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Slàinte, Seirbhísí Sóisialta agus Sábháilteachta Poiblí
Poustie, Resydènter Heisin an Fowk Siccar

Prepared On Behalf Of

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1. LIST OF ACRONYMS

A&E	Accident and Emergency
ACRA	Advisory Committee on Resource Allocation
BIC	British Irish Council
CAPU	Central Anti Poverty Unit
CCMS	Council for Catholic Maintained Schools
CDHN	Community Development and Health Network
CHD	Coronary Heart Disease
CoE	Centre of Excellence [for Public Health]
CSP	Community Safety Partnership
CTCC	Community Treatment in Care Centres
DACT	Drug and Alcohol Co-ordination Team
DARD	Department of Agriculture and Rural Development
DCAL	Department of Culture, Arts and Leisure
DE	Department of Education
DEL	Department for Employment and Learning
DETI	Department of Enterprise, Trade and Investment
DFLE	Disability Free Life Expectancy
DFP	Department of Finance and Personnel
DHSSPS	Department of Health, Social Services and Public Safety
DOE	Department of Environment
DRD	Department for Regional Development
DSD	Department for Social Development
EHSSB	Eastern Health and Social Services Board
EIFHP	Eastern Investing for Health Partnership
ELB	Education and Library Board
EMA	Education Maintenance Allowance
ESRC	Economic and Social Research Council
EU	European Union
FE	Further Education
FSME	Free School Meal Entitlement
GB	Great Britain
GDP	Gross Domestic Product
HAZ	Health Action Zone
HEI	Higher Education Institute
HIA	Health Impact Assessment
HIP	Health Improvement Plan

HLE	Healthy Life Expectancy
HPA	Health Promotion Agency
HSC	Health and Social Care
HSCB	Health and Social Care Board
HSENI	Health and Safety Executive NI
HSS	Health and Social Services
HWIP	Health and Well-being Investment Plan
IFH	Investing for Health
IMG	Inter-Ministerial Group
IMTAC	Inclusive Mobility and Transport Advisory Committee
INIsPHO	Ireland and Northern Ireland's Population Health Observatory
IPH	Institute of Public Health in Ireland
LAA	Local Area Agreement
LCG	Local Commissioning Group
LEMIS	Local Employment Intermediary Service
LLTI	Limiting Long-Term Illness
LLW	Learning for Life and Work
LSP	Local Strategic Partnership
MARAC	Multi Agency Risk Assessment Conference
MGPH	Ministerial Group on Public Health
MRC	Medical Research Council
OECD	Organisation for Economic Co-ordination and Development
OFMDFM	Office of the First Minister and Deputy First Minister
NHS	National Health Service
NI	Northern Ireland
NICCIP	Northern Ireland Climate Change Impact Partnership
NICS	Northern Ireland Civil Service
NIE	Northern Ireland Electricity
NIEA	Northern Ireland Environment Agency
NIFHP	Northern Investing for Health Partnership
NIGEAE	Northern Ireland Guide to Expenditure Appraisal and Evaluation
NIHE	Northern Ireland Housing Executive
NIPH	National Institute of Public Health [Sweden]
NIO	Northern Ireland Office
NPA	National Prevention Agency [Australia]
NR	Neighbourhood Renewal
NRT	Nicotine Replacement Therapy
NSD	New Strategic Direction (on Alcohol & Drugs)

OHS	Occupational Health Service
PCT	Primary Care Trust
PDMU	Personal Development and Mutual Understanding
PEHAW	Pupil's Emotional Health and Wellbeing
PFA	Priorities for Action
PfG	Programme for Government
PHA	Public Health Agency
PPS	Planning Policy Statement
PSA	Public Service Agreement
PSI	Promoting Social Inclusion
PSNI	Police Service of Northern Ireland
PYLL	Potential Years of Life Lost
R&D	Research & Development
POC	Programme of Care
ROI	Republic of Ireland
ROSPA	Royal Society for the Prevention of Accidents
RPA	Review of Public Administration
SARC	Sexual Assault Referral Centre
SEA	Single European Act
SHSSB	Southern Health and Social Services Board
SIFHP	Southern Investing for Health Partnerships
SRS	Safer Routes to School
TNC	Teacher Negotiating Committee
TSN	Targeting Social Need
QUB	Queens University Belfast
UK	United Kingdom
UKCRC	United Kingdom Clinical Research Collaboration
VFM	Value for Money
WHAZ	Western Health Action Zone
WHO	World Health Organisation
WHSSB	Western Health and Social Services Board
WIFHP	Western Investing for Health Partnership

2. EXECUTIVE SUMMARY

FGS McClure Watters were commissioned by the Department of Health, Social Services and Public Safety (DHSSPS) to complete a review of the Investing for Health Strategy (IFH). This section presents an overview of the main report.

2.1 Background to Investing for Health Strategy

IFH is the public health strategy of the Northern Ireland Executive. Following a two year process of development and consultation the final IFH Strategy was published in 2002.

IFH clearly demonstrates that the range of factors influencing health extends beyond the remit of the DHSSPS and the health and social care family; it therefore contains two wide ranging goals and seven objectives. The two goals seek to "*… improve the health of our people and to reduce inequalities in health*" through the achievement of seven objectives that focus on the wider determinants of health including poverty; education; the environment;, reducing deaths and injuries from accidents; promoting positive mental health and well-being; and encouraging people to make healthy choices. Within these objectives, priority was given to initiatives which would also help to reduce inequalities in health.

Given the cross-Departmental and inter-sectoral nature of IFH, structures were established to support its delivery both across Departments and at a local level.

DHSSPS allocated £2.5-2.9m per annum between 2002-03 and 2008-09 (initially through Executive Programme Funds until these were mainstreamed) for the operation of the Investing for Health Partnerships and the delivery of local actions plans. The Partnerships also successfully levered in funds from other organisations.

2.2 Context and Structures

There have been developments in the public health arena since the publication of IFH in 2002, including a restructuring of health and social care through the Review of Public Administration. In addition, a number of key themes have emerged internationally in public health research, policy and practice.

2.2.1 Health and Wellbeing in Northern Ireland

A number of improvements can be seen in the overall levels of population health in Northern Ireland since the introduction of IFH in 2002, for example the increase in life expectancy for both males and females. However, despite these improvements in overall health levels, persistent inequalities still exist. In addition, healthy life expectancy in Northern Ireland is worse than the UK average for both male and females. Chronic conditions have reduced the quality of the extra years that have been gained. The full report (section 4.2) and Statistical Analysis Annex contains further detail on population health status.

2.2.2 Structures to deliver Investing for Health

2.2.2.1 Ministerial Group on Public Health

The MGPH was set up in 1997 with a remit to support the Health Minister in taking forward the Government's agenda *'to improve the health of the population'.* IFH defines the role of MGPH as "*managing the partnership across Government, and co-ordinating and monitoring the implementation of the Strategy."* It also states that "*the Investing for Health Partnerships will be accountable to MGPH, and that Departmental representatives will be responsible for monitoring the progress of the bodies for which they are responsible*".

2.2.2.2 Department of Health Social Services and Public Safety

DHSSPS is responsible for setting policy, performance management of the health and social care system, and ensuring accountability and governance. Within DHSSPS the IFH Team was responsible for supporting MGPH and co-ordinating the development of the Strategy when it was launched in 2002. This dedicated team existed within the Health Development Directorate until 2003 when it was merged with another Branch Responsibilities include the review and ongoing policy development of the Strategy, review of progress against the IFH objectives and targets, Health Impact Assessment, resourcing implementation and providing secretariat to MGPH. The Branch also has responsibility for a number of other public health policies.

2.2.3 Pre Re-Organisation of the Health System in 2009

IFH has been delivered in a period when the health system in Northern Ireland has undergone significant change. Original Health and Social Services delivery structures are summarised below – the report also references the roles and contribution of some other key partner organisations.

2.2.3.1 Health and Social Services Boards

Before the 2009 Health and Social Care Reform, the four Health and Social Services (HSS) Boards were responsible for commissioning health services in their local area. . In 2002 the HSS Boards were tasked with establishing IFH Partnerships for their areas that would bring together key statutory, voluntary and community organisations. The Partnerships were responsible for developing cross-sectoral Health Improvement Plans (HIPs), in line with IFH Strategy. The HSS Boards were encouraged to work with, and build on, existing partnerships (e.g. Health Action Zones) and networks to the greatest possible extent.

In April 2009 the functions and responsibility for all IFH Partnerships was transferred to the Public Health Agency (PHA).

2.2.3.2 Health and Social Care Trusts

There are currently five Health and Social Care (HSC) Trusts, which came into being on 1st April 2007. They were created from the merger of nineteen former Trusts. Each Trust has a

Health Improvement Team, but as the Trusts are structured differently the Health Improvement staff report into different directorates.

The Trusts' roles and responsibilities for health and wellbeing did not change in 2009.

2.2.3.3 Health Action Zones

There are four Health Action Zones (HAZs) in Northern Ireland. The HAZ Model uses an integrated, community-led partnership approach targeting of health and social well-being inequalities, where there is clear evidence of health and social disadvantage. This model involves the preparation of targeted Action Plans in each community, tailored to local needs, which make the best use of local and other resources.

In April 2009, the functions and responsibility for the HAZ Teams work was transferred into the PHA.

2.2.3.4 Health Promotion Agency

The Health Promotion Agency (HPA) provided a regional focus for health promotion. Its statutory functions included advising the Department on matters relating to health promotion; undertaking health promotion activity; delivering, sponsoring and commissioning research and evaluation; providing a regional centre of information and advice on health promotion; and making grants to and otherwise supporting voluntary organisations.

In April 2009, the functions of the Health Promotion Agency were absorbed into the PHA.

2.2.4 Restructuring of Health System in 2009

Significant restructuring of the health and social care system was only completed in April 2009, therefore it is too soon to analyse its impact on IFH, however it is important to consider if the changes in these structures and processes can benefit the delivery of the Strategy. The key structural changes which relate to IFH are:

- A **single regional Health and Social Care Board (**replacing the four HSS Boards) focusing on commissioning, resource management, and performance management and improvement.
- A **regional Agency for Public Health and Social Well-being - the Public Health Agency -** that incorporates and builds on the work of the Health Promotion Agency and has wider responsibility for health protection, health improvement, and addressing health inequalities and public health issues.
- A **single Patient and Client Council (**replacing the Health and Social Services Councils) with five local offices operating in the same geographical areas as the existing Trusts, to provide a strong voice for patients, clients and carers.

- A smaller **Department** focused on policy and strategy development.

The reform has created a new commissioning system which aims to give appropriate weight to the public health agenda and ensure commissioning reflects the drive to improve health and reduce health inequalities.

2.2.5 Northern Ireland Policy

A number of policies and strategies have been developed by Northern Ireland Government Departments since the publication of IFH which have impacted and contributed to IFH aims and targets, for example the Neighbourhood Renewal strategy which has a focus on deprivation in urban communities and also adopts a collaborative, partnership approach

The 2002-05 Programme for Government (PfG) reflected many of the key issues to be addressed through IFH, including improving the health of all our people and reducing health inequalities; ensuring an environment that supports healthy living and the safe production of food; and promoting public safety by reducing the numbers of injuries and deaths caused by accidents at home, at work and on the roads.

The key priority of the current PfG (2008-11) is growing the economy, and only a number of the IFH outcome targets are now included as PfG targets. The PfG targets are key to getting IFH positioned at the heart of government. There is an opportunity as we move closer to the development of the next PfG to have the IFH agenda influencing Government priorities for the subsequent three years and beyond.

2.2.6 Emerging Themes in Public Health

Since the publication of IFH, a considerable amount of evidence has been published to support the rationale for tackling the social determinants of health as the key to addressing health inequalities and improving outcomes for society as a whole. These societal influences, such as early childhood care, education and literacy, employment and working conditions, access to health services, housing, income and its distribution, social exclusion, social security and unemployment and job insecurity, all impact on health at individual and population-wide levels. This increased emphasis on the social determinants of health, the "causes of the causes," complements and enhances the traditional public health focus on disease prevention and behavioural risk factors such as body weight, physical activity, diet, and alcohol and tobacco use.

Early childhood interventions are a particularly important area that can help reduce the societal inequalities rooted in poverty by providing young children from disadvantaged backgrounds with a more equitable start in life. This investment in early childhood also has the potential to multiply returns over the life-course.

2.3 Benchmarking

A benchmarking exercise was completed with three countries in order to examine how practices in Northern Ireland compare and to identify key issues in relation to how policies,

priorities and targets might be made more effective. The comparison of benchmarking countries is based upon their public health processes (including organisation, funding and decision-making) and the performance of key public health outcomes over time. England, Australia and Sweden were selected as suitable benchmarks. Each of the countries has individual strengths in the design and delivery of their health system.

England's approach to tackling health inequalities was similar to Northern Ireland, in that it focused on developing a cross-Governmental plan with a number of inequalities targets to be achieved by 2010. Based on the most recent data, these targets look unlikely to be met. England finds itself in a similar position to Northern Ireland in that it has seen considerable gains in the absolute levels of health in its whole population, however there has also been an underlying widening of the gap between social groups.

Australia has a long history of creating evidence-based health policy. Public health interventions have been extensively monitored and evaluated since the 1970s, and future actions are based on the results of this research. Australia's focus on evaluation ensures value for money and efficiency on the basis that only interventions that have been proven effective are implemented and mainstreamed.

In Sweden, which adopted a social perspective of health many decades ago, the responsibility for health care is decentralised to regional and local Government (with the exception of overall goals and policies, which are determined at national level) which allows decisions to be made based on local need. This decentralised model is one of the main strengths of the Swedish health care system and has led to a culture of collaboration between the different levels of Government and locally-based organisations in achieving shared health goals.

The benchmarking exercise also looked at the relative spend by countries on health promotion and disease prevention as a proportion of total health care expenditure Given the differences in the way health promotion and disease prevention activities are funded and organised between the benchmark countries and Northern Ireland it has not been possible to draw any firm comparisons without further analysis. However it is recommended that consideration should be given to ensuring the NI spend is on a par with the level of the benchmark countries, and that at the very least current investment is protected and maintained.

2.4 Progress and Impacts

Using baseline figures from IFH, the outcomes have been assessed in terms of whether each target has been met, or is on track to being met within the set timeframe. A survey of MGPH members was also conducted to assess how each Department and relevant Agencies have actioned IFH and to consider the extent to which IFH is reflected in a range of policies and strategies.

2.4.1 Performance

Five of the 13 targets were impact targets with shorter timescales, and these were to be achieved within two or three years of the IFH being published.

- The target to reduce the percentage of pupils who achieve no GCSEs in the 25% of secondary schools with the highest percentage FSME from 8.5% to 5% by 2005-06 was successfully achieved.
- The target set for the percentage of children achieving the expected level in Key Stage 2 English and Maths was not met by 2005-06, although improvements were made compared to the baseline figures (the proportion not achieving the expected level in Key Stage 2 English was reduced from 40% to 30.5% and from 36% to 33% for Maths).
- The target to reduce the level of fuel poverty by 2004 was achieved.
- The target on the number new dwelling starts by housing associations fell short of the target by a small amount (239 new dwelling starts).
- The target to reduce the concentrations of the seven main air pollutants by 2005 was not achieved. Again the margin by which it failed was small and considerable improvements had been made over the time period. Only two of seven air pollutants failed to meet their targets and of these, the Nitrogen Dioxide target was exceeded at only one of its fifteen measurement sites.

The outcome targets with longer timescales look likely to have varied levels of success.

- The target to increase life expectancy for men 77.5 years and for women to 82.6 years, is on track to being met by 2010 if the trends in improvements since 1998-00 continue at the rate observed over the period analysed.
- The target to reduce the proportion of people with a potential psychiatric disorder to 19% by 2010 was on track to be achieved, based on data for 2006.
- The percentage of obese men has risen from 17% in 1997 to 25 % in 2005-06 and women from 20% to 23%. The level of obesity is unlikely to be reduced below the baseline figures by 2010. However, it should be noted that the rise in obesity levels is a global problem that has increased at rapid rate since the publication of IFH in 2002.
- The gap in life expectancy between the most deprived areas and the Northern Ireland average at 1998-00 was 3.1 years for men and 2.5 years for women. The rate of change was extrapolated and is predicted to be to 3.6 years for men and 2.2 years for women in 2009-11. This suggests that gaps in life expectancy are forecast to narrow for women but widen for men.
- In 2003, the proportion of children living in low income households (after housing costs) was 26%. In 2009, this proportion remained unchanged at 26%.

IFH set targets at a Northern Ireland level; it did not set operational targets for each Department detailing what was required from them individually as Departments, in order that the overall targets might be obtained. This then makes it difficult for us to evaluate the impact at a Departmental level.

All Departments have implemented measures that have made considerable progress in addressing these actions since the publication of IFH in 2002. The analysis at a Departmental

level highlights that a significant number of areas only started to progress from 2006 and on. There has also been a significant level of strategy and policy work in 2009 which has not had time to work through into outputs or impacts. There is also a degree of difficulty in identifying to what extent identified impacts and benefits would have been achieved in the absence of IFH, or to what extent other influences played a role.

In evaluating the evidence collected through the Departments survey, we also find that Departments have a strong focus on reporting activities rather than achievements or outcomes. Whilst monitoring activities is important in the short-term it is clearly important that there is a focus on what impacts are being delivered. The analysis at Departmental level also demonstrates that in some cases there is a lack of evidence of monitoring and evaluation taking place.

2.4.2 IFH Partnership Performance

The four IFH Partnerships each developed a Health Improvement Plan (HIP) based on local need, which focuses on addressing the two goals and seven objectives in the Strategy. The Partnerships receive funding from DHSSPS for infrastructure and implementation of their HIPs. In addition to this funding, they lever in resources from their partners. Although it was difficult to analyse the aggregate impacts of the IFH Partnerships due to the volume of work they have conducted since inception it is evident that the work of the Partnerships has had a positive impact on the local population. These impacts can mainly be categorised as quantifiable impacts resulting from project/programme work. However, the work of the Partnerships extends to a number of other unquantifiable areas that will impact on the health of each area's population, including mainstreaming public health issues in partner organisations, increasing knowledge and understanding of health issues within the local population, and building capacity for change within the area.

Each of the Partnerships has an ad hoc approach to monitoring and evaluating programmes and investments made. They were required to submit annual monitoring reports to DHSSPS detailing progress against their HIPs. There was no agreed format for the monitoring reports, a consistent reporting style across all Partnerships would allow for improved monitoring and comparative analysis.

2.4.3 Health Impact Assessment

Research shows that policies not directly related to health can have direct effects on the physical and mental health and wellbeing of populations, as well as indirect effects through the wider social determinants of health. One way of ensuring that policies minimise the risk to health and maximise opportunities for health gain is through the use of Health Impact Assessments (HIAs). HIA is the systematic prediction of the potential positive and negative health and wellbeing impacts of new policies and programmes including how these impacts are distributed across a population.

2.4.3.1 Promotion of HIA

Taking forward the development of these HIA has been overseen and co-ordinated by DHSSPS with the support of a dedicated HIA expert based within the IPH. HIAs of non-health policies are increasingly seen as a tool to facilitate cross-sectoral action and to promote health and reduce inequalities.

DHSSPS is continuing to promote access to HIA training to raise awareness and improve the skills of policy makers and analysts and provide up-to-date HIA guidelines. In addition, DHSSPS is considering a report commissioned by the IPH to externally review HIA activity over the period 2001-2009 and provide suggestions for the future direction of this work. Consideration should also be given to a mandatory requirement for all Departments to conduct HIAs and/or the Health in All policies approach in their policy development processes.

2.5 Value for Money

Investing in public health is a long-term investment not a cost. IFH has delivered a considerable amount in a short timeframe with a relatively small investment from DHSSPS. The IFH Partnerships and HAZs have been effective in levering in resources from their partner organisations – these include considerable financial resources and in-kind contributions.

A value for money analysis was conducted to consider the levels of economy, efficiency, effectiveness and additionality achieved by IFH. The cross-cutting nature of IFH makes it difficult to quantify the extent to which other Departments' resources have contributed. As a result, the value for money analysis focuses on the DHSSPS funding only. Furthermore, as it is difficult to separate out DHSSPS funding to other areas that support IFH (e.g. Health Promotion Strategies), analysis is focused on the funding that is allocated for partnership working to support the implementation of IFH, specifically through the IFH Partnerships and HAZs.

2.5.1 Cost of Ill Health

There is strong evidence from both developing and developed countries which demonstrates a two-way relationship between health and economic growth. Therefore there is a strong case for considering investment in health as one of the key options by which a country can achieve their economic objectives. The report contains some examples of the cost implications of various diseases in Northern Ireland.

2.5.2 Economy

2.5.2.1 Cost of Health Promotion & Disease Prevention

In the 2008/09 financial year, a total expenditure of £80m on health promotion and disease prevention represented 2.9% of the total health spend. This is planned to rise to around 3.1% of all health expenditure in 2009-10. This is still a relatively small proportion of the overall health budget, the majority of which is spent on the treatment of disease.

2.5.2.2. Cost of IFH Partnerships & HAZs

The IFH Partnerships were allocated £1m per annum for infrastructure costs to support the Partnership and £1.5m per annum (these amounts rose annually to take account of inflation) for the implementation of the cross-sectoral Health Improvement Plans (HIPs). The HAZs were allocated annual funding to support infrastructure. The total investment by DHSSPS in the IFH Partnerships and HAZs from 2002-03 to 2008-09 was £23.55.

2.5.3 Efficiency

The IFH Partnerships and HAZs were successful in levering in a significant level of resources form their partners. The total amount of additional funding levered in (excluding in-kind contributions) was calculated for the Western IFHP and Northern Neighbours HAZ to demonstrate their efficiency. The analysis shows that:

- For every £1 of DHSSPS investment over the period from 2002-03 to 2007-08, WIFHP levered in an additional £0.93; and
- For every £1 of DHSSPS investment over the period from 2001-02 to 2008-09, NNHAZ levered in an additional £1.43.

2.5.4 Effectiveness

Improvements have been made to the levels of life expectancy in Northern Ireland since 2002. In addition, significant progress has been made towards achieving the 14 targets set out in IFH. Three of the four targets set to be achieved by 2004 were achieved within the timescale. Of the 10 targets to be achieved by 2010, 2 are on track to be achieved, 4 are not on track to being achieved and 4 were not directly comparable to the baseline as the method of recording data has changed since the baseline was established in 2002. Given that the targets set were considered to be challenging and aspirational, IFH has achieved a considerable amount in many areas in a relatively short time scale, while challenges remain in relation to health inequalities.

In addition, IFH has resulted in a number of unquantifiable impacts through the collective mobilisation of effort for health improvement, such as the engagement and involvement of communities in health improvement, especially in disadvantaged areas.

In terms of delivery of IFH, there are a number of areas where effectiveness can be improved:

- the levels of financial resources levered in by the IFH Partnerships could potentially be improved;
- both IFH Partnerships and HAZs need access to more sustainable sources of funding revenue; and
- POC 8 receives the smallest proportion of the total health budget; extending IFH's remit to influence resource allocation under other POCs would enable a stronger focus on public health issues across all areas of health care.

2.6 Consultation Feedback

A number of consultations were completed as part of this review, and these have highlighted a number of areas of strength but also areas for development.

2.6.1 Awareness / Buy in to the Strategy

Stakeholders spoke of the common focus and language Investing for Health provided to all working in this area; and its emphasis on partnership working.

Stakeholders were also very positive about the process that had been used to develop IFH. As a result the stakeholders had been aware of IFH from when it was launched and many had been involved in its development.

2.6.2 Relevance of the Strategy

Stakeholders all felt that IFH had been, and still was, hugely relevant. Many mentioned the uniqueness of the Strategy when it was first published, in devising a cross-Departmental approach that was clearly focused on partnership working. A number of consultees outside the health sector noted that it provided for them the sense of purpose, allowing them to demonstrate to others how their work was contributing not only to their own Department's objectives, but to health and wellbeing generally. Local stakeholders felt that IFH was as relevant now as it had been in 2002, and that *"there was still much work to be done"*. Others at a strategic level felt that IFH needed to be refocused on a smaller number of areas with early years and children getting top priority.

2.6.3 Performance

Stakeholders felt that the Strategy had been hugely successful in:

- providing a common language and a focus for all those focused on health and wellbeing improvement;
- providing structures which allowed local stakeholders to come together and renew needs and agree priorities for the way ahead;
- developing 'local solutions to local problems' and therefore creating buy-in for the community in doing so;
- levering in resources from other sources outside the DHSSPS ; and
- accessing 'unpaid for time' through the work of local community representatives or the partnership groups.

However, a number of stakeholders felt there was less clarity in whether the targets were being achieved. Strategic stakeholders appeared not to have a clear sense of what was happening at a local level. The lack of joined up working across Government was highlighted. Others noted:

- the confusion over roles and responsibilities of the Health Improvement Staff in Trusts and IFH Partnership & HAZ staff;
- that Neighbourhood Renewal (DSD) set up its own structures rather than working through existing IFH structures; and
- the perceived lack of connectivity between Sure Start and IFH delivery on the ground.

In respect of the IFH Partnerships it was commented that:

- the partnerships work independently from each other which meant that some providers had to submit separate proposals to different Partnerships and that there was little or no tie-across from one partnership to another. It was suggested that IFH Partnerships should consider jointly commissioning projects;
- the partnerships tend to be composed of the same local champions and they had not been as successful in a recruiting "new blood" into the groups; and
- the Partnerships involved too many stakeholders whose agenda was to get funding for their specific projects rather than looking at what would work best.

2.6.4 Leadership

Stakeholders identified either the MGPH or the DHSSPS as holding the leadership function for IFH. The following observations were made on leadership:

- a number mentioned the importance of the Minister being seen to support IFH;
- some (local stakeholders in particular) felt that MGPH had not been successful in holding Departments to account for deliverables; and
- stakeholders agreed that the leadership function needed to be strengthened, although there was no common agreement as to how this could happen.

2.6.5 Performance Management and Accountability

Performance Management of the IFH Partnerships was through the Department and this was felt to work reasonably effectively as the IFH Partnership Managers provided regular progress reports. However, the consultation highlighted the need for a feedback mechanism to the IFH Partnership Managers on how their work is supporting the overall delivery and identifying areas that are working well and those were further action is needed.

The majority of stakeholders felt generally that accountability was weak and there was no one organisation or person holding key stakeholders to account. Many stakeholders also highlighted that PfG / Public Service Agreement (PSA) / Priorities for Action (PfA) targets were their priority. Any IFH targets that were also PSA/PfA targets were therefore automatically focused on and those that were not PSA/PfA targets were not necessarily given the same level of attention.

2.6.6 Structures

A number of strategic stakeholders commented that they were not very aware of what was happening at a local level and therefore could not comment on the local Partnership structures. Others who were aware, spoke positively of the local partnerships and felt that these structures were effective at including a range of local stakeholders focused on improving health and wellbeing. All saw the need to ensure that IFH structures complemented the Community Planning Structures.

Health and Social Care stakeholders felt that the roles and responsibilities of the Department, the PHA and the HSCB needed to be updated in light of the restructuring in 2009. They felt that the PHA's role was key in working with:

1. the HSCB in commissioning work from Trusts and in ensuring that IFH is integrated into all aspects of the Trusts work;
2. the Department in exploring the possibility of including public health related activities in the work of all Health & Social Care Professionals to ensure that they helping to deliver IFH related outcomes; and
3. Community Planning networks to ensure that IFH is positioned at the centre of any new local strategies.

Many stakeholders felt that there was insufficient emphasis placed on research and evaluation; and learning from best practice. It was felt that the structures needed to support both of these areas to ensure that resources were being invested in interventions that provided the best Value for Money against IFH deliverables and that all the stakeholders could learn more from each other with regard to what works/what doesn't work. Finally, there was felt to be a need to have a structure in place that allowed for the effective monitoring of progress and impacts against the Strategy.

2.7 Structures and Resources

IFH exists in a health and social care system which has undergone significant changes in 2009. These structures now face further evolution as the Health and Social Care structures bed in and further changes may occur in local Government and other structures.

2.7.1 Effectiveness of the New Structures to deliver Investing for Health

2.7.1.1Strengths

The main strengths of the existing structures are as follows:

- The IFH Partnerships have created significant buy-in and engaged local communities in the IFH Agenda.
- The Partnerships are well connected with representatives in their own areas and considerable time has gone into developing these relationships and getting people to a stage where they feel they can work together.

- At a strategic level, Ministerial involvement and commitment were seen as essential to the Strategy's success.
- The new Health and Social Care Structures are much better equipped to deliver IFH, than the structures that existed prior to 2009.
- The establishment of the PHA provides the opportunity for strategic co-ordination and management of IFH deliverables.
- The planned appointment of 5 local Health Improvement Team leads within the PHA provides the necessary resource to co-ordinate local action and provide the rest of the IFH system with information on what works and what doesn't.
- The existing expertise and capacity regarding research and innovation within the PHA - R&D Division, the CoE for Public Health Research and the IPH.
- The links that Belfast Healthy Cities has with the rest of the WHO and their ability to provide information and research on what is working effectively elsewhere.

2.7.1.2 Areas for Development

There are a number of areas that need strengthened or developed:

- Accountability arrangements for IFH need to be clarified and strengthened.
- Research resources in Public Health need to be better connected and coordinated, with research informing practice where possible.
- Resource and partners must be in place within and outside of DHSSPS to influence other strategy work and budgets in Northern Ireland.
- IFH Partnership structures need to be linked to the Community Planning Structures;
- Need for continued awareness raising,, sharing best practice and learning with IFH stakeholders.
- Monitoring performance.

2.8 Relevance and Need

2.8.1.1. Why is a Strategy for Investing in Health in Northern Ireland Needed?

A number of improvements have been made to the overall levels of population health in Northern Ireland since the introduction of IFH in 2002; however there is still a significant amount of work to be done. Lifestyle factors are continuing to impact negatively on the health and wellbeing in Northern Ireland. Research has shown that persistent inequalities still exist between socio-economic groups and genders.

Analysis of the impacts achieved against the targets set for IFH demonstrates a mixed set of results. However this misses that one of the purposes of IFH was to inspire, motivate and encourage co-operation among Departments and Agencies. This is a critical issue in the successful delivery of any strategy, however it is also the hardest area to develop and sustain.

The consultation feedback and the analysis of impacts has demonstrated that IFH has had limited success in getting Departments and Agencies to significantly reconsider their existing services and how they could be energised to deliver IFH. There is evidence that there are significant opportunities for Departments to rethink service provision in a more integrated and connected way to deliver the IFH outcomes.

Changes in population health are a long term goal and, in some cases, can take decades to achieve. IFH is crucial to Northern Ireland's success in tackling health inequalities and it needs to be supported with the appropriate systems and structures to ensure it can effectively be delivered.

2.8.2 Relevance of Investing for Health

The current IFH strongly correlates to all of the priorities and a number of key goals that have been set out in the most recent PfG (2008-2011). Specifically, Priority 2: Promoting Tolerance, Inclusion and Health and Social Well-being, notes that those experiencing poverty and social exclusion are more likely to suffer ill health. The priority notes the need to address significant inequalities in health and education. Priority 2 of the PfG also notes that Northern Ireland continues to have high incidences of CHD, Stroke, Cancer and obesity which places an increased strain on public and social services. IFH notes that healthy public policies should help make healthy choices the easy choices.

While much of IFH remains relevant and consistent with many of the aims and priorities set out in the current PfG (2008-11), there is a clear need to update it to take account of changes to the landscape within which we now live and address some of the significant issues that have emerged since the Strategy's publication in 2002.

2.8.3 Emerging Issues

There have been a number of social, economic and legislatives issues and developments that have emerged since publication of Investing for Health, which have potential to impact upon its continued relevance.

2.8.3.1 Economy

When IFH was published the Northern Ireland and UK economy was experiencing a period of sustained growth. By the end of 2008 the UK economy was in recession. It has been widely acknowledged that the economy and the related impacts on an individual's socio-economic status have a direct impact on public health.

2.8.3.2 Obesity

Obesity is a major global public health problem and, in recent decades, there has been a significant rise in the number of overweight and obese people in many developed countries, including Northern Ireland. The prevalence of childhood obesity has also increased dramatically over the past two decades.

2.8.3.3 Climate Change and Sustainability

Climate change has both direct and indirect impact on health and well-being, and given the associated effects on food and fuel prices can also have the greatest impact on the most deprived and vulnerable people in society. In addition, there are health and wellbeing benefits that can accrue from sustainable/green policies such as the encouragement for sustainable communities, healthier environments, healthier forms of transport etc.

2.8.3.4 Early Years

There is a growing body of evidence to support the argument for investing in early years interventions. Supporting parents and children through this crucial lifestage (from 0-3 years) is the key to reducing health inequalities and promoting good health across the lifecourse. In addition, there is also a strong economic case for supporting early interventions as the return on investment is higher than interventions aimed at any other lifestage.

2.8.4 Strategic Review of Health Inequalities in England – The Marmot Report

The Marmot Review (2010) collected a significant amount of evidence on the most effective evidence-based strategies for reducing health inequalities in England, much of which is also relevant to Northern Ireland.

2.9 Recommendations

Based on the evidence gathered through the review, the following recommendations have been proposed:

Recommendation1: There is a clear need for a public health strategy based on the ethos and principles of the current IFH Strategy. As it comes to an end in 2012, there will be a need to ensure that a new strategic direction is in place and follows on from the first. The new strategy should be set within the updated policy context and should continue to be built around the evidence of the impact of key determinants model in respect of improving both physical and mental health and well-being. The strategy should distinguish those determinants that the evidence base shows are most powerful in reducing health inequalities and should have a clear focus on upstream interventions in this regard.

Recommendation 2: As the social determinants of health inequalities are clearly cross-sectoral in nature and have a concomitant relevance for all Departments, there is a need to ensure that the health and wellbeing and health inequalities agenda has a prominent position at the centre of the PfG and that agreed shared PSA targets reflect the priorities for IFH. There should also be a clear acknowledgement of the linkages and synergy between relevant Government and Departmental objectives and IFH to encourage collaborative working and investment for mutual gain. In particular, a more joined up focus on wellbeing across public sector organisations should improve value for money.

Recommendation 3: Noting the depth and breadth of evidence gathered through the Strategic Review of Health Inequalities in England (the Marmot Review), which reported in February 2010, the development of strategy on public health in Northern Ireland should include consideration in detail of Marmot's recommended policy objectives, in the context of the powers and responsibilities of the Northern Ireland Executive and in the context of a "Health in all Policies" approach. The Marmot Review policy objectives are:

- Give every child the best start in life;
- Enable all children, young people and adults to maximise their capabilities and have control over their lives;
- Create fair employment and good work for all;
- Ensure healthy standard of living for all;
- Create and develop healthy and sustainable places and communities; and
- Strengthen the role and impact of ill health prevention.

Recommendation 4: The existing MGPH should be supported by a Delivery Board ,with responsibility for co-ordinating implementation of Investing for Health. This could include officials from Government Departments, relevant agencies, the HSC and Local Government who are responsible for the operational delivery of the Strategy. The Delivery Board should meet at least quarterly to review progress and to direct action on areas of underperformance. MGPH should meet annually to review a monitoring report from the Delivery Board, and to propose a report to the Executive to include any recommendations for further strategic support or remedial action required. Consideration could be given to MGPH becoming a meeting of those Ministers most involved in policy in regard to key determinants of health.

Recommendation 5: It is essential that a more robust Monitoring and Performance Management system is developed, closely aligned to the PfG process. This should enable targets, indicators and available data to be better aligned at both the regional and local level, which in turn should enable a more informed formative and summative reporting system to be developed. This process must be carried out as part of the development of any new IFH strategy. Informed by quarterly reports from the Delivery Board, DHSSPS would continue to report to OFMDFM on the progress of the PSA targets for which it has lead responsibility.

Recommendation 6: Departments should explicitly require their Agencies and NDPBs to reflect linkages and interdependencies with the IFH agenda, and relevant PSA targets, including setting of appropriate objectives and targets. This could be better achieved through a particular focus on short, medium and long term outcomes. Local Government needs to be equally focused – this should be further facilitated through the ongoing development of local planning processes. Within the Health and Social Care sector, business planning processes should also ensure appropriate connections are made particularly with delivery organisations in support of IFH targets.

Recommendation 7: All Departments and service delivery organisations should be supported by DHSSPS and PHA to maximise their delivery of the IFH Strategy. DHSSPS needs to be adequately resourced to provide leadership and coordination across Departments and service delivery organisations and PHA needs to be resourced to provide:

1. solid and quantitative evidence linking the social and environmental determinants of health with their ultimate health outcomes;
2. research that shows and quantifies the effect of policies and specific interventions on these determinants; and
3. the development of policy-linked indicators which provide a quantitative estimate of the health that would be gained (or disease burden that could be avoided) by adoption of a specific policy.

Recommendation 8: Consideration of potential health impacts of policies throughout government (together with the benefits for other policy areas of health interventions) should be a mandatory requirement for all Departments as part of the policy development process. Further consideration needs to be given to the processes to ensure this can be affected, including that all Departments should be supported in this process.

Recommendation 9: PHA should continue its work with Local Government to ensure that IFH Partnership/ local engagement arrangements evolve over time and are connected into local planning and delivery structures in the future. This should ensure that such plans reflect IFH priorities as relevant for the local area.

Recommendation 10: IFH should build on and further develop engagement with and involvement of the third sector in the design and delivery of services, in support of empowerment of individuals and communities.

Recommendation 11: The proportion of Northern Ireland's total health expenditure spent on preventative and health promoting activities needs to be brought up to the level of the benchmark countries, such as England and Australia. At the very least, the current funding level needs to be protected and maintained and ideally more investment should shift towards working upstream on prevention.

3. BACKGROUND TO INVESTING FOR HEALTH STRATEGY

"… inequities in health, avoidable health inequalities, arise because of the circumstances in which people grow, live, work, and age, and the systems put in place to deal with illness. The conditions in which people live and die are, in turn, shaped by political, social, and economic forces."[1]

3.1 IFH Strategy

Investing for Health is the public health strategy of the Northern Ireland Executive. Launched in 2002, IFH was regarded as a pioneering strategy in the area of public health. It set out an overarching framework for cross-cutting action to improve health and wellbeing and reduce health inequalities through addressing the social determinants of health – the social, economic, physical and cultural environment in which people live that impact on their health. The IFH Strategy aims to provide direction on the prevention of ill health based upon partnership working amongst Government Departments, public bodies, local communities, voluntary bodies, District Councils and social partners.

Speaking at the first IFH conference in December 2003, Sir Donald Acheson, former Chief Medical Officer of England, described the Strategy as

"...by far the best health policy document at national level from a country in the English speaking world I have seen".

3.1.1 Development Process

In 2000, the Executive commissioned the Minister for Health, Social Services and Public Safety to develop a new inter-Departmental framework for action to improve health and reduce health inequalities. The Ministerial Group on Public Health (MGPH), made up of senior officials from all eleven Departments of the Executive, published the IFH Consultation Paper in November 2000. The Consultation Paper outlined a new approach to improve health, characterised by partnership working across Departments and all sectors.

A wide reaching consultation exercise was designed to obtain the views from a broad range of sectors. Presentations were made to a number of organisations to inform their response and a debate was held in the Assembly which supported the aims and objectives of IFH. The MGPH engaged the Community Development and Health Network (CDHN) to help secure community participation in the consultation exercise. A number of non-traditional methods were used to engage key target groups, including community arts projects, themed workshops, and a photographic competition.

[1] WHO (2008): Commission on the Social Determinants of Health. Final Report.

As part of the consultation process, the four Health and Social Services Councils also commissioned a survey of people's perceptions of health. For every person who thought the health of the Northern Ireland population was good, there was another who thought it was poor. The most affluent interviewees were more likely to consider their own health and well-being to be good; the least well off were more likely to consider it poor.

The three priority groups proposed in the Consultation Paper – the very young, children, and older people - did not attract widespread support, and it was widely suggested that the focus should be on the most disadvantaged in society, whatever their age group. The Strategy therefore concentrated on the most disadvantaged neighbourhoods and on the most disadvantaged population groups wherever they are living.

The consultation period ended in May 2001. There was a predominantly positive response from individuals and organisations across a wide range of sectors and interests, from which it was clear that there was overwhelming endorsement of a new inter-sectoral approach. The IFH Strategy was published in 2002.

3.1.2 Vision, Objectives and Targets

IFH has a total of two goals and seven objectives. The first two goals address the overarching aim of IFH, which is "*to improve the health of our people and to reduce inequalities in health*". The first purpose of these goals was to inspire and motivate and to encourage co-operation among agencies. The second had a more practical purpose – namely, to help measure progress towards the overall aim. These goals will be achieved through seven objectives which were selected to reflect the cross-cutting nature of IFH. They concern the wider determinants of health including poverty, education and the environment. There are also objectives to reduce deaths and injuries from all types of accidents; to promote positive mental health and well-being and to encourage people to make healthy choices. In selecting the objectives, priority was also given to ones which would have an impact on health inequalities.

The goals and objectives are expressed in qualitative terms but for each, where possible, quantitative targets are given. Timescales vary according to the nature of target – longer for outcome targets and shorter for impact targets.

3.1.3 Corporate Governance and Management of Delivery – Regional and Local Level

The range of factors influencing health extends far beyond the remit of the Department for Health, Social Services and Public Safety (DHSSPS) and the health service. Structures were established to deliver IFH, both across Departments and at a local level through IFH Partnerships. The following section details the partnerships were developed to take forward the IFH agenda.

At a regional level, the Minister chairs the MGPH which comprises senior officials from all Departments. MGPH is responsible for managing the inter-Departmental partnership, co-ordinating and monitoring the implementation of the Strategy. The Ministerial Group is supported and serviced by the IFH Team, based in DHSSPS.

At a local level, four IFH Partnerships were created. The broad purpose of the Partnerships is to identify opportunities for improving the health of the people in its area by addressing the social, cultural, economic and environmental determinants of health. The Partnerships were intended to comprise the key voluntary, community and statutory organisations in the area. They bring together different organisations in partnership to ensure that actions to improve health are properly co-ordinated, and that a plan of action is agreed to improve the health and well-being of the local population in line with the IFH Strategy. DHSSPS provides funding to maintain the infrastructure of the Partnerships. In addition to this core funding, the Partnerships have been successful in leveraging funding and non-financial contributions from their partner organisations.

3.1.4 IFH Funding

IFH was set up as a new Inter-Departmental framework to be used by all 11 Departments in order to improve health and reduce inequalities. It existed therefore to inform and influence Departments to consider how they could improve health and wellbeing whilst still delivering their own Departmental core priorities. There are many actions which contribute to IFH within and beyond DHSSPS and its agencies.

DHSSPS allocated between £2.5-2.9m per annum through Executive Programme Funds (initially and then these funds were mainstreamed) for the establishment and maintenance of IFH Partnerships between 2002-03 and 2008-09. These Partnerships were successful in leveraging funds from other organisations (this is discussed in further detail in Section 7). In addition to this, DHSSPS invests an annual amount of approximately £22m in the implementation of the strategies which promote healthier choices (i.e. those that contribute to IFH objective 7). Health Promotion strategies funding, while supportive of IFH Objectives, is largely "standalone".

3.2 Purpose of this Review

The purpose of this review of IFH is to:

- Assess the progress and impact of IFH against the objectives and targets set for it;
- Assess the relevance of the Strategy's objectives, targets, actions and interventions in the context of emerging priorities and issues and in the context of the Strategy's progress towards its objectives, identify any gaps and how they might be addresses; and
- Make recommendations to MGPH on the basis of the findings.

The Terms of Reference for the review can be found in Appendix 6. The remainder of the report is structured as follows:

Section 4: Context and Structures;

Section 5: Benchmarking;

Section 6: Progress and Impacts;

Section 7: Value for Money;

Section 8: Consultation Section;

Section 9: Structures and Resources;

Section 10: Relevance and Need; and

Section 11: Conclusions and Recommendations.

3.3 Acknowledgements

We would like to thank the Steering Group members for being available for meetings and providing access to the information that we required for this review. In addition, we would like to express our gratitude to Professor David Hunter for his assistance with the Benchmarking section and providing access to information that was required.

We would also like to express our thanks to the stakeholders which we interviewed during the course of the review and the members of the Departments who took part in our survey.

4. CONTEXT AND STRUCTURES

4.1 Introduction

The local and international context in which IFH was developed was considered in detail when the Strategy was drafted in 2002. Since then, there have been many developments the national and international public health arena. This section outlines the context in which IFH has been operating since its introduction in 2002. It begins with a snapshot of some of the key public health indicators to give an indication of the current state of the Northern Ireland's health. It then considers the structures that were, and are, in place to deliver IFH. Finally, a number of the key themes in public health that have emerged since 2002 and how these support the continued need for IFH are considered. In particular, we have focused on evidence that supports the rationale for continued investment in public health and addressing the gap in socio-economic health inequalities.

4.2 State of Health and Wellbeing in Northern Ireland

The following section outlines some indicators of population health in Northern Ireland. These are based on the most recently available data and, where possible, show changes since the introduction of IFH in 2002. Where applicable, data from Northern Ireland has also been compared to the rest of the UK (a full statistical analysis of all the indictors included in IFH can be found in the Statistical Annex).

4.2.1 Life Expectancy

Table 4.1 shows the life expectancy for men and women in Northern Ireland for the period from 1999-2007. The life expectancy of males has increased each year, with the exception of 2004-06 and 2005-07 when it remained static. Similarly, female life expectancy has increased consistently each year.

Table 4.1: Average levels of life expectancy for men and woman, NI

	1999-01	2000-02	2001-03	2002-04	2003-05	2004-06	2005-07
Male	74.8	75.3	75.6	75.9	76.1	76.2	76.3
Female	79.8	80.2	80.5	80.6	80.9	81.0	81.3

Source: NISRA

Comparing life expectancy figures to the rest of the UK helps to put the Northern Ireland figures into context. The life expectancy at birth and age 65 for each gender is shown in table 4.2 for the UK and each constituent country. Northern Ireland scores lower than the UK average for measurements of life expectancy for males and females at birth and at age 65. When compared to the other countries, Northern Ireland scores lower than Wales and England for all measures, but scores higher than Scotland.

Table 4.2: Life expectancy at birth and age 65: by country and gender 2004-06		
	Country	**Life expectancy (years)**
At birth: Males	UK	76.9
	England	77.2
	Wales	76.6
	Scotland	74.6
	NI	**76.1**
At birth: Females	UK	81.3
	England	81.5
	Wales	80.9
	Scotland	79.6
	NI	**81.0**
At age 65: Males	UK	16.9
	England	17.1
	Wales	16.7
	Scotland	15.8
	NI	**16.6**
At age 65: Females	UK	19.7
	England	19.9
	Wales	19.5
	Scotland	18.6
	NI	**19.4**
Source: Office for National Statistics (2008): Health Statistics Quarterly, Winter 2008		

4.2.2 Health Inequalities

There are clear disparities in health levels between the socio-economic groups within Northern Ireland. Table 4.3 shows the life expectancy at birth for deprived and non-deprived areas by gender. There is a clear gap in life expectancy between those living in deprived and non-deprived areas. The gap between the genders is also evident as a female living in a deprived area still has a higher life expectancy at birth than a male in a non-deprived area. The life expectancy of a male living in a deprived area is particularly low at 72, which is 10 years less than a female from a non-deprived area can expect to live. Life expectancy for all groups has increased over the time period shown; this increase has been smallest for males in deprived areas at 1.3 years and highest for females in deprived areas at 1.7 years.

The gap between females living in deprived and non-deprived areas has decreased from 3.5 years in 1999-01 to 3.2 years in 2005-07. The gap between males living in deprived and non-deprived areas has increased from 5.1 years in 1999-01 to 5.2 years in 2005-07.

Table 4.3: Life expectancy at birth in deprived areas, NI								
	1999-01	1999-01	2000-02	2001-03	2002-04	2003-05	2004-06	2005-07
Deprived	Male	70.8	71.0	71.4	71.9	72.6	72.3	72.1
	Female	77.0	77.4	77.8	78.1	78.6	78.4	78.7
Non-deprived	Male	75.7	76.4	76.7	76.9	76.9	77.1	77.3
	Female	80.5	80.9	81.2	81.2	81.5	81.7	81.9
Source: DHSSPS								

In addition, comparing the gap in life expectancy between those living in deprived areas with the Northern Ireland average shows clear and consistently present disparities. Table 4.4 shows the gap between the life expectancy between people living in deprived areas and the Northern Ireland average by gender for the 1999 to 2007 period (using the mid-point of each three-year time period). The gap in life expectancy for men has not shown any signs of decreasing over time and remains at approximately 4 years. The gap for females has shown some signs of improvement, but this is by only a marginal amount.

Table 4.4: Gap in life expectancy (in years) between deprived areas and NI average by gender		
	Male	Female
1999-01	4.0	2.8
2000-02	4.2	2.7
2001-03	4.2	2.6
2002-04	3.9	2.5
2003-05	3.4	2.2
2004-06	3.8	2.6
2005-07	4.1	2.5
Source: DHSSPS		

4.2.3 Prevalence of Chronic Disease

Chronic conditions are responsible for a significant proportion of early deaths. Although life expectancy of the population is increasing, chronic conditions have reduced the quality of the extra years that have been gained. The estimates of prevalence of the four most common chronic diseases in NI are shown in table 4.5.

Table 4.5: Estimates of prevalence of chronic disease in NI (2007)							
	Males	Females	All	16-44 yrs	45-64yrs	65-74 yrs	75+yrs
Hypertension	29.8%	27.6%	28.7%	9.2%	39.6%	65.1%	71.9%
Angina & CHD	6.5%	4.5%	5.4%	0.4%	6.1%	16.5%	22.4%
Stroke	2.4%	2.4%	2.4%	0.3%	2.0%	6.8%	11.8%
Diabetes (Type 1 &2)	4.5%	6.0%	5.3%	0.5%	3.1%	13.4%	-

Table 4.5: Estimates of prevalence of chronic disease in NI (2007)							
	Males	Females	All	16-44 yrs	45-64yrs	65-74 yrs	75+yrs
Source: IPH (2010): Making Chronic Conditions Count							

The percentages shown in the table translate into the following figures:

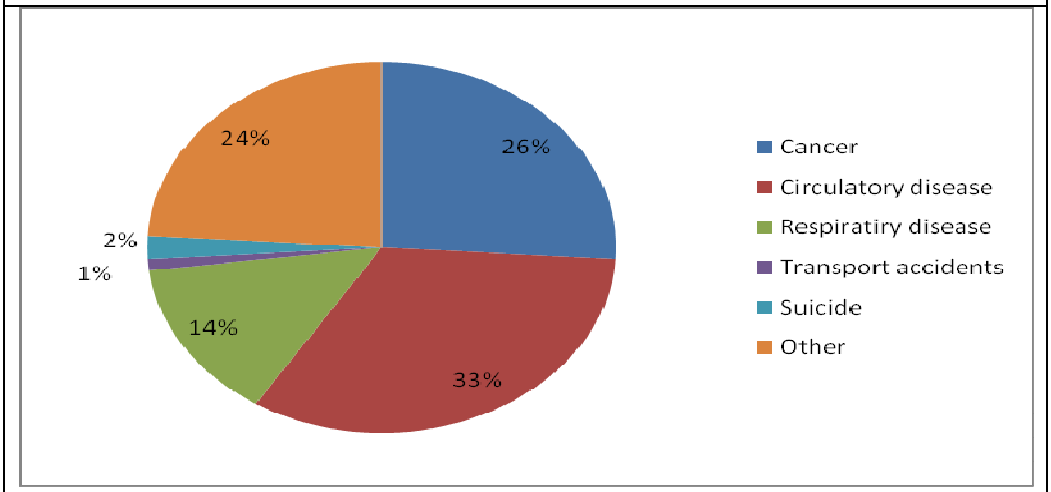
- 396,000 adults aged 16 years and over in Northern Ireland have high blood pressure (i.e. hypertension);
- 75,000 adults aged 16 years and over in Northern Ireland have ever had angina or a heart attack;
- 33,000 adults aged 16 years and over in Northern Ireland have ever suffered a stroke;
- 67,000 adults aged 20 years and over in Northern Ireland have diabetes (Type 1 and Type 2 combined).

With the exception of diabetes, the prevalence estimates for these chronic conditions are more common amongst males. The prevalence of each of these conditions increases significantly with age.

4.2.4 Common Causes of Death

Figure 4.1 shows the main causes of death in Northern Ireland in 2007. Cancer and Circulatory disease remain the most common causes of death, accounting for 59% of deaths in 2007. Circulatory disease is the most frequent cause of death. The chances of developing circulatory disease, including heart disease and stroke, are heavily impacted upon by lifestyle factors such as smoking, unhealthy diet, raised blood pressure, obesity, diabetes and physical inactivity. Cancer is the second most common cause of death. Similarly, the likelihood of developing a number of cancers is influenced by lifestyle factors such as smoking and diet.

Figure 4.1: Cause of death, NI 2007



Source: NISRA

4.2.5 Quality of Life

Healthy life expectancy (HLE) is an indicator that measures the balance between length and quality of life. Therefore, the emphasis is not exclusively on the length of life as in the case of life expectancy, but also on the quality of life. Self-reported overall general health status (as collected through the General Household Survey) has been increasingly used to calculate HLE. Levels of reported ill health are combined with mortality data to estimate the number of years of healthy life an individual will live. HLE for males and females at birth and at age 65 is shown in table 4.6. HLE for males and females in Northern Ireland is lower than the UK average at birth and at age 65. The gap between the Northern Ireland score and the UK average is higher for females than males.

Disability-free life expectancy (DFLE) measures disability by looking at reported limitations in day to day activities such as work, school and leisure activities. DFLE is derived using information on limiting long-term illness and mortality. DFLE is also shown in table 4.6. Again, DFLE for males and females in Northern Ireland is lower than the UK average at birth and at age 65. The gap between the Northern Ireland score and the UK average is also higher for females than males.

Table 4.6: Healthy life expectancy and disability-free life expectancy at birth and age 65: by country and sex 2004-06

	Country	Healthy life expectancy (years)	Disability-free life expectancy (years)
At birth: Males	UK	68.2	62.4
	England	68.5	62.8
	Wales	66.7	59.8
	Scotland	66.5	61.7
	NI	**66.9**	**60.0**
At birth: Females	UK	70.4	63.9
	England	70.7	64.1
	Wales	68.9	63.5
	Scotland	69.6	63.4
	NI	**68.8**	**60.7**
At age 65: Males	UK	12.8	10.1
	England	12.9	10.2
	Wales	12.3	9.5
	Scotland	12.2	9.8
	NI	**12.7**	**9.1**
At age 65: Females	UK	14.5	10.6
	England	14.7	10.7
	Wales	13.3	9.8
	Scotland	14.2	10.7
	NI	**13.8**	**9.0**

Source: Office for National Statistics (2008): Health Statistics Quarterly, Winter 2008

DFLE is closely related to socioeconomic status, with a steeper socioeconomic gradient (based on neighbourhood income deprivation) than for life expectancy. The DFLE at birth by deprivation decile for males and females in England is shown in table 4.7 (comparable figures for Northern Ireland were not available at the time of this report). The difference in DFLE between the most and least deprived areas in England is 12.4 years for males and 9.9 years for females born in the period 1994-99. The Marmot Review (2010) published more up-to-date figures showing that the gap in DFLE between the most and least deprived areas in England has increased to 17 years for people born in the period 1999-2003.

Table 4.7: DFLE at birth, by deprivation decile and sex in England, 1994-99

At birth deprivation decile	DFLE at birth (1996-99)	
	Males (years)	Females (years)
1 (least deprived)	63.1	64.6
2	62.4	63.3
3	61.4	64.2
4	60.9	62.1
5	59.9	61.3
6	58.1	58.8
7	57.0	59.2
8	55.4	58.7
9	54.0	56.6
10 (most deprived)	50.7	54.6
England (average)	58.4	60.4
Difference (least-most)	12.4	9.9

Source: Office for National Statistics (2009)

A limiting long-term illness (LLTI) is defined as a long-term illness, health problem or disability which limits a person's daily activities or the work that they can do, including problems that are due to old age. The total number of people in Northern Ireland reporting a LLTI has remained at a similar level of approximately 25% over the time period from 1998 to 2009. Women are more likely to report a LLTI than men with an average of 26.5% and 23.5% respectively over the same time period. There are also clear disparities between groups as defined by levels of household income and economic activity. There is a clear link between income and probability of reporting a LLTI with those in the lowest income bands up to four times more likely to report a LLTI as those in the highest bands. Those who are employed are least likely to report a LLTI (at an average level of 9.6%) while levels amongst the economically inactive are considerably higher in the 35-45% range.

4.2.6 Summary

A number of improvements have been made to the overall levels of population health in Northern Ireland since the introduction of IFH in 2002. This is evidenced in the increase in life expectancy for both males and females. However, despite these improvements in overall health levels, clear and persistent inequalities still exist between socioeconomic groups and genders. In addition, quality of life (as measured by healthy life expectancy) in Northern

Ireland is worse than the UK average for both male and females. Chronic conditions are also responsible for a significant proportion of early deaths in Northern Ireland. Although life expectancy of the population is increasing, chronic conditions have reduced the quality of the extra years that have been gained.

4.3 Structures in Place to Deliver IFH

4.3.1 Ministerial Group on Public Health

The MGPH was set up in 1997. Its remit was to support the Minister with responsibility for public health in taking forward the Government's agenda *'to improve the health of the population'*.

The first meeting of MGPH was held on 25th September 1997. The minutes of the meeting record that the then Minister said MGPH should be "*an action group, responsible for initiating action to promote public health, but also for ensuring that the exercises that it commissioned would be brought to a successful conclusion. Success will depend on co-operation across Departments and the group being prepared to take a fresh look at public health needs, and in being innovative in its efforts to address these*."

Between 1997 and 1998 MGPH met regularly, however there was a hiatus during the period immediately following the Good Friday Agreement.

IFH was published in March 2002 and clearly sets out a role for MGPH in supporting and monitoring its implementation. The Strategy defines the role of MGPH as "*managing the partnership across Government, and co-ordinating and monitoring the implementation of the Strategy."* It also states that "*the Investing for Health Partnerships will be accountable to MGPH, and that Departmental representatives will be responsible for monitoring the progress of the bodies for which they are responsible*". The Strategy also identifies a key role for the Group in the development of a Health Impact Assessment methodology and for individual MGPH members to encourage and monitor its use within their Departments.

By 2004, it was recognised that the MGPH was not fulfilling the functions set for it. A Review of the Group was completed in December 2004 and the conclusions and recommendations were as follows:

1. There is a need for a high level strategic inter-departmental Ministerial Group (i.e. MGPH) to drive forward public health policy in Northern Ireland. This Group should provide an authoritative and influential alliance facilitating cross-departmental working to ensure integrated strategic planning, monitoring and implementation of policies and strategies, including IFH, which will improve the health of the population and reduce inequalities.
2. To enable MGPH to fulfil this strategic role, formal structures will need to be put in place to monitor progress and also allow open communication between the Group and the local structures which currently exist to implement IFH. This could be achieved by the establishment of two standing sub-groups – one to advise on monitoring and evaluation, the other to report on progress or difficulties at operational level.

In section 8 we consider the feedback on the effectiveness of the MGPH and consider the need for change and our recommendations for moving ahead.

4.3.2 Department of Health Social Services and Public Safety

DHSSPS is responsible for setting policy, performance management of the health system and ensuring accountability and governance of resources and funding. Within the Department the IFH Team was responsible for supporting the MGPH and co-ordinating the development of the Strategy when it was launched in 2002. This dedicated team existed within the Health Development Directorate until 2003, a year after the Strategy was published, when it was merged with the former Health Promotion Team (with the loss of a Principal Officer), which then became the IFH Team.

Initially in 2003, the reformed Team was not only responsible for IFH, but also the development of policies and strategies on healthy choices (with the exception of the Drugs and Alcohol Strategy). At this time the Team was also allocated two major key Ministerial priorities i.e. the introduction of tobacco legislation/ smoking controls in public places and the development of the suicide prevention strategy - Protect Life. It also later assumed responsibility for the implementation of Fit Futures - the childhood obesity strategy.

In 2007, the work of the IFH Team and the Alcohol and Drugs Policy branch was reconfigured and they were jointly renamed the IFH Unit with two branches, Health Development Policy Branch and the Health Improvement Policy Branch.

The Health Improvement Policy Branch is responsible for other policy areas such as:

- Tobacco;
- Mental Health promotion and Suicide Prevention;
- Sexual Health Promotion;
- Teenage Pregnancy; and
- Accident Prevention.

The Health Development Policy Branch is currently responsible for:

- IFH;
- New Strategic Direction on Alcohol and Drugs; and
- Development of a Population/ Lifecourse Approach to Obesity Prevention.

The IFH Team's responsibilities include the review and development of the Strategy, the review of progress against the IFH objectives and targets, HIA, resourcing implementation and providing a secretariat service to the MGPH. Since 2003, the team has taken on additional policy and strategy responsibilities, reducing the amount of time available for IFH. In section 7 we consider the work of the IFH team and the implications for resources.

4.4 Pre Re-Organisation of the Health System in 2009

4.4.1 Introduction

IFH has been delivered in a period when the health structures in Northern Ireland have undergone significant change. This section details the health structures and some key partner organisations that existed from 2002 to 2009 and in section 4.5 we set out the current structures.

4.4.2 Health and Social Services Boards

Pre-2009 Health and Social Care Reform, the Health and Social Services (HSS) Boards were responsible for commissioning services including health promotion.

The four HSS Boards were directed to take the lead in steering and coordinating the IFH process at a local level. They were asked to establish cross-sectoral IFH Partnerships for their areas through bringing together key statutory, voluntary and community organisations. Core members were to be included[2]; however beyond this the composition of the partnerships was to be determined locally. The Partnerships were to be responsible for identifying opportunities for improving the health of their local populations through addressing the wider determinants of health, and for developing long term local cross-sectoral Health Improvement Plans (HIPs) in line with IFH Strategy, ensuring that actions taken to improve health were properly co-ordinated. These long term (3 or more years) HIPs were then reflected in the Board's annual Health and Wellbeing Investment Plans.

In relation to partnership working, the Boards were encouraged to work with and build on existing partnerships (Including HAZs, Healthy Cities and Local Strategy Partnerships) and networks to the greatest possible extent. The HSS Boards were expected to ensure that all key stakeholders had the opportunity to contribute fully to the development of their plans for health improvement.

The IFH Partnerships were established as planned in 2002 as the key local delivery structures for the Strategy. Each partnership coordinates action plans to improve the health and well-being of the local population, in line with the Strategy. Representation on these Partnerships is strong from Local Government, the Health and Social Care Sector, NIHE, Environmental Health, Community and Voluntary sector.

As of 1st April 2009 all IFH Partnership responsibilities have been transferred to the Public Health Agency.

4.4.3 Health and Social Care Trusts

There are currently five Health and Social Care (HSC) Trusts as follows:

- Belfast HSC Trust;

[2] The IFH strategy recommended that District Councils, Housing Executive, Education and Library Boards and HSS Trusts were to be included. It also highlighted that composition of the Partnerships should evolve over time.

- Northern HSC Trust;
- Southern HSC Trust;
- South Eastern HSC Trust; and
- Western HSC Trust.

The 5 HSC Trusts came into being on 1st April 2007, as a first phase of the Health Reforms contribution to the Review of Public Administration (RPA). They were created from the merger of nineteen former trusts. HSC trusts are the main providers of health and social care in Northern Ireland. The HSC Trusts health and wellbeing improvement functions are:

- To deliver health improvement programmes and services in line with commissioning plans;
- To participate (and provide local leadership) in the design, development, delivery, monitoring and evaluation of local programmes in response to local needs in order to achieve agreed outcomes within a commissioning framework;
- Inform commissioning plans through contributing knowledge based on established local relationships;
- To work with front line health and social care staff to maximise opportunities for health improvement for health and social care users and within health and social care settings; and
- To work with communities, other statutory organisations, community and voluntary groups and the private sector at local level (for example through Neighbourhood Renewal Partnerships, SureStart, Healthy Living Centres) to support them in their efforts to improve health and reduce inequalities and to adapt programmes to local needs.

Each Trust has a Health Improvement team, but as the Trusts are structured differently the Health Improvement staff report into different directorates. This can mean that Trusts take a slightly different approach to IFH depending on the directorate they report into.

The Trusts' roles and responsibilities for health and wellbeing did not change in 2009.

4.4.4 Investing for Health Forum

The IFH Strategy also set out that the value of an IFH Forum would be explored. The Forum's role could be to:

- Raise awareness and understanding of IFH across society;
- Engaging the efforts of important partner groups;
- Sharing relevant experience, information and plans;
- Identifying issues of concern and emerging priorities; and

- Identifying obstacles to full implementation and helping to overcome them.

In December 2003, a half-day Forum and full day conference was organised which included presentations and discussions with representatives from the still fairly recently established IFH Partnerships. Feedback from this conference was that there should be biennial IFH conferences held for sharing of ideas and progress. Regional Conferences were also held in 2005 and 2007.

Since 2007, no further conferences have been held.

4.4.5 Health Action Zones

There are four Health Action Zones (HAZs) in Northern Ireland, two of which have been operational since 1999 and two since 2001 (therefore pre-IFH). The HAZ Model uses an integrated, community-led partnership approach to the targeting of health and social well-being inequalities, where there is clear evidence of health and social disadvantage. This model involves the preparation of targeted Action Plans in each partner community, tailored to local needs, which make the best use of local and other resources.

The Action Plans are drawn up in partnership with the local community and key partner agencies, following consultation within each neighbourhood. The HAZ team then brings together relevant agencies, regional and local, with responsibility for planning and delivering services and encourages them to co-operate in implementing the Action Plans in partnership with each other and the local community. IFH recommended that the IFH Partnerships should learn from and build on the HAZ model. An external review of HAZ completed in 2005, recommended continued funding of the HAZ teams and the clarification and communication of IFH Partnership and HAZ roles to stakeholders.

Each HAZ was originally provided with £150k per year by DHSSPS to cover infrastructure costs (this figure has risen yearly with inflation). Subsequent to the review in 2005, the funding for HAZ was mainstreamed and placed in Boards' baselines.

In 2009, the HAZ teams work was integrated into the new Public Health Agency (PHA).

4.4.6 Health Promotion Agency

The Health Promotion Agency (HPA) provided a regional focus for health promotion. Its statutory functions included:

- Advising the Department on matters relating to health promotion;
- Undertaking health promotion activity;

  Planning and carrying out regional or local actions in cooperation with HSS Boards, Districts Councils, Education and Library Boards, voluntary organisations and other key interests;
- Sponsoring research and evaluation;
- Assisting the provision of training;
- Providing a regional centre of information and advice on health promotion; and

- Making grants to and otherwise supporting voluntary organisations.

Under the IFH Strategy, it was responsible for:

- Contributing to the development of policy and strategy in priority areas of health and health promotion;
- Assessing training and development needs and preparing and implementing resources and programmes to meet those needs including developing the capacity of those working to promote health in a range of settings and sectors;
- Establishing and facilitating networks to share experience, information and learning about effective practice in promoting health and tackling inequalities in health;
- Developing and maintaining a central information function to support those working in public health;
- Developing and providing guidance on monitoring and evaluation of health promotion activity;
- Working in partnership with other organisations and sectors to enable the development and implementation of health promotion programmes in a range of settings; and
- Providing public and professional information in a range of media and channels to ensure that appropriate and relevant health information is available.

The Health Promotion Agency was abolished and its functions absorbed in April 2009 into the newly formed Public Health Agency which now has a wider range of functions and responsibilities.

4.4.7 Belfast Healthy Cities

Belfast Healthy Cities preceded IFH and is an active and key stakeholder partner in the IFH process.

Belfast Healthy Cities is a limited company with charitable status. It aims to shape, influence and develop healthy public policy. It promotes equity and health improvement through intersectoral collaboration. It also aims to introduce new concepts and ways of working, through its participation in the World Health Organisation (WHO) European Healthy Cities Network. It works closely with decision makers in government Departments and the public sector as well as the voluntary and community sectors. Belfast is a leading member of the WHO European Healthy Cities Network, which currently has 80 member cities across Europe. Belfast programmes are determined by the overarching themes and requirements for a WHO Healthy City, but are developed within a local context.

4.4.8 Institute of Public Health in Ireland

The Institute of Public Health in Ireland (IPH) was established in 1998 and has offices in Belfast and Dublin. The Institute is primarily funded by DHSSPS and the Department of Health and Children and is accountable to the two Departments through its Management Board. IPH promotes cooperation for public health between Northern Ireland and the Republic of Ireland by:

- strengthening public health intelligence;
- building public health capacity; and
- policy and programme development and evaluation.

Tackling inequalities in health has been a central focus for its work. IPH work to support IFH has included health impact assessment (HIA), leadership development, evaluation of programmes and development of information and research. In line with the IFH strategy IPH has worked closely with DHSSPS and the Department of Health and Children to develop quality assurance and HIA guidelines, produce tools for use in Northern Ireland, run a highly valued intersectoral capacity building programme, develop and manage a web library of public health information resources, and establish practitioner networks that link to international networks. IPH has also produced reviews on issues such as the health impact of transport, the built environment and education.

IPH has also established the all island public health observatory, Ireland and Northern Ireland's Population Health Observatory (INIsPHO). The Observatory is linked to a network of UK observatories. Making data available and accessible in manageable form is a key goal. INIsPHO supports practitioners and policy-makers by producing and disseminating health intelligence, and strengthening public health research. This work includes producing comparative local data and reports on the prevalence of diseases which can be used by planners and policy-makers.

IPH is a key partner in two recently established research centres, the UKCRC Centre of Excellence for Public Health (Northern Ireland), one of five UK centres created as part of a new £20 million investment, and the HRB Centre for Health and Diet Research in UCC which aims to support evidence-based diet and nutrition policy in Ireland.

Between 2003 and 2006, IPH carried out an R&D Office funded research programme to help partnerships measure their performance, monitor their progress and assess benefits.

To meet the need for strong leadership for public health IPH developed a highly innovative leadership programme for people from diverse disciplines and sectors. Between 2002 and 2007 this programme resulted in over 100 people in key leadership positions strengthening their leadership skills for public health. IPH has played a key role in the foundation of North-South initiatives such as the Centre for Ageing Research and Development.

Over the past ten years the Institute has produced over 60 publications, held more than 30 conferences and workshops and responded to relevant policy consultations. These have been aimed at strengthening public policy for health.

4.4.9 Centre of Excellence for Public Health

The Centre of Excellence (CoE) for Public Health comprises academics from five different Schools in Queens University Belfast (QUB), as well as researchers and collaborators from the IPH and Health and Social Care. The Centre works to ensure that the needs of policy makers, practitioners, and public representatives are built into all aspects of its work, including setting the research agenda, the facilitation of applied research, and disseminating research outputs in the most effective ways to influence practice.

The Centre has a Management Board, a smaller Management Executive and an International Scientific Advisory Committee. The Management Board provides leadership and vision, ensures partnership working with policy makers, the wider public sector and the public, helps set strategy and builds organisational commitment. Apart from the Scientific Director of the Centre, its membership includes representatives of: the Chief Medical Officer, DHSSPS and the Northern Ireland Statistics and Research Agency; the Regional Director of Public Health, Public Health Agency (now responsible for the DHSSPS R&D Office); the Health and Social Services Council; the IPH; the CDHN; and the University Management Board. An International Scientific Advisory Committee also reviews performance on a regular basis and advises on research strategy and direction.

The work of the CoE builds upon two existing major collaborative areas of strength in QUB, namely nutrition and physical activity and their association with chronic disease and the social and economic determinants of chronic disease, providing opportunities for multi-disciplinary research and training by exploiting data-sets. Each workstream is divided into a number of research programmes, some of which build on existing successful research, some of which are branching into new collaborative ventures.

Following the inception of the UKCRC Centre of Excellence Award in August 2008, the Centre has been successful in obtaining further funding from the ESRC, DEL, MRC and the EU of approximately £4 million to support these new ventures.

4.5 Restructuring of Health System in 2009

4.5.1 Introduction

A number of significant changes have taken place in all sections of public administration in Northern Ireland, particularly within the health sector. As these changes were only introduced in April 2009, it is too soon to analyse their impact on IFH delivery, however it is important to consider if the changes in these structures can benefit the delivery of the Strategy.

The key structural changes which relate to IFH are:

- A **single regional Health and Social Care Board** replacing the existing four Health and Social Services Boards that focuses on commissioning, resource management and performance management and improvement;
- A **regional Agency for Public Health and Social Well-being** that will incorporate and build on the work of the Health Promotion Agency but will have much wider responsibility for health protection, health improvement and development to address existing health inequalities and public health issues for all the people of Northern Ireland;
- A **single Patient and Client Council** replacing the current Health and Social Services Councils with five local offices operating in the same geographical areas as the existing Trusts, to provide a strong voice for patients, clients and carers; and
- A much smaller and more focused **Department**.

4.5.2 Health and Social Care Board and Local Commissioning Groups

The Health and Social Care (Reform) Act (Northern Ireland) 2009 dissolved the four Health and Social Services Boards and established a body corporate known as the Health and Social Care Board (HSCB). The body also incorporated the Service Delivery Unit and some functions from the Directorate of Information Services of DHSSPS.

The HSC Board has three main functions:

- To arrange or "commission" a comprehensive range of modern and effective health and social care services for the 1.7 million people who live in Northern Ireland in line with Departmental requirements;
- To establish service and budget agreements with health and social care Trusts and other providers and ensure that these are performance managed to achieve optimal quality and value for money in line with relevant government targets; and
- To effectively deploy and manage its annual funding from the DHSSPS to ensure that this is targeted upon need and reflects the aspirations of local communities and their representatives.

Commissioning structures are being revised to reflect the new organisational arrangements. A commissioning plan has been prepared by HSCB and PHA staff for 2010/11, and Ministerial consideration.

There are 5 LCGs located across the region and each is supported by a Commissioning Lead and associated staff from both the HSCB and PHA. The role of the LCGs is as follows:

- To assess health and social care need;
- To plan to meet these needs; and
- To secure delivery of appropriate services to meet needs.

The five LCGs (Belfast; Northern; South Eastern; Southern and Western) are committees of the Health and Social Care Board. Each LCG is currently co-terminus with their respective Health and Social Care Trust area subject to review when the outcome of Local Government Reform is known.

4.5.3 Public Health Agency

The PHA has been recently established in April 2009. It was set up to improve health and social wellbeing and to protect the community. It is responsible for health protection, screening, HSC Research and Development, safety and quality of services, and regional and local health and wellbeing improvement work previously carried out by the four Health Social Services Boards, incorporating and building on the work of the HPA and developing structures and supports to enhance cross-sectoral working. It also provides public health, nursing and allied health professional advice to support the new HSC Board and its LCGs in their respective roles in commissioning, resource management, performance management and improvement, and has a statutory role in approving the commissioning plan of the HSCB.

As already mentioned, the IFH Partnership and HAZ teams were transferred to the PHA in 2009. The PHA is committed to ensuring its staff work closely with Local Government staff in support of promoting health improvement and this is an essential step in strengthening cross-sectoral working. As part of this work, the Belfast Health Development Unit was established in 2010, involving staff from the PHA, Belfast HSC Trust and Belfast City Council.

The PHA also acquired the R&D function which commissions research in health and social care related areas. PHA action plans and commissioned interventions are based on research evidence. The Agency has also made more regular links with QUB, University of Ulster, CoE and IPH. This will provide more opportunities in the future for research proposals and studies of local public health programmes, including IFH- related. Having a network of academics, researchers and policy makers working together at different stages in the policy life cycle, follows the approach already taken by the WHO, and ensures that all the resources are being used effectively.

The PHA uses data from a range of sources to monitor progress against targets, shape its own plans and target resources to areas and populations who experience the greatest inequalities Examples include:

- Public Health Observatory of the IPH;
- The Northern Ireland Statistics and Research Agency;
- Universities;
- The Northern Ireland Cancer Registry;
- DHSSPS Information and Analysis Directorate; and
- Using primary care data held by the Regional Health and Social Care Board and Regional Health and Social Care Board.

Information and research staff are members of PHA health improvement teams. They bring the evidence base, link with researchers and the monitor progress

Under legacy and current arrangements, health improvement programmes have typically been piloted and evaluated before substantive recurrent investment is made. While this helps ensure that programmes are effective, it has led to multiple small scale short term pilots rather than sustained investment in some core programmes. The PHA intends to address this in its commissioning.

4.5.4 Patient and Client Council

The Patient and Client Council was set up to:

- Promote public and user involvement in the design, commissioning and delivery of health and social care programmes and services including those relating to health and social wellbeing improvement;
- Represent the public interest in health and social care at regional and local level; and
- Provide a public, patient and client perspective on the work of the PHA and HSCB on health and wellbeing improvement.

They provide the external voice, which will be key in ensuring that progress is made to improve Health Improvement and Disease Prevention within the Health Service. It is critical that the Council is a driver in this change process.

4.6 Northern Ireland Policy

All of the Northern Ireland Government Departments have a role in implementing the IFH Strategy and are expected to consider the principles of IFH and how they can address the determinants of health when developing their own policies. A wide number of policies and strategies have been developed in Northern Ireland since the publication of the IFH Strategy – many of these have impacted and contributed to IFH aims and targets.

A number of cross-Departmental strategies were published following IFH that have directly impacted on health outcomes. One of these is the Neighbourhood Renewal strategy (which was published in 2003). This strategy focuses on the most deprived urban areas and amongst its main objectives is 'Social Renewal'; to improve conditions for people who live in the most deprived neighbourhoods through better co-ordinated public services and the creation of safer environments. Activities to achieve this include improving the health of people living in the most deprived urban neighbourhoods.

Similar to IFH, the Neighbourhood Renewal Strategy adopts a collaborative, partnership working approach. A number of Neighbourhood Partnerships were established across Northern Ireland to deliver the strategy on the ground. Their membership includes representation from the statutory, private and voluntary and community sectors. The composition of individual Neighbourhood Partnerships reflects local circumstances bringing together the different parts of the public, private, business and community and voluntary

sectors so that different initiatives and services support each other and work together. There are continuing opportunities for synergy between the IFH and NR strategies at local level.

4.6.1 Programme for Government

The Programme for Government (PfG) sets the strategic priorities and key plans for the Northern Ireland Executive as well as the longer term aspirations and intentions. It informs the allocation of the Executive's budget and investment priorities and is underpinned by Departmental Public Service Agreements (PSAs) which include the key targets for government. The 2002-05 PfG reflected many of the key issues to be addressed through IFH. This PfG had five key priorities:

1. Growing as a Community;
2. Working for a Healthier People;
3. Investing in Education and Skills;
4. Securing a Competitive Economy; and
5. Developing North/South, East/West and International Relations.

Under the second priority, Working for a Healthier People, a number of sub-priorities were set that were explicitly linked with the IFH agenda:

- Improving the health of all our people and reducing health inequalities;
- Ensuring an environment that supports healthy living and the safe production of food;
- Promoting public safety by reducing the numbers of injuries and deaths caused by accidents at home, at work and on the roads;

The 2002-05 PfG also emphasised the importance of joined-up working between Departments and with partners in the private, community and voluntary sectors.

The key priority of the current PfG (2008-11) is growing the economy. However, a number of PSA targets relating to promoting health and addressing inequalities are directly relevant and complementary to IFH. These PSAs and their associated objectives are shown in the table below.

Table 4.9: Overview of PSAs relevant to IFH

PSA	Objectives
PSA 7: Making People's Lives Better: *Drive a programme across Government to reduce poverty and address inequality and disadvantage*	Take forward action to provide for measurable reductions in the levels of poverty and particularly child poverty
	Take forward co-ordinated strategic action to promote social inclusion for: • Lone parents; • People with physical/sensory disability; • Older people; • New and established Minority; and • Ethnic Communities.
	Speedier access to Mental Health and Learning Disability community services, and fewer long stay patients in Mental Health and Learning Disability hospitals
	Reduce levels of fuel poverty
	Promote equality and the enforcement of Rights
	Working with the Commissioner for Victims and Survivors, to develop and implement a new, comprehensive strategy approach to Victims and Survivors
PSA	**Objectives**
PSA 8 : Promoting Health and Addressing Health Inequalities: *Promote healthy lifestyles, address the causes of poor health and wellbeing and achieve measurable reductions in health inequalities and preventable illnesses*	Promote uptake in screening and immunisation programmes to forestall avoidable disease and reduce mortality rates
	Promote smoking cessation and measures to tackle obesity and physical inactivity, particularly among children, and reduce health inequalities
	Reduce binge drinking and illicit drug use, particularly among young people and vulnerable groups
	Reduce the incidence of suicide
	Improve sexual health and reduce the rate of teenage pregnancy

PSA 12: Housing, Urban Regeneration and Community Development: *Promote decent, energy efficient, affordable housing and regenerate disadvantaged areas and towns and city centres, and support community development to create environments which enhance quality of life and contribute to well-being*	Provide access to decent, affordable and energy efficient housing.
	Promote viable and vital towns and city centres, helping to create shared spaces that are accessible to all and where people can live, work and socialise
	Regenerate disadvantaged urban areas
	Promote a strong vibrant and sustainable voluntary and community sector to enable better delivery of services
	Promote strong, integrated, sustainable communities where people want to live work and socialise
Source: NI Assembly (2008): Programme for Government 2008-11	

4.6.2 Summary

Northern Ireland Executive recognised the importance of a cross- cutting approach to improving health and well-being and reducing health inequalities through its endorsement of the IFH Strategy launched in 2002. A wide number of policies and strategies have been developed in Northern Ireland since the publication of the IFH Strategy. Many of these have impacted and contributed to IFH aims and targets, both directly and indirectly. However, IFH is one of many strategies in government and critically only a number of the IFH outcome targets are now included as PfG targets. The PfG targets are key to getting IFH positioned at the heart of government. There is an opportunity as we move closer to the development of the next PfG to have the IFH agenda influencing government priorities for the subsequent three years and beyond.

The full extent to which IFH has influenced Departments' work is examined in further detail in Section 6.

4.7 Emerging Themes in Public Health

Since the publication of IFH in 2002, a considerable amount of evidence has been published to support the rationale for tackling the social determinants of health as the key to addressing health inequalities and improving outcomes for society as a whole. This section considers some of the salient issues that arise from a selection of key documents (a full synopsis of each of the cited documents can be found in Appendix 1).

4.7.1 Societal Inequality

In November 2008, Professor Sir Michael Marmot was commissioned by the Secretary of State for Health to conduct an independent review and to propose the most effective evidence-based strategies for reducing health inequalities in England from 2010. Fair Society, Healthy Lives: The Marmot Review (published in February 2010) is the report of the Review's work. The Review states that health inequalities stem from avoidable inequalities in society such as income, education, employment and neighbourhood circumstances. Action on health inequalities requires action across all the social determinants of health.

Research published by Wilkinson, & Pickett[3] also shows evidence linking income inequality to morbidity and mortality, obesity, teenage birth rates, mental illness, homicide, low trust, low social capital, hostility, racism, educational performance and social mobility. In addition, the prevalence of a range of health and social problems are higher in countries with higher levels of income inequality. This research suggests that social stratification is more than just income inequality and is deeply rooted in our personal and class characteristics, including many of the early childhood influences on social and cognitive development.

Addressing these social inequalities will have wide-ranging impacts. Wilkinson & Pickett's research shows that the achievement of higher national standards of performance may be substantially dependent on reducing inequalities in each country. As well as improving health, reducing inequality may also raise the educational performance of school children, increase trust, while decreasing violence and teenage births. The Marmot Review also emphasised that action taken to reduce health inequalities will benefit society in many ways. Among these are the economic benefits in reducing losses from illness associated with health inequalities. These currently account for productivity losses, reduced tax revenue, higher welfare payments and increased treatment costs.

4.7.2 Social Gradient

In considering inequalities in health, there is a well-established relationship between a person's social background and their health outcomes. Those from a disadvantaged background are more likely to suffer ill health and die younger than their counterparts from less disadvantaged backgrounds. However, the relationship between health and social circumstances is graded: the lower a person's social position, the worse his or her health. Evidence analysed by the Commission on the Social Determinants of Health (CSDH), set up by the WHO (also headed by Sir Michael Marmot), found that in countries at all levels of income, health and illness follow a social gradient whereby the lower the socioeconomic position of an individual, the worse their health. This is not confined to poor countries; low socioeconomic position in a rich country means poor education, lack of amenities, unemployment and job insecurity, poor working conditions, and unsafe neighbourhoods. All these factors have consequent impacts on individual's health.

[3] The Problems of Relative Deprivation: Why Some Societies do Better than Others (2007) and The Spirit Level. Why More Equal Societies Almost Always do Better (2009)

Action to tackle inequalities in health should focus on reducing the gradient in health. The CSDH set out 3 principles of action to achieve health equity:

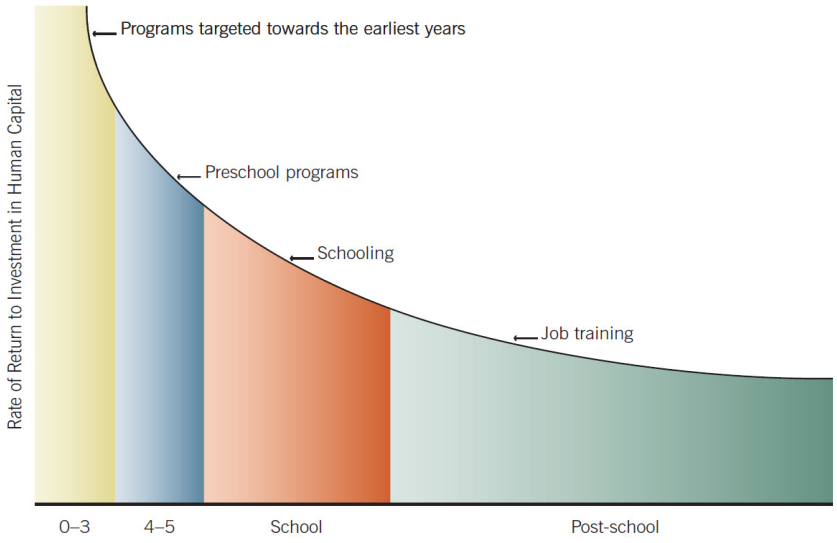
- Improve the conditions of daily life – the circumstances in which people are born, grow, live, work, and age;
- Tackle the inequitable distribution of power, money, and resources – the structural drivers of those conditions of daily life – globally, nationally, and locally; and
- Measure the problem, evaluate action, expand the knowledge base, develop a workforce that is trained in the social determinants of health, and raise public awareness about the social determinants of health.

4.7.3 Early Years Interventions

Early childhood is increasingly being recognised as the most important period of development. The Marmot Review provides evidence to support the theory that action to reduce health inequalities must start before birth and be followed through the early life of the child. To achieve equity from the start, investment in the early years is crucial. There is also considerable evidence to show that the return on investment in early years is much larger than at any other stage of the lifecourse. For example, a recently published paper by the New Economics Foundation, Backing the Future (2009), demonstrates the economic case for investing in preventative services for children and young people to address the structural factors affecting the circumstances of their lives, such as poverty and inequality, together with psychological and social dimensions of their well-being. The paper estimates that the return to the UK economy of investing in an early years preventative approach would total a minimum of £486 billion over 20 years. This is roughly five times the current annual budget of the entire NHS.

James Heckman (a Professor of Economics at the University of Chicago) has conducted a large amount of research into early childhood interventions and provides strong evidence to show that the economic returns to early investments are high. Figure 4.2 shows the model Heckman developed to demonstrate the return on each US$ invested in programmes targeted at children at different life stages. It is clear that the highest return on investment is achieved at the 0-3 years stage. The return on investment reduces considerably at each subsequent life stage.

Figure 4.2: Returns to a unit US$ invested



Source: J.Heckman (2008): Return on Investment: Cost vs. Benefits. University of Chicago

4.7.4 A Shared Responsibility

The Marmot Review states that taking action to reduce inequalities in health requires action across the whole of Government and society. The Review states that national policies will not work without effective local delivery systems focused on health equity in all policies.

4.7.5 Monitoring, Evaluation & Evidence

There is a strong evidence base to support the need for thorough monitoring and evaluation of population health in order to make evidence-based decisions. The Appleby Review of Health and Social Care in Northern Ireland (2005) recommended the routine collection of self-assessed health status data at a population level. The aim of this is to compile comparative data on population health status at a Northern Ireland level which will enable informed decisions on public health interventions to be based. The Wanless Review, Securing Good Health for the Whole Population (2004), also makes the case for assessing public health interventions as the evidence base for policymakers and practitioners is weak with respect to the differential effectiveness and relative cost-effectiveness of different interventions, particularly with respect to different populations groups or settings. Wanless recommends that the following principles are adopted by governments when developing new public health policy to ensure targeted interventions increase both health and welfare:

- Interventions should tackle public health objectives and the causes of any decision-making failures as directly as possible;
- Interventions should be evidence-based, though the lack of conclusive evidence should not, where there is serious risk to the nation's health, block action proportionate to that risk;

- The total costs of an intervention to the Government and society must be kept to a minimum and be less than the expected benefits over the life of the policy: interventions should be prioritised to select those which represent best value;
- The distributional effects of any programme of interventions should be acceptable; and
- The right of the individual to choose their own lifestyle must be balanced against any adverse impacts those choices have on the quality of life of others.

4.7.6 Summary

Since the launch of IFH in 2002, there have been a number of reports in the UK, EU and beyond raising awareness of the drivers of ill health and health inequalities. The social determinants model as a means of tackling health inequalities has received particular support. This increased emphasis on the social determinants of health, the "causes of the causes," complements and enhances the traditional public health focus on disease prevention and behavioural risk factors such as body weight, physical activity, diet, and alcohol and tobacco use.

Early childhood interventions are a particularly important area that can help reduce the societal inequalities rooted in poverty by providing young children from disadvantaged backgrounds with a more equitable start in life. This investment in early childhood also has the potential to multiply returns over the life-course many times the amount of the original investment.

This recent research can provide useful context in which to evaluate the impact of IFH and provide a basis for developing a new Strategy.

4.8 Conclusion

Since the publication of IFH in 2002, a number of significant strategic developments have taken place that have been, and continue to be, relevant to the delivery of IFH.

A wide number of policies and strategies have been developed in Northern Ireland since 2002 which have impacted and contributed to IFH aims and targets, both directly and indirectly. Critically, only a number of the IFH outcome targets are included as targets in the current PfG (2008-11). The PfG sets the strategic priorities and key plans for the Executive as well as informing the allocation of their budget. The PfG targets (and associated Departmental PSAs) are key to getting IFH positioned at the heart of government. Action should be taken urgently to ensure the health and wellbeing and health inequalities agenda features prominently in any new PfG.

A number of significant structural changes have also taken place in all sections of public administration in Northern Ireland as a result of the RPA, particularly within the health sector. A key aim of the reforms within the health sector was to improve health and tackle health inequalities - this has been galvanised by the establishment of the PHA in April 2009 which has provided a level of regional coordination of health improvement work not previously possible under the prior structures. As these changes were only introduced in April 2009, it is

too soon to analyse their impact on IFH delivery, however it is important to consider if the changes in these structures can benefit the delivery of the Strategy. The development of a successor strategy will also need to consider further structural developments due to take place between now and 2012 and beyond.

The governance and accountability arrangements for IFH should reflect the new organisational structures, their respective roles and responsibilities, and lines of accountability.

A snapshot of the current public health indicators shows that while Northern Ireland has made considerable gains in improving the health of the population, there is still work to be done, particularly in addressing the disparity in health levels between different socioeconomic groups. An extensive amount of research and evidence in support of tackling the social determinants of health as the key to addressing health inequalities and improving outcomes for society as a whole has been published in recent years. It is now accepted that health inequalities are to be found in the way a society is organised and how resources are distributed among the population. These societal structures, such as early childhood care, education and literacy, employment and working conditions, gender parity, access to health services, housing, income and its distribution, social exclusion, social security and unemployment and job insecurity, all impact on health at an individual and population-wide level. There is therefore a clear need for a public health strategy that is based on the ethos and principles of IFH, i.e. a strategy that tackles the social determinants of health.

5. BENCHMARKING

5.1 Introduction

This section of the report describes the models of public health delivery in three countries, England, Australia and Sweden. This information will be used to examine how practices in Northern Ireland compare against these international benchmarks. It will also identify key issues in relation to how policies, priorities and targets might be made more effective in Northern Ireland going forward.

The comparison of benchmarking countries will be based upon their public health processes (including organisation, funding and decision-making processes) and their public health performance over time. Specifically, the following key issues will be taken into consideration:

1. Organisation at:
    - National level;
    - Local level; and
    - Supporting agencies.
2. Funding and resource allocation
    - Proportion of government funding spent on health care and public health; and
    - Departments/agencies responsible for budget management/delivery.
3. National strategies/policies
    - Main targets, goals and priorities.
4. Intersectoral collaboration

The benchmarking countries and areas to be investigated were agreed with the steering group in November 2009.

5.2 England

5.2.1 Introduction

England was selected as a useful benchmarking country as it is can be closely compared to Northern Ireland in terms of health service delivery through the National Health Service (NHS). England also published a public health strategy with ambitious targets to reduce inequalities by 2010.

5.2.2 Health Service Organisation

Health matters, including public health, are the responsibility of the Secretary of State for health in England. Health ministers are supported by the Department of Health while the NHS provides health care. Authorities and Trusts are the organisations responsible for running the NHS at a local level. England is split into ten strategic health authorities (SHAs), set up in 2002 to develop plans for improving health services in their local area and to ensure their local NHS organisations are performing well. Within each SHA, the NHS is split into different types of trusts that take responsibility for running the different NHS services in their local area.

5.2.3 Funding & Resource Allocation

5.2.3.1 Funding Process

The NHS 2008/9 budget roughly equates to a contribution of £1,774 expenditure per head in England.[4] The majority of funding for the NHS is provided by the Department of Health, which provides funds directly to SHAs and Primary Care Trusts (PCTs)[5], which they are then responsible for spending. PCTs receive 80% of these funds, in line with the particular health priorities in their areas, to allocate and pay NHS Trusts, NHS Foundation Trusts[6], primary healthcare providers, and private-sector healthcare providers for the healthcare that they commission from them. Four elements are used to determine the actual allocation received by each PCT[7]:

- Weighted capitation targets – set according to the national weighted capitation formula which calculates PCTs' target shares of available resources based on the age distribution of the population, additional need and unavoidable geographical variations in the cost of providing services;
- Recurrent baselines – represent the actual current allocation which PCTs receive. For each allocation year the recurrent baseline is the previous year's actual allocation, plus any adjustments made within the financial year;
- Distance from target – this is the difference between weighted capitation targets and recurrent baselines. If a weighted capitation target is greater than a recurrent baseline, a PCT is said to be under target. If a weighted capitation target is smaller than a recurrent baseline, a PCT is said to be over target; and
- Pace of change policy – this determines the level of increase which all PCTs get to deliver on national and local priorities and the level of extra resources to under-target PCTs to move them closer to their weighted capitation targets (i.e. PCTs do not receive their target

[4] House of Commons (2009): NHS Expenditure in England

[5] PCTs are responsible for running primary care, which is the first point of contact most people have with the NHS. It includes services provided by GPs, opticians, dentists, pharmacists, health workers and other community-based practitioners.

[6] Foundation trusts are a type of NHS hospital run by local managers, staff and members of the public, which are tailored to the needs of the local population. Foundation trusts have been given much more financial and operational freedom than other NHS trusts and have come to represent the government's commitment to de-centralising the control of public services. These trusts remain within the NHS and its performance inspection system. They were first introduced in April 2004.

[7] Department of Health (2008): Departmental Report

allocation immediately but are moved to it over a number of years). The pace of change policy is decided by Ministers for each allocations round.

Following the Acheson Report into inequalities in health in 1998[8], Ministers announced a review of the allocation formula, emphasising its active role in reducing 'avoidable health inequalities'. A number of additional needs adjustments have been made to the allocations formula since then. The most recent changes to the 2009-10 and 2010-11 allocations were informed by a comprehensive review undertaken by the Advisory Committee on Resource Allocation (ACRA), which started in 2005 and was completed in December 2008. The review and resulting allocations were guided by broadly similar principles to those set out in the Acheson report; namely "*to provide equal access to healthcare for people at equal risk and to contribute to the reduction in avoidable health inequalities".*[9]

One of the more notable changes is the adoption of a separate formula for health inequalities. ACRA determined that it was not technically possible to fully achieve both objectives of equal access for equal need and a reduction in health inequalities within a single formula. Therefore, it recommended a separate formula be specifically designed to address the objective of reducing avoidable health inequalities, and that this formula be applied to all three components of recurrent revenue allocations (hospital and community health services, prescribing and primary medical services). The measure of health inequality they selected as most objective and robust was Disability Free Life Expectancy, the weighting of this formula within the overall additional need adjustment was set at 15%.

5.2.3.2 Public Health Expenditure

The most recent data for expenditure on prevention and public health services in England shows that a total of £3.4bn was spent in 2006/7 (this figure is in line with the Organisation for Economic Co-ordination and Development (OECD) definition of prevention and public health services, *"services designed to enhance the health status of the population as distinct from the curative services, which repair health dysfunction").* Of this, primary prevention (i.e. preventing the onset of undesirable states) accounted for £35m and secondary prevention (i.e. early stage disease detection and interventions) accounted for £3.3bn. Prevention expenditure in England, as a proportion of total health expenditure, was 4.0% in 2006/07.[10]

5.2.4 National Strategies

In 1997, the newly elected Labour government was committed to a health inequalities agenda as a means to address the root causes of ill health. The Acheson Report found that the health gap between social groups had widened between the mid-1970s and the early 1990s. The Inquiry also highlighted the need for action across a broad front, including poverty, education, employment, housing and the environment – as well as through the NHS. Following the Acheson inquiry, health inequalities emerged as a higher priority. In 2001, the Government signalled its commitment by setting the national target for health inequalities for the first time in the national health inequalities Public Service Agreement target:

[8] Independent Inquiry into Inequalities in Health Report 1998

[9] House of Commons (2009): NHS Expenditure in England

[10] Health England (2009): Public Health and Prevention Expenditure in England

"By 2010 to reduce inequalities in health outcomes by 10% as measured by infant mortality and life expectancy at birth"

The cross-government health inequalities plan (Tackling Health Inequalities: A Programme for Action, published in July 2003) set out how the Government planned to deliver the PSA target and to take action on the wider determinants of health. It included the PSA health inequalities target, 12 cross-government headline indicators and 82 cross-government commitments. It also included an undertaking to monitor progress through a series of independent status reports, produced by a scientific reference group chaired by Professor Sir Michael Marmot.

For the 2004 Comprehensive Spending Review, the Department of Health agreed two more detailed targets to be added to the original PSA target:

- Starting with children under one year, by 2010 to reduce by at least 10% the gap in mortality between routine and manual groups and the population as a whole; and
- Starting with local authorities, by 2010 to reduce by at least 10% the gap in life expectancy between the fifth of areas with the worst health and deprivation indicators (the Spearhead group) and the population as a whole.

The Spearhead group consists of the 70 Local Authority areas that are in the bottom fifth nationally for 3 or more of the following 5 factors:

- Male life expectancy at birth;
- Female life expectancy at birth;
- Cancer mortality rate in under 75s;
- Cardiovascular disease mortality rate in under 75s; and
- Index of Multiple Deprivation 2004 average score.

The Spearhead group contains 28% of the total population of England and 44% of the Black and Minority Ethnic population of England.

The most recent data (for 2006-08) shows that some progress has been made against the indicators[11]. Since 1997, there have been significant absolute improvements in the health of disadvantaged groups and areas. However, the data also shows that, despite the absolute improvements, inequalities remain stubborn and persistent. Life expectancy in England and in the Spearhead Group is at record levels. However, the increase in Spearheads is not as great as in non-Spearheads so the gap has widened. For males the relative gap between the England population as a whole and the Spearhead Group was 7% wider than at the baseline (compared with 4% in 2005-2007), and for females 14% wider (compared with 11% in 2005-2007). The 2010 target is therefore unlikely to be met.

Likewise, for infant mortality, the latest 2006-08 figures show that the gap between the population as a whole and the Spearhead groups has remained constant since last year. Both groups have experienced historic low levels of infant mortality in 2006-08, with a reduction in

[11] Department of Health (2009): Tackling Health Inequalities: 2006-08 Policy and Data Update for the 2010 National Target

the rate across the whole population being matched by a reduction in the rate for the Spearhead group. Over the period since the target baseline (1997-99), the gap had widened, although there have been year-on-year fluctuations in the intervening years. The infant mortality rate in the Spearhead groups was 16% higher in 2005-07 and 2006-08,17% higher in 2004-06, 18% higher in 2003-05 and 19% higher in 2002-04 (the widest point since baseline). These figures compare with a gap of 13% in the baseline period 1997-99. The target to narrow the gap by 10% by 2010 remains unlikely.

5.2.5 Intersectoral collaboration

The NHS has the most significant role to play in the delivery of health care in England, and thus has the largest potential to impact on health inequalities at a local level. Particularly through PCTs whose remit is to commission and provide health care services and lead the NHS in addressing health improvement and health inequalities in partnership with local stakeholders. However, local government also has a key role to play in promoting the health of their local communities. The response to developing effective partnerships between the NHS and local government was the establishment of local strategic partnerships (LSPs) in 2001 to provide a local action focus. LSPs bring together local organisations from the public, private, community and voluntary sector. Tackling health inequalities successfully and sustainably means LSPs working in partnership to address the wider determinants of health such as poverty, employment, poor housing and poor educational attainment with PCTs and Local Authorities being the key partners, leading and driving change locally. The LSPs have been strengthened by aligning priorities, planning and performance through local area agreements (LAAs).

The development of LSPs has led to the potential for joint appointments across partner agencies, in particular between Local Authorities and PCTs. Currently 80% of Directors of Public Health are appointed between PCTs and Local Authorities[12] (this post has responsibility to deliver health intelligence to inform and direct the commissioning of services, health protection advice and leadership, and effective health promotion). This leads to a more integrated approach to public health and provides an opportunity to strengthen the leadership of public health at local level.

The Local government and Public Involvement in Health Act 2007 required Local Authorities and PCTs to produce a Joint Strategic Needs Assessment of the health and wellbeing of their local communities. This links in with the introduction of the World Class Commissioning programme in 2007. Under the World Class Commissioning Initiative[13], PCTs are expected to adhere to 11 competencies in to demonstrate how they contribute to:

"better health and well-being for all, better care for all and better value for all: adding life to years and years to life".

[12] Marmot (2009): Fair Society, Healthy Lives

[13] World class commissioning is a statement of intent, aimed at delivering outstanding performance in the way in which health and care services are commissioned in the NHS. The 11 competencies are: work with community partners; locally lead the NHS; engage with public and patients; collaborate with clinicians; manage knowledge and assess needs, prioritise investment; stimulate the market; promote improvement and innovation; secure procurement skills; manage the local health system; and make sound financial investments. (Department of Health (2007): World class commissioning: competencies)

This encourages PCTs to focus more on providing better quality of care and reduce health inequities in local communities as a result of joint working and partnership. The Government expects PCTs to:

- Commission services based on evidence of need, not historical patterns of spend, and to performance manage contracts with providers and develop new provision accordingly;
- Work with GPs, pharmacists, dentists and optometrists to ensure that primary care services reflect the needs of – and reach out to – people in relatively disadvantaged groups;
- Commission and develop community health services in ways that are responsive to the needs of people in disadvantaged groups;
- Act as local leaders on health inequalities, bringing together all the different local organisations – such as local authorities and all the partners in Children's Trusts – that can make a difference; and
- Support and supplement the new regulatory system, by using information intelligently to identify services which are not reducing health inequalities.

The Marmot Review states that while the introduction of the Joint Strategic Needs Assessment and World Class commissioning programme offer an opportunity to improve health and wellbeing and reduce health inequalities across local communities through joint working and partnership, the impact of this policy initiative is as yet unclear.

5.2.6 Lessons to be learnt

England's approach to tackling health inequalities focused on developing a cross-government plan with a number of targets to be achieved by 2010. The most recent data (for 2006-08) shows that while there have been significant absolute improvements in the health of disadvantaged groups and areas, the gap between these groups and the population average has widened. The 2010 targets are therefore unlikely to be met. The Northern Ireland IFH Strategy also set a number of ambitious inequalities targets to be met by 2010. In a similar situation to England, Northern Ireland has seen considerable gains in the absolute levels of health in its whole population with an underlying widening of the gap between social groups.

The Marmot Review lists a number of barriers that have hindered progress at a national and local level in the effective development of policies and interventions to reduce health inequalities. On a national level, these include:

- Responsibility for health inequalities and health improvement being with the Department of Health although the main determinants of health inequalities require action by other government Departments;
- The fragmentation of policy delivery processes, resulting in disconnected action rather than coordinated and systemic change;
- A succession of policy changes and organisational restructures;

- Pursuit of short-term objectives and targets based on a 'quick win' ethos, instead of allowing existing initiatives to mature, and limited commitment to longer term cycles. This can be related to short-term political cycles;
- A preoccupation with NHS Acute Services, access and waiting times and NHS financial balance;
- A proliferation of highly targeted projects and new initiatives;
- An emphasis on the need for new money and new initiatives, despite the widespread recognition of the need to change the way mainstream resources are used and services delivered; and
- Lack of attention to building workforce capacity and creating a context within which action on the determinants of health can be delivered.

On a local level, progress has been hindered by:

- Inadequate understanding by relevant stakeholders of the key drivers of health inequalities and patchy delivery not scaled up to address the key drivers of the social determinants;
- Partnership working has been a central feature of health inequalities policy approaches but there is little evidence that this has produced better health outcome for local communities;
- Reliance on small scale health improvement projects and programmes, often downstream focused, with delivery systems failing to penetrate either because they are not comprehensive or sustained enough to reach the most disadvantaged, who require proportionately more effort and resources to achieve equitable outcomes;
- Lack of understanding about the need for evidence, what constitutes good evidence and a lack of agreed protocols for systematic sharing of information between agencies to underpin evidence based strategic action;
- Significant variation in engaging the senior personnel necessary to deliver effective partnerships and strategic change; and
- Overemphasis on targets and pressure to demonstrate quick short-term wins to the detriment of the long-term strategic progress.

Although these barriers are specific to England, many are applicable to Northern Ireland due to the similar structure of health service delivery and approach in addressing health inequalities. Marmot makes a recommendation on how to develop effective delivery mechanisms to reduce inequalities in both the social determinants of health and health outcomes. Again, the theory behind this recommendation can be applied to Northern Ireland. Marmot states that strategies intervening in just one part of the system will be insufficient. An integrated, whole system approach is needed with activity dedicated at policy at three levels:

a. The macro level (e.g. the imperative of greater social justice and sustainability and the implications for policies to redistribute power and resources, improve financial systems, and develop different responses to global forces);

b. The meso level (e.g. policies to maintain and improve universal health and welfare systems); and
c. The micro level (e.g. developing/improving local services and implementing interventions to achieve better outcomes for communities and individuals).

5.3 Australia

5.3.1 Introduction

Australia was selected as a good example of evidence-based policy making. For many decades, Australia has focused on the use of economic evaluation in public health decision-making and currently spends more on public health research than any other OECD country.

5.3.2 Health Service Organisation

Australia's health care system is a partnership between the federal, state and territory governments. Through the Health and Ageing portfolio (which includes the Minister for Health and Ageing, Minister for Indigenous Health, Rural and Regional Health and Regional Services Delivery, Minister for Ageing, Minister for Sport, Parliamentary Secretary for Health, Department of Health and Ageing), the Australian Government provides national leadership, determines national policies and outcomes and shares responsibility for funding services. The vision of the Department of Health and Ageing is for: *"Better health and active aging for all Australians".*

The Department of Health and Ageing Corporate Plan 2006-09 states that this is to be achieved by improving health and well-being through strengthening of evidence-based policy advice and improvement of programme management, research, regulation, and partnerships with other government agencies, consumers and stakeholders. Australia aims to achieve this through the following top priorities:

- Focusing the health and aged care system more on healthy lifestyles, prevention and early intervention and a 'best practice' handling of chronic disease;
- Improving the transparency, accessibility, accountability and quality of public and private health and aged care service provision through financing and agreements with stakeholders, industry and state and territory governments;
- Consolidating and progressing reforms to ensure choice and access to quality aged care services;
- Working together with the States and Territories to reduce duplication and gaps, and to deliver efficient, value-for-money health and aged care services through an adaptable and sustainable health and aged care workforce;
- Working towards improved health for Aboriginal and Torres Strait Islander peoples through whole-of-government arrangements for policy development and service delivery, and improved access to, and responsiveness of, the mainstream health system;

- Improving choice for consumers through strong private sector involvement, effectively integrated with the public sector; and
- Leading a whole-of-government approach to strengthening Australia's readiness for disease threats, national emergencies and other large scale health incidents.

5.3.3 Funding & Resource Allocation

5.3.3.1 Public Health Activities

The widely used definition of public health in Australia is *"the organised response by society to protect and promote health, and to prevent illness, injury and disability; the starting point for identifying public health issues, problems and priorities, and for designing and implementing interventions, is the population as a whole, or population subgroups."*[14]

Public health activities in Australia generally take the form of programmes, campaigns, or events. They draw on a large range of methods such as health education, lifestyle advice, infection control, risk factor monitoring, and tax loadings to discourage unhealthy lifestyle choices. These activities are also applied in a multitude of settings (such as schools, homes, workplaces and media outlets), and relate to a broad spectrum of health issues. Public health activities are carried out by the Australian Government, state, territory and local governments; NGOs and private health professionals.

5.3.3.2 Government Funding of Public Health Activities

Total government funding of public health activities during 2007-08 was estimated at AUS$2,158.8m, this was an increase on AUS$1,714m spent in 2006-07. The Australian Government, as well as funding expenditures incurred through its own programmes, provides funding to states and territories through Public Health Outcome Funding Agreements for public health activities.

5.3.3.3 Government Expenditure on Public Health Activities

Australian public health activity is reported against eight core categories. Expenditure in 2007-08 on each of these categories is shown in the table 5.1.[15] Total expenditure on public health activities in 2007-08 was AUS$2,158.8m; the largest proportion of this was spent on organised immunisation (32.6%). A significant proportion, 7%, is spent on public health research. This was the highest proportion spent on public health research in any OECD country in this year. (It should be noted that the analysis below includes some categories which are organized and funded differently in Northern Ireland, for example Environmental Health and Food Standards and Hygiene.)

[14] The National Public Health Partnership, 2008

[15] Expenditure is detailed in terms of current and constant prices. 'Current prices' refers to expenditure reported for a particular year, unadjusted for inflation. Expenditure at 'constant prices' has been 'deflated' to remove the effects of inflation, so that expenditure in one year can be compared with expenditure in other years. This deflation is achieved by using annually re-weighted chain price indexes produced by the Australian Bureau of Statistics (ABS).

Table 5.1: Government expenditure on public health activities, current prices, by activity, 2007–08 ($m)			
Activity	**Description**	**Total spend (AUS$m)**	**Average spend per person (AUS$)**
Communicable disease control	Includes all services associated with the development and implementation of programs to prevent the spread of communicable disease.	**256.7**	12.08
Selected health promotion	Population-wide initiatives that foster healthy lifestyles and a healthy social environment, and other initiatives that target health risk factors.	**366.6**	17.26
Organised immunisation	Includes all services associated with the promotion, distribution, provision and administration of vaccines.	**704.3**	33.15
Environmental health	Includes areas includes sanitation, drinking water quality, food safety, disease control and housing conditions.	**95.5**	4.50
Food standards and hygiene	Includes all activities relating to the development, review and implementation of food standards, regulations and legislation as well as the testing of food by regulatory agencies	**38.6**	1.82
Screening programs	To identify disease early, thus enabling earlier intervention and management to reduce mortality and morbidity.	**289.1**	13.61
Prevention of hazardous and harmful drug use	Aimed at preventing the uptake of harmful drug use and reducing the harmful effects of licit and illicit drugs	**254.3**	11.97
Public health research	Includes on-going programme monitoring and evaluation of public health activities and investigative research	**153.6**	7.23
Total	**-**	**2,158.8**	**-**
Source: AIHW (2008): Public Health Expenditure 2007-08			

5.3.4 National Strategies

5.3.4.1 National Preventative Health Strategy

The National Preventative Health Strategy was launched in September 2009. The strategy includes a broad range of recommendations to be implemented in three stages until 2020 to reduce the burden of chronic disease currently caused by obesity, alcohol and tobacco on Australian's health and wellbeing. The Strategy sets a number of ambitious targets:

- Halt and reverse the rise in overweight and obesity(47% of women and 63% of men were overweight or obese in 2007);
- Reduce the prevalence of daily smoking to 10% or less (the proportion in 2009 is 17.4%);

- Reduce the proportion of Australians who drink at short-term risky/high-risk levels to 14% (the proportion in 2009 is 20%), and the proportion of Australians who drink at long-term risky/high-risk levels to 7% (the proportion in 2009 is 10.3%); and
- Contribute to the 'Close the Gap' target for Indigenous people, reducing the life expectancy gap between Indigenous and non-Indigenous people.

In total, the overall cost to the healthcare system associated with the three risk factors, obesity, smoking and alcohol consumption, is in the order of almost AUS$6 billion per year, while lost productivity is estimated to be almost AUS$13 billion. The strategy is directed at primary prevention and addresses all relevant arms of policy and all available points of leverage, in both the health and non-health sectors. The strategy sets out an implementation plan that is staged and sequenced over three phases:

- Phase 1: sets in place the urgent priority actions;
- Phase 2: builds on phase 1 actions, learning from new research, the experiences of program implementation and the national trials carried out in the first phase; and
- Phase 3: ensures long-term and sustained action, again based on learnings from the first two phases.

The preventative Task Force identified seven critical strategic directions to be developed and implemented for the National Preventative Health Strategy to be effective. These are focused around partnership working at all levels, reducing inequality, early years intervention and life-long education. These are shown in the table below.

Table 5.2 National Preventative Health Strategy's critical directions

Shared responsibility – developing strategic partnerships	Responsibility for preventative health is shred by all Australian Individuals, families and communities: • All levels of government • Multiple sectors: including the health care system, business, industry, unions, professional associations, research community, non-government organisations and other sectors.
Engage Communities	Act and engage in preventative health activities with people in the settings where they live, work and play. Inform, enable and support people to make healthy choices: • Trial community-based interventions to identify what works in prevention at the local level • Build on existing workplace health promotion initiatives. • Promote good health and wellbeing through school policies, programs and environments
Reduce Inequity	Act to reduce inequalities: • Target disadvantage by addressing the social and structural determinants of health • Recognise the distribution of risk across the social gradient, address the highest risk and the absolute risk in the population
Close the Gap for Indigenous	Reduce the life expectancy gap between Indigenous and non –Indigenous Australians:

Communities	• Broad multi-faceted action on the social determinants of health, • Comprehensive primary care • Targeted efforts towards the contribution of alcohol, tobacco and obesity to health inequities
Act early in life and sustain action across the life course	Give children the best start in life by addressing preventative health in pregnancy and the early years: • Starting in the antenatal period, indentify family risk and need, and respond early • Monitor child health, development and wellbeing • Service redevelopment and workforce training to meet family and childhood needs Encourage healthy ageing through: • Better lifestyles and improved integration in the economy and community • Attack the underlying social and environmental factors affecting healthy ageing • Adapting health systems to the needs of the elderly
Influence Markets and Develop connected and coherent policies	• Ensure the public is well informed to make the best decisions about their health and wellbeing • Keep people and families at the centre of preventative health action and empower them to manage their health and wellbeing • Use responsive regulation to create environments that me it easy for individuals to make healthy choices.
Refocus health Systems towards prevention	• Include preventative health in all elements of the health care system, and especially in primary health care • Develop an integrated primary health care system which provides quality preventative health services, including risk factor assessment and behaviour change support, which are responsive to the local needs of the community
Source: Department of health and Ageing (2009): national Preventative Health Strategy	

5.3.5 Intersectoral collaboration

The National Preventative Health Strategy also recommended that a new national capacity, the National Prevention Agency (NPA), be developed to monitor, evaluate and build evidence in the area of public health. The Coalition of Australian Governments' National Prevention Partnership has committed to a establishing this within the next two years. The NPA will be responsible for leading the prevention agenda across many sectors and within a diverse range of stakeholders through collaborative partnerships, coordination of activity at the national, state and local levels, and the provision of strategic advice to inform government policy. The proposed model for the agency includes the following approaches:

- A national body, established by enabling legislation;
- Have an expert, cross-sectoral Board of Governance comprising 10 to 12 members, selected on merit for their expertise;
- Be a facilitator/coordinator and, as required, implementer and commissioner of interventions through and with partners; and

- Be independent from but working closely with government, reporting to the Commonwealth Parliament through the Minister for Health.

The Strategy also acknowledges the importance of intersectoral collaboration within and between Government Departments in terms of policy making. It states that weaknesses can exist in non-health policies that have unintended adverse consequences on health. The strategy states that the 'siloed' portfolio nature of government can result in policies that are consistent with the objectives of the Department, but which are not necessarily in the interest of the wider society, or specifically on population health. To mitigate the negative health impacts of non-health policies, the strategy suggests the use of HIAs and the Health in All Policies approach, in which health and wellbeing are taken into consideration in the policies of other government sectors.

The Strategy also details how health is a shared responsibility, with individuals, families and local neighbourhoods at the centre, supported by developing strategic partnerships with a range of sectors, including:

- *Community-based organisations* such as Aboriginal Community Controlled Health organisations, local health, sporting, recreational, cultural and welfare groups;
- *Local governments* play a pivotal role in providing local amenities, and can partner with local organisations in areas such as exercise, active recreation and sport, food security, managing alcohol outlets and tobacco regulations. They can also assist with planning to increase physical activity and active use of the local government area;
- *State and territory governments* are key leaders, funders, legislators, regulators, service providers and employers across a range of sectors that underpin the nation's capacity to promote health and prevent illness; for example, health, education, alcohol licensing, law enforcement, urban planning, transport and housing;
- *The Australian Government* has the overall responsibility for national leadership, policy, legislation and regulation, and for the funding and implementation, measurement and accountability for the Strategy. All three levels of government are major employers, for whom promoting health and preventing illness will also mean increasing productivity;
- *Non-government organisations* play a vital role at the national and state levels as providers of research and development, advocacy, social marketing and primary care;
- Whether as producer, marketer or employer, the *private sector* has a profound influence on the health of Australians. The most relevant are the food, beverage and alcohol industries, media, advertising, private health insurance, workplace insurance, self-medication, fitness and weight-loss industries;
- *National and state entities* such as the National Health and Medical Research Council (NHMRC), Australian Research Council (ARC), the Australian Bureau of Statistics (ABS), the Australian Institute of Health and Welfare (AIHW), the Social Inclusion Board and the state-based Health Promotion Foundations are essential providers of research and practice expertise, advice, funding capacity and policy direction;

- *Professional associations* across a range of health promotion, primary care and other non-health sector disciplines and research and academic groups are essential to maintaining and growing the prevention research and practice workforce; and
- *New partnerships* developed to improve the health of 10 million Australians in the workplace. These can be between private and public sector employers, insurers, health insurers, unions and workplace health promotion providers. Similarly, partnerships between police, local government and hospitality and entertainment venues can better enhance alcohol licensing and tobacco regulations.

5.3.6 Lessons to be learnt

Australia has a long history of creating evidence-based health policy. Public health interventions have been extensively monitored and evaluated since the 1970s and future actions are based on the results of this research. Australia's expenditure on public health research is the highest of all OECD countries – it represented 7.1% of all public health expenditure in 2007-08.

The targets and objectives set out in the recently published National Preventative Health Strategy (published in June 2009) are evidence-based, or where the evidence is yet to be developed, evidence-building. The Strategy is also designed to be implemented in three stages. This approach is to allow for evaluation of the programmes and interventions that are implemented in each stage in order to assess their effectiveness and merit in being continued.

Following publication of the Strategy, the Coalition of Australian Governments have committed to establishing a new national body, the National Prevention Agency (NPA), to monitor, evaluate and build evidence in the area of public health. The NPA will also be responsible for leading the prevention agenda across many sectors and stakeholders through collaborative partnerships, coordination of activity at the national, state and local levels, and the provision of strategic advice to inform government policy. It will have an expert, cross-sectoral board of members and be independent from but working closely with the government.

5.4 Sweden

5.4.1 Introduction

Sweden was selected as it has some of the best health indicators in the world and was the first European country to establish a national, state-funded centre for the coordination and delivery of public health activities. The Swedish decentralised model of health system delivery also provides an interesting contrast to the centralised system in Northern Ireland.

5.4.2 Health Service Organisation

The aim of Swedish health and medical care is for the entire population to have equal access to good care services. Resources within the health system are distributed according to need

and there are three basic principles underpinning the decisions and priorities concerning health and medical care in Sweden. They are as follows (ranked in order of importance):

- The principle of human dignity;
- The principle of need and solidarity; and
- The principle of cost-effectiveness.

The Swedish health care system is a regionally-based, publicly operated health service. It is organised into three independent government levels: the national government, the regional county councils and the local municipalities. Overall responsibility for the health care sector rests, at the national level, with the Ministry of Health and Social Affairs (assisted by two other ministers, including a Minister for Elderly Care and Public Health) who ensure the system runs efficiently. Although the central level is responsible for setting national guidelines, the regional and local levels have considerable autonomy in the application of these guidelines.

During the 1980s, responsibility for health care planning was decentralised from the national level to the 18 county councils, giving them full responsibility for matters relating to health care planning, including provision of health care, health promotion and disease prevention for their residents. At the local level, Sweden has 290 municipalities which are responsible for delivering and financing social welfare services, including child care, school health services and the care of elderly, disabled people and long-term psychiatric patients. There is no hierarchical relation between municipalities and county councils since both have their own self-governing local authorities with responsibility for different activities.

5.4.3 Public Health Organisation

In 1987, the government formed a high-level group for public health policy to address the fact that, despite health developments among Sweden's population being generally positive, there were large differences in rates of illness and death among different age groups, between the sexes, among different social groups, between native Swedes and immigrants, and among different parts of the country. One result to come out of this group was the formation of a national public health institute in 1992 (the Swedish National Institute of Public Health (NIPH)). The main role for the NIPH was to reach particularly vulnerable groups in society and to reduce the unequal distribution of health. The role of the NIPH has been expanded over time to include monitoring and implementation of the national public health policy, exercising supervision in the fields of alcohol and tobacco and to become a national centre of knowledge for the development and dissemination of methods and strategies in the field of public health.

The 18 county councils, which are divided into healthcare districts, are responsible for developing population health services. There are regional cooperation bodies, established by the county councils, to implement a population-based public health approach. In this system, both general practitioners and specialists work as public practitioners. Apart from medical services and consultations, they provide preventive care such as health screening and vaccination services. The Government supports the county councils' disease-prevention and health promotion work through annual transfers of funds.

The municipalities also play a central role in implementing preventive measures in a number of areas. For example, in the childcare sector and in schools, teachers and school nurses give general health education. Preventive and population-oriented health care has been integrated into primary health care at a municipal level. At health centres, measurement of blood pressure and blood cholesterol is determined by the clinical situation or is obtainable by request. Recently, the focus of public health at municipal level has shifted towards the structural determinants of health, e.g. unemployment, education and the environment.

5.4.4 Funding & Resource Allocation

The Swedish health care system is primarily funded through taxation (75-80%). Both county councils and municipalities have the right to levy proportional income taxes on their respective populations. There are no earmarked taxes for health or health care services, which makes it difficult to specify precisely what proportion of the taxes is directly connected with the provision of these services. The most data estimates that public health expenditure accounts for 5% of total health expenditure per annum.[16]

In addition to taxation revenue, financing of health care services is supplemented by state grants (which are financed through national income taxes and indirect taxes) and user charges. Central government grants to the county councils and municipalities are partly based on a formula that reallocates resources across municipalities and county councils on the basis of demographic, geographic and socio-economic indicators. This formula for re-allocating resources across local government bodies was adopted in 1996 to give county councils the opportunities to maintain similar standards irrespective of differences in average income and/or need. It is based on individual level data, and uses demographic and socioeconomic variables as proxy measures of health care need. The purpose is to give local government bodies in different areas, with different social needs, the opportunity to maintain similar standards.

Health care expenditure as a proportion of GDP has remained at an approximate level of 9% since 2000. Sweden's health care expenditure (US$ purchasing power parity) per capita was US$3,323 in 2007. The annual rate of expenditure per capita grew at a high rate from 2000-02 to a highest point of 5.9%. It then slowed and the year-on-year growth rate in 2006-07 was the smallest Sweden has experienced within the decade.

Table 5.3: Health expenditure in Sweden 2000-2007 (US$)

	2000	2001	2002	2003	2004	2005	2006	2007
Total expenditure on health, % of GDP	8.2	9.0	9.3	9.4	9.2	9.2	9.1	9.1
Total health expenditure per capita, US$ PPP	$2,283	$2,508	$2,697	$2,829	$2,950	$2,958	$3,124	$3,323
Annual growth rate of total expenditure on health per capita, in real terms %	4	5.0	5.9	2.7	1.4	2.5	2.6	1.9

Source: OECD (2009): OECD Health Data

[16] European Observatory on Health Systems and Policies (2005): Health Systems in Transition

5.4.5 National Strategies

In 1997, Sweden launched a parliamentary committee, the National Public Health Committee, consisting of politicians representing all seven political parties, health advisors, public health experts and a number of experts from academia, trade unions, authorities and civil society organisations. The Committee's remit was to propose national objectives for public health as well as strategies for achieving these objectives. During the three years of its work, the committee engaged with the general public, politicians and civil servants at the national, regional and municipal level, with research workers, and with representatives of different organisations and trade unions. The committee's report, Health on Equal Terms (2000), led to the Government's Public Health Objectives Bill, which was adopted unanimously by all of the political parties in power in April 2003.[17] This Bill became Sweden's first Swedish public health policy and marked the government's commitment to improve public health and reduce health inequalities between various population groups. The overarching aim of the policy was to *"Create societal conditions which ensure good health, on equal terms, for the entire population".*

The policy contains eleven public health objective domains based on the main socio-economic, behavioural and environmental determinants of health covering both up-stream and down-stream determinants:

1. Participation and influence in society;
2. Economic and social security;
3. Secure and favourable conditions during childhood and adolescence;
4. Healthier working life;
5. Healthy and safe environments and products;
6. A more health-promoting health service;
7. Effective protection against communicable diseases;
8. Safe sexuality and good reproductive health;
9. Increased physical activity;
10. Good eating habits and safe food; and
11. Reduced use of tobacco and alcohol, a society free from illicit drugs and doping and reduction in the harmful effects of excessive gambling.

A new bill, "A renewed public health Policy" (Government Bill 2007/08:110), was passed by Swedish Parliament in March 2008. It maintains the 2003 objectives, but puts special focus on strengthening and supporting parents in their parenthood, intensifying suicide prevention efforts, promoting healthy eating habits and physical activity and reducing the use of tobacco. Furthermore, it builds on joint responsibility and involvement of different societal actors and

[17] European Observatory on Health Systems and Policies (2005): Snapshots of Health Systems

supports the development of evidence-based health promotion methods. The NIPH is responsible for monitoring and implementing the national public health policy.

5.4.6 Intersectoral Collaboration

Intersectoral collaboration was central to the process of developing the public health policy. It was seen desirable to involve all relevant sectors and actors at different levels, so intersectoral collaboration was built into the process of developing the public health policy. The aim of the process was to develop a *"pro-active, multisectoral public health approach at all levels"*[18]. As a result, the National Public Health Committee consisted of members from many different sectors. The working reports of the Commission were sent to more than 500 stakeholders for consultation, representing authorities, universities, municipalities, counties, trade unions and organisations from all areas.

The NIPH is responsible for the coordination of the public health policy activities in all sectors. In 2005, the NIPH developed new monitoring indicators appropriate to the policy's transversal objectives. This process involved over 40 central and regional agencies across all sectors. This process made it possible to bring out correlations between the different sectors' work and helped to foster the partners' feeling of ownership for the health objectives[19]. The monitoring indicators provide a framework against which progress towards achieving the objectives can be measured. The NIPH conducts cross-sectoral follow-up and evaluation of the extent to which these indicators are being met. Progress is reported to the Government every four years in the form of a public health report, which provides the basis of discussions on how successfully the policy is influencing public health (the first NIPH's public health report was published in 2005).

The first version of the public health policy in 2003 also set out the important role of HIA methods in achieving public health goals. The rationale for using HIAs was to raise awareness and put public health higher on the political agenda and to systematically analyse health impacts of political proposals in all sectors.

The policy sets out explicit rules for how HIAs should be implemented across all sectors. It is not sufficient for a HIA merely to assess the extent to which the health of a population will be affected by a proposed policy, it is important to ensure that differences in ill-health are not increased. Therefore, groups that suffer from, or are at risk of, poor health are studied - these are referred to as prioritised or vulnerable groups. The following issues are considered when examining how a decision affects health equity[20]:

- Age;
- Ethnicity;
- Socioeconomic background;

[19] European Observatory on Health Systems and Policies (2005): Snapshots of Health Systems

[19] Swedish Council for Working Life and Social Research & Swedish National Institute of Public Health (2004): International evaluation of Swedish public health research

[20] Ministry of health and social affairs (2002). Public Health targets. Governmental proposal, no 2002/03:35.

- Sexual orientation;
- Disability; and
- Gender.

In accordance with the public health policy, the NIPH was also charged with developing HIA methods to support the application of HIA at central, regional and local levels. The NIPH has developed a number of projects to promote HIAs, including[21]:

- Supporting governmental agencies within different sectors to implement HIA in their work;
- Promoting HIA as a methodology for social sustainable regional development; and
- Developing HIA methodology for municipalities.

5.4.7 Lessons to be learnt

The decentralised nature of provision is a fundamental characteristic of the health care system in Sweden. This structure allows health care decisions and provision to be tailored to local need. Unlike Northern Ireland, Swedish councils and municipalities can use their tax-raising and wide-ranging policy powers to provide health care based on specific local needs, which can vary greatly form one areas to another. Central Government grants are also allocated to county councils and municipalities based on local level need using demographic and socioeconomic data.

Sweden's public health strategy has 11 public health objectives that address health determinants rather than focusing explicitly on health outcomes. A key difference between the Swedish public health policy and the IFH strategy is that it is not target-driven. Instead, it focuses on the provision of services and creating the right environment for people to improve their own health. This puts more emphasis on individual responsibility.

The Swedish process of formulating their public health policy is a good example of encouraging cross-sectoral collaboration: the policy has a broad social vision of health which encompasses many sectors and it has strong political support due to the cross-party representation and buy-in from civil society organisations due to the involvement of the stakeholders. The policy's success is reflected in the unanimous decision to adopt it by all of the political parties in power. The NIPH monitors cross-sectoral progress in meeting the public health strategy objectives and reports to the government every four years. The latest update report was due to be published in 2009, but as this is currently behind schedule it is not possible to comment on the impact of the policy as yet.

The establishment of the state-funded NIPH in 1992 has been central in coordinating public health work at a national level. The NIPH acts as a national centre of knowledge for the development and dissemination of methods and strategies in the field of public health. This provides a central source of knowledge and support to government, county councils,

[21] European Observatory on Health Systems and Policies (2007): The Effectiveness of Health Impact Assessment. Scope and limitations of supporting decision-making in Europe

municipalities and other organisations working in health promotion and disease prevention. This is particularly important in deciding upon effective interventions as the NIPH collects information on effective methods of promoting public health based on national and international scientific evidence. The work of the NIPH is carried out in close collaboration with stakeholders on local and regional level, since that is where the majority of the practical public health activities take place. The NIPH is also responsible for monitoring the performance of stakeholders in their progress in meeting the objectives. This has also helped to improve intersectoral collaboration.

5.5 Conclusion

Health and wellbeing improvement has become a priority for governments across the world as they deal with the economic and social burdens of ill health. The approach to health improvement taken in England, Australia and Sweden has been considered in this section in order to identify any lessons that can be learnt for Northern Ireland in moving forward.

The context within which public health policies are developed varies greatly among the selected countries. Although the broad goals, to achieve better health for all, may often be similar, the strategies used and the structures within which decisions are made can vary greatly. The countries also differ in terms of the structure of government, in particular whether the country has a centralised or federal structure, and the proportionate resources allocated to public health. Each of the countries has individual strengths in the design and delivery of their health system and as such can provide useful example of good practice.

Sweden adopted a social perspective of health many decades ago and is often cited as an internationally recognised model of best practice for population health and social policies due to the excellent health of the Swedish population by international standards. The responsibility for health care is decentralised to regional and local governments (with the exception of overall goals and policies, which are determined at national level) which allows decisions to be made based on local need. This decentralised model is one of the main strengths of the Swedish health care system and has led to a culture of collaboration between the different levels of government and locally-based organisations in achieving shared health goals.

Australia has a long history of creating evidence-based health policy. Public health interventions have been extensively monitored and evaluated since the 1970s and future actions are based on the results of this research. The targets and objectives set out in the recently published National Preventative Health Strategy are evidence-based, or where the evidence is yet to be developed, evidence-building. The strategy is also designed to be implemented in three stages to allow for evaluation of the programmes and interventions that are implemented in each stage in order to assess their effectiveness and merit in being continued. Australia's focus on evaluation ensures value for money and efficiency on the basis that only interventions that have been proven effective are implemented and mainstreamed.

England's approach to tackling health inequalities was similar to Northern Ireland in that it focused on developing a cross-governmental plan with a number of inequalities targets to be achieved by 2010. Based on the most recent data, these targets look unlikely to be met. England finds itself in a similar position to Northern Ireland in that it has seen considerable

gains in the absolute levels of health in its whole population with an underlying widening of the gap between social groups. The 2010 Marmot Review has brought together a substantial body of national and international evidence in support of the social determinants approach to tackling health inequalities. The Marmot Review contains a number of recommendations and findings that are relevant to Northern Ireland and should be taken into consideration in the development of a successor IFH strategy.

Although different from each other in many respects, the selected benchmark countries also demonstrate a number of common themes that are applicable to Northern Ireland:

- A common goal of promoting equity due to the widespread occurrence of inequality in health between different societal groups;
- A recognition that the intersectoral nature of public health makes it necessary to develop linkages with stakeholders in many sectors in order for any public health policy to succeed;
- A focus on engaging a wide range of stakeholders. The benchmark countries have been dynamic in looking at ways to expand the range of stakeholders involved in the public health process. For example, Australia has been developing strategic partnerships with the private sector, such as the food, beverage and alcohol industries, media, advertising, private health insurance, workplace insurance, self-medication, fitness and weight-loss industries; and
- A focus on monitoring the performance of stakeholders at all levels against agreed goals and targets.

A further issue is the relative spend by countries on health promotion and disease prevention. Information gathered shows that in 2006 - 07 England's spend on health promotion activities was £3.7bn which represents 4% of total health expenditure[22], while Australia's public health expenditure was 2.2% of total health expenditure (- Australia's expenditure on public health activities increased considerably to 7.1% of total health expenditure in 2007-08 – the highest of all OECD countries in that year [23].) Latest figures for spend on health promotion in Northern Ireland for 2008-09 suggest a spend of 2.9 % of the total health budget. (Further information on the investment and how funding is allocated in Northern Ireland is at Section 7.) However, given the differences in the way health promotion activities are organised and funded in Northern Ireland and the benchmark countries it has not been possible to draw any firm comparisons in respect of the financial investment without further more detailed analysis. It is recommended that consideration should be given to ensuring that the proportion of spend in Northern Ireland is at least on a par with the level of the benchmark countries.

[22] Health England (2009): Public Health and Prevention Expenditure in England

[23] AIHW (2008): Public Health Expenditure 2007-08

6. PROGRESS AND IMPACTS

6.1 Introduction

This section considers the impact IFH has made since its introduction in 2002. The Strategy has two overarching goals – to improve health and reduce health inequalities, and seven objectives in total. The goals would be achieved through the objectives and targets which were selected to reflect the cross-cutting nature of the Strategy and which concern the wider determinants of health. The targets moved away from the traditional focus on disease outcomes and risk behaviour although some of those are used as indicators in monitoring progress towards reaching the high level objectives.

The objectives are expressed in both qualitative and where possible quantitative targets. The targets were set to be challenging but attainable and were based on historical trends. They also took account of actions and targets contained in other strategies where appropriate. Each target was given a baseline figure to measure progress against and a timeframe within which to be achieved.

Following publication of IFH, a monitoring framework of lower level indicators to help monitor progress towards achievement of the objectives and targets was developed, led by EHSSB in partnership with Belfast Healthy Cities. This contains a number of additional outcomes and indicators. The primary aim of setting indicators was to[24]:

- Facilitate more evidence-based, rational decision making and priority setting in relation to health planning;
- Create visibility of health problems;
- Provide a baseline of information to make comparisons over time; and
- Assist in monitoring and evaluation of activities/programmes to assess their success.

6.2 Approach

Using the baseline figures, we have assessed outcomes in terms of whether each target has been met, or is on track to being met within the set timeframe. We have used quantitative data relating to each of the targets and indicators and assessed the extent to which progress has been made over the period the data is most recently available for. The statistical analysis was completed using data from a number of sources. The completed analysis was sent to all relevant Departments' statisticians for comment. Full analysis of the data relating to the indicators can be found in the Statistical Annex.

The quantitative information is however only part of the picture and we have also taken into account the activities underway by the key stakeholders, working towards the achievement of these outcomes for the future. FGS McClure Watters conducted a survey of MGPH members in November-December 2009 (a copy of the survey can be found in Appendix 2). The aim

[24] EHSSB & Belfast Healthy Cities (2005): Investing for Health Indicators

was to assess how each Department and relevant Agencies have actioned IFH and to consider the extent to which IFH – or its aims of improving health and reducing health inequalities - are reflected in their policies and strategies. We have used information provided to us through this process to assess progress made within each Government Department in working towards each IFH objective.

IFH recognised the importance of partnership working – at regional and local level – in delivering its agenda. We have also used data collected through the MGPH survey to determine the degree of partnership working that has taken place as a result of the introduction of IFH.

6.3 Performance

This section considers the performance of IFH in terms of meeting the targets and indicators set under each Goal and Objective. The Strategy set out a number of Departments that would be responsible for delivering actions under each Objective. This section will also examine the key measures implemented by each Department in working towards meeting the IFH objectives over the period from 2002 to present. It will also provide an overview of the key partnerships that were established as a result of joint working on delivering IFH.

6.3.1 Goal 1 - Longer Healthier Lives

6.3.1.1 Aims & Rationale

The aim of Goal 1 is 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**. Life expectancy gives a good indication of the population's overall health and can be used to monitor progress and make comparisons with other countries.

6.3.1.2 Impacts

One target was set for Goal 1, to increase life expectancy by three years. Improvements have been made in life expectancy and death rates from different forms of disease, but some disparities still remain when the death rates are reviewed on the basis of gender and level of deprivation. Between 1998-00 and 2005-07, male life expectancy at birth increased from 74.5 to 76.2 years, an increase of 1.7 years. Between 1998-00 and 2005-07, female life expectancy at birth increased from 79.6 to 81.3 years, which is also an increase of 1.7 years.

The target set for Goal 1, to achieve an increase in life expectancy of three years by 2009-11, is forecast to be met if the change in life expectancy continues to grow at the rate experienced up to 2005-07.

However, there is a clear gap in life expectancy between genders and people living in areas of different levels of deprivation. While life expectancies for people living in all areas have increased over the period from 1998-00 to 2005-07; this increase has been smallest for males in deprived areas at 1.3 years and highest for females in deprived areas at 1.7 years. The life expectancy of a male living in a deprived area is 10 years less than a female from a non-

deprived area can expect to live. The gap between the genders is also evident as a female living in a deprived area still has a higher life expectancy at birth than a male in a non-deprived area.

6.3.2 Goal 2 - Reduce Health Inequalities

The aim of Goal 2 is to **reduce inequalities in health between geographic areas, socio-economic and minority groups**. Reducing health inequalities is a key aim of IFH; this will be achieved by increasing the comparative health status of the most disadvantaged in society. There is a social gradient in health – the lower a person's social position, the worse his or her health. Action should be focused on reducing the gradient in health.

6.3.2.1 Impacts

Two targets were set for Goal 2, to reduce the gap in life expectancy and the incidence of longstanding illness for those living in the most deprived areas. The gap in life expectancy between deprived areas and the Northern Ireland average is forecast to be 3.6 years for men and 2.2 years for women by 2009-11. The baseline figures in 1998-00 were 3.1 and 2.5 years for men and women respectively. For men, the gap is forecasted to increase and for women it will have improved slightly. It is very unlikely that the target to halve the gap will be met.

There is a clear gap in life expectancies based on gender and socioeconomic status. People living in non-deprived areas will tend to live longer than those in deprived areas, and females will tend to live longer than males.

The death rates from different forms of disease follow the same pattern. The cancer mortality rates show that men are more likely to die of cancer at all ages than women. The death rate from cancer in non-deprived areas has remained fairly constant over time and the rate in deprived areas shows signs of decreasing over time, but the disparity between the areas remains fairly large.

The death rate from circulatory and respiratory diseases has decreased over the time period, but the differential between death rates in deprived and non deprived areas still exists.

The total number of people reporting a limiting long-term illness (LLTI) has remained at a similar level of approximately 25% between 1998-09. Women are more likely to report a LLTI than men. There is a clear link between income and probability of reporting a LLTI with those in the lowest income bands up to four times more likely to report a LLTI as those in the highest bands. Those who are employed are least likely to report a LLTI and this level has remained fairly constant over time while the economically inactive are more likely to report a LLTI.

6.3.3 Objective 1 – Reducing Poverty in Families with Children

The aim of Objective 1 is to **reduce poverty and social exclusion especially in families with children.** Poverty, social exclusion and interrelated factors such as low income, unemployment, poor housing etc, have a negative impact on people's health. These negative effects are cumulative and can result in a downward spiral of deprivation and poor health.

6.3.3.1 *Responsibility*

The Strategy sets out a number of actions under Objective 1. These represent the areas that are to be addressed in order to achieve the aim of the Objective. Responsibility for contributing to each action under objective 1 is attributed to the relevant Department(s). These are as follows:

Table 6.1: Departments responsible for actions under Objective 1

Action	Department(s)
New TSN	Cross-Departmental
Welfare reform	DEL
Promoting social inclusion	Cross-Departmental
Job creation and economic development	DETI
Learning, training & employment	DEL
Urban regeneration	DSD

Source: Investing for Health Strategy

6.3.3.2 *Progress*

A number of Departments have been working to alleviate some of the problems caused by poverty. The following table highlights some of the pertinent areas of development for relevant Departments.

Table 6.2: Departments' progress towards Objective 1

Dept/ Agency	Progress made since IFH Strategy published
OFMDFM	• The Executive has adopted the broad architecture and principles of the cross-Departmental anti-poverty and social inclusion strategy, Lifetime Opportunities. An Executive Sub-Committee has been created to determine priority actions to implement the strategy and a monitoring framework has been developed. OFMDFM will continue to work with Departments and voluntary and community organisations to identify ways to eradicate poverty and promote social inclusion. • The UK Government is enshrining child poverty targets in legislation - Royal Assent to the Child Poverty Bill is anticipated in March/April 2010. The Assembly passed a Legislative Assent Motion that the legislation should apply here. ○ OFMDFM will have to demonstrate how they contribute to meeting the targets through three-year child poverty strategies and annual reports to the Assembly. A strategic directions paper is being developed to support achievement of the statutory targets. ○ We also have a Programme for Government target to "work towards the elimination of severe child poverty by 2012". • An economic appraisal of childcare options is being completed and the report is due in March/April 2010. This will inform policy on eradicating poverty and child poverty by 2020. • Involvement of the Third Sector/Voluntary and Community Sector is the theme of the current British Irish Council social inclusion strand, and Ministers from the various administrations will consider the report of the working group at a meeting scheduled for March 2010. • Work has been completed in relation to particular groups in relation to social inclusion including lone parents, people with a disability and older people.

Table 6.2: Departments' progress towards Objective 1

Dept/ Agency	Progress made since IFH Strategy published
	○ The Report of the Promoting Social Inclusion Working Group on Disability was presented to the First Minister and deputy First Minister in December 2009 and the Executive will be asked to respond to the report with a view to completing a public consultation exercise on the proposals that emerge. ○ OFMDFM is working closely with the Older People's Advocate and the Older People's Advisory Panel to review its strategy for older people "Ageing in an Inclusive Society" with an inter-sectoral event planned for April 2010. The review will consider health inequalities and other evidence to help identify how to eradicate poverty and address social exclusion for older people. OFMDFM is also bringing forward legislation to create an Older People's Commissioner who will forward an independent voice for older people and help identify key issues for older people in relation to eradicating poverty and ensuring full participation in society. ○ Work on lone parents will be taken forward in the context of eradicating child poverty. • OFMDFM is the lead department in implementing the United Nations Convention on the Rights of Persons with a Disability that was ratified by the UK Government in June 2009. The Convention includes a unique monitoring mechanism that includes the establishment of an independent monitoring framework and a requirement that civil society, in particular persons with disabilities and their representative organisations, be involved and participate fully in the monitoring process. OFMDFM is working with the Equality Commission, NI Human Rights Commission and disability organisations to develop ways of implementing the Directive fully.
DE	• Provides free school meals and uniform grants to non-working families; education maintenance allowances to students to allow them to stay in education (this is paid directly to young people from households with an income of £33,061 or less who stay on in post-compulsory education) and family support programmes through Sure Start aimed at those with children aged 0-4 in top 20% ward areas of disadvantage. The Pre-School Education Expansion Programme provides one year of free pre-school education for children aged 3-4 in the year before they commence compulsory education. Places are provided in statutory, voluntary and private settings and the level of provision of places was estimated at 97% in 2008/09.
DEL	• Provides support for the long -term unemployed in areas of high deprivation. It also provides learning support to those at risk of social exclusion, child care support to those who need it in order to participate in employment and training programmes and to attend college, reviews the skill needs of the NI economy and ensures individuals have access to the opportunity to maximise their potential, through the wide range of DEL programmes and services including Steps to work, Pathways to Work, disablement employment programmes and the Local Employment Intermediary Service (LEMIS).
DRD	• Operates specific transport schemes to help reduce social exclusion. These include the Concessionary Fares Scheme, The Transport Programme for People with Disabilities and the Rural Transport Fund. In November 2009, the Minister for Regional Development announced the introduction of two new rural transport schemes – Dial-a-Lift and the Assisted Rural Transport Scheme. These have been developed to provide transport opportunities to rural dwellers and to help reduce social exclusion
DSD	• Has responsibility for the implementation of the Neighbourhood Renewal Strategy (2003). One of the strategy's main objectives is 'Social Renewal' to improve conditions for people who live in the most deprived neighbourhoods through better co-ordinated public services and the creation of safer environments. Activities to achieve this involve improving the health of people living in the most deprived neighbourhoods. This includes working jointly with IFH Partnerships/initiatives. A mid-term review of the Neighbourhood Renewal Strategy is currently underway. Implementation of 'Positive Steps' (published in 2005) this further supports the work of the Voluntary and Community Sector in NI. • A Strategy to Promote the Social Inclusion of Homeless People, and Those at Risk of becoming Homeless, in NI (2007). This strategy was launched in the context of Promoting Social Inclusion

Table 6.2: Departments' progress towards Objective 1	
Dept/ Agency	**Progress made since IFH Strategy published**
	(PSI) which is part of the wider Lifetime Opportunities anti-poverty and social inclusion strategy for NI.
DHSSPS:	• Support continued for the Health Action Zones established in 1999 and 2001, which were set up to co-ordinate efforts to tackle health inequalities and social exclusion through inter-agency working on the social determinants of health. • Have commissioned a Traveller's All Ireland Health Study in partnership with the Department of Health & Children in the Republic of Ireland. It is expected that the outcome of the study will be key in identifying the health inequalities experienced by members of the traveller community in NI and will allow for appropriate planning of services to address those identified inequalities. The Belfast Trust manages the Interpreting/ Translation service on behalf of all HSC Trusts which is of benefit to the ethnic community. This is to help overcome considerable disadvantage the Traveller Community experience compared to the settled community. • Actions to protect and care for vulnerable children • Developed & implemented the following plans/strategies that address poverty and social exclusion: o Teenage Pregnancy & Parenthood Strategy (2002) ; o Fit Futures Implementation Plan (2007) contains specific actions for vulnerable groups; and o New Strategic Direction for Alcohol and Drugs (NSD) and Young People's Drinking Action Plan contain specific references and prioritised actions for vulnerable groups.
DCAL	• In 2009 "Sport Matters: The NI Strategy for Sport and Physical Recreation, 2009-2019" was approved by the NI Executive. Sport Matters contains 26 high level targets, to be achieved over the next 10 years for sport and physical recreation. These include a target to improving participation rates amongst socio-economically disadvantaged groups and further targets to improve participation rates amongst other groups currently under represented in sport (e.g. people with disabilities, women, older people).
Source: FGS McClure Watters (2010): Investing for Health Departmental Survey	

6.3.3.3 Summary of progress

A number of Departments implemented policies designed either directly or indirectly to reduce poverty in Northern Ireland. These were designed to deliver impacts at a group or area level, but the overall level of poverty has not reduced. External factors, such as the global economic crisis, have impacted greatly on the incidence of poverty. This makes it difficult to evaluate the success of the policies. The expected Child Poverty Strategy to be developed by OFMDFM is an opportunity to tackle this issue directly.

6.3.3.4 Impacts to Date

When the IFH Strategy was developed in 2002, baseline data on the proportion of children living in households with low incomes was not available. Therefore, no high level targets were formulated at the time. A target was later set based on the PfG 2008-11 PSA 7 'Making Peoples' Lives Better' objective 1 which commits to: *"Take forward action to provide for measurable reductions in the levels of poverty and particularly child poverty".*

The target in support of this PSA objective states the intention to: *"Work towards the elimination of poverty in Northern Ireland by 2020 and reducing child poverty by 50% by 2010".*

Household income is used as a proxy measure for 'child poverty'. A household is defined as having a low income (i.e. in poverty) if its income is less than 60% of the median UK household income. The percentage of households with below average outcome, both before and after housing costs, has remained around the same level of 20-22% over the time period since the introduction of IFH. There has been no reduction in the percentage of households with below average incomes. The proportion of households with a low income before housing costs has remained at 22% while the proportion after housing costs showed a decline of 4% between 2003 and 2005 before returning to 26% in 2006.

A paper published by the Joseph Rowntree Foundation in September 2009 found that the proportion of children in low-income households in Northern Ireland (after housing costs) in 2007-08 remained at 26%[25]. Therefore, the target to reduce child poverty by 50% by 2010 is very unlikely to be met; in fact the proportion of children living in poverty has increased over the last 7 years.

However, there have been some indicators of positive improvements. The percentage of children and adults living in households in receipt of Income Support in Northern Ireland has decreased by 2% and 1% respectively between 2004 and 2007. In terms of long-term unemployment, the percentage of unemployed people claiming benefits who have been out of work for more than one year has been falling between 2005 and 2008. JSA claimants claiming for up to two years has fallen by 33.9% while the number claiming for more than two years has fallen by 45.4%.

6.3.3.5 Impact on Partnership Working

A positive outcome from the Strategy has been the extent to which Departments and Agencies are working together to deliver shared outcomes. Table 6.3 shows examples of the types of partnership working in place to deliver on Objective 1.

Table 6.3: Departmental partnerships delivering on Objective 1

Department	Partner	Details of joint working
OFMDFM	All Departments	OFMDFM's Central Anti poverty Unit (CAPU) coordinates the delivery of the Lifetime Opportunities Strategy and works in partnership with all Departments. Similar partnership working underpins much of the work covered in Section 6.2.3.2
	All NICS departments Voluntary & Community sector A wide range of public bodies	CAPU work with partners in developing and implementing policy in the field of social exclusion through a number of groups including: • Equality and Social Needs steering group • Equality Practitioners group • Inter-departmental working groups

[25] Joseph Rowntree Foundation (2009): Monitoring Poverty and Social Exclusion in NI

		• PSI working groups • British Irish Council social inclusion strand
DE	DHSSPS/Health & Social Care Trusts	Partnership working is a core principle of Sure Start. One of the main pathways to Sure Start continues to be through referral from community midwives and health visitors. The development of Sure Start is supported by the 4 Childcare Partnerships in the HSCB, and in many of the 32 Sure Start Partnerships the local Health Trust is the lead accountable body.
	ELBs and Advice NI	Working together to encourage uptake of free school meals.
DEL	Further Education Colleges	Working together on the Learner Access and Engagement programme and Care to Learn scheme.
	Universities	Working together on Widening Participation
	LEMIS Providers	Delivery of LEMIS provision to help economically inactive clients including the long-term unemployed in Belfast, Londonderry and Strabane has made a significant impact in these areas since the service began in April 2007. A total of 1,034 participants i.e. those furthest from the labour market were helped by community mentors to progress into work. Over 70% of these clients sustained the employment for 13 weeks.
DRD	Rural Community Transport Partnerships, Inclusive Mobility & Transport Advisory Committee, DSD	DRD participates in the DSD Neighbourhood Renewal Initiative. Roads Service engineers and Translink District Managers sit as members of a number of Neighbourhood Renewal Partnerships. DRD is also represented on the Belfast Strategy group and Ministerial Committee Roads Service continues to work with DSD in the development and implementation of environmental improvement projects.
DSD	Neighbourhood Partnerships	Neighbourhood Partnerships represent Neighbourhood Renewal areas across NI. Their membership includes representation from the statutory, private and voluntary and community sectors. The composition of individual Neighbourhood Partnerships reflects local circumstances bringing together the different parts of the public, private, business and community and voluntary sectors so that different initiatives and services support each other and work together.
	North West programme Group / Belfast Strategy Group	These Groups bring together statutory and Departmental representatives to facilitate a co-ordinated approach to the provision of services in Neighbourhood Renewal areas.
	Ministerial Group on Neighbourhood Renewal	This group provides cross-Departmental steer to the co-ordination of services in Neighbourhood Renewal areas. e.g. Health, Education, Employment etc.
DHSSPS	OFMDFM /DE	Membership of inter-Departmental groups on e.g. Children & Young Peoples Strategy
	DSD	Membership of inter-Departmental groups

		(Ministerial Group NR & Belfast Strategy Group)
	NIO, DSD, DE, DEL, DOE, PHA, Com/Vol Groups.	New Strategic Direction on Alcohol & Drugs (NSD) Structures at both the local and regional level.
NIO	DHSSPS, OFMDFM & Vol & Community Groups	Delivery partners on NSD, Domestic Violence and Safety of Older People Strategies.
DCAL	Ministerial Sport Matters Monitoring Group	This Group is being established by the Minister of Culture, Arts and Leisure and will be responsible for overseeing the implementation of Sport Matters: The NI Strategy for Sport and Physical Recreation 2009-2019. Membership includes representatives of DHSSPS, DE, DSD, District Councils, sports governing bodies. Much of the focus of its work will be in ensuring delivery of sports participation targets aimed groups currently under represented in sport, including those suffering socio-economic disadvantage.
Source: FGS McClure Watters (2010): Investing for Health Departmental Survey		

6.3.4 Education & Skills

The aim of Objective 2 is 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**. Education plays a vital role in tackling health inequalities by improving life course opportunities for the most disadvantaged young people. There is also strong evidence that investing in early years and education can break the cycle of deprivation.

6.3.4.1 Responsibility

The Strategy sets out a number of actions under Objective 2. These represent the areas that are to be addressed in order to achieve the aim of the Objective. Responsibility for contributing to each action under objective 2 is attributed to the relevant Department(s). They are as follows:

Table 6.4: Departments responsible for actions under Objective 2

Action	Department(s)
Education & learning	DE, DCAL
Youth service	DE, DHSSPS
SureStart	DE/ Cross-Departmental
Children's strategy	OFMDFM
Source: Investing for Health Strategy	

6.3.4.2 Progress

A number of Departments have been working to promote educational attainment in children and young people. The following table highlights some of these areas of work:

Table 6.5: Departments' progress towards Objective 2

Dept/ Agency	Progress made since IFH Strategy published
DE	• The revised curriculum was progressively introduced from 2007/08 to 2009/10 and all children in NI are now taught to this. The Personal Development and Mutual Understanding (PDMU) (Primary) and Learning for Life and Work (LLW) (Post-Primary) elements of the curriculum provides for children to learn about keeping themselves healthy and safe and about healthy eating. • The Department introduced Every School a Good School – a policy for school improvement from April 2009. The policy is pupil-centred and sets out how the Department of Education plans to deliver improvement in the education system. The policy document lists 'child-centred provision' as being one of the characteristics of a good school and an indicator of this is that a commitment exists, through being a healthy school, to supporting healthy children, who are better able to learn and develop. • The 2006 Public Accounts Committee report on Literacy and Numeracy urged the Department to give particular attention to underachievement in socially deprived communities in Belfast by putting in place evidence-based actions to tackle this issue. The 'Achieving Belfast' and 'Achieving Derry – Bright Futures' initiatives were set up in response to these concerns. • Education Maintenance Allowances (EMAs) were introduced in 2004 to enable young people from low income backgrounds to remain in post compulsory education thereby raising participation and retention rates and encouraging them to fulfil their educational potential. A review of the EMA Scheme is underway (led by DEL) to determine the extent to which the EMA Scheme is achieving its objectives. • Sure Start continues to have particular focus on supporting the healthy development of children. Delivery of the 32 Sure Start partnerships focused on 34,000 children aged 0-4, living within the top 20% disadvantaged ward areas. Most Sure Starts are supported by the direct involvement of health professionals such as health visitors, midwives and speech and language therapists, providing among other services, the development of specialised programmes for parents and children. This work helps to raise health awareness, for example nurturing programmes, nutritional programmes, ante natal and breastfeeding support, physical activity programmes, smoking cessation and drug and alcohol awareness. • DE's work in the youth service is ongoing in tackling issues which are relevant to young people today. Through the youth work curriculum, health education programmes dealing with issues such as obesity, drugs, alcohol and the benefits of exercise are provided for young people at youth clubs and organisations. The Department wrote to all youth settings in 2008 encouraging the uptake of healthy options through any facilities that they have that provide food for young people, including the availability of healthy eating choices in tuck shops and vending machines in clubs. Youth Centres and Projects and Residential Centres also provide ongoing programmes which include physical activities such as sports, hill walking, orienteering and sailing. In this way, the youth service gives young people the opportunity to participate in healthy physical activity and to develop healthy pastimes and leisure pursuits. Coaching in a range of sporting activities is also available, which can further develop young people's skills in their chosen sport and can help to encourage them to continue with that sport into adulthood. • The Education Minister will shortly bring forward a strategy to raise standards in literacy and numeracy. The strategy focuses on closing the achievement gaps between the highest and lowest achievers and between the most and least disadvantaged. The aim is to make sure that all our young people leave compulsory education with the literacy and numeracy skills they need for all aspects of life and to progress to further and higher education and employment. • The Extended School (ES) programme, introduced in 2006 aims to reduce underachievement and improve the life chances of children and young people by enhancing their educational development and fostering their health, well being and social inclusion through the integrated delivery of the support and services necessary to ensure every child has the best start in life. The ES programme targets additional financial support on schools serving areas of the highest social disadvantage which allows almost 500 schools to provide for a wide range of services and activities outside of the traditional school day. A key aim of the programme is to promote healthy lifestyles and is reflected in the High Level Outcome of "Being Healthy". Approximately 1,350 of the total 3,720 ES activities

Table 6.5: Departments' progress towards Objective 2

Dept/ Agency	Progress made since IFH Strategy published
	(36%) offered in the 2009/10 programme supported this objective through the provision of a range of activities such as Breakfast Clubs, after school sports clubs, access to specialist support services, including Health and Social Services, fitness classes, healthy eating programmes and a variety of other health promotion events. • Introduction of two Full Service Projects in areas suffering from severe social deprivation, one in West Belfast (Full Service Community Network in Ballymurphy) and one in North Belfast (Boys and Girls Models Schools). These pilot programmes are designed to deliver partnership working between schools, statutory agencies, and voluntary and community groups to provide integrated services and learning opportunities for pupils, their families, and the wider community. The intention is to bring about a new relationship between the school and the community and help remove the barriers to learning through providing access to a comprehensive and cohesive range of support services across a number of areas including education, health and well being and employment. Health Activities offered through the pilots include counselling, mentoring and programmes to address problems such as bullying, alcohol and substance misuse amongst many others.
DEL	• DEL's Careers Service provides impartial information, advice and guidance to young people and adults. Careers Advisers help clients to become effective career decision makers, leading to increased and appropriate participation in education, training and employment. • DEL has nominated a further education (FE) Sector representative to the Food and Nutrition Advisory Group. FE colleges have also been advised to promote a balanced diet and nutrition messages and provide healthy options on their premises. The FE sector is piloting a Health Promoting College initiative involving Southern Regional College and South West College aimed at improving the health and well-being of staff and students. The aim is promote healthy lifestyles and reduce health inequalities through interventions in the College and to the wider community. Improving nutritional standards in catering facilities and curriculum is one particular aim, this includes: • Implementation of CHOICE standard (Craigavon Borough Council) - aims to reach same nutritional standards as currently set for schools; • Introduction of 'Healthy Tuesdays' - healthier food is much more available and concessions are given for choosing these such as 'meal deal'; • Provision of free filtered water to all staff and students; • Production of College Healthy Cookbook by students; and • Revision of healthy eating module within the catering curriculum.
NIO	• Sponsorship (via Community Safety Partnerships) of Bee Safe and Healthy Relationships programmes in schools.

Source: FGS McClure Watters (2010): Investing for Health Departmental Survey

6.3.4.3 Summary of progress

DE has the largest responsibility for delivering on the outcomes under Objective 2 and has implemented a number of measures. Major developments have been within the last three years and include the introduction of the revised curriculum in 2007-08 and the Policy for School Improvement in 2009 which includes the 2008-11 PSA targets. The IFH targets set for Objective 2 were to be achieved by 2005-06, the new PSA targets supersede these. They are:

- Increase to 30% the percentage of students by 2011, with entitlement to Free School Meals, gaining a Level 2 qualification by the time they leave school;
- By 2010 bring the attainment levels of primary and post primary schools identified as having 51% or more pupils living at a postcode within a Neighbourhood Renewal Area, up to within 5 percentage points of the Northern Ireland average at Key Stage 2 and 3 percentage points of the Northern Ireland average at GCSE; and
- By 2010, reduce the number of pupils achieving no GCSEs attending schools identified as having 51% or more of their pupils living at a postcode within a Neighbourhood Renewal Area, to within 1 percentage point of the Northern Ireland average.

Prior to this, DE & DEL introduced Education Maintenance Allowances in 2004; this is an important development as it provides an incentive for young people to stay in education. The Achieving Belfast and Achieving Derry – Bright Futures programmes were also introduced as a response to a Public Accounts Committee report which urged the DE to give particular attention to underachievement in socially deprived communities.

SureStart continues to support early years development in children. However, it should be noted that SureStart was introduced to Northern Ireland in 2000 and pre-dates IFH. Forthcoming work in the area of education includes a strategy to raise standards in literacy and numeracy and closing the achievement gaps between the highest and lowest achievers and between the most and least disadvantaged. A new draft Early Years 0-6 Strategy to be issued in 2010 sets out a vision and plan for ensuring better outcomes for children by improving the provision and quality of services to children and families in the next five years. DEL has a role to play to a lesser extent through the provision of further education and skills for post-compulsory age school leavers.

6.3.4.4 Impacts

The targets set for this objective in IFH related solely to educational performance of children in schools with the highest free school meal entitlement (FSME).

The first target of reducing the proportion of pupils not achieving the expected level at Key Stage 2 in English and Maths by 2005-06 was not met. The percentage of pupils achieving the expected level in Key Stage 2 English in 2005-06 was 32.9%; this was 7.9% short of the target. The percentage achieving the expected level in Maths was 30.5%; this was 4.9% short of the target.

The second target to reduce the proportion of Year 12 pupils in the most disadvantaged schools achieving no GCSEs by 2005/06 was achieved. Data relating to other key indicators in education showed that the proportion of mainstream secondary school pupils with special education needs has increased over time from 8% in 2004-05 to 11.9% in 2008-09.

The data relating to education uptake following school leaving age is also positive. The majority of all school leavers achieve at least 5 GCSE passes (grade A* to C) and this has been increasing over time from 57% in 1998-99 to 70% in 2008-09. The level of enrolments in higher education and further education has also increased over the time same period 1999 to 2009.

6.3.4.5 Impact on Partnership Working

A number of partnerships have developed to deliver shared outcomes within the education sector. We set out in Table 6.6 below shows examples of the types of partnership working in place to deliver on Objective 2.

Table 6.6: Departmental partnerships delivering on Objective 2

Department	Partner	Details of joint working
DE	All 5 Education and Library Boards, Council for Catholic Maintained Schools (CCMS), Education and Training Inspectorate[26].	Involvement in a number of working groups on literacy and numeracy. Supporting the implementation of/providing support to schools on the 'Every School a Good School – a Policy for School Improvement'.
	Education and Library Boards.	Collaboration on the Achieving Belfast and Achieving Derry – Bright Futures programmes
	DEL	Education Maintenance Allowances policy review.
	DHSSPS/Health Promotion Agency (now PHA)	Promotion and co-ordination of Health Promoting Schools initiative, development of health education materials, input to curriculum development etc. Membership of a number of joint working groups addressing health education issues, including: • Obesity; • Suicide Prevention; and • New Strategic Direction for Alcohol and Drugs Steering Group.
	DHSSPS/Health and Social Care Trusts	Partnership working is a core element of Sure Start. Many Sure Starts have formal agreements with HSC Trusts to provide services and support health professionals within Sure Start settings.
	ELB's, range of statutory agencies and government departments including DHSSPS and DSD, Voluntary, Community and Youth Sector, Neighbourhood Renewal Partnerships.	Extended Schools are encouraged to consult, engage and work in partnership with neighbouring schools and local statutory, voluntary and community organisations in an effort to help meet the particular needs of their pupils, their families and the local community. Additionally both Full Service pilot programmes provide collaborative and integrated services involving a number of delivery partners to address local needs including schools, statutory agencies, voluntary, community and youth organisations.

Source: FGS McClure Watters (2010): Investing for Health Departmental Survey

6.3.5 Objective 3 – Promote Mental Health and Emotional Well-being

The aim of Objective 3 is to **promote mental health and emotional wellbeing at individual and community level.** Mental and emotional health is fundamental to our sense of wellbeing and quality of life. There is also a clear link between mental ill health and poverty and deprivation.

[26] Note: The structure prior to RPA

6.3.5.1 Responsibility

The Strategy sets out a number of actions under Objective 3. These represent the areas that are to be addressed in order to achieve the aim of the Objective. Responsibility for contributing to each action under objective 3 is attributed to the relevant Department(s). These are as follows:

Table 6.7: Departments responsible for actions under Objective 3

Action	Department(s)
Mental health promotion	DHSSPS
Suicides & attempted suicides	DHSSPS
Mental health & the working environment	DETI, DEL
Mental health & the troubles	OFMDFM
Mental health & education	DE
Domestic violence	DHSSPS

Source: Investing for Health Strategy

6.3.5.2 Progress

A number of Departments have been working to promote mental health and emotional wellbeing. The following table outlines some examples of this work.

Table 6.8: Departments' progress towards Objective 3

Dept/ Agency	Progress made since IFH Strategy published
DHSSPS	It should be noted that all policies and strategies which have a focus on the individual and community, especially in respect of behaviour change will 'de facto' ideally promote such issues as personal development, self esteem and locus of control. These typically address the broader issue of empowerment, and together these will be necessary factors in relation to promoting mental health and emotional well being. The policies and strategies below are reflective of this position: • Promoting Mental Health Strategy (2003) is currently under review with a new mental health and wellbeing promotion strategy due in September 2010 • Suicide Prevention Strategy 2006/11 – currently under review. The refreshed strategy will consider a wider range of performance indicators – in support of reduction target on overall suicide level - to more comprehensively assess impact of the strategy. The challenge is the wide range of individual, family, neighbourhood, and societal factors that impact on suicide & self harm rates. • There has been no significant improvement in suicide rates; over the past two years the rate has flattened out at around 15 per 100,000 of population from a much lower pre-2005 rate of around 10 per 100,000. There are many reasons for this including: a greater willingness to record a death as suicide (conversely one of the successes of the strategy has been to help generate greater openness on the issue and this has probably made families more willing to acknowledge a family member's death as suicide); and changes to the coroner recording system which has seen fewer deaths recorded as "undetermined" (in the past most undetermined deaths were in fact suicides). Also, the crude overall suicide is a health indicator influenced by many factors external to the remit of, and beyond the control of, DHSSPS and Protect Life. For example, family

Table 6.8: Departments' progress towards Objective 3

Dept/ Agency	Progress made since IFH Strategy published
	upbringing, the level of poverty, crime, social exclusion, employment, education etc (i.e. the wider social determinants of health and wellbeing). It does not readily indicate the impact of Protect Life actions. Hence, the need, through the refreshed Protect Life, to have performance indicators against which progress can be measured and which do show the impact of the Strategy. Obviously, the overall suicide rate has to be retained as the health indicator because this is what we are trying to reduce in the long run, but the reduction target is essentially aspirational. It will take some time to develop a full range of performance indicators and, in some cases; measurement against these will be over a substantial period (up to five years). As part of the refresh of the strategy, an extensive international review of evidence and best practice has been undertaken, and this has resulted in a substantial overhaul of the strategy's action plan. Consideration is also being given to how best to refocus the existing PSA 8 (promoting health and addressing health inequalities) target. • DHSSPS commissioned research on suicide by people in contact with mental health services in NI. Two additional pieces of research have been commissioned focusing on Geodemographic factors associated with deliberate self harm and death by suicide: a within and between neighbourhoods analysis and; Suicide in NI: service use and needs in urban and rural settings. • As part of all-island co-operation on suicide prevention, development of a Men's Mental Health Forum and establishment of media monitoring service in NI is under active consideration. Action to take forward findings of Public Health Agency review of training on mental health promotion & suicide prevention. • An Inter-Ministerial Group on Domestic and Sexual Violence has been established in NI. The Group is Chaired by DHSSPS and includes membership from all Government Departments involved in addressing domestic and sexual violence. • DHSSPS is joint lead with NIO on delivering the Government's strategy for addressing domestic violence - Tackling Violence at Home (2005). • DHSSPS is funding a number of programmes aimed at providing counselling/support to victims of domestic violence and their children. DHSSPS is funding the delivery of educational programmes for school children on personal safety/developing healthy non-violent relationships. These programmes have been delivered in Primary and Secondary schools over the past few years by Women's Aid. In conjunction with DE work is now being taken forward with the aim of integrating these programmes into the curriculum. • A tripartite arrangement between DHSSPS, NIO and PSNI has been agreed to introduce Multi Agency Risk Assessment Conferences (MARAC) to protect domestic violence victims who are at highest risk. It will bring together around one table all agencies best placed to assess the risk to victims and put in place appropriate services and a safety plan to better protect them. MARAC is being rolled out across NI during 2009/10. NIO, DHSSPS and PSNI have agreed a funding package for MARAC for the period 1 April 2009 until 31 March 2011. • DHSSPS is joint lead with NIO on delivering the Government's strategy for addressing sexual violence - Tackling Sexual Violence and Abuse (2008). • A key aim of the 'Tackling Sexual Violence and Abuse' campaign is to raise awareness of sexual violence and abuse across NI. A public information media campaign (delivered through a range of media such as TV, billboards and online) to raise awareness of sexual violence and abuse was launched on 1st November 2009 and ran until the end of March 2010. • DHSSPS in partnership with the PSNI, is funding the establishment of a new Sexual Assault Referral Centre (SARC) in NI. The SARC to be located in the grounds of Antrim Area Hospital will provide 24 hour crisis response to adults and children who are the victims of sexual violence or abuse. The SARC will be operational during 2011. • In 2008/09, approximately 1,200 counselling sessions were provided to male victims of domestic violence; approximately 1600 support sessions were delivered to mothers and children; 7145

Table 6.8: Departments' progress towards Objective 3

Dept/ Agency	Progress made since IFH Strategy published
	school children participated in the educational programmes delivered by Women's Aid. • A review of regional counselling services is underway across the voluntary and statutory sectors to increase capacity and improve timescales for victims of sexual violence accessing services. A regional directory detailing existing services for children and adults who are victims of sexual violence will be published in early 2010. Routine domestic violence enquiry is to be extended to A&E Departments and GP surgeries during 2009/10. . • New Strategic Direction for Alcohol and Drugs (NSD) and Young People's Drinking Action Plan contain specific references and prioritised actions for vulnerable groups
NIO	• NIO and DHSSPS share policy responsibility for addressing domestic violence through Government's 5-year strategy Tackling Violence at Home (2005)
OFMDFM	• Strategy for Victims and Survivors was published in December 2009. The main aim of the strategy is to secure a measurable improvement in the well being of victims and survivors.
DE	• The revised curriculum was progressively introduced from 2007/08 to 2009/10 and all children in NI are now taught to this. The Personal Development and Mutual Understanding (PDMU) (Primary) and Learning for Life and Work (LLW) (Post-primary) elements of the curriculum provides for children to learn about strategies to keep themselves healthy and safe. LLW at post-primary provides opportunities for pupils to understand the importance of recognising and managing factors that may influence emotional/mental health. • Independent Counselling Support Service for Schools: Access to professional counselling support for young people in post-primary schools during difficult and vulnerable periods in their lives has been in place since September 2007. Counselling contributes to tackling barriers to learning which may result from personal trauma, difficult home circumstances, stress, bullying and child abuse. • Pupils' Emotional Health and Wellbeing Programme: In September 2007, DE began work in partnership with all key statutory and voluntary and community sector stakeholders and interested parties to develop a 'Pupils' Emotional Health and Wellbeing (PEHAW) Programme'. The programme focuses on positive prevention by building coping skills in children and young people and complements the personal development strand of the curriculum.
DEL	• Ensures that the FE sector is aware and responsive to the needs of its students, including having in place comprehensive pastoral care arrangements which can signpost those in need of help to the appropriate sources. The Department has commissioned a Scoping Study to consider the protection of children and vulnerable adults within the FE sector in NI to generate practical suggestions as to how pastoral care can be further improved across the sector. • Given that financial difficulties are viewed as one of factors contributing to the incidence of suicide and self harm, under the arrangements in place for student finance, due care is paid to managing the sensitive issue of student debt. DEL, through Student Finance Branch, works closely with other stakeholders including Education and Library Boards, Student Loans Company, Higher Education Institutes and National Union of Students – Union of Students in Ireland (NUS-USI) to ensure that students and their families are fully informed of the financial and other support/advice available to mitigate the costs of higher education. • Pathways Incapacity Benefit Personal Advisers have received awareness training of how to deal with customers with serious mental health problems which may include suicidal tendencies. • DEL has contracts with a number of Voluntary and Community Organisations, under Training for Success, to provide specialist support and referral mechanisms to training suppliers, to ensure that individual participants get the help/support they need, e.g. in engaging with young people who are vulnerable, have been affected by drugs, alcohol, glue or prescription drugs or are at risk of taking their own lives. • DEL also provides support through its Progress2Work pilot for those with a background of homelessness, recovering from drug and alcohol abuse or ex-offenders, to help move them back into work.

Table 6.8: Departments' progress towards Objective 3	
Dept/ Agency	**Progress made since IFH Strategy published**
	• A key area for DEL is also the welfare of its own staff and in line with practices in place across the NI Civil Service, there are support services available at all times to staff accessible via the Department's Welfare Officer. • DEL delivers the Condition Management Programme (CMP) to assist people, with a range of conditions, better manage their condition with the aim of improving their opportunities to enter the world of work. People with mental health conditions are a target group for CMP.
DRD	• DRD recently commissioned research to ascertain the impact on people with learning disabilities of the policies and actions contained in the Accessible Transport Strategy (2005). The research will provide an assessment of the accessibility to people with a learning disability of services supported by DRD. It will also consider areas such as the provision of travel information, training provision and personal safety and confidence issues. The research will also address a wide range of the barriers that impede the use of the transport system by people with a learning disability. (NB: Learning disability is included under the Mental Health Programme of Care)
DETI	• The health and Safety Executive NI (HSENI) is the DETI agency with the largest role to play in workplace health. In November 2004 Health and Safety Executive GB published management standards for work-related stress which provide a practical framework to undertake risk assessment for work-related stress. They also describe a set of conditions that reflect high levels of health, well-being and organizational performance. Since this, HSENI have promoted HSE's management standards for work-related stress primarily in the public sector. The Workplace Strategy was also published in 2003. • In 2009, HSENI held detailed discussions with all Local Government Organisations and the NICS advising them of their duty to manage this issue and how the management standards provide a systematic way to create a more positive work environment. HSENI are currently developing a guidance document on mental well-being in the workplace.
DFP	• DFP implemented the NICS People Strategy 2009-13. A key component is employee health, wellbeing and engagement, which affords the NICS further opportunity to take action to invest in the health of its workforce.
Source: FGS McClure Watters (2010): Investing for Health Departmental Survey	

6.3.5.3 Summary of progress

Significant work has been taken forward on development of strategies to promote mental health and emotional wellbeing and on suicide prevention. In addition a crucial and significant development in the area of mental health since the introduction of IFH in 2002 was the Bamford Review of Mental Health and Learning Disability. This was commissioned by DHSSPS in 2002 and was an independent review of the law, policy and provision affecting people with mental health needs or a learning disability in Northern Ireland. The final publication was in 2007. The Bamford review made proposals for widespread changes, including the introduction of new mental capacity legislation to protect all people who are unable to make decisions for themselves. DHSSPS are currently reviewing and refreshing the Promoting Mental Health and Suicide Prevention strategies. In addition, DHSSPS has initiated a number of measures in the areas of domestic violence and sexual abuse, working in partnership with NIO and PSNI.

Apart from DHSSPS, significant work is also being implemented by DE and DEL to promote mental health and emotional wellbeing and provide counselling support. The majority of DETI's work in this area has been through HSENI. However, the focus of HSENI's work has been skewed towards the public sector; working with the private sector is an area for further development.

6.3.5.4 Impacts

The target for Objective 3 is to reduce the proportion of people with a potential psychiatric disorder (as measured by the GHQ-12 score) by a tenth by 2010. This target is on target to be met as the proportion of adults with a potential psychiatric disorder in 2006 was 19%, which is a decrease of 3% on the 2001 baseline figure. The percentage of adults aged 16 and over stating they were depressed also fell from 21% in 2001 to 19% in 2006. However, the data on the percentage of people who are on prescribed drugs for mood and anxiety disorders has increased by 2.2% from 2004 to 2008 and the number of deaths from suicide and undetermined intent has been increasing over time.

6.3.5.5 Impact on Partnership Working

A number of partnerships have been developed to deliver shared outcomes to improve mental health and wellbeing. We set out in Table 6.9 below examples of the types of partnership working in place to deliver on Objective 3.

Table 6.9: Departmental partnerships delivering on Objective 3

Department	Partner	Details of joint working
DHSSPS	NIO	Joint leads in delivering Domestic Violence & Sexual Violence. They conduct regular meetings to discuss progress.
	DE	DHSSPS is working with DE on the development of the Pupils' Emotional Health & Wellbeing Programme.
	DSD, DE, DFP, DEL, OFMDFM, NI Court Service (Domestic & Sexual Violence)	Members of Inter-Ministerial Group and representation on Inter-Departmental Strategy/Steering Groups and Working Groups. IMG Group meets twice yearly to oversee progress/developments on delivery on strategies.
	HSENI	Work together on work place health strategy (2003). Workplace setting likely to be priority area for Promoting Mental Wellbeing Actions under new Promoting Mental wellbeing Strategy.
DFP	All Departments	DFP liaises with other government departments in drawing up NICS policy in respect of its corporate HR policies
DETI	Health and Safety Executive GB	Joint workshops for HSENI Inspectors and District Council Environmental Health Officers (as outlined in the attachment)
	Health and Safety Authority (Republic of Ireland)	A cross-border pilot was established which used the HSEGB stress management standards and targeted one health, education and local authority organisation in each of the two jurisdictions (see attachment)
	Labour Relations Authority	Joint workshops have been held between HSENI and

Table 6.9: Departmental partnerships delivering on Objective 3		
Department	**Partner**	**Details of joint working**
		the Labour Relation Agency since 2005. HSENI have focussed on stress in the workplace – Legal implications (see attachment)
	Various partners	Establishment of various networks (e.g. Stress Learning circle and NI workplace Health Network) which have focussed on this issue.
Source: FGS McClure Watters (2010): Investing for Health Departmental Survey		

6.3.6 Objective 4 - The Living and Working Environment

The aim of Objective 4 is to **offer everyone the opportunity to live and work in a healthy environment and to live in a decent affordable home**. Health risks can arise from living in poor housing, such as respiratory disease and hypothermia. The incidences of poor housing and home accidents are more prevalent in areas of deprivation. People can also be exposed to health risks in the workplace. However, the workplace provides opportunities to both improve the health of the workforce and address both health and social inequalities.

6.3.6.1 Responsibility

The Strategy sets out a number of actions under Objective 4. These represent the areas that are to be addressed in order to achieve the aim of the Objective. Responsibility for contributing to each action under objective 4 is attributed to the relevant Department(s). These are as follows:

Table 6.10: Departments responsible for actions under Objective 4	
Action	**Department(s)**
Housing conditions	DSD, DOE
Homelessness & access to housing	DSD
Fuel poverty	DSD
Radon gas	DSD, DOE, DETI
Health in the workplace	DETI HSENI
Source: Investing for Health Strategy	

6.3.6.2 Progress

A number of Departments have been working to promote healthy living and working environments. For example:

Table 6.11: Departments' progress towards Objective 4	
Dept/ Agency	**Progress made since IFH Strategy published**
DSD	• A 2006 independent stock condition survey of the NI Housing Executive Housing Stock

Table 6.11: Departments' progress towards Objective 4

Dept/ Agency	Progress made since IFH Strategy published
	concluded that the Housing Executive housing stock is of the highest quality and maintained to a high standard. The most recent house condition survey began in 2009. • Since April 2008 all new build social housing must comply with a minimum rating of level 3 in the Code for Sustainable homes thus producing more sustainable energy efficient homes. • Published Ending Fuel Poverty: A Strategy for NI (2004). • Continued and increased support for the Warm Homes Scheme (first introduced in 2001, provides financial support to those in receipt of qualifying benefits assistance for insulating their home) to address fuel poverty. DSD's budget for the Warm Homes Scheme was as follows: £11·85 million in 2005-06; £15·85 million in 2006-07; £16·85 million in 2007-08; and £21·4 million in 2008-09. • A Strategy to Promote the Social Inclusion of Homeless People, and Those at Risk of becoming Homeless, in NI (2007). This strategy was launched in the context of Promoting Social Inclusion (PSI) which is part of the wider Lifetime Opportunities anti-poverty and social inclusion strategy for NI. The strategy underlines the need for a multi-agency approach to ensure that homeless people and those threatened with homelessness can access the services to which they are entitled. • NIHE published their most recent Homelessness Strategy in 2005 – this has not been evaluated.

DOE	• Several recent draft development plans prepared by Planning Service have specifically identified sites for social housing following consultation with NIHE.
	• DOE is working with DSD to examine ways of developing contributions to support social and affordable housing.
	• DOE published in August 2009 PPS 18 Renewable Energy which encourages and facilitates the provision of renewable energy and heat generating plants in appropriate locations and promotes the use of Passive Solar Design in new developments. As well as assisting in countering the effects of climate change, using renewable energy will also help to reduce other forms of environmental and social damage arising from the use of fossil fuels e.g. the impact of acid rain on water and forest ecosystems and reduce localised air pollution and its subsequent health impacts.
	• DOE is working DETI and DHSSPS on implementing the Government's response to the Sage report on Extremely Low Frequency Electromagnetic Fields. It is considering how the 1998 International Commission on Non-Ionising Radiation Protection (CNIRP) EMF exposure guidelines might be incorporated into the planning system with regard to proposed development near to high voltage power lines and the sitting of new power lines. The health of people living near existing and proposed power lines will be safeguarded.
	• On 25th November 2009, the NIEA published a report (Radon in Dwellings in NI: 2009 Review and Atlas) which contains a 1 kilometre grid square map for the whole of NI showing the proportion of homes exceeding the Action Level for radon, which has been set by Government at an activity concentration of 200 Becquerels per cubic metre in air, in each grid square. In conjunction with various District Councils and Public Health Groups, the NIEA have run several radon campaigns to raise awareness about radon.
	• DOE is responsible for the issue of legislation and policy on noise control and is a designated Competent Authority under the Environmental Noise Directive (END). END has been transposed in NI by the Environmental Noise (NI) Regulations 2006. The aim of the END is to avoid, prevent or reduce on a prioritised basis the harmful effects, including annoyance, due to exposure to environmental noise from, road, rail, industrial and airport sources. It focuses on the impact of such noise on individuals, complementing existing EU legislation, which sets standards for noise emissions from specific sources.
	• The Competent Authorities for each of the other sources of noise covered by the END in NI are
	  • The Department of Regional Development for Roads;
	  • The NI Transport Holding Company for Railways;
	  • Belfast International Airport; and

Table 6.11: Departments' progress towards Objective 4

Dept/ Agency	Progress made since IFH Strategy published

	• George Best Belfast City Airport
	• The three main actions that the END requires of Members States are to:
	  • Determine the noise exposure of the population through noise mapping;
	  • Make information on environmental noise and its effects available to the public;
	  • Establish Action Plans based on the mapping results.
	• NI Competent Authorities Noise Action Plans have been consulted on and are currently in the process of being formally adopted by the Department. Once adopted Action Plans become policy as specified under the Regulations.
	• DOE is also developing a suite of technical guidance during 2010 to assist Competent Authorities in designating Noise Management Areas and Quiet Areas.
	• DOE is working on High Hedges legislation which would provide a means of redress for persons suffering detriment due to a neighbouring high hedge. A public consultation on draft legislation closed on 1 March 2010. The aim is to have legislation in place by March 2011. High Hedge problems are widespread and the fact that very little can be done at present causes stress and can have a negative impact on the health and well-being of those adversely affected.

DETI	• HSENI published the Workplace Health Strategy in 2003. The strategy consists of a wide variety of public and private sector representatives participating in its various Programme Teams as well as the NI Workplace Health Network. A number of initiatives have been developed to improve workplace health in the public and private sectors.
DEL	• DEL, through the pilot Progress2Work programme, provides additional support for people, including the homeless, to help move them back into work. The Department commenced a review of the programme recently. DEL also works with hostel staff to outline the DEL services available to homeless people. • DEL's Careers Service has continued to develop and build upon networks/partnership agreements with a number of organisations who act as advocates for young people with varying barriers, including homelessness, to progress to education, training or employment, specifically in relation to children in care/leaving care, the Careers Service has developed, with Health and Social Services Trusts, Good Practice Guidance in relation to joint working between the Careers Service and the Trusts, to address the Careers Information, Advice and Guidance needs of young people with care experience. In addition, DEL is supporting the participation of NI FE Colleges in a pilot programme to achieve Frank Buttle Trust Quality Mark status which will require them to ensure that they have in place robust mechanisms to identify and track the progress of those with a background in care in their student body and to take steps to address their needs. • Specifically in relation to children in care/leaving care, the Careers Service has developed, with Health and Social Services Trusts, Good Practice Guidance in relation to joint working between the Careers Service and the Trusts, to address the Careers Information, Advice and Guidance needs of young people with care experience. • The Careers Service has been working very closely with Include Youth and the Give and Take scheme which reaches out to the most marginalised and vulnerable young people. These young people have very low levels of literacy, numeracy and I.T skills and present with multiple barriers including care backgrounds, disabilities, victims of abuse, self harming, bereavement, etc. There are also a group at particular risk of becoming homeless.
DE	• From 1 April 2009, the employing authorities have introduced an independent 24 hour confidential telephone counselling service for all teachers. Additionally, a range of schemes to improve the flexibility of teachers' working patterns was ratified by the Teacher Negotiating Committee (TNC) in June 2009. Revisions made in 2008 to the Teacher Attendance Procedure should help schools to take prompt action where teachers are absent through stress. • The TNC are currently developing a guidance document and desk-aid for teachers which gives guidance on the handling, recording and reporting of violent incidents against staff in schools. A questionnaire has issued to a random sample of teachers which allows them to anonymously record incidents of violence and comment on the measures in place to deal with such incidents.

Table 6.11: Departments' progress towards Objective 4	
Dept/ Agency	**Progress made since IFH Strategy published**
	• A draft strategy to promote a more proactive approach to teachers' health and wellbeing is currently being drafted by a working group of the Teacher Negotiating Committee. A working group is being set up to consider the introduction of a "Winding Down" scheme for teachers nearing the end of their careers. This would be in addition to the existing arrangements for phased retirement. • In February 2008 the Education Minister announced the Department's commitment of almost £12million over three years to address the particular problems faced by primary school teaching Principals. The resource is to help ensure that at least two days' per week release from teaching duties is available for teaching Principals of primary schools from September 2008.
DRD	• Roads Service aims to reduce the number of days lost due to injuries at work by 20% (from the level in March 2008) by March 2011. An internal report is produced at the end of the financial year to show progress towards this aim.
DFP	• The Occupational Health Service (OHS) has delivered the Lifestyle and Physical Activity Assessment programme to over 10,000 civil servants. • The OHS, within the context of the NICS People Strategy (2009-13) is responsible for taking forward a number of projects relating to employee health wellbeing and engagement: ○ Lifestyle & Physical Activity Assessment (LPAA) Programme; ○ Health and Wellbeing Improvement Study ○ Stress Awareness Roadshows ○ Young Persons Health Promotion Programme ○ Guidance leaflet relating to the suicidal ○ Health Promotion Newsletter ○ Health Surveillance Programmes ○ Vaccination Programmes
Source: FGS McClure Watters (2010): Investing for Health Departmental Survey	

6.3.6.3 Summary of progress

Significant work has been undertaken to improve the quality of the housing stock and to promote energy efficient homes. Encouragingly, the total number of homes dependent on solid fuel or electricity has more than halved over the period from 2001 to 2006, falling from 22.6% to 9.9%. There have been some improvements in the energy efficiency of buildings as the proportion of buildings with the highest energy efficiency rating, SAP 60+, increased from 37% in 2001 to 41% in 2006. However, there has been little improvement in the proportion of buildings at the lowest end of the energy efficiency scale.

The most recent NIHE statistics show that in 2008-09, 18,076 people presented as homeless. This was a 5% decrease on the previous year, the annual homeless figures from 2001-02 to 2007-08 remained largely unchanged.[27] Under the Housing (Northern Ireland) Order 1988, the NIHE has certain statutory duties towards homeless people and DSD has the responsibility for developing policies and legislation to deal with the accommodation needs of homeless people.

[27] NIHE (2009): NIHE Homelessness statistics 2008-09

In respect of the working environment the departmental survey evidences that there has also been significant action taken to promote healthier working environments in both the private and public sector.

6.3.6.4 Impacts

Targets were set for Objective 4 to reduce fuel poverty and to increase the number of lower cost, affordable homes. The number of households in Northern Ireland estimated to be in fuel poverty in 2004 was 153,530. Taking the results of the 2001 Northern Ireland Housing Condition Survey as the baseline, this is a decrease of 49,730 homes. The target to reduce the number of homes in fuel poverty by 20,000 by 2004 was therefore met, and exceeded by a total of 29,730 homes. This is a substantial achievement given that this target was largely impacted upon by the global increase in fuel prices.

The target to build 2,400 lower cost, affordable homes by 2004 was not met as the total number of housing association starts in 2003 and 2004 was 2,061. However, this was only a shortfall of 339. The PfG 2008-11 has since set a target for DSD to identify new initiatives to ensure the provision of 10,000 social and affordable houses by 2013 (this is under PSA 12, housing, urban Regeneration and Community Development).

6.3.6.5 Impact on Partnership Working

A number of partnerships have been developed to improve the living and working environment of Northern Ireland inhabitants of Northern Ireland. We set out in Table 4.12 below examples of the types of partnership working in place to deliver on Objective 4.

Table 6.12: Departmental partnerships delivering on Objective 4

Department	Partner	Details of joint working
DSD	NIHE / Housing Associations	Delivering DSD Housing Agenda
DE	Teacher Negotiating Committee (TNC)	Through the TNC, the Department works with the employing authorities and the five recognised teacher unions to implement improvements to teachers' term and conditions of service that will impact positively on their health and wellbeing.
DEL	DSD	DEL is represented on DSD's Homelessness Steering Group, Employability Sub Group and Youth Sub Group.
DOE	NI Climate Change Impact Partnership (NICCIP)	NICCIP's aim is to widen the understanding and knowledge of the impacts of climate change within NI and the adaption actions necessary to deal with it.
DFP	All NICS Departments	OHS works with all NICS departments in delivering its business objectives
DHSSPS	DSD	Representation on Interdepartmental Fuel Poverty Group led by DSD and on Homelessness Steering Group.
	HSE, and Health Promotion Agency (now PHA)	Representation on interdepartmental groups relating to workplace health issues

Source: FGS McClure Watters (2010): Investing for Health Departmental Survey

6.3.7 Objective 5 – Neighbourhoods and Wider Environment

The aim of Objective 5 is to **improve our neighbourhoods and wider environment**. Many aspects of the environment, such as air and water quality, pollution and access to services and transport, have direct and indirect effects on health.

6.3.7.1 Responsibility

The Strategy sets out a number of actions under Objective 5. These represent the areas that are to be addressed in order to achieve the aim of the Objective. Responsibility for contributing to each action is attributed to the relevant Department(s) as follows:

Table 6.13: Departments responsible for actions under Objective 5

Action	Department(s)
Air quality	DOE
The neighbourhood environment	DSD, DARD, NIO
Regional development	DRD
Transport	DRD
Sustainable development	OFMDFM (Responsibility was transferred from DOE)
Planning	DOE
Water & health	DOE

Source: Investing for Health Strategy

6.3.7.2 Progress

A number of Departments have been working to improve neighbourhoods and the wider environment. For example:

Table 6.14: Departments' progress towards Objective 5

Dept/ Agency	Progress made since IFH Strategy published
DOE	• A Draft Addendum to PPS 7 to protect the character of established residential neighbourhoods was published for public consultation in November 2009. Existing planning policy to create good quality residential environments is already contained in PPS7, PPS8 & in the Creating Places Guide • As part of the Draft West Tyrone Area Plan preparation (work now temporarily ceased), the plan team worked with IFH & the IPH on an HIA for the plan area. This was undertaken to identify the key health issues facing the district and would have informed any policy response in the plan. • The draft Belfast Metropolitan Area Plan 2015 plan proposals seek to support an improved quality of life through an appropriate allocation of land for health facilities within the settlements.

Table 6.14: Departments' progress towards Objective 5

Dept/ Agency	Progress made since IFH Strategy published
	The development of healthier lifestyles in support of Belfast City Council's Healthy Cities Project is encouraged through increased provision for walking and cycling facilities together with policies which seek to provide an alternative to travel by car. Reduction in car travel offers the potential for improvement in air quality on major routes. Community greenways are identified including parks, playing fields and natural areas to create a network of open spaces and opportunities for leisure and recreation. In addition, the plan proposals identify new lands for open space. • Planning Service has also been actively involved in developing a number of initiatives through the Belfast Healthy Cities Project. Such initiatives included the development of inter agency training for Health and Planning professionals, the development of a health indicator data catalogue for planners and the Urbact 2 bid.[28] • NI Water has direct responsibility for delivering public drinking water quality in accordance with the regulatory standards. However the Drinking Water Inspectorate, a Unit within NIEA, acts as an independent regulator of drinking water quality. The Inspectorate prepares an annual report containing a comprehensive account of drinking water quality in NI and describing the work of the Inspectorate. The level of compliance in 2008 (the most recent figures available) was 99.49%. • Plans in future will continue to consider and integrate as appropriate health issues under the EU Single European Act Directive requirements. As part of planning reform proposals for a new development plan system to be taken forward by 11 new Councils the Department intends to move towards a process of sustainability appraisal which is likely to incorporate consideration of health issues as appropriate.
DRD	• Roads Service is continuing to work with Belfast City Council in monitoring the local air quality management areas (set up in August 2004). • In areas where there is a risk of car pollutants exceeding target levels, then Roads Service has been working with local councils to develop air quality action plans. Derry City, Limavady, Newtownabbey, Armagh and Newry & Mourne Councils have identified Air Quality Management Areas. Road Service is working with Councils to address concerns. • Key objectives of the revised Regional Development Strategy include the reduction of carbon emissions by reducing reliance on the car and taking actions to reduce our carbon footprint. It facilitates adaption to climate change by increasing the use of renewable energies and sustainable management of waste. • The Regional Transportation Strategy (2002-12) is currently under review. A new strategy is being developed that will provide a strategic direction for transportation here on the themes of economic, environmental and societal impacts. It will have a series of strategic outcomes including the reduction of greenhouse gases and other environmental impacts. • Roads Service is committed to sustainable development and has implemented a Construction Sustainability Action Plan (2007) and a Biodiversity Implementation Plan (2008). Accordingly it uses CEEQUAL Assessments on our major road projects (greater than £5m) which aim to encourage the attainment of environmental excellence in civil engineering. Many of our major road schemes offer the opportunity to integrate sustainable drainage systems (SuDS) which can reduce damage to local biodiversity and environmental quality. • A Sustainable Procurement Action Plan was also implemented in 2009. It ensures that we are taking social and environmental factors into consideration alongside financial factors in making procurement decisions. This Action Plan will enable the effective use of Roads Service procurement to change the market for innovative and sustainable solutions, making them more affordable and widely available. It presents a package of actions to deliver the step change we need to ensure that Supply Chains and Public Services will increasingly be low waste, higher in recycled content, respect biodiversity and deliver our wider sustainable development goals.

[28] Urbact is a European funding programme to promote sustainable urban regeneration.

Table 6.14: Departments' progress towards Objective 5	
Dept/ Agency	**Progress made since IFH Strategy published**
DFP	• DFP published its internal Sustainable Development Strategy in May 2006 and an Action Plan in January 2007 detailing the action DFP will take on the themes of waste, ICT, water, energy, estate, procurement and travel. Sustainable Development Action Plan 2008/11 sets internal departmental targets and these are monitored quarterly.
DARD	• Supply Chain Branch, SCDB, have supported Investing for Health in the RAFAEL initiative and will follow up work to increase the amount of locally produced food purchased through procurement contracts. • The Forest Service published the Forest Service Recreation and Social Use Strategy in July 2009, which recognises that forests offer significant opportunities to contribute to wider government objectives, including health. However it also recognises that Forest Service cannot maximise opportunities on its own and will seek to work in partnerships with others to enable these opportunities to be realised. Forest Service is already working with DHSSPS to explore opportunities.
DSD	• £169m has been spent in 36 Neighbourhood Renewal areas since the introduction of the NR Strategy in (2003). This contributes towards meeting the 'Physical Renewal' objective within the Neighbourhood Renewal strategy – to help create attractive, safe, sustainable environments in the most deprived neighbourhoods. The mid-term review of the Neighbourhood Renewal Strategy is currently underway.
DHSSPS	• All new health & social care developments must meet stringent targets in respect of Sustainable Development. There is investment in sustainable models of care such as the development of Community Treatment in Care centres (CCTC). There are 42 planned CCTCs to be constructed across NI that will deliver a new sustainable model of primary care. The buildings orientation allows for passive heating but with design features to minimise summer overheating & there are also some design features to reduce energy consumption such as extensive daylight penetration & use of natural ventilation. Many CTCCs are located at interface areas, providing safe local access by communities to a comprehensive range of Health & Social Care Services – e.g. Grove Wellbeing centre combines health & social care provision with leisure & library services. • All capital development schemes include evaluation of options for sustainable energy provision.
Source: FGS McClure Watters (2010): Investing for Health Departmental Survey	

6.3.7.3 Summary of progress

Significant work and investment has taken place on improving the neighbourhood and wider environment, for example through the Neighbourhood Renewal and other strategies, and is continuing to be developed including OFMDFM's overarching work in the area of sustainable development.

Improvements in air quality for example may be reflected to an extent in the fact that the death rate from circulatory and respiratory diseases has decreased over the time period, however the differential between death rates in deprived and non deprived areas still exists.

6.3.7.4 Impacts

The target set for Objective 5 was to reduce levels of respiratory and heart disease by meeting the health-based objectives for the 7 main air pollutants by 2005. There were improvements in pollutant levels and only two of seven air pollutants failed to meet their targets and of these, the Nitrogen Dioxide target was exceeded at only one of its fifteen measurement sites.

With regards to crime, the rates of burglary and theft have decreased over time by 34% and 43% respectively. The rates of violence and criminal damage both increased year-on-year to 2006 and then declined to 2007. Over 90% of people feel safe or very safe walking alone during the day in their neighbourhood - this proportion falls for feeling safe after dark to 60-70%.

6.3.7.5 Impact on Partnership Working

A number of partnerships have been developed to improve neighbourhoods and the wider environment. We set out in Table 6.15 below examples of the types of partnership working in place to deliver on Objective 5.

Table 6.15: Departmental partnerships delivering on Objective 5

Department	Partner	Details of joint working
DRD	Local Councils (Belfast, Derry City, Limavady, Newtownabbey, Armagh and Newry & Mourne councils)	Development of Air Quality Action Plans as appropriate for individual areas.
DHSSPS	IPH and Belfast Healthy Cities	Representation on interdepartmental groups
	DRD	Links with DRD through their Regional Development Strategy to consider Health Impact Assessment and on their Regional Transportation Strategy and with work looking at sustainable/active transport through the Obesity Prevention Strategic Framework
	DOE	Links with DOE Planning and Health Estates in respect of addressing obesogenic environment

Source: FGS McClure Watters (2010): Investing for Health Departmental Survey

6.3.8 Objective 6 – Accidental Deaths and Injuries

The aim of Objective 6 is to **reduce accidental injuries and deaths in the home, workplace and from collisions on the road**. Accidents in the home, on the road, and in the workplace are a major cause of death and injury and contribute significantly to potential years of life lost.

6.3.8.1 Responsibility

The Strategy sets out a number of actions under Objective 6. These represent the areas that are to be addressed in order to achieve the aim of the Objective. Responsibility for contributing to each action is attributed to the relevant Department(s) as follows:

Table 6.16: Departments responsible for actions under Objective 6	
Action	**Department(s)**
Home accidents	DHSSPS
Road traffic collisions	DOE
Road safety education	DOE
Workplace accidents	DETI
Source: Investing for Health Strategy	

6.3.8.2 Progress

A number of Departments have been working to reduce the number of accidental injuries and deaths. For example:

Table 6.17: Departments' progress towards Objective 6	
Dept/ Agency	**Progress made since IFH Strategy published**
DOE	• DOE has lead responsibility for road safety issues in NI. Its activities include a programme of road safety education in schools, advertising and publicity, and policy and legislation on vehicles, drivers and operators. Some positive impacts include: o The number of road deaths in NI fell from 171 in 2000 to a record low of 107 in 2008. o Since 2000, serious injuries on the roads have fallen from 1,786 to 990, a reduction of 45%. • DOE provides an extensive programme of road safety education in schools. This involves, for example, working with teachers to deliver regular curriculum-linked road safety tuition in classrooms, and supporting the cycling proficiency and practical child pedestrian safety training schemes. Some positive impacts include: o Road deaths amongst children fell from 18 in 1999 to 7 in 2008 o Serious injuries from 191 in 1999 to 94 in 2008 o light injuries from 1,746 in 1999 to 952 in 2008 • DOE has the following areas of work planned: o A new road safety strategy is being developed for publication in 2010, two years ahead of the expiry of the existing 2002-12 strategy o UK-wide consultation has been completed on 'Learning to Drive', an initiative designed to raise standards of driver training and testing o Public consultation has been completed on the introduction of new lower drink driving limits in NI, and the way forward is being considered
DRD/DE	• DE and Education & Library Boards have implemented a series of recommendation made by the Environment Committee in 2002 to improve the safety children travelling on school transport. These include the removal of 3 for 2 seating and the use of seat belts. £2.8m was made available recently to replace aged non-seat belted buses and accordingly the Board school transport fleet will be fully seat belted by 31 March 2010. • The review of the Regional Transport Strategy (2002) will have an outcome to achieve a safer transportation network. Policy measures will help to achieve a reduction in the number of killed or seriously injured on our roads • DRD (Roads Service and Travelwise NI) work closely with the DE and other Departments on the Safer Routes to School (SRS) Programme. The Programme seeks to make the school journeys safer and more sustainable through a range of road engineering measures outside schools, so that drivers are made aware of the presence of children. SRS measures include flashing warning signs, pedestrian facilities, bus bays and enhanced road markings. Schools that encourage school children to walk or cycle to school will have additional safety measures, such as traffic calming, to

Table 6.17: Departments' progress towards Objective 6

Dept/ Agency	Progress made since IFH Strategy published
	improve the safety for school journeys. These schemes are included in the proposed 130 Local Transport and Safety Projects as part of Roads Service Corporate and Business Plan 2009-10
DETI	• HSENI has implemented a number of measures to protect against workplace accidents. HSENI data shows that there has been a 27% reduction in the number of reportable workplace injuries in the 2000-08 period.
DHSSPS	• Home Accident Prevention Strategy & Action Plan (2004-2009) has an overall aim to *"To reduce the number of accidental deaths and injuries in the home"*. Progress has been made towards implementation of the Strategy's 14 actions, many of which require a multi-disciplinary approach and partnership working. The actions are grouped under four areas: policy development; improving awareness; improving information and accident information. The Strategy set 6 targets relating to its aim, and there has been a significant reduction in the number of accidental injuries in the home. The extent to which the targets and actions have been progressed will form part of the review of the Strategy which will take place in 2010. • The NSD for Alcohol and Drugs contains actions relevant to enforcing regulations in relation to drink and drug driving • DHSSPS, together with the DE, Heritage and Local Government are rolling out a project - supported by the EU Programmes Body (SEUPB) for funding under INTERREG IVA - to improve road safety services in NI and the six border counties. The project is expected to run until December 2012. The project has three key themes: improved access to road safety services; education and information; and workforce mobility. The expected outcomes include: ○ *Improved Access to Road Safety Services* A more integrated and collaborative approach to the provision of local road traffic collision services; increased capacity to deliver services where previously gaps existed; improved response times; extrication training; and a contribution to the reduction in the number of people killed or seriously injured in the eligible area. ○ *Education and Information* Increased availability and provision of information through a hub and network approach; information sessions targeting over 1,000 young people in road safety awareness campaigns; 140 young women trained within advocacy project 'Angels' over three year period; 140 young men to participate in 'safe to drive' programme and information seminars to 90-120 parents; cross border approach to policy. ○ *Workforce Mobility* Effective intervention at the scene of accidents; rapid notification of RTCs, the provision of the nearest appliance with the right equipment, personnel; reduced fatalities; increased opportunities for over 300 personnel to be involved in cross-border training; development of sustained networks and partnerships; and strategic training framework developed to ensure standardised approach.
DCAL	• DCAL has, for some years, had in place a safe sports grounds initiative, the aim of which is to help owners and operators of major sports grounds in NI address substantial public safety deficiencies at their venues. As part of that initiative, the Department has brought into operation a new, statutory safety certification scheme for larger sports grounds and non-temporary spectator stands. The scheme will be administered and enforced by District Councils and was commenced in December 2009 under The Safety of Sports Grounds (NI) Order 2006.

Source: FGS McClure Watters (2010): Investing for Health Departmental Survey

6.3.8.3 Summary of progress

A significant amount of work has been carried out to reduce and prevent the number of road deaths and accidents. In particular, a large amount of work has been undertaken to educate children in road safety. DETI (through its agency, HSENI) has also conducted a significant amount of work to address workplace accidents and safety.

A significant number of actions and interventions have been taken forward through the Home Accident Prevention Strategy for example Home Safety schemes targeted at the most vulnerable groups e.g. young and older people.

6.3.8.4 Impacts

The target set for Objective 6 was to reduce the death rate and the rate of serious injuries from accidents in people of all ages. Specifically, to reduce the death rate from accidents and the rate of serious injuries by at least one fifth between 2000 and 2010 respectively. Changes to data recording methods since 2002 prevent direct comparisons being made to the baseline position.

There was a 37% reduction in the number of road deaths between 2000 and 2008, from 171 to 107 deaths. However, the number of road deaths rose by 8% in 2009 (the most recent data available). There has been a downward trend in the total number of road collision injuries and it has fallen by 13.4% (from 2,031 to 1,759) between 2004-05 and 2007-08.

The overall number of hospital admissions due to accidents has been falling annually. The 65+ age group is the most likely to be admitted to hospital due to an accident in the home. This number of hospital admissions due to accidents occurring at school has increased by 4% from 428 in 2004-05 to 445 in 2007-08.

6.3.8.5 Impact on Partnership Working

A number of partnerships have been developed to reduce the number of accidental injuries and deaths in the home, workplace and collisions on the road. We set out in Table 6.18 below examples of the types of partnership working in place to deliver on Objective 6.

Table 6.18: Partnership working in place to deliver on Objective 6

Department	Partner	Details of joint working
DOE	DRD PSNI NI Fire & Rescue Service NI Ambulance Service	Key partners in relation to the current NI road safety strategy
	Department for Transport (GB) Driving Standards Agency (GB) Vehicle & Operator Services Agency (GB)	Key partners in relation to developing and delivering new road safety initiatives, including those emanating from the EU
	Road Safety Authority (Ireland)	Works closely with DOE on a number of relevant issues including advertising and cross-border enforcement

Table 6.18: Partnership working in place to deliver on Objective 6		
Department	**Partner**	**Details of joint working**
DHSSPS	The Royal Society for the Prevention of Accidents (ROSPA)	ROSPA chairs multi-agency Home Accident Prevention Strategy Implementation Group.
	New Strategic Direction for Alcohol and Drugs (NSD)	Partnership working through the NSD in respect of drink/drug driving.
	The Royal Society for the Prevention of Accidents (ROSPA), HSC sector, NIFRS, councils	ROSPA on behalf of DHSSPS leads in home accident prevention and chairs and facilitates a multi-agency Home Accident Prevention Strategy Implementation Group to oversee action in line with the Strategy. Partnership working through the NSD in respect of drink/drug driving.
DRD	DE and schools	Work together in the Safer Routes to School Programme: seeks to make the school journeys safer and more sustainable through a range of road engineering measures outside schools, so that drivers are made aware of the presence of children.
Source: FGS McClure Watters (2010): Investing for Health Departmental Survey		

6.3.9 Objective 7 – Making Healthier Choices

The aim of Objective 7 is to **enable people to make healthier choices**. Lifestyle factors are a major contributor to ill health. Equipping people with the information and opportunities to make healthier choices is seen as key in overcoming increasingly common health problems such as obesity.

6.3.9.1 Responsibility

The Strategy sets out a number of actions under Objective 7. These represent the areas that are to be addressed in order to achieve the aim of the Objective. These are as follows:

Table 6.19: Departments responsible for actions under Objective 7	
Action	**Department(s)**
Smoking	DHSSPS
Physical activity	DHSSPS, DRD, DCAL, DE
Food & nutrition	DHSSPS,DE
Breastfeeding	DHSSPS
Folic acid	DHSSPS
Alcohol	DHSSPS
Drug misuse	DHSSPS

Sexual health	DHSSPS
Oral health	DHSSPS, DE
Health education	DE
Source: Investing for Health Strategy	

6.3.9.2 Progress

A number of Departments have been working to encourage people to make healthier lifestyle choices. For example:

Table 6.20: Departments' progress towards Objective 7

Dept/ Agency	Progress made since IFH Strategy published

DHSSPS	• DHSSPS has implemented a number of measures in relation to smoking:
	  ○ The development of a five year Tobacco Action Plan covering 2003-2008
	  ○ The introduction of smoke-free legislation in April 2007 aimed at protecting the population from the harmful effects of second-hand smoke in enclosed public and work places
	  ○ Legislation to increase the minimum age-of-sale for tobacco products from 16 to 18 years in September 2008.
	  ○ Investing in the development of smoking cessation services – currently over 600 smoking cessation services provided in a range of settings available throughout NI
	  ○ Making pharmaceutical smoking cessation services more available including Nicotine Replacement Therapy (NRT) which is now free to those who don't pay prescription charges
	  ○ Funding comprehensive public information campaigns, and a freephone smokers' helpline
	  ○ Consultation on tougher sanctions for retailers who persistently flout the tobacco age of sale legislation
	  ○ Ongoing work on the development of a new tobacco control strategy, and on introducing legislation banning point of sale displays of tobacco products and the sale of tobacco products from vending machines
	• The final report of the Fit Futures taskforce to MGPH was published in March 2006. The report identified a number of priority approaches and made over 70 recommendations. In order to take these forward an Implementation Plan was developed and was issued for consultation in February 2007.
	• The plan joins up health, education and sport in seeking to reduce obesity in children. The taskforce concluded that delivery of the challenging PSA target, to halt the rise in obesity in children by 2010, would require a sustained commitment to delivering on all the recommendations within the report.
	• The Implementation Plan developed a number of priorities for action which included developing joined-up healthy public policy with Government departments and agencies working effectively with key partners such as the food and leisure industries; providing real choice through healthy options which are accessible and affordable, supporting healthy early years by providing quality opportunities for daily physical activity and good nutrition; creating healthy schools which are seen as a key vehicle for the delivery of health promotion messages and activities; encouraging the development of healthy communities to help address inequalities in health and building the evidence base to help assess the effectiveness of interventions to prevent obesity
	• Development underway of a new Obesity Prevention Strategic framework across the life course.

Table 6.20: Departments' progress towards Objective 7

Dept/ Agency	Progress made since IFH Strategy published
	Some indication that levels of obesity in Primary One children are beginning to 'plateau'. • Breastfeeding Strategy published in 1999 is currently being reviewed. DHSSPS has provided funding for a Regional Breastfeeding Co-Ordinator post since 2002. The initial incidence of breastfeeding rate in NI has increased from 54% in 2000 to 63% in 2005, but the regional rate is still lower than in England, Scotland & Wales. • Sexual Health Promotion Strategy 2008-13. Since 2003, DHSSPS has provided funding towards action in line with the draft Strategy, and increased the funding allocation to £900k towards implementation of the published Strategy and Action Plan. The Department is currently establishing a Sexual Health Promotion Network chaired by the PHA to steer regional implementation of the strategy. In addition the Department provides funding to voluntary bodies involved in promoting sexual health. • The Teenage Pregnancy and Parenthood Strategy and Action Plan 2002-2007 aims to facilitate a reduction in the number of unplanned births to teenage mothers and minimise the adverse consequences of those births to teenage parents and their children. Action includes support for young mothers to remain in formal education, teen parenting programmes, parent/ child communication programmes and personal development programmes for young people. Considerable progress to reduce rate of teenage pregnancies has been made in line with Teenage Pregnancy and Parenthood Strategy 2002-2007. o In 2008 there were 1,426 births to mothers aged under 20 years, of which 148 were to mothers aged under 17 years. o The Strategy set a target to achieve a 40% reduction in the rate of births to mothers aged under 17 years from the baseline rate of 4.1 (1998-2000). The current rate has stabilised around 2.9/3.0 (29% reduction). • The Department continues to support the Strategy, which will be reviewed in 2010, and plans to integrate future actions with Sexual Health Promotion Strategy and Action Plan. • There have been a range of campaigns, initiative and programmes addressing binge drinking, young people's drinking, alcohol and drug misuse, cocaine misuse, etc. Progress and positive impacts include: o The proportion of men in NI who drink over the recommended weekly limit has fallen from 33% in 2002/3 to 28% in 2006/7 (latest figures) o The proportion of adult drinkers who binge drink has fallen from 38% in 2005 to 32% in 2008. o The proportion of young people (aged 11-16) who reported getting drunk in 2007 was 30.0% against a baseline of 32.9% in 2003. o Based on the All-Ireland Drug Prevalence Survey 2006/07, the proportion of young adults taking illegal drugs was 6.1% in 2002/03 and 5.9% in 2006/07. o £8 million has been allocated to the implementation of the NSD in 2009/10; o regional alcohol and drug public information campaigns are being taken forward; o development and implementation of a "Hidden Harm Action Plan"; o young people's counselling and mentoring services for substance misuse have been put in place across NI, along with community support service; o development and implementation of a Young People's Drinking Action plan; and o the four local Drug and Alcohol Co-ordination Teams (DACTs) are implementing their own Local Action Plans. • An Oral Health Strategy was published in June 2007. Fluoride toothpaste schemes for 5 year old children are operating in the 20% most deprived wards. In addition A new trial aimed at reducing tooth decay in the under fives was launched on 23 November 2009.The 'NI Caries Prevention in

Table 6.20: Departments' progress towards Objective 7

Dept/ Agency	Progress made since IFH Strategy published
	Practice' trial will investigate the effectiveness of professionally applied fluoride varnish in preventing tooth decay in children under five. These children will also use fluoride toothpaste at home. Around 2,400 children and 50 dental sites across NI will be involved in the trial. Each child will be monitored over three years to check if they develop dental caries (decay).
NIO	• NIO in partnership with DHSSPS, PHA, PSNI and the NI Policing Board developed the You, Your Child and Alcohol campaign as one contribution towards DHSSPS priorities to address binge drinking and the numbers of young people being drunk and, in parallel, NIO PSA targets on serious and violent crime and reducing anti-social behaviour. Alcohol consumption may of course lead to more serious incidents, including assaults.
DCAL	• In 2009, the NI Executive approved Sport Matters: The NI Strategy for Sport and Physical Recreation, 2009-2019. The strategy contains 26 high level targets, to be achieved over the 10 year period, for sport and physical recreation. These include 11 targets aimed at improving participation rates in sport and physical recreation in NI and further targets designed to improve the quality of and access to sports facilities at community level.
DE	• Under the revised curriculum PE remains compulsory for all pupils up to age 16. In addition to the curriculum a Primary Sports Programme has been in operation since 2007/08 the aim of which is to improve the physical literacy of youngest primary pupils. Home Economics is now also compulsory for all Key Stage 3 pupils. • Nutritional Standards for School Lunches were introduced in Schools in 2007. Nutritional Standards for Other Food and Drinks in Schools were introduced in 2008. These apply to food sold or served in schools through vending machines, tuck shops, breakfast clubs and break times. DE and DHSSPS have recently consulted on a Food in Schools Policy which advocates a whole-school approach to food and nutrition addressing the full range of issues that impact on the food choices that children make. • DE has issued comprehensive guidance to schools on drawing up a drugs and alcohol policy and drugs and alcohol education programme. The revised curriculum provides opportunities for young people to develop the knowledge, understanding and skills to deal with issues such as drugs and alcohol. Schools are also supported in the delivery of drugs and alcohol education by the ELBs' Drugs and Alcohol Education Officers. • Under the revised curriculum, Relationships and Sexuality Education (RSE) is incorporated in the Personal Development and Mutual Understanding (Primary) and Learning for Life and Work (post-Primary) areas of learning. • DE intends to develop an overarching Healthy Schools policy to ensure all schools are healthy schools by 2015/16 and an Active Schools policy to deliver an increase in the levels of physical education and after school sport and physical activity.

DEL	• A considerable amount of work has been done to encourage FEs and HEIs to promote no smoking and provide assistance to those wishing to quit. As autonomous organisations, FE Colleges and Universities have varying policies in place, but many are making efforts to remove the sale of cigarettes on their premises. FE Colleges continuously provide numerous anti–smoking and health messages to students using a variety of media and approaches. These include initiatives (not exhaustive) such as:
	  • regular information sessions / health and safety campaigns;
	  • interventions / presentations from external health promotion agencies (such as Action Cancer, Health Promotion Agency, Health Trust and The Stroke association amongst others) to educate students;
	  • anti–smoking and general health information is included within student induction packs, student intranet sites and promoted within health care curricular areas where appropriate;
	  • special events held to promote National No Smoking Day every year

Table 6.20: Departments' progress towards Objective 7	
Dept/ Agency	**Progress made since IFH Strategy published**
	• smoking cessation clinics offered where available; and • continuous awareness advertising throughout the colleges such as posters and leaflets • Training for Success providers must promote health-related topics such as awareness of alcohol in planning provision for personal and social development. Support can be provided through DEL's specialist support arrangements tied to the programme. • The Condition Management Programme provides a range of supports to assist people with a range of health conditions move closer to the world of work. The provision which is individually tailored, can include assistance in areas such as smoking cessation, exercise regime, dietary and nutritional advice.
DRD	• A key element of the Regional Transportation Strategy (2002-12) is to encourage more people to walk and cycle as part of the normal travel plans (the strategy is currently under review). Roads Service continues to builds new cycle lanes and footways as part of its annual improvement programme in support of cycling and walking.
Source: FGS McClure Watters (2010): Investing for Health Departmental Survey	

6.3.9.3 Summary of progress

One of the most important public health changes in the last decade was the introduction of the smoking ban in April 2007. The legislation, which was aimed at protecting people from harmful exposure to second-hand smoke, especially while at work, has been very successful, with latest compliance figures of 98% recorded from April to September 2009. Smoke-Free Legislation in Northern Ireland - One Year Review (published by DHSSPS in March 2009) stated that there had been a fall in smoking prevalence among adults from 25% in 2006/07 to 23% in 2007/08. Legislation increasing the minimum age-of-sale for tobacco products from 16 to 18 years was introduced in September 2008 and further legislation to ban point of sale displays of tobacco products and the sale of tobacco products from vending machines is currently under development. Fit Futures has been implemented since 2006. The plan joins up health, education and sport in seeking to reduce obesity in children.

A number of measures have been introduced by DHSSPS to tackle the rising problem of obesity. Fit Futures (a plan joins up health, education and sport in seeking to reduce obesity in children) was implemented in 2006. DE introduced Nutritional Standards for School Lunches in schools in 2007. Nutritional Standards for Other Food and Drinks in Schools were introduced in 2008. These apply to food sold or served in schools through vending machines, tuck shops, breakfast clubs and break times. DE and DHSSPS have recently consulted on a Food in Schools Policy which advocates a whole-school approach to food and nutrition addressing the full range of issues that impact on the food choices that children make. Home Economics is now also compulsory for all Key Stage 3 pupils. . Development of a new Obesity Prevention Strategic framework across the life course is currently underway. DE has also been playing a key role in tackling obesity in children. Under the revised curriculum PE remains compulsory for all pupils up to age 16. In addition to the curriculum a Primary Sports Programme has been in operation since 2007/08 the aim of which is to improve the physical literacy of youngest primary pupils.

6.3.9.4 Impacts

Two targets were set for Objective 7, one relating to obesity and one relating to dental decay among children (the data used to set the baseline for this target is no longer collected). Target one was 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%. The proportion of obese people has increased from the time the baseline figure was recorded and 2005-06. The percentage of obese men has increased considerably by 8% and women by 3%. If the number continues to grow at the current rate, the target of reducing the levels of obesity will not be met.

The lifestyle data for adults is not encouraging. The data for the levels of physical activity for adults has remained largely unchanged over time and in 2005-06, with only 30% getting more than the recommended level of exercise and only 27% of adults were eating the recommended levels of fruit and vegetables daily. The available data suggest that nearly one third of adults binge drink, and that the proportion of males who binge drink is higher than the proportion of females. Males were also roughly three times as likely to be a problem drug user as females from 2005 to 2006. The proportion of female problem drug users increased in 2008. Smoking prevalence rates amongst adults has seen a small reduction from 26% in 2002/03 to 24% in 2008/09.

The lifestyle data for young people is more encouraging. The proportion of young people aged 11 to 16 eating fruit and vegetables daily has increased over time. The proportion of young people in this age group who do not smoke has increased over time to over 60% and the proportion who had never been drunk has also increased over time to over 40%.%. The percentage of 11-16 year olds smoking cigarettes regularly has decreased from 14.5% in 2000 to 8.8% in 2007.

The proportion of overweight and obese girls has fluctuated over time; the rates rose between 1999-01 and 2003-04 and then fell sharply to 2006-07. The proportion of overweight and obese boys has increased slightly over time but a slower and more consistent rate. A higher proportion of girls are overweight and obese than boys.

In relation to oral health, School Dental Screening, which included a caries-free measure, is used as an alternative measure to the target set in IFH. In the baseline year of 2003-04, 45.8% of 5 year old children were caries free. In 2007-08, this had risen to 52.5%. The continued success of the evidence-based caries reduction programmes (fluoride toothpaste schemes) is expected to further improve this figure

The Priorities for Action 2008 set a target that b*y 2008, Boards and Trusts should reduce the difference in dental decay levels between 5 year old children in the fifth most deprived wards in each Community Trust area and the Northern Ireland average by 20%.* The 2007-08 School Dental Screening return showed that the 2008 PfA target was met for Northern Ireland overall. Only one of the nineteen legacy Trusts narrowly failed to meet its individual target.

6.3.9.5 Impact on Partnership Working

A number of partnerships have been developed to encourage people to make healthier choices. We set out in Table 6.21 below examples of the types of partnership working in place to deliver on Objective 7.

Table 6.21: Departmental partnerships delivering on Objective 7

Department	Partner	Details of joint working
DHSSPS	Ulster Cancer Foundation, PHA and District Councils	Anti-smoking campaigns Promoting smoke-free workplaces Introduction of smoke free legislation – awareness raising, guidance for business, enforcement staff and the public - compliance enforcement Nicotine Replacement Therapy
	PHA, HSC sector, voluntary and community sector, District Councils, local businesses	Promotion and support of breastfeeding Breastfeeding Strategy Implementation Group to oversee action in line with the Strategy's recommendations
DE	DHSSPS, ELB Catering Managers, CCEA Food Standards Agency ,Safefood, NHSCT Dietitian, ETI Nutritional Associates and PHA	Draft Food in Schools policy and introduction of nutritional standards for school lunches and other food and drinks in schools.
	DHSSPS, DCAL and Sport NI	Development of an Active Schools policy.
DEL	DHSSPS, FE Colleges, Training Providers, Universities	Promoting smoke-free environments and the introduction of the Health Promoting Colleges Initiative being piloted between Southern Regional College and South West College to promote ongoing improvement and development of physical and emotional health.
DETI	Multiple partners were involved with the creation of the Drug and Alcohol in the workplace packs including DHSSPS and other external stakeholders	Production of packs on drugs and alcohol in the workplaces.

Source: FGS McClure Watters (2010): Investing for Health Departmental Survey

6.3.10 Overall Summary

A total of 14 high level targets were set for the strategy's goals and objectives. These targets were believed to be challenging yet attainable. Each target was assigned a timescale which varied depending on the nature of the target – longer for outcome targets and shorter for impact targets. Responsibilities for the associated actions were attributed to Departments. Based on the most recent available data, a summary of the performance against the targets is given below.

Five of the 13 targets were impact targets with shorter timescales. These targets were set to be achieved within two or three years of the strategy being published, i.e. 2004-05. One of these targets was successfully achieved – to reduce the percentage of pupils who achieve no

GCSEs in the 25% of secondary schools with the highest percentage FSME from 8.5% to 5% by 2005-06. Although the target set for the percentage of children achieving the expected level in Key Stage 2 English and Maths was not met by 2005-06, improvements were made compared to the baseline figures. The proportion not achieving the expected level in Key Stage 2 English was reduced from 40% to 30.5% and from 36% to 33% for Maths.

Two targets were set under objective 4 to be achieved by 2004. One of these targets, to reduce the level of fuel poverty, was met. The number new dwelling starts by housing associations fell short of the target by a small amount (239 new dwelling starts).

The objective 5 target to reduce the concentrations of the seven main air pollutants by 2005 was not achieved, however the margin by which it failed was small and considerable improvements had been made over the time period.

The outcome targets with longer timescales look likely to have varied levels of success. The target for objective 3, to reduce the proportion of people with a potential psychiatric disorder to 19% by 2010 was on track to be achieved, based on data for 2006. The target set for Goal 1, to increase life expectancy for men 77.5 years and for women to 82.6 years, is on track to being met by 2010 if the trends in improvements since 1998-00 continue at the rate observed over the period analysed.

Some of the longer term targets have seen their position worsen compared to the baseline measurement due to trends in public health. For example, the percentage of obese men has risen from 17% in 1997 to 25 % in 2005-06 and women from 20% to 23%. The level of obesity is unlikely to be reduced below the baseline figures by 2010. However, it should be noted that the rise in obesity levels is a global problem that has increased at rapid rate since the publication of IFH in 2002.

The targets set to address inequality are not on track to being fully achieved. The gap in life expectancy between the most deprived areas and the Northern Ireland average at 1998-00 was 3.1 years for men and 2.5 years for women. The rate of change was extrapolated and is predicted to be to 3.6 years for men and 2.2 years for women in 2009-11. This suggests that gaps in life expectancy are forecast to narrow for women but widen for men. In 2003, the proportion of children living in low income households (after housing costs) was 26%. In 2009, this proportion remained unchanged at 26%.

We have used the available data to evaluate the progress in reaching these targets within their given timeframe. Some of the targets were met within timescale and some are forecasted to be met within timescale.

In addition, extraneous factors that were unforeseeable at the time of developing the Strategy make certain areas more difficult to achieve. An example is the impact of significant rises in obesity. The global economic crisis has hugely impacted on employment, income levels and the cost of living. This can exacerbate existing income inequalities between socioeconomic groups which will in turn impact on the health inequality gap between these groups.

IFH set targets at a Northern Ireland level; it did not set operational targets for each Department detailing what was required from them individually as Departments, in order that

the overall targets might be obtained. This then makes it difficult for us to evaluate the impact at a Departmental level.

All Departments have implemented measures that have made considerable progress in addressing these actions since the publication of IFH in 2002. The analysis at a Departmental level highlights that a significant number of areas only started to progress from 2006 and on. There has also been a significant level of strategy and policy work in 2009 which has not had time to work through into outputs or impacts. There is also a degree of difficulty in identifying to what extent identified impacts and benefits would have been achieved in the absence of IFH, or to what extent other influences played a role.

In evaluating the evidence collected through the Departments survey, we also find that Departments have a strong focus on reporting activities rather than achievements or outcomes. Whilst monitoring activities is important in the short term it is clearly important that there is a focus on what impacts are being delivered. The analysis at Departmental level also demonstrates that in some cases there is a lack of evidence of monitoring and evaluation taking place.

6.4 IFH Partnership Performance

6.4.1 Introduction

The four IFH Partnerships each developed a multi-sectoral Health Improvement Plan (HIP) based on local need, which focuses on addressing the two goals and seven objectives in the Strategy. The Partnerships receive funding from DHSSPS for infrastructure and implementation of their HIPs. In addition to this funding, they leverage resources from their partners. This section examines the structure, progress and impacts achieved by each of the four IFH Partnerships. It should be noted that, due to the volume of work undertaken by the four partnerships since their inception, it would be difficult to document every achievement. We have therefore selected a number of examples that are representative of the work of each of the Partnerships.

6.4.2 Northern IFH Partnership

6.4.2.1 Structure and Partners

The Northern IFH Partnership (NIFHP) comprises senior representatives from more than 40 organisations and alliances from across the health and social care, housing, education, local Government and community and voluntary sectors. Partnership development and working has progressed through networking and information sharing with partners, including other pre-existing partnerships and multi-disciplinary health improvement colleagues, e.g. Neighbourhood Renewal, Northern Group Systems, Local Strategic Partnerships, Local Commissioning Groups, Health Promotion, Nursing, Social Services, Allied Health Professions and Environmental Health. Connections have been strengthened through a range of IFH related posts, based with partner organisations and made possible through joint funding or in-kind support from partners, e.g. Fuel Poverty Advisers, Community Involvement Workers, Home Accident Prevention Workers, Health Inequality Officers, schools based

Dietitian etc. Partnership capacity development work includes sharing of health improvement statistics and information, research and evaluation, training and mentoring programmes, conferences, seminars and workshops.

6.4.2.2 Approach

The main vehicle for delivering on the IFH objectives and targets is the NIFHP HIP. This five-year, multi-agency plan sets out more than 50 key actions which partners agree to implement collectively across the themes of:

- Poverty;
- Living, working and environmental health;
- Health and social well-being; and
- Life skills, including education and training.

6.4.2.3 Progress & Impacts

The work of the NIFHP has resulted in the following impacts:

- Mainstreaming of the IFH agenda into policy and planning systems - more than 25 NIFHP organisations have incorporated IfH priorities into their corporate/business plans;
- Stronger support from communities – more than 650 local community groups are now engaged in implementation of the IFH agenda and are taking a lead in rolling out more than 100 community and voluntary sector led initiatives; and
- Cross-sectoral, co-ordinated action contributing to the achievement of regional and local priorities in relation to:
    - the creation of a tobacco free society;
    - halting the rise in levels of obesity in children;
    - reducing the suicide rate;
    - reducing the rate of births to teenage mothers; and
    - increasing life expectancy and reducing the gap in life expectancy between the most disadvantaged and the Northern Ireland average.

The following table outlines the return on investment for a number of projects supported by NIFHP.

Table 6.22: NIFHP project return on investments

Project	Description	Investment	Return
Telecare support for older people	This project was developed to support vulnerable older people and people who suffer from mild dementia who remain more independent through the use of	£144,000 between 2004 and 2009 to deliver telecare technology to	• Over 300 clients received the service. • The service resulted in significant changes in professional practice and procedures when assessing client options for change – 8 clients

	assistive technology.	identified clients	continue to be cared for in their homes that otherwise would have to be omitted to nursing homes. • Recurrent funding was secured to mainstream and further develop the service in 2008/2009.
Community Involvement Programme	Development of a pilot project (2005 to 2008) to promote community involvement in achieving the IFH goals in 2 rural and 2 urban areas. An intersectoral Steering Group was established and 2 community-based IFH workers were appointed to engage with and involve local communities.	Approximate annual investment from NIFHP of £100,000.	• Community profiling local needs assessment undertaken. • Wide ranging awareness raising and action achieved among local communities including action relating to suicide prevention/mental health promotion; alcohol and drugs issues; tackling obesity; physical activity; accident prevention; screening and poverty.
Fuel Poverty	The establishment of a unique Fuel Poverty Infrastructure within the Northern area, comprising: a Fuel Poverty Co-ordinator and local Energy Efficiency Advisers across the 10 local Council areas. In addition, the development of 6 Council based Fuel Poverty Implementation/ Working Groups.	Approximate annual financial investment from NIFHP of £140,000	• 427 local people trained in fuel poverty awareness through NEA. • The local co-ordination, identification and referral of over 1,658 fuel poor clients who can benefit from Fuel Poverty Support schemes including - the NIE Energy Efficiency Programme; Warm Homes; and Warm Homes Plus - resulting in approximately £1,870,286 (of heating and insulation measures) being accessed for clients living within the Northern area. • Over, £700,000 of unclaimed benefits being recovered. • Fuel Stamp Schemes currently operational across 8 Council areas within the Northern region.
Obesity Prevention & Intervention Initiatives	Establishment of a range of initiatives designed to prevent and address issues relating to obesity including awareness raising, community engagement, professional training, community education and training.	Approximate annual financial investment from NIFHP of £140,000 grant funding	• Local evidence of the effectiveness of 21 obesity prevention projects • The development of increased intersectoral collaboration based on the evaluation findings
Source: Provided by NIFHP			

6.4.3 Eastern IFH Partnership

6.4.3.1 Structure and Partners

The Eastern IFH Partnership (EIFHP) covers some of the most densely populated and urbanised areas of Northern Ireland. As a result of the demographic composition of the Partnership area, it was decided to split the Partnership into four separate sub-areas, or 'localities'. These are:

- North Down & Ards;
- South and East Belfast & Castlereagh;

- North and West Belfast; and
- Down & Lisburn.

The EIFHP (which is also known as the 'Wellnet Partnership') consists of over 200 members from the local statutory, voluntary, community and business sectors. Any organisation in the Eastern area working to improve the health and wellbeing of the local population are encouraged to register as members. The process for joining the local Partnership involves:

- Registering on the Wellnet website and providing details of the oraganisation's core aims and objectives and indicate where the organisation currently contributes to the IFH goals and objectives.
- The organisation can register as a member of any of the "Communities of Interest", which enable it to receive up-to-date information on meetings, workshops, conferences, training programmes, and potential sources of funding.
- The website can then be used as a means of sharing information on Partner organisations' work, seeking ideas and networking with members throughout the Eastern area.

6.4.3.2 Approach

The EIFHP designs its work around nine 'Communities of Interest', which are based in the IFH goals and objectives:

- Mental Health and Emotional Wellbeing;
- Longer and Healthier Lives;
- Reducing Inequalities;
- Poverty;
- Education and Skills;
- Healthy Environments and Good Housing;
- Neighbourhood Improvement;
- Accidental Injuries; and
- Healthier Choices.

Partnership organisations can be a member of more than one Community of Interest.

6.4.3.3 Progress & Impacts

The initial five-year HIP 2003-2005 identified a number of key actions, which would be developed over the 5 years to assist with the implementation of the IFH Strategy in the Partnership area. The following table shows an overview of some key areas of progress made against each of the seven objectives in the North Down and Ards locality.

Table 6.23: EIFHP achievements against 2003-05 HIP objectives

Objective	Achievements

1: To reduce poverty, especially in families with children.	• North Down & Ards Over 50's Forums targeting socially excluded older people. Activities include:
	  ○ Good Morning call service in North Down
	  ○ 8 senior information events in TSN areas
	  ○ Moneywise Information Event for financial advice and support
	• Families Together Programme
	• Learning Style Training Workshops to support people back into education improving employment opportunities
	• Fuel Poverty/Energy efficiency information sessions

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.	• Delivery of a wide variety of education and training programmes from peer education to accredited training programmes e.g. drugs and alcohol, sexual health, "Cook It," basic computer courses, IFA Soccer Coaching, etc • Successful introduction of CHAT (Confidential Help and Advice for Teenagers) programmes in North Down & Ards

3: To promote mental health and emotional well-being at individual and community level.	• £50,000 invested locally to improve the mental health and emotional wellbeing of people in the area, including:
	  ○ 2 training courses on Mental Health First Aid
	  ○ Production of a directory of mental health services
	  ○ Provision of counselling services
	  ○ 3,000 Relaxation CDs distributed to people in the community and voluntary sectors
	• £104,000 invested in suicide prevention programmes:
	  ○ ASIST Suicide Prevention Training
	  ○ Support for those bereaved by suicide from CRUSE
	  ○ Counselling services

4: To offer everyone the opportunity to live and work in a healthy environment and to live in a decent affordable home.	• Establishment of two Tenant Support Schemes • Substantial home improvements across a number of local housing estates • Establishment of a local group to take forward action on Fuel Poverty, actions included: • Training for over 40 staff in health, housing, voluntary and community organisations on fuel poverty and energy efficiency • Production of a Fuel Poverty calendar distributed to lone parents and older people
5: To improve our neighbourhoods and wider environment.	• Successful implementation of the local Community Safety Partnerships action plans. • The development of local neighbourhood action plans in five of the six targeted areas in North Down through the work of the North Down Neighbourhood Partnership. • Continued development of the PACT community transport scheme in the Peninsula area. • Publication of a "Report on the Health & Wellbeing Needs of 6 TSN areas in North Down" • Training on health issues for communities in Kilcooley, Rathgill, Whitehill, Breezemount, Bloomfield and Redburn/Loughview

6: To reduce accidental injuries and deaths in the home, workplace and from collisions on the road.	• Merging of the two local Home Accident Prevention Groups in North Down and Ards.
	• Addressing the issue of home accident prevention through:
	  ○ Distribution of promotional material on home accident prevention
	  ○ Development of the home safety check schemes for Under 5's and Older People

Table 6.23: EIFHP achievements against 2003-05 HIP objectives	
Objective	**Achievements**
	○ Providing the "Beesafe" project to over 1,000 P7 pupils ○ Providing local community groups with information on accident prevention in the home
7: To enable people to make healthier choices.	• SET provided awareness and support for the introduction of the Smoke Free legislation • Appointment of Smoking Cessation Coordinator to support patients to stop smoking • Fit Futures Community of Interest met 4 times annually and agreed priorities for funding which included fresh fruit for playgroups in TSN areas, Top Tot training for child minders, delivering Cook-it programme and a multi-skills programme. • Sexual Health Community of Interest met regularly and the priorities for the year were training and services for young people. The group organised a range of training courses including: ○ Promoting Sexual Health (for parents) ○ Keeping Safe and other OCN accredited training on Sexual Health issues. • The CHAT clinic ran every week in North Down YMCA and Ards Arena • Breast feeding support groups run regularly across the Trust area and the Ulster Hospital gained re-accreditation for Baby Friendly.
Source: HIP North Down and Ards Locality, 2008-10	

6.4.4 Southern IFH Partnership

6.4.4.1 Structure and Partners

The Southern Health and Social Services Board (SHSSB) began the process of establishing a Southern Investing for Health Partnership (SIHP) in early 2002, seeking commitment and endorsement from key agencies, organisations and communities already working for health and social wellbeing within the Southern area, which is still defined as the five Council Districts covering Armagh, Banbridge, Craigavon, Dungannon and South Tyrone and Newry and Mourne. The SIHP comprises senior representatives of key social and statutory partners. Members are nominated to reflect geographical, professional and sectoral issues. Balance of gender and age is pursued, as well as the inclusion of people living with disability. At present there are 16 statutory partners and 20 Social Partners.

6.4.4.2 Approach

SIFHP Published their first HIP, Dare to Dream, in 2003. Central to the HIP was a commitment to base all the Partnership's work on the needs of the local population, to follow an evidence-based approach to interventions where possible and to be innovative and work together in new ways to achieve the goals, objectives and targets of the IFH Strategy. Since the publication of the HIP in 2003, SIFHP have carried out a number of significant needs assessments to ensure they are working on issues central to the identified needs of the local population. Four sub-groups within the SIHP have been established to action work in priortised areas of need. These 'Issue Groups' are the driving force of the Partnership in

bringing forward practical initiatives which will achieve the IFH agenda. The four Issue Groups are:

- Poverty & Disadvantage;
- Education & Life-skills;
- Neighbourhoods and Environment; and
- Healthy Choice.

6.4.4.3 Progress & Impacts

Central to the Partnership's work has been the ethos of building capacity amongst its partners, sectors, organisations and in particular community groups across the Southern area, to ensure everyone is actively engaged in working towards the IFH goals and targets. This has been supported through providing direct funding from SIHP, but also by a re-orientation of existing funds by partners. An example of this has been the employment of the three IFH Officers based in local Councils. This joint working arrangement is financially supported by all five Councils, the Southern Group Environmental Health Committee and the SHSSB. Also the employment of a Community Energy Efficiency Worker based in TADA Rural Network funded by SIHP and Home Safety Officers based in all five Local Councils funded by both SIHP and each Council and co-ordinated and managed by the Southern Group Environmental Health Committee. Positive outcomes of selected programmes delivered and supported by SIFHP are shown in the table below.

Table 6.24: SIFHP project outcomes

Project	Description	Outcomes
Women and Family Health Initiative	In 2004, SIHP began a 3.5 year association with the Women and Family Health Initiative which aims to meet the needs of disadvantaged families and individuals living in the rural community of South Armagh.	• Training 'Cook-It' facilitators to run programmes in South Armagh • exercise and stress management programmes; • Capacitor training • Art and health courses • Family support programmes for South Armagh wards outside Sure Start areas • Health and creative sessions for individuals with physical and learning disabilities

Loughshore Care Partnership 2004-08	Loughshore Care Partnership aims to deliver locally based services for people living in the Loughshore area. SIHP provided some long-term small funding to support people to come together to reduce social isolation and provide them with social and health opportunities in a neutral community setting.	• Providing transport to bring people from isolated rural areas
		• Ensuring everyone had a hot meal
		• Supporting new opportunities to engage in health and social activities, for example:
		  ○ card making,
		  ○ arm chair aerobics
		  ○ music & story telling.

Working to alleviate child poverty	Recent reports have identified Dungannon and South Tyrone LGD, as one of the highest areas of child poverty in NI. SIHP in partnership with	There are a range of projects being delivered across the Dungannon area working to alleviate child poverty including: • Breakfast Clubs/Healthy Snacks within two

Table 6.24: SIFHP project outcomes

Project	Description	Outcomes
	Armagh and Dungannon HAZ have developed a number of projects which focus on making a positive impact on child poverty, particularly within the Dungannon area.	primary schools • The St Vincent de Paul's 'Reaching Out Project' which to date has provided assistance to almost 50 people over the winter by helping with home heating oil, coal, electric and food vouchers to those most in need • The 'Vineyard Church Compassion Project' which also provides assistance to families in need • The 'School Uniform Recycling Project' • The 'Benefits and money/debt advice information sessions' • 'Shop and Drop' project which provides transport for 3 rural areas to help isolated families shop in larger supermarkets and have access to a wider range of fresh products
Healthy Eating in Post Primary Schools Programme	Schools in the area used funding from the SIFHP to buy a range of equipment including; water coolers, salad bars and Panini and smoothie makers to extend the range of healthy eating and drinking choices. Some chose to offer taster meals and menus and promote these with parents as well as pupils and staff.	• The outcomes of the programme have proved very positive, one school reported a 60% reduction in the consumption of chips in the first week of introducing a salad bar and an increase in the number of yogurts. • Evaluation of the overall programme shows a significant increase in the number of students eating more fruit, drinking more water and taking more exercise. Teachers also reported a positive change in the concentration and behaviour of students.
Community Energy Efficiency Project	SIHP, in partnership with TADA Rural Support Network developed the Community Energy Efficiency Project. The project aims to tackle fuel poverty by taking a community development approach to providing information, advice and referrals to enable people to stay warm and healthy.	• To date the project has worked directly with over 4,600 local people and has trained 12 qualified Community Energy Advisors. • Links have been forged with key energy advice organisations and relationships have been built with Health and Social Care Trusts and Councils developing the programme successfully at a local level.

Source: SIFHP (2009): Dare to Dream. A Review 2003-09

6.4.5 Western IFH Partnership

6.4.5.1 Structure and Partners

The Western IFH Partnership (WIFHP) was established in September 2002 following consultation with local stakeholders. The partnership is made up of approximately 30 partners from the community and voluntary sectors, the statutory sector and the private sector. Applications to join the partnership board were invited from representatives of the community and voluntary sectors followed by a selection process to ensure a broad cross-spectrum of interests were represented. As well as being responsible for taking forward the IFH agenda locally, the partnership oversees the Western Health Action Zone (WHAZ).

6.4.5.2 Approach

Initially, seven subgroups were established, one for each IFH target. In 2004, following a strategic review of the partnership, it was recognised that the number of subgroups was unwieldy and the seven IFH target subgroups were replaced by four subgroups based on life stages:

- Early Years;
- Teenage Transition;
- Adult Life; and
- Later Years.

6.4.5.3 Progress & Impacts

The Institute of Public Health (IPH) conducted a review of the WIFHP in 2005. This report detailed some of the impacts achieved by the Partnership's project work. The following are examples of positive impacts:

Table 6.25: WIFHP project impacts

Project	Impact
Action research projects	• Stimulation of learning • The contribution of the learning from research on up-take of the warm homes scheme to the fuel poverty consultation • NIHE's introduction of bathroom locked medicine cabinets into all home improvement schemes as a result of research on unused medicines • Leveraging of substantial new funding from other sources based on their action research projects, enabling an expansion of project activities.
Night bus service	• A night bus service to take young people home in Londonderry- this was seen as a good example of an non-health initiative with beneficial health impacts
Appointment of Council health and safety officers	• Appointment of health and safety officers in the five councils - this has been helpful in securing councillor commitment to IFH
Health awareness in farmers' marts	• helped increase awareness of health issues amongst farmers

Source: IPH (2005): WIFHP Experiences form 2002-05

In addition, a number of HAZ projects have had positive impacts. For example the 'home telecare project' was taken up by a mainstream service provider (Sperrin and Lakeland Trust), was expanded into other areas in the Western area, and now includes different client groups from the initial pilot (initially victims of crime and people with chronic illness and now young people with disability following accidental injury). The 'debt and consumerism project' which

was originally set up to help people living in poverty and struggling with debt, led to a project responding to the needs of families with a disabled member.

6.4.6 Summary

Each of the four Partnerships have been structured in a broadly similar way, comprising members from the community and voluntary, statutory and (to a lesser extent) private sectors. Beyond these core members, the composition of the Partnerships was intended to be determined locally and evolve over time. The work of each Partnership was intended to be based on the specific needs of their local area, which also informed the development of the Partnership's HIP. As a result, each Partnership has approached their work in a way that is tailored to address the needs within their locality.

This section has outlined a number of positive impacts achieved by each Partnership. It is evident, even from this small sample, that the work of the Partnerships has had a positive impact on the local population. These impacts can mainly be categorised as quantifiable impacts resulting from project/programme work. However, the work of the Partnerships extends to a number of other unquantifiable areas that will impact on the health of each area's population. These include mainstreaming public health issues in the work of the Partner organisations, increased knowledge and understanding of health issues within the local population and building capacity for change within the area.

Each of the Partnerships has an ad hoc approach to monitoring and evaluating programmes and investments made. Only a number of evaluations have been published, and these are largely conducted in-house as opposed to being independently evaluated. The Partnerships were required to submit annual monitoring reports to DHSSPS to detail their progress against their HIPs. There was no agreed format for the monitoring reports and each Partnership decided upon the content of their own report. A consistent reporting style across all Partnerships would allow for comparative analysis and may enable easier monitoring of progress towards the IFH objectives.

6.5 Health Impact Assessment

6.5.1 Policy context

Research shows that policies not directly related to health can have direct effects on the physical and mental health and wellbeing of populations, as well as indirect effects through the wider social determinants of health. One way of ensuring that policies minimise the risk to health and maximise opportunities for health gain is through the use of Health Impact Assessments (HIAs). HIA is the systematic prediction of the potential positive and negative health and wellbeing impacts of new policies and programmes including how these impacts are distributed across a population.

IFH acknowledged that the success of much of its proposed agenda for action would depend on the impacts of all Departments policies. It contained a commitment to develop a

methodology to enable departments and agencies to identify and evaluate the health implications of significant new policy developments to influence decision making in favour of health. It was also proposed to explore the possibility of integrating HIA with other policy assessment processes.

6.5.2 Promotion of HIA

Taking forward the development of these actions has been overseen and co-ordinated by DHSSPS with the support of a dedicated HIA expert based within the IPH who can provide training, advice and information. HIAs of non-health policies are increasingly seen as a key tool to facilitate cross-sectoral action and as a measure to promote health and reduce inequalities. DHSSPS are working with the MGPH and the IPH to develop an incremental implementation programme for HIA.

The IPH has established a dedicated HIA website which contains details on a range of past and current HIAs[29]. The most recent HIA guidance was published in 2009 incorporating both North and South HIA examples. The guidance provides a step-by-step process to assist Departments and other organisations to conduct HIA.

DHSSPS is continuing to promote access to HIA training which will raise awareness and improve the skills of policy makers and analysts and provide up-to-date HIA guidelines.

In addition the use of the Policy Toolkit , developed by OFMDFM to support policy makers to undertake the various impact assessment processes (e.g. equality impact, rural proofing, health impact assessment, environmental impact assessment) is also encouraged by DHSSPS. This Toolkit replaced the Integrated Impact Assessment and DHSSPS offers comments and suggestions to improve the profile of HIA on a regular basis.

In the survey conducted by FGS McClure Watters, Departments were asked about the extent to which they, and their associated Agencies, used HIAs in policy development. Analysis of the Department survey shows that a number of respondents are unsure as to what their Department's involvement with HIAs has been.

In addition, DHSSPS is currently considering a report commissioned by the IPH to externally review HIA activity over the period 2001-2009 and provide suggestions for the future direction of this work.

DHSSPS is keen to continue with the current engagement with other Departments to ensure this buy-in and bring about the strategic influence which will help move HIA up the policy-making agenda. It will seek to explore the wider social determinants of health that occur at a high strategic level with other Departments in ways which bring about mutual gain. This would

[29] this can be accessed at www.publichealth.ie

be clearly demonstrated in terms of, for instance, economic development or educational outcomes.

DHSSPS will advocate that stronger links are built between itself and other Government Departments in specific cross-cutting public and environmental health policy areas so that all policy makers will see health considerations as an integral part of good policy development.

6.6 Health in All Policies

HIAs were one approach to ensuring and facilitating the acknowledgement by non-health Departments and sectors that non-health specific policies often impact either directly on the health and well-being of the population and/or on those determinants on health described elsewhere.

A more recent development has been the 'Health in all Policies' movement. This was initially formulated by Finland during its EU Presidency in 2006. It placed particular emphasis on the fact that decisions influencing people's health do not concern only health services or 'health policies', but decisions in many different policy areas have their influence on health determinants.

Getting health into the agendas of all policy makers remains a challenge. There is however a lack of identifiable information showing the effect of non-primary health policies on population health.

Those working in this area argue that further research and awareness-raising is needed to focus on three related areas that would frame health information in such a way that the implications for decision-makers from non-health sectors are clear:

- research in order to provide solid and quantitative evidence linking the social and environmental determinants of health with their ultimate health outcomes;
- research that shows and quantifies the effect of policies and specific interventions on these determinants; and
- the development of policy-linked indicators which provide a quantitative estimate of the health that would be gained (or disease burden that could be avoided) by adoption of a specific policy.

6.6.1 Summary

There is some evidence to suggest that the approach taken to the promotion of HIA has had any some influence on the development of government policies in favour of health. Consideration should be given to a mandatory requirement for all Departments to conduct HIAs and/or the Health in All policies approach in their policy development processes.

6.7 Conclusion

In delivering IFH at a regional level, the Strategy set macro targets (i.e. at a Northern Ireland level); it did not set operational targets for each Department detailing what was required from them individually in order that the overall targets might be achieved. As a result it is difficult to evaluate the direct contribution made at a Departmental level. However, Departments have implemented many measures that have made considerable progress in addressing the objectives and targets set out in IFH. The analysis at a Departmental level highlights that a significant number of areas only started to progress from 2006 onwards. The time lag between IFH being published and the start of this work may be the result of a 'bedding-in' period where the Strategy has taken time to infiltrate and influence Departments' work. There has also been a significant level of strategy and policy work in 2008-09 which has not had time to work through into outputs or impacts. There is also a degree of difficulty in identifying to what extent identified impacts and benefits would have been achieved in the absence of IFH, or to what extent other influences played a role.

In evaluating the evidence collected through the Departments survey, we also find that Departments have a strong focus on reporting activities rather than achievements or outcomes. Whilst monitoring activities is important in the short term, it is clearly important that there is a focus on what impacts are being delivered.

Health Impact Assessment (HIA) of non-health policies and programmes is considered to be a key tool to promote health and wellbeing and reduce health inequalities. Evidence collected through the Department survey would suggest that successfully embedding health and health equity considerations into the policy making process remains a challenge. Departments may benefit from further awareness raising, information and support on how to implement HIAs and/or the Health in All policies approach in their policy development processes.

In respect of implementation at the local level, IFH clearly acknowledged that its successful implementation would be dependent on engagement at local level. This would be achieved through the commitment, actions and co-operation of individuals, community groups and organisations as well as a range of other partners including District Councils, the business, community and voluntary sector. The extent to which this has happened can be clearly seen in the progress made by the IFH Partnerships which have successfully engaged a wide range of local stakeholders and levered in significant financial and non-financial resources from partners. Other strengths of implementation at local level included:

- mainstreaming public health issues into the policy and planning systems of other partners organisations;
- increased knowledge and understanding of health issues within the local populations; and
- building capacity for change in local communities.

Drawing from the evidence gathered for this review it can be concluded that IFH would appear to be successful as a process at the local level. It is suggested that this is reflective of the capacity and commitment of the local public health workforce, and the level of engagement with, and commitment to the IFH values and principles which had been achieved amongst local communities and organisations.

7. VALUE FOR MONEY

7.1 Introduction

This section examines how the IFH Strategy performed in terms of value for money. It will consider the levels of economy, efficiency, effectiveness and additionality achieved by the Strategy.

The cross-cutting nature of the Strategy makes it difficult to quantify the extent to which other Departments' resources have contributed to IFH. As a result of this limitation, we have focussed our analysis on the DHSSPS funding only. Furthermore, as it is difficult to separate out DHSSPS funding to other areas that support IFH (e.g. Health Promotion Strategies), we have focussed our analysis on the funding that is allocated for partnership working to support the implementation of IFH, specifically through the IFH Partnerships and HAZs.

7.2 Cost of Ill Health

There is strong evidence from both developing and developed countries which demonstrates a two-way relationship between health and economic growth: that economic growth improves health but improved health also significantly enhances economic productivity and growth. A review of cost of illness studies found that the cost of chronic diseases ranged up to 6.77% of a country's GDP. Cardiovascular disease in particular was found to account for between 1-3% of GDP in most developed countries.[30]

Health is no longer seen as a just a by-product of economic development, but as one of several key determinants of economic development. There is a strong case for considering investment in health as one of the key options by which a country can achieve their economic objectives.

In addition, there is a wealth of evidence to show the enormous costs of failing to tackle health inequalities. The Marmot Review (2010) estimated the cost of taking no action against health inequalities, and found that each year the health inequalities in England account for productivity losses of £31-33 billion, lost taxes and higher welfare payments of around £20-32 billion, and additional NHS healthcare costs well in excess of £5.5 billion. If no action is taken, the cost of treating the various illnesses that result from inequalities in the level of obesity alone will rise from £2 billion per year to nearly £5 billion per year in 2025 in England and Wales.

The burden of disease in developed countries is mainly due to non-communicable diseases, most of which are impacted upon by lifestyle-related factors. There are a number of cost-of-illness studies in high-income countries that estimate the quantity of resources (in monetary terms) used to treat these diseases as well as the size of the negative economic consequences (in terms of lost productivity) of illness to the society. These studies

[30] IPH DETERMINE (2010): Working Document #4: Economic Arguments for Addressing Social Determinants of Health Inequalities.

demonstrate the economic burden of ill health, showing that the magnitude of the economic impact is substantial, and provide a rationale for investing in their prevention.

In Northern Ireland, smoking is the greatest single cause of preventable illness and preventable death. It is responsible for 2,300 deaths each year. Smoking is responsible for one in three of all cancer deaths and 84% of lung cancer deaths, smoking is also a major risk factor for CHD, strokes and other circulatory diseases. It is also a major cause of health inequalities and is the principal cause in the gap in life expectancy between rich and poor.[31] The total economic cost of smoking each year is estimated at £3.1 billion in Northern Ireland.[32]

Obesity has been identified as a risk factor for a wide range of health conditions, including heart disease, cancer, hypertension and diabetes. The IPH estimates that obesity causes 450 deaths per year, costs £14.2 million in lost productivity and £90 million in health and social care costs in Northern Ireland alone. This has major consequences for the Northern Ireland economy due to the loss of productivity and health care costs. If the current growth in obesity levels continues, the IPH forecast that over the period 2005 to 2015 there will be a 26% increase in the proportion of people with Type 2 diabetes.[33] This will put additional costs pressures on the NHS and result in increased morbidity and mortality rates.

The prevalence of childhood obesity has also increased dramatically over the past two decades. Approximately 20% of Primary 1 children in Northern Ireland are classified as overweight or obese (around 5% of these children are classified as obese). Children who are obese are more likely to have certain cardiovascular risk factors, a higher incidence of premature atherosclerosis (particularly in males) and insulin resistance (a precursor of type 2 diabetes). Obese children are also more likely to have lower levels of physical fitness and are more likely to experience long-term social and economic discrimination and lower quality of life. The long term impacts are also significant as childhood obesity tracks into adulthood: 26-41% of children who are obese at pre-school age and 42-63% of obese school-age children become obese adults. Adults who were obese as children carry a risk of poorer health and increased mortality compared with adults who were not obese as children.[34]

Mental ill health has a significant social and economic impact on Northern Ireland. There is evidence to suggest that Northern Ireland has up to 30% higher levels of psychiatric morbidity than the rest of the UK. In part, this may be due to the fallout from 30 years of sectarian violence and is likely to reflect relatively high levels of deprivation.[35]

In addition to its impact on individuals and families, poor mental health and wellbeing is associated with low educational outcomes, loss of productivity; and increased anti-social behaviour, youth offending and crime. Mental ill health also represents a growing concern for the benefits system. It is estimated that the direct and indirect costs arising from mental ill

[31] Provided by DHSSPS Economics Branch, Information and Analysis Directorate

[32] DHSSPS 5 year Tobacco Action Plan 2003 – 2008.

[33] IPH (2009): Response to Northern Ireland Assembly Inquiry into Sustainable Transport (January 2010)

[34] Department of Health (2004): At Least Five a Week. Evidence on the Impact of Physical Activity and its Relationship to Health

[35] Tomlinson, M (2006): The Trouble with Suicide. Mental Health, Suicide and the Northern Ireland Conflict: a review of the evidence. School of Sociology, Social Policy and Social Work, Queen's University Belfast

health in Northern Ireland is £2.7 billion per year.[36] In addition, the total annual estimated cost of suicide to Northern Ireland, including direct, indirect and intangible costs, is £262 million or £1.68 million per suicide victim.[37] Self-harm also has a significant economic impact in Northern Ireland, accounting for 1.5% of all hospital admissions over the five year period from 2001-06. These incidents have been calculated as costing the economy £6.6 million due to lost earnings, hospital costs and other lost output.[38]

Recent research commissioned by DHSSPS shows that social and health costs associated with alcohol misuse are between £600 and £800 million per annum in Northern Ireland.[39] In addition, 750 people die prematurely in Northern Ireland each year as a direct result of alcohol related harm.[40]

There are similar studies for the other UK regions that demonstrate the economic impact of ill health. In Scotland, mental illness is estimated to incur costs of £1.5 billion per annum to NHS Scotland and more than £7 billion per annum in wider economic and social costs. Alcohol related illness in Scotland is estimated to cost the NHS £110 million per annum while the wider economic, human and social costs amounted to some £736 million per annum.[41]

The economic cost of obesity in England is between £3.3 and £3.7 billion per year, of which £1 billion was directly attributable to the costs of treating obesity and its consequences.[42] In Great Britain, 10% of NHS spending - or £1 million per hour – is spent on treating those suffering from diabetes.[43] The increase of Type 2 is linked to the increasing incidence of obesity.

7.3 Economy

The Northern Ireland Guide to Expenditure Appraisal and Evaluation (NIGEAE) defines economy as '*the use of resources carefully to minimise expense, time or effort'.* The following section outlines the resources used to deliver health promotion & disease prevention and IFH.

7.3.1 Cost of Health Promotion & Disease Prevention

Health funding allocations are split into nine Programmes of Care (POC). The POC related to public health is POC 8: Health Promotion and Disease Prevention. This covers Women's screening services, Community dental, Family planning, Health visiting, Paediatric medicine, immunisation, School nursing and other community services. It should be noted however that there are also other elements of funding, for example for administration of childhood vaccines

[36] Provided by DHSSPS Economics Branch, Information and Analysis Directorate.

[37] Ibid

[38] DHSSPS (2006): The Northern Ireland suicide prevention strategy and action plan 2006-11.

[39] FGS McClure Watters (2010): Social Costs of Alcohol Misuse Draft Report.

[40] DHSSPS (2004): A Healthier Future: a Twenty Year Vision for Health and Wellbeing in Northern Ireland 2005- 2025.

[41] Scottish Government (2008): Report of the Ministerial Taskforce on Health Inequalities. Equally Well.

[42] House of Commons Health Committee (2004): Obesity, Third Report of Session 2003-04.

[43] Diabetes UK (2008): Diabetes: The Silent Assassin.

by GPs and their practice staff, and through maternity and child services which are not accounted for under POC8.

The highest proportion of the POC 8 budget has historically been spent on health visiting (around a range of 20- 21%). In addition, up to April 2009 some funds were held centrally for health promotion and improvement activities to be commissioned through the Health Promotion Agency and the former Health and Social Services Boards. This funding is now largely the responsibility of the PHA.

The following summarises the spend on health promotion and disease prevention activities for the last three financial years. (This summary includes the amounts allocated to the Investing for Health Partnerships and HAZ.)

Table 7.1: Summary of expenditure on Health Promotion and disease prevention in NI 2006 – 2009*

	£m 2006/07	£m 2007/08	£m 2008/09
1 Health Promotion & Disease Prevention (POC 8)	42	46.6	47
2. Centrally held funds	30	32	33
3. Total	**72**	**78.6**	**80**

Source: Information supplied by DHSSPS Strategic Financial Analysis Unit, and from Strategic Resources Framework.

For the last year for which there are actual spend figures, i.e. 2008-09, the £80m spent on Health Promotion and Disease Prevention represents 2.9% of the total Health Expenditure for Northern Ireland. Total planned expenditure on Health Promotion and Disease Prevention for 2009-10 is due to rise to £98m which would represent around 3.1% of the total planned health spend[44].

7.3.2 Cost of IFH Partnerships & HAZs

Due to the difficulty in isolating and quantifying all costs associated with delivering the many facets of IFH, we have focused our analysis on the funding provided to the IFH Partnerships and HAZs as the local delivery mechanisms for IFH. The emphasis with both the IFH Partnerships and HAZs was to stimulate new ways of working through partnership and collaboration. The IFH Partnerships, which were geographically broader and more strategic in function, were encouraged to work with and build on existing initiatives such as the HAZ. The IFH Partnerships and HAZs both work to the same strategic objectives as laid out in the IFH Strategy and their work is complementary and symbiotic.

The funding provided by DHSSPS to the IFH Partnerships and HAZ since 2002 is shown in the table below. The IFH Partnerships were allocated £1m per annum for infrastructure costs to support the Partnership and £1.5m per annum (these amounts rose annually to take account of inflation) for the implementation of the cross-sectoral Health Improvement Plans (HIPs). The HAZs were allocated annual funding to support infrastructure. The total DHSSPS

[44] Information supplied by DHSSPS Strategic Financial Analysis Unit, and from Strategic Resources Framework

investment by DHSSPS in the IFH Partnerships and HAZs from 2002-03 to 2008-09 was £23.55.

Table 7.2: DHSSPS investment in IFH Partnerships & HAZ 2002-09

Year	IFH Partnerships	HAZ	Total
2002-03	£2.5m	£600,000	£3.1m
2003-04	£2.562m	£660,000	£3.222m
2004-05	£2.626m	£660,000	£3.286m
2005-06	£2.692m	£660,000	£3.352m
2006-07	£2.759m	£700,000	£3.459m
2007-08	£2.828m	£700,000	£3.528m
2008-09	£2.899m	£700,000	£3.599m
Total	£18.866m	£4.68m	£23.546m

Source: Provided by DHSSPS and HAZs

7.4 Efficiency

NIGEAE defines efficiency as *'delivering a given level of service for minimum input of cost, time or effort; or obtaining maximum benefit from a given level of input'.*

The partnership approach to delivering IFH has allowed a large number of partners to be involved in the Strategy at a local level in both the development of HIPs and the delivery of projects aimed to meet the needs of local people. This approach meant that IFH Partnerships and HAZs were able to make the best use of partner's resources as well as leveraging financial support. The following sections provide examples of the financial resources levered in by the IFH Partnerships and HAZs.

7.4.1 Money Levered in by IFH Partnerships

The IFH Partnerships levered in a significant level of monetary resources from their partners. Each Partnership also levered in considerable 'in-kind' contributions from partners, as part of these organisations' input into projects. This includes, for example, the use of accommodation for meetings and time of personnel.

We have analysed the total amount of additional funding levered in by the WIFHP from 2002-03 to 2007-08 as an example of the efficiency of the IFH Partnerships as the local delivery mechanism for IFH. We have not included 'in-kind' contributions from partners in our analysis as this is difficult to quantify.

Table 7.3: WIFHP money levered in 2002-03 to 2007-08				
Year	**Income from DHSSPS**	**Resources Levered in**	**Total Income**	**Amount Levered in for Every £1 of DHSSPS Investment**
2002-03	£207,377	£60,000	£267,377	£0.29
2003-04	£307,884	£300,000	£607,884	£0.97
2004-05	£310,253	£314,500	£624,753	£1.01
2005-06	£397,503	£81,422	£478,925	£0.20
2006-07	£303,477	£510,000	£813,477	£1.68
2007-08	£349,783	£484,000	£833,783	£1.38
Total	**£1,876,277**	**£1,749,922**	**£3,626,199**	**£0.93**
Source: Provided by WIFHP				

It is clear from the analysis that the WIFHP has successfully levered in funding from various sources for health and wellbeing initiatives from 2002-03 to 2007-08. For every £1 of DHSSPS investment over the period, WIFHP levered in an additional £0.93.

Example of IFH Partnership Project Return on Investment

The NIFHP invested £120,000 annually from April 2006 to March 2009 in the Advice 4 Health project. This project was developed in partnership between the Citizens Advice Bureau and local HPSS organisations and provides advice, information, support and practical help to local people living within the Northern Board area. The project was developed in an attempt to reduce poverty and tackle disadvantage by maximising benefit uptake in the community, with a particular focus on the elderly, people with disabilities, people with mental health difficulties and families living in poverty. An evaluation of the project found that, given that the key input to the project was the funding of £120,000 from the Northern IFH Partnership, the ratio of outputs in terms of benefits take-up has been considerable. Actual additional benefit entitlement take-up has exceeded £720,000 giving a ratio of over £6 generated for every £1 invested by NIFHP.

Source: CENI (2006): Advice 4 Health Evaluation Report

7.4.2 Money Levered in by HAZ

Each of the four HAZs also levered in significant levels of resources from their partners. The total amount of additional funding levered in by NNHAZ has been analysed for the period from 2001-02 to 2008-09 as an example of the HAZs' efficiency. During this period, considerable 'in-kind' contributions were also levered in from NNHAZ's partners - this has not been included in our analysis as it is difficult to quantify.

Table 7.4: HAZ money levered in 2001-09				
Year	Income from DHSSPS	NNHAZ Resources Levered in	Total Income	Amount Levered in for Every £1 of DHSSPS Investment
2001-02	£150,000	£60,000	£210,000	£0.40
2002-03	£150,000	£292,737	£442,737	£1.95
2003-04	£165,000	£729,067	£894,067	£4.42
2004-05	£165,000	£8,166	£173,166	£0.05
2005-06	165,000	£45,871	£210,837	£0.28
2006-07	£175,000	£146,715	£321,715	£0.84
2007-08	£175,000	£394,196	£569,196	£2.25
2008-09	£175,000	£217,174	£392,174	£1.24
Total	**£1,320,000**	**£1,893,926**	**£3,213,892**	**£1.43**
Source: Provided by NNHAZ				

NNHAZ has successfully levered in a substantial level of resources from their partners. For the period from 2001-02 to 2008-09, NNHAZ has levered in a total of £1.43 for every £1 invested by DHSSPS. However, there are sizable variations in the amounts levered in each year, suggesting that there may be a degree of insecurity in their funding streams.

Given the relatively small investment made by DHSSPS (£3.1m - £3.2m per annum), the IFH Partnerships and HAZs have been successful in leveraging a significant amount of financial resources from partner organisations. In addition to these financial resources, an unquantifiable amount of time and personnel resources have been contributed by partners. Other unquantifiable benefits have also accrued such as the co-ordination of effort through working groups and new working relationships established to support IFH working locally. This was one of the key aims behind the rationale for establishing and supporting partnership working – which has been successfully realised.

7.5 Effectiveness

NIGEAE describes effectiveness as *'delivering a successful outcome and meeting objectives as fully as possible'*.

As detailed in Section 4, improvements have been made to the levels of life expectancy in Northern Ireland since the introduction of IFH in 2002. In addition, as Section 6 outlines,

significant progress has been made towards achieving the 14 targets set out in IFH. Three of the four targets set to be achieved by 2004 were achieved within the timescale. Of the targets 10 to be achieved by 2010, 2 are on track to be achieved, 4 are not on track to being achieved and 4 were not directly comparable to the baseline as the method of recording data has changed since the baseline was established in 2002. Given that the targets set were considered to be challenging and aspirational, IFH has achieved a considerable amount in a relatively short time scale.

In addition, IFH has resulted in a number of unquantifiable impacts through the collective mobilisation of effort for health improvement, such as the engagement and involvement of communities in health improvement, especially in disadvantaged areas.

In terms of delivery of IFH, there are a number of areas where effectiveness can be improved:

- The levels of financial resources levered in by the IFH Partnerships could potentially be improved. The HAZs have demonstrated a higher level of leverage with a smaller annual investment from DHSSPS. However, it should be noted that the IFH Partnerships' remit is more broad-ranging and strategic and their impacts extend to areas such as building capacity among partner organisations and influencing policy and service delivery;
- Both IFH Partnerships and HAZs need access to more sustainable sources of funding revenue. IFH is a long term Strategy and the successful delivery of projects is dependent on a consistent long term funding stream; and
- POC 8 receives the smallest proportion of the total health budget. Extending IFH's remit to influence resource allocation under other POCs would enable a stronger focus on public health issues across all areas of health care.

7.6 Conclusion

Investing in public health is a long term investment not a cost. There have been a number of detailed studies looking at the impact of investing in health across the UK, these have looked at the effectiveness of various public health initiatives on different populations. For example, a recently published paper by the New Economics Foundation, Backing the Future (2009), demonstrates the economic case for investing in preventative services for children and young people to address the structural factors affecting the circumstances of their lives, such as poverty and inequality, together with psychological and social dimensions of their well-being. The paper states that the cost to the UK economy of continuing to address current levels of social problems will amount to almost £4 trillion over a 20 year period. This includes addressing problems such as crime, mental ill health, family breakdown, drug abuse and obesity. Making the transition to a move preventative approach will require investment; however, the paper estimates that the returns to the UK economy would total a minimum of £486 billion over 20 years. This is roughly five times the current annual budget of the entire NHS. There is also considerable evidence to show that investment in early years is vital to reducing health inequalities. Gaps between individuals and social groups emerge early in the life course so it is vital to tackle it at this stage. In addition, returns on investment in early childhood are higher than at any other stage in life.

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Example of Early Years Intervention Return on Investment

Dunbartonshire Family Service provides short-term, focused and flexible support for children, young people and families in crisis. The aims of the service are to:

- Reduce the number of children being looked after and accommodated;
- To support parents to better meet their children's needs;
- To help children and young people address issues that may be affecting their lives and wellbeing; and
- To contribute to assessments of children's needs and parents' capacity to meet these

For every £1 invested annually in the East Dunbartonshire Family Service, £9.20 is generated in benefits to society (social value). The share of social value by stakeholder is as follows:

- The most significant value (34%) is obtained by the state, which recouped its investment by the end of one year. This is primarily due to the reduction in need for foster care and its associated costs;
- Children derive 31% of the value; and
- Parents/carers derive 20% of the value.

Source: New Economics Foundation (2009): Backing the Future

Investing in workplace health and wellbeing also makes sound commercial sense. Evidence shows that immediate benefits include reduced sickness absence, staff turnover and injuries, and increased employee satisfaction, productivity and company profile. Bottom line benefits include reduced staff costs, recruitment costs, legal costs/claims, insurance premiums, health care costs and management time. Studies have shown that every £1 invested can yield as much as £84.45

The IFH Strategy has delivered a considerable amount in a short timeframe with a relatively small investment from DHSSPS. The partnership delivery structure of IFH has been efficient. The IFH Partnerships and HAZs have been effective in leveraging resources from their partner organisations – these include considerable financial resources and in-kind contributions. However, there are a number of areas for improvement in the delivery of IFH, including increasing the level of resources levered in by the IFH Partnerships, ensuring that Partnerships have sufficient research and evidence to identify the best solutions to dealing with their local issues in a VFM way and the ability to leverage the resources required from the Departments and Agencies. The Partnerships will need to be linked through the

[45] Scottish Government (2008): Report of the Ministerial Taskforce on Health Inequalities. Equally Well.

Department to the Research resources that exist within the IPH, the PHA and others. While many policies and local action plans are evidence-based, the work programmes of partnerships also need to be informed by evidence, where it exists. Where evidence is lacking, interventions should be evaluated using methods that are proportionate to the cost of intervention.

DHSSPS needs to provide information and evidence on what interventions have worked best elsewhere in order that IFH Partnerships can best match interventions to their needs. Partnerships also need equipped with the information and case studies on what has worked so that they might influence local statutory representatives and thereby increase the potential for others to be contributing to the delivery of IFH outcomes.

8. CONSULTATION SECTION

8.1 Introduction

In this section we set out the findings from the consultations completed which influence the findings in the remaining sections of this report. A table showing the name and job title of each consultee along with the approach used is included in Appendix 3.

8.2 Findings

8.2.1 Introduction

The consultation process was designed in order to access feedback from as many stakeholders as possible within budget constraints for this project. We used different forms of consultation specifically 1:1 interviews; group sessions and surveys to assist with this process. The consultation meetings were all specifically designed for each interviewee, but they followed a number of core themes, namely:

- Awareness/ Buy in to the Strategy;
- Relevance of the Strategy;
- Performance;
- Leadership;
- Performance Management and Accountability; and
- Structures.

8.2.2 Awareness / Buy in to the Strategy

All stakeholders spoke of the extent to which the Strategy had been unique when it was first launched due to:

- Its focus on identifying and actioning the determinants of health and wellbeing;
- The common focus and language it provided to all working in this area; and
- Its emphasis on partnership working.

Stakeholders were also very positive about the process that had been used to develop the Strategy. All felt it had been highly inclusive and recognition was given to the CDHN in how it had conducted the whole process.

As a result the stakeholders had been aware of the Strategy from when it was launched and many had been involved in its development. All were therefore primed and ready to support delivery of the Strategy from when it was launched.

8.2.3 Relevance of the Strategy

Stakeholders all felt that the Strategy had been, and still was, hugely relevant. Many mentioned the uniqueness of the Strategy when it was first published, in devising a cross-Departmental strategy that was clearly focused on partnership working. Many mentioned the focus and the common language it provided to all working in this area. A number of consultees outside of Health noted that it provided for them the sense of purpose they had needed, allowing them to demonstrate to others how their work was contributing not only to their own Department objectives, but to health and well being generally. This was something they had been aware off, but had never seen formalised in a Strategy.

Local stakeholders felt that the Strategy was as relevant now as it had been in 2002, as *"there was still much work to be done"*. Others at a strategic level felt that the Strategy needs to be refocused in a smaller number of areas with early years and children getting top priority.

8.2.4 Performance

Stakeholders felt that the Strategy had been hugely successful in:

- Providing a common language and a focus for all those focused on health and wellbeing improvement;
- Providing structures which allowed local stakeholders to come together and renew needs and agree priorities for the way ahead;
- Developing 'local solutions to local problems' and therefore creating buy-in for the community in doing so;
- Levering in monies from other sources outside the DHSSPS (note section 7 has detail on examples of additional funding levered in); and
- Accessing 'unpaid for time' through the work of local community representatives or the partnership groups.

A number of stakeholders felt however that they had no clear understanding of whether the targets were being achieved or not, but there was a sense that they were unlikely to have been achieved as *"not enough had changed in general"*.

Many highlighted the lack of joined up working and for example noted that:

- There was confusion around the roles of the HAZ and IFH partnerships, particularly in the early years of the Strategy;
- Also some felt there was confusion over roles and responsibilities of the Health Improvement Staff in Trusts and IFH partnership & HAZ staff;
- Neighbourhood Renewal set up its own structures rather than working through existing IFH structures; and
- The perceived lack of connectivity between Sure Start and IFH delivery on the ground.

All the IFH partnerships work independently from each other. Providers such as CDHN highlighted that they often had to submit separate proposals to different Partnerships and that

there was little or no tie-across from one partnership to another. This was felt to be inefficient for not only the partnerships but the community and voluntary sector providers involved. It was suggested that IFH Partnerships should consider jointly commissioning projects.

A number of local stakeholders highlighted the need for Partnerships to work together more and learn from each other.

One of the Trusts highlighted that the Partnerships tended to be composed of the same local activists already known to the Trust and that the Partnership had not been successful in a recruiting new blood into the group. As a result the same ideas and projects were getting discussed at a Partnership level as were being, or had been, discussed within the Trust.

Another Trust felt that their local Partnership involved too many stakeholders whose agenda it was to get funding for their specific projects rather than looking at what would work best.

Community and Voluntary sector representatives felt that the Strategy had not influenced Departments in any significant way. Most felt that Departments had sought to highlight work they were doing anyway as evidence as to what they were delivering under the Strategy, and that opportunities had been missed as a result.

8.2.5 Leadership

Stakeholders identified either the MGPH or the DHSSPS as holding the leadership function for the Strategy. A number mentioned the importance of the Minister being seen to support the Strategy. Many felt that the number of Ministerial changes since the Strategy was launched had had a detrimental impact on the Strategy's delivery.

The MGPH also came in for criticism as it was felt (by local stakeholders in particular) that it had not been successful in holding Departments to account for deliverables, however it was acknowledged that accountability is a key challenge in a government structure of independent departments.

Stakeholders were clear that the leadership function needed to be strengthened, although there was no common agreement as to how this could happen. It was recognised that this was an issue common to many cross-departmental strategies.

A number of stakeholders highlighted the importance of the Minister showing leadership for the Strategy. Minister McGimpsey was praised for his press on the inequalities of health and specific mention was made of his reference in a press release that *"Health inequalities are an issue we simply have to address. It cannot be tolerated that your life expectancy and health status is determined by where you are born."*[46]

One stakeholder felt that a Commission was needed to develop the widespread support needed for tackling inequalities. A Commission would be independent of Departments and seek to advise Minister on the actions required. Others felt that given the pressures on

[46] NI Executive Press Release (3 December 2008): McGimpsey urges co-ordinated approach to tackling health inequalities

government budgets, this would not be an action that could be taken forward at this stage and that advisors existed who could fulfil this role.

8.2.6 Performance Management and Accountability

Stakeholders in the Health & Social Care system highlighted that PFA (Priorities for Action) targets were their priority. These are the annual direction on the Health Ministers priorities that is given to the HSC. PFA targets were consistent with and contributed to PSA (PFG Public Service Agreement) targets – in respect of IFH they included e.g. smoking, obesity etc. Any IFH targets that were also PSA/ PFA targets were therefore automatically focused on. Those contained in IFH that were not PSA/ PFA targets were not necessarily given the same level of attention.

It was highlighted by all stakeholders that IFH needed to be central to Programme for Government (PfG) if it was to be taken seriously by Departments.

Performance Management of the IFH partnership work was through the Department and this was felt to work reasonably effectively as the IFH Partnership Managers provided regular progress reports. Also an overall impact report was completed in 2006. However, the consultation highlighted that there needs to be a feedback mechanism to the IFH Partnership Managers on how their work is feeding into the overall delivery of the Strategy and identifying areas that are working well and those were further action is needed. (Note: as identified in section 4, the performance management of IFH Partnerships will move to the PHA and this should become part of their role).

The majority of stakeholders felt that accountability was weak and there was no one organisation or person holding key stakeholders to account.

8.2.7 Structures

All stakeholders welcomed the review and felt it was timely given the changes to Health & Social Care structures in 2009. As already mentioned local stakeholders felt the IFH Partnership Groups worked very well. A number of strategic stakeholders in the Trusts, NIHE and Local Government spoke highly of the local partnerships and felt that these structures were effective at including a range of local stakeholders focused on improving health and wellbeing.

All saw the need to ensure that IFH structures were linked into the Community Planning Structures. It was also highlighted that IFH needed to be at the heart of Community Planning strategies, therefore local IFH representatives, with PHA, need to be influencing the Community Planning Strategies and Structures, as they develop .

The PHA highlighted the work undertaken with Belfast City Council and the Belfast Health and Social Care Trust to co-locate workers and establish the new Belfast Health Development

Unit. This unit will allow all those involved to work together to meet Health and Wellbeing needs in the Belfast Council area.

Health & Social Services stakeholders felt that the roles and responsibilities of the Department, the PHA and the HSCB needed to be updated in light of the restructuring in 2009. They felt that the PHA's role was key in working with the:

- HSCB in commissioning work from Trusts and in ensuring that IFH is integrated where possible into all aspects of the Trusts work;
- Department in exploring the possibility of including public health related activities in the work of all Health & Social Care Professionals to ensure that they helping to deliver IFH related outcomes; and
- Community Planning networks to ensure that IFH is positioned at the centre of any new local strategies.

Many stakeholders felt that there was insufficient emphasis placed on

- Research and evaluation; and
- Learning from best practice.

It was felt that the structures needed to support both of these areas in order to ensure that monies were being invested in interventions that provided the best Value for Money against IFH deliverables and that all the stakeholders could learn more from each other with regard to what works/what doesn't work therefore reducing duplication – particularly across the Partnership Groups. The PHA is best placed to hold these functions. However the consultation identified research work within the IPH the Centre of Excellence for Public Health and to a lesser degree in the Health Improvement Divisions of Trusts.

Finally, there was felt to be a need to have a structure in place that allowed for the effective monitoring of progress and impacts against the Strategy. This would involve ensuring that the data was collected in the right form to support the objectives and targets set in the Strategy; ensuring that the data was collected and the progress information fed through to all the stakeholders on a regular basis whilst also highlighting the areas where performance is on or above target and those areas where further action is required and by whom.

8.3 Conclusion

The consultations have highlighted a number of areas of strength but also areas for development. A key strength of the IFH Strategy has been the work done at a local level in developing relationships between Councils, the Community and Voluntary sector, the NIHE, Environmental Health representatives and the IFH Partnership Managers. It is essential that these relationships are maintained and that other stakeholders are brought into the Partnership Groups where relevant. The consultations highlighted a number of areas for development, namely Prioritising, Performance Management and Accountability and Leadership of the Strategy.

9. NEW STRUCTURES AND RESOURCES

9.1 Introduction

This section provides comment on the strengths and areas for development of the structures and organisations in place pre- and post-Health and Social Care Reform, specifically those which took place in 2009, as evidenced from our programme of consultations. It is important to note that the structures within Health and Social Care are still undergoing significant change, particularly since the establishment of the PHA and Regional Health and Social Care Board.

9.2 Effectiveness of the New Structures to deliver Investing for Health

The Health Structures have changed significantly over the last few years. This has created a major focus on change which is still ongoing. Our consultations provided feedback from a range of stakeholders (see Section 8) on the effectiveness of the structures. We set out below a summary of the strengths and also areas for development with regard to the current delivery structures.

9.2.1 Strengths

The main strengths of the existing structures are as follows:

- The IFH Partnerships have created significant buy in and engaged local communities in the IFH Agenda. We saw evidence of this commitment and enthusiasm for the Strategy through consultation with a number of local group representatives. This could only have been developed through the approach and hard work of the IFH and HAZ representatives. The Partnerships are all well connected with representatives in their own areas and considerable time has gone into developing these relationships and getting people to a stage where they feel they can work together;
- At a strategic level, Ministerial involvement and commitment were seen as essential to the Strategy's success and this has been evident through for example Ministerial promotion of the Strategy and more recently the current Minister, Michael McGimpsey's focus on health inequalities;
- The new Health Structures are much better equipped to deliver IFH, than the structures that existed prior to 2009. The establishment of the PHA in particular provides the opportunity for strategic coordination and management of IFH deliverables across the Health Service. The inclusion of the IFH and HAZ staff within the PHA provides the Agency with the opportunity to use this resource in a more coordinated and therefore efficient way, than when they were reporting into different structures;

- The planned appointment of 5 local Health Improvement Team leads within the PHA provides the necessary resource to coordinate local action and provide the rest of the IFH system with information on what works and what doesn't; and
- The existing expertise and capacity regarding research and innovation within the PHA - R&D Division, the CoE for Public Health Research and the IPH. Also the links that Belfast Healthy Cities has with the WHO and their ability to provide information and research on what is working effectively elsewhere.

9.2.2 Areas for Development

There are a number of areas that need strengthened or developed and we first highlight these and then consider in section 9.3.1 how structures can help action these:

- Accountability for the IFH Strategy needs clarified and strengthened;
- The research resources in Public Health are good, but these need to be better connected and coordinated, with research informing practice where possible;
- The need to have the resource and partners in place to influence other strategy work and budgets in Northern Ireland government;
- IFH Partnership structures need to be linked to the Community Planning Structures;
- There is a need to continue to raise awareness, share best practice and learnings with IFH stakeholders;
- Ensuring the resource is in place within the Department to deliver IFH; and
- Monitoring performance.

9.3 Areas for Development

9.3.1 Strengthening the Accountability and Performance Management System

The existing system is not working effectively with regard to holding stakeholders to account regarding delivering on IFH targets this is one of the key challenges. In a government structure of independent departments with mainly separate and closely defined funding streams, finding a mechanism which encourages cross – department co-operation whilst at the same time works within the current accountability mechanisms is naturally complicated. Shared PSA targets are one way of addressing this, but to what extent this leads to shared accountability is less clear. Within the constraints of the current government structures IFH delivery at the departmental level has all too often been more down to the level of interest and commitment of individuals rather than to a corporate manifestation through a department's business plan for instance. Therefore it is imperative for improved co-ordination and accountability that any new IFH strategy addresses these structural issues

To hold Departments to account, it is essential to have Ministers involved and consideration could be given to strengthening Ministerial involvement in the MGPH – for example to become a meeting of those Ministers most involved in taking forward the wellbeing agenda.

MGPH should also be supplemented by a Delivery Board composed of officials from Government Departments, the HSC, Local Government and the Third Sector who are responsible for the operational delivery of the strategy. The Delivery Board should meet quarterly to review and report progress and to direct action to areas of underperformance. MGPH should meet annually to review a monitoring report from the Delivery Board, and to propose a report to the Executive to include any recommendations for further strategic support or remedial action required. We suggest that the IFH Team in DHSSPS continues to provide secretariat support to the Ministerial Group.

To support the accountability system it is necessary to have a strong performance management system in place which regularly reviews progress being made against agreed objectives and targets. The monitoring of progress under the Strategy has not been as effective as it might have been and it is essential that the necessary systems and processes to collect quarterly performance reports from each of the stakeholders are established. This information then needs to be presented to the Delivery Board in a way which allows them to check if progress is on, above or below the target set. A traffic light system should be used to identify those targets which are on schedule to be met; close to being met and those that will not be met. It will be the responsibility of the Delivery Board to work out cross-Departmental actions that will where possible ensure that targets are met within budget constraints.

9.3.2 Coordinating the Research Resources

There is a strong research foundation in Northern Ireland in public health. In addition, these research resources are well networked to other international bodies also working on health and health inequalities issues. At present these resources work in an informal way together. However it is essential that these research resources are maximised and to ensure this it is necessary to have them linked to the policy agenda, better connected and co-ordinated including with practitioners so that learning from proven interventions can be shared.

9.3.3 Influencing Strategies and Budgets

To deliver on the vision and objectives set for it the IFH Strategy needs to influence other strategies under development. To do this it needs to sit at the heart of government and be clearly seen in the new PfG once it is developed. In turn the IFH also needs to be influencing the strategies of Departments and Local Government (specifically Community Planning Strategies). Reference has already been made in section 6 to having Health in All Policies and the actions needed to support this happening. This will require significant effort by the IFH Team within DHSSPS in conjunction with the IPH, the PHA and other stakeholders to ensure that the message is getting to those in policy development roles of the contribution a healthy population can make to our society.

9.3.4 Linking IFH Partnerships and Community/ Local Planning Structures

We welcome the work to establish enhanced joint working arrangements between PHA and local government to support local cross-sectoral partnership.

It is critical to the effectiveness of IFH Partnerships that they are linked into the planning structures at a local level. We feel that the work being undertaken by PHA is positioning the local groups well so that they can move forward in a connected way with local government representatives and other key stakeholders.

9.3.5 Sharing Best Practice

The IFH forums were run biennially from 2003 through to 2007 and provided a useful forum for stakeholders to learn about what others were doing across Northern Ireland. There is a need to resurrect these forums and run them annually. They should provide stakeholders the opportunity to:

- Learn from others across Northern Ireland about what has worked/ not worked;
- Learn about interventions that have been used successfully internationally and the evidence that exists on the impacts achieved;
- Discuss ways in which to leverage funding through Departments and other sources; and
- Discuss progress and ways in which any underperforming areas can be actioned.

9.3.6 Resources

The Health Development Policy Branch is currently responsible for devising a new strategic direction for Alcohol and Drugs; Obesity Prevention and IFH. IFH will require significant investment of time as it moves towards the time when an extensive consultation process needs to start in the development of a new IFH Strategy. The consultations and review of performance management arrangements have identified the need for the development and strengthening of the monitoring systems in place and for more regular updates of progress than at present to be considered.

Finally, as mentioned the Team will be required to ensure that the information is in place to encourage the Health in all Policies approach referred to in section 6. This will place a significant burden on a small team and may require additional resource to deliver.

9.4 Conclusion

IFH has existed in a health and social care system which has undergone significant change in 2009. Now these structures face further change as the Health and Social Care structures bed in and planned changes are expected to local government structures.

The Review is therefore timely in providing the opportunity to check the fitness for purpose of the existing structures. This has shown that the local IFH Partnership structures have worked very well at involving a range of local stakeholders in IFH delivery. The opportunity now exists to update these and ensure they evolve with the changing administrative and policy context.

Further strengthening is required at a strategic level. Strengthened Ministerial involvement in MGPH should be considered with an annual meeting to review performance and to hold Departments to account. MGPH should be supported by a Delivery Board which includes senior officials from Government Departments, the HSC - in particular the PHA, and Local Government to meet quarterly to review and report, and take action on progress against targets.

Consideration should be given to holding IFH Forums once a year to ensure that stakeholders can be advised of research, best practice and developments. Further work is also required by the Department in influencing the strategies of others to incorporate IFH, and to promote Health Impact Assessment. Finally the resources need to be reviewed within the Department's IFH Team to ensure that are able to deliver on this widened brief.

10. RELEVANCE AND NEED

10.1 The Rationale for an Investing for Health Strategy

10.1.1 Introduction

In this section we consider why any Government would wish to invest in health, particularly at this time with government budgets are under pressure. We also consider the benefits of an IFH Strategy and why one continues to be needed in Northern Ireland.

10.1.2 Why Invest in Health?

There are a number of arguments that support the rationale for investing in the health of a nation. The most pervasive argument makes the link between health and economic growth (this was detailed in Section 7). The essential premise for this argument is that healthier people are more productive. A report by the WHO Commission on Macroeconomics and Health[47] found that poor health in low-income countries reduced economic growth. Later work showed that this also applies to high- and middle-income countries. People in poor health are less likely to work and, when employed, are less productive. For example, a study in the Russian Federation found that good health increases wages by 22% for women and 18% for men compared with less good health[48]. People in poor health are less likely to invest in their own education or to save for retirement and thus to support the wider economy. Better health also reduces the demands on health care now and in the future.

There is also a moral argument for investing in health, and reducing the inequalities in health in particular. This argument proposes that people have the human right to the highest attainable standard of physical and mental health, without discrimination of any kind. Enjoyment of the human right to health is vital to all aspects of a person's life and well-being, and is crucial to the realisation of many other fundamental human rights and freedoms. The Marmot Review (2010) supports this argument stating that *"health inequalities that could be avoided by reasonable means are unfair"*. The report also proposes that reducing health inequalities is a matter of fairness and social justice.

10.1.3 Why is a Strategy for Investing in Health in Northern Ireland Needed?

The consultation findings in section 8 highlighted concerns from stakeholders over the number of strategies in Northern Ireland. This therefore raises the question do we need an IFH Strategy in Northern Ireland or not? To deal with this question, we need to consider what

[47] *Health systems, health and wealth: assessing the case for investing in health systems* edited and written by Josep Figueras, Martin McKee, Suszy Lessof, Antonio Duran and Nata Menabde, discussed at the WHO European Ministerial Conference on Health Systems: "Health Systems, Health and Wealth" in Tallinn, Estonia on 25–27 June 2008. The electronic version of the document is available on http://www.euro.who.int/document/hsm/3_hsc08_eBD3.pdf

[48] WHO (2008): European health ministers meet to focus on link between health and economic success.

it has achieved to date and what we would lose if IFH had not existed. Also we need to consider the potential for Northern Ireland for the future.

Section 6 sets out the impacts achieved against the targets set and these demonstrate a mixed set of results. However this misses that one of the purposes of the Strategy was to inspire and motivate and to encourage co-operation among Departments and Agencies.

This is a critical issue in the successful delivery of any strategy, however it is also the hardest area to develop and sustain. For example Government Departments and Agencies are under significant pressure with regard to their budgets and maximising the delivery of their objectives. They also have the majority of their funds already committed to programmes and therefore they have limited scope for transferring or finding new monies for new areas of work. This cannot happen easily, and there would need to be quantitative evidence linking the social and environmental determinants of health with their ultimate health outcomes and showing the effect of policies and specific interventions on these determinants, before Departments could practically make any significant changes to policies.

The consultation feedback and the analysis of impacts has demonstrated that the Strategy has had some success in getting Departments and Agencies to reconsider their existing services and how they could be energised to deliver IFH. There is evidence that there is potential for more and better cross- departmental working.

There are significant opportunities for Departments to rethink service provision in a more integrated and connected way to deliver the IFH outcomes. The Strategy will be key in this regard as it provides the vision and target outcomes that need to be focused on as these key stakeholders work out how to connect together to deliver these in an efficient and effective manner. It will need to be supported by evidence and research which will be sufficient to influence significant policy change. There is a need to re-visit the existing Strategy, update it with regard to our current policy context as set out in section 3 and re-communicate it back to stakeholders with a strong focus on target outcomes.

10.1.4 Summary

Whilst a number of improvements have been made to the overall levels of population health in Northern Ireland since the introduction of IFH in 2002, there is still a significant amount of work to be done. Meanwhile lifestyle factors are continuing to impact negatively on the health and wellbeing levels in our province. Research has shown that persistent inequalities still exist between socioeconomic groups and genders.

Changes in population health are a long term goal and, in some cases, can take decades to achieve. The Strategy provides all the key stakeholders with a common focus and purpose and sets out the direction all need to travel in to address this situation. The Strategy is crucial to Northern Ireland's success in tackling health inequalities and it needs to be supported with the appropriate systems and structures to ensure it can effectively be delivered.

10.2 Relevance of Investing for Health

The current objectives of the IFH Strategy cover a range of wider determinants of health to focus action on – poverty in families with children, education and life skills, mental health, living and working environment, wider environment, accidents and healthier choices. This section considers if the IFH Strategy's aims, objectives and targets are still relevant to current need, priorities and best practice.

10.2.1 Programme for Government

The PfG sets the strategic priorities and key plans for the Northern Ireland Executive as well as the longer term aspirations and intentions. It informs the allocation of the Executive's budget and investment priorities and is underpinned by Departmental Public Service Agreements. The current PfG runs from 2008-11. IFH pre-dates the current PFG, however as a cross-cutting Strategy it remains relevant to the priorities and a number key goals that have been set out in the most recent PfG (2008-2011). IFH life expectancy targets are reflected in the PSA objectives and in addition specifically, Priority 2: Promoting Tolerance, Inclusion and Health and Social Well-being, notes that those experiencing poverty and social exclusion are more likely to suffer ill health. The priority notes the need to address significant inequalities in health and education.

Priority two of the PfG also notes that Northern Ireland continues to have high incidences of CHD, Stroke, Cancer and obesity which places an increased strain on public and social services. IFH objectives include providing support and help for people to lead healthier lives. This will contribute towards reducing the risks of experiencing CHD, Stroke, Cancer and obesity.

The following table provides an overview of the areas of complementarily between the PfG (2008-2011) and the IFH Strategy's objectives.

Table 10.1: Overview of IFH relevance to the PfG

PfG (2008 – 2011)	IFH	Comment
Priority 2, Goal 1: To work towards the elimination of child poverty by 2020 to reducing child poverty by 50% by 2010.	**Objective 1:** To reduce poverty on families with children	DSD, DEL has specific actions to implement including the Welfare Reform Programme and Neighbourhood Renewal.
Priority 2, Goal 9: Achieving a position by 2011 where 30% of school leavers entitled to free school meals obtain 5 or more GCSE passes at A* to C including English and maths.	**Objective 2, target 2:** In the 25% of Secondary Schools with the highest percentage of Free School Meal Entitlement, to reduce the proportion of year 12 pupils achieving no GCSEs to 5% by 2005/06	DE is responsible for implementing the School Improvement policy and other initiatives aimed at raising educational standards.
Priority 2, Goal 12: Reducing by 33% the overall number of people, and by 50% the number of children, killed or seriously injured on	**Objective 6**: To reduce accidental injuries and deaths in the home, workplace and from collisions on the road.	As the department responsible for road safety DOE implemented an action to deliver a number of road safety initiatives across departments and agencies.

Table 10.1: Overview of IFH relevance to the PfG		
PfG (2008 – 2011)	**IFH**	**Comment**
our roads by 2012.		
Priority 2, Goal 11: By 2011 reducing the suicide rate by 15%.	**Objective 3**: to promote mental health and emotional well-being at individual and community level	A number of actions were established under this objective of the IFH. DHSSPS was responsible gathering reliable baseline information on which to base a meaningful approach to reducing suicide rates. In addition to this DHSSPS also published a strategy to promote mental health and tackle suicide.
Priority 2, Goal 2: Investing over £500m in regenerating disadvantaged communities, neighbourhoods, towns and cities by 2012.	**Objective 5:** To improve our neighbourhoods and wider environment	Objective 5 is complementary to the PFG priority, including for example the actions associated with improving air quality and planning. Objective 1, reducing poverty in families with children is also directly relevant.
Priority 4, Goal 5: Investing £925m in social and affordable housing by 2011 and at least £1.8bn by 2018.	**Objective 4:** to offer everyone the opportunity to live and work in a healthy environment and to live in decent affordable housing	IFH had noted a number of actions under this objective for work to improve the quality of social housing, and for example for DSD and the NIHE to support housing providers to increase the number of special needs homes.
Source: Programme for Government 2008-11		

Broadly speaking, the IFH Strategy remains relevant to the wider PfG aims and objectives and the actions that strategies that have arisen from the PfG (2008 – 2011).

10.3 Emerging Issues

There have been a number of social, economic and legislatives issues and developments that have emerged since the launch and implementation of the IFH Strategy, each of which had the potential to impact upon its continued relevance. A few of the most pertinent issues are discussed in the following section.

10.3.1 Economy

When IFH was published in 2002 the Northern Ireland and UK economy was experiencing a period of sustained growth. However, by the end of 2008 the UK economy was in recession, meaning that an increased number of people were experiencing economic hardship. It has been well documented that those who are economically disadvantaged are also more likely to experience poor health. The impact of the economic downturn on health is best demonstrated by highlighting the health inequalities that exist in the UK between the poorest and the richest people in society. The Marmot Review (2010) shows that the poorest people in the UK are more likely to suffer disabilities and to die on average seven years earlier than those who live in most affluent neighbourhoods. In addition to this, infant mortality rates are higher among those in routine and manual occupations than those in managerial or

professional occupations. Life expectancy is also less among those from routine and manual occupations than those in professional occupations.

Marmot also noted that there are a number of health related behaviours that are correlated with socio-economic status. The negative impacts of unemployment on health are well-documented, for example unemployed people have increased rates of limiting long-term illness[49], mental illness[50] and cardiovascular disease[51]. The experience of unemployment has also been consistently associated with an increase in overall mortality, and in particular with suicide[52]. The unemployed have much higher use of medication[53] and much worse prognosis and recovery rates[54]. Unemployment has both short and long-term effects on health. The immediate negative impact of being made redundant on a person's health outcomes has also been frequently reported[55].

As noted in the Marmot Review there are three core ways in which unemployment affects levels of morbidity and mortality, they are financial difficulties, distress and health behaviours. The financial problems associated with unemployment result in lower living standards, which may in turn reduce social integration and lower self-esteem. Secondly, unemployment can trigger distress, anxiety and depression. Many psychosocial stressors contribute to poor health not only among the unemployed themselves, but also among their partners and children. Loss of work results in the loss of a core role which is linked with one's sense of identity, as well as the loss of rewards, social participation and support. Thirdly, unemployment impacts on health behaviours, being associated with increased smoking and alcohol consumption and decreased physical exercise. These adverse impacts on health are the greatest among the long-term unemployed.

Therefore, it has been widely acknowledged that the economy and the related impacts on individual's socio-economic status have a direct impact on public health. Those who live in deprived areas are more likely to experience ill-health and have shorter life expectancies. Additionally, people who have are unemployed are more likely to experience a number of short and long-term negative impacts and are also more likely to engage in behaviours that can damage health and well-being such as smoking and drinking alcohol.

[49] Bartley M (2004): Health inequality: an introduction to theories, concepts and methods. Cambridge: Polity.

[50] Thomas C, Benzeval M, and Stansfeld S (2005): Employment Transitions and mental health: An analysis from the British household panel survey. Journal of Epidemiology and Community Health 59: 243-249.

[51] Gallo W, Teng H, Falba T, Kasl S, Krumholz H and Bradley E (2006): The impact of late career job loss on myocardial infarction and stroke: a 1 year follow up using the health and retirement survey. Occupational Environment Medicine 63: 683-687

[52] Voss M, Nylén L, Floderus B, Diderichsen F, Terry P D (2004): Unemployment and Early Cause-Specific Mortality: Study Based on the Swedish Twin Registry. American Journal of Public Health 94 (12): 2155-2161.

[53] Jin R, Shah CP, Svoboda TJ (1997): The impact of unemployment on health: A review of the evidence. Journal of Public Health Policy 18(3): 275-301.

[54] Leslie S, Rysdale J, Lee A et al (2007): Unemployment and deprivation are associated with a poorer outcome following percutaneous coronary angioplasty. International Journal of Cardiology 122

[55] Stuckler D, Basu S, Suhrcke M, Coutts, McKee M (2009): The public health effect of economic crisis and alternative policy responses in Europe: An empirical analysis. The Lancet 374(9686): 315-323

Return on Investment for Targeting Fuel Poverty

One of the IFH targets relates to lifting households out of Fuel Poverty, house condition is therefore identified as a key priority as cold and damp in housing can cause a number of respiratory diseases, can lead to hypothermia, and may contribute to the excess of winter deaths seen in older people. The PHA has invested £780,000 in 2009-10 to combat fuel poverty. This investment is over double the previous year's funding and is indicative of the importance the PHA puts on addressing fuel poverty and reducing its impact on the health and well being of individual householders. The funding has enabled a number of households to receive emergency Keep Well Keep Warm Packs, to get assistance through energy efficiency advice, insulation measures, whole house solutions, awareness raising sessions, and referrals to grant schemes, access to benefits and development and implementation of local action plans for fuel poverty. This investment has levered approximately £1.76 million in energy efficiency grants for householders via the NIE Levy Fund and Warm Homes Scheme. In addition a significant improvement in household income has been generated through benefit maximisation schemes throughout NI as part of the PHA's fuel poverty programmes. Additional leverage has also been made available through partnership working including £667,000 from the Department of Agriculture to the PHA, the outcomes of which will be realised in 2010-11.

Source: DHSSPS

10.3.2 Obesity

The IFH Strategy noted that obesity levels are increasing in Northern Ireland and globally. Obesity is a major global public health problem and, in recent decades, there has been a significant rise in the number of overweight and obese people in many developed countries. The prevalence of obesity in all age groups poses such a serious problem that the World Health Organisation has described it as a "global epidemic"[56].

In Northern Ireland, data from the 2005/06 Health and Social Well Being Survey (conducted by NISRA) found that 24% of adults were obese. This is one quarter of the adult population. An additional 35% of adults were classified as overweight making 59% of the adult population overweight or obese.

Obesity has been identified as a risk factor for a wide range of health conditions, including heart disease, cancer, hypertension and diabetes. The IPH estimates that obesity causes 450 deaths per year, costs £14.2 million in lost productivity and £90 million in health and social care costs in Northern Ireland alone. This has major consequences for the Northern Ireland economy due to the loss of productivity and health care costs. If the current growth in obesity levels continues, the IPH forecast that over the period 2005 to 2015 there will be a 26%

[56&63] http://www.who.int/dietphysicalactivity/publications/facts/obesity/en/ (accessed 29th January 2010)

increase in the proportion of people with Type 2 diabetes.[57] This will put additional cost pressures on the NHS and result in increased morbidity and mortality rates.

The prevalence of childhood obesity has also increased dramatically over the past two decades and is already classified as epidemic in some developed countries and on the rise in others. Approximately 22 million children under five are estimated to be overweight worldwide, while the prevalence of obese children aged 6 to 11 years has more than doubled since the 1960s.[58]

The incidence of obesity at an early age frequently persists into adulthood and is associated with increased morbidity and mortality in later life. The following table shows the percentage of Primary 1 children in Northern Ireland that are classified as overweight or obese between 1999 and 2008. This data is based on height and weight information extracted from the Child Health System (which is maintained by the Health and Social Care Boards). The information relates to children aged between 54 and 66 months on the date of their measurements. The children' BMI is rated using the International Obesity Task Force standard of obesity classification.

The proportion of overweight or obese children has remained at around 21% since 1999-01. Around 5% of these children were classified as obese. While there are early indications that the proportion of obese children is starting to level-off (it has remained at 5.0-5.1% sine 2005-06), there are no signs of the levels decreasing.

Table 10.2: Childhood Overweight and Obesity Rates in NI (Primary 1 children)

Year	Overweight	Obese	Total overweight or obese
1999-01	16.4	4.7	21.1
2002-03	16.1	5.4	21.5
2003-04	16.9	5.7	22.6
2004-05	16.2	5.4	21.6
2005-06	15.4	5.1	20.5
Year	Overweight	Obese	Total overweight or obese
2006-07	16.7	5.0	21.7
2007-08	15.7	5.1	20.8

Source: Ninis

As noted above global increase in obesity places additional importance on the targets that were established in the IFH, it is also likely to have had an impact on the ability to meet the targets. Obesity levels are a major challenge to public health in Northern Ireland, and are a

[57] IPH (2009): Response to Northern Ireland Assembly Inquiry into Sustainable Transport. (http://www.publichealth.ie/publications/iphrespondtonorthernirelandassemblyinquiryintosustainabletransport) (accessed on 29th January 2010)

[58] WHO(2003): Global Strategy on Diet, Physical Activity and Health

significant cost to the health and social care system. Given the increasing levels of childhood obesity these associated costs will increase without a significant investment in prevention strategies.

10.3.3 Climate Change and Sustainability

There are a number of direct and indirect impacts on health associated with climate change. The Marmot Report noted a few direct impacts such as an increase in skin cancers and cataracts associated with the waves experienced in the UK. In addition, floods and storms have created immediate health hazards associated with pollution from chemicals and sewage[59].

There are also a number if indirect effects associated with climate change, for example the Stern report (2006)[60] noted the economic impacts associated with climate change. This included an increase in fuel and foods costs. The Stern Report notes that the effects of climate change will have the greatest impact on the poorest people in society. For example in developed countries any increase on household expenditure is most likely to have the greatest impact on the most deprived in society and as noted previously can have a negative impact on health.

"climate change is likely to reduce further already low incomes and increase illness and death rates in developing countries. Falling farm incomes will increase poverty and reduce the ability of households to invest in a better future, forcing them to use up meagre savings just to survive. At a national level, climate change will cut revenues and raise spending needs, worsening public finances". [Stern, 2006]

Furthermore, adverse weather events such as storms or flooding have also been shown to increase levels of mental health problems such as depression[61]

Equally public health strategies can also have a positive impact on climate change, for example, as noted in International Journal of Epidemiology[62], that obese people eat more food and as such have a greater carbon foot print, as food production accounts for 20% of global greenhouse gas emissions. As such, any strategies designed to tackle obesity is also thought to have a positive impact on the environment. Additionally, public strategies aimed at increasing activity levels and encouraging people to drive less can also have a positive environmental impact by increasing the use of public transport, cycling and walking and therefore reducing emissions from private transport.

10.3.4 Early Years

There is an ever-growing body of evidence to support the argument for investing in early years interventions. Supporting parents and children through this crucial lifestage (from 0-3

[59] Department of Health (2008): The Health Effects of Climate Change in the UK.

[60] Stern N (2006): The economics of climate change: The Stern Review. Cabinet Office and HM Treasury.

[61] Costello A, Abbas M, Allen A et al (2009): Managing the health effects of climate change. The Lancet 373(9676): 693-1733.

[62] Edwards P and Roberts I (2009): Population adiposity and climate change. International Journal of Epidemiology

years) is the key to reducing health inequalities and promoting good health across the lifecourse. The Marmot Review supports this argument, stating that:

"The foundations for virtually every aspect of human development – physical, intellectual and emotional – are laid in early childhood. What happens during these early years (starting in the womb) has lifelong effects on many aspects of health and well-being– from obesity, heart disease and mental health, to educational achievement and economic status. To have an impact on health inequalities we need to address the social gradient in children's access to positive early experiences. Later interventions, although important, are considerably less effective where good early foundations are lacking."

Example of Early Years Intervention Return on Investment

Caerphilly Family Intervention Team / 5+ Project is an early intervention service for children, young people and families with recently emerging emotional or behavioural problems. The targets set for the service are:

- The project will work with 80 families per year
- 80% of families worked with will report improved relationships with their children.
- 90% of children worked with will not enter the looked after system during intervention.
- 80% of parents will report improved self esteem.
- 90% of families will report that they have found the service to have been of benefit to them.
- Children/young people worked with will report improved self esteem and emotional well-being.

For every £1 invested annually in the Family Intervention Team/5+ Project it generates £7.60 worth of benefits to society (social value). The share of social value by stakeholder is as follows:

- The most significant value (39%) is obtained by the children.
- Parents/carers obtain 22% of the value.
- The state derives approximately 26% of the total value; by the end of year three, the state has recouped its investment in the project.

Source: New Economics Foundation (2009): Backing the Future

There is considerable evidence to show that investment in early years is vital to reducing health inequalities. Gaps between individuals and social groups emerge early in the life course so it is vital to tackle it at this stage. In addition, there is also a strong economic case for supporting early interventions as the return on investment is higher than interventions aimed at any other lifestage. In particular, returns on investment in early childhood are higher than in adolescence. Later remediation is possible but it has been estimated to cost 40% more to attain later what can be accomplished by early investment.[63]

A recently published report by the New Economics Foundation analysed three services taking an early intervention and preventative approach targeting children. The findings revealed that for every £1 invested annually in targeted services designed to catch problems early and prevent problems from reoccurring, society benefits by between £7.60 and £9.20. This social

[63] Marmot (2010): Fair Society. Healthy Lives.

value can be generated, for example, through improved family relationships, reduced incidence of crime and disruptive behaviour.

10.4 Potential Gaps

In this section we consider whether there are gaps in the existing Strategy. To do this we recognise the need for information on Northern Ireland's social gradient to be compared with other societies and then priorities developed based on areas of underperformance.

Marmot proposes six policy objectives which are intended to be illustrative of the ways in which policies can be developed in the most significant areas. The six policy objectives and their priority objectives are shown in the table below.

Table 10.3: Marmot Review proposed priority objectives

Policy Objective	Priority objectives
1. Give every child the best start in life	1. Reduce inequalities 1 in the early development of physical and emotional health, and cognitive, linguistic, and social skills. 2. Ensure high quality maternity services, parenting programmes, childcare and early years education to meet need across the social gradient. 3. Build the resilience and well-being of young children across the social gradient.
2. Enable all children, young people and adults to maximise their capabilities and have control over their lives	1. Reduce the social gradient in skills and qualifications. 2. Ensure that schools, families and communities work in partnership to reduce the gradient in health, well-being and resilience of children and young people. 3. Improve the access and use of quality lifelong learning across the social gradient.
3. Create fair employment and good work for all	1. Improve access to good jobs and reduce long-term unemployment across the social gradient. 2. Make it easier for people who are disadvantaged in the labour market to obtain and keep work. 3. Improve quality of jobs across the social gradient.
4. Ensure healthy standard of living for all	1. Establish a minimum income for healthy living for people of all ages. 2. Reduce the social gradient in the standard of living through progressive taxation and other fiscal policies. 3. Reduce the cliff edges faced by people moving between benefits and work.
5. Create and develop healthy and sustainable places and communities	1. Develop common policies 1 to reduce the scale and impact of climate change and health inequalities. 2. Improve community capital and reduce social isolation across the social gradient.
6. Strengthen the role and impact of ill health prevention	1. Prioritise prevention 1 and early detection of those conditions most strongly related to health inequalities. 2. Increase availability of long-term and sustainable funding in ill health prevention across the social gradient.

Source: Marmot (2010): Fair Society, Health Lives

The gaps in Northern Ireland can only be identified by measuring the results for NI with other countries and identifying areas that need further focus and attention. This is an area of work that could be taken forward in advance of any successor Strategy being prepared.

10.5 Conclusion

The analysis of public health indicators throughout this review provides clear evidence of the continuing challenge of tackling health inequalities and the need for renewed effort and an updated strategic direction. There is a clear need for a public health strategy in Northern Ireland and international and national evidence reinforces the need for this to continue to adopt the social determinants approach as the most effective way to tackle inequalities and improve health and wellbeing.

Much of the IFH Strategy remains relevant and remains consistent with many of the aims and objectives that are set out in the current PfG (2008-11). However, there is a need to update it to take account of changes to the landscape within which we live. One of these is the recent downturn in the economy, which has effectively made the objectives and targets within the IFH more significant, not least because there is a great deal of evidence detailing the negative impact of unemployment and reduced disposable incomes on health and well-being, as well as the health inequalities associated with economic difficulties. Furthermore, the prevalence of chronic conditions associated with lifestyle factors have been increasing rapidly across all developed countries which have created a significant public health concern in all regions of the UK, as well as making financial demands on the health service. In the current economic context there will be significant challenges in successfully making the argument for upstream investment in public health initiatives, however this is vitally important if health inequalities are to be addressed. There is also evidence that indicates that improvements in the health and wellbeing of the population can contribute to a better performing economy as well as reducing the burden of cost on the health service.

Our understanding of how climate change can impact on health and wellbeing has developed over the past seven years. Climate change has both direct and indirect impact on health and well-being, given the associated effects on food and fuel prices can also have the greatest impact on the most deprived people in society. In addition, there are health and wellbeing benefits that can accrue from sustainable/green policies such as the encouragement for sustainable communities, healthier environments, healthier forms of transport etc.

There is a considerable body of evidence to support investment in early years interventions. As well as providing benefits across the lifecourse of the individual and reducing inequalities, this targeted approach yields the greatest return on investment.

The IFH Strategy has remained largely consistent with current government objectives and priorities and as such can still be considered to be relevant. However, a number of issues have emerged since the development of the Strategy that have the potential to impact on public health. These issues will need to be taken into account and addressed in any successor strategy.

11. CONCLUSIONS AND RECOMMENDATIONS

11.1 Introduction

In this section we revisit the purpose of the review and the approach taken, summarise the conclusions reached and put forward recommendations to be considered for the way ahead.

11.1.1 Investing for Health

IFH is an overarching framework for cross-cutting action to improve health and wellbeing and reduce health inequalities. The strategy aims to provide direction on the prevention of ill health through an emphasis on the wider determinants of health and based on partnership working across a wide range of partners both at regional and local levels.

It has two overarching goals – to improve health and reduce health inequalities, and seven objectives selected to reflect the cross cutting nature of the strategy. These concern the wider determinants including poverty, education, and the environment.

11.1.2 Purpose and Approach

The purpose of this review of IFH is to assess the strategy's impact to date, to consider how resources are deployed and to make recommendations for any changes that would improve progress towards improving health and wellbeing and to reduce health inequalities.

The Terms of Reference for the Review are set out at Annex 7. Given the overarching and extensive nature of the strategy it is important to stress that the task set was to undertake a high level strategic review of IFH against the various elements of the terms of reference.

It was envisaged that the review outcomes would include recommendations to be considered and actioned in the short term, and also recommendations for the longer term which would provide a foundation for a longer programme of policy development work to result in a successor public health strategy from 2012 and beyond.

The methodology adopted for this review has involved a number of elements including: desk research, statistical review, consultation, review of delivery structures, benchmarking, and analysis of value for money. The wide ranging nature of IFH, ongoing contextual and structural changes and in particular the timing of this review have all placed challenges on what can be achieved and therefore the review outcomes.

The review has been conducted at a time of continuing major organisational development and reform, and there has been the challenge of taking account of the many ongoing policy and structural developments both locally and nationally.

In respect of the scope of this review a number of other factors need to be acknowledged:

- the many and varied factors that influence health and wellbeing – these are often complex and inter-dependent, and include deprivation, employment, educational attainment, living conditions, lifestyle choices;
- that inequalities in health are reflective of inequalities in the social determinants, and that it is this that needs to be tackled;
- the complexity of attributing outcomes to interventions – it is often difficult to assess to what extent any identified impacts or benefits would have been achieved in the absence of the IFH strategy; also to what extent variations/ improvement in public health indicators can be attributed to IFH, or to what extent other influences have played a role.

11.2 Contextual Factors

A number of significant strategic issues and developments have been relevant to both the review and also to moving policy and strategy development forward:

11.2.1 Programme for Government

The PfG sets the strategic priorities and key plans for the Northern Ireland Executive as well as the longer term aspirations and intentions. It informs the allocation of the Executive's budget and investment priorities and is underpinned by Departmental Public Service Agreements. The current PfG runs from 2008-11. In the context of a new planning cycle it is suggested that action should be taken urgently to ensure the health and wellbeing and health inequalities agenda features prominently in any new PfG.

11.2.2 Review of Public Administration

The review has taken place in the context of a newly restructured Health and Social Care system. A key aim of this reform was to strengthen efforts to improve health and tackle health inequalities and to put this at the centre of the HSC system. This is reflected in the establishment of the new PHA and joint commissioning arrangements with the Regional Health and Social Care Board.

Prior to March 2009, implementation of IFH was led locally by the four Health and Social Services Boards, with oversight and reporting through the DHSSPS. As well as providing capacity locally, the establishment of the PHA in April 2009 will provide a level of regional co-ordination of health improvement work. While the Agency has already set new directions in terms of a greater emphasis on evidence based interventions, new early childhood development programmes, learning from best practice elsewhere, making research an integral part of programmes, and using community development as an important part of their approach, it is still undergoing organisational development and the full benefits of the new arrangements are yet to be fully realised. It is anticipated that the development of a new IFH (post-2012) will need to run alongside the bedding in of the new structures, including any further developments regarding public administration reform.

11.2.3 Local Emphasis

Government policy is continuing to place emphasis on addressing local need and providing locally relevant services. Local Government's role and functions will be defined and strengthened through Local Government Reform, the timescale for which is at this stage unclear.

The new Public Health Agency will also work closely with local government and other agencies to enhance and strengthen local partnership working for health improvement. Plans to pilot new joint working arrangements with Council clusters are already underway, with a new Health Development Unit for Belfast having been announced in April 2010.

The development of a successor strategy to IFH will need to consider further structural and contextual developments due to take place between now and 2012, and beyond.

11.2.4 Developments in Public Health elsewhere

The Strategic Review of Health Inequalities in England, led by Sir Michael Marmot and published in February 2010, has brought together a substantial body of national and international evidence in support of the social determinants approach to tackling health inequalities. Due consideration of the conclusions and findings of the Marmot report should be given in taking forward the public health agenda in Northern Ireland.

11.2.5 Economic Context

The links between poverty, low income and unemployment and health are well rehearsed. Unemployed people incur a multiplicity of elevated health risks. They have increased rates of limiting long term illness, mental illness and cardiovascular disease. Insecure and poor quality employment is associated with an increased risk of one's physical and/ or mental health worsening, from conditions caused by work that in turn lead to absence and worklessness. In the current economic context there will be significant challenges in successfully making the argument for upstream investment in public health initiatives, however it is vitally important if health inequalities are to be addressed that this argument is made. In addition there is evidence which indicates that improvements in the health and wellbeing of the population can also contribute to a better performing economy.

11.2.6 Climate change and sustainability

Two issues which have received more attention since the development of IFH are Climate Change and 'sustainability'. Climate change has both a direct and indirect impact on health and well-being, given the associated effects on food and fuel prices which can have the greatest impact on the most deprived people in society. In addition there are health and wellbeing benefits which can accrue from sustainable development/ green policies such as the encouragement for sustainable communities, healthier environments, healthier forms of transport etc.

11.3 Relevance and Need

The essence of IFH was to inspire a shift from treatment of ill health to tackling the factors that impact on health and health inequalities. In so doing a key purpose was to inspire and motivate co-operation across sectors and organisations in partnership with local communities.

In respect of the gap in life expectancy between the most deprived areas and the Northern Ireland average the rate of change suggests that gaps in life expectancy are forecast to narrow slightly for women but widen for men. In 2003, the proportion of children living in low income households (after housing costs) was 26%. In 2009, this proportion remained unchanged at 26%. It is worth pointing out that the Northern Ireland performance in tackling lifestyle issues and health inequalities is no different to other UK Countries where similar difficulties have been experienced. For example in England latest 2006-08 data from ONS shows that since the target baseline (1995-1997), the relative gap in life expectancy between England and the Spearhead Group (disadvantaged areas) has increased by 7% for males (compared to 4% in 2005-07) and by 14% for females (compared to 11% in 2005-07). Looking beyond to the European Union countries there is a similar pattern where inequalities in health follow a social gradient with varying intensity levels.

Thus the analysis of impacts and projected trends in population health data provide clear evidence of the continuing challenge of tackling health inequalities and the need for renewed efforts and an updated strategic direction. International and national evidence reinforces the need for this effort to continue to adopt the social determinants approach, which requires action at all levels of society.

There are now significant opportunities to rethink implementation in a more integrated and connected way to deliver the outcomes IFH envisaged. The IFH Strategy is key. It provides vision and target outcomes for key stakeholders to work together in an efficient and effective manner. There is a need to re-visit the existing Strategy, place it within a current policy context and communicate this to stakeholders with a strong focus on target outcomes.

It is our considered view that the IFH Strategy remains relevant and consistent with many of the aims and objectives that are set out in the current PfG (2008-11). As such, the IFH is clearly consistent with current government objectives and priorities and is particularly relevant to a number of issues that have emerged since the development of the Strategy. However it does need to be updated to take account of the evidence and developments which have emerged since the development of the Strategy. The recent downturn in the economy has highlighted the importance of the objectives and targets within the IFH, not least because there is a great deal of evidence detailing the negative impact of unemployment and reduced disposable incomes on health and well-being, as well as the health inequalities associated with economic difficulties.

Recommendation1: *There is a clear need for a public health strategy based on the ethos and principles of the current IFH Strategy. As it comes to an end in 2012, there will be a need*

to ensure that a new strategic direction is in place and follows on from the first. The new strategy should be set within the updated policy context and should continue to be built around the evidence of the impact of key determinants model in respect of improving both physical and mental health and well-being. The strategy should distinguish those determinants that the evidence base shows are most powerful in reducing health inequalities and should have a clear focus on upstream interventions in this regard.

***Recommendation 2:** As the social determinants of health inequalities are clearly cross-sectoral in nature and have a concomitant relevance for all Departments, there is a need to ensure that the health and wellbeing and health inequalities agenda has a prominent position at the centre of the PfG and that agreed shared PSA targets reflect the priorities for IFH. There should also be a clear acknowledgement of the linkages and synergy between relevant Government and Departmental objectives and IFH to encourage collaborative working and investment for mutual gain. In particular, a more joined up focus on wellbeing across public sector organisations should improve value for money.*

***Recommendation 3:** Noting the depth and breadth of evidence gathered through the Strategic Review of Health Inequalities in England (the Marmot Review), which reported in February 2010, the development of strategy on public health in Northern Ireland should include consideration in detail of Marmot's recommended policy objectives, in the context of the powers and responsibilities of the Northern Ireland Executive and in the context of a "Health in all Policies" approach. The Marmot Review policy objectives are:*

- *Give every child the best start in life;*
- *Enable all children, young people and adults to maximise their capabilities and have control over their lives;*
- *Create fair employment and good work for all;*
- *Ensure healthy standard of living for all;*
- *Create and develop healthy and sustainable places and communities; and*
- *Strengthen the role and impact of ill health prevention.*

11.4 Mainstreaming implementation and accountability

For sustainable success in improving health and well being and tackling health inequalities, efforts will need to be galvanised across a wide range of partners from strategic level across government, and right through the regional and local levels. A whole system approach is needed in which activity is co-ordinated, monitored and evaluated across the various levels of the system.

One of the key challenges is that of accountability. In a government structure of independent departments with mainly separate and closely defined funding streams, finding a mechanism which encourages cross – department co-operation whilst at the same time works within the current accountability mechanisms is naturally complicated. Shared PSA targets are one way of addressing this, but to what extent this leads to shared accountability is less clear. Within

the constraints of the current government structures IFH delivery at the departmental level has all too often been more down to the level of interest and commitment of individuals rather than to a corporate manifestation through a department's business plan for instance. Therefore it is imperative for improved co-ordination and accountability that any new IFH strategy addresses these structural issues

The aims of the establishment of the IFH structures – i.e. the MGPH (at government department level) and local IFH Partnerships (at the former HSS Board level), were to provide strategic direction and leadership, and co-ordination of actions to improve health and reduce health inequalities. In reality effective linkages, monitoring and communication processes between these and other levels of the delivery system were developed but could be strengthened and clarified for greater impact. An additional, slightly complicating factor is that whilst the MGPH was perhaps the earliest manifestation of a cross-departmental strategic group, since 2002 more over-arching strategies have been developed supported by cross-departmental groups. In these circumstances there is a risk that the system can become 'over-loaded' with a subsequent dilution of engagement and collaboration.

Change is therefore required at a strategic level, where there is scope to strengthen the effectiveness of current structures. At Executive level there is a scope for more consistent, strategic direction and high level targets to be established through a PfG which has improving population wellbeing (and therefore tackling health inequalities) at its heart. This will require Executive/Ministerial buy-in. This agenda needs to be owned and championed by all Ministers, with the Minister for Health having lead responsibility for working with other Ministers to deliver results.

It is also essential that reporting arrangements for IFH are aligned with those of PfG, and it is suggested that progress on IFH is included as an agenda item for the Executive on an annual basis.

There is an argument that the current MGPH continues to meet, chaired by the Health Minister, but be supplemented by a Delivery Board which includes senior officials from Government Departments, relevant agencies, the HSC, and Local Government. The Delivery Board should meet quarterly to review progress and direct further action. Consideration could also be given to strengthening Ministerial involvement in the MGPH, for example to become a meeting of those Ministers most involved in taking forward the wellbeing agenda.

Recommendation 4: *The existing MGPH should be supported by a Delivery Board ,with responsibility for co-ordinating implementation of Investing for Health. This could include officials from Government Departments, relevant agencies, the HSC and Local Government who are responsible for the operational delivery of the Strategy. The Delivery Board should meet at least quarterly to review progress and to direct action on areas of underperformance. MGPH should meet annually to review a monitoring report from the Delivery Board, and to propose a report to the Executive to include any recommendations for further strategic*

support or remedial action required. Consideration could be given to MGPH becoming a meeting of those Ministers most involved in policy in regard to key determinants of health.

Recommendation 5: *It is essential that a more robust Monitoring and Performance Management system is developed, closely aligned to the PfG process. This should enable targets, indicators and available data to be better aligned at both the regional and local level, which in turn should enable a more informed formative and summative reporting system to be developed. This process must be carried out as part of the development of any new IFH strategy. Informed by quarterly reports from the Delivery Board, DHSSPS would continue to report to OFMDFM on the progress of the PSA targets for which it has lead responsibility.*

11.5 Delivery of Investing for Health

A key element of this review was the discussion and deliberations over the way in which IFH had been delivered at both the regional and local level.

The IFH strategy set targets at a Northern Ireland level; it did not set operational targets for each department detailing what was required from them individually as departments in order that the overall targets might be obtained. As a result it is difficult to evaluate the contribution at a departmental level. Departments have implemented strategic measures that have made considerable progress in addressing many of the IFH priority areas. The analysis at a departmental level would highlight that a significant number of areas only started to progress from 2006 on, and there has been a significant level of policy work in 2009 which has not had time to work through into outputs or impacts. Evidence collected through the Departments survey, shows a focus on reporting activities rather than achievements or outcomes. Whilst monitoring activities is important in the short term it is clearly critical that there is a focus on what impacts are being delivered.

Health Impact Assessment (HIA) of non-health policies and programmes is seen as a key tool to promote health and well being and reduce health inequalities. A separate report of HIA activity is currently being considered by the Department, however evidence gathered for this review would suggest that successfully embedding health and health equity considerations into the policy making process remains a challenge. It is suggested that further awareness raising, information and support is required.

11.5.1 Local implementation

In respect of implementation at the local level, IFH clearly acknowledged that its successful implementation would be dependent on engagement at local level. This would be achieved through the commitment, actions and co-operation of individuals, community groups and organisations as well as a range of other partners including District Councils, the business, community and voluntary sector. While there has been a degree of disjointedness at local level, the extent to which local stakeholders have been energised and inspired, as evidenced by the commitment shown to the delivery of work through the cross-sectoral local IFH Partnerships can be highlighted as a key area of success for IFH. This level of engagement

has continued to be sustained, even through the period of organisational change within the Health and Social Care sector. Consultees highlighted for example the benefit of having a Strategy which provided a common focus and language for all to buy into health and wealth improvement. Other strengths of implementation at local level included:

- mainstreaming public health issues into the policy and planning systems of other partners organisations
- increased knowledge and understanding of health issues within the local populations
- building capacity for change in local communities.

Drawing from the evidence gathered for this review it can be concluded that IFH would appear to be successful as a process at the local level. It is suggested that this is reflective of the capacity and commitment of the local public health workforce, and the level of engagement with, and commitment to the IFH values and principles which had been achieved amongst local communities and organisations.

With the establishment of the PHA there is an opportunity now for cohesion and co-ordination at the regional level, and a link between regional and the local level in support of local action. Ways in which the PHA can strengthen efforts include - identifying and investing in best practice, supporting capacity building for health at all levels of the system, engaging with and developing local communities, working with and building on local partnership arrangements, and working alongside local government reform.

The IFH Strategy needs to facilitate and empower regional and local implementation including delivery of services. Crucially the whole systems approach will require the IFH agenda to be embedded in Local Commissioning Plans and in future local planning processes. The Public Health Agency has the key role for ensuring that this happens.

As the development of a successor to Investing for Health (for 2012 and beyond) moves forward there will be a need to ensure that the Investing for Health Partnership model evolves with the changing context.

Recommendation 6: *Departments should explicitly require their Agencies and NDPBs to reflect linkages and interdependencies with the IFH agenda, and relevant PSA targets, including setting of appropriate objectives and targets. This could be better achieved through a particular focus on short, medium and long term outcomes. Local Government needs to be equally focused – this should be further facilitated through the ongoing development of local planning processes. Within the Health and Social Care sector, business planning processes should also ensure appropriate connections are made particularly with delivery organisations in support of IFH targets.*

Recommendation 7: *All Departments and service delivery organisations should be supported by DHSSPS and PHA to maximise their delivery of the IFH Strategy. DHSSPS*

needs to be adequately resourced to provide leadership and coordination across Departments and service delivery organisations and PHA needs to be resourced to provide:

4. *solid and quantitative evidence linking the social and environmental determinants of health with their ultimate health outcomes;*
5. *research that shows and quantifies the effect of policies and specific interventions on these determinants; and*
6. *the development of policy-linked indicators which provide a quantitative estimate of the health that would be gained (or disease burden that could be avoided) by adoption of a specific policy.*

Recommendation 8: *Consideration of potential health impacts of policies throughout government (together with the benefits for other policy areas of health interventions) should be a mandatory requirement for all Departments as part of the policy development process. Further consideration needs to be given to the processes to ensure this can be achieved, including that all Departments should be supported in this process.*

Recommendation 9: *PHA should continue its work with Local Government to ensure that IFH Partnership/ local engagement arrangements evolve over time and are connected into local planning and delivery structures in the future. This should ensure that such plans reflect IFH priorities as relevant for the local area.*

Recommendation 10*: IFH should build on and further develop engagement with and involvement of the third sector in the design and delivery of services, in support of empowerment of individuals and communities.*

11.6 Lessons from elsewhere

The review considered those approaches to health improvement taken in Sweden, Australia and England. Although very different in many respects a number of common themes have been identified –

- a common goal of promoting equity due to the widespread occurrence of inequality in health between different societal groups;
- recognition that the inter-sectoral nature of public health makes it necessary to develop linkages with stakeholders in many sectors in order for any public health policy to succeed;
- focus on evidence-based policy making, with a strong emphasis on monitoring and evaluation; and
- focus on monitoring the performance of stakeholders at all levels against agreed goals and targets.

11.7 Investing in Public Health

A further issue considered during the benchmarking exercise was the relative spend by countries on health promotion and disease prevention. Information gathered shows that in 2006 - 07 England's spend on health promotion activities was £3.7bn which represents 4% of total health expenditure[64], while Australia's public health expenditure was 2.2% of total health expenditure (- Australia's expenditure on public health activities increased considerably to 7.1% of total health expenditure in 2007-08 – the highest of all OECD countries in that year [65].) Spend in NI on health promotion and disease prevention activities amounted to 2.9% of the overall health spend in 2008/09. Given the differences in the way health promotion activities are organised and funded in Northern Ireland and the benchmark countries it has not been possible to compare like for like, and therefore draw any firm comparisons in respect of the financial investment without further more detailed analysis. However it is recommended that consideration should be given to ensuring the proportion of spend in Northern Ireland is on a par with the level of the benchmark countries. At the very least, the current funding level needs to be protected and maintained.

Health and wellbeing improvement has become a priority for governments across the world as they come to deal with the impacts preventable diseases have on their health systems and ultimately on their economies. It has to be emphasised that investing in public health is a long term investment, not a cost. This was particularly highlighted by the Wanless and Appleby reports. These estimated the funding implications associated with a failure to engage with the public and encourage them to take more responsibility for their own health status (in terms of future funding requirements Wanless concluded that if the NHS fails to engage with the public and encourage them to take more responsibility for their own health status the UK Government could expect, by 2022, to have to spend £30 billion more on the NHS than it might otherwise have to).

Other reports also looked at the effectiveness of various public health initiatives on different populations. For example, a recently published paper by the New Economics Foundation, Backing the Future (2009), demonstrates the economic case for investing in preventative services for children and young people to address the structural factors affecting the circumstances of their lives, such as poverty and inequality, together with psychological and social dimensions of their well-being. The paper states that the cost to the UK economy of continuing to address current levels of social problems will amount to almost £4 trillion over a 20 year period. This includes addressing problems such as crime, mental ill health, family breakdown, drug abuse and obesity. Making the transition to a more preventative approach will require investment; however, the paper estimates that the returns to the UK economy would total a minimum of £486 billion over 20 years. This is roughly five times the current annual budget of the entire NHS.

[64] Health England (2009): Public Health and Prevention Expenditure in England

[65] AIHW (2008): Public Health Expenditure 2007-08

There is also considerable evidence to show that investment in early years is vital to reducing health inequalities. Gaps between individuals and social groups emerge early in the life course so it is vital to tackle it at this stage. In addition, returns on investment in early childhood are higher than in adolescence. Later remediation is possible but it has been estimated to cost 40% more to attain later what can be accomplished by early investment.[66]

Recommendation 11: *The proportion of Northern Ireland's total health expenditure spent on preventative and health promoting activities needs to be brought up to the level of the benchmark countries, such as England and Australia. At the very least, the current funding level needs to be protected and maintained and ideally more investment should shift towards working upstream on prevention.*

[66] Marmot (2010): Fair Society. Healthy Lives.

APPENDICES

APPENDIX 1: EMERGING RESEARCH DOCUMENTS

Appleby (2005): Independent Review of Health and Social Care Services in Northern Ireland

The main objectives of this review were to examine the likely future resource requirements of the health & social care sector in Northern Ireland and to consider how resources could be used more effectively. The review was also tasked with making recommendations for further measures to improve health and well-being which can reduce the demand for health and social services.

The review states that the health of any population is a complex function of many economic, social, cultural, lifestyle, educational and other factors, as well as the level and consumption of health and social care services, provided and used over people's lifetimes. In terms of demand and funding, factors which drive the pressure to spend more on health and social care include:

- technological developments and medical advance;
- higher expectations regarding the range and quality of health care provided;
- demographic and patterns of morbidity; and
- extent to which resources are used efficiently

The review states that an ageing population, changes in public expectations and technological developments will increase the demand for resources, while improvements in public health behaviour such as smoking and diet and increases in productivity will reduce requirements.

This review examined the implied demand for health and social care services arising from the current state of health of the Northern Ireland population, the actual demand based on the use of services and the extent to which health and social care resources are currently being used effectively to address needs and provide acceptable levels of access to services. It also considered the performance of the Northern Ireland health and social care sector compared to the rest of the UK across a range of indicators, which provided a broad indication of relative performance at the time of the review. The main findings were:

- Hospital activity per member of staff is 19% lower than the UK average;
- Hospital activity per pound of health spend is 9% lower than the UK average;
- Hospital activity per available bed is 26% lower than in England;
- The unit cost of procedures is 9% higher in Northern Ireland than England with day care unit costs 9% lower and elective inpatient unit costs 12.6% higher;
- There are significant variations in unit costs between trusts;
- Day case rates are higher than the UK average and have risen significantly since 1990/91;
- Length of stay has remained broadly unchanged over the past five years; and

- Average unit prescribing costs are nearly 30% higher in Northern Ireland than in England

Overall, the analysis showed that in Northern Ireland fewer outputs were achieved per given level of input than in England. This may be due to more than simple inefficiency. It may in part be explained by problems that are specific to Northern Ireland such as maintaining hospitals in rural locations and higher costs of delivering services in deprived areas. In addition, health status in Northern Ireland (as measured by a self-reporting survey) was found to be slightly worse than in the rest of the UK - linked to poorer diets, heavy smoking, lack of exercise and other lifestyle and environmental causes. As a result, hospital activity tends to be higher than in England. These unhealthy lifestyles not only affect health outcomes but also place significant resource pressures on the health and social care system.

The review makes two recommendations in relation to public health:

- Routine collection of self-assessed health status data at population level would yield useful comparative data on population health status. In addition, the potential for routine collection of patient related outcome measures in health care services should be explored; and
- On the basis of current lifestyle data, the funding recommendations based on the Wanless 'fully engaged' scenario imply considerable effort will be needed to engage the Northern Ireland population through expanded public health services and other means.

Marmot (2010): Fair Society, Healthy Lives - The Marmot Review

In November 2008, Professor Sir Michael Marmot was commissioned by the Secretary of State for Health to conduct an independent review and to propose the most effective evidence-based strategies for reducing health inequalities in England from 2010. Fair Society, Healthy Lives: The Marmot Review (published in February 2010) is the report of the Review's work.

The Review analyses the trends in public health in England and confirms that not only do health inequalities still exist in England, but that the social gradient is not closing. Additionally, there is also evidence for regional gradients. The Review states that Inequalities in health arise because of inequalities in society – in the conditions in which people are born, grow, live, work, and age. So close is the link between particular social and economic features of society and the distribution of health among the population, that the magnitude of health inequalities is a good marker of progress towards creating a fairer society. Taking action to reduce inequalities in health does not require a separate health agenda, but action across the whole of society.

The Review goes on to collate as much evidence as possible, investigate measurement, indicators and targets, and finally suggest a strategy for implementing a reduction in health inequalities. The key messages of the Review are as follows:

- Reducing health inequalities is a matter of fairness and social justice. In England, the many people who are currently dying prematurely each year as a result of health inequalities would otherwise have enjoyed, in total, between 1.3 and 2.5 million extra years of life.
- There is a social gradient in health – the lower a person's social position, the worse his or her health. Action should focus on reducing the gradient in health.
- Health inequalities result from social inequalities. Action on health inequalities requires action across all the social determinants of health.
- Focusing solely on the most disadvantaged will not reduce health inequalities sufficiently. To reduce the steepness of the social gradient in health, actions must be universal, but still with a scale and an intensity that is proportionate to the level of disadvantage. This is called proportionate universalism.
- Action taken to reduce health inequalities will benefit society in many ways. It will have economic benefits in reducing losses from illness associated with health inequalities. These currently account for productivity losses, reduced tax revenue, higher welfare payments and increased treatment costs.
- Economic growth is not the most important measure of a country's success. The fair distribution of health, well-being and sustainability are important social goals. Tackling social inequalities in health and tackling climate change must go together.
- Reducing health inequalities will require action on six policy objectives. These are aimed at intervening along the entire life course, but specifically targeted at earlier stages where greater impacts can be achieved. These are:
  - Give every child the best start in life;
  - Enable all children, young people and adults to maximise their capabilities and have control over their lives;
  - Create fair employment and good work for all;
  - Ensure a healthy standard of living for all;
  - Create and develop healthy and sustainable places and communities; and
  - Strengthen the role and impact of ill-health prevention.
- Delivering these policy objectives will require action by central and local government, the NHS, the third and private sectors and community groups. National policies will not work without effective local delivery systems focused on health equity in all policies.
- Effective local delivery requires effective participatory decision-making at local level. This can only happen by empowering individuals and local communities.

Wanless (2004): Securing Good Health for the Whole Population

This review is a follow-up to Wanless' 2002 review of the resources required to deliver an effective health service over the next two decades. The 2002 review concluded that the UK would need to devote a substantially larger share of national income to health, with a large proportion in the short term in order to deliver the required improvements in standards as

quickly as possible, and address issues around the utilisation of resources in the health services. To model the different outcomes, Wanless developed three scenarios. The 'fully engaged' scenario delivered the best health outcomes of the three scenarios. This was based on a dramatic improvement in public engagement where people actively take ownership of their own health and reduce risk behaviour. This reduction in risk behaviour was assumed to be highest amongst people in the most deprived areas, therefore contributing to further reductions in socio-economic inequalities in health. Many of the benefits of engaging people in living healthier lives occur in the long term but there are also immediate and short-term benefits when demand for health services can be reduced, especially in those areas such as acute services where capacity is seriously constrained.

This follow-up review focuses particularly on prevention and the wider determinants of health in England and on the cost-effectiveness of action that can be taken to improve the health of the whole population and to reduce health inequalities. The review uses the following definition of public health:

"the science and art of preventing disease, prolonging life and promoting health through the organised efforts and informed choices of society, organisations, public and private, communities and individuals."

The review states that although individuals are ultimately responsible for their own health, they need to be actively supported to make better decisions because there are widespread, systematic failures that influence the decisions individuals currently make regarding their health. The review lists some of these failures as:

- A lack of full information;
- The difficulty individuals have in considering fully the wider social costs of particular behaviours;
- Engrained social attitudes not conducive to individuals pursuing healthy lifestyles and addictions; and
- Significant inequalities related to individuals' poor lifestyles related to socio-economic differences.

These failures must be recognised and tackled by wide ranging action by health and care services, national and local government, media, businesses, society at large, families and the voluntary and community sector. These actions must respect the individual's right to choose as interventions to improve public health have the potential to reduce significantly personal freedoms.

For the NHS to be capable of facilitating a "fully engaged" population, it must shift its focus from treating disease to preventing it. The review recommends the following the actions for Government to take:

- Set a clear national framework of objectives for all the key risk factors such as smoking and obesity;

- Set out principles for action and a framework for assessing the role of economic instruments, such as taxes and public spending, to choose the right set of policy levers to deliver public health goals; and
- ensure that everybody is given access to personalised high quality information, advice and support in accessible formats to help them make informed decisions about their health.

The review also recommends that the following principles are adopted by governments when developing new public health policy to ensure targeted interventions increase both health and welfare:

- Interventions should tackle public health objectives and the causes of any decision-making failures as directly as possible;
- Interventions should be evidence-based, though the lack of conclusive evidence should not, where there is serious risk to the nation's health, block action proportionate to that risk;
- The total costs of an intervention to the Government and society must be kept to a minimum and be less than the expected benefits over the life of the policy: interventions should be prioritised to select those which represent best value;
- The distributional effects of any programme of interventions should be acceptable; and
- The right of the individual to choose their own lifestyle must be balanced against any adverse impacts those choices have on the quality of life of others.

The review also makes the case for assessing public health interventions as the evidence base for policymakers and practitioners is weak with respect to the differential effectiveness and relative cost-effectiveness of different interventions, particularly with respect to different populations groups or settings.

Wilkinson, R. G., & Pickett, K. E: The Problems of Relative Deprivation: Why Some Societies do Better than Others (2007) and The Spirit Level. Why More Equal Societies Almost Always do Better (2009)

The report considers evidence from published research to show that greater income inequality is associated with a higher prevalence of ill health and social problems in a society as a whole, regardless of its social distribution. The report shows evidence linking income inequality to morbidity and mortality, obesity, teenage birth rates, mental illness, homicide, low trust, low social capital, hostility, racism, educational performance and social mobility.

The report suggests that social stratification is more than just income inequality and is deeply rooted in our personal and class characteristics, including many of the early childhood influences on social and cognitive development.

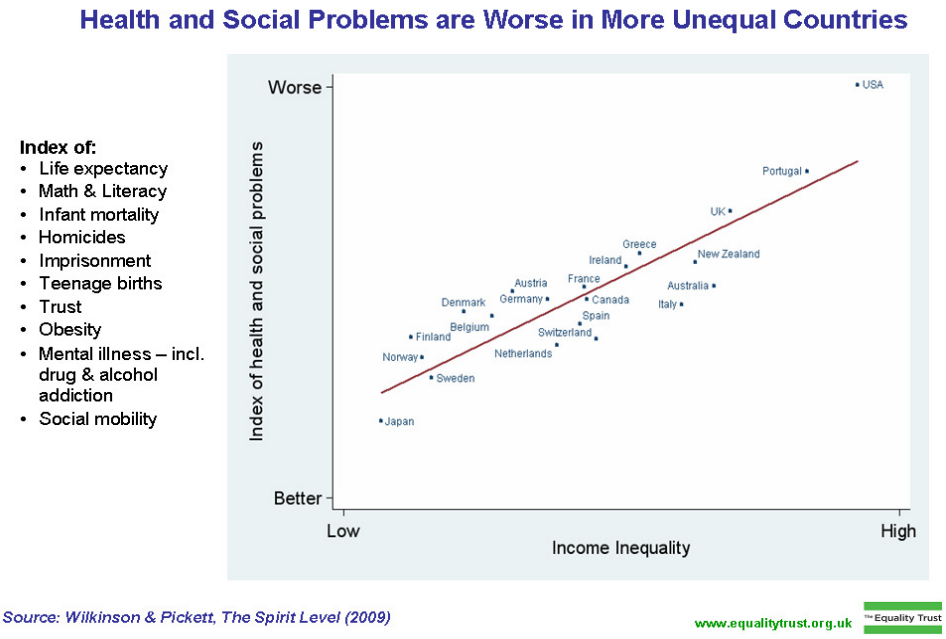
The report highlights that the achievement of higher national standards of performance may be substantially dependent on reducing inequalities in each country. As well as improving

health, reducing inequality may also raise the educational performance of school children, increase trust, while decreasing violence and teenage births. The report suggests that success will be achieved through decreasing the burden of relative deprivation rather than focusing on attempts to reduce its impacts.

The evidence found in the Problems of Relative Deprivation report was further built upon in The Spirit Level (the following figures, figure 3.1 and 3.2 have been reproduced with the author's permission). The first figure, figure 3.1 shows that the incidence of a range of health and social problems are higher in countries with higher levels of income inequality. The second figure, figure 3.2, shows that the incidence of these health and social problems is not related to average income in the same countries.

Figure 3.1

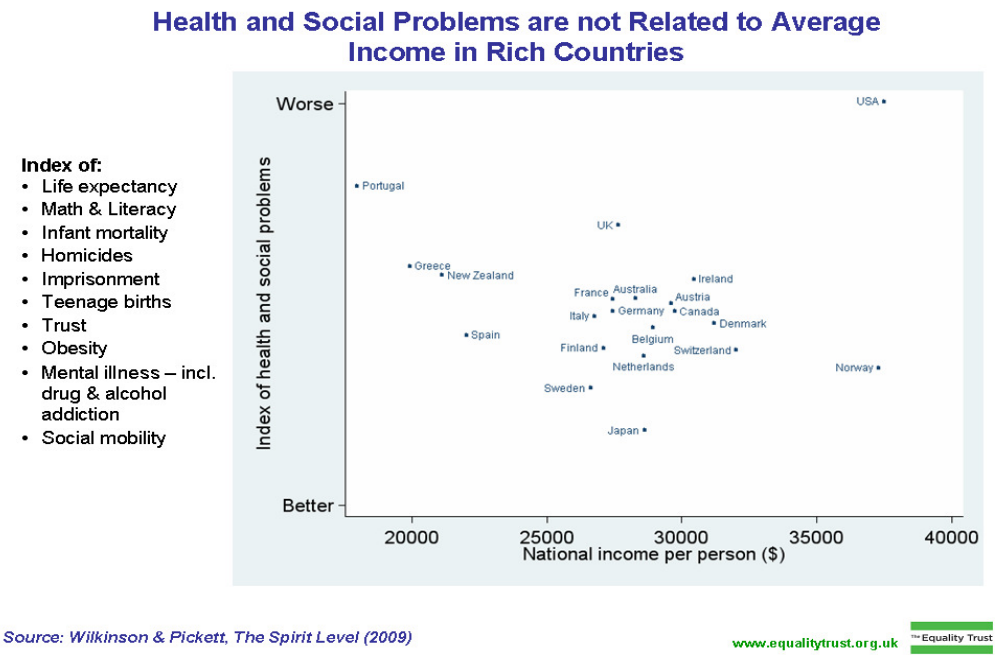
Health and Social Problems are Worse in More Unequal Countries



Source: Problems of Relative Deprivation report

Figure 3.2

Health and Social Problems are not Related to Average Income in Rich Countries



Source: Problems of Relative Deprivation report

WHO (2008): Commission on Social Determinants of Health Final Report: Closing the Gap in a Generation. Health Equity through Action on the Social Determinants of Health.

The Commission on Social Determinants of Health was set up by the World Health Organisation (WHO) in 2005 to bring together a global evidence base on the social determinants of health and make recommendations on how to promote health equity. It is a global collaboration of policy-makers, researchers and civil society led by Commissioners with political, academic and advocacy backgrounds. In collecting evidence, the Commission considered countries at all stages of development and levels of income. The report proposes the aspirational goal of closing the gap in health equity within a generation.

The evidence analysed by the report finds that health equity is a universal issue and is affected by the economic and political systems in place within each country. In countries at all levels of income, health and illness follow a social gradient whereby the lower the socioeconomic position of an individual, the worse their health. This is not confined to poor countries, low socioeconomic position in a rich country means poor education, lack of amenities, unemployment and job insecurity, poor working conditions, and unsafe neighbourhoods. All these factors have consequent impacts on individual's health.

The report highlights that strengthening global health equity requires a broader focus than concentrating on the causes of disease. The Commission developed a framework that focuses on the 'cause of the causes' which they consider to be 'the fundamental global and national structures of social hierarchy and the socially determined conditions these create in which people grow, live, work, and age'. The framework suggests that interventions should be aimed at taking action on the determinants of health. These include the following circumstances of daily life:

- differential exposures to disease-causing influences in early life, the social and physical environments, and work, associated with social stratification. Depending on the nature of these influences, different groups will have different experiences of material conditions, psychosocial support, and behavioral options, which make them more or less vulnerable to poor health;
- health-care responses to health promotion, disease prevention, and treatment of illness;

and the following structural conditions of society:

- the nature and degree of social stratification in society;
- biases, norms, and values within society;
- global and national economic and social policy; and
- processes of governance at the global, national, and local level.

Based on evidence collected, the report lays out three principles of action to achieve the goal of health equity. A number of more detailed recommendations are contained within each principle and are shown in more detail below.

	Principles of Action to Achieve Health Equity
1	Improve the conditions of daily life – the circumstances in which people are born, grow, live, work, and age.
2	Tackle the inequitable distribution of power, money, and resources – the structural drivers of those conditions of daily life – globally, nationally, and locally.
3	Measure the problem, evaluate action, expand the knowledge base, develop a workforce that is trained in the social determinants of health, and raise public awareness about the social determinants of health.

Source: WHO (2008): Commission on Social Determinants of Health Final Report

Improving Daily Living Conditions

The report finds evidence of inequalities in the structure of all societies. This is apparent in the conditions of early childhood and schooling, the nature of employment and working conditions, the built environment and the quality of the natural environment in which people lie. The nature of these environments not only impacts on the individual's health and quality of life, they also have wider implications for society.

The report recommends the following actions to help improve the conditions of daily life in a number of areas:

1: Improving daily living conditions	
Area	**Action**
Equity from the start: early childhood development	Commit to and implement a comprehensive approach to early life, building on existing child survival programmes and extending interventions in early life to include social/emotional and language/cognitive development
	Expand the provision and scope of education to include the principles of early child development (physical, social/emotional, and language/cognitive development).
Healthy places, healthy people:	Place health and health equity at the heart of urban governance and planning.
	Promote health equity between rural and urban areas through sustained investment in rural development, addressing the exclusionary policies and processes that lead to rural poverty, landlessness, and displacement of people from their homes.
	Ensure that economic and social policy responses to climate change and other environmental degradation take into account health equity.
Fair employment and decent work	Make full and fair employment and decent work a central goal of national and international social and economic policy-making.
	Achieving health equity requires safe, secure, and fairly paid work, year-round work opportunities, and healthy work-life balance for all.
	Improve the working conditions for all workers to reduce their exposure to material hazards, work-related stress, and health-damaging behaviours.
Social protection across the lifecourse	Establish and strengthen universal comprehensive social protection policies that support a level of income sufficient for healthy living for all.
Universal healthcare	Build health-care systems based on principles of equity, disease prevention, and health promotion.
	Ensure that health-care system financing is equitable.
	Build and strengthen the health workforce, and expand capabilities to act on the social determinants of health.
Source: WHO (2008): Commission on Social Determinants of Health Final Report	

Tackling the inequitable distribution of power, money and resources

The report proposes that is necessary to address inequities in the way society is organised in order to address health inequities, and inequitable conditions of daily living. This will require:

- a strong public sector that is committed, capable, and adequately financed.
- space and support for civil society
- an accountable private sector,
- people across society to agree public interests and reinvest in the value of collective action

The report recommends a number of actions to address inequity in the distribution of power, money and resources:

2. Tackle the inequitable distribution of power, money and resources	
Area	**Action**
Health equity in all policies, systems & programmes	Place responsibility for action on health and health equity at the highest level of government, and ensure its coherent consideration across all policies.
	Adopt a social determinants framework across the policy and programmatic functions of the ministry of health and strengthen its stewardship role in supporting a social determinants approach across government.
Fair financing	Strengthen public finance for action on the social determinants of health.
	Increase international finance for health equity, and coordinate increased finance through a social determinants of health action framework.
	Fairly allocate government resources for action on the social determinants of health.
Market responsibility	Institutionalize consideration of health and health equity impact in national and international economic agreements and policy-making.
	Reinforce the primary role of the state in the provision of basic services essential to health (such as water/sanitation) and the regulation of goods and services with a major impact on health (such as tobacco, alcohol, and food).
Gender equity	Address gender biases in the structures of society – in laws and their enforcement, in the way organizations are run and interventions designed, and the way in which a country's economic performance is measured.
	Develop and finance policies and programmes that close gaps in education and skills, and that support female economic participation.
	Increase investment in sexual and reproductive health services and programmes, building to universal coverage and rights.
	Empower all groups in society through fair representation in decision-making about how society operates, particularly in relation to its effect on health equity, and create and maintain a socially inclusive framework for policy-making.

2. Tackle the inequitable distribution of power, money and resources	
Area	**Action**
Political empowerment – inclusion and voice	Enable civil society to organize and act in a manner that promotes and realizes the political and social rights affecting health equity.
Good global governance	Make health equity a global development goal, and adopt a social determinants of health framework to strengthen multilateral action on development.
	Strengthen WHO leadership in global action on the social determinants of health, institutionalising social determinants of health as a guiding principle across WHO departments and country programmes.
Source: WHO (2008): Commission on Social Determinants of Health Final Report	

Measuring and understanding the problem and addressing the impact of action

The report suggests that health inequity should be measured and evaluated - within countries and globally. Routine monitoring of health inequity, the social determinants of health and the health equity impact of policy and action should be carried out to create an evidence base of best practice. Training for public health stakeholders policy makers is also recommended. A number of actions are suggested to achieve this:

3. Measure and understand the problem and assess the impact of action	
Area	**Action**
The social determinants of health: monitor, research and training	Ensure that routine monitoring systems for health equity and the social determinants of health are in place, locally, nationally, and internationally.
	Invest in generating and sharing new evidence on the ways in which social determinants influence population health and health equity and on the effectiveness of measures to reduce health inequities through action on social determinants.
	Provide training on the social determinants of health to policy actors, stakeholders, and practitioners and invest in raising public awareness.
Source: WHO (2008): Commission on Social Determinants of Health Final Report	

APPENDIX 2: DEPARTMENT SURVEY

DHSSPS: Investing for Health Strategy Review

Survey

FGS McClure Watters have been appointed to carry out the Investing for Health Strategy Review on behalf of DHSSPS.

For reference purposes you can access the strategy through the following link: http://www.dhsspsni.gov.uk/show_publications?txtid=10415

The purpose of this Review is to:

Assess the progress and impact of Investing for Health against objectives and targets set for it;

Assess the relevance of the strategy's objectives, targets, actions and interventions in the context of emerging priorities and issues and in the context of the strategy's progress towards its objectives, identify any gaps and how they might be addressed, and

Make recommendations to MGPH on the basis of the findings.

Background to the Strategy

Investing for Health (IfH), published in 2002, is Northern Ireland's cross-cutting public health strategy. It was originally developed by the cross- departmental group the Ministerial Group on Public Health. The overarching aims of the Strategy are:

- to improve the health status of all our people, and
- to reduce inequalities in health.

To achieve these aims the IfH aimed to tackle the main causes of preventable ill health and premature death by addressing the wider determinants of health. The strategy identified two goals and seven objectives:

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: 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. [Now PSA 8 Indicator 4 and 4a – By 2012 increase average life expectancy by 3 years for men and by 2 years for women]

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. [Now PSA 8 Indicator 4b – By 2012 facilitate a 50% reduction in the life expectancy differential between the most disadvantaged areas and the Northern Ireland average.]

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.

Guidance on this Questionnaire

A key element of the review is to assess how each Department and relevant Agencies have actioned Investing for Health, and to consider the extent to which Investing for Health – or its aims of improving health and reducing health inequalities - is reflected in their policies and strategies.

You are being asked as a current member of MGPH to complete this questionnaire on behalf of your Department and its agencies. This may require you to seek input from relevant business areas.

The questionnaire is structured to obtain information relating to Departments' contributions to date, new or planned developments, the strategic management of the strategy, and the strategy's relevance now and for the future.

The main part of the questionnaire (Section 2) relates to the strategy's 7 objectives, the associated targets and the original underpinning actions as outlined in the strategy. The review of necessity needs to reflect on what the strategy originally set out to do, but it is acknowledged that the context of much of this work has changed over time and so it is anticipated that your reply may also need to reflect developments that have happened since 2002.

Given that the objectives are much wider than the targets or original actions, we would also be happy for Departments/agencies to reflect any additional contributions they feel have contributed/ are contributing to this agenda.

Section 2 also asks for supportive evidence – this can include for example references/ links to published reports, performance measurement data etc.

Timetable

In order to deliver to the DHSSPS Steering Group's requirements, we would appreciate your response by the **30th November**. If you have any questions about this survey, please do not hesitate to contact either Joanna Clearkin at FGS McClure Watters (Joanna.Clearkin@fgspartnership.com) or Stephanie Tallentire at DHSSPSNI (Stephanie.Tallentire@dhsspni.gov.uk).

Section 1: Background Information

•	**Department and Agency Details**	
	Department Name (please also list all agencies covered by this response)	
	Respondent Name	

•	**How long have you been the Departmental representative responsible for Investing for Health**	
	No of Years	

Section 2: Overview of Delivery and Resources

Q3	Summarise your Department's and Agency's involvement in the support and delivery of Investing for Health since 2002

Q 4	Is it possible to provide details of your Department/and or Agency's expenditure in respect of Investing for Health objectives/ targets? If yes, please provide details of expenditure and IFH objectives it was addressing.		
	If no, please explain:		
	Year	Budget £m	Activities
	2002		
	2003		
	2004		

Q 4	**Is it possible to provide details of your Department/and or Agency's expenditure in respect of Investing for Health objectives/ targets?** **If yes, please provide details of expenditure and IFH objectives it was addressing.**		
	If no, please explain:		
	2005		
	2006		
	2007		
	2098		
	2009		

Section 3: Contribution to Delivery

This section covers each of the 7 IFH Objectives, targets and associated actions as outlined in the strategy. Please confirm each objective's relevance to the work of your Department and/ or its Agencies and complete the questions as appropriate.

Objective 1: Poverty and Social Exclusion

Q5a	Poverty and Social Exclusion: Confirm whether this issue is of relevance to the work of your Department/ Agencies.	
	Yes	☐ **If Yes, please complete Q5b-Q5d**
	No	☐ **If no, please go to Q6**

Q5b	Poverty and Social Exclusion			
	Objectives / Targets	**Actions**	**Describe Department's/ Agencies contributions including any developments/ changes since.**	**Please provide supporting evidence on impacts/ performance. This could include links to e.g. reports/ performance measurement data and can include contextual information on successes/ challenges.**
	Tacking Poverty and Social Exclusion			
	Objective 1: To reduce poverty in families with children	New Targeting Social Need		
		Welfare Reform		

Q5b	Poverty and Social Exclusion			
	Objectives / Targets	**Actions**	**Describe Department's/ Agencies contributions including any developments/ changes since.**	**Please provide supporting evidence on impacts/ performance. This could include links to e.g. reports/ performance measurement data and can include contextual information on successes/ challenges.**
	Tacking Poverty and Social Exclusion			
		Promoting Social Inclusion		
		Job Creation and Economic Development		
		Learning, Training and Employment		
		Urban Regeneration		
		Childcare Strategy		
		Children's Fund		
		Any other Contribution		

Q5c	**Please comment on the range and extent of any partnership working your Department/Agencies have undertaken as a result of / in support of this IFH objective**	
	Partner Organisation	Details of Joint Working

Q5d	**Are there any new or planned developments in support of addressing this objective? Please detail**

Objective 2: Education

Q6a.	Education: Confirm whether this issue is of relevance to the work of your Department/ Agencies.	
	Yes	☐ **If Yes, please complete Q6b-Q6d.**
	No	☐ **If no, please go to Q7.**

Q6b.	Education			
	Objectives / Targets	**Actions**	**Department's/ Agencies contributions including any developments/ changes since.**	**Please provide supporting evidence on impacts/ performance. This could include links to e.g. reports/ performance measurement data and can include contextual information on successes/ challenges.**
	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 ii: In the 25% of Secondary Schools with the highest percentage Free School Meal Entitlement, to	Education and Learning		
		The Youth Service		

Q6b.	Education			
	Objectives / Targets	**Actions**	**Department's/ Agencies contributions including any developments/ changes since.**	**Please provide supporting evidence on impacts/ performance. This could include links to e.g. reports/ performance measurement data and can include contextual information on successes/ challenges.**
	reduce the proportion of year 12 pupils achieving no GCSEs to 5% by 2005/06. Target i: In the 25% of Primary Schools with the highest percentage Free School Meal Entitlement, 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.	Sure Start		
		Children's Strategy		
		Any other Contribution		

Q6c	**Please comment on the range and extent of any partnership working your Department/Agencies have undertaken as a result of / in support of this IFH objective**	
	Partner Organisation	Details of Joint Working

Q6d	**Are there any new or planned developments in support of addressing this objective? Please detail**

Objective 3: Mental Health and Wellbeing

Q7a.	Mental Health and Emotional Wellbeing: Confirm whether this issue is of relevance to the work of your Department/ Agencies.	
	Yes	☐ **If Yes, please complete Q7b-Q7d.**
	No	☐ **If no, please go to Q8.**

Q7b	Mental Health and Emotional Wellbeing			
	Objectives / Targets	**Actions**	**Department's/ Agencies contributions including any developments/ changes since.**	**Please provide supporting evidence on impacts/ performance. This could include links to e.g. reports/ performance measurement data and can include contextual information on successes/ challenges.**
	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	Mental Health Promotion		
		Suicides and attempted suicides		
		Mental Health and the working environment		
		Mental Health and the Troubles		
		Mental Health and education		

Q7b	Mental Health and Emotional Wellbeing			
	Objectives / Targets	**Actions**	**Department's/ Agencies contributions including any developments/ changes since.**	**Please provide supporting evidence on impacts/ performance. This could include links to e.g. reports/ performance measurement data and can include contextual information on successes/ challenges.**
	disorder (as measured by the GHQ-12 score) by a tenth by 2010.			
		Domestic Violence		
		Any other Contribution		

Q7c	Please comment on the range and extent of any partnership working your Department/Agencies have undertaken as a result of / in support of this IFH objective	
	Partner Organisation	Details of Joint Working

Q7d	Are there any new or planned developments in support of addressing this objective? Please detail

Objective 4: The Living and Working Environment

Q8a.	The Living and Working Environment: Confirm whether this issue is of relevance to the work of your Department/ Agencies.	
	Yes	☐ **If Yes, please complete Q8b-Q8d.**
	No	☐ **If no, please go to Q9.**

Q8b	The Living and Working Environment			
	Objectives / Targets	**Actions**	**Department's/ Agencies contributions including any developments/ changes since.**	**Please provide supporting evidence on impacts/ performance. This could include links to e.g. reports/ performance measurement data and can include contextual information on successes/ challenges.**
	Objective 4: To offer everyone the opportunity to live and work in a healthy environment and to live in decent affordable housing. Target i: To lift at least 20,000 households out of fuel poverty by	Housing Conditions		
		Homelessness and access to Housing		
		Fuel Poverty		

	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.	Radon Gas		
		Health in the Workplace		
		Any other Contribution		

Q8c	**Please comment on the range and extent of any partnership working your Department/Agencies have undertaken as a result of / in support of this IFH objective**	
	Partner Organisation	Details of Joint Working

Q8d	Are there any new or planned developments in support of addressing this objective? Please detail

Objective 5: The Wider Environment

Q9a.	The Wider Environment: Confirm whether this issue is of relevance to the work of your Department/ Agencies.	
	Yes	☐ **If Yes, please complete Q9b-Q9d.**
	No	☐ **If no, please go to Q10.**

Q9b	The Wider Environment			
	Objectives / Targets	**Actions**	**Department's/ Agencies contributions including any developments/ changes since.**	**Please provide supporting evidence on impacts/ performance. This could include links to e.g. reports/ performance measurement data and can include contextual information on successes/ challenges.**
	Objective 5: To improve our neighbourhoods and wider environment. Target i: To reduce the levels of respiratory and heart disease by meeting the health-based	Air Quality		
		The Neighbourhood Environment		
		Regional Development		
		Transport		
		Sustainable Development		
		Planning		

Q9b	**The Wider Environment**			
	Objectives / Targets	**Actions**	**Department's/ Agencies contributions including any developments/ changes since.**	**Please provide supporting evidence on impacts/ performance. This could include links to e.g. reports/ performance measurement data and can include contextual information on successes/ challenges.**
	objectives for the 7 main air pollutants	Water and Health		
		Any other Contribution		

Q9c	**Please comment on the range and extent of any partnership working your Department/Agencies have undertaken as a result of / in support of this IFH objective**	
	Partner Organisation	Details of Joint Working

Q9d	Are there any new or planned developments in support of addressing this objective Please detail

Objective 6: Accidental Deaths and Injuries

Q10a.	Accidental Deaths and Injuries: Confirm whether this issue is of relevance to the work of your Department/ Agencies.	
	Yes	☐ **If Yes, please complete Q10b-Q10d.**
	No	☐ **If No, please go to Q11.**

Q10b	Accidental Deaths and Injuries			
	Objectives / Targets	**Actions**	**Department's/ Agencies contributions including any developments/ changes since.**	**Please provide supporting evidence on impacts/ performance. This could include links to e.g. reports/ performance measurement data and can include contextual information on successes/ challenges.**
	Objective 6: To reduce accidental deaths and injuries 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	Home Accidents		
		Home Zones		
		Road Traffic Collisions		
		Road Safety Education		
		Any other Contribution		

Q10b	Accidental Deaths and Injuries			
	Objectives / Targets	**Actions**	**Department's/ Agencies contributions including any developments/ changes since.**	**Please provide supporting evidence on impacts/ performance. This could include links to e.g. reports/ performance measurement data and can include contextual information on successes/ challenges.**
	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.			

Q10c	Please comment on the range and extent of any partnership working your Department/Agencies have undertaken as a result of / in support of this IFH objective	
	Partner Organisation	Details of Joint Working

Q10d	Are there any new or planned developments in support of addressing this objective? Please detail

Objective 7: Making Healthier Choices

Q11a.	Making Healthier Choices: Confirm whether this issue is of relevance to the work of your Department/ Agencies.	
	Yes	☐ **If Yes, please complete Q11b-Q11d.**
	No	☐ **If No, please go to Q12.**

Q11b	Making Healthier Choices			
	Objectives / Targets	**Actions**	**Department's/ Agencies contributions including any developments/ changes since.**	**Please provide supporting evidence on impacts/ performance. This could include links to e.g. reports/ performance measurement data and can include contextual information on successes/ challenges.**
	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%.	Smoking		
		Physical Activity		
		Food and Nutrition		
		Breastfeeding		
		Folic acid		
		Alcohol		
		Drug misuse		

Q11b	Making Healthier Choices			
	Objectives / Targets	**Actions**	**Department's/ Agencies contributions including any developments/ changes since.**	**Please provide supporting evidence on impacts/ performance. This could include links to e.g. reports/ performance measurement data and can include contextual information on successes/ challenges.**
	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%.	Drug and Alcohol Joint Implementation Model		
		Sexual Health		
		Oral health		
		Health Education		
		Any other Contribution		

Q11c	Please comment on the range and extent of any partnership working your Department/Agencies have undertaken as a result of / in support of this IFH objective	
	Partner Organisation	Details of Joint Working

Q11d	Are there any new or planned developments in support of addressing this objective? Please detail

Section 4: Impact on Department/Agencies

Q12	To what extent has the 2002 Investing For Health Strategy with its emphasis on health improvement and reducing health inequalities influenced Policy development and Strategic planning within the Department and/or its Agencies?	
	Detail the Policy or Strategy within the Department	Describe how IFH influenced its development?

Q13	To what extent has Investing for Health with its emphasis on health improvement and reducing health inequalities influenced resource allocation within the Department and / or its agencies? (may include staff resources) Please provide details.

Q14	To what extent has/ is your Department/ Agencies making use of Health Impact Assessment in policy development- please provide appropriate examples where possible

Q15	To what extent does Investing for Health/ delivery of Investing for Health contribute to your Department/ Agencies strategic priorities?

Q16	**Your Department and Agencies is represented on the MGPH as the key structure to deliver the Strategy across Departments. Please provide comment on your Department's involvement at these meetings and your opinion on how effective this structure is at leading and managing delivery of the Strategy (e.g. is there sufficient clarity about roles, responsibilities etc)**

Q17	**What suggestions would you make to improve the strategic management of the strategy and (i) its interaction with other strategic policy structures/ inter- departmental groups and (ii) with local implementation arrangements?**

Q18	**Investing for Health was developed during 2000 – 02 and therefore reflects issues pertaining at that time.** **(i) To what extent do you feel the objectives of Investing for Health are still relevant?** **(ii) Looking to the future, are there any new issues/ priorities you feel the IFH Strategy should address in the immediate and or longer term? If yes, what are these?**

Q19	**Please provide any other comments?**

Thank you for taking the time to complete this survey –
If you have any queries, please do not hesitate to contact Joanna.Clearkin@fgspartnership.com or phone 028 9023 4343.
Please email your response to: Joanna
Or Post to: Joanna Clearkin
FGS McClure Watters
No 1 Lanyon Quay Belfast
BT1 3LG

APPENDIX 3: LIST OF CONSULTEES

List of Consultees

Job Title	Name	Approach
Permanent Secretary	Andrew McCormick	1 to 1
Chief Medical Officer	Dr Michael Mc Bride	1 to 1
Deputy Chief Medical Officer	Dr Elizabeth Mitchell	1 to 1
Director of Population Health	Andrew Elliott	1 to 1
Chief Pharmaceutical Officer Chief Dental Officer Chief Nursing Officer Chief Social Services Officer Chief Environmental Health Officer	Dr Norman Morrow Donncha O'Carolan represented by Kathy Fodey represented by Christine Smith Nigel McMahon	Group session
Health Service Contacts		
Chief Scientist	Prof Bernie Hannigan	1 to 1
Chief Executive Health & Social Care Board	Mr John Compton	1 to 1
Chief Executive Patient and Client Council	Ms Maeve Hully	Email
Chief Executive for Public Health Agency/ Director Public Health/ Assistant Director-PHA/ Director of Performance Improvement /Director of Corporate Affairs (future vision and the past)	Dr Eddie Rooney Dr Carolyn Harper Ms Mary Black Mr Ed McClean	Group Session with PHA.
Chief Executive Western HSCT	Elaine Way and representative	1 to 1
Acting Chief Executive Southern HSCT	Mairead McAlinden and representative	1 to 1
Chief Executive Belfast HSCT	William McKee and Lesley Boydell	1 to 1
Chief Executive Northern HSCT	Colm Donaghy and representative	1 to 1
Chief Executive South Eastern HSCT	Hugh McCaughy and representatives	1 to 1
Investing for Health Partnerships	IFH partnership managers/ HAZ managers and ex Health promotion Agency representative	Focus Group session
Investing for Health Partnership representatives	IFH Managers invited representatives from their partnerships, including from local government, community sector and other organisations and the Health Action Zones to attend.	Focus Group session
NICVA representatives	CEO NICVA invited a number of Health and Social Care Community and Voluntary sector providers and NICEM to attend a focus group	Focus Group session
SOLACE	Anne Donaghy	Telephone Interview
Commissioner for Children and Young People	Patricia Lewsley	1 to 1

Job Title	Name	Approach
Commissioner for Older People	Joan Harbison	1 to 1
Unison	Patricia McKeown & Thomas Mahaffy	1 to 1
Institute of Public Health	Dr Jane Wilde	1 to 1
Centre of Excellence for Public Health	Professor Frank Kee	1 to 1
Belfast Healthy Cities	Joan Devlin	1 to 1
NILGA	Heather Moorehead	1 to 1
Departments/MGPH representatives	11 Departments	Email questionnaire (see Appendix 4)

APPENDIX 4: CONSULTATION TOPIC LIST

Consultations: IFH Partnership Managers

Introduction to FGS and team

Summary of the purpose of the Investing for Health Review- our timescales and methodology

The purpose of the Review is to:

- *Assess the progress and impact of Investing for Health against objectives and targets set for it;*
- *Assess the relevance of the Strategy's objectives, targets, actions and interventions on the context of emerging priorities and issues and in the context of the Strategy's progress towards its objectives, identify any gaps and how they might be addressed, and*
- *Make recommendations to MGPH on the basis of the findings.*

Key Areas of Questioning will include, but will not be restricted to:

The IFH Strategy

- What impact do you feel the Strategy has had on the work of IFH Managers? What evidence do you have for this?
- What do you see as the purpose of IfH? Are you clear on its purpose?
- Did you use the IFH Strategy to influence the development of local action plans? Do these plans include IFH outcome targets?
- To what extent has the IFH Strategy influenced the work of others locally- namely the Departments/ Agencies/ Voluntary and Community and private sector?
- What has worked/ What areas of development are there?

Relevance of the Strategy (Refer to Strategy and the Objectives)

- How relevant where the IFH objectives when they were set in 2002? Why do you say that?
- How relevant are the IFH objectives now in 2009?
- How relevant will they be for the next 7 years? To what extent do they cover the issues that you feel that are critical to Public Health? What more is needed?

Points to check in this section:

Involving local communities is key to improving public health- do you feel the Strategy and its associated actions went far enough? Is more or less needed? Who else needs to be involved? Health Inequalities is a key theme in Public Health- Did IFH go far enough in addressing the issues driving health inequality, is more/less needed/ Who else needs to be involved?

Leadership and Accountability

- Who/ which organisation(s) do you see as responsible for the strategic leadership of the Strategy? Is this working? If not, what needs to change?
- Who/ which organisation(s) do you feel is/are accountable for delivering the Strategy? Is this working? If not what needs to change?
- To what extent have you seen effective collaboration in action with regard to delivery of IFH?
    - At Department Level
    - At Local Levels
    - With the Community and Voluntary sector
    - With the private sector
    - With clients?

Structures

- How effective do you feel the structures are in implementing the Strategy? What worked? What didn't work?
- What suggestions do you have for any new delivery structures (if appropriate, and how would these deliver improved outcomes)

Performance of the Strategy

- How informed are you on the performance of the Strategy against objectives and outcome targets?
- What information have you received on the performance of specific initiatives undertaken under IFH that worked? To what extent has this information influenced the work areas you have focused on?
- Likewise, what information have you received on initiatives that appear not to have worked as well as they could have done? To what extent has this info influenced your work areas?
- What more management information if any, would you wish to see on the performance of the IFH? How could this be used?

Resources

- Do you feel that Public Health resources are being used effectively at present? Why do you say this?
- What further is needed to support delivery of the Strategy?

APPENDIX 5: REVIEW TERMS OF REFERENCE

Investing for Health Strategy Review Terms of Reference

- Assess the progress and impact of Investing for Health against the objectives and targets set for it and the various actions to be implemented by Departments, Agencies and other organisations and partnerships;

- Assess the relevance of the strategy's objectives, targets, actions and interventions in the context of Ministerial priorities and emerging issues, such as sustainable development; climate change and the scope for greater engagement by the population in regard to health, and identify any gaps, including those relating to resources, research and evidence base;

- Assess the extent and effectiveness of strategic leadership, collaboration and delivery through the structures put in place to implement the strategy;

- Assess the extent to which non-health departments have taken health impact assessment into account when developing policy, and assess the extent to which they have undertaken work that contributes to the achievement of IfH objectives and targets;

- Assess the value for money of the strategy and the appropriateness of the allocation of resources among the main component parts of the strategy;

- Benchmarking where appropriate against international best practice, and taking into account the Review of Public Administration (RPA) in Northern Ireland, consider how policies, priorities and targets might be made more effective, both in the context of Health and Social Care commissioning strategy and across Executive departments, especially in relation to tackling health inequalities;

- Make recommendations to the Ministerial Group on Public Health (MGPH) on the basis of the findings.