

- as part of the programme of Needs and Effectiveness Evaluations as outlined in the Programme for Government, research findings will be collated to produce a cost benefit analysis of prevention options against treatment in the areas of smoking, alcohol, drugs and physical activity.

20.4 Three reports from the first Health and Social Well-being Survey here were published in November 2001 on Health and Health Service Use: Social Variations⁶⁰; Health and Lifestyle; and Informal Carers. Headline results from the second survey were also published in December 2001. A series of short topic reports will be published approximately monthly from January 2002.

Areas for development

20.5 A major challenge will be to pull together the various research strands into an inclusive, inter-sectoral effort to strengthen the research effort for *Investing for Health*. The strategic approach will be to link research outputs from Recognised Research Groups, inequalities research, health and social well-being surveys and other community based *Investing for Health* research, with ongoing policy development, using new knowledge to steer inter-Departmental work on inequalities and social inclusion.

20.6 The capacity for *Investing for Health* research will be strengthened by:

- a) enhancing structures and systems for public health research; and
- b) maximising training opportunities.

a) Enhancing structures and systems:

- the Ministerial Group on Public Health has a key role to play in linking the research programmes of different Departments;
- MGPH will ensure that high quality research findings influence policy development consistently across Departments to reduce inequalities and promote health;
- *Investing for Health* research, including research on inequalities should be explicitly promoted and mainstreamed;
- the R&D Office will be fully supported in developing a public health strand within the commissioned research programme;
- the R&D Office is already collaborating with the Health Research Board (HRB) in the South on a number of issues such as building all-island research capacity, cancer research and encouraging participation in the Cochrane

collaboration. We propose that consideration should be given to building an island wide research community and that the Institute of Public Health should take the lead in developing this in collaboration with the R&D Office and HRB;

- linkages need to be developed at all levels. For example, participatory research can provide an effective route for local community 'voices'. This can be developed further through action research where change is guided and evaluated collaboratively by researchers and local people;
- Health and Well-being Investment Plans will provide a favourable context for local cross-sectoral partnerships for *Investing for Health* research;
- at another level, research expertise for *Investing for Health* can be promoted through research partnerships between universities and HSS bodies as exemplified by the RRGs and between research teams here and in the South of Ireland, England, Scotland and Wales, and internationally.

b) Promoting training opportunities:

- R&D Office studentships, fellowships and bursaries offer important routes through which *Investing for Health* research capability and capacity can be developed. This is already producing an expanding cadre of competent researchers. Opportunities for developing joint training initiatives should be explored by the research offices in the North and South of Ireland, England, Scotland and Wales;
- the R&D Office is actively promoting *Investing for Health* Research expertise by facilitating access to the annual Public Health Career Scientist Award offered by the Department of Health/ NHS R&D Programme in England;
- key stakeholders from the University of Ulster and The Queens University of Belfast are jointly developing a multi-disciplinary MSc in Public Health that includes a strong research component.

20.7 The development of a career pathway for public health practitioners will have a positive effect. To achieve this, HSS Boards and Trusts will be encouraged to engage with Healthwork UK in identifying competencies and standards for public health practice and career progression for people from a range of sectors and professions.

- 20.8 A systematic means whereby individuals, communities and research teams can readily identify sources of funding for *Investing for Health* projects needs to be developed. This needs to be complemented by an efficient, inclusive dissemination process across sectors, disciplines and communities.

Information

- 20.9 *Investing for Health* should be based on the best available evidence of our population's health status, relative to other regions. Information is required for policy making health impact assessments. The past decade has seen considerable progress in the development of information sources and systems.
- 20.10 However, the overall picture is of a wealth of information that is often collected in an ad hoc way and does not easily lend itself to comparisons. The challenge is to develop co-ordinated systems of data collection for databases that can be accessed by a wide range of users, when required, for comparative purposes, needs assessment, health intervention and monitoring. Better co-ordination of data collection and dissemination would facilitate easier identification of information gaps.

Information gaps

- 20.11 During the target setting process and development of the *Investing for Health* Strategy, a number of information gaps were identified. These relate to health status, health inequalities and the determinants of health.

a) Health status

- 20.12 Measures of mental health are limited and in particular we do not know the number of people here with a mental illness. The GHQ12 score estimates levels of mental well-being. This was contained in the last Health and Social Well-being Survey carried out in 2001.
- 20.13 At present there is little information on morbidity. Information on admissions to hospitals is held centrally and is available by diagnosis. From this information it is possible to report on, for example, the number of hip replacements, admissions due to coronary heart disease or admissions due to serious accidents.
- 20.14 For those conditions where a patient does not require an admission to hospital, for example diabetes or asthma, information is limited. Currently, the Data Retrieval from General Practice (DRGP) project based in Queens University of Belfast, can extract data from a number of GP practices, but no data on consultations are available. It is planned to develop accessibility to primary care data in the next few years.

20.15 DHSSPS currently has a Unique Patient Client Identifier (UPCI) project underway for the development of a new Health and Care Number Index for the population. This unique number will hold among other information, data on name, address, date of birth, GP and postcode. The index will enable linkages to be made at individual level across different Health and Personal Social Services (HPSS) operational data systems, and also longitudinally for the same patients over time.

20.16 Data on attendances at Accident and Emergency Departments (A&E) is currently collected at hospital sites. DHSSPS is currently working with the Royal Society for the Prevention of Accidents (ROSPA) to secure data that will be held centrally to provide regional data on accidents.

b) Health inequalities

20.17 To measure inequalities in health, a significant amount of quantitative data is required. In particular postcode and socio-economic group (or occupation) are required for New Targeting Social Need. An Equality Information Steering Group has been set up to develop the information held on HPSS systems. The primary objective of this group is to develop quantitative information on each of the nine equality groups to support Equality Impact Assessments in line with Section

75 of the Northern Ireland Act and to develop geographic identifiers and occupation data. Improving occupation data on health related systems will result in better measurement of the gap that exists in health between low and high socio-economic groups.

c) Determinants of health

20.18 OFMDFM are responsible for a target in the New TSN action plan to develop a poverty measure. The Family Resources Survey is due to be carried out here for the first time in April 2002. This survey collects detailed information on income and this will enable poverty to be measured using a recognised definition based on income. Results from the survey will be available late in 2003.

20.19 At present, it is not possible to effectively record and collate information on domestic violence because adequate systems are not in place. The report '*Children in Northern Ireland: Domestic Violence and Professional Awareness*'⁶¹ recommends that a standardised form for recording the details of domestic violence should be developed and data should be made available to all interested parties on a quarterly basis.

Comparative Information

20.20 A positive step is the compilation of a paper '*Comparators of Health - Data sources for statistics for Europe, Ireland and*

United Kingdom' on sources of health statistics for Europe, Ireland and England, Scotland and Wales, with websites, by the Information and Analysis Unit of DHSSPS. It is possible to obtain information from a wide range of databases such as Statbase for key economic and social statistics, the Data Retrieval in General Practice (DRGP) database, as well as census information, population trends and neighbourhood statistics.

20.21 Individuals, communities and the range of sectors concerned with *Investing for Health* need to have ready access to databases such as those listed above, and others that provide evidence of effective practice for health improvement. These include the University of York Centre for Reviews and Dissemination, the Social Science Information Gateway (SOSIG), the Cochrane Collaboration and the Campbell Collaboration. It will be important to enable communities to access information quickly and in an understandable form, as a prerequisite for community development.

20.22 An important goal of *Investing for Health* is to make better use of existing information. There is scope for linking information from different sources, such as profession-specific databases, community based projects and more general information sources. Health, social services, housing and education professionals routinely collect

health-related data that could be collated and used more effectively to build an overall picture of health inequalities. There are many local community assessments of need that could be cross checked against deprivation indices and neighbourhood statistics to inform policy at local level, while bearing in mind the requirements of the 1988 Data Protection Act and issues of consent and confidentiality.

20.23 Networks for health and inequalities information gathering and sharing will be developed. The Institute of Public Health in Ireland has a vital information gathering and sharing function. Existing links should be strengthened between IPHI, the R&D Office, the Health Research Board in Ireland, the Information and Analysis Unit of the DHSSPS and equivalents in other Departments here, the Department of Health and Children in the South, and NISRA. The aim is to improve the compatibility of information between the North and South of Ireland and with different regions of Britain.

20.24 NISRA is leading work in conjunction with OFMDFM to develop data systems and methodologies to help all Departments identify disadvantaged people, groups and areas, to target resources and monitor progress. The 2001 Census will provide an extensive range of information on the characteristics of the

population. In addition, the Noble Measures of Deprivation were published in July 2001.

20.25 NISRA has a Geographical Information System (GIS) Unit responsible for the collation of geographically referenced data. This will be updated regularly and key information is available on the NISRA website.



CHAPTER 21 : MONITORING AND ACCOUNTABILITY

- 21.1 The *Investing for Health* Strategy is concentrated around 2 goals and 7 objectives. A number of measurable targets are linked to these objectives, and progress towards meeting these targets will be monitored on an annual basis, where possible. The data for some of the targets are available only every other year or longer – it will not be possible to monitor annual progress towards these targets.
- 21.2 Due to the nature of many of the targets, significant progress towards achieving them will not be seen in the early years. In some cases, such as the obesity target, arrangements will have to be made for the data to be collected on the Health and Social Well-being Survey, as it is not routinely collected. The cross-departmental nature of the strategy means that the data required to monitor progress on achievement of the targets will have to be collected from the appropriate Departments. The results of this annual monitoring progress will be published.
- 21.3 As the achievement of the overall aims of the strategy and the objectives and targets within it will not be evident for some years, it will be important in the early years to monitor progress on the implementation of the strategy. This will include the establishment of the Investing for Health Partnerships, the involvement and commitment of all the partner organisations, the identification of the health and well-being needs of their local populations through a robust needs assessment, the development of locally integrated health improvement plans within the Boards' wider HWIPs, and the implementation of those plans. Progress on these processes will be reported on annually.
- ### Regional level
- 21.4 As outlined in Chapter 16, the Minister for Health, Social Services and Public Safety will be accountable to the Executive for co-ordinating and steering the *Investing for Health* process across Government. The Minister for Health, Social Services and Public Safety will continue to chair and be supported by the Ministerial Group on Public Health (MGPH). This group will be cross-Departmental and will be responsible for managing the partnership across Government, and for co-ordinating and monitoring the implementation of the Strategy within a performance management framework.
- 21.5 The Minister for Health Social Services and Public Safety and her Department, through the Health Development Directorate, will continue to be responsible for co-ordinating and steering inter-departmental action in specific areas within the *Investing for Health* framework e.g. drug and alcohol misuse, smoking, physical activity, etc. Other Departments will take the lead in areas for which they have principal responsibility.

Local level

Investing for Health Partnerships

21.6 As outlined in chapter 16, four Investing for Health Partnerships will each prepare the health improvement element of the Board's wider HWIP, based on an assessment of the health and well-being needs of the local population. Responsibility for implementing those plans will lie with the appropriate partner organisation(s). Each partner organisation will be accountable for its actions within the plan through its own normal accountability arrangements. Overall the Investing for Health Partnerships will be accountable to the Ministerial Group on Public Health. Departmental representatives on the Ministerial Group on Public Health will be responsible for monitoring the progress of the bodies for which they are responsible.

Health & Wellbeing Investment Plans

21.7 Accountability and monitoring issues are seen as essential ingredients of a successful HWIP. Health and Wellbeing Investment Plans will be the main instrument of accountability for the Health and Personal Social Services. They must, therefore, fully reflect HPSS responsibilities under the Programme for Government as interpreted in the Minister's Priorities for Action. The Department will hold the HPSS to account for their roles and

responsibilities in HWIPs and will monitor progress against targets and objectives through an annual accountability review process.

21.8 The timetable for HWIPs will therefore be inextricably linked to the Programme for Government (PfG) timetable and, as with PfG, it is envisaged that HWIPs will have a 3-year horizon, subject to annual review.

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ANNEX 1 : EQUALITY IMPLICATIONS

1. Introduction

Northern Ireland Act 1998

1.1 Section 75 of the Northern Ireland Act 1998 requires each Department, in carrying out its functions relating to Northern Ireland, to have due regard to the need to promote equality of opportunity –

- between persons of different religious belief, political opinion, racial group, age, marital status or sexual orientation;
- between men and women generally;
- between persons with a disability and persons without; and
- between persons with dependants and persons without.

1.2 In addition, without prejudice to the above obligation, each Department must also have regard to the desirability of promoting good relations between persons of different religious belief, political opinion or racial group.

Background

1.3 Although there have been real improvements in our health here throughout the last century, we continue to lag far behind the best in Europe as regards reducing levels of ill health and premature death resulting from the major diseases. Coronary heart disease, cancer and

respiratory disease account for over 66% of all deaths here, with many of these being preventable. In addition, many of our population suffer inequalities in health. Poverty is the greatest risk factor for health, with the gap in health status between rich and poor widening since the 1970's. In the Continuous Household Survey of 2000/01 33% of men and 36% of women reported that they had a long-standing illness.

1.4 In its first Programme for Government, the Executive identified health improvement as one of its five overarching priorities, under the heading of 'Working for a Healthier People', as part of its commitment to provide equality of opportunity and tackle social disadvantage. It was recognised that a new strategic approach was needed to work towards the health improvement of the general population, whilst also specifically aiming to reduce the inequalities that exist within our society.

1.5 The Executive commissioned the Minister for Health, Social Services and Public Safety to take forward the development of a new strategy to improve health and reduce inequalities by addressing the wider determinants of health and well-being through a cross-Departmental, multi-sectoral approach.

- 1.6 The Minister brought together senior officials from each Department to form the Ministerial Group on Public Health (MGPH), to work on the development of the new strategy. A consultation paper was published in November 2000, and set out the following core values:
- Health is a fundamental human right;
 - Policy should actively pursue equity and social inclusion; and
 - Individuals, groups and local communities should be involved fully in decision-making on matters relating to health.
- 1.7 The Community Development and Health Network (CDHN) were commissioned to develop a fully inclusive and innovative consultation process, and to carry this out on behalf of MGPH. The consultation period ran until 31 May 2001.
- 1.8 The overall consultation process realised 414 responses through a variety of methods. These were analysed and a Consultation Summary Report was produced in October 2001. The majority of responses were generally favourable and broadly in agreement with the principles and values set out in the consultation document. All of the responses have been carefully considered in the development of the final Strategy Paper.

2. Aims of the Strategy

- 2.1 The overall aims of the *Investing for Health* Strategy are to improve the health of the whole population, and to reduce the inequalities in health that are evidently experienced amongst the more disadvantaged sections of our society.
- 2.2 *Investing for Health* sets out a broad strategic framework to achieve the necessary improvement in the state of our health, and identifies a number of priority areas for action. From it, individual policies and thematic strategies will be defined by the Departments or Agencies responsible, and implemented by those Departments in conjunction with other Departments, statutory bodies and voluntary/community sector bodies as appropriate.

3. Groups Affected by the Strategy

- 3.1 Implementation of the strategy should lead to improvements in health for the population generally. In particular, it will improve the health of the most disadvantaged in society who experience the worst health. In terms of the equality categories listed in 1.1 the groups that may be most likely to be affected are those with a disability, ethnic minorities, age and gender. It is not considered that it will result in any group being adversely affected.

- 3.2 The requirement to promote equality of opportunity here was reflected in the consultation document. Respondents were specifically asked to comment on the potential equality implications of *Investing for Health*. Responses to this point are reflected in the final Strategy Paper, with the main change being a decision to shift the focus from particular priority groups within the population, to focusing on reducing inequalities where they existed.

4. Consideration of Available Data/Research on Section 75 Categories

- 4.1 When considering the equality implications of the Strategy, account was taken of information provided by existing surveys and other research information in relation to inequalities in health as set out below. Information on the 9 Section 75 Groups was considered in relation to long-standing illness and life expectancy.

Religion

- 4.2 The Continuous Household Survey 2000/01 shows 32% of Roman Catholic males and 33% of Protestant males reporting that they are affected by long-standing illness, with the rest unwilling to answer the question. The figures for women are 35% and 38% respectively. There is no information available on life expectancy in the different religious groups.

Political Opinion

- 4.3 There is no information available for groups of differing political opinions.

Gender

- 4.4 The Continuous Household Survey of 2000/01 shows that for the past few years a greater proportion of women than men report that they are affected by long standing illness. The figure covering all age groups was 36% of women and 33% of men. Life expectancy for women is higher than for men. Most recent figures quote 79.6 years for women and 74.5 years for men.

Race

- 4.5 There is no meaningful information available on people in racial groups for either long standing illness or life expectancy as numbers in surveys have been exceedingly small. However, it is known that Travellers as a group have a life expectancy of about 15 years less than the settled community. Only 1 in 10 are over 40 years of age, with 1 in 100 over the age of 65.

Disability

- 4.6 There is no specific information available on life expectancy or long standing illness for people with disabilities.

Age

- 4.7 The proportion of adults reporting a long-standing illness increases with age. For 2000/01, the Continuous Household Survey shows that 75% of women and 72% of men over age 75 are affected (figures for all age groups being 36% and 33% respectively). These results are not surprising, due to the natural aging process.

Marital Status

- 4.8 Single people report the lowest incidence of being affected by long-standing illness (ranging from 18% to 24% for those living alone or cohabiting). Married people of both sexes are the next lowest group, with separated women in a similar range (35% - 39%). Separated men show a marked increase at 63%, similar to widows (66%) and widowers (61%). There is no information on life expectancy for this group.

Dependants

- 4.9 The Continuous Household Survey findings show that a greater percentage of young people with dependants (child dependants only, does not include those with elderly or disabled dependants) report long-standing illness than those without dependants. However, as people get older (from age 35 onwards) this trend reverses, and those with dependants report less long-standing illness than those without. There is no information available on life expectancy in this area.

Sexual Orientation

- 4.10 There is no specific information available on life expectancy or long-standing illness for this group.

5. Available Data

- 5.1 NISRA has worked with all Departments to audit the extent and quality of coverage of section 75 groups in key Departmental data sources. This audit has demonstrated that the data available in relation to the respective categories varies. Work will be taken forward to develop further the information base, which will be helpful to the Executive and to individual Ministers and their Departments in considering the future direction of policy.

6. Assessment of Impact

- 6.1 Given the aims of the Strategy to improve the long term health and well-being of the population generally and reduce inequalities in health, it is not envisaged that any of the categories will be adversely affected. The implementation of this Strategy will entail many other Departments producing and implementing policies and strategies to take forward its aims. These individual policies will themselves be subject to full Equality Impact Assessments in line with each Department's Equality Scheme.
- 6.2 The Strategy aims to seek improvements in areas of disadvantage and deprivation in particular, and in so doing, will also address the health

inequalities faced by people in some of these categories, for example religious belief, people with disabilities, lone parents, or ethnic minorities.

- 6.3 It is recognised that all groups have particular needs, and should have equal rights of access to information and services. The Strategy has been developed with this in mind and it is our view that it should not have an adverse impact on any of the categories listed, and positively promotes equality of opportunity for all.

7. Monitoring of Impact of Policy

- 7.1 Action Plans developed for the implementation of the Strategy will work towards the achievement of a range of specific targets that have been set and are detailed in the document. These targets are long term, and progress made towards meeting them will be measured annually, also providing an opportunity to consider if there is any adverse impact on any particular group.

ANNEX 2 : LIST OF CONSULTATION RESPONSES RECEIVED

Action Cancer
 Age Concern
 Altnagelvin Hospitals Health & Social Services Trust
 Altnagelvin Hospitals HSS Trust – Central Nursing Advisory Committee
 Antrim Area Hospital Consultants
 Antrim Borough Council
 Antrim District Citizens Advice Bureau
 Ards Borough Council
 Armagh & Dungannon Health & Social Services Board
 Armagh and Dungannon Health Action Zone (HAZ)
 Armagh City & District Council
 Armagh Primary Care Commissioning Pilot
 Armoy Community Association
 Arthritis Care in NI
 Association of Independent Advice Centre NI
 Association of Lactation Consultations in Ireland
 Ballybeen Women's Centre
 Ballymena Borough Council
 Ballymena Community Meeting
 Ballymoney Borough Council
 Banbridge District Council
 Barnardos
 Belfast City Council
 Belfast City Hospital Trust
 Belfast Education & Library Board
 Belfast Healthy Cities
 Belfast Healthy Cities Community Forum
 Belfast North & West Health Action Zone Youth Group
 Beragh Care & Development Association
 Boots the Chemists Ltd.
 Breaking the Silence, Ulster People's College
 Breakthru Drug Awareness
 British Endocrine Societies
 Business and Professional Women UK Limited (BPW Northern Ireland)
 Care for Northern Ireland
 Carrickfergus Community Forum
 Carrickfergus Community Meeting
 Central Pharmaceutical Advisory Committee
 Central Services Agency
 Centre for Voluntary Action Studies, University of Ulster
 Chartered Society of Physiotherapy NI (CSP NI)
 Child Care NI
 Church of Ireland Board for Social Responsibility (NI)
 Clinical Issues Group, Eastern Multifund
 Coleraine Borough Council
 Committee, Administration of Justice
 Community Development and Health Network (CDHN)
 Community Practitioners and Health Visitors Association
 Confederation of Community Groups

Conservation Volunteers
Construction Industry Training Board
Cookstown District Council
Council for the Homeless NI
Council on Social Responsibility, Methodist Church in Ireland
Craigavon & Banbridge Community Health & Social Services Trust
Craigavon & Banbridge Community Voluntary Sector
Craigavon Borough Council
Craigavon Standing Conference of Women's Organisations
Dental Health, Western Health & Social Services Board
Department of Clinical Chemistry, Royal Group of Hospitals
Department of Nutrition and Dietetics, Braidvalley Hospital
Derry City Council
Derry Healthy Cities
Derry Healthy Cities Community Forum
Derry Well Woman
Diabetes UK NI
Disability Action
Donard Primary Care Commissioning Group
Down District Council
Down's Syndrome Association
Dr R Barr
Dr R Cooke
Dr MJJ Cunningham
Dr Ferguson
Dr T Lee
Drs TD & MC Magowan
Drumcree Community Association
Dungannon & South Tyrone Borough Council
East Belfast Health Issues Working Group
Eastern Area Dental Advisory Committee (EADAC)
Eastern Health & Social Services Board
Educational Guidance Service for Adults
Enterprise Trade and Industry Committee
Environmental Health & Health Promotion Joint Working Group, SHSSB
Equality Commission for Northern Ireland
Farming and Retailing Movement (NI)
Foundation for People with Learning Disabilities
Foyle Health & Social Services Trust
General Consumer Council
Greenpark Healthcare Trust
Groundwork Northern Ireland
Health & Environmental Services, Home Accident Prevention Ballymoney
Health & Social Services Councils
Health Care, Foyle Health & Social Services Trust
Health Issues Working Group – East Belfast Partnership
Health Promotion, EHSSB
Health Promotion Agency NI

Health Promotion Department, Westcare Business Services
 Health Visitors for Foyle Health & Social Services Trust
 Health Visitors, District Nurses, Primary Care, EHSSB
 Heartstart Glens Alert
 Help the Aged (NI)
 Home Accident Prevention Ards Group
 Home Accident Prevention Bangor Group
 Home Accident Prevention Coleraine Group
 Home Accident Prevention Limavady Group
 Homefirst Community Dental Service
 Homefirst Community Trust
 Human Resource Adviser, Duke of Edinburgh Award Scheme
 Institute of Directors – Belfast
 Institute of Public Health in Ireland, Royal College of Physicians
 Inter-Departmental Group on Voluntary Activity and Community Development
 Irish Association of Dermatologists
 Irish Congress of Trade Unions
 Lagan Valley Hospital
 Larne Borough Council
 Larne Community Meeting
 Learn & Grow, Belfast
 Lisburn Primary Care Commissioning Pilot
 Macmillan Cancer Relief
 Mater Hospital Trust
 Medical Committee of Area Medical Advisory Committee
 N.I. Affairs Committee of the Faculty of Public Health Medicine
 N.I. Association of Citizens Advice Bureau
 N.I. Tenants Action Project
 NATFHE, The University & College Lecturer's Union
 National Board for Nursing, Midwifery and Health Visiting for NI (NBNI)
 National Carers Association
 National Childbirth Trust (Region 8)
 National Deaf Children's Society
 National Energy Action Charity
 National Schizophrenia Society
 Newry and Mourne District Council
 Newtownabbey Community Meeting
 Nexus
 NI Centre Chartered Institute for Environmental Health
 NI Committee for Public Health Medicine & Community Health, BMA
 NI Physical Strategy Implementation Group
 NI Regional Network of Health Promoting Hospitals
 NI Section Royal College of Psychiatrists
 NI Council Ethnic Minorities (NICEM)
 North & West Belfast Health & Social Services Trust
 North & West Belfast Health Action Zone (HAZ)
 North & West Belfast HAZ - Lenadoon Community Forum
 North & West Belfast HAZ - North Belfast Partnership Board Community Forum
 North & West Belfast HAZ - Poleglass & Twinbrook Community Forum

North & West Belfast HAZ - Shankill Community Forum
North and West Belfast HAZ - Falls Forum
North & West Locality Primary Care Consortium
North Antrim Community Network
North Down Borough Council
North Down Primary Care Association
North Eastern Education & Library Board
North West Institute of Further and Higher Education
Northern Health & Social Services Board
Northern Ireland Assembly - Culture, Arts and Leisure Committee
Northern Ireland Assembly - The Committee of the Centre
Northern Ireland Assembly - Health, Social Services & Public Safety Committee
Northern Ireland Assembly - Social Development Committee
Northern Ireland Campaign for M.E./C.F.S. Healthcare
NI Centre for Post-Graduate Pharmaceutical Education & Training (NICPPET)
Northern Ireland Environment Link
Northern Ireland Fire Brigade
Northern Ireland Housing Executive (NIHE)
Northern Ireland Human Rights Commission
Northern Ireland Women's European Platform
Nutrition and Dietetic Department Causeway Health & Social Service Trust
Oaklee Housing Association
Occupational Health Service
Omagh District Council
Omagh Women's Area Network
Parenting Forum NI
Pedal Power
Pharmaceutical Society of Northern Ireland
Public Health Alliance for NI
Rathenraw Community Development Project
Regional Forum for Domestic Violence
Relatives for Justice
Royal College of Nursing
Royal Hospitals, Belfast
Royal Victoria Hospital, Accident & Emergency Unit
Royal Society for the Prevention of Accidents (ROSPA)
Rural Community Network
Rural Development Council
School of Nursing & Midwifery, Queens University Belfast
School of Public Policy, Economics & Law, University of Ulster, Jordanstown
Simon Community
Society of Health Education & Health Promotion Specialists (SHEPS NI)
South & East Belfast Primary Care Group
South & East Belfast Trust
South Belfast Partnership
South Eastern Education & Library Board
Southern Area Health Promotion Department, SHSSB
Southern Area Obstetrics & Gynaecology Division, Craigavon Area Hospital

Southern Area Pharmaceutical Advisory Committee
 Southern Education & Library Board Youth Service
 Southern Health & Social Services Board
 Speech Matters
 Sperrin Lakeland Health & Social Services Trust
 Sports Council for Northern Ireland
 Strabane District Council
 The British Psychological Society (Division of Clinical Psychology NI)
 The Civic Forum
 The Committee of the Centre, Northern Ireland Assembly
 The Men's Project
 The Northern Ireland Confederation for Health and Social Services (NICON)
 The Northern Ireland Federation of Housing Associations
 The Royal College of Anaesthetists
 The Royal College of Midwives
 The Royal Group of Hospitals Health & Social Services Trust
 The Samaritans
 Threshold
 TTT Holistics Ltd
 Ulster Cancer Foundation
 Ulster Community and Hospitals Trust
 Ulster Community & Hospitals Trust – Health & Care Centre
 Ulster Community & Hospitals Trust – Breastfeeding Adviser
 Ulster Gynae Urology Society, Antrim Area Hospital
 UNISON
 United Hospitals Health & Social Services Trust
 University of Ulster at Coleraine
 Voluntary Service Belfast
 Volunteer Development Agency
 West Belfast Economic Forum
 West Belfast Homeopathy Support Group
 Western Area Nursing & Midwifery Advisory Committee, WHSSB
 Western Health & Social Services Board
 Western Health Board (Galway)
 Women's Aid Federation
 Women's Forum Northern Ireland
 Women's Information Group
 Work-Life Balance Campaign Executive, Business in the Community NI
 World Health Organisation (WHO) Healthy Cities & Urban Governance

Ms Sandra Adams
 Ms Gerry Bleakney
 Mr Norman Campbell
 Ms Joanne Campbell
 Miss Heather Collins
 Ms Oonagh Conway
 Ms Meg Doherty
 Ms Nuala Donaghy
 Mr Tom Gourley

Mr Robert Hicks
Ms Anna Leech
Ms Angela McCrystal
Mr Noel McKenna
Ms L McWilliams
Mr Noel Mitchell
Ms Mary Mooney
Ms Fiona Mulholland
Ms Pauline O'Hare
Mrs Elizabeth O'Loughran
Mr Andrew Richardson
Mr Peter Ruddy
Mr Pat Scully
Mr Paul Smyth
Ms Alison Sutherland
Ms Mary Taylor
Ms S Wilson
Mr Carson
Ms Walker

5 Anonymous responses were also received

ANNEX 3 : GOALS, OBJECTIVES AND ASSOCIATED TARGETS

– TECHNICAL SUPPLEMENT

This Annex describes the sources and methods for calculating measures for each of the targets. It also explains the rationale behind the target setting, taking cognisance of historical trends and actions and targets contained in other strategies.

Overarching Goals

GOAL 1

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

Target (i):

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

Data source

Registrar
General's Report.

Baseline

Baseline figures were taken from the Registrar General's Report 2000. The latest available year for life expectancy was 1998-00. Life expectancy is calculated based on 3 years of deaths data, in this case, 1998, 1999 and 2000.

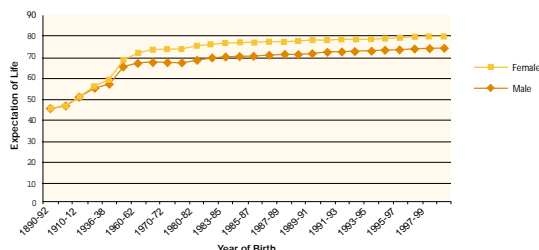
The life expectancy for males born in 1998-00 was 74.5 years and for women it was 79.6 years.

Historical trends

Life expectancy has been rising since 1890-92, when it was 46.3 for men and 45.7 for women (Figure 1). The Government Actuary's Department calculate life expectancy projections for England, Scotland, Wales and here. These projections are based on mortality rates. The mortality rates for the first year of the projection, 2000-01, are based on the best estimates that could be made in the autumn of 2001 of the numbers of deaths at each age in 2000-01. Expectation of life at birth based on these rates in 2000-01 is 75.5 years for men and 80.5 years for women.

Future improvements in mortality rates are based on the trend in mortality rates in the years up to 1999. The same future improvements have been assumed for all countries except that slightly smaller improvements in the period to 2025 have been assumed at some ages for males in Scotland. These improvements are based on reductions in mortality rates, based on cohort trends and period trends up to 2025.

Figure 1
Life expectancy at birth 1890-1999



Source: Continuous household survey

Life expectancy for a baby boy born in 2010-11 will be 76.8 and for a baby girl it will be 81.3 according to Government Actuary Projections.

European comparisons

Life expectancy for males here is 2.1 years less than in Sweden (the best in Europe for males). For females, life expectancy is 2.4 years less than in France (the best in Europe for females).

Target to be achieved

The target is to increase life expectancy by 3 years for men and by 2 years for women between 1998-00 and 2009-11. If this target is met, life expectancy for men will increase from 74.5 to 77.5 and for women from 79.6 to 81.6.

Rationale

Government Actuary Projections show that life expectancy is expected to increase to 76.8 for men and 81.3 for women in 2010-11. It has been estimated that the objectives, targets and actions within this strategy will result in these projected figures being surpassed, resulting in life expectancy of 77.5 years for men and 81.6 years for women (an increase of 3 years for men and 2 years for women between 2000 and 2010). It is recognised that many factors contribute to the expectation of life and it is therefore impossible to predict with absolute certainty that this target will be achieved. There are many factors such as lifestyle choices (smoking, alcohol consumption, physical activity etc.) that impact on life expectancy. To take account of all such factors would require a complex piece of research to be carried out and this was not possible within the timescale for the production of the strategy. With regard to European comparisons as discussed above, the difference in life expectancy in 1998 for males here compared to the best in Europe was 2.1 years and for females it was 2.4 years. Therefore, this target will move life expectancy here towards that of the best in Europe. It is recognised that these goal posts are shifting, that is, as life expectancy here increases, it is expected that life expectancy for the other European countries will also increase.

Goal 2:

To reduce inequalities in health between geographic areas, socio-economic and minority groups.

Target (i):

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

Data source

The sources are deaths data from the General Register Office and ward population figures from the 1991 Census of Population. Deprived wards have been identified using the Noble Multiple Deprivation Measure.

Baseline

Average life expectancy - Baseline figures for the average life expectancy were taken directly from the Registrar General's Report 2000. The latest available year for life expectancy was 1998-00.
Life expectancy for the fifth most

deprived wards - Life expectancy for residents in these wards were calculated using standard methodology used by DMB to calculate life expectancy. Deaths data from the General Register Office for residents in the 20% most deprived wards who had died during 1998-2000 were applied to the calculation.

Historical trends

Historical data are available for average life expectancy. Historical life expectancy data are not available for the fifth most deprived wards. This is because the deprived wards were selected using the Noble Deprivation Measures. These measures were published in July 2001. It is not practical to apply these deprivation measures prior to 1998 because a different set of deprivation measures applied at this time. In the future, the Noble measures will be updated and therefore it will be possible to identify the fifth most deprived wards accurately.

Target to be achieved

The Target is to reduce the gap in life expectancy between those living in the fifth most deprived wards and the average life

Table 1. Life expectancy figures 1998-00

| Area | Males (years) | Females (years) |
|---------------------------|---------------|-----------------|
| NI average | 74.5 | 79.6 |
| Fifth most deprived wards | 71.4 | 77.1 |
| Gap at 1998-00 | 3.1 | 2.5 |
| Target gap in 2009-11 | 1.55 | 1.25 |

expectancy here for both men in women. This will result in the gap for men decreasing from 3.1 years in 1998-00 to 1.55 years in 2009-11 and the gap for women decreasing from 2.5 years in 1998-00 to 1.25 years in 2009-11.

Rationale

In the absence of historical trends of life expectancy for the fifth most deprived wards, it has not been possible to predict life expectancy for this group in 2009-11. The current gap in life expectancy is 3.1 years for men and 2.5 years for women. It has been agreed that the reduction in this gap should be challenging and therefore it has been decided to reduce the gap for both men and women by 50%. This is in line with the overriding aim of *Investing for Health* to reduce health inequalities.

Target (ii):

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

Data source

The source for the data is the Continuous Household Survey. The proportion of people aged 16+ with a long standing illness in socio-economic groups 1 & 2 and 6 & 7 has been calculated.

Definition of socio-economic group classifications:

Socio-economic group 1
Professional

Socio-economic group 2
Employer, manager

Socio-economic group 3
Intermediate non-manual

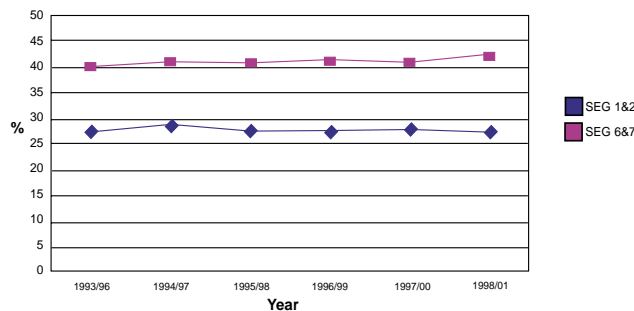
Socio-economic group 4
Junior non-manual

Socio-economic group 5
Skilled manual

Socio-economic group 6
Semi-skilled manual

Socio-economic group 7
Unskilled manual

Figure 2
Trends in long-standing illness by socio-economic group (3 year moving average)



Source: Continuous Household Survey

Baseline

The proportion of people reporting a long standing illness over the three years 1998/99-2000/01 was 27.3% in socio-economic groups 1 & 2 (SEG 1&2) and 42.2% in socio-economic groups 6 & 7 (SEG 6&7). The average over 3 years has been calculated to account for any sampling errors that may have occurred.

Historical trends

The trends in long standing illness in SEG 1&2 and SEG 6&7 are shown in Figure 2. The trends are presented in terms of 3 year moving averages. The gap in the proportion of people reporting long standing illness has remained fairly constant between 1993/96 and 1998/01, although the largest gap occurred in this last year (a difference of 15 percentage points). If it was assumed that this trend will continue, no reduction in the gap would be expected by 2010.

Target to be achieved

The target is to reduce the gap in the proportion of people with a long-standing illness between those in the lowest and highest socio-economic groups by one fifth between 2000 and 2010. If achieved, this will result in a reduction in the gap from 15 percentage points in 1998/99-2000/01 to 12 percentage points in 2008/09-2010/11.

Rationale

One of the main aims of *Investing for Health* is to reduce the gap in health inequalities. While the historic trends do not indicate that a reduction in the gap would be expected, it is hoped that the objectives, targets and actions in *Investing for Health* will result in such a reduction.

Objective 1:

To reduce poverty in families with children

No high level target.

Objective 2:

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

Target (i):

- In the 25% of Primary Schools with the highest percentage Free School

Meal Entitlement (FSME), to reduce the proportion of pupils not achieving the expected level (level 4) at Key Stage 2 to 25% in both English and Mathematics by 2005/06.

Target (ii):

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

Target (i)

Data source

The source of the data is Key Stage 2 results. Key Stage 2 covers years 5, 6 and 7 in primary school. These data are based on teacher assessment and consist of summary information at school level of the results achieved by pupils aged 11 at the end of Key Stage 2 (year 7).

Baseline

Baseline figures were taken from the Key Stage 2 results for 2000/01. The proportion of pupils not achieving the expected level in the 25% of primary schools with the highest percentage of FSME in English was 40%. The equivalent figure for Mathematics was 36%.

Historical Trends

Key Stage assessments were first introduced here in 1997. However due to industrial action data from that initial year were unreliable. Data for the last four years are presented below.

The proportion of pupils not achieving the expected level (level 4) at Key Stage 2 in the 25% of Primary Schools with the highest percentage Free School Meal Entitlement

| | English | Mathematics |
|-----------|---------|-------------|
| 1997/98 | 47.4% | 41.3% |
| 1998/99 | 44.9% | 38.8% |
| 1999/2000 | 42.1% | 36.2% |
| 2000/01 | 39.5% | 36.4% |

Target to be achieved

This target is to reduce the proportion of primary school children at the most socially disadvantaged schools who do not achieve the expected level at the end of Key Stage 2 (year 7). If this target is achieved, the proportion of primary school children not achieving the expected level at Key Stage 2 will be reduced to around two-thirds of the current proportion.

Rationale

Based on a linear extrapolation of historical trends, the proportion of primary school children not achieving the expected level by 2005/06 would be 26% for English and 28% for Mathematics. This target has been set to be slightly more challenging but is felt to be achievable.

Target (ii)

Data source

The source of the data is the Summary of Annual Examination Results (formerly the School Performance Survey). These data are obtained from schools via the CLASS system and collated into a summary format on an annual basis.

Baseline

Baseline figures were taken from the Summary of Annual Examination Results for 1999/2000. The proportion of post-primary pupils in schools with the highest level of FSME achieving no GCSEs was 8.5%.

Historical Trends

School performance results have been produced here since 1991/92. Data for the last five years are presented below.

The proportion of year 12 pupils achieving no GCSE in the 25% of Post-Primary Schools with the highest percentage Free School Meal Entitlement

| | % |
|-----------|------|
| 1995/96 | 10.9 |
| 1996/97 | 9.7 |
| 1997/98 | 8.0 |
| 1998/99 | 7.7 |
| 1999/2000 | 8.5 |

Target to be achieved

This target is to reduce the proportion of year 12 pupils in schools with the highest level of FSME achieving no GCSEs. If this target is achieved, the proportion of year 12 pupils achieving no GCSEs will be reduced by between one third and one half.

Rationale

Based on a linear extrapolation of historical trends the proportion of post-primary pupils not achieving GCSEs would be 5%.

OBJECTIVE 3:

To promote mental health and emotional well-being at individual and community level.

Target (i):

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

Data source

The source of the data is the Health and Social Well-being Survey. The survey uses the General Health Questionnaire (GHQ12) to assess levels of depression, anxiety, sleep disturbance and happiness in the population. A GHQ12 score of 4 or more - a 'high GHQ12 score' - indicates a potential psychiatric disorder. The GHQ12 score is explained in more detail in the section titled 'Further explanation of GHQ12 score'.

Baseline

Baseline figures were taken from the 2001 Health and Social Well-being Survey. The proportion of people with a potential psychiatric disorder in 2001 was 21%.

Historical Trends

There is little historical data on GHQ12 as the Health and Social Well-being Survey has only been run here in 1997 and 2001.

Target to be achieved

The target is to reduce the proportion of people with a potential psychiatric disorder by a tenth. If this is met, the proportion of people with a potential psychiatric disorder in 2010 will be 19%.

Rationale

The projections show that based on historic figures, the proportion of people with a psychiatric disorder is falling. It is recognised that this is only based on two years of historic data. The target has been set to reduce the proportion to 19% by 2010. It is expected that the actions contained within the strategy will ensure that this target is met.

Further explanation on GHQ12

The GHQ is the most widely used population measure of psychological disturbance in the United Kingdom. It was developed in England in the 1960s and 1970s and was intended for use in the setting of general practice. In the Health and Social Well-being Survey the 12-item form (GHQ12) was used, which is more suitable for use with older and more frail people. The GHQ is a self-completion questionnaire which concentrates on the broader

components of psychological morbidity especially anxiety and depression. Each of the twelve items has four possible answers; the positive (e.g. better than or about the same as usual) are given a score of 0 and the negative responses (e.g. doing less well or much less well than usual) are given a score of 1. A maximum score of 12 is possible for each individual. A low score represents low probability of psychological morbidity whereas a high score indicates probable psychological disturbance. In this case, a score of 4 or more indicates that the person has a potential psychiatric disorder.

OBJECTIVE 4:

To offer everyone the opportunity to live and work in a healthy environment and to live in a decent affordable home.

Target (i):

- **To lift at least 20,000 households out of fuel poverty by December 2004.**

Target (ii):

- **Over the 2 year period April 2002 to March 2004, to support housing providers to build around 2,400 lower cost, affordable homes for people on lower incomes.**

Target (i) Data Source

Northern Ireland Family Expenditure Survey (NIFES)

Baseline

Baseline figures were calculated using three years data (1995-1998) from the NIFES. This estimated that 170,000 households are at risk of fuel poverty (needing to spend more than 10% of total income to maintain a satisfactory heating regime). The results of the 2001 House Condition Survey, available in autumn 2002 will provide more accurate count.

Historical trends

No historical data are available.

Target to be achieved

The target is to reduce the total number of households living in fuel poverty by 20,000 by December 2004.

Rationale

Fuel Poverty contributes to ill health and causes excess winter deaths. The main vehicle for eradicating fuel poverty is the Warm Homes Scheme. The scheme provides insulation and heating systems for vulnerable households. 4,500 heating and insulation jobs were carried out during 2001/02. It is expected that at least 6,250 homes will be targeted in 2002/03.

Target (ii) Data source

The Housing Executive publishes 'The Northern Ireland Housing Market - Review and Perspectives' on an annual basis. This provides a comprehensive insight into all housing sectors and determines the level of social housing need, now provided almost exclusively by the housing association sector.

Baseline

The Housing Executive's Net Stock Model indicates a gross annual need of 1500 units of social housing. However, current budgets will provide only 1200 units per annum.

Historical Trends

The social housing increase in provision for rent from 1997 to 2002 is set out in the table below.

| Year | Provider | | Totals |
|---------|-------------------|----------------------|--------|
| | Housing Executive | Housing Associations | |
| 1997/98 | 452 | 1600 | 2052 |
| 1998/99 | 90 | 2108 | 2198 |
| 1999/00 | 49 | 1744 | 1793 |
| 2000/01 | 42 | 1104 | 1146 |
| 2001/02 | - | 1200 | 1200 |

OBJECTIVE 5:

To improve our neighbourhoods and wider environment.

Target (i):

- **To reduce levels of respiratory and heart disease by meeting the health-based objectives for the 7 main air pollutants (see Table) by 2005.**

Data source

Standards for air pollution are concentrations over a given time period that are considered to be acceptable in the light of what is

known about the effects of each pollutant on health and on the environment. They can also be used as a benchmark to see if air pollution is getting better or worse. Air pollution data from the UK air quality monitoring networks is collated and presented through the UK National Air Quality Information Archive www.aeat.co.uk/netcen/airqual/

Baseline data

In 2000, the average number of exceedences of the National Air Quality Objectives across all monitoring sites in here were as recorded below:

| Pollutant | Objective | | Average number of exceedences of NAQS objective in 2000 |
|------------------|---|----------------|---|
| | Concentration | Measured As | |
| Particles (PM10) | 50 µg/m ³ not to be exceeded more than 35 times a year | 24 hour mean | 5 |
| Sulphur dioxide | 350 µg/m ³ (132ppb) not to be exceeded more than 24 times a year | 1 hour mean | 1 |
| | 266 µg/m ³ (100ppb) not to be exceeded more than 35 times a year | 15 minute mean | 24 |

Source: UK National Air Quality Information Archive

Historical Trends

There have been no exceedences of the National Air Quality Objective standards for benzene, 1,3-butadiene and carbon monoxide since 1995. Lead concentrations have fallen dramatically since the reduction of the lead content of leaded petrol in 1986 and the introduction of unleaded petrol in 1987. Whilst lead is not monitored on an on-going basis here, a report⁶² on the monitoring of metals around industrial sites published in 2001, concluded that the Objective standard was not exceeded at any monitoring location. There have been no exceedences of the nitrogen dioxide Objective standards at Belfast or Derry since 1997. For particulate matter (PM10), exceedences of the 24 hour mean have shown a general improvement since 1997. There have been no exceedences of the Objective standards at the rural site at Lough Navar in Co. Fermanagh. The Belfast East monitoring station has consistently recorded a greater number of exceedences of the Objective standards for sulphur dioxide than the City Centre site. The number of exceedences recorded at the Belfast Centre site has fallen significantly, however, peak and annual average levels at all local sites remain higher than for most other UK sites.

Target to be achieved

The target is to reduce levels of respiratory and heart disease by

meeting the health-based objectives for 7 key air pollutants (see table 11a) by 2005.

Rationale

The main causes of outdoor air pollution here are our high dependence on solid fuel for domestic heating and emissions from motor vehicles. Air pollution is more common in urban areas, places that are often characterised by other indicators of disadvantage. Analyses^{63,64} of air pollution and social deprivation in four cities including Belfast have indicated tentative evidence for a general positive correlation between background air pollution (nitrogen dioxide and particulate matter (PM10)) and deprivation index. The Acheson Report⁶⁵ on Inequalities in Health comments on the causal link between air pollution and respiratory disease. The *Programme for Government* has as one of its actions "by May 2003, to have in place a policy and legislative framework to deliver our contribution to the targets in the UK Air Quality Strategy". The Strategy objectives are generally based on the recommendations of the Expert Panel on Air Quality Standards (EPAQS) and are derived from medical and scientific evidence of how each pollutant affects human health.

District Councils are currently reviewing and assessing local air quality to identify areas where health based objective limits are, or are likely to be exceeded. The actions likely to impact most on air quality include smoke control

programmes, the Housing Executive's programme to replace solid fuel room heaters, the development of the local natural gas market, improvements in vehicle engine and fuel technology and integrated transport management measures.

OBJECTIVE 6:

To reduce accidental injuries and deaths in the home, workplace and from collisions on the road.

Target (i):

- **To reduce the death rate from accidents in people of all ages by at least one fifth between 2000 and 2010.**

Target (ii):

- **To reduce the rate of serious injuries from accidents in people of all ages by at least one tenth between 2000 and 2010.**

Target (i)

Data source

Standardised death rates were calculated using data from the deaths database maintained by the General Register Office and Mid Year population estimates. Rates are age standardised to the 1991 Census of Population per 100,000 population. With regard to deaths, diagnosis of ICD-9* E800-E949 were selected.

Baseline data

In 2000, the age standardised death rate from accidents was 20.6 per 100,000 population.

Historical Trends

Standardised death rates from accidents in 1995 to 2000 are given in Table 2. The figures have fluctuated year to year but between 1995 and 2001 the death rate dropped by 11.6%. However this is mainly due to the drop between 1999 and 2000.

Table 2

| Year | Standardised death rate |
|------|-------------------------|
| 1995 | 23.3 |
| 1996 | 23.6 |
| 1997 | 25.1 |
| 1998 | 22.1 |
| 1999 | 23.6 |
| 2000 | 20.6 |

Source: GRO
MYE population estimates Standardised to 1991 Census of Population

Target to be achieved

The target is to reduce the death rate from accidents in people of all ages by at least one fifth between 2000 and 2010. This will result in a reduction from 20.6 per 100,000 in 2000 to 16.5 per 100,000.

Rationale

(see under 'Rationale' for Target ii).

Target (ii)

Data source

The source for the data is the Hospital Inpatients System. Serious injuries are classified as admissions to hospital requiring a stay of four days or more.

- Primary diagnosis must indicate an injury, ICD-10* code S00 – T98X.
- External cause code must be in the range:
V01 – V99 Transport Accidents
W00 – X59 Other external cause of accidental injury (mostly falls).
Y40 – Y84 Complications of medical and surgical care.

* ICD-9, ICD-10 (International Classification of Diseases Ninth and Tenth revision)

The World Health Organisation maintains a statistical classification of diseases, injuries and causes of death, which is internationally recognised and used. The ninth revision of this classification (ICD-9) was used here in 2000 for differentiating causes of death, but the tenth revision (ICD-10) is used for classifying hospital episodes. ICD-10 will be used for coding mortality from the year 2001.

Age standardised admission rates were calculated using data from the Hospital Inpatients System and Mid Year population estimates. Rates are age

standardised to the 1991 Census of Population per 100,000.

Baseline

The age-standardised admission rate for serious injuries per 100,000 in 2000/01 was 406.6.

Historical trends

The trends in admission rates for serious injuries are shown in Table 3

Table 3

| Year | Standardised admission rate |
|---------|-----------------------------|
| 1996/97 | 277.1 |
| 1997/98 | 351.0 |
| 1998/99 | 446.2 |
| 1999/00 | 373.6 |
| 2000/01 | 406.6 |

Source: Hospital Inpatients System
MYE population estimates Standardised to 1991
Census of Population

The figures fluctuate from year to year, but overall between 1996/97 and 2000/01 the rate increased by 46.7%.

Target to be achieved

The target is to reduce the rate of serious injuries from accidents in people of all ages by one tenth between 2000 and 2010. This will result in a reduction from 407 serious injuries per 100,000 in 2000/01 to 366 per 100,000.

Rationale

Targets i and ii have not been set based on historical trends.

Rather, both have been set to mirror the English targets in 'Saving Lives: Our Healthier Nation'. This is to ensure the targets are challenging and that a reduction in both deaths and serious injuries from accidents is achieved. To substantiate the reason for setting the same target here, there are currently a number of targets in other departmental strategies aimed at a reduction of serious injuries from accidents by more than 20%. For example, the Department of the Environment are currently considering a target to reduce the numbers killed or seriously injured by 33% by 2010.

OBJECTIVE 7:

To enable people to make healthier choices.

Target (i):

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

Target (ii):

- **By 2010 to increase the levels of 5 year old children with no dental**

decay experience to 55% and to reduce the gap between the best and worst decayed/missing/filled scores by 20%.

Target (i)

Data source

The source for the data is the 1997 Health and Social Wellbeing Survey. From measurements of height and weight, informants' Body Mass Index (BMI) was calculated as the respondent's weight in kilograms divided by the square of their height in metres. Obesity was defined as having a BMI greater than 30 kg/m², and being overweight (but not obese) was defined as having a BMI in the range 25 kg/m² to 30 kg/m². These measurements were not collected in the 2001 Health and Social Wellbeing Survey, and therefore no obesity figures are available.

Baseline

In 1997, the proportion of men and women who were obese was 17% and 20%.

Historical Trends

Data are only available for 1990, 1994 and 1997 (Table 4).

Table 4. Proportion of people aged 16+ who were obese

| Year | Men | Women |
|------|------|-------|
| 1990 | 8.3% | 16% |
| 1994 | 16% | 21% |
| 1997 | 17% | 20% |

Source: Change of Heart Baseline 1990
Health and Activity Survey 1994
Health and Social Wellbeing Survey 1997

These figures show a large increase in the proportion of people who were obese between 1990 and 1994. Between 1994 and 1997, there was a slight increase for men of 1 percentage point, while for women there was a slight decrease of 1 percentage point.

Target to be achieved

The target is to ensure that by 2010, the levels of obesity do not increase above the levels of 17% for men and 20% for women.

Rationale

It is recognised that no specific target measure of obesity has been set for 2010. This is because there is no evidence based on historical trends that a reduction will be achieved. It is accepted that any increase in the proportion of men and women who are obese is unacceptable and therefore the target has been set to reflect this. This target is designed to reflect the aims of other strategies such as the Physical Activity Strategy and the Food and Nutrition Strategy. For example, one of the targets in the Physical Activity Strategy is to reduce the proportion of men and women aged 16 and over who are classified as sedentary.

Target (ii) First part of target

Data source

The source of this data is the UK Child Dental Health Survey. This

survey is run every ten years and was last conducted in 1993. Estimate III of the proportion of 5 year old children estimated to have no decay experience was used. Estimate III assumes:

- all missing teeth except incisors were extracted due to decay or were diseased before they exfoliated;
- missing upper incisors had exfoliated without being diseased unless three or four of the upper incisors were absent without any eruption of the permanent dentition;
- missing lower incisors had exfoliated without being diseased unless any of the lower anterior teeth were present and diseased or either canine was missing, in which case assumes the missing lower incisors were decayed.

Baseline

The percentage of 5 year old children with no dental decay experience in 1993 was 37%.

Historical trends

In 1983, 22% of 5 year old children had no dental decay experience, compared to 37% in 1993 (UK Child Dental Health Surveys). In 1999, Community Dental screening programmes for Primary 2 children showed that 43% had no dental decay experience.

Rationale

This target is based on a target that was set during the mid-term evaluation of the Oral Health Strategy in 2001. The original target (set in 1995) was to increase the proportion of 5 year old children with no dental decay experience from 37% to 60% in 2003. This was revised in 1998 from 60% to 45% to reflect the extent to which the strategy depended upon the introduction of fluoridation. When the 1999 figures from Community dental screening became available and showed that 43% of 5 year old had no dental decay experience, it was decided to revise the target again from 45% to 50% in 2003. It is recognised that these sources are not directly comparable, but it was felt that they were sufficiently relevant to inform the decision as to whether the target set in 1998 would continue to be relevant and robust. It was agreed that a suitable target for 2010 would be 55% based on the target of 50% being achieved in 2003.

Second part of target

Data source

The source for the data is Community Screening data. This is collected by HSS Trust Community Dental Officers during the screening of Primary 1 children in all schools here. Data quality problems due to standardisation and positive consent in recent years mean that the most recent robust data available is for 1996/97. An average decayed/missing/filled

(dmf) score is available for the pupils in Primary 1 in each school. The dmf score is the number of teeth in a person's mouth that are decayed, missing or filled.

In 1996/97, a number of schools had a dmf score of 0, while others had a score of 7. These extreme scores are more probably due to data error than bad teeth. Therefore it has been agreed that a suitable measurement would be the gap between the scores at the 10th and 90th percentiles to remove these outliers.

Presently, a new Community Screening database is being piloted in the Western Health and Social Services Board. It is anticipated that this system will be adopted across all Trusts and lead to the production of reliable data. This source will be used to monitor the target in the future.

Baseline

The best and worst dmf scores in 1996/97, that is, at 10th and 90th percentiles, were 0.6 and 3.5 respectively. Therefore, the gap in 1996/97 was 2.9.

Historical trends

No historical data are available.

Target to be achieved

The target is to reduce the gap in the best and worst score by a fifth. At present, the gap between the 10th and 90th percentiles is 2.9. A reduction of a fifth will result in a gap of 2.32.

Rationale

In the absence of historical screening data to predict dmf scores in 2010. It has been agreed that the reduction in this gap should be challenging and therefore a decision has been made to reduce the gap by a fifth. This is in line with the overriding aim of *Investing for Health* to reduce health inequalities.

ANNEX 4 : KEY RESPONSIBILITIES IMPACTING ON HEALTH OF EACH DEPARTMENT (WITH CONTACT POINTS)

Department for Social Development (DSD)

MGPH representative:
Mrs Pauline Keegan
(Tel No: 028 9056 9262)

The Department for Social Development's mission statement is "Together, tackling disadvantage, building communities." Many of its policies impact on health and well-being. It interacts on a regular basis with many of the poorest in our society. It has a key role to play in Targeting Social Need and it is tasked with tackling disadvantage, and has responsibility for improving housing, delivering social security benefits, providing child support services, strengthening and developing the community infrastructure, and regenerating the most disadvantaged urban neighbourhoods. Key elements of current DSD strategies include:

Introducing comprehensive strategies to address the problems of multiple disadvantage in urban areas, which will:

- target action on the most disadvantaged neighbourhoods;
- empower communities to shape and then drive Neighbourhood Renewal initiatives in their own areas;
- commit Government to long term support for these

neighbourhoods; and

- include action to improve health.

Assisting the Housing Executive and the Housing Association movement to provide housing and deliver a range of services including:

- building high quality affordable social housing for those on low incomes;
- remedying unfitness in social and private sector housing;
- assisting homeless people;
- increasing adaptations to existing houses to make them accessible to people with disabilities;
- providing more special needs housing for disabled people and other vulnerable groups;
- developing appropriate permanent accommodation which meets the special needs of Travellers;
- improving energy conservation and reducing fuel poverty;
- designing safety into housing provision.

Promoting policies to sustain and enhance local communities, particularly those in the most disadvantaged areas by:

- rebuilding a sense of community by encouraging and supporting all forms of community involvement;
- strengthening areas of weakest community infrastructure;
- introducing community support plans through District Councils to underpin the work of local voluntary and community groups.

Implementation of the Welfare Reforms and Modernisation Programme, including:

- Child Support Reforms, which puts the interests of children first and will make a significant contribution to eliminating child poverty;
- assisting the Inland Revenue to implement the integrated child credit to provide increased financial support for people on low incomes;
- implementing fully the ONE Initiative across Departments and agencies to provide joined up welfare and employment services.

In areas such as social security, where policies are determined at Westminster, the Executive will seek to ensure that they protect

our interests and advance our health improvement objectives.

Department of Education (DE)

MGPH representative:
Mr Stephen Peover
(Tel No: 028 9127 9313)

The Department of Education is taking active steps to provide, for all children and young people, opportunities to acquire:

- the critical skills to evaluate realistically the situations and decisions they face in life;
- the information necessary for them to make informed decisions about their personal behaviour, be it on diet and hygiene, care of their environment, alcohol or other drug-taking, smoking or danger of abuse by others;
- the confidence and self-esteem to be able to make the decisions which are in their own best interests, even where this may mean temporary unpopularity.

These skills are already an integral part of most schools' pastoral care and personal development programmes, and are intrinsic to the new revised statutory curriculum which is currently being consulted upon. They are also integral to the purpose and curriculum of the youth service, where they can be reinforced in informal settings.

Teaching about health matters and healthy lifestyles, including how the body works, and education specifically on the harmful effects of alcohol, smoking and drugs misuse, is already a statutory requirement in all schools, and has been so for the past 8 years.

The revised curriculum will take particular account of the need for improved health education, including sex education, which young people themselves, in a survey, have identified as a priority. The Department has issued revised guidance on Relationships and Sexuality Education, supported by guidance to teachers prepared by the Northern Ireland Council for the Curriculum, Examinations and Assessment.

The involvement of 24 schools here in the European Network of Health Promoting Schools has provided a context and environment for demonstrating, as well as learning about, healthy lifestyles, by all members of the school community. In the area of teenage pregnancy, with partners in the statutory and voluntary sectors, we are investing in a pilot project designed to help school-age mothers in completing their education.

We need also to update the guidance for nutritional quality in school meals and encourage whole school approaches to healthy nutrition through mechanisms such as School Nutrition Action Groups.

Department of the Environment (DOE)

MGPH representative:
Mr Dan Kennedy
(Tel No: 028 9025 4816)

The Department of the Environment has amongst its strategic objectives:

- to protect, conserve and enhance the natural and built environment for the benefit of present and future generations;
- to improve and promote road safety and ensure the proper regulation of drivers, vehicles and operators with a target to ensure continued reduction in road casualties;
- to support a system of local government which meets the needs of citizens and ratepayers.

Other specific key DOE policies include:

- Air Quality Strategy which includes plans to improve and protect ambient air quality with particular focus on eight main air pollutants which affect health;
- Waste Management Strategy which seeks to encourage the sustainable management of waste;
- Nature Conservation and the Countryside: caring for the countryside and wildlife extends to safeguarding a range of sites and species

but also encouraging and promoting enjoyment and helping others to conserve nature;

- Protecting and Recording the Built Heritage in its wider sense contributes to the quality of the environment and plays a significant part in a sense of heritage and well-being.

The Department of the Environment is charged, in collaboration with the other Departments with developing a strategy for implementation of Sustainable Development, taking as the definition "Development that meets the needs of the present without compromising the ability of future generations to meet their own needs". Early sustainable development strategies tended to concentrate on promoting economic growth that was sustainable in terms of meeting objectives on environmental protection and the use of finite natural resources. The latest thinking adds economic and social objectives and clearly has significant potential implications for the health of the public.

Department of Agriculture and Rural Development (DARD)

MGPH representative:
Mr Tony McCusker
(Tel No:028 9052 4628)

The Department of Agriculture
and Rural Development (DARD)

makes a major contribution through its Veterinary and Science Services to the improvement of food safety standards in Northern Ireland and through the advisory function of the Agri-Food Development Service to increasing the availability and accessibility of safe and quality food.

DARD provides information on diet and nutrition through the National Food Survey which has recently been merged with the Family Expenditure Survey. This would mean that data on meals eaten outside the home could be included in the surveys which would provide a better and more complete picture on the Northern Ireland diet.

DARD also has a significant role in the safeguarding of public health with particular reference to the detection and control of zoonotic diseases. Mandatory programmes exist for the control of both bovine tuberculosis and bovine brucellosis. DARD also makes a major contribution to public health and food safety through its work on meat hygiene inspections, ante and post mortem inspections at slaughterhouses, research and development, analytical/diagnostic work and advice and education in both the food and animal disease fields.

It is also one of the Department's major objectives to contribute to the development of rural communities, helping to combat

rural poverty and promoting social inclusion. DARD's contribution to public health is acknowledged in the Programme for Government.

The Department conducts a range of surveillance for the more important zoonotic diseases and carries out work on both chemical and microbiological food safety which includes all the major food borne pathogens. DARD is reviewing its existing surveillance programme to ensure that it continues to be properly focused and prioritized within local, national and EU requirements.

Department of Enterprise, Trade and Investment (DETI)

MGPH representative:
Mr Mike Warnock
(Tel No: 028 9052 9397)

The aim of the Department of Enterprise, Trade and Investment (DETI) is "A balanced, competitive, innovative, knowledge-based and fast growing economy where there are plentiful opportunities for all." DETI's objectives are:

- (1) To encourage the growth of the economy by promoting knowledge-based business competitiveness and an enterprise culture; and

- (2) To develop and maintain the policy and regulatory environment to achieve economic growth with equal opportunities for all.

In regard to the regulatory environment the role played by the Health and Safety Executive for Northern Ireland (HSENI) is pivotal.

HSENI is working to develop an occupational health strategy for Northern Ireland that will tackle, in partnership with all the key stakeholders, the burden of ill health brought on by work or made worse by work.

In addition it will work with the Health Promotion Agency in using the workplace as arena to promote better health and lifestyle practices.

HSENI has opened an ICT based information and Advice Centre with regional outlets that will help those responsible for worker's health, and workers themselves, make informed choices and decisions about workplace health strategies.

In addition DETI is working with other Departments and agencies to raise public health awareness in areas such as encouraging a responsible approach to drugs and alcohol.

Department of Health, Social Services and Public Safety (DHSSPS)

MGPH representative:
Mr John McGrath
(Tel No: 028 9052 2733)

The primary purpose or mission of the Department of Health, Social Services and Public Safety (DHSSPS) is:-

"To improve the health and social well-being of the people of Northern Ireland".

DHSSPS has a clear responsibility for setting the strategic direction and overseeing the delivery of the health and personal social services. It also promotes voluntary activity and community development in the health sector.

DHSSPS also has responsibility for promoting health and social wellbeing. In this regard, we are developing and implementing a range of lifestyle strategies on smoking, physical activity, nutrition, alcohol, and drugs. Work is underway to take forward strategies dealing with home accidents and workplace health. Action is being taken to promote positive mental health, particularly targeting suicide in young men.

DHSSPS has an important health protection and disease prevention role. Communicable diseases such as meningitis and influenza continue to present a danger. Immunisation

programmes have made an important contribution to improving health protection this century and our childhood immunisation rates have improved over the past decade. However, there are still some areas with low uptake rates where there is the potential for epidemics to occur. We need to do more to ensure awareness of the benefits of immunisation and to improve uptake. Similarly, among high-risk groups of all ages, but in particular the elderly, annual flu and pneumococcal immunisations reduce the risk of illness, during winter months, but the current uptake rates need to be improved with co-ordinated effort, and appropriately resourced. Screening programmes for breast and cervical cancer are already in place as are a range of antenatal and neonatal screening programmes.

Department for Employment and Learning (DEL)

MGPH representative:
Ms Bernie O'Hare
(Tel No: 028 9025 7769)

DEL's key strategy will be to help people without employment find work and also to promote a policy of lifelong learning. In education and lifelong learning DEL aims to widen access to under-represented sections of society and to increase participation across all age groups. In further education, the Department's aim is to

review and enhance the provision of literacy skills education and reduce the number of adults with low literacy skills. A review of literacy skills education and under-representation of sections of society will be completed. The Department will increase the number of places available in further and higher education. In employment DEL aims to provide an efficient and effective employment service matching people with jobs or appropriate training opportunities. In training programmes, the Department will aim to extend help to the unemployed, particularly disadvantaged groups, to improve their opportunities to gain suitable employment. In addition, the Department will also aim to provide young people with new training opportunities, to improve skills and motivation and enhance employment prospects.

Work-Life Balance is the term given to DEL's promotional campaign to encourage employers to consider the business benefits of enabling their employees to achieve and maintain a better balance between their work and the other aspects of their lives. The basis of the 'Work-Life Balance' campaign is that everyone benefits from good practice in Work-Life Balance and businesses particularly will find it easier to deliver services, easier to recruit, retain and motivate their staff and easier to reduce stress, sick leave, staff turnover and absenteeism. DEL has been working in partnership with

the Northern Ireland business community in developing the campaign which will provide practical advice and guidance to employers and employees on Work-Life Balance practices.

Further Education Colleges and Higher Education establishments have a major preventative role to play in addressing the problems of the misuse of drugs and other substances. All Higher Education establishments have their own drug policies and strategies in place and the Further Education sector has established a Curriculum Development project which aims to develop a healthy living programme. Training organisations are also aware of the need to address alcohol, drugs and solvent abuse problems and initiatives are being considered through a number of programmes.

Department for Regional Development (DRD)

MGPH representative:
Mr David Crabbe
(Tel No: 028 9054 1195)

DRD's objectives from a health perspective include:

- Formulating a strategy, the Regional Development Strategy, which will set out how Northern Ireland might develop over the next 25 years. The Strategy, which has been a subject of wide public consultation, provides a spatial framework for action addressing a range of social, environmental and community

issues which are relevant to promoting sustainable development and social cohesion in Northern Ireland;

- Developing and maintaining an integrated, sustainable and safe transport network which supports the Regional Development Strategy and facilitates the rapid, predictable and efficient movement of people and goods. A 10-year Regional Transportation Strategy is being prepared which will provide a strategic framework to facilitate the future development of the region's roads and railways. The emphasis in future will be more directed to movement of people and goods in a sustainable, integrated transport system and a more responsible use of the car. Support for public transport will continue and the Department will seek ways of ensuring that public transport services are a safe, attractive option for both those who use cars and for those who do not have access to them. This will include, for example, support and development of rural public transport services through the Rural Transport Fund;
- Contributing to the health and wellbeing of the community and the protection of the environment through the provision of cost-effective water and sewerage services. This will be achieved by developing water and sewerage services to meet

required quality and environmental standards. We will also be endeavouring to increase provision of a public water supply to isolated, rural houses.

Department of Culture, Arts and Leisure (DCAL)

MGPH representative:
Dr Eddie Rooney
(Tel No: 028 9025 8821)

DCAL's potential contribution to improving health and well-being is encapsulated within two of the Department's strategic goals:

- to increase participation in culture, arts and leisure through enhancing access to, and the quality of, facilities and services; and
- to preserve and make available our cultural and information resources to the widest possible audience.

Progress made towards achieving these goals will help to promote public health by:

- increasing health-related physical activity across all sections of the population, especially through promoting life-long participation in sport and exercise;
- helping to increase social inclusion and build self-esteem through participation in culture, arts and leisure activities;

- contributing to therapeutic services in collaboration with health and social care agencies;
- establishing new ways to enable the public to access health information through, for example, maximising the use of the public library service's ICT developments.

DCAL has a particular role to play in the development of policy on linguistic diversity and in ensuring that language does not act as a barrier to accessing health information and advice.

Department of Finance and Personnel (DFP)

MGP representative:
Mr Rodney Scott
(Tel No: 028 9127 7655)

DFP should be able to make a positive contribution by:

- giving appropriate Ministerial and top management commitment to the strategy;
- at a practical level, through the promotion of healthy working environments;
- through the public expenditure process.

More specific contributions would be provided from the following Divisions.

Accommodation and Construction Division is responsible for the provision of office accommodation for civil servants and the making of

Building Regulations. Through compliance with Health and Safety legislation in its buildings the department makes a continuous contribution to the health and well-being of staff. Buildings Regulations make an important, and continuous contribution to public health and safety in a wide range of areas:

- safety glazing in homes and in public buildings to help reduce cutting injuries;
- requirements for smoke alarms in domestic property, and fire prevention and safety measures in other buildings to reduce deaths or injury by fire;
- regulations on the structure and design of stairs to reduce accidents;
- requirements for clean water supply and the proper disposal of foul water to maintain public health;
- measures to prevent the ingress of radon, water and damp;
- minimum ventilation standards for domestic building.

Central Personnel Group (CPG) has general responsibility for management issues associated with occupational health policies in the Civil Service working in close co-operation with the Occupational Health Service (OHS) which is based in DHSSPS and the Office Accommodation Branch of

DFP's Central Support Group. One of the main roles of Central Finance Group (CFG) is to advise Ministers on the allocation of resources to Departments from the Public Expenditure Block agreed with the Treasury. In its advice to Ministers, CFG incorporates information on a variety of issues including for example the New TSN implications of public expenditure options. This allows Ministers to consider New TSN objectives together with other priorities, bearing in mind that economic and social issues are cross-cutting themes in the public expenditure process.

Office of the First Minister and Deputy First Minister

MGPH representative:
Mrs Katrina Godfrey
(Tel No 028 9052 2516)

The Office of the First Minister and Deputy First Minister is a Department with responsibilities that include the co-ordination of the Executive's Programme for Government, economic policy and equality & human rights. The Department's key objectives are:

- To assist the Executive in making and implementing well-informed and timely policy decisions and improving public services by supporting OFMDFM Ministers and the Institutions of Government and building a Programme for Government and Modernising Government programme; and
- To promote equality of opportunity, human rights and improved community relations, tackle poverty and social disadvantage and meet the needs of victims. The Department is committed to playing its part in taking forward work to deliver the commitments contained in Investing for Health. Key areas of activity that are of particular relevance to Investing for Health include:
 - The Programme for Government and associated Budget process
 - Driving forward policy on New Targeting Social Need across all departments
 - Promoting equality of opportunity and human rights
 - The Victims Strategy and work to support victims of the conflict
 - The appointment of a Commissioner for Children and work to develop a Children's Strategy
 - Community relations policy and strategy

ANNEX 5 : ROLE OF THE HPSS WORKFORCE

Paragraph 17.18 refers to the contribution made by professional staff to promoting health. The role of some of these is outlined below.

Nursing

The research report *The Contribution of Nurses, Midwives and Health Visitors to the Public Health Agenda*⁶⁶ demonstrated that community nursing spans the full spectrum of public health activity from, for example, meningococcal immunisation and promoting continence to working with teenage mothers, the Traveller community, homeless people and other vulnerable groups.

We fully support the key role of community nurses in assessing health needs and identifying inequalities in health at local community level. Community nurses are formally educated to conduct systematic health profiles of local populations. Informally, over time, community nurses often gain the trust of local people. They 'know' communities intimately and will be in a strong position to voice local health needs within Local Health and Social Care Groups and at wider organisational and strategic levels.

We will continue to facilitate the development of close links between community nurses and local communities by advocating geographical/ local-community based working as far as possible within LHSCG populations and structures.

To further enhance the public health capability of community nurses, we will work with HSS Boards to develop new service and Budget Agreements that more effectively reflect the public health orientation of community nursing practice.

Increasingly, nursing practice crosses boundaries between hospitals, community and home settings. For example, nurses working in Intensive Therapy and Rehabilitation Units in hospitals may work with others to create opportunities for people to live as independently as possible with support from a range of services and agencies. This illustrates the importance of a public health approach as the foundation for nursing care and health promotion in all settings. We will work with the universities to mainstream public health principles and approaches in nurse education at all levels.

DHSSPS and the Department of Health and Children are leading a project to create an all Ireland approach to public health and nursing, outlined in *A Nursing Vision of Public Health - All Ireland Statement on Public Health and Nursing*.⁶⁷ The Departments are driving a programme with North/ South planning groups to develop public health leadership, education and practice in nursing in Ireland. With DOHC, we will support the development of public health networks, North/ South shared learning opportunities and roll out of best-practice models for public health and nursing.

Public Health Function

Public health is concerned with improving the health status of the population and underpins all health service related activities. The public health function is delivered at all levels of the health and social services, although public health professionals are currently concentrated in the four Health and Social Services Boards and in the Chief Medical Officer's branch DHSSPS.

Each Health and Social Services Board has a public health department led by the Director of Public Health and staffed by consultants and specialist registrars in public health medicine and other public health professionals for example nurses and statisticians.

The core roles and responsibilities of public health departments include:

- **Health surveillance, monitoring and analysis** - This includes the regular review of the health of the population to identify the principal health problems and define health priorities;
- **Control of communicable disease** - Surveillance of communicable disease, investigation and control of disease outbreaks, epidemics and bioterrorism incidents.
- **Control of non-communicable environmental hazards and major incidents** - Surveillance, investigation and control of non-communicable disease clusters, assessing risks to health from environmental hazards and chemical incidents.
- **Disease prevention and health protection** - Establishing, designing and managing health promotion and disease prevention programmes, such as immunisation and screening programmes.
- **Promoting health and reducing inequalities** - Enabling and empowering communities and individuals to promote health and reduce inequalities. Creating and sustaining inter-sectoral partnerships to improve health and reduce inequalities.
- **Supporting clinical effectiveness and audit** - Ensuring the effective performance of health services to meet goals in improving health, preventing disease and reducing inequalities and developing the evidence base.

The Role of Medical Practitioners in delivering the public health function

All general practitioners and hospital and community medical staff are involved in delivering the public health agenda. Examples of programmes include:

- primary and secondary prevention of coronary heart disease
- chronic disease management e.g. diabetes care
- cervical cytology, mammography and the early detection of other cancers
- child health surveillance
- lifestyle and risk factor modification including exercise, weight, smoking, alcohol, drug abuse and safe sex
- mental health care
- care of older people helping them to retain independence and quality of life
- care for the vulnerable, especially children and those with learning difficulties

The future delivery of the public health function rests on partnerships, not least the key partnership between public health professionals and members of primary health care teams.

Social Services

Social services aim to improve the lives of individuals, some of whom are amongst the most vulnerable and disadvantaged in

our society. It does so by identifying their needs and understanding what is happening to them in order to take action to improve their health and social well-being. These services are provided to individuals, to families and groups in day centres, hospital settings, residential homes and in their own homes.

Children's services include:

- child protection, to ensure that children are protected from emotional, physical and sexual abuse and neglect,
- care of looked after children, working to improve educational attainment
- supporting children leaving care,
- providing fostering and residential care, family support services, and adoption services
- children in need
- supporting and providing services for children with a disability and their carers, and
- providing a range of day care facilities for children, including respite services.

Social services is also about developing responsive and comprehensive services that meet the special needs of children and adolescents with mental health problems and providing support and rehabilitation to children and young people with alcohol and drug abuse problems.

Social services also provide a wide range of services to adults.

It aims to promote independence of adults assessed as needing social care, to enable them to live as safe, full and normal a life as possible in their own homes whenever feasible.

Services provided include support for those who are assessed as needing care and those who provide care. These include;

- older people
- adults with mental health needs,
- those with a drug and alcohol abuse problem, and
- adults with a disability, including learning disability and sensory impairment.

Social services seek to ensure that informal carers who care can continue to do so for as long as they and their service user wish. This is achieved by supporting both the service user and the carer.

Services provided to adults and older people include:

- intensive domicillary care,
- home help services,
- meals on wheels,
- day care and residential care including short-term respite breaks.

Social services actively involve user and carers in the planning of services and in tailoring individual packages of care to meet their needs.

Pharmaceutical Services

It is estimated that about 160,000 people both healthy and ill, visit pharmacies here every day. A reported 93% of the resident population welcome an extended pharmacy health promotion service. Eight out of ten people use the same pharmacy consistently. The public hold the service in high regard - convenience, customer-staff relationships and easy access to health advice being the most critical factors.

A core function of pharmacists at all levels is to prevent ill health and promote and protect public health. This encompasses a vast range of activity, from the provision of health promotion advice to advised self care for those presenting with minor or self-limiting ailments, to medicine management programmes which encourage the safe and effective administration of medicines. Community pharmacies provide a unique forum for health development as they have the opportunity to target people who would otherwise have little or no contact with health promotion messages. The position of the community pharmacy with its visibility, accessibility and loyal customer patronage renders it an ideal Health Promotion Centre of cross-Departmental initiatives.

Public health pharmacy is concerned with lifestyle advice, early detection of disease, disease prevention, appropriate

use of medicines and supporting local communities. DHSSPS has recently published an innovative paper on this latter aspect, 'Building the Community – Pharmacy Partnership'⁶⁸.

We will support and encourage community pharmacists to:

- work with local communities to develop services tailored to their particular needs;
- develop health promoting pharmacies, including community outreach (e.g. school visits), and offering the opportunity for other professions and agencies to provide their services there;
- make optimal use of their specialised knowledge of medicines, leading to safer and more effective use of those medicines;
- participate in co-ordinated health promotion programmes e.g. smoking cessation, sexual health, medicines education, travel health advice, healthy eating and exercise (in liaison with the Health Promotion Agency)
- develop as a public health resource, by establishing a community-based indicator which records relevant self care data. This could help form part of an early warning system to identify outbreaks of communicable diseases in the community;

- target the medicines education and advice needs of those who are most at risk from the adverse effects of medication (e.g. elderly and mentally ill people), directly or through those who care for them;

A coordinated approach is essential for the optimum dissemination of the required level of information to members of the public. It is no longer a bolt-on activity but a professional requirement fundamental to the pharmacist's primary role. This approach will involve the community pharmacists working in close liaison with the Health Promotion Agency.

Clearly there is much to gain by exploiting the opportunity that the community pharmacy-public interface presents, to offer health promotion in a care environment.

Dental Services

About 60% of the population regularly attends a dentist. Children in schools have access to the dental team. People with a variety of special needs also have access to the dental team on a regular basis. The interface that the dental team have with the population puts them in a strong position to help people to improve not only their oral health but their general health. Better knowledge of nutrition issues can help to reduce dental decay, obesity and all related diseases. The dental team can also publicise the damaging effects

of smoking, not only in terms of oral cancer and other types of cancer, but also in terms of gum disease.

Professions Allied to Medical Services (PAMS)

From 1 April 2002 the professions formerly called the Professions Allied to Medicine will be called the Health Professions due to the Introduction of the New Health Professions Council. These professionals include:- Dieticians, Orthoptists, Occupational Therapists, Physiotherapists, Podiatrists, Therapeutic and Diagnostic Radiographers and Speech Language Therapists.

The Health Professions help people to manage their physical and mental health conditions, to overcome disability, to live as independently as possible and to adjust to their conditions, disorder or disability providing an improved lifestyle quality. These professions have an important and specific public health role to play in the promotion of physical, mental health and social well-being within local populations and with existing service users. Through the opportunities presented in direct patient/client assessment and treatment, members of the Health Professions are uniquely placed to convey key health promotion messages targeted to individual needs by virtue of face to face contacts.

Core specialist knowledge, skills and expertise already exist within the Health Professions with many staff having undertaken post graduate qualifications in health promotion.

The Health Professions deliver a range of services within primary care settings such as, clinics, patient's own home, residential nursing homes, schools, work places and various other community settings. Services provided by the Health Professions span all age groups and practitioners work across primary, community and acute care sectors.

Health Professions are increasingly engaged in community development activities such as Sure-Start Projects, Health Action Zones, Healthy Living Centres, Community Rehabilitation Programmes including Cardiac Rehabilitation and Mental Health Promotion.

ANNEX 6 : INFORMATION SOURCES

NI Assembly
NI Executive

www.ni-assembly.gov.uk
www.nics.gov.uk

Government Departments

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|---|--|
| Department of Agriculture & Rural Development | www.dardni.gov.uk |
| Department of Culture, Arts & Leisure | www.dcalni.gov.uk |
| Department of Education | www.deni.gov.uk |
| Department for Employment and Learning | www.delni.gov.uk |
| Department of Enterprise, Trade & Investment | www.detini.gov.uk |
| Department of the Environment | www.doeni.gov.uk |
| Department of Finance & Personnel | www.dfpni.gov.uk |
| Department of Health, Social Services and Public Safety | www.dhsspsni.gov.uk |
| Department for Regional Development | www.drdni.gov.uk |
| Department of Social Development | www.dsdni.gov.uk |
| Office of the First Minister & Deputy First Minister | www.ofmdfmi.gov.uk |

Health & Social Services Boards

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|---|--|
| Eastern Health & Social Services Board | www.ehssb.n-i.nhs.uk |
| Northern Health & Social Services Board | www.nhssb.n-i.nhs.uk |
| Southern Health & Social Services Board | www.shssb.n-i.nhs.uk |
| Western Health & Social Services Board | www.whssb.n-i.nhs.uk |

Health Action Zones (HAZs)

| | |
|---|--|
| North & West Belfast Health Action Zone | www.haz-nwbelfast.org.uk |
| Armagh & Dungannon Health Action Zone | www.adhaz.org.uk |
| Northern Board HAZ | |
| Western Board HAZ | |

Education and Library Boards

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|---|--|
| Belfast Education and Library Board | www.belb.org.uk |
| North Eastern Education and Library Board | www.neelb.org.uk |
| Western Education and Library Board | www.welbni.org |
| South Eastern Education and Library Board | www.seelb.org.uk |
| Southern Education and Library Board | www.selb.org |

District Councils

| | |
|----------------------------------|--|
| Antrim Borough Council | www.antrim.gov.uk |
| Ards Borough Council | www.ards-council.gov.uk |
| Armagh City and District Council | www.armagh.gov.uk |
| Ballymena Borough Council | www.ballymena.gov.uk |
| Ballymoney Borough Council | www.ballymoney.gov.uk |
| Banbridge District Council | www.banbridge.com |
| Belfast City Council | www.belfastcity.gov.uk |
| Carrickfergus Borough Council | www.carrickfergus.org |

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| Castlereagh Borough Council | www.castlereagh.gov.uk |
| Coleraine Borough Council | www.colerainebc.gov.uk |
| Cookstown District Council | www.cookstown.gov.uk |
| Craigavon Borough Council | www.craigavon.gov.uk |
| Derry City Council | www.derrycity.gov.uk |
| Down District Council | www.downdc.gov.uk |
| Dungannon and South Tyrone Borough Council | www.dungannon.gov.uk |
| Fermanagh District Council | www.fermanagh.gov.uk |
| Larne Borough Council | www.larne.gov.uk |
| Limavady Borough Council | Site being currently developed |
| Lisburn Borough Council | www.lisburn.gov.uk |
| Magherafelt District Council | www.magherafelt.gov.uk |
| Moyle District Council | www.moyle-council.org |
| Newry and Mourne District Council | www.newryandmourne.gov.uk |
| Newtownabbey Borough Council | www.newtownabbey.gov.uk |
| North Down Borough Council | www.northdown.gov.uk |
| Omagh District Council | www.omagh.gov.uk |
| Strabane District Council | www.strabanedc.com |

Others

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| The Health Promotion Agency | www.healthpromotionagency.org.uk |
| | www.smoke-free.co.uk |
| | www.up-2-you.net |
| The Institute of Public Health in Ireland | www.publichealth.ie |
| Northern Ireland Statistical & Research Agency | www.nisra.gov.uk |
| Research & Development Office | www.rdo.csa.n-i.nhs.uk |
| Public Health Laboratory Service | www.phls.co.uk |
| Community Development & Health Network | www.cdhn.org |
| Drugs Prevention Net | www.drugsprevention.net |
| New Opportunities Fund | www.nof.org.uk |
| Sexual Health | www.coolsexinfo.org.uk |
| Northern Ireland Voluntary Trust | www.nivt.org |
| NI Council for Voluntary Action | www.nicva.org |
| NI Housing Executive | www.nihe.gov.uk |
| Food Standards Agency | www.food.gov.uk |
| Food Safety Promotion Board | www.safefoodonline.com |
| Rural Community Network | www.ruralcommunitynetwork.org |
| Health Development Agency | www.hda-online.org.uk |
| World Health Organisation | www.who.dk |
| Department of Health and Children | www.doh.ie |
| Department of Health | www.doh.gov.uk |
| Belfast Healthy Cities | www.belfasthealthycities.com |
| Derry Healthy Cities | |

ANNEX 7 : GLOSSARY OF TERMS

| | | |
|--------|---|---|
| A & E | - | Accident and Emergency |
| BSP | - | Building Sustainable Prosperity |
| CAP | - | Common Agricultural Policy |
| CAWT | - | Co-operation and Working Together for Health Gain and Social Well-being |
| CCEA | - | Council for the Curriculum, Examinations and Assessment |
| CCGAAD | - | Central Co-ordinating Group for Action Against Drugs |
| CDHN | - | Community Development and Health Network |
| CHD | - | Coronary Heart Disease |
| CMO | - | Chief Medical Officer |
| DAISG | - | Drugs and Alcohol Implementation Steering Group |
| DARD | - | Department of Agriculture and Rural Development |
| DCAL | - | Department of Culture, Arts and Leisure |
| DE | - | Department of Education |
| DEES | - | Domestic Energy Efficiency Scheme |
| DEL | - | Department for Employment and Learning |
| DELTA | - | Developing Everyone's Learning and Thinking Abilities |
| DFP | - | Department of Finance and Personnel |
| DHSSPS | - | Department of Health, Social Services and Public Safety |
| DETI | - | Department of Enterprise, Trade and Investment |
| DOE | - | Department of the Environment |
| DOH | - | Department of Health |
| DOHC | - | Department of Health and Children |
| DRD | - | Department for Regional Development |
| DRGP | - | Data Retrieval from General Practice |
| DSD | - | Department for Social Development |
| EC | - | European Community |
| EDF | - | Economic Development Fund |
| EHS | - | Environment and Heritage Service |
| EHSSB | - | Eastern Health and Social Services Board |
| EIA | - | Environmental Impact Assessment |
| ENHPS | - | European Network of Health Promoting Schools |
| EPF | - | European Programme Funds |
| EU | - | European Union |
| EYLL | - | Expected Years of Life Lost |
| FSA | - | Food Standards Agency |
| FSPB | - | Food Safety Promotion Board |
| GIS | - | Geographical Information System |
| GP | - | General Practitioner |
| GUM | - | Genito Urinary Medicine |
| HAZ | - | Health Action Zone |

| | | |
|---------|---|--|
| HELG | - | Health and Education Liaison Group |
| HEI | - | Higher Education Institution |
| HIA | - | Health Impact Assessment |
| HLC | - | Healthy Living Centre |
| HPA | - | Health Promotion Agency |
| HRB | - | Health Research Board |
| HSSB | - | Health and Social Services Board |
| HSENI | - | Health and Safety Executive of Northern Ireland |
| HSST | - | Health and Social Services Trust |
| HWIP | - | Health and Well-being Investment Plan |
| | | |
| ICT | - | Information and Advice Centre |
| IDB | - | Industrial Development Board |
| IFH | - | Investing for Health |
| IHP | - | Investing for Health Partnership |
| ILA | - | Individual Learning Account |
| IPHI | - | Institute of Public Health in Ireland |
| | | |
| LHSCG | - | Local Health and Social Care Group |
| | | |
| MGPH | - | Ministerial Group on Public Health |
| MMR | - | Measles Mumps and Rubella |
| | | |
| NGOS | - | Non Government Offices |
| NHS R&D | - | National Health Service Research and Development |
| NHSSB | - | Northern Health and Social Services Board |
| NIPPA | - | Northern Ireland's pre Playschool Association |
| NICMA | - | Northern Ireland Child Minding Association |
| NIHE | - | Northern Ireland Housing Executive |
| NIO | - | Northern Ireland Office |
| NISRA | - | Northern Ireland Statistics and Research Agency |
| NOF | - | New Opportunities Fund |
| NSMC | - | North/South Ministerial Council |
| NewTSN | - | New Targeting Social Need |
| | | |
| OFMDFM | - | Office of the First Minister and Deputy First Minister |
| | | |
| PE | - | Physical Education |
| PfG | - | Programme for Government |
| PPS | - | Planning Policy Statements |
| PSE | - | Poverty and Social Exclusion |
| PSI | - | Promoting Social Inclusion |
| PYLL | - | Potential Years of Life Lost |
| R & D | - | Research and Development |
| RDS | - | Regional Development Strategy |
| ROSPA | - | Royal Society for the Prevention of Accidents |
| RRGs | - | Recognised Research Groups |

| | | |
|---------|---|---|
| RSE | - | Relationships and Sexuality Education |
| RSEO | - | Road Safety Education Officers |
| RTS | - | Regional Transportation Strategy |
| SAMs | - | School Age Mother's |
| SHSSB | - | Southern Health and Social Services Board |
| SNAGs | - | School Nutrition Action Groups |
| SOSIG | - | Social Science Information Gateway |
| SSA | - | Social Security Agency |
| STI | - | Sexually Transmitted Infection |
| T & HSG | - | Transport and Health Study Group |
| UPCI | - | Unique Patient Client Identifier |
| US | - | United States |
| USA | - | United States of America |
| WHO | - | World Health Organisation |
| WHSSB | - | Western Health and Social Services Board |

SOCIO ECONOMIC CLASSIFICATIONS

Surveys and administrative databases currently use two different classifications here – social class and socio-economic group. These are defined as follows:

Social Class

Social Class is based on occupation, formerly the Registrar General 's social class. It is a scale for classifying people into five groups (one sub-divided). The composition of the classes brought together, as far as possible, people with similar levels of occupation skill. The final version was based on the 1990 edition of the Standard Occupational Classification.

- I Professional etc occupations
- II Managerial and Technical occupations
- III (N) Skilled Non-manual occupations
- III (M) Skilled Manual occupations
- IV Partly-skilled occupations
- V Unskilled occupations

Socio-economic group

The classification aimed to bring together people with similar social and economic status into 8 groups. It was derived from occupational unit group, employment status and size of establishment. The final version was based on the 1990 edition of the Standard Occupational Classification.

SEG1 Professional

- SEG2 Employer/manage
- SEG3 ntermediate/non-manual
- SEG4 Junior non-manual
- SEG5 Skilled manual
- SEG6 Semi-skilled manual
- SEG7 Unskilled manual
- SEG8 No SEG or Army.

National Statistics Socio-Economic classification

A new classification has been developed called the National Statistics Socio-economic classification. This will be used in all official statistics and surveys and has begun to be introduced here this year. It will replace social class and socio-economic groups. It is an occupation based classification but has rules to provide coverage of the whole adult population. The information required to create it is occupation coded to the unit groups of the Standard Occupational Classification 2000 and details of employment status (whether an employer, self employed or employee; whether a supervisor; number of employees at the workplace).

CALCULATION OF ECONOMIC COSTS

Economic costs of death have been calculated with reference to DETR's "Highways Economics Notes No. 1" which currently stands at around £1.1million per death.

This includes the following costs to the economy:-

- lost output (present value of the expected loss of earnings plus any non-wage payments paid by the employer. Wages are taken as shadowing productive output);
- medical and ambulance costs (the associated costs of hospitalisation and subsequent death); and,
- the human costs of death (based on willingness to pay principles, to include the pain, grief and suffering to the fatality, relatives and friends & the intrinsic loss of enjoyment of life).

EXPECTED YEARS OF LIFE LOST

Expected years of life lost (EYLL) calculations include age cohort, gender specific life expectancies, discounted at 1.5% pure time preference rate for lifetime effects (i.e., the offer of the next year of life is valued higher by a 21 year old compared to an 85 year old who has already lived the majority of their lifespan) and applies them to avoidable deaths calculated across the age cohorts and gender.

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Produced by:
Department of Health, Social Services & Public Safety

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March 2002 Ref: 229/01

