SERVICE SPECIFICATIONS

Service	**Devon and Torbay NHS Health Checks Programme**
Authority Lead	**Patsy Temple**
Period	**April 2017-March 2018 (with the option to extend by 2 separate 12 month periods)**
Date of Review	**March 2018**

1. Population Needs

1.1 National/local context and evidence base

Reducing avoidable premature mortality is a government priority. From 2009/10, the NHS was asked to implement a uniform and universal vascular risk assessment and management programme called 'vascular checks' for people in England aged between 40 and 74. Vascular diseases include heart disease, stroke, diabetes and kidney disease and are the biggest cause of death in the UK. From April 2013 Local Authorities are mandated to offer health checks to their eligible population.

A recent review of the evidence has shown that the programme is targeting people from across the range of socioeconomic backgrounds and risk profiles. PHE says the scheme, underpinned by NICE guidance, provides 'a significant opportunity' to directly engage people in a conversation about what they can do to keep themselves healthy and well.

Collectively, vascular disease - heart disease, stroke, diabetes and kidney disease affect the lives of more than four million people and kill 170,000 every year. They also account for more than half the mortality gap between rich and poor. Modelling work undertaken by the Department of Health has found that offering NHS Health Checks to all people between 40 and 74, and recalling them every five years would be clinically and cost effective.

The programme has the potential to reduce the prevalence of heart disease, kidney disease, stroke and diabetes. The cost per QALY (quality adjusted life year) is £3000. This represents significantly greater cost effectiveness than the QALY threshold of £20-30,000 used by NICE and the Peninsula Health Technology Commissioning Group. Using the DH Ready Reckoner the health checks programme for Devon becomes cost saving at year 14 this tool includes the cost of resources to complete the health check. However, these DH calculated figures are for universal screening a more targeted approach may result in earlier savings and could be used to assist in reducing health inequalities. Health checks are a universal service within which there can be a targeted element.

Each year 20% of the eligible population in Devon and Torbay should be offered an NHS health check and at least 50% of those offered a check should receive one. The percentage uptake will increase each year and must take account of its impact on health inequalities by ensuring certain groups and individuals are not excluded. Thus each individual within the cohort, unless excluded (see below) should be offered a health check, **once every 5 years.**

This service should be aware of, and work in conjunction with, the NHS Health Check Outreach Programme, which will be working with the practices who are not commissioned to provide the standard NHS Health Check Programme and targeting at risk groups who may be less willing to engage in the standard NHS Health Check Programme.

The NHS Health Check should be compliant with the Best Practice Guidance published in February 2017.
A completed vascular risk assessment as part of an NHS Health Check includes:

- A risk assessment
- Communication of risk given to the individual
- Individual lifestyle advice given to the person and
- Referral, as appropriate, to a lifestyle intervention or for further medical investigation

The population should be adjusted to exclude people who have been diagnosed with conditions such as: Coronary heart disease, stroke, diabetes, chronic kidney disease (stages 3 to 5), hypertension, Atrial Fibrillation, Transient Ischaemic Attack (TIA), Familial Hypercholesterolemia, Heart failure, and Peripheral Arterial Disease (PAD) a link to the exclusion codes is available in 3.4.

The Public Health Outcomes framework for 2013-2016 sets out a framework for measuring public health outcomes and includes an outcome for the percentage of eligible people who receive an NHS Health Check. The requirements of the health check do not change but will be commissioned by the local authority for its residents. An increased uptake is deemed important to identify early signs of poor health leading to opportunities for primary prevention and early interventions. The programme can and should reduce health inequalities.

Both the Devon Joint Health and Wellbeing Strategy 2013-2016 and The Torbay Joint Health and Wellbeing Strategy 2015-2020 have a number of lifestyle related priorities including reducing hypertension, reducing the risks of cardio vascular disease and cancer the programme should promote behaviour change in the population.

2. Key Service Outcomes

2.1 Service Outcomes

The health check programme is designed reduce the risk of vascular disease in the eligible population. The programme will identify some people with previously unidentified established disease and it is important that these people get the maximum benefit that early diagnosis and treatment will bring. For others at risk of developing vascular disease primary prevention and early intervention and lifestyle changes will prevent future ill health. For others the programme will increase awareness of the risk and reinforce the lifestyle messages to prevent vascular disease and other lifestyle related ill- health which include:

- Stop smoking if you smoke
- Eat a healthy diet
- Keep your weight and waist in check
- Take regular physical activity
- Cut back if you drink a lot of alcohol

The service will deliver the public health outcome which relates to the take up of the NHS health check programme - by those eligible.

The service will contribute towards delivery of a number of other health improvement outcomes including:

- Reduction in smoking prevalence (adults over 18)
- Reduction of proportion of adults who are overweight or obese
- Increase in the number of adults achieving at least 150 minutes of physical activity a

week
- Improved mental health and wellbeing
- Identification and recording diabetes
- Reduction in alcohol related hospital admissions
- Increased dementia awareness and improved diagnosis

The service will contribute towards reducing premature mortality by reducing mortality from all cardiovascular diseases (including heart disease and stroke)

In the first year the provider will work towards a minimum uptake of 50% of those offered a health check receiving a health check and this target will increase year on year working towards an expected 75% overtime.

The provider will evaluate the impact of its health checks on health inequalities for its practice population when inviting and following up invitations to eligible patients.
Devon County Council and Torbay Council will evaluate the programme in their areas and feed back to practices to ensure the programme reaches populations and communities that experience health inequalities.

Service Quality and Clinical Governance
Practices taking part in the programme must meet all national standards of service quality and clinical governance including those set out in Standards for Better Health.
http://www.healthcheck.nhs.uk/commissioners_and_providers/guidance/national_guidance1/

These core and developmental standards of provision are designed to cover the full spectrum of health care as defined in the Health and Social Care (Community Health and Standards) Act 2003. The seven domains are safety, clinical and cost effectiveness, governance, patient focus, accessible and responsive care, the care environment and public health. Compliance with relevant NICE guidance is required.

3. Scope

3.1 Aims and objectives of service

To provide a Health Check (vascular risk assessment) and management for people in Devon and Torbay in the target group (people aged 40 to 74 years of age who have not had a previous diagnosis of vascular disease) in order to improve the person's awareness of their vascular risk (heart disease, stroke, diabetes and kidney disease) and how to minimise or manage that risk. The eligible population will be offered a health check every 5 years.

3.2 Service description/pathway

Individuals who attend a health check following invitation will receive a risk assessment in accordance with this specification and the risk assessment will comply with the DH national requirements, in order that NHS Health Checks are delivered in a uniform, systematic and integrated manner.

The results of the risk assessment will be communicated to the person and will be added to the person's GP clinical record.

The person will be offered brief healthy lifestyle advice and support to assist them with managing and / or reducing their risk.

People who are found to be at moderate or high risk will be offered appropriate interventions and referral, where required, in line with national and local guidance.

Where pre-existing disease is suspected or identified the person will be referred to their GP.

Whoever carries out the vascular risk assessment, the expectation is that it is carried out face-to face, in a setting or an area which allows a private conversation.

Consenting people will have the following parameters measured and / or recorded:

- Age
- Gender
- Smoking status
- Level of physical activity
- Family history of vascular disease
- Ethnicity;
- Body Mass Index; with waist measurement
- Random blood cholesterol measurement (Total and HDL cholesterol)
- Blood pressure.
- Pulse check
- Alcohol use
- Dementia awareness – for those aged 65-74

A diabetes filter, based on BMI and blood pressure measurement, will be used to determine whether the person should undergo a blood glucose HbA1c measurement.

Detailed information about how to assess and manage vascular risk can be found in **"Putting Prevention First" NHS Health Check: Vascular Risk Assessment and Management Best Practice Guidance"**

www.healthcheck.nhs.uk/document.php?o=227

The vascular risk assessment will consist of:

1. An interview to obtain any missing demographics, and perform any missing measurements and any blood tests indicated.
2. A lifestyle assessment to identify those in need of brief physical activity intervention, smoking cessation advice, brief intervention for alcohol and support with healthy eating/weight reduction
3. A risk calculation will be undertaken (using QRISK® 2) to estimate their 10 year risk of cardiovascular disease and the individual's risk whether high, moderate or low will be clearly explained to them with advice as to how to make any necessary lifestyle changes, and an assessment of the individual's motivation to change.
4. Where necessary onward referral within the practice for further screening tests or disease management will be arranged

This health check should focus on the individual's needs and preferences and maximise the support provided to that individual to help them manage their risk and stay well for longer – the ultimate aim of the NHS Health Check programme. A practice may prefer to deliver all of the elements in one check or may arrange blood tests initially followed by face to face assessment.

HC 1 (at the end of the document) provides a diagrammatic overview of the vascular risk assessment and management programme to which the alcohol and dementia awareness elements are added.

Invitation letter
An invitation letter template has been developed and tested, and is available to download from the DH publications order line (www.orderline.dh.gov.uk). You can amend this letter to suit your needs,

Patients should be invited once every 5 years, together with the national invitation leaflet. Invitations should be repeated up to three times invites either by letter, text or telephone call within one month of previous invitation. Record each invitation and DNA.

Stratification could be achieved in many ways; or could be effectively first come first served basis.

(For example eligible practice population could be invited to attend for a health check in the financial quarter of their 40th, 45th, 50th, 55th, 60th, 65th, 70th birthday).

Where appropriate, it is also recommended that practices work with others to encourage attendance. For example, carer support workers, local healthy lifestyle service providers and the NHS Health Checks Devon Outreach Programme who work with the traveller and black and minority ethnic groups (BME) and most deprived communities.

The practice must enter health check details from other providers to remove from eligible population lists those that have had a health check which meets the requirements of this specification.

Information leaflet for people invited for a check
People who are invited for a check should be informed about what the check entails. The NHS Health Check information leaflet is available free of charge to Local Authorities and NHS from DH publications order line (www.orderline.dh.gov.uk). Translated versions of the leaflet will be available to download. When a person attends for their check, the person carrying it out is responsible for ensuring that they are informed about the process. Further information will be available on the health and wellbeing pages of our website with resources for professionals. www.devonhealthandwellbeing.org

It is important to establish that the person has received, read and understood the patient information leaflet, and for them to be offered an opportunity to ask any questions. All staff carrying out any part of the check needs to be able to answer accurately any queries the person may pose, and we have provided a frequently asked questions section on the NHS Choices website (www.nhs.uk/nhshealthcheck) to support them in this task.

At the assessment

Consenting people will have the following parameters measured and recorded:

- **Age**
- **Gender**
- **Postcode**
- **Smoking status** (QRISK® 2 requires data on smoking status as follows: Current smoker or non-smoker (including ex-smoker)

- **Level of physical activity;**
  Recommended use of a validated screening tool such as GPPAQ to assess whether an individual is inactive; moderately inactive; moderately active; active

- **Family history of vascular disease;**
  Family history of coronary heart disease in first-degree relative under 60 years

- **Ethnicity;**
  Self-assigned ethnicity is recorded in QRISK® 2 (white/not recorded, Indian, Pakistani, Bangladeshi, Other Asian, black African, black Caribbean, Chinese, other including mixed)

- **Body Mass Index; with waist measurement**
  BMI provides one approach to identifying those at high risk of developing diabetes or who have existing undiagnosed diabetes, and is required for the assessment of diabetes risk. Where the individual's BMI is in the obese range as follows, a blood glucose test is required:
  - BMI is 27.5 or over in individuals from the Indian, Pakistani, Bangladeshi, Other Asian and Chinese ethnicity categories
  - BMI is 30 or over in other ethnicity categories

- **Random blood cholesterol measurement (Total and HDL cholesterol);**
  For the purposes of initial assessment of CV risk non-fasting cholesterol and HDL ratio is adequate. If you tick lipid profile high risk on the pathology form then HDL/LDL/triglycerides will automatically be performed. Fasting makes little difference to HDL and therefore risk calculation. It is most important in estimating raised total cholesterol levels. Before treatment with statins is considered a referral to the OneSmallStep service in Devon, or the Lifestyles Service in Torbay, for lifestyle support should be offered.
  If point of care testing (POCT) is undertaken follow the protocol at HC 3
  Practices can opt to use POCT testing or take venous samples.

- **Pulse check and Blood pressure**
  Both Systolic (SBP) and Diastolic Blood Pressure (DBP) are required for the diabetes filter, and for assessment for chronic kidney disease and hypertension.
  If the individual has a blood pressure at, or above, 140/90mmHg, or where the SBP or DBP exceeds 140mmHg or 90mmHg respectively, the individual requires:
  - an assessment for hypertension (refer on within the practice)
  - a fasting plasma glucose (FPG) test
  - an assessment for chronic kidney disease (blood test for eGFR)

Key points: To identify hypertension (persistent raised blood pressure, above 140/90mmHg), ask the patient to return for at least two more appointments; check blood pressure twice on each occasion, under the best conditions available.

Related stages of the check: Pulse rhythm for 60 seconds should be taken prior to a blood pressure check. Individuals who are found to have an irregular pulse rhythm should be referred to the GP for further investigation of atrial fibrillation. Individuals diagnosed with hypertension should be added to the hypertension register and treated through existing care pathways. They will then exit the health checks programme.

Qrisk score calculator available at http://qrisk2.org/ (HC 2 provides supporting documentation)

There is additional data which may not be required for the cardiovascular, diabetes and chronic kidney disease risk assessments, but is required for the QRISK® 2 risk engine. This data may also be required to support decisions on appropriate lifestyle interventions.

For QRISK® 2 the following additional data is required:

- Diagnosis/history of treated hypertension and at least one current prescription of at least one antihypertensive agent)
- history of rheumatoid arthritis
- history of chronic renal disease
- history of atrial fibrillation

- **Alcohol use**

Practitioners carrying out the NHS Health Check will use the validated *WHO developed Alcohol Use Disorder Identification Test (AUDIT)* - AUDIT-C and AUDIT screening tools. HC 2 provides supporting documentation and shows the audit tool.
http://www.alcohollearningcentre.org.uk/Topics/Browse/BriefAdvice/?parent=4444&child=4896

- **Dementia awareness**

Under the PM Challenge on Dementia, people aged 65 to 74 will be given information at the time of the risk assessment to raise their awareness of dementia and the availability of memory services as part of the NHS Health Check programme.

The NHS Dementia Health Checks Awareness Leaflet can be found at http://www.healthcheck.nhs.uk/national_resources/dementia_resources/ Along with a dementia training tool.

Point of Care Testing equipment– Providers will be expected to adhere to Medicines and Healthcare Regulatory products Agency (MHRA) advice and guidance on selection of appropriate equipment, training in its use and ongoing management, troubleshooting, and quality assurance processes that ensure the accuracy and reproducibility of test results.

Ref: MDA DB 2002(03): The management and Use of IVD Point of Care Testing Devices. Medical Devices Agency UK 2002 (www.mhra.gov.uk/Publications/Safetyguidance/DeviceBulletins/CON007333

HC 3 provides a protocol for use of POCT.

Testing for diabetes

Not every patient will need testing for diabetes

Diabetic filter

Perform a non-fasting HbA1c if:

- **BMI** is in the obese range (**30** or over, or **27.5** or over in individuals from the Indian, Pakistani, Bangladeshi, Other Asian and Chinese ethnicity categories)

or

- **Blood pressure** is at or above **140/90mmHg**, or where the SBP or DBP exceeds 140mmHg or 90mmHg respectively.

It is important to consider the situation of the individual person, as some people who do not fall into the categories above 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)

See also NICE guidance preventing type 2 diabetes: risk identification and interventions for individuals at high risk (guidance www.nice.org.uk/PH38) – when undertaking a diabetes assessment, a validated risk assessment tool should be used.

Individuals should be considered as being at high risk of diabetes using the following thresholds for the corresponding validated risk assessment tools:

- QDiabetes score is greater than 5.6
- Cambridge diabetes risk score is greater than 0.2
- Leicester practice risk score is greater than 4.8
- Leicester risk assessment score is greater than or equal to 16

HbA1c is now recognised as a first-line test for diagnosis of type 2 diabetes. Therefore, perform a HBA1c test as the **preferred test unless the following apply**:

- Pregnancy
- Suspected type 1 diabetes
- Short duration of diabetes symptoms (<2 months)
- Acutely ill patients
- Advanced renal disease - CKD stage 4/5 (or lesser degrees but with renal anaemia)
- Significant anaemia (eg. iron deficiency or haemolytic)
- Presence or high suspicion of a haemoglobinopathy
- Acute pancreatic damage or post-pancreatic surgery
- HIV infection
- Patients recently commenced on steroids or antipsychotic drugs

In the above cases, a fasting glucose test should be performed

Acting on results.

When using HbA1c for the diagnosis of type 2 diabetes, the following should be followed:

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Testing for kidney disease;
Thresholds:
≥**140/90mmHg.** If the individual has a blood pressure at or above 140/90mmHg, or where the SBP or DBP exceeds 140mmHg or 90mmHg respectively, the individual requires an assessment for chronic kidney disease by a GP who will follow up abnormal results following creatinine testing. The results of the serum creatinine test should be used to

calculate the estimated glomerular filtration rate (eGFR) in order to assess the level of kidney function, and recorded on the individual's patient record.

60ml/min/1.73m^2 Where eGFR is **above or equal to 60ml/ min/1.73m^2**, no further assessment is required, unless the individual is diagnosed with hypertension or diabetes mellitus. In this case, their risk of kidney disease will be monitored as part of the management of their hypertension and/or diabetes.

<60ml/min/1.73m^2 Where eGFR is **below 60ml/min/1.73m^2** , management and assessment for chronic kidney disease is required in line with NICE clinical guideline 73 on chronic kidney disease. This will include an assessment of the urine albumin: creatinine ratio (ACR) to identify and detect proteinuria. Further management will depend on the ACR results.

Communicating risk
Everyone who undergoes a check should have their results and their NHS Health Check assessment of vascular risk conveyed to them.

Everyone will be at some level of risk and this need to be clearly explained. The communication of risk and what it means for the individual is of paramount importance to the programme meeting its objective of helping people stay well for longer. Levels of risk need to be discussed alongside what each individual can do to manage their risk, such as taking regular physical activity, eating a healthy diet, reducing their calorie and alcohol intake as a way of managing their weight, and stopping smoking.

The following information relating to the person undergoing the health check shall be communicated to that person as soon as reasonably practicable after the test has taken place—
(a) body mass index;
(b) cholesterol level;
(c) blood pressure;
(d) cardiovascular risk score;
(e) AUDIT score

Branded leaflets will be available on the practitioner health and wellbeing pages (www.devonhealthandwellbeing.org) with information about local services and support and a health check results leaflet will be developed and provided by Devon County Council to support delivery of the programme. The NHS Health check website provides free resources and copies of all leaflets. (http://www.healthcheck.nhs.uk/commissioners_and_healthcare_professionals/)

Lifestyle intervention
The Department of Health stipulates that as part of the check individuals should be sign posted to appropriate services to enable them to make life-style changes. The current services for both Devon and Torbay are included HC 4. It should be noted that these will be subject to change and NHS Health Checks providers will be kept notified of any changes.

Torbay's Healthy Lifestyles team offer a wide range of lifestyle intervention courses and advice sessions to the public of Torbay. Healthy Lifestyles Team can be contacted on 0300 456 1006 or http://www.torbayandsouthdevon.nhs.uk/services/healthy-lifestyles/

In Devon the OneSmallStep service is contactable on 0800 298 2654 or https://www.onesmallstep.org.uk

Smoking
Anyone who is a smoker and wants to quit should be offered the support of a local NHS Stop Smoking Service.
In Devon the OneSmallStep service is contactable on 0800 298 2654 or https://www.onesmallstep.org.uk

In Torbay the Healthy Lifestyles Team can be contacted on 0300 456 1006 or http://www.torbayandsouthdevon.nhs.uk/services/healthy-lifestyles

Alcohol
For those patients who are AUDIT positive, the AUDIT score will help the NHS Health Check practitioner decide what to do next. The AUDIT score should then be fed back to the patient and to the GP.
For those patients whose drinking (AUDIT score) is placing them at increasing or higher risk of future health damage, NICE guidance recommends that NHS Health Check practitioners provide them with brief advice about how alcohol can contribute to health problems and encourage the patient to reduce their alcohol consumption. This advice should be supported by giving the patient an appropriate leaflet to reinforce the messages delivered.

For those patients whose AUDIT score is high and indicates that they may possibly be dependent on alcohol, the NHS Health Check practitioner or the GP should consider and discuss with the patient a referral to local specialist services for appropriate assessment and treatment.

About 22% of adults are drinking above lower-risk guidelines. Most people attending a NHS Health Check will be assessed as low risk for alcohol consumption and can simply be congratulated on their lower-risk use of alcohol and be encouraged to maintain this lifestyle.

For patients with an AUDIT score between 8-19 the provision of information and brief advice focusing on how alcohol can contribute to health problems and discussing practical ways of reducing alcohol consumption. These discussions should be reinforced by providing written information and with an offer of contact information for the OneSmallStep offer contactable on 0800 298 2654 or https://www.onesmallstep.org.uk

In Torbay the Healthy Lifestyles Team can be contacted on 0300 456 1006 or http://www.torbayandsouthdevon.nhs.uk/services/healthy-lifestyles

For patients with an AUDIT score above 20 indicating possible dependency or a score of 16-20 with complex needs such as mental health then consider referral to a specialist service. Currently in Devon this is RISE Recovery and Integration Service and in Torbay it is Walnut Lodge of the Torbay Drug and Alcohol Service.

Physical Activity
The Chief Medical Officer recommends that for general health benefits adults should take a total of 30 minutes a day of at least moderately intense physical activity on five or more days a week (or 150 minutes per week). The recommended levels of activity can be achieved either by doing all the daily activity in one session, or through several shorter bouts of activity of 10 minutes or more. The activity can be lifestyle activity or structured physical activity or sport, or a combination of these. OneSmallStep provides assistance across Devon to facilitate increased physical activity levels contactable on 0800 298 2654 or https://www.onesmallstep.org.uk/

In Torbay the Healthy Lifestyles Team can be contacted on 0300 456 1006 or

http://www.torbayandsouthdevon.nhs.uk/services/healthy-lifestyles

Key points:
If, through DH's validated tool GPPAQ, the individual is identified as less than active, practitioners should offer a brief intervention in physical activity as follows. The 2006 NICE physical activity public health intervention guidance recommends that primary care practitioners should take the opportunity, whenever possible, to identify inactive adults and advise them to aim for 30 minutes of moderate activity on five days of the week (or more), and to offer adults who are less than active a Brief Intervention in Physical Activity.

Four commonly used methods to increase physical activity: brief interventions in primary care, exercise referral schemes, pedometers and community-based exercise programmes for walking and cycling. NICE Public Health Intervention Guidance PHI002. March 2006. www.nice.org.uk/PHI002
General Practice Physical Activity Questionnaire: www.dh.gov.uk/en/ Publications and statistics/Publications/ Publications Policy And Guidance.

Weight management

In Devon, the commissioned offer is provided by the OneSmallStep holistic lifestyle service. There are no funded Tier 2 weight management services in Devon.

Torbay Council commission Healthy Weight Services which aim to support clients who want support to manage their weight and are 16 years and over, ready to change and either self-referred or referred by a health professional. Clients will be supported with an assessment of readiness to change, followed by a brief intervention of varying length (depending on the needs of the client), the agreement of an action plan and the provision of support material and follow-up.

Following the risk assessment

- Patients will be classified into 3 risk categories which will be recorded on their record including the NHS Health Check Register
  Low Risk ≤ 10%
  Moderate risk 10-20%
- High Risk ≥20%
  Record the outcomes from any further interventions in the patient record
- Provide reports on activity and outcomes to Torbay Council
- Administer the recall process

Recall
Patients with a risk score ≥ 20% will exit the programme and be managed accordingly under the GMS contract.
Patients with a risk score < 20% will remain in the programme and be recalled every 5 years.

Activity Reporting

Activity data was previously reported through the quarterly returns and included health checks offered and received. The details of the health check as per the complete latest NHS Health Check data set must be recorded on the practice system using the relevant supplied clinical codes (see the 'HC5 Read codes for recording of NHS health check activity' section below for a full list of read codes). Data extraction will either be undertaken through a direct extract from the primary care data warehouse, or through a supplied MIQUEST query run in

the practice on a quarterly basis and sent by secure email to Public Health for contract monitoring and programme evaluation purposes. Further guidance on the NHS Health Check Secondary Use Data Set, including exclusion codes is available here:
http://content.digital.nhs.uk/nhshealthcheck

3.3 Population covered

All eligible people registered with a GP practice within Devon and Torbay who are aged between 40-74 years.

3.4 Any acceptance and exclusion criteria

People who are on a CVD related disease register or have been diagnosed with coronary heart disease, chronic kidney disease (CKD stages 3-5), diabetes or who have had a stroke are excluded from the programme as they will already be managed using existing care pathways.

In addition, people who have been diagnosed with the following are also **excluded**:

- Hypertension
- Atrial Fibrillation
- Transient Ischaemic attack (TIA)
- Hypercholesterolaemia
- Heart failure
- Peripheral Arterial Disease (PAD)
- Those prescribed statins
- Those identified as high risk (≥ 20%) - those identified as high risk are managed accordingly under QOF under are no longer part of the health checks programme.

People who have been diagnosed as obese are **not** excluded from the NHS Health Check, and should be called routinely every five years like all other people as they are likely to benefit from the NHS Health Check. People with blood clotting diseases such as haemophilia and Hughes syndrome are not excluded from the programme. Again, they do not have existing vascular disease and will benefit from the advice and support provided through the NHS Health Check.

People who have CKD stages 1 and 2 **are included** in the programme because they will not be routinely managed and monitored for other vascular conditions such as diabetes and hypertension.

A full list of exclusion codes are available at:
http://www.ic.nhs.uk/services/datasets/document-downloads/nhs-health-check

Practices must create and maintain a register of patients eligible for an NHS Health Check. Patients with a diagnosis of cardiovascular disease must be entered onto the disease register and follow the relevant care pathway. People who have had a health check which meets the requirements of the specification in the past five years are excluded.

3.5 Interdependencies with other services

The service will be integrated with other providers as part of the patients care pathway. The service will work with:

- Clinical Commissioning Groups
- Other GP practices

- Outreach Programme
- Community Groups
- Secondary care services
- Pathology services
- Pharmacies
- Lifestyle Services
- Alcohol treatment services
- Diabetes Intervention Programme (once its available)
- Dementia services
- Devon County Council
- Torbay Council
- Equipment providers
- Carers health and wellbeing check providers
- Any other interested parties.

NEW Devon and South Devon and Torbay CCG provide carers health and wellbeing checks and new carers identified through the health check programme should be informed of the wider carers health and wellbeing checks.

3.6 Any activity planning assumptions

Devon has an eligible population of 237,435 for 2017-22 and on this basis 47,487 individuals should be invited for a health check per annum across Devon. However Torbay only has a budget to be able to deliver approximately 1000 NHS Healthchecks per annum. These checks have been disaggregated to an individual practice level and are detailed in the table below.

	A	B	C	D	
	Total estimated eligible population	**Annual estimated eligible population**	**Annual target uptake number**	**Annual Cap**	**Annual maximum earnings £**
	*	**	***	****	
Croft Hall Medical Practice	2347	469	310	62	£1,486
Southover Medical Practice	1596	319	211	42	£1,011
The Old Farm Surgery	1218	244	161	32	£773
Parkhill Medical Practice	2791	558	368	74	£1,768
Chilcote/Dewerstone Surgery	3128	626	413	83	£1,983
Corner Place Surgery (Incl. Withycombe from 01/06/17)	4250	850	561	112	£2,692
Withycombe Lodge Surgery (until 31/05/17)	116	23	15	3	£73
Brunel Medical Practice	4651	930	614	123	£2,946
Chelston Hall Surgery (incl. Barton, Shiphay Manor and Abbey Road)	6287	1258	830	166	£3,985
The Mayfield & Cherrybrook Medical Centre	3159	632	417	83	£2,002
St Lukes Medical Centre	2133	427	282	56	£1,353
Pembroke House (Incl. Paignton Medical Partnership)	5605	1121	740	148	£3,551
Compass House Medical Centres	3752	750	495	99	£2,376
	41033	**8207**	**5417**	**1083**	**£26,000**

- Devon's Public Health budget allocation means that we are able to deliver 11,417 NHS Healthchecks across Devon 2017/18, meaning that we may have to cap individual Practice

activity. A forecast activity level for the practice is shown in the attached payment schedule which assumes that 50% of those invited to receive a health check will attend. **£24 is payable for each completed Healthcheck** (ie patient seen and data completed and provided to Devon County Council and Torbay Council.

Payment will be made in accordance with Appendix B of the contract, whereby one twelfth of the overall expected annual value will be paid each month, and the overall value reconciled no less than twice a year.

As the health check programme is a five year programme it is assumed that 20% of the eligible population will be invited each year and for payment purposes it has been assumed that 50% will attend. The objective in Devon is to increase uptake to 66%.

4. Applicable Service Standards

4.1 Applicable national standards e.g. NICE

'NHS Health Check Programme: Best Practice Guidance; Programme standards for self-assessment framework; Competence Framework and Programme Standards: http://www.healthcheck.nhs.uk/commissioners_and_providers/guidance/national_guidance1/

'Putting Prevention First' NHS Health Check: Vascular Risk Assessment and Management. Best Practice available at

www.healthcheck.nhs.uk/document.php?o=227

MHRA: Management and use of IVD point of care test devices Dec 2013 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/371800/In_vitro_diagnostic_point-of-care_test_devices.pdf

Four commonly used methods to increase physical activity: brief interventions in primary care, exercise referral schemes, pedometers and community-based exercise programmes for walking and cycling. NICE Public Health Intervention Guidance PHI002. March 2006. www.nice.org.uk/PHI002

See also NICE guidance preventing type 2 diabetes: risk identification and interventions for individuals at high risk (guidance www.nice.org.uk/PH38)

4.2 Applicable local standards

POCT protocol – HC 3

Audit

An audit is required and a programme of practice audits will be developed and undertaken by the Commissioner to provide a sample of the effectiveness of the programme.

- To ensure that services for which a fee is claimed have actually taken place and thereby protect the public against fraud
- To evaluate the effectiveness of the NHS Health Checks programme in picking up CVD related risks and diseases
- To inform future needs for lifestyle service development

Professional competency, education and training

- Healthcare staff delivering the service will be appropriately trained to perform a NHS Health Check including all relevant clinical skills, risk communication and brief intervention.
- Devon County Council and Torbay Council are able to support training prior to implementation and practice staff will be invited to attend and the Councils will provide ongoing support and resources.
- Health care assistants should be supervised by appropriate senior staff including regular observation of their work and Devon County Council and Torbay Council require a named NHS Health Checks Champion in each practice to oversee the NHS Health Checks.
- Involved staff should complete the online e-training tools available at

http://www.healthcheck.nhs.uk/commissioners_and_providers/training/elearning_resources1/

- For those involved in the delivery of alcohol IBA it is recommended that, as a minimum, they undertake a short e-learning course. An accessible online training module is available to support the delivery of alcohol IBA in Primary Care. http://www.alcohollearningcentre.org.uk/eLearning/IBA/
- Practices are expected to comply with the standards published in the NHS booklet 'Putting Prevention First – NHS Health Check: Vascular Risk Assessment and Management, Best Practice Guidance'

www.healthcheck.nhs.uk/document.php?o=227

- The Competencies framework document is available at http://www.healthcheck.nhs.uk/commissioners_and_providers/training/
- All equipment used to perform the physiological measurements must be validated and calibrated according to national guidance.
- A web based dementia tool can be found at

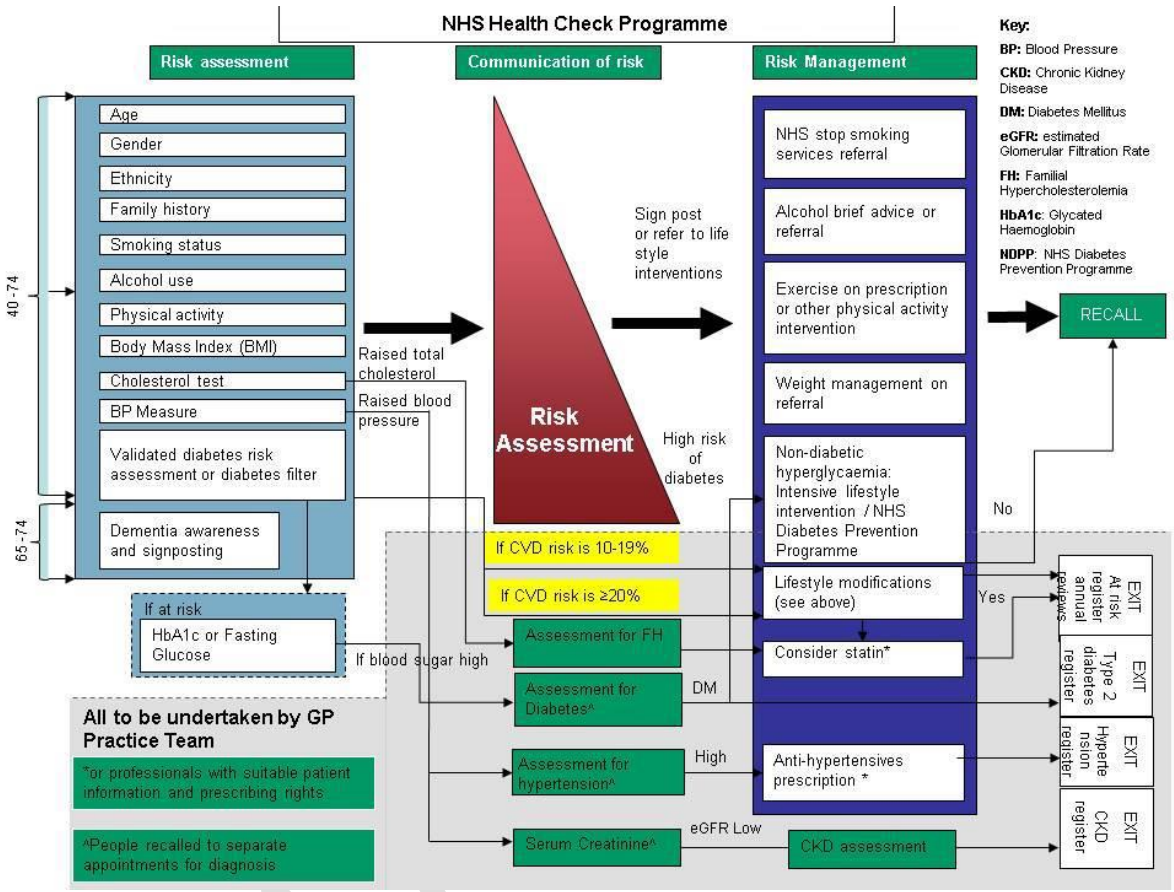
http://www.healthcheck.nhs.uk/commissioners_and_providers/training/dementia_training/

A practitioner page has been set up on the Devon Health and Wellbeing website and on Torbay Public Health pages with downloadable resources and details of training events and links to guidance and best practice. The link for Devon practices is: http://www.devonhealthandwellbeing.org.uk/library/prof/health-checks/

5. Location of Provider Premises

The Provider's Premises are located at: GP Practice premises

Department of Health Vascular Health Checks Programme
(Updated)



\\ds2chx005.ds2.devon.gov.uk\User$\Richard.Merrifield\Documents\NHS Healthchecks\Overview of the vascular risk assessment and management programme.docx

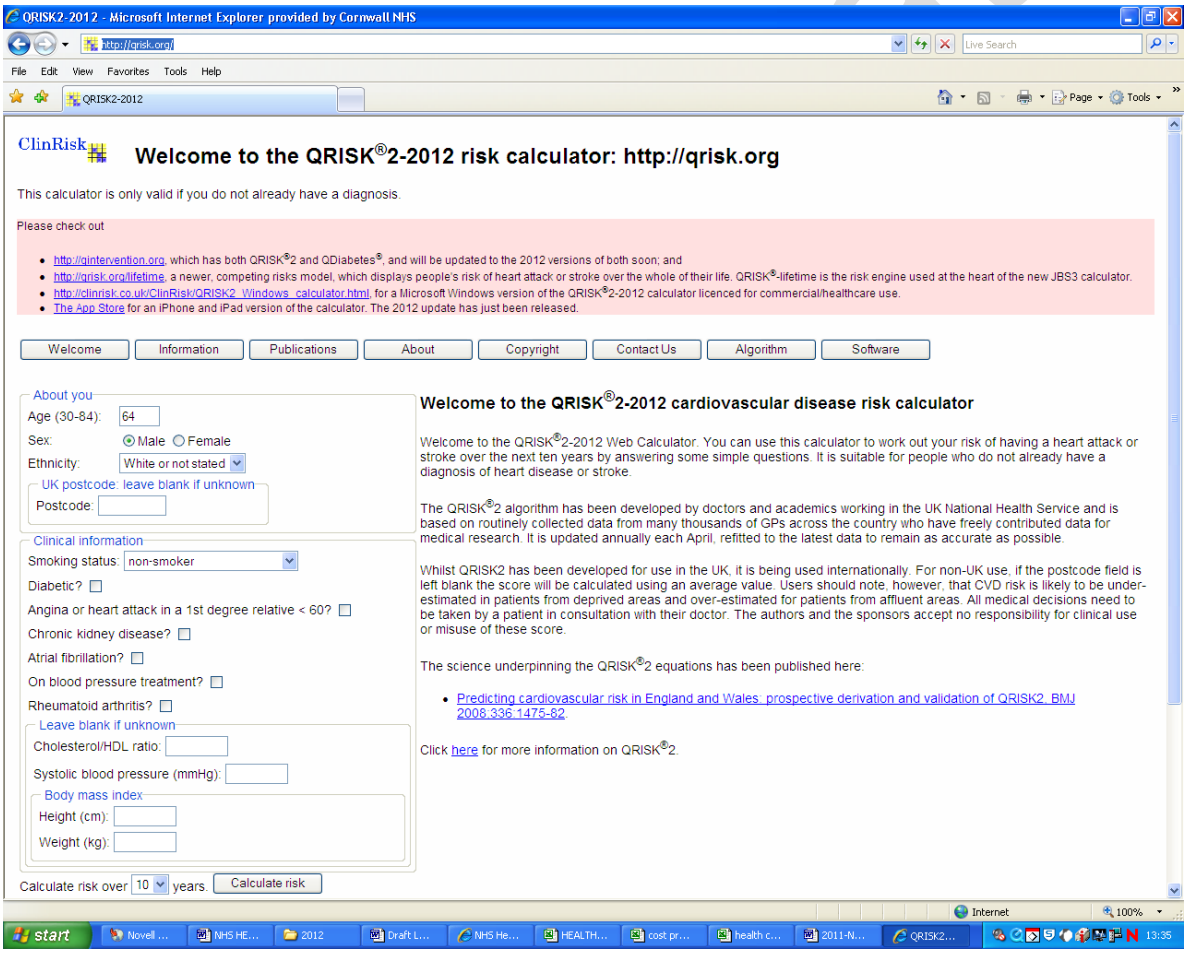
Changes:

1. Raised Cholesterol- Lifestyle interventions before Statins
2. Diabetes risk management- optional use of validated tool or use diabetes filter- Lifestyle modification or once NHS Diabetes Prevention programme is available refer to this.

Supporting Documentation

CVD risk

- Pulse should be checked for rate and rhythm
- The CVD risk in patients is calculated using a web based risk calculator that can be accessed from this http://qrisk2.org/
- On completion of the above tool a risk score will be produced. However, this initial score may need to be further weighted to take into account the effects of abdominal fat (waist circumference measurement) and other risk factors not included in this equation. Example of tool below



Alcohol Audit Tool
AUDIT – C

A revised Alcohol Use Disorders Identification Test Consumption (AUDIT C) which places questions 1, 2 and 3 of the AUDIT first with the remaining 7 AUDIT questions after. (2008, DH)

Questions	Scoring system					Your score
	0	1	2	3	4	
How often do you have a drink containing alcohol?	Never	Monthly or less	2 - 4 times per month	2 - 3 times per week	4+ times per week	
How many units of alcohol do you drink on a typical day when you are drinking?	1 -2	3 - 4	5 - 6	7 - 9	10+	
How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	

Scoring:
A total of 5+ indicates increasing or higher risk drinking.
An overall total score of 5 or above is AUDIT-C positive.

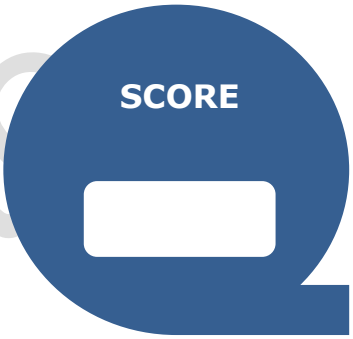
AUDIT

The full Audit, providing 10 alcohol identification questions, is the gold standard of identification tests and was developed by WHO.

Questions	Scoring system					Your score
	0	1	2	3	4	
How often do you have a drink containing alcohol?	Never	Monthly or less	2 - 4 times per month	2 - 3 times per week	4+ times per week	
How many units of alcohol do you drink on a typical day when you are drinking?	1 -2	3 - 4	5 - 6	7 - 9	10+	
How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you failed to do what was normally expected from you because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you needed an alcoholic drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you been unable to remember what happened the night before because you had been drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Have you or somebody else been injured as a result of your drinking?	No		Yes, but not in the last		Yes, during the last	

			year		year	
Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested that you cut down?	No		Yes, but not in the last year		Yes, during the last year	

Scoring: 0 – 7 Lower risk, 8 – 15 Increasing risk, 16 – 19 Higher risk, 20+ Possible dependence



Point of Care Testing Protocol

1. The Lipid near patient testing device will be quality checked on a locally agreed regular basis, by following the guidelines for quality assurance in accordance with the manufacturer's instructions supplied with the device.

2. Internal quality control (IQC*)* procedure will be followed by the analysis of an appropriate control material (supplied by the manufacturer of the device), providing reassurance that the system is working correctly. The results of the IQC must be recorded appropriately and performed at an appropriate frequency.

3. External quality assessment (EQA) of samples with unknown values from an external source will be performed on a scheduled basis. This will be operated through dedicated EQA providers, such as the UK National External Quality Assessment service or the local hospital laboratory.

4. All QA results, faults, repairs and maintenance must be documented and held by the operator of the Health Check service.

5. Adverse incidents involving medical devices will be reported to the manufacturer and to the MHRA.

Current Lifestyle Services in Devon add Torbay

(these will be subject to change)

Commissioned Lifestyle Services available to support the NHS Health Check in Devon				
Provider/Tool	**Service**	**Health Professional Referral?**	**Self - Referral?**	**How to Refer?**
OneSmallStep	Physical Activity Healthy Eating Stop Smoking	YES	YES	Email: hello@onesmallstep.org.uk Tel: 0800 298 2654 (freephone) or 01392 908 139 (local rate)
RISE (Recovery and Integration Service)	Drug and Alcohol Treatment and Support	YES	YES	Email: rise.referral@riserecovery.cjsm.net Exeter, East and Mid Devon - Tel: 0300 303 3384 North & Torridge- Tel: 0300 303 3384 South - Tel: 0300 303 3384
Various (GP, Pharmacy and community settings)	**Stop Smoking Support**	YES	YES	Website: http://www.smokefreedevon.org.uk/support-to-quit-smoking/quit-smoking-through-your-gp-pharmacy-or-dentist/ Resources: http://resources.smokefree.nhs.uk/resources/
Various (Leisure providers)	Exercise on Referral schemes	YES	N/A	Website: www.devonhealthandwellbeing.org.uk/wp-content/uploads/2012/10/Exercise-Referral-Schemes_Devon1.pdf
Get Active Devon (e-tool)	Physical activity opportunities finder.	N/A	N/A	Website: www.getactivedevon.co.uk
Devon Partnership Trust	Depression and Anxiety Services	YES	YES	Exeter - Tel: 01392 675 630 email: dpn-tr.ExeterDAS@nhs.net East and Mid Devon - Tel: 01392 385 170 email: dpn-tr.EastandMidDevonDAS@nhs.net

				North Devon - Tel: 01271 335 041 email: dpn-tr.NorthDevonDAS@nhs.net South and West Devon Tel: 01626 203 500 email: dpn-tr.SouthandWestDevonDas@nhs.net Website: http://www.devonpartnership.nhs.uk/DAS.385.0.html
Commissioned Lifestyle Services available to support the NHS Health Check in Torbay				
Service	**Provider**	**Health Professional Referral?**	**Self - Referral?**	**How to Refer?**
Drug and Alcohol Treatment and Support	Torbay Drug and Alcohol Service	YES	YES	http://www.torbayandsouthdevon.nhs.uk/services/drug-and-alcohol-service/
Online Alcohol Treatment and Support	Torbay Drug and Alcohol Service	YES	N/A	http://www.torbayandsouthdevon.nhs.uk/services/drug-and-alcohol-service/
Specialist Stop Smoking Service	Lifestyle Torbay	YES	YES	http://www.torbayandsouthdevon.nhs.uk/services/healthy-lifestyles/ Tel: **0300 456 1006**
Stop Smoking Support (GP, Pharmacy and community settings)	Various	YES	YES	http://www.torbayandsouthdevon.nhs.uk/services/healthy-lifestyles/ Tel: **0300 456 1006**
Community-Based Weight Management Services	Lifestyles Torbay	YES	N/A	http://www.torbayandsouthdevon.nhs.uk/services/healthy-lifestyles/ Tel: **0300 456 1006**
Exercise Referral Scheme (non-funded)	Lifestyles Torbay	YES	N/A	http://www.torbayandsouthdevon.nhs.uk/services/healthy-lifestyles/ Tel: **0300 456 1006**
Get Active Devon	N/A	N/A	N/A	Website: www.getactivedevon.co.uk

(e-tool)				
Depression and Anxiety Services	Devon Partnership Trust	YES	YES	South and West Devon Tel: 01626 203 500 email: dpn-tr.SouthandWestDevonDas@nhs.net Website: http://www.devonpartnership.nhs.uk/DAS.385.0.html

Read codes for recording of NHS health check activity

NHS Health Check Data Items	Data Values	Version 2	CT v3
Organisation Details			
Organisation Code (Code of Commissioner)		ODS Data	ODS Data
Organisation Code (NHS Health Check Provider)		ODS Data	ODS Data
NHS Health Check Programme			
Eligible Population Total (NHS Health Check)		*To be derived by clinical system suppliers*	*To be derived by clinical system suppliers*
Invitation Offer Sent Indicator (NHS Health Check)	Yes	9mC.. | NHS Health Check invitation 9mC0. | NHS Health Check telephone invitation 9mC1. | NHS Health Check invitation first letter 9mC2. | NHS Health Check invitation second letter 9mC3. | NHS Health Check invitation third letter 9mC4. | NHS Health Check verbal invitation	XaRBR | NHS Health Check invitation XaR9z | NHS Health Check verbal invitation XaRBT | NHS Health Check invitation first letter XaRBU | NHS Health Check invitation second letter XaRBV | NHS Health Check invitation third letter XaRBS | NHS Health Check telephone invitation
	No	Where this data item is flowed as null in a record then it will be mapped to the value [N] No	Where this data item is flowed as null in a record then it will be mapped to the value [N] No
Demographics			
Lower Layer Super Output Area		*To be derived by clinical system suppliers*	*To be derived by clinical system suppliers*
Age at Assessment		*To be derived by clinical system suppliers*	*To be derived by clinical system suppliers*
Gender	Male Female Not Known	1K0.. | Male 1K1.. | Female 1K2.. | Gender Unknown 1K3.. | Gender Unspecified	X768D | Male X768C | Female Xalg1 | Gender Unspecified Xalg0 | Gender Unknown

Ethnic Category	British or Mixed British Irish Any other white background Mixed White and Black Caribbean White and Black African White and Asian Any other mixed background Asian or Asian British Indian Pakistani Bangladeshi Any other Asian background Black or Black British Caribbean African Any other black background Other Ethnic Groups Chinese Any other ethnic group Not Stated Not Known	White 9i0..% | British or mixed British - ethnic category 2001 census 9i1..% | Irish - ethnic category 2001 census 9i2..% | Other White background - ethnic category 2001 census Mixed 9i3..% | White and Black Caribbean - ethnic category 2001 census 9i4..% | White and Black African - ethnic category 2001 census 9i5..% | White and Asian - ethnic category 2001 census 9i6..% | Other Mixed background - ethnic category 2001 census Asian or Asian British 9i7..% | Indian or British Indian - ethnic category 2001 census 9i8..% | Pakistani or British Pakistani - ethnic category 2001 census 9i9..% | Bangladeshi or British Bangladeshi - ethnic category 2001 census 9iA..% | Other Asian background - ethnic category 2001 census Black or Black British 9iB..% | Caribbean - ethnic category 2001 census 9iC..% | African - ethnic category 2001 census 9iD..% | Other Black background - ethnic category 2001 census Other Ethnic Groups 9iE..% | Chinese - ethnic category 2001 census 9iF..% | Other - ethnic category 2001 census 9iG..% | Ethnic category not stated - 2001 census 916E.% | Patient ethnicity unknown	XaJQv% | British or mixed British - ethnic category 2001 census XaJQw% | Irish - ethnic category 2001 census XaJQx% | Other White background - ethnic category 2001 census Mixed XaJQy% | White and Black Caribbean - ethnic category 2001 census XaJQz% | White and Black African - ethnic category 2001 census XaJR0% | White and Asian - ethnic category 2001 census XaJR1% | Other Mixed background - ethnic category 2001 census Asian or Asian British XaJR2% | Indian or British Indian - ethnic category 2001 census XaJR3% | Pakistani or British Pakistani - ethnic category 2001 census XaJR4% | Bangladeshi or British Bangladeshi - ethnic category 2001 census XaJR5% | Other Asian background - ethnic category 2001 census Black or Black British XaJR6% | Caribbean - ethnic category 2001 census XaJR7% | African - ethnic category 2001 census XaJR8% | Other Black background - ethnic category 2001 census Other Ethnic Groups XaJR9% | Chinese - ethnic category 2001 census XaJRA% | Other - ethnic category 2001 census XaJRB% | Ethnic category not stated - 2001 census XaLN0% | Patient ethnicity unknown

Person Observations			
Body Mass Index		22K..% | Body Mass Index *Excluding* 22K9. | Body Mass Index centile	22K..% | Body Mass Index *Excluding* XaVwA | Body Mass Index centile Xa7wG% | Observation of Body Mass Index
Blood Pressure Sitting		246.. | O/E - blood pressure reading 246R. | Sitting diastolic blood pressure 246Q. | Sitting systolic blood pressure	X773t | O/E - blood pressure XaJ2F | Sitting diastolic blood pressure XaJ2E | Sitting systolic blood pressure 246.. | O/E - blood pressure 246R. | Sitting diastolic blood pressure 246Q. | Sitting systolic blood pressure
Total Cholesterol/High-Density Lipoprotein Ratio		44PF. | Total cholesterol:HDL ratio 44I2. | cholesterol/HDL ratio 44IF. | Serum cholesterol/HDL ratio 44IG. | Plasma cholesterol/HDL ratio	44PF. | Total cholesterol:HDL ratio XaERR | cholesterol/HDL ratio XaEUq | Serum cholesterol/HDL ratio XaEUr | Plasma cholesterol/HDL ratio
Total Cholesterol Level		44OE. | Plasma total cholesterol level 44P.. | Serum cholesterol 44P1. | Serum cholesterol normal 44P2. | Serum cholesterol borderline 44P3. | Serum cholesterol raised 44P4. | Serum cholesterol very high 44PH. | Total cholesterol measurement 44PJ. | Serum total cholesterol level	XalRd | Plasma total cholesterol level XE2eD% | Serum cholesterol level XaJe9 | Serum total cholesterol level 44P1. | Serum cholesterol normal 44P2. | Serum cholesterol borderline 44P3. | Serum cholesterol raised 44P4. | Serum cholesterol very high 44PH. | Total cholesterol measurement 44PJ. | Serum total cholesterol level
Physical Activity Level	Inactive Moderately Inactive Moderately Active Active	138X. | General practice physical activity questionnaire physical activity index: inactive 138Y. | General practice physical activity questionnaire physical activity index: moderately inactive 138a. | General practice physical activity questionnaire physical activity index: moderately active 138b. | General practice physical activity questionnaire physical activity index: active	XaPP8 | General practice physical activity questionnaire physical activity index: inactive XaPPB | General practice physical activity questionnaire physical activity index: moderately inactive XaPPD | General practice physical activity questionnaire physical activity index: moderately active XaPPE | General practice physical activity questionnaire physical activity index: active

Smoking Status Code	Current Smoker	137.. | Tobacco consumption 1372. | Trivial smoker - < 1 cig/day 1373. | Light smoker - 1-9 cigs/day 1374. | Moderate smoker - 10-19 cigs/d 1375. | Heavy smoker - 20-39 cigs/day 1376. | Very heavy smoker - 40+cigs/d 137C. | Keeps trying to stop smoking 137D. | Admitted tobacco cons untrue? 137G. | Trying to give up smoking 137H. | Pipe smoker 137J. | Cigar smoker 137M. | Rolls own cigarettes 137P. | Cigarette smoker 137Q. | Smoking started 137R. | Current smoker 137V. | Smoking reduced 137X. | Cigarette consumption 137Y. | Cigar Consumption 137Z. | Tobacco Consumption NOS 137a. | Pipe tobacco consumption 137b. | Ready to Stop Smoking 137c. | Thinking about stopping smoking 137d. | Not interested in stopping smoking 137e. | Smoking restarted 137f. | Reason for restarting smoking 137h. | Minutes from waking to first tobacco consumption 137m. | Failed attempt to stop smoking	137R.% | Smoker XE0og% | Tobacco smoking consumption 137C. | Keeps trying to stop smoking 137G. | Trying to give up smoking 137M. | Rolls own cigarettes XaIIu | Smoking reduced XaItg | Reason for restarting smoking XaJX2 | Minutes from waking to first tobacco consumption *Excluding* XaXP9 | Smoker before confirmation of pregnancy XaIuQ | Cigarette pack - years

	Ex Smoker	1377. | Ex-trivial smoker (<1/day) 1378. | Ex-light smoker (1-9/day) 1379. | Ex-moderate smoker (10-19/day) 137A. | Ex-heavy smoker (20-39/day) 137B. | Ex-very heavy smoker (40+/day) 137F. | Ex-smoker - amount unknown 137K. | Stopped smoking 137N. | Ex-pipe smoker 137O. | Ex-cigar smoker 137S. | Ex-smoker 137T. | Date ceased smoking 137j. | Ex-cigarette smoker 137l. | Ex roll-up cigarette smoker	Ub1na% | Ex-smoker *Excluding* XaQzw | Recently stopped smoking XaXP8 | Stopped smoking before pregnancy XaXP6 | Stopped smoking during pregnancy
	Non Smoker	137L. | Current non-smoker	137L. | Current non-smoker Ub0oq | Non-smoker
	Never Smoked	1371. | Never smoked tobacco	XE0oh | Never smoked tobacco
	Unknown	137E. | Tobacco consumption unknown	XE0oo | Tobacco smoking consumption unknown
Cardiovascular Disease Risk Score		38DF. | QRISK cardiovascular disease 10 year risk score 38DP. | QRISK2 cardiovascular disease 10 year risk score 662k. | JBS cardiovascular disease risk <10% over next 10 years 662l. | JBS cardiovascular disease risk 10-20% over next 10 years 662m. | Joint British Societies cardiovascular disease risk > 20% up to 30% over next 10 years 662n. | JBS cardiovascular disease risk >30% over next 10 years 38DR. | Framingham 1991 cardiovascular disease 10 year risk score	XaPBq | QRISK cardiovascular disease 10 year risk score XaQVY | QRISK2 cardiovascular disease 10 year risk score XaKCr | Joint British Societies cardiovascular disease risk less than 10% over next 10 years XaKCs | Joint British Societies cardiovascular disease risk 10% to 20% over next 10 years XaKCt | Joint British Societies cardiovascular disease risk >20% up to 30% over next 10 years XaKCu | Joint British Societies cardiovascular disease risk >30% over next 10 years XaQaG | Framingham 1991 cardiovascular disease score

Information and Advice			
Information and Advice Provided (General Lifestyle Advice)	Yes	66CQ. | Intervention for risk to health associated with overweight and obesity, general advice on healthy weight and lifestyle	XaX5k | Intervention for risk to health associated with overweight and obesity, general advice on healthy weight and lifestyle
	No	Where this data item is flowed as null in a record then it will be mapped to the value [N] No	Where this data item is flowed as null in a record then it will be mapped to the value [N] No
Information and Advice Provided (Stop Smoking Advice)	Yes	8CAL. | Smoking cessation advice 6791. | Health ed. - smoking 9N2k. | Seen by smoking cessation advisor 67H1. Lifestyle advice regarding smoking	Ua1Nz | Smoking cessation advice
	No	8IAj. | Smoking cessation advice declined	XaRFh | Smoking cessation advice declined
Information and Advice Provided (Weight Management Advice)	Yes	8Cd7. | Advice given about weight management 679P. | Health education - weight management 67I9. | Advice about weight	XaX5F | Advice given about weight management XaKHd | Health education - weight management XaADJ | Advice about weight Xa1dF | Patient advised to lose weight
	No	Where this data item is flowed as null in a record then it will be mapped to the value [N] No	Where this data item is flowed as null in a record then it will be mapped to the value [N] No
Brief Intervention (Physical Activity)	Yes	9Oq3. | Brief intervention for physical activity completed	XaPjx | Brief intervention for physical activity completed
	No	Where this data item is flowed as null in a record then it will be mapped to the value [N] No	Where this data item is flowed as null in a record then it will be mapped to the value [N] No
Signposting (Physical Activity Service)	Yes	8Cd4.| Physical activity opportunity signposted	XaREx | Physical activity opportunity signposted
	No	Where this data item is flowed as null in a record then it will be mapped to the value [N] No	Where this data item is flowed as null in a record then it will be mapped to the value [N] No
Signposting (Stop Smoking Service)	Yes	8CdB. | Stop smoking service opportunity signposted	XaXnG | Stop smoking service opportunity signposted

	No	Where this data item is flowed as null in a record then it will be mapped to the value [N] No	Where this data item is flowed as null in a record then it will be mapped to the value [N] No
Signposting (Weight Management Service)	Yes	8CdC. | Weight management service opportunity signposted	XaXnI | Weight management service opportunity signposted
	No	Where this data item is flowed as null in a record then it will be mapped to the value [N] No	Where this data item is flowed as null in a record then it will be mapped to the value [N] No
Referrals			
Referral Acceptance to Physical Activity Service	Accepted	8H7s. | Referral to physical activity programme	XaIQY | Referral to physical activity programme
	Declined	138S. | Declined referral to physical exercise programme	XaL1X | Declined referral to physical exercise programme
Referral Acceptance to Stop Smoking Service	Accepted	8HTK. | Referral to stop-smoking clinic 8H7i. | Referral to smoking cessation advisor 8HkQ. | Referral to NHS stop smoking service	XaFw9 | Referral to stop-smoking clinic XaItC | Referral to smoking cessation advisor XaQT5 | Referral to NHS stop smoking service
	Declined	137d. | Not interested in stopping smoking	XaIkY | Not interested in stopping smoking
Referral Acceptance to Weight Management Service	Accepted	8HHH. | Refer to weight management programme 8HHH0 | Referral to local authority weight management programme	XaJSu | Refer to weight management programme XaXZ9 | Referral to local authority weight management programme
	Declined	8IAM. | Referral to weight management service declined	XaQUp | Referral to weight management service declined
Further Assessments			
Assessment for Diabetes	Further assessment is required	6872. | Diabetes mellitus screen	6872. | Diabetes mellitus screening
	No further assessment is required	Where this data item is flowed as null in a record then it will be mapped to the value [N] No further assessment is required	Where this data item is flowed as null in a record then it will be mapped to the value [N] No further assessment is required

Assessment for Serum Creatinine	Further assessment is required	44J3.% | Serum Creatinine 44JC. | Corrected plasma creatinine level 44JD. | Corrected serum creatinine level 44JF. | Plasma creatinine level	XE2q5% | Serum Creatinine level 44J30 | Serum creatinine abnormal 44J31 | Serum creatinine low 44J32 | Serum creatinine normal 44J33 | Serum creatinine raised XaETQ | Plasma creatinine level XaERX | Corrected plasma creatinine level
	No further assessment is required	Where this data item is flowed as null in a record then it will be mapped to the value [N] No further assessment is required	Where this data item is flowed as null in a record then it will be mapped to the value [N] No further assessment is required
Assessment for Hypertension	Further assessment is required	68B1. | Hypertension screen	68B1. | Hypertension screening
	No further assessment is required	Where this data item is flowed as null in a record then it will be mapped to the value [N] No further assessment is required	Where this data item is flowed as null in a record then it will be mapped to the value [N] No further assessment is required
Assessment for Fasting Cholesterol	Further assessment is required	44O5. | Fasting blood lipids	XaFs9 | Fasting cholesterol level
	No further assessment is required	Where this data item is flowed as null in a record then it will be mapped to the value [N] No further assessment is required	Where this data item is flowed as null in a record then it will be mapped to the value [N] No further assessment is required
Assessment for Impaired Fasting Glycaemia/Impaired Glucose Tolerance Lifestyle Management	Further assessment is required	8HIS. | Referral for impaired glucose management	XaXR7 | Referral for impaired glucose management
	No further assessment is required	Where this data item is flowed as null in a record then it will be mapped to the value [N] No further assessment is required	Where this data item is flowed as null in a record then it will be mapped to the value [N] No further assessment is required
Prescriptions			
Statins Prescription	Yes	DERIVABLE FROM PRESCRIPTION RECORD	DERIVABLE FROM PRESCRIPTION RECORD
	No	Where this data item is flowed as null in a record then it will be mapped to the value [N] No further assessment is required	Where this data item is flowed as null in a record then it will be mapped to the value [N] No further assessment is required

Anti-Hypertensives Prescription	Yes	DERIVABLE FROM PRESCRIPTION RECORD	DERIVABLE FROM PRESCRIPTION RECORD
	No	Where this data item is flowed as null in a record then it will be mapped to the value [N] No further assessment is required	Where this data item is flowed as null in a record then it will be mapped to the value [N] No further assessment is required
Diagnosis			
Diagnosis Chronic Kidney Disease (Stage 3)	Yes	1Z12. | Chronic kidney disease stage 3 1Z15. | Chronic kidney disease stage 3A 1Z16. | Chronic kidney disease stage 3B 1Z1B. | Chronic kidney disease stage 3 with proteinuria 1Z1C. | Chronic kidney disease stage 3 without proteinuria 1Z1D. | Chronic kidney disease stage 3A with proteinuria 1Z1E. | Chronic kidney disease stage 3A without proteinuria 1Z1F. | Chronic kidney disease stage 3B with proteinuria 1Z1G. | Chronic kidney disease stage 3B without proteinuria	XaLHI% | Chronic kidney disease stage 3
	No	Where this data item is flowed as null in a record then it will be mapped to the value [N] No further assessment is required	Where this data item is flowed as null in a record then it will be mapped to the value [N] No further assessment is required
Diagnosis Chronic Kidney Disease (Stage 4)	Yes	1Z13. | Chronic kidney disease stage 4 1Z1H. | Chronic kidney disease stage 4 with proteinuria 1Z1J. | Chronic kidney disease stage 4 without proteinuria	XaLHJ% | Chronic kidney disease stage 4
	No	Where this data item is flowed as null in a record then it will be mapped to the value [N] No further assessment is required	Where this data item is flowed as null in a record then it will be mapped to the value [N] No further assessment is required

Diagnosis Chronic Kidney Disease (Stage 5)	Yes	1Z14. | Chronic kidney disease stage 5 1Z1K. | Chronic kidney disease stage 5 with proteinuri 1Z1L. | Chronic kidney disease stage 5 without proteinuri	XaLHK% | Chronic kidney disease stage 5
	No	Where this data item is flowed as null in a record then it will be mapped to the value [N] No further assessment is required	Where this data item is flowed as null in a record then it will be mapped to the value [N] No further assessment is required
Diagnosis Type 2 Diabetes	Yes	C10F.% | Type 2 diabetes mellitus *Excluding* C10F8 | Reavens syndrome	X40J5 | Type II diabetes mellitus X40J6 | Insulin treated Type 2 diabetes mellitus
	No	Where this data item is flowed as null in a record then it will be mapped to the value [N] No further assessment is required	Where this data item is flowed as null in a record then it will be mapped to the value [N] No further assessment is required
Diagnosis Hypertension	Yes	G2… | Hypertensive disease G20..% | Essential Hypertension G24.. | Secondary Hypertension G240. | Secondary malignant Hypertension G2400 | Secondary malignant renovascular Hypertension G240z | Secondary malignant Hypertension NOS G241. | Secondary benign Hypertension G2410 | Secondary benign renovascular Hypertension G241z | Secondary benign Hypertension NOS G244. | Hypertension secondary to endocrine disorders G24z. | Secondary Hypertension NOS G24z0 | Secondary renovascular Hypertension NOS G24zz | Secondary Hypertension NOS G2y.. | Other specified hypertensive disease G2z.. | Hypertensive disease NOS Excluding G24z1 | Hypertension secondary to drug	XE0Ub | Hypertensive XE0Uc% | Essential hypertension G24..% | Secondary hypertension G2...% | Hypertensive disease Xa0Cs | Labile hypertension XSDSb | Diastolic hypertension G202. | systolic hypertension Xa3fQ | Malignant hypertension *Excluding* 61462 | Hypertension induced by oral contraception pill

	No	Where this data item is flowed as null in a record then it will be mapped to the value [N] No further assessment is required	Where this data item is flowed as null in a record then it will be mapped to the value [N] No further assessment is required
Diagnosis Non Diabetic Hyperglycaemia	Yes	C11y3 | Impaired fasting glycaemia R10D0 | [D]Impaired fasting glycaemia R10D1 | [D]Stress induced hyperglycaemia R10C. | [D]Drug induced hyperglycaemia C11y2 | Impaired glucose tolerance R10E. | [D]Impaired glucose tolerance	R10D0 | [D]Impaired fasting glycaemia XaIRY | Impaired fasting glycaemia XaIRK | [D]Impaired fasting glycaemia C11y3 | Impaired fasting glycaemia XaFs1 | [D]Drug induced hyperglycaemia X40Jg | Metabolic stress hyperglycaemia C11y2 | Impaired glucose tolerance R10E. | [D]Impaired glucose tolerance X40Jh | Impaired glucose tolerance XaInl | [D]Impaired glucose tolerance
	No	Where this data item is flowed as null in a record then it will be mapped to the value [N] No further assessment is required	Where this data item is flowed as null in a record then it will be mapped to the value [N] No further assessment is required