your

Health Matters

THE ANNUAL REPORT OF THE CHIEF MEDICAL OFFICER FOR NORTHERN IRELAND 2014

I am a cancer survivor...

My son has Downs Syndrome...

I'm a carer...

My little girl died because of a blind cord...

I tried to take my own life...

Instead of a flu vaccination my child got the nasal spray...

I'm getting old...

My surgery was cancelled twice...

I quit smoking...

The ambulance crew saved my grandfather's life...

I waited too long in A&E...

I'm pregnant, I got the whooping cough vaccination to protect my baby...

I binge drink...

Not sure I eat my five-a-day...

Sometimes I'm lonely...

Department of
Health, Social Services and Public Safety
www. i .

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

In previous reports I have highlighted a range of initiatives aimed at delivering effective healthcare. That focus has continued this year through implementation of Quality 2020, work by the Safety Forum, a system wide response to improving Emergency and Urgent care services and the Donaldson review.

In his Report "The Right Time, The Right Place", published in January 2015, Professor Sir Liam Donaldson sets out the scale of the challenge facing the health and social care sector in Northern Ireland. Avoidable harm occurring is a feature of health and social care services across the world. However, it would be dangerous for us to accept the paradigm that universality makes this somehow acceptable in Northern Ireland. Such complacency would do a great disservice to the people who use our health and social care services – that a service designed and a staff committed to providing care should cause preventable harm is unacceptable.

Donaldson may have given a new voice to a number of problems which already existed in Northern Ireland. Although many were already known, it is important that he has looked at those problems through fresh eyes and provided a new perspective on them. He highlights that we simply cannot afford to be satisfied with services which are 'good enough' and that, with a clear appreciation of the current challenges facing quality and safety, everyone must be committed to working together to strive to make our health and social care system amongst the best in the world.

It is Donaldson's view that it is realistic to make Northern Ireland a world leader in quality and safety of its care. I share Donaldson's view that in implementing the recommendations "the leaders of the Northern Ireland health and social care system should be clear in their ambition, which in our view is realistic, of making NI a world leader in the quality and safety of its care. Northern Ireland is the right place for such a transformation, and now is the right time." Achieving this will require the commitment and support of everyone involved in the provision of health and social care and its oversight. To fail to act now is unconscionable; no and slow are not options in response to the transformation required.

Another key publication last June was the new public health framework – Making Life Better. It builds on the Investing for Health strategy and sets the direction for policies and actions to improve the health and wellbeing of the people of Northern Ireland. It is important that individuals and communities can take control of their own lives. A key aim of the framework is to create the conditions which allow them to do so. Although the health of the public continues to improve greater targeting and levels of support is needed for those with greater social, economic and health disadvantage.

The impact that certain lifestyle factors have on the health of the public is of great concern to me. In addition to educating the public we need to look at other measures to reduce the numbers who are putting their health and lives at risk. Alcohol misuse is a significant health and social problem. Research has shown that introducing Minimum Unit Pricing will go some way to reduce excessive alcohol consumption and, in addition to having a positive effect on health, will reduce antisocial behaviour. As CMO I fully support evidence-based intervention to improve the health of the population.

We are now seeing the benefits of the smoking ban in public places with a significant reduction in the number of young people who report smoking and a decline in the average number of cigarettes smoked by adults during the day. This has also resulted in a significant reduction in exposure to second-hand tobacco smoke. A worrying development, however, is the rising popularity of e-cigarettes particularly among young people. There are risks that this will again normalise smoking.

Achieving good mental health for everyone remains a challenge. We now know that careful nurturing of a child's social and emotional health during their early years is vital to their mental health development and helps build resilience for emotional challenges they may face in later life. The Infant Mental Health Framework and Action Plan will help staff deliver the necessary support to families to allow their infants maximise their social and emotional development.

Preventing deaths and injuries from blind cords remains a priority for me. I have been deeply affected by those who have tragically lost children in this way. I welcome and am reassured by the valuable work being undertaken by manufacturers and others to raise awareness of blind cord safety and reduce the risk of accidents.

Internationally last year's outbreak of Ebola was one of the most devastating outbreaks of a disease in living memory. It stretched the health care systems in the affected African countries well beyond their capacity to deal with the outbreak. Support from the international community was vital to bring the outbreak under control and prevent spread to other countries. I would like to thank all of those who volunteered to go out and help, especially health care staff from Northern Ireland. I would wish to acknowledge all the work, across the HSC, that has gone into preparing for a possible imported case so that we might protect the public we all serve.

Dr Michael McBride
Chief Medical Officer

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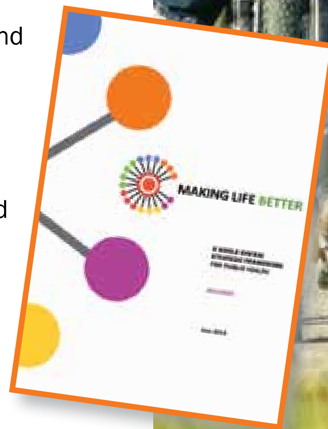
Making Life Better

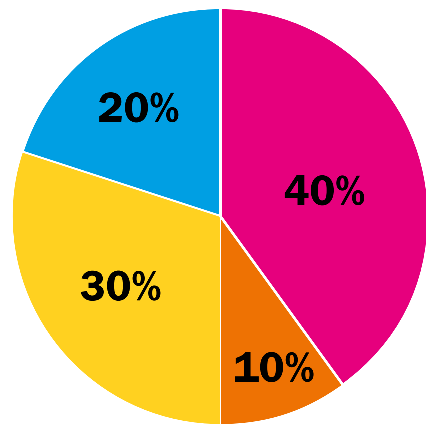
Like other developed countries the health of people in Northern Ireland continues to improve. Although people are living longer, too many people still die prematurely or live with conditions they need not have. Also people living in different social circumstances experience different levels of health.

Many studies show that health is affected to a greater extent by economic, social and environmental factors than by health behaviours or health and social care services. This is why Making Life Better, the ten year strategic framework for public health, focuses on working collaboratively, in a coherent way, across government departments and sectors, with individuals, communities and partner organisations, to address the wide range of issues which affect health and wellbeing and inequalities in health.



Published in June 2014, Making Life Better sets the direction for policies and actions to improve the health and wellbeing of the people of Northern Ireland and reduce inequalities in health. It builds on the *Investing for Health* strategy (2002/12) and retains a focus on the broad range of social, economic and environmental factors which influence health and wellbeing.

Factors Determining the Best Health Outcomes for Populations



- Social and economic issues such as education, employment and violent crime.
- Health behaviours such as alcohol, tobacco and sexual behaviour.
- Clinical services including quality of and access to health care.
- Other factors

A key aim of the framework is to create the conditions for individuals and communities to take control of their own lives. This will require action to improve services for everyone, but with greater targeting or levels of support for those with greater social, economic and health disadvantage.

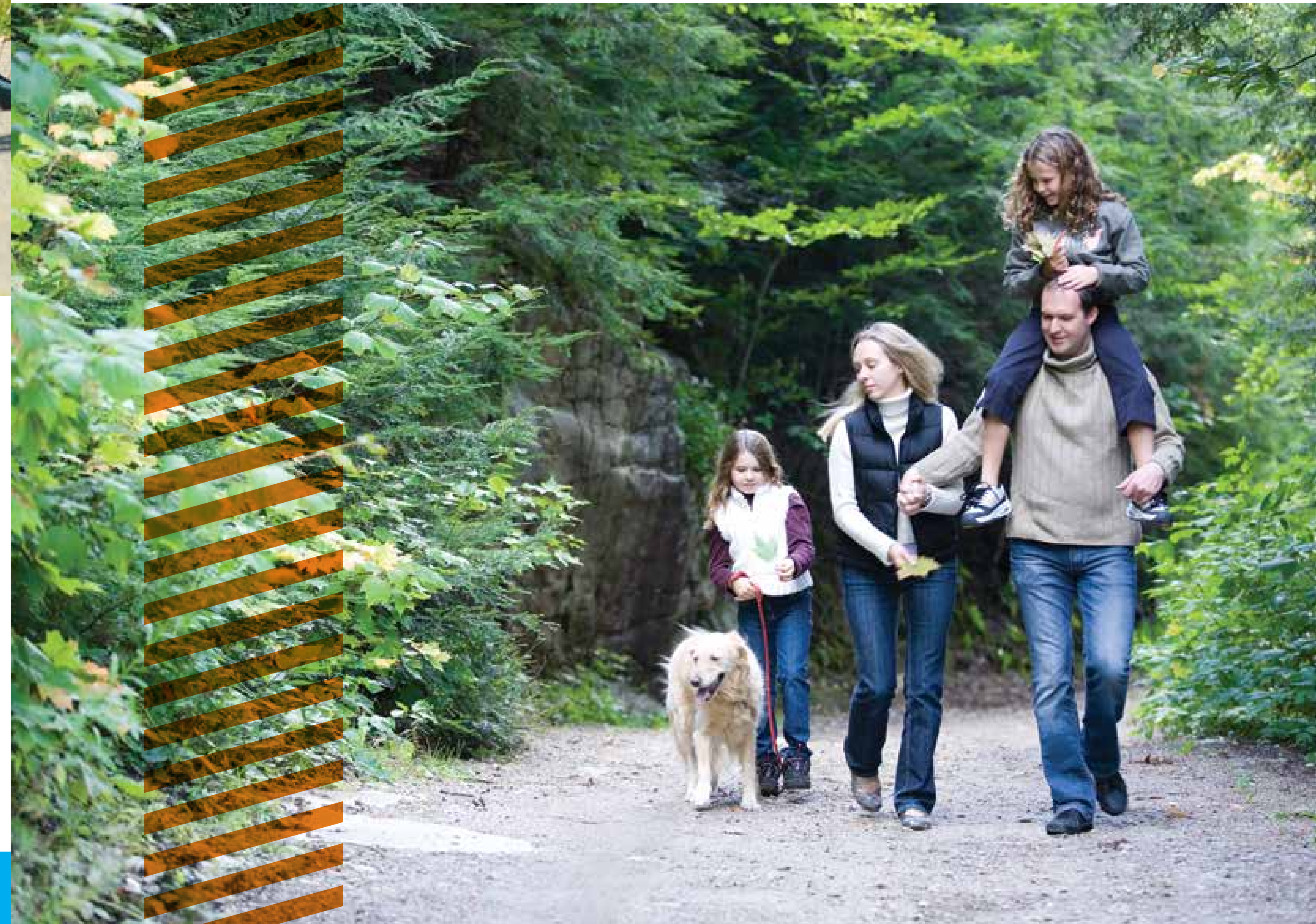
VISION – All people are enabled and supported in achieving their full health and wellbeing potential

AIMS – Achieve better health and wellbeing for everyone and reduce inequalities in health

The actions committed to in the framework are grouped around 6 themes. These reflect both a lifecourse approach and focus on the wider factors influencing health. Within each of these themes, there are particular outcomes which lend themselves to a cross-sectoral or thematic approach across departments and organisations.

Making Life Better - Themes

1. **Giving Every Child the Best Start** – has a strong emphasis on empowering and supporting parents and on education.
2. **Equipped Throughout Life** - has a focus on supporting individual's transitions into and through working age and older age.
3. **Empowering Healthy Living** – seeks to empower people of all ages to identify the risks to their health, choose healthy behaviours, and make informed decisions about their health. It also emphasises the need to embed prevention across all health and social care activity.
4. **Creating the Conditions** – recognises the need for joint working across government to address the wider structural, economic, environmental and **social conditions** impacting on health at population level.
5. **Empowering Communities** – promotes partnership working with local communities to build on assets in communities and to work in partnership with local government and other key agencies to address community issues.
6. **Developing Collaboration** – identifies both strategic and local actions to enhance collaboration.



The use of physical space is one example where collaboration for public health will be beneficial. Many reports identify how the quality of both the natural and the built environment impact on our physical and mental wellbeing. Environments which enable walking or cycling, age-friendly towns and cities, access to green spaces and to local services, the general appearance of our neighbourhoods are all issues to which many sectors can contribute.

Governance and Implementation

Mutual benefits and shared goals can be achieved by working together effectively. The framework aims to promote a whole system approach which develops a sense of coherence, and strengthens and maximises linkages across other relevant policies and programmes and the various levels of delivery of the framework. It will be important too that connections are made with other structures, for example the Children and Young People's Strategic Partnership, that are working on issues that will contribute to the outcomes of Making Life Better.

A formal structure has been established to take forward the implementation of Making Life Better.

> "Local Government will continue to be a natural partner in helping to deliver health improvements and a reduction in health inequalities at local level. Making Life Better provides a mandate for this, and sets the agenda for the public health element of community planning."
>
> Source: Making Life Better

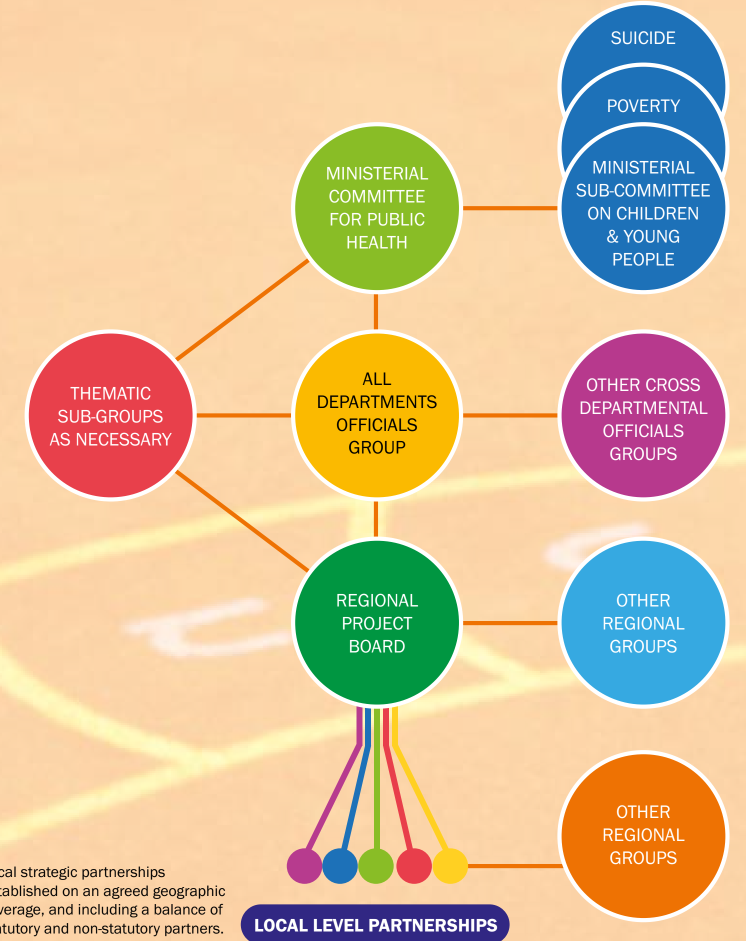
Public access to an outdoor gym.

A set of key indicators has been identified to monitor the wider social determinants of health and wellbeing associated with Making Life Better. These indicators and baseline information can be found at **http://www.dhsspsni.gov.uk/hscims-mlb-2014.pdf**

Making Life Better can be found at - **http://www.dhsspsni.gov.uk/index/mlb.htm**

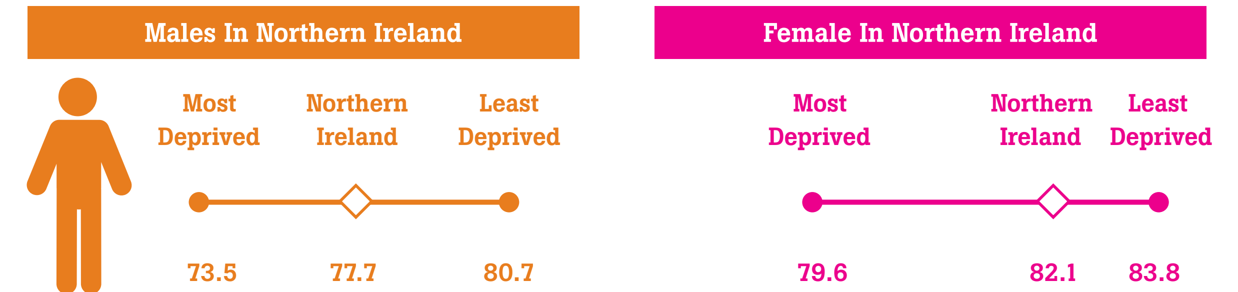
Making Life Better

Governance and Implementation

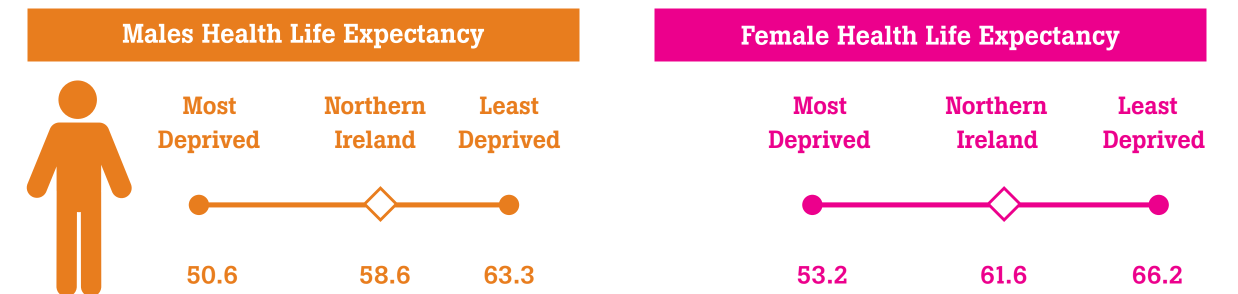


Life Expectancy by Deprivation 2010–12

Females in the least deprived areas (83.8 years) can expect on average, to live 10.3 years longer than their male counterparts living in most deprived areas (73.5 years).



Both males and females living in the least deprived areas can expect to live in good health for 13 years longer than those in the most deprived areas.



Source: DHSSPS Health Inequalities – NI Health and Social Care Inequalities Monitoring System – Regional 2014.

Creative Local Action Response & Engagement (C.L.A.R.E.)

The "Creative Local Action Response & Engagement" (C.L.A.R.E.) project is a community led initiative that aims to build the capacity of local people to support vulnerable adults to live independently in caring and responsive communities, delivering better outcomes for the individual and reducing the pressure and early reliance on adult health and social care services.

It aims to do this by encouraging people to volunteer and become **'Community Champions'**. Through these skilled community champion volunteers, vulnerable adults and older people will be supported to identify the services, resources and practical support they require, and will be assisted to engage with the wider services they need.

This model of delivery will ensure vulnerable individuals have information and access to the right support at the right time, remove potential barriers to engagement and effectively enable them to maintain their independence, prevent deterioration in health outcomes and improve health and wellbeing.

Many aspects of this ground-breaking project resonate with a key aspiration of Transforming Your Care – promoting home as the hub of care. In seeking to empower individuals and communites it is also a clear demonstration of the agenda for collaborative action outlined in the public health framework – 'Making Life Better'.

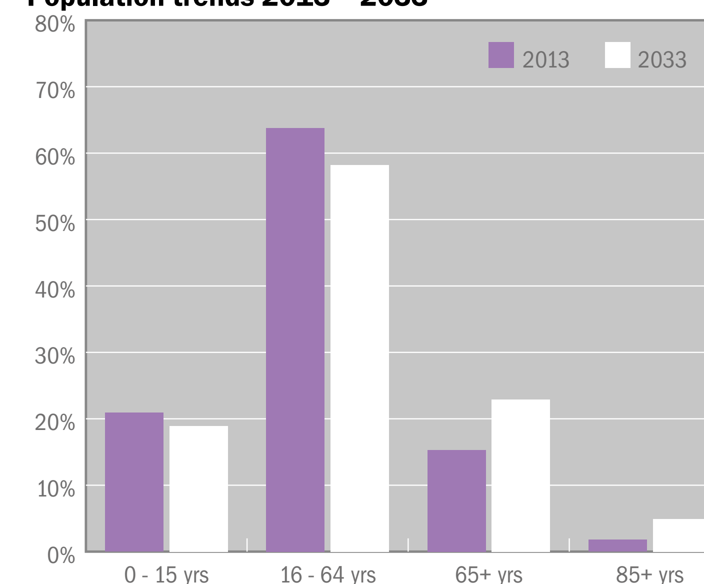
The CLARE Project is part funded through the Public Health Agency and is the first project in Northern Ireland to receive investment from The Big Society Capital.

The programme is based in Mount Vernon and is currently operational within 7 wards in North Belfast, but there are plans to expand it more widely in future years.

Our Ageing Population

People are now living longer than they did 40 or 50 years ago and as a result the number of older people in our community is increasing. In 2013 there were estimated to be 279,000 people aged 65 and over with 33,000 of them over 85 years. These figures are projected to increase considerably in the next 20 years to 456,000 and 79,000 respectively.

Population trends 2013 – 2033



This increase in life expectancy is to be celebrated but highlights the need for us to plan for the increasing number of older people in our population. In addition to adding years to life we want to see older people spending as many of those years as possible both healthy and active.

Much of the focus on ageing is on the costs to society such as pensions, welfare payments and increased health and social care needs however, this is not entirely accurate. Many older people live active lives and contribute to community life in different ways – as friends, neighbours, carers, grandparents, volunteers and employees. They contribute more both financially and non-financially than people realise. In 2010, it was estimated that the over 65s made a net contribution of £40 billion to the UK economy through taxes, personal spending, provision of social care, volunteering and in a variety of other ways.

Ageing does however, bring an increased likelihood of some degree of disability and dependency and older people are the main users of our health and social care. In Northern Ireland:

- two thirds of acute hospital beds are occupied by people over 65 years.
- 9,840 people over 65 live in residential care or nursing homes.
- approximately 23,400 clients receive domiciliary care weekly.

Service Framework for Older People

A Service Framework for Older People was published in 2013. It sets standards of care that service users, their carers and wider family can expect to receive. It sets standards in relation to:

1. Person-centred Care
2. Health and Social Wellbeing Improvement
3. Safeguarding
4. Carers
5. Conditions more Common in Older People
6. Medicines Management
7. Transitions of Care

What is lining our larders and filling up our fridges?

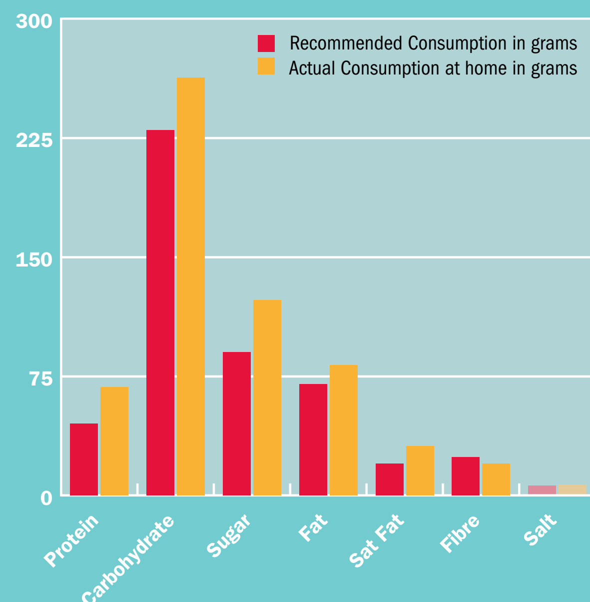
The Food Standards Agency (FSA) in Northern Ireland has been participating in the UK-wide Kantar survey to establish a picture of what the population of Northern Ireland is purchasing from supermarkets.

> The aim of the research is:
>
> To provide insight into the nutritional balance of the overall take home diet; inform our measurement of the Obesity Prevention Strategy "Marker Foods" and help inform the FSA in NI's work going forward with retailers and industry.

Northern Ireland households average 244 shopping trips per year across 1 big, 1 medium and 3 small shops a week. The average spend is £74 per household per week on approximately 55 items. In 2013, 29% of total grocery spend was on items being sold on promotion. Confectionery, alcohol, soft drinks, take home savouries (including nuts and crisps), ready meals and meat and fish products are most likely to be sold on promotion; with starchy carbohydrates, fruit and vegetables least likely.

The Kantar data relates only to take home food and drink, that is, food bought in supermarkets and prepared or consumed at home Food consumed outside the home, for example in restaurants, from take-aways or snacks on- the-go is not included.

Actual consumption per person per day is compared to the recommended daily intake for a female. The recommended intake for men is higher and for children may be lower depending on their age.



Based on take home food alone, apart from fibre, we are eating more than the recommended levels for all nutrients. Saturated fat intake is 50% higher than the recommended level and sugar nearly 40% higher. The calorie intake is also higher at 2137 versus 2000.

Kantar WorldPanel Data

Kantar data relies purely on retail sales and whilst operating worldwide, household panels are run in Great Britain, Northern Ireland and the Republic of Ireland. The Northern Ireland Panel comprises a sample of households (n=650) which is representative of the Northern Ireland population. Each household Panel is given a barcode scanner and maintains diaries for all purchases brought into the home.

Kantar captures households' postcodes to facilitate data being analysed by level of deprivation. Price and expenditure data are recorded as are consumers' perception as to whether the item bought was on promotion. It is possible to track demographics, attitudes, food products, food categories, pricing, promotions and trends over time. From this data, FSA in Northern Ireland will be in a position to understand:

- Which Food & Drink categories are most important to shoppers in Northern Ireland?
- Which of the Marker Foods categories are shoppers spending more or less on?
- What are the perceived promotional levels across the different categories?
- What is the price paid across the different Food & Drink categories?
- Which categories are becoming more expensive and which are becoming cheaper?

A full report based on the Kantar purchase data will be available in 2015.

A FITTER FUTURE FOR ALL

Overweight and obesity remain key issues for this Department and we all need to respond in a co-ordinated manner and support individuals to overcome barriers and constraints in order to enable them to make healthier choices. By adopting simple lifestyle changes we can reduce the likelihood of developing obesity related conditions which place significant costs on our health care system.

To help reduce the harm related to overweight and obesity the Department, with a number of stakeholders, developed the *Framework for Preventing and Addressing Overweight and Obesity in Northern Ireland 2012-2022:* **A Fitter Future for All** which was launched in March 2012. This Framework aims to "empower the population of Northern Ireland to make healthy choices, reduce the risk of overweight and obesity related diseases and improve health and wellbeing, by creating an environment that supports and promotes a physically active lifestyle and a healthy diet". http://www.dhsspsni.gov.uk/index/phealth/php/obesity-prevention.htm

An update report of this Framework is now available and can be accessed on the Department's Obesity webpage at the above link. The Framework is also undergoing its first three-year review in 2015 and revised outcomes will also be published at this link when complete.

A FITTER FUTURE FOR ALL

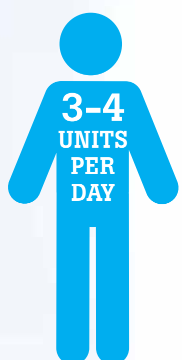
Framework for Preventing and Addressing Overweight and Obesity in Northern Ireland 2012-2022

ALCOHOL CONSUMPTION
STILL A CONCERN

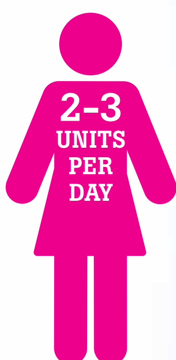
In Northern Ireland almost 1 in 5 of the adult population who drink alcohol consume it at levels above those recommended by the four UK CMOs, that is 3-4 units per day for men and 2-3 units per day for women. This group accounts for two thirds of all alcohol consumed. Harm caused by alcohol misuse is wide-ranging and varied – drinkers are at higher risk of cancer, mental health problems, liver disease and injury. Families and communities can also suffer through anti-social behaviour and domestic violence, while businesses and the economy also face the consequences of excessive alcohol consumption through presenteeism, absenteeism, crime and hospital admissions. A recent report suggests that the true social cost of alcohol misuse to the Northern Ireland economy is as much as £900m per year. However, this financial burden can never fully describe the impact that alcohol misuse has on individuals, on families, and on our communities. We owe it to those individuals who drink heavily, and their families, to do something about this.

RECOMMENDED alcohol consumption

MEN



WOMEN



Standardised Hospital Admissions Rate

In 2010/11 – 2012/13 the hospital admission rate due to alcohol-related conditions was over one and a half times higher for males than females. The rate among males in the most deprived area was **5 times higher** than males in the least deprived areas.

MEN

Least Deprived	Northern Ireland	Most Deprived
415	997	2,338

WOMEN

Least Deprived	Northern Ireland	Most Deprived
176	385	783

ALCOHOL PRICING

The University of Sheffield was commissioned to produce an academic report modelling the effects of introducing Minimum Unit Pricing (MUP) in Northern Ireland. This report **(http://www.dhsspsni.gov.uk/mup_ni_report_from_university_of_sheffield.pdf)** confirms that MUP has the potential to make a real difference in tackling the harms caused by alcohol misuse. While it is not a "cure-all" the robust evidence base demonstrates that it will go some way in curbing excessive drinking in our population and help those who drink too much to reduce the harms they cause to themselves and our communities. This alone makes MUP a policy worth pursuing.

The evidence produced by the University of Sheffield shows that it is those people who drink the most buy the cheapest alcoholic drinks – own brand spirits and white cider. They will therefore be the most affected by MUP as the retailers will have to sell these stronger drinks at higher prices.

The Sheffield Report shows that a MUP of 50p per unit would reduce average weekly alcohol consumption across all types of drinkers by 5.7% (moderate by 1.6%, hazardous by 5% and harmful by 8.6%). For those who drink the most this means an annual reduction of some 384 units per year, equivalent to almost 79 litres of 5% ABV cider.

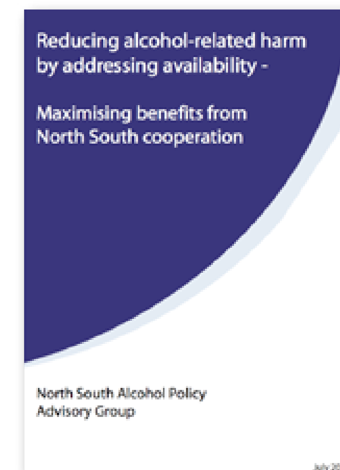
The immediate impacts of a 50p MUP will include reduction in crime of 5,200 offences in the first year and a reduction of 35,000 "sick days". This would be in addition to the reductions in anti-social behaviour and fewer injuries caused by alcohol-induced falls and brawls. The health impacts will take longer to accrue, but the report suggests that after 20 years there would be 60 fewer deaths per year and 2,400 fewer alcohol-related hospital admissions. Over the 20 years a 50p MUP would see the total societal value of these reductions in health, crime and workplace harms produce savings estimated at £950m.

Drink	Minimum Price
A 35ml measure of 37.5% Vodka	£0.66
A 700ml bottle of 40% Gin	£14.00
A 500ml can of 9% Super Strength Lager	£2.25
24 cans of 440ml 4% Lager	£21.12
A pint (568ml) of 4.5% Ale	£1.28
A 750ml bottle of 12.5% White Wine	£4.69
A 2 litre bottle of 6% Cider	£6.00
A 250ml bottle of 5% Alcopop	£0.63

North/South Alcohol Policy Advisory Group

Alcohol Misuse isn't just a problem in Northern Ireland – the rest of the UK and Ireland are dealing with similar issues and coming forward with a range of solutions. Given the nature of the harm and patterns of cross-border trade, my counterpart in the Republic of Ireland and I established a public health North/South Alcohol Policy Advisory Group to bring together experts in both jurisdictions to look at the challenges facing us, and see if our solutions can be improved by working together.

The group, chaired by the Institute of Public Health in Ireland, has met on a number of occasions and shared information on a range of polices and issues such as Minimum Unit Pricing and hidden harm. In particular, the group developed and published a very useful paper on addressing alcohol misuse through tackling availability. This paper **http://www.publichealth.ie/reducingalcohol.pdf** highlights a range of actions that can be taken to reduce alcohol-related harm through addressing availability. These are now under active consideration by both governments.



TOBACCO CONTROL

Smoking remains the single greatest cause of preventable illness and death in Northern Ireland, killing around 2,300 people each year. It is also one of the leading causes of health inequalities. In the past fifteen years, we have made considerable progress into reducing the harm caused by smoking, with latest figures showing that adult smoking prevalence is down from 29% in 1998/99 to 22% in 2013/14. Measures such as smokefree legislation, increasing the age of sale for tobacco to 18 and banning displays of tobacco in shops, have all contributed to this reduction.

A typical e-cigarette design

Electronic Cigarettes

E-cigarettes were developed as an alternative to tobacco products and, since the introduction of smokefree legislation, the number of people using them in the UK has grown year on year. They are battery-powered vapour inhaler devices which generally contain nicotine and/or flavourings. It is estimated that there are around 400 different products available on the UK market.

While perceived to be less harmful than tobacco, e-cigarettes are currently unregulated and it has not been determined that they are safe to use. In addition, e-cigarettes are legally available for sale to minors, a situation that will be remedied through the inclusion of provisions in the Health (Miscellaneous Provisions) Bill.

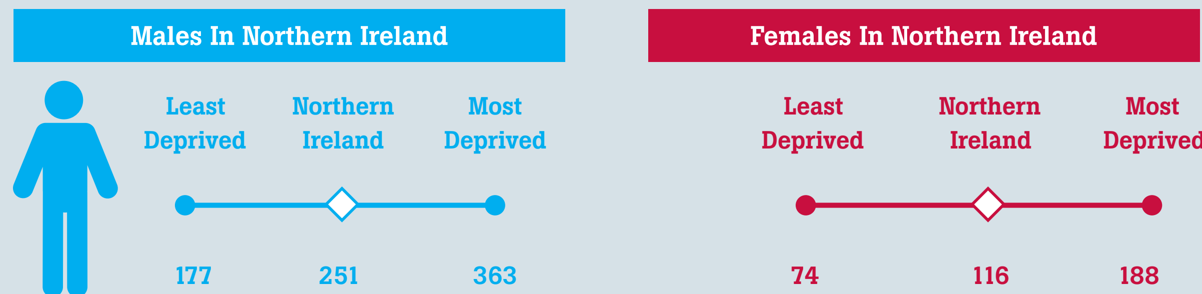
Preventable Deaths

A death is preventable if all or most deaths from that cause could be avoided by public health interventions in the broadest sense.

In 2008-2012 smoking related deaths among males was more than double that for females.

It was highest in men in the most deprived areas and was almost 5 times the rate for females in the least deprived areas.

Standardised Death Rate - Smoking



	Least Deprived	Northern Ireland	Most Deprived
Males In Northern Ireland	177	251	363
Females In Northern Ireland	74	116	188

A recently adopted EU Directive requires all e-cigarettes up to a certain nicotine threshold to be regulated as consumer products from May 2016. Specific additional safeguards for consumers, as well as restrictions on advertising and promotion, will also apply.

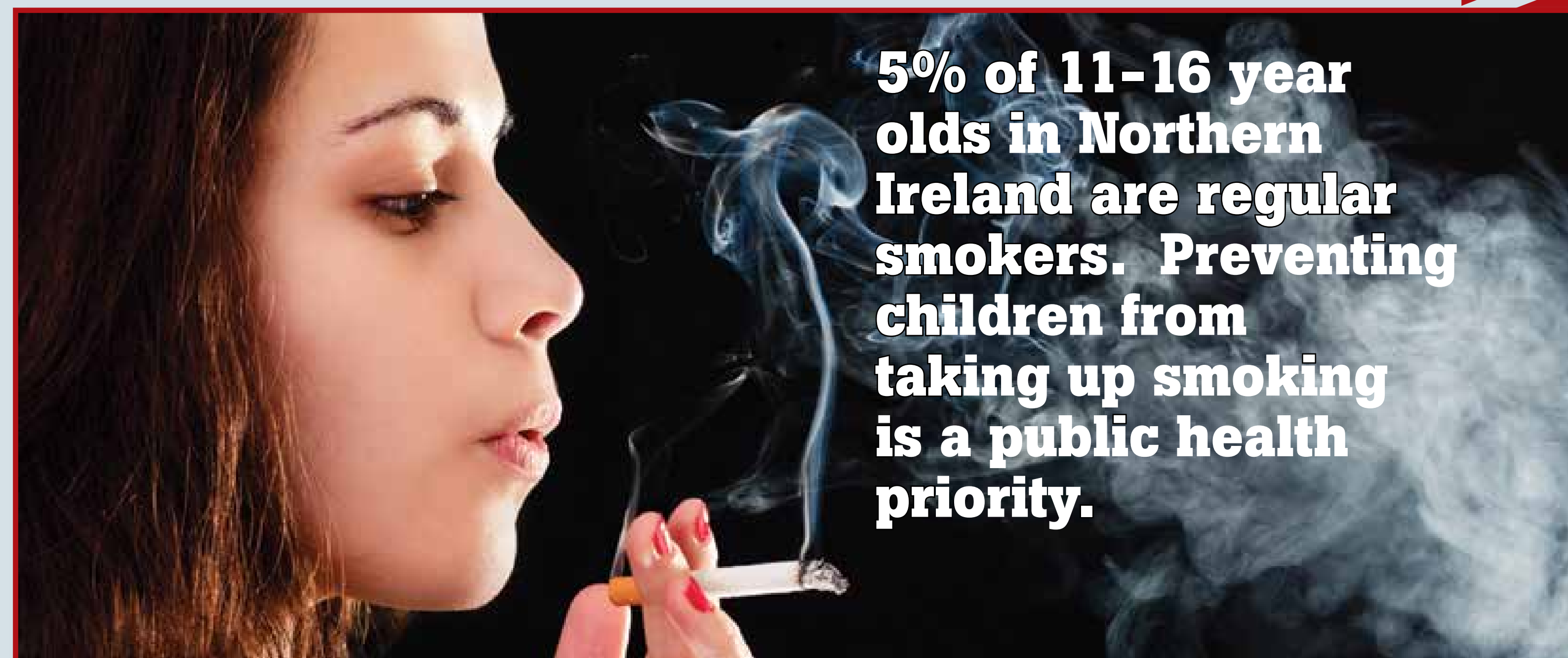
There are a number of concerns around the rising popularity of e-cigarettes, namely –

- the aggressive promotion and marketing of e-cigarettes which has led to their increased awareness and use by children and young people. This was highlighted by a recent YouGov survey which found that:
  - over 80% of young people are aware of e-cigarettes (up from under 70% in 2013); and
  - 10% of young people have tried e-cigarettes (up from 7% in 2013);
- the potential for the public use of e-cigarettes to renormalise smoking behaviours – behaviours to which a whole generation of children and young people from non-smoking homes are largely unaccustomed; and
- the addictive nature of nicotine. Not only may nicotine addiction through e-cigarettes act as a gateway into tobacco smoking but adolescent exposure to nicotine may also have long-term consequences for brain development.

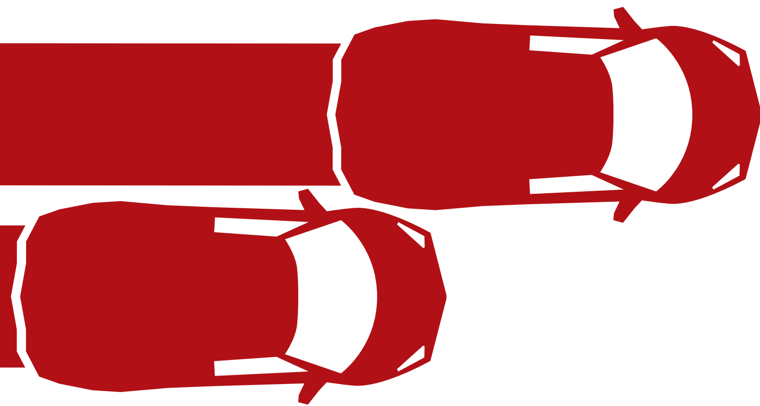
Standardised Packaging of Tobacco Products

Last year I reported on the development of a policy to introduce standardised retail packaging for tobacco products. Since then, following a consultation exercise carried out to seek views on draft regulations, Northern Ireland has been included in UK-wide regulations which will be commenced from May 2016.

The aim of standardised packaging is to prevent the uptake of smoking by children and young people. Evidence shows that this group is more receptive to tobacco advertising than adults, and that young people exposed to tobacco advertising and promotion are more likely to take up smoking. If these children continue to smoke, half of them will face an early death as a result of their addiction.



Smoking in Cars



It is vital that we protect people from exposure to secondhand tobacco smoke. In my annual report of 2008 I first highlighted the number of children who are still exposed to smoke in the home or in the car.

Children are particularly vulnerable to the effects of smoking and, with no escape from secondhand tobacco smoke in vehicles, are more likely to develop long-term conditions such as asthma, at an early stage.

Action on restricting smoking in private vehicles carrying children is progressing in the rest of the UK and Ireland and there may now be scope to introduce an amendment to the Health (Miscellaneous Provisions) Bill to include powers to restrict smoking in cars in Northern Ireland. This Bill is expected to be introduced to the Assembly by Summer 2015.

Benefits of Smoking Ban in Public Places

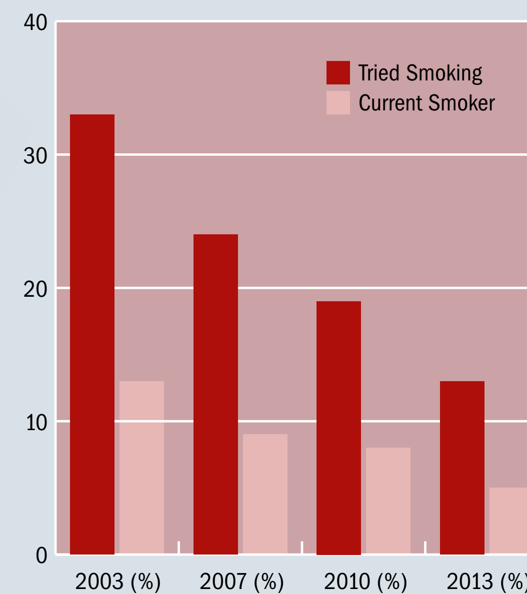
From 30 April 2007, it has been an offence to smoke in an enclosed or substantially enclosed public or work place in Northern Ireland. In April 2015, the Department, in partnership with the Institute of Public Health, published a report of smoke-free spaces in Northern Ireland which incorporated a 5 year review of smokefree legislation.

In addition to confirming how well embedded smokefree legislation is in our society, the report also highlighted a number of positive health outcomes which have arisen since the legislation was introduced. These include:

- a decline in the average number of cigarettes smoked by adults during the day;
- the proportion of young people who reported currently smoking or being regular smokers being halved between 2007 and 2013;
- a decline in the number of pregnant women who smoke;
- an increase in the number of households where smoking is not allowed; and
- a highly significant improvement in the air quality in pubs and bars.

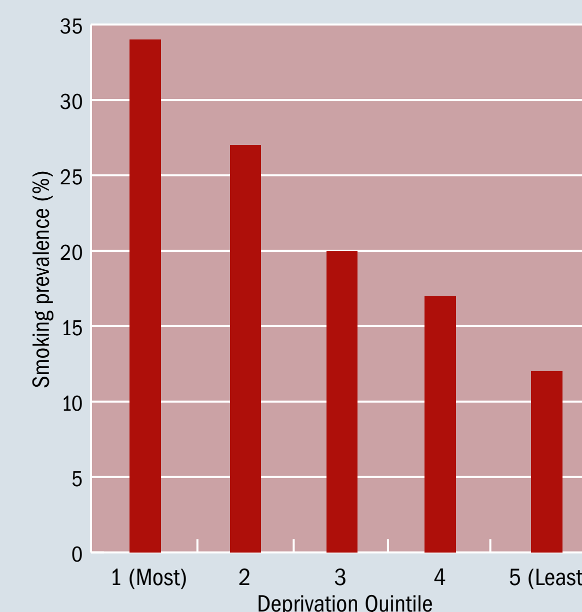
The report also draws attention to the challenges faced by public health in terms of reducing exposure to secondhand smoke. These challenges include: continued high smoking prevalence amongst adults; the inequalities gap in smoking prevalence between those on higher and lower income; and unacceptable levels of exposure to secondhand smoke, both in the home and in family cars, particularly by children.

Smoking levels in Northern Ireland's young people from 2003



Source: Young Person's Behaviour and Attitudes Survey 2003, 2007, 2010 & 2013

Smoking prevalence among adults (aged 16+) by deprivation level (2012/13)



Source: Health Survey NI 2012/13

MENTAL HEALTH ISSUES

Mental illness is the single largest cause of disability, and leading cause of sickness absence from work, in the UK. People with a mental illness die on average 15 to 20 years earlier than those without, often from avoidable causes. We must therefore strive to achieve parity between mental health and physical health, working more closely in partnership with those who use our services and their carers. The following initiatives are important developments in caring and supporting those with mental health problems.

RECOVERY

Across our mental health services there is now increasing emphasis on "recovery" and a specific programme of "Implementation of Recovery through Organisational Change (IMROC)" is being taken forward. Recovery in this context is a personal journey of discovery for those people with mental health problems. It involves:

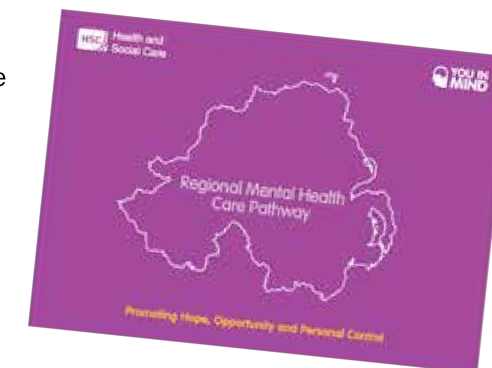
- making sense of, and finding meaning in what has happened;
- becoming a expert in your own self care;
- building a new sense of self and purpose in life;
- discovering your own resourcefulness and possibilities; and
- using these and the resources available to you, to pursue your aspirations and goals.

The IMROC programme works within a framework consisting of 10 key challenges. Locally Trusts have trained staff in the recovery approach and person-centred care planning, employing and embedding peer support workers within services, developing Team Recovery Implementation Plans, promoting use of recovery tools and co-production of information and resources.

Recovery Colleges

A specific focus has been the development of Recovery Colleges across all 5 Trust areas in a range of community settings. They will assist organisations and services to become more recovery focused and also assist the individuals with mental health problems in their personal and collective journeys of recovery, while breaking down the barriers that prevent people with mental health difficulties feeling included in society. The Recovery Colleges provide the courses that are co-produced and co-delivered by people who have experienced mental health problems, along with people who have clinical and specialist expertise, and are designed to re-skill and assist people with mental health problems to grow, have a say in what works for them and to have more control over their lives. The courses and workshops are available to people who have used mental health services, their carers, families and staff.

Regional Mental Health Care Pathway



Another initiative which will improve the experience of people with mental health problems when accessing services is the new Regional Mental Health Care Pathway "With You in Mind", launched in October 2014. The Care Pathway supports recovery through promoting hope, opportunity and personal control, and was co-produced with local people who have experience of mental illness personally or as carers. The Care Pathway will be a template for other mental health conditions and treatment specific care pathways and, as these are implemented, will strengthen the delivery by services of care both in line with evidence based NICE Guidelines and through a greater focus on psychological, social and physical outcomes.

Give something back
Relate to other people
Exercise your body
Appreciate your world
Try something new

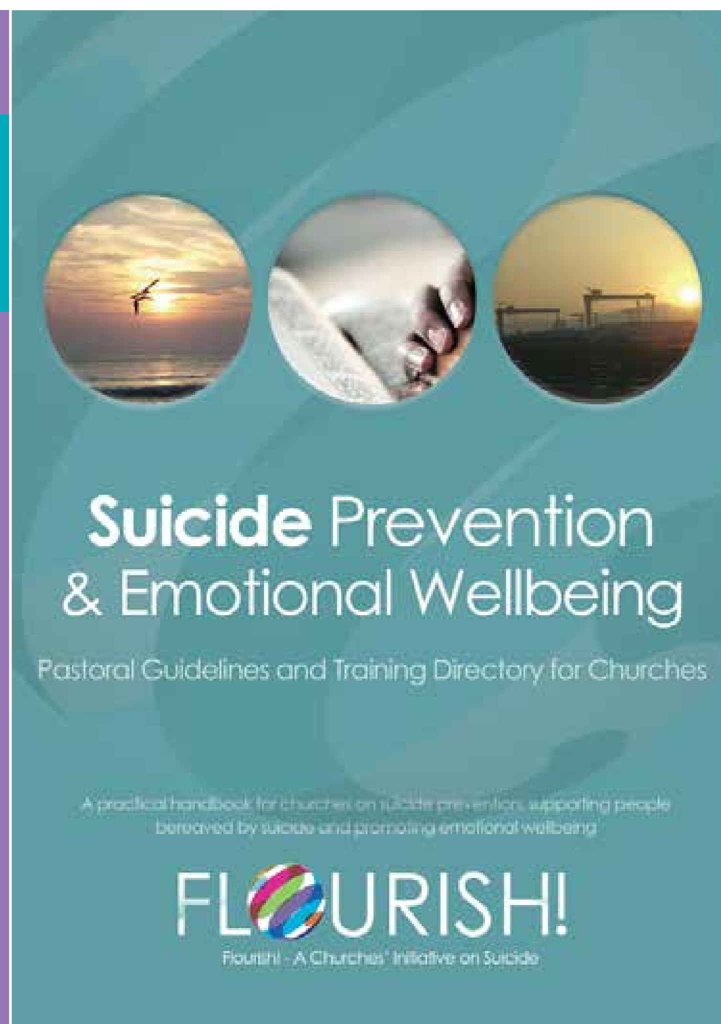
FLOURISH! – A CHURCHES' INITIATIVE ON SUICIDE

FLOURISH!

Our clergy and church communities are often the first points of contact for people in emotional distress and for those bereaved by suicide. One of the priority actions of the *Protect Life* Suicide Prevention Strategy for Northern Ireland, is to support churches in responding to the needs of people in these circumstances.

In light of this, the *Flourish!* inter-church suicide prevention initiative has been developed by Lighthouse Ireland, Churches' Community Work Alliance NI, the Public Health Agency, and Clergy from across the Christian churches in Northern Ireland. The initiative has the support of the leaders of the four larger Churches in Ireland and has included the development of good practice guidelines for clergy, church leaders and pastoral teams, supplemented by tailored training.

The guidelines provide practical support to help clergy, church staff and volunteers respond confidently, sensitively and appropriately to people affected by suicide. They include advice on promoting positive mental health as well as guidance on how clergy can look after their own mental wellbeing while providing support for others.



FLOURISH! SUNDAYS

"Often clergy, lay pastors, youth workers and other church staff and volunteers find themselves overwhelmed when caring for people experiencing mental and emotional health difficulties and families bereaved by suicide. These resources offer guidelines, including Scripture passages and prayers that have been prepared thoughtfully and carefully, which help the pastoral carer to respond sensitively and appropriately to people affected by suicide. The guidelines help to remove the sense of isolation and include a comprehensive list of contact details for other agencies who will offer specialist and ongoing support".
Reverend Mervyn Ewing from the Methodist Church in Ireland

Copies of 'Suicide Prevention and Emotional Wellbeing – Pastoral Guidelines and Training Directory for Churches' have been sent to over one thousand churches across Northern Ireland by the partnership group Flourish! A website has also been developed for clergy and can be accessed via **www.wewillflourish.com**

Lifeline
NEED HELP OR SUPPORT?
CALL 24/7 0808 808 8000

EARLY INTERVENTION FOR LIFELONG POSITIVE MENTAL HEALTH:

THE REGIONAL INFANT MENTAL HEALTH FRAMEWORK

Infant Mental Health may sound like a peculiar term but it needs to be seen in the broader context of the first three years of life. It is essentially, the investigation and promotion of optimal social and emotional development of infants and their families. This includes a child's ability to form relationships with other children and adults; to recognise and be able to express emotions; and to explore and learn about their environment in a safe and happy way.

Taking it in this broader context, we can see how vital a mentally healthy infancy is for lifelong health and wellbeing. What a child experiences during their early years has considerable influence in later life because the areas of the brain that control social and emotional development are most active during the first 3 years.

The capacity for resilience in the face of emotional challenges in adolescence and later life depends largely on the quality of the emotional bond – the security of attachment - that the infant develops with a primary carer, usually its mother. Careful nurturing of a child's social and emotional health during their early years is vital to provide them with the skills necessary to form relationships and interact positively with society later in life. All parents/carers play a critical role in ensuring good mental health development for their children. The wider family and society have a role in providing the support necessary for the primary carer to create a nurturing infancy.

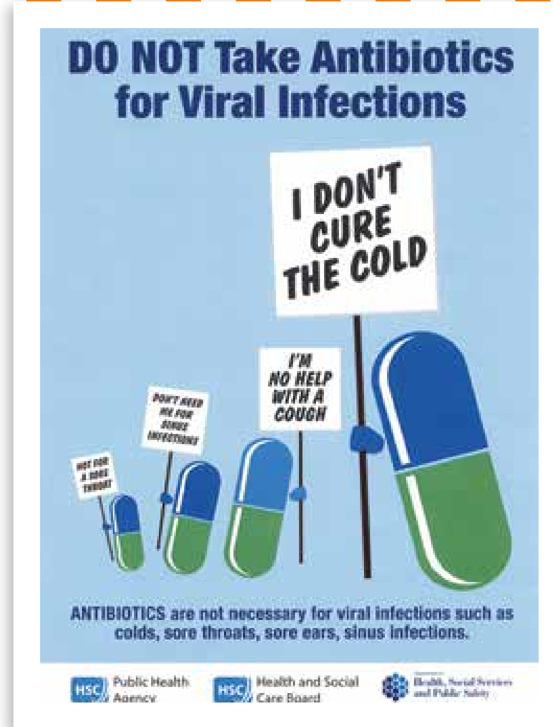
Securing a strategic approach to early child development and family support – especially for those children who experience inequalities is a key priority. The Public Health Agency is developing an Infant Mental Health Framework and Action Plan to promote positive social and emotional development from pre-birth to age 3 in Northern Ireland. It went out for public consultation on 13 March 2015.

The Framework will support commissioners and early years service providers to deliver optimal support for families and their infants, particularly in addressing the needs of infants in vulnerable circumstances.

The goal is to achieve the following key outcomes:

Parents and practitioners understand the importance of attachment and the essential elements of positive social and emotional health in infants.	Parents and practitioners have skills to engage positively with infants to maximise their social and emotional development.
Parents and practitioners are able to respond to predictors of vulnerability in infants and families, and identify early signs of delayed social and emotional development and /or emotional distress in infants.	Appropriate services are in place and available to respond to infant mental health and wellbeing needs.

HALTING Antimicrobial Resistance



Antibiotics are essential medicines for treating bacterial infections in both humans and animals, however they are losing their effectiveness at an increasing rate. This is because bacteria can adapt and find ways to survive the effects of an antibiotic. They become 'antibiotic resistant' so that the antibiotic no longer works. The more you use an antibiotic, the more bacteria become resistant to it.

Antibiotics should be taken as prescribed, never saved for later or shared with others. It is important to use antibiotics in the right way - the right drug, at the right dose, at the right time for the right duration. Appropriate use of antibiotics will slow down the development of antibiotic resistance.

Many antibiotics are prescribed and used for mild infections when they don't need to be. All colds and most coughs, sinusitis, otitis media (earache) and sore throats often get better without antibiotics. Community pharmacists are well placed to help provide advice on over-the-counter medicines to treat symptoms.

There are very few new antibiotics in the development pipeline, which is why it is important we use our existing antibiotics wisely and make sure these life-saving medicines continue to stay effective for ourselves and future generations.

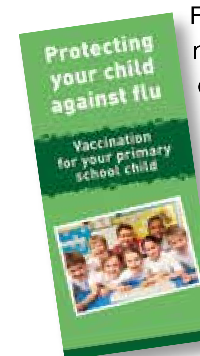
This year a new Antibiotic Guardian programme was introduced. The programme explains that 'without effective antibiotics, many routine treatments will become increasingly dangerous. Setting broken bones, basic operations, even chemotherapy all rely on access to antibiotics that work'. It goes on to explain that 'to slow resistance we need to cut the use of unnecessary antibiotics. European Antibiotic Awareness Day is held on 18 November each year. As part of that we're asking everyone in the UK, the public and the medical community to become Antibiotic Guardians. Each person is asked to choose one simple pledge about how they will make better use of antibiotics and help save this vital medicine from becoming obsolete.

For more information and to make a pledge yourself, go to
http://antibioticguardian.com

VACCINATION programmes

Vaccination is true primary prevention as it stops a disease occurring in the first place, rather than dealing with the symptoms or after effects. In last year's report I shared with you details of a number of new vaccination programmes or changes to existing programmes that had been introduced in Northern Ireland. Over the last year there have been further developments to a number of existing programmes.

Flu vaccination of children



Flu vaccination is now being rolled out to all children, in the form of a nasal spray rather than an injection. Vaccinating children has two benefits, as it protects them directly, but also stops them spreading flu to other family members or contacts. In 2014/15 all pre-school children aged two years and over, plus all primary school children were offered vaccination. In 2014/15 80% of school children took up the offer of vaccination.

Pertussis (whooping cough) vaccination for pregnant women

In 2011/12 the number of cases of whooping cough in the population increased and a number of very young babies died. In response, pertussis vaccine was introduced for women in the last three months of pregnancy. This has greatly reduced the number of cases of infection in babies under 3 months of age and also saved lives in this age group. The pertussis programme is being kept under review but is recommended for at least the next five years. All pregnant women are offered pertussis vaccine, ideally between 28 and 32 weeks of pregnancy. However vaccine can be offered beyond the 32nd week to those who miss out during this period. There have been no safety issues found in the vaccination of thousands of pregnant women.

Meningitis C vaccination – catch up for students

Vaccination against Meningitis C was introduced in 1999/2000 and in June 2013 the schedule was changed to include a vaccination for adolescents aged 13-15 years instead of 4 months of age as it was found this would provide better overall protection without reducing the benefits to the infants. The risk of meningitis is greatest in two distinct age groups – infants under a year, and adolescents aged 15-19. One group of the population at particular risk are those young people who are going to university for the first time, especially if they are living in halls of residence or in shared accommodation. In the summer of 2014 a 'catch-up' programme of Meningitis C vaccination was introduced for all those young people aged 19-25 attending university for the first time. This programme will run for the next four years, until the adolescents who have already received Meningitis C vaccine at school reach university age.

HPV (Human Papilloma Virus) vaccine

Cervical cancer is caused by the human papillomavirus or HPV, which is spread from one person to another during sexual activity. However, HPV vaccine can reduce the risk of a girl getting cervical cancer by over 70%. Girls are offered the HPV vaccine when they are 12 to 13 years old, in Year 9 at school. This means that they will get the most benefit from the vaccine and be protected from HPV infection whenever they do become sexually active. Until recently it had been recommended that girls receive three doses of the vaccine, but recent research has shown that two doses will give as good protection in 12 to 13 year old girls. However, if a girl is aged 15 years or over at the time of her first dose she will still need three injections within a 12 month period. This is because the research hasn't shown two doses to be as good as three doses in this older age group.

Emerging evidence from evaluation of HPV programmes around the world has shown that the number of young people with pre-cancerous lesions is falling and protection is expected to be long term.

Outbreak of Ebola

2014 saw the rapid development of one of the most devastating outbreaks of an infectious disease in living memory.

The outbreak of Ebola virus disease that took hold in Guinea, Liberia and Sierra Leone during 2014 has caused a major humanitarian crisis and is an ongoing challenge to the international community. By the end of 2014 there had been twenty thousand confirmed, probable or suspected cases in the three countries worst affected, with almost eight thousand deaths.

There have also been cases in neighbouring Mali, Nigeria and Senegal, and imported cases in the USA, Spain and the UK.

What is Ebola virus disease?

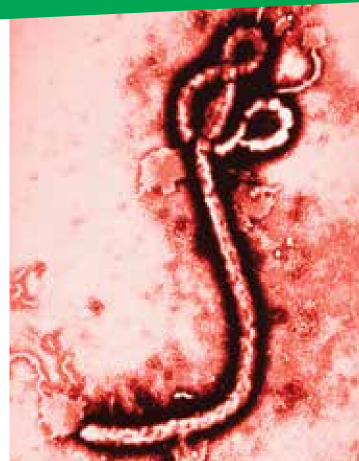
Ebola virus disease is a serious disease which originated in Africa. The initial symptoms include sudden fever, severe weakness, muscle pain and a sore throat. Later, symptoms include vomiting, diarrhoea and, in some cases, internal and external bleeding.

It is spread between humans through direct contact with infected blood, bodily fluids or organs, or close contact with an animal infected with Ebola or indirectly through contact with contaminated environments. Contact with the body of a person who has died of Ebola is especially dangerous.

As yet there is no proven cure or vaccine, although a vaccine is being developed and fast-tracked through the licensing processes in view of the scale and impact of the outbreak. Trials using this vaccine have started.

Response to the outbreak

There are two elements of the response to the outbreak: the healthcare and public health response in the countries affected, and the measures that have been put in place to prepare all parts of the UK for the possibility of imported cases.



The healthcare systems in Guinea, Liberia and Sierra Leone have been stretched beyond their capacity to deal with the outbreak, and have themselves suffered terrible losses. By the end of 2014 almost 700 healthcare workers had been infected with Ebola and over half of these workers had died. Support from the international community – governments and NGOs – has been vital, not only to bring the outbreak under control in these three countries but also to prevent further spread in other countries. The

Responding to the outbreak

Ebola treatment centre in Sierra Leone. Photograph: AFP/Getty

UK's response has focused on Sierra Leone, with the USA and France concentrating their efforts on Liberia and Guinea respectively. The UK has deployed over 800 defence personnel to Sierra Leone; over 1600 UK frontline healthcare workers and public health specialists, including staff from Northern Ireland, have volunteered to work in Sierra Leone, and the UK has helped to establish 880 dedicated beds. In addition the UK has supported the development of an Ebola vaccine.

Preparedness in the UK and Ireland

Within the UK and Ireland, preparedness work has covered a wide range of measures including protocols for managing and treating suspected and confirmed cases; plans for transferring any Ebola patients to an appropriate hospital; ensuring that the appropriate personal protective equipment (PPE) is available and that staff are fully trained in putting on and taking off PPE; and entry-screening for passengers arriving in the UK from the three badly affected countries.

These measures have been thoroughly tested, both by planned exercises and by actual events including suspected cases and one confirmed case - a healthcare worker returning from Sierra Leone. On each occasion the measures have been shown to be robust.

Should we be worried?

Ebola virus disease can only be contracted through direct contact with blood or body fluids from someone who is infected and is in the later symptomatic phase, or from a person who has died from Ebola. For any resident of Northern Ireland who does not go to one of the affected countries and who does not have direct contact there with symptomatic Ebola patients or with a deceased patient, the risk of catching Ebola is extremely remote, particularly in view of the preparedness measures that have been undertaken across the UK. Crucially, we have sophisticated public health systems and a well-developed infrastructure which mean that any sort of widespread outbreak is highly unlikely.

By contrast, in Guinea, Liberia and Sierra Leone, at the time of writing, while there are signs that case numbers may be levelling off in some regions, the devastation is continuing. In addition to the suffering and grief in the affected communities, it is clear that the outbreak will have serious long-term impacts on people's lives and livelihoods. Both humanitarian concern and enlightened self interest tell us to focus our efforts on helping those countries to control and end the outbreak.

BLIND CORDS/ CHAIN SAFETY

Since my last report I am delighted to see the implementation of new European Standards which are aimed at manufacturers to improve safety of window blinds and reduce risks to children.

The British Blind & Shutter Association (BBSA) has reported that the new standards have had a significant impact on the way in which blinds are sold. A range of new products, aimed at improving safety, are being developed. Suppliers are introducing systems that eliminate cords and chains or ensure that they are hidden away. BBSA members are offering customers free safety devices and low cost retrofit. In addition, BBSA has distributed over 100,000 of their new surveyor and fitter pocket books and recently printed their 2 millionth "Make it Safe" brochure. I very much welcome these developments and innovative initiatives.

I recently chaired a UK-wide working group to look at ways in which we can reduce deaths and injuries from blind cords and I am extremely encouraged and reassured by the significant amount of valuable work currently being undertaken across all four jurisdictions.

Within Northern Ireland, initiatives include a pilot scheme currently underway in the Northern Trust whereby health visitors at a baby's 6-9 month assessment provide cleats to parents and instruct them how to install them. At the next assessment health visitors will follow up to ensure that the cleats have been installed. A formal evaluation of the pilot will be carried out in the autumn and, if deemed to be successful it will be recommended for roll-out across all the Trust areas. The *Make It Safe* brochure has been translated into a number of different languages, including the top ten languages in Northern Ireland. Last year I reported on a scheme in the five District Councils in the Eastern area whereby information about blind cord safety is given to parents or carers while they are registering the birth of the baby. This initiative will now be rolled out across Northern Ireland.

A home safety officer demonstrates how to make blind cords safer.

Blind cord and chain deaths and injuries are both avoidable and preventable by applying simple but effective interventions.

Effective Interventions

The Royal Society for the Prevention of Accidents (RoSPA) in Northern Ireland has, over the last number of months, undertaken a programme of work to raise awareness of the dangers associated with blind cords and chains. RoSPA, in partnership with Home Accident Prevention NI, funded by the Public Health Agency, conducted 11 Blind Cord Safety Awareness workshops across Northern Ireland. The workshops took place in Ballymena, Londonderry, Newtownabbey, Antrim, Belfast, Omagh and Kircubbin. In total, 204 participants from a range of backgrounds, including parents, representatives from councils, social housing, retail, childminders and health sectors attended the workshops.

Whilst I welcome the significant efforts of all those involved across the respective sectors, and notwithstanding the introduction of the new standards, regrettably this has not prevented further tragic deaths during 2014 bringing the number of fatalities that we know about to 30 in the UK since 1999, 17 of these since the beginning of 2010. It is for this reason that we all must redouble our efforts to minimise the dangers of blind cords and chains.

It is also important to be aware that there remain approximately 200 million blinds already fitted in UK properties where the dangers still prevail and I am disappointed to learn that, despite the introduction of the new standards and significant efforts to raise awareness about blind cord dangers, many consumers are still reluctant to make their existing blinds safer. This is why it is important to continue to raise awareness among parents, grandparents and carers and to encourage them to make sure that blind cords and chains are made safe.

EMERGENCY PLANNING FOR CYCLING EVENT

Giro d'Italia

Northern Ireland turned pink for the arrival of the Giro d'Italia which took place from 9 to 11 May 2014. The is one of the biggest cycle events in the world and the Northern Ireland stage covered large areas of the country including Greater Belfast, Causeway Coast and Armagh.

As usual for an event of this size and importance, emergency planners in HSC organisations and the Northern Ireland Fire and Rescue Service (NIFRS) were involved with the event organisers in planning for the race to ensure any risks to competitors and the public were minimised.

HSC organisations worked to maintain normal access to health and social care services and public health advice. Northern Ireland Ambulance Service worked with voluntary ambulance services to provide emergency medical cover for spectators, whilst the event organisers ensured private medical services were in place for the competitors. In addition, the NIFRS produced a detailed strategic event plan and put effective fire and rescue arrangements in place.

This high profile event attracted large numbers of spectators and proved very successful and enjoyable.

QUALITY IMPROVEMENT AND INNOVATION

A Strategy for Research and Development in Health & Social Care

Research and Development is an integral part of ensuring that the health and social care services we provide, both in HSC and primary care, are of the highest quality and informed by the best available, up-to-date evidence. Through world-renowned, high quality research in health and social care, conducted in Northern Ireland, the population not only benefits in terms of health and wellbeing, but also from the wider economic prosperity that it brings.

A draft strategy for consultation was developed in collaboration with a wide range of people from across health and social care, the public sector, academic institutions, voluntary and charitable organisations and private companies. The strategy sets out our commitment to support research, researchers and the use of evidence from research to improve the quality of both health and social care and better inform policy-making. It describes our ambition to increase investment in R&D by competing successfully for R&D funding, with all the benefits that brings.

Northern Ireland has a proud heritage of research, with many success stories. In addition to the health and social care sector other parts of the public sector, private companies and the charitable organisations also support and undertake R&D that benefits the people of NI as well as enabling economic progress. A wide range of partnerships both within NI and further afield is a hallmark of our strategy and this will continue into the future. Involvement in R&D is an important way in which we engage with other regions and researchers internationally. This strategy will contribute to Northern Ireland as an outward-looking region that welcomes and supports the work of highly educated, experienced researchers and health and social care professional staff, however we must ensure that sufficient emphasis is given to local needs and priorities.

The HSC R&D strategy for Better Health and Social Care was issued for consultation on 29 September 2014, and closed on 2 January. Almost 40 organisations or individuals responded to the consultation. Their views and opinions are being considered at present and will inform the final strategy which will be published shortly.

Quality 2020 is the ten year quality strategy for health and social care in Northern Ireland. It defines quality under three main headings:

Safety – avoiding and preventing harm to patients and clients from the care, treatment and support that is intended to help them.

Effectiveness – the degree to which each patient and client receives the right care (according to scientific knowledge and evidence-based assessment), at the right time, in the right place, with the best outcome.

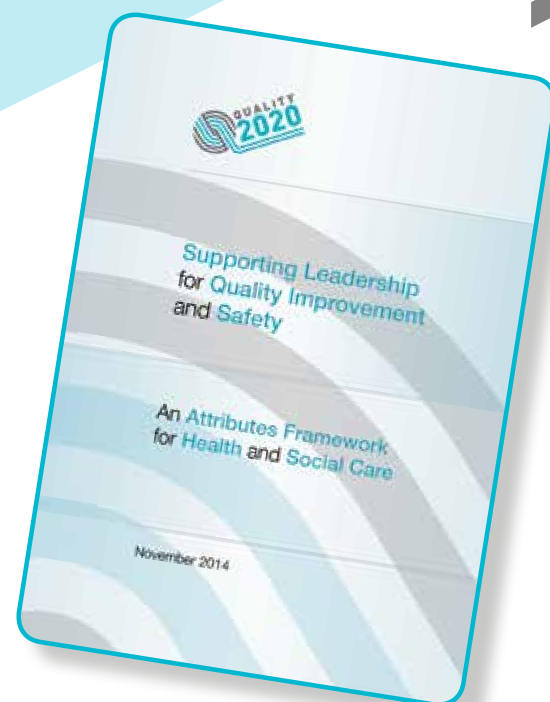
Patient and Client Focus – all patients and clients are entitled to be treated with dignity and respect and should be fully involved in decisions affecting their treatment, care and support.

Implementation includes a focus on initiatives designed to support improvements in the safety and quality of services delivered in the HSC.

Annual Quality Reports
The development of the Annual Quality Reports by all Arms Length Bodies (ALB) is one of the initiatives taken forward as part of the implementation of Quality 2020. All the ALBs published a Quality Report on 13 November 2014 to coincide with World Quality Day. The reports are available on each organisation's website.

Initially the indicators were mostly hospital-focused but have been expanded to include some social care indicators. Further work is being taken forward to make subsequent reports more standardised and patient-focused.

The Attributes Framework – Supporting Leadership for Quality and Safety in Health and Social Care



One of the goals of the Quality 2020 implementation plan has been to develop leaders who can champion and enable improvement and innovation. This is a leadership role which any and every staff member should have the potential to fill. A group of stakeholders was convened by the Health and Social Care Safety Forum and Northern Ireland Practice and Education Council (NIPEC) to develop an attributes framework to support staff development.

Leadership for quality means *making it possible for everyone, everyday to do a better job with greater satisfaction, learning from and with their colleagues, in order to improve services* (adapted from Deming, 1986).

The purpose of the framework is to assist individuals in assessing their current attributes (knowledge, attitudes and skills) in relation to leadership for quality improvement and safety and to help organisations to build the capacity and capability of the workforce to participate in, and lead, initiatives which develop quality care and services.

The framework was launched by the Minister in December 2014.

The Donaldson Review

On 27 January 2015, "The Right Time, The Right Place" - the report of the expert examination of the application of health and social care (HSC) governance arrangements for ensuring the quality care provision in Northern Ireland was published. The examination was led by Sir Liam Donaldson, former CMO for England, who was supported by Dr Paul Rutter and Dr Michael Henderson.

This review was commissioned in March 2014 by the then Minister, Edwin Poots to examine the HSC in its entirety in respect of its openness and transparency, appetite for enquiry and learning, and approach to redress and making amends.

The report makes ten recommendations against six key themes:

1. A system under the microscope;
2. The design of the system hinders high quality, safe care;
3. Insufficient focus on key ingredients of quality and safety improvement;
4. Extracting full value from incidents and complaints;
5. The benefits and challenges of being open; and
6. The voices of patients' families and clients are too muted.

In his statement launching the report, Minister Wells announced a number of initiatives designed to support the implementations of several recommendations including:

- **The commencement of the process to introduce a statutory duty of candour for Northern Ireland;**
- **A review of commissioning arrangements for the HSC;**
- **A Never Events list to be developed for Northern Ireland, with urgent consideration of the applicability of the list for England as an interim measure;**
- **The conclusion of the work to introduce a regional morbidity and mortality review system as well as the development of proposals, in conjunction with DFP and DOJ, for a new independent system to review deaths in Northern Ireland complementing the role of and working with the Coroner;**
- **Instructions to the HSCB and PHA to prioritise changes to the Serious Adverse Incident (SAI) system;**
- **The request to speed up the roll-out of unannounced inspections of acute hospitals by RQIA;**
- **New policy proposals to review the 2003 Quality, Improvement and Regulation Order with a view to introducing a stronger system of regulation of acute health care providers;**
- **Proposals to the Executive for changes to the existing system of regulation of non-acute services with the aim of issuing these proposals for consultation by June 2015;**
- **A review of the operation of whistleblowing in health and social care bodies with recommendations on how to improve its effectiveness; and**
- **How to apply the best available worldwide evidence on measuring patient/client experience and design a framework to strengthen the voice of patients at every level.**

The report is out for consultation which closes on 22 May 2015.

Duty of Candour
In response to the Donaldson review the Minister announced plans to introduce a statutory duty of candour for Northern Ireland. That duty came to prominence in England as a result of conclusions from the Francis report – a public inquiry into the Mid Staffordshire NHS Foundation Trust. Openness and transparency are crucial elements of patient safety. When things go wrong, patients, service users and the public have a right to expect that they will be communicated with in an honest and respectful manner and that every effort will be made to correct errors or omissions and to learn from them to prevent a recurrence.

The Health and Social Care service in Northern Ireland already operates under statutory duties of both quality and involvement. Meaningful engagement with patients and clients, carers and the public will improve the quality and safety of services. It is not the intention of the duty of candour to promote a culture of fear, blame and defensiveness in reporting concerns about safety and mistakes when they happen.

HSC Safety Forum

The HSC Safety Forum, which was established in 2007, supports organisations as they strive to provide safe high quality care. It also provides leadership in quality improvement and patient safety.

Delivering Safer Care Conference

In March 2014 the all-island 'Delivering Safer Care' Conference, hosted by the Public Health Agency's Health and Social Care Safety Forum and the Republic's Health Service Executive, reviewed recent developments, shared good practice, and discussed key challenges and successful approaches to sustaining safety and quality care for patients and service users.

As well as local presentations, the conference included keynote presentations from experts in Safety & Improvement from the Institute of Healthcare Improvement (USA), the Social Care Institute for Excellence (UK) and from other sectors including Formula 1 Racing.

The Forum leads quality improvement collaboratives, involving key staff from all Trusts, in scheduled care; unscheduled care; maternity; paediatrics; mental health; nursing homes and primary care. A number of initiatives have been implemented through these collaboratives.

Paediatric Quality Improvement Collaborative

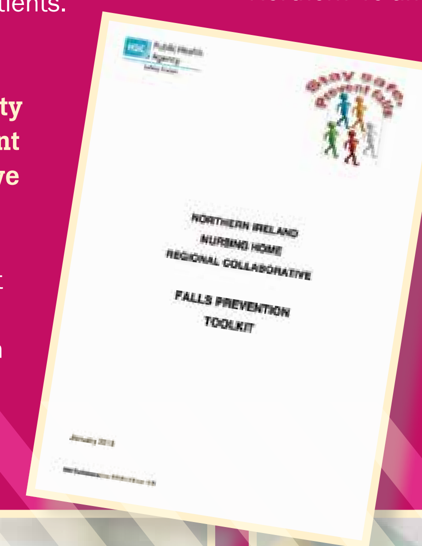
The HSC Safety Forum has six Improvement Programmes, one of which focuses on paediatric care. Frontline multidisciplinary teams from all Trusts learn together, share best practice and develop plans to further improve quality and safety for children. Teams test and implement changes in their local settings and collect data to measure whether their changes are leading to better outcomes for children.

The collaborative has worked on improving communication using, for example, structured handovers, communication tools and safety briefs. A parent safety poster has been developed to empower parents to take an active role in the safety of their child whilst in hospital. This work was led by a service user.

Another focus of the work is the early detection and management of children whose condition is deteriorating and includes the introduction of age-adjusted regional paediatric Early Warning Score charts and escalation protocols. This completes a two-year programme by the Safety Forum which means that all Trusts in Northern Ireland are using a regionally agreed Early Warning Scoring System for Adults, Children and Maternity patients.

Nursing Home Quality Improvement Collaborative

The nursing home improvement collaborative was set up in 2012. The first focus of improvement was on falls prevention and in 2013 the collaborative achieved a reduction in falls of 25%. The falls prevention toolkit developed during this work has been made available to all nursing homes in Northern Ireland.



Eighteen nursing homes are currently working on improving nutrition, hydration and the prevention of pressure ulcers. A transfer form has also been developed and is being tested for patients being transferred from nursing home to emergency departments to improve communication.

IMPROVING EMERGENCY AND URGENT CARE SERVICES

When we need emergency or urgent care, whether for our family or ourselves, we want access to the best care and treatment possible, delivered by staff who are not only experts in their clinical field but who are compassionate and caring.

We also know that the pressures faced by these services continues to grow, whether in general practice, our hospitals or in our community. In response to some of these challenges, the Unscheduled Care Task Group, was established by the Minster. The aim of this group was to find solutions to the challenges faced by the health and social care service in emergency and urgent care services.

Workstreams were established focusing on Care of Frail Older Patients, Care of Respiratory Patients, Patient Flow, Out-of-Hospital Services, and Escalation and Diagnostics. Each of these groups worked in different ways, holding workshops, working virtually, holding focus groups, testing and trying new ideas and involving as many front line staff as possible.

The following are examples of the service improvements developed by the workstreams.

Marie Curie Nursing Partnership

One of the key areas identified by the Out-of-Hospital workstream was the need to strengthen the nursing support to the Out-of-Hours GP teams for patients with palliative needs. In response the HSCB and PHA have worked with Marie Curie to appoint new nursing staff to pilot an out-of-hours Rapid Response palliative care nursing service.

These skilled nurses will work with GPs to help provide support and comfort, particularly to those identified as being in the last year of life. The emphasis will be on supporting patients to stay in their home, through the provision of expert advice and care in areas such as pain management or relief of symptoms such as nausea. The initiative also involves Northern Ireland Ambulance Service (NIAS) by providing a protocol enabling direct referrals from NIAS to Marie Curie, therefore avoiding unnecessary attendances at the Emergency Departments. The pilot is being expanded in the northern and southern Trusts and implemented in areas within the western Trust. It will complement services already available in the other Trusts. The first appointments have been made in January 2015 with the aim to have all staff in post by April 2015.

Care and Compassion in the Emergency Care Environment

When we, our families or friends need access to the care and services our teams in the emergency departments provide we want access to the best care possible. We want this delivered by staff who are experts in their clinical field and staff who are compassionate and caring. Central to the expression of a caring, respectful culture is the delivery of the fundamentals of care.

This workstream has developed a short tool or aide to help assess whether the fundamentals of nursing care are being delivered and what barriers prevent staff from delivering the standards of care they want. The emphasis is on celebrating where care is good, and taking action where standards are not as good as we would wish, including support and training for staff and resources or practical help from managers.

> The Patient Flow Workstream has been listening to patients, families, carers and colleagues who work in the emergency care environment. What they heard was that while most of the care and treatments given were excellent, there were times when care and in particular the fundamentals of care were not delivered in a way we would we expect.

Care of Frail Older People

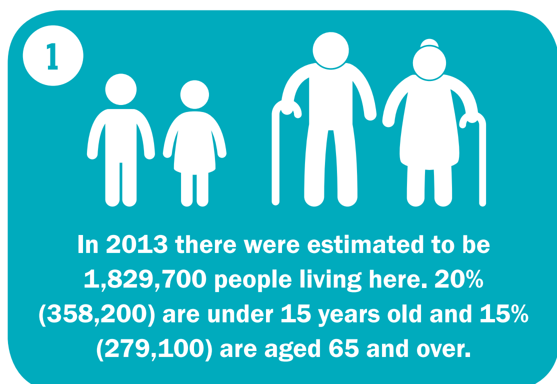
As a first step in the work of the Frail Older People's Workstream, two new standards of care were developed.

The first standard relates to the number of ward transfers older people experience during a hospital stay. We know that every time an older person moves wards it can add to confusion and distress, increase the risk of incidents, falls and infection and can cause frustration for families and friends. There will be times that, to ensure an older patient receives the right care a move between wards is necessary, for example when more specialist care is needed. The new standard requires Trusts to ensure that older people experience no more than two moves unless it is necessary on clinical grounds.

The second standard relates to the time at which patients are discharged home. Ensuring patients are discharged safely is a fundamental part of a patients journey. If discharges are not planned in a coordinated way, with the full involvement of the patient and their family they can result in distress, anxiety and at times prompt a readmission to hospital. Discharges of frail older people late into the evening can cause anxieties for patients and their families. The new standard requires Trusts to ensure that older patients are not discharged after 8pm in the evening unless the patient and, if required, their family agree.

The Health and Social Care Board will monitor Trust performance of adherence to these standards.

KEY STATISTICS

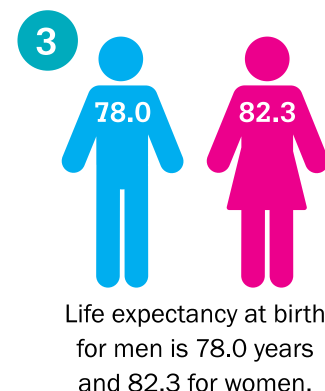


1

In 2013 there were estimated to be 1,829,700 people living here. 20% (358,200) are under 15 years old and 15% (279,100) are aged 65 and over.

2

There are 32,400 people from minority ethnic groups living here (Census 2011).



3

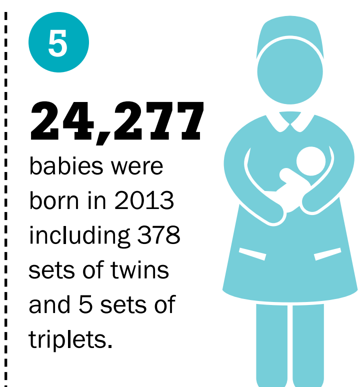
Life expectancy at birth for men is 78.0 years and 82.3 for women.

4

Those living in the least deprived areas can expect to live in good health for **13 years longer** than those in the most deprived areas.

5

24,277 babies were born in 2013 including 378 sets of twins and 5 sets of triplets.



6

14,968 people died in 2013; 7,261 males and 7,707 females. 5,147 were aged 85 and over; 1,816 men and 3,331 women.

7

In 2013 there were 4,230 deaths from cancer and 2,475 from heart disease.

8

303 people died by suicide in 2013 – 229 males and 74 females.

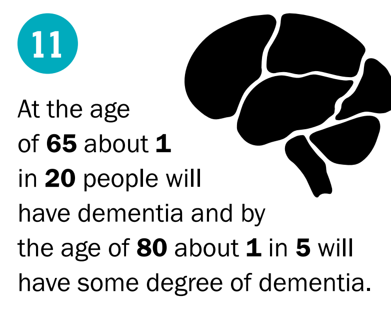
9

In 2008-12 alcohol related deaths among males was 24 per 100,00 population and 251 per 100,000 for smoking related deaths. In females the rates were 11 and 116.

10

Drug related acute admissions to hospital among males in the most deprived areas was 593 per 100,000 compared to 123 per 100,000 for males in least deprived areas.

11



At the age of **65** about **1** in **20** people will have dementia and by the age of **80** about **1** in **5** will have some degree of dementia.

12

During 2013/14, **609,320** patients were admitted to HSC hospitals in Northern Ireland, of which **307,144** were inpatients and **302,176** were day cases.

13

In 2013/14, there were a total of **727,466** attendances at emergency care departments.

14

During 2013/14, a total of **368,218** patient journeys were made by the Northern Ireland Ambulance Service (NIAS), of which 119,890 (32.6%) were categorised as emergency journeys.

15

At 31 March 2014, 2,828 residential and 7,012 nursing home care packages were in effect in Northern Ireland for people over 65.

16

There were 38,824,359 prescription items dispensed in the community in 2013/14 at a cost of £412,040,651.

www.dhsspsni.gov.uk/phealth