

The NHS Health Check Programme

Service Specification No.	
Service	The NHS Health Check programme
Authority Lead	Sarah Wallace
Provider Lead	Multiple Providers
Period	April 2026 - March 2033 (5+1+1)
Date of Review	January 2029

Contents

1. Introduction and Context.....	4
1.1. Population Needs and National Context.....	4
1.2. Local Context and Local Needs Assessment	4
2. Service Model.....	5
2.1. Summary of the Service Model	5
2.2. Provider Eligibility	5
2.3. NHS Health Check Overview	6
2.4. Inviting service users	6
2.5. Booking appointments.....	8
2.6. Blood Testing.....	9
2.7. Risk Assessment	9
2.8. Risk Communication	10
2.9. Raising awareness of dementia	11
2.10. Cancer and Abdominal Aortic Aneurysm Screening Questions	11
2.11. Risk Management: Behavioural Risk Factors	11
2.12. Clinical Risk Management.....	15
2.13. National Digital NHS Health Check Programme.....	17
2.14. Point of Care Testing	17
2.15. Working with outreach NHS Health Check providers	18
2.16. Sub-contracting, lead provider and working in partnership.....	18
3. Eligibility, Accessibility, Location and Availability.....	19
3.1. Service User Eligibility.....	19
3.2. Out of Scope	20
3.3. Accessibility	20
3.4. Location of services.....	20
3.5. Opening hours.....	20
4. Outcomes, Objectives and Activity Levels	20
4.1. Priority Objectives and Outcomes	20
4.2. Activity Levels.....	21
5. Quality.....	22
5.1. Relevant National Quality Service Standards.....	22
5.2. Patient Safety Incident Response Framework (PSIRF).....	23
5.3. Safeguarding.....	23

5.4. Service Improvement	23
5.5. Complaints	24
5.6. Clinical Governance	24
6. Workforce.....	24
6.1. Available workforce and workforce planning.....	24
6.2. Training.....	24
6.3. Human Resources (HR) approach and policies	25
6.4. Capacity or service delivery issues	25
6.5. Business continuity and Emergency Planning.....	26
7. Managing Delivery and Tracking Performance and Quality	26
7.1. Outcome and Performance Measures.....	26
7.2. Monitoring and Recording Arrangements	27
7.3. Quality improvement projects	27
8. Contract and Terms	28
8.1. Payment	28
8.2. Contract period	28
9. Sustainability, Climate Change, Equalities, Inclusion and Social Value	28
9.1. Sustainability and Climate Change.....	28
9.2. Equalities.....	28
9.3. Inclusion Health Groups	29
9.4. Social Value.....	29
10. Service User Involvement.....	29
11. Communications, Campaigns, Insights, Marketing and Branding	29
11.1. The provider.....	29
11.2. Promotional Material.....	30
11.3 Product Endorsement.....	30
12. The Armed Forces Covenant.....	30
13. Data Systems	30
13.1 Provider IT systems and data collection	30
13.2 Reporting System.....	31
Appendix A: Quality Indicators.....	32
Appendix B: Draft Annual Reporting Form.....	34
Appendix C: Training	36

1. Introduction and Context

1.1. Population Needs and National Context

The NHS Health Check programme is a nationally mandated public health service which aims to prevent heart disease, stroke, type 2 diabetes and kidney disease, and raise awareness of dementia both across the population and within high risk and vulnerable groups.

Cardiovascular disease (CVD) is responsible for one in four premature deaths (deaths under the age of 75); it is estimated that as much as 85% of CVD related deaths are preventable. CVD is one of the conditions most strongly associated with health inequalities, with death from CVD more than two times higher amongst people in the most deprived communities compared to those that are in the most affluent. Men are more likely to die prematurely of CVD compared with women, and people with severe mental illness are more likely to die prematurely of CVD compared with the general population.

The 2025 [10 Year Health Plan for England](#) prioritises cardiovascular disease prevention through the planned Modern Service Framework, aiming to cut premature deaths from heart disease and stroke. Early detection and management of high-risk conditions, such as high blood pressure, cholesterol, and atrial fibrillation are central as are action on behavioural risk factors. NHS Health Checks play a crucial role in early detection and prevention, aligning with the 'left shift' ambition through early identification and management of high-risk conditions, ultimately reducing premature mortality and enhancing overall health equity. This contributes to reducing health inequalities and improving population health outcomes.

1.2. Local Context and Local Needs Assessment

In Hampshire there were 3,691 deaths from CVD in 2023, of which an estimated 22% were premature (under 75 years).

In 2024 it was estimated that there were 418,621 people in Hampshire who were eligible for an NHS Health Check; this represented 66.9% of the Hampshire population between 40 and 74 years old. The prevalence of eligibility drops as age increases, with vast majority of the eligible population within working age (40-64). In 2029 the eligible population is projected to have increased by 25,000 to over 443,000.

In the 5 years from 2021/22 Q1 - 2025/26 Q1, 370,066 people in Hampshire had been invited for an NHS Health Check which represents 88% of the eligible population. Over the same period 29% of the eligible population received a health check (122,098). While numbers of invitations and checks have steadily increased since the COVID-19 pandemic, uptake has remained low – 33% on average over the last 5 years compared to 38% in England.

2. Service Model

2.1. Summary of the Service Model

The NHS Health Check programme in Hampshire will be known as the NHS Health Check. The aim of the programme is to contribute to the reduction of premature mortality from CVD and associated morbidity in Hampshire.

The programme aims to:

- Improve and promote **early identification** of risk factors for cardiovascular disease.
- Support service users to effectively **manage** and **reduce behavioural risks** associated with conditions through information, behavioural and evidence-based interventions. This support should be co-produced with service users.
- Reduce **health inequalities** associated with CVD risk factors, related conditions and mortality
- Promote and support appropriate **research** and **evaluation** to optimise programme delivery and impact, nationally and locally

The programme will achieve this by focusing on quality of the checks, increasing uptake and reducing inequalities, with new quality payments and also a new expectation for providers to undertake an annual quality improvement project – this will also support achievement of quality indicators.

To reduce inequalities, reduce barriers to access and increase uptake, providers of this invitation-based programme are now required to work with an outreach provider (where available). Providers are asked to raise awareness of the programme to local service users and communities within their sphere of influence, with a particular focus on those who are less likely to attend.

Good quality conversations with service users are central to the effectiveness of the programme, therefore emphasis has been placed on training, with a new requirement for all those delivering NHS Health Checks to have undertaken commissioner funded training every 2 years.

To support national cancer and abdominal aortic aneurysm (AAA) screening programmes and increase uptake, providers will also use the opportunity of the check to review screening uptake and discuss the benefits of and access to screening where people have not taken this up.

2.2. Provider Eligibility

To be eligible to provide the Hampshire NHS Health Check programme, providers must:

- Be able to fulfil the requirements of the programme as documented in the national best practice guidance and the specification, including (but not limited to) undertake accurate and quality assured blood tests as required (venous sample or point of care testing), face-to-face (including via video call) risk assessment and communication, referral to relevant lifestyle providers and ensure the service user can access

appropriate clinical follow-up. Be a general practice with a registered patient list and/or be working with a named general practice(s) to identify and invite the eligible population, return results to the patient record and return data to the commissioner via specified method

- Have adequate insurance as outlined in the contract
- Be registered with the Care Quality Commission (CQC) (unless the provider delivers NHS Health Checks by only Point of Care Testing, and does not undertake other regulated activities)
- Have an NHS Digital Organisation Data Service (ODS) code and published current 'standards met' or 'standards exceeded' Data Security and Protection Toolkit self-assessment.

2.3. NHS Health Check Overview

The NHS Health Check is a risk detection and reduction programme and comprises of three key aspects:

1. Risk assessment – to assess a person's risk of heart disease, stroke, kidney disease and diabetes.
2. Risk communication – to ensure that a person's cardiovascular risk score, calculated using QRISK, is communicated in a clear way that they understand and can take action to maintain or improve. This must be completed **in person** (face-to-face, including via video call).
3. Risk management – to inform and support a person in reducing or managing their CVD risk through individually tailored advice and appropriate referral for healthy lifestyle interventions and/or clinical investigation and management.

Providers must ensure that a clear and robust service model is developed which delivers a high-quality NHS Health Check in accordance with the latest national NHS Health Checks guidance including the NHS Health Checks Best Practice Guidance, Programme Standards and competency framework (current guidance available here <https://www.healthcheck.nhs.uk/commissioners-and-providers/national-guidance/>). Where these are updated, providers will be required to update their programmes accordingly.

Providers are required to record and code NHS Health Checks in a standardised way (see the Professional Records Standards Body [NHS Health Checks guidance](#) and [national NHS Health Checks guidance](#)). The commissioner reserves the right to create local templates or amend the recording format, and providers will be required to meet new changes as required.

2.4. Inviting service users

The provider must be able to identify and invite the eligible population (see Section 3.1 for eligibility) or ensure that this occurs.

Any provider who does not hold an eligible list must demonstrate how they will work with specified general practice(s) to invite service users – this is a pre-requisite to eligibility to be a provider. The registered general practice issuing invitations directing the service user to the provider of the NHS Health Checks is an acceptable solution. If the provider and the registered general practice would like to work in a different way (e.g. sharing data for the provider to issue invitations), they must be able to demonstrate they have the appropriate measures in place in compliance with the ICO guidance.

If the provider is not the same organisation who is issuing invitations, the information provided to the service user must provide clear information on who will be providing the check and how their data will be used/shared this must comply with the Data Protection Legislation and Information Commissioner guidance.

Practices may use any of the following methods to invite service users:

- Letter: This should be based on the adapted national invitation template letter: [NHS Health Check - Invitation letter and results card](#). The letter should be made available in other formats (including easy read, translated into alternative languages where applicable).
- SMS: The commissioner will provide wording for practices to adapt as required
- Email: This should be based on the adapted national invitation letter
- Telephone call (although must be accompanied by written information e.g. SMS, email etc.)
- NHS App (must be other options available where users do not have the App or do not access it)

Invitations should use behaviour change techniques to encourage uptake. The invitation should include or signpost to local or national online patient information or use the [NHS Health Check patient information leaflet](#) to ensure informed choice. Individuals should be provided with clear information so that they understand the NHS Health Check process. If aged between 65-74 years, the invitation should include a [Dementia NHS Health Check leaflet](#) along with information on local memory clinic services.

Where the provider of the NHS Health Checks is not the service user's registered GP, the invitation must also indicate that the data will be returned to the general practitioner, and/or have a link to the privacy policy of the NHS Health Checks provider which includes this information.

Invitations, including method of invitation, must be documented in accordance with the NHS Health Check national guidance. The Commissioner will advise providers on documentation of NHS Health Check invites to ensure that first invitations in every five-year cycle can be identified in order to comply with National Reporting requirements.

Any service user who does not respond to the invitation or book an appointment must receive a further two invitations, and the provider should consider how they can increase uptake and reduce inequalities e.g. through targeted telephone calls and opportunistic booking. Providers should utilise system flags/prompts to enable opportunistic discussions about NHS Health Checks. Where the NHS Health Checks are offered opportunistically,

written (digital or hard copy) information should be provided. If an individual opts out this should be recorded on the person's medical record. An auditable process should be in place to recall in five years, if they remain eligible.

Where a practice chooses to use text- or app-based invitation systems they must have an alternative invitation method which they use depending on service user preference e.g. for service users who have opted-out of text communication or who do not have a recorded mobile number.

On request, the provider will make invitation templates available to the commissioner, who may require amendments to the template which practices use.

Providers should consider how to identify and take steps to increase uptake in priority populations to reduce health inequalities (programme priority populations are: people from most deprived quintile, smokers, people who are overweight and obese, people with a family history of CVD, people from minority ethnic communities and carers).

Best practice for inviting service users to NHS Health Checks includes:

- Letters followed by text reminders are successful at increasing uptake compared to letters alone
- Telephone call invitations are successful at increasing uptake
- GP computer system prompts are shown to be successful at increasing uptake
- Utilising behaviour change techniques in wording including urgency, clear call to action, benefit to the individual.

For Year 2026/27 only in line with the commissioned NHS Health Checks Catch-up programme: If applicable and with agreement from the commissioner, general practice providers may choose to invite to the 3rd party provider catch-up programme. Invites to the catch-up programme attract a £1.30 fee per invitation which directs service users to the catch-up programme. Should a provider wish to utilise this opportunity, they must discuss with the commissioner.

2.5. Booking appointments

- NHS Health Check appointments are a minimum duration of 30 minutes in length to ensure adequate time is given to carry out the required tests and provide service users with appropriate support. It is intended that the 30-minute appointment should incorporate sufficient time for undertaking any appropriate referrals/action arising from the check.
- Where possible the provider should utilise an online self-booking system, with telephone options available for those who are not able to access online options.
- Providers should be able to offer the service user an appointment within 1 month of enquiry.

- Confirmation notifications should be sent to all service users who have booked an appointment to reduce DNA rates.
- Service users who did not attend should be followed up by phone or text to offer re-booking.
- Where possible, providers should offer NHS Health Checks during extended opening hours e.g. evenings and weekends to improve uptake and accessibility.

2.6. Blood Testing

- The provider is permitted to either use venous sampling with lab testing or point of care testing (POCT) devices for the cholesterol and HbA1C/glucose blood test (if eligible). The results must be available at the time of the face-to-face NHS Health Check.
- The cholesterol result must be available at the time of the check – therefore where laboratory testing is used, this must be taken prior to the date of the check.
- The two approved approaches for testing for diabetes are fasting plasma glucose (FPG) tests or HbA1c (glycated haemoglobin). Where using venous sampling, the provider is recommended to take HbA1C at the same time as lipids in advance of the appointment to reduce the need for further venepuncture. Where Service Users do not have an HbA1C result at the time of appointment, the provider will identify individuals who are high risk and therefore require further testing using a validated risk assessment tool (as recommended in [NICE guidance](#)).
- All POCT devices will be used in line with the quality assurance and training mechanisms outlined as in Section 2.14.

2.7. Risk Assessment

The risk assessment is a systematic process which collects information in order to evaluate an individual's risk of cardiovascular disease

Every risk assessment must include **all** elements of the most up-to-date [national best practice guidance](#). The commissioner reserves the right not to pay for an NHS Health Check where mandatory elements of the check are missing.

The provider may wish to collect some elements of the check prior to the appointment (e.g. through digital forms or on the phone) – in these circumstances providers must ensure that the questions are accessible and that there is no detrimental impact on accuracy of the information collected. Height and weight and blood pressure must be measured and recorded by the provider of the check and not self-reported.

Providers will, as a minimum, ensure that:

- Service users presenting for a risk assessment are informed about the check and given the opportunity to ask questions.
- All consultations must be confidential and conducted in a private consultation room/area.
- Prior to proceeding with the 'Risk Assessment', service users must understand what will happen to the data recorded for the NHS Health Check, including that the data collected in the check will be returned to their registered general practice (if applicable).

The Risk assessment must include calculation of QRISK score. QRISK3 should be used where available; [NICE guidance 258](#) and national NHS Health Checks guidance should be followed where QRISK3 is not yet embedded within clinical systems.

2.8. Risk Communication

This section sets out the information required in the 'Communication of Risk' conversation, further to the Risk Assessment. This must be undertaken face-to-face or via video call and with the QRISK score results; for the avoidance of doubt this means that there must be a recent cholesterol result (within the last 6 months) available at the time of the appointment. A telephone call which is not a video call is not sufficient to meet the requirements of this specification. The appointment must be booked for no less than 30 minutes.

To maximise benefits, everyone who has a 'Risk Assessment' with the service, regardless of their CVD risk score, will be supported by the provider to understand:

- what their risk means for them
- consider what changes they might need to implement to help them reduce their risk of CVD
- how they might undertake these changes to help them reduce their risk of ill health
- what next steps or follow-up they require (if any)

The provider will, as a minimum, ensure that all service users:

- that receive a 'Risk Assessment' have their CVD risk score communicated in such a way that they can understand it. This must include a discussion of absolute 10-year risk, relative risk and healthy heart age.
- receive a digital copy or printed copy of their risk assessment following the check to assist with the communication of risk, and information on where to access support. Where possible providers should operate a 'digital first' offer for sharing the risk assessment to reduce printing, however if this is shared digitally, this must be undertaken securely and in accordance with data protection regulations.
- are given adequate time and opportunity to ask questions and obtain further information about their CVD risk and results
- service users with 'slightly raised' blood pressure (120-139mmHg systolic and 80-89 diastolic) should understand that they are at increased risk of high blood pressure

(hypertension) in the future and understand the ways in which they can reduce this risk.

2.9. Raising awareness of dementia

There are two dementia components to the NHS Health Check. Neither require any formal assessment or memory testing.

- Firstly, everyone who has an NHS Health Check should be made aware that the risk factors for CVD are the same as those for dementia – ‘what is good for the heart is good for the brain’.
- Secondly, for service users aged 65 to 74, the provider will offer service users with the NHS Health Check programme dementia leaflet (printed or electronic) and raise awareness of:
 - The signs and symptoms of dementia.
 - How people can reduce their risk of getting dementia and slow its progression.
 - The availability of memory services that offer further advice and assistance to people who may be experiencing signs and symptoms of dementia.

2.10. Cancer and Abdominal Aortic Aneurysm Screening Questions

The provider has the option to include assessment through questions or review of the clinical record participation in screening programmes for which the service user is eligible. Where eligible service users have not taken up screening programmes the provider will discuss with them the purpose of screening, what screening involves, where to find out more information and how to access the screening programme. This discussion will be documented in the clinical record.

The provider will ensure that the staff member delivering the check has suitable knowledge and training to have these discussions.

Screening programmes which may be applicable include:

1. Cancer screening programmes: cervical, breast and bowel
2. Abdominal aortic aneurysm (AAA) screening
3. Lung cancer screening programme (where available)

2.11. Risk Management: Behavioural Risk Factors

The staff delivering NHS Health Checks need to be familiar with local behavioural risk factor services and able to competently discuss and refer into these services as is relevant to service user needs. The provider must ensure that the service it offers fulfils national best practice guidance ([Best Practice Guidance](#)).

The expectation is that the provider will refer by default rather than signpost for self-referral; this will be reflected in the quality indicators.

The provider will, as a minimum, ensure that:

- all service users receiving a 'Risk Assessment', regardless of their CVD risk score, are given appropriate 'Risk Management' lifestyle advice with an agreed co-produced plan, in writing and verbally, to help service users manage and reduce their CVD risk.
- all service users will be given individually tailored advice that will help motivate them and support the necessary lifestyle changes required to help them manage their CVD risk. This includes supporting and encouraging maintenance of healthy behaviours even where CVD risk is low. This approach echoes the competencies set out in Making Every Contact Count which enables the opportunistic delivery of consistent and concise healthy lifestyle information.

Detailed information on behavioural risk factor interventions

Providers are required to keep up-to-date with any changes to local pathways, contact details or criteria for the below risk factors. Providers are asked where possible, and always with the service user's consent, to undertake referrals to the available behavioural risk factor services (rather than simply signposting).

Stop Smoking Very Brief Advice

The provider will use every opportunity to deliver very brief advice and follow-up, where appropriate, with a referral into effective support in line with [NICE Guidance 209](#) to service users who smoke. This [Very Brief Advice](#) consists of three steps:

- Ask – establish and record smoking status as part of the 'Risk Assessment'.
- Advise – if a service user is currently smoking advise the service user verbally and in writing that the best way of stopping smoking is with a combination of Local Stop Smoking Service support and pharmacotherapy, such as medicine, patches and gum or a vape assisted method.
- Act – offer a referral to a local Stop Smoking Service

Weight Management Interventions

Advice and action should be consistent with [NICE guidance 246](#). The provider will use every opportunity to reinforce to service users the benefits of healthy eating and being physically active following the steps outlined in [Let's Talk About Weight](#).

When discussing weight management, or referring service users, the provider will take [a personalised approach](#). This includes considering the individual's characteristics (age, ethnicity, gender, lifestyle) as well as:

- Information about the severity of their overweight and obesity and central adiposity and impact this has on their risk of developing long-term conditions
- Offer advice and discuss the possibility of referral to an overweight or obesity management programme taking into account their individual needs.

- This should include discussion of any previous or ongoing intervention and approaches including acknowledging any progress already made, their experiences of the intervention, any barriers or concerns they have about meeting their personal goals and any cultural or social context or assumptions about health and diet
- Discuss and agree realistic, personalised health goals, including short term goals such as clothes fitting better and finding it easier to breathe when walking or climbing stairs
- Discuss the importance of making sustainable longer-term changes to dietary behaviours and increasing physical activity levels

In addition, the individual's alcohol intake must be considered as key context within discussions about energy intake. Staff delivering this service must use this opportunity to highlight links between alcohol intake, obesity and fatty liver disease.

Service users will be directed to information on the importance of a balanced diet, as shown in the [Eatwell Guide](#) and signposted to [NHS Choices - Eat Well Guide](#), for further tips on achieving a healthier weight.

Where applicable, the service user should be offered referral to the [local Adult Weight Management Service](#) in Hampshire in accordance with the [local weight management pathway](#). The provider will also consider additional weight management interventions, such as NHS Digital Weight Management Programme, National Diabetes Prevention Programme, NHS Weight loss 12-week app, and training offers by [Energise Me](#).

If referral is declined acknowledge and respect their choice and explore the reason sensitively or delay until an appropriate time. Ensure they have the opportunity to discuss referral in the future (and the option to [self-refer](#)) and give them information about other ways to make sustainable, long-term changes to their dietary behaviours and physical activity levels.

Physical Activity

The provider will use every opportunity to raise awareness of the importance of physical activity and encourage all service users to increase or maintain their activity levels in line with [NICE Guidance and quality standards](#), and in accordance with the adult consultation guides as defined by [Moving Medicine](#).

The provider must complete the [GPPAQ \(General Practice Physical Activity Questionnaire\)](#) as well as qualitative information gained to have a rounded discussion on physical activity. While the GPPAQ asks questions about walking and activities of daily living, these are not included in the calculation, due to the significant levels of over-reporting on the amount and intensity of these physical activities during validation. The practitioner delivering the NHS Health Check will need to use their judgement whether service users meet the minimum physical activity levels for those classified as less than active.

If the individual is not achieving the [recommended physical activity levels](#) (as defined by the UK Chief Medical Officer), the provider will:

- offer information on the recommended physical activity levels (useful infographics can be found [here](#)).

- within the personalised context of the individual, discuss health status, preferences and what the individual might do to become more active, and agree these goals.
- provide access to written information about various types of activities and local opportunities to be active.

If the individual is defined as sedentary or 'inactive' following the GPPAQ, the provider will ,

- if eligible, offer a referral to the Hampshire Physical Activity Service - [Be Active Hampshire](#) if eligible
- offer a referral to an exercise referral programme (if they have a pre-existing health condition or eligible risk factors)
- signpost to local physical activity offer (see [Energise Me Activity Finder](#))
- follow up at appropriate intervals over a three to six-month period where appropriate
- access free 'Physical Activity Clinical Champion (PACC) training to boost confidence, knowledge and skills to talk about the benefits of physical activity and help service users to become more active. Information about PACC training can be found [here](#) or express your interest directly to Rebecca Gould via: rebecca.gould11@nhs.net

Active Practice Charter

Where applicable, it is encouraged that the provider is signed up to become an Active Practice to demonstrate the commitment to increasing activity and reducing sedentary behaviour in service users and staff. For more information, visit [Physical Activity Hub: Active Practice Charter \(rcgp.org.uk\)](#)

Alcohol use interventions

Where an individual has scored 5 or more on the Audit C a full AUDIT screen should be undertaken.

If an individual has been identified as drinking alcohol above low-risk levels (defined as an AUDIT score of eight or above), the provider will advise the service user to reduce their alcohol intake, in line with [NICE Guidance](#). This advice is most effective when delivered immediately after the AUDIT assessment. Reducing alcohol use is an essential part of helping service users manage CVD and other risks that alcohol poses to their health, currently and in the future.

Audit C Score	Risk	Action
1-7	Low Risk	
8 -15	Increasing Risk	a. The provider will deliver Alcohol Brief Advice and discuss with the individual strategies to help reduce alcohol intake. Signpost service user to Rethink your drink - alcohol awareness pages and / or refer to alcohol brief interventions service Alcohol Support - Inclusion Hants for up to 6 sessions of structured support
16-20	Higher Risk	b. referral to individual's GP for an assessment for cirrhosis c. Provide structured brief advice or a longer, more motivationally-based session (extended brief intervention). Offer referral to alcohol brief interventions service Alcohol Support - Inclusion Hants for up to 6 sessions of structured support.
20+	Possible dependence	Action as per b. and c. (above) AND d. where the AUDIT score is 20 or more, this may indicate alcohol dependence, and the provider will offer a referral to the community treatment services for adults in Hampshire by calling 0300 124 0103 or online via Support for alcohol - Inclusion Hampshire .

Advice provided will consist of, but not be limited to:

- understanding alcohol units – ensuring the individual understands how much they are drinking.
- understanding risk levels – explaining the guidance around alcohol units and how health risk rises with higher levels of alcohol intake.
- informing service users of their level of risk – communicating the individual's AUDIT score, the risk level that this indicates and comparison of their risk levels to the general adult population.
- benefits of cutting down – explain to the individual the benefits of reducing their alcohol consumption.
- tips for cutting down – provide the individual with a menu of options to try to cut back on their alcohol consumption.
- Where possible the service user should be referred by the provider, however individuals are also able to self-refer. Additional exploratory conversations may be required to assist the individual with self-referral.

2.12. Clinical Risk Management

The Risk Assessment will identify service users that require additional testing and clinical follow-up for undiagnosed conditions or are at high risk of developing CVD or diabetes.

Protocols must be in place for additional testing and clinical follow-up as appropriate, including protocols for clinical urgencies or emergencies which are identified during the check. The provider must ensure that the service it offers fulfils national best practice guidance ([Best Practice Guidance](#)) and adheres to local and national guidelines.

The provider will, as a minimum, ensure that

- service users have been informed in writing of the recommended additional tests and clinical follow-up required and how they should access this.
- where applicable, the level of urgency of accessing follow-up care has been clearly communicated to the individual
- there are pathways in place to investigate and manage service users in line with national guidance (including NICE guidance) and local pathways and offers, this includes but is not limited to:
 - Managing individuals with high CVD risk ($\geq 10\%$)
 - Considering need for statins as outlined in [NICE Guidance 238](#)
 - Assessment for familial hypercholesterolemia (FH) or other lipid abnormalities
 - Follow-up testing and diagnosis of hypertension (systolic $\geq 140\text{mmHg}$ or diastolic $\geq 90\text{mmHg}$).
 - Assessment for chronic kidney disease where an individual has raised blood pressure.
 - Assessment for atrial fibrillation for those with an irregular pulse
 - Abnormal fasting blood glucose or HbA1C indicating non-diabetic hyperglycaemia (blood glucose $\geq 5.5 - 6.9 \text{ mmol/l}$ or HbA1c $42-47 \text{ mmol/mol}$ or $6\%-6.4\%$) or assessment for diabetes (blood glucose $\geq 7\text{mmol/l}$ or HbA1c $\geq 48 \text{ mmol/mol}$).
 - Assessment for cirrhosis for alcohol AUDIT score of 16 or over.

Where applicable (if the provider is not the service user's registered general practice), written digital communication is required to send information back to the individual's general practice detailing advice given and further assessment advised. The service user must understand what action they need to take. The provider should undertake all relevant referrals to behavioural risk factor services agreed with the service users (smoking cessation, weight management, physical activity and drug and alcohol services). This must be transmitted in a safe, secure and timely manner. Automation should be considered, providing it is in line with data protection requirements. In this circumstance the provider may agree with the registered general practice(s) they are working with, that they undertake some steps which might include (but is not limited to):

- direct referral to the National Diabetes Prevention Programme (if permitted by local pathways)
- distribute written information on lipid lowering therapy for people at increased CVD risk
- advise individuals with raised blood pressure to attend local pharmacies offering Ambulatory Blood Pressure monitoring under the '[NHS Community Pharmacy Blood Pressure Check](#) Service' and/or borrow a blood pressure monitor from their local

library. Local pharmacies offering blood pressure checks and a lifestyle discussion can be seen here: [Hypertension Case Finding Service 10/2024 – Google My Maps](#).

Important additional considerations

Consideration should be given to the connection between poor physical health and poor mental wellbeing. Information about local mental health and wellbeing providers and signposts to local and national online information such as [Mental Wellbeing Hampshire](#) and [Better Health](#) should be utilised wherever appropriate.

2.13. National Digital NHS Health Check Programme

The provider will collaborate with the commissioner to integrate any future NHS digital health check offer as it becomes available. The commissioner will provide guidance on the requirements and timelines for implementation once details of the digital offer are confirmed.

2.14. Point of Care Testing

Should a provider choose to use Point of Care testing (POCT), the provider will be responsible for purchasing the POCT device, consumables, maintenance, and internal and external quality assurance. If POCT is the chosen method, the provider must have had the specific device and standard operating procedures (SOPs) approved by a local hospital laboratory POCT specialist. The use of POCT must be approved with the commissioner before implementation, and a set-up and ongoing audit must be submitted.

Where the provider uses POCT, this must be quality assured by an external quality assurance scheme. Inadequate quality assurance of POCT may lead to potentially inaccurate results, affecting clinical management and clinical risk for the provider, as well as being a threat to the integrity of the programme and to clinical engagement.

The provider must submit quarterly evidence of Internal Quality Control (IQC) and External Quality Assurance (EQA) performed to the commissioner on a quarterly basis. Failure to comply with the above equipment and material quality assurance processes may result in immediate suspension of the Contract, until sufficient evidence of compliance is provided.

Where POCT is being used, the following elements are required (adapted from [Medicines and Healthcare Products Regulation Agency POCT guidance](#) and NHS Health Checks programme standards):

- **a hospital pathology laboratory must be involved**
- **a POCT co-ordinator is identified** to manage the creation, implementation and management of a provider's POCT service and governance structure. They must be aware of their responsibility for clinical governance and of the medico-legal implications of an erroneous result.
- The provider should **link to a local POCT committee where available**

- **potential hazards** associated with the handling and disposal of bodily fluids, sharps and waste reagents outside of a laboratory setting should be considered
- **staff who use POCT devices must be trained. Only staff whose training and competence** has been established and recorded should be permitted to carry out POCT. This must include regular updates and continuing support.
- **the equipment instructions should always be adhered to** and staff should be particularly aware of situations when the device should not be used
- **standard operating procedures (SOPs)** which must include the manufacturer's instructions for use, are developed. Particular attention should be paid to any storage and handling requirements of the machine and cassettes.
- **quality assurance must be addressed**, implementing quality control (QC) procedures provides assurance that the system is working correctly. Appropriate internal quality control and external quality assurance processes must be in place in accordance with the [MHRA Guidelines on POCT](#) devices and local hospital laboratory POCT specialist advice. A QC record should be in place for each machine.
- **each POCT location is registered in and participating in an appropriate external quality assessment (EQA) programme** through an accredited (CPA or ISO 17043) provider that reports poor performance to the National Quality Assessment Advisory Panel (NQAAP) for Chemical Pathology. This can be checked on the UKAS website: www.ukas.com.
- Staff that review the POCT results are appropriately qualified and cited on the service users' history
- **record keeping** is essential and must include service user results, test strip lot
- **maintaining devices** according to the manufacturer's guidance is essential, to ensure that they continue to perform accurately

Any adverse incidents involving medical equipment should be reported to the commissioner and to the manufacturer as well as the MHRA and managed according to providers' governance arrangements as per NHS Health Check programme standards, ([NHS Health Checks, 2020](#)).

2.15. Working with outreach NHS Health Check providers

To reduce inequalities in access, all applicable providers (general practices with a registered patient list) are required to accept automated data returns from a third-party commissioned outreach provider back into the general practice clinical system, if available. This includes automated transfer and will require the provider to sign data transfer agreements or similar to comply with data protection legislation.

2.16. Sub-contracting, lead provider and working in partnership

Providers may wish to work in partnership or as a lead provider or through sub-contracting arrangements. Examples include one general practice in a primary care network (PCN)

delivering on behalf of the PCN, a GP federation or non-NHS provider delivering to specified practice populations, and other models. For payment and quality and delivery monitoring purposes, there must be only one organisation who is responsible for reporting and accepts payment for each general practice list. The model must be specified as part of the on-boarding process for a new provider and approval provided from the commissioner. Where a current provider wishes to amend its delivery model, Hampshire County Council (HCC) must give written permission for proposed arrangements.

Providers working in sub-contracting, lead provider and partnership models will need to provide evidence that the following are in place:

- Access to a registered eligible patient list – any provider that does not hold its own registered patient list must name the practice(s) they will be working with and how they will identify and invite eligible service users – as described in Section 2.4 (Inviting service users).
- Information governance and data protection legislation are adhered to and ensuring the secure transfer of service user data back into the patient record
- A secure method of returning data to the general practice patient record.
- Patient pathways in place which demonstrate how results will be returned to the service user's registered GP and agreement to accept and action the results as required following the health check
- Suitable indemnity arrangements which comply with the contractual requirements
- One provider organisation who is responsible for reporting and who receives payment. Agreement from the general practice holding the list to support access for reporting via the clinical reporting system commissioned for this purpose.

3. Eligibility, Accessibility, Location and Availability

3.1. Service User Eligibility

All Hampshire residents or those registered with a Hampshire-based general practice who are aged 40 to 74 who do not have any of the following pre-existing conditions:

- heart disease
- chronic kidney disease
- diabetes
- hypertension
- atrial fibrillation

- transient ischaemic attack
- familial hypercholesterolemia
- heart failure
- peripheral arterial disease
- stroke
- currently being prescribed statins to lower cholesterol
- previous QRISK of 20% or higher

Individuals are eligible if they have not had an NHS Health Check in the last 5 years.

3.2. Out of Scope

Investigation and management of any identified clinical conditions is out of scope of this service.

3.3. Accessibility

The practice must have policies to support eligible residents with additional needs to access NHS Health Checks, including learning disabilities and autism. Providers should have access to interpretation services, including video translation for sign language users; relatives must not interpret for NHS Health Checks appointments. Premises must be accessible for people with disabilities.

3.4. Location of services

The NHS Health Check will take place in a private consultation room or area. The provider will conform to the national standards and quality objectives of the NHS and infection control policies when carrying out NHS Health Checks. Providers are encouraged to consider delivery from community-based locations, as long as they adhere to these requirements.

To reduce barriers to access services should be accessible to users using active travel options, public transport and private vehicles.

3.5. Opening hours

To reduce barriers to access for people in full-time work or education, and people with caring responsibilities, where possible the provider should offer evening and weekend appointments in addition to working-hours appointments. This is not a mandatory requirement.

4. Outcomes, Objectives and Activity Levels

4.1. Priority Objectives and Outcomes

a. Service-level objectives

- Offer all eligible people an NHS Health Check once every five years (minimum threshold of 90% of annual eligible people)

- ii. Reduce inequalities in the programme through focussing on increasing uptake in priority populations – these include people from most deprived quintile, smokers, people who are overweight and obese, people with a family history of CVD, people from minority ethnic communities, and carers.
- iii. Reach the national threshold of 50% uptake of NHS Health Checks

b. Strategic Outcomes to which the service contributes.

- i. Local authorities have a legal duty to plan for everyone aged 40-74 years to be offered an NHS Health Check once in every five years and for them to be recalled for another check every five years, while they remain eligible.
- ii. Hampshire Public Health Strategy objectives:
 - ensure residents most at risk of cardiovascular disease can access an NHS health check every five years, and are supported to adopt healthier habits and to access health services to help them reduce this risk
 - support residents, especially those at most risk, to stop smoking, drink responsibly, maintain a healthy weight and be physically active

4.2. Activity Levels

Providers will be provided with annually amended invitation targets based on total eligible populations. They will be offered the opportunity to review the eligible population calculation and raise any concerns.

- a. Expected activity levels – Providers are expected to invite 100% of their annual eligible population each financial year (or approximately 20% of their total eligible population). Any practice which is below 90% of their annual eligible population may not be entitled to claim for quality payments. Eligible service users are expected to be invited within the financial year of eligibility, although quarterly invitations may fluctuate. In rare circumstances the commissioner may need to set a cap on number of invitations or suspend the programme; in this circumstance the requirement to invite 90% of the annual eligible population will be appropriately amended.
- b. Where a provider anticipates that they are unlikely to meet the 90% threshold they should discuss with commissioners at the earliest opportunity. From date of contract commencement, where providers have not invited 80% of the eligible population by the end of each quarter; the commissioner reserves the right (if required) to seek a written plan to ensure that at least 90% of eligible residents are invited annually and, if needed, to require that the provider work with another provider(s) to ensure that the 90% threshold is met.
- c. If a practice plans to invite more than 30% of their total eligible population (e.g. due to a backlog), they must gain permission in advance from the commissioner.

5. Quality

5.1. Relevant National Quality Service Standards

The service is underpinned by the following:

NHS Health Check Programme

- Best Practice: [NHS Health Check Best Practice guidance](#)
- Programme Standards: [NHS Health Check Programme Standards](#)
- [NHS Health Check Programme Pathway](#)
- Training, development and learning: [NHS Health Check Competency Framework](#)
- Training, development and learning: [NHS Health Check learner and assessor workbook](#)

Cardiovascular Disease

- [NICE Public Health Guideline PH25 Cardiovascular disease prevention](#)
- [NICE Public Health Guideline PH15 Cardiovascular disease: identifying and supporting people most at risk of dying early](#)
- [Cardiovascular disease: risk assessment and reduction, including lipid modification NG238](#)

Hypertension

- [Recommendations | Hypertension in adults: diagnosis and management | Guidance | NICE](#)
- [Quality statement 2: Blood pressure control | Chronic kidney disease in adults | Quality standards | NICE \(QS5\)](#)
- [Overview | Familial hypercholesterolaemia: identification and management | Guidance | NICE \(CG71\)](#)

Chronic Kidney Disease

- [Overview | Chronic kidney disease: assessment and management | Guidance | NICE \(NG203\)](#)

Diabetes

- [Healthier You | Diabetes Prevention Programme](#)
- [Overview | Type 2 diabetes: prevention in people at high risk | Guidance | NICE](#)
- [Overview | Type 2 diabetes in adults: management | Guidance | NICE](#)

Behaviour Change

- [NICE Public Health Guideline PH6 Behaviour change: general approaches](#)
- [NICE Public Health Guideline PH49 Behaviour change: individual approaches.](#)

Smoking Cessation

- [Overview | Tobacco: preventing uptake, promoting quitting and treating dependence | Guidance | NICE \(NG209\)](#)

Weight Management

- [Overview | Overweight and obesity management | Guidance | NICE](#)

Physical Activity

- [NICE Guidance and quality standards: lifestyle-and-wellbeing - physical-activity](#)
- [NICE Public Health Guideline PH44 Physical activity: brief advice for adults in primary care](#)
- Moving Medicine: a set of resources to support medical professionals with promoting physical activity to their patients. <https://movingmedicine.ac.uk/>

Alcohol

- [Alcohol Guidelines Review – Report from the Guidelines development group to the UK Chief Medical Officers](#)
- [NICE Public Health Guideline PH24 Alcohol-use disorders: prevention](#)
- NICE Clinical Guideline CG115 Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence
- [Overview | Cirrhosis in over 16s: assessment and management | Guidance | NICE \(NG50\)](#)

MHRA

- [Management and use of IVD point of care test devices - GOV.UK](#)
- [B0722-Point-of-Care-Testing-in-Community-Pharmacies-Guide January-2022.pdf](#)

NB: *Please note this is not an exhaustive list of the guidance available. Service Providers shall ensure services reflect updates in guidance and recommendations as and when they are produced.*

5.2. Patient Safety Incident Response Framework (PSIRF)

5.2.1. The requirements are set out in the terms and conditions.

5.3. Safeguarding

5.3.1 All organisations have a duty under the Children Acts 1989 and 2004 to safeguard and promote the welfare of children and under the Care Act 2014 to safeguard adults with care and support needs who are at risk of harm and abuse. Providers must ensure compliance with national legislation and both Hampshire Children's Safeguarding Partnership (HCSP) and Hampshire Safeguarding Adults Board (HSAB). The requirements are set out in the terms and conditions.

5.4. Service Improvement

The commissioner will expect to work with the provider during the course of the contract to identify developments, efficiencies and improvements within the service. The provider will ensure continuous service improvement using an evidence-based methodology to improve service and population outcomes.

5.5. Complaints

The provider is required to have a comprehensive complaints procedure and policy in place that complies with Part 5 of The NHS Bodies and Local Authorities (Partnership Arrangements, Care Trusts, Public Health and Local Healthwatch) Regulations 2012. The provider will share information and any lessons learned relating to service user complaints with the commissioner.

5.6. Clinical Governance

Clinical governance is an established system in the NHS and the independent healthcare sector to deliver and demonstrate that quality and safety of its services are of a high standard that is continually improving.

Hampshire County Council is committed to improving the quality of clinical interventions through a systematic approach. The provider and individual clinicians must take account of both formal and informal clinical governance structures.

The provider and service should abide by local and national arrangements for clinical governance and reporting of incidences. A robust clinical governance framework should be developed and adhered to by the provider.

6. Workforce

6.1. Available workforce and workforce planning

Developing a competent workforce is crucial to ensuring a high standard of service delivery for service users.

The providers will ensure:

- capacity and flexibility to respond to the likely pattern of demand; and
- appropriate grade of staff to provide the service
- appropriate clinical supervision

The provider will inform the commissioner within 1 month if there is a risk to fulfilling the requirements of the specification as a result of workforce/staffing gaps.

6.2. Training

6.2.1 Core Competencies

The [NHS Health Check Competency Framework 2020](#) outlines core, clinical and programme competencies required for staff delivering NHS Health Checks.

The provider will ensure that staff delivering the NHS Health Checks are trained and meet the competencies outlined in the framework to fulfil all elements of the programme pathway.

The provider should have processes in place to ensure that staff delivering NHS Health Checks are signed off against the competencies as appropriate to their role.

The provider will keep records of staff training to evidence that the staff delivering NHS Health Checks meet the required competencies, including evidence of completion of the foundation NHS Health Checks training and any recommended supplementary training provided by the commissioner to support delivery of Health Checks. (See Appendix C). The provider must use the [Learner and Assessor Workbook](#) to document competence of all individuals delivering NHS Health Checks.

The provider will identify a named NHS Health Check lead that is responsible for ensuring all staff involved in NHS Health Checks delivery meet the competencies for their roles.

6.2.2 Training Offer

The commissioner will provide NHS Health Checks foundation training and will provide and/or signpost to supplementary training to support delivery of NHS Health Checks. See Appendix C for more information.

The provider will ensure that all staff delivering Health Checks complete Foundation NHS Health Checks training (provided free of charge to providers by the commissioner). The commissioner will also specify mandatory supplementary training as outlined in Appendix C. The provider may also wish to include non-clinical staff involved in the delivery of NHS Health Checks in the foundation NHS Health Checks training. Refresher training should be completed at least every two years, or more often as required.

6.3. Human Resources (HR) approach and policies

6.3.1 The requirements are set out in the terms and conditions.

6.4. Capacity or service delivery issues

The provider will alert the commissioner to any capacity or service delivery issues in a timely and appropriate way. Risk assessment and risk management policies should be in place. The provider will ensure it has an operational risk management strategy with measures in place to identify and manage risk at all levels in the service and staff that are suitably trained.

Key risks will be highlighted to the commissioner as soon as possible, escalating highly likely and high impact risks as a matter of urgency if they arise. The provider will work with the commissioner to agree and implement solutions as necessary.

Further guidance regarding risk management can be accessed below:

- https://www.england.nhs.uk/wp-content/uploads/2021/05/An_exemplar_operational_risk_management_strategy.pdf
- <https://nhsproviders.org/topics/governance/a-guide-to-good-governance-in-the-nhs/the-essentials-of-risk-management>.

6.5. Business continuity and Emergency Planning

6.5.1 A business continuity plan must be in place.

7. Managing Delivery and Tracking Performance and Quality

7.1. Outcome and Performance Measures

7.1.1. Outputs – quarterly reporting

Indicator	Description
Number of eligible people invited in the quarter	Number of eligible people invited for an NHS Health Check in the quarter (counting only invitation number 1 in each five year cycle)*
Number of eligible people who have not been invited in the last five years	Number of outstanding eligible people who have not received one or more invitations for an NHS Health Check in the last 5 years, at the end of the quarter
Number of checks completed	Number of checks completed in the quarter**
Percentage uptake	Number of checks completed x 100 / Number of eligible people invited in the quarter (counting only invitation number 1 in each five year cycle)*

* Individuals should only be included in this list once every five years

** The commissioner reserves the right not to pay for an NHS Health Check where mandatory elements of the check are missing.

Practices should assure themselves of their accuracy prior to submission, as these will be the numbers used to report nationally and for payment. In the event of problems with functionality of the system, the provider will be asked to report these to the commissioner via email to hcc.hampshirehealthchecks@nhs.net. Personal identifiable data must not be shared with the commissioner.

7.1.2. Quality Indicators – annual reporting and review

These are defined in Appendix A with a draft reporting template in Appendix B, and these determine the annual quality related payment. All providers must submit the annual reporting template by 30th April each year.

Quality indicators will be reviewed annually, and Hampshire County Council reserves the right to amend, expand or reduce these requirements in response to service user surveys, service priorities, needs assessments, transformation of service delivery, service performance or legislation or other relevant strategy updates. Stakeholders will be consulted. Performance against agreed outcomes will be monitored and reviewed annually to set targets

for following contractual year. These will be communicated to providers as soon as possible after the previous year's quality indicator returns have been received.

7.1.3. National Reporting

The provider will comply with all nationally directed reporting requirements.

7.2. Monitoring and Recording Arrangements

7.2.1. In order to assess service performance, contribution to outcomes and aid future planning the provider will be required to collect and collate information in an accurate and timely way to demonstrate delivery of the contract requirements; compliance with agreed outcomes; and performance indicators for the service. The provider will be responsible for compliance with the programme outcomes and quality indicators set out in Appendix A.

7.2.2. The commissioner will monitor the quarterly/annual outputs and outcomes via the commissioned IT platform where possible. If data from the IT platform is not available, aggregate data will be requested from the provider, who will have 15 days to provide the information from the date of request. If the provider of the checks is not a general practice, the IT platform will still be used to monitor the outcomes of the checks, received from the practice(s) the provider is working with.

7.2.3. There is an annual expectation for providers to complete an annual monitoring form (Appendix B) and submit the report of a quality improvement project related to the programme. The annual elements will be due on the 30th April following the end of the relevant financial year.

7.2.4. The commissioner may undertake review meetings which will take the form of announced periodic visits which (either in person or online) to the service and will meet the provider's representative(s). The provider shall supply additional monitoring information on these occasions if required by the commissioner. This will include information regarding service delivery, training needs and opportunities for shared learning and quality improvement. Additional visits may be required if there are quality or performance concerns identified.

7.3. Quality improvement projects

7.3.1 The provider will be expected to undertake one quality improvement (QI) project per year related to the NHS Health Checks programme. The commissioner will specify this topic and any requirements at the beginning of the financial year (topics may include health inequalities, increasing uptake, improving quality). It is the provider's responsibility to ensure the person tasked with has the skills required and has appropriate senior supervision. The QI project must be presented and results reviewed at a meeting which includes senior leadership within the organisation. There will be one project requested per financial year, with the report submitted to the commissioner no later than the 30th of April following the end of the relevant financial year. The

commissioner will review and where appropriate may request amendments or additions.

7.3.2. The provider may be required to submit anonymous data to enable the commissioner to undertake a Health Equity Audit to ensure the service is accessible to those most at risk of health inequalities. The commissioner may utilise population health management (PHM) platforms for this purpose if available. The aggregated results of this will be shared with providers to support quality improvement.

8. Contract and Terms

8.1. Payment

Tariffs will be published here <https://www.hants.gov.uk/business/procurement/PHPCS>. and reviewed annually.

NHS Health Check payment will be split between a quarterly payment per check undertaken, and an additional annual quality percentage payment for checks undertaken in the financial year. The quality payment will depend on achievement of quality indicators, as defined in this specification Appendix A; the quality indicators will be reviewed annually, and providers will be engaged as they are updated.

8.2. Contract period

The contract will commence on 1/4/2026 for five years with an option to extend for up to two years (5+1+1).

9. Sustainability, Climate Change, Equalities, Inclusion and Social Value

9.1. Sustainability and Climate Change

The requirements are set out in the terms and conditions.

9.2. Equalities

The provider will comply with the Equality Act 2010. The service will be delivered in a way that is non-discriminatory and advances equality of opportunity for people from different communities. This applies both to service users and staff. The Service must make reasonable adjustments to ensure accessibility for people with physical and learning disabilities and must also ensure the provision of interpretation and translation services where needed, such as foreign languages and British Sign Language.

The service will understand the demographic diversity of the local community and will take active steps to engage with underrepresented groups with due regard to protected characteristics and address barriers to access. The service will be provided in a safe environment, free from discrimination, where all individuals are treated fairly with dignity

and respect. The provider will have an Equality and Diversity Policy in place which clearly demonstrates how equality and inclusion are embedded throughout the organisation.

9.3. Inclusion Health Groups

The service will consider the needs of people in Inclusion Health Groups who are socially excluded, who typically experience multiple overlapping risk factors for poor health, such as poverty, violence, and complex trauma e.g. related to [domestic abuse](#). This includes people who experience homelessness, drug and alcohol dependence, vulnerable migrants, Gypsy, Roma and Traveller communities, sex workers, people in contact with the justice system and victims of modern slavery. The service will adopt a trauma informed approach (TIA) in line with national and local guidance and best practice (e.g. [Working definition of trauma-informed practice - GOV.UK](#) and [local self-assessment toolkit](#)).

9.4. Social Value

9.4.1 The requirements are set out in the terms and conditions.

10. Service User Involvement

This will be core to continuous improvement of the service.

The provider will seek service user feedback, which is specific to NHS Health Checks, to help ensure that services are effective, high quality and responsive to the changing patterns of need. The provider will submit an annual brief summary of feedback and subsequent action taken in response.

The provider will actively encourage participation from groups who face barriers to access and inclusion health groups and will engage service users when developing the service.

11. Communications, Campaigns, Insights, Marketing and Branding

11.1. The provider

There is known to be a low awareness of the NHS Health Checks programme among the general population, which contributes to the low uptake of the programme. The provider is responsible for marketing the service to their eligible population and is expected to support awareness raising. This may include on social media, via local patient and community groups, provider website and posters/digital content. The commissioner may also undertake social marketing campaigns, and providers will be asked to support these campaigns through available channels. Communications support and approval for press releases (if appropriate) should be sought from Hampshire County Council (Corporate Communications).

11.2. Promotional Material

Promotional material (e.g. social media, posters and digital screens) will be developed and shared by the commissioner – any requests for additional or different material should be made to them. Should the provider wish to use other promotional material, it must be appropriately branded, inclusive, clear, appropriate, user-friendly, accessible, and tailored to the target audience. Information should be available in different formats and languages and advertised through digital, print or other channels, as appropriate. Please seek approval for use of the Hampshire County Council logo from the HCC Corporate Marketing team. The accessibility regulations aim to help make sure online public services are accessible to all users, including people with additional needs.

11.3 Product Endorsement

Specific product endorsement is not part of the programme, beyond the service which has been commissioned to deliver the intervention. As such, the service will be expected to ensure that any product endorsement is only made alongside other options and is clearly stated as a product endorsement/advertisement. The commissioner should be notified of any product endorsement/advertisement.

12. The Armed Forces Covenant

The service will give due regard to the Armed Forces Covenant, which is a promise from the nation to those who serve or who have served, and their families. The service must ensure that, in accordance with the Armed Forces Covenant, those in the armed forces, reservists, veterans and their families are treated fairly and that they are not disadvantaged in accessing the service.

Consideration should be given to introducing a policy to routinely ask all service users about their veteran, reservist, or military family status when they attend for services, to ensure that their needs are appropriately identified and met.

13. Data Systems

The provider must comply with the relevant data protection clauses included in the contract terms and conditions.

13.1 Provider IT systems and data collection

The IT system used by the provider must be consistent with information governance and data protection legislation, and able to fulfil the requirements of the programme, including:

1. identification of the eligible population
2. invite eligible population and record invitations sent
3. to record the data collected and the results of the NHS Health Check, using clinical codes and free text.

4. (if applicable) to return data securely into the clinical record of the service user's registered general practice.
5. (if applicable) to undertake automated searches of the GP patient list to identify patients eligible for NHS Health Checks. This includes identifying high-risk or priority groups, as per service specifications, to support targeted invitations.
6. (if applicable) to flag patients who are eligible for NHS Health Checks but have not attended to support opportunistic invitation.
7. to store data securely and compatible with legislation for retention of clinical records.
8. to enable the service user to receive a written record of the NHS Health Check and subsequent plan.

Only coded data will be eligible to receive a payment.

All emails containing any personal identifiable data (PID) must be transmitted via an DCB1596 Secure Email system.

13.2 Reporting System

The commissioner will supply an IT system which supports reporting of activity to the commissioner and certain quality indicators.

The IT system will provide the commissioner with aggregated data including (but not limited to):

- Invite and health check activity
- Eligible population
- Health check element completion (as defined by programme standards)
- Referral and outcome data

This data will be used for payment, reporting, monitoring, quality and performance, including inequalities assessment. No personal identifiable information will be shared with the commissioner.

As the data will be submitted via the registered general practice, where the provider is not the general practice the proposed model of delivery will need to consider this.

In the event that the IT system is not functioning or unavailable, the quality indicators which require the IT system will not be used and other indicator weights will be increased. In this circumstance, providers will need to provide quarterly outputs as per Section 7.1.1.

Appendix A: Quality Indicators

These will be used to determine quality related payment as described in the table below. All providers must submit their Quality Indicator report by 30th April following the end of the relevant financial year.

In the event that an informatics system which can provide the data is unavailable, the weight management and smoking referrals indicators will not be used, and the other indicator weights will be increased.

	Quality Payment	Numerator	Denominator	Quality Indicator Points (sum of 100)	Lower Threshold (gains 0 points)	Upper threshold (gains all points for indicator)	Evidence
Invitations							
1	Flags/prompts applied to patients' clinical records where individuals have not had an NHS Health Check in the last 5 years	-	-	10	No	Yes	Form from provider
2	Telephone call or face-to-face invitations (those receiving this must be selected from programme priority groups (people from most deprived quintile, people who smoke, people who are overweight and obese, people with a family history of CVD, people from minority ethnic communities, and carers)).	Number of people classed as high risk of CVD who have received telephone or face-to-face invitations.	Number of eligible people invited for an NHS Health Check (counting only invitation number 1 in each five-year cycle)	16	0%	20%	Form from provider or Informatics system

	Quality Payment	Numerator	Denominator	Quality Indicator Points (sum of 100)	Lower Threshold (gains 0 points)	Upper threshold (gains all points for indicator)	Evidence
Process							
3	NHS Health Checks delivered in extended access hours (after 6pm weekdays and/or weekend)	Number of NHS Health Checks delivered in evenings (after 6pm) and weekends/bank holidays.	Number of NHS Health Checks delivered	10	0%	15%	Form from provider
Outcomes							
4	Referrals to weight management services (must be referral not simply signposting)	Number of service users who have been referred to weight management services following an NHS Health Check	Number of completed Health Checks where the service user is eligible for a Tier 2 weight management service	12	20%	50%	Informatics system
5	Referrals to LA smoking cessation service (must be referral not simply signposting)	Number of service users who have been referred to smoking cessation services following an NHS Health Check	Number of completed NHS Health Checks where the service user is a current smoker	12	10%	50%	Informatics system
6	Percentage uptake	Number of completed Health Checks	Number of individuals receiving one or more invitations	24	30%	60%	Informatics system or quarterly returns
Quality Improvement Project							
7	Participation in NHS Health Checks Quality Improvement (QI) training and project presented by provider at learning event (commissioner to organise both)	-	-	16	5%	15%	Form from provider

Appendix B: Draft Annual Reporting Form

Below is an example only – this may be altered.

DRAFT NHS Health Check Practice Annual Reporting Form Financial Year X

Provider Organisation Name	
Name of person completing the form	
Position of person reporting the form	
Date of form completion	

Training	Yes	No	Comments
Number of people delivering NHS Health Checks in the organisation ('practitioners')?			
Have all practitioners completed foundation NHS Health Check Training within the last 2 years?			
Have all practitioners undertaking NHS Health Checks got up-to-date safeguarding training?			
Have all practitioners had an NHS Health Check competency framework declaration (using the learner and assessor workbook) signed by a clinical manager in the last 12 months?			

Booking	Yes	No	Comments
My organisation has an online NHS Health Check self-booking system for service users (not mandatory)			
My organisation has an alert /flag on the clinical system for service users who have been invited but have not attended their NHS Health Check (not mandatory, but linked to quality payments)			
What percentage of your NHS Health Check appointments are delivered out of hours (weekends, bank holidays or after 6pm on weekdays) – please also provide numbers of appointments in hours and numbers out of hours in an average week (linked to quality payments).			

Awareness
Please describe how you have raised awareness of the programme within the eligible service user population/local community e.g. through website, posters, display screens, your website etc.

Service user Feedback

Number of service users who have provided feedback on their NHS Health Check in the financial year x:

Summary of feedback received:**Summary of action taken as a result:**

Declarations	Yes	No	Comments
My Health Checks are exclusively undertaken face-to-face with the results of the cholesterol test; my service users all receive their QRISK results at the face-to-face NHS health check appointment (including video call).			
My service users all receive a copy (electronic or hard copy) of the results of their NHS Health Checks			
I have signed up to accept automated transfer of results back from X provider of outreach NHS Health Checks			

Appendix C: Training

Summary of Mandatory Training Requirements

	Repeat
Must be completed prior to delivering NHS Health Checks	
1. Foundation training specified by the commissioner	2 years
2. Behavioural Risk factor training (smoking, alcohol, weight/healthy eating, and physical activity)	2 years
3. Completed learner and assessor workbook for the NHS Health Checks competency framework, signed off by clinical supervisor	Reviewed a minimum of annually
Within 6 months of starting and then every 2 years	
4. Half-day face-to-face (or where required might consider virtual) training including motivational interviewing and communication of risk	2 years

Preliminary training and Practical NHS Health Checks training

The provider is responsible for ensuring that preliminary training and supervised practical NHS Health checks training is completed by staff delivering Health Checks. The NHS Health Checks Competency Framework and Learner and Assessor workbook outline the required competencies for staff.

Other Mandatory NHS Health Checks training

The provider will ensure that all staff delivering Health Checks complete Foundation NHS Health Checks training. The commissioner will provide Foundation NHS Health Checks training, which will be offered in the format of:

- a one-day group training session in person or virtually, or
- an e-learning course specified by the commissioner, or
- a combination of face-to-face training and e-learning

The commissioner will advise on the availability and format options for foundation training each year. The cost of delivery of training will be funded by the commissioner, with the exception of payment for the time of the staff, which will be borne by the provider.

All those delivering NHS Health Checks will be required to evidence training in behavioural risk factor (lifestyle change) conversations and referrals (covering smoking cessation, healthy weight, alcohol and physical activity) and risk communication/motivational interviewing at least once every two years.

Supplementary NHS Health Checks training

The commissioner will provide information on availability of optional training sessions, webinars and support resources at regular intervals throughout each year for the duration of the contract. The listed topics for optional supplementary training will be offered as they are available or identified from provider feedback, visits or programme reviews.