SPECIFICATION

Service	**NHS Health Checks – Pharmacy**
Council Lead	**Angela Hannant Public Health Programme Lead**
Provider Lead	**See Contract Particulars**
Period	**1ST April 2017 - 31st March 2018**

1. Population Needs

This Specification is intended for pharmacy staff to provide a standardised approach to delivering the NHS Health Check service.

1.1 National/local context and evidence base

The NHS Health Check Programme aims to improve health and wellbeing of adults aged 40-74 years through the promotion of earlier awareness, assessment, and management of the major risk factors and conditions driving premature death, disability and health inequalities in England.

Reducing avoidable premature mortality is a government priority. For males 28% of the gap in life expectancy between the most and least deprived fifth of areas in England is due to excess deaths from circulatory diseases, and for females this figure is 24%. If diabetes and urinary conditions are added to circulatory diseases, then excess deaths from these conditions together contribute to 31% of the gap between the most and least deprived fifth in England for males and 28% for females. Additionally, the cost of social and health care from the rise in levels of obesity, type 2 diabetes and dementia makes the prevention and risk reduction of these conditions key drivers of the programme.

The NHS Health Check is a systematic vascular risk assessment and management programme to help prevent cardiovascular diseases (CVD) including heart disease, stroke, diabetes, dementia and kidney disease. Local authorities are mandated to commission the risk assessment element of the NHS Health Check programme under the Health and Social Care Act (2012). Where additional testing and follow up is required, for example, where someone is identified as being at high risk of having or developing vascular disease, this remains the responsibility of primary care and will be funded through NHS England.

The Department of Health estimated that the programme could prevent 1,600 heart attacks and strokes, at least 650 premature deaths, and identify over 4,000 new cases of diabetes each year. At least 20,000 cases of diabetes or kidney disease could be detected earlier, allowing individuals to be better managed to improve their quality of life. The estimated cost per quality adjusted life year (QALY) is approximately £3,000.The evidence reviews for the programme can be found here

http://www.healthcheck.nhs.uk/commissioners_and_providers/evidence/

The NHS Health Check programme aims to:

- improve life expectancy for local people
- reduce the life expectancy gap due to vascular disease between Gateshead and the rest of England through the provision of NHS Health Checks (risk identification, assessment and management) for 40-74 year olds, not previously diagnosed with vascular disease
- promote and improve the early identification and management of the individual behavioural and physiological risk factors for vascular disease and the other conditions associated with these risk factors
- support individuals to effectively manage and reduce behavioural risks and associated conditions through information, behavioural and evidence based clinical interventions

The NHS Health Check Programme offer is for each eligible person aged 40-74 to be offered a NHS Health Check once in every five years and for each person to be recalled every five years if they remain eligible. There are national programme standards set out in the NHS Health Check Programme Best Practice Guidance (March 2016):
http://www.healthcheck.nhs.uk/commissioners_and_providers/guidance/

- the risk assessment includes specific tests and measurements
- the person having their health check is told and understands their cardiovascular risk score,
- other results are communicated to them,
- Tailored lifestyle advice and behaviour change support
- specific information and data is recorded and,
- where the risk assessment is conducted outside the Service User's GP practice, for that information to be forwarded to the responsible GP and recorded in the patient records.

Since 2013, the programme has also aimed to reduce levels of alcohol related harm, and to raise awareness of the signs of dementia and signpost people for help. Everyone attending a NHS Health Check will have their alcohol consumption risk assessed. In addition, people aged 65-74 will be informed of the signs and symptoms of dementia and sign posted to memory clinics if needed. Please refer to NHS Health Check Programme Best Practice Guidance (March 2016)

The Department of Health expects 20% of the eligible population to be invited each year over the five year rolling programme with a continuous improvement in the percentage of eligible individuals taking up the offer. This means target uptake moving from a minimum 50% towards an aspirational 75% of eligible people.

One of the programme's objectives is to reduce health inequalities. Local authorities may tailor the delivery of the programme in a number of ways to achieve this. Although local authorities have a duty to offer the NHS Health Check to all eligible people, PHE supports approaches that prioritise invitations to those with the greatest health risk. For example, by prioritising invitations to people with an estimated ten-year CVD risk score greater than 10% or those living in their most deprived areas.

The persistent inequality between the least and most deprived areas in England is a further reason for the pressing need to improve the scale and reach of preventive services. In order for NHS Health Checks to be effective at reducing health inequality, it is important to have high and equitable uptake in high risk populations, as risk factors of tobacco use, high blood pressure, excess alcohol consumption, high cholesterol and being overweight are key reasons for inequalities in health and life expectancy.
The NHS Health Check programme can reduce health inequalities by:

- increasing healthy life expectancy by through lifestyle and clinical management of risk factors that cause preventable disease and disability
- reducing differences in healthy life expectancy and overall life expectancy within and between communities at ward level within local authorities
- reducing premature preventable death by assessing the risk of developing a condition and providing necessary treatment if the condition presents itself

In addition, local areas will wish to ensure that the NHS Health Check programme they offer is in keeping with the Equality Act 2010. This duty recognises that equality of opportunity cannot be achieved simply by treating everyone the same. Active consideration should be given locally with regard to both access to and delivery of the NHS Health Check for everyone but specifically in respect of those who share one of the nine protected characteristics: age, disability, gender reassignment, pregnancy and maternity, race – this includes ethnic or national origins, colour or nationality, religion or belief – this includes lack of belief, sex, sexual orientation. For example, the way that wheelchair users access their NHS Health Check, as well as how their risk assessment is undertaken and how they are supported to improve their lifestyle will require specific consideration and action.

An effective way to find people with undiagnosed heart disease is through NHS Health Checks. The Quality and Outcomes Framework (QOF) is a voluntary incentive scheme for GP practices in the UK. The QOF contains groups of indicators, against which practices score points according to their level of achievement, rewarding contractors for the provision of quality care. The NHS Health Check aligns strongly with QOF, supporting the achievement of a number of assessment and clinical management indicators. These are summarised in annex A (p56) of NHS Health Check Best Practice Guidance March 2016.

The Provider is to adopt a motivational interviewing technique in delivering NHS Health Checks, which is also used in the House of Care approach adopted by GP Practices and promoted by the CCG. Trained health care professionals i.e. GPs and Nurses are trained to communicate risk and diagnosis as part of their professional training. Other primary care staff who deliver NHS Health Checks must be trained appropriately for the element of NHS Health Checks they are delivering e.g. collecting data (height and weight), using equipment for point of care testing and/or undertaking a NHS Health Check assessment and informing Service Users of their level of risk. Training requirements are detailed in Schedule 1 - conditions precedent section of this contract.

In Gateshead, over the last few years, there has been a consistent approach to driving up the number of NHS Health Checks delivered. The Gateshead NHS Health

Checks programme appears to be finding people at high risk of CVD. For every 10 health checks, 2 new high risk individuals are identified and 1 person with previously unrecognised hypertension (Lambert, M (2015) Assessing potential local routine monitoring indicators of reach for the NHS health checks programme. Public Health. journal homepage: www.elsevier.com/puhe)

Data on the performance of the national NHS Programme by regions and local areas can be found here http://www.healthcheck.nhs.uk/commissioners_and_providers/data/. For Gateshead 2013-18 (5 year cumulative) 41,581 people have been offered an NHS Health Check, and 22,461 have received an NHS Health Check. This is 54% uptake of people offered who then had an NHS Health Check.
In Gateshead local data is also recorded on outcomes following an NHS Health Check such as lifestyle interventions and diagnoses.

The key to optimising the clinical and cost effectiveness of the NHS Health Check programme is to ensure a high percentage of those offered a NHS Health Check actually receive one. This is especially important for populations with the greatest health needs and will impact on the programme's and local area's abilities to narrow health inequalities.

Further information on the Public Health Outcomes Framework can be found here: http://www.phoutcomes.info/

Further information on the health issues for Gateshead can be found here: Health and Wellbeing Board and**Joint Strategic Needs Assessment**

2. Key Service Outcomes

The service is to be provided in a manner that will contribute to achievement of the following outcomes from the Public Health Outcomes Framework:

- Cumulative percentage of the eligible population aged 40-74 offered a NHS Health Check in the five year period 2013/14 - 2017/18 (2.22iii).
- Cumulative percentage of eligible population aged 40-74 offered a NHS Health Check who received a NHS Health Check in the five year period 2013/14 - 2017/18 (2.22iv).
- Cumulative percentage of eligible population aged 40-74 who received a NHS Health Check in the five year period 2013/14 - 2017/18 (2.22v)
- Mortality rate from causes considered preventable (4.03)
- Under 75 mortality rate from all cardiovascular diseases (4.04i)
- Under 75 mortality rate from all cardiovascular diseases considered preventable (4.04ii)
- Excess weight in adults (2.12)
- Percentage of physically active adults (2.13)
- Prevalence of smoking among persons aged 18 years and over (2.14)
- Recorded Diabetes (2.17)
- Alcohol-related hospital admissions (2.18)

- Estimated diagnosis rate for people with dementia (4.16)
- Overarching indicators for life expectancy and inequality

The following outcomes are to be achieved by the Provider under this Contract:

- Minimum of 120 NHS Health Checks completed over a 12 month period by the Provider
- Hard copy of NHS Health Check results given by the Provider to each Service User
- Hard copy of NHS Health Check results given by the Provider to General Practitioner ("GP") for each of their Service Users within 48 hours.
- All Service Users identified as being high risk will be followed up by the Provider via telephone after 4 weeks to determine whether or not they have made an appointment to see their GP.
- A summary list of all Service Users, who have undertaken the NHS Health Check, is given to GPs on a monthly basis by the Provider.

3. Scope

The aim of this Service is to prevent heart disease, stroke, diabetes and chronic kidney disease by identifying risk factors and managing them appropriately in the eligible population.
The NHS Health Check programme provides a structured approach to cardiovascular risk management for all people aged 40-74 years old, who are not already on any patient risk register.

Through the check, their risk of heart disease, stroke, kidney disease and diabetes is assessed through some straightforward tests and standard questions about their lifestyle and family medical history.

Personalised advice and support is then offered to help lower the risk of developing cardiovascular disease.

Those with low or moderate risk are likely to receive advice about changes to their lifestyle, whilst individuals with a higher risk may also be offered medical support (in addition to lifestyle advice) through primary care and onward referral to other specialist support services e.g. smoking cessation and/or weight management.

The scope of the programme is:

- Identification of those people who are eligible (including targeting of hard to reach populations)
- Risk assessment and identification of associated risk factors
- Communication of results and level of risk
- Management of risk (including advice, brief interventions, referral for clinical support, signposting and referral to other services if appropriate)

The core objectives of the Service for the Provider to meet are:

ENGAGEMENT

- Identification of the eligible population using a pre-check questionnaire
- Invitation of the eligible population
- Proactive approach to reach potentially high risk groups
- To encourage uptake of the Health Check

ASSESSMENT

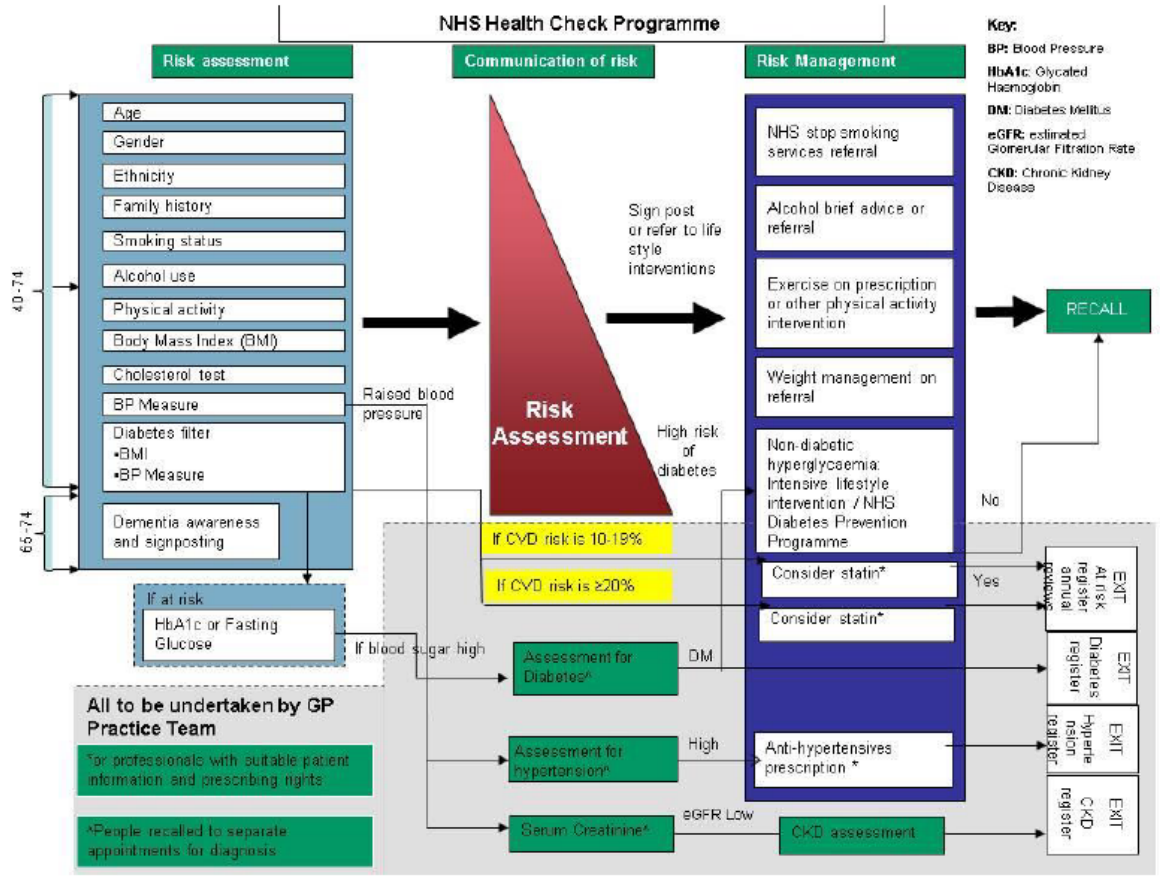
- face to face assessment of a Service User's cardiovascular risk (which includes heart disease, diabetes, chronic kidney disease and stroke risk)
- Communication of cardiovascular disease risk to Service Users. Everyone having the NHS Health Check should be provided with individually tailored advice that will help motivate them and support the necessary lifestyle changes to help them manage their risk.
- The Provider will provide lifestyle advice to ALL Service Users having a Health Check, regardless of their risk score on how to maintain/improve their vascular health, unless deemed clinically inappropriate.
- Lifestyle measures that can reduce CVD risk include:
  - Smoking cessation.
  - Weight loss if overweight or obese.
  - Eating a healthy diet.
  - Keeping alcohol consumption within the recommended limits.
  - Being physically active.
- Every Service User who has a NHS Health Check must have their cardiovascular risk score communicated to them. The person having their check should also be told their BMI, cholesterol level, blood pressure and AUDIT score.
- A diagram of the risk assessment and management can be seen below. (Figure 2).
  - If level of risk is less than10% provide tailored lifestyle advice based on the assessment results. This may include written information, signposting/referral to a lifestyle service for evidence based behaviour change support for e.g. stop smoking support. It must be made clear both verbally and in writing that service users do not need to seek further follow up from their GP, and that they only need a Health Check once every 5 years.
  - If level of risk is 10% or greater treatment with statins may be recommended in addition to lifestyle changes. If Service User agrees to statins, they will be considered as being managed and will not be eligible for further NHS Health Checks. If the Service User refuses statins, they will be eligible for a NHS Health Check in five years
  - If the service user needs further follow up from their GP, they should be advised of the relative urgency of this follow-up and this should also be recorded on their Health Checks results leaflet.
  - If level of risk is 20% or greater, the Service User should be transferred to the appropriate treatment pathway in Primary care, in addition to lifestyle changes.
  - If the service user does not need to see their GP, it must be made clear

both verbally and in writing that they do not need to seek further follow up from their GP, and that they only need a NHS Health Check once every 5 years.

- If the service user needs further follow up from their GP, they should be advised of the relative urgency of this follow-up and this should also be recorded on their Health Checks results information.

NHS Health Check Best Practice Guidance

Figure 2. Overview of the vascular risk assessment and management programme



MANAGEMENT

Management of risk factors in line with National Best Practice and NICE guidance including:

- Advice on lifestyle risk factors and signposting to other services as appropriate
- Referral to GP for medical management of cardiovascular risk if required
- To increase awareness of dementia specifically among 65 to 74 year olds
- To provide advice on maintaining healthy lifestyles for all levels of risk and referral to health improvement services were appropriate
- To collect and record data in the clinical system as per the updated templates.

QUALITY ASSURANCE

- Copy of results given to Service User, in an appropriate language and

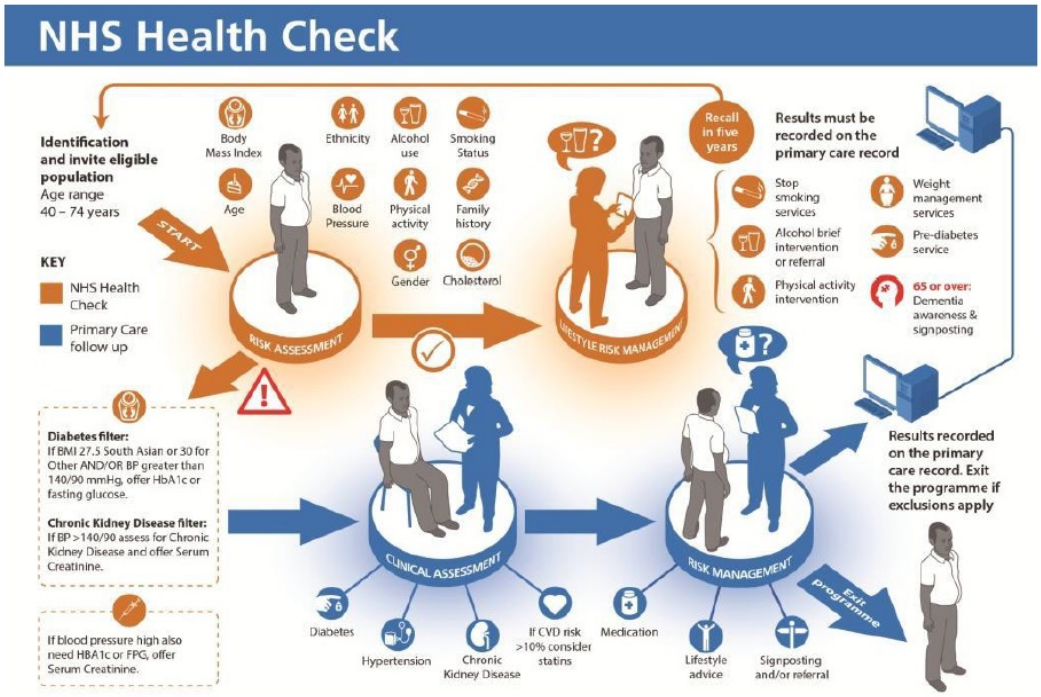
format

- The results booklet can be found here: http://www.healthcheck.nhs.uk/latest_news/updated_nhs_health_check_results_booklet/
- Accurate recording of NHS health check
- Record on PharmOutcomes
- Providers using Point of Care Testing equipment for e.g. LDX Cholestech Machine or equivalent, to perform required checks with every use of machine and monthly external quality assurance testing (Bolton Quality Assurance Testing). Further information can be found in Section 3.2
- Motivational interviewing techniques should be used to guide, encourage and support behaviour change
- The Provider will carry out NHS Health Checks in accordance with best practice advice provided by the National NHS Health Checks Team http://www.healthcheck.nhs.uk/national_guidance/ and Gateshead Council's policies and procedures.
- Ensure there are clear documented procedures for infection control, storage and disposal of clinical waste, needle stick injuries/spillage and SUI's
- Work with Gateshead Council as appropriate to support delivery of the NHS Health Check Programme

3.2 Service description/pathway

Figure 1 shows a diagram of the National NHS Health Check Programme

Figure 1. NHS Health Check pathway



PRIORITISATION AND INVITATIONS

The invitation could be in the form of a letter, telephone call, text message or other communication as preferred by the Provider and Service User. An information leaflet about the NHS Health Check is available here: http://www.healthcheck.nhs.uk/information_leaflets The information leaflet, as recommended by the DH is also available in Braille, large print and audio versions. Paper copies can be ordered via the Department of Health orderline: https://www.orderline.dh.gov.uk/ and search for NHS Health Checks. The provider must be registered with the DH Orderline to be able to utilise the free information leaflets.

A template invitation letter is also available http://www.healthcheck.nhs.uk/inviting_your_population/. Mixed methods of invitation, such as using letter, opportunistic discussion, telephone and text messaging have been shown to increase uptake.

To help reduce health inequalities, the Provider could invite those living in areas of Gateshead with the most deprivation as a priority, and/or with known risk taking behaviour as a priority e.g. to identify those in the 40-74 age range without an existing diagnosis who smoke, are overweight and/or use alcohol at harmful levels (>14 units per week for men and women). A map showing Gateshead's Lower Super Output Areas by deprivation can be found here: http://www.gateshead.gov.uk/Health-and-Social-Care/JSNA/Topics/Population-and-Deprivation/Deprivation/Deprivation.aspx

Health inequalities are the unfair and avoidable differences in people's health across social groups and between different population groups. Health inequalities can result in people who are worst off experiencing poorer health and shorter lives.

HEALTH CHECK ASSESSMENT

The Provider will initially complete a pre-check questionnaire with the Service User to ascertain eligibility for entering into the Service.

In line with national guidance, a NHS Health Check will be undertaken and the results inputted into PharmOutcomes.

For further guidance on the Health Check Assessment, please refer to Chapter 3 The Risk Assessment of the NHS Best Practice Guidance

Everyone receiving a NHS Health Check is to have a risk assessment from the Provider which will look at individual risk factors, as well as their risk of having, or developing, vascular disease in the next ten years. During the assessment, the Provider is to ensure that the specific tests and measures listed below are completed during the risk assessment and that the results are recorded.

- **Age**
  Data required: age recorded in years.
  Thresholds: the age of the individual should be 40-74 years (inclusive).

- **Gender**

Data required: the gender should be recorded as reported by the individual. If the individual discloses gender reassignment, they should be provided with CVD risk calculations based on both genders and advised to discuss with their GP which calculation is most appropriate for them as an individual.

- **Smoking status**
  Data required: non-smoker, ex-smoker, light smoker (fewer than 10 a day), moderate smoker (11-19 a day), heavy smoker (≥ 20 a day).
  A smoker who wants to quit can be offered a referral to a local stop smoking service.

- **Family history of coronary heart disease**
  Data required: information on family history of coronary heart disease in first-degree relative under 60 years.
  Key points: first-degree relative means father, mother, brother or sister.

- **Ethnicity**
  Data required: self-assigned ethnicity using one of the following categories: white/not recorded, Indian, Pakistani, Bangladeshi, other Asian, black African, black Caribbean, Chinese, other including mixed.
  Key points: ethnicity is needed for the diabetes risk assessment. Ethnicity should be recorded using the Office for National Statistics 2001 census codes.

- **Body mass index (BMI)**
  Data required: BMI is required for the CVD risk calculation. It also provides one approach to identifying those at high risk of developing diabetes, or those who have existing undiagnosed diabetes, and is required for the diabetes risk assessment.
  Thresholds: a blood sugar test is required where the individual's:
  - BMI is greater than 27.5 for people from black, Asian and other ethnic groups
  - BMI is greater than 30 (rest of population)

  Note: if the Service User cannot have their height and or weight measured, the Service User's estimate of their own height and weight can be used as approximations but these are prone to error. Arm span can also be used as an approximation for height.

  Note: NICE diabetes guidance also recommends in high risk and vulnerable groups people aged 25 and over of south Asian, Chinese, African-Caribbean and black African origin who have a BMI greater than 23kg/m^2 consider a blood test.

- **Cholesterol level - Total cholesterol/HDL Ratio**
  Data required: cholesterol must be measured as the ratio of total serum cholesterol to high density lipoprotein cholesterol.
  Key points: a random cholesterol test should be used for this assessment. A fasting sample is not required.
  New advice – where a Service User's cholesterol level is found to be above 7.5mmol/l refer to GP for consideration of familial hypercholesterolaemia

- **Blood pressure measurement.**
  Both systolic (SBP) and diastolic blood pressure (DBP) are required for the diabetes filter and for assessment for chronic kidney disease and hypertension within primary care.

  If the Service User has a blood pressure at, or above, 140/90mmHg, or where the SBP or DBP exceeds 140mmHg or 90mmHg respectively, the Service User requires referral to their GP for:
  - A HbA1c test.
  - An assessment for hypertension
  - An assessment for CKD

  As set out in NICE clinical guideline 127 (2011) practitioners should perform a pulse rhythm check prior to taking blood pressure to detect any pulse irregularities that could affect the reading from an automated device. Service Users who are found to have an irregular pulse rhythm should be referred to the GP for further investigation.

  In addition to Service Users meeting the high risk filter criteria for blood glucose testing, it is important to consider the situation of the Service User, as some people who do not fall into the filter categories will still be at significant risk. This includes:
  - people with first-degree relatives with type 2 diabetes or heart disease
  - people with tissue damage known to be associated with diabetes, such as retinopathy, kidney disease or neuropathy
  - women with past gestational diabetes
  - those with conditions or illnesses known to be associated with diabetes (e.g., polycystic ovarian syndrome or severe mental health disorders)
  - those on current medication known to be associated with diabetes (e.g., oral corticosteroids)

  Supplementary information on managing familial hypercholesterolemia, cholesterol, irregular pulse, and HbA1c can be found in Chapter 5 of NHS Health Checks Best Practice Guidance.

  Key points: checking the pulse rhythm
  NICE Hypertension clinical guideline 127 (2011) recommends that practitioners should perform a pulse rhythm check prior to taking blood pressure to detect any pulse irregularities. Irregularities can lead to inaccurate blood pressure readings when an automated device is used. Individuals who are found to have an irregular pulse rhythm should be referred to the GP for further investigation of atrial fibrillation.

- **Physical activity level** - inactive, moderately inactive, moderately active or active
  For the Physical activity assessment, a validated tool is recommended, such as DH's General Practitioner Physical Activity Questionnaire (GPPAQ) to measure the activity levels of individuals.
  GPPAQ has been tested and validated for self-completion. It provides a measure of an individual's physical activity levels, which have been shown to correlate with cardiovascular risk, classifying people as inactive, moderately inactive, moderately

active, and active.

NICE guidance on physical activity interventions recommends that primary care practitioners should take the opportunity, whenever possible, to identify inactive adults. The UK Chief Medical Officer recommended that all adults should be physically active daily. Over a week, activity should add up to at least 150 minutes. For further information please see:
https://www.nice.org.uk/guidance/qs84

Thresholds: a brief intervention on physical activity can help support Service Users to become and remain active and will be appropriate for the majority of people who fall into all GPPAQ classifications other than active.

- **Alcohol assessment** – using alcohol use disorders identification test (AUDIT) score Here is a link to the Audit-C questions AUDIT - C

  Initial assessment threshold: (AUDIT-C >5) If the individual scores five or more using AUDIT-C, the second phase should be undertaken.
  Full AUDIT: if the Service User scores above the initial assessment threshold then the second phase is to complete the remaining questions of the full AUDIT. It is this full AUDIT score that can identify the risk level of the Service User.

  AUDIT threshold: > 8. If the total AUDIT score from the full ten questions is eight or more, this indicates the individual's consumption of alcohol might be placing their health at increasing or higher risk of harm. The AUDIT score should be recorded and fed back to both the individual and, where the risk assessment is carried out outside the Service User's GP practice, to the Service User's GP.
  Related stages of the check: although this is not a mandated requirement, if the Service User meets or exceeds the AUDIT threshold of eight, they should be given brief alcohol advice to reduce their health risk and to help reduce alcohol related harm. A referral to alcohol services should be considered for those Service Users scoring 20 or more on AUDIT.
- New UK alcohol guidelines were published in January 2016 which recommend a lower threshold of alcohol units for men.
- Further Alcohol resources can be found here:
  http://www.alcohollearningcentre.org.uk/

- **Diabetes risk assessment**
  Data required: ethnicity, BMI and blood pressure are required for the diabetes risk assessment.
  Thresholds:
  - blood glucose (HbA1c) test if an individual's BMI is: greater than 27.5 for people from black, Asian and other ethnic groups or greater than 30 (rest of population)

  or
  - blood pressure is at or above 140/90mmHg, or where the SBP or DBP exceeds 140mmHG or 90mmHg respectively
  This is to identify people at high risk of developing, or living with undiagnosed diabetes, and to undertake the necessary HbA1c test. Only those identified as at higher risk should have a HbA1c test as part of their NHS Health Check risk assessment; it is not considered clinically effective or cost effective to test

everyone.

- Diabetes filter - the national NHSHC Expert Scientific and Clinical Advisory Panel (ESCAP) are going to hold a public consultation about the existing diabetes filter used in the programme (announced July 2016). The consultation will detail the intention to align with the NICE guidance on Type 2 Diabetes but also identify clear thresholds for when people should go on to receive follow-up blood testing. The outcome of this may result in changes (variation) to this specification.

- **Dementia**
  The dementia component of the NHS Health Check does not require any formal assessment or memory testing. The purpose of the intervention is to raise awareness of dementia and the availability of memory services which offer further advice and assistance to people who may be experiencing signs and symptoms of dementia. Everyone who has an NHS Health Check should be made aware that the risk factors for cardiovascular disease are the same as those for dementia. What is good for the heart is good for the brain.
- In addition, those aged 65-74 should be made aware of the **signs and symptoms of dementia** and sign posted to memory services if this is appropriate.

  An updated NHS Health Check Dementia leaflet for use with people aged between 65 and 74 years, can be found here: NHS Health Check dementia resourcesThe web based dementia training can also be accessed here http://www.healthcheck.nhs.uk/increasing-dementia-awareness-training-resource/

- The Provider should offer all Service Users sufficient time to conduct the full risk assessment, communicate the results in a way the Service User understands and offer ongoing referral to relevant lifestyle support services. National guidance indicates that the full NHS Health Check takes around 20-30 minutes to complete.
- The presence of other conditions that increase CVD risk are also to be recorded during the consultation i.e. rheumatoid arthritis, premature menopause, (before the age of 45) erectile dysfunction.

Cardiovascular risk score using Qrisk2

The Service User's risk is then calculated, using QRisk2, with the results communicated by the Provider to the Service User in a way that the Service User understands. NB only QRisk2 should be used; any other risk assessments will not qualify as a NHS Health Check and will not attract a payment. In the lifestyle risk management part of the NHS Health Check, the risk score is communicated to the Service User. The results will be discussed and lifestyle advice and support offered. This will be tailored to the Service User's results and may involve a brief intervention.

- All Service Users having a NHS Health Check are to receive healthy lifestyle advice on how to maintain/improve their vascular health and reduce their risk of developing CVD.
- All Service Users will receive a copy of their results in a suitable language and format
  The national results cards and booklets can be found here:

http://www.healthcheck.nhs.uk/commissioners_and_providers/delivery/invitation_letter_and_results_card/

- The Provider will actively involve the Service User in agreeing what advice and/or interventions are to be pursued and encouraged/supported to develop a behaviour change action plan (goal setting)
- Any decisions made or tests/measurements undertaken by the Provider must be in partnership with the Service User and with the Service User's informed consent

- Cardiovascular disease (CVD) risk should be communicated using everyday, jargon-free language. Service Users should be offered information about their absolute risk of CVD and about the absolute benefits and harms of an intervention over a ten-year period. NICE guidance advises that:
  - the decision whether to start statin therapy should be made after an informed discussion between the GP or nurse and the Service User about the risks and benefits of statin treatment, taking into account additional factors such as potential benefits from lifestyle modifications, informed patient preference, comorbidities, polypharmacy, general frailty and life expectancy

Cardiovascular risk score below 10%

- Service Users identified as being at less than 10 percent risk of developing CVD should to be recalled after five years yet may also need lifestyle interventions to maintain or improve their vascular health (e.g. referral to a stop smoking service, advice regarding weight management or physical activity interventions)
- Providers will share NHS Health Check results with the service User and their GP.

Cardiovascular risk score over 10%

- Service Users with a 10% or greater ten-year risk of developing CVD should be offered appropriate lifestyle advice and behaviour change support in relation to increasing physical activity, smoking cessation, safe alcohol consumption and healthy diet
- Service Users with high CVD risk should be advised that the potential benefits from lifestyle modifications will also reduce their risk of dementia
- Where lifestyle modification has been ineffective or is inappropriate, Service Users with a 10% or greater ten-year risk of developing CVD should be offered statin therapy for the primary prevention of CVD. Providers should refer to primary care.
- Providers will share NHS Health Check results with the service User and their GP.
- If a Service User agrees to statins, they will be considered as being managed and will not be eligible for further NHS Health Checks. If the Service User refuses statins, they will be eligible for a NHS Health Check in five years
- **Key point:** Service Users that are either prescribed a statin or have a CVD risk score ≥20% should exit on to an at risk register in Primary Care

Referrals may be made for stopping smoking, weight management, alcohol use, memory problems, physical activity interventions and pre-diabetes.
Referral is to be made by the Provider as appropriate to GP, Lifestyle services or other appropriate services
All results, advice, referrals and interventions are to be recorded on the pharmacy

record, and included on information transferred to the GP.

For further information on Risk management and Lifestyle interventions please see Chapter 4 of the NHS Health Check Best Practice Guidance. For further information on Risk management and secondary prevention please see Chapter 5 of the NHS Health Check Best Practice Guidance.

Point of Care Testing (POCT) or Near Patient Testing (NPT)

Providers must ensure that they comply with the specific guidance on POCT set out in the NHS Health Check Programme Standards (2016). The use of point of care testing machines (POCT) is recommended as best practice for the Gateshead NHS Health Checks Programme and should be used where appropriate quality assurance mechanisms are in place.

The Provider should offer all Service Users sufficient time to conduct the full risk assessment, communicate the results in a way the Service User understands and offer ongoing referral to relevant lifestyle support services. National guidance indicates that the full NHS Health Check takes around 20-30 minutes to complete.

Point of Care Testing may be utilised by the Provider when delivering the NHS Health Check to allow the clinician to deliver the full results of the check immediately, without the requirement for bloods to be sent away for testing and a further contact with the Service User to deliver the results.

POCT, also known as near patient testing, has several advantages:

- Immediate test results – no repeat appointments needed
- The Service User receives instant feedback on their health status, brief intervention and support which has been found to increase Service User understanding and compliance with recommendations
- Increased uptake of NHS Health Checks
- Enhanced care – address individual risk factors, immediate care for high risk Service Users
- Positive Service User experience

A new requirement for 2017/18 is for the Providers to purchase and maintain their POCT equipment for NHS Health Checks. Those Providers with an existing LDX machine can retain the equipment for NHS Health Checks but are required to undertake the maintenance of the equipment. It is the Provider's responsibility to provide all necessary equipment and facilities required to conduct a Health Check. This includes a private area for assessment, height and weight measuring devices, blood pressure monitors, point of care testing equipment, consumables (including suitable storage and disposal facilities e.g. refrigerator and sharps bins)

The Cholestech LDX is the preferred system for cholesterol testing across Gateshead as it historically appears one of the most accurate on the market, it has a reported lifespan of 10 years and those currently delivering health checks across Gateshead have been trained to use it. The unit is certified for Total Cholesterol and HDL-Cholesterol by the CDC's Cholesterol Reference Method Laboratory Network, confirming that the accuracy and reproducibility of the POCT lipid profile method is

comparable to centralised laboratory testing, regardless of the blood testing method. There are of course other systems available on the market, the Council is in no way urging the Provider to use a particular system.

The Provider must undertake appropriate mandatory training and annual update training (see Schedule 1). The Provider must ensure compliance with quality control testing as these are crucial to ensure that health care professionals can be confident that the LDX unit continues to deliver lab- accurate results.

The Provider will require the following equipment:

Cardiovascular Equipment

- Cholestech LDX Cholesterol Analyser (or equivalent) including: analyser, power supply, optics check cassette, user manual, training video
- External Accredited Quality Assurance Scheme such as Bolton Quality Assurance Scheme
- TC/HDL Cholesterol Cassettes
- Heparinised glass tubes and plungers 40ul
- Unistik 3 Lancets
- Swabs, disposable gloves, plasters
- AA Approved BP Unit, UA 767
- Large Blood Pressure Cuff
- Seca 761 analogue scales
- Height Meter

Further details on recommended POCT machines are available in the NHS Purchasing and Supply Agency Buyer's Guides for POCT for Cholesterol (2009)

- The Provider is responsible for the safe disposal of all medical waste, sharps and other refuse generated by the service in accordance with the relevant Health and Safety Regulations.
- It is the Provider's responsibility to make arrangements for ordering consumables. Should the Provider wish to continue ordering with Health Diagnostics Ltd, it is their responsibility to arrange this. Contact details for Health Diagnostics are Telephone 01244 669 700 or email: Support@healthdiagnostics.co.uk
- The Provider is expected to adhere to Medicines and Healthcare Regulatory Agency (MHRA) advice on selection of appropriate equipment, training in its use and ongoing management, troubleshooting, and quality assurance processes that ensure the accuracy and ability to reproduce results.
- The Provider will report any adverse incidents involving medical equipment to the relevant manufacturer as well as the Medicines and Healthcare products Regulatory Agency (MHRA), follow the ESCC Incident Reporting Policy and process, and manage in accordance with providers' governance arrangements and council requirements.
- An adverse incident is an event that causes, or has the potential to cause, unexpected or unwanted effects involving the accuracy and/or safety of device users (including Service Users) or other persons.

- Providers will ensure that an appropriate internal quality control (IQC) process is in place. Providers should note that NHS Programme Standards8 indicate that an appropriate internal quality control (IQC) process for POCT should be delivered in accordance with the MHRA guidelines9 on POCT, 'Management and use of IVD point of care test (POCT) devices. Device bulletin 2010 (02) February 2010'. This should take the form of at least a daily "go/no go" control sample (use of a liquid sample) on days when the instrument is in use. This may require other procedures e.g. optical check to be performed in addition to the use of a liquid control sample.

Quality Assurance (QA) Scheme for POCT

It is essential that Providers are registered with an accredited Quality Assurance scheme (such as Bolton Quality Assurance Scheme / BQAS). It is the Provider's responsibility to make arrangements for an accredited quality assurance scheme. The current QA scheme provided by the Council ends March 31st 2017. Should the Provider wish to continue with the current QA scheme with Health Diagnostics Ltd, it is their responsibility to arrange this with a new agreement between the Provider and Health Diagnostics Ltd. Please contact Health Diagnostics on Telephone 01244 669 700 or email: Support@healthdiagnostics.co.uk Or an alternative external quality assurance scheme can be sourced.
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Providers are required to sign-up to and participate in an External Quality Assessment (EQA) scheme such as BQAS. All equipment should be fully functional, accurate and regularly calibrated. POCT equipment should be checked internally either daily, or on those days it is being utilised. It is the Provider's responsibility to do this.

Your local hospital laboratory or other accredited provider can be consulted for advice regarding appropriate quality control process for POCT. In addition local healthcare scientists can offer support to services wishing to set up POCT services (NHSHC National Programme Standards section 5).

The monthly Quality Assurance scheme ensures that the cholesterol analysers and the Providers are delivering accurate assessments at all times. Usually for each POCT machine, a monthly sample from the pathology laboratory at the Hospital will be sent to the Provider's named lead. On alternative months a sample will be sent with the expected values provided. During the intervening months, a blind sample will be sent and the site will send their results on email to the lab. Providers will get an immediate response as to whether they have passed or failed. The Providers will know almost instantaneously how their system is performing. **Providers must make arrangements to share the monthly QA results with the Council.**

Documentation relating to the quality assurance processes utilised by the Provider should be made available to the Council on request. Failure to comply with the required QA processes will result in suspension of this Contract, until sufficient evidence of compliance is provided. Participation in the BQAS scheme provides reassurance that Service User results are reliable and accurate. It is important that the Provider submits results for each machine / site on a monthly basis as this not

only guarantees the accuracy of the analyser, but also tests the operator to ensure they are carrying out the correct protocol.

For additional information see:

- *NHS Health Check programme standards: a framework for quality improvement*. Public Health England. February, 2014.
- NHS Purchasing and Supply Agency (2009) Buyers' Guide Point-of-care testing for cholesterol measurement

http://www.healthcheck.nhs.uk/Library/pointofcare_testing_for_cholesterol_measurement.pdf

- NHS Improvement (2009) Delivering the NHS Health Check: A Practical Guide to Implementation–A Practical Guide to Point of Care Testing www.improvement.nhs.uk

Referral to Lifestyle Support
The Provider is required to offer lifestyle advice and support as part of a NHS Health Check as referred to in Section 3.2. and to follow agreed referral pathways
Guidance on lifestyle interventions can be found in Chapter 4 of the Best Practice Guidance

Promotion and Marketing
The Provider is required to promote the uptake of NHS Health Checks and to promote NHS Health Check campaigns.
The NHS Health Check http://www.healthcheck.nhs.uk/ provides up-to-date NHS data, syndicated content for websites, toolkits and branded materials to help with promotion and marketing. Materials can be downloaded for print. You will need to register for full access.
There is a factsheet with Top tips to increasing the uptake of NHS Health Checks (August 2016)
http://www.healthcheck.nhs.uk/commissioners_and_providers/guidance/national_guidance1/

The Health Checks information leaflet can also be downloaded or ordered for free through the Department of Health (DoH) Order line
https://www.orderline.dh.gov.uk/ecom_dh/public/home.jsf
The leaflet is available in a range of different languages and accessible formats. They can be ordered directly through the DoH Order line. You will need to register your details to make orders. Maximum limits apply.

The Dementia Health Check leaflet can also be ordered via the DoH Order line website (as above).

3.3 Population covered

ELIGIBLE POPULATION
The Provider is to deliver the Service of NHS Health Checks to all potential Service Users registered with a GP, and living or working in Gateshead between the ages of 40-74 without known CVD.

3.4 Any acceptance and exclusion criteria

As the programme is a public health programme aimed at preventing disease, people with previously diagnosed vascular disease or meeting the criteria below are excluded from the programme. Potential Service Users should already be being managed and monitored through existing care pathways.

Exclusion criteria:

- coronary heart disease
- chronic kidney disease (CKD) which has been classified as stage 3, 4 or 5 within the meaning of the National Institute for Health and Care Excellence (NICE) clinical guideline 182 on Chronic Kidney Disease
- diabetes
- hypertension
- atrial fibrillation
- transient ischaemic attack
- hypercholesterolemia
- heart failure
- peripheral arterial disease
- stroke
- prescribed statins
- people who have previously had a 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 ten years

NOTE: Where someone has a CVD risk of 10-19%, they would not be excluded from recall unless they meet one of the other exclusion criteria, e.g., being prescribed a statin.

- All Service Users must receive a copy of their results from the Provider in a suitable language and format
- The national results cards and booklets can be found here: http://www.healthcheck.nhs.uk/results_cards_and_booklets/
- All Service Users having a NHS Health Check are to receive healthy lifestyle advice on how to maintain/improve their vascular health and reduce their risk of developing CVD.

The Provider must produce and maintain an up-to-date list of all Service Users who they have worked with under this Contract.

The Provider must maintain adequate records of the Service provided, incorporating all known information relating to any significant events.

The Provider must have a system for collecting data on adverse incidents, which should be aligned to the relevant guidance contained in Gateshead Council Serious Incident Reporting Policy. Please refer to Schedule 1 of the Terms and Conditions for serious incident reporting procedure (The Council will provide a copy of the policy upon request and training can be arranged).

ELIGIBLE POPULATION

- Males and females aged 40 to 74 years
- People registered with a GP, and living or working in Gateshead. If not registered with a GP but live in the Gateshead area the Provider should advise Service Users on how to register with a local GP.
- People must not:
  - have had a NHS Health check in the last 5 years
  - be currently prescribed any vascular disease treatment, including the management of hypertension and high cholesterol be diagnosed with diabetes, heart disease, stroke or kidney diseases
- Providers must ensure they require Service Users to give signed consent to entering into the NHS Health Checks programme. Consent is required:
  - to inform the Service User's GP of the test results
  - to allow the Provider or the Council to contact the Service User and the Service User's GP for follow up purposes and to discuss the Service User's experiences and outcomes
  - to provide Service User anonymised data to the Council for the purposes of Contract monitoring, publication and research.

3.5 Interdependencies with other services

GPs

Data collection for all NHS Health Checks is collected via the GP practice system EMIS. This relies on Service User reports being sent to the practice by the provider and uploaded on to the EMIS system by the GP Practice.

Data from the Provider is to be entered into the PharmOutcomes system using the appropriate module in the system.

The Community Incentive programme aims to get community organisations to use their networks to find people, who are eligible to become Service Users, arrange local Health Check sessions and provide support on the day itself. The NHS Health Checks are carried out in community venues using trained Provider Staff. GP Practices will receive the results of NHS Health Checks carried out by the Provider. The Provider must ensure that the results of NHS Health Checks are sent to the Service User's GP Practice within 48hours as detailed in section 3.6.

For individuals eligible for a NHS Health Check but do not wish to have the appointment in the Pharmacy, the Provider should signpost to another NHS Health Check Provider.

3.6 Activity planning assumptions

The Provider must reach 120 NHS Health Checks per year, this equates to a minimum of 10 per month

The Provider is to ensure that it delivers the following when providing the Services:-

- A standardised approach to delivering NHS Health Checks.
- The Provider will be responsible for ensuring that all Staff who undertake NHS Health Checks are fully trained and able to demonstrate and maintain the

required competencies. For guidance on competencies the Provider is referred to the NHS Health Check Competency Framework (March 2015) The Providers will also ensure that staff maintain competencies and record evidence of competencies.

- All Staff involved in delivering NHS Health Checks must have read and understood the Contract Specification for NHS Health Checks and National Best Practice Guidance http://www.healthcheck.nhs.uk/national_guidance/
- To ensure that the health check takes place in a consistent, accurate and safe manner.
- Transfer of data to General Practice
  The Provider must transfer Service User identifiable data to the general practice in a secure and safe way in line with Council policy in order that responsibility for the Service User remains with the GP. It is expected that the Provider will adhere to information governance in the delivery of such information by gaining consent from the Service User and ensuring Service User data is sent by first class post within 48 hours. This report should be the standard format from PharmOutcomes which includes the NHS Health Check header. The letter contents must include coding information and full assessment results.
- All Service Users identified as being higher risk must receive a follow up from the Provider via telephone after 4 weeks to determine whether or not they have made an appointment to see their GP.
- Any Service User identified as a smoker will be offered referral to the pharmacy stop smoking service by the Provider.
- The Provider must maintain up to date information about where Service Users are to be signposted to.
- The report sent to the GP by the Provider must highlight where the Service User has been signposted.
- All appropriate recordings and interventions must be accurately recorded on the software by the provider and reported to the service users GP.
- The results of each test/measurement must be explained to the Service User by the Provider and appropriate referral and advice given, and shared with the GP where relevant
- The Provider must utilise a professional and Service User centred approach to maximise the likelihood of a positive and motivational experience for the Service User.
- The Service must be provided within the locality of Gateshead within the opening hours of the Provider. The Service must be delivered from facilities and settings which are suitable for the purpose and support the confidentiality and dignity of the Service User.
- The Provider as a pharmacy is eligible to offer NHS Health Checks and be involved in the community outreach work (Community Incentive Scheme) across Gateshead in various community settings. The Public Health lead at the Council (Angela Hannant, Email: angelahannant@gateshead.gov.uk Tel no: 0191 433 3055) must be informed of any planned outreach work.
- NHS Health Checks must be conducted in a venue that offers a private and comfortable environment. Where individual rooms cannot be used then a private space is required such as a portable cubicle or the use of a screened off area. It must allow for the Service User's privacy and dignity to be respected. All community venues used to carry out NHS Health Checks must be appropriate

venues for privacy and safety requirements. Venue checks are carried out for all venues involved in the NHS Health Check Community Incentive Scheme.

- The Provider shall work with the Council to review progress and identify any further training needs.
- Ensure that there are suitable contingency plans in place to cover leave (both anticipated and unanticipated) of any Staff leaving the Provider.
- Notify the Council immediately if the Service is not available due to workforce issues.
- Participate in any Gateshead Council organised audit of service provision or health equity audit on access to and take-up of health checks. Co-operate with any national or Gateshead Council led assessment of Service User experience.
- The Department of Health has set minimum levels for the number of people invited and having a check. These are 20% and 10% respectively of the eligible population. Local results are reported to the national team on a quarterly basis. Results can be accessed via the NHS Health Check website www.healthcheck.nhs.uk and there is a NHS Health Check national interactive data map

4. Applicable Service Standards

4.1 Applicable national standards

Best Practice Guidance
National NHS Health Check Best Practice Guidance (March 2016) http://www.healthcheck.nhs.uk/commissioners_and_providers/guidance/There are links to all NHS Health Check guidance and Resources, and links to guidance on risk factors and management in the National Best Practice Guidance (Annexes D and E)

Revised NHS Health Check information governance data flows (October 2016)
http://www.healthcheck.nhs.uk/latest_news/revised_nhs_health_check_information_governance_data_flows/
Mandated data requirements are covered in Appendix K

National NHS Health Check programme standards - Feb 2014

Information on the national NHS Health Check Competence Framework can be found here:
http://www.healthcheck.nhs.uk/commissioners_and_providers/training/competence_framework_supporting_workbooks/

NHS Health Check Programme Pathway Diagram can be found here: http://www.healthcheck.nhs.uk/commissioners_and_providers/delivery/

NICE Guidelines
Lipid modification - July 2014

NHS Health Check Briefing (LGB15)
https://www.nice.org.uk/advice/lgb15/chapter/Introduction Feb 2014

Type 2 Diabetes: prevention in people at high risk (PH38) https://www.nice.org.uk/guidance/ph38 July 2012

Hypertension in adults (CG127) https://www.nice.org.uk/guidance/cg127August 2011

Cardiovascular disease prevention (PH25) https://www.nice.org.uk/guidance/ph25June 2010

Alcohol-use disorders: Prevention (PH24) https://www.nice.org.uk/guidance/ph24 June 2010

Chronic Kidney Disease (CG182) Jan 2015 https://www.nice.org.uk/guidance/CG182

Obesity (CG189) November 2014 https://www.nice.org.uk/guidance/cg189

Smoking: brief interventions and referrals (PH1)March 2006 https://www.nice.org.uk/guidance/ph1

Other relevant publications:
Living Well for longer: progress 1 year on (March 2015) https://www.gov.uk/government/publications/living-well-for-longer-progress-1-year-on

UPDATED The Handbook for Vascular Risk Assessment, Risk Reduction and Risk Management 2012 http://www.healthcheck.nhs.uk/latest_news/the_handbook_for_vascular_risk_assessment_risk_reduction_and_risk_management/# This updated version of the handbook should be used in conjunction with the original Handbook for Vascular Risk Assessment, Risk Reduction and Risk Management, 2008 (PDF 6.4MB)

NICE Guidance for Prevention of Type 2 Diabetes - July 2012
Cardiovascular Disease Outcomes Strategy (2013) https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/217118/9387-2900853-CVD-Outcomes_web1.pdf

Putting prevention first- vascular checks: risk assessment and management - next steps guidance for primary care trusts - November 2008

5. Location of Provider Premises

See Contract Particulars

SCHEDULE 1

CONDITIONS PRECEDENT

1. **General Pharmaceutical Council**
Provide the Council the General Pharmaceutical Council Registration Number for the pharmacy premises along with details of a Pharmacy Superintendent and their GPhC Number.

2. Insurance

Provide the Council with a copy of the insurance policies to illustrate that the Required Insurances are in place;

3. Training & Qualifications

All providers delivering NHS Health Checks must:

- Identify the Pharmacist/Pharmacy Manager as the person who has overall responsibility for ensuring that the service is delivered in accordance with this specification.
- Be able to demonstrate that the pharmacy staff who wish to participate in the delivery of this service achieve and maintain appropriate clinical competence and that they have undertaken suitable education and training. The competency framework and learner and assessor workbooks can be used to record evidence and can be accessed here http://www.healthcheck.nhs.uk/commissioners_and_providers/training/competence_framework_supporting_workbooks/
- Be familiar with the NHS Health Check Best Practice Guidance (March 2016) http://www.healthcheck.nhs.uk/commissioners_and_providers/guidance/
- Undertake the mandatory training prior to delivering NHS Health Checks, and undertake an annual update. It is the provider's responsibility to arrange POCT training with their equipment/consumables provider.
- All staff delivering NHS Health Checks must have received training to do so. Please contact Angela Hannant (angelahannant@gateshead.gov.uk) for further information

The national NHS Health Check team has developed several videos to help train people who carry out NHS Health Checks http://www.healthcheck.nhs.uk/commissioners_and_providers/training/training_videos1/

On the NHS Health Check Website there are also some e-learning packages http://www.healthcheck.nhs.uk/commissioners_and_providers/training/elearning_resources1/

Providers should access the Web based NHS Health Check dementia training tool (dementia awareness training). It is aimed at those individuals providing the NHS Health Check and includes a self-assessment section which will then provide a certificate of completion. The NHS Health Check dementia leaflet has been developed to support the dementia information and should be given

to those aged 65-74 years of age during their appointment. These leaflets are available to order free of charge in a variety of formats and languages through the Department of Health order line

4. Reporting

All NHS Health Checks must be recorded onto the PharmOutcomes system using the appropriate module in the system. The Provider will report health check activity data on PharmOutcomes according to the Council's requirements on a monthly basis.

The Provider must transfer Service User identifiable data to the general practice in a secure and safe way in line with Council policy in order that responsibility for the Service User remains with the GP. It is expected that the Provider will adhere to information governance in the delivery of such information by gaining consent from the Service User and ensuring Service User data is sent by first class post within 48 hours. This report should be the standard format from PharmOutcomes which includes the NHS Health Check header. The letter contents must include coding information and full assessment results.

5. Immunisation and equipment

All Staff involved in blood testing will be immunised against the hepatitis B virus.

The Provider will ensure that Staff are given appropriate equipment and appropriate safety clothing.

Hand washing facilities with running hot water in the consultation room or close by. In the absence of a sink then antibacterial hand wipes must be provided and used in line with Council policy.

6. **Patient Group Directive**

Not applicable

SCHEDULE 2
PERFORMANCE INDICATORS

Performance Indicators	Threshold	Method of Measurement	Consequence of breach
The NHS Health Checks Community Pharmacy Programme will be monitored monthly. An indicative target has been set by the Council of a minimum of 120 NHS Health Checks per annum (30 quarterly) by the Provider.	10 per month	Information supplied	Appropriate action under Clause 24 (Default and Suspension)
The Provider will report activity data on PharmOutcomes according to the Council's requirements.	Data reported monthly	Reported to the Council monthly – the Council has access to PharmOutcomes	Appropriate action under Clause 24 (Default and Suspension)
The Provider must ensure transfer of data to General Practice	Every NHS Health Check	Information supplied	Appropriate action under Clause 24 (Default and Suspension)

SCHEDULE 3

PRICING

In consideration of the Provider delivering the Service the Council will pay the Provider the following Price

Element to be Delivered	**Amount**	**Conditions**
NHS Health Check	£40 per NHS Health Check completed	Application of the eligibility criteria A completed NHS Health Check comprises invitation/s, full Health Check assessment, communication of risk, lifestyle advice/referral and risk management Evidence of monthly QA check completed NHS Health Checks must be recorded on PharmOutcomes

The Provider shall submit to the Council on a monthly basis via the PharmOutcomes system. The Council shall pay the Provider the Price following verification of the claim form, within 30 days of submission of the claim form.

The Price shall remain as set out in this Schedule during the financial year 2017/2018.

In the event that the Contract is extended in accordance with Clause 2.4 of the Terms and Conditions the Price shall continue at the same rate, unless a variation is agreed with Council.