



Public Health
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Protecting and improving the nation's health

NHS Health Check information governance and data flows

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Published October 2016

PHE publications gateway number: 2016386

This document is available in other formats on request. Please call 020 7654 8000 or email: PHE.enquiries@phe.gov.uk



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Revised second edition (2016)

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Foreword

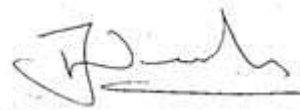
The use and sharing of confidential personal data is often an important component of efforts to improve population health. Quite rightly the use of such data is strictly controlled in order to protect the interests of patients and the public while ensuring that important functions can continue. Sadly, uncertainty about these rules, regulations and laws can too often become an impediment to important public health projects such as the NHS Health Check programme.

We are delighted therefore to be publishing this revised authoritative information governance pack, which aims to resolve much of the uncertainty about how data can be used in relation to the Health Check programme. It provides practical guidance on information governance but leaves room for local authorities to decide how best to commission NHS Health Checks in their own area for their population. This revised edition includes case studies of the information governance implications that result from the working relationships between commissioners and providers of the NHS Health Check.

We would like this work to be seen as a model of how Public Health England can provide practical support to local work through its national work programme. We hope the pack will be useful to you whatever your interest and role in the NHS Health Check programme. We would welcome any feedback on the pack or suggestions for additional work in this area.



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Purpose of this document

This document offers guidance to local commissioning and management of the NHS Health Check. It is for local authority public health teams as commissioners and data controllers in common of the NHS Health Check, GPs as data controllers in common, and other potential data processors to help ensure the local arrangements for data use comply with all the relevant legal requirements. PHE cannot give out legal advice to local authorities or to GPs, who should retain their own legal counsel if they want assistance in interpreting the law and complying with it.

This work takes place as part of the wider NHS Health Check programme in Public Health England (PHE), and is run jointly by the Health and Wellbeing directorate and the Chief Knowledge Officer's directorate. This information governance (IG) workstream reports into the NHS Health Check IG and data subgroup.

Following the transition of public health into local authorities, GPs and local authorities have raised some IG concerns related to the NHS Health Check. To address these, this document presents the end-to-end data flows for NHS Health Check, clarifying the guidance and processes for effectively implementing the three main data flows for the programme. These are:

1. Identifying and inviting the eligible population
2. Transferring NHS Health Check assessment data from non-GP NHS Health Check providers back to the GP practice
3. Data extraction from GP practices for local monitoring, evaluation and quality assurance of NHS Health Check

An area of concern for GPs has been the IG issue surrounding inviting eligible people for the NHS Health Check, specifically that the selection and invitation process may breach patient confidentiality.

In the actions recommended in this document, the GP remains data controller for patient data in instances where the GP is commissioned to provide NHS Health Checks, with only anonymised data flowing to the local authority. As the commissioner determining the purpose for which the data is being collected, local authorities are data controllers in common. However, as stated, local authorities will only have access to anonymised patient data. It continues to be the responsibility of local authorities and GPs to ensure that their local arrangements comply with the law, including by taking independent legal advice as appropriate.

The intent of PHE is that by describing these options and the associated IG considerations, it will help overcome barriers that are currently hampering the

programme. This, combined with other efforts to promote the NHS Health Check, will encourage and facilitate GP engagement in supporting the delivery, directly and indirectly, of this important public health programme.

This new guidance replaces the earlier issue published in 2014. The major change to the new guidance is a recognition of the role played by local authorities as commissioners of NHS Health Checks, acting as data controllers in common with GPs (though, importantly, with different responsibilities and access to different levels of data when compared to GPs). The new guidance also adds the feature of case studies to illustrate the different relationships between data controllers and data processors for the purposes of commissioning and delivering NHS Health Checks.

Introduction

1.1 Background to the NHS Health Check

The NHS Health Check is fully supported by PHE, DH, NHS England, the National Institute for Health and Care Excellence (NICE) and the Local Government Association (LGA). The programme is described in the updated 'Best Practice Guidance' published in March 2016, and the case for the NHS Health Check programme is set out in 'NHS Health Check: our approach to the evidence'.¹ Economic modelling was undertaken in 2008 to estimate the benefits of the programme prior to its introduction and the ready reckoner was updated in May 2014 to include analyses for upper-tier local authorities.²

The primary purpose of the NHS Health Check is to reduce the burden of preventable heart disease, stroke, diabetes and kidney disease in England, and to reduce health inequalities. It is a universal and systematic programme for everyone eligible between the ages of 40-74 that assesses people's risk of developing these conditions and supports them to manage that risk by offering individually tailored support and advice.

It is estimated that the NHS Health Check will stop more than 4,000 people a year from developing type 2 diabetes, preventing at least 650 deaths a year, and detect 19,000 people a year with previously undiagnosed diabetes and 24,000 cases of kidney disease earlier,³ allowing individuals to be better managed and improve their quality of life and health outcomes.

The programme is included as an indicator in the public health outcomes framework and aims to support the delivery of the NHS outcomes framework by reducing morbidity and premature mortality from several major causes of death.

Responsibility for NHS Health Check moved to local authorities following the coming into force of the Local Authorities (Public Health Functions and Entry to Premises by Local Healthwatch Representatives) Regulations 2013⁴. These regulations emphasise the importance of NHS Health Checks to improve public health. This move means that many historic contracting arrangements for NHS Health Check, such as locally enhanced services between former primary care trusts (PCT) and GP practices, may no longer be in force. Furthermore, as a result of procurement rules, contracts for the

¹ http://www.healthcheck.nhs.uk/commissioners_and_healthcare_professionals/national_guidance/

² Ready reckoner:

http://www.healthcheck.nhs.uk/commissioners_and_providers/managing_your_programme/making_the_case/

³ Cost-benefit analysis:

http://www.healthcheck.nhs.uk/commissioners_and_providers/managing_your_programme/making_the_case/

⁴ SI 2013/351

provision of NHS Health Check themselves must be open to not only GPs but also to other providers.

1.2 PHE support for NHS Health Check information governance

National and regional networks exist for the NHS Health Check, and specific support available for this IG work is as follows.

PHE centres

The PHE centre NHS Health Check leads are the local experts supporting implementation and local networking to share best practice around IG and data flows. They are the main point of contact for local authorities and for any communications coming from the central PHE project team.

PHE central project team

The central project team in PHE will share best practice and provide guidance on IG issues relating to the NHS Health Check. This team is supported by the NHS Health Check IG and data sub group. This pack aims to provide answers to the majority of IG queries about the programme, but please contact your PHE centre lead in the first instance if there are issues that have not been addressed in this document. The central project team can also initiate discussions with organisations such as NHS England to resolve national issues that may be getting in the way of NHS Health Check delivery.

1.3 Local authority leadership

The approach outlined in this guidance is highly dependent on GP practices inviting people for a NHS Health Check (either directly themselves or using a data processor); accepting data transferred from non-GP providers; and allowing extraction of anonymised data to local authorities to enable the monitoring, evaluation and quality assurance of the NHS Health Check. To achieve this, good working relationships need to be maintained with primary care. The specific activities that local authorities could undertake include:

- local stakeholder engagement to show the benefits of a data extraction system for primary care and increase buy-in with stakeholders. The main stakeholders who need to be informed about or involved in this work include:
 - local primary care (GP practices) via local medical committee (LMC), practice manager meetings, locality meetings, clinical commissioning group (CCG) protected learning time (or equivalent)
 - other commissioned NHS Health Check providers
 - CCGs, who may wish to access the anonymised data set, and with whom the cost could potentially be shared
 - primary care IT teams in commissioning support units (CSUs), who may have an interest in data extraction from primary care if a system is not already in place

- NHS England area teams, who could use this data extract mechanism to monitor other programmes delivered in primary care e.g. screening or immunisation uptake
- supporting GPs to enter into contracts with one or more data processors to send out invitations where GPs choose not to do this themselves (the invitation process may be funded by the local authority, but the contract for data sharing must be between the GP and data processor)
- potentially entering into procurement processes (quotes or tenders, value dependent) for a data processor and NHS Health Check provider
- tailoring existing reports from data extract suppliers, or alternatively use the 'off-the-shelf' reports already in existence from these suppliers
- the NHS Health Check commissioner is the lead for local implementation of these systems and so the local authority will need to lead on the resolutions of any problems addressed, with the support of the PHE centre
- forwarding issues related to NHS Health Check IG which cannot be resolved locally to the PHE centre NHS Health Check lead

Local authorities as data controllers in common

Local authorities have a statutory obligation to provide or make arrangements to secure the provision of NHS Health Checks to be offered to the eligible population in their areas. As the determiner of the purpose for processing data, local authorities are data controllers in common for the NHS Health Check. Importantly, under data controller in common situations, participation of the different parties involved may take different forms and need not be equally shared across processing, including the manner of processing and control over the purpose of processing.⁵ This means that general practice can maintain control over personal confidential data, with only anonymised data being available to local authorities. This relationship should be articulated in contractual arrangements – including the specifics of any data sharing agreements - between local authorities and general practices.

The local authority role as data controller in common continues to apply in circumstances in which the local authority commissions the provision of NHS Health Check to providers that are not GPs. In those situations, the local authority has the responsibility to state in relevant contracts the specific rights and responsibilities that apply to data processors delivering the programme. In these circumstances, with patient information being sent back securely to GPs, the GPs also remain data controllers in common.

Where the local authority is responsible for securing the social, environmental and wellbeing of the population in their area, either with the provision of NHS Health Check

⁵ <https://ico.org.uk/media/for-organisations/documents/1546/data-controllers-and-data-processors-dp-guidance.pdf>

or by providing a Wellbeing service such as Weight Management or a Stop Smoking service, a primary contractor may be commissioned to coordinate, integrate and performance manage all the elements of the new integrated wellbeing approach and will hold overall responsibility for the management and delivery of the model. The primary contractor will both deliver services and sub-contract with other service providers and voluntary organisations where appropriate.

In these circumstances, where the primary contractor or third party provider contracted to deliver this service has the requirement to generate personal or sensitive data, then the local authority as the data controller has the legal responsibility for complying with the Data Protection Act 1998. The local authority as data controller also has a duty to ensure that the data processor's security arrangements are at least equivalent to the security the data controller would be required to have in place if it were processing the data itself.⁶

As part of the local authority's responsibilities under the Data Protection Act 1998, it may seek to undertake an independent audit of any primary contractor or third party provider acting as data processors for the local authority. The audit review may necessitate a visit to the primary contractor/third party provider's data centre and/or main office where access to, or processing of, sensitive/personal information is being undertaken on behalf of the local authority. The objective of the site visit(s) will be to assess the adequacy of the physical, logical and operational controls in place and assess whether the supplier's approved IT security procedures are embedded within day to day operations and this process should be part of any contractual agreement.

⁶ ICO Data controllers and data processors, version 1.0 (05/06/2014)

The data flows

This section presents the three main data flows for the NHS Health Check:

1. Identifying and inviting the eligible population
2. Transferring NHS Health Check assessment data from non-GP NHS Health Check providers back to the GP practice
3. Data extraction from GP practices for LA monitoring, evaluation and quality assurance of the NHS Health Check

In the invitation process and other data flows described in this document the GP remains as data controller for personal confidential data (PCD) (other than for the option where National Health Applications and Infrastructure Services (NHAIS) [Exeter] is used and for the optional flows described in section 2.4). PHE has obtained guidance from the DH legal team and the Information Commissioner's Office to confirm that the flows set out in this document should comply with the Data Protection Act (DPA) 1998 and other relevant legal requirements, such as duties of confidentiality or privacy. However, responsibility remains with the GP (as data controller) to ensure that all detailed local arrangements are compliant with the law. Local authorities may wish to assist GP practices in doing this. A template privacy impact assessment (PIA) screening example is available on the IG section of the NHS Health Check website to help local authorities and GPs in considering the obligations of the data controller under the DPA. Further information on PIA is found in appendix I.

Local authorities may assist GPs with setting up their invitation service, for example by:

- providing advice on how to run queries on GP systems to identify the eligible cohort
- introducing GPs to suitable data processors and offering advice on how these relationships should be managed
- commissioning and paying for the data processing service

In all cases, the GP will remain as data controllers in common, alongside local authorities – with the local authorities not having access to PCD without explicit consent from the patient. Unless explicit consent has been gained from patients, only anonymised information will flow back to the local authority from the GP practice.

The data flows are summarised in the following diagrams, which outline two options for inviting the eligible population. The first diagram describes a process where the GP sends the invitations and the second diagram describes a process where a data processor does so.

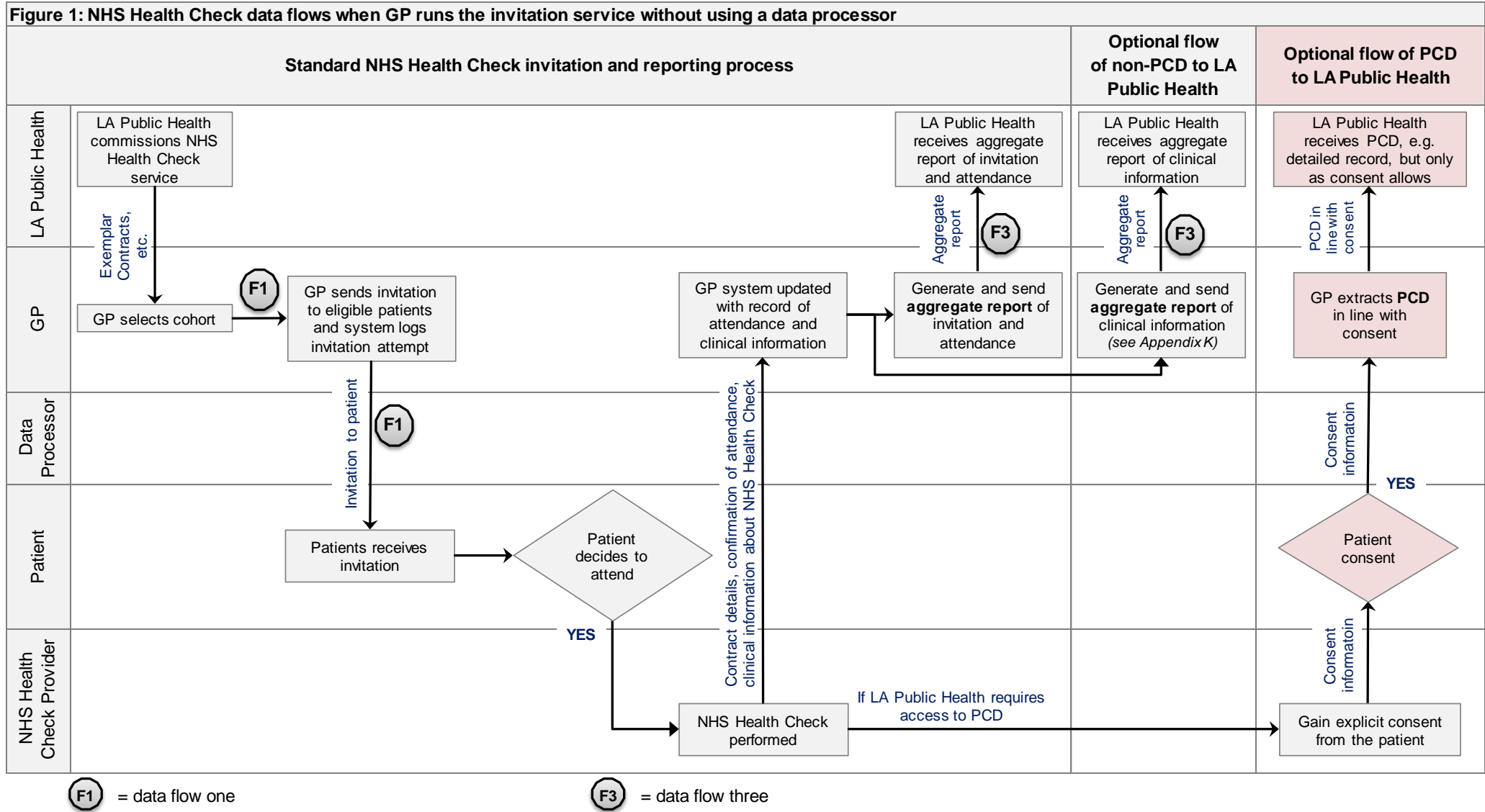
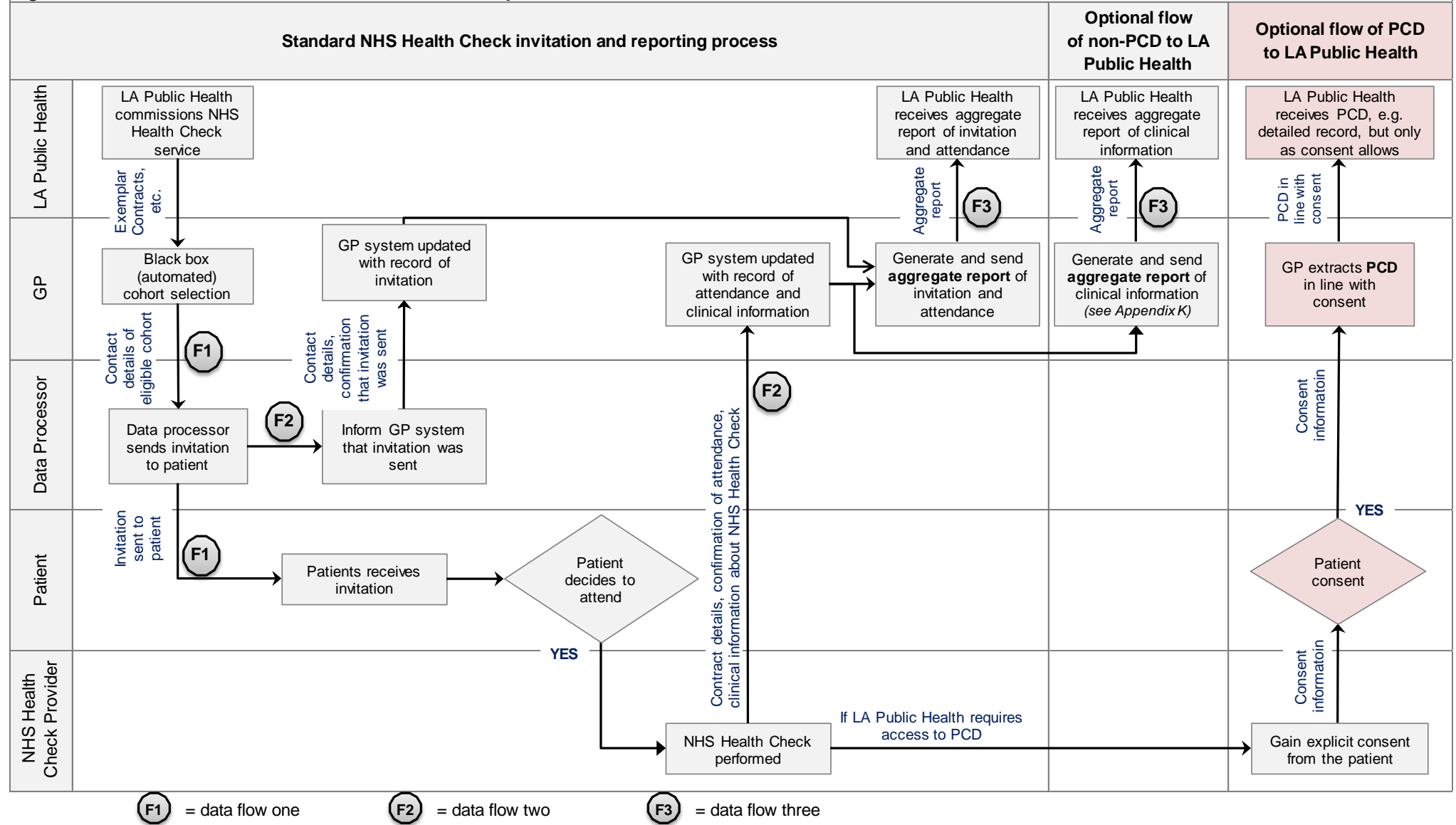


Figure 2: NHS Health Check data flows when GP uses a data processor



2.1 Data flow one: identification and invitation of the eligible population

This section outlines two options to enable local authorities to assist GPs in inviting patients for NHS Health Check, while leaving control of PCD with the GP, and a further option where NHAIS is used. In the options presented, local authorities will not have any access to PCD without patient consent (other than in a limited set of circumstances where they could act as data processor for the GPs as described below, or consent is obtained for data sharing as part of the NHS Health Check).

In this data flow, there are two options for the process by which patients eligible for NHS Health Check may be invited to attend by their GP. The principal difference is that with option one, the GP performs the identification and invitation of patients from within the practice, whereas in option two, the GP uses a data processor to identify and/or invite the patients. It may require separate data processors to identify the eligible population from records and send the invitations.

It should be noted that these options are not mutually exclusive and local authorities may commission more than one model for their local area.

Option one: GP practice identifies and invites the eligible population

In this option, the selection of patients and the sending of invitations are handled entirely by the patient's own practice. GP practices select and invite the eligible population (to attend for a NHS Health Check at the practice or elsewhere) and manage ongoing call-recall as required. The selection of eligible patients is carried out by GP practice staff, on practice systems entirely within the GP practice environment. It is the GP's responsibility to ensure the security of this data as part of their General Medical Services (GMS) contract, in addition to their usual obligations to patients.

The GP practice staff ⁷ run a query on their patient record system to select appropriate patients, using the exclusions listed in the regulations ⁸ (see appendix M).

In 2011, DH and the Health and Social Care Information Centre (HSCIC - now NHS Digital) commissioned Primary Care Information Services (PRIMIS) to develop a national query for GP practices to use. It can be used to conduct a practice audit to determine eligible population for an NHS Health Check. This is available free of charge, along with the Care and Health Analysis in Real Time (CHART) software needed to run the query. It can be downloaded by practices from the PRIMIS NHS Health Check webpage ⁹.

⁷ This may include staff on temporary or honorary contracts, but that these contracts must include appropriate clauses describing the member of staff's obligations relating to how patient data should be handled. Including their duty to respect patient confidentiality and their obligations under data protection law.

⁸ <http://www.legislation.gov.uk/ukdsi/2012/9780111531679/regulation/4>

⁹ <http://www.primis.nottingham.ac.uk/index.php/news/hot-news/838-nhs-health-check-recall-query-library>

An example of fair processing notice is shown in appendix A, which GP practices may choose to use if they do not have one in place already. This explains to patients how their data is handled.

If GP practices are commissioned by the local authority to manage the invitation process themselves, local authorities should ensure through contract monitoring and quality assurance processes that the call-recall system being used, by each practice, is robust. An example call-recall process is inviting by five year age bands: each year invite all 40, 45, 50, 55, 60, 65, and 70 year olds who are not subject to the exclusions in the regulations. After five years all eligible people will have been invited.

The invitation must include contact details of the GP practice (or alternative providers if in place). An example letter for local modification is given on the NHS Health Check website.¹⁰

Option two: using a data processor to select and/or invite the eligible population

In some circumstances GPs may choose not to manage the selection or invitation process themselves. In this option, the selection of eligible patients is performed using a query on the GP practice system to create a list of eligible patients and their contact details. It may be that the GP practice staff run this query themselves, or that a data processor (for example, a private company) is commissioned (usually by the local authority) to generate the eligible population from the GP practice system. A list of such companies is found in appendix D.

If the GP practice has chosen not to invite the patients themselves, the contact details of the people to be invited are then securely transferred to the commissioned data processor. A valid data processing contract between the GP and data processor must be in place which explains the responsibilities of the processor to only act under the instructions of the GP as data controller. This data processor then sends the invitations to the patient in line with the call-recall schedule system agreed with the GP practice and the local authority. It is possible that the data processor creating the eligible list from the GP system and the company sending the invitations could be two separate organisations. They are likely to be commissioned by the local authority and both require data processing contracts with each GP practice. Appendix B contains further guidance about data processing contracts.

PHE and local authorities can advise GPs on the potential options for selecting data processors, and the local authority may commission data processors on behalf of GPs. In this case the local authority will have no access to the data held by the data

¹⁰http://www.healthcheck.nhs.uk/commissioners_and_healthcare_professionals/national_resources/promotional_materials/invitation_letter/

processor, and a data processing contract will still need to be in place between the GP and data processor.

The data processor may be any of the following, and some of these are already commissioned to send invitations:

- a commercial organisation (including alternative NHS Health Check providers themselves)
- an NHS organisation such as a CSU, primary care support agency, hospital or community trust
- local authorities, who may set up a processing service for the purpose of sending out invitations that is firewalled and separate from other local authority activities (so as not to breach the terms of the data processing agreement as described below)

In all cases a valid, contractually binding and enforceable data processing contract must be in place. The organisation acting as data processor will be contractually bound to:

- only use the patient contact data for the purposes of contacting patients for NHS Health Check
- retain data for a limited period of time, which must be no more than is required to perform their contractual function and any necessary follow up, and dispose of them appropriately ¹¹
- otherwise process data in line with the Data Protection Act 1998 (for example, to gain approval from the GP as data controller for any subcontracting of the data processing, and to make clear the lines of responsibility and accountability)

To comply with the DPA it is essential that the data processor makes it clear that it is acting on behalf of the GP for NHS Health Check only. This information must be provided to patients. Guidance on the text for this is in appendix C.

All data processors must be Information Governance Toolkit level 2 compliant.¹²

¹¹ <http://www.primis.nottingham.ac.uk/index.php/news/hot-news/838-nhs-health-check-recall-query-library>

¹² <https://www.igt.hscic.gov.uk/>

Option three: using NHS England local area teams to obtain a list of 40-74 year olds

If GP practices are not able to provide an eligible population list, local authorities can ask their NHS England local area teams for a list of 40-74 year olds from NHAIS and a data processor can be commissioned to send invitations. NHS England is the data controller for National Health Application and Infrastructure Services (NHAIS), also known as Open Exeter, and a data processing contract needs to be in place between the area team and the commissioned data processor. The NHAIS list can be converted to an accurate eligible population list if GP practices can work with the area team to remove exclusions. If this is not possible, then the list of complete 40-74 year olds can be used.

2.2 Data flow two: transfer of data from alternative providers back to the GP practice

When patients attend NHS Health Checks not provided by their GP, there are two data flows back to the GP:

1. The GP must be notified who has had a NHS Health Check. This should be clinically coded in the GP clinical system to enable later reporting about the uptake of NHS Health Checks and to manage call-recall
2. Clinical information generated by the NHS Health Check should be returned to the GP as required by the Local Authorities (Public Health Functions and Entry to Premises by Local Healthwatch Representatives) Regulations 2013.¹³ Patient consent is not required for this data flow as it is a legal requirement, but the patient must be informed that such data will be returned to the GP

This information must be transferred securely in order to comply with the requirements of the Information Governance Toolkit,¹⁴ which states that “all transfers of personal and sensitive information are conducted in a secure and confidential manner”. A number of commercial providers offer electronic solutions to transferring data to GP practices as part of their NHS Health Check service. See appendix D for a list of these companies.

The current information standard for NHS Health Check and associated clinical codes can be found on the NHS Digital website¹⁵.

¹³ An overview of the data items collected that will be returned to the GP is available at: <http://www.nhs.uk/Planners/NHSHealthCheck/Pages/The-tests.aspx>

¹⁴ <https://www.igt.hscic.gov.uk/>

¹⁵ <http://content.digital.nhs.uk/nhshealthcheck>

2.3 Data flow three: GP practice data extraction for anonymised reporting to local authorities

A system will need to be established to enable GP practices to regularly provide anonymised information to local authorities either as a simple data extract or as part of reporting software for contract monitoring, payment, evaluation and quality assurance. Examples of the types of reports that could be developed or commissioned by the local authority are given in appendix K. Local authorities can then use this information to take any follow-up actions necessary to improve uptake of the service, including advertising and communication campaigns targeted at specific groups and areas with low uptake. These extracts/reports are subject to disclosure control as described in the NHS anonymisation standard¹⁶ to ensure there is no breach of confidentiality. For example, small numbers will need to be suppressed.

The process for implementing data extraction from GP practices will vary in different areas as some local authorities, CSUs or CCGs may already have a middleware data extract system in place, or use MIQUEST queries in individual practices, or may have no system currently in place. Appendix L gives further advice on implementation of this type of system.

All NHS Health Check providers need to use the national information standard for NHS Health Check, which details the agreed clinical codes:

<http://content.digital.nhs.uk/nhshealthcheck>

The NHS Health Check network will be informed once this work is completed and GP system suppliers will be notified of the changes by PHE.

2.4 PCD flows back to local authorities

In some circumstances, local authorities may need access to PCD, although the majority of NHS Health Check monitoring can be undertaken with anonymised data. There is no data controller responsibility for non-PCD data (anonymous or non-identifiable data), since “Data protection law does not apply to data rendered anonymous in such a way that the data subject is no longer identifiable.”¹⁷ However, some local authorities may require this information to operate a “lifestyle hub,” which holds PCD in order to be able to refer people onto lifestyle services and monitor uptake of these services.

These optional flows, shown in figures 1 and 2, are outside the scope of this document. However, it must be emphasised that for such flows explicit consent from the patient will be needed before data transfer is possible and the local authority will become a

¹⁶ <http://www.isb.nhs.uk/documents/isb-1523/amd-20-2010/1523202010guid.pdf>

¹⁷ <https://ico.org.uk/media/1061/anonymisation-code.pdf>

separate data controller for these data. Local authorities will need to check with the local IG lead/data protection officer and/or Caldicott guardian to ensure all of the appropriate protections and contractual agreements are in place to comply with the Data Protection Act and that local authorities are at least Information Governance Toolkit level 2 compliant or certified to ISO 27001.

2.5 Case studies for commissioning and delivery of NHS Health Check

GPs/local authorities as data controllers in common

Actor	Role in NHS Health Check programme delivery	Role in data flow
Local authority	Commissions NHSHC	Controller in common, responsibility for management of data
General practice	Invites own eligible patients and provides NHSHC	Controller in common, responsibility for PCD

The local authority has commissioned the service, with general practices delivering the service for their registered patients. As service commissioners determining the purpose for which the data is being collected, local authorities are data controllers in common, alongside GPs, who are responsible for their patients' data. GPs control the PCD, which may only be sent to the local authority in anonymised format.

Local authorities commissioning pharmacies

Actor	Role in NHS Health Check programme delivery	Role in data flow
Local authority	Commissions NHSHC	Controller in common
General practice	Patients' named GP	Controller in common, responsibility for PCD received
Pharmacy	Invites eligible patients	Data processor
Pharmacy	Provides NHSHC	Data processor

The local authority has commissioned pharmacies to deliver NHS Health Check. The local authority must have a contract with pharmacies that indicates the pharmacies' roles and responsibilities as a data processor to securely and appropriately return data to the NHS Health Check recipient's general practice. As the commissioner of the service, the local authority is the data controller in common, alongside GPs, who will receive the patient information from the check. The local authority would not have an automatic right to access PCD, which is being sent to the GP practice.

Local authorities commissioning other third parties to deliver NHS Health Check in community or commercial settings (for example, private or voluntary sector providers)

Actor	Role in NHS Health Check programme delivery	Role in data flow
Local authority	Commissions NHSHC	Controller in common, responsibility for management of data
General practice	Patients' named GP	Controller in common, responsibility for PCD received
Third party	Invites eligible patients	Data processor
	Provides NHSHC	Data processor

The same applies as in local authorities and pharmacies. Namely, the third party has been commissioned (and contracted) specifically to provide the NHS Health Check service and is thus a data processor. The local authority commissioner is a data controller in common alongside GPs. The latter being the sole recipients of PCD.

Allowances should be written into contracts to ensure that the current providers' data sub set (which will contain PCD) is transferred securely to a new provider in a readable format, in the event that a contract is due to expire and a new provider is commissioned under contract by the local authority. This is particularly relevant if the current provider of the service is using a bespoke software management system different to an incoming provider of service and not a system commonly used within the NHS.

Someone has had an NHS Health Check and is referred to another service – for example, a stop smoking service

Actor	Role in NHS Health Check programme delivery	Role in data flow
Local authority	Commissions NHSHC	Controller in common, responsibility for management of data
General practice	Patients' named GP	Controller in common, responsibility for PCD
Stop smoking service	Follow up patient referred following NHSHC	To be agreed in contract

In this situation, a new clinical relationship has begun that goes beyond the NHS Health Check. As with the cases above, contractual arrangements and appropriate data protection and transfer should be pursued by the commissioning bodies, referring parties and the stop smoking service itself.

One private company (third party 'A') is in charge of invitation, one voluntary sector organisation (third party 'B') provides the NHS Health Check

Actor	Role in NHS Health Check programme delivery	Role in data flow	
		Contact details	Clinical information
Local authority	Commissions NHSHC	Controller in common, responsibility for management of data	Controller in common, responsibility for management of data
General practice	Patients' named GP	Controller in common, responsibility for PCD	Controller in common, responsibility for PCD
Third party A	Invites eligible patients	Data processor	N/A
Third party B	Provides NHSHC	Data processor	Data processor

In this instance, both third party A (which has invited the eligible population) and third party B have been commissioned (and contracted) by the local authority specifically to invite patients to and provide the NHS Health Check service respectively. Thus, parties A and B are both data processors. The local authority commissioner is data controller in common alongside GPs. The latter being the only recipients of PCD.

Glossary

A more detailed glossary can be found at Information: To share or not to share? The Information Governance Review (2013):

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/192572/2900774_InfoGovernance_accv2.pdf

Aggregated data: statistical data about several individuals that has been combined to show general trends or values without identifying individuals within the data.

Anonymisation: the process of rendering data into a form that does not identify individuals and where identification is not likely to take place.

Caldicott guardian: a senior person responsible for protecting the confidentiality of patient and service user information and enabling appropriate information sharing by providing advice to professionals and staff.

CHART: Care and Health Analysis in Real Time. A software tool designed for GP practices.

Commissioning (and commissioners): commissioning is essentially buying care in line with available resources to ensure that services meet the needs of the population. The process of commissioning includes assessing the needs of the population, selecting service providers and ensuring that these services are safe, effective, people-centred and of high quality. Commissioners are responsible for commissioning services.

Confidential data or information: see 'Personal confidential data'.

Confidentiality Advisory Group (CAG): provides independent expert advice to the Health Research Authority (for research applications) and the Secretary of State for Health (for non-research applications) on whether applications to access patient information without consent should or should not be approved under Section 251 of the NHS Act (2006) and the Health Service (Control of Patient Information) Regulations 2002 in line with the Health Research Authority Directions 2013. This includes providing advice in relation to regulations 2, 3(4) and 5, in line with regulation 7. The role of CAG is to review applications and advise whether there is sufficient justification to access the requested confidential patient information. Using CAG advice as a basis for their consideration, the HRA or Secretary of State take the final approval decision.

Data controller: an individual or organisation who determines the purposes for and the manner in which any personal confidential data are or will be processed. Data

controllers must ensure that any processing of personal data for which they are responsible complies with the Data Protection Act 1998:

- **Joint data controllers** control how data is processed jointly in that they must agree and make such decisions together
- **Data controllers in common** agree to pool data and are both responsible for how it is used, but each may process the data independently for its own purposes. All of the data controllers in common are still responsible for ensuring it is adequately protected

Data loss: a breach of the seventh data protection principle (“unauthorised or unlawful processing or accidental loss, destruction or damage”) established by the Data Protection Act 1998, or an inappropriate breach of confidentiality.

Data processor: any person (other than an employee of the data controller) who processes the data on behalf of the data controller. Data processors are not directly subject to the Data Protection Act 1998, but the Information Commissioner’s Office recommends that organisations should choose data processors carefully and have in place effective means of monitoring, reviewing and auditing their processing. A written contract detailing the information governance requirements must also be in place to ensure compliance with principle 7 of the DPA.

De-identified data: refers to personal confidential data that has been through anonymisation in a manner conforming to the Information Commissioner’s Office anonymisation code of practice. There are two categories of de-identified data:

- **De-identified data for limited access** is deemed to have a high risk of re-identification if published, but a low risk if held in an accredited safe haven and subject to contractual protection to prevent re-identification
- **Anonymised data for publication** is deemed to have a low risk of re-identification, enabling publication

Demographic data: information relating to the general characteristics of an individual or population. For example, ethnicity, gender, geographical location, socio-economic status.

Identifiable information: see ‘Personal confidential data’.

Identifier: an item of data that by itself or in combination with other identifiers enables an individual to be identified.

Information: the “output of some process that summarises, interprets or otherwise represents data to convey meaning”.¹⁸ Data becomes information when it is combined in ways that have the potential to reveal patterns in the phenomenon.

Information governance: how organisations manage the way information and data are handled within the health and social care system in England. It covers the collection, use, access and decommissioning as well as requirements and standards organisations and their suppliers need to achieve to fulfil the obligations that information is handled legally, securely, efficiently, effectively and in a manner that maintains public trust.

Middleware: software that facilitates exchange of data between two application programs within the same environment, or across different hardware and network environments.

Personal confidential data: personal information about identified or identifiable individuals that should be kept private or secret. For the purposes of this document ‘personal’ expands on the Data Protection Act 1998 definition of personal data (which only covers living people), so as to include dead as well as living people, and ‘confidential’ includes both information ‘given in confidence’ and ‘that which is owed a duty of confidence’ as well as ‘sensitive’ as defined in the DPA.

Personal data: data that relates to a living individual who can be identified from that data, or from that data and other information that is in the possession of, or is likely to come into the possession of, the data controller. This includes any expression of opinion about the individual and any indication of the intentions of the data controller or any other person in respect of the individual.

Personal information: see ‘Personal confidential data’.

Primary care: services provided by GP practices, dental practices, community pharmacies and high street optometrists, but can also be used just to refer to GP practices.

PRIMIS: Primary Care Information Services (commissioned by DH in 2011 for the NHS Health Check call-recall query).

Privacy impact assessment: a systematic and comprehensive process for determining the privacy, confidentiality and security risks associated with the collection, use and disclosure for personal data prior to the introduction of or a change to a policy, process or procedure. This allows for mitigating actions to be set out against the identified risks.

¹⁸ <http://data.gov.uk/sites/default/files/Cabinet%20Office%20Open%20Data%20Strategy.pdf>

Processing: obtaining, recording or holding the information or data or carrying out any operation or set of operations on the information or data, including:

- organising, adapting or altering the information or data
- retrieving, consultation or use of the information or data
- disclosing the information or data by transmitting, disseminating or otherwise making it available
- aligning, combining, blocking, erasing or destroying the information or data

Pseudonymisation: the process of distinguishing individuals in a data set by using a unique identifier, which does not reveal their 'real world' identity (see also 'Anonymisation' and 'De-identified' data).

Sensitive personal data: data that is capable of identifying a living individual and consisting of information about any of the following: his or her racial or ethnic origin; political opinions; religious beliefs or other beliefs of a similar nature; membership of a trade union; physical or mental health or condition; sexual life; convictions for or accusations of criminal activity, including any legal proceedings against that individual whether imminent, ongoing, or historical. See also 'Personal confidential data'.

Appendices

Appendix A: fair processing notice

A fair processing notice can also be referred to as a 'privacy notice'. It is highly recommended that GPs (as data controllers) have registered with the Information Commissioner's Office and display a 'fair processing notice' that explains to patients their rights surrounding the personal information they provide and its uses. As part of this, it is important that patients are informed about how information will be used for the NHS Health Check programme.

Fair processing notices should be made available to all patients, for example, by being on display in the practice and on the practice website.

In relation to NHS Health Check, such fair processing notices should state clearly:

- that the GP is data controller in common with sole access to PCD and may use sensitive personal information for providing health care to the patient, for monitoring and managing health care, and for inviting patients to attend health care services, including NHS Health Check
- that the GP may use a data processor to process data on their behalf. The data processor will handle patient information only under direct instruction from the GP and will comply with the Data Protection Act 1998, and any other laws that apply (such as those relating to confidentiality and privacy)
- who the patient should contact with any queries

An example fair processing notice

Note: There is no required legal template for a notice, meaning that a GP can tailor it to the particular circumstances and requirements.

Our GP practice keeps records about your health and the care you receive. These may include:

- basic details about you, such as address and next of kin
- contacts we have had with you, such as GP appointments and clinic visits
- reports about your health and any treatment or care you need
- details and records about the treatment and care you receive
- results of investigations, such as X-rays and laboratory tests
- relevant information from other health professionals, relatives or carers

To ensure you receive the best possible care, we may contact you to invite you to participate in health improvement programmes. For example, the NHS Health Check, a cardiovascular disease prevention programme for people aged 40-74 not previously diagnosed with cardiovascular disease.

We may invite you for an appointment using a data processor who works entirely under our direction. Nobody outside the healthcare team in the practice will see confidential information about you during the invitation process.

We maintain our legal duty of confidentiality to you at all times. We will only ever use or pass on information about you if others involved in your care have a genuine need for it. We will not disclose your information to third parties without your permission unless there are exceptional circumstances, such as when the health or safety of others is at risk, or where the law requires information to be passed on.

You have a right under the Data Protection Act 1998 to find out what information we hold about you. This is known as 'the right of subject access'. If you would like to make a subject access request, please do so in writing to the practice manager. If you would like to know more about how we use your information, or if you do not want us to use your information in this way, please contact the practice manager.

Appendix B: data processing contract for sending invitations

GPs as data controllers may choose to use a data processor for sending out invitations to patients. The data processor should only be provided with the list of contact details of invitees and should not have access to any clinical information.

The GP will remain as data controller and in order to comply with the Data Protection Act 1998 must ensure that there is a valid and legally enforceable contract with the data processor that sets out the responsibilities of the data processor to act only under the instructions of the GP, in particular that:

- the data supplied should only be used for the purpose of writing to patients to invite them for NHS Health Check
- the data should not be used for any other purpose whatsoever
- the supplied data must be held in confidence and must not be disclosed to any third party and must be deleted by the data processor as soon as possible
- there are appropriate physical and logical security arrangements in place eg the organisation is at least Information Governance Toolkit level 2 compliant
- that in any contact made with patients it is made clear that the data processor is acting on behalf of the GP for the purpose of inviting patients for NHS Health Check (see Appendix C)

An example data processing contract will be available on the NHS Health Check website: www.healthcheck.nhs.uk/

Appendix C: information governance content of invitation letters

Invitations may be by letter,¹⁹ telephone call, email, text or other means as appropriate to the local situation. At least one written invitation must be made to ensure individuals can make an informed decision about whether to attend for a NHS Health Check.

The letter should include general information about the NHS Health Check, its purpose, and any benefits and risks to the individual.

In order to comply with fair processing under the Data Protection Act 1998, it is essential that invitations to patients include the following:

- the fact that it is the responsibility of the GP to identify patients eligible for NHS Health Check and to ensure they are invited
- who is contacting the patient – either it is:
 - the GP or a member of staff directly employed by the practice or
 - a member of staff from an organisation acting as data processor on behalf of the GP specifically in order to invite eligible patients for NHS Health Check
 - in any event the communication should be set out as from the GP
- contact information for the GP practice to enable patients to confirm the legitimacy of the invitation should they wish
- further information to enable the patient to be able to attend the NHS Health Check which may include:
 - the contact details of the GP surgery or a specific member of staff in the practice responsible for NHS Health Check
 - the contact details of any other provider commissioned to provide NHS Health Check in the local area

¹⁹ National invitation letter templates for NHS Health Check can be found at:
http://www.healthcheck.nhs.uk/commissioners_and_providers/delivery/marketing_and_branding/invitation_letters_appointment_cards/

Appendix D: companies offering solutions for one or more of the data flows

The table below lists suppliers known to be delivering one or more of the data flows for the NHS Health Check and was accurate at the time of publishing. PHE is not able to recommend any one supplier over another for this work. This list is not definitive and will change over time.

Company	Eligible population identification	Call-recall system	Electronic data transfer back to GPs	Data extract for LA monitoring of NHS Health Check	Comments
Advanced Health and Care	N	N	Y	Y	Results can be sent as read codes (Read v2 and CTV3)
BMJ Informatica	Y	Y	Y	Y (see comments)	Invite query can write invite read codes back into GP record. Not yet compatible with CTV3 (SystemOne). Data extract is activity monitoring
dtpgroup	Y	N	N	Y	Work via CSU
EHS Healthcare	Y	Y	Y	Y	
Health Diagnostics	Y	Y	Y	Y	GP and non-GP settings. Results can be sent as read codes (Read v2 and CTV3)
Health Intelligence	Y	Y	Y	Y	GP and non-GP settings. Results sent as pdf
Medvivo	N	N	Y	Y	GP and non-GP settings. Results sent as pdf. Data extract only available from Medvivo database
MSDi	Y	Y	Y	Y	Data extract hosted by CSU. Results can be sent as read codes (Read v2 and CTV3)
Oberoi	Y	N	Y	Y	Results can be sent as read codes (Read v2 and CTV3)
PRIMIS	Y	N	N	Y	Created national call-recall query
QMS	Y	Y	Y	Y	Results sent as pdf
TCR, Nottingham	Y	Y	Y	Y	Results can be sent as read codes (Read v2 and CTV3)
ToHealth	Y	Y	Y	Y (see comments)	GP and non-GP settings. Results can be sent as read codes (Read v2 and CTV3). Run extract from their own database (not GP records)

Some GP system suppliers (EMIS and SystemOne) are also able to run queries to identify the population eligible for NHS Health Check and reports to monitor the programme. If there is only one type of GP IT system in your area, you may wish to approach the supplier direct to see if they are able to offer this service.

If any suppliers have been omitted, please email: PHE.enquiries@phe.gov.uk

Appendix E: key points for GP practices

Background

From 2012-2013 local authorities have a statutory responsibility to commission the NHS Health Check for their local population. Public Health England, an executive agency of the Department of Health, has national responsibility for delivering this programme and supports local authorities in commissioning this important public health programme.

The NHS Health Check is a disease prevention programme that involves a cardiovascular risk assessment and onward referral and/or treatment to help individuals manage and reduce this risk. Approximately 70% of people aged 40-74 are eligible for the NHS Health Check.

Local authorities are required to invite their eligible populations on a rolling basis over a five year period (for example, one fifth of the eligible population every year). As stated previously, primary care has an important role to play in implementing the NHS Health Check programme. Many local authorities commission their GP practices to create this eligible list, and GP practice staff then either send the invitations directly or contract a data processor.

Information governance considerations

Since the move of public health to local authorities, the information governance situation has changed leaving local authority public health teams unable to access the data they previously could when employed in the NHS. This has made commissioning the NHS Health Check less straightforward.

To secure the continued delivery of this work, the DH legal team has confirmed that GP practices can continue to invite their patients for a NHS Health Check (at their practice or elsewhere) without breaching confidentiality or the Data Protection Act 1998. If GP practices choose not to send invitations themselves, using a data processor to send invitations does not breach confidentiality either.

If the local authority and the GP practices have agreed to use a data processor, a data processing contract is required between the GP practice (the data controller) and the data processor. The data processor can be any organisation that is Information Governance Toolkit level 2 compliant. It is likely the local authority will directly commission the data processor if this model is used and so there will also be a contract and service specification between the local authority and the data processor. However, no personal confidential data will be seen by the local authority unless it has a legal basis to process this data (for example, patient consent or appropriate legislation), enters into a data processing contract with the data controller, and is Information Governance Toolkit level 2 compliant or certified to ISO27001.

Some local authorities use NHAIS (Exeter) to create a list of all 40-74s to invite for an NHS Health Check. Where this takes place, it is done with the approval of NHS England (the data controller for NHAIS) and is often delivered by the commissioning support unit (CSU) or a primary care agency/support service (PCA/PCSS) under a data processing contract. This data set does not contain the clinical data found in a GP patient list and so does not allow for ineligible patients to be removed. The preferred solution is for GPs to identify and send invitations to the appropriate patients or to contract with an Information Governance Toolkit Level 2 compliant data processor to do so.

Conclusion

PHE has provided this guidance to reassure GP practices that the work they are asked to do by local authorities for the NHS Health Check does not breach the Data Protection Act 1998 and confidentiality law. Provided the appropriate data protection arrangements are in place, commissioners and providers should feel confident that they can deliver NHS Health Checks securely, including the receipt and dispatch of patient data.

As with any new service or service change, local authorities and GP practices should always check the arrangements with their local IG/data protection leads or Caldicott guardian to ensure they are satisfied with the proposed arrangements.

For a more comprehensive explanation of this work, please see the full NHS Health Check information governance pack. Please contact your local authority public health team if you have further queries.

Appendix F: summary for health and wellbeing boards

Background

From 2012-2013 upper-tier local authorities have a statutory responsibility to commission the NHS Health Check for their local populations. Public Health England has a national responsibility to support local authorities in commissioning this work.

The NHS Health Check is a disease-prevention programme that involves a cardiovascular risk assessment and onwards referral or treatment to help individuals manage this risk. Local authorities are required to invite their eligible population on a rolling basis over five years.

Information governance considerations

Since the move of public health to local authorities, the information governance situation has changed and public health teams are less able to access some of the data they could previously when in the NHS.

The primary issue is that although local authorities have a statutory responsibility for commissioning the NHS Health Check, there is no explicit legislation to allow local authority access to a list of the people eligible for the programme. Local authorities are therefore reliant on the cooperation of data controllers (GPs or NHS England) to provide this list. Although local authorities are data controllers in common for NHS Health Check, the local authorities are still reliant on GPs or NHS England, as these groups hold the patient data and information.

Other issues that data controllers have in the past viewed as unclear:

Processing must be fair and lawful

There must be a legal basis to process personal confidential data (PCD). Even for data controllers any PCD processing must have a legal basis, be in line with the ICO registration, and be expected by the individual. Information Governance Toolkit Level 2 compliance is required when using PCD. The majority of organisations already have this in place, or are working towards it, but it can take time to implement if not in place already.

Data processing contracts

If PCD processing is done by an organisation other than the data controller, a data processing contract is needed (and the processor must comply with Information Governance Toolkit Level 2). Not all organisations may have this in place.

Anonymisation

There have been concerns surrounding sharing anonymised data about people who have been invited for, or have attended, an NHS Health Check. Sharing anonymised data is acceptable as long as it is in line with the Information Commissioner's Office anonymisation code of practice and NHS anonymisation standard. If a data controller contracts another organisation to undertake the anonymisation, a data processing contract is required between the two organisations as PCD must be processed in order to produce the anonymised data. The data processor must also comply with Information Governance Toolkit Level 2.

NHS Health Check data flows

These three specific data flows are necessary for the effective running of the NHS Health Check, along with the IG issues and options for resolution.

1. Identifying and inviting the eligible population

- **Issue:** local authorities rely on data controllers for a list of the eligible population
- **Resolution:** there are three ways the eligible population can be identified and invited: the GP sends invitations; GP or local authority commissions a data processor; or a list of 40-74 year olds is obtained from NHAIS. If a data processor is to be used a data processing contract and Information Governance Toolkit Level 2 compliance are required

2. Data transfer back to GP practices from non-GP providers

- **Issue:** some areas are not aware this data flow is a statutory requirement
- **Resolution:** as this data flow is a statutory requirement and has a legal basis, consent is not required. Data must be transferred securely back to the GP practice, for example, via NHS mail or the government secure network

3. Anonymised data extract from GP practices

- **Issue:** generalisations cannot be made on what is PCD or anonymised data. Additionally, the anonymisation process may require a data processor for extract and/or analysis
- **Resolution:** any anonymised data must be risk assessed before release to maintain disclosure control, as the context and use often defines whether the data are anonymous or not. If anonymisation is not undertaken by the data controller, a data processing contract is required and the data processor needs to be Information Governance Toolkit level 2 compliant

Local authority action

There is as much responsibility to share as to protect data to improve health and so it is critical that perceived barriers to information sharing are overcome. The key to delivery of NHS Health Check data flows is effective management of any data sharing risks. Any arrangements made for data sharing should always be checked with the appropriate

members of staff, such as those working in information governance, data protection, legal, or the Caldicott guardian.

Public Health England has produced a detailed pack on the information governance issues related to NHS Health Check that explains how these can be addressed. The pack contains:

- an outline of the data flows, and the information governance and legal considerations related to each of these
- options for delivering each of the data flows
- a range of template documents, including a data processing contract, briefing for GP practices and a list of IT suppliers to help with generating the eligible population list and producing monitoring reports

Local authorities are invited to use the NHS Health Check information governance pack to take forward the NHS Health Check where issues relating to information governance may be hampering the programme in their local areas. Further support is available from your PHE centre NHS Health Check lead.

Appendix G: references and useful information summary

Information Commissioners' Office:

www.ico.org.uk/

Confidentiality Advisory Group:

www.hra.nhs.uk/resources/confidentiality-advisory-group/

Caldicott 2 review:

www.gov.uk/government/publications/the-information-governance-review

The Local Authorities (Public Health Functions and Entry to Premises by Local Healthwatch Representatives) Regulations 2013 (outline of NHS Health Check responsibilities):

www.legislation.gov.uk/uksi/2013/351/contents/made

PRIMIS NHS Health Check call-recall query (free registration with PRIMIS and CHART software needed):

www.primis.nottingham.ac.uk/index.php/news/hot-news/838-nhs-health-check-recall-query-library

NHS Health Check sample invitation letters:

http://www.healthcheck.nhs.uk/commissioners_and_providers/delivery/invitation_letter_and_results_card/

NHS Health Check national dataset and Read codes:

www.hscic.gov.uk/nhshealthcheck

HSCIC (NHS Digital) Information Governance Toolkit:

www.igt.hscic.gov.uk/

NHS/HSCIC (NHS Digital) anonymisation standard:

www.isb.nhs.uk/documents/isb-1523/amd-20-2010/1523202010guid.pdf

HSCIC (NHS Digital) Guide to Confidentiality – overview:

<http://content.digital.nhs.uk/media/12822/Guide-to-confidentiality-in-health-and-social-care/pdf/HSCIC-guide-to-confidentiality.pdf>

HSCIC (NHS Digital) Guide to Confidentiality - references (more detail):

<http://content.digital.nhs.uk/media/12823/Confidentiality-guide-References/pdf/confidentiality-guide-references.pdf>

NHS confidentiality code of practice:

www.connectingforhealth.nhs.uk/systemsandservices/infogov/codes/confcode.pdf

ICO anonymisation code of practice:

ico.org.uk/for_organisations/data_protection/topic_guides/anonymisation

NHS Health Check implementation review and action plan:

http://www.healthcheck.nhs.uk/latest_news/nhs_health_check_implementation_review_and_action_plan1/

Privacy impact assessment:

www.ico.org.uk/for_organisations/data_protection/topic_guides/privacy_impact_assessment

NHS records retention code of practice:

www.gov.uk/government/publications/records-management-nhs-code-of-practice

Regional and Centre Lead Group – NHS Health Check:

http://www.healthcheck.nhs.uk/commissioners_and_providers/governance/regional_and_centre_lead_subgroup/

Appendix H: frequently asked questions

1. What is the NHS Health Check information governance and data work about?

The NHS Health Check information governance and data flow work aims to clarify guidance on the information governance aspects of the three main data flows: sharing data for cohort invitation, transferring data back from non-GP providers to GPs and extracting data from GP practices. The IG pack signposts to national guidance and example documents such as a data processing agreement. It aims to simplify the information governance and legal requirements for the NHS Health Check and provide support to the practical implementation of data solutions.

2. Will there be any costs involved for local authorities?

If local authorities already have a system that can electronically extract data from GP practices on a regular basis, it is very unlikely that there will be further costs beyond the normal costs for commissioning NHS Health Check. If there is no system in place and you would like to procure a comprehensive reporting system, costs can range from £500-£1500 per GP practice per year (there is usually no additional cost for branch practices), and possibly additional development costs. This would provide a fully set up and managed service. CCGs or CSUs may already have such a system in place, or be interested in this information if it became available, and so if a new system is needed it may be worth talking to them about sharing this cost. Alternatively, lower cost options could be developed in-house.

3. Aren't GPES already collecting this kind of information?

GPES collects some, but not all, of the data required for the monitoring and evaluation of NHS Health Check. Using this system will be a long term aim, but as timeframes are unknown at present, PHE has decided to support the implementation of locally commissioned systems with local authorities in parallel with the longer term GPES plan. In addition, locally-commissioned systems put control in the hands of local authorities as they can be customised to local data needs and are likely to be more useful to commissioners.

4. I've heard there are lots of information governance/data protection issues with NHS Health Check. What are the rules and how do we ensure we abide by them?

Information governance should not be a barrier to the local delivery of this national health improvement programme, but sufficient safeguards need to be put in place to ensure PCD are used appropriately. This pack provides information on the models for delivering the data flows required for NHS Health Check within an acceptable information governance framework.

5. What are the benefits of this data quality work for the public health team?

In the areas that have implemented these systems, local authorities are able to generate their eligible population, see progress with the delivery of NHS Health Check, and use anonymised data for a wide range of analyses to support the effective local targeting of NHS Health Check. This anonymised data set could potentially be widened out to include any kind of read-coded data from GP practices and could be used for work such as for the public health core offer to CCGs, or monitoring immunisation uptake. Some areas have already chosen to broaden the remit of this data collection to include all public health commissioned services from primary care.

6. What support will there be from PHE?

Your PHE centre NHS Health Check lead and the PHE central project team can help you with any question you have about NHS Health Check data flows. We can share best practice from areas where NHS Health Check data systems work well, and support public health teams who may need to develop new reporting systems from scratch. This IG pack clarifies some of the concerns local authorities have around information governance and data.

7. I've seen a few evaluations of NHS Health Check published recently, so isn't the programme data already being collected at a national level?

Recent papers include an evaluation of NHS Health Check, published in January 2016.²⁰ The work PHE is now doing aims to support local authorities to systematise data collection across the whole of England. This will be achieved by supporting local authorities to implement systems that allow invitation of the eligible population, improve data quality and give a comprehensive dataset for local monitoring, evaluation and quality assurance.

8. Who can I contact for further information?

Go to your PHE centre NHS Health Check lead in the first instance who can then forward on your query to the central project team at PHE if required. The information about the implementation review and action plan is available on this site:

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

²⁰Robson J, Dostal I, Sheikh A, et al. The NHS Health Check in England: an evaluation of the first 4 years. *BMJ Open* 2016;6:e008840. doi:10.1136/bmjopen-2015-008840. <http://bmjopen.bmj.com/content/6/1/e008840.full>

Appendix I: privacy impact assessment screening

A privacy impact assessment helps to assess and identify any privacy concerns for services and projects and address them at an early stage. As part of best practice local authorities and GPs should conduct PIA screening to see if a small or large scale PIA is needed for NHS Health Check, or if the risks can be managed through normal risk management processes.

Full guidance on the PIA process can be found on the Information Commissioner's Office website:

www.ico.org.uk/for_organisations/data_protection/topic_guides/privacy_impact_assessment

The process is useful in identifying any perceived or real risks in the data sharing that may take place as part of NHS Health Check commissioning. Once these risks are identified, mitigations can be put in place to prevent the risk from occurring.

An exemplar PIA screening checklist is available on the information governance and data section of the NHS Health Check website, which indicates that if the arrangements in this document are followed a PIA will not be required, but the risks identified still need to be managed as part of the NHS Health Check programme locally.

However, local authorities and GPs remain responsible for their own local arrangements and should consult their data protection lead and/or Caldicott guardian.

Appendix J: key considerations for commissioning middleware solutions

The key capabilities a company must have to extract data successfully from GP practice systems for either cohort identification or reporting to LAs are as follows:

- be able to put in place a data processing contract with the GP practices to allow data extraction
- be capable of accurately extracting read-coded data from GP practices for both Read v2 (EMIS, Vision, Evolution) and clinical terms v3 (SystemOne) and SNOMED (required from April 2017)
- be able to anonymise data at source to allow linking of data over time
- use anonymisation processes that are compliant with the NHS and ICO anonymisation codes of practice
- be able to analyse data to provide reporting functions determined by local authority commissioners
- be able to securely transfer or make available the pseudonymised data analysis to local authorities
- be at least level 2 compliant with the Information Governance Toolkit

Appendix K: anonymised reports/extracts from the GP to the local authority

This section lists examples of reports that may be useful for local authorities to monitor the uptake and impact of the NHS Health Check, and that can be developed using extracts from GP systems. These anonymised reports/extracts must be in a format that ensures there is no disclosure of PCD. Further information on this is available in the NHS anonymisation standard.²¹

Thanks are given to Buckinghamshire County Council for sharing the examples below of their monitoring reports. The following reports could be available at local authority level and individual GP practice level.

1.0 Invite and uptake

1.1 Invites (last quarter and year-to-date)

- total number
- five year age bands breakdown (eg 40-44, 45-49 etc.)
- gender breakdown
- ethnicity breakdown (census 2011)
- deprivation score – average score of invited

1.2 Attendees (last Q, YTD)

- total number
- five year age bands breakdown
- gender breakdown
- ethnicity breakdown
- deprivation score – average score of attended

1.3 Non-attendees (invitees with no Health Check completed/risk score) (last Q, YTD)

- total number
- five year age bands breakdown
- gender breakdown
- ethnicity breakdown
- deprivation score – average score of non-attenders

2.0 Clinical profile of attenders

²¹ http://www.isb.nhs.uk/documents/isb-1523/amd-20-2010/index_html

- number and percentage of attendees with BP \geq 140/90
- number and percentage of attendees with BMI \geq 30
- number and percentage of attendees with raised cholesterol
- number and percentage of attendees with low eGFR $<$ 60
- number and percentage of attendees with low physical activity levels (GPPAQ)
- number and percentage of attendees with raised sugar (FPG: \geq 5.5mmol/l, HBA1c: \geq 6% or 42mmol/mol)
- number and percentage of attendees that smoke
- number and percentage with FHx of CVD
- number and percentage of attendees with high AUDIT (\geq 8)
- number and percentage of those with high-risk score (20% or greater)

3.0 Clinical profile of non-attenders

For results entered in last 12 months, categories as above (except risk score)

4.0 Follow up

Since start of scheme:

- high-risk people reviewed (use clinical code/score of high risk by any risk calculator, look for cardiovascular disease high-risk review code within 18 months – timeframe not based on guidance)
- high-risk prescribed statins or declined statins within six months (may need to check timeframe)
- high sugar re-test (HBA1c or FPG) within six months of HC (\geq 7mmol/l, \geq 6.5%, 48 mmol/mol (no symptoms))
- low eGFR – repeat eGFR within one month of HC (NCIE guidance is two weeks) and albumin creatinine ratio (no timeframe given in guidance, use six months)
- raised BP f/u (\geq 140/90) within six months (may need to check timeframe)

5.0 Signposting, referral, referral declined

- general lifestyle advice given
- smokers given advice, signposted, referred, declined smoking cessation
- high sugar (FPG: \geq 5.5 to $<$ 7mmol/l, HBA1c: 6% to 6.4% or 42-47 mmol/mol) referred, declined IFG/IGT (pre-diabetes) service
- number signposted, referred, declined health trainer
- low PA brief intervention, signposted, referred, declined PA service
- BMI \geq 30 given advice, signposted, referred, declined weight management
- alcohol brief intervention, referral, declined specialist alcohol service

6.0 Diagnoses

(Timeframe since HC/HC invite, for example, 1, 3, 6, 12 months. Attenders vs non-attenders)

- coronary heart disease
- chronic kidney disease (CKD), stage 3, 4 or 5
- diabetes

- hypertension
- atrial fibrillation
- transient ischaemic attack
- hypercholesterolaemia
- heart failure
- peripheral arterial disease
- stroke

7.0 CV admissions

Incidence in attenders versus non-attenders (use date of attended versus invitation respectively)

8.0 Data quality

Data completeness (95% target) for mandated NHS Health Check fields (gender, age, ethnicity, FHx <60 yrs, BMI, smoking status, PA level, chol, chol:HDL, BP, AUDIT score, CV risk score)

Appendix L: implementing primary care data extract services

The following table starts where any current methods of data extraction from primary care are unknown and so investigative work must take place before deciding on further plans.

It then splits into one of two options: where no system is in place, or where an existing electronic extract takes place from primary care.

Table 1. Proposed process and options for implementing local primary care data extract service

Current data extract situation unknown	
<p>1. Check with local authority colleagues to check if a data system is being used to extract data from GP practices</p> <p>If no known system in place, then:</p> <p>2. Contact CSU primary care IT team to ask if an extract system is in place</p> <p>If no known system in place, then:</p> <p>3. Contact CCGs to ask if an extract system is in place</p> <p>Then proceed with one of the below options:</p>	
Option one. No system in place	Option two. System in place
<p>If no funding available:</p> <ul style="list-style-type: none"> contact system suppliers listed in appendix D to gain understanding of potential costs of this system contact CCGs to see if costs could be shared put together business case for local authority funding application <p>If funding available:</p> <ul style="list-style-type: none"> undertake appropriate local stakeholder engagement for example with LMC start procurement process to contract supplier. This may require a full tender process, depending on total value 	<p>Check what the system includes:</p> <ul style="list-style-type: none"> does it collect clinically coded data? what is the method by which data is extracted? what is the frequency of reporting? how are reports received? who commissions the system? can the system be extended to include NHS Health Checks data? what would be the costs of extension? does the system have sufficient assurance for information governance? <p>It may be after asking these questions that a separate system needs to be commissioned – see option 1 for possible process.</p>

Appendix M: eligible cohort selection criteria

The eligible population for an NHS Health Check is defined in the Local Authorities (Public Health Functions and Entry to Premises by Local Healthwatch Representatives) Regulations 2013. The eligibility criteria are that the invitee must:

- be aged from 40 to 74 years
- must not have received a NHS Health Check within the previous five years
- must not have been diagnosed with:
 - coronary heart disease
 - chronic kidney disease (CKD), being CKD which has been classified as stage 3, 4 or 5 CKD within the meaning of the National Institute for Health and Clinical Excellence clinical guideline 73 on Chronic Kidney Disease, published September 2008
 - diabetes
 - hypertension
 - atrial fibrillation
 - transient ischaemic attack
 - hypercholesterolaemia
 - heart failure
 - peripheral arterial disease
 - stroke
- must not be being prescribed statins for the purpose of lowering cholesterol
- must not have been assessed through a check undertaken by the NHS as having a 20% or higher risk of having a cardiovascular event during the ten years following the check

The selection of eligible individuals is only currently possible directly or indirectly from GP systems as this is the only place where the data items to enable selection (age, past medical history and current treatments) are held.