QUALITY ASSURANCE FOR NHS HEALTH CHECKS
COMMISSIONING GUIDANCE
FINAL VERSION
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Prepared on behalf of the SHA Health Check Leads

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1. Aim of this paper

This guidance is to help commissioners define the key areas of any quality assurance (QA) framework they might commission in order to monitor and provide widespread confidence in the NHS Health Checks Programme.

It 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.

This guidance complements the following documents:

- DH (2009) Putting Prevention First – NHS Health Check Vascular Risk Assessment and Management Best Practice Guidance www.dh.gov.uk/vascularchecks Gateway reference 11473
- DH (2008) Putting Prevention First – Vascular checks: risk assessment and management. 'Next steps' Guidance for Primary Care Trusts www.dh.gov.uk/vascularchecks Gateway reference 10729
- UK National Screening Committee & University of Leicester (2008) The handbook for vascular risk assessment, risk reduction and risk management www.screening.nhs.uk/vascular/VascularRiskAssessment.pdf
- NHS Heart of Birmingham GP Handbook for NHS Health Check www.healthcheck.nhs.uk/_guidancedocuments.aspx
- DH and Skills for Health (2009) Vascular Risk Assessment Workforce Competencies www.healthcheck.nhs.uk/Library/VRAWorkforceCompetences294521_PreventionFirst_v3.pdf

2. Background

2.1 Assumptions

The NHS Health Check Programme invites individuals who have no existing clinical history of cardiovascular disease or a diagnosis of diabetes, kidney disease, cerebrovascular or ischaemic heart disease for an assessment of their lifestyle and a few a basic investigations – a "health check". On the basis of the findings of their health check the individual is offered a range of lifestyle advice to support future health gain and, where appropriate referred on for further investigations. Once an individual has been assessed and found to be at an increased risk there is a duty of care on all those delivering and commissioning the programme to ensure that:

- the individual is not lost from the programme;
- the individual is offered the appropriate advice, further investigation and treatment;
- the health check is delivered as per defined best practice;
- the benefits and risks of any intervention to the individual is appropriately monitored;
- the long term outcome of interventions to the individual are assessed;

The Coalition Government confirmed in December 2010 that the NHS should continue to roll-out the Health Check Programme. The aim of the Programme is to reduce current levels of vascular disease morbidity and mortality in England towards those seen in some

countries of Western Europe. Through this Programme it is expected that the personal toll and rising NHS expenditure on treatments for these conditions would be reduced. Economic modelling indicates that an annual investment of £332m per year by the NHS would, when fully implemented, achieve an annual benefit of £3.8bn, at a Programme cost of £2,142 per QALY[1]. If the Programme is rolled out in accordance with the Best Practice Guidance, conservative estimates predict that it could on average per year:

- Prevent 1,600 heart attacks and strokes
- Prevent over 4,000 people from developing diabetes
- Detect at least 20,000 cases of diabetes or kidney disease earlier

The focus of NHS Health Checks so far has been on the implementation and roll out of this new Programme. A great deal 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 the 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 programme 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.

This document describes a commissioning framework for use by those directly commissioning NHS Health Check Programmes, recognising that this may be delivered by a number of providers in a range of settings.

This guidance outlines a pragmatic, yet robust, light-touch and low-cost, solution for QA that minimises the need for onerous data collection, inspection, self-reporting and audit. It builds on and extends the work with patient-level monitoring to detect outliers and ensure robust failsafe procedures and quality of care.

2.2 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;

[1] Quality Adjusted Life Year

- 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[2] 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.

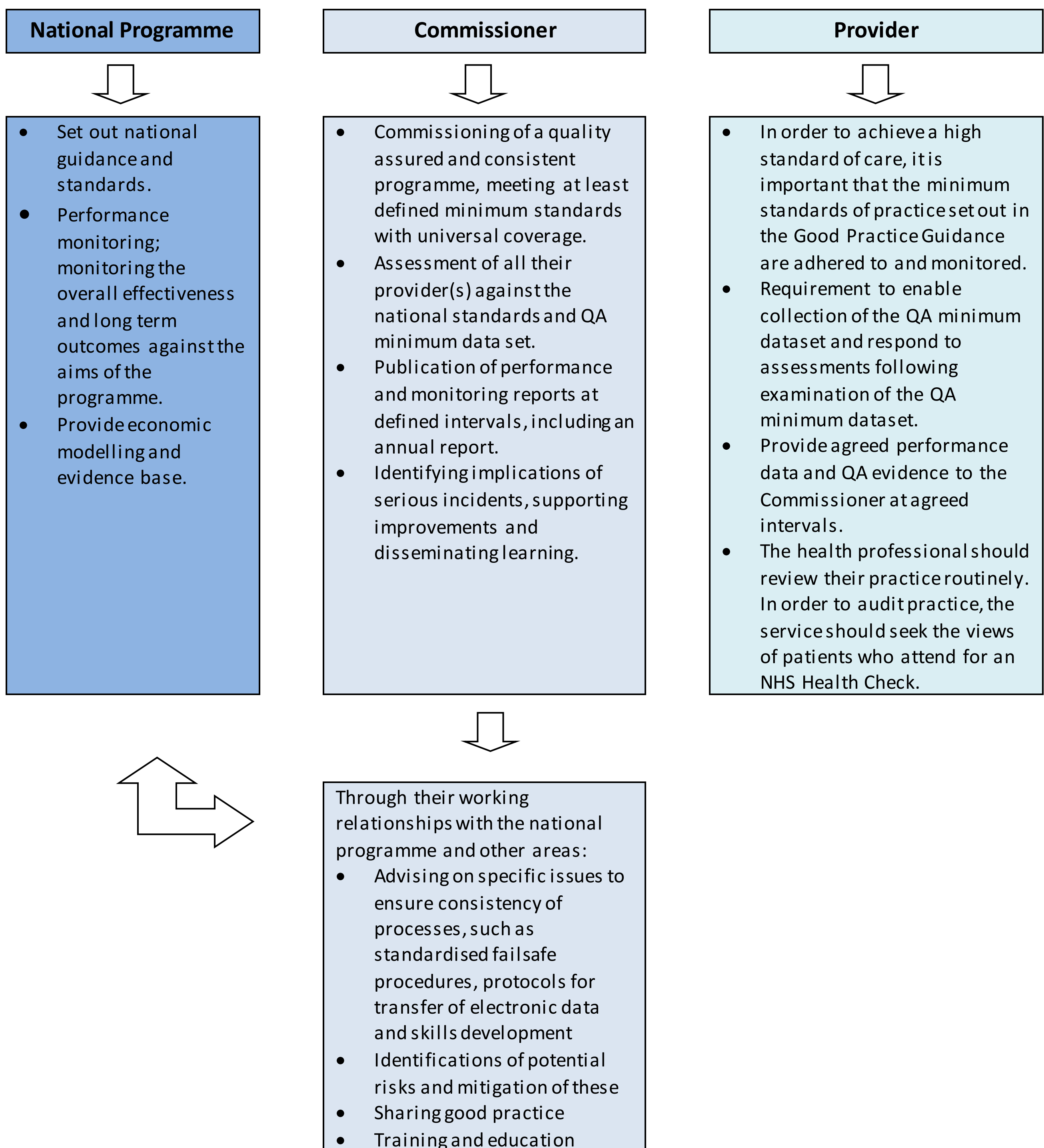
3. Quality Assurance Framework

To work effectively the QA framework must be able to track all patients along the care pathway with sufficient detail to detect an aberrant event that might suggest systematic or local quality issues. QA therefore requires patient-identifiable data and a close collaboration between the commissioners of the Service and the providers.

QA data collection can also be tightly integrated with the wider national, Department of Health-led, Programme Monitoring. The latter could choose to use aggregated data derived from the more granular patient-level data which is required for QA.

[2]The QA Minimum Dataset is in development and will build on NHS Health Check Data Set Key Performance Requirements/ Information Requirements.

Figure 1 Roles of those responsible for elements of QA



4. Risk Assessment of the Programme

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

4.1 Stakeholder engagement

In order to identify the risks that exist across the pathway we held a workshop for commissioners and stakeholders from over 35 organisations (a full list of the organisations represented can be found in Appendix 1). 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 are 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 where these key risks occur on the pathway.

The workshop attendees also prioritised the importance of each risk based upon the likelihood of occurrence and potential impact. The owner of each risk was identified and this was used to consider how they might be mitigated through the commissioning and contracting arrangements.

Effective commissioning and robust QA can ensure that some of these risks 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. Section 5 outlines the QA mechanisms required to reduce these risks.

The table in Appendix 2 details the risks identified and does so within a risk register template. It gives you the ability to score each risk based on a consequence likelihood matrix, to describe your risk avoidance and/or mitigation actions and record and monitor progress. This template is purely an example; you can adapt as necessary or may already have adequate risk assessment and governance systems in place.

5. Standards for Care

5.1 Philosophy

NHS Health Checks should be offered to the eligible population in a timely manner; and those who attend should receive the results of their risk assessment with sufficient information to understand it, suitable lifestyle and behaviour change advice and appropriate treatment and follow up if required. The value of this programme will be diminished if appropriate action is not always taken to ensure that the right people are invited, or if the right action is not taken to follow up those where further management is required.

5.2 The role of the health professional

NHS Health Checks can be delivered in different settings and by different health professionals. There should be assurance that each health care professional delivering NHS Health Checks is sufficiently competent in line with the Vascular Risk Assessment Workforce Competencies.
www.healthcheck.nhs.uk/Library/VRAWorkforceCompetences294521_PreventionFirst_v3.pdf

There needs to be agreement regarding the roles and responsibilities of each health care professional in delivering NHS Health Checks, and this should include their interaction with the patient and their working relationship with other providers and stakeholders.

The General Practitioners Committee of the British Medical Association and the National Pharmacy Association have produced a practical workbook to help GPs and community pharmacists manage their day-to-day communications in such a way as to maximise efficiency and ensure a safe and effective service to patients. The workbook describes various Community Pharmacy-GP interactions, including those relating to the NHS Health Check (see interface 9), and highlights some principles of good practice. www.healthcheck.nhs.uk/Library/Improving_Communications_between_Community_Pharmacy_and_General_Practice.pdf

5.3 Delivery of the NHS Health Check Programme

This section divides the NHS Health Checks pathway into four broad steps:

1. Identification and offer
2. The risk assessment
3. Communication of results
4. Management and follow up

Delivery of NHS Health Checks should achieve the minimum standards of care as outlined in the NHS Health Checks Best Practice Guidance and follow latest NICE guidance.

The latest version of the Health Checks Best Practice Guidance was published in April 2009 www.dh.gov.uk/dr_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_098410.pdf

These standards of care should be clearly defined within the commissioning framework and understood by all those delivering NHS Health Checks. There should also be a mechanism in place for updating providers when new guidance is released.

Each step is briefly outlined in table 1 together with the QA principles that should be in place and the potential sources of evidence that could be used to demonstrate assurance.

This table will be incorporated into a self-assessment tool which is currently being developed and will form part of a QA pilot taking place early on in the new financial year. It is envisaged that the tool will provide further detail regarding what needs to be in place in order to quality assure each step on the pathway, will identify key lines of enquiry and provide a standard mechanism in which to self assess the NHS Health Check Programme you commission.

Table 1: NHS Health Checks Standards of Care and QA standards

Step on the pathway	QA Principles	Potential Sources of Evidence
Invitation and offer All eligible patients between the ages of 40-74 in England should be invited for a free check every five years as part of a national programme. At invitation access to appropriate educational material must be available. Ensure targeted work to encourage vulnerable and hard to reach groups, including the non registered population, to access health checks.	• Consistent and accurate cohort identification; ability to identify all members of the population who are eligible for the health checks programme • Agreed and standardised process for offer of a Health Check (eg. Agreement on the number of invites sent to each eligible individual) • Offer of Health Check recorded • Agreed and consistent process for non-responders and those who opt out • Ensure Health Check information is available in other formats (Braille, language, easy read, translation services etc)	Uptake data Local policy outlining consistent process for identification of eligible population (specified read codes), offer and for those who do not respond Offer recorded in patient notes Notes audit – for example analysis of read codes used Examples of information used – standard letter Outreach activity data on targeted work Health equity audit/ impact assessment
The Risk Assessment A complete face to face health check containing and recording all elements as outlined in the current NHS Health Checks Best Practice Guidance	• Obtain Informed Consent • Receiving a complete Health Check; ensuring that everyone gets the same face to face Health Check (risk assessment element), that this is a complete and meets the minimum standard of care outlined in the current Best Practice Guidance • All equipment used for Health Checks should be regularly calibrated and used as per manufacturer's instructions and local protocols • For Health Checks undertaken in outreach/	Documentation of: • Consent requested and obtained/ declined • Health Check complete recorded • Name of Health Professional undertaking health check • Appointment length • QA minimum dataset completed • Date of Health Check Notes audit against QA standards Standard health check template used Equipment checks Local protocol outlining outreach/ community setting

Step on the pathway	QA Principles	Potential Sources of Evidence
	community settings ensure secure, timely data transfer systems are in place with the relevant GP practice	arrangements and expectations.
Communication of the Result: Risk communication & lifestyle/behaviour change advice Everyone who undergoes a check should have the results of their NHS Health Check assessment of cardiovascular disease (CVD) risk conveyed to them and lifestyle/behaviour change advice given as per the NHS Health Checks Best Practice Guidance.	• Results should be communicated effectively and written information should also be provided. • Provision and timely access to high quality risk management interventions should be in place as per the Best Practice Guidance. • Referral pathway(s) should be consistently in place across all health check providers.	Agreed Patient Pathway Documentation of: • lifestyle advice given • offer of referral made • Referral declined • referral to intervention made • outcome Example of written information used Notes audit against QA standards Training and education materials available for health professionals Patient survey
Management and Follow Up As per the NHS Health Check Best Practice Guidance high risk patients, identified though the Health Check should be offered further tests as appropriate and based on the findings of those tests added to the relevant register and managed as per NICE/ Map of Medicine guidelines	• Timely access to further diagnostic testing as outlined in the Best Practice Guidance. • Systems in place to ensure follow up test(s) undertaken and results received. • For those people identified as needing treatment to manage a diagnosed condition(s), the provision of timely and high quality lifestyle, treatment, and other appropriate advice as outlined in the Best Practice Guidance. • Disease management undertaken in line with Best Practice Guidance and NICE	Local protocol and clinical pathway in place to outline process for follow up. Updated annually and shared with clinicians Evidence of interpretation guides for results/ standard operating procedures Documentation in patient notes of referral if made, test results, the patient's transfer to the appropriate long term condition register Recorded as a result of the health check. Notes audit against QA standards Patient survey

Step on the pathway	QA Principles	Potential Sources of Evidence
	guidance	

5.4 QA systems

In addition to the QA standards outlined at each point of the pathway, there should also be assurance that the following are in place:

- **Documentation;** systems of documentation must be agreed and established in line with the QA minimum data set so that accurate data are recorded for audit, quality assurance and outcome monitoring.
- **Audit;** providers are accountable for auditing their own clinical practice, timescales and expectations should be set.
- **Benchmarking**; should be in place against national standards, performance outcomes and the QA minimum data set.
- **Identification and investigation of serious incidents;** clear roles and responsibilities should be outlined and systematic open sharing and learning from incidents as detailed in section 7.
- **Patient Satisfaction**; a mechanism should be in place to seek and respond to the views of individuals going through the health check pathway.

6. Performance Monitoring: Key Performance Indicators (KPIs)

KPIs have been designed for the NHS Health Check programme to allow the performance of the programme to be measured. They allow evaluation of the progress, and the success, of the NHS Health Check programme against its objectives and goals.

The following table outlines the rationale behind each of the KPIs. Further information on the NHS Health Check Information Requirements for each of these KPIs can be found at

www.ic.nhs.uk/webfiles/Services/Datasets/NHS%20Health%20Check/NHS_Health_Check_Information_requirements_KPIs.pdf

KPI	Rationale
Coverage	For all those eligible (i.e. those between 40 and 74 who do not have previously diagnosed vascular disease), to be offered a NHS Health Check every five years and for the check to be carried out in line with the best practice guidance.
Referrals and risk management	That the NHS Health Check programme is clinically and cost effective, and that it remains so. Help people live longer, healthier lives by: ▪ reducing the risk, and incidence, of heart attacks and strokes, type II diabetes and chronic kidney disease ▪ detecting cardiovascular disease, chronic kidney disease and type II diabetes earlier, allowing people to be managed earlier and in doing so improve their quality of life
Outcomes	Rationale as above
Health inequalities	Reduce health inequalities – including socio-economic, ethnic and gender inequalities that result from vascular disease (heart disease, stroke, type II diabetes and chronic kidney disease). To measure those: ▪ who are considered to be living within the most deprived 20% of areas according to the Indices of Multiple Deprivation (IMD) 2007, or both), based on the postcode of their usual address. ▪ Who are from different self-assigned ethnicity groups (white/not recorded, Indian,

KPI	Rationale
	Pakistani, Bangladeshi, other Asian, black African, black Caribbean, Chinese, other including mixed).

7. Management of Serious Incidents (SIs)

Whilst NHS Health Checks is not under the responsibility of the UK National Screening Committee the principles outlined in Managing Serious Incidents in English National Screening Programmes (June 2010) can usefully be applied to the NHS Health Checks Programme.

There are four key principles underpinning the investigation, handling and learning from serious incidents

1. To provide assurance of governance and safety for the most serious incidents
2. To facilitate the sharing of learning arising from serious incidents, locally, regionally and nationally
3. To help prevent reoccurrence where a serious incident has occurred and reduce the chance of the same serious incident happening elsewhere
4. To support service improvement by providing information, guidance and recommendations which support managers in directing resources where they are most needed in order to improve quality and safety, including engagement with relevant bodies for full investigation and identification of learning from a serious incident

It is important to note that the following are most likely to prevent incidents:

- Allocation of clear accountabilities;
- Clear oversight of the entire pathway by the lead commissioning PCT;
- Existence of a robust comprehensive quality assurance programme;
- Putting into place fail-safe mechanisms or checks at strategic points in the patient / client pathway;
- Systematic open sharing and learning from Incidents and Serious Incidents.

It is essential to have in place:

- A shared understanding amongst all providers and stakeholders of the definition of a SI
- Clear guidance outlining who is responsible for calling an SI
- Agreement on the responsibilities and defined routes for reporting
- Requirement that recommendations are outlined and communicated in order to learn from and respond to national lessons

Managing Serious Incidents in English National Screening Programmes (June 2010) www.screening.nhs.uk/quality-assurance#fileid9903 offers useful guidance on all of the above.

Appendix 1: 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
Anglia Support Partnership
Beds & Herts Heart and Stroke Network
Birmingham & Solihull NHS Cluster
Boots Pharmacy
Cambridge University Hospital Foundation Trust
Chirus Limited
Department of Health
Essex Cardiac & Stroke Network
Institute of Public Health, Cambridge University
NHS Bedfordshire
NHS Cambridgeshire
NHS Coventry
NHS Derby City
NHS Derbyshire County PCT
NHS Hertfordshire
NHS Kent and Medway
NHS Luton

NHS Mid Essex
NHS Midlands and East
NHS Milton Keynes
NHS Norfolk
NHS North East Essex
NHS North Staffordshire
NHS Northamptonshire
NHS Peterborough
NHS South East Essex
NHS South West Essex
NHS Stoke on Trent
NHS Suffolk
NHS Telford
NHS Warwickshire
NHS West Essex
QARC East of England
Robert Frew Medical Centre
South West Essex Community Services

Point on Pathway	Risk Description	Ownership	Risk Score	Risk Response Avoidance and Mitigation	Progress/ Comments
Throughout	**Poor Information Transfer; Clinical & Reputational** There are a number of potential issues surrounding data flows for example: • If NHS Health check undertaken in community setting delay in relevant GP practice receiving information and results • Ensuring confidential transfer of patient identifiable data • Errors surrounding accuracy of data inputted These process failures could lead to a breach in confidentiality, 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	Service Provider Service Commissioner			
	Inadequately Trained Staff; Clinical, Reputational Inadequately trained staff or staff undertaking NHS Health Checks without the experience and competency required to do so. Potential impact on the accuracy of the test and the communication of results leading to potential misunderstanding of risk, inappropriate follow up action and potential harm and/or loss of potential benefit to individual	Service Provider			
Identification and offer	**Eligible Population Missed; Clinical** Some of eligible population missed due to not being registered with a GP. There is a danger health inequalities will be exacerbated if non registered population are not offered a check. This also presents a major challenge to the delivery of effective outcomes for this population as well as impacting on the public health objectives of reducing vascular disease health inequalities.	Service Provider Service Commissioner			
	Inaccurate identification of Eligible Population; Clinical & Reputational Accurate identification of the eligible population relies on up to date GP records and contemporaneous recording. If not in place, eligible individuals may potentially be missed and not invited for Health Check. Non-eligible individuals may be invited inappropriately. This could lead to potential harm and/or loss of	Service Provider			

Point on Pathway	Risk Description	Ownership	Risk Score	Risk Response Avoidance and Mitigation	Progress/ Comments
	potential benefit to individual				
The test	**Variance in Risk Tool Used; Clinical & Reputational** No one risk tool has been agreed which could lead to variance in total risk calculated and therefore subsequent interventions - the same patient may receive treatment under one risk tool, but not another. This could reduce confidence in the programme and/ or clinician and lead to potential harm and/or loss of potential benefit to individual	Service Provider Service Commissioner			
	Unknown Blood Results; Clinical Where a request for bloods is made prior to NHS Health Check appointment there is a risk that the patient may not turn up at NHS Health Check appointment and therefore not be aware of blood results, in addition, if results are not received the necessary action (if required) may not take place. Loss of potential benefit to individual	Service Provider			
Communication of results	**Poor Communication of Risk; Clinical, Reputational, Financial** Vascular risk assessment systems used are based on indicators that are a continuum of risk with no specific high and low cut off points. However, the Health Check is categorical, i.e. higher or lower risk at either side of 20%. Below 20% this is further subdivided into 10% to <20% medium risk, and <10% low risk this is in line with NICE guidance for prescribing statins. This categorical approach is common to national screening programmes. But it does mean that some individuals who have been categorised as being at medium or low risk, will unfortunately have vascular disease diagnosed between their Health Checks. Furthermore, given the high numbers being checked nationally, it is almost certain that because of the nature of vascular diseases, a few participants will have major (myocardial infarction) or catastrophic (death) outcomes. People do not understand their level of risk and so do not have the information on which to base a decision about whether to act upon it.	Service Provider Service Commissioner			

Point on Pathway	Risk Description	Ownership	Risk Score	Risk Response Avoidance and Mitigation	Progress/ Comments
	Inappropriate lifestyle advice given; reputational, clinical People are not given appropriate lifestyle advice and therefore do not have the opportunity to change their behaviour. Potential harm and/or loss of potential benefit to individual. Financial benefits of programme are not achieved.	Service Provider			
Management and follow up	**Appropriate follow up not undertaken; Clinical** Required further diagnostic test(s) are not undertaken and/or results are not received and not communicated to the patient or recorded in the patient notes. Inappropriate follow up of the individual. Potential harm and/or loss of potential benefit to individual.	Service Provider			
	Appropriate Management not undertaken; Clinical, Reputational Variable quality of disease management in primary care, inappropriate follow up action. Following diagnosis failure to register patient on appropriate risk register and manage accordingly. The benefits of the programme for individuals are not realised because risk is not reduced or managed.	Service Provider			
	Inappropriate Management in Outreach settings; Clinical, Reputational If screening in a community setting out of hours there needs to be a protocol in place that outlines the appropriate acute management of a high risk individual if identified. That appropriate follow up is not undertaken for a high risk individual that requires immediate treatment. Potential harm and/or loss of potential benefit to individual	Service Provider			
	Patient 'lost' following health check; Clinical Patient does not attend appointment following a referral or referral appointment is not made. No feedback mechanism in place to track patients through the system and flag if an expected appointment has not happened. No improvement of health check risk score, individual remains high risk.	Service Provider			

Appendix 2 continued

Risk Scoring Matrix from the National Patient Safety Agency

Consequence x likelihood (C x L)

	Likelihood				
Likelihood score	**1**	**2**	**3**	**4**	**5**
	Rare	**Unlikely**	**Possible**	**Likely**	**Almost certain**
5 Catastrophic	5	10	15	20	25
4 Major	4	8	12	16	20
3 Moderate	3	6	9	12	15
2 Minor	2	4	6	8	10
1 Negligible	1	2	3	4	5

The score obtained from the risk matrix are assigned grades as follows:

1-3 low risk
4-6 moderate risk
8-12 high risk
15-25 extreme risk
The score assigned will have an impact on the management actions required and level of monitoring.

Scoring
Likelihood (Frequency or Probability) is the likelihood of the event/hazard/ incident occurring or reoccurring. The table below sets out the definitions for the five levels of likelihood and must be used to allocate a likelihood score.

Likelihood (frequency or probability)					
Descriptor	1	2	3	4	5
	Rare	Unlikely	Possible	Likely	Almost Certain
Frequency	Not expected to occur for years	Expected to occur at least annually	Expected to occur at least monthly	Expected to occur at least weekly	Expected to occur at least daily
Probability	< 1%	1 – 5%	6 – 20%	21 – 50%	> 50%
	Will only occur in exceptional circumstances	Unlikely to occur	Reasonable chance of occurring	Likely to occur	More likely to occur than not

Consequence (Severity) The actual or potential outcome of an event/risk/hazard occurring. The table below sets out 5 levels of consequence and must be used to allocate a score to the actual or potential outcome of an event/risk/hazard.

Consequence (Severity)					
	1	2	3	4	5
Descriptor	**Insignificant**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Objectives / Projects	Insignificant cost increase / schedule slippage. Barely noticeable reduction in scope or quality	< 5% over budget / schedule slippage or minor reduction in quality / scope	5 -10% over budget / schedule slippage or reduction in scope or quality.	10 - 25% over budget / schedule slippage or failure to meet secondary objectives	> 25% over budget / schedule slippage or doesn't meet primary objectives
Injury (Physical / Psychological)	Minor injury not requiring first aid or no apparent injury	Minor injury or illness, first aid treatment needed	RIDDOR / Agency reportable	Major injuries, or long term incapacity / disability (loss of limb)	Death or major permanent incapacity
Patient Experience / Outcome	Unsatisfactory patient experience not directly related to patient care	Unsatisfactory patient experience - readily resolvable	Mismanagement of patient care, short term effects (less than a week)	Serious mismanagement of patient care, long term effects (more than a week)	Totally unsatisfactory patient outcome or experience
Complaints / Claims	Locally resolved complaint	Justified complaint peripheral to clinical care	Below excess claim. Justified complaint involving lack of appropriate care	Claim above excess level. Multiple justified complaints	Multiple claims or single major claim
Service / Business Interruption	Loss / interruption > 1 hour	Loss / interruption > 8 hours	Loss / interruption > 1 day	Loss / interruption > 1 week	Permanent loss of service or facility
HR / Organisational Development **Staffing and Competence**	Short term low staffing level temporarily reduces service quality (< 1 day)	Ongoing low staffing level reduces service quality	Late delivery of key objective / service due to lack of staff. Minor error due to ineffective training. Ongoing unsafe staffing level	Uncertain delivery of key objective / service due to lack of staff. Serious error due to ineffective training	Non delivery of key objective / service due to lack of staff. Loss of key staff. Critical error due to insufficient training
Financial	Small loss	Loss > 0.1% of budget	Loss > 0.25% of budget	Loss > 0.5% of budget	Loss > 1% of budget
Inspection / Audit	Minor recommendation s Minor non-compliance with standards	Recommendatio ns given. Non-compliance with standards	Reduced rating. Challenging recommendation s. Non-compliance with core standards	Enforcement Action. Low rating. Critical report. Major non-compliance with core standards	Prosecution. Zero Rating. Severely critical report
Adverse Publicity / Reputation	Rumours	Local Media - short term. Minor effect on staff morale.	Local Media - long term. Significant effect on staff morale.	National Media < 3 Days	National Media > 3 Days. MP Concern (Questions in House)

Acknowledgements: Scoring tables thanks to NHS Buckinghamshire

Appendix 3 NHS Health Checks Pathway