

**Public Health Service Specification for  
NHS Health Check Programme in  
General Practice**

**1<sup>st</sup> April 2025 – 31<sup>st</sup> March 2029**

## 1. National Context

- 1.1 The NHS Health Check is a prevention programme which aims to reduce the chance of a heart attack, stroke or developing some forms of dementia in people aged 40-74. It achieves this by assessing the top seven risk factors driving the burden of noncommunicable disease in England, and by providing individuals with behavioural support and, where appropriate, pharmacological treatment.
- 1.2 Cardiovascular disease is a general term for conditions affecting the heart and blood vessels. Mortality rates from cardiovascular disease (CVD) have been declining since 1961 but the rate of decline has slowed since 2010. Ischaemic Heart Disease (IHD) or coronary heart disease (CHD) is the most common cause of premature death (under 75 years) in the UK and was the leading cause of death worldwide in 2019. It can be largely prevented by modifying behavioural and physiological risk factors.
- 1.3 In England, one in six people will have a stroke in their lifetime. It is estimated that around 30% of people who have a stroke will go on to experience another stroke. Stroke is one of the biggest killers in the UK, causing around 35,000 deaths each year, it is also the single biggest cause of severe disability in the UK.
- 1.4 Behavioural risk factors that pose a risk to health include, but are not limited to smoking, poor diet, harmful alcohol use, drug misuse, and physical inactivity. They are some of the most important causes of early death and disability in England. Behavioural risk factors do not occur in isolation and are interlinked with other wider determinates of health such as social, economic and environmental factors. Together they contribute to some of the widest health inequalities in England and are not a product of individual choice alone. In B&NES the top four risk factors contributing to the percentage of deaths in males and females are tobacco use, dietary risk, alcohol misuse and low physical activity. All these risk factors form part of an NHS Health Check.

1.5 The government green paper 'Advancing our Health: Prevention in the 2020s' recognised that the NHS Health Check has achieved much in the past decade but has the potential to do more to support the government's commitment to ensure people enjoy healthy lives. The NHS Long Term Plan aims to prevent up to 150,000 heart attacks, strokes, and cases of dementia over the next 10 years and the NHS Health Check programme is key to helping deliver these milestones.

## 2. Policy context

2.1 In April 2013 the NHS Health Check became a statutory public health service in England. Local authorities are responsible for making provision to offer an NHS Health Check to eligible individuals aged 40-74 years once every five years as set out in regulations 4 and 5 of the Local Authorities (Public Health Functions and Entry to Premises by Local Health Watch Representatives) Regulations 2013, S.I. 2013/351.

2.2 Local authorities have a legal duty to make arrangements:

- for each eligible person aged 40-74 to be offered a NHS Health Check once in every five years and for each person to be recalled every five years if they remain eligible
- for the risk assessment to include specific tests and measurements
- to ensure the person having their health check is told their cardiovascular risk score, and other results are communicated to them
- for specific information (such as BMI, blood pressure etc.) and data to be recorded and, where the risk assessment is conducted outside the person's GP practice, for that information to be forwarded to the person's GP
- continuously improve the percentage of eligible people having an NHS Health Check

2.3 The NHS Health Check programme supports the delivery of the following national ambitions regarding prevention and public health, reducing inequalities, reducing variation in outcome performance and the promotion of self-care:

- Major Conditions Strategy; Case for change and strategic framework (2023)<sup>1</sup>
- The NHS Long Term Plan<sup>2</sup> (2019)
- National Diabetes Prevention Programme<sup>3</sup>

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<sup>1</sup> <https://www.gov.uk/government/publications/major-conditions-strategy-case-for-change-and-our-strategic-framework/major-conditions-strategy-case-for-change-and-our-strategic-framework--2>

<sup>2</sup> <https://www.longtermplan.nhs.uk/>

<sup>3</sup> <https://www.england.nhs.uk/diabetes/diabetes-prevention/>

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- NHS Right Care programme<sup>4</sup>

2.4 The programme also contributes to achieving the aims of the following local strategies:

- BSW ICB Inequalities Strategy (2021 – 2024)<sup>5</sup>
- B&NES Joint Health and Wellbeing Strategy (2023 - 2028)
- BE Well B&NES Health Improvement Framework (2024 -2034)
- Smoke Free B&NES Tobacco Control Strategy (2019 - 2024)
- B&NES Drug and Alcohol Strategy (2021 – 2024)

## 3. Local Context

3.1 Circulatory diseases were responsible for 24% of all male deaths registered in B&NES, and 12% of female deaths in 2021. <sup>6</sup>

3.2 As a whole, the B&NES population has a lower number of diagnoses of CHD and a lower number of hospital admissions due to CHD than England, there are however smaller geographies within B&NES where the numbers are higher than for England overall. These include Keynsham South, Oldfield Park and Weston.

3.3 In 2020-21 there were 3,896 people that were registered with having had a stroke on the GP register within Primary Care Networks (PCNs) in B&NES. Whilst, as a whole, the B&NES population has a lower prevalence of stroke and a lower number of hospital admissions due to stroke than for England in total, there are smaller geographies within B&NES where numbers are higher. These include Weston, Twerton, Keynsham North and High Littleton.

3.4 The total population of Bath and North East Somerset is approximately 196,357<sup>7</sup> and of these approximately 75,502 are in the 40 – 74 age group. The estimated population for NHS Health Checks, excluding those who are ineligible in B&NES, is approximately 50,891. Those eligible are currently offered an NHS Health Check once every 5 years, so around 10,200 people will be eligible and invited for their check every year. However, as B&NES has a relatively healthy population, with less people living with long term conditions on disease registers, our eligible population is slightly higher than national estimates and results in approximately 12,000 people being invited every year.

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<sup>4</sup> <https://www.england.nhs.uk/rightcare/>

<sup>5</sup> <https://bsw.icb.nhs.uk/document/bsw-inequalities-strategy-2021-24/>

<sup>6</sup> [https://www.bathnes.gov.uk/sites/default/files/Strategic%20Evidence%20Base%20-%20Main%20Document%202024%20July%202024\\_1.pdf](https://www.bathnes.gov.uk/sites/default/files/Strategic%20Evidence%20Base%20-%20Main%20Document%202024%20July%202024_1.pdf)

<sup>7</sup> <https://beta.bathnes.gov.uk/strategic-evidence/document-library/population>

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3.5 The local estimated impact for each of the first five years of the programme in B&NES at 55% take-up was:

- 342 additional people will complete weight loss programme
- 198 additional people will be taking statins
- 88 additional people will be compliant with an Impaired Glucose Regulation lifestyle
- 48 additional people will be diagnosed with diabetes
- 147 additional people will be taking anti-hypertensive drugs
- 122 additional people will be diagnosed with chronic kidney disease
- 88 additional people will increase physical activity
- 6 additional people will quit smoking

3.6 B&NES NHS Health Check Programme has consistently performed well against regional and national benchmarks<sup>8</sup>. The majority of GP practices in B&NES are actively inviting their eligible population and completing NHS Health Checks. During 23/24 in B&NES 17,199 people were offered an NHS Health Check, of which 6,489 received an NHS Health Check in general practice. This represents a take up of 38%.

## 4. Evidence

4.1 A large study published in 2016 led by Queen Mary University<sup>9</sup> found the NHS Health Check is effectively identifying and supporting people at risk of developing cardiovascular disease. In addition, a conservative estimate based solely on medical treatment received by those at highest risk suggests that over the first five years of the programme, at least 2,500 people would have avoided a heart attack or stroke. People having the NHS Health Check were much more likely to have their major risk factors recorded than those receiving routine care. Referral rates to lifestyle services were twice as high for smokers, three-to-four times as high for people with obesity and six times higher for people with hazardous drinking than for those not receiving the health check. In addition, the programme also successfully identified:

- A new case of hypertension in every 27 appointments
- A new case of diabetes in every 110 appointments
- A new case of chronic kidney disease in every 265 appointments

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<sup>8</sup> <https://fingertips.phe.org.uk/profile/nhs-health-check-detailed>

<sup>9</sup> Robson J et al. 2016 The NHS Health Check in England: An evaluation of the first 4 years. BMJ Open 2016 Vol 6 Issue 1 <http://bmjopen.bmj.com/content/6/1/e008840.full>

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- One person in eight found to have a 10-year risk of a major cardiovascular incident above 20%.

4.2 National estimates of the impact of the programme predict the following reduction in morbidity and mortality annually:

- 1,600 heart attacks and strokes prevented,
- 650 premature deaths prevented,
- 4000 new cases of diabetes prevented, and
- 20,000 cases of chronic kidney disease and diabetes detected earlier

4.3 A 10 year review of the programme in 2021 stated that 'even just a few years after an NHS Health Check, attendees tend to show better health outcomes, including lower levels of hospital admissions and death from heart attacks and strokes'<sup>10</sup>. Economic modelling suggests that, compared to no provision, and from a societal perspective, every £1 spent on the current NHS Health Check programme achieves a return of £2.93. It is also likely to reduce absolute health inequality by 2040.

The 10 year review also found that:

- People attending an NHS Health Check have high levels of modifiable risk factors that vary with ethnicity, gender and age.
- The most deprived are more likely to have multiple risk factors than the most affluent.
- Providers most commonly prioritise invitations to an NHS Health Check by age. As age has the greatest weighting within the 10-year CVD risk calculation this approach serves as a simple proxy for identifying the people who are likely to have the greatest clinical risk. However, this approach fails to recognise other important definitions of need such as deprivation, ethnicity and geography, which highlights an opportunity to consider how these factors might be used to improve prioritisation.

4.4 Following the review the government committed to strengthening and improving the programme based on 6 recommendations, which focus on ensuring the NHS Health Check it is more proactive, predictive and personalised. This included a commitment to developing a national digital NHS Health Check.

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<sup>10</sup> <https://www.gov.uk/government/publications/nhs-health-check-programme-review/preventing-illness-and-improving-health-for-all-a-review-of-the-nhs-health-check-programme-and-recommendations>

## 5. A digital NHS Health Check offer

5.1 The government has committed to developing a digital NHS Health Check (currently in test, with a target for full roll out by 2028) to support local authority delivery of the programme. A digital approach aims to increase accessibility, engagement and convenience and enable people to do the check at a time convenient to them and choose from a range of providers to undertake the physical measurements that are part of the check. As a result the local delivery model for the programme will need to adapt to incorporate this change in due course. It is likely that a digital offer will provide the universal element of the programme and that face-to-face health checks can then be targeted at higher risk individuals and those who experience barriers to engagement via digital and self -service models.

5.2 In preparation for this development we are proposing a modified approach to inviting the eligible population from April 2025. We are asking providers to prioritise invitations to the eligible population who also have additional risk factors for cardiovascular disease. (see section 7.1 below).

5.3 Public Health England (PHE), now the Office for Health Improvement and Disparities (OHID), encourages all local authorities to adopt a proportionate universalism (PU) approach to delivery of the NHS Health Check programme. The application of PU in many areas has ensured that the resourcing and delivery of a universal NHS Health Check programme is done at a scale and intensity proportionate to the degree of need.

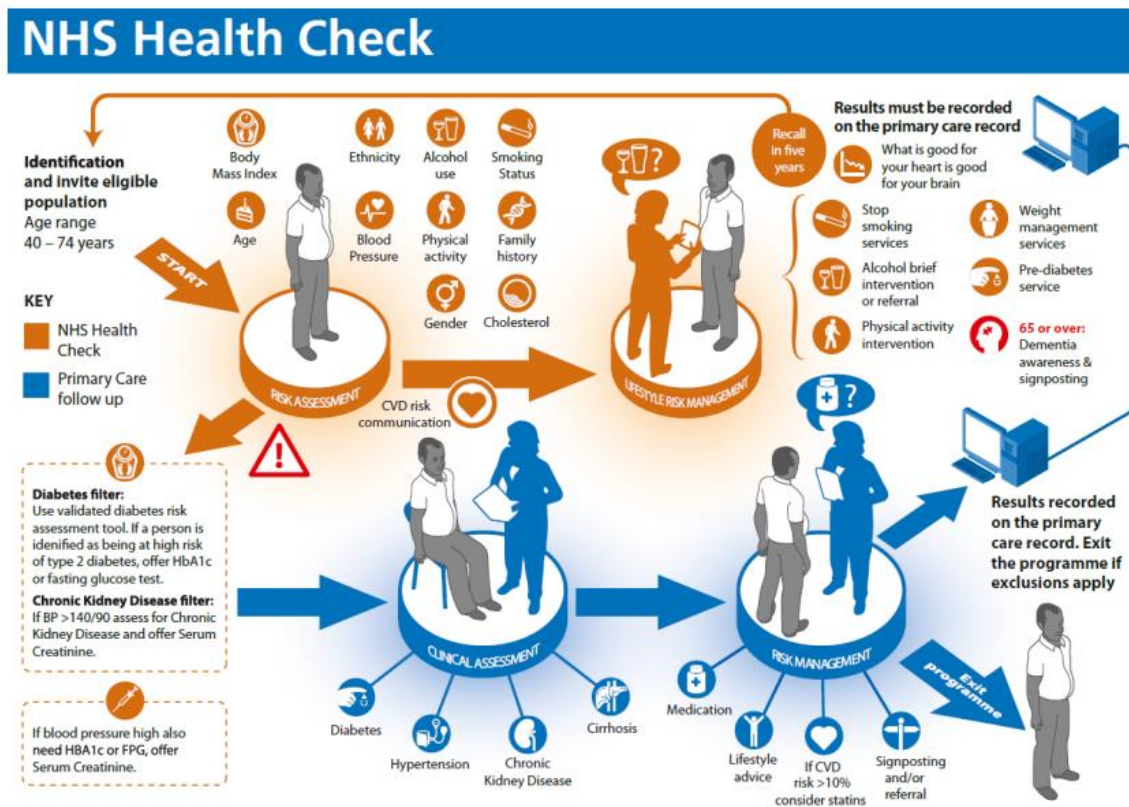
## 6. Service Model

6.1 The NHS Health Check programme is a population wide, primary prevention programme using a systematic approach to identify asymptomatic people aged between 40 – 74 years of age who are then offered a range of tests of risk factors in order to estimate their risk of cardiovascular disease (CVD) and deliver interventions to prevent disease occurring.

6.2 Face to face consultations include measurements of blood pressure, cholesterol, body mass index (BMI) and where necessary diabetes and kidney disease. Information is recorded on family history of CHD, ethnicity, smoking, alcohol consumption and physical activity. The results of these investigations are used to estimate CVD risk over the next 10 years. All individuals are offered behavioural risk advice and those identified as high risk of CVD will be offered specific interventions to reduce or manage this risk. A risk assessment for dementia awareness is also included for everyone aged 65 – 74 years. The risk factors for developing vascular dementia (which accounts for 20 – 30% of all dementias) are the same as those for CVD.



6.3 The NHS Health Check Programme Pathway is outlined below:



For an accessible version of this information, please visit <https://www.gov.uk/government/publications/nhs-health-check-programme-review/preventing-illness-and-improving-health-for-all-a-review-of-the-nhs-health-check-programme-and-recommendations#appendix-nhs-health-check-pathway>

### 6.3.1 Cardiovascular risk assessment

The NHS Health Check is made up of three key components: risk assessment, risk awareness and risk management. During the risk assessment standardised tests are used to measure key risk factors and establish the individual's risk of developing cardiovascular disease. The outcome of the assessment is then used to raise awareness of cardiovascular risk factors, as well as inform a discussion on, and agreement of, the lifestyle and medical approaches best suited to managing the individual's health risk.

Local authorities have a legal duty to ensure that the specific tests and measures listed below are completed during the risk assessment and that the results are recorded. Where the risk assessment is conducted outside the individual's GP practice, there is also a legal duty for the following information to be forwarded to the individuals GP:

- age
- gender
- smoking status
- family history of coronary heart disease
- ethnicity
- body mass index (BMI)
- cholesterol level
- blood pressure
- physical activity level
- alcohol use disorders identification test (AUDIT) score

### 6.3.2 Cardiovascular risk score

The NHS Health Check must include a face-to-face assessment, including: CVD risk calculation and risk-factor review; and advice (approximately 20 mins). Providers will undertake the vascular risk assessment using the QRISK3 CVD risk assessment tool. The assessment will include a cholesterol blood test, using point of care testing where possible. Ideally this will be completed in a single appointment using a 'one stop shop' approach.

#### QRisk 3

Estimated 10-year risk of developing CVD should be calculated using QRISK®3.<sup>11</sup>

In 2019, ClinRisk replaced the 10-year CVD risk factor calculator QRISK® 2 with QRISK® 3 which uses a further eight fields of data. The inclusion of additional clinical variables in QRISK® 3 (chronic kidney disease (scope of CKD widened to include stage 3), a measure of systolic blood pressure variability (standard deviation of repeated measures), migraine, corticosteroids, Systemic lupus erythematosus (SLE), atypical antipsychotics, severe mental illness, and erectile dysfunction) can help enable clinicians to more accurately identify those at most risk of heart disease and stroke. Given this transition from QRISK2 to QRISK3 agreement was gained between Medicines and Healthcare Products Regulatory Agency (MHRA), PHE and ClinRisk on how QRISK®3 could be used within the NHS Health Check Programme. This agreement was taken to the NHS Health Check Expert Scientific and Clinical Advisory Panel (ESCAP), who considered and made and will continue to keep under review the following recommendations for practice.

In general practice (using one of the GP clinical systems TPP SystemOne, EMIS Web, InPS Vision and Microtest Evolution) If a person has any of the newly included variables recorded in the clinical system medical records this information should automatically be pulled through into the QRISK® 3 calculator. This means that there

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<sup>11</sup> <https://www.nice.org.uk/guidance/cg181/chapter/Recommendations#identifying-and-assessing-cardiovascular-disease-risk-for-people-without-established-cardiovascular>



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does not need to be extra questions about the new variables added to the NHS Health Check. The resulting QRISK® 3 score can be acted upon according to the result. If a person does have any of the new variables coded, their QRISK® 3 will be higher, this is a knowledge and training issue for the communication of risk.

Outside of general practice or GP clinical system third party software\*

Wherever the check is delivered outside of general practice or where a third-party supplier is being used in a GP practice, QRISK® 3 may, for the time being, be used with the QRISK® 2 fields only. A score calculated in this way is considered a 'limited QRISK® 3 score'. When the results are sent back to general practice/ general practice clinical system, the person may benefit from having a full QRISK® 3 score calculated. This would be outside of the NHS Health Check.

**6.3.3 Point of Care Testing**

For the purpose of the NHS Health Check programme a random cholesterol test is adequate. Providers are recommended to use cholesterol point of care testing to ensure patients are able to receive their full health check results during the appointment.

**6.3.4 Communication of results**

Everyone who undergoes an NHS Health Check must have their cardiovascular risk score communicated to them. The person having their check should also be told their BMI, cholesterol level, blood pressure and AUDIT score.

In addition to recording this information on provider databases this information should also be recorded in paper form and given to the patient to take away with them.

**6.3.5 Behaviour change support and referral to wellbeing services**

The NHS Health Check is a preventative programme which is intended to help people live longer healthy lives. To maximise these benefits, everyone who has an NHS Health Check, regardless of their risk score, should be given clinically appropriate risk factor advice, to help them manage and reduce their risk. Everyone having the check should be provided with individually tailored advice that will help motivate them and support the necessary changes to help them manage their risk. This approach echoes the competencies set out in Making Every Contact Count (MECC). MECC enables the opportunistic delivery of consistent and concise healthy conversations with individuals at scale.

The assumption is that delivering health messages should encourage people to cease or adopt certain behaviours, which in turn is likely to result in health improvement. In the context of cardiovascular disease prevention, behaviour change services are often linked to modifiable cardiovascular disease risk factors that can be

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managed by changes to an individual's daily life. Individual-level behaviour change interventions can be delivered through different methods, including:

- brief advice
- brief interventions
- motivational interviewing

NICE PH49 guidance on individual behaviour change recommends that practitioners deliver very brief advice, brief advice, or an extended brief intervention to support individual behaviour change. The intensity of support should be based on individual need. Different tools such as health coaching, motivational interviewing, cognitive behavioural therapy etc, can all be used to underpin this approach and are not mutually exclusive.<sup>12</sup>

### Capability, opportunity and motivation

For any change in behaviour to occur, a person must:

- Be physically and psychologically capable of performing the necessary actions.
- Have the physical and social opportunity. People may face barriers to change because of their income, ethnicity, social position or other factors.
- Be more motivated to adopt the new, rather than the old behaviour, whenever necessary.

Risk management support and behaviour change support should be offered at the point of delivery of the NHS Health Check. If a person would benefit from additional support with behaviour change then referral to appropriate support services should be offered. In B&NES this would be via referral to the Wellness Service or other support programmes such as the NHS Diabetes Prevention Programme (NDPP) or NHS Digital Weight Management Programme for example.

### **6.3.6 Referrals into NHS Diabetes Prevention Programme (NDPP) via the NHS Health Check programme**

All patients who trigger the diabetes filter criteria as part of their NHS Health Check should be offered an HBA1c or Fasting Blood Glucose test. In line with the NHS Health Check Best Practice Guidance (October 2019 updated March 2020) patients trigger a blood test when the identified thresholds are reached. Following recording of blood test results on the GP system, patients who meet the criteria for NDPP will be offered access to the NDPP programme, in line with locally agreed referral protocols.

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<sup>12</sup> <https://www.nice.org.uk/guidance/ph49>

### **6.3.7 Further tests and clinical management**

The NHS Health Check programme will identify individuals who have undiagnosed conditions such as hypertension or chronic kidney disease and people who are at high risk of developing cardiovascular disease or diabetes. These individuals will require additional clinical assessment and follow up and this is the responsibility of primary care.

Additional testing and clinical follow up, where someone is identified as being at high risk of having or developing vascular disease, is the responsibility of primary care and is funded through NHS England. As such this element of the service model is not part of this service specification.

## 7. Identification and Invitation of the eligible population

For each eligible individual aged 40-74 to be offered an NHS Health Check once in every five years and for each individual to be recalled every five years if they remain eligible.

GP practices are expected to ensure a robust invitation and recall system and a practice register search to identify all eligible patients.

### **7.1 Risk Stratification approach (new from 1<sup>st</sup> April 2025)**

Providers are encouraged to proactively seek to increase uptake of NHS Health Checks amongst groups at greater risk of CVD. To support providers with this, specific searches and instructions for use will be provided by B&NES Enhanced Medical Services (BEMS+) to identify the eligible population who also have one or more of the following risk factors for cardiovascular disease and likely to experience the poorest health outcomes.

1. Live in an area of socioeconomic deprivation (core 20%)<sup>13</sup>
2. From a minority ethnic group
3. Current diagnosis of rheumatoid arthritis
4. BMI  $\geq 30$  (adjusted for ethnicity)
5. Current diagnosis of severe mental illness
6. Current smoker

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<sup>13</sup> <https://www.england.nhs.uk/about/equality/equality-hub/national-healthcare-inequalities-improvement-programme/core20plus5/>

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Providers are encouraged to proactively invite the above population as a priority using a range of methods as referenced in 5.4 below. Following this, providers can then invite the wider eligible population without the above risk factors, with an agreed ceiling on activity aligned with programme budget (to be agreed).

This risk stratification process will be reviewed annually to evaluate its effectiveness and impact on practice-based activity, payments and outcomes.

## 7.2 Inclusion and exclusion criteria

### Inclusion Criteria

- Aged 40 to 74.
- With no known existing cardiovascular disease.
- Who have not received an NHS Health Check within the last 5 years.

### Exclusions

- Anyone outside of the 40-74 years age banding
- Anyone who has had an NHS health Check within the last 5 years
- The regulations state that people aged 40 – 74 years who have any of the following conditions are not eligible for a check, on the basis that they already have a diagnosis and will be known to health services:
  - coronary heart disease
  - chronic kidney disease (CKD), which has been classified as stage 3, 4 or 5 within the meaning of the National Institute for Health and Care Excellence (NICE) clinical guideline 182 on CKD
  - diabetes
  - hypertension
  - atrial fibrillation
  - transient ischaemic attack
  - hypercholesterolemia – defined as familial hypercholesterolemia
  - heart failure
  - peripheral arterial disease
  - stroke
  - is currently being prescribed statins for the purpose of lowering cholesterol
  - people who have previously had an NHS Health Check, or any other check undertaken through the health service in England, and found to have a 20% or higher risk of developing cardiovascular disease over the next ten years

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Where someone has a CVD risk of 10-19%, they would not be excluded from recall. This is unless they meet one of the other exclusion criteria, for example, if the individual is being prescribed a statin.

The provider may choose not to invite people for whom an NHS Health Check would not benefit their quality of life (e.g. patients on an end-of-life pathway).

## 8. Additional information: Eligibility, invitation method

### 8.1 Eligibility

Within each year of delivery (April – March) the provider will need to invite people whose 40<sup>th</sup>, 45<sup>th</sup>, 50<sup>th</sup>, 55<sup>th</sup>, 60<sup>th</sup>, 65<sup>th</sup>, and 70<sup>th</sup> birthday fall within the time period. These age ranges will be invited every year so that after 5 years the entire eligible population will have been invited for an NHS Health Check.

### 8.2 Invitation method

A variety of methods should be used to invite people for a Health Check. Written NHS Health Check information should be provided to all or links to this information <https://www.nhs.uk/conditions/nhs-health-check/> outlining the risks and benefits of the programme.

The initial invitation can be a letter plus the national patient leaflet, an email, phone call or a SMS. Patients who do not respond to the first invitation must be contacted again twice using different methods.

The NHS Health Check national team in OHID have produced guidance and advice<sup>14</sup> on how to increase uptake of NHS Health Checks including advice on wording of letters, the use of clinical prompts, text message primers and reminders and behaviourally informed messaging.

If a patient indicates they do not wish to be contacted after the initial invitation the provider may exclude them from further invitation for that year, however they must be re-invited again in 5 years' time.

## 9. Interdependencies and other services

The Provider will establish and maintain efficient working relationships with allied services, agencies and stakeholders to ensure equitable access to the programme and quality of care and onward support is enhanced.

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<sup>14</sup> <https://www.healthcheck.nhs.uk/commissioners-and-providers/national-guidance/>

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Providers will be expected to work closely with B&NES Wellness services and to build relationships with specialist support services to ensure a clear pathway of support for individuals in terms of behaviour change support and risk management.

A small outreach NHS Health Checks service is integrated into the B&NES Wellness Service specification to specifically allow resources to be targeted into workplaces and communities where take up is low. The provider is expected to work collaboratively with the Wellness service and where possible look at ways of working together to supplement the universal services offered in GP practices.

The provider will have clear policies and pathways in place to support referral and signposting to and from other local services. These services will include community pharmacy, wellness services, drug and alcohol services, mental health services, learning disability services and the community wellbeing hub.

Providers will be expected to develop data sharing agreements to enable the capture of outcomes in relation to referral to services and active management of risk factors.

### **9.1 Behavioural support and specialist services**

The provision of specific behaviour change and wellbeing support services is subject to a separate service specification for B&NES Wellness service. Equally the provision of specialist services such as Drug and Alcohol Treatment Services are subject to separate service specifications and as such are not part of this specification. Providers will be expected to work closely with wellness support services in particular, and to build relationships with other specialist support services to ensure a clear pathway of support for individuals in terms of behaviour change support and risk management.

The service will work with the range of commissioners across adult health promotion and cardiovascular disease prevention including the local authority, ICB and NHS England.

## 10. Applicable Service Standards

### **10.1 National standards**

Providers are expected to follow the national vascular risk assessment and management programme guidance when undertaking a NHS Health Check.

National Best Practice Guidance October 2019 (updated 2020) is available here:

<https://www.healthcheck.nhs.uk/commissioners-and-providers/national-guidance/>

### **10.2 Quality Assurance**

Providers will need to demonstrate that all elements of the NHS Health Check programme are being delivered to a high quality and systematically recorded to



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ensure consistency, safety and quality of patient experience and tracking of patient outcomes.

All service providers will be expected to deliver the NHS Health Checks in keeping with the core structure and standards set out in the national guidance and comply with local clinical guidance and data transfer standards.

See NHS Health Checks: Programme Standards: A framework for quality improvement (July 2020) <https://www.healthcheck.nhs.uk/commissioners-and-providers/national-guidance/>

### 10.3 Professional competency

The provider must be able to demonstrate that all staff delivering the NHS Health Checks programme are competent in the following areas:

- Knowledge of the national and local NHS Health Checks programme
- Measuring blood pressure
- Vascular disease risk assessment including the use of risk assessment tool (QRISK3)
- Risk communication
- The use of point of care testing
- Provision of behaviour change support and onward referral
- Appropriate referral for clinical assessment and management.

Staff carrying out the NHS Health Check need to be able to demonstrate competency in line with the NHS Health Checks Competency Framework (July 2020).

[http://www.healthcheck.nhs.uk/commissioners\\_and\\_providers/guidance/national\\_guidance1/](http://www.healthcheck.nhs.uk/commissioners_and_providers/guidance/national_guidance1/)

If required, provider staff carrying out NHS Health Checks should be able to demonstrate their professional eligibility, competence and continuing professional development to the commissioner by producing relevant documentation.

### 10.4 Equipment and Point of Care Testing

Providers must ensure all equipment used for the NHS Health Check is fully functional, used regularly, CE marked, validated, maintained and is recalibrated according to manufacturer's instructions. This includes height and weight measuring devices, blood pressure monitors and point of care testing equipment.

B&NES Council, through a separate contract, will provide Point of Care Testing equipment for providers and access to support with usage, maintenance and calibration. Providers will be responsible for the purchase of all consumables. An appropriate internal quality control (IQC) process should be in place in accordance with the MHRA guidelines on POCT.

Point of care testing should only be used by staff who have been trained (by a competent trainer) to use the equipment. They should have an understanding of analytical principles, interpretation of test results, limitations of use and quality assurance. Point of care testing must be carried out in line with NHS Health Check programme standards (July 2020) <https://www.healthcheck.nhs.uk/commissioners-and-providers/national-guidance/>

Clear lines of responsibility should be agreed and documented for clinical governance, health and safety, infection control, maintenance of equipment, quality records and audit. This should be evident in provider documented standard operating procedures, which provide detailed information on how to operate a device to give accurate results.

### **10.5 External quality assurance for Point of Care Testing**

The National Programme Standards for Quality Assurance for the NHS Health Check programme requires that commissioned providers of the B&NES NHS Health Check Programme, including GP surgeries, pharmacies and outreach providers should be registered in and participating in an appropriate EQA programme through an accredited (CPA or ISO 17043) provider.

B&NES Council will commission a EQA provider and expects all providers to register and engage with the requirements of the quality assurance programme.

Poor performance will be reported to the National Quality Assessment Advisory Panel (NQAAP) for Chemical Pathology following consultation with the B&NES Council commissioner.

### **10.6 Data transfer**

Where the risk assessment is conducted outside the person's GP practice, there is a legal duty for the above information to be forwarded to the person's GP. Data must be transferred in a timely and secure method to the patient's GP practice (legal requirement in the 2013 regulations)

<http://www.legislation.gov.uk/ukxi/2013/351/regulation/5/made>

Clients deemed high risk must be asked to make an appointment with their GP surgery and a referral letter/electronic data transfer should also be sent to the GP surgery with the client's test results.

A timely referral back to the GP practice should be made in line with Information Governance and Data Protection Act guidelines, to ensure appropriate follow up is undertaken (see standard 10 of Programme Standards (July 2020) and PHE NHS Health Checks IG and Data Flows pack.

<https://www.healthcheck.nhs.uk/commissioners-and-providers/national-guidance/>

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Data transferred to GP practice from outreach NHS Health checks carried out by the B&NES Wellness Service for example, should be recorded on the patient record and the health check recorded as completed by a third party.

### 11. Local standards

Providers are expected to ensure delivery of the NHS Health Check programme complies with any local clinical guidance.

### 12. Activity Plan

It is currently a requirement that 100% of the eligible population will be invited for a NHS Health Check over each 5 year period i.e. 20% of eligible population invited per annum, and that those still eligible are recalled for their NHS Health Check every 5 years.

### 13. Location of provider premises

The provider will ensure that access to NHS Health Checks is available at varied times and days of the week to increase patient choice and ability to attend. Providers should consider offering weekend and evening appointments to increase accessibility. The NHS Health Check should take place face to face in the provider premises or at a local suitable community location.

### 14. Data Collection, Monitoring and Performance Measurement

#### 14.1 Data and monitoring requirements

To support data transparency and to enable public access to data, local authorities are required to report information on basic programme activity. From April 1<sup>st</sup> 2013 Public Health England has required local authorities to submit quarterly data on

- the number of eligible population people offered a NHS Health Check and
- the number of people who received a NHS Health Check.

Summary activity data is added to the Single Data List which is reported nationally on the Public Health Outcome Framework (PHOF) indicators.

This information is published on the DHSC Fingertips website:

<https://fingertips.phe.org.uk/>

For the number of NHS Health Checks offered, providers should count the first invitation or offer only, in the five-year period and the date that this was made would indicate the quarter in which it reported.

For the number of NHS Health Checks received the check is counted in the quarter that it happened. In order to avoid double counting you should only count for activity in the quarter being reported, and only once per person in the five-year period.

## Improving People's Lives

The commissioners will support provision of activity data from GP practices through direct data extraction via the ICB Data Team. This data will be supplied to the provider no later than 1 week after the end of the reporting period and providers are asked to check accuracy of data and submit revisions within 10 days of receipt. If no response data will be assumed to be accurate reflection of activity. Opportunities to review activity data will be provided at least one point during each 12 month period.

The data received by the council will be activity data only for monitoring and reporting purposes and will be completely anonymised.

Data is required to be reported by local authorities quarterly by the last day of the month following the completed quarter.

## 15. Payment Structure

### 15.1 Payment structure from April 2025

For a completed NHS Health Check and CVD risk communication to the patient;

- £21.50 without POCT for Cholesterol
- £25.00 with POCT for Cholesterol

#### **For patients with one or more CVD risk factor (as previously outlined above)**

For a completed NHS Health Check and CVD risk communication to the patient

- £24.50 without POCT for Cholesterol
- £28.00 with POCT for Cholesterol

In addition to above reporting requirements providers will be asked to report quarterly on the number of health checks completed where patients have one or more CVD risk factors. This information will be used to calculate associated payments.

Payment for activity will be made quarterly, within 30 days of receipt of claim.

Commissioners will initially review activity and payments quarterly in the 25/26 to evaluate the effectiveness of the risk stratification approach and impact on practice activity and payment. Overall activity will need to be monitored and capped where necessary to ensure the programme stays within its annual budget.