



Public Health  
England

Protecting and improving the nation's health

# **NHS Health Check** **Best practice guidance**

February 2015

# About Public Health England

Public Health England exists to protect and improve the nation's health and wellbeing, and reduce health inequalities. It does this through world-class science, knowledge and intelligence, advocacy, partnerships and the delivery of specialist public health services. PHE is an operationally autonomous executive agency of the Department of Health.

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# Chapter 1. Background

This section provides an overview of and background to the NHS Health Check programme.

## 1.0 Introduction

The delivery of the NHS Health Check programme was extremely successful in 2013-14. Not only was there a safe transition of responsibility from primary care trusts to local authorities but for the first time since its launch there was full coverage across England. The number of people being invited for, and taking up the offer of, an NHS Health Check also grew substantially. PHE recognises this as a great achievement and would like to thank local authority commissioners and providers for their support in delivering the programme.

The NHS Health Check programme aims to prevent heart disease, stroke, diabetes and kidney disease, and raise awareness of dementia both across the population and within high risk and vulnerable groups. In April 2013 the NHS Health Check became a mandated 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 \(Public Health Functions and Entry to Premises by Local Healthwatch Representatives\) Regulations 2013, S.I. 2013/351](#).

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.

The original Department of Health (DH) modelling showed the average annual cost of the programme as £332m each year at full roll out<sup>1</sup> and the benefit as £3.678bn with a cost per quality adjusted life year (QALY) of around £3000. This modelling also suggests that it is cost effective with potential savings to the NHS of around £57m per year after four years, rising to £176m per year after 15 years.

The modelling shows that the NHS Health Check could, on average, prevent 1,600 heart attacks and strokes and save at least 650 lives each year as well as prevent over 4,000 people a year from developing diabetes and detect at least 20,000 cases of diabetes or

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<sup>1</sup> Defined as 75% of the total five year eligible population receiving an NHS Health Check once every five years

kidney disease earlier, allowing individuals to be better managed and improve their quality of life.

Achieving these health outcomes is dependent on close working between local authorities and their partners across the health care system, including primary care. This will help ensure any additional testing and clinical follow up is undertaken, for example, where someone is identified in the risk assessment as being at high risk of having or developing a vascular disease.

This update to the programme’s best practice guidance helps local commissioners and providers to understand the legal requirements underpinning the programme’s delivery. It identifies where there is scope for local flexibility and innovation in delivery. It also signposts to a wide range of tools and resources that will support the delivery of a high quality local NHS Health Check programme.

This guidance updates and replaces the previous NHS Health Check best practice guidance<sup>2</sup> published in October 2013. Key changes from the previous edition are listed in table 1.

Table 1. Key changes from the previous best practice guidance edition

<b>Change</b>	<b>Section</b>
A new programme pathway diagram to accompany the existing clinical flow chart	1.1
Clarification of local authority’s legal duty to deliver the programme	2.0-2.5
Clarification of NHS England’s legal duty to deliver the programme in prisons and detained settings	2.0
Removing the recommendation to use Framingham as a risk score calculator, in line with NICE guidance	3.1
Recommending that a pulse rhythm check is completed as part of the blood pressure check, in line with NICE guidance	3.1
New information on the use of point of care testing	3.3
Recommending that statins are considered for people with a cardiovascular disease risk greater than 10%, in line with NICE guidance	5.3
New information on communication and marketing	6.0-6.5
New information on training, learning and development	7.0-7.4 Annex C
New information on national programme governance	8.0-8.2
New information on information governance and data flow	Annex A

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<sup>2</sup> Putting Prevention First. NHS Health Check: Vascular Risk Assessment and Management. Best Practice Guidance. Department of Health. 3 April 2009. Gateway reference: 11473

## 1.1 The NHS Health Check programme

Reducing avoidable premature mortality is a government priority. Through early identification and management of risk factors and early detection of disease the NHS Health Check will help achieve the ambitions set out in 'A call to action to reduce premature mortality',<sup>3</sup> and the 'Cardiovascular disease outcome strategy.'<sup>4</sup>

Together diabetes, heart and kidney disease and stroke make up a third of the difference in life expectancy between the most deprived areas and the rest of the country. Additionally, the cost of social and health care from the rise in levels of obesity, type 2 diabetes and dementia makes the prevention and risk reduction of these conditions key drivers of the programme.

The NHS Health Check programme offers a fantastic opportunity to help people to live longer, healthier lives. It aims to improve health and wellbeing of adults aged 40-74 years through the promotion of earlier awareness, assessment, and management of the major risks factors and conditions driving premature death, disability and health inequalities in England.

The programme will achieve this by:

- promoting and improving the early identification and management of the individual behavioural and physiological risk factors for vascular disease and the other conditions associated with these risk factors
- supporting individuals to effectively manage and reduce behavioural risks and associated conditions through information, behavioural and evidence based clinical interventions
- helping to reduce inequalities in the distribution and burden of behavioural risks, related conditions and multiple morbidities
- promoting and supporting appropriate operational research and evaluation to optimise programme delivery and impact, nationally and locally

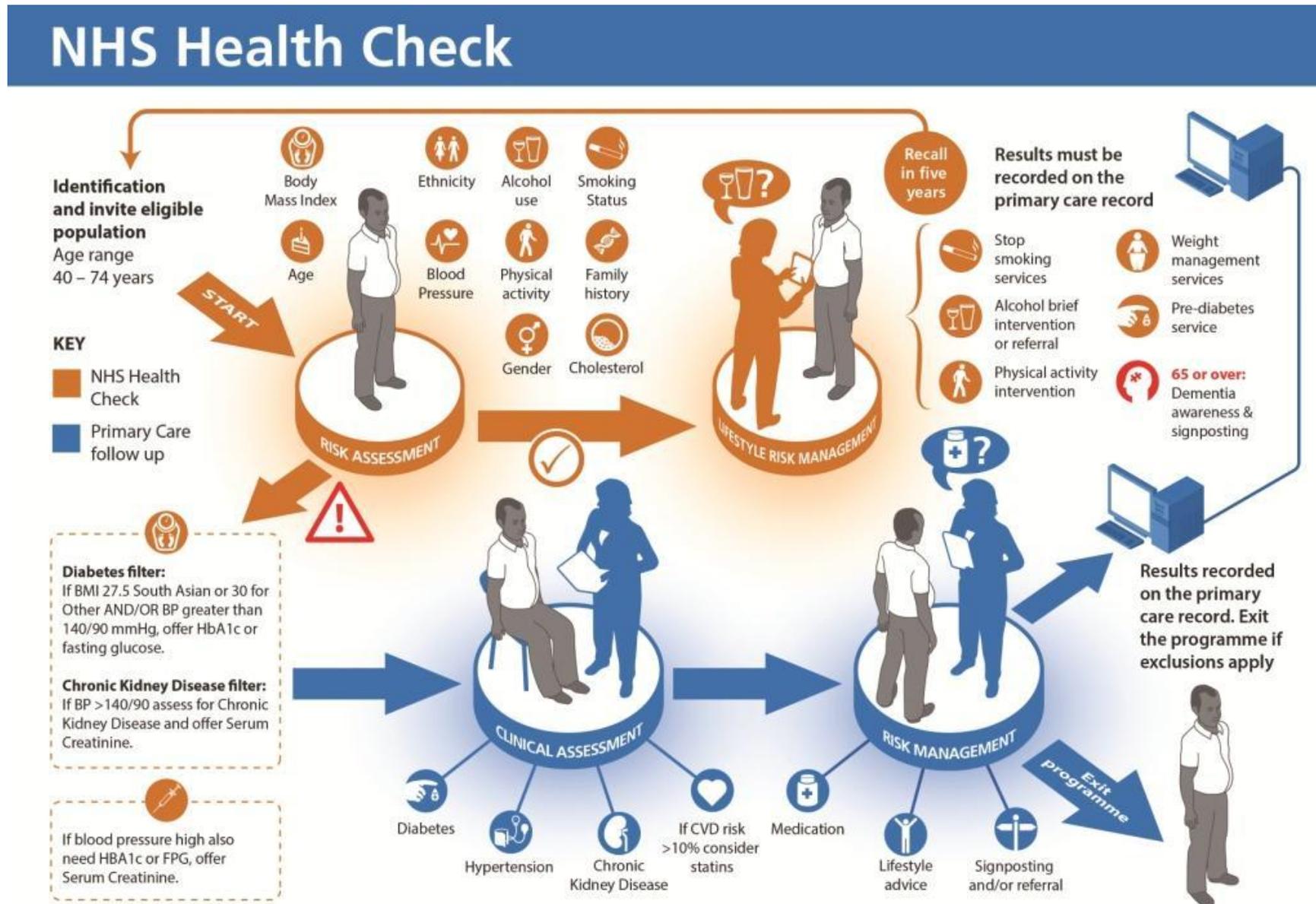
A diagrammatic overview of a NHS Health Check is provided in figure 1.

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<sup>3</sup> Living Well for Longer: a call to action to reduce premature mortality. Department of Health. 5 March 2013. Gateway reference: 18716

<sup>4</sup> Cardiovascular Disease Outcomes Strategy: Improving outcomes for people with or at risk of cardiovascular disease. Department of Health. 5 March. Gateway reference: 18747.

Figure 1. Overview of the vascular risk assessment and management programme



## 1.2 Funding and working across the health care system

On 1 April 2013 local authorities became responsible for the risk assessment and life style interventions for the programme, funded through the public health ring fenced budget. The risk assessment element of the check is a mandatory function which local authorities are required to commission or provide.

Additional testing and follow up, for example, where someone is identified as being at high risk of having or developing vascular disease, remains the responsibility of primary care and will be funded through NHS England. Local authorities will need to work closely with their partners across the health care system, including through health and wellbeing boards, to ensure these different elements of the programme link together.

As part of the financial accountability arrangements local authorities will have to provide DH with a revenue outturn form detailing public health expenditure. This will include reporting expenditure against set public health categories including the NHS Health Check programme, more guidance can be found [here](#).

## 1.3 Equality and the NHS Health Check programme

One of the programme's objectives is to contribute to narrowing health inequalities. Local authorities may tailor the delivery of the programme in a number of ways to achieve this. Although local authorities have a duty to offer the NHS Health Check to all eligible people, PHE is supportive of approaches that prioritise invitations to individuals with the greatest health risk. For example, by prioritising invitations to people with an estimated ten-year CVD risk score greater than 10% or those living in their most deprived areas.

The programme has also been designed so that the majority of the check, including the tests and measurements required for the risk assessment, can be delivered in different settings. This will help ensure the programme is accessible to a wide range of people. A broad selection of case studies that demonstrate how local authorities have targeted groups with the greatest health need can be found on the [NHS Health Check website](#).

In addition, local areas will wish to ensure that the NHS Health Check programme they offer is in keeping with the Equality Act 2010. A [quick start guide](#)<sup>5</sup> is available which is intended to help public sector organisations understand a key measure in the Equality Act, the public sector equality duty, which came into force on 5 April 2011. Local areas will be familiar with the purpose and provisions of the Act and understand, for example,

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<sup>5</sup> Public sector: quick start guide to the public sector Equality Duty. [www.gov.uk/government/publications/public-sector-quick-start-guide-to-the-public-sector-equality-duty](http://www.gov.uk/government/publications/public-sector-quick-start-guide-to-the-public-sector-equality-duty)

that reasonable adjustments need to be made for disabled people when providing services and exercising public functions.

This duty recognises that equality of opportunity for disabled people cannot be achieved simply by treating disabled and non-disabled people alike. This needs to be given active consideration locally in terms of both access to and delivery of the NHS Health Check. For example, the way that wheelchair users access their NHS Health Check, as well as how their risk assessment is undertaken and how they are supported to improve their lifestyles, will require local consideration and action.

## Chapter 2. Legal requirements for local authorities

This section sets out local authority's legal duties for delivering the NHS Health Check and returning data to PHE.

### 2.0 Summary of statutory requirements

The Local Authorities (Public Health Functions and Entry to Premises by Local Healthwatch Representatives) Regulations 2013 S.I. 2013/351 set out a number of mandatory public health functions for local authorities from 1 April 2013. These Regulations have been made by the Secretary of State for Health under powers conferred by the [National Health Service Act 2006](#)<sup>6</sup> and the [Local Government and Public Involvement in Health Act 2007](#).<sup>7</sup>

This document provides guidance on what local authorities need to do to comply with the regulations and where there is flexibility. Legal duties exist on offering NHS Health Checks (referred to as 'health checks' in the regulations), the content of the risk assessment, communication of results, data recording, transfer and take up rates. It is important that local authorities are satisfied that they are fulfilling their legal duties.

Legal duties exist for local authorities 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 NHS Health Check is told their cardiovascular risk score, and other results are communicated to them
- for specific information 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

Local authorities are also required to continuously improve the percentage of eligible individuals taking up their offer of an NHS Health Check. Further information on these provisions is provided in this document.

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<sup>6</sup> Sections 6C (1) to (3), 186A (4) (b) and 272(7) and (8) of the National Health Service Act 2006.

<sup>7</sup> Sections 225(1) to (3) and (7) (e), 229(2) and 240(10) of the Local Government and Public Involvement in Health Act 2007.

Local authorities are not responsible for offering eligible prisoners or people in detained settings an NHS Health Check. Section 7A of the National Health Service Act 2006, as amended by the Health and Social Care Act 2012, requires NHS England to provide public health services in prisons and detained settings, this includes offering all detainees aged between 40 and 74 an NHS Health Check. PHE recommends that the NHS and local government work closely together to ensure that those people released from custody are able to access services in the community.

## 2.1 Offering the NHS Health Check to those eligible

Local authorities have a legal duty to make arrangements for everyone eligible aged 40 to 74 to be offered an NHS Health Check once in every five years and for them to be recalled for another check every five years after that, while they remain eligible.

As the NHS Health Check is a public health programme aimed at preventing disease, people with previously diagnosed vascular disease or who meet the criteria set out below are excluded from the programme. These individuals should already be receiving appropriate management and monitoring through existing care pathways.

Exclusion criteria:

- 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 Chronic Kidney Disease
- diabetes
- hypertension
- atrial fibrillation
- transient ischaemic attack
- hypercholesterolemia
- heart failure
- peripheral arterial disease
- stroke
- prescribed statins
- 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

NOTE: Where someone has a CVD risk of 10-19%, they would not be excluded from recall unless they meet one of the other exclusion criteria, e.g., being prescribed a statin.

Local authorities may choose to extend the programme to cover a wider age range of people or to include additional tests to the risk assessment according to the needs of their local population but they will need to consider the cost and benefits of doing so. Additional people who do not form part of the eligible population as stipulated in the regulations should be excluded from the quarterly data returns.

## 2.2 The risk assessment

Everyone receiving an NHS Health Check will have a risk assessment which will look at individual risk factors as well as their risk of having, or developing, vascular disease in the next ten years.

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 person's GP practice, there is also a legal duty for the following information to be forwarded to the person's GP:

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

In addition, those aged 65-74 should be made aware of the signs and symptoms of dementia and sign posted to memory services if this is appropriate.

Local authorities can decide on the delivery setting for the risk assessment as long as the staff who carry them out are **appropriately trained and qualified**. For example, they may wish to use a combination of pharmacies and other community settings, as well as GP practices to help ensure the programme is as accessible to as many people as possible. The tests, measurements and risk calculations that make up the risk assessment part of the NHS Health Check are stipulated in legislation because of the importance of a uniform, quality offer.

## Communication of results

The use of a risk engine to calculate the individuals' risk of developing cardiovascular disease in the next ten years is required, and everyone who has 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.

### A note on safety and quality

Although local areas can determine where and who delivers the risk assessment, local authorities will wish to consider how the tests and measurements are standardised and quality assured.

This is not a legal requirement of the regulations but equally this is key to providing a high quality and safe service.

It is pivotal that the actions taken at certain thresholds are the same and in line with national guidelines, including those issued by NICE, so that people receive the necessary and appropriate care. Further information and guidance on providing a high quality and safe service can be found in the [NHS Health Check programme standards](#).

## 2.3 Continuous improvement in take up rates

Local authorities have a legal duty to seek continuous improvement in the percentage of eligible individuals taking up their offer of an NHS Health Check.

Ensuring a high percentage of those offered an NHS Health Check actually receive one is key to optimising the clinical and cost effectiveness of the programme. This is especially important for populations with the greatest health needs and will impact on the programme's and local area's ability to narrow health inequalities.

Local authorities have the flexibility to decide how best to approach this. Social marketing, use of local champions, convenient locations and opening times, or a combination of these, are some examples of approaches which have already been employed. You can find further information in the [marketing and branding section](#) of the NHS Health Check website.

It should be noted that although a take up rate of 100% is unlikely to be achieved, local areas are expected to maximise participation in the programme and secure continuous improvement. PHE aspires to achieve a national take up rate in the region of 75% of the eligible population receiving an NHS Health Check once every five years. The higher the take up rates for the programme, the greater its reach and impact.

It is up to local authorities to decide how to secure continuous improvement in this area bearing in mind that the take up rate for the NHS Health Check programme is an indicator in the public health outcomes framework (PHOF).<sup>8</sup>

## 2.4 Information governance and data flow

Data flow between parties involved in the NHS Health Check programme is subject to the Data Protection Act and information governance rules, more information is available on the [Information Commissioner's Office website](#). It is lawful and appropriate to move the data in the manner described for the NHS Health Check, so long as all stated processes are complied with. There should be no impediment to moving data safely between parties who require the data.

In all cases, the GP will remain as data controller, a legally defined role with significant responsibilities. Commissioners should continue to recognise this responsibility when negotiating with GP colleagues. Unless explicit consent has been gained from patients, only anonymised information may flow back to the local authority from the GP practice. The actual process and requirements of securing data is subject to change, readers are therefore directed to the NHS Health Check website to review the [Information Governance and Data Flows Pack](#). It is the responsibility of those storing or moving data to ensure that all systems required are in place and up to date.

The level of data required by the commissioner to properly assess the impact of the programme is set in the NHS Health Check minimum data set. The current template can be found on the [NHS Health Check national website](#); this information can also be found on the Health and Social Care Information Centre (HSCIC) [national website](#).

## 2.5 Reporting NHS Health Check data

The NHS Health Check is one of the components of the [single data list](#) (ref 254-00) which is a list of all the datasets that local government must submit to central government. As a result, local authorities have a legal duty to provide data relating to the number of NHS Health Checks offered and the number of NHS Health Checks received at the end of each quarter.

PHE manages this process and collates the data return each quarter via the [programme website](#). The portal opens a month before the deadline and the nominated person in

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<sup>8</sup> Public Health Outcomes Framework for England, 2013-2016. Department of Health. January 2012. Gateway reference: 16891. [www.gov.uk/government/publications/healthy-lives-healthy-people-improving-outcomes-and-supporting-transparency](http://www.gov.uk/government/publications/healthy-lives-healthy-people-improving-outcomes-and-supporting-transparency)

each local authority enters the number of NHS Health Checks offered and received in the previous quarter.

PHE requires that an individual nominated by the director of public health submits data on behalf of the local authority by the deadline otherwise a nil return will be published. Where there is a change to the nominated person returning the data the local authority must **contact PHE** well in advance of the deadline to request a change in nominee form.

The data returned to PHE is treated as an official statistic and is quality assured following submission. It is then published every three months according to the timetable set out on the **official statistics website and on the programme website**. Data is also published on **Fingertips**, **Healthier Lives** and as three indicators on the **PHOF** to allow national and local comparisons.

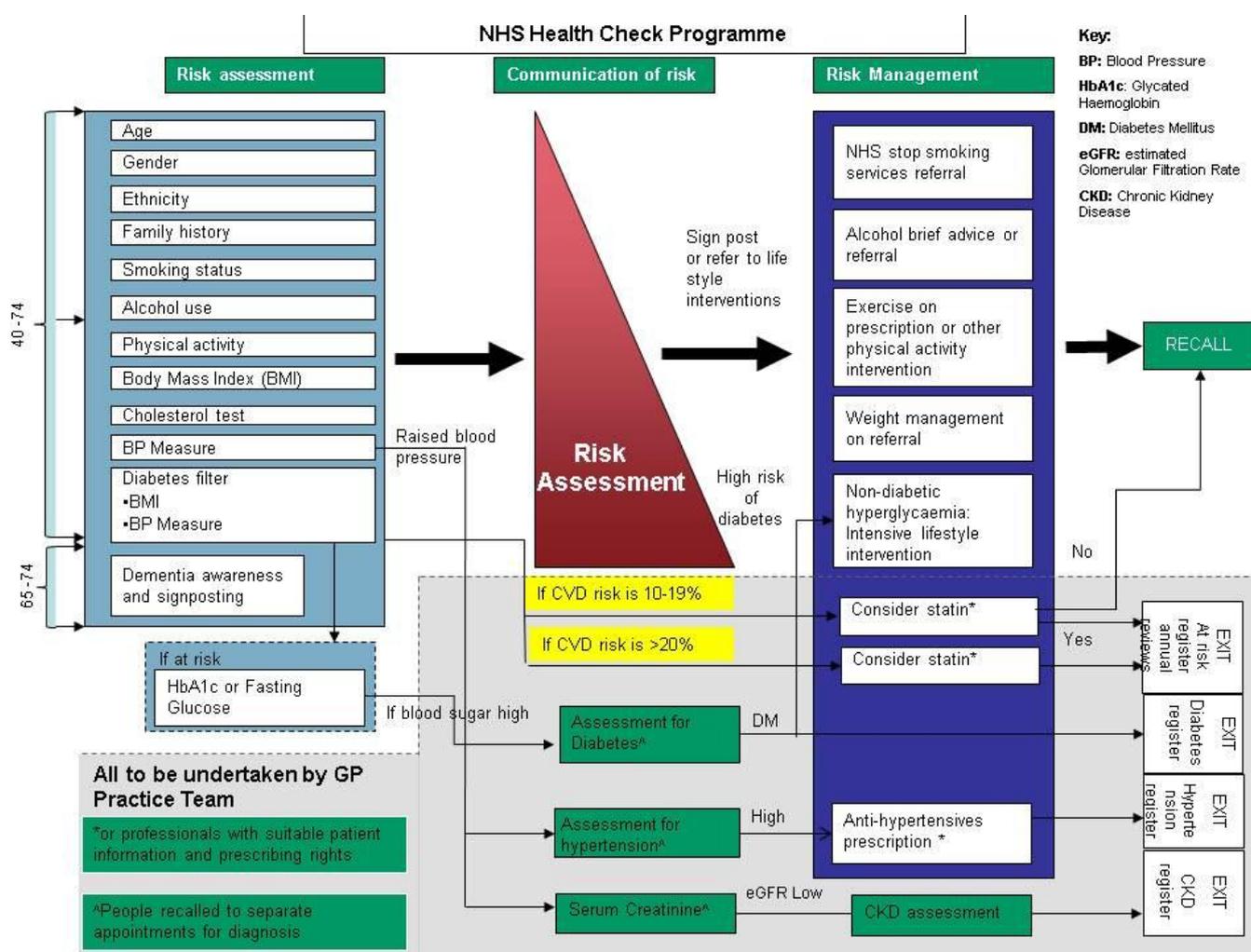
A summary of the data returns process is available in annex A but more detailed guidance is available on the **programme website**.

# Chapter 3. The risk assessment

## 3.0 Introduction

This section provides information on how to assess someone's cardiovascular risk and defines what information and measurements are required for the NHS Health Check risk assessment, see figure 2.

Figure 2. Overview of the vascular risk assessment and management programme



### 3.1 Cardiovascular risk assessment

The NHS Health Check risk assessment requires the use of a risk engine to calculate the individual's risk of developing cardiovascular disease in the next ten years. NICE now advises that QRISK® 2 should be the engine used,<sup>9</sup> rather than the previous recommendation that local areas should choose between using Framingham or QRISK® 2. The NHS Health Check expert scientific and clinical advisory panel supports this recommendation, therefore the following information explains what data is required for the QRISK® 2 risk engine, and the best practice for obtaining it.

#### Age

**Data required:** age recorded in years.

**Thresholds:** the age of the person should be 40-74 years (inclusive).

#### Gender

**Data required:** the gender should be recorded as reported by the individual. If the individual discloses gender reassignment, they should be provided with CVD risk calculations based on both genders and advised to discuss with their GP which calculation is most appropriate for them as an individual.

#### Ethnicity

**Data required:** self-assigned ethnicity using one of the following categories: white/not recorded, Indian, Pakistani, Bangladeshi, other Asian, black African, black Caribbean, Chinese, other including mixed.

**Key points:** ethnicity is needed for the diabetes risk assessment. Ethnicity should be recorded using the Office for National Statistics 2001 census codes.

#### Smoking status

**Data required:** current smoker or non-smoker (including ex-smoker).

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<sup>9</sup> National Institute for Health and Care Excellence (2014) Lipid modification: cardiovascular risk assessment and the modification of blood lipids for the primary and secondary prevention of cardiovascular disease  
[www.nice.org.uk/Guidance/CG181](http://www.nice.org.uk/Guidance/CG181)

**Related stages of the check:** local authorities may wish to ensure processes are in place so a smoker who wants to quit can be offered a referral to a local stop smoking service.

## Family history of coronary heart disease

**Data required:** information on family history of coronary heart disease in first-degree relative under 60 years.

**Key points:** first-degree relative means father, mother, brother or sister.

## Body mass index

**Data required:** BMI is required for the CVD risk calculation. It also provides one approach to identifying those at high risk of developing diabetes, or those who have existing undiagnosed diabetes, and is required for the diabetes risk assessment (covered later in this section).

**Thresholds:** where the individual's BMI is in the obese range then a blood sugar test is required:

- BMI is 27.5 or over in individuals from the Indian, Pakistani, Bangladeshi, Other Asian and Chinese ethnicity categories.
- BMI is 30 or over in individuals from other ethnicity categories.

Note: if the individual cannot have their height and or weight measured, the individual's estimate of their own height and weight can be used as approximations but these are prone to error. Arm span can also be used as an approximation for height.

## Cholesterol test

**Data required:** cholesterol must be measured as the ratio of total serum cholesterol to high density lipoprotein cholesterol.

**Related stages of the check:** cholesterol is a major modifiable risk factor of vascular disease, and can be reduced by dietary change, physical activity and medicines, and local areas will wish to consider what support to offer individuals. The specific reduction measures taken will depend on the overall risk score of the individual. If the ten- year risk is 10% or greater, and the NHS Health Check is undertaken outside of general practice the individual should be referred to their GP for further assessment and management.

**Key points:** a random (not fasting) cholesterol test can be used under the NHS Health Check programme to help ensure maximum take-up.

### **Additional guidance**

*Lipid modification: cardiovascular risk assessment and the modification of blood lipids for the primary and secondary prevention of cardiovascular disease.* NICE clinical guideline 181. July 2014.

### **Systolic and diastolic blood pressure**

**Data required:** both systolic (SBP) and diastolic blood pressure (DBP) are required for the diabetes filter and for assessment for chronic kidney disease and hypertension within primary care.

**Threshold:** if the individual has a blood pressure at, or above, 140/90mmHg, or where the SBP or DBP exceeds 140mmHg or 90mmHg respectively, the individual requires:

- a fasting plasma glucose (FPG) or HbA1c test (see section on diabetes risk assessment). This is part of the risk assessment element of the NHS Health Check and local authorities will need to consider its provision
- an assessment for hypertension (see the section on additional testing and clinical follow up). This will take place in primary care and will mean local authorities will need to work closely with their partners to ensure people receive appropriate clinical follow up
- an assessment for CKD (see the section on additional testing and clinical follow up). Again this will take place within a GP setting and links across the system are essential

**Key points:** as set out NICE clinical guideline 127 (2011) practitioners should perform a pulse rhythm check prior to taking blood pressure to detect any pulse irregularities that could affect the reading from an automated device. Individuals who are found to have an irregular pulse rhythm should be referred to the GP for further investigation. As blood pressure is one of the top modifiable risk factors for preventing premature mortality, commissioners and providers will wish to familiarise themselves with the NICE hypertension guidance.

### **Additional guidance**

*Hypertension: clinical management of primary hypertension in adults.* NICE clinical guideline 127. August 2011.

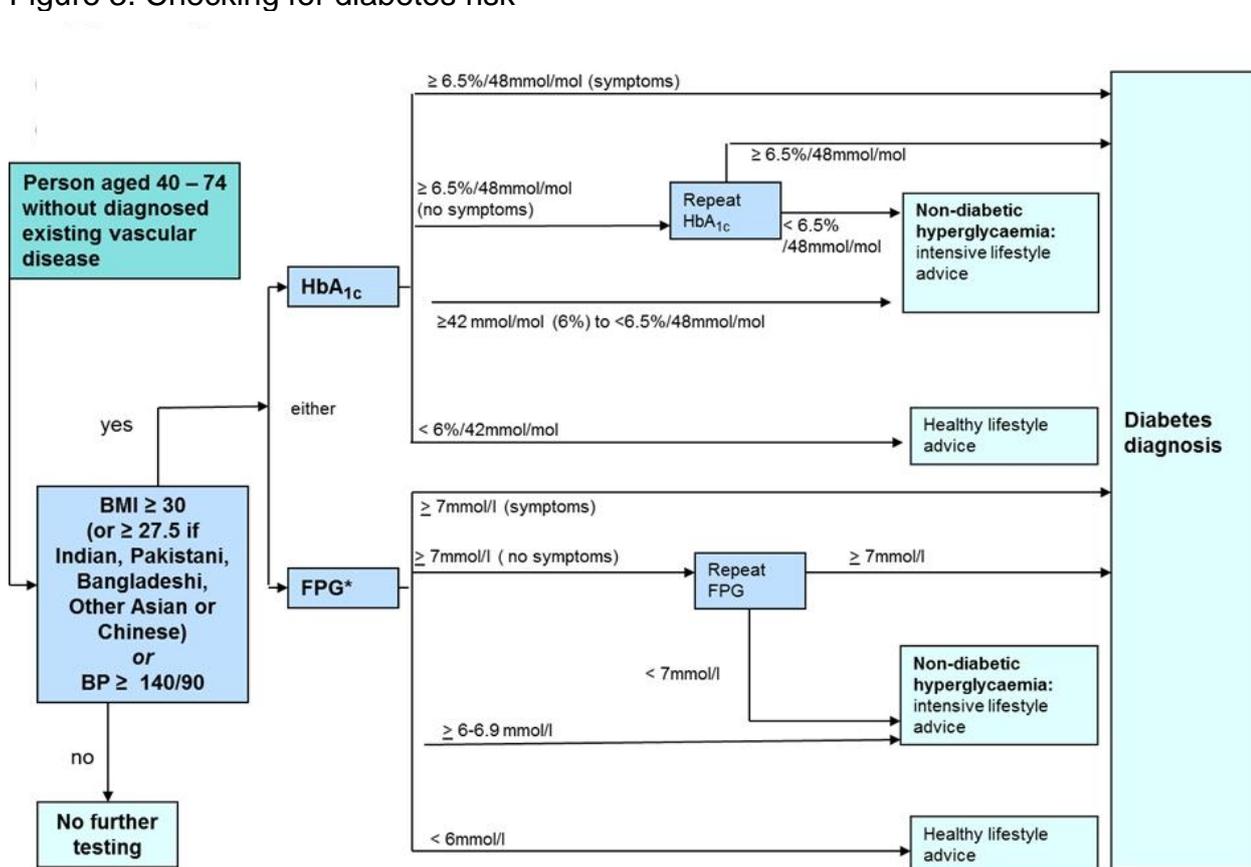
### 3.2 Diabetes risk assessment

#### Identifying those at higher risk of diabetes

This section provides guidance on how to identify people at high risk of developing, or living with undiagnosed, diabetes, and to undertake the necessary blood glucose test – either an HbA1c which is recommended, or a fasting blood glucose test. Only those identified as at higher risk should have a blood glucose test as part of their NHS Health Check risk assessment; it is not considered clinically effective or cost effective to test everyone.

There is no single accepted way of identifying people who are at risk of diabetes or who have existing undiagnosed diabetes. There are a number of ways of determining who is at high risk. This guidance describes using BMI (adjusted for ethnicity) and blood pressure to identify people at high risk that should go on to receive a blood glucose test. Making arrangements for the blood glucose test is a local authority responsibility. The outcome of the test will establish how best they can be managed. Figure 3 provides a diagrammatic overview of this approach as well as additional testing and treatment pathways.

Figure 3. Checking for diabetes risk



The thresholds specified will not pick up everyone at risk of diabetes, but this approach achieves a balance between sensitivity (ie, finding those people at risk of diabetes as accurately as possible) and feasibility (ie, the practicalities involved in delivering the check). It means that just under half of people put through the filter nationally will go on to have a blood glucose test.

While the filter remains the current approach for identifying people at high risk of diabetes through the NHS Health Check, NICE guidance recommends that a validated risk engine is used. Therefore, the programme's expert scientific and clinical advisory committee is considering the feasibility of transitioning to a validated risk tool as part of the content review process. You can find further updates on the NHS Health Check website as this process progresses.

**Key points:** only individuals identified as at high risk of diabetes using BMI or blood pressure as a filter should have a blood glucose test. It is not clinically effective or cost effective to test everyone. It is also important to note that only HbA1c or a *fasting* plasma glucose test is recommended. Random (non-fasting) plasma glucose tests should *not* be used as the results will vary markedly depending on what the person has consumed – false positives and negatives may therefore result.

**Data required:** ethnicity, BMI and blood pressure are required for the diabetes risk assessment.

**Thresholds:** where the individual's BMI is in the obese range as follows or their blood pressure is at or above 140/90mmHg, the individual requires a blood glucose test.

The diabetes filter

- Blood glucose test if: BMI is in the obese range (30 or over, or 27.5 or over in individuals from the Indian, Pakistani, Bangladeshi, other Asian and Chinese ethnicity categories)
- or
- blood pressure is at or above 140/90mmHg, or where the SBP or DBP exceeds 140mmHG or 90mmHg respectively

Blood glucose testing

In addition to individuals meeting the high risk filter criteria it is important to consider the situation of the individual person, as some people who do not fall into the filter categories will still be at significant risk. This includes:

- people with first-degree relatives with type 2 diabetes or heart disease

- people with tissue damage known to be associated with diabetes, such as retinopathy, kidney disease or neuropathy
- women with past gestational diabetes
- those with conditions or illnesses known to be associated with diabetes (eg, polycystic ovarian syndrome or severe mental health disorders)
- those on current medication known to be associated with diabetes (eg, oral corticosteroids)

**Key points:** as with the other tests in the check, it is important that those people who do not go on for further testing understand that everyone has some level of risk. They should also be made aware of the risk factors for diabetes as part of the general lifestyle advice that should be offered to everyone having a check regardless of their risk.

There is no single universally recognised way of testing blood for high risk of diabetes or for diabetes itself. Random (non-fasting) blood glucose tests are so influenced by food they are not recommended. Fasting blood glucose tests, while less convenient, are a better method. An HbA1c test can also be used. These two main approaches for testing blood glucose – fasting plasma glucose and HbA1c – are set in the following sections.

#### Fasting plasma glucose (FPG)

**Key points:** an FPG test is recognised as an acceptable first test to identify those with potential diabetes or at high risk. To undertake an FPG test, the person being tested should be informed of the fasting requirement in writing or over the phone and if possible the appointment should be scheduled for 11am or earlier to make fasting easier.

#### HbA1c (glycated haemoglobin)

**Key points:** HbA1c testing does not require fasting so can be more convenient. Blood can be taken venously. HbA1c is formed when glucose binds to haemoglobin in red blood cells. The higher the blood glucose over the past two or three months, the higher the HbA1c. Even within the non-diabetic range, HbA1c has been shown to be a risk marker for vascular events and can be used to assess the risk of diabetes.

In 2011, the World Health Organisation (WHO) accepted HbA1c as an alternative method in the diagnosis of diabetes provided:

- stringent quality assurance methods are in place
  - measurements are standardised
  - no conditions exist which preclude HbA1c's accurate measurement such as haemolytic anaemia, iron-deficiency anaemia and some variant haemoglobins.
- HbA1c is not recommended for the diagnosis of diabetes in pregnancy when an

oral glucose test is still required. HbA1c reflects glycaemia over the preceding 2-3 months so may not be raised if blood glucose levels have risen rapidly

- situations where blood glucose levels have risen rapidly require urgent/same day assessment by a GP, diabetologist or accident & emergency. Examples include:
  - all symptomatic children and young people
  - symptoms suggesting type 1 diabetes (any age)
  - short duration diabetes symptoms
  - patients at high risk of diabetes who are acutely ill
  - patients taking medication that may cause rapid glucose rise, eg, corticosteroids, anti-psychotics
  - acute pancreatic damage/pancreatic surgery

The WHO did not provide specific guidance on HbA1c criteria for people at increased risk of type 2 diabetes. However, a UK expert group on the implementation of the WHO guidance recommends using HbA1c values between 42 and 47mmol/mol (6.0-6.4%) to indicate that the person is at high risk of type 2 diabetes. NICE public health guidance 38: Preventing type 2 diabetes: risk identification and interventions for individuals at high risk, supports this recommendation. This advice should be used in conjunction with the [programme standards](#).

### **Additional guidance**

#### *Use of Glycated Haemoglobin (HbA1c) in the Diagnosis of Diabetes Mellitus*

World Health Organization. 2011. Abbreviated Report of a WHO Consultation. WHO/NMH/CHP/CPM/11.1.

*Consensus statement: Use of haemoglobin A1c (HbA1c) in the diagnosis of diabetes mellitus.* The implementation of World Health Organisation (WHO) guidance 2011, Practical Diabetes, 2011, 1, 12a

NICE public health guidance 38: *Preventing type 2 diabetes: risk identification and interventions for individuals at high risk.* July, 2012.

*NHS Health Check programme standards: a framework for quality improvement.* Public Health England. February, 2014.

### 3.3 Near patient testing and quality control

This section provides guidance and advice on the use of point of care testing (POCT) or near patient testing (NPT) for the blood tests required for the NHS Health Check. It provides advice on training and quality assurance to support the safe use of POCT.

Fasting blood glucose or HbA1c POCT may be suitable for initially filtering out those who are unlikely to have diabetes or non-diabetic hyperglycaemia. However, diagnosis of diabetes or of non-diabetic hyperglycaemia requires a venous blood sample to be tested in the laboratory. See the overview of the testing pathways set out in figure 2.

Where the introduction of POCT is being considered the Medicines and Healthcare Products Regulation Agency advises that:

- **the local hospital pathology laboratory is involved** as it can play a supportive role in providing advice on a range of issues including the purchase of devices, training, interpretation of results, troubleshooting, quality control, and health and safety. They will also be far more likely to support you if there are any challenges if they have been involved from the outset
- **a POCT co-ordinator is identified** to manage the creation, implementation and management of a POCT service and governance structure
- **potential hazards** associated with the handling and disposal of bodily fluids, sharps and waste reagents outside of a laboratory setting should be considered
- **staff who use POCT devices must be trained. Only staff whose training and competence has been established and recorded should be permitted to carry out POCT**
- **the equipment instructions should always be read** and staff should be particularly aware of situations when the device should not be used
- **standard operating procedures (SOPs)** which must include the manufacturer's instructions for use, are developed. You should pay particular attention to any storage and handling requirements of the machine and cassettes
- **quality assurance must be addressed.** Implementing quality control (QC) procedures provides assurance that the system is working correctly. A QC record should be in place for each machine
- **which staff review the results should be considered,** staff should be appropriately qualified and cited on the patient's history
- **record keeping** is essential and must include patient results, test strip lot number and operator identity
- **maintaining** devices according to the manufacturer's guidance is essential to ensure that they continue to perform accurately

Where POCT is used, the Care Quality Commission's (CQC) diagnostic and screening procedure confirms that non-ambulatory blood pressure monitoring and blood tests

carried out by means of a pin prick test are excluded from the CQC registration requirement. However, provider organisations are legally required to satisfy themselves as to whether CQC registration is required for any other service they provide.

Where it is agreed that POCT will be undertaken then local arrangements should also seek to meet the relevant NHS Health Check **programme standards**.

### **Additional guidance**

*Pathology quality assurance review*; NHS England, 2014

*Management and Use of IVD Point of Care Test Devices. Device Bulletin 2002(03).* Medical Devices Agency. March 2002. The bulletin provides extensive guidance, including advice on clinical governance issues relating to the setting up and management of POCT, pathology and laboratory involvement, staff training, health and safety, standard operating procedures and quality issues.

*Buyers' guide: Blood glucose systems.* Purchasing and Supply Agency, Centre for Evidence-based Purchasing. May 2008.

*NHS Health Check programme standards: a framework for quality improvement.* Public Health England. February, 2014.

## **3.4 Physical activity assessment**

**Data required:** NICE guidance on physical activity interventions recommends that primary care practitioners should take the opportunity, whenever possible, to identify inactive adults. The UK Chief Medical Officer recommended that all adults should be physically active daily. Over a week, activity should add up to at least 150 minutes. A validated tool is recommended, such as DH's General Practitioner Physical Activity Questionnaire (GPPAQ) to measure the activity levels of individuals.

**Key points:** GPPAQ as a testing tool is part of Let's Get Moving (LGM): a physical activity care pathway. GPPAQ has been tested and validated for self-completion. It provides a measure of an individual's physical activity levels, which have been shown to correlate with cardiovascular risk, classifying people as inactive, moderately inactive, moderately active, and active.

**Thresholds:** a brief intervention on physical activity can help support people to become and remain active and will be appropriate for the majority of people who fall into all GPPAQ classifications other than active. Individuals who are identified as inactive could be considered for exercise referral where local services exist.

### **Additional guidance**

*Four commonly used methods to increase physical activity: brief interventions in primary care, exercise referral schemes, pedometers and community-based exercise programmes for walking and cycling.* NICE Public Health Guidance 2. March 2006.

*Everybody Active, Every Day: An evidence-based approach to physical activity.* Public Health England. 2014

*Exercise referral schemes to promote physical activity* – Recommendation 5 of PH2 is updated with PH54 September 2014

*Physical activity: brief advice for adults in primary care.* NICE public health guidance 44. NICE Public Health Guidance 44. May 2013. This supersedes recommendations 1-4 in Four commonly used methods to increase physical activity

*Start Active, Stay Active. A report on physical activity for health from the four home countries' Chief Medical Officers.* Department of Health. July 2011.

*Let's Get Moving: Commissioning Guidance - A physical activity care pathway.* Department of Health. March 2012.

### 3.5 Alcohol risk assessment

Local authorities need to ensure that everyone having an NHS Health Check has their alcohol consumption assessed.

**Key points:** to identify the risk of harm from alcohol, the World Health Organisation (WHO) alcohol use disorder identification test (AUDIT) questionnaire should be used. This questionnaire is validated, has been used all over the world and is considered to be the 'gold standard' alcohol risk questionnaire.

The AUDIT questionnaire is ten questions long and will take approximately three minutes to complete. Not everybody will need to be asked all ten questions.

The assessment can be split into two phases:

- an initial assessment to identify those who may be at risk, and
- a second phase to identify the level of risk.

Figure 4 presents the care pathway for alcohol risk assessment.

**Initial assessment:** can be undertaken by using a brief initial questionnaire; a sub-set of the full AUDIT.

The two recommended initial assessment questionnaires, AUDIT-C and the fast alcohol screening test (FAST), are both validated and widely used in England. Both can be self-completed by the individual or the questions can be verbally asked of the person and their response recorded. AUDIT-C consists of the first three questions of AUDIT- the consumption questions. FAST consists of four of the ten questions from AUDIT.

These initial assessment questionnaires are about 80% as accurate as the full AUDIT and are enough to rule someone in or out for further investigation concerning their alcohol risk.

**Initial assessment threshold:** (AUDIT-C  $\geq 5$  ; FAST  $\geq 3$ ) If the patient scores five or more using AUDIT-C, or three or more using FAST this indicates the individual is positive on the initial assessment questionnaire and the second phase should be undertaken.

**Full AUDIT:** if the patient scores above the initial assessment threshold then the second phase is to complete the remaining questions of the full AUDIT. It is this full AUDIT score that can identify the risk level of the person.

**AUDIT threshold:**  $\geq 8$ . If the total AUDIT score from the full ten questions is eight or more, this indicates the person's consumption of alcohol might be placing their health at increasing or higher risk of harm.

The AUDIT score should be recorded and fed back to both the individual and, where the risk assessment is carried out outside the person's GP practice, to the person's GP.

**Related stages of the check:** although this is not a mandated requirement, if the individual meets or exceeds the AUDIT threshold of eight, the individual should be given brief alcohol advice to reduce their health risk and to help reduce alcohol related harm. A referral to alcohol services should be considered for those individuals scoring 20 or more on AUDIT. Further guidance on this is provided in section 4.

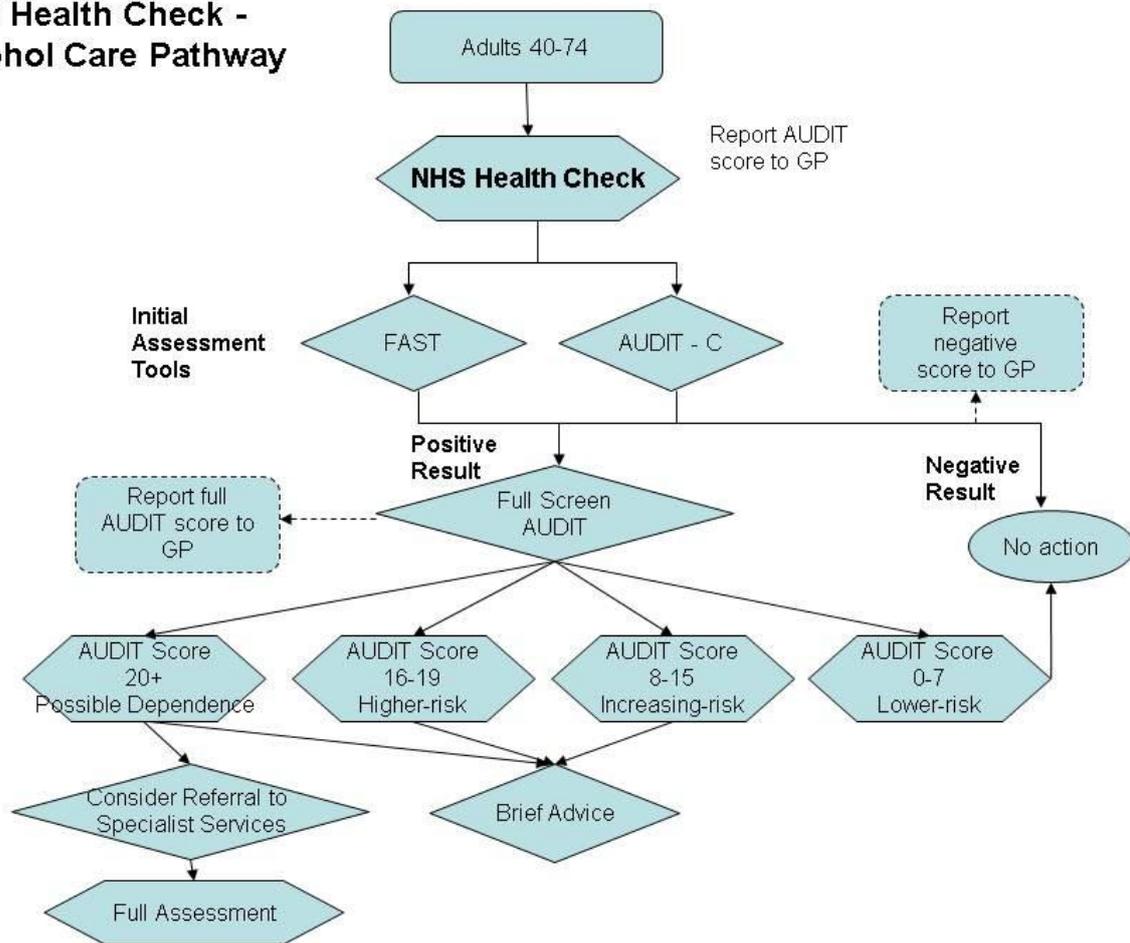
**Data required:** AUDIT score

#### **Additional guidance**

*Alcohol-use disorders: preventing harmful drinking*. NICE public health guideline 24.  
June 2010

Figure 4. Alcohol care pathway

### NHS Health Check - Alcohol Care Pathway



### 3.6 Raising awareness of dementia

The dementia component of the NHS Health Check does not require any formal assessment or memory testing. The purpose of the intervention is to raise awareness of dementia and the availability of memory services which offer further advice and assistance to people who may be experiencing memory difficulties, including the diagnosis of dementia.

Everyone who has a NHS Health Check should be made aware that the risk factors for cardiovascular disease are the same as those for dementia. In addition, everyone aged 65-74 who has a NHS Health Check should be made aware of the signs and symptoms of dementia and be signposted to memory services if this is appropriate. A leaflet for individuals having their check and training materials for those carrying out the check have been produced to support this. These resources are available [to order](#) or to [download from our website](#) in a variety of formats and languages.

# Chapter 4. Risk management and lifestyle interventions

## 4.0 Introduction

The NHS Health Check is a preventative programme which is intended to help people live longer healthy lives. Although the risk management element of the programme is not a legal responsibility for local authorities it is essential if the programme is to benefit the public's health.

To maximise these benefits, everyone who has an NHS Health Check, regardless of their risk score, should be given clinically appropriate lifestyle advice, to help them manage and reduce their risk. So, unless it is deemed clinically unsafe to do so, everyone having the check should be provided with individually tailored advice that will help motivate them and support the necessary lifestyle changes to help them manage their risk.

Depending on the delivery model in place, this advice and the completion of the risk assessment may be completed by different professionals. So it is important that information such as smoking status, blood pressure, levels of physical activity and history of vascular disease in the family is transferred in written form between individuals and within the delivery team as necessary. This will help ensure continuity of care and a positive experience for the person having the check.

## 4.1 Local stop smoking services referral

**Key points:** as with all of the lifestyle interventions which form part of the NHS Health Check, the provision of stop smoking services are funded through the public health ring fenced budget. Although offering these services as part of the programme is not mandated, they provide an essential contribution to its ultimate objective by helping people who smoke to manage or reduce their risk of developing future disease. Local authorities may therefore like to consider how anyone who smokes and who wants to stop, is offered the support of a local stop smoking service.

NICE Public Health Intervention Guidance no. 1 *Brief interventions and referral for smoking cessation in primary care and other settings* makes a number of practical recommendations on who should receive advice, as well as on who should advise smokers and how.

DH's local stop smoking service monitoring and delivery guidance 2012-13 illustrates the importance of using every opportunity to systematically identify people who smoke,

deliver very brief advice (VBA) and follow up, where appropriate, with a referral into effective support. This very brief advice consists of three steps:

- establish and record smoking status (ASK)
- advise that the best way to stop is with a combination of pharmacotherapy and support (ADVISE)
- offer a referral to a specialist service (ACT)

A free training module on the delivery of VBA is available on the National Centre for Smoking Cessation and Training's [website](#).

### **Additional guidance**

*Brief interventions and referral for smoking cessation in primary care and other settings.* NICE Public Health Intervention Guidance no. 1. March 2006.

*NCSCT local stop smoking services: service and delivery guidance* – 2014. September 2014. NCSCT.

## **4.2 Physical activity interventions**

The UK Chief Medical Officers recommend that all adults should aim to be active daily. Activity should add up to at least 150 minutes of moderate intensity activity in bouts of ten minutes or more over a week. One way to approach this is to do 30 minutes at least five days a week. Alternatively, comparable benefits can be achieved through 75 minutes of vigorous intensive activity spread across the week, or a combination of moderate and vigorous intensity activity. It should be emphasised that all adults should minimise the amount of time spent being sedentary for extended periods.

**Key points:** if a person is identified as not achieving these levels, practitioners should offer a brief intervention to increase physical activity as follows:

- provide physical activity advice, taking into account the individual's needs, preferences and circumstances
- provide written information about the various types of activities and the local opportunities to be active
- offer a referral to an exercise referral programme, where appropriate
- follow up at appropriate intervals over a three to six-month period

## Additional guidance

*Four commonly used methods to increase physical activity: brief interventions in primary care, exercise referral schemes, pedometers and community-based exercise programmes for walking and cycling.* NICE Public Health Intervention Guidance 2. March 2006.

*Start Active, Stay Active. A report on physical activity for health from the four home countries' Chief Medical Officers.* Department of Health. July 2011.

*Let's Get Moving. A physical activity care pathway Commissioning Guidance.* March 2012.

*Physical activity: brief advice for adults in primary care.* NICE public health guidance 44. May 2013. The recommendations supersede recommendations 1-4 in *Four commonly used methods to increase physical activity*, NICE Public Health Guidance 2.

*Everybody Active, Every Day: An evidence-based approach to physical activity.* Public Health England. 2014

## 4.3 Weight management

Preventing and managing obesity is complex. Where an individual's weight status is a key risk factor, advice or onward referral should be provided in line with the [NICE clinical guideline CG43 on the prevention, identification, assessment and management of overweight and obesity in adults and children](#) and the relevant updates [ph53](#) and [cg189](#). Where the individual's weight status is not a risk factor, it is still an opportunity to reinforce the benefits of healthy eating and being physically active.

When providing advice around weight management or referring individuals on to more long-term interventions, it will be important to take a personalised approach. This may require consideration of factors including the individual's:

- willingness and motivation to change
- particular barriers to lifestyle change (for example, lack of time or knowledge)
- self-esteem
- current levels of fitness
- the views of family and community members

Local areas may have their own care pathway for overweight and obesity in adults, involving different tiers of services, in line with NICE guidance.

Any advice or more sustained lifestyle interventions on weight management provided as part of the risk management element of the check should comply with the NICE overweight and obese adults lifestyle weight management guidance.

In addition, the individual's alcohol intake could be considered as part of any discussion about energy intake, and the opportunity used to highlight links between alcohol intake and obesity with liver disease.

### **Additional guidance**

*Obesity: guidance on the prevention, identification, assessment and management of overweight and obesity in adults and children.* NICE guideline CG43. December 2006

*Overweight and obese adults – lifestyle weight management.* NICE guideline PH53. May 2014

*Obesity: identification, assessment and management of overweight and obesity in children, young people and adults.* NICE guideline CG189. November 2014

*Lipid modification: Cardiovascular risk assessment and the modification of blood lipids for the primary and secondary prevention of cardiovascular disease.* NICE clinical guideline 181. July 2014

*Healthy Weight, Healthy Lives: A toolkit for developing local strategies.* National Heart Forum et al. October 2008. This toolkit was produced to help PCTs and local authorities plan, coordinate and implement comprehensive strategies to prevent and manage overweight and obesity.

## **4.4 Alcohol use interventions**

The UK Chief Medical Officer recommends that men should not drink on a regular basis more than three to four units per day, and that women should not drink on a regular basis more than two to three units a day (with 'regular' here meaning most days or every day of the week) for lower-risk drinking.

**Key points:** local authorities may wish to consider how individuals identified as drinking alcohol above lower risk levels (an AUDIT score at or above eight) can be offered advice to reduce their alcohol use. This would be considered an appropriate measure to improve the health of the people in its area and a way to discharge its general duty to take steps to improve public health.

Advice to reduce alcohol use is an essential part of helping people manage the risk alcohol poses to their health and the risk of developing disease in the future. Evidence suggests this advice is most effective when delivered immediately or as soon as

possible after the AUDIT assessment – the ‘teachable moment’. This advice can take as little as five minutes and consists of:

- understanding alcohol units – ensuring the person understands how much they are drinking
- understanding risk levels – explaining the lower-risk guidance and how the health risk rises above this level
- informing them of their level of risk – informing the person of their AUDIT score (a mandatory requirement), what risk level this indicates and where their risk level compares to the rest of the population
- benefits of cutting down – explain some of the benefits that could come from reducing their alcohol consumption.
- tips for cutting down – providing the person with a menu of things they could try to cut back on their alcohol consumption

This brief advice could be supported by an information leaflet or booklet given to the person to reinforce the brief advice given and for future use.

Providing information and brief advice on lower risk drinking is also recommended as part of the guidance on lifestyle interventions within the NICE clinical guideline on hypertension and NICE public health guidance on preventing harmful drinking. It is also a topic likely to be raised in discussing lifestyle issues as part of this programme.

If the person’s AUDIT score is 20 or more, this may indicate alcohol dependence and consideration can be given to referring the person to more structured alcohol treatment services for a full assessment and any necessary treatment. Those wanting to stop drinking who are experiencing difficulty should be considered for referral to specialist services using locally agreed referral methods. This referral can be made from the NHS Health Check provider or from the person’s GP.

### **Additional guidance**

*Alcohol-use disorders - preventing harmful drinking*. NICE Public Health Guidance 24, June 2010.

*Alcohol Identification and Brief Advice e-Learning course*

*Primary Care Service Framework: Alcohol Services in Primary Care*. NHS. May 2009.

# Chapter 5. Additional testing and clinical follow-up

## 5.0 Introduction

The NHS Health Check programme is primarily a public health programme aimed at preventing disease but it will also identify individuals who are living with undiagnosed disease or who are at high risk of developing disease who will require some additional clinical testing and follow-up. So there is a need for different parts of the system to work closely together to ensure this happens, with health and wellbeing boards playing a pivotal role.

This section provides information on additional testing and clinical follow-up triggered by the initial risk assessment. This is likely to be undertaken by a GP practice team, or by health professionals with suitable patient information and prescribing responsibilities. The following sections are advice and best practice only that local authorities and primary care staff may wish to consider.

## 5.1 Assessment for hypertension

**Threshold:  $\geq 140/90$ mmHg:** if the individual has a blood pressure at, or above, 140/90mmHg, or where the SBP or DBP exceeds 140mmHg or 90mmHg respectively, the individual requires an assessment for hypertension by the GP practice team.

**Related stages of the check:** individuals diagnosed with hypertension should be added to the hypertension register and treated through existing care pathways. They should be reviewed in line with existing NICE clinical guidelines and should not be recalled as part of the NHS Health Check programme.

Discussions with these people about possible hypertension diagnosis and management may raise questions about the relationship between lifestyle and blood pressure management. Such discussion will normally take place as part of the further hypertension assessment or once a patient is placed on the hypertension register. It will however be useful for practitioners to be aware of the lifestyle interventions recommended in the NICE guideline on hypertension:

- ask people about their diet and exercise patterns, and offer guidance and written or audiovisual materials to promote lifestyle changes
- ask people about their alcohol consumption and encourage them to cut down if they drink excessively

- discourage excessive consumption of coffee and other caffeine-rich products
- encourage people to keep their salt intake low or substitute sodium salt
- offer people who smoke advice and help to stop smoking
- tell people about local initiatives (for example, run by healthcare teams or patient organisations) that provide support and promote lifestyle change
- do not offer calcium, magnesium or potassium supplements as a method of reducing blood pressure
- relaxation therapies can reduce blood pressure and people may wish to try them. However, it is not recommended that primary care teams provide them routinely

### Additional guidance

*Hypertension: clinical management of primary hypertension in adults.* NICE clinical guideline 127. August 2011.

## 5.2 Assessment for chronic kidney disease

If the individual has a blood pressure at or above 140/90mmHg, or where the SBP or DBP exceeds 140mmHg or 90mmHg respectively, the individual requires an assessment for chronic kidney disease by a GP.

**Data required:** SBP and DBP.

**Threshold:**  $\geq 140/90$ mmHg.

Assessment for chronic kidney disease

**Data required:** the results of a serum creatinine test should be used to calculate the estimated glomerular filtration rate (eGFR) in order to assess the level of kidney function, and recorded on the individual's patient record.

**Threshold:**  $eGFR < 60 \text{ml/min/1.73m}^2$  or  $\geq 60 \text{ml/min/1.73m}^2$

Where eGFR is **above or equal to  $60 \text{ml/min/1.73m}^2$** , no further assessment is required, unless the individual is diagnosed with hypertension or diabetes mellitus. In this case, their risk of kidney disease will be monitored as part of the management of their hypertension and/or diabetes.

$< 60 \text{ml/min/1.73m}^2$

Where eGFR is **below  $60 \text{ml/min/1.73m}^2$** , further assessment for chronic kidney disease is required in line with NICE clinical guideline 182 on chronic kidney disease. In people with a new finding of reduced eGFR, the eGFR should be repeated within two weeks to confirm that it is abnormal.

**Key points:** a venous blood sample is required for this test. NPT is not considered appropriate. A serum creatinine test should be requested from the laboratory. This can be requested at the same time as a cholesterol test from the laboratory (if NPT is not used to assess cholesterol).

### **Additional guidance**

*Chronic kidney disease: early identification and management of chronic kidney disease in adults in primary and secondary care.* NICE clinical guideline 182. July 2014.

*Hypertension: clinical management of primary hypertension in adults.* NICE clinical guideline 127. August 2011.

*Lipid modification: Cardiovascular risk assessment and the modification of blood lipids for the primary and secondary prevention of cardiovascular disease.* NICE clinical guideline 181. July 2014

## **5.3 Managing those with high cardiovascular risk**

CVD risk should be communicated using everyday, jargon-free language. People should be offered information about their absolute risk of CVD and about the absolute benefits and harms of an intervention over a 10-year period. Other points to note include:

- the decision whether to start statin therapy should be made after an informed discussion between the GP or nurse and the individual about the risks and benefits of statin treatment, taking into account additional factors such as potential benefits from lifestyle modifications, informed patient preference, comorbidities, polypharmacy, general frailty and life expectancy
- people with a 10% or greater ten-year risk of developing CVD should be offered appropriate lifestyle advice and behaviour change support in relation to increasing physical activity, smoking cessation, safe alcohol consumption and healthy diet
- people with high CVD risk should be advised that the potential benefits from lifestyle modifications will also reduce their risk of dementia
- people with a 10% or greater ten-year risk of developing CVD should be offered statin therapy for the primary prevention of CVD

**Key point:** individuals that are either prescribed a statin or have a CVD risk score >20% should exit on to an at risk register (figure 2).

# Chapter 6. Communications, marketing and branding

## 6.0 Introduction

PHE has developed several means of sharing resources and communicating with commissioners, local councillors and members of the public. We encourage everyone involved in the programme to engage with us and we welcome the opportunity to share and showcase locally developed materials which may help to inspire and drive innovation elsewhere. Some important tools and resources are described below.

## 6.1 PHE communications

### National website

The programme has a dedicated national website [www.healthcheck.nhs.uk](http://www.healthcheck.nhs.uk) which is aimed at commissioners, providers and local government. Most content is freely available, some sections require registration. It is a vital tool to find national guidance and resources, latest news and a wide suite of support materials.

### e-bulletin

The monthly **NHS Health Check e-bulletin** is sent out to stakeholders on the last day of each month. The bulletin provides an update on what is happening on the programme and is a good source of national and local information. Subscribe to the e-bulletin [here](#).

### Social media

The NHS Health Check team uses social media to promote the programme. PHE has national **twitter**, **Facebook** and **LinkedIn** accounts that are used to promote events, announcements or publications. There are also regional PHE accounts that are used to promote local programme activity.

## 6.2 Marketing and branding guidance

A toolkit has been developed to provide marketing support for promoting and implementing the NHS Health Check programme locally. The marketing toolkit includes:

- NHS Health Check identity guidelines designed to provide the information needed to produce effective local NHS Health Check materials

- templates for press advertising, posters, letters, presentations and roller banners
- an image bank which includes photos that are free to use in local NHS Health Check campaigns

## Quality controls and using the NHS Health Check brand

Local areas will need to build quality controls and standardisation into their commissioning and contract management arrangements. This will be required if areas wish to use the NHS Health Check brand, which represents a free, uniform and quality service regardless of which local authorities are commissioning it.

## 6.3 Local PR and communication

### PR toolkit

This provides tools and collateral to support local communications and PR, including suggested activity, messaging and template copy. [It is available to download here.](#)

### Information leaflets and support materials

PHE has developed an information leaflet to accompany the invitation letter. This sets out the aims of the NHS Health Check and what a participant can expect at their appointment. It also explains the risk factors associated with vascular disease. It is available [to order](#) or [download from our website](#) in a variety of languages and accessible formats.

The national NHS Health Check team is working closely with the behavioural insights team within PHE to develop a letter template and various ways of utilising tools that will encourage people to take up their offer of the check. Pilot work with volunteer local areas is underway to investigate the effect of applying behavioural insights on uptake. While these projects are on-going some studies have been completed. The report from [Medway](#) can be found on the website and [a sample invitation letter](#) used in the trial is also available. Commissioners are welcome to use the [sample invitation letter](#) provided if they wish or the standard [invitation letter template](#) if a more traditional approach is preferred.

## 6.4 NHS Choices

In May 2014, new NHS Health Check content was launched on the [NHS Choices](#) website. The redesigned content enhances the user journey with a “mega menu” for easy access to what is being sought, discussion-based information, video case studies and options for social media such as Twitter and HealthUnlocked.

The number of page visits since May 2014 is averaging around 100,000 per month, which is an increase of 70% on the same period the previous year with the old content. PHE is continually working with NHS Choices to improve the user experience. Content has been optimised for users who visit the site via a smartphone or tablet devices, a [service directory](#) provides general information on the types of services available locally and a pre-check heart age tool will prompt users to have an NHS Health Check.

The following link [www.nhs.uk/NHSHealthCheck](http://www.nhs.uk/NHSHealthCheck) should be used by local authorities when directing people to the NHS Health Check content on NHS Choices website. Content on NHS Choices is generic about the programme and will not contain local information. It is therefore recommended content is syndicated via a live feed to a local authority website.

### NHS Health Check widget

All NHS Health Check content (including videos, links and apps) on NHS Choices is available to upload onto local authority websites, for free, via a process called syndication. There are a range of options available to syndicate content; the most popular is the NHS Health Check widget. Visit the [FAQ](#) page on the national website to find out more about the syndication options available.

Each month ten million people access syndicated content on NHS Choices via 500 partner websites. So far, 130 local authorities have signed up to use syndicated content from other parts of the NHS Choices website, with more joining every month.

Content and resources which are syndicated onto local authority websites can then be used by the local authority to support local communications and marketing campaigns. This includes using quotes from the content and case studies.

To syndicate content, approval will need to be sought from the person who is responsible for managing content on the local authority website. To register complete the [registration form](#) and a member of the syndication team at NHS Choices will contact you to talk through the syndication process.

### NHS Health Check service directory

Visitors to the NHS Health Check pages on NHS Choices can search for information on how to access an NHS Health Check within their local authority catchment area. Each local authority can request to have a profile page on the directory. Currently the NHS Health Check service directory has 125 live local authority profile pages on [NHS Choices](#).

Each month NHS Choices perform a directory refresh, giving local authorities the opportunity to update their profiles with the most current information about their NHS Health Check services. To request adding a new profile, or editing an existing profile email [enquiries@phe.gov.uk](mailto:enquiries@phe.gov.uk)

Once your request has been received, you will be asked to complete an NHS Health Check service directory profile form to document the exact content you wish to appear on the profile page for your local authority. The form provides guidance notes, suggested content and any specific field conditions (ie, mandatory fields and maximum character counts).

If you encounter a technical error on the service directory page on the NHS Choices website, [email the NHS Choices service directory team](#).

## 6.5 Conferences and symposia

There is a national NHS Health Check conference held every year. The conference is an opportunity to hear about latest developments with workshops and a marketplace showcasing service to help deliver successful local programmes. Other conferences and symposia are held on various programme areas throughout the year. Details on the latest conferences and symposia can be found [here](#).

# Chapter 7. Training, learning and development

## 7.0 Programme standards

The NHS Health Check is a national programme, delivered locally in a way that best suits the needs of local populations. Crucially, this gives local authorities flexibility on who to commission to provide the service and what locations are used. It is important, however, that the tests and measurements themselves are consistent to help ensure the quality and effectiveness of the programme. National standards setting out what good looks like provide a framework to ensure that the NHS Health Check programme operates within parameters that maximises benefits, reduces potential harms for the population and ensures cost effectiveness.

The standards have been developed with extensive input from local authorities to support local commissioners in assuring themselves of the quality of the service(s) they commission. They will also be of help to providers of NHS Health Checks in order to monitor service delivery and ensure continuous improvement in quality.

These standards are not mandatory and do not introduce new targets, they set out aspirational, but achievable, programme standards where reducing variation and assessing quality is particularly important. While acknowledging local innovation, the standards define specific elements of the pathway to help ensure that, at these critical points, the NHS Health Check programme is delivered in a consistent and uniform way across England. You can find the programme standards in the national guidance section of the [NHS Health Check website](#).

## 7.1 Competence framework

Regardless of how commissioners choose to deliver the NHS Health Check programme, they must consider workforce skills and training. The [NHS Health Check competence framework](#) outlines the core and technical competences are required of people carrying out an NHS Health Check. The competence framework makes use of National Occupational Standards (NOS) which describe the skills, knowledge and understanding needed to undertake a particular task or job to a nationally recognised level.

The competence framework provides a template for minimum standards when commissioning or creating training packages for people who deliver the NHS Health Check. The competences and their underpinning criteria should be used to identify the training requirements for people involved in delivering the NHS Health Check

programme. Free e-learning courses on how to conduct an NHS Health Check and support behaviour change are available [here](#).

## Competence workbooks

The **learner workbook** guides people who are delivering the NHS Health Check on the learning outcomes and the types of assessments required to progress towards full competence against the competence framework. It can be used as a way of keeping record of the learning undertaken in each unit and for gathering evidence to demonstrate full competence of delivering an NHS Health Check.

The **assessor workbook** describes the role of the assessor, working with the learner to review existing competences and assessment principles. It can also act as a tool to identify potential gaps in internal assessments and existing training. The assessment is usually done in-house, by the employing organisation but could be carried out via a college or other programme of study.

## 7.2 Dementia training tool

The **dementia training tool** is aimed at those individuals providing the NHS Health Check and includes a self-assessment section which will then provide a certificate of completion.

PHE encourages commissioners to include the dementia component in future local training and competency programmes.

Providers must complete each module in its entirety before progressing to the next one and it is not possible to skip through the video. With this in mind, providers should plan to complete the training in one session. The module may not work on older internet browsers so an up to date browser is required to ensure full functionality.

## 7.3 Alcohol resources

There are numerous alcohol resources available online which can help commissioners and providers understand the delivery of this component of the NHS Health Check.

The **Alcohol Learning Centre** provides online resources and learning for commissioners, planners and practitioners working to reduce alcohol-related harm. It contains alcohol specific documents, guidance and tools, examples of alcohol harm reduction initiatives across England and provides training resources to support frontline practitioners and commissioners.

## Identification and brief advice resources

Another term for alcohol risk assessment is **identification and brief advice (IBA)**. IBA is opportunistic case finding followed by the delivery of simple alcohol advice. Links are provided to AUDIT and all the initial identification tools needed for the NHS Health Check and information leaflets to support the delivery of brief advice.

There are short, free **E-learning modules on IBA** that provide professionals with all they need to know to deliver simple alcohol identification and brief advice in healthcare settings.

There are also some further alcohol tools and resources available that you may find helpful however you should note they cover a wider age range than those eligible for the NHS Health Check; these include the **PHE Alcohol Stocktake** and the **Alcohol Ready Reckoner**. There are also materials and further information available to members of the public via NHS Choices which you can signpost participants to. In addition, there are specific GP templates available for download which can be used on GP clinical systems.

## 7.4 Case studies and webinars

### Case studies

PHE, in partnership with NHS Improving Quality, is rolling out a suite of case studies to help share learning between local authorities and to encourage commissioners to think creatively about engagement with key segments of the population.

PHE encourages local authorities to come forward to work with NHS IQ to develop case studies to showcase their work on engaging with underserved populations. Topics range from running outreach programmes to particular religious groups to integrating existing services with the NHS Health Check and using alternative providers.

These case studies are available to view [here](#).

### Webinars

PHE runs a series of regular webinars which complement the suite of case studies that are being developed as well as addressing key topics of interest to commissioners of the programme. More information is available [here](#).

## Chapter 8. Programme governance

### 8.0 Introduction

As part of its leadership function PHE has introduced a new programme governance structure. In the interests of transparency, this structure and the functions and key responsibilities of each committee and sub-group, how frequently they meet and the deliverables they are responsible for, are all published on the [national website](#). For convenience, they are detailed below.

### 8.1 NHS Health Check programme governance structure

#### NHS Health Check national advisory committee

The NHS Health Check national advisory committee is ultimately responsible to Secretary of State for Health and has been established to oversee the implementation of the NHS Health Check programme which is set-out in *The Local Authorities Public Health Functions and Entry to Premises by Local Healthwatch Representatives Regulations 2013*.

In addition to ministerial accountability, each member of the committee is responsible for representing their specific agency/organisation and ensuring that there is a clear line of accountability and reporting back into their host agency/organisation. This committee provides a national executive forum for the NHS Health Check programme, acting in an advisory capacity to oversee successful roll-out, maintenance, evaluation and continued improvement based on emerging evidence

#### NHS Health Check national steering group

The NHS Health Check national steering group (NSG) is accountable to the NHS Health Check national advisory committee (NAC). The group has been established to advise the NAC on the progress and performance on the delivery of PHE's annual NHS Health Check work plan and that of the sub groups.

The NSG is responsible for monitoring performance and progress against PHE's national delivery plan. The group provides a robust check and challenge function to support the sub-groups in delivering key commitments to time, quality and cost.

## Expert scientific and clinical advisory panel

The **expert scientific and clinical advisory panel** (ESCAP) is an expert forum for the NHS Health Check programme, acting in an advisory capacity to support successful implementation, improvement and evaluation of the programme.

## Data, intelligence and information governance subgroup

The data, intelligence and information governance subgroup ensures robust information governance processes are in place to support effective implementation of the NHS Health Check programme.

## Communications, marketing and engagement sub-group

The **communications, marketing and engagement sub-group** supports and advises on the development of strategic and effective communications, marketing and stakeholder engagement plans as part of supporting local delivery of the NHS Health Check programme.

## Regional and centre NHS Health check sub-group

The **regional and centre NHS Health Check sub-group** ensures effective matrix working and communication on the NHS Health Check programme by PHE's national, regional and centre teams to support programme delivery.

## Local implementer national forum

The **Local implementer national forum** brings together groups of local authority implementers delivering the NHS Health Check programme and relevant Public Health England teams to ensure effective and frequent dialogue and communication on key priorities for the programme.

## Prisons and detained settings NHS Health Check advisory group

The prisons and detained settings NHS Health Check advisory group is an expert forum advising on, and supporting successful roll-out of the NHS Health Check programme in prisons and detained settings.

## 8.2 Content review process

As the NHS Health Check programme has become established it is recognised that the benefits of the programme might be extended to other areas. This has led to requests for removing, amending or introducing new elements to the programme.

PHE recognises the importance of considering proposals to change the NHS Health Check programme and the need to have a robust case underpinning any such request. In 2013, PHE established ESCAP. A key responsibility of this group is to consider proposals to change the content of the NHS Health Check programme and to make an informed, evidence-based, recommendation to health ministers.

A robust content review process will support ESCAP in making evidence-based recommendations to the Department of Health and ministers on possible changes to the programme. You can find more information and guidance [here](#).

## Annex A. Making the data return

This is only a summary of the process. For more detail please refer to the **Single data list guidance**.

Local authorities have a month to gather the data from the previous quarter and make the return; PHE encourages areas to make the return early.

Where the nominated person is on leave, appropriate arrangements should be put in place well in advance to set up an alternative person to return the data thus avoiding a missed deadline.

The deadlines are on a fixed schedule, falling on **midday** of the last day of the month following the end of the quarter. Where the deadline falls on a weekend, the portal will close at **midday** on the Friday before. These deadlines are published on the submission portal.

1. Go to [www.healthcheck.nhs.uk/interactive\\_map/submit\\_quarterly\\_data/](http://www.healthcheck.nhs.uk/interactive_map/submit_quarterly_data/)
2. login to portal using the allocated username and the password
3. Click on 'submit data'
4. Enter the number of NHS Health Checks offered in the previous quarter
5. Enter the number of NHS Health Checks received in the previous quarter
6. Click continue
7. You will be asked to reconfirm the figures – enter them again and click 'submit'
8. Your figures have been submitted and your return will be checked and quality assured by our data analyst

# Annex B. Management of people found to have abnormal fasting blood sugar or HbA1c

Key points: If the individual's fasting blood glucose on HbA1c is above the threshold for diabetes and the individual has no symptoms, they should be referred non urgently to the GP practice for a repeat blood test and further assessment. They should be told that the results suggest that they may have diabetes but that they require further investigation.

If the individual's fasting blood glucose on HbA1c is above the threshold for diabetes and the individual has symptoms to suggest diabetes, they should be referred to the GP practice on the same or next day. They should be told that the results suggest that they may have diabetes but that they require further investigation urgently.

If the individual's fasting blood glucose on HbA1c is above the threshold for non-diabetic hyperglycaemia but below the threshold for diabetes the individual may have non diabetic hyperglycaemia and should be referred to the GP practice non urgently for a repeat blood test and further assessment. They should be told that the results suggest that they may be at increased risk of diabetes and that they require further investigation.

## **Additional guidance**

*Type 2 diabetes: The management of type 2 diabetes.* NICE clinical guideline 87. May 2009

*Diabetes in adults quality standard.* NICE quality standard 6. March 2011

National Institute for Health and Care Excellence. *Preventing type 2 diabetes: risk identification and interventions for individuals at high risk.* National Institute for Health and Care Excellence. 2012.

National Institute for Health and Care Excellence. *Chronic kidney disease: early identification and management of chronic kidney disease in adults in primary and secondary care.* National Institute for Health and Care Excellence. 2014.

*Lipid modification: Cardiovascular risk assessment and the modification of blood lipids for the primary and secondary prevention of cardiovascular disease.* NICE clinical guideline 181. July 2014.

# Annex C. NHS Health Check guidance and resources

## Programme standards

- NHS Health Check programme standards – Feb 2014

## Training, development and learning

- NHS Health Check competence framework – June 2014
- Case studies
- Dementia training tool

## Information governance and data

- NHS Health Check IG and data flows pack – Feb 2014
- NHS Health Check single data list returns guide – Oct 13 refresh – Oct 2013

## Background and evidence

- Ready reckoner tool – V.9 28th May 2014
- NHS Health Check: our approach to the evidence – July 2013
- Living well for longer: a call to action to reduce avoidable premature mortality – March 2013
- NHS Health Check programme impact assessment
- Economic modelling for the NHS Health Check programme
- Costs and benefits of implementing the NHS Health Check programme
- NICE guidelines on prevention of CVD

## Communications, marketing and branding

- Department of Health order line
- Download NHS Health Check information leaflets
- Download NHS Health Check dementia leaflets
- Sample invitation letters

## Annex D. Relevant guidance

### Alcohol

- *Alcohol-use disorders: preventing harmful drinking*. NICE public health guideline 24. June 2010

### Diabetes and kidney disease

- *Use of Glycated Haemoglobin (HbA1c) in the Diagnosis of Diabetes Mellitus World Health Organization*. 2011. Abbreviated Report of a WHO Consultation. WHO/NMH/CHP/CPM/11.1.
- *Consensus statement: Use of haemoglobin A1c (HbA1c) in the diagnosis of diabetes mellitus*. The implementation of World Health Organisation (WHO) guidance 2011, Practical Diabetes, 2011, 1, 12a
- NICE public health guidance 38: *Preventing type 2 diabetes: risk identification and interventions for individuals at high risk*. July, 2012.
- *Type 2 diabetes: The management of type 2 diabetes*. NICE clinical guideline 87. May 2009
- *Diabetes in adults quality standard*. NICE quality standard 6. March 2011
- National Institute for Health and Care Excellence. *Chronic kidney disease: early identification and management of chronic kidney disease in adults in primary and secondary care*. National Institute for Health and Care Excellence. 2014.

### Hypertension

- *Hypertension: clinical management of primary hypertension in adults*. NICE clinical guideline 127. August 2011.
- *Quick reference guide. Hypertension: clinical management of primary hypertension in adults*. NICE. August 2011.

## Lipids

- *Lipid modification: Cardiovascular risk assessment and the modification of blood lipids for the primary and secondary prevention of cardiovascular disease.* NICE clinical guideline 181. July 2014.

## Physical Activity

- *Four commonly used methods to increase physical activity: brief interventions in primary care, exercise referral schemes, pedometers and community-based exercise programmes for walking and cycling.* NICE Public Health Guidance 2. March 2006.
- *Everybody Active, Every Day: An evidence-based approach to physical activity.* Public Health England. 2014
- *Exercise referral schemes to promote physical activity* – Recommendation 5 of PH2 is updated with PH54 September 2014
- *Physical activity: brief advice for adults in primary care.* NICE public health guidance 44. NICE Public Health Guidance 44. May 2013. . This supersedes recommendations 1-4 in Four commonly used methods to increase physical activity
- *Start Active, Stay Active. A report on physical activity for health from the four home countries' Chief Medical Officers.* Department of Health. July 2011.
- *Let's Get Moving: Commissioning Guidance* - A physical activity care pathway. Department of Health. March 2012.

## Point of care testing

- *Pathology quality assurance review; NHS England, 2014*
- *Management and Use of IVD Point of Care Test Devices.* Device Bulletin 2002(03). Medical Devices Agency. March 2002. The bulletin provides extensive guidance, including advice on clinical governance issues relating to the setting up and management of POCT, pathology and laboratory involvement, staff training, health and safety, standard operating procedures and quality issues.
- *Buyers' guide: Blood glucose systems.* Purchasing and Supply Agency, Centre for Evidence-based Purchasing. May 2008.

- *NHS Health Check programme standards: a framework for quality improvement.* Public Health England. February, 2014.

## Obesity

- *Obesity: guidance on the prevention, identification, assessment and management of overweight and obesity in adults and children.* NICE guideline CG43. December 2006
- *Overweight and obese adults – lifestyle weight management.* NICE guideline PH53. May 2014
- *Obesity: identification, assessment and management of overweight and obesity in children, young people and adults.* NICE guidance CH189. November 2014
- *Healthy Weight, Healthy Lives: A toolkit for developing local strategies.* National Heart Forum et al. October 2008. This toolkit was produced to help PCTs and local authorities plan, co-ordinate and implement comprehensive strategies to prevent and manage overweight and obesity.

## Smoking

- *Brief interventions and referral for smoking cessation in primary care and other settings.* NICE Public Health Intervention Guidance no.1. March 2006.
- *NCSCT local stop smoking services: service and delivery guidance – 2014.* September 2014. NCSCT.