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**Pharmacy Health Checks:
Views and experiences of
Local Pharmaceutical Committees and pharmacists**

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Executive summary

The Department of Health in England included community pharmacies as one of the providers of the NHS Health Check programme, at its launch in 2009, but little is known about the overall provision of NHS Health Checks at national (England) level. This study sought to determine various aspects of service commissioning, including fees, support and training provided, from the perspectives of both Local Pharmaceutical Committees and pharmacist providers.

Two questionnaires were distributed in November 2014, one to all 76 Local Pharmaceutical Committees (LPC) in England and one to 30 selected community pharmacists known to be providing NHS Health Checks.

42 (55%) LPC members responded, representing 83 Local Authorities, of which 15 respondents indicated pharmacy NHS Health Checks were commissioned in 22 of the areas they covered. Four indicated that pharmacy Health Checks were commissioned directly (not via the LPC) and five that Health Checks had been de-commissioned in their area. 38 LPC respondents (91%) believed there was a need for pharmacy Health Checks in their area and 36 (86%) considered local pharmacies would be willing to deliver the service given the opportunity.

12 pharmacists responded and indicated that on average Health Checks took up 12 minutes of pharmacist time and 26 minutes of other staff time. LPC respondents indicated that most pharmacists were paid between £20 and £30 per Check. The training provided varied but was mostly rated highly by pharmacists receiving it, with behaviour change techniques receiving the lowest rating. Support was also varied but again generally rated highly, except for provision of additional computers, which was infrequent. A wide range of promotional methods were used, with individual letters to patients being less well rated for effectiveness than posters/leaflets, mass media or GP-led promotion.

Data were recorded electronically with most systems generating a referral to the client's GP. Pharmacists received no direct feedback from GPs, but did note instances of patients having relevant prescriptions initiated, new diagnoses or changing lifestyle after the Health Check.

Many respondents, particularly from LPCs, were of the view that commissioners preferentially offered the NHS Health Check to general practices.

The potential for reaching a different population from those seen in general practice by delivering NHS Health Checks through community pharmacies appears to be underutilised.

Background

The Department of Health in England included community pharmacies as one of the providers of the NHS Health Check programme, at its launch in 2009. This national programme is designed to assess an individual's risk of developing coronary heart disease, stroke, diabetes or chronic kidney disease and targets the entire population aged between 40 and 74 years and is supported by Public Health England. Commissioning of pharmacy-based NHS Health Checks was initially the remit of Primary Care Trusts, but moved to Local Authorities in April 2013. Some areas took the opportunity from the start to involve pharmacists in this programme. Other areas do not use pharmacies to provide NHS Health Checks at all.

Only one evaluation of NHS Health Checks provided by pharmacies has been published¹, but other studies have shown that most pharmacists feel reasonably confident in their ability to provide Health Checks², although there are inevitably some barriers to involvement³.

Little is known about the overall provision of NHS Health Checks at national (England) level, even within the national programme at PHE. A national survey of LA commissioners is ongoing which should provide information about which providers (pharmacies, general practices, other providers) have been commissioned to deliver Health Checks. However more detailed information about the varied commissioning methods and support, training, fees provided etc for community pharmacy providers is needed to enable an evaluation of the service to take place. This study sought to determine various aspects of service commissioning, including fees, support and training provided, from the perspective of the pharmacy profession to complement the LA survey.

Objective

To assess the commissioning of NHS Health Checks from community pharmacies, training and support offered by commissioners, data capture and referral methods, from the perspectives of both Local Pharmaceutical Committees and pharmacist providers.

Methods

Two questionnaires were used, one distributed electronically and by mail to all Local Pharmaceutical Committees (LPC) in England and one to selected community pharmacists known to be providing NHS Health Checks. The study was conducted in November 2014.

The first asked whether or not NHS Health Checks are commissioned from pharmacies, reasons for failure to commission, willingness to provide, plus details of any commissioned services in terms of:

pharmacy numbers/selection processes, training and support provided, target populations, promotional methods, fees, data capture methods and referral procedures.

The second sought pharmacists' views on providing NHS Health Checks, training and support provided, promotional methods, data capture methods, referral procedures and uptake. It also requested additional information on whether and how NHS Health Checks are linked to other services provided by the pharmacies, the staff involved and time spent on delivering Health Checks. This questionnaire was distributed electronically to between one and three pharmacies (n=30) in areas where information from the LPC indicated the service was provided and also pharmacists working for a national chain were also provided with access to the questionnaire.

Results

Health Check provision

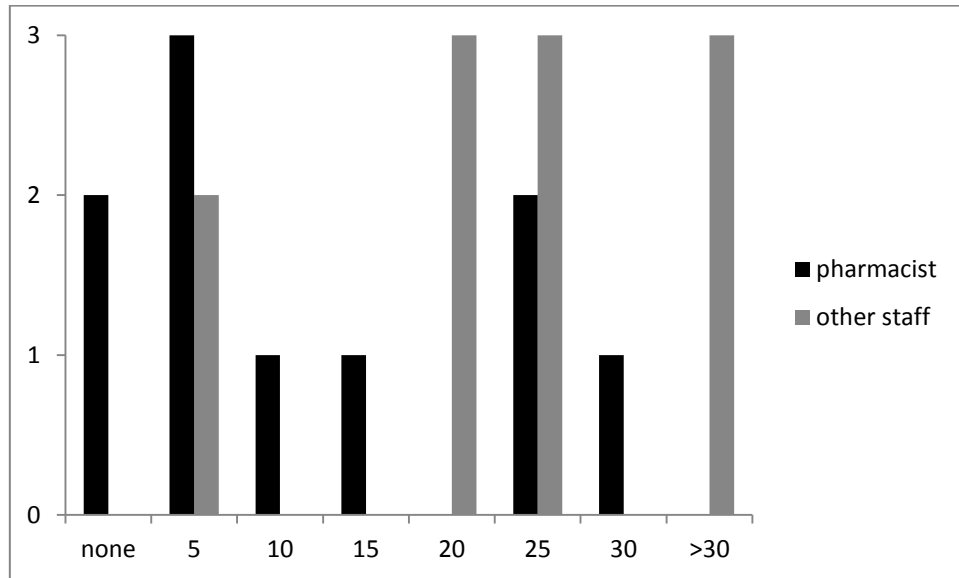
The LPC questionnaire was distributed to all 76 LPCs with 42 being returned (55%), covering 83 (55%) Local Authorities. Of these only 15 respondents had commissioned provision of NHS Health Checks in their area, in 22 (27%) Authorities. There were 14 who provided information on the numbers of pharmacies delivering the service. In seven LPC areas between 10 and 25 pharmacies were commissioned, but in a further seven, there were over 30 pharmacies involved. Factors affecting selection of pharmacies by commissioners were: location in area of high deprivation (7), provision of other services (7) and pharmacy reputation (3).

Four further respondents indicated that pharmacy Health Checks were commissioned directly (not via the LPC) and five said that Health Checks had been de-commissioned in their area.

Twelve respondents indicated that services were not commissioned because of GP domination, four that other providers were delivering the programme in their area, two offered budgetary reasons, in one area a pilot had not been successful and one area had decided not to commission because of poor uptake elsewhere. However 38 of the 42 LPC respondents (91%) believed there was a need for pharmacy Health Checks in their area and 36 (86%) considered local pharmacies would be willing to deliver the service if they had the opportunity. Mostly respondents considered that there was a need for pharmacy Health Checks because of failure to reach target numbers through GP provision and several mentioned the different reach of pharmacies compared to general practices.

All of the 12 pharmacist respondents provided information about the staff involved in providing NHS Health Checks and ten about the time they take. In 11 pharmacies, at least one pharmacist (the manager) was involved and in three a second pharmacist, but in one pharmacy the only person

involved in delivery was a technician. Medicines counter assistants were involved in three of the pharmacies. The estimated time involved in delivery is shown in the figure below.



The data suggest that on average pharmacists spent 12 minutes and other staff 26 minutes in providing Health Checks. Nine respondents also provided information on the frequency of provision, which was fewer than 5 per week in four pharmacies, 5 to 9 in a further four and ten or more in the ninth.

Fourteen LPC respondents provided information about fees, 12 indicated that pharmacists were paid between £20 and £30, but one gave a fee of £13 and one £39 to £42 for the three LAs covered by the LPC. Thus there appears to be a three-fold difference in payments for this standard service.

Training and support

Respondents' reported frequency of provision of training for delivery of Health Checks is shown in the table below, together with ratings provided by pharmacist responders about its quality. LPC respondents' mean rating of training overall was 3.8 on the scale of (1 = poor to 5 = excellent).

Element of training	LPC responses (n=15)	Pharmacist responses (n=12)	Pharmacist rating of training (1 = poor to 5 = excellent)
CVD risk assessment	15	8	4.5
Near patient testing	13	9	3.7
Behaviour change techniques	15	9	3.6

In addition, 10 pharmacists reported receiving training in identifying clients (rating 4.1), eight in communicating CVD risk (rating 4.0) and one also reported additionally completing CPPE training.

The different support provided for delivery of Health Checks is shown below, with pharmacist ratings. Nine pharmacists also reported receiving support with referral processes. LPC respondents' mean rating of support overall was 3.5.

Element of support	LPC responses (n=15)	Pharmacist responses (n=12)	Pharmacist rating of support (1 = poor to 5 = excellent)
Additional computer	2	3	3.2
Point of care equipment	12	9	4.1
Quality assurance procedures	6	9	4.3

The promotional methods used area shown below, together with pharmacist ratings of perceived effectiveness. The LPC respondents' mean rating of promotional methods was 2.9.

Promotional method	LPC responses (n=15)	Pharmacist responses (n=12)	Pharmacist rating of method (1 = poor to 5 = excellent)
Leaflets	7	8	3.8
Posters	12	6	4.5
Mass media	10	4	3.5
Via GPs	9	6	3.8
Individual letters to patients	7	7	3.0

Several pharmacists described how they had used promotional materials provided: large window displays (3), bag stuffing (2), or developed their own: "individual patient letters using info from pharmacy database" (1). Other external mechanisms were described by both pharmacist and LPC respondents, for example: large banner, presence at local show, 'feather flags' outside pharmacies.

Recording, referral and feedback

All 15 LPC respondents indicated that electronic methods of recording were in use, with seven of these indicating the system was PharmOutcomes. The others indicated a variety of systems. Nine of the pharmacists also indicated they used electronic systems. Ten LPC respondents indicated that letters were sent to GPs for referral, with ten pharmacists indicating that these were generated by the computer system and sent electronically through the system (4), e-mailed (2) or delivered by

other methods. Only one relied on the patient to take the letter to the GP. Two also indicated that they would either phone or take the patient to the surgery if CVD risk score was very high.

Relevant additional services were provided by most pharmacies: smoking cessation (8), alcohol screening and brief advice (9) and weight management (3). However not all pharmacists referred clients to these services (7, 5 and 3 respectively). Two pharmacists said that linking services worked well, but two also indicated that the Health Check did not link well to the MUR service, because Health Check clients were not usually on long-term medicines.

Eight pharmacists indicated that they had had some feedback about the NHS Health Check service, mostly via prescriptions and patients, rather than directly from practices, six of whom indicated that patients have commenced treatment for hypertension and/or diabetes. Two others indicated patients told them of improved health due to lifestyle changes.

Additional comments

Several comments from LPC respondents indicated that preferential commissioning from general practices was in place which they considered unjustified. For example:

“A pilot was undertaken in a small number of pharmacies being those in areas where GPs were not providing NHS Health checks in 2013. Outcomes were very positive with pharmacies providing high quality services to a large cohort of patients. As a result of the pilot GPs who had previously not provided the service undertook to provide NHS health checks and pharmacies were no longer commissioned to do so. GPs and LMCs are against pharmacies providing the services quoting loss of GP incomes. LCC tendering process in 2014 was a closed bidding process solely to GPs - no other providers were able to submit bids to provide the service.”

“Pharmacies have previously provided the service and were doing relatively well, the reasons for moving the service to solely GPs was not particularly well ratified, and the GPs are not doing any better. Joint commissioning bringing GPs and pharmacies working together would have a better success rate and catch a bigger percentage of the population. Pharmacies are equipped and ready to provide, providing the payment is on the same rate as GPs.”

One pharmacist respondent also indicated that GP Health Check were regarded preferentially by commissioners:

“Too heavily biased towards GPs. the letters they send out are heavily biased towards the patient choosing the GP scheme even though pharmacy is listed as an option.”

Many LPC respondents were of the view that pharmacists were willing to provide the service:

“Contractors have asked about the opportunities.”

However one did indicate the lack of evidence for Health Checks in general as a potential reason for the service not being commissioned, while another expressed concern about delivery:

“NHS Health Checks are a complex service to deliver well and there are scant examples of where there has been consistent and sustainable delivery. We would need to be assured that we were not replicating poor examples of service implementation elsewhere before progressing.”

Conclusion

Although pharmacies seem to be an ideal location for providing this national service, with potential for reaching a different population from those seen in general practice, the opportunity to do so seems to be underutilised (62% of LPC respondents said the service was not commissioned locally). Where it is commissioned there is considerable variation, particularly in training provision, fees, promotional methods and support provided, although uniformity of this national service is desirable⁴. Pharmacists do not appear to receive direct feedback from practices, after referring patients to them, but based on patient feedback or prescriptions, indicate positive outcomes have been achieved.

Limitations

This study sought views of all LPC representatives, however only 55% responded. The pharmacist survey involved a small number selected mainly from the LPC areas where Health Checks were known to be provided, but the number of responses was also low.

Acknowledgements

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Ethical considerations

The study was approved by Medway School of Pharmacy Research Ethics Committee.

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