Safe Surgery Saves Lives

Continuing the Fight Against Healthcare Associated Infections

Positive Parenting - Securing Children’s Futures

Your Health in Your Hands

Sexual Health

Department of Health, Social Services and Public Safety

AN RIAN
Sláinte, Seirbhísí Sóisialta agus Sábháileachta Poiblí

MÁNNYSRIE O
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Maintaining and improving the health of the public in Northern Ireland within the current financial position will pose significant challenges. It is however not an optional extra; it is a prerequisite for an ethical and flourishing society where we are all equally well, with equal life opportunities. It reflects our values as a society.

We all have a part to play. It is imperative that we continue to maximise the resources that are available to us whilst recognising the increasing demands of an ageing population and the costs of new treatments. That means adding more value and better outcomes for the population with the money we have, not more of the same for less. Everyone has a contribution to make. Health professionals must ensure that care is optimised and the public, by adopting simple lifestyle measures, can reduce the likelihood of developing conditions which place significant burdens on our healthcare system.

In Northern Ireland, we provide “joined-up” health and social care and this is a great strength. An individual’s needs don’t start or end at the door of the GP Practice or on discharge from hospital; our community and social services ensure that there is continuity of care, often providing a vital safety net for the most vulnerable in society and those in greatest need. The public and patients rightly expect seamless care, not disjointed care or a disconnected system of care.

Rightly there has been an increased focus on the quality of care that is provided. Over recent years the safety forum has supported health care providers and much has been achieved. In the past year we have approved 26 NICE guidance recommendations ensuring that patients in Northern Ireland have access to the same right and potentially life saving treatments as in the rest of the UK. It is well accepted that good quality care costs money however poor quality care costs more in terms of the human costs and financial implications.

Encouraging and supporting people in making healthy lifestyle choices remains the primary focus of public health. In recent years strategies to address a range of lifestyle issues have been implemented. It is however essential that these strategies remain appropriate and relevant to the issue and present day context, and, for this reason, a number of them are currently being reviewed and updated.

Alcohol misuse continues to be a major concern, as it has serious short and long term effects on people’s physical and mental health. It is estimated that alcohol misuse costs health and social care over £170 million per year. Smoking and obesity are major factors in the development of cancer, heart disease, diabetes and respiratory disease. Malignant melanoma, the most serious form of skin cancer, has increased threefold in the last 20 years. Greater adherence to care in the sun is required by everyone though the legislation which is being introduced to regulate the sunbed industry is another important measure in preventing skin cancer.

Positive mental health and wellbeing is core to a better quality of life. There is much that each of us can do to help protect our mental health and help us lead more fulfilled and productive lives. There is now a ‘five a day’ programme which involves us connecting and helping others.

More work has been done to get a better understanding of those who deliberately self-harm particularly who is more at risk and what precipitates it.

The outbreak of swine flu last year was a major test of the Northern Ireland pandemic flu plans. Fortunately for the majority, the illness was
relatively mild, though tragically it did cause severe illness and death in some people. Much has been learnt from this experience and, as a result, pandemic plans are being updated so that we can be better prepared than ever before, should another pandemic come along.

Cancer continues to be a major cause of ill-health and death so any initiative which can reduce the burden is to be welcomed. The bowel cancer screening programme which started in April aims to save around 60 lives per year.

We must almost be pushing back the boundaries of our knowledge and translating that evidence into benefits for patients. Research and development plays a very important role in the understanding of many conditions and effective treatments of them. Through the Northern Ireland Clinical Research Network a significant number of people here have had the opportunity to enter clinical research studies. Participation in these studies has enabled them to access new and innovative treatments that are not yet available through routine services.

Our health is in our hands in so many ways; from those in Government in relation to the relative priority it is afforded, those tasked with policy responsibility, those of us that develop the evidence of what is effective and those who provide that treatment, to the very decisions that you and I make from day to day and the examples we set our children.

DR MICHAEL McBRIDE
CHIEF MEDICAL OFFICER
THE COST OF HEALTHCARE IN A DIFFICULT FINANCIAL CLIMATE

There is little doubt that the projected public finances for the next number of years pose significant challenges for those involved in the health arena. However, if we continue to focus merely on the need to make financial ends meet, we will have missed the whole point of what it is we do and, in all likelihood, have missed an opportunity to continue to meet public expectation and deliver high quality services. This will require us to continue to modernise and reform healthcare and healthcare systems. The change to the health and social care system in Northern Ireland under the Review of Public Administration has proven a significant step in this direction, removing bureaucratic tiers and reducing the overall number of individual organisations involved in the oversight and delivery of health and social care locally.

However, these steps alone will not serve to make the fundamental changes that are needed in the current and projected financial climate. It is suggested that doctors and commissioners feel less in control of changes being made around them and, although governments can make adjustments to the external environments surrounding care, it is only those working on the frontline who can modify their own work to better meet society’s needs. For that to happen, a significant contribution from those who provide and benefit from frontline services will be required.

£3.6billion is the cost of the health service in Northern Ireland

The general public also has a key role. By adopting simple lifestyle measures they can reduce the likelihood of developing conditions which place significant burdens on our healthcare system. Adherence to a healthy diet, regular exercise, avoiding smoking and excessive alcohol consumption will all contribute to reducing demand on the health service in both the short and longer term. In addition, responsible use of services will similarly reduce this demand. All clinicians, not only those in formal leadership roles, have a key responsibility in ensuring that care is optimised and delivered effectively and efficiently. This is in keeping with the General Medical Council’s guidance, Good Medical Practice, which states that doctors providing care must make good use of the resources available to them.

Good quality care costs, poor quality costs society more

The relationship between cost and quality is not a straightforward one. Evidence from the United States suggests there is little, if any, relationship. The Mayo Clinic, which has a worldwide reputation for high quality care, is among the lower cost healthcare systems in the US. Its approach has been to focus primarily on what is best for patients and, only following that, give consideration to financial aspects. The Clinic’s Chief Executive characterises the organisation’s approach as sharing expertise to get more thinking and less testing. Consequently the Clinic’s overall costs are lower than comparable organisations with no negative impact on the quality of care.

Don Berwick, former President of The Institute for Healthcare Improvement, some 16 years ago set out what he termed the aims for clinical leadership of health system reform. These included:

- Reducing inappropriate surgery, hospital admissions and diagnostic tests
- Reducing key underlying root causes of illness (notably smoking, childhood injuries and alcohol abuse)
• Reducing Caesarean section rates
• Reducing the use of unwanted medical procedures at the end of life
• Simplifying medication use
• Increasing active patient participation in therapeutic decision making
• Decreasing waiting times in healthcare settings.

Do things right and do the right thing

These are sentiments echoed in The Health Foundation’s report of September 2009, Does Improving Quality Save Money? http://www.health.org.uk/publications/research_reports/does_quality_save.html. This significant publication concluded that although the scientific evidence is not strong, improvement initiatives can reduce costs to service providers. To achieve this requires careful planning, leadership, expertise, perseverance and not a little healthy scepticism. It especially requires a sustained and relentless focus on high quality implementation.

£400million spent on 35 million prescriptions in the community in 2009/10

Work to address many of these is currently ongoing. The health and social care safety forum has, over recent years, supported healthcare providers in reducing many of the inherent complications of admission to hospital in the modern era. An example is the significant reduction of Surgical Site Infections (SSI) in orthopaedic units throughout Northern Ireland. Between 2004 and 2007 there was a 45% decrease in the SSI rate but for those who developed an SSI the average length of stay in hospital after surgery was 12 days longer than those who did not.

Continued overleaf
Evidence suggests that improvement in all these areas relies on a number of common factors. Greater clinical involvement of clinicians, particularly doctors, in bringing about these changes is one example. Meaningful engagement is reliant upon:

- Discovering a common purpose between management and clinicians
- Making doctors partners in the activity
- Identifying those enthusiasts who will take forward these projects
- Using data sensibly
- Ensuring support at the highest level within the organisation
- Providing visible support.

£2,950 million was spent by Trusts on the provision of health and social care in 2008/09, an increase of 10% on the previous year but our ageing population and demand for services is increasing.

In these challenging times it has never been more necessary for the health and social care family to act in a mutually supportive way:

- Within clinical teams
- Between clinicians and managers
- Between providers and commissioners and between government and the health and social care system.

There are many tools available which help ensure that the health of the population of Northern Ireland is the best it can be. The venous thromboembolism risk assessment tool is the first of our series of examples.

Preventing Venous Thromboembolism

Venous thromboembolism (VTE) is a relatively common and preventable cause of extended patient stay. It occurs when a blood clot forms in a vein. If part of the clot breaks off it can travel and lodge in the lung. This is known as a pulmonary embolism and can be very serious for the patient. VTE risk assessment tools have been developed and their use is commended to all HSC Trusts. While the principal benefit is more patients returning home more quickly and thus being able to undertake their rehabilitation more promptly, there is also the secondary benefit of reduced healthcare costs. The safety forum has been asked to lead in this area.

VTE accounts for up to 25,000 deaths in the UK every year.
SAVING LIVES

BOWEL CANCER SCREENING

The introduction of a bowel cancer screening programme in Northern Ireland in April this year was a major public health initiative which aims to save around 60 lives per year.

Bowel cancer screening is the first new cancer screening programme to be introduced in Northern Ireland (after cervical and breast) in 20 years and the only one to include men.

All men and women aged 60–69, who are registered with a GP, will be invited to take part in this programme every two years. The test kit, with information and instruction leaflets, will be sent to the person’s home for them to complete and return. The test – called a ‘faecal occult blood’ test, or ‘FOB’ for short – looks for tiny amounts of blood in the bowel motions. This is an early warning sign that something may be wrong and will require further assessment. About 10 out of every 500 people tested will have a positive result, however, 9 of them will not have cancer.

The bowel cancer screening programme can detect signs of bowel cancer at a very early stage, when there is a 90% chance that treatment will be successful.

Each year, there are more than 1,000 new cases and over 400 deaths from bowel cancer in Northern Ireland

Research indicates that 1 in 6 deaths from bowel cancer can be avoided by screening.

Bowel cancer is the second most common type of cancer found in men and women in Northern Ireland. About 1 in 20 people will develop it in their lifetime. However, through participation in the screening programme the outcomes for these people will be significantly improved.

The message of the programme is ‘Don’t die of embarrassment – when you receive your screening invitation use it. This test could save your life’.

Initial signs and symptoms of bowel cancer include:

- Blood in stools and/or bleeding from the back passage (rectum)
- A change in normal bowel habit that persists for more than six weeks, such as diarrhoea, constipation, or passing a bowel motion more frequently than usual
- Pain or swelling in the abdomen
- Unexplained weight loss.
During the first three years of life, the brain develops to 90% of its adult size and will have in place the structures that will govern all future emotional, behavioural, social and physiological functions during life. A nurturing, stimulating and stable environment will have a positive influence on how the brain grows and will help the child develop feelings of security, creativity and self-confidence. An absence of stimulation early on impedes full development of the brain; neglect is linked with poor emotional expression and reduced ability to experience happy feelings.

New evidence has emerged about how babies grow and develop in the first few years of life and the importance of the development of their nervous system, especially the brain. A baby’s environment has an enormous impact on how its brain develops. The most significant thing in the baby’s environment is their emotional relationships, and how secure and attached they feel with their parents, particularly their mother.

When babies feel secure it enables them to:

- Grow into a child and adult who has high self-esteem
- Be able to trust others and understand how others feel
- Learn and take full advantage of education
- Be emotionally strong
- Develop good social skills.
recently launched Healthy Futures, a review of health visiting and school nursing which recognises and reinforces the support all parents need in the early years. The review, along with a newly updated Child Health Promotion Programme for Northern Ireland, delivered by health visitors, school nurses, midwives and GPs, places emphasis on:

- A greater focus on pregnancy
- Providing effective parenting programmes which begin in early pregnancy
- Stressing the importance of attachment and positive parenting in the first years of life
- Recognising the specific impact that mothers and fathers have on their children, as well as their combined influence, for example mental health within the family
- Building child health programmes for all families and children, tailored to address the different risk factors on children’s future life chances
- Identifying families in need of additional support and providing this in a timely way to help ensure that difficulties do not get worse
- Ensuring programmes encourage adults to adopt healthier lifestyles for themselves and be positive role models for their children.

Services must look beyond the child to their family. Family health and parent health behaviours have a direct impact on the future health and wellbeing of children and need to be addressed. Parents, extended families, community/voluntary services, health and social care services, and early years care providers all have a role in ensuring that our children grow up as healthy and well adjusted individuals capable of reaching their full potential in all aspects of their lives.

Of course, many families experience common problems in the early years of parenthood and most cope well and find ways to address these. This is part of normal life. However, when problems are severe or persistent, and are not addressed, healthy development is put at risk. Prolonged exposure to high levels of parental stress, neglect and abuse can have a severe impact on the brain development of a baby. People who have experienced this in childhood have an increased risk of poor mental health in adulthood, are more likely to be unemployed, are more prone to addiction/substance misuse, and have a much greater probability of spending time in prison.

Infants who do not experience positive, loving parenting and strong early bonds can face adverse consequences throughout life. These include increased risk of poor physical and mental health, lower achievement in school, and emotional difficulties or behaviour problems.

It is crucial therefore that parents are educated about child development in the early years, the importance of positive nurturing, and the overriding need to develop strong parent-child attachment in the first years of life. Mothers and fathers need to be supported during pregnancy and the first years of their baby’s life and where risk factors are identified, support needs to be stepped up.

Providing children with the best start in life

There is evidence to show that concentrating efforts on the early years of life, from before birth to three years of age, is likely to bring the best long-term outcomes of improved health and wellbeing to the population. Health and social care organisations recognise this and are working closely together to help families to flourish. In support of this, the Minister
CONTINUING THE FIGHT AGAINST HEALTHCARE ASSOCIATED INFECTIONS

People have a right to expect their healthcare to be safe. Much work has been done across the whole healthcare estate in the fight against healthcare associated infections (HCAIs). While it is gratifying to report that we are moving in the right direction, more needs to be done.

Clostridium difficile (C. difficile) infections are down 54% in three years and Meticillin-Resistant Staphylococcus Aureus (MRSA) is down 44%.

For the most part, high quality treatment and good outcomes do not make the headlines, so public perceptions of the safety of healthcare may be influenced more by events in the news than by what is happening in hospitals day in, day out.

There are a number of different types of HCAIs, but two in particular have come to be regarded as barometers of the prevalence of HCAIs. These are C. difficile and MRSA. C. difficile (which got the name because it is difficult to grow in a laboratory) is the major cause of antibiotic-associated diarrhoea and colitis, an infection of the intestines. MRSA causes bloodstream infections and chest infections and can invade the body through a wound. MRSA is resistant to commonly used, but not all, antibiotics.

There is ongoing monitoring of HCAIs, and surveillance figures for recent years show that real progress has been made in making healthcare safer in Northern Ireland (Figure 1).
2006 was the last year before the major outbreak of *C. difficile* in Northern Trust hospitals so the 54% reduction achieved since that year is therefore a truer reflection of progress. Both *C. difficile* and MRSA infections are now at their lowest levels since mandatory surveillance began.

**Figure 1 Fall in reports of *C. difficile* and MRSA**

A number of initiatives have contributed to this reduction including:

- The 2006 strategy *Changing the Culture*
- Ministerial targets for reducing HCAIs
- More prudent antibiotic prescribing
- Better environmental cleaning
- The regional hand hygiene campaign
- The programme of unannounced hygiene inspections of hospitals.

**Making healthcare safer is important.**

We also need to restore and improve public confidence in the safety of our healthcare system. That confidence must of course be based on reality, so the surveillance figures are crucial for that purpose.

**Changing the Culture 2010**

While these reductions in HCAIs are a significant achievement, clearly we still have further to go. In January 2010 the Minister launched the new strategic regional action plan for the prevention of HCAIs, entitled *Changing the Culture 2010*. The title of the earlier strategy has been kept because the new action plan is underpinned by the same core principles:

- Infection prevention and control is an integral part of safe healthcare, and
- Infection prevention and control is everyone’s business.

*Changing the Culture 2010* is about establishing a culture of zero tolerance of HCAIs. It includes a series of actions under five headings:

- Providing a safe environment
- Improving surveillance and learning from adverse incidents
- Antimicrobial resistance and antibiotic prescribing
- Public knowledge, engagement and feedback
- Research.

*Public Inquiry into the *C. difficile* outbreak*

In October 2008 the Minister announced a public inquiry into the *C. difficile* outbreak that affected Northern Trust hospitals between June 2007 and August 2008.

The public inquiry, headed by Dame Deirdre Hine, a former Chief Medical Officer for Wales, started work in April 2009. The purposes of the inquiry are to find out how many people died as a result of the outbreak and to examine the experiences of those who were affected by the outbreak.

Whilst it is not possible to set a strict deadline for the completion of a public inquiry, the aim is to present a report to the Minister in the first quarter of 2011.

*More information about the inquiry is available at: http://www.cdiffinquiry.org*
Swine Flu Virus — To return?

_Catch It! Bin It! Kill It!_ — this phrase brings back memories of the swine flu pandemic which was steadily gaining momentum this time last year. On 24 April 2009, reports on TV told of a new influenza virus causing respiratory illness and deaths in Mexico and the US. Many people wondered if this was the ‘big one’ that would cause the pandemic we had all been waiting for.

Staff from the UK health departments and health and social care organisations had been developing pandemic plans for a number of years. These were immediately put into action to tackle the most widespread, severe and sustained threat that the HSC has had to face in recent years.

As the flu pandemic unfolded over the next days, weeks and months in Northern Ireland:

- Over 800,000 leaflets were distributed to households;
- GPs coped with the highest levels of consultations for flu and flu-like illness since detailed records began;
- Over 334,000 people were vaccinated against swine flu;
- Over 24,000 courses of antivirals were prescribed;
- 1,369 swab tests were positive for swine flu, (although these only represented a proportion of the total number infected);
- 580 people were hospitalised;
- 50 of these were admitted to Intensive Care, including 8 pregnant women and 12 children;
- 18 people died.

On 10 August 2010, the World Health Organisation declared that the Pandemic was officially over and that we are now in a post pandemic phase. After any emergency situation, it is important to learn from the experience in order to better prepare for the future.

An independent review described the UK response as proportionate and effective and commended the dedication and professionalism of health and social care staff. An overview of how all parts of our health and social care system in Northern Ireland worked together to manage the response has also been completed. Lessons and recommendations from these two reports are being used to update our pandemic plans. The people of Northern Ireland can have confidence that we will be better prepared than ever before, should another pandemic come along.

This winter the swine flu virus is expected to return as the main influenza virus.

This year’s seasonal flu vaccine WILL protect you against the swine flu virus, so if you normally get called for seasonal flu vaccination, don’t forget to go!

If you are pregnant, ask your GP or midwife about flu vaccination to protect you and your baby. And remember, for all respiratory viruses — *Catch it! Bin it! Kill it!* — the message remains as important as ever!
One of the main aims of public health remains the promotion and consolidation of healthy lifestyles across the Northern Ireland population. There are two elements to this work: first is the development of a strategy or policy to address the issue; and second the action or implementation plan.

Developing a strategy can be very complex. It is based on evidence of what works and what doesn’t, is informed by experience from here and elsewhere, and is modified and informed by the views of the public and interested parties. It often entails wide consultation and discussion with key stakeholders as well as the gathering, collating and analysis of relevant data.

Any strategy is only as good as its implementation, and so it is usually supported by an action plan or implementation plan which details the actions that will be taken to achieve the aims, objectives and targets of the strategy.

As lifestyle issues are by their nature dynamic and subject to changing trends and circumstances, strategies and action plans are carefully monitored and reviewed so that they remain appropriate and relevant to the issue and the present day context. Work on reviewing strategies has been ongoing for a range of lifestyle issues, some of which are highlighted here.
Promoting Positive Mental Health and Wellbeing

Positive mental health and wellbeing holds the key to a better quality of life for all. It contributes to good physical health and is fundamental to achieving improved educational attainment, increased employment opportunities, reduced social exclusion, and reduced health inequalities. The Foresight Report found that engaging in simple activities such as gardening can help protect mental health and assist people to lead more fulfilled and productive lives. It recommends a ‘five a day’ programme for positive mental health.

The Foresight Report’s ‘five a day’ for positive mental health:

- **Connect** – building connections with family, friends, colleagues or through shared interests and communities can enrich life and bring support.
- **Be active** – sports, hobbies, and daily light exercise make people feel good and maintain mobility and fitness.
- **Be curious** – reflecting on positive, uplifting aspects and moments of everyday life helps people to appreciate what matters to them.
- **Learn** – the challenge and satisfaction of learning new things brings fun and builds confidence; examples are taking up an instrument or cooking, or learning a language.
- **Give** – Helping friends and strangers links a person’s happiness to a wider community and is very rewarding.

It is also important that people are able to recognise the symptoms of a decline in their mental wellbeing as this will allow them to take action early so that the effects can be minimised. Common signs include:

- Feeling anxious, worried or overwhelmed by problems
- Feeling angry for no reason
- Changes in sleeping or eating patterns
- Difficulty concentrating or making decisions
- Loss of confidence, withdrawal
- Difficulties in communicating
- Impairment in work functioning
- Feeling tired or emotional.

A new strategy for the promotion of mental health and wellbeing in Northern Ireland will be published later this year.
As has been highlighted in previous reports, obesity and alcohol have in recent years become key public health concerns as both present a significant challenge to the future health of Northern Ireland.

While work addressing the Northern Ireland diet and lack of physical activity has taken place for a number of years, over the last year a more co-ordinated obesity framework has been developed. It addresses the whole population and recognises that tackling obesity is not just an issue for health but is the responsibility of all sectors and all Government Departments. The framework is due to go out to consultation later in the autumn.

**Obesity**

- Causes around 450 deaths each year in Northern Ireland
- Reduces life expectancy by up to nine years
- Increases the risk of coronary heart disease, cancer and diabetes
- 1 in 4 girls and 1 in 6 boys in Primary One are overweight or obese
- Nearly 60% of all adults are either overweight (35%) or obese (24%) (survey data)
Deliberate Self–Harm Registry

As part of the rollout of the Northern Ireland Suicide Prevention Strategy and Action Plan 2006–2011 ‘Protect Life – A Shared Vision’, a Registry of Deliberate Self-Harm was established as a pilot in the Western Trust area. The aim of the registry was to obtain a greater understanding of deliberate self-harm including its prevalence, the methods used and the times when it was occurring. This registry is linked with the national Registry of Deliberate Self-Harm in the Republic of Ireland. It also allows comparisons with several centres in the UK which also monitor self-harm presentation at accident and emergency units. The registry also provides the health and social care services with the information that allows services to be planned in response to those requiring our help.

Data for the first year (2007) of the pilot found the highest rates of self-harm were among 20 to 24 year old men and women (Figure 2). There were greater numbers presenting on a Saturday and a Sunday and in over 60% of episodes alcohol was a contributory factor. In 2008 alone there were over 4,000 cases of self-harm in the Western Trust area. Accident and emergency or an inpatient ward in hospital, they are aware of sources of help and have details of follow-up arrangements for their ongoing care. The ‘Card Before You Leave’ scheme provides such information which, although a relatively simple measure, has the potential to decrease further self-harm or even prevent suicide by reassuring the person that they need not feel alone or forgotten.

The ‘Card Before You Leave’ Initiative

People who present to hospitals having self-harmed are usually very distressed and at risk of further self-harm so it is crucial that, before they leave

Alcohol was a contributory factor in over 60% of cases of deliberate self-harm
Why do some people self-harm?

To try and get a better understanding of why some people self-harm, a survey involving over 3,500 pupils aged 15–16 was undertaken in Northern Ireland. Ten per cent of them reported having self-harmed at some point and of this group almost 60% had self-harmed in the past 12 months. This is of particular concern because of the link between self-harming and suicide. Girls were 3.5 times more likely to self-harm than boys. The main reasons given for self-harm are shown in Figure 3.

Economic recession and suicide

It is widely accepted that the current economic climate is likely to lead to a rise in unemployment. This is of great concern in terms of our efforts to address suicide. Studies indicate that unemployed people are two to three times more at risk of suicide, and international research has found that a 1% increase in unemployment is met with a corresponding 0.7% increase in suicide. This reflects the scale of the challenge that we all face over the coming years as we try to reduce suicide in our society.

Tackling the high level of suicide in our local communities remains a key priority for the Department. The Northern Ireland Suicide Prevention Strategy ‘Protect Life – A Shared Vision’, published in October 2006 has been extended to 2013. It is currently being updated and will provide an opportunity to consider initiatives to mitigate the potential impact of rising unemployment.

Figure 3 Reasons given by 15–16 year olds for self-harming
ALCOHOL AND DRUGS

The New Strategic Direction for Alcohol and Drugs (NSD) was launched in 2006 and runs through to October 2011. It has been agreed that, rather than carrying out a full formal review and subsequent new strategy development, a process should be put in place to update and extend the NSD for a further five years.

The review process will involve an assessment of the current aims and objectives and their continuing relevance as well as an assessment of progress against the short-term outcomes. The process will provide an opportunity to consider changes that have occurred since 2006, including emerging issues of concern, for example: young people’s drinking; legal highs; children living with parents/carers who are problem alcohol/drug users (‘hidden harm’); misuse of prescription drugs.

A revised and extended NSD will aim to achieve a balance between approaches and initiatives which target the whole population (universal prevention) and those which target identified vulnerable, ‘at risk’ groups (targeted/indicated prevention).

Some facts about alcohol misuse in Northern Ireland:

- 35% of men and 29% of drinkers currently binge drink
- 9,619 admitted to acute hospitals in 08/09 due to alcohol misuse
- 3,328 individuals were in treatment for alcohol misuse on 1 March 2010
- 283 people died directly as a result of alcohol misuse in 2007, an increase of 34% since 2001
- 1 in 6 people attending A&E for treatment have alcohol related injuries.

The annual cost to the health service of alcohol misuse is estimated to be £122 million. A further £48 million is spent on social care.
Mephedrone (sometimes known as meow-meow) has received most media attention, and it has been linked to some tragic events across the UK. Mephedrone, reportedly being sold as bags of white powder or in capsule or tablet form, is used as a stimulant drug because it has similar effects to cocaine and amphetamines. These effects include increased energy, confidence and euphoria. Reported negative effects include nose bleeds, heart palpitations, nausea, vomiting, teeth/jaw grinding, skin rashes, aggression, depression and suicidal/self-harm feelings, particularly when ‘coming down’ from the drug. Given the concerns about mephedrone it was classified as a Class B drug under the Misuse of Drugs Act in April 2010. A Class B drug carries a penalty of up to five years in prison or an unlimited fine for possession and up to 14 years in prison for supplying the drug.

The new Coalition Government in Westminster is proposing to bring forward legislation that would temporarily ban new psychoactive substances as they emerge. This would give time for the Advisory Council on the Misuse of Drugs (ACMD) to fully investigate the safety of these substances before a final decision is made as to whether they should be added to the Misuse of Drugs Act or not.

Legislation is not a silver bullet solution. Banning them will reinforce the message that these drugs are not safe and may be potential killers. However, it is critical that we continue to inform and educate our young people, and their parents, about the real risks associated with taking drugs. There is also a clear message to anyone considering buying a ‘legal high’ – just because they are advertised or marked as legal does not mean that they are safe or indeed legal. Users are putting their health at risk and could be committing a criminal offence.

The Department continues to work with health professionals, education and the Department of Justice to look at what further action can be taken in this area to ensure that the public are informed about the dangers these drugs pose.

There have been a number of reports in the media about so-called ‘legal highs’. While the term is often misused, these are generally taken to be substances that have a psychoactive effect but are not currently illegal under the UK-wide Misuse of Drugs Act.

The Legal Highs Fact Sheet can be downloaded at the following link: http://www.publichealth.hscni.net/publications/hsc-rd-today-issue-13-sum?page=1
SEXUAL HEALTH

Sexual health is an important part of physical and mental health, as well as emotional and social wellbeing. The Sexual Health Promotion Strategy which covers the period 2008–2013 aims to improve, protect and promote the sexual health and wellbeing of the population in Northern Ireland.

Many factors can adversely impact on people’s sexual health including poverty, unemployment, poor education, substance misuse and social exclusion. Improving sexual wellbeing therefore requires a holistic approach that incorporates personal, social, emotional and spiritual, as well as physical aspects of sexuality.

Attitudes to relationships and sexual behaviour vary greatly and are influenced by upbringing, including culture, religious beliefs, the media and peers. The Strategy therefore recognises that the promotion of good sexual health and prevention of sexual ill-health are not just matters for health professionals. Education professionals, community and voluntary groups, the family, churches and faith groups all have an important role to play. Over the past year, the DHSSPS and Public Health Agency have established a multi-agency Sexual Health Improvement Network to oversee the implementation of the strategy’s action plan which focuses on prevention, training, education and access to services.

Over the last decade there has been a significant rise in the number of new cases of sexually transmitted infections (STIs) with over 12,000 people being diagnosed in 2009. The highest rates of STIs are in the 20-24 year old age group. Young people are particularly vulnerable to distorted information or a lack of information and this can encourage risky behaviour. The Strategy, therefore, supports the provision of positive and accurate information about sexual health issues, including the message that everyone should treat their own, and other people’s bodies, with respect.

Key objectives of the Sexual Health Promotion Strategy:

- To enable the population to develop and maintain the knowledge, skills and values necessary for improving sexual health and wellbeing.
- To promote opportunities to enable young people to make informed choices before engaging in sexual activity, especially empowering them to delay first intercourse until an appropriate time of their choosing.
- To reduce the number of unplanned births to teenage mothers.
- To ensure that all people have access to sexual health services.
- To reduce the incidence of sexually transmitted infections including HIV.
Chlamydia Infection

Chlamydia is the most common bacterial STI diagnosed in genitourinary medicine (GUM) clinics in Northern Ireland, and the rates of chlamydia infection have risen by almost a third over the past five years. In 2009, there were 1,906 new episodes of uncomplicated chlamydial infection diagnosed, with the highest number of episodes (774) in those aged between 20 and 24 years (Figure 4).

The increase in chlamydia infection may be in part due to increasing public and professional awareness and increased chlamydia testing. A significant proportion of cases, particularly among women, are asymptomatic. Undetected and untreated chlamydial infection can result in various complications. In women, untreated chlamydial infection can cause chronic pelvic pain and lead to pelvic inflammatory disease, ectopic pregnancy and infertility. An infected pregnant woman may also pass the infection to her baby during delivery. Complications in men include urethritis (inflammation of the urine tube), and epididymitis (inflammation of the tube connected to the testes) which, if left untreated, can lead to infertility.

Symptomatic chlamydia testing is undertaken within primary care and the sexual health service. Testing is offered to asymptomatic young people by a range of providers including Brook clinics, pharmacies, young people’s services and GP practices.

HIV Infection

New HIV infections continue to be diagnosed here each year, with 65 new cases reported during 2009. HIV is a viral infection for which there is as yet no cure. The key routes of transmission remain sexual contact between men who have sex with men (MSM) and sexual contact between men and women though it can also be transmitted by the sharing of HIV contaminated needles and syringes and from mother to baby before, during or shortly after birth.

Heterosexual transmission of HIV is increasing (Figure 5) and currently accounts for 45% of those who have contracted it. This highlights the ongoing need for sexual health education, for both the heterosexual and MSM communities. The risks of unprotected casual sex both within and outside Northern Ireland also need to be highlighted.
Smoking remains the single greatest cause of preventable illness and premature death in Northern Ireland, and is also the leading cause of health inequalities in our society. While considerable progress has been made in the past 20 years to reduce the number of people who smoke, prevalence rates still remain too high, particularly among those from socially or economically deprived groups (Figure 6). Latest research found that 24% of males and 24% of females aged 16 and over currently smoke; among manual workers the figure was 31%.

A new Tobacco Control Strategy is being developed and will replace the Department’s five year Tobacco Action Plan 2003-2008. The new strategy is expected to be issued for consultation in the autumn and while it will continue to target the whole population, it will focus on three main priority groups:

- Children and young people,
- Pregnant women who smoke, and
- Disadvantaged people who smoke.

The key objectives are: fewer people starting to smoke; more smokers quitting; and greater protection for the population from tobacco-related harm.
Skin Cancer Prevention

Skin cancer is now the most common form of cancer in Northern Ireland, with over 2,700 new cases diagnosed annually of which around 230 are malignant melanoma - the most serious form of skin cancer. The incidence of melanoma has increased threefold in the last 20 years. Although 40% of the cases are in those aged under 50, the bigger rise has been seen in older men. The majority of skin cancer cases could be prevented by the adoption of simple care in the sun, though other factors such as cheaper foreign sun holidays and longer lifespans (thus giving cancers time to develop) have also contributed to its rise.

Following a review of the 1997 Northern Ireland Melanoma Strategy, a working group was established to develop a new 10-year strategy and action plan for the prevention of skin cancer. This new strategy is being issued for consultation in October 2010.

Sunbed Legislation

Legislation to regulate the sunbed industry is expected to complete its passage through the Northern Ireland Assembly by March 2011. The legislation will:

- prohibit persons under 18 from using, buying or hiring sunbeds;
- prohibit unsupervised sunbed premises;
- ensure adults are warned about the health risks – through the display of health warning signs and detailed written information;
- prevent operators from make spurious claims about health benefits to be had from sunbeds, and
- ensure protective eyewear is available.
For all of us, realising our potential and being able to work productively and contribute to our communities are important for health and wellbeing and for quality of life. In recent years there has been a greater acknowledgement of the positive influence of work on health and of the negative health consequences of being out of work. At the same time there has been a greater appreciation of the sheer scale of the cost of working age ill–health with figures from Great Britain for 2007 estimating an annual cost of over £100billion. In Northern Ireland the cost is estimated to be over £3billion.

Addressing these issues requires action on a number of fronts. Already the Department of Employment and Learning requires people newly in receipt of certain benefits to participate in its “Pathways to Work” programme. Participants have a number of choices including an option of referral to a Condition Management Programme which enables access to health interventions. Similarly some workplaces have provided access to physiotherapy services to support people who suffer from musculoskeletal problems to return to work as quickly as possible.

Healthcare professionals also need a better understanding of the crucial relationship between work and health and of the evidence that work can be both good for health and have a therapeutic value. Those involved in the treatment of people of working age should consider their needs in relation to work, to enable them to remain in, or return to work. These principles are contained in the Dame Carol Black review “Working for a Healthier Tomorrow”, which also advocated the replacement of the Sick Note with a “Fit Note”.

**Fit Note**
The new “Fit Note” came into effect in Northern Ireland on 6 April 2010. “Fit Notes” can be issued when patients are off work for more than seven days. Whilst doctors can still use the “Fit Note” to advise that a patient is unfit for work a new option to advise that the “person may be fit for work taking account of the following advice” has been introduced. The doctor can provide relevant, additional information on the functional consequences of the illness and advise on the types of amendments to work which an employer may wish to consider. Where such amendments cannot be put in place the patient and the employer can use the note as if the doctor had advised that the patient was “not fit for work”. Like the Sick Note the new “Fit Note” is advice to the patient which can be used as evidence of fitness for sick pay or benefits purposes and, as was previously the case, it is not binding on employers.
Research and Development (R&D) within health and social care plays a very important role in furthering the understanding of many conditions and effective treatment of them.

Across the UK, each of the four health departments provides funding for R&D that can deliver improved care for patients and lead to better health for the wider community.

Great advances in knowledge have been made by researchers working in Northern Ireland and elsewhere in the world so now real priority is given to implementing their results into practice. This process is known as translation, or ‘translational research’. Translational research leads to improvements in the prevention, detection, treatment or cure of diseases; improvements in the care of patients or clients, and improvements in how services are organised. Many studies have shown that health and social care organisations that are active in research are more likely to deliver the highest quality services.

There are many examples of how research is improving quality throughout the province. Through the Northern Ireland Clinical Research Network (NICRN), almost 7,000 patients have entered clinical research studies across the five HSC Trusts. Participation in these studies has enabled the patients to access new and innovative treatments that are not yet available through routine services. Many of those patients will have experienced better health outcomes than if they had received the standard treatment. Currently the Northern Ireland Clinical Research Network involves studies in nine disease areas.

Northern Ireland also has a good record of clinical research on cancer with an excellent model of international collaboration that also involves the Republic of Ireland and the National Cancer Institute in the USA. This Cancer Consortium has now been in place for a decade and supports research, education and care on all aspects of cancer ranging from prevention through to palliative care. The Consortium’s 2009 Annual Activities Report was launched recently jointly by Ministers McGimpsey and Harney.

Fuller details on research activities funded by HSC R&D are provided in its biannual newsletter ‘R&D Today’. The most recent issue is available on the website of the Public Health Agency, of which HSC R&D is a Division.

SUSTAINABLE DEVELOPMENT IN HEALTH AND SOCIAL CARE

At the start of the 21st century countries across the world are facing up to the global threat of unsustainable development that risks causing damage to such an extent that the planet would no longer have the capability to support human life. Unsustainable development across the world is overexploiting resources and creating pollution, changing habitats and driving species to extinction. It is creating social problems which are exacerbated by the inequalities in health, wealth, education and employment that accompany it.

The new Sustainable Development Strategy ‘Everyone’s Involved’, was published by the Executive on May 2010 and builds on the 2006 strategy ‘First Steps Towards Sustainability’. It sets out the Executive’s vision for a peaceful, fair, prosperous and sustainable society. The strategy aims to identify and develop actions that will improve the quality of life for ourselves and future generations.

Social and economic factors impact significantly on the health and wellbeing of the population and significant investment in both acute and community health and social care facilities support both urban regeneration and social development. The Department is committed to ensuring that all new health and social care developments must meet stringent targets in respect of sustainable development. All capital development schemes include an evaluation of options for ensuring sustainable development is incorporated into the scheme design.
Active design elements include the use of both proven and innovative environmental technologies such as renewable energy sources like geothermal heating, biomass boiler plant, solar hot water, rainwater recovery and wind power generation. The sustainable evaluation that is undertaken for each project is used to determine the most suitable sustainable technology which is then incorporated into the project design.

Passive design elements include issues such as pedestrian access, making the use of public transport more attractive and so reducing car use, using the building’s orientation to allow for passive heating but with appropriate design features to minimise summer overheating, the use of extensive daylight penetration to reduce energy consumption through reducing the need for artificial lighting and the incorporation of natural ventilation as opposed to the use of an electrically driven ventilation unit.

In delivering the new DHSSPS sustainable model of care, the objective is to provide access to a comprehensive health and social care service integrated with other local services that impact on the health and wellbeing of local communities. A good example is the recently completed Grove Wellbeing & Treatment Centre which provides local health and social care services alongside community services such as leisure facilities and library services.

The Grove Wellbeing Centre is a ‘one stop shop’ for leisure, health and library facilities. It aims to provide wellbeing by delivering high quality health, social care, leisure, lifestyle and life long learning services.

During the first 3 years (2005-07) when the wind turbine at Antrim hospital was operational the total savings for the hospital from wind energy was £185,000 with an associated savings of 1,085 tonnes of Carbon Dioxide.

In Northern Ireland Greenhouse Gas (GHG) emissions from the energy sector (power stations) represent 22% of total emissions, agriculture 21%, road transport 22%, residential 16%, industrial combustion 5%, and waste 3.8% (AEA 2009).
The census of the population is undertaken every 10 years with the next one due on Sunday 27 March 2011. This head count is unique as it provides comprehensive demographic information for small areas and small population groups, as well as for Northern Ireland as a whole.

The information obtained is used extensively across the public, private and voluntary sectors. It is used in a number of ways including:

- Planning and delivery of services at both regional and local level
- Informing policy and funding across all parts of Government, including housing, education, healthcare, social welfare and transport
- Identifying and targeting areas of need and disadvantage
- Providing information on small population subgroups, such as ethnic minority populations, for which sample surveys cannot provide robust statistics.

Accurate census population data is also important as it is the baseline from which the mid-year population estimates are calculated in subsequent years. It will also provide updated information on the size and origin of our ethnic populations. This will be particularly interesting given the considerable increase in people from different ethnic backgrounds now living in Northern Ireland.

It is important that every household completes a census return on 27 March 2011.
GET INVOLVED – HAVE YOUR SAY

Health and Social Care services in Northern Ireland belong to us all – we quite rightly expect that they will help us to stay well, and be available to provide support or treatment when we or our families need it. It is important that our services are provided in a way which best meets the needs of people living in Northern Ireland, and doing this effectively means listening to what people think of our services – their experiences of their care or treatment, as well as their views on how services are planned, organised and delivered.

Public and Professional Involvement (PPI) is an umbrella term to describe engagement, active participation and partnership working with those that have an interest in our business. This includes any individual or group of people who use services directly or indirectly and the communities we serve and their health and social care organisations and representatives.

There is evidence that working in genuine partnership with users, carers and communities can deliver:

- Greater local ownership of health and social care services
- A better understanding of why and how services need to change and develop.

The Patient Client Council has developed a membership scheme to support people who are interested in becoming involved in health and social care issues, and is recruiting people aged 16 and over who live in Northern Ireland.

People can get involved as much or as little as they wish, and can join either by calling freephone 0800 917 0222, or e-mailing pccmembership@hscni.net

Service frameworks promote equal healthcare and treatment

Everyone in Northern Ireland has the right to expect the same access to treatment and services no matter where they live. The development of the Service Framework Programme sets out the basis of what people can expect across a range of care programmes.

A key milestone in the Service Framework Programme was reached in June 2009 with the launch of the first Framework, namely the Cardiovascular Health and Wellbeing Service Framework. This was followed in November 2009 with the launch of the Service Framework for Respiratory Health and Wellbeing. The draft Service Framework for Cancer Prevention, Treatment and Care was published for consultation in October 2009. Service frameworks for mental health and wellbeing, learning disability, the health and wellbeing of children and young people and the health and wellbeing of older people are also at various stages of development.

Further details are available at www.dhsspsni.gov.uk/index/phealth/sqs/sqsd-standards-service-frameworks.htm
Listening, Learning, Improving – Effective Feedback about Health and Social Care Services

In any area of life there can be room for improvement and a commitment to do things better. With this in mind, a new system for handling complaints about health and social care services in Northern Ireland was implemented in April 2009.

The new procedure is simpler and easier to use and is the same system across all health and social care services. It encourages speedier and more effective local resolution of complaints. There is also a renewed emphasis on learning, so that mistakes are acted upon and, where necessary, services can be improved.

Leaflets and posters across health and social care facilities explain in detail what to do if you have a complaint. These explain:

- **Who can complain?**
  Anyone who uses Health and Social Care services in Northern Ireland can complain. You can also complain on behalf of someone else, although you will generally need their consent to do so.

- **Who to complain to**
  If you have a complaint, you can speak to any of the staff who are dealing with your treatment or care and they will try to resolve your complaint straight away. If you don’t feel comfortable doing this, all HSC organisations will have a member of staff who is responsible for dealing with complaints and you can also raise your concerns with them.

- **How to complain**
  You can complain in the way that best suits you – this can be face-to-face, on the telephone, in a letter or by email.

- **Help with making a complaint**
  Health and Social Care Service complaints managers can provide you with more information on how to make a complaint. You can also contact the Patient and Client Council who can provide free and confidential advice, information and help to make a complaint.

Further information on the new procedure is available on the DHSSPS website at www.dhsspsni.gov.uk/hsccomplaints.htm
SAFE SURGERY SAVES LIVES

Hospitals in eight cities around the globe have successfully demonstrated that during major operations the use of a simple surgical checklist, developed by the World Health Organisation (WHO), can lower the incidence of surgery-related deaths and complications by one third.

The checklist was launched in 2008 by WHO as a second Global Patient Safety Challenge, ‘Safe Surgery Saves Lives’ to reduce the number of surgical deaths across the world.

It identifies a core set of surgical safety standards that can be applied in all healthcare settings. It requires only a few minutes to complete at three critical points during operative care – before anaesthesia is administered, before skin incision and before the patient leaves the operating room. It is intended to ensure the safe delivery of anaesthesia, appropriate prophylaxis against infection, effective teamwork by the operating room staff and other essential practices in perioperative care.

The WHO checklist contains the core set of safety checks but can be adapted locally or for specific specialties through Trust clinical governance procedures. A study of the use of the checklist in nearly 8,000 surgical patients, published in the New England Journal of Medicine, (21/1/09) showed a reduction in deaths and complications.
1. In 2008 there were estimated to be 1,775,000 people living here.

2. Life expectancy for men is 76.3 years and 81.2 for women.

3. 25,746 babies were born in 2008.

4. 14,907 people died in 2008; 7,227 males and 7,680 females. 2,125 were age 90 or over when they died; 553 men and 1,572 women.

5. In 2008 there were 3,971 deaths from cancer and 2,847 from heart disease.

6. Between 2008 and 2020 the number of people over 75 is projected to increase by 40%.

7. 9,485 people aged 65 and over are cared for in residential and nursing homes.

8. 9,619 people were admitted to acute hospitals in 2008/09 for treatment of alcohol misuse.

9. Alcohol is a contributory factor in over 60% of cases of deliberate self-harm.

10. The average age at which pupils were first offered drugs (not including solvents) was 12.9 years.

11. In 2008/09, 24% of people were smokers (24% males and 24% females); this compares with 29% of people smoking in 1996/97 (31% males and 27% females).

12. The number of melanoma skin cancers has increased from 80 cases in 1984 to 233 cases in 2008.

13. 1 in 14 people aged over 65 have a form of dementia, rising to 1 in 6 people over 80 and 1 in 3 over 85.

14. There were almost 600,000 inpatient and day case admissions to hospital in 2009/10.

15. 35 million prescriptions were dispensed in the community in 2009/10 at a cost of £400 million.

16. Over 1.5 million patients were seen at consultant-led services within hospitals in 2009/10.