Public Health Agreement for the Health Checks Programme in Pharmacy

For adults aged 40 to 74 years

1 April 2025 to 31 March 2028

BETWEEN Surrey County Council **AND** The Pharmacy

1.0 Introduction

1.1 This specification outlines the more specialised care being offered above that normally provided through essential and advanced services that pharmacies are contracted nationally to provide. No part of this specification by commission, omission or implication defines or redefines essential or additional services.

1.4 The Health Checks programme is included in the Public Health Outcomes Framework and is mandatory for local authorities. It supports Surrey CC's Health & Wellbeing strategy of developing a preventative approach see Health and wellbeing strategy | Healthy Surrey

1.5 The services and fees will be reviewed on an annual basis.

1.6 In the delivery of any services commissioned on behalf of the Council, Providers must demonstrate awareness and be responsive to the accessibility and needs of underserved groups in attempting to access services.

2.0 Background and Summary of Local Needs

2.1 It is well known that people living in deprived circumstances have poorer health than the rest of the population. This is strongly reflected in vascular diseases where people in lower socioeconomic groups tend to suffer earlier and more severe disease. What is perhaps less well known or understood is that vascular disease in some ethnic groups makes a significant contribution to premature death. For example, in the UK, mortality from coronary heart disease is currently 46% higher for men and 51% higher for women of South Asian origin than in the non-Asian population. The occurrence of diabetes in individuals of South Asian origin is twice that of the general population and the occurrence of chronic kidney disease is six times the rest of the population, which in turn also increases their risk of coronary heart disease.

2.2 Surrey is an affluent county but does have geographical pockets of deprivation as well as population groups that experience health inequalities. The programme also provides an opportunity to promote 'proportionate universalism' which is to be done by providing services for all as well as targeting at risk populations. The health checks programme will be rolled out Surrey wide.

3.0 Aims

3.1 The purpose of the vascular check is to identify an individual's CVD risk, for this risk to be communicated in a way that the individual understands, and for that risk to be managed by appropriate follow-up, including being recalled every five years for assessment. The Health Checks programme facilitates behaviour change around modifiable lifestyle factors.

3.2 To reduce the burden of cardiovascular disease in the community by enabling more people to have their CVD risk identified and managed at an early stage of vascular change. This national service is open to everyone aged between 40 and 74

3.3 Offer the opportunity to make significant inroads into health inequalities, including socio-economic, ethnic and gender inequalities.

3.4 To sustain the continuing increase in life expectancy and reduction of premature mortality that is under threat from the rise in obesity and sedentary living.
Patient groups excluded from the programme

- CHD
- Stroke
- CKD stages 3-5
- Diabetes
- Atrial fibrillation
- Hypertension
- Familial hypercholesterolaemia
- Transient Ischaemic attack (TIA)
- Heart failure
- Peripheral Arterial Disease (PAD)
- Hypercholesterolaemia treated with statins

3.5 To increase population awareness of dementia specifically among 65 to 74 year olds

3.6 To identify level of potentially harmful drinking

3.7 NHS Health Check Programme Standards

The NHS Health Check programme standards were updated in July 2020 (NHS Health Check - National guidance). The ten standards encompass three key processes for community pharmacy to focus on; risk assessment, risk communication and risk management. Each process is detailed below.

3.9 Risk Assessment

3.9.1 To offer adults access to an individual risk assessment through a number of different validated strategies

3.9.2 To promote healthy lifestyle advice focusing on potential benefits of reducing vascular disease risk

3.9.3 To detect undiagnosed T2DM facilitating early implementation of prevention strategies and vascular disease intervention

3.10 Risk Communication

3.10.1 Offer all adults undergoing a risk assessment, appropriate feedback of the results with subsequent care planning (i.e.to simply and effectively communicate their current risk of vascular disease). Patients will have the opportunity to have their results explained clearly to them, and implications of any results outside of normal ranges.

3.10.2 To agree an action plan designed to reduce risk of incident vascular disease

3.10.3 To consider onward referrals to locally commissioned lifestyle services where appropriate. [See Appendix 3].

3.10.4 To provide patient with advice to go back to their GP in order to gain onwards referral to NHS lifestyle services such as the National Diabetes Prevention Programme, and the NHS Digital Weight Management Programme. [See Appendix 3].

3.11 Risk Management

3.11.1 To integrate activities of the programme with primary prevention activities in the general population

3.11.2 To ensure those identified as high risk of T2DM are offered appropriate diagnostic testing delivered according to agreed Standard Operating Procedures (SOPs)

3.11.3 To ensure the overall programme addresses potential inequalities in healthcare

4.0 Assessment

All patients attending the pharmacy for a health check will be assessed for their CVD risk using the CVD risk tool stated in the 'NHS Health Check Best Practice Guidance' document. The following information will be collected and investigations carried out (this list should be updated to reflect the requirements of the recommended CVD risk tool):

- Blood pressure
- Pulse rhythm check (**see Pulse Check best practice guidance note at end of this specification)*
- Smoking status
- BMI
- Physical activity levels (GPPAQ questionnaire)
- Total cholesterol level
- HDL cholesterol level
- HBA1C (for those at high risk of diabetes)
- Family history of diabetes and premature heart disease
- Ethnicity
- Postcode (to enable deprivation score to be calculated)
- Alcohol (Audit C screen) – see appendices
- Dementia awareness for 65–74-year-olds (use NHS Health Checks Dementia Awareness Booklet) – see appendices

5. 0 Scope and Definition of Service

5.1 The service is primarily a preventive one; **it is not intended for those people who already have vascular disease, e.g. people with existing diagnosis of diabetes, hypertension, heart disease, stroke, TIA, CKD.** It is assumed that these people will be on the appropriate disease registers and receiving treatment as necessary. Anyone on high risk register is excluded.

5.2 It is expected that the service will be delivered proactively in a structured and systematic way and can include work outside of the pharmacy with workplaces for example. This should be done in liaison with Surrey CC public health team.

5.3 The pharmacy will deliver checks opportunistically and will **deliver a minimum equal to 8 Health Checks a month**. Those failing to achieve this target will receive support from Surrey County Council and the LPC to improve performance.

5.4 The pharmacy will identify and risk score patients with high CVD risk.

6.0 Service Outline

The Pharmacy will:

6.1 Ensure that only appropriately trained staff provide the service. (See item 7.1)

6.2 Ensure that all equipment used is maintained and accurately calibrated in accordance with manufacturers' guidelines and MHRA guidelines as a minimum; 'Management and use of IVD Point Of Care testing equipment Guidance Document Blood Pressure management devices MHRA Blood Pressure Management devices . Also see NHS Health Checks Programme Standards.

6.3 **It is mandatory that you provide results via the monthly EQA reports requested by BHR Biosynex as the provider of your Point of Care testing and consumables.**

6.4 Complete a cardiovascular risk assessment (QRisk) using the recommended tool as per the 'NHS Health Check Best Practice Guidance' document.

6.5 Be able to identify eligible clients confirming age of client, ie aged 40 – 74 years who are not currently having treatment for diseases listed in item 3.4.

6.6 Undertake a standard assessment, based on the following questions and measurements: height, gender, ethnicity, weight, hip/waist ratio, pulse rhythm check current medicines, age, family history, smoking and blood pressure and a blood test for total / HDL cholesterol. Those who have been identified at risk of diabetes or kidney disease may then have further blood and urine tests (see algorithm, Appendix 1)

6.7 Communicate the risk (high, moderate, low) to people, with appropriate advice, support and interventions depending on the level of identified risk. If the ten- year risk is 10% or greater, the individual should be referred to their GP for further assessment and management. See Additional guidance: Overview | Cardiovascular disease: risk assessment and reduction, including lipid modification | Guidance | NICE

6.8 Ensure that all patients receive lifestyle advice on how to maintain/improve their vascular health. Patients identified at high risk will require further investigation and (if applicable) signposted to a lifestyle management programme e.g. smoking cessation, weight management, healthy walks.

6.9 Involve the patient actively in agreeing what advice and/or interventions are to be pursued.

6.10 Make decisions in partnership with the patient and with the patient's informed consent.

6.11 Have the flexibility to decide how to implement the vascular risk assessment programme – for example through allocated appointment times or open clinics. It may be that there are times when opportunistic assessment can take place.

7.0 Training, Governance and Requirements

7.1 The county council will provide training **three times a year** and support for all staff delivering the Health Checks Programme. Pharmacy teams must have a planned, regular programme of education, training and support for their staff. It is also expected that the level of training required for all staff providing this service specification is identified and provided by SCC.

7.2 Healthcare staff delivering the service will be required to demonstrate their professional eligibility, competence and continuing professional development in order to remain up-to-date and deliver an effective service which is culturally appropriate.

7.3 Practitioners must have the required competencies for the risk assessment and risk communication process at an appropriate level. See **Workforce competencies:** NHS Health Check - Training

7.4 Pharmacy teams should ensure safe staffing capacity at all times.

7.5 Services will be structured with consideration to clinical governance issues where appropriate including:

- Clear lines of responsibility and accountability.
- Participation in quality improvement activities where appropriate.
- Adherence to policies and procedures, and consideration given to risk management.
- A commitment to further training for staff where necessary and maintenance of skills.
- Procedures for all professional groups to identify and remedy poor performance.
- The use of clinical guidelines is considered to be consistent with good practice.

8.0 Performance Monitoring and payment

8.1 Payment will be made monthly in arrears.

8.2 All claims are made via the PharmOutcomes portal made available by the public health team.

8.3 See Appendix 2 for payment structure.

8.4 The Council has the right to audit a pharmacy against the claims received. Reasonable notice will be given to the pharmacy prior to the audit

8.5 By providing this public health service you agree to sharing of anonymised activity data with Surrey LPC for the purposes of service development.

9.0 Point of care testing equipment

9.1 Pharmacies will be provided with a budget of up to £2750 to purchase point of care testing equipment and support to carry out Health Checks. This will be a one-off payment claimable in the first quarter of service delivery. Approval to purchase equipment is required from Surrey County Council. Receipt for the equipment should be provided, and this amount will then be added to the next monthly payment. This funding is subject to ongoing activity monitoring. The equipment purchased must be able to measure cholesterol and HbA1c and be in line with the POCT MHRA Guidance documents in the appendices. If following ongoing discussion, training and support from the public health team, the pharmacy is not able to achieve the minimum required number of health checks (as per 5.3), ceases to provide health checks to patients and there are no plans for future provision, the situation will be discussed with the pharmacy and arrangements may be made to re-allocate the equipment for use in another location.

9.2 Where an online portal is provided by Surrey County Council for submission of EQA and IQC results, the provider is responsible for submitting the data as per the manufacturer's guidelines. Failure to submit IQC and EQA data as required could result in a review of the service and reallocation of POCT equipment.

9.3 The pharmacy will purchase consumables, maintain the equipment in terms of calibration, and internal and external quality assurance.

9.4 Pharmacy providers should ensure:

- only staff who have been trained (by a competent trainer) use the POC equipment. Training is available via our supplier and can be arranged through Surrey Council on an ad-hoc basis.
- That an appropriate internal quality control (IQC) process is in place up-to-date register of trained/competent operators
- That there is a named POCT coordinator in the pharmacy
- That records of results of quality control performed are maintained
- That they evidence regular EQA on a monthly basis.

Appendices

Appendix 1. Health checks pathway

Best Practice Guidance 2019:

https://www.healthcheck.nhs.uk/commissioners-and-providers/national-guidance/

MHRA POC Management and Guidance

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/371813/Management_of_In_Vitro_Diagnostic_Medical_Devices.pdf

QRisk

http://www.qrisk.org/

Audit C Questionnaire :

AUDIT-C for Alcohol Use

Appendix 2. Payment Structure

NHS Health Checks

£30 per NHS Health Check completed. A completed NHS Health Check is defined above and comprises a risk assessment (including risk assessment for diabetes, hypertension & CKD, dementia prompt and Alcohol AUDIT C as required), and the appropriate instigation of risk management as defined by the Best Practice Guidelines. See Appendix 1

Appendix 3: Onwards signposting to lifestyle services.

Weight management

One You Surrey is the free adult (18 years and older) lifestyle service commissioned by Surrey County Council Public Health. The service offers a range of programmes such as Slimming World, Gloji Groups and Man v Fat that are delivered online or in the community to support adults with a BMI greater than 30, or greater than 27.5 if they are from a Black, Asian and Minority community. **Patients are able to self-refer if signposted to the One You Surrey website.**

NHS Digital weight management programme: The NHS Digital Weight Management Programme is provided by NHS England. It supports adults living with obesity who also have a diagnosis of diabetes, hypertension or both, to manage their weight and improve their health. The programme is available for anyone who has a BMI greater than 30, and 27.5 for people from Black, Asian, and minority ethnic backgrounds. To access this, the individual must have a smartphone, tablet, or computer with internet access. **Please signpost the patient to their GP in order to be referred through to the programme.**

NHS Diabetes Prevention Programme (DPP): Unlike type 1 diabetes, type 2 diabetes is largely preventable through lifestyle changes. The Healthier You NHS Diabetes Prevention Programme, also known as the **Healthier You** programme, identifies people at risk of developing type 2 diabetes and refers them onto a nine-month, evidence-based lifestyle change programme. The Healthier You programme is available both as a face-to-face group service and as a digital service. When referred into the programme, people are free to choose between the two. This service is free and available across Surrey and nationwide, based on a set of **eligibility criteria**. **Please signpost the patient to their GP in order to be referred through to the programme.**

Smoking support

One You Surrey is the Council's commissioned Adults Healthy Lifestyle service which offers free, evidence-based stop smoking support. The service offers 12 weeks of behavioural support, as well as free access to quitting aids such as NRT and vape starter kits. **Patients are able to self-refer if signposted to the One You Surrey website.**

Alcohol support

i-access is the main service commissioned by Surrey Public Health for adults aged over 18 years who use drugs and/or alcohol. It is led by the Surrey and Borders Partnership NHS Foundation Trust (SABP) who subcontract VIA (formerly known as Westminster Drug Project) for certain elements of the contract. **Patients can self-refer if signposted to the i-access website.**