Dorset Council

Public Health Dorset
Part of BCP and Dorset Councils

Service 1

Provision of NHS Health Checks

Reference DN709907
April 2024

Service Specification

1. Introduction

1.1. Public Health Dorset (PHD) aims to improve and protect the health and wellbeing of the local population with an emphasis on reducing health inequalities. We are a shared service across Bournemouth, Christchurch and Poole (BCP) Council and Dorset Council.

1.2. Public Health Dorset is the Commissioner of Community Health Improvement Services (CHIS) which includes NHS Health Checks, Emergency Hormonal Contraception (EHC), Long-Acting Reversible Contraception (LARC), Needle Exchange, Supervised Consumption and Smoking Cessation.

1.3. This Service Specification sets out the requirements for the provision of NHS Health Checks in accordance with the national programme. The focus of the Service is to provide NHS Health Checks to the eligible population within Dorset County boundaries.

1.4. LiveWell Dorset (LWD) is a free service for adults in the county of Dorset who would like to improve their health and wellbeing. https://www.livewelldorset.co.uk/ LWD provides a single point of contact and referral management for health improvement services.

1.5. LWD offers additional behavioural support for people who may benefit from it including support pathways for weight management, physical activity, smoking cessation, and brief interventions for alcohol.

1.6. LWD will also provide additional capacity to the system by delivering NHS Health Checks to communities with high cardiovascular disease risk and in communities without primary care delivery.

1.7. The Provider will work in conjunction with LiveWell Dorset (LWD) to deliver the NHS Health Checks service.

1.8. Public Health Dorset will maintain real-time online lists of active Providers of the service which will be accessible by the public.

1.9. A description of the pathway of delivery of NHS Health Checks and the referral processes to either 1) GPs or 2) LWD are set out in Paragraph 3-Service Description and Pathways.

2. Scope of Service

2.1. The aims of the Service are to:

- Reduce the risk of cardiovascular disease in the eligible population of Dorset County
- Reduce health inequalities
- Increase awareness of the risks relating to lifestyle surrounding cardiovascular disease

- Increase uptake of behaviour change programmes to improve health outcomes in the local population

2.2. Access to service

2.2.1. Eligible service users are:

- Aged between 40 and 74*
- Not received a NHS Health Check in the last 5 years*
- Not have a previously identified disease as listed below*
  - coronary heart disease
  - chronic kidney disease (CKD) (classified as stage 3, 4 or 5 within the National Institute for Health and Care Excellence (NICE) CG 73)
  - diabetes
  - hypertension
  - atrial fibrillation
  - transient ischaemic attack
  - familial hypercholesterolaemia
  - heart failure
  - peripheral arterial disease
  - stroke

2.2.2. In addition, individuals:

- must not be being prescribed statins for the purpose of lowering cholesterol*
- must not have been assessed through a NHS Health Check, or any other check undertaken through the health service in England, and found to have a 20% or higher risk of developing cardiovascular disease over the next ten years*

  *as declared by individual at point of presentation

2.2.3. Providers are encouraged to invite patients who may have a greater risk of developing cardiovascular disease for a NHS Health Check. Patients with the following risk factors are a key target population:

- BMI> 30
- Smokers
- BP >140/90 (one off reading)
- Living in quintiles 1 or 2
- Of black ethnicity
- Aged 40-49

2.3 Service User Support

2.3.1. The provider shall signpost Service Users who are identified with an increased risk of cardiovascular disease as set out by the NHS Health Checks Referral Criteria. Service users identified as requiring further support can be signposted to:

- Their registered GP for further testing, advice and/or support

LWD www.livewelldorset.co.uk to enable them to make changes to their lifestyle to reduce their risk of CVD

3. Service Description

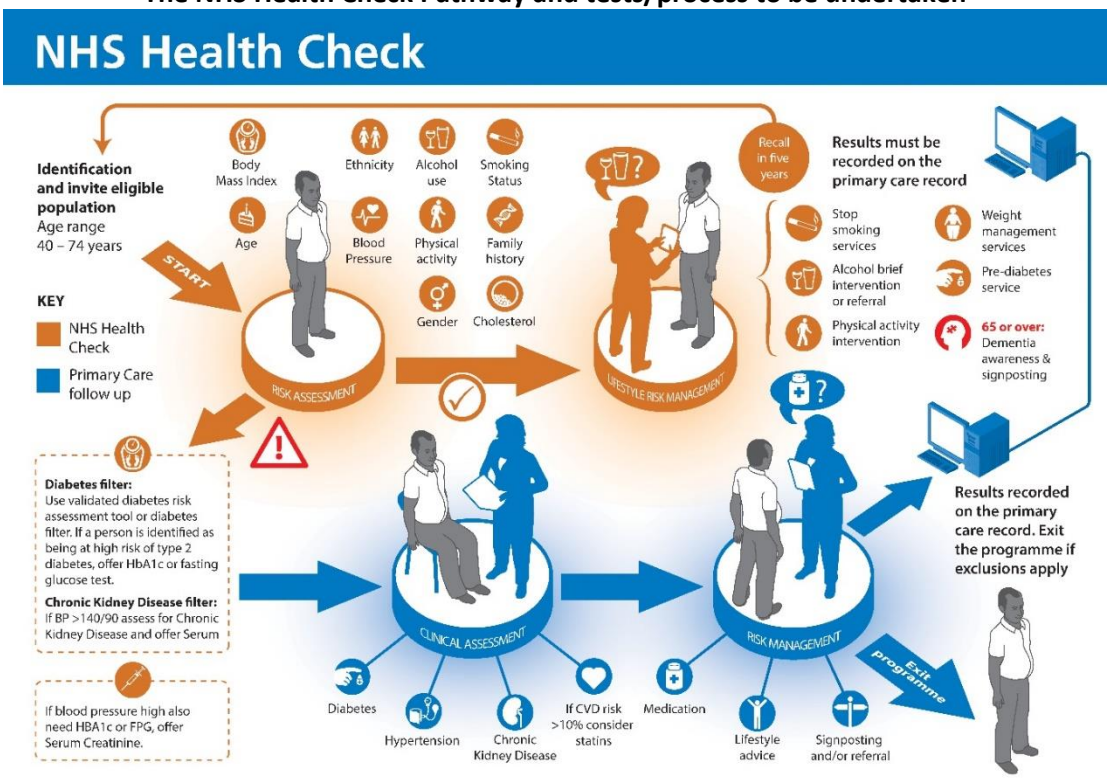
3.1. Best practice Guidance

3.1.1. The Provider shall deliver NHS Health Checks (The Service) in accordance with this agreement and NHS Health Checks Best Practice Guidance (Public Health England (OHID) updated March 2020: https://www.healthcheck.nhs.uk/seecmsfile/?id=1480

3.2. Service Availability Requirements

3.2.1. The Provider must be available to deliver a minimum of 5 NHS Health Check appointments* per calendar month.
*Some Providers may offer opportunistic NHS Health Check appointments at point of user contact rather than a booked appointment system.

The NHS Health Check Pathway and tests/process to be undertaken



3.3. <u>THE RISK ASSESSMENT</u>: ensuring a complete health check for those who accept the offer is undertaken and recorded

3.3.1. Description:

i. A complete NHS Health Check must include all the elements outlined in the best practice guidance all taken at the time of the check unless specified:
   - age
   - gender
   - ethnicity
   - smoking status
   - family history of coronary heart disease
   - blood pressure, systolic (SBP) and diastolic (DBP)
   - body mass index (height and weight)
   - General practice physical activity questionnaire (GPPAQ)
   - Alcohol use score (AUDIT-C or FAST can be used as the initial screen, further guidance is in the best practice guidance 2013)
   - cholesterol level: total cholesterol and HDL cholesterol (either point of care or venous sample if within the last six months)
   - cardiovascular risk score: a score relating to the person's risk of having a cardiovascular event during the ten years following the health check, derived using an appropriate risk engine that will predict cardiovascular risk based on the population mix within the local authority's area
   - dementia awareness (for those aged 65 to 74)
   - diabetes filter (BMI and BP)

ii. The Provider shall take no less than 20 minutes per NHS Health Check risk assessment completing all of the above tests.

3.3.2. Rationale:

i. The tests, measurements and risk calculations that make up the risk assessment part of the NHS Health Check are stipulated in legislation because of the importance of a uniform, quality offer.

ii. Every individual who receives an NHS Health Check should receive a good quality, complete risk assessment, irrespective of where they live, or the provider.

iii. An incomplete risk assessment may lead to an inaccurate calculation of their risk score and therefore have clinical implications and in turn, reputational implications for the programme.

3.4. <u>THE RISK ASSESSMENT</u>: equipment use

3.4.1. Description:

i. Ensure all equipment used for the NHS Health Check is: fully functional, used regularly, CE marked, validated, maintained and is recalibrated according to the manufacturer's instructions. This includes height and weight measuring devices, blood pressure monitors and point of care testing equipment.

ii. Any adverse incidents involving medical equipment should be reported to the manufacturer as well as the Medicines and Healthcare products

Regulatory Agency (MHRA) and managed according to providers' governance arrangements.

iii. An adverse incident is an event that causes, or has the potential to cause, unexpected or unwanted effects involving the accuracy and/or safety of device users (including patients) or other persons.

iv. For example:
- a patient, user, carer or professional is injured as a result of a medical device failure or its misuse
- a patient's treatment is interrupted or compromised by a medical device failure
- a misdiagnosis due to a medical device failure leads to inappropriate management and treatment
- a patient's health deteriorates due to medical device failure (MHRA)

v. Providers shall be required to supply all equipment and ensure that quality control, clinical disposal and training is undertaken as per manufacturers recommendations.

3.4.2. Rationale:

i. If equipment is not used correctly, there is a risk that incorrect readings are given, affecting the risk score and potentially the clinical management of the individual.

ii. Incidents should be reported as soon as possible. Some apparently minor incidents may have greater significance when aggregated with other similar reports.

3.5. THE RISK ASSESSMENT: quality control for point of care testing

3.5.1. Description:

i. Point of care test (POCT) is a device the manufacturer has intended to be used for examining specimens derived from the human body including blood and urine.

ii. Where using POCT, providers should ensure:
- They should only be used by healthcare professionals and staff who have been trained (by a competent trainer) to use the equipment (see para 6.1).
- An individual is identified as the named POCT coordinator.
- That an appropriate internal quality control (IQC) process is in place in accordance with the MHRA guidelines on POCT, 'Management and use of IVD point of care test (POCT) devices. Device bulletin 2010(02) February 2010'. This should take the form of at least a daily "go/no go" control sample (use of a liquid sample) on days when the instrument is in use. This may require other procedures e.g. optical check to be performed in addition to the use of a liquid control

sample. All record keeping on this process should be accurate & contemporaneous.

- That each POCT location is registered in and participating in an appropriate External Quality Assessment (EQA) programme through an accredited (CPA or ISO 17043) provider that reports poor performance to the National Quality Assessment Advisory Panel (NQAAP) for Chemical Pathology. This can be checked on UKAS or CPA websites: www.ukas.com/ www.cpa-uk.co.uk.

3.5.2. Rationale:

i. Inadequate Quality Assurance of POCT may lead to potentially inaccurate results affecting clinical management and clinical risk for the provider. As well as being a threat to the integrity of the programme and to clinical engagement.

3.6. COMMUNICATION OF RESULTS: ensuring results are communicated effectively and recorded

3.6.1. Description:

i. All individuals who undergo a NHS Health Check must have their cardiovascular risk score calculated and explained in such a way that they can understand it. This communication should be face to face at the time of the NHS Health Check.

ii. Staff delivering the NHS Health Check should be trained in communicating, capturing and recording the risk score and results, and understand the variables the risk calculators use to equate the risk. (ref para 6.1)

iii. When communicating individual risks, staff should be trained to:

- communicate risk in everyday, jargon-free language so that individuals understand their level of risk and what changes they can make to reduce their risk
- use behaviour change techniques (such as motivation interviewing) to deliver appropriate lifestyle advice and how it can reduce their risk
- establish a professional relationship where the individual's values and beliefs are identified and incorporated into a client- centred plan to achieve sustainable health improvement.

iv. Individuals receiving the NHS Health Check should be given adequate time to ask questions and obtain further information about their risk and results.

v. Individualised written information should be provided that includes their results, bespoke advice on the risks identified and self-referral information for lifestyle interventions.

vi. This should include and provide an explanation of their:

- BMI

- cholesterol level (total cholesterol and HDL cholesterol)
- blood pressure
- alcohol use score (AUDIT C or FAST)
- risk score and what this means
- referrals onto lifestyle or clinical services (if any)

vii. Providers shall ensure that the following consent is secured from all Service Users receiving the NHS Health Check. Consent that NHS Health Check results can be shared with:

- Public Health Dorset for monitoring and evaluation purposes only
- The Service User's registered GP if the NHS Health Check has not been undertaken at their registered practice
- LWD or any other third-party health improvement provider as agreed with the Service User.

3.6.2. Rationale:

i. Legal duties exist for local authorities to make arrangements to ensure the people having their NHS Health Checks are told their cardiovascular risk score, and other results are communicated to them.

ii. NHS Health Checks is a preventative programme to help people stay healthy for longer. To maximise these benefits, efforts should be made to ensure individuals understand their level of risk and their results. Everyone who has a NHS Health check, regardless of their risk score, should also be given lifestyle advice to help them manage and reduce their risk. That means that, unless it is deemed clinically unsafe to do so, everyone having a NHS Health Check should be provided with individually tailored advice that will help motivate them and support the necessary lifestyle changes to manage their risk. This includes supporting and encouraging individuals to maintain a healthy lifestyle where no change is required.

3.7. <u>RISK MANAGEMENT</u>: high quality and timely lifestyle advice given to all

3.7.1. Description:

i. Provision and timely access to high quality and appropriate risk-management interventions should be in place in line with the best practice guidance. This includes signposting to evidence-based and accessible interventions:

- stop-smoking services
- physical activity interventions
- weight management interventions
- alcohol-use interventions

ii. LWD is the PHD behavioural change resource for Dorset and Appendix 1 outlines the referral criteria to the service for the outlined pathways above. Providers are expected to refer individuals to LWD to support the advice and guidance they provide within the NHS Health Check.

iii. Public Health Dorset will provide the NHS Health Check results booklet for issue to each individual at the time of the NHS Health Check.

3.7.2. Rationale:

i. NHS Health Checks is a preventative programme to help people stay healthy for longer. To maximise these benefits, all individuals who have a NHS Health Check, regardless of their risk score, should be given lifestyle advice, where clinically appropriate, to help them manage and reduce their risk. Unless it is deemed clinically unsafe to do so, everyone having the check should be provided with individually tailored advice that will help motivate them and support the necessary lifestyle changes to manage their risk. This includes supporting and encouraging individuals to maintain a healthy lifestyle where no change is required.

ii. It is pivotal that the actions taken at a certain threshold are the same and in line with national guidelines, including those issued by the National Institute for Health and Care Excellence (NICE), so that people receive the necessary and appropriate care.

3.8. <u>RISK MANAGEMENT</u>: additional testing and clinical follow up

3.8.1. Description:

i. Additional testing and clinical follow up, for example, where someone is identified as being at high risk of having or developing vascular disease, remains the responsibility of primary care. Individuals should not leave the NHS Health Check until all abnormal parameters have been followed up and an appropriate referral has either been made or ruled out. Timely access to further diagnostic testing should take place as outlined in the best practice guidance at the following thresholds:

a) Following the diabetes filter undertaken as part of the risk assessment, a follow up blood glucose test should be conducted; either fasting plasma glucose or HbA1c (glycated haemoglobin) for all identified as high risk. Indicated by either:

- BP >140/90 mmHg or where the SBP or DBP exceeds 140mmHg or 90mmHg respectively
- BMI > 30 or 27.5 if individuals from the Indian, Pakistani, Bangladeshi, other Asian and Chinese ethnicity categories
- Individuals identified with pre-diabetes need to be reviewed at least annually.

b) Assessment for hypertension by GP practice team when indicated by:

- BP >140/90 mmHg
- Or where the SBP or DBP exceeds 140mmHg or 90mmHg respectively
- Individuals diagnosed with hypertension to be added to the hypertension register and treated through existing care

pathways. They should be reviewed in line with NICE guidance, including provision of lifestyle advice.

c) Assessment for chronic kidney disease by GP practice team when indicated by:
   - BP >140/90 mmHg
   - Or where SBP or DBP exceeds 140mmHg or 90mmHg respectively
   - All who meet these criteria to receive serum creatinine test to estimate glomerular filtration rate (eGFR).

d) Assessment for familial hypercholesterolemia by GP practice team when indicated by:
   - Total cholesterol >7.5 mmol/L

e) Alcohol risk assessment, use of full AUDIT when indicated by:
   - AUDIT C Score >5
   - Or FAST >3
   - If the individual meets or exceeds the AUDIT C or FAST thresholds above the remaining questions of AUDIT should be administered to obtain a dull AUDIT score. If the individual meet or exceeds a threshold of 8 on AUDIT, brief advice is given. For individuals scoring 20 or more on AUDIT referral to alcohol services should be considered.

f) Where the individual's BMI is in the obese range as indicated by:
   - BMI >27.5 in individuals from the Indian, Pakistani, Bangladeshi, other Asian and Chinese ethnicity categories
   - BMI > 30 individuals in other ethnicity categories
   - Then a blood glucose test is required.

Appendix 1 refers to the referral criteria for clinical and behaviour change advice and guidance where any of the above criteria highlight a need for additional follow up tests to be taken. The individual should be advised of the reason for each and any referral.

3.8.2. Rationale:

i. Only through the early detection and management of risk factors can the NHS Health Check maximise its public health impact and reduce premature mortality.

ii. It is key that the actions taken at these thresholds are the same to assure a systematic and uniform offer across England. Systems should be in place to ensure follow up tests are undertaken, and results received in order to provide assurance that appropriate follow up and management is undertaken. Disease management should be undertaken in line with NICE guidance including provision of appropriate lifestyle intervention.

3.9. THROUGHOUT THE PATHWAY: confidential and timely transfer of patient identifiable data

3.9.1. Description:

i. Where the risk assessment is conducted outside the individual's GP practice, the provider shall send the following information to the person's GP:
   - age
   - gender
   - smoking status
   - family history of coronary heart disease
   - ethnicity
   - body mass index (BMI)
   - cholesterol level
   - blood pressure
   - physical activity level - inactive, moderately inactive**,** moderately active or active
   - cardiovascular risk score
   - alcohol use disorders identification test (AUDIT) score (AUDIT C or FAST)

ii. A protocol also needs to be in place for timely referral of patients where abnormal parameters are identified including the referral process to LWD.

iii. For all individuals who require additional testing and clinical follow up, GP practices should follow Programme Standards 8 and 9. (OHID, July 2020).

iv. Providers are responsible for:
   - Storing and transferring collected data should be in accordance with the Data Protection Act (2018). Where the Provider is not the Service User's registered GP the Provider will forward the results of each assessment to the Service User's registered GP practice within 10 (Ten) working days. All results information shall be recorded through the electronic data system as specified by the Commissioner.
   - The Provider shall use one of the following electronic systems to record all consultations and activity and ensure that claims for payment for provision of this service can be collected through the electronic data system as specified by the Commissioners who will provide the results capture template:
     - Pharmoutcomes
     - SystemOne

3.9.2. Rationale:

i. Legal duties exist for local authorities to make arrangements for specific information and data to be recorded and where the risk assessment is conducted outside the individual's GP practice, for that information to be forwarded to the individual's GP.

ii. There are a number of potential issues surrounding data flows for example:

- if NHS Health Checks are undertaken in a community setting, there may be delay in the GP practice receiving the information and results
- ensuring confidential transfer of patient-identifiable data
- errors surrounding accuracy of data inputted

iii. These process failures could lead to a breach in confidentiality and/or inappropriate action undertaken due to inaccurate or delayed information being received. If information is not recorded it is unknown whether appropriate intervention and follow up has been undertaken.

iv. These standards only focus on a limited number of points on the delivery pathway. They focus on describing what good looks like, and they are a starting point for increasingly robust assessment of quality.

v. There is an expectation that the Provider will adapt their delivery accordingly and as appropriate in consultation with Public Health Dorset where the need arises throughout the life of this contract.

4. Training and Competency Requirements

4.1. The Provider shall ensure that all practitioners who conduct NHS Health Checks are fully trained to deliver the programme as per the NHS Health Check Competence Framework (March 2021) and NHS Health Check Competence Framework (June 2021). Resources are available

https://www.healthcheck.nhs.uk/commissioners_and_providers/training/

4.2. The Provider shall undergo Point of Care Testing machine familiarisation provided by the machine manufacturer.

4.3. The Provider shall ensure that all practitioners who conduct NHS Health Checks are fully skilled to provide the behaviour change advice and guidance as per NICE guidance PH6. https://www.nice.org.uk/Guidance/ph6 Healthy Living Pharmacy (HLP)Level 1 or PSPH Award level 2 demonstrate this skill requirement.

4.4. The Provider shall fully engage in quality assurance as and when requested to by The Commissioner, in line with national guidance **NHS Health Check StARS framework: A systematic approach to raising standards**

5. Activity, Performance and Reporting Requirements

5.1 The Provider shall have internet access in place at all times and shall use appropriate electronic systems to record all consultations and activity and ensure that claims for payment for provision of this service can be collected through the electronic system as stipulated by the Commissioner.

5.2 The Provider shall record all activity and performance data using one of the following electronic systems:

- PharmOutcomes
- SystmOne

Providers using PharmOutcomes:

5.3 The Provider shall complete the relevant template on PharmOutcomes to submit their activity to Public Health Dorset on a **monthly** basis.

5.4 Any late Provider data submissions will not be paid until the following month.

5.5 Providers using PharmOutcomes will not be paid for data submitted more than six months after the activity was undertaken.

Providers using SystmOne:

5.6 Providers shall extract a "search" of data on SystmOne using the Public Health Dorset NHS Health Checks template (outlined in the Public Health Dorset step by step guide on how to complete a SystmOne search report) to submit their activity data to Public Health Dorset on a **quarterly** basis. The required templates are outlined in the quarterly CHIS reminder emails from phcontracts@dorsetcouncil.gov.uk

5.7 Public Health Dorset will continue to review the data submission process, to improve efficiency and align with any system developments. Public Health Dorset will notify the Provider of any changes to the search template to be used.

5.8 Public Health Dorsetreserves the right to reject or withhold payment for any data submitted using an incorrect SystmOne "search" template. It is expected that providers will use the Public Health Dorset template over any others, such as Ardens.

5.9 In exceptional circumstances, Public Health Dorset will accept a completed Excel template, available from the Public Health Dorset website, instead of a SystmOne search. Providers shall ensure they prioritise reporting through a SystmOne search and should liaise with Public Health Dorset by emailing phcontracts@dorsetcouncil.gov.uk if they experience any issues with this process.

5.10 The completed template should be submitted to Public Health Dorset via the dedicated "PH Contracts" mailbox using the email address: phcontracts@dorsetcouncil.gov.uk

5.11 The deadline to submit the Public Health Dorset reporting template via email to Public Health Dorset is the 20th of the month following quarter end:

(Q1) 1st April – 30th June	Data due 20th July
(Q2) 1st July – 30th September	Data due 20th October
(Q3) 1st October – 31st December	Data due 20th January
(Q4) 1st January – 31st March	Data due 20th April

5.12 Providers using SystmOne will not be paid for data submitted more than one quarter late.

5.13 Any late Provider data submissions will not be paid until the following quarter.

5.14 No claim shall be submitted more than one month after the end of this agreement.

6. Quality Assurance

6.1 Both parties are required to regularly assess contract performance and address any additional matters during Review Meetings, scheduled at intervals and in a format determined by the Commissioner.

6.2 Public Health Dorset may request a review meeting within 5 business days following notice.

6.3 Quality control checks may take place at any point at the discretion of the Commissioner.

7. Notifying Public Health Dorset of Changes to Delivery or Organisational Details

7.1 The Provider is required to contact Public Health Dorset (Public Health Dorset) via email phcontracts@dorsetcouncil.gov.uk , to provide formal notification of changes to:

- Bank details
- Contact details
- Changes to ownership

7.2 If the Provider is temporarily unable to deliver the service, they must notify Public Health Dorset by emailing phcontracts@dorsetcouncil.gov.uk or by phoning **01305 224400** within one-working day to agree any contingency plans and enable Public Health Dorsett maintain up to date records of active Providers.

7.3 The Provider should contact Public Health Dorset as soon as possible if they wish to permanently cease delivery of a service or services.

8. Minimum Provider Qualification Requirements:

8.1 The Provider shall have capacity to deliver a minimum of 5 NHS Health Checks per calendar month, taking into account staff turnover, annual leave, sickness absence or maternity leave. (It is acceptable for providers to offer opportunistic NHS Health Check at point of user contact rather than a booked appointment system.

8.2 The Provider shall source and maintain the equipment used within the NHS Health Check. This includes height and weight measuring devices, blood pressure monitors and point of care testing (POCT) equipment.

8.3 The Provider shall ensure that each POCT location is registered and participating in an appropriate External Quality Assessment (EQA) programme through an accredited (CPA or ISO 17043) provider.

8.4 The Provider shall receive POCT machine familiarisation and updates by the machine manufacturer.

8.5 The Provider shall have frontline delivery staff who are fully trained to deliver the programme as per the NHS Health Check Competence Framework (March 2021) and the NHS Health Check Competence Framework (March 2021). https://www.healthcheck.nhs.uk/commissioners_and_providers/training/

8.6 The Provider shall have frontline delivery staff trained to:

- Communicate risk in everyday, jargon-free language so that individuals understand their level of risk and what changes they can make to reduce their risk use behaviour change techniques (such as motivation interviewing) to deliver appropriate lifestyle advice and how it can reduce their risk.

- Establish a professional relationship where the individual's values and beliefs are identified and incorporated into a client-centred plan to achieve sustainable health improvement.

NICE guidance PH6 refers: https://www.nice.org.uk/Guidance/ph6

HLP level 1 or PSPH Award Level 2 demonstrate this skill requirement.

8.7 The Provider shall sign up to receive alerts of Best Practice updates and other notifications at www.nhshealthchecks.co.uk.

8.8 The Provider shall have robust, secure methods of sharing individual personal data as per GDPR legal guidance within 2 calendar weeks of the NHS Health Check being delivered with i) GP practices across Dorset ii) LWD iii) Commissioners (as required)

9. Complaints, Safeguarding and Data Protection

9.1 The Provider shall ensure that their employees are fully aware of the Providers obligations in respect of the contract and service provision, in particular:

- Complaints refer to the Contract Terms, specifically B2.2 (b), B17, Appendix B & Appendix E.
- Safeguarding Vulnerable Adults and Children refer to the Contract Terms, specifically B10, C37 and Appendix J.
- Data Protection refer to the Contract Terms, specifically B37.

Appendix 1: NHS Health Checks Referral pathways

CHOLESTEROL		
Total serum cholesterol:HDL ratio	4.4 – 6.0	Advise on diet and exercise to maintain health
	>6.0	Refer to GP for fasting blood test
Total cholesterol	>7.5mmol/l	Refer to GP for fasting blood test
PULSE RHYTHM CHECK		
Pulse Rhythm	Regular	No action
	Irregular	Refer to GP for further tests
BLOOD PRESSURE		
Blood Pressure (mmHg) (*where systolic and/ or diastolic raised*)	<140/90	Advise on exercise, alcohol and weight to maintain health
	≥140/90	Refer to GP for further tests
	≥180/110	Refer to GP same day
BODY MASS INDEX		
BMI Measurement	≤24 (≤22 if S Asian* or Chinese)	Advise on exercise and diet to maintain health
	25 - 29 (23 – 27.4 if S Asian* or Chinese)	Offer referral to LiveWell Dorset
	≥30 (≥27.5 if S Asian* or Chinese)	Refer to GP
PHYSICAL ACTIVITY		
GP Physical Activity Questionnaire	Inactive	Offer referral to LiveWell Dorset
	Moderately Inactive	Offer referral to LiveWell Dorset
	Moderately Active	Offer referral to LiveWell Dorset
	Active	Advise on physical activity to maintain health
TOBACCO		
Smoking Status	Non-Smoker	No action
	Ex-Smoker	Encourage but no referral
	Current Smoker	Offer referral to LiveWell Dorset
	Smoking tobacco and using E-Cigarettes	Offer referral to LiveWell Dorset
ALCOHOL		
Audit C Initial Assessment; (where score is above 5, Full AUDIT)	0 - 7	Low risk, brief lifestyle advice to remain healthy
	8 - 15	Increasing risk, offer referral to LiveWell Dorset
	16 - 19	Higher risk, refer to GP for onward referral and support as necessary
	≥20	Possible dependence, refer to GP to access referral to alcohol treatment services (Dorset – REACH; Bournemouth – BEAT; Poole - SMART)
Q RISK RESULT		
QRisk2 Result (age/gender appropriate)	<10%	Brief lifestyle advice to remain healthy
	10% - 19%	Signpost to LiveWell Dorset
	≥20%	Refer to GP for further testing
DEMENTIA		
Dementia Awareness	No concerns	Advise on healthy lifestyle to remain healthy
	Concerns about memory	Advise an appointment with GP for assessment
LIVEWELL DORSET		
Service User requires advice on lifestyle support	Request from patient for lifestyle support around exercise, diet/ weight, smoking or alcohol	Signpost to LiveWell Dorset