

## **SERVICE FRAMEWORK FOR CARDIOVASCULAR HEALTH AND WELL BEING**

### **SECTION 5: STANDARDS FOR HEALTH IMPROVEMENT / PREVENTION**

The World Health Organisation (WHO) has identified certain key factors, which they propose may have a significant impact on health. These include the physical, social and economic environment, such as housing, air quality, income etc as well as individuals/families/communities/cultural behaviours and characteristics. Many of these 'determinants of health' are not under the direct control of the individual and, therefore, one person's health may differ from another's depending upon their circumstances.

Addressing these wider determinants of health and social wellbeing will ultimately have a major impact on the health of our population. However, it will require action across all Departments not just Health. Investing for Health, the Public Health Strategy for Northern Ireland 2002, recognised that 'health improvement is largely about acting before people need medical care and that it requires action right across Government and beyond in addressing a broad range of economic, social and environmental policy issues.'

In order to influence policy which will impact on the wider determinants of health and wellbeing, all health care providers should work with other sectors and act as advocates for health. The nature of this work does not fit easily into the framework template and so has not been included as a standard, but it is clearly one of the most important actions within the health service in terms of potential to improve health.

This framework sets standards and performance indicators for the health service, the latter to allow us to monitor progress against the standards. Within the field of health promotion there are many potential areas of work, but in terms of cardiovascular disease we have concentrated on the areas of smoking prevention and cessation, nutrition, physical activity and obesity.

The development of the health improvement standards included in this document was challenging. The standards were developed for the Framework for Cardiovascular Health and Wellbeing, but also had to be generally applicable to subsequent Frameworks, such as Respiratory and Cancer. There have been difficulties both with

## **SERVICE FRAMEWORK FOR CARDIOVASCULAR HEALTH AND WELL BEING**

applying the framework template and with data availability for monitoring outcomes. Following a lengthy process we hope that meaningful and effective standards and performance indicators have been developed.

## SERVICE FRAMEWORK FOR CARDIOVASCULAR HEALTH AND WELL BEING

### Overarching standard 3:

Health and social care should work in cooperation with voluntary, education, youth and community organisations to prevent the recruitment of young people to smoking.

#### Rationale:

Smoking is one of the recognised risk factors for CVD, hypertension and renal disease. Its effects are related to the amount of tobacco smoked daily and the duration of smoking.

Stopping young people from starting to smoke is crucial to reducing smoking levels, as evidence suggests that 82% of adult smokers started in their early teens (Tobacco Action Plan). The Young People Behaviour and Attitude Surveys in 2000 and 2003, have shown that the rates of boys smoking every day has remained constant (25.2% and 23.9% of sample) whilst girls who smoke every day has increased (24.9% and 30.6% of sample).

Current interventions have not been shown to stop recruitment to smoking by young people. There is some evidence that 'The Smoke Busters' programme delays the age of onset. NICE guidance on smoking and young people is expected in July 2008 and this standard may need revised at that time.

#### Evidence:

A 5 year Tobacco Action Plan was produced in 2003, detailing a comprehensive programme of action to reduce the harm caused by tobacco use <http://www.dhsspsni.gov.uk/publications/2003/tobaccoplan.pdf>

The prevention of recruitment of young people to smoking was identified as a key area of action in the Tobacco Action plan

Fit Futures <http://www.dhsspsni.gov.uk/ifh-fitfutures.pdf>

'Preventing the uptake of smoking by children and young people – review of effectiveness', NICE rapid review, June 2008  
<http://www.nice.org.uk/nicemedia/pdf/PH14reviewofeffectiveness.pdf>

#### Responsibility for delivery / implementation

Health and Social Care Board  
Public Health Agency  
HSC Trusts  
Primary Care

**SERVICE FRAMEWORK FOR CARDIOVASCULAR HEALTH AND WELL BEING**

<b>Quality Dimension</b>			
<p><b>Equitable</b> Tobacco education should be accessible to all young people in a range of media settings.</p> <p><b>Patient Centred</b> Lifeskills development programmes for young people should include input on tobacco as well as drugs, alcohol and solvents.</p>			
<b>Performance Indicator:</b>	<b>Data source</b>	<b>Anticipated Performance Level</b>	<b>Date to be achieved by</b>
Percentage of 12, 14 and 16 year old boys and girls who smoke.	Establish baseline data from Young People Behaviour and Attitude Survey (2007) in 12, 14 and 16 year olds	5% decrease on 2007 baseline for boys (rate has been constant)	March 2012
	Survey repeated 3 yearly*  * subject to available resource	Maintain at 2007 baseline for girls (rate has been increasing therefore initial target to halt rise)	March 2012

## SERVICE FRAMEWORK FOR CARDIOVASCULAR HEALTH AND WELL BEING

### Overarching standard 4:

All health and social care professionals should identify people who smoke, make them aware of the dangers of smoking, advise them to stop and provide information and then to signpost them to the well developed specialist cessation services available

#### Rationale:

Smoking is one of the recognised risk factors for CVD, hypertension and renal disease. Its effects are related to the amount of tobacco smoked daily and the duration of smoking.

Currently there is a range of specialist smoking cessation services commissioned across Northern Ireland. These services offer counselling and support in addition to the use of pharmacotherapy by trained specialist advisors.

#### Evidence:

A 5 year Tobacco Action Plan was produced in 2003, detailing a comprehensive programme of action to reduce the harm caused by tobacco use <http://www.dhsspsni.gov.uk/publications/2003/tobaccoplan.pdf>

NICE produced guidance on brief interventions and referral for smoking cessation in primary care and other settings in March 2006, which represents best practice <http://www.nice.org.uk/Guidance/PH1>

NICE guidance on 'Smoking Cessation Services, in primary care, pharmacies, local authorities and workplaces, particularly for manual working groups, pregnant women and hard to reach communities, February 2008 <http://www.nice.org.uk/Guidance/PH10>

#### Responsibility for delivery / implementation

Health and Social Care Board  
Public Health Agency  
HSC Trusts  
Primary Care

**SERVICE FRAMEWORK FOR CARDIOVASCULAR HEALTH AND WELL BEING**

<b>Quality Dimension</b>			
<p><b>Patient Centred</b> People who are ready to stop smoking should be able to access specialist smoking cessation services in a choice of settings.</p> <p><b>Effective, Efficient</b> Brief Intervention Training for Health and Social Care Staff will ensure clients receive consistent and timely advice on smoking cessation.</p> <p><b>Equitable, Effective</b> Specialist smoking cessation services will be delivered to regional quality standards ensuring equitable service provision.</p>			
<b>Performance Indicator:</b>	<b>Data source</b>	<b>Anticipated Performance Level</b>	<b>Date to be achieved by</b>
Number of people attending specialist smoking cessation services.	Elite Monitoring System	Maintain 2007/08 baseline levels	March 2010
		4% increase in uptake	March 2011
		4% increase in uptake	March 2012
Number of clients quitting at 4 and 52 weeks.	Elite Monitoring System	Maintain 2007/08 baseline levels	March 2010
		2% increase in number of quitters (4% increase in uptake of services)	March 2011
		2% increase in number of quitters (4% increase in uptake of services)	March 2012

## SERVICE FRAMEWORK FOR CARDIOVASCULAR HEALTH AND WELL BEING

### Overarching standard 5:

Health and social care professionals should identify inactive\* individuals and, where appropriate, provide them with advice and support to accumulate a minimum of 30 minutes of moderate activity\*\* on 5 days of the week or more.

\*inactive refers to all people who do not meet the recommended level of physical activity

\*\*walking briskly, walking downstairs, dancing, biking, swimming, gardening, housework eg washing floors

(<http://www.paho.org/English/HPP/HPN/whd2002-factsheet2.pdf>)

### Rationale:

National Institute for Health and Clinical Excellence (NICE) has fully endorsed the importance of physical activity as a means of promoting good health and preventing disease. Lack of physical activity is associated with an increase in the risk of coronary heart disease.

### Evidence:

WHO Global Strategy on Diet, Physical Activity and Health

[http://www.who.int/dietphysicalactivity/strategy/eb11344/strategy\\_english\\_web.pdf](http://www.who.int/dietphysicalactivity/strategy/eb11344/strategy_english_web.pdf)

National Institute for Health and Clinical Excellence (NICE) Public Health Intervention Guidance No.2 (2006) Four commonly used methods to increase physical activity: Brief intervention in primary care, exercise referral schemes, pedometers and community-based exercise programmes for walking and cycling

<http://www.nice.org.uk/Guidance/PH2>

Fit Futures <http://www.dhsspsni.gov.uk/ifh-fitfutures.pdf>

### Responsibility for delivery / implementation

Health and Social Care Board

Public Health Agency

HSC Trusts

Primary Care

### Quality Dimension

#### Effective, Efficient

Appropriate physical activity brief intervention training should be provided for Health and Social Care Staff to ensure clients receive consistent and timely advice.

**SERVICE FRAMEWORK FOR CARDIOVASCULAR HEALTH AND WELL BEING**

<b>Performance Indicator:</b>	<b>Data source</b>	<b>Anticipated Performance Level</b>	<b>Date to be achieved by</b>
Percentage of people being asked and advised about their physical activity	Audit	Establish baseline  Performance level to be determined once baseline established	March 2010
Percentage of people advised who achieve the recommended level of physical activity	Audit	Establish baseline  Performance level to be determined once baseline established	March 2010

## SERVICE FRAMEWORK FOR CARDIOVASCULAR HEALTH AND WELL BEING

### Overarching standard 6:

All people should be provided with healthy eating support and advice, appropriate to their needs, in a range of settings.

#### Rationale:

Reducing fat and salt in the diet and increasing fruit and vegetable consumption is associated with a reduction in the risk of cardiovascular disease and hypertension.

#### Evidence:

WHO Global Strategy on Diet, Physical Activity and Health

[http://www.who.int/dietphysicalactivity/strategy/eb11344/strategy\\_english\\_web.pdf](http://www.who.int/dietphysicalactivity/strategy/eb11344/strategy_english_web.pdf)

Fit Futures <http://www.dhsspsni.gov.uk/ifh-fitfutures.pdf>

Scientific Advisory Committee on Nutrition recommendations on healthy eating for the general population <http://www.sacn.gov.uk/reports/>

#### Responsibility for delivery / implementation

Health and Social Care Board  
Public Health Agency  
HSC Trusts  
Primary Care

#### Quality Dimension

##### Effective

All stakeholders should promote a consistent nutrition message by using the Eat Well – getting the balance right plate model.

##### Effective

Training and education should be available for child carers / group care workers.

##### Equitable

Support and advice to develop skills for healthy eating in a range of settings should be available.

##### Patient centred

Schools / hospitals / residential care and nursing homes should be supported in the implementation of nutrition standards.

**SERVICE FRAMEWORK FOR CARDIOVASCULAR HEALTH AND WELL BEING**

<b>Performance Indicator:</b>	<b>Data source</b>	<b>Anticipated Performance Level</b>	<b>Date to be achieved by</b>
Percentage of nutrition advisers using the Eat Well Plate model	Audit to establish baseline	Establish baseline  Performance level to be determined once baseline established	March 2010
Percentage of people eating the recommended 5 pieces of fruit or vegetables a day.	Health and Social Wellbeing Survey  Repeated 5 yearly	10% increase on 2005/06 baseline	March 2011

## SERVICE FRAMEWORK FOR CARDIOVASCULAR HEALTH AND WELL BEING

### Overarching standard 7:

Health and social care professionals should work with early years settings, schools, workplaces and communities in the promotion and support of breastfeeding, healthy eating and physical activity to prevent obesity.

#### Rationale:

As body weight increases, so does the risk of cardiovascular disease, diabetes and hypertension.

#### Evidence:

The DHSSPS established a task force on childhood obesity which published 'Fit Futures' – a framework for action in 2006

<http://www.dhsspsni.gov.uk/ifh-fitfutures.pdf>

National Institute for Health and Clinical Excellence (NICE) have produced 'Evidence based guidance on the prevention, identification and management of overweight and obesity in adults and children <http://www.nice.org.uk/CG43>

#### Responsibility for delivery / implementation

Health and Social Care Board

Public Health Agency

HSC Trusts

Primary Care

## SERVICE FRAMEWORK FOR CARDIOVASCULAR HEALTH AND WELL BEING

### Quality Dimension

#### **Effective**

Training should be facilitated for early years providers to assist them in implementing physical activity and nutrition programmes.

#### **Patient Centred**

DHSSPS should develop childcare standards which include the need to provide opportunities for daily physical activity and a requirement to meet nutrition standards.

Health and Social Care should work with employers to provide opportunities for staff to eat a healthy diet and be physically active.

The public should be provided with information and support on how to eat healthily and engage in health enhancing physical activity for the prevention of obesity.

#### **Equitable**

Health and Social Care staff will work with partners to ensure that schools have and implement policies which help children and young people to maintain a healthy weight, eat a healthy diet and be physically active.

**SERVICE FRAMEWORK FOR CARDIOVASCULAR HEALTH AND WELL BEING**

<b>Performance Indicator:</b>	<b>Data source</b>	<b>Anticipated Performance Level</b>	<b>Date to be achieved by</b>
Percentage of people who have a BMI of above 25.	Health and Social Wellbeing Survey 2005/06  Survey repeated 5 yearly.	2% decrease on 2005/06 baseline	March 2011
Percentage of Primary 1 children who have a BMI of above 25  Note: these PIs will be reviewed in light of the forthcoming Obesity Strategy	Child Health System	Establish baseline  Performance level to be determined once baseline established	March 2010

## SERVICE FRAMEWORK FOR CARDIOVASCULAR HEALTH AND WELL BEING

### Overarching standard 8:

Primary care professionals should identify people who consume hazardous / harmful amounts of alcohol, make them aware of the dangers, advise them to reduce or stop and provide information and signposting to specialist services if appropriate.

#### Rationale:

Excessive alcohol consumption is associated with many diseases such as cancers (oesophagus, liver etc), cirrhosis of the liver and pancreatitis. There are also direct effects of alcohol and an increased association with injuries and violence. Excessive alcohol consumption can affect the cardiovascular system, and is associated with high blood pressure, abnormal heart rhythms, cardiomyopathy and haemorrhagic stroke.

#### Evidence:

SIGN: The Management of harmful drinking and alcohol dependence in Primary Care <http://www.sign.ac.uk/pdf/sign74.pdf>

New Strategic Direction for Alcohol and Drugs (2006-2011) Consultation Document

[http://www.dhsspsni.gov.uk/new\\_strategic\\_direction\\_for\\_alcohol\\_and\\_drugs\\_\(2006-2011\).pdf](http://www.dhsspsni.gov.uk/new_strategic_direction_for_alcohol_and_drugs_(2006-2011).pdf)

#### Responsibility for delivery / implementation

Health and Social Care Board  
Public Health Agency  
HSC Trusts  
Primary Care

#### Quality Dimension

##### Effective, Efficient

Brief Intervention Training for Health and Social Care Staff will ensure clients receive consistent and timely advice on alcohol consumption.

**SERVICE FRAMEWORK FOR CARDIOVASCULAR HEALTH AND WELL BEING**

<b>Performance Indicator:</b>	<b>Data source</b>	<b>Anticipated Performance Level</b>	<b>Date to be achieved by</b>
Percentage of people who receive Brief Intervention in Primary Care to reduce alcohol related risk	Cardiovascular DES	Establish baseline  Performance level to be determined once baseline established	March 2010

## SERVICE FRAMEWORK FOR CARDIOVASCULAR HEALTH AND WELL BEING

### Overarching standard 9:

Health and social care professionals should work with schools, workplaces and communities to raise awareness of and access to emergency life support (ELS) skills.

#### Rationale:

Life threatening emergencies are common. Heart and circulatory disease is the UK's biggest killer. Someone dies of a heart attack every 6 minutes.

According to research, the majority of cardiac arrests in the UK happen out of hospital. In Northern Ireland up to 84% of these happen in the home, up to 9% in a public place and up to 8% in care institutions. If each link in the chain of survival is strong and intervention is prompt the chance of survival from the out of hospital cardiac arrest is significantly increased.

With every minute without CPR following sudden cardiac arrest, the probability of survival reduces by 7-10% per minute. Overall, bystander CPR increases survival 2-3 times compared to no bystander CPR. An ELS education programme will help participants to recognise the signs and symptoms of a heart attack, perform CPR, deal with choking, serious bleeding and an unconscious breathing casualty. These life skills will enable lay people to become equipped with knowledge and skills that will benefit them and their own communities.

In research commissioned by the British Heart Foundation it was found that out of a sample of 6,118 adults across the UK, respondents in Northern Ireland were less likely to have received CPR training than any other region, with a total of 81% claiming to have not been trained in the last 5 years.

#### Evidence:

Valenzuela T.D. et al, (1997), "Estimating effectiveness of cardiac arrest interventions: A logistic regression survival model", *Circulation*. 1997;96:3308-3313 <http://circ.ahajournals.org/cgi/content/full/96/10/3308>

Holmberg M. et al, (2000), "Effect of bystander cardiopulmonary resuscitation in out-of-hospital cardiac arrest patients in Sweden", *Resuscitation*, 47:59-70 [http://www.resuscitationjournal.com/article/S0300-9572\(00\)00199-4/abstract](http://www.resuscitationjournal.com/article/S0300-9572(00)00199-4/abstract)

Larsen M.P. et al, (1993), "Predicting survival from out-of-hospital cardiac arrest: A graphic model", *Ann Emerg Med*, 22:1652-1658 [http://www.annemergmed.com/article/S0196-0644\(05\)81302-2/abstract](http://www.annemergmed.com/article/S0196-0644(05)81302-2/abstract)

## SERVICE FRAMEWORK FOR CARDIOVASCULAR HEALTH AND WELL BEING

Moore MJ et al, (2006), "Demographic and temporal trends in out of hospital sudden cardiac death in Belfast", Heart, 92; 311-315

<http://heart.bmj.com/cgi/content/abstract/92/3/311>

Moore MJ et al, (2008), "The Northern Ireland Public Access Defibrillation (NIPAD) study; effectiveness in urban and rural populations", Heart, 94:1614-1619 <http://heart.bmj.com/cgi/content/abstract/94/12/1614>

British Heart Foundation (2007) 'Coronary Heart Disease statistics'

<http://www.heartstats.org/datapage.asp?id=6799>

Stiell et al, (1999) Ontario Prehospital Advanced Life Support study (OPALS). 6,816 consecutive cardiac arrests, (Citizen CPR training significantly improved survival) Those who had bystander CPR increased the odds ratio of survival by 3.9 (2.7-5.5)

Western C et al (1997) strongest predictor of a poor outcome was delay to CPR.

Herlitz et al, (2005), "Efficacy of bystander CPR: Intervention by lay people and by health care professionals", Resuscitation, 66:291-295

[http://www.resuscitationjournal.com/article/S0300-9572\(05\)00176-0/abstract](http://www.resuscitationjournal.com/article/S0300-9572(05)00176-0/abstract)

Cummins et al (1991) Improving Survival from Sudden Cardiac Arrest: The "Chain of Survival" Concept, Circulation, 1991;83:1832-1847

<http://www.circ.ahajournals.org/cgi/reprint/83/5/1832>

British Heart Foundation: CPR training report Dec 2006

### **Responsibility for delivery / implementation**

Health and Social Care Board

Public Health Agency

HSC Trusts

**SERVICE FRAMEWORK FOR CARDIOVASCULAR HEALTH AND WELL BEING**

**Quality Dimension**

**Effective**

The ELS programme will provide members of the public with the skills to respond to a life threatening emergency. The window of opportunity for a successful outcome from an out of hospital cardiac arrest can be widened if there are more bystanders give ‘basic life support’ in the form of chest compressions and rescue breathing.

**Equitable**

Training in ELS skills should be made available in a range of settings such as schools, the workplace and community organisations. Approaches and resources can be tailored to ensure that we can address inequality thereby giving all members of the population fair and impartial access to this learning.

<b>Performance Indicator:</b>	<b>Data source</b>	<b>Anticipated Performance Level</b>	<b>Date to be achieved by</b>
Percentage of people trained in ELS skills	Survey (NISRA Omnibus Survey)	Baseline established	March 2010
		Performance levels to be determined	March 2012
Percentage of people surviving out of hospital cardiac arrests	Audit	Baseline established	March 2010
		Performance levels to be determined	March 2012