Department of Health, Social Services and Public Safety

Client
Department for Health, Social Services and Public Safety

Project
Investing for Health Strategy Review

Statistical Analysis Annex

Division
Management Consultancy

July 2010

RSM International
global excellence in audit, tax & consulting

Presented To

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

An Roinn
Sláinte, Seirbhísí Sóisialta agus Sábháilteachta Poiblí

Männystrie o
Poustie, Resydènter Heisin an Fowk Siccar

Prepared On Behalf Of

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1 STATISTICAL REVIEW

1.1 Background

This section considers the impact the IfH strategy has made since its introduction in 2002. The strategy has two overarching goals and seven objectives in total (see table 1.1). The objectives are expressed in qualitative terms and, where possible, quantitative targets set for each with appropriate timescales. The targets were set based on historical trends and actions and targets contained in other strategies. Each target has been given a baseline figure.

Following publication of the IfH strategy, a monitoring framework was developed by DHSSPS. This contains a number of additional outcomes and indicators. The primary aim of setting indicators is to[1]:

- Facilitate more evidence-based, rational decision making and priority setting in relation to health planning
- Create visibility of health problems
- Provide a baseline of information to make comparisons over time
- Assist in monitoring and evaluation of activities/programmes to assess their success

We have reviewed the data relating to these indicators and assessed the extent to which progress has been made over the period the data is available for. Where available, the equivalent data for Scotland and/or England has been provided for comparison.

1.2 Summary of outcomes against targets

Table 1.1 summarises the targets set for each goal and objective. Using the baseline figures, we have assessed outcome in terms of whether each target has been met, or is on track to being met within the set timeframe. Analysis of the data relating to the indicators can be found in the appendices.

[1] EHSSBS (2005): Investing for Health Indicators

Table 1.1

Summary of outcomes against targets

	Goal/Objective	Target(s)	Outcome
Goal 1	To improve the health of our people by increasing the length of their lives and increasing the number of years they spend free form disease, illness and disability	To improve the levels of life expectancy here towards the levels of the best EU countries, by increasing life expectancy by at least 3 years for men and 2 years for women between 2000 and 2010.	The baseline life expectancy for males born in 1998-00 was 74.5 years and for women it was 79.6 years. The target is to increase life expectancy for men 77.5 years and for women to 82.6 years. The latest available data (taken from NI Health & Social Care Inequalities Monitoring System) showed that in 2005-07, life expectancy for men was 76.2 years and for women was 81.3 years. The trend from 1998-00 to 2005-07 was extrapolated to 2009-11 and showed that if life expectancy continued to grow at the same rate it would reach 77.6 years for men and 82.4 years for women by 2010 (see Appendix 2). ***Target (i) set for Goal 1 is on track to being met by 2010*** ***(the target life expectancy for men will be exceeded by 0.1 years, however, the target for women will be short by 0.6 years)***
Goal 2	To reduce inequalities in health between geographic areas, socio-economic and minority groups	To halve the gap in life expectancy between those living in the fifth most deprived electoral wards and the average life expectancy for both men and women between 2000 and 2010.	The gap in life expectancy between the most deprived areas and the NI average at 1998-00 was 3.1 years for men and 2.5 years for women. The target is to halve this gap to 1.55 years for men and 1.25 years for women. The latest available data from DHSSPS showed that in 2005-07, the gap between the life expectancy in deprived areas and the NI average for men

			was 4.5 years and for women was 2.5 years. The trend between 1999-01 and 2005-07 was extrapolated to 2009-11 to forecast what the gap would be if it continues to decrease at the same rate. The gap in life expectancy between deprived areas and the NI average is forecast to be 3.6 years for men and 2.2 years for women (see Appendix 3). ***Target (i) set for Goal 2 is not on track to being met by 2010***
		To reduce the gap in the proportion of people with a longstanding illness between those in the lowest and highest socio-economic groups by a fifth between 2000 and 2010.	The gap between the proportion of people with a longstanding illness in socioeconomic groups 1&2 and 6&7 in 1998-09 to 2001-02 was 15%. The target is to reduce this gap to 12% by 2010 (see Appendix 3).
Objective 1	To reduce poverty in families with children	When the Investing the Health Strategy was developed in 2002, baseline data on the proportion of children living in households with low incomes was not available. Therefore, no high level targets were formulated at the time. A target was later set based on the Programme For Government PSA 7: "Drive a programme across Government to reduce poverty and address inequality	The Family Resources Survey, which was first undertaken in NI in 2002-03, established the number of children living in poverty, defined as households receiving income of less than 60% of the GB median. It is measured before and after housing costs. DSD data showed that in 2003, the proportion of children living in low income households (after housing costs) was 26%. In 2006, this proportion remained unchanged at 26%. A paper published by the Joseph Rowntree Foundation in September 2009 found that the proportion of children in low-income households (after housing

		and disadvantage". The target is to: Work towards the elimination of child poverty in Northern Ireland by 2020 and reducing child poverty by 50% by 2010.	costs) in 2007-08 remained at 26%. ***The Target set for Objective 1 is not on track to being met by 2010***
Objective 2	To enable all people and young people in particular to develop the skills and attitudes that will give them the capacity to reach their full potential and make healthy choices	In the 25% of primary schools with the highest percentage of free school meal entitlement (FSME) to reduce the proportion of pupils not achieving the expected level (level 4) at Key Stage 2 to 25% in both English and maths by 2005-06	In the 25% of primary schools with the highest percentage of FSME in 2000-01, 40% of children were not achieving the expected level in Key Stage 2 English and 36% in Maths. The target was to reduce this to 25% for both English and maths by 2005-06. The data for 2005-06 from DE shows that 30.5% of children did not achieve the required level in English and 32.9% did not in Maths (see Appendix 4). ***Target (i) set for Objective 2 was not achieved within the target timeframe***
		In the 25% of secondary schools with the highest percentage FSME, to reduce the proportion of year 12 pupils achieving no GCSEs to 5% by 2005-06.	In 2000-01, 8.5% of pupils in the 25% of secondary schools with the highest percentage FSME achieved no GCSEs. The target was to reduce this to 5% by 2005-06. The data for 2005-06 from DE shows that 4.8% of pupils in the most disadvantaged schools achieved no GCSEs (see Appendix 4). ***Target (ii) set for Objective 2 was achieved by 2005-06***

Objective 3	To promote mental health and emotional wellbeing at individual and community level	To reduce the proportion of people with a potential psychiatric disorder (as measured by the GHQ-12 score) by a tenth by 2010.	In 2001, the proportion of people with a potential psychiatric disorder is 21%. The target is to reduce this 19% by 2010. Data from the 2005-06 Health and Social Well Being Survey shows that the proportion of adults with a potential psychiatric disorder was 19% (see Appendix 5). ***Target (i) set for Objective 3 is on track to being achieved by 2010***
Objective 4	To offer everyone the opportunity to live and work in a healthy environment and to live in a decent affordable home	To lift at least 20,000 households out of fuel poverty by December 2004	The baseline figure for households in fuel poverty in 1995-98 was 170,000. The target was to reduce this figure to at least 150,000 by 2004. Data from the 2004 Northern Ireland House Condition Survey shows that the number of households in fuel poverty in 2004 was 153,530 (see Appendix 6). ***Target (i) set for Objective 4 was not achieved was not achieved within the target timeframe***
		Over the 2 year period April 2002 to March 2004, to support housing providers to build around 2,400 lower cost, affordable homes for people on lower incomes	The target was to achieve 2,400 new dwelling starts by housing associations by 2004. The aggregated data for 2003 and 2004 shows 1,806 new dwelling starts over the two-year period of the timeframe specified, which is 594 short of the target (see Appendix 6).

			Target (ii) set for Objective 4 was not achieved was not achieved within the target timeframe
Objective 5	To improve our neighbourhoods and wider environment	To reduce levels of respiratory and heart disease by meeting the health-based objectives for the 7 main air pollutants by 2005	The 7 main air pollutants had target concentrations set by the National Air Quality Strategy 2000. DOE measurements of the 7 pollutants taken at December 2004 show that 5 of the main air pollutants met their target levels and 2 did not (see Appendix 7). ***Target (i) set for Objective 5 was not fully achieved***
Objective 6	To reduce accidental injuries and deaths in the home, workplace and from collisions on the road	To reduce the death rate from accidents in people of all ages by at least one fifth between 2000 and 2010	In 2000, the age standardised death rate from accidents was 20.6 per 100,000 population. The target is to reduce this to less than 16.5 per 100,000 population by 2010 (see Appendix 8).
		To reduce the rate of serious injuries from accidents in people of all ages by at least one tenth between 2000 and 2010.	In 2000-01, the age standardised rate of serious injuries from accidents was 406.6 per 100,000 population. The target is to reduce this to less than 366 per 100,000 population by 2010 (see Appendix 8).
Objective 7	To enable people to make healthier choices	To stop the increase in the levels of obesity in men and women so that by 2010, the proportion of men who are	In 1997, 17% of men and 20% of women were classified as obese. The target was to lower both these figures by 2010.

		obese is less than 17% and of women, less than 20%	Data from the 2005-06 Health and Social Well Being Survey show that 25% of men and 23% were classified as obese (see Appendix 9). This indicates that overall levels of obesity are increasing rather than falling, for both men and women. ***Target (i) set for Objective 7 is not on track to being met by 2010***
		By 2010 to increase the levels of 5 year old children with no dental decay experience to 55% and to reduce the gap between the best and worst decayed/missing/filled (dmf) scores by 20%.	This target consists of two components: The baseline figure in 1993 for 5 year olds with no dental decay was 37%. The target is to increase this to 55% by 2010. The gap between the best and worst dmf scores was 2.9 in 1996-07. The target is to reduce this gap to 2.32 by 2010 (see Appendix 8).

1.3 Conclusions

A total of 13 high level targets were set for the strategy's goals and objectives. These targets were believed to be challenging yet attainable. Each target was assigned a timescale which varied depending on the nature of the target – longer for outcome targets and shorter for impact targets. We have used the available data to evaluate the progress in reaching these targets within their given timeframe. Some of the targets were met within timescale and some are forecasted to be met within timescale. Other targets have not been met by varying margins and this is often the result of extraneous factors that were unforeseeable at the time of developing the strategy. A summary of progress against the targets is given below.

Five of the 13 targets were impact targets with shorter timescales. These targets were set to be achieved within two or three years of the strategy being published, i.e. 2004-05. One of these targets was successfully achieved – to reduce the percentage of pupils who achieve no GCSEs in the 25% of secondary schools with the highest percentage FSME from 8.5% to 5% by 2005-06. Although the target set for the percentage of children achieving the expected level in Key Stage 2 English and Maths was not met by 2005-06, improvements were made compared to the baseline figures. The proportion not achieving the expected level in Key Stage 2 English was reduced from 40% to 30.5% and from 36% to 33% for Maths.

Two targets were set under objective 4 to be achieved by 2004. Neither of these targets were met, but it should be highlighted that the margins by which they failed were very small. The number of households in fuel poverty in 2004 was 153,530; the target was to reduce the number of homes in fuel poverty to below 150,000 was therefore not met, but only by a small number. While the target was not met, the number of households in fuel poverty was successfully reduced by 9.7% from the baseline figure. Also to be taken into consideration is the global rise in fuel prices that occurred in the first half of the decade which impacted greatly on the incidence of fuel poverty. The number new dwelling starts by housing associations fell short of the target by a small amount (239 new dwelling starts).

The objective 5 target to reduce the concentrations of the seven main air pollutants by 2005 was not achieved. Again the margin by which it failed was small and considerable improvements had been made over the time period. Only two of seven air pollutants failed to meet their targets and of these, the Nitrogen Dioxide target was exceeded at only one of its fifteen measurement sites.

The outcome targets with longer timescales look likely to have varied levels of success. The target for objective 3, to reduce the proportion of people with a potential psychiatric disorder to 19% by 2010 was on track to be achieved, based on data for 2006. The target set for Goal 1, to increase life expectancy for men 77.5 years and for women to 82.6 years, is on track to being met by 2010 if the trends in improvements since 1998-00 continue at the rate observed over the period analysed.

Some of the longer term targets have seen their position worsen compared to the baseline measurement due to unforeseen trends in public health. For example, the percentage of obese men has risen from 17% in 1997 to 25 % in 2005-06 and women from 20% to 23%. The level of obesity is unlikely to be reduced below the baseline figures by 2010.

The targets set to address inequality are not on track to being fully achieved. The gap in life expectancy between the most deprived areas and the NI average at 1998-00 was 3.1 years for men and 2.5 years for women. The rate of change was extrapolated and is predicted to be to 3.6 years for men and 2.2 years for women in 2009-11. This suggests that gaps in life expectancy are forecast to narrow for women but widen for men.

In 2003, the proportion of children living in low income households (after housing costs) was 26%. In 2009, this proportion remained unchanged at 26%.

APPENDICES

2 APPENDIX 1: GOAL 1 - LONGER HEALTHIER LIVES

Goal 1 is *"To improve the health of our people by increasing the length of their lives and increasing the number of years they spend free from disease, illness and disability".*

2.1 Target i:

Target i is to improve the levels of life expectancy here towards the levels of the best EU countries, by increasing life expectancy by at least 3 years for men and 2 years for women between 2000 and 2010.

The life expectancy for males born in 1998-00 was 74.5 years and for women it was 79.6 years. The target to be achieved is shown in the table below.

Table 2.1

Goal 1, Target 1

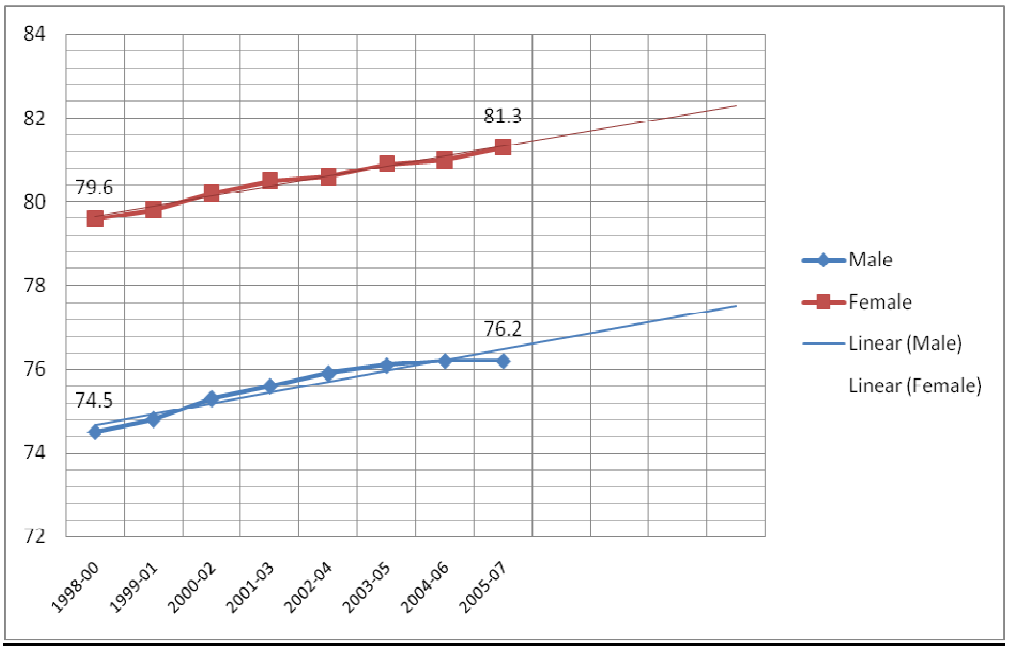
	Males (years)	Females (years)
Baseline: NI average 1998-00	74.5	79.6
Target 2009-11	77.5	82.6
Source: DHSSPS (2002): Investing for Health Strategy Baseline (taken from the Register Generals Report 2000): Life expectancy is calculated based on 3 years of deaths data, in the case of the baseline, 1998, 1999 and 2000.		

2.2 Average levels of life expectancy

The expected years of life at birth is based on mortality patterns in the period in question (i.e. average number of years of life remaining that newborns might expect to live if current age-specific mortality conditions persist for the rest of their lives). It is based on the average deaths over a three year period and uses the middle year population as the reference population. The data is based upon the number of deaths provided by the General Register Office and mid-year estimates provided by NISRA. The overall Northern Ireland figures are calculated by the Government Actuary's Department. DHSSPS calculates the sub Northern Ireland level figures.

Figure 2.1

Trends in life expectancy in NI 1999-01 – 2005-07



Source: NI Health & Social Care Inequalities Monitoring System (NIHSCIMS)

Between 1998-00 and 2005-07, male life expectancy at birth increased from 74.5 to 76.2 years, an increase of 1.7 years. The target is to achieve an increase of three years by 2009-11. The trend line, which shows the outcome if life expectancy continues to grow at the average rate, shows that male life expectancy will reach approximately 77.6 years by 2009-11. If male life expectancy continues to grow at its current rate it will achieve its target of 77.5 years by 2009-11.

Between 1998-00 and 2005-07, female life expectancy at birth increased from 79.6 to 81.3 years, which is also an increase of 1.7 years. The trend line shows that female life expectancy will reach approximately 82.4 years by 2009-11. The target set by IfH is 82.6 years, if female life expectancy continues to grow at its current rate it will achieve its target by 2009-11.

Table 2.2

Average Levels of Life Expectancy for Men and Woman

	1998-2000	1999-2001	2000-2002	2001-2003	2002-2004	2003-2005	2004-2006	2005-2007
Male	74.5	74.8	75.3	75.6	75.9	76.1	76.2	76.2
Female	79.6	79.8	80.2	80.5	80.6	80.9	81	81.3
Source: NI Health & Social Care Inequalities Monitoring System (NIHSCIMS)								

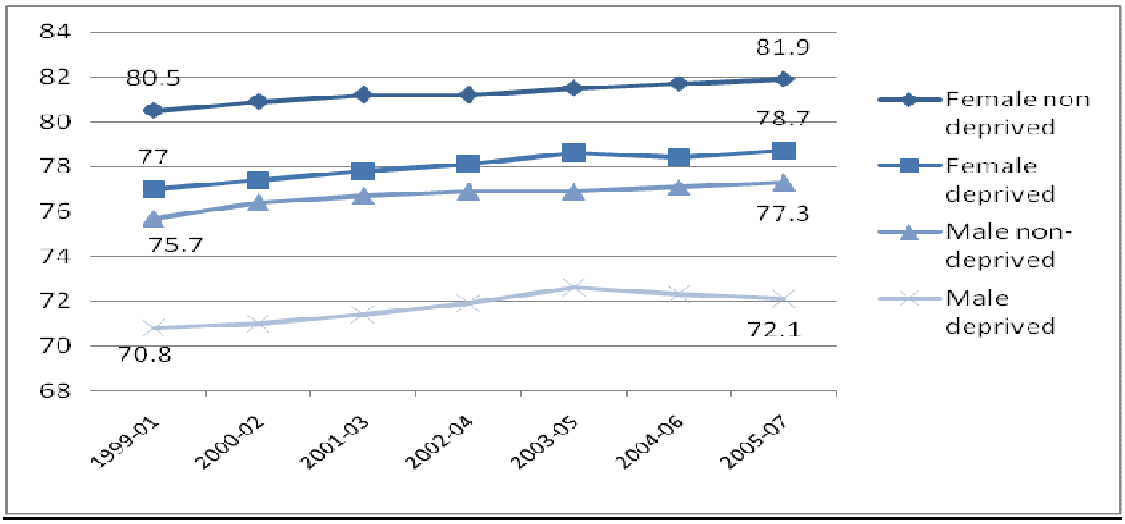
The difference in life expectancy between areas of deprivation by gender is shown in below in figure 2.2. Life expectancy has increased over the time period by an average of 1.5 years for each group. The life expectancy for a male has increased each year, with the exception of 2004-06 and 2005-07 when it remained static. Similarly, female life expectancy has increased consistently each year.

However, there is a clear gap in life expectancy between deprived areas and non-deprived areas. The gap between the genders is also evident as a female living in a deprived area still has a higher life expectancy at birth than a male in a non-deprived area. The life expectancy of a male living in a deprived area is particularly low at 72, which is 10 years less than a female from a non-deprived area can expect to live. Life expectancy for all groups has increased over the time period; this increase has been smallest for males in deprived areas at 1.3 years and highest for females in deprived areas at 1.7 years.

The gap between females living in deprived and non-deprived areas has decreased from 3.5 years in 1998-00 to 3.2 years in 2005-07. The gap between males living in deprived and non-deprived areas has increased from 4.9 years in 1998-00 to 5.2 years in 2005-07.

Figure 2.2

Life expectancy at birth in deprived areas



Source: DHSSPS

Table 2.3

Life expectancy at birth in deprived areas

		1999-2001	2000-2002	2001-2003	2002-2004	2003-2005	2004-2006	2005-2007
Deprived	Male	70.8	71	71.4	71.9	72.6	72.3	72.1
	Female	77	77.4	77.8	78.1	78.6	78.4	78.7
Non-deprived	Male	75.7	76.4	76.7	76.9	76.9	77.1	77.3
	Female	80.5	80.9	81.2	81.2	81.5	81.7	81.9

2.3 Life expectancy: UK comparisons

The life expectancy, healthy life expectancy and disability-free life expectancy at birth and age 65 for each gender is shown in table 2.4 for the UK and each constituent country. Each measure of life expectancy at birth and at age 65 is lower in NI than the UK average, with the exception of life expectancy for males at age 65 which is 0.7 years higher than the UK average.

The level of life expectancy and health life expectancy in Scotland is consistently lower than in NI for both genders at both life stages.

Table 2.4

Life expectancy, healthy life expectancy and disability-free life expectancy at birth and age 65: by country and sex 2004-06

	Country	Life expectancy (years)	Healthy life expectancy (years)	Disability-free life expectancy (years)
At birth: Males	UK	76.9	68.2	62.4
	England	77.2	68.5	62.8
	Wales	76.6	66.7	59.8
	Scotland	74.6	66.5	61.7
	NI	**76.1**	**66.9**	**60.0**
At birth: Females	UK	81.3	70.4	63.9
	England	81.5	70.7	64.1
	Wales	80.9	68.9	63.5
	Scotland	79.6	69.6	63.4
	NI	**81.0**	**68.8**	**60.7**
At age 65: Males	UK	15.9	12.8	10.1
	England	17.1	12.9	10.2
	Wales	16.7	12.3	9.5
	Scotland	15.8	12.2	9.8
	NI	**16.6**	**12.9**	**9.1**
At age 65: Females	UK	19.7	14.5	10.6
	England	19.9	14.7	10.7
	Wales	19.5	13.3	9.8
	Scotland	18.6	14.2	10.7
	NI	**19.5**	**13.8**	**9.0**

Source: Office for National Statistics (2008): Health Statistics Quarterly, Winter 2008

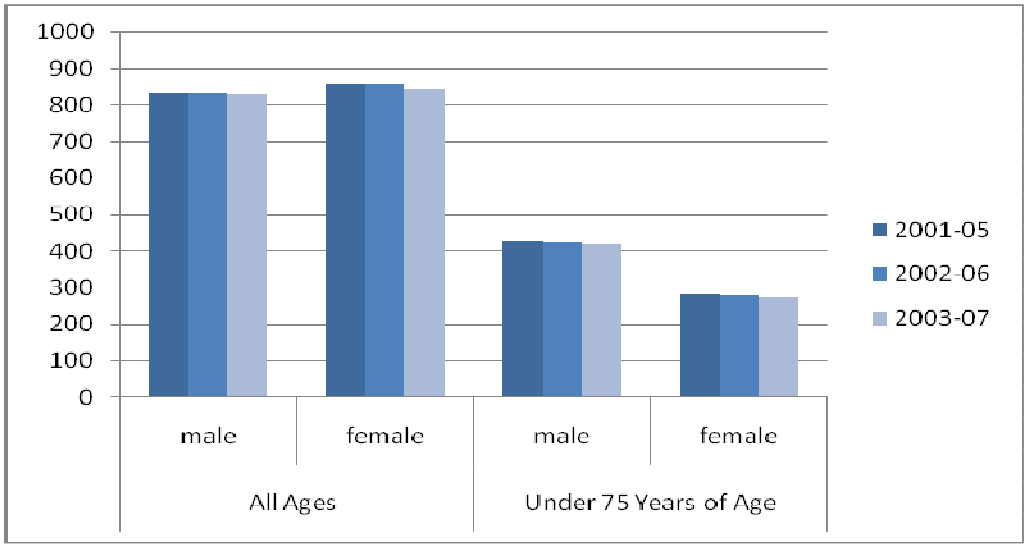
2.4 Standardised Mortality Rates

The average death rate is based on deaths over a four-year period standardised to the mid-year population estimate. The data is based upon the number of deaths provided by the General Register Office and 2002 Mid-Year Estimates provided by NISRA at LGD level and above. As there is a degree of statistical error in the age standardised death rate at a sub-NI level, NI averages are shown.

2.5 Mortality rates for all deaths

Figure 2.5

Age Standardised mortality rate (per 100,000 persons) for men and women, NI



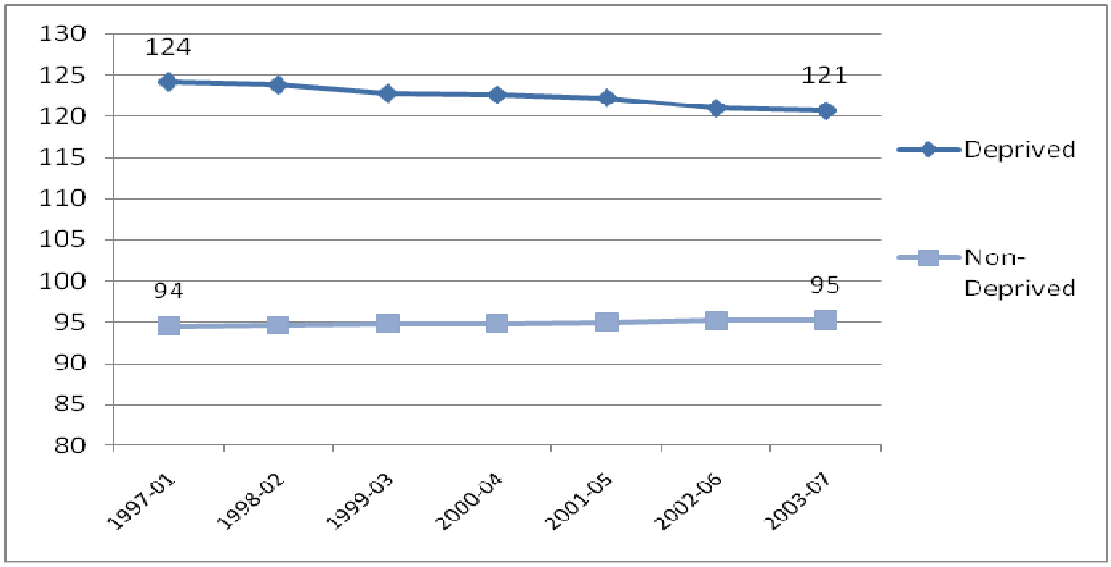
Source: DHSSPS

Men under the age of 75 have a higher death rate than women in the same age band. The rates for both sexes have been decreasing at a slow rate over the time period shown. When we consider deaths among all ages, the rate is higher amongst women. This can be explained by the longer life expectancy of women.

The mortality rate for all deaths is shown by area of deprivation in figure 2.4. The death rate is clearly higher for those living in a deprived area. The death rate of those living in deprived areas has shown some improvements over the time period and is slowly declining. The rate of the non-deprived area has remained largely unchanged at a rate of 95 per 100,000 persons.

Figure: 2.5

Standardised mortality rate for all deaths by area of deprivation, NI



Source: DHSSPS

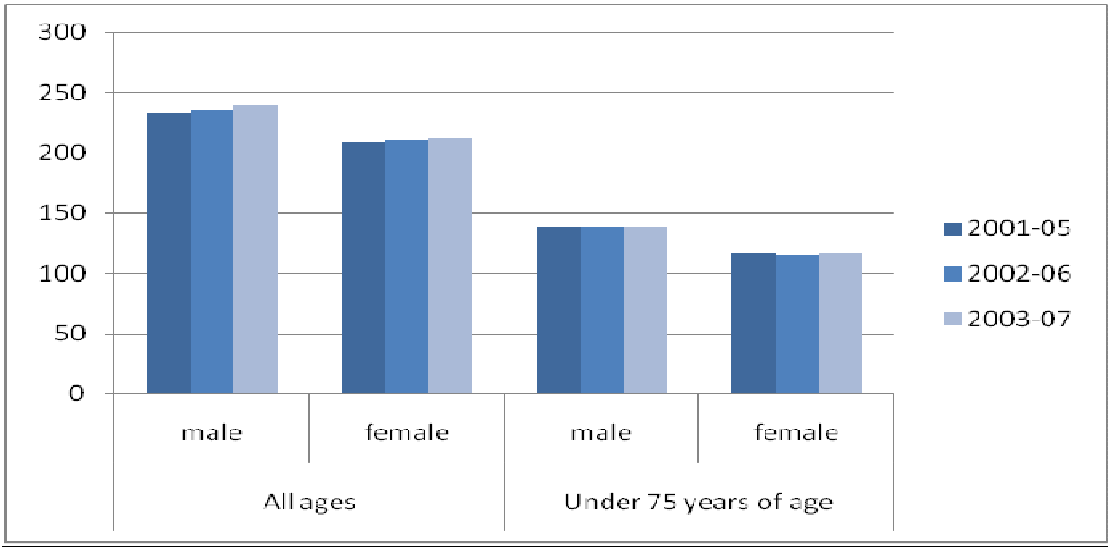
2.6 Mortality rates for cancer deaths

The cancer mortality rates show that men are more likely to die of cancer at all ages (figure 2.6). The cancer mortality rate for the under 75s has remained fairly constant over the time period, while the rate for all ages has increased slightly during this time.

The analysis suggests there is a marked gap between mortality rates from cancer in deprived and non-deprived areas. The rate in non-deprived areas has remained fairly constant over time and the rate in deprived areas shows signs of decreasing over time (figure 2.6).

Figure 2.6

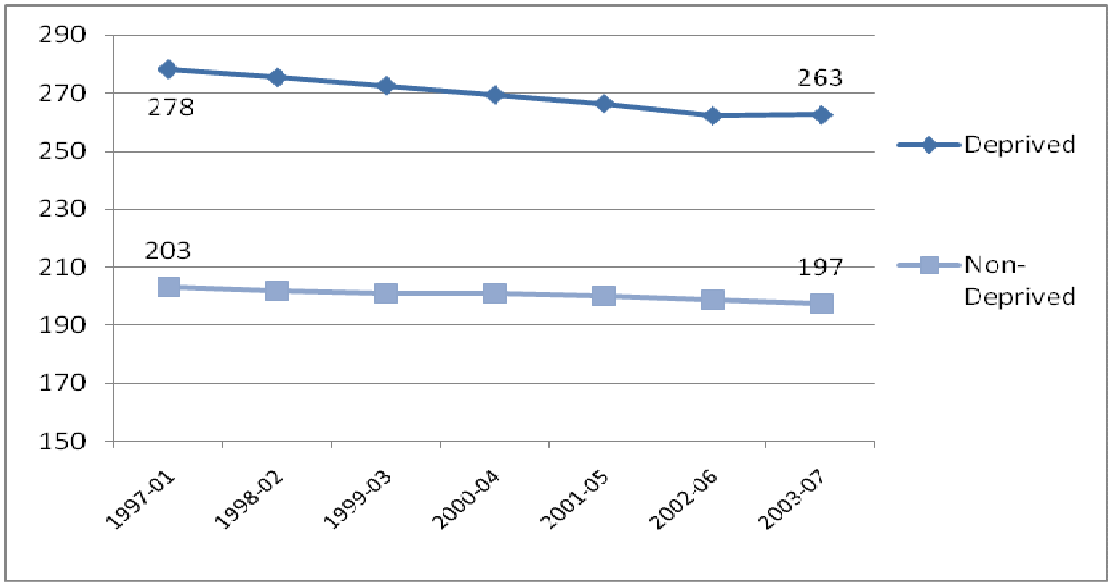
Age Standardised cancer mortality rate (per 100,000 persons) for men and women, NI



Source: DHSSPS

Figure 2.6

Standardised mortality rate for cancer deaths by area of deprivation, NI



Source: DHSSPS

Box 2.1: Cancer Deaths in Scotland

In 2008, 15,211 people died from cancer in Scotland.

- Taking all cancers combined, age-standardised cancer mortality rates have decreased by about 7% over the 10 year period of 1998-2008, with a greater decrease in males than in females (12% and 5% decreases, respectively)
- Taking all cancers combined, the rate of cancer mortality in the under 75 year olds has decreased by just over 20% since 1995. The Scottish Government has a target to reduce the cancer mortality rate in this age group by 20% between 1995 and 2010.
- Significant patterns exist when examining incidence and mortality rates by deprivation in Scotland. Considering all cancers combined, the most deprived areas have incidence rates almost 40% higher than the least deprived areas; mortality rates for all cancers combined are approximately 75% higher in the most deprived than the least deprived areas.
- However, there are variations in this pattern when looking at specific types of cancer. For example, while lung cancer incidence and mortality rates are higher in the most deprived areas of Scotland, incidence and mortality rates of malignant melanoma of the skin (melanoma skin cancer) are higher in the least deprived areas of Scotland.
- Cancers most directly associated with smoking tend to be strongly correlated with deprivation, having the highest incidence and mortality rates in the most deprived areas; these include cancers of the trachea, bronchus and lung, oral cavity and larynx.
- The incidence of (and mortality from) cervical cancer tends to be higher in more deprived women, reflecting socio-economic differences in exposure to risk factors, and lower attendance for cervical screening, which aims to prevent cervical cancer by diagnosing and treating pre-cancerous changes. In contrast, the incidence of breast cancer tends to be higher in less deprived areas. Again, this is likely to reflect differences in exposure to risk factors, and higher rates of attendance at breast screening, since breast screening is not designed to prevent breast cancer, but rather to diagnose the disease as early as possible, when treatment is more likely to be effective.
- Similarly, incidence of prostate cancer is negatively correlated with deprivation (higher incidence in the less deprived areas) but mortality has no correlation with deprivation quintile. The higher incidence of prostate cancer in less deprived areas may reflect higher rates of PSA testing of the populations in these areas.

Source: IDS Scotland (2009): Statistical publication notice. Cancer mortality 2008.

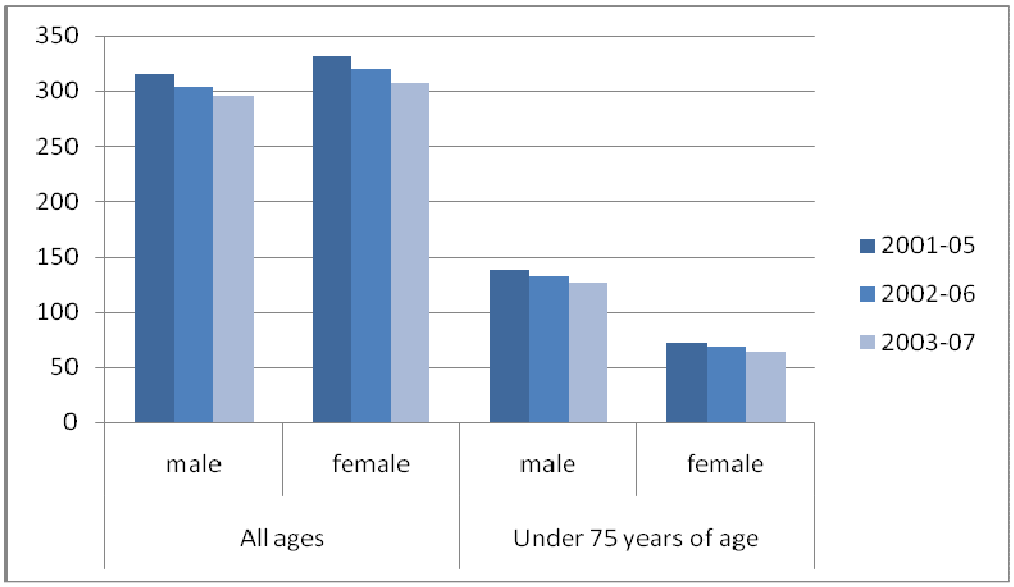
2.7 Mortality rates for circulatory deaths

Males under the age of 75 are more like likely to die from circulatory disease than women, however the converse is true when all ages are considered. The mortality rate has decreased over the time period for both age groups and genders (figure 2.7) which is consistent with the aim of Goal 1 to improve the health of people by increasing the number of years they spend free from disease and illness.

Again, there is a noticeable gap in the rates between areas of deprivation. Both deprived and non-deprived areas have seen the death rate decrease over time, but the differential shows only a small decrease (figure 2.8).

Figure 2.7

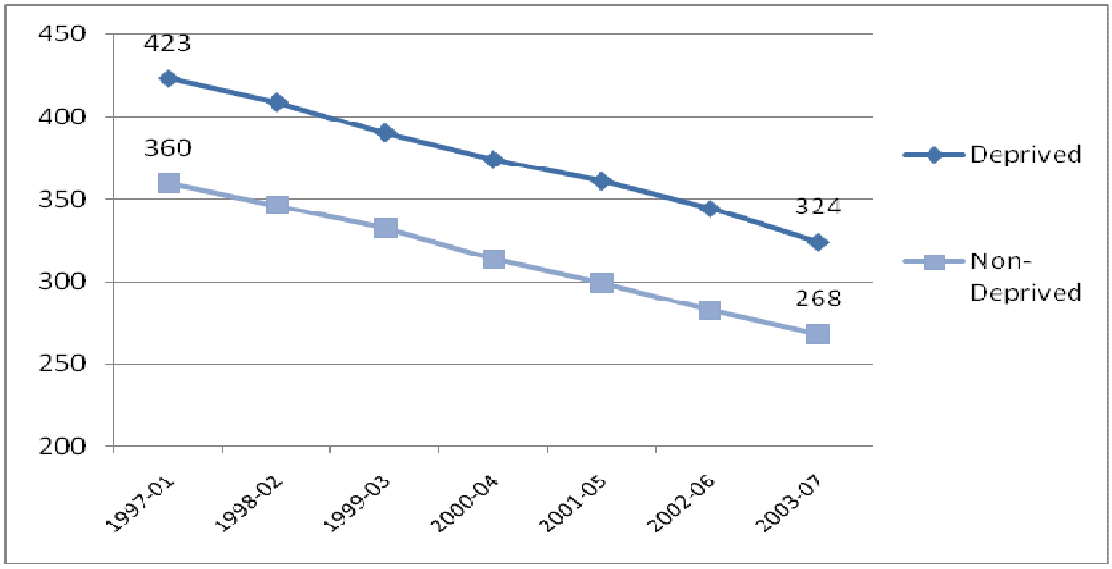
Age Standardised circulatory mortality rate (per 100,000 persons) for men and women



Source: DHSSPS

Figure 2.8

Standardised mortality rate for circulatory deaths by area of deprivation



Source: DHSSPS

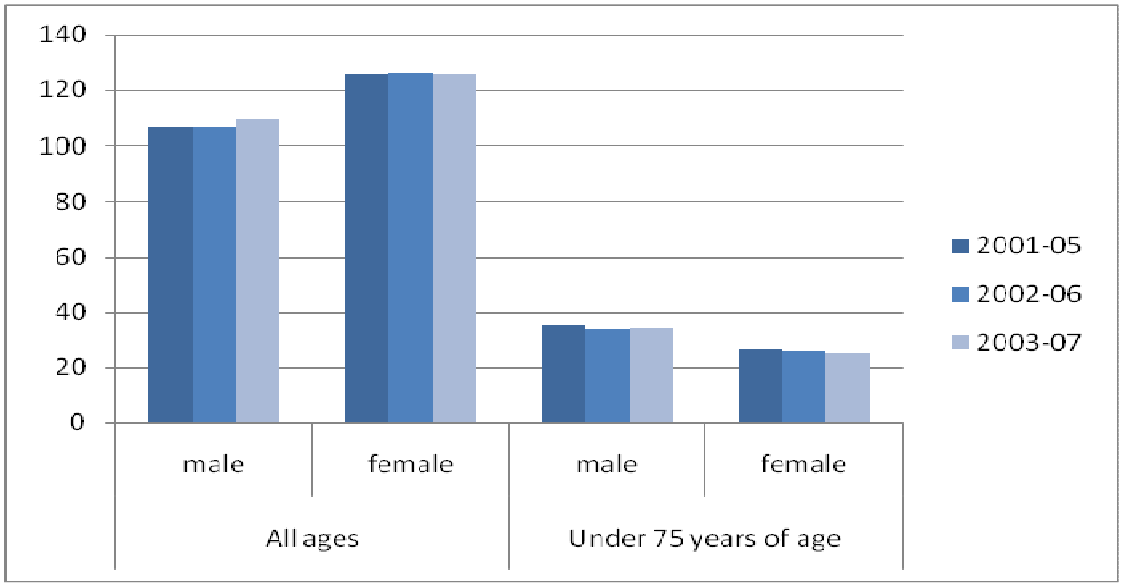
2.8 Mortality rates for respiratory deaths

Based on the data available, males under the age of 75 are more like likely to die from respiratory disease than women, however the converse is true when all ages are considered (figure 2.9). The mortality rates have shown little improvement over the time period for both age groups and genders.

Again, there is a noticeable gap in the rates between areas of deprivation. Both deprived and non-deprived areas have seen sharp decreases in the death rate decrease over time, both around 30%. This rate if decrease has slowed over the last few years and the differential shows only a small decrease (figure 2.10).

Figure 2.9

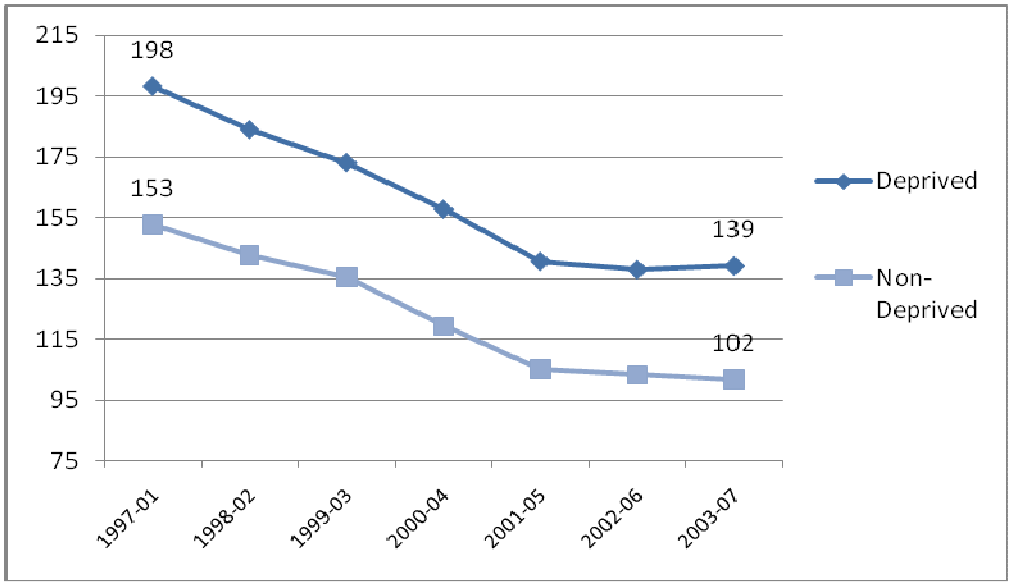
Age Standardised respiratory death rate (per 100,000 persons) for men and women



Source: DHSSPS

Figure 2.10

Standardised mortality rate for respiratory deaths by area of deprivation



Source: DHSSPS

2.9 Potential years of life lost per year by gender and age group

Potential years of life lost (PYLL) is the number of years of life "lost" from a death, when a person dies "prematurely" - defined as dying before age 75. For example, a death at age 25 has lost 50 potential years of life. The data shows PYLL per 100 persons and is available from 2001 to 2007.

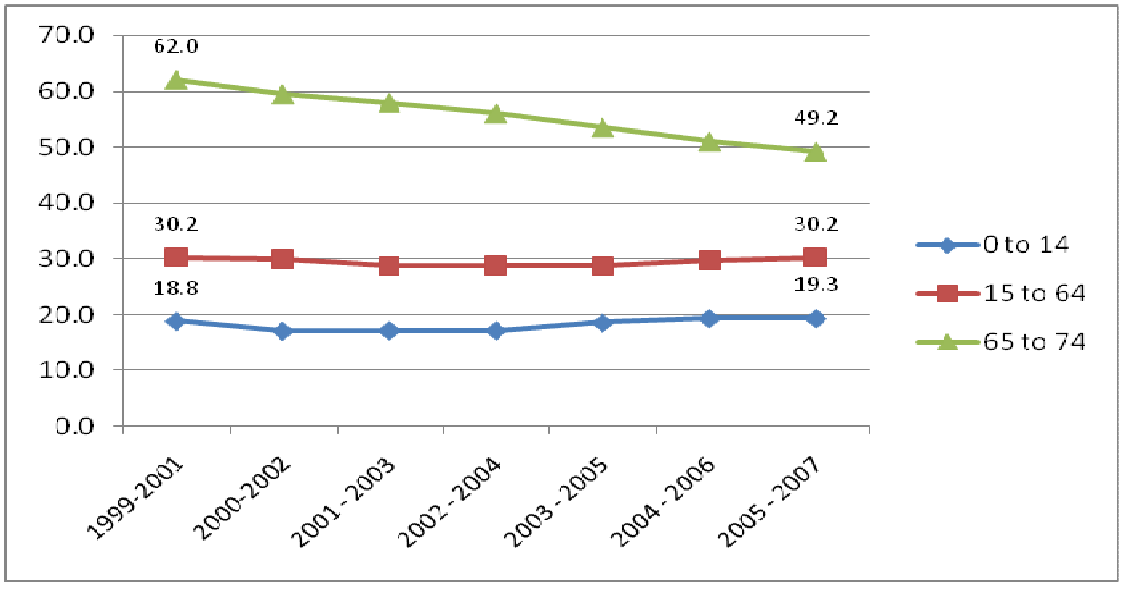
The data is based upon the number of deaths provided by the General Register Office and mid-year Estimates provided by NISRA at LGD level and above.

NB: There was a change in methodology over the time period shown. From 2006, the middle year is used as the reference population for mid-year estimates (i.e. for 2005-07 use 2006). Previously, the latest year was used as the reference population for mid-year estimates (i.e. for 2001-2003 used 2003).

The PYLL by age group is shown in figure 2.11.

Figure 2.11

Potential years of life lost by age group

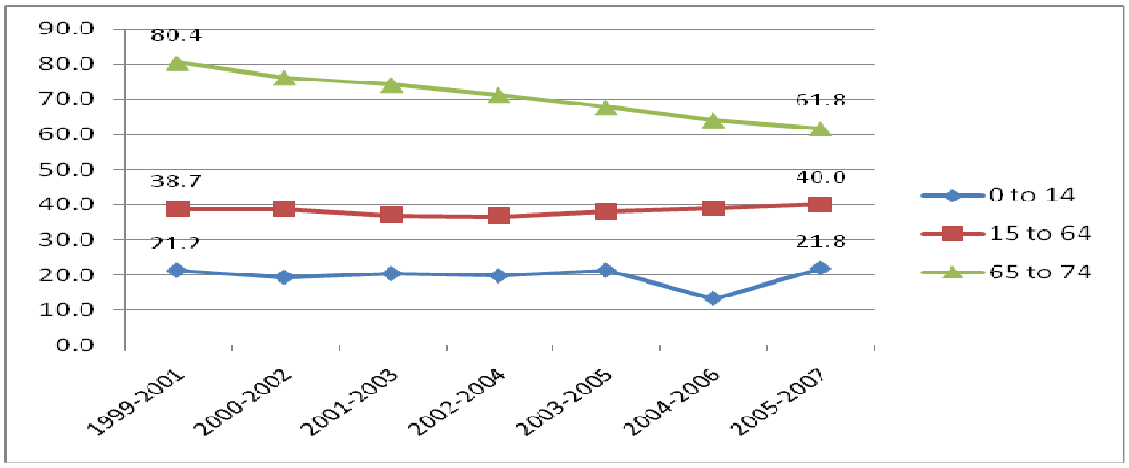


Source: NI Health & Social Care Inequalities Monitoring System (NIHSCIMS)

The PYLL for the 0-14 and 15-64 age groups have remained stable over the time period. The 65-74 age group has seen considerable improvement with a decrease of 12.8. The trends in the PYLL by gender are shown below.

Figure 2.12

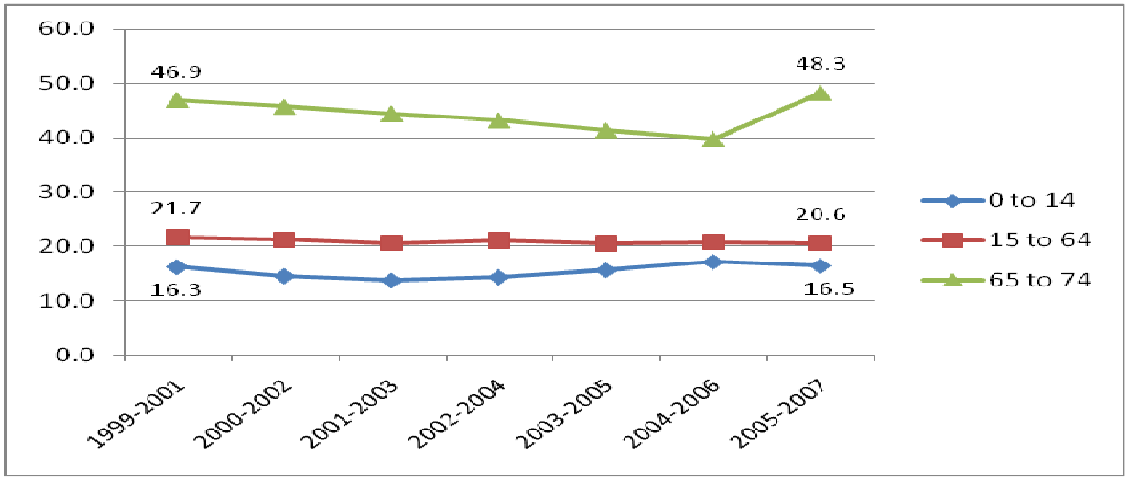
PYLL for males by age group



Source: NI Health & Social Care Inequalities Monitoring System (NIHSCIMS)

Figure 2.13

PYLL females



Source: NI Health & Social Care Inequalities Monitoring System (NIHSCIMS)

The trends between age groups 0-14 and 15-64 are similar for both genders with both remaining fairly constant over time. The age group 65-74 in both genders have experience a large decrease in the PYLL over the time period (with the exception of a jump in PYLL for females in the 2005-07 measurement). The differential between male and female PYLL is large for all age groups. This differential is reducing over time for the 65-74 age group, but shows no signs of change in the other two age groups.

2.10 Childhood immunisation rates

This is measured as the percentage of children receiving immunisation for Diphtheria, Polio, Tetanus (DPT), Pertussis (Whooping cough), Haemophilus Influenza Type b (Hib), Meningitis C (Men C) and Measles, Mumps, Rubella (MMR) before reaching their second birthday (for example, the data for 2005 is for children born in 2003 etc.) The numbers of children immunised against various diseases is extracted by each Health and Social Services Board at ward level from the Child Health System. This is supplied to DHSSPS who compile the data to generate data aggregated to various geographic levels. The data is available for 2005-2007.

Table: 2.5

Percentage uptake rates in childhood immunisation

	DPT3			MenC3			Hib3			MMR			Pertussis		
HSSB	**2005**	**2006**	**2007**	**2005**	**2006**	**2007**	**2005**	**2006**	**2007**	**2005**	**2006**	**2007**	**2005**	**2006**	**2007**
EHSSB	96.4	96.9	97.0	95.1	95.6	95.6	96	97	97.0	86.1	93.4	93.4	97	97.3	97.3
NHSSB	98	98.1	97.9	97.7	97.8	97.9	97.9	97.7	97.7	97.3	97.1	97.1	89.5	94.2	94.3
SHSSB	97.6	97.8	97.9	96.8	95.9	95.8	97	97.1	97.1	96.1	92.5	92.4	89.7	97.1	97.0
WHSSB	97.5	97.3	97.4	97.1	97.5	97.5	96.9	97.4	97.4	95.5	96.3	96.3	95.5	94.7	94.6
NI	97.3	97.4	97.5	96.5	96.5	96.5	96	97.3	97.3	92.8	94.6	94.6	93.3	96	96.0
Source: DHSSPS (taken from Ninis)															

Table: 2.6

Percentage change in immunisation rates between 2005 and 2007

HSSB	DPT3% change	MenC3 % change	Hib3 % change	MMR % change	Pertussis % change
EHSSB	0.6	0.5	1	7.2	0.3
NHSSB	-0.1	0.2	0.2	-0.2	4.6
SHSSB	0.3	-1	0.1	-3.7	7.3
WHSSB	-0.1	0.4	0.5	0.8	-0.9
NI	0.2	0	1.3	1.8	2.7
Source: DHSSPS (taken from Ninis)					

Childhood immunisation rates have changed little over the time period with the NI percentage coverage remaining above 90%. The MMR immunisation had some of the lowest immunisation rates in 2005, which is likely to be a result of the negative press coverage linking it to autism, but this has been improving and is now around the NI average rate for all immunisations.

Box 2.2: Childhood immunisation rates in Scotland

In Scotland the target of the national immunisation programme is for 95% of children to complete courses of the following childhood immunisations by 24 months of age: diphtheria, tetanus, pertussis (whooping cough), polio, Haemophilus influenzae type b (Hib) and Meningococcal group C (MenC). An additional national target of 95% uptake of one dose of MMR vaccine by 5 years of age (with a supplementary measure at 24 months) was introduced in 2006 to focus efforts on reducing the number of susceptible children entering primary school.

There have been a number of changes to the childhood immunisation programme for children around 0-5 years of age since September 2006:

- a new Pneumococcal Conjugate Vaccine (PCV) immunisation was introduced
- a change was made to the schedule given in the first 4 months of life
- there was the addition of an appointment at around 12 months to deliver the Hib/Men C booster

- a pneumococcal catch up campaign commenced in September 2007 a Hib vaccination catch up programme was introduced an initiative to reduce the age at which pre-school immunisation is routinely offered, to around 3.5 years of age.
- For the quarter ending 31 March 2009, at Scotland level:
- Uptake rates by 12 months of age for primary courses of diphtheria, tetanus, pertussis, polio, Hib, MenC and PCV remain above 95%.

- Uptake rates by 24 months of age for primary courses of diphtheria, tetanus, pertussis, polio, Hib, MenC and PCV remain high and stable at around 96% to 98%.

- The combined Hib/MenC booster (normally given at around 12 months of age) was introduced in September 2006. This required the inclusion of an additional immunisation appointment in the childhood schedule. Uptake of this vaccine by 24 months of age has risen each quarter to reach 94.1% for the latest quarter (the previous quarterly figure was 93.7%).

- A booster dose of PCV was also introduced in September 2006 (normally given at the same appointment as the first dose of MMR at around 13 months of age). Uptake for this vaccine by 24 months of age is 93.8%, the same as the previous quarterly figure.

- Uptake of one dose of MMR (MMR1) by 24 months is 93.3% (up by 0.4 percentage points on the previous quarterly figure of 92.9%). MMR1 uptake rates by 24 months have continued to be above 90% since autumn 2005.

- Uptake of one dose of MMR (MMR1) by 5 years is 96.2%, an increase of 0.6 percentage points on the previous quarter when the rate was 95.6%. This once again exceeds the 95% target. By 24 months the reported uptake for this cohort of children was 91.9% showing that a significant number of children are immunised beyond the standard age.

- Uptake of the second dose of MMR (MMR2) by 5 years old is 87.5%. This is an increase of 0.3 percentage points on the previous quarter when the rate was 87.2%. Uptake rates for other pre-school booster vaccines remain stable at around 89%.

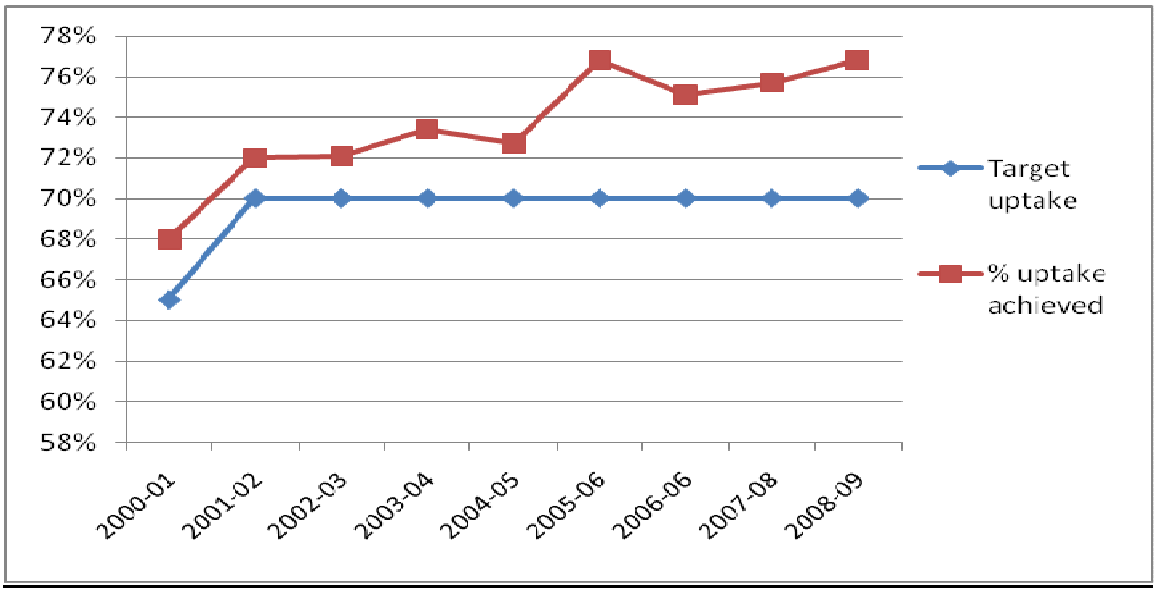
Source: IDS Scotland (2009): Statistical publication notice. Childhood immunisation uptake rates, quarter ending 30th June 2008

2.11 Uptake rate for flu immunisation in people aged 65 and over

The data is based on GP end of year returns received at HSSB/CDSC and is available for 2000-09. A target rate of 70% was set for flu immunisation of people aged 65 and over. The percentage uptake rate surpassed this target in 2001-02 and continues to grow (figure 2.14).

Figure: 2.14

Uptake rate for flu immunisation in people aged 65 and over



Source: CDSC NI

Table: 2.7

Percentage change in immunisation rates between 2005 and 2007

	2000-01	2001-02	2002-03	2003-04	2004-05	2005-06	2006-06	2007-08	2008-09
Total vaccines	155030	163972	166514	171308	168569	180372	178242	166068	170818
Target uptake	65%	70%	70%	70%	70%	70%	70%	70%	70%
% uptake achieved	68%	72%	72.10%	73.40%	72.70%	76.80%	75.10%	75.70%	76.80%

Source: CDSC NI

2.12 Uptake rate for breast cancer screening

The Northern Ireland Breast Screening Programme currently invites all women between the ages of 50 and 64 to have a mammogram every 3 years. The uptake rate is the number of women accepting their invitation out of the number of women invited, expressed as a percentage. The data is collected at Health Board level and is available from 2000 to 2008.

Table: 2.8

Uptake rate for breast cancer screening 2000 and 2007

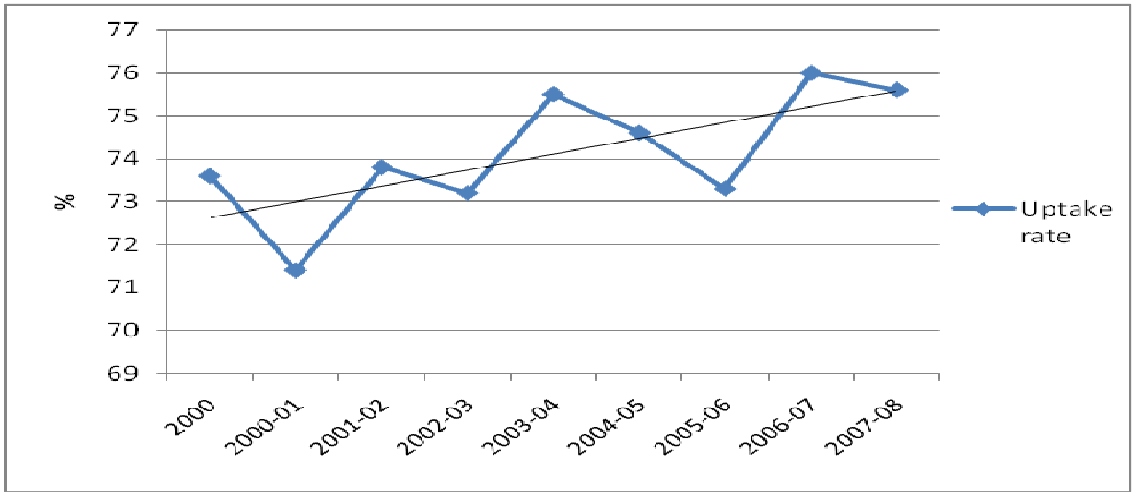
HSSB	2000	2000-2001	2001-2002	2002-2003	2003-2004	2004-2005	2005-2006	2006-2007	2007-2008
EHSSB	69.2	62.5	70.5	67.4	68.5	70.9	69.2	65.8	73.1
NHSSB	80.5	80.5	76.9	81.2	82.8	79.3	69.3	82.6	78.7
SHSSB	72.1	75.5	78.1	74.9	76.4	77.9	77.1	78.6	78.2
WHSBB	76	76.8	74.9	74.7	78.8	77.1	79.2	80.1	73.7
NI	73.6	71.4	73.8	73.2	75.5	74.6	73.3	76	75.6

Source: Quality Assurance Reference Centre (HPSS) via DHSSPS

The total percentage of women in NI attending breast screenings has risen over the time period with an increase of 2%, from 73.6% to 75.6%.

Figure: 2.15

Uptake rate for breast cancer screening



Source: DHSSPS (taken from Ninis)

The uptake rates within health boards show different trends. None of the board areas have achieved a sustained increase year-on-year as the uptake rates fluctuate from one year to the next. The uptake rate has increased in two of the boards (Eastern and Southern) and decreased in two (Northern and Western). The percentage change is shown in the table below.

Table 2.9

Percentage change in breast screening uptake rate between 2000 and 2008 by board

HSSB	% change
EHSSB	3.9
NHSSB	-1.8
SHSSB	6.1
WHSBB	-2.3
Source: DHSSPS (taken from Ninis)	

Box 2.3: Scottish Breast Screening Programme

The Scottish Breast Screening Programme is part of a UK-wide programme of free mammographic screening for breast cancer, which was set up in 1988 with the aim of reducing mortality. Since full national coverage was attained in 1991 there have been over 2.1 million screening episodes and in excess of 15,300 breast cancers diagnosed. In Scotland, women aged 50-64 years were invited for a routine screen once every three years until 2003-04, when the age range for invitation was extended to include women up to the age of 70 years. The attendance figures at 31st March 2008 showed that uptake was approximately 76%. Uptake rates have remained at this level for the last five year, exceeding the minimum standard of >70%.*

Breast cancer is the most common cancer in women, with the incidence rate continuing to rise. Over the ten-year period, 1996-2006, the incidence rate has increased by 10%; this is partly due to increased detection by the Scottish Breast Screening Programme, which has seen a rise in attendance over the same time period, and the extension in the age range invited for screening to include women up to the age of 70 years. However, increases in the incidence of breast cancer might also be anticipated with higher prevalence of known risk factors among the female population, such as increases in the mother's age at the birth of her first child, and increases in alcohol consumption.**

*: ***Source: IDS Scotland (2009): Statistical Publication Notice. Breast cancer screening programme statistics 2008-09***

****: Source: IDS Scotland (2009): Statistical Publication Notice. Cancer Incidence 2006***

2.13 Coverage of cervical cancer screening

Cervical screening in Northern Ireland is calculated as "Coverage over 5 years" where:

The eligible female population aged 25-64, minus women ceased for a valid reason - divided by the number of smears taken over the last 5 years, expressed as a percentage. The data is collected at Health Board level and is available from 2000 to 2008.

Table 2.10

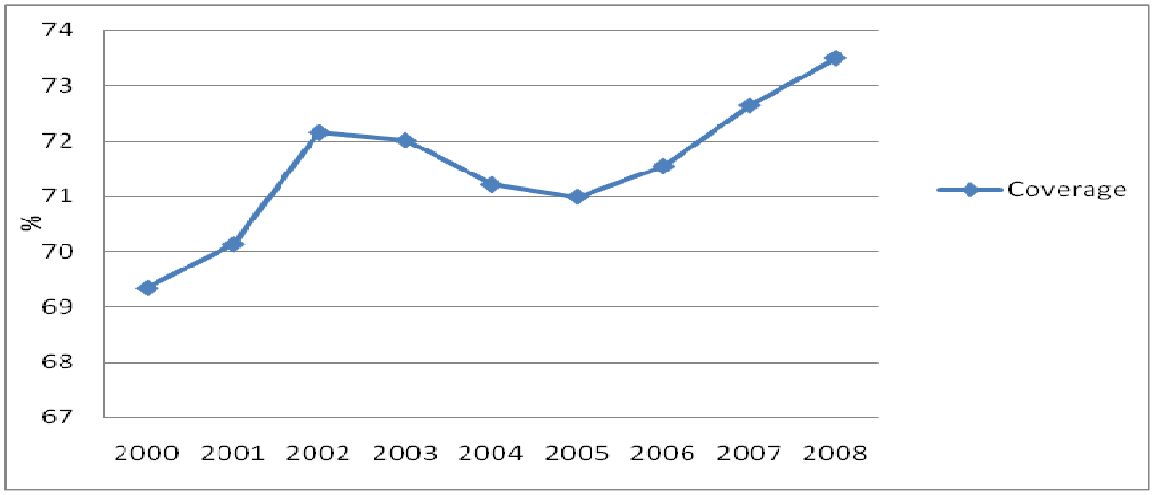
Percentage change in breast screening uptake rate between 2000 and 2008 by board

HSSB	2000	2001	2002	2003	2004	2005	2006	2007	2008
EHSSB	66.17	66.99	69.17	69.16	68.01	67.49	70.07	69.36	70.3
NHSSB	74.34	74.98	76.97	77.14	75.98	76.52	73.69	77.36	78.2
SHSSB	71.24	72.54	74.48	74.47	73.91	73.25	74.75	72.90	73.7
WHSSB	67.65	67.98	69.66	68.71	68.92	69.56	68.87	73.54	74.1
NI	69.34	70.13	72.15	72.01	71.21	70.99	71.54	72.64	73.5
Source: Quality Assurance Reference Centre (HPSS) via DHSSPS									

The NI coverage has increased by 4.2% over the time period. All health boards have increased their coverage by at 2.5 – 6.5%

Figure: 2.16

Coverage of cervical cancer screening



Source: Quality Assurance Reference Centre (HPSS) via DHSSPS

The percentage change in coverage of cervical cancer screening between 2000 and 2008 are shown in the table below. All health boards have seen an increase in cervical cancer screening.

Table 2.11

Percentage change in cervical cancer screening coverage between 2000 and 2008 by board

HSSB	% change
EHSSB	4.13
NHSSB	3.86
SHSSB	2.46
WHSSB	6.45
NI	4.16
Source: Quality Assurance Reference Centre (HPSS) via DHSSPS	

Looking at the percentage uptake of those women who had a record of a previous smear taken in the last 5.5 years, all NHS Boards experienced a rise compared to 31st March 2008. Ten out of fifteen boards exceeded the NHS QIS Minimum Standard of >80%.

Box 2.4: *Cervical Cancer Screening: Scotland*

Cervical screening was introduced in Scotland in the 1960s. Although large numbers of women were offered tests, the service at this time was not introduced as a population based programme. In 1978 committees were established by the UK Department of Health and a review was carried out in Scotland resulting in the Strong Report. In 1988/1989 NHS Boards and Trusts introduced computerised call/recall systems. The national cervical screening programme was introduced in Scotland in 1988 with the aim of reducing the incidence of invasive cancer of the cervix. Cervical smears are routinely offered to eligible women aged 20-60 every three years. Women with an abnormal smear history will continue to be invited for follow-up as appropriate.

At 31st March 2009, 73.4% of eligible women had been screened in the previous 3.5 years, a rise of approximately 4% compared to 31st March 2008. In contrast to 31st March 2008, uptake rates have increased across all NHS Boards; the highest proportion was found in NHS Shetland, with a rate of 81.4%. The number of women attending cervical screening has also improved across all five year age bands within the target age group of 20-60 years; the largest increase, of more than 6%, was found in the lowest age band of 20-24 years. The rise in the number of women attending cervical screening most likely reflects the impact of the publicity surrounding Jade Goody's death from cervical cancer.

Source: ***Source: IDS Scotland (2009): Statistical Publication Notice. Scottish cervical screening programme statistics 2008/09.***

2.14 Summary

The aim of Goal 1 is to improve the health of our people by increasing the length of their lives and increasing the number of years they spend free from disease, illness and disability. Improvements have been made in life expectancy and death rates from different forms of disease, but disparity still remains between gender and area of deprivation.

Between 1998-00 and 2005-07, male life expectancy at birth increased from 74.5 to 76.2 years, an increase of 1.7 years. Between 1998-00 and 2005-07, female life expectancy at birth increased from 79.6 to 81.3 years, which is also an increase of 1.7 years. The target set for Goal 1, to achieve an increase in life expectancy of three years by 2009-11, is forecast to be met if the change in life expectancy continues to grow at its current rate.

However, there is a clear gap in life expectancy between area of deprivation and gender. Life expectancy for all groups has increased over the time period; this increase has been smallest for males in deprived areas at 1.3 years and highest for females in deprived areas at 1.7 years. The life expectancy of a male living in a deprived area is 10 years less than a female from a non-deprived area can expect to live. The gap between the genders is also evident as a female living in a deprived area still has a higher life expectancy at birth than a male in a non-deprived area.

The standardised death rates for both sexes have been decreasing at a slow rate over the time period. However, gaps still exist between gender and areas of deprivation. The death rates from different forms of disease follow the same pattern with differences between areas of deprivation remaining. The cancer mortality rates show that men are more likely to die of cancer at all ages than women. The death rate from cancer in non-deprived areas has remained fairly constant over time and the rate in deprived areas shows signs of decreasing over time, but the disparity between the areas remains. The number of newly diagnosed cases of cancer has also increased by 10.22% between 1993 and 2005. The death rate from circulatory disease has decreased over the time period for both age groups and genders which is consistent with the aim of Goal 1 to improve the health of people by increasing the number of years they spend free from disease and illness. Both deprived and non-deprived areas have seen the circulatory disease death rate decrease over time, but the differential between areas shows only a small decrease. The respiratory disease death rates have shown little improvement over the time period for both age groups and genders. The differential between areas of deprivation has shown only a small decrease.

The trends in potential years of life lost between age groups 0-14 and 15-64 are similar for both genders with both remaining fairly constant over time, while those in the 65-74 age group in both genders have experience a large decrease in the PYLL. The differential between male and female PYLL is large for all age groups.

Childhood immunisation rates have changed little over the time period 2005-07 with the NI percentage coverage remaining above 90%. Flu immunisation of people aged 65 and over

surpassed the 70% target 2001-02 and continues to grow. The proportion of women attending breast screenings and cervical cancer screening has also increased over time.

3 APPENDIX 2: GOAL 2 – REDUCE HEALTH INEQUALITIES

Goal 2 is *"to reduce inequalities in health between geographic areas, socio-economic and minority groups".*

3.1 Target i

Target (i): To halve the gap in life expectancy between those living in the fifth most deprived electoral wards and the average life expectancy for both men and women between 2000 and 2010.

Table 3.1

Goal 2, Target1

Area	Males (years)	Females (years)
Baseline: NI average life expectancy	74.5	79.6
Life expectancy for the fifth most deprived wards	71.4	77.1
Gap at 1998-00	3.1	2.5
Target gap in 2009-11	1.55	1.25
Source: DHSSPS (2002): Investing for Health Strategy Baseline (taken from the Registrar General's Report 2000)		

3.2 Target ii

To reduce the gap in the proportion of people with a longstanding illness between those in the lowest and highest socio-economic groups by a fifth between 2000 and 2010.

Table 3.2

Goal 2, Target 2

Area	Proportion of people aged 16+ with a long standing illness
Baseline: gap between socioeconomic groups 1&2 and 6&7 in 1998-09 - 2001-02	15%
Target gap 2008-09 - 2010-11	12%
Source: DHSSPS (2002): Investing for Health Strategy Baseline (taken from the Continuous Household Survey)	

Socio-economic groups are defined as follows:

1. Professional;
2. Employer, manager;
3. Intermediate non-manual;
4. Junior non manual;
5. Skilled manual;
6. Semi-skilled manual; and
7. Unskilled manual.

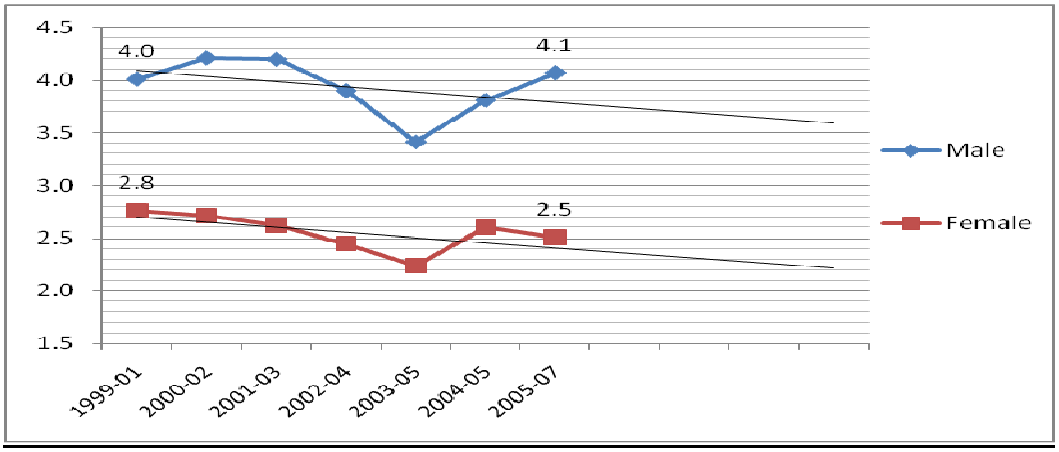
3.3 Life Expectancy Gaps

The gap between the life expectancy in deprived areas and the NI average by gender is shown in figure 3.1 and table 3.3 for the 1999 to 2007 period (using the mid-point of each three-year time period). The gap in life expectancy for both genders has shown an overall downward trend over time. The trend line has been extrapolated forward to 2009-11 to forecast what the gap would be if it continues to decrease at the same rate. The gap in life expectancy between deprived areas and the NI average is forecast to be 3.6 years for men and 2.2 years for women.

The target is to halve the gap in life expectancy between the most deprived areas and the NI average this gap to 1.55 years for men and 1.25 years for women by 2010. If the gap in life expectancy between deprived areas and the NI average continues to decrease at forecasted rate, the target will not be met.

Figure 3.1

Gap in life expectancy between deprived areas and NI average (years)



Source: DHSSPS

Table 3.3

Gap in life expectancy between deprived areas and NI average (years)

	Male	Female
1999-01	4.0	2.8
2000-02	4.2	2.7
2001-03	4.2	2.6
2002-04	3.9	2.4
2003-05	3.4	2.2
2004-05	3.8	2.6
2005-07	4.1	2.5
Source: DHSSPS		

3.4 General Dental Practitioner Registrations

The number of children registered with a General Dental Practitioner as a percentage of those registered with a General Medical Practitioner is shown in table3.4. The data is available for 2005, 2007 and 2008 (the data for 2006 was unavailable) and is split by age groups 3-5 years and under 3 years of age. The NI average has remained unchanged over time with 26% of children under 3 registered and 62% of those aged 3-5 years registered.

There are some differences when analysed at a Health Board level. NHSSB has a consistently higher than average registration rate while WHSSB has a consistently lower rate. The difference between these two boards for the registration of 3-5 year olds is 10% each year.

Table 3.4

Number of children registered with a dentist as a percentage of children registered with a GP by health board

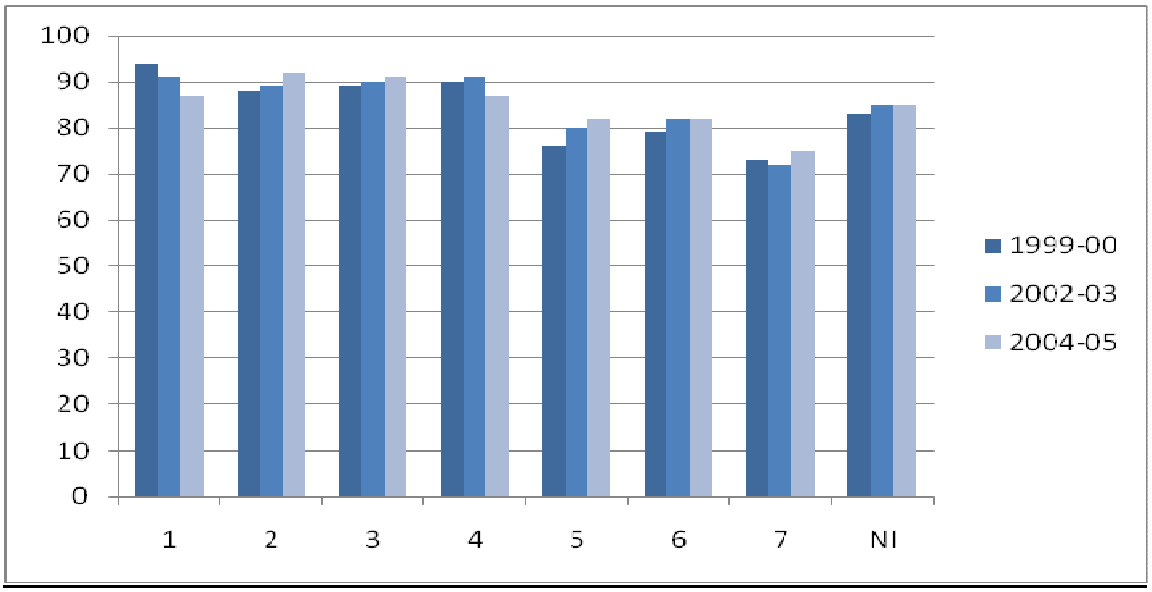
Year	Board	% Dental Registrations for children aged Under 3	% Dental Registrations for children aged 3-5
2005	EHSSB	27	61
	NHSSB	27	67
	SHSSB	25	63
	WHSSB	22	57
	NI	26	62

Year	Board	% Dental Registrations for children aged Under 3	% Dental Registrations for children aged 3-5
2007	EHSSB	25	60
	NHSSB	28	68
	SHSSB	25	61
	WHSSB	22	57
	NI	26	62
2008	EHSSB	26	60
	NHSSB	29	66
	SHSSB	26	60
	WHSSB	22	56
	NI	26	62
Central Services Agency, DHSSPS			

Figure 3.2 and table 3.5 shows the percentage of adults (ages 16 years and over) who are registered with a dentist by socio-economic group (1 is the highest level and 7 is the lowest). The data is available for the 1999 to 2005 period (using the mid-point of each three-year time period). There is an obvious disparity between registrations in the higher and lower socio-economic groups. The data is also shown split by gender in table 3.5. This shows that women are more likely to be registered with a dentist across all socio-economic groups.

Figure 3.2

Percentage of adults (16+) registered with a dentist by socio economic group



Source: Continuous Household survey 2004-05

Table 3.5

Percentage of adults (16+) registered with a dentist by socio economic group and gender

	Male			Female		
	1999-00	2002-03	2004-05	1999-00	2002-03	2004-05
Professional	93	89	83	97	96	94
Employer, manager	86	90	92	92	88	92
Intermediate non-manual	83	86	89	92	93	91
Junior non manual	88	86	86	90	92	87
Skilled manual	76	78	82	76	85	83
Semi-skilled manual	75	78	75	80	84	85
Unskilled manual	63	63	74	77	83	77
Total	80	81	84	85	88	87
Source: Continuous Household survey 2004-05						

Table 3.6 shows the number of dentists per 1,000 persons by Health Board from 2006 to 2008. Over this time period, the number of dentists has increased in each area with the exception of EHSSB which has remained constant.

Table 3.6

Number of dentists per 1,000 population by health board

	Dentists per 1,000 population		
	2006	2007	2008
EHSSB	0.50	0.50	0.54
NHSSB	0.43	0.42	0.44
SHSSB	0.46	0.45	0.5
WHSSB	0.42	0.42	0.42
NI	0.48	0.46	0.49

Source: Central Services Agency, DHSSPS

Northern Ireland totals do not match up for each geographic level due to dentists potentially working in multiple areas on one or more contract or subcontract.

3.5 Average Travel Time to A&E Hospital

The data is based on the availability of accident and emergency departments in Northern Ireland hospitals at the end of 2004. Travel times are calculated using the New Matrix Generator (NMG) developed on behalf of DHSSPS. They are worked out on the basis of assigning average off-peak road speeds to NI roads based on whether they are a Motorway, A-road, B-road or minor connecting road. The point of origin for the journey to the hospital is taken to be the Census Output Area (COA) of the area of residence. The data should be treated as an approximation and is dependent upon the average travel speeds chosen for input into the model used. The road speed data were taken from Department of Transport in England as NI specific data were not available at the time of production.

There is some disparity between Health Boards with EHSSB having the shortest travel time to A&E at 8 minutes. This time is nearly doubled in WHSSB.

Table 2.7

Average travel time for persons resident in area to the nearest hospital with an accident and emergency department (2004)

	Average time to nearest hospital with A&E (min) excluding Minor Injury Units	Average time to nearest hospital with A&E (min) including Minor Injury Units
EHSSB	9	8
NHSSB	15	14
SHSSB	18	13
WHSSB	15	15
NI	13	12
Source: DHSSPS (taken from Ninis)		

3.6 Limiting Long-Term Illness

A limiting long-term illness (LLTI) is defined as a long-term illness, health problem or disability which limits a person's daily activities or the work that they can do, including problems that are due to old age. The data is available from 1998 to 2009.

The total number of people reporting a LLTI has remained at a similar level of approximately 25% over this time period. Women are more likely to report a LLTI than men.

Table 2.8

Percentage of people reporting a LLTI by age and gender (aged 16+)

Sex and age	1998-99	1999-00	2000-01	2001-02	2002-03	2003-04	2004-05	2005-06	2006-07	2007-08	2008-09
All Persons											
16-44	13	14	13	13	14	13	13	13	13	10	12
45-64	31	35	34	31	32	32	31	29	29	30	27
65-74	48	45	43	47	46	46	42	42	41	46	41
>=75	54	56	59	58	55	56	54	53	51	57	53
Total	**25**	**27**	**26**	**25**	**26**	**25**	**25**	**25**	**24**	**25**	**24**
Males											
16-44	12	12	11	13	12	12	10	12	12	10	11
45-64	31	36	33	31	32	30	33	29	28	28	25
65-74	47	43	42	49	45	41	41	36	41	45	39
>=75	51	57	58	54	55	55	46	51	46	53	53
All Males	**24**	**26**	**24**	**24**	**24**	**23**	**24**	**22**	**23**	**23**	**22**
Females											
16-44	14	16	15	14	15	14	15	15	13	11	13
45-64	32	33	34	32	32	33	30	30	30	32	29
65-74	48	47	44	45	47	49	44	48	42	46	43
>=75	56	55	60	61	54	57	60	54	53	60	53
All Females	**27**	**28**	**27**	**26**	**27**	**27**	**27**	**27**	**25**	**26**	**25**
Source: Continuous Household Survey 2005/06											

The percentage of people reporting a LLTI is also shown split by economic activity (figure 3.3). The level of economic activity is defined by the International Labour Organisation (ILO) as follows:

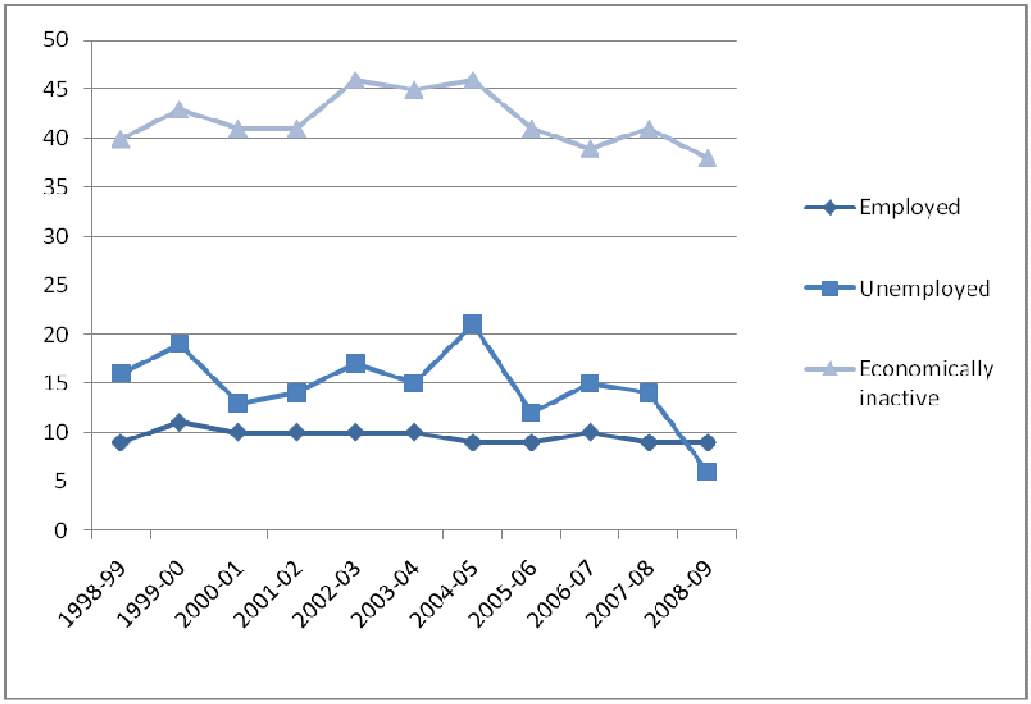
- Employed is defined as those who did some paid work as an employee or self-employed, had a job they were temporarily away from (e.g. holiday), those participating in government employment or training programmes and those doing unpaid family work.
- Unemployed is defined as those who were out of work and had looked for work the previous 4 weeks or would have looked but for a temporary sickness or injury and was available to start work in the next 2 weeks, or those waiting to start a job.
- Economically inactive is defined as all those not classed as employed or unemployed.

Those who are employed are least likely to report a LLTI and this level remains fairly constant over time. The percentage of unemployed people reporting a LLTI is higher, but the levels have been showing a downward trend over time. The levels of reported LLTIs reported amongst the economically inactive are considerably higher in the 35-45% range.

Table 3.9 shows the percentage of people reporting a LLTI by levels of household income. There is a clear link between income and probability of reporting a LLTI with those in the lowest income bands up to four times more likely to report a LLTI as those in the highest bands.

Figure: 3.3

Percentage of people reporting a LLTI by ILO Economic Activity (aged 16+)



Source: Continuous Household Survey 2005/06

Table: 3.9

Percentage of people reporting a LLTI by ILO Economic Activity (aged 16+)

	1998-1999	1999-2000	2000-2001	2001-2002	2002-2003	2003-2004	2004 2005	2005-2006	2006-2007	2007-2008	2008-2009
Employed	9	11	10	10	10	10	9	9	10	9	9
Unemployed	16	19	13	14	17	15	21	12	15	14	6
Economicall y Inactive	40	43	41	41	46	45	46	41	39	41	38
Source: Continuous Household Survey 2005/06											

Table 3.10

Percentage of people reporting a LLTI by Gross Household Income, 1998-99 to 2008-09

Gross Household Income	1998-1999	1999-2000	2000-2001	2001-2002	2002-2003	2003-2004	2004-2005	2005-2006	2006-2007	2007-2008	2008-2009
£ 0-£ 5210 pa	38	45	40	44	46	48	53	42	33	45	42
£ 5210-£10430 pa	42	50	49	44	49	50	25	48	46	49	47
£10430-£15640 pa	29	37	33	34	34	34	38	37	34	40	37
£15640-£20860 pa	16	19	20	24	24	20	19	24	24	22	19
£20860-£26070 pa	15	17	16	14	18	18	19	20	15	19	23
£26070-£31290 pa	9	11	13	9	13	14	17	15	14	13	11
More than £31290 pa	11	13	11	7	11	10	13	10	11	11	11

Source: Continuous Household Survey 2005/06

3.7 Cancer Diagnosis

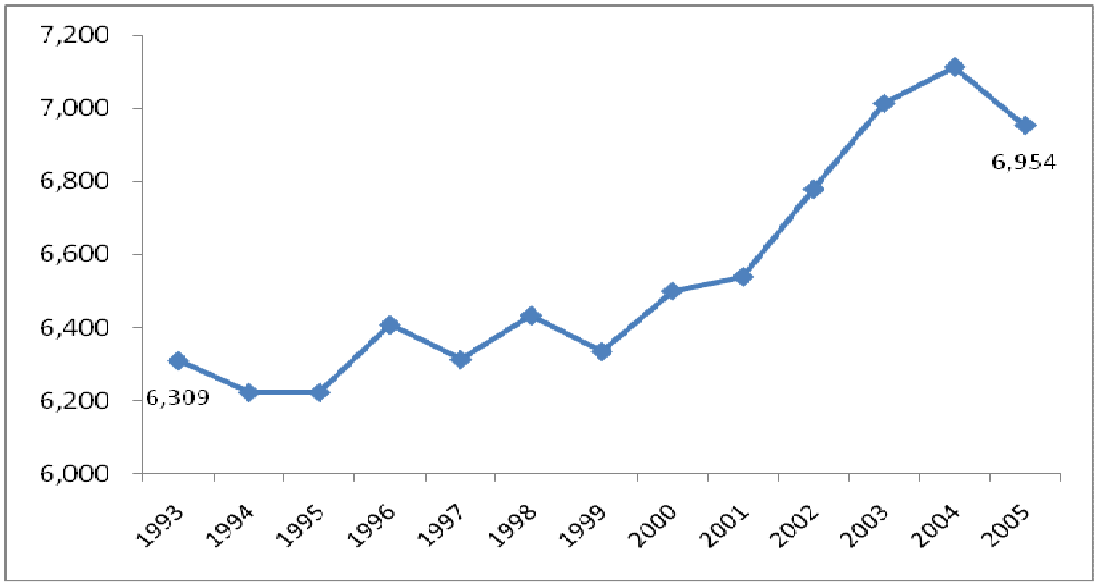
Data on cancer incidence are available from multiple sources, primarily pathological records, hospital discharges and death registrations from the GRO. This data is captured electronically, collated and quality assured on a regular basis to provide a population-based registry of cancer incidence for Northern Ireland.

The number of cancer cases (excluding non-melanoma skin cancer) by year of diagnosis is shown in figure 3.4. There is clear upward trend in the incidence of cancer over the time period with the total number of cases diagnosed increasing by 10%. The data is split further by Board in Table 3.11. It is not possible to make comparisons between Boards as only absolute numbers are provided so we have calculated the percentage change over the time period within each Board. EHSSB had the smallest increase in the number of cancer diagnoses at 5.5%, NHSSB had the highest increase at 14%.

The number of newly diagnosed cases of cancer has increased by 10.22% over the time period shown.

Figure 3.4

All newly diagnosed malignant cancers occurring between 1993 and 2005 excluding non-melanoma skin cancer



Source: Northern Ireland Cancer Registry

Table: 3.11

Incidence of all cancers (excluding non-melanoma skin cancer) by Board and year of Diagnosis: 1993-2005

HSSB Code	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	% change between 1993-05
EHSSB	2,772	2,739	2,755	2,870	2,779	2,830	2,697	2,779	2,752	2,843	2,930	2,965	2,924	5.48
NHSSB	1,491	1,532	1,471	1,533	1,532	1,513	1,517	1,612	1,655	1,672	1,774	1,841	1,700	14.02
SHSSB	1,095	1,048	1,008	1,047	1,080	1,079	1,147	1,094	1,081	1,194	1,240	1,223	1,224	11.78
WHSSB	890	870	940	910	892	990	935	960	987	997	1,015	1,034	1,005	12.92
Unknown	61	33	48	47	29	21	38	55	64	73	55	51	101	~
NI	6,309	6,222	6,222	6,407	6,312	6,433	6,334	6,500	6,539	6,779	7,014	7,114	6,954	10.22

Source: Northern Ireland Cancer Registry

Box 3.1: Incidence of cancer in Scotland

Approximately 13,100 males and 13,800 females were diagnosed with cancer (excluding non-melanoma skin cancer) in 2006. Over the last decade (1996-2006) the age-standardised incidence rate of cancer has fallen steadily in males (a 9% decrease) and decreased slightly in females (3% decrease). Lung cancer is the most common cancer overall, and is the most common cancer in males, but second most common cancer in females. The long-term decline seen in the incidence rate in males has continued, with a significant fall in the incidence rate of 23% over the ten-year period 1996-2006. Lung cancer incidence rates in females continue to increase, with a 5% increase over the same time period. To a large extent, these trends reflect historic trends in the prevalence of smoking, which have differed between men and women.

Source: IDS Scotland (2009): Statistical Publication Notice. Cancer Incidence 2006

Box 3.2: Incidence of cancer in England

There were around 245,300 new cases of cancer registered in England in 2007 (excluding nonmelanoma skin cancer). Compared with 2006, the number of registrations increased by around 1,570 cases in males, with a similar increase in females.

For males, the overall cancer incidence rates (after adjustment for age) fell slightly to 402 per 100,000 population in 2007, and for females rose slightly to 352 per 100,000; but within the expected range of year on year variation. The three most common cancer in males are prostrate, lung and colorectal and in females are breast, colorectal and lung. Together these account for just over half of all cancers.

Source: Office for National Statistics (2009): Health Statistics Quarterly, Winter 2009

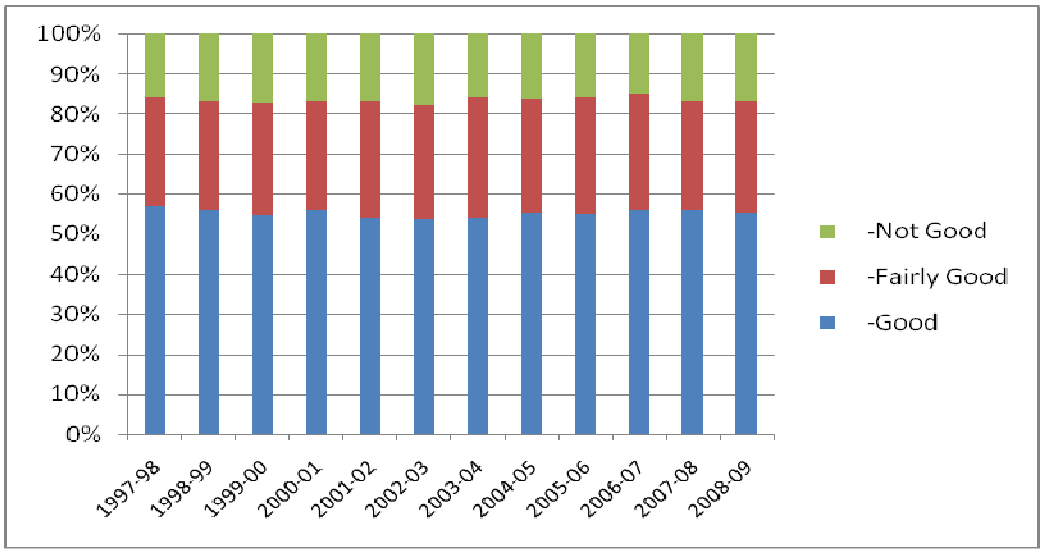
3.8 Self Reported General Health

Respondents to the Continuous Household Survey are asked to assess their levels of health as good, fairly good or not good. Figure 3.5 shows the percentages of all people reporting each level of health over the time period. The levels remain fairly constant over time with majority of people, over 50% each year, reporting their health as good, while less than 20% consider their health to be not good.

The percentage of people reporting their health as either good or not good are shown in figure 3.6 split by gender. Females are more likely to report their health as not good. The proportions of people reporting each level of health remains fairly constant over time for both genders.

Figure: 3.5

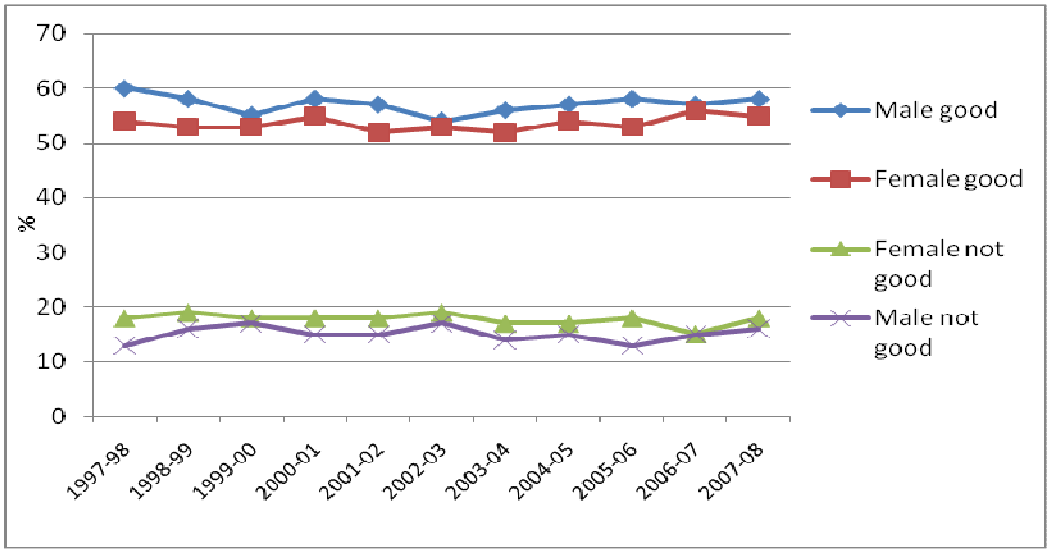
Self reported general health for all people



Source: Continuous Household Survey 2005/06

Figure: 3.6

Self reported general health by gender



Source: Continuous Household Survey 2005/06

Table 3.12

Percentage of people reporting a LLTI by Gross Household Income, 1998-99 to 2008-09

	1997-98	1998-99	1999-00	2000-01	2001-02	2002-03	2003-04	2004-05	2005-06	2006-07	2007-08	2008-09
All Persons												
Good	57	56	54	56	54	54	54	55	55	56	56	56
Fairly Good	27	27	28	27	29	29	30	28	29	29	27	28
Not Good	16	17	17	17	17	18	16	16	16	15	17	17
Males												
Good	60	58	55	58	57	54	56	57	58	57	58	57
Fairly Good	27	26	28	27	28	29	30	28	29	28	26	27
Not Good	13	16	17	15	15	17	14	15	13	15	16	16
Females												
Good	54	53	53	55	52	53	52	54	53	56	55	55
Fairly Good	28	28	29	27	29	28	31	28	29	29	27	29
Not Good	18	19	18	18	18	19	17	17	18	15	18	17

Source: Continuous Household Survey 2005/06

3.9 Summary

The aim of Goal 2 is to reduce inequalities in health between geographic areas, socio-economic and minority groups. Two targets were set, to reduce the gap in life expectancy and the incidence of longstanding illness for those living in the most deprived areas.

The gap in life expectancy between deprived areas and the NI average is forecast to be 3.6 years for men and 2.2 years for women by 2009-11. The baseline figures in 1998-00 were 3.1 and 2.5 years for men and women respectively. For men, the gap is forecasted to increase and for women it will remain largely unchanged. It is very unlikely that the target to halve the gap will be met.

The total number of people reporting a limiting long-term illness (LLTI) has remained at a similar level of approximately 25% between 1998-09. Women are more likely to report a LLTI than men. Women are also more likely report their health as not good. There is a clear link between income and probability of reporting a LLTI with those in the lowest income bands up to four times more likely to report a LLTI as those in the highest bands. Those who are

employed are least likely to report a LLTI and this level remains fairly constant over time while the economically inactive are more likely to report a LLTI.

4 APPENDIX 3: OBJECTIVE 1 – REDUCING POVERTY & SOCIAL EXCLUSION IN FAMILIES WITH CHILDREN

Objective 1 is "to reduce poverty and social exclusion especially in families with children" No high level targets were set for this objective at the time of drafting the strategy.

Northern Ireland Programme for Government (2008 - 2011). The accompanying public service agreements (PSA) reflect a specific focus on children and their families in poverty through PSA 7 'Making Peoples' Lives Better' objective 1 which commits to: *"Take forward action to provide for measurable reductions in the levels of poverty and particularly child poverty".*

The target in support of this PSA objective states the intention to: *"Work towards the elimination of poverty in Northern Ireland by 2020 and reducing child poverty by 50% by 2010".*

Table 4.1

Goal 3, Target1

Area	% of children in poverty
Baseline in 2003	26%
Target in 2010	<13%
Baseline (taken from Statistics & Research Branch, DSD)	

4.1 Household Income and Child Poverty

Household income is used as a proxy measure for 'child poverty'. A household is defined as having a low income (i.e. in poverty) if its income is less than 60% of the median UK household income.

The measure of Households Below Average Income (<60% of the GB Median) uses data collected in the Family Resources Survey (FRS) in Northern Ireland. The FRS is a cross-sectional household survey which collects income data on private households only across the UK. All the results therefore exclude people living in institutions. Household disposable incomes are adjusted for household size and composition, as a proxy for material living standards or, more precisely, for the level of consumption of goods and services that people could attain given the disposable income of the household in which they live. Information is usually presented on two bases: Before Housing Costs (BHC) and After Housing Costs (AHC). The data is available for the 2003 to 2006 period.

The percentage of households with below average outcome, both before and after housing costs, has remained around the same level of 20-22% over the time period. There has been no reduction in the percentage of households with below average incomes. The proportion

before housing costs has remained at 22% while the proportion after housing costs showed a decline of 4% between 2003 and 2005 before returning to 26% in 2006. A paper published by the Joseph Rowntree Foundation in September 2009 found that the proportion of children in low-income households (after housing costs) in 2007-08 remained at 26%[2].

The target for this objective is to half the number of children living in poverty by 2010. While this in not on target to being achieved, the number of children living in poverty has not increased between 2003 and 2008.

Table: 4.2

Proportion of households with below average incomes

		Percentage of Households with Incomes Less Than 60% of the UK Median		Percentage of Households with Children under 16 with Incomes Less Than 60% of the UK Median	
		Before Housing Costs	After Housing Costs	Before Housing Costs	After Housing Costs
2003-04	EHSSB	18	19	21	24
	WHSSB	28	26	25	28
	SHSSB	18	19	20	24
	NHSSB	21	20	24	26
	NI	20	20	22	26
2004-05	EHSSB	18	18	18	21
	WHSSB	26	26	26	30
	SHSSB	18	16	16	18
	NHSSB	25	25	26	27
	NI	21	21	21	24
2005-06	EHSSB	19	19	21	21
	WHSSB	27	30	28	32
	SHSSB	21	18	23	22
	NHSSB	20	17	16	17
	NI	21	20	21	22
2006-07	EHSSB	21	20	17	21
	WHSSB	25	24	29	34
	SHSSB	22	23	26	34
	NHSSB	23	18	22	22
	NI	22	20	22	26

Source: Households Below Average Income, Analytical Services Unit, DSD.

[2] Joseph Rowntree Foundation (2009): Monitoring Poverty and Social Exclusion in NI

Proportion of individuals in poverty in Scotland

The percentage of people living in poverty in Scotland in 2006-07 was 17%.

This is the percentage of people living below 60% of the median UK household income. The income measure used is equivalised net disposable income before housing costs. This is income from all sources (including earnings, benefits, tax credits, pensions, and investments) after deductions for income tax, national insurance contributions, council tax, pension contributions and maintenance payments but before deductions for housing costs such as rent and/or mortgage payments.

Source: Family Resources Survey 2006 (The Family Resources Survey is a sample survey including approximately 4,500 households in Scotland)

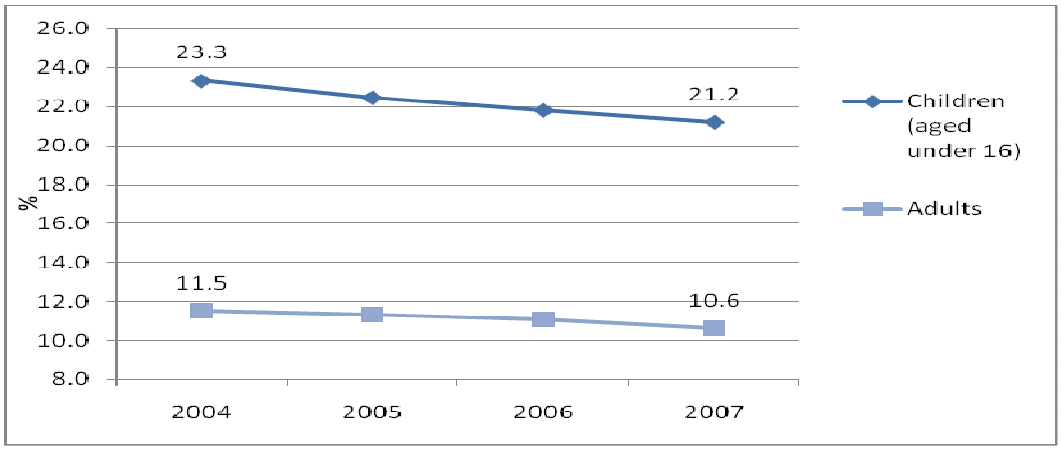
4.2 Income Support Households

Table 4.1 shows the percentage of children (ages under 16) and adults who live in households in receipt of Income Support (IS) over the period 2004 to 2007. The percentage of children and adults living in IS households in NI has decreased over this time by 2% and 1% respectively.

Analysis at Board level shows that the percentage of adults and children living in IS households has decreased over time in all areas. However, disparities between Board areas remain. In 2007 there were 11.5% more children living in IS households in WHSSB compared to NHSSB, this is only a 1% improvement on the 12.5% difference in 2004. The difference in the percentage of adults between WHSSB and NHSSB has only decreased by 0.4% (from 6.1% to 5.7%) over the same time period.

Figure: 4.1

Percentage of Children and Adults living in IS Households: NI



Source: Source: DSD, Social Welfare Statistics & Consultancy Branch (taken from Ninis)

Table: 4.1

Percentage of adults and Children (under 16) living in Income Support Households

		Percentage Children in IS Households	Percentage Adults in IS Households
2004	EHSSB	25.7	11.8
	NHSSB	17.0	8.8
	SHSSB	21.3	11.6
	WHSSB	29.5	14.9
	NI	23.3	11.5
2005	EHSSB	24.7	11.6
	NHSSB	16.5	8.6
	SHSSB	20.2	11.2
	WHSSB	28.7	14.8
	NI	22.5	11.3
2006	EHSSB	24.1	11.5
	NHSSB	16.0	8.4
	SHSSB	19.7	10.9
	WHSSB	27.7	14.4
	NI	21.8	11.1
2007	EHSSB	23.9	11.2
	NHSSB	15.4	8.0
	SHSSB	18.6	10.2
	WHSSB	26.9	13.7
	NI	21.2	10.6

Source: DSD, Social Welfare Statistics & Consultancy Branch (taken from Ninis)

4.3 Uptake of Pension Credit

Pension Credit was introduced in October 2003. This replaced Income Support for people age 60+. The data is provided for 2004 to 2008.

Table 4.3

Pension Credit Claimants

		PC Claimants Male 60-64	PC Claimants Male 65+	PC Claimants Female 60-64	PC Claimants Female 65+
2004	EHSSB	3,007	7,382	2,431	17,039
	NHSSB	1,916	4,997	1,327	10,217
	SHSSB	1,620	4,758	1,088	8,605
	WHSSB	1,668	4,637	1,201	7,468
	NI	8,211	21,774	6,047	43,329
2005	EHSSB	3,364	9,070	2,704	19,125
	NHSSB	2,084	6,187	1,478	11,565
	SHSSB	1,746	5,461	1,216	9,262
	WHSSB	1,842	5,265	1,311	7,973
	NI	9,036	25,983	6,709	47,925
2006	EHSSB	3,436	9,431	2,802	19,209
	NHSSB	2,039	6,454	1,498	11,667
	SHSSB	1,796	5,644	1,262	9,411
	WHSSB	1,848	5,445	1,374	7,973
	NI	9,119	26,974	6,936	48,260
2007	EHSSB	3,378	9,696	2,823	18,985
	NHSSB	2,020	6,577	1,501	11,643
	SHSSB	1,810	5,764	1,280	9,353
	WHSSB	1,916	5,547	1,401	7,932
	NI	9,124	27,584	7,005	47,913
2008	EHSSB	3,284	9,934	2,912	18,754
	NHSSB	1,952	6,802	1,529	11,630
	SHSSB	1,807	5,967	1,302	9,320
	WHSSB	1,919	5,488	1,412	7,779
	NI	8,962	28,191	7,155	47,483

Source: Social Welfare Statistics & Consultancy Branch, DSD

4.4 Job Seekers Allowance Claimants

The Claimant Count records the number of people claiming unemployment- related benefits. This has been used as a main indicator of labour market activity since the 1970's and figures are derived from records of claimants held at Social Security Offices. The term 'claimants' in the claimant count is used to include those who claim Jobseekers Allowance (JSA) and National Insurance credits. The figures include severely disabled claimants, but exclude students seeking vacation work and the temporarily stopped. The data is provided for 2005 to 2008.

Table 4.4 shows the number of claimants each year and as a percentage of the population. It shows that the percentage has remained unchanged over the time period.

Table: 4.4

Claimant count: annual averages

	Claimant Count All Persons	Claimant Count Percentage
2005	28,708	2.7
2006	27,950	2.6
2007	24,429	2.3
2008	27,860	2.6
Statistics Research Branch, DETI		

The percentage of unemployed people claiming benefits who have been out of work for more than one year is shown in table 4.5. Over the time period shown, the number of JSA claimants claiming for up to two years has fallen by 33.9% while the number claiming for more than two years has fallen by 45.4%.

Table: 4.5

JSA Claimants by Duration of Claim

	Totals						Percentage of all claimants					
Duration	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**
1 to under 2 years	4,820	4,195	3,495	3,580	N/A	3,185	14.7	14.9	12.7	13.7	~	9.7
2 years or over	4,670	3,955	3,650	3,300	N/A	2,550	14.2	14.1	13.2	12.7	~	7.8
Source: DSD (2008): JSA: summary of statistics												
The data is unavailable for 2007												

4.5 Supporting Employment

New Deal for 18-24 year olds and New Deal 25+ were introduced as part of the Government's Welfare to Work Initiative with the primary aim of helping unemployed adults find sustained employment. New Deal for 18-24 year olds is mandatory for those people aged 18 to 24 who have been unemployed and claiming JSA for a continuous period of 6 months or longer. New Deal 25+ is mandatory for those people aged 25+ who have been unemployed and claiming JSA for 18 months or longer, or for 18 months out of the last 21 months. The data is collected by the Jobcentres/Jobs and Benefits Offices and Training Organisations in NI and input into DELs Client Management System. Fujitsu provide Research and Evaluation Branch with a monthly download of this information for analysis.

The data for the percentage of people finding employment through New Deal 25+ from 2001 to 2007 is shown in table 4.6. The percentages have shown small variations within the range of 16-21% over the time period and have increased by 1.4% between 2001 and 2007.

Table 4.6

Percentage of People aged 25+ moving into Employment through New Deal

Year	Percentage of leavers moving into sustained unsubsidised employment through New Deal 25+
2001	19.6
2002	16.0
2003	18.4
2004	18.8
2005	17.3
2006	18.9
2007	21.0
Source: DEL	

4.6 Summary

The aim of Objective 1 is to reduce poverty and social exclusion especially in families with children. The target for this objective is to half the number of children living in poverty by 2010. While this in not on target to being achieved, the number of children living in poverty has not increased between 2003 and 2009 at 26%.

The percentage of children and adults living in households in receipt of Income Support in NI has decreased by 2% and 1% respectively between 2004 and 2007.

In term of long-term unemployment, the percentage of unemployed people claiming benefits who have been out of work for more than one year has been falling between 2005 and 2008. JSA claimants claiming for up to two years has fallen by 33.9% while the number claiming for more than two years has fallen by 45.4%.

5 APPENDIX 4: OBJECTIVE 2 – EDUCATION & SKILLS

Objective 2 is *"to enable all people and young people in particular to develop the skills and attitudes that will give them the capacity to reach their full potential and make healthy choices."*

5.1 Target i

In the 25% of primary schools with the highest percentage of free school meal entitlement (FSME) to reduce the proportion of pupils not achieving the expected level (level 4) at Key Stage 2 to 25% in both English and maths by 2005/06.

Table 5.1

Objective 2, Target 1

	English	Maths
Baseline 2000/01	40%	36%
Target 2005/06	25%	25%
Source: DHSSPS (2002): Investing for Health Strategy ***Baseline taken from Key Stage 2 results for 2000/01***		

Table 5.2 shows the percentage of pupils not achieving the expected level (Level 4 or above) in Key Stage 2 Assessments in the most disadvantaged primary schools (25% of schools with highest FSME) by Board for the academic year 2005-06.

The percentage of pupils achieving the expected level in Key Stage 2 English in 2005-06 was 30.5%, this was 4.5% short of the target. The percentage achieving the expected level in Maths was 4.9% short of the target.

Table: 5.2

Percentage of primary pupils not achieving the expected level in Key Stage 2, 2005-06

	Percentage of pupils not achieving Maths Key Stage 2 Level 4+	Percentage of pupils not achieving English Key Stage 2 Level 4+
EHSSB	35.9	39.9
NHSSB	33.7	35.5
SHSSB	24.8	27
WHSSB	23.8	24.2
NI	30.5	32.9
Source: Statistics and Research Branch, DE		

5.2 Target ii

In the 25% of secondary schools with the highest percentage FSME, to reduce the proportion of year 12 pupils achieving no GCSEs to 5% by 2005/06.

Table 5.3: Objective 2, Target 2

Number of preschool pupils by Board

	% Achieving no GCSEs
Baseline 2000/01	8.5%
Target 2005/06	5%
Source: DHSSPS (2002): Investing for Health Strategy ***Baseline taken from Summary of Annual Examination Results 1999/2000***	

Table 5.4 shows the percentage of year 12 pupils in most the disadvantaged secondary schools (the 25% with highest FSME) who gained at least one GCSE and those who achieved no GCSEs in the academic year 2006-07. The target was to reduce the level of pupils in the most disadvantaged schools who achieve no GCSEs to 5% by 2005-06. This target had been achieved by 2006-07.

Table: 5.4

GCSE performance of pupils in the most disadvantaged schools, 2006-07

	% achieving no GCSEs	% achieving 1+ GCSEs
EHSSB	5.50	94.50
NHSSB	5.96	94.04
SHSSB	4.17	95.83
WHSSB	3.63	96.37
NI	4.8	95.2
Source: Department of Education Statistics and Research Branch		

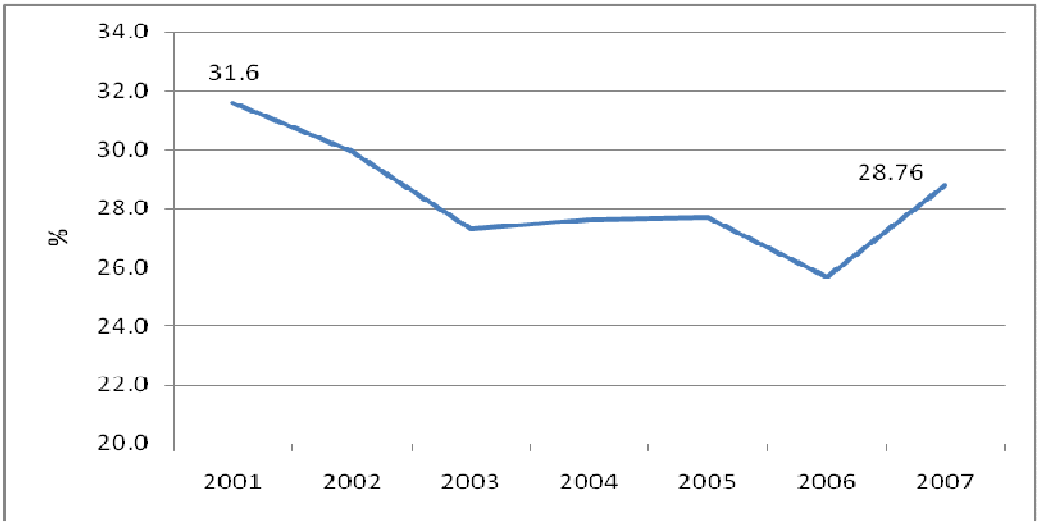
5.3 Percentage of people aged 18-24 finding employment through New Deal

New Deal for 18-24 year olds was introduced as part of the Government's Welfare to Work Initiative with the primary aim of helping unemployed adults find sustained employment. New Deal for 18-24 year olds is mandatory for those people aged 18 to 24 who have been unemployed and claiming Jobseeker's Allowance (JSA) for a continuous period of 6 months or longer. The data is obtained on a monthly basis from DELs Client Management System (CMS).

Figure 5.1 shows the percentage of 18-24 year olds finding sustained employment through New Deal for the 2001-07 period. A participant is considered to have sustained employment if they remain in the same spell of employment for 13 weeks or more. The proportion of young people finding employment through New Deal 18-24 shows a downward trend over the time period.

Table: 5.1

Percentage finding sustained employment through New Deal 18-24



Source: Department for Employment and Learning

Table: 5.5

Percentage finding sustained employment through New Deal 18-24

NI	Percentage of leavers moving into sustained unsubsidised employment through New Deal 18 to 24
2001	31.6
2002	29.9
2003	27.3
2004	27.6
2005	27.7
2006	25.6
2007	28.76
Source: Department for Employment and Learning	

5.4 Provision & uptake of pre-school education

Table 5.6 shows the number of children attending the three different types of preschool from 2004-05 to 2008-09. This information is collected through the annual school census exercise, returns are provided from each school. The dataset is gathered annually at a specified date in early October.

Table: 5.6

Number of preschool pupils by Board

	Nursery class	Nursery school	Reception class	Total
2004-05	7895	6121	883	14,899
2005-06	8049	6175	754	14,978
2006-07	8105	6053	658	14,816
2007-08	~	5855	630	6,485
2008-09	8226	5869	607	14,702

Source: DE

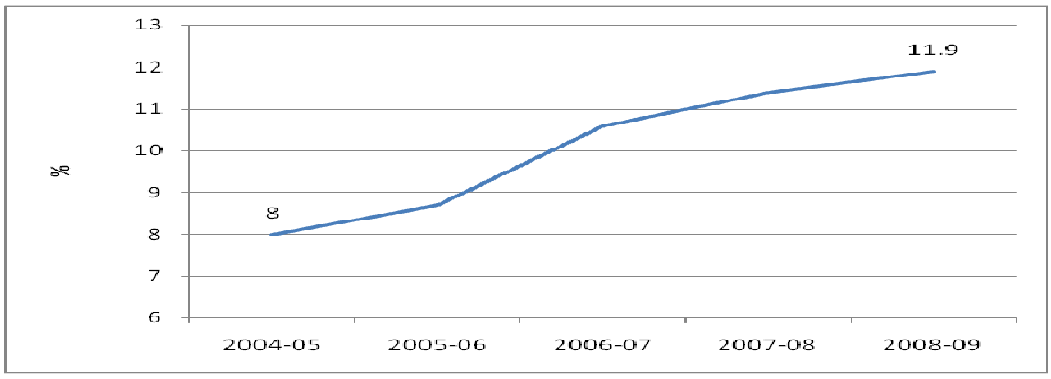
~ Nursery class enrolment figures are unavailable for 2007-08

5.5 Post-Primary Special Needs Education

Figure 5.2 shows the percentage of pupils in mainstream secondary schools with special education needs from 2004-05 to 2008-09. This information is collected through the annual school census exercise, returns are provided from each school. The dataset is gathered annually at a specified date in early October. The proportion of secondary pupils with special education needs has increased over time from 8% in 2004-05 to 11.9% in 2008-09.

Figure: 5.2

Percentage of post-primary with special education needs in mainstream schools



Source: DE

Table: 5.7

Percentage of post-primary with special education needs in mainstream schools

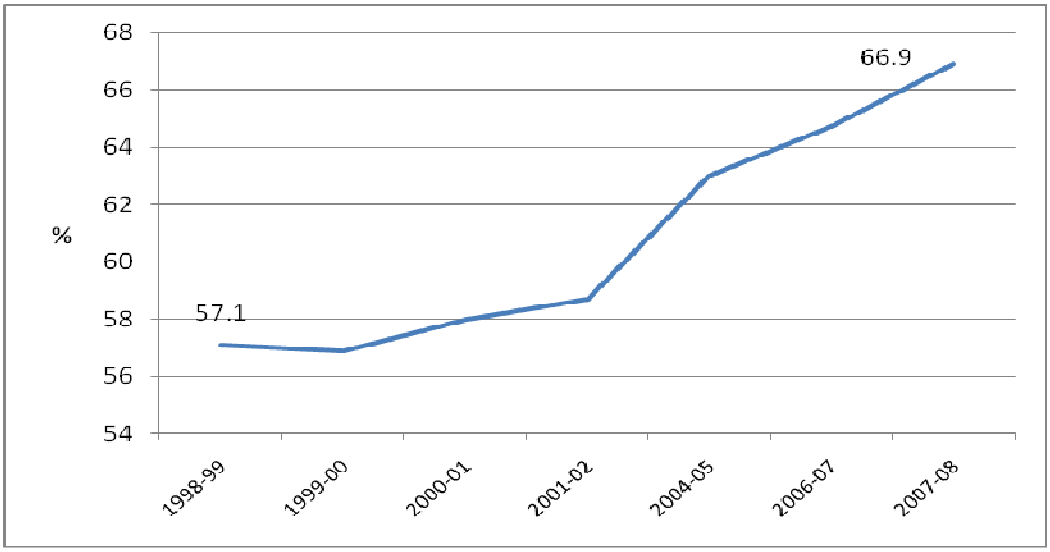
Year	% of pupils at SEN stage 1-4
2004-05	8
2005-06	8.7
2006-07	10.6
2007-08	11.4
2008-09	11.9
Source: DE	

5.6 GCSE Performance

Figure 5.3 shows the percentage of school leavers who pass at least 5 GCSEs (i.e. achieve a grade A* to C) from 1998-99 and 2007-08. The data comes from the School Leavers Survey and is gathered annually in November. It shows that the majority of school leavers achieve at least 5 GCSE passes. The percentage who achieve this has been increasing over time form 57% in 1998-99 to 67% in 2007-08.

Figure: 5.3

Percentage of school leavers achieving 5+ GCSEs at grades A* to C



Source: Statistics and Research Branch, DE

Table: 5.8

Percentage of school leavers achieving 5+ GCSEs at grades A* to C

NI	Percentage Achieved At Least 5 GCSE's grades A*-C (or equiv)
1998-99	57.1
1999-00	56.9
2000-01	58
2001-02	58.7
2004-05	63
2006-07	64.7
2007-08	66.9
Source: Statistics and Research Branch, DE	

5.7 No/Low Levels of Qualification

Table 5.9 shows the percentage of the population who have no/low levels of qualifications. A 'low level' of qualification is considered to be NVQ level 2 or equivalent or below.

Table: 5.9

Proportion of working age adults (aged 25-59) with no or low levels of qualifications (NVQ level 2 or equivalent)

	No qualifications	Level 1	Level 2	% Population with no/low levels of qualifications
EHSSB	107598	59608	45283	54.5
NHSSB	78976	40883	31584	59.6
SHSSB	60180	27165	21686	61.2
WHSSB	57601	23992	17503	63.6
NI	304355	151648	116056	58.6
Source: Census 2001				

Box 5.1: Low or no qualifications levels in Scotland

The percentage of working age people with low or no qualifications in 2007-08 was 14.8%. **T**his is defined as working-aged people (16-59/64 yrs) with no qualifications or qualifications at SCQF level 4 or lower.

Source: Scottish National Statistics

5.8 Further Education

Figure 5.4 shows the number of students enrolled in further education (FE) in NI. The information is data derived from the Further Education Statistical Record, a computerised return consisting of an individual record for each enrolment on a vocational course in NI FE Institutions. The dataset is gathered annually at the 1st November. The overall level has increased over time by 62,670 to a total of 142,100 in 2007-08. The proportion of females in FE is higher than males.

Figure 5.5 shows the number of FE enrolments by age group. The level of enrolments increased for all age groups over the time period. The under 19 age group has the highest representation followed by mature students aged 26 and over. Figure 5.6 shows the number of students enrolled on a full- and part-time basis. The number of full-time students has stayed a similar level over the time period. However, the number of part-time students has shown a steep incline over time.

Figure: 5.4

Number of students enrolled in FE by gender

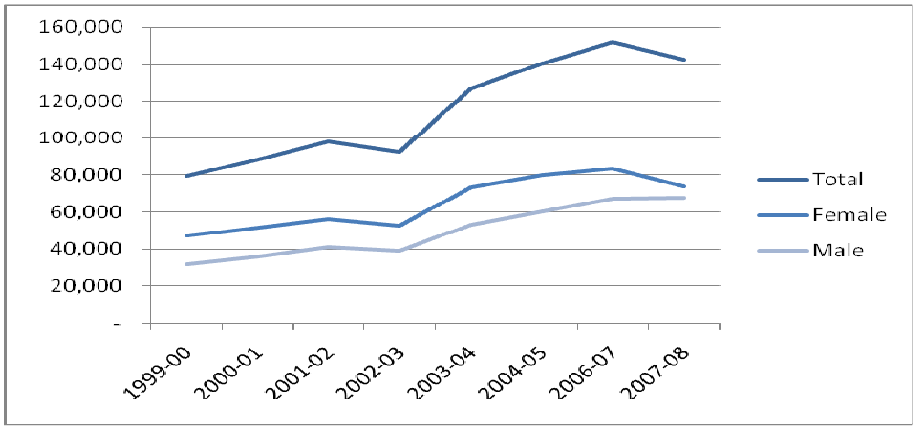


Figure: 5.5

Number of students enrolled in FE by age

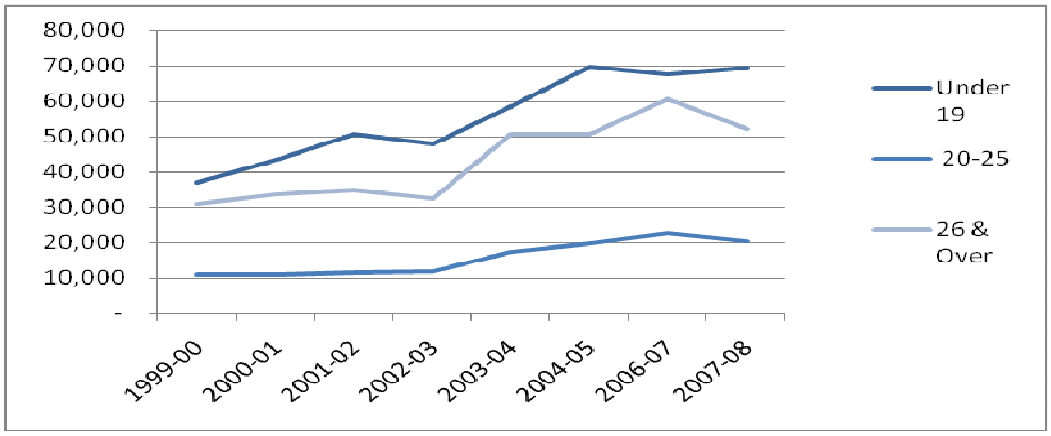
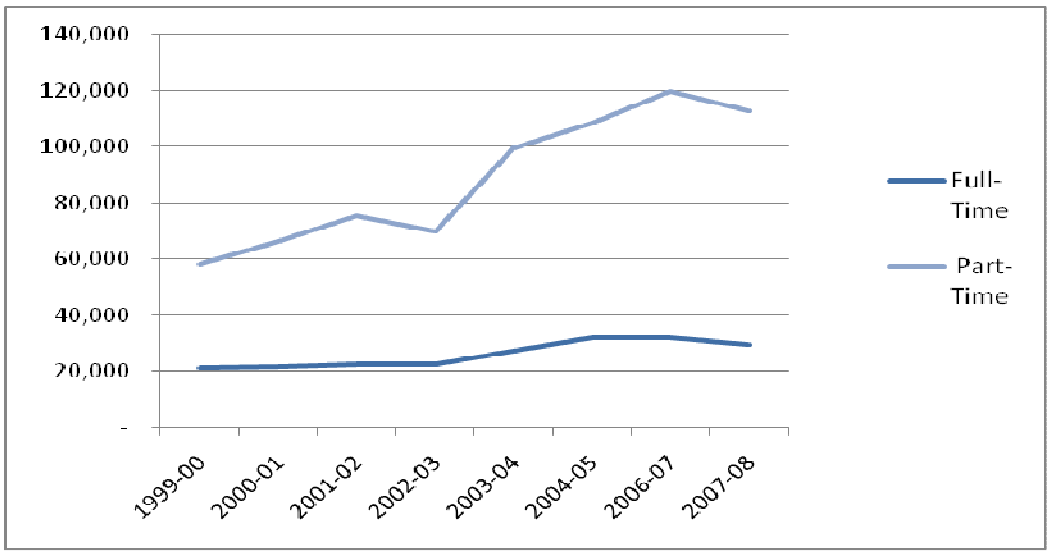


Figure: 5.10

Number of students enrolled in pattern of study



Source: Department for Employment and Learning (taken from NINIS)

Table: 5.10

Number of students enrolled in FE colleges by gender, age and pattern of study

NI	No of Students at FE College	No of Female students	No of Male students	Students aged Under 19	Students aged 20-25	Students aged 26 & Over	No of Full-Time students	No of Part-Time students
1999-00	79,430	47,272	32,158	36,937	11,080	31,096	21,162	58,268
2000-01	88,317	52,035	36,282	43,207	11,015	33,665	21,783	66,534
2001-02	97,781	56,523	41,258	50,600	11,569	35,069	22,554	75,227
2002-03	92,405	52,986	39,419	47,812	11,896	32,697	22,528	69,877
2003-04	126,755	73,462	53,290	58,468	17,529	50,758	27,149	99,606
2004-05	140,265	79,820	60,445	69,733	19,866	50,666	31,841	108,424
2006-07	151,288	83,572	67,716	67,684	22,960	60,644	31,666	119,622
2007-08	142,100	74,119	67,981	69,476	20,462	52,162	29,213	112,887

Source: Department for Employment and Learning (taken from NINIS)

5.9 Higher Education

Figure 5.11 shows the number of students enrolled in higher education from 1999-00 to 2007-08. The information refers to NI domiciled students enrolled at higher education institutions (HEIs) in the UK. The dataset is collected annually by the Higher Education Statistical Agency and is based on enrolments in UK higher education institutions on 1st December each year. The dataset is then provided to DEL for analysis. Figures have been rounded to the nearest five. Due to rounding the sum of numbers may not match the total shown.

The number of students enrolled in HEIs has increased slightly over time by both sexes. There are more females enrolled in HEIs than males. Figure 5.12 shows the number of students enrolled by age group. The level of enrolments has increased for all age groups over the time period, there was a sharp increase in the number of 25 and over enrolments between 2001-02 and 2004-05. The under-20 age group account for the largest proportion of enrolments.

Figure: 5.11

Number of students enrolled in HEIs by gender

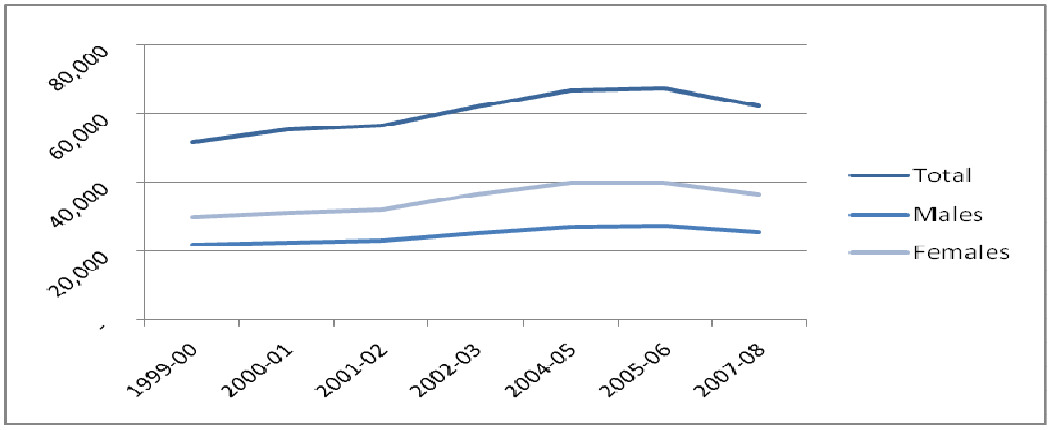


Figure: 5.12

Number of students enrolled in FE by age

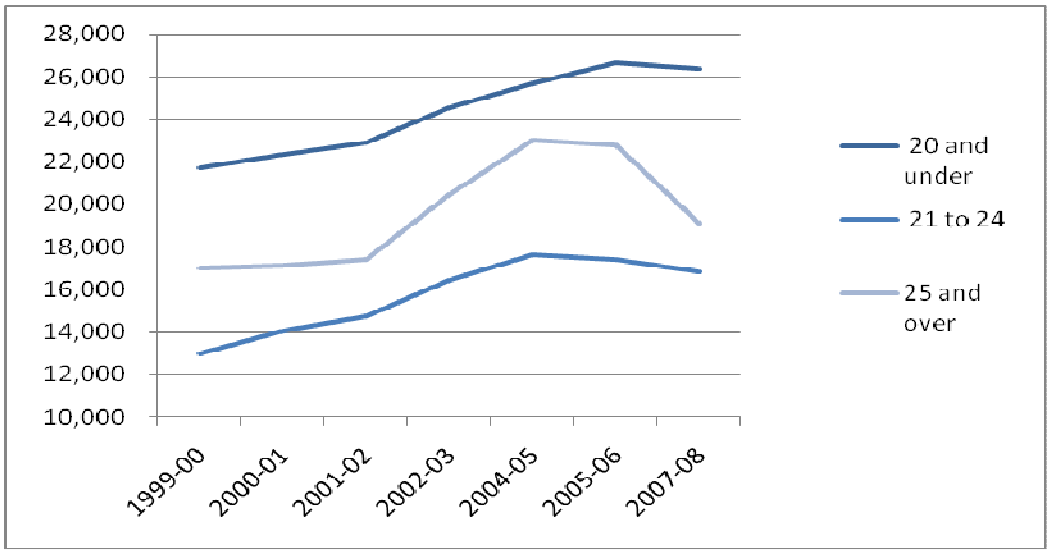


Table: 5.11

Number of students enrolled in HEIs by gender, age and pattern of study

NI	Total enrolments at HE	Students aged 20 and under	Students aged 21 to 24	Students aged 25 and over	Number of Males	Number of Females
1999-00	51,989	21,701	12,954	17,002	21,864	30,125
2000-01	55,467	22,304	14,031	17,103	22,397	31,323
2001-02	56,633	22,870	14,717	17,409	23,181	32,121
2002-03	61,918	24,528	16,454	20,473	25,409	36,509
2004-05	6,830	25,661	17,621	23,032	26,980	39,850
2005-06	67,289	26,618	17,405	22,808	27,436	39,853
2007-08	62,300	26,315	16,830	19,110	25,575	36,725
Source: Department for Employment and Learning (taken from NINIS)						

Box 5.2: Destination of school leavers: Scotland

- Percentage of leavers from publicly funded secondary schools going to Further Education 2007-08: 24.8%
- Percentage of leavers from publicly funded secondary schools going to Higher Education 2007-08: 31.3%
- Percentage of leavers from publicly funded secondary schools going into training 2007-08: 4.9%
- Percentage of leavers from publicly funded secondary schools going into Employment 2007-08: 25.6%

Source: Skills Development Scotland (the data relate to the latest known destination of leavers in the September of the school year after they left)

5.10 Summary

The aim of Objective 2 is to enable all people and young people in particular to develop the skills and attitudes that will give them the capacity to reach their full potential and make healthy choices. The targets related to educational performance of children in schools with the highest free school meal entitlement (FSME).

The first target of reducing the proportion of pupils not achieving the expected level at Key Stage in English and maths by 2005-06 was not met. The percentage of pupils achieving the expected level in Key Stage 2 English in 2005-06 was 30.5%, this was 4.5% short of the target. The percentage achieving the expected level in Maths was 4.9% short of the target. The target to reduce the proportion of year 12 pupils in the most disadvantaged schools achieving no GCSEs by 2005/06 was achieved. The data also showed that the proportion of mainstream secondary school pupils with special education needs has increased over time from 8% in 2004-05 to 11.9% in 2008-09.

The data relating to education uptake following school leaving age is positive. The majority of all school leavers achieve at least 5 GCSE passes (grade A* to C) and this has been increasing over time form 57% in 1998-99 to 67% in 2007-08. The level of enrolments in higher education and further education has increased over the time period 1999 to 2008. However, the percentage of 18-24 year olds finding sustained employment through New Deal has shown a downward trend over the time period 2001-07.

6 APPENDIX 5: OBJECTIVE 3 – PROMOTE MENTAL HEALTH AND EMOTIONAL WELL BEING

Objective 3 is *"to promote mental health and emotional wellbeing at individual and community level".*

6.1 Target i

Target i is to reduce the proportion of people with a potential psychiatric disorder (as measured by the GHQ-12 score) by a tenth by 2010.

Table 6.1

Objective 3, Target 1

	% with potential psychiatric disorder
2001	21%
Target 2010	19%
Source: DHSSPS (2002): investing for Health Strategy Baseline: Health and social wellbeing survey 2001	

Table 6.2 shows the percentage of adults aged 16+ with a potential psychiatric disorder. This is measured by the GHQ12 score, which is a widely used set of questions called the General Health Questionnaire used to identify the possible existence of a mental health problem such as depression. All data comes from the 2001 and 2005/06 Health and Social Well Being Survey conducted by the Central Survey Unit. The survey is based on a random sample of 5,000 private addresses in Northern Ireland. The 2005-06 data has large sampling errors so we have used the NI figures.

The proportion of adults with a potential psychiatric disorder in 2006 was 19%, which was the target set by the IfH strategy. The target in this area is therefore on track to being achieved within the planned timeframe.

Table 6.2 also shows the percentage of adults aged 16 and over stating they were depressed. The proportion had fallen from 21% in 2001 to 19% in 2006. The 2001 Health and Social Well Being Survey asked respondents about the effect of the troubles on their lives and the lives of their immediate family, 9% felt hat they had been affected a lot.

6.2 Adults with Potential Psychiatric Disorders

Table: 6.2

Proportion of adults with potential psychiatric disorder, depressed and citing troubles as a factor

	NI Proportion of adults (16+) with a potential psychiatric disorder	Proportion of adults (16+) who have stated they are depressed	Proportion of adults (16+) who state that the "troubles" have affected their lives and the lives of their immediate family a lot
2001	21	21	9
2006	19	19	~
Source: Health and Social Well Being Survey 2001 & 2005/06 (taken from NINIS) ***~ data for 2006 not available***			

Table 6.3 shows the percentage of people who are on prescribed drugs for mood and anxiety disorders for the period 2004 to 2008. The number of individuals suffering from mood or anxiety disorders is estimated using prescription data by GP practice for anxiolytic (a drug used for the treatment of symptoms of anxiety) and anti-depressant drugs. The proportion of people prescribed medication for these conditions has increased each year by a total of 2.2% from 2004 to 2008.

Table: 6.3

Percentage on prescribed drugs for mood and anxiety disorders

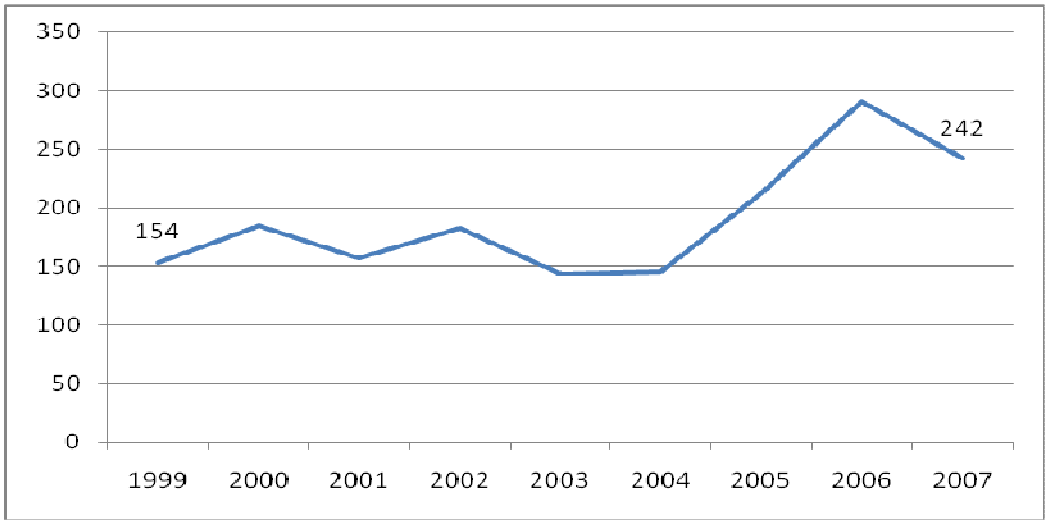
Year	Percentage on Prescribed Drugs for Mood and Anxiety Disorders
2004	9.2
2005	9.2
2006	9.7
2007	10.4
2008	11.4
Source: DHSSPS (taken from NINIS)	

6.3 Deaths from Suicide

Figure 6.1 shows the number of deaths from suicide and undetermined intent from 1999 to 2007. This information is aggregated data from the GRO death files, which are gathered when deaths are registered at the Registrar's Office. The dataset is gathered annually in December. The number of death has been increasing over time with a steep increase from 2004 to 2006.

Figure: 6.1

Deaths from suicide and undetermined intent



Source: GRO (taken from Ninis)

Table: 6.4

Deaths from suicide and undetermined intent

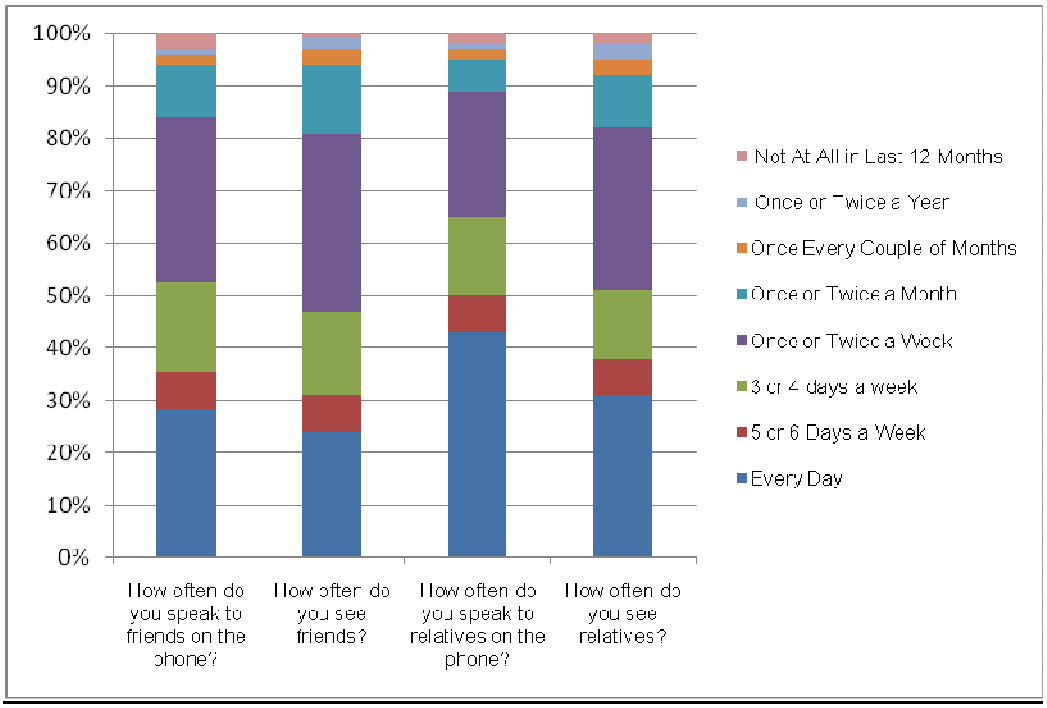
NI	Deaths from suicide and undetermined intent
1999	154
2000	185
2001	158
2002	183
2003	144
2004	146
2005	213
2006	291
2007	242
Source: GRO (taken from NINIS)	

6.4 Social capital - Networks with Friends and Relatives

Figure 6.2 shows how often respondents to the Continuous Household Survey 2005-06 have contact with friends and family. The data is based on a systematic random sample of 4,500 addresses in NI. Frequency of contact with friend and relatives is an important measure of a person's health and wellbeing. The vast majority of people, over 90%, see or speak to friends/relatives more than once a month. Over 80% of people see friends or relatives more than once a week.

Figure: 6.2

Frequency of contact with friends/relatives



Source: Continuous Household Survey 2005/06

Table: 6.5

Frequency of contact with friends/relatives

%	Every Day	5 or 6 Days a Week	3 or 4 days a week	Once or Twice a Week	Once or Twice a Month	Once Every Couple of Months	Once or Twice a Year	Not At All in Last 12 Months
How often do you speak to friends on the phone?	28	7	17	30	10	2	1	3
How often do you see friends?	24	7	16	35	14	3	2	1
How often do you speak to relatives on the phone?	43	7	15	24	6	2	1	2
How often do you see relatives?	31	7	13	31	10	3	3	2
Source: Continuous Household Survey 2005/06								

6.5 Summary

The aim of Objective 3 is to promote mental health and emotional wellbeing at individual and community level. The target is to reduce the proportion of people with a potential psychiatric disorder (as measured by the GHQ-12 score) by a tenth by 2010. This target is on track to being met as the proportion of adults with a potential psychiatric disorder in 2006 was 19%, which is a decrease of 3% on the 2001 baseline figure. The percentage of adults aged 16 and over stating they were depressed also fell from 21% in 2001 to 19% in 2006. The vast majority of people, over 90%, see or speak to friends/relatives more than once a month and over 80% of people see friends or relatives more than once a week. This is encouraging as social contact is an important measure of a person's health and wellbeing.

However, the data on the percentage of people who are on prescribed drugs for mood and anxiety disorders has increased by 2.2% from 2004 to 2008 and the number of deaths from suicide and undetermined intent has been increasing over time.

7 APPENDIX 6: OBJECTIVE 4 – THE LIVING AND WORKING ENVIRONMENT

Objective 4 is *"to offer everyone the opportunity to live and work in a healthy environment and to live in a decent affordable home".*

7.1 Target i

Target i is to life at least 20,000 households out of fuel poverty by December 2004.

Table 7.1

Objective 4, Target 1

	No of homes at risk of fuel poverty
Baseline 1995-98	170,000
Target Dec 2004	< 150,000
Source: DHSSPS (2002): Investing for Health Strategy Baseline taken from the NI Family Expenditure Survey	

Table 7.2 shows the number and percentage of households in fuel poverty. The information was collected through the 2004 Northern Ireland Interim Housing Condition Survey. The 2004 Northern Ireland Interim House Condition Survey was based on a stratified random disproportionate sample of 3,000 (300 properties were selected for 10 different areas across Northern Ireland).

The sample was drawn from the sampling database held at NISRA and was stratified by NAV, to reflect the fact that properties in poor condition tend to be concentrated in lower NAV bands. The process of weighting and grossing ensured that the final figures corrected for the disproportionate stratification and reflected the actual housing stock in NI in 2004. Almost 2,300 inspections were successfully carried out giving an overall response rate of 76%.

The number of households in NI estimated to be in fuel poverty in 2004 was 153,530. This is a 9.7% decrease on the baseline figure. The target to reduce the number of homes in fuel poverty to below 150,000 was therefore not met, but only by a small number. Also to be taken into consideration is the global rise in fuel prices that occurred in the first half of the decade – This which impacted greatly on the incidence of fuel poverty.

Table: 7.2

Households in fuel poverty

2006	In Fuel Poverty No.	In Fuel Poverty %
Northern Ireland	153,530	23.9%
Source: Northern Ireland Interim Housing Condition Survey 2004		

7.2 Target ii

Target ii is to support housing providers, over the 2 year period April 2002 to March 2004, to build around 2,400 lower cost, affordable homes for people on lower incomes.

Table 7.3

Objective 4, Target 2

	New lower cost homes built
Baseline 2002	–
Target 2004	+ 2,400
Source: DHSSP (2002): Investing for Health Strategy Baseline taken from NIHE The NI Housing Market, Review and Perspectives	

Table 7.4 shows the number of new dwellings that are being built by housing associations. Data on housing association starts are provided by Housing Associations Branch (DSD).

The target to build 2,400 lower cost, affordable homes by 2004 was not met as the total number of housing association starts in 2003 and 2004 was 1,806.

Table: 7.4

New dwelling starts by housing associations

NI	New Dwelling Starts Housing Associations
2003	673
2004	1,133
2005	1,044
2006	1,229
2007	732
2007-08	1,167
2008-09	863
Source: ***2007: District Council Building Control Offices and Housing Associations Branch (DSD) through the Department for Regional Development*** ***2007-08, 2008-09: District Council Building Control Offices and Northern Ireland Housing Executive***	

7.3 Household Fuel Source

Table 7.5 shows the number and percentage of homes that are dependent on solid fuel or electricity as a source of central heating. The total number of homes in NI dependent on solid fuel or electricity has more than halved over the period from 2001 to 2006, falling from 22.6% to 9.9%.

Table: 7.5

Percentage of homes dependent on solid fuel or electricity as source of central heating

Year	Area	Central heating solid fuel boiler AND electricity: number	Central heating solid fuel boiler OR electricity Percentage
2001	Eastern	62,910	9.7
	Northern	38,070	5.9
	Southern	25,900	4.0
	Western	19,430	3.0
	Northern Ireland	**146,310**	**22.6**
2006	Eastern	28,340	4.0
	Northern	17,070	2.4
	Southern	14,580	2.1
	Western	9,820	1.4
	Northern Ireland	**69,810**	**9.9**

Source: Research Unit Northern Ireland Housing Executive

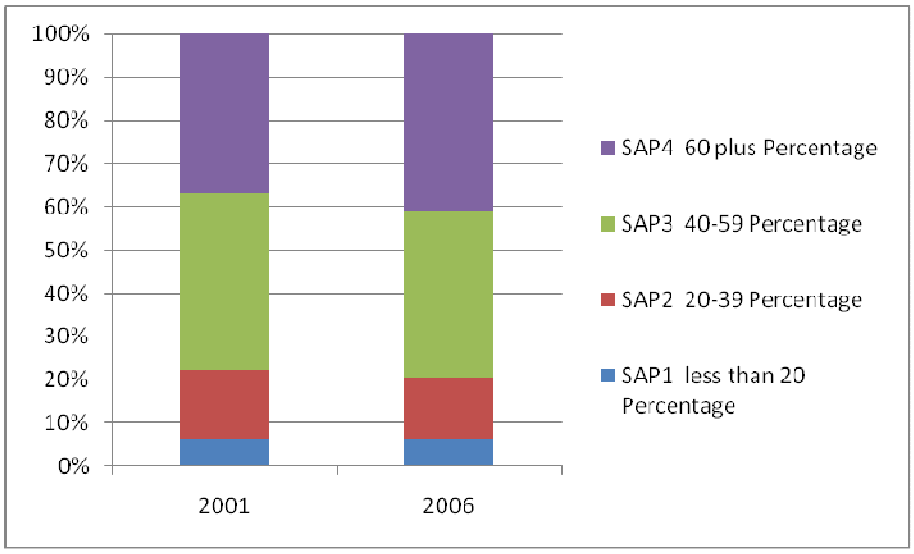
7.4 Energy Efficiency of Dwellings

Figure 7.1 shows the energy efficiency of dwellings using the Standard Assessment Procedure (SAP). This is the Government's recommended system for energy rating of dwellings. The procedure produces the SAP rating, on a scale from 1 to 120, based on the annual energy costs for space and water heating. The higher the SAP rating, the more energy efficient the building.

There has been little change in the energy efficiency of buildings between 2001 and 2006. At the lowest end of the energy efficiency scale there has been no change over time, dwellings with a SAP rating of 20% or less accounted for 6.5% in 2001 and 2006. The proportion of buildings with the highest energy efficiency rating, SAP 60+, increased slightly from 37% in 2001 to 41% in 2006.

Figure : 7.1

Energy efficiency of dwellings



NIHE House Condition Survey 2001 & 2006

Table: 7.6

Energy efficiency of dwellings

	SAP1 less than 20 Percentage	SAP2 20-39 Percentage	SAP3 40-59 Percentage	SAP4 60 plus Percentage
2001	6.4	15.9	41.0	36.7
2006	6.5	14.1	38.5	40.9
NIHE House Condition Survey 2001 & 2006				

7.5 Summary

The aim of Objective 4 is to offer everyone the opportunity to live and work in a healthy environment and to live in a decent affordable home. Targets were set to reduce fuel poverty and to increase the number of lower cost, affordable homes.

The number of people in fuel poverty decreased by 9.7% between the baseline measurement at 1995-98 and 2004. Although this was 3,530 households short of the target, this was largely impacted upon by the global increase in fuel prices. Encouragingly, the total number of homes dependent on solid fuel or electricity has more than halved over the period from 2001 to 2006, falling from 22.6% to 9.9%. There have been some improvements in the energy efficiency of buildings as the proportion of buildings with the highest energy efficiency rating, SAP 60+, increased from 37% in 2001 to 41% in 2006. However, there has been little improvement in the proportion of buildings at the lowest end of the energy efficiency scale.

The target to build 2,400 lower cost, affordable homes by 2004 was also not met as the total number of housing association starts in 2003 and 2004 was 1,806. However, his was only a shortfall of 594.

8 APPENDIX 7: OBJECTIVE 5 – NEIGHBOURHOODS AND WIDER ENVIRONMENT

Objective 5 is "*to improve our neighbourhoods and wider environment*".

8.1 Target i

Target i is to reduce levels of respiratory and heart disease by meeting the health-based objectives for the 7 main air pollutants by 2005.

Table 8.1

Objective 5, Target 1

Pollutant	Baseline 2000		Target Dec 2005
	Concentration	Measured as	
Sulphur dioxide	350 µg /m^3 Not to be exceeded more than 24 times a year	I hour mean	1 hour mean of 350 µg /m^3 not to be exceeded more than 24 times a year
Benzene	16.25 µg /m^3 (5ppb)	Running annual mean	Running annual mean to be less than 16.25 µg /m^3
1,3-Butadiene	2.25 µg /m^3 (1ppb)	Running annual mean	Running annual mean to be less than2.25 µg /m^3
Carbon monoxide	11.6mg/m^3 (10ppm)	Running 8 hour mean	Running 8 hour mean to be less than 11.6mg/m^3
Lead	0.5 µg /m^3	Annual mean	Annual mean to be less than 0.5 µg/m^3
Nitrogen dioxide	200 µg /m^3 (105ppb) not to be exceeded more than 18 times per year	1 hour mean	200 µg /m^3 (105ppb) not to be exceeded more than 18 times per year
Particles (PM10)	50 µg /m^3 Not to be exceeded more than 35 times a year	24 hour mean	24 hour mean of 50 µg /m^3 not to be exceeded more than 35 times a year
Source: DHSSPS (2002): Investing for Health Strategy Baseline taken from UK National Air Quality Information Archive			

Table 8.2

Air quality monitoring in NI 2004

Pollutant	Result at December 2004	Target met
Sulphur dioxide	No sites recorded any incidences of exceeding the 1-hour mean objective of 350 µg m-3.	Yes
Benzene	No sites recorded any incidences of exceeding the running annual mean of 16.25 µg /m^3	Yes
1,3-Butadiene	No sites recorded any incidences of exceeding the running annual mean of 2.25 µg /m^3	Yes
Carbon monoxide	No sites recorded any incidences of exceeding the 8 hour mean of 11.6mg/m^3	Yes
Lead	annual mean ambient lead concentrations were below 0.5 µg /m^3	Yes
Nitrogen dioxide	Only one site, Belfast Westlink, exceeded the hourly mean of 200 µg /m^3 more than 18 times	No
Particulate Matter (PM10)	Four sites exceeded the AQS Objective of 50 µg m-3 (gravimetric equivalent) for the 24-hour mean, on more than the permitted 35 occasions: these were Ballymoney, Belfast Westlink, Newry Trevor Hill, and Strabane.	No
Source: DOE (2005): Air quality monitoring in NI 2004		

The objective 5 target to reduce the concentrations of the seven main air pollutants by 2005 was not achieved. The margin by which it failed was small and considerable improvements had been made over the time period. Only two of seven air pollutants failed to meet their targets and of these, the Nitrogen Dioxide target was exceeded at only one of its fifteen measurement sites.

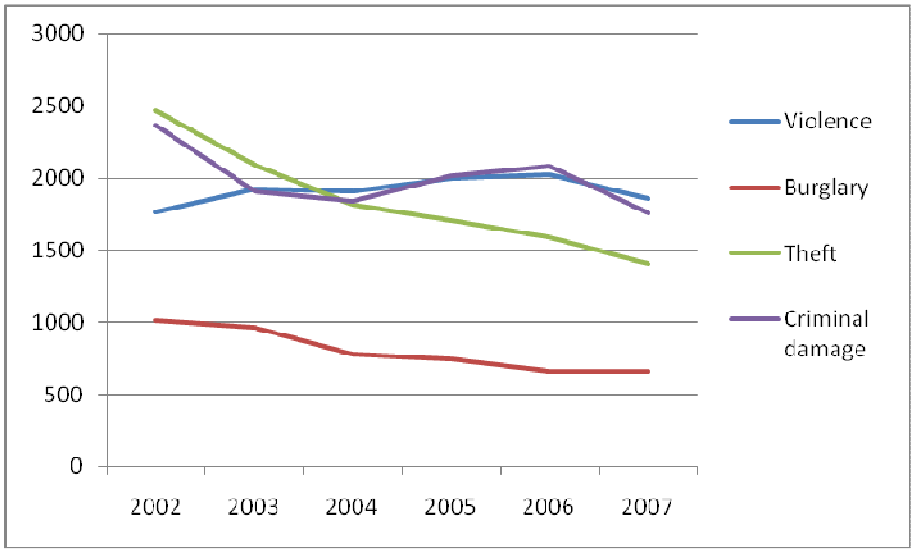
8.2 Crime

Figure 8.1 shows the crime rates per 100,000 persons for the period from 2002 to 2007. This information is compiled from crime forms that are submitted by police officers and entered onto a PSNI crime recording system, datasets are produced on a financial year basis. The data is then extracted and merged with the CPD, and aggregated information forwarded to Ninis.

The rates of burglary and theft have decreased over the time period by 34% and 43% respectively. The rate of violence increased year-on-year to 2006 and then declined. Similarly, the rate of criminal damage showed increases between 2003 and 2006 and then declined to 2007.

Figure: 8.1

Crime rates per 100,000 population



Source: Police Service of Northern Ireland (taken form Ninis)

Table: 8.3

Crime rates per 100,000 population

NI	Violence rate per 100,000 pop	Burglary rate per 100,000 pop	Theft rate per 100,000 pop	Criminal damage rate per 100,000 pop
2002	1761.5	1014.8	2469.6	2365.0
2003	1922.6	962.6	2096.2	1903.1
2004	1900.9	782.8	1818.2	1837.8
2005	1995.4	744.4	1709.6	2018.1
2006	2022.4	663.9	1594.3	2085.5
2007	1850.0	665.0	1406.0	1756.2

Source: Police Service of Northern Ireland (taken form Ninis)

Box 8.1: Crime and Violence in Scotland

The findings below show the overall levels of personal and household crimes that occurred between April 2005 and March 2006 in Scotland*:

- Around 1 in 5 people (22 per cent) had been the victim of at least one household or personal crime.
- Crime against households appears to have fallen between 2003-04 and 2005-06, specifically housebreaking and theft from motor vehicles; while, crime against people has increased, mainly driven by the number of minor assaults recorded.
- Violence (robbery and minor/serious assaults) had increased between 2003-04 and 2005-06, mainly driven by the rise in minor assault.
- Where victims were able to say anything about the person or people who committed the crime against them, 45 per cent said that the person/people were under the influence of alcohol. This proportion was higher for victims of personal crime and highest for incidents of assault (67 per cent).
- Findings from a separate Scottish Crime and Victimisation Survey based report focused on drugs showed that around 37 per cent of 16-59 year olds had taken one or more illicit drugs in their lifetime, while 17 per cent had used one or more Class A drug.
- The experience of crime is strongly related to the type of area people live in. Households in areas classified as most deprived using the Scottish Index of Multiple Deprivation experience more crime and anti-social behaviour than the least deprived areas.

Violence is an important public health issue in Scotland. The following points are derived from a number of Scottish Government publications and show the levels of violence recorded between 2007-08:**

- There were 114 victims of homicide recorded in 2007-08, compared with 119 in 2006-07.
- The homicide rate for males - 36 victims per million population - was four times the rate for females - 9 victims per million population.
- The most common method of killing was with a sharp instrument, occurring in 55 cases (48 per cent).
- Forty-five per cent of the 148 persons accused in homicide cases were reported to have been drunk or on drugs at the time of the incident.
- There were 49,655 incidents of domestic abuse recorded in 2007-08, equating to just under a two per cent increase on 2006-07 and continuing the steady increase in incidents reported since 1999-00, the first year for which data are available.
- The number of offences in which a firearm was fired and killed or caused injury to a person decreased, from 248 in 2006-07 to 211 in 2007-08.

**Source: Scottish Crime and Victimisation Survey 2006*

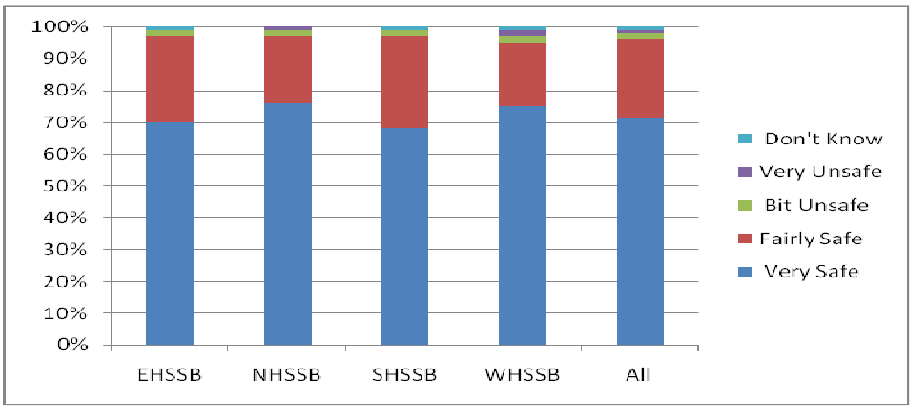
*** Source: Recorded Crime in Scotland, 2007/08, Domestic Abuse recorded by the police in Scotland, 2007-08, Homicide in Scotland, 2007-08, Recorded Crimes and Offences Involving Firearms, Scotland, 2007-08*

8.3 Social Capital: Neighbourhood Safety

Figure 8.2 shows questions from the Continuous Household Survey relating to respondent's feelings of safety in their neighbourhood. The vast majority, over 90% in all Boards, feel safe or very safe walking alone during the day. This proportion falls for feeling of safety after dark to 60-70%.

Figure : 8.2

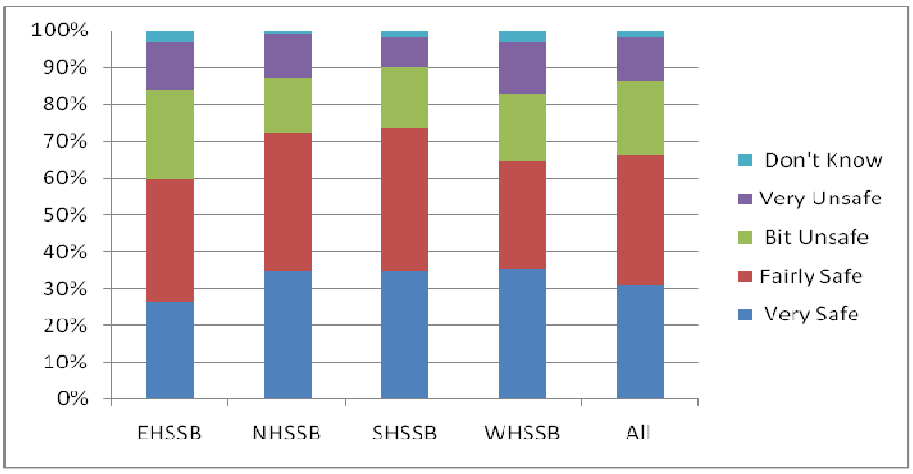
Feelings of safety walking alone in neighbourhood at day by Board



Source: Continuous Household Survey 2005-06

Figure : 8.3

Feelings of safety walking alone in neighbourhood after dark by Board



Source: Continuous Household Survey 2005-06

Table: 8.4

Social Capital - Levels of Safety by Health Board

	How safe do you feel walking alone in this area during the day? (n=2,130)				
	(%) Very Safe	(%) Fairly Safe	(%) Bit Unsafe	(%) Very Unsafe	(%) Don't Know
EHSSB	70	27	2	<1	1
NHSSB	76	21	2	1	0
SHSSB	69	29	2	<1	1
WHSSB	75	20	2	2	1
All	72	25	2	1	1
	How safe do you feel walking alone in this area after dark? (n=2,127)				
	(%) Very Safe	(%) Fairly Safe	(%) Bit Unsafe	(%) Very Unsafe	(%) Don't Know
EHSSB	26	33	24	13	3
NHSSB	35	38	15	12	1
SHSSB	35	39	17	8	2
WHSSB	35	29	18	14	3
All	31	35	20	12	2
Source: Continuous Household Survey 2005-06					

8.4 Cars per Household

Table 8.5 shows the number of car owed per household in each Board.

Table: 8.5

Household car ownership

		Cars per Household
2003-05	**NHSSB**	**1.24**
	EHSSB	0.98
	SHSSB	1.16
	WHSBB	1.05
	NI	1.08
2004-06	**NHSSB**	**1.22**
	EHSSB	1
	SHSSB	1.19
	WHSBB	1.06

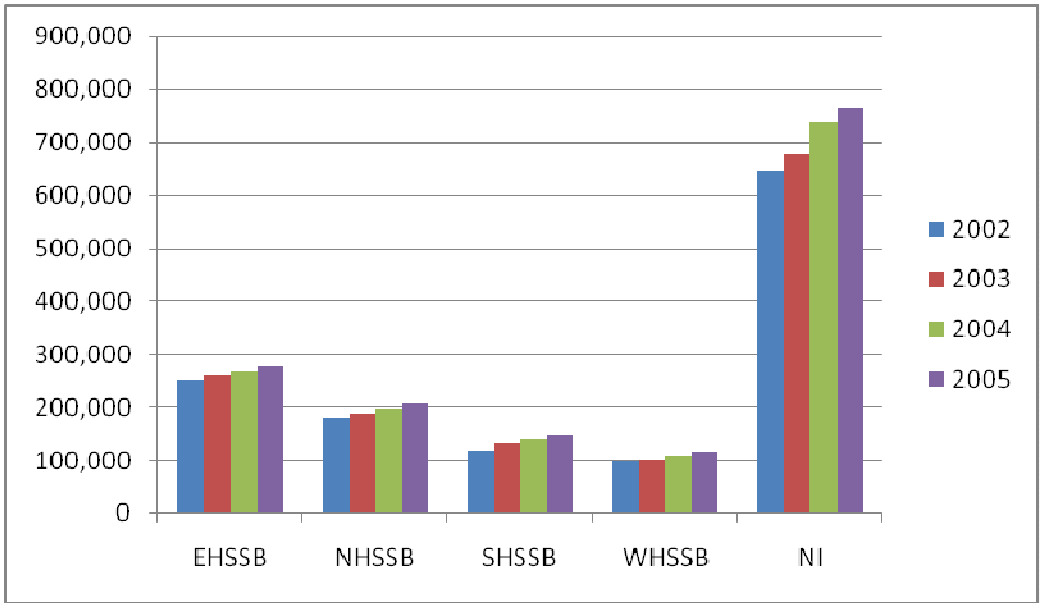
		Cars per Household
	NI	1.09
2005-07	**NHSSB**	**1.23**
	EHSSB	1.01
	SHSSB	1.21
	WHSBB	1.04
	NI	1.1
Source: Travel Survey for Northern Ireland via Central Survey Unit, Northern Ireland Statistics and Research Agency		

8.5 Annual Car Registrations

Figure 8.4 shows the number of car registrations per year. The information was compiled from a DVLNI database. It shows the number of car registrations has increased each year from 2002 to 2005 in each Board.

Figure: 8.4

Car Registrations



Source: Driver Vehicle Licensing NI

8.6 Access to Public Transport

Figure 8.5 shows the percentage of people who have access to a bus service that runs at least once an hour. People living EHSSB have the best access to frequent public transport at over 60%. The provision of frequent bus services has stayed constant in all Boards with the exception of WHSSB, which has increased over the time period from 27% to 36%

Table: 8.6

Access to a bus service running at least once an hour

Year	Board	Number of Registered Cars 2005
2002	**EHSSB**	**251,915**
	NHSSB	180,189
	SHSSB	117,116
	WHSSB	97,485
	NI	646705
2003	**EHSSB**	**258315**
	NHSSB	187866
	SHSSB	129513
	WHSSB	101064
	NI	676758
2004	**EHSSB**	**265,452**
	NHSSB	196,473
	SHSSB	139,121
	WHSSB	108,652
	NI	736,706
2005	**EHSSB**	**274,994**
	NHSSB	204,338
	SHSSB	145,708
	WHSSB	114,227
	NI	763,663
Source: Driver Vehicle Licensing NI		

Figure: 8.5

Access to a bus service running at least once an hour

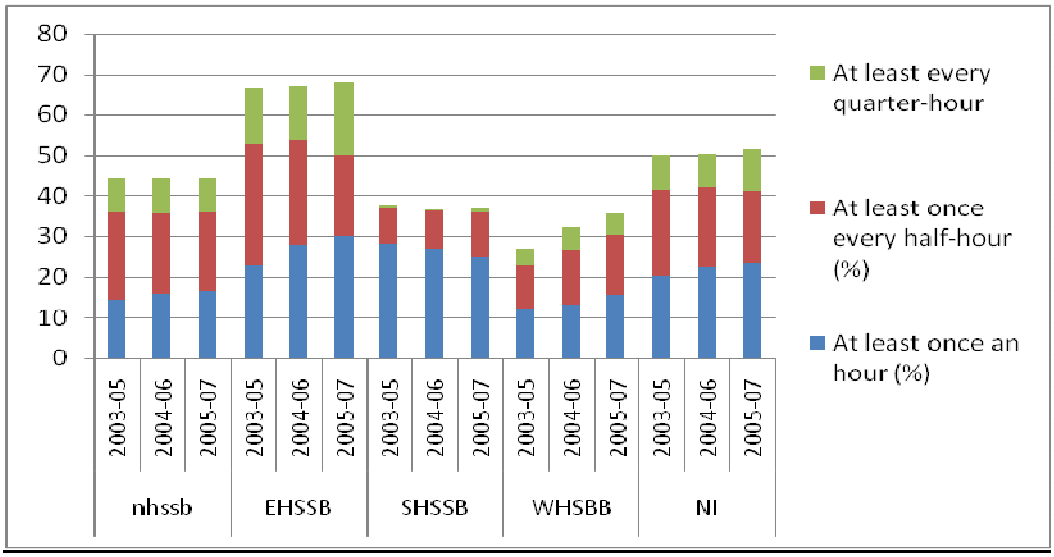


Table: 8.7

Access to a bus service running at least once an hour

		At least once an hour (%)	At least once every half-hour (%)	At least every quarter-hour
2003-05	NHSSB	14.4	21.6	8.2
	EHSSB	22.8	30.0	13.9
	SHSSB	28.2	8.6	1.0
	WHSBB	12.3	10.6	3.8
	NI	20.2	21.2	8.7
2004-06	NHSSB	15.8	20.0	8.4
	EHSSB	28.1	25.7	13.1
	SHSSB	26.8	9.5	0.4
	WHSBB	13.0	13.6	5.6
	NI	22.6	19.4	8.4
2005-07	NHSSB	16.3	19.6	8.4
	EHSSB	30.1	20.0	17.9
	SHSSB	25.1	11.0	0.9
	WHSBB	15.4	15.0	5.2
	NI	23.6	17.4	10.5

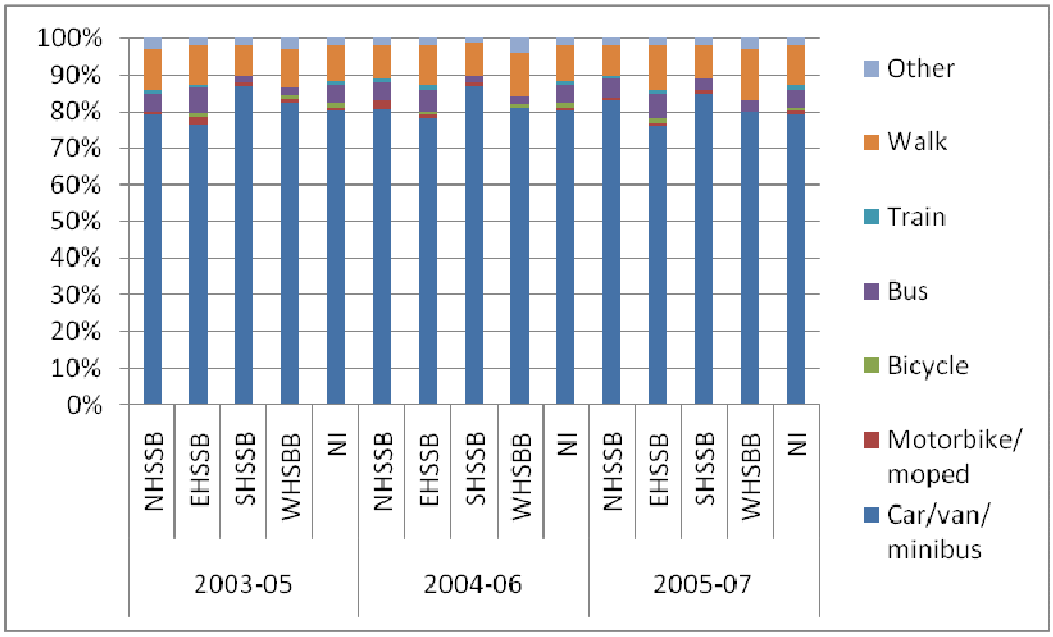
Travel Survey for Northern Ireland 2005 via Central Survey Unit, NISRA

8.7 Main mode of Transport

Figure 8.6 shows the main mode of transport people use to travel to work. Cars and vans are the most common mode at up to 80% for all Boards. The next common mode is walking followed by bus.

Figure: 8.6

Main mode of transport to work



Source: Travel Survey for Northern Ireland 2005 via Central Survey Unit, NISRA

Table: 8.8

Main Mode of Travel to Work: How do you usually travel to work?

		Car/van (include minibus/ works van) (%)	Motorbike/ moped/ scooter (%)	Bicycle (%)	Bus (include coach, private bus) (%)	NIR Train (%)	Walk (%)	Other (%)
2003-05	NHSSB	79	1	0	5	1	11	3
	EHSSB	78	2	1	7	1	11	2
	SHSSB	86	1	0	2	0	8	2
	WHSBB	84	1	1	2	0	11	3
	NI	81	1	1	5	1	10	2
2004-06	NHSSB	80	2	0	5	1	9	2
	EHSSB	78	1	1	6	1	11	2
	SHSSB	86	1	0	2	0	9	1
	WHSBB	81	0	1	2	0	12	4
	NI	81	1	1	5	1	10	2
2005-07	NHSSB	82	1	0	5	1	8	2
	EHSSB	76	1	1	7	1	12	2
	SHSSB	85	1	0	3	0	9	2
	WHSBB	79	0	0	3	0	14	3
	NI	80	1	1	5	1	11	2

Source: Travel Survey for Northern Ireland 2005 via Central Survey Unit, NISRA

Box 8.2: Mode of transport to work: Scotland

The proportion of adults usually travelling to work by car in Scotland level in 2008 was 67.3%.

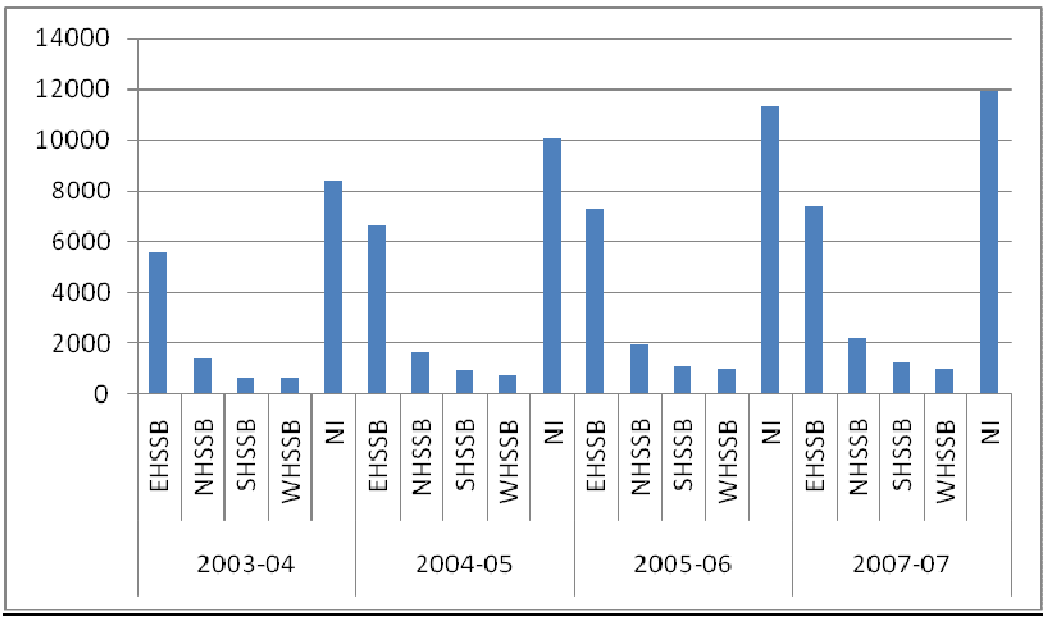
Source: Scottish Household Survey 2008

8.8 Noise Complaints

Figure 8.7 shows the total number of noise complaints by Board. The commonly accepted definition of noise is 'sound which is undesired by the recipient'. In other words, noise can be any sound which is intrusive, disturbing or annoying. The total number of noise complaints has increased over time. EHSSB has a considerably higher number of complaints than any other board.

Figure: 8.7

Total Noise Complaints by Health and Social Services Board



Source: Environment and Heritage Service Air and Environmental Quality Unit, DOE Environmental Policy Division

Table 8.9

Total Noise Complaints by Health and Social Services Board

		Total Noise Complaints
2003-04	**EHSSB**	**5581**
	NHSSB	1441
	SHSSB	665
	WHSSB	710
	NI	8397
2004-05	**EHSSB**	**6637**
	NHSSB	1688
	SHSSB	926
	WHSSB	796
	NI	10047
2005-06	**EHSSB**	**7330**
	NHSSB	1922
	SHSSB	1090
	WHSSB	995
	NI	11337
2007-07	**EHSSB**	**7443**
	NHSSB	2199
	SHSSB	1286
	WHSSB	995
	NI	11923
Source: Environment and Heritage Service Air and Environmental Quality Unit, DOE Environmental Policy Division		

8.9 Summary

The aim of Objective 5 is to improve our neighbourhoods and wider environment. The target set was to reduce levels of respiratory and heart disease by meeting the health-based objectives for the 7 main air pollutants by 2005. There were improvements in pollutant levels and only two of seven air pollutants failed to meet their targets. The analysis for Goal 1 showed that the death rate from circulatory disease has decreased over time for both genders while the respiratory disease death rates have shown little improvement over the time.

With regards to crime, the rates of burglary and theft have decreased over time by 34% and 43% respectively. The rates of violence and criminal damage both increased year-on-year to 2006 and then declined to 2007. Over 90% of people feel safe or very safe walking alone

during the day in their neighbourhood. This proportion falls for feeling of safety after dark to 60-70%.

The availability of public transport has shown little improvement as the provision of frequent bus services has stayed constant in all Boards with the exception of WHSSB, which has increased over the time period from 27% to 36%. Cars and vans the main mode of transport people use to travel to work at up to 80% for all Boards. The next common mode is walking followed by bus.

9 APPENDIX 8: OBJECTIVE 6 – ACCIDENTAL DEATHS AND INJURIES

Objective 6 is *"to reduce accidental injuries and deaths in the home, workplace and from collisions on the road".*

9.1 Target i

Target i is to reduce the death rate from accidents in people of all ages by at least one fifth between 2000 and 2010.

Table 9.1

Objective 6, Target 1

	Age standardised death rate from accidents
Baseline 2000	20.6 per 100,000 population
Target 2010	< 16.5 per 100,000 population
Source: DHSSP (2002): Investing for Health Strategy Baseline taken from the General Register Office	

The table below shows the death rates per 100,000 population from accidents by age group. This is the most recent data available.

Table 9.2

Death rates per 100,000 persons from accidents by age, 2007

	all ages	under 1 year	1 -4	5 – 9	10 - 14	15-24	25-34	35-44	45-54	55-64	65-74	75-84	85 +
Male	38	8	4	5	11	39	31	36	32	45	49	132	403
Female	19	34	2	5	-	10	6	10	11	12	17	81	272
Source: Registrar General Annual Report 2007													

9.2 Target ii

Target ii is to reduce the rate of serious injuries form accidents in people of all ages by at least one tenth between 2000 and 2010. The age-standardised admission rate for serious injuries per 100,000 in 2000/01 was 406.6. The target is for 366 per 100,000 in 2010.

Table 9.3

Objective 6, target 2

	Age standardised rate of serious injuries from accidents
Baseline 2000-01	406.6 per 100,000 population
Target 2010	< 366 per 100,000 population
Source: DHSSP (2002): Investing for Health Strategy Baseline taken from the Hospital Inpatients System	

The following table shows the age-standardised admission rate for serious injuries per 1,000 from serious accidents for 2006-07 to 2008-09. Serious Injury has been identified using the ICD10 Classifications S00 - T98 where total length of stay was 4 days or more.

Table 9.4

Admissions to Health and Social Care Hospitals in Northern Ireland with a diagnosis of Serious Injury.

	Age standardised rate of serious injuries from accidents
2006-07	687.5 per 100,000 population
2007-08	707.8 per 100,000 population
2008-09	694.8 per 100,000 population
Source: Hospital Inpatient System	

9.3 Road Deaths

Figure 9.1 and table 9.4 shows the number of road deaths per year by Board. The data covers only those injury road traffic collisions reported to police, any unreported collisions will not be included in this dataset. The data set excludes the following,

a. collisions resulting in damage only

b. collisions in car parks and picnic areas

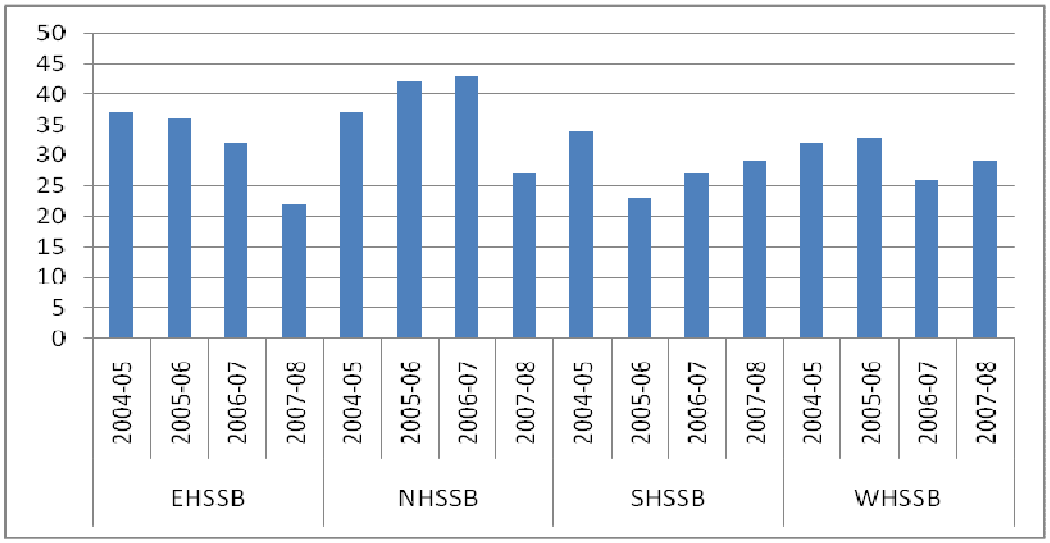
c. collisions reported to the police 30 days or more after their occurrence

d. collisions on a road closed to the public by order of the Department of the Environment, during the holding of motor car, motor cycle, pedal cycle races etc.

NHHSB has had a higher number of road deaths in each year than the other Boards with the exception of 2007-08. EHHSB has made the most progress in reducing the number of road deaths over time.

Figure: 9.1

Road Deaths per Year



Source: Police Service of Northern Ireland

Table: 9.4

Road Deaths per Year

		Injury Road Traffic Collisions - Killed
2004-05	**EHSSB**	**37**
	NHSSB	37
	SHSSB	34
	WHSSB	32
	NI	140
2005-06	**EHSSB**	**36**
	NHSSB	42
	SHSSB	23
	WHSSB	33
	NI	134
2006-07	**EHSSB**	**32**
	NHSSB	43
	SHSSB	27
	WHSSB	26
	NI	128
2007-08	**EHSSB**	**22**
	NHSSB	27
	SHSSB	29
	WHSSB	31
	NI	110
Source: Police Service of Northern Ireland		

9.4 Hospital Admissions Due to Injuries

Figure 9.2 shows the number of admissions to hospital due to road traffic accidents (RTA) in NI by age. There has been a downward trend in the total number of RTA injuries as it has fallen by 13.4% (from 2,031 to 1,759) between 2004-05 and 2007-08. Figure 9.3 shows the number of hospital admissions due to accidents in the home. The overall number of accidents has been falling annually. The 65+ age group is the most likely to be admitted to hospital due to an accident in the home. Figure 9.4 shows the number of hospital admissions due to accidents occurring at school. This has increased over the time period shown by 4% from 428 in 2004-05 to 445 in 2007-08.

Figure 9.2

Admissions to hospital due to injuries from road traffic collisions by age

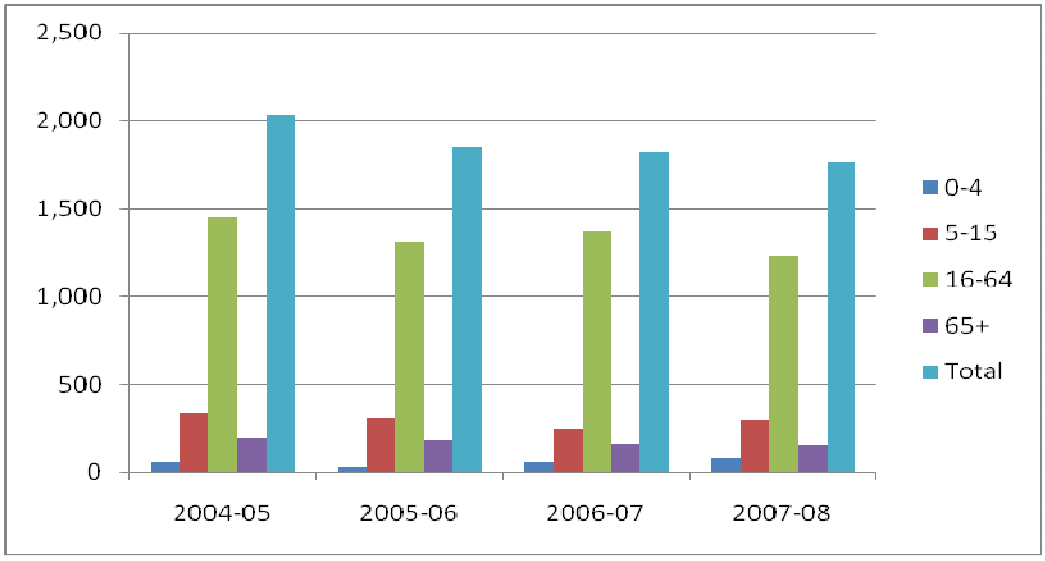


Figure: 9.3

Admissions to hospital due to accidental injuries in the home by age

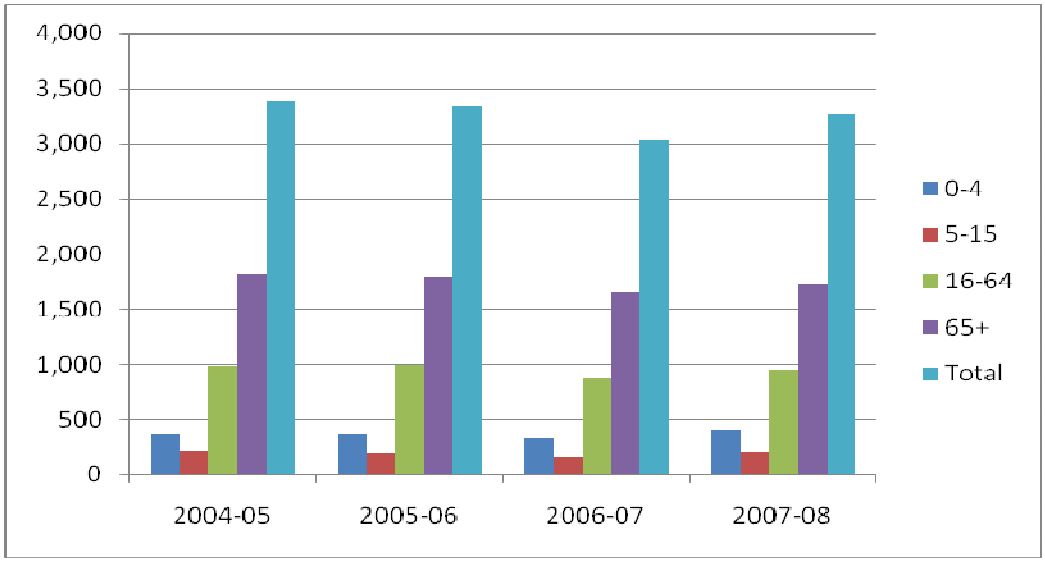
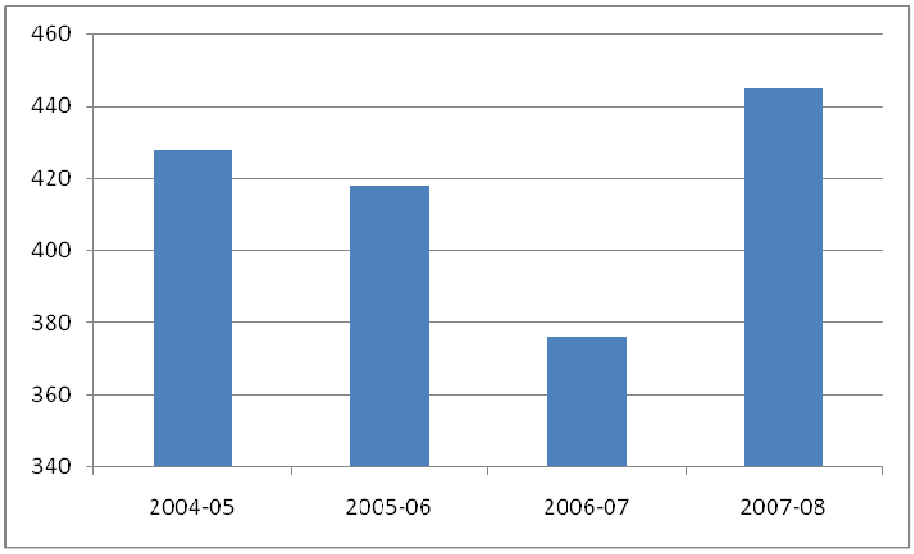


Figure: 9.4

Admissions to hospital due to accidental injuries occurring at school



Source: DHSSPS Hospital Information Branch

Table: 9.5

Admissions to hospital due to injuries from road traffic collisions by age

		Admissions to hospital due to injuries from road traffic collisions 2004/05				
		0-4	5-15	16-64	65+	Total
2004-05	**EHSSB**	**17**	**87**	**426**	**85**	**615**
	NHSSB	11	85	367	53	516
	SHSSB	12	69	322	29	432
	WHSSB	13	84	287	28	412
	Unassigned	3	7	43	3	56
	NI	56	332	1,445	198	2,031
2005-06	**EHSSB**	**15**	**109**	**387**	**53**	**564**
	NHSSB	11	70	346	60	487
	SHSSB	13	70	268	37	388
	WHSSB	16	51	261	29	357
	Unassigned	3	3	49	3	58
	NI	58	303	1,311	182	1,854
2006-07	**EHSSB**	**11**	**70**	**332**	**46**	**459**
	NHSSB	13	62	408	55	538

		Admissions to hospital due to injuries from road traffic collisions 2004/05				
		0-4	5-15	16-64	65+	Total
	SHSSB	11	55	327	32	425
	WHSSB	17	45	243	21	326
	Unassigned	3	9	52	3	67
	NI	55	241	1,362	157	1,815
2007-08	**EHSSB**	**33**	**105**	**331**	**57**	**526**
	NHSSB	9	76	358	46	489
	SHSSB	12	52	251	24	339
	WHSSB	17	63	236	26	342
	Unassigned	3	3	54	3	63
	NI	74	299	1,230	156	1,759
Source: DHSSPS Hospital Information Branch						

Table: 9.6

Admissions to hospital due to accidental injuries in the home by age

		Admissions to hospital due to accidental injuries in the home 2004/05				
		0-4	5-15	16-64	65+	Total
2004-05	**EHSSB**	**113**	**70**	**434**	**786**	**1,403**
	NHSSB	64	40	205	447	756
	SHSSB	87	27	134	313	561
	WHSSB	102	70	194	259	625
	Unassigned	3	3	12	14	32
	NI	369	210	979	1,819	3,377
2005-06	**EHSSB**	**132**	**65**	**443**	**818**	**1,458**
	NHSSB	87	35	204	472	798
	SHSSB	49	25	137	238	449
	WHSSB	88	58	195	251	592
	Unassigned	10	3	11	14	38
	NI	366	186	990	1,793	3,335
2006-07	**EHSSB**	**91**	**41**	**416**	**728**	**1,276**
	NHSSB	81	50	182	391	704
	SHSSB	29	17	121	285	452
	WHSSB	135	50	155	228	568
	Unassigned	3	3	10	12	28

		Admissions to hospital due to accidental injuries in the home 2004/05				
		0-4	5-15	16-64	65+	Total
	NI	339	161	884	1,644	3,028
2007-08	**EHSSB**	**157**	**71**	**395**	**739**	**1,362**
	NHSSB	64	38	200	381	683
	SHSSB	65	31	161	356	613
	WHSSB	114	55	175	227	571
	Unassigned	3	3	14	17	38
	NI	403	198	945	1,720	3,267
Source: DHSSPS Hospital Information Branch						

Table: 9.7

Admissions to hospital due to accidental injuries occurring at school

		Accidents occurring at school 2004/05
2004-05	**EHSSB**	**149**
	NHSSB	145
	SHSSB	53
	WHSSB	78
	Unassigned	3
	NI	428
2005-06	**EHSSB**	**183**
	NHSSB	126
	SHSSB	35
	WHSSB	71
	Unassigned	3
	NI	418
2006-07	**EHSSB**	**178**
	NHSSB	97
	SHSSB	49
	WHSSB	49
	Unassigned	3
	NI	376
2007-08	**EHSSB**	**206**
	NHSSB	108
	SHSSB	62
	WHSSB	63

		Accidents occurring at school 2004/05
	Unassigned	6
	NI	445
Source: DHSSPS Hospital Information Branch		

9.5 Summary

The aim of Objective 6 is to reduce accidental injuries and deaths in the home, workplace and from collisions on the road. The target is to reduce the death rate the rate of serious injuries from accidents in people of all ages.

NHHSB has had a higher number of road deaths in each year than the other Boards with the exception of 2007-08. EHHSB has made the most progress in reducing the number of road deaths over time. There has been a downward trend in the total number of road collision injuries as it has fallen by 13.4% (from 2,031 to 1,759) between 2004-05 and 2007-08.

The overall number hospital admissions due to accidents have been falling annually. The 65+ age group is the most likely to be admitted to hospital due to an accident in the home. Figure 9.4 shows the. This number of hospital admissions due to accidents occurring at school has increased by 4% from 428 in 2004-05 to 445 in 2007-08.

10 APPENDIX 9: OBJECTIVE 7 – MAKING HEALHIER CHOICES

Objective 7 is *"to enable people to make healthier choices".*

10.1 Target i

Target i is to stop the increase in the levels of obesity in men and women so that by 2010, the proportion of men who are obese is less than 17%, and of women, less than 20%.

Table 10.1

Objective 7, Target 1

	Obese men	Obese women
1997	17%	20%
Target 2010	<17%	<20%
Source: DHSSP (2002): Investing for Health Strategy Baseline taken from the Health and Social Wellbeing Survey 2000		

Figure 10.2 shows the proportion of adults in each HSSB who were overweight or obese by gender. This shows that the proportion of obese people has increased from the time the baseline figure was recorded and 2005-06. The percentage of obese men has increased considerably by 8% and women by 3%.

The trend in each gender has been extrapolated to 2010. The proportion of obese men and women has increased over time. If the number continues to grow at the current rate, the target of reducing the level of obese men to below 17% and women below 20% by 2010 will not be met.

Table: 10.2

Proportion of Adults who were overweight or obese by gender 2005-06

	% Overweight			% Obese		
HSSB Name	All	Male	Female	All	Male	Female
Eastern	32	36	29	21	21	21
Northern	37	38	35	26	27	24
Southern	35	41	29	28	27	28
Western	36	44	28	23	26	21
NI	35	39	30	24	25	23
Source: Health and Social Well Being Survey 2005/06						

Table 10.3 shows the self-reported perception of weight of respondents to the 2005-06 Health and Social Well Being Survey. This is not one of the IfH monitoring framework indicators. But interestingly, it shows that only 39% of people believe themselves to be too heavy when 59% are in fact classified as overweight or obese.

Table: 10.3

Self-reported perception of weight

	About The Right Weight			Too Heavy			Too Light			Not Sure		
HSSB Name	All	Male	Female	All	Male	Female	All	Male	Female	All	Male	Female
Eastern	48%	53%	43%	40%	35%	45%	5%	5%	5%	7%	7%	8%
Northern	46%	50%	41%	43%	36%	49%	5%	5%	4%	7%	8%	6%
Southern	47%	54%	41%	38%	33%	44%	3%	4%	2%	12%	10%	13%
Western	50%	52%	47%	32%	25%	39%	3%	4%	2%	16%	20%	11%
NI	47%	52%	43%	39%	33%	45%	4%	5%	4%	9%	10%	9%
Source: Source: Health and Wellbeing Survey 2005/06,												

Box 10.1: Adult obesity in England

- In 2007, 24% of adults (aged 16 or over) in England were classified as obese (BMI 30 kg/m^2 or over); an overall increase from 15% in 1993
-
- Men and women were equally likely to be obese, however men were more likely than women (41% compared to 32%) to be overweight (Body Mass Index (BMI) 25 to less than 30 kg/m^2)
-
- 37% of adults had a raised waist circumference in 2007 compared to 23% in 1993. Women were more likely than men (41% and 33% respectively) to have a raised waist circumference (over 88cm in women, over 102cm in men)
-

Source: NHS: the information centre for health and social care (2009): Statistics on Obesity, Physical Activity and Diet: England

10.2 Target ii

Target ii is to increase the levels of 5 year old children with no dental decay experience to 55% and to reduce the gap between the best and worst decayed/missing/filled (dmf) scores by 20% by 2010.

Table 10.4

Objective 7, Target 2

	No dental decay
1993	37%
Target 2010	55%
Source: DHSSPS (2002): Investing for health Strategy Baseline taken from Child Dental health survey	

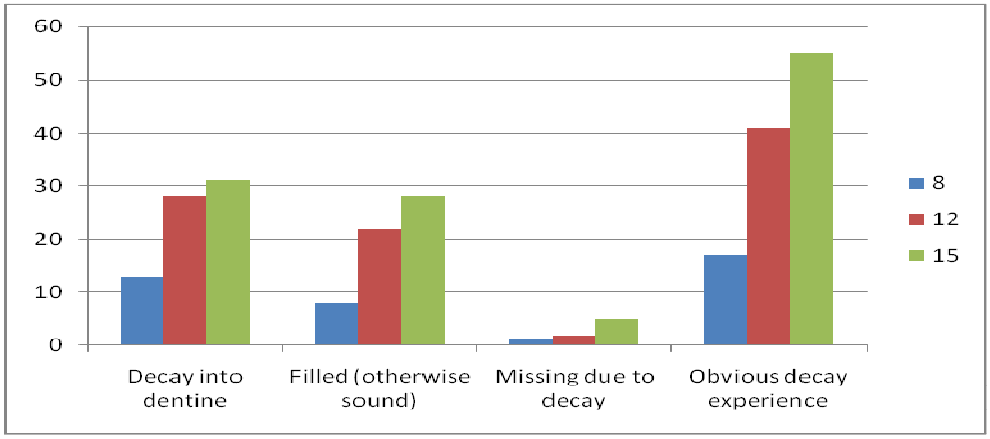
Table 10.5

Objective 7, Target 2

	Best DMF score (10th percentile)	Worst DMF score (90th percentile)	Gap
1996/97	0.6	3.5	2.9
Target gap 2010	x	x	2.32
Source: DHSSPS (2002): Investing for health Strategy Baseline taken from Community Screening data			

Figure: 10.1

Proportion of children with obvious decay experience by age in NI



Source: National statistics (2003): Obvious decay experience: Children's Dental Health in the United Kingdom

Table: 10.6

Proportion of children with obvious decay experience (D3cvMFT) in permanent teeth by country and age, 2003

	Age	NI	England	UK
Decay into dentine	8	13	25	14
	12	28	44	29
	15	31	46	32
Filled (otherwise sound)	8	6	15	7
	12	22	54	25
	15	38	66	41
Missing due to decay	8	1	1	1
	12	2	14	3
	15	5	17	6
Obvious decay experience	8	17	34	19
	12	41	73	43
	15	55	78	57

Source: National statistics (2003): Obvious decay experience: Children's Dental Health in the United Kingdom

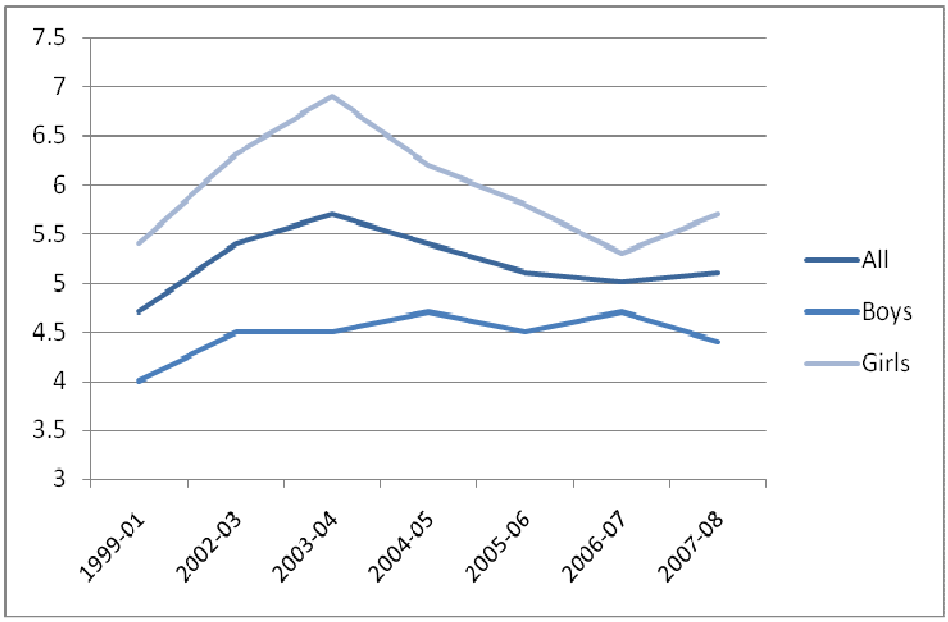
10.3 Childhood obesity

Figure 10.2 shows the proportion of Primary 1 children that are classified as overweight and obese. Height and weight information is extracted from the Child Health System (which is maintained by the Health Boards). The information currently relates to children aged between 54 and 66 months on the date of their measurements. The children's BMI is rated using the International Obesity Task Force (IOTF) standard of obesity classification. The area data is determined by the postcode of the school rather than the postcode of the home address.

A higher proportion of girls are overweight and obese than boys. The proportion of overweight and obese girls has fluctuated over time; the rates rose between 1999-01 and 2003-04 and then fell sharply to 2006-07. The proportion of overweight and obese boys has increased slightly over time but a slower and more consistent rate.

Figure : 10.2

Childhood Overweight and Obesity Rates (Primary 1 children)



Source: Child Health System

Table 10.7

Childhood Overweight and Obesity Rates (Primary 1 children)

NI	All %	Boys %	Girls %
1999-01	4.7	4.0	5.4
2002-03	5.4	4.5	6.3
2003-04	5.7	4.5	6.9
2004-05	5.4	4.7	6.2
2005-06	5.1	4.5	5.8
2006-07	5.0	4.7	5.3
2007-08	5.1	4.4	5.7
Source: Child Health System (taken form Ninis)			

Box 10.2: Childhood obesity in Scotland

All NHS Boards in Scotland provide a Child Health Surveillance Programme where children are offered routine reviews at various stages of their life. The majority of Boards record these reviews using the Child Health Systems Programme (CHSP). Statistics in this release are derived from height and weight measurements collected at routine health reviews in Primary 1 through the CHSP-School system. As CHSP-School is implemented in the majority of NHS Boards, data from this system can be used to estimate prevalence of over- and under- weight children in Scotland.

The following related to Primary 1 children in the ten participating NHS Boards in 2007/08:

- 20.0% of Primary 1 children were classified as overweight, including 7.9% obese and 3.9% severely obese.
- Levels of high BMI increased slightly, and very gradually, between 2000/01 and 2005/06. Over the last two years, levels of high BMI have decreased slightly and the percentages for 2007/08 are similar to those for 2000/01 (19.7% overweight, including 8.0% obese and 3.9% severely obese). As the number of NHS Boards submitting data has increased since 2000/01 (from four to ten Boards) the trend for 'All participating NHS Boards' should be interpreted with a degree of caution. However, a similar trend is observed among the Boards participating throughout the eight year period.
- In Primary 1, levels of high BMI amongst boys tend to be slightly higher than those for girls. In school year 2007/08, 20.5% of boys were classified as overweight (including 8.2% obese and 4.1% severely obese) compared to 19.6% of girls (including 7.6% obese and 3.6% severely obese).
- Primary 1 figures for 2007/08 indicate that the most deprived areas have the highest percentage of children classified as overweight, obese and severely obese (21.7% overweight, including 9.2% obese and 4.5% severely obese) while the least deprived areas had the lowest percentage (18.1% overweight, including 6.3% obese and 3.0% severely obese), however this pattern is not clearly observed for all previous years.
- The percentage of Primary 1 school children with low BMI (classified as underweight) was 3.2% in 2007/08. Levels of low BMI have remained relatively stable at around 3% in recent years
-

Source: IDS Scotland (2009): Statistical publication notice. Childhood obesity: Primary 1 statistics for school year 2007-08

Box 10.3: Childhood obesity in England

- In 2007, 17% of boys aged 2 to 15, and 16% of girls were classed as obese, an increase from 11% and 12% respectively in 1995. Indications suggest that the trend in obesity may be flattening out and the next couple of years' data will be important in confirming whether this is a continuing pattern
-
- In 2007, boys aged 2 to 15 were more likely than girls to meet the recommended levels of physical activity with 72% of boys and 63% of girls reporting taking part in 60 minutes or more of physical activity on each of the seven days in the previous week
-
- During the 2007/08 academic year, 90% of pupils took part in at least two hours of high quality PE and sport at school a week, a gradual increase since 2003/04 when the figure was 62%
-
- Only a small proportion of children aged 11 to 15 said they thought they should be doing physical activity at the level of the current minimum recommendation (10%). A further 8% of boys and three per cent of girls overestimated the minimum recommendation
-
- Girls were more likely than boys to want to do more physical activity, 74% of girls aged 11 to 15 compared to 61% of boys.
-

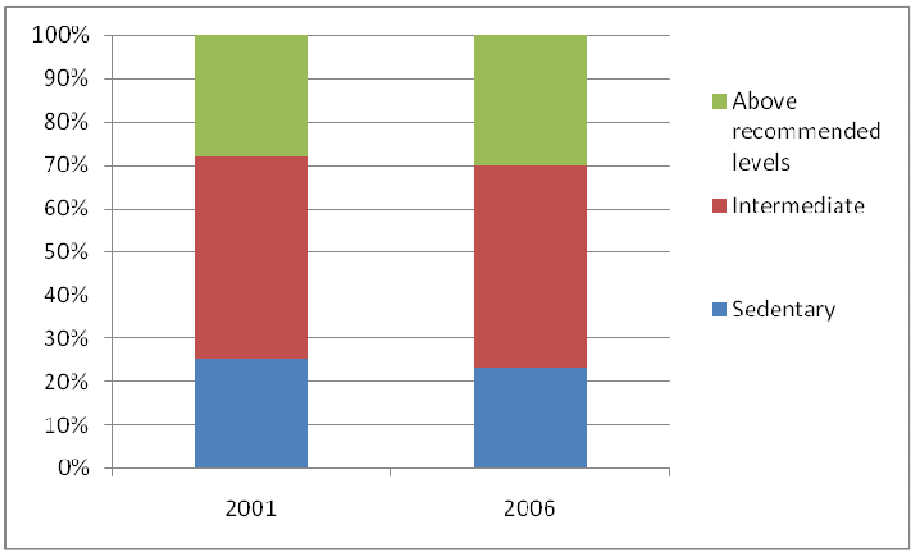
Source: NHS: the information centre for health and social care (2009): Statistics on Obesity, Physical Activity and Diet: England

10.4 Physical activity and diet

Figure 10.3 shows the level of physical activity of adults aged 16 and over. The recommended level of activity is 30 minutes of moderate physical activity per day for 5 days out of the week. Sedentary behaviour describes those people who take very little physical exercise. i.e. they had not taken any activity of at least moderate level, lasting 20 minutes, on one or more occasion in the previous 7 days. The level of physical activity for adults has remained largely unchanged over the time period.

Figure : 10.3

Adult level of physical activity



Source: Health and Social Well Being Survey 2001 & 2005/06

Table: 10.8

Level of physical activity (Proportion of adults 16+)

		Sedentary	Intermediate	Above recommended levels
2001	**Eastern**	**26**	**49**	**25**
	Northern	20	46	34
	Southern	27	47	26
	Western	25	45	29
	NI	25	47	28
2006	**Eastern**	**22**	**49**	**29**
	Northern	20	48	32
	Southern	26	46	27
	Western	25	41	34
	NI	23	47	30

Source: Health and Social Well Being Survey 2001 & 2005/06

NB: For 2005-06: Caution is needed when comparing figures at HSSB Level as some of the data has large sampling errors and as a result, the 95% confidence intervals around the HSSB estimates may overlap. Where this is the case any differences between HSSB estimates are not usually statistically significant

Box 10.4: Adult physical activity in England

- Overall, physical activity has increased among both men and women since 1997, with 40% of men and 28% of women meeting the recommended levels in 2006 (at least 30 minutes of at least moderate intensity activity at least five times a week) compared with 32% and 21% respectively in 1997
- In 2007, approximately a third of adults had not heard of the government guidelines for physical activity (34% of men and 29% of women)
- When asked how much physical activity adults thought people their age should do, 16% of men and 9% of women specified a level equivalent to the Chief Medical Officer's minimum recommended target.
- A further 25% of men and 23% of women specified a level of physical activity greater than the minimum recommendations, while most adults (69% of men and 68% of women) either under-estimated how much physical activity adults should do or did not know
- Over two-thirds of adults (66% of men and 69% of women) said they would like to do more physical activity
- Among men, the most common reason given which stopped them doing more physical activity was work commitments (45%), followed by lack of leisure time (38%).
- Women were most likely to report a lack of leisure time (37%), with work commitments almost as frequently mentioned (34%)
-

Source: NHS: the information centre for health and social care (2009): Statistics on Obesity, Physical Activity and Diet: England

Table 10.9 shows the level proportion of adults eating the recommended five portions of fruit and vegetables a day. In 2005-06, only 27% of adults were eating the recommended levels of fruit and vegetables on a daily basis.

Table: 10.9

Proportion of adults stated eating 5 pieces of fruit/vegetable each day 2005/06

HSSB Name	Less Than 5 a Day %	5 or More a Day %
Eastern	74	26
Northern	73	27
Southern	75	25
Western	69	31
NI	73	27

Source: Health and Wellbeing Survey 2005/06

Caution is needed when comparing figures at HSSB Level as some of the data has large sampling errors and as a result, the 95% confidence intervals around the HSSB estimates may overlap. Where this is the case any differences between HSSB estimates are not usually statistically significant

Box 10.5: Adult diet in England

- In 2007, 27%of men and 31% of women consumed five or more portions of fruit and vegetables a day, up from 22% and 25%respectively in 2001.
- Women were more likely than men to know the recommended number of portions per day (78% of women compared to 62% of men)

Source: NHS: the information centre for health and social care (2009): Statistics on Obesity, Physical Activity and Diet: England

Table 10.10 shows the proportion of children who eat fruit and vegetables more than once a day. The data comes from the Young Persons Behaviour and Attitudes Survey, which is a school-based survey conducted among 11-16 year-olds. The research covers a range of topics, relevant to the lives of young people today such as nutrition, smoking and alcohol. A random sample of post-primary schools in Northern Ireland is drawn from a list held by the Department of Education. The sample is representative of school size, selection type (i.e. Secondary, Grammar), management group (i.e. Controlled, Voluntary, Roman Catholic Maintained, Grant Maintained Integrated etc) and Education and Library Board area. To ensure the achieved sample reflects the composition of the population of pupils in post-primary education with regard to key characteristics (i.e. gender, year group) the data is weighted accordingly. Figures from the DE school census are used to derive the weights. The proportion eating fruit and vegetables daily has increased over the time period shown. There is some disparity between Boards. EHSSB consistently has the highest levels.

Table: 10.10

Proportion of young people eating fruit and vegetables more than once a day

		(%) More than once a day- Fruit	(%) More than once a day- Vegetables
2000	**EHSSB**	**35.6**	**17.8**
	NHSSB	30.7	14.0
	SHSSB	31.8	17.1
	WHSSB	31.0	15.0
	All	32.5	16.1
2003	**EHSSB**	**31.1**	**17.0**
	NHSSB	27.3	14.2
	SHSSB	29.0	15.6
	WHSSB	27.3	15.3
	All	28.8	15.6
2007	**EHSSB**	**40.3**	**23.3**
	NHSSB	36.2	19.4
	SHSSB	30.0	14.7
	WHSSB	30.1	16.7
	All	35.1	19.1
Source: Young Persons Behaviour and Attitudes Survey			

Box 10.6: Childhood diet in England

- Among children aged 5 to 15, in 2007, 21% of both boys and girls consumed five or more portions of fruit and vegetables a day, up from 11% of both boys and girls in 2001

- 63% of boys and 73% of girls knew that five portions of fruit and vegetables a day was the recommendation.

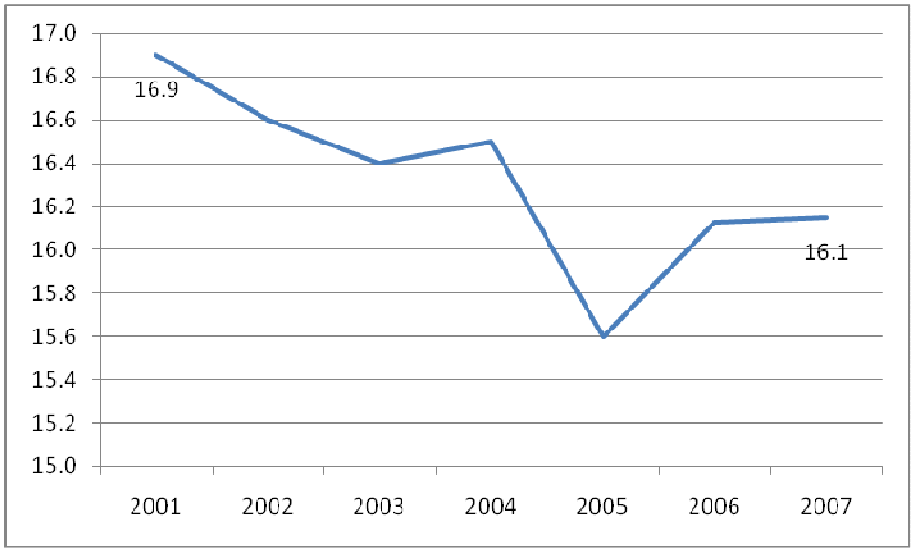
Source: NHS: the information centre for health and social care (2009): Statistics on Obesity, Physical Activity and Diet: England

10.5 Teenage Birth Rate

Figure 10.4 shows the rate of teenage births per 1,000 female population aged 13-19. The information is aggregated data from the GRO birth files, which are gathered when children are registered at the Registrar's Office. The overall rate has fallen by a small amount over the time period 2001 to 2007. Table 10.11 shows the data by Health Board. The EHSSB have the highest annual rate of teenage births.

Figure: 10.4

Teenage birth rate per 1,000 female population aged 13-19



Source: GRO (taken from Ninis)

Table: 10.11

Teenage birth rate per 1,000 female population aged 13-19

		Number of births to Teenage Mothers	Teenage birth rate per 1,000 female population aged 13-19
2001	EHSSB	652	19.0
	NHSSB	350	16.0
	SHSSB	255	14.7
	WHSSB	267	16.1
	NI	1,524	16.9
2002	EHSSB	641	18.8
	NHSSB	347	15.7

		Number of births to Teenage Mothers	Teenage birth rate per 1,000 female population aged 13-19
	SHSSB	222	12.7
	WHSSB	292	17.4
	NI	1,502	16.6
2003	EHSSB	687	19.6
	NHSSB	314	14.3
	SHSSB	232	13.6
	WHSSB	250	15.1
	NI	1,483	16.4
2004	EHSSB	673	19.3
	NHSSB	344	15.7
	SHSSB	227	13.3
	WHSSB	242	14.7
	NI	1,486	16.5
2005	EHSSB	661	19.1
	NHSSB	299	13.6
	SHSSB	213	12.5
	WHSSB	222	13.8
	NI	1,395	15.6
2006	EHSSB	641	18.9
	NHSSB	328	15.1
	SHSSB	209	12.1
	WHSSB	249	15.9
	NI	1,427	16.1
2007	EHSSB	636	19.0
	NHSSB	295	13.7
	SHSSB	246	14.6
	WHSSB	228	14.9
	NI	1,405	16.1
Source: GRO (taken from ninis)			

Box 10.7 Teenage pregnancy in Scotland

The national target for teenage pregnancy reduction in Scotland is to reduce by 20% the pregnancy rate (per 1000 population) in under 16 year olds from 8.5 in 1995 to 6.8 in 2010. The following statistics relate to monitoring in 2007:

- The teenage pregnancy rate has been fairly steady for the past decade. In 2007, in the under 16 age group there were 8.1 pregnancies per 1,000, the same rate as 2006. The rates in the older age groups have risen slightly with the under 18s rising from 41.5 per 1,000 in 2006 to 42.4 per 1,000 in 2007 and the under 20s from 57.9 per 1,000 to 58.6 per 1,000.
- In mainland NHS boards in 2007, NHS Highland recorded the lowest rate of teenage pregnancy in the under 16 age group (5.8 per 1,000) and Borders recorded the lowest rate of teenage pregnancies in the under 18 age group (26.7 per 1,000) and also in the under 20 age group (45.2 per 1,000).
- NHS Tayside has the highest teenage pregnancy rates across all three age groups with a rate of 12.1 per 1,000 for the under 16s, 55.3 per 1,000 for under 18s and 74.9 per 1,000 for the under 20s.
- In mainland council areas, for the three year period 2005/07, Argyll and Bute recorded the lowest rate of teenage pregnancy (3.0 per 1,000) in the under 16 group and East Renfrewshire Council in under 18 year olds (20.1 per 1,000). Dundee City Council had the highest teenage pregnancy rate in both these age groups, 18.6 per 1,000 in the under 16 age group and 77.7 per 1,000 in under 18s. In 2007, the lowest and highest rates in the under 20 age group in mainland council areas are 29.8 per 1,000 in Stirling and 96.3 in Dundee City Council.
- Over the years there has been a change in the balance between teenage conceptions which are aborted and those which continue to delivery. In the under 18 and under 20 age groups the rate of abortion has risen slightly but still remains considerably lower than the delivery rate. In the under 16 year age group the abortion rate has been higher than the delivery rate since 2001.
- In 2007, in mainland NHS board areas, the delivery rate in the under 20 age group was highest in Tayside and lowest in Grampian NHS board areas (42.2 and 26.2 per 1,000, respectively). The abortion rate was highest in Tayside and lowest in the Borders NHS board areas (32.7 and 18.2 per 1,000, respectively).
- There is a strong deprivation gradient. In the under 20s, the most deprived groups have approximately ten times the rate of delivery as the least deprived (70.4 per 1,000 and 8.3 per 1,000) and nearly twice the rate of abortion (31.0 per 1,000 and 17.3 per 1,000) These proportions have not varied much over the most recently available eight years, and do not vary much with age.
- In the most deprived areas in 2007 the rate of teenage pregnancies in the under 16 age group was more than 4 times the rate in the least deprived areas (15.0 per 1,000 and 3.2 per 1,000 respectively). A similar pattern was also present in the under 18 age group, with 80.3 per 1,000 in the most deprived group and 18.7 per 1,000 in the least deprived. Within the under 20 age group the rates were 101.4 within the most deprived groups and 25.6 per 1,000 within the least deprived.

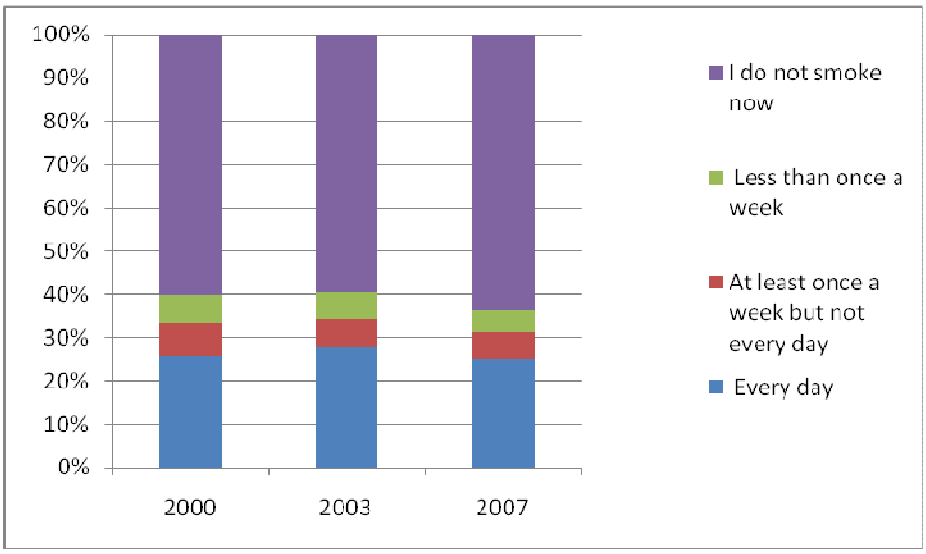
Source: IDS Scotland (2009): Statistical publication notice. Teenage pregnancy statistics 2007

10.6 Proportion of Population who Smoke

Figure 10.5 shows how often young people aged 11 to 16 have smoked. The proportion of young people in this age group who do not smoke has increased over time to over 60%.

Table 10.5

Percentage of young people who smoke



Source: Young Persons Behaviour and Attitudes Survey

Table: 10.11

Percentage of young people who smoke

		(%) Every day	(%) At least once a week but not every day	(%) Less than once a week	(%) I do not smoke now
2000	EHSSB	28.5	8.2	6.8	56.5
	NHSSB	26.2	8.2	5.2	60.4
	SHSSB	24.8	8.3	5.3	61.6
	WHSSB	22.3	6.0	8.3	63.4
	All	25.6	7.7	6.5	60.2
2003	EHSSB	30.9	7.5	5.2	56.3
	NHSSB	27.0	7.2	8.1	57.8
	SHSSB	19.9	5.0	6.5	68.7
	WHSSB	28.7	6.3	5.1	59.9

		(%) Every day	(%) At least once a week but not every day	(%) Less than once a week	(%) I do not smoke now
	All	27.5	6.7	6.1	59.7
2007	EHSSB	26.9	6.9	5.5	60.7
	NHSSB	25.5	8.0	2.8	63.7
	SHSSB	19.2	4.2	6.7	70.0
	WHSSB	25.4	4.9	5.4	64.4
	All	25	6.3	4.9	63.8
Source: Young Persons Behaviour and Attitudes Survey					

10.7 Smoking Cessation Services

Figure 10.6 shows the proportion of adults who have successfully given up smoking for different lengths of time. These figures only relate to those availing of specialist smoking cessation services across Northern Ireland. It is important to note that other individuals may avail of brief intervention, which is also available but is not currently monitored. Other individuals made also quit by themselves and therefore this information is not available. Figures are based on the number of attempts at quitting smoking and having set a quit date within the financial year specified. This information was taken from a standard questionnaire completed by Smoking Cessation Specialists, through a web based recording system.

Figure: 10.6

Proportion of adults successfully quitting at 4 and 52 weeks

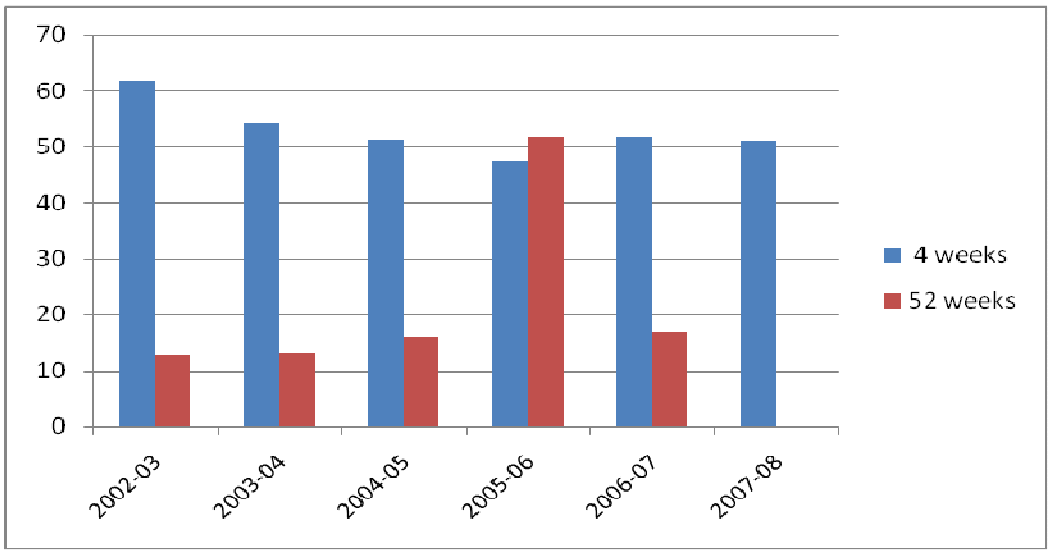


Table: 10.12

Proportion of adults successfully quitting at 4 and 52 weeks

NI	Percentage successfully quit (self-report) at 4 weeks	Percentage successfully quit (self-report) at 52 weeks
2002-03	61.8	12.7
2003-04	54.2	13.2
2004-05	51.2	16.0
2005-06	47.3	51.8
2006-07	51.8	17.1
2007-08	51.1	N/A
Source: DHSSPS Hospital Information Branch		

Box 10.8: Smoking cessation services in England

This information relates to the number of people setting a quit date and the number who successfully quit at the 4 week follow-up. This data is from the monitoring of the NHS Stop Smoking Services (NHS SSS) in England during the period 1 April to 30 June 2009.

- 163,946 people set a quit date through NHS Stop Smoking Services, an increase of 10% (14,551) on the final figure for same period in 2008/09 (149,395), but a decrease of 4% (7,246) on the final figure for the same period in 2007/08 (171,192).
- At the 4 week follow-up 79,351 people had successfully quit (based on self-report), 48% of those setting a quit date. This is an increase of 8% (5,990) on the final figure for the same period in 2008/09 (73,361), but a decrease of 9% (7,430) on the final figure for the same period in 2007/08 (86,781).
- 69% of successful quitters at the 4 week follow-up had their results confirmed by Carbon Monoxide (CO) verification. This percentage was 67% based on final figures for the same period in 2008/09 and 61% based on final figures for the same period in 2007/08.
- Total expenditure on NHS Stop Smoking Services was £20.5 million, an increase of 30% (£4.7 million) on the final figure for the same period in 2008/09 (£15.7 million) and an increase of 55% (£7.3 million) on the final figure for the same period in 2007/08 (£13.2 million). The cost per quitter is £258 compared with £215 based on final figures for the same period in 2008/09 and £152 based on final figures for the same period in 2007/08. These figures do not include expenditure on pharmacotherapies.
- For Quarter 1 in 2008/09, the increase between the provisional figures and the final figures was 11.4% for the number setting a quit date and 12.3% for the number of successful quitters (based on self-report). This suggests that, for 2009/10, the final figures and the increases from the same period in 2008/09 may be higher than the provisional figures stated above. It also suggests that the decreases from the same period in 2007/08 may be less than stated above (or will show as an increase).
- For Quarter 1 in 2008/09, there was a decrease of 1.7% between the provisional and final Quarter 1 expenditure figure. This suggests that, for 2009/10, the final figure and the increase from 2008/09 may be lower than the provisional figure stated above.

Source: NHS: the information centre for health and social care (2009): Statistics on NHS Stop Smoking Services: England, April 2009 to June 2009 (Q1 - Quarterly report)

10.8 Adult Alcohol Use

The key findings are used to provide an up-to-date picture of adult drinking patterns in Northern Ireland in 2008. The information is collected from a survey of a representative sample of adults aged between 18 and 75 years old (inclusive), living in private households in NI, carried out in April-June 2008. It examines the amount of alcohol respondents consumed, when, where and what they drank and who they drank with, together with binge and problem drinking.

The available data suggest that nearly one third of adults binge drink, and that the proportion of males who binge drink is higher than the proportion of females.

Table: 10.13

Percentage of adults who binge drink 2008

	% Males	% Females	% All
EHSSB	34	34	34
NHSSB	34	28	31
SHSSB	30	24	27
WHSSB	42	22	33
NI	35	29	32

Source: DHSSPS, Public Health Information and Research Branch

Box 10.9: Adult alcohol consumption in England

In England in 2004, 74% of men and 59% of women reported drinking an alcoholic drink on at least one day in the week prior to interview. 15% of men and 8%of women reported drinking on every day in the previous week.

39% of men and 22% of women had drunk more than the recommended number of units on at least one day in the week prior to interview.

Older people were more likely to drink regularly – 30% of men and 19% of women aged 45-64 drank on five or more days in the week prior to interview compared to 8 per cent of men and 5 per cent of women aged 16-24. Younger people were more likely to drink heavily, with 48% of men and 39% of women aged 16-24 drinking above the daily recommendations compared to 19% of men and 5% of women aged 65 and over.

In the UK in 2004, 61% of people reported that they had heard of the government guidelines on alcohol intake. Of these people, more than a third (36%) said that they did not know what the recommendations were.

In the UK in 2000, 30% of mothers who drank before pregnancy reported giving up drinking during pregnancy. Those mothers who continued to drink during pregnancy reported drinking very little, with 71% consuming less than 1 unit of alcohol a week, on average

In 2004/05, there were around 35,600 NHS hospital admissions with a primary diagnosis of mental and behavioural disorders due to alcohol.

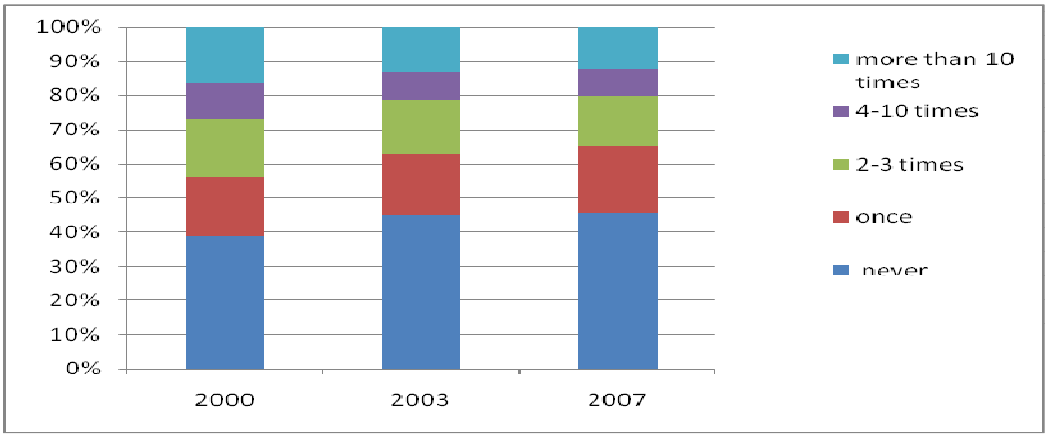
Source: NHS: the information centre for health and social care (2006): Statistics on Alcohol: England, 2006

10.9 Young Person Alcohol Use

Figure 10.7 shows how often young people aged 11-16 have got drunk based on the Young Persons Behaviour and Attitudes Survey question 'Have you ever had so much alcohol that you were drunk?' The proportion of respondents who had never been drunk has increased over time to over 40%. Table 10.7 shows the figures broken down by Board. Young People in EHSSB are more likely to get drunk more often.

Figure: 10.7

Proportion of young people getting drunk



Source: Young Persons Behaviour and Attitudes Survey

Table: 10.13

Proportion of young people getting drunk

		(%) No, never	(%) Yes, once	(%) Yes, 2-3 times	(%) Yes, 4-10 times	(%) Yes, more than 10 times
2000	EHSSB	34.9	17.2	17.7	10.6	19.7
	NHSSB	38.7	16.2	17.8	11.3	16.0
	SHSSB	42.2	19.6	14.5	8.5	15.2
	WHSSB	40.3	16.4	17.7	10.4	15.1
	All	38.6	17.3	17.0	10.3	16.8
2003	EHSSB	40.1	18.0	18.1	9.4	14.4
	NHSSB	48.3	17.9	11.1	8.4	14.2
	SHSSB	44.4	20.8	15.9	8.2	10.7
	WHSSB	47.7	16.0	16.9	7.8	11.7
	All	44.8	18.1	15.6	8.5	13.0
2007	EHSSB	41.4	19.4	14.5	8.6	16.2
	NHSSB	48.7	17.8	14.7	8.6	10.3

		(%) No, never	(%) Yes, once	(%) Yes, 2-3 times	(%) Yes, 4-10 times	(%) Yes, more than 10 times
	SHSSB	50.9	21.0	14.2	5.0	8.9
	WHSSB	42.9	22.5	13.7	9.0	11.9
	All	45.4	19.8	14.3	8.1	12.3
Source: Young Persons Behaviour and Attitudes Survey						

Box 10.10: Young persons' alcohol consumption in England

In 2005, 22% of pupils in England aged 11-15 reported drinking alcohol in the week prior to interview; the proportion doing so has fluctuated around this level since the mid 1990s. Average weekly consumption almost doubled between 1990 (5.3 units) and 2000 (10.4 units), fluctuating around this level since then

Source: NHS: the information centre for health and social care (2006): Statistics on Alcohol: England, 2006

10.10Drug Use

Table 10.14 shows the percentage of problem drug users by age. The data comes from the Drug Misuse Database which collects information from drug treatment agencies on problem drug users presenting to services for the first time, or for the first time in six months or more. All data is based on analysis of DMD forms where consent is given. The age band recorded changed between 2006 and 2007.

Males were roughly three times as likely to be a problem drug user as females from 2005 to 2006. The proportion of female problem drug users increased in 2008.

Table: 10.14

Percentage problem drug users by age

	Male	Female	15 years & under	16-19 years	20-25 years	26-29 years	30-39 years	40 years & over
2005 %	76	24	8	16	25	12	24	15
2006 %	72	28	9	20	23	13	21	15
2007 %	73	27	14	13	12	15	27	20
2008 %	62	38	4	11	11	10	24	40
Source: DHSSPS, Drug & Alcohol Information & Research Unit								

10.11 Summary

The aim of Objective 7 is to enable people to make healthier choices. The target set is to stop the increase in the levels of obesity in men and women so that by 2010, the proportion of men who are obese is less than 17%, and of women, less than 20%. The proportion of obese people has increased from the time the baseline figure was recorded and 2005-06. The percentage of obese men has increased considerably by 8% and women by 3%. If the number continues to grow at the current rate, the target of reducing the levels of obesity will not be met.

The lifestyle data for adults is not encouraging. The data for the levels of physical activity for adults has remained largely unchanged over time and in 2005-06, with only 30% getting more than the recommended level of exercise and only 27% of adults were eating the recommended levels of fruit and vegetables daily. The available data suggest that nearly one third of adults binge drink, and that the proportion of males who binge drink is higher than the proportion of females. Males were also roughly three times as likely to be a problem drug user as females from 2005 to 2006. The proportion of female problem drug users increased in 2008.

The lifestyle data for young people is more encouraging. The proportion of young people aged 11 to 16 eating fruit and vegetables daily has increased over time. The proportion of young people in this age group who do not smoke has increased over time to over 60% and the proportion who had never been drunk has also increased over time to over 40%.

The proportion of overweight and obese girls has fluctuated over time; the rates rose between 1999-01 and 2003-04 and then fell sharply to 2006-07. The proportion of overweight and obese boys has increased slightly over time but a slower and more consistent rate. A higher proportion of girls are overweight and obese than boys.