



Public Health
England

Protecting and improving the nation's health

Physical Health Checks in Prisons Standards

A framework for quality improvement

About Public Health England

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

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Introduction

These standards have been developed to improve the quality of the delivery of the Physical Health Checks in Prisons Programme. They are aimed at both commissioners and providers to enable the fulfilment of the requirement for delivering the Physical Health Check in Prisons Programme under the Section 7A Agreement.

1. Invitation and offer

Identifying the eligible population and offering Physical Health Checks in Prison

Description

Each prison healthcare provider is to ensure systems are in place to consistently and accurately identify the population, establish eligibility and offer the Physical Health Check to all eligible persons in its prison in a five-year period. The eligibility criteria are that the invitee must:

- be aged 35 to 74
- AND with a period of incarceration of 2 years or more
- must not have been offered a health check within the previous five years

Specifically people already diagnosed with the following are excluded from the programme:

- coronary heart disease
- chronic kidney disease (CKD) (classified as stage 3, 4 or 5 within NICE CG 73)
- diabetes
- hypertension
- atrial fibrillation
- transient ischaemic attack
- familial hypercholesterolaemia
- heart failure
- peripheral arterial disease
- stroke

In addition, individuals:

- must not be being prescribed statins for the purpose of lowering cholesterol
- must not have been assessed through a NHS Health Check, or any other check undertaken through the health service in England, and found to have a 10% or higher risk of developing cardiovascular disease over the next ten years

A clearly written invitation letter, available in other formats (Braille, language, easy read, translation services); outlining the potential benefits and risk of the Physical Health Check in Prison process should be provided to all. Where the Physical Health Check is offered opportunistically, written information should still be provided.

Rationale

There is a legal duty for NHS England to commission physical health checks in prisons to: a) make arrangements for each eligible person aged 35 to 74 AND with a period of incarceration of 2 years or more to be offered a Physical 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.

A written Physical 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 Physical Health Check process and can give informed consent.

Ensuring a high percentage of those offered a Physical Health Check actually receive one is key to optimising the clinical and cost effectiveness of the programme. This is especially important for populations with the greatest health needs and will impact on the programme's and local area's abilities to narrow health inequalities. The higher the take up rates for the programme, the greater its reach and potential impact.

Quality indicators

The number of invitations and the number of Physical Health Checks actually received must be recorded and monitored by the local health care provider. The information to be submitted to the NHS England commissioner is

- 1a. The number of prisoners identified as being eligible
- 1b. The number of physical health checks offered in the quarter
- 1c. The number of physical health checks received in the quarter

Evidence to demonstrate achievement

Written invitation letter detailing the potential risks and benefits of the Physical Health Check in prison process.

Evidence that the Physical Health Check information is available in other formats (Braille, language, easy read, translation services).

Social marketing plans in place.

Local Physical Health Check Champions in place in the prison, 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.

Further information

Research has shown that adapting invitations to support improved uptake from local population groups is pivotal to success. PHE will work with local authority NHS Health Check teams to test the potential impact of behavioural insight and marketing interventions on uptake and will share information through www.healthcheck.nhs.uk

2. Invitation and offer

Consistent approach to non-responders and those who do not attend their risk assessment

Description

An agreed process should be in place for those eligible for the Physical Health Check in prisons, who either do not respond to the offer or do not attend (DNA) their appointment. At least two contacts should be made: a written invitation letter should be followed up by a reminder if there is no response.

Providers may agree on the most appropriate reminder method for their population (eg, phone, text, letter, email, in person).

Rationale

Low uptake and variation leads to some people given more chance than others to participate. Ensuring a high percentage of those offered a Physical Health Check actually receive one is key to optimising the clinical and cost effectiveness of the programme. This is especially important for populations with the greatest health needs and will impact on the programme's and local area's abilities to narrow health inequalities. The higher the take up rates for the programme, the greater its reach and potential impact.

Quality indicator (s)

2a. Proportion recorded as do not respond.

2b. Proportion recorded as DNA.

2c. Proportion of these individuals recalled in five years, if they remain eligible

Evidence to demonstrate achievement

- locally agreed protocol in place defining standard approach to non- responders and DNAs. Protocol should detail number and method of reminders made
- number and method of reminder made should be recorded
- physical health check information available in other formats (Braille, language, easy read, translation services, etc)
- individuals who opt out should be read coded. An auditable process should be in place to recall in five years, if they remain eligible

3. The risk assessment

Ensuring a complete health check for those who accept the offer is undertaken and recorded

Description

A complete Physical Health Check in prison must include all the elements outlined in the short guidance, all taken at the time of the check unless specified:

- a. age
- b. gender
- c. ethnicity
- d. smoking status
- e. family history of coronary heart disease
- f. blood pressure, systolic (SBP) and diastolic (DBP)
- g. body mass index (height and weight)
- h. General practice physical activity questionnaire (GPPAQ)
- i. Alcohol use score (AUDIT-C or FAST can be used as the initial screen)
- j. cholesterol level: total cholesterol and HDL cholesterol (either point of care or venous sample if within the last six months)
- k. cardiovascular risk score: 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
- l. dementia awareness (for those aged 65 to 74)
- m. validated diabetes risk tool

Rationale

The tests, measurements and risk calculations that make up the risk assessment part of the Physical Health Check in prison are stipulated in legislation because of the importance of a uniform, quality offer.

Every individual who receives a Physical Health Check in prison should receive a good quality, complete risk assessment, irrespective of where they live, or the provider. 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.

Quality indicator

3a. Proportion of those who accept the offer that receive a complete Physical Health Check in prison with all indicators listed above recorded at the time of delivery.

Evidence to demonstrate achievement

Provider has a record of the following for each Physical Health Check in prison undertaken:

- all indicators listed above
- 'Physical Check in prison complete' recorded
- name of health professional delivering the Physical Health check in prison
- date of Physical Health check in prison

Evidenced through regular electronic data extraction and production of reports, read code audit or if not possible, notes audit.

Healthcare 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.

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>

4. The risk assessment

Equipment use

Description

Ensure all equipment used for the Physical Health Check in prison 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.

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.

An adverse incident is an event that causes, or has the potential to cause, unexpected or unwanted effects involving the accuracy and/or safety of device users (including patients) or other persons.

For example:

- a patient, user, carer or professional is injured as a result of a medical device failure or its misuse
- a patient's treatment is interrupted or compromised by a medical device failure
- a misdiagnosis due to a medical device failure leads to inappropriate management and treatment
- a patient's health deteriorates due to medical device failure (MHRA)

Rationale

If equipment is not used correctly, there is a risk that incorrect readings are given, affecting the risk score and potentially the clinical management of the individual. Incident should be reported as soon as possible. Some apparently minor incidents may have greater significance when aggregated with other similar reports.

Quality indicators

To develop locally, as appropriate.

Evidence to demonstrate achievement

- documentation of equipment checks
- audit
- use of equipment and notification of incidents included within provider's governance arrangements

Further information

www.mhra.gov.uk/Safetyinformation/Reportingsafetyproblems/Devices/

MHRA Blood pressure measurement devices, December 2013

www.mhra.gov.uk/home/groups/dts-iac/documents/publication/con2024250.pdf

5. The risk assessment

Quality control for point of care testing

Point of care test (POCT) is a device the manufacturer has intended to be used for examining specimens derived from the human body including blood and urine.

Where using POCT, providers should ensure:

- 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 eg optical check to be performed in addition to the use of a liquid control sample. All record keeping on this process should be accurate & contemporaneous.
- 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

Rationale

Inadequate quality assurance 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 indicators

Proportion of providers using POCT that can demonstrate the four criteria in place (as outlined in the description above).

Evidence to demonstrate achievement

- 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

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.

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.

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

A practical guide to POCT: www.healthcheck.nhs.uk/document.php?o=129

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)

Buyers' guide: blood glucose systems, May 2008:

www.healthcheck.nhs.uk/document.php?o=232

Buyers' guide: point of care testing for cholesterol measurement.

September 2009: www.healthcheck.nhs.uk/document.php?o=11

Buyer's guide: point of care testing for HbA1c. June 2009:

www.healthcheck.nhs.uk/document.php?o=12

6. Communication of results

Ensuring results are communicated effectively and recorded

Description

All individuals who undergo a Physical Health Check in prison 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.

Staff delivering the Physical Health Check in prison 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.

When communicating individual risks, staff should be trained to:

- communicate risk in everyday, jargon-free language so that individuals understand their level of risk and what changes they can make to reduce their risk
- use behaviour change techniques (such as motivation interviewing) to deliver appropriate lifestyle advice and how it can reduce their risk
- establish a professional relationship where the individual's values and beliefs are identified and incorporated into a client- centred plan to achieve sustainable health improvement

Individuals receiving a Physical Health Check in prison should be given adequate time to ask questions and obtain further information about their risk and results.

Individualised written information should be provided that includes their results*, bespoke advice on the risks identified and self referral information for lifestyle interventions.

*This should include and provide an explanation of their:

- BMI
- cholesterol level (total cholesterol 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

Legal duties exist for healthcare providers to make arrangements to ensure the people having their Physical Health Check in prison are told their cardiovascular risk score, and other results are communicated to them.

The Physical Health Check in prison programme is a preventative programme to help people stay healthy for longer. To maximise these benefits, efforts should be made to ensure individuals understand their level of risk and their results. Everyone who has a Physical 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 Physical Health Check should be provided with individually tailored advice that will help motivate them and support the necessary lifestyle changes to manage their risk. This includes supporting and encouraging individuals to maintain a healthy lifestyle where no change is required.

Quality indicators

6a. Proportion of Physical Health Checks in prison undertaken where cardiovascular risk score, BMI, cholesterol level, blood pressure and alcohol use score (AUDIT C or FAST) score is communicated face to face.

6b. Proportion of Physical health checks in prison undertaken where written, tailored information is provided at the same time.

Evidence to demonstrate achievement

- 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
- Evidence to demonstrate achievement

Further information

Cardiovascular disease: risk assessment and reduction, including lipid modification

<https://www.nice.org.uk/guidance/cg181>

7. Risk management

High quality and timely lifestyle advice given to all

Rationale

The Physical Health Checks in prisons programme is a preventative programme to help people stay healthy for longer. To maximise these benefits, all individuals who have a Physical Health Check in prison, regardless of their risk score, should be given lifestyle advice, where clinically appropriate, to help them manage and reduce their risk. That means that, unless it is deemed clinically unsafe to do so, everyone having the check should be provided with individually tailored advice that will help motivate them and support the necessary lifestyle changes to manage their risk. This includes supporting and encouraging individuals to maintain a healthy lifestyle where no change is required.

It is pivotal that the actions taken at a certain threshold are the same and in line with national guidelines, including those issued by the National Institute for Health and Care Excellence (NICE), so that people receive the necessary and appropriate care.

Quality indicators

7a. Proportion of Physical Health Checks in prison undertaken where record exists that brief advice provided.

7b. Proportion of Physical Health Checks in prison undertaken where referral to lifestyle intervention is made, where appropriate.

7c. Proportion of individuals where a record of outcome following lifestyle intervention is available (ie, four-week smoking quit/ 5% reduction in body weight)

Evidence to demonstrate achievement

- evidence-based and accessible lifestyle intervention services in place
- agreed patient pathway in place
- documentation of:
 - brief advice, record of specific lifestyle advice given
 - signposted to local provision
 - offer of referral made
 - referral declined
 - referral to intervention accepted
 - outcome
- example of written information used
- 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 asks about lifestyle change
- number of patient complaints received

Further information

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

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

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

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

NICE clinical guideline 127. Hypertension: clinical management of primary hypertension in adults. August 2011. www.nice.org.uk/nicemedia/live/13561/56008/56008.pdf

NICE public health guidance 24. Alcohol-use disorders – preventing harmful drinking (PH24), June 2010. guidance.nice.org.uk/PH24

The 'Vascular risk assessment: workforce competencies' is currently under review. The revised framework is expected to be published in April 2014.

Vascular risk assessment: workforce competencies. June 2009.

www.healthcheck.nhs.uk/commissioners_and_healthcare_professionals/national_guidance/

NHS Health Check dataset and read code mapping:

<http://www.hscic.gov.uk/nhshealthcheck>

8. Risk management

Additional testing and clinical follow up

Description

Individuals should not exit the programme until all abnormal parameters have been followed up and a diagnosis has either been made or ruled out. Timely access to further diagnostic testing should take place at the following thresholds:

Individuals should be considered as being at high risk of diabetes using the following thresholds for the corresponding validated risk assessment tools:

- QDiabetes score is greater than 5.6
- Cambridge diabetes risk score is greater than 0.2
- Leicester practice risk score is greater than 4.8
- Leicester risk assessment score is greater than or equal to 16

If you are unable to introduce the use of a validated tool then the diabetes filter can still be used. In this case, people at high risk of diabetes, and so eligible for a blood glucose test, include:

- an individual from black, Asian and other ethnic groups with BMI greater than or equal to 27.5

or

- an individual with BMI greater than or equal to 30

or

- those with blood pressure at or above 140/90mmHg, or where the SBP or DBP exceeds 140mmHG or 90mmHg, respectively

2. Assessment for hypertension by GP practice team when indicated by:

- a. BP >140/90 mmHg
- b. Or where the SBP or DBP exceeds 140mmHg or 90mmHg respectively

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.

3. Assessment for chronic kidney disease by GP practice team when indicated by:

- a. BP >140/90 mmHg
- b. Or where SBP or DBP exceeds 140mmHg or 90mmHg respectively

All who meet these criteria to receive serum creatinine test to estimate glomerular filtration rate (eGFR).

4. Assessment for familial hypercholesterolemia by GP practice team when indicated by:

a. Total cholesterol >7.5 mmol/L

5. Alcohol risk assessment, use of full AUDIT when indicated by:

a. AUDIT C Score >5

b. Or FAST >3

If the individual meets or exceeds the AUDIT C or FAST thresholds above the remaining questions of AUDIT should be administered to obtain a full AUDIT score. If the individual meet or exceeds a threshold of 8 on AUDIT, brief advice is given. For individuals scoring 20 or more on AUDIT referral to alcohol services should be considered.

6. Where the individual's BMI is in the overweight and obese range as indicated by:

a. BMI >25

Then a blood glucose test is required.

For all, systems and process should be in place to ensure follow up test(s) undertaken and results received.

Only through the early detection and management of risk factors can the Physical Health Check in prison maximise its public health impact and reduce premature mortality. It is key that the actions taken at these thresholds are the same to assure a systematic and uniform offer. Systems should be in place to ensure follow up tests are undertaken and results received in order to provide assurance that appropriate follow up and management is undertaken. Disease management should be undertaken in line with NICE guidance including provision of appropriate lifestyle intervention.

Quality Indicators

Where thresholds met:

8a. Proportion of individuals with investigations undertaken

8b. Proportion of individuals with outcome recorded

Evidence to demonstrate achievement

- record of individuals identified as:
- pre diabetic/diabetic
- hypertensive
- CKD
- familial hypercholesterolemia

- audit C >5/ FAST >3
- BMI > 25
- results communicated to patient and recorded using appropriate read code
- Healthcare provider 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

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

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

NICE clinical guideline 66. Type 2 diabetes: the management of type 2 diabetes, December 2008. <http://guidance.nice.org.uk/CG66>

NICE quality standard 6. Diabetes in adults, March 2011.
publications.nice.org.uk/diabetes-in-adults-quality-standard-qs6

NICE clinical guideline 127. Hypertension: clinical management of primary hypertension in adults, August 2011.
www.nice.org.uk/nicemedia/live/13561/56008/56008.pdf

NICE public health guidance 24. Alcohol-use disorders – preventing harmful drinking (PH24), June 2010. guidance.nice.org.uk/PH24

NICE clinical guideline 71. Familial Hypercholesterolaemia
<http://www.nice.org.uk/guidance/cg71>

NICE Quality Standards 41 for Familial Hypercholesterolaemia. August 2013
<http://guidance.nice.org.uk/QS41>

Estimated detection rates of NDH and type 2 diabetes between validated risk assessment tools. Public Health England. 2016
http://www.healthcheck.nhs.uk/commissioners_and_providers/delivery/making_the_case/

9. Risk management

Appropriate follow up for all if CVD risk assessed as 10% and greater

Description

All individuals with >10% CVD risk should be managed according to NICE guidance including provision of lifestyle advice and intervention, assessment for treatment with statins and an annual review this may be through maintaining a high risk register. People found to be at or above 10% risk should exit the programme irrespective of whether they have signs of disease.

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.

Rationale

With appropriate management and follow up, the rate of progression of CVD and risk factors can be reduced.

Quality indicators

9a. Proportion of those identified with a CVD risk of 10% and greater managed according to NICE guidelines.

Evidence to demonstrate achievement

Healthcare providers 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

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

Further guidance on the appropriate follow up of those with a CVD risk of 10% and greater is being explored.

10. Throughout the pathway

Confidential and timely transfer of patient identifiable data

Description

Where the risk assessment is conducted outside the individual's GP practice, the healthcare providers have a legal duty to arrange for the provider to send the following information to the person's registered GP on release:

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

A protocol also needs to be in place for timely referral of patients where abnormal parameters identified. For all individuals who require additional testing and clinical follow up, Healthcare providers should follow Standards 8 and 9.

Rationale

There are a number of potential issues surrounding data flows for example:

- ensuring confidential transfer of patient-identifiable data
- errors surrounding accuracy of data inputted

These process failures could lead to a breach in confidentiality and/or inappropriate action undertaken due to inaccurate or delayed information being received. If information is not recorded it is unknown whether appropriate intervention and follow up has been undertaken.

Quality indicator

10 a. Number of prisoners registered with a GP on release.

Evidence to demonstrate achievement

Electronic data transfer in place between prison provider and GP practices
Read code or notes audit. Agreed protocol for data transfer between prison provider and GP practices

Protocol in place for timely referral of patients where abnormal parameters identified by the prison provider, including outlining action when urgent referral required.