# your Health Matters

THE ANNUAL REPORT OF THE CHIEF MEDICAL OFFICER FOR NORTHERN IRELAND 2010


Department of Health, Social Services and Public Safety
www.dhsspsni.gov.uk

# My report on the health of the population of Northern Ireland

Maintaining, improving and protecting the health of the public in Northern Ireland remains my top priority. While in this, my fifth annual report, I can report that the general health of the population shows signs of improvement, as measured by life expectancy, too many people still die too young or live with conditions that could have been prevented. Of concern also is the gap in health status between the most and least advantaged in our society. Where you live should not determine how long you live.

The 10-year public health strategy for Northern Ireland, Investing for Health, and the various lifestyle strategies which it embraces have made a significant contribution to improvements in health, however addressing many of the causes of ill health are outside the scope of the health service and require an all government approach so that health is in all government policy.

Investing for Health will be succeeded by a new 10-year public health strategy which is currently under development. This strategy will have a particular emphasis on addressing health inequalities as well as looking at interventions to maintain health throughout life, focusing on what has been shown to work at key life stages. To succeed it will need to be a high level, cross government strategic framework based on delivering outcomes.

In addition to the specific lifestyle strategies that are currently in place, the service frameworks, of which there are now four, all address the important issue of health improvement and provide a means for improving health. They all include standards on smoking, physical activity, healthy eating and alcohol thus highlighting the importance to health care staff of the need to promote health as well as treating the patient. The service frameworks also define evidence-based standards that patients and carers should expect, driving improvement in quality and securing the best outcomes and experience for patients irrespective of where they live. Research is essential in determining the most effective approaches to improving health. It provides access to potentially new treatments, attracts and retains the best staff and improves the quality of care whilst contributing to the wider economy with all the associated health benefits.

In recent years the introduction of legislation has been used as a means to encourage behaviours known to improve health.

Legislation banning smoking in public places has been in place since April 2007 and in September 2008 it became illegal to sell tobacco products to anyone under the age of 18. Regulations banning displays of tobacco products at point of sale and the sale of tobacco from vending machines are planned. The Sunbeds Act 2011 will help ensure that adults who use sunbeds are aware of the risks and should reduce the number of young people using them. To reduce the real harm caused to individuals and communities, the principle of introducing a minimum price per unit for alcohol has been consulted upon.

Scotland has legislation to support mothers who wish to breast and bottle feed their babies in public places.

Northern Ireland should consider similar legislation as our breastfeeding rates remain the lowest in the United Kingdom.

Screening programmes are important public health initiatives that can detect a problem before the person has any signs or symptoms. I am pleased that from June 2012 screening for abdominal aortic aneurysm (AAA) will be offered to all men in their 65th year. This programme will prevent around 40 deaths per year from ruptured AAAs.

Climate change is predicted to cause more and more extreme weather events which are likely to have a negative impact on health as well as the environment. Providing health and social care to all those who needed it during the extreme weather of last winter was a challenge. However the dedication of all HSC staff ensured that there was minimal impact on patient and client care. Such extreme weather may continue to add to the level of fuel poverty in our community and increase inequalities in health impacting most on the sick and vulnerable.

The gift of life that comes with an organ donation is all too evident to the recipient. The benefits should have been apparent to all of us when we saw over 600 athletes complete in the Transplant Games in Belfast earlier this year. We should all discuss our wishes with our family and join the Organ Donor Register.

**Dr Michael McBride**
**Chief Medical Officer**

# Contents

# Investing in the health of the public


*Investing for Health*, Northern Ireland's public health strategy, is largely built on the concept of the social determinants of health. These are the conditions in which people are born, grow, live, work and age, including the health system.

The social determinants of health are also mostly responsible for health inequalities – the unfair and avoidable differences in health status seen within and between countries. Addressing health inequalities in Northern Ireland is an essential cornerstone of *Investing for Health*, and reducing the gap in life expectancy between the most and least advantaged remains a key Government target – though one which has a number of obvious challenges in the current economic climate.

The level of deprivation within an area has an impact upon

**Life expectancy at selected points along a Belfast Metro bus line (2006-08)**

| | Donegal Square | Queen's University | Upper Malone Road | Finaghy Road South |
|---|---|---|---|---|
| Metro 8 | ● | ● | ● | ● |
| Male life expectancy | 71 years | 74 years | 79 Years | 80 years |
| Female life expectancy | 77 years | 81 years | 82 Years | 83 years |
| NYDMN Ward rank (1-most deprived ward 582=least deprived ward) | 22 | 237 | 328 | 550 |

Source: DHSSPS (figures presented are at electoral ward level.)

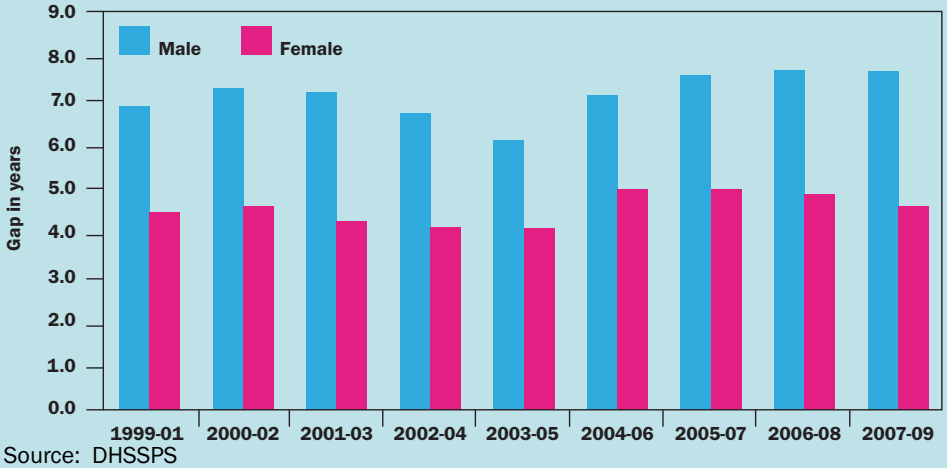
## New ten-year public health strategy

*Investing for Health* has been reviewed, and whilst progress has been made those challenges relating to health inequalities clearly remain. A new ten-year public health strategy is under development and will be launched in 2012. It will have a particular emphasis on addressing health inequalities across the whole life course with a clear focus on addressing the social determinants of health.

*Investing for Health* also embraces a number of lifestyle strategies covering a wide range of issues such as smoking, obesity, alcohol and drug misuse, suicide and sexual health.

### Life Expectancy

**Gap between those living in the most deprived areas and least deprived areas**

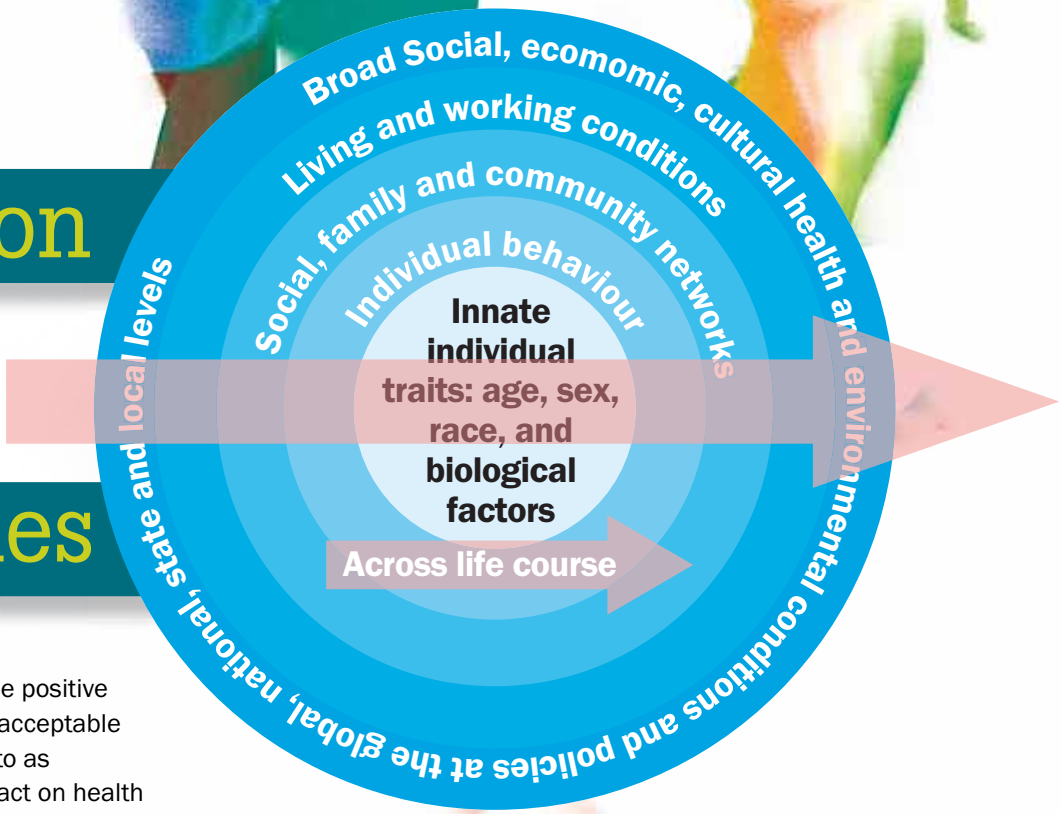



Source: DHSSPS

Investing for Health

the average life expectancy of its inhabitants. People in the least deprived areas can expect to live longer on average than people in more deprived areas. The "Metro bus map" illustrates, within Belfast, how life expectancy increases from more deprived city centre areas through to more affluent suburban areas.

# Deprivation and health inequalities




Source: Adapted from Healthy People 2020

If people and communities lack the positive resources which they need for an acceptable quality of life this can be referred to as 'deprivation'. Deprivation can impact on health and wellbeing in many ways, resulting in lack of social support and low satisfaction with the neighbourhood, feelings of financial strain, low self-esteem, unhealthy lifestyle choices and risk taking behaviour, and poor access to health information and quality services. All of these are key contributors to poorer health and health inequalities.

## LIFE COURSE APPROACH

From birth an individual is exposed to a wide range of experiences – social, economic, psychological and environmental which change as they progress through the different stages of life. It is the accumulation of these experiences and interactions that influence social development, behaviour, health and wellbeing of the individual.

Each of life's transitions can affect health, however people who have been disadvantaged in the past are at greater risk. One particular feature of the life course is that it shows how disadvantages tend to congregate among the same people and that their effects accumulate through life and are passed on from generation to generation.

# Alcohol and drug misuse

**Alcohol and drug misuse have been significant public health and social issues in Northern Ireland for some years. They continue to be key priorities having an all too real and quantifiable impact on the individual, their family, friends, and community. Alcohol misuse increases the risk to individuals of poor mental health, self-harm and suicide, as well as other health problems such as liver disease, cancer and heart disease. It also leads to greater risk of being involved in accidents and committing or being the victim of violence and crime.**

A recently published research paper placed the social costs of alcohol misuse in Northern Ireland at as much as £679 million pounds each and every year. The cost to the health service alone may be as high as £122 million and the costs to social services as much as £48 million. The report is available at www.dhsspsni.gov.uk/social_costs_of_alcohol_misuse_200809.pdf

### Strategic response

An updated five-year strategic plan – New Strategic Direction for Alcohol and Drugs – with regional and local outcomes, to address the harm related to alcohol and drug misuse in Northern Ireland is due to be published shortly. The Public Health Agency will have responsibility for developing local and regional initiatives in respect of the health-related aspects of the strategy.

## Minimum unit pricing for alcohol

Evidence from around the world makes it very clear that there is a link between the price (or affordability) of alcohol and the level of consumption. **In the last thirty years we have seen over a 60% increase in the affordability of alcohol – and with this has come an increase in consumption, and an increase in related harms such as hospital admissions and alcohol-related deaths.**

# The more units a drink contains, the stronger it is and therefore the more expensive it will be.

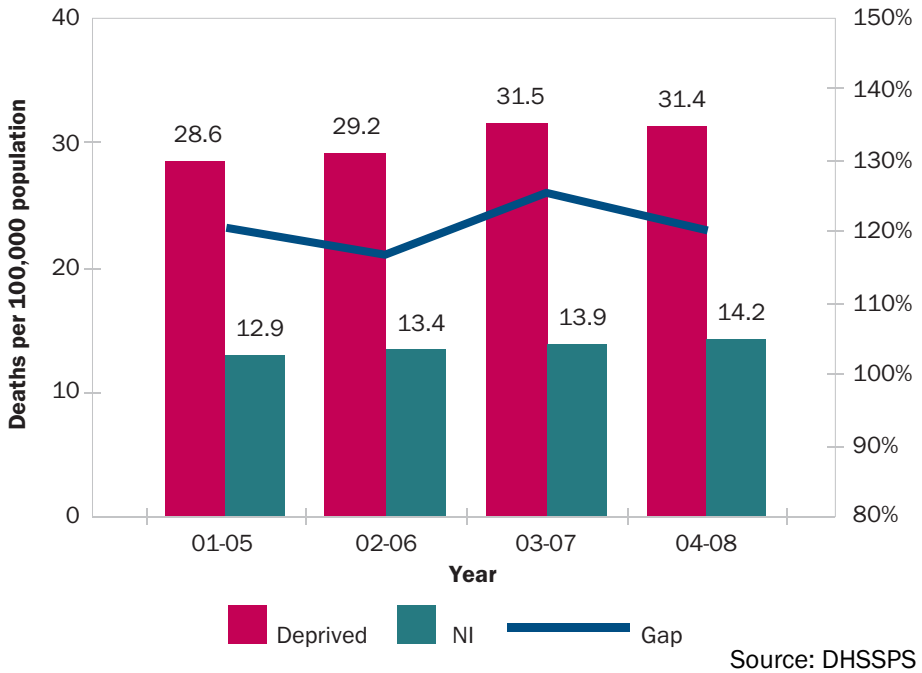

Alcohol is not an ordinary commodity and should not be available in supermarkets priced as a "loss leader" or cheaper than bottled water.

Earlier this year the Department for Social Development and Department of Health, Social Services and Public Safety carried out a joint consultation on the principle of introducing minimum unit pricing for alcohol. Responses to the consultation are being analysed and options for the way forward are being developed.

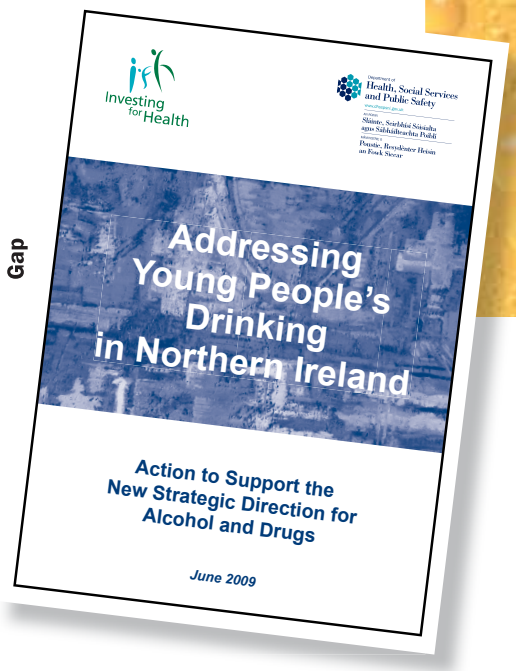
Minimum unit pricing is seen as a targeted way of making sure strong alcohol products are sold at a sensible price. It increases the price of drinks, such as own-brand spirits, high strength beers and white cider, which have high alcohol content but are usually very cheap. It sets a floor price for a unit of alcohol, meaning it cannot be sold for lower than that.

From a public health perspective and based on the existing evidence the introduction of minimum unit pricing in Northern Ireland is a highly desirable public health intervention given the clear evidence-based relationship between price and consumption.

**The alcohol-related death rate in the deprived population is over twice that of the Northern Ireland population.**




Source: DHSSPS



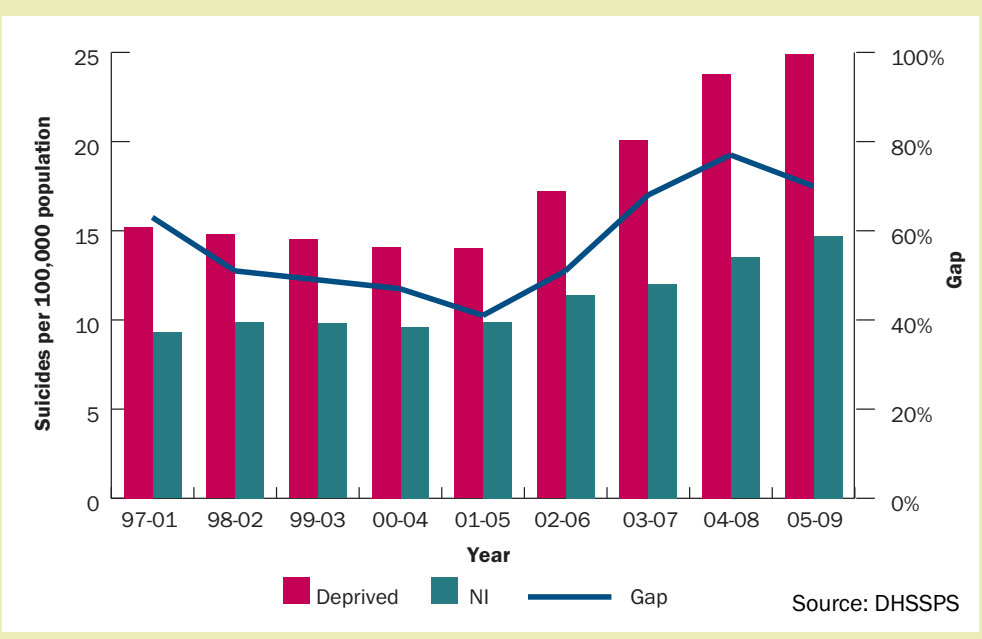
# Promoting positive mental health

**Positive mental health and wellbeing holds the key to a better quality of life for all. It is linked to good physical health and is fundamental to achieving improved educational attainment, increased employment opportunities, reduced criminality and social exclusion, and reduced health inequalities.**

All aspects of life interact and impact on our mental wellbeing. There are broader social, economic, and environmental influences as well as at a more individual level such as family and personal relationships, physical health, childhood experience, and lifestyle. These factors help determine our levels of mental resilience and our ability to cope with adverse life events and stressful circumstances.

It is estimated that one in five adults in Northern Ireland have a mental health condition (such as anxiety or depression) at any one time and that the annual cost to Northern Ireland of mental illness exceeds £3.5 billion each year.

**Suicide rates in Northern Ireland and deprived areas**



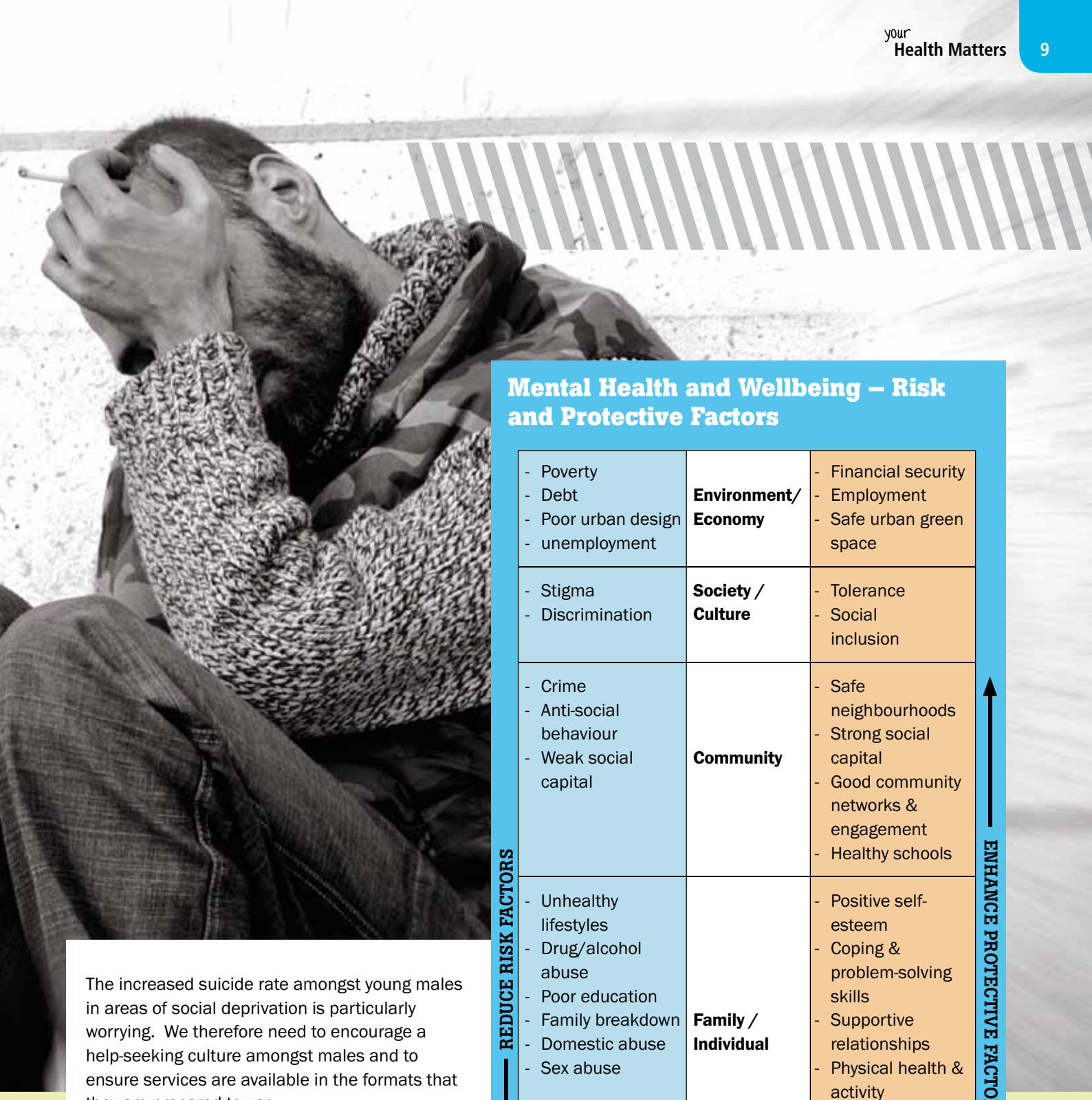

The Department is currently working on a new Mental Health and Wellbeing Promotion Strategy which will be published in 2012. The new strategy will focus on interventions to promote positive mental health at various stages in the life course and in various settings such as schools and workplaces.

There will be a major focus on intervention in the early years (0 to 3) as the evidence shows that this is where the greatest gains can be made.

## Suicide Prevention

Suicide is a highly complex issue and deeply concerning challenge for all sectors of society in Northern Ireland. The number and rate of suicide in the general population has increased steadily from 2005 with a total of 313 suicides recorded in 2010 – the highest figure ever recorded here. Unfortunately the trend continues upwards despite strenuous suicide prevention efforts across the statutory, community and voluntary sectors.

Suicide is inextricably linked with deprivation. Between 2001 and 2005, the gap between the suicide rate in deprived areas and the Northern Ireland average narrowed but, since then, the gap has increased considerably.



The increased suicide rate amongst young males in areas of social deprivation is particularly worrying. We therefore need to encourage a help-seeking culture amongst males and to ensure services are available in the formats that they are prepared to use.

## Causes of suicide

Every death by suicide takes place in a unique set of personal circumstances and there is probably no single causal factor in any one case. Wider social determinants of health and wellbeing – such as poverty levels, debt, upbringing, employment, education, and community safety – all have an impact on suicide levels. Suicide reduction objectives cannot be met by health and social services alone.

There are a number of recognised risk and protective factors for poor mental health and wellbeing.

## Mental Health and Wellbeing – Risk and Protective Factors

REDUCE RISK FACTORS

| | | |
|---|---|---|
| - Poverty<br>- Debt<br>- Poor urban design<br>- unemployment | **Environment/ Economy** | - Financial security<br>- Employment<br>- Safe urban green space |
| - Stigma<br>- Discrimination | **Society / Culture** | - Tolerance<br>- Social inclusion |
| - Crime<br>- Anti-social behaviour<br>- Weak social capital | **Community** | - Safe neighbourhoods<br>- Strong social capital<br>- Good community networks & engagement<br>- Healthy schools |
| - Unhealthy lifestyles<br>- Drug/alcohol abuse<br>- Poor education<br>- Family breakdown<br>- Domestic abuse<br>- Sex abuse | **Family / Individual** | - Positive self-esteem<br>- Coping & problem-solving skills<br>- Supportive relationships<br>- Physical health & activity<br>- Educational attainment<br>- Social engagement |
| - Neglect<br>- Abuse<br>- Parental mental illness | **Infancy** | - Healthy pregnancy<br>- Emotional attachment bond<br>- Positive, engaged parenting<br>- Sensory rich environment<br>- Early intervention & support |

ENHANCE PROTECTIVE FACTORS

# Economic downturn and suicide

The rise in unemployment associated with the economic downturn is of major concern. Studies indicate that unemployed people are 2-3 times more at risk of suicide and that a 1% increase in unemployment is met with a corresponding 0.79% increase in suicide. It is therefore important to consider how the adverse psychological impact of redundancy and unemployment might be mitigated.

Lifeline

0808 808 8000

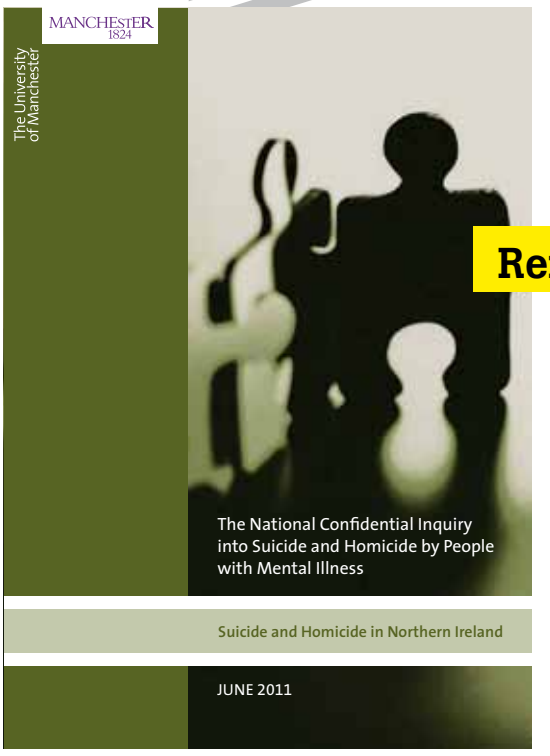
## New approaches to suicide prevention

Our feedback from local communities is that existing services and programmes are undoubtedly saving lives. However, the suicide rate remains unacceptably high and has been rising. It is therefore imperative that new approaches to suicide prevention are considered and tested. The Public Health Agency is piloting a service which reaches out to young men and is based on local research into the experiences of suicidal young males. The Health and Social Care sector is considering how to create "places of safety" for emotionally distressed people who have presented at A&E departments and who could benefit from immediate emotional support. Consideration is also being given to delivering more assertive outreach to those patients who miss psychiatric appointments and to the development of a public information campaign that deals more directly with the issue of suicide.

## Suicide by people with mental illness

The Manchester University-based National Confidential Inquiry into Suicide and Homicide by People with Mental Illness published a Northern Ireland report in June 2011. The report covers a nine-year period from 2000 to 2009 during which there were 1,865 suicides and probable suicides in Northern Ireland. The report's findings and recommendations will inform policy related to suicide prevention as well as clinical services and practice. The main findings include:

- Northern Ireland has a higher rate of suicide compared to England and Wales.
- 29% of all suicides were by people who had been in contact with mental health services.
- Alcohol misuse was a common feature of patient suicide.
- 18% (332) of all suicides occurred in people under 25 years.
- Young people who died by suicide were more likely than other age groups to be living in the poorest areas.
- Young mental health patients who died by suicide tended to have high rates of drug misuse and alcohol misuse, and had previously self-harmed.





## Refresh of the Protect Life Strategy

The Protect Life Strategy is being refreshed in light of the Health Committee "Inquiry into the Prevention of Suicide and Self Harm" and latest international evidence on suicide prevention. The refreshed strategy is due to published shortly.

# Skin cancer continues to increase


**Skin cancer is the most common form of cancer in Northern Ireland. During the period 2005-2009 an average of 3,128 new cases were diagnosed annually – around 261 of which were malignant melanomas, the most serious form of skin cancer.**

Over-exposure to ultra violet radiation, whether from sunlight or sunbeds, is widely accepted as the underlying cause. By reducing sun exposure, and avoiding sunbed use entirely, the majority of people in Northern Ireland could significantly decrease their risk of developing skin cancer.

### New ten-year strategy and action plan

A new ten-year strategy for the prevention of skin cancer was launched on 15 July 2011. It aims "*to reduce the incidence of skin cancer and deaths from it among people in Northern Ireland*". The strategy covers the whole population and identifies two target groups that require particular action:

- children and young adults; and
- people who spend a significant amount of time outdoors, including those who regularly participate in outdoor sports.

The Public Health Agency will be responsible for ensuring implementation of the strategy.

# Regulating sunbeds

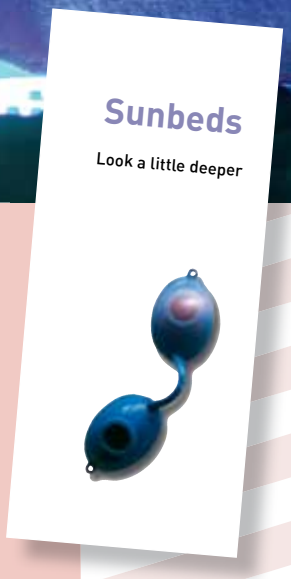
Using sunbeds before the age of 35 increases the risk of developing melanoma by up to 75%, and sunbed use accounts for around 100 deaths per year in the UK. UV radiation also causes sunburn, premature ageing, suppression of the immune system and eye damage.

Around 400 outlets in Northern Ireland offer sunbed sessions, and many people rent or buy sunbeds to use in their homes.

The Sunbeds Act (NI) 2011 received Royal Assent on 3 May 2011. The Act will help prevent cases of, and deaths from, skin cancer. It is the strongest sunbeds legislation in the UK. The Sunbeds Act should reduce the number of young people using sunbeds, and ensure that adults who use sunbeds are aware of the risks.

The Act also includes powers to set up a licensing system for sunbed operators; to require operators to ensure that their staff are trained to certain standards, and to require operators to ensure that the sunbeds meet certain technical specifications.

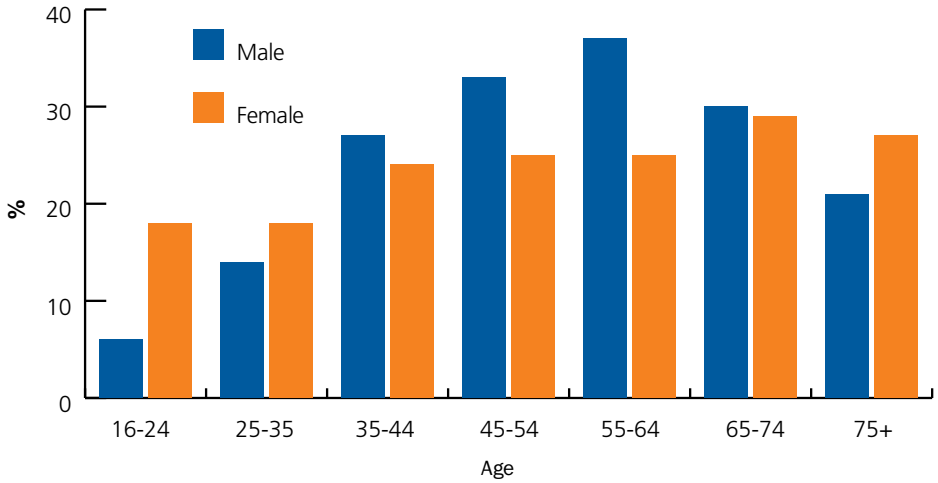
District Councils will be responsible for enforcing the legislation.



# Obesity

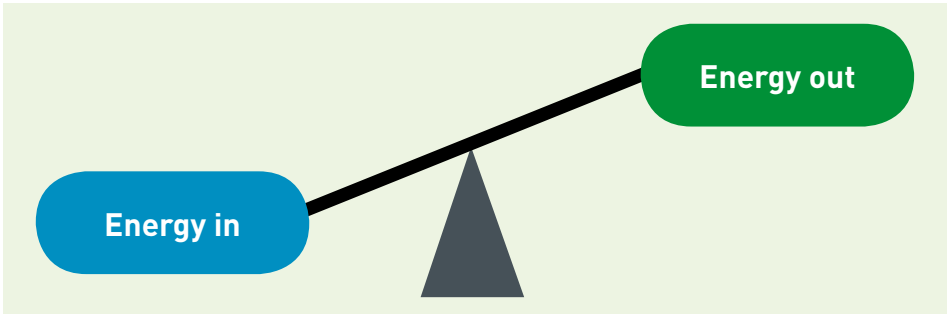
**As I highlighted in 2006 and in subsequent reports, obesity is one of the most important public health challenges facing Northern Ireland today. It knows no age limits, no boundaries, it does not discriminate and brings with it increased risks of developing serious health problems. Research has shown that obesity can reduce life expectancy by up to nine years; increase the risk of Northern Ireland's biggest killers, coronary heart disease and cancer; increase the risk of developing Type 2 diabetes; and affect emotional/psychological wellbeing and self-esteem, especially among young people.**

## Levels of obestity by age and sex




Source: Health Survey Northern Ireland – 2010/11

## Energy needs to be balanced




Source: Investing for Health Update 2004 - http://www.dhsspsni.gov.uk/ifh-update-2004.pdf

The report, Guidelines for the Management of Obesity in Secondary Care (CREST 2005), estimated that just stopping the year-on-year increase in levels of obesity would save this Department £210 million over the next twenty years. In addition there is also a significant cost to the economy in terms of lower productivity and the cost of absenteeism.

# The Health Survey

## Northern Ireland - 2010/11

The first results from the 2010/11 Health Survey Northern Ireland were published in November 2011. During the last year just over 4,000 people, from across Northern Ireland, were surveyed about a range of health and wellbeing issues. Findings in relation to obesity are given below.

- 59% of adults measured were either overweight (36%) or obese (23%). A similar proportion of males and females were obese (23%) however males were more likely to be overweight (44%) than females (30%).
- Obesity was more prominent amongst the middle and older age-groups than the younger age-groups. A quarter of those aged 35-44 were classified as obese and around 30% of those in the 45-54, 55-64 and 65-74 age-groups were obese compared with 12% of 16-24 year olds and 16% of 25-34 year olds.
- In relation to children, aged 2-15 years, 8% were assessed as being obese based on the International Obesity Task Force guidelines, 8% of boys and 9% of girls.
- A third of respondents reported consuming 5 or more portions of fruit or vegetables a day with females more likely to be meeting this guideline than males (36% and 27% respectively).
- Thirty-eight percent of respondents were classified as meeting the recommended level of physical activity, with males (44%) more likely to be meeting it than females (35%).
- 25% of respondents to the Health Survey Northern Ireland can be classed as sedentary, 28% of females and 21% of males. The proportion of respondents classified as sedentary increased with age, from 14% amongst 16-24 year olds to 62% of those aged 75 and over.

### Strategic response

A cross-Departmental Framework for Preventing and Addressing Overweight and Obesity in Northern Ireland 2012-2022 – A Fitter Future for All – has been developed and should be issued shortly. The Framework seeks to address a number of key issues, including:

- increasing the levels of breastfeeding;
- weight management interventions for expecting mothers;
- improving access to physical activity facilities for children and their families;
- developing food skills and knowledge;
- encouraging participation in physical activity;
- reducing the exposure of children to the advertising of unhealthy foods;
- active travel and the obesogenic environment (ie an environment which causes people to be overweight);
- continuation of reformulation of processed foods (ie fat content).

## Who is responsible?

# Tobacco Control

**Smoking remains the single greatest cause of preventable illness and premature death in Northern Ireland, killing around 2,300 people each year. There is also a strong relationship between smoking and inequalities, with more people dying of smoking-related illnesses in disadvantaged areas of Northern Ireland than in more affluent areas.**

Over the past ten years the number of adults smoking has fallen from 29% in 1998/99 to 24% in 2009/10. However, the rate of decrease has slowed and smoking levels within some groups, particularly manual workers, remain very high – 31% in 2009/10.

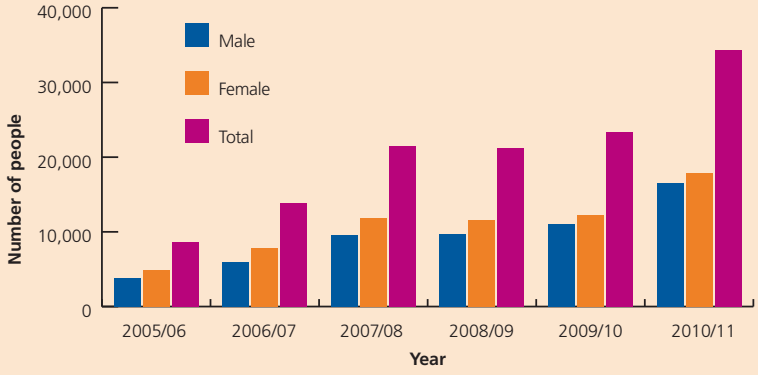
## New tobacco strategy

A new tobacco control strategy will be published in the new year. It will set out the strategic direction for tobacco control over a ten year period. The focus will remain on three target groups:

- adult smokers living in areas of social/ economic need,
- pregnant women who smoke, and
- children and young people.

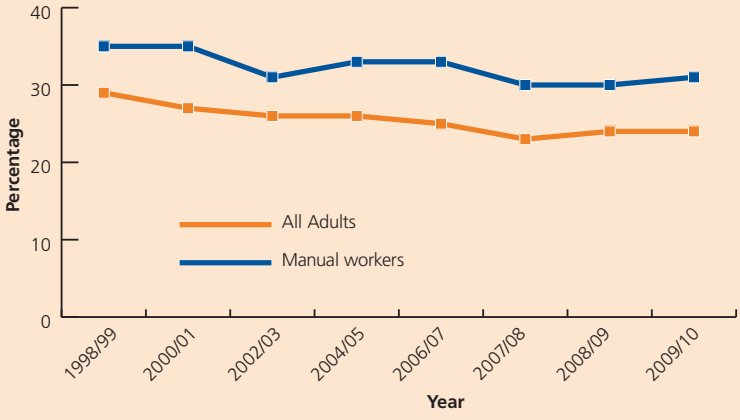
The objectives for the new strategy will be to prevent people from starting to smoke; support smokers to quit; and protect people from the damage caused by second-hand smoke.

### Numbers of people setting a quit date through smoking cessation services between 2005/06 & 2010/11




(Source – NISRA - Smoking Cessation Statistics in Northern Ireland 2005/06 - 2010/11)

### Smoking prevalence in Northern Ireland 1998/99 to 2009/10




(Source – Continuous Household Survey)

### Smoking cessation services

Supporting smokers to quit is crucial. More than three in five of current smokers would like to quit, however, nicotine is a highly addictive substance and support is often required.

Significant resources are invested in smoking cessation services with almost 650 specialist cessation services across Northern Ireland. Most are provided in community pharmacies. Other settings include hospitals, GP surgeries, community centres, schools and workplaces.

There have been year-on-year increases in the number of people accessing cessation services: from 8,702 in 2005/06 to over 34,000 in 2010/11. Clearly people are keen to stop smoking, and are willing to seek the help of professionals in doing so. The good news from last year is that at the four-week follow up almost 18,000 of these "quitters" had successfully quit – almost 6,000 more people than in the previous year.

### Tobacco control regulations

While the Tobacco Advertising and Promotion Act 2002 was effective in reducing promotional opportunities, the tobacco industry has responded by investing more effort into promoting their products through tobacco display gantries in shops. There is clear evidence that promotional activities such as these encourage children to start smoking, which is why it is important that these displays are prohibited.

There are plans to introduce tobacco control regulations banning displays of tobacco products at point of sale and the sale of tobacco from vending machines. The intention is to introduce the vending machine ban and display bans in large shops in 2012 and for smaller shops in 2015 in line with the rest of the UK.

The new measures will discourage children and young people from taking up the smoking habit and create a supportive environment for people who want to quit.

## The good news for those who quit is that health benefits begin almost immediately

| After | Health Benefit |
|---|---|
| **20 minutes** | Blood pressure and pulse return to normal. |
| **24 hours** | Carbon monoxide is eliminated from the body and the lungs start to clear out the build up of tar. |
| **48 hours** | There is no nicotine left in the body. Taste and smell are greatly improved. |
| **2-12 weeks** | Circulation improves, making walking and running a lot easier. |
| **3-9 months** | Coughs, wheezing and breathing problems improve as the lungs have room for up to 10 per cent more oxygen. |
| **1 year** | Risk of heart attack is halved. |
| **10 years** | Risk of lung cancer is halved. |
| **15 years** | Risk of heart attack is at the same level as non-smokers. |

**Health benefits begin almost immediately for those who quit**

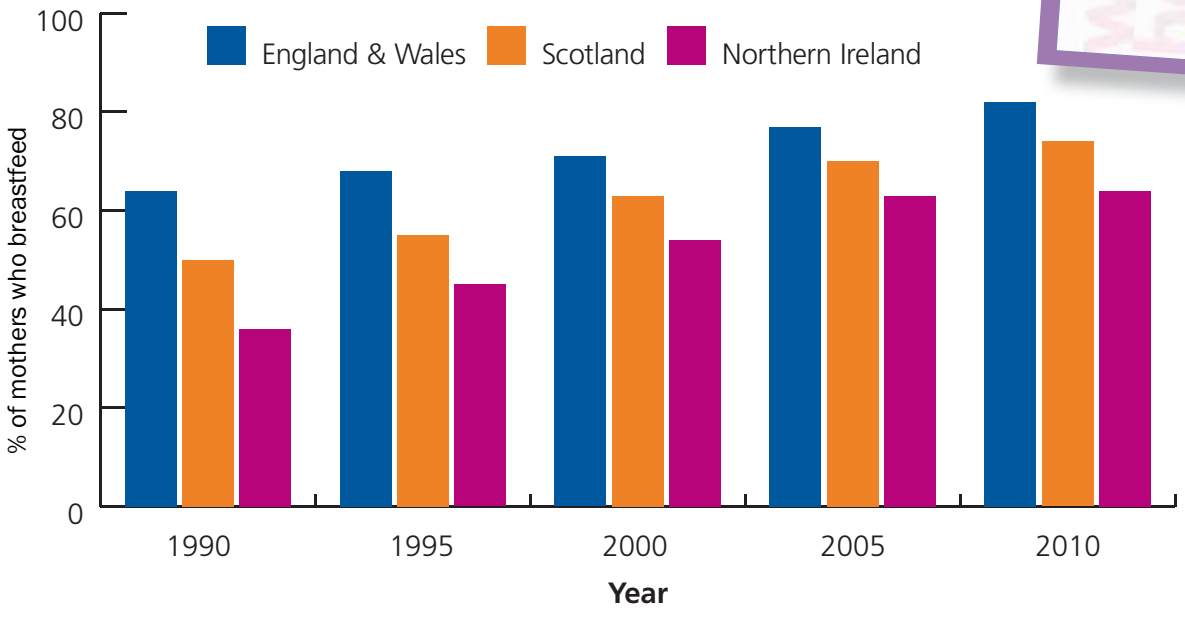
## Tobacco control initiatives around the world – can we do better?

| Country | Smoking prevalence | Tobacco control initiatives |
|---|---|---|
| **Australia** | 19% (2007) | Plans to introduce plain packaging from July 2012<br>Display ban in several states<br>Western Australia banned smoking in cars carrying children, on sections of beaches, and within 10m of playground equipment from Sept 2010. |
| **Republic of Ireland** | 24% (2010) | Display ban introduced in July 2009. Comprehensive ban on smoking in public places from 2004. |
| **California** | 12% (2010) | A ban on smoking inside or within 6m of any public building. Smoking is also banned in restaurants, bars and enclosed workplaces – and on beaches. |
| **New York City** | 16% (2009) | Extended smoking ban in May 2011 to include municipal parks, beaches and pedestrian areas, including in Times Square. |
| **Northern Ireland** | 24% (2009/10) | Smoke-free legislation introduced in April 2007. Age of sale for tobacco products increased from 16 to 18 in September 2008.<br>Ban on sales of tobacco from vending machines planned from February 2012.<br>Ban on displays of tobacco products in shops to be commenced in Spring 2012. |

# Breastfeeding Strategy – is legislation needed?

**Breastfeeding is the best means of giving infants a healthy start to life. Exclusive breastfeeding is recommended by the World Health Organisation and the DHSSPS for the first six months of life, with continued breastfeeding combined with solid foods up to two years or beyond. The health benefits of breastfeeding for both mother and child are well documented, yet a recent UK Infant Feeding Survey showed that breastfeeding rates in Northern Ireland, though increasing, are the lowest in the UK.**


## Breastfeeding Rates




Source: Infant Feeding Survey 2010: Early Results


Breastfeeding welcome here scheme

Any amount of breastfeeding has a positive effect, but the longer a mum breastfeeds, the more likely her child will get the health benefits of breastfeeding. Mums who start breastfeeding in Northern Ireland are also likely to stop sooner than in other parts of the UK. They say that getting support from partners and their own mothers helps them to continue to breastfeed. We know that social and cultural attitudes are also important influences on a mum's infant feeding choices. Our low rates of breastfeeding indicate that breastfeeding is not currently viewed as the norm in our society.

Changing people's attitudes can take time, and legislation is sometimes used by Governments to assist change. In 2005, the Scottish Executive brought forward legislation to ensure that breast and bottle feeding mothers and babies are given equal and unimpeded access to public services and spaces where children are entitled to be, and to encourage and make provision in relation to the promotion of breastfeeding. This legislation provides support to help bring about a change in public attitudes.

Bringing forward similar legislation to strengthen our laws to protect breastfeeding in public may be a good way to support and promote breastfeeding in Northern Ireland.

I have asked for consideration of the evidence to be given to similar legislation in Northern Ireland.

A new breastfeeding strategy will shortly issue for consultation. It will focus on supporting mothers to breastfeed but also recognise the importance of public support for mothers who are breastfeeding.

# DELIVERING ROOTS OF EMPATHY IN CLASSROOMS

ROOTS OF EMPATHY: CHANGING THE WORLD CHILD BY CHILD

Founded in Toronto, Canada in 1996 by educator Mary Gordon, Roots of Empathy is an evidence-based classroom programme that has shown significant effect in reducing levels of aggression among school children while raising social/emotional competence and increasing empathy.

Roots of Empathy has reached hundreds of thousands of children worldwide. Here in Northern Ireland, the programme is currently delivered to 675 primary 5 children at 28 schools.

Our Goals

- To foster the development of empathy
- To develop emotional literacy
- To reduce levels of bullying, aggression and violence, and promote children's pro-social behaviours
- To increase knowledge of human development, learning, and infant safety
- To prepare students for responsible citizenship and responsive parenting

At the heart of the programme are a **neighbourhood infant and parent** who visit the classroom **nine times** during the school year. A certified Roots of Empathy instructor guides the students in observing the relationship between baby and parent, following the baby's development and celebrating milestones. This experiential learning is reinforced through instructor visits the week before and the week after each Family Visit, with the full programme encompassing **27 class visits** and allowing for both preparation and prediction, as well as critical thinking, problem solving and discussion. The specialised curriculum covers **nine themes** and supports children as they learn to understand the baby's perspective, label the baby's feelings and extend that learning to reflect on their own feelings and those of others.

Research Findings

Children in the Roots of Empathy programme exhibit:

- A decrease in aggression
- An increase in prosocial behaviour
- An increase in social and emotional understanding
- An increase in knowledge of parenting
- The perception of a caring classroom environment

A follow-up study of the programme also indicates that improvements in prosocial behaviour and reduced aggression are maintained and enhanced for years afterwards.

Roots of Empathy is a cooperative community programme:

**Instructors** can be Public Health Nurses/Social Workers, Police Officers, Child Welfare/Youth and Family Workers, Early Childhood Educators, School-based Instructors and Administrators. (May not be delivered by a teacher in his/her own classroom.)

**Teachers** attend an introductory presentation; welcome and support the Roots of Empathy Family and instructor, maintaining regular communication. They participate and assist in all lessons.

**Principals** attend an introductory presentation; indicate a strong understanding and support for the programme, finding an enthusiastic classroom teacher to act as host; welcome and support the Roots of Empathy Family; facilitate occasional use of office equipment and supplies, and may participate in media events, evaluation and research.

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www.rootsofempathy.org

**Building emotional resilience in children is a key challenge for public health, both for children's own mental health and wellbeing and the impact that this has into adult life.**

Roots of Empathy is a classroom-based programme, which has been shown to reduce levels of aggression and bullying among school children, while also improving social and emotional competence and increasing empathy. Significantly, it provides an effective approach to reducing the risk factors which cause violence. The programme was originally developed in Canada and is currently being introduced to Northern Ireland. The programme centres on a baby and parent from the local community, who visit the classroom on a monthly basis. A trained instructor coaches students to observe the baby's development and to label the baby's feelings. This "emotional literacy" lays the foundations for more safe and caring classrooms. Children become more competent in understanding their own feelings and the feelings of others (empathy) and are therefore less likely to physically, psychologically and emotionally hurt each other through bullying. The Public Health Agency is working with the Health and Social Care Trusts and Education and Library Boards to develop the Roots of Empathy programme as a key early years intervention in primary schools. From autumn 2011 over 1,000 children in 50 primary schools across Northern Ireland are benefiting from the programme.

**37% of 16 year olds in Northern Ireland said they had been bullied in school.**

**Young Life and Times Survey**

**Family Nurse Partnership Programme**

**Investment in children's early years forms an essential building block for achievements in later life and evidence now supports the need to improve health and wellbeing by investing in the early years of childhood as a means to realising benefits in health, educational attainment, employment, and crime reduction.**

# EARLY INTERVENTION – EARLY YEARS

As health and social care costs continue to increase it is essential that improvement in health is secured by prioritising services which focus on prevention and early intervention.

The DHSSPS recent review of Health Visiting and School Nursing, 'Healthy Futures' (2010) recognises the need to provide support to all children and their families with intensive home visiting to individuals and families who would benefit from the additional support of programmes. The Family Nurse Partnership (FNP) programme was chosen as the model for piloting in Northern Ireland.


The FNP programme is an intensive preventive licensed programme for vulnerable, first time young parents that begins in early pregnancy and ends when the child reaches two years of age. It is delivered by specially trained family nurses and is being used by the PHA to improve the health and wellbeing of our most disadvantaged families and children. The programme is offered to young mothers aged under 19 years having their first baby. The programme covers issues such as:

- personal health,
- child development,
- the role of the mother and,
- relationships with family and friends.

The FNP programme is backed by thirty years of research and has shown significant benefits for children and families including improvements in women's antenatal health, reduction in childhood injuries, increased involvement of fathers, improved school readiness, and reduced anti-social behaviours. It works with mothers, their partners and broader family members and friends, and places a major emphasis on building on the strengths of young people.

**Other Benefits**

Independent economic evaluations in the United States have shown that:

- For every $1 invested in the FNP there is a saving of $5 for high risk families.
- There is a saving of $15,000 per family by the time the child reaches 15 years.
- For high risk families the costs were recovered by the time the children reached four years due to reduced use of health services and benefit savings.

Whilst it is too early to know what the actual cost benefits are in the UK, some key facts are:

- It costs £2,500/week to keep a child in care, £400/week to support a child in need at home and a child who has emotional and behavioural and offending problems can cost between £40k and £79k/year.
- The cumulative costs to public services for a child with troubled behaviour is 10 times that of other children at £15k/year.
- The average cost of the FNP per client is likely to be around £3k/year.

Northern Ireland is currently testing the FNP programme and the first site has been introduced in the Western Trust. It recruits women up to the 28th week of pregnancy. At June this year, 67 women had been enrolled and 10 babies have been born into the programme. One of the positive outcomes to date was that 7 of the 10 young mothers chose to breastfeed their babies.

**"It has given me real confidence in becoming a mum."**
**Mother on FNP**

# Health Effects of Extreme Weather Conditions

## Climate Change

**Over the next century our climate is predicted to change as a consequence of man-made greenhouse gas emissions. Limiting these emissions over the next 40 years is crucial if we are to avoid changes to the climate that will make life unsustainable for future generations. However, due to the current level of greenhouse gases already in the atmosphere there will be unavoidable changes to the climate, which will require many communities to adapt. As I highlighted in my 2008 Report, this change in climate will have an important and largely negative effect on health as well as the environment.**

In recent years Northern Ireland has experienced a number of extreme weather events including flooding in different areas of Belfast and Fermanagh, several heath land and gorse fires across Northern Ireland and the prolonged snowfall and freezing temperatures of winter 2010. A number of different groups in the community are potentially more vulnerable to the effects of such extreme weather events than the rest of the population, these include:

- older people and pensioners;
- people with disabilities or chronic health problems;

## Northern Ireland Climate Change Predictions

- Higher temperatures in summer and winter
- Increased winter rainfall, but a decrease in summer rainfall
- More heavy rainfall days (ie depth greater than 25mm) in summer and winter
- Rise in sea level
- More frequent and more intense extreme event rainfall
- More extreme events (flood, heat and cold) and a greater magnitude of extremes
- Increases in sunlight and UV radiation

Source: UK Climate Change Impacts Programme

- lower income groups;
- geographic communities living in places more susceptible to flooding or where extreme weather might cause increased problems.

**Winter 2010 – a challenge for all**

The prolonged period of snowfall, followed by freezing temperatures and then the rapid thaw that took place during winter 2010 was a challenging time for the Health and Social Care (HSC) service as well as other public services. Their staff worked closely with the private and voluntary sector to ensure services were maintained and those most at risk were identified and their needs met.

For example:

- HSC Trusts and the local councils, with the support of the British Red Cross, worked together to ensure that vulnerable people in the community, including those not routinely known to the HSC organisations, were not left without assistance and water during the period.
- The HSC Board ensured similar assistance was provided to nursing and residential homes.
- The PHA ensured that relevant up-to-date advice and guidance was issued on hygiene and safety, particularly in the face of water shortages.
- HSC staff gave selflessly of their time, working extra shifts and standing in for colleagues who were unable to travel in the severe weather conditions.
- Estates managers across the Trusts faced a significant maintenance challenge with repairs and interruptions to water supplies in hospitals and other HSC facilities. However NI Fire and Rescue Service assisted with supplies of water at some sites as an interim measure.

All of this sterling effort ensured that there was minimal impact on patient and client care.

As with other events of a similar magnitude, the health sector sought to examine its response to see if lessons could be learned, to ensure its future resilience in the face of similar circumstances. As a result, a number of new procedures have been agreed and longer-term planning issues identified that will assist in enhancing any future response. In particular, a top priority was to ensure that vulnerable people in the community could be identified quickly so that they receive assistance in a timely manner.

# Seasonal Flu – main messages

Flu has hit the headlines now for the past two years. First we had the pandemic in 2009/10, followed last year by seasonal flu which was more widespread and severe than initially expected. At this stage it is difficult to predict what might happen in 2011/12, however plans are in place to make sure that we are as well prepared as possible and to avoid increasing pressure on health services through public alarm.

**You can help prepare for the winter in three main ways.**

1. **Seasonal flu vaccination:** everyone in clinical at-risk groups, pregnant women at any stage of pregnancy and frontline health and social care staff should all receive the seasonal flu vaccine. If you are in one of these groups, then take up the offer of vaccine early in the season to protect yourself. GPs are inviting relevant patients for vaccination, while Occupational Health departments have arrangements to vaccinate health and social care staff. If you are not sure if you should be vaccinated, then your GP, practice nurse or Occupational Health department will be able to advise. Flu vaccine protects against the three flu viruses most likely to be circulating this season. And remember, you can't get flu from the vaccine.

2. **Keep a high standard of personal hygiene:** to protect yourself and others against any respiratory virus, including flu, you should cover coughs and sneezes; bin tissues and wash your hands thoroughly.

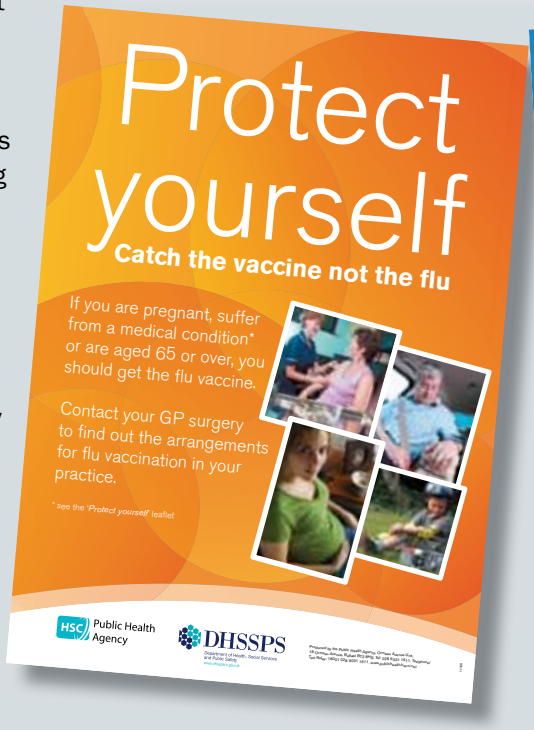
3. **Stay at home if you are ill:** anyone with flu or flu-like symptoms should minimise contact with others and stay away from work, school or childcare until recovered. Most cases of flu are likely to be mild and can be managed at home with over-the-counter remedies. People who are in at-risk groups or who are becoming more ill should stay at home and contact their GP promptly for advice and possible treatment.

# Fuel Poverty

Fuel poverty means that some people are unable to afford to heat their homes to a level that is healthy and safe. The number of households living in fuel poverty is estimated to be around 40%. This figure is likely to increase as the economic downturn results in more people being unemployed and an increased number are dependent on benefits.

Fuel poverty has important direct and indirect effects on health and contributes to health inequalities. It can result in:

- Increased risk of death in cold weather.
- Increased risk of respiratory illness.
- Increased blood pressure and cardiovascular events.
- Increased risk of accidents at home.
- Social isolation.
- Impaired mental health.
- Adverse effects on children's wellbeing.




# AAA – A new men only screening programme

**A new screening programme targeted at men only will be introduced in Northern Ireland from June 2012. All men registered with a GP will be offered screening for abdominal aortic aneurysm (AAA) in the year they turn 65.**

The aorta is the main blood vessel that supplies blood to your body. In some people, as they get older, part of the wall of the aorta can become weak and form a bulge which is known as an abdominal aortic aneurysm.

Over time aneurysms can expand in size and can rupture unexpectedly causing death in around 85% of cases. The person will often have no symptoms. The condition is most common in men aged 65 and older. Smoking, high blood pressure and a family history of AAA are all risk factors for it. Men are six times more likely to have this aneurysm than women.

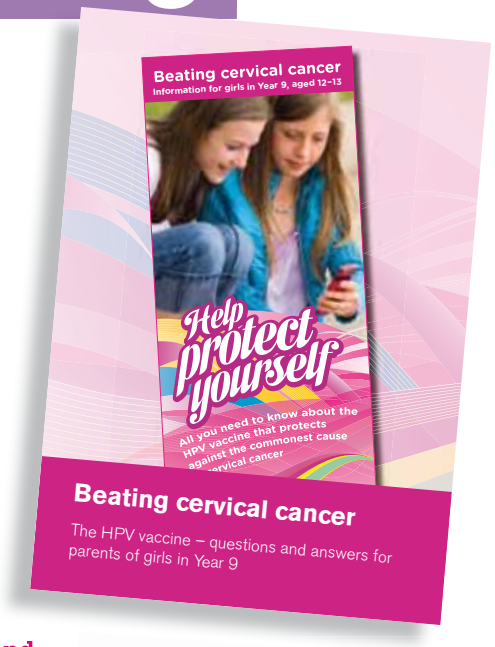
It is possible to screen for AAA using a simple ultrasound scan of the abdomen to measure the diameter of the aorta. The screening test is painless and takes about ten minutes. In the vast majority of men the width of the aorta will be within normal limits however in some it will be larger.

Those with a small aneurysm will have regular scans to check if the aorta is getting bigger. About five per 1000 screened will have a large aneurysm and will be offered surgery to repair it. Screening has been shown to reduce the overall death rate from ruptured aneurysms by around 50%. There are around 80 deaths per year in Northern Ireland due to a ruptured AAA.

**Men are six times more likely to have this aneurysm than women.**

# Changes to the Cervical Screening Programme

**The cervical screening programme is an important public health initiative in the prevention of cervical cancer. Through early detection and treatment seven out of ten cervical cancers can be prevented.**




In January 2011 two changes were made to the cervical screening programme in Northern Ireland. The age at which women are first invited for cervical screening has been raised from 20 to 25 years, and the screening interval between appointments has been lowered from five years to three years for women aged 25 to 49 years. Women aged 50 to 64 are invited every five years.

## 23% women do not attend for cervical screening

This change to the screening age was recommended following a review of the most recent clinical evidence which found that women who have been screened at aged 20 to 24 are as likely to develop cancer as women who have not been screened at that age. Also, there is evidence that treatment for abnormalities in this age group can lead to an increased risk of subsequent premature births. Since the introduction of the screening programme over 20 years ago, the incidence of cervical cancer in the UK in women aged 20-24 has remained largely the same. In contrast, the number of cervical cancers in women aged 30 and over has decreased significantly.

### Why do women not attend for screening?

An average of 80 women are diagnosed each year with cervical cancer. Over half these women have never had a cervical smear or have not attended regularly for screening.

Although it is encouraging that the number of women attending for a cervical screening has been increasing steadily 23% still do not attend when invited.


# Human Papilloma Virus and Cervical Cancer

In my 2008 report I highlighted the introduction of the Human Papilloma Virus (HPV) immunisation programme. The vaccine is offered to all girls in school year 9. It protects against HPV types 16 and 18 which cause over 70% of all cases of cervical cancer. It will however be some years before the benefit of the HPV vaccination programme is seen in terms of reducing cervical cancer. Also, it is important for women to continue to attend for screening when invited as

# Bowel Cancer Screening to be Extended


From April 2012 the bowel cancer screening programme in Northern Ireland will be extended to include men and women up to the age of 71. The Programme, which was launched in April 2010, has been rolled out on a phased basis across Northern Ireland and will be in place in all Health and Social Care Trust areas from January 2012. Currently screening is offered to all eligible men and women aged 60-69. It is proposed that the screening programme will be further extended in 2014/15 to include those up to age 74.

Bowel Cancer is the third most common cancer in Northern Ireland, with approximately 1,000 people diagnosed each year and around 400 dying from it. Over 80% of cases occur in people who are aged 60 and over. Symptoms often develop late in the disease, leaving limited scope for treatment and potential cure. Bowel cancer screening allows early detection and treatment, significantly improving outcomes for those with the disease. When detected at a very early stage treatment for bowel cancer can be 90% successful.

All men and women eligible for screening will receive a testing kit for them to complete at home. The kit is used to detect traces of blood in the bowel motion, this indicates that further tests need to be carried out. Most people who are tested will have a negative result and will be invited to repeat the screening test again in 2 years time. Around 10 people in every 500 who complete the test kit will have a positive result and will be invited for further tests. On average only 1 of these will have bowel cancer.

### Complete and return your screening test – it could save your life

### Be aware of the symptoms

As bowel cancer can develop at anytime, it is vital that everyone is aware of the signs and symptoms associated with the disease. These include

- Blood in your stools and/or bleeding from the back passage (rectum).
- A change in normal bowel habit lasting six weeks or more, such as diarrhea, constipation, or passing a bowel motion more frequently than usual
- Unexplained weight loss
- Pain or swelling in your abdomen

If you develop any of these symptoms contact your GP, do not wait to receive the screening kit.

30% of cervical cancers will not be prevented by the vaccine.

Testing for the presence of HPV in abnormal smear samples has recently been shown to improve the accuracy and efficiency of the screening programme. If a person has an abnormal smear they require regular repeat smears, sometimes for up to ten years later. However research has found that women whose follow up smear after treatment is negative for HPV can return to the routine recall for screening rather than have annual smears. HPV testing can also inform the management of women who have a borderline or low risk smear result.

The implications of incorporating HPV testing into the Northern Ireland Cervical Screening Programme are currently under consideration.

# GROUP B STREPTOCOCCUS AND PREGNANCY

Group B Streptococcus (GBS) is a bacterium carried by up to 30% of people without causing harm or symptoms. In women it is found in the intestine and vagina. In the majority of pregnant women it causes no problem though in a very small number it infects the baby, usually just before or during labour, and can lead to serious illness and sadly death of the baby in some cases.

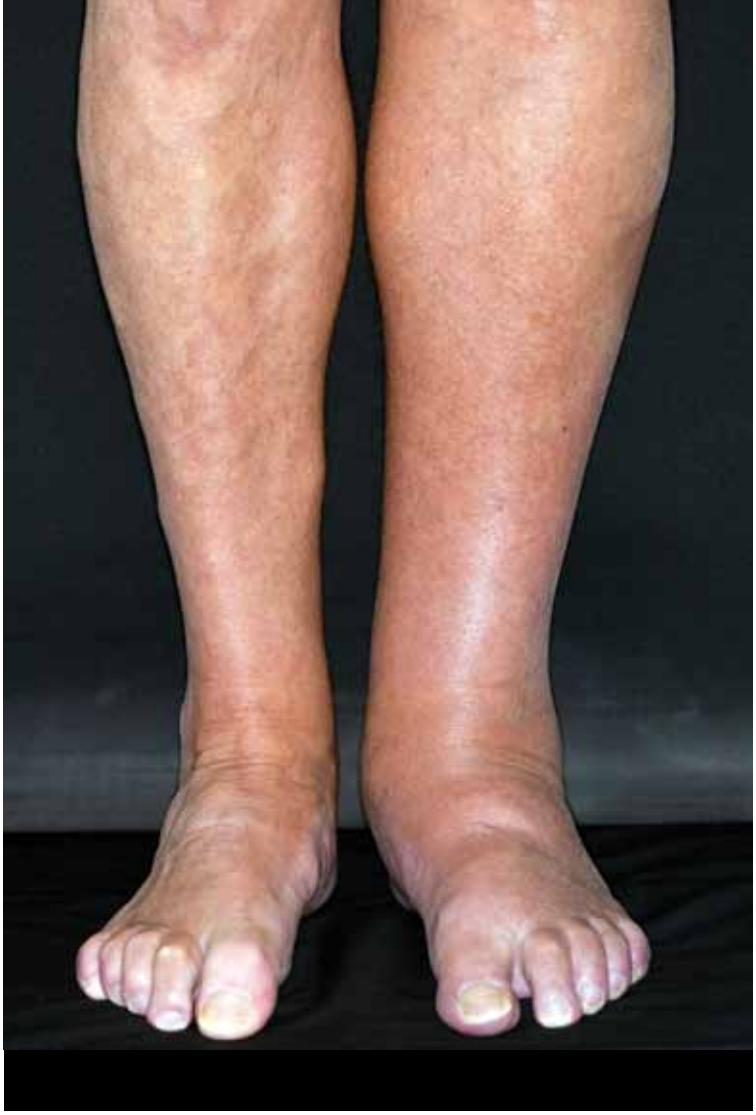
In some circumstances antibiotics can reduce the possibility of a baby developing GBS when given during labour to women with known risk factors. Antibiotics may be offered during labour if the woman:

- has previously had a baby with GBS infection
- GBS has been found in her urine in the current pregnancy
- GBS has been found on swabs from her vagina and/or rectum which have been taken for another reason during the pregnancy
- has a high temperature during labour
- goes into labour prematurely (prior to 37 weeks of pregnancy)
- waters have broken more than 18 hours and she has not yet given birth.

The UK National Screening Committee, NICE and the Royal College of Obstetricians and Gynaecologists have all advised that routine testing for GBS in pregnancy is not currently recommended because there is insufficient evidence to support it. This position is kept under regular review.

Any woman who is concerned about GBS should discuss it with her doctor or midwife. Further information is also available from the following websites.

**http://www.publichealth.hscni.net/gbs**
**http://www.nidirect.gov.uk**
**http://www.rcog.org.uk**
**http://www.gbss.org.uk**
**http://www.babycentre.co.uk**



# Routine Assessment for Venous Thromboembolism

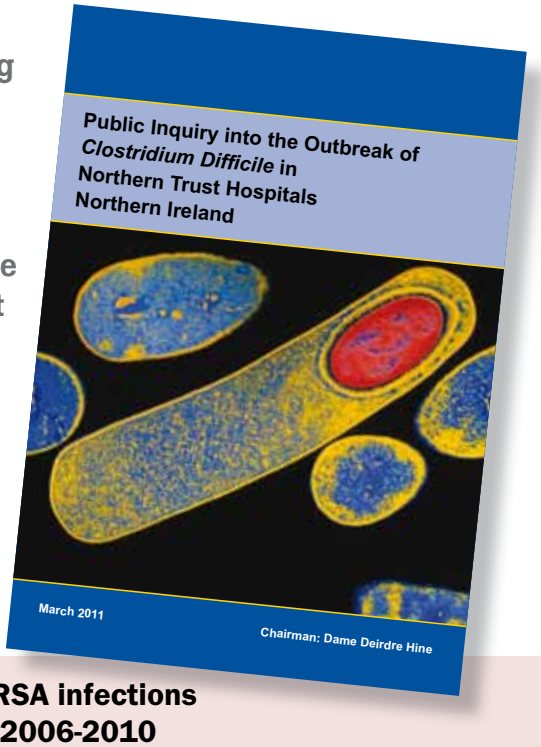
**Venous thromboembolism (VTE) is a condition in which a blood clot forms in a vein. It occurs most commonly in the deep veins of the leg or pelvis and is known as a deep vein thrombosis (DVT). An embolism occurs if all or a part of the clot breaks off from the site where it forms and travels through the venous system. If the clot lodges in the lung a potentially serious and sometimes fatal condition, pulmonary embolism (PE) occurs. Venous thrombosis can occur in any part of the venous system. However, DVT and PE are the commonest manifestations of venous thrombosis.**

The HSC Safety Forum VTE Advisory Group has developed and agreed a single risk assessment form which should be completed when adult patients are admitted to hospital in Northern Ireland. In addition to assessing their risk of clotting it also assesses their risk of bleeding.

All Trusts have been encouraged to use this VTE risk assessment form in an effort to meet the Trust's specific targets for the prevention of venous thromboembolism.

# Healthcare associated infections – C. difficile and MRSA downward trends continue

**During 2010 HSC Trusts made further progress in reducing MRSA and Clostridium *difficile* infections among hospital in-patients. In the four years since 2006, C. *difficile* infections in hospital in-patients aged 65 and over have decreased from 1,073 to 414: a reduction of 62%. In the same group of patients, MRSA bloodstream infections have also been reduced by 53% – from 246 to 116. The greatest reduction was between 2009 and 2010 when C. *difficile* infections fell by 26% and MRSA bloodstream infections by 28%. This reduction is due to the ongoing work of the health and social care staff who continue to make infection prevention and control a high priority throughout the service.**




Factors contributing to the success in reducing healthcare associated infections (HCAI) include:

- Ministerial targets clearly setting out HCAI improvements required.
- Robust HCAI improvement programmes delivered by Trusts.
- Quality assurance of clean healthcare environments through RQIA programme of announced and unannounced inspections.
- Robust surveillance system delivered by PHA.

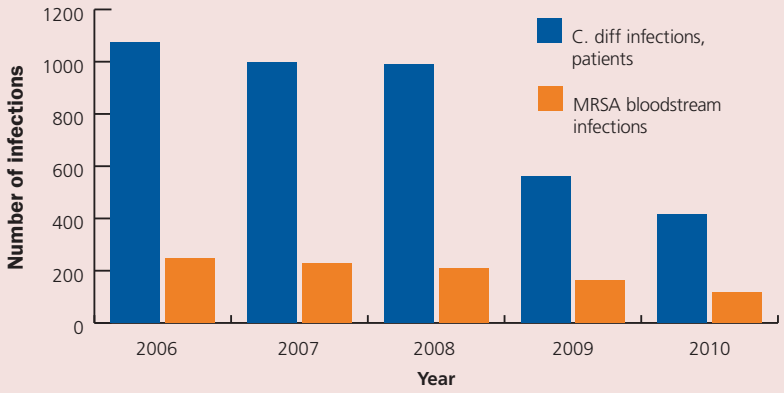
## Public Inquiry into the 2008/09 C. *difficile* outbreak

March 2011 saw the conclusion of the Public Inquiry into the outbreak of C. *difficile* in Northern Trust hospitals that occurred in 2008/09. The Inquiry had two terms of reference: to establish how many deaths occurred in Northern Trust hospitals during the outbreak, for which C. *difficile* was the underlying cause of death or was a condition contributing to death, and to examine the experiences of patients and others who were affected by the outbreak.

The Inquiry reported one finding and made 12 recommendations. The finding was that C. *difficile* was implicated in 31 deaths, as the underlying cause of death in 15 cases and as a contributory cause of death in 16 cases.

Most of the Inquiry's recommendations were addressed in the first instance to the Northern Trust. But it is clear that recommendations arising from the Inquiry apply to all HSC Trusts.

**C.difficile and MRSA infections Northern Ireland 2006-2010**




Source: Public Health Agency

They address a range of issues including communications with patients and their relatives; governance; record-keeping; isolation of patients; end-of-life care; death certification; guidance on infection prevention and control; outbreak control plans; the role of infection prevention and control staff, and risks associated with organisational change.

We are all indebted to the Inquiry team and to all those who gave evidence to the Inquiry.

**The report is available at: www.cdiffinquiry.org**


Diabetes Project of the Year Award 2010

# Improving quality of care in difficult financial times

**In last year's annual report I set out some key elements relevant to protecting the quality of the services we provide in the difficult circumstances we face at present and for the foreseeable future. These are worthy of repeating.**

Those working in the frontline are best placed to modify their work to better meet patient's needs. We all have a key responsibility in ensuring that care is optimised and delivered effectively and efficiently. This applies to all clinicians, not solely those in formal leadership roles.

Of course, frontline staff will not achieve this on their own; they need support from their organisation and the health and social care system more widely. Organisations that have achieved this aim of improving quality in difficult financial circumstances, have focused primarily on what is best for patients with financial considerations a secondary concern. Improvement initiatives can reduce cost but it must be recognised that they require careful planning, leadership, expertise, and perseverance. Meaningful involvement of clinicians, particularly doctors, is critical to achieving this aim.

**Leadership is necessary not just to maintain high standards of care but to transform services to achieve even higher levels of excellence.**

That involvement is essential, to inspire others, to promote the values of the service, to empower and to focus on the needs of the patients being served. Leadership is necessary not just to maintain high standards of care but to transform services to achieve even higher levels of excellence.

Research has suggested that doctors have the most influence when it comes to implementing change that leads to improved performance. This reflects the nature of healthcare organisations where frontline staff have a large measure of control of their day-to-day work relying on professional networks rather than the organisation's formal management structure. Reliance solely on this structure will not achieve the levels of engagement necessary.

**Leadership is necessary at every level within organisations**

Many of the skills and competences required for leadership are intrinsic to high quality clinical practice which is increasingly a team-based endeavour rather than an individual pursuit. However, there remains the perception leadership is somehow intrinsic to gifted inspirational individuals and denied to those of us whose innate talents are more limited. For some time, work has been aimed at addressing the reality that leadership consists of a set of skills like any others that can be identified, developed and refined.

The medical leadership competency framework highlights the need for:

- specific personal qualities;
- the ability to work with others;
- the ability to manage services;
- the ability to improve services;
- and particularly the ability to set direction for self and others.

Clinicians at all levels within organisations can draw on a competency framework to develop leadership skills appropriate to their role whether that be as a consultant leading a small team or a medical director on the board of a large trust. Alongside these developments, the past year has seen The Academy of Medical Royal Colleges establish a faculty of medical leadership and management. This demonstrates the growing acknowledgement amongst the leaders of the profession of the inherent value of these skills to the delivery of high quality services.

However, whilst encouraging individual practitioners to increasingly take on leadership roles and develop their leadership skills, there remains an onus on organisations to use these skills and support these roles to secure the most benefit to patients. Again, research suggests that greater personal interaction between senior managers and clinical staff both formally and informally is critical to this end.

Research on the value of engaging doctors places an onus on chief executives to highlight their role in ensuring engagement with their clinical staff. As part of work on engaging clinical staff, a survey of chief executives suggested ways in which such engagement could be enhanced. Greater involvement of clinicians in the wider aspects of running the organisation is another relevant factor, which clinicians should not shy away from.


**Epilepsy Project of the Year Award 2010**

At every level within organisations there is a need to develop leadership at a personal level, exhibit leadership at every opportunity and create the environment in which leadership and all the resultant benefits will flourish. This is as true for those on the frontline, as it is for directors on the boards of organisations or those in formal leadership roles throughout the system.

# Service Frameworks – improve quality of care

**Service Frameworks are important tools in improving the quality of patient care. They set out the standards of care that people can expect to receive regardless of where they live. Much progress has been made in their development with the third and fourth Frameworks being launched in 2011.**

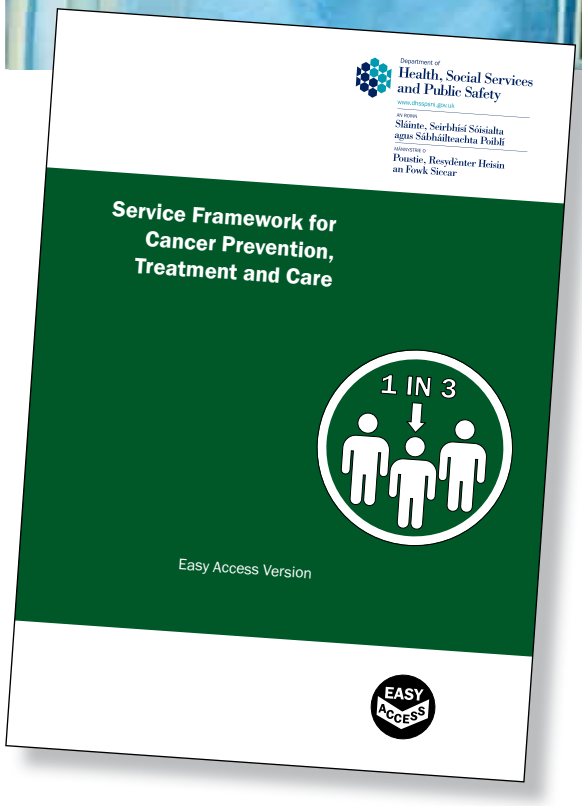
## Cancer

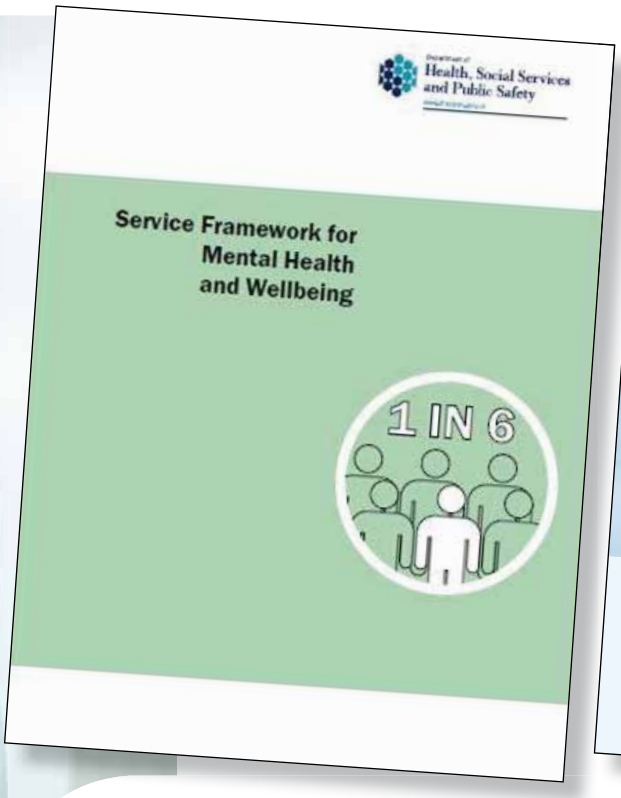
The Framework on Cancer Prevention, Treatment and Care, published in February 2011, sets standards that are generic across all cancers, and also includes standards specific to certain types of cancers including breast, bowel, lung, brain, gynaecological, skin and cancer in children and young people.

The Health and Social Care Board and Public Health Agency commissioning team has been requested to prepare an implementation plan for approval by the Department by December 2011. The phasing of its implementation will be set out in this plan.

## Mental Health and Wellbeing

The Service Framework for Mental Health and Wellbeing was published in October 2011. The aim of the Framework is to improve the mental health and wellbeing of the population







of Northern Ireland, reduce inequalities and improve the quality of health and social care in relation to mental health.

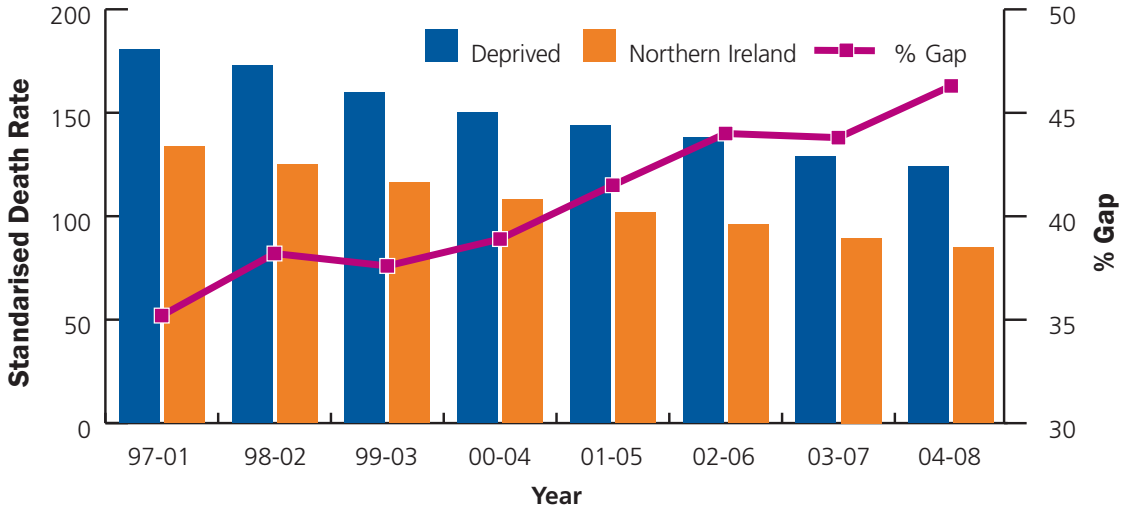
### Cardiovascular Service Framework addresses health inequalities

Heart disease is the main contributor to inequalities in morbidity in Northern Ireland. Heart disease is determined not only by access to services and lifestyle choices but also by the social and economic conditions in which people live. These include housing, employment, transport and access to fresh food.

A Health Impact Assessment (HIA) of the Cardiovascular Service Framework for Health and Wellbeing was undertaken by the PHA. Each standard in the Framework was assessed on how it could be implemented effectively and efficiently to reduce health inequalities and inequities and a health action plan developed.

**Further information is available on: http://www.publichealth.hscni.net/publications/putting-health-inequalities-focus-northern-ireland-cardiovascular-service-framework-sum**

**Standardised death rate from circulatory disease before age 75**



# THE GIFT OF LIFE


**In my 2008 report I highlighted the urgent need for more organ donors. Over the last couple of years there has been excellent progress in organ donation. The Specialist Nurses in Organ Donation in particular, have played a very important role in increasing the number of available organs from deceased donors. In 2010/11, there were 40 deceased donors compared to 18 donors the previous year.**

Organs from the deceased donors are given to people on the UK Transplant Register who are an appropriate match. This means that not all organs donated here go to people living here, however people in Northern Ireland do receive organs from elsewhere in the UK.

Only kidney transplants are carried out in Northern Ireland and in the last year 77 people received a kidney; 26 from a deceased donor and 51 from a live donor. A further 30 organ transplants were carried out on Northern Ireland residents in other centres in Great Britain. The total of 107 people having a transplant in 2010/11 is a significant increase on the 79 transplants done the previous year.

| Organ Transplants in 2010/11 | |
|---|---|
| Kidney | 77 |
| Liver | 21 |
| Heart | 4 |
| Lungs | 4 |
| Heart/Lungs | 1 |

Although the increase in the number of transplants is very welcome more still needs to be done as there are around 300 people in Northern Ireland currently waiting for an organ transplant.

organdonation.nhs.uk

**Becoming a Donor**

Everyone should consider joining the Organ Donor Register and also discuss their wishes with their family and friends. To join the register, either:

**go to www.organdonation.nhs.uk or ring 0300 123 23 23**

# DONOR TRANSPLANT CO-ORDINATOR NAMED NURSE OF THE YEAR

Pauline Haslett, was named as Royal College of Nursing Northern Ireland Nurse of the Year for 2011 – she is the live donor transplant co-ordinator at the Belfast City Hospital.

Pauline, working with colleagues, facilitated the setting up of a one-day assessment process for live donors. Through this new service she has made it easier for people who wish to donate a kidney to do so. She has undoubtedly improved the quality of life for patients and, ultimately, saved lives.

# BELFAST HOSTS TRANSPLANT GAMES 2011

The British Transplant Games 2011 were held in Belfast from 4-7 August 2011. A total of 600 athletes competed in the four-day event with a team from Northern Ireland which included both adults and children. The competitors whose ages ranged from 4 and 82 years have all had a life-saving transplant.

The Belfast adult team had a very successful games winning 48 Gold, 33 Silver, 18 Bronze medals and 10 Trophies including The Ross Taylor Rose Bowl for Best Team. Congratulations to the team and good luck in the next Transplant Games.

At the presentation ceremony Janet Coleman won the Lifetime Achievement Award for her outstanding contribution to the Transplant Games. Janet has worked incredibly hard to raise awareness of Organ Donation. She is Chair of the charity Transplant Sports Northern Ireland and has been involved in transplant sports for 28 years.

**300 people are waiting for an organ transplant.**

# RESEARCH BENEFITS EVERYONE

**Research supported through the Health and Social Care Research & Development Fund benefits everyone. It can take place in hospitals or in the community and helps us to understand what causes ill health and what medicines or treatments are the most effective. Research also helps to improve services so that everyone can get the care they need. The involvement of patients, clients and the general public is vital for research. Here are just a few examples of positive experiences that were reported to locally-based researchers.**

## Economic benefits of R&D

**The development of the research and developments base is also important to the wider economy of Northern Ireland. It can help drive innovation and attract companies into the local economy as well as assist and support companies working in Health and Life Sciences to expand into more global markets. As well as scope for significant economic returns it can reduce the 'brain drain' and keep knowledge and skills in Northern Ireland.**

**Cystic Fibrosis**

Research undertaken in Belfast alongside international partners has demonstrated for the first time that a drug can effectively overcome the fundamental defect in many cases of cystic fibrosis (CF). Patients attending CF clinics agreed to participate in the drug trial and one person told researchers:

*"Taking part in this trial has changed my life ... the results are life changing ... After two weeks I felt my chest not as tight. In the morning I usually cough and do physio but it's hard work ... now it's not as hard work ..."*

# We owe each person who takes part in a clinical trial or other research study a real debt of gratitude.

**Cancer**
Many patients participate in clinical trials of possible new cancer drugs. Here are some of their views of research:

*"In my opinion the benefits of the clinical trials system are the feeling that you are helping others as well as yourself, and you receive closer monitoring and better access to the medical profession, and the potential benefit from cutting edge technology." (Patient 1)*

*"What the drug trial means to me? It means hope. My understanding is that a number of years ago my prognosis would have been quite different. Now I have hope that with the help of dedicated people like my consultant and her team, I have the chance of a healthy future. The drug trial also means that maybe the results of my journey will help future people diagnosed with CML (leukaemia) ..." (Patient 2)*

**Suicide**
Research involving formerly suicidal young men sought their views which revealed many insights about services and mental health professionals.

For example, one young man revealed:

*"Every now and again the thought would still sorta creep in, but I ... teach myself not to have it as an option ..."*

**Care in the Community**
Research that allows patients and carers to express their views about services can also lead to cost savings and efficiencies. The Northern Health & Social Care Trust made a significant saving when part of a community nursing workforce was re-configured into a chronic illness case management team. The nursing teams focussed on older people with more than one chronic condition and were able to reduce by 60 per cent the cost of emergency bed days.

A patient and a carer commented:

*"When I first got sick the GP and the hospital doctor looked after me ... now I have the nurse and she told me to call her when I get sick and that is what I do ... I haven't been to hospital since." (Male patient aged 69)*

*"I never had anyone to help the way the new nurse does ... I think I must have been invisible to people before then ... the nurse asks how are you doing. Is there anything I can do to help." (Female caregiver aged 74)*

# KEY STATISTICS

1. In 2009 there were estimated to be 1,789,000 people living here.
2. Life expectancy for men is 76.8 years and 81.4 for women.
3. 25,029 babies were born in 2009.
4. 14,413 people died in 2009; 6,914 males and 7,499 females. 8,876 were aged 75 and over when they died, 3,669 men and 5,207 women.
5. In 2009 there were 3,885 deaths from cancer and 2,860 from heart disease.
6. 23% of women invited for breast or cervical cancer screening do not attend.
7. Alcohol misuse costs the health Service £122 million per year.
8. 9,826 people were admitted to acute hospitals in 2009/10 for treatment of alcohol misuse.
9. 59% of adults (age 16 or over) are either overweight (36%) or obese (23%).
10. 27% of children (2-15 years) are overweight or obese.
11. 107 people in Northern Ireland had an organ transplant in 2010/11. Over 300 are waiting for an organ transplant.
12. In 2010/11 there were 730,000 attendances at Accident and Emergency Departments.
13. In 2010/11 there were 1,500,000 attendances at outpatients, a further 358,000 did not attend their appointment.
14. In 2010/11 there were 295,000 admissions to hospital and 289,000 people treated as a day case.
15. Almost 36 million prescriptions were dispensed in the community in 2010.
16. In 2010, 55 people died on the roads and 892 were seriously injured.