SERVICE SPECIFICATION Schedule Service Specification for the provision of NHS Health Checks

1 Overview

1.1 Local Authority procuring the Service

West Sussex County Council

1.2 Why the Service is being procured

1.2.1 The NHS Health Check is a national programme commissioned by local authorities, as a mandated service through the public health grant.

1.2.2 The NHS Health Check programme helps to underpin the NHS Long Term Plan commitments to prevent 150,000 heart attacks, strokes and cases of dementia, and to double referrals to the NHS Diabetes Prevention Programme [1].

1.2.3 Through early identification and management of risk factors and early detection of disease the NHS Health Check will help achieve the ambitions set out in "A call to action to reduce premature mortality" [2] and the "Cardiovascular disease outcome strategy" [3]. Together diabetes, heart disease (CHD), chronic kidney disease (CKD) and stroke make up a third of the difference in life expectancy between the most deprived areas and the rest of the country. Additionally, the cost of social and health care from the rise in levels of obesity, type 2 diabetes and dementia makes the prevention and risk reduction of these conditions' key drivers of the programme.[4]

1.2.4 The local position in West Sussex for prevalence of Cardiovascular Disease (CVD) conditions and premature mortality <75yrs) associated with CVD [5] is as follows:

• Approximately 25% of deaths of West Sussex residents registered in the period 2017 were due to circulatory diseases; among the under 75s the percentage was 20%.

• The risk of CVD increases with age with the main causes being high blood pressure and diabetes. There is evidence that progression is more rapid in people from Black, Asian, and other Minority Ethnic groups and people in more deprived areas are at higher risk.

• With an increased level of adult obesity and ageing population the numbers of people with diabetes is projected to increase above the general increase in population. Using current GP figures a 22% increase is projected over the next five years. Diabetes is estimated to increase your risk of cardiovascular morbidity and mortality up to four-fold. An estimated 12,000 people are living with diabetes but are undiagnosed (2017/18).

• In East Surrey and Sussex in 2015/16 there were 4,750 first events of coronary heart disease, 2,250 of stroke and, 700 of heart failure. For West Sussex (2017/18) there were 1,400 stroke admissions, 1,250 admissions for heart failure, and 4,600 admissions for CHD. These figures are total admissions not just first events, and so some of these individuals would not be eligible for an NHS Health Check as they have a pre-existing condition.

1.2.5 Evidence supports the NHS Health Check Programme in the following way

• Reducing blood pressure in all adults with diagnosed and undiagnosed hypertension by 5 mmHg: reduces risk of CVD events by 10%

• Statin therapy to reduce cholesterol by 1 mmol in people with a 10-year risk of CVD risk greater than 10%: reduces risk of CVD events by 20-24%

• Anti-coagulation of high-risk Atrial Fibrillation (AF) patients: averts one stroke in every 25 treated.

If treatment is optimised in AF and hypertension in East Surrey and Sussex the potential savings over 3 years are up to £22 million (Public Health England – size of the prize).

2. Scope of Services

2.1 Aims and objectives of Service

2.1.1The aim of the Service is to address inequalities and reduce premature deaths and ill health from heart attacks, strokes, dementia and diabetes. To underpin the Long Term Plan commitment to prevent 150,000 cases of these conditions and to double the NHS Diabetes Prevention Programme. To improve health outcomes by identifying people at increased risk of CVD, enabling more people to be identified at an earlier stage of vascular change.

2.1.2 The national target of inviting 20% of the eligible population each year to have an NHS Health Check on a 5 year rolling programme, with 75% of those being invited taking up the service, far exceeds recent local activity levels. In recent years the local target has been achieved across the range of providers. Additional NHS Health Checks are delivered through the West Sussex Wellbeing Programme and by nurse advisors within the prevention assessment teams. Activity from all providers will contribute towards achieving the target.

2.1.3 Providers being paid via more than one arrangement or route of activity for delivery of NHS Health Checks will not be considered for delivery of this community NHS Health Check Service.

This approach reduces the risk of paying twice, ensures best use of public funds and supports highest possible impact with the resources available.

2.1.4 The objectives of the service are:

• To offer a service to people aged 40 to 74 who meet the eligibility criteria as set out in 2.3 & 2.4 of the service specification.

• To deliver the NHS Health Check assessment in accordance with the National Best Practice Guidance October 2019 (updated March 2020).

• To measure and assess Service Users' risk factors and identify those who would benefit from further clinical testing and/or management with onward referral into their general practice.

• To offer specific brief interventions to Service Users with lifestyle risk factors and signpost or refer those Service Users to lifestyle support services.

2.2 Service description/care pathway

2.2.1 The NHS Health Check service is designed to provide one to one support to identify risk factors for cardiovascular disease, and signpost Service Users who would benefit from further management, including referring onto other services.

2.2.2 This is a complementary service to that being delivered within the integrated lifestyle service offer of the West Sussex wellbeing programme and the nurse advisors within prevention assessment teams.

2.2.3 The Service Provider will:

• Identify those who are eligible for an NHS Health Check, following a search of general practice clinical system, or opportunistically using a Make Every Contact Count (MECC) approach in line with the West Sussex MECC programme.

https://www.westsussexwellbeing.org.uk/topics/information-for-professionals/making-every-contact-count.

• Target those eligible for an NHS Health Check that are deemed at highest risk such as mental health secondary care service users, substance misuse service users, those with learning disabilities, routine and manual workers, those who are obese, those who smoke and carers. This also includes those with protected characteristics https://www.equalityhumanrights.com/en/equality-act/protected-characteristics.

• Offer the service to those who present for an NHS Health Check, which may be as a result of a formal invitation and to those who self-refer assuming they meet the service eligibility criteria.

• ensure the Service User is fully informed about the NHS Health Check and its implications.

• deliver the NHS Health Check Assessment in accordance with the national best practice guidance [6] as well as NICE guidance as cited in paragraph 3 of this specification.

• measure and assess Service Users' risk factors and identify those who would benefit from further clinical testing and/or management from their general practice

• offer specific brief interventions to Service Users with lifestyle risk factors and signpost or refer Service Users to lifestyle support services.

2.2.4 Where the Service Provider for NHS Health Checks also delivers the annual physical health checks for those with serious mental illness and for those people with a learning disability, they should incorporate the NHS Health Check with these annual checks, for those meeting the eligibility criteria as paragraph 2.3, on a five-year cycle.

2.3 Who is eligible for the service?

People aged 40-74 who are resident, registered with a GP within West Sussex or work within West Sussex are eligible for the service providing they have not under-gone an NHS Health Check within the preceding 5 year period and are not ineligible under the exclusion criteria in paragraph 2.4.

2.4 Exclusion criteria

People diagnosed with:

• Coronary heart disease;

• Chronic kidney disease;

• Diabetes;

• Hypertension;

• Atrial fibrillation;

• Transient ischaemic attack;

• Hypercholesterolemia;

• Heart failure;

• Peripheral arterial disease;

• Stroke;

• People on prescribed statins;

• People who have previously had an NHS Health Check or any other NHS check in England and have been found to have a 20% or higher risk of developing CVD in the next 10 years.

2.5 Interdependencies with other services

2.5.1 The Service Provider will use a Making Every Contact Count (MECC) approach to engage with eligible Service Users. Service Providers should be aware of the other Service Providers within their locality such as neighbouring practices or pharmacies, the West Sussex Wellbeing Programme and Nurse Advisors and work with them to ensure timely initial engagement.

• Service Users assessed as 'low Risk' (CVD Risk score 0-10%, with no abnormal results) should be signposted to local services and pathways detailed at Appendix A.

• Service Users assessed as 'medium risk' (CVD Risk score >10-<20%) should be advised to contact their GP for follow up as per individual GP Practice defined protocol (Appendix B)

• Service Users assessed as 'high risk' (>20% 10 year CVD risk) should be advised to contact their GP for follow up in line with NICE Guidance.

2.6 Information Provision

2.6.1 The Service Provider shall:

• Provide appropriate verbal and written information to the service user, which explains fully what the implications of having a NHS Health Check are.

• Ensure information, support and guidance is available to all wishing to access the Service. This may include interpreting services and or documents produced in different language or formats. https://www.healthcheck.nhs.uk/commissioners_and_providers/marketing/leaflets/.

• Have an understanding of and take account of the needs and requirements of different cultures, religions, race and gender.

2.7 Any activity planning assumptions and caseloads

2.7.1 The Service Provider should:

• Consider seasonal fluctuation, workload, staff capacity and any awareness campaigns they

may wish to run their assumptions.

• Submit an Activity Schedule to Healthcheck@westsussex.gov.uk before the start of each financial year, using the template provided/ attached in Appendix C. Activity schedule should meet the Key Performance Indicators set out in Section 6, including the required minimum of 12 service users per trained individual to receive an NHS Health Check each year (minimum of 1 a month). It is the responsibility of the Clinical Lead for each provider to ensure this is adhered to.

• Inform the Council of any significant disruption to the NHS Health Check Service which is likely to impact on delivery of the Contract such as staff vacancies

• Target mental health secondary care Service Users, substance misuse Service Users, those with learning disabilities, routine and manual workers, those who are obese, those who smoke and carers. This also includes those with protected characteristics https://www.equalityhumanrights.com/en/equality-act/protected-characteristics.

2.7.2 The Service Provider and the Council will monitor delivery against this schedule alongside the Service Specification.

• The Council, at its discretion, may supply the Service Provider with a quarterly or annual performance statement to assist with monitoring.

• The Council and partners across the health and care system in West Sussex maintain an overall oversight and overview of NHS Health Check services. The activity schedule submitted by the Service Provider is subject to agreement with the Council and where necessary. The Service Provider will be contacted by the Commissioner/ Council's representative in order to agree any adjustments required to the activity schedule in advance.

• In the event of higher levels of activity being delivered or forecast for delivery than those set out in the agreed activity schedule the Service Provider is required to notify the council via Healthcheck@westsussex.gov.uk immediately so a solution can be established.

- The Council may apply upper limits on the number of Service Users accessing the service based on the annual activity schedule submitted by the Service Provider and detailed in Appendix C. On this basis, the Service Provider may be directed to limit numbers of Service Users accessing the service for a defined period.

• Payment will be made within agreed levels of activity and the Council reserves the right not to pay the Service Provider for levels of activity that are greater than those agreed in the activity schedule without written advance agreement.

3. Applicable Service Standards

3.1 Applicable national standards and Guidance

Service standards and best practice guidance are located on the national NHS Health Check website at www.healthcheck.nhs.uk.

The Council will notify the Service Provider of new and revised applicable national standards and guidance as they are published on the website. The Council will advise of any changes to be made and the Service Provider will respond to these changes and incorporate them into the delivery of the Programme.

3.2 Applicable local standards

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3.2.1 The Service Provider will:

• Ensure the results of each Service User's NHS Health Check is securely transferred to the Service User's registered GP practice within 2 working days.

• Encourage Service Users not registered with a GP to register with a GP Practice. Retain the Service User's results outcome form to be made available to the Service User's GP should they register within 5 years of their NHS Health Check.

• Advise the Service User to contact their GP practice the next working day if the NHS Health Check is delivered out of regular hours ie evenings, weekends or bank holiday where clinically significant results which require urgent attention have been identified.

• Stop the NHS Health Check and immediately contact the Service User's GP where clinically significant results which require immediate attention have been identified. In the event of this occurring when the GP practice is closed, the Service Provider will contact the Out of Hours GP Service. 3.2.2 Service Providers under this contract must ensure professionals delivering this service have completed the West Sussex approved training programme. This training programme will be provided free of charge through the Council.

The training consists of the following components, all of which need to be completed:

• Completion of the locally developed On-Click e-mentor tool for NHS Health Checks and the assessment. https://learnpublichealth.westsussex.gov.uk/ (this is free for all staff to register and access). A Make Every Contact Count (MECC) module is also available on this platform.

• Training in the point of care testing (POCT) equipment used to deliver NHS Health Checks in West Sussex is available from BHR, info@bhr.co.uk. Service Providers will be issued with a CardioChek machine for this service and will be enrolled onto the external quality assurance (EQA) scheme at this training.

• Each individual delivering the service must familiarise themselves with NHS Best Practice Guidance October 2019 (updated March 2020) PHE NHS Health Check Competency Framework (July 2020) and complete the PHE NHS Health Check Learner & Assessor Workbook (July 2020).

• A face-to-face training session(s) are available on demand should professionals delivering the service require additional support. This would include training on carrying out cardiovascular risk assessment, motivational interviewing and brief interventions in line with PHE NHS Health Check Competence Framework July 2020, NHS Best Practice Guidance October 2019 (updated March 2020) and assistance to complete the NHS Health Check Learner Workbook (2020).Please email HealthChecks@westsussex.gov.uk to make these requests. Providers will also be informed directly as new training opportunities are made available.

3.2.3 On completion of the West Sussex approved training programme, a telephone/video consultation can be arranged with a member of the public health team to discuss.:

• Details of data collection and invoicing, including PharmOutcomes.

• A confirmation the Service Provider has received their CardioChek starter kit and enrolment on to the RIQAS External Quality Audit (EQA) scheme.

• Ensure the Service Provider has all the necessary resources to commence delivery of the service.

This can be supplemented with a site visit if required.

3.2.4 The Service Provider must ensure that trained staff update their knowledge and skills through regular use of the online training and any face-to-face training available. This also is applicable to staff who have had a break in service of longer than 6 months. To maintain competency each NHS Health Check advisor will be required to deliver an NHS Health Check to a minimum of 1 Service User per month.

3.2.5 The Service Provider is responsible for provision of consumables.

3.2.6 The Council reserves the right to request an audit of anonymised NHS Health Checks undertaken and quality assurance based on the seven dimensions of quality set out by West Sussex Public Health (Appendix D)

3.2.7 The Service Provider will be responsible for ensuring staff delivering the service are:

1) DBS checked.

2) Vaccinated against Hepatitis B. Standard guidance requires those carrying out an NHS Health Check to be vaccinated against Hepatitis B due to the potential exposure associated with the cholesterol test that involves a finger prick test. Full protection involves having 3 injections of the hepatitis B vaccine at the recommended intervals initial then at 1 month then at 6 months. Staff may offer the NHS Health Check when they are satisfied that the level of risk is appropriately managed based on the outcome of their employing organisation's risk assessment. feel comfortable. According to The Green Book chapter 18 'A reasonable level of protection can be assumed following the second dose, provided that completion of the schedule can be assured'.

3) Aware of all guidance and where to access it is listed in paragraph 3.1 of the Service Specification.

4) Supported clinically and there is adequate oversight of the quality and delivery of the service.

3.3 Infection Control

3.3.1 Service Providers will have systems in place to manage and monitor the prevention and control of infection in line with the Care Certificate workbook Infection Prevention and Control Standard 15. https://www.skillsforcare.org.uk/Learning-development/inducting-staff/care-certificate/Care-Certificate.aspx.

• Someone with the appropriate knowledge and skills will be the named lead in infection prevention control (and cleanliness) for each provider.

• Policies, procedures, and guidance are required and should be in place including-Standard infection prevention and control precautions; Safe handling and disposal of sharps; Decontamination of reusable medical devices; Single-use medical devices; Safe handling and disposal of healthcare waste; Purchasing, cleaning, decontamination, maintenance and disposal of equipment; Environmental cleaning guidelines.

• Staff should be trained on infection prevention and control.

• Governance arrangements are in place to ensure that key policies and practices are being implemented, updated and adhered to appropriately.

3.3.2 Service Providers will provide and maintain a clean and appropriate environment in managed premises that facilitate the prevention and control of infections.

• Cleaning responsibilities and routines should be clearly outlined.

• Staff should carry out ongoing assessment of the standards of cleanliness.

• Adequate hand hygiene facilities should be available at the point of care.

3.3.3 Service Providers should have a system in place to manage the occupational health needs and obligations of staff in relation to infection.

• How exposure to infections will be managed.

• Prevention of occupational exposures to BBV- including risk assessments of the need for immunisations such as influenza vaccination and Hep B.

• The responsibility of staff to report episodes of illness.

• The circumstances under which staff may need to be excluded from work.

3.3.4 Further information and guidance can be found in the Nice Healthcare-associated infections: prevention and control in primary and community care (updated 2017) here: https://www.nice.org.uk/guidance/cg139.

4. Statutory Requirements

4.1 Applicable Legislation

4.1.1 The Local Authorities (Public Health Functions and Entry to Premises by Local Healthwatch Representatives) Regulations 2013 S.I. 2013/351 set out a number of mandatory public health functions for local authorities from 1 April 2013. These Regulations have been made by the Secretary of State for Health under powers conferred by the National Health Service Act 2006 and the Local Government and Public Involvement in Health Act 2007

4.2 Statutory Guidance

Legal duties exist on offering NHS Health Checks (referred to as 'health checks' in the regulations), the content of the risk assessment, communication of results, data recording, transfer and take up rates.

Legal duties exist for local authorities to make arrangements:

• for each eligible person aged 40-74 to be offered an NHS Health Check once in every five

years and for each person to be recalled every five years if they remain eligible.

• for the risk assessment to include specific tests and measurements

• to ensure the person having their NHS Health Check is told their cardiovascular risk score,

and other results are communicated to them

• for specific information and data to be recorded and, where the risk assessment is conducted

outside the person's GP practice, for that information to be forwarded to the person's GP Local authorities are also required to continuously improve the percentage of eligible individuals taking up their offer of an NHS Health Check.

5. Service Requirements

5.1 Description of the Service

5.1.1 The NHS Health Check assessment will consist of a face-to-face consultation of approximately 30 minutes with the Service User covering the standardised tests, measurements and data set as defined in the NHS Health Check Best Practice Guidance October 2019 (updated March 2020) and listed below:

• Age;

• Gender;

• Smoking status;

• Family history of coronary heart disease;

• Ethnicity;

• Body mass index (BMI);

• Waist Measurement;

• Cholesterol level – Total, HDL, Ratio;

• Blood pressure;

• Physical activity level – using the DH General Practitioner Physical Activity Questionnaire (GPPAQ);

• Alcohol Use Disorders Identification Test score – using AUDIT C;

• Cardiovascular risk score – calculated using the most up to date Q risk calculator, as agreed with the Council;

• Registered GP (if applicable);

• Pulse check for Atrial Fibrillation Screening;

• Dementia awareness;

5.1.2 Communicating Results

The Service Provider will provide:

• A clear communication of CVD risk and advice regarding how the Service User could reduce their modifiable risk factors and check for their understanding.

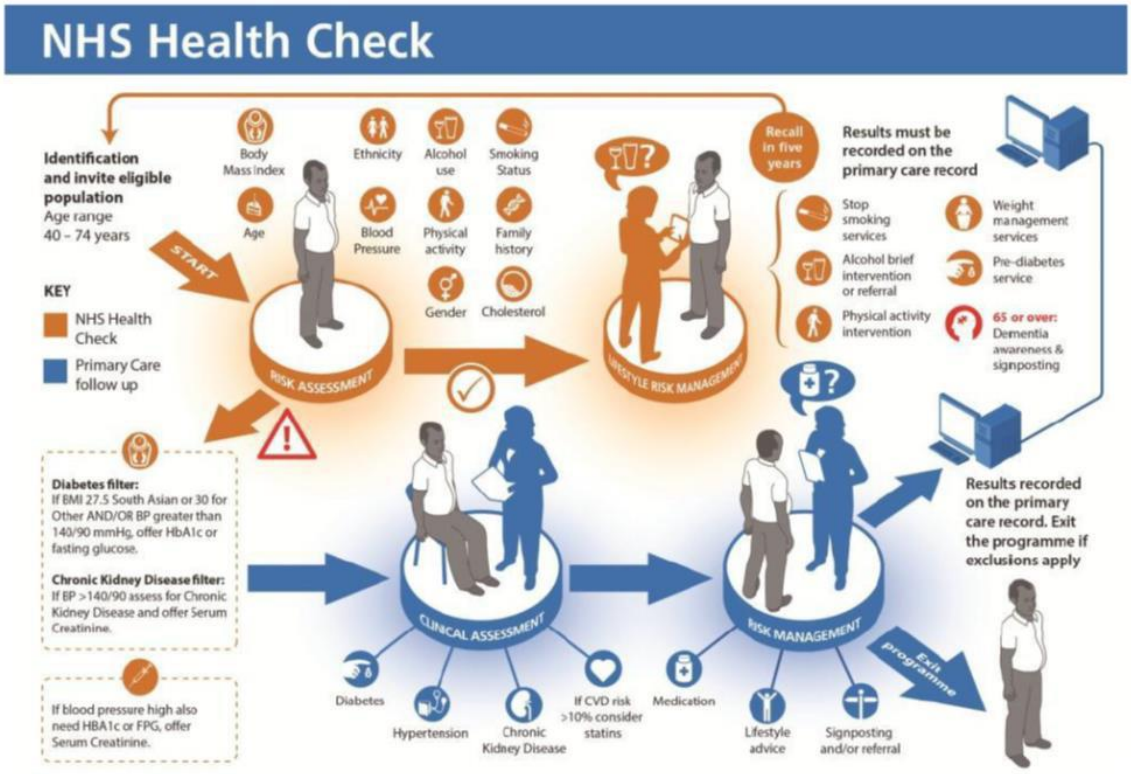
• An assessment of motivation to change health behaviour and requirements for onward support.

• An appropriate onward signposting for further clinical assessment and/or lifestyle support as shown in Figure 1: Overview of Vascular Risk Assessment and Management and local pathways as defined in (Appendix B) of the Service Specification.

5.1.3 Where clinical assessment is required by a GP, advise the Service User that it is the responsibility of the Service User to contact their GP and make an appointment.

Service Users not registered with a GP should be advised to register with a GP practice and share their results. Service Users with clinically significant results requiring further investigation by a GP should be advised they should present at any GP practice and request to be seen under the "Immediate need for treatment" arrangement.

Figure 1. Overview of the vascular risk assessment and management programme



5.1.4 Recording Outcomes and transfer of Results

The Service Provider will:

• Record the results of the standardised tests, measurements, and data set for each NHS Health Check as set out in 5.1.1.

• Record the number of invites sent out monthly and submit this figure

• Have arrangements in place for the secure electronic or paper transfer of the Health Check results to the Service User's registered GP practice.

• Provide a copy of the results to the Service User and retain and securely store the GP copy where the Service User is not registered with a GP to be made available to the Service User's GP should they register within 5 years of their health check.

The NHS Health Check must be recorded on the PharmOutcomes West Sussex NHS Health Check template or for GP providers a West Sussex specified data collection template (until an alternative process is implemented at which point GP providers will need to adopt). This should then be submitted to West Sussex Public Health Department and/or the councils nominated I.T system.

The Service User should be encouraged to complete the satisfaction survey located at the back of the NHS Health Check booklet provided during their treatment programme. These will be used to monitor Service User satisfaction and to inform improvements in service provision, quality, and development.

5.2 Quality Requirements

I. The Service Provider shall fully comply with the Pan-West Sussex Multi Agency Safeguarding Adults Policy: http://pansussexadultssafeguarding.proceduresonline.com/.

and the Pan West Sussex Local Safeguarding Children's Board Inter-Agency Procedures for Children and Young People http://sussexchildprotection.procedures.org.uk.

II. The Service Provider shall ensure that relevant safety alerts and Medical & Healthcare Products Regulatory Agency (MHRA) notices are circulated to staff and acted upon where Necessary: https://www.gov.uk/government/organisations/medicines-and-healthcare- products-regulatory-agency.

III. The Service Provider shall address complaints from Service Users in relation to this service through their own complaints' procedure in the first instance. If further help is required, contact the Council as detailed within the contract.

IV. The Service Provider shall ensure that a process is in place for any member of the professional team to raise concerns in a confidential and structured way.

V. The Service Provider shall participate in the Council's organised audit of service provision.

VI. The Service Provider shall fully co-operate with any national or the Council led assessment of Service User experience.

VII. The Service Provider shall demonstrate that clear and accurate records are kept.

VIII. The Council shall undertake visits to the Service Provider's practice as appropriate as part of quality monitoring, verification of claims and payments and to ensure that the Service Provider is meeting the Service Specification.

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Public Health England has worked with key partners to develop a systems approach to raising standards in the delivery of the NHS Health Check programme (StARS): https://www.healthcheck.nhs.uk/commissioners-and-providers/delivery/nhs-health-check-stars-framework/.

The StARS Framework draws on advice and standards from existing national guidance.

The Council and the Service Provider will work collaboratively to progressively develop the service in line with the StARS Framework.

5.3 Consent

The Service Provider will:

Obtain informed consent from the Service User to (if consent is not given by the Service User then the NHS Health Check cannot take place):

• Share anonymised information for the purposes of local monitoring and evaluation. Summary data will be forwarded for regional and national evaluation.

• Share information and results with Service Users' registered GP

• Share information to assist onward referral to support services organisations

• Consent to sharing anonymised/aggregated activity data, per named Service Provider, with relevant professional bodies, such as the Local Pharmaceutical Committee (LPC) who will offer to support those Service Providers struggling to deliver to contract

5.4 Location of Services

5.4.1 The Service Provider will ensure that premises are risk assessed and suitable for the provision of Health Checks with a consultation room that allows for privacy and dignity as well as have access to hand washing facilities and Broadband.

5.4.2 Premises and staff performing the NHS Health Check need to have standards for infection control and the safe disposal of contaminated waste that complies with current NHS infection control standards. See section 3.3.

5.4.3 The Service Provider will ensure there is a delivery contingency plan in place in case of staff sickness or unforeseen changes to premises.

5.5 Hours of Service delivery

5.5.1 The Service Provider will determine when the service will be offered in order to best meet the requirements of its Service Users in terms of access and to ensure capacity meets demand.

5.6 Equipment and Consumables

5.6.1 The Service Provider must have adequate mechanisms and facilities, including premises and equipment, as are necessary to enable the proper provision of this Service.

The Service Provider will provide the following equipment:

• Scales for weighing should be Class 111– electronic or manual;

• Height measure;

• Tape measure;

• Automated blood pressure machine or sphygmomanometer -the Service Provider must use a machine/s which is on the list of validated devices on the British Hypertension Society (BHS) website http://www.bhsoc.org/bp-monitors/bp-monitors/ If using an automated blood pressure device ensure an appropriate cuff size is used.

• Personal protective equipment.

5.6.2 The Service Provider will be responsible for:

• The provision, storage, maintenance, calibration and servicing all equipment and all associated consumables listed above required to undertake the NHS Health Check.

The Council will provide, free of charge to the Service Provider:

• A point of care testing (POCT) Blood Analyser System and a consumables starter pack which is approved by and compliant with the Medical Devices Agencies requirements for the point of care testing of cholesterol and HDL Cholesterol.

• Full training in the use, maintenance, storage, and quality assurance processes of the analyser system via the system manufacturer.

The machine must be used solely for the purpose of delivering NHS Health Checks and only by staff who are trained to use it. In the event that the Service Provider ceases to deliver Health Checks, the Service Provider must make arrangements to return the machine and case, minus the consumables, to the Council.

5.6.3 The Service Provider will be responsible for:

• Ensuring that staff attend the POCT training and that the system, it's reagents and samples are properly used, stored and maintained in accordance with the manufacturers' instructions

• Maintaining an up-to-date record of all staff trained and competent to use the system

• Ensuring lancing devices used to obtain finger prick blood samples must be single use and disposable.

• Ensuring the internal quality control (IQA) procedures are carried out in order to provide reassurance that the system is working correctly. The Service Provider must, as a minimum, carry out IQA as per the manufacturer's IQA protocol supplied. The Council advises that IQA should be carried out as defined in Department of Health practice guidance Pathology Quality Assurance Review 2015:

www.england.nhs.uk/wp-content/uploads/2014/01/path-qa-review.pdf.

The Council reserves the right to request from the Service Provider, evidence of IQA processes carried out. In line with MHRA Devices Bulletin 2010(02) February 2010, the analyser machine is supported by a dedicated independent quality assurance service, Randox International Quality Assessment Scheme (RIQAS). This external quality assurance acts as an independent verification that the system is providing accurate readings.

5.6.4 The Council will be responsible for:

• Enrolment of the Service Provider on to the RIQAS External Quality Assurance Programme

(EQA)

• The payment of annual EQA support fees for each analyser system supplied to

the Service Provider.

The Service Provider will be responsible for:

• Participating in the EQA process and ensuring monthly returns are made to RIQAS.

• Ensuring the Council and RIQAS is notified of changes in personnel and contact details.

The Council will carry out regular audits of returns and reserves the right to suspend delivery if providers are non-compliant.

5.6.5 The Service Provider will need suitable IT infrastructure to:

• Access the specified data collection templates as detailed by the Council. This template is either available directly to General Practices or via PharmOutcomes for non-GP providers. Service Providers with an existing PharmOutcomes login will use that login for this service. Providers who do not have existing PharmOutcomes provision will be granted access once agreement has been given by The Council that all training requirements have been met.

• Access the West Sussex Wellbeing website, for information for professionals as well as service users.

• Access the Public Health England (PHE) Campaign Resource Centre.

• Facilitate immediate inputting of information.

• Access: www.healthcheck.nhs.uk

• Access: https://www.gov.uk/government/publications/nhs-health-checks-increasing-uptake

• Access to the On-Click e-mentoring Platform. Access to the Onclick platform is restricted to up-to-date secure browsers such as Chrome, Firefox, Safari, IE11 and Microsoft Edge.

• Access to suitable I.T systems to manage appointments.

• Receive electronic referrals via a secure email address. The email address being used needs to be notified to the Council and must be monitored every working day and responded too.

5.7 Mobilisation

Prior to commencing delivery of the service, the Service Provider will confirm to the Council:

• Staff designated to deliver the service have received West Sussex Health Check Core Skills Training and are competent to deliver the service.

• On-going supervision and oversight arrangements are in place.

• Contact details of the clinical lead/responsible person.

• Staff involved in delivering the service are fully aware and understand the relevant requirements, guidance and policies within the Service Specification associated with their function.

• How the provider will promote the service to Service Users.

• Support interdependent functions within the Service Provider's team e.g. Admin Staff are aware the Provider will be offering the Service.

• The service activity for this service for the financial year ahead.

5.8 Reporting of Incidents and Risk Management:

• The Service Provider must report all Serious Untoward Incidents (SUIs) to the Council on the next working day 24 hours of occurrence and provide details of root cause analysis (RCA), recommendations and actions taken as a result.

6. Key Performance Indicators (KPI's) / Service Levels

The following performance indicators need to be measured and reported against

Performance Indicator	Annual Target	Method of Measurement
Number of NHS Health Checks delivered	At least one NHS Health Check is delivered every month	Monthly data reports
% Service User receiving a Health Check from high risk groups. That is those who are current smokers or obese (BMI 30 or over).	At least 30% of those receiving an NHS Health Check are high risk	Monitored quarterly based on monthly data reports
% Service Users returning a satisfaction survey	At least 10% of service users return a completed satisfaction survey.	Monthly data reports

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7. Reporting Requirements and Service Specification Review

7.1 Data reporting and written reports:

Service providers should collect the standardised tests/ measurements and data set as defined in the NHS Health Check best practice guidance October 2019 (updated March 2020).

The service provider will record the data for each NHS Health Check as it is carried out onto the corresponding West Sussex NHS Health Check Template within Pharmoutcomes or for General Practice a specified data collection template.

The Pharmoutcomes system will generate and submit automated reports and claims each month as per schedule B Part 1 of Public Health based services contract.

Specified data collection template for General Practice need to be submitted to healthchecks@westsussex.gov.uk by the first working day of the following month. These dates are in line with national reporting requirements.

The Council reserves the right to request the Service Provider to provide an audit of anonymised NHS Health Checks delivered.

7.2 Service Specification Review

It is recognised within this Service Specification that the Service may be subject to change due to a range of national and local policy initiatives. For example, government guidance and legislation, industry professional standards, NICE Guidance, Office of Health, Inequalities & Disparities (OHID) or West Sussex County Council Policy.

It is the responsibility of the service provider to make the necessary amendments to the service to reflect these changes. The Council will advise the Service Provider of any changes to be made.

This review may also include a review of tariff.

Appendix A

Risk Management/Lifestyle interventions

WEIGHT MANAGEMENT AND PHYSICAL ACTIVITY	ALCOHOL REDUCTION	SMOKING CESSATION
Wellbeing Hubs Arun - 01903 737862 https://arun.westsussexwellbeing.org.uk/ Crawley- 01293 585317 https://crawley.westsussexwellbeing.org.uk/ Chichester 01243 521041 https://chichester.westsussexwellbeing.org.uk/ Worthing & Adur – 01903 221450 https://adur-worthing.westsussexwellbeing.org.uk/ Horsham – 01403 215111 https://horsham.westsussexwellbeing.org.uk/	DrinkCoach – Digital Alcohol Support The DrinkCoach Alcohol Test allows people to anonymously find out if you they drinking at harmful levels and to get advice and information about alcohol. DrinkCoach online coaching is for anyone wanting to reduce their drinking. DrinkCoach is professional, convenient and confidential. People can access the service anywhere and at any time to suit: weekdays, evenings and weekends. All that's needed is a Skype connection.	Full list of WSCC providers can be found here https://www.westsussexwellbeing.org.uk/local-service

Mid Sussex - 01444 477191 https://midsussex.westsussexwellbeing.org.uk/ Hubs will direct Service Users to their local weight management services and monitor their progress.	Visit DrinkCoach.org.uk Anyone living or working in West Sussex can enter the code WSWELL to get the session for free DAWN – Specialist Alcohol Support DAWN, the West Sussex Drug and Alcohol Wellbeing Network, provides support to people of any age, who are looking to reduce or stop their drinking. Young people aged 24 and under can contact the service via: Text: 07779339954 (someone will ring you back) Call: 0300 303 8677 Email: wsypsms@cgl.org.uk Adults aged 25 and over can contact the service via: Call: 0300 303 8677 Email: WestSussex.contact@cgl.org.uk West Sussex Wellbeing The Wellbeing hubs can offer face-to-face support for drinking a bit too much, a little too often. Visit www.westsussexwellbeing.org.uk/alcohol for more information

Appendix B
Referral and follow up

RISK FACTOR	THRESHOLD	ACTION
CVD Risk Score	(Low to Normal) 0-9% and no abnormal results	Reinforce healthy lifestyle advice
	(Moderate) 10 -19% over 10 years and no abnormal results	Advise and reinforce healthy lifestyle. Refer to relevant services and or Wellbeing Hub for Lifestyle support. Refer to GP for further advice and discussion.
	(High) ≥20%	Refer to GP for further investigation and pharmacological interventions if needed
Cholesterol	If Total Cholesterol <7.5 mmols or If TC/HDL ratio >4 mmols but CVD risk is <10%	Offer healthy lifestyle advice, particularly focusing on smoking cessation, alcohol intake, diet and physical activity

	If >= 7.5 mmols or If CVD risk score is >10%	Refer to GP for Familial Hypercholesterleamia
Diabetes Risk	BMI ≥27.5 for Indian, Pakistani, Bangladeshi, other Asian and Chinese ethnicity categories BMI ≥ 30 for other ethnicity categories Y4NDI3OC4xLjAuMTY3NzY4NDI3OC42MC4wLjA. OR BP≥140/90	Refer to GP for HbA1c – See Checking for Diabetes Risk https://riskscore.diabetes.org.uk/start?_gl=1*13hba3w*_ga*NTU2Mjg1NTMzLjE2Nzc2ODQyNzk.*_ga_J1HFNSGEX6*MTY3Nz Y4NDI3OC4xLjAuMTY3NzY4NDI3OC42MC4wLjA.
Blood pressure		
Low	If BP <90/50 with symptoms of dizziness/fainting	Refer to GP, reassure and encourage hydration
	If BP <90/50	Reassure and encourage hydration
Raised	BP ≥ 140/90mmHG or where SDP or DBP exceeds 140mmHG or 90mmHG respectively	Refer to GP for further BP measurement/diabetes filter
High	BP≥ 180/110	Urgent same day referral to GP or A&E
	Automated BP machine displaying error Reading	This may indicate that the BP cannot be picked up because of an irregular heart rhythm i.e. atrial fibrillation. The BP should be checked using an alternative machine if one is available. IF alternative machine is not available or the second machine reads ERROR then refer the Service User to their GP for a PULSE test and manual BP check.
Chronic Kidney Disease	BP ≥ 140/90mmHG or where SDP or DBP	Refer to GP for eGFR

	exceeds 140mmHG or 90mmHG respectively	
	BP≥ 180/110	Urgent same day referral to GP
Pulse	Low pulse with associated symptoms ≤60bpm along with associated symptoms	Refer to GP/Practice Nurse for assessment
	Very High Pulse ≥140bpm	Refer to GP/Practice Nurse for assessment
	Irregular resting pulse taken for 30 seconds To detect if undiagnosed rhythm disorder	Refer to GP/Practice Nurse for assessment

Weight management	BMI 25-29.9 (White European) BMI 23-27.5 (Asian population)	Offer advice regarding healthy eating and increased physical activity. Recommend support for weight loss consider referral to local Wellbeing Hub
	BMI ≥ 30 (White European) BMI ≥ 27.5 (Asian population)	Highlight risks and offer referral for weight management support via Wellbeing Hub
Physical Activity	Activity level ≤ 150 minutes per week/	Offer brief intervention and referral to Wellbeing Hub Activity Co-ordinator

	less than active on GPPAQ Score	
Alcohol	Scoring < 5 on AUDIT- C and two alcohol free days a week	Offer alcohol reduction advice
	AUDIT- C score ≥ 5	Ask remaining AUDIT questions. Total the score for all ten questions and follow the West Sussex Alcohol Care Pathway.
Smoking	Smoker	Offer stop smoking referral to in house service or to NHS service via Wellbeing website.
Dementia	Aged below 65	Include dementia risk reduction message
	Aged over 65	Provide dementia awareness advice and leaflet in accordance with the online training module http://www.healthcheck.nhs.uk.uk/increasing-dementia-awareness-training-resource/

Appendix C

Activity Template

Name of Service Provider:

Date Commencing Delivery:

Financial year activity plans relate to (delete as appropriate):

2023/2024 2024/2025

Please complete this form with your best estimate for invites (where applicable) and the number of checks you estimate you will complete each month until the end of the financial year. Forms to be sent to healthchecks@westsussex.gov.uk.

SERVICE SPECIFICATION Schedule Service Specification for the provision of NHS Health Checks

Month	April	May	June	July	Aug	Sept
No of Invites to be sent out						
No of checks Service Provider expects to deliver						
Month	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
No of Invites to be sent out						
No of checks Service Provider expects to deliver						

Appendix D

West Sussex Public Health Quality Framework for Providers

SERVICE SPECIFICATION Schedule Service Specification for the provision of NHS Health Checks

West Sussex County Council -Public Health

Quality, Performance and Risk Framework- Information for Providers.

AUTHORS: Rachel Loveday- Health Protection Lead and Lesley Wilkes-Healthcare Intelligence Manager

1. Introduction and Background

1.1 The purpose of this document is to share the Key elements of West Sussex Council Quality Performance and Risk Framework to support collaborative working between commissioners and providers. We would like to build a strong partnership approach to quality with existing and new partners; working with them through a shared understanding and commitment to quality. We request support for this collaboration to enable us to maximise the investment in the public health system and to champion high quality in Public Health Services. [1]

1.2 Prevention is crucial to improving the health of the population and to help secure the health and social care services we all value and rely on.[2] Commissioners are responsible for commissioning services that meet the needs of their local populations. It is essential to ensure that these services are effective and that the care commissioned achieves good outcomes, promotes a good quality of life, and is based on the best available evidence.[3]

1.3 No single person or organisation owns quality it has to be co-produced, [4] the provider's relationships with the commissioners is vital, as is the relationship with the people who use our services. It will require collaboration and a shared commitment to truly embed high quality public health services that improve the health and wellbeing outcomes for the population of West Sussex.

2.0 WSCC Public Health Department Definition of Quality:

In order to establish a single view of quality that is clearly understood by public health colleagues and internal and external stakeholders, a review of the literature and guidance has been undertaken.[1,2,3,4,5,6,7,8,9] For West Sussex County Council Public Health going forward-quality will be defined in **7 dimensions**:

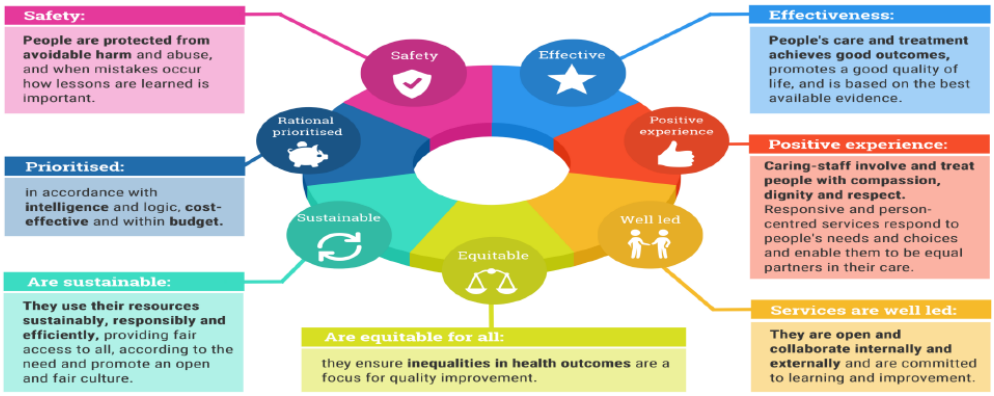


Figure 1 WSCC 7 dimensions of Quality

3.0 Quality, Performance and Risk Reporting Process:

3.1 The West Sussex Public Health Directorate commissions a range of services to improve the local populations' health. Public health is not a risk- free activity, as it could lead to programmes of action that have adverse population health effects, or fail to implement programmes that have significant health benefits.[2] Therefore, it is essential that robust system-wide governance processes are in place to ensure safety and high standards of care are delivered to our residents.

3.2 An important part of the WSCC Quality, Performance and Risk framework is the identification of and response to, issues of concern, risk, and clinical incidents, including serious incidents; to ensure people are protected from avoidable harm and abuse, and how lessons are learned should mistakes occur.

3.3 The aim of the framework is to set out a consistent approach for managing quality and risk. To set out the decision-making mechanisms for monitoring quality, escalating concerns if necessary, and reporting/communicating the actions being taken by the council to improve and mitigate risks.

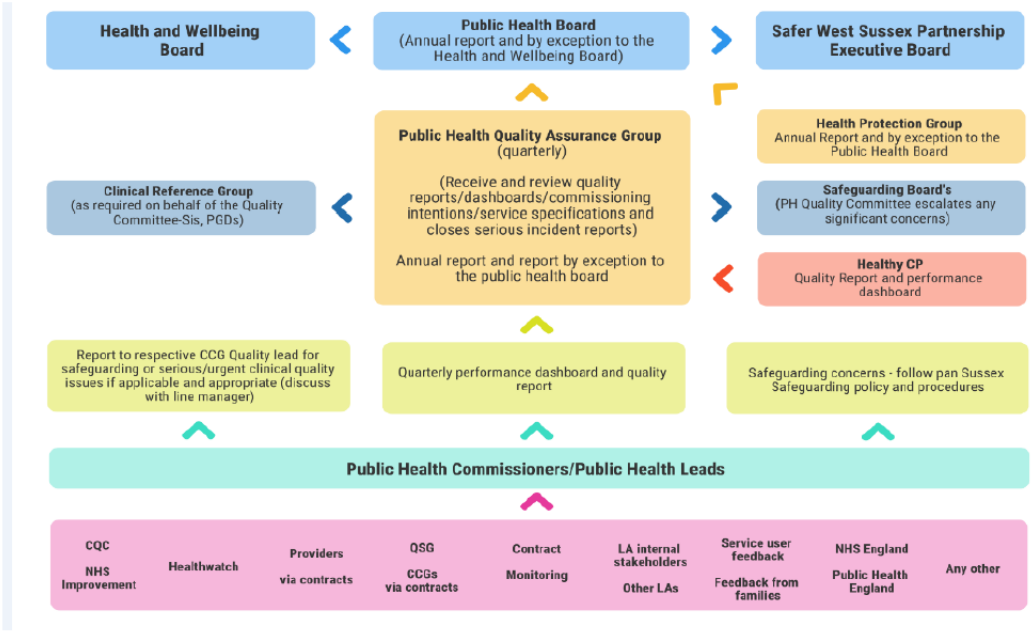
3.4 A quarterly Quality and Performance dashboard will be produced based on performance data and information from routine contract meetings. Examples of the indicators that will underpin the dashboard Appendix A. ***NB the examples of indicators that will underpin the Quality and Performance Dashboard are not exhaustive and it is recognised not all examples will be applicable to all services***

3.5 It is also accepted that not all commissioned services will be in a position to align all their reporting of quality and performance data to a quarterly cycle; consensus on reporting of performance data should be reached in collaboration with the commissioner.

3.5 For all commissioned public health services, **Quality Assurance for individual services is the responsibility of the providers** who should have robust systems, processes, policies and procedures in place to ensure that all quality elements are embedded in their services and are able to tackle any quality issues promptly. The provider should ensure that they inform the commissioner as soon as they discover any quality issue. The provider should manage the quality issue from start to finish and keep the commissioner informed of any progress.

3. 6 As part of their responsibility for quality, the commissioners will provide advice and support to providers to meet the required quality standards.

3.7 Quality, Performance and Risk Reporting Process



7 Dimensions of Quality-Examples that will underpin the dashboard.

NB: The Examples for the Quality and Performance Dashboard are not exhaustive/ nor will all examples be applicable to all services

Dimensions of quality	Quality and performance dashboard (Examples)
1. **Safety**: people are protected from avoidable harm and abuse, and when mistakes occur how lessons are learned is important.	• Serious incident reporting & management • Clinical incident reporting & management • Safeguarding reporting & management. • Clinical and organisational audit • Effective pathways for managing and evaluating clinical risk. • Duty of Candour (regulation 20)
2. **Effectiveness**: people's care and treatment achieves good outcomes, promotes a good quality of life and is based on the best available evidence.	• Quality standards & NICE guidance are used to underpin clinical practice. • Evidence based metrics are used to measure outcomes.
3. **Positive experience:** Caring-staff involve and treat people with compassion, dignity and respect. Responsive and person-centred services respond to people's needs and choices and enable them to be equal partners in their care.	• Feedback from service user involvement forums, friends and family test. • Build person-centred outcomes into the service. • Provides specially designed information resources tailored to the individual's needs. • Identifies and supports carers
4. **Services are well led**: they are open and collaborate internally and externally and are committed to learning and improvement.	• Quality and safety and performance is overseen at board level. • Staff satisfaction surveys. • Staff turnover. • Workforce planning- to ensure at all levels capacity and capability are in place to deliver the service now and in the future. • Clinical supervision is in place and is robust.

	• Competencies are in place for staff and effective education and training is commissioned to meet these needs.
5. **Use resources sustainably:** they use their resources responsibly and efficiently, providing fair access to all, according to need and promote an open and fair culture.	• Allocation of resources is clear, transparent and regularly reviewed, ensuring systems are in place to monitor caseloads and workload to facilitate person-centred outcomes. • Use a wide range of approaches to promote behaviour change and self-care. • Ensure behaviour change and self-management is measured as an outcome.
6. **Are equitable for all:** they ensure inequalities in health outcomes are a focus for quality improvement.	• Ensure the diverse needs of communities and inequalities for access and outcome is assessed and reduced. • Share population data with communities and clinicians to develop a co-production solution for future healthcare needs. • Develop solutions to identifying and meeting unmet need.
7. **Prioritised:** in accordance with intelligence and logic, cost effective and within budget.	• Model individual and locality needs using population health management systems (e.g JSNA) • Have robust business management systems and plans in place, to delivering the service within budget and have systems in place to highlight any emerging risks or barriers to the delivery of services for the population.

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