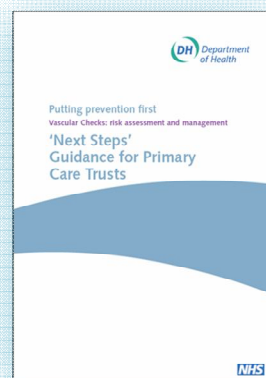
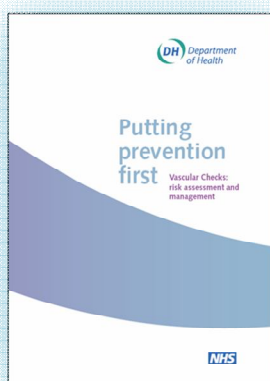


Vascular Risk Assessment (Vascular Checks) *- a new Local Enhanced Service*

Part 1 Background information

Version 1.2

February 2009



Guidance prepared by PSNC to support
Local Pharmaceutical Committees

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About this guidance

This guidance has been written to support LPCs in getting a community pharmacy Vascular Risk Assessment (VRA) service commissioned. It contains a wealth of information and links relating to VRA, setting up the service, standards, assessment of costs, and much more.

Part 1 of the guidance contains background information to support LPCs' preparation prior to developing a local VRA service.

Part 2 supports LPCs with making the case for a VRA service commissioned from community pharmacy. It provides a step by step approach to making a bid. Not all steps may be relevant in your area, depending on local circumstances. This section also includes a number of templates to support LPCs in the bidding process.

Part 3 of this guide contains financial spreadsheets and costing material to assist LPCs in developing an effective bid.

As this is a working resource for a new and evolving Enhanced service and the documents contain a large number of embedded links to other resources, they are only available in electronic format from www.psnc.org.uk.

If you have any comments on this guidance or suggestions on how it may be improved please contact alastair.buxton@psnc.org.uk.

Introduction and historical context

Where did it all start?

The NHS National Screening Committee (NSC) has for a long time held the view that population screening for *diabetes* is not an effective intervention, but some targeted screening of at risk populations may prove beneficial in certain circumstances.

The Diabetes, Heart Disease and Stroke (DHDS) Pilot Prevention Project, funded by the Department of Health, assessed the feasibility of screening for Type 2 diabetes in primary care between October 2003 and September 2005.

A significant idea to emerge during the course of the DHDS Pilot Prevention Project was the concept of thinking in terms of 'the vascular syndrome', as opposed to individual diseases such as coronary artery disease or diabetes. People who happen to be diagnosed as having diabetes almost always have vascular disease and the prevalence of diabetes in people with, for example, coronary artery disease is significantly higher than in the general population.

Another important theme was to move away from tackling risk factors, either singly or in combination, rather to focus on people at risk. Therefore, diabetes can be viewed as another risk factor for vascular disease, as well as a condition in its own right. Also, controlling the risk factors for vascular disease is seen as being as important as the management of blood glucose levels in people with diabetes. This finding was included in the proposal for a *Vascular Disease Risk Factor Assessment and Management Programme* – submitted to the NSC meeting in November 2005.

As a result of the DHDS prevention project, the NSC recommended to the four Chief Medical Officers, the introduction of a *Vascular Risk Management Programme*, in which the whole population (over 40 years) would be offered risk assessment that could include measurement of risk factors such as blood pressure, cholesterol and glucose.

A number of different options were considered by the NSC including:

1. self-assessment of risk through the NHS Life Check Programme;
2. record-based assessment to identify people at highest risk who are not receiving comprehensive risk advice and management. This would involve interrogation of GP records, basing assessments on data already held on individuals; and
3. primary care population-based risk assessment which would offer those who are not at highest risk, as identified by record-based assessment, the opportunity of risk assessment.

These developments clearly provide an opportunity for community pharmacy to play a role in vascular risk assessment, specifically by providing a venue for option 3 – the population-based risk assessment. This would involve a service that assessed vascular risk in the 40+ target population, who are not in regular contact with their GP, hence will not have been assessed by the record-based approach.

PSNC identified vascular risk assessment (VRA) as a target service for community pharmacy provision in 2006 and has been lobbying the Department of Health and other key influencers to ensure inclusion of pharmacy within government plans since that time.

A draft Enhanced service specification has been developed and was submitted to the Department of Health (DH) for consideration in 2007.

Putting prevention first

In April 2008 DH published *Putting prevention first. Vascular Checks: risk assessment and management* which announced the development of a VRA service across England, commencing in April 2009. Two days after that announcement DH published its pharmacy White Paper, *Pharmacy in England - Building on strengths, delivering the future*, which highlighted the role of community pharmacy in the provision of VRA.

The DH Vascular Team has subsequently provided more details on the national programme and has commissioned NHS Improvement to provide support to PCTs in rolling out the programme. As the programme is still in development, including a national branding, the term Vascular Risk Assessment will be used in this document.

We anticipate that DH will rename the service in due course to support public engagement and local marketing activity.

It will be clear to LPCs that there is a great potential for community pharmacy to play a significant part in the delivery and success of this programme.

What is the aim of the programme?

The aim of the VRA programme is to offer a straightforward risk assessment for diseases affecting the vascular system, including diabetes and chronic kidney disease, to everyone over 40 years.

It is expected that once fully implemented, the programme will prevent on average 1,600 heart attacks and strokes, and save at least 650 lives each year¹.

The longer term aims of the VRA programme are:

- To reduce premature death from related vascular conditions including Coronary Heart Disease, Chronic Kidney Disease, Diabetes Mellitus, stroke, Transient Ischaemic Attacks and Peripheral Arterial Disease;
- To reduce the incidence of these related vascular conditions; and
- To narrow inequalities in premature death from these related vascular conditions.

When will it start?

After a period of modelling and refinement DH decided that the programme will be introduced by PCTs from 1st April 2009. All PCTs must 'show some evidence of participation' with the programme during 2009.

PSNC expects a spread of activity across the country with the spearhead PCTs being likely to be the first to fully implement the programme. Many PCTs are already piloting the service and a small number have fully implemented a VRA programme that matches the national programme requirements.

DH has secured extra funding from HM Treasury to fund the roll out of the service (in the region of £250m). This funding will start to be added to PCTs' baseline funding in 2009/10; the Department plans to phase the introduction of the service and the funding:

Year	% funding for PCTs
1	40%
2	55%
3	70%
4	85%
5 onwards	100%

¹ DH estimates based on early modelling.

Section 1 - The Vascular Risk Assessment and Management Service

The VRA service is a set of processes which are designed to determine a person's 'risk' or likelihood of developing a number of chronic conditions which affect the vascular system, i.e. veins, arteries, capillaries and organs of the circulatory system.

These vascular diseases include:

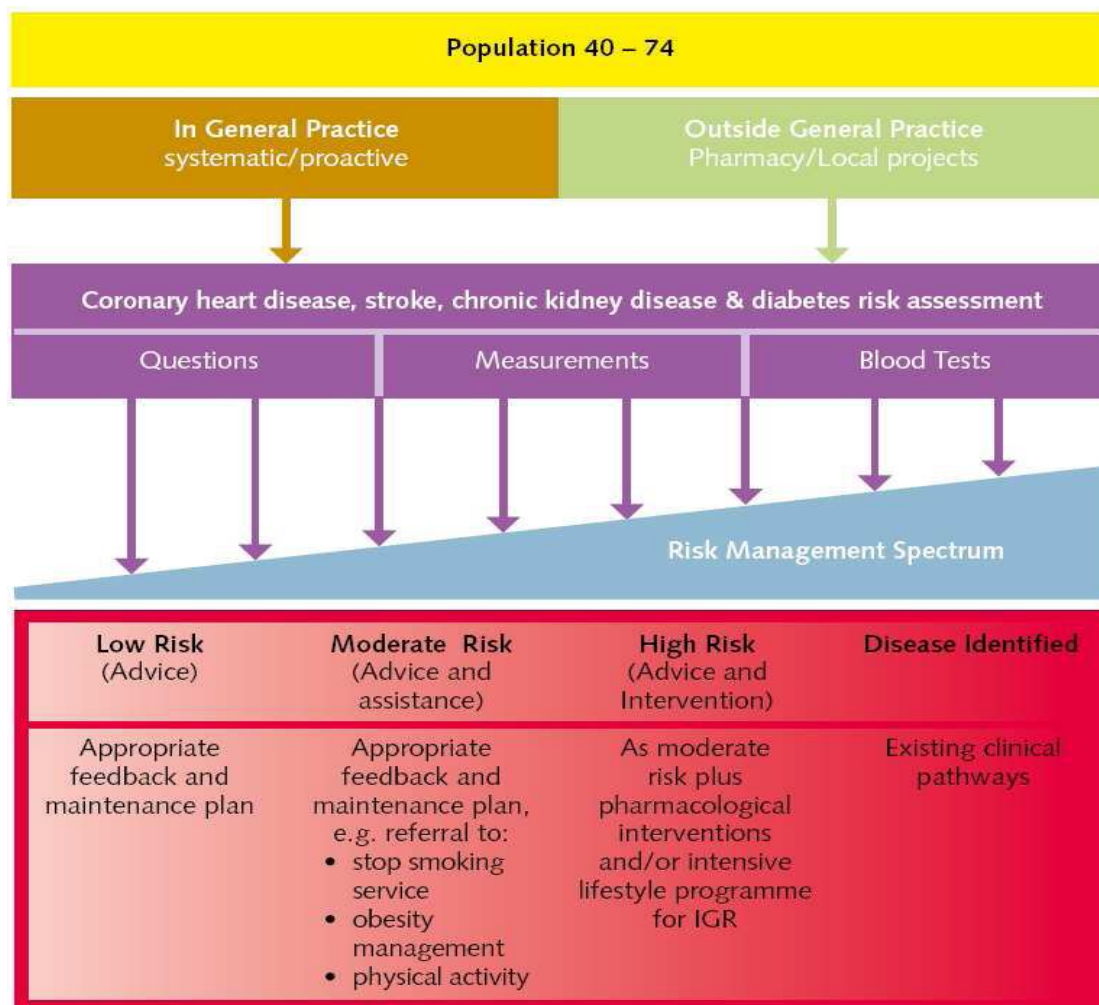
- Coronary heart disease (heart attacks and angina);
- Stroke;
- Diabetes; and
- Kidney Disease.

These diseases all affect the body in different ways. However, they are linked by a common set of risk factors:

- obesity;
- physical inactivity;
- smoking;
- high blood pressure;
- disordered blood fat levels (dyslipidaemia); and
- impaired glucose regulation (higher than normal blood glucose levels, but not as high as in diabetes).

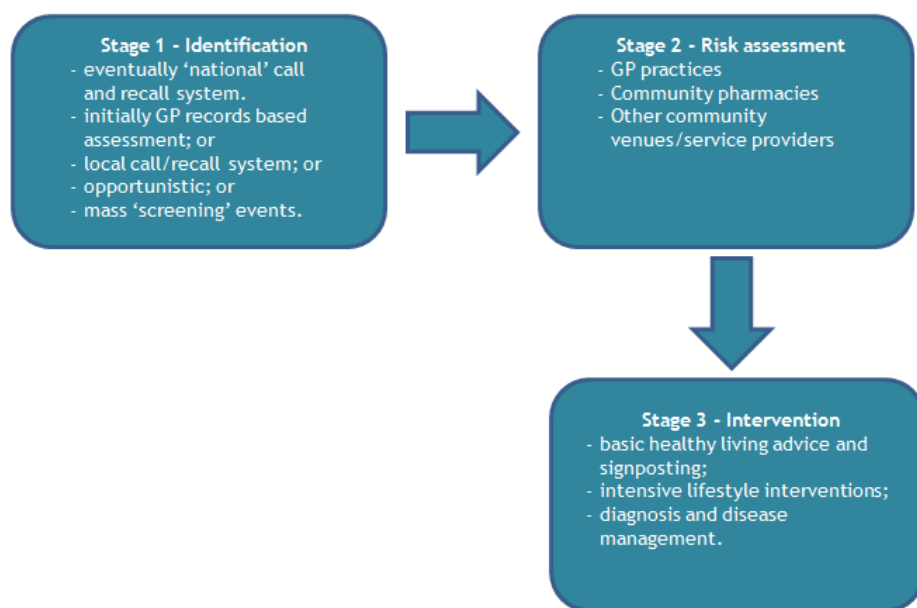
Having one vascular condition increases the likelihood of an individual suffering others.

Figure 1 outlines the approach proposed by the Department of Health.



From an LPC perspective it is useful to view this new service as three separate stages:

Figure 2 The three stages of the Vascular Risk Programme



Stage 1 - Identification of individuals eligible for VRA

DH are developing a national 'call and recall' system that will operate in a similar way to the National Breast Cancer Screening programme which uses a database of all women in the target age group to remind them when a mammogram is due. This system is unlikely to be in operation before 2011 so alternative approaches to identifying patients need to be used in the interim period.

Using GP records to target individuals at increased risk of vascular disease is likely to be used in some areas. Some PCTs are actively using GP records to check that people with pre-existing vascular diseases have had a risk assessment and an appropriate management plan has been put in place.

GP records may also be used as the basis of a local call and recall system, prior to the national system being implemented. A pharmacy based VRA service could be an assessment option that is offered to people targeted by a local call and recall system.

A further option is opportunistic assessment in pharmacies for people in the target group, using local marketing to encourage use of the pharmacy service. Community pharmacy could also facilitate mass 'screening', e.g. at local sporting events.

LPCs may want to discuss the development of local strategies, based on social marketing techniques, to drive the delivery of VRA in pharmacies. This approach lends itself to the targeting of people who do not normally visit their GP on a regular basis.

So far PCTs that have commissioned the service from community pharmacy have tended to use the opportunistic approach, but it appears that many are now likely to prefer a more targeted approach to VRA using a local call and recall system. This approach allows risk stratification techniques to be applied, targeting higher risk groups first. It also allows the PCT to phase the implementation of the programme in order to match the likely number of referrals for follow up following the risk assessment with the capacity in the local health economy to manage these referrals.

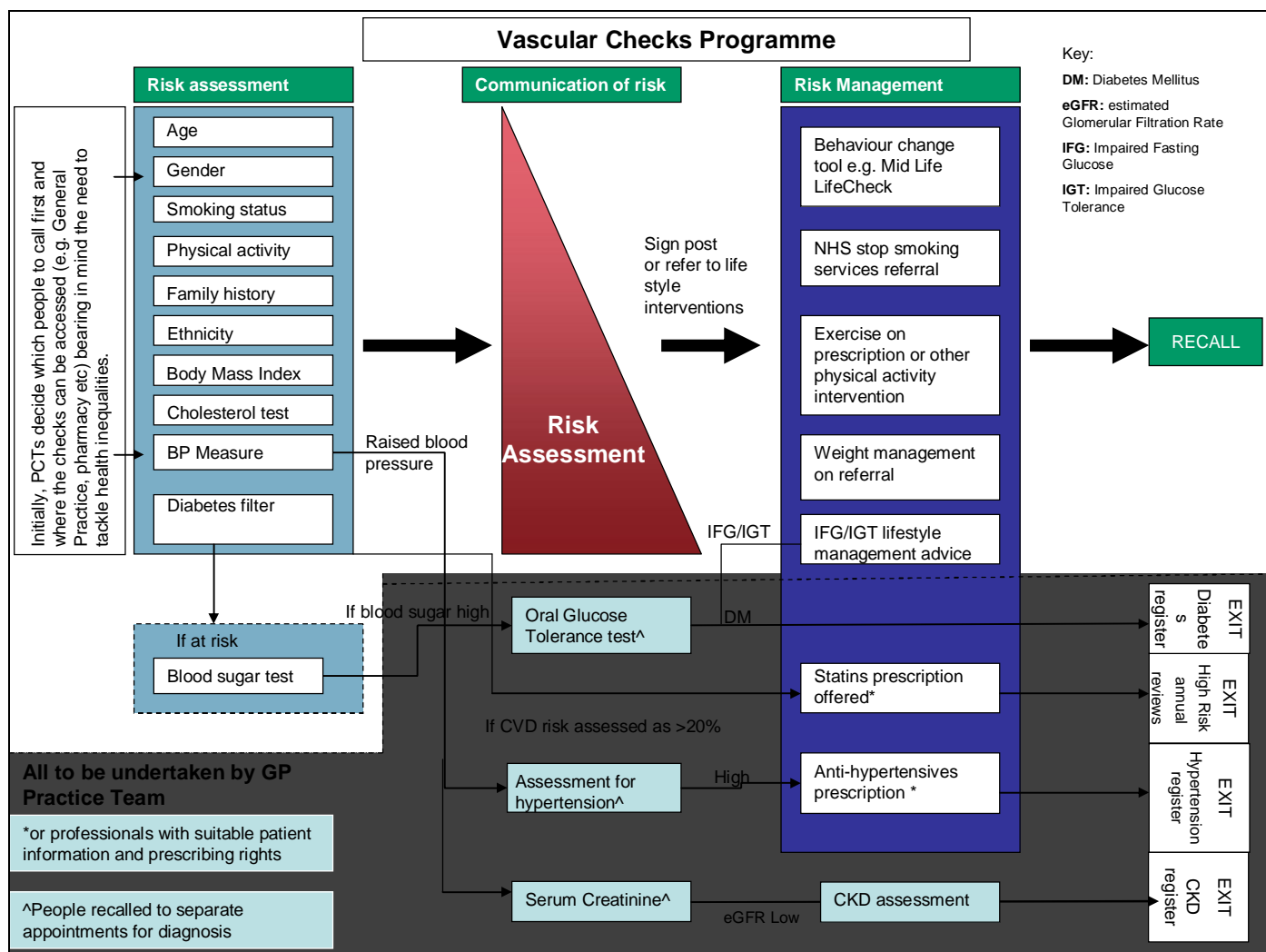
Stage 2 - Risk assessment

Pharmacies can play a significant role in stage 2 of the service, with the additional possibility of extending their service offering into Stage 3.

DH wants the service to be as inclusive as possible, both in term of providers and in terms of users. Community pharmacy will have to compete with other providers to supply this service.

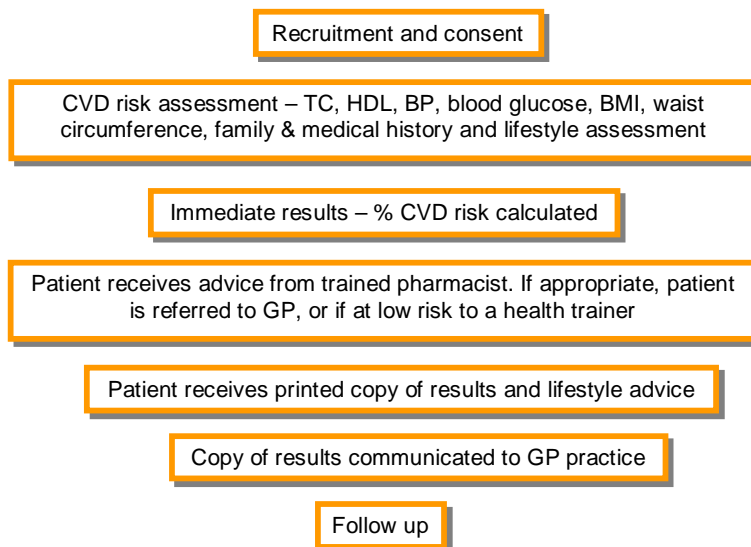
The testing element is made up of data collection from the patient and a number of clinical measurements described in the following schematic.

Figure 3 outlines the VRA programme.



DH commissioned NHS Primary Care Contracting to develop a Primary Care Framework² for the VRA service. This document has been written with commissioners in mind. PSNC’s draft VRA service specification is still being considered by DH. It is hoped the final version will be available in late February 2009. The current draft is available in Annex 1 of this document.

Figure 4. The community pharmacy patient journey.



² http://www.pcc.nhs.uk/uploads/primary_care_service_frameworks/vascular_checks_final_version.doc

Stage 3 - Intervention: advice, signposting and patient management

Stages 1 and 2 take the patient up to the point of having completed a test. Stage 3 involves any subsequent intervention that is required including healthcare advice, signposting, formal referral, lifestyle interventions and disease management. This stage is where the majority of the cost of the programme will be spent.

DH envisage a range of interventions being made; Figure 3 lists interventions extracted from DH's *Economic Modelling for Vascular Checks* document³.

Figure 5. Table of interventions assessed from *Economic Modelling for Vascular Checks*.

Cost component	£m p.a.	%
Impaired Glucose Tolerance (IGT) lifestyle intervention	67.8	42%
Statins - drugs and lab costs	28.3	18%
Anti-hypertensives - drugs and lab costs	20.9	13%
Exercise chat	4.7	3%
Stop Smoking services	4.3	3%
Diabetes management	3.4	2%
Weight loss programmes	2.1	1%
Intervention costs: nurse time	1.9	1%
Intervention costs: GP time	27.6	17%
Intervention costs: Healthcare Assistant time	0.1	0%
TOTAL	161.1	100%

The success of the VRA programme is dependent on effective interventions following the testing and risk assessment process. There is significant potential for community pharmacy to play a part in Stage 3 of the programme using existing Enhanced services and new services commissioned to complement the VRA programme. Service examples include:

- Stop smoking service;
- Weight management service;
- Basic health living and exercise interventions; and
- Disease management programmes, e.g. diabetes management.

³ http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_085869

Section 2 - Stakeholders and their motivations

The main stakeholders in this service are:

- Department of Health
- Strategic Health Authorities (SHAs)
- Primary Care Trusts / Practice Based Commissioners / Local Authorities
- LMCs / General Practitioners
- LPCs / Pharmacy Contractors
- Other community healthcare providers
- The general public over 40 years of age

PCTs are of primary importance in this service and as such, are given a section of their own - see Section 3.

Department of Health

In January 2008, the Prime Minister announced the Government's intention to shift the focus of the NHS towards empowering patients and preventing illness. As part of this, he set out his ambitions to dramatically extend the availability of 'predict and prevent' checks to give people information about their health, support lifestyle changes and, in some cases, offer earlier interventions. In a speech he said:

...there will soon be check-ups on offer to monitor for heart disease, strokes, diabetes and kidney disease - conditions which affect the lives of 6.2 million people, cause 200,000 deaths each year and account for a fifth of all hospital admissions.

DH is responsible for delivering on the Prime Minister's commitment and has developed the VRA programme following the initial scoping of this service by the National Screening Committee. The programme is overseen by the DH Vascular Board.

Strategic Health Authorities (SHAs)

SHAs have responsibility for:

- overseeing the development of PCT plans for improving health services;
- making sure local health services are of a high quality and are performing well;
- increasing the capacity of local health services - so they can provide more services; and
- making sure national priorities are integrated into local health service plans.

In 2008 SHAs led the development of visions⁴ for the future of the local NHS as part of Lord Darzi's NHS Next Stage Review.

SHAs will have an important role in performance managing and supporting the development of VRA by PCTs. The SHA's Regional Director of Public Health and the SHA Medical Directors who are currently being appointed are likely to play a key part in this support for PCTs and consequently LPC regional groups may want to consider talking to these SHA directors about the role of community pharmacy in VRA.

DH is currently considering the performance management criteria for the service.

Primary Care Trusts / Practice Based Commissioners / Local Authorities

The PCT (potentially working with Practice Based Commissioners) will have to commission a VRA service for their population starting in 2009/10. They will also have a role in supporting the delivery of the service by the commissioned providers. The development of the VRA programme has been relatively rapid and until recently there has been little detailed information on which PCTs could base their plans for developing the service.

DH has determined that the implementation of the service will be phased over 5 years; however some PCTs may choose to move to full implementation more quickly (particularly the Spearhead PCTs). The phased approach to implementation allows the gradual development of capacity to support and manage people who are found to be at moderate and high risk. It will also assist PCTs in managing the cost pressures that this extra activity, including prescribing, will have on budgets.

VRA is featured in the *Next Stage Review, High Quality Care for All, Our Vision for Primary and Community Care* and the *Pharmacy White Paper*. The VRA programme, where delivered sensitively, has the potential to

⁴ http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_085400

substantially contribute to key delivery targets for PCTs. It provides an opportunity to strengthen and improve performance in the following areas:

- reducing health inequalities (Public Service Agreement 18.2);
- improving life expectancy (Public Service Agreement 18.1); and
- reducing mortality from circulatory diseases (SR 2004 Public Service Agreement 1.1 and 6.1).

Not only are these DH priorities for action, they are also key Local Area Agreement indicators that many Local Strategic Partnerships have agreed to focus on, particularly in areas of deprivation.

The VRA programme is underpinned by three National Service Frameworks (NSFs) - Coronary Heart Disease, Diabetes and Renal Disease - and the National Stroke Strategy, which was launched in December 2007. It offers a tool to provide shared primary prevention elements from the NSFs and the Stroke Strategy. The programme will strengthen the work across all four disease areas by drawing together common elements and existing activity, specifically on risk assessment and management.

Vascular risk score (VSC23) is a Tier 3 indicator in the *NHS Operating Framework Vital Signs 2008/09*. The VRA programme will also contribute to a number of improving health and reducing health inequality vital signs, such as:

- the all-age all-cause mortality rate per 100,000 population;
- the cardiovascular disease (CVD) mortality rate among people under 75 years of age;
- implementation of the Stroke Strategy;
- smoking prevalence among people aged 16 or over in routine and manual groups;
- healthy life expectancy at age 65; and
- the proportion of people where health affects the amount/type of work they do.

PCTs will benefit from the introduction of the VRA service in the following ways:

- it facilitates early detection of high risk patients;
- it helps to reduce health inequalities within socially deprived areas; and
- early identification of vascular disease should help to reduce long term costs.

All PCTs are performance managed by their SHA; a new part of the performance regime is the assessment of the PCT's commissioning ability measured against the World Class Commissioning (WCC) competencies:

1. Locally lead the NHS;
2. Work collaboratively with community partners;
3. Engage with the public and patients;
4. Collaborate with clinicians to inform strategy, service design and resource utilisation;
5. Manage knowledge and assess current and future needs;
6. Identify and prioritise investment requirements and opportunities;
7. Influence provision to meet demand and secure outcomes;
8. Drive continuous improvement in quality and outcomes through innovation;
9. Deploy procurement skills that ensure providers have appropriate contracts;
10. Manage the local health system; and
11. Make sound financial investments.

Further information on world class commissioning is available at www.dh.gov.uk/worldclasscommissioning/. The DH Vascular team have outlined how PCTs can demonstrate they are meeting the World Class Commissioning competencies through the effective implementation of the VRA service. The latest DH guidance to PCTs (*Putting prevention first- vascular checks: risk assessment and management - next steps guidance for primary care trusts*⁵) was issued on 13 Nov 2008 and it includes an annex on WCC.

Local Authorities will also have a keen interest in the development of the VRA service as a result of the wider responsibility for public health that they share with PCTs through Local Strategic Partnerships and the Local Area Agreements they jointly formulate.

GPs

The GP held record will be the central repository in which peoples' VRA results will be stored. GPs will also take the lead in conducting follow up investigations and the management of vascular diseases that are detected via the VRA process. As a consequence they will have a central role in the service.

⁵ http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_090277

The recent changes to the GMS Quality and Outcomes Framework (QOF) will also see increased involvement of GPs in the prevention of vascular disease. Details of the relevant additions are contained in Figure 6.

Figure 6:

Cardio Vascular Disease CVD - Primary Prevention (13 points)

Two new indicators:

PP 1: In those patients with a new diagnosis of hypertension (excluding those with pre-existing CHD, diabetes, stroke and/or TIA) recorded between the preceding 1 April to 31 March: the percentage of patients who have had a face to face cardiovascular risk assessment at the outset of diagnosis using an agreed risk assessment treatment tool. (8 points; thresholds 40 - 70%) For the purposes of QOF measurement, 'at the outset of diagnoses is defined as within three months of the initial diagnosis.

PP 2: The percentage of people diagnosed with hypertension diagnosed after 1 April 2009 who are given lifestyle advice in the last 15 months for: increasing physical activity, smoking cessation, safe alcohol consumption and healthy diet. (5 points; thresholds 40 - 70%).

As a consequence of these changes, when pharmacists refer a person with potential hypertension to their GP this may provide an opportunity for the GP to achieve the new QOF points. Full details on the additional QOF points which have been added in 2009 can be found at www.nhsemployers.org/gms.

It is highly likely that most GP practices will wish to offer vascular checks to their eligible patients and therefore there will be competition between them as providers and other potential providers such as community pharmacy. LPCs and pharmacy contractors should initiate dialogue with Local Medical Committees (LMCs) and GPs early in the development of a pharmacy VRA service proposal in order to try to mitigate the possibility of conflicts at a later date.

Pharmacy Contractors

Pharmacy contractors are well placed to deliver Stage 2 of the service. Pharmacies have unique advantages that are important for the successful delivery of the service:

- Community pharmacy can reach persons who would not normally visit a GP practice;
- Community pharmacies are open longer and more convenient hours than GP practices which suits people's busy lifestyles;
- The community pharmacy service uses point of care testing (POCT) which has the dual advantage of efficiency and convenience for patients;
- A pharmacist's intervention is readily available during any testing if required. Where tests are carried out in surgeries a patient can expect to see a nurse or a health care assistant and not a GP;
- The community pharmacy tests use approved testing equipment and do not involve remote laboratories and hence does not require patients to call back for their results;
- Patients do not normally require an appointment; and
- Pharmacies may on occasion, and in agreement with local PCTs, be able to offer VRA in locations other than their pharmacy.

A template PowerPoint presentation⁶ on the unique benefits of using community pharmacy to provide VRA is available from the PSNC website.

The strategic significance of the VRA service for community pharmacy is high, as successful implementation of this service will provide a strong example of how pharmacies can play a leading part in health improvement and disease prevention. The pharmacy White Paper envisages community pharmacies developing into health promoting pharmacies that have a strong focus on wellbeing. Implementation of the VRA service can help to make this vision a reality and could have a significant impact on changing the perception of community pharmacy in the minds of the public.

Other community healthcare providers

DH expects that other healthcare providers will also wish to become involved in offering the service. Examples of these may include:

⁶ http://www.psn.org.uk/data/files/LPCOnly/VRA_toolkit/selling_the_pharmacy_vra_service.ppt

- Nurse led screening service providers;
- NHS health trainers;
- Third sector (charitable) organisations, e.g. British Heart Foundation;
- Mobile units run by occupational healthcare providers; and
- Health club/Gyms, e.g. Nuffield Health and Wellbeing Centres (formerly Cannons Health Clubs)

LPCs should ensure they assess the potential for other service providers to provide VRA in their area when developing plans for a community pharmacy service. Any concern about local service providers should be discussed with your PCT at an early stage.

Some of the potential service providers listed above may have the ability to provide the Stage 3 follow up interventions, particularly the lifestyle and exercise advice. This provides both a threat to potential pharmacy provision of such services, but also an opportunity to explore strategic alliances between pharmacy contractors and other providers.

The general public over 40 years of age

Surveys and public consultations on the future of healthcare provision have consistently shown that the public want to have easier access to healthcare and improved support to self care and stay healthy. The VRA service therefore addresses a gap in current NHS provision. The service should increase public awareness of risk factors for CVD and help individuals to make positive lifestyle adjustments to prevent disease.

Section 3 - Issues for consideration by potential service providers

Pharmacy contractors will need to be fully aware of the implications of providing the service before they are commissioned by the PCT. Among other things, they will need to consider the:

- financial investment required;
- training requirements for pharmacists and support staff;
- equipment and consumable costs;
- IT requirements;
- service pricing and invoicing procedures; and
- the quality and standards for the service.

Only when these are fully understood can a pharmacy contractor decide if it would be financially attractive to offer this service. Guidance on formulating an attractive bid and costing the service is found in parts 2 and 3 of this guidance.

Recommended minimum standards

DH commissioned NHS Primary Care Contracting to develop a Primary Care Framework⁷ for the VRA service. This document has been written with commissioners in mind and it sets out what issues PCTs must consider when commissioning the service.

The Primary Care Framework is a high level document so we recommend that LPCs read this in combination with the PSNC service specification which has been prepared for pharmacy contractors. PSNC's draft VRA service specification is still being considered by DH. It is hoped the final version will be available in late February 2009. The current draft is available in Annex 1 of this document and on the PSNC website⁸.

A range of issues that LPCs and pharmacy contractors will have to consider when developing a proposal for a VRA service and its subsequent implementation are outlined below.

Consultation facilities

A private consultation area will need to be used for carrying out VRAs. The consultation area should prevent conversation being overheard and should provide an appropriate degree of visual privacy. There should be sufficient space within the consultation area to safely store and operate testing equipment, safely handle blood samples and deal with any resultant clinical waste. Hand washing facilities will need to be available in a convenient location in or close to the consultation area.

Guidance on consultations rooms, including financial issues, optimal utilisation and design are available to NPA members from www.npa.co.uk.

Patient testing and equipment requirements

Depending on the details of the local service specification, a VRA may involve:

- measuring blood pressure;
- measuring height;
- measuring weight
- measuring hip/waist ratio; and
- performing a finger-prick blood test to assess Total and HDL cholesterol.

A range of Point of care testing (POCT) equipment will be required to measure these variables. A system should be in place to ensure the on-going maintenance and quality assurance of this equipment within community pharmacies.

We anticipate that commissioners will often wish to specify the use of specific testing equipment as part of the locally agreed VRA service.

Point of care testing governance

POCT or near patient testing, refers to the use of analytical equipment (including test kits and analysers), by a suitably trained healthcare operator near to the patient rather than in a clinical laboratory. POCT can be used to describe what happens in a pharmacy during a screening consultation.

⁷ http://www.pcc.nhs.uk/uploads/primary_care_service_frameworks/vascular_checks_final_version.doc

⁸ http://www.psn.org.uk/publications_detail.php/232/draft_enhanced_service_specifications

DH is developing an accreditation system for pathology point of care testing, in order to improve quality assurance in this area. An increasing amount of pathology testing is being carried out at the point of care, with more and more tests being done in GP practices, pharmacies, retail outlets, ambulances and other settings outside of hospitals. The project's key objectives are:

- to define a set of competences for POCT practitioners;
- to develop approaches that will assess the competence of the individuals, organisations, networks or other arrangements that deliver POCT;
- to ensure that the assessment and accreditation approaches are designed to be capable of responding to changes in the nature, scope and delivery of POCT;
- to ensure that assessment and accreditation approaches to POCT will work whether carried out in the public or private sectors;
- to encourage confidence in the accuracy, reliability and validity of the results for those who use POCT;
- to create the e-learning materials that will equip organisations and individuals with the skills to carry out POCT to the standards and competences defined by the assessment and accreditation approaches; and
- to pilot, validate, implement, roll out and support access to the training and accreditation product for its various audiences and user groups in their locations, as required.

PSNC and the other pharmacy bodies are actively participating in this work.

The RPSGB is also developing practice guidance on diagnostic testing/screening services. This is expected to be published in early 2009.

*Putting prevention first- vascular checks: risk assessment and management - next steps guidance for primary care trusts*⁹ includes a section on the use of POCT.

The MHRA has issued guidance on the Management and Use of IVD Point of Care Test Devices (DB 2002(03))¹⁰ and Lancing devices (used in pharmacy settings) - all brands (MDA/2008/046)¹¹.

The British Society for Haematology (British Committee for Standards in Haematology) has issued guidance on issues to be considered when procuring POCT equipment in *GH/016 Guidelines for point of care testing: haematology* which can be downloaded from www.bcsghguidelines.com.

Standard operating procedures (SOPs)

Community pharmacies should have SOPs to cover the activities that make up the VRA service. At the time of preparing this document DH is developing a detailed description and standard operating procedures for the standard tests contained in the VRA service.

The National Pharmacy Association is also preparing template SOPs for the service.

Clinical waste, infection control and immunisation

Community pharmacists and their staff should be familiar with NHS infection control standards and commissioned services must comply with the standards. The requirements are detailed in *The Health and Social Care Act 2008: Code of Practice for the NHS on the prevention and control of healthcare associated infections and related guidance*¹² and the NICE clinical guideline *Infection control, prevention of healthcare-associated infection in primary and community care*¹³.

A clinical waste disposal service will need to be commissioned for each participating pharmacy. The pharmacy will need to allocate a safe place to store equipment required for the provision of the service and the resultant clinical waste.

Hand washing facilities will need to be available in a convenient location in or close to the consultation area. Appropriate protective equipment, including gloves, overalls and materials to deal with spillages, will need to be readily available close to the site where the service is provided and clinical waste is stored.

⁹ http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_090277

¹⁰ <http://www.mhra.gov.uk/Publications/Safetyguidance/DeviceBulletins/CON007333>

¹¹ <http://www.mhra.gov.uk/Publications/Safetywarnings/MedicalDeviceAlerts/CON020531>

¹² http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_093762

¹³ <http://www.nice.org.uk/CG002>

Staff involved in handling blood samples should be immunised against Hepatitis B and should be shown to have made a serological response to the vaccine. The Health Protection Agency offers guidance on Hepatitis B in the occupational setting¹⁴. DH's publication *Immunisation against infectious disease - 'The Green Book'*¹⁵ also contains a chapter on Hepatitis B. Immunisation may take up to 6 months to confer adequate protection.

Pharmacies should have a needle stick injury procedure in place.

Training and skill mix

Performing a VRA involves a number of separate processes which require the provider to exercise separate skills, levels of communication and psychological awareness.

A pharmacist will need to be the clinical lead for the service in each pharmacy and will take clinical responsibility for the VRA service. However some of the tasks involved in performing the service can be delegated to other appropriately trained staff working in the pharmacy.

DH have commissioned Skills for Health (the health sector Skills Council) to develop a competency framework for VRA. It will contain relevant competencies for all staff who may be involved in vascular checks, including health trainers, pharmacists, pharmacy staff, healthcare assistants, nurses and GPs. Competencies covered will include, among others:

- phlebotomy;
- infection control;
- communication of risk; and
- lifestyle advice.

The competencies and their underpinning criteria can be used to support the commissioning of training for those who will be involved in the vascular checks service and will be available on the Skills for Health website at www.skillsforhealth.org.uk.

A record of competency assessments successfully completed must be kept on all staff members who provide aspects of the VRA service. Having demonstrated competence, staff should participate in CPD related to VRA.

A number of education and training / academic institutions are currently offering short courses in cardiovascular risk assessment including:

- The Primary Care Training Centre (PCTC) (www.primarycaretraining.co.uk) offer a 1-day course on CV risk assessment at a cost of £100 + VAT. Optional accreditation (10 credits at level 2) can be obtained through Teesside University on completion of a written assignment. For large groups the course can be delivered locally by the PCTC.
- Education for Health (www.educationforhealth.org.uk) offer a diploma module consisting of 2 study days and additional support materials which is undertaken over a period of 6 months. The cost is £545 and the course accredited by the Open University. They also offer a one day workshop with informal lectures and interactive practical sessions which will give participants the knowledge and skills to deliver VRA. The 'Putting prevention first' workshops cost £115.

Note - both Education for Health and the PCTC have received funding from DH for the sponsorship of healthcare professionals to access training in CVD risk assessment and management in deprived areas. This will be available on a first come first served basis. For further information please call Sarah Naylor at the PCTC on 01274 617617 or email admin@primarycaretraining.co.uk or Nina Rawstone at Education for Health on 01926 838969 or email n.rawstone@educationforhealth.org.uk.

- POCT equipment providers will provide some training on the use of the equipment and potentially on wider VRA issues.

Following the DH announcement of the VRA programme, it is anticipated that more short courses will become available. LPCs and / or commissioners should liaise with their local education and training providers to encourage sufficient provision to facilitate a planned roll out of the VRA service.

¹⁴ http://www.hpa.org.uk/web/HPAweb&HPAwebStandard/HPAweb_C/1195733772505

¹⁵ http://www.dh.gov.uk/en/PublicHealth/Healthprotection/Immunisation/Greenbook/DH_4097254

CPPE is developing a programme of support for the pharmacy sector. From 1st May 2009, there will be 90 CPPE events on VRA across England, which will be based on a two book Focal Point programme. PCTs, LPCs and other local groups will also be able to use the materials to run local training events. CPPE will prepare an outline agenda for PCTs to use in local training that will cover aspects of the service that the core CPPE training will not, such as blood sampling and blood pressure measurement. They will also provide maps to the VRA competency framework and an online assessment will be available. The objectives of the Focal Point programme on VRA are detailed in the box below.

On completion of all aspects of this programme you should be able to:

- have an understanding of why vascular risk is part of current health policy and how it fits into the context of healthy living centres endorsed in the Pharmacy White Paper;
- assess an individual's risk of developing cardiovascular disease (CVD) using appropriate evidence based tools and methodologies;
- develop strategies for the communication of the identification of CVD risk, including advice on how an individual can reduce their risk;
- appreciate the importance of respecting an individual's privacy, dignity and choice with regard to vascular risk assessment schemes;
- explain management options for both modifiable and non-modifiable risk factors following a vascular risk assessment; and
- identify situations where referral to another practitioner is appropriate following a vascular risk assessment.

IT and data transfer

Ultimately, the aim is for a national call and recall system, linking locally, to help ensure that a systematic and universal programme of vascular checks is offered to everyone eligible. This will be developed by DH but will not be ready in the first years of the programme. PCTs will therefore need to devise their own data recording and transfer solutions for use in the interim to ensure that the individual's GP receives the results of their checks.

PCTs will also need to devise their own system to collect and collate core data to ensure that all sections of the community are participating in the programme and that additional effort is made to ensure that health inequalities are being narrowed. This data will be collected later at a national level in order to gain a national picture of activity over the first few years. DH intends to publish a minimum data set which will need to be captured as part of the VRA service in due course. They are also working on Read/SNOMED CT codes to support standardised recording of VRAs in clinical records.

Once the core data set is published by DH, PSNC will issue a template data transfer form that can be used by community pharmacies to inform GPs of the results of a VRA.

Risk engines

Risk engines or algorithms are used to determine the vascular risk score or rating based on the information collected from the person. Framingham is the most widely used Risk engine for calculating vascular risk and is recommended by NICE. However it is based on US population studies from the 1950s and there is currently an active debate in medical circles on its appropriateness for application to the contemporary British population.

A number of alternative risk engines have been proposed as being more applicable to the UK, including the QRISK algorithm¹⁶ that has been derived from the QResearch database¹⁷ (which contains anonymised records from patients of medical practices using the EMIS clinical management system). It is understood that NICE is currently reviewing its choice of vascular risk algorithm in the light of new evidence.

Pharmacy contractors should use the risk engine recommended by their PCT.

Service outcomes and review

LPCs and pharmacy contractors should consider methods of recording basic outcomes from the VRA service in order that they can demonstrate the added value that pharmacy is bringing to people accessing the service. Consideration should be given to recording follow up actions and outcomes where known.

¹⁶ <http://qr2.dyndns.org/index.php>

¹⁷ <http://www.qresearch.org/Public/WhatIs.aspx>

Section 4 - Marketing

Effective marketing of the service will be key to its ultimate success; social marketing techniques will need to be deployed as part of the marketing effort. Social marketing is the systematic application of traditional marketing techniques along with other concepts and techniques to achieve specific behavioural goals for a social good.

DH is currently working on a national branding for VRA in order that there is strong brand recognition by the public for locally commissioned services. They will also commission a national advertising campaign ('Reduce your risk') to highlight the VRA service to the public, in line with the commitment made in *High Quality Care for All*.

To be successful this service must positively change individuals' lifestyle and diet. This will require significant marketing support to assist service delivery. PCTs will need pay particular attention to targeting hard to access groups of the population.

LPCs should highlight to PCTs the importance of marketing to the success of the service, and also the costs of effective marketing and associated materials to support delivery of the service.

LPCs may wish to suggest that if the PCT commissions local pharmacies to provide a VRA service, they could use the public health campaigns element of the Essential tier NHS contract to promote VRA to the public.

Section 5 - Further reading and support

Key reference materials

Putting prevention first - vascular checks: risk assessment and management - next steps guidance for primary care trusts www.dh.gov.uk/vascularchecks

The Handbook for Vascular Risk Assessment, Risk Reduction and Risk Management (University of Leicester) www.screening.nhs.uk

NHS Primary Care Contracting Primary Care Service Framework for Vascular Checks - www.pcc.nhs.uk/uploads/primary_care_service_frameworks/vascular_checks_final_version.doc

Support for pharmacy contractors

The NPA are currently developing a toolkit to support members wanting to provide a VRA service.

VRA case studies

A selection of case studies is available on the NHS Improvement website. www.improvement.nhs.uk/vascularchecks

The PSNC services database contains details of a number of pharmacy based VRA services. Log in to the LPC Members' area to access associated documents such as Service Level Agreements for the featured services. www.psn.org.uk/database

If your LPC has developed a VRA service please share details via the database!

Useful CPD resources

The National Prescribing Centre interactive website contains resources on vascular diseases and the communication of risk to patients. www.npci.org.uk/lift/lift.php

Annex 1 - draft PSNC VRA service specification

PSNC is in the process of agreeing its draft service specification with the Department of Health. Once the final version is agreed it will be added to this document.

LPCs can access the draft service specification at:

www.psn.org.uk/publications_detail.php/232/draft_enhanced_service_specifications