Screening Activity

Preparation for screening
Screening process
Screening equipment
Copy of patient letters
  Invitation to screening
  'What to expect' information sheet
  Free NHS Health Check Invitation
  Results letters - high risk
  Results letters - low risk
Clinical audit poster - for display in patient waiting room
Screener performance guidelines
Screener role
Practice coordinator role
Procedures
  Blood Pressure and Pulse
  Waist
  Height, Weight, Body mass index (BMI)
  Issuing a pedometer
  Phlebotomy
  Evening bloods, their storage and viability
  Completed sample lab forms
    Heart of England
    Sandwell & W B'ham
    UHB
  CVD template & interpretation
Thresholds for measurements and blood results
DASH Diet

Adult Services - Stop Smoking

Stop Smoking Referral Pathway
Stop Smoking Service Specification
  Referral form
  Information letter
  Feedback form
Adult Services - Physical Activity
Get Active....Get Walking Service Specification - self-referral route
Be Active Service Specification - self-referral route
  Scheme Information Sheet
  Leisure Centre Details
Exercise on Prescription Referral Pathway
Exercise on Prescription Service Specification
  Health and Fitness Advisor contact list
  Prescription card
  Exit Report
Calorie Chart

Adult Services - Nutrition & Weight Management
Size Down Service Specification - self-referral route
My Choice Weight Management Pilot
Postnatal Size Down Service Specification
Fit Moms Service Specification
Maternal Nutrition Team Referral Form
Ethnic Categories
Postnatal Size Down Letter
Dietetic Appointment Referral Pathway
Dietetic Appointment Service Specification - professional/self-referral route
  Referral form
  Feedback form
Specialist Obesity Referral Pathway
Specialist Obesity Service Specification - professional referral route
  Referral form
  Feedback form

Adult Services - Alcohol and Drug Services
Alcohol Single Point of Contact Pathway
Alcohol Service Specification - professional/self-referral route
Drug Service Specification - professional/self-referral route
Adult Services - Expert Patient Programme
- Expert Patient Referral Pathway
- Expert Patient Service Specification
  - Looking After Me information sheet
  - Referral/registration form

Adult Services - Health Exchange
- Health Exchange Service Community Sites
- Health Exchange Service Specification - self-referral route
- Health Trainer Referral Pathway
- Health Trainer Service Specification - professional referral route
  - Referral form
  - Feedback form
- Chronic Disease Educator Referral Pathway
- Chronic Disease Educator Service Specification - professional referral route
  - Referral form
  - Patient questionnaire/evaluation

Lifestyle
- Key Healthy Eating Messages for Patients
- Setting a SMART Goal
- Behaviour Change Model
- Diary sheets for patient use
  - Food
  - Physical Activity
  - Smoking
  - Pedometer
  - Alcohol
- My Health - patient-held screening record sheet (A4)
- Patient certificate

Sundries
- Marketing campaign poster & Schedule
- Payments Page
- Contact Details
- Acknowledgments and References
Despite recent advances in medicine, at least 50% of deaths in the HoB area occur before the age of 75 years, over more than 300 people in our area die prematurely before the age of 75 each year from heart disease, diabetes or chronic kidney disease - "the deadly trio".

**Our service model of CVD prevention and early treatment**

- Screening and assessment of risk for CVD
- Health promotion to decrease CVD risk and encourage patients to:
  - stop smoking
  - eat a healthier diet
  - increase physical activity
  - regulate/moderate their alcohol intake
- Early intervention to reduce CVD risk

**We expect**

- More people identified at an earlier stage of vascular change with a better chance of putting in place positive ways to substantially reduce the risk of premature death or disability.
- The prevention of diabetes in many of those at increased risk of this disease.
- Sustained increase in life expectancy and the reduction in premature mortality from the rise of obesity and sedentary living.
- To reduce health inequalities e.g. ethnic, gender and socio-economic.
Suggested Preparation for Screening Process

Identify screening cohort
Male and Female, aged 40-74 not on a CVD QoF register

Arrange:
- Clinic dates and times
- Appropriate equipment
- Named co-ordinator
- Screener

Ensure screener has had required training

Agree within practice the method of invitation to patients
  e.g. invite 70-74 year olds first or opportunistic screening

A sample letter is included in the handbook

Send out
- Invitation to patients and record
- What to expect from your appointment information sheet
  OR
- Free NHS Health Check Invitation

To reorder Free NHS Health Check invitations www.nhs.uk/nhshealthcheck or 0845 850 9850
Suggested Screening Process

Screen

Screening appointment at GP surgery

Immediate lifestyle advice provided

Issue “My Health” and relevant leaflets

Test results received by patient

High Risk: Needs clinical review one or more options

Option 1
Referral/signpost to lifestyle services

Option 2
Prescription guardian drugs

Follow up
Place on appropriate Disease Register*

Low Risk

Option 3
Appointment in three years’ time

Self-referral if signs or symptoms become apparent

D.N.As
Follow up 3 times

A sample letter is included in the handbook

* Disease Registers that will be monitored are Diabetes/CKD/CHD/AF/Stroke/Hypertension/Hyperlipidaemia
Equipment Needed for Clinic

1. Urine test strips

2. Blood Pressure monitor (electronic - Omron or similar, stethoscope if using manual sphygmomanometer) duly calibrated and quality tested

3. Watch with second hand

4. Scales - electronic or manual, duly calibrated and quality tested
   - All weigh scales should be checked to confirm they meet the class relevant to their clinical location.
   - Ensure all scales for weighing patients in relation to medication, treatment or diagnosis are of Class III type.
   - There should be a system in place for checking the accuracy of weighing equipment.
   - Practices should ensure all scales are regularly checked and maintained to ensure correct calibration.
   - Any weighing equipment that may be giving inaccurate readings should be removed and re-calibrated. They should be re-checked after a short period to ensure there are no undetected problems.

For further details please see Section 2 of the ‘Estates & Facilities Alert’ available on: http://www.dh.gov.uk

5. Height measure

6. Tape measure (for waist)

7. BMI chart

8. 'My Health' patient held record

9. Relevant lifestyle leaflets and booklets

10. Phlebotomy equipment

11. Access to computer and patient clinical system (EMIS or similar)
The Free NHS Health Check Identity

The Department of Health has issued guidelines on promotional materials and patient communication to be used as part of the “Free NHS Health Check” (CVD Screening).

These guidelines will apply to:-

- letters of invitation (see opposite page)
- all written communications to patients relating to the screening process
- all information leaflets to be sent out to patients.

The NHS Health Check programme is a national initiative and therefore the promotional materials have been produced to ensure consistency of message and to save time and money.

Please use the letter of invitation on the opposite page to invite patients in for CVD Screening.

The letter is available to download at the following web page address:

http://nww.pctnet.wmids.nhs.uk/hobintranet/docs/gphandbook.pdf on the HoBtPCT intranet under Key Documents section.

The information leaflet is available free of charge from the DH publications orderline: www.orderline.dh.gov.uk or, alternatively, please contact the Deadly Trio Team for copies (see Contact Us section for details).
Dear Xxxx

We are inviting you to attend your free NHS Health Check on xx xxxxxx xxxx at xxxx.

NHS Health Checks are being offered to people aged between 40 and 74 once every five years.

The check is to assess your risk of developing heart disease, stroke, kidney disease or diabetes. If there are any warning signs, then together we can do something about it.

By taking early action, you can improve your health and prevent the onset of these conditions. There is good evidence for this.

The check should take about 20–30 minutes and is based on straightforward questions and measurements such as age, sex, family history, height, weight and blood pressure. There will also be a simple blood test to measure your cholesterol level.

Following the check, you will receive free personalised advice about what you can do to stay healthy.

Take a look at the enclosed leaflet for more information about the NHS Health Check and how it could benefit you.

If you cannot attend this appointment, please call the xxxx on xxx xx xxx and we will arrange a more suitable time for you.

Yours sincerely

xxxxxxxxxxxxxxxx

(Name of health care professional to go here)
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 blood test taken and will be asked for a urine sample
- 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.

Free NHS Health Check
Helping you prevent heart disease, stroke, diabetes and kidney disease
What to expect at your appointment (fasting)

- Please fast before your appointment (fasting means nothing to eat or drink apart from water from at least 10pm the night before)
- 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 blood test taken and will be asked for a urine sample
- 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.
Working together to improve your health

Everyone is at risk of developing heart disease, stroke, diabetes or kidney disease. The good news is that these conditions can often be prevented – even if you have a history of them in your family. Have your free NHS Health Check and you will be better prepared for the future and be able to take steps to maintain or improve your health.

Why do I need an NHS Health Check?

We know that your risk of developing heart disease, stroke, type 2 diabetes and kidney disease increases with age. There are also certain things that will put you at even greater risk. These are:

- being overweight
- lack of exercise
- smoking
- high blood pressure
- high cholesterol.

Both men and women can develop these conditions, and having one could increase your risk of developing another in the future.

- In the brain a blocked artery or a bleed can cause a stroke.
- In the heart a blocked artery can cause a heart attack or angina.
- The kidneys can be damaged by high blood pressure or diabetes, causing chronic kidney disease and increasing your risk of having a heart attack.
- Being overweight and a lack of exercise can lead to type 2 diabetes.
- If unrecognised or unmanaged, type 2 diabetes could increase your risk of further health problems, including heart disease, kidney disease and stroke.
Even if you're feeling well, it's worth having your NHS Health Check now. We can then work with you to lower your chances of developing these health problems in the future.

What happens at the check?

This check is to assess your risk of developing heart disease, type 2 diabetes, kidney disease and stroke.
- The check will take about 20-30 minutes.
- You'll be asked some simple questions. For example, about your family history and any medication you are currently taking.
- We'll record your height, weight, age, sex and ethnicity.
- We'll take your blood pressure.
- We'll do a simple blood test to check your cholesterol level.

What happens after the check?

We will discuss how we can support you to reduce your risk and stay healthy.
- You'll be taken through your results and told what they mean. Some people may be asked to return at a later date for their results.
- You'll be given personalised advice on how to lower your risk and maintain a healthy lifestyle.
- Some people with raised blood pressure will have their kidneys checked through a blood test.
- Some people may need to have another blood test to check for type 2 diabetes. Your health professional will be able to tell you more.
- Treatment or medication may be prescribed to help you maintain your health.

Questions you may have

Why do I need this check? I feel fine!
The NHS Health Check helps to identify potential risks early. By having this check and following the advice of your health professional, you improve your chances of living a healthier life.

But don't these conditions run in the family?
If you have a history of heart disease, stroke, type 2 diabetes or kidney disease in your family then you may be at more risk. Taking action now can help you to prevent the onset of these conditions.

I know what I'm doing wrong, how can the doctor help me?
If you would like help, we will work with you to find ways to reach your healthy weight, take more exercise or stop smoking. You may be prescribed medication to help lower your risk.

If I am assessed as being at 'low risk', does this mean I won't develop these conditions?
It is impossible to say that someone will or won't go on to develop one of these conditions. But taking action now can help you lower your potential risk.

Will everyone have this check?
This check is part of a new national scheme to help prevent the onset of these health problems. Everyone between the ages of 40 and 74 who has not been diagnosed with the conditions mentioned will be invited for a check once every five years. If you are outside the age range and concerned about your health, you should contact your GP.

For more information visit www.nhs.uk/nhshealthcheck or call the NHS Health Check helpline on 0845 850 9850

Calls cost a maximum of 5p per minute from a BT landline. Mobiles and other networks may vary. You may be charged a minimum cost per call.

Local NHS Health Check provider stamp here:
Dear …………………

Health Check Results

Thank you for attending your recent health check.

Your results have come back to the surgery and we would like to discuss them with you.

Option 1
An appointment has been made for you to attend the surgery on ………... at ........If this is not convenient please contact us on the number above to re-arrange.

Option 2
Please contact us on the number above to arrange an appointment convenient to you.

Yours sincerely

The information collected during this screening will be used by the NHS for provision of your healthcare and for planning future service needs. This information will be anonymised. All staff have a legal responsibility to comply with the Data Protection Act 1998 and NHS Confidentiality Code of Practice. For further information about how your information may be used, please contact your surgery or visit www.hobtpct.nhs.uk/our_trust/data_protection

Free NHS Health Check
Helping you prevent heart disease, stoke, diabetes and kidney disease
Dear ....................

Health Check Results
Thank you for attending your recent health check.

I am pleased to let you know that your results indicate that you are currently at low risk of developing heart disease.

You will be invited for another health check in three years’ time. We will contact you when this is due.

In the meantime, please remember that staying healthy involves:

- eating at least five portions of fruit and vegetables a day as part of a Mediterranean-style diet
- not smoking (call the Stop Smoking Service on 0800 052 5855 if appropriate)
- taking regular exercise each week
- keeping your alcohol intake below the recommended limit

If you would like further information on any of the issues mentioned above, please contact the Health Exchange on 0800 158 3535 or visit their website www.healthexchange.org.uk.

Yours sincerely

The information collected during this screening will be used by the NHS for provision of your healthcare and for planning future service needs. This information will be anonymised. All staff have a legal responsibility to comply with the Data Protection Act 1998 and NHS Confidentiality Code of Practice. For further information about how your information may be used, please contact your surgery or visit www.hobtpct.nhs.uk/our_trust/data_protection
Clinical Audit

• Clinical audit is essential to the provision of good care. All practitioners have a duty to participate in clinical audit.

• As a patient, your data may be used in clinical audits in an anonymised format.

• If you have any objections to your data being used for clinical audit purposes, please inform the practice/department.

• If you have any queries regarding the use of your data for audit purposes, please ask for further information.
Screener Performance Guidelines

You need to

1. Explain clearly to individuals
   - your own role and its scope, your responsibilities and accountability
   - the information that will be obtained and stored in records and with whom this information might be shared
   - what is involved in the assessment

2. Respect individuals' privacy (i.e. using the individual's name of choice, being courteous and polite), wishes and beliefs (e.g. who may work with the individual, who else may need to be present, preparation for certain activities)

3. Minimise any unnecessary discomfort and encourage individuals' full participation in the assessment

4. Obtain individuals' informed consent to the assessment process

5. Use appropriate tools and methodologies to measure individuals' physical indicators of risk of Cardiovascular Disease

6. Find out about factors in individuals' family history and lifestyle that may affect the levels of risk

7. Find out any symptoms individuals have that may indicate they have Cardiovascular Disease

8. Find out about any other conditions individuals have that may affect their levels of risk

9. Calculate individuals' level of risk based on your measurements and findings

10. Refer people to other practitioners when their needs are beyond your own role or scope of practice

Valid Consent (England Definition)

For consent to be valid, it must be given voluntarily by an appropriately informed person (the patient or where relevant someone with parental responsibility for a patient under the age of 18) who has the capacity to consent to the intervention in question. Acquiescence where the person does not know what the intervention entails is not "consent".
Screener Role

- Prepare clinic
- Screen patients in line with the NMC Code: Standards of conduct, performance and ethics for nurses and midwives
- Record data, keeping clear and accurate records, using the CVD Risk Management template, ensuring all tests required by the LES are completed and the risk score is calculated
- Explain the screening purpose and process including the potential recall to patient
- Give immediate lifestyle advice and issue "My Health" patient-held record
- Signpost/refer patient to lifestyle services where appropriate
- Ensure the patient record is updated accordingly
- Issue certificate to patient for achievement, if appropriate

Suggested Named Practice Co-Ordinator Role

- Identify patients eligible for screening
- Ensure screener(s) have had appropriate training (Staff training sessions run by the PCT will be provided on an annual basis)
- Arrange screening clinic timetable ensuring time, space and staff are co-ordinated
- Ensure invitation for screening letters or phone calls are sent/made in line with the clinic timetable
- Remind patients of screening appointment by letter, or text/phone where possible
- Send second and third appointments to patients who DNA by letter, or text/phone where possible
- Ensure blood samples are labelled and stored correctly, maintaining the integrity of the specimen and transported within time limits
- Send follow-up appointment to patients whose screening results warrant follow-up
- Liaise with the "Deadly Trio" team
- Ensure the computer with MSDi is left on overnight to allow the automatic upload of data to the "deadly trio" team. The team will advise on the dates
- Ensure that the cardiovascular QoF registers are updated and maintained
- Ensure the patient record has been updated with feedback from lifestyle services
- Ensure that the practice has sufficient stocks of the "My Health" patient-held record and lifestyle leaflets
- Ensure that the "Clinical Audit" poster is displayed in the practice waiting room (available in GP Handbook)
- Liaise with Health Exchange for Health Trainer and Chronic Disease Educator services
Phlebotomy - Obtaining venous blood samples

Competence Specification

Competent practice is a combination of the application of skills and knowledge informed by values and ethics. This specification details the knowledge and understanding required to carry out competent practice in the performance described in this unit.

When using this specification it is important to read the requirements in relation to expectations and requirements of your job role.

You need to show that you know, understand and can apply in practice:

Legislation and organisational policy and procedures

1. A factual knowledge of the current European and national legislation, national guidelines and local policies and protocols which affect your work practice in relation to obtaining venous blood

2. A working knowledge of your responsibilities and accountability in relation to the current European and national legislation, national guidelines and local policies and protocols

Theories and Practice

3. A working knowledge of the importance of obtaining positive confirmation of individuals’ identity and consent before starting the procedure, and effective ways of getting positive identification

4. A factual knowledge of the importance of working within your own sphere of competence and seeking advice when faced with situations outside your sphere of competence

5. A working knowledge of the importance of applying standard precautions and the potential consequences of poor practice

6. A working knowledge of how infection is spread and how its spread may be limited - including how to use or apply the particular infection control measures needed when working with blood

Anatomy and Physiology

7. A factual knowledge of the structure of blood vessels

8. A factual knowledge of the position of accessible veins for venous access in relation to arteries, nerves and other anatomical structures

9. A factual knowledge of blood clotting processes and factors influencing blood clotting

Care and Support

10. A working knowledge of the extent of the action you take, which includes any information you may give, particularly in relation to clinical issues

11. A working knowledge of the contra-indications and changes in behaviour and condition, which indicate that the procedure should be stopped and advice sought

12. A working knowledge of the concerns which those giving blood/donors may have in relation to you obtaining venous blood
13. A working knowledge of how to prepare those giving blood/donors for obtaining venous blood, including how their personal beliefs and preferences may affect their preparation

14. A working knowledge of what is likely to cause discomfort to individuals during and after obtaining venous blood, and how such discomfort can be minimised

15. A working knowledge of common adverse reactions/events to blood sampling, how to recognise them and the action(s) to take if they occur

Materials and equipment

16. A working knowledge of the type and function of different blood collection systems

17. A working knowledge of what dressings are needed for different types of puncture sites, how to apply and what advice to give individuals on caring for the site

Procedures and Techniques

18. A working knowledge of the factors to consider in selecting the best site to use for venous access

19. A working knowledge of the equipment and materials needed for venepuncture/phlebotomy and how to check and prepare blood collection systems

20. A working knowledge of the importance of ensuring venous access sites are cleaned effectively and how and when this should be done

21. A working knowledge of the correct use of tourniquets

22. A working knowledge of the importance of correctly and safely inserting and removing needles

23. A working knowledge of how to recognise an arterial puncture, and the action to take if this occurs

24. A working knowledge of the factors involved in the procedure which could affect the quality of the blood

25. A working knowledge of the remedial action you can take if there are problems in obtaining blood

26. A working knowledge of the complications and problems that may occur during venepuncture, how to recognise them and what action(s) to take

27. A working knowledge of when and how to dress venous puncture sites

Reporting, Recording and Documentation

28. A working knowledge of the information that needs to be recorded on labels and other documentation

29. A working knowledge of the importance of completing labels and documentation clearly, legibly and accurately

30. A working knowledge of the importance of immediately reporting any issues which are outside your own sphere of competence without delay to the relevant member of staff

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Checklist for obtaining venous blood from individuals

1. You apply standard precautions for infection control, any other relevant health and safety measures
2. You select and prepare an appropriate site for obtaining the venous blood, immediately before the blood is obtained, in line with organisational procedures
3. You apply, use and release a tourniquet at appropriate stages of the procedure
4. You gain venous access using the selected blood collection system, in a manner which will cause minimum discomfort to the individual

You obtain the blood from the selected site:

5. In the correct container according to investigation required
6. In the correct volume
7. In the correct order when taking multiple samples.
8. You take appropriate action to stimulate the flow of blood if there is a problem obtaining blood from the selected site, or choose an alternative site
9. You mix the blood and anti-coagulant thoroughly WHEN anti-coagulated blood is needed
10. You promptly identify any indication that the individual may be suffering any adverse reaction/event to the procedure and act accordingly
11. You remove blood collection equipment and stop blood flow with sufficient pressure at the correct point and for the sufficient length of time to ensure bleeding has stopped
12. You apply a suitable dressing to the puncture site according to guidelines and/or protocols, and advise the individual about how to care for the site

Label and prepare blood for transportation

13. You label blood samples clearly, accurately and legibly, using computer-prepared labels where appropriate
14. You place samples in the appropriate packaging and ensure the correct request forms are attached
15. You place samples in the nominated place for collection and transportation, ensuring the blood is kept at the required temperature to maintain its integrity
16. You document all relevant information clearly, accurately and correctly in the appropriate records
17. You ensure immediate transport of the blood to the relevant department when blood sampling and investigations are urgent
Evening bloods, their storage and viability

- HbA1c values are stable over time
- Do not measure non-fasting glucose values
- Creatinine values are inclined to be higher when stored. This is usually not significant clinically but, as usual, if a result appears clinically inappropriate it would need to be repeated
- Total cholesterol values will be higher in the evening but will not be affected by storage
- If practices have access to a centrifuge machine; use as appropriate
Heart of England Lab Form Non-Fasting
Heart of England Lab Form Fasting
<table>
<thead>
<tr>
<th>Test Request</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood Glucose</td>
<td>Fasting Blood Glucose</td>
</tr>
<tr>
<td>HbA1c</td>
<td>Glycosylated Hemoglobin A1c</td>
</tr>
<tr>
<td>Renal Function</td>
<td>Renal Panel</td>
</tr>
<tr>
<td>Liver Function</td>
<td>Liver Function Panel</td>
</tr>
</tbody>
</table>

**Reason for Request:**
- Diabetes Management
- Chronic Kidney Disease
- Hypertension Management
- Lipid Profile Monitoring

**Specimen Type:**
- Blood
- Urine

**Investigation Required:**
- Fasting Blood Glucose
- HbA1c
- Renal Panel
- Liver Function Panel

**Labeling:**
- Attach label to specimen bottle
- Use a ballpoint pen for legibility

**Additional Information:**
- Specimen must becollected in fasting state.
- specimens should be refrigerated until transport.

**Important Notes:**
- Commercial copying, hiring, lending is prohibited.
- Legal action will be taken against anyone failing to observe these conditions.

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# UHB Lab Form Non-Fasting

<table>
<thead>
<tr>
<th>Surname</th>
<th>Forename</th>
<th>Registration No.</th>
<th>Date Collected</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

**Investigations:**
- Lipid Profile
- Cholesterol
- Gamma GT
- Bone Profile
- Fibrinogen
- Fibrinogen Screen
- Thromboplastin Time
- C-reactive Protein (CRP)
- HbA1c
- MCV
- MCH
- MCHC
- Urine

**Specimen Type:**
- Blood

**Urgent requests must be pre-booked - phone 0121 627 2708. Enter Ref. No.**

**TREATMENT:**

**Copy to:**

**Please use ballpoint pen and block capitals.**

---

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Screening Activity
Blood Pressure

- Choose an appropriately sized cuff
- Apply the cuff to the upper arm of the patient ensuring the tube is placed over an artery
- Secure the cuff using the velcro
- Ensure neither you nor the patient is talking whilst the BP is being measured. Make sure that the patient’s legs are not crossed
- Press the "on" button
- Press the "start" button
- The cuff will inflate and deflate giving a reading that should be entered onto the template
- Record on CVD Risk Management template and on "My Health" patient-held record

Pulse

- Seat the patient
- Using a watch with a second hand, take the patient’s pulse for 30 seconds
- Establish if the pulse is regular or irregular

NB. If the pulse is irregular refer patient to the GP
**Waist circumference**

This should be measured over bare skin or light clothing.

- Ask the patient to stand with their arms by their sides and to relax, not to deliberately hold stomach in or out, looking straight ahead
- If possible, kneel or sit on a chair to the side of the patient
- Palpate the lower rib margin (coastal margin) and the iliac crest and mark half-way between the two points. This is the level at which the measurement of waist circumference should be taken
- The measuring tape should be placed horizontally on the circumference and you should check that it is not kinked or twisted; this is best done by looking sideways on. As well as checking the front, peer around the subject's back to inspect their left side. The tape should rest on the skin, not indent it. Do not pull too tightly
- Take the reading at the end of expiration
- Measure to the nearest (cm)
- Record on CVD Risk Management template and on "My Health" patient held-record

Central obesity is present if the waist circumference is > 102cms (40.2") in men and 88cms (34.5") in women. For the Asian population, lower values of waist circumference are more appropriate: > 90cms (35.4") in men and 80cms (31.4") in women.
**Height measurement**

The height should be measured on a firm, level surface.

- Ask the patient to remove their shoes and stand with their back to the measure
- Tell them to stand as tall and straight as possible with feet together, arms held loosely at the side and shoulders relaxed
- Ensure that the patient is looking straight ahead with the head not tilted up or down
- Lower the head plate so that it gently rests on the highest part of the subject’s head. Press down to flatten hair
- Read the height measurement from where the arrow points to on the measure to the nearest (cm)
- Record (usually in metres) in CVD Risk Management template and on “My Health” patient-held record

**Weight**

The participant should remove their shoes and coat and heavy outerwear for this test.

- Ensure scales have been calibrated/serviced within specified time range
- Set scale to '0'
- Ask patient to step on scales
- Wait for weight to register properly
- Record weight (usually in KG) in CVD Risk Management template and on “My Health” patient-held record
BMI - Body Mass Index

The body mass index is used to assess if a person’s weight lies within the healthy range for their physical height. This can be determined if you know your weight in kilograms and your height in metres.

- BMI will be calculated automatically when the height and weight have been entered onto the CVD template

Alternatively you can calculate your BMI in three ways:

- Use an automatic calculator via the internet
- Calculate your BMI yourself using the following steps:
  - Work out your height in metres and multiply the number by itself, e.g. if your height is 1.6 then 1.6 x 1.6 = 2.56
  - Measure your weight in kilograms
  - Divide this by the answer to question 1. For example, you might be 1.6 metres tall and weigh 65 kilograms. The calculation would then be 1.6 x 1.6 = 2.56. BMI would be 65 ÷ 2.56 = 25.4
- If you know your height in metres (or in feet and inches) and your weight in kilograms (or in pounds) you can calculate your BMI using the chart opposite
Issuing a pedometer: Criteria

Ask the main question:

"How do you feel about being more active?"

The general aim is to do at least 30 minutes a day, five days a week, of activity that makes you feel warm and slightly puffed.

If the individual fits any of the below criteria, they may benefit from using a pedometer.

"I've started to be more active"

- Praise and encourage
- If a plan was issued, review to see if changes are needed
- Re-assure the patient that the odd lapse is normal
- Suggest a pedometer to look at how much they do and to give positive feedback on their effort

"I'm definitely planning to be more active"

- Set some realistic goals
- Give record sheet and pedometer

"I'm just thinking about being more active"

- Identify any barriers e.g. difficulties/problems
- Suggest trying a pedometer to look at how much walking/exercise they do already

Questions to ask

1. Can you tell me anything about the benefits of walking?
   - Helps to reduce the risk of coronary heart disease and stroke
   - Helps control body weight
   - Reduces anxiety and depression
   - Helps build and maintain healthy bones, muscles and joints
2. Where does walking fit into your daily life?
3. Do you know what a pedometer is?
4. Would you be interested in using a pedometer?

If answer is "yes" go ahead and issue a pedometer.
CVD Risk Management Screening Template
Examples from EMIS PCS

Use to record screening appointment with patients

Please ensure that you have the correct template. Changes to the template and explanations are listed by the screen shot where relevant.

Screening for cardiovascular disease - Very important that all screened patients have this boxed ticked.

Diary entry for CVD risk assessment - select the date when the patient next needs to come back to the practice.

Framingham score - When all related values are completed (i.e. bloods, etc) a risk score will automatically be calculated.

Alcohol Status - Teetotaller - This refers to a person who never drinks alcohol.
BMI and Blood Pressure - As part of the CVD Risk Management

BMI - This will be calculated automatically when the height and weight have been entered.

O/E - height cm
O/E - weight Kg
BMI: Body Mass Index

Systolic blood pressure mm Hg
Diastolic blood pressure mm Hg

OK Cancel

Weight-reducing diet - tick if patient has been signposted to Size Down or referred to Dietetic Service.

Patient advised re diet - tick if patient has been given advice on cardio protective diet. Use leaflets from www.5aday.nhs.uk, FSA (www.eatwell.gov.uk) or British Heart Foundation (www.bhf.org.uk).

Diet and Exercise - As part of the CVD Risk Management

Oily Fish Intake

Weight reducing diet
Patient advised re diet
Not advised re low salt diet
Lifestyle advice regarding exercise
Health education - weight management

Exercise Activity

OK Cancel

Patient advised re low-salt diet - it is still important and useful if somebody can adhere to a low-salt diet. Reduction in salt intake could help with improving blood pressure, although it is not as beneficial as eating two portions of oily fish per week, reducing saturated fat and increasing fruit & veg i.e. a Mediterranean diet. Not evidence-based for CVD prevention.
Plasma fasting glucose - Added

Not interested in giving up smoking

Refuses obesity monitoring - (covers all weight management related services)

Both have been added. Please tick if patient refuses service.

Screening Activity

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CVD Screening and Thresholds

Priority setting

While we aim to screen all people aged between 40 and 74 registered with a HoB GP, you may wish to start the programme by screening those at higher risk. Two possible strategies are given below.

1. Those known to be probably at high risk of cardiovascular disease

Many people have some investigations that have been performed previously which suggest that they may be at an increased risk of CVD. This patient cohort should be tackled early. If you need help with this, please let the "Deadly Trio" team know.

2. Those who are likely to have a high risk of Diabetes

If you want to specifically look for people who may have diabetes, then you may wish to use QDScore [http://www.qdscore.org/].

Remember the classical risks:

1. Increased risk from ethnicity:
   - When compared with white people as a risk of 1, people from
     - Bangladesh have a risk of about 4
     - Pakistan have a risk of about 2
     - India have a risk of 1.8
     - Black folk have a risk of 0.8 [women] - 1.5 [Black African]

2. The older the individual, the higher the risk

3. Men have a higher risk [except Chinese]

4. Deprivation increases risk

5. Family history [first degree relatives] doubles the risk

6. Treated hypertension increases the risk by 1.7

7. Cardiovascular disease increases the risk by 1.5

8. Steroid treatment increases the risk by 1.4

Recommended action to take once screening has occurred

Calculate Framingham risk.

Additional factors to allow for in the Framingham calculator if you wish:

- Social deprivation: multiply by 1.5
- Glucose intolerance/Impaired Fasting Glycaemia: multiply by 1.25

If you have no ECG evidence of left ventricular hypertrophy score 0, otherwise 1.

Ethnicity is usually incorporated in most practice systems, if not increase risk by 50% [i.e. 13.5% becomes 20%]. This is important for all people who came from, or whose forefathers came from, the Indian subcontinent.
Once risk is established as 20% or more or if an isolated risk is identified:

Priority should be given when possible to lifestyle intervention, such as the DASH diet*, exercise, weight loss and stopping smoking.

Total cholesterol and HDL should then be re-measured after an adequate period of improved lifestyle, usually 1-3 months, and in the fasting state.

If the CVD risk remains raised then start pharmacological treatment with Simvastatin.

Aspirin should be offered to high-risk patients without any contraindication.

**What should you do if risk is not more than 20% but isolated values seem raised?**

Many of these need lifestyle advice. Listed below are actions which may be needed:

### Blood Pressure

<table>
<thead>
<tr>
<th>Systolic</th>
<th>Diastolic Blood Pressure</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 140</td>
<td>Less than 90</td>
<td>Acceptable give lifestyle advice</td>
</tr>
<tr>
<td>If more than 140 on 2 separate visits</td>
<td>Or more than 90 on 2 separate visits</td>
<td>Offer DASH diet* and or drug therapy</td>
</tr>
<tr>
<td>If more than 140</td>
<td>Or more than 90</td>
<td>Arrange a repeat measurement at another visit</td>
</tr>
<tr>
<td>If then on second visit more than 140</td>
<td>Or more than 90</td>
<td>Arrange review by GP</td>
</tr>
<tr>
<td>If more than 180</td>
<td>Or more than 110</td>
<td>Refer to GP</td>
</tr>
<tr>
<td>If more than 180</td>
<td>Or more than 110</td>
<td>Refer to GP if signs of accelerated hypertension such as papilloedema</td>
</tr>
</tbody>
</table>

### Waist measurement

<table>
<thead>
<tr>
<th>Gender</th>
<th>Central Obesity Present if…</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Men</td>
<td>More than 102cms / 40.2 inches</td>
<td>Provide Lifestyle advice - diet and physical activity</td>
</tr>
<tr>
<td>Asian Men</td>
<td>More than 90cms / 35.4 inches</td>
<td>Provide Lifestyle advice - diet and physical activity</td>
</tr>
<tr>
<td>Women</td>
<td>More than 88cms / 34.5 inches</td>
<td>Provide Lifestyle advice - diet and physical activity</td>
</tr>
<tr>
<td>Asian Women</td>
<td>More than 80cms / 31.5 inches</td>
<td>Provide Lifestyle advice - diet and physical activity</td>
</tr>
</tbody>
</table>

* The Dietary Approaches to Stop Hypertension (DASH) is detailed at the end of this section
### BMI

<table>
<thead>
<tr>
<th>BMI</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 18.5</td>
<td>Below normal/healthy</td>
</tr>
<tr>
<td>More than 18.5 &amp; less than 25</td>
<td>Normal/healthy weight</td>
</tr>
<tr>
<td>More than 25 &amp; less than 30</td>
<td>Over Weight - provide lifestyle advice - diet and physical activity</td>
</tr>
<tr>
<td>More than 30 &amp; less than 40</td>
<td>Increase Risk - refer to HoB Dietician or weight management programme</td>
</tr>
<tr>
<td>More than 40</td>
<td>Refer to specialist obesity service</td>
</tr>
<tr>
<td>More than 37.5 Asian Men &amp; Women</td>
<td>Refer to specialist obesity service</td>
</tr>
<tr>
<td>More than 35 with co-morbidities</td>
<td>Refer to specialist obesity service</td>
</tr>
<tr>
<td>More than 32.5 Asian Men &amp; Women with co-morbidities</td>
<td>Refer to specialist obesity service</td>
</tr>
</tbody>
</table>

### Smokers

<table>
<thead>
<tr>
<th>Smokers</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anyone who smokes</td>
<td>Offer brief intervention &amp; advice</td>
</tr>
<tr>
<td>Anyone who smokes &amp; wants to quit</td>
<td>Refer to Smoking Cessation</td>
</tr>
</tbody>
</table>

### Fasting

From 10pm the night before, nothing to eat or drink, apart from water.  
*(Preferably 10 hours before the test)*

<table>
<thead>
<tr>
<th>Random capillary or venous plasma glucose</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>If more than 5.5 mmol/l</td>
<td>Investigate with fasting plasma and HbA1c</td>
</tr>
</tbody>
</table>

### Plasma Glucose

#### Fasting Glucose

<table>
<thead>
<tr>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>If less than 4.0</td>
</tr>
<tr>
<td>If more than 4 &amp; less than 5.5</td>
</tr>
<tr>
<td>If more than 5.4</td>
</tr>
</tbody>
</table>

### HbA1c

#### Casual HbA1c

<table>
<thead>
<tr>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>If less than 6% [42 mmol/mmol]</td>
</tr>
<tr>
<td>If 6% to 6.4% [42 to 47 mmol/mmol]</td>
</tr>
<tr>
<td>If 6.5% with no symptoms of diabetes [48 mmol/mmol]</td>
</tr>
<tr>
<td>If 6.5% with symptoms of diabetes [48 mmol/mmol]</td>
</tr>
</tbody>
</table>
## Cholesterol

<table>
<thead>
<tr>
<th>Total Cholesterol</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>If more than 7.5 mmol/l &amp; Family History of Myocardial Infarction [if first degree relative younger than 60, if second degree relative younger than 50]</td>
<td>Consider a diagnosis of familial Hypercholesterolemia</td>
</tr>
<tr>
<td>OR Family History of total cholesterol more than 7.5 mmol/l in adult first or second degree relatives</td>
<td>Consider a diagnosis of familial Hypercholesterolemia</td>
</tr>
</tbody>
</table>
DASH Diet

The Dietary Approaches to Stop Hypertension (DASH)

Studies have shown that the greatest reductions in blood pressure are observed with a diet that is:

Low in
- salt
- total fat and saturated fat

Rich in
- fruit (4-5 servings a day)
- vegetables (4-5 servings a day)
- low-fat dairy foods (3 servings a day)
- grains & grain products - starchy foods
- nuts, seeds & legumes (4-5 servings a week)

Studies

1. The Dietary Approaches to Stop Hypertension (DASH) trial (Appel et al, 1997) assessed the effects of dietary patterns on blood pressure.

   **Results:** compared with a typical US diet, a diet rich in fruit, vegetables and low-fat dairy products (the DASH diet) significantly reduced average blood pressure by 5.5/3.0mmHg.

2. The DASH Sodium trial (Sacks et al, 2001) examined the combined effect of the DASH diet and reduced salt intake.

   **Results:** The greatest reductions in blood pressure were observed with the DASH diet and low salt intake (3g) which reduced blood pressure by an average 8.9/4.5mmHg below the control diet (representing a typical US diet) at the high salt (9g) level.

   The DASH Sodium trial also showed that reducing salt intake reduced average blood pressure levels of people on the DASH diet or the control diet. The effects were observed in those with and without hypertension, in both sexes and across ethnic groups.
Your Stop Smoking Service can offer FREE advice, support and a choice of nicotine replacement medications to help improve your chances of staying stopped for good.

Smoking. Don’t keep it in the family. _SMOKEFREE_
Smoking Referral

Client Smokes

Client referred to PCT Stop Smoking Service using referral form

Ensure screener has correct referral form or procedure for practice

Initial outcome letter to practice from LSSS whether client is booked/not interested/wrong number

Client booked into LSSS clinic

Client attends clinic for five consecutive weeks. Advisors chase their own DNAs

Client booked into Pharmacy

Call to client from call centre one week after initial contact (follow up to ensure service has been accessed)

Outcome fed back to practice

Call centre follow up clients who have a quit date at 12 weeks, 26 weeks and 56 weeks to confirm status
Stop Smoking Service Specification

Universal Access

Service Description
An evidence-based NHS service developed to help smokers quit via a programme of behavioural and pharmacological support available through community clinics, local pharmacies and GPs.

Age Range
No restriction

Referral Criteria
Anyone who smokes and WANTS to stop smoking.

Who can Refer
- Self
- Healthcare Professional
- GP

Referral Method
Telephone: 0121 224 4065 or 0800 0525 855
Fax: 0121 224 4700
Post: Heart of Birmingham Stop Smoking Service
Ladywood Health & Community Centre
St Vincent St West
Ladywood
Birmingham
B16 8RP

Send referral to
Heart of Birmingham Stop Smoking Service

Feedback
Yes

Service Contact
Stop Smoking Service Manager 0121 224 4065

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Stop Smoking Service Referral Form

Please refer only patients who are assessed as being motivated to engage in this support programme (i.e. express an interest in stopping smoking). Patients who do not wish to stop smoking should not be referred.

<table>
<thead>
<tr>
<th>Surgery Address:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Post Code:</th>
<th>Referred by:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tel no:</td>
<td>Referral Date:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Patient Name:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Address:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Post Code:</th>
<th>D.O.B:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tel no (home)</td>
<td>Age:</td>
</tr>
<tr>
<td>Mobile No.</td>
<td>Gender:</td>
</tr>
<tr>
<td>NHS No:</td>
<td>Is Patient Pregnant? Yes/No</td>
</tr>
</tbody>
</table>

Please complete the above details and fax to:

(0121) 224-4700

For information on what support is available to smokers within the Heart of Birmingham area, contact the HoB Stop Smoking Team direct on:

(0121) 224-4065
22nd January, 2009

Dear Colleague,

Re: New GP Referral Form for Stop Smoking Referrals

Smoking remains the main cause of preventable ill health and premature death in England and accounts for over 2,200 deaths in Birmingham every year.

GP\'s and nurses are ideally placed to raise awareness of both the benefits of quitting and the effectiveness of local NHS stop smoking services - smokers are four times more likely to quit with support than if they go "cold turkey".

To make the process of referral for stop smoking support easier, the Heart of Birmingham Stop Smoking team have developed a referral template that will self-populate with all the relevant patient information, allowing your practice to complete referrals in a more efficient manner.

In addition, the Stop Smoking team will shortly implement a system to provide practices with information on the outcome of referrals to local pharmacies and clinics. Further information will be sent out about this in the near future.

Yours faithfully,

Dale Ricketts
Smoking Cessation & Public Health Manager
STOP SMOKING REFERRAL FEEDBACK

Patient Name:_________________________ DOB:____________
ID____________
GP:_________________________
Practice:______________________________

Thank you for referring this patient to the Stop Smoking Service. Following your referral, the following outcome was recorded:

Patient has been booked into a local stop smoking support programme (see booking letter for details). Feedback on outcome for this patient will be provided in due course.

Patient was referred to another NHS Stop Smoking Service:

Patient did not wish to access NHS Stop Smoking Service:

Patient could not be contacted by telephone (see non-contact letter)
Please reinforce the importance of stopping smoking for those patients who could not be contacted or did not wish to receive NHS help to stop smoking.

Yours sincerely,

The Stop Smoking team
Get Active…Get Walking Service Specification

Universal Access

Service Description
The programme provides residents with the opportunity to access regular supervised walks on a weekly basis from a wide range of locations, from local parks to community centres.

There will be a total of 30 walks set up, including two or three in each HoBTPCT ward.

Age Range
18+

Referral Criteria
Available to everyone, either turn up to an organised Get Active…Get Walking walk or contact the Health Exchange.

Who can Refer
• Self

Referral Method
Health Exchange
Telephone: 0800 158 3535

Send referral to
N/A

Feedback
No

Service Contact
Health Exchange
Telephone: 0800 158 3535
'Be Active' Service Specification

Universal Access

Service Description

Free gym, exercise classes and swimming at Council-run Leisure Centres. Time restrictions may apply.

Available to people resident in Heart of Birmingham TPCT until 31/03/2011.

Patient to see individual Leisure Centres for details.

Age Range

15+

Referral Criteria

Aged 15 and above for the standard Council Leisure Centres
Aged 8-16 for children's ICE Gyms

Who can Refer

• Self

Referral Method

Signpost patient to individual Leisure Centres.
See information on next page for Heart of Birmingham Leisure Centres.

Send referral to

N/A

Feedback

N/A

Service Contact

Individual Leisure Centres. See information on next page.
'Be Active' Scheme Information

The Be Active scheme currently provides free gym, exercise classes and swimming in Council run Leisure Centres to residents of the Heart of Birmingham Teaching Primary Care Trust area.

To find out if you are covered by the scheme, visit your local Leisure Centre or visit our website at www.hobtpct.nhs.uk which will allow you to check your postcode online.

Can anyone take part?

Anyone living in the Heart of Birmingham area can enjoy the offer, as long as they are 15 and over for the standard Leisure Centres or aged 8-16 for the children's ICE Gyms.

To which gyms does the offer apply?

The scheme covers Council-run local Leisure Centres, and the two children's ICE Gyms in the Heart of Birmingham area (Aston Villa ICE Gym and Hamstead Hall Community Learning Centre ICE Gym).

Are there any restrictions?

As long as there is room at your local Leisure Centre, we'll be able to offer you a free pass - all we ask is that you actively attend the Leisure Centre at least four times a month. Currently, gym, swimming and exercise sessions are included so you will need to pay for any other sport. Time restrictions may also apply for free use, so please check with your local Leisure Centre for information. This is currently running until 31/03/2011.

How do I get involved?

All you need to do to register is take some proof of identity and address with you to your local Leisure Centre:

- 1 x Proof of identity with photo, e.g. driving licence, passport
- 2 x Proof of address e.g. bank statement, utility bill

For the Children's Gyms, the parent/guardian will need to provide the above.

The receptionist will take some details from you and you will then be informed whether you are eligible for Be Active.
## Leisure Centre Details

<table>
<thead>
<tr>
<th>Leisure Centre</th>
<th>Address 1</th>
<th>Address 2</th>
<th>Post Code</th>
<th>Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alexander Stadium</td>
<td>Walsall Road</td>
<td>Perry Barr</td>
<td>B42 2LR</td>
<td>(0121) 464 8008</td>
</tr>
<tr>
<td>Beeches Pool &amp; Fitness Centre</td>
<td>Beeches Road</td>
<td>Great Barr</td>
<td>B42 2HQ</td>
<td>(0121) 464 6296</td>
</tr>
<tr>
<td>Birmingham Sports Centre</td>
<td>Balsall Heath Road</td>
<td>Balsall Heath</td>
<td>B12 9DL</td>
<td>(0121) 464 6060</td>
</tr>
<tr>
<td>Handsworth Leisure Centre</td>
<td>Handsworth Road</td>
<td>Handsworth</td>
<td>B20 2BY</td>
<td>(0121) 464 6336</td>
</tr>
<tr>
<td>Neckells</td>
<td>Holly Road</td>
<td>Neckells</td>
<td>B7 5DT</td>
<td>(0121) 464 4373</td>
</tr>
<tr>
<td>Beeches Road Secondary School</td>
<td>Newtown Road</td>
<td>Albert Street</td>
<td>B19 2SW</td>
<td>(0121) 360 3262</td>
</tr>
<tr>
<td>Aston</td>
<td>Beecles Road</td>
<td>Aston</td>
<td>B10 9RX</td>
<td>(0121) 464 2370</td>
</tr>
<tr>
<td>Sparkhill</td>
<td>Sparkhill Road</td>
<td>Sparkhill</td>
<td>B11 4EA</td>
<td>(0121) 464 1873</td>
</tr>
<tr>
<td>Winson Green</td>
<td>Stratford Road</td>
<td>Winson Green</td>
<td>B18 4EJ</td>
<td>(0121) 303 0863</td>
</tr>
<tr>
<td>Handsworth Wood</td>
<td>Winson Green Road</td>
<td>Handsworth Wood</td>
<td>B20 1HL</td>
<td>(0121) 464 8008</td>
</tr>
<tr>
<td>Aston Villa ICE Gym</td>
<td>Villa Park</td>
<td>Aston Villa</td>
<td>B6 6HE</td>
<td>(0121) 464 8008</td>
</tr>
</tbody>
</table>

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Exercise on Prescription Referral

Patients identified with two or more major risk factors of CHD:
- Family history of CHD
- Smoking
- Raised Cholesterol
- Obese - BMI >30 or BMI > 25 plus one other risk factor

Patients suffering from well-controlled chronic medical conditions
- Mild or controlled asthma
- Chronic Bronchitis
- Controlled DM
- Mild to moderate depression and/or anxiety
- People exhibiting motivation to change

Patients for whom the onset of osteoporosis may be delayed through regular exercise
- Borderline hypertensive patients with a BP no higher than 160/102, prior to medication

GP practice telephones Health and Fitness Advisor stating surgery, patient name and contact details
Fills out and gives patient an EoP card

Patient attends first appointment for an entry consultation (no more than one hour)

Patient has a supported exercise programme over a 10-week period

Patient attends exit consultation with Health and Fitness Advisor

Feedback to practice at end of 10-week programme
Exercise on Prescription Service Specification
First line management

Service Description
A supported exercise programme over a 10-week period including an entry/exit consultation with a Health and Fitness Advisor (HFA). Exercises on the scheme are predominantly gym or exercise class based, but also include walking groups and swimming.

Age Range
18+

Referral Criteria

Inclusion Criteria
People with two or more major risk factors of Coronary Heart Disease:
- Family history of CHD
- Smoking
- Raised Cholesterol
- Obese - BMI > 30 or - BMI > 25 plus one other risk factor
- People suffering from well-controlled chronic medical conditions:
  - Mild or controlled asthma
  - Chronic bronchitis
  - Controlled diabetes mellitus
  - Mild to moderate depression and/or anxiety
- People for whom the onset of osteoporosis may be delayed through regular exercise: ie post-menopausal women
- Borderline hypertensive: patients with a blood pressure no higher than 160/102, prior to medication
- People exhibiting motivation to change

Exclusion Criteria
- Angina pectoris
- Moderate to high (or unstable) hypertension - 160/102 or above
- Poorly-controlled, insulin-dependant diabetes
- History of myocardial infarction within the last six months - unless the patient has completed Stage III cardiac rehabilitation
- Established cerebro-vascular disease
- Severe chronic obstructive airways disease
- Uncontrolled asthma

Who can Refer
- GP

Send referral to
Relevant Health and Fitness Advisor

Referral Method
**Telephone:** individual HFA's number on contact list
1) Fill out and give the patient an EoP prescription card.
2) Telephone HFA directly, stating surgery, patient name, patient contact details. Choose closest Leisure Centre.

Feedback
Yes - 10 week Exit report

Service Contact
Your assigned HFA Or Health and Fitness Projects Officer
0121 464 6056

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Health and Fitness Advisor - Contact List

Scheme Management:

- Email: firstname_lastname@birmingham.gov.uk

Sarah Barge
Projects Officer - Health and Fitness
House of Sport, 300 Broad Street
Birmingham, B1 2DR
Tel: 464 6056  Fax: 464 6035  E:

Health and Fitness Advisors:

Sally Formon
Cocks Moors Woods Leisure Centre
Alcester Road South
Kings Heath, B14 6ER
Tel: 464 0303  Fax: 464 0562  E:

Alan Hodson
Newtown Pool and Fitness Centre
Newtown Road
Aston, B19 2SW
Tel: 464 0832  Fax: 464 4338  E:

Trevor Emms
Shard End Community Centre & Sports Hall
170 Packington Avenue
Shard End, B34 7RD
Tel: 464 0824  Fax: 464 2008  E:

Michelle Harrison
Northfield Pool & Fitness Centre
Bristol Road South
Northfield, B31 2PD
Tel: 464 0799  Fax: 464 0359 E:
Health and Fitness Advisor - Contact List

- Email: firstname_lastname@birmingham.gov.uk

Cheryl Emery  
Wyndley Leisure Centre  
Clifton Road  
Sutton Coldfield, B73 6EB  
Tel: 675 0733  Fax: 675 0733  E: •

Maria Joseph  
Saltley Community Leisure Centre  
Broadway Avenue  
Bordesley Green, B9 5YD  
Tel: 464 8556  Fax: 464 8707  E: •

Ivy Daley  
Handsworth Leisure Centre  
Holly Road  
Handsworth, B20 2BY  
Tel: 464 1513  Fax: 464 7151  E: •

Chad Boden  
Fox Hollies Leisure Centre  
Shirley Road  
Acocks Green, B27 7NS  
Tel: 464 0557  Fax: 464 0796  E: •

Richard Henry  
Castle Vale Community Leisure Centre  
Farnborough Road  
Castle Vale, B35 7NL  
Tel: 675 2564  Fax: 776 7292  E: •

Phil King  
Stechford Cascades  
Station Road  
Stechford, B33 8QN  
Tel: 464 1764  Fax: 464 8411  E: •

Vanessa Trench & Geoff Moyes  
Kingstanding Leisure Centre  
Dulwich Road  
Kingstanding, B44 0EW  
Tel: 464 0370  Fax: 464 1748  E: •

Richard Henry  
Erdington Pool & Turkish Suite  
Mason Road  
Erdington, B24 9EJ  
Tel: 464 0854  Fax: 464 8718  E: •

Louisa Knowles  
Sparkhill Pool & Fitness Centre  
Stratford Road  
Sparkhill, B11 4EA  
Tel: 464 0811  Fax: 464 8783  E: •
The Exercise on Prescription scheme helps people to be healthier by being more active. The first appointment with your health and fitness advisor is an opportunity to talk about a healthy lifestyle, ways to be more active that are the most suitable for you and for you both to plan your new exercise programme.

The programme will be designed especially for you, taking into consideration any medical conditions, your likes and dislikes, your current level of fitness and any commitments such as family or work.

Your time with the advisor is free, but taking part in the leisure centre activities incurs a cost. More information will be available at your first appointment.

The scheme aims to give you the knowledge and skills to enable you to be able to continue independently with a more active lifestyle.

Your health and fitness advisor will monitor your progress for 10 weeks, after which he or she will discuss with you your achievements and your future activity plans.

Your surgery will be informed of your progress.

www.birmingham.gov.uk/eop

Prescription Card

First Name:
Surname:
Address:
Postcode:
Tel No:

Date and time of Appointment:
Name of Health and Fitness Advisor:
Exercise Venue:
Contact Telephone Number:

Further Information
1. Your first appointment with your health and fitness advisor will be for an informal talk.
2. Exercise clothing is NOT needed on your first appointment
3. The first appointment will last a maximum of one hour and you will have the opportunity to be shown around the centre and consider activities to which you are most suited and/or preferred by you
4. There is no charge for your first appointment or for the time spent with your advisor
5. IMPORTANT - as your health and fitness advisor will be waiting for you to arrive, it is important that you telephone in advance if you cannot keep your appointment. An alternative date and time will then be arranged

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Example of 10 week exit report

<table>
<thead>
<tr>
<th>Name:</th>
<th>Number:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Start Date:</td>
<td>Exit Date:</td>
</tr>
</tbody>
</table>

Reason for Referral:

- [ ] To aid weight loss
- [ ] To aid general mobility and joint stiffness
- [ ] To aid reduction in blood pressure
- [ ] To aid heart health
- [ ] To reduce stress
- [ ] To improve general well-being
- [ ] To assist in the prevention of Osteoporosis
- [ ] Chronic Medical Condition:_____

<table>
<thead>
<tr>
<th>Results</th>
<th>Start</th>
<th>Exit</th>
<th>Change</th>
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</thead>
<tbody>
<tr>
<td>Weight</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Body Mass Index</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Waist</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hips</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Waist:Hip Ratio</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Body Fat Percentage</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lean Body Mass</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aerobic Fitness</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Exercise Programme:

Comments:
## Calorie Chart

<table>
<thead>
<tr>
<th>Activity</th>
<th>Rank (1 being most intense)</th>
<th>Intensity</th>
<th>Kcalories used in 20 minutes of activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Playing squash</td>
<td>1</td>
<td>Very high</td>
<td>200</td>
</tr>
<tr>
<td>Running (speed unspecified)</td>
<td>2</td>
<td>Very high</td>
<td>190</td>
</tr>
<tr>
<td>Aerobic dancing - (high)</td>
<td>3</td>
<td>Very high</td>
<td>170</td>
</tr>
<tr>
<td>Playing cricket</td>
<td>4</td>
<td>High</td>
<td>160</td>
</tr>
<tr>
<td>Playing football</td>
<td>5</td>
<td>High</td>
<td>140</td>
</tr>
<tr>
<td>Swimming</td>
<td>6</td>
<td>High</td>
<td>132</td>
</tr>
<tr>
<td>Aerobic dancing - (moderate)</td>
<td>7</td>
<td>High</td>
<td>130</td>
</tr>
<tr>
<td>Climbing stairs (moderate)</td>
<td>8</td>
<td>High</td>
<td>130</td>
</tr>
<tr>
<td>Dancing</td>
<td>9</td>
<td>High</td>
<td>130</td>
</tr>
<tr>
<td>Cycling on flat ground (10mph - moderate cycling)</td>
<td>10</td>
<td>High</td>
<td>125</td>
</tr>
<tr>
<td>Gardening</td>
<td>11</td>
<td>Medium</td>
<td>110</td>
</tr>
<tr>
<td>Bed making</td>
<td>12</td>
<td>Medium</td>
<td>100</td>
</tr>
<tr>
<td>Golf</td>
<td>13</td>
<td>Medium</td>
<td>100</td>
</tr>
<tr>
<td>Climbing stairs (slow)</td>
<td>14</td>
<td>Medium</td>
<td>95</td>
</tr>
<tr>
<td>Playing table tennis</td>
<td>15</td>
<td>Medium</td>
<td>90</td>
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<tr>
<td>Walking on the level (moderate)</td>
<td>16</td>
<td>Medium</td>
<td>85</td>
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<tr>
<td>Dusting</td>
<td>17</td>
<td>Low</td>
<td>70</td>
</tr>
<tr>
<td>Playing pool</td>
<td>18</td>
<td>Low</td>
<td>65</td>
</tr>
<tr>
<td>Cleaning windows</td>
<td>19</td>
<td>Low</td>
<td>60</td>
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<tr>
<td>Washing dishes</td>
<td>20</td>
<td>Low</td>
<td>49</td>
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<tr>
<td>Walking on the level (slow)</td>
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<td>Low</td>
<td>45</td>
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<tr>
<td>Playing cards</td>
<td>22</td>
<td>Very Low</td>
<td>40</td>
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<tr>
<td>Surfing the internet</td>
<td>23</td>
<td>Very Low</td>
<td>30</td>
</tr>
<tr>
<td>Talking on the phone</td>
<td>24</td>
<td>Very Low</td>
<td>24</td>
</tr>
<tr>
<td>Watching TV</td>
<td>25</td>
<td>Very Low</td>
<td>23</td>
</tr>
<tr>
<td>Sleeping</td>
<td>26</td>
<td>Very Low</td>
<td>20</td>
</tr>
</tbody>
</table>

Size Down Service Specification
First Line Intervention

Service Description
A six session weight management group with two follow-ups after weeks four and weeks eight
Delivered by Food Health Advisors
Held at local community venues: Sparkbrook Family Centre, Birmingham Central Library and Soho Health Centre

Age Range
18+

Referral Criteria
Patients with BMI of 25+

Who can Refer
• Self

Referral Method
Telephone: 0121 465 2786

Send referral to
Fernbank Medical Centre

Feedback
No

Service Contact
Team Secretary
Telephone: 0121 465 2786
My Choice Weight Management Pilot
First Line Intervention

Service Description
Weight management service delivered within your GP practice.
12 weekly one to one appointments and 3 follow up appointments
To help patients identify easy and practical lifestyle changes they could make to help them lose weight and keep it off.

Age Range
18+

Referral Criteria
Patients with BMI of 30+ or 28+ (with co-morbidities)
Asian Population: BMI 25+ or 23+ (with co-morbidities)
Patient needs to be motivated to make lifestyle changes

Who Can Refer
- Any member of practice staff. GP, PN, HCA.

Referral Method
Refer patient to the member(s) of staff delivering the My Choice programme within your practice.

Send Referral to
N/A

Feedback
N/A

Service Contact
Sarah Mills, Commissioning and Development Manager, Tackling Obesity Team, 0121 255 0749
My Choice Weight Management Pilot
First Line Intervention

Service Description
Weight management service delivered within local pharmacies.
12 weekly one to one appointments and 3 follow up appointments
To help patients identify easy and practical lifestyle changes they could make to help them lose weight and keep it off.

Age Range
18+

Referral Method
Signpost patient to a participating pharmacy
See information on next page for participating pharmacies

Referral Criteria
Patients with BMI of 30+ or 28+
(with co-morbidities)
Asian Population: BMI 25+ or 23+
(with co-morbidities)
Patient needs to be motivated to make lifestyle changes

Who Can Refer
• Self

Send Referral to
N/A

Feedback
N/A

Service Contact
Sarah Mills, Commissioning and Development Manager, Tackling Obesity Team, 0121 255 0749

Participating Pharmacies

<table>
<thead>
<tr>
<th>Name</th>
<th>Address</th>
<th>Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blue Cross Pharmacy</td>
<td>Soho Road Health Centre, 249 Soho Road</td>
<td>0121 523 1500</td>
</tr>
<tr>
<td>Health Plus Pharmacy</td>
<td>221 Aston Lane, Perry Barr</td>
<td>0121 356 5358</td>
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<tr>
<td>Gill Pharmacy</td>
<td>341 Rookery Road, Handsworth Wood</td>
<td>0121 554 2487</td>
</tr>
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<td>Laser Pharmacy</td>
<td>9 Oakwood Road, Sparkhill</td>
<td>0121 778 2921</td>
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<tr>
<td>Nechells Pharmacy</td>
<td>55 Nechells Park Road</td>
<td>0121 327 0380</td>
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<tr>
<td>Pauls Pharmacy</td>
<td>31 Revesby Walk, Nechells</td>
<td>0121 359 2731</td>
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<tr>
<td>Raj Pharmacy</td>
<td>128 Stoney Lane, Sparkbrook</td>
<td>0121 449 1945</td>
</tr>
<tr>
<td>Rx Pharmacy</td>
<td>256 Wellington Road, Perry Barr</td>
<td>0121 356 3620</td>
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<tr>
<td>Shah Pharmacy</td>
<td>491 Stratford Road, Sparkhill</td>
<td>0121 772 0792</td>
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<tr>
<td>Shire Pharmacy</td>
<td>214 Edward Road, Balsall Heath</td>
<td>0121 440 1642</td>
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<tr>
<td>Soho Pharmacy</td>
<td>2 Trafalgar Road, Handsworth</td>
<td>0121 554 9723</td>
</tr>
<tr>
<td>Vantage Pharmacy</td>
<td>24 Church Road, Aston</td>
<td>0121 326 7159</td>
</tr>
</tbody>
</table>
Postnatal Size Down Service Specification

First line intervention

Service Description
A six session weight management group tailored specifically for women who have recently had a baby within the last 3 years. There are two follow-ups at four and eight weeks after completion.

Delivered by Food Health Advisors
Held at local community centres such as Children’s Centres and Health Centres
Free crèche provided for infants and children under 4 years

Age Range
Women of childbearing age (18 – 46 years)

Referral Criteria
No BMI cut off. Any woman with excess weight to lose after childbirth

Who can Refer
- Self
- GP
- Health care professional

Referral Method
Telephone: 0121 446 1021
Fax: 0121 446 1020
Completed Maternal Nutrition Referral Form

Send Referral to
Nutrition & Dietetic Service, St Patrick’s Centre for Community Health

Feedback
Yes – Standard letter sent to GP unless the patient objects

Service Contact
Maternal Nutrition Team Administrator, St Patrick’s
Telephone: 0121 446 1021

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Fit Moms Service Specification

Specialist service

Service Description

A healthy lifestyle and support group for obese pregnant women to assist them to minimise weight gain through the pregnancy. It consists of three group sessions followed by monthly weight checks throughout the rest of the pregnancy. A final appointment in the postnatal period will signpost into appropriate weight management for ongoing support such as Postnatal Size Down.

The group sessions include healthy eating, staying active in pregnancy and promotion of breastfeeding.

Delivered by Dietitians

Held at local community centres such as Children’s Centres and Health Centres

Free crèche provided for infants and children under 4 years.

Age Range

Women of childbearing age (18 – 46 years)

Referral Criteria

Pregnant women with a pre-pregnancy BMI 30 or more

Who can Refer

- Self
- Midwife
- GP and other health care professionals

Referral Method

Telephone: 0121 446 1021
Fax: 0121 446 1020
Completed Maternal Nutrition Referral Form

Send Referral to

Nutrition & Dietetic Service, St Patrick’s Centre for Community Health

Feedback

Yes. Written entries in the green pregnancy notes. Letter to GP after postnatal visit

Service Contact

Maternal Nutrition Team Administrator or Lead Dietitian, St Patrick’s
Telephone: 0121 446 1021
Birmingham Community Nutrition & Dietetic Service

MATERNAL NUTRITION TEAM
REFERRAL FORM FOR DIETITIAN

<table>
<thead>
<tr>
<th>Surname</th>
<th>First Name</th>
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<td>Miss/Mrs/Ms/Other</td>
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<table>
<thead>
<tr>
<th>Address</th>
<th>GP</th>
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<table>
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<tr>
<th>Postcode</th>
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<table>
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<th>Telephone No.</th>
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<th>NHS Number</th>
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<th>S</th>
<th>W</th>
<th>D</th>
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<table>
<thead>
<tr>
<th>Number of weeks pregnant</th>
<th>Maternity Unit booked into</th>
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<th>Reason for referral:</th>
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<table>
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<th>List any medical conditions:</th>
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</table>

<table>
<thead>
<tr>
<th>List any medication:</th>
<th>If relevant to referral:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Weight:</td>
</tr>
<tr>
<td></td>
<td>Height:</td>
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<table>
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<tr>
<th>List any relevant social issues:</th>
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</table>

<table>
<thead>
<tr>
<th>Are there any safety/security issues involved in seeing this patient?</th>
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<tbody>
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<td>Yes</td>
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<table>
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<tr>
<th>Afternoon commitment to pick up nursery/school children?</th>
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<table>
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<tr>
<th>Is an interpreter required?</th>
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<td>No</td>
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<td>What Language?</td>
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<th>Referred by (please print)</th>
<th>Designation</th>
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<td>Community Midwifery Team</td>
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<table>
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<th>Signature</th>
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<thead>
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<th>Date of referral</th>
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<table>
<thead>
<tr>
<th>This referral has been agreed with the patient</th>
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</thead>
<tbody>
<tr>
<td>Yes</td>
</tr>
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</table>

Please complete this form in full as it will allow us to process the referral more efficiently

Return the completed form to:
Nutrition & Dietetic Department, St Patrick’s Centre for Community Health, Frank Street, Highgate, Birmingham B12 0YA
Tel: 0121 446 1021 Fax: 0121 446 1020
www.dietetics.bham.nhs.uk

* See over for ethnic categories
# Ethnic Categories

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<thead>
<tr>
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<th>Black or Black British</th>
<th>Other Ethnic Groups</th>
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<td>Irish</td>
<td>B African</td>
<td>N</td>
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<td>Any other white background</td>
<td>C Any other Black background</td>
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<tbody>
<tr>
<td>White and Black Caribbean</td>
<td>D Caribbean</td>
<td>R Chinese</td>
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<tr>
<td>White and Black African</td>
<td>E African</td>
<td>S Any other ethnic group</td>
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<tr>
<td>White and Asian</td>
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<td>Any other mixed background</td>
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<table>
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<td>Pakistan</td>
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<tr>
<td>Bangladesh</td>
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</table>
My Choice Weight Management Pilot
First Line Intervention

Service Description
Weight management service delivered within your GP practice.
12 weekly one to one appointments and 3 follow up appointments
To help patients identify easy and practical lifestyle changes they could make to help them lose weight and keep it off.

Age Range
18+

Referral Criteria
Patients with BMI of 30+ or 28+ (with co-morbidities)
Asian Population: BMI 25+ or 23+ (with co-morbidities)
Patient needs to be motivated to make lifestyle changes

Who Can Refer
• Any member of practice staff. GP, PN, HCA.

Referral Method
Refer patient to the member(s) of staff delivering the My Choice programme within your practice.

Send Referral to
N/A

Feedback
N/A

Service Contact
Sarah Mills, Commissioning and Development Manager, Tackling Obesity Team, 0121 255 0749
My Choice Weight Management Pilot
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Service Description
Weight management service delivered within local pharmacies.
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To help patients identify easy and practical lifestyle changes they could make to help them lose weight and keep it off.

Age Range
18+

Referral Method
Signpost patient to a participating pharmacy
See information on next page for participating pharmacies

Referral Criteria
Patients with BMI of 30+ or 28+ (with co-morbidities)
Asian Population: BMI 25+ or 23+ (with co-morbidities)
Patient needs to be motivated to make lifestyle changes

Who Can Refer
• Self

Send Referral to
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Feedback
N/A

Service Contact
Sarah Mills, Commissioning and Development Manager, Tackling Obesity Team, 0121 255 0749

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</tbody>
</table>

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Maternal Health Team
Community Nutrition and Dietetic Service
St Patrick’s Centre for Community Health
Frank Street
Highgate
Birmingham
B12 0YA

SD3

DATE
Dr
ADDRESS

Tel: 0121 446 1021
Fax: 0121 465 1021

Dear Dr

Re: Name, D.O.B.
Address

For Information

The above patient has recently completed our 6 week postnatal Size Down Programme. This is a weight management programme run by Food Health Advisors as part of the Birmingham Community Nutrition and Dietetic Service.

Current Weight =
BMI =
Weight loss =

If you like any further information about this patient or the Size Down Programme. Please do not hesitate to contact me at the above number.

Yours sincerely

Food Health Advisor
Dietetic Appointment Referral

Patients identified with BMI >30
Or >28 + co-morbidities
Asian Ethnicity >25
Or >23+ co-morbidities

GP practice sends fax or letter to Fernbank Medical Centre

Opt-in letter goes to patient with a list of appointment venues and times for patient choice

Patient phones and books assessment appointment

Patient attends first appointment (Up to 5-week lead time for appt)

Patient attends up to six appointments over 6-12 month period

No contact or patient declines service

Feedback to practice via letter

Feedback to practice at end of episode i.e. DNA/completed successfully/partially successful
Dietetic Appointment Service Specification

First Line Intervention

Service Description
A 45-minute assessment with up to six follow-ups (can be groups)
Consists of advice on undertaking activity as well as behavioural, lifestyle and complex issues

Age Range
18+

Referral Criteria
Patients with BMI of 30+ or 28+ (with co-morbidities)
Asian population: BMI 25+ or 23+ (with co-morbidities)

Who can Refer
• Self
• GP
• Healthcare Professional

Referral Method
Fax: 0121 465 2776
Post: Fernbank Medical Centre
508-516 Alum Rock Road
Ward End
Birmingham, B8 3HX

Send referral to
Fernbank Medical Centre

Feedback
Yes - Feedback letter sent to referrer and copy to GP

Service Contact
Clinic Administrator or Lead Clinical Dietitian, Fernbank Medical Centre,
0121 465 2780
# Nutrition and Dietetic Service Referral Form

<table>
<thead>
<tr>
<th>Surname</th>
<th>First Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address</td>
<td></td>
</tr>
<tr>
<td>Post code</td>
<td></td>
</tr>
<tr>
<td>DOB</td>
<td></td>
</tr>
<tr>
<td>Telephone No.</td>
<td>Post Code</td>
</tr>
<tr>
<td>NHS Number</td>
<td>Ethnicity*</td>
</tr>
<tr>
<td>Sex: M F</td>
<td>Civil Status: M S W D</td>
</tr>
<tr>
<td></td>
<td>GP Code</td>
</tr>
</tbody>
</table>

**Medical Diagnosis / Condition:**

**Date of Diagnosis:**

- Underweight  
- Diabetes  
- Obesity  
- CHD  
- IBS  
- Allergy/intolerance  
- Eating Disorders  
- Faltering Growth  
- Nutritionally Compromised  
- BP  

**Reason for Dietetic Input** (e.g., to lose or gain weight; to improve diet; education on diet; supplementary feeding etc.)

Has first line advice been given? YES [ ] NO [ ]

**Relevant medication**

**Relevant recent measurements** (e.g., BMI, weight, height, BP, HbA1c, lipids, Nutrition Screening Tool Score)

**Other services involved** (e.g., District Nurse, CPN, Health Visitor, CCN, Hospital Services/Consultant etc.)

Non Urgent [ ] Urgent [ ] If urgent why?

Is a home visit required NO [ ] Yes [ ] If yes, why?

Are there any safety/security issues involved in seeing this client? Yes [ ] No [ ] If yes, what?

Is an interpreter required? NO [ ] Yes [ ] What language?

Referred by (please print)

Signature

Date of referral

Designation (if not GP)

This referral has been agreed with the patient

Yes [ ] No [ ] Base if not at GP practice

Telephone No.
<table>
<thead>
<tr>
<th>Ethnic Categories</th>
<th>Please circle</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>White</strong></td>
<td></td>
</tr>
<tr>
<td>British</td>
<td>A</td>
</tr>
<tr>
<td>Irish</td>
<td>B</td>
</tr>
<tr>
<td>Any other White background</td>
<td>C</td>
</tr>
<tr>
<td><strong>Mixed</strong></td>
<td></td>
</tr>
<tr>
<td>White and Black Caribbean</td>
<td>D</td>
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<tr>
<td>White and Black African</td>
<td>E</td>
</tr>
<tr>
<td>White and Asian</td>
<td>E</td>
</tr>
<tr>
<td>Any other mixed background</td>
<td>E</td>
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<tr>
<td><strong>Asian or Asian British</strong></td>
<td></td>
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<tr>
<td>Indian</td>
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<td>Pakistani</td>
<td>J</td>
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<tr>
<td>Bangladeshi</td>
<td>K</td>
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<tr>
<td>Any other Asian background</td>
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<tr>
<td><strong>Black or Black British</strong></td>
<td></td>
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<tr>
<td>Caribbean</td>
<td>M</td>
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<tr>
<td>African</td>
<td>N</td>
</tr>
<tr>
<td>Any other Black background</td>
<td>P</td>
</tr>
<tr>
<td><strong>Other ethnic groups</strong></td>
<td></td>
</tr>
<tr>
<td>Chinese</td>
<td>R</td>
</tr>
<tr>
<td>Any other ethnic group</td>
<td>S</td>
</tr>
<tr>
<td><strong>Not Stated</strong></td>
<td></td>
</tr>
<tr>
<td>Not stated</td>
<td>Z</td>
</tr>
</tbody>
</table>
Example of Feedback Form

Date

Dear Dr

Re: DOB:
NHS No: Address:

Thank you for referring the above patient to the Dietetic Service for advice.
They were seen in clinic on......................................................... and assessed as follows:-
Height......................m/cm Weight.........................kg
BMI........................kg/m2

Advice and information regarding the following was given.

<table>
<thead>
<tr>
<th>Weight reducing (weight reduction of 5-10% body weight)</th>
<th>Diabetes Mellitus</th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthy eating</td>
<td>(Balance of Good Health)</td>
</tr>
<tr>
<td>Food intolerance/allergy</td>
<td>Cardio protective diet</td>
</tr>
<tr>
<td>IBS</td>
<td>Lifestyle/behavioural changes</td>
</tr>
<tr>
<td>Other (more details provided under other comments)</td>
<td>Disordered Eating</td>
</tr>
<tr>
<td>Other Comments:-</td>
<td></td>
</tr>
</tbody>
</table>

A follow-up has been arranged for
............................................................................................................................

No follow-up has been arranged and therefore the patient has been discharged from our service
............................................................................................................................

Please contact me if further information is required.

Yours sincerely
...............................................................................................................Signature

Dietitian........................................................................................................Print Name
Specialist Obesity Service Referral

GP/practice staff referral

Criteria:
- BMI over 40 (37.5 if Asian)
- BMI over 35 with co-morbidities (32.5 if Asian)

In addition to one or both of the following:
- Emotional/comfort eating
- Previous attempts to lose weight, e.g. dietetic services, commercial groups etc.

Referral faxed/posted to Specialist Obesity Service

Client attends service currently held at both Aston Pride and Greet Health Centres

Outcomes fed back to practice including confirmation of attendance and consultation notes

Run by a multi-professional team including a cognitive behavioural therapist, specialist dietitian, nurse and GP
Specialist Obesity Service Specification
Specialist Service

Service Description
Service to treat people with morbid obesity. Run by a multi-professional team including a cognitive behavioural therapist, specialist dietitian, nurse and GP. The service aims to provide a more intensive approach and ensure that all options have been tried before someone is considered for bariatric surgery.

Age Range
18+

Referral Criteria
GP referral for patients with:
- BMI over 40 (over 37.5 if Asian ethnicity)
- BMI over 35 with co-morbidities (over 32.5 if Asian ethnicity)
In addition one or both of the following:
- Emotional/comfort eating
- Previous attempts to lose weight e.g. dietetic services/practice-based programmes/commercial groups/pharmacotherapy

Who can Refer
- GP
- Practice Staff

Referral Method
Fax: 0121 627 8834
Post: Obesity Service Administrator
Nutrition and Dietetics
Springfields Centre
Raddlebarn Road
Selly Oak
Birmingham, B26 6JB

Send referral to
Specialist Obesity Service

Feedback
Yes - A copy of consultation notes and confirmation of attendance is faxed to GP

Service Contact
Lead Obesity Dietitian
Telephone: 0121 204 1584
Specialist Obesity Service referral form

Criteria for referral

Please detail previous interventions, e.g. if seen by community dietician before

- BMI over 40 (over 37.5 for Asians)
- BMI over 35 with co-morbidities (over 32.5 for Asians)
- Emotional eating
- Previous attempts to lose weight

<table>
<thead>
<tr>
<th>Surname Mr/Mrs/Miss/Ms/Other</th>
<th>First Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address</td>
<td>GP Practice Address</td>
</tr>
<tr>
<td>Post code</td>
<td>Post Code</td>
</tr>
<tr>
<td>DOB</td>
<td></td>
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<tr>
<td>Telephone No.</td>
<td>Telephone</td>
</tr>
<tr>
<td>NHS Number</td>
<td></td>
</tr>
<tr>
<td>Sex: M/F Civil Status: M/S/W/D</td>
<td>GP Code</td>
</tr>
</tbody>
</table>

Relevant Medical History

Current Height =
Current Weight =
Current BMI =
Summary of previous weight management interventions

Relevant Medication

Relevant recent measurements (e.g. BP, HbA1c, lipids)
(PLEASE INCLUDE LATEST BLOOD TEST RESULTS)

Other services involved e.g. Exercise on Prescription

Are there any safety/security issues involved in seeing this client? Yes/No
If yes, what?

Is an Interpreter required? No/Yes What language?

<table>
<thead>
<tr>
<th>Referred by (please print)</th>
<th>Base if not at GP practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Signature</td>
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<td>Date of referral</td>
<td></td>
</tr>
<tr>
<td>Designation (if not GP)</td>
<td></td>
</tr>
<tr>
<td>This referral has been agreed with the patient? Yes/No</td>
<td>Telephone number</td>
</tr>
<tr>
<td>Ethnic Categories</td>
<td>Please circle</td>
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<tr>
<td>-----------------------------------------</td>
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</tr>
<tr>
<td>White</td>
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<td>British</td>
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<td>S</td>
</tr>
<tr>
<td>Not Stated</td>
<td>Z</td>
</tr>
</tbody>
</table>

Please return to:

Obesity Service Administrator
Nutrition and Dietetics
Springfields Centre
Raddlebarn Road
Selly Oak
Birmingham
B26 6JB

Tel:     0121 204 1584
Fax:     0121 627 8834

Thank you for completing this form in full as it will allow us to process the referral more efficiently.
Example of Feedback Form

Date:

Dear

Re:..........................................................DoB:..........................

Address:...........................................................

NHS Number:..............................................

The above patient has attended their first appointment at the Specialist Obesity Service.

Weight:       Height:       BMI:

<table>
<thead>
<tr>
<th>Overall Aim of Treatment :</th>
</tr>
</thead>
<tbody>
<tr>
<td>5-10% weight loss</td>
</tr>
</tbody>
</table>

Doctor Comments

Dietitian Comments

We will review them regularly over the next 6-12 months and will keep you informed of their progress.

Yours sincerely

Trisna Patel, Senior Dietitian in Obesity Management

BCNDS Specialist Weight Management Clinics are staffed by:
Dr George Areje and Dr Mohammed Waheed GP’s with a Special Interest in Obesity
Alison French, Lisa Jack, Trisna Patel, Linda Hindle, Specialist Dietitians in Obesity Management
David Kendrick Consultant Bariatric Psychologist
Frances Lumley and June Silverthorne Counsellors and Therapists
Claire Barnes Trainee Counsellor and Exercise Specialist
Balwinder Bhachu and Ade Suberu Obesity Clinic Administrator’s
and managed by Alison French RD Obesity Lead Dietitian
Alcohol Single Point of Contact (SPOC) Tel: 0800 073 0817

Self

Tier 1 Services

GPs

Statutory Health Services

Critical Medical Need 999

Full audit undertaken Harm minimisation given

SPOC

Note: Referral dependent upon level of motivation and request

Audit Score 0-7

Tier 1

Brief Intervention

• Brief advice given by SPOC
• Leaflet sent
• Web links
• Local Lloyds Pharmacy address

Audit Score 8-19

Tier 2

Extended brief interventions (6 sessions)

Aquarius Consortium:

• Community based provision (including 16-21 age group)
• SIFA (Homelessness)
• IWIC
• The A team
  Primary care Services

Audit Score 20+

Tier 3

Complex need or physical dependency + rehabilitation

• Aquarius/BSMHT
• HIAH (13-19 years)

Audit Score 20+

Tier 4

Residential Rehab + inpatient detox

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Alcohol Service Specification
Universal Access

Service Description
All tiers of service can be accessed through the alcohol services Single Point of Contact (SPOC). On contact a short triage session will be made to assess what is the most appropriate service for referral.

Brief advice and information can also be offered.

Tier 1
- Lloyds pharmacist
  - Offering 1:1 advice, information and support

Tier 2
- NACRO/RAPT - Primary Care Services
- Aquarius - Community based services
  - offering ongoing specialist advice, information and support
- SIFA (Fireside) - Community-based service
  - Offering specialist advice and support to those who are socially disadvantaged or excluded on issues around alcohol and homelessness

Tier 3
- Birmingham & Solihull Mental Health Trust
  - Home detox programme
- Aquarius
  - In-depth psycho/social support

Tier 4
- In-patient detox and rehabilitation

Age Range
16+

Referral Method
Telephone: 0800 073 0817

Referral Criteria
Free access

Feedback
None at present

Who can Refer
- Anyone
- Self-referral or professional referral

Service Contact
Telephone: 0800 073 0817
Drugs Service Specification
(Birmingham Drug & Alcohol Action Team)

Universal Access

Service Description

A wide range of services for help and support for problems with heroin, cocaine, crack, other stimulants and cannabis. Contact the Single Point of Contact (SPOC) in the Drug & Alcohol Action Team and a brief assessment will be made of what is the most appropriate service for referral.

For further details of the GP Locally Enhanced Service for drugs treatment, contact tony.mercer@hobtpct.nhs.uk.

Open Access Services

- Information and advice
- Needle exchange
- Blood-borne virus testing and vaccination
- Assessment for structured treatment

Structured Treatments

- Specialist substitute prescribing
- GP substitute prescribing
- Structured day care
- Counselling and psychology services
- In-patient detox
- Residential rehabilitation

Specialist Services

- Mother and baby/pregnancy
- Sex workers (male & female)
- Rough sleepers

Age Range

18 +

Referral Method

Telephone: 0800 073 0817

Referral Criteria

Free access

Feedback

None at present

Who can Refer

- Anyone
- Self-referral or professional referral

Service Contact

Telephone: 0800 073 0817

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Expert patient referral pathway

**Expert Patient Programme (EPP)**

**EPP**
For patients with long-term conditions

Health Professional e-mails referral from to epp.hobtpct@nhs.net

Patient/carer attends Expert Patient Programme/Looking After Me for six weeks (2½ hours per week)

Patient/carer must attend minimum of four weeks in order to receive certificate of completion

Patient/carer learns skills and techniques to effectively manage long term illness on daily basis

Patient/carer completes 6-week programme and receives certificate of attendance

Patient/carer given option of applying to become EPP tutors on completion of programme

Peer to Peer support network established and/or signposted to other services

Looking After Me for carers of patients with long-term conditions

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Expert patient service specification
Expert Patient Programme (EPP)

Universal Access

Service Description
A free training course for patients and carers to help them live with a long-term illness (see examples listed below). The course lasts six weeks (2½ hours per week) and provides them with a variety of skills and techniques to better manage their illness on a daily basis.

The training is delivered by patients with a long term condition, who have successfully completed the programme, and is delivered in a range languages and locations.

Age Range
18 +

Referral Criteria
Any patient (and their carer if they have one) with a long-term illness. Examples include; Heart Disease, Diabetes, Chronic Kidney Disease, IBS, Parkinson’s Disease, MS, Anxiety/Depression, Arthritis, etc.

Who can Refer
• Health Professionals

Referral Method
E-mail referral form to address below

Send referral to
epp.hobtpct@nhs.net

Feedback
N/A

Service Contact
Expert Patient Programme
Co-ordinator
0121 255 0742
Looking After Me

Looking After Me is a free course for adults who care for someone living with a long-term health condition or disability. The course is about you making time to look after your own health needs. It aims to help you take more control of your situation and make a difference to your life.

The course looks at:

- relaxation techniques
- dealing with tiredness
- exercise
- healthy eating
- coping with depression
- communicating with family, friends and professionals
- planning for the future

Who can take part?

Any adult who cares or gives help to a relative or friend who is ill, disabled, elderly or in need of emotional support (in other words, they are a carer).

How can it help you?

By taking part in a Looking After Me course, you will:

- learn new skills to help you to cope with your caring situation
- develop the confidence to take more control of your life
- meet with others who share similar experiences

How has it helped others?

People who have taken part in a Looking After Me course have reported that it has helped them to:

- feel confident and more in control of their life
- manage their caring situation more effectively
- be realistic about the impact of their caring situation on themselves and their family
- develop more effective relationships with health and care professionals
- use their skills and knowledge to lead a fuller life

(For more Information complete the referral/registration form and e-mail to epp.hobtpct@nhs.net)
Expert Patient Referral/Registration Form

Email to epp.hobtpct@nhs.net

Mr/Mrs/Miss/Ms: ______________
First Name: ________________  Surname: _______________________

Address: ______________________________________________________

_________________________________________________________________

Post code: __________________

Tel: ____________________  Mobile: _____________________________

Email: __________________________

Date of birth: _____________  Male / Female: __________________

Religion: ____________________  Ethnicity: ______________________

Long term condition (please state):________________________________

Are you a carer? Yes / No  Is patient disabled? Yes / No

If YES please give details__________________________________________

1st spoken language (please state):________________________________

Referred by: ___________________________________________________
Health Exchange Community Sites
(Access to health information and supporters)

1. Afro Caribbean Millennium Centre  
   339 Dudley Road, Winson Green, B18 4EZ

2. Chinese Community Centre  
   98 Bradford Street, Digbeth, B12 0NS Tel: 0121 685 8510

3. Finch Road Health Centre  
   Finch Road, Lozells, B19 1HS

4. Handsworth Library  
   Soho Road, B21 9DP

5. Health Exchange Hub  
   5th Floor, Central Library, Chamberlain Square, B3 3HQ

6. Nishkam Centre  
   6 Soho Road, Handsworth, B21 9BH

7. Patient Information Centre  
   Birmingham Treatment Centre, City Hospital, Dudley Road, B18 7QH

8. Pertemps People Development Centre  
   Newtown Advancement Centre, Unit 40, Newtown Shopping Centre, Newtown, B19 2SS

9. Saheli Women's Centre  
   Court Road, Balsall Heath, B12 9LB Tel: 0121 446 6137

10. Small Heath Library  
    Muntz Street, B10 9RX

11. Soho Health Centre  
    Louise Road, Handsworth, B21 9RY

12. Spring Hill Library  
    Spring Hill, Birmingham, B18 7BH

13. Summerfield Health Centre  
    Winson Green Road, Winson Green, B18 7AG

14. Sure Start - Soho Children's Centre  
    Louise Road, Handsworth, B21 0RY

15. Sure Start - Summerfield Children's Centre  
    42 Cape Street, Winson Green, B18 4LE

16. The Mu'ath Trust  
    Bordesley Centre, Stratford Road, Birmingham, B11 1AR

17. UK Asian Women's Centre  
    23 Hamstead Road, Hockley, B19 1BX

18. Women's Help Centre  
    321 Rookery Road, Handsworth, B21 9PR
Health Exchange Service Specification

Universal Access

Service Description
The Health Exchange is a free one-stop shop for information on health services in your local community. For venues, please see facing page. Information on services is provided by locally-recruited Health Exchange supporters.

Age Range
Any

Referral Criteria
Free access

Who can Refer
• Self
• Primary Care Staff

Referral Method
Telephone: 0800 158 3535

Send referral to
Health Exchange

Feedback
N/A

Service Contact
Operations Director Health Exchange
0121 607 0113
www.healthexchange.org.uk
Health Trainer Referral

1. Patient interested in making lifestyle changes
2. Practice e-mails/faxes referral form to the Health Exchange (HE)
3. HE input onto National Database
4. Within 48 hours telephone client to make 1st appointment
5. HE allocate Health Trainer
6. 1st session - re-confirm appointment on day, plan agreed with client
7. Last session with client
8. Report sent to practice
9. Offered Health Exchange membership
Health Trainer Service Specification

Health Exchange

Service Description
The service offers support to patients to make lifestyle changes using a mix of goal-setting (maximum of three goals set, e.g. weight loss), monitoring and motivational coaching.

It consists of 6-8 one-to-one appointments lasting approximately one hour each in the practice*.

Patients are assigned a dedicated Health Trainer who will use the patients' first language wherever possible.

Age Range
18+

Referral Criteria
Clients must have at least one of the following risk factors:

- Smokes
- BMI 25+
- Alcohol usage necessary for referral

Who can Refer
- GP
- Practice Staff

Referral Method
Fax: 0121 607 0137
E-mail: healthtrainers@healthexchange.org.uk

Feedback
Yes, but must be requested

Please state:
Feedback form to GP Practice

Send referral to
Health Exchange

Service Contact
Health Trainer Co-ordinator
0121 607 0110

* if your practice is not signed up for this service, ring Health Exchange on 0121 607 0110

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Referral Form
FAX to HEALTH EXCHANGE 0121 607 0137
or email to Healthtrainers@healthexchange.org.uk

<table>
<thead>
<tr>
<th>Name of Patient</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Address</td>
<td></td>
</tr>
<tr>
<td>Telephone Number</td>
<td>Home</td>
</tr>
<tr>
<td>Date of Birth</td>
<td></td>
</tr>
<tr>
<td>Gender</td>
<td>Male</td>
</tr>
<tr>
<td>Religion</td>
<td></td>
</tr>
</tbody>
</table>

**Interests**

(please mark the relevant box with an x)

<table>
<thead>
<tr>
<th>Interest</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Weight reduction</td>
<td></td>
</tr>
<tr>
<td>Healthy Eating</td>
<td></td>
</tr>
<tr>
<td>Increase Exercise</td>
<td></td>
</tr>
<tr>
<td>Stop Smoking</td>
<td></td>
</tr>
<tr>
<td>Reduce Alcohol Intake</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Is Patient Disabled?</th>
<th>Yes/No</th>
</tr>
</thead>
<tbody>
<tr>
<td>If YES, please give details</td>
<td></td>
</tr>
</tbody>
</table>

Does the patient speak English? Yes/No

If not, does the patient speak one of the following languages?

Punjabi Bengali Urdu Gujurati Other If other, please specify

Referred by

Position

Practice Code Source

Chronic Disease Register
Cardio-vascular disease Screening Other

Please ensure you have the patient's consent to make this referral
Example of Feedback Form

Health Trainers

Health Trainer: .................................................................

Name of Practice...............................................................

Address..................................................................................

Postcode.................................................................

Telephone Number..........................................................

Contact.............................................................................

Name of Client.................................................................

Address................................................................................

Home Tel:................................................................. Mob:..........................................................

This Patient is NOT suitable for referral at this time for the following reason:

☐ On Holiday/Out of country
☐ Not contactable
☐ Inappropriate age (all patients MUST be 18 and over)
☐ Failed to attend 3 consecutive appointments
☐ Inconvenient time. Would prefer to wait a while.
☐ Not interested in Health Exchange services

Comments:...........................................................................
..................................................................................

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Chronic Disease Educator Referral

Patient’s name added to CVD Register

GP practice sends letter to patient offering Chronic Disease Educator Service

Health Exchange assigns Chronic Disease Educator to patient

Patient offered group session at location and time that suits them best

First group session

Last group session

Three months after final session follow-up questionnaire sent to patient

Patient questionnaire fed back to GP practice

GP practice sends a copy of the letter to Health Exchange by fax/e-mail

Chronic Disease Educator contacts patient (telephone) to arrange appointment

Patient attends four group sessions (1½ hours) once a week

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Chronic Disease Education Service Specification

Health Exchange

Service Description
The service provides group education sessions for people with one or more long-term conditions. There are four sessions in a programme and they run once a week.

A session consists of tasks, information, visual aids, useful advice, tips about food, exercise and lifestyle and how to increase confidence to manage condition.

Patients’ partners are welcome and the sessions are suitable for newly-diagnosed and long-term patients who need to accept condition, implications and lifestyle changes.

Age Range
18+

Referral Criteria
- One or more long-term conditions e.g. diabetes, heart disease and chronic kidney disease
- Patient’s consent

Who can Refer
- Practice clinical staff

Referral Method
Fax: 0121 607 0137
E-mail: CDEducators@healthexchange.org.uk

Send referral to
Health Exchange - AS ABOVE

Feedback
Questionnaire is sent to patient and practice updated with outcome

Service Contact
Operations Manager Health Exchange
0121 607 0113

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Chronic Disease Educators Referral

FAX to HEALTH EXCHANGE 0121 607 0137
or email to CDEducators@healthexchange.org.uk

Name of Patient

Address


Telephone Number

Home ___________________________ Mobile ___________________________

Date of Birth ________ Male / Female ________ Religion ____________________

Condition: Please Tick

Diabetes □ Coronary Heart Disease □ Chronic Kidney Disease □

Date Diagnosed ________________________________

Is Patient Disabled Yes / No

"YES Please give details _______________________

Does the patient speak English? Yes / No

If not does the patient speak one of the following languages: Please Tick

Punjabi □ Mirpuri □ Urdu □ Bengali □

Other Please Specify ______________________________

Referred By ______________________________

Position __________________________ Practice Code ______________________

Please ensure you have the patients consent to make this referral.

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Example of patient questionnaire

Did you decide to try and change your lifestyle in some way?
Yes  No

<table>
<thead>
<tr>
<th>If Yes in what way did you decide to change?</th>
<th>Were you Successful</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Please Tick)</td>
<td>(Please Tick)</td>
</tr>
<tr>
<td>Eat more Healthily</td>
<td></td>
</tr>
<tr>
<td>Take More Exercise</td>
<td></td>
</tr>
<tr>
<td>Lose Weight</td>
<td></td>
</tr>
<tr>
<td>Take medication on a more regular basis</td>
<td></td>
</tr>
<tr>
<td>Reduce / Stop Drinking Alcohol</td>
<td></td>
</tr>
<tr>
<td>Stop Smoking</td>
<td></td>
</tr>
<tr>
<td>Relax More</td>
<td></td>
</tr>
</tbody>
</table>

How useful was the course in helping you make the change?

<table>
<thead>
<tr>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
</tr>
</thead>
</table>
Not very useful                         Very Useful
Evidenced-based information

Key Healthy Eating Messages

Base your meals on starchy foods

- Try to include a helping of starchy food with each of your main meals (bread, cereals, rice or pasta)
- Try to choose wholegrain varieties

Eat lots of fruit and vegetables

- Try to eat at least five portions (one portion = approx. one handful) of a variety of fruit and vegetables every day
- Choose from fresh, frozen, dried, tinned and juiced (1 glass a day)

Eat more fish, including a portion of oily fish each week

- Aim for at least two portions of fish a week, including one portion of oily fish (e.g. salmon, mackerel, sardines)

Cut down on saturated fat and sugar *

- Try to cut down on foods high in saturated fat (processed meat, cheese, butter, cakes and biscuits) and eat foods rich in unsaturated fat (rapeseed/olive oils, oily fish, nuts and seeds) instead
- Cut any visible fat off meats
- Try to eat fewer foods that contain added sugar (e.g. sweets, cakes, biscuits and fizzy drinks)

Try to eat less salt - no more than 6g a day for adults *

- Most of the salt we eat is already in the food we buy, e.g. breakfast cereal, soups, sauces, bread and ready meals
- Try other flavourings such as herbs, spices, lemon, onion and garlic

Drink plenty of water

- Aim to drink about six to eight glasses of water every day
- When the weather is warm or when we get active, our bodies need more than this

Don’t skip breakfast

- Breakfast can help give us the energy we need to face the day
- Eating breakfast helps people to control their weight

* See visual aid
Smart Goals
(Specific Measurable Achievable Relevant Timely)

Deciding on a goal...

When helping the patient to choose a goal get them to think about changes they could make (these can be either long-or short-term).

Ensure that they are happy that the change they want to make is:

1. Important to them!
2. Something they are confident they can work towards

Setting a SMART goal...

When helping set goals with your patient, it is important that it is a SMART goal and not a general goal.

Often when people are setting goals for something they want to change about themselves or their behaviour, they set themselves goals that are too vague and difficult to achieve.

For example, many people set the goal "I want be healthier" or "I want to do more exercise"; in reality this is difficult to measure when we are assessing how successful we are in achieving this goal.
Smart Goal Glossary

Specific
It is important to set goals that are clear and precise. To help set goals that are specific, it is useful to ask the following questions:

- What are you going to do?
- How are you going to do it?
- Where are you going to do it?
- When are you going to do it?
- Who are you going to do it with?

Measurable
If the goal has been made specific then this should also make the goal easy to measure. If the goal is easy to measure then we can also assess success or failure to achieve a given goal much easier.

For example, a measurable goal would be, "I will go to aerobics class for an hour on a Monday between 7pm and 8pm for a whole month". With this goal the individual can then record whether or not they went to aerobics class for an hour every Monday in a given month; if they didn’t then we can safely say they did not achieve their goal.

Achievable
It is important that goals are set that are within the patient's reach and not unrealistic. For example, setting a goal such as "I am going to give up all chocolate and sweets now" is unrealistic and it is most likely the patient will fail.

Failing to achieve a goal can then have a negative effect on motivation and may lead to the patient giving up the goal altogether.

A more achievable and realistic goal would be "I will eat no more than three portions of chocolate or sweets in the next seven days." It is important to make the first goal quite easy to achieve to boost the patient’s self-confidence and encourage them to carry on with the goal.

The most effective way to change behaviour and maintain behaviour change is to build on small successes.

Relevant
The patient needs to feel that the goal set is relevant to them and their behaviour. It is easy for us to project our own goals for change on to people, but we need to remember that if the goal is not something that the patient wants to achieve then it follows that it won’t be achieved. It needs to be relevant.

Timely
A timeframe needs to be set for when they are to achieve their goal by; if there is no completion date, the goal could go on forever without being achieved.

The patient needs to set a realistic timeframe in which to achieve their goal.
Changing Behaviours
Section 1. Stages of behaviour change

Pre-contemplation
Patient not intending to make any change to their behaviour
E.g. I like eating take-away food and I’m not going to stop

Contemplation
Patient is thinking about maybe changing their behaviour
E.g. I can’t fit into my favourite clothes anymore. Maybe I should try to eat more healthily.

Preparation
Patient begins to make small changes
E.g. I’ve started to cook healthy meals

Action
Patient is actively engaging in behaviour change
E.g. I’m eating healthily and have now lost a stone in weight

Maintenance
Patient has sustained the change over time
E.g. I don’t eat as much take-away food and I’m continuing to lose weight

Patient is not yet ready to make behaviour change therefore offer Health Trainer service contact details for future reference

Patient is showing signs of readiness therefore go through Importance and Confidence scales with patient (section 2)

Go through section 2 with patient. Check the behaviour that they are trying to change is still important to them

Note - Patients will often have temporary lapses in behaviour and fall back into a previous stage of change or relapse (e.g. permanently returning to their old habits. This is normal and part of the behaviour change process.

(Prochaska & DiClemente, 1982)
Changing Behaviours

Section 2. Assessing readiness to change

Assessing whether the patient is motivated, ready and willing to change behaviour.

Importance

<table>
<thead>
<tr>
<th></th>
<th>1</th>
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<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
</tr>
</thead>
<tbody>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Very important</td>
</tr>
</tbody>
</table>

On a scale of 1-10, how important is it that you...? (insert behaviour change)

What number would you give yourself?

What could you do to increase your score on the scale?

Confidence

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
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</thead>
<tbody>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Very confident</td>
</tr>
</tbody>
</table>

On a scale of 1-10, how confident are you that you...? (insert behaviour change)

What number would you give yourself?

What could you do to increase your score on the scale?

Tackling barriers to change

- Get the patient to think about the behaviour they have chosen to change
- Then get them to list benefits of making the change
- Briefly allow the patient to look at the COSTS vs. BENEFITS of making this change

IF the COSTS outweigh the benefits, get them to think about a couple of things they could do to help make this change easier and discuss ways in which these obstacles can be tackled (E.g. I don't have enough money to exercise could be overcome by suggesting free walks in the park)

- Get the patient to think of a couple of things that may hinder them making this change, then how they may be able to overcome them
- Get the patient to think about a couple of things to help them make the behaviour change
**Food Diary (optional use)**

Use this diary sheet to record what you eat and drink every day.

<table>
<thead>
<tr>
<th></th>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
<th>Thursday</th>
<th>Friday</th>
<th>Saturday</th>
<th>Sunday</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Breakfast</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Morning snacks</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Lunch</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Afternoon snacks</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Evening meal</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Evening snacks</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Remember: Eat a variety of fruit and vegetables and aim for at least "5 a day".*
**Physical Activity (optional use)**

Use this diary sheet to record the exercise you take every day.

Write down how long you spend doing these activities.

Remember physical activity includes walking, using stairs and gardening as well as sports and the gym.

<table>
<thead>
<tr>
<th></th>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
<th>Thursday</th>
<th>Friday</th>
<th>Saturday</th>
<th>Sunday</th>
</tr>
</thead>
<tbody>
<tr>
<td>Morning</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Afternoon</td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Evening</td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

*Be active every day if you can.*

*The recommendation for health is at least 30 minutes on five days a week of activity that makes you slightly out of breath.*

*Physically active people are 50% less likely to develop major diseases like heart disease.*
**Smoking Diary (optional use)**

Use this diary sheet to record how many cigarettes you smoke every day.

Writing down how many cigarettes you smoke each day will help act as a reminder of how many cigarettes you smoke each week.

<table>
<thead>
<tr>
<th></th>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
<th>Thursday</th>
<th>Friday</th>
<th>Saturday</th>
<th>Sunday</th>
</tr>
</thead>
<tbody>
<tr>
<td>Morning</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Afternoon</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Evening</td>
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<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Remember that smoking causes heart disease, cancer and second-hand smoke harms the health of those around you.*
## Pedometer Diary (optional use)

Use this diary sheet to record how many steps you take each day.

Writing down how many steps you take each day will act as a reminder of how many steps you have taken each week and how well you have done.

<table>
<thead>
<tr>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
<th>Thursday</th>
<th>Friday</th>
<th>Saturday</th>
<th>Sunday</th>
</tr>
</thead>
<tbody>
<tr>
<td>Steps Taken</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Monday</td>
<td>Tuesday</td>
<td>Wednesday</td>
<td>Thursday</td>
<td>Friday</td>
<td>Saturday</td>
<td>Sunday</td>
</tr>
<tr>
<td>Steps Taken</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Monday</td>
<td>Tuesday</td>
<td>Wednesday</td>
<td>Thursday</td>
<td>Friday</td>
<td>Saturday</td>
<td>Sunday</td>
</tr>
<tr>
<td>Steps Taken</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Try to exercise every day.

Try to increase the number of steps you take each week.

Don't give up if you have a bad week.
### Alcohol Diary (optional use)

Use this diary sheet to record how many alcoholic drinks you have each day.

Writing down how much alcohol you drink each day will help to remind you of how much alcohol you drink each week.

<table>
<thead>
<tr>
<th>Monday Morning</th>
<th>Monday Afternoon</th>
<th>Monday Evening</th>
<th>Tuesday Morning</th>
<th>Tuesday Afternoon</th>
<th>Tuesday Evening</th>
<th>Wednesday Morning</th>
<th>Wednesday Afternoon</th>
<th>Wednesday Evening</th>
<th>Thursday Morning</th>
<th>Thursday Afternoon</th>
<th>Thursday Evening</th>
<th>Friday Morning</th>
<th>Friday Afternoon</th>
<th>Friday Evening</th>
<th>Saturday Morning</th>
<th>Saturday Afternoon</th>
<th>Saturday Evening</th>
<th>Sunday Morning</th>
<th>Sunday Afternoon</th>
<th>Sunday Evening</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>

*Men should not regularly drink more than three to four units of alcohol per day.*

*Women should not regularly drink more than two to three units of alcohol per day.*
# My Health - Setting my SMART Goal

<table>
<thead>
<tr>
<th></th>
<th>Recommendations</th>
<th>My Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>BMI</td>
<td>Healthy Range:</td>
<td>It is important to set a goal that you can reach!</td>
</tr>
<tr>
<td>Weight</td>
<td>Healthy Range:</td>
<td>What are you going to do?</td>
</tr>
<tr>
<td>Waist</td>
<td>Healthy Range:</td>
<td>How are you going to do it?</td>
</tr>
<tr>
<td>BP</td>
<td>Healthy Range:</td>
<td>Where are you going to do it?</td>
</tr>
<tr>
<td>Exercise</td>
<td>Aim for at least 30 minutes five times a week</td>
<td>When are you going to do it?</td>
</tr>
<tr>
<td>Diet</td>
<td>5 A Day (fruit &amp; veg) Cut down fat &amp; sugar Eat breakfast</td>
<td>Who are you going to do it with?</td>
</tr>
<tr>
<td>Alcohol</td>
<td>Less than three units per day (women) Less than four units per day (men)</td>
<td></td>
</tr>
<tr>
<td>Smoking</td>
<td>0</td>
<td></td>
</tr>
</tbody>
</table>

## Recommendations

- **BMI**: Results:  
  - Healthy Range:  
  - Yes/No

- **Weight**: Results:  
  - Healthy Range:  
  - Yes/No

- **Waist**: Results:  
  - Healthy Range:  
  - Yes/No

- **BP**: Results:  
  - Healthy Range:  
  - Yes/No

- **Exercise**: Exercise is important for your heart, lungs and blood pressure as it increases the fitness of all muscles allowing them to work better. It also decreases the amount of fat in the body helping you to manage weight.

- **Diet**: Eating a healthy, balanced diet every day may help reduce the risk of heart disease, stroke and some cancers.

- **Alcohol**: Too much alcohol causes serious health risks including liver disease, stomach disorders and some cancers, particularly of the mouth, throat and gullet.

- **Smoking**: Smoking causes heart disease, cancer and second-hand smoke harms the health of those around you.

---

### Free NHS Health Check

Helping you prevent heart disease, stroke, diabetes and kidney disease
Marketing Campaign

- Residents magazine
- Bus (Internal bulkhead) campaign - Winter 2009/2010
- Ad Van 10 days x 2 - Winter 2009 / Spring 2010
- Bus (Internal bulkhead) - Winter 2009 / Spring 2010
- TV - Dr Felix Burden appearance
- Radio
- Newspapers
- Mail shots
"Last year over 10,000 people had a free health check in Birmingham. Why don’t you?"

If you are aged between 40-74 years old, contact your GP or call for a free health check: 0345 245 0790

Free NHS Health Check
Helping you prevent heart disease, stroke, diabetes and kidney disease.
Payment

Practices will be paid:

- Within the financial year
- According to the percentage of patients screened

<table>
<thead>
<tr>
<th>Percentage achieved</th>
<th>Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Up to 20%</td>
<td>£10 per patient</td>
</tr>
<tr>
<td>21% - 50%</td>
<td>£15 per patient</td>
</tr>
<tr>
<td>51% - 74%</td>
<td>£18 per patient</td>
</tr>
<tr>
<td>75% or more</td>
<td>£20 per patient</td>
</tr>
</tbody>
</table>

Practices will be expected to provide the Trust with an interim report via MSDi of patients screened.

The Trust reserves the right to terminate this LES.

Retrospective payments will be made to take into account the increased percentage of patients screened.
Contact Details

Deadly Trio Clinical Lead:
- Dr Felix Burden
- Tel: 0121 255 0153
- E-mail: felix.burden@hobtpct.nhs.uk

Deadly Trio Programme Manager:
- Mrs Mary Rutledge
- Tel: 0121 255 0763
- E-mail: mary.rutledge@hobtpct.nhs.uk

Deadly Trio Programme Officers:
- Mrs Linda Burnett
- Tel: 0121 255 0765
- E-mail: linda.burnett@hobtpct.nhs.uk

Practice Support Practitioner
- Ms Kathy Lee
- Tel: 0121 255 0632
- E-mail: kathleen.lee@hobtpct.nhs.uk

Postal Address:
Heart of Birmingham teaching PCT
Public Health
Bartholomew House
142 Hagley Road
Birmingham
B16 9PA
Acknowledgments and References

The following references and documents have guided this handbook.

Dr AC Burden (2009) Clinical Director Long-Term Conditions
Dr Gwyn Harris (2009) GP Prescribing Advisor
Armitage, C.J. (2007) Effects of an implementation intention-based intervention on fruit consumption. Psychology and Health, 22(8), 917-928
British Nutrition Foundation www.nutrition.org.uk
Food Standards Agency www.eatwell.gov.uk
Food Standards Agency http://www.salt.gov.uk/science_on_salt.html
NICE guidelines http://www.nice.org.uk/nicemedia/pdf/PH001_smoking_cessation.pdf)

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