Public Health Agreement

for the NHS Health Checks Programme in Primary Care

For adults aged 40-74 years

1st April 2025– 31st March 2026

BETWEEN Surrey County Council **AND** The General Practice

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; (ie 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 prior to invitation to NHS Health Check
- Patients with a diagnosed mental health condition (not on the SMI register) 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 black and minority 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 Health in last five years

For advice on templates and searches to use Contact Public Health team 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 CC's Health & 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 underserved groups in attempting to access services.

1.7 As part of delivery of this service,
- anonymised activity data will be shared with commissioners and the ICB 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 populations 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 of qualifying deprivation in Surrey;
- patients with a CVD QRisk2 Score of ≥ 10 prior to invitation to NHS Health Check
- Patients with a diagnosed mental health condition (not on the SMI register)
- 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 black and minority ethnic groups

2.2 General practices support the NHS commitment to moving towards a greener future way of working (NHS England » Moving towards a greener general practice) as part of a national requirement. Working towards impacting climate change positively, has subsequent effects on reducing health inequalities and improving patient health.

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.

3.5 To increase population awareness of dementia for **all those attending the NHS Health Check**

3.6 To identify level of potentially harmful drinking

4.0 NHS Health Check Programme Standards

The NHS Health Check programme standards were updated in July 2020 (NHS Health Check - National guidance). The ten standards encompass four key processes within the NHS Health Check; invitation and offer, risk assessment, risk communication and risk management. Each process is detailed below.

4.1 Invitation and Offer

4.1.1 Ensure alternative methods of invitation are available to use within practice.

4.1.2 Ensure appointment times are appropriate and adequate and offer a variety of options to cater for all eligible patient groups.

4.2 Risk Assessment

4.2.1 To offer adults access to an individual risk assessment through a number of different validated strategies

4.2.2 To promote healthy lifestyle advice focusing on potential benefits of reducing vascular disease risk

4.2.3 To detect undiagnosed T2DM facilitating early implementation of prevention strategies and vascular disease intervention

4.3 Risk Communication

4.3.1 Offer all adults undergoing a risk assessment, appropriate feedback of the results with subsequent care planning (i.e.to simply and effectively communicate their current risk of vascular disease). **All patients should have access to view their results upon completion of their NHS Health Check.** Results card and booklets. can be found at the following link: NHS Health Check - Invitation letter and results card

4.3.2 To agree an action plan designed to reduce risk of incident vascular disease

4.3.3 To provide onward referrals to lifestyle services where appropriate. [See Appendix 4].

4.3.4 In addition to the above, practices should be aware of signing up to the 'Enhanced Service Specification – Weight Management' (Enhanced Service Specification - Weight Management 2024/25) to receive further payments for referring patients to weight management services. **25/26 spec is yet to be released.**

4.4 Risk Management

4.4.1 To integrate activities of the programme with primary prevention activities in the general population

4.4.2 To ensure the overall programme addresses potential inequalities in healthcare

4.4.3 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

5.0 Assessment

5.1 **All patients attending the practice for a health check will be assessed 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 **for all patients** (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

5.2 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.

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

5.4 Please note that not completing or documenting the QRISK score of a patient may result in payments being delayed for the service carried out.

6. 0 Scope and Definition of Service

6.1 The service is primarily a preventive 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 a high-risk register is excluded.

6.2 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 CC public health team.

6.3 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.

7.0 Service Outline.

7.1 Ensure that only appropriately trained staff provide the service. [See item 8.1]

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

7.3 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 Document Blood Pressure management devices MHRA Blood Pressure Management devices. **If applicable**, **it is mandatory that you provide results via the monthly EQA reports requested by BHR Biosynex as the provider of your Point of Care testing and consumables.**

7.4 Use the cardiovascular risk score (QRisk) specified in the latest version of 'NHS Health Checks Best Practice Guidelines'.

7.5 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 involve 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 CC.

7.6 DNAs should be managed in line with the practice's own local DNA policy.

7.7 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 a 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).

7.8 Communicate the risk (high, moderate, low) to people, with appropriate advice, support and interventions depending on the level of identified risk.

7.9 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

7.10 Involve the patient actively in agreeing what advice and/or interventions are to be pursued.

7.11 Make decisions in partnership with the patient and with the patient's informed consent.

7.12 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.

7.13 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.

8.0 Training and Governance

8.1 NHS Health Check Training

The county council will organise a live online training session **three times a year** 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.

8.2 Healthcare staff delivering the service will be required to demonstrate their professional eligibility, competence and continuing professional development in order to remain up-to-date and deliver an effective service which is culturally appropriate.

8.3 Practitioners must have the required competencies for the risk assessment process at an appropriate level.

8.4 Practices should ensure safe staffing capacity at all times.

8.5 Staff should be able to demonstrate that they have participated in organisational mandatory and update training, for example infection control, manual handling, risk assessment and risk communication as required.

Workforce competencies and other training available:

- NHS Health Check - Training

8.7 Services 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.

9.0 Monitoring and payment

Please read this section carefully and note that the claims process will be different for 2025/26 due to the council moving to the digital platform, Ardens Manager, to monitor activity across NHS Health Checks.

9.1 Payment will be made quarterly in arrears.

9.2 Practices shall receive payment following the use of Ardens Manager. Ardens Manager extracts data daily from EMIS Web and SystmOne and automatically uploads it to GP Practice dashboards. Via the dashboards, the Council will be able to view non-identifiable activity data. This activity data will provide the basis for automated quarterly invoices to be generated by Ardens Manager at the fee level stated in the service specifications.

9.3 There will be a 10 calendar day 'Grace Period' whereby amendments to the clinical systems can be conducted after the quarter end, but before payment claims are finalised with Surrey County Council. To ensure a prompt payment, practices are advised to raise any concerns within the below grace periods given for each quarter of 2025/26 financial year. Ardens Manager data should be reviewed and changes in the clinical systems undertaken, if necessary. Data will be pulled on the day following the end of each quarter. On the 15th of each month, the data will be exported again reflecting any changes made to the clinical system and payment will be made based on this data export.

2025-2026	**Claim submission deadline**
Q1	1st – 10th July 2025
Q2	1st – 10th October 2025
Q3	1st – 10th January 2026
Q4	1st – 10th April 2026

9.4 The Council shall pay the Fees for the Service by BACS within 30 days of receipt by the Council of the Ardens Manager generated quarterly invoice following continued successful performance of the Service in accordance with the Contract and the Specification.

9.5 All components of the NHS Health Check must be entered and coded correctly. Ardens Manager contains all relevant codes associated to the NHS Health Check and particularly the payment activity. Appendix 5 provides further information.

9.6 If your practice has not signed up to the appropriate Ardens Manager invitations and data sharing agreements, please see Appendix 5 for further information.

9.7 Throughout each contract year the Council will monitor claims to ensure that activity does not exceed the overall budget. Where this looks likely, the Council has the right to introduce a cap on activity by provider.

9.8 If a patient within your practice has received an NHS Health Check via a third party subcontractor, it is your job to record the health check in clinical records. Please make a note of these patients as Ardens Manager will pick up patients who have received a health check via a third party and exclude them from payments. It is a requirement that any arrangement with a third party is discussed with the commissioner and prior agreement is sought.

9.9 **Please note (as per 5.4) that not completing or documenting the QRISK score of a patient may result in payments being delayed for the service carried out.**

10.0 Point of care testing equipment

10.1 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.

10.2 The practice will purchase consumables, maintain the equipment in terms of calibration, and internal and external quality assurance.

10.3 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

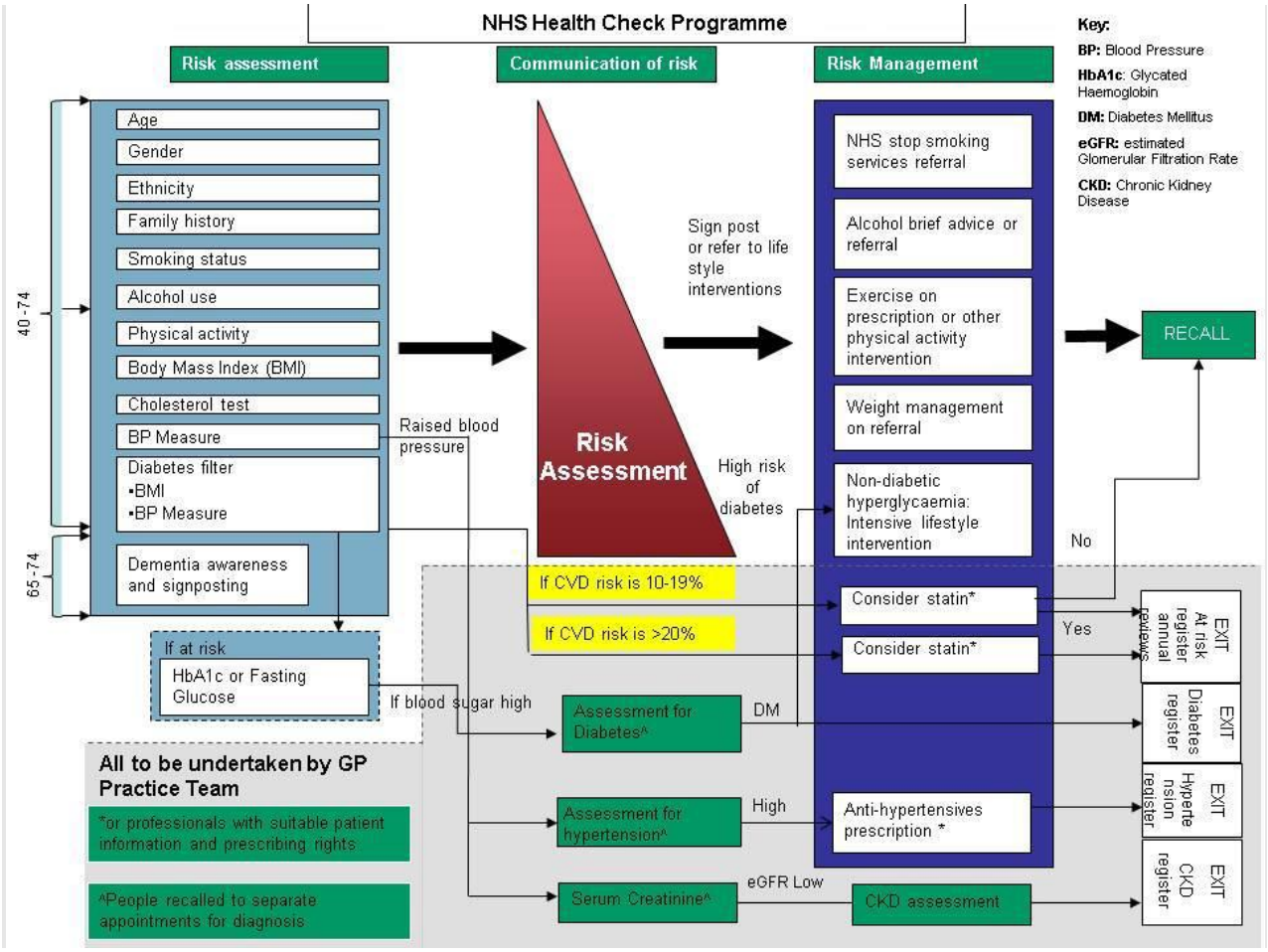
- That they can evidence registration in an accredited external quality control EQA scheme reporting to NQAAP

(the above is based on the MHRA guidelines already referred to.)

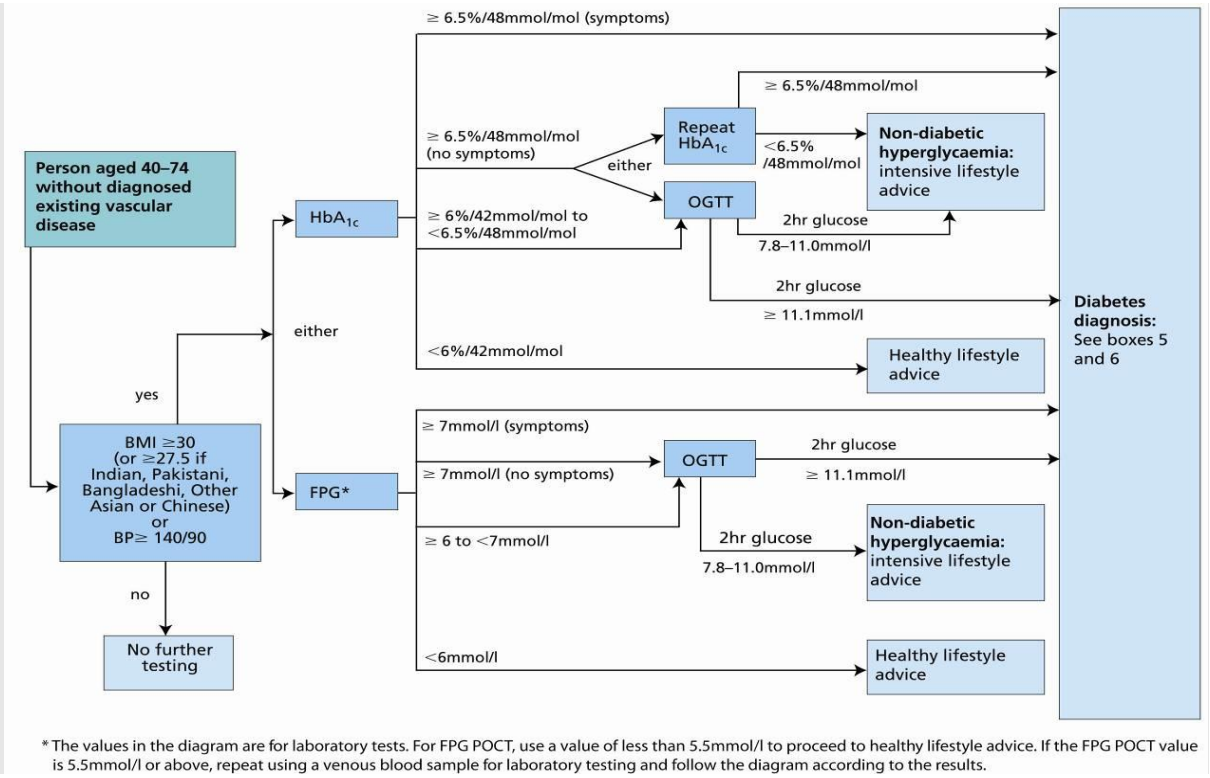
10.4 If following ongoing discussion, training and support from the public health team, the practice is not then able to provide health checks to patients and there are no plans for future provision, the situation will be discussed with the practice and arrangements will be made to re-allocate the equipment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

A P P E N D I C E S

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 : https://www.gov.uk/government/publications/general-practice-physical-activity-questionnaire-gppaq
- Audit C Questionnaire : http://www.alcohollearningcentre.org.uk/Topics/Browse/BriefAdvice/?parent=4444&child=4898
- Diabetes UK Risk Score tool https://www.diabetes.org.uk/resources-s3/2018-02/DiabetesRiskScore_form.pdf
- Or Leicester Diabetes org http://leicesterdiabetescentre.org.uk/The-Leicester-Diabetes-Risk-Score

***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 factors for preventing premature mortality, commissioners and providers will wish to familiarise themselves with the NICE hypertension guidance.
Additional guidance
Hypertension: clinical management of primary hypertension in adults. NICE clinical guideline 127. August 2011.
Best Practice Guidance : DoH publication NHS Health Checks Best Practice
http://www.healthcheck.nhs.uk/national_guidance/

POC Management and Guidance

http://www.mhra.gov.uk/Publications/Safetyguidance/DeviceBulletins/CON071082

QRisk : http://www.qrisk.org/

Patient Information:

- Department of Health (Alcohol, Change4Life, Health Check **Dementia** booklet) https://www.orderline.dh.gov.uk/ecom_dh/public/saleproducts.jsf
- NHS Choices (NHS interactive Livewell Information including weight loss tools) http://www.nhs.uk/Conditions/nhs-health-check/Pages/NHS-Health-Check.aspx
- Diet and Lifestyle advice http://www.nhs.uk/change4life/Pages/change-for-life.aspx
- Patient advice and leaflets on Blood Pressure and Cholesterol : https://www.bhf.org.uk/publications

Appendix 3: NHS Health Checks payment structure

- **Prioritised Health Check –**

The County Council will pay GP providers **£30.00** for a completed Health Check

- living in an area of qualifying deprivation in Surrey*; (ie 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 ≥ prior to invitation to NHS Health Check
- Patients with a diagnosed mental health condition (not on the SMI register)
- 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 black and minority ethnic groups

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

- **Standard Health Check –**

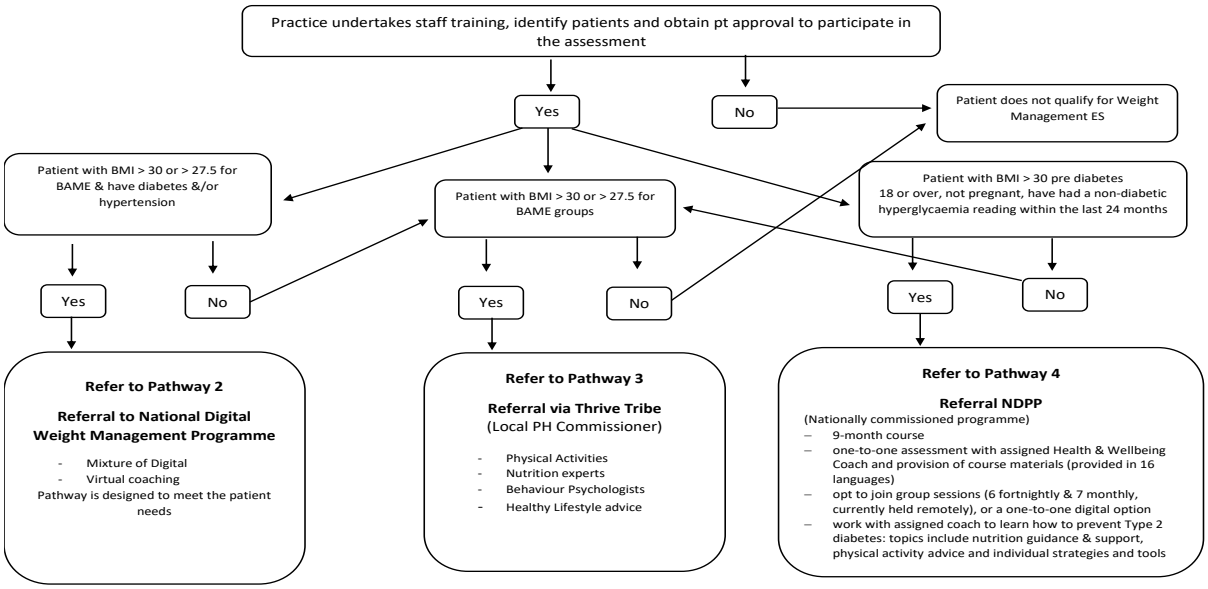
The County Council will pay GP providers **£20** for a completed Health Check to patients who are eligible but do not meet the described priority criteria.

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

Appendix 4: Onwards referral to lifestyle services.

Weight Management



One You Surrey is the free adult (18 years and older) lifestyle service commissioned by Surrey County Council Public Health. The service offers a range of programmes such as Slimming World, Gloji Groups and Man v Fat that are delivered online or in the community to support adults with a BMI greater than 30, or greater than 27.5 if they are from a Black, Asian and Minority community. **Patients are able to self-refer if signposted to the One You Surrey website.**

NHS Digital weight management programme: The NHS Digital Weight Management Programme is provided by NHS England. It supports adults living with obesity who also have a diagnosis of diabetes, hypertension or both, to manage their weight and improve their health. The programme is available for anyone who has a BMI greater than 30, and 27.5 for people from Black, Asian, and minority ethnic backgrounds. To access this, the individual must have a smartphone, tablet, or computer with internet access. **Please refer the patient through clinical system.**

NHS Diabetes Prevention Programme (DPP): Unlike type 1 diabetes, type 2 diabetes is largely preventable through lifestyle changes. The Healthier You NHS Diabetes Prevention Programme, also known as the **Healthier You** programme, identifies people at risk of developing type 2 diabetes and refers them onto a nine-month, evidence-based lifestyle change programme. The Healthier You programme is available both as a face-to-face group service and as a digital service. When referred into the programme, people are free to choose between the two. This service is free and available across Surrey and nationwide, based on a set of **eligibility criteria**. **Please refer the patient through clinical system.**

Smoking Support

One You Surrey is the Council's commissioned Adults Healthy Lifestyle service which offers free, evidence-based stop smoking support. The service offers 12 weeks of behavioural support, as well as free access to quitting aids such as NRT and vape starter kits. **Patients are able to self-refer if signposted to the One You Surrey website.**

Alcohol Support

i-access is the main service commissioned by Surrey Public Health for adults aged over 18 years who use drugs and/or alcohol. It is led by the Surrey and Borders Partnership NHS Foundation Trust (SABP) who subcontract VIA (formerly known as Westminster Drug Project) for certain elements of the contract. **Patients can self-refer if signposted to the i-access website. Alternatively, you can download the referral form to your EPR on the following link: Getting Help : Surrey and Borders Partnership NHS Foundation Trust**

Appendix 5: Ardens Manager

Key Contacts

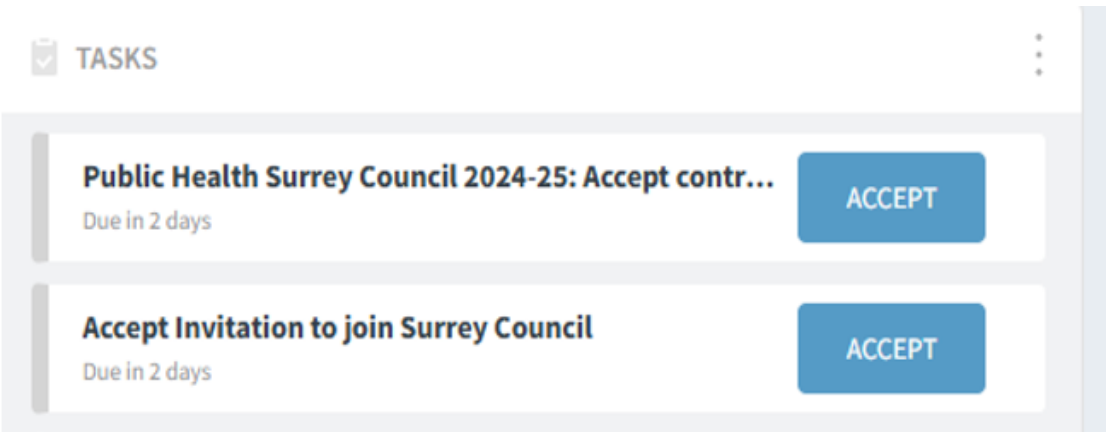
Ardens Manager: support-manager@ardens.org.uk or 01865 648 555.

Surrey Council: Publichealthclaims@surreycc.gov.uk

Sign-up Process

To get started:

1. **Log in to Ardens Manager:** Please **Log-in** to Ardens Manager.
2. **Navigate to your homepage**: Once you have access to Ardens Manager navigate to your 'Tasks' section (top right), which will have invitations for you to action – see the below example



Coding for Priority Populations

Sub report Title	Coding used
PH - NHS Health Check: Cohort - Targeted: Ethnic Minority	Ardens cluster created from QOF codes ^ARD-000-000-782  ethnicity---all-code-descendants.csv
PH - NHS Health Check: Cohort - Targeted: IMD 1-3	Patient • Postcode > IMDDecil (Current) ≤ 3 Activity • Code is Registered in deprived area (184165003) • Done date (any) is after Contract date RPSD - 1 years
PH - NHS Health Check: Cohort - Targeted: Latest QRISK >=10%	QOF code "QRISK_COD" **^999018091000230108**
PH - NHS HC | Cohort - Priority: Is a Carer	Ardens Cluster -  informal-carer-(ard-p)-code-descendants.c
PH - NHS HC | Cohort - Priority: Smoker	QOF code -" LSMOK_COD (^999004211000230104)"
PH - NHS HC | Cohort - Priority: Homeless	Ardens Cluster  homeless-ard-d-code-descendants.csv
PH - NHS HC | Cohort - Priority: MH (not SMI)	QOF Codes : - DEPR_COD (^999004611000230102) Or - LD_COD (^999002611000230109) Exclusion of MH_COD (^999001091000230104)
PH - NHS HC | Cohort - Priority: Latest BMI >=30	QOF Code : BMIVAL_ (^999011171000230101)