



Department of  
**Health, Social Services  
and Public Safety**

An Roinn

**Sláinte, Seirbhísí Sóisialta  
agus Sábháilteachta Poiblí**

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Your Ref:  
Our Ref:  
Date: 25 October 2004

Dear Janis

## **NI MULTIPLE DEPRIVATION MEASURE (MDM) 2004 - DHSSPS CONSULTATION COMMENTS**

Thank you for the opportunity to comment on this important exercise.

DHSSPS makes extensive use of the current Noble MDM, for example, as a complementary tool to its own resource allocation formulae, for the allocation of funding to specific projects, inequalities monitoring, target-setting, etc. We therefore strongly welcome this review and update of the existing index in order to make better use of new and more relevant datasets and as an opportunity to move to the latest 1992 ward based geography.

As you are aware, Martin Mayock is the DHSSPS representative on the Review Steering Group and he has kept me apprised of all major developments. He has also ensured that DHSSPS issues have been fed into the Group at an early stage and most of these have been resolved prior to publication of the consultation document. We are content that the majority of the proposals represent an improvement on the existing MDM so comments will be restricted to those few, but nevertheless, important areas where DHSSPS still has some concern. These are listed in the order in which they are presented in the consultation document rather than in order of importance.

## Health Deprivation and Disability Indicators

The 'Emergency Admissions to Hospital' indicator is, on the face of it, a good proxy for serious morbidity and the proposed data source, the Hospital Inpatient System (HIS), is of excellent quality. However, resource allocation work suggests that there is a strong potential for urban bias with such an indicator, as generally there is a greater tendency to use hospital services with increasing accessibility. This should be less of a problem with emergency admissions, compared to elective, but is still likely to be a factor. The so called "Supply" effect in relation to hospital services is well known to local representatives. It is imperative therefore that we are seen to be testing for urban/rural bias particularly with this indicator. I understand that the researchers are to be provided with 'length of stay' attached to each HIS record which would allow various cut-off points to be investigated. Statisticians within DHSSPS would be happy to liaise with the team on this issue.

The inpatient element of the 'Mental Health' indicator will need to cover the six main Mental Illness hospitals not covered by HIS. This is an added complication and will require an ad-hoc data collection exercise. We are currently exploring the feasibility of this but, if it does not prove to be feasible, only to use HIS data would again introduce an urban bias (for example, the entire Western HSS Board are covered by two of the excluded hospitals).

It may be useful to explore dental registration data as a fall-back indicator should other indicators end up being rejected (or possibly to even consider as a supplementary indicator). Unfortunately, comprehensive dental extractions data are no longer available but research reveals a link between registrations, where good quality data are available, and deprivation.

## Geographical Access to Services

Whilst not explicitly mentioned in the consultation document, I understand that it has been suggested at a recent Steering Group meeting that the 'Road Distance to an A&E Hospital' indicator should take into account cross-border provision. We would caution against going down this route. The same argument could equally be applied to the "Road Distance to a General Food Store" indicator and, notwithstanding political sensitivities, there is a need to have a consistent approach across indicators. I would doubt that point location data for the latter indicator is easily obtainable and although we can certainly provide you with x-y coordinates for relevant Southern hospitals, we would not wish these to be considered a special case.

## Geography

The proposal to move exclusively to a Super Output Area (SOA) geography for the new MDM causes us most concern. Whilst we warmly welcome this new geography and can see immediate merits in its use in certain circumstances, we do not feel that it should be at the expense of an electoral ward based geography. DHSSPS has assembled a range of historic datasets at ward level not all of which could be easily mapped to a new SOA geography. Our resource allocation indicators are a prime example as they have been developed at ward level through statistical modelling and are therefore fixed to this geography. To lose the Noble MDM as a source of cross-validation for our various allocation formulae would seriously undermine its usefulness to DHSSPS.

In addition, we have recently developed a Health and Social Care Inequalities monitoring system at ward level which relies on the Noble MDM for the identification of the most deprived areas. This has been developed on a 1992 geography and, as an interim measure, we have been using an updated Noble Income Domain to select our deprived wards. We had planned to use the new Noble MDM as soon as it became available but an SOA based measure presents us with serious difficulties. To not use the new Noble MDM could damage the credibility of our system, while to remap or request that existing data be resupplied according to the new SOA geography would be very resource intensive. Even if we did this, the greater homogeneity of SOAs compared to wards, will inevitably mean that the inequality gap between the most deprived areas and the NI average will increase purely due to a methodological change. Whilst I agree that the new SOA method is better, we are already tied in to a range of targets that have been developed at ward level based on an analysis of ward level data. The methodological refinement would likely be lost on the majority of users.

We have canvassed DHSSPS users of the existing MDM for their opinion on the proposed change of geography. The overwhelming view was that the ward geography should be retained. I would therefore propose that the MDM is produced at both SOA and at ward level. I am not suggesting that the ward level geography should be given preferred status but that it remains available for those who wish to use it. I can foresee that a ward based geography will eventually become redundant as systems, allocation formulae and targets are migrated to the new SOA geography. However, this will occur only over a period of time as users become more comfortable with the new geography.

## Population Denominators

I understand that the review team are producing 2003 population estimates at SOA level to use as the denominator in the construction of the various domain indicators. However, no information has been provided in the consultation document as to the methodology. These estimates would undoubtedly be a useful addition to existing demographic data and could be useful for a number of purposes outside of the actual deprivation review. We therefore would welcome more detail on the precise methodology to be used and an opportunity to comment, particularly if GP registrations data are to be used as part of the calculation.

I hope that you find the above comments useful, and we wish you well with the remainder of the review.

Yours sincerely



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Cc **Board Members**  
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