SCHEDULE 2:

STANDARD OPERATING PROCEDURES (FOR COMMUNITY PROVIDERS)

NORFOLK COUNTY COUNCIL

PUBLIC HEALTH

NHS HEALTH CHECK PROGRAMME

-

STANDARD OPERATING PROCEDURES FOR COMMUNITY PROVIDERS

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BACKGROUND

1. PURPOSE OF STANDARD OPERATING PROCEDURES (SOP)

1.1. This document is intended for all Providers of the NHS Health Check Programme, both clinical and administrative.

1.2. The purpose of this document is to ensure a standardised and consistent delivery of the NHS Health Check Programme across the county of Norfolk in a consistent, safe and accurate manner.

1.3. This document details those tests and measurements that can be undertaken by any community provider undertaking a NHS Health Check.

2. OBJECTIVES

2.1. To provide vascular risk checks within the NHS Health Check programme and identify individuals who have not yet developed vascular disease but are at high risk of doing so by virtue of lifestyle factors, family history or previously undiagnosed disease.

2.2. To ensure that each component of the Health Check (tests and measurements) are accurately undertaken and recorded.

2.3. To ensure that the results of each test/measurement are explained appropriately to the individual and appropriate advice and/or referral given.

2.4. To effectively communicate the results of the tests and vascular risk in a clear and comprehensible manner to maximise the individual's understanding of their personal risk and modifiable risk factors.

2.5. To undertake the elements of the Health Check in a professional manner to maximise the likelihood of a positive and motivational experience for the client.

3. SCOPE

3.1. This manual of Standard Operating Procedures (SOPs) details the methods to be used for the tests and measurements constituting the NHS Health Check.

3.2. Elements of this SOP may be subject to change following local or national developments.

3.3. The information in this document relates to the delivery of NHS Health Checks for individuals aged 40 to 74 years inclusive meeting the eligibility criteria set out in Section 7, Pre assessment steps, in this SOP document.

4. NHS HEALTH CHECK PROGRAMME OVERVIEW

4.1. The NHS Health Check programme is a public health programme in England for people aged 40 – 74 which aims to keep people well for longer.

4.2. The NHS Health Check programme is a risk assessment and risk management programme to prevent or delay the onset of diabetes, heart and kidney disease and stroke.

4.3. A diagrammatic overview of the programme is provided figure 1.

4.4. A Health Check appointment should last between 20 - 30 minutes to ensure delivery of a health check of sufficient quality covering the
mandatory areas of

- risk assessment.
- risk communication.
- risk management.

4.5. Patients are invited for a NHS Health Check every five years providing they remain eligible.

In Norfolk the programme is currently delivered by most GP surgeries (80%) and by some community providers (20%) such as Pharmacy, Workplaces and Prisons.

NHS Health Check Programme
Risk assessment
Communication of risk
Risk Management
Key:
BP: Blood Pressure
HbA1c: Glycated Haemoglobin
DM: Diabetes Mellitus
eGFR: estimated Glomerular Filtration Rate
CKD: Chronic Kidney Disease
RECALL
EXIT Diabetes register
EXIT High Risk annual reviews
EXIT Hypertension register
EXIT CKD register
NHS stop smoking services referral
Alcohol brief advice or referral
Exercise on prescription or other physical activity intervention
Weight management on referral
Non-diabetic hyperglycaemia: Intensive lifestyle intervention
Consider statin therapies*
Anti-hypertensives prescription*
CKD assessment
Sign post or refer to life style interventions
High risk of diabetes
Risk Assessment
DM
High
eGFR Low
If CVD risk assessed as >20%
Assessment for Diabetes^
Assessment for hypertension^
Serum Creatinine^
Raised blood pressure
If blood sugar high
Age
Gender
Ethnicity
Family history
Smoking status
Alcohol use
Physical activity
Body Mass Index (BMI)
Cholesterol test
BP Measure
Diabetes filter
• BMI
• BP Measure
Dementia awareness and signposting
If at risk
HbA1c or Fasting Glucose
All to be undertaken by GP Practice Team
*or professionals with suitable patient information and prescribing rights
^People recalled to separate appointments for diagnosis
40-74
65-74

Figure 1

5 SERVICE REQUIREMENTS

5.1 WORKFORCE SKILLS AND COMPETENCES

Skills for Health have compiled details of the competences required for delivery of the Health Check assessment. This information is given in the document 'Vascular Risk Assessment: Workforce Competences (April 2009)' Appendix 1.

5.2 In brief, the competences covering the NHS Health Check include:

CVD EF3	Carry out assessment with individuals at risk of developing cardiovascular disease
CVD ED2	Provide information and advice about how to reduce the risk of cardiovascular disease
CHS131	Obtain and test capillary blood samples
CHS19	Undertake physiological measurements

5.3. The pharmacy / community provider must ensure that the healthcare professionals delivering NHS Health Checks are competent in the appropriate skills, and that appropriate governance systems are in place to ensure assessment and attainment of these competencies.

5.4. The pharmacy / community provider is expected to make staff delivering Health Checks available to participate in any other training or updates as identified by Norfolk Public Health or practice / pharmacy which would be deemed beneficial to the implementation of this service.

5.5. The pharmacy / providers identify a lead clinician or manager for the NHS Health Check programme and submit their contact details to Norfolk Public Health.

The Health Check lead will:

- ensure all staff involved with the delivery of NHS Health Checks are informed and aware of the standard of performance they are required to provide.
- ensure all staff delivering NHS Health Checks have the relevant training and/or experience to enable them to undertake the Health Checks to the standards detailed in this service specification.
- ensure all staff delivering NHS Health Check assessments have been fully trained in the use of the point of care testing machines

- ensure staff performance is routinely monitored and that any remedial action is taken where levels of performance are not in line the agreed standard of performance
- liaise with the Norfolk Public Health and LPC as required

6. EQUIPMENT

6.1 Equipment Specification

6.1.1 To ensure standardisation of delivery of NHS Health Checks across all Providers, the equipment defined in Table 1 will be used for all health checks.

Table 1 Equipment specification

Measure	Equipment
Height	An appropriate height measure currently being used for other clinical use.
Weight	Any Class 3 scales currently being used for other clinical work.
Fasting blood glucose	An appropriate blood glucose monitor currently being used for other clinical use. Cholestech LDX or Cardio Check PA.
Total Cholesterol	Cholestech LDX or Cardio Check PA.
HDL Cholesterol	Cholestech LDX or Cardio Check PA.
HbA1c	See Buyers' guide: Point of Care devices for the measurement of HbA1c and low concentration albumin in urine CEP08057 June2009 NHS Purchasing and Supply Agency. Centre for evidence based purchasing.
Blood pressure	British Hypertension Society accredited BP monitors for clinical use listed at: www.bhsoc.org/bp-monitors/bp-monitors.

6.1.2 All equipment must be calibrated in accordance with the manufacturer's instructions.

6.1.3 All operators of the equipment must be fully compliant in their use and prepare the equipment in accordance to manufacturer's instructions.

6.1.4 The provider must have a sharps container for the disposal of all sharps from point of care testing.

6.1.5 The provider must also have a contract for the disposal of sharps and soft clinical waste.

6.2 NEAR PATIENT TESTING AND QUALITY CONTROL

6.2.1 This section provides guidance and advice on the use of point of care testing (POCT) or near patient testing (NPT) for the blood tests required for the NHS Health Check. It provides advice on training and quality assurance to support the safe use of POCT.

6.2.2 Fasting blood glucose or HbA1C POCT may be suitable for initially filtering out those who are unlikely to have diabetes or non-diabetic hyperglycaemia. However, diagnosis of diabetes or of non-diabetic hyperglycaemia requires a venous blood sample to be tested in the laboratory. See the diagrammatic overview of the testing pathways set out in Figure 2 for further information.

6.2.3 The guidance document Management and Use of IVD Point of Care Test Devices aims to provide advice and guidance on the management and use of POCT in vitro diagnostic devices (IVDs).

6.2.4 An IVD is a device the manufacturer has intended to be used for the examination of specimens derived from the human body including blood and urine and this guidance may provide a useful resource on:

- the importance of identifying a clinical need before a decision is made to introduce POCT.
- clinical governance issues relating to the setting up and management of POCT.
- the need for local hospital pathology laboratory involvement in all aspects of a POCT service.
- the need for training, updating and monitoring of all staff involved in the POCT service.
- quality issues, including:
    - accreditation by an external certification body
    - the need for an appropriate quality control procedure
    - membership of an external quality
    - assessment scheme (where available).
    - the importance of health and safety.
    - the need for standard operating procedures and for regular reviews and updates when necessary.

6.2.5 NPT should only be used by healthcare professionals and staff who have been trained (by a competent trainer) to use the equipment.

6.2.6 There is a need for clearly defined procedures for infection control, storage and disposal of clinical waste, needle stick injuries and spillages. As part of this, appropriate hand washing facilities nearby or within any room where blood is taken or handled is required.

6.2.7 For guidance including advice on clinical governance issues relating

to the setting up and management of POCT, pathology and laboratory involvement, staff training, health and safety, standard operating procedures and quality issues see *Management and Use of IVD Point of Care Test Devices. Device Bulletin 2002(03). Medical Devices Agency. March 2002. www.mhra.gov.uk/Publications/ Safewtyguidance/ DeviceBulletins?CON007333*.

6.3 INFECTION CONTROL

This section provides guidance and advice on Infection control

6.3.1 The provider must have in place clearly defined procedures for infection control, storage and disposal of clinical waste, needle stick injuries and spillages.

6.3.2 The provider should have a dedicated room or private area for the NHS Health Check assessments, with appropriate hand washing facilities nearby or within any room where blood is taken or handled.

6.3.3 The NHS Health Check room / private area should be regularly cleaned and any blood and body fluid spillages are cleaned with chlorine releasing agents made up at a dilution of 10,000 PPM.

6.3.4 Hand hygiene is to be performed before and after EVERY patient/service user contact.

6.3.5 Providers should arrange their own clinical waste and sharps collection service (Appendix 2 Correct Waste Disposal) provides advisory guidance.

PRE-ASSESSMENT STEPS

7.1 ELIGIBILITY

The patient must meet all of the inclusion criteria (7.2, 7.3) and none of the exclusion criteria (7.5, 7.6, 7.7)

7.2 NHS Health Checks is a primary prevention programme for individuals aged 40 to 74 years inclusive.

7.3 Individuals are eligible if they are registered with a GP practice in the county of Norfolk or are resident in Norfolk but unregistered with any practice.

7.4 NHS Health Checks is a primary prevention programme therefore individuals with established vascular disease are not included. Such individuals should already be receiving appropriate active management of risk factors as part of their standard care.

7.5 Individuals are not eligible for this programme if they have previously been diagnosed with any of the following:

- Coronary heart disease
- Chronic kidney disease (CKD)
- Diabetes
- Hypertension
- Atrial fibrillation
- Trans ischaemic attack (TIA)
- Hypercholesterolaemia
- Heart failure
- Peripheral disease
- Stroke

7.6 Also excluded are people:

- Being prescribed statins
- Who have previously had an NHS Health check, or any other check undertaken through the health service in England and found to have a 20% or higher risk of developing cardiovascular disease over the next 10 years.

7.7 Individuals are temporarily not eligible if they have already received an NHS Health Check assessment within the preceding 5 year period.

7.8 An Eligibility flow chart can be found in Appendix 4.1

8 PROMOTING NHS HEALTH CHECKS

8.1 An NHS Health Check must always be called, branded and promoted as an NHS Health Check to distinguish it from other health checks, health assessments and health MOT's that might be offered by the provider.

8.2 When promoting the NHS Health Check Service providers should follow the NHS Health Check brand guidance. Found here http://www.healthcheck.nhs.uk/commissioners_and_healthcare_professionals/national_resources/nhs_health_check_brand_identity/

8.3 Providers can also order free local NHS Health Check resources from HILS http://www.heron.nhs.uk/pidd/HILSIndex.aspx to promote and support their programme.

8.4 Community providers should use the Department of Health NHS Health Check booklet (Appendix 3.) to provide potential service users with information about the NHS Health Check;

- Booklets in English, Large print and the key languages in Norfolk can be ordered free from Norfolk's Health Information Leaflet Service (HILS) http://www.heron.nhs.uk/pidd/HILSIndex.aspx

- Booklets in minority languages spoken in Norfolk can be downloaded from the NHS Health Check website http://www.healthcheck.nhs.uk/commissioners_and_healthcare_professionals/national_resources/promotional_materials/information_leaflets/

8.5 Community providers should participation in Norfolk County Council NHS Health Check campaigns e.g. by displaying posters in Pharmacy or Workplace if appropriate.

8.6 **Pharmacy only:**

If a person comes into a Pharmacy and asks for a non-specified health check the Pharmacy should first check if the person is eligible for a free NHS Health Check, before offering alternative private fee paying health checks, health assessments or health MOT's.

9 RECORDING INFORMATION FROM THE HEALTH CHECK

9.1 Pharmacy

9.1.1 Each NHS Health Check must be recorded on the Pharm Outcomes Web based reporting system.

9.1.2 Completed record must be sent to the patients GP practice using the inbuilt encrypted email option (preferable) or by printing the automatically generated report and sending securely to the GP practice.

9.1.3 If a pharmacy cannot access Pharm Outcomes for any reason they may record the results manually then add to the system at the next available opportunity.

9.2 Other Providers (not Pharmacy)

9.2.1 Each NHS Health Check must be recorded on the agreed templates as stated in the service level agreement.

9.2.2 Completed health check records must be sent to the patients GP practice using a secure N3 nhs.net email account (if possible) or by posting securely to the GP practice as stated in the contract.

9.2.3 A copy of the patient record must be kept securely by the provider.

THE NHS HEALTH CHECK – RISK ASSESSMENT

The following details the elements of the NHS Health Check to be delivered to the individuals meeting the eligibility criteria given in section 7**.**

10 INFORMATION AND CONSENT

10.1 The assessor should ensure that all individuals that attend for a Health Check are provided with the same information about the service and the purpose of the Health Check prior to the process commencing.

10.2 The assessor will reassure the individual and give an overview of the tests and questions that they will go through in order for them to make an informed choice as to whether or not they consent for the Health Check to take place.

10.3 Prior to the commencement of a Health Check, it is essential that the individual gives their consent for the check to take place. The individual must give his/her consent for all measurements to be made during the Health Check and consent to a finger prick blood sample to be taken if using POCT.

10.4 The assessor must inform the individual that the information obtained at the Health Check will be shared in a secure manner with the individual's GP practice. The individual will be asked if they consent to this and given the option to decline.

10.5 If the individual gives his/her consent to the terms above then the Health Check can continue.

10.6 If the individual refuses to give consent to the terms above then the Health Check must be terminated.

11 CVD RISK ASSESSMENT

11.1 Everyone having a NHS Health Check will have a risk assessment which will look at the level of risk associated with developing cardiovascular disease in the next 10 years.

11.2 The risk assessment requires the following tests and measures to be carried out and information collected as set out below.

- QRISK2 cardiovascular risk score
  - age
  - gender
  - postcode
  - ethnicity
  - smoking status
  - family history or coronary heart disease
  - body mass index (BMI): weight and height
  - cholesterol levels
  - blood pressure
- physical activity level
- Alcohol Use Disorders Identification Test (AUDIT C)
- Dementia awareness raising (aged 65 – 74 years only)

12 RISK ENGINE

The NHS Health Check requires the use of a risk engine to calculate the individual's risk of developing cardiovascular disease in the next 10 years

12.1 Assessors should use the QRISK 2 risk engine to calculate the individual's risk of developing cardio vascular disease.

12.2 When a Health Check risk assessment is not conducted in the individuals GP practice, the assessor must securely send the complete data set including the CVD risk score for all individuals to their GP.

12.3 GP's in receipt of Health check risk assessment results from Health Checks carried out by a community provider such as a Pharmacy, Outreach, Workplace or Prison must update patients' medical records using Read Codes.

12.4 If the individual's CVD risk score is ≥ 20%, the assessor should reassure the individual and explain that as their risk is above a certain level and refer them to their GP practice. See section 33 (CVD risk ≥ 20%).

12.5 The following variables are required to perform this calculation. The procedures for obtaining these measurements have been detailed within the referenced sections**:**

Postcode	13
Family history of premature CHD	14
Age	15
Gender	16
Ethnicity	17
Smoking status	18
BMI	20
Systolic blood pressure	21
Total cholesterol	22
HDL cholesterol	22

13 CONTACT INFORMATION

The assessor will ask the individual for the following information and record the responses given:

Date of birth	
Name of GP practice	
Full Name	*Title*
	Forename
	Middle Name or Initials
	Surname
Full address	*House Name or No*
	Address Line 1
	Address Line 2
	City
	County
	Postcode
Telephone number	*Landline*
	Mobile

14 FAMILY HISTORY

14.1 Family history of coronary heart disease in a first degree relative under 60 years is required for the NHS Health Check risk assessment.

14.2 The assessor will ask the individual if he/she has a family history of:

- premature coronary heart disease (including angina) in a first-degree relative (defined as a mother, father, brother or sister)
- diabetes (Type 1 or Type 2)
- stroke
- hypertension

- If there is a family history of stage 5 CKD or hereditary kidney disease

15 AGE

The individual's age is to be recorded in years.

16 GENDER

An individual's reported gender should be recorded as male or female.

17 ETHNICITY

17.1 An individual's self-assigned ethnicity should be recorded using the Office for National Statistics categories.

17.2 The following Read Codes should be used for recording ethnicity as in Table 2.

Table 2 Read codes for recording ethnicity

Demographics			
Ethnicity	British or mixed British - ethnic category 2001 census	9i0	XaJQv
	Irish - ethnic category 2001 census	9i1	XaJQw
	Other White background - ethnic category 2001 census	9i2	XaJQx
	White and Black Caribbean - ethnic category 2001 census	9i3	XaJQy
	White and Black African - ethnic category 2001 census	9i4	XaJQz
	White and Asian - ethnic category 2001 census	9i5	XaJR0
	Other Mixed background - ethnic category 2001 census	9i6	XaJR1
	Indian or British Indian - ethnic category 2001 census	9i7	XaJR2
	Pakistani or British Pakistani - ethnic category 2001 census	9i8	XaJR3
	Bangladeshi or British Bangladeshi - ethnic category 2001 census	9i9	XaJR4
	Other Asian background - ethnic category 2001 census	9iA	XaJR5
	Caribbean - ethnic category 2001 census	9iB	XaJR6
	African - ethnic category 2001 census	9iC	XaJR7
	Other Black - ethnic category 2001 census	9iD	XaJR8
	Chinese - ethnic category 2001 census	9iE	XaJR9
	Other - ethnic category 2001 census	9iF	XaJRA
	Ethnic category not stated 2001census	9iG	XaJRB
	Patient ethnicity unknown	916E.	XaLN0

17.3 If an individual declines to answer this question, the assessor should explain that this information is being collected as some ethnic groups have a higher risk of specific diseases such as diabetes.

17.4 Patients who decline to answer should be recorded as white / not recorded default in order for the Health Check to continue and a QRISK score to be able to be generated.

18 SMOKING STATUS

18.1 An individual's smoking status should be recorded as (Appendix 4.3)

- Non-Smoker
- Ex-Smoker
- Light Smoker
- Moderate Smoker
- Heavy Smoker

18.2 The assessor must explain that 'smoking' means the inhalation of any tobacco product and includes shop bought cigarettes, roll ups, cigars, pipes etc.

19 PHYSICAL ACTIVITY LEVEL

19.1 The GP Physical Activity Questionnaire (GPPAQ) (see Appendix 5) should be used to measure physical activity levels.

19.2 GPPAQ provides a measure of an individual's physical activity level that correlates with cardiovascular risk.

19.3 Individuals physical activity level should be recorded as:

- GPPAQ physical activity index: inactive
- GPPAQ physical activity index: moderately inactive
- GPPAQ physical activity index: moderately active
- GPPAQ physical activity index: active

19.4 Thresholds:

- A brief intervention on physical activity and sign post to Norfolk's Living Well should be given to all people other than an "active" GPPAC classification.
- Individuals classified as "inactive" should be considered for exercise referral if appropriate and available.

20 BODY MASS INDEX (BMI)

20.1.1 Body Mass Index (BMI) is required for the CVD risk calculation.

20.1.2 Body Mass Index (BMI) should be calculated as kg/m2.

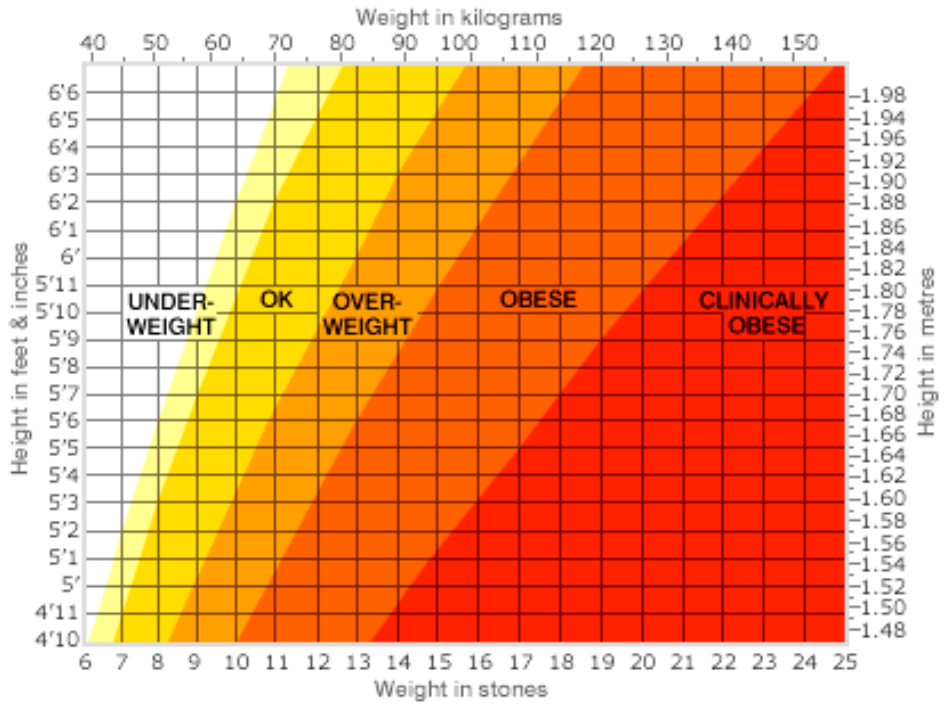
20.1.3 Body Mass Index (BMI) also provides an approach to identifying those at risk of developing diabetes, or those who have existing undiagnosed diabetes and is required for diabetes risk assessment. (covered in section 23).

20.1.4 Thresholds: where individual's BMI is in the obese range as follows then a blood sugar test is required (see Appendix 4.3):

- BMI 27.5 or over in individual from the Indian, Pakistani. Bangladeshi, Other Asian and Chinese ethnicity categories
- BMI 30 or over in individuals from other ethnicity categories.

Table 3 BMI Chart

$$\text{BMI} = \frac{\text{(Weight in kg)}}{\text{(Height in m2)}}$$



20.2 Weight measurement (in kilograms, kg)

20.2.1 The individual should not be weighed if he/she does not feel safe standing still, or if the assessor does not feel safe to support the individual whilst he/she is being measured.

20.2.2 How to measure weight

- The individual should remove their shoes and coat and heavy outerwear for this test.
- Ensure scales have been calibrated/ serviced within the specified time range.
- Set scale to '0'.
- Ask the individual to step on scales.
- Wait for weight to register properly.
- Record weight (in kg).

20.3 Height measurement (in centimetres, cm)

20.3.1 The height should be measured with the base plate on a firm and level surface, preferably with a perpendicular surface to ensure the measure is vertical.

20.3.2 How to measure height

- Ask the individual to remove his/her shoes and stand on the base plate with their back to the measure.
- If the individual has a ponytail or other hair dressing that may affect the result, ask him/her to remove it.
- Ask the individual to stand as tall and straight as possible with feet together and arms loosely at the side and shoulders relaxed.
- The head should be placed in the Frankfurt Plane, such that an imaginary line joining the upper margin of the external auditory meatus and the lower border of the eye is horizontal. (Ensure that the individual is looking straight ahead with the back of their head against the plate.)
- Lower the head plate so that it gently rests on the highest part of the individual's head. Press down to flatten hair.
- Read the height measurement from where the arrow points to on the measure and record to the nearest cm.

21 BLOOD PRESSURE

21.1 Overview

21.1.1 The procedure for measuring blood pressure must follow guidance from the British Hypertension Society www.bhsoc.org/latest-guidelines/

21.1.2 It should be explained that the measurement may be repeated several times in order to obtain the most accurate reading.

21.1.3 The individual's arm circumference must be accurately measured to ensure an appropriate cuff size is used (see Figure 2 Table 4) below.

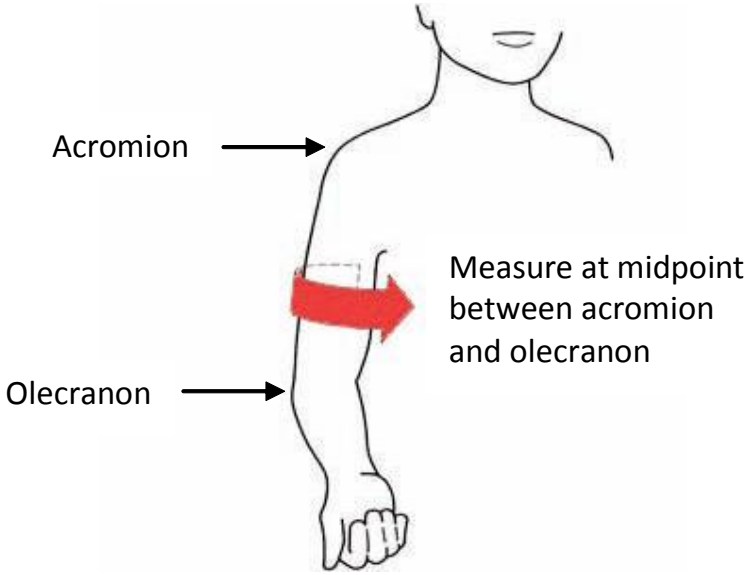


Table 4 Guide to cuff sizes for blood pressure measurement (source: British Hypertension Society)

Indication	Width(cm)*=	Length(cm)*=	BHS Guidelines Bladder width & length (cms)*	Arm circ.(cm)*
Small Adult	10 – 12	18 – 24	12 x 18	<23
Standard Adult	12 – 13	23 – 35	12 x 26	<33

Large Adult	12 – 16	35 – 40	12 x 40	<50
**** The range for columns 2 and 3 are derived from recommendations from the British Hypertension Society (BHS), European Hypertension Society (ESH) and the American Heart Association. Columns 4 and 5 are derived from only the BHS guidelines.*** = ***Bladders of varying sizes are available so a range is provided for each indication (applies to columns 2 and 3)***				

21.1.4 Devices for measuring blood pressure must be properly validated and maintained, and regularly recalibrated according to manufacturer's instructions.

21.1.5 Where possible, standardise the environment when measuring blood pressure: the environment should be relaxed, quiet and warm.

21.1.6 Ensure that the individual has been sitting down for at least 5 minutes and is comfortable, and any tight or restrictive clothing has been removed from the arm.

21.1.7 Place the cuff on neatly with the indicator mark on the cuff over the brachial artery. The bladder should encircle at least 80% of the arm (but not more than 100%). If this is not the case, then a more appropriate sized cuff should be utilised. A guideline to cuff sizes is given in Table 3.

21.1.8 The arm must be supported at the level of the heart and the blood pressure (BP) monitor should be placed on an even flat surface.

21.1.9 The assessor should ensure that the individual's legs are not crossed and ask him/her not to talk whilst the blood pressure is being measured. The assessor should also not talk to the individual during the measurement.

21.1.10 The individual's blood pressure must be measured twice and the average value used for CVD risk calculation. The systolic and diastolic blood pressure must be recorded.

21.2 Blood pressure measurement with electronic blood pressure monitors[1]

21.2.1 Most monitors allow manual blood pressure setting selection where you choose the appropriate setting. Other monitors will automatically inflate and re-inflate to the next setting if required.

21.2.2 Repeat three times and record measurement as displayed. Initially test blood pressure in both arms and use arm with highest reading for subsequent measurement.

21.3 Blood pressure measurement with mercury blood pressure monitors[2]

21.3.1 The column of mercury must be vertical, and at the observer's eye level.

21.3.2 Estimate the systolic beforehand:

- Palpate the brachial artery
- Inflate cuff until pulsation disappears
- Deflate cuff
- Estimate systolic pressure

21.3.3 Then inflate to 30mmHg above the estimated systolic level needed to occlude the pulse.

21.3.4 Place the stethoscope diaphragm over the brachial artery and deflate at a rate of 2-3mm/sec until you hear regular tapping sounds.

21.3.5 Measure systolic (first sound) and diastolic (disappearance) to nearest 2mmHg.

21.4 Finding of high blood pressure

21.4.1 If an individual's blood pressure is ≥ 140/90mmHg, **or** the systolic blood pressure is >140mmHg **or** the diastolic blood pressure is >90mmHg, the measurement should be

[1] Source: BHS blood pressure measurement with electronic blood pressure monitors (accessed March 2012)

[2] Source: BHS Blood pressure measurement with mercury blood pressure monitors (accessed March 2012)

repeated, if it remains high it should be taken for a third time towards the end of the Health Check assessment.

21.4.2 If the blood pressure is still recorded as ≥ 140/90mmHg, **or** the systolic is >140mmHg **or** diastolic is >90mmHg, the assessor should reassure the individual and explain that blood pressure will vary amongst individuals according to the time of day, meals, smoking, anxiety, temperature, and the season of the year. If their blood pressure is a certain level, they will be referred to their GP for further investigation within 1 week.

21.4.3 If very high blood pressure is recorded systolic is >179mmHg, the individual should be reassured and kept calm and be immediately referred to the GP as an urgent referral. See section 26 (assessment for hypertension).

21.4.4 Thresholds: where individual's Blood Pressure is ≥ 140/90mmHg a blood sugar test is required (Follow pathway Appendix 4.4)

22 CHOLESTEROL (TOTAL AND HDL)

22.1 Cholesterol is a major modifiable risk factor of vascular disease, and can be reduced by dietary change, physical activity and drugs.

22.2 A random (non-fasting) point of care test (POCT) cholesterol test can be used under the NHS Health Check programme to help ensure maximum take-up. Health Check programme. (see Appendix 4.5)

22.3 QRISK2 specifies cholesterol to be measured as a ratio of total serum cholesterol to high density lipoprotein cholesterol.

22.4 In order to perform a quality finger stick puncture the assessor should follow manufacturer's instructions, infection control guidance and the employer's health and safety guidance.

22.5 LDX Processes

The assessor should follow the manufactures guidance.

Training can be provided by the manufacture.

22.6 Cardio check Processes

The assessor should follow the manufactures guidance.

Training can be provided by the manufacturer.

23 DIABETES RISK

23.1.1 Only those identified as at higher risk should have a blood glucose test or HbA1C test as part of their NHS Health Check risk assessment. (It is not considered clinically effective or cost effective to test everyone).See Appendix 4,7.

23.1.2 For the NHS Health Check you should use the following diabetes filter in figure 3 which uses BMI (adjusted for ethnicity) and blood pressure to identify people at high risk.

23.1.3 Using these factors as a filter, those at higher risk can be identified and these should go on to receive a blood glucose test either an HbA1c which is recommended, or a fasting blood glucose test.

The outcome of the test will establish how best they can be managed.

23.1.4 Where FPG or HbA1c is not possible, a random glucose maybe used for filtering patients requiring further testing (FPG or HbA1c) See Appendix 4.6

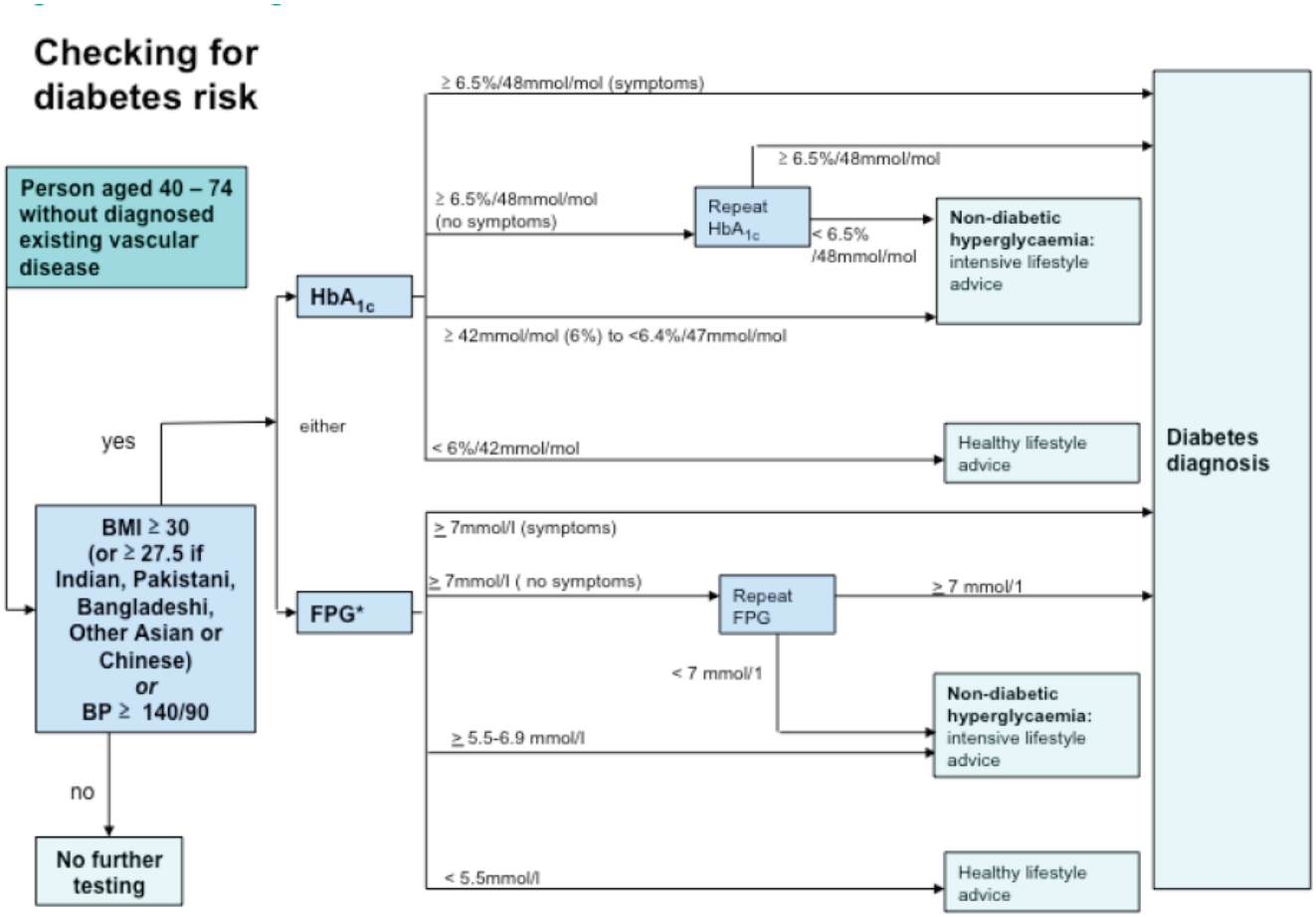


Figure 3 Diabetes Risk

23.2 HbA1c

23.2.1 HbA1c testing does not require fasting so can be more convenient. Blood can be taken from a vein for a laboratory test or capillary (finger prick) for a near-patient testing.

23.2.2 HbA1c is formed when glucose binds to haemoglobin in red blood cells. The higher the blood glucose is over the past two or three months, the higher the HbA1c.

23.2.3 Even within the non-diabetic range, HbA1c has been shown to be a risk marker for vascular events and can be used to assess the risk of diabetes.

23.2.4 In 2011, the World Health Organization accepted HbA1c as an alternative method in the diagnosis of diabetes provided:

- stringent quality assurance methods are in place.
- measurements are standardised.
- no conditions exist which preclude HbA1c's accurate measurement such as haemolytic anaemia, iron-deficiency anaemia and some variant haemoglobins. However there are some test kits that give correct reading despite abnormalities in haemoglobin (Hb).
- HbA1c is not recommended for the diagnosis of diabetes in pregnancy when an oral glucose tolerance test is still required.

23.2.5 HbA1c reflects glycaemia over the preceding 2–3 months so may not be raised if blood glucose levels have risen rapidly.

23.2.6 Situations where blood glucose levels have risen rapidly require urgent/same day assessment by a GP, diabetologist or Accident & Emergency.

Examples include:

- ALL symptomatic children and young people
- symptoms suggesting type 1 diabetes (any age)
- short duration diabetes symptoms
- patients at high risk of diabetes who are acutely ill
- patients taking medication that may cause rapid glucose rise, e.g. corticosteroids, anti-psychotics
- acute pancreatic damage/ pancreatic surgery.

23.3 Fasting plasma glucose (FPG)

23.3.1 To undertake an FPG test, the person being tested should be informed of the requirement to fast overnight in writing or over the phone. Fasting is defined as no caloric intake for at least 8 hours, water is allowed.

23.3.2 If possible the appointment should be scheduled for as early in the day as possible to make fasting easier.

23.3.3 Fasting plasma glucose may be measured either by a venous blood sample or POCT. Measurement thresholds differ depending on the method used.

24 ALCOHOL RISK ASSESSMENT

24.1 Alcohol risk assessment is now part of the NHS Health Check.

24.2 The AUDIT questionnaire should be used to assess alcohol consumption (See Appendix 6).

24.3 The AUDIT questionnaire is 10 questions long and takes approximately 3 minutes to complete. Not everyone will need to answer all 10 questions.

24.4 The assessment is split into two phases:

i. An initial screen AUDIT C to identify those who may be at risk, and
ii. A second phase to identify the level of risk.

24.4 Initial Screening can be self-completed by the individual or the questions can be verbally asked of the person and their results recorded.

24.5 **Initial Screening threshold (AUDIT C >5)**

If the patient scores above 5 this indicates that the individual is positive on the initial screening questionnaire and the second phase of the questionnaire should be completed.

24.6 **Full AUDIT**

If the patient scores above 5 in the AUDIT C initial screening questionnaire, the second phase is to complete the remaining questions of the full AUDIT. The full AUDIT score identifies the risk level of the person.

24.7 **AUDIT threshold: > 8**

If the total AUDIT score from the full ten questions is 8 or more, this indicates the persons alcohol consumption might be placing their health at increasing or higher risk of harm

24.8 If the person meets or exceeds the AUDIT threshold of 8, the individual should be given brief alcohol advice to reduce their health risk and help them reduce alcohol related harm.

25 RAISING AWARENESS OF DEMENTIA

25.1 Everyone aged 64 – 74 who has an NHS Health Check should be made aware of the symptoms of dementia and be sign posted to memory services if this is appropriate.

25.2 Assessors should highlight the relationship between cardiovascular risk factors and those risk factors associated with vascular dementia.

25.3 A dementia leaflet should be given to all individuals aged 65 – 74 having a NHS Health Check (see Appendix 7).

25.4 Leaflets (English, large print and easy read) can be ordered for free from HILS and leaflets in in different languages and different formats can be downloaded from the resources section of the NHS Health Check website www.healthcheck.nhs.uk

25.5 Dementia training for staff delivering NHS Health Checks can be found on http://www.healthcheck.nhs.uk/increasing-dementia-awareness-training-resource/

THE NHS HEALTH CHECK – RISK COMMUNICATION

26 COMMUNICATING CVD RISK SCORE

26.1 A key purpose of this programme is risk reduction and management. It is therefore essential that all communication of risk is explained based on the continuum of risk.

26.2 The language of “risk reduction” should be adopted so that all individuals can expect to be given targeted and individualised advice about what they could do to reduce personal future risks, rather than the reassurance of an “all-clear” result.

26.3 The assessor should use jargon-free language to communicate information on risk. If technical terms are used, these should be clearly explained.

26.4 The assessor should explain to the individual that everyone is at risk of CVD; this risk may be increased by their family history or lifestyle (i.e. physical inactivity).

26.5 People should be informed that CVD risk equations can only provide an estimate of risk. Risk may be underestimated if people have recently changed a health damaging behaviour e.g. stopped smoking.

26.6 The assessor should use a combination of verbal explanation and visual aids to communicate the individual’s level of risk.

27 HEALTH CHECK RESULTS

27.1 Individuals should be given a NHS Health Check Results Card (Appendix 8) which can be ordered from health Information Leaflets Service (HILS) http://www.heron.nhs.uk/pidd/Catalogue.aspx.

27.2 The following information should be filled in discussed and given to the individual to keep for their reference.

- Date of NHS Health Check
- CVD RISK score
- Blood Pressure
- BMI and weight
- Cholesterol
- Physical Activity level
- Referral or Sign Post to Health Services.

27.3 Adequate time should be set aside during the consultation to discuss the results of the Health Check, the meaning of risk and the steps the individual can take to reduce his/her risk, and to allow any questions to be answered.

28 THE NHS HEALTH CHECK – RISK MANAGEMENT AND LIFESTYLE REFERRAL

28.1 Everyone who has a NHS Health Check, regardless of their risk score, should be given lifestyle advice, where clinically appropriate, to help them manage and reduce their risk.

28.2 That means that, unless it is deemed clinically unsafe to do so, everyone having the check should be provided with individually tailored advice that will help motivate them and support the necessary lifestyle changes to manage their risk.

28.3 For those at low risk, this might be basic health promotion messages tailored to the individual.

28.4 Others at moderate to high risk may benefit from referral to a Health Trainer as a facilitator of behaviour change to identify lifestyle programmes through a patient centred approach from which the individual could benefit including weight management, stop smoking service, a brief intervention to increase levels of physical activity, or voluntary organisations.

28.5 Those at the highest risk might also require medication with statins or blood pressure treatment, or an intensive lifestyle management programme for those identified with impaired glucose regulation.

28.6 **SIGNPOSTING:** Individuals may be signposted to relevant lifestyle services, where signposting is considered to mean when the individual is informed about a service, e.g. verbally or by leaflet, but no further action is taken by the assessor

28.7 All individual having an NHS Health Check should given general healthy lifestyle advice and be made aware of the Norfolk Public Health one stop shop for healthy lifestyle service Norfolk's Living Well http://www.norfolkslivingwell.org.uk/ so that they can access services when they are ready to change.

28.8 **REFERRAL:** Individuals may be referred to relevant lifestyle services, where referral is considered to mean the individual is actively referred into a lifestyle service by the assessor who passes on the individual's details with their permission.

28.9 Advice and management of risk factors should follow national guidance/best practice.

28.10 Table 6 gives relevant interventions and corresponding National Institute for Health and Clinical Excellence (NICE) guidance. All these interventions are recommended by NICE and are cost effective.

Table 5 Interventions offered and respective NICE guidance

Intervention offered	Existing guidance
Stop smoking services	NICE guidance PH1 Brief interventions and referral for smoking cessation in primary care and other settings (March 2006) http://www.nice.org.uk/PH1 NICE PH10 Smoking cessation services (Feb 2008) in primary care, pharmacies, local authorities and workplaces, particularly for manual working groups, pregnant women and hard to reach communities NICE guidance PH45 Tobacco harm reduction (June 2013) partially updates and replaces PH10
Brief exercise intervention	NICE guidance PH2 four commonly used methods to increase physical activity (March 2006). www.nice.org.uk/PH2 NICE Physical activity PH44: brief advice for adults in primary care: guidance (May 2013). The recommendations supersede recommendations 1-4 in four commonly used methods to increase physical activity PH2 www.nice.org.uk/PH444 NICE Walking and cycling PH41: local measures to promote walking and cycling as forms of travel or recreation (Nov 2012) www.nice.org.uk/PH41
Multi-component weight loss programmes	NICE clinical guideline CG43 Obesity: the prevention, identification, assessment and management of overweight and obesity in adults and children (Updated January 2010) www.nice.org.uk/CG43 NICE BMI and waist circumference - black, Asian and minority ethnic groups PH46 (July 2013) assesses links to the risk of a range of non-

Intervention offered	Existing guidance
	communicable diseases.
Behaviour change	NICE Behaviour change PH6 (Oct 2007) : the principles for effective interventions NICE Behaviour change: PH49 (Jan 2014) individual approaches aims to help someone with a specific health condition, or a behaviour that may affect their health.
Alcohol – brief intervention and referral	NICE guidance PH24 Alcohol-use disorders: preventing harmful drinking (May 2010) http://www.nice.org.uk/PH24
Prevention of diabetes / Impaired glucose regulation (IGR) intensive lifestyle management	NICE Preventing type 2 diabetes - risk identification and interventions for individuals at high risk (PH38) July 2012 NICE guidance PH35 Preventing type 2 diabetes: population and community-level interventions in high-risk groups and the general population (May 2011) www.nice.org.uk/PH35 NICE clinical guideline CG43 Obesity: the prevention, identification, assessment and management of overweight and obesity in adults and children (Updated January 2010) http://www.nice.org.uk/CG43

29 STOP SMOKING SERVICES

29.1 All individuals who smoke should be offered referral to the local Stop Smoking Service.

Phone 0800 0854113

Text QUIT to 65000

Visit www.smokefreenorfolk.nhs.uk

29.2 DH guidance advocates the provision of very brief advice to help support smoking cessation, and consists of the following three steps:

- Ask and record smoking status.
- Advise individual of health benefits.
- Act on individual's response.

29.3 A free training module on the delivery of Very Brief Advice is available from the National Centre for Smoking Cessation and Training. www.ncsct.co.uk/vba

30 PHYSICAL ACTIVITY

30.1 All individual identified as less than active, should be offered a brief intervention to increase their physical activity as follows:

- Provide physical activity advice; take into account the individual's needs, preferences and circumstances.
- Provide written information about Active Norfolk www.activenorfolk.org and the various types of activities and local opportunities to be active and refer to Norfolk's Living Well. www.norfolkslivingell.org.uk

30.2 A brief intervention is most appropriate for the majority of patients who are classified by GPPAQ as less than active. Only patients who require supervised sessions due to their level of risk should be considered for an exercise on referral or condition-specific exercise programme.

30.3 The assessor should explain that for general health benefits the Chief Medical Officer recommends adults;

- Aim to be active daily
- Activity should add up to at least 150 minutes of moderate intensity activity a week
- Activity should be in bouts of at least 10 minutes
- One way to approach this is to do 30 minutes on at least 5 days a week.

31 WEIGHT MANAGEMENT

Preventing and managing overweight and obesity are complex problems.

31.1 Where an individual's weight status is a key risk factor, advice or onward referral should be provided in line with the NICE clinical guideline 43 on the prevention, identification, assessment and management of overweight and obesity.

31.2 GP Practice NHS Health Checks: Refer to your local CCG Obesity / weight management pathway

31.3 Community NHS Health Check: Refer to the Health Trainer service or signpost to Norfolk's Living Well.

31.4 Where the individual's weight status is not a risk factor, it is nonetheless an opportunity to reinforce the benefits of healthy eating and being physically active.

31.5 When providing advice around weight management or referring individual on to more sustained interventions, it will be important to take a personalised approach. This may require consideration of factors including the individual's:

- Willingness and motivation to change
- particular barriers to lifestyle change (e.g. lack of time or knowledge)
- self-esteem
- current levels of fitness
- the views of family and community members.

31.6 In addition, the individual's alcohol intake could be considered as part of any discussion about energy intake, and the opportunity used to highlight links between alcohol intake and obesity with liver disease.

32 ALCOHOL USE INTERVENTIONS

32.1 The assessor should explain that for lower-risk drinking, men should not drink on a regular basis more than three to four units per day, and that women should not drink on a regular basis more than two to three units a day (with 'regular' here meaning most days or every day of the week).

32.2 Current DH guidance on alcohol identification and brief advice recommends that assessors advise individuals who are drinking alcohol above lower risk levels to reduce their alcohol use.

32.3 Brief advice can take as little as five minutes and consists of;

- understanding alcohol units
- understanding risk levels
- knowing level of risk (AUDITC score)
- understanding benefits of cutting down
- tips for cutting down.

32.4 The assessor should refer to the Alcohol pathway Appendix 6.2.

32.5 Those with an AUDIT C score of 5 or more should be given brief advice and should be supported by an information booklet ordered from HILS.

32.6 Those with an AUDIT score of 20 or more should be considered for referral to Norfolk Recovery Partnership (NRP) 0300 7900 227 www.norfolkrecoverypartnership.org.uk

33 REFERRAL TO GENERAL PRACTICE FOR ADDITIONAL TESTING AND CLINICAL FOLLOW UP

33.1 The NHS Health Check programme is primarily aimed at preventing disease but it will also identify individuals at high risk of developing or having disease who will require additional clinical testing and follow-up.

33.2 All abnormal parameters must have been reported to the patient's general practitioner so that a diagnosis can either be made or ruled out.

33.3 Timely access to further diagnostic tests should take place following these thresholds

33.4 Patients with CVD risk score ≥ 20% (see Appendix 4.8) should be referred to their GP and should exit the NHS Health Check programme.

Table 6 Referral thresholds

Reason for appointment	Threshold	Action	Time
High CVD risk	≥ 20%	See practice nurse or GP	Approximately 2 weeks
Weight management	BMI > 35	See practice nurse or GP for intensive lifestyle management	Approximately 2 weeks
Blood pressure	140 to 159 systolic 90 to 110 diastolic	See practice nurse or GP	Approximately 2 weeks
	160 to 179 systolic > 110 diastolic	See practice nurse or GP	Approximately 1 weeks
	> 179 systolic	Urgent referral to GP	Immediate
FPG	≥ 7mmol/l	Repeat FPG, intensive lifestyle advise or refer to GP	Approximately 1 weeks
HbA1c	≥ 6.5%/48mmol/mol	Repeat HbA1c, intensive lifestyle advise or refer to GP	Approximately 1 weeks
Total cholesterol	> 7.5 mmol/l	See practice nurse or GP	Approximately 2 weeks

STANDARD OPERATING PROCEDURES

NHS HEALTH CHECKS FOR COMMUNITY PROVIDERS

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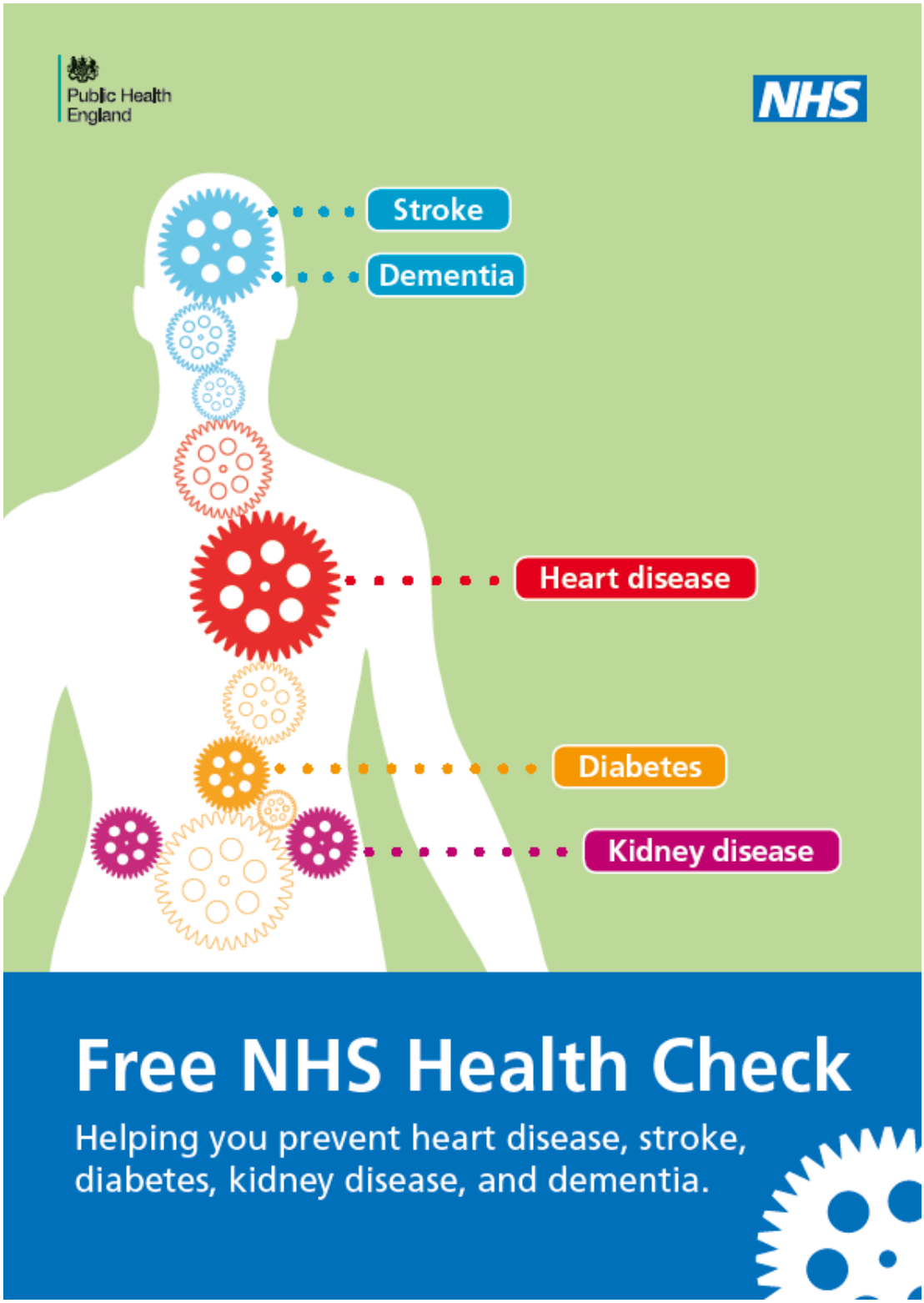
APPENDIX 1 WORKFORCE COMPETENCIES

SOP Appendix 1
Workforce Competen

APPENDIX 2 CORRECT WASTE DISPOSAL

SOP Appendix 2
Correct Waste Dispos

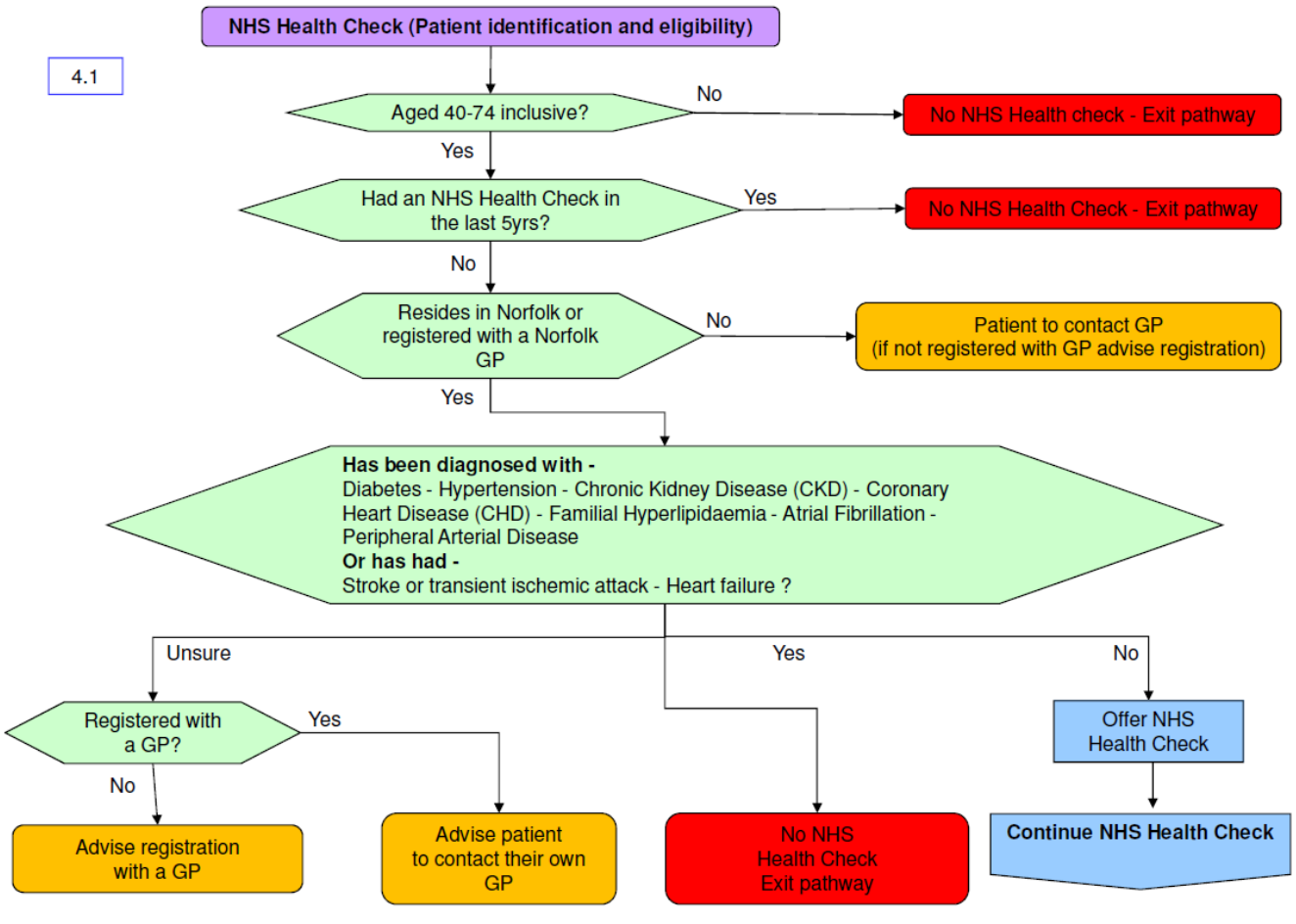
APPENDIX 3 DEPARTMENT OF HEALTH BOOKLET



SOP Appendix 3 HC Booklet.pdf

APPENDIX 4 HEALTH CHECK PATHWAYS

Eligibility 4.1



Health Check Pathways - Eligibility 4

Lifestyle Behaviors - Smoking Status and Physical Activity 4.2

4.2

NHS Health Check (Lifestyle Assessment)
GPPAQ & Smoking status

GPPAQ?

Physical exercise and/or cycling (hr/wk)	Occupation: Sedentary	Standing	Physical	Heavy manual
0	Inactive	Moderately Inactive	Moderately Active	Active
Some but <1	Moderately Inactive	Moderately Active	Active	Active
1-2.9	Moderately Active	Active	Active	Active
>3	Active	Active	Active	Active

Inactive | Moderately Inactive | Moderately Active | Active

Smoking Status?

Status	Per day
Non-Smoker	0
Ex Smoker	0
Light Smoker	<10
Moderate Smoker	10<20
Heavy Smoker	>20

Non smoker | Ex smoker | Light smoker | Moderate smoker | Heavy smoker

Physical Activity Communication tool

Brief intervention for smokers

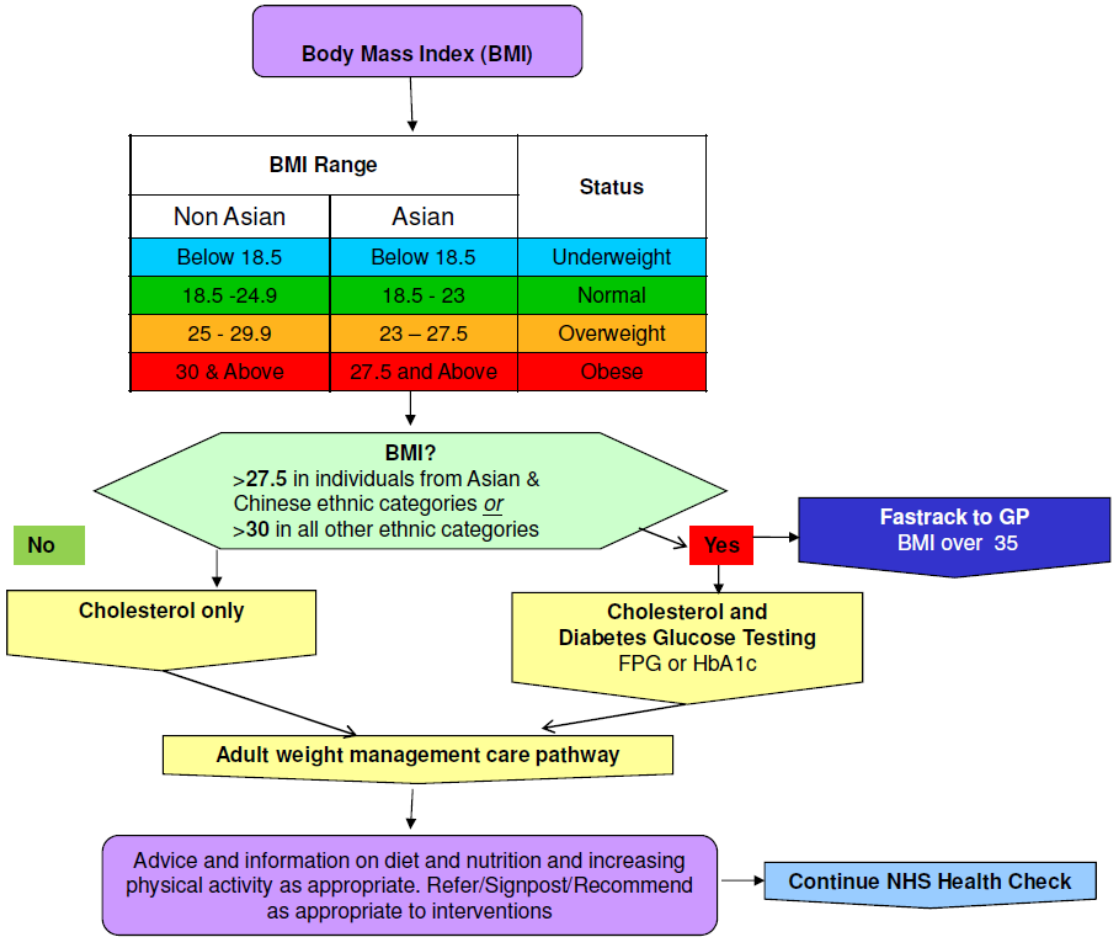
Advice on diet/nutrition, increasing physical activity and smoking as appropriate. Refer/Signpost/Recommend as appropriate to interventions

Continue NHS Health Check

Health Check Pathways - Lifestyle I

Body Mass Index (BMI) 4.3

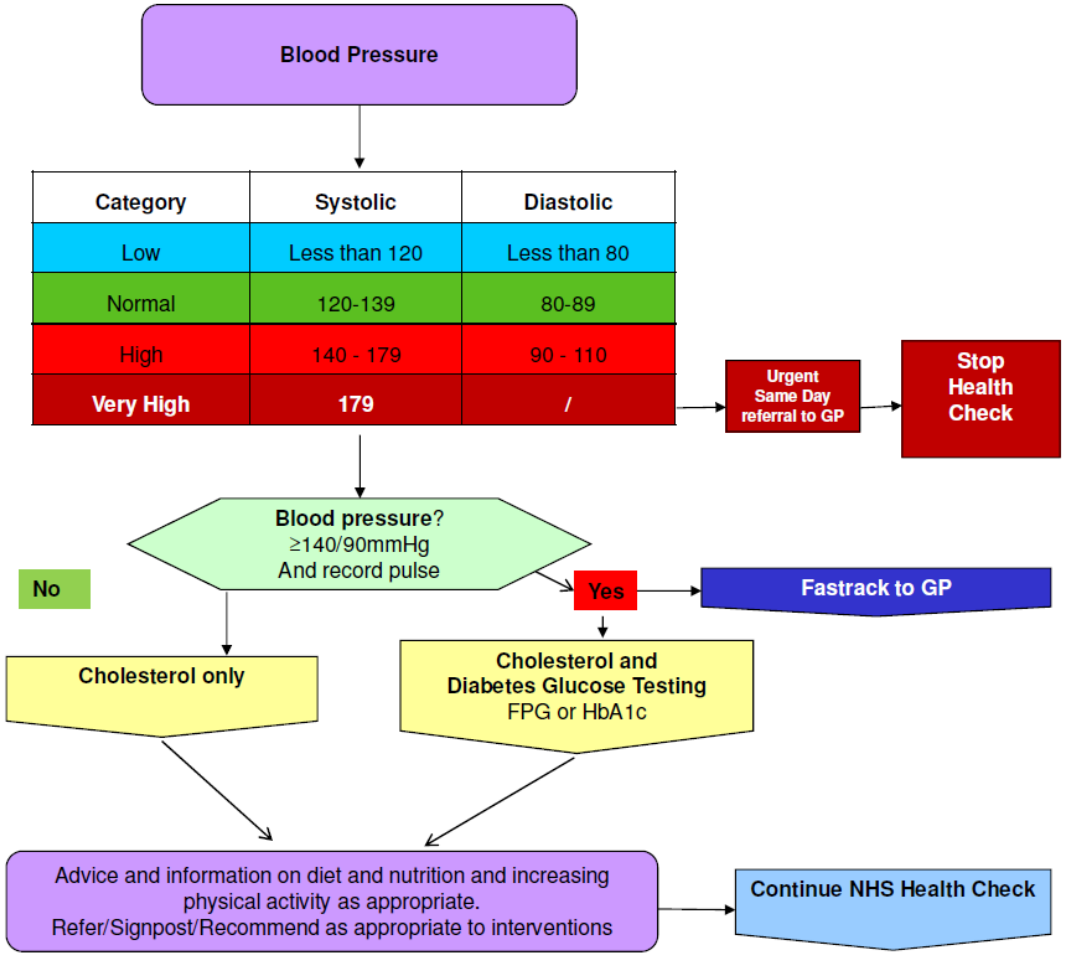
4.3



Health Check Pathways - Body Mas

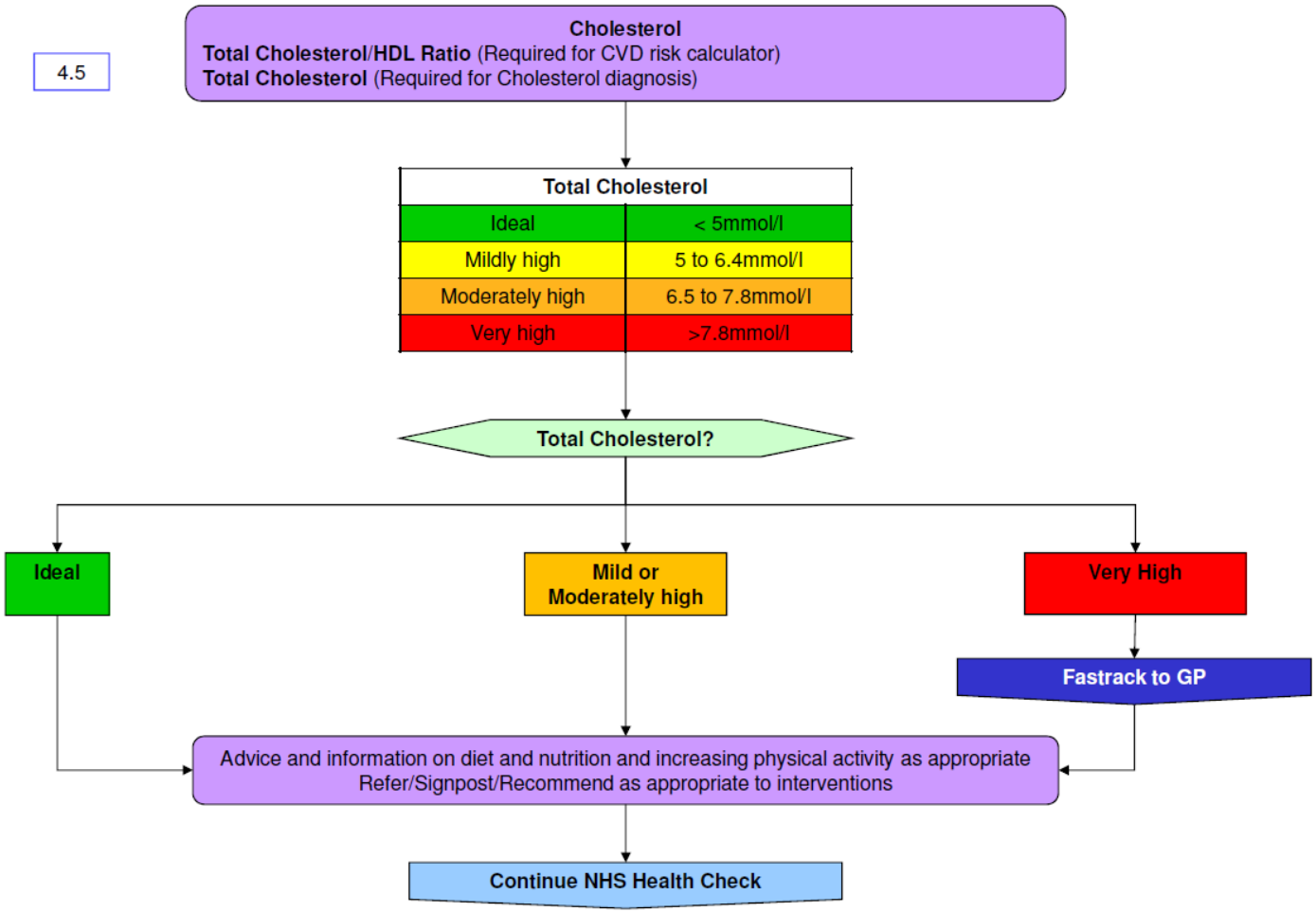
Blood Pressure 4.4

4.4



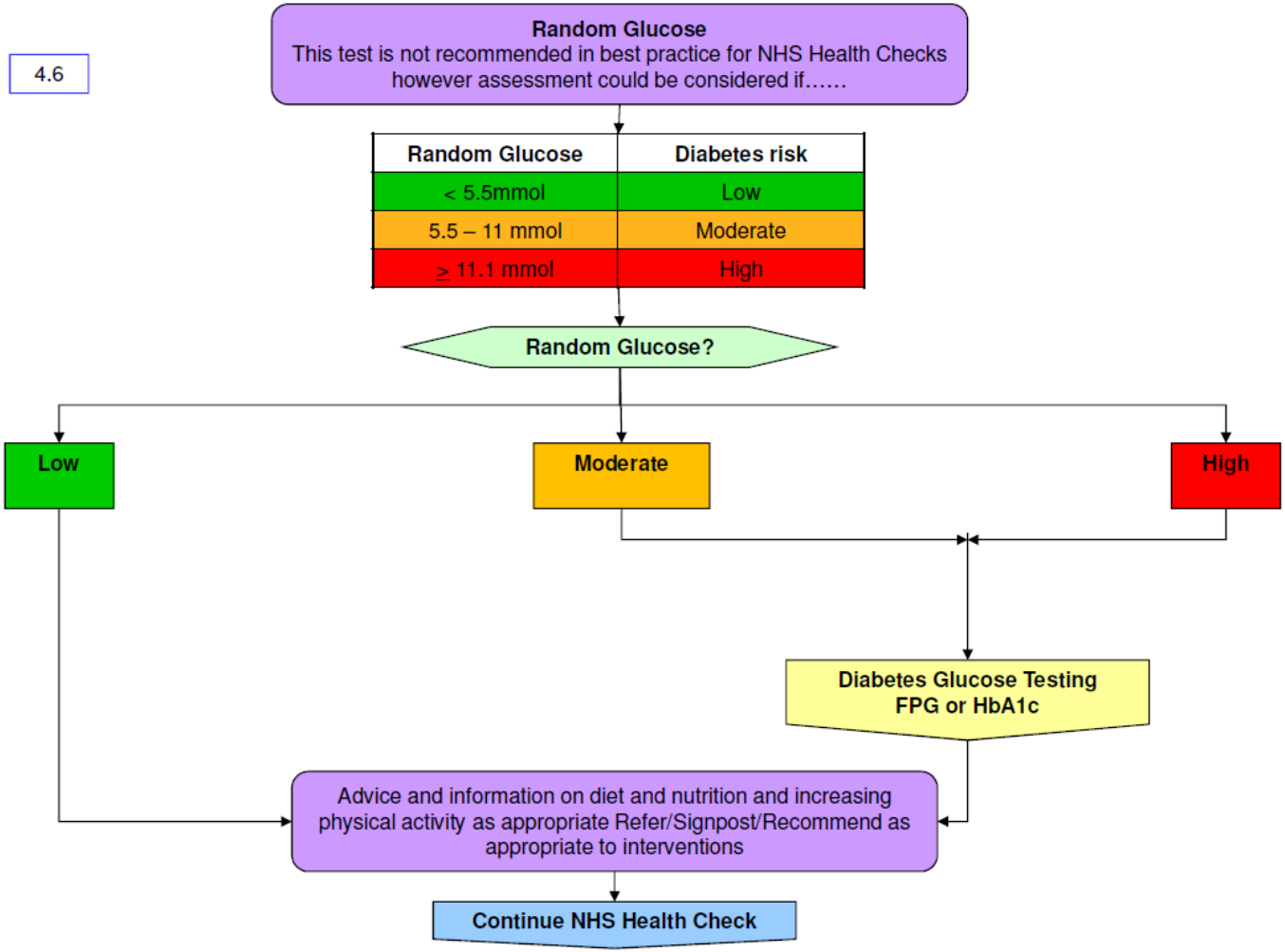
Health Check Pathways - Blood Pre

Cholesterol 4.5



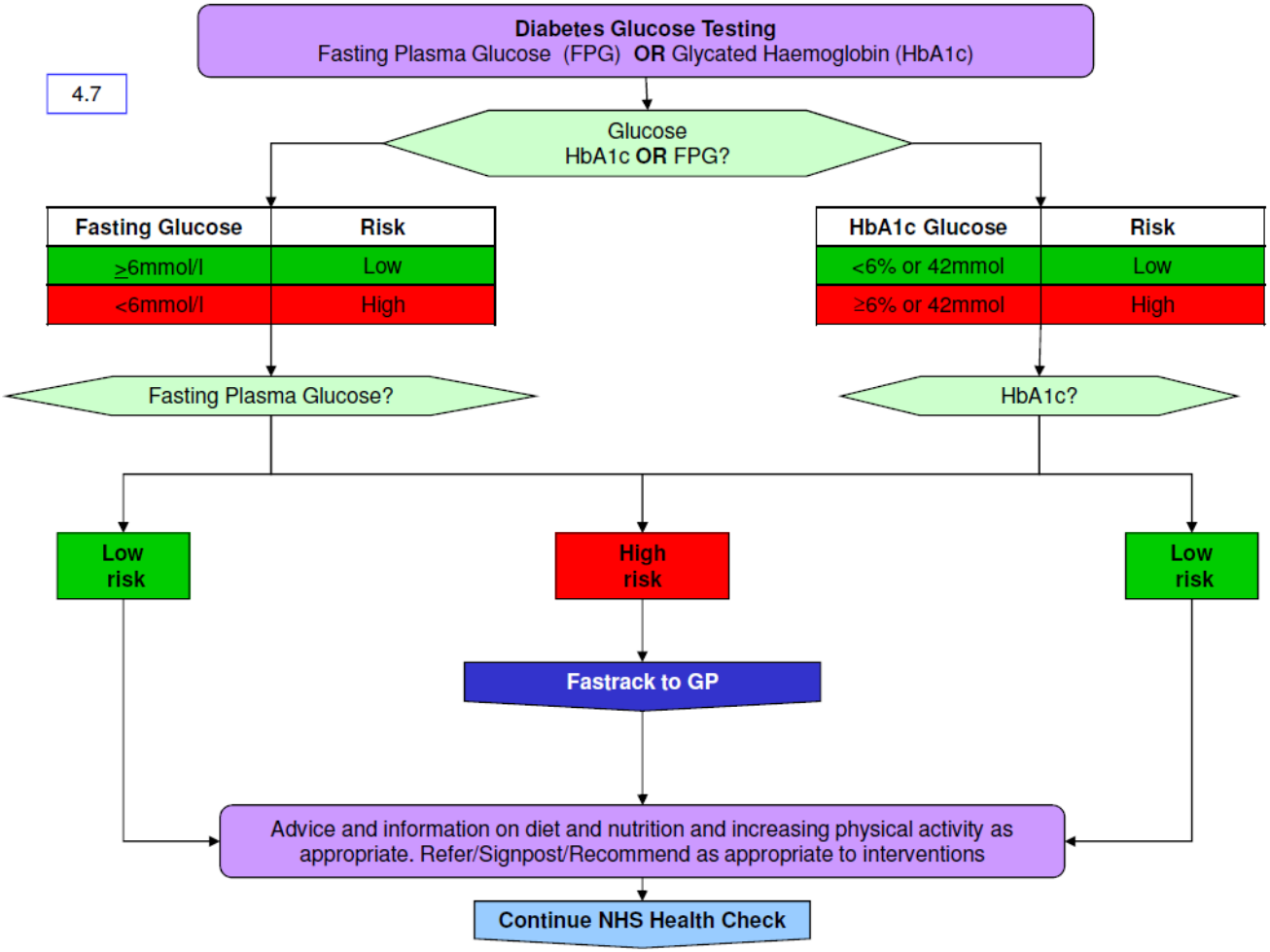
Health Check Pathways - Cholester

Random Glucose 4.6



Health Check Pathways - Random (

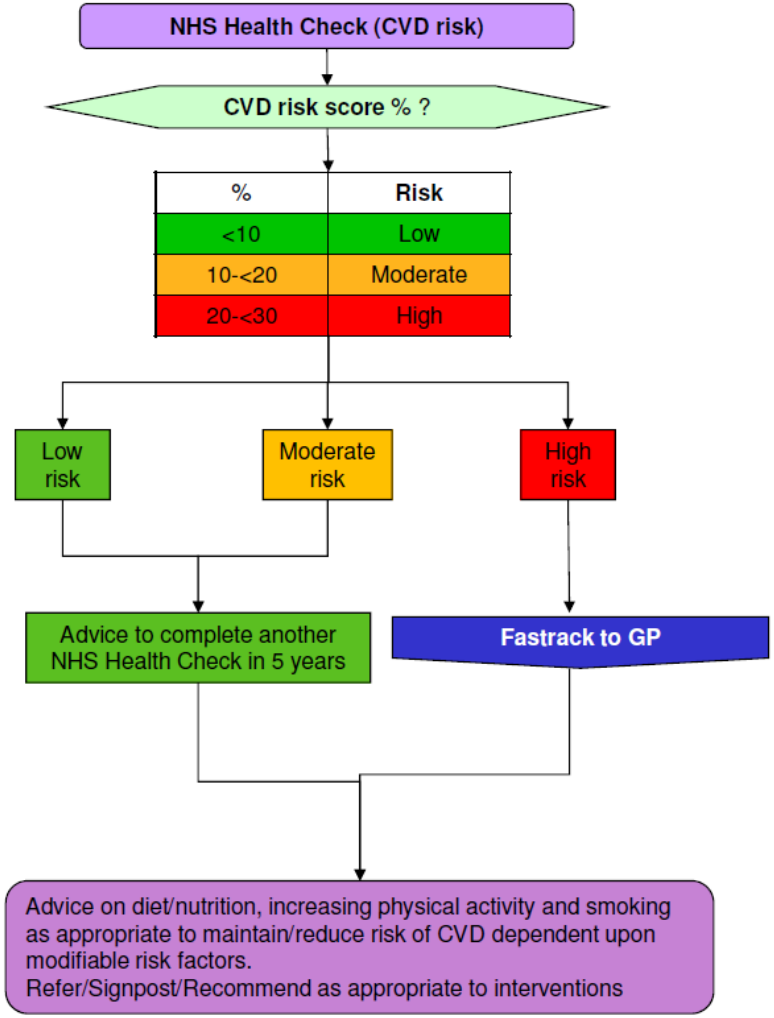
Diabetes Glucose Testing 4.7



Health Check Pathways - Diabetes

CVD Risk Score 4.8

4.8



Health Check Pathways - CVD Risk

APPENDIX 5 GPPAQ

Patients can be classified into four categories based on the original EPIC index from which the GPPAQ was developed.

Inactive	Sedentary job and no physical exercise or cycling
Moderately inactive	Sedentary job and some but < 1 hour physical exercise and / or cycling per week OR Standing job and no physical exercise or cycling
Moderately active	Sedentary job and 1-2.9 hours physical exercise and / or cycling per week OR Standing job and some but < 1 hour physical exercise and / or cycling per week OR Physical job and no physical exercise or cycling
Active	Sedentary job and ≥ 3 hours physical exercise and / or cycling per week OR Standing job and 1-2.9 hours physical exercise and / or cycling per week OR Physical job and some but < 1 hour physical exercise and / or cycling per week OR Heavy manual job

Note: Questions concerning Walking, Housework/Childcare and Gardening/DIY have been included to allow patients to record their physical activity in these categories, however these questions have not been shown to yield data of a sufficient reliability to contribute to an understanding of overall physical activity levels. As noted above further questioning is required.

B. SUMMARY OF THE PAI

	Occupation			
Physical exercise and / or cycling (hr/wk)	Sedentary	Standing	Physical	Heavy Manual
0	Inactive	Moderately Inactive	Moderately Active	Active
Some but < 1	Moderately Inactive	Moderately Active	Active	Active
1-2.9	Moderately Active	Active	Active	Active
≥ 3	Active	Active	Active	Active

C. COMBINING RESPONSES FOR PHYSICAL EXERCISE AND CYCLING

Cycling / Physical Exercise	**0**	**Some but < 1**	**1-2.9**	**≥3**
0	0	Some but < 1	1-2.9	≥3
Some but < 1	Some but < 1	Some but < 1	≥3	≥3
1-2.9	1-2.9	≥3	≥3	≥3
≥3	≥3	≥3	≥3	≥3

D. GPPAQ READ CODES

4 Byte	Version 2	CTV3	
138X. | GPPAQ physcl act ind: inactive	138X. | General practice physical activity questionnaire physical activity index: inactive	XaPP8 | General practice physical activity questionnaire physical activity index: inactive	366121000000108 | General practice physical activity questionnaire physical activity index: inactive (finding)
138Y. | GPPAQ phys act ind: mod inactv	138Y. | General practice physical activity questionnaire physical activity index: moderately inactive	XaPPB | General practice physical activity questionnaire physical activity index: moderately inactive	366171000000107 | General practice physical activity questionnaire physical activity index: moderately inactive (finding)
138a. | GPPAQ phys act ind: mod active	138a. | General practice physical activity questionnaire physical activity index: moderately active	XaPPD | General practice physical activity questionnaire physical activity index: moderately active	366211000000105 | General practice physical activity questionnaire physical activity index: moderately active (finding)
138b. | GPPAQ physical act ind: active	138b. | General practice physical activity questionnaire physical activity index: active	XaPPE | General practice physical activity questionnaire physical activity index: active	366241000000106 | General practice physical activity questionnaire physical activity index: active (finding)

APPENDIX 6 ALCOHOL

6.1 Audit C

AUDIT – C

Questions	Scoring system					Your score
	0	1	2	3	4	
How often do you have a drink containing alcohol?	Never	Monthly or less	2 - 4 times per month	2 - 3 times per week	4+ times per week	
How many units of alcohol do you drink on a typical day when you are drinking?	1 -2	3 - 4	5 - 6	7 - 9	10+	
How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	

Scoring:
A total of 5+ indicates increasing or higher risk drinking.
An overall total score of 5 or above is AUDIT-C positive.

SOP Appendix 6.1 AUDIT-C.doc

6.2 Alcohol Referral Pathway

SCORING: ADD the 2 scores together to identify necessary action (e.g. Brief Advice)

AUDIT C _____ + AUDIT _____ = ☐

"Based on your answers, your drinking places you in the … risk category."
(for 8+ scores lead to Brief Advice with) "How do you feel about that?"

AUDIT SCORE	RISK CATEGORY		DESIRED ACTION
0 –7	Lower risk	=	No intervention required
8 –15	Increasing risk	=	Brief Advice
16-19	Higher risk	=	Brief Advice and/or extended BA
20+	Possible dependence	=	Referral to services (see below)

Brief Intervention (IBA) pathway

AUDIT-C
(3 questions)

→ Where individual scores below 5, no further action required

Where individual scores 5+, ask remaining 7 AUDIT questions for total score

AUDIT Score 0-7	AUDIT Score 8 -15	AUDIT Score 16-19	AUDIT Score 20+
Congratulate and reinforce benefits of lower risk drinking.	Deliver 'Brief Advice' e.g using 2-sided *Brief Advice Tool.* *Give a leaflet (awaiting for DAT to advise)*	Deliver 5 mins 'Brief Advice' using 2-sided Brief Advice Tool. And Give a leaflet. Then offer 20-30 min follow-up session of Extended Brief Advice *from Health Trainer Service)*	With patient consent, refer to: **Patients living in Norfolk** Norfolk Recovery Partnership (NRP) 0300 7900 227 www.norfolkrecoverypartnership.org.uk

Lower risk
This level of drinking means that in most circumstances you have a low risk of causing yourself future harm

Increasing risk
Drinking at a level that increases the risk of damaging your health and could lead to serious medical conditions.

Higher risk
This level of drinking has the greatest risk of health problems.

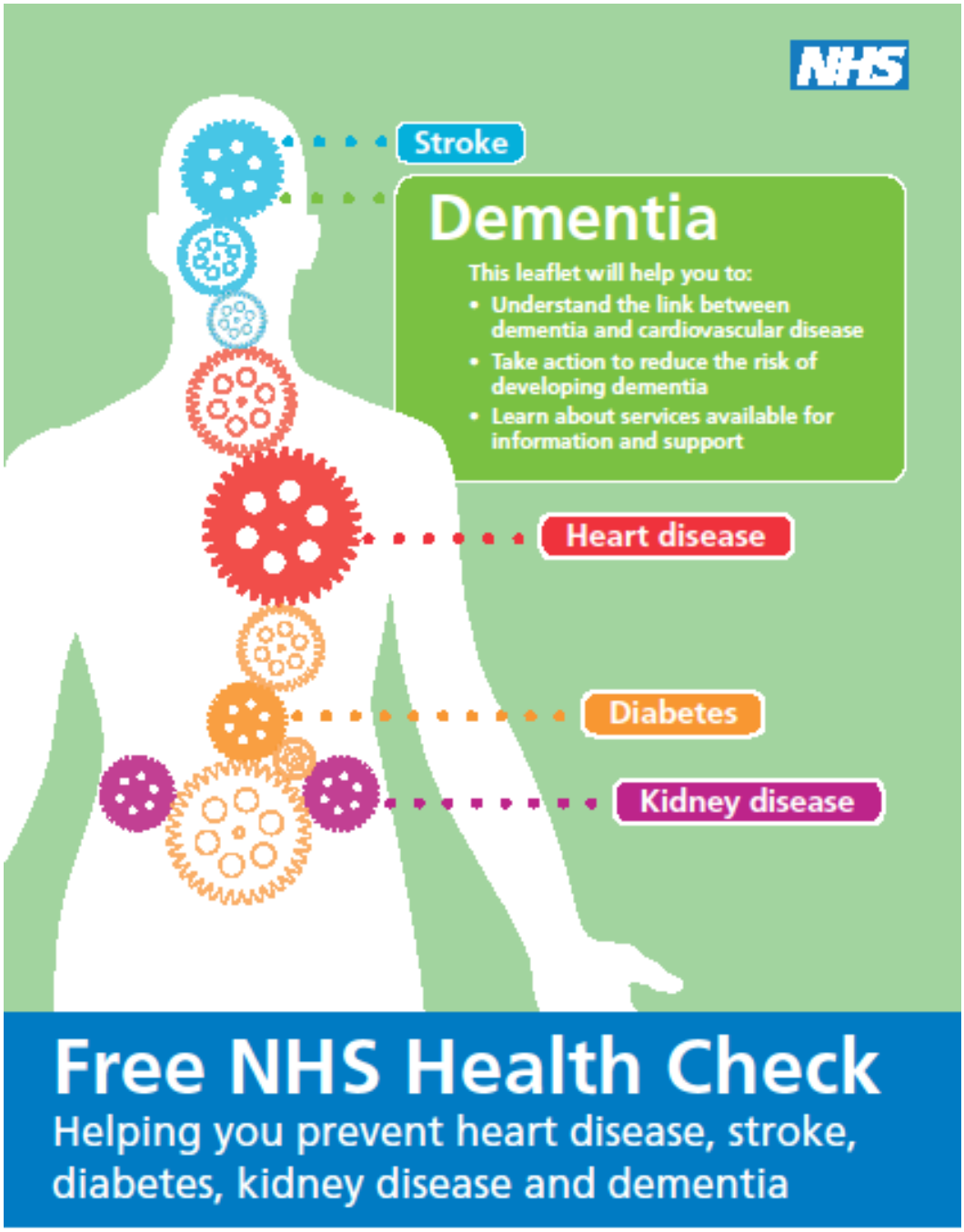
Where individual does not respond to Brief Advice or wants to discuss further, an 'Extended Brief intervention' (i.e. 20-30 mins motivational interviewing), should be offered.

Drug and Alcohol practitioners or those trained in Motivational Interviewing can deliver a number of 'extended brief interventions'.

For Brief Intervention/IBA tools and e-learning visit www.alcohollearningcentre.org.uk and see 'topics'> 'IBA'

SOP Appendix 6.2
Alcohol pathway.doc

APPENDIX 7 NHS HEALTH CHECK LEAFLET – DEMENTIA



NHS

Public Health England

Alzheimer's Society

SOP Appendix 7 Dementia HC leaflet.

APPENDIX 8 RESULTS CARD

You had your Free NHS Health Check

on

Your next NHS Health Check is due in 5 years

Your results

Cardiovascular disease	risk score	
Blood Pressure	Your result	
Body Mass Index (BMI)	Your result	
Your weight today		
Cholesterol (total)	Your result	
Physical activity level	Your result	

Your risk of developing Cardiovascular disease in the next 10 years is: low medium high

To reduce your Cardiovascular risk you have been advised to:

- make an appointment with your GP
- contact the health trainer service
- increase your physical activity
- eat a healthier, more balanced diet
- stop smoking
- reduce your alcohol intake

If any of your results are amber or red your health care provider will advise you on how to improve your health and signpost you to healthy lifestyle services. If your results are high (red) you may be referred to your GP for further investigation.

norfolk's living well

To find healthy lifestyle services to support you to make changes to improve your health visit **www.norfolkslivingwell.org.uk** or call **0344 800 8029**

Norfolk County Council

SOP Appendix 8 HC Result Card.pdf