Public Health Agreement for Health Checks Programme in Primary Care

1 April 2021 to 31 March 2022

SURREY
COUNTY COUNCIL

1.0. Introduction and Local Strategic aims and priorities

1.1. A revised strategy of delivery for the programme in Surrey has resulted in an enhanced fee for prioritising patient groups with higher risk factors for cardiovascular disease. These prioritised patients must be eligible for the NHS Health Check and:

- Living in an area of qualifying deprivation in Surrey (i.e. living in quintiles 1 and 2 of areas of deprivation: as per the most up to date IMD score)
- Patients with a CVD QRisk2 score of ≥ 10
- Patients with mental health illness and eligible
- Patients registered as homeless
- Patients registered with caring responsibilities and eligible
- Patients registered as smokers and eligible
- Patients registered as obese (BMI ≥ 30) and eligible
- Patients from BAME (non=white) ethnic groups

Patient groups excluded from the programme:

- Coronary Heart Disease
- Stroke
- Chronic Kidney Disease stages 3-5
- Diabetes
- Atrial Fibrillation
- Hypertension
- Familial hypercholesterolaemia
- Transient Ischaemic attack (TIA)
- Heart failure
- Peripheral Arterial Disease (PAD)
- Hypercholesterolaemia treated with statins
- Over the age of 74
- Had an NHS healthi n last five years

For advice on templates and searches to use, contact Public Health on publichealthclaims@surreycc.gov.uk

1.2. The Health Checks programme is included in the Public Health Outcomes Framework and is a five year call and recall programme for the 40-74 year old population.

1.3. The Health Check programme relates to Surrey County Councils Health and Wellbeing Strategy of developing a preventative approach.

1.4. This specification outlines the more specialised care being offered above that normally provided through essential and additional services that General Medical Services are contracted to provide. No part of this specification by commission, omission or implication defines or redefines essential or additional services.

1.5. The services will be reviewed on an annual basis.

1.6. In the delivery of any services commissioned on behalf of the Council, Providers must demonstrate awareness and be responsive to the accessibility and needs of undeserved groups in attempting to access services.

1.7. As part of delivery of this service:

- Anonymised activity data will be shared with local CCGs to support understanding of and improvement in provision
- Practices will receive information on related local public health services relevant to our patients

2.0. Background and summary of local needs

2.1. Locally in Surrey we are building on the existing programme to prioritise population groups at higher risk of CVD and would benefit sooner from a Health Check. In particular those patients who are eligible for the NHS Health Check and are:

- Living in an area qualifying deprivation in Surrey
- Patients with a CVD QRisk2 Score of ≥ 10
- Patients with mental health illness and eligible
- Persons registered as homeless
- Patients registered with caring responsibilities and eligible
- Patients registered as smokers and eligible
- Patients registered as obese (BMI ≥ 30) and eligible

3.0. Aims

3.1. The purpose of the vascular check is to identify an individual's CVD risk, for this risk to be communicated in a way that the individual understands, and for that risk to be managed by appropriate follow-up including being recalled every five years for assessment. The Health Checks programme facilitates behaviour change around modifiable lifestyle factors.
3.2. To reduce the burden of cardiovascular disease in the community by enabling more people to have their CVD risk identified and managed at an early stage of vascular change.
3.3. Offer the opportunity to make significant inroads into health inequalities, including socio-economic, ethnic and gender inequalities.
3.4. To sustain the continuing increase in life expectancy and reduction of premature mortality that is under threat from the rise in obesity and sedentary living.
Patient groups excluded from the programme:

- Coronary Heart Disease
- Stroke
- Chronic Kidney Disease stages 3-5
- Diabetes
- Atrial fibrillation
- Hypertension
- Familial hypercholesterolaemia
- Transient Ischaemic attack (TIA)
- Heart failure
- Peripheral Arterial Disease (PAD)
- Hypercholesterolaemia treated with statins

3.5. To increase population awareness of dementia for all those attending the NHS Health Check.
3.6. To identify a level of potentially harmful drinking.

3.7. Risk assessment

3.7.1 To offer adults access to an individual risk assessment through a number of different validated strategies.
3.7.2. To promote healthy lifestyle advice focusing on potential benefits of reducing vascular disease risk.
3.7.3 To detect undiagnosed T2DM facilitating early implementation of prevention strategies and vascular disease intervention.

3.8. Risk communication

3.8.1. Offer all adults undergoing a risk assessment, appropriate feedback of the results with subsequent care planning (i.e. to communicate simply and effectively their current risk of vascular disease)
3.8.2. To agree an action plan designed to reduce risk of incident vascular disease.

3.9. Risk management

3.9.1. To integrate activities of the programme with primary prevention activities in the general population.
3.9.2. To ensure the overall programme addresses potential inequalities in healthcare.

3.9.3. To ensure the optimal integration of these policies with existing systems and initiatives for example Quality and Outcomes Framework (QOF), to avoid duplication and unnecessary testing and/or assessment.

4.0. Assessment

4.1. All patients attending the practice for a health check will be assesses for their CVD risk using the CVD risk tool (QRisk) stated in the 'NHS Health Check Best Practice Guidelines'. The following information will be collected and investigations will be carried out (subject to change as per the recommended CVD risk tool):

- Age
- Gender
- Pulse rhythm check (*see Pulse Check best practice guidance note at end of this specification)
- Blood pressure
- Smoking status
- BMI
- Physical activity levels (GPPAQ Questionnaire)
- Total cholesterol level
- HDL cholesterol level
- HBA1C (for those at high risk of diabetes)
- Family history of diabetes and premature heart disease
- Ethnicity
- Postcode (to enable deprivation score to be calculated)
- Alcohol intake (Audit C screen) see appendices
- Dementia awareness for all patients attending (use NHS Health Checks Dementia Awareness Booklet) – see appendices

4.2. Where appropriate, it may be possible to complete some elements of the health check digitally (e.g. via footfall). However, physical measurements (blood pressure, cholesterol, HBA1C etc.) will still require a physical appointment.

4.3. Regardless of the format of the health check (digital or in person), it is essential that the CVD risk score (QRisk) and a discussion about health behaviours is completed verbally ensure the patient understands their risk and the changes they can make to reduce their risk of CVD and diabetes.

5.0. Scope and definition of service

5.1. The service is primarily a preventative one; it is not intended for those people who already have vascular disease, e.g. people with existing diagnosis of diabetes, hypertension, heart disease, stroke, TIA, CKD. It is assumed that these people will be on the appropriate disease registers and receiving treatment as necessary.

Anyone on high risk register is excluded.

5.2. It is expected that the service will be delivered proactively in a structured and systematic way and can include work outside of the practice with workplaces for example. This should be done in liaison with Surrey County Council public health team.

5.3. This primary care service should not be confused with (and sits outside of) essential and additional GMS or PMS services already provided, current Quality and Outcomes (QOF) indicators and any National Enhanced Services.

6.0. Service outline

6.1. Ensure that only appropriately trained staff provide the service (see item 7).

6.2. Ensure that for all completed Health Checks a complete record is made on the patient's clinical record.

6.3. Ensure that all equipment used is maintained and accurately calibrated in accordance with manufacturers' guidelines and MHRA guidelines; 'Management and use of IVD Point of Care testing equipment Guidance Documentv Blood Pressure management devices MHRA Blood Pressure Management devices.
6.4. Use the cardiovascular risk score (QRisk) specified in the latest version of 'NHS Health Checks Best Practice Guidelines'.
6.5. The practice will have in place a call and re-call register, with individual patients only claimed for once in every 5 years. This will involved inviting patients to access the service, record their results and recalling them in five years' time. Where patients fail to attend or refuse to have their risk assessed, this will be recorded accordingly. A fail or refusal will be recorded after attempting to contact them on three separate occasions by either telephone, text or letter. The practice will also take appropriate follow-up actions to encourage non-attendees to have their vascular risk assessed. Template invite letters are available via NHS Health Checks website and standard Patient Information letters are available from Surrey County Council.
6.6. DNAs should be managed in line with the practice's own local DNA policy.
6.7. Undertake a standard assessment, based on the following questions and measurements: height, gender, age, ethnicity, weight, hip/waist ratio, current medicines, age, family history, smoking status, pulse rhythm check, blood pressure and blood test for total/HDL cholesterol. Those who have been identified at risk of diabetes or kidney disease may then have further blood and urine tests (see diagram 1&2 below).
6.8. Communicate the risk (high, moderate, low) to people, with appropriate advice, support and interventions depending on the level of identified risk.
6.9. Ensure that all patients receive lifestyle advice on how to maintain/improve their vascular health. Patients identified as high risk will require further investigation and (if applicable) referred to a lifestyle management programme e.g. smoking cessation, weight management, healthy walks and Diabetes Prevention Programme.
Practices should follow their local protocols and referral pathways for those identified as high risk of T2DM. (Where HbA1c is 42-47 mmol/mol (6.0-6.4%) and refer to the NHS Diabetes Prevention Programme for intensive lifestyle behaviour change.
6.11. Involve the patient actively in agreeing what advice and/or interventions are to be pursued.
6.12. Make decisions in partnership with the patient and with the patient's information consent.
6.13. Have the flexibility to decide how to implement the vascular risk assessment programme – for example through allocated appointment times or open clinics. It may be that there are times when opportunistic assessment can take place.
6.14. Participate in the programme monitoring process by producing quarterly data and annual audit data as requested including the follow-up of high-risk individuals who have moved onto a disease register and exited the NHS Health Checks Programme.

7.0. Training and governance

7.1. The county council will provide training and support for all staff delivering the Health Checks Programme. Practices must have a planned, regular programme of education, training and support for their staff including HCAs delivering the NHS Health Check.
7.2. Any staff delivering NHS Health Checks are required to have completed the 'Health Check Mentor' eLearning module via the OnClick portal.
7.3. Healthcare staff delivering the service will be required to demonstrate their professional eligibility, competence and continuing professional development in order to remain up-to-dare and deliver an effective service which is culturally appropriate.
7.4. Practitioners must have the required competencies for the risk assessment process at an appropriate level.
7.5. Practices should ensure safe staffing capacity at all times.
7.6. Staff should be able to demonstrate that they have participated in organisational mandatory and update training, for example as infection control, manual handling, risk assessment and risk communication as required.

Workforce competencies from NHS Health Check UK.
7.7. Service will be structured with consideration to clinical governance issues where appropriate including:

- Clear lines of responsibility and accountability.
- Participation in quality improvement activities where appropriate.
- Adherence to policies and procedures, and consideration given to risk management.
- A commitment to further training for staff where necessary and maintenance of skills.
- Procedures for all professional groups to identify and remedy poor performance.
- The use of clinical guidelines is considered to be consistent with good practice.

8.0. Monitoring and payment

8.1. Payment will be made quarterly in arrears.
8.2. All claims are made via the quarterly claim form provided by the public health team or where agreed by public health, additional local mechanisms that have been developed to submit via a CCG or local GP federation can be used.
8.3. Practices must provide the required data monitoring activity to support their claims. Failure to provide this may result in the claim being delayed until the information is provided.
8.4. In addition to the claim form (or locally agreed submission), practices must provide results for each aspect of an NHS Health Check as per section 4. This data should be anonymised but is required for all completed NHS Health Checks. Failure to provide this may result in the claim being delayed until the information is provided.
8.5. See appendix 4, page 31, for payment structure.
8.6. The Council has the right to audit a practice against the claims received. Reasonable notice will be given to the practice prior to the audit.

9.0. Point of care testing equipment

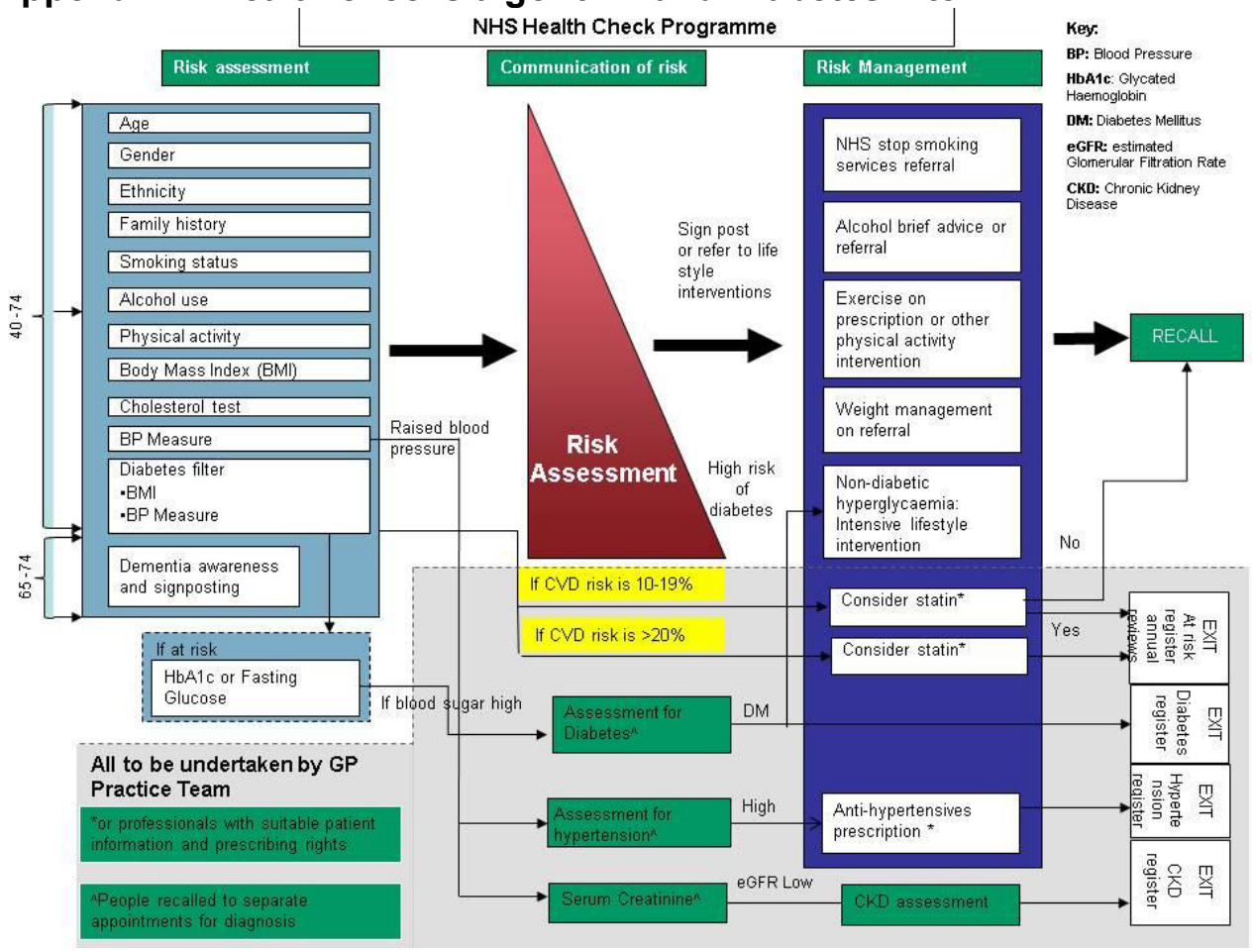
9.1. If appropriate practices will be provided with a budget of up to £2750 to purchase point of care testing equipment and support to carry out Health Checks. This will be a one off payment claimable in the first quarter of service delivery and can be submitted separately to the quarterly claim form for faster payment. This funding is subject to ongoing activity monitoring. The equipment will need to be able to measure cholesterol and HbA1c and be in line with the POCT MHRA Guidance documents in the appendices.
9.2. The practice will purchase consumables, maintain the equipment in terms of calibration and internal and external quality assurance.
9.3. Practice providers should ensure:

- Only staff who have been trained (by a competent trainer) use the POC equipment
- That an appropriate internal quality control (IQC) process is in place
- Up to date register of trained/competent operators
- That there is named POCT coordinator
- That records of results of quality control performed
- That they can evidence registration in an accredited external quality control EQA scheme reporting to NQAAP

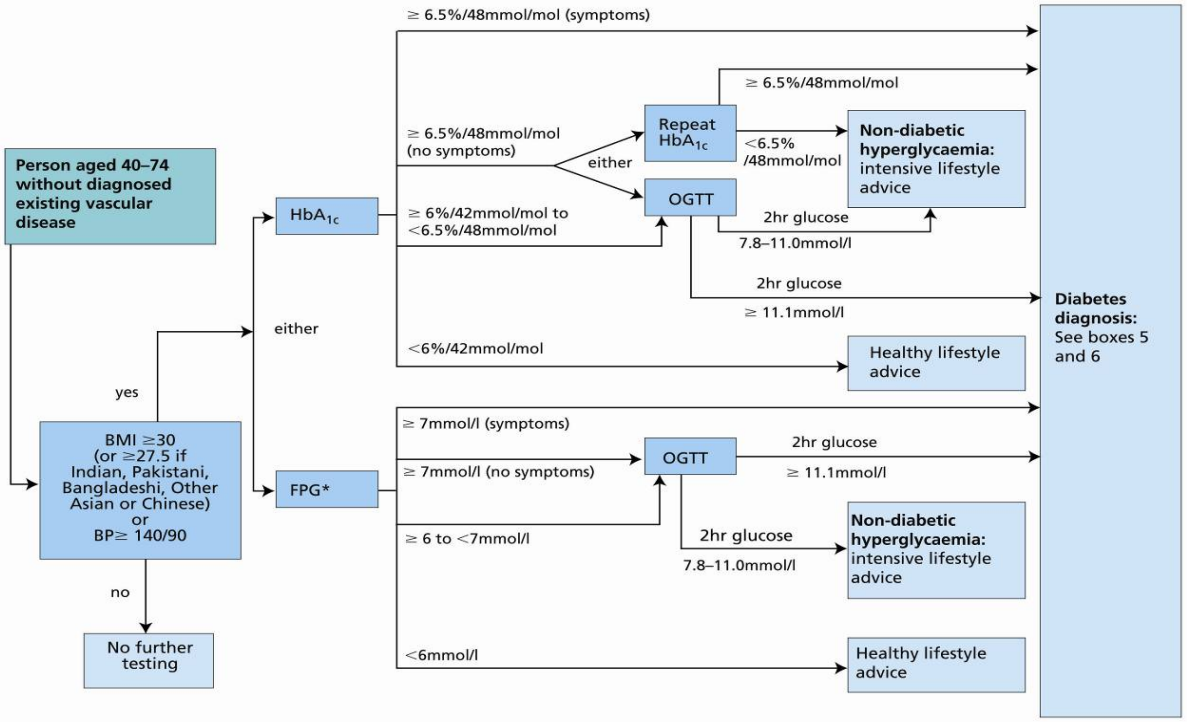
The above is based on the MHRA guidelines already referred to.
9.4. If following ongoing discussion, training and support from the public health team, the practice is not then able to provide health checks to patients and there are no plans for future provision, the situation will be discussed with the practice and arrangements will be made to re-allocate the equipment for use in another practice or location.

Appendices

Appendix 1. Health checks algorithm and Diabetes filter



Diabetes Filter



* The values in the diagram are for laboratory tests. For FPG POCT, use a value of less than 5.5mmol/l to proceed to healthy lifestyle advice. If the FPG POCT value is 5.5mmol/l or above, repeat using a venous blood sample for laboratory testing and follow the diagram according to the results.

Appendix 2 Useful links and information

Patient audits

- GPAQ Questionnaire
- Audit C Questionnaire
- Diabetes UK Risk Score Tool
- Leicester Diabetes org

***Pulse check key points:**

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

Additional guidance

Hypertension: clinical management of primary hypertension in adults.
NICE clinical guideline 127, August 2011.
Best Practice Guidance

POC Management and guidance

Alerts and recalls for drugs and medical devices

QRisk

QRisk website

Patient information

- Department of Health (Alcohol, Change4Life, Health Check Dementia Booklet)
- NHS Choices (NHS Interactive Livewell Information including weight loss tools)
- Diet and lifestyle advice
- Patient advice and leaflets on Blood Pressure and Cholesterol

Appendix 3 NHS Health Checks payment structure

Prioritised Health Check

The County Council will pay GP providers £45 for a completed Health Check.

- Living in an area of qualifying deprivation in Surrey* (i.e. living in quintiles 1 and 2 areas of deprivation: as per the most up to date IMD score)
- Patients with a CVD QRisk2 Score of > 10 prior to the NHS Health Check
- Patients with mental health illness and eligible
- Persons registered as homeless
- Patients registered with caring responsibilities and eligible
- Patients registered as smokers and eligible
- Patients registered as obese (BMI > 30) and eligible
- Patients from BAME (Non-white) ethnic groups

(*The County Council will provide relevant post codes for practices to search patient lists).

Standard Health Check

The County Council will pay GP providers £10 for a completed Health Check to patients who are eligible but do not meet the described priority criteria.
For advice on templates and searches to use Contact Public Health team on:
publichealthclaims@surreycc.gov.uk
A completed NHS Health Check is defined in this specification and comprises a risk assessment (including risk assessment for diabetes, hypertension and CKD, dementia prompt for 65 years and over, and Alcohol AUDIT C as required), and the appropriate instigation of risk management as defined by the Best Practice Guidelines. See Appendix 1