NHS
West Sussex
The Causeway
Goring-by-Sea
Worthing
West Sussex
BN12 6BT

GP Practice:

GP Practice Address:

Local Enhanced Service

Issue date: June 2011
Version 2

Review date: as required for service development and with Department Health and national guidance and service developments

Agreed with LMC
Agreed with LPC
Agreed with Enhanced Services Group

Introduction

This Local Enhanced Service for GMS and PMS contractors is to support the delivery of the West Sussex NHS Health Checks service. All providers are expected to provide the full range of essential and those additional/advanced services as set out in their contracts. This enhanced service level agreement is designed to cover the enhanced aspects of the clinical care provided to the patient, all of which are beyond the scope of essential services. No part of the specification by commission, omission or implication defines or redefines essential or additional services.

With provision of this service, consideration must be given to addressing inequalities in health. This primary care service provides an opportunity to narrow the inequalities gap by providing the service to eligible cohort, but also to engage those in disadvantaged groups with poor health outcomes. As the service develops, ways of engaging people who do not normally access healthcare services will be explored. This service must be provided in a way that ensures it is equitable in respect of race, creed, culture, diversity, disability.

Background

Cardiovascular disease is a major cause of morbidity and mortality and is a significant contributory factor towards the current level of health inequalities in West Sussex. 34.7% of deaths in 2006/ 8 (NCHOD Statistics) were attributed to this, the highest cause of premature death. A structured approach to cardiovascular risk management for all people aged 40-74 years old, who are not already on any patient risk register, is expected to be established by 2012 / 13. The service is referred to as “NHS Health Checks”. NHS Health Check is an ambitious program which will develop cardiovascular prevention activity in line with Best Practice Guidance (DH April 2009). This structured approach will mean implementing systems and evaluation linked to clear processes and pathways for lifestyle interventions. NHS Health Check West Sussex is a prime opportunity to influence the CVD prevention agenda and to be a vehicle and context for increasing an individual’s awareness of their risk and supporting their health behaviour changes.

Aims of the service

- To appropriately measure and assess cardiovascular risk factors in adults within the 40 – 74 year old eligible cohort
- To reduce risk and prevent development of conditions such as diabetes
- To encourage people into lifestyle interventions to address the modifiable risk factors
- To improve health outcomes and quality of life by enabling more people to be identified at an earlier stage of vascular change. This will give a better chance of putting in place positive ways to make substantial reductions in the risk of cardiovascular morbidity, premature death or disability.(Domain 2 NHS Outcomes Framework)
- To identify those who (once lifestyle changes have been tried) would benefit from medication (except where there are clear overriding medical indications e.g. identification of diabetes, hypertension or familial hyperlipidaemia).
- To offer a vehicle to support future health gain and to raise awareness of risks associated with obesity, sedentary living, smoking and alcohol intake
- To be a vehicle to actively signpost onto other support services such as Stop Smoking / Why Weight? / health trainers / Wellbeing HUBS where available
- To make significant inroads into reducing health inequalities, including socio-economic, ethnic and gender inequalities. (Domain 1 NHS Outcomes framework)
- To offer convenience and accessibility for the service by providing a choice of location and hours of availability to support access for a majority that fall into a working age population
- To be a vehicle to improve CVD prevention knowledge / awareness (public and Health professionals) and skills (health professionals).

Critical success factors

Learning from the West Sussex pilot start of NHS Health Check identifies the following critical success factors required for successful delivery of the service within GP practice. These include:

- More than one dedicated member of staff trained to deliver health checks / contingency planning
- Dedicated clinics developed above and beyond usual clinics acknowledging the access needs of this cohort
- Adequate administration support allocated within the practice for data returns / sending invites etc
- Positive attitudes towards CVD prevention within the practice
- Realism and planning regarding taking on a new service regarding capacity i.e. nurse time / clinic room space / and annual leave

Tiered involvement in the NHS Health Check service

This LES is comprised of a tiered LES agreement that will be offered to all GP practices.

The tiers allow each practice to decide their level of involvement within the service according to their unique capacity and demands, yet allow some flexibility for service development and service provision.

Tier 1 –

- To accept NHS Health Check Data from NHS Health Check providers. This may come in paper format, but it is envisaged that where possible pharmacy and outreach providers will use E versions sent via NHS email accounts to generic GP NHS email address.

- To input and record above data (from all NHS Health Checks that have been carried out within community pharmacy / outreach or from a pre-arranged cluster GP practice), in a timely and accurate way, onto the clinical system using the designated national read codes. Clinical system templates for Health Check are available to assist data entry and should include entries as per Appendix C.
- To report back an annual retrospective audit of health outcomes from the data of high risk or those requiring onward investigations **(expected to total approx 10- 20 % of all health check data inputted)** i.e. searching against NHS Health Check code and care pathways i.e. Diabetes / Hypertension / CHD / Stroke / CKD / AF / COPD or have starting statins when > 20 % risk (post health check)
- The audit to be returned to the Karen Davies Quality and Development Lead NHS Health Check (Karen.davies@westsussexpct.nhs.uk - Public Health 01243 815127) reflecting an analysis of April - Jan / Feb 2011/12). Currently methods to support this extraction from the clinical systems are being explored.

Tier 2 – All of the above plus:
To identify patients who meet the "eligibility criteria", set up call and recall systems and sending invites to support a designated named pharmacy provider signed up to NHS Health check SLA / to support current pilot pharmacy sites / or a designated "cluster " GP practice as deliverer of the check. Mutually agreed arrangements between the above parties for allocation and booking individuals into NHS Health Check appointments need to be arranged.

DH guidance states that eligible patients will be those who:

Are aged between 40 and 74 years and are **NOT** on one of the following disease registers:

Diabetes
CHD
Heart Failure
Atrial Fibrillation
Hypertension
Stroke/TIA
Renal disease / CKD
Peripheral Vascular Disease

Haven't had a NHS Health Check in the last five years

Palliative Care (practices will manually identify and exclude those patients that are on the palliative care register)

Using an equivalent of the template letter provided, written invitations should sent to patients eligible to attend a health check and should include:

- A copy of the Department of Health NHS Health Check information leaflet
- Information re how to make appointment at the designated pharmacy
- Sheet (available from Quality and Development lead for the service) containing a list of pharmacy providers delivering NHS Health Check.

Invitations must include details of available choice of provider and venue. **Current reporting requirement to the DH include numbers of invitations sent per month**. Practices will need to record and report to the Karen Davies - Quality and Development Lead for NHS Health Check, numbers of invites sent per month via the web form.

- The Lump payment allows for 500 letters (0.50 p to be sent throughout the year at a suggested 100 invites bi monthly).
- Practices may also want to explore ways to maximise take up e.g. using new patient reviews.

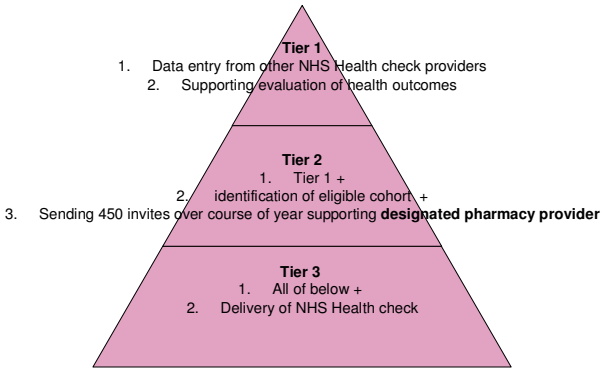
- Practices are required to record two attempts at contacting the patient. Where necessary, the second attempt may be by telephone or text message. It is recommended that the time between contact attempts is approximately one month.
- All practices must order and maintain supplies of the DH leaflets to send out with the letters of invitation. Orders are made directly from the Health Promotion Resources Unit NHS West Sussex 01903 700290.
- Establishment of call and recall process -by 2012/13, the PCT will be required to ensure that 20% of the population is offered screening annually, with a 5 year call and recall system in place. The call and recall system will ultimately be a national arrangement, but until that is in place, local arrangements will need to be made.

- **Tier 3** – All of the above + delivery of the health checks within the GP surgery (payment will be per Health check). It is expected that providers will deliver between 4-8 Health checks per week or 250 year. **If able to deliver more than this number this needs to be agreed by prior arrangement with the Quality and Development lead for NHS Health Checks.**

- **Tier 4** – the above + delivery of the health checks for an other pre determined local surgery signed up to Tier 2 (payment per Health check delivered)

Tiered GP LES – NHS Health Check

NHS West Sussex



health & wellbeing, for life

Delivery of the health checks – Tier 3 & 4

It is a requirement that best practice guidance is followed at all times. To be consistent with Department of Health Best Practice Guidance (DH 2009) a health check will be:

- A full and holistic face to face cardiovascular assessment for individuals, within the eligible cohort, and performed as per the DH Standard Operating Framework (2008). This will include the use of risk engine Qrisk 2 or Framingham to calculate the risk score.
- A clear communication of CVD risk and advice regarding how that individual could reduce their modifiable risk factors.
- This may include advice on physical activity, weight reduction, a healthy diet, relaxation and limiting alcohol and salt intake.
- A brief stop smoking intervention for current smokers – as per best practice **A**SK / **A**DVISE / **A**CT
- Assessment of motivation to change health behaviour and requirements for onward support
- Appropriate onward and active referral for lifestyle support
- Adherence to data requirements needed to evaluate and inform this service and to support any future requirements regarding DH minimum data set for the service.
- All persons undergoing a Health Check will be given a copy of their results on the West Sussex NHS Health Check results sheet.
- In addition to the above, people who are found to be at high risk or where a pre-existing disease is suspected or identified (e.g. Diabetes) will be identified to their GP practice as requiring further investigation and management.
- The service provider will be expected to demonstrate a clear understanding of the services available locally to individuals to support healthier lifestyles and communicate this information to the appropriate individuals.
- The service provider will supply the individual with relevant information, appropriate to their needs. PCT recommended resources are available from the Health Promotion Resources Department and can ordered directly **01903 700290**.
- The service will be expected to be available at suitable times which support and maximise uptake in this primarily working age population.

To support best practice all service providers will attend at least one clinical meeting per annum to share best practice and discuss service development and improvements.
The Health check will include within a 20- 30 minute consultation the recording and assessment of:
Age
Gender
Family History
Ethnicity
Smoking Status – Brief Intervention for current smokers
Height
Weight
Waist circumference
Body Mass Index
Dietary / alcohol intake
Physical activity levels via GPPAQ
Cholesterol Test TC / HDL (via LDX point of care testing device)
Blood Pressure
Pulse Check for the over 60 years for Atrial Fibrillation Screening

Process for health checks delivered by other providers – Tier 4

The service provider will ensure that people presenting for an NHS Health Check are informed about the process of the service and are given the opportunity to ask questions. The provider will seek consent for the assessment and the communication of results to back to their GP. Invitation letters will contain a clause stating that consent to share information with their GP is a requirement for having a Health Check. Persons who decline this consent should be refused a Health Check.

The service provider will ensure clinical governance / health and safety adherence by ensuring:

Essential equipment is available for the health check and maintained according to manufacturer's instructions.
Blood pressure devices used are validated by the British Hypertension Society (BHS) and standards for monitoring of Blood pressure as per their guidance
Lancing devices used to obtain finger prick blood samples must be a single use disposable system
All consumables are stored in accordance with the manufacturer's instructions and batch numbers and expiry dates should be recorded.
Internal quality control (IQC*)* procedures are followed by the analysis of an appropriate control material monthly (supplied by the manufacturer of the device and purchased from W Sussex health), providing reassurance that the system is working correctly. The results of the IQC must be recorded on the monitoring form and performed monthly.
All staff performing the Health checks are required to attend training in the point of care testing meter and are proficient and competent in the obtaining of blood samples via point of care testing equipment.

All staff performing the health check must have completed NHS Health Check West Sussex Core skills or (PCTC / Education for Health /CPPE vascular risk course or equivalent)
Training dates for the NHS Health Check core skills will be provided.

All staff who have direct contact with any blood sampling procedure should have the opportunity by their employer to be immunised against Hepatitis B
Service providers must have room to hold and store the necessary equipment.
Premises are suitable for the provision of health checks with a consultation room with access to hand washing facilities and N3 Broadband
Premises and staff performing the health check need to have standards for infection control and the safe disposal of contaminated waste that complies with NHS infection control standards.
Service providers will ensure there is a contingency plan in place in case of staff sickness or unforeseen changes to premises.

Best practice data protection

Data governance and data protection is maintained as per Data Protection Act see appendix
Accurate records are maintained, stored, electronically or otherwise, along with their consent forms, measurements and any recommendations made. This information will be kept confidential
Pharmacy or cluster GP providers will ensure information regarding outcomes of the health check will be communicated back to an individuals GP practice containing information on appendix C in a timely manner
Data from external providers will be transferred back where possible via NHS net accounts
Outcome data from the health Checks will be reported back monthly via the Sussex HIS Web form.
This data submitted will be used to correctly align multi payments quarterly

NHS West Sussex will:

- Provide the loan of the LDX system for the contract duration.

- Organise and provide training opportunities for CV risk core skills training and for the point of care testing device.
- Ensure clear reporting mechanisms are in place and are adhered to, for reporting the outcomes of the pilot and to ensure the service meets its objectives.
- Provide opportunities for feedback from and to providers on the outcomes of the service.
- Fund the Internal Quality Control scheme for the point of care testing device for the duration of the contract.
- Communicate onward referral pathways for weight management / stop smoking services / alcohol.
- Will provide a template invitation letter and updated list of all participating pharmacies to all GP surgeries signing up to tier 2.
- Will ensure the clinical guidance and pathways associated with the service are reviewed and updated annually in accordance with best practice.
- Will ensure any changes are disseminated to providers.

Monitoring
NHS West Sussex will:

- Monitor and feedback onward referrals post health check as best practice benchmarking.
- Monitor and feedback the data reporting elements of this contract.
- Monitor and feedback the adherence to the quality control scheme.
- Providers will need to monitor activity levels and numbers of health checks performed.

Re monitoring of activity and payments – It is recognised that some GP Practices will have larger numbers of the eligible cohort to invite. It is expected that most GP practices will achieve activity of between 150 – 250 Health Checks in 2011/12.

Providers that are approaching, or are likely to exceed health check activity levels beyond 250 in the financial year will need to seek prior agreement with the Quality and Development lead for NHS Health check, so that overall financial balance for the service in 2011/12 can be assured.

Termination of contract

It is not envisaged that either party would give notice to terminate the Local Enhanced Service during this one year period. However, should this issue arise; NHS West Sussex and the provider must jointly agree an appropriate strategy to manage existing services.

The contractor must advise NHS West Sussex of its wish to opt out of the LES. This Local Enhanced Service may be suspended or terminated:

Immediately if the provider becomes bankrupt or insolvent;

If either party commits a fundamental breach of the terms of the agreement at any point during the period of agreement.

Pricing

Tier 1 service only -
£100 per practice once per annum.

Tier 2 – *(practices must have applied for, and are delivering the tier 1 service, to qualify for tier 2).*
Practices signing up for the tier 2 service will receive an additional £250 to support the administration of 500 invites over the annum (suggested 100 invites bi monthly)

Tier 3 & 4 - The Health Check
Providers will be paid for each, completed health check episode.
A completed episode equates and includes any further administration costs / Health care provider time delivering the health check / recording and passing on outcome data to GP and Quality and Development Lead NHS Health Check.

Payment will be £28 per health check episode. The submitted data will inform the multi claim payments

The DH document Economic modelling for Vascular checks (DH 2008) forms the basis for this pricing.

NHS West Sussex will provide the point of care testing device for the duration of the contractual arrangement. With any discontinuation of the contract the Cholestec LDX device needs to be returned to NHS West Sussex Lead for NHS Health check.

Providers will pay for the consumables associated with the point of care testing device and allowance of the costs for the cartridges is accounted for within the base price.

There is 2 year warrantee on the meter with Alere Ltd from date of purchase. Contractual arrangements with the supplier Alere Ltd (0161 483 5884) are to replace the unit within this period at no cost.

To satisfy clinical governance arrangements it is expected the provider will need to use two additional LDX cartridges per month for the quality control tests.

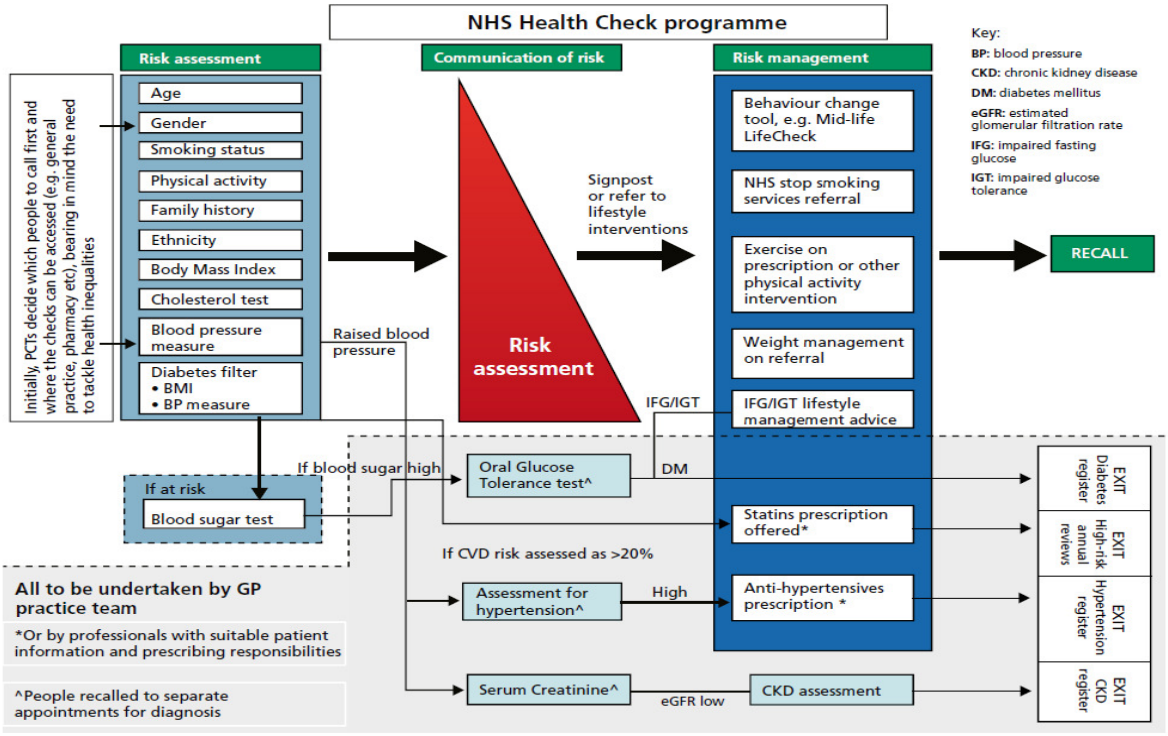
Health Check payments will be made quarterly via enhanced services multi- claims. Payments will be collated against data submitted.

Recall and Quality and Outcomes framework (QOF)

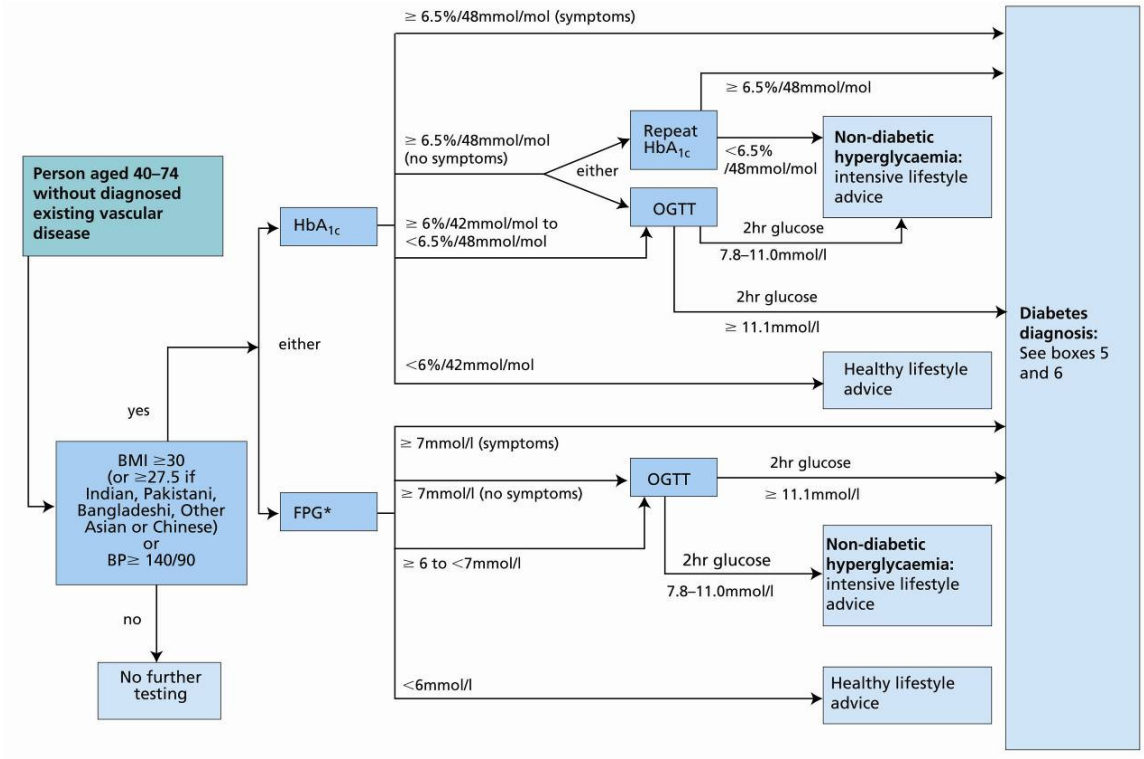
- Individuals with a CV risk less than < 20% over 10years should be recorded on their patient record as requiring a recall for NHS health check in five years.
- Individuals with CV risk assessment greater than 20% over 10 years should have this recorded in their patient record. They should **not** be put into the recall system as they do not need their CV risk assessed again but should be managed according to national guidance.
- Patients newly diagnosed as having Hypertension, Diabetes, Chronic Kidney Disease, Coronary Heart Disease, or Peripheral Arterial Disease should be coded and placed on the appropriate Disease Register and managed according to appropriate guidelines and do **not** need to be recalled for a further NHS Health Check in 5 years;
- Patients suspected of having Familial Hyperlipidaemia according to NICE guideline criteria for diagnosis should **not** have a Cardiovascular Risk Assessment as they are already considered at high risk and should be treated with statin therapy and family members screened. Consider referring to Lipid Clinic.
- Although the Health check is not covered within QOF there are a number of entries that relate to it. The relevant indicators introduced for CVD primary prevention are listed below:

REC11	REC 17
REC23	OB1
PP1	PP2
	BP1
BP4	BP5

Appendix A
Diagrammatic overview of the vascular risk assessment and management programme taken from Putting Prevention First- Best Practice Guidance 2009



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 B Referral and follow up

Factor	Threshold	Action	Referral or GP follow up
Cardiovascular risk assessment	CV risk is assessed as >20% over 10 years	Offer intensive lifestyle advice and refer to GP for follow up after 3 months Record on clinical system and for data **Person no longer for NHS Health Check recall 5 years**	Management of risk and consideration of statin prescribing (if lifestyle advice has been attempted for 3 months)
Total Cholesterol TC:HDL ratio >6	TC is ≥ 7.5	Refer to GP practice for full fasting lipids Refer to GP practice as above	To assess for possibility of familial hypercholesterolaemia Will need fasting lipids
Hypertension risk assessment	BP is ≥ 140/90 BP is ≥ 200/100	Ask person to return for 2 more appointments * and check BP at least twice on each occasion. If the BP is still ≥ 140/90 refer to GP practice Refer to GP immediately	Management for hypertension
Diabetes risk assessment	BMI is ≥27.5 in individuals from Indian, Pakistani, Bangladeshi, Other Asian and Chinese ethnicity categories BMI is ≥ 30 in other ethnicity categories BP is ≥ 140/90 (either measurement)	People with symptoms of diabetes must be referred immediately People without symptoms requested to return to surgery/pharmacy for Fasting Plasma Glucose Test or HbA1c as per DH filter	Follow up at GP practice with oral glucose tolerance test or repeat HbA1c as per diabetes filter to establish possible diagnosis of diabetes
Chronic kidney disease risk assessment *(as for hypertension risk above)*	BP is ≥ 140/90 BP is ≥ 200/100	Ask person to return for 2 more appointments * and check BP at least twice on each occasion. If the BP is still ≥ 140/90 refer to GP Refer to GP immediately	Person requires assessment for CKD by GP practice

Factor	Threshold	Action	Referral or GP follow up
Smoking status	Smoker	Ask and record smoking status. Advise person of health benefits. Act on person`s response Use NCAT charts as point of reference for symptoms requiring further Investigations Record for data	Offer 1:1 Smoke Stop support in surgery/pharmacy if available or referral to NHS West Sussex Stop Smoking service 0300 100 1823 Refer any individual for spirometry who has symptoms as per NCAT charts
Weight management	BMI is ≥ 28 + co morbidities BMI > 30 without co morbidities	Consider: Overall readiness to commit to making changes Barriers to change Self-esteem Life stage Cultural preferences Record for data	Offer weight / lifestyle management service Why Weight? 0300100 123 0892 Or GP LES / WOW Crawley or referral to Healthy Choices
Physical activity	Activity levels are below the recommended levels of 30 minutes at least 5 times per week/less than active on GPPAQ**	Brief intervention in physical activity Goal setting Information	Consider referral to wellbeing HUB Exercise on prescription if available locally
Alcohol	Alcohol consumption is over recommended daily levels of 3-4 units for men and 2-3 units for women	Provide "know your limits" information and refer to GP if have concerns Audit C tool if > recommended intake Record for data (other)	Assessment and further referral if necessary http://www.westsussex.nhs.uk/alcoholprofessionals

** GP Physical activity questionnaire can be accessed at:
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_063812

Appendix C

Vascular Risk Example Assessment Template

Setting for NHS health check: I.e. In house / pharmacy / outreach Date of health check:

Name:	
Date of birth:	Age: Sex: Click here
Address:	
Postcode:	Tel:
NHS Number:	GP Practice:

Ethnicity: Click here

Height	
Weight	
BMI	**#DIV/0!**

Waist

Advice on diet: ☐ Ref to Weight Management: ☐

Smoking: Click here Smoking advice: ☐ Action -logged: ☐

Alcohol: units/week Alcohol Advice : ☐ Audit C assessment

GP PAQ : Click here Advice: ☐ Ref to Exercise or wellbeing HUB: ☐
Activity assessment

Total Cholesterol: HDL cholesterol:

Total Cholesterol / HDL Cholesterol: Random Blood Glucose if taken :

FH Diabetes in first degree relative: Click FH CVD in first degree relative <65: Click here

BP1: Follow up: ☐

BP2: Date:

BP3: Date: ACTION/ S for GP
Record if for 5 year recall for NHS Health Check

CVD Risk score:

Appendix D Data Reporting

Data to be submitted monthly (by the 7th of each new month) to http://nww.activity.sussexhis.nhs.uk/ Please note IT IS THE SUBMITTED DATA THAT WILL BE USED TO CROSS REFERENCE PAYMENTS VIA MULTI CLAIM.

Click on WSXHealthcheck_web
Enter password - **H**ealthcheck

Activity reporting	**Numbers invited per month (Only enter the invites sent for the actual month not accrued number)** **Numbers attending** **Number within age bands** **40- 45 Males Females** **46- 49** **50- 59** **60- 74**
Outcomes lifestyle	**Numbers of current smokers seen - Ask / Advise / Action** **Outputs from Actions** 1. **Numbers of smokers referred into in-house stop smoking** 2. **NHS Stop smoking** 3. **Numbers smokers identified potential symptoms COPD/ early detection cancer – referred spirometry** 4. **Numbers not requesting referral to Stop smoking** **Numbers with BMI > 28 + co –morbidities eligible to be referred to Why weight?** **Numbers with BMI > 30 eligible to be referred to Why Weight?** **Numbers not wanting referral for healthy weight services**
Outcome risk	**Numbers identified high risk > 20 %** **Numbers referred further investigations according to DH diabetes filter** **Numbers referred for investigations hypertension** **Numbers referred to GP practice for further lipids** **Numbers referred for ECG / AF - irregular pulse** **Numbers referred for other please state reason (Text)**

The service to be provided will be underpinned by the values and principles detailed in the following documents:
Putting Prevention First (DOH, March 2008)
The Handbook for Vascular Risk Assessment, Risk Reduction and Risk Management (UK National Screening Committee, March 2008)

Putting Prevention First – Best Practice Guidance (April 2009) (http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_098410.pdf)
Outlines the skills and competencies as per Vascular Risk Assessment: Workforce Competences - June 2009e Active Be Healthy: (DOH, February 2009)

Application for NHS Health Checks Local Enhanced Service 2011/2012 Signatory Sheet

Practice Name:

Tier 1 only	
Tier 2 only **Please state partner Pharmacy site that will be delivering the checks or " cluster " GP practice and named individual from that site**	
Tier 3 only	
Tier 4 only **Please state Cluster surgery and named individual in that site**	

Authorised Signatory on behalf of the Practice/ Clinical Lead:

Signature	Name and Title	Date

Signature on behalf of the NHS West Sussex, Louise Hanney - Assistant Head, Primary Care Contracting and Performance

Signature	Name and Title	Date

Named individual on behalf of the provider who will be responsible for the data reporting:

E mail	Name and Title	Date

Please sign where indicated and return this form to Jo Yearsley, Primary Care Contracts Officer, 1 The Causeway, Goring-by-Sea, Worthing, BN12 6BT or electronically to: jo.yearsley@westsussexpct.nhs.uk