Clinical Governance

It is the individual Primary Care Team’s responsibility to maintain this toolkit and ensure the latest version is adhered to.
This guidance on delivery of NHS Health Checks has been produced for providers commissioned by Public Health at North Somerset Council, to support them in delivering checks. It reflects best practice and North Somerset policies and procedures as of the time of writing. We expect to amend and update this pack as practice informs process.

A production of this nature comes from the hard work of many people. We wish to offer our sincere thanks to everyone who has contributed to this toolkit. In particular we would like to thank the following:

Jan Bond
Chris Burton
Karin Dixon
Caroline Laing
Liz Lansley
Rebecca Stathers
Fiona Miles

Thanks to Jackie Davidson at NHS Greenwich for sharing the NHS Greenwich Toolkit which acted as an inspiration to our own.

To submit comments or amendments to this version or receive an electronic copy of this please contact:

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Section 1: Introduction

1.1 Introduction

The NHS Health Check programme aims to prevent heart disease, stroke, diabetes and kidney disease, and raise awareness of dementia both across the population and within high risk and vulnerable groups. In April 2013 the NHS Health Check became a mandated public health service in England. Local authorities are responsible for making provision to offer an NHS Health Check to eligible individuals aged 40-74 years once every five years as set out in regulations 4 and 5 of the Local Authorities (Public Health Functions and Entry to Premises by Local Healthwatch Representatives) Regulations 2013, S.I. 2013/351. Early detection of vascular conditions and identification of risk, with a motivational approach to the check should result in risk reduction in individuals and improved population health. The NHS Health Check is not appropriate for populations who already have cardiovascular or other related diseases, for example, coronary heart disease (CHD), chronic kidney disease (CKD) stages 3 and 4, stroke and diabetes mellitus (DM). These patients are already known to be high risk and assumed to be managed as part of being on a disease register and are not eligible for an NHS Health Check.

1.2 Programme Rationale

Vascular disease includes coronary heart disease, stroke, diabetes and kidney disease and vascular dementia. It currently affects the lives of over 4 million people in England. It causes 36% of deaths (170,000 a year in England) and is responsible for a fifth of all hospital admissions. It is the largest single cause of long-term ill health and disability, impairing the quality of life for many people. The burden of these conditions falls disproportionately on people living in deprived circumstances and on particular ethnic groups, such as South Asians. Vascular disease accounts for the largest part of the health inequalities in our society.

The North Somerset Director of Public Health Report 2014 demonstrated that between 2009 and 2011, 49% of male deaths and 42% of female deaths in the most deprived areas were ‘excess’. In other words these deaths would not have occurred if all areas in North Somerset had the same mortality profile as the least deprived area. GP Profile data from Public Health England (2011 data) show that in more deprived areas there are greater levels than would normally be expected of undiagnosed coronary heart disease, people presenting late to their GP or hospital and higher mortality rates from Coronary Heart Disease. There is also a substantial percentage of patients who have not had hypertension diagnosed and many who have not had blood pressure recorded. The NHS Health Check will be a key approach in addressing this (see Graph below based on 2011 data).

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1 Putting Prevention First, Vascular Checks: risk assessment and management, Department of Health, 2008
3 fingertips.phe.org.uk/profile/general-practice
The greatest inequality in male life expectancy in the South West is in North Somerset. Men living in the most deprived areas of North Somerset die almost 10 years earlier than their neighbours in the least deprived areas.

Most vascular disease is considered to be preventable and there already exists a wealth of evidence around the effectiveness of the questions and measurements that the tests include. One of the largest studies is the INTERHEART study that identified nine key modifiable risk factors\(^4\). The design of NHS Health Checks nationally is based on advice from numerous experts inputting to the Vascular Programme Board who oversaw its development. The original Department of Health (DH) modelling showed the average annual cost of the programme as £332m each year at full roll out\(^5\) and the benefit as £3.678bn with a cost per quality adjusted life year (QALY) of around £3000. This modelling also suggests that it is cost effective with potential savings to the NHS of around £57m per year after four years, rising to £176m per year after 15 years. The modelling shows that the NHS Health Check could, on average, prevent 1,600 heart attacks and strokes and save at least 650 lives each year as well as prevent over 4,000 people a year from developing diabetes and detect at least 20,000 cases of diabetes or kidney disease earlier, allowing individuals to be better managed and improve their quality of life. It is estimated that 670,000 people are living with dementia in England. Up to half have Alzheimers disease and that up to a third of people have vascular dementia. In many cases these conditions


\(^5\) Defined as 75% of the total five year eligible population receiving an NHS Health Check once every five years
coexist and are likely to be subject to a delay in symptoms if the common risk factors are managed. It is estimated that 850,000 people in England are unaware that they have type 2 diabetes; half of people diagnosed have serious complications. Local modelling has estimated that 335 CVD events may be saved in North Somerset over 5 years, with a further 293 saved from improvements in secondary prevention for those already on disease registers.

The latest guidance published in Feb 2015 outlines Best Practice identifies where there is scope for local flexibility and innovation in delivery.

1.3 Purpose and Scope of the Toolkit

The North Somerset NHS Health Check Toolkit has been produced to support providers commissioned by Public Health at North Somerset Council to deliver the NHS Health Checks consistently in line with current best practice. It is aimed at those undertaking the health checks, those administering or leading the process and those needing to respond to newly identified clinical need. It reflects the best practice guidance that exists at this current time and will need updating on a regular basis as new evidence becomes available.

1.4 Objectives of the Toolkit

To provide best practice guidance to those delivering the NHS Health Checks to ensure consistency, quality assurance and safety across North Somerset by:

- Outlining how the check should be undertaken
- Describing how parameters and data should be measured
- Identifying thresholds which would trigger appropriate follow-up and interventions
- Outlining lifestyle brief interventions that can be undertaken at practice level and care pathways and referral mechanisms to other lifestyle support services
- Identifying best practice guidance in the management of clinical risk factors
- Providing a range of practical tools and information, such as sample invite letters
- Giving guidance to assist in achievement of the National NHS Health Check Competencies

1.5 Summary of the NHS Health Check Programme

All patients aged 40-74 years old will be entitled to a NHS Health Check every five years to assess and manage their vascular risk. The call and recall of patients will exclude those already with existing disease.

Figure 1 provides an overview of the National NHS Health Check Programme.

Figure 2 provides a detailed overview of the North Somerset NHS Health Check Programme

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6 Available from Helen.Yeo@nsomerset-pct.nhs.uk
7 http://www.healthcheck.nhs.uk/commissioners_and_healthcare_professionals/national_guidance/
Figure 1: Diagrammatic overview of the NHS Health Check programme
1. Arranging NHS Health Checks Programme (section 2)

**Identify**
Lead Pharmacist to oversee the programme
Pharmacy NHS Health Check Champion – to coordinate, manage and carry out NHS Health Checks and order resources and publicity

**Equipment**
Ensure correct equipment in place and private room available with
1. Computer with NHS template on PharmOutcomes
2. Cardiochek unit (from Public Health)
3. Test strips for Cholesterol (and HbA1C if used)
4. Blood pressure monitor (validated)
5. Height measure
6. Floor scales
7. Patient Results leaflet (from Public Health)
8. Patient information leaflets and models (from Public Health)

**Training**
Lead pharmacist and all delivering NHS HCs to attend:
1. Public Health NHS Health Check Training
2. Clinical Skills training (as required to meet competencies)
3. Motivational interviewing training (as required to meet competencies)

2. Booking appointments for NHS Health Checks (section 3)

**Identify**
Practices will identify all eligible patients from 40 -75 every 5 years (not eligible if they have coronary heart disease, chronic kidney disease stages 3-4, diabetes, hypertension or atrial fibrillation or have had a stroke or TIA)

Pharmacies will identify customers who they believe are not registered at a GP practice or do not regularly attend a GP Practice and give information about the NHS Health check to determine interest and eligibility

**Invitations**
Practices will send out invitations to eligible people every 5 years and include the “What to expect from a health check” leaflet. They should also include the names of local Pharmacies delivering NHS Health Checks and explain a patient could choose to have a health check there.

Practices will remind patients about the Health Check if they do not attend the GP practice or pharmacy.

**Arrange**
1. Pharmacies will receive enquiries at the counter and make appointments for an NHS Health Check or carry it out immediately if practical once eligibility has been determined.
2. Pharmacies may advertise with posters (available from Public Health) and/or approach customers, as appropriate, to determine interest and eligibility.
3 The Risk Assessment (section 4)

Prepare Patient
1. Explain what is involved in the assessment
2. Obtain patient consent and that patients knows their GP practice – which must be in North Somerset
3. Ensure open questioning, reflective listening and summarising throughout the NHS Health Check Process

Risk Assessment
1. Utilising cardiochek unit, measure and determine – total cholesterol, HDL and ratio
2. Take blood pressure and pulse
3. Measure height and weight and waist measurement and BMI
Enter patient details family history of vascular disease and results into PharmOutcomes and use the template to:
1. Determine alcohol consumption (Audit C)
2. GPPAQ to determine activity level
3. Record smoking status
4. Pulse
5. Raise awareness of dementia (if aged 65-74)
6. DETERMINE RISK OF HEART ATTACK or STROKE IN NEXT 10 YEARS using QRISK

FILL IN AND GIVE OUT “YOUR RESULTS” LEAFLET
1. Explain risk score (in a group of 100 people just like you ....)
2. If referral to GP practice for further checks is necessary – ensure this is entered on template AND tell patient to make an appointment (or support them to do so)
3. Go through results leaflet, providing lifestyle advice and referring, as appropriate, for further life style change support

CVD Risk = or >10%
Refer for lipid assessment and possible statin commencement

CVD Risk = or >20%
Refer to GP
- Hypertension assessment
- Cholesterol assessment
- HbA1c or fasting glucose
- CKD assessment

Complete Health Check template on PharmOutcomes
Ensure this sends e mail to patient’s GP

Follow up
At 1 month contact all who required a GP referral appointment to ensure they have attended their GP.

CVD Risk = or >10%
Refer for lipid assessment and possible statin commencement

See Section 5 Health Behaviour Change

High BMI
- Over 27.5 (Asian and Chinese ethnicity)
- Over 30 (other ethnic groups)
Refer to GP for Hba1c or fasting glucose test

High BP
- 140/90 mmHg or above OR
- SBP 140 mmHg or above OR
- DBP 90 mmHg or above (average 3 readings)
Refer to GP for Hypertension assessment, CKD assessment and HbA1c or fasting glucose

See Section 4.1/4.2 Thresholds for referral
Section 2: Arranging NHS Health Check Clinics

2.1 Team Roles

Lead Clinician: There should be a nominated lead clinician who is responsible for overseeing the service. The clinician should be either a nurse, GP, pharmacist or other appropriate person. The lead clinician will be responsible for ensuring that all staff delivering this service have attended the appropriate training and acquired the necessary experience and competencies. Details of these competencies is contained in section 6.1. The lead clinician will also act as a point of contact for North Somerset Public Health for the NHS Health Check service. The lead clinician will ensure that equipment to undertake the check has been maintained and calibrated.

Practitioners undertaking NHS Health Checks: There is no set guidance on who should undertake health checks, however, it is anticipated that they will be provided by Health Care Assistants, Nurses, Pharmacists and others. Staff providing the NHS Health Check will need to attend the mandatory NHS Health Check training and other modules supporting the delivery of the programme e.g. annual updates. In addition, they should have all the necessary equipment suitably maintained and calibrated.

Administrator: The administrator will be responsible for general administrative support. This may be setting up access to the clinical system and issuing invitations, publicising the service and follow-up of any patients requiring ongoing care or who DNA. The administrator may also be responsible for reporting any minimum data set requirements to Public Health North Somerset.

NHS Health Check Champion: The practitioner and administrator could be the same person. Best practice elsewhere has illustrated that giving one person the responsibility for the publicity and call and recall and the checks and referrals leads to a more efficient and cost effective service.

Please see 6.1 for a copy of workforce competencies for practitioners delivering NHS Health Check. The framework will enable the lead clinician to assess competency and readiness to conduct NHS Health Checks.
2.2 Equipment
The following is a sample guide to the range of equipment required to deliver the NHS Health Check Programme.

<table>
<thead>
<tr>
<th>Measure</th>
<th>Equipment</th>
<th>Measuring range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Height</td>
<td>SECA Leicester Portable Height Measure (or similar)</td>
<td>0 – 2.07 meters</td>
</tr>
<tr>
<td>Total Cholesterol</td>
<td>Cardiochek PA units will be purchased by Public Health North Somerset for all practices. Training on their use will be provided. Guidelines can be found at: <a href="http://www.ptsdiagnostics.com/cardiochek-pa.html">http://www.ptsdiagnostics.com/cardiochek-pa.html</a></td>
<td>2.59 – 12.93 mmol/L (TC) 0.39 – 2.59 mmol/L (HDL)</td>
</tr>
<tr>
<td>HDL Cholesterol</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blood Pressure</td>
<td>Either automated unit or with sphygmomanometer</td>
<td>BP 0 – 299 mm Hg  Pulse 40 – 180 /min</td>
</tr>
<tr>
<td>Weight</td>
<td>SECA 884 Class III Floor scales with RS232 interface capability (or similar)</td>
<td>Capacity 160 Kg x 200g</td>
</tr>
</tbody>
</table>

- All equipment should be calibrated in accordance with manufacturer’s instructions.
- Practices will need to comply with quality assurance measures required for the safe and effective use of equipment.
- All operators of the equipment should be fully compliant in their use and prepare the equipment in accordance to manufacturer’s instructions.
- A sharps container should be available for disposing of all sharps.
- Clinical waste will be disposed of via local general practices or via local pharmacies.

2.3 Near Patient Testing
Pharmacies that have signed up to the 2013/15 NHS Health Check service specification will be provided with a Near Patient Testing (NPT) machine (Cardiochek PA) for cholesterol testing. This will enable all pharmacies to deliver the initial risk assessment part of the check in a single visit with minimal impact on phlebotomy and pathology services. If pharmacies purchase additional test strips the machine will also allow testing of HbA1c to give a clearer initial indication of risk of diabetes. This is not required as part of the NHS Health Check and is purely at the discretion of the pharmacy.

2.4 Patient Information and Leaflets
Pharmacies should ensure that all available leaflets are stocked within the practice. This will include the national patient information leaflet (to be enclosed in the invite letter or handed to customers); the leaflet ‘NHS Health Check – Dementia Information Leaflet’ and the booklet ‘Your Results’ and any subsequent information that may support brief interventions e.g. healthy eating leaflets.

The NHS Health Check patient information leaflet and the ‘Your Results’ leaflet (in English) will be supplied to the practices by the PH Directorate. They are also available in a range of formats e.g. Braille, large print and audio, and translations e.g. Chinese, Czech, French, Somali, Bengali, Urdu, Guajarati, Punjabi, Hindi etc. Electronic versions and other resources...
which can be ordered directly from the Department of Health can be viewed at the following link. 
http://www.healthcheck.nhs.uk/commissioners_and_healthcare_professionals/branding_and_branding/

### 2.5 NHS Health Check Template

A template on PharmOutcomes will electronically record data gathered as part of the NHS Health Check. This will e-mail the patient identifiable results of the NHS Health Check by secure e-mail to the patient’s GP (providing he knows/is registered with a GP, and that the GP is in North Somerset) to allow the practice to update the patient record and ensure follow up appointments are made.

If the patient is registered with a GP outside North Somerset the NHS Health Check should not be carried out. If the patient is not registered with a GP carry out the check, print off a copy of the record for the patient and support the patient to register with a GP.

**Please contact**:  
Richard Brown MRPharmS  
Chief Officer  
Avon LPC  
07725 887883  
if there are any problems with the template.

### 2.6 Information Governance

Using and sharing confidential personal data is often an important component of efforts to improve population health. The use of such data is strictly controlled in order to protect the interests of clients and the public while ensuring that important functions can continue. Where data is initially held by the GP they are the data controller and is required by law to satisfy themselves that the need to move data is fair and lawful.

There are three main data flows for the NHS Health Check programme, these are:

A. identifying and inviting the eligible population

B. transferring NHS Health Check assessment data from non-GP NHS Health Check providers back to the GP practice

C. data extraction from GP practices for local monitoring, evaluation and quality assurance of NHS Health Check

It is a legal requirement that people working with client identifiable data and personal confidential data work within the Data Protection Act (1998) and Information Governance principles. The penalties for breaching this requirement can be severe, however, the NHS Health Check IG and data flow pack details actions that should be taken and can be found here:  

Those delivering the NHS Health Check must be compliant with the NHS Health Check IG and data flow pack as well as the Data Protection Act 1998.
Section 3: Inviting People to attend: Call, Recall and Improving Uptake

3.1 Protocol for inviting people to attend the programme

1. GP practices are responsible for identifying and inviting eligible patients once every five years.
2. They are also responsible for reminding patients who do not attend.
3. GP Practices will make clear in the invitation letters that a patient could attend the NHS Health Check at a local pharmacy. Participating pharmacies will be named in the letter and patients asked to bring the letter to the pharmacy with them.
4. Pharmacies can also publicise that they offer free NHS Health Checks and encourage opportunistic appointment – ensuring first however, that the customer meets the eligibility criteria:-
   i. Aged between 40 – 75
   ii. Not registered with a GP outside North Somerset
   iii. Has not had an NHS Health Check in the last 5 years
   iv. Does not have existing
      * coronary heart disease,
      * chronic kidney disease stages 3-4,
      * diabetes
      * hypertension
      * atrial fibrillation or
      * had a stroke or TIA
5. Pharmacies should particularly target customers who they are aware do not / are unlikely to attend a GP practice
6. An alternative approach would be to organise and invite eligible customers to an open clinic session, particularly choosing times when patients would be most likely to attend (evening or Saturday morning)
7. On completion of initial health check appointment the patient should be offered the following:
   i. A copy of any clinical findings and QRISK 2 printout
   ii. If over 65 the NHS Health Check dementia information leaflet
   iii. The completed ‘Your Results’ sheet
   iv. A copy of any referral letters, for example, exercise referral forms.
   v. A follow up appointment from their GP practice if required e.g. for hypertension assessment, Diabetes assessment etc.
8. On completion of the initial health check appointment the patient record should be e mailed to the GP Practice (via PharmOutcomes) and the practice should:
   i. Complete NHS Health Check template
   ii. Make a diary date entry for any practice follow up (where applicable)

3.2 Sample Invitation Letter to be sent out by GP Practices (see next page)
Dear (Title, Surname),

**Why it’s worth having your free NHS Health Check**

Even if you’re feeling well, by finding signs early, lots can be done to prevent:
- heart disease
- stroke
- diabetes
- kidney disease
- dementia

We are inviting all our patients aged 40 – 74 to make an appointment. Over 10,000 people in North Somerset have received their check already. It only takes 20-30 minutes and involves a few questions and measurements such as blood pressure and cholesterol.

To book your free NHS Health Check or to ask a question about what the appointment involves, call the GP practice today on «Registered_GP_phone_number»

We look forward to seeing you soon.

Dr.…………….. & Partners


If you cannot attend the practice, you could also get a free NHS Health Check at:
- One of the **Pharmacies** below – just call in and ask.
  - Morrisons (Locking Castle, Weston), Boots (Locking Castle, Weston), Towerhouse Pharmacy (Nailsea), Tesco (Clevedon), Lloyds (Waterloo Street, Weston), Lloyds (Whitecross Road, Weston), Co-operative Pharmacy (Sunnyside Road Clevedon), Rowlands (Clevedon), Locking Pharmacy (Locking), ASDA (Weston)
3.3 Sample Reminder letter

Practice details
Phone number
Date

Dear

Reminder about invitation for NHS Health Check

You may remember that we wrote to you recently to invite you to make an appointment for a health check. I notice from our records that you have not yet booked an appointment.

We would like to encourage you to call as soon as possible and book an appointment for this important check. This will give you peace of mind about your risk of heart disease, having a stroke or developing diabetes and if we do detect anything out of the ordinary we can start to deal with it before it becomes serious. The appointment will only take 20-30 minutes and with our clinic times we can usually find a time that will be convenient for you.

Alternatively – remember that the pharmacies listed overleaf can also provide you with and NHS Health Check if that location, or their opening times are more convenient for you – just call in to see them and arrange your NHS Health Check.

Of course, if you do not wish to have your check done at this time but would like to be invited in the future please let us know.

With kind regards

xxxxxxxxxxxxxxxxxxx

(NAME of health care professional to go here)
### Pharmacies offering a NHS Health Check

<table>
<thead>
<tr>
<th>Pharmacy</th>
<th>Address</th>
<th>Town</th>
<th>Postcode</th>
<th>Telephone Numbers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Morrisons Pharmacy</td>
<td>Summer Lane, Locking Castle</td>
<td>Worle</td>
<td>BS24 7AY</td>
<td>01934 521135</td>
</tr>
<tr>
<td>Boots the Chemist Ltd</td>
<td>Unit 2 Locking Castle</td>
<td>Worle</td>
<td>BS24 7AY</td>
<td>01934 525048</td>
</tr>
<tr>
<td>Tesco Stores Pharmacy</td>
<td>Kenn Road</td>
<td>Clevedon</td>
<td>BS21 6LH</td>
<td>01275 750447</td>
</tr>
<tr>
<td>Locking Village Pharmacy</td>
<td>62 Grenville Ave</td>
<td>Weston Super Mare</td>
<td>BS22 6NR</td>
<td>7771903572</td>
</tr>
<tr>
<td>Tower House Pharmacy</td>
<td>Stockway South</td>
<td>Nailsea</td>
<td>BS48 2XX</td>
<td>01275 855109</td>
</tr>
<tr>
<td>Rowlands Pharmacy</td>
<td>111 Old Street</td>
<td>Clevedon</td>
<td>BS21 6BP</td>
<td>01275 876797</td>
</tr>
<tr>
<td>ASDA Pharmacy</td>
<td>Phillips Road</td>
<td>Weston Super Mare</td>
<td>BS23 3UZ</td>
<td>01934 410710</td>
</tr>
<tr>
<td>Day Lewis Pharmacy</td>
<td>3 Broad Street</td>
<td>Congresbury</td>
<td>BS49 5DS</td>
<td>01934 832062</td>
</tr>
<tr>
<td>Lloyds Pharmacy</td>
<td>23 Waterloo Street</td>
<td>Weston Super Mare</td>
<td>BS23 1LF</td>
<td>01934 628845</td>
</tr>
<tr>
<td>Co-op Pharmacy</td>
<td>2 Sunnyside Road</td>
<td>Clevedon</td>
<td>BS21 7TA</td>
<td>01275 873425</td>
</tr>
</tbody>
</table>
3.4 Sample information to include in invitation letter – together with the NHS Health Check information leaflet

What to expect at your appointment

- Please allow about 30 minutes for your appointment
- Bring along any tablets or medicines you are taking at the moment
- Your blood pressure may be taken up to three times throughout the appointment so we can get an average reading
- Wear clothing with loose sleeves
- You will have a pinprick for a drop of blood which we will test for cholesterol
- We will measure your height and weight
- We will measure your waist
- We will discuss:
  - Your lifestyle - diet, exercise, smoking etc
  - Family history of heart disease and/or diabetes

Some patients will be invited for a follow-up appointment for more blood tests and/or blood pressure checks. You will be told about this within two weeks of your visit.
3.5 Making Every Contact Count: Ideas for Maximising Uptake and Reducing DNAs

(Based upon the Health Inequalities National Support Team model which allows consideration of the factors which will help ensure optimal outcomes for all of the population
http://www.hinstassociates.co.uk/page/useful-resources )

To have the greatest impact in reducing the incidence and impact of cardio vascular disease (CHD, diabetes, stroke and chronic kidney disease) it is important to be systematic in ensuring uptake of health checks is equitable and that certain parts of the population are not excluded. Individuals who self exclude for whatever reason may well be those who will benefit most from the check.

This simple series of questions can be considered to help address factors which prevent uptake. Backed up by some best practice examples of how these factors have been successfully addressed, the table below provides a selection of strategies which may be considered as appropriate within different practices.
These are summarised in the Top 10 Potential Actions at the end of this section.

They should contribute to:
1. More effective and cost effective delivery of health checks
2. Increased early diagnosis of CVD
3. Long term reduction in incidence of CVD
4. Reduction in health inequalities and variation in outcomes within the practice population
Aim to: increase the perceived benefits of a health check while removing the perceived barriers

1. Local service effectiveness
   Questions to consider - Is performance reporting is accurate? Are referrals for further blood tests, prescribing and lifestyle support being recorded and actioned? What education and training do we need within the practice to support this?

Best practice examples
   a) Use PharmOutcomes template and in GP practices the template arranged by the Public Health Directorate which contains defined READ codes and updates patient record (Avon Commissioning Support Unit will supply and train staff)

   b) Develop a protocol which ensures that within 4 months of the health check someone in the practice checks that referrals (to GPs and lifestyle services) have been taken up by patient and registers have been updated as appropriate and chase this if not.

   c) Pharmacies should develop a protocol to ensure all people who had an NHS Health Check at their pharmacy and were referred for further appointments, are followed up after 4 weeks to ensure they have attended a referral consultation.

   d) Motivate and encourage all staff to be involved in promoting and supporting health checks. Training and motivational session can be provided in the practice by Public Health
2. **Cost effectiveness**

**Questions to consider** - Are we getting best value for money? What can we learn from other practices and pharmacies? Do we have benchmarking information to compare our service (costs and outcomes) with other practices and pharmacies?

**Best practice examples**

a) Public Health will provide analysis of progress of practices and pharmacies, to allow comparison of progress and learn from best practice of others

b) Buddy up with a similar practices/pharmacies, share trained staff and support each other to achieve economy of scale

c) Follow best practice examples which will reduce DNA rate

d) A personal communication via a letter of invitation from their own GP, door drops, word of mouth recommendation, direct marketing, outdoor advertising and finally posters are the ‘most to least’ cost effective in this order

3. **Accessibility**

**Questions to consider** - Is the service accessible to people? Can we take the service out into the community or provide it at different times? Are there other access issues?

**Best practice examples**

a) Provide appointments for health checks both within and outside of working hours (Saturday or evenings) and offer the choice to people

b) Provide drop in sessions (mornings/evenings/all day Saturday). These could include other aspects of care (eg immunisations, stop smoking advice, health trainers) to avoid long waits, be provided in a community venue if more convenient for people and involve more than one practice/pharmacy

c) Consider groups of the registered practice population who may find access difficult (language, transport, learning disability etc) and find strategies to specifically target these groups

4. **Engaging the public**

**Questions to consider** – Do we deliver health checks based on the needs of the providers or do we adapt to meet needs and wants of the people? Are service user inputs collected and acted on and do they include inputs from those who do not engage well with the practice?

**Best practice examples**

a) Make it routine to collect the views of people who attend health checks, those who refuse and those who DNA. Use all staff to collect views from all people in the appropriate age group as part of their routine appointments or visits to pharmacy.
Adapt the service accordingly. (Public Health can provide sample questions and questionnaires)

b) Public Health will support, using a recent MOSAIC analysis, to analyse information collected about non responders and those who DNA and suggest and provide mechanisms and materials to engage these people, and those like them, in future health checks

5. Population Health Needs

Questions to consider – What does our JSNA and other needs assessments tell us in detail about need? What do we expect the need to be here based on national and local trends and our own demography taxonomy groupings and practice profiles?

Best practice examples
a) Use information about what you would expect to be the prevalence of CVD and obesity and hypertension and which of the practice population are likely to be at highest risk to make extra efforts to encourage them to attend for a health check (eg through phone calls). PH can provide this information.

6. Expressed Demand

Questions to consider – What is it that prevents people from attending for health check – ie the barriers? How can more people hear positive messages about the Health Check which would encourage them to attend?

Best practice examples
a) Use PR and marketing to ‘sell’ the benefits of a health check. Posters, leaflets in the practice or pharmacy, leaflets and notes in information sent out from the practice and health checks promotion on the information screen in the practice publicity in the pharmacy and mentions by all staff

b) Work with partners to get the message out to people not routinely using the services of the practice – local pharmacy, community health workers, social workers district nurses. Promote the benefits of a HC through word of mouth, leaflets in prescription bags, posters etc

c) Engage family and friends and those who have had a health check, whose encouragement may convince people to attend

7. Responsive services

Questions to consider – How appropriate is the service to those attending? Do we respond appropriately to individual needs? Are we making best use of our existing services and systems to encourage attendance?

Best practice examples
a) Where appropriate, carry out opportunistic health checks or opportunistic intervention which will persuade a patient of the benefit of coming for a health check

b) Put alerts and pop ups on clinical systems to remind/encourage eligible people to attend

8. **Supported self management**
   **Questions to consider** – Are we considering the targeted support which may be required by some groups e.g. those with chaotic lifestyles or learning disabilities?

   **Best practice examples**
   a) Text or ring to remind people of their appointment

   b) Consider home calls for the health check

9. **Balanced service portfolio**
   **Questions to consider** – Are there bottlenecks in the system which increase fallout of the most vulnerable who may not manage setbacks?

   **Best practice examples**
   a) Adjust staffing to ensure sufficient trained staff are available at the times in most demand

   b) Make referral appointments to GPs or other practice staff and to lifestyle services

10. **Networks, leadership and co-ordination**
    **Questions to consider** – Is there good leadership and coordination between all members of staff and between GP practice and local pharmacy? Is there good communication with PH?

    **Best practice examples**
    a) Appoint a lead person in the practice and the pharmacy as the Health Checks Champion and give them responsibility for ensuring an effective and efficient service coordinated across all staff and partners

    b) Work with PH to communicate the outcomes, benefits and gains of the health checks among staff and partners and the wider public
### 3.6 Top 10 Actions for Pharmacy staff

1. **Appoint a lead person as the Health Checks Champion and give them responsibility for ensuring an effective and efficient service coordinated across all practice staff and partners.**

2. **Motivate and encourage all staff to be involved in promoting and supporting health checks. Training and motivational session can be provided in the practice by the Public Health Directorate (PH).**

3. **Provide appointments for health checks both within and outside of working hours (Saturday or evenings) and offer the choice to people.**

4. **Provide drop in sessions (mornings/evenings/all day Saturday). These could include other aspects of care (e.g. immunisations, stop smoking advice, health trainers) to avoid long waits, be provided in a community venue if more convenient for people and involve more than one practice and pharmacy.**

5. **Make it routine to collect the views of people who attend health checks, those who refuse and those who DNA. Use all staff to collect views from all people in the appropriate age group as part of their routine consultations. Adapt the service accordingly. (PH can provide sample questions and questionnaires). PH will support a practice, using a recent MOSAIC analysis, to analyse information collected about non responders and those who DNA and suggest and provide mechanisms and materials to engage these people, and those like them, in future health checks.**

6. **Consider and find ways to provide for the range of differing needs of the patients least likely to attend appointments and likely to be at highest risk of CVD. Carry out opportunistic health checks or opportunistic intervention which will persuade a patient of the benefit of coming for a health check, put alerts and pop ups on clinical systems to remind/encourage eligible people to attend, text or ring to remind people of their appointment and consider home calls for the health check.**

7. **Promote the benefits of a HC through word of mouth, mentions from all staff, leaflets in prescription bags, posters and leaflets in the practice and pharmacy, leaflets and notes in prescription bags. Work with partners to get the message out to people not routinely using the services of a practice–community health workers, social workers and district nurses.**

8. **Engage family and friends and those who have had a health check, whose encouragement may convince people to attend.**

9. **Use the reasons for attending the pharmacy to identify patients likely to be at highest risk (e.g. smokers, obese) and offer them a specifically tailored invitation.**

10. **Develop a protocol which ensures that within 4 months of the health check someone in the pharmacy checks that referrals (to GPs and lifestyle services) have been taken up by patient and registers have been updated as appropriate and chase this if not.**
Section 4 NHS Health Check Clinical Protocol

4.1: Public Health North Somerset Health Checks Process Guidelines

1. Explain clearly to individuals
   a. What you will be doing during the Health Check
   b. That the information will be stored in the patient’s medical records

2. Obtain individual’s informed verbal consent.

3. Using the tools and methodologies as described in the toolkit measure and record on the patient’s health check template:
   a. Blood pressure (repeat this two more times during the consultation if high and use the final reading)
   b. Height
   c. Weight
   d. Cholesterol/HDL ratio
   e. Pulse (optional)
   f. HbA1C (optional)

4. Use the QRisk2 and in consultation with the individual find out and fill in on the template:
   a. Age
   b. Postcode
   c. Ethnicity
   d. Family history of CVD
   e. Smoking
   f. Other conditions they may have

5. Calculate, print off if possible, and explain the individual’s CVD risk score.

6. From the lifestyle questionnaires filled in by the individual prior to the appointment, or online in PharmOutcomes, determine and discuss their activity levels, diet and alcohol consumption.

7. For people over 65 years of age use the NHS Health Check Dementia Information Leaflet to explain the common risk factors for vascular disease and some forms of dementia. Explain that making changes can reduce the risks of dementia in the future. If the patient has concerns about their memory encourage them to discuss this with a GP.
(Essential online training in delivering this intervention is at http://www.healthcheck.nhs.uk/commissioners_and_healthcare_professionals/national_resources_and_training_development_tools/dementia_resources/the_dementia_training_tool/)

8. Use the Results leaflet and motivational interviewing techniques to discuss any lifestyle change which may be appropriate/desired by the patient and refer the patient to lifestyle services where appropriate.

9. Make appointments for further tests (or flag up on PharmOutcomes) which may be needed as a result of the risk assessment – ie for CKD, diabetes, high blood pressure, high cholesterol or CVD risk = or >10% (see referral guidelines in the toolkit).

10. Ensure the patient record is sent to GP practice by completing the HC template in PharmOutcomes.

11. Ensure a follow up check is carried out to be sure any appointments and referrals made were attended.

4.2: Stage 1: The Risk Assessment
To enable the practitioner to perform a health check, it is essential that a number of clinical measurements are taken as well as asking the client a number of questions. The results of the measurements and the answers to the questions will be recorded on the QRISK template (template is available via most clinical systems or is available on line at http://qrisk.org/ a screen shot of the web page is included in section 7).

It is also important that this information also updates the practice template and patient records. (If not this will have to be done manually)

1. Age
Data required: age recorded in years.
Thresholds: the age of the person should be 40-74 years (inclusive).
2. Gender
Data required: the gender should be recorded as reported by the individual. If the individual discloses gender reassignment, they should be provided with CVD risk calculations based on both genders and advised to discuss with their GP which calculation is most appropriate for them as an individual.
3. Ethnicity
Data required: self-assigned ethnicity using one of the following categories: white/not recorded, Indian, Pakistani, Bangladeshi, other Asian, black African, black Caribbean, Chinese, other including mixed.
Key points: ethnicity is needed for the diabetes risk assessment. Ethnicity should be recorded using the Office for National Statistics 2001 census codes.
4. Smoking status
Data required: current smoker or non-smoker (including ex-smoker)
Related stages of the check: ensure a smoker who wants to quit can be offered a referral to a local stop smoking service
5. **Family History of coronary heart disease**
   
   **Data required:** information on family history of coronary heart disease in first-degree relative under 60 years.
   
   **Key points:** first-degree relative means father, mother, brother or sister.

6. **Body mass index**
   
   **Data required:** BMI is required for the CVD risk calculation. It also provides one approach to identifying those at high risk of developing diabetes, or those who have existing undiagnosed diabetes, and is required for the diabetes risk assessment (covered later in this section).

   **Thresholds:** where the individual’s BMI is in the obese range then a blood sugar test is required:
   - BMI is 27.5 or over in individuals from the Indian, Pakistani, Bangladeshi, Other Asian and Chinese ethnicity categories.
   - BMI is 30 or over in individuals from other ethnicity categories.

   **Note:** if the individual cannot have their height and or weight measured, the individual’s estimate of their own height and weight can be used as approximations but these are prone to error. Arm span can also be used as an approximation for height.

7. **Cholesterol test**
   
   **Data required:** cholesterol must be measured as the ratio of total serum cholesterol to high density lipoprotein cholesterol.

   **Related stages of the check:** cholesterol is a major modifiable risk factor of vascular disease, and can be reduced by dietary change, physical activity and medicines, and local areas will wish to consider what support to offer individuals. The specific reduction measures taken will depend on the overall risk score of the individual. If the ten-year risk is 10% or greater, and the NHS Health Check is undertaken outside of general practice the individual should be referred to their GP practice for further assessment and management.

   **Key Points:** A random (not fasting) cholesterol test can be used under the NHS Health Check programme to help ensure maximum take-up

   **Additional guidance**
   

8. **Systolic and diastolic blood pressure**
   
   **Data required:** both systolic (SBP) and diastolic blood pressure (DBP) are required for the diabetes filter and for assessment for chronic kidney disease and hypertension within primary care.

   If blood pressure measured is 140/90 mmHg or higher:
   - Take a second measurement during the consultation.
   - If the second measurement is substantially different from the first, take a third measurement.

   Record the lower of the last two measurements as the clinic blood pressure

   **Threshold:** if the individual has a blood pressure at, or above, 140/90 mmHg, or where the SBP or DBP exceeds 140 mmHg or 90 mmHg respectively, the individual requires:
   - a fasting plasma glucose (FPG) or HbA1c test (see section on diabetes risk assessment). This is part of the risk assessment element of the NHS Health Check and local authorities will need to consider its provision

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• an assessment for hypertension (see the section on additional testing and clinical follow up). This will take place in primary care and will mean local authorities will need to work closely with their partners to ensure people receive appropriate clinical follow up.

• an assessment for CKD (see the section on additional testing and clinical follow up). Again this will take place within a GP setting and links across the system are essential.

Key points: as set out NICE clinical guideline 127 (2011) practitioners should perform a pulse rhythm check prior to taking blood pressure to detect any pulse irregularities that could affect the reading from an automated device. Individuals who are found to have in irregular pulse rhythm should be referred to the GP for further investigation. As blood pressure is one of the top modifiable risk factors for preventing premature mortality, commissioners and providers will wish to familiarise themselves with the NICE hypertension guidance.

Additional guidance

Hypertension: clinical management of primary hypertension in adults. NICE clinical guideline 127. August 2011.9

See section 4.4 for details of criteria for referral

4.3: Stage 2: Communicating CVD Risk

Everyone who undergoes a check should have the results of their NHS Health Check assessment conveyed to them. The communication of risk and what it means for the individual is of paramount importance to the programme meeting its objective of helping people stay well for longer. Levels of risk need to be discussed alongside what each individual can do to manage their risk, such as taking regular exercise, eating a healthy diet, reducing their calorie and alcohol intake as a way of managing their weight, and stopping smoking.

Risk communication must be delivered by a trained health care professional. The health care professional should explain to the patient that everyone who has a health check is at risk of developing CVD; this risk may be increased by their medical history (i.e. diabetes, high blood pressure, kidney disease etc), family history or lifestyle (i.e. smoking, diet, physical inactivity etc). When communicating risk to a client it is important for the health care professional NOT to talk of high and low risk so as not to convey either a false sense of alarm or a false sense of security. The clinician should explain the risk in an easy to understand way: for example “In a group of 100 with the same risk factors as you 31 of them will have a heart attack or have a stroke in the next 10 years”.

The health care professional should use the NHS Health Check ‘Your Results’ booklet as an aid and may also use a visual representation prop to support the verbal explanation as illustrated in figure 2.

9 http://www.nice.org.uk/guidance/cg127
If the individual’s risk is 10% or greater the health care professional should explain that they will be referred to their GP practice for lipid assessment and assessment of the need for other medical treatment to reduce their risk and offered appropriate lifestyle support and referral as set out in the brief interventions and care pathways in section 5.
4.4: Stage 3: Risk management and Intervention

The advice below will assist in making a decision as to actions following individual risk assessment readings, regardless of the overall risk score.

1. CVD risk score
To calculate the risk score a Qrisk 2 calculator should be used. Remember a risk calculator offers an estimation of risk.

<table>
<thead>
<tr>
<th>Risk</th>
<th>Result</th>
<th>Advice &amp; Action</th>
<th>REVIEW</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low to Normal Risk</td>
<td>0 - 9% (no abnormal results)</td>
<td>Reinforce healthy lifestyle. Encourage to continue</td>
<td>NHS Health Check repeat in 5 Years</td>
</tr>
<tr>
<td>Moderate Risk</td>
<td>10 - 19%</td>
<td>Refer for lipid assessment with view to possible statin commencement. Advise &amp; reinforce healthy lifestyle. Refer to relevant Wellbeing support</td>
<td>NHS Health Check 5 years recall ONLY for those where statin not commenced</td>
</tr>
<tr>
<td>High Risk</td>
<td>&gt; = 20%</td>
<td>Consider below PLUS refer to GP practice for further investigation &amp; pharmacological interventions</td>
<td>Enter Care pathways (QOF) or further review within GP practice</td>
</tr>
</tbody>
</table>

Ref: NICE Clinical Guideline 67; Lipid Modification. Cardiovascular Risk Assessment & the Modification

Individual readings – cholesterol
An ideal TC: HDL ratio is ≤ 6 (JBS2) however you do not need to refer patients for further tests if this is the only abnormal result and their overall risk score is moderate or low risk.

<table>
<thead>
<tr>
<th>Cholesterol Test</th>
<th>Results</th>
<th>ACTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Cholesterol (TC)</td>
<td>&gt; = 7.5mmol/l</td>
<td>Regardless of CVD risk the patient should be referred to their GP for Familial Hypercholesterolaemia screening within 1 month</td>
</tr>
</tbody>
</table>

Ref: NICE Guidelines May 2008; CG67 Lipid Modification CG71 Familial Hypercholesterolemia Clinical guidance changes frequently & it is the responsibility of the individual to keep up to date with changes in guidance.

Smoking

<table>
<thead>
<tr>
<th>Status</th>
<th>Goal</th>
<th>ACTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never Smoked</td>
<td>N/A</td>
<td>Reinforce healthy lifestyle</td>
</tr>
<tr>
<td>Ex-Smoker</td>
<td>Maintain Smoking Cessation</td>
<td>Advise &amp; reinforce healthy lifestyle. Highlight benefits / demonstration on charts tool the difference this make to CV risk and health benefits &amp; encourage continuing.</td>
</tr>
<tr>
<td>STOP</td>
<td>STOP</td>
<td>Refer to NHS smoking cessation or local service</td>
</tr>
</tbody>
</table>

Ref: http://smokefree.nhs.uk
### Pulse check

<table>
<thead>
<tr>
<th>Status</th>
<th>Goal</th>
<th>ACTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Steady regular pulse</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Irregular resting pulse taken for 30 seconds</td>
<td>To detect if undiagnosed rhythm disorder</td>
<td>Refer to GP or practice nurse for assessment if further tests ECG requires</td>
</tr>
</tbody>
</table>

### Blood Pressure

<table>
<thead>
<tr>
<th>Category of BP</th>
<th>Systolic BP (mmHg)</th>
<th>Diastolic BP (mmHg)</th>
<th>ACTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hypotension</td>
<td>&lt; 90</td>
<td>&lt; 50</td>
<td>Reassure and encourage hydration ONLY refer to GP if suffering symptoms of low BP e.g. Dizziness / Fainting</td>
</tr>
<tr>
<td>Ideal for primary prevention only not secondary prevention</td>
<td>≤ 140</td>
<td>≤ 90</td>
<td>Reinforce healthy lifestyle &amp; encourage to continue</td>
</tr>
<tr>
<td>Hypertension</td>
<td>141 - 179</td>
<td>91 - 109</td>
<td>Refer patient to GP practice for further BP measurement / diabetes filter as per DH guidance</td>
</tr>
<tr>
<td>Hypertension</td>
<td>&gt; 180</td>
<td>&gt;110</td>
<td>Refer patient same day to GP practice or A&amp;E</td>
</tr>
</tbody>
</table>

**AUTOMATED BP MACHINE DISPLAYING ERROR READING**  
This may indicate that the BP cannot be picked up because of an irregular heart rhythm i.e. atrial fibrillation. The BP should be checked using an alternative machine if one is available (preferably a manual sphygmomanometer if a staff member is trained to use it). If an alternative machine isn't available or the 2nd machine reads ERROR then the patient should be referred to their GP practice for a PULSE test & MANUAL BP check.


If systolic BP & diastolic BP fall into different categories the higher value should always be taken for classification.

### The Diabetes Filter for NHS Health Check

Those more at risk of developing type 2 diabetes are individuals with
- A family history of Type 2 diabetes
- Severe mental health problems
- Learning disabilities
- Those taking medication that can increase the risk of developing diabetes such as steroids, antiretroviral and some antipsychotics
- Polycystic ovary syndrome
- Low birth weight, that is less than 2.5kg (5.5lbs)
- Women with a history of diabetes in pregnancy (gestational diabetes) and women who have had a baby that weight more than 4.5kg (9lbs) at birth.
DH guidance is to use the filter below and a random glucose is **not** required for an NHS Health Check due to the potential for false positives.

### BMI

<table>
<thead>
<tr>
<th>BMI</th>
<th>Result (BMI)</th>
<th>ACTION</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Ideal Weight</strong></td>
<td>18.5 – 24.9 White European 18.5 – 22.9 Asian population</td>
<td>Reinforce healthy lifestyle &amp; encourage to continue</td>
</tr>
<tr>
<td><strong>Overweight</strong> (increased risk)</td>
<td>25 - 29.9 White European 23- 27.5 Asian population</td>
<td>Advice regarding healthy lifestyle &amp; increased physical activity. Recommend support for weight loss</td>
</tr>
<tr>
<td><strong>Higher risk</strong></td>
<td>&gt; = 30.0 White European &gt; = 27.5 Asian population</td>
<td>Highlight risks &amp; refer to lifestyle providers <strong>Refer for HbA1c or fasting glucose</strong></td>
</tr>
</tbody>
</table>

NICE public health guidance Issued: July 2013 PH46

### Physical activity via GPPAQ

<table>
<thead>
<tr>
<th>Status</th>
<th>Goal</th>
<th>ACTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Active</td>
<td></td>
<td>Reinforce healthy lifestyle</td>
</tr>
<tr>
<td>Moderately inactive</td>
<td>Increase motivation for activity</td>
<td>Advise &amp; reinforce healthy lifestyle. Highlight benefits for health – physical activity pathway</td>
</tr>
<tr>
<td>Moderately active</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
All patients should be offered lifestyle advice to reduce their cardiovascular risk. The health care professional will discuss with the patient any lifestyle changes which they wish to make and this should be recorded on the NHS Health Check template along with all lifestyle advice given. Any lifestyle advice or interventions given at the practice should be in line with best practice guidance as outlined in each of the lifestyle intervention care pathways in Section 5. These include:

- Stopping smoking: See Stop Smoking Brief Intervention and Care Pathway (sect 5.6)
- Weight Management: See Weight Management Brief Intervention & Care Pathway (sect 5.7)
- Physical activity: See Physical Activity Brief Intervention & Care Pathway (sect 5.8)
- Dietary Management: See Healthy Eating Brief Intervention & Care Pathway (sect 5.9)
- Alcohol: See Alcohol Screening, Brief Intervention & Care Pathway (sect 5.10)

As a result of the NHS Health Check, there may be a number of clinical issues identified that require management by the GP, or other professional with suitable patient information and prescribing rights.

Section 1.5 fig 2 summarises these actions.
4.5: Stage 4: Follow Up and Audit
Patients on established primary prevention treatment should be placed on the QOF register (eg OB1, PP1, PP2, BP1, BP4 and BP5) and reviewed annually as a minimum. In addition patients may be placed on appropriate disease registers (DM, CKD and CHD according to the outcome of the health check and managed appropriately according to practice protocols.
It is vital to ensure that as a result of the health check, patients found to be at risk are followed up.

It is the responsibility of the Health Checks Champion or the administrator to check that all referrals and appointments made as a result of the health check are attended and carried out and that patients at risk are on the appropriate registers to ensure ongoing risk management. 4 month follow up as laid down in the service specification.

Data Collection, Audit and Evaluation
Data should be collected in line with that identified in the NHS Health Check Service specification and should be entered onto the NHS Health Check Template. In addition to practice based health checks there will be a number screened in community settings. When this occurs information regarding these checks will be sent to the practice and data should be entered onto the NHS Health Check Template.

The service will be subject to a full evaluation by Public Health North Somerset. In addition a national evaluation framework is in place which monitors and reports the number of health check invitations sent, and the uptake rate.
Section 5: Health Behaviour Change

5.1 Introduction

This section of the toolkit is designed to help you to make small changes in how you work with patients. These adjustments will help patients to be more engaged and respond more positively with an increase in motivation.

When patients come for an NHS Health Check they may be well informed and already have some ideas about what they could do to be more healthy. Others may not and your job will be to work out how ready they are for change and then support them in planning what they could do. The diagram below of the Cycle of Change is a useful reminder of the different stages in the change process. The section a few pages on will guide you in some detail in the skills and approaches you can use when working with patients to help them to make changes.

First watch!
http://www.youtube.com/watch?v=D1zF2BdBF3s&feature=player_embedded

A new CPPE course is also available now for Pharmacy staff to help improve consultation skills - http://www.consultationskillsforpharmacy.com/about6.asp?P=5&N=3

The NHS Health Checks website also provides useful training videos, demonstration the effect of motivational approaches
http://www.healthcheck.nhs.uk/commissioners_and_healthcare_professionals/national_resources_and_training_development_tools/training_videos/

5.2 The Cycle of Change

![The Cycle of Change Diagram]

1. **Pre-contemplation** - People are not considering change in the next six months.
2. **Contemplation** - The person is ambivalent – in that they are in two minds about what they want to do. Sometimes they feel the need to change their use and at other times they do not.
3. **Decision** - The person has decided it is time to change. They begin to prepare and plan for this change.
4. **Action/maintenance** - The person is putting into action the plans and preparation they have been making to change. This is usually a very motivated and exciting time. Reinforcement, Motivation and Support is key during this stage. In maintenance the change has been integrated into the person’s life. Some support may still be needed through this stage.
5. **Relapse and Lapse** - are essential to the Cycle of Change and do not equate to failure. Ultimately changing our behavior is difficult and it is not uncommon for people to “slip up” or lapse.

Based on Prochaska and DiClemente’s model.
5.3 Motivational Interviewing

Motivational interviewing uses a guiding style to work with patients, clarify their hopes and strengths, voice their own motivations for change, and promote patient involvement in decision making.

You can learn motivational interviewing in three steps: practise a guiding rather than directing style; develop strategies to elicit the patient’s own motivation to change; and refine your listening skills and respond by encouraging change talk from the patient.

Motivational interviewing has been shown to promote behaviour change in various healthcare settings and can improve the doctor-patient relationship and the efficiency of the consultation.

Motivational Interviewing is about:
Working as a partner with the patient with a more equal power balance
Assisting the patient to voice what they already have- unlocking their own motivation and resources for change
Honouring patient autonomy- Most of us resist being coerced and told what to do. Acknowledging someone’s right and freedom sometimes makes change possible.

Four Guiding Principles
These four principles will help you to stay within the spirit of Motivational interviewing. The word RULE will help you to remember them.

RESIST the Righting Reflex- this means resist the temptation to put things right
UNDERSTAND your patient’s motivations- it will be their reasons for change and not yours which are most likely to trigger change.
LISTEN to your patient- MI involves as much listening as informing
EMPOWER your patient – asking open questions will empower the patient to explore his feelings
The next section is adapted from approaches written by Pip Mason and Christopher Butler with the kind permission of Pip Mason. For full references and links for further resources please see page 35 and appendix 4.
This diagram can guide your discussions in consultation (it is adapted from Behavior Change, Mason and Butler 2010, Churchill Livingstone). Before getting started on any of these tasks rapport will be established and the agenda set. Then centrally, you will need to assess the patient’s readiness to change in terms of how important it is to them and how confident they feel about being able to do it. On the basis of this assessment we might explore in more depth the importance of the change and also build their confidence in their ability to make it happen. At any point in the consultation it may be appropriate for an exchange of information between patient and health practitioner. We might also need to ‘roll with’ any resistance the patient puts up - question and explore rather than challenge. The spirit of the consultation is vital. The practitioner structures it and offers relevant information while the patient is the active decision-maker. The practitioner’s manner is empathic, curious and collaborative.
Establishing rapport and setting the agenda
Some people will attend for an NHS Health Check because they are highly motivated about health. For others building up some rapport with them will be crucial in getting them to set foot through the door. The rapport needed for an NHS Health Check and a constructive discussion about behaviour change will differ from the rapport you may already have when you are in a more directive or treatment-giving role.
When raising the issue of behaviour change it is particularly important that understand how the individual behaviours relate to their risk of developing disease and not that you are judging them- or trying to get them to be perfect!
For many people following an NHS Health Check there will be several health behaviours that could be discussed. The ‘agenda-setting chart’ below was developed by Pip Mason and Christopher Butler to assist in such situations. Below is an example of how it might be used to consider which behaviour changes are most likely to be considered as part of an NHS Health Check. The possible behaviour changes are drawn in bubbles on the paper and the patient is invited to consider them and decide where the best place to start is.

Assessing; are they ready, willing and able?
Being ready to make a change comes from;
- A belief that it is important to attend for an NHS Health Check or to make a change
- A belief that it will be possible to do so
- A sense that this is the right time.

Some people may be afraid of setting foot through the door, this may be about a fear of needles, of hearing bad news or just something connected with an uncomfortable previous experience of the NHS. Sometimes patients have a lot on their plate: they know it is important to change but they don’t feel it is possible. Other patients are confident that, they could change if they wanted to but they are not convinced they need to or that it would help in any way meaningful to them. Sometimes it’s just not the right time.
If you find that in making telephone calls to people to prompt them to attend or to follow up someone who missed an appointment it may be useful to skip forward to the “Exchanging Information” step below.

Assessing these elements of decision-making may begin to take place if you are making a phone call to follow up a written invitation to attend for an NHS Health Check. Alternatively the assessment is made as part of the process of listening to the patient’s story when they actually attend. It can help focus the conversation.

Another approach is to use scaling questions along the lines of;
- **On a scale of 1-10 how important is it to you to do this?**
- **Why that low rather than higher number? What would it take to move it up one point?**
- **On a similar scale how confident are you that you could, if you gave it a go?**
- **So how ready to change do you think you are?**

**Exploring importance**
If it does not seem important to the patient to make the change (despite it being important to the practitioner that they do so!) you can try to explore this in more depth. It often works well to acknowledge that the patient is ambivalent about change. You can then ask them how they see the pros and cons of the situation, encouraging them to express both sides of the debate.
- **What are the good things about......?**
- **What are the not so good things about......?**
- **[summarise] What else? Where does this leave you now?**

Sometimes when people hear themselves say what the positives are this can help to build on their motivation, if you can reflect back to them what you have heard them say this can help to tip the balance

**Building confidence**
When patient can see the importance to changing but does not have the confidence or can’t visualise themselves being able to do it; it can be useful to look at the practicalities in more detail. You can do this by inviting the patient to come up with ideas for getting over the obstacles. To maintain rapport, you will need to acknowledge these obstacles and not to minimise them.
Another way to build confidence is to focus on skills or knowledge that the patient already has that will help them to make this particular change. You could also signpost them in the direction of further support. There are examples of places you can signpost people on to at the back of this toolkit.
**Information Exchange**

You may find that on the telephone or in consultations to promote behaviour change you will often be exchanging information with patients. Please try to **only** give information in order to:

- Open up the discussion
- Ensure the patient has all the relevant facts they need to make a decision
- Help build motivation for change
- Offer assistance/referral.

You need to collect the information the patients have to offer about:

- How the behaviour in question fits into and affects the rest of their lives
- Reasons they might be reluctant to attend or change
- Views and aspirations
- Possibilities for change

Patients have to be able to go away and make changes without us. The important thing is not *what does the practitioner say?* but *what does the patient take from information given?*

A useful sequence to follow is:

1. **Elicit** readiness to change and interest in hearing more. Find out what they already know and what it means to them. Ask permission to tell them more.

2. **Provide** neutral information, sticking to facts rather than opinions or predictions.

3. **Elicit** their interpretation of the facts provided; what does it all mean to them? What do they make of it? Reflect on their reactions to the information given.

The same principles can be applied to information leaflets. Ask people what they would like, give only what is relevant and if you see them again elicit their response to reading it.
Rolling with resistance
When a patient puts up resistance in a consultation about behaviour change you have choices how you will respond;

1. Keep persisting and repeat why they should change
2. Come up with heaps of ideas how to go about change
3. Warn them of the dangers of not changing
4. Listen and reflect back why the patient doesn’t want to change at this time
5. Listen and reflect back to the patient what difficulties they expect
6. Ask them what they think the pros and cons are of changing
7. Acknowledge that they have a choice whether to change or not.

If one or more of the first 3 are chosen you may find that you get into an argument or the patient may feel that they haven’t been heard or that you really don’t understand. The practitioner may win the argument but frequently patients become more entrenched in their own views by defending them. The last 4 options are ways of ‘rolling with resistance’; an approach drawn from motivational interviewing (Miller and Rollnick 2002). Instead of arguing with resistance the practitioner seeks to understand it better and have a more open discussion about the topic. In doing so the patient often moves on from the resistance and begins to talk more positively.

Finishing the consultation
Usually we have a goal to come up with a solution and put it into action. (e.g.put on a dressing, make a referral) Consultations where we are helping people to change behaviour don’t always end as neatly as that. Sometimes the seed of change has been planted but has not yet germinated. Sometimes it has, indeed fallen upon stony ground! If the patient is not ready the best thing you can do is to leave open the possibility of future change without generating resistance by trying to push them too far, too fast.

(please note that this section refers only to behaviour change. Any clinical risk factors such as high blood pressure or CVD risk of 10% or more, should be referred for treatment, by making an appointment for the patient)

If you would like to see a video demonstration of Motivational Interviewing in action please go to http://www.elsevierhealthbehaviorchange.com/video.php

References and Further reading
Mason P and Butler CC (2010) Health Behavior Change (2nd ed.) Churchill Livingstone
5.4 Different levels of intensity of support.

You may be familiar with the idea of stepped care. It is based on the principle that we offer people the level of support that is right for them. Using the example of mental health; not everyone with a mental health problem needs to see a psychiatrist. As we have described earlier in this chapter; Motivational Interviewing will help you to identify readiness and willingness to change. Some people who are ready and willing will just need a brief intervention and signposting to the right information or resources to start to make a change or to keep up the behaviours that are beneficial. The right level of intervention for them will be at tier 1 or tier 2. Others as you can see in the diagram below may need more of your support or may need a referral e.g. to a slimming group to make changes which will improve their health.

The sections that follow give you guidance on how to do a brief intervention on the health behaviours people will be most likely to need to change and then the information you will need to signpost people or refer them to more intensive support.

5.5 Recording the goals and actions people plan to carry out

Use the results booklet to make a record of the conversation you have with patients about what changes they plan to make. It can also be used to help guide you through the feedback. Further copies can be obtained from Lin Griffiths on 01275 88 5152 or linda.griffiths@n-somerset.gov.uk

If patients want referral to a lifestyle service make sure you make the referral, record it in the patient template and in 4 months talk to the patient to check on progress (see Service Specification)
Your goals

Use these pages to set yourself some goals to work towards. Start off with one or two changes that you could make to improve your health. Remember that small changes to your lifestyle can make a big difference to your health.

What would I like to achieve?

[Blank lines for input]

What small thing can I commit to changing?

[Blank lines for input]

How can I measure it?

[Blank lines for input]

How will I know if I’m successful?

[Blank lines for input]

What might get in the way?

[Blank lines for input]

How will I stop that happening?

[Blank lines for input]

Who can help me?

[Blank lines for input]
5.6 Support to Stop Smoking

Why is this important?

Stopping Smoking is the best thing you can do to improve your health and it has immediate and long-term benefits.

In North Somerset approximately 300 residents die prematurely from smoking-related illness each year. In 2010/11 there were 2046 smoking attributable hospital admissions with an estimated cost of £4.4 million. The total cost to the NHS of smoking in North Somerset is £8.5 million. Health damage from second hand smoke is substantial. Smoking is the single greatest cause of premature death and disease in North Somerset. It is the single largest factor in health inequalities and a major driver of poverty. http://ash.org.uk/localtoolkit/R9-SW.html

- Remember: It’s never too late to quit.

The Support to Stop Smoking Service is both a clinically effective and cost effective service - it works and patients are 4 times more likely to quit using an NHS Support to Stop Smoking Service.

Brief Intervention guidance

65% of smokers want to give up

Smokers are Four Times more likely to quit if they use the NHS Support to Stop service

(Smoking and smoking cessation in England; findings from the Smoking Toolkit Study October 2010)
Remember: a brief intervention:

- Is taking the opportunity to talk to someone about their smoking
- Can take from 2-10mins depending on the time available
- Is to help the smoker move closer to the point of deciding to quit
- Is NOT about trying to force smokers into stopping
Referral pathway

Most GP practices offer a Support to Stop Smoking service, referrals for support in the first instance should therefore be to the in house Support to Stop Smoking Advisor. If for some reason this isn’t possible or the waiting time is greater than 2 weeks, patients can be referred to pharmacies, drop in clinics or courses run by the specialist service, details can be found here:


or order the ‘Smokers Wanted’ leaflet from Public Health.
### Service Specification

This service is based on stop smoking advice, behavioural support and pharmacotherapy. The service is designed to help smokers

- Get local support while they quit.
- Make a personal plan to stop smoking.
- Set a quit date.
- Deal with cravings.
- Know about Nicotine Replacement Therapy (NRT) and get it on prescription.
- Know about Varenicline (Champix) and Bupropion (Zyban) and get this on prescription.
- Stay stopped.

Remember smokers are 4 times more likely to quit using an NHS Support to Stop Smoking service.

### Service location(s)

Most GP practices and pharmacies offer a Support to Stop Smoking Service.

The specialist Support to Stop Smoking team offer the following Courses and Drop-Ins:

#### Tesco In-Store Café
Station Road, Weston-super-Mare BS23 1XG
Wednesdays. Please drop-in between 6.15 and 7.45pm and take a numbered card. Please note that due to the nature of the drop-in session, there may be a short wait to be seen.

#### Health Trainers at the Town Hall
Walliscote Grove Road, Weston-super-Mare BS23 1UJ
Health Trainers offer support on a wide range of health issues including smoking. For all health issues, a drop-in service is offered on Monday, Tuesday, Thursday and Friday between 12–2pm. Alternatively, call 01934 627 250 for a chat or to arrange an appointment outside of these times.
Further information is also available at: www.nshealthtrainers.co.uk

#### Stop Smoking Course at the Badger Centre
3–6 Wadham Street, Weston-super-Mare, BS23 1JY
Join us on Wednesdays from 1–2pm for our Stop Smoking Course. For more information, availability and to book an appointment, call 01275 546 744.

#### Stop Smoking Course at the Sub Station
1 St Andrews Parade, Weston-super-Mare, BS23 3SS
Join us on Thursdays from 1:00 – 2.00pm
For more information, availability and to book an appointment, call 01275 546 744.
Additional groups are run throughout the year in a variety of locations, please call us on 01275 546 744 for further details and availability.

#### Health Trainers at the Town Hall
Walliscote Grove Road, Weston-super-Mare BS23 1UJ
Health Trainers offer support on a wide range of health issues including smoking. For all health issues, a drop-in service is offered on Monday, Tuesday,
Thursday and Friday between 12–2pm. Alternatively, call 01934 627 250 for a chat or to arrange an appointment outside of these times. Further information is also available at: www.nshealthtrainers.co.uk

The following link provides information about services in North Somerset which can be printed:


<table>
<thead>
<tr>
<th>Age range</th>
<th>Any smoker over the age of 12</th>
</tr>
</thead>
<tbody>
<tr>
<td>Referral criteria</td>
<td>Any smoker who is motivated and wanting to make a quit attempt</td>
</tr>
<tr>
<td>Who can refer</td>
<td>Any health professional or self referral</td>
</tr>
</tbody>
</table>

**North Somerset Stop Smoking Service**

**BRIEF OPPORTUNISTIC ADVICE**
Primary Healthcare Team, Dentists, pharmacists, hospital staff, teachers, youth workers, TSOs etc

**SUPPORT TO STOP APPOINTMENTS**
Trained Stop Smoking Practitioners in GP Practices and other settings

**SPECIALIST SERVICE**
Smoking Cessation Specialists

**Referral method**
Follow practice procedure re referral to in house Support to Stop Smoking advisor.

**Send referral to**
Follow practice procedure re referral to in house stop smoking practitioner

**Service contact details**
Smokefree North Somerset
Post Point 1
Castlewood
Tickenham Road
Clevedon
BS21 9FW
01275 546 744 or you can email us at smokefree@n-somerset.gcsx.gov.uk

**Copy of useful resource for practitioners to use**
http://smokefree.nhs.uk/quit-tools/

**No referral form required**
5.7 Physical Activity

Why is this important?

- Around 1 in 4 people in England say they would become more active if they were advised to do so by a doctor or nurse.
- Physical activity can help prevent and manage over 20 conditions and diseases including coronary heart disease, stroke, type 2 diabetes and cancer. It also promotes mental well being and helps people to manage their weight.
- The greatest benefits are obtained by sedentary adults becoming a bit more active rather than those who are already active becoming more active.
- Department of Health (DH) recommends that adults should be active to a moderate intensity for 150 minutes a week. (in 10 minute bouts or more).
- Evidence suggests that only 10.5% of adults in North Somerset are currently meeting this guidance. Another way of putting this is to say almost 160,000 people in North Somerset are not active enough to maintain good health.

**Brief Intervention Guidance**

**Assess motivation**

- Ask how do you feel about being more active?
- On a scale of 0-5 how important is it?
- On a scale of 0-5 how confident do you feel about being more active?
- What could you stick to on a daily basis?
- Encourage them to choose something that could be included in your daily routine.
- What do you like doing? - suggest looking at [www.go4life.org](http://www.go4life.org) or use the Active Directory to discuss opportunities. Paper copies should be available. If not...
- Call 01278 882 730 or email go4life@n-somerset.gov.uk

**Remember: a brief intervention is about**

- It is taking the opportunity to talk to someone about their activity levels
- It can take from 2-10mins depending on the time available
- It is to help the person move closer to the point of being more active
- It is NOT about trying to force people into going to the gym

**Referral Pathways**

A range of services are available in the community to promote healthy and active living; see next pages for details.

---

10 Health Survey for England 2007
Complete the 'Brief Interventions for Physical Activity Form' (see below) and return to the Active Lifestyles Team.

Result of GPPAQ questionnaire shows ACTIVE OR MODERATELY ACTIVE.
WHAT IS GO4LIFE?

If you search on this web address: www.go4life.org this is the statement that you will read:

‘If you want to become more active then Go4Life is for you, helping you to become fitter and healthier and feel better about yourself’

The small team that administrate and deliver for this partnership work for North Somerset Council. They are the ‘Sports and Active Lifestyles Team’ (SAL). Like most local authorities, in North Somerset there is a drive to increase active and healthy living by bringing together statutory, private business and voluntary agencies. Go4Life is the branding given to the North Somerset initiative.

We believe our Go4Life programme is very good value for money and a number of initiatives have been set up under the Go4Life banner. To support this work, we have commissioned the SAL team to co-ordinate, train and publicise the Health Walks (currently 100 volunteers and hundreds are walking every week across the district). We try to join up with the sustainable travel team who also do a lot of work to encourage active living and have been successful in applying for a grant to improve sustainable travel on the main commuter routes out of North Somerset and in workplaces in North Somerset. This work is also part of ‘Go4Life’ partnership and has considerable implications for health.
Brief Interventions in Physical Activity

Suitable for patients who are inactive or moderately inactive (following GPPAQ)

We need your help when conducting NHS Health Checks to advise those who are inactive and moderately inactive to take part in physical activity!

If the patient would like information about what is available to help them get active please tick below the interventions the patient would like further information about. You can give a quick overview of what is available using the brief descriptions below, a sheet for patients to take away has also been provided. There is something for everyone and all abilities are catered for. We will contact patients to explain further, no need for long referral forms and extra paper work!

<table>
<thead>
<tr>
<th>Tick</th>
<th>Intervention</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Health Walks (FREE)</td>
<td>Organised short walks across North Somerset for those who are inactive or moderately inactive, ideal for those with long term health conditions.</td>
</tr>
<tr>
<td></td>
<td>Active Directory</td>
<td>A guide to physical activity classes and other healthy living information. Lists over 200 opportunities.  <strong>Note:</strong> If you would like copies of the directory to give out yourself, request this by calling 01275 882 730.</td>
</tr>
<tr>
<td></td>
<td>Sport / Exercise Vouchers (FREE)</td>
<td>Ten vouchers giving free access to over 50 sport/exercise sessions in Weston. Low impact sessions available.  <strong>Note:</strong> Must live in Weston to be eligible.</td>
</tr>
<tr>
<td></td>
<td>Leisure (Swim / Gym) Vouchers (FREE)</td>
<td>Ten vouchers giving free access to swimming and gym access (induction included) at the following leisure centres: Strode (Clevedon), Parish Wharf (Portishead), Scotch Horn (Nailsea), Hutton Moor (WSM), Hans Price (WSM), Churchill and Backwell.</td>
</tr>
<tr>
<td></td>
<td>Inclusive Sport</td>
<td>A dedicated guide of inclusive sport and exercise sessions for disabled people.</td>
</tr>
<tr>
<td></td>
<td>Staying Steady Exercise Classes (FREE)</td>
<td>A guide of gentle exercise classes aimed at 50+, run by Age UK. Some classes are free, others have a small entrance fee.</td>
</tr>
<tr>
<td></td>
<td>Adult cycle training (FREE)</td>
<td>1-2-1 cycle training for adults, ideal for beginners and inexperienced cyclists.</td>
</tr>
<tr>
<td></td>
<td>Borrow a bike scheme (FREE)</td>
<td>Borrow a bike for 2-4 weeks. Hybrid, electric and folding bikes available from your nearest participating cycle shop.</td>
</tr>
</tbody>
</table>

Contacting patients

<table>
<thead>
<tr>
<th>Tick</th>
<th>How the patient would like to hear from us:</th>
<th>Please provide preferred contact details below:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Phone</td>
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<td></td>
<td>Text Message</td>
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<td>Post</td>
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</table>

Patients name:
Name of person completing health check:
Role of person completing health check:

**You can return this form by post to:** Sport and Active Lifestyles, North Somerset Council, Town Hall, Walliscote Grove Road, Weston-super-Mare, BS23 1UJ by email to: go4life@n-somerset.gov.uk or Fax: 01275 884743. **We will contact patients within seven days of receiving this form.**
Had your NHS Health Check and now you would like information about what is available to help you get active locally?

Many of us aren’t too keen on the idea of exercise. It might be that we’re too busy or we simply can’t face the thought of it. But most people are not getting the amount of activity they need to stay healthy. Only 1 in 20 people are actually doing the right kind of activity they need each week. And sitting down for hours – maybe at work or watching TV – can also increase the risk of poor health.

Building activity into your day keeps your heart healthy, reduces your risk of serious illness and strengthens muscles and bones. It can also be a great way of reducing your stress levels and lifting your mood if you’re feeling down.

Adults should aim to be active daily. Over a week activity should add up to at least 150 minutes (2 ½ hours) in bouts of 10 minutes or more. One way to approach this is to do 30 minutes on at least 5 days a week. Activity should cause you to get warmer, breathe harder and your heart to beat faster.

Being active is all about having fun. If we don’t enjoy it, we won’t keep it up. Try our ideas below for easy ways to get going every day, many activities are free. Just let us know which activities you would like information about (via the person completing your check) and we will be in touch!

Health Walks (FREE) - Organised short walks across North Somerset for those who are inactive or moderately inactive, ideal for those with long term health conditions.
Active Directory - A guide to physical activity classes and other healthy living information. Lists over 200 opportunities.

Sport / Exercise Vouchers (FREE) - Ten vouchers giving free access to over 50 sport/exercise sessions in Weston. Low impact sessions available. Note: Must live in Weston to be eligible.

Leisure (Gym/Swim) Vouchers (FREE) - Ten vouchers giving free access to swimming and gym access (induction included) at the following leisure centres: Strode (Clevedon), Parish Wharf (Portishead), Scotch Horn (Nailsea), Hutton Moor (WSM), Hans Price (WSM), Churchill and Backwell.

Inclusive Sport - A dedicated guide of inclusive sport and exercise sessions for disabled people.

Staying Steady Exercise Classes - A guide of gentle exercise classes aimed at 50+, run by Age UK. Some classes are free, others have a small entrance fee.

Adult cycle training (FREE) - 1-2-1 cycle training for adults, ideal for beginners and inexperienced cyclists.

Borrow a bike scheme (FREE) - Borrow a bike for 2-4 weeks. Hybrid, electric and folding bikes available from your nearest participating cycle shop.

Useful web based information: www.go4life.org
www.nhs.uk/Change4Life/Pages/be-more-active.aspx
www.nhs.uk/LiveWell
ACTIVE DIRECTORY

The Go4Life Active Directory has a selection of all kinds of activity from gardening to badminton. Samples of projects across the district are included in this directory.

Where? This is a North Somerset wide directory.

Age Range: Aimed at adults but families and children are welcome to attend many of the activities listed.

Referral criteria: Available to all

Who can refer: Pick up a copy from your surgery, library or download online [www.go4life/activedirectory](http://www.go4life/activedirectory)

Referral Method: Full information can be found on the Go4life website [www.go4life.org](http://www.go4life.org)
5.8 Eating Well

Why is this important?
Good nutrition is vital to good health. While many people in England eat well, a large number do not. A significant proportion of the population consumes less than the recommended amount of fruit and vegetables and fibre but more than the recommended amount of fat, saturated fat, salt and sugar.

Poor nutrition is a major cause of ill health and premature death in England. Cancer and cardiovascular disease, including heart disease and stroke, are the major causes of death in England, accounting together for almost 60% of premature deaths. Furthermore, about one-third of cancers can be attributed to poor diet and nutrition.

Increasing the consumption of fruit and vegetables can significantly reduce the risk of many chronic diseases. It is estimated that eating at least 5 varied portions of fruit and vegetables a day can reduce the risk of deaths from chronic diseases such as heart disease, stroke, and cancer by up to 20%. Research has shown that each increase of one portion of fruit or vegetables a day lowers the risk of coronary heart disease by 4% and the risk of stroke by 6%. Evidence also suggests that an increase in fruit and vegetable intake can help lower blood pressure.

Brief Intervention guidance

- Eat breakfast
- Eat lots of fruit and vegetables (5 a day)
- Base meals of starchy food
- Eat more fish
- Drink plenty of water
- Saturated fat and sugar
- Salt- have no more than 6g per day

Remember: a brief intervention is about
- It is taking the opportunity to talk to someone about their eating habits
- It can take from 2-10mins depending on the time available
It is to help the person move closer to the point of making changes about their eating habits.

### Am I eating healthily?

**Answering the following questions can give you a good idea:**

- Are you eating five portions* of fruit and vegetables daily? □
- Do you eat reduced fat or fat-free varieties of dairy products? □
- Are you mainly using fats that are soft or liquid? □
- Do you drink 6-8 glasses of water a day? □
- Are your soft drinks always sugar free? □
- Are you active enough to maintain a healthy weight? □
- Are you eating oily fish such as salmon and mackerel at least twice a week? □

A portion of fresh, frozen or canned fruit or vegetables is about a handful. Dried fruit counts and a portion is about the same as you would eat if it were fresh – e.g. 3 apricots, 2 figs. Juice can only count as 1 portion a day, however much you drink. Potatoes don’t count towards 5 A DAY portions.

### Scoring the healthy eating quiz

If they answered NO to any of the above questions then there is a good chance that they would benefit from a few changes to their diet.

### Discussing the Healthy Eating Quiz

Ask the individual how they feel about their score OR begin a discussion using the following:

Your score suggests you could benefit from making a few changes to what you eat and drink. What do you think?

Do they have all the information they need to motivate them to want to change? Use the information below to highlight the benefits of changing to a healthier diet, as well as what a healthy diet should consist of.

### A healthy diet

A well-balanced diet includes food from the five main food groups. These are:

- Starchy foods: bread, cereals, pasta, rice and potatoes,
- Fruit (including fresh fruit juice) and vegetables,
- Meat and fish,
• Milk and dairy foods, and
• Fat and sugar.
Most people should be eating three main meals a day. Most people need to eat more starchy foods and more fruit and vegetables, as well as reduce their fat intake, drink less alcohol and eat less salt. Look for labels that say food is low in fat (particularly saturated fat), low in salt and sugar-free.

**Bread, rice, potatoes, pasta and other starchy foods**
Eat plenty, choose wholegrain varieties when you can

**Fruit and vegetables**
Eat plenty, at least five portions of a variety of fruit and vegetables a day. Choose a rainbow of colours of fruit and veg to help keep you healthy. Fresh, frozen, chilled, canned, 100% juice, and dried fruit and vegetables all count. Fruit and vegetables are packed with vitamins and minerals, low in calories and high in fibre. Eating lots of fruit and vegetables keeps the heart and body healthy. They are also an ideal alternative to eating crisps and chocolate as snacks between meals.

**Milk and dairy foods**
Eat some, choose lower fat alternatives whenever possible or eat higher fat versions infrequently or in smaller amounts.

**Meat, fish, eggs, beans and other non-dairy sources of protein**
Eat some, choose lower fat alternatives whenever possible or eat higher fat versions infrequently or in smaller amounts. Aim for at least two portions of fish a week, including a portion of oily fish.

**Fat and sugar**
Eat just a small amount.

**Salt**
Most of the salt we eat is already added to the food we choose – like bread, cereals, prepared sauces and meals. Try to choose options that are lower in salt when you can. Adults should have no more than 6 grams of salt a day.

**Healthy eating**
*Leaflets:*
5 A Day leaflet
5 A Day z card
Change4Life swap it don’t stop it
Change4Life top tips for top kids
[www.orderline.dh.gov.uk](http://www.orderline.dh.gov.uk)

*Web sites:*
For good information on all aspects of Healthy Living go to: [www.nhs.uk/livewell](http://www.nhs.uk/livewell)

For guidance on healthy activity and healthy eating guidance go to: [www.nhs.uk/change4life](http://www.nhs.uk/change4life)
5.9 Weight Management

Why is this important?

**Mortality**
- Obesity is associated with premature death, increasing the risk of a number of diseases, including the two major killers - cardiovascular disease and cancer;
- It is estimated that, on average, obesity reduces life expectancy by between three and 13 years – the more severe the obesity and the earlier it develops, the greater the excess mortality.

**Morbidity**
In public health terms, the greatest burden of disease arises from obesity-related morbidity:
- Type 2 diabetes is probably the most common obesity-related disease and that which is likely to cause the greatest health burden, with diabetes about 20 times more likely to occur in people who are very obese compared with people who are a healthy weight;
- Obese people have twice the risk of having physical disability, 84% increased risk of musculoskeletal illness and 35% increased risk of back problems;
- The risk of developing osteoarthritis is 3.5 times higher for obese people, the risk of other arthritis 4 times higher and the risk of having a disability requiring personal care 2.5 times higher.

**Brief interventions guidance - National guidelines**
There are four elements in a weight-loss programme that works:
- Eating right
- Being active
- Changing behaviour
- Getting support from family, GP, slimming club, or health trainer.

The best way to succeed in losing weight is to start making one or two realistic changes that can be kept to. Over time, they’ll begin to see results.

**Remember – a brief intervention**
- It is taking the opportunity to talk to someone about their excess weight or obesity
- It can take from 2-10mins depending on the time available
- It is to help the person move closer to the point of deciding to lose weight and understanding what works through taking one or more of the steps above
- It is NOT about trying to force people to lose weight
North Somerset Slimming on Referral Service
April 2015

Map of Medicine (Public Health > Lifestyle advice > Excess Weight NSCCG)
The complete care pathway with supporting information and referral forms for North Somerset Slimming on Referral Services is available on Map of Medicine.
Please use Map of Medicine to refer patients to this service if you are able

Information for GPs and Practice Nurses and Pharmacies
The Slimming on Referral service enables surgeries and pharmacies in North Somerset to refer obese adult patients for personalised weight management. This service is delivered in partnership with Weight Watchers® Health Solutions. Referrals can be made by GP’s or practice nurses. The first 12 weeks of the Slimming on Referral service is provided FREE to the patient. The scheme is funded by North Somerset Council’s Public Health team at a cost of £55 per patient. During the summer practices will start to receive monthly feedback reports from Weight Watchers® including details of referrals they have made to the service.

Patient Outcomes
Outcomes for patients are good with 74% of those completing 12 weeks of support losing 5% or more of their body weight.

Eligibility Criteria
Patients referred to the service must fulfil the following criteria to enter the scheme:

- Person aged 16 years or over and resident in North Somerset
- Person has not attended a commercial weight management group in the 12 months prior to referral (self-funded or referred by health professional)
- Person is not pregnant (if pregnant, refer to MSHINE programme, Tel: 01934 647082)
- Ready to lose weight (if not, refer to “Get Ready for Change” – Tel: 0300 300 0834).
- BMI 30 or more or BMI 27.5 or more if from BME population or BMI 28 with comorbidity*(Please check BMI before referring)
  OR
  - BMI > 98th centile on gender appropriate centile BMI charts, if aged 16-18 (Please check BMI before referring)

Exclusion criteria:
- Person has an eating disorder.
- Person has underlying medical cause for obesity which requires more intensive support.
- Patients with more complex needs, such as learning difficulties and mental health issues should be considered on an individual basis.
- Person is pregnant (refer to MSHINE programme, Tel: 01934 647082)

Referral Information
GP/Practice Nurse/Pharmacy:
If the patient has had their BMI checked, is eligible and demonstrates readiness to make behavioural change:
For Map of Medicine

- GP/practice nurse opens “Patient Referral Letter” which auto-populates with patient information from Map of Medicine.
- GP/practice nurse checks pre-populated patient information on letter, and completes any missing sections.
- GP/Practice nurse prints and gives Slimming on Referral “Patient Referral Letter” to patient.
- GP/practice nurse opens “GP Slimming Referral Form” which auto-populates with patient information from Map of Medicine.
- GP/practice nurse submits “GP Slimming Referral Form” through Map of Medicine.

If Map of Medicine is not available

- Send scanned version of referral form (available in NHS Health Checks Toolkit) via secure email to: slimming.onreferral@n-somerset.gcsx.gov.uk
  (Temporarily we will accept hard copies, please send them to: Slimming on Referral Team, North Somerset Council, Post point 10, Public Health, Castlewood, Tickenham Road, Clevedon, BS21 6FW, or by fax: 01275 884 184)

Patient:

- Patient calls telephone number on “Patient Referral Letter” and quotes code WWRS082 and their NHS number. (Tel: 0345 602 7068, Monday to Sunday 8:00am – 8:00pm)
- When patient contacts Weight Watchers® they will double check their eligibility, book them on to their preferred group and issue them with their vouchers.

An up to date list of local Weight Watchers® groups can be found online here: www.weightwatchers.co.uk/util/mtf/wide.aspx

Subsequent referrals

Patients with a starting BMI greater than 35 who complete the first 12 weeks may be eligible for a second set of funded vouchers.

Practice feedback

During the summer Public Health will start to send out quarterly reports on patient progress to practices. The practice will then be responsible for following up with patients, supported by the information from Public Health.

Map of Medicine (Public Health > Lifestyle advice > Excess Weight NSCCG)

The complete care pathway with supporting information for North Somerset Weight Management Services is available on Map of Medicine.

Information

For more information about the Slimming on Referral service please contact:
Samuel Hayward
Email: Samuel.hayward@n-somerset.gov.uk, Tel: 01934 42 6528

*Comorbidities include: Cardiovascular/Coronary Heart Disease, Hypertension/High Blood Pressure, Stroke, Type 2 Diabetes, Abnormal Blood Fats, Metabolic Syndrome, Cancer, Osteoarthritis/Limited Mobility, Sleep Apnoea, Reproductive Problems, Depression, Asthma, Liver disease, Kidney disease and Gallstones
# Slimming on Referral Form

1. This form should be completed electronically (hard copies accepted)
2. Email to the secure address shown or print and post to address below.
3. Please inform the patient their contact details are being forwarded to the Slimming on Referral Team at North Somerset Council.
4. The patient needs to contact Weight Watchers to complete their referral with information contained in the Patient Referral Letter

<table>
<thead>
<tr>
<th>Patient name:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS number:</td>
<td>Current BMI:</td>
</tr>
<tr>
<td>Date of birth:</td>
<td>Gender:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Address:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phone (home):</td>
</tr>
<tr>
<td>Referrer’s name:</td>
</tr>
<tr>
<td>Practice name and address:</td>
</tr>
<tr>
<td>Practice code:</td>
</tr>
</tbody>
</table>

**Referral details**
Please check the boxes to show the patient is eligible for referral to the scheme.

- [ ] Aged 16 years or over and resident in North Somerset
- [ ] Has not attended a commercial weight management group in the 12 months prior to referral (self-funded or referred by health professional)
- [ ] Not pregnant (if pregnant, refer to MSHINE)
- [ ] Ready to lose weight (if not, refer to “Get Ready for Change”)
- [ ] BMI 30 or more or BMI 27.5 or more if from BME population or BMI 28 with comorbidity*  
- **OR**  
  - [ ] BMI > 98th centile on gender appropriate centile BMI charts, if aged 16-18

- [ ] The patient has received a Slimming on Referral “Patient Referral letter”

**Please return this form to the Slimming on Referral team**

<table>
<thead>
<tr>
<th>Method</th>
<th>Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>By email:</td>
<td><a href="mailto:Slimming.onreferral@n-somerset.gcsx.gov.uk">Slimming.onreferral@n-somerset.gcsx.gov.uk</a> (secure email)</td>
</tr>
<tr>
<td>By post:</td>
<td>North Somerset Council, Public Health, Castlewood, Tickenham Road, Clevedon, BS21 6FW</td>
</tr>
<tr>
<td>By Fax:</td>
<td>01275 884184</td>
</tr>
</tbody>
</table>

* Comorbidities include: Cardiovascular/Coronary Heart Disease, Hypertension/High Blood Pressure, Stroke, Type 2 Diabetes, Abnormal Blood Fats, Metabolic Syndrome, Cancer, Osteoarthritis/Limited Mobility, Sleep Apnoea, Reproductive Problems, Depression, Asthma, Liver disease, Kidney disease and Gallstones
North Somerset Slimming on Referral Service

Section to be completed by referring health professional:

<table>
<thead>
<tr>
<th>Date:</th>
<th>NHS number:</th>
</tr>
</thead>
<tbody>
<tr>
<td>GP Practice code:</td>
<td>Referrer’s name:</td>
</tr>
<tr>
<td>Referrer’s position:</td>
<td>Referrer’s phone:</td>
</tr>
</tbody>
</table>

Dear Patient,

Your doctor or practice nurse or Pharmacy has suggested you would like to join the North Somerset Slimming on Referral service. This service is designed to support you to lose weight. Losing weight can significantly benefit your health and wellbeing, so it’s great that you would like to join our service. North Somerset Council is working in partnership with Weight Watchers® to offer a programme of support to help you reach a healthier weight.

Call this number to complete your booking or to be given further information:

**0345 602 7068* quoting WWRS082**

Monday – Sunday 8.00 am – 8.00 pm

*0345 numbers from a landline will cost around 2p per minute to call during the daytime and about 0.5p per minute at all other times dependent on the provider. Calling from mobiles will incur higher costs.*

Weight Watchers® friendly staff will talk you through the process and make sure this is what you really want to do. The team will help you find a suitable meeting to join, make you an appointment and send you your pack for 12 weeks membership at Weight Watchers® for FREE!

For more information about Weight Watchers® visit [www.weightwatchers.co.uk](http://www.weightwatchers.co.uk)

Weight Watchers® meetings are welcoming, motivating, supportive, friendly and great fun! They are run by Leaders who themselves have successfully lost weight with Weight Watchers®. They have learnt how to deal with the challenges of losing weight and are passionate experts in supporting others to achieve weight loss. Every week in our hour long meetings different real life weight loss topics are discussed and ideas, solutions and support shared. You also get individual, confidential support at your weekly weigh in to help you achieve your weight loss goals.

Good luck on your journey to a new healthier you!

Yours sincerely,

Carmen Page

Slimming on Referral Team
Weston-super-Mare Men’s Weight Management Service
April 2015

Information for Health Professionals
The new Man v Fat service will enable health professionals in North Somerset to refer obese men for personalised weight management support. This service is funded by North Somerset Council’s Public Health team and is delivered in partnership with Man v Fat. Referrals can be made by any health professional or by self referral. The first 12 weeks of support will be provided FREE to the participants.

Inclusion criteria:
Men aged 18 years or more and resident in Weston-super-Mare, North Somerset with:

- BMI equal to or greater than 30.
- BMI equal to or greater than 28 with a comorbidity* or from BME population.
- Man is ready to lose weight (if not, refer to “Get Ready for Change”- 0300 300 0834)

Suitability criteria:
The services suitability for men should be considered on an individual basis with details shared with Man v Fat. Please consider suitability for:

- Men with more complex needs, such as learning difficulties and mental health issues.
- Young men aged 16 or 17 years.

Exclusion criteria:

- Man has an eating disorder.
- Man has underlying medical cause for obesity which requires more intensive support.

Referral information
The first Man v Fat groups will be running in Weston-super-Mare over the summer months. If you work with men who would like to join the sessions, or would like more information about Man v Fat, then please give them this number to call:

0800 020 9535

Or simply email their contact details to:

paul@manvfat.com

Service information
If you have any questions regarding this new service, are interested in working in partnership with Man v Fat, or would like to host or deliver a Man v Fat group, then please get in touch with Paul Rossiter who is delivering the service: paul@manvfat.com

www.manvfat.com

*Comorbidities include: Cardiovascular/Coronary Heart Disease, Hypertension/High Blood Pressure, Stroke, Type 2 Diabetes, Abnormal Blood Fats, Metabolic Syndrome, Cancer, Osteoarthritis/Limited Mobility, Sleep Apnoea, Reproductive Problems, Depression, Asthma, Liver disease, Kidney disease and Gallstones
READY TO SAY GUT RIDDANCE?
MAN v FAT CLUB IS HERE TO HELP

MAN v FAT Club is a weekly, no-nonsense, men only weight loss group that will help you reach your goals.

We support you, motivate you and give you information and challenges to get you healthy.

OVER 30,000 MEN LOSE WITH US EVERY WEEK
NOW IT’S YOUR TURN!

CALL 0800 020 9535 TO BOOK NOW. LIMITED PLACES AVAILABLE

FOR MORE INFORMATION EMAIL PAUL@MANVFAT.COM OR VISIT WWW.MANVFAT.COM
5.10 Alcohol

Why is this important?

- Drinking above recommended limits exposes individuals to increased risk to some common diseases which the NHS Health Check is designed to address.
- Men who regularly drink above 3 to 4 units per day are four times more likely to develop hypertension and twice as likely to have a stroke than men who drink within recommended limits.
- Women who regularly drink above recommended limits of 2-3 units per day are twice as likely to develop hypertension and four times more likely to have a stroke than women who drink within recommended limits.
- For some people alcohol consumption contributes to weight gain and may be an important consideration in a weight loss programme.
- A large number of randomised controlled trials have shown that opportunistic screening and brief intervention is effective and cost-effective in reducing excessive alcohol consumption in primary care—even more effective than advising people to quit smoking!

Those people already with disease who are estimated to be drinking above recommended guidelines on a regular basis

<table>
<thead>
<tr>
<th>Condition</th>
<th>Men</th>
<th>Women</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hypertension</td>
<td>42%</td>
<td>10%</td>
</tr>
<tr>
<td>CHD</td>
<td>34%</td>
<td>6%</td>
</tr>
<tr>
<td>Stroke</td>
<td>33%</td>
<td>7%</td>
</tr>
<tr>
<td>Diabetes</td>
<td>35%</td>
<td>8%</td>
</tr>
<tr>
<td>Kidney Disease</td>
<td>26%</td>
<td>6%</td>
</tr>
<tr>
<td>Depression</td>
<td>42%</td>
<td>16%</td>
</tr>
</tbody>
</table>

Everyone should be asked about the frequency at which they are drinking alcohol. For many people, drinking alcohol with friends and family will be part of their social lives and not be problematic; however, there will be a significant group of people who are drinking at increasing or high risk levels. Brief intervention in the form of advice and information is
very effective getting people to modify their behaviour. One in eight people will modify their drinking to within lower risk levels as a result of being given brief advice by a trained professional. The summarised brief intervention and an example conversation are provided below:

Remember: A brief intervention is about
- It is taking the opportunity to talk to someone about their drinking
- It can take from 2-10 mins depending on the time available
- It is to help the person move closer to the point of deciding to modify their drinking
- It is NOT about trying to force people to cut down or stop
Alcohol Care Pathway
NHS Health Check Route Highlighted

- Requesting help with alcohol problem
- Newly registered? Assess using DES
- Other health complaint

Initial screen with AUDIT-C

- Positive result
  - Full screen AUDIT (or further clinical assessment)
  - Suspected significant dependence or complex case of higher or increasing risk drinking
    - Refer to ARA for full assessment
  - Suspected uncomplicated case of higher or increasing risk drinking
    - Provide Brief Advice

- Negative result
  - Congratulate and provide brief information on benefits of lower risk drinking

Addaction 35 Boulevard Weston-super Mare BS23 1PE

Opening times: Mon, Tue, Thu (8am-5pm), Wed, Fri (8am-8pm), Sat (10am-1pm), Sun (10.30am-12.30pm) Town Hall Library.

Addaction provide a full range of services including:
- Specialist treatment for both drug and alcohol problems.
- What are lower risk drinking levels
- Patient is already at higher risk
- What are the health risks
- The potential benefits of cutting down
- Some suggestions/tips for cutting down
- Options for added support if necessary
- Give leaflet below
How many units are in your drink?

- **PINT OF LAGER**
  - 4% ABV
  - **2.3 UNITS**

- **PINT OF BITTER**
  - 5% ABV
  - **2.8 UNITS**

- **PINT OF STRONG BEER/LAGER/CIDER**
  - 5.2% ABV
  - **3 UNITS**

- **500ml CAN OF LAGER**
  - 3.8% ABV
  - **1.9 UNITS**

- **750ml BOTTLE OF WINE**
  - 13.5% ABV
  - **10 UNITS**

- **175ml GLASS OF RED OR WHITE WINE**
  - 13% ABV
  - **2.3 UNITS**

- **250ml GLASS OF RED OR WHITE WINE**
  - 13% ABV
  - **3.3 UNITS**

- **50ml GLASS OF FORTIFIED WINE (E.G. SHERRY)**
  - 20% ABV
  - **1 UNIT**

- **25ml SINGLE SPIRIT AND MIXER**
  - 40% ABV
  - **1 UNIT**

- **50ml DOUBLE SPIRIT AND MIXER**
  - 40% ABV
  - **2 UNITS**

- **275ml BOTTLE OF ALCO-POP**
  - 5% ABV
  - **1.4 UNITS**

- **50ml DOUBLE IRISH CREAM LIQUEUR**
  - 20% ABV
  - **1 UNIT**
Section 6: Practical Guidance for NHS Health Checks

6.1 NHS Health Check Competence Framework
It is crucial that anyone delivering the NHS Health Check does so to a minimum standard. This will support the overall aim of equality in delivery and the best possible outcomes for people having an NHS Health Check.

The competences reflect the minimum standards expected of all practitioners delivering the NHS Health Check, regardless of their level. Commissioners and NHS Health Check providers must satisfy themselves, in a manner that is auditable, that this is the case and that it continues to be so as the programme evolves and staff members change.

The Competence Framework was published in February 2015 and contains details of all the relevant competencies for all staff who may be involved in NHS Health Checks, including health trainers, pharmacists, pharmacy staff, healthcare assistants, nurses and GPs. The framework is accompanied by a Learner Handbook and an Assessor Handbook to enable those delivering NHS Health Checks to be sure they meet all the competencies and to support those assessing to be sure the competencies are met. A link to the three documents is here. http://www.healthcheck.nhs.uk/commissioners_and_healthcare_professionals/national_guidance/

All those delivering NHS Health Checks in North Somerset should be assessed to ensure they meet the competencies by April 2016. North Somerset Council is facilitating this assessment by producing materials to assist learning and assessment and employing a Nurse lead to support practices.
6.2 On line QRISK2 Calculator

Welcome to the QRISK®2-2011 risk calculator: http://qrisk.org

Please check out:
- http://nightingale.org, which has both QRISK® and QRISK®2, and will be updated to the 2011 versions of both soon, and

Welcome to the QRISK®2-2011 cardiovascular disease risk calculator

Welcome to the QRISK®2-2011 risk Calculator. You can use this calculator to work out your risk of having a heart attack or stroke over the next ten years by answering some simple questions. It is suitable for people who do not already have a diagnosis of heart disease or stroke.

The QRISK®2 algorithm has been developed by doctors and academics working in the UK National Health Service and is based on routinely collected data from many thousands of GPs across the country who have freely contributed data for medical research. It is updated annually each April, retitled to the latest data to remain as accurate as possible.

Whilst QRISK®2 has been developed for use in the UK, it is being used internationally. For non-UK use, if the postcode field is left blank the score will be calculated using an average value. Users should note, however, that CVD risk is likely to be underestimated in patients from deprived areas and overestimated for patients from affluent areas. All medical decisions need to be taken by a patient in consultation with their doctor. The authors and the sponsors accept no responsibility for clinical use or misuse of these scores.

The science underpinning the new QRISK® equations has been published in the British Medical Journal.

Click here for more information on QRISK®2.

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6.3 Blood Pressure Measurement

- Outline the procedure briefly; in particular warning them of the minor discomfort caused by inflation and deflation of the cuff.
- Explain that measurement may be repeated three times.
- Ensure the client is sitting down. Once they are comfortable ask the client to remove any tight or restrictive clothing from the arm.

Measuring blood pressure

- Healthcare professionals taking blood pressure measurements need adequate initial training and should have their performance reviewed periodically. Training should reflect the most recent NICE guidance.
- Devices for measuring blood pressure must be properly validated, maintained and regularly recalibrated according to manufacturers’ instructions.
- If using an automated blood pressure monitoring device, ensure that the device is validated and an appropriate cuff size for the person’s arm is used.
When measuring blood pressure provide a relaxed, temperate setting, with the person quiet and seated, and their arm outstretched and supported. Palpate the radial or brachial pulse before measuring blood pressure, since automated devices may not measure blood pressure accurately if there is pulse irregularity (for example, due to atrial fibrillation). If pulse irregularity is present, measure blood pressure manually, using direct auscultation over the brachial artery. If the blood pressure measurement exceeds 140mm/Hg systolic and/or 90mm/Hg diastolic, take a secondary reading after 2-3 minutes and again 2-3 minutes later (or towards the end of the health check) and take the average of the second and third readings.

Relevant NICE Guidance (Hypertension: Clinical management of primary hypertension in adults: August 2011)
http://www.nice.org.uk/CG127

6.4 Height Measurement for QRISK2
- Height measurement should not be taken if the individual is immobile and/or does not feel safe standing still, or if the practitioner does not feel safe to support the client whilst they are being measured.
- In measuring for height, the clinician should place the stadiometer against a wall on an even, flat surface; ideally a hard floor.
- The client must be positioned with their feet together, feet flat on the ground and heels touching the back plate of the stadiometer. Their legs must be straight, buttocks against the backboard, scapula wherever possible against the backboard and arms loosely at their side.
- The clinician should then pull down the upper section of the stadiometer until the horizontal plate touches the individual's head.
- The clinician should then make a note of the individual's height in centimetres. This data should then be entered onto the template.
- If the individual requests their height measurement in feet and inches the clinician should use a conversion chart to cross reference the height against metres and centimetres.

6.5 Weight Measurement for QRISK2
- The clinician should not weigh the individual if they are immobile and/or does not feel safe standing still, or if the clinician does not feel safe to support the client whilst they are being measured.
- The clinician should place the scales on an even, flat surface; ideally a hard floor.
- The clinician should then level the scales by adjusting the feet underneath, using the level on the side of the scales as a guide.
- Once the scales turn off the clinician should tap them to turn back on and they should show zero.
• The clinician should ensure both of the individual’s feet are in the middle of the scales and that they have let go of anything they may have been holding once they have their balance.
• The clinician should then make a note of the individual’s weight in kilograms. This data should then be entered into the template.
• If the client requests their weight measurement in stones and pounds the clinician should use a conversion chart to cross reference the weight against kilograms and grams.

6.6 Interpreting Body Mass Index
Body mass index (BMI) is used to assess if a person’s weight lies within the healthy range for their physical height and age. This can be determined using the patient’s weight in kilograms and height in metres.

The on line QRISK2 risk assessment tool or PharmOutcomes will automatically calculate BMI using height and weight. When you give the results to the client use the results pack to explain what this means. The chart below will help you to explain what this means and in setting a goal with someone.

<table>
<thead>
<tr>
<th>Obesity Classification</th>
<th>BMI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under weight</td>
<td>Less than 18.5</td>
</tr>
<tr>
<td>Healthy weight</td>
<td>18.5-24.9</td>
</tr>
<tr>
<td>Overweight</td>
<td>25-29.9</td>
</tr>
<tr>
<td>Obesity I</td>
<td>30-34.9</td>
</tr>
<tr>
<td>Obesity II</td>
<td>35-39.9</td>
</tr>
<tr>
<td>Obesity III</td>
<td>40 or more</td>
</tr>
</tbody>
</table>

Thresholds:
BMI of 27.5 or over in individuals from the Indian, Pakistani, Bangladeshi, other Asian and Chinese ethnicity categories
BMI of 30 or over in other ethnicity categories.

6.7 Performing a fingerstick Puncture
In order to perform a quality fingerstick puncture the assessing clinician should:
• Ensure the Individual’s finger is clean and dry.
• Use one of the middle fingers of the non-writing hand.
• Clean the finger with an alcohol swab, to remove any fats.
• Dry the finger thoroughly with sterile gauze, to wipe off residual alcohol.
• Prepare a single retractable blade lancet.
• Place the finger on the table, to allow the practitioner to press down firmly.
• Perform a deep and firm puncture, in the side of the middle finger approximately 5mm from the edge of the nail; pressing down firmly to ensure a deep enough penetration.
• Dispose of the lancet in the sharps container.
• Create a free flowing drop of blood.
• Wipe off the first large drop of blood, as this may contain tissue fluid and tissue detritus.
• Keeping the patients hand below heart level, squeeze the tip of the finger until a second large drop of blood forms.
• Hold the capillary tube at a slightly descending angle to the drop of blood.
• Touch the capillary tube into the drop of blood and the tube will fill by capillary action.
• If there is not enough blood then the process should be repeated.
• Dispense the blood from the filled capillary tube using manufacturer's instructions.
• Dispose the used capillary tube in the sharps container.

6.8 Performing a Cholesterol Test

This should be performed in line with the manufacturer's instructions. These can be found at: http://cardiochek.com/index.php?option=com_content&view=article&id=96&Itemid=250

The local Cardiochek rep will also come to the practice to provide training.

Explaining Cholesterol Readings

Cholesterol is a lipid (fat chemical) that is made in the liver from fatty foods that we eat. A certain amount of cholesterol is present in the bloodstream. Some cholesterol is needed to keep healthy. Cholesterol is carried in the blood as part of particles called lipoproteins. There are different types of lipoproteins, but the most relevant to cholesterol are:

- Low-density lipoproteins carrying cholesterol - LDL cholesterol. This is often referred to as bad cholesterol. This is the one mainly involved in forming atheroma. (Atheroma is the main underlying cause of various cardiovascular diseases). The majority of cholesterol in the blood is LDL cholesterol, but how much varies from person to person.
- High-density lipoproteins carrying cholesterol - HDL cholesterol. This is often referred to as good cholesterol. This may prevent atheroma forming.

Cholesterol blood levels

The following levels are generally regarded as desirable:

- **Total cholesterol** should be 5.0 millimoles per litre (mmol/l) or lower. The average in the UK is actually around 5.5 mmol/l for men and 5.6 mmol/l for women.
- **LDL cholesterol** should be 3mmol/L or lower
- **HDL level** above 1 mmol/l
- **Ratio of total cholesterol to HDL** - total cholesterol divided by HDL - should be below 5

People with higher risks, such as heart disease or high blood pressure will be set lower targets:

NB the CardioChek Analyser as used within N Somerset, uses cholesterol testing strips (use according to instructions and training) and gives 3 measurements as a result.

1. Total cholesterol (in mmol/L)
2. HDL cholesterol (in mmol/L)
3. Ratio of TC/HDL (sometimes this reading is not displayed – just a line. This indicates that the ratio is excellent (very low – beyond the capacity of the machine to calculate)
Appendix 1 – Assessing physical activity

General Practice Physical Activity Questionnaire

Date.................................
Name.................................

1. Please tell us the type and amount of physical activity involved in your work.

<table>
<thead>
<tr>
<th></th>
<th>Please mark one box only</th>
</tr>
</thead>
<tbody>
<tr>
<td>a</td>
<td>I am not in employment (e.g. retired, retired for health reasons, unemployed, full-time carer etc.)</td>
</tr>
<tr>
<td>b</td>
<td>I spend most of my time at work sitting (such as in an office)</td>
</tr>
<tr>
<td>c</td>
<td>I spend most of my time at work standing or walking. However, my work does not require much intense physical effort (e.g. shop assistant, hairdresser, security guard, childminder, etc.)</td>
</tr>
<tr>
<td>d</td>
<td>My work involves definite physical effort including handling of heavy objects and use of tools (e.g. plumber, electrician, carpenter, cleaner, hospital nurse, gardener, postal delivery workers etc.)</td>
</tr>
<tr>
<td>e</td>
<td>My work involves vigorous physical activity including handling of very heavy objects (e.g. scaffoldor, construction worker, refuse collector, etc.)</td>
</tr>
</tbody>
</table>

2. During the last week, how many hours did you spend on each of the following activities?
Please answer whether you are in employment or not

<table>
<thead>
<tr>
<th></th>
<th>None</th>
<th>Some but less than 1 hour</th>
<th>1 hour but less than 3 hours</th>
<th>3 hours or more</th>
</tr>
</thead>
<tbody>
<tr>
<td>a</td>
<td>Physical exercise such as swimming, jogging, aerobics, football, tennis, gym workout etc.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b</td>
<td>Cycling, including cycling to work and during leisure time</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c</td>
<td>Walking, including walking to work, shopping, for pleasure etc.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>d</td>
<td>Housework/Childcare</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>e</td>
<td>Gardening/DIY</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

3. How would you describe your usual walking pace? Please mark one box only.

- Slow pace (i.e. less than 3 mph)
- Brisk pace
- Steady average pace
- Fast pace (i.e. over 4 mph)
**Basic GP PAQ Calculation**

The General Practice Physical Activity Questionnaire (GP PAQ) takes approximately 30 seconds to fill in. It is a validated screening tool that:

- Is used to assess adult (16–74 years) physical activity levels.
- Provides a simple, 4-level Physical Activity Index (PAI) of – **Active, Moderately Active, Moderately Inactive, and Inactive** – that is correlated to cardiovascular disease risk.
- Is used to help inform a practitioner of when a brief intervention to increase physical activity is appropriate. All patients who receive a score less than **Active** should be offered a Brief Intervention in Physical Activity.

**A. CALCULATING THE 4-LEVEL PHYSICAL ACTIVITY INDEX (PAI)**

**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.

<table>
<thead>
<tr>
<th>Hours per week</th>
<th>Occupation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Spent on Physical Exercise such as Swimming, Jogging, Gym, Football etc...</strong></td>
<td><strong>Not in employment OR Most of my time at work is spent sitting</strong></td>
</tr>
<tr>
<td>None</td>
<td>inactive</td>
</tr>
<tr>
<td>Less than 1 Hour</td>
<td>moderately inactive</td>
</tr>
<tr>
<td>Between 1 and 3 Hours</td>
<td>moderately active</td>
</tr>
<tr>
<td>More than 3 Hours</td>
<td>active</td>
</tr>
</tbody>
</table>
B. ASSESSING INACTIVE PATIENTS WHO SELF REPORT 3 HOURS OR MORE PER WEEK OF WALKING

Patients who fall within the inactive category, but claim to undertake significant amounts of walking may require a modified, brief intervention that probes their understanding of walking and walking pace and the basis upon which they have declared the amount of walking accumulated during the last week.

For those patients who remain confident that they achieve the recommended levels of physical activity by virtue of their walking intensity and duration, encourage them to continue.

Ensure you assess the level of intensity of walking, you can use the following tool to assess intensity:

0 breathing easily, conversation is easy
1 breathing lightly and talking easily but heart rate increases
2 still talking comfortably but breathing more quickly body warming up
3 breathing more deeply and harder, talking with a little more difficulty
4 breathing very hard and short of breath, cannot carry on a conversation

Light Activity 0-1 Moderate Activity 2-3 Vigorous Activity 4

Patients should be hitting 2-3 for the walking to count towards their activity level
Appendix 2 – Alcohol questionnaire

**AUDIT – C**

<table>
<thead>
<tr>
<th>Questions</th>
<th>Scoring system</th>
<th>Your score</th>
</tr>
</thead>
<tbody>
<tr>
<td>How often do you have a drink containing alcohol?</td>
<td>Never</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Monthly or less</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>2 - 4 times per month</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>2 - 3 times per week</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>4+ times per week</td>
<td>4</td>
</tr>
<tr>
<td>How many units of alcohol do you drink on a typical day when you are drinking?</td>
<td>1 - 2</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>3 - 4</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>5 - 6</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>7 - 9</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>10+</td>
<td>4</td>
</tr>
<tr>
<td>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?</td>
<td>Never</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Less than monthly</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Monthly</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Weekly</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Daily or almost daily</td>
<td>4</td>
</tr>
</tbody>
</table>

**Scoring:**
A total of 5+ indicates increasing or higher risk drinking.
An overall total score of 5 or above is AUDIT-C positive.
Score from AUDIT- C (other side)
Remaining AUDIT questions

<table>
<thead>
<tr>
<th>Questions</th>
<th>Scoring system</th>
<th>Your score</th>
</tr>
</thead>
<tbody>
<tr>
<td>How often during the last year have you found that you were not able to</td>
<td>Never Less than monthly Monthly</td>
<td>Daily or almost daily</td>
</tr>
<tr>
<td>stop drinking once you had started?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>How often during the last year have you failed to do what was normally</td>
<td>Never Less than monthly Monthly</td>
<td>Daily or almost daily</td>
</tr>
<tr>
<td>expected from you because of your drinking?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>How often during the last year have you needed an alcoholic drink in the</td>
<td>Never Less than monthly Monthly</td>
<td>Daily or almost daily</td>
</tr>
<tr>
<td>morning to get yourself going after a heavy drinking session?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>How often during the last year have you had a feeling of guilt or remorse</td>
<td>Never Less than monthly Monthly</td>
<td>Daily or almost daily</td>
</tr>
<tr>
<td>after drinking?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>How often during the last year have you been unable to remember what</td>
<td>Never Less than monthly Monthly</td>
<td>Daily or almost daily</td>
</tr>
<tr>
<td>happened the night before because you had been drinking?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have you or somebody else been injured as a result of your drinking?</td>
<td>No Yes, but not in the last year</td>
<td>Yes, during the last year</td>
</tr>
<tr>
<td>Has a relative or friend, doctor or other health worker been concerned</td>
<td>No Yes, but not in the last year</td>
<td>Yes, during the last year</td>
</tr>
<tr>
<td>about your drinking or suggested that you cut down?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**TOTAL (including score from page 1)**

**Scoring:** 0 – 7 Lower risk, 8 – 15 Increasing risk, 16 – 19 Higher risk, 20+ Possible dependence
Appendix 3

Quality Control Schedule

A grey Check Strip is included in the analyser carrying case to verify the CardioChek PA’s basic functionality of the electronic and optic systems. **This test should be carried out at the beginning of every testing day**

**How to Use the Check Strip:**
1. Turn the analyser ON by pressing either button (        or        )
2. When INSTALL MEMO CHIP or RUN TEST is displayed, press        until UTILITY is displayed. Press        
3. Press        when CK STRIP is displayed
4. Insert the Check Strip, ribbed side up, into the Test Strip Insert Opening
5. The analyser should display PASSED (If the display reads FAILED, try again with the other strip supplied)
6. Remove the Check Strip and store it in the analyser carrying case
7. Press        until EXIT is displayed. Press        
8. Press        until RUN TEST is displayed
9. Press        . The analyser is ready to run tests

**Internal Quality Control**
Controls are tested to verify the performance of your entire test system: **You should run one colour every time you open a new pack of strips.** So when the first pack is opened, use the white solution on the first strip. When the next pack of strips is opened, use the yellow on the first strip. When all the colours have been used (after 4 packs), re-cycle through the colours in the same order.

**NOTE:** When running the Mulitchemistry solutions (white & red), only read the total cholesterol and the glucose readings. When using the HDL solutions (yellow & green), only read the HDL results. Both sets of solutions come with their own reference range sheet.

The **yellow** glucose strip is a **single analyte** strip so you will need to refer to the top row of the reference ranges (illustrated on the next page). The **turquoise** cholesterol & HDL strip is a **multi analyte** strip and therefore on the bottom row of the reference ranges.

**How to Run a Quality Control Test:**
1. Install correct MEMo Chip for the lot of strips that you are using
2. Press either button (        or        ) to turn the analyser ON
3. Press        until the display reads UTILITY
4. Press        Press        until RUN CONTROL is displayed. Press        
5. Insert the test strip into the analyser. The CardioChek PA will display APPLY SAMPLE. This indicates the system is ready for a sample (control) to be applied. Immediately replace the vial cap, making sure the strip vial is closed tightly.
6. Remove control cap and turn bottle upside down. **CONTROL MUST BE APPLIED TO TEST STRIP WITHIN 2 MINUTES OF REMOVING THE STRIP FROM THE VIAL.**
7. Hold bottle directly over and perpendicular to the white reaction area on the test strip. Squeeze bottle so that a small drop of control solution is formed. Allow the drop of control solution to fall onto the test strip. Do not allow the tip of the bottle to touch the test strip. Replace control cap
8. Results will be displayed within about one to two minutes (for most tests)
9. Remove and discard test strip
10. Compare control results to the values on the Quality Control Range Card included with control solutions. Make sure to match the correct test strip lot number(s) and levels depending on the control solution used (please see below, ranges pictured are examples only).
14. To exit the control testing menu press twice. RUN CONTROL will be displayed
15. Press until EXIT is displayed. Press
16. Press until RUN TEST is displayed. Press
External Quality Control

A 30 μl Minipet (as shown) is supplied with the first Distribution after enrolment and MUST be used for the Chol and HDL panel. This should be kept in a safe place as it will be required to process the monthly BQAS samples.

If a replacement is required please contact BHR.

Bolton Quality Assurance Scheme

QA Sample Testing

QA Testing kit – sent in black plastic bag
Store samples in fridge 2-8°C if you are unable to process immediately

+ [Image of test tube] + [Image of syringe] =

Analyse QA sample using the same system that you would a patient sample, but using the appropriate Minipet with a pipette tip

Discard QA sample, pipette tip and test strip

Submit results to Bolton Quality Assurance Scheme via email BQAS@boltonft.nhs.uk on template (example below) before deadline

[Image of template with instructions]
Ensure your practice or pharmacy contacts BHR if your results are unsatisfactory (after checking other possible reasons in table below)
<table>
<thead>
<tr>
<th>MESSAGE/PROBLEM</th>
<th>POSSIBLE CAUSE</th>
<th>SOLUTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHANGE BATTERY</td>
<td>Replace battery</td>
<td>Replace all batteries (AAA batteries).</td>
</tr>
<tr>
<td>LOW TEMP</td>
<td>Analysser below acceptable temperature to operate.</td>
<td>Move the analyser to a warmer environment.</td>
</tr>
<tr>
<td>HI TEMP</td>
<td>Analysser above acceptable temperature to operate.</td>
<td>Move the analyser to an environment at room temperature.</td>
</tr>
<tr>
<td>INSTALL MEMO CHIP</td>
<td>Memo chip not inserted correctly.</td>
<td>Re-insert the memo chip or use a different memo chip.</td>
</tr>
<tr>
<td>EXPIRED LOT</td>
<td>Test strips have expired or wrong memo chip inserted.</td>
<td>Check correct memo chip is inserted.</td>
</tr>
<tr>
<td></td>
<td>Analysser date is incorrect.</td>
<td>Check expiry date on test strip tube.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Check date is correct on analyser.</td>
</tr>
<tr>
<td>TEST ABORTED</td>
<td>Test strip removed before the test was complete or the test strip was not properly inserted.</td>
<td>Run the test again using a fresh test strip.</td>
</tr>
<tr>
<td>- - - - or N/A</td>
<td>Result not available due to value being outside the measuring range of the machine, or due to missing value from calculation.</td>
<td>Run the test again using a fresh test strip.</td>
</tr>
<tr>
<td>A displayed result reads &gt; (greater than) a value.</td>
<td>Result is above the range able to be measured by the machine.</td>
<td>Run the test again using a fresh test strip.</td>
</tr>
<tr>
<td>A displayed result reads &lt; (less than) a value.</td>
<td>Result is below the range able to be measured by the machine.</td>
<td>Run the test again using a fresh test strip.</td>
</tr>
</tbody>
</table>

Always check the following:

- Test strips are stored correctly according to the Manufacturer’s Guidelines.
- Ensure the test strip insert opening is free of any debris. Clean as per Manufacturer’s recommendations.
- Check the test strips and Memo chip have the same Lot Number.
- The lid is replaced on the test strip tube when not in use. Ensure the lid is not left off the tube for any length of time.