Waterall	National lead, NHS Health Check programme, PHE (Chair)

Thanks are given to the numerous individuals and organisations that provided feedback and contributed to this document. They are listed in Appendix 1

This is the first release of National Standards for NHS Health Checks. They will be reviewed on an annual basis and will remain responsive to national policy.

These standards should be read in the context of national and local guidelines on training and competencies and in conjunction with NHS Health Check programme best practice guidance September 2013 www.healthcheck.nhs.uk/document.php?o=456

1. Rationale: why these standards were developed

The focus of NHS Health Checks so far has been primarily on implementing and rolling out this relatively new programme. A large amount of work has been carried out in order to achieve implementation; it is now an opportune time to build on this to ensure that commissioned services are of a consistently high quality, along the whole pathway, in a sustainable way.

The first step in achieving a high quality programme is to describe what good looks like by setting out standards that can measure the quality of the programme.

NHS Health Checks has been implemented with clear recognition of the need to monitor the overall success, uptake, benefit and value for money of the programme. Standards are an important component of a system focused on high quality services that is designed to ensure continuous improvement in the delivery of the programme and to reduce errors.

NHS Health Checks is a national programme, delivered locally in a way that best suit the needs of local populations. Crucially, this gives local authorities flexibility on who to commission to provide the service and what locations are used. It is important, however, that the tests and measurements themselves are consistent to help ensure the quality and effectiveness of the programme. Ensuring that those offered a NHS Health Check actually receive a complete 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 abilities to narrow health inequalities.

Equally, it is important that the actions taken at critical points on the pathway are the same, to assure a systematic and uniform offer across England and to maximise the public health impact of the programme. National standards setting out what good looks like will provide a framework to ensure that the NHS Health Check programme operates within parameters that maximise benefits, reduce potential harms for the population and ensure cost effectiveness.

Finally, the development of national standards is a direct response to feedback from local commissioners and public health leads and is also highlighted within Public Health England's (PHE) ten-point action plan following the NHS Health Check implementation review.

2. Purpose

These 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 NHS Health Checks in order to monitor service delivery and ensure continuous improvement in quality.

These standards are not mandatory and do not introduce new targets, they set out aspirational but achievable programme standards where reducing variation and assessing quality is particularly important. While acknowledging local innovation, the standards define specific elements of the pathway to help ensure that, at these critical points, the NHS Health Check programme is delivered in a consistent and uniform way across England.

Commissioners and providers should incorporate the standards in planning and delivering the NHS Health Check programme, as part of their general duty to secure continuous improvement in quality. The standards seeks to support sector-led improvement at a Local Authority level by helping to shape the outcomes Local Authorities want to achieve in their NHS Health Check commissioning role.

The aim is that every person eligible for an NHS Health Check is offered a good quality, complete risk assessment and follow-up, irrespective of where they live, or the provider commissioned to deliver it.

3. Definition

The overriding aim of national standards is to describe what good looks like for *the whole pathway*, from the identification of an individual as eligible and through 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.

4. How these standards were developed

A national quality assurance working group was established in late August 2013. Its purpose is to coordinate and oversee the establishment and implementation of national standards for quality in NHS Health Checks. The group worked to consolidate existing knowledge and expertise through discussion and input from a range of stakeholders, together with learning from other relevant programmes.

4.1 Risk assessment of the programme

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.

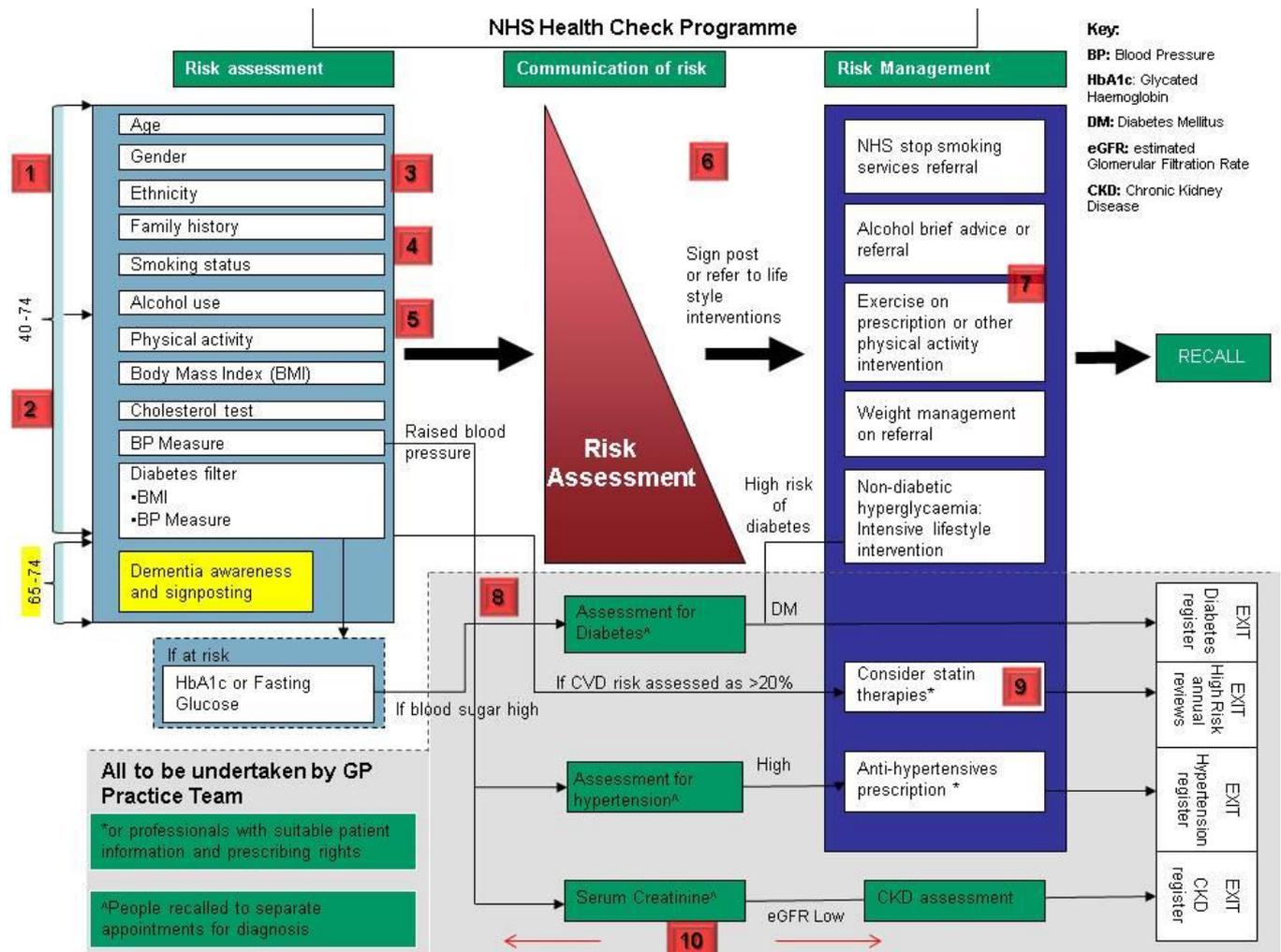
To inform this work, extensive stakeholder engagement was undertaken. Stakeholders felt that there were significant risks during the identification of the eligible population, the offer of a health check, the risk assessment, communication of results, subsequent management, follow-up and appropriate 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 (figure 1) 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.

Figure 1: Standards mapped against the NHS Health Check programme pathway



4.2 Principles

The following principles have been used to develop these standards. 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.

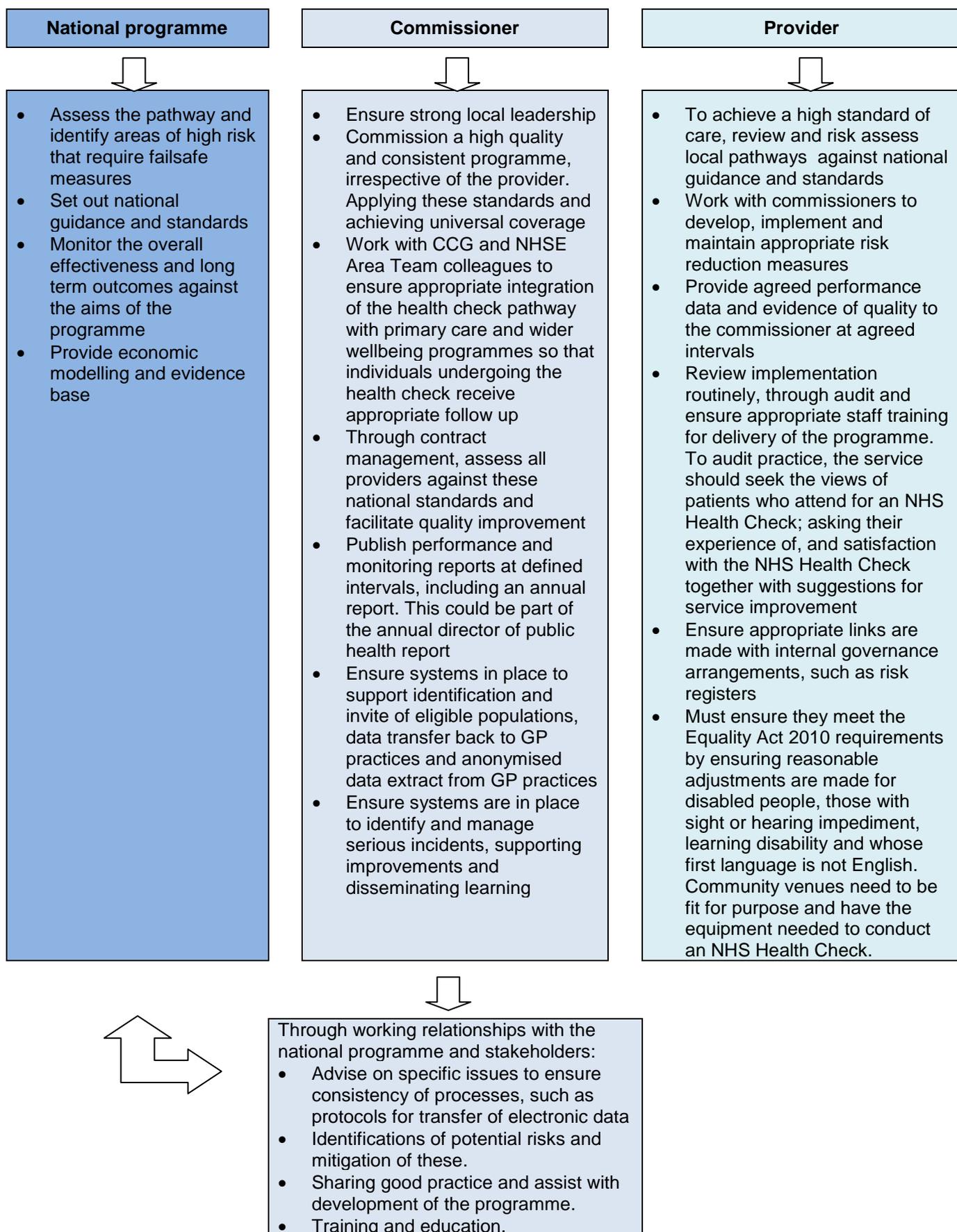
5. **Are supported by stakeholders:** they have been developed from consensus between stakeholders.
6. **Are realistic and attainable for all:** they set out the expectations for providers in delivering NHS Health Checks.
7. **Are applicable:** irrespective of the provider or setting in which they are 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.

5. Implementing the standards: roles and responsibilities

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 local authorities to explore options for the way forward.

Assessment and improvement of quality should be embedded into the delivery of the programme at every level. Figure 2 outlines the anticipated roles and responsibilities nationally and locally.

Figure 2: Roles of those responsible for elements of QA



The focus of this first release is to set standards that help local commissioners assess the quality of the services they commission, to identify any potential issues and to work with their providers to put in place appropriate mitigating actions.

The aim is to establish a culture of quality assessment and improvement that is integrated into contract management processes. It is anticipated that commissioners will incorporate these national standards within service specifications and through contracting monitoring.

Equally, providers can use the standards to monitor service delivery, to highlight areas for further improvement; and to evidence the quality of programme delivery.

5.1 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 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 will produce guidance for local authorities 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) early in 2014. PHE will also review the existing information standard for NHS Health Checks and ensure it is implemented appropriately.

6. 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 a new set of targets or mandatory indicators for performance management. The aim is that they help to understand the programmer, benchmark it and improve it.

In the main, expected levels of achievement for quality indicators are not specified. These standards are intended to drive up the quality of the programme, and so where thresholds are not specified, achievement levels of 100% should be aspired to. However, we recognise that this may not always be appropriate in practice, taking account local service models, choice and professional judgment, and therefore desired levels of achievement should be defined locally. Supplementary guidance specifically on

the quality indicators will be available through the quality assurance pages of the NHS Health Check programme website:

http://www.healthcheck.nhs.uk/commissioners_and_healthcare_professionals/managing_your_programme/quality_assurance/

No.	Standard	Point on the Pathway
1	Identifying the eligible population and offering an NHS Health Check	Invitation and offer
2	Consistent approach to non-responders and those who do not attend their risk assessment appointment	Invitation and offer
3	Ensuring a complete health check for those who accept the offer is undertaken and recorded	The risk assessment
4	Equipment use	The risk assessment
5	Quality control for point of care testing	The risk assessment
6	Ensuring results are communicated effectively and recorded	Communication of results
7	High quality and timely lifestyle advice given to all	Risk management
8	Additional testing and clinical follow up	Risk management
9	Appropriate follow up for all if CVD risk assessed as 20% and greater	Risk management
10	Confidential and timely transfer of patient identifiable data	Throughout the pathway

7. The standards

1. INVITATION AND OFFER: identifying the eligible population and offering an NHS Health Check	
Description	<p>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:</p> <ul style="list-style-type: none"> • be aged 40 to 74 • must not have been offered a health check within the previous five years <p>Specifically people already diagnosed with the following are excluded from the programme:</p> <ul style="list-style-type: none"> • 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 <p>In addition, individuals:</p> <ul style="list-style-type: none"> • 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 <p>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.</p>
Rationale	<p>Legal duties exist for local authorities 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 (Local Authorities (Public Health Functions and Entry to Premises by Local Healthwatch Representatives)</p>

	<p>Regulations 2013).</p> <p>A written NHS Health Check information letter 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.</p> <p>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.</p>
<p>Quality indicator(s)</p>	<p>The number of invitations and the number of NHS Health Checks actually received must be recorded and monitored by local authorities as per the 'NHS Health Check single data list returns: a brief guide for local authorities'. The information that will need to be submitted on a quarterly basis to PHE is:</p> <p>1a. the number of NHS Health Checks offered in the quarter 1b. the number of NHS Health Checks received in the quarter</p> <p>These two measures are stated indicators for health improvement within the public health outcomes framework for England 2013-16.</p> <p>The acceptable threshold for these indicators are:</p> <ul style="list-style-type: none"> • 100% of the eligible population invited every five years • $\geq 50\%$ take up, aspiring to $\geq 75\%$ take up.
<p>Evidence to demonstrate achievement</p>	<ul style="list-style-type: none"> • Written invitation letter detailing the potential risks and benefits of the NHS Health Check process • 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
<p>Further information</p>	<p>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 www.healthcheck.nhs.uk</p>

	<p>Local Authorities (Public Health Functions and Entry to Premises by Local Healthwatch Representatives) Regulations 2013: www.legislation.gov.uk/uksi/2013/351/contents/made</p> <p>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</p> <p>NHS Health Check dataset and read code mapping: http://www.hscic.gov.uk/nhshealthcheck</p> <p>NHS Health Check single data list returns: a brief guide for local authorities: www.healthcheck.nhs.uk/document.php?o=454</p>
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2. INVITATION AND OFFER: consistent approach to non-responders and those who do not attend their risk assessment	
Description	<p>An agreed process should be in place for those eligible for the NHS Health Check who either do not respond to the offer or do not attend (DNA) their appointment.</p> <p>At least two contacts should be made: a written invitation letter should be followed up by a reminder if there is no response.</p> <p>Local areas may agree on the most appropriate reminder method for their population (eg, phone, text, letter, email, in person).</p>
Rationale	<p>Low uptake and variation leads to some people given more chance than others to participate.</p> <p>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.</p>
Quality indicator(s)	<p>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).</p>
Evidence to demonstrate achievement	<ul style="list-style-type: none"> • 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,

	<p>language, easy read, translation services, etc)</p> <ul style="list-style-type: none"> • 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	<p>www.healthcheck.nhs.uk/commissioners_and_healthcare_professionals/managing_your_programme/inviting_your_population/</p> <p>NHS Health Check dataset and read code mapping: http://www.hscic.gov.uk/nhshealthcheck</p>

3. THE RISK ASSESSMENT: ensuring a complete health check for those who accept the offer is undertaken and recorded	
Description	<p>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:</p> <ol style="list-style-type: none"> age gender ethnicity smoking status family history of coronary heart disease blood pressure, systolic (SBP) and diastolic (DBP) body mass index (height and weight) General practice physical activity questionnaire (GPPAQ) Alcohol use score (AUDIT-C or FAST can be used as the initial screen, further guidance is in the best practice guidance 2013) cholesterol level: total cholesterol and HDL cholesterol (either point of care or venous sample if within the last six months) cardiovascular risk score: a score relating to the person's risk of having a cardiovascular event during the ten years following the health check, derived using an appropriate risk engine that will predict cardiovascular risk based on the population mix within the local authority's area dementia awareness (for those aged 65 to 74) diabetes filter (BMI and BP) see standard 8
Rationale	<p>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.</p> <p>Every individual who receives an NHS Health Check should receive a good quality, complete risk assessment, irrespective of where they live, or the provider.</p> <p>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.</p>

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	<p>Provider has a record of the following for each NHS Health Check undertaken:</p> <ul style="list-style-type: none"> • all indicators listed above • ‘NHS Health Check complete’ recorded • name of health professional delivering the NHS Health Check • date of NHS Health Check <p>Evidenced through regular electronic data extraction and production of reports, read code audit or if not possible, notes audit.</p> <p>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.</p> <p>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.</p>
Further Information	<p>Best practice guidance September 2013: www.healthcheck.nhs.uk/document.php?o=456</p> <p>NHS Health Check dataset and read code mapping: http://www.hscic.gov.uk/nhshealthcheck</p> <p>To access information on AUDIT-C and FAST, the two recommended initial screening tools used in the NHS Health Check; http://www.alcohollearningcentre.org.uk/Topics/Browse/BriefAdvice/</p>

4. THE RISK ASSESSMENT: equipment use

Description	<p>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.</p> <p>Any adverse incidents involving medical equipment should be reported to the manufacturer as well as the Medicines and Healthcare products Regulatory Agency (MHRA) and managed according to providers’ governance arrangements.</p> <p>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.</p>
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	<p>For example:</p> <ul style="list-style-type: none"> • 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 • a patient's health deteriorates due to medical device failure (MHRA)
Rationale	<p>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.</p> <p>Incident should be reported as soon as possible. Some apparently minor incidents may have greater significance when aggregated with other similar reports.</p>
Quality indicator(s)	To develop locally, as appropriate
Evidence to demonstrate achievement	<ul style="list-style-type: none"> • Documentation of equipment checks • Audit • Use of equipment and notification of incidents included within provider's governance arrangements
Further information	<p>www.mhra.gov.uk/Safetyinformation/Reportingsafetyproblems/Devices/</p> <p>MHRA Blood pressure measurement devices, December 2013</p> <p>www.mhra.gov.uk/home/groups/dts-iac/documents/publication/con2024250.pdf</p>

5. THE RISK ASSESSMENT: quality control for point of care testing	
Description	<p>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.</p> <p>Where using POCT, providers should ensure:</p> <ol style="list-style-type: none"> 1) They should only be used by healthcare professionals and staff who have been trained (by a competent trainer) to use the equipment 2) An individual is identified as the named POCT coordinator 3) That an appropriate internal quality control (IQC) process is in place in accordance with the MHRA guidelines on POCT, 'Management and use of IVD point of care test (POCT) devices. Device bulletin 2010(02) February 2010'. This should take the form of at least a daily "go/no go" control sample (use of a liquid sample) on days when the instrument is in use. This may require other procedures e.g. optical check to be performed in addition to the use of a liquid control sample. All record keeping on this process should be

	<p>accurate & contemporaneous.</p> <p>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 or CPA websites: www.ukas.com/ www.cpa-uk.co.uk</p>
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 the four criteria in place (as outlined in the description above)
Evidence to demonstrate achievement	<ul style="list-style-type: none"> • up-to-date register of trained/competent operators • name of POCT coordinator • records of results of quality control performed • evidence of registration in an accredited EQA scheme reporting to NQAAP
Further information	<p>The WHO consultation concluded that HbA1c can be used as a diagnostic test for diabetes, provided that stringent quality assurance tests are in place and assays are standardised to criteria aligned to the international reference values, and there are no conditions present that preclude its accurate measurement.</p> <p>Your local hospital laboratory or other accredited provider can be consulted for advice regarding appropriate quality control process for POCT. In addition local healthcare scientists can offer support to services wishing to set up POCT services.</p> <p>MHRA device bulletin. Management and use of IVD point of care test devices DB2010(02) February 2010: www.mhra.gov.uk/Publications/Safetyguidance/DeviceBulletins/CON071082</p> <p>A practical guide to POCT: www.healthcheck.nhs.uk/document.php?o=129</p> <p>The latest buyers' guides from the NHS Purchasing and Supply Agency, Centre for Evidence Based Purchasing (Please note, The Centre for Evidence Based Purchasing has since disbanded on 31 March 2010 so these documents have not been updated)</p> <p>Buyers' guide: blood glucose systems, May 2008: www.healthcheck.nhs.uk/document.php?o=232</p> <p>Buyers' guide: point of care testing for cholesterol measurement.</p>

	<p>September 2009: www.healthcheck.nhs.uk/document.php?o=11</p> <p>Buyer's guide: point of care testing for HbA1c. June 2009: www.healthcheck.nhs.uk/document.php?o=12</p>
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6. COMMUNICATION OF RESULTS: ensuring results are communicated effectively and recorded
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Description	<p>All individuals who undergo a NHS Health Check must have their cardiovascular risk score calculated and explained in such a way that they can understand it. This communication should be face to face.</p> <p>Staff delivering the NHS Health Check should be trained in communicating, capturing and recording the risk score and results, and understand the variables the risk calculators use to equate the risk.</p> <p>When communicating individual risks, staff should be trained to:</p> <ul style="list-style-type: none"> • 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. <p>Individuals receiving a NHS Health Check should be given adequate time to ask questions and obtain further information about their risk and results.</p> <p>Individualised written information should be provided that includes their results*, bespoke advice on the risks identified and self referral information for lifestyle interventions.</p> <p>*This should include and provide an explanation of their:</p> <ul style="list-style-type: none"> • BMI • cholesterol level (total cholesterol and HDL cholesterol) • blood pressure • alcohol use score (AUDIT C or FAST) • risk score and what this means • referrals onto lifestyle or clinical services (if any)
Rationale	<p>Legal duties exist for local authorities 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.</p> <p>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</p>

	<p>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.</p>
Quality indicator(s)	<p>6a. Proportion of NHS health checks undertaken where cardiovascular risk score, BMI, cholesterol level, blood pressure and alcohol use score (AUDIT C or FAST) score is communicated face to face.</p> <p>6b. Proportion of NHS health checks undertaken where written, tailored information is provided at the same time.</p>
Evidence to demonstrate achievement	<ul style="list-style-type: none"> • in addition to record of risk assessment indicators as outlined in standard 3; ‘results communicated’ should be recorded • examples of written information used • training and education materials 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	<p>The ‘Vascular risk assessment: workforce competencies’ is being refreshed to reflect changes within the health and social care system. It will specifically consider the widening range of providers in the market and link to competency frameworks from other sectors. The new framework is scheduled to be published in April 2014 after extensive consultation. Full details will be available from the NHS Health Checks website http://www.healthcheck.nhs.uk/ and released through normal media channels.</p> <p>Vascular risk assessment: workforce competencies. June 2009: www.healthcheck.nhs.uk/commissioners_and_healthcare_professionals/national_guidance/</p> <p>Best practice guidance. October 2013: www.healthcheck.nhs.uk/commissioners_and_healthcare_professionals/managing_your_programme/delivering_the_nhs_health_check/</p> <p>National results pack and booklet: www.healthcheck.nhs.uk/commissioners_and_healthcare_professionals/national_resources/promotional_materials/results_packs/</p> <p>NICE clinical guidance 67. Lipid modification: cardiovascular risk assessment and the modification of blood lipids for the primary and secondary prevention of cardiovascular disease. May 2008 (last modified March 2010): publications.nice.org.uk/lipid-modification-cg67/guidance</p>

7. RISK MANAGEMENT: high quality and timely lifestyle advice given to all

<p>Description</p>	<p>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:</p> <ul style="list-style-type: none"> • stop-smoking services • physical activity interventions • weight management interventions • alcohol-use interventions
<p>Rationale</p>	<p>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.</p> <p>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.</p>
<p>Quality indicator(s)</p>	<p>7a. Proportion of NHS Health Checks undertaken where record exists that brief advice provided.</p> <p>7b. Proportion of NHS Health Checks undertaken where referral to lifestyle intervention is made, where appropriate.</p> <p>7c. Proportion of individuals where a record of outcome following lifestyle intervention is available (ie, four-week smoking quit/ 5% reduction in body weight)</p>
<p>Evidence to demonstrate achievement</p>	<ul style="list-style-type: none"> • evidence-based and accessible lifestyle intervention services in place • agreed patient pathway in place • documentation of: <ul style="list-style-type: none"> – 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 • read code or notes audit against indicators outlined above • training and education materials available for health professionals • patient survey or other patient feedback mechanism that

	<p>asks about lifestyle change</p> <ul style="list-style-type: none"> • number of patient complaints received
Further information	<p>Let's get moving. A physical activity care pathway commissioning guidance, March 2012. www.gov.uk/government/publications/let-s-get-moving-revised-commissioning-guidance</p> <p>NICE public health intervention guidance 1, brief interventions and referral for smoking cessation in primary care and other settings, March 2006. www.nice.org.uk/PHI001</p> <p>NICE public health intervention 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, March 2006. guidance.nice.org.uk/PH2/Guidance</p> <p>NICE clinical guideline 43. Obesity: guidance on the prevention, identification, assessment and management of overweight and obesity in adults and children. December 2006 guidance.nice.org.uk/CG43</p> <p>NICE clinical guideline 127. Hypertension: clinical management of primary hypertension in adults. August 2011. www.nice.org.uk/nicemedia/live/13561/56008/56008.pdf</p> <p>NICE public health guidance 24. Alcohol-use disorders – preventing harmful drinking (PH24), June 2010. guidance.nice.org.uk/PH24</p> <p>The 'Vascular risk assessment: workforce competencies' is currently under review. The revised framework is expected to be published in April 2014.</p> <p>Vascular risk assessment: workforce competencies. June 2009. www.healthcheck.nhs.uk/commissioners_and_healthcare_professionals/national_guidance/</p> <p>NHS Health Check dataset and read code mapping: http://www.hscic.gov.uk/nhshealthcheck</p>

8. RISK MANAGEMENT: additional testing and clinical follow up

Description	<p>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:</p> <ol style="list-style-type: none"> 1. Following the diabetes filter, undertaken as part of the risk assessment, blood glucose test; either fasting plasma glucose or HbA1c (glycated haemoglobin) for all identified as high risk. Indicated by either: <ol style="list-style-type: none"> a. BP \geq140/90 mmHg or where the SBP or DBP exceeds
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	<p>140mmHg or 90mmHg respectively</p> <p>b. BMI \geq 30 or 27.5 if individuals from the Indian, Pakistani, Bangladeshi, other Asian and Chinese ethnicity categories</p> <p>Individuals identified with pre-diabetes need to be reviewed at least annually.</p> <p>2. Assessment for hypertension by GP practice team when indicated by:</p> <p>a. BP \geq140/90 mmHg</p> <p>b. Or where the SBP or DBP exceeds 140mmHg or 90mmHg respectively</p> <p>Individuals diagnosed with hypertension to be added to the hypertension register and treated through existing care pathways. They should be reviewed in line with NICE guidance, including provision of lifestyle advice.</p> <p>3. Assessment for chronic kidney disease by GP practice team when indicated by:</p> <p>a. BP $>$140/90 mmHg</p> <p>b. Or where SBP or DBP exceeds 140mmHg or 90mmHg respectively</p> <p>All who meet these criteria to receive serum creatinine test to estimate glomerular filtration rate (eGFR).</p> <p>4. Assessment for familial hypercholesterolemia by GP practice team when indicated by:</p> <p>a. Total cholesterol $>$7.5 mmol/L</p> <p>5. Alcohol risk assessment, use of full AUDIT when indicated by:</p> <p>a. AUDIT C Score \geq5</p> <p>b. Or FAST \geq3</p> <p>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 considered.</p> <p>6. Where the individual's BMI is in the obese range as indicated by:</p> <p>a. BMI \geq27.5 in individuals from the Indian, Pakistani, Bangladeshi, other Asian and Chinese ethnicity categories</p> <p>b. BMI \geq 30 individuals in other ethnicity categories</p> <p>Then a blood glucose test is required.</p> <p>For all, systems and process should be in place to ensure follow up test(s) undertaken and results received.</p>
Rationale	Only through the early detection and management of risk factors can the NHS Health Check maximise its public health impact and reduce

	<p>premature mortality.</p> <p>It is key that the actions taken at these thresholds are the same to assure 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...</p>
Quality indicator(s)	<p>Where thresholds met:</p> <p>8a. Proportion of individuals with investigations undertaken</p> <p>8b. Proportion of individuals with outcome recorded</p>
Evidence to demonstrate achievement	<ul style="list-style-type: none"> • Record of individuals identified as: <ul style="list-style-type: none"> ○ pre diabetic/diabetic ○ hypertensive ○ CKD ○ familial hypercholesterolemia ○ Audit C ≥ 5/ FAST ≥ 3 ○ BMI ≥ 27.5 • 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	<p>Best practice guidance. October 2013. www.healthcheck.nhs.uk/commissioners_and_healthcare_professionals/managing_your_programme/delivering_the_nhs_health_check/</p> <p>NICE public health guidance 38. Preventing type 2 diabetes: risk identification and interventions for individuals at high risk, July 2012. guidance.nice.org.uk/PH38</p> <p>NICE clinical guideline 73. Chronic kidney disease: national clinical guideline for early identification and management in adults in primary and secondary care, September 2008. www.nice.org.uk/Guidance/CG73/Guidance/pdf/English</p> <p>NICE clinical guideline 66. Type 2 diabetes: the management of type 2 diabetes, December 2008. http://guidance.nice.org.uk/CG66</p> <p>NICE quality standard 6. Diabetes in adults, March 2011. publications.nice.org.uk/diabetes-in-adults-quality-standard-qs6</p> <p>NICE clinical guideline 127. Hypertension: clinical management of primary hypertension in adults, August 2011.</p>

	<p>www.nice.org.uk/nicemedia/live/13561/56008/56008.pdf</p> <p>NICE public health guidance 24. Alcohol-use disorders – preventing harmful drinking (PH24), June 2010. guidance.nice.org.uk/PH24</p> <p>NICE clinical guideline 71. Familial Hypercholesterolaemia http://www.nice.org.uk/guidance/cg71</p> <p>NICE Quality Standards 41 for Familial Hypercholesterolaemia. August 2013 http://guidance.nice.org.uk/QS41</p>
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9. RISK MANAGEMENT: appropriate follow up for all if CVD risk assessed as 20% and greater	
Description	<p>All individuals with $\geq 20\%$ 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.</p> <p>People found to be at or above 20% risk should exit the programme irrespective of whether they have signs of disease.</p> <p>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).</p> <p>Those diagnosed with 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.</p>
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 20% and greater managed according to NICE guidelines.
Evidence to demonstrate achievement	<ul style="list-style-type: none"> • 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	<p>NICE clinical guidance 67. Lipid modification: cardiovascular risk assessment and the modification of blood lipids for the primary and secondary prevention of cardiovascular disease. May 2008 (last modified March 2010) guidance.nice.org.uk/CG67</p> <p>Further guidance on the appropriate follow up of those with a CVD risk of 20% and greater is being explored.</p>

10. THROUGHOUT THE PATHWAY: confidential and timely transfer of patient identifiable data	
Description	<p>Where the risk assessment is conducted outside the individual's GP practice, local authorities have a legal duty to arrange for the provider to send the following information to the person's GP:</p> <ul style="list-style-type: none"> • 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) <p>A protocol also needs to be in place for timely referral of patients where abnormal parameters identified.</p> <p>For all individuals who require additional testing and clinical follow up, GP practices should follow Standards 8 and 9.</p>
Rationale	<p>Legal duties exist for local authorities 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.</p> <p>There are a number of potential issues surrounding data flows for example:</p> <ul style="list-style-type: none"> • 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 <p>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.</p>
Quality indicator(s)	<p>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).</p> <p>10b. Proportion of GP practices that then record these results on their</p>

	clinical system results in a timely way (the suggested expectation is within two working days).
Evidence to demonstrate achievement	<ul style="list-style-type: none"> • 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 dataset and read code mapping: http://www.hscic.gov.uk/nhshealthcheck

8. Next Steps

As outlined previously, 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 develop. PHE will work closely with local authorities to explore options and develop mechanisms to support local commissioners. This programme of work will continue through ongoing discussion and engagement with local commissioners, utilising existing programme networks.

Already, following consultation of this document with local commissioners and stakeholders, a large amount of feedback and intelligence has been gathered. In response, comments have been incorporated and a number of additions and changes have been made. There are however, some issues that require further exploration in order to find a resolution together with ideas for future development. These have been summarised within an issues log and PHE plan to work through these during the next phase of development. The log is available through the quality assurance pages of the NHS Health Check programme website
http://www.healthcheck.nhs.uk/commissioners_and_healthcare_professionals/managing_your_programme/quality_assurance/

Appendix 1

Lola Abudu	East Midlands PHE Centre
Clare Beard	NHS Improving Quality
Slade Carter	Heart UK
Sue Cecconi	Lincolnshire County Council
Amanda Chappell	Bristol City Council
Richard Cienciala	Department of Health
Shelia Cleary	Dudley County Council
Nicolas Collins	NHS Improving Quality
Sue Cohen	National Screening Committee, PHE
Elizabeth Dormandy	National Screening Committee, PHE
Ann-Marie Diaper	Anglia and Essex PHE Centre
Christopher Eggett	University of Sunderland
Richard Fluck	National Clinical Director for Renal Disease, NHS England
Rachel Fluke	Croydon Council
Frances Fuller	London Borough of Lewisham
Ellis Friedman	London Borough of Sutton
Catherine Goodall	Anglia and Essex PHE Centre
Huon Gray	National Clinical Director for Heart Disease, NHS England
Catherine Gregson	Healthy Equity and Impact, PHE
Samantha Hewitt	Coventry City Council
Justine Hottinger	Norfolk County Council
Simon How	Anglia and Essex PHE Centre
Zafar Iqbal	Stoke on Trent City Council
Paul Johnstone	Regional Director North, PHE
Ann-Marie Johnston	Wakefield Council
Matt Kearney	GP and National Clinical Advisor PHE & NHS England
Jagdish Kumar	Stoke on Trent City Council
Don Lavoie	Alcohol Programme Manager, PHE
Viv Mussell	West Sussex County Council
Paul Ogden	Local Government Association
Chima Olughu	Royal Borough of Greenwich
Tim Reynolds	Chair Joint Working Group on Quality Assurance, Royal College of Pathology
Anthony Rudd	National Clinical Director for Stroke, NHS England
Danny Ruta	London Borough of Lewisham
Charles Ryan	Peterborough City Council
Elaine Salvati	Tees Valley Public Health Shared Service
Melanie Sirokin	Cheshire and Merseyside PHE Centre Director
Rosanne Sodzi	Avon, Gloucestershire & Wiltshire PHE Centre
Rosemary Smith	NHS Central South Commissioning Support Unit

Victoria Smith	North Lincolnshire County Council
Jeremy Speed	Wessex PHE Centre
Chloe Todd	Hampshire County Council
Suzanne Vernazza	NHS England
Jo Wall	NHS England
Jo Whelhan	Roche
Rebecca Willans	Wansworth Council
Paul Williams	GP, Stockton on Tees