

DRAFT

SERVICE SPECIFICATION

FOR

NHS HEALTH CHECKS

PHARMACY PILOT

INTEGRATED COMMISSIONING UNIT

NOVEMBER 2016

SERVICE SPECIFICATION

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1 Background

1.1 *National Context*

The NHS Health Check is a Department of Health (DH) national programme for a systematic and integrated programme of vascular risk assessment and management. It aims to identify people between the ages of 40-74 who are at risk of developing vascular disease and offer appropriate lifestyle interventions and treatment to reduce their overall risk.

Vascular disease includes Coronary Heart Disease, Stroke, Diabetes, Kidney Disease, Vascular Dementia and Peripheral Vascular Disease. It affects the lives of over 4 million people in England. It is the largest single cause of long term ill health and disability, impairing the quality of life of many people. These conditions fall disproportionately on people living in deprived areas and in certain ethnic groups such as South Asians. Vascular Disease is the largest single contributor to inequalities in health as well as the life expectancy gap between the most deprived and affluent areas of the City.

1.2 *Local Context*

The NHS Health Checks Service is a statutory service commissioned by Public Health at Southampton City Council for the population of Southampton. 57,000 people are eligible to attend an NHS Health Check in Southampton which means that approximately 11,400 people should be invited each year.

2 Outcomes

2.1 To provide NHS Health Checks as stipulated by the Best Practice Guidance, Programme Standards and appropriate management of diagnosed conditions according to the relevant NICE guidance (http://www.healthcheck.nhs.uk/commissioners_and_providers/guidance/) for the Southampton City CCG population.

2.2 The programme aims to reduce the risk of the development of type-II diabetes, vascular dementia, manifestations of CVD including death from heart attack and stroke or symptoms of TIA, angina, heart failure, chronic kidney disease or loss of limb through peripheral artery disease in the local population.

3 Scope of the Service

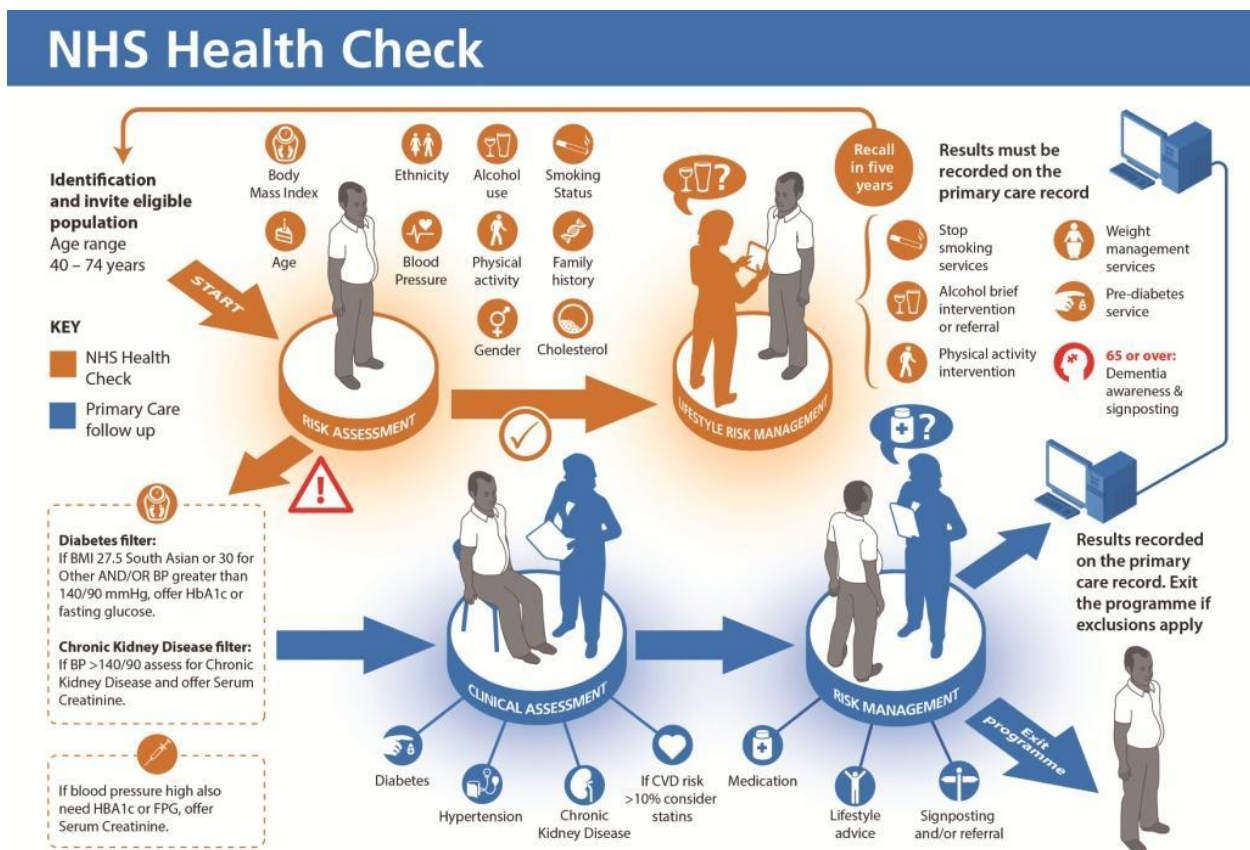
3.1 The eligible population of approximately 57,371 should be invited over a five year period which started in April 2013 (approximately 11,474 people per annum for the Southampton City CCG registered population).

4 Location of Service

4.1. The Service Provider shall be based in their own premises in Southampton. The contractor should provide the service in primary care settings covering the Southampton City CCG population.

5 Service to be provided

5.1 This is an opportunistic programme offered to all eligible patients (40 – 74 year olds without pre-existing CVD); support or onward referral to reduce risk factors.



5.1.1 Cholesterol Test

Bloods taken with Point of Care Testing during the assessment. This does not need to be a fasting cholesterol in order to allow the pharmacy the flexibility to offer appointments throughout the day.

5.1.2 Assessment

Appointments should be 30 minutes and cover the elements below that should be recorded on PharmOutcomes:

- BP
- BMI
- Cholesterol
- Age
- Ethnicity
- Family History
- Physical Activity
- Alcohol consumption – AUDIT
- Smoking status
- Dementia risk reduction **for all patients – not just 65+**

5.1.3 NHS Health Check Results Booklet

Patients should be given an NHS Health Check Results Booklet and their results recorded in it. They can take this away as it has good advice and also contact details for self-referral and further advice.

5.1.4 Informing the Patient of their Risk Score

Patients should be told their risk score and the meaning of this score should be explained.

5.1.5 Brief Intervention

During the assessment specific brief advice/interventions should be given to address elements where the patient is at risk – ie smoking, lack of exercise, poor diet and high levels of alcohol consumption. This should be recorded using the practice clinical system template.

5.1.6 Onward Referral

Patients who are keen to change their lifestyle can be seen in the pharmacy for smoking cessation or referred to behaviour change service appropriately.

5.1.7 Further Diagnosis

- For patients with three high BP readings they should see their GP for hypertension diagnosis and subsequent management.
- **For patients with a high BP or high BMI patients should be referred onto their GP for an HbA1c or blood glucose to determine diabetes or borderline diabetes.**

- 5.2 Training (commissioned by SCC) will be provided for practitioners delivering the service.

Guidance documents can be found on the NHS Health Check website http://www.healthcheck.nhs.uk/commissioners_and_providers/guidance/

6 Service Eligibility Criteria and Referrals

- 6.1 The Service shall be provided to Service Users who meet the following criteria:

- People aged 40-74 years who are at risk of developing vascular disease and do not have a diagnosis of diabetes, CHD, Chronic Kidney Disease, Stroke/TIA.
- Southampton City CCG registered population
- People working in Southampton

7 Safety, Safeguarding and Professional Standards

- 7.1 The Service Provider shall ensure the safety of Personnel and Service Users. This includes lone worker safety policy and practice.

- 7.2 The Service Provider shall carry out a risk assessment which shall include assessment of any risk which may be presented to Personnel, the Service Users or the public in the provision of the Services. The Service Provider is to take all reasonable steps to minimise risks in line with current legislation and regulations.

- 7.3 Where a risk is identified, a plan to ensure safety shall be developed and recorded before contact is made and shared with other relevant Personnel [and Service Users].

- 7.4 All staff and volunteers involved in delivering the service are required to:

7.4.1 Have an up to date enhanced DBS in place.

7.4.2 Have undertaken Safeguarding Adults Training in line with Local Safeguarding Adults' Board guidance and maintain their Safeguarding practice in line with policy updates/changes.

- 7.5 The Service Provider will ensure that:

- 7.5.1 Its Safeguarding policy is compliant with the requirements of the Local Safeguarding Adults' Board

- 7.6 The Service Provider will:

7.6.1 Have the necessary skills and experience to carry out the required procedures – see the Competency Framework

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

7.6.2 Demonstrate compliance with professional standards, including: relevant Ethical Frameworks and policies on Equality and Diversity.

7.6.3 Actively demonstrate Continuous Professional Development for all staff and volunteers involved in delivering the service by attending updates commissioned through SCC.

8 Monitoring

8.1 The Service Provider shall

- Provide the Council with PharmOutcomes information on a monthly basis.

9. Management Information and Performance Indicators

9.1 The Service Provider shall provide the following Management Information for inclusion in the quarterly and annual reports.

| Management information number | Management information | Reporting frequency | Target (if appropriate) |
|-------------------------------|--|---------------------|-------------------------|
| 1. | Number of completed checks | Monthly | 5 |
| 2. | Number of patients seen for check who received Dementia awareness discussion <ul style="list-style-type: none">• XaaD1/67DF NHS Health Check raising awareness about dementia and memory clinics | Monthly | N/A |
| 3. | Number of patients actively referred to behaviour change services for smoking cessation, weight management and alcohol reduction | Annually | N/A |

9.2 The Service Provider shall comply with the following Performance Indicators.

| Performance Indicator Number | Performance Indicator | Reporting frequency | Target |
|------------------------------|--|---------------------|--------|
| 1. | Number eligible patients receiving an NHS Health Check | Annually | 60 |

10 Unit costs

10.1 The unit cost for each completed NHS Health Check is £18.00.