A Framework for Personalised Care and Population Health for Nurses, Midwives, Health Visitors and Allied Health Professionals

Caring for populations across the lifecourse
Foreword

This framework has been developed to underpin our national programme to maximise the impact of nurses, midwives, health visitors and allied health professionals (AHPs) on improving health outcomes and reducing inequalities. It aims to support and shape “health promoting practice” that encompasses both personalised care and population health across all ages, care places and with individuals, families and communities. We know that such health-promoting practice is essential to meet the health challenges in our society and that we need to develop practice, leadership and systems to value health and wellbeing and therefore support prevention and health promotion as well as high-quality treatment. Our professional groups already make a huge contribution to health and care and can do more to meet this goal and be a powerful voice in building what has been described as a “Culture for Health.”

The framework is intended for use nationally and locally to promote health promoting practice and raise visibility of our professions’ contribution to improving and protecting health. It is a resource to support practitioners’ access to best evidence for practice and to support clinical leaders, managers and commissioners to develop services which use the knowledge and skills of nurses, midwives, health visitors and AHPs to deliver the best health outcomes for the populations they serve.

This is the second release of the framework, which has been developed with practitioners and leaders. Development will continue to enable healthcare professionals to connect practice to the overarching approach to improving health. I would like to thank everyone who has contributed so far and hope you will continue to do so as part of building our social movement for “Personalised Care and Population Health.”
Caring for populations across the lifecourse

The content of this framework has been developed by professional leaders in the field and was current at the time of publication.

Publication date: 21 November 2014
**Introduction | What is the framework?**

This framework has been developed to underpin our national programme to maximise nurses, midwives, health visitors and AHPs impact on improving health outcomes and reducing inequalities.

The framework supports and shapes health promoting practice and embeds personalised care and population health across all ages, care places and with individuals, families and communities. It is a resource to support practitioners’ access to best evidence for practice and to support nurse managers and commissioners to develop services which use the knowledge and skills that nurses, midwives, health visitors and AHPs use to deliver the best health outcomes for the populations they serve.

There are six key areas of population health activity in the framework, which can be seen listed on the right. In each population health activity area are one or more worked examples on national health priority areas that illustrate how the framework should be used. It also provides links to the outcomes frameworks, especially the Public Health Outcomes Framework, to demonstrate and measure impact, and provides links to national guidance and evidence to underpin practice.
Structure of the Framework for Personalised Care and Population Health

Public health practitioners and consultants, health visitors, school nurses and public health specialist midwives and AHPs

Nurses, midwives and AHPs with specific primary and secondary prevention roles, eg general practice nurses, community nurses, sexual health nurses

All nurses, midwives and AHPs maximising their role in health and well being through Making Every Contact Count

Lifecourse

Activities for population health

Improving the Wider Determinants of Health

Health Protection

Making Every Contact Count

Outcome measures:

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Underpinned by evidence including NICE, research, education and professional engagement
All health practitioners can make a difference – this is set out as a pyramid. At the base are all nurses, midwives, health visitors and AHPs; so for example, every single practitioner can “make every contact count” for improving health and wellbeing. At the next level are practitioners who, as well as this, have responsibilities for prevention and for a wider population, such as caseloads, practice lists and communities. At the top level are those whose main role is public health, such as health visitors, school nurses, public health practitioners and consultants. The practitioners at levels two and three build on all practitioner actions at level one and have specific and additional responsibilities because they have explicit roles in prevention, protection and population health.

There are 52 NICE guidance materials for public health to support roles/practice at all levels.
The second component of the framework is the six key areas of population health activity. The first four activities are related to the four domains in the Public Health Outcomes Framework, while the last two activities (in grey) are areas within Compassion in Practice. Each activity area provides links to supporting evidence including NICE guidance, relevant policy documents and patient experiences. Just click on any of the tabs on the right, or the ovals in the diagram above, to find out more about these activities and see worked examples of how they might be used.
The third component shows how to use outcomes frameworks to identify areas of health and care needs for prioritisation, and how to demonstrate and measure the impact of interventions.

The link in the top right corner of this page takes you to the outcome measures that are used in this framework. It includes indicators from the Public Health Outcomes Framework, NHS Outcomes Framework, Adult Social Care Outcomes Framework and other relevant outcomes measures. By searching on a topic eg smoking, any relevant outcome indicators can be found quickly and easily.
Applying the Framework

The framework will support practice on a number of levels:

- **Frontline nurses, midwives, health visitors and AHPs (healthcare practitioners):** to provide staff with a tool that will support them in delivery of the population health elements of their role.

- **Professional leaders and managers:** to develop services which uses the knowledge and skills of healthcare practitioners to deliver the best health outcomes for the populations they serve.

- **Commissioners:** to develop local commissioning using practitioners’ professional and local knowledge in identifying health and wellbeing priorities and informing evidence-based locally sensitive service development.

- **Educators:** to provide information to inform curricula development and as a tool for teaching the role of population health in healthcare practitioners’ undergraduate and postgraduate programmes.

- **Researchers:** to provide evidence to identify research questions based on local and national priorities and inform grant applications.

- **National professional leaders:** to guide policy development based on what works well, and raise the national profile and visibility of nurses, midwives, health visitors and AHPs by making explicit their contribution to population health.
Improving the wider determinants of health

**AIM:** To achieve improvements against wider factors that affect health and wellbeing and health inequalities.

People in the poorest neighbourhoods will die on average seven years earlier than people in the richest areas and the disability-free gap is on average 17 years. Despite overall improvement in the health of populations, health inequalities persist. Action on health inequalities requires action across all the social determinants of health.

Health practitioners have roles in action on the causes of health inequality and care that narrows the gap. This includes community development, health promotion, education, improved access to services and early identification and action on ill health.

Tackling inequalities requires collaborative working with local authorities and their partners, including the police and criminal justice system, Early Years teams, schools, housing, transport, employers, and the business and voluntary sectors. The [Public Health Outcomes Framework](#) includes 19 indicators that measure these factors.

The [Health Equalities Framework](#) is an outcomes framework that is designed to help commissioners, providers, people with learning disabilities and family carers determine the impact and effectiveness of services for people with learning disabilities.

See example of how to use the Framework for Homelessness
Improving the wider determinants of health | Fast facts

Fact:
Around 1 in 10 winter deaths are caused by fuel poverty, which equates to 2,700 people per year. This is more than are killed on the roads each year.

Action:
Use the *Keep warm, keep well* leaflet with those identified as at risk and refer for benefits assistance if needed.

Fact:
People with severe mental health illness can die on average 20 years earlier than the general population.

Action:
Promote mental health resilience – 5 ways to well being: *Connect, Be Active, Take Notice, Keep Learning* and *Give*

Fact:
Most people with learning disability have poorer health than the rest of the population and are more likely to die at a younger age.

Action:
Use the Health Equalities Framework (HEF) for people with learning disability to reduce health inequalities.
Health improvement: Making Every Contact Count (MECC)

AIM: people are helped to live healthy lifestyles, make healthy choices and reduce health inequalities.

Making Every Contact Count focuses on staff working with the public, trained to give opportunistic, appropriate and timely advice on health and wellbeing to patients/service users, their carers, staff and communities they come into contact with.

There is much that health practitioners can do to promote healthy lifestyles as part of their day-to-day role through considering how their interactions can be an opportunity to promote health and wellbeing. This includes providing advice geared towards encouraging people to quit smoking, reduce excessive alcohol intake, improve diet and lose weight and also signposting people to information and services that provide the support they need. It will involve healthcare professionals using new skills, such as motivational interviewing and behavioural insights. These activities will, in the main, be led locally through health and wellbeing initiatives such as MECC.

There are 24 indicators in the Public Health Outcomes Framework that can be used to measure outcomes in this activity area.

See example of how to use the Framework for Alcohol
Fact: Physical inactivity is a contributor to around 17% of premature deaths, while 67% of men and 57% of women have excess weight.

Action: Use NICE guidance on individual-level interventions aimed at changing health-damaging behaviours (PH49) opportunistically as part of MECC.

Fact: Smoking is the primary cause of preventable and premature death accounting for 80,000 deaths in England in 2011.

Action: Use NICE guidance on individual-level interventions aimed at changing health-damaging behaviours (PH49) and promote access to smoking cessation services.

Fact: The number of people dying from liver disease is rising, up 23% over the last decade to 13,000 deaths.

Action: Use NICE guidance on individual-level interventions aimed at changing health-damaging behaviours (PH49) and promote use of alcohol support groups.
Health protection

AIM: to protect the population’s health from major incidents and other threats.

Healthcare practitioners play a vital role in protecting health and building resilience at individual, community and population levels and in all settings.

Interventions are wide-ranging and varied, such as running immunisation programmes, teaching effective hand washing, contact tracing and educating the public on the causes and prevention of infectious diseases.

By using the Public Health Outcomes Framework, staff can demonstrate the vital role they play in contributing to high quality practice in all care and specialist health protection services to keep people safe.

See examples of how to use the Framework for Tuberculosis and Antimicrobial Resistance
Health protection | Fast facts

Fact:
Each year immunisation averts an estimated 2-3 million deaths globally.

Action:
Promote and provide immunisations to protect individual, community and population health.

Fact:
9,000 cases of tuberculosis are reported in the UK annually.

Action:
Detect TB cases early and support treatment completion to help cure and control the disease.

Fact:
Antibiotics are becoming less effective, the more they are used the more antibiotic resistance develops.

Action:
Prescribe and use antibiotics wisely – spread the message not the infection.
**Healthcare public health**

**AIM:** to reduce the numbers of people living with preventable ill health and people dying prematurely.

Good population health outcomes, including reducing health inequalities, rely not only on health protection and health improvement, but on the quality and accessibility of healthcare services. This is called 'healthcare public health' and examples of healthcare public health practice include:

- increasing health promotion, symptom awareness, signposting and referral for early diagnosis and treatment
- supporting care co-ordination and self-management for 1.9m people with multiple long-term conditions
- providing prevention and health improvement services to reduce the forecast 2.9m increase in long-term health conditions in 10 years
- leading on actions to improve access to services for marginalised groups

There are 16 indicators in the [Public Health Outcomes Framework](#) that can be used to measure outcomes in this activity area.

*[See example of how to use the Framework for Respiratory Disease]*
Healthcare public health | Fast facts

Fact:
The number of people living with more than one long-term health condition is expected to increase from 1.9 to 2.9 million over the next decade.

Action:
Make use of technology that is available to support people in the self-management of long-term health conditions.

Fact:
The number of people diagnosed with diabetes over the last 20 years has increased from 1.4 to 2.9 million.

Action:
Encourage early diagnosis and use NICE guidance on individual-level interventions aimed at changing health-damaging behaviours (PH49) to promote healthy lifestyles.

Fact:
In 2012, 62,000 people under the age of 75 died of cancer (not including liver cancer).

Action:
Raise awareness of the early signs of cancer and promote attendance at cancer screening services.
Supporting health, wellbeing and independence

**AIM:** to help people stay independent, maximising wellbeing and improving health outcomes.

Supporting health, wellbeing and independence requires action at individual, family and population levels that includes prevention, early intervention and health promotion as well as treatment of ill health. It involves:

- working with patients, their families and carers to encourage wellbeing, self-management and proactive approaches such as supporting and maintaining mobility
- working across health and care boundaries to provide support and services which enable people to remain active, connected and independent in their own homes for as long as they want or are able.

This activity area is closely linked to inequalities in health. The Public Health Outcomes Framework indicators 0.1 and 0.2 are useful for measuring inequalities in health between regions of England, as well as comparing individual regions with England as a whole.

See examples of how to use the Framework for Dementia and Falls
Supporting health, wellbeing and independence | Fast facts

Fact:
5.8 million people identify themselves as unpaid carers.
Action:
Promote the health and wellbeing of carers, both for their benefit and for the people in their care.

Fact:
1 in 2 people over 80 years of age will have a fall. Falls cost the NHS more than £2 billion a year.
Action:
Promote balance classes and physical activity to enhance functional independence and prevent deteriorating mobility.

Fact:
Providing adaptations to support an older person to remain at home for just one year can save £28,000 on long-term care costs.
Action:
Ensure that older or disabled people are living in a safe environment that supports their wellbeing. Refer for assessment by occupational therapy or social services if needs are identified.
**Lifecourse**

**AIM:** this is an overarching population activity that refers to reducing the impact of health challenges at key stages to improve population health. It will involve some or all of the other five activity areas.

The lifecourse approach to public health targets specific health challenges at different times in a person’s life, such as maternal and newborn, child and adolescent, working age adult and older age. For example, evidence shows that secure early attachment and positive health behaviours set the foundations for life.

**This framework will only cover the early years of lifecourse at this time but other stages of the lifecourse will be added later.**

Outcome indicators from the Public Health Outcomes Framework that have been mapped to the lifecourse were published in June 2013.

See example of how to use the Framework for Beginning of Life and Healthy 2 Year Olds
**Fact:**
Attachment issues will have an impact on resilience and physical, mental and socioeconomic outcomes in later life.

**Action:**
Support delivery of targeted parenting programmes.

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**Fact:**
Unintentional injuries are the major cause of morbidity and premature mortality for children and young people.

**Action:**
Provide timely information on accident prevention and safety in the home.

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**Fact:**
Maternal mental health has an impact on infant mental health and future adolescent and adult health.

**Action:**
Early identification of maternal mental health concerns through routine questions and assessment.
Interventions

The definition of Public Health by the UK Faculty of Public Health in 2010 is:
“The science and art of promoting and protecting health, wellbeing, preventing ill-health and prolonging life through the organised efforts of society.”

The following principles for public health interventions by nurses is equally applicable to the practice of midwives and AHPs. They are based on the WHO Declaration of Alms Ata (1978) and supported by the International Council of Nurses (2008) and have been adopted by the Republic of Ireland (2013). They state that public health interventions:
1. Are evidence based
2. Use appropriate technology
3. Promotes community participation in decisions about health services
4. Are provided at a cost the community can afford
5. Encourage self-care and empowerment
6. Are the first line of contact with the health system
7. Bring health care as close as possible to where people, live, work and play

Interventions within this Framework are all evidence-based and are focused on practice at three levels:
1. Individual/family
2. Community
3. Population
Models for priority interventions

Use of the framework is illustrated through examples in each of the activities for population health. The examples that have been selected are national health priorities which will be reviewed and updated regularly.

Health priority examples:

- **Alcohol** [Health Improvement and making every contact count]
- **Tuberculosis** [Health protection]
- **Antimicrobial Resistance** [Health protection]
- **Falls** [Health, Wellbeing and independence]
- **Dementia** [Health, Wellbeing and independence]
- **Beginning of Life** [Lifecourse]
- **Healthy 2 year olds** [Lifecourse]
- **Respiratory Disease** [Healthcare Public Health]
- **Homelessness** [Wider Determinants of Health]
Homelessness | Quick links

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Homelessness | Introduction

Being homeless can have a critical impact on a person’s health. A person experiencing homelessness may be rough sleeping, living in hostel accommodation, or moving between friends’ houses. Improving the health of individuals during transitions (leaving prison, leaving care, leaving the forces, fleeing violence) is a key focus for the national healthcare system. Interventions from a mix of professionals are essential so that patients get the support they need.

Conditions among people who are homeless are frequently co-occurring, with a complex mix of severe physical, psychiatric, substance use and social problems. High stress, unhealthy and dangerous environments, and an inability to control food intake often result in visits to accident and emergency and hospitalisation.

Homeless people are at greater risk of a wide range of health conditions including poor mental health, drug and alcohol-related conditions, tuberculosis, HIV, hepatitis B and C, influenza, oral cancer and type 2 diabetes\(^1\).

\(^1\) National Health Care for the Homeless Council, Homelessness and Health – What’s the connection?
Homelessness | Facts

- The life expectancy of a rough sleeper in the UK is equivalent to a person living in a nation that has the lowest life expectancy in the world\(^1,2\)

- 80% of homeless people report some form of mental health issue, 45% have a diagnosed mental health condition, compared to 25% of the general population\(^3\)

- 41% of homeless people report a long-term health condition, compared with 28% of the general population\(^3\)

- 10% of patients with TB had at least one social risk factor (history of alcohol or drug misuse, homelessness or imprisonment)\(^4\)

- In the UK, the prevalence of TB is at least 34 times greater in homeless people than in the general population, and the prevalence of hepatitis C infection is nearly 50 times greater\(^5\)

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1. NHS England, Cost of Health Inequalities
3. Homeless Link, The unhealthy state of homelessness, 2014
Homelessness | NICE Guidance

Mental health

- Borderline personality disorder: Treatment and management [CG78](#)

Behaviour

- Antisocial behaviour and conduct disorders in children and young people: recognition, intervention and management [CG158](#)

Drug and alcohol misuse

- Alcohol-use disorders: Diagnosis and clinical management of alcohol-related physical complications [CG100](#)
- Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence [CG115](#)
- Drug misuse – psychosocial interventions [CG51](#)
- Quality Standard for Drug Use Disorders [QS23](#)

Physical health

- Tuberculosis: Clinical diagnosis and management of tuberculosis, and measures for its prevention and control [CG117](#)
- NICE Press Release 2013: Housing for homeless people with TB
- Advice on HIV Testing [LGB21](#)
- NICE Clinical Pathway for Hepatitis B and C testing
- NICE Clinical Pathway for Oral Health Needs Assessment
Homelessness | Interventions: Population level

Population level interventions that health professionals can undertake include:

- raising awareness and influencing policy on health inequalities in your organisation
- ensuring your Health and Wellbeing Board includes homelessness in their Joint Strategic Needs Assessment
- ensure health commissioners are adhering to commissioning standards available for homeless health (see examples of good practice)
- ensuring provider organisations’ IT systems are measuring data on patients that are experiencing homelessness
- get involved in the development of food banks in areas of need
- commissioning of TB Chest X-Ray Screening Programmes
- measuring homeless and other populations facing health inequalities
- involving homeless people in local Healthwatch groups
- undertake research on the impact of nursing/health visiting for the homeless
Community level interventions that health professionals can undertake include:

- get to know support services available in your area. Local authorities are a useful source of contact details but you can also use the national listing at [Homeless UK](http://www.homelessuk.org)
- targeted mental health work with at-risk young people in schools and youth settings
- running health clinics in deprived communities
- running education groups – for example, infection prevention and self-care
- contributing to the [QNI Homeless Health Network](http://www.qni.org.uk) by sharing best practice
- developing targeted public health campaigns
- involve local people as health trainers and peer supporters to improving health
- starting patient groups and running patient surveys
- commissioning street-based mental health workers, drug and alcohol workers, outreach, oral health checks
- commissioning hostel-based or homelessness drop-in based healthcare
- commissioning hospital discharge workers for the homeless who would provide access to hospital discharge accommodation and supported care homes
- commissioning prison and holistic hospital discharge schemes
- commissioning specialist health visitor provision for homeless families
Individual/family level interventions that health professionals undertake include:

- healthcare support at the point families visit local authority housing departments to declare themselves homeless
- support to attend appointments and advocacy
- holistic health assessments for people experiencing homelessness
- contribute to the Assessment of Children in Need and their Families
- ensuring attendance for child development checks and immunisation appointments
- ensuring at-risk patients get access to vaccinations and screening programmes
- promoting access to community family programmes and activities that support healthy family relationships run by local voluntary and community groups
- provisions of smoking cessation support PH10
- building trust with patients
**Homelessness | Outcome measures (1)**

**Outcome measures specific to homelessness**

There are two outcome indicators in the Public Health Outcomes Framework linked to homelessness:

- 1.15i – Statutory Homelessness – homelessness acceptances
- 1.15ii – Statutory homelessness – households in temporary accommodation

Public Health England and partner organisations are currently revising The Public Health Outcomes Framework to include health outcomes relating to single adult’s homelessness.

Number of homeless families with children living in temporary accommodation is recorded in the Health and Social Care Information Centre: LBOI indicator 2.1, and enables comparisons to be made between local authorities in England.
Homelessness | Outcome measures (2)

Outcome measures indirectly related to homelessness

- **1.1 Under 75 mortality rate from cardiovascular disease** (18% of homeless people die from cardiovascular disease);
- **1.2 Under 75 mortality rate from respiratory disease** (8.4% of homeless people die from respiratory disease);
- **1.3 Under 75 mortality rate from liver disease** (14.4% of homeless people die due to alcohol. Many die as a result of advanced liver disease.);
- **1.4 Under 75 mortality rate from cancer** (9.8% of homeless people die from cancer);
- **1.5 Excess under 75 mortality rate in adults with serious mental illness** (8.5% of homeless people die from suicide or undetermined cause. The suicide rate in the housed population is under 1%).

- **2.1 Proportion of people feeling supported to manage their condition**
- **4.1 Patient experience of outpatient services**
Homelessness | Outcome measures (3)

Outcome measures indirectly related to homelessness

- 4.2 Responsiveness to inpatient’s personal needs
- 4.3 Patient experience of A&E services
- 4.4.i. Access to GP services
- 4.4.ii. Access to NHS dental services
- 4.6 Improving the experience of care for people at the end of their lives
- 4.7 Patient experience of community mental health services
- 1a.ii Potential years of life lost (PYLL) from causes considered amenable to healthcare - Children and young people
- Income Deprivation Affecting Children Index (IDACI), 2010, practice attributed dataset
Homelessness | Examples of good practice

Free networks for health professionals

- Homeless Health Network and Homeless Health News (The Queen’s Nursing Institute)
  
  Homeless Health News is published every 2 months, plus other guidance, reports and free learning events and e-learning open to all health professionals working with homeless people.

- Faculty of Homeless and Inclusion Health (Pathway: transforming health services for homeless people)
  
  A network working on improving commissioning via the Pathway Model, with local meetings and events.

Learning

- to develop your learning further, visit The QNI’s Learning Area
- visit the Twitter forum #homelesshealthQNI

Commissioning guidance

- Improving access to healthcare for Gypsies and Travellers, homeless people and sex workers (Royal College of General Practitioners)
- Standards for commissioners and service providers (Faculty for Inclusion and Homeless Health)
- Commissioning Toolkit – Reducing Health Inequalities (NHS England)
Alcohol | Quick links

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Alcohol-related harm is a major health problem. It is estimated that in England in 2012/13 one million hospital admissions were due to an alcohol-related condition or injury. This is a 1% increase on the number of alcohol-related admissions in 2011/12, and a 28% increase compared with 2008/09.

Over 27% of adults in England consume alcohol in a way that reflects either increasing risk, or is potentially harmful, to their health and wellbeing.

In 2012/13, alcohol was associated with over 300,000 recorded crimes in England (Local Alcohol Profiles for England 2014, Public Health England). The Crime Survey for England and Wales 2012-13 indicates that almost half (49%) of all violent crime is alcohol related. This is the case in just over two thirds (69%) of stranger violence and over a third (38%) of domestic violence incidents.

Up to 17 million working days are lost annually through absences caused by drinking – and up to 20 million are lost through loss of employment or reduced employment opportunities.
Alcohol | Facts

- Alcohol use is now the third biggest risk factor for preventable ill-health and death behind smoking and raised blood pressure.

- Nine million adults regularly drink above the lower-risk alcohol guidelines.

- In England, alcohol dependence affects 4% of adults (6% of men, 2% of women).

- Alcohol causes or contributes to more than 60 health conditions.

- There are over one million alcohol-related hospital admissions every year.

- Alcohol misuse costs the NHS £3.5 billion annually.
Caring for populations across the lifecourse

Alcohol | Guidance

NICE pathways sets out a structured approach to identification of alcohol related harm through the use of risk factors, screening tools and effective interventions to reduce harmful drinking: NICE (2011) Brief interventions for alcohol use disorders. NICE pathways.

NICE (2010) Alcohol-use disorders: preventing harmful drinking (PH 24) sets out the evidence for interventions to reduce alcohol misuse at a population level. It also includes screening and structured brief advice by health and social care professionals.

The alcohol dependence and harmful alcohol use NICE quality standard QS11 sets out the actions that should be taken by health and social care services to reduce alcohol related harm. Organisations can benchmark themselves against these criteria.

The NICE clinical guideline CG115 offers evidence-based advice on the diagnosis, assessment and management of harmful drinking and alcohol dependence in adults and in young people aged 10–17 years.

NICE clinical guideline CG100 covers the care of adults and young people (aged 10 years and older) who have physical health problems that are completely or partly caused by alcohol use.
Alcohol | Interventions

Healthcare practitioners should receive training in providing alcohol screening and structured brief advice. Training does not need to be extensive and e-learning opportunities are available: Training Resources and E-learning Courses.

Routinely alcohol screening should be carried out as a part of practice including, new patient registrations, managing long-term conditions, medicines reviews, antenatal reviews, treating minor injuries and promoting sexual health. Focus should be on those at increased risk including, those with hypertension, gastro-intestinal or liver disorders, with relevant mental health problems, those who experience accidents or assaults and those with sexual health issues.

Use validated alcohol questionnaire (FAST or AUDIT-C) appropriate to the setting to determine need for brief intervention or referral. See QS11.

Refer those with alcohol dependence to specialist alcohol services.

Extended brief interventions should be offered to those who do not respond to brief intervention. Patients should be followed up and referred to specialist services if they do not respond.

Public Health England Alcohol Learning Resources contains screening tools and brief interventions. A number of brief advice leaflets have been produced:
- Change4Life Drinks Checker
- Your Drinking and You
- Identification and Brief Advice Tool
Alcohol | Outcome measures

The are eight outcome indicators in the Public Health Outcomes Framework in relation to alcohol use. One of those indicators, PH 2.18, is the number of admissions involving an alcohol-related primary diagnosis or an alcohol-related external cause per 100,000 population (age standardised). The number is estimated by assigning an attributable fraction to each relevant admission, based on the diagnosis codes and age and sex of the patient. The attributable fractions represent the proportion of cases of conditions that can be attributed to alcohol and are based on the latest review of research undertaken by Public Health England.

The Health and Social Care Information Centre contains seven indicators that are directly related to alcohol use.

Local Alcohol Profiles for England (LAPE) also includes a number of other alcohol indicators relating to health and community safety.
Alcohol | Examples of good practice

A number of organisations have provided details of local alcohol initiatives to enable the sharing of knowledge and practice across England. These can be viewed at: Good practice examples and demonstrate compliance with relevant guidelines.

Public Health England’s Alcohol Learning Resources provides online resources and learning for commissioners, planners and practitioners working to reduce alcohol-related harm.
Tuberculosis | Quick links

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Tuberculosis | Introduction

Tuberculosis (TB) is an infectious disease caused by bacteria belonging to the *Mycobacterium tuberculosis* complex. Only the pulmonary form of TB disease is infectious, following prolonged close contact with an infectious case. TB is curable with a combination of specific antibiotics, treated for at least six months.


Around 9,000 cases of TB are currently reported each year in the UK. Most cases occur in major cities, particularly in London.

Public Health England has published the following information for healthcare practitioners to use:

- **useful information about TB in a [TB Fact Sheet](#)**

- **Multi-lingual information on TB** and its treatment and prevention is available from the Department of Health in the following languages: Albanian, Bengali, Chinese, Farsi, French, Greek, Gujarati, Italian, Kurdish, Pashto, Polish, Portuguese, Punjabi, Romanian, Somali, Spanish, Tamil, Turkish, Urdu and Vietnamese

- **Frequently asked questions** about TB

- it is possible to contract TB soon after transmission has occurred, however it is thought that most TB cases in the UK occur as a result of reactivation of **latent TB infection (LTBI)**, which occurred a long time before TB developed

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*Caring for populations across the lifecourse*
A presentation to educate frontline staff on the diagnosis and management of tuberculosis, and measures for its prevention and control can be accessed from the NICE website: TB presentation.

NICE Clinical guidelines, CG117 - Issued: March 2011 offer the latest information on the diagnosis and management of tuberculosis, and measures for its prevention and control. This guidance is being reviewed and revised guidance will be published in October 2015.

NICE Guidance on Public Health Outcome Domain Three: Health Protection
Evidence based public health nursing and midwifery contains information on TB services.

NICE guidance is also available for identifying and managing TB among hard-to-reach groups (PH37) and TB Pathways.

Further guidance is available which makes recommendations on individual-level interventions aimed at changing health-damaging behaviours among people aged 16 or over: PH49.

A NICE pathway for the commissioning of TB services is also available.
Tuberculosis | Interventions

- **TB active case finding** Active case finding (ACF) is a strategy to identify and treat people with TB who would otherwise not seek prompt medical care.

- **TB awareness raising**
  
  TB awareness raising makes healthcare professionals and members of the public more alert to the epidemiology and clinical manifestations of TB.

- **Pre entry TB screening for migrants**
  
  All persons who apply for a UK visa for more than six months and who are resident in a country where TB is common (over 40/100,000), will be screened for pulmonary TB at one of the UK approved TB screening centres.

- **directly observed therapy** is undertaken by healthcare practitioners to ensure that people with lifestyle/behavioural factors that make it difficult for them to adhere to the regimen, complete their treatment programme. This is recommended in NICE Guidance PH37.
Tuberculosis | Outcome indicators

Public Health Outcome Indicators:
This database allows comparisons between indicators in areas of England with England as a whole. There is one indicator for TB: 3.05i-Treatment completion for TB (select correct indicator from drop-down list).

Health and Social Care Information Centre:
This gathers together data from the following sources:
- clinical commissioning group
- compendium of population health indicators
- local basket of inequalities indicators
- GP practice data
- Adult Social Care Outcomes Framework
- quality accounts
- NHS Outcomes Framework
- summary hospital-level mortality data

This information can be accessed through the Indicator Portal. Entering tuberculosis into the search box will bring up 15 different indicators.
Tuberculosis | Good practice

Tuberculosis case management and cohort review (Royal College of Nursing, April 2013)

Best Practices in Prevention, Control and Care of Drug Resistant Tuberculosis (World Health Organization 2013)

Race Against Tuberculosis: an agenda for action (Race for Health/ TB Alert 2010). This document contains the following examples of good practice in four different areas:
- good practice in community engagement in TB
- commissioning TB awareness: learning from other health conditions
- linking clinical and social approaches to TB control
- embedding better TB approaches with public sector partners
Antimicrobial resistance

Quick links

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- Examples of good practice
Antimicrobial resistance

| Introduction

Infections are increasingly developing that cannot be treated. The rapid spread of multi-drug resistant bacteria means that the time may soon arrive when we cannot prevent or treat everyday infections or diseases. Many existing antimicrobials are becoming less effective. Bacteria, viruses and fungi are adapting naturally and becoming increasingly resistant to medicines used to treat the infections they cause. Inappropriate use of these valuable medicines has added to the problem.

The UK Five Year Antimicrobial Resistance Strategy 2013 – 2018 sets out the actions that are needed across all sectors to respond to and address the challenge of AMR. The strategy has been developed collaboratively with the UK devolved administrations and the bodies that will be responsible for delivering the work and identifies the priorities to be addressed and includes a call to action.

The Longitude Prize 2014 is a challenge with a £10 million prize fund to help solve one of the greatest issues of our time. Antibiotics were voted by the public to be the winning challenge of the Longitude Prise 2014. Now that the antibiotic challenge has been chosen, everyone (from amateur scientists to the professional scientific community) is needed to try and solve it.
Antimicrobial resistance

Facts:

There are few public health issues of greater importance than antimicrobial resistance (AMR) in terms of impact on society. The problem is not restricted to the UK. It concerns the entire world and requires action at local, national and global level.

Public Health England has produced a generic Fact Sheet in the form of a question and answer sheet to assist both health professionals and the public in understanding antimicrobial resistance.

The World Health Organisation (WHO) has published an AMR Infographic Poster as well as a Fact Sheet about the global implications of AMR.

The Annual Report of the Chief Medical Officer (2011) Volume 2 is an in-depth specific review addressing infection and antibiotic resistance.
Antimicrobial resistance Guidance (1):

There are numerous resources available for guidance on AMR depending on the circumstances. The aim of all guidance is to improve the diagnosis, treat the patient appropriately, improve the use of the microbiology services and target the use of appropriate antibiotics.

The Royal College of Nursing and Infection Prevention Society Toolkit supports the commissioning of infection prevention and control as a resource for both commissioner and provider organisations. It includes a basket of indicators that can be used or adapted at local level to meet local needs and support on-going improvement in HCAI reduction. Version 2 of the toolkit is due for release imminently and will contain a basket of indicators that have been mapped against the UK Five Year Antimicrobial Resistance Strategy.

An Acute Trust Toolkit for the early detection, management and control of Carbapenemase producing Enterobacteriaceae provides expert practical advice for frontline clinicians and staff to prevent or reduce the spread of these bacteria into and within health and residential care settings. It also provides some basic public health risk assessment tools and information for the patient and their contacts.
Antimicrobial resistance
Guidance (2):

NICE – Quality Standard QS61 – Infection Prevention and Control was issued in April 2014 and describes high priority areas for quality improvements. This quality standard covers the prevention and control of infections for people receiving health care in primary, community and secondary care settings. Quality Statement 1 relates to Antimicrobial Stewardship.

NICE are also developing a clinical guideline on medicines and prescribing in AMR, and public health guidance on education and information on antibiotic use for the public and professionals. These are due to be published in 2015/16.

The British Society for Antimicrobial Chemotherapy (BSAC) has a website which collates Guidelines, Standards and Publications arising from working party activity on numerous diseases, conditions and infections including MRSA, hospital-acquired pneumonia and endocarditis.

The Royal College of General Practitioners have produced a TARGET antibiotics toolkit as a central resource for clinicians and commissioners about safe, effective, appropriate and responsible antibiotic prescribing.
Antimicrobial resistance

Interventions (1):

To help prevent the development of current and future bacterial resistance, it is important to prescribe antibiotics according to the principles of antimicrobial stewardship, Start Smart – Then Focus, and carry out strict infection prevention and control precautions when caring for patients with resistant organisms.

This guidance will help providers assess whether they meet Criterion 9 of the Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance.
Antimicrobial resistance
Interventions (2):

Antimicrobial prescribing and stewardship competencies are designed to complement the NICE National Prescribing Centre generic competency framework. Regulators, educators, educational providers and professional bodies can also use them to inform the development of standards, guidance and training.

The NHS National Prescribing Centre has issued a Quick Guide for Commissioners in relation to Non-Medical Prescribers that will be of interest to nurses, optometrists, pharmacists, physiotherapists, podiatrists, radiographers and any other healthcare professional interested in becoming an independent prescriber.
Antimicrobial resistance

Outcome measures (1):

Indicators of good outcomes are to ensure that no patient is harmed by an avoidable infection ie no cross-infection of preventable infection has occurred due to a lapse in care. This will be evidenced by the reduction in MRSA and *Clostridium difficile* rates, and other resistant organisms. Adherence to antibiotic prescribing policies and good antimicrobial stewardship is vital to achieve an overall outcome of reducing the amount of antibiotics prescribed unnecessarily.


As antimicrobial resistance is a global phenomenon we can learn from the experience of other countries. Australia has produced a paper on Measuring the Performance of Antimicrobial Stewardship Programmes, which recommends quality indicators are monitored to assess appropriate prescribing practices and compliance with policy therefore improving outcomes, and may be of interest to commissioners.
Antimicrobial resistance
Outcome measures (2):

The Journal of Antimicrobial Chemotherapy published a paper on improving the quality of antibiotic prescribing in the NHS by developing a new antimicrobial stewardship programme “Start Smart – Then Focus”. This paper also references all of the official texts and guidance from the Department of Health and national bodies to improve antibiotic prescribing and stewardship and is an excellent source of information in assisting with patient safety and quality outcomes.

It is an established fact that inappropriate use of antibiotics can contribute to the risk of developing Clostridium difficile infection (CDI). The Guidance for Dealing with CDI is available via the following link and Chapter 4 specifically outlines the prevention of CDI through antibiotic prescribing.
Antimicrobial resistance

Good practice:

Good practice demonstrates compliance with relevant guidelines, the Code of Practice and antimicrobial prescribing guidelines. All independent prescribers and nurses involved in the administration of medicines must understand the principles and demonstrate competence in the prevention and control of infections. This includes those that are associated with healthcare and apply this knowledge as a routine part of their daily practice.

The Nursing and Midwifery Council (NMC) has produced a Medicines Management and Prescribing document which is information for nurses and midwives in applying medicines management and prescribing standards in practice.

NICE offers a comprehensive suite of guidance, advice and support for delivering quality, safety and efficiency in the use of medicines, including antimicrobials.

The Royal College of Nursing has published a booklet entitled Wipe it Out which is Essential Practice for Infection Prevention and Control – Guidance for Nursing staff. This also includes a section on use of antimicrobial agents.
There are 800,000 people living in the UK with dementia and this is estimated to rise to 1.2 million by 2021 and to 1.7 million by 2050. Most people associate dementia with older people but there are 17,000 people in the UK under the age of 65 years who are affected by dementia. Dementia costs society £19 billion per year in England alone; more than the cost of cancer, heart disease or stroke.

The rise in the number of people living with dementia has been recognised as a global problem with 44 million people diagnosed with this devastating condition worldwide, a figure that has been predicted to double every 20 years.

The Care Quality Commission in October 2014 published: Cracks in the pathway: Our review of dementia care. This thematic review highlights the problems that people living with dementia experience as they moved between care homes and acute hospitals.

The first G8 Summit on dementia was held on 11 December 2013. This resulted in a global meeting held on 19 June 2014 which looked at barriers to investment in research and ways to increase investment in innovation, including the need for earlier diagnosis, better management and new treatments.
Dementia | Facts

Dementia is a syndrome characterised by catastrophic, progressive global deterioration in intellectual function and is a main cause of late-life disability. The prevalence of dementia increases with age and is estimated to be approximately 20% at 80 years of age. In a third of cases, dementia is associated with other psychiatric symptoms such as depressive disorder, adjustment disorder, generalised anxiety disorder and alcohol related problems.

The Alzheimer’s Society produces a large number of helpful Fact Sheets that staff can use to direct families to information and advice.

In partnership with Alzheimer’s Society, BILD has created two new Easy Read factsheets on dementia for people with learning disabilities

Factsheet one: What is dementia?
Factsheet two: Supporting a person with dementia

NHS Choices provides a wide variety of Fact Sheets for people who care for those with dementia, as well as information on signs and symptoms and social care support that is available.
Dementia | Guidance

- NICE guidelines on dementia GC42
- Support for commissioning dementia care CMG48
- There are two NICE Quality Standards for dementia:
  - Dementia Quality Standard QS1
  - Quality Standard for Supporting People to Live Well with Dementia QS30

- A new NICE Guideline is in development that is expected to be issued in February 2015: Disability, dementia and frailty in later life - mid-life approaches to prevention

- NICE will also publish health guidance in February 2015 on mid-life interventions to prevent disability, dementia and frailty in later life. This is the first guidance that addresses dementia prevention and demonstrates that mid-life changes can reduce risk and increase healthy years in later life.
Dementia | Interventions

Specialist nurses working in teams provide post diagnostic support which is crucial for people with dementia and their families in helping them to adjust to the diagnosis and plan for future care, including developing advanced care plans. Evidenced based interventions such as cognitive stimulation therapy, psychosocial interventions plus flexible support services/ social engagement can contribute to people with dementia living a better quality of life for as long as possible in their communities. Links to useful information:

- a [Dementia Care Pathway](#) has been produced by NICE
- [Nursing vision and strategy for dementia care](#) published by the Department of Health
- [Dementia : A state of the nation report on dementia care and support in England](#) published by the Department of Health
- [Dementia self-assessment framework](#) – a tool developed to ensure implementation of the nursing contribution to dementia care, including the 6Cs and dementia pathway
- [Dementia Friendly Communities](#) can be viewed on the Department of Health’s website
- [Caring for a person with dementia](#) – information and support from the Alzheimer’s Society
Dementia | Outcome measures

The Alzheimer’s Society’s Talking Point is an online discussion forum for anyone affected by dementia. It’s a place to ask for advice, share information, join in discussions and feel supported. This is a good place to get some qualitative feedback from service users.

A database on the prevalence of dementia reported from general practice.

This database lists the proportion of patients with dementia in a GP registered population. This definition applies to all patients diagnosed with dementia either directly by the General Practitioner or through referral to secondary care.

The face to face dementia review should focus on support needs of the patients and their carers. As the illness progresses, and more agencies are involved, the review should additionally focus on assessing the communication between health and social care and non-statutory sectors as appropriate, to ensure that potentially complex needs are addressed.

The estimated diagnosis rate for people with dementia taken from the NHS Outcomes Framework, indicator 2.6.i.
Dementia | Examples of good practice

- Nurses have a key role in providing health education to promote healthy lifestyles that reduce risks of developing dementia and that support people to remain active and live well. See example of Specialist Link Nurses in Surrey

- The role of nursing in primary and community care is also vital in helping to identify early signs and symptoms of dementia, to facilitate access to good quality, timely diagnosis, to offer post diagnostic support and to help avoid unnecessary admissions to hospital. See Primary care early detection and support services for dementia in Kent and Medway

- Admiral Nurses work in a range of settings to support families and offer support with accessing diagnosis, post diagnostic support and education/advice which supports wellbeing and promotes health for family carers and people with dementia

- Dementia First Aid Course: Manual for Family Carers

- Early Memory Diagnosis and Support Service

- Liveability Service promoting the health and independence of people aged 50 and over

- The South London and Maudsley NHS Foundation Trust provide a Mental Health Older People’s Service and a Dementia Management Home Treatment Team
Falls | Quick links

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Falls | Introduction

Falls and fractures in older people are a costly and often preventable public concern. In England between 1998/99 and 2008/2009 the overall rise for both men and women was 17%, with the number of bed days attributed to hip fractures increased by 32%.

Projections show that based on current trends, by 2036 there could be as many as 140,000 admissions for hip fracture a year in the UK, an increase of 57% on 2008 admissions.

Much can be done to prevent fractures through proper identification, treatment and care for individuals with osteoporosis and/or at risk of falls.

The best way of reducing number of fragility fractures suffered by older people is through a comprehensive falls and fracture prevention service.
Falls | Facts

The following facts have been taken from Age UK’s Falls Prevention Guide, which explores the evidence base on the use of exercise to prevent falls:

- Falls and fractures in people aged 65 and over account for over 4 million hospital bed days each year in England alone
- The healthcare cost associated with fragility fractures is estimated at £2 billion a year
- Injurious falls, including 70,000 hip fractures annually, are the leading cause of accident-related mortality in older people
- After a fall, an older person has a 50% probability of having their mobility seriously impaired and a 10% probability of dying within a year
- Falls destroy confidence, increase isolation and reduce independence, with around 1 in 10 older people who fall becoming afraid to leave their homes in case they fall again
- A tailored exercise programme can reduce falls by as much as 54%
Falls | Guidance

The following NICE guidelines are available:

- Hip fracture: the management of hip fracture in adults CG124
- Osteoporosis: assessing the risk of fragility fracture CG146
- Falls: assessment and prevention of falls in older people CGC161
- Quality Standard for hip fractures QS16
Falls | Interventions

- The Falls and Fractures Alliance was set up in 2012 by the National Osteoporosis Society in partnership with Age UK to bring together organisations to focus on preventing falls and fractures.

- The Chartered Society of Physiotherapy has produced further information on falls and frailty.

- The Care Inspectorate has issued a resource pack Managing falls and fractures in care homes for older people.

- Dehydration is a key area which may contribute to increasing the likelihood of an older person falling. The British Dietetic Association Fact Sheet provides guidance of amount of daily fluid intake.

- The Fallsafe falls prevention resource has been developed by the Royal College of Physicians. It is available through e-Learning and has a huge array of collaborative multi-professional practice.
Falls | Outcome measures

The following outcome indicators are available in the Public Health Outcomes Framework:

- Hip fractures in people aged 65 years and over 4.14i
- Hip fractures in people aged 65 years and over – aged 65-79 4.14ii
- Hip fractures in people aged 65 years and over – aged 80+ 4.14iii

Mortality rates from accidental falls can be found in the Health and Social Care Information Centre Portal.
**Falls | Examples of good practice**

The Activity Matters Toolkit is designed to support occupational therapists in implementing NICE Public Health Guidance 16: Occupational therapy interventions and physical activity interventions to promote the mental wellbeing of older people in primary care and residential care (2008).

**Start Active, Stay Active:** A report on physical activity for health from the four home countries’ Chief Medical Officers.

The Chartered Society of Physiotherapy has produced advice on ageing well and staying active.

Occupational therapists offer effective and cost-effective falls prevention services.

The Royal College of Nursing bring together resources and links that support best practice in falls and injury in collaboration with RCP: Fallsafe.
Respiratory disease | Quick links

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Respiratory disease | Introduction

Respiratory disease affects one in five people and is the third biggest cause of death in the UK. For the purpose of this example respiratory disease does not include all respiratory diseases, but does include chronic obstructive pulmonary disease (COPD) and asthma.

Asthma affects people of all ages with approximately 20% of those diagnosed being children and young people. In adult asthma and child asthma, the aim of treatment is to prevent people unnecessarily dying each year, and support people to reach the ultimate and achievable goal of freedom from their symptoms. Asthma is not a progressive condition but the condition can worsen. Most asthma deaths are considered to be avoidable.

Patients with COPD tend to be older than those with asthma, with 13% of people over 35 years of age having been diagnosed with COPD. Many people with COPD have been smokers. The condition is a deteriorating one and the number of deaths from COPD is much higher than from asthma. Treatment should be proactive by focusing on prevention and earlier diagnosis and treatment.
Respiratory disease | Facts (1)

COPD:

- estimated figures suggest that there are 900,000 diagnosed cases in England and Wales, however, allowing for under diagnosis, the true prevalence could be 1.5 million\(^1\)

- about 25,000 people each year die from COPD in England and Wales, and it is expected to be the third leading cause of death globally by 2030\(^2\)

- the direct cost of COPD to the UK healthcare system is estimated to be between £810-930 million a year, but the broader economic cost is nearer to £3.8 billion\(^2\)

- people with mental health problems are more likely to have COPD because they are more likely to smoke, and people diagnosed with COPD are more likely to have depression and anxiety because of their diagnosis\(^2,3\)

3. An Outcomes Strategy for COPD and Asthma in England (July 2011)
Respiratory disease | Facts (2)

Asthma:

- the number of people affected by asthma in the UK is among the highest in the world
- up to 5.4 million people in the UK are currently receiving treatment for asthma
- during 2011 to 2012, there were over 65,000 hospital admissions for asthma in the UK
- the UK has one of the highest asthma mortality rates in Europe

1. The National Review of Asthma Deaths
2. Report on inquiry into Respiratory Deaths
Respiratory disease | NICE guidance

COPD:
- NICE Clinical Guidance CG101 is written for people with COPD but it may also be useful for their families or carers or for anyone with an interest in the condition.
- NICE Quality Standard QS10 defines best clinical practice for COPD.
- NICE Commissioning Guide CMG43 specifies supportive and palliative care for people with COPD.
- NICE has published a COPD Pathway.

Asthma:
- NICE Quality Standard QS25 covers the diagnosis and treatment of asthma in adults, young people and children aged 12 months and older.
- NICE Technology Appraisal TA10 provides guidance on the use of inhaler systems (devices) in children under the age of five years with long-term asthma (2000).
- Updated information to TA10 was published by NICE in 2002 – TA38.

Smoking cessation:
- NICE Quality Standard QS43 covers smoking cessation, which includes support for people to stop smoking and for people accessing smoking cessation services.
Respiratory disease

| Interventions: Population level (1)

Healthy Lives, Healthy People (2011) is a tobacco control plan for England. It includes commitment to:

- implement legislation to end tobacco displays in shops

- look at whether the plain packaging of tobacco products could be an effective way to reduce the number of young people who take up smoking and to support adult smokers who want to quit, and consult on options by the end of the year

- continue to defend tobacco legislation against legal challenges by the tobacco industry, including legislation to stop tobacco sales from vending machines from October 2011

- continue to follow a policy of using tax to maintain the high price of tobacco products at levels that impact on smoking prevalence

- promote effective local enforcement of tobacco legislation, particularly on the age of sale of tobacco

- encourage more smokers to quit by using the most effective forms of support, through local stop smoking services

- publish a three-year marketing strategy for tobacco control
Respiratory disease

| Interventions: Population level (2)

- **An evaluation of screening for COPD against the National Screening Committee criteria** recommended against population screening as there was insufficient evidence of its effectiveness. However, they also stated that cost-effective evidence does exist for case-finding symptomatic individuals and this should continue.

- Nurses, midwives and AHPs have a role to play in raising awareness of health issues and influencing policies that affect health: [www.arns.co.uk](http://www.arns.co.uk)

- The **British Lung Foundation** is the only charity supporting everyone affected by all the different lung diseases. It works towards positive change by campaigning, raising awareness, supporting people with lung disease and their families and funding world-class research. **Asthma UK** is the largest asthma charity in the UK.

- The **Cold Weather Plan for England** sets out a series of clear actions triggered by a Met Office alert system. These actions are to be taken by the NHS, social care and other public agencies – professionals working with vulnerable people as well as by individuals and local communities themselves – designed to minimise the effects of severe cold weather on health.
Respiratory disease
| Interventions: Community level (1)

There are three key approaches that should be adopted to help people recover from episodes of ill health at a community level. They are:

1. Provide the right care in the right place at the right time – agreeing locally a pathway of care – including timing and location of initial assessment and delivery of care (hospital, GP surgery/community care, or in their own home)

2. Ensure structured hospital admissions – ensuring patients are seen by a respiratory specialist on admission to hospital and receive key interventions – such as non-invasive ventilation for COPD patients – promptly, and self management plans

3. Support post-discharge – ensuring people who have been admitted to hospital with a exacerbation of COPD or asthma attack are given supported to prevent readmissions.
Respiratory disease
| Interventions: Community level (2)

Commissioning

Admission to hospital is a major adverse outcome for people with COPD and is not always necessary. There is great variation in the thresholds for hospital admission between comparable areas in England showing that in many areas there is substantial scope for reducing admissions. Because spend on COPD admissions is so high, action to prevent admissions could save substantial amounts of money as well as improving outcomes for people with COPD.

Local clinical commissioning groups that have achieved lower emergency admission rates have done so by ensuring more proactive care and by commissioning alternatives to admission, including:

- reviewing admissions to identify frequent exacerbators that need more proactive management
- early discharge schemes and hospital at home services commissioned to support evidence-based admission avoidance
- long-term disease management in primary and community care should include clear action plans, optimisation of therapy and support for self-management and home provision of standby medication
- referral for pulmonary rehabilitation should occur when indicated; a treatment that has been shown to reduce admissions, improve exercise capacity and improve health related quality of life
- prompt support for people when they develop new or worsening symptoms, with access to specialist-led care in the community when appropriate
Respiratory disease

| Interventions: Individual level (1) |

- **Early diagnosis**
  It is important that all patients with respiratory diseases are diagnosed as early as possible so that treatment can be used to try to slow down the deterioration.

- **Smoking**
  It has been well established that stopping smoking will slow the rate of deterioration of lung function and prevent flare-ups. Research has shown that there is a four-fold increase in success if NHS support services are used along with stop-smoking medicines such as patches or gum. Healthcare professionals are advised to follow NICE Quality Standard [QS43](#) when providing advice and support for smoking cessation.

- **Education**
  All patients with asthma should receive a written personalised action plan. These are provided as part of structured education, and can improve outcomes such as self-efficacy, knowledge and confidence. For people with asthma who have had a recent acute exacerbation resulting in admission to hospital, written personalised action plans may reduce readmission rates.

- **Commissioning**
  NICE Commissioning Guide [CMG43](#) states specific educational packages should be developed for COPD that take into account the different needs of patients at different stages of the disease.

- **Inhaler technique**
  Patients need to be able to use their inhaler correctly to ensure they receive the correct dose of treatment. There are several types of inhaler and it is important that [training and assessment are specific to each inhaler](#). Training and assessment need to take place before any new inhaler treatment is started, to ensure that changes to treatment do not fail because of poor technique.
Respiratory disease

| Interventions: Individual level (2)

Self-management
The main aim is to prevent exacerbations and to acquire the skills to treat exacerbations at an early stage. An exacerbation is a sustained worsening of the patient’s symptoms from his or her usual stable state that is beyond normal variations and is acute.

There is good evidence that prompt therapy in exacerbations results in less lung damage, faster recovery and fewer admissions (and subsequent readmissions) to hospital. People should be able to access clinical help early in the course of an exacerbation and, as recommended in the NICE Quality Standard for COPD QS10, should be given a course of antibiotic and corticosteroid tablets to keep at home for use as part of a self-management strategy.

Patients with respiratory conditions should be encouraged to monitor air quality via the Daily Air Quality Index, which provides advice on actions to take when the air quality is poor.

The NICE Quality Standard covers in more detail the management of exacerbations, for management in primary care and in patients referred to hospital. It also covers the use of pharmacological management, oxygen therapy, and respiratory physiotherapy.
Respiratory disease

| Outcome measures |

The Quality and Outcomes Framework (QOF) is the annual reward and voluntary incentive programme detailing GP practice achievement against specific indicators. Since its introduction in 2004, the QOF has included indicators related to the identification and management of COPD, and asthma, to incentivise high quality management and care by GP practices.

There are 10 outcomes related to Respiratory Disease in the Public Health Outcomes Framework.

The Health and Social Care Information Centre contains:

- 39 outcome measures relevant to COPD
- 36 outcome measures that are relevant to asthma.
Respiratory disease

Examples of good practice

- The Association of Respiratory Nurse Specialists provides latest updates and network support for nurses.

- The British Lung Foundation runs workshops in the self-management of COPD for professionals. The workshops aimed to increase knowledge and understanding of COPD self-management and to enable GPs and nurses to use the BLF self-management pack confidently with patients.

- The British Thoracic Society produce a number of guidelines to support NICE clinical guidelines and quality standards.

- The British Thoracic Society also produces clinical audit tools and undertakes research studies to support the quality of care provided.

- Asthma UK provides tools and resources to for healthcare professionals to use in their support and management of patients with asthma.

- The Primary Care Respiratory Society UK produce improvement tools that provide a structured, systematic way of reviewing the respiratory care being delivered and identifies ways in which the standards of care can be optimised within a single practice or across multiple practices in a given locality.
Beginning of Life | Quick links

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Beginning of Life | Introduction

Transition to Parenthood and the first 1001 days from Conception to age two is widely recognised as a crucial period that will have an impact and influence on the rest of the life course. Services are primarily delivered by midwives and health visitors but may also involve other health or social care professionals as required.

There is good evidence that the outcomes for both children and adults are strongly influenced by the factors that operate during pregnancy and the first years of life. This is a time when parents are particularly receptive to learning and making changes. A healthy pregnancy is important to the health of the baby. Health messages on the need to stop smoking, drinking alcohol during pregnancy, are key, as is the importance of emphasising uptake of immunisations.

New information about neurological development and the impact of stress in pregnancy, and further recognition of the importance of bonding and attachment, all make early intervention and prevention an imperative. Secure attachment and bonding will have an impact on resilience and physical, mental and socioeconomic outcomes in later life.

Six Early Years High Impact Areas have been developed that focus on the areas having the biggest impact on a child's life.
Transition to parenthood:

- pregnancy to age two is the most important period for brain development, and is a key determinant of intellectual, social and emotional health and wellbeing

- there is increased potential for domestic violence and abuse to start or escalate during pregnancy

- smoking in pregnancy has detrimental effects for the growth and development of the baby and health of the mother

- smoking in pregnancy leads to 3,000-5,000 miscarriages and 2,200 premature births per year in the UK

- strong positive attachment is essential for healthy brain development and social and emotional resilience in later life

Maternal mental health:

- around 1 in 10 mothers will experience mild to moderate postnatal depression and it can have a significant impact on the mother and baby, and also on her partner and the rest of the family
Breastfeeding:
- breastfeeding is a priority for improving children’s health. Breastfed babies have a reduced risk of respiratory infections, gastroenteritis, ear infections, allergic disease and Sudden Infant Death Syndrome.

Obesity:
- over a fifth of 4-5 year olds are overweight or obese. Healthy eating habits are established in the early years and begin with promotion to pregnant women and their partners to establish these habits before the baby is born.

Child development:
- poor nutrition and unhealthy eating habits impact on the development of the child both physically and intellectually. Children who are overweight are at increased risk of poor health outcomes such as type 2 diabetes and poor mental health.
- focus on good oral hygiene has an impact on health and wellbeing throughout life. Over 27% of 5-year-olds have tooth decay.

Hospital admissions:
- illness such as gastroenteritis and upper respiratory tract infections, along with injuries caused by accidents in the home, are the leading causes of attendances at accident and emergency departments and hospitalisation among those under five years of age.
There are a range of NICE guidance documents that focus on the management of the high impact areas which are crucial in the early years, some encompassing more than one area.

**Transition to parenthood:**
- Social and emotional wellbeing - early years: guidance [PH40](#)

**Maternal mental health:**
- Postnatal care [CG37](#)
- Antenatal and postnatal mental health [CG45](#)
- Pregnancy and complex social factors: A model for service provision for pregnant women with complex social factors [CG110](#)

**Breastfeeding:**
- Postnatal care [QS37](#)
- Maternal and child nutrition [PH11](#)
Beginning of Life | NICE Guidance (2)

**Obesity:**
- Promoting physical activity for children and young people [PH17](#).
- Weight management before, during and after pregnancy: guidance [PH27](#).
- Behaviour change: the principles for effective interventions [PH6](#).
- Behaviour change: individual approaches [PH49](#).

**Hospital admissions:**
- Strategies to prevent unintentional injuries among under-15s [PH29](#) and [PH30](#).

**General:**
- Brief interventions and referral for smoking cessation [PH1](#).
- Quitting smoking in pregnancy and following childbirth [PH26](#).
Beginning of Life

Interventions: Population level

population level = wider determinants of health

All interventions link in with the Healthy Child Programme evidence base:

- search for health needs, using population data, demographics
- provision of antenatal and newborn screening programmes
- achieving population wide “herd” immunity through increased uptake of immunisations in both children and adults
- stimulation of awareness of health needs, linking to housing, poverty issues
- influencing policies affecting health
- influencing joint strategic needs assessments and commissioning intentions
- raising awareness, reducing stigma eg to mental health issues
- supporting health campaigns/promoting safety messaging
All interventions link in with the Healthy Child Programme evidence base.

Interventions are mapped to the National Four Level Model for Health Visiting services. Examples of community level interventions, ie the ‘Your Community’ level, includes local action, building community capacity, assets based community development (ABCD) and group activities for:

- facilitating health enhancing behaviours
- aligning work with other services to improve health and wellbeing outcomes and building community capacity
- linking people to community resources, signposting to information eg parenting support, benefits, housing, relationship advice
- signposting to or delivery of targeted parenting programmes
- reducing social isolation, links to community groups eg cookery classes, outdoor activities
- developing peer support groups eg breastfeeding cafés, signposting to support services
Beginning of Life

| Interventions: Family/ Individual level

Four level model for health visiting services:

- **Your community**
  - Local action and public health campaigns building
  - Community capacity/assets based community development (ABCD), group activities

- **Universal services**
  - The Healthy Child Programme
  - Supporting early attachment and perinatal mental health
  - Promoting and supporting breastfeeding
  - Immunisations managing minor illness safe homes
  - Health and development checks

- **Universal plus**
  - Rapid response services for specific expert help/early intervention,
  - For example with postnatal depression, a sleepless baby,
    weaning or answering any concerns about parenting

- **Universal partnership plus**
  - Ongoing health contribution to multi agency support for families with complex long-term difficulties. Includes: Support for families with child with disability or serious illness; Supporting ‘troubled families’ and child protection

**Six high impact areas:**
- Transition to parenthood and the early weeks
- Maternal mental health (PND)
- Breastfeeding (initiation and duration)
- Obesity – including nutrition and physical activity
- Health and wellbeing - the 2 year old integrated review and support to be “ready for school”
- Managing minor illness and reducing accidents
Beginning of Life

| Outcome measures (1)

Public Health Outcomes Framework

Data from the Public Health Outcomes Framework that are relevant to the early years can be accessed below:

- Low birth weight of babies
- Breastfeeding prevalence
- Smoking status at time of delivery
- Under 18 conceptions
- Excess weight at age 4-5 years
- Vaccination coverage
- Infant mortality
- Tooth decay in children age 5
Beginning of Life

| Outcome measures (2)

Early Years Profile:

- the [Early Years Profile](#) has been developed by NHS England and the Child and Maternal Health Intelligence Network as a health profile of public health outcomes relating to early years (children aged 0-5 years). Using the profiles, you can see at a glance how your local area performs against key indicators and use the information to design and commission services to meet local needs.

- [NHS Outcome Framework](#)
  Health Episode Statistics data on non-elective admissions for 0-4s. Local data can be obtained setting out top ten primary diagnoses. These data, as well as data on stillbirth rates and perinatal mortality can be accessed via the [Health and Social Care Information Centre](#).

- Ages and Stages Questionnaire 3 (placeholder) covering five separate areas of development: Communication; Gross Motor; Fine Motor; Problem solving; Personal-social.
the **UK Baby Friendly Initiative** is based on a global accreditation programme of UNICEF and the World Health Organization and includes **Baby Friendly Standards**. It is designed to support breastfeeding and parent infant relationships by working with public services to improve standards of care.

the Centre for Maternal and Child Enquiries published the eighth report into a review of maternal deaths during 2006-2008: **Saving Mothers’ Lives**. It lists top ten recommendations to reduce avoidable maternal deaths, highlights key points of good perinatal care and also covers public health issues that contribute to inequality of maternal outcomes between different socioeconomic groups.
the Marmot Review proposed the most effective evidence-based strategies for reducing health inequalities in England from 2010. It includes two specific policy areas for children:

1. Give every child the best start in life
2. Enable all children, young people and adults to maximise their capabilities and have control over their lives

the Six Early Years High Impact Areas have been developed to support the transition of commissioning of the health visiting and integrated children’s early years services to local authorities from 1 October 2015 and to articulate the contribution of health visitors to the 0-5 agenda
Beginning of Life | Service model

Caring for populations across the lifecourse
Healthy two year old

Contents of this section

- Introduction
- Healthy Two Year Old Facts
- NICE guidance
- Population level interventions
- Community level interventions
- Individual/family level interventions
- Outcome measures
- Examples of good practice
Age two is an important time for children and their parents. The child is learning to talk and how to interact with others. They may begin to spend time in an early education setting, for example in a nursery or with a child-minder.

Planned contact with all children and their parents at this age can help to make a real difference to a child’s future outcomes. It is a time when a child’s need for additional support, for example with language development or behaviour, can start to be identified and support put in place to be “ready for school.” Health, Wellbeing and Development of the Child Age 2 is one of the Six Early Years High Impact Areas, and health visitors are the lead professionals in this area. Working with other healthcare professionals for the 0-5 years group they have a significant impact on improving outcomes for children, families and communities. Two other high impact areas are vitally important at this stage: obesity – including nutrition and physical activity; and, managing minor illness and reducing accidents.

Both health and early education recognise the importance of this stage in children’s lives. The Healthy Child Programme (HCP) recommends a health review for all children at age 2 – 2 ½ years. This HCP review can also be integrated with the Early Years Progress Check at age two, which is offered to all children in early education at this age. The review will be a mandated part of the HCP when commissioning of health visiting services transfers to local authorities in October 2015.

From this time health visiting providers will use the evidence-based Ages and Stages Questionnaires (ASQ-3) as part of HCP health reviews at age two, in order to help reach an overall judgement about children’s development and to generate comparative data for a population measure.
Early parenting matters
A positive and warm parenting style and the home learning environment are the two factors with biggest impact on a child’s cognitive development. What parents do is more important than who they are – parents have the key role in creating a rich home learning environment that supports their child’s development. This includes things like reading to children, having regular bedtimes and visiting the library. Link to NHS choices pages on play and reading.

Speech, language and communication
Research suggests that children from lower income homes may hear 30 million fewer words by age three. By age five large gaps exist in the results from vocabulary tests between children from middle and low income families in the UK. Children from low income backgrounds in the UK are 19 months behind their better off peers. Research suggests that these gaps in vocabulary between children from the richest and poorest families are established even before age two.

But it is not poverty per se which matters most. The child’s communication environment is a more important predictor of language development at two, and school entry ‘baseline’ scores at four than socio-economic background alone.

A Health Start for All Children
From evidence into action: opportunities to protect and improve the nation’s health (PHE, October 2014) has committed to achieving an increase in the proportion of children ‘ready to learn at two and ready for school at five’, as part of ensuring that every child has the best start in life.
Personal, social and emotional development
Social and emotional wellbeing forms the basis for healthy child development and 'readiness for school'. The bond that children develop with their parents, particularly as babies and toddlers, is fundamental to their flourishing. Children without secure parental bonds are more likely to have behaviour and literacy problems.

Difficulties with speech, language and communication may contribute significantly to social and emotional wellbeing problems and the resulting behaviour that may ensue. According to one study 59% of children aged 3 years with language delay had behavioural problems, compared with 14% without language delay.

Nutrition and physical activity
Once walking, pre-schoolers should be physically active for at least three hours spread throughout the day. This develops their movement and co-ordination, as well as improving cardiovascular and bone health and contributing to a healthy weight. Nutrition and physical activity is one of the Six Early Years High Impact Areas.

The Chief Medical Officer for England has issued recommendations on Physical Activity Levels for Pre-school Children (under 5s).
Healthy two year old | NICE Guidance

There are a range of NICE guidance documents which are relevant to the Health, Wellbeing and Development of the Child Age 2:

Parenting:
- Social and emotional wellbeing - early years: guidance PH40

Obesity:
- Promoting physical activity for children and young people PH17
- Behaviour change: the principles for effective interventions PH6
- Behaviour change: individual approaches PH49

Hospital admissions:
- Strategies to prevent unintentional injuries among under-15s PH29 and PH30

General:
- Brief interventions and referral for smoking cessation PH1
- Quitting smoking in pregnancy and following childbirth PH26
Healthy two year old
Interventions: population level

Population level interventions that health professionals can undertake include:

- **Bookstart** offers the gift of free books to all children at two key ages before they start school to inspire a love of reading that will give children a flying start in life and to help families enjoy reading together every day [High Impact Area (HIA)6]

- **The Communication Trust** is a coalition of almost 50 not-for-profit organisations who work together to support everyone who works with children and young people in England to support their speech, language and communication [HIA6]

- by supporting families and enabling children to achieve their potential it contributes to **A New Approach to Child Poverty**

- influencing policy on food labelling and food marketing, including product placement in supermarkets [HIA4]

- supporting culture change attitudes to food [HIA4]

- supporting access to healthy food vouchers and vitamins [HIA4]

- influencing policy affecting healthy environment eg smoke free environments and access to early years education places [HIA6]

- influencing safety campaigns and safety messages, including road safety [HIA5]
Healthy two year old

| Interventions: community level |

- Community work to support links to child friendly and accessible open spaces, playgrounds and community groups [HIA4]
- Group work in children’s centres eg cooking healthy meals on a budget, dental care, ditch the buggy [HIA4]
- Advice and health promotion work on issues such as healthy development, play, sleep, clean and dry for school [HIA6]
- Accident prevention campaigns, links to safety schemes [HIA5]
- Supporting early years settings with healthy snacks agenda [HIA4]
- Advice and support to early years settings on management of infectious disease outbreaks [HIA6]
- Promoting, signposting, developing and /or delivering parenting support programmes [HIA6]
- Working with Early Years and Early Intervention to provide seamless services [HIA6]
Healthy two year old

| Interventions: family/individual level |

- referral and signposting to appropriate support services [HIA6]
- supporting parents with two year old provision/ early years education opportunities [HIA6]
- empowering families to self manage minor illnesses and understanding when to seek medical advice [HIA5]
- supporting family lifestyle changes eg family mealtimes, smoking cessation, and activity [HIA4]
- promoting activities for developing child language and communication skills through play [HIA6]
- screen time advice [HIA6]
- clean and dry for school – continence advice [HIA6]
- managing behaviour and supporting emotional resilience [HIA6]
- promoting independence skills, including dressing and handwashing [HIA6]
- advice on age appropriate interventions and activities [HIA6]
Healthy two year old
Outcome measures (1)

- from 2015 there will be a public health outcome measure of child development at age 2-2½, included in the Public Health Outcomes Framework
- this will provide information about children’s development at age two at local and national levels, across five domains of development: communication, gross motor skills, fine motor skills, problem-solving and personal-social
- in order to generate data for the measure, health visitors will need to be using the Ages and Stages Questionnaires (ASQ-3) as part of The Healthy Child Programme health reviews at age two from 2015
- there are plans to incorporate the Ages & Stages Questionnaires: Social-Emotional (ASQ:SE) at a later stage, so that information on children’s social and emotional development can be captured
Healthy two year old

Outcome measures (2)

Public Health Outcomes Framework (PHOF) Indicators

There are four indicators in the PHOF linked to the child aged 2 years:

- 3.03viii - Population vaccination coverage - MMR for one dose (2 years old)
- 3.03i - Population vaccination coverage - Hepatitis B (2 years old)
- 3.03iii - Population vaccination coverage - Dtap / IPV / Hib (2 years old)
- 3.03vi - Population vaccination coverage - Hib / MenC booster (2 years old)
- Child development at age 2-2½ years [under development]

Health and Social Care Information Centre – Indicator Portal

- LBOI Indicator 11.9 - Prevalence of obesity in reception year pupils
Healthy two year old

| Examples of good practice |

- **Every Child a Talker: Guidance for Early Language Lead Practitioners** (ECaT) is a national programme that has been designed to:
  - raise children’s achievement in early language
  - improve practitioners’ skills and knowledge
  - increase parental understanding and involvement in children’s language development

- **The Triple P – Positive Parenting Program** is an effective evidence-based parenting programme that gives parents simple and practical strategies to help them confidently manage their children’s behaviour, prevent problems developing and build strong, healthy relationships.

- **The Incredible Years** is a series of interlocking, evidence-based programmes for parents, children, and teachers. The goal is to prevent and treat young children's behaviour problems and promote their social, emotional and academic competence

- **Early Intervention: the next steps** is a report about interventions in children's earliest years, and how that can eliminate or reduce costly and damaging social problems
Outcome measures

The Framework for Personalised Care and Population Health uses outcome measures, in the main, from the Public Health Outcomes Framework, NHS Outcomes Framework and the Adult Health and Social Care Outcomes Framework. However, there may also be other relevant outcome measures that can be accessed via the Health and Social Care Information Centre. Using data from the outcomes frameworks can assist in identifying local priority areas for action and demonstrate the value of health practitioners' interventions.

Public Health England:
The Public Health Outcomes Framework sets out the overarching vision for public health, the outcomes for achievement and the indicators that can be used to measure whether improvements are being realised. The indicators allow comparisons between areas of England and with England as a whole. Outcome Indicators can be searched for under each of the domains of public health. Outcome indicators from the Public Health Outcomes Framework, mapped to professional groups, was published in June 2013. Longer Lives highlights premature mortality across every local authority in England, providing important information to improve the health of the community. Health Profiles provide summary health information to support local authority members, officers and community partners to lead for health improvement.

Health and Social Care Information Centre:
This gathers together data from a variety of sources that includes the NHS Outcomes Framework and the Adult Social Care outcomes Framework. These outcomes data can be accessed through the Indicator Portal. Entering a search term into the search box will bring up all available relevant data for that topic.
Technology to support you

NHS Choices Health Apps Library
The Health Apps Library makes it simple for you to easily find safe and trusted apps to help people manage their health. These have been reviewed by the NHS to ensure they are clinically safe and relevant to people living in England.

NHS Networks is a free resource for clinicians, commissioners, care professionals, managers, staff, leaders, followers – and anyone who works in the NHS and social care. It enables the sharing of information, discussion and creation of virtual communities of interest ("networks"). If you run or belong to a network somewhere else, a presence on NHS Networks could complement your existing activities – helping to keep the conversation going between meetings and giving you easy ways to manage and communicate with members.


References