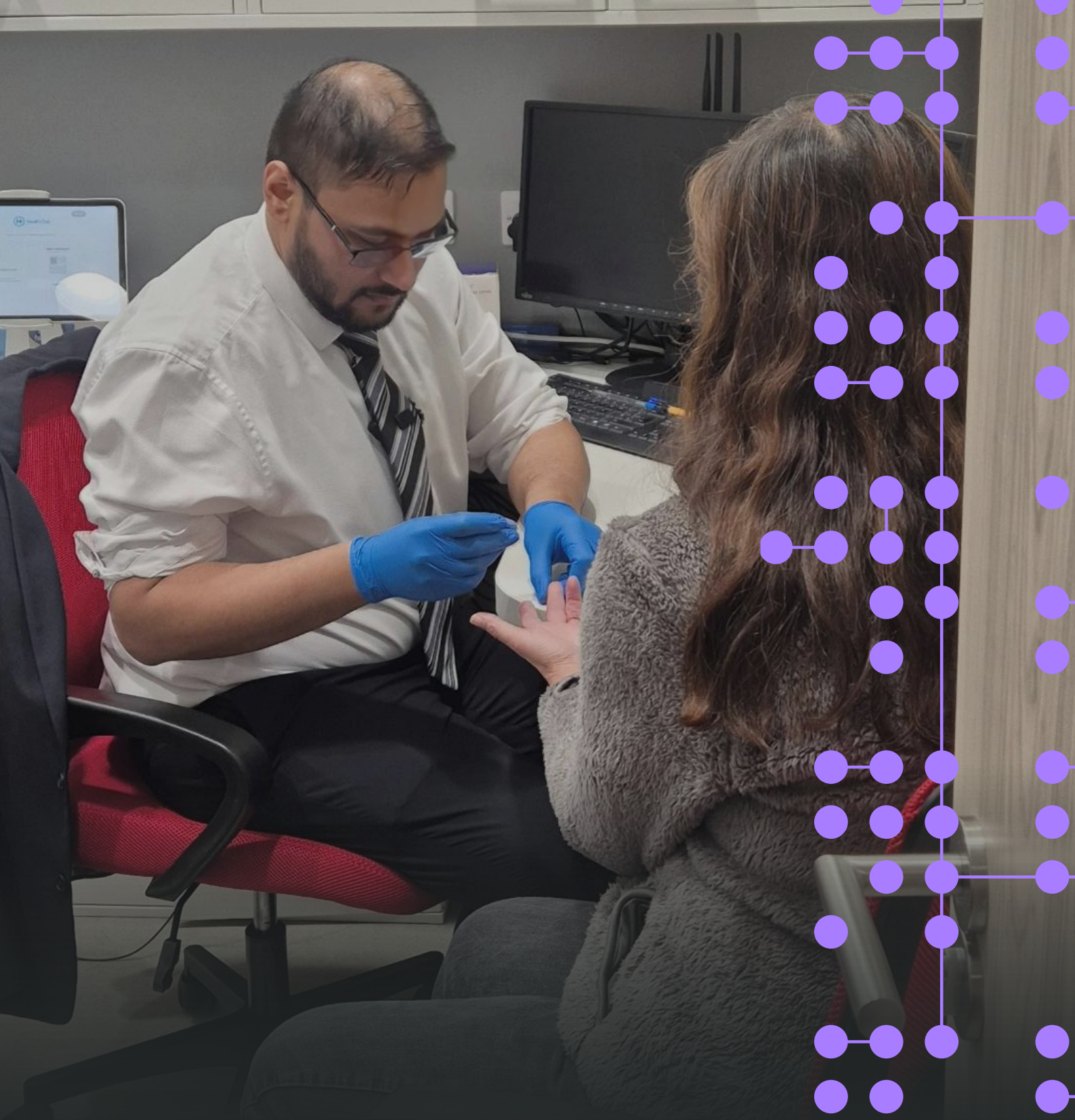


Cholesterol Point of Care Testing

Final evaluation report

October 2026

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Table of Contents

Reflections of evaluation partners 2
Acknowledgements 5
Executive Summary 6
Context 8
Evidence review 17
Evaluation Methods 20
Results 24
- Operational Effectiveness 24
- Clinical Effectiveness 28
- Staff and Patient Acceptability 35
- Equity of Access 45
- Wider System Impact 56
- Scale-Up and Sustainability 62

Conclusions 69
Recommendations 70

Reflections of evaluation partners

Dr Sotiris Antoniou Divisional Director, Clinical Services, Barts Health NHS Trust Clinical Lead, ELoPe-CVD Point-of-Care Testing Workstream

Cardiovascular disease remains one of the greatest causes of preventable ill health and premature mortality, with a disproportionate burden experienced by people living in the most deprived communities and by some ethnic minority groups. In 2025/26 approximately 3.8 million people were invited to attend an NHS Health Check[1]. Of these, 1.3 million accepted the offer, while approximately 2.5 million declined or did not take up the opportunity. If we are to improve cardiovascular outcomes and reduce health inequalities, prevention cannot depend solely on people presenting to traditional healthcare settings. We need to identify risk earlier, intervene sooner and increasingly deliver care closer to home, within the neighbourhoods where people live and work.

The ELoPe-CVD community pharmacy point-of-care testing programme was established to test whether we could do exactly that. Importantly, this has never simply been a programme to measure cholesterol. We have developed an end-to-end cardiovascular prevention pathway combining point-of-care testing with blood pressure measurement, cardiovascular risk assessment, personalised lifestyle intervention with culturally appropriate advice, appropriate referral and, where enabled through independent pharmacist prescribing, initiation of lipid-lowering treatment. This is underpinned by competency-based training, clinical governance, quality assurance and digital communication of results.

This evaluation demonstrates that this model is feasible, acceptable and capable of identifying clinically important cardiovascular risk within the community. The findings continuously show that approximately one in five people assessed had a QRISK3 score of 10% or greater, despite engaging a substantial working-age population. Importantly, the programme reached ethnically diverse populations and people living in areas of greater deprivation, Core20PLUS5 groups – usually underserved populations in which the burden of premature cardiovascular disease is often greatest.

Community pharmacies are highly accessible, where 90% of the population in England live within a 20-minute walk of a pharmacy, and often have longstanding relationships with the populations they serve. There was overwhelmingly positive experience of residents valuing the convenience, speed and quality of pharmacy-based testing, with some indicating that they would not otherwise have sought a GP appointment for this type of preventive care. This provides an opportunity not simply to relocate an existing NHS service, but to extend the reach of prevention to people who may otherwise remain unidentified and undertreated.

This model also demonstrates how community pharmacy can contribute to neighbourhood working, supported and clinically led by a tertiary cardiac centre. Rather than operating as a parallel service, pharmacy should form part of an integrated prevention pathway alongside general practice (GP) and wider neighbourhood services. Cardiovascular risk identified in a pharmacy should connect seamlessly with the rest of an individual's care, with each part of the system contributing according to its

[1] Department of Health and Social Care. Fingertips, Public Health Profiles [online] Available at: https://fingertips.phe.org.uk/profile/nhs-health-check-detailed/data.

expertise and accessibility. In effect, care should move around the individual rather than requiring the individual to navigate the healthcare system. This programme builds on established services such as NHS Community Pharmacy Hypertension Case-Finding Advanced Service as well as enabling independent prescribing in the setting to manage primary prevention.

Identifying elevated cholesterol or cardiovascular risk has limited value without a clear route to intervention. Bringing together point-of-care diagnostics, clinical decision-making and independent prescribing provides an opportunity to close the prevention loop: identify risk, assess it, intervene through supporting lifestyle change and initiating or optimising treatment, communicate across the neighbourhood team and follow up. Ultimately, success should be measured not simply by the number of tests undertaken, but by how effectively cardiovascular risk is reduced.

The programme has also demonstrated that successful point-of-care testing requires considerably more than placing diagnostic equipment into pharmacies. Clinical governance, analytical quality assurance, workforce competency, appropriate remuneration, digital interoperability and integration with general practice clinical systems care are fundamental. These are important lessons for commissioners considering implementation at scale and form an important part of the transferable learning generated through ELoPe-CVD.

The strategic environment has evolved significantly since this work began. The principles underpinning ELoPe-CVD are increasingly reflected within the Cardiovascular Disease Modern Service Framework[2], including proactive prevention, earlier identification of cardiovascular-kidney-metabolic risk, contributing to the national ambition of reducing premature mortality from heart disease and stroke by 25% within 10 years.

The NHS is seeking to make fundamental shifts from hospital to community, from sickness to prevention and from analogue to digital. Community pharmacy-based cardiovascular prevention brings these ambitions together: diagnostics and clinical intervention closer to home; earlier identification and management of risk; and digitally connected care across organisational boundaries.

Building on the learning generated through ELoPe-CVD, NHS England has funded a wider expansion of cholesterol point-of-care testing in community pharmacy pilot, extending the approach to around 100 pharmacies nationally. The progression from local innovation to wider NHS-supported implementation provides important validation of the model and an opportunity to apply the learning generated in North East London at greater scale.

Our ambition should be for community pharmacy to become one of the front doors to cardiovascular prevention – finding the missing millions supporting people to live well for longer.

[2] Department of Health and Social Care. Cardiovascular disease (CVD) modern service framework (MSF): a cardiovascular-kidney-metabolic approach. July 2026.

Aurora Todisco, Lived Experience Partner

My name is Aurora Todisco, and I have been involved as a Patient and Public Involvement and Engagement (PPIE) contributor supporting this evaluation. I bring lived experience as a carer, alongside experience of contributing to research, service improvement and healthcare evaluation. From a patient perspective, I believe this work is important because cardiovascular disease remains a major cause of ill health, yet many people face barriers to accessing preventative care. Services need to meet people where they are, rather than expecting everyone to navigate increasingly complex healthcare systems.

What stands out most to me about this programme is its focus on bringing prevention closer to communities through community pharmacies. Pharmacies are trusted, familiar and accessible places that many people visit regularly. The evaluation highlights how this approach reached people from ethnically diverse communities and areas of higher deprivation, groups that often experience poorer health outcomes and greater barriers to care. It is particularly encouraging to see that many people who took part may not otherwise have sought cholesterol testing or preventative cardiovascular support. The ability to combine testing, risk assessment, personalised advice and referral pathways within a convenient local setting has the potential to make prevention more accessible, timely and equitable.

The findings demonstrate that community pharmacy can play an important role in identifying people at increased cardiovascular risk before serious health problems develop. For me, this is about more than cholesterol testing. It is about creating opportunities for earlier conversations, informed decision-making and action that can help people live healthier lives for longer. As healthcare continues to move towards prevention, neighbourhood working and reducing health inequalities, I hope the learning from this programme helps shape future services. Patient and public voices must remain central to that process, ensuring that innovation is not only clinically effective but also accessible, inclusive and responsive to the needs of the communities it serves.

Acknowledgements

The UCLPartners POCT evaluation team would like to express their sincere thanks to all those who contributed to this evaluation.

Above all, we are deeply grateful to the patients who generously gave their time to share their experiences and perspectives. Their insights have been central to understanding the impact of the programme and have greatly enriched the findings presented in this report.

We would also like to thank the community pharmacists and wider pharmacy teams who took part in interviews, sharing their expertise, experiences and reflections on programme delivery. Their contributions provided important insight into the implementation and operation of the service.

Our thanks extend to the ELoPe Barts team, the POCT Steering Group, the Barts Health implementation team and the many stakeholders who contributed their expertise, insight and support throughout the programme and evaluation. This includes colleagues from HEART UK, North East London Local Pharmaceutical Committee (LPC), NEL ICB and other partner organisations. We are also grateful to programme leaders at both UCLPartners and Barts Health NHS Trust for their ongoing support in enabling this independent evaluation to be undertaken.

We would additionally like to acknowledge the contribution of the UCLPartners Patient and Public Involvement and Engagement (PPIE) team and the POCT Patient Representative, Aurora Todisco, for their support in ensuring that patient perspectives remained central to the programme and evaluation on contributing a foreword to this report.

This report was prepared by the Evaluation and Insights Team at UCLPartners, including Sarah Houston, Rohit Syed-Hasan, Liz Stovold and Kate Cheema. The authors would also like to acknowledge the contribution of Jo Setters, whose work on previous interim evaluation reports helped inform and shape this final report

Executive Summary

Bringing cardiovascular prevention closer to home

The Cholesterol Point of Care Testing (POCT) Programme was developed to improve access to cardiovascular disease (CVD) prevention, support earlier identification of cardiovascular risk and reduce health inequalities through delivery in community pharmacies. The programme was implemented across 13 community pharmacies in North East London (NEL) and North Central London (NCL), integrating cholesterol testing, QRISK3 cardiovascular risk assessment, lifestyle intervention, referral pathways and, in some sites, independent prescribing. This evaluation examined the programme's operational effectiveness, clinical effectiveness, equity of access, acceptability, wider system impact and potential for scale and sustainability.

Designing a safe, scalable community pharmacy pathway

The evaluation found that cholesterol POCT can be delivered safely and effectively within community pharmacy settings when supported by robust governance, quality assurance processes, workforce development and clear clinical pathways. Between January 2025 and February 2026, the programme delivered 1,209 cholesterol POCT to inform cardiovascular risk assessment consultations across 13 pharmacies. Activity increased following expansion into a neighbouring ICB - NCL, demonstrating the transferability of the model and its ability to scale beyond the initial pilot sites. Most patients (83%) were managed entirely within community pharmacy, while a smaller proportion required referral to general practice or onward clinical management for significantly elevated lipid panel tests.

Reaching communities at greatest risk

The programme successfully reached populations at increased risk of cardiovascular disease and health inequalities. Participants were more likely than the wider NEL population to live in the most deprived communities, and the service engaged a diverse population, particularly people from Asian communities. Community pharmacy delivery, combined with opportunistic case-finding, enabled engagement with individuals who may not otherwise have accessed preventative services. Qualitative findings suggested that convenience, trusted relationships with community pharmacy and ease of access were important mechanisms underpinning this reach.

Uncovering hidden cardiovascular risk

The programme identified substantial unmet cardiovascular risk. Two-thirds of patients had at least one cardiovascular risk factor, and one in five patients with a recorded QRISK3 score were identified as having elevated cardiovascular risk (≥10%). Elevated clinic blood pressure was also common, affecting over 40% of participants. While relatively few patients demonstrated markedly abnormal lipid results, the broader cardiovascular risk assessment enabled identification of individuals who may have otherwise remained undetected through cholesterol measurement alone. Across the evaluation period, 74 patients initiated lipid-lowering therapy following assessment and follow-up.

Highly valued by patients and pharmacy teams

Acceptability of the service was exceptionally high among both patients and pharmacy teams. Patient survey findings showed that almost all respondents found the service easy to access, rated their experience positively and would recommend it to others. Interviews highlighted the value patients placed on rapid access to results, personalised discussion, and the opportunity to receive preventative care closer to home. Pharmacy teams reported that the service aligned well with their existing clinical role and broader ambitions for community-based prevention.

Unlocking wider benefits for the health system

The evaluation also identified potential wider system benefits. Stakeholders viewed the programme as contributing to NHS ambitions around prevention, neighbourhood healthcare and reducing health inequalities. Community pharmacy was seen as an important setting for delivering cardiovascular risk assessment without relying on traditional laboratory pathways, while creating opportunities for more integrated cardiovascular, metabolic and kidney disease prevention services. However, the evaluation timeframe was insufficient to demonstrate impacts on long-term cardiovascular outcomes, healthcare utilisation or system costs, and further longitudinal evaluation will be required.

What is needed to scale with impact

Several considerations emerged for future implementation. Variation in activity between pharmacies, workforce capacity constraints, service awareness, digital exclusion, language accessibility and the need for stronger engagement with general practice were identified as important areas for development. Stakeholders also emphasised the importance of sustainable commissioning, clear governance arrangements, quality assurance processes and digital interoperability to support future expansion.

A case for community pharmacy prevention

Overall, the evaluation demonstrates that community pharmacy-based cholesterol POCT was a feasible, acceptable and equitable model for delivering cardiovascular prevention closer to home. The programme successfully identified previously unrecognised cardiovascular risk, reached underserved populations and generated high levels of patient and professional support. The findings suggest that cholesterol POCT could play an important role in future community-based cardiovascular prevention pathways, complementing and extending accessible clinical services such as blood pressure checks and independent prescribing in community pharmacy. This model could support the wider management of long-term conditions in line with the ambitions set out in the NHS 10 Year Plan. Successful scale-up is likely to require sustainable funding, strong governance, continued focus on reducing health inequalities and ongoing evaluation of longer-term outcomes and impact.

Context

Background

Cardiovascular disease (CVD) is a major public health challenge and a key priority within the NHS 10 Year Health Plan.[1] As one of the leading causes of premature mortality, CVD disproportionately affects people living in more deprived communities, where premature mortality rates were more than twice as high as those in the least deprived areas of England in 2023.[2]

Addressing cardiovascular risk factors is central to NHS England's Core20PLUS5 approach to reducing health inequalities. Hypertension case-finding and optimal lipid management are two one of its five clinical priorities, reflecting the significant contribution of cardiovascular disease to premature mortality and inequalities in health outcomes.[3] High cholesterol is one of the most important modifiable risk factors for cardiovascular disease, with around half of UK adults estimated to have cholesterol levels above recommended thresholds.[4]

Across North London, socioeconomic deprivation remains an important driver of cardiovascular health inequalities. In North London, 23% of neighbourhoods fall within the 20% most deprived areas in England, with deprivation concentrated in several boroughs. Notably, three of England's ten most deprived local authorities are located within the region.[5] These inequalities contribute to a substantial burden of preventable cardiovascular disease and highlight the importance of accessible approaches to prevention, early identification and intervention.

Hypertension provides a clear example of this potential unmet need. In NEL, recorded hypertension prevalence was 10.7% in 2023/24, with a further 7.7% of adults estimated to have undiagnosed hypertension.[7] Proactive case-finding and cardiovascular risk management therefore represent important opportunities to reduce cardiovascular disease burden and associated health inequalities across North London.

Recent national policy has further strengthened the focus on prevention and early detection. The NHS 10 Year Health Plan sets out a strategic shift towards community-based care and preventative healthcare, with a strong emphasis on identifying and managing cardiovascular risk factors through neighbourhood health services.[1] In addition, the 2026 Cardiovascular Disease Modern Service Framework (CVD MSF) established a national ambition to reduce premature deaths from heart disease and stroke by 25% over the next decade.[8] The framework recognises high cholesterol as a key modifiable risk factor and highlights the importance of proactively identifying and managing cardiovascular-kidney-metabolic (CKM) risk factors, particularly among underserved populations and communities experiencing the greatest health inequalities.[8]

Cholesterol point-of-care testing (POCT) supports these national objectives by enabling rapid cardiovascular risk assessment in community settings, reducing barriers associated with traditional

laboratory testing pathways, and facilitating timely referral and treatment. By improving access to cholesterol testing for people who may be less likely to engage with routine primary care services, POCT has the potential to increase detection of elevated cholesterol, support earlier intervention, and help reduce cardiovascular health inequalities.[1,8]

Description of the POCT programme

North East London received funding through Wave 1 of the Innovation for Healthcare Inequalities Programme (InHIP) in 2022 to deliver a multidisciplinary CVD prevention programme. The programme aimed to better understand inequalities in cardiovascular risk and develop tailored interventions to improve prevention and cardiovascular health outcomes.

Building on the progress of Wave 1, NEL secured further funding through InHIP Wave 2 to develop and evaluate a community pharmacy-based POCT service for cholesterol. The programme was designed to improve access to cardiovascular risk assessment, support earlier identification of elevated cardiovascular risk and strengthen prevention pathways within community settings. It was delivered alongside the existing NHS Community Pharmacy Hypertension Case-Finding Advanced Service and aligned with wider ambitions to improve access to preventative care and care closer to home. The purpose of the programme was to provide a POCT service, to support identification of individuals with poor lipid control who may be at high risk of CVD and to develop pathways to optimise CV risk reduction medication in the community.

The programme utilised the Afinion™ 2 Analyser, linked to the HealthTab digital platform, to provide rapid cholesterol testing and cardiovascular risk assessment within community pharmacies. The Afinion™ 2 Analyser analyses a small sample of blood, taken from a finger prick, in order to produce a full lipid panel. In addition to the blood sample, the person being tested provides additional information to produce a QRISK3 score [9], which estimates a person's 10-year risk of developing cardiovascular events, such as heart attacks or strokes.[10]

Patients are recruited for cholesterol POCT directly by community pharmacists according to eligibility criteria (Table 1), either through opportunistic interactions or by patient engagement with promotional materials in the pharmacy. Pharmacists discuss results with patients during the same consultation, including any further referrals or lifestyle changes recommended (Figure 1). The results are automatically uploaded to a patient-accessible digital health dashboard and are also transferred to the NHS App with the patient's consent, enabling patient self-management and communication of results with general practice teams. As part of the programme, patients with a high QRISK3 score (≥10%) were followed up by telephone at 1 and 3 months to collect information on treatment outcomes and prompt them to contact their GP, if required.

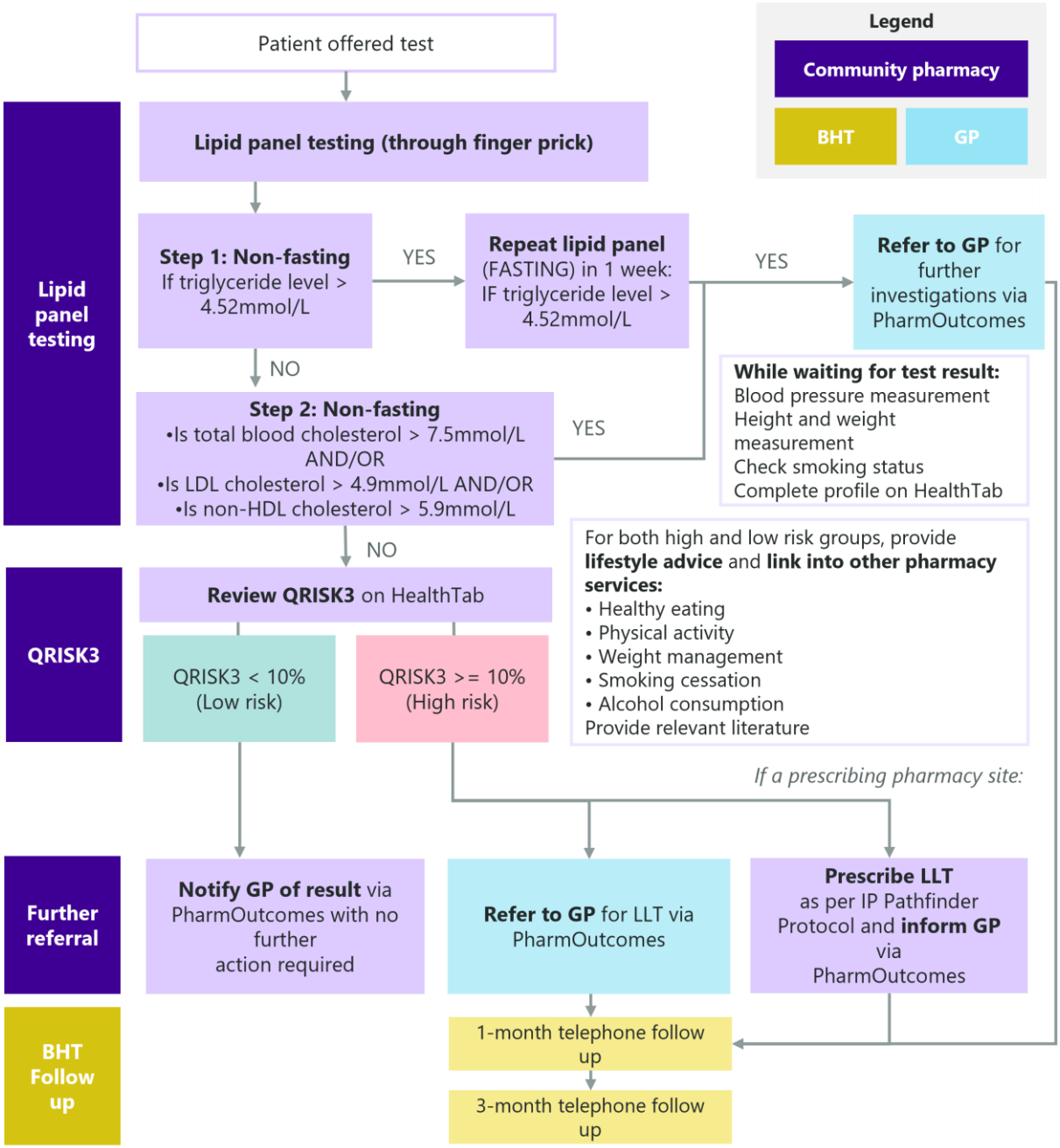


Figure 1: Cholesterol POCT Patient pathway map (Updated pathway as of June 2026). IP: Independent prescribing, LLT: Lipid-lowering therapy.

Inclusion Criteria	Exclusion Criteria
Patients for this service are to be identified when: Consenting to a clinic blood pressure test (via the existing NHS Community Pharmacy Blood Pressure Check Service or privately in the community pharmacy) Collecting their own medicines indicated for hypertension (e.g. antihypertensives) Collecting their own medicines indicated for type 2 diabetes (e.g. taking metformin)	Under 35 years of age Over 84 years old People established on lipid lowering therapy (i.e. statins, ezetimibe, bempedoic acid, injectables such as inclisiran or PCSK9 inhibitors) People who are unable to, or do not, give consent to participate
	People who have established CVD, e.g. angina, peripheral vascular disease, or a previous CVD event such as acute coronary syndrome (heart attack/unstable angina) or stroke Type 1 diabetes Known familial hypercholesterolaemia or other inherited disorders of lipid metabolism Acutely unwell, e.g. severe abdominal pain, nausea and vomiting, fever*

* People with pancreatitis may present with these symptoms

Table 1: Patient pathway inclusion and exclusion criteria (June 2026)

Programme delivery and implementation

Programme Aims and Development

The cholesterol POCT programme was developed as part of a broader ambition to strengthen community-based cardiovascular disease prevention and reduce health inequalities across North East London. The programme was designed to align with national and local priorities, including prevention, care closer to home, reducing inequalities through the Core20PLUS5 approach, and improving identification and management of cardiovascular risk factors within community settings.

Locally, the programme aligns with the East London Cardiovascular Disease Prevention (ELoPe) strategy, which aims to reduce premature cardiovascular disease (CVD) mortality and address health inequalities across East London communities. Developed and led by Barts Health NHS Trust, the ELoPe programme operates across NEL and provides a coordinated framework for CVD prevention, supporting collaboration and integration across relevant care pathways.

The original objective was to assess the feasibility of delivering cholesterol POCT within community pharmacies and to understand whether testing could be integrated into existing cardiovascular prevention pathways. The programme built upon established NHS Community Pharmacy Hypertension Case-Finding Advanced Service and was closely linked to the Independent Prescribing (IP) Pathfinder programme, creating opportunities for more comprehensive cardiovascular risk assessment and management within pharmacy settings.

From the outset, an important ambition was to develop a model that could move beyond a local pilot and, if successful, be scalable and transferable to other systems. As the programme developed, consideration was also given to how POCT could support wider cardiovascular and metabolic pathways. The Afinion™ 2 Analyser used within the programme is capable of delivering additional tests, including HbA1c and urine albumin-to-creatinine ratio (ACR), creating opportunities for future integration with diabetes, kidney disease and broader cardiovascular disease prevention programmes.

Governance and Programme Structure

Significant preparatory work was undertaken before implementation to establish the governance, operational and clinical foundations of the programme. This included development of service specifications, service level agreements (SLAs), clinical pathways, quality assurance procedures, training materials and stakeholder engagement mechanisms.

The programme adopted a phased implementation approach with formative learning opportunities influencing scaled delivery. Delivery initially commenced within a single pilot pharmacy site before expanding to additional pharmacies. This enabled learning from early implementation to inform service refinement and operational improvements prior to wider rollout.

A key component of programme governance was the quality assurance framework supporting the POCT process. Participating pharmacies were required to undertake regular internal quality control checks on testing equipment. In addition, external quality assessment was provided through HealthTab's quality assurance programme, using independently reference-valued samples to monitor the accuracy and consistency of cholesterol testing across participating pharmacies.

Considerable attention was also given to the selection of testing technology. The programme team selected a point of care testing platform that was externally certified through the Centres for Disease Control and Prevention Cholesterol Reference Method Laboratory Network (CRMLN), which is widely recognised as a benchmark of analytical accuracy for cholesterol testing. The intention was that results generated within community pharmacies could be used confidently within wider care pathways without the routine need for repeat laboratory testing. The programme utilised guidelines from NHS England, endorsed by the Royal Pharmaceutical Society and the General Pharmaceutical Council, which outline how to select point of care testing, including the necessary governance validation checks, how to select equipment, and how to train users [11].

Participating pharmacies operated under a service level agreement with Barts Health NHS Trust, which specified service requirements, governance arrangements, data collection requirements and quality standards. Pharmacies received financial reimbursement through a combination of a set-up payment and an activity-based payment for completed cholesterol POCT consultations.

Stakeholder Engagement and Patient and Public Involvement

Stakeholder engagement formed a central component of programme development and implementation. A multidisciplinary steering group and working group were established to support programme design, governance and oversight.

Stakeholders involved in programme development included:

- NHS England representatives
- Integrated Care Boards (ICBs)
- Commissioners
- Community pharmacy leaders
- Local Pharmaceutical Committees (LPCs)
- Acute providers
- Pathology specialists
- Technology partners
- Evaluation partners

Patient and public involvement and engagement (PPIE) was embedded throughout programme governance. Support was provided through the UCLPartners PPIE team and a representative with lived experience participated in the programme steering group. HEART UK also provided patient-centred perspectives and advice relating to patient information resources, communication and engagement.

While engagement was generally broad, the programme team identified engagement with general practice as an area requiring continued attention. As implementation progressed, stakeholders highlighted the importance of involving GP practices and Local Medical Committees (LMCs) early in pathway design and communication processes.

Pharmacy Recruitment and Rollout

The selection of participating pharmacies combined considerations of population need and operational readiness. Initially, geographical areas were identified using measures of deprivation and cardiovascular disease burden, reflecting the programme's focus on reducing inequalities and improving access to preventative services. This approach aligned with Core20PLUS5 priorities and aimed to target communities most likely to benefit from earlier cardiovascular risk identification.

Recruitment was undertaken in partnership with local pharmacy leaders and Local Pharmaceutical Committees. Expressions of interest were invited from pharmacies operating within target areas.

Selection criteria included:

- Location within areas of higher deprivation.
- Availability of a private consultation room.
- Sufficient workforce capacity to deliver the service.
- Weekend opening, with Saturday availability as a minimum requirement.
- Demonstrated willingness to adopt and deliver innovative services.

Stakeholders reported strong interest from community pharmacies, with demand to participate exceeding the number of places available during initial implementation phases.

In January 2025, seven community pharmacies across North East London were selected to participate in the initial rollout. One pharmacy was initially onboarded as a “pilot site” for two months to gather lessons learned for wider rollout. The six pharmacies subsequently onboarded were also participating in the Independent Prescribing Pathfinder programme, enabling prescribing of statins for eligible patients in line with NICE guidance.[12]

Following implementation and review within North East London, the model was subsequently adopted within North Central London. Six additional community pharmacies were recruited and began offering cholesterol POCT and cardiovascular risk assessment in June 2025, using the

implementation materials, governance arrangements and training model developed during the original rollout.

Workforce Development and Support Model

Workforce development was a major component of implementation and was viewed as essential to ensuring safe, effective and consistent service delivery.

Training was delivered by specialist CVD pharmacists from BHT through a combination of online and face-to-face approaches and covered both clinical and operational aspects of the programme. Key components included:

- The purpose and objectives of the service
- Cardiovascular disease prevention and health inequalities
- Operation of the Afinion™ 2 Analyser
- Interpretation of cholesterol results and QRISK3 scores.
- Use of the HealthTab platform
- Consultation and communication skills
- Case-based learning and clinical scenarios

Competency assessment formed an integral part of implementation. Pharmacists were observed by their trainers both delivering consultations and conducting tests within their own pharmacy environments. Assessment included both technical competency, such as blood sample collection and machine operation, and wider consultation skills, including communication of results and risk discussion.

Following initial training, participating pharmacies received ongoing support through regular review meetings, performance monitoring and feedback mechanisms. As implementation progressed, additional learning emerged around consultation length, digital connectivity, data transfer processes and management of test supplies. These experiences informed subsequent refinements to training, operational processes and support arrangements, particularly during expansion into North Central London.

Previous reports

An interim evaluation report was produced in December 2025 and focused on the implementation and activity of the cholesterol point of care testing service across seven participating pharmacies in North East London (NEL). This final report builds on the interim findings by incorporating data from a longer evaluation period and a broader cohort of participating pharmacies. The analysis includes data from 13 pharmacies across North East London and North Central London (NCL), providing a more comprehensive assessment of service reach, population characteristics, outcomes and programme delivery, as well as further insights on future scope, scale and sustainability of the programme.

Evidence review

Introduction

A rapid review of published evidence was undertaken in October 2025 to identify published evidence relating to the implementation, feasibility, equity and treatment outcomes of cholesterol POCT delivered through community pharmacies.

The review used adapted systematic review methods, comprising searches of PubMed, the Cochrane Library and Google Scholar, supplemented by reference checking and targeted searches. Studies involving adults receiving cholesterol POCT in community pharmacy settings were eligible for inclusion if they reported implementation strategies, feasibility, equity, adherence or related outcomes.

The review addressed the following research questions:

- What is the existing evidence on the feasibility of cholesterol POCT in community pharmacies?
- What is the existing evidence on the equity of cholesterol POCT in community pharmacies?
- What is the existing evidence on patient adherence to treatment initiated based on the cholesterol POCT result?

A summary of the review is provided here, alongside the principal evidence gaps identified in the literature. These gaps informed both the design of the programme and the evaluation framework, particularly in relation to implementation, health inequalities, patient experience and outcomes following identification of cardiovascular risk. The section also highlights areas in which the programme contributes to addressing limitations in the existing evidence base.

Table 2: Methods summary of rapid evidence review

Component	Summary
Review approach	Rapid evidence review using adapted systematic review methods
Search date	August 2025
Studies identified	464 records identified, 17 publications included
Types of evidence	6 systematic reviews,11 primary studies
Geographical coverage	Global evidence base including UK, USA, Canada, Australia, Sweden, Thailand, Iran, Nigeria and Malta
Population studied	Adults without known cardiovascular disease alongside selected high-risk and socioeconomically disadvantaged populations
Interventions included	Cholesterol POCT alone or as part of wider cardiovascular risk screening programmes
Limitations	The review was conducted using a rapid methodology with potential limitations in scope and depth. Due to the scarcity of cholesterol POCT-specific research, broader CVD screening and management studies were included, which may limit the direct applicability of findings.

Review Findings

What is the existing evidence on the feasibility of cholesterol POCT in community pharmacies?
The evidence indicates that cholesterol POCT in community pharmacies is feasible, with systematic reviews and primary studies consistently showing that pharmacists can successfully deliver testing, identify individuals at elevated cardiovascular risk and facilitate appropriate referral or treatment pathways. Studies also reported good analytical performance of POCT devices and high levels of patient acceptability.

What is the existing evidence on the equity of cholesterol POCT in community pharmacies?
Evidence on equity is limited. While community pharmacies are recognised as accessible settings that may help reach underserved populations and people who do not regularly engage with primary care services, few studies explicitly examined equity, health inequalities or differential outcomes across population groups. Equity considerations were largely absent from implementation and evaluation approaches published.

What is the existing evidence on patient adherence to treatment initiated based on the cholesterol POCT result?
Evidence on adherence is very sparse. Only one study identified in the review reported adherence outcomes, finding that 84% of patients prescribed lipid-lowering medication following pharmacist-led cholesterol POCT management remained adherent during the follow-up period. No substantial additional evidence on treatment adherence following cholesterol POCT was identified.

Summary of literature findings

Overall, the literature demonstrates that community pharmacy cholesterol POCT is feasible and acceptable, but highlights important evidence gaps relating to implementation, equity, patient experience, treatment adherence and longer-term outcomes.

Recommendations for practice included the development of national policies to regulate and support POCT in pharmacies; structured training and remuneration mechanisms; and closer collaboration with GPs to ensure continuity of care. Future research should adopt rigorous study designs, incorporate economic evaluations, investigate patient experiences, and focus on long term outcomes, sustainability, and approaches tailored for disadvantaged populations.

Areas of innovation of the Cholesterol POCT Programme

Integrated cardiovascular pathway

Unlike many published studies that focused primarily on screening, the programme embedded cholesterol POCT within a wider cardiovascular prevention pathway. This aimed to combine validated cholesterol testing, QRISK3 assessment, lifestyle advice, shared decision-making, independent prescribing and integration with NHS systems and pathways.

Addressing evidence gaps

The programme and evaluation address several gaps identified in the literature by generating evidence on implementation, governance, workforce training, patient experience, treatment initiation and follow-up outcomes. It provides practical learning on how pharmacy-based cholesterol POCT can be delivered and scaled within routine NHS services.

Consideration of equity in approach

Equity was a key consideration in programme design. Pharmacies were selected in areas of high deprivation and delivery aligned with Core20PLUS5 priorities, supporting access for ethnically diverse and underserved populations. This evaluation also examines participation and outcomes across different population groups, addressing a major evidence gap in the existing literature.

Summary of review

The programme reflects a more comprehensive approach than that typically described in the published literature, combining cholesterol POCT with cardiovascular risk assessment, independent prescribing, health inequality considerations and integration into NHS care pathways.

The programme therefore could contribute practical learning beyond the published literature about how an integrated pharmacy-based cardiovascular prevention pathway could be implemented, governed, delivered equitably and evaluated within a real-world NHS setting.

Evaluation Methods

Evaluation design

UCLPartners' Evaluation and Insights team undertook a mixed-methods evaluation of the POCT programme, using a parallel convergent design in which quantitative and qualitative data were collected and analysed concurrently.

The evaluation combines quantitative analysis of programme activity and outcome data with qualitative research involving patients, pharmacy teams and wider stakeholders. A logic model was developed at the outset of the programme to inform the evaluation design and identify the programme's intended mechanisms, outcomes and impacts. The evidence review (described previously) also contributed to establishing the aims of the evaluation.

The evaluation aims include:

- Assess the **operational effectiveness** of the programme
- Audit the **equity of access** for patients according to demographic characteristics, deprivation and clinical need
- Assess the **clinical effectiveness** of the programme, to:
    - Identify people with high-risk cardiovascular disease
    - Optimise medication in the community setting
- Assess **staff and patient acceptability** of the programme
- Understand the **wider system impact** of the programme and **potential for scale**

For more information on design of the evaluation and methods used, please see **Supplementary Materials.**

Data collection

Qualitative

Patient experience survey

Patients who received a cholesterol POCT were invited to complete a patient experience survey electronically at the time of their test. The survey captured views on service accessibility, satisfaction, understanding of results and perceived impact. Survey respondents were also given the opportunity to provide contact details if they wished to participate in a follow-up interview.

Interviews

Stakeholder interviews

Interviews were conducted with five key stakeholders involved in programme design, delivery and oversight across North East London and North Central London in September to November 2025 to further develop the evaluation framework and provide context to the programme. These included representatives involved in programme leadership, commissioning, implementation, community pharmacy, cardiovascular prevention and patient advocacy.

Pharmacist interviews

Semi-structured interviews were conducted with six pharmacists involved in delivering the programme across seven pharmacies. All pharmacists were recruited for interview as part of the pilot phase of the programme in North East London. Interviews took place in July 2025 explored implementation experiences, training and support, operational delivery, patient engagement, perceived benefits and challenges, and views on future sustainability and scale-up.

Patient interviews

Semi-structured interviews were undertaken with 13 patients who had received a cholesterol POCT through participating pharmacies. Participants were self-selecting, recruited through the patient survey and volunteered to be contacted for follow-up interviews. Interviews took place between August and November 2025 and explored experiences of the service, perceived benefits, barriers to access, and views on future delivery.

Interview analysis

Findings were analysed thematically and triangulated with pharmacy team and stakeholder interviews to build a broader understanding of the programme's contribution to equitable access to cardiovascular prevention.

Declaration: *Microsoft Copilot was used as a supplementary tool to support thematic analysis of qualitative data. AI-generated outputs were subject to review, interpretation and quality assurance by human analysts, who retained responsibility for all final findings and conclusions.*

Quantitative

POCT programme data

Quantitative analysis was undertaken using routinely collected programme data from multiple sources, including:

- **HealthTab data,** including demographic information, cardiovascular risk factors and QRISK3 scores
- **Afinion™ 2 Analyser testing data**, including cholesterol results

- **Follow-up outcome data** collected via follow up telephone calls by the programme team, including prescribing information
- **Service activity** and **operational delivery** data

Programme data was provided in a minimised and anonymised format to UCLPartners as part of the service evaluation. Where possible, programme datasets were linked by the programme team to enable analysis of patient demographics, cardiovascular risk profiles, service activity and reported outcomes.

Equity data

To assess the equity of access of the programme, patient characteristics were compared with wider population and service datasets. Comparator datasets included:

- **Office for National Statistics (ONS) Census data (2021)** to understand how the demographic profile of individuals receiving cholesterol POCT compared with the local population
- **Index of Multiple Deprivation (IMD) data** to assess whether the programme was reaching patients from more deprived communities
    - To maintain consistency with the programme's original design and analyses, deprivation measures are based on IMD 2019, which was the most recent dataset available at the time. More recently published IMD 2025 data are therefore not reflected in this report.
- **NHS Health Check programme data** to compare uptake patterns and understand whether community pharmacy POCT was reaching populations engaged with, or potentially missed by, existing cardiovascular prevention programmes
- **CVDPrevent data** to identify an "at-risk" CVD population for comparison
- **NHS Business Services Authority (NHSBSA) community pharmacy data** to map participating pharmacies against deprivation indices and compare the distribution of programme sites with the wider pharmacy network across NEL and NCL

Limitations

Qualitative data limitations

- The patient survey was only available in English. As a result, the views and experiences of patients with limited English proficiency may be underrepresented.

- Patient interviews were recruited through the patient survey and relied on participants volunteering to take part. Individuals with particularly positive or negative experiences may have been more likely to participate, introducing the potential for self-selection bias. In

addition, the interview sample may underrepresent certain population groups, as individuals with higher levels of English proficiency or greater familiarity and confidence with research participation may have been more likely to engage.

- Pharmacy interviews were conducted with staff involved in the initial NEL implementation sites. Their views may not fully reflect experiences from later phases of delivery or other participating areas.
- The number of stakeholder interviews was relatively small and focused on individuals closely involved in programme design and implementation. Findings may not capture the full range of perspectives across the wider health and care system.
- No general practice stakeholders were interviewed as part of the evaluation. Insights relating to general practice were therefore obtained indirectly through pharmacy and stakeholder interviews rather than directly from GPs or Primary Care Networks.

Quantitative data limitations

- Data were only available for individuals who received a cholesterol POCT. Information was not available on patients who attended participating pharmacies but did not receive a test, including those who declined or were not eligible. It was therefore not possible to estimate uptake rates among all potentially eligible patients or fully assess reasons for non-participation.
- Linked primary care, prescribing and hospital activity data were not available for the evaluation. As a result, it was not possible to assess the impact of the programme on general practice activity or longer-term outcomes.
- The evaluation focused primarily on programme delivery, implementation, acceptability and short-term outcomes. However, many anticipated benefits of cardiovascular prevention interventions occur over longer timeframes than those covered by the evaluation period. Longer-term follow-up and linked healthcare data would be required to assess sustained behaviour change, treatment optimisation, changes in cardiovascular risk and wider system impacts.

Regional changes

From 1 April 2026, NHS North Central London ICB became part of the newly established NHS West and North London ICB following its merger with NHS North West London ICB. As this programme began in 2024, NCL ICB is referred to throughout this report by its former name. For consistency, references to geographical areas relate only to the former North Central London area.

Results

Operational Effectiveness

Context

Operational effectiveness in this evaluation refers to how effectively the programme established and implemented the POCT pathway across community pharmacies, enabling timely testing and appropriate patient management in line with the agreed pathway. Operational data has been analysed across the timeframe of the cholesterol POCT programme (January 2025 – February 2026) across all NEL and NCL sites.

Operating model

Patients receive a point-of-care lipid panel test at the community pharmacy, followed by lipid threshold checks and QRISK3 assessment. All patients will receive some form of lifestyle advice. Depending on risk level, patients are referred to their GP or receive initiation of lipid-lowering therapy at the pharmacy (if a prescribing site), with telephone follow-up at one and three months.

Demand and throughput

The Cholesterol POCT service performed 1,209 tests between January 2025 and February 2026 across 13 pharmacies in NEL and NCL (Figure 2). Weekly testing activity rose following the Phase 2 launch in North Central London and the expansion to 13 pharmacies, reaching a peak of 66 tests in one week.

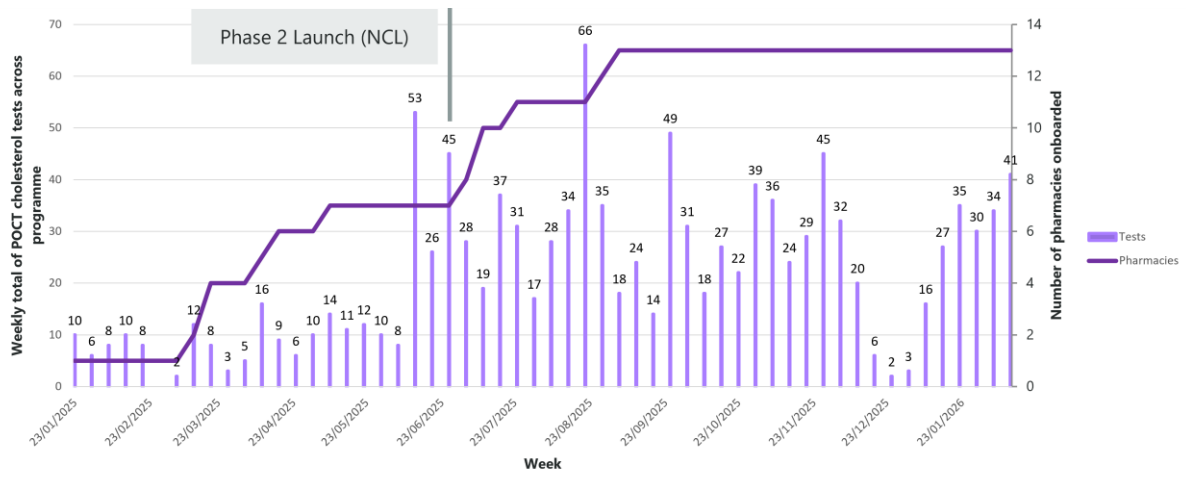


Figure 2: Weekly cholesterol POCT activity and cumulative pharmacy onboarding

Pathway flow and management

Most tests (1002, 82.9%) were managed within community pharmacy without onward referral, while 189 patients (15.6%) were referred to general practice (Figure 3). Overall, 74 patients initiated pharmacological treatment- 63 following GP referral and 11 through the independent-prescriber pathway, equivalent to approximately 6% of those tested.

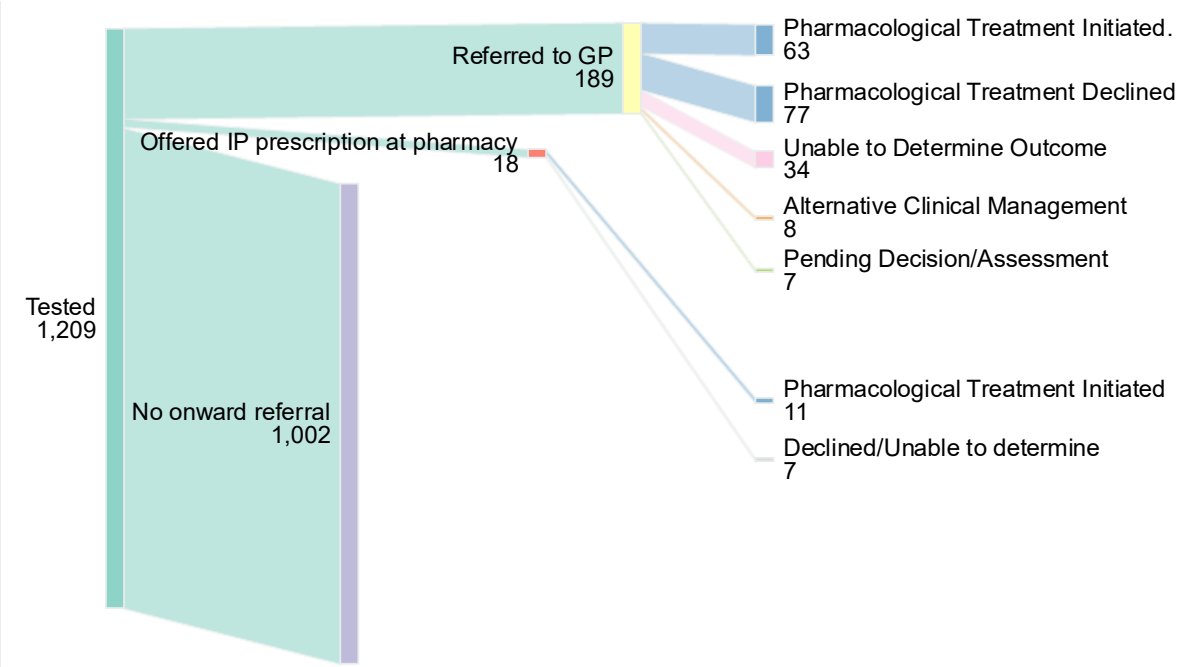


Figure 3: Sankey diagram of patient flow through POCT programme

Variation in delivery

Variation over time

Weekly testing increased following the Phase 2 launch, with the average rising from 11 tests per week in Phase 1 to 28 in Phase 2 (Figure 4). Activity fluctuated considerably, including a significant decline between late November 2025 and January 2026. This period coincided with the seasonal vaccination programme, suggesting that competing demands on pharmacy capacity may have temporarily reduced POCT delivery. By February 2026, the number of weekly tests appears to have recovered. To pre-vaccination season levels.

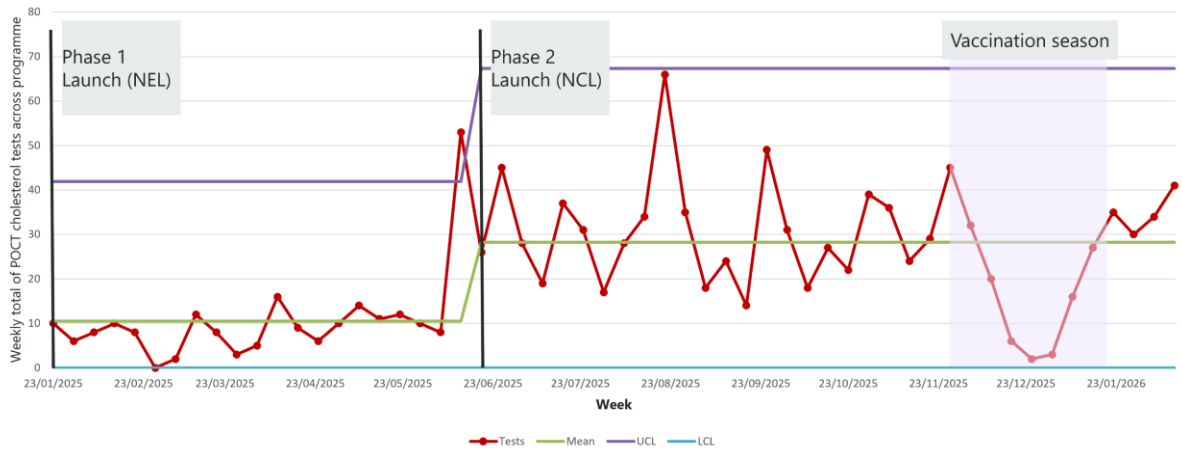


Figure 4: Statistical process control chart (xmr) of weekly cholesterol POCT tests completed across the programme

Variation across pharmacies

There was substantial variation in testing activity between pharmacies. Although 13 pharmacies participated in the programme, two pharmacies accounted for over half of all tests conducted (51.8%) (Figure 5). The highest-volume pharmacies were located across both NEL and NCL, suggesting that differences in onboarding timing alone do not explain the variation in testing activity. Similarly, pharmacies with independent prescribing status were distributed across the full range of testing volumes, with both high- and low-performing sites represented, indicating no clear relationship between IP status and test activity.

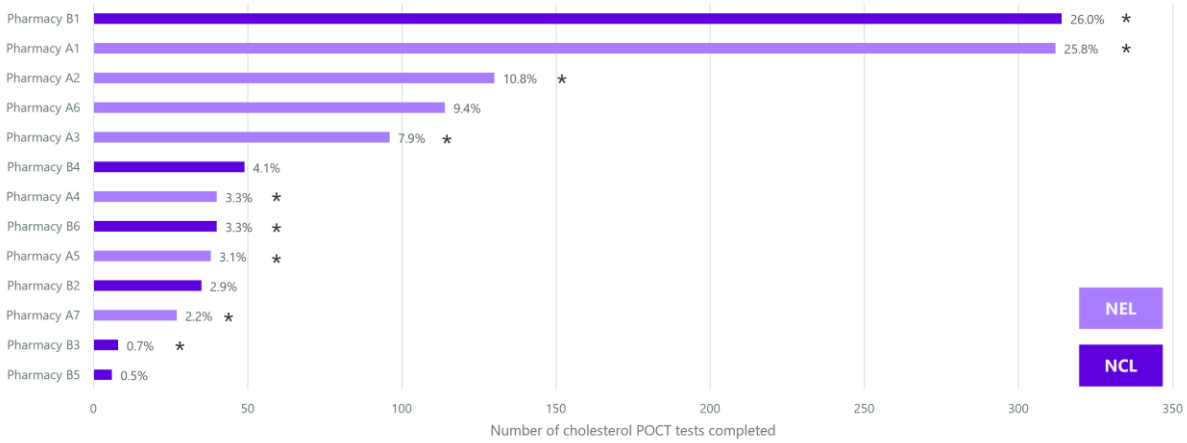


*Figure 5: Number and proportion of cholesterol POCT tests completed by each participating pharmacy. Pharmacies are coloured by their respective ICBs. * Indicates a pharmacy with independent prescribing status.*

Clinical Effectiveness

Context

Clinical effectiveness in this evaluation refers to how successfully the programme identified people with elevated or previously undetected cardiovascular risk and supported appropriate clinical management, including referral, prescribing and treatment outcomes.

Patient population

People accessing POCT were predominantly aged 40–59 years (60.7%), and 65.9% were female (Figure 6). The population was ethnically diverse: 39.2% identified as Asian or Asian British, 22.5% as White and 12.8% as Black or Black British. Most tests were delivered to people living in more deprived areas, with 59.5% from IMD deciles 2 and 3. However, ethnicity was not recorded for 17.3% of patients, limiting assessment of equitable access and under-estimating accurate cardiovascular-risk calculation.

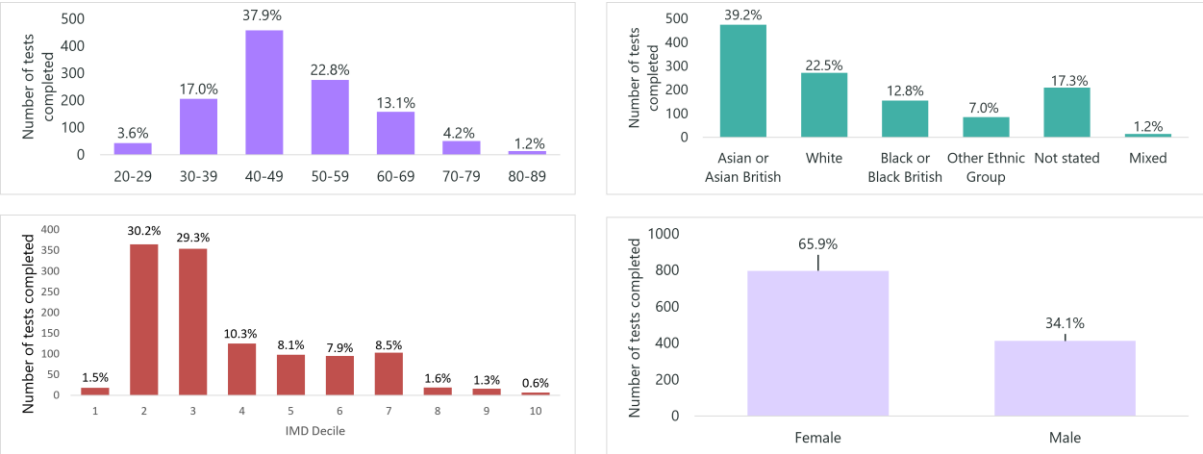


Figure 6: Demographic profile of patients accessing cholesterol POCT, by age, ethnicity, deprivation and sex

Further analysis of patient demographics, including comparison to the local population in NEL, is included in the Equity section of this report.

Identification of cardiovascular risk

Risk profiles of patients

The following analysis explores the burden of relevant cardiovascular risk factors among people accessing the POCT service and how this varies across demographic groups. Table 3 outlines the definitions and thresholds used for each risk factor.

Risk Factor	Threshold / Definition used
BMI	≥ 30 kg/m^2; ≥ 27.5 for South Asian and other higher-risk ethnic groups
Blood Pressure	Hypertension defined as ≥ 140/90 mmHg in consultation
Smoking	Current smoking (including "moderate" or "heavy")
Chronic kidney disease	Self-reported history
Diabetes	Diabetes (type 1 or type 2) or family history of diabetes
Atrial Fibrillation	Self-reported history

Table 3: Definitions and thresholds used to identify cardiovascular risk factors

The majority of people accessing the service had at least one listed cardiovascular risk factor. Around two-thirds of patients (66%) had one or more risk factors identified. Almost one in four patients (24%) had two risk factors, and a smaller group (7%) had three or more, indicating a cohort with substantial opportunities for preventative intervention. (Figure 7)

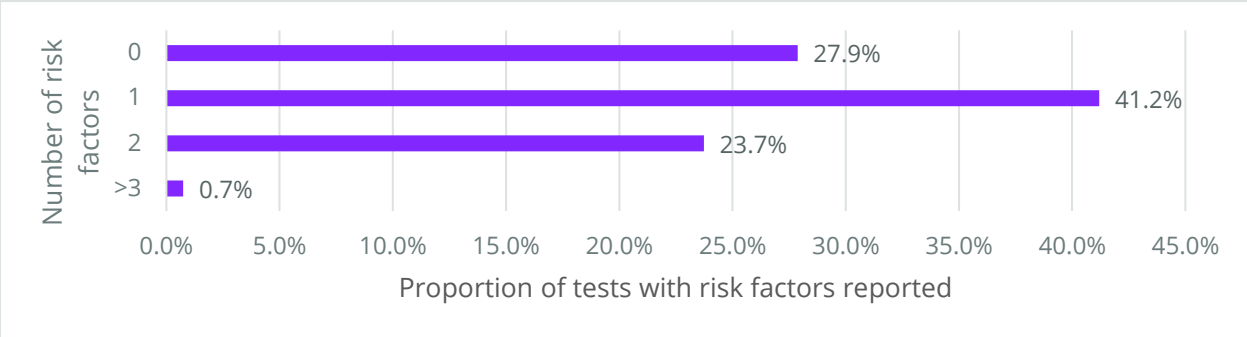


Figure 7. Number of cardiovascular risk factors among POCT patients

The prevalence of multiple risk factors generally increased with age. Patients aged 40-59 years had the highest proportion with two or more risk factors (36%), reflecting the age group in which cardiovascular risk factors commonly emerge and accumulate. While most people in every age category had at least one risk factor, the findings suggest that the service is reaching individuals at a stage where preventative intervention is likely to have significant benefit. (Figure 8)

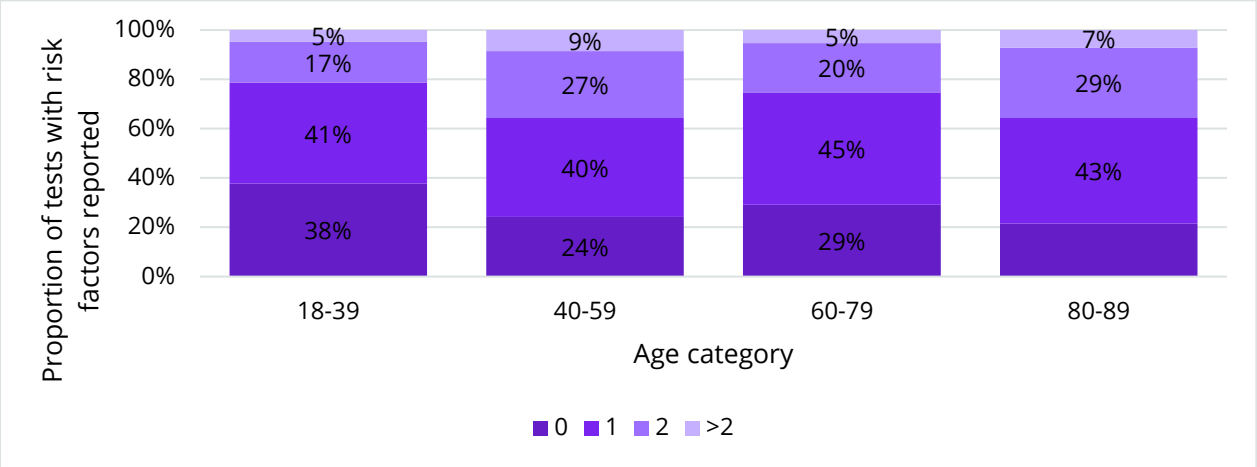


Figure 8. Cardiovascular risk factor burden by age group

A social gradient was observed in cardiovascular risk factor burden. Patients living in the most deprived areas (IMD1) were less likely to have no identified risk factors and more likely to have multiple risk factors compared with those living in less deprived areas. (Figure 9)

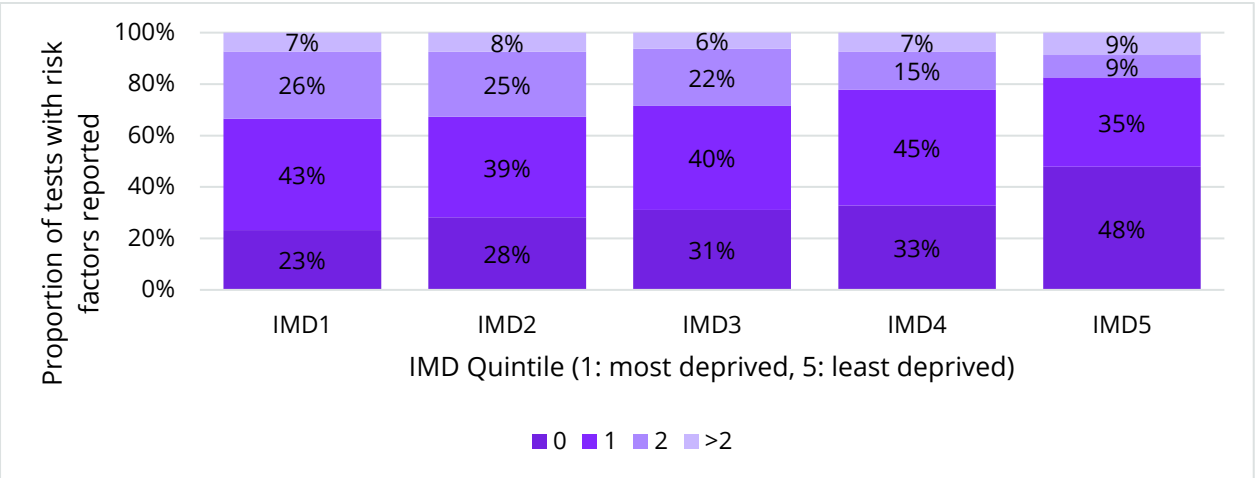


Figure 9. Cardiovascular risk factor burden by deprivation quintile

Test findings

Most patients had lipid results within the specified thresholds, with individual abnormalities recorded in 1–5% of test metrics (Figure 11). However, the broader QRISK3 assessment identified substantially more people at elevated cardiovascular risk: 234 patients (20.5% of those with a recorded score) had a QRISK3 score of 10% or above. This indicates that combining POCT lipid testing with a comprehensive risk assessment was important for identifying patients who may benefit from further clinical management.

Result	n	% of total
Total cholesterol > 7.5 mmol/L	**21**	**2%**
LDL > 4.9 mmol/L	8	1%
Non-HDL > 5.9 mmol/L	14	1%
Triglycerides > 4.52 mmol/L	61	5%
Low HDL < 1.0 mmol/L	59	5%

Result	Median (mmol/L)
Total cholesterol	5.05
HDL	1.49
LDL	2.47
Non-HDL	3.38
Triglycerides	1.67

Result	n	% of total
QRISK ≥ 10%	**234**	**20.5%**
QRISK < 10%	909	79.5%

Figure 11. Lipid result findings and QRISK3 risk identification. All patients with a recorded QRISK3 score (n = 1,143) were included in the data. Patients were excluded from QRISK3 analysis if they were referred for further investigations before QRISK3 assessment according to the patient pathway (Figure 1).

Blood pressure

A blood pressure check was provided alongside the cholesterol point of care test. A high proportion of patients had elevated clinic blood pressure (41.4%, Figure 12), with the largest proportion observed in the Core20 population (IMD1, 47%, Figure 13). Blood pressure risk generally increased with age; however, elevated readings were also common among younger patients (20-49 years old), suggesting potentially unmet cardiovascular risk in these groups (Figure 13). Given that opportunistic blood pressure case-finding in community pharmacy is limited to people aged 40 and over, these findings suggest that combining cholesterol POCT and blood pressure assessment may help engage younger populations who might otherwise be less likely to access cardiovascular risk assessment.

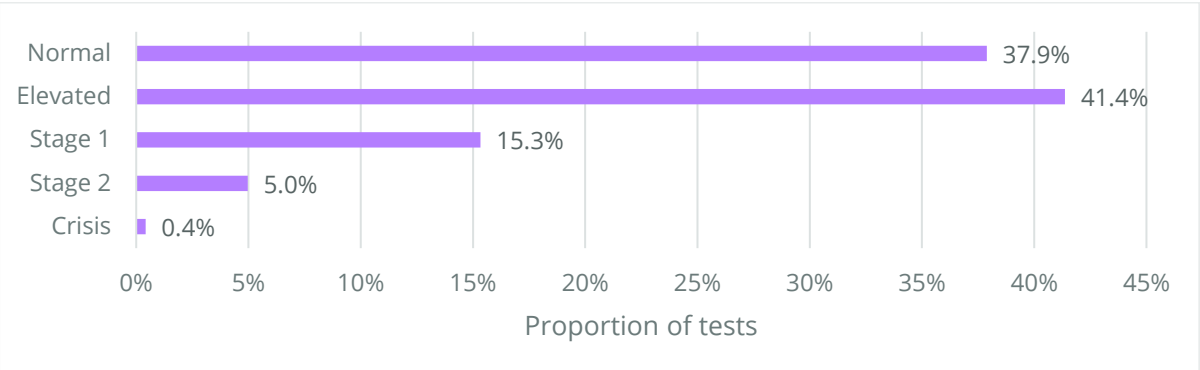


Figure 12. Blood pressure categories among POCT patients

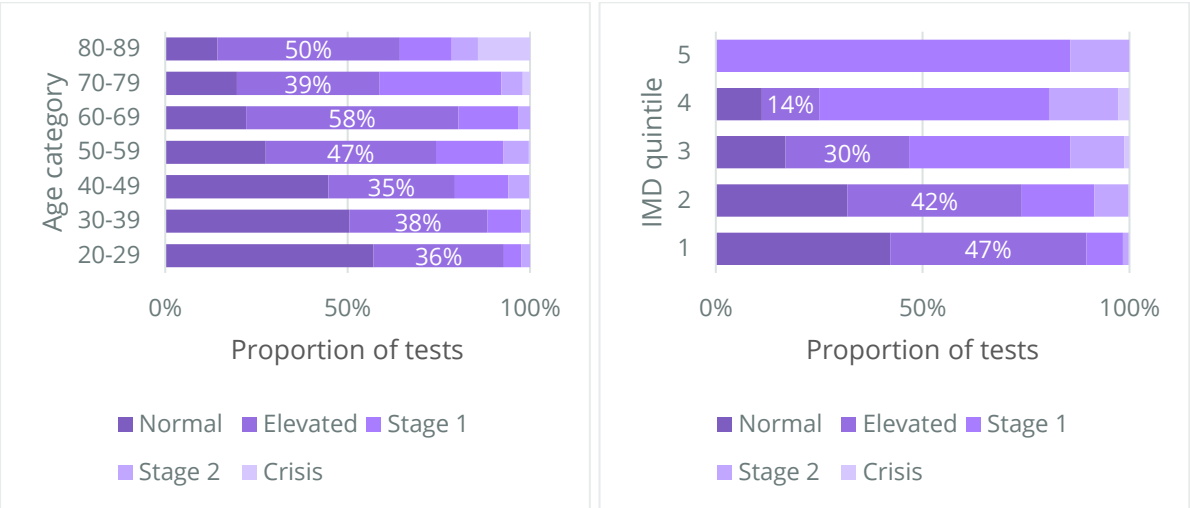


Figure 13. Blood pressure categories by age group and IMD quintile

Patients identified as requiring intervention

QRISK3 Scores

Most tests (75.2%) recorded a low (<10%) QRISK3 score (Figure 14). Around one in five patients (19.4%) had an elevated score of 10% or above, including 5.5% classified as very high risk. A small proportion of patients had no QRISK3 score recorded as they were referred for further investigations before QRISK3 assessment according to the patient pathway (Figure 1).

QRISK3 is a composite risk score based on factors including age, ethnicity and IMD. Demographic comparisons are provided here for descriptive purposes only. This proportion of patients identified as high QRISK3 were similar across deprivation levels and ethnic groups, and increased with age (as expected due to nature of algorithm).

QRISK3 score	Number of tests	% of tests
Low (<10%)	909	75.2%
High (10–19%)	168	13.9%
Very High (≥20%)	66	5.5%
Excluded	66	5.5%

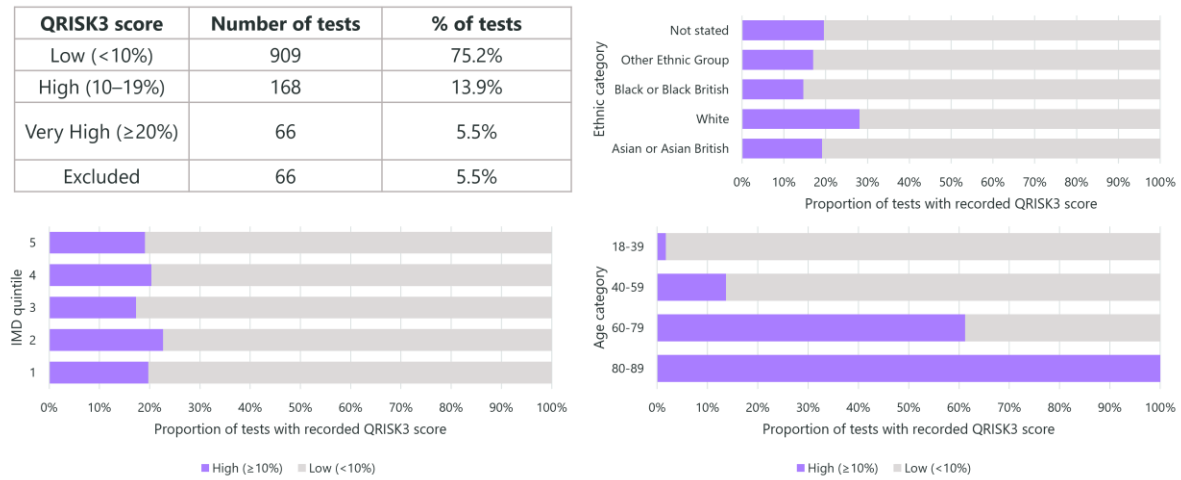


Figure 14. QRISK3 score categories among POCT patients. Patients were excluded from QRISK3 analysis if they were referred for further investigations before QRISK3 assessment according to the patient pathway (Figure 1).

Medication optimisation

In this time period following a 3-month follow-up call, 74 patients were initiated on lipid lowering therapy (LLT) through the POCT programme (Figure 15). The sample size is therefore small and limited segmentation of data can occur for further analysis by demographic characteristics. Of those patients who declined pharmacological treatment, 50% (41/82) shared they would be willing to consider LLT following a period of lifestyle change. Of those patients whose outcome was unable to be determined, 61% (22/36) were unable to be contacted. Patients who underwent alternative clinical management include those who were referred to secondary care, and those whose GP recommended no further treatment.

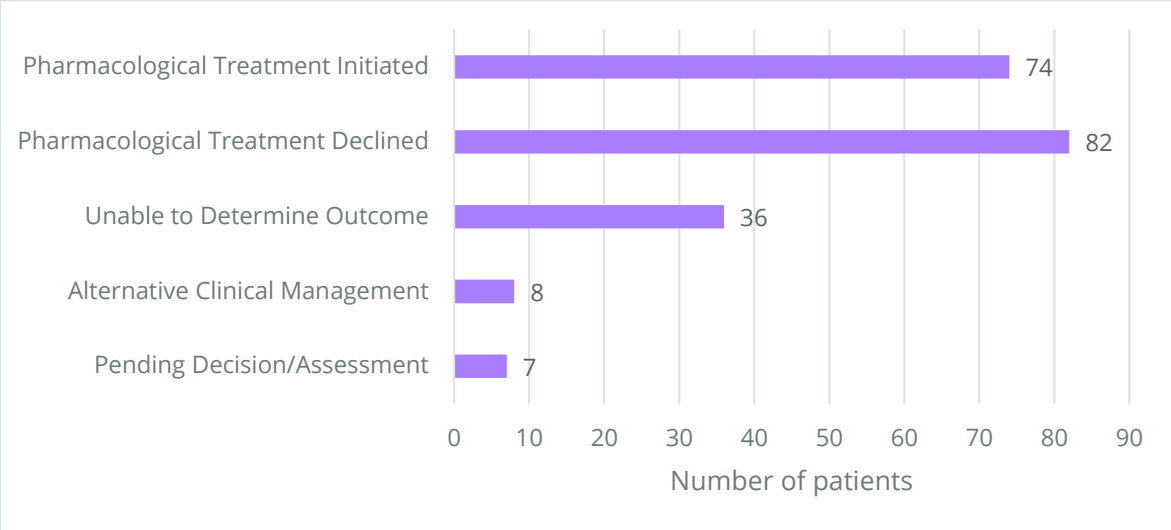


Figure 15. Medication optimisation outcomes following 3-month follow-up.

Most patients who were prescribed statins via the programme were referred to their GP (189/207, 91.3%). Those who were seen by the independent prescriber in the community pharmacy were more likely to initiate pharmacological treatment (11/16, 69%) than those referred to the GP (63/140, 45%); however, the sample was small and the impact was not statistically significant (Fisher's exact test, two-sided p = 0.11).

Tailored lifestyle advice would have been offered to all patients according to the patient pathway, however the uptake and impact of that advice is not quantifiable with the data available. More detail on the potential impact of this is provided through qualitative patient feedback in **Acceptability of service**.

Staff and Patient Acceptability

Introduction

Staff and patient acceptability were important determinants of the feasibility and sustainability of the cholesterol POCT programme. This section explores how the service was experienced by pharmacy teams and patients, drawing on interviews, surveys and implementation data.

Pharmacist Experiences of Delivering the Service

Joining the Programme

Pharmacy teams reported that the cholesterol POCT service aligned closely with services they were already delivering, particularly blood pressure monitoring and Independent Prescribing Pathfinder activity. Respondents viewed the service as a natural extension of their existing role in cardiovascular prevention and welcomed the opportunity to offer a more holistic cardiovascular risk assessment pathway.

> *"As part of the IP Pathfinder service for hypertension we got introduced about the cholesterol point of care testing, which sounds very interesting to us because we can recruit patients while doing the hypertension consultation as well. So it sits in nicely to monitor the cardiovascular risk of patients."*
>
> Pharmacist interview

Training and Support

The introduction of the service was viewed positively across participating pharmacies. Interviewees consistently praised the support provided by the Barts Health implementation team, including training on the clinical pathway, use of the technology and supervised delivery during the early stages of implementation.

> *"I was very happy with the startup. I had help starting up setting up the machine. Obviously, we then had some shadow sessions, where I was shadowed, conducting the service for some patients within the pharmacy."*
>
> Pharmacist interview

Whilst respondents recognised that onboarding and competency assessment required a considerable investment of time, this was generally viewed as appropriate given the clinical nature of the service and the importance of maintaining quality standards.

Implementation Experience

Overall, pharmacies described implementation as straightforward once training had been completed and workflows became established. The service was viewed as fitting well alongside existing pharmacy services and within pharmacists' professional competencies.

Recruitment initially relied heavily on pharmacy teams proactively identifying eligible patients through routine interactions, including blood pressure checks, medication reviews and prescription collections. Over time, respondents reported growing awareness of the service and increasing self-referral through community word-of-mouth.

> *"Initially it was us, trying to identify people that would be eligible… But then after that it became a mixture… because of the positive word of mouth, there was a lot of people in the local community coming in and asking."*
>
> Pharmacist interview

Technology and Systems

Pharmacy teams reported few significant problems with the technology and were generally positive about the responsiveness of technical support. Some initial issues were reported around connectivity and duplication of data entry, although these were largely resolved over time. A recurring challenge related to consumable supplies.

> *"Even one box, I could get through one box maybe in like two days, whereas it takes seven days for an order to come through."*
>
> Pharmacist interview

Despite these challenges, confidence in the testing platform remained high.

Capacity and Workflow

The most commonly reported implementation challenge related to workforce and consultation room capacity, given the growing demand for clinical services in community pharmacy. Delivering the service generally required 15-20 minutes once testing, documentation, QRISK3 assessment and discussion were included.

> *"[The pharmacy has] only got one consultation room and because of that there is a little bit of a fight to get access to the room."*
>
> Pharmacist interview

Several pharmacies reported balancing walk-in and appointment-based models to manage demand. Those interviewed also noted the workload associated with more complex patients who required additional explanation, referral or follow-up.

Relationships with General Practice

Some pharmacists reported improved recognition from GP practices and Primary Care Networks as being contributors to cardiovascular prevention. However, awareness of the programme remained variable, and some respondents perceived concerns among GPs regarding workload and follow-up responsibilities.

Professional Satisfaction

Interviewees consistently expressed satisfaction with being able to deliver a preventative clinical service that extended beyond traditional dispensing roles.

"In practice it's been good, especially when it's been tied into other consultations, either the IP Pathfinder consultations or other consultations that the patients come in for."

Pharmacist interview

Acceptability of service

Accessibility and Convenience

Pharmacy teams consistently reported that patients valued the convenience and immediacy of receiving testing and results within a community pharmacy setting. Respondents perceived that patients appreciated avoiding additional appointments and obtaining results during a single visit.

Survey findings demonstrated very high levels of patient satisfaction. Among patient survey respondents, 98% rated their overall experience as either "Excellent" or "Good" (178/182), while 99% reported that access to the service was "Easy" or "Very Easy" (180/182). Similarly, 98% stated that they would recommend the service to friends and family (178/182), indicating strong overall acceptability and willingness to promote the service within local communities. Acceptability also seems to have been maintained throughout the rollout, with patient satisfaction rising in the first few months of the programme, with patients rating the service as “excellent” varying from 70% to 100% (Figure 16).

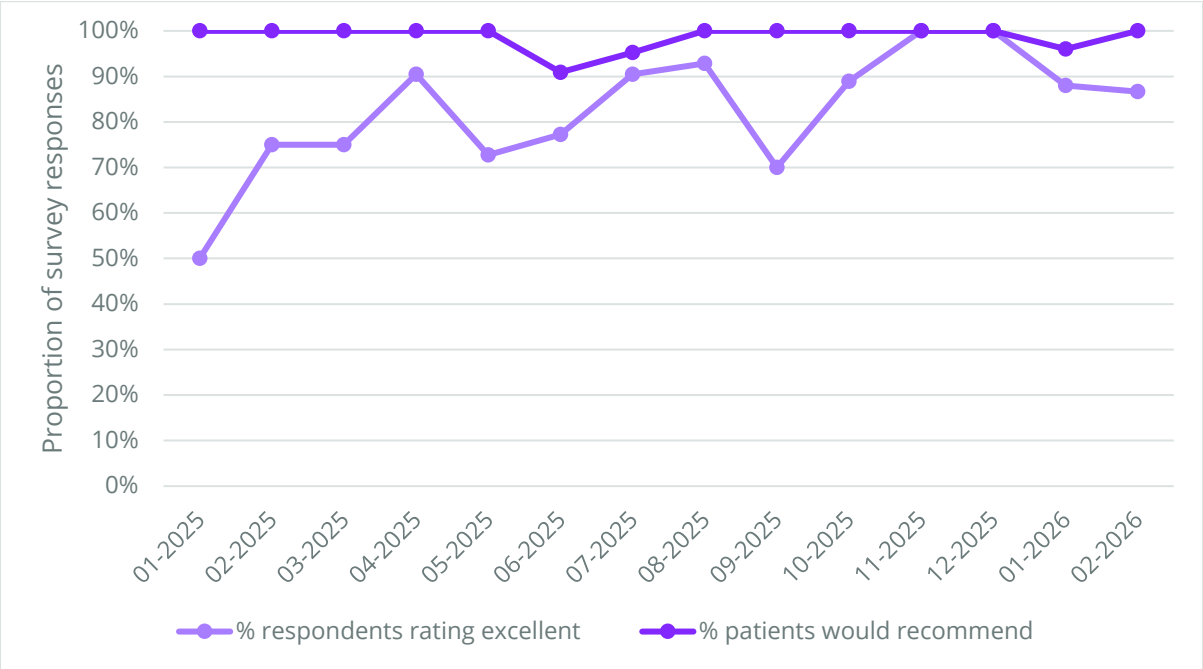


Figure 16. Patient satisfaction and willingness to recommend the POCT service over time

Patient interviews strongly reinforced these views. Convenience was one of the most consistently reported benefits of the service, with participants describing pharmacies as easier to access than hospitals or general practice and highlighting the speed of testing and discussion of results.

"It was really really convenient that it was in the pharmacy and I did not have to go up to the hospital or anything like that to have it all done."

Patient interview

Survey respondents frequently highlighted the speed and convenience of accessing testing through community pharmacy, while others highlighted the practical accessibility of pharmacies.

"I find the chemist easier. It's closer to my house."

Patient interview

"I prefer having it in the pharmacy because it is quick and fast. For the GP, I will have to call and book appointment."

Patient interview

Some interview participants also described a reluctance to use GP appointments for preventative issues.

"I don't like bothering the GP unless it is something important. I don't want to drain the service."

Patient interview

Overall, patient and pharmacy team interviews were highly consistent in identifying convenience, speed and ease of access as major strengths of the service.

Opportunistic Engagement

The service was frequently delivered through opportunistic case-finding during routine pharmacy contacts. Pharmacy teams described offering cholesterol testing during blood pressure consultations, medication reviews and prescription collections, while patient interviews confirmed this was often how individuals first became aware of the service.

Ten of the thirteen interviewed patients (77%) reported that the test was offered opportunistically rather than actively seeking it themselves.

"I was in having a blood pressure monitor fitted and the pharmacist just said, 'Have you had your cholesterol checked lately?'"

Patient interview

Several interview participants stated explicitly that they would not otherwise have pursued testing.

"I wouldn't have even thought about it."

Patient interview

At the same time, a small number of interviewees reported actively seeking testing after becoming aware of the service through pharmacy promotion.

"I saw that there's a free cholesterol test at the pharmacy so I went in and I did my booking."

Patient interview

These accounts suggest that both opportunistic engagement and local promotion played a role in service uptake.

Understanding Cardiovascular Risk

Pharmacy teams believed that the service improved patients' understanding of cardiovascular risk by providing immediate results alongside personalised explanation and discussion.

Interviewees described QRISK3 scores and visual presentation of results as particularly useful in helping patients understand their risk profile. This was echoed in the patient survey, where respondents described results being explained in an easy-to-understand format.

"The results were very easy to understand as it used the traffic light system."

Survey respondent

Patient interviews broadly supported this view. Many interview participants described increasing awareness of cholesterol, cardiovascular health and the relationship between lifestyle and future risk.

"I didn't know anything about cholesterol."

Patient interview

"It's made me aware of what the impact of controlling the cholesterol is."

Patient interview

For some patients, the consultation provided new information about previously unidentified risk.

"They were quite bad really. So I was quite shocked."

Patient interview

Others described gaining reassurance about their current health status.

"I had a feeling I was fairly healthy, but it's good to get confirmation."

Patient interview

Together, these accounts suggest that the service functioned both as a mechanism for identifying risk and as an opportunity to increase awareness and understanding of cardiovascular health.

Lifestyle Conversations and Behaviour Change

Pharmacists consistently described consultations as an opportunity to discuss healthy behaviours and preventative health. Interviewees highlighted the value of having sufficient time to explain results and provide tailored advice relevant to individual circumstances.

"I think what they appreciate is the time that we took to discuss, interpret the results, what it means, what they can do to try to reduce it and to keep their cholesterol under control."

Pharmacist interview

Patient interviews suggested that these conversations often prompted reflection on diet, exercise and other health behaviours. Over half of interviewees described making at least one lifestyle change following the consultation, such as dietary modifications or increase in exercise.

"I've stopped eating takeaways."

Patient interview

This is corroborated in the patient survey, where nine in ten respondents (90%; 164/182) reported intending to make at least one lifestyle change following testing. The most commonly reported planned changes were adopting a healthier diet (79%) and increasing physical activity (55%) (Figure 17). Only 10% reported no intention to change behaviour. Most survey respondents (84.6%; 154/182) intended to change at least one aspect of their lifestyle following the test. This also provides insight into which areas may be best to direct development of patient materials for, e.g. recipe recommendations.

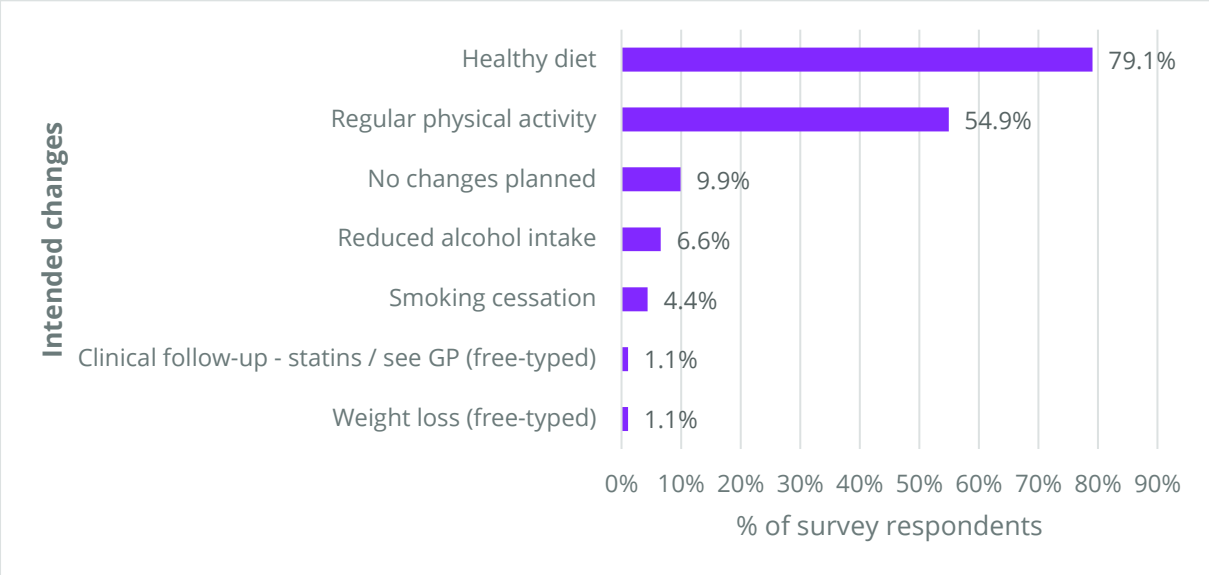


Figure 17. Intended lifestyle changes reported by patient survey respondents following POCT

Statin Discussions and Treatment Preferences

A recurring theme across interviews was the mixed response to statin therapy. Pharmacy teams described many patients expressing a preference for lifestyle modification before commencing medication.

"It's quite mixed. I would say some people would say, can we try lifestyle advice first? Can we try to change diet and incorporate more exercise before I start on the statins?"

Pharmacist interview

Patient interviews reflected this observation closely. Concerns about medication and a preference for non-pharmacological approaches were common. However, interview participants generally framed lifestyle modification and medication as part of a continuum rather than viewing them as mutually exclusive approaches.

"I was very negative about taking statins."

Patient interview

"I prefer natural remedies if possible before going down the pharmaceutical route."

Patient interview

These preferences were also reflected in programme outcomes. As reported, among patients for whom a treatment outcome was recorded, more patients declined pharmacological treatment than initiated treatment, and around half of those declining treatment indicated that they wished to pursue lifestyle modification before reconsidering lipid-lowering therapy. This suggests that, for many patients, POCT consultations may act as an important first step in behaviour change and shared decision-making rather than leading to immediate treatment initiation.

Trust, Communication and Consultation Quality

A particularly strong and consistent theme across patient interviews related to communication and the quality of the consultation experience.

Pharmacy teams felt that patients valued the time available for discussion and explanation, and patients consistently described pharmacists as approachable, patient and knowledgeable.

"Everything was explained to me in layman's terms that I could understand. There was no medical terminology."

Patient interview

Several patients contrasted the consultations with experiences elsewhere in the healthcare system.

"I think the pharmacists gave quite a lot of time and in GP you don't get that much time."

Patient interview

Interview participants also frequently described feeling comfortable during the consultation.

"He took his time, he explained everything. He made me feel very comfortable, made me feel at ease."

Patient interview

These findings suggest that explanation, discussion and interpersonal aspects of the consultation formed an important component of the service experience.

Reassurance and Peace of Mind

In addition to identifying potential risk, a number of patients described reassurance as a key aspect of testing. For some patients, receiving normal results provided confirmation that their existing lifestyle or management strategies were appropriate, while others described a broader sense of relief or peace of mind.

"For me, my results were normal, so it was more about reassurance."

Patient interview

"It sort of put my mind at ease."

Patient interview

This theme emerged consistently across patients who reported having lower-risk results and suggests that patients valued the service even when no immediate intervention was required.

Summary

Overall, both pharmacy teams and patients described highly positive experiences of the service. Patients consistently referred to the testing process as straightforward, convenient and well explained.

"It was so easy. I can't believe how easy it was."

Patient interview

Several interview participants also expressed interest in repeat testing to monitor progress over time, although as described later in the report, this may present challenges when communicating the limitations of testing with patients.

"I really want it to be done again."

Patient interview

"I was disappointed that it was a one-off."

Patient interview

Together, the reflections from patients and community pharmacists indicate that the service was generally viewed as acceptable, convenient and easy to engage with, with patients particularly valuing the accessibility of community pharmacy, the immediate availability of results and the opportunity for personalised discussion.

Equity of Access

Introduction

Improving equity in CVD prevention was a core objective of the cholesterol POCT programme. This section examines whether the programme was delivered and experienced equitably. Quantitative findings are complemented by qualitative insights from patients, pharmacy teams and stakeholders to understand how the programme may have supported inclusion, reduced barriers to prevention and contributed to addressing health inequalities.

Access location

The programme was intentionally delivered through community pharmacies, with recruitment of pharmacies prioritising locations serving populations experiencing higher levels of deprivation and cardiovascular risk. Comparison of participating pharmacies with the wider community pharmacy network in NEL and NCL suggests that recruitment was successfully targeted towards more deprived communities.

	North East London	North Central London
Percentage of community pharmacies in IMD Quintile 1 (n)	37.5% (140/373)	29.9% (87/291)
Percentage of cholesterol POCT community pharmacies in IMD Quintile 1 (n)	42.9% (3/7)	62.7% (4/6)

Table 4. Distribution of participating POCT pharmacies by deprivation compared with the wider community pharmacy network. Source: NHS Business Services Authority [13]

In North East London, 42.9% (3/7) of participating cholesterol POCT pharmacies were located in the most deprived IMD quintile (IMD Decile 1-2, Core20), compared with 37.5% (140/373) of all community pharmacies in the region (Table 4, Figure 18). The difference was more pronounced in North Central London, where 62.7% (4/6) of participating pharmacies were located in Core20 areas, compared with 29.9% (87/291) of all community pharmacies. Overall, participating pharmacies were at least as likely, and in North Central London substantially more likely, to be located in the most deprived communities than would be expected based on the distribution of pharmacies across the wider sector.

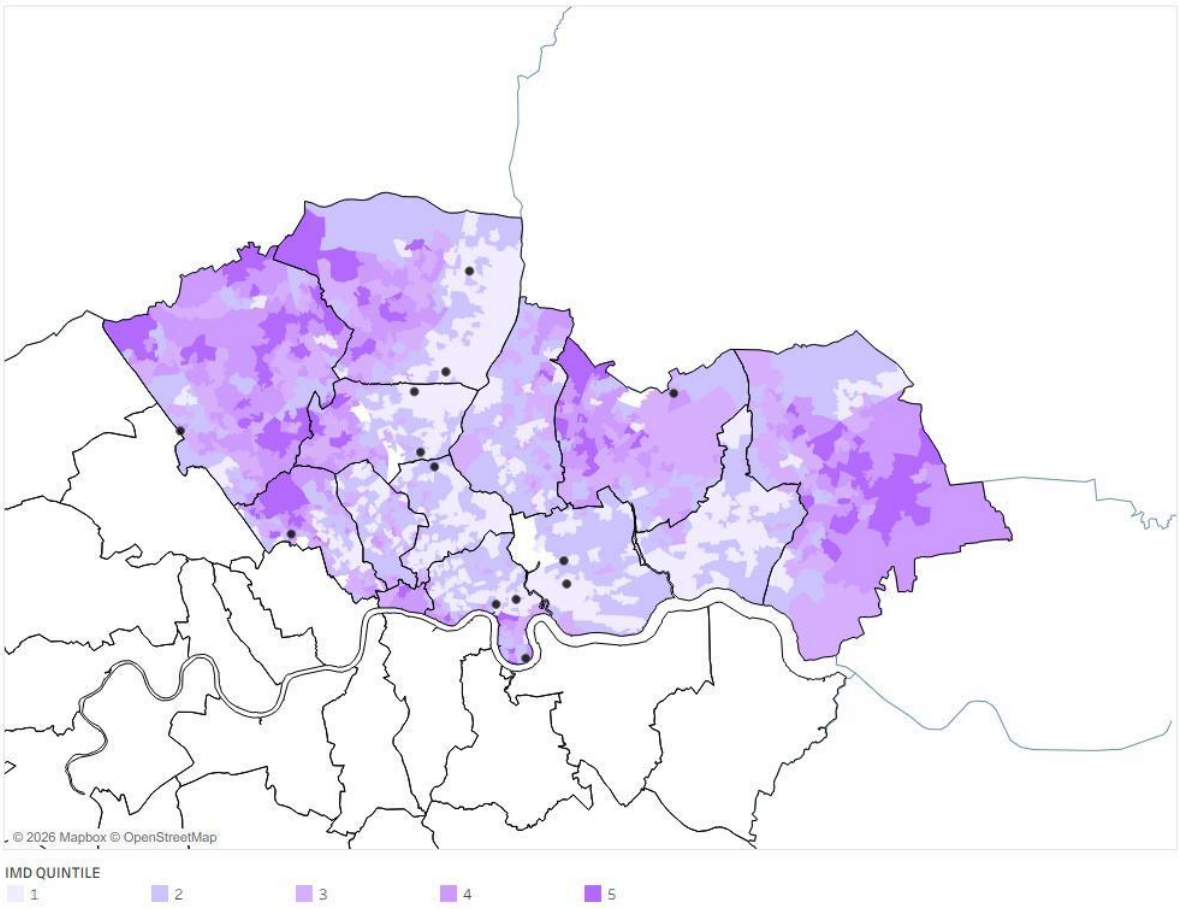


Figure 18. Location of participating cholesterol POCT pharmacies across North East and North Central London, against map of IMD quintiles at LSOA level (1: most deprived, 5: least deprived).

Population comparison

Method

To assess whether the programme was reaching populations most likely to benefit from cardiovascular prevention, the characteristics of people accessing cholesterol POCT in NEL were compared with two reference populations: the general NEL population (based on the 2021 Census [14]) and the estimated number individuals with cardiovascular disease (as per the narrow definition of CVD[3]) recorded in CVDPrevent [15,16]. This comparison was undertaken across age, ethnicity and deprivation measures to understand whether the programme reflected the wider population, or

[3] Narrow definition: GP recorded CVD (includes coronary heart disease, non-haemorrhagic stroke and stroke cause not specified, transient ischaemic attack, and peripheral arterial disease)

whether it was disproportionately engaging groups at higher cardiovascular risk and greater risk of health inequalities.

Unless otherwise stated, individuals aged over 80 years were excluded from population-level comparisons due to programme eligibility criteria excluding patients over 85 years, and population data categories being limited to 80+ years. Ethnicity categories recorded as "other", "unknown" or "not stated" were excluded from some subgroup analyses but remain important considerations in the interpretation of findings.

Findings

The age profile of people accessing POCT differed from both the general NEL population and the population with established cardiovascular disease (Figure 19). The programme predominantly engaged adults aged 40-59 years, who accounted for almost 60% of patients. This age group was overrepresented compared with the general population but underrepresented compared with the CVD population, suggesting the service is engaging people at a stage where cardiovascular risk factors are emerging, before the development of established disease.

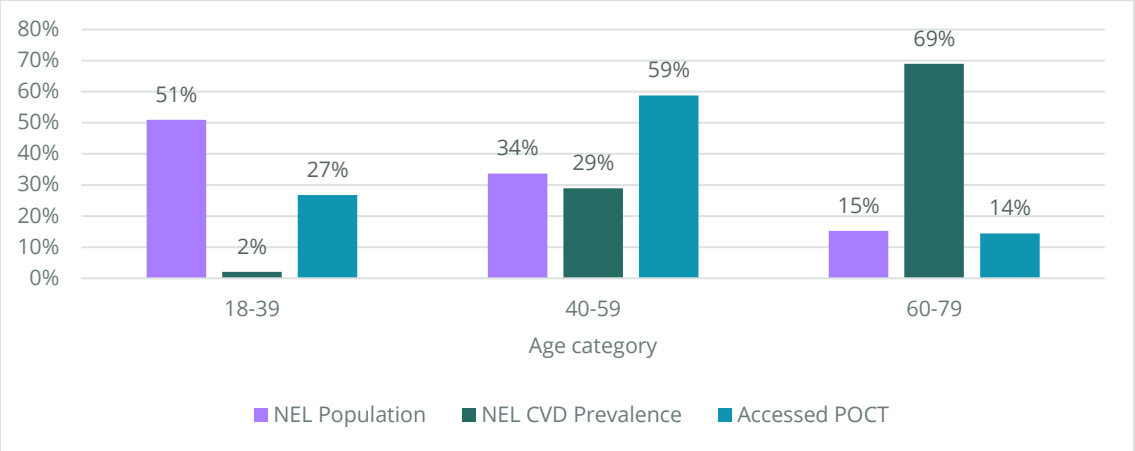


Figure 19. Age distribution of the NEL population, NEL CVD population and POCT cohort

More than 88% of people accessing POCT lived in the two most deprived IMD quintiles, substantially higher than both the wider NEL population and the CVD comparator population (Figure 20). This suggests that the programme successfully targeted communities experiencing greater socioeconomic disadvantage and therefore a higher risk of cardiovascular disease and poorer health outcomes.

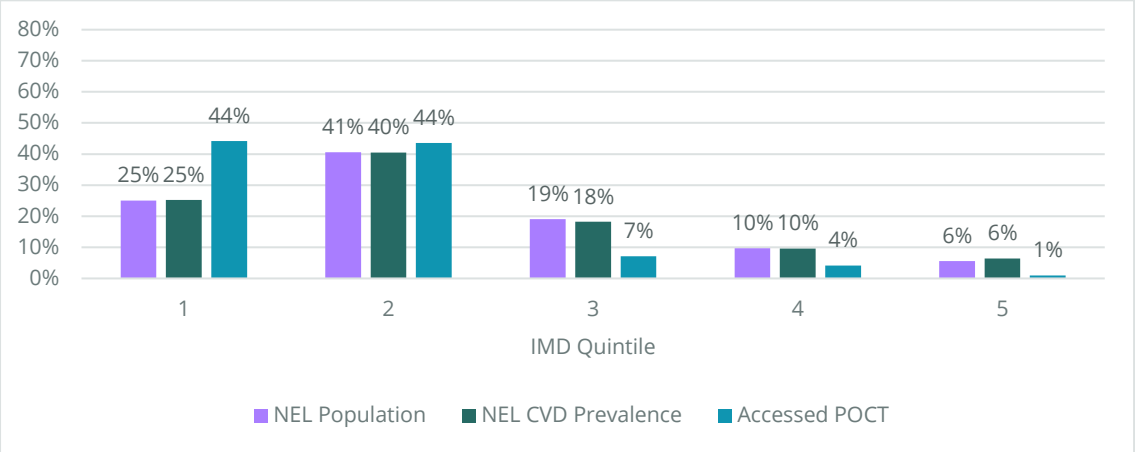


Figure 20. Deprivation profile of the NEL population, NEL CVD population and POCT cohort

The programme engaged a diverse population, with Asian patients accounting for a larger proportion of participants (47%) than both the wider NEL population (30%) and the recorded CVD population (34%) (Figure 21). These findings suggest that the community pharmacy model may be particularly effective in reaching ethnically diverse populations known to experience elevated cardiovascular risk.

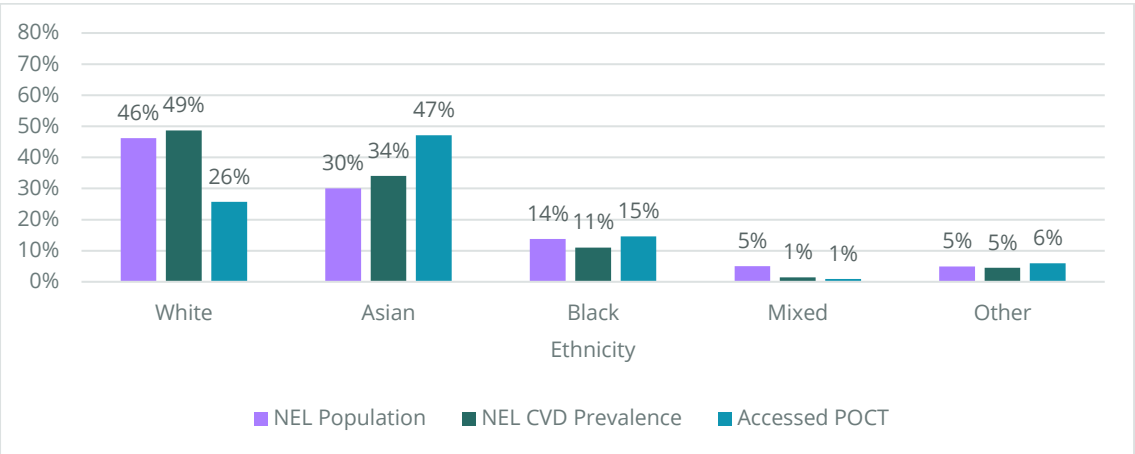


Figure 21. Ethnicity profile of the NEL population, NEL CVD population and POCT cohort

Equity of experience

In the patient experience survey, a proportion of patients (n = 173) chose to share their demographic details alongside their experience. Across all recorded ethnic groups, levels of satisfaction were high (Table 5). Between 96% and 100% of respondents reported that they would recommend the service to friends and family, while 96% to 100% rated the service as either "excellent" or "good".

Broad ethnic group	n respondents	% would recommend to friends and family	% rated the service as "excellent" or "good"
White	76	97%	99%
Asian / Asian British	48	96%	96%
Black / Black British	33	100%	97%
Other ethnic group	10	100%	100%
Prefer not to say / Not answered	6	100%	100%

Table 5. Patient experience survey findings by broad ethnic group

Similarly, experience was highly positive across age groups (Table 6). The proportion of respondents who would recommend the service ranged from 92% among those aged 65 years and over to 100% among respondents aged 35 to 64 years. Ratings of "excellent" or "good" ranged from 86% among those aged 35 to 44 years to 100% among respondents aged 45 years and over. While some variation was observed between groups, differences were small and should be interpreted cautiously given the relatively small sample size for age recording (n = 78).

Age group	n respondents	% Would recommend to a friend or family member	% rated the service as "excellent" or "good"
35-44	22	100%	86%
45-54	21	100%	100%
55-64	23	100%	100%
65+	12	92%	100%

Table 6. Patient experience survey findings by age group

Qualitative insights on equity

This section summarises perspectives from patients, pharmacy teams and stakeholders on the programme's contribution to improving equitable access to cardiovascular prevention. The findings explore the mechanisms by which cholesterol POCT may help reach underserved populations, support earlier identification of risk and reduce barriers to accessing preventative care.

Reaching Underserved and Higher-Risk Populations

Improving equitable access to cardiovascular prevention was a central objective of the cholesterol POCT programme and emerged as one of the most consistent themes across stakeholder, pharmacy team and patient interviews. Quantitative findings indicate that the programme successfully engaged patients from diverse ethnic backgrounds and areas of higher deprivation, particularly the Core20 population, suggesting that the service is reaching populations who may benefit most from earlier identification of cardiovascular risk.

Stakeholders consistently described equity as one of the programme's principal strengths. Interviewees highlighted deliberate targeting of community pharmacies located in Core20 and high deprivation areas and emphasised the potential for pharmacy-based testing to reach individuals who may not routinely engage with general practice or NHS Health Checks. One stakeholder described community pharmacy as particularly effective at identifying previously undiagnosed cardiovascular risk among people with unmet need.

Importantly, patient interviews largely validated these perceptions. Across the patient sample, 8 of the 13 patients interviewed (62%) had either never previously had a cholesterol test or had not had one for many years.

> "I've never had any tests like that before, so I had no clue whether I was healthy or not."
>
> Patient interview

Survey findings provide further evidence that the programme reached people who may not otherwise have accessed cardiovascular assessment. Nearly two-fifths of respondents (39%, 70/182) reported that they had not received a cholesterol test within the previous 12 months, with a further eight respondents unsure whether they had been tested.

Stakeholders additionally highlighted the programme's role in identifying clinically significant risk that might otherwise have remained undetected.

> "We've picked up patients who have got like a QRISK3 of 50% and they're walking around and they don't know... they've got that result in the same day within a couple of minutes."
>
> Stakeholder interview

This perception is supported by patient accounts describing first-time identification of raised cholesterol levels and subsequent lifestyle changes following testing.

> "I am actually trying to eat healthy food and I've actually tried to live a bit healthier... not eating anything from take out, trying to avoid it, cooking at home."
>
> Patient interview

Equity by Design

Implementation stakeholders described equity as an explicit design principle underpinning the programme. Participating pharmacies were intentionally selected in areas with higher deprivation and cardiovascular disease burden, reflecting both the Core20PLUS5 approach and wider NHS ambitions around prevention and reducing health inequalities.

A particularly important stakeholder insight was that equity was viewed not simply in terms of geography or deprivation, but also in relation to healthcare engagement. Several interviewees suggested that pharmacy settings may appeal to people who are reluctant to attend traditional healthcare environments.

"People who probably struggle massively with anxiety or social anxiety don't want to go and speak to anyone... they just want to go and have a test and sit with those results."
Stakeholder interview

While patients rarely described anxiety explicitly, several interview participants emphasised valuing the informality, convenience and non-judgemental nature of the pharmacy environment.

"If this was available at the pharmacy, I'd never go to the GP for it. No need. I'd just pop into the pharmacy... The results go to the GP anyway, so why go through all the GP hassle?"

Patient interview

Similarly, stakeholders highlighted that some participants actively preferred information without formal NHS follow-up.

"They said, 'I just wanted to know what my cholesterol level was.'"
Stakeholder interview

Accessibility and Opportunistic Engagement

All participant groups identified accessibility as one of the programme's key strengths. Stakeholders consistently viewed community pharmacy as uniquely positioned to offer preventative care during routine interactions and repeatedly emphasised opportunistic case finding as the programme's primary mechanism of engagement. One stakeholder noted:

"Patients don't often know it... it's about us opportunistically picking all our patients and saying, 'Have you had a cholesterol test?'"
Stakeholder interview

This aligns closely with patient experiences. Ten of the 13 interviewed patients (77%) reported accepting testing after it was offered opportunistically during blood pressure monitoring, medication reviews, prescription collection or other routine pharmacy interactions.

"The pharmacy team actually offered it."
Patient interview

"They said, 'While you are here would you like to have a cholesterol test'?"
Patient interview

There was also strong agreement between stakeholders and patients that community pharmacy reduced barriers associated with healthcare navigation. Stakeholders described the service as a "one-stop-shop" model that reduced the need for patients to move between multiple appointments and providers.

"From a patient point of view, the benefit is that they are not being passed from pillar to post"

Stakeholder interview

Several stakeholders additionally argued that community pharmacy may improve prevention by identifying people who do not respond to invitations for NHS Health Checks. This aligns with patient interviews, where 8 of the 13 participants reported never having received an NHS Health Check or were unsure whether they had ever had one.

Trust, Relationships and Community-Based Care

An important theme that emerged more strongly from stakeholder interviews than patient interviews concerned the role of longstanding pharmacist-patient relationships.

Stakeholders argued that community pharmacies possess detailed knowledge of their local populations and are often able to identify suitable moments to introduce preventative discussions.

"They know their patients... they kind of know when to ask."
Stakeholder interview

Stakeholders also contrasted pharmacy consultations with the perceived formality of general practice.

"At the GP, it feels really formal and a bit judgy."
Stakeholder interview

Patient interviews broadly reinforced this observation. Participants repeatedly described pharmacists as approachable, patient and willing to spend time discussing results, often comparing this favourably with GP appointments.

"They give you time basically and they listen as well."
Patient interview

Together these findings suggest that community pharmacy may improve equitable engagement not only because of physical accessibility, but because of trusted relationships and a less intimidating consultation environment.

Cultural Tailoring, Language and Inclusion

There was strong agreement across all participant groups that cultural tailoring and language accessibility remain important considerations.

Pharmacy teams described adapting advice to reflect local dietary practices and using multilingual staff and interpretation services. Stakeholders similarly recognised language as a continuing challenge, highlighting limitations within current digital systems and patient-facing platforms.

"When it comes to them reading the questions... the testing is in English."
Stakeholder interview

Patients echoed these concerns and suggested additional language support.

"Some people don't understand English... it can be written in other languages."
Patient interview

Across interviews there was broad consensus that accessible and locally relevant communication may be an important contributor to service acceptability and uptake. Pharmacy teams described adapting advice to local populations, patients valued recommendations that reflected their lifestyles and dietary practices, and stakeholders, including HEART UK, highlighted the importance of clear patient education and information resources.

"As an Asian, we have lots of butter and lots of oil so they gave [me] a list of things we can eat alternatively."
Patient interview

Survey respondents also highlighted the value of accessible information resources. The most common suggestion for improvement was provision of written results, patient information leaflets or lifestyle guidance (22%, 7/32 of free text suggestions).

Remaining Barriers to Equitable Access

Although findings were overwhelmingly positive, stakeholders and patients identified several barriers that may require attention during future scale-up.

Awareness

A notable area of agreement concerned service awareness and the role of opportunistic engagement. Stakeholders consistently argued that while there was a clear need for cholesterol testing, many patients did not realise that they would benefit from testing or that the service was available through community pharmacies.

One stakeholder reflected that successful engagement depended on proactively asking patients if they were interested in a test. The patient interviews strongly supported this finding. Approximately three-quarters of interviewed patients reported that they had not actively sought testing, but instead accepted it when it was offered opportunistically during another interaction, such as collecting medication, attending a blood pressure check or reviewing prescriptions. Several participants stated that they would not otherwise have pursued testing.

Consistent with interview findings, patient survey respondents identified awareness of the service as an ongoing challenge. Several respondents reported being unaware that cholesterol testing could be accessed through community pharmacies and suggested greater publicity and promotion.

"Awareness of such service should be more publicised"

Survey respondent

These findings suggest that equity gains may arise not simply because pharmacies are geographically accessible, but because they reduce the "activation burden" on patients. Individuals do not need to know they are eligible, understand NHS prevention pathways, book appointments or actively seek testing. Instead, risk assessment is offered during routine interactions, allowing the programme to engage people who might otherwise remain outside traditional prevention services.

Digital exclusion

Patients highlighted difficulties experienced by some older adults when using digital systems, which may limit their ability to engage with the digital elements of the programme.

"The elderly are not familiar with using digital information."
Patient interview

Stakeholders similarly noted wider concerns regarding health literacy, interpretation of results and the increasing complexity of information available through online and AI-generated sources, which may impact how people understand and act on their testing results.

Risk of postcode lottery

Stakeholders highlighted the importance of ensuring that access to cholesterol testing is not determined by where people live. While the programme intentionally focused on areas with higher levels of deprivation, some stakeholders expressed concern that uneven availability across localities could result in inequitable access to preventative services.

"The thing that we all need to avoid... is postcode lottery."
Stakeholder interview

Stakeholders generally agreed that community pharmacy-based cholesterol testing has the potential to improve equitable access to prevention, but noted that achieving this benefit will depend on

ensuring that communities with similar levels of need have comparable opportunities to access services.

Summary

The quantitative findings suggest that the programme successfully reached populations at increased risk of cardiovascular disease and health inequalities. Compared with the wider NEL population, people accessing POCT were substantially more likely to live in the most deprived areas, while the age profile indicates the service predominantly engaged adults aged 40-59 years, a group in which cardiovascular risk factors commonly emerge. The programme also reached a diverse population, with particularly strong engagement among Asian communities.

Qualitative findings help explain these patterns, highlighting the role of community pharmacy in supporting opportunistic case-finding, reducing barriers to access and engaging people who may not have used traditional prevention services. Patient experience was consistently positive across demographic groups, although language accessibility, digital exclusion, service awareness and equitable rollout remain important considerations for future scale-up.

Wider System Impact

Introduction

Stakeholders and pharmacy teams frequently discussed the programme in the context of wider health system priorities, including prevention, earlier identification of cardiovascular risk and care delivered closer to home. This section summarises these perspectives and considers the conditions required for longer-term impacts to be realised. It also includes a high-level return on investment analysis to explore the potential economic implications of the programme and the mechanisms through which benefits may accrue over time.

Impact on Pharmacy Services

Workforce Development and Enhanced Clinical Role

Pharmacy teams frequently described the service as an opportunity to use clinical skills more fully, particularly in relation to cardiovascular risk assessment, interpretation of results, QRISK3 discussions and lifestyle advice. Several respondents viewed cholesterol POCT as consistent with the broader development of community pharmacy as a provider of preventative and clinical services rather than principally a dispensing service.

Stakeholders echoed these views and described the programme as an example of how pharmacists could contribute to earlier identification of cardiovascular risk and broader prevention activity.

> *"I think for pharmacies it's great because they feel that they're adding value to people... this is really using their clinical skills."*
>
> Stakeholder interview

At the same time, participants highlighted the workforce implications of this expanded role. Delivering comprehensive consultations required time for testing, interpretation of results, discussion of lifestyle modification, documentation and patient follow-up. Interviewees noted that sufficient staffing, consultation space and administrative support would be important in sustaining these activities.

> *"[They've] got to put the data into two different systems. All of that isn't understood because it's an admin task, but they don't have admin people to do all of this... It's the pharmacist doing it all."*
>
> Stakeholder interview

Integration Within Neighbourhood Care

Community-Based Prevention

Stakeholders and pharmacy teams frequently discussed the programme within the context of prevention and care delivered closer to home, as described previously. Community pharmacies were described as accessible locations where cholesterol testing could be incorporated into routine healthcare interactions, including blood pressure consultations, medication reviews and prescription collections.

"The convenience of testing and getting closer to people's homes… if it's more local to them within their local communities, I think that's the biggest benefit of all this."

Stakeholder interview

Several pharmacy teams described the service as fitting naturally alongside blood pressure monitoring, QRISK3 assessment and Independent Prescribing services, allowing multiple elements of cardiovascular prevention to be delivered within a single consultation.

GP Relationships and Partnership Working

Stakeholders described the programme as involving collaboration between community pharmacies, general practice, acute providers and voluntary sector organisations, highlighting communication and clearly defined pathways as important aspects of delivery.

Stakeholders and pharmacy teams consistently highlighted the importance of relationships between community pharmacy and general practice. Participants reported that awareness and understanding of the programme varied across GP practices. Some interviewees described concerns among GPs regarding workload associated with referrals, follow-up and prescribing decisions.

"I think it was tricky in the beginning in getting GPs to understand that, because they were like, 'Oh, this is extra work for us.'"

Stakeholder interview

Others emphasised the importance of engaging GP practices and Local Medical Committees early in programme development.

"If you haven't done that early engagement and then you're trying to play catch up, it's harder because the trust straight away is eroded before you can even build it."

Stakeholder interview

Impact on General Practice

Interviewees identified both potential opportunities and challenges for general practice teams arising from pharmacy-based cholesterol testing.

Several stakeholders suggested that community pharmacy offered an alternative setting for initial cardiovascular risk assessment and cholesterol testing. Participants noted that immediate results and pharmacist-led discussions could reduce reliance on GP appointments for initial testing and reduce demand for phlebotomy appointments used solely for screening purposes.

"They haven't got to make an appointment and wait weeks and then wait weeks for a blood test appointment."

Stakeholder interview

At the same time, interviewees recognised that successful case-finding would appropriately identify patients requiring further assessment, prescribing decisions or monitoring through general practice. Some stakeholders described this as generating additional activity in the short term, while also viewing this activity within the wider context of prevention.

"It's not extra work if you look at the grand scheme of in the future, you know, someone's not going to have a heart attack or a stroke."

Stakeholder interview

Stakeholders also reported anecdotal examples of repeated testing following referral from community pharmacy to general practice, suggesting opportunities to strengthen communication and confidence in pharmacy-generated results.

One limitation of this evaluation is the lack of direct engagement with general practice teams. Future evaluations would benefit from exploring GP perceptions of the service, including its impact on workload, referral pathways, prescribing decisions and integration with existing prevention services.

Impact on Population Health

Stakeholders frequently discussed the programme in relation to earlier identification of cardiovascular and metabolic risk factors. Interviewees highlighted examples of patients with previously unidentified elevated cholesterol, QRISK3 scores or diabetes-related indicators.

"We've had patients who have had [an abnormal result] and they're walking around… they've got no indication that there's something wrong."

Stakeholder interview

Several stakeholders also emphasised the educational component of the service and its role in increasing awareness of cholesterol and cardiovascular risk. Participants viewed immediate availability of results and discussion during the same consultation as important features of the model.

"Giving patients more awareness... there's a lot of patients who don't understand what cholesterol is or really know what cholesterol does in the body."

Stakeholder interview

Conditions for Demonstrating Long-Term Impact

Stakeholders frequently noted that many outcomes associated with cardiovascular prevention occur over longer timescales than were captured within the evaluation period, i.e. 1-3 months. One stakeholder highlighted the time required for lifestyle modification, repeat testing, prescribing decisions and treatment optimisation, and how this time may vary across populations and regions.

"There's a lot of GPs who turn around and say, lifestyle advice, change your lifestyle for three months, come back in three months, and then we'll check your blood."

Stakeholder interview

Several interviewees therefore suggested that longer-term follow-up would be required to understand impacts on cholesterol management, prescribing, cardiovascular events and healthcare utilisation.

Potential Economic Impact

Although a cost-benefit economic assessment was outside the scope of this evaluation, stakeholders discussed several mechanisms through which longer-term benefits might be realised. These included earlier identification of cardiovascular risk, increased uptake of preventative treatment, potential reductions in future cardiovascular events and reduced reliance on traditional testing pathways. Some stakeholders also noted that benefits may extend beyond cardiovascular outcomes, including more efficient use of healthcare resources, improved utilisation of the community pharmacy workforce and wider societal gains through reduced productivity losses. Participants cautioned that demonstrating such benefits would require larger-scale implementation, longer follow-up periods and access to linked healthcare data.

Potential Impact on NHS Health Checks

Context

NHS Health Checks are an established national prevention programme for adults aged 40 to 74 years and include assessment of blood pressure, cholesterol and cardiovascular risk.[17] However, recent evidence suggests that a substantial proportion of eligible individuals do not attend. Although it is an established national programme, uptake varies between areas and some underserved communities face barriers to engagement.

The NHS Health Check programme provides a useful comparator for the POCT programme, as both target a similar population and include cholesterol testing within a broader cardiovascular risk

assessment. This comparison explores whether community pharmacy POCT could complement NHS Health Checks by reaching individuals who may otherwise remain untested.

Findings

Open-source NHS Health Check data is limited and can only be analysed at borough level, without detailed local demographic information.[18] While POCT testing may help address unmet need arising from missed Health Check appointments, current activity remains too small to have a significant impact on overall uptake (Table 7). Four of the seven NEL boroughs currently providing POCT services have relatively low Health Check uptake, suggesting an opportunity for targeted expansion.

Nationally, 15.6% of NHS Health Checks are delivered to people living in IMD quintiles 1 and 2, compared with 33% of NEL POCT tests, indicating that POCT may be reaching more deprived populations.

NEL Borough	HC delivered	HC uptake %	Estimated remaining HC	POCT tests delivered	% of tests in Core 20
Waltham Forest	9821	61.8%	6079	n/a	
Tower Hamlets	7539	57.4%	5593	377	40%
Newham	10507	56.1%	8221	210	32%
Redbridge	5380	53.6%	4652	40	0%
Hackney	10141	46.0%	11903	130	25%
City of London	259	41.8%	360	n/a	
Havering	5342	37.8%	8789	n/a	
Barking & Dagenham	4827	13.8%	30062	n/a	

Table 7. NHS Health Check activity [18], estimated unmet need and POCT activity by NEL borough

The wider evidence base also supports the potential role of community pharmacy POCT. A recent study in North West London found that fewer than half (48%) of eligible adults attended an NHS Health Check, while almost three-quarters (76%) of non-attendees were aged 40 to 49 years.[19] These findings suggest that community pharmacy POCT could complement existing NHS Health Check programmes by engaging younger adults who are less likely to access traditional prevention services.

Prevention of Cardiovascular Events

This analysis estimates the potential number of cardiovascular (CV) events prevented over five years through new statin initiation following POCT. It translates observed programme activity, and a scenario in which all identified high-risk patients initiate treatment, into estimated heart attacks and strokes prevented. The purpose is to illustrate the programme's potential longer-term clinical impact at its current scale and if delivery were expanded. It is important to note these are modelled estimates rather than observed outcomes, and only relate to the numbers needed to treat (NNT) based on new statin initiation.[20]

Despite the perceived impact of the programme, the number of estimated avoided CV events is low and may not describe the extended impact of the programme. Greater scale of testing, higher initiation of statins, longer follow up and longer time horizons may highlight this impact on CV events better.

CV events prevented over 5 years	In this programme:		Assuming scale up:	
	On LLT (n=72)	If all high-risk initiated (n=251)	Per 1,000 initiated	Per 1,000 tested*
Heart attacks prevented	0.69	2.25	9.62	1.92
Strokes prevented	0.47	1.52	6.49	1.30
Combined CV events	**1.16**	**3.77**	**16.11**	**3.22**

*Table 8. Estimated cardiovascular events prevented over five years through statin initiation following POCT. Source: The NNT, Statins for Heart Disease Prevention (Without Prior Heart Disease) [20]; POCT outcomes data. *Assuming 20% of patients have a high* (≥10%) *QRISK3 score.*

Scale-Up and Sustainability

Introduction
Findings from stakeholders, pharmacy teams and patients indicate that the cholesterol POCT model has potential for wider implementation. The service was generally viewed as acceptable, feasible and well aligned with existing pharmacy activity. However, scale-up should not be understood simply as increasing the number of participating pharmacies. Sustainable expansion would require a defined service model, commissioning route, governance framework, workforce plan, digital infrastructure and evaluation approach.

Transferability of the model
Stakeholders shared that the model is transferable because it builds on services, skills and infrastructure already present in community pharmacy. Cholesterol testing complements blood pressure monitoring, cardiovascular risk discussions and independent prescribing activity. Pharmacy teams reported that implementation became straightforward once training had been completed and workflows were established. This suggests that the core model could be adopted by other pharmacies, provided that they have suitable consultation space, trained staff, access to equipment and clear pathways for follow-up.

Transferability is also supported by patient demand and the acceptability of community pharmacy as a setting for preventative care. Patients valued convenience, immediacy and the opportunity to receive explanations from pharmacy staff. These factors are likely to be relevant beyond the pilot sites, particularly in areas where access to general practice is constrained or where people are not routinely engaging with NHS Health Checks.

Commissioning and funding
Funding was the most consistently identified sustainability requirement. Stakeholders were concerned that reliance on short-term pilot funding could undermine continuity, confidence and service development.

"It always stopped because of money. They ran out of money. They only ever have money to do pilots… I don't want it to be another pilot."

Stakeholder interview

A sustainable model would need to recognise the true cost of delivery, including pharmacist time, support staff involvement, equipment, consumables, training, data entry, communication with general practitioners and quality assurance.

National or regional commissioning was described a preferred option, as it could support consistency and reduce the risk of variation in access. A nationally commissioned service would provide a clearer framework for reimbursement, training, governance and reporting, while a regional hub model could retain local knowledge and relationships while providing oversight, implementation support and

shared infrastructure. The most appropriate approach may be a hybrid model that combines consistent service standards with local flexibility to reflect population need.

"It would be really good to do something in partnership to have regional models of care… whether that be based at the new neighbourhood centres… a cholesterol clinic or a CVRM clinic that we could do jointly."

Stakeholder interview

Workforce and operational capacity

Scale-up will depend on whether pharmacies have the capacity to deliver comprehensive consultations without compromising other services. The service requires consultation room availability and sufficient staffing to support testing, risk assessment, explanation of results and documentation. Some pharmacies may need to transition between walk-in and appointment-based delivery depending on local demand and room availability. As described earlier in this report, there is also seasonal variability in capacity for delivery due to competing priorities, e.g. vaccinations. These operational requirements should be considered explicitly when deciding whether all pharmacies, selected pharmacies or a phased rollout model should be used.

"There is a big problem about the resource being pushed to pharmacists… the GP surgeries haven't got the resource. Now it's been pushed out to pharmacists."

Stakeholder interview

Additionally, there is a balance between maximising access and maintaining quality in pharmacy selection. Universal availability could reduce postcode variation, but only if participating pharmacies can meet quality, capacity and governance standards. A selective model could support higher quality and more efficient oversight, but risks inequitable access if selection is not based on need. Future rollout should therefore consider a staged approach, prioritising areas of high cardiovascular risk and deprivation while building capacity across the wider pharmacy network.

Governance, quality assurance and clinical accountability

Sustainable scale-up requires clear governance and accountability arrangements. This includes responsibility for training standards, competency assessment, clinical oversight, audit, incident management, equipment quality assurance and pathway monitoring. Governance arrangements should also clarify how responsibilities are shared between community pharmacies, commissioning organisations, general practice and any specialist clinical support.

"There has to be that join up between the ICBs and the GP surgeries… because GPs don't want to increase their workload, so how much autonomy is going to be given to the pharmacist?"

Stakeholder interview

Interviewees generally expressed confidence in the quality and validity of the testing process but identified a number of requirements for quality assurance at scale. Stakeholders highlighted the importance of maintaining consistent training standards, competency assessment and ongoing monitoring of service delivery. Existing implementation support arrangements were viewed as valuable mechanisms for ensuring quality and consistency across sites with the flexibility to adapt the programme as it developed, however the current funding arrangement was seen as limiting in terms of long-term sustainability and scale.

Participants also identified governance arrangements as an area requiring further development as the programme expands, such as:

- Accountability for service oversight
- Clinical governance arrangements
- Quality monitoring processes
- Audit and assurance requirements
- Responsibilities across organisational boundaries

Data systems and interoperability were also highlighted as important considerations. Several interviewees noted the burden associated with multiple data entry systems for community pharmacists in this programme and suggested that improved digital integration would support both service efficiency and governance.

Finally, stakeholders emphasised the importance of maintaining public and professional confidence in POCT results. Continued quality assurance processes, robust governance structures and clear clinical pathways were viewed as critical enablers of future scale-up.

"It'll be that one time when something goes wrong with a patient or a service user. And then we need to understand where roles and responsibilities and accountabilities lie."

Stakeholder interview

Standardised quality assurance processes would also help ensure consistency across sites and reduce the likelihood of unnecessary repeat testing, a risk previously described in the report. Clear clinical guidance and communication protocols would also support general practitioners' confidence in pharmacy-generated results, helping to reduce duplication and improve patient flow through the pathway.

Equity considerations for future rollout

Stakeholders felt that equity should remain a central design principle for scale-up. At the same time, expansion should address practical barriers that could limit equitable uptake. These include awareness of the service, language accessibility, digital exclusion and culturally relevant patient information. Pharmacy teams' local knowledge and trusted relationships are important assets, but they should be

supported by translated materials, accessible communication and outreach approaches that reduce reliance on patients actively seeking testing.

Future success of programme
Each stakeholder was asked, *"What would success look like if the programme were implemented at scale?"*. Across all stakeholder interviews, there was strong agreement that success would be defined by the programme becoming a sustainable, widely available service that improves detection of cardiovascular risk while remaining accessible, integrated and equitable. Rather than focusing solely on the number of tests conducted, participants described success in terms of long-term patient, system and population health outcomes.

Critical success factors for scale-up
Across all evaluation themes, the following factors appear critical to successful scale-up:

- A sustainable commissioning model that reflects consultation time, administrative work, consumables, training and quality assurance.
- A clear pathway between pharmacy and general practice, including agreed processes for sharing results, follow-up and prescribing responsibilities.
- Robust training and competency assessment for pharmacists and wider pharmacy teams.
- Ongoing implementation support, troubleshooting and opportunities for peer learning across sites.
- Digital systems that minimise duplication of data entry and support integration with NHS records and reporting requirements.
- Quality assurance processes that maintain confidence in POCT results and consistency across providers.
- An equity-led approach to site selection and rollout, ensuring that access is aligned with population need rather than local availability alone.

Future development of the model
Since the period covered by this evaluation, the programme has continued to evolve beyond cholesterol testing alone. The programme has expanded beyond North London to sites across England, and community pharmacies are now delivering HbA1c testing and are expanding into urine albumin-creatinine ratio (ACR) testing, enabling a more integrated approach to identifying cardiovascular, metabolic and kidney-related risk factors. In addition, the programme has secured British Heart Foundation funding to support the administration of Inclisiran within community pharmacies in NEL from September 2026.

HbA1c and Cholesterol POCT

Case Study

Introduction

In February 2026, the cholesterol POCT programme expanded into a combined offer of cholesterol and HbA1c testing in pharmacies across England. This is a summary provided to describe the initial outputs of the programme and explore the potential of the programme to scale.

Findings

In one month (March 2026), over 1000 HbA1c POCT tests (n = 1,002) were conducted in 46 pharmacies. Of those, 37% of tests also included a cholesterol check. Compared to the Cholesterol POCT programme, patients who had a HbA1c+Cholesterol test in the expanded programme tended to be younger and more deprived but similarly ethnically diverse. (Figure 22)

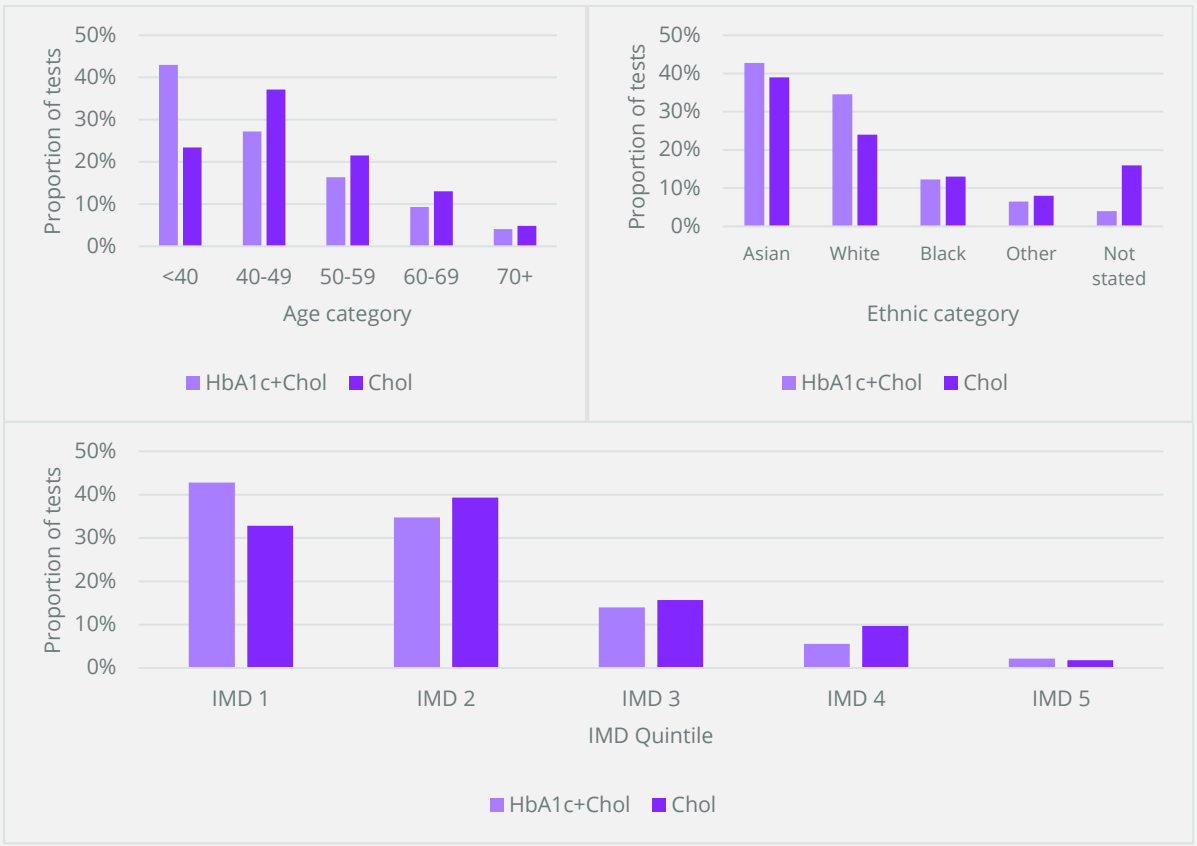


Figure 22. Demographic characteristics from combined HbA1c and cholesterol point-of-care testing

Category	Measure	Tests (n)	% of tests
HbA1c result	Normal	930	92.8%
	Prediabetes	53	5.3%
	Diabetes	19	1.9%
Diabetes risk (QDiabetes)	Low	133	13.3%
	Medium	372	37.1%
	High	274	27.3%
	Very high	123	12.3%
Cardiometabolic integration	HbA1c + lipid, same visit	369	36.8%
	≥1 cardiometabolic abnormality (BP / QRISK / HbA1c)	208	20.8%
Outcomes[1]	Statin initiated	22	—
	Blood-pressure treatment initiated	7	—
	Diabetes treatment initiated	8	—
	Statin + BP + Diabetes treatment initiated	<5	—

Table 9. Clinical results and treatment outcomes from combined HbA1c and cholesterol point-of-care testing. Percentages are based on available records. [1]Outcomes reflect follow-up to 30/6/26. "<5" denotes a suppressed small count.

In terms of testing outputs, a small proportion of all patients tested had abnormal HbA1c result (Prediabetes + Diabetes: 7.2%) (Table 9). However, similar to QRISK3, QDiabetes assessment highlighted a larger cohort who are at risk of developing diabetes (High + Very high: 39.6%). 36.8% of HbA1c tests were conducted with lipid testing and 1/5 people tested had at least one abnormal finding (20.8%) from the consultation.

Summary

The expansion of the programme to combined HbA1c and cholesterol testing demonstrates that the POCT model can be delivered at considerably greater scale and supports the feasibility of a broader CVKM prevention service delivered through community pharmacies. Early findings suggest that combining tests and risk assessment tools may identify a larger population at elevated risk of future cardiovascular and metabolic disease, creating opportunities for earlier intervention and more integrated prevention pathways.

Scale-Up and Sustainability Summary

The cholesterol POCT model is felt to be suitable for wider implementation, but stakeholders shared that sustainable scale-up will require more than replication of the pilot. The evidence points to a need for stable commissioning, adequate reimbursement, workforce capacity, general practice integration, digital interoperability, clear governance and an equity-led rollout strategy. Early evidence also suggests the model has the potential to deliver value for money and wider system benefits, although realising these benefits will require sustainable commissioning and implementation at scale.

Conclusions

The Cholesterol POCT programme successfully established and delivered a community pharmacy-based model for cardiovascular risk assessment and management across North East and North Central London. The programme demonstrated that cholesterol POCT can be safely and effectively integrated into routine pharmacy practice when supported by robust governance, quality assurance processes, workforce training and clear clinical pathways. Activity was sustained throughout the evaluation period and the model was successfully transferred to additional pharmacies and geographies.

The programme reached populations at increased risk of cardiovascular disease and health inequalities. People accessing the service were more likely to live in deprived communities than the wider North East London population, and the programme engaged a diverse population while maintaining high levels of satisfaction across demographic groups. Qualitative findings suggest that community pharmacy may improve accessibility through convenience, trusted relationships and opportunistic case-finding, helping to engage patients who may not otherwise access preventative services. The programme also identified substantial unmet cardiovascular risk. Most participants had at least one cardiovascular risk factor, one in five had a QRISK3 score indicating elevated cardiovascular risk, and the pathway supported referral, treatment initiation and lifestyle intervention for those requiring further management who may otherwise not receive care.

Acceptability of the service was high among both patients and pharmacy teams. Patients consistently valued the convenience of community pharmacy, rapid access to results and personalised discussion with pharmacists. Pharmacy teams viewed the service as a natural extension of their clinical role and reported that it aligned well with wider ambitions for community-based prevention.

The evaluation also highlights the potential for wider system benefit. Stakeholders viewed community pharmacy POCT as supporting earlier identification of cardiovascular risk, reducing barriers to testing and strengthening neighbourhood-based prevention. While longer-term impacts on cardiovascular outcomes and healthcare utilisation could not be assessed within the timeframe of this evaluation, the programme provides a promising model for delivering care closer to home and supporting NHS prevention ambitions.

This evaluation suggests that community pharmacy POCT is a feasible model for delivering preventative cardiovascular care closer to home. The next phase could focus on scaling the model sustainably, preserving its ability to reach underserved populations and generating stronger evidence on long-term clinical, economic and system outcomes. Continued evaluation, strengthened data linkage and an ongoing focus on equity would be essential to maximise the programme's contribution to reducing cardiovascular disease and health inequalities.

Recommendations

Operational effectiveness

- Incorporate awareness of seasonal pressures on community pharmacies in any future performance targets set for testing.
- Review reasons for variation across pharmacies.
- Support higher-throughput pharmacies to share learning with those conducting fewer tests, e.g. through Community of Practice.

Clinical effectiveness

- Engage with community pharmacists to understand limitations in collecting data on ethnicity and consider adapting training programme to improve this.
- Consider embedding independent prescribing into all future sites where workforce capability permits, reducing delays between identification of risk and treatment initiation and acknowledging the potential for greater LLT uptake.
- Explore ways to engage with the "non-contactable" cohort, to improve recording of outcomes. Consider alternative approaches for follow-up, including text messaging, digital questionnaires or NHS App integration, to reduce the proportion of patients classified as uncontactable.
- Develop consultation aids to support discussions regarding lifestyle change versus medication, particularly given the high proportion of patients initially preferring non-pharmacological approaches.

Staff and patient acceptability

- Maximise on positive feedback to involve patients and pharmacists in wider communication on POCT, to support the uptake of programme from both perspectives.
- Create opportunities for all pharmacies to feed back on their experience, to minimise risk of bias.
- Utilise the data on intended lifestyle changes to prioritise specific communications materials for patients, e.g. HEART UK Exercise content.
- Embed ongoing patient feedback collection beyond pilot phases to identify emerging implementation issues and opportunities for improvement.

- Engage pharmacists and patients with positive experiences as programme ambassadors to support future engagement and awareness campaigns.

Equity

- Maintain an equity-led approach to site selection and service rollout, prioritising communities with the highest burden of cardiovascular disease, deprivation and unmet preventative need.

- Include routine monitoring of equity outcomes within service specifications, including access by deprivation, ethnicity, age, sex and language needs, to ensure the programme continues to reduce rather than inadvertently widen health inequalities as it scales.

- Improve the completeness and quality of demographic data collection, particularly ethnicity data, to support more robust equity monitoring and accurate cardiovascular risk assessment

- Translate patient-facing materials, questionnaires and digital content into the most spoken local languages.

- Make non-digital routes for accessing results and educational materials more consistent to ensure equal access for patients with limited digital literacy.

- Strengthen outreach activity by combining opportunistic case-finding with targeted community engagement in underserved groups less likely to visit pharmacies regularly.

- Undertake research with eligible individuals who decline testing or are not reached by the service to better understand remaining access barriers.

Wider clinical impact

- Develop formal engagement processes with general practice, Local Medical Committees and Primary Care Networks during future implementation phases.

- Standardise and strengthen engagement with general practice to understand potential reasons for non-engagement, duplication of testing and to champion POCT testing in communities.

- Utilise longitudinal, linked primary and secondary care data in future, across a longer time horizon, to understand the specific impact of POCT on prescribing, treatment adherence, cardiovascular events, healthcare utilisation and cost-effectiveness.

- Engage with areas of low NHS Health Check uptake, particularly as the programme scales, to address the unmet need in this group.
- The number of estimated avoided CV events is low and may not describe the extended impact of the programme. Greater scale of testing, higher initiation of statins, longer follow up and longer time horizons may highlight this impact on CV events better.
- Build on the emerging HbA1c programme to develop integrated prevention pathways that address multiple risk factors through a single community pharmacy consultation.

Scale and sustainability

- Scope nationalisation of the cholesterol POCT programme as an option to ensure sustainability of funding and address limitations in scale, governance and wider uptake.
- Develop nationally agreed and standardised governance arrangements covering:
    - Quality assurance
    - Competency requirements
    - Incident management
    - Clinical oversight
    - Performance monitoring
- Develop service specifications that clearly define essential programme components to ensure consistency while allowing local adaptation where appropriate.
- When scaling outside of NEL, consider a delivery model which accounts for local knowledge and existing partnerships, e.g. regional hubs.
- Evaluate the full economic impact of community pharmacy POCT, including wider clinical and societal benefits beyond cardiovascular disease prevention.

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