

Director of Public Health Annual Report

2013



Public Health
Agency

Poverty
Maternity services
G8 Summit
Cook & Lelli
Support models
OPTIMISED EYE CARE
Cancer screening
MSM
Farm families
Travellers
Equality
Sexual health
Disabilities
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Foreword

Foreword



"There are not more than five musical notes, yet the combinations of these five give rise to more melodies than can ever be heard.

There are not more than five primary colours, yet in combination they produce more hues than can ever be seen.

There are not more than five cardinal tastes, yet combinations of them yield more flavours than can ever be tasted."

Sun Tzu

Welcome to the *Director of Public Health Annual Report 2013*.

The theme of this year's report is to celebrate diversity in our population. Diversity is about people and how we value and appreciate those who are not like us. The ways in which we define ourselves are complex. We are all constantly defining and redefining different aspects of ourselves in the context of our physical characteristics, histories, influences, behaviours, cultures and subcultures.

Dr Carolyn Harper

When we talk about diversity we mean respecting and valuing all forms of difference in individuals. People differ in all sorts of ways which may not always be obvious or visible. These differences might include race and ethnicity, culture and belief, gender and sexuality, age and social status, ability, and use of health and social care services.

A deep association exists between diversity and our work in public health. It is well recognised that some people find it more difficult to enjoy their full health. It is also evident that minority groups experience poorer health outcomes and have significantly lower access to services.



Meeting the challenges

Understanding the distribution of the determinants of health within these groups is essential if we are to reduce health inequalities. Without this, it would be impossible to create services that address the real needs of our population. Northern Ireland has well-developed health information systems and significant work is underway to improve data that will allow us to analyse and monitor the differences in health status between groups.

Health inequality is a complex issue and many factors influence the differences in health status between population groups. The public health interventions employed to improve the population's health are wide-ranging and cross-cutting. It is therefore essential to continue effective partnership working to address these issues. There are a range of initiatives in place and we are working closely with many strategic partners to develop new, and expand existing, programmes for all subgroups within the population of Northern Ireland.

Our public health programmes are based on robust evidence where it is available and seek innovation where evidence is limited. The redesign of patient care pathways with a focus on prevention empowers people to manage their own health and avoid needing hospital care. It also offers a local approach different to traditional medical models, whilst operating under difficult financial conditions.

The report sets out some new public health priorities for Northern Ireland, as well as reiterating priorities in my previous reports for the period 2010 to 2012, around early years and elderly health.

My report recognises the opportunities and challenges posed by population diversity and highlights some of the key programmes introduced to meet these needs. The main purpose of public health is to protect and improve health and social wellbeing and to tackle health inequalities through strong partnership with individuals, communities, and other key public, private and voluntary organisations. Central to our ambition is to place the patients and the public at the heart of everything we do.

I hope you enjoy reading this report and want to thank you all for your commitment and enthusiasm for improving health in Northern Ireland, for making sure that we focus on reducing health inequalities and for putting working programmes in place that make a real difference. To inform future reports, I would also be pleased to receive feedback on this report's content, presentation and usefulness.



Dr Carolyn Harper
Director of Public Health

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Introduction

Report structure

This is the fifth *Director of Public Health Annual Report*, detailing the main public health challenges in Northern Ireland. It also provides information on the wide variety of work undertaken by the Public Health Agency (PHA) and its partners during 2013 to improve the health and social wellbeing of the population. Each year, the Director of Public Health (DPH) report focuses on an overarching theme, and this year the theme is 'Population diversity'.

The report structure reflects the main areas of public health action:

- improving health and reducing inequalities;
- improving health through early detection;
- improving health through high quality services;
- improving health through research;
- protecting health.

For ease of reference, the sections are colour coded.

On page 70, the report also lists core tables for 2012 relating to key statistical data on, among others, population, birth and death rates, mortality by cause, life expectancy, immunisation and screening. In addition to the core tables, a specific set of tables relating to various aspects of diversity are published alongside this report.

Both sets of tables are available as a portable document format (PDF) file on the PHA website at: www.publichealth.hscni.net

Background

The PHA was established to:

- protect public health and improve the health and social wellbeing of people in Northern Ireland;
- reduce inequalities in health and social wellbeing through targeted, effective action;
- build strong partnerships with key stakeholders to achieve tangible improvements in health and social wellbeing.

The PHA takes direct public health action and commissions or facilitates action by others, including a wide range of community, voluntary and statutory partners across all sectors.

Diversity: redefining difference

Diversity literally means difference. When it is used as a contrast or addition to equality, it involves:

- recognising individual as well as group differences;
- treating people as individuals;
- placing positive value on differences in the community and population.

Although there have been improvements in the overall health of the Northern Ireland population, these have not been experienced by all groups at the same rate. The economic downturn is a further risk factor with a disproportionate impact likely to be experienced by those already disadvantaged.

It is therefore important that public health principles, core services, research and programmes take into account the diversity in communities and the population. There is no single way to divide the population into specific sub-groups. However, for the purpose of this report, we have looked in detail at 12 groups.

There are opportunities and challenges for public health posed by diversity within the Northern Ireland population. The health problems faced by different population groups are immensely varied and this overview highlights some of the most important public health issues experienced by these diverse groups.

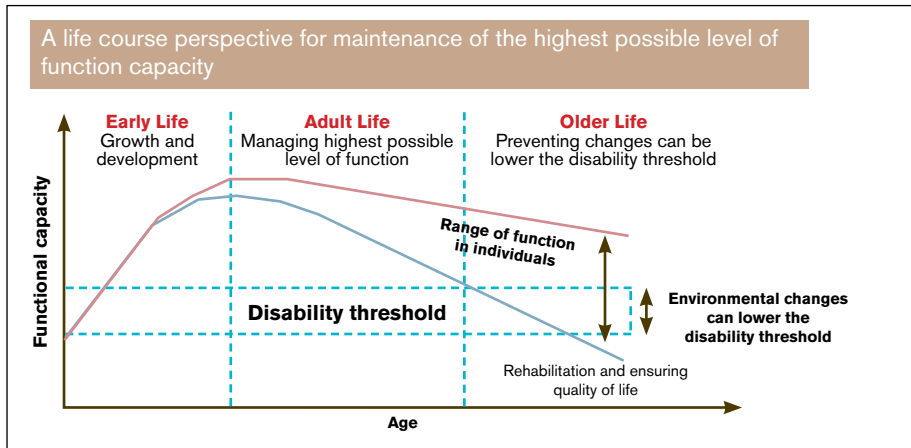
1. Public health and age

Age is one of the most important characteristics of health.¹ The current life course approach in public health refocuses our attention on the importance of age as a fundamental characteristic of individuals and society.^{1,3}

Public health programmes cover the full life course from pre-conception to end of life care. The early years of life are a vital stage as they establish the foundations for later health, while the ages between 10–24 cover the key changes that pave the way to adulthood and reinforce many of the values and behaviours that will impact on health throughout the rest of life.^{1,2,3}

In line with recommendations in *Fair society, healthy lives*, the Marmot Review of health inequalities in England, the PHA has a strategic goal to give every child and young person the best start in life. Investment in early years of life brings significant benefits later across a wide range of outcomes in relation to health and wellbeing, education and employment.⁴

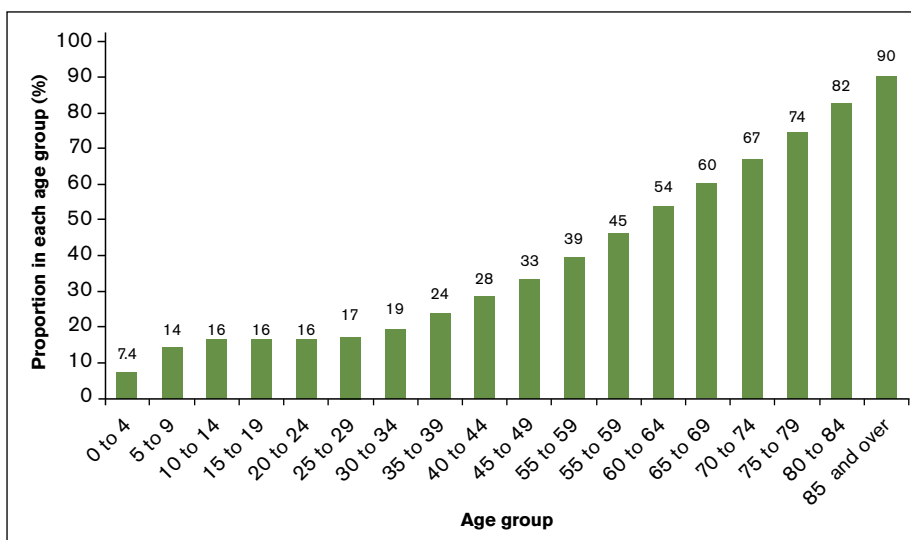
Figure 1: Life course approach in public health



Middle age is characterised as the time when the aggregated harms of the previous decades of life start to have their impact on health and, therefore, it is a time of greater concentration on healthier behaviours.^{2,3} On the other hand, in older age, the focus is more on maintenance of functions and reduction of the gap between life expectancy and healthy life expectancy.²

The fall in fertility rates and the significant improvement in life expectancy have inevitably resulted in an older population overall in Northern Ireland.⁵ As illness is more common in later life, it follows that the incidence of illness and disability will also increase.

Figure 2: Proportion of those in each age group with at least one long-term condition



Based on the 2011 Census, the proportion of the population who assess their general health as 'bad' or 'very bad' increases with age, from less than 1% among those aged 0–9 years to 10% among those in their 50s and 17% among those aged 85 and over.

In a similar way, the proportion of the population who have at least one long-term condition increases from 11% among children aged 0–9 years to 42% among those in their 50s and 90% among those aged 85 and over.⁵

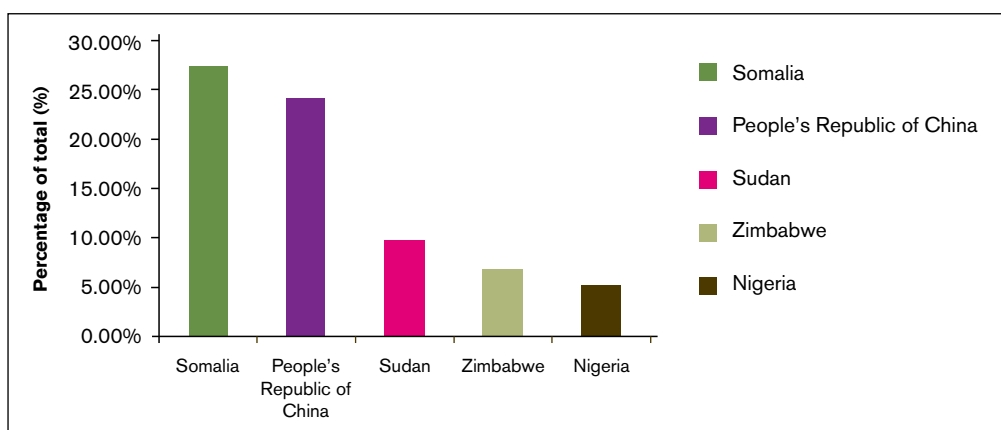
An active, secure and healthy older population can bring huge benefits to families, friends, workplaces and society as a whole. Given that the number of people of current pensionable age in Northern Ireland is projected to increase by around 40% by 2023, it is important to have in place a range of comprehensive programmes to ensure fair, high quality, integrated Health and Social Care (HSC) services for older people.⁶

The PHA has put in place a range of programmes to address the needs of all life course stages. Examples of these have been highlighted in previous DPH reports.^{7,8}

2. Asylum seekers and refugees

It is difficult to accurately assess the number of asylum seekers and refugees in Northern Ireland. A small but growing number of people are seeking asylum in Northern Ireland, entering through one of the Northern Ireland ports or the Republic of Ireland.⁹ The report *Forced to flee* published by the Refugee Action Group estimated that around 2,000 refugees from about 30 different countries currently reside in Northern Ireland.⁹

Figure 3: Five most common countries of origin for first-time asylum applicants between 1 January 2011 and 31 October 2012



Source: Northern Ireland Strategic Migration Partnership

The Northern Ireland Strategic Migration Partnership reported 115 first-time asylum applicants in Northern Ireland in 2011 and 140 between January and October 2012 (10 months).¹⁰

Aggregated data for first-time asylum applicants between 1 January 2011 and 31 October 2012 show that five countries (Somalia, China, Sudan, Zimbabwe and Nigeria) accounted for 73% of applications (Figure 3).¹⁰

It is important to note that, by virtue of their history and experiences, the health needs of asylum seekers and refugees are different to those of the indigenous population. Many may have endured acute hardship, abuse and persecution in their country of origin, and have multiple health and social care problems. As a result, they may require a broader range of health services, particularly in the area of psychology and mental health. There may also be added trauma for asylum seekers due to detention or delays in processing their claims.¹¹

The PHA is working closely with organisations such as the Northern Ireland Council for Ethnic Minorities (NICEM), the National Asylum Support Service (NASS) and other related organisations to address these issues. In addition, the PHA, in collaboration with the Health and Social Care Board

(HSCB) and Belfast Health and Social Care Trust (HSCT), has established the Northern Ireland New Entrant Service (NINES) to offer a regional, holistic service and facilitate access to mainstream Health and Social Care for new entrants, including migrants, asylum seekers and refugees.

3. Public health and carers

Carers are a socially and demographically diverse group and, as the demand for care is projected to grow, people are increasingly likely to become informal providers of care at some point in their lives. The importance of unpaid care was reflected by its inclusion as an item in both the 2001 Census and 2011 Census. *Valuing care*, a report published in 2011, estimated that carers save the Northern Ireland economy over £4.4 billion a year.¹²

In the 2011 Census, approximately one in eight people living in household in Northern Ireland (12%) provided unpaid care to family members, friends, neighbours or others.¹³ The provision of unpaid care was related to age, increasing from under 1% among children aged 5–9 to a peak of 23% among those aged 50–54, and thereafter declining to 6.7% among those aged 85 years and over. The number of people providing unpaid care in Northern Ireland has increased from 185,000 to 214,000 between 2001 and 2011.¹³

Current evidence suggests that caring is more commonly undertaken by women and is more intensive in deprived areas.¹⁴ Carers are put under significant constraints through the physical and emotional demands of caring. The evidence also suggests the physical and mental health of those providing high levels of care is worse than that of non-carers.^{15,16,17} The PHA is engaged with other strategic partners to provide support, training and educational programmes for carers in Northern Ireland.

4. Public health and disability

The population of disabled people is heterogeneous, not only in terms of impairments but also demographically, socially and economically.

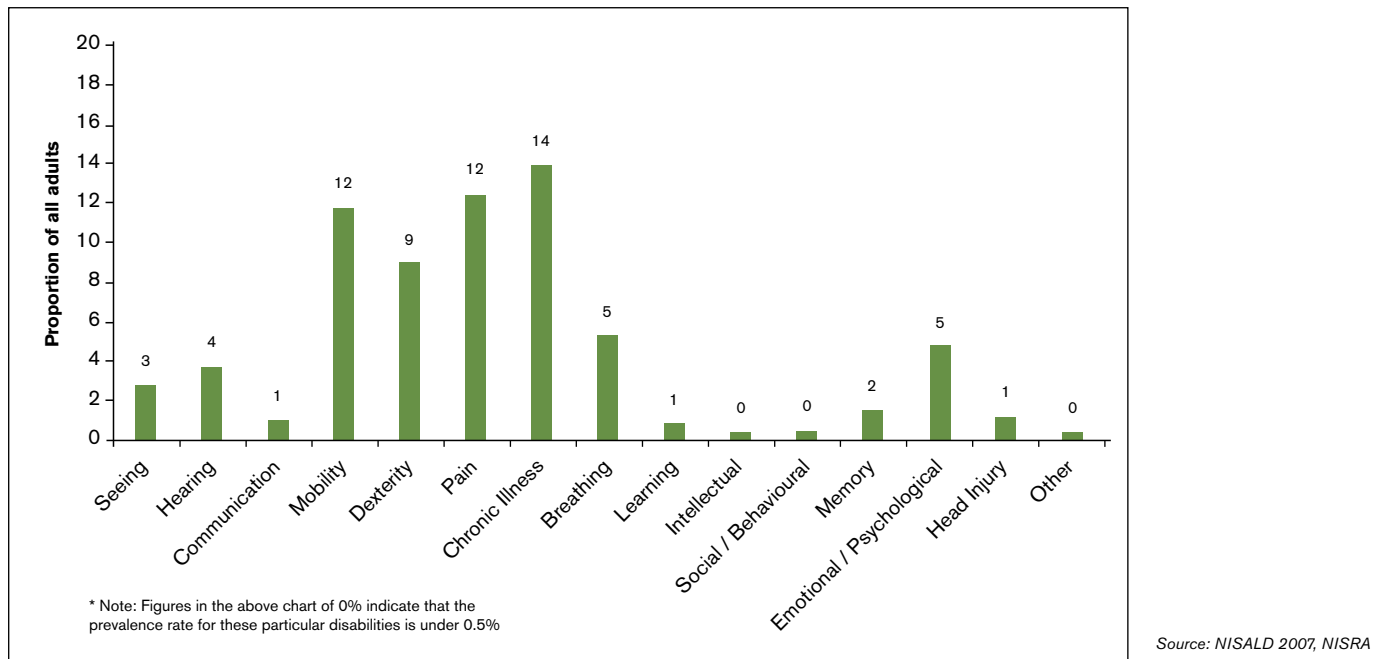
Good quality information on people in Northern Ireland with a disability is limited, especially in terms of their multiple identities and their experiences across a range of social and economic contexts, such as education, employment, transport and claiming of benefits.

In 2007, the Northern Ireland Statistics and Research Agency (NISRA) reported that nearly one in five people (18%) in households in Northern Ireland are limited in their daily activities for reasons associated with disability.¹⁸ The 2011 Census included a new question about the nature of any long-term condition or disability that respondents experienced, including, for example:

- deafness;
- blindness;
- a mobility or dexterity difficulty;
- shortness of breath or difficulty breathing;
- a chronic illness.

People experiencing any such long-term condition or disability were less likely than those without such a long-term condition to assess their general health as 'very good' (12% compared with 64%). Broadly similar proportions among those with or without a long-term health problem or disability assessed their general health as 'good' (31% and 32% respectively).

Figure 4: Prevalence of different disabilities among adult household population in Northern Ireland



There is evidence that people with serious mental health problems are at high risk of coronary heart disease and stroke before the age of 55.^{19,20} Similarly, people with learning difficulties are at high risk of respiratory disease, malnutrition and obesity.

Cervical and breast screening uptake rates are lower among people with learning disabilities.²⁰ There is also evidence that suggests people with disabilities are more likely to be living in poverty.²¹ In addition, people with mental health problems and learning disabilities are more likely to experience social stigma and discrimination, which put them at greater disadvantage.^{22,23}

Disability is not a simple reflection of an individual impairment or function, but a reflection of both physical and social environments that act as a barrier or facilitator in individual life. The PHA, in collaboration with partner organisations, is involved in improving the range and quality of services for people of all ages with disabilities across Northern Ireland.

5. Public health and ethnicity

Ethnicity reflects social differences between people and communities which may change over time. People may want to identify themselves with more than one ethnic group, which is why a new ethnic category 'Mix' was introduced in the 2011 Census.

Ethnic groups are non-homogenous, reflecting a highly diverse range of cultures and languages. On Census day 2011, 1.8% (32,400) of the Northern Ireland population were from ethnic minority groups, more than double the proportion in 2001 (0.8%). The main, non-white minority ethnic groups were Chinese (6,300 people), Indian (6,200), mixed (6,000) and other Asian (5,000), each accounting for around 0.3% of the resident population. A further 0.1% (1,300) were Travellers. Belfast (3.6%), Castlereagh (2.9%) and Dungannon (2.5%) had the highest proportions of residents from minority ethnic groups.

Table 1: Minority ethnic groups in Northern Ireland, 2001–2011

Ethnic group	Census 2001		Census 2011		Difference
	Count	Per cent of total population	Count	Per cent of total population	Count
Total residents	1,685,267	100	1,810,863	100	125,596
White	1,670,988	99.2	1,778,449	98.2	107,461
Chinese	4,145	0.2	6,303	0.4	2,158
Indian	1,567	0.1	6,198	0.3	4,631
Mixed	3,319	0.2	6,014	0.3	2,695
Irish Traveller	1,710	0.1	1,301	0.1	-409
Other	1,290	0.1	2,345	0.1	1,063
Pakistani	666	0	1,091	0.1	425
Black African	494	0	2,345	0.1	1,851
Black other	387	0	899	0.1	512
Black Caribbean	255	0	372	0	117
Bangladeshi	252	0	540	0	288
Other Asian	194	0	4,998	0.3	4,804

Source: NISRA

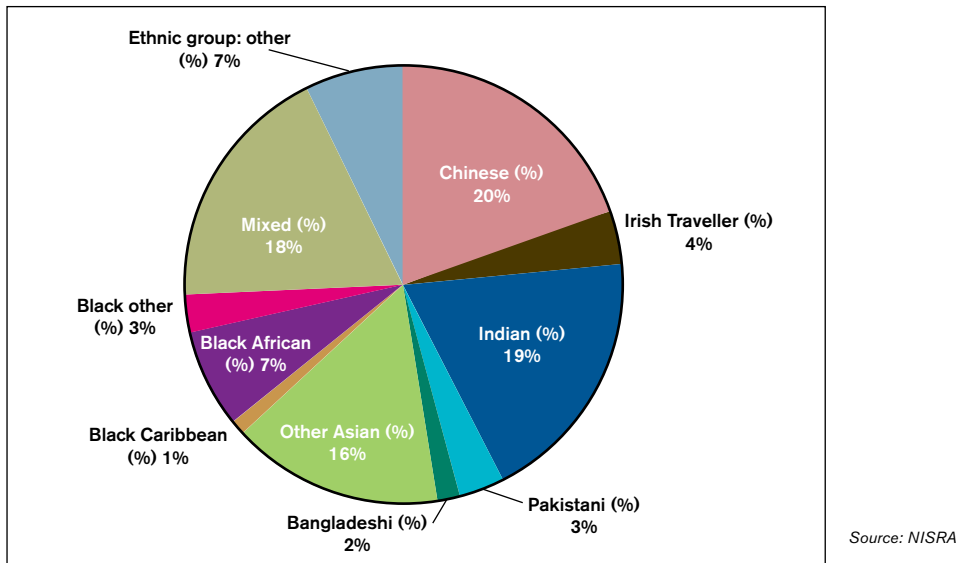
In the last few decades, the Northern Ireland population has become more ethnically diverse. It is clear that net inward migration during the last decade has supplemented existing minority ethnic communities and changed the ethnic mix of many places, both urban and rural. Ethnic minorities, however, have persistent barriers to healthy living, such as language, relatively lower socioeconomic class, inferior working and living conditions, lack of cultural awareness, and lack of understanding of HSC systems.

Ethnic groups within the Northern Ireland population bring different opportunities as well as challenges. These include:

- issues around health protection (eg hepatitis B, hepatitis C, HIV);
- vulnerability to non-communicable diseases;
- experience of health care (immunisation, prevention, screening, treatment);
- cultural beliefs about health/illness;
- acceptability of treatments.

There are also major challenges in the areas of education, employment, housing, poverty, racism and discrimination.^{20,21,24,25,26}

Figure 5: Northern Ireland minority ethnic population, by ethnic group, 2011



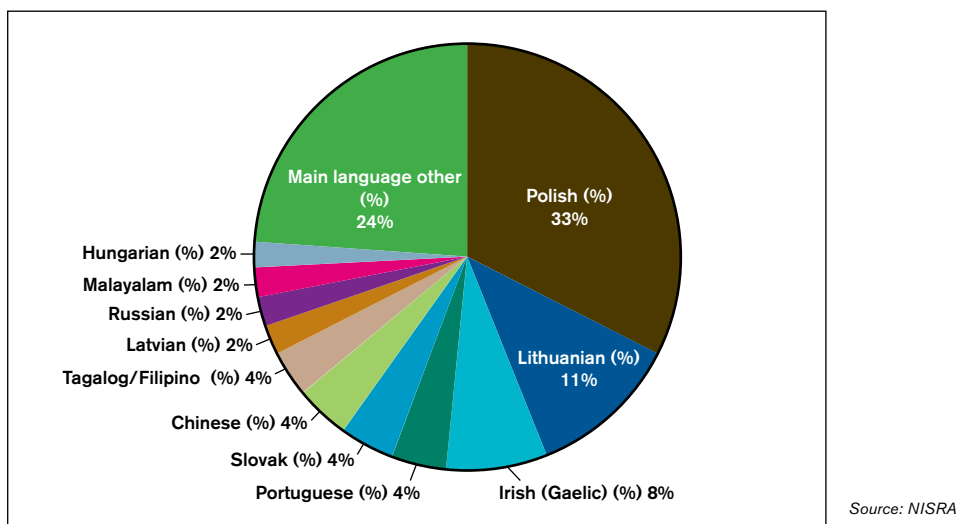
The PHA recognises the great wealth of experience and culture the minority ethnic population brings to Northern Ireland and is well aware of their specific needs as they can also represent one of our most vulnerable groups. The PHA is working in partnership with the Department of Health, Social Services and Public Safety (DHSSPS), HSCB, HSCTs, voluntary organisations and other strategic partners to address these needs.

6. Public health and language diversity

English is the main language in Northern Ireland and a lack of English language skills can therefore prevent or obstruct participation in society at the most basic level.

The 2011 Census found that English was not the main language for 3.1% (54,500) of Northern Ireland residents aged three years and over.²⁵ The most prevalent main language other than English was Polish (17,700 people). Other main languages spoken included: Lithuanian (6,300 people), Irish (4,200), Portuguese (2,300), Slovak (2,300), Chinese (2,200), Tagalog/Filipino (1,900), Latvian (1,300), Russian (1,200), Malayalam (1,200) and Hungarian (1,000).²⁷

Figure 6: Northern Ireland minority ethnic population, by main language, 2011



Little or no knowledge of English is considered the most significant barrier to accessing HSC, as well as service delivery. This can lead to an over-reliance on friends, family and minority ethnic support organisations to provide information on services.

Current evidence suggests that people who are not fluent in English:

- have less access to healthcare;
- receive fewer preventive measures;
- may have poor experience of service.^{28,29,30}

On the other hand, competency in English:

- is linked to quality of life improvements;
- enables people to secure employment;
- contributes to inclusion, integration and active citizenship.

Many people whose first language is not English are migrants, asylum seekers, refugees or from ethnic minorities, so it is plausible that some of the health issues faced by non-English speakers are similar to those groups.^{24,25,26} Communication barriers within HSC:

- prolong appointments;
- take up more staff time;
- increase the risk of misdiagnosis, misunderstanding and non-consent to examination, treatment or care.

The PHA supports other organisations working to improve English language skills and access to HSC for people who do not speak English. For example, the Northern Ireland Health and Social Care Interpreting Service (NIHSCIS) provides free interpreting to those who do not speak English as a first or competent second language.

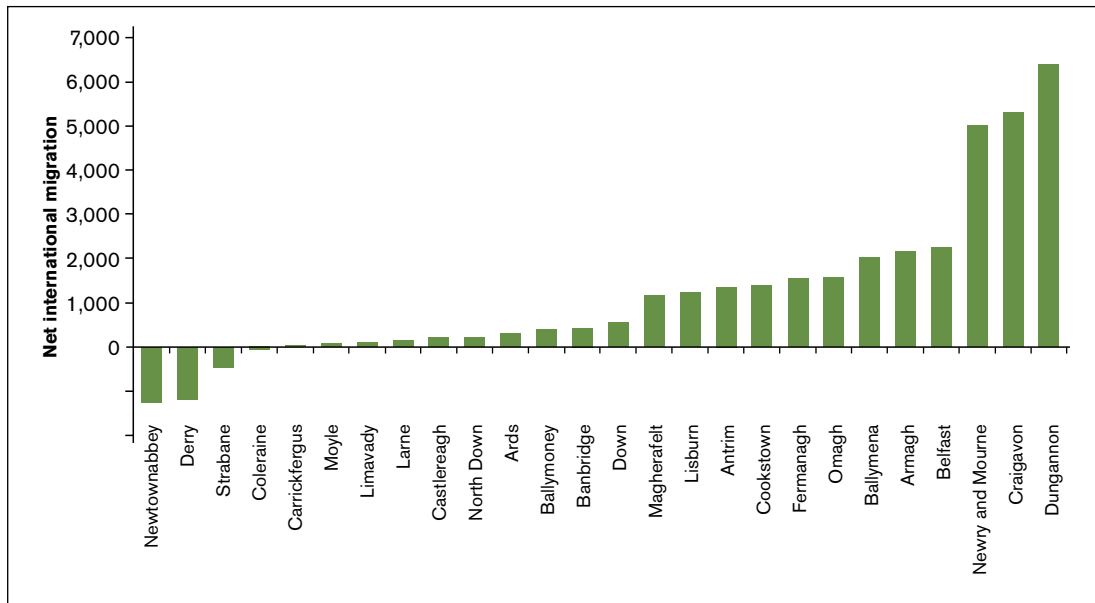
7. Public health and migrants

Migration has significant implications for all areas of public health practice. Patterns of disease, health needs and the type of health services required are different for migrant populations.

Between 2001 and 2009, it is estimated that around 110,000 migrants came to Northern Ireland. Previous immigrants to Northern Ireland tended to be from China and India, but more recently, eastern European migrants increased in number. During the tenure of the Worker Registration Scheme, figures showed relatively high numbers of migrants to Northern Ireland from A8 countries (eight eastern European countries that joined the European Union in 2004), compared with the UK as a whole. More than half of those migrants were from Poland, which continues to be the largest national minority group in Northern Ireland.^{31,32}

Since 2009, migration figures in Northern Ireland have started to stabilise and most recent figures indicate a slight decrease. NISRA figures show a total of 12,900 people came to live in Northern Ireland from outside the UK in the period from mid-2011 to mid-2012, with migrants from outside the UK and Republic of Ireland making up approximately 4.5% of the overall population. Only 2% of the overall population – about 36,000 people – are migrants from outside the European Union.^{32,33}

Figure 7: Estimated net international migration, by Local Government District



Source: NISRA

There is evidence that mental and social health problems are an issue for many migrants.³³ In general, the physical health of migrants is likely to be similar to the local population of the same age, but there are some differences, eg the smoking levels among Polish migrants in other countries were found to be higher than the local population.³⁴

Access to and knowledge of the health systems among migrant populations is reported to be limited, with language as a recurring barrier.^{28,29} The PHA is working on a number of programmes in partnership with the DHSSPS, HSCTs, voluntary organisations and other partners, to address the key challenges faced by migrant populations.

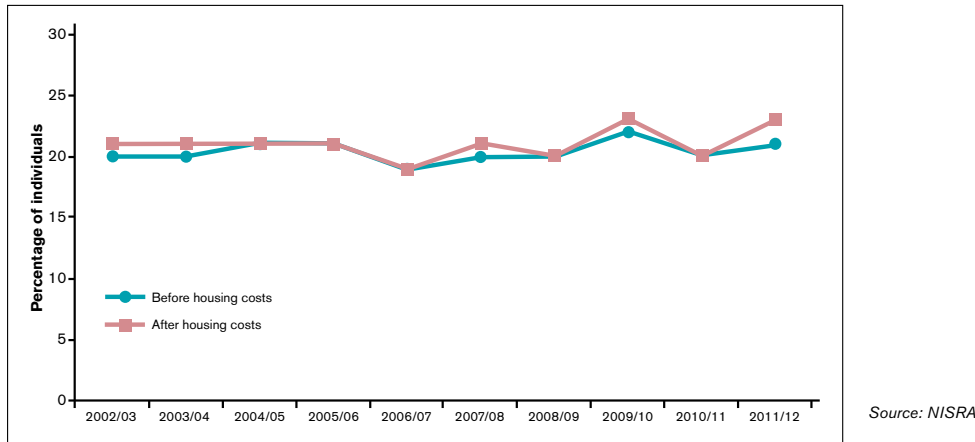
8. Poverty and public health

Poverty affects health throughout the life course. Evidence suggests that poverty can continue through generations with today's children who are living in poverty often going on to have children of their own who in turn experience poverty.³⁵ In addition, adults who experienced poverty in adolescence are more likely to be poor in their early 30s, with the association stronger than that seen for childhood poverty.³⁶ Similarly, events in later life – the onset of retirement, loss of a spouse and onset of disability – are the three most commonly studied life events affecting later life poverty and low income.³⁷

The overall level of relative poverty in Northern Ireland has increased between 2010/11 and 2011/12.³⁸ This increase was more marked for some population groups. Approximately one fifth of the population (21%, 379,000 people) were in relative poverty and almost a quarter (24%, 422,000 people) were in absolute poverty before housing costs.³⁸

In 2011/12, 22% of the child population (almost 95,000 children) were in relative poverty and 25% (109,000 children) were in absolute poverty before housing costs.³⁸ The latter represents a 4% increase on the previous year.³⁸ Similarly, a fifth of working age adults (20%, 213,000 people) were in relative poverty and more than a fifth (22%, 235,000) were in absolute poverty before housing costs.³⁸

Figure 8: Relative poverty in Northern Ireland, 2002/03–2011/12



In 2011/12, a quarter of pensioners (25%, 72,000 people) were in relative poverty and more than a quarter (27%, 79,000 people) were in absolute poverty before housing costs. The latter figure represents a 5% increase on the previous year.³⁵

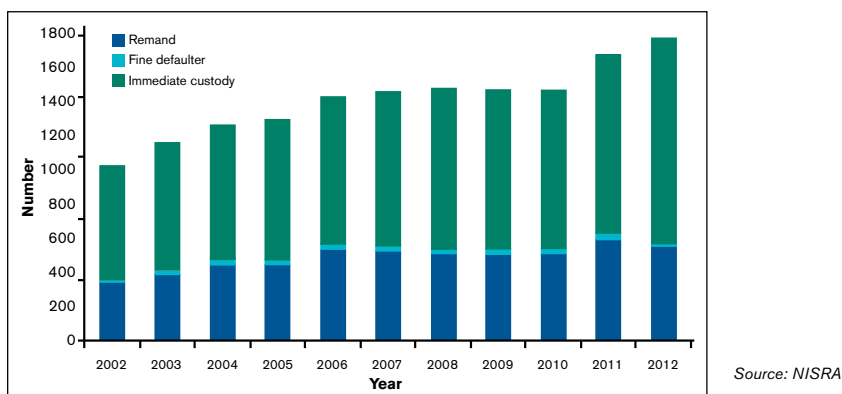
There is growing evidence that poverty is associated with high levels of poor health and increased HSC needs. Children’s early experience of poverty affects their health, not only when they are young, but also later in life. Adult health-related behaviours like smoking and poor diet are also strongly linked to poverty, with clear gradients from high to low income households.^{39,40} Similarly, mental health problems, obesity and sexual health problems are linked to poverty.^{41,42}

Across Northern Ireland, the PHA is working with voluntary and statutory partners on a range of initiatives to support vulnerable groups and address the wider and more complex determinants of health.

9. Prisoner population

Prisoners are a unique population that present distinct health challenges and exceptional health improvement opportunities. In 2012, there were an average 1,774 prisoners in Northern Ireland, 97% of whom were male. Fifty two percent of the immediate custody prison population were between the ages of 17 and 29 years at the time of entry. Life sentence prisoners made up 17% of the average immediate custody population in 2012.⁴³

Figure 9: Average number of prisoners in Northern Ireland, by prisoner type, 2002–2012



There is growing evidence that the physical, mental and social wellbeing of prisoners is poor compared to people of the same age in the general population.^{43,44} There are also high rates of blood-borne

diseases, asthma, epilepsy, sexually transmitted infections and dental decay. Drug and alcohol misuse and smoking are also more prevalent among prisoners than the general population.⁴⁴

Evidence suggests that prisons can make a major contribution to improving the health of some of the most disadvantaged and excluded individuals in society, tackling health inequalities in the process.⁴⁴

The PHA has recently completed a comprehensive health needs assessment of the prison population in Northern Ireland and is working with partner organisations on the implementation of resultant recommendations.⁴⁴

10. Religion and beliefs

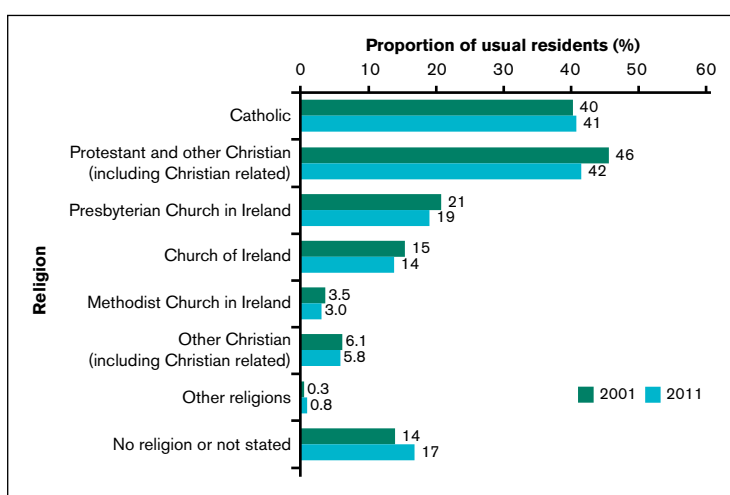
There are a diverse range of religious beliefs in Northern Ireland. It is likely that these beliefs have a role in and impact on people’s health.⁴⁵ Religion and beliefs may also affect the acceptability of certain medical practices, eg diagnostic procedures, certain types of treatment, organ donation, blood transfusion.⁴⁵

Current evidence suggests religious beliefs may have both positive and negative impacts on health and morbidity. Religious involvements may increase physical, mental and social wellbeing.⁴⁶ On the other hand, discrimination based on religion and beliefs can contribute to poor health.^{46,47}

The Census in 2001 and 2011 asked ‘What religion, religious denomination or body do you belong to?’ The main aim of this question was to determine religious affiliation, ie whether or not someone belongs to or identifies with a religion, irrespective of actual practice or belief.

Between 2001 and 2011, the proportion of people who belonged to Protestant or other Christian (including Christian-related) denominations fell from 46% to 42%, while the proportion of Catholics increased from 40% to 41%.⁴⁵

Figure 10: Reported religious affiliation of Northern Ireland population, 2001 and 2011 Census



Source: NISRA

On Census day 2011, the largest other Christian (including Christian-related) categories were: Baptist (1% of usual residents), Christian (0.8%) and Pentecostal (0.7%). The most prevalent other religions were: Muslim (0.2%), Hindu (0.1 %) and Buddhist (0.1%).⁴⁵

Some of the healthy behaviours of different religions and beliefs may provide a meaningful entry point into people’s lives to address some of the key public health issues in Northern Ireland.^{46,47}

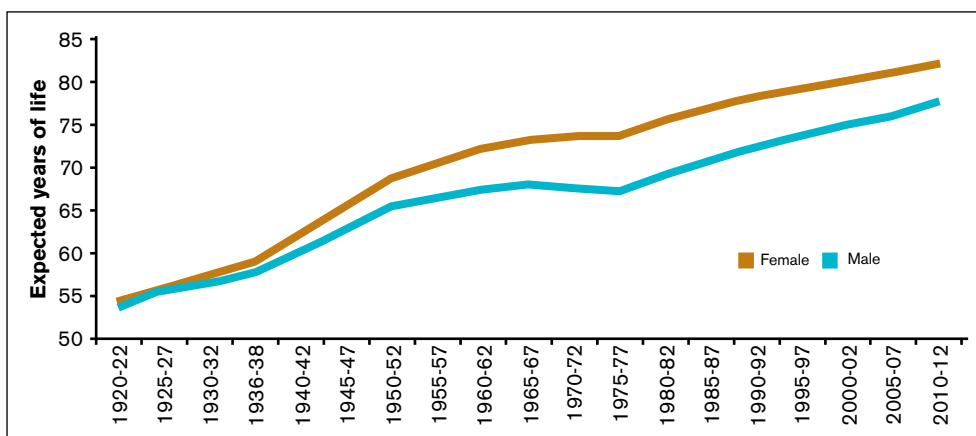
11. Sex and gender identity

Although the terms sex and gender are often interchanged, they have distinct meanings. Sex is a classification based on biological differences, while gender is a classification based on social construct. The differences in the health of males and females often reflect the simultaneous influences of both sex and gender.⁵

NISRA data from 2011 show there were more females (51%) than males (49%) in Northern Ireland.⁵ In contrast, no reliable information is available on the number of transgender people living in Northern Ireland. In the UK, it is estimated the number of transgender people ranges from about 1 in 100 to as many as 1 in 20.⁴⁸

Based on current death rates, males born between 2010 and 2012 could expect to live until they are 77.7 years and women could expect to live until they are 82.1 years. While women aged 65 years today can expect to live another 20.1 years, their male counterparts can expect to live another 17.3 years.⁵

Figure 11: Expected life years of the Northern Ireland population, by gender, 1920–2012



Source: NISRA

The largest contributor to the gap in life expectancy between genders was the higher mortality rate among men for coronary heart disease (1.3 years). Suicide and accidents (including transport accidents) each contributed 0.5 years to the gap, while cancer (other than breast and prostate cancer) contributed 1.2 years.⁴⁹ Breast cancer in women subtracted 0.5 years from the gender gap; however, this was largely offset by prostate cancer in men, which added 0.4 years to the gap.^{49,50}

Recent research evidence highlighted that women generally have better health-related behaviours than men with regard to dietary habits, alcohol consumption and smoking. However, sub-groups within the population vary significantly between males and females.^{51,52}

Challenges for women's health include cardiovascular diseases, cancer and osteoporosis. In contrast, men are characterised by their shorter lifespan and the fact that they do not use the health services, health improvement programmes or screening programmes as much as women.⁵²

There is limited information available on transgender health. A survey conducted in the UK reported that 34% of transgender people attempted suicide and about 50% experienced discrimination at work.^{49,50,51}

The PHA is working with strategic partners, including transgender sector organisations to address the wider determinants of health and wellbeing that will promote societal change, with a view to eliminating gender-based barriers to good health.

12. Sexual orientation

There are no robust data on the number of lesbians, gay men and bisexuals in Northern Ireland. However, research in the UK estimates that around 5–7% of the population is lesbian, gay, or bisexual (LGB).^{51,53} This equates to about 65,000–90,000 of the Northern Ireland population. Although the acronym LGB is used as an umbrella term and the health needs of this community are often grouped together, each of these groups represents a distinct population with its own health concerns.

The availability of general health information on LGB people is patchy. Recent research concluded that LGB people are at significantly higher risk of mental disorders, suicidal thoughts, substance misuse and deliberate self-harm. Local evidence from Northern Ireland shows that 82% of LGB people have experienced harassment and 55% have experienced homophobic violence.^{53,54} LGB people's experience of healthcare suggests there are numerous barriers, including:

- homophobia and heterosexism;
- lack of appropriate protocols;
- an absence of LGB-friendly resources.^{55,56,57}
- misunderstandings and lack of knowledge;
- poor adherence to confidentiality;

Local research evidence also suggests substance misuse and risky sexual behaviours are more prevalent among the LGB population. Individuals of alternate sexual orientation are over-represented among patients with sexually transmitted infections, including syphilis and HIV.^{58,59}

The PHA is responsive to the fact the LGB community, like other disadvantaged groups, has a higher incidence of physical, mental and social health problems, which are likely to have substantial, negative impacts on their life. The PHA is working in a lead role and in partnership with LGB sector organisations to help address these issues.

The aim of public health programmes

Public health programmes aim to:

- prevent ill health;
- detect and treat diseases early;
- address health inequalities;
- improve the health and wellbeing of the whole population.

The PHA's challenge is to:

- increase awareness of the significance of health diversity;
- highlight the impact of health diversity on the population as a whole;
- lead on the actions necessary to improve health outcomes;
- broaden leadership for addressing health inequalities at all levels.

Public health programmes in Northern Ireland are based on scientific and economic evidence where it exists, or on innovative practice if evidence is limited. This report highlights some examples from our range of public health programmes, particularly those that have led to significant improvements in the health and wellbeing of population sub-groups in Northern Ireland.

Further information

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Improving health and reducing inequalities

Overview

E-learning aims to promote workplace LGB&T inclusion

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Understanding Traveller attitudes towards breastfeeding

Cook it! programme reaches out to local BME groups

Raising awareness of STIs among MSM community

Guidelines to support the needs of older LGB&T people

Overview

Improving health and reducing inequality requires coordinated action across many different sections of government and delivery organisations. Action is required to embed health and social wellbeing improvement into the commissioning of HSC services alongside developing effective partnerships with other sectors that can influence the wider determinants of health.

Professor Sir Michael Marmot's review has highlighted that inequalities in health and wellbeing are avoidable and socially unjust.⁶⁰ He has also reinforced the fact that action must be universal and at a scale and intensity proportionate to the level of disadvantage.

In Northern Ireland, there is a strong pattern of inequalities in health and wellbeing at a geographic level, which is persistent over time. However, it is also recognised that some groups experience increased inequality and marginalisation, which contributes significantly to poorer health outcomes.

It is for this reason that the PHA has sought to develop actions to meet the needs of groups that are at greater risk of inequality. This section of the report focuses on actions to promote health and wellbeing, taking these particular needs into account.

Throughout the year, the PHA has continued to focus on four building blocks:

1. Give every child and young person the best start in life.
2. Ensure a decent standard of living for all.
3. Build sustainable communities.
4. Make healthy choices easier.

The following articles are illustrative of a range of work being undertaken to respond to the specific needs of groups experiencing inequalities. An important principle is direct engagement with those who are most affected in order to shape and design services that will best meet those needs and which empower individuals and communities.

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E-learning aims to promote workplace LGB&T inclusion

Public health challenge

Addressing the health and social wellbeing inequalities of lesbian, gay, bisexual and transgender (LGB&T) people is a key priority for the PHA. A regional thematic action plan has been developed, which includes the following objectives:

- Reduce stigma and discrimination by increasing public awareness, understanding and skills, and create a safe and open environment for people who are LGB&T.
- Ensure HSC and related services are accessible and sensitive to the needs of LGB&T people.

Actions

In July 2013, as part of the PHA's support for Belfast PRIDE, a new e-learning programme was launched, aimed at raising awareness and understanding of LGB&T issues in the workplace.

The e-learning programme entitled 'Lesbian, Gay, Bisexual and Transgender Creating Inclusive Workplaces' supports the PHA in addressing health and social wellbeing inequalities, while enabling staff members to safely explore LGB&T issues in a confidential and secure way. The programme was developed in partnership with the Southern HSCT and members of LGB&T sector organisations. It aims to educate staff so they better understand the difference between sexual orientation and gender identity, and the equality implications from both an employer and employee perspective.



Members of the writers group pictured at the launch of the LGB&T e-learning programme with (second left) Mary Black, Assistant Director of Public Health (Health and Social Wellbeing Improvement) and (right) Hugh McPoland, Director of Human Resources, PHA.

Impact

Research suggests that creating a workforce that is more engaged enables organisations to gain through:

- increased productivity;
- lower staff turnover;
- better recruitment and retention of staff;
- enhanced reputation.⁶¹

The programme is open to all workplaces and will help staff recognise the barriers associated with disclosure of sexual orientation and/or gender identity in the workplace. It will also help staff understand how LGB&T awareness within the workplace can help create a more welcoming, safe and productive work environment.

The programme offers staff working across a range of HSC and other settings the flexibility to engage in ongoing learning and development at a time that suits them. It is designed to be used by individuals working in any setting and has relevance to a wide audience, including staff with management or recruitment roles within organisations. It is hoped the programme will be seen as complementary to face-to-face interactive training.

The e-learning programme is available at: www.lgbtelearning.hscni.net

Next steps

The PHA continues to promote the programme within HSC and more widely afield. The programme is also promoted within HSCTs as part of ongoing equality and diversity training for new and existing staff. Significantly, the PHA is using this development to promote good practice and influence other parts of the public sector.

Key facts



- Having LGB&T supportive policies in the workplace is associated with reduced incidence of discrimination, and less discrimination is associated with better psychological health and increased job satisfaction among LGB&T employees.
- A workplace climate that includes LGB&T supportive policies and more broad support from co-workers and supervisory staff is associated with a greater likelihood that LGB&T employees feel comfortable disclosing their sexual orientation at work.
- Increased disclosure of sexual orientation is related to improved psychological health outcomes among LGB&T employees.⁶²

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LGB&T staff forum advocates diversity within HSC

Public health challenge

In 2011, The Rainbow Project research report *Through our eyes: Experiences of lesbian, gay and bisexual people in the workplace* highlighted that:

- nearly 25% of respondents working in the public sector had concealed their sexual orientation;
- 40% of respondents working in the public sector had heard negative comments about LGB&T people from a colleague or colleagues in the workplace.⁶³

Actions

The PHA has worked in partnership with unions and other healthcare organisations to help establish an LGB&T forum for staff working across all HSC settings. To help inform this process, an online survey was conducted with LGB&T staff and a number of focus group discussions were held to ascertain views on the establishment of a forum. The main messages that emerged were:

- There are LGB&T staff within the HSC organisations who are not 'out' due to fear of potential discrimination.
- There is a need to increase visibility of LGB&T issues throughout the HSC organisations. This could be done through effective and relevant diversity training, which all staff, including senior management, would attend.
- Visibility of LGB&T issues could be increased through information in induction packs, staff intranet sites and staff bulletins.
- There must be a zero tolerance approach if staff are subject to homophobic/transphobic comments, harassment and bullying.

Impacts

A member of the forum outlines her personal experience of being involved:

The HSC LGB&T staff forum has provided the opportunity to have conversations about diversity and its inclusion in the workplace, and the opportunity to create a reality where all sorts of differences are valued and around which we feel comfortable.

The forum has given some of us the opportunity to step forward and talk about our interaction in our working and personal lives – in the workplace and as service users. It has given us a place to interact, be heard, access peer support, acknowledge the support of our organisations, and discuss issues around being a member of a minority group and the many and varied experiences within this group. The forum members have the opportunity to be involved in creating an inclusive working environment for all who perceive themselves to be contextually different within the HSC organisations, and the existence of the forum confirms that LGB&T employees are members of the HSC organisations.

Next steps

A website has been developed, which will provide an opportunity for staff who are not 'out' in the workplace to have access to a range of information, including links to organisations that can provide support on issues relating to health and wellbeing.



Key facts

- The Equality Commission's most recent *Equality awareness survey* in 2011 found that while there was a decline in negative attitudes towards LGB people since 2008, there was not a corresponding increase in positive attitudes.⁶⁴
- The survey showed high levels of negative attitudes towards LGB people in specific scenarios, such as in the workplace or in the local community.⁶⁴
- Public bodies can make a significant contribution to LGB interaction, including taking measures to promote positive attitudes towards LGB employees, office holders and customers.⁶⁵

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Northern Ireland New Entrant Service established

Public health challenge

New immigrants often have complex health needs. They can have a higher incidence of communicable diseases such as tuberculosis (TB), HIV, hepatitis B and C, and they may not be fully vaccinated, making them more vulnerable to vaccine preventable diseases. They may also experience a higher prevalence of long-term conditions such as hypertension, cardiovascular disease and cancer.⁶⁶

Many new entrants to Northern Ireland have difficulty engaging with health professionals due to:

- language barriers;
- cultural differences;
- understanding HSC services;
- lack of entitlement to HSC services.⁶⁶

Actions

In 2012, the PHA, in collaboration with Belfast HSCT, HSCB and other key stakeholders, established a regional service for migrants called NINES.

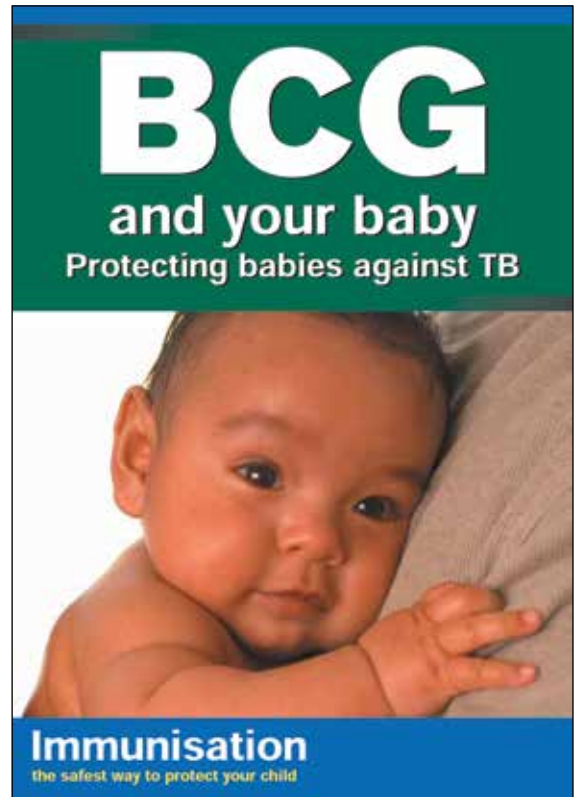
NINES allowed for the expansion and enhancement of existing TB screening services within Belfast HSCT, including:

- a comprehensive health assessment;
- health promotion;
- immunisation services;
- screening for communicable diseases such as HIV.

Impacts

- A client-held passport has been developed in five languages to enhance communication between primary and secondary care. Service users carry their health passports to appointments with NINES, allowing a more complete health record.
- Communication networks have improved the transition for clients from emergency housing to Northern Ireland Housing Executive NASS Housing. They are the providers for asylum clients going through the process to gain refugee status.
- Information flyers have been developed by NINES. These have been specifically targeted at emergency department (ED) clinical managers and lead nurses, thereby raising staff awareness of how they can access NINES, and highlight why the client group may attend the emergency department for medical care.
- Direct referral pathways have been established between NINES and Belfast City Hospital x-ray, Genito Urinary Medicine (GUM), chest clinic, sexual and reproductive health, and dental services.
- Referral pathways to health services provide better health outcomes for the client group. Fast-tracking for chest x-rays allows early detection of TB and onward referral to the chest clinic for investigation and treatment if required.

- NINES can make referrals to the midwifery booking clinic in Royal Jubilee Maternity Hospital (RJMh) for any asylum seekers that arrive pregnant and requiring urgent referral. Clients are seen within 48 hours, therefore reducing any potential risk to mother and baby.
- The Health for Youth through Peer Education (HYPE) team is facilitating a relationship and sexual health education programme for Roma women. Negotiation is ongoing with other relevant partners to facilitate further group work.
- A weekly Roma clinic with input from a consultant paediatrician is provided for Roma families. The clinic is targeted at children aged up to five years and facilitates the commencement of family health assessments and growth parameters.
- NINES facilitates registration with GPs for those who are eligible. These clients can now obtain a medical card to allow registration with dentists and opticians.
- Blood testing for hepatitis B and C, and HIV, commenced in July 2012. Clients who test positive are referred to hepatology/GUM.



Next steps

Subject to a favourable review, NINES will be widened through inter-sectoral partnership working to include more multi-sector elements, such as housing, poverty, community relations and education.

Key facts

- 1,367 appointments were booked for the client group to attend a range of clinics.
- 365 health passports have been distributed to the client group.
- 174 children and 306 adults attended NINES for Mantoux (TB) testing and 94 children were given a BCG vaccination.
- 75 clients required onward referral to the chest clinic.
- 585 clients were assisted to register with a GP.

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Service users lead creation of addictions network

Public health challenge

People with alcohol or drug addictions come from a range of backgrounds and have diverse needs when it comes to services. It is sometimes said that existing drug and alcohol services are more attractive to men than women. There is also evidence of an increased need for drug and alcohol services among ethnic minorities, who may find traditional services have not been designed with them in mind. The only effective way to ensure our services meet the needs of the diverse range of users is to ask them what they require.

Actions

In 2012, the PHA invited drug and alcohol service users from across Northern Ireland to oversee the development of a regional service user network (SUN). The purpose of the network is to strengthen the involvement of service users in the development of drug and alcohol services and policy. SUN members are adults who have current or past experience of using drug or alcohol services, or people with experience of addictions who have not used services. The latter group's inclusion is important, as they offer valuable insight into the reasons why some people do not use services.

The SUN was designed and agreed by service users across Northern Ireland. It focuses on supporting service users and organisations to work together. The Council for the Homeless NI (CHNI) was awarded the contract in May 2013 and appointed two full-time staff to take this work forward, along with their manager. The first challenge was to develop and provide a range of specific training programmes for service users and this has successfully taken place.

Impacts

This is a long-term approach, as it requires capacity-building among service users and the organisations they need to influence. However, we have already seen a number of short-term impacts:

- The SUN has provided representatives for a range of decision-making groups, including the Bamford drug and alcohol subgroup, and the DHSSPS New Strategic Direction steering group, chaired by the Chief Medical Officer.
- Awareness of service user groups has grown, and service users are increasingly the first to be consulted about services, as should always be the case.
- Increased information sharing and support among groups across the region has led to feelings of empowerment.



Extern's service user group 'Suitcase' with PHA Chief Executive Eddie Rooney (left) at the launch of a new pocket pack for homeless people. The packs were distributed to vulnerable people sleeping rough or in crisis accommodation around Belfast by members of Suitcase, who have close contact with various homeless people and the local organisations who support them, including outreach services.

One service user, Stephen Patterson, said: “Service users have sought and fought for an identity and role in Northern Ireland society for years... more importantly, to be recognised as valid participants, advisors, and experts by experience, leading to essential partnerships with service and treatment providers. Through the support of the PHA and the development of the regional service user network, we are representing our peers on decision-making bodies to inform, input and consult on the future of addiction services at a local and regional level. Without CHNI and the regional SUN, I believe service user involvement would be struggling with no direction, support or purpose.”

Next steps

The next challenge is to build capacity and willingness in drug and alcohol services to engage with service users, and help those services recognise the value of service user input.



Belfast Experts By Experience (BEBE) members (from left) Stuart Fowler, Deborah Tully, Terry Sheils, Darryl Cuthbertson, Dennis Carson, Nicola Keegan and Jonathan Lacey speaking at the first regional SUN conference at Grosvenor House in Belfast. The event was organised by CHNI and attended by around 100 people, including service users from all parts of Northern Ireland. BEBE is an activist group working out of Belfast HSCT’s Drug Outreach Team who aim to challenge negative stereotypes of drug users and promote harm reduction principles.

Key facts

- It is estimated that 1 in 20 people in Northern Ireland drink at dangerous levels.
- More than a quarter of those aged 16–59 years have used illicit drugs or drugs not prescribed for them.
- Around 500 people are receiving treatment in statutory addiction services at any one time.
- 2,100 visits were made to a needle exchange last year.

Further information

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PHA health checks for our farming communities

Public health challenge

The farming community is particularly susceptible to poor health and wellbeing, partly because of the various demands impacting on farmers across a range of social and economic factors.⁶⁷ They often work long and anti-social hours, which can lead to isolation, and often have difficulty accessing traditional healthcare services.⁶⁸ The PHA has responsibility for improving people's health and wellbeing and reducing health inequalities, so the Farm Families Health Checks programme plays an important role in helping us do this in rural areas.


Actions

The Department of Agriculture and Rural Development (DARD) joined forces with the PHA and the Northern HSCT to develop and implement the Farm Families Health Checks programme.

The on-going three year programme will see a specially developed health check van visit all rural markets on a bi-annual basis and also a number of rural community venues. The trained nursing staff on board carry out a detailed health assessment of those who consent to a check. This consists of:

- blood pressure monitoring;
- body mass index (BMI) reading;
- cholesterol check;
- diabetic risk assessment screening.



 A local farmer receives a health check at the launch of the Farm Families Health Checks programme, which was attended by the Health Minister Edwin Poots and Dr Eddie Rooney, Chief Executive of the PHA.

In addition, individual lifestyle advice is given on a range of health and safety issues.

After the assessment, clients are presented with a record of the findings and, where necessary, advised to attend their GP or signposted to other support services. Those who are advised to visit their GP will get a call from a nurse approximately six to eight weeks later to provide further advice or support.

Impacts

Since the programme was launched in July 2012, the health check van has attended 170 events, with more than 3,600 clients accessing the service. Just over 50% of clients have been advised to see their GP following their check. Almost 1,000 clients have been referred to the Maximising Access in Rural Areas (MARA) project to help them access local services, grants or benefits, and more than 400 clients have been signposted to farm safety training funded by DARD.

Norman Henning, a dairy farmer from the Newry area, has benefited from the programme. Norman explained: “One day when visiting Camlough Mart, my wife encouraged me to visit the health check mobile as I hadn’t been feeling very well. I had my blood sugar taken and it was found to be high. I was referred to my GP where I was diagnosed with type 2 diabetes.”

Norman is managing his diabetes without the help of medication and it is under control. He is now looking after his health and diet. He added: “I have cut out sugar in my tea, changed my eating habits, and I am being more physically active, such as walking to the cattle instead of driving the tractor. I have lost 12 kilos in weight.”



 Agriculture Minister Michelle O’Neill (left) and Health Minister Edwin Poots (second right) launch the Farm Families Health Checks programme at Ballymena Market.

Next steps

The programme is exploring options for extending the service to target other members of the agricultural workforce, such as workers in the agri-food industry.

Key facts

Data gathered from clients who attended the health checks programme during the evaluation period (January–April 2013) show that:

- 82% of clients were given advice, signposted to other services and/or advised to see their GP;
- 37% were categorised as being at moderate or high risk of developing diabetes within the next 10 years;
- 47% of clients had a cholesterol level outside normal ranges;
- 30% of clients had high blood pressure.

Three months after the evaluation period, using a matched sample of clients who completed screening and the follow-up questionnaire (n=54):

- 42% were eating more healthily as a result of their health check;
- 28% were trying to lose weight;
- 24% were being more active.

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People with disabilities empowered by Fit 4 U project

Public health challenge

Across HSC, greater emphasis is being placed on the promotion of health and wellbeing and the reduction of health inequalities among all people, including those with disabilities.

People with disabilities are susceptible to the same chronic illnesses experienced by the general population (eg cardiovascular disease, respiratory disease, poor mental health), very often in addition to conditions secondary to their disabilities.

Creating equality of choice and opportunity for people with disabilities to adopt a healthier lifestyle is a key factor in promoting improved health and wellbeing.

Actions

The PHA provides funding for a unique intervention in the Southern area, which offers physical activity and leisure opportunities for people with physical and/or sensory disabilities.

The 'Fit 4 U' project is delivered in partnership with the Southern HSCT, local councils, Active Community coaches, voluntary organisations and other volunteers.

The project aims to empower people with physical and/or sensory disabilities to improve their health through participation in a range of physical activity and leisure opportunities. Fit 4 U promotes independence and citizenship by providing safe, accessible programmes within a range of settings and supporting participants in accessing local leisure services.

Fit 4 U delivers the following core activities:

- weekly core exercise programmes – boxercise, fitness suite and group activities;
- inclusive sports – boccia and new age kurling;
- other sports and activities – archery, badminton, golf, swimming and walking;
- southern area/regional events – Southern area boccia competition, Southern area archery competition, Disability Sports NI boccia.

Fit 4 U works with existing support services in the area and utilises external funding opportunities as appropriate to meet gaps in provision. The project adopts a person-centred approach to meet the needs of both service users and local communities.



Fit 4 U service users (from left) Gareth Heslip, Mary Bodel, Patricia McMahon and Mark Doran, participants at New Age Kurling in Newry Sports Centre.

Impacts

Each year, more than 230 people from local communities and day care centres have the opportunity to engage with the Fit 4 U project. These are people with physical and/or sensory disabilities, who are leading sedentary lifestyles and at increased risk of obesity, diabetes or cardiovascular disease.

Through Fit 4 U, service users are supported to improve their physical and mental health and wellbeing by socialising and competing in a range of games and activities. People with physical and/or sensory disabilities gain increased independence, become more integrated into their communities and experience reduced feelings of isolation.

As a result of the Fit 4 U project, local leisure facilities have become aware of the needs of disabled users. Specific access issues have been raised with leisure service providers and training has been delivered to staff on visual awareness and all-inclusive activities.

Next steps

The PHA Southern office continues to support the provision of physical activity and leisure opportunities for people with physical and/or sensory disabilities in the Southern area, and will explore ways to further enhance these services in partnership with other key stakeholders.



Fit 4 U service users and winners of the Southern Area Boccia Competition (from left) Paul Careless, Eric Flowers and David Wylie are presented with awards from Mayor Sean McGuigan, Dungannon and South Tyrone Borough Council.

Key facts

NISRA produced estimates in 2007 that show:

- 18% of all people living in private households in Northern Ireland have some degree of disability (21% of adults and 6% of children have a disability);
- the prevalence of disabilities increases with age, ranging from 5% among young adults to 67% among those who are very old (85+ years).⁶⁹

The Department of Culture, Arts and Leisure (DCAL) has set a target of a 6% increase in people with a disability participating in sports and physical recreation by 2019.⁷⁰

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Understanding Traveller attitudes towards breastfeeding

Public health challenge

The 2010 *All Ireland Traveller Health Study* (AITHS) highlighted that Travellers are the group most unlikely to breastfeed in Northern Ireland, with only 7.1% of Traveller children having been breastfed.⁷¹ Figures for the Southern area, in particular, showed that Traveller mothers were not breastfeeding at discharge from hospital.⁷² However, statistics for the settled community demonstrated a steady increase between 2001 and 2011/12 in mothers breastfeeding at discharge.⁷²

Action

In response to findings in the AITHS and Children and Young People's Strategic Partnership (CYPSP) *Outcome monitoring report* for 2011, the PHA's Southern office commissioned a scoping exercise among the Traveller community to ascertain awareness of, and attitudes towards, breastfeeding.

The scoping exercise was undertaken by Uplift breastfeeding counsellors. Uplift consulted with 40 local Travellers to identify:

- why they do not breastfeed;
- the barriers currently in place;
- their awareness of the health benefits of breastfeeding.

Uplift also visited Dublin to explore how the Pavee Point Traveller organisation has worked with Travellers to deliver health information and training within their own communities. Uplift also produced a report on the scoping exercise, with a number of key recommendations to raise awareness of breastfeeding among the Traveller community.

Impact

The scoping exercise was conducted through five focus groups and one-to-one interviews, which resulted in the following:

- Increased understanding of the reasons why Irish Travellers prefer to use formula rather than breastfeeding, a finding also true of the settled community in Northern Ireland (responses from Travellers included 'lack of antenatal education' and 'unaware of the protective qualities of breast milk to a mother and baby').
- Highlighting the most appropriate methods and supportive environments for Travellers to receive education and support (responses from Travellers included 'current literature is not focused towards the literacy levels of the Traveller community, unlike black and minority ethnic (BME) groups who have specific literature available to them').
- Increased understanding among the Traveller community of the preferred support mechanisms to encourage Travellers to consider breastfeeding (responses from Travellers included 'unaware of most of the protective qualities of breast milk and feel let down and frustrated about this' and 'non-attendance at antenatal classes should not preclude us from finding out the facts').

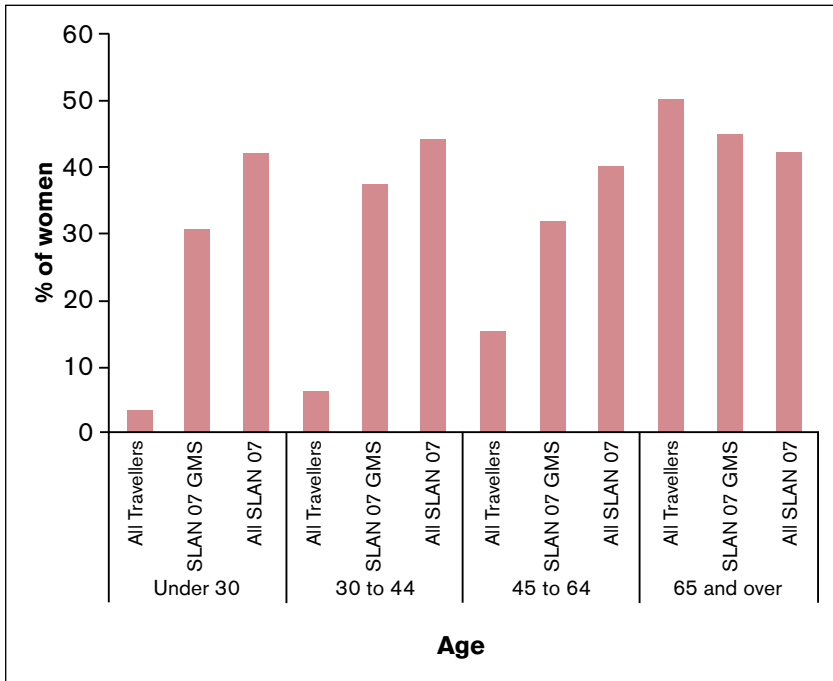


Figure 12: Breastfeeding rates in the AITHS and Survey of Lifestyle, Attitudes and Nutrition (SLAN) studies, by age at the time of interview

Key facts

- The PHA *Breastfeeding Action Plan 2013–2014* states that ‘A number of factors including birth order, education level, age of mother and socioeconomic status influence breastfeeding rates.’⁷³
- The highest incidences of breastfeeding are found among mothers from managerial and professional backgrounds, those with the highest educational levels, those aged 30 or over, and first-time mothers.⁷³
- Research by the Department of Health (DH) in 2009 shows that public health initiatives that target pregnancy and the first few years of a child’s life are known to be more effective, as during this period, adults are more receptive to learning and making changes.⁷⁴

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Cook it! programme reaches out to local BME groups

Public health challenge

The population of BME groups has increased substantially in recent years, from 1% (14,279) in the 2001 Census to 1.7% (31,113) in the 2011 Census.^{75,76}

During that time, the population profile of BME groups has shown marked changes, which are largely reflective of the European Union's expansion and the increased ease of movement.

In the 2001 Census, the BME groups living in Northern Ireland were mainly Chinese, Vietnamese, Indian, Pakistani and Irish Traveller communities.⁷⁵ More recently, immigrants have been from Poland, the Czech Republic, Slovakia, Slovenia, Hungary, Latvia, Lithuania, Estonia, Bulgaria and Romania.⁷⁷ There have also been increasing numbers of immigrants from Portuguese speaking countries such as Portugal, East Timor, Brazil, Mozambique, Goa and Angola.⁷⁷

Responding to the needs of this increasing immigrant population is an important public health challenge. It is acknowledged that people from BME groups are at increased risk of poverty and social exclusion.⁷⁸ Experience of racism and discrimination can contribute to further social isolation and these circumstances, along with language and cultural barriers, may further compromise health and wellbeing.^{78,79}

Actions

Cook it! is a nutrition education programme, which is delivered in local communities by facilitators who are specially trained by *Cook it!* teams based within the HSCTs. The programme:

- provides practical hands-on experience of preparing and cooking healthy, low-cost meals from scratch;
- increases knowledge of healthy eating;
- builds awareness about handling food safely.

During 2013/14, work has been undertaken to develop a new module for the *Cook it!* programme, which meets the specific needs of the main BME groups living in Northern Ireland.

The new draft module includes background information on the cultural norms relevant to the main BME groups, as well as a selection of 'traditional' recipes from each BME population. The recipes have been adapted in discussion with the groups to ensure they meet the healthy eating guidelines.



↑ Colette O'Brien (left), a dietitian with Southern HSCT, alongside Laila Damani and Mr & Mrs Ilya testing Indian recipes for the new *Cook it!* module

Training workshops have equipped *Cook it!* teams with the necessary knowledge and skills to pilot the draft materials with groups of single and mixed ethnicities.

Impacts

The new module will allow locally-based *Cook it!* teams and facilitators to respond to the needs of BME groups within their areas by providing nutrition information and basic cooking skills sessions in an enjoyable, interactive and social environment.

Participants will benefit from enhanced knowledge about healthier eating and good food hygiene, and increased confidence in cooking meals from their own and other cultural backgrounds.

Perhaps more importantly, the BME module of the *Cook it!* programme will lead to increased social interaction within and between ethnic groups. This will reduce isolation, promote integration and improve health and wellbeing.

Next steps

Following the pilot with each of the BME groups to inform final amendments, the new module will be printed and made available in 2014/15.

Key facts



- The population profile of BME groups in Northern Ireland has changed in recent years, with the largest BME communities now Eastern European (Polish and Lithuanian), followed by Chinese, Indian, Irish Travellers and migrants from Portugal and the Philippines.^{76,77}
- English is not the main language for 3.1% (54,500) of the population and English proficiency varies by age, gender, country of origin, education and social class.⁷⁶
- Limited English is the most significant barrier to accessing HSC.⁷⁸
- Mental health is an important issue for many BME groups living in the UK and Ireland, who are more likely to be prescribed the wrong medication or placed in institutionalised care.⁸⁰

Further information



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Raising awareness of STIs among MSM community

Public health challenge

Surveillance data from GUM clinics in Northern Ireland have shown an increase in diagnoses of gonorrhoea, syphilis and HIV in men who have sex with men (MSM). Surveillance reports show that MSM remain disproportionately affected by sexually transmitted infections (STIs) and HIV.

Analysis of results for Northern Ireland from the 2010 *European MSM Internet Sex Survey* (EMIS) shows that half of respondents had never been tested for HIV and around one third had been tested in the last year.⁸¹

Actions

A campaign aimed at raising awareness of the increase in STI diagnoses has been developed in partnership with The Rainbow Project and the regional GUM service. The campaign entitled 'Don't leave it to chance' was launched at the Annual Regional Sexual Health Conference in November.

The key messages of the campaign are that:

- MSM, like all sexually active people, need to consistently use condoms to prevent the spread of STIs and HIV;
- sexually active MSM need to be tested at least once a year, or once every three months if changing partners on a regular basis.

MSM should be aware that HIV has not gone away and that infection with syphilis, gonorrhoea and other STIs can lead to increased risk of acquiring HIV.

A suite of three posters that include the key campaign messages has been developed and distributed to a number of venues. The campaign also includes a range of online messages developed for social networking sites, dating sites, and peer and social support services targeting MSM.



Impacts

Collaborative work with The Rainbow Project on the development and implementation of the campaign has ensured the key messages target the priority group through a range of formats, including posters and online messaging. Reports show an increase in the number of MSM accessing the rapid testing service offered by The Rainbow Project and an increase in referrals of MSM to GUM services.

Next steps

A key action within the *Sexual health promotion: Strategy & action plan 2008–2013* relating to public information campaigns is:

“To develop a phased sexual health public information campaign which is accessible to all groups and aims to: promote sexual health and wellbeing; raise awareness of specific sexual health issues, including HIV/AIDS with particular focus on those most at risk and; tackle discrimination and stigma associated with HIV, STIs and sexual orientation.”⁸²

The PHA recognises the importance of this campaign for raising awareness of the increase in gonorrhoea, syphilis and HIV in MSM in Northern Ireland, and for reinforcing the need to reduce risky sexual behaviours by taking greater personal responsibility and practicing safer sex. This campaign was phase one of a wider sexual health campaign that the PHA plans to develop in the future.

Key facts

- HIV is still on the increase among MSM in Northern Ireland. Only a third of MSM have been tested for HIV in the last year.⁸³
- Gonorrhoea cases in MSM have more than trebled since 2010.⁸⁴
- 9 out of 10 syphilis cases last year occurred in MSM.⁸⁴

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Guidelines to support the needs of older LGB&T people

Public health challenge

Northern Ireland has the fastest ageing population in the UK and this will continue to increase every year as the number of older people continues to grow. It is estimated that there are 24,012 men and women of pensionable age in Northern Ireland who will identify as something other than heterosexual.⁸⁵

There are 80 to 100 transgender people known to, or who are accessing, support services within Northern Ireland. However, it is widely known that transgender people remain invisible and the numbers are estimated to be much higher. Older people who identify as LGB&T are likely to have a greater need for HSC services.

Compared to their heterosexual peers, LGB&T people are:

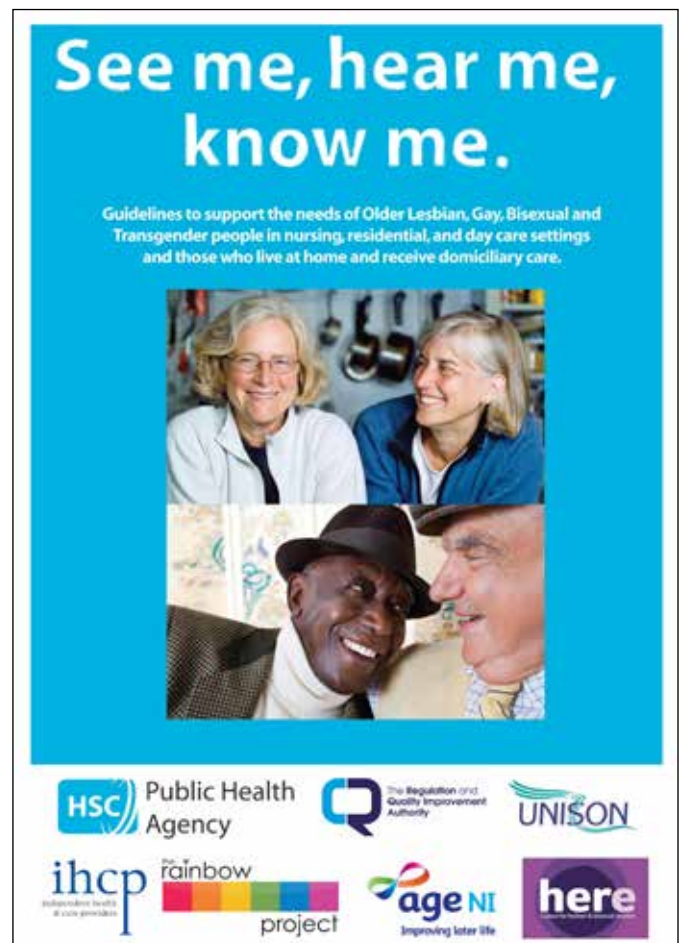
- two and a half times more likely to live alone;
- twice as likely to be single;
- four and a half times more likely to have no children to call on in times of need.⁸⁶

Actions

The needs of older people who identify as LGB&T are a key priority area within the PHA's regional thematic action plan for LGB&T. Informed by a scoping exercise carried out in 2011 by AgeNI and The Rainbow Project, the PHA worked in partnership with AgeNI, The Rainbow Project, HereNI, Unison, the Regulation and Quality Improvement Authority (RQIA) and independent healthcare providers to develop guidelines to support the needs of older LGB&T people in nursing, day care, residential and domiciliary care settings.

Impacts

The guidelines, entitled *See me, hear me, know me*, are a practical resource to help those involved in the development and delivery of care better understand the needs of older people who identify as LGB&T, and respond to these needs in a range of care settings. The guidelines are a tool that we hope will help all staff strive to improve the delivery of person-centred care to older LGB&T people in Northern Ireland.



It is also hoped that the guidelines will help address the issue of invisibility experienced by many LGB&T older people and their carers, and encourage staff to reflect on their practice.

Next steps

The guidelines were launched in March 2014 for all registered nursing, day care, residential and domiciliary care settings.

Key facts



- Research has indicated that people from the LGB&T community generally have poorer health. This manifests in higher rates of cervical, breast and anal cancers, as well as increased drug, alcohol and tobacco misuse.^{87,88,89,90}
- In a survey of LGB&T people aged 40 years and over:
 - 18% had self-harmed;
 - 39% had experienced suicidal thoughts;
 - 21% had attempted suicide;
 - 60% had experienced depression.⁹¹
- In a recent Northern Ireland survey of LGB&T people, more than 20% of respondents identified as living with a disability. The most common forms of disability were physical (64.4%) and mental (57.8%).⁹²

Further information



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Improving health through early detection

Overview

Screening for women at higher risk of breast cancer

Informed choice to improve cancer screening uptake

Overview

Overview

Early detection of disease often produces better outcomes for patients. At this stage, treatment may be more effective and may prevent significant ill health or, in some cases, premature death.

Population screening programmes have a key role to play in the early detection of disease. A range of programmes are available in Northern Ireland and the PHA has responsibility for commissioning, coordinating and quality-assuring them.

However, screening is not suitable for every condition. Organised screening programmes are only established on the recommendation of the UK National Screening Committee (NSC) and according to the best available evidence. Any proposed screening programme must meet a number of stringent criteria before it is recommended by the NSC.

The bowel cancer screening programme is available to all men and women aged 60–74 years after it was extended in April 2014.

Screening for abdominal aortic aneurysm (AAA) is also now an established programme with high uptake rates.

In 2013, the cancer screening programmes developed an action plan to improve informed choice and introduced a screening surveillance programme for women at higher risk of breast cancer.

This section focuses on:

- the introduction of a screening surveillance programme for a small group of women who are at higher risk of breast cancer because of their genetic characteristics or a specific radiotherapy treatment they have received;
- the work undertaken to improve informed choice for cancer screening, with particular emphasis on those groups who find services harder to reach.

Further information

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Screening for women at higher risk of breast cancer

Public health challenge

A small number of women are at much higher risk of developing breast cancer than the majority of the female population. This may be because they have been diagnosed with a particular genetic disorder that can cause the disease, eg the BRCA1 or BRCA2 gene, or because they had radiotherapy treatment that included the breast area before the age of 30.

Some of these women decide to have a bilateral mastectomy to reduce their risk of breast cancer. Others decide not to have surgery and attend a number of hospital clinics for surveillance, including mammography, to detect any early signs of cancer.

The challenge was to identify all women in Northern Ireland who are at higher risk of breast cancer and ensure their surveillance is managed to new national standards.⁹³

Actions

The PHA introduced a screening surveillance programme for women at higher risk of breast cancer on 1 April 2013. It is closely linked to the Northern Ireland Breast Screening Programme. However, there are significant differences between the two programmes.

The higher risk screening surveillance programme is available only to those women who are known to be at higher risk and these women are normally invited for breast screening every year rather than every three years. They are also invited from a much earlier age (usually from the age of 30) and can have breast magnetic resonance imaging (MRI) and/or mammography.



Breast MRI is a painless test that involves lying face down on the scanning bed.

Because of the relatively small numbers, and the need to maintain expertise and quality in the use of these tests in this group of women, the service is based at a single site - Antrim Area Hospital.

Impacts

More than 300 women at higher risk of breast cancer have been identified so far. All of these women will be invited to attend for regular breast surveillance screening in accordance with national standards. This will ensure the women have access to a breast imaging service that is quality assured to the same high standards as the regular breast screening programme.

Next steps

The work to identify women at higher risk of breast cancer is continuing. A quality assurance process will be established to ensure this new programme meets the national quality standards.

Key facts

- Around 50% of women with the BRCA1 or BRCA2 genetic defect decide to have bilateral mastectomy to reduce their risk of getting breast cancer.
- An MRI scan is an imaging procedure that uses magnetic fields and radio waves to take pictures of the body.
- Breast MRI is better at detecting breast cancer in younger women.
- Mammography is better at detecting breast cancer in older women.
- A breast MRI scan usually takes between 30 minutes and an hour.

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Informed choice to improve cancer screening uptake

Public health challenge

The Quality Assurance Reference Centre (QARC) of the PHA is responsible for commissioning and quality assuring the bowel, breast and cervical cancer screening programmes.

It is acknowledged that not everyone who receives an invite will participate in screening. There are many reasons why individuals do not take up their invitation, and for some this will be a fully informed choice. However, for many the decision may not be conscious or well-informed, and others may not find the programmes accessible to them. In addition, some population groups are less likely to attend.

While uptake of screening in Northern Ireland is largely in line with that seen elsewhere in the UK, there is always room for improvement.

The challenge is to promote informed choice of cancer screening with a view to increasing uptake of each programme.

Actions

The QARC established a strategy group to explore why some groups of people found screening less accessible and to propose ways of removing any obstacles. The focus of this work was on:

- LGB&T people;
- BME groups;
- Travellers;
- prisoners;
- people with physical or sensory disabilities;
- people with learning disabilities;
- people living in deprived communities.

A series of meetings were held with voluntary organisations that represent each of these population groups. The work culminated with a workshop to identify proposals to make screening more accessible and acceptable.

A four year *Informed Choice Action Plan (2012–15)* was developed and agreed following the workshop.



Impacts

The action plan coordinates work being done to promote informed choice in relation to the three cancer screening programmes. One of the key outcomes is that the PHA has now established common objectives with many stakeholders in the community and voluntary sectors, and with HSC organisations. Some examples of progress so far are outlined below:

- The Women's Resource Development Agency (WRDA) delivers a peer facilitator programme to educate and raise awareness of breast and cervical cancer screening with community groups. During 2013, this service was extended to include promotion of bowel screening. The trained facilitators delivered awareness sessions to 50 community groups throughout the year. The WRDA also arranged for women from the community groups to attend special breast screening clinics. This means a group of women with a learning disability, for example, can attend for screening together at a specially organised clinic.
- Work has been undertaken to review patient information resources, including leaflets and the website, and these have been updated where appropriate to meet the needs of different groups of people.
- An online training toolkit, developed by the Lesbian and Gay Foundation, was disseminated to GP practices and smear takers.⁹⁴ The toolkit enables cervical screening practitioners to improve the patient experience for lesbian and bisexual women.
- Breast screening information is now being disseminated via social media and a pilot has been undertaken for women to receive text reminders for their breast screening appointment.
- The QARC now confirms at quality assurance review visits that staff providing screening services have completed equality and diversity training.

Next steps

The action plan runs through to 2015, so work is ongoing on a range of issues. The QARC will continue to work with the various stakeholders to take forward the remaining actions and promote uptake of the three screening programmes among diverse communities.

Key facts

- 70 people from 16 organisations attended the workshop and contributed to the formation of the action plan.
- There are 52 recommendations to be delivered in the action plan.
- 13 special breast screening clinics were arranged in 2013/14, each accommodating screening for eight women.

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Improving health through high quality services

Overview

Providing high-quality maternity services for everyone

Overview

Overview

It is recognised that the provision of high quality antenatal and obstetric care is important for improved outcomes for both mother and baby.

The health of a mother is very important for the outcome of a pregnancy and the health of a newborn infant. National reports show that outcomes for pregnant women from minority groups are worse than those for the general population, which is now being addressed as a health priority.

In this section, we outline the challenges to the HSC system in meeting the maternity needs of migrant and minority ethnic women and the most vulnerable sub-groups.

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Providing high-quality maternity services for everyone

Public health challenge

In the last decade, Northern Ireland has experienced an increase in immigration, resulting in a growth in the number of births to non-UK and non-Republic of Ireland (ROI) born mothers.

In accordance with *A strategy for maternity care in Northern Ireland 2012–2018*, the DHSSPS aims to provide high-quality, safe, sustainable and appropriate maternity services to ensure the best outcome for all women and babies.⁹⁵ National reports on maternal and perinatal deaths have shown worse outcomes for migrant and minority ethnic women, including Irish Travellers, than white women.^{96,97,98,99}

As a result, minority ethnic and migrant women were identified as a priority in the *Maternity Service Team equality/inequalities action plan 2013/2014*.

Actions

The Maternity Service Team commissioned a scoping review to gain a better understanding of the issues and needs of such women when accessing maternity services. Maternity issues were identified from available published literature, local unpublished reports and anecdotal views of individuals working in the statutory and voluntary sectors.

Impacts

Research carried out by the Northern Ireland Council of Ethnic Minorities (NICEM) on the experiences of more than 400 minority ethnic women living in Northern Ireland shows that the majority of women are satisfied with their experiences of childbirth.¹⁰⁰

The findings also highlight issues that present challenges for HSC services in meeting the maternity needs of the growing number of migrant and minority ethnic women. In particular, sub-groups of vulnerable women are at higher risk of poorer maternity outcomes and have specific maternity needs. These include women from the Roma community, Irish Travellers, asylum seekers, refugees and undocumented migrants.

Black African and Caribbean women have maternity mortality rates more than three times that of white women. Indian and Pakistani women also have higher mortality rates than their white counterparts.⁹⁹ Mothers of black and Asian origin are more likely than mothers of white origin to have a stillbirth or neonatal death.¹⁰¹

Barriers to accessing maternity services include:

- speaking little or no English;
- lack of awareness of the local health system;
- confusion over entitlements;
- difficulty registering with primary care;
- different expectations of healthcare.¹⁰²

Minority ethnic and migrant women are more likely to book later in pregnancy, less likely to take up antenatal screening and more likely to have certain medical conditions. They are more likely to have a complicated delivery as a result of complex medical conditions, female genital mutilation and late access to antenatal care. They are more likely to have a longer hospital post-natal stay and more likely to be followed up for longer. Higher rates of post-natal depression and domestic violence have also been described. Rates of breastfeeding are higher in some minority ethnic women, although Irish Traveller mothers have one of the lowest rates.



A variety of initiatives, such as diversity and cultural awareness training, employment of bilingual healthcare workers and the Regional Interpreting Service have enabled HSCTs to largely cater for the needs of migrants in the local population.¹⁰³ As a result, the vast majority of women have their needs met within current services. However, there is more than could be done to address the needs that disproportionately affect the most vulnerable groups.

Next steps

Consideration is being given to the appointment of a regional specialist midwife, who could be a source of advice and training for maternity and community staff. The service could also link with relevant voluntary organisations, which provide vital support and assistance for migrant and minority ethnic individuals.

Key facts



- In 2012, 2,459 births in Northern Ireland were to non-UK and non-ROI born women (1 in 10 births).¹⁰⁴
- Half of these births were to women born in one of the A8 countries, compared to less than 1% in 1997. The A8 countries are: Czech Republic, Estonia, Hungary, Latvia, Lithuania, Poland, Slovakia and Slovenia.¹⁰⁴
- According to the 2011 Census, 1.8% (32,414) of the population declare themselves to be from a minority ethnic group and 4% (80,621) were born outside the UK and ROI.¹⁰⁵

Further information



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Improving health through research

Overview

Community support models address the transition of adults with intellectual disabilities into old age

Mobility aids for children with physical impairments

Eyecare for children with developmental disability

Mortality patterns among Section 75 equality groups

Overview

The PHA continues to support HSC research in its widest sense. The research funded may be commissioned in response to specific needs or may be supported in response to a proposal put forward by a research team. The overriding aim is to fund research that can secure lasting improvements in the health and wellbeing of the entire population of Northern Ireland.

By including representatives from service users and the public in the evaluation of research proposals, the HSC Research and Development (R&D) Division aims to ensure that the research involves service users and the public in a meaningful and appropriate way at every stage from design and evaluation through to dissemination of the results.

The Northern Ireland Public Health Research Network (NIPHRN) has continued to flourish during 2013 and has demonstrated success in securing external funding through collaboration with diverse stakeholders. The network draws together research development groups (RDGs), which create research proposals to secure funding for studies that address key public health priorities.

The HSC R&D Division often works in partnership with other funders to help bring additional research funding into Northern Ireland. This year has seen the renewal of funding for a number of major pieces of infrastructure and new partnership funding for others. This includes the continued funding of the Northern Ireland Centre of Excellence in Public Health for a further five years, as well as a Northern Ireland Administrative Data Research Centre (ADRC), one of four in the UK, awarded by the Economic and Social Research Council. Along with the recently-established Honest Broker Service, the ADRC will be part of an emerging system that will facilitate access to and use of routinely collected HSC data for important research studies.

As well as commissioning research in important areas such as dementia care and mental health, the HSC R&D Division is also working to support and facilitate researchers to secure funding from major external sources. 2013 has seen a good success rate, bringing significant funds back to Northern Ireland from UK-wide funding streams and building up a strong profile for Northern Ireland in Europe.

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Community support models address the transition of adults with intellectual disabilities into old age

Public health challenge

As the general population gets older, so too do people with intellectual disabilities (ID), with many now living into their 70s and 80s.¹⁰⁶

Within the UK, and especially within Northern Ireland, the majority of people with ID live with their ageing parent(s) or siblings. The *Equal lives* report from the Bamford Review identified ageing as an area that required specific planning within ID services:

“Recommendation 52: The DHSSPS should produce a strategic plan to address current deficiencies in services and future service provision for older people with a learning disability and their families.”¹⁰⁷

Transforming your care says: “The diversity and age appropriate nature of day services remains an issue for people with ID... a one size fits all service will be less attractive in the future.”¹⁰⁸

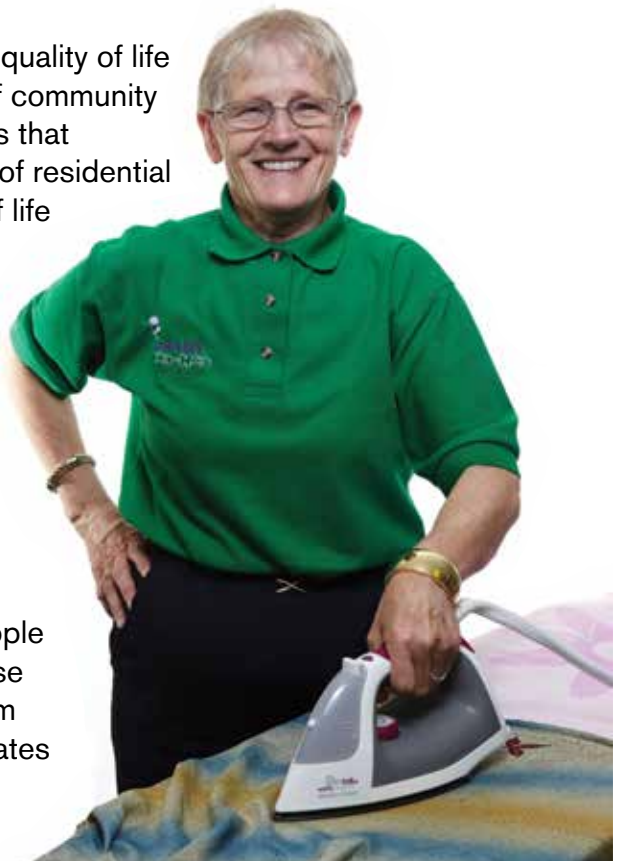
Moreover, the *Learning disability service framework* proposed that all people aged 50 years and over with an ID should have the impact of ageing taken into account when having their future needs assessed and proactively managed, and that this population should be enabled to remain in their own home with their family carer for as long as possible, with appropriate care and support to do so.¹⁰⁹

Actions

There is considerable evidence available on the improved quality of life outcomes and cost efficiencies associated with models of community accommodation for adults with ID. A review of 118 papers that reported the comparative benefits and cost-effectiveness of residential and community models found ample evidence of quality of life improvements in community settings, but also a need for more research on costs.¹⁰⁶

However, the current costs of day services for older people with ID in Northern Ireland have not been assessed, and no resource models have been developed to account for possible future costs of day and carer support provision arising from increased dependency.

It has been said that current prevalence rates of older people with ID do not reflect the increased life expectancy of these people.¹¹⁰ Some researchers have used mortality data from English case registers to revise upwards the prevalence rates of ID in people aged over 50 years.¹⁰⁶



Using their figures, 35.7% of the Northern Ireland population in 2021 will be aged over 50 years. This means statutory and voluntary services must plan to ensure this growing older population with ID can be accommodated in age-appropriate day activities, respite and domiciliary care. The current study is designed to provide robust evidence that will contribute to the realisation of these goals.

Impacts

The study commenced in May 2013 and is funded for three years by the HSC R&D Division's Bamford Implementation Programme. It has four stages. Ethical approval and research governance has been obtained. Stage one has begun and comprises a series of focus groups involving older people with ID, their ageing family carers and other stakeholders.

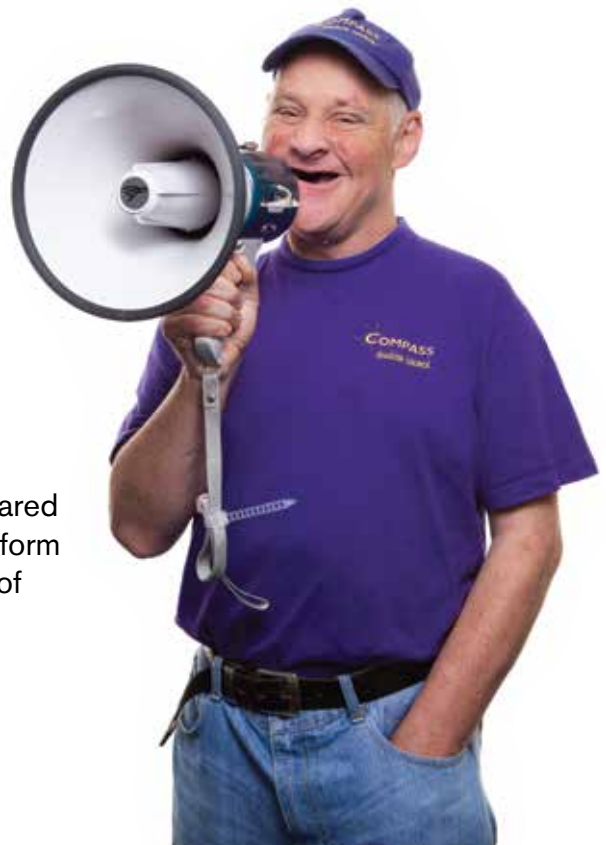
Stage two will involve a series of one-to-one interviews, with managers from both ID and older people's care programmes exploring what constitutes age-appropriate day activities, respite and domiciliary care for this population, and the costs associated with each.

During stage three, data will be gathered on a quota sample of older people with ID and family carers in relation to their current service usage, likely future needs/preferences, and the costs of such services.

Stage four will use a consensus building process to bring together stakeholders who will develop service specifications designed to meet the identified needs of older people with ID and their ageing family carers.

Next steps

It is envisaged that the findings from this study will be shared and agreed with key stakeholders and policymakers to inform the decision-making process around the future planning of services for the growing older population with ID in Northern Ireland.



Key facts



It is estimated that across the UK, more than 30,000 older parents (60+ years) are caring for their son/daughter with an ID. Over the next few decades, the average age of this group of people with ID will steadily increase.

Further information



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Mobility aids for children with physical impairments

Public health challenge

Children with physical impairments often find walking difficult and for some it isn't even a possibility, therefore mobility aids or wheelchairs are often required. Having the ability to move and subsequently explore can have a great impact on a young child's development.^{111,112} Mobility is important for enabling young children to participate in daily living activities, school and community activities.

Actions

Currently, children who need a wheelchair for mobility are assessed by occupational therapists. They are then provided with a wheelchair that best meets their physical needs and promotes optimum participation. However, the cost of wheelchairs has been increasing, putting increased demand on both service providers and caregivers. A regional wheelchair training coordinator was appointed in 2013, along with an annual training budget, to ensure therapists are skilled and competent in undertaking these client-centred assessments.

Impacts

Existing research into the use of wheelchairs by children can be broadly categorised into the areas of:

- prescription of assistive technologies;
- powered wheelchairs;
- development of outcome measurement tools for wheelchair use;
- impact of caregiving for these children.

Parents of children who use wheelchairs can often struggle to accept that their child needs to use the wheelchair and the normality of its appearance, and worry about how others will react to their child in public.^{113,114} However, parental attitudes become more positive once they observe the effect the wheelchair has on their child's development and realise the independence their child achieves as a wheelchair user.¹¹⁵

There is often a realisation by parents and therapists that providing a child with a wheelchair is not a last resort but a very positive move. The child's use of the wheelchair not only increases their mobility, but can also empower them to explore their environments.¹¹⁶ This in turn promotes the child's learning ability and independence, and



Wheeled mobility gives young children a great deal more independence and can have a very positive impact on their development.

helps them develop a sense of control and self-esteem, both of which are vital for a child to become an active participant in society or have any quality of life.^{117,118}

There still remain a number of barriers to the active participation and inclusion of children who are wheelchair users. These include:

- a lack of wheelchair skills training for children and carers;
- inadequate transportation;
- inaccessible physical environments;
- the attitudes of others.^{119,120,121}

Additionally, parents need support to maintain their emotional and physical wellbeing, and to minimise their risk of social isolation.^{118,122}

Next steps

Work is ongoing to ensure greater involvement of service users in the delivery of the regional therapist wheelchair skills training programmes. The University of Ulster is working with both the South Eastern and Belfast HSCTs to develop research proposals on the effectiveness of a children's wheelchair skills community integration programme, as well as the ability of primary school-aged children to use power wheelchairs outdoors.

Key facts



- In Northern Ireland, there are approximately 2,562 children who use a wheelchair for their mobility.
- In 2012/13, 54 therapists completed the Regional Foundation level wheelchair training and 61 completed the Regional Intermediate level training, 21 of whom did the children's course.
- In 2013, both of these courses received professional body endorsement.

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Eyecare for children with developmental disability

Public health challenge

Research shows that children with developmental disability have more eye and vision problems than typically developing children, and they often go undetected as other health issues take precedence.^{123,124}

An audit of adults with disabilities showed high levels of previously unrecognised visual loss, including easily correctable defects present since childhood but compounded by long-term neglect.¹²⁵ Undetected and untreated visual problems in childhood have a detrimental impact on visual and educational outcomes, social interactions and ultimately quality of life.^{126,127,128,129,130,131} For many, management of visual problems may simply involve wearing glasses or an appreciation by parents, carers and teachers of modifications needed to improve visibility of educational and recreational material.

A key component in successful management of visual problems is appropriate dissemination of information gathered by eyecare professionals, so that families, teachers, therapists and other professionals all understand children's visual strengths and limitations.¹³²

Actions

Funded by the HSC R&D Division, University of Ulster researchers teamed up with clinicians from Belfast HSCT to do the following:

- **Explore the visual status of children with developmental disability.**

This work revealed significant visual deficits and unresolved visual need, particularly in relation to focusing difficulties and need for glasses.^{133,134,135,136,137,138}

- **Pilot and audit a multi-disciplinary visual assessment service for children with the most complex neurological problems.**

A novel feature was the issuing of jargon-free reports for parents and other stakeholders. A recipient audit highlighted that the service was valued and reports were appreciated, understood and used in children's care and education.¹³⁹

- **Develop web-based resources that provide open-access information for professionals and parents regarding vision/visual function in the context of developmental disability.**

Downloadable examples of suitable print sizes for visually impaired children, strategies to limit the impact of visual deficits on 'real world' function, and assistance for eyecare professionals writing vision reports are provided at: <http://biomed.science.ulster.ac.uk/vision/-Visual-Acuity-.html> Professional and lay users from the UK and Ireland have acknowledged the value of the resource.¹⁴⁰



Professor Kathryn Saunders (right) and members of the research team, Dr Julie McClelland (left) and Dr Julie-Anne Little, have developed web-based resources with information about vision for lay and professional stakeholders.

- **Explore, through focus groups with families, support groups, education, eye and health professionals, perceptions of current eyecare services for children with disabilities.**

A perceived disconnect emerged between what families, therapists and educators understand about vision and the clinicians' appreciation of children's visual status and needs.¹⁴¹

Impacts

The research, clinical and knowledge transfer work undertaken raised the profile of visual needs of children with disabilities. In response, and aligned with the agenda of the DHSSPS *Physical and sensory disability strategy and action plan 2012–2015*, the HSCB approved a new, regional visual assessment service for children with complex neurological impairment and unresolved questions around visual status. Communication of written information on visual status for all stakeholders will be embedded. University and HSCB expertise will be utilised and training incorporated to disseminate skills across HSCTs.

The work has widened attention, beyond those with the most complex conditions, to all children in special education. Clinical and research projects are planned and/or underway to improve and standardise access to high quality eyecare through in-school services. A new orthoptic post in Belfast HSCT, with responsibility for enhancing eyecare for children with disabilities, has been introduced.

Next steps

Our researchers are participating in a large UK-based service model evaluation led by SeeAbility (a national charity for people with learning disabilities), exploring ways to maximise uptake and success of early eyecare by incorporating services into special schools alongside other therapies.

Key facts



- Children with developmental disability are at higher risk of visual problems than typically developing children.^{123,124,142}
- 12–17% of children in special schools have a visual impairment and 53% have a significant, often unrecognised, need for glasses.^{123,124}
- Eyecare services are not routinely funded to provide written communication of children's visual status to parents/educators.
- When written reports of visual status are provided, they impact positively on care – 75% of parents use the information 'daily' to care for their child.^{139,140}

Further information



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Mortality patterns among Section 75 equality groups

Public health challenge

Inequalities in health continue to exist between geographic areas, socioeconomic groups and minority groups across Northern Ireland. It is known that people from lower socioeconomic groups tend to experience worse health, die earlier and be more likely to engage in unhealthy behaviours than their peers in higher socioeconomic groups.

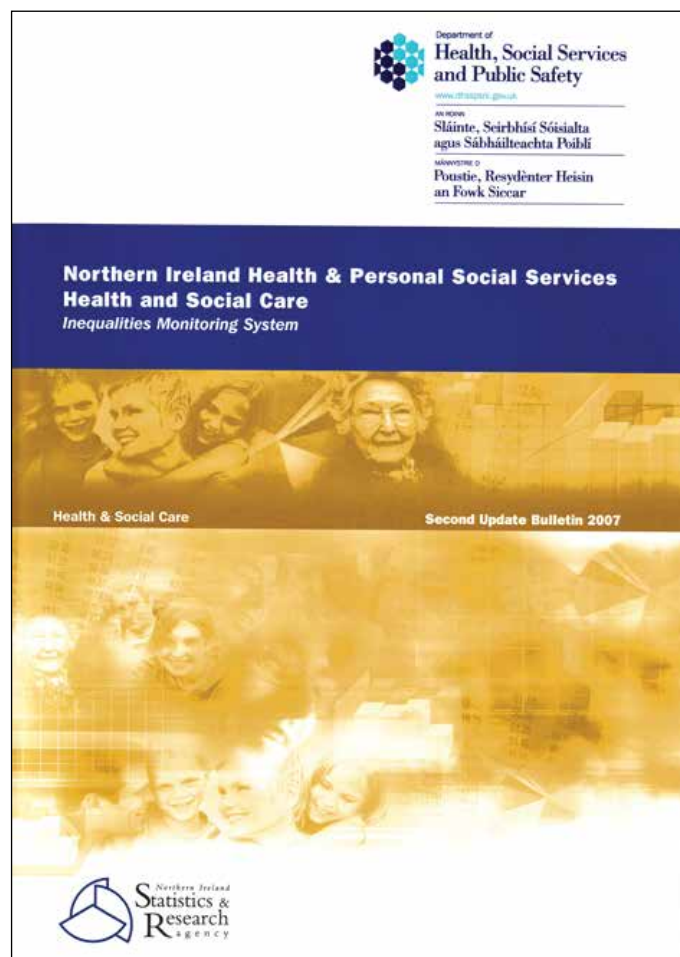
Communities in Northern Ireland are becoming increasingly diverse and, therefore, are experiencing increasingly diverse health needs. The DHSSPS, in aiming to improve the health and wellbeing of the Northern Ireland population, recognises the importance of its role in reducing health inequalities and is fully committed to the discharge of its Section 75 obligations.

Actions

Within the DHSSPS, cause-specific mortality, particularly for cancers and heart disease, has been routinely used to provide indicators for policy monitoring. However, such analyses have normally been limited to the information provided on death certificates. In terms of availability by Section 75 equality groups, this has amounted to population sub-groups based on gender, age and marital status only.

The Northern Ireland Longitudinal Study (NILS) and its sister project, the Northern Ireland Mortality Study (NIMS) allow exploration of health and socio-demographic characteristics by a wider range of Section 75 individualities.

The DHSSPS monitors the health outcomes of Section 75 groups and disadvantaged populations as part of its Northern Ireland Health and Social Care Inequalities Monitoring System (HSCIMS).¹⁴³ This initial research project concentrated on analysing mortality data from NIMS, with the aims of pinpointing differences in mortality between Section 75 groups and examining whether or not they can be explained by social and economic disadvantage factors. This research builds upon previous Office of the First Minister and Deputy First Minister (OFMDFM) work.¹⁴⁴



Impacts

This research has enabled the DHSSPS to monitor and review its progress of equality duties within public health strategies as well as in the promotion of equal opportunity among the Section 75 groups. It has also provided valuable data for the screening of DHSSPS policies.

The DHSSPS equality scheme states that it will seek to develop more effective and wide-ranging monitoring and data collection arrangements. It is intended that this research will be repeated to create an ongoing monitoring system using longitudinal data, which will allow observation of changes to mortality rates and life expectancy, and possibly include analyses of various morbidity outcomes.

Next steps

The findings have been disseminated and presented across a wide number of forums. The DHSSPS intends to continue this research with the establishment of an ongoing monitoring system, and also plans to include linkages to other health-related data in order to extend the research beyond mortality.

Key facts



- Age and gender were the two main predictors for determining mortality.
- The greatest differences in Section 75 characteristics were seen between those with a limiting long-term illness (higher age-specific mortality rate – higher ASMR) and those without (lower ASMR).
- Social deprivation had a bigger effect on mortality and life expectancy than Section 75 characteristics – excluding age, gender and limiting long-term illness.
- Those from a Catholic background had a slightly higher ASMR and lower life expectancy.
- Those who were married or cohabiting experienced the lowest ASMRs and highest life expectancy.

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Protecting health

Overview

Regional plan ensures coordinated approach to managing incidents and outbreaks across Northern Ireland

Meeting the public health challenges of the G8 Summit

Focusing on the health needs of migrant populations

Overview

The PHA's health protection department continues to provide a high-quality service to safeguard the population of Northern Ireland from communicable disease and environmental hazards. These include targeted interventions for vulnerable groups within the population.

During 2013, the health protection service delivered responses to a number of challenges. The G8 Summit was held in Fermanagh in 2013 and planning for it was a major undertaking.

Emergency preparedness staff and the health protection service worked closely with the DHSSPS, HSCB and HSCT colleagues to lead preparations, including surveillance and outbreak response, healthcare response to major incidents and casualty preparedness. Notably, a new Enhanced Syndromic Surveillance System (EDSSS) was developed and delivered to support our ability to monitor the impact of the G8 Summit in health terms.

Delivering the response to infectious disease incidents and outbreaks remains a key health protection responsibility. During 2013, the health protection team led the development of an updated Northern Ireland infectious disease incident/outbreak plan to ensure a coordinated approach is taken throughout Northern Ireland to the investigation and control of infectious disease incidents and outbreaks. The plan clarifies roles and responsibilities, and further training will be taken forward during 2014 to ensure clarity across the service in respect of outbreak investigation response.

During 2013, health protection colleagues worked with others in the PHA to ensure the organisation met its responsibilities to prevent the spread of infection in vulnerable migrant populations. This included targeted messages for vulnerable groups and working closely with members of the community health teams who have specific responsibility for migrant communities.

The PHA has also worked closely with the Belfast HSCT to develop NINES aimed at meeting the health and wellbeing needs of new immigrants. These approaches have ensured that communicable disease control services cover the entire population including vulnerable migrant groups.

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Regional plan ensures coordinated approach to managing incidents and outbreaks across Northern Ireland

Public health challenge

Infectious disease outbreaks and incidents can impact on the health of anyone – young and old, those born within the UK and those born elsewhere. Outbreak and incident management aims to protect public health by:

- promptly identifying the source of infection;
- implementing necessary measures to prevent further spread or recurrence;
- ensuring appropriate medical attention for those infected;
- communicating with patients/clients, the public and professionals.

Actions

The *Northern Ireland Infectious Disease Incident/Outbreak Plan* has been developed to ensure a coordinated approach is taken throughout Northern Ireland to the investigation and control of infectious disease incidents and outbreaks. It is a generic template that can be used by organisations to identify, risk assess and manage an incident or outbreak of infectious disease.

The plan was developed by the PHA in liaison with HSCT and DHSSPS colleagues as part of the implementation of the RQIA *Review of outbreaks of Pseudomonas aeruginosa in neonatal units in Northern Ireland*.¹⁴⁵ The plan is based on the most up-to-date guidance available on leading and managing an incident or outbreak.

Impacts

A range of organisations may be involved in the response to an incident/outbreak. These will vary according to the nature of the outbreak, but can include the PHA, environmental health departments in local councils, HSCTs, Food Standards Agency (FSA) and DHSSPS. The plan clearly identifies the roles and responsibilities of organisations in the response.

The plan also clarifies the role of the outbreak control team formed to respond to the incident and identifies the professional groups that should be represented on the team. The role of outbreak team members and their areas of personal responsibility are clearly stated.

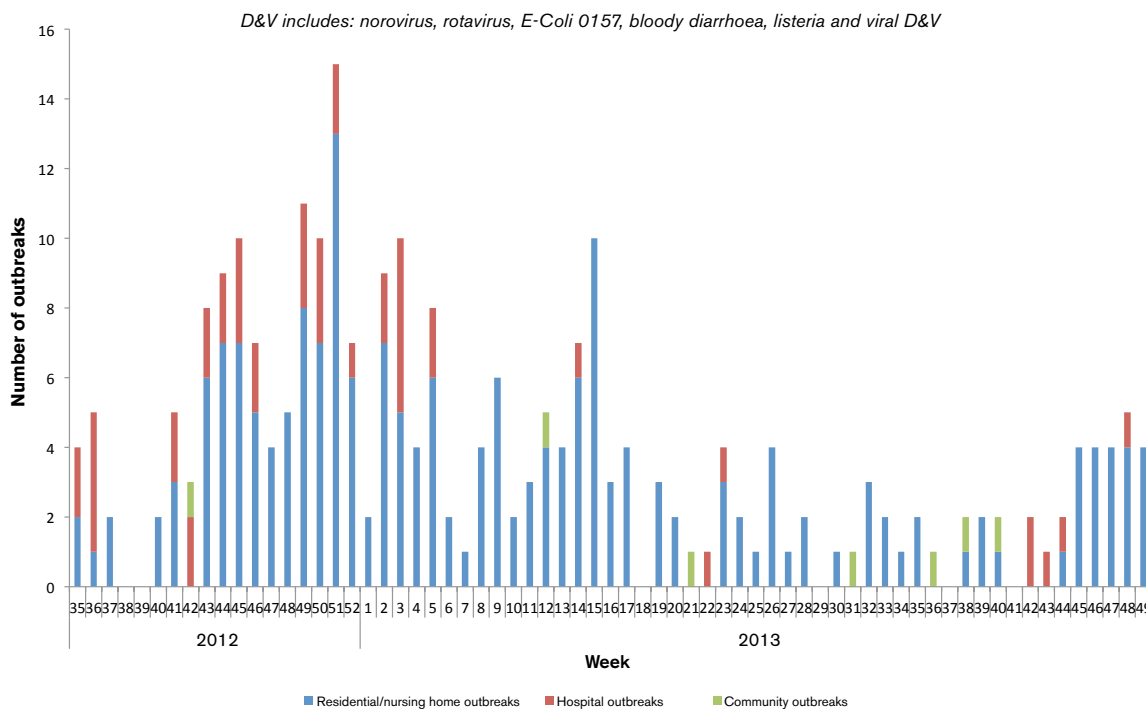
In addition, the plan provides guidance on the management and organisational aspects of outbreak and incident response, communication in these situations, and disease investigation and control procedures. A range of appendices, such as a dynamic risk assessment model, are included for use during incidents and outbreaks.

Next steps

The plan will be shared with HSCTs and other key stakeholders to enable each organisation to develop or refine their own outbreak plan(s), consistent with this regional plan.

To ensure a consistent approach to outbreaks and incidents across the region, the PHA will arrange training on outbreak planning and response in 2014.

Figure 13: Number of diarrhoea and vomiting (D&V) outbreaks reported to the PHA per week in 2012–13



Key facts

- During 2012, there were 164 outbreaks of infectious gastrointestinal illness in residential institutions, affecting at least 2,693 people, and a further 10 outbreaks linked to other sites (eg nurseries, schools/universities), affecting at least 588 people.
- The most common causative agent of non-foodborne gastrointestinal outbreaks in 2012 was norovirus, which accounted for 117 outbreaks (47% of all outbreaks).
- In the UK, there are up to 17 million cases and 1 million GP consultations due to infectious gastrointestinal illness every year.¹⁴⁶
- In the United States, it is estimated that foodborne outbreaks result in 76 million illnesses, 325,000 hospitalisations and 5,000 deaths each year.¹⁴⁷

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Meeting the public health challenges of the G8 Summit

Public health challenge

On 17 and 18 June 2013, the five star Lough Erne Hotel and Golf Resort hosted the G8 Summit. This major event saw 10 world leaders, along with 3,500 delegates and staff and large numbers of world media, visit Northern Ireland. Based on previous summits and international intelligence, large numbers of protesters were also predicted to attend the event. This brought with it specific security risks and public health challenges for multi-agency emergency planners.

All major events such as the G8, with the temporary increase in local population density, bring with them potential public health risks that have to be assessed and managed.¹⁴⁸ These risks include possible increased illness from the importation, transmission and mixing of infections that are not endemic in Northern Ireland with local endemic infections, and, on occasion, an ensuing strain on local health services.

Actions

The Chief Medical Officer asked the PHA to project manage and oversee all the operational HSC preparations for the G8. Emergency planners in the PHA's health protection department worked closely with DHSSPS, HSCB and HSCT colleagues to lead HSC preparations for this event.

Figure 14: WHO outline framework for public health planning for mass gatherings

<p>Population health</p> <ul style="list-style-type: none"> • Disease surveillance and outbreak response • Environmental health, food and water safety • Health promotion opportunities 	<p>Health services</p> <ul style="list-style-type: none"> • Emergency medical care (pre-hospital, hospital care and diagnostics etc) • From first aid to specialist care • Surge capacity • Impact of event on local services, eg from road closures • Specific arrangements for individual athletes, trainers, spectators, protesters and VIPs. 	<p>Disaster planning and response</p> <ul style="list-style-type: none"> • Mass casualties • CBRN/HAZMAT incidents (MPC plans) • Severe weather • Command and control arrangements/resilience
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The World Health Organization (WHO) outline framework for public health planning for mass gatherings (Figure 14) was used as the basis of the HSC preparations. Despite the very short timescales, the PHA successfully worked with DHSSPS, HSCB, HSCT and environmental health colleagues to carry out effective risk assessment and public health planning in the areas of:

- disease surveillance and outbreak response;
- environmental health, food and water safety;
- healthcare capacity and mass casualty preparedness;
- chemical and radiation incident response;
- public information and health promotion.

Impacts

Northern Ireland can be proud that the many weeks of preparation, both within HSC and across all the partner organisations, resulted in what was internationally acclaimed as the most peaceful G8 Summit ever held.

Special command and control arrangements were put in place for the four days leading up to and including the days of the summit. PHA staff worked closely with DHSSPS colleagues and other partner agencies in the central coordination room.

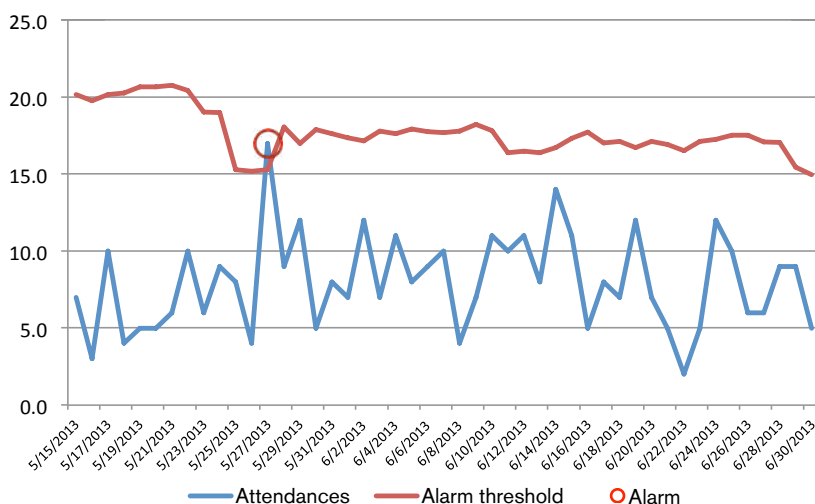
Health protection staff worked with Public Health England (PHE) colleagues to put in place a surveillance system for emergency departments (EDSSS), which was piloted in three Northern Ireland hospitals (Figure 15). A Dedicated Operations Centre (DOC) was set up and run by health protection staff to facilitate the collation and risk assessment of a range of surveillance information including the EDSSS.

Next steps

Significant learning was gained through the G8 preparations, both within the PHA and across HSC. This learning formed the basis of HSC preparations for the other two major events in 2013, the World Police and Fire Games and the All-Ireland Fleadh Cheoil.

The EDSSS proved very successful and funding is being sought to ensure this system is now embedded as part of the health protection core surveillance function.

Figure 15: EDSSS alert graph – respiratory attendances at two emergency departments in Northern Ireland, May–June 2013



Source: Health Protection Surveillance Team, PHA

Note: Alarm thresholds are based on an upper prediction level calculated using the Shewhart methodology.

Further information

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Focusing on the health needs of migrant populations

Public health challenge

Migrants make up an increasing proportion of the UK population. The 2011 Census estimated the total migrant population to be 81,400 in Northern Ireland (4.5% of the population).¹⁴⁹

The majority of long-term migrants to the UK are young people with plans to study or work, who have general health needs similar to individuals of equivalent age and sex in the indigenous UK population.¹⁵⁰

A smaller proportion will experience a range of health needs including (but not limited to):

- access to healthcare;
- racism and racial harassment;
- mental health issues;
- children's health issues;
- health protection issues.

Asylum seekers, refugees and clients who are unable to register for GP services are particularly vulnerable groups.¹⁵¹

Actions

The health protection service within the PHA is responsible for the prevention and control of communicable infectious diseases and provides an acute response function to major issues such as outbreaks of infection.

To ensure the PHA meets its responsibilities to prevent the spread of infection in vulnerable migrant communities, a range of approaches have been taken in response to incidents:

- collaborating with local community workers to explain issues and gain the support of the community for screening and treatment;
- tailoring infection prevention and control messages to meet the communication needs of the community;
- joint working with members of the community health team who have specific responsibility for migrant communities;
- organisation of vaccination clinics to encourage uptake of childhood vaccinations in vulnerable migrant populations.



Transmission of respiratory infections commonly occurs through droplets from coughs and sneezes. Encouraging the public to use tissues to catch coughs or sneezes, bin the tissues and kill the germs by washing their hands can reduce the spread of infection within the community.

The PHA has also provided funding for the Belfast HSCT to develop NINES. This offers a holistic service to meet the health and wellbeing needs of new immigrants, including asylum seekers and children aged 0–18 years, through a range of clinics. These are accessed by self-referral and referral by professionals from health, voluntary and other sectors.

Impacts

Our approaches have ensured communicable disease control services cover all of our population, including vulnerable migrant groups such as those unable to register for GP services.

Through NINES, screening for communicable diseases such as TB, hepatitis B, hepatitis C and HIV is offered to clients from high risk countries. Immunisations against communicable diseases are offered to those who require them. Where appropriate, we also provide assistance with registration for GP and dental services, signposting to other services and onward referral.

Next steps

The PHA will continue to develop new approaches for reaching migrant populations. NINES will be widened to include more multisectoral elements, such as housing, poverty, community relations and education. Clinic sessions will be further developed to include a GP clinic and a consultant-led paediatric clinic.

Key facts



- 12,900 people came to live in Northern Ireland from outside the UK between mid-2011 and mid-2012.¹⁴⁹
- Health risks to the non-UK born population can continue for many years after arrival in the UK. For example, 77% of non-UK born TB cases in 2010 were diagnosed two or more years after arrival in the UK.¹⁵⁰
- There is little evidence that the wider population is at risk of significant levels of transmission of disease from affected migrants, especially during normal social contact.¹⁵²

Further information



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Abbreviations and acronyms

A

AAA	Abdominal aortic aneurysm
ADRC	Administrative Data Research Centre
AIDS	Acquired immunodeficiency syndrome
AITHS	All Ireland Traveller Health Study
ASMR	Age-specific mortality rate

B

BEBE	Belfast Experts By Experience
BME	Black and minority ethnic
BMI	Body mass index

C

CBRN	Chemical Biological Radiological Nuclear
CHNI	Council for the Homeless NI
CYPSP	Children and Young People's Strategic Partnership

D

DARD	Department of Agriculture and Rural Development
DCAL	Department of Culture, Arts and Leisure
DH	Department of Health
DHSSPS	Department of Health, Social Services and Public Safety
DOC	Dedicated Operations Centre
DPH	Director of Public Health
D&V	Diarrhoea and vomiting

E

ED	Emergency department
EDSSS	Enhanced Syndromic Surveillance System
EMIS	European MSM Internet Sex Survey
ESRC	Economic and Social Research Council

F

FSA	Food Standards Agency
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G

GP	General practitioner
GUM	Genito Urinary Medicine

H

HAZMAT	Hazardous materials
HIV	Human immunodeficiency virus
HSC	Health and Social Care
HSCB	Health and Social Care Board
HSCIMS	Health and Social Care Inequalities Monitoring System
HSCT	Health and Social Care Trust
HYPE	Health for Youth through Peer Education

I

ID	Intellectual disabilities
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L

LCG	Local Commissioning Group
LGB	Lesbian, gay or bisexual
LGB&T	Lesbian, gay, bisexual and transgender
LGD	Local Government District

M

MARA	Maximising Access in Rural Areas
MRI	Magnetic resonance imaging
MSM	Men who have sex with men

N

NASS	National Asylum Support Service
NI	Northern Ireland
NICEM	Northern Ireland Council of Ethnic Minorities
NIHSCIS	Northern Ireland Health and Social Care Interpreting Service
NILS	Northern Ireland Longitudinal Study
NIMS	Northern Ireland Mortality Study
NINES	Northern Ireland New Entrant Service

NIPHRN Northern Ireland Public Health Research Network

NISRA Northern Ireland Statistics and Research Agency

NSC National Screening Committee

O

OFMDFM Office for the First Minister and Deputy First Minister

P

PDF Portable document format

PHA Public Health Agency

PHE Public Health England

PYLL Potential years of life lost

Q

QARC Quality Assurance Reference Centre

R

R&D Research and Development

RDG Research development group

RJMH Royal Jubilee Maternity Hospital

ROI Republic of Ireland

RQIA Regulation and Quality Improvement Authority

RSU Research Support Unit

S

SLAN Survey of Lifestyle, Attitudes and Nutrition

STI Sexually transmitted infection

SUN Service user network

T

TB Tuberculosis

U

UK United Kingdom

V

VIP Very important person

W

WHO World Health Organization

WRDA Women's Resource Development Agency

Drugs and alcohol

Prisoners

beliefs

Cultural

Diversity

Disabilities

Sexual health

Language

Section 7

Black and minority



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