5. STANDARDS FOR HEALTH PROMOTION

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 and wellbeing.

This framework sets standards and performance indicators for health and social services, 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 respiratory disease we have concentrated on the areas of smoking prevention/avoidance and cessation, physical activity and immunisation standards.

The development of the health promotion 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. Some additional standards have been

developed for respiratory disease. There have been difficulties both with 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.

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 respiratory disease, particularly COPD and asthma. Effects are related to the amount of tobacco smoked daily and the duration of smoking.

There is evidence that smoking in the antenatal period increases the risk of the development of asthma in childhood.

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% sample 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 of smoking. NICE guidance on smoking and young people is expected in July 2008 and this standard may need revised after that.

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			
HSC Board Public Health Agency HSC Trusts Primary Care (including pharmacy) In partnership with voluntary / community organisations			
Quality Dimension			
1. Tobacco education should be accessible to all young people in a range of media settings. 2. Life skills development programmes for young people should include input on tobacco as well as drugs, alcohol and solvents.			
Performance Indicator	**Data source**	**Anticipated Performance Level**	**Date to be achieved by**
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 Survey repeated 3 yearly* *subject to available resource	5% decrease on baseline for boys (rate has been constant) Maintain at baseline for girls (rate has been increasing therefore initial target to halt rise)	March 2012 March 2012

Overarching standard 4:
All relevant 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 signposting to specialist cessation services.

Rationale:
Smoking (both active and passive) is one of the recognised risk factors for respiratory disease, particularly COPD and asthma, as well as the effects of passive smoking. Effects are related to the amount of tobacco smoked daily and the duration of smoking.

There is evidence that smoking in the antenatal period increases the risk of the development of asthma in childhood.

Currently there are 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://guidance.nice.org.uk/PHI1/guidance/pdf/English

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

Moshammer H et al. Parental smoking and lung function in children; an international study. Am J Respir Crit Care Med 2006; 173: 1255-1263 http://171.66.122.149/cgi/content/full/173/11/1255

Responsibility for delivery / implementation
HSC Board Public Health Agency HSC Trusts Primary Care (including pharmacy) In partnership with voluntary / community organisations
Quality Dimension
1. People who are ready to stop smoking should be able to access specialist smoking cessation services in a choice of settings. 2. Brief Intervention Training for Health and Social Care Staff will ensure clients receive consistent and timely advice on smoking cessation. 3. Specialist smoking cessation services will be delivered to regional quality standards ensuing equitable service provision.

Performance Indicator	Data source	Anticipated Performance Level	Date to be achieved by
Number of people attending specialist smoking cessation services.	Elite Monitoring System	Maintain 2007/08 baseline levels 4% increase in uptake 4% increase in uptake	March 2010 March 2011 March 2012
Number of clients quitting at 4 and 52 weeks	Elite Monitoring System	Maintain 2007/08 baseline levels 2% increase in number of quitters (4% increase in uptake of services) 2% increase in number of quitters (4% increase in uptake of services)	March 2010 March 2011 March 2012
Percentage of women attending antenatal clinics that are asked about smoking and advised appropriately	Child Health System Audit of antenatal records	95% 98%	March 2011 March 2012
Percentage of families where children are aged less than 1 year that are asked about smoking and advised appropriately by health visitors	HSC Trust report	95%	March 2013

Overarching standard 5:
All relevant 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 e.g. washing floors
(http://www.paho.org/English/HPP/HPN/whd2002-factsheet2.pdf)

Rationale:
NICE has fully endorsed the importance of physical activity as a means of promoting good health and preventing disease. Appropriate levels of physical activity are important in maintaining health and wellbeing in all individuals and particularly important in maintaining appropriate body mass index in people who have respiratory disease; maintaining the benefits of pulmonary rehabilitation; and in the prevention and management of obstructive sleep apnoea syndrome.

Evidence:
WHO Global Strategy on Nutrition and Physical Activity
http://www.who.int/dietphysicalactivity/strategy/eb11344/strategy_english_web.pdf

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/nicemedia/pdf/word/PH002_physical_activity.doc

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

Responsibility for delivery / implementation

HSC Board
Public Health Agency
HSC Trusts
Primary Care

Quality Dimension			
1. Appropriate physical activity brief intervention training should be provided for Health and Social Care Staff to ensure clients receive consistent and timely advice.			
Performance Indicator	**Data source**	**Anticipated Performance Level**	**Date to be achieved by**
Percentage of people being asked and advised about their physical activity	Audit	Establish baseline Performance level to be determined once baseline established	March 2010 March 2011
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 March 2011

Overarching standard 6: Health and social care 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 developing certain respiratory diseases such as obstructive sleep apnoea / hypopnoea syndrome. Maintaining an appropriate BMI is important for the health and wellbeing of people with respiratory disease. **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 Scottish Intercollegiate Guidelines Network (SIGN) Management of Obesity in Children and Young People No 69 April 2003
Responsibility for delivery / implementation
HSC Board Public Health Agency HSC Trusts Primary Care

Quality Dimension			
1. **Effective** Training should be facilitated for early years providers to assist them in implementing physical activity and nutrition programmes. 2. **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. 3. **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.			
Performance Indicator	**Data source**	**Anticipated Performance Level**	**Date to be achieved by**
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 P1 children who have been identified as being overweight and obese	Child Health System	Establish baseline Performance level to be determined once baseline established	March 2010 March 2011

Overarching Standard 7:
All individuals should be up to date with their personal vaccine schedule.

Rationale:

Many of the routine childhood immunisations, particularly pneumococcal, pertussis, Hib and measles, protect children against pneumonia and complications such as bronchiectasis.

Influenza vaccination is recommended for those at "high risk" of mortality from influenza or pneumonia as studies have shown that this reduces admissions for pneumonia and influenza in the elderly and "high risk" groups, and/or reduces mortality from respiratory and all causes. There is also a reduction in hospitalisation and fewer outpatient visits for all respiratory conditions.

Pneumococcal vaccine is recommended for all those aged 2 years and older in those in whom pneumococcal infection is likely to be more common or more dangerous. There is evidence of overall efficacy for pneumococcal vaccination in reduction in invasive and non invasive disease incidence in both vaccinated and older unvaccinated populations (herd immunity).

Evidence:

Immunisations against infectious disease (Green Book) Joint Committee on Vaccination and Immunisation (2006).
http://www.dh.gov.uk/en/Publichealth/Healthprotection/Immunisation/Greenbook/DH_4097254

British Thoracic Society (BTS) Guidelines for the management of Community Acquired Pneumonia in Adults Thorax 2001; 56 (suppl. IV)
http://thorax.bmj.com/cgi/content/full/56/suppl_4/iv1

British Thoracic Society (BTS) Guidelines for the management of Community Acquired Pneumonia in Adults – 2004 update.
http://www.uphs.upenn.edu/bugdrug/antibiotic_manual/btscap04update.pdf

Scottish Intercollegiate Guidelines Network (SIGN) Community Management of Lower Respiratory Tract Infection in Adults No. 59 June 2002.
http://www.sign.ac.uk/guidelines/fulltext/59/index.html

Responsibility for delivery / implementation			
HSC Board Public Health Agency HSC Trusts Primary Care			
Quality Dimension			
1. All babies and children should receive their routine childhood vaccines, which, particularly in relation to respiratory disease, are pneumococcal, pertussis, Hib and measles. 2. Patients aged over 65 and those under 65 in "at risk" groups (as defined in the Green Book and subsequent JCVI advice) should have an annual flu vaccine and a "one-off" pneumococcal vaccine as recommended.			
Performance Indicator	**Data source**	**Anticipated Performance Level**	**Date to be achieved by**
Percentage of children receiving routine childhood vaccines	COVER statistics	92% for MMR 97% for all other vaccines (by age 2 years)	March 2011
Uptake rate for flu vaccine and pneumococcal vaccine in over 65s and those under 65 with respiratory disease	QOF LTC DES (to be reviewed)	Establish baseline Performance level to be determined once baseline established	March 2011 March 2012