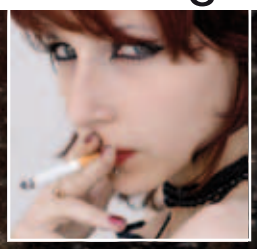
your Health Matters

THE ANNUAL REPORT OF THE CHIEF MEDICAL OFFICER FOR NORTHERN IRELAND 2008

SWINE FLU
CATCH IT, BIN IT, KILL IT.

Young smokers a burning issue



Childhood obesity a growing concern

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

AN ROINN
Sláinte, Seirbhísí Sóisialta agus Sábháilteachta Poiblí

MÂNNYSTRIE O
Poustie, Resydènter Heisin an Fowk Siccar

My Report on the Health of the Population of Northern Ireland

This is my third annual report as Chief Medical Officer and, as we complete the second phase of the reorganisation of health and social care in Northern Ireland, I have chosen to focus on the key opportunities and challenges we face.

In the past year, a year which marked the 60th anniversary of the Health Service, we have seen fundamental changes to the way our health service works, with the establishment of the Health and Social Care Board, Public Health Agency, Business Services Organisation, and Patient and Client Council. These changes are designed to put the public and the patient at the centre.

Indeed, the words of Aneurin Bevin in 1948 are as apt today as 60 years ago:
"This service must always be changing, growing and improving."

And so the need for change, but also the limitations of our current experience, knowledge, technology and skills provides the very drive that motivates all of us in health; whether as patients, professionals, researchers, managers, or volunteers; whether as users of services or workers within the community, voluntary or statutory sector, all strive to make things better.

Everyone in the health system is committed to doing the best they can. We need you to tell us where we measure up and where we fall short, but we also need you to help keep you well. As a society we need to take more responsibility to stay healthy. Coronary heart disease, stroke and cancer remain our biggest killers. As I highlighted in my report last year, deaths and harm from alcohol-related problems continue to rise. Tragically thousands of us are dying from these conditions years earlier than we should.

Considerable work had already taken place over the last few years to develop detailed plans for managing an influenza pandemic.

We have, however, also seen significant improvements in services and outcomes for people with a range of conditions. New vaccination and screening programmes have been introduced and others extended to prevent and detect problems earlier. But there is always more that we can achieve.

In the past the difficulties faced by many in accessing care was simply unacceptable. Our waiting times for outpatient, inpatient and day case procedures have been transformed by the hard work and commitment of health professionals and health service managers.

The challenge now is that this commitment is focused and sustained on the areas that will result in even better outcomes for patients.

The service frameworks which are being developed are an example of this; they will set out the standard of care that patients and their carers can expect to receive and all us in health will work to achieve. These standards are intended to make sure that we measure the things that matter to patients and that all patients and their carers receive the

same high quality care and support regardless of where they live in Northern Ireland.

The importance and benefits of partnership working are also highlighted in this report. Improving the health and wellbeing of the population and reducing health inequalities can only be achieved by supporting people and the community through working with a range of partners.

A major public health challenge which emerged earlier this year was the outbreak of swine flu, which, following the rapid spread of the infection to many people and countries, was declared a pandemic by the World Health Organisation.

Considerable work had already taken place over the last few years to develop detailed plans for managing an influenza pandemic. These continue to be refined to allow us to deal with whatever lies ahead. We have stocks of antiviral medicines to treat people and a vaccine will be available later this year.

People should adhere to the advice issued on how to protect themselves and reduce the spread of any type of respiratory virus, including swine flu.

DR MICHAEL McBRIDE
CHIEF MEDICAL OFFICER

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Swine flu

Swine flu has been on all our minds over the past few months, and as autumn and winter approach it's going to be back on the agenda.

It first hit the news headlines in late April 2009, when a number of people in the USA and Mexico were found to have a flu-like illness caused by the same virus, influenza A/H1N1.

Similar viruses had been found previously in pigs, hence the name 'swine flu'. Influenza A/H1N1 is a new (novel) virus, which means chances of getting it are increased because we have no immunity to it.

Within a month the World Health Organisation had declared a global pandemic, meaning it was a widespread infection occurring in many people in many countries.

Considerable work has taken place over the past few years to develop detailed plans for managing an influenza pandemic, and these were in place long before the current swine flu outbreak. However since late April, we have set in place arrangements for managing the current situation and continue to refine plans for dealing with whatever lies ahead.

Scientists advise us to prepare for an increase in infections in the autumn, as we move into the 'flu season'.

The illness is generally mild, although it can be more severe in a minority of people. Most healthy people recover with rest, fluids and simple painkillers, however we have stocks of antiviral medicine for those who require treatment, such as people with underlying health conditions and pregnant women. Antivirals are available on prescription from your GP.

A vaccination programme is due to begin in the autumn with the priority groups being vaccinated first. These groups have been determined nationally by the Joint Committee for Vaccination and Immunisation. Frontline health and social care staff will also receive the vaccine, starting at the same time.

People also have a responsibility to protect themselves and others by taking steps to reduce spread of any type of respiratory virus, including swine flu. Leaflets have already been delivered to every household across Northern Ireland informing people about swine flu and reminding them of the key health messages. Keep your leaflet safe in case you need to refer to it in the future.

The illness is generally mild, although it can be more severe in a minority of people.

Flu viruses spread through coughs and sneezes.

- **Always carry tissues.**
- **Use clean tissues to cover your mouth and nose when you cough and sneeze.**
- **Bin the tissues after one use.**
- **Wash your hands with soap and hot water or a sanitiser gel often.**

CATCH IT, BIN IT, KILL IT.

The leaflet can also be accessed online at: http://www.nidirect.gov.uk/swine-flu

SWINE FLU VACCINE

Swine flu vaccine should be available in the autumn. The priority groups who will be first to receive the vaccine are:

- Individuals aged between six months and 65 years in the current seasonal flu vaccine clinical at risks groups.
- All pregnant women, subject to licensing considerations.
- Household contacts of immunocompromised individuals.
- People aged 65 and over in the current seasonal flu vaccine clinical at risk groups.
- Frontline health and social care staff (starting at the same time as the first risk group).

SWINE FLU Frequently Asked Questions

What are the symptoms of swine flu?

The symptoms of this swine flu in people are similar to the symptoms of regular human seasonal flu and include:

- Fever
- Fatigue
- Lack of appetite
- Coughing
- Sore throat
- Pain in muscles and joints
- Headache and chills

Some people with swine flu have also reported vomiting and diarrhoea.

Can I catch it?

The virus is contagious and can spread between people, much the same as seasonal flu:

- From person to person by coughing or sneezing.
- From touching an object such as a door handle which has virus on it from someone infected with flu.

Swine flu viruses are not transmitted by food and there is no risk of catching the illness from eating properly handled and cooked pork or pork products.

What do I do if I have these symptoms?

If you have these symptoms, then stay at home and first contact your GP or Out-of-Hours service by phone. Do not go along to the surgery or A&E in case you spread the infection to others. If you develop symptoms at work or school, you should go home as soon as possible and keep contact with others to a minimum. You should not return to work or school until your symptoms have disappeared.

Should I go to work or school if I have been in contact with someone who I know has swine flu?

Yes, as long as you do not have flu-like symptoms. If you are feeling well, you should go about your normal activities, including going to school or work.

It can take up to seven days (normally two to five days) after infection for swine flu symptoms to develop. If you develop symptoms, stay at home and follow the general advice.

How can I reduce my chances of catching swine flu?

General hygiene can help to reduce transmission of all viruses, including the swine flu virus. This includes:

Covering your nose and mouth when coughing or sneezing, using a tissue when possible – **catch it, bin it, kill it**.

- Disposing of dirty tissues promptly and carefully.
- Maintaining good basic hygiene, for example washing hands frequently with soap and water to reduce the spread of the virus from your hands to your face or to other people.
- Cleaning hard surfaces (such as door handles) frequently using a normal cleaning product.

Can swine flu be treated?

Most healthy people can recover with just rest, fluids and simple painkillers. However antiviral medication is recommended for those with underlying health conditions and pregnant women. The antivirals, oseltamavir (Tamiflu) and zanamivir (Relenza) will lessen symptoms and may also shorten the duration of the illness. They should be taken as soon as possible, ideally within 48 hours of the infection starting.

From credit crunch to packed lunch

The credit crunch and subsequent recession has impacted on all aspects of our life, particularly our health.

In fact, the current economic position serves as a timely, if unwanted, reminder that being healthy is not just a matter of being free of disease, and that there are many aspects of our lives which impact on our health.

Public health professionals refer to these as the social determinants of health: factors that not only affect our health and quality of life, but also provide the focus for public health efforts to prevent ill health.

The recession impacts on society at a number of levels: the individual, the community and the wider society – and all these will impact on health.

For the individual, financial difficulties, unemployment or the prospect of joblessness are clearly associated with a recession. All these can cause stress. While a little stress is normal, acute or chronic stress can be unhealthy and could develop into a mental health problem, such as depression.

There are also some indications that the recession can impact on efforts to tackle obesity. According to a recent survey, a quarter of people are putting healthier eating on the back burner in the wake of the financial crisis. It reports that one in four UK adults feel that healthier eating is now less important, with more than half saying price is more important when choosing food.

However, there is also evidence that people are changing their food-buying habits in terms of not eating out as much and taking a packed lunch to work or school. This clearly is an opportunity to remind people of the benefits of eating a healthy diet, including fresh fruit and vegetables.

On a wider scale, one impact of the recession is that less resources or priority may be given to preventative initiatives. Governments need to maintain a balanced view on the overall health of their people, ensuring that resources are made available to invest in the health of the population and address both prevention and treatment issues.

Unemployment and health

Research has shown that people in work recover from illness faster, and deaths are doubled in men who have been made redundant compared to those in work.

Social determinants of health

The World Health Organization describes the social determinants of health as those conditions in which people are born, grow, live, work and age, including the health system. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels, which are themselves influenced by policy choices.

The social determinants of health are mostly responsible for health inequalities – the unfair and avoidable differences in health status seen within and between countries. In Northern Ireland, our public health strategy Investing for Health is designed to address these health inequalities.

Better to stop people falling into a river… than fish them out

Imagine a river where people are drowning. Lifesavers are diving in and pulling the victims from the water and trying to revive them, but their efforts are not always successful. A bystander might ask: "Why did these people all end up in trouble downstream? Let's look upstream for the answer."

This analogy is used to describe public health interventions – which can be either 'upstream' or 'downstream'. Upstream interventions focus on prevention, with the goal of eliminating or reducing the risk of becoming unhealthy and keeping healthy people healthy. Downstream interventions are when people come to a doctor for treatment.

Northern Ireland's public health strategy, *Investing for Health*, moves the focus from downstream and all the drowning (ie ill health) to preventing the problem by intervening further upstream. The strategy recognises that it is far more efficient and cost effective to stop people falling ill than having to use resources to treat them.

Put simply, prevention is better than cure.

The upstream and downstream approaches in public health can be applied to smoking. It's about applying health promotion initiatives to inform people about the dangers of smoking and the benefits of stopping.

Such upstream policies targeted at the population as a whole have a broader set of benefits to the health of the public than downstream approaches, such as treating individuals who develop lung cancer and heart disease as a result of **smoking**.

Obesity is another example. Reducing obesity through advice on healthy diets, and encouraging physical activity, means that in later life fewer people will need to be treated for the wide range of conditions caused or exacerbated by obesity, such as heart disease, stroke, diabetes, certain types of cancer, and gallbladder disease.

Stressful times for mental wellbeing

Financial worries, rising unemployment and pessimism about the economic climate will inevitably impact on the mental health of our population.

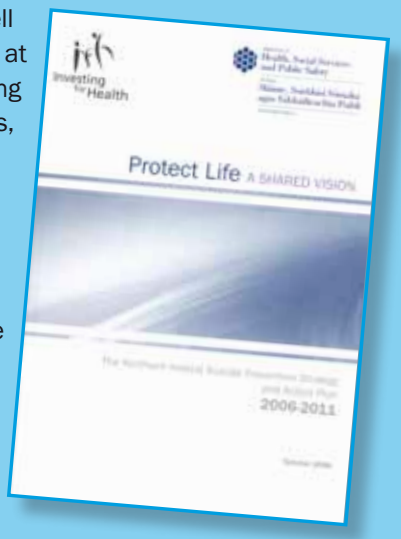
In such stressful times it can be hard to maintain a positive sense of wellbeing and underlying belief in our own and others' dignity and worth. It is therefore vital to promote the mental wellbeing of individuals, families, organisations and communities.

To strengthen the focus on mental health promotion, the 2003 *Promoting Mental Health: Strategy and Action Plan* is being reviewed. This review is linked to progress and investment in the *Protect Life – A Shared Vision: Suicide Prevention Strategy and Action Plan* and the *Bamford Review of Mental Health and Learning Disability.*

The new Mental Health and Wellbeing Strategy, expected to be published later this year, will recognise the importance of efforts to improve the ability of our population to cope with life's stresses and challenges through an increased focus on wellbeing.

Issues emerging include the importance of early years' interventions, as well as targeted support at groups such as young men, single mothers, and people from socially deprived environments.

It is also recognised that employers have a key role and that Health and Social Care, in particular, should be actively promoting the positive mental health and wellbeing of its employees.



Climate change a major threat to public health

Climate change is the biggest environmental concern facing the world today, but global warming also presents a major threat to human health.

With rising temperatures, changing sea levels and extreme weather patterns, climate change is increasingly recognised as a public health priority.

The potential health effects of climate change are immense. The heatwaves of 2003 in Europe caused up to 70,000 deaths, especially from respiratory and cardiovascular conditions. In 2007, parts of the UK were hit by the worst floods for 60 years, resulting in a number of deaths, billions of pounds worth of damage and disruption to water supplies.

Over the past 20 years, incidence rates for skin cancer have more than doubled. Increasing ultraviolet radiation by depletion of the ozone layer is among the factors making skin cancer the most common cancer in the UK.

The threat to global health from climate change arises from factors such as:

Changing patterns of disease
Rising temperatures affect the spread of insect and rodent-transmitted diseases such as malaria and cholera.

Food
Global warming can reduce yields of staple food crops such as maize, wheat and rice, leading to under-nutrition.

'What happens globally affects locally'

Water and sanitation
Reduced rainfall has implications for access to clean water and good sanitation, increasing risk of diarrhoea and other diseases.

Urbanisation
Urban settlements like cities increase vulnerability to climate-related hazards such as floods

Potential public health implications of climate change

Negative

- Heat-related summer deaths from heart disease and breathing difficulties.
- Increased cases of food poisoning.
- Increase in diseases transmitted to humans by insects, eg mosquitos/ malaria.
- Increase in the risks associated with severe weather such as winter gales and flooding.
- Increased exposure to sunlight, leading to a rise in skin cancers.

Positive

- Decline in cold-related winter deaths.
- People using their cars less to reduce greenhouse gases, and walking or cycling more.
- Decline in the effects of air pollutants on health.

and landslides, leading to injury and disease.

Extreme weather-related events

Natural catastrophes such as heatwaves, coldwaves, floods, droughts and cyclones can result in fatalities, water contamination/disease, food shortages/malnutrition, and mental health conditions.

In Northern Ireland, there is a clear need to understand the likely local effects of climate change in order to develop strategies to lessen the consequences and to estimate any increased burden likely to be imposed on our health and social care system.

Public concern about climate change has increased from 13% to 39% in the last five years.

SNIFFER
SCOTLAND & NORTHERN IRELAND FORUM FOR ENVIRONMENTAL RESEARCH

DHSSPS has begun to address the issue, with representation on the Northern Ireland Climate Change Impacts Partnership (NICCIP). The report *Preparing for a Changing Climate in Northern Ireland,* produced by the Scotland and Northern Ireland Forum for Environmental Research (SNIFFER) in February 2007, has helped us to begin to understand the likely health effects of climate change.

Not all the effects will be negative. Overall, the report suggests that with adequate planning, the health and social care system should cope well with the impacts of climate change.

Protecting schoolgirls from cervical cancer

The development of the human papillomavirus (HPV) vaccine that can prevent cervical cancer has been a major breakthrough. It will protect against HPV types 16 and 18, which cause over 70% of all cases of the disease.

The routine HPV immunisation programme was launched in September 2008, with the vaccine offered to all girls in school year 9, and is delivered in the school.

To date, uptake of the vaccine, which is given in three doses over a six-month period, has been excellent. At the end of June 2009, 90% had received the first dose, 86% the second dose and 84% the third.

I would like to congratulate all those involved for their help in ensuring the successful introduction of the HPV immunisation programme.

An accelerated catch-up programme offering this vaccine to all girls born between July 1991 and July 1995 is also in place. It will be completed by June 2010, rather than June 2011 as originally envisaged. To achieve this, the programme will be delivered through schools and through primary care.

Service frameworks – setting out standards of care

We all want to ensure that Health and Social Care (HSC) services are safe, that they improve the health and wellbeing of individuals and communities and, at the same time, make best use of the available resources.

It is important that services, as far as possible, meet the needs and preferences of people, and are accessible to everyone - regardless of where they live or who they are. The experience and outcome for all patients and their carers should be the same.

To make this happen, DHSSPS has started work on developing a common set of standards for key areas of health and social care. Patients, clients, carers and their wider families will be able to use these 'Service Frameworks' to understand the standard of care they can expect to receive.

HSC organisations will also use them in planning and delivering services. The standards in the framework documents will detail the levels of performance to be achieved over a three-year period.

The first group of frameworks focuses on the most significant causes of ill health and disability in Northern Ireland: cardiovascular disease, respiratory disease, cancer, mental health, and learning disability. Their development is well underway and work has recently started on two further service frameworks – children and young people, and older people.

The development of each service framework involves input from all aspects of health and social care and, critically, from patients, clients and carers.

The frameworks will be regularly reviewed and refined to ensure they provide a sound basis for continued improvement in the quality of health and social care services.

CARDIOVASCULAR SERVICE FRAMEWORK

The *Service Framework for Cardiovascular Health and Wellbeing* was the first to be published in June 2009. The framework sets 45 standards for the prevention, diagnosis, treatment, care, rehabilitation and palliative care of individuals and communities at a greater risk of developing cardiovascular disease.

The first group of frameworks focuses on the most significant causes of ill health and disability in Northern Ireland: cardiovascular disease, respiratory disease, cancer, mental health, and learning disability.

Sudden Cardiac **Death** in the young

Most of us cannot imagine what it must be like to lose a young person – particularly if the death is sudden and unexpected. Sadly, a number of such deaths have occurred in young sportsmen in Northern Ireland in recent years.

This is undoubtedly a tragic loss for any family and community and, understandably, there have been calls for more to be done to prevent future occurrences of Sudden Cardiac Death (SCD), including screening for it.

SCD is an umbrella term used for the many different causes of unexpected sudden cardiac arrest in the young. More than 20 conditions have been identified as causes, including abnormalities of the heart muscle (cardiomyopathies), coronary artery disease, congenital heart defects, and abnormalities of the main blood vessel (aortic dissection).

Research suggests there are 10-15 sudden deaths in young people each year in Northern Ireland. In up to 30% of cases, no structural abnormality can be detected at post-mortem – this is known as SADS (Sudden Adult Death Syndrome/Sudden Arrhythmic Death Syndrome) and in these cases a cardiac arrhythmia (an irregularity of the heart rhythm) is thought to be the likely cause.

Hypertrophic cardiomyopathy (HCM), an abnormal thickening of the heart muscle, is the most common cause of SCD. It is estimated to affect 1 in 500 people in the UK, though many will be unaware that they have it unless they develop symptoms.

It is essential that family members of victims of SCD are referred for specialist assessment as many of the common causes are known to be inherited forms of cardiac disease.

Unfortunately, there is no one test which can identify all those at risk of SCD. Even in those who are found to have a cardiac problem, it is not always possible to know who is at high risk of sudden death. There is also a lack of evidence as to whether stopping people taking part in sport and exercise reduces the risk of sudden death.

In fact, the majority of people with these underlying conditions do not have any symptoms for all or most of their lives, and many will live a normal lifespan. It is only in a small number of cases that the condition leads to unexpected death, often in early adulthood. At present, it is difficult to predict who will die suddenly and who will have a normal lifespan.

The public are encouraged to undertake early life support training which includes recognising the signs and symptoms of a cardiac arrest (heart attack) and performing Cardio Pulmonary Resuscitation (CPR).

For every minute without CPR following sudden cardiac arrest, the chance of survival reduces by 7-10% per minute. CPR given by a bystander increases the chance of survival 2-3 times compared to no bystander CPR.

There are also concerns about the negative aspects of screening, including employment opportunities and medical fitness to carry out certain activities (eg driving and operating certain machinery), securing insurance or a mortgage in the future, and forced changes in lifestyle.

There is also the psychological impact for individuals who are told that they could be at risk of sudden death. Should young people decide that they want to be screened, it is important that they are fully informed about the advantages and limitations of screening.

The UK National Screening Committee, which advises the four UK health departments, has reviewed the research evidence on screening for HCM and has advised that: “Pre-participation screening of athletes for HCM or other causes of sudden cardiac death should not be instituted at present.”

It is essential that family members of victims of SCD are referred for specialist assessment as many of the common causes are known to be inherited forms of cardiac disease. This requirement is one of the standards set within the *Service Framework for Cardiovascular Health and Wellbeing.*

Young smokers a burning issue

Tobacco is the leading cause of preventable death in Northern Ireland and remains a principle cause of health inequalities.

Every effort must be made to discourage young people from smoking. From 1 September 2008, it became illegal in Northern Ireland to sell tobacco products to anyone under the age of 18. The change in the law came about after public consultation elicited 90% support for raising the age of sale from 16.

The amendment to the legislation brings Northern Ireland in line with the rest of the UK and the Republic of Ireland, and forms part of the drive by DHSSPS to reduce the level of smoking among children and young people.

While it is accepted that raising the age of sale will not, of itself, solve the problem of children smoking, it will complement improved enforcement activity and the ongoing prevention work undertaken by many agencies.

Almost 1 in 10 children aged between 11 and 16 are regular smokers.

Surveys regularly show that the majority of adult smokers adopt the habit in their teens and obtain their cigarettes from a variety of sources. Almost 1 in 10 children in Northern Ireland aged between 11 and 16 are regular smokers. This is an unacceptable situation and it is essential that we do more to prevent young people from taking up this life-threatening habit.

In line with the rest of the UK and the Republic of Ireland, the Health Minister intends to put new legislation in place:

- preventing access to tobacco vending machines by children and young people under 18 years of age;
- banning the display of tobacco products at retail outlets.

It is expected that draft regulations will be issued for consultation this autumn.

Smoke-free legislation – one year on

A report published on No Smoking Day 2009 highlighted the benefits to the public since Northern Ireland went smoke-free on 30 April 2007. *Smoke-Free Legislation in Northern Ireland: A One Year Review* reported that the air in pubs is cleaner, more people are trying to quit smoking, and compliance with the smoke-free legislation remains high.

District councils have carried out excellent work in enforcing the new laws, and the commitment shown by businesses and the general public has resulted in compliance levels of 97%. People are also quitting in larger numbers since the introduction of the legislation, with 21,476 quit dates set through the smoking cessation services in 2007/08 – an increase of 56% on the figure for the same period the previous year.

21,476 quit dates set through the smoking cessation services

Research carried out for the report found that the legislation has impacted positively on children's exposure to second-hand smoke. This includes decreased self-reported exposure to second-hand smoke in public places and greater restrictions on smoking within the home.

However, further work is required if we are to achieve the ultimate aim of a tobacco-free society. An unacceptably high number of children are still exposed to smoke at home or in the car by one or more of their parents. High smoking prevalence among manual workers is also an area of concern.

Improving the care of patients with lung cancer

Lung cancer is the most common cause of cancer death here – with almost 500 men and 300 women dying annually from the disease. It is of concern that, for women, the number of new cases and deaths continues to increase year on year.

Cigarette smoking contributes to more than 90% of cases. Those who smoke are 20 times at greater risk of contracting lung cancer than those who have never smoked, and levels of smoking are much higher in people living in deprived areas.

Lung cancer tends to be a disease of older people – with over half of the cases aged 70 and over. However, it also affects a number of younger people – with 1 in 11 aged under 55 when diagnosed.

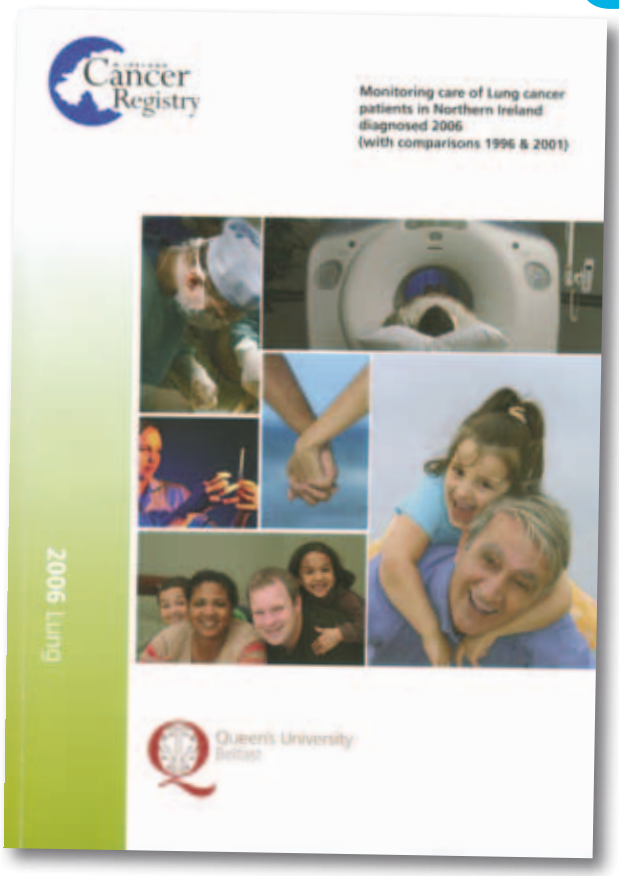
A Northern Ireland audit of the care of lung cancer patients diagnosed in 2006 was published this year. This report also made comparisons with the care of lung cancer patients from 1996 and 2001.

The audit found that over the 10 years there was an increase in the number of people still alive at 21 months after diagnosis – 17% in 2006 compared to 11% in 1996. However, for those who presented at an early enough stage where surgery could be undertaken, the survival at 21 months was much better – 74% in 2006 compared to 44% in 1996.

Effective management of lung cancer patients requires input from a range of experts. National Institute for Clinical Excellence (NICE) guidelines state that all patients with a likely diagnosis of lung cancer should be discussed at a lung cancer multi-disciplinary team (MDT) meeting.

Between 1996 and 2006, there was a significant increase in the number of patients recorded as having their case discussed at an MDT meeting – about 1 in 5 in 1996 compared to two thirds of cases in 2006. Although this is encouraging, there is still room for further improvement.

The full report can be accessed at http://www.qub.ac.uk/research-centres/nicr/publications



Lung cancer symptoms

Symptoms associated with lung cancer include cough, weight loss, shortness of breath, pain, lack of energy, hoarseness, chest infections, coughing up blood and difficulty in swallowing. It is important that people contact their GP early if they develop any of these symptoms.

The audit found that almost a quarter of those diagnosed with lung cancer in 2006 had a symptom which lasted more than six months, and one in six had a symptom for over a year.

The report also found that in 2006, for every one person diagnosed with lung cancer in the most affluent areas there were 2.7 diagnosed in the most deprived areas.

If these lung cancer rates for those from the most deprived areas were reduced to those for the least deprived areas, there would be 360 fewer people diagnosed with lung cancer each year.

ALCOHOL – OUR FAVOURITE DRUG

Last year I highlighted the problem of alcohol misuse and my concerns about young people's drinking. Alcohol misuse is one of the biggest public health issues facing Northern Ireland. Our attitudes to alcohol are deeply embedded in our culture. It has become our drug of choice.

Alcohol misuse can cause real and lasting damage to a person's health and well-being. Excessive intake of alcohol can also lead to anti-social behaviour, criminal activity, accidents, unsafe sexual behaviour and can also impact on relationships, work, school and mental health.

The extent of alcohol misuse among children and young people is a major concern. Four out of five 16-year-olds have had an alcohol drink. Indeed by the age of 13 almost half of all children and young people have had an alcohol drink. And by the age of 16, three out of four of those who have had an alcoholic drink have been drunk at least once.

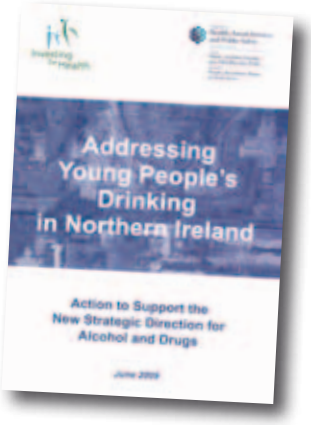
Excess alcohol consumption across all age groups costs Northern Ireland approximately £800million per year. Within the health sector, figures from 2006/07 reveal that 8,313 people were admitted to acute hospitals with alcohol-related problems – and out of this figure, around 200 were under 18. As of 1 March 2007, 3,476 people were in treatment for alcohol misuse – 11% of whom were under the age of 18.

The Young People's Drinking Action Plan, which was published in June 2009 outlines how DHSSPS is working with partners across all sectors, including the alcohol industry, to address alcohol misuse and to make it more difficult for young people to get access to alcohol in the first place.

We all have a responsibility to ensure that young people know the facts about alcohol, about the real harm it does, about how getting drunk can lead to all sorts of unwanted consequences – and not just the hangover. We all need to ensure that young people find it difficult to get hold of alcohol. Above all, we as adults and as parents need to ensure that we help young people learn about alcohol. We also need to be aware that they are already learning from us in how we talk about alcohol and how we ourselves use alcohol.

Alcohol is 62% more affordable than it was 30 years ago

Addressing Young People's Drinking in Northern Ireland



The Young People's Drinking Action Plan is a cross Departmental plan that seeks to prevent and reduce the harm suffered by children and young people in Northern Ireland from alcohol misuse.

The Action Plan, which was launched by the Minister in June 2009, highlights that children and young people are more vulnerable than adults to suffering physical, emotional and social harm from their own and from other people's drinking.

Although the emphasis of this action plan is on young people, it recognises that their drinking patterns are influenced by modelling the drinking patterns of all adults in our society – and so contain actions that will impact on the entire population. This Action Plan should be the catalyst through which action is taken to address these issues across all sectors and organisations.

The Action Plan identifies three different themes through which work to address consumption of alcohol among children and young people will be undertaken:

- Reducing young people's demand for alcohol by providing information, education and training to young people and their parents.
- Restricting the supply of alcohol via measures to reduce accessibility to alcohol (including how alcohol is priced, marketed, and promoted).
- Providing treatment and support for those who require additional help.

This Action Plan should be the catalyst through which action is taken to address these issues across all sectors and organisations.

Information leaflets are available at: www.publichealth.hscni.net/publications

GIVE THE GIFT OF LIFE TO SOMEONE

The first kidney transplant in Northern Ireland was performed at the Belfast City Hospital in 1968. Some of the longest surviving kidney transplant recipients in the world were Belfast City Hospital patients. Since then, 1,300 kidney transplants have taken place in Northern Ireland, averaging between 40 and 60 kidney transplant operations per year in recent years.

Many people are alive today because they have received the gift of a donated organ. Transplants of the kidney, heart, liver and lungs are regularly carried out. As medicine advances, other vital organs, including the pancreas and small bowel, are also being used in transplants. Tissue such as corneas, heart valves, skin and bone can also be donated. The majority of organs used in transplants are obtained from patients who have died suddenly, with a small number being transplanted from living donors.

The increasing effectiveness of transplantation means that many more patients can be considered for treatment in this way, though there is a serious shortage of donors. For some people this means waiting, sometimes for years, and undergoing difficult and stressful treatment. For all too many it means they will die before a suitable organ becomes available.

There are currently more than 10,000 people in the UK who need an organ transplant. Most are waiting for a kidney, others for a heart, lung or liver transplant. But the reality is that last year just over 3,500 transplants were carried out. There are 455,274 people with a Northern Ireland postcode on the UK Organ Donor Register. The rate of sign-up to the Register across the UK ranges from 22% - 32% and for Northern Ireland the rate is 25%.

Urgent need for more donors

There is an urgent need for more donors. About 1,000 people who are in need of a transplant - on average three a day - die every year before an organ becomes available.

The more people who pledge to donate their organs after their death by joining the NHS Organ Donor Register the more people will benefit. By choosing to join the NHS Organ Donor Register you could help make sure life goes on.

It is very important that everyone talks to their family about organ donation and makes them aware of their wishes. The main reason for families refusing to donate organs is that they do not know if it is what the patient would have wanted.

You can register by calling the NHS Organ Donor Line:
0300 123 23 23

or visit:
www.uktransplant.org.uk

The rate of sign-up to the Register across the UK ranges from 22% – 32% and for Northern Ireland the rate is 25%.

The Wall of Life

An exciting new online marketing campaign has been launched to encourage more people to join the NHS Organ Donor Register. The Wall of Life invites supporters to upload their photo to a mosaic pixel 'wall' to create the image of a young heart transplant recipient, Louisa McGregor-Smith. Supporters can also build a personal profile, add a comment to explain their motivation for signing up and help to spread the word about the campaign amongst their own online contacts.

Join the Wall of Life

NHS Blood and Transplant

To find out how to save a life, call: the Donor Line on

0300 123 23 23

Childhood obesity a growing concern

Levels of obesity in children and adults in Northern Ireland continue to be a major health concern. Recent surveys indicate that around one in four girls and one in six boys in Primary One are overweight or obese, and that almost 60% of all adults measured are either overweight (35%) or obese (24%). They also found that around 30% of young men and women aged 16-24 are either overweight or obese.

Obese children are more likely to become obese adults, and children of obese adults are significantly more likely to become obese – creating the potential for an upward spiral in levels of obesity.

What is being done about it? DHSSPS is aiming to reduce obesity in children through *Fit Futures* – a plan for joining up health, education and sport. Progress to date includes healthier school food for children, clearer food labelling, tougher restrictions on advertising food high in fat and sugar, and improved physical activity levels at school.

A framework for preventing obesity in the rest of the population is also being developed and will incorporate actions on food and nutrition, and physical activity.

Obesity is also addressed in the *Service Framework for Cardiovascular Health and Wellbeing*. This includes a standard for health and social care to work in schools, workplaces and communities to tackle obesity and help people lose weight.

The impact of obesity on health

- **Causes around 450 deaths each year in Northern Ireland.**
- **Reduces life expectancy by up to nine years.**
- **Increases the risk of coronary heart disease and cancer.**
- **Increases the risk of developing Type 2 diabetes – an obese woman is 10 times more likely to become diabetic.**
- **Affects emotional and psychological wellbeing and self-esteem, especially among young people.**

Partnerships a key element in health reform

DHSSPS is committed to a service that is centred on the needs of patients, clients, carers and the wider population.

Improving health and social wellbeing, and reducing health inequalities, can only be achieved through effective partnerships – working with people and not just for people, working across all sectors and within sectors.

The Review of Public Administration (RPA), and in particular Health and Local Government reform, provides a unique opportunity to put in place structures, develop new relationships and engage more positively with local people on their health and wellbeing. Of course, partnerships are not new and there are many in place – from local level in neighbourhoods and communities, to area and regional levels.

But new approaches are called for in tackling the underlying causes of poor health and wellbeing, and reducing inequality often associated with socio-economic status and disadvantaged areas.

The health and social care element of the RPA process included the establishment, in April 2009, of the Public Health Agency, the Health and Social Care Board and its Local Commissioning Groups.

The Public Health Agency has a particular responsibility for promoting improved partnership working with local government and other sectors to bring about real improvements in the population's health and wellbeing. The service needs to work with a wide range of partners from across the community, statutory, voluntary and private sectors contributing to health and wellbeing, eg housing, education, planning and policing.

DHSSPS is committed to a service that is centred on the needs of patients, clients, carers and the wider population.

Work is ongoing to develop and pilot new models of working based around the new 11 council boundaries. A pilot phase will test whether new ways of working can demonstrate positive impact, added value and the delivery of agreed outcomes. Councils are already well represented and acting on existing Investing for Health partnerships.

Health partnerships in local communities

Much progress has been made over the years in tackling major diseases and causes of illnesses, but many major public health challenges remain.

One of the most testing of these is reducing the gap in health status between rich and poor. Sadly, it is a fact that those living in deprived areas and circumstances are more likely to live in poor housing, be unemployed, have lower educational attainment, and be more likely to suffer ill health and an earlier death.

Coordinated partnership working at all levels of society is key to tackling this issue. As a result of the Investing for Health strategy, four cross-sectoral partnerships, reflecting the legacy Health and Social Services Board geographical areas, have been working since 2002 together with local communities to identify and address local health and wellbeing priorities.

Northern Investing for Health Partnership

Southern Investing for Health

Wellnet

Western Investing for Health

An example of one such initiative is the cross-sectoral group established by the Northern Investing for Health Partnership to implement locally the regional Fuel Poverty Strategy. Actions to date include:

- **the employment of a network of energy efficiency and fuel poverty benefit advisers;**
- **the establishment of eight local oil stamp schemes;**
- **training and awareness-raising events that have resulted in 1,658 households referred to energy efficiency support schemes;**
- **£693,497 in increased income from benefits accessed by families;**
- **more than 427 people trained in energy efficiency and more than 257 energy efficiency talks delivered to local communities.**

Healthcare networks put focus on patients

Managed Clinical Networks (MCNs) are groups of health professionals, patients and organisations working together in a coordinated way, ensuring good communication and actively promoting and sharing good practices.

Their key aim is to improve the health and wellbeing of patients by:

- ensuring the coordinated strategic development of services;
- ensuring equity of access and a uniform quality of services for the population covered by the network;
- involving patients in service planning;
- promoting the delivery of continuous improvement of high quality, safe and effective services.

MCNs ensure a focus on service planning and provision that is clinically-led and patient-focused. They enable the development of standards and guidelines that deliver equitable, evidence-based, high-quality, safe care.

They help to ensure the coordination and integration of regional services across organisational and professional boundaries, to give a smooth pathway for a patient's whole care.

Well-established regional MCNs include those for cancer services, cardiac services and critical care.

MCNs also have an important role to play in ensuring that the standards of the service frameworks are achieved.

Northern Ireland Cancer Network

The Northern Ireland Cancer Network (NICaN) was the first regional managed clinical network. Its aim is to work towards the continuous improvement in cancer care and cancer survival for the people of Northern Ireland.

NICaN does this by supporting groups of health professionals, patients and charities to work together in a coordinated way, ensuring good communication and sharing good practice.

Further information is available at www.cancerni.net

Driving patient safety and quality

The Health and Social Care (HSC) Safety Forum was launched in June 2007 to support HSC organisations such as Trusts as they strive to deliver safe, high quality health and social care.

It contributes towards the health service's principles of patient-centred care, value for money, and improved access by listening to both health professionals and patients.

The HSC Safety Forum urges you and your family to become part of Northern Ireland's patient/client safety community. Patient/client safety is about doing the right thing for you all the time. That means reducing harm or errors which may result from an episode of care.

For any patient/client safety programme to be truly effective, providers need you to be fully informed and actively involved in your care. Your active involvement will help your health and social care providers consistently do the right thing, at the right time, for the right person – **you**.

You can find out more about the Safety Forum at: www.hscsafetyforum.com

Fighting healthcare-associated infections

Last year I reported on the outbreak of Clostridium difficile in Northern Health and Social Care Trust hospitals, and set out the main control measures that help to reduce C.difficile infections.

Infection prevention and control is an integral part of healthcare, and infection prevention and control is everyone's business

These include prudent use of antibiotics, hand hygiene, environmental cleaning, isolation/cohort nursing, and use of personal protective equipment by staff.

The outbreak was declared over at the end of August 2008, and an independent review by the Regulation and Quality Improvement Authority (RQIA) produced 53 recommendations for action across Northern Ireland.

The Trusts, DHSSPS and the new Health and Social Care (HSC) bodies are now implementing

Public Inquiry into C.difficile Outbreak

Following the RQIA review, the Health Minister commissioned a public inquiry to establish how many people died in the outbreak, and to ask patients and others how they were affected. The inquiry is chaired by Dame Deirdre Hine, former Chief Medical Officer for Wales, and the inquiry panel is to report back to the Minister by the end of March 2010.

It is important that every lesson that needs to be learned from the outbreak is picked up by the inquiry, and acted on. If you were affected by this outbreak, please contact the inquiry at (028) 9051 7125 or inquiry@cdiffinquiry.org

Measures to reduce infections

In January 2008, a series of measures aimed at reducing healthcare-associated infections as far as possible were announced. These included:

- **single rooms for new hospitals;**
- **a rolling programme of unannounced hygiene inspections of hospitals;**
- **restrictions on hospital visiting;**
- **a dress code for all healthcare staff;**
- **a regional hand hygiene campaign;**
- **MRSA screening for high risk patients;**
- **rapid response cleaning teams;**
- **regular publication of Trusts' infection control performance;**
- **funding for a pharmacist in each Trust area to promote safer prescribing of antibiotics.**

these recommendations, with each Trust developing an infection control action plan.

The general trend in healthcare-associated infections is encouraging – the number of C.difficile cases in inpatients aged 65 and over fell by 12% in 2008/09 compared to 2007/08 figures. MRSA cases fell by 8% in the same age group.

It is not possible to completely eliminate healthcare-associated infections (30% of older people normally carry C.difficile in their intestines without coming to any harm). However, there is always scope to make healthcare safer and reduce the rates of infection to a minimum. The Department, the Trusts and the HSC bodies are working together on the next phase of the *Changing the Culture* strategy, an action plan for the prevention and control of healthcare-associated infections in Northern Ireland.

This will build on the significant progress that has been made in recent years as well as taking into account the recommendations from the RQIA review of the C.difficile outbreak.

There are challenging new targets for reductions in C.difficile, MRSA and MSSA. The aim is to reduce them by 35% from the 2007/08 level. They are challenging but they can be achieved, and I have no doubt about the commitment of staff and management across the health service in Northern Ireland to make healthcare as safe as possible.

KEY STATISTICS

1. In **2007** there were estimated to be **1,759,100** people living in Northern Ireland.
2. Life expectancy for men is **76.2** years and **81.2** for women.
3. **24,553** babies were born in **2007**.
4. **14,649** people died in **2007**; **7,208** males and **7,441** females. **9,093** were age **75** or over when they died; **3,814** men and **5,279** women.
5. In **2007** there were **3,870** deaths from cancer and **2,982** from heart disease.
6. One in **4** of males and **1** in **5** females drink more than the weekly recommended levels.
7. The average age at which pupils were first offered drugs (not including solvents) was **12.9** years.
8. In **2007/08**, **23%** of people were smokers (**23%** males and **23%** females); this compares with **29%** of people smoking in **1996/97** (**31%** males and **27%** females).
9. Over **1** in **5** children (**22%**) aged **4–5** are either overweight or obese.
10. The average household produces **1.29** tonnes of waste per year. In **2007**, **32%** of waste was recycled or composted.
11. The number of melanoma skin cancers has increased from **80** cases in **1984** to **233** cases in **2007**.
12. There were **160,000** emergency admissions to hospital during the year.
13. In **2007** there were over **700,000** attendances at Accident and Emergency Departments.
14. The Ambulance Service provides almost **350,000** patient journeys, over a quarter were classed as emergency.
15. Over **2.6** million prescription items are dispensed every month.
16. On average, **124** people are killed as a result of collisions on our roads each year.

www.dhsspsni.gov.uk/phealth