

**2012/13 NHS STANDARD CONTRACT
FOR ACUTE, AMBULANCE, COMMUNITY AND MENTAL HEALTH
AND LEARNING DISABILITY SERVICES
(MULTILATERAL)**

SECTION B PART 1 - SERVICE SPECIFICATIONS

Service Specification No.	
Service	NHS Health Check Outreach Service
Commissioner Lead	Kerri-Anne Collins NHS Health Check Project Manager
Provider Lead	
Period	
Date of Review	2013/14

1. Population Needs

A comparison of the modelled prevalence data from the East of England Public Health Observatory (ERPHO) with the recorded disease prevalence on GP registers, gives an indication of the number of undiagnosed conditions. It is estimated for example, that over 19,700 people in Medway who have hypertension have not yet been diagnosed (JSNA).¹

Emergency admission rates for Coronary Heart Disease (CHD), Heart Failure (HF) and stroke have reduced since 2003/4. However, they still account for 59% of emergency admissions to hospital. This suggests that individuals are not being identified early enough and therefore first identified on admission to hospital.

CVD mortality rates (2012) in Medway are significantly higher for males (224.7 per 100,000) than for females (134.6 per 100,000) and similarly, higher for people living in the most deprived areas of Medway (227 per 100,000) when compared with those living in the least deprived areas of Medway (141.1 per 100,000).

Major risk factors associated with CVD include obesity and smoking. National statistics estimate that around 23% of adults are currently obese. A projection report suggests that this will rise to 60% of men and 50% of women by 2050.

In 2010 the smoking prevalence rate in Medway was 24.9%. This is higher than the national average. The variation in smoking prevalence across the Medway area is significant and statistics suggest that there is a strong link between deprivation and smoking. There were around 54,344 smokers in Medway in 2010, the largest group being made up of routine and manual workers.

The NHS Medway's delivery strategy for NHS Health Checks consists of two parts. The first part will offer checks via a systematic invitation to all eligible adults registered with a GP. The second part will offer an opportunistic check within the community with a focus on targeting hard to reach groups who fail to attend when invited for a check at the GP surgery. This specification describes the requirements of the second part of this programme.

Inequalities exist within the current GP delivered NHS Health Check programme, with attendance levels varying by ward, age range, ethnicity and deprivation.

The GP NHS Health Check database since the inception of the programme from April 2010 to September 2012 flags up five wards with the lowest attendance rates (appendix one):

- Gillingham North
- Peninsula

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- Luton and Wayfield
- Gillingham South
- Chatham Central

The data also highlights that attendance rates are lowest in the most deprived areas (appendix two) and in the lower age groups (appendix three). Data for ethnicity is incomplete for those who have not attended a check. However, available data suggests that some specific ethnic groups are not attending (appendix 4).

The programme can contribute towards addressing the above needs by;

- Providing individuals with early identification of risk factors, opportunity to modify these risks, thereby reducing the likelihood of disease developing and improving quality of life through reduction of ill health
- Offering a real opportunity to make significant contributions in tackling health inequalities.

This will benefit the local economy by;

- Prevention of disease progression, thereby reducing demand on primary, secondary and tertiary services and prescribing
- Opportunity to manage less severe disease in primary care.

2. Scope

2.1 Aims of service

To provide NHS Health Checks in the Medway community to those aged 40-74yrs without existing CVD with a particular emphasis on targeting hard to reach groups (as identified in this service specification) who may not access the NHS Health Check in GP surgeries.

2.2 Objectives of service

1. To raise awareness and benefit of the NHS Health Check programme
2. To raise awareness of Cardiovascular disease and diabetes
3. To identify individuals eligible for the NHS Health Check outreach service and assess their cardiovascular risk.
4. To communicate to individuals their cardiovascular risk in a way that the individual understands
5. To refer/ signpost these individuals at risk or are eligible for intervention to appropriate services as required (weight management, exercise referral, community alcohol team stop smoking team).
6. To collect data as required by the national health check minimum dataset for every service user that attends the service and electronically transfer data securely back into the GP practice clinical system.
7. To identify people with undiagnosed disease/condition and electronically refer those individuals back to their GP for further monitoring as highlighted in the Putting Prevention First Best Practice Guidance.
8. To offer a convenient, flexible and accessible service by providing a choice of location and hours of availability to support access for a majority that fall within the working age population

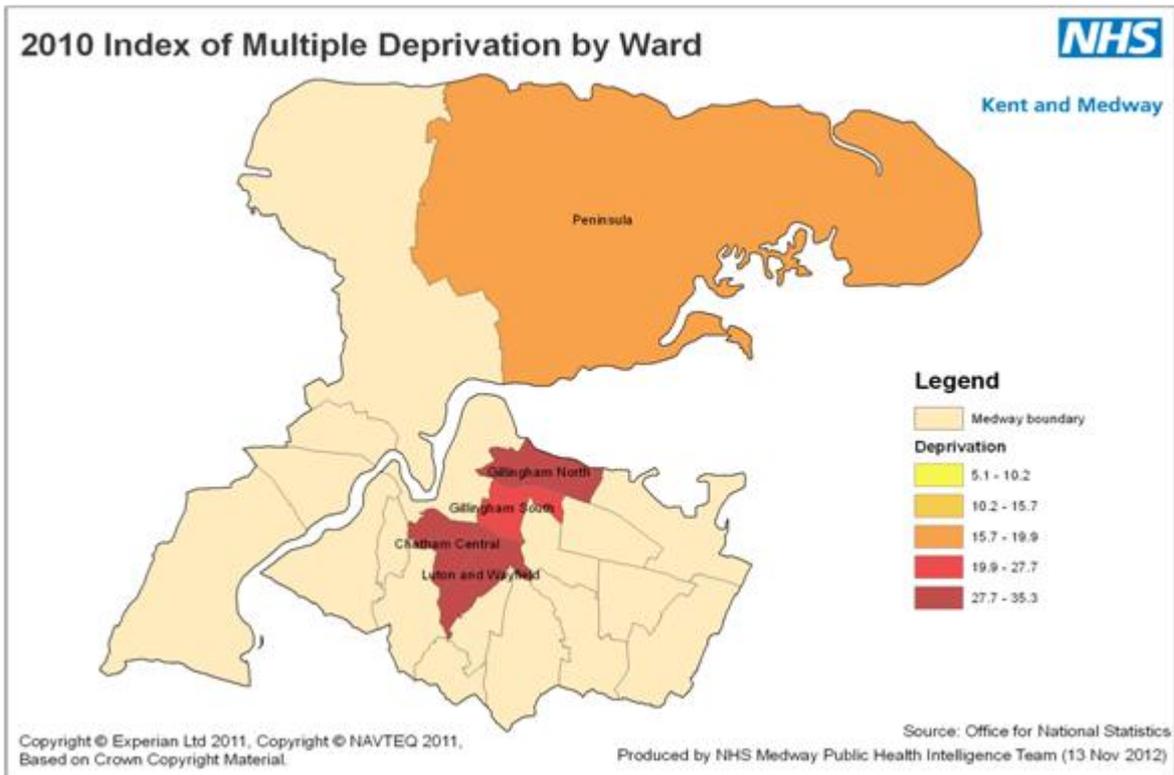
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2.3 Population covered

The Outreach NHS Health Check service will only be offered to those who;

- are residents of Medway
- and have not already had an NHS Health Check

This service will only be offered within the five wards listed below;



- Gillingham North
- Peninsula
- Luton and Wayfield
- Gillingham South
- Chatham Central

The 'hard to reach' groups which the outreach service should target within the five wards include;

All individuals aged between 40-55yrs with specific focus on men.

Ethnic groups;

- African
- Caribbean
- Bangladeshi
- Other Asian
- Chinese

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- Pakistani
- Other Mixed
- Other black

A descriptive list of ethnic groups that are to be targeted can be found in appendix five.

The Service shall be provided for all eligible patients irrespective of culture, belief, disability, and accessibility.

It will be the responsibility of the provider to identify and book potential venues for the service to be carried out. Ideal venues may include community halls, churches, sports halls, health centres, libraries, mobile unit or business property. The commissioner will support the provider by providing some key individual and group contacts.

2.4 Whole system Relationship

2.4.1 The provider will not work in isolation and must work in collaboration with commissioners and partners to ensure that the needs of the patient are met, a positive experience of the service is achieved and that outcomes are attained. They shall develop positive working partnerships to facilitate integrated working with the following organisations, in order to increase signposting and / or referrals.

- General Practitioners and practice staff within Medway
- Health improvement services at the local authority
- Alcohol community services
- Memory clinic
- Healthwatch
- Developing Neighbourhood Areas Resident working group (EU funding group)
- Medway Council
- Medway Programme Management Groups

2.4.2 The Provider shall:

- Meet (as appropriate) with key health improvement leads to ensure that all staff have an understanding of what the service offers, the referral criteria and the care pathway.
- Together with the commissioner, meet as appropriate with key community, local authority and NHS staff to discuss and feedback the service and ensure that all key community staff have an understanding of the service.
- Engage by telephone with GP practice staff to ensure patients that require immediate review are seen in a timely manner

2.4.3 The Provider shall be required to collaborate with the Commissioner in the following areas:

- Structures - to ensure that links are maintained with key stakeholders within the local health economy
- Process- to ensure that consistent policies and protocols are in place between the Provider and the Commissioner e.g. clinical pathways.
- Outcomes – to ensure that key clinical indicators are recorded to allow benchmarking with other service providers and contribute towards the Commissioner's own performance indicators. Please see section 4.1 key performance indicators.

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This specification sets out the minimum service requirements for the service. It is set out in such a way as to encourage and promote innovation and ensures that both the Provider and the Commissioner work jointly in consultation, cooperation and partnership.

2.5 Interdependencies with other services

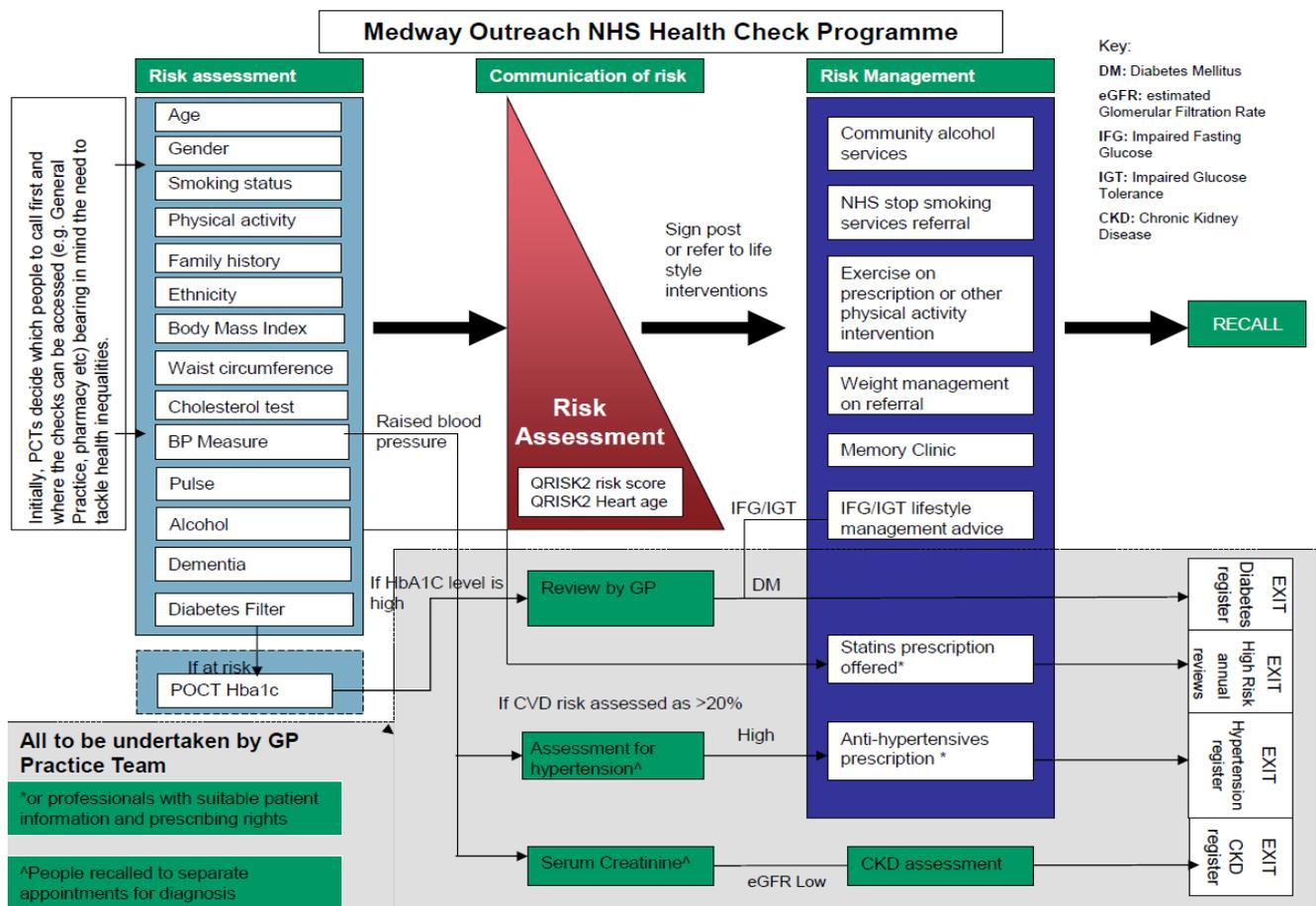
The provider shall ensure:

- Pathways are established with Medway Service Providers to provide referral on to intervention services within Medway (referral forms for improvement services can be found in appendix seven).
- That they fully understand the consequences of its clinical and non-clinical practices on other services and modifies its behaviour so best value is achieved through the provision of the entire care pathway.

2.6 Relevant Clinical Networks and Screening Programmes

The Provider shall ensure the services are linked to and can demonstrate their participation or contribution in relevant local clinical networks and support programmes by nominating when necessary a representative to attend such programmes.

2.7 Service Model



Department of Health (2009) Putting prevention first best practice guidance modified to reflect local need.

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The outreach NHS Health check will include a 20- 30 minute face to face consultation. The consent in appendix six will be completed by the individual prior to commencing the check and will be stored with any clinical records of the individual held by the provider

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

2.7.1 The **Risk assessment** will consist of the following elements

- a) Age
- b) Gender
- c) Family and medical history, including family history of Coronary Heart disease, stroke and Diabetes
- d) Ethnicity (using 16 categories)
- e) Body Mass Index (requiring weight and height measurement)
- f) Waist circumference if BMI is 25 or more
- g) Blood Pressure
- h) Pulse check for the over 60 years for Atrial Fibrillation Screening
- i) Physical Active status (using GPPAQ questionnaire)



GPPAQ questionnaire
template.xlsx

- j) Smoking Status (current, non-smoker, ex-smoker for at least the last four weeks).
- k) If a smoker, how many do they smoke a day?
- l) Alcohol status (using AUDIT C assessment tool)
- m) Number of alcohol units a week



AUDIT C Tool.doc

- n) Dementia awareness (people aged 65-74) using Department of Health Leaflet

The provider will be expected to carry out point of care testing (POCT) as it offers increased opportunity to carry out a complete risk assessment

- o) Total/ HDL Cholesterol ratio (requiring both Total cholesterol and HDL cholesterol)
- p) HbA1c (if required see service model and risk factor threshold table)

2.7.2 Risk communication

- a) The provider will be expected to clearly explain the results of the NHS Health Check.
- b) The provider will be expected to calculate the individual's risk of developing vascular disease using a risk assessment tool. QRISK2 has been recommended as the most appropriate risk engine for use on the population of Medway.
- c) In conjunction with the QRISK CVD risk score the provider will use the QRISK2 heart age measurement to highlight the service users current health status by comparing heart age with actual age.

<http://www.qrisk.org>

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- d) The provider will be expected to communicate the results to the individual in a way he/she will understand, avoiding concepts of 'high' or 'low risk.'
- e) The provider will then be expected to utilise motivational interviewing techniques to better understand behavioral barriers and motivators to health.
- f) The provider will discuss ways that the individual will be able to manage their risk level.

2.7.3 Risk management

- a) The provider will be expected to follow the risk factor threshold table when promoting a healthy lifestyle by offering advice, information or intervention to the individual (referral forms provided in appendix 7)
- b) Goal setting will be used by the provider to allow the patient to determine for themselves what steps they feel able to take to improve their health and CVD risk.
- c) The provider will be expected to summarise the findings and discussions of what has been discussed during the check. A report card with all data collected will be supplied to the individual to take away (appendix eight)

Risk Factor Threshold table

No.	Risk Factor Threshold for Intervention	Level 1 Intervention Brief intervention or test to be carried out at point of check	Level 2 Intervention On-going referral
1	BMI greater than 30 kg/m ²	Lifestyle Advice Weight Management Advice HbA1c POCT test	Offer referral to community weight management programme* (referral form- appendix 6). Referral to GP if POCT HbA1c exceeds 5.5% (37mmol/mol)
2	BMI greater than 27.5 kg/m ² if Indian, Pakistan, Bangladeshi, Other Asian or Chinese	Lifestyle Advice Weight Management Advice HbA1c POCT test	Offer referral to community weight management programme* (referral form- appendix 6). Referral to GP if POCT HbA1c exceeds 5.5% (37mmol/mol)
3	BP greater than or equal to 140/90 mmHg (or where SBP or DBP exceed 140mmHg or 90mmHg respectively) after 3 separate readings BP is ≥ 200/100 (refer to GP immediately)	Provide individual with lifestyle advice and information to reduce blood pressure Hba1c POCT test	Referral back to GP for further blood pressure assessments Referral back to GP for assessment for Chronic Kidney Disease Referral to GP if POCT HbA1c exceeds 5.5% (37mmol/mol)
4	Pulse Check for those >60yrs		Refer back to GP for assessment
5	Cholesterol Total serum greater than 5.0 mmol/l	Provide individual with lifestyle advice and information to reduce cholesterol level	Referral back to GP for fasting test and to consider familial hypercholesterolaemia using the Simon Broome Criteria
6	If smoker	Smoking cessation advice and information	Offer referral to NHS stop smoking service

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		on services available	medwaystopsmokingservice@nhs.net 08002346805
7	GPPAQ classification as less than active	Brief Intervention to increase physical activity	Offer referral to exercise on prescription or other physical activity intervention (referral form- appendix 6)
8	Alcohol audit C	Brief intervention to increase awareness of drinking	Referral to community alcohol services if a problem is identified (referral form- appendix 6).
9	Dementia for those age 65-74 years	Provide information on dementia (leaflet) and links to CVD risk factors	Referral to GP for full assessment

*The community weight management programme is expected to be launched in April 2013

Providers **will NOT** be expected to carry out recall for this service.

The provider will submit anonymised data back to the commissioner as stated in 4.1 and 4.2 for payment and evaluation purposes.

Any attendees that access the service and are not registered with a GP should be encouraged to register. Data collected by these individuals must still go onto the monthly recording sheet with 'no GP' in the practice code column.

2.7.4 Information Technology

The provider will ensure that a secure and efficient electronic method of transferring clinical information captured during the check will be sent back to the person's GP. This will include all elements of the check as identified in the service model, any advice provided, GP referrals and referrals to lifestyle improvement services.

The transfer process must include a review by the person's GP practice before going into their clinical records. It will include all elements of the Department of Health minimum dataset and their relevant read codes.

Each NHS Health Check will be recorded as completed by a third party provider using the appropriate read codes (provided by the commissioner).

2.8 Staffing Competencies

The provider shall ensure that all staff carrying out NHS Health Checks have the required competencies as identified in the Department of Health and Skills workforce competencies 2009.



DHS- Workforce
Competencies

It is required that the service provider will have completed the Dementia eLearning training prior to commencing the service (once available).

The service provider will be expected to provide evidence of training and protocols regarding infection control, blood tests and providing lifestyle advice, including motivational interviewing. Staff may be

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required to attend training prior or during service provision provided by NHS Medway. It is the provider's responsibility to ensure that all staff are trained to use the equipment according to the manufacturer's instructions

There are several criteria relating to blood tests that must be met:

- Staff must demonstrate competency in taking blood tests using the finger-prick method.
- Staff involved in taking blood samples, or handling blood products should be or have been vaccinated against Hepatitis B infection, and shown to have made a serological response to the vaccine.
- Staff involved in blood testing must have appropriate Infection Control training and be able to demonstrate good clinical practice with regard to the infection control process, including hand hygiene, standard precautions, sharps safety, clinical waste and cleaning and disinfection of equipment, and have access to and knowledge of using blood spillage kits

Relevant local policy



Guidelines for
Infection control in th

Service providers will ensure that there is a contingency plan in place in case of staff sickness or unforeseen changes to premises.

2.9 Referral Criteria

Providing the individual meets the eligibility criteria to receive an outreach NHS Health Check as detailed in this specification they may self-refer into the service or be referred by a NHS Health Care Professional.

2.10 Referral Route

It will be the responsibility of the provider to design referral routes into the outreach service and that individuals meet the eligible criteria. It is expected that the provider uses innovative methods to fill appointments and that these will be made up of both fixed and opportunistic slots, covering both weekdays and weekends.

The provider will ensure that all promotional material will include the blue Free NHS Health Check national branding as supplied by the commissioner.

2.11 Response Time and Prioritisation

- Should the provider identify an individual with symptoms of a coronary event or other medical emergency they are expected to call 999 immediately
- Should the provider identify an individual with risk factors that need reviewing within 24 hours by a General Practitioner, the provider will be expected to assist the service user in booking an appointment with their surgery following their NHS Health Check. GP contact details will be supplied by the commissioner.

2.12 Criteria

Inclusion Criteria;

The Outreach NHS Health Check service **will only be offered to those who;**

- Resident within Medway
- Aged between 40-74yrs
- Have not already had an NHS Health Check

Exclusion Criteria;

- People with existing cardiovascular disease as list below. These patients are routinely managed through their GP practice.
 - Coronary Heart disease (CHD),
 - Hypertension
 - Heart Failure (HF)
 - Diabetes
 - Stroke
 - Peripheral vascular disease (PVD)
 - Chronic Kidney Disease (CKD) stage 3-5
 - Atrial Fibrillation (AF)
- People aged outside the range 40-74yrs

2.13 Service User Empowerment

The Provider shall in the delivery of the service empower individuals:

- To have confidence, personal control and choice in managing and maintaining their health and wellbeing.
- Improve services by involving the individual in the planning and development of the service and support they receive.
- At the individual level, provide information and support to assess their personal risk, and to access and use services effectively to improve their health and wellbeing.
- By providing clear, unambiguous information and support, including information and exploration of risk management strategies for achieving and maintaining positive health and wellbeing.

2.14 Information

The provider shall ensure that each individual is provided with information that;

- Is made available to them in a format or form that is acceptable and appropriate to their need
- Is aligned to the individuals preferences
- Is agreed, and endorsed by the individual
- Empowers and supports them in decision about their own care
- Is evidence based practice

3. Applicable Service Standards

3.1 National/local context and evidence base

The cardiovascular checks programme announced in January 2008 aims to offer a vascular check to everyone aged 40 to 74 years of age, without a pre-existing cardiovascular diagnosis, once every 5 years. It was subsequently renamed the NHS Health Check Programme

Cardiovascular Disease, which includes heart disease, stroke, diabetes and kidney disease is the biggest causes of death in the UK and the vascular checks programme could on average prevent 1600 heart attacks and strokes and save at least 650 lives each year. The vascular checks programme could prevent over 4,000 people a year from developing diabetes and detect at least 20,000 cases of diabetes or kidney disease earlier allowing individuals to be better managed and improve their quality of life.

The strategy for delivery is one of national policy, local implementation

The programme has been designed to fit within the Department's wider policy framework, in particular the increasing emphasis on prevention and to further progress work on tackling health inequalities.

This strategy offers a real opportunity to make significant inroads in tackling health inequalities, including socio-economic, ethnic and gender inequalities.

Reference to the evidence base can be found below (links embedded):

1. [Putting prevention First NHS Health Check: Vascular Risk Assessment and Management \(DH 2009\)](#) This document is fully referenced for all aspects of the check and should be the main reference document.
2. [Impact Assessment: Putting Prevention First \(DH 2009\)](#)

3.2 Service User Dignity and Respect

The provider shall:

- Ensure that if requested individuals are supported by their choice of advocate
- Allow individuals to have their personal clinical details discussed with them by a person of the same gender, if specifically requested for by the individual and reasonably practicable.
- Ensure that staff behave professionally and with discretion towards all service users and visitors at all times.

3.3 Safety

The Provider shall protect individuals through systems that:

- Data governance and data protection is maintained as per Data Protection Act
- Accurate records are maintained, stored, electronically or otherwise, along with their consent forms, measurements and any recommendations made. This information will be kept confidential
- Identify and learn from all patient safety incidents and other reportable incidents, and make improvements based on local and national experience and information derived from the analysis of incidents;
- Patient safety notices, alerts and other communications concerning patient safety that require

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- action are acted upon within required time-scales;
- Demonstrate that evidence based clinical protocols are being used; and
- Have in place appropriate health and safety and risk management systems.

The Provider shall keep Patients, Staff and visitors safe by having systems to ensure that:

- The risk of health care acquired infection to patients is reduced, with particular emphasis on high standards of hygiene and cleanliness
- All risks associated with the acquisition and use of medical devices are minimised
- The prevention, segregation, handling, transport and disposal of waste is properly managed so as to minimise the risks to the health and safety of staff, Patients, the public and the safety of the environment.

4. Key Service Outcomes

4.1 Key Performance Indicator

No.	Activity Performance indicators	Method of Measurement	Baseline Target
1	To raise awareness and benefits of the NHS Health Check programme	To monitor the number of eligible individuals that are offered an outreach NHS Health check	Yearly activity levels Q1 = 563 Q2 = 563 Q3 = 400 Q4 = 724
2	To increase the uptake of hard to reach (specified groups within service specification) eligible individuals into the NHS Health Check programme	The number of individuals that attended and completed the outreach NHS Health Check programme within the specified groups or reside within the specified areas; The number of individuals that attended and completed the outreach NHS Health Check programme which are not within the specified groups or reside within the specified areas;	This will be dependent on the final incentive scheme applied to the service. However an approximate target of 80% of those that attend should be in the defined hard to reach cohorts. The outreach service will be offered equally in all hard to reach groups as identified by service specification and not focused in one group. Findings to be highlighted and discussed in yearly evaluation
3	To better understand the health needs of individuals that attend the outreach service and how these relate to different communities	To collate the health information from those that attended the outreach service. Measurements to include: 1. % of attendees with a smoking status of either current (heavy, moderate, low), non-smoker or ex-	Data to be submitted to commissioner in a quarterly report (results should be cumulative from service started date). Findings to be highlighted and discussed in yearly

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		<p>smoker (quite more than 4 weeks)</p> <p>2. % of attendees with an exercise GPPAQ status of active, moderately active, moderately inactive and not active.</p> <p>3. % of attendees with AUDIT C alcohol scores as categorized as; 0-7 lower risk, 8-15 Increasing risk, 20+ possible dependence.</p> <p>4. % of attendees with a Body Mass Index grouped as underweight, normal weight, overweight, obese and morbidly obese.</p> <p>5. % of attendees with a Blood pressure >140/90</p> <p>6. % of attendees with a total cholesterol level above 5 mmol/L</p> <p>7. % of attendees with irregular heart rate</p> <p>8. % of attendees with a low, moderate and high CVD risk score (QRISK2)</p> <p>9. % of attendees with a Qrisk2 Heart Age 5yrs, 10yrs, 15yrs or 20yrs above actual age.</p>	evaluation
4	To monitor the rate of individuals referred to each improvement service for lifestyle intervention	<p>The percentage of attendees that were referred to each intervention service, grouped as;</p> <ol style="list-style-type: none"> 1. Community weight management programme 2. Exercise referral 3. Stop smoking 4. Community Alcohol team 	<p>20% of those that attend the service should be referred directly by the provider to intervention services (this should not include those referred to the GP).</p> <p>Findings to be highlighted and discussed in yearly evaluation</p>
5	To monitor the rate of individuals referred to their GP for further monitoring	<p>The percentage of attendees that were referred to their GP for further monitoring, grouped as:</p> <ol style="list-style-type: none"> 1. Hypertension monitoring 2. Diabetes 	<p>No baseline target set.</p> <p>Findings to be highlighted and discussed in yearly evaluation</p>

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		3. Hypercholesterolaemia 4. eGFR (CKD) 5. Arrhythmia	
6	To assess attenders experience of the Outreach NHS Health Check programme	To undertake a user experience survey to gain perspectives on the Outreach NHS Health Check programme. Areas of assessment should include; <ol style="list-style-type: none"> 1. Had they heard of the programme before? How? 2. What they did and didn't like? 3. Is it likely to motivate them to make lifestyle changes? 4. Where would they prefer to have a future Health Check? 	20% of attenders to complete the survey. Review attender experience survey as part of quarterly report and include implementation plan. Findings to be highlighted and discussed and implementation plan provided in yearly evaluation.

4.2 Activity

Planning of the outreach NHS Health Check service and its venues should commence from the date the contract is awarded with delivery expected two weeks later.

A plan of health check activity /workload including sites and settings of Health checks arranged per month will be completed and sent to the commissioner contract project manager at least two weeks in advance. This data may be used to offer a choice of venue to those individuals who do not wish to attend the service via their GP practice.

4.2.1 Reporting

Two separate data output reports will be submitted by the provider to the commissioner.

- **Monthly report**

Monthly data will be submitted to the commissioner identifying patient ID number (supplied by provider), GP practice code (available from commissioner), age, gender, postcode and ethnicity for every eligible outreach NHS Health Check that is completed. Eligible individuals may access this service only once and should therefore be entered once in this report. A suggested spread sheet can be found in appendix 9.

- **Quarterly report**

Providers will be expected to provide a quarterly report to commissioners on KPI activity (as documented above). Reports should be with commissioners no later than two weeks following the end of each quarter.

- End of quarter one June 30th
- End of quarter two September 30th
- End of quarter three December 31st
- End of quarter four March 31st

4.2.2 Evaluation

At the end of the financial year the provider will supply the commissioner with an annual evaluation report. The evaluation will address all the activity points within the KPI framework and will cover the key points below;

- Service and attender Demographic profile
- Health needs
- CVD Risk score and Heart age
- Referral to GP and lifestyle improvement services
- Patient experience of service
- Lessons learnt

4.3 Activity Volumes and Payment

Quarterly activity levels

Q1	=	563
Q2	=	563
Q3	=	400
Q4	=	724

Yearly total = 2,250

Payment will be based on each eligible completed NHS Health Check (only one payment per person).

Providers are asked to include demonstration of an incentive scheme to ensure activity targets are met.

5. Location of Provider Premises

5.1 Locations of Services Delivery

The provider is responsible for identifying and securing a range of venues for delivering the NHS Health Check outreach service.

The Provider shall ensure:

- That the service is positioned and located in areas of greatest need but not restricted to geographic areas identified in service specification. As a guide, individuals could reasonably be expected to travel up to 3 miles in an urban area and 5 miles in a rural area to access clinics. Locations shall be close to main road networks and be accessible by public transport.
- That the requirements of the Disability Discrimination Act will be adhered to. The Act gives new rights to people who have or who have had a disability and makes it difficult for them to carry out normal day to day activities.
- That staff should have a professional appearance.
- That all service areas should be clean and tidy
- That premises used for the provision of services under the Contract are suitable for the

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delivery of those services; and sufficient to meet the reasonable needs of the patients.

- That the NHS Health Checks are carried out face to face in a setting or area which allows a private conversation.

5.2 Equipment

The provider will be responsible for the procurement of all equipment and consumables required to provide the service which is subject to this specification. The provider must ensure that equipment used meets the requirements to complete the checks. All devices used for near patient testing (NPT) should be CE-marked, denoting compliance with the relevant essential requirements of the Medical Devices Directives covering aspects of safety and performance.

All equipment must be used, cleaned, calibrated and serviced as advised by the manufacturer.

5.2.1 Point Of Care Testing (POCT)

POCT is defined as any analytical test performed for a patient by a healthcare professional outside the conventional laboratory setting. Users of POCT should have a sound understanding of the relevant analytical principles, issues such as quality assurance (QA), and interpretation of test results. Health care professionals planning to use POCT should be aware of guidance issued by the MHRA in 2010³ which supplements previous guidance issued in 2002.² In addition the NHS Purchasing and Supply Agency issued a Buyer's guide for POCT cholesterol measurement.⁴

- The provider will be expected to carry out Point of Care Testing (POCT).
- POCT protocols must be in place directing the use, cleaning, quality assurance (internal and external), calibration and servicing of POCT equipment and they must be followed.

5.3 Days/Hours of Operation

The Provider shall ensure:

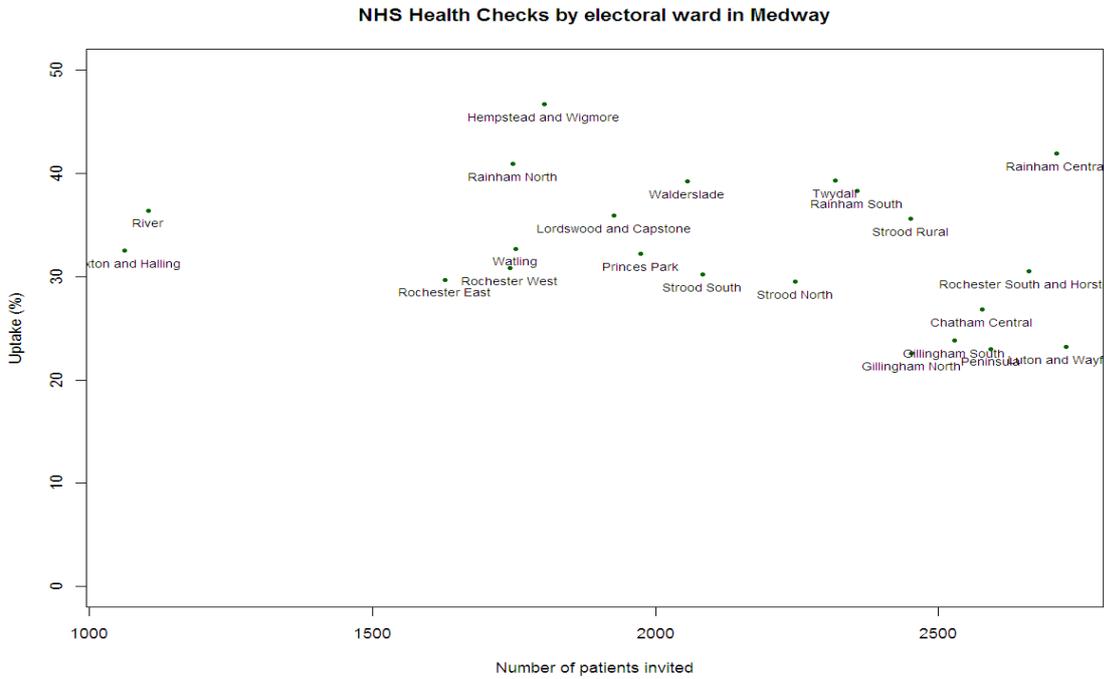
That the service is available at times convenient to the targeted groups. This will include normal working hours but also outside normal working hours in the evening and at the weekend. There is no requirement for on call or emergency availability.

1. <http://www.medwayjsna.info/jsna-appendices.html> [accessed 01/11/2012]
2. *Management and Use of IVD Point of Care Testing Devices MHRA DB 2010 (02) February 2010*
3. *Management and Use of IVD Point of Care Testing Devices MHRA DB 2002 (03) March 2002*
4. *Buyer's Guide Point of Care Testing for cholesterol measurement CEP09020 NHS Purchasing and Supply Agency, September 2009*

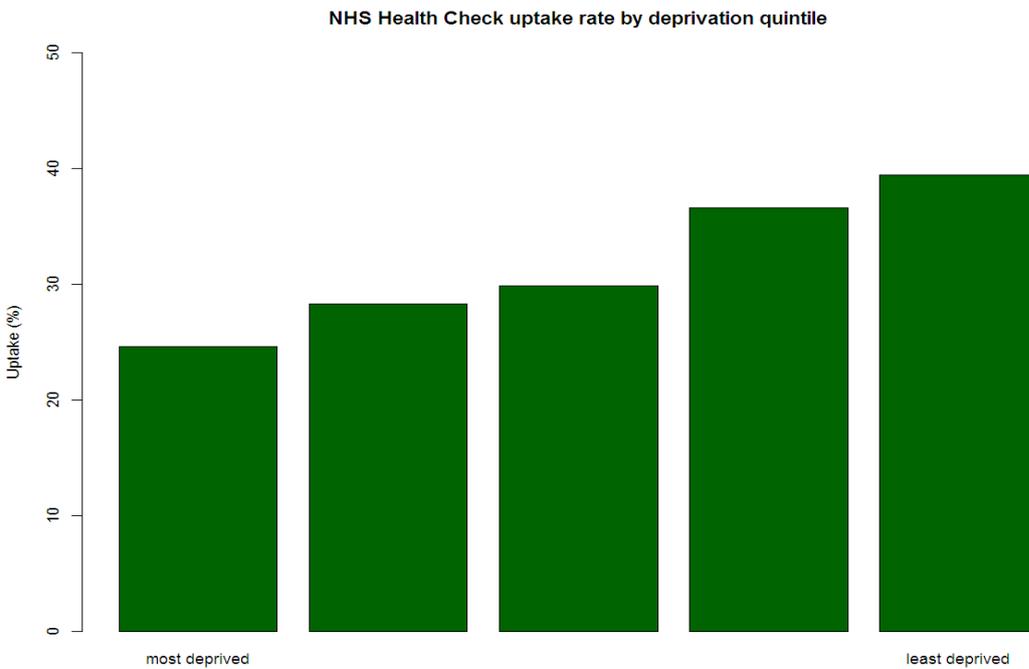
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AND LEARNING DISABILITY SERVICES
(MULTILATERAL)**

SECTION B PART 14 – REPORTING AND INFORMATION MANAGEMENT

APPENDIX 1:

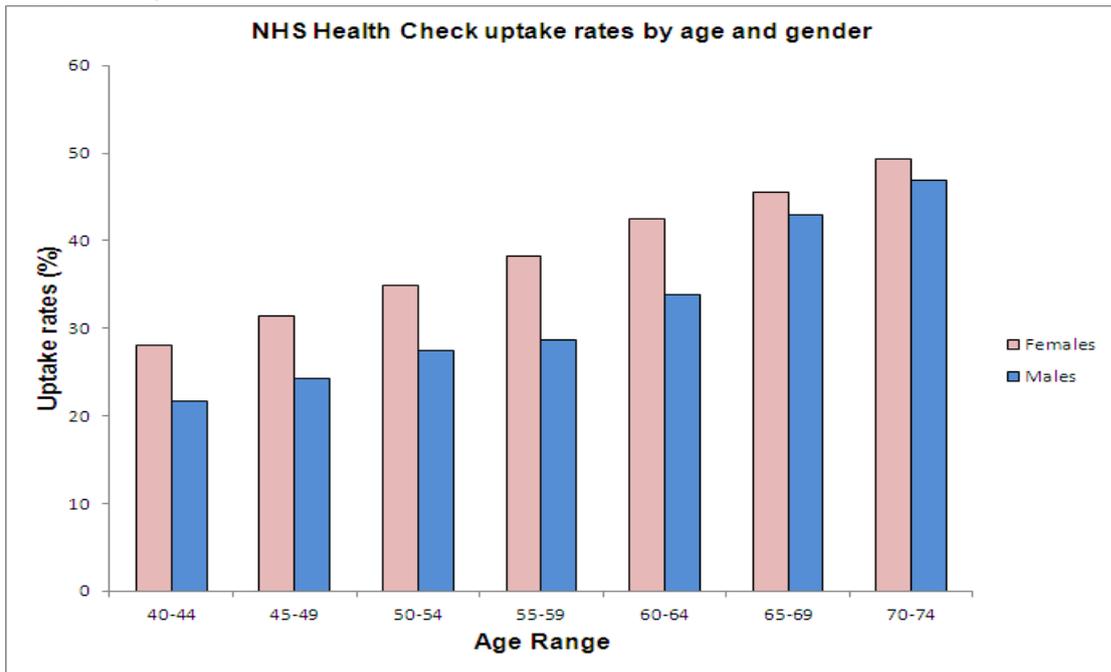


APPENDIX 2:

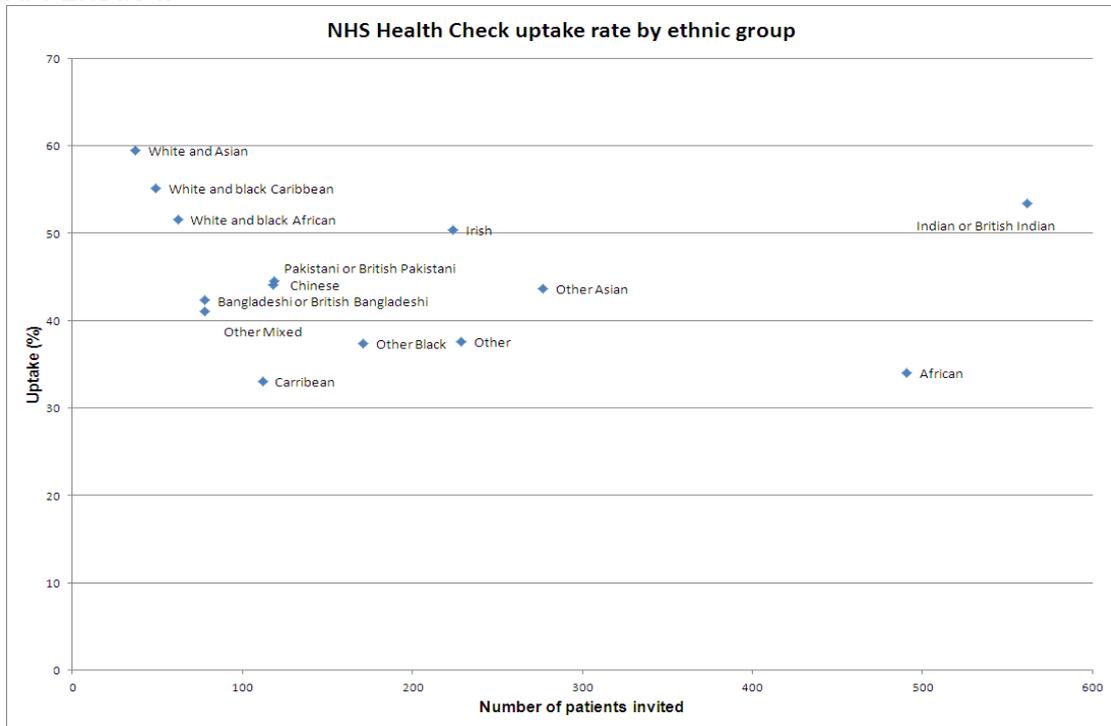


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APPENDIX 3:



APPENDIX 4:



The 'white British', 'not known' and 'not stated' categories have been removed for the purpose of clearly showing the minority ethnic groups in the figure.

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APPENDIX 5:

Ethnic descriptions list for 'Harder to reach group.'



Harder to Reach
Ethnic group descripti

APPENDIX 6:

Consent form



Medway NHS Health
Checks outreach Con

APPENDIX 7:

Improvement service referral forms

Exercise referral



Exercise Referral
Form2011.doc

Template letter to accompany exercise referral form back to GP for sign off. GP to forward referral form to improvement service.



AHP Letter to GP
exercise referral acc

Community weight management referral form to be available once service provider selected.

Stop smoking service



Stop smoking E-
referral template May

Community alcohol services



External Referral
Form - Community Alc

APPENDIX 8:

NHS Health Check results leaflet to be available once service provider selected.

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APPENDIX 9:

Monthly data output report

Patient Id number (supplied by provider)	GP practice code	Age	Gender	Postcode	Ethnicity (using 16 category framework)

Individuals with no GP should still be entered onto the output report with 'No GP' in the GP practice code column.