Service Level Agreement:

NHS Health Checks

Between

Halton Borough Council

and

GP Practices

DATE: 1st October 2013 – 31st March 2016

Signature Sheet

This document constitutes the agreement between the GP Practice and Halton Borough Council in regards to the delivery of NHS Health Checks that will be offered during the period of 1st October 2013 to 31st March 2016. The authority will review the operation of NHS Health Checks prior to 31st March 2016 and reserves the option to extend the agreement on an annual basis for up to a maximum of two years.

Signature: ………………………………	Signature …….…………………………
For and on behalf of the Commissioner	For and on behalf of the Provider
Date:	**Date:** ……………………………
Name:	**Name:** ……………………………
Position: Director of Public Health Halton Borough Council	**Position:** ……………………………

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Section A

1. PARTIES TO THE AGREEMENT

1.1 This Service Level Agreement ("Agreement") is between:

a) Halton Borough Council, Municipal Buildings, Kingsway, Widnes, WA8 7QF ("The Commissioner")

And

b) Dr
Add 1
Add 2
Add 3
Add 4
Add 5
Post Code ("The Provider")

2. VARIATION TO THIS AGREEMENT

2.1 If the Commissioner wishes to add, modify, or withdraw any part of the service, the Commissioner shall notify the Provider, in writing, two months in advance of the change. Any such variation will only be valid if it is in writing.

If the Provider wishes to withdraw from the service the Provider shall notify the Commissioner, in writing, two months in advance of the change.

3. RESOLUTIONS OF DISPUTES

3.1 In the event of any dispute or difference arising out of the Agreement the matter will be dealt with, initially by the Agreement Managers recorded or nominated managers (see signature sheet). Every effort shall be made by both parties to resolve differences as quickly as practicable. If the Agreement Managers cannot resolve the matter, then the matter will be referred to the Chief Executive (nominated executive) of the Commissioner and the Senior Partner / Chief Executive of the Provider.

4. LEVEL OF PROVISION / SERVICE AND QUALITY STANDARDS

4.1 Providers must comply with any relevant NICE or other clinical guidance. Participation in NHS Health Checks must not reduce the quality or availability of other service provision.

5. TERMINATION

5.1 This Agreement will terminate on: 31st March 2016

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6. RISK MANAGEMENT / PATIENT SAFETY

6.1 Reporting and investigation of adverse incidents

6.1.1 Adverse incidents must be reported and investigated in line with relevant legislation, national and local guidance.

6.1.2 Following analysis of the causes of the adverse incident, any learning that can be shared to prevent recurrence of the incident should be shared with the Council for distribution to other GP practices.

6.2 Identification and mitigation of risks:

6.2.1 All risks relating to the treatments contained in the service should be identified recorded and scored in accordance with national and local guidance.

6.2.2 Halton Borough Council and relevant stakeholders, including staff, are to be kept informed of and, where appropriate, consulted on the management of significant risks faced by the Commissioner and/or Provider.

7 ELIGIBILITY TO PROVIDE NHS HEALTH CHECKS

7.1 Satisfactory facilities and equipment

7.1.1 Adequate and appropriate equipment should be available for the provider to undertake the procedures chosen in line with prevailing national guidance on premises standards.

7.2 Training

7.2.1 The Provider must ensure that all staff involved in providing any aspect of care under these schemes has the necessary training and skills to do so.

7.2.2 Staff undertaking the NHS Health Check must have the relevant core skills identified in the Vascular Risk Assessment Workforce Competencies (CVD EF3). **See Appendix 1**

7.3 Accreditation

7.3.1 Those doctors who have previously provided services similar to NHS Health Checks and who satisfy at appraisal and revalidation that they have such continuing medical experience, training and competence as

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is necessary to enable them to contract for the service shall be deemed professionally qualified to do so.

7.4 Nursing support

7.4.1 Nurses and Health Care Assistants should be appropriately trained and competent, taking into consideration their professional accountability and the Nursing and Midwifery Council guidelines on the scope of professional practice.

8. The Service

8.1 Consent

8.1.1 In each case the patient should be fully informed of the Health Check Assessment procedure. A record of the patient's consent should be filed in the patient's lifelong medical record.

8.2 Education and continuing information for patients

8.2.1 The Provider shall ensure that all newly treated patients (and/or their carers when/where appropriate) receive appropriate education and advice on management of and the prevention of secondary complications of their conditions. This should include written information where appropriate.

8.2.2 The Provider must ensure all patients who receive an NHS Health Checks assessment are given a copy of the NHS Health Check Patient Workbook with their personalised details and the results from their assessment appropriately recorded.

8.3 Verification

8.3.1 Verification may involve the Council randomly selecting a number of case records of patients to confirm that the components of the Service have been undertaken and recorded.

9. Referral policies

9.1 Where appropriate the Provider shall refer patients promptly to other necessary services and to the relevant support agencies using locally agreed guidelines where these exist.

9.2 The Council has commissioned a wide range of lifestyle services to support patients to lead healthier lifestyles and assist in the prevention of ill health. These include weight management and physical activity programmes, stop smoking support services and drug and alcohol intervention and falls

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prevention services. **Appendix 2** provides more detail about the range of services available and appropriate contacts.

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SECTION B

NHS HEALTH CHECKS

1. Service aims and objectives

1.1 The aim of this service is to prevent heart disease, stroke, diabetes and chronic kidney disease by identifying risk factors and managing them appropriately and to raise awareness of dementia amongst the over 65s.

1.2 The core objectives of the service include the following:

- Identification of the eligible population;
- Call and recall of the eligible population;
- Provide a face to face assessment of a patient's cardiovascular risk (which includes heart disease, diabetes, chronic kidney disease and stroke risk);
- Communication of cardiovascular disease risk to individuals;
- Health check to be carried out on all patients with a risk of less than 20 percent, once every 5 years;
- High risk review to be carried out on all patients with a risk of greater than 20 percent, annually (at this stage patients are excluded from the Health Check Programme but should be monitored by another service);
- Development and continued maintenance of a risk register for patients with a risk of 20 percent or more;
- Management of risk factors including:
    - ✓ Advice on lifestyle risk factors and signposting to other services as appropriate;
    - ✓ Medical management of cardiovascular risk if required;
    - ✓ Referral to other services as required.
- Undertake an alcohol risk assessment using AUDIT-C where a patient is identified as at risk by initial screening questions;
- Raise awareness of dementia symptoms with eligible patients over the age of 65.

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2. Service outline

2.1 Eligible Population

The service will deliver the NHS Health Check to all individuals registered with a GP in Halton between the ages of 40-74 without known CVD, by inviting 20 percent of them every year over a period of 5 years.

2.2 Exclusions

As NHS Health Checks is a public health programme aimed at preventing disease, people with previously diagnosed vascular disease or meeting the certain criteria set out below are excluded from the programme. These

individuals should already be being managed and monitored through existing care pathways.

People diagnosed with the following are excluded from the programme:

- Cardio vascular disease;
- Chronic kidney disease;
- Diabetes;
- Hypertension;
- Atrial fibrillation;
- Transient ischaemic attack;
- Hypercholesterolaemia;
- Heart failure;
- Peripheral arterial disease;
- Stroke

Also excluded are people:

- Being prescribed statins;
- 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 10 years.

2.3 Prioritisation

All eligible patients (see criteria above) are required to be invited for a Health Check over a five year period. In selecting which patients to invite for a health check in the early years of the scheme Providers are requested to prioritise the following:

- Eligible patients exhibiting risk factors of CVD (e.g. overweight, smokers, family history of CVD);
- Eligible patients who are known to have caring responsibilities (this is to support them to stay healthy and continue these responsibilities);
- Eligible patients living in a deprived community (to help bridge the health inequalities gap);
- Eligible patients who are classed as vulnerable adults[1].

To maximise the benefit of the programme a Risk Assessment on the practice clinical system data to identify the cohort of patients who would most benefit

[1] A vulnerable adult is defined as
•a person aged 18 years and over "who is or may be in need of community care services by reason of mental or other disability, age or illness"
•who is or may be unable to take care of him or herself or unable to protect him or herself against significant harm or exploitation (No Secrets, 2000)
A vulnerable adult can be anyone over the age of 18 who receives social care services or has a personalised budget or has a physical or sensory impairment, learning disability or mental health problem or may not be able to protect themselves from abuse or harm. It can also include ex-offenders or transient populations including travellers and asylum seekers (this is not an exhaustive list)

from a HC must be carried out. The Council will be able to support this process as outlined in the attached Data Sharing Agreement. The agreement has the support of the LMC, the Clinical Commissioning Service Development Committee and the Council's Executive Board.

The Provider will need to sign and return the Data Sharing Agreement below to the commissioner to enable the practice to benefit from this service. See **Appendix 3**

Where a Provider does not wish to use this service the commissioner will provide Risk Stratification documentation which will need to be applied locally to identify the eligible cohort.

2.4 Inviting patients for a Health Check

Providers can select the most appropriate method for inviting eligible patients for a Health Check according to their normal communication methods. This can include, for example, letter, telephone call, email, SMS text messaging or opportunistically. If inviting patients by letter the template attached below should be used and should be accompanied by the NHS Health Check leaflet below. Providers will initially be supplied with a stock of leaflets but thereafter these can be ordered free of charge directly from the NHS orderline webpage.
http://www.orderline.dh.gov.uk/ecom_dh/public/home.jsf See **Appendices 4 and 5.**
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Whichever method is used to invite eligible patients it is important that the invitation is recorded using the appropriate read code even if the initial invitation was opportunistic (this should be recorded as a verbal invitation). This is to ensure that the Council can demonstrate that it is reaching the required target of 20% of eligible patients invited per year.

If the patient does not respond to the invitation for a Health Check this should be recorded on the practice's clinical system so that future attempts can be made to opportunistically screen them. No less than three invitations should be sent to the eligible patient before they can be recorded as "Did not respond". It is recommended that a variety of methods of invitation for each patient be used to maximise the response rate.

Providers can only claim for one invitation per patient regardless of the number of invitations the person receives.

In order that the NHS Health Check is delivered in a uniform, systematic and integrated manner, the service will comply with prevailing national guidance.

2.5 Health Check Assessment

The Health Check assessment is designed to:

- Facilitate the early detection of major illnesses and 'case-find' adults who have established disease in order they can be offered evidence based care to manage the existing disease
- Identify those patients as being at high risk of developing a range of major illnesses, so that they can then be offered interventions in order to prevent or manage their disease onset that will maximise their quality of life and minimise their incidence of the disease.
- Identify patients who are in need of lifestyle and/or primary prevention interventions.
- Raise awareness of dementia in people aged over 65.

Providers will invite and undertake a Health Check assessment on the eligible population using the Health Check assessment

- Each Health Checks assessment shall be evidenced by a completed Health Checks assessment template or GP Clinical System Template

- Read codes for Health Checks offered and completed and for all other significant findings as identified in the assessment document should be added to the patient's records.

- Providers must comply with data and verification requests from the Council or third party acting on the Council's behalf (e.g. St Helens and Knowsley NHS Trust's Health Informatics Service) in a timely manner and comply with requests for data to inform the NHS Health Checks Returns. Verification requests from the Council will take the form of a quality assurance visit to the practice.

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During the assessment, which is expected to take approximately 20 minutes, the following information should be collected and recorded:

- Age
- Gender
- Smoking status
- Level of physical activity
- Family history (CVD, diabetes)
- Ethnicity
- Height, weight (BMI)
- Total cholesterol testing (using near patient testing were possible)
- Total cholesterol/HDL Ratio (using near patient testing were possible)
- Impaired Glucose Regulation status
- Blood pressure measurement (those with a raised BP and or BMI of 25 or more also require a HbA1c. Patients with raised BP also require a serum creatinine and electrolytes
- AUDIT-C Alcohol assessment

- Dementia awareness raising (a leaflet and training tool are available of the NHS Health Check website - http://www.healthcheck.nhs.uk/national_resources/dementia_resources

- Peak flow assessment
- Information, advice and signposting on brief intervention
- Referral as appropriate

The presence of other conditions that increase CVD risk should also be recorded during the consultation i.e. rheumatoid arthritis, premature menopause, erectile dysfunction.

The individual's CVD risk will then be calculated, using a risk assessment tool, QRisk2 or JBS2 and lifetime risk tool JSB3 with the results communicated to them in a way that the individual understands.

Collaborative work between Public Health and CCG commissioners has led to the addition of Impaired Glucose Regulation (IGR) detection as the initial pathways and management options are the same. People with IGR have 12 times the risk of developing type 2 diabetes and as a result there is an associated CVD risk.

A pulse check has been included to detect Atrial fibrillation. AF is the most common arrhythmia seen in primary care, affecting up to 1% of the population. The condition is important to diagnose early as it is a major risk factor for stroke – people with AF have a one in twenty chance of having a stroke. This will enable a larger cohort of patients to be tested and contributes directly to one of the CCG quality premium metrics.

Peak Flow assessment is included to provide a lung age score to patients who smoke and who may be falsely reassured by a low CVD risk score, and to enhance decision making about potential lifestyle change.

2.6 Outcomes from the Health Check

It is expected that:

- Following assessment, the CVD risk-score of the patient shall be recorded in the patient's life long clinical record and the NHS Health Check Patient Workbook;

- All patients must be provided with an NHS Health Check Patient Workbook (see attached) with their individual results that will communicate overall risk and be supported where necessary with an individual care management plan;

- People identified as being at less than 20 percent risk will be recalled after 5 years yet may also need lifestyle interventions to maintain or improve their vascular health (e.g. referral to a stop smoking service, weight management programme or physical activity interventions);

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- People identified at high (greater than 20 percent) risk will be managed separately according to national guidance and will not be invited for further health checks.

- Where pre-existing disease is identified, the patient will be managed separately accordingly by general practice using existing local clinical pathways;

- Where no existing condition or risk is identified the patient should receive basic advice to enable them to maintain a healthy lifestyle;

- The Provider will actively involve the patient in agreeing what advice and/or interventions are to be pursued;

- Any decisions made or tests/measurements undertaken must be in partnership with the patient and with the patient's informed consent.

The practice shall ensure that lifelong medical records are kept up to date. NHS HealthCheck workbooks will be provided to practices.

2.7 Relationship with lifestyle services

Where relevant it is expected that Providers will, with the patients consent, refer patients into an appropriate lifestyle support service currently delivered by Halton's Health and Well Being Service as set out in Part A section 9.2.

Currently the Health and Well Being Service carries out an opportunistic assessment which includes many of the questions undertaken as part of the Health Check. To prevent duplication and to ensure that an appropriate cardiovascular risk assessment and recording on GP systems takes place an agreement to share the information has been reached which will still allow primary care to claim a full Health Checks payment.

3. Level of Provision/Service Standards

3.1 The responsibility for the provision of the service lies with Halton Borough Council and the Provider named in this agreement.

3.2 Providers should manage patient's needs in line with the following NICE guidance

NICE TA 094	Cardiovascular Disease – Statins. January 2006
NICE CG 067	Lipid Modification. May 2008
NICE CG127 Hypertension: NICE guideline	Clinical management of primary hypertension in adults August 2011

DRAFT

NICE CG 043	Obesity: the prevention, identification, assessment and management of overweight adults and children. Dec 2006
NICE CG 015	Diagnosis and Management of Type 1 Diabetes in children, young people and adults. July 2004
NICE CG 073	Chronic Kidney Disease. September 2008
NICE CG 068	Diagnosis and initial management of acute stroke and TIA. July 2008
NICE CG 101	COPD guidelines June 2010
NICE PH 025	Prevention of Cardiovascular disease June 2010
NICE QS 06	Diabetes in Adults March 2011
NICE CG 066	Type 2 diabetes (partially updated by CG 87) May 2008
NICE PH 038	Preventing type 2 diabetes – risk identification and interventions for individuals at high risk July 2012
NICE PH 035	Preventing type 2 diabetes – population and community level interventions in high risk groups and the general population May 2011
NICE CG 42	Dementia: supporting people with dementia and their carers in health and social care Nov 2006

3.3 Providers should manage patient's needs in line with the following National guidance

	Dec 07	National Stroke Strategy
NSF	Mar 01	Older People
NSF	Mar 2000	Coronary Heart Disease
NHS Health Check Programme	Apr 2009	Best Practice Guidance for the Assessment and Management of Vascular Risk
PHE	May 2013	Draft Best Practice Guidance for the NHS Health Check Programme http://www.healthcheck.nhs.uk/commissioners_and_healthcare_professionals/national_guidance/

4. Quality

4.1 Providers are required to:

- Operate a complaints policy and procedure that complies with NHS Standards;
- Provide assurance of full compliance with the prevailing guidance relating to standards of quality and patient safety as they apply to this service;

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- Have a quality assurance system and mechanisms to monitor and quality assure the service;

- Support clinical audits of the service to demonstrate compliance with NICE and other national guidance.

4.2 To provide this service Providers shall ensure that:

- All health care professional responsible for the assessment and management of the patients have a responsibility for ensuring that their skills are regularly updated;

- Robust record keeping is in place;

- Any health care professional carrying out physical measurements or diagnostic procedures on patients should be appraised on what they do and take action where inappropriate variance is identified. E.g. inappropriate referrals;

- Health care professionals delivering Health Checks participate in necessary supportive educational activity.

5. Performance monitoring

5.1 Health check data is monitored by St Helens and Knowsley NHS Trust on behalf of the Council on a monthly and quarterly basis. Providers are required to support the collection of data through timely verification to enable data submissions within required timescales.

5.2 Monthly data records outcomes from the Health Checks e.g. number of people identified as having the following conditions:

- Diabetes
- Chronic Kidney Disease
- Hypertension

The monthly data collection also records CVD risk score, smoking status, alcohol risk, Body Mass Index, physical activity status and follow up activity.

5.3 Quarterly data returns collect the following performance indicators:

- Total patients aged 40 to 74 years who are eligible for a Health Check in the reporting quarter;
- Total eligible patients who have been invited for a Health Check (Providers are required to invite 20% of the eligible population over a 12 month period);

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- Total eligible patients who have been invited for and received a Health Check (Providers are expected to aim for a 75% conversion rate from invitations);
- Number of eligible patients who failed to respond to a Health Check invitation;
- Number of eligible patients who did not attend a Health Check appointment;
- Number of eligible patients who have refused or declined a Health Check;
- Number of eligible patients who have had a Health Check done in the community.

5.4 The Council may from time to time request to visit GP practices and other Provider's premises for the purpose of conducting quality assurance inspections in relation to the delivery of Health Checks.

6. The Fee

6.1 Each Provider contracted to provide this service will receive a payment of:

- **£1.00** per each eligible patient invited for a Health Check. A single payment will be made per patient invited for HealthCheck regardless of the number of invitations they receive or method used to contact them.
- **£18.00** per patient for each HC Assessment carried out and completed by the Provider.
- **£1.00** per each completed HC Assessment recorded on the Practice Clinical System regardless of who has completed the HC assessment.

Only 1 payment per patient can be made during any 5 year period.

6.2 This fee will be paid on a monthly basis upon submission of the required Claim form to:

Contracts and Commissioning Officer (Public Health)
Halton Borough Council
Runcorn Town Hall
Heath Road
Runcorn
WA7 5TD

6.3 All claims must be made within a month of the Health Check being carried out.

6.4 The Council will only pay for health check claims undertaken on the eligible population up to a maximum of 20% of the practice patient list per year.

6.5 Failure to verify monthly and quarterly data returns or significant variations between recorded data and claim forms may result in payments being delayed.

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7. Claims, Audit and monitoring arrangements

Providers are expected to submit a monthly claim on the agreed electronic template as follows:

- The number of NHS Health Check invitations sent in the last month (9mC0;9mC1;9mC2; 9mC3; 9mC3; 9m25.) £1.00
- The number of NHS Health Check Assessments completed by the Provider within the last month (8BAg; 8BAg0; 6B5...) £18.00
- The number of NHS Health Check Assessments entered onto the clinical system in the last month (8Bag; 8BAg0) + (6B5..) £1.00

The Council or an organisation working on its behalf will collect the NHS minimum data set for NHS Health Checks. Currently HIS collects this data for the Council.

8. Patient Experience

The Provider shall ensure that patients are offered the opportunity to complete a patient experience survey. See **Appendix 6**. Completed surveys should be returned to:

Public Health Contracts and Commissioning Officer
Halton Borough Council
2nd floor Runcorn Town Hall
Heath Road
Runcorn
WA7 5TD

References

See **Appendix 7**

9. QOF Indicators included in the NHS Health Check

9.1 There is potential for work carried out within an NHS Health Check to overlap with work which affects the achievement of Quality and Outcome Framework (QOF) points.

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