NHS HEALTH CHECK SERVICE SPECIFICATION

Service Specification No.	Lot 1
Service	Provision of NHS Health Check Programme
Authority Lead	Angela Odell, Public Health, Derby City Council
Period	1st April 2022 – 31st March 2025 (with optional extension 1 + 1 year)
Date of Review	1st April 2023
Supporting/Additional Documentation	Appendix A: Training & Resources Appendix B: Read Codes for monitoring reports Appendix C: Relevant guidance Appendix D: Glossary of Terms and Abbreviations

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1. Background and context

1.1 Introduction

This Specification sets out the requirements for the provision of the NHS Health Check Programme 2022 to 2025. The Council is seeking to appoint Service Providers for the delivery and management of the NHS Health Check Programme for a period of three years from 1st April 2022, with the option to extend for a further two 12-month periods subject to satisfactory performance.

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

The NHS Health Check is a prevention programme which aims to reduce the chance of a heart attack, stroke or developing some forms of dementia in people aged 40-74. It achieves this by assessing the top seven risk factors driving the burden of noncommunicable disease in England, and by providing individuals with behavioural support and, where appropriate, pharmacological treatment. The seven modifiable risk factors for CVD are:

1. High blood pressure
2. Smoking
3. Cholesterol
4. Obesity
5. Poor diet
6. Physical inactivity
7. Alcohol consumption

With any provision of service, consideration must be given to addressing inequalities in health. This Service provides an opportunity to narrow the inequalities gap by providing services not only to the mainstream population but also to those disadvantaged groups with poor health outcomes.

1.2 National and Local context

The Government and NHS continue to recognise the importance of CVD prevention and the opportunity that the NHS Health Check offers to support this. In 2018 PHE published its action plan and future commitments in the CVD prevention initiatives[1] publication and its National CVD prevention ambitions in 2019[2].

In 2019 NHS England's Long-term plan[3] confirmed its commitment to the broader CVD prevention agenda which included working with local authorities and PHE to improve the effectiveness of approaches such as the NHS Health Check. The Long-term plan also committed to a doubling of the Healthier You diabetes prevention programme over the next five years. The NHS Health Check programme has a key role to play in supporting the implementation of this service. It provides a systematic mechanism, delivered across England, for identifying people who would benefit from the diabetes prevention service.

The Prevention Green Paper recognises that the programme has achieved a great amount over the last 10 years and sets out the Government's intention to maximise its impact over the next 10 years[4].

Additionally, the Government set its ambition to ensure that people can enjoy at least five years of healthy extra life by 2035, while narrowing the gap between the richest and the poorest[5].

Reducing avoidable premature mortality is a key health priority in Derby City. Through the early identification and management of risk factors and early detection of disease the NHS Health Check will help achieve the ambitions set out in:

- Derby City Council Plan 2019 – 2023
- Joined Up Care Derbyshire STP Plan (refreshed 2019)
- Health and Wellbeing Strategy Derby City (refreshed 2019)
- Derby Tobacco Control Plan 2020 - 2025
- The Move More Derby Strategy 2018 - 2023

Derby is a small, culturally diverse city with a population of 257,302 and an eligible health check population of around 93,000. Approximately 25% of Derby's population are from ethnic minority communities, with its largest ethnic group comprised of Asian/Asian British individuals. Within this group, the Pakistani community represent the largest BME group in Derby (5.9%), and the Indian community represent 4.4%. One-hundred and eighty-two nationalities are known to be represented, speaking 71 languages with 83 distinct dialects.

Derby's ethnic diversity is mirrored by its great variations in levels of deprivation. Overall, the city is within the 30% most deprived areas in the country. Pockets of deprivation are mainly concentrated to the city centre Arboretum and Normanton wards, but also to the more suburban wards of Sinfin and Alvaston. Incidentally these are also within the top 10% most deprived areas in England. These wards are characterised by high rates of unemployment and households with a lower than average annual income. Conversely, Allestree and Mickleover wards are amongst the least deprived 10% of wards in the country. This unfortunately translates into vast health inequalities within Derby (see Figure 1).

Those in the most deprived 10% of the population are almost twice as likely to die as a result of CVD than those in the least deprived 10% of the population. Supporting the residents of Derby to stop smoking and to develop healthy attitudes and practices around nutrition, exercise and alcohol consumption will impact on the rates of preventable and premature deaths locally.

[1] Public Health England. CVD prevention initiatives. 2018 [Available from www.healthcheck.nhs.uk/search-results/?search=prevention+initiatives&submit=]

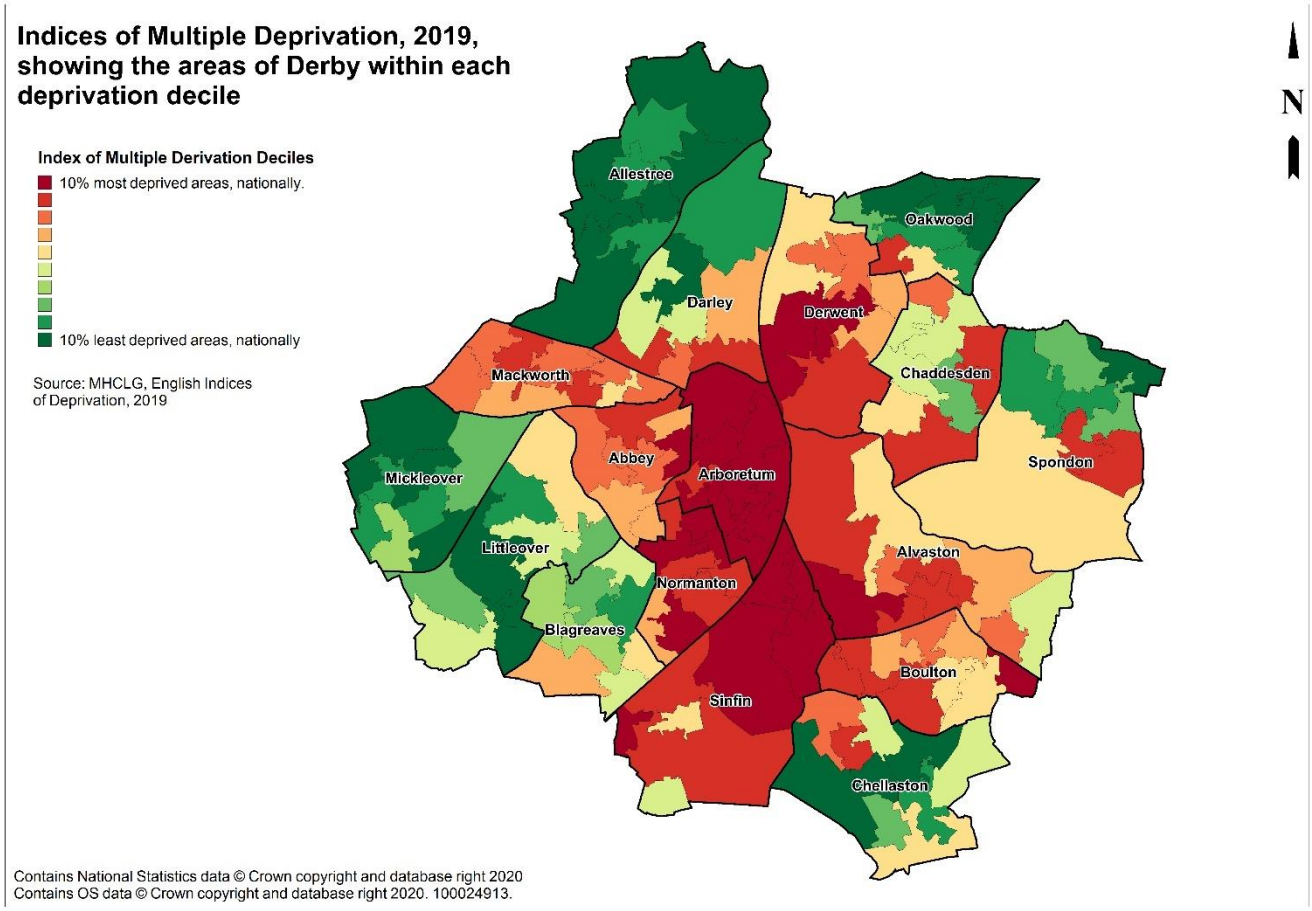
[2] Public Health England. Ambitions set to address major causes of cardiovascular disease. 2019. [Available from www.publichealthmatters.blog.gov.uk/2019/02/14/healthmatters-preventing-cardiovascular-disease/]

[3] National Health Service (NHS). NHS Long Term Plan. 2019. [Available from www.longtermplan.nhs.uk/] 11. Department for Business, Energy and Industrial Strategy.The grand challenges. 2019. [Available from www.gov.uk/government/publications/industrial-strategythe-grand-challenges/industrial-strategy-the-grand-challenges#ageing-society]

[4] Department of Health and Social Care. Advancing our health: prevention in the 2020s. 2019. [Available from www.gov.uk/government/consultations/advancingour-health-prevention-in-the-2020s/advancing-our-health-prevention-in-the2020s-consultation-document]

[5] Department for Business, Energy and Industrial Strategy. The grand challenges. 2019. [Available from www.gov.uk/government/publications/industrial-strategy[1]the-grand-challenges/industrial-strategy-the-grand-challenges#ageing-society

Figure 1 shows a map of the deprivation across the city.



1.3 Evidence Base

Whilst we may be living longer, we are not necessarily living healthier for longer. There is a rising trend of people living with one or more long term health condition, the cost of which is significant, amounting to 70% of the total health and social care budget[6]. The risk to a person's health increases directly with the number of risk factors, including unhealthy behaviours. 70% of adults in England report two or more unhealthy behaviours, with the poorest communities disproportionately affected. An adult in mid-life who smokes, drinks above low risk levels, is inactive and eats unhealthily is four times more likely to die in the next 10 years than someone who does none of these things[7].

The global burden of disease study shows that many long-term conditions can be avoided and that 85% of CVD is preventable[8]. Increasing physical activity levels, stopping smoking, maintaining a healthy weight and low risk levels of alcohol consumption all help reduce the risk of cardiovascular disease (CVD).

6 Department of Health and Social Care. Long Term Conditions Compendium of Information Third Edition. 2012

7 The Kings Fund.Tackling multiple unhealthy risk factors: Emerging lessons from practice. 2018

8 Global Burden of Disease Study. Institute for Health Metrics and Evaluation. 2017

Nationally it is estimated that the Health Check Programme will save at least 650 lives annually, prevent 1,600 heart attacks and strokes, and prevent 4,000 cases of diabetes. At least 20,000 cases of diabetes or kidney disease could be detected earlier, allowing individuals to be better managed to improve their quality of life. The estimated cost per quality adjusted life year (QALY) is approximately £3,000.

2. Key service outcomes

2.1 Key service outcomes

The Service Provider will ensure that the most appropriate mix of invitation methods are used to encourage uptake of the programme with a focus to increase uptake amongst deprived and disproportionately disadvantaged groups.

The Service Provider will provide an accessible Service for working individuals by offering appointment times which include evening and/or weekend appointments for an NHS Health Check.

The Service Provider will deliver tailored face-to-face feedback for each individual on their future risk of cardiovascular disease. In addition to the appropriate medical management of risk this will include advice on lifestyle and referral to local lifestyle interventions as appropriate.

The Service will contribute to achievement on the following outcomes from the Public Health Outcomes Framework:

- Mortality rate from causes considered preventable (E03)
- Under 75 mortality rate from all cardiovascular diseases (including heart disease and stroke) (E04)
- Excess weight in adults (C16)
- Physically active and inactive adults (C17)
- Prevalence of smoking - adults (over 18s) (C18)
- Take up of the NHS Health Check programme – by those eligible (C26)
- Alcohol-related admissions to hospital (C21)

3. Scope

Aims and objectives of Service

3.1 Overall aim

This service aims to improve the health outcomes and quality of life amongst Derby City residents by identifying individuals at an earlier stage of vascular change. It provides opportunities to empower them to substantially reduce their risk of cardiovascular morbidity or mortality. In turn this will lead to a reduction in the incidence of acute cardiovascular events in the Derby population.

3.2 Objectives

- To offer an NHS Health Check to 20% of the eligible population every year with an uptake level of 50-75%
- To enable the early detection of hypertension
- To enable the prevention and early detection of diabetes
- To enable the early detection of chronic kidney disease
- To identify individuals with a high risk of future cardiovascular disease
- To initiate the appropriate medical management of newly diagnosed chronic diseases
- To identify levels of potentially harmful drinking
- To increase population level awareness of dementia specifically among 65 to 74 year olds
- To work collaboratively with individuals whom require lifestyle modification and offer them on-going support through referral to one or more of the following local lifestyle intervention:
    - Livewell Lifestyle Service
    - National Diabetes Prevention Programme

The NHS Health Check programme links into a number of high-level priorities in primary care. The registration and on-going management of new patients with vascular disease will contribute to current Quality and Outcomes Framework (QOF) indicators.

3.3 Service description

This Specification will continually be reviewed in line with national recommendations in order to ensure adherence with best practice, quality assurance standards and national and local requirements.

Figure 2: NHS Health Check pathway

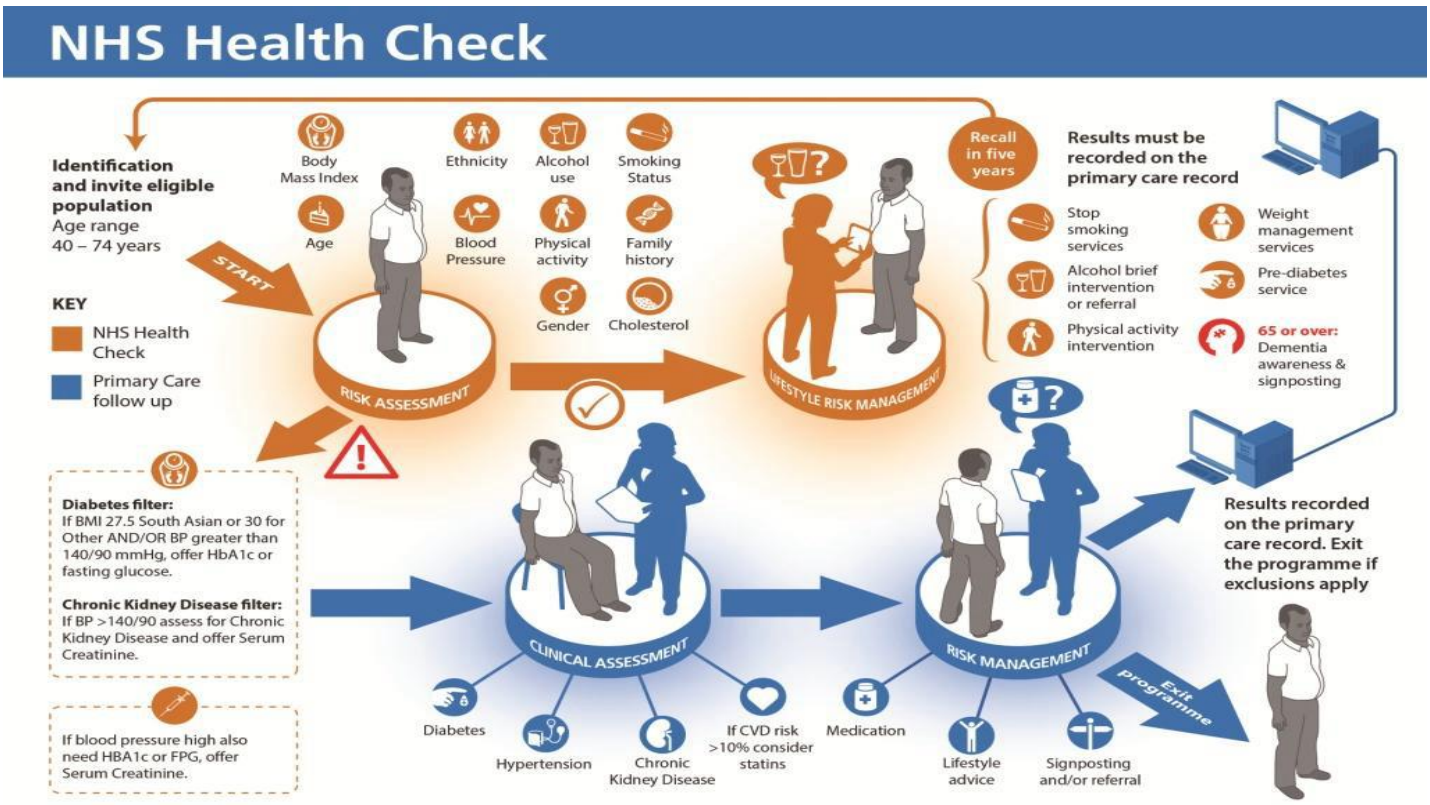
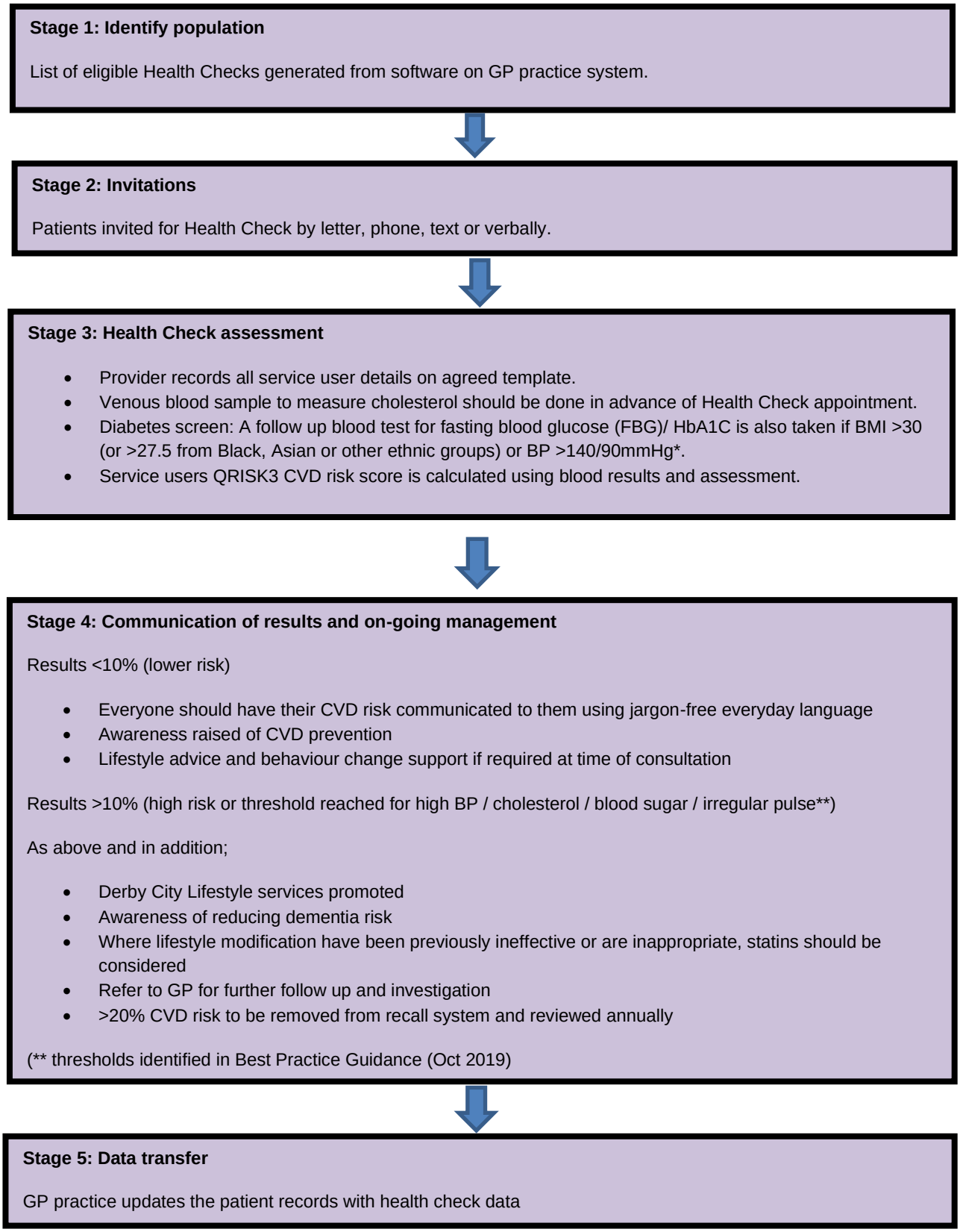


Figure 3: Stages of the NHS Health Check



3.4 Stage 1: Identify eligible population

The Service Provider will record patient information concerning invitation, risk assessment and risk management using the standardised clinical data template, as defined by Derby City Council. The IT software installed on GP systems will provide each Practice with a list of their target population to invite in order of highest QRisk scores.

Eligibility criteria

The regulations state that people aged 40 – 74 years who do not have any of the following conditions are eligible for a check:

- Coronary heart disease
- Chronic kidney disease (CKD), which has been classified as stage 3, 4 or 5 within the meaning of the national institute for health and care excellence (nice) clinical guideline 182 on CKD
- Diabetes
- Hypertension
- Atrial fibrillation
- Transient ischaemic attack
- Hypercholesterolemia – defined as familial hypercholesterolemia
- Heart failure
- Peripheral arterial disease
- Stroke
- Is currently being prescribed statins for the purpose of lowering cholesterol
- People who have previously had an NHS health check, or any other check undertaken through the health service in England, and found to have a 20% or higher risk of developing cardiovascular disease over the next ten years

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

3.5 Stage 2: Inviting eligible population

To successfully invite the eligible population, the Service Provider will operate a call/recall process that ensures that every eligible Patient in the practice cohort is invited to have an NHS Health Check once every five years.

The Service Provider will make up to two attempts to invite Patients for a Health Check with approximately a month in between invitations. Service Providers can decide on the optimal call and recall strategy, including for example writing to Patients, email*, or contacting patients by telephone**. If inviting Patients by phone, this should be followed up with a written confirmation, including details of the venue, and a copy of the DH Health Check leaflet.
A text message is allowed as a second invitation if the patient has received a previous letter/email with the information leaflet about the programme.

*An email can only be used as an invitation if the Patient has specifically identified it as a preferred method of contact. The email should also include an attachment of the NHS Health Check leaflet.

** A telephone call attempt should be made at least twice at different times of the day. If there is no contact made with the patient, they have not been invited and therefore a letter would still be required as a second invitation.

Any first invitation should be coded as a 'First letter invite'. **Any** second invitation should be coded as 'second letter invite' (see full list of read codes in Appendix B).

If both invitation attempts fail to get a response, then the Patients should be coded as a 'non responder'. This Patient will then be re-entered into the system and invited again in 5 years. If a Patient actively declines or DNAs, the Patient should be coded as 'decline' or 'DNA' as appropriate. These Patients will also be invited again in 5 years.

If a Patient has a health check opportunistically, this must still have a 'first letter' invitation read code.

The NHS Health Checks lead will provide advice and information on how to order Patient information leaflets and other promotional materials to be used for the programme.

The Service Provider will offer patients a choice of appointments for the initial risk assessment. All attempts to contact Patients will be recorded using the agreed local template.

The Service Provider must order and maintain supplies of the DH leaflets to send out with letters of invitation and appointment confirmations. Orders are made directly from the Department of Health order line.[9]

Consent – medical services

Those involved with administering the NHS Health Check must understand the nature, risks and benefits associated with the NHS Health Check itself. Consent for an NHS Health Check should be voluntary and informed. The recording of consent should fit the environment the NHS Health Check is delivered in. In a clinical setting this can be verbal consent, whereas outside a clinical setting consent should be recorded.

Consent – data transfer

Those involved with administering the NHS Health Check must understand how data is transferred and shared. They should also be able to effectively communicate this to the public. In general, the individual should be informed of:

a. how their information is being recorded and retained
b. the kind of information sharing that will occur and the protections in place to ensure non-disclosure of their information

This information should be found in the organisation's Privacy Notice.

[9] http://www.orderline.dh.gov.uk/ecom_dh/public/home.jsf

3.6 Stage 3: NHS Health Check assessment

All Patients will receive a standard risk assessment as described below. In addition, some Patients will require further risk assessments for diabetes, hypertension or chronic kidney disease.

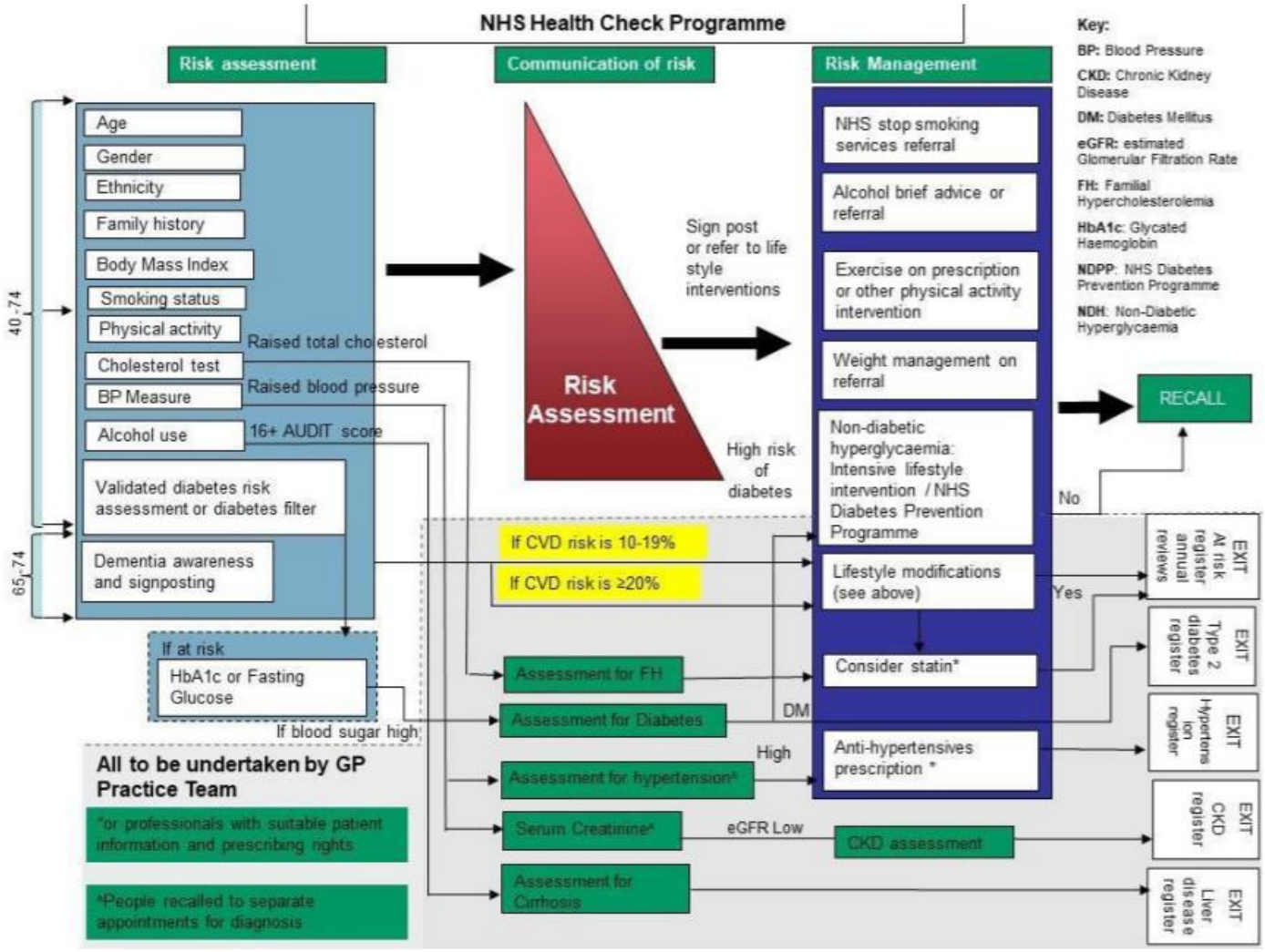
Standard Risk assessment:

The Service Provider will assess and record the following information, on the agreed local template, for ALL eligible patients who attend for an NHS Health Check:

- Age
- Gender
- Ethnicity
- Smoking status
- Family history of coronary heart disease (history of CHD in first-degree relative under 60 years)
- Level of physical activity (GPPAQ questionnaire)
- Body Mass Index (BMI)
- Pulse check to detect atrial fibrillation
- Blood pressure measurement (systolic and diastolic)
- Initial alcohol screening test (AUDIT-C or FAST)
- Blood test for random total cholesterol and HDL (either point of care sample or a venous sample within the last six months)
- Cardiovascular risk score (Qrisk3)
- Raise awareness of dementia for individuals aged over 65
- Raise awareness of cancer (through local booklet provided)
- Blood test for HbA1c or FBG if at risk of diabetes (BMI ≥ 30 (or ≥27.5 if Indian, Pakistani, Bangladeshi, Other Asian or Chinese) or BP ≥140/90)

A venous blood sample will be required to measure the Patient's cholesterol (and HbA1c if required). It is the responsibility of the Service Provider to make arrangements for blood tests. Patients should be invited to have their blood taken in advance of the NHS health check assessment to enable all measures to be discussed with the Patient at the time of the assessment. .

Figure 4. Overview of the vascular risk assessment and management programme



Qrisk

Estimated 10-year risk of developing CVD should be calculated using QRISK®3.

Note: In 2019, ClinRisk replaced the 10-year CVD risk factor calculator QRISK® 2 with QRISK® 3 which uses a further eight fields of data. The inclusion of additional clinical variables in QRISK® 3 (chronic kidney disease (scope of CKD widened to include stage 3), a measure of systolic blood pressure variability (standard deviation of repeated measures), migraine, corticosteroids, Systemic lupus erythematosus (SLE), atypical antipsychotics, severe mental illness, and erectile dysfunction) can help enable clinicians to more accurately identify those at most risk of heart disease and stroke.

If a person has any of the newly included variables recorded in the clinical system medical records this information should automatically be pulled through into the QRISK® 3 calculator. This means that there does not need to be extra questions about the new variables added to the NHS Health Check. The resulting QRISK® 3 score can be acted upon according to the result.

Age

Data required: age recorded in years.

Key points: The age of the individual should be 40-74 years (inclusive).

Gender

Data required: the gender should be recorded as reported by the individual.

Key points: 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: non-smoker (never smoked), ex-smoker (previously smoked), light smoker of (fewer than 10 a day), moderate smoker of (11-19 a day), heavy smoker (≥ 20 a day).

Key points: a person's smoking status is defined as smoking tobacco, vaping status is excluded from this definition.

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 (BMI)

Data required: BMI is calculated from the weight of the individual, divided by their height squared.

Key points: if the individual cannot have their height and/or weight measured, including amputees, the individual's waist circumference, in supine position where possible, can be used to assess whether the person is overweight or obese, and their risk of developing diabetes. The thresholds for waist circumference are set out in the NICE obesity clinical guidelines. The QRISK® 3 calculation will default to population averages where information is not added, so it will estimate BMI based on the age and gender entered into it.

Related stages of the check: BMI is required for the CVD risk calculation. It may also be used by the diabetes validated risk assessment tools and diabetes filter to identify individuals at risk of type 2 diabetes.

Cholesterol test

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

Key points: a random cholesterol test should be used for this assessment. A fasting sample is not required.

Related stages of the check: cholesterol is a major modifiable risk factor of vascular disease and can be reduced by dietary change and physical activity, but medicines may also be required depending on the degree of elevated risk.

Systolic and diastolic blood pressure

Data required: both systolic (SBP) and diastolic blood pressure (DBP).

Key points: pulse rhythm should be taken prior to a blood pressure check, in line with NICE Hypertension clinical guideline. Individuals who are found to have an irregular pulse rhythm should be referred to the GP for further investigation of atrial fibrillation.

Related stages of the check: 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 non-fasting hba1c test or a fasting plasma glucose (FPG)
- An assessment for hypertension
- An assessment for CKD

Physical activity assessment

Data required: Level of physical activity as categorised using the General Practice Physical Activity Questionnaire (GPPAQ).

Key points: GPPAQ provides a measure of an individual's physical activity levels, which have been shown to correlate with cardiovascular risk. It is the only validated measure for physical activity that correlates with all-cause mortality and is advocated by NICE for use for this purpose. While the GPPAQ asks questions about walking and activities of daily living, these are not included in the calculation, due to the significant levels of over-reporting in the amount and intensity of these physical activities during validation. Clinicians will need to use their judgement whether patients meet the minimum physical activity levels for those classified as less than active.

Related stages of the check: 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. NICE guidance recommends that individuals identified as inactive who have existing health conditions or other factors that put them at increased risk of ill health should be considered for exercise referral where local services exist. Other individuals identified as inactive or only moderately active should be given brief advice on physical activity and suggested physical activity opportunities.

Alcohol risk assessment

Data required: alcohol use disorder identification test-consumption score (AUDIT-C). Fast alcohol screening test (FAST) or alcohol use disorder identification test (AUDIT) score.

If the individual achieves a score of five or more on AUDIT-C or three or more on FAST, the second phase should be undertaken, see Figure 5, the Alcohol Care Pathway.

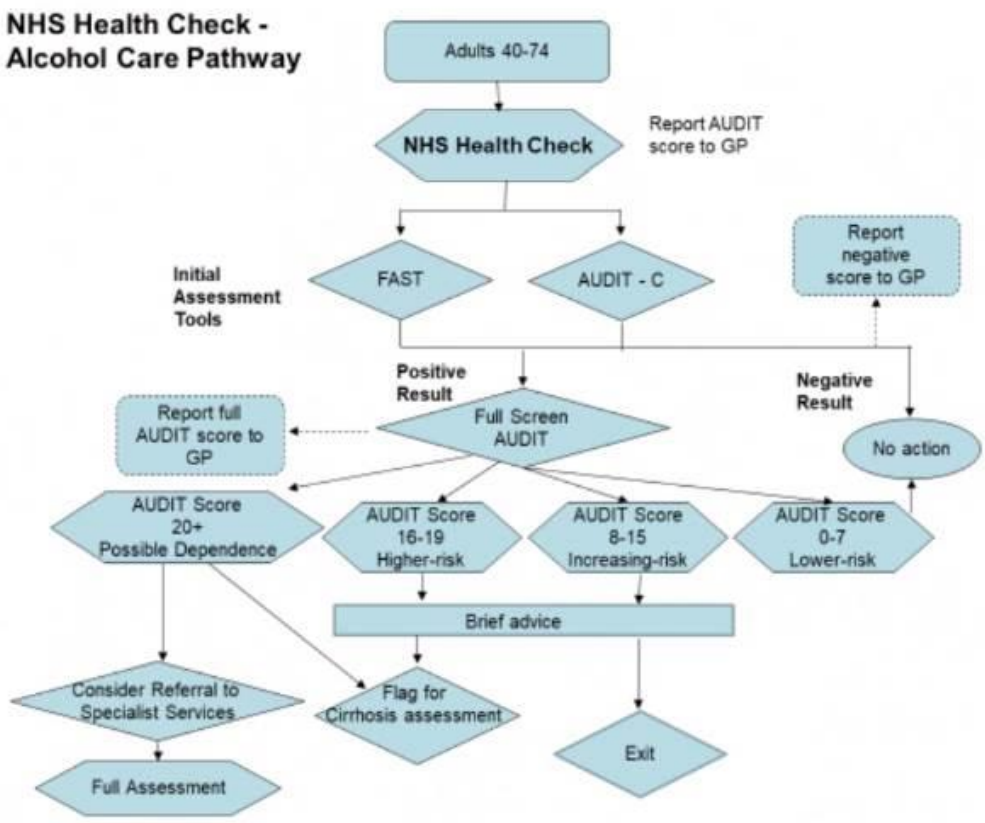
The second phase involves completing the remaining questions of the full AUDIT. It is this full AUDIT score that can identify the risk level of the individual. If the total AUDIT score from the full ten questions is eight or more, this indicates the individual's consumption of alcohol might be placing their health at increasing or higher risk of harm.

Key points: To identify the risk of harm from alcohol, the World Health Organization (WHO) recommends that the full 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. AUDIT-C, FAST and full AUDIT can be self-completed by the individual or the questions can be verbally asked of the individual and their response recorded.

Alcohol guidelines recommend that men and women should not regularly exceed 14 units per week to keep their risk of alcohol-related harm low.

Related stages of the check: 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. If the individual meets or exceeds an AUDIT score of 16 (higher risk) this should be flagged with the individual's GP so that an assessment for cirrhosis can be undertaken. A referral to alcohol services should be considered for those individuals scoring 20 or more on AUDIT.

Figure 5: NHS Health Check Alcohol Care Pathway



Diabetes risk assessment

Data required: this varies depending on the validated diabetes risk assessment tool used, but can include age, gender, ethnicity, family history of diabetes, BMI, diagnosis of hypertension, waist circumference, smoking status, history of CVD, taking regular steroid tablets. Individuals should be considered as being at high risk of diabetes using the following thresholds for the corresponding validated risk assessment tools:

- QDiabetes score is greater than 5.6
- Cambridge diabetes risk score is greater than 0.2
- Leicester practice risk score is greater than 4.8
- Leicester risk assessment score is greater than or equal to 16

If a validated tool is not applied, then the diabetes filter can still be used. In this case, people at high risk of diabetes, and so eligible for a blood glucose test, include:

- An individual from black, Asian and other ethnic groups with BMI greater than or equal to 27.5

Or

- An individual with BMI greater than or equal to 30

Or

- Those with blood pressure at or above 140/90mmhg, or where the SBP or DBP exceeds 140mmhg or 90mmhg, respectively

In addition to individuals meeting the high-risk filter criteria, it is important to consider the situation of the individual, because 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 (e.g.polycystic ovarian syndrome or severe mental health disorders).
- Those on current medication known to be associated with diabetes (e.g. Oral corticosteroids).

Key points: The assessment of diabetes risk should be undertaken in two stages; the first step should be to use a validated risk tool (or where that is not possible, the diabetes filter) to identify people at risk. The second step involves performing a blood test to indicate whether an individual is at risk of type 2 diabetes. A diagnosis of type 2 diabetes can only be made on the blood glucose results from a venous blood sample. Where a person has no symptoms but falls above the threshold for type 2 diabetes, a second blood test should be undertaken before a diagnosis is made.

Individuals who are identified as being at high risk of type 2 diabetes should receive either a fasting plasma glucose test or HbA1c, as part of an NHS Health Check.

Blood glucose testing

Key points: there is no single universally recognised blood test for high risk of diabetes, or for diabetes itself. Random (non-fasting) plasma glucose tests are not recommended. Fasting plasma glucose tests, while less convenient, are a better method. An HbA1c test can also be used. Further details for both testing methods can be found in the NHS Health Check Best Practice Guidance 2019.

Raising Awareness of Risk Factors for Dementia

Key points: There are two dementia components to the NHS Health Check. Neither require any formal assessment or memory testing. The first is that everyone who has an NHS Health Check should be made aware that the risk factors for cardiovascular disease are the same as those for dementia. What is good for the heart is good for the brain.

Up to 35% of dementia is preventable through modifiable risk factors, including physical activity, healthy diet, reduced alcohol intake and not smoking. The second is that people aged 65-74 should be made aware of the signs and symptoms of dementia and be signposted to memory services if this is appropriate.

Raising awareness of cancer

Information about risk factors for CVD should also include a dialogue about risk factors for cancer. Information about cervical, breast and bowel cancer screening programmes should be provided as appropriate for the Patient / Service User. Information on cancer signs and symptoms is provided within the NHS Health Check booklet made available from the Commissioner.

3.7 Stage 4: Communication of CVD risk, supporting behaviour change and on-going management

The staff delivering the NHS Health Check should be trained in communicating, capturing and recording the risk score and results and understand the variables used by the risk engine to calculate the risk score.

When communicating individual risk, staff should be trained to:

- Communicate risk in everyday, jargon-free language so that individuals understand their level of risk and what changes they can make to reduce their risk.
- Use behaviour change techniques (such as motivational interviewing) to deliver appropriate lifestyle advice and how it can reduce their risk.
- Create a two-way dialogue to explore individual values and beliefs to facilitate a client-centred risk-reduction plan.

Individuals receiving an NHS Health Check should be given adequate time to ask questions and obtain further information about their risk and results. Appropriate written information should also be provided. This should include personalised feedback to discuss their:

- BMI
- Cholesterol level
- Blood Pressure
- Alcohol score (AUDIT C or FAST)
- CVD risk score and what this means
- Lifestyle
- Referrals on to lifestyle or clinical services (if any)

The Service Provider will offer lifestyle advice to ALL patients after a Health Check on how to maintain/improve their vascular health.

Stop smoking interventions

NICE guidance on stop smoking interventions and services makes a number of practical recommendations about identifying smokers, offering advice on how to quit, and who this should be delivered by. The National Centre for Smoking Cessation and Training (NCSCT) local stop smoking service and delivery guidance 2014, illustrates the importance of using every opportunity to systematically identify people who smoke and deliver very brief advice (VBA). Follow up, where appropriate, with a referral into effective support. This very brief advice consists of three steps:

• ASK – establish and record smoking status
• ADVISE – advise that the best way to stop is with a combination of pharmacotherapy and support
• ACT – offer a referral to a specialist service
A free training module on the delivery of VBA is available on the NCSCT website (see Appendix A).

Weight management interventions

Practitioners may find it helpful to follow the steps outlined in Public Health England's Let's Talk About Weight – a step by step guide to brief interventions with adults for health and care professionals. The guide supports health and care professionals to refer individuals to tier 2 and tier 3 weight management services for adults. It provides further information and scenarios for each of the steps outlined below:

- ASK – weigh and measure the individual
- ADVISE – consider referral options to local weight management services
- ASSIST – depending on the outcome of the conversation, refer the individual to the weight management service, and always offer a follow up opportunity with yourself or another health care professional. Individuals can be directed to information on the importance of a balanced diet, shown in the Eatwell Guide[10] and if wishing to consider tips on achieving a healthier weight, can be signposted to www.nhs.uk.

The individual's alcohol intake should also be considered as part of any discussion about energy intake. The opportunity can be used to highlight links between alcohol intake and obesity, and the impact these can have on liver disease.

Physical Activity

The UK Chief Medical Officers' Guidelines[11] recommend that all adults should aim to be active daily. Activity should add up to at least 150 minutes of moderate intensity activity over a week. One way to approach this is to do 30 minutes at least five days a week.

[10] Public Health England. The Eatwell Guide. 2016.[Available from www.gov.uk/government/publications/the-eatwell-guide]

[11] DHSC. UK Chief Medical Officers' Physical Activity Guidelines 2019 [Available from https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment _data/file/832868/uk-chief-medical-officers-physical-activity-guidelines.pdf] Physical activity diagram

Alternatively, comparable benefits can be achieved through 75 minutes of vigorous intensity activity spread across the week, or a combination of moderate and vigorous intensity activity. More is better. In addition, adults should also do muscle strengthening exercises at least two days each week. Older adults also benefit from activities that develop balance and aid flexibility. It should be emphasised that all adults should minimise the amount of time spent being sedentary (sitting) for extended periods.

Alcohol use interventions

Advice to reduce alcohol use for those drinking above low risk, an AUDIT score of 8 or above, (but who are not indicating dependence) is an essential part of helping people manage the risk alcohol poses to their health and the potential 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 just takes a couple of minutes and consists of:

- Understanding alcohol units – ensuring the individual understands how much they are drinking
- Understanding risk levels – explaining the low-risk guidance and how the health risk rises above this level
- Informing them of their level of risk – informing the individual 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 individual with a menu of things they could try to cut back on their alcohol consumption

The UK Chief Medical Officers recommend that men and women should not regularly drink more than 14 units a week, to keep their risk of harm from alcohol low. If an individual is consuming up to 14 units a week, it is best to spread this over three days or more. For individuals who wish to cut down the amount they drink, a good way to achieve this is to have several drink-free days each week.

Healthier You: NHS Diabetes Prevention Programme

Key points: If the individual's fasting plasma glucose (5.5 – 6.9 mmol/l) or HbA1c (42 – 47 mmol/mol or 6% – 6.4%) is above the threshold for non-diabetic hyperglycaemia but below the threshold for diabetes, there is very robust evidence that intensive lifestyle interventions in these individuals substantially reduces the risk of developing diabetes. Healthier You: NHS Diabetes Prevention Programme offers an intensive intervention that supports people to lose weight, to increase physical activity and to eat more healthily. The long-term intervention allows individuals to set and achieve goals and make positive changes to their lifestyle. More information on the NHS Diabetes Prevention Programme can be found here. Where the programme is already available individuals should be referred to it in line with the local care pathway.

3.8 Clinical risk management

Appropriate assessments for high CVD risk, hypertension, chronic kidney disease, diabetes, full alcohol risk assessment and familial hypercholesterolemia will be carried out on patients/ service users in primary care with abnormal parameters after the initial standard risk assessment. The GP practice will manage newly diagnosed diabetes, hypertension or chronic kidney disease according to existing local clinical pathways and relevant NICE guidance, under the terms of their general medical contract with NHS England. Newly diagnosed Patients with diabetes, hypertension, chronic kidney disease or Patients at high risk of a CVD event will be placed on the respective register. These Patients will exit the NHS Health Check programme and will not be eligible for recall, as they will be followed up separately on an annual basis.

Table 1 summarises the actions and referral processes within the Health Check pathway. Further reference should be made to NHS Health Checks Best Practice Guidance 2019[12].

3.9 Table 1: Guidance for referrals and follow-up assessments

Factor	Threshold	Action	GP follow up
Cardiovascular risk assessment	CVD risk is assessed as >10% over 10 years CVD risk score ≥20%	Offer intensive lifestyle advice and refer to GP for follow up. Patients should exit from health check programme and be put on to an at-risk register	Management of risk and consideration of statin prescribing. Annual review of high-risk patients.
Total Cholesterol	TC is ≥ 7.5	Refer to GP	To assess for possibility of familial hypercholesterolemia
Hypertension risk assessment	BP is ≥ 140/90 BP is ≥ 180/110	Refer to GP for assessment Refer to GP the same day	Management for hypertension, (NICE Clinical Guidelines NG136)
Diabetes risk assessment	BMI is ≥27.5 in individuals from Indian, Pakistani, Bangladeshi, Other Asian and Chinese ethnicity categories	Refer to GP for Fasting Plasma Glucose Test or HbA1c	Follow up at GP practice with oral glucose tolerance test or repeat HbA1c as per diabetes filter to establish possible diagnosis of diabetes

[12] NHS Health Check Best Practice Guidance. PHE. Oct 2019

	BMI is ≥ 30 in other ethnicity categories BP is ≥ 140/90 (either measurement)	People with symptoms of diabetes must be referred immediately	
Chronic kidney disease risk assessment *(as for hypertension risk above)*	BP is ≥ 140/90 BP is ≥ 180/110	Refer to GP for assessment Refer to GP the same day	Person requires assessment for CKD by GP
Smoking status	Smoker	Ask and record smoking status. Advise person of health benefits / lifestyle advice. Act on person's response. Signpost to Derby City Lifestyle Services e.g. Livewell	
Weight management	BMI ≥30	Lifestyle advice. Consider readiness to change. Signpost to Derby City Lifestyle Services e.g. Livewell	
Alcohol	Hazardous drinker Dependent drinker	Lifestyle advice – brief intervention	 Refer to specialist alcohol services or GP

Managing those with high cardiovascular risk

Key points: NICE guidance advises that:

- 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.

- As part of a conversation about CVD risk, all people should be advised that the potential benefits from lifestyle modifications will also reduce their risk of dementia.

- Where lifestyle modification has been ineffective or is inappropriate, people with a 10% or greater, ten-year risk of developing CVD should be offered statin therapy for the primary prevention of CVD.

- Individuals that are either prescribed a statin or have a CVD risk score ≥20% should exit on to an at-risk register.

Cholesterol

Risk threshold for primary prevention:

- If cholesterol is identified as being raised (ratio of total serum cholesterol to high density lipoprotein cholesterol greater than 4) but the person's 10-year CVD risk, calculated using QRISK, is less than 10%, the individual should be offered healthy lifestyle advice, particularly focusing on smoking, alcohol intake, diet and physical activity.

- If the ten-year CVD risk, calculated using QRISK, is 10% or greater, appropriate lifestyle advice and behaviour change support should also be offered. Where lifestyle modification has been ineffective or is inappropriate, Atorvastatin 20mg should be offered for primary prevention. If the NHS Health Check is undertaken outside of general practice the individual should be referred to their GP or nurse for further assessment and management.

- All Individuals whose total cholesterol level is found to be above 7.5mmol/l should be referred to their GP for consideration of Familial Hypercholesterolemia (FH) and for cascade testing of family members if a FH diagnosis is confirmed.

- CVD risk is heavily influenced by age, while younger people are less likely to have a 10-year risk of >10%, it is important to also look at total cholesterol and to determine if cholesterol is raised.

Secondary prevention: The NICE lipid modification guideline recommends commencing statin treatment with atorvastatin 80 mg in people with diagnosed CVD. However, a lower dose of atorvastatin is recommended if any of the following apply: potential drug interactions; high risk of adverse effects; patient preference. NICE recommends measuring total cholesterol,

high density lipoprotein (HDL) cholesterol and non-HDL cholesterol in people who have been started on high intensity statin treatment at three months of treatment, aiming for > 40% reduction in non-HDL cholesterol.

Related stages of the check: Individuals diagnosed with high cholesterol should be treated through appropriate care pathways and measures, as recommended by NICE. The NICE guideline provides recommendations for the management of people diagnosed with high cholesterol, including:

- Communication about risk assessment and treatment options
- Lifestyle modifications for the primary and secondary prevention of CVD, including advice on:
  - Cardio protective diet
  - Physical activity
  - Combined interventions of diet and physical activity
  - Weight management
  - Alcohol consumption
  - Smoking cessation
  - Lipid modification therapy options

Assessment for hypertension

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

Key points: The individual requires an assessment for hypertension by the GP practice team.

Related stages of the check: Where a diagnosis of hypertension is confirmed by a clinician, the individual should be added to the hypertension register and treated in line with NICE guidelines. Once diagnosed with hypertension, individuals should not be recalled as part of the NHS Health Check programme. When blood pressure is found to be high, discussions 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 audio-visual 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 advice to people who smoke 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.

Assessment for chronic kidney disease (CKD)

Threshold: If the individual has a blood pressure at or above 140/90mmHg, or where the SBP or DBP exceeds 140mmHg or 90mmHg.

Key points: The individual requires further assessment to check for CKD. This is the responsibility of the GP or primary care nurse. 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).

Diagnosing CKD:

Data required: the results of a serum creatinine test should be used to calculate the estimated glomerular filration rate (eGFR) in order to assess the level of kidney function and recorded on the individual's patient record. Threshold: eGFR<60ml/min/1.73m2 or ≥60ml/min/1.73m2. Where eGFR is above or equal to 60ml/min/1.73m2, 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. Where eGFR is below 60ml/min/1.73m2, further assessment for CKD is required in line with NICE clinical guideline 182 on CKD. In people with a new finding of reduced eGFR, the eGFR should be repeated within two weeks to confirm that it is abnormal. This is the responsibility of the GP or primary care nurse.

Identifying individuals with an irregular pulse

Key points: individuals found to have an irregular pulse require further assessment to determine if atrial fibrillation is present. This is the responsibility of the GP or primary care nurse and assessment will include an ECG to confirm the rhythm. If atrial fibrillation is diagnosed, the individual should be managed in line with NICE guidance.

Management of people found to have abnormal fasting blood sugar or HbA1c

Threshold: If the individual's fasting blood glucose (≥7mmol/l) or HbA1c (≥48 mmol/mol) is above the threshold for diabetes and the individual has no symptoms.

Key points: Refer the individual 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.

Threshold: If the individual's fasting blood glucose (≥7mmol/l) or HbA1c (≥48 mmol/mol) is above the threshold for diabetes and the individual has symptoms to suggest diabetes.

Key points: Refer the individual 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.

Assessment for cirrhosis

Threshold: an alcohol AUDIT score of 16 or above.

Key point: individuals indicated as drinking at higher risk levels are at elevated risk of cirrhosis and should be referred, via local care pathways, for a transient elastography (a non-invasive test to assess whether the liver has been damaged by their alcohol consumption) in line with NICE guidance. Where an individual is diagnosed with cirrhosis, they should be referred to a specialist in hepatology and treated in line with NICE guidelines.

3.10 Stage 5: Data transfer

All ServiceProviders will use the Health Check software provided by Derby City Council to capture the NHS Health Check data that is both captured in GP Practices and by community providers. We expect all Service Providers to submit their data by using pre-approved Derby City Council NHS Health Check Programme template.

GP Practices will be required to complete all elements of the template and upload the data on a monthly basis using the software provided by Derby City Council.

All data flows should comply with national guidance and the Data Protection Act 2014 and the NHS Health Check Governance and Data Flows 2016[13]. To ensure the security of confidential information the ServiceProvider should be at least level 2 compliant with the IG toolkit or can demonstrate significant progression towards achieving this level.

3.11 Population covered

People registered to a Derby City GP practice or Derby City unregistered resident who is:

- Aged between 40 and 74 years
- Must not have been offered a health check within the previous five years

Exclusion criteria:

People already diagnosed with the following conditions:

[13] NHS Health Check Information Governance and Data Flows. PHE. 2016

- Diabetes
- Hypercholesterolaemia / already on a statin
- Hypertension
- Ischaemic heart disease
- Stroke/TIA
- Atrial fibrillation
- Peripheral arterial disease
- Heart failure
- CKD (stages 3-5)
- High-risk of cardiovascular disease – patients who have already had a formal Health Check and have been identified as high-risk (QRISK > 20%) and placed on a high-risk register.

In addition, individuals:

- Must not be being prescribed statins for the purpose of lowering cholesterol.
- Must not have been assessed through an NHS Heath Check (or any other check undertaken through the health service in England) and found to have a 20% or higher risk of developing CVD over the next 10 years.

3.12 Interdependencies with other services

People who fit the criteria would benefit from a lifestyle intervention should be referred to:
Derby City Council Lifestyle Services e.g. Livewell
https://www.livewellderby.co.uk/

People who require support from alcohol services are referred to the City's substance misuse service:

Derby City Drug and Alcohol Service
St Andrews House
201 London Road
Derby
DE1 2TZ

Telephone: 0300 790 0265

All patients with a ≥ 10 % CVD risk score or meet the disease risk thresholds are referred to local practices for further investigation and treatment.

3.13 Location of Provider services

Services should be delivered from suitable premises within Derby City these must comply infection control and phlebotomy regulations.

3.14 Training and resources

Training

All staff involved in the provision of NHS Health Checks must complete the face to face training provided by Derby City Council. Evidence of this accreditation is required. The Service Provider organisations are responsible for ensuring that all staff who deliver health checks are competent. This means that both registered and non-registered health care professionals must achieve the core competencies and clinical skills competencies, prior to achieving the NHS Health Check programme competencies. These all set out in the NHS Health Check competency framework.

Additional resources and e- learning on NHS Health Checks, behaviour change, smoking, dementia, alcohol, and diabetes to support with the provision and quality of the Health Check can all be found in Appendix A.

4 Applicable service standards

4.1 Applicable standards

The Service Provider should refer to the following guidelines for the delivery of the NHS Health Check programme as well as the NICE guidance identified in Appendix C:

- NHS Health Check best practice guidance – Oct 2019
- NHS Health Check competency framework – July 2020
- NHS Health Check Learner and Assessor Workbook – July 2020
- NHS Health Check programme standards – July 2020
- NHS Health Check IG and data flows pack – Oct 2016
- NHS Health Check Single Data List Returns Guide - Oct 13 Refresh

4.2 Governance

The Service Provider will be expected to comply with any professional standards or audits of practice required by the Local Authority. This will include proof of qualifications, professional accreditation / continual development. These standards will be augmented and audited in the agreement with both parties.

4.2.1 Information governance and security

The Service Provider must put in place appropriate governance and security for the Information Management and Technology (IM&T) system to safeguard patient information, including compliance and completion of working towards the Information Governance Toolkit.

The Service Provider must ensure that the IM&T system and processes comply with statutory obligations for the management and operation of IM&T within the Local Authority and NHS, including, but not exclusively:

- Common law duty of confidence;
- Data Protection Act, 2018;
- Freedom of Information Act, 2000;
- Computer Misuse Act, 1990; and
- Health and Social Care Act, 2012

4.2.2 Information management

The Service Provider will:

- Ensure the Service adheres to national and local rules on confidentiality and data protection.
- Ensure that Information sharing protocols are consistent with guidance from the local Caldicott guardian.
- Ensure everyone in the Service understands the importance of information rights, and their own responsibility for delivering them.
- Regularly review and assess your services data security arrangements.

4.2.3 Clinical Governance, Competencies and Quality Assurance

The Service Provider will:

- Demonstrate compliance with all relevant national standards for service quality and clinical governance including compliance with the NHS Standards for Better Health Framework, relevant NICE guidelines and the NHS Health Check Competency Framework.

- Demonstrate the principle of 'best value' through continuous improvement considering a combination of effectiveness (successful outcomes), efficiency (high productivity) and economy (costs).

- Ensure there are designated clinical leadership and accountability, and clear clinical protocols for effective clinical governance.

- Ensure that staff providing the Service are suitably qualified and competent and that there are in place appropriate arrangements for maintaining and updating relevant skills and knowledge and for supervision.

- Clinical guidelines should be followed when measuring height, weight, blood pressure, cholesterol and cardiovascular risk and referring people for additional testing.

- Individuals/organisations will be required to participate in any competency assurance framework defined by the commissioner.

- All serious incidents will be reported in accordance with the National Serious Incident Framework

4.2.4 Clinical Audit

The Service Provider will:

- Ensure the implementation of a clinical audit process to review performance and provide a framework to enable improvements to be made.

- Allow Derby City Public Health or their nominated representatives' access to their premises in order to facilitate a clinical audit or inspection of the Service being provided.

4.2.5 Risk management

The Service Provider will:

- Ensure there are robust processes, working practices and systematic activities that prevent or reduce the risk of harm to clients.

- Ensure there are robust processes in place to support the reporting and review of all untoward incidents at the earliest opportunity. This will include the documentation, investigation and follow up with appropriate action of all untoward incidents.

- Ensure this learning is disseminated across the organisation and shared with the commissioners.

- Ensure that an effective complaints procedure for patients is in place, in line with the current NHS Complaints Procedure guidance or equivalent complaints procedure, to deal with any complaints in relation to the provision of the Service, which is available for audit.

- Ensure that a process is in place for any member of the professional team to raise concerns in a confidential and structured way.

- Ensure the Service has a nominated lead for safeguarding issues and adheres to the Derby and Derbyshire Safeguarding policies and procedures:

    - The Derby and Derbyshire Safeguarding Children Procedures
      https://www.derby.gov.uk/health-and-social-care/safeguarding-children/

      https://derbyshirescbs.proceduresonline.com/register_updates.html

- Derby and Derbyshire Adults Protection Policy and Procedures
  http://www.derby.gov.uk/health-and-social-care/safeguarding-adults-at-risk/safeguarding-vulnerable-adults

  https://www.derbysab.org.uk/

  https://www.ddscp.org.uk/
  https://www.derbysab.org.uk/media/derby-sab/content-assets/documents/Joint-Derby-and-Derbyshire-SAB-Policy--Procedures-December-2019.pdf

- This should include understanding safeguarding referral procedures and referral pathways to social care.
- Service Providers must notify the Public Health team at Derby City Council of any breaches of Applicable National Standards.

- Ensure appropriate health and safety, infection prevention and control, and risk management systems are in place. All staff involved in delivering the NHS Health Check to have standard Disclosure and Barring Service (DBS).

- As part of an on-going transition plan and risk register consider staff coverage for sickness absence and maternity cover where necessary.

- Ensure that staff are made aware of the risk associated with the handling of clinical waste and the correct procedures to be used to minimise those risks.

- A needle stick injury and spillage procedure must be in place in line with Health and Safety Executive guidance and PHE guidance.

4.2.6 Patient and Carer experience and involvement

- Ensure that Patients can make informed decisions about their treatment and care in partnership with healthcare professionals. If Patients do not have the capacity to make decisions staff should follow the DH advice on consent and the code of practice that accompanies the Mental Capacity Act.

- Demonstrate a robust information Service/source for Patients/Service Users and review regularly based on Patient/Service User feedback.

- If asked, the Service provider should be able to explain to Derby City Council how it responds to Patient/Service User feedback and how this feedback is used to develop and improve the Service Provider's NHS Health Check Service.

4.2.7 Facilities, Equipment and Access

- Ensure that all premises and equipment used for the provision of the Service are always suitable for the delivery of the Service and sufficient to meet the reasonable needs of Patients/ Service Users.

- The site must be accessible by Patients/ Service Users and should be compliant with Equality Act (2010).

- Ensure that treatment, care and information provided is culturally appropriate and is available in a form that is accessible to people who have additional needs, such as people with physical, cognitive or sensory disabilities, and people who do not speak or read English.

- All premises must meet national minimum standards set out by the Care Quality Commission where appropriate. An accredited consultation area where privacy can be maintained. A sink and hand-washing facilities should be available to carry out the assessment. Space for the equipment (desktop PC/laptop, blood pressure monitor (clinically validated by the British Hypertension Society), medical weighing scales (of at least accuracy Class III or higher), height meter and tape measure will be required for the provision of the Service.

- The Service Provider will be expected to adhere to Medicines and Healthcare products Regulatory Agency (MHRA) and Derby City Council advice, guidance and policies on appropriate standard equipment, training in its use and on-going management, troubleshooting, and quality assurance processes that ensure the accuracy and reproducibility of test results. This applies to weighing scales, height measures, blood pressure monitors, cholesterol testing machines and any other clinical equipment used during NHS Health Checks.

- Appropriate protective equipment, including gloves, aprons, and materials to deal with blood spillages, must be readily available on the premises where the Service is provided.

- There should be space identified that would be of adequate size and functionally suitable to safely store and operate patient testing equipment, handle blood samples and any resultant clinical waste.

4.2.8 Professional standards and indemnity:

- The Service Provider should ensure that all locums are accredited with Derby City Council standard training if they provide the Service.

4.2.9 Communications and relationships for Service Providers:

- If the person delivering the health check leaves, they should inform the Commissioner to discuss any alternate arrangements and training required for the new person.

- The staff should ensure that front desk/sales staff are aware about the NHS Health Checks Programme and can advise people enquiring about it.

4.2.10 Responsibility of the Commissioner

To facilitate the delivery of this Service Derby City Council will:

- Update the Service provider on any changes to the pathway and protocols for the NHS Health Check programme.
- Supply the Service Provider with information on local initiatives and services to support lifestyle change.
- Develop local publicity materials and run targeted marketing campaigns to promote the Service.
- Organise annual update training on the NHS Health Check programme.
- Conduct monthly monitoring and evaluation of Service.
- Supports the sharing of best practice amongst providers including the implementation of the NHS Health Checks QA standards.

The Council may audit all Service Providers and their submitted data returns annually as they see fit. All Service Providers will agree to co-operate with any request to audit activity data. This will include audit of the follow-up of high-risk individuals who have exited the NHS Health Checks programme.

The screening programme will be made free of charge to the client at the local authority's expense.

The Service Provider will encourage people who are not registered with a local general practitioner to do so and refer them to the local Patient Advisory & Liaison Services (PALS) for advice on how and where to register.

Derby City Council reserves the right to use 'mystery shoppers' as part of their quality assurance framework.

5.0 Quality and performance standards

Quality Performance Indicator	Threshold	Method of measurement	Report Due
% of eligible population receiving a first invite for a health check	20% annually	Measured by Service – data extracted via strategic reporting or Miquest	Monthly
% of non – responders receiving a second invite for a health check	100%	Measured by service – data extracted via strategic reporting or Miquest	Monthly
% of eligible patients receiving a health check	50% of those offered	Measured by Service – data extracted via strategic reporting or Miquest	Monthly
% of invites read coded appropriately (see appendix B)	100% (including opportunistic health checks)	Measured by service – data extracted via strategic reporting or Miquest	Monthly
% of Health Checks read coded appropriately (see appendix B)	100%	Measured by Service – data extracted via strategic reporting or Miquest	Monthly
% of software downloads	100% per month	Measured by Service – data extracted	Monthly

conducted		via strategic reporting or Miquest	

6. Costs

Basis of contract	**Price**
Cost per health check	£25 per completed health check. Payments will be based only on those who are identified as eligible.

Payments will be made based on all eligible health checks completed each month. All claims for activity undertaken should be made through a Commissioner defined invoicing system and submitted on a monthly basis.

Appendix A: Training and Resources

Health Check training courses will be made available by the Commissioner for new Service Providers to be trained as and when these are required. In addition to attending a course, all staff new to delivering NHS Health Checks need to complete the NHS Health Check e-learning course, behaviour change course and dementia training identified below.

NHS Health Check e-learning course

This e-learning resource is primarily for staff involved in the delivery of the NHS Health Check to enhance knowledge about the programme and the effective delivery of a check. It was developed by Health Education England's local team in the West Midlands, in collaboration with Public Health England West Midlands. To access the e learning course click here

Behaviour and lifestyle Change e-learning

An e-learning resource to help staff support clients with behaviour and lifestyle change. The resource, developed by the Royal College of Nursing, is free to use and includes motivational interviewing techniques, making every contact count (MECC) and a tool kit to use when discussing change with clients. To access the e-learning course click here. To access Making Every Contact Count (MECC): practical resources click here.

Smoking

A free training module on the delivery of very brief advice (VBA) is available on the NCSCT website NCSCT e-learning

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. Additional dementia training tool resources can be found here:

- The Alzheimers Society
- The Dementia Challenge

Diabetes e-learning

The Diabetes in Healthcare Training Course is an introductory course for healthcare professionals who are not specialists in diabetes but want to know more about the condition.

Alcohol

Alcohol Identification and Brief Advice Programme 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.

Useful links and resources:

- Go to One You - drinking
- Go to NHS Choices - alcohol misuse

National Health Check Information leaflets

This information leaflet should be provided with the invitation letter. Hard copies of the national information leaflet in the most popular languages and in a range of alternative formats including Braille, BSL and Easy Read are available for order here.

NHS Health Check dementia leaflet

NHS Health Check dementia leaflet (2904520) - The NHS Health Check dementia leaflet has been developed to support the dementia information given to those who attend an NHS Health Check appointment. These leaflets are available to order free of charge in a variety of formats and languages through the Department of Health order line (0300 123 1002).

NHS Health Check results booklets

These booklets are designed to be completed during the Health check to record the patients' results. They are a local resource produced by Public Health. Please contact the Commissioner Lead to receive further copies.

Appendix B: Read Codes for monitoring reports

Please make sure the identified Read Codes are adopted. If the appropriate Read Codes are not recorded the practice performance against KPI targets cannot be accurately calculated.

Prompt	READ Code Title	Ctv3 Systm One	5 byte EMIS LV
Invitations	NHS Health Check telephone invitation	XaRBS	9mCO.
	NHS Health Check invitation first letter	XaRBT	9mC1.
	NHS Health Check invitation second letter	XaRBU	9mC2.
	NHS Health Check invitation third letter	XaRBV	9mC3.
	NHS Health Check verbal invitation	XaR9z	9mC4.
	Failed to respond to NHS Health Check invitation*	XaRAF	9Nj5.
	DNA Health Check appointment	XaRAA	9NiS.
	NHS Health Check declined	XaX8h	8IAX.
Provider of Encounter	Seen by health carer	XE2NJ	9n2.
	Seen by Pharmacist	XaAUv	9NIQ.
	NHS Health Check completed by third party	XaZPq	
Ethnicity	British or missed British – ethnic category 2001 census	XaJQv	9i0..
	Irish – ethnic category 2001 census	XaJQw	9i1..
	Other White background – ethnic category 2001 census	XaJQx	9i2..
	White and Black Caribbean – ethnic category 2001 census	XaJQy	9i3..
	White and Black African – ethnic category 2001 census	XaJQz	9i4..
	White and Asian – ethnic category 2001 census	XaJR0	9i5..
	Other Mixed background – ethnic category 2001 census	XaJR1	9i6..
	Indian or British Indian – ethnic category 2001 census	XaJR2	9i7..
	Pakistani or British Pakistani – ethnic category 2001 census	XaJR3	9i8..
	Bangladeshi or British Bangladeshi – ethnic category 2001 census	XaJR4	9i9..
	Other Asian background – ethnic category 2001 census	XaJR5	9iA..
	Caribbean – ethnic category 2001 census	XaJR6	9iB..
	African – ethnic category 2001 census	XaJR7	9iC..
	Other Black background – ethnic category 2001 census	XaJR8	9iD..
	Chinese – ethnic category 2001 census	XaJR9	9iE..
	Other ethnic category 2001 census	XaJRA	9iF..
	Ethnic category not stated 2001 census	XaJRB	9iG..
	Ethnic group not given – patient refused	XaE4B	9SD..
	Patient ethnicity unknown	XaLNO%	916E.%

Family History	FH: Ischaemic heart dis. <60	XE0oG	12C2.
	FH: Angina in 1st degree female relative <65 years	XalyY	12CL.
	FH: Angina in 1st degree male relative <55 years	XalyZ	12CM.
	FH: Myocardial infarct in 1st degree female relative <65 years	Xalya	12CN.
	FH: Myocardial infarct in 1st degree male relative <55 years	Xalyb	12CP.
	FH cardiovascular disease in 1st degree female relative <65 years	XaP9M	12CW.
	FH cardiovascular disease in 1st degree male relative <55 years	XaP9K	12CV.
	FH: Diabetes mellitus	1252	1252
	Family history of familial hypercholesterolaemia	1269	1269
	No significant family history of CVD	11541	11541
	Adopted family history not known	XaJIq.	12V0.
BMI / Weight	O/E – height	229..	229..
	O/E – weight	22A..	22A..
	Body Mass Index	22K..	22K..
	Ideal weight	66CB.	66CB.
	Waist circumference	Xa041	22N0.
	Advice about weight	XaADJ	67I9.
	Signposting to weight management service	XaXnl	8CdC.
	Refer to dietician	XaBSz	8H76.
	Referral to dietician declined	Xalla	813A.
	Refer to weight management programme	XaJSu	8HHH.
	Referred to LA weight management programme	XaXZ9	8HHH0
	Declined referral to weight management programme	XaQUp	8IAM
	Referral to Lifestyle coaching programme	XaMe8	8Hk7
	Declined Lifestyle coaching programme	XaPpd	9m43
	Provision of general lifestyle advice	XaX5k	66CQ

AUDIT – C	Alcohol consumption	Ub171	136..
	Audit – C score	XaORP	38D4.
	Audit score	XM0aD	38D3.
	Brief intervention for excessive alcohol consumption completed	XaPPv	9k1A.
	Brief intervention for excessive alcohol consumption declined	XaPty	8IAF.
	Referral to community alcohol team	XaIPn	8H7p.
	Declined referral to specialist alcohol treatment service	XaPwp	8IAJ.

GP Physical Activity	General practice physical activity questionnaire physical activity index: active	XaPPE	138b.
	General practice physical activity questionnaire physical activity index: moderately active	XaPPD	138a.
	General practice physical activity questionnaire physical activity index: inactive	XaPP8	138X.
	General practice physical activity questionnaire physical activity index: moderately inactive	XaPPB	138Y.
	Brief intervention for physical activity completed	XaPjx	9Oq3.
	Signposting to Physical Activity Service	XaRExx	8Cd4.
	Referral to physical exercise programme	XaIQY	8H7s.
	Declined referral to physical exercise programme	XaL1X	138S.
Smoking	Never smoked tobacco	XE0oh	1371
	Current smoker	137R.	137R.
	Ex-smoker	Ub1na	137S.
	Pipe smoker	137H.	137H.
	Cigar smoker	137J.	137J.
	Rolls own cigarettes	137M.	137M.
	Cigarette smoker	XE0oq	137P.
	Date ceased smoking	137T.	137T.
	Trying to give up smoking	137G.	137G.
	Ready to stop smoking	XalkX	137b.
	Thinking about stopping smoking	XalkW	137c.
	Not interested in stopping smoking	XalkY	137d.
	Wants to stop smoking	XaLQh	……
	Smoking cessation advice	Ua1Nz	8CAL.
	Seen by smoking cessation advisor		9N2k
	Lifestyle advice regarding smoking		67H1
	Nicotine replacement therapy	XaEKU	8B2B.
	Over the counter nicotine replacement therapy	XaFst	8B3Y.
	Nicotine replacement therapy free	XaIQn	8B3f.
	Signposting to Stop Smoking Service	XaXnG	8CdB.
	Referral: smoking cessation advisor	XaltC	8H7i.
	Referral to stop-smoking clinic	XaFw9	8HTK.
	Refer to NHS Stop Smoking Service	XaQT5	8HkQ.
	Smoking cessation advice declined	XaRFh	8lAj
	Declined referral to Stop Smoking Service	XaREz	8IEK.

COPD	Recurrent chest infections?	XaQna	H06Z2
	Breathlessness/Dyspnoea	XE0QQ	2322
	Referral to Spirometry	XaK02	8HRC.
	Spirometry declined	XaK27	8I3b.
Pulse	O/E – pulse rate	X773s	242..
	O/E – pulse rhythm regular	XMO2J	2431
	O/E – pulse rhythm irregular	X76JE	…..
	O/E – pulse rhythm	Yes/no	243..
	Refer for ECG recording	8HR1.	8HR1.
Blood Pressure	Systolic BP	2469	2469
	Diastolic BP	246A	246A
Cholesterol	Total cholesterol measurement	XSK14	44PH.
	Serum HDL cholesterol level	44P5.	44P5.
	Total cholesterol: HDL ratio	44PF.	44PF.
Blood Glucose	Fasting blood glucose level	XE2mq	44TK.
	Plasma glucose level	XM0Iy	44g..
	HbA1c (for non-fasting blood)	42W5.	42W5.
Risk Assessment	QRisk2 calculator	XaQVY	38DP
	High risk of heart disease	14O70	14O70
Management	General Lifestyle advice Intervention for risk to health associated with overweight and obesity, general advice on healthy weight and lifestyle	XaX5k XaJlt XaQau Xajlr	66CQ.
	NHS Health Check – raising awareness about dementia & memory clinics	XaaD1	67DF.
	Statins contraindicated	XaG2V	8127.
	Statin not tolerated	XaJYw	8176.
	Statin causing adverse effects in therapeutic use	XalsC	U60CA
	Adverse reaction to simvastatin	Xa5bQ	TJC24
	Adverse reaction to pravastatin	Xa5bS	TJC25
	Statins declined	XalN3	8I3C.
	Further assessment for diabetes required Diabetes mellitus screen	6872.	6872.
	Only required if BP >140/90 Further assessment for Serum Creatinine is required	XE2q5	44J3.
	GFR calculated abbreviated MDRD	XaK8y	451E.
	Further assessment for hypertension	68B1.	68B1.
	Further assessment for fasting cholesterol	XaFs9	44O5.

	Further assessment for impaired fasting glycaemia/glucose tolerance	XaXR7	8HIS.
	Cancer information offered / advice given	X71Eu	677H
Payment	NHS Health Check completed	XaRBQ	8BAg.

Note: Identical concepts are not always available in Clinical Terms version 3 (ctv3) and Read version 2 (5 byte).

These READ Codes are subject to change upon amendments to the National Minimum Dataset and Key Performance Indicators required by the Department of Health. Therefore, the IT Solution will need to be able to adjust for GP and the Authority reporting purposes incurring no additional charge.

Appendix C: Relevant guidance

BMI

- Obesity: identification, assessment and management. NICE Clinical Guideline CG189. November 2014.
- Body mass index thresholds for intervening to prevent ill health among black, Asian and other minority ethnic groups. NICE advice LGB13. January 2014

Cholesterol

- 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 (updated 2016)
- Familial hypercholesterolemia: identification and management. NICE clinical guideline 71. August 2008

Systolic and diastolic blood pressure

- Hypertension in adults: diagnosis and management. NICE clinical guideline 136. August 2019
- Blood Pressure - How can we do better? November 2016.

Fasting plasma glucose (FPG)

- Public Health England (2016) Estimated detection rates of NDH and type 2 diabetes between validated risk assessment tools. Public Health England. February 2017.
- NHS Health Check programme standards: a framework for quality improvement. Public Health England. July, 2020
- Preventing type 2 diabetes: risk identification and interventions for individuals at high risk. NICE public health guidance 38. July 2012 (updated 2017)
- Use of Glycated Haemoglobin (HbA1c) in the Diagnosis of Diabetes. WHO. 2011. Abbreviated Report of a WHO Consultation. WHO/NMH/CHP/CPM/11.1

Local stop smoking services referral

- NCSCT local stop smoking services: service and delivery guidance. NCSCT. 2014. September 2014
- Stop smoking interventions and services. Nice guideline 92. March 2018

Weight management

- Non-alcoholic fatty liver disease: assessment and management. NICE guideline NG49. July 2016.
- Preventing excess weight gain. NICE guideline NG7. March 2015
- 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 CG181. July 2014 (updated 2016)
- Overweight and obese adults – lifestyle weight management. NICE public health guideline 53. May 2014
- BMI: preventing ill health and premature death in black, Asian and other minority ethnic groups. NICE public health guideline 46. July 2013
- Obesity: guidance on the prevention, identification, assessment and management of overweight and obesity in adults and children. NICE clinical guideline 43. December 2006 (updated March 2015)

Physical activity

- Physical activity benefits for adults and older adults. Department of Health, September 2015
- Everybody Active, Every Day: An evidence-based approach to physical activity. Public Health England. 2014
- Physical activity: brief advice for adults in primary care. NICE public health guidance 44. May 2013.
- Physical Activity: UK Chief Medical Officers' Physical Activity Guidelines. Department of Health and Social Care. 2019.
- Let's Get Moving: Commissioning Guidance - a physical activity care pathway. Department of Health. March 2012.

Alcohol use

- Alcohol Guidelines Review – Report from the Guidelines development group to the UK Chief Medical Officers. Department of Health. January 2016
- Alcohol-use disorders: preventing harmful drinking. NICE public health guideline 24. June 2010
- UK Chief Medical Officers' Low Risk Drinking Guidelines. Department of Health. 25 August 2016.
- Alcohol Identification and Brief Advice e-Learning course
- Alcohol-use disorders - preventing harmful drinking. NICE Public Health Guidance 24, June 2010

Familial hypercholesterolemia

- Identification and management of familial hypercholesteroalemia. NICE clinical guideline CG71. August 2008

Assessment for chronic kidney disease

- Chronic kidney disease: early identification and management of chronic kidney disease in adults in primary and secondary care. NICE clinical guideline 182. July 2014 (updated Jan 2015)
- Lipid modification: Cardiovascular risk assessment and the modification of blood lipids for the primary and secondary prevention of cardiovascular disease. NICE clinical guideline CG181. July 2014 (updated 2016)
- Hypertension in adults: diagnosis and management. NICE clinical guideline 136. August 2019

Management of people found to have abnormal fasting blood sugar or HbA1c

- Chronic kidney disease: early identification and management of chronic kidney disease in adults in primary and secondary care. NICE clinical guideline 182. July 2014 (updated Jan 2015)
- Lipid modification: Cardiovascular risk assessment and the modification of blood lipids for the primary and secondary prevention of cardiovascular disease. NICE clinical guideline CG181. July 2014 (updated 2016)
- Preventing type 2 diabetes: risk identification and interventions for individuals at high risk. NICE public health guideline 38. 2012 (updated Sept 2017)
- Diabetes in adults quality standard. NICE quality standard 6. March 2011 (updated Aug 2016)
- Type 2 diabetes: The management of type 2 diabetes. NICE clinical guideline 87. May 2009 (updated Dec 2014)

Appendix D: Glossary of Terms and Abbreviations

AF	Atrial Fibrillation
BMI	Body Mass Index
BP	Blood Pressure
CHD	Coronary Heart Disease
CKD	Chronic Kidney Disease
CVD	Cardiovascular Disease
DBS	Disclosure and Barring Service
DM	Diabetes Mellitus
DNA	Did Not Attend
DH	Department of Health
ECG	Electrocardiogram
eGFR	estimated Glomerular Filtration Rate
FAST	Fast Alcohol Screening Tool
FBG	Fasting Blood Glucose
GP	General Practitioner
IGT	Impaired Glucose Tolerance
MUR	Medicines Use Review
PCO	Primary Care Organisation
PHE	Public Health England
POCT	Point of Care Test
PVD	Peripheral Vascular Disease
QALY	Quality Adjusted Life Year
QOF	Quality and Outcome Framework
SI	Serious Incident
TIA	Transient Ischaemic Attack
TC: HDL ratio	Total Cholesterol: High-density lipoprotein cholesterol
VBA	Very Brief Advice