1. Purpose

1.1 This service specification outlines the delivery requirements, terms and conditions for the Public Health Community Based Service for the NHS Health Checks Programme in Leicester City. By signing this agreement, the provider commits to delivering the NHS Health Check programme in compliance with all details presented in this service specification.

1.2 The Leicester City NHS Health Check programme should be delivered in accordance with the contractual and statutory requirements of the GMS /PMS /APMS contracts/agreements.

1.3 The provider must comply with all applicable statutory and other legal requirements and regulations, all relevant voluntary and compulsory codes of conduct, all relevant professional standards and all applicable National Health Service and City Council directives, guidelines and codes, as stipulated in this service specification.

1.4 If the provider ceases to be able to deliver the NHS Health Check programme in accordance with this specification, patients should have the opportunity to receive this service elsewhere. The alternative provider will be appointed by the commissioner. Furthermore, in this event, the provider would be expected to cooperate with the commissioner to ensure their commitment is fulfilled by proxy of the identified approved provider.

2. Contract Price and Payment Methods

2.1 Leicester City Council will be responsible for payments (see below) made to the accredited providers (see Section 5) for the complete delivery of NHS Health Checks (see Sections 3 and 4) within Leicester City for the duration of the Community Based Service (CBS) (see Section 1).

2.2 For full completion of this CBS (as detailed in this specification) the following payment structures and tariffs are applicable to individual providers (please note that these payment structures and tariffs are subject to change/review.)
<table>
<thead>
<tr>
<th>Activity</th>
<th>Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Checks delivered to the eligible population</td>
<td>£20</td>
</tr>
<tr>
<td>Management of high risk patients</td>
<td>£28</td>
</tr>
<tr>
<td>Incentive payments for achieving targets</td>
<td>£3.50</td>
</tr>
</tbody>
</table>

2.3 Costs related to delivering this specification that are not detailed in Section 2.2, will be met by the provider, unless otherwise agreed by the commissioner. All cost associated with the delivery of the Health Checks pathway (see Appendix A), including the infrastructure needed to access patients primary care records will be covered by the provider, unless otherwise stated by the commissioner.

2.4 It is the provider’s responsibility to ensure that the Commissioner has accurate and up to-date account details for activity payments related to this CBS for NHS Health Checks and the following terms and conditions apply:

- The commissioners will make payments to the awarded provider on a quarterly basis, in arrears of receipt of claims.
- All claims should be received by Commissioners within 14 days of the quarter.
- Commissioners require both an official invoice and an activity information (as specified in Section 4) when making payments for goods and services.
- Payment must be supported by all requested quarterly performance information (see Section 4).

2.5 All pathology costs incurred by providers for services associated with the NHS Health Checks process will be covered by the standard pathology arrangements.

2.6 Near patient testing is not compulsory, but will be supported in place of standard pathology services on the condition that providers are appropriately trained and satisfy all criteria (see Sections 4 and 5). The payment to the provider will not exceed that currently paid as part of standard pathology arrangements.

3. Service Delivery

This section will detail the service scope, the service delivery stages and the delivery pathway.

3.1 Scope of the service:

3.1.1 **AIM:** to reduce levels of Cardiovascular Disease (CVD) risk and associated premature mortality in Leicester City through primary care; ensuring systematic and proactive identification and management of patients with >20% risk of CVD event in next 10 years (based on a 10-year risk equation). This is in line with the 2008 NICE Guidance on vascular risk assessment.
3.1.2 **Objectives:** this aim will be delivered through effective implementation of the following stages:

1. Identification of those people who are eligible;
2. Continue to monitor the eligible population on a rolling basis by the use of a robust call/recall system;
3. Ensure that 100% of the provider’s eligible population are offered an NHS Health Check over a five year period from a baseline of 2013-14.
4. Risk assess and identify associated risk factors for a CVD event in the next 10 years for those in the eligible population;
5. Communication of results and level of risk to all people checked;
6. Management of risk for high, medium and low risk groups;
   - **High risk:** place those who are deemed at risk for any conditions identified at the NHS Health Check on management plans. Make every contact count (MECC) to provide brief interventions for lifestyle changes and if necessary refer such patients to lifestyle change services.
   - **Low to Medium risk:** MECC to provide brief interventions for lifestyle changes and if necessary refer such patients to lifestyle change services.
7. Ensure the specific information and data to be recorded in the patient’s lifelong record, held by their GP practice.

3.1.3 The providers will deliver this service to the eligible population only (see below). Payments will not be made for NHS Health Checks delivered to people who do not meet these eligibility criteria (see point 3.1.4).

3.1.4 Eligible population for NHS Health Checks in Leicester City are:

1. People aged 40 to 74 years old **AND**
2. Who have not previously been diagnosed with:
   - Coronary Heart Disease
   - Chronic Kidney Disease
   - Diabetes (ALL)
   - Hypertension (ALL)
   - Atrial Fibrillation
   - Transient Ischemic Attack
   - Familial Hypercholesterolemia
   - Heart Failure Peripheral Arterial Disease
   - Stroke
   - Patients on statins Palliative Care Patients /DALE
   - People who have had an NHS Health Check in the last five years and have been assessed as having a ≥20% of developing CVD over the next 10 years.

3.1.5 Providers will be expected to invite 100% of the total eligible population once every five years (from a baseline of 2013/14). The number of people an individual provider will need to invite each year will be given by the commissioner.

3.1.6 Providers will be expected to work independently and collaboratively with commissioners to demonstrate their commitment to on-going improvements and to meeting the national full roll out target of 75% of the ‘annually eligible population receiving a health check’.
3.2 Service delivery stage:

3.2.1 Stage One: invitation

There are two main methods for identifying the eligible population for an NHS Health Check. These are referred to as: **opportunistic invites** and **non-opportunistic invites**. Providers are expected to demonstrate the routine use of both methods in delivering this programme.

- **Opportunistic invites**: providers should opportunistically invite people to have an NHS Health Check and who meet the eligibility criteria (see Section 3.1.4). This could be through the point of access for alternative services (e.g. visit to GP practice for routine medical appointment).

- **Non-opportunistic invites**: providers will be expected to use the clinical systems available to them to identify the eligible population for NHS Health Checks. Using READ codes to interrogate the patient’s lifelong medical records (held in primary care) providers should methodically identify patients who meet the eligibility criteria (see Section 3.1.4)

3.2.2 Stage Two: Identifying the eligible population

- **Opportunistic invites**: people identified opportunistically should be filtered at the point of contact to ensure that they are eligible to proceed to an NHS Health Check. Filtering criteria should include:
  1. has not had a previous NHS Health Check in last 5 years;
  2. is registered with a Leicester City GP or resident in the City; **AND**
  3. meets the eligibility criteria (see Section 3.1.4)

- **Non-opportunistic invites**: providers should use their clinical systems to methodically identify eligible patients based on the specified criteria (see Section 3.1.4). Each year, one fifth of the total identified eligible population should be invited for an NHS Health Check either: verbally, by telephone, or by letter.

- Annual targets are presented and may be up-dated by the commissioner in line with national guidelines.

- When a person has been invited, attends or declines a health check, the provider must ensure this is recorded in the patients’ lifelong medical records using the appropriate READ codes (see Appendix B).

- When a patient receives an NHS Health Check the details of the check and subsequent results and risk management interventions must be recorded onto the patient’s lifelong records using the stipulated READ codes in Appendix B.

- When a patient is identified as High risk (using the national programme criteria which is currently >20% risk of a CVD event in the next 10 years) this must be recorded onto the patient’s lifelong records using the stipulated READ code in Appendix B.

- If the patient’s GP Practice is working with an external provider or another GP Practice, the host GP practice must gain recorded patient consent to share their contact details. This recorded consent must be provided to the commissioner upon
request. Alternatively, the host GP practice could send a letter to eligible patients, on behalf of the external provider or another GP practice, inviting the patient for a Health Check at the alternative venue.

3.2.3 Stage Three: the check

- Providers should ensure an NHS Health Check is a face to face consultation which is undertaken by an accredited clinician.

- All NHS Health Checks must use and ensure the collection of ALL the following patient details in order to assess their risk:
  1. Age
  2. Gender
  3. Recording of ethnicity and first language;
  4. Lipid profiling including cholesterol;
  5. Blood pressure recording;
  6. Pulse reading to check for Atrial Fibrillation (AF);
  7. ECG if pulse is irregular;
  8. Measurement of Body Mass Index (BMI);
  9. Make use of diabetes filter (use BMI (adjusted for ethnicity) and blood pressure to identify people at high risk of diabetes) to undertake blood sugar tests for high risk diabetic patients;
  10. Vascular dementia awareness raising for those NHS Health Check patients aged 65 to 74 years (Appendix C: FAQ sheet on the new dementia component and Appendix D: national leaflet);
  11. Alcohol related risk reduction using the initial three questions of the Alcohol Use Disorder Identification Test (AUDIT)-C tool (see Appendix E). Patients who are identified as higher risk using the AUDIT-C tool should feed into an extended assessment using the Full AUDIT tool, for those delivering the alcohol-related risk reduction community based service, or given brief advice about alcohol risk (Appendix F)
  12. Recording of smoking status;
  13. Recording of physical activity levels;
  14. Recording of family history of CHD in a first degree relative;
  15. Explanation of CVD risk and risk score;
  16. Lifestyle review and discussion of appropriate lifestyle factors.
  17. HbA1c Blood test

- All elements of the check (as outlined above), must be delivered in full accordance with the most recent NICE clinical guidance or guidelines.

- Providers must ensure that the clinicians delivering the NHS Health Check are aware and implementing the most recent NICE clinical governance and guidelines for all the elements identified above.
• Results will be deemed valid for all tests performed in the six months prior to the date of the patients’ initial NHS Health Check appointment.

3.2.4 Stage Four: Review and action assessment results:

• The review and action stage for ALL patients having had a check should include:

  1. Review and action blood tests as they become available;
  2. Review assessment information and risk score and action follow up
  3. Response to abnormal clinical findings e.g. very high BP;
  4. Refer or extend patients assessment to feed into other community based/specialist services (e.g. NHS England Dementia DES, Leicester City Council alcohol related risk reduction scheme community based service);
  5. Commence relevant medication should patients be found to need treatment;
  6. Follow up and titrate medication should treatment be required.

• Review and action stage: patients with <20% low to medium risk: ensure the following guidance, pharmacological management and lifestyle advice is provided (as appropriate) for those patients with a CVD risk score of <20% (i.e. low to medium risk):

  1. Explain the patients risk score related to risk factors, including their BMI, cholesterol level, blood pressure and Audit C score.
  2. Manage any other conditions found incidentally (e.g. CKD or non-vascular dementia).

• Use making every contact count (MECC) approach to provide brief interventions for lifestyle changes, including (but not exclusive to):

  1. Provide information about reducing modifiable risk factor(s) and signpost to appropriate community based lifestyle support services such as weight management services; exercise on referral and/or stop smoking services.
  2. Encourage patients to develop a behaviour change action plan and to set manageable goals in order to adopt and maintain a healthier lifestyle.

• Review and action stage: ≥20% High risk: ensure the following guidance, pharmacological management and lifestyle advice is provided (as appropriate) for those patients with a CVD risk score of ≥20% (i.e. high risk):

  1. Explain the patients risk score related to risk factors, including their BMI, cholesterol level, blood pressure and Audit C score.
  2. Recommend commencing the use of statins, regardless of cholesterol level, with advice unless contra-indicated or declined;
  3. Recommend commence anti-hypertensive treatment indicated (Use of 24 hour ambulatory BP monitoring (ABPM) as the
preferred method of diagnosing primary hypertension); 
4. Manage any other conditions found incidentally (e.g. CKD or non-vascular dementia) as per normal clinical Provider; 
5. Patients found to be diabetic should be offered referral to the DESMOND programme; 
6. Provide appropriate management for patients with high CVD risk through pharmacological management, relevant referrals and lifestyle improvements. 
7. Use making every contact count (MECC) approach to provide brief interventions for lifestyle changes, including (but not exclusive to): 
   1. Provide information about reducing modifiable risk factor(s) and signpost to appropriate community based lifestyle support services such as weight management services; exercise on referral and/ or stop smoking services. 
   2. Encourage patients to develop a behaviour change action plan and to set manageable goals in order to adopt and maintain a healthier lifestyle.

3.2.5 Stage Five: Recording the check 
1. The provider should use the NHS Health Checks template when provided by the commissioner to ensure an accurate recording of the Patients Health Check status. 
2. It is the provider’s responsibility to ensure the patient’s lifelong medical records held in primary care are up-dated within two working days of the health check using the stipulated READ codes in order to reflect their NHS Health Check status and other subsequent activities resultant from their check. 
3. When the provider does not have direct access to the patient’s life long medical records it is their responsibility to ensure the recorded patients details are securely provided to their appropriate GP practice and uploaded within two days of being check. 
4. Methods to deliver point 3 in Section 3.2.5, mainly relevant to non-GP providers, should be approved in advance of use by commissioners and fully compliant with the NHS Health Check information governance and data flow guidance (2014) http://www.healthcheck.nhs.uk/commissioners_and_healthcare_professionals/national_guidance/ 
5. The provider will also cover the costs for all activities described in Section 3.2.5 and the cost of possible subsequent activity.
3.3 service delivery pathway:
The NHS Health Check programme delivery in Leicester City should follow the outlined pathway in Appendix A.

The service provider will provide the health checks program in accordance with nationally issued guidance\(^1\) will adhere to all stipulations contained within that guidance.

It will be the choice of the service provider how to split the eligible population into what percentage of the practice's eligible population are offered health checks each year.

It should be noted from experience however and service providers should be aware that patients will become progressively harder to engage and so Providers should ensure adequate time and resource is available to guarantee that the most difficult to reach patients are provided for.

However, this is not mandated and the requirement is that 100% of the eligible populated have been offered a health check at the end of the 5 year period.

It will be left at the discretion of individual service provider(s) as to how exactly the health checks are offered to patients, i.e. what media will be used to contact them (such as e-mails, texts, letters, etc. or a combination thereof).

The service provider(s) will:
- Accept referrals from primary care, all healthcare professionals and relevant stakeholders.
- Accept eligible self-referrals.
- Make onward referrals to other relevant health and social care services where appropriate. E.g. STOP!

Specifically, the service provider will undertake the following activities:
- The service provider will ensure that health checks are offered to its entire eligible population (as described in Section 3.1.4) over the 5 year period of the contract.
- Undertake the health checks as specified in the National Guidance\(^2\) to included updated guidance on alcohol awareness testing using the AUDIT-C tool, and dementia awareness and, where appropriate, signposting.
- Record; the number of health checks offered and by what means, the number of health checks undertaken and the number of patients as the result of the health check placed on management plans. This should be recorded within the SystmOne management system or some other such suitable record management system.
- Create (and maintain) a robust call and recall system so that all eligible patients are offered a health check every 5 years, on a rolling basis.


• Ensure that those patients placed on a management plans are given appropriate treatment for their conditions and removed from the list of eligible patients requiring health checks.
• The service provider will proactively promote the health checks program to those who meet the eligibility criteria.

4. Service Criteria

This section will detail the necessary equipment, resources, and performance monitoring and auditing tools.

General

• Providers will be expected to be able to demonstrate a clear knowledge and understanding of the local patient population that they will be delivering health checks to.

4.1 Equipment and Resources:

• Providers of the NHS Health Check programme are responsible for the provision, quality and standards relating to all premises, staffing, equipment and consumables required to deliver this service.

• Providers will ensure suitable premises for the completion of an NHS Health Check ensuring patient dignity; privacy and care are supreme and that clinical standards are maintained (See sections 4 and 5).

• Providers will provide suitable equipment to identify, conduct the full assessment of patients, record their status of delivery on their lifelong medical records and deliver their risk management or referrals, if necessary. For example, BP machine, scales, access to a safe consultation room with a computer, consumables relevant to that of the role of CVD Risk Assessment Clinician e.g. blood-taking paraphernalia, sharps box, etc. and access to primary care records.

• Providers will ensure that all equipment used is maintained and calibrated in accordance with the manufacturers’ guidelines and meet the cost of this (See section 2.4).

• Providers will ensure the service will be structured with consideration to clinical governance issues where appropriate including:
  1. Clear lines of responsibility and accountability;
  2. Participation in quality improvement activities where appropriate;
  3. Adherence to policies and procedures, and consideration given to risk management;
  4. A commitment to further training for staff where necessary and maintenance of skills;
  5. Procedures for all professional groups to identify and remedy poor performance;
  6. The use of clinical guidelines is considered to be consistent with good
Clinical practice.

- The Commissioner requires that the provider lead (see Section 3.2.1) ensures Health Check services are properly led and supervised both clinically and managerially, in line with National Quality Board guidelines (2012) and the NHS Health Check Guidance (2012).

- Provide appropriate administrative support ensuring:
  1. Administrative support is set up to access clinical systems and issue patient invitations and any reminders or appropriate follow up appointments;
  2. Each person from the list of patients identified for a full assessment under this specification are invite at least once over a five year period and this attempt should be recorded in the patient's lifelong record;
  3. Access to paper/envelopes/stamps and telephone to contact patients identified and follow-up any patients.

- Provider should maintain a register of all eligible patients and include the patient's name; identification number and other relevant information to the service (see Section 3.2.3). This information must also be included within the patient's lifelong medical record.

- Any marketing communications (e.g. promotions or advertising) implemented by the provider must be in full compliance with the NHS Health Checks identify guidelines (March 2014) http://www.healthcheck.nhs.uk/commissioners_and_healthcare_professionals/marketing_and_branding/

- It is the provider responsibility to order and use relevant leaflets for NHS Health Checks programme and specific elements of the check (e.g. vascular dementia awareness). These are available from: http://www.healthcheck.nhs.uk/commissioners_and_healthcare_professionals/national_resources_and_training_development_tools/dementia_resources/

Providers of the NHS Health Check programme should use the READ Codes stated in Appendix B.

4.2 Performance Monitoring and Auditing:

- The commissioner shall, at all times, have the right to inspect, monitor and evaluate compliance with all aspects of this agreement by the providers.
- Performance, monitoring and auditing of Providers will be implemented using the standard READ codes (See Appendix B) for NHS Health Check, as detailed in this specification.
- It is the Providers responsibility to ensure they use the correct and accurate READ codes for all elements relating to NHS Health Checks to avoid unnecessary delays in payments or additional auditing.
- Providers will generate and submit quarterly reports using the community based
service claim form. These reports will identify the total number of patients:

1. **Total number (and percentage) of people who have been offered a Health Check each quarter.**
2. **Total number (and percentage) who took up the offer of Health Check each quarter.**
3. **Total number (and percentage) of people who are placed on a management plan as a result of the Health Check.**
4. **Broad Demographic information to include:**
   - a. The ethnicity of 1-3 above – percentage.
   - b. The gender of 1-3 above – percentage.
   - c. The age of 1-3 above broken down by 5 year age bracket.
5. **Total number (and percentage) of people who received an NHS Health Check and who were also identified as high risk each quarter.**
6. **Total number (and percentage) of people who have declined an NHS Health Check each quarter.**

- Regional performance indicators are submitted to Public Health England on a quarterly basis, providers will ensure the requested information for this submission is provided to the commissioner accurately and within the stated timescales.
- The results Leicester City, the East Midlands region and England as an average are available on-line: [www.healthcheck.nhs.uk/interactive_map/midlands_and_east_of_england/east_midlands/?la=Leicestershire&laid=41](http://www.healthcheck.nhs.uk/interactive_map/midlands_and_east_of_england/east_midlands/?la=Leicestershire&laid=41)
- The commissioner will provide IT query to gather appropriate existing READ codes stipulated in this service specification, for predefined variable. This query will be run by either by the Provider or by an approved NHS organisation, if they provider would prefer.
- The indicators gathered for this audit would include but not be exclusive READ codes details under the indicators listed in Appendix B.
- An intermediate step will be implemented to ensure all data provider submitted to the commissioner is not patient identifiable. This process will be fully compliant with the NHS Health Check information governance and data flow guidance (2014) [http://www.healthcheck.nhs.uk/commissioners_and_healthcare_professionals/national_guidance/](http://www.healthcheck.nhs.uk/commissioners_and_healthcare_professionals/national_guidance/) and approved by the Caldecott Guardian(s) of the relevant CCGs. Providers will ensure there are effective methods for gaining, collating reporting the views and experiences of their patients/ service users.

### Quality Outcome Indicators
- A high quality programme must:
  - monitor the delivery of national standards that cover the entire pathway, defined here as identification of the eligible population through to their exit from the programme either by turning 75 years old, dying, moving outside of England, or receiving a diagnosis that means they are no longer eligible for the programme
  - have robust failsafe procedures to identify problems early thereby minimising harm and error
  - support and underpin improvements in delivery by professionals and providers, and through liaison with commissioners
  - reduce risks by ensuring that errors are dealt with competently, that lessons are learnt and that there are robust, documented, processes to allow serious incidents to be identified and subsequently managed
  - have robust information systems to collect a standard dataset, sufficient for
the comparison of programmes and to benchmark performance against agreed national key performance indicators
  
  - ensure a coherent and explicit programme of quality improvement related activities including processes that ensure the effective sharing of lessons learnt.

- The National Quality Standards for the NHS Health Check programme that providers are expected to adhere to are specified in: http://www.healthcheck.nhs.uk/news/nhs_health_check_programme_standards_launched/

- The stipulated indicators are listed below and a clear description and rational for each standard is stipulated within the guidance.

- The Commissioners will review the quarterly monitoring reports and will have a discussion if required with the Service Provider to ensure output is achieved. Action may also be taken under the contract management provisions of the contract (clause B29).

<table>
<thead>
<tr>
<th>Standard</th>
<th>Measured By</th>
<th>Supporting Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>1  Identifying the eligible population and offering an NHS Health Check</td>
<td>The acceptable threshold for these indicators are: 100% of the eligible population invited every five years Target &gt;75% take up.</td>
<td>Recording on clinical system extract or submission. Periodic external audit</td>
</tr>
<tr>
<td>2  Consistent approach to non-responders and those who did not attend their risk assessment appointment</td>
<td>2a. Proportion recorded as do not respond. 2b. Proportion recorded as DNA. 2c. Proportion of these individuals recalled in five years, if they remain eligible.</td>
<td>Recording on clinical system extract or submission. Periodic external audit</td>
</tr>
<tr>
<td>3  Ensuring a complete health check for those who accept the offer is undertaken and recorded</td>
<td>3a. Proportion of those who accept the offer that receives a complete NHS Health Check with all indicators listed above recorded at the time of delivery.</td>
<td>Recording on clinical system extract or submission. Periodic external audit</td>
</tr>
<tr>
<td>4  Equipment use</td>
<td>TBC</td>
<td>TBC</td>
</tr>
<tr>
<td>5  Quality control of point of care testing (if used)</td>
<td>Proportion of providers using POCT that can</td>
<td>Submitted documentation</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>6</td>
<td>Ensuring results are communicated effectively and recorded</td>
<td>demonstrate the four criteria in place (as outlined in the national guidance document p19)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>6a. Proportion of NHS health checks undertaken where cardiovascular risk score, BMI, cholesterol level, blood pressure and alcohol use score (AUDIT C or FAST) score is communicated face to face. 6b. Proportion of NHS health checks undertaken where written, tailored information is provided at the same time.</td>
</tr>
<tr>
<td>7</td>
<td>High quality and timely lifestyle advice given to all</td>
<td>7a. Proportion of NHS Health Checks undertaken where record exists that brief advice provided. 7b. Proportion of NHS Health Checks undertaken where referral to lifestyle intervention is made, where appropriate. 7c. Proportion of individuals where a record of outcome following lifestyle intervention is available (ie, four-week smoking quit/ 5% reduction in body weight)</td>
</tr>
<tr>
<td>8</td>
<td>Additional testing and clinical follow up</td>
<td>Where thresholds met: 8a. Proportion of individuals with investigations undertaken 8b. Proportion of individuals with outcome recorded</td>
</tr>
<tr>
<td>9</td>
<td>Appropriate follow up for all CVD risk assessed as 20% and greater</td>
<td>9a. Proportion of those identified with a CVD risk of 20% and greater managed according to NICE guidelines.</td>
</tr>
</tbody>
</table>
10 Confidential and timely transfer of patient identifiable data (where applicable) 10a. Proportion of non-GP service providers that send data to the relevant GP practice in a timely way (the suggested expectation is within two working days). 10b. Proportion of GP practices that then record these results on their clinical systems Provider submissions Recording on clinical system extract or submission. Periodic external audit

- Audits will be conducted to ensure providers are delivering the NHS Health Check programme in accordance with the National Quality Standards for the programme.

5. Accreditation

5.1 The Provider must satisfy the Commissioner that all health care professionals are appropriately accredited and trained to provide the services detailed in this Service Specification and can meet the Service Criteria as detailed in Sections 3 and 4.

5.2 Providers must ensure that:

- Health care professionals providing the service hold membership of an approved professional body and are approved and included on a performers list within England;
- Health care professionals have regular appraisal and maintain professional development
- All relevant staff should receive appropriate training to ensure safe and competent delivery of the Health Checks service. Online training available at: [http://learning.wm.hee.nhs.uk/course/health-check](http://learning.wm.hee.nhs.uk/course/health-check)
- Up-to-date certifications of competency must be maintained and may be requested by the Commissioner.

5.3 Following any service review process carried out, providers may be required to undertake any identified refresher training which is deemed necessary by Commissioners to enable them to continue service provision.

5.4 The Provider will ensure all health care professionals are compliant with the Provider protocols for the clinical management of all patients in receipt of services commissioned. These protocols must be in line with best Provider clinical guidelines and be reviewed on a regular basis. The Provider must ensure that all protocols reflect up-to-date national and local guidance and are amended in the light of any
changes.

5.5 Health care professionals delivering the NHS Health Check consultation should be able to evidence successfully completing training for making every contact count (MECC) and vascular dementia awareness. On-line training is available at:

- MECC http://www.makingeverycontactcount.co.uk/
- Dementia http://www.healthcheck.nhs.uk/commissioners_and_healthcare_professionals/national_resources_and_training_development_tools/dementia_resources/

5.6 Providers must ensure that all necessary Indemnity Insurances are in place for the undertaking of Health checks.

5.7 The commissioner reserves the right to request evidence of said accreditations at any time for the duration of the contract (see Section 1).

5.8 Oversight of the performance of the Health Check programme will be through the local authority Quality and Clinical Governance Board reporting to the Health and Wellbeing Board.

6. Excluded Services

In general the service should not be provided to patients who lie outside the eligibility criteria outlined in section 3.1.4.

7. Appendices
Appendix (A) – Pathway

The following figure shows the NHS Health Check pathway. There are two main methods for identifying the target population. These are referred to as: opportunistic invites and non-opportunistic invites.

Target Population = 40 to 74 Years
Exclusions:
1. Diabetes
2. IHD
3. TIA / CVA
4. Familial Hypercholesterolemia
5. Previous NHS Health check
6. Hypertension diagnosed before 1st April 2009

HISTORY:
1. Ethnicity
2. Family History
3. Lifestyle

Measurements:
1. Height
2. Weight
3. Blood Pressure

Blood Tests:
1. Lipids
2. U&E
3. Hbac1
4. BS

Lifestyle Advice & GEN VASC Study

CVD Score

> 20% ?

No

Isolated Risk Factors?

No

Yes

Hypertension or Diabetes or Hyperlipidaemia or AF or IHD?

No

Yes

GP Examination

Management Plan

Claim1

Claim2

Normal Recall

END
## Appendix (B) – NHS HEALTH CHECK READ CODES

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Clinical Term</th>
<th>5 byte</th>
<th>Version 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Invitation</td>
<td>(Invitation to patients) At high risk of CVD monitoring – letter invite</td>
<td>9mC%</td>
<td>XaRBR% or XaNOi</td>
</tr>
<tr>
<td>XaPI0</td>
<td>(Invitation to patients) At high risk of CVD monitoring – phone invite</td>
<td>9mC%</td>
<td>XaRBR% or XaNOh</td>
</tr>
<tr>
<td>Assessment</td>
<td>CVD risk assessment completed – 10 year value</td>
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**Dementia awareness raising**

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**Referral**

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**Plan**

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Appendix C: Frequently Asked Question: Dementia awareness component of the NHS Health Check

Appendix D: Health Check National Leaflet Dementia

Appendix E: AUDIT-C first three questions

Appendix F: Leaflet supporting Alcohol Brief Advice