

Quality Assurance for NHS Health Checks
National Review
May 2013
Final Version

i. Executive Summary

This paper describes and evaluates different Quality Assurance (QA) mechanisms in place across England in the commissioning and delivery of NHS Health Checks. These QA solutions have all been developed and implemented locally to enhance implementation of the Health Check programme. Local leads have kindly shared and reviewed their approach.

The QA solutions that were identified can be grouped into three main approaches, Section 5 provides case studies for each with further details, but broadly they are:

- Patient level data extraction and monitoring followed up by face to face QA visits undertaken in GP practices
- QA visits undertaken only
- Patient level data extraction and monitoring only

Reviewing each approach has generated generalizable knowledge relating to implementing a QA mechanism for NHS Health Checks, with the view to inform decision making regarding potentially developing a national QA approach.

To inform this work, extensive stakeholder engagement was undertaken (Section 3.1). It was universally felt that a robust QA mechanism is needed for NHS Health Checks, although the focus to date for the majority of stakeholders has been on implementing the programme and increasing uptake. Existing processes are unable to guarantee that every individual entering the pathway is being managed appropriately, consistently, accurately and is not lost. Until the NHS Health Check programme is subject to section 251, the ability to track individuals through the pathway will continue to be limited. If services were subject to external scrutiny we would be unable to guarantee and demonstrate that the required failsafe processes are in place.

Stakeholders felt that there were significant risks during the identification of the eligible population, the offer of a health check, the test, communication of results and subsequent management and follow up. The second strong message from stakeholders was that when looking at potential QA approaches, the solution needs to be pragmatic, light touch and low cost.

In terms of the findings, it is apparent that establishing a QA mechanism for NHS Health Checks is feasible; although limited in number, there are good examples in place. These approaches have been established locally with relatively limited capacity and investment to date; working across a number of GP practices and different IT systems.

This review identifies a number of benefits to establishing QA, not only in improving the quality and the safety of the pathway and minimising risk for patients but also in raising the profile of NHS Health Checks and gaining greater engagement from providers, reducing inefficiencies, improving consistency of delivery, facilitating service improvement, improving data quality and monitoring outcomes.

It must be noted that the transition of NHS Health Checks to Local Authorities took place during this review. This change in commissioning responsibility to local government brings additional factors that have not been fully explored within this paper but need to be taken into account when considering options moving forward.

A national QA approach, if adopted, was identified by stakeholders to be of great value, in order to avoid duplication of effort, enhance the quality and safety of local delivery and improve consistency of approach across the country. It is recommended that the findings of this review inform the development of options regarding the characteristics and requirements of a potential national QA approach.

Contents

1. Aim of this paper.....	4
2. Background	4
3. Quality Assurance Pilot	4
4. Methodology.....	5
5. Findings	6
6. Conclusions	14
7. Recommendation.....	14

1. Aim of this paper

This paper describes and evaluates different Quality Assurance (QA) mechanisms in place across England in the commissioning and delivery of NHS Health Checks. These QA solutions have all been developed and implemented locally. Local leads have kindly shared their approach and evaluated its success against defined criteria; the findings have helped generate generalizable knowledge related to QA for NHS Health Checks.

The overall purpose of this review is to explore the concept and feasibility of a QA solution for NHS Health Checks and inform recommendations regarding the characteristics and requirements of a potential national QA solution, if adopted more widely.

2. Background

The focus of NHS Health Checks so far has been on the implementation and roll out of this new Programme. A large amount of work has been carried out across the NHS in order to achieve full implementation; it is now an opportune time to build on this to ensure that commissioned services are quality assured along the whole pathway.

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; this scrutiny forms the backbone of the programme monitoring overseen by DH. The QA work described here is tightly integrated with the programme monitoring, but is designed to ensure further safety and quality of the Service for each individual managed through the programme.

QA Commissioning Guidance was developed in early 2012, on behalf of the SHA Health Check Leads, to help commissioners define the key areas of any QA framework they might commission in order to monitor and provide widespread confidence in the NHS Health Checks Programme.

The guidance defines:

- the health check pathway and possible areas of risk;
- the minimum standards of care at each point on the pathway;
- the QA mechanisms that need to be in place;
- the identification and subsequent management of a serious incident;
- the continuous performance monitoring of the Programme.

In addition, it was highlighted by the SHA Leads that commissioners should have appropriate QA arrangements in place in order to ensure the quality and safety of NHS Health Checks for each individual going through the programme.

3. Quality Assurance Pilot

In March 2012 it was agreed by the SHA Leads and DH Policy team that a pilot be initiated to test the concept and feasibility of a QA solution for NHS Health Checks. Initially, the aim of the pilot was to create, and test, a pragmatic, yet robust, QA solution for NHS Health Checks. To identify whether patient-level monitoring could be put in place to detect outliers and ensure robust failsafe procedures and quality of care. The objective was to identify a solution that would be light-touch and low-cost, minimising the need for onerous data collection, inspection and audit.

The scope was to look at an approach that could be used in GP settings, with the view to consider how this could best be adapted for use in outreach work or alternative providers.

3.1 Stakeholder Engagement

In order to develop the commissioning guidance a workshop for commissioners and stakeholders from over 35 organisations across the Midlands and East of England was held to identify whether there were any risks across the pathway.

It was felt that existing processes are unable to guarantee that every individual entering the pathway is being managed appropriately, consistently, accurately and is not lost. If services were subject to external scrutiny we would be unable to guarantee and demonstrate that the required failsafe processes are in place. The stakeholders felt that there were significant risks during the identification of the eligible population, the offer of a health check, the test, communication of results and subsequent management and follow up. There were also some risks that were spread throughout the pathway (appendix 3 shows the key risks on the pathway).

The next step, and the first element of the pilot, was to understand what was already in place, to identify whether any local areas had developed any QA mechanisms in response to the risks identified. Workshops were held at the National NHS Health Check update day and stakeholder engagement continued with teams across England, contact often facilitated by the SHA Leads. We also met with those leading on data extraction and IT for the Health Check Programme (a list of all organisations involved can be found in appendix 2). The same risks and concerns were echoed throughout these discussions.

From these conversations it became apparent that a small number of areas had developed QA mechanisms locally. Responding to this new information, the approach of the pilot was adapted. Rather than create a new solution, the focus shifted to examining and learning from what was already in place.

Three main approaches to QA became apparent, all to date, with a focus on GP providers rather than outreach provision:

- Patient level data extraction and face to face QA visits undertaken in GP practices
- QA visits undertaken only
- Patient level data extraction only

Section 5 uses case studies to describe each of these approaches in more depth.

4. Methodology

There were three parts to the review:

- 1) A Donabedian evaluation framework was adopted¹; this seeks details on the structure (resources required, including staffing and budget), process (the actions; what is actually delivered) and outcomes (what have been the results) of the QA approach undertaken (section 5.1).
- 2) A quantitative assessment; against 24 criteria grouped under the four categories of²; Safety, effectiveness, efficiency, added value. Local Health Check leads were asked to provide a score against each based on how well they perceived that the QA mechanism in place meets the criteria (section 5.2).
- 3) A short stakeholder questionnaire; that sought views on the process; what worked well and what could be improved (section 5.3).

¹ Donabedian, A (1980) The quality of care, how can it be assessed? JAMA, 260, 1743-8.

² Adapted from Fordham, R et al (2012) Economics Assessment of Quality Assurance for Antenatal and Newborn Screening Programmes

5. Findings

5.1 Description of Each Approach

5.1a Patient Level Data Extraction and QA visits

Buckinghamshire

QA was identified as important locally in making sure that health checks are effective by ensuring that all aspects of health checks were carried out according to guidance, abnormal results followed up, patients treated, signposted, advised and referred appropriately and that resources are not being wasted. It was identified that GP practices needed a lot of 1:1 support to deliver the health check effectively. It is a fairly large workload for a practice and so cannot be squeezed into existing staff capacity.

There are two key aspects to the approach taken in Buckinghamshire:

a) Data: QA framework

Patient level data from practices are collected centrally by TCR (The Computer Room) via Quest, from locally developed NHS Health Check templates for all practice systems in use (EMIS LV, EMIS PCS, EMIS Web, iSoft Premiere, iSoft Synergy, Vision, SystemOne). The QA framework includes analysis of this data at practice level to assure that the practice meets the standards for the programme. The main searches look at completeness of the Health Check Programme (number and percentage invited, completed Health Checks) and completeness of health check data against the standardised NHS Buckinghamshire Health Check templates, all by practice. Further specific searches are undertaken looking at a number of different indicators including; uptake in target groups, referrals to lifestyle interventions, abnormal results and prescribing. Where issues are identified these will be discussed with practice staff during follow up QA visits and actions agreed. The data quality is part of the QA framework and less than 80% field completeness means GP practices aren't paid.

b) QA practice visits

A part time cardiac nurse (20 hours per week), is employed with working knowledge of the Health Check to undertake GP practice visits with a QA framework. The nurse has access to a large set of data regarding the health checks at the practice, tests done, follow up of patients, new diagnoses, etc. This framework identifies any areas of non-compliance and agrees remedial actions with the practice to address. It also identifies areas that the PCT may need to resolve about the delivery of the programme. The nurse follows up these actions with the practice to ensure they are delivered. The visits are between 1-2 hours each and the whole practice health check team (Practice Manager, admin, GP, Nurse/Health Care Assistant) are encouraged to attend. There can on occasion be further visits to a practice where more support is required. This more intensive support is reserved for practices in the most deprived areas, where levels of cardiovascular disease mortality is highest

The QA meetings have been very useful in getting 'buy in' to the Health Check, plus identifying process issues that may not be picked up by the collected read coded data (e.g. what leaflets are given, is it done over one or two appointments, does the GP see all high risk patients etc). All GP practices work very differently and so trying to apply a prescriptive single approach has not worked, so these visits help tweak the processes to deliver the guidance to ensure it fits with existing electronic and administrative systems in the practice. There are also varied IT skills in practices and so some staff need extra support to use the data entry and reporting system.

It a requirement for every GP practice to have a QA visit each year. In the first 6 months, 20/57 practices have had a QA visit.

Findings at a practice level included:

- Identifying Ineligible blood tests undertaken outside protocol
- Follow up of abnormal tests results not undertaken in every instance
- Some practices just invite opportunistically rather than send letters
- Staff are not all trained in behaviour change
- Practices are not always calculating a risk score using QRISK2
- Staff do not always signpost or refer onto lifestyle services (combination of no referral and referral declined)

Learning from a commissioning perspective included:

- GPs are not always involved in the programme
- There are many facets to the programme and practice staff feel they are overwhelmed by the information with which they need to be familiar
- TCR Nottingham (who run Quest) have to provide a significant amount of IT support to some practices due to old infrastructure or lack of IT skills
- QA visits very well received by majority of practices
- Dedicated administration time to support the QA process is essential and not always in place in practices, so non-responding patients are not always followed up

Nottingham City

A number of other areas use the same data extraction software provider as Buckinghamshire, including Nottingham City. From the monitoring of this data Nottingham City have then focused on engaging those practices that have lower levels of activity and commissioning training where training needs are identified. They also have a programme of practice visits and support in place, currently these focus on ensuring processes are in place for systematic invitation, follow-up, targeting etc. Capacity allowing, they plan to develop these visits further in the future.

5.1b Patient Level Data Extraction Only: Medway

The current approach was not necessarily planned and developed as a quality assurance system. It was created through the project management process to aid problem solving, evaluation and monitoring. The need to have a robust data extraction system was great as there is only one member of staff to manage all elements of the NHS Health Check Medway programme including QA.

Medway use the IT system Informatica to extract data from their GP practices, this system covers 53 of the 57 GP surgeries (the clinical systems from the other four surgeries currently do not work with Informatica at their own choice) and is also used for other primary care data extraction purposes not just NHS Health Checks .

The informatica system has its own template for health checks regardless of whether the surgery are on EMIS LV, PCS, Web, Vision or Synergy. The NHS Health Check completed code will only be entered once all data is entered (this excludes the blood results).The electronically collected patient level data provides information for a number of indicators, allowing the commissioner to check up on practice performance.

Data is sent automatically on a weekly basis from the GP practices. Data from the four remaining surgeries is sent quarterly via an excel spread sheet. All data is uploaded to our access NHS Health check database on a quarterly basis for payment, performance management, quality assurance and evaluation purposes. All NHS Health Checks must be completed fully for surgeries to gain payment. A quarterly performance report or 'ranking list' is sent to all GP practices for benchmarking based on the automatic data extraction.

Practice visits, face to face training/assessment sessions are currently taking place on an ad hoc basis where issues are identified.

Findings from this system have resulted in delivery changes at GP level such as;

- the correct pathology tests are being carried out,
- ensuring that the motivational interviewing element is carried out
- the patient receiving their CVD risk score and the healthcare professional understanding what it means and how it is calculated
- Ensuring all healthcare professionals use Informatica when carrying out the check

Findings from this system have resulted in PCT service changes including;

- Writing IT system requirements into the GP and outreach service specifications,
- Ensuring that all elements of Informatica fit with national best practice and are mandatory for practices to carry out
- Ensuring the software uses the read codes set out in the minimum data set
- Health care professional new staff training

The plan is for the quality assurance system to be more robust in the future with a more structured approach to its roll out, starting with auditing the worst performing practices and local evaluation will be incorporated into this once in place.

5.1c Practice QA visits only: Bedfordshire

There were two primary reasons for creating a QA process:

1. It was recognised that the annual spend on delivery of NHS Health Checks dictated that some form of QA should be delivered.
2. There was anecdotal evidence of differing practice that may be leading to inequity of delivery.

The rationale behind the construction of the QA template was to ensure correct and essentially highly similar procedures were being delivered across Bedfordshire (allowing for local variation and different risk engines).

The QA process and template was developed in a collaborative manner between Public Health, a number of local GPs, Primary Care Contracting and nurses experienced in community delivery. This approach and use of locally recognised clinical staff with considerable experience of delivery was decided upon to maximise Practice engagement. This has led to full take up of the QA across Bedfordshire.

It was decided that all 56 Practices would be assessed in the first year followed by 20% per year thereafter in a pseudo randomised manner. The requirement to accept a QA is embedded within the Local Enhanced Service and new SLA, signed by all Practices. There is no additional payment but payment can be withheld if a Practice refuses to accept a QA visit.

The task of delivering quality assurance (QA) checks was outsourced to Horizon Health Choices, a private company formed from clinicians previously operating within the local Practice Based Commissioning Group. The staff delivering QA visits went through a familiarisation process to ensure consistency of delivery. Two primary assessors were identified, both of whom had significant experience of delivering Health Checks and were known in the local health environment.

The outcome of each action in the template was recorded as 'achieved' or 'not achieved', where the latter was true a clear description of remedial action was identified. Where there was a 'not achieved' result the Practice was given a timescale in which to resolve the issue, this was discussed and agreed with consideration to the specific reason/issue identified.

The local end of year evaluation has not been completed but evidence to date shows improvement in the Practices requesting additional training off the QA check. Process outcomes are demonstrated below:

There are 56 Practices across Bedfordshire, at the end of February 2013 the position was:

- 35 Passed
- 12 to revisit (reason predominantly lack of class III scales or lack of in date calibration)
- 1 declined (ongoing discussion over access to records)
- 8 to visit

5 asked for additional training. The general level of acceptance and feedback was very positive

Table 1 provides details on the cost of each approach, from the commissioner perspective, together with the strengths and limitations.

Table 1

Area/ approach	Cost From the commissioner perspective.	Strengths	Limitations
<p>Bucks</p> <p>Data collection and QA visits</p>	<p>Year 1 Cost c. £98,000 Annual Cost c. £88,500</p> <p>Quest reporting – £48,000/year Quest reports to analyse collected data - £10,00 one off payment, plus running costs/ year £500. Band 7 nurse 20 hours a week.</p> <p>Plus 0.1WTE PH consultant oversight 0.2WTE Project management (8b) 0.05WTE GP lead</p> <p>Pls note many of these costs would have been incurred as part of ‘routine’ programme delivery. Data reporting and staff time is required to process invoices, answer queries from practices and to evaluate the service.</p> <p>Provider costs (eg. staff time) have not been included</p>	<ul style="list-style-type: none"> • Data monitoring relatively quickly identifies issues that can negatively impact the programme. These can then be followed up in more depth through a face to face visit. • Ensures approach is embedded into existing systems and linked to GP payment so is more sustainable. For example, Bucks didn’t see any drop off in health checks done during flu season this year. • QA mechanism is consistent across Buckinghamshire • Develops better relationship with providers and supports improvements in delivery; the QA visits help practices solve the problems that affect delivery of the programme. ‘They don’t seem to allocate time as a practice to doing this in a lot of the practices that were visited. Simply by putting the team together in a room and facilitating the discussion solves the issues a lot of the time. It helps to ensure health checks fits with what they currently do and that they see the benefits of doing it’. • Use of QA team with expertise; the approach has been developed using clinicians experienced in the delivery of Health Checks and they are recognised by practices as there to assist and support them. • Maximises effectiveness of health checks programme; ensures that providers are working to guidance and protocol, improves ongoing management and follow up of patients. • Improves data quality, and enables monitoring of programme outcomes. 	<ul style="list-style-type: none"> • Resource intensive; relies on dedicated staff resource and capacity to follow up where practices may need more support. • Does not assess individual competencies of practice staff or physically check calibration of equipment used. • Requires practice buy-in for QA visit. Some practices may not make the time for the visit. It can stop practices from ‘thinking’, as, for example, ‘we have been asked by practices what they should do if they get a high BP, or raised sugar. Although this is covered in the guidance, they should also be doing this as part of standard patient care and so should have a protocol. They seem to forget what they would ‘normally’ do at times’.

Area/ approach	Cost	Strengths	Limitations
<p>Medway</p> <p>Data collection only</p>	<p>Annual Cost c. £43,600</p> <p>Informatica software and support- approx. £40,000 pa (estimate as the full package includes more than just NHS Health Checks)</p> <p>Staff time- estimation of 7.5 hours a week (band 7)</p> <p>Pls note: Provider costs (eg. staff time) have not been included</p>	<ul style="list-style-type: none"> • Data monitoring relatively quickly identifies issues that can negatively impact the programme • Use of a robust data extraction system minimises staff costs; is cost effective and efficient as it relies mainly on an IT system to carry out and identify issues. • Reduces time investment required from providers and commissioner. • Ensures approach is embedded into existing systems and linked to GP payment so is more sustainable. • Improves data quality, and enables monitoring of programme outcomes. • System is consistent across Medway 	<ul style="list-style-type: none"> • Limited ability to provide follow up QA visits to help address issues identified. • Does not pick up on elements not visible through data monitoring such as the communication and the advice/referral element of the check. • Limited ability to develop relationship with providers and foster improvements in service delivery. Although sharing of performance data between GP practices does take place.
<p>Beds</p> <p>QA visits only</p>	<p>Year 1 cost c. £30,000</p> <p>The programme costs were made up of staff time (RGN and admin support), training and development of staff, ICT and licenses, travel, co-ordination and data transfer, return to Practices not satisfactory (assessed as 15%), option to deliver additional training to Practices (which was taken up by 5 Practices).</p> <p>Ongoing costs will be staff time (RGN and admin support), ICT licenses, travel return to Practices not satisfactory (assessed as 5%)</p> <p>Pls note: Provider costs (eg. staff time) have not been included</p>	<ul style="list-style-type: none"> • Use of QA team with expertise; the approach has been developed using clinicians experienced in the delivery of Health Checks and they are recognised by practices as there to assist and support them. • QA mechanism is consistent across Bedfordshire • Ensures approach is embedded into existing systems through requirements in the SLA • Develops better relationship with providers and supports improvements in delivery; ‘To date it has achieved near 100% take up, improvement in provision in a number of practices and identification of procedural errors in others. It identifies weaknesses in the system and allows for a collaborative response. The fact that there is an option to return and support inbuilt enables further resolution.... It shares learning and dissemination of best practice’ • Maximises effectiveness of health checks programme; ensures that providers are working to guidance and protocol, improves ongoing management and follow up of patients. 	<ul style="list-style-type: none"> • Data very limited and currently resource intensive to generate. Therefore limited ability to quickly identify issues through patient level monitoring. • Resource Intensive • On-going cost of QA visits ‘although I expect to justify this with improvements across the programme’ • Data submission and QA not explicitly linked to payment for GP practices, although outlined in the SLA still requires degree of ‘buy-in’ by practices

5.2 Quantitative Scoring

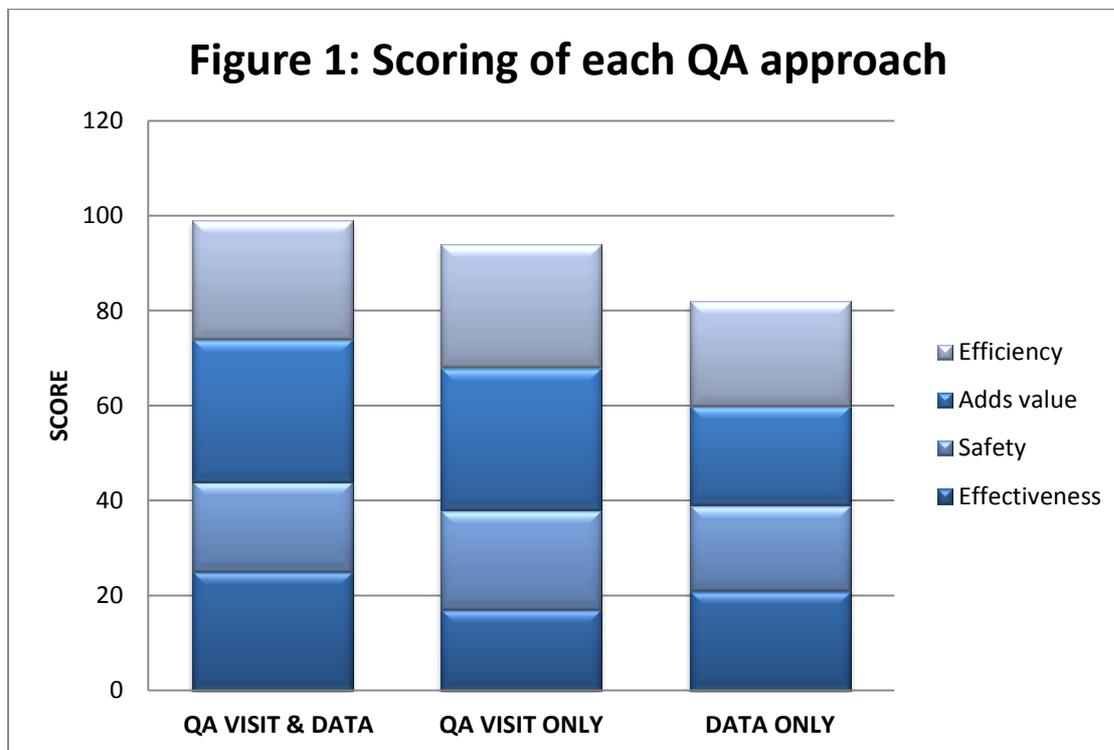
Leads were also asked to score the approach they have taken against a list of 24 criteria, grouped under four headings of safety, effectiveness, added value and efficiency. The full list of criteria are outlined in table 2 below.

Table 2 Scoring Criteria

a) Determines the safety of NHS Health Checks
Can identify that NHS Health Checks are delivered by competent staff
Can identify that all relevant equipment is appropriate
Identify the triggers that indicate further scrutiny is required
Is responsive, ie can alert of potential risks where further scrutiny may be required in a timely manner
Can accurately describe the quality of Providers governance and accountability
Can detect Providers which fall outside of expected outcome parameters
b) Assesses the effectiveness of NHS Health Checks
Can Assess uptake ie the eligible population who were offered and accept an invitation have a NHS Health Check undertaken
Can identify that a complete health check is undertaken as defined by the programme
Can identify that the result of the Health Check has been communicated appropriately to the patient
Can identify that appropriate lifestyle/ behaviour change advice has been given
Can identify that appropriate ongoing management has been undertaken
Assesses timeliness of all areas of Health Check pathway
c) Adds value to existing performance management processes
Provides support for targeted improvement
Shares and fosters good practice
Enables benchmarking
Is embedded in Provider management and commissioning systems
Raises the profile of NHS Health Checks quality with providers and commissioners
Celebrates success and feeds back to staff
d) Efficiency
Is a transparent process
Considers the whole Health Check pathway
Is applicable to all Providers
Does not put an undue load on the Providers
Optimises use of time for those being Quality Assured
Optimises use of time for those undertaking the Quality Assurance

Each criteria could be scored from 0-5 based on how well the local lead felt the approach demonstrated each aspect (5 being the best). A maximum of 30 could be scored under each of the four headings, 120 in total. The resulting scores are illustrated in figure 1.

It should be noted that these scores are a result of local leads rating their own QA approach. They are the local experts and have the necessary knowledge and understanding of the local situation to undertake this level of analysis at this stage. However, to strengthen comparison there may also be merit in using this criteria in the future to externally evaluate each more fully.



5.3 Findings of the Stakeholder Questionnaire

In terms of the barriers in developing QA it was felt that the focus to date was on implementation of the programme and increasing uptake. Staff capacity was also identified as an issue. At the time of this work transition of Health Checks into Local Authorities limited this capacity further. Many areas indicated that they wanted to explore developing QA but at this point simply did not have the time.

The lack of a national steer was also identified as an issue; all of the areas that had developed QA mechanisms had invested time and resource in developing not only the systems and processes but also creating local templates and guidance. It was felt this was inefficient and a duplication of effort which national solutions or better information sharing could help resolve.

Some local leads felt it would have been difficult to have put a QA strategy in place at the beginning of implementing the programme as it would have been more difficult to accurately identify the potential risks and issues at the outset. However, in hindsight they would have factored in more time for detailing the QA approach into their initial project planning for implementation.

For consideration is the need to draw a line somewhere as to what is day to day general practice, whose quality the GPs are responsible for. There was a feeling that built into the QA approach for Health Checks there needs to be clarity that clinical responsibility for patients remains with the GPs.

All felt that robust QA added value to the programme, not only in improving the quality and the safety of the pathway, improving consistency and minimising risk for patients but also in gaining greater engagement from providers, facilitating service improvement, improving data quality and monitoring outcomes.

When local leads were asked to describe a successful QA mechanism they highlighted the following key elements to the approach:

- that it delivers a **safe, high quality**, effective and reliable service, that ultimately leads to demonstrable improvements in health outcomes,
- that it has the ability to **identify potential issues/ adverse events quickly**; through the use of patient level data extraction and regular monitoring,

- that it achieves **full engagement** from all providers and stakeholders at a senior level, including GPs and CCG and locality leads,
- that it is **embedded into contracts/ payment** systems for Providers,
- that it ensures **equity and consistency in delivery** across a given population to a set of agreed standards,
- that it is **value for money**,
- that it is **supportive, shares learning and dissemination of best practice for service improvement**, and that it ensures feedback to providers,
- that it is **provided by an informed and flexible team**,
- that it has access to **adequate resources for quick issue resolution** if required.

6. Conclusions

Effective commissioning and robust QA can ensure that some of the risks identified in the Health Check pathway are removed and/or mitigated since most risks and errors in the pathway can be predicted. They often arise from systems failure occurring along the pathway, as opposed to individual error.

Establishing a QA mechanism for NHS Health Checks is feasible; although limited in number there are local examples in place with positive findings. These approaches have been established with relatively limited capacity and investment to date; working across a number of GP practices with different IT systems.

This review identifies a number of benefits to establishing QA, not only in improving the quality and the safety of the pathway and minimising risk for patients but also in raising the profile of NHS Health Checks and gaining greater engagement from providers, reducing inefficiencies, improving consistency of delivery, facilitating service improvement, improving data quality and monitoring outcomes.

It must be noted that the transition of NHS Health Checks to Local Authorities took place during this review. This change in commissioning responsibility to local government brings additional factors that have not been fully explored within this paper but need to be taken into account when considering options moving forward.

A national QA approach, should it be adopted, was identified by stakeholders to be of great value, in order to avoid duplication of effort, enhance local delivery and improve consistency of approach across the country.

7. Recommendation

To use the findings of this review to inform the development of options regarding the characteristics and requirements of a potential national QA approach for NHS Health Checks.

Sarah Stevens, Consultant in Public Health

Dr Jem Rashbass, National Deputy Director Disease Registration, Public Health England

With thanks to:

Victoria Sprules	Buckinghamshire County Council
Veena de Souza	Buckinghamshire County Council
Gwenda Strong	Buckinghamshire County Council
Kerri-Anne Collins	Medway Council
Craig Lister	Bedford Borough Council
Lisa Hoole	Nottingham City Council

Appendix 1

Quality Assurance (QA)

The over-riding aim of QA is to ensure the safety of *the whole patient pathway* from the identification of an individual as eligible and then 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.

Any QA process should:

- identify potential adverse events that may affect an individual in the programme
- be designed to provide a system of alerts to detect issues before they cause widespread harm.

As QA aims to ensure a safe and effective programme it must:

- monitor the delivery of national standards that cover the entire pathway;
- ensure robust failsafe procedures are in place to minimise harm and error;
- support improvements in delivery by professionals and provider organisations 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 the identification and subsequent management of serious incidents;
- ensure robust information systems are in place to collect a standard, QA minimum dataset sufficient for the comparison of programmes and to benchmark performance against agreed national key performance indicators;
- ensure a coherent and explicit programme of QA related activities including processes that ensure the effective sharing of lessons learnt.

Appendix 2: Organisations Represented at NHS Health Checks workshop

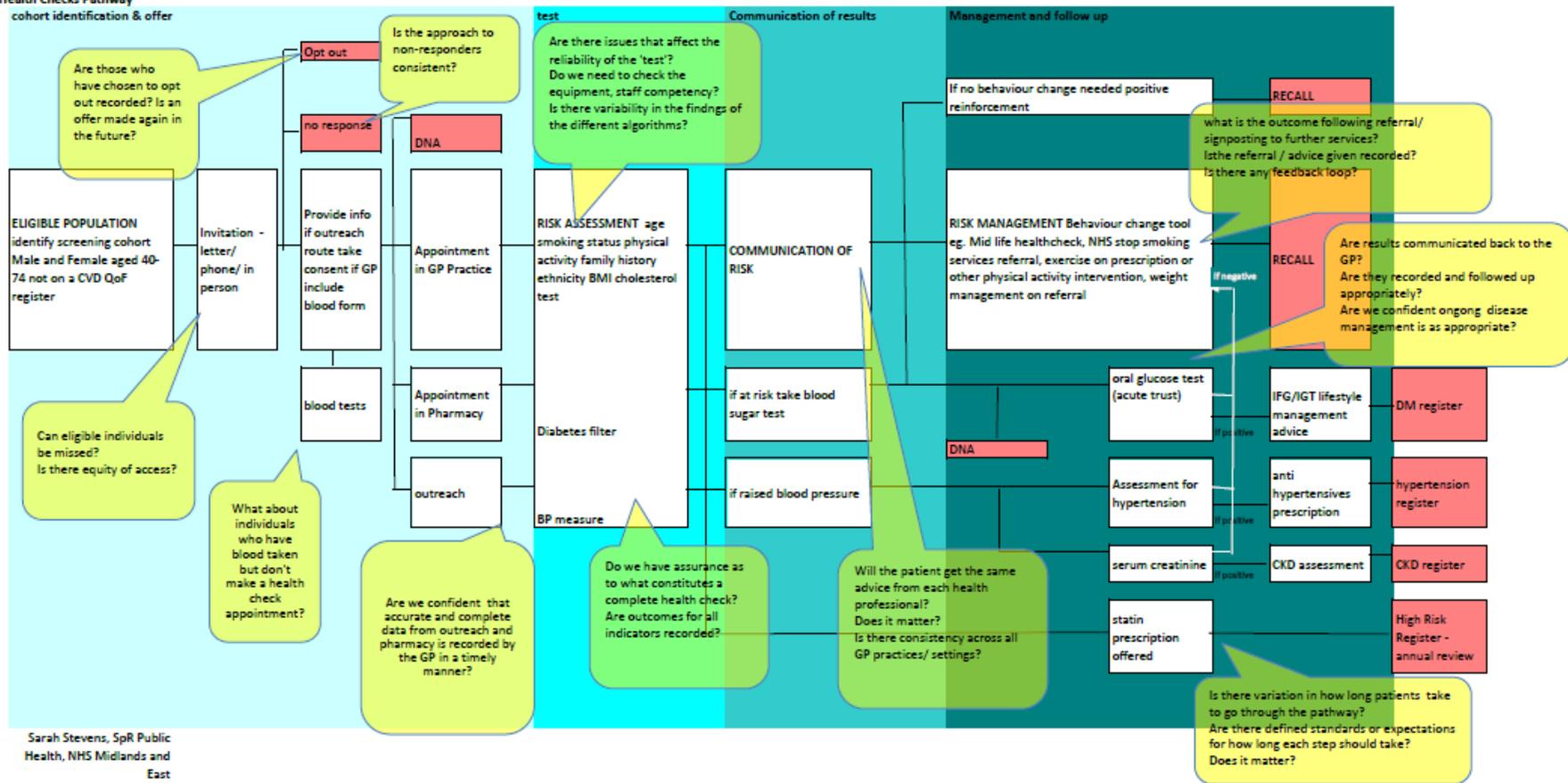
NHS Midlands and East held a workshop in Cambridge on 2 November 2011. Representatives from the following organisations attended and were involved in a workshop focusing on whether there is a need for QA within the NHS Health Check Programme.

Anglian Community Enterprise CIC	NHS Mid Essex
Anglia Support Partnership	NHS Midlands and East
Beds & Herts Heart and Stroke Network	NHS Milton Keynes
Birmingham & Solihull NHS Cluster	NHS Norfolk
Boots Pharmacy	NHS North East Essex
Cambridge University Hospital Foundation Trust	NHS North Staffordshire
Chirus Limited	NHS Northamptonshire
Department of Health	NHS Peterborough
Essex Cardiac & Stroke Network	NHS South East Essex
Institute of Public Health, Cambridge University	NHS South West Essex
NHS Bedfordshire	NHS Stoke on Trent
NHS Cambridgeshire	NHS Suffolk
NHS Coventry	NHS Telford
NHS Derby City	NHS Warwickshire
NHS Derbyshire County PCT	NHS West Essex
NHS Hertfordshire	QARC East of England
NHS Kent and Medway	Robert Frew Medical Centre
	South West Essex Community
NHS Luton	Services

In addition representatives from the following organisations have also expressed an interest and/or contributed to this work:

NHS Heart of Birmingham, Birmingham East and North and Birmingham South Cluster
NHS Medway
NHS West Sussex
NHS Buckinghamshire and Oxfordshire Cluster
NHS Portsmouth City
NHS Nottingham City
NHS Derbyshire County
NHS Nottinghamshire County
NHS Telford and Wrekin
NHS East Lancashire
NHS North Lancashire
NHS Sefton
NHS Bolton
Connecting for Health
NHS North
NHS Midlands and East
NHS South

Appendix 3 NHS Health Checks Pathway



Sarah Stevens, SpR Public Health, NHS Midlands and East
07-Dec-11