Department of
Health, Social Services and Public Safety
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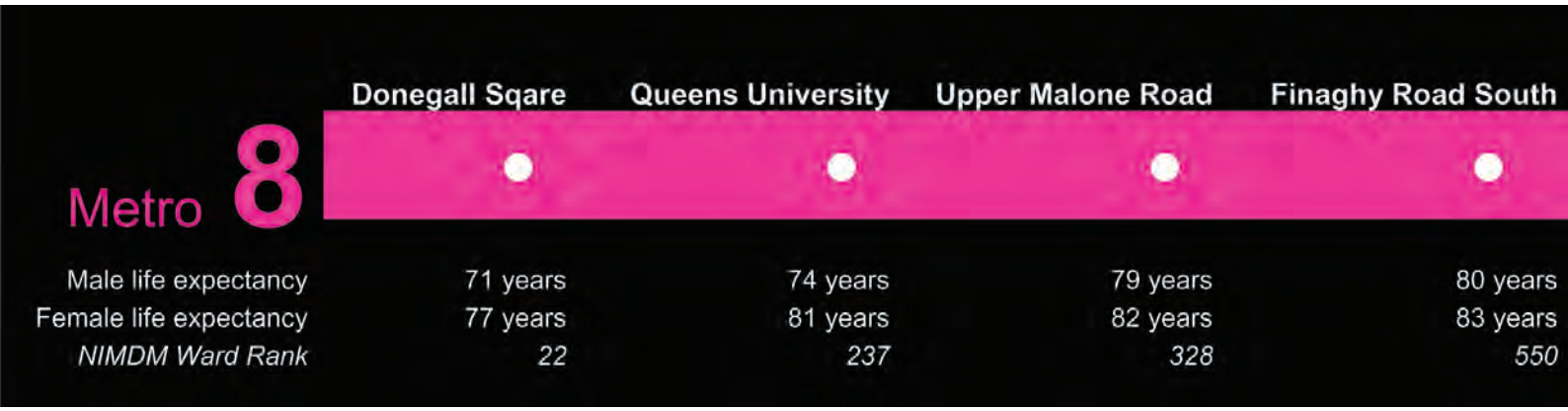
Fit and Well

Changing Lives – 2012-2022



A 10-Year Public Health Strategic Framework for Northern Ireland
A Consultation Document

CONTENTS

FOREWORD

Good health and wellbeing is important to all of us – as individuals, as a society, and for our children. We all want to keep fit and well so that we can live life to the full.

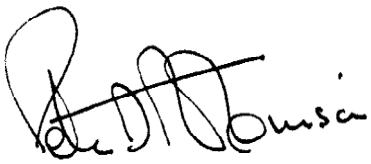
In general, the health of the Northern Ireland public has been improving over time. Social, economic, environmental and health improvements have meant that people are living longer than before. Advances in treatment and care have also meant that chronic conditions can be managed differently with the aim of securing a better quality of life for longer.

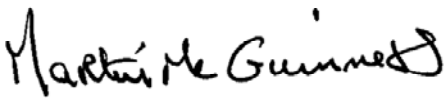
Unfortunately those who are disadvantaged in our society do not have an equal chance of experiencing good health and wellbeing and too many still die prematurely or live with conditions that they need not have. While taking a population-wide approach to health improvement, we must seek to reduce such inequalities.

Our genetic make-up plays some part in our chances of leading long and healthy lives, but there are many more factors within and beyond individual control which interact to influence our health and wellbeing at various stages in our lives.

It is important that we look for ways in which our collective efforts across government can support healthy people, healthy families and health communities. This framework proposes for consideration some priority areas for more focused collaboration.

We invite you to consider this document carefully and let us have your views – we encourage you to play an active part in shaping how we organise our efforts.



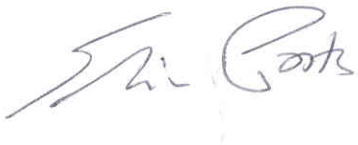


RT HON PETER D ROBINSON MLA MLA

First Minister

MARTIN McGUINNESS MP

deputy First Minister



EDWIN POOTS MLA

Minister of Health, Social Services and Public Safety

INTRODUCTION

About this Framework

This document proposes an updated Strategic Direction for Public Health for the next ten years, bringing together actions at government level to improve health and reduce health inequalities, and which will guide implementation at regional and local level.

This is a consultation document and as such is intended to be formative. It is open for everyone to provide comments or feedback on the approach and the questions posed. The consultation period will cover from 19th July to 31st October 2012. Respondents can reply by completing the separate Questionnaire and using the following email address, in addition a small number of events are planned – news of these will be published on the DHSSPS website.

Email consultation responses to: fitandwellconsultation@dhsspsni.gov.uk

What this seeks to achieve

This is a high level strategic document which seeks to re-invigorate action on current and future public health and wellbeing priorities.

It will -

- build on and promote the values, principles and successes of Investing for Health
- take account of emerging social, economic and policy developments as well as new bodies of evidence available
- provide vision and updated strategic direction
- facilitate whole-government synergy to address the range of key socio-economic factors which influence health and wellbeing
- provide direction for delivery and implementation at the regional and local levels through partnership working.

<u>This document is set out in three parts –</u>

Part 1 – The Issues - explains the background, and context for the updated approach including the health challenges for Northern Ireland.

Part 2 – The Approach – considers a whole systems approach and contains the strategic framework, which is structured around a population and lifecourse approach, and two underpinning themes. It includes proposed long-term aspirations for 2022 and outcomes to be achieved by 2015.

This section also proposes 6 Priority Areas for Collaboration – the aim is to provide focus for partnership working at strategic and local levels on issues that can have population- wide benefits. These ideas are at a developmental stage and are included to seek your views.

Part 3 – Taking It Forward – outlines proposed arrangements for implementing and monitoring the strategic framework, including the roles of departments and partners.

PART ONE – THE ISSUES

Chapter One

Background

1.1 In general, the health of the Northern Ireland public has been improving over time. Social, economic, environmental and health improvements have meant that people are living longer than before - between 1981 and 2009 life expectancy has increased here for both men and women by almost 8 and 6 years respectively. Advances in both treatment and care have also meant that chronic conditions can be managed differently with the aim of securing better quality of life for longer.

1.2 Unfortunately not everyone has had an equal chance of experiencing good health and wellbeing and too many still die prematurely or live with conditions that they need not have. This is particularly the case for those who are disadvantaged in our society, leading to a gap in health between those who live in more affluent circumstances and those whose circumstances are deprived. One stark illustration of this is the "Metro bus map" [Fig 1] which shows how life expectancy increases by as much as 9 years for men along a Belfast bus route from more deprived city centre areas through to the more affluent suburbs. While genetic make- up plays some part in our chances of leading long and healthy lives, there are many more factors within but importantly also beyond individual control, which interact to influence our health and wellbeing at various stages in our lives.

1.3 In 2002 the Northern Ireland Executive recognised the importance of the social, economic, physical and cultural environment to the health of the population and published a cross-cutting ten year public health strategy, Investing for Health. This strategy aimed to improve health and reduce health inequalities. Ten years later this document "Fit and Well - Changing Lives" takes account of the conclusions of a strategic review of Investing for Health published in 2010, the regional, national and international evidence and information base with regard to health and wellbeing, and the current socio-economic context and proposes an **updated strategic framework which seeks to build on Investing for Health and is based on outcomes to aspire to over the next ten year period to 2022, and short term outcomes to achieve by 2015.**

Metro 8

	Donegall Sqare	Queens University	Upper Malone Road	Finaghy Road South
Male life expectancy	71 years	74 years	79 years	80 years
Female life expectancy	77 years	81 years	82 years	83 years
NIMDM Ward Rank	*22*	*237*	*328*	*550*

Fig 1.

Investing for Health

1.4 Investing for Health (IfH), published in 2002, is Northern Ireland's 10 year cross-cutting public health strategy. Its lifespan is therefore due to end in 2012. It was developed by the cross-departmental Ministerial Group on Public Health (MGPH)*.

*MGPH is a cross-departmental group, chaired by the Minister for Health, Social Services and Public Safety and comprised of senior representatives from each NI government department.

1.5 Investing for Health examined the range of factors influencing health and wellbeing, demonstrating that many of these extend beyond the remit of DHSSPS and the Health and Social Care family. The strategy aimed to shift the focus from treatment of to the prevention of ill health, and set out a cross-cutting agenda to tackle the wider factors which adversely affect health and perpetuate health inequalities

1.6 The Strategy had two overarching goals – **to improve health and reduce health inequalities -** and seven objectives**,** which focussed on the wider determinants of health including **poverty, education and skills, the living and working and wider environment, reducing deaths and injuries from accidents, promoting mental health and wellbeing and encouraging people to make healthy choices.** It was an **overarching strategic framework for action,** based on the premise that, to be effective in achieving health improvement, multi-sectoral partnership working is required across government, public bodies, local communities, voluntary bodies, District Councils and social partners. Reflecting the range of cross-cutting issues it sought to address, local inter-sectoral structures were established to support the delivery of the strategy.

Strategic Review of Investing for Health

1.7 A review of Investing for Health was to commence in 2008, however it was postponed until 2009/10 to allow the major Health and Social Care (HSC) structural reform, which was part of the Review of Public Administration programme, to be worked through. In 2010 the outcomes of the high level strategic review were published on the DHSSPS website.

1.8 The review highlighted that much of its approach remains relevant today – in particular its emphasis on partnership working to address the wider socio-economic and environmental influences on health and wellbeing. The key finding is that there is a clear need for a public health strategy based on the ethos and principles of the current Investing for Health.

1.9 The review also concluded that there is a need to ensure that a new updated strategic direction builds on and follows on from Investing for Health. There is now a much more developed evidence base from which to draw lessons and in addition it is important to consider and reflect on the changed socio-economic context – the reality of the current economic climate needs to be acknowledged and efforts made to mitigate against the potential for damaging effects on health and wellbeing as a whole, and on certain population groups.

1.10 **Key findings** also included –

- Mixed success in terms of evidence of health improvement outcomes - this is no different to other countries within the UK and beyond;
- A key area of success has been the extent to which local stakeholders have been energised and inspired to work for health improvement as evidenced by the commitment shown to local delivery through the cross-sectoral partnerships;
- There is evidence of increased knowledge and understanding of health issues within local populations and building capacity for change in local communities;
- The strategy has provided a common focus, purpose and language and there is continued commitment and ownership of the Investing for Health values and principles;
- Strengths of implementation at local level include that public health issues have been mainstreamed into the policy and planning systems of other partner organisations;
- In terms of challenges, there is some disconnection at local and regional level, but a particular challenge with coordination at regional, and also between regional and local levels;
- To deliver on the vision and objectives public health strategy needs to inform other strategies under development and sit at the heart of government policy;
- It welcomed Ministerial involvement, and finds a need for strengthened structures at strategic level;
- A "mainstreamed" or whole systems approach in which activity is monitored and evaluated is required;
- It finds opportunities with the establishment of the Public Health Agency (PHA) for improved cohesion and co-ordination.

www.dhsspsni.gov.uk/health_development-final_report_-_september_2010.pdf

About this Framework

1.11 In July 2011 the Health Minister, Minister Poots MLA, sought the agreement of Executive colleagues to develop a successor to Investing for Health in the form of a ten year public health strategic framework which will adopt a "whole-Government approach". Fit and Well – Changing Lives is Northern Ireland's proposed new 10-year public health framework. It is designed to be strategic, providing direction for policies and actions to improve the health and wellbeing of the people of Northern Ireland. It also acknowledges and harnesses the aims and aspirations of related, complementary government strategies (such as those which address the wider determinants of health as well as those

which focus on specific health behaviours) in an outcomes focussed framework.

1.12 On 12 March 2012, the First Minister and deputy First Minister published the Programme for Government (PFG) 2011-2015. The Programme for Government identifies the actions the Executive will take to deliver its number one priority – a vibrant economy which can transform our society while dealing with the deprivation and poverty which has affected some of our communities for generations. A number of the priorities outlined in the PFG acknowledge the interrelationship between health, disadvantage, inequality, the social and physical environment and longer term economic growth.

This framework is also a building block towards the achievement of the priorities identified in the PFG, in particular Priorities 1, 2 and 3-

- Priority1: Growing a Sustainable Economy and Investing in the future
- Priority 2: Creating Opportunities, Tackling Disadvantage and Improving Health and Well-Being
- Priority 3: Protecting our People, the Environment and Creating Safer Communities.

1.13 A clear aim of this framework, reinforced by the outcomes of the Investing for Health Review, must be to secure more coherence cross- departmentally with a clear focus on upstream interventions which will improve health and tackle health inequalities. Importantly however it should also provide strategic direction for work to be taken in support of this at both regional and local levels, with public agencies, local communities and others working in partnership.

1.14 There is now a clearer understanding of the links between mental wellbeing, physical health and the social conditions within which people live. New evidence, for example from Australia, Scandinavian countries and from Sir Michael Marmot's Strategic Review of Health Inequalities in England ("Fair Society, Healthy Lives"), has re-enforced the importance of shared policy goals across government, and the need to consider the potential of policies to impact on health and health inequalities within the population. Also vital are effective local delivery systems which are participatory and which seek to empower individuals and local communities. Importantly, if strategies to tackle health inequalities are to be effective, there needs to be strong connections between regional and local delivery.

Therefore to be effective this strategy will require buy-in from not just Executive departments but, crucially, broad cross-sectoral buy-in at regional and local levels including from key organisations, and from individuals and local communities.

What this Framework seeks to achieve – Vision and Aims

1.15 In 2002 the overarching aims of Investing for Health were:

"To improve the health and well-being status of all our people, and to reduce inequalities in health"

It is proposed that these aims continue to be relevant and that these will remain the aims of this 10-year Public Health Strategic Framework.

Question 1: **Are these aims still valid? If not, what alternatives should be considered?**

Building on these aims, it is proposed that the framework will move NI towards a vision -

> **"Where all people are enabled and supported in achieving their full health potential and well-being."**

This vision is around creating the conditions for individuals and communities to take control of their own lives and requires social action.

Key to achieving a reduction in the significant inequalities in health in Northern Ireland will be to place public health and wellbeing at the heart of decision making about policies and services at regional and local level.

This is also reflective of the new European health policy, Health 2020, which is currently being developed in partnership with Member States, civil society, academic institutions and networks and professional associations.

http://www.euro.who.int/en/what-we-do/event/first-meeting-of-the-european-health-policy-forum/health-2020

http://www.euro.who.int/__data/assets/pdf_file/0007/147724/wd09E_Health2020_111332.pdf

Chapter Two

What Determines our Health?

Introduction

2.1 Health is a multi-faceted concept, and similarly there are many, often inter-related, factors which impact on our health. There is also an imperative to address those health inequalities which currently exist in Northern Ireland. Developing a strategic framework to improve health and to reduce health inequalities therefore has to both acknowledge and understand these factors, and also make sense of the complex inter-relationships involved.

Health and Well-being

2.2 It has been widely accepted since the WHO definition of health was formulated in 1946 that health is more than the absence of disease. ***It is a state of "complete physical, mental and social wellbeing."***

In 1977, WHO Member States added to this concept of health, deciding that the main social target of governments and WHO should be for all citizens of the world to attain by the year 2000 "a level of health which will permit them to lead a socially and economically productive life".

Well-being includes physical, cognitive, social and emotional dimensions and is influenced by development across the life course. Of particular importance to this framework is that as a concept, well-being attracts the commitment of other sectors. ***It is this broad definition of well-being which will be used throughout this document.***

Public Health

2.3 Public Health has been described as:

> "The science and art of promoting health, preventing disease, and prolonging life through the organized efforts of society."

Reference: adapted from the "Acheson Report", London, 1988

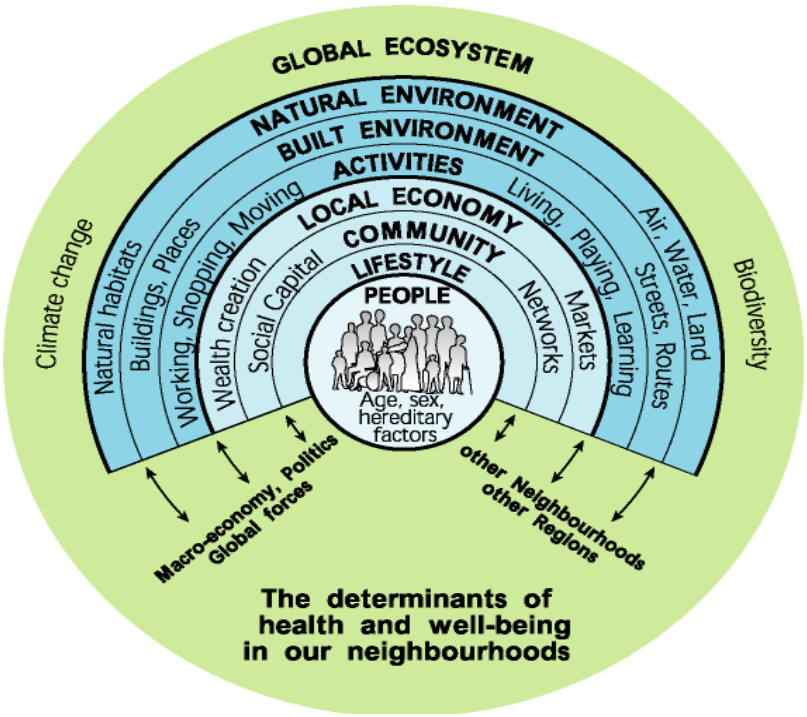
More recently public health has encompassed a comprehensive understanding of the ways in which lifestyles and living conditions determine health status, and a recognition of the need to mobilise resources and make sound investments in policies, programmes and services which create, maintain and protect health by supporting healthy lifestyles and creating supportive environments for health.

Social Determinants of Health

2.4 An individual's health is determined first of all by individual factors such as age, gender and genetic makeup. These factors are modified by the individual's lifestyle. In turn lifestyle and health are influenced by the condition of the environment in which they live. Beyond this health is influenced by the

community and social conditions and these are influenced by the wider political and economic circumstances.

This is illustrated in the figure below:



Reference: Barton H., and Grant M – a health map for the local human habitat. Journal of the Royal Society for the Promotion of Health, 126(6).

The table below provides a summary of the determinants and their relationship to health.

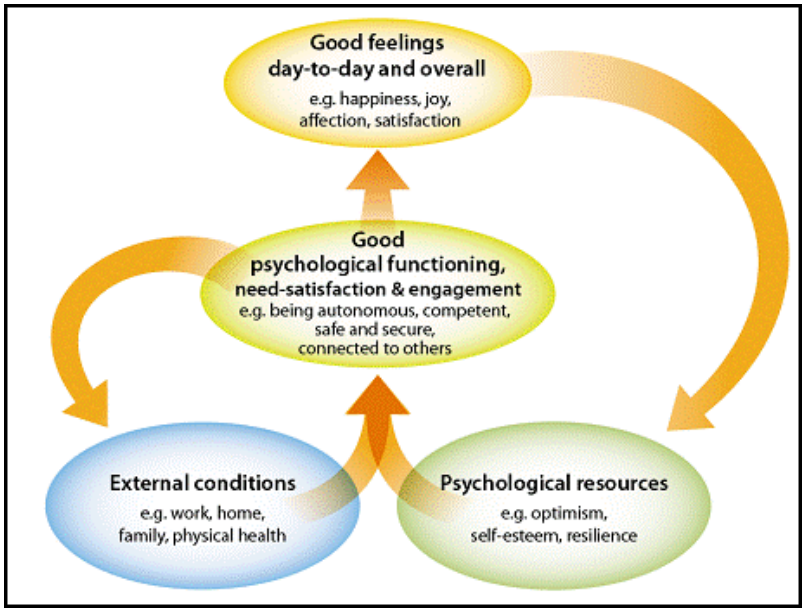
Summary of Determinants of Health

Determinant	Impact on health
Genetics	Inheritance plays a part in determining lifespan, healthiness and the likelihood of developing certain illnesses.
Gender and age	Men and women suffer from different types of diseases at different ages
Personal behaviour and coping skills	Balanced eating, keeping active, smoking, drinking, and how we deal with life's stresses and challenges all affect health. However lifestyle choice is also impacted upon by social environment and circumstances.
Social support networks	Greater support from families, friends and communities is linked to better health. The links that connect people within communities (described as social or community capital) can provide a source of resilience through social support. People's participation in communities and the added control over their lives that this brings, has the potential to contribute to well-being and other health outcomes.

Culture	Customs and traditions, and the beliefs of the family and community all affect health.
Education and early life	Low education levels are linked with poor health, more stress and lower self-confidence. There is a strong relationship between socio-economic background and educational attainment levels. Educational attainment for both women and men directly contributes to better health and the ability to participate fully in a productive society, and creates engaged citizens.
Income and social status	Higher income and social status are linked to better health. There is strong nternational evidence that *the* key social determinant is poverty or deprivation. World Health Organisation (WHO) asserts that poverty is the single largest determinant of health, and ill health is an obstacle to social and economic development. Poorer people live shorter lives and have poorer health than affluent people – this is a pattern repeated in many countries, including in Northern Ireland. Deprivation also influences health and wellbeing in many ways, such as lack of social support and low satisfaction with the neighbourhood, feelings of financial strain, low self esteem, unhealthy lifestyle choices and risk taking behaviour, poor access to health information and quality services.
Economy, Employment and working conditions	Unemployment has a significant adverse effect on both physical and mental health. Unemployed people and their families suffer a substantially increased risk of premature death. They have more serious chronic illnesses, greater prevalence of disability and suffer more psychological illness, stress and anxiety. Unemployed people are less likely to have strong support networks. Long term unemployment increases the risk of self-harm, suicide and attempted suicide and has a negative effect on the health of children. Children with no parent in paid employment are more likely to have serious chronic illnesses. Childhood poverty and parental unemployment have an enduring effect on health over the life course. Being in good, safe and sustainable employment is protective of health.
Health services	Access to and use of services that prevent and treat disease influences health
Physical, including built environment	Safe water and clean air, healthy workplaces, safe houses, communities and roads, access to green spaces all contribute to good health. Housing design and infrastructure planning that take account of health and well-being (e.g. insulation, ventilation, public spaces, refuse removal, etc.) and involve the community can improve social cohesion and support for development projects. Well-designed, accessible housing and adequate community services address some of the most fundamental determinants of health for disadvantaged individuals and communities.

A dynamic model of well-being

2.5 Researchers have attempted to measure well-being in many ways. In 2008 New Economics Foundation developed a conceptual model of well-being and its determinants (as part of the Government Office for Science's *Foresight Project on Mental Capital and Well-Being)*. This integrates the different approaches, and an adapted version of this model is presented below.



The model describes how an individual's external conditions (*bottom left*) – such as their income, employment status, housing and social context – act together with their personal resources (*bottom right*) – such as their health, resilience and optimism – to allow them to function well (middle) in their interactions with the world and therefore experience positive emotions (*top*).

Health Inequalities

2.6 People in different social circumstances experience avoidable differences in health, wellbeing and length of life - inequalities in health arise because of inequalities in society. This has also been described as the "health gap" (between rich and poor.) In Northern Ireland this has been used to refer to the difference in health status between those living in the most deprived areas compared to the NI average. A more detailed description of the health inequalities gap is provided in Chapter 4, but in summary, the last ten years has not seen a noticeable narrowing of this gap in Northern Ireland.

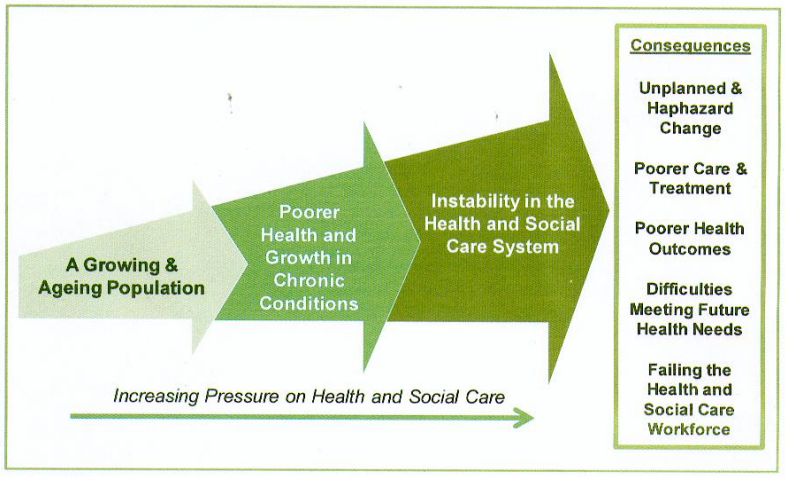
2.7 By their very nature the social determinants, as discussed previously, are not exclusive to health – poverty for instance is a key determinant for poor education outcomes, as well as poor health, and perhaps linked to a greater propensity to be involved in criminal behaviour.

Conversely population health is a determinant for other social outcomes, for example, if efforts can be applied in ways that secure good health and wellbeing this in turn can lead to social and economic benefits for society as a

whole – for example economic growth improves health, but improved health also significantly enhances economic productivity and growth. At the same time the aim of a fair distribution of health and wellbeing resonates with those of sustainable development, tackling poverty, building strong communities, raising educational attainment levels etc.

Health Systems

2.8 The capacity and efficiency of health systems must also be seen as an important health determinant. This Framework acknowledges that the strengthening of health systems and improvements in the ways that these systems work are of vital importance and will make a growing contribution to health and well-being, as technologies improve. Within Northern Ireland the report, *Transforming Your Care*, published in December 2011, clearly set out the current and future challenges to the health system and argued strongly the case for change. The diagram below shows the pressures on the health system identified by the Report and the likely consequences if no changes were made.



Marmot Review

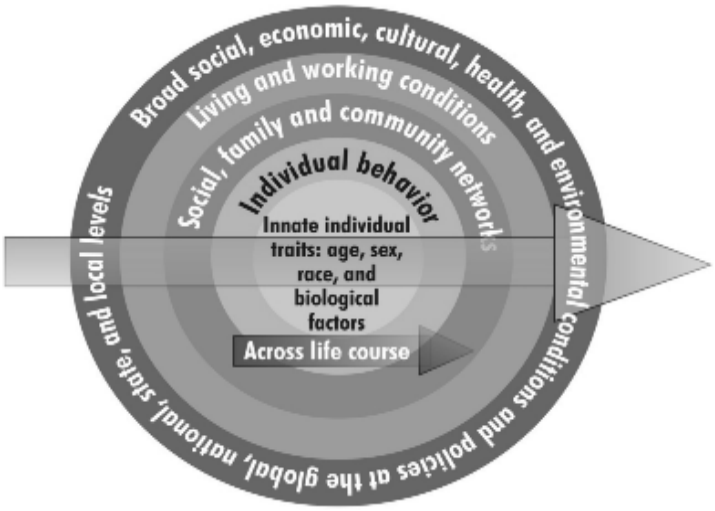
2.9 The Marmot Review into health inequalities in England. ("Fair Society, Healthy Lives" – A Strategic Review of Health Inequalities in England 2010) demonstrated that much of the incidence of premature death or illness is preventable, and it presented a substantial body of evidence locally, regionally and globally on health inequalities, including on effective interventions, which reinforces the argument that addressing this issue requires co-ordinated action across the social determinants of health.

The review also put forward some additional key perspectives which directly inform this framework. (A summary of the Marmot report is at Annex A, and a link to the report is below.)

http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review

Life Course Approach

2.10 Inherent within the Marmot Report was the prominence given to the impact of the determinants of health across the life course. Six cross-cutting policy recommendations were made, with a life course approach being central to the review, focusing on the conditions in which people are born, grow, live, work and age. The report therefore argues that action to reduce health inequalities must start before birth and be followed through the life of the child, if the close links between early disadvantage and poor outcomes throughout life are to be broken. For this reason "giving every child the best start in life" is the report's highest priority recommendation.



Source: Adapted from Healthy People 2020

Each of life's transitions can affect health by moving people onto a more or less advantaged path; however people who have been disadvantaged in the past are at greater risk. Disadvantages tend to congregate among the same people and their effects accumulate through life and are passed on from generation to generation.

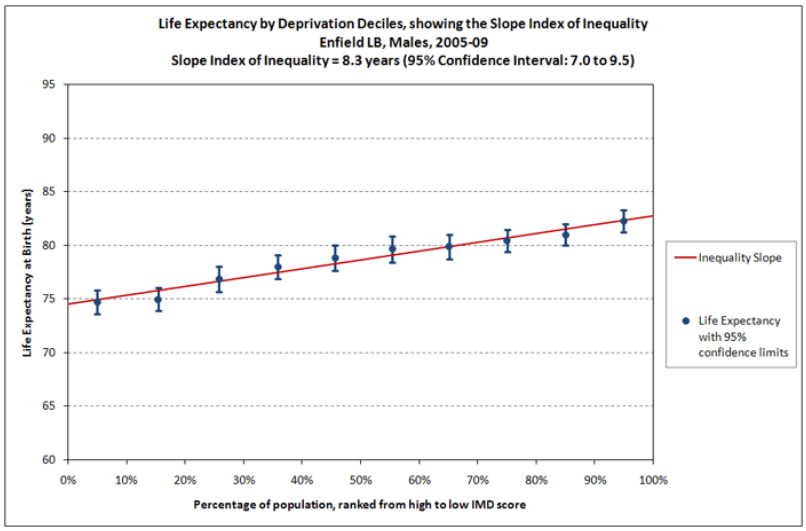
In support of this C.Hertzman (Hertzman and Power 2004) outlines three health effects that have relevance for a life-course perspective.

- Latent effects are biological or developmental early life experiences that influence health later in life. Low birth weight, for instance, is a reliable predictor of incidence of cardiovascular disease and adult-onset diabetes in later life. Experience of nutritional deprivation during childhood has lasting health effects.
- Pathway effects are experiences that set individuals onto trajectories that influence health, well-being, and competence over the life course. As one example, children who enter school with delayed vocabulary are set upon a path that leads to lower educational expectations, poor employment prospects, and greater likelihood of illness and disease across the lifespan. Deprivation associated with poor-quality neighbourhoods, schools, and housing sets children off on paths that are not conducive to health and well-being.

- Cumulative effects are the accumulation of advantage or disadvantage over time that manifests itself in poor health. These involve the combination of latent and pathways effects. Adopting a life-course perspective directs attention to how social determinants of health operate at every level of development—early childhood, childhood, adolescence, and adulthood—to both immediately influence health and provide the basis for health or illness later in life.

Disadvantage and the Social Gradient

2.11 The Marmot Review highlighted that variation in health status is not only evident at the extreme ends of the socioeconomic spectrum but follows a gradient, with overall health tending to improve with each step up the socioeconomic ladder. This social gradient of health runs across society and, while the most profound differences in health can be seen between the most and least disadvantaged, the gradient exists across the population.



2.12 To reduce the steepness of the gradient the Marmot report argued that, while greater intensity of action is likely to be needed for those with greater social and economic disadvantage, actions must be universal but with a scale and intensity proportionate to the level of disadvantage. This is known as proportionate universalism.

2.13 Of relevance to this is the acknowledgement that tackling the determinants of health does not automatically tackle the determinants of health inequalities. It has been argued [Ref: Healthcare Commission - Evidence of Health Inequalities: Raleigh & Polato 2004] that health promotion initiatives and improvements in technology and service delivery can increase inequalities because higher social classes are more likely to avail of them. Policies that have achieved overall improvements in key determinants like living standards and smoking have often increased inequalities in these major influences on

health. It is therefore important to distinguish between the overall *level* and the *social distribution* of health determinants and interventions.

Chapter Three

What are the wider Public Policy Influences?

International Context

Recognition globally of the interaction between the social determinants and health and wellbeing has led for many decades to a call for greater consideration of health in the development of wider public policy.

The World Health Organisation Commission on the Social Determinants of Health

3.1 The World Health Organisation Commission on the Social Determinants of Health completed a two-year investigation into the social causes of health inequalities in 2008 (CSDH 2008). The report concluded that health inequalities cannot be fully explained by poverty or variation in income alone. In addition to these factors, the Report concluded that health inequalities are caused by inequitable distribution of more fundamental social, political and economic forces, the 'social determinants of health'.

3.2 A central precept of CSDH is that health depends on many factors and policies that are outside of the remit of health ministries. The CSDH made a large number of recommendations for government action at different levels: to improve basic living conditions, health services, education, and working conditions; to reduce inequalities in power and resources; and to create transparency by monitoring and measuring inequalities in health.

Rio Political Declaration on Social Determinants of Health

3.3 Invited by the World Health Organization, Heads of Government, Ministers and government representatives came together in October 2011 in Rio de Janeiro to express their determination to achieve social and health equity through action on social determinants of health and well-being by a comprehensive inter-sectoral approach. At the meeting member states reiterated their determination to take action on social determinants of health as collectively agreed by the World Health Assembly and reflected in resolution WHA62.14 ("Reducing health inequities through action on the social determinants of health").

3.4 The meeting resulted in a declaration which identified five key action areas critical to addressing health inequities:

(i) to adopt better governance for health and development;
(ii) to promote participation in policy-making and implementation;
(iii) to further reorient the health sector towards reducing health inequities;
(iv) to strengthen global governance and collaboration; and
(v) to monitor progress and increase accountability.

Health 2020

3.5 Currently an updated EU framework for public health**, Health 2020,** is being developed. Health 2020 is a joint project between the WHO Regional Office for Europe and the 53 European Member States.

3.6 Health 2020 will reflect a renewed commitment to public health, with a considerable emphasis on prevention, while at the same time advocating for stronger health systems and the appropriate development of national health policies and strategies.

3.7 A key element in bolstering public health is to integrate its principles and services more systematically into all parts of society through increased **whole-of-government and intersectoral working**, through **a "Health in All Policies**" approach, and through participation, transparency, communication and accountability.

3.8 Health 2020 argues strongly, supported by WHO, that all parts of government need to work together to recognize risk patterns and identify solutions, act through multiple levels, and share responsibility across policy fields and sectors. These issues are considered in more detail later in the framework.

National Context

Healthy Lives, Healthy People

3.9 At a UK level there is generally a movement towards strengthening public health across national and local government levels.

3.10 The white paper: Healthy lives, healthy people – our strategy for public health in England, published in November 2010, aims to create a 'wellness' service (Public Health England) and to strengthen both national and local leadership. In response to Sir Michael Marmot's report it outlines the cross-government framework that will enable local communities to reduce inequalities and improve health at key stages in people's lives.

3.11 DOH is working collaboratively with business and the voluntary sector through the "Public Health Responsibility Deal" to promote, for example, socially responsible retailing, better information for consumers about food etc. Some of these initiatives may also benefit Northern Ireland and other UK countries. DOH has also recently published a Public Health Outcomes framework to guide regional and local action.

Children's Environment and Health Strategy for the UK

3.12 At the fourth World Health Organization (WHO) conference on environment and health in 2004, ministers from the countries across the WHO European Region, including the UK, agreed to the development of the Children's Environment and Health Action Plan for Europe (CEHAPE). This plan commits countries to the development of national Children's Environment and

Health Action Plans to protect the health of children and young people from environmental hazards. CEHAPE consists of four Regional Priority Goals covering: water, sanitation and health; accidents, injuries, obesity and physical activity; respiratory health, indoor and outdoor air pollution; and chemical, physical and biological hazards (Children's Environment and Health Action Plan for Europe, WHO Europe, June 2004).

3.13 To meet the UK commitments to CEHAPE a Children's Environment and Health Strategy (CEHS) has been prepared in order to provide an overview of current activities in the UK, make recommendations on the measures necessary to improve children's and young people's health by improving their environment, and to encourage a coherent cross-government approach to these issues. (A Children's Environment and Health Strategy for the UK, Health Protection Agency, March 2009).

NI Policy Context

3.14 A number of the priorities outlined in the **Programme for Government** (PFG) 2011-2015 – Building a Better Future acknowledge the interrelationship between health, disadvantage, inequality, the social and physical environment and longer term economic growth.

3.15 This framework is also therefore a building block towards the achievement of a number of the priorities identified in the PFG. For these priorities to be achieved there will need to be effective interaction at strategic and delivery levels between this public health framework and other key government strategies which impact on the social determinants, communities and particular population groups, eg strategies and action plans on Sustainable Development, Economy and Employment, Poverty, Education, Urban Regeneration and Neighbourhood Renewal, Rural Development, Community Safety and Reducing Offending, Delivering Social Change, Children and Young People's strategy, Older People's strategy etc. In a complex policy field consideration will also need to be given to connecting governance arrangements.

Chapter Four

What are the Health Challenges for Northern Ireland?

There have been some improvements in the state of our health in Northern Ireland – over time people generally have been able to enjoy major social, economic and health improvements that have meant being healthier and living longer than ever before.

Whilst this improvement is welcome we face a raft of significant and growing pressures which we must plan for and address – this chapter illustrates some of these challenges.

1. Current Trends

Demography

The demographic make-up of our community is changing. We have a growing and ageing population, and we face a growth in chronic conditions.

NI currently has a population of 1.8 million people. This is the fastest growing population in the UK and it is continuing to grow. In 2010, 21.2% of the population was aged under 16 years old, while 14.5% were aged 65 years or older.

It is estimated that by 2020 the number of people 75 years old and over will increase by almost a third and those over 85 by 51% compared with 2010 levels – indeed by 2014, it is estimated that the number of 85 year olds will have increased by almost 20%.

All of this brings the potential for increased demand on treatment and care services, and in a time of severe financial constraint makes it even more difficult, but pressing to invest in prevention.

Age Distribution

There are also significant demographic differences within the region which can put disproportionate pressure on local economies, public services and communities to respond in ways that promote health.

Figure 1 – Map of NI population 2010 - % of population aged under 5 years (LGD)

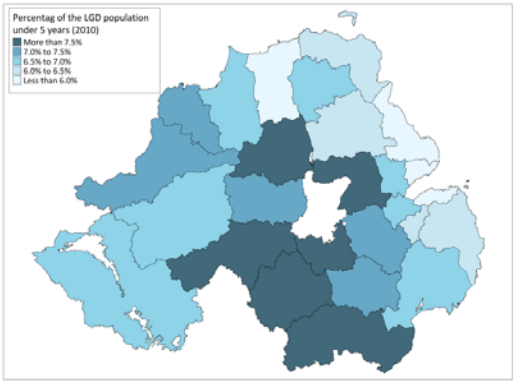
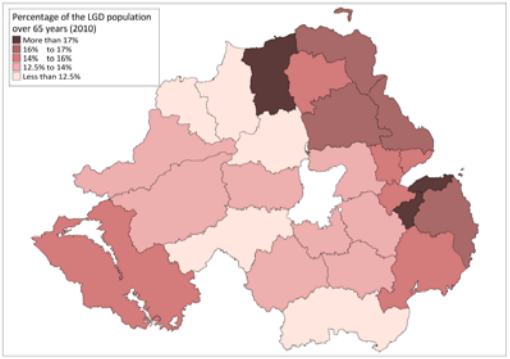


Figure 2 – Map of NI population 2010 - % of population aged over 65 years (LGD)



Figures 1 and 2 above provide illustrations of the diversity of age distributions at local levels, showing the proportion of the population in each Local Government District (LGD) that were young children (i.e. aged under 5 years old) and those in their later years (i.e. aged 65 years and over) in 2010. Comparing these maps together shows that Newry and Mourne, Dungannon and Magherafelt LGDs had both a higher proportion of young children (greater than 7.5%) and a lower proportion of older people (less than 12.5%), while North Down and Coleraine LGDs had a lower proportion of young children (less than 6%) and a higher proportion of older people (greater than 17%). These factors bring particular local service demands for childcare, education and housing, all of which are fundamentals for good health and wellbeing.

Migration

In addition to age trends, a further demographic trend is the balance between outward and inward migration. The period since 2004 has seen population growth with immigration exceeding emigration. The scale of this, however, has fallen in recent years from 32,300 people coming to live in Northern Ireland in 2006-7 to 23,500 people in 2008-9, leading to overall net migration (immigration minus emigration) falling.

Overall migration trends vary - Health Service registrations show that in some parts of particularly Belfast and Dungannon Local Government Districts, immigrations last year exceeded 1 in 20 of the resident population. The percentage of residents with an A8* background ranges from 8% in Dungannon LGD to less than 0.5% of the population in Larne LGD. The Labour Force Survey estimates that there are 80,000 persons who were born outside the UK and Ireland living in Northern Ireland in 2010.
(A8* countries include Czech Republic, Estonia, Hungary, Latvia, Poland, Slovakia, Slovenia)

In 2009, just under 1 in 10 births here (2,300 births out of 24,900) were to mothers born outside the UK and Ireland, compared to 3% of births in 2001 (700 births out of 22,000). Figures for 2010 are likely to be similar to those of 2009. The 2010/11 School Census shows that 3.3% of primary and 1.7% of post-primary school pupils have English as an additional language.

Population Health

Life Expectancy

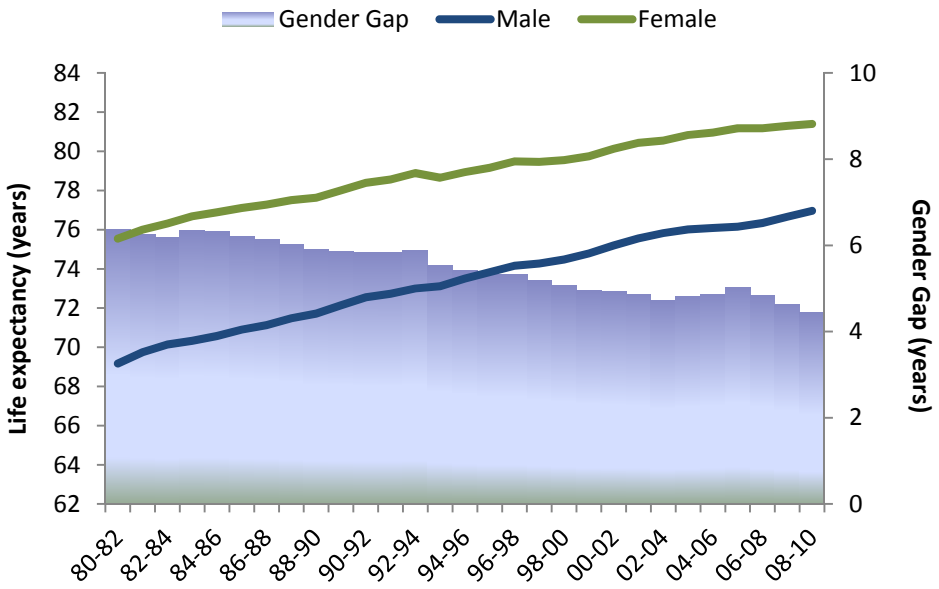
	Males	Females
Northern Ireland	77.0	81.4
England	78.4	82.4
Scotland	75.8	80.3

Wales	77.5	81.7
UK	78.1	82.1

Fig 3 - Life expectancy at birth in the UK, 2008-10

Life expectancy is used internationally as a measure of population health. Life expectancy in NI was lower than in the rest of the UK, with the exception of Scotland. Males and females in NI could expect to live 1.4 and 1.0 years less on average than their counterparts in England respectively.

Figure 4 - NI Period life expectancy at birth 1981 to 2009 by gender



Life expectancy between 1980-82 and 2008-10 increased steadily for both males and females by almost 8 and 6 years. Female life expectancy has consistently been higher than that for males however as male life expectancy has grown at a faster rate since 1981, **the gender gap has declined from 6.4 years to 4.4 years in 2009.** Life expectancy here is projected to continue to increase to around 86 years for males and 90 years for females by 2059.

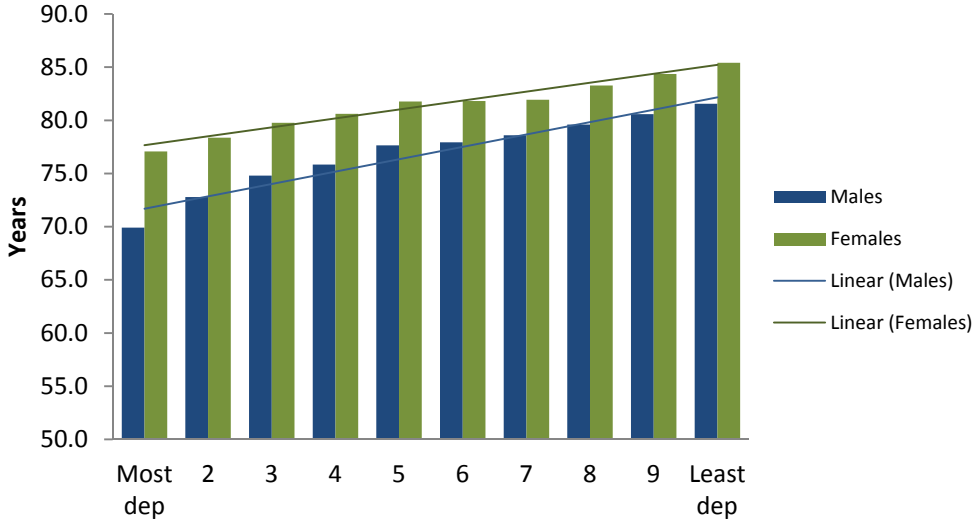
Gap in Life Expectancy

While there are some signs of general improvement, not everyone has been able to avail fully of the benefits of this progress. Unfortunately, social inequality has endured to the extent that health outcomes for some groups remain poorer than for others, and smoking, obesity, misuse of drugs and alcohol, teenage conception rates, poor mental health are disproportionally concentrated amongst particular deprived groups.

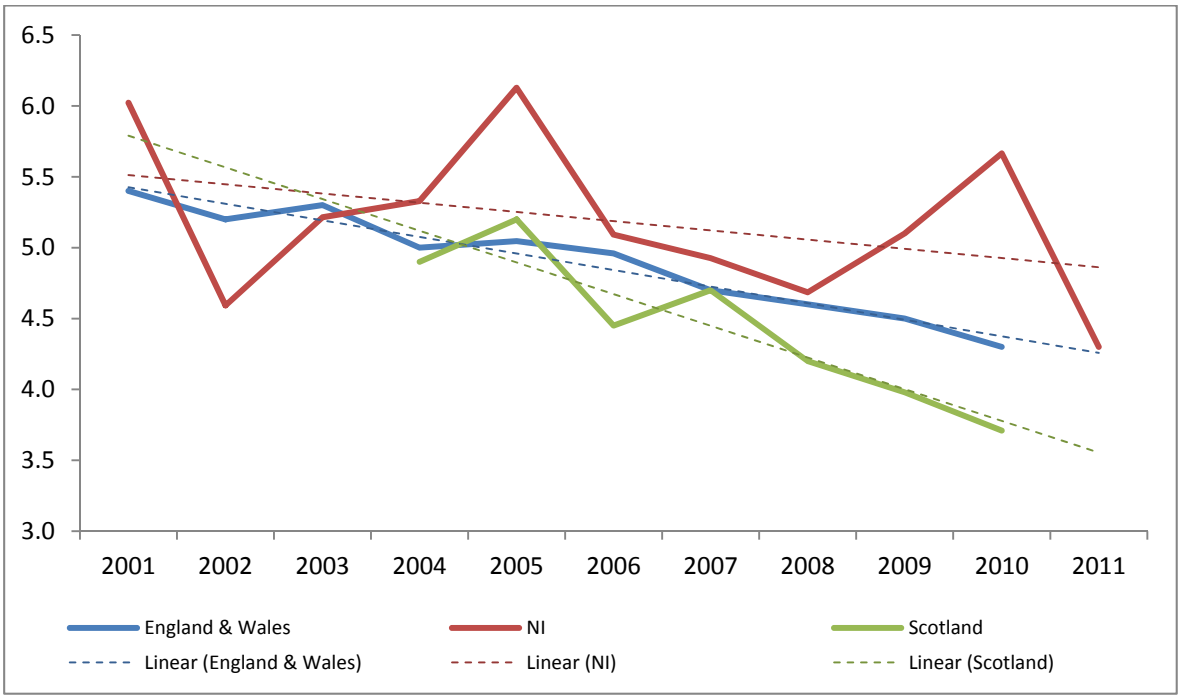
The influence of social conditions and lifestyle behaviours is evident when we compare life expectancy and other health outcomes across geographical areas and population groups.

For example, males living in the 10% least deprived areas in NI could expect on average to live almost **12 years** longer than their counterparts living in the 10% most deprived areas. For females, the gap is more than **8 years**. Figure 5 below shows life expectancy at birth by deprivation decile. For females the scope of inequalities in life expectancy across the population is lower than for males which is evidenced by the steeper gradient across the deciles for males.

Figure 5- Life expectancy by Deprivation decile 2008-10



Infant Mortality



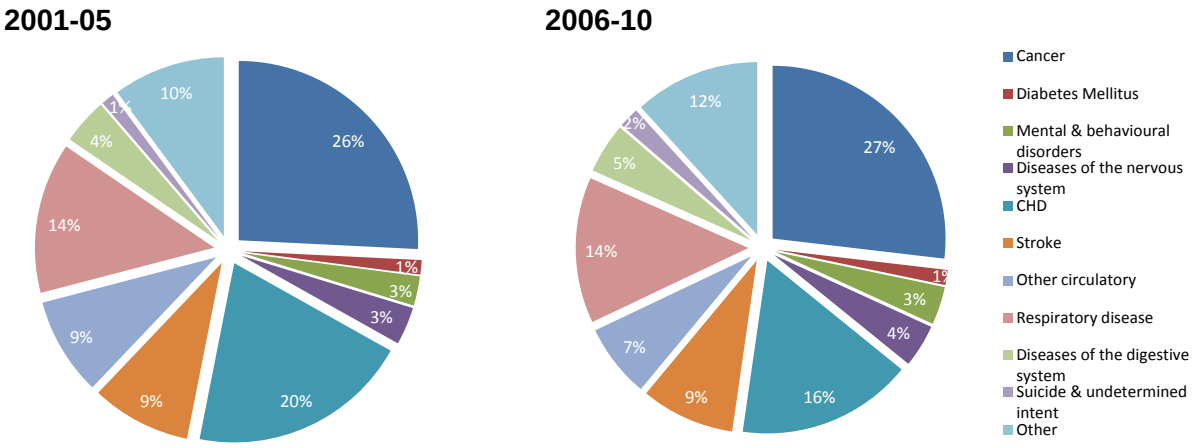


Fig 6 – UK Infant Mortality Rates (2001–2011)

Infant mortality rates are key measures of health outcomes. Infant mortality rates (the number of children dying before their first birthday per 1,000 live births) have fallen across the UK in recent years. Despite sizeable year-on-year fluctuation in the NI rate, it can be seen to be generally improving however at a slower than in the rest of the UK. Provisional figures for 2011 show 110 infant deaths in NI which shows a marked improvement from the 360 infant deaths that occurred in 1981.

Figure 7 - Cause of death 2006-10

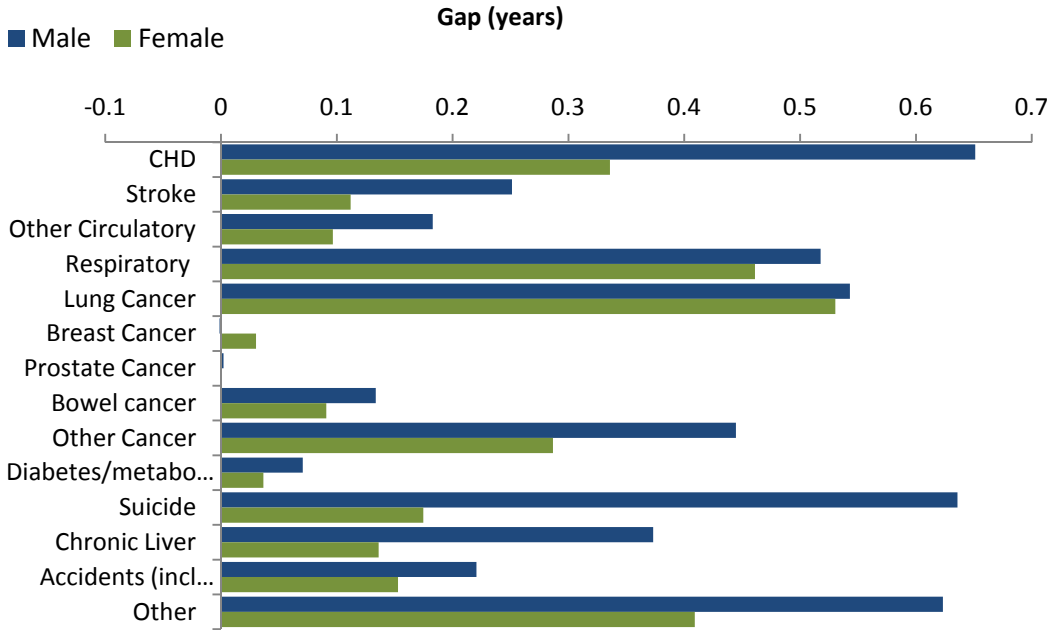
Causes of Death

Coronary Heart disease (CHD), cancer and respiratory disease continue to be the main causes of death for both sexes. Many of these deaths occur before 65 years of age and are potentially preventable, since smoking, unhealthy diet, raised blood pressure, diabetes and physical inactivity are major contributors to a large proportion of these conditions.

Figure 7 shows the proportions of deaths that are attributed to different causes of mortality. Around a third of all deaths that occurred in 2006-10 were due to circulatory disease with half of these deaths due to CHD. Cancer accounted for more than a quarter of deaths that were registered during 2006-10. Deaths due to respiratory diseases accounted for a further one in seven deaths during the period.

The most noticeable change in the distribution of deaths for 2001-05 and 2006-10 is the relative decline in the proportion of deaths due to circulatory disease (most notably, CHD). There were relative increases in the proportion of deaths due to cancer, suicide, digestive system disease and diseases of the nervous system. A reduction in mortality due to circulatory disease was the main reason why life expectancy improved for both males and females between 2001-03 and 2006-08.

Fig 8 Decomposition of the Life expectancy gap between the most deprived areas and NI overall 2006-08



The figure above illustrates the breakdown of the reasons for the life expectancy gap between the most deprived areas and the overall NI average in 2006-08. The male life expectancy gap can be explained mostly by higher mortality rates in the most deprived areas for CHD, suicide, lung cancer, respiratory disease, chronic liver disease and other cancers. Similarly the female gap was mostly due to higher mortality in the most deprived areas due to lung cancer, respiratory disease, CHD and other cancer.

Cancer and Chronic Conditions

Figure 9 – Standardised Death Rate (SDR) due to cancer for population aged under 75 years by Deprivation Decile, 2005-09

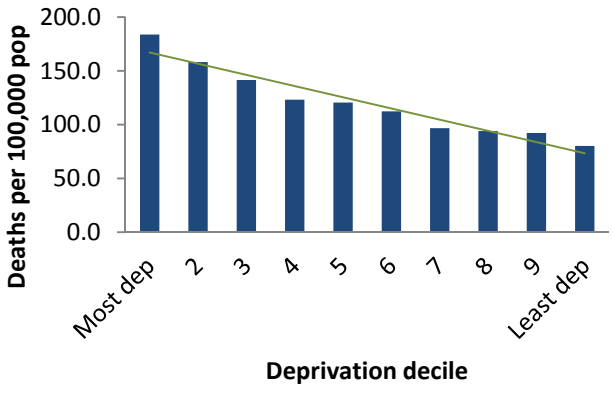


Figure 10 – Standardised Death Rate (SDR) due to lung cancer for population aged under 75 years by Deprivation Decile, 2005-09

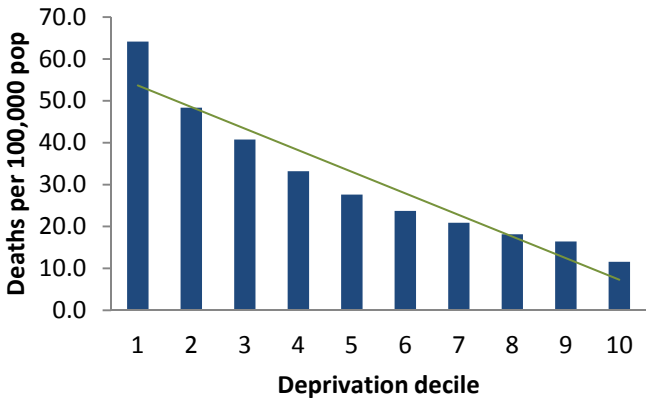


Figure 11 – Standardised Death Rate (SDR) due to circulatory disease for population aged under 75 years by Deprivation Decile, 2005-09

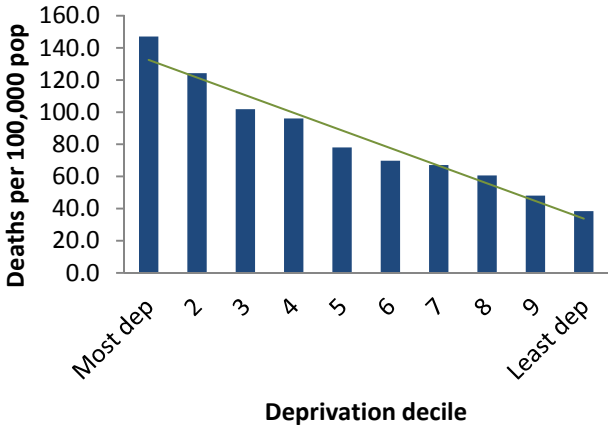
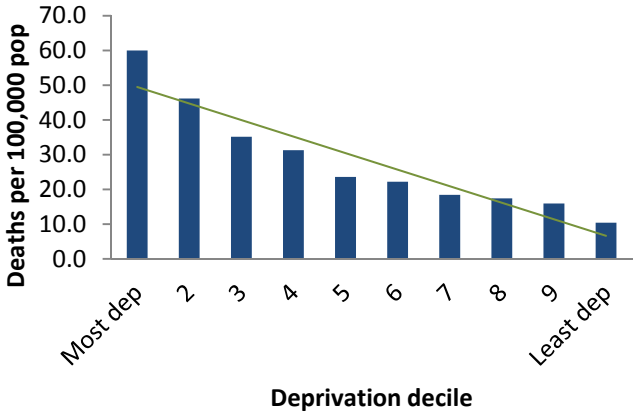


Figure 12 – Standardised Death Rate (SDR) due to respiratory disease for population aged under 75 years by Deprivation Decile, 2005-09



The graphs above illustrate the social gradient in relation to death rate under 75 due to cancer, lung cancer, circulatory disease and respiratory disease for the period 2005 – 09.

- Cancer related mortality in the most deprived decile was more than twice that in the least deprived and **one and a half times** that in NI as a whole
- Lung cancer related mortality in the most deprived decile was **five and a half times** that in the least deprived
- Death rate for circulatory disease in the 10% most deprived areas was nearly **four times** that experienced in the 10% least deprived areas
- Death rate for respiratory disease in the most deprived decile was nearly **six times** that in the least deprived.

Behaviours

Figure 13 - Smoking prevalence by age and sex

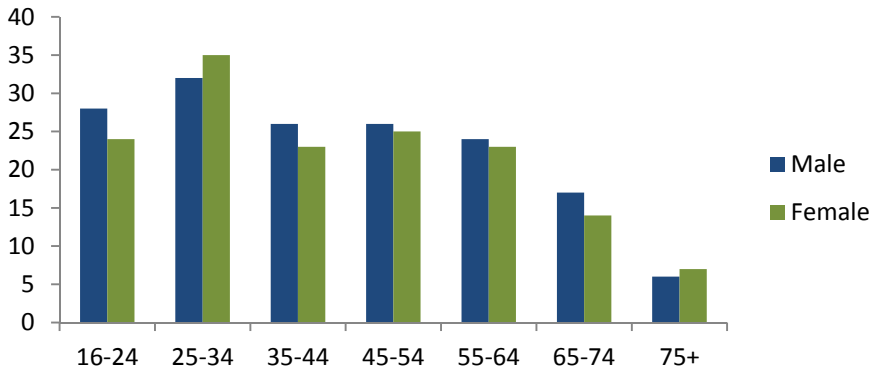


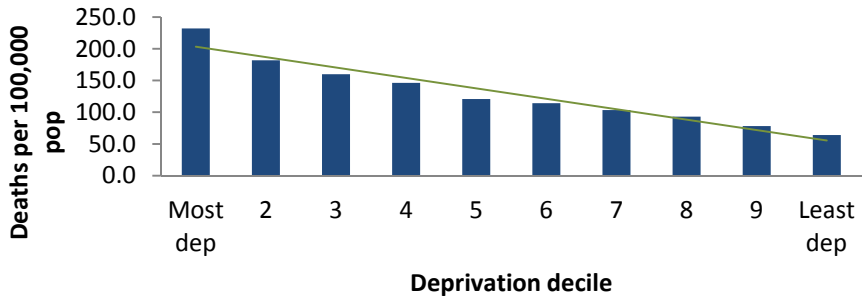
Figure 12

Source: Health Survey for Northern Ireland 2010/11

Over the past ten years we have made many inroads into reducing the harm caused by smoking, with latest figures showing that adult smoking prevalence is currently 24% (300,000 of adult population, down from 27% in 2000/01) - 25% of males and 23% of females. Smoking prevalence was highest amongst the 25-34 age-group at 34% and lowest amongst those aged 75 and over at 7% (Figure 12). Around 8 in 10 current smokers have tried to quit smoking at some stage.

Smoking rates are highest among people who earn the least and lowest amongst those on higher incomes, for example while smoking prevalence amongst the general population is now 24%, amongst manual workers it remains high at 31%.
Smoking remains the single greatest cause of preventable death and is one of the primary causes of health inequality in Northern Ireland, causing over 2,300 deaths a year (almost one third of which are from lung cancer). This equates to almost 7 people a day, 48 individuals every week.

Figure 14 – Standardised Death Rate (SDR) due to smoking related causes by Deprivation, 2005-09

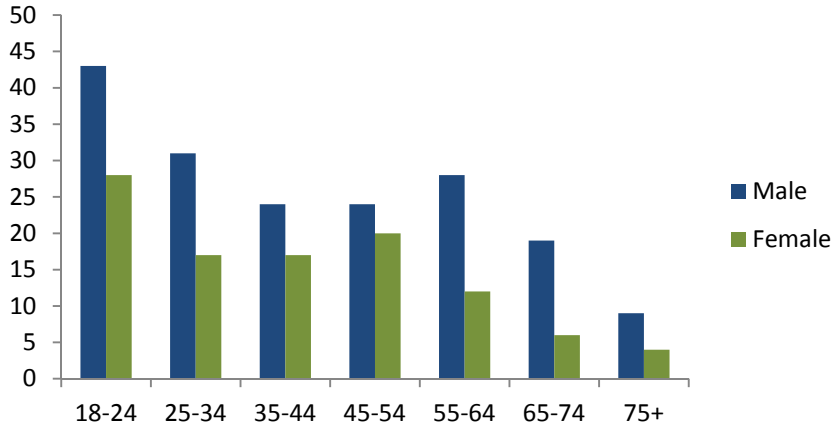


The SDR for smoking related causes in areas within the most derived decile was nearly **four times** that in the least deprived. Smoking related mortality generally decreased as the level of deprivation in an area also decreased.
The total Northern Ireland hospital costs of treating smoking related diseases is in the region of £119m per annum (2008/09).

Reducing smoking rates in our more disadvantaged communities represents one of the greatest challenges in public health, but is vital if we are to make progress on closing the inequalities gap in health.

Alcohol and Drugs

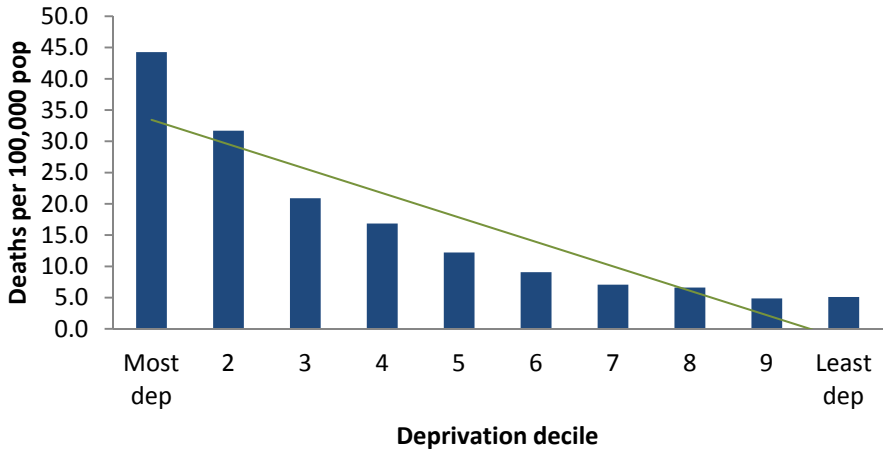
Figure 15 – Respondents drinking above weekly limits by age and sex



Source: Health Survey for Northern Ireland 2010/11

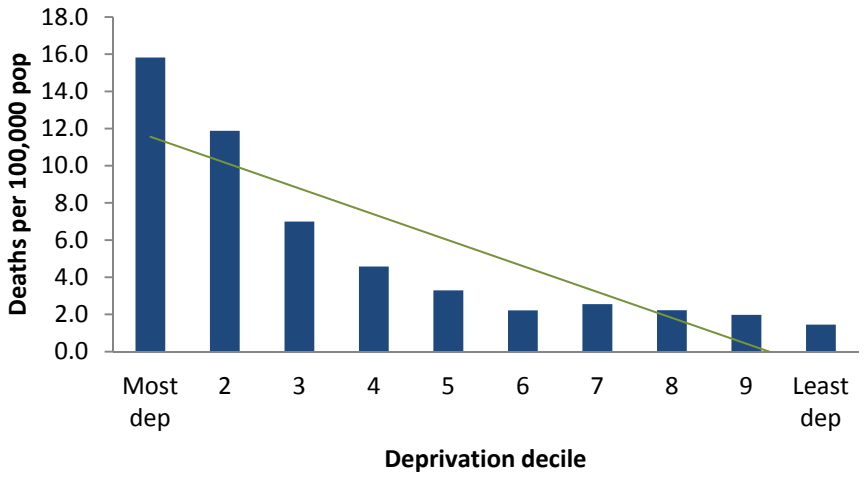
Seventy-seven percent of respondents to the 2010/11 HSNI, aged 18 and over, indicated that they drink alcohol (81% of males and 74% of females). Of all respondents aged 18 and over, 20% reported drinking in excess of the weekly drinking limits. Around a quarter of males (27%) drank above weekly limits compared with 16% of females (Figure 15).

Figure 16 – Standardised Death Rate (SDR) due to alcohol related causes by Deprivation Decile, 2005-09



Alcohol related mortality in the 10% most deprived areas was almost **nine times** that in the 10% least deprived areas.

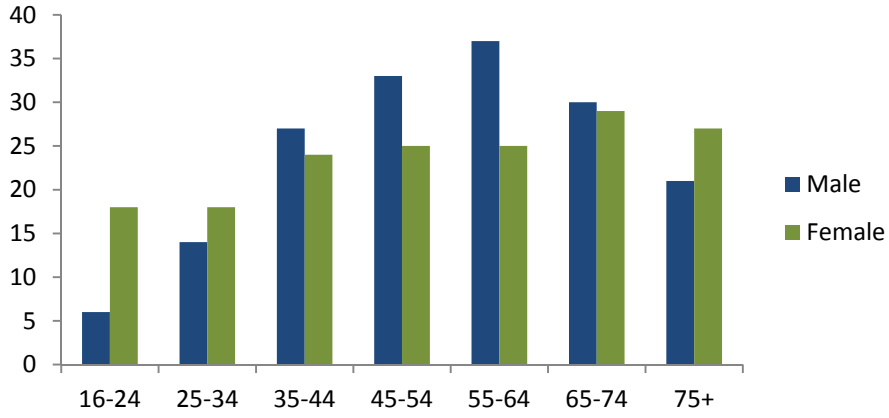
Figure 17 – Standardised Death Rate (SDR) due to drug related causes by Deprivation Decile, 2005-09



A similar pattern to alcohol related mortality occurs when looking at drug related mortality although the overall number of deaths is lower. The death rate in the 10% most deprived areas was more than **eleven times** that in the least deprived decile. Drug related mortality was generally higher for males than females across the social gradient. Results from the All- Ireland Drug Prevalence Survey showed that illegal drug use was lowest in the managerial and professional occupations and intermediate professions while it was highest in semi-routine and routine occupations, never worked/long term unemployed and the not classified groups.

Obesity and Overweight

Figure 18 – Obesity levels by age and sex



Source: Health Survey for Northern Ireland 2010/11

Fifty-nine percent of adults measured were either overweight[1] (36%) or obese[2] (23%). A similar proportion of males and females were obese however males were more

[1] In adults, a Body Mass Index of between 25 and 29.9kg/m^2 is considered overweight.
[2] A Body Mass Index of 30kg/m^2 or above is considered obese.

likely to be overweight (44%) than females (30%). Obesity was more prominent amongst the middle and older age-groups than younger age-groups. A quarter of those aged 35-44 were classified as obese and around 30% of those in the 45-54, 55-64 and 65-74 age-groups, compared with 12% of 16-24 year olds and 16% of 25-34 year olds (*Figure 18*).

In relation to children, aged 2-15 years, 8% were assessed as being obese based on the International Obesity Task Force guidelines, 8% of boys and 9% of girls.

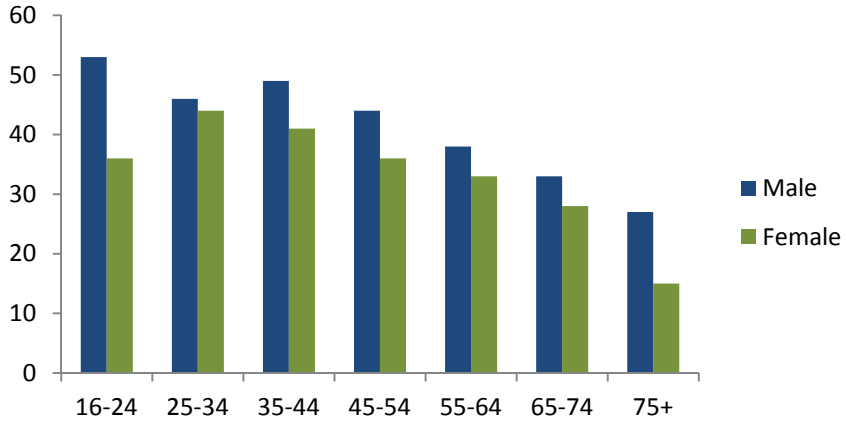
Evidence indicates that being obese can reduce life expectancy by up to 9 years and can affect emotional psychological wellbeing and self- esteem.

Rates of obesity tend to rise in association with increasing social disadvantage in developed countries, although the pattern is considerably more marked among women than men. For example in women rates of overweight and obesity in England show a consistent rise with increasing social disadvantage, from 19% in the managerial and professional group to 29% in the routine and semi – routine group. For men the differences in the rates of obesity between different groups are less marked.

Physical Activity

Being physically inactive is an independent risk factor for coronary heart disease (CHD) and for Type 2 diabetes, obesity and high blood pressure.

Figure 19 - Respondents meeting the recommended physical activity levels by age and sex



Source: Health Survey for Northern Ireland 2010/11

Thirty-eight percent of respondents to the Health Survey were classified as meeting the recommended level of physical activity[3], with males (44%) more likely than females (35%). The proportion of respondents meeting the recommended level of physical activity varied by age, ranging from 19% amongst those aged 75 and over to 45% of those in the 25-34 age-group (*Figure 19*).

[3] The Chief Medical Officer issued guidelines on the amount of physical activity a person should do to achieve a healthy lifestyle. During the fieldwork of the 2010/11 HSNI, the recommended guidelines for adult physical activity were 30 minutes of moderate activity on at least 5 days a week.

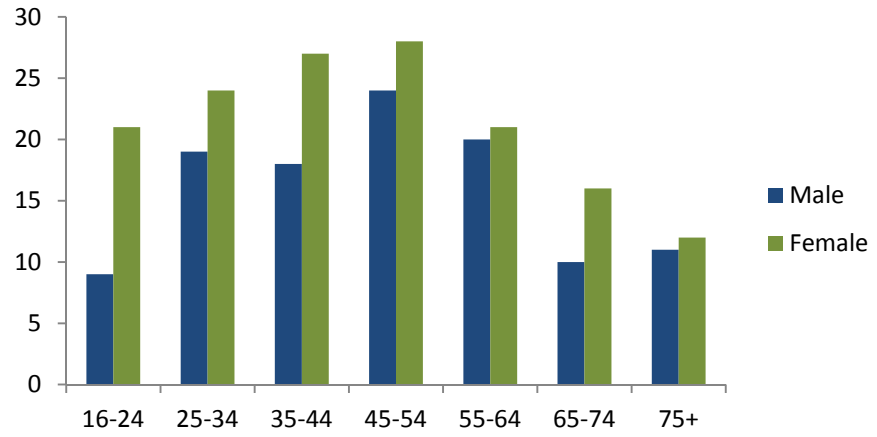
Food and Nutrition

Whilst 86% of respondents to the Health Survey said they were aware of the Department of Health advice to have at least 5 portions of fruit or vegetables each day, the proportion of respondents assessed as meeting this guideline was 33%. Females were more likely to be meeting this guideline than males (36% and 27% respectively). In relation to age of respondent, the proportion indicating that they consumed 5 or more portions ranged from 28% of those aged 75 and over to 36% of those in the 55-64 age-group.

Mental Health

Mental illness is one of the major causes of ill health and disability in Northern Ireland. Northern Ireland has a disproportionately high rate of mental illness with 25% higher overall prevalence of mental health problems than in England.
Physical health and mental health are inextricably linked, with each impacting upon the other. People with poor physical health are at a higher risk of experiencing common mental health problems, and people with mental health problems, especially those with severe and enduring mental illness, are more likely to have poor physical health.

Figure 20 - Respondents with a high GHQ-12 score[4] by age and sex



Source: Health Survey for Northern Ireland 2010/11

One in 5 respondents showed signs of a possible mental health problem, by scoring highly on the GHQ12. Females were more likely to show signs of a possible mental health problem (23%) than males (17%). Differences in gender were reported in the 16-24 and 35-44 age-groups. Overall 16% of respondents in the youngest age-group (16-24 years) scored highly, around one in ten males (9%) compared with around

[4] The General Health Questionnaire (GHQ12) is designed to detect the possibility of psychiatric morbidity in the general population. People are asked to respond to 12 questions about general levels of happiness, depression, anxiety and sleep disturbance. A score is constructed from their responses, with a score of 4 or more being classified as respondents with a possible psychiatric disorder, and is referred to as a 'high GHQ12 score'.

one in five females (21%). Almost a quarter of respondents (23%) in the 35-44 age-group scored highly, 18% of males compared with 27% of females.
The annual cost of mental ill-health in NI is estimated to be approximately £2.7 billion.

Suicide

Overall during 2006-10, there was an average annual suicide rate of 15.7 deaths per 100,000 population. **Over the same period, the crude suicide rate in the most deprived decile (35.6 deaths per 100,000 population) was more than five times that within the least deprived areas** (6.7 deaths per 100,000 population). The relative difference is even greater when looking at males only (58.2 and 10.0 deaths per 100,000 population respectively). A similar picture emerges when examining self-harm admissions to hospital over the same period with the rate in the most deprived areas **six times** that in the least deprived areas.

Overall the highest suicide rates occurred in Belfast West and Belfast North PCAs, while North Down PCA had the lowest suicide rate. Male suicide rates ranged from a high of 43.0 deaths per 100,000 population in Belfast North to a low of 14.0 deaths per 100,000 population in Lagan Valley. Female suicide rates ranged from a high of 22.6 deaths per 100,000 population in Belfast West to a low of 8.4 deaths per 100,000 population in North Down.

Irish evidence identifies employment status as the most important predictor of psychological distress. The Health Research Board (2008) and the National Suicide Research Foundation (2008) draws attention to the association of unemployment with a two to three–fold increased risk of suicide among men.

Sexual Health

Sexually transmitted infections (STIs) can have long term effects on people's lives, with possible associated complications such as infertility, cervical cancer, ectopic pregnancy. Sexual ill-health can affect anyone however some groups are particularly vulnerable.

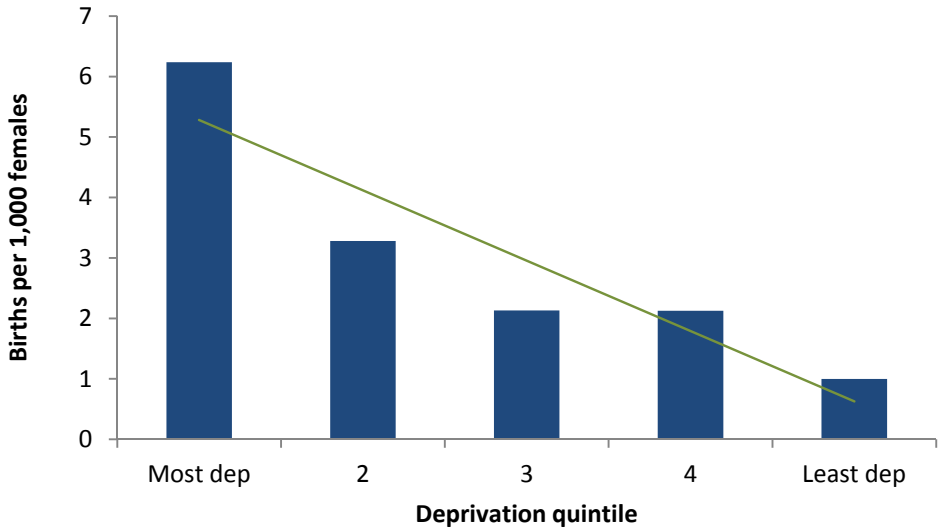
For example, the highest rates of new chlamydia infection in both men and women across the 2003 to 2010 period were diagnosed in the 20-24 years age group - during 2010, 54% of new STI diagnoses for which age group information is available occurred in young people under the age of 24.

Men who have sex with men (MSM) is the group at highest risk of acquiring gonorrhoea and infectious syphilis.

Teenage Births

There are strong links between social deprivation and teenage pregnancies.

Figure 21 - Teenage birth rate 2008-10



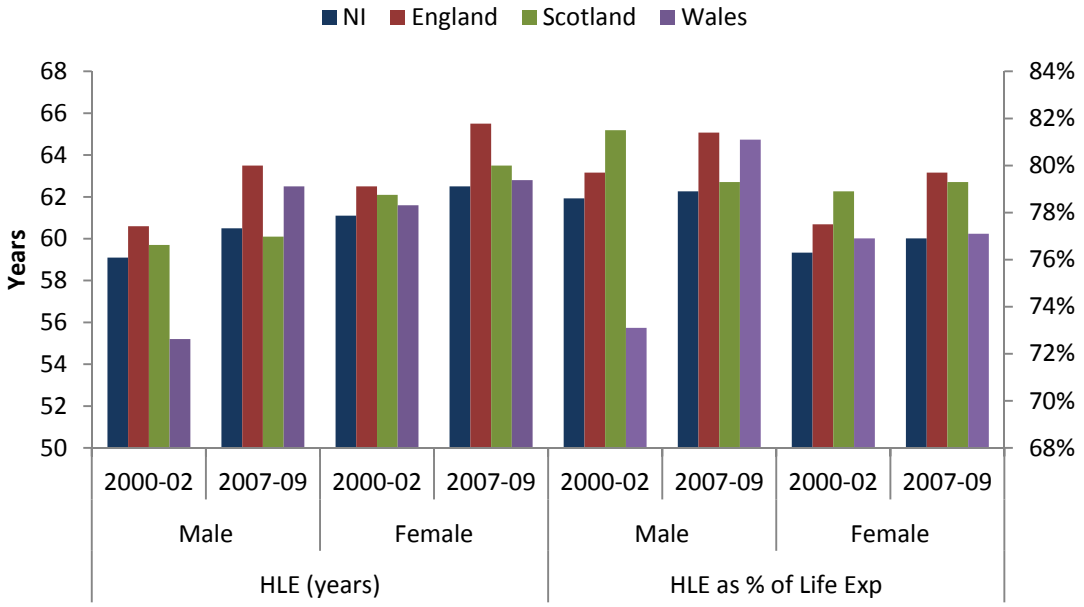
Due to the relatively small numbers involved, teenage births are presented by deprivation quintile in figure 21. The birth rate in the 20% most deprived areas was more than **six times** that in the 20% least deprived areas.

Oral Health

NI has the highest levels of dental decay in the UK and Ireland. This is linked to deprivation and lifestyle. The average Northern Ireland household spends more money per week on cigarettes, confectionary and sugared soft drinks than any other part of the UK. At the same time we eat less fruit and vegetables and brush our teeth less frequently than UK neighbours.

- 3 year old children in NI have low levels of decay: 25% have dental caries
- 5 year old children in NI have high levels of decay: 60% have dental caries
- NI has significantly poorer oral health than ROI and greater oral health inequalities
  (ROI has fluoridated its water supplies)
- A 5 year old in NI has, on average, over 2.5 teeth affected by decay
- A 5 year old in RoI has, on average, less than 1 tooth affected by decay
- A 5 year old in England has, on average, over 1.5 teeth affected by decay
- The number of General Anaesthetic (GA) extractions in young children has been falling which is a positive sign:
- 2004: 8,631 children underwent GA for dental extraction & 39,682 teeth were extracted
- 2010: 5,595 children underwent GA for dental extraction &23,806 teeth were extracted.

Figure 22 - Healthy Life Expectancy.

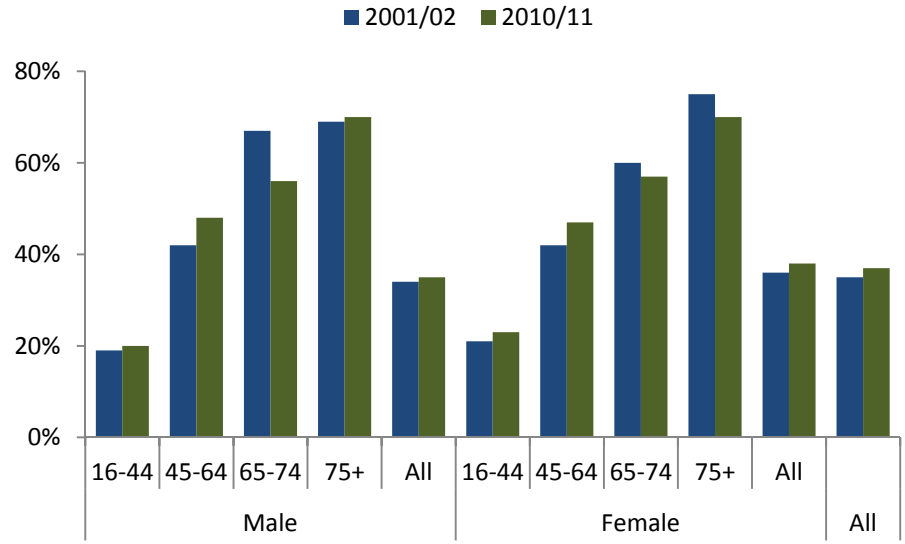


** Healthy Life Expectancy figures from 2005-07 onwards are based on a five point response general health question, in order to compare, the 2000-2002 figures which were originally based on a three point question have been simulated.*

In terms of healthy life expectancy - the number of years an individual might expect to live in good health - figure 22 above shows that between 2000-02 and 2007-09, it increased in NI for both males and females by around 1.4 years to 60.5 years and 62.5 years respectively. NI generally fares worse than the other UK countries, particularly England, and this is true for both the number of years and the proportion of an individual's life that might be expected to be lived 'in good health'. **The gap between healthy life expectancy in NI and England doubled over the period to 3.0 years for both males and females in 2007-09.**

This analysis is based on survey data relating to a self-reported health assessment question. It is not possible to break Healthy Life Expectancy down further at this time (eg geographically). As it is based on self-reported data, differences may to an extent be the result of differences in perceptions of health between the different countries. It is useful however in that it provides further context to life expectancy and other measures of longevity in giving an assessment of **quality of life**, especially in later years. Census 2011 figures when they are published should allow a robust subregional breakdown of both healthy and disability free life expectancy.

Figure 23 - Long-standing illness by age and sex



Source: Continuous Ho usehold Survey 2001/02, Health Survey for Northern Ireland 2010/11

The majority of respondents (85%) to the 2010/11 Health Survey for Northern Ireland (HSNI) indicated that their health has been good or fairly good in the previous 12 months. **37% of respondents reported that they have a long-standing illness,** that is, something that has troubled them over a period of time or is likely to affect them over a period of time. Similar proportions were found for males and females, 35% and 38% respectively. The proportion of respondents indicating they have a long-standing illness increased with age.

Comparing the 2010/11 figures with results for the same question asked in the 2001/02 Continuous Household Survey show broadly similar proportions overall reporting a long standing illness.

Respondents were also asked about the life they lead, with around 9 in 10 respondents describing their life as either very healthy or fairly healthy (89%). Nearly three-quarters of respondents felt that they could do something to make their own life healthier, with males (74%) more likely to indicate this than females (71%). Among these respondents, the most frequently reported changes were being more physically active (55%) and eating more healthily (50%), for both males and females.

2. Wider Determinants

It is crucial to understand the wider context in which health is shaped – poverty, neighbourhood deprivation, housing conditions, employment and educational opportunities are powerful drivers of the choices people can or cannot make, and consequently of ill health and health inequalities, as information in this chapter illustrates.

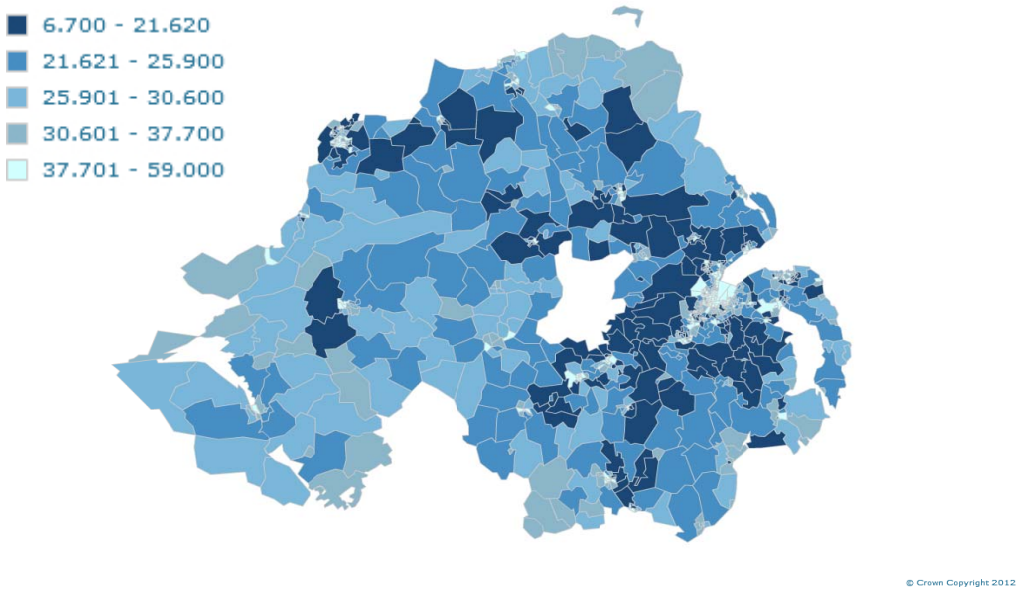
Poverty

Poverty is the greatest risk factor for health and wellbeing. It affects health in many ways:

- Those who are poor have less to spend on good food, housing, heat etc
- They are unable to participate in activities and are excluded
- They are less likely to live in safe environments
- They are more likely to leave school with few or no qualifications
- They are less likely to feel in control of their lives, and face constant stresses which damage health.

As in the rest of the UK, health outcomes for people living in deprived areas here are generally worse than country wide average. The figure below shows the geographic distribution of poverty.

Figure 24 - % of households estimated to be below the poverty line (60% of the UK median income) 2004/05



The level of relative income poverty for children in 2010/11 was 21%. The relative poverty rate for children of 21% is one percentage point lower than the previous series low point of 22% in 2006/07**. NI has a rate of child relative income poverty above the UK average** - 18% in 2010/11. NI has had a consistently

higher rate than UK since 2002/03 with the exception of 2006/07 when the rates were equal. The proportion of pensioners in NI in relative poverty has decreased from a series high of 30% in 2008/09 to a series low of 22% in 2010/11.

[Child relative income poverty is the proportion or number of children who live in households below the income poverty line in each year. The income poverty line in a particular year is set at 60% of the median level of household income in the UK]

The report "Broke - not broken" published by the Prince's Trust in 2011found that:

- More than one in five children are growing up below the poverty line;
- There is a clear aspiration gap between Northern Ireland's richest and poorest young people;
- The research also shows how one in ten young people growing up in poverty did not have their own bed when they were growing up;
- More than a quarter had few or no books in their home, while one in three were rarely or never read to by their parents;
- More than one in six young people in Northern Ireland say their parents struggled to put food on the table due to lack of money;
- More than one in five did not have anywhere quiet at home to do their schoolwork and one in ten were bullied about their clothes when they were growing up.

Education

Education has a profound impact on self esteem, lifelong training and employment opportunities and income. Children from low income families and deprived areas tend to achieve lower examination results than those from more affluent areas. There is a direct correlation between poverty, poor educational attainment and poor health.

Inequalities in educational attainment are as stark and persistent as those in health and are subject to a similar social gradient.

While there has been significant improvement in the attainment levels of school leavers with a steady increase in young people achieving at least five good GCSEs including English and Maths, the proportion of school leavers not attaining five good GCSEs including English and Maths is still high at 41%. This figure rises to 60% for school leavers from the 20% most deprived areas and compares with a figure of 24% for those in the 20% least deprived areas. The proportion of children leaving school in 2009/10 with no formal qualifications in the most deprived areas (3.5%) was almost six times that in the least deprived areas (0.6%).

Fig 25 % School leavers achieving at least 5 GCSEs (grade A*-C) by LGD 2009/10

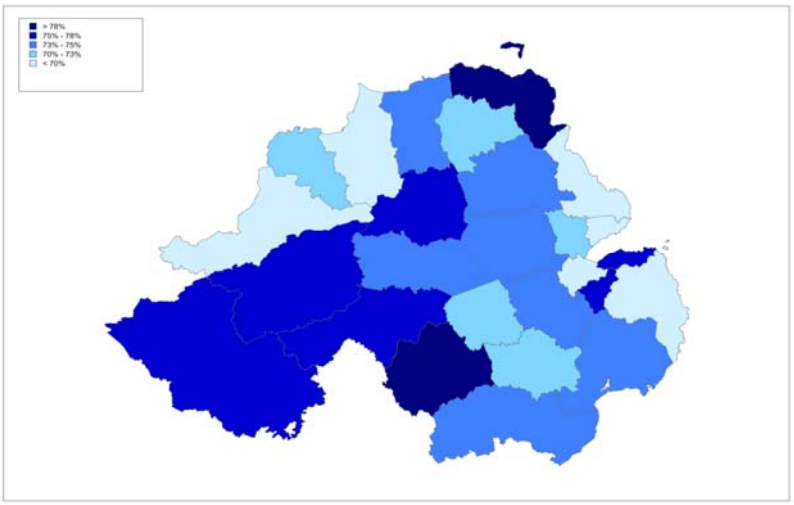


Fig 26 - Qualifications of school leavers by free school entitlement 2009/10

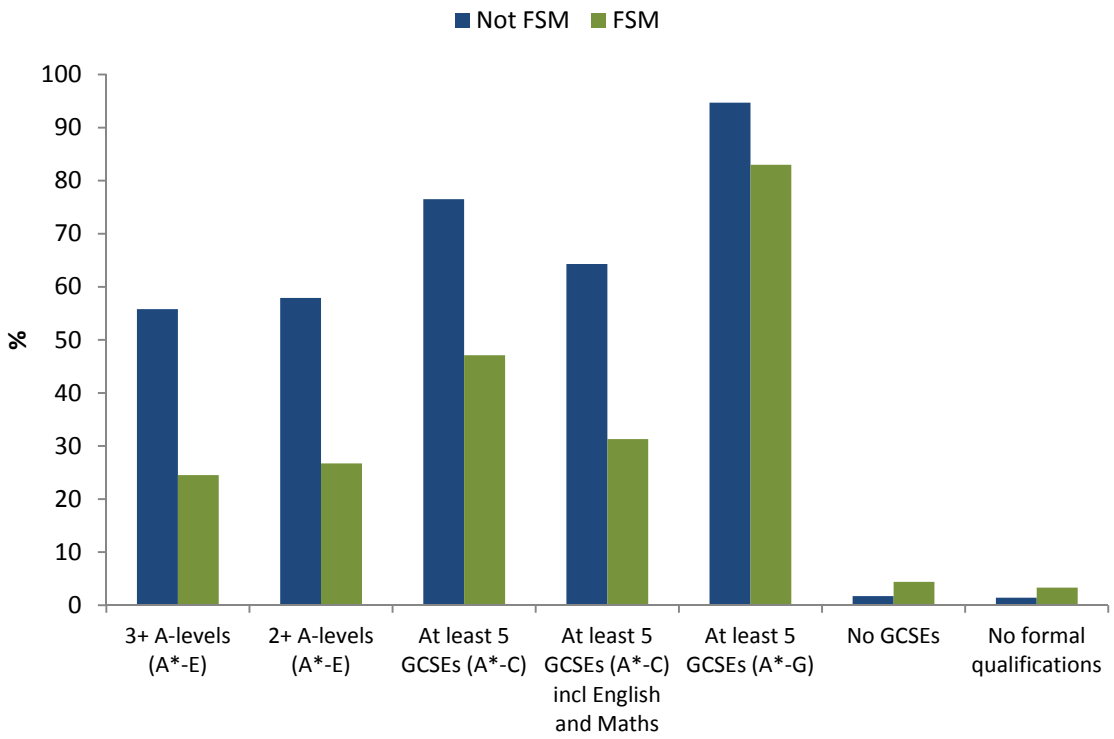


Fig 27 - Destinations of school leavers by free school meal entitlement 2009/10

Employment

Good employment is protective of health whilst insecure work or adverse working conditions can impact negatively.

Unemployment has both short and long term effects on health. There are more immediate effects which accompany lower living standards such as lower self esteem and reduced social integration. Over time distress, anxiety and depression can be triggered, contributing to poor health not only among the unemployed but also among their families. Unemployment also impacts on health behaviours – it is associated with increased smoking and alcohol consumption and decreased physical exercise. Unemployment contributes to poor health which in turn increases the likelihood of unemployment.

According to the Labour Market statistics released in February 2012 –

- The unemployment rate for the period October - December 2011 was estimated at 7.2%. The latest NI rate was lower than the UK (8.4%) rate

- The economic inactivity rate for those aged 16-64 in NI stands at 27.2%. The NI rate remained above the UK average rate (23.1%) and was the highest rate among the twelve UK regions.

- The more recent seasonally adjusted claimant count stood at 61,500 (7.0%) at January 2012, up 600 from the previous month's revised figure. On this measure NI had the second highest unemployment rate among the twelve UK regions. However, the annual increase in NI claimants (4.6%) was the second lowest among the UK regions (the annual increase in the UK was 10.0%).

Unemployment is more common among those with few qualifications and skills, those with long term illnesses or disability and in particular young people.

Housing Conditions

High quality warm, secure housing is vital for mental and physical wellbeing.
In 2004 it was estimated that 51,000 children were living in homes failing the decent homes standard, the 2009 estimate is 33,300, a decrease of 35%.

6,122 families presented as homeless during the year 2009/10. This is an increase of 7% on that recorded at baseline in 2004/05 (5,700).

2,008 families were provided with temporary accommodation during 2010/11.
Fuel poverty impacts on many areas of health and wellbeing. A link between living in cold, damp conditions and a number of illnesses, including poor mental health, respiratory disease, and premature mortality has long been accepted. Low home temperatures especially impact on infants and children, the elderly and those living with chronic conditions such as osteoarthritis, neurological conditions, stroke and dementia, respiratory and cardiovascular disease.

Recent research has demonstrated the beneficial effects of tackling fuel poverty on:

- Improvements in adult physical health
- Improvements in children's health (particularly respiratory health)
- Improvements in adult mental health (reduction in stress)
- Other positive effects on children include improvements in education

The 2009 House Condition Survey reported the level of fuel poverty in Northern Ireland as **44%** (**302,310 households**), a 10 percentage point increase from **34%** (**225,580 households**) when the level of fuel poverty was last measured in 2006 by the House Condition Survey.

The Survey also showed that 83% of older people who live alone need to spend more than 10% of their income on energy costs and therefore are living in fuel poverty.

Environment and Neighbourhoods

People's health and wellbeing is influenced by the environment in which they live. This includes both the direct and indirect effects of chemical, physical (including ionising and non-ionising radiation, and noise) and biological hazards on health and well-being; and encompasses some aspects of the physical and social environment that influence health and wellbeing, such as the quality of housing and the neighbourhood environment, urban development, land use, access to green space and transport.

Well-designed neighbourhoods can contribute significantly to the general health and wellbeing of individuals and communities. The more deprived the neighbourhood the

more likely it is to have characteristics which pose risks to health such as poor built environment, higher rates of crime, poorer air quality ,risks from traffic etc.

Air pollution is linked with greater risks for those with respiratory diseases or heart conditions and is estimated to reduce life expectancy in the UK by an average 7 to 8 months according to a report by the Chartered Institute of Environmental Health. Emissions from road traffic are a particular issue for focus, with children living near busy roads showing an increased risk of respiratory illnesses including asthma, according to a study carried out by the Royal Commission on Environmental Pollution.

Physical environments can be designed to promote health and wellbeing through, for example, providing access to services and opportunities for social interaction. Numerous studies point to the physical and mental health benefits of access to green spaces and better air quality. Physical places can also help to promote social networks, a sense of community and social cohesion which also influences the health and wellbeing of the individuals within them.

Rurality

Generally health outcomes in rural areas tend to be better than in NI overall. However evidence suggests that health inequalities have a significant impact on people living in rural communities. Challenges faced by many people living in rural areas include:

- Deprivation and fuel poverty;
- Social isolation and social exclusion - small, sparsely distributed populations;
- A growing ageing population and changing population patterns; and
- Adequate access to services.

Pressures felt by wider society as a result of the economic climate are often exacerbated in rural areas resulting in increasing numbers of rural people finding themselves in positions of poverty and exclusion. These challenges are compounded with many needs and issues hidden as a result of isolation in the rural setting.

Rural poverty manifests itself differently from poverty in urban areas; it is not spatially concentrated and is therefore more difficult to identify. Rural poverty is clearly associated with the remote rural regions although obviously not confined to them. The *New Policy Institute* found, for example, that disadvantage was more prevalent in western districts of Northern Ireland. Broader research carried out across rural areas in the UK indicates that most rural areas are affluent, with rural poverty scattered and hidden amongst general affluence.

People in rural communities are less likely to identify they are in poverty and there is a culture of making do. This is evidenced in part by the lower than average take-up of benefits in rural areas (*see Bramley et al 2000)*. In 2007 – 2008 in Northern Ireland, of those who earned 50 per cent below the UK Mean Income before Housing Costs, almost half (46 per cent of individuals) lived in rural areas.

Crime

The proportion of respondents from the 20% most deprived areas in NI to the 2010/11 Northern Ireland Crime Survey that reported high levels of worry about burglary, car crime or violent crime was approximately double that reported from those in the 20% least deprived areas. Similarly with regards to personal safety, respondents from the most deprived areas were more likely to feel “very unsafe” walking alone in their area after dark or being alone in their home at night. One in six respondents in the most deprived areas (16%) felt very worried about crime overall which compares with 6% in the least deprived areas.

Findings from the 2010/11 Northern Ireland Crime Survey indicate that the adult victimisation (prevalence) rate for violent offences in the 20% most deprived areas in NI (5.1%) was four times that in the least deprived areas (1.2%).

Domestic Violence and Sexual Violence

Domestic violence and sexual violence and abuse are serious problems in Northern Ireland (as they are worldwide), affecting people from all cultural, social and ethnic backgrounds and across all age groups. PSNI statistics reveal that in 2011/12 there were 10,387 crimes recorded with domestic abuse motivation and 1836 sexual offences recorded. Whilst PSNI statistics vary each year and the number of reported crimes is between 15% and 20% of actual crimes, it is anticipated that reporting of such incidents will continue to increase year on year as further strategic initiatives through the “Tackling Violence at Home” and “Tackling Sexual Violence and Abuse” strategies are rolled out and public awareness is raised.

In terms of prevalence, 1 in 4 females and 1 in 9 males will experience domestic violence in their lifetime. Children living in homes where domestic abuse takes place are very much the hidden victims. Regarding sexual violence, 1 in 5 girls and 1 in 10 boys will experience some form of child sexual abuse.

Climate Change

Over the next century our climate is predicted to change in ways that will have an important and largely negative effect on health as well as the environment. Limiting man made greenhouse gas emissions over the next 40 years is crucial, however, due to the current levels already in the atmosphere, there will be unavoidable changes to the climate which will require many communities to adapt.

The first UK Climate Change Risk Assessment was published in January 2012. The main impacts on health and wellbeing for people in Northern Ireland, especially the vulnerable, are likely to be those associated with more frequent extreme weather events, particularly flooding; higher summer temperatures including heatwaves and water shortages; and an increase in the levels of ozone related summer air pollution. The number of deaths and hospital admissions attributable to cold weather is projected to decline as winters become milder. Air pollution and its associated health impacts may also decrease in winter (UK2012 Climate Change Risk Assessment, Defra, January 2012).

Northern Ireland has experienced a number of extreme weather events in recent years, including flooding, prolonged freezing temperatures and wildfires. There are a number of different groups that might be considered potentially more vulnerable to the effects of these events than the rest of the population, for example:

- older people;
- people with disabilities or chronic health problems;
- lower income groups;
- geographic communities living in areas more susceptible to the affects of these events.

Longer term, co-ordinated adaptation planning and responses will be required. An important focus will be to ensure that those most vulnerable in the community are able to be identified and supported, and that adaptation strategies address the potential for climate change impacts to exacerbate existing health inequalities.

3. At Risk Groups

In addition to the impact of social inequalities on health outcomes across the population, there are particular groups of people whose circumstances are likely to give rise to poorer health outcomes.

Children in Care

Looked after children are at greater risk of poor health and other adverse societal outcomes, for example, in education and involvement in crime.

Recent key findings on young care leavers aged 16 – 18 indicate care leavers continue to have higher proportions of young people coping with disability (16%) than in the general population (6%). In terms of education, higher proportions of care leavers had received Statements of Educational Need (18%), compared with the general school population (4%).

The proportion of care leavers obtaining 5 GCSEs (A*-C) or higher has decreased by three percentage points from 17% in 2009/10 to 14% in 2010/11. This remains much lower than for school leavers as a whole (72%). The proportion of care leavers leaving care with no qualifications also continues to fall, from 43% to 30% in 2010/11, though this remains over 15 times that for general school leavers (2%).

In terms of economic activity, of care leavers for whom information was available, over half were in education or training (58%) - an increase of seven percentage points from 2009/10 - 7% were working, 26% were unemployed and 9% were economically inactive. Care leavers with no qualifications were twice as likely as those with qualifications to be unemployed or economically inactive.

Ref: DHSSPS statistical bulletin summarising information on young care leavers aged 16 to 18 in Northern Ireland who left care during the year ending 31 March 2011.

People with Disabilities

The results of a Northern Ireland Survey of Activity Limitation and Disability, commissioned by a PSI Working Group on Disability indicate that in 2006/07, 18% of all people living in private households had some degree of disability. The prevalence rate for adults is 21% and 6% for children.

This is a significant proportion of the population who, in their everyday lives, experience significant disadvantage, leaving them at much greater risk of poverty and social exclusion than others. In general, the results from this and other surveys show that on most indicators of social and economic wellbeing, such as labour market, income and educational attainment, people with disabilities continue to be among the most disadvantaged groups in society.

Evidence from the Households below average Income NI 2009/10 report highlights that households with disabled adults are at greater risk of poverty than those without, showing a clear link between poverty and disadvantage. Thirty per cent of adults who live in households that contain one or more disabled adults are in poverty compared to 21% of adults who live in households with no disabled adults. (Ref: draft Disability Strategy 2012).

In general people with disabilities are likely to be less well qualified, much less likely to be economically active and therefore in employment, much more likely to be in poverty, much less likely to enjoy an active social life and much more likely to suffer poor health including poor mental health.

People with Learning Disability

People with a learning disability are more likely to experience major illnesses, to develop them younger and die of them sooner than the population as a whole. UK reports indicate they have higher rates of obesity, respiratory disease, some cancers, osteoporosis, dementia and epilepsy. It is estimated that people with learning disability are 58 times more likely to die prematurely.

However, even with such a dramatic health profile, the learning disabled population are less likely to get some of the evidence-based screening, checks and treatments they need, and continue to face real barriers in accessing services. Information on, and activities in, health promotion can be difficult to access. These factors contribute to preventable ill health, poor quality of life and potentially, premature death.

http://www.improvinghealthandlives.org.uk/projects/particularhealthproblems

Minority Ethnic Groups

Different migrant groups, depending on country of origin, bring different challenges in relation to issues of health protection (Tb, Hep B, Hep C, HIV), vulnerability to non-communicable diseases, experience of health care (immunisation, prevention, screening, treatment), cultural beliefs about health/illness and acceptability of treatments. Experiences from country of origin (eg conflict, war, torture) have lasting

impact. Many migrants experience discrimination and are disadvantaged in relation to the wider determinants of health.

The report *Barriers to health: migrant health and wellbeing in Belfast*, prepared by the Belfast Health Development Unit (BHDU, 2011), provides a general summary on the health status and needs of ME groups and the wider determinants of health such as legislation around immigration and work, entitlement to social security benefits and health and social care, work, housing, education, etc. Mental health is an important issue for many ME groups - social isolation can lead to loneliness and depression as well as to excessive alcohol consumption. About 1 in 5 migrants in the WHSCT area who reported stress, anxiety or depression said that missing their family had caused their mental health problem (Jarman 2009). Poor levels of English can increase the experience of isolation.

Traveller's Health

In NI, ***The All Ireland Traveller Health Study (***AITHS)estimate a population of 3,905 Travellers living in 1,562 families with an age profile that is markedly different from that of the general NI population, with **70% of people under thirty and only 1% aged over sixty-five**. This reflects in part a higher birth rate, higher mortality rates and inward migration from ROI.

AITHS examined issues about accommodation, education, work and employment, health status (including both morbidity and mortality), and provision of and access to health services – key findings are -

- The largest proportion of NI-based Travellers reside in the Belfast area (22%), followed by Dungannon (17%), Craigavon (12%), and Derry (11%)
- A high proportion of adult Travellers have no formal qualifications although this is improving slightly in the younger age groups.
- An overall employment rate of 15% of the Traveller community, 20% being unemployed, with the remainder not being economically active.
- Experience of discrimination is widespread and affects every area of their life eg in getting accommodation, at school, getting work, when getting health care etc.
- Parents rate their children's health positively and uptake of immunisations (93% of under 5s) and dental care is high (79%, 77%, and 71% respectively of 5, 9, and 14 year olds had seen a dentist in last 12 months).
- In comparison to the general population, Travellers do not have a higher prevalence of disability that limits daily activity. In fact, it is lower in those 65 and older which may be a result of the high early mortality rate.
- Overall, mortality is 3.5 times higher than in the general population for both genders (males 3.7; females 3.1).
- Similarly infant mortality is approximately three and a half times that in the general population.
- Most common causes of death include heart disease/stroke and respiratory disease, with external causes of death being particularly prevalent among men (which include alcohol and drug overdose and suicide). Male Travellers have a suicide rate which is 6.6 times that of men in the general population.

- For female Travellers life expectancy at birth is **70.1 years – eleven years less than the general population** and equivalent to that of women in the early nineteen-sixties.
- For male Travellers life expectancy at birth is **61.7 years – fifteen years less than that of the general population** and now at the level of the ROI overall population on the later part of nineteen-forties.

LGBT / Sexual Orientation

The difficulties in estimating the proportion of Lesbian, Gay, Bisexual and Transgender (LGBT) individuals in a population are recognised. It is only in recent years with the emergence of equality and human rights legislation that there has been a substantive research focus on the lives of LGBT people in Northern Ireland. Although the acronym is used as an umbrella term, and the health needs of this community are often grouped together, each of these groups represented by the acronym is a distinct population with its own health concerns.

A number of reviews have concluded that LGBT people are at significantly higher risk of mental disorder with higher rates of anxiety, depression, self harm and suicidal behaviour as well as higher problem drug and alcohol use (Shout 2003, Young Life and Times Survey 2009). Mental health issues often relate to homophobia (including internalised homophobia) having a profound effect on self esteem, discrimination, family rejection and isolation.

Other issues include access to services and attitudes. The Rainbow Project (2009) highlighted that 39% of lesbian, gay and bisexual people have been the victim of some sort of crime in the previous three years and 56% of all incidents against LGB people in that period, regardless of motivation, were never reported to police.

A report by the Rainbow Project in 2011 also indicated that around 1 in 4 respondents from the private sector (26.9%) and public sector (24.5%) conceal their sexual orientation in the workplace. Many believe that their sexual orientation will have a negative impact on their chances of progressing at work.

Reviews have also indicated that LGBTs experience significant barriers to accessing health services eg service providers assume their needs are similar to those of heterosexual men and women.

Homeless People

6,122 families presented as homeless during the year 2009/10. This is an increase of 7% on that recorded in 2004/05 (5,700).

Homelessness presents a considerable risk to both mental and physical health. Homeless people have a significant number of complex needs.

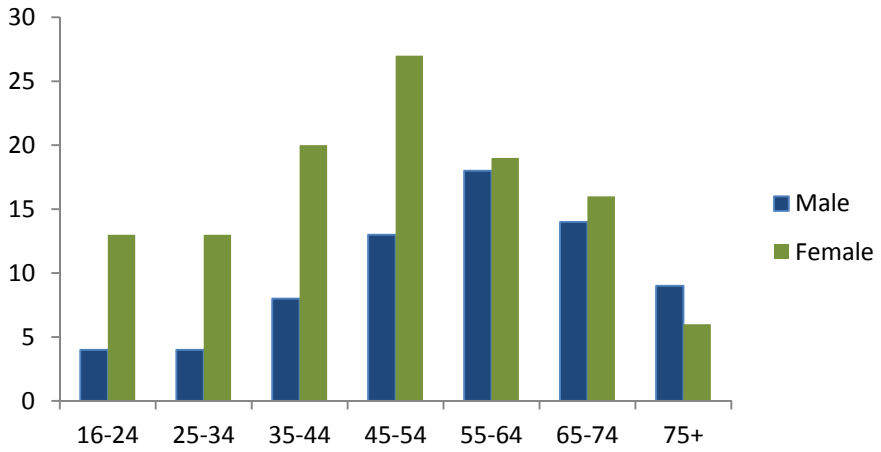
Socially excluded households are more likely to become homeless. Households that are homeless, or threatened with homelessness, may find it more difficult to access relevant services, including education, social security, financial and health services. Accessing and keeping employment and retaining social and community links are

also more difficult. Yet being homeless is likely to create a greater need for some services. Homelessness can therefore be both a cause and an effect of social exclusion and can create or contribute to a continuous downward spiral.

Homelessness is not an isolated problem, but part of a broader phenomenon of social exclusion. Research across Europe suggests that there is persuasive evidence about the relationship between homelessness and other factors which are either an indicator of social exclusion or associated with high social risk. Two such factors are poverty and long-term unemployment.

People with Caring Responsibilities

Figure 23 - People with caring responsibilities by age and sex



Source: Health Survey for Northern Ireland 2010/11

Fourteen percent of respondents indicated that they cared for someone else on an informal basis with females more likely to be carers than males (17% and 10% respectively). In respect of males, the proportion ranged from 4% of 25-34 year olds to 18% of 55-64 year olds and for females the proportion of respondents caring for others ranged from 6% of those aged 75 and over to 27% of 45-54 year olds.

Maintaining health and well being is important for carers to continue in their caring role, but often they neglect their own needs because they become pre-occupied with providing care or simply do not have time. Carers are more likely to experience high levels of psychological distress, including anxiety, depression and loss of confidence and self esteem than non carers. Carrying out a caring role can also have a significant effect on the carer's financial situation, which in turn can lead to poorer health outcomes.

Young people who fulfil a caring role can experience the same detrimental effects. In addition their capacity to fully develop and benefit from education may be compromised.

PART TWO – THE APPROACH

Chapter Five

Whole Systems Approach

This chapter puts forward the rationale for a whole systems approach. For sustainable success in improving health and tackling health inequalities it is argued that a whole systems approach is needed in which activity is co-ordinated, monitored and evaluated across the various levels of the system.

5.1 There is now a clear acknowledgement that:

- Many of the social determinants of health lie outside the direct influence of the health system
- The improvement of health and well-being is a fundamental responsibility of society as a whole.

Therefore it is the whole of the government and beyond which must address the full spectrum of health determinants. *Health 2020* argues strongly, supported by WHO, that all parts of government need to work together to recognize risk patterns and identify solutions, act through multiple levels, and share responsibility across policy fields and sectors. Health is increasingly understood as an outcome of complex and dynamic relationships between this wide range of determinants. Successful governance for health is cognizant of this complexity and therefore requires a "whole-of-government" approach.

Government Level Interventions

5.2 In this respect it is clear that Government policies and programmes, by what they do, and fail or choose not to do, can have a significant impact on the health of population. They include for instance policies and/or strategies which:

- Reduce income inequality through taxes and subsidized public services
- Provide free government service such as health, education and public transport.
- Secure jobs and inward investment
- Address the physical and social environment (housing, planning and environmental health policies)
- Address heating and cooking fuel for disadvantaged people in particular (fuel poverty)
- Maintain people with chronic illness within the workforce.
- Provide welfare benefits for disadvantaged people in particular
- Provide early childhood development programmes, including the provision of nutritional supplements, regular monitoring by health staff and cognitive development for children of pre-primary school age

Where the social determinants relate to economic factors such as income inequality, it is clear that some national issues such as, minimum wage, welfare benefit levels, and taxation cannot be addressed in a public health framework for Northern Ireland – this framework aims to highlight links to related policies and intended outcomes to address those issues which are within the remit of the NI Executive.

5.3 The whole–of-government approach is also strongly supported by WHO Commission on Social Determinants of Health (2008) which argued strongly for policy coherence across government eg:

- Place responsibility for action on health and health equity at the highest level of government, and ensure its coherent consideration across all ministerial and departmental policy-making.
- Ministers of health can help bring about global change – they will be pivotal in helping to create buy-in by the head of state and from other ministries.

Similarly, Health 2020 (op cit) argues that a key element in bolstering public health is to integrate its principles and services more systematically into all parts of society through increased whole-of-government and intersectoral working, through a "Health in All Policies" approach, and through participation, transparency, communication and accountability.

5.4 In respect of Northern Ireland, since the publication of *Investing for Health* in 2002, a number of cross-Government strategies and initiatives have been issued and developed which have a specific focus on social determinants (e.g. Poverty, Fuel Poverty Neighbourhood Renewal, Road Safety, Community Safety) with health and well-being as a component part.

There is also now a wide range of strategies and policies being developed or implemented which adopt a life course or life stage perspective, (examples are the Children and Young People strategy, Child Poverty Action Plan, Ageing in an Inclusive Society/ Older People's strategy, Programmes for Young People not in Education, Training or Employment) again with health and well-being identified as a key component.

5.5 This illustrates a growing acknowledgement of the impact of public policies on each other and the need therefore for inter-connectedness, reinforcement and cross-government collaboration. There is also an increasing trend for public policies to look more upstream at preventative measures rather than focussing on problems that arise. Substantial bodies of evidence are coming forward which illustrate inter-relationships – a clear example is that of the evidence in respect of the effectiveness of Early Years interventions on a wide range of personal and wider societal outcomes for example in education, employment, justice and health and wellbeing.

5.6 Clearly the opportunity comes from Departments being able to build in reciprocal outcomes into each other's strategies and policies, with the scope then for a consistent use of language and concepts, and a sense of coherence which should also flow through to implementation at delivery level.

Therefore a more systematic and structured approach to addressing the reciprocal nature of health and other Government policies will be a particular priority for this Framework.

Delivering Social Change

5.7 A key commitment within the Programme for Government is to ***'Deliver a range of measures to tackle poverty and social exclusion through the Delivering Social Change delivery framework.'*** Delivering Social Change is a comprehensive new delivery framework which aims to deliver the following two outcomes:

(i) a sustained reduction in poverty and associated issues, across all ages; and:

(ii) an improvement in children and young people's health, wellbeing and life opportunities thereby breaking the long-term cycle of multi-generational problems.

The inter-relationships between the Delivering Social Change programme and this framework are reflected in later sections.

Strategic Links with NI Economic Strategy

5.8 The NI Economic Strategy, published in March 2012, identifies the Executive's economic policy priorities and the following economic vision for 2030:

"An economy characterised by a sustainable and growing private sector, where a greater number of firms compete in global markets and there is growing employment and prosperity for all".

Increased prosperity will create opportunities for all sectors of the economy and help the Executive tackle disadvantage and the wider effects of deprivation. The Economic Strategy recognises that delivering growth and prosperity requires co-ordinated action from all sectors of the economy and includes specific commitments from all Executive Departments.

The NI Economic Strategy explicitly recognises the positive link between prosperity and health outcomes. Healthier people are more productive and improved health & well-being will lead to positive economic outcomes for both individuals and wider society. The NI Economic Strategy explicitly notes that implementation of strategies which deliver improved health outcomes will enhance individual's opportunities to secure employment and make a positive contribution to delivery of our wider economic goals.

Social Capital and Community-level Interventions

5.9 Studies of adult populations have shown that living in supportive, cohesive communities where interpersonal trust and civic pride are strong and civic

involvement is common relates to better health, less illness and longer life expectancy.

5.10 Therefore while there is a clear role for Government and Departments to address the structural determinants of health though public policy, there is also a clear role for community-based interventions as part of a whole systems approach to address specific identified needs at local level. While such interventions may not necessarily directly address the strategic underlying causes of for example poverty and social exclusion, communities should be empowered and supported to develop policies, services and support that address those local health inequities that arise from them.

5.11 Alongside universal services or interventions community-led initiatives are far better placed to have an effect on those healthy lifestyle factors described earlier such as social connectedness and the sense of efficacy, since collective action can influence both social ties and the experience of changing communities and systems. The extent of the engagement achieved at local level through Investing for Health was identified as a key area of success on which to build.

5.12 In addition the DSD- led Volunteering Strategy provides an example of action being taken to involve more people as volunteers with two key effects:

- the benefits to the individual of being involved in their community, building self esteem, having a sense of purpose and combating many of the factors that lead to social exclusion including disability, unemployment, low educational standards.
- the benefits to society through community development and increased social capital means that the capacity of organisations to deliver services is increased.

Asset Approach

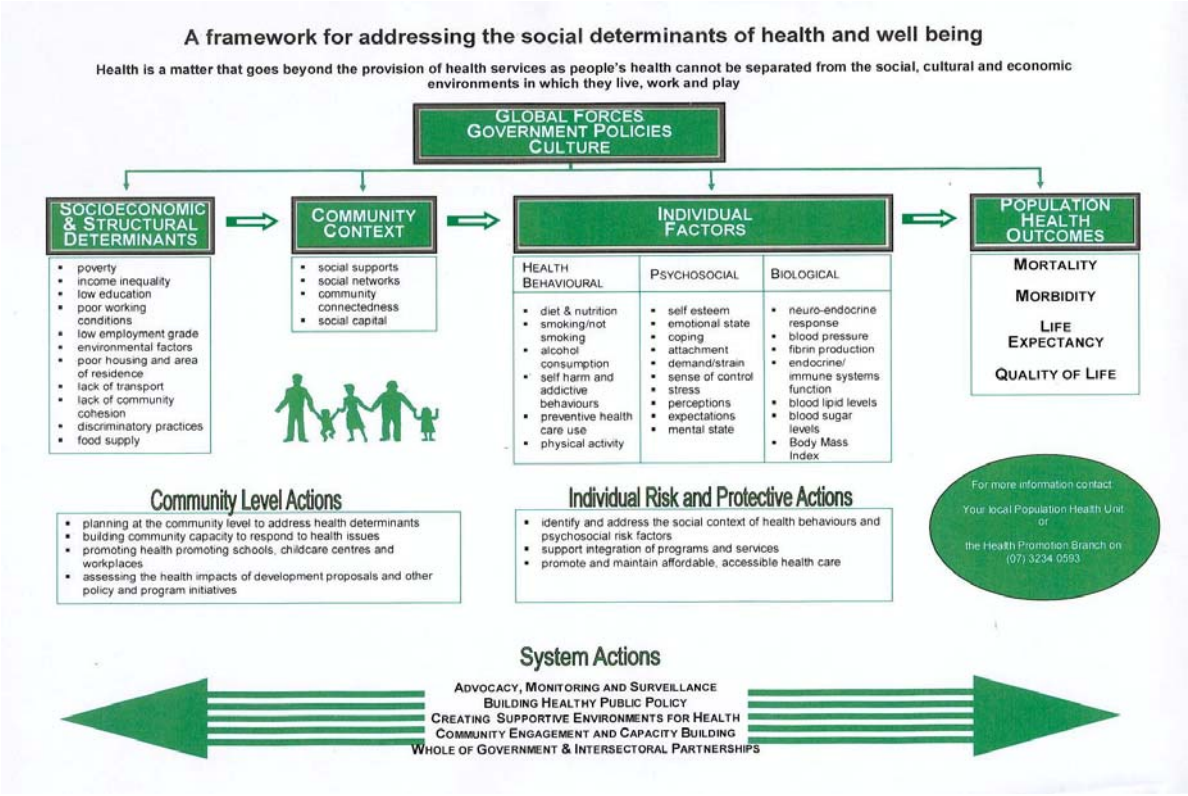
5.13 In this respect the asset approach is growing in importance.

"A health asset is any factor or resource which enhances the ability of individuals, communities and populations to maintain and sustain health and well-being. These assets can operate at the level of the individual, family or community as protective and promoting factors to buffer against life's stresses."

A growing body of evidence shows that when practitioners begin with a focus on what communities have (their assets) as opposed to what they don't have (their needs) a community's efficacy in addressing its own needs increases, as does its capacity to lever in external support. It provides practitioners with a fresh perspective on building bridges with socially excluded people and marginalised groups.

Whole Systems approach - summary

5.14 The whole systems approach described in this chapter can be usefully summarised by the diagram below which has been developed by Queensland, Australia.



This diagram clearly encapsulates the complexities of a whole-systems approach to improving health and well-being and reducing health inequalities by addressing the social determinants of health.

Chapter Six

Strategic Framework

This chapter introduces a proposed framework for addressing health improvement and health inequalities, and outlines the aims, vision, values and principles to guide action.

6.1 Based on the rationale outlined in the previous chapters the framework must encompass and acknowledge a wide range of health-related issues, other Government strategies, complex multi-causal factors, and cross-sector aspirations and expectations. This approach is clearly reflective of current international and national thinking. It was also central to Investing for Health and reaffirmed by the strategic review of this strategy.

Aims, Vision, Values and Principles

6.2 The overarching aims of Investing for Health:

"To improve the health and well-being status of all our people, and to reduce inequalities in health"
will remain the aims for this framework.

Building on these aims the framework will move NI towards a vision -

"Where all people are enabled and supported in achieving their full health potential and well-being."

Values/Principles

6.3 The strategic review of Investing for Health also found that its guiding values and principles remain relevant and it is therefore proposed that these should continue to inform all aspects of the implementation of this framework. These values and principles are –

Values

- **Health is a fundamental human right**
- **Policies should actively pursue equality of opportunity and promote social inclusion**
- **Individuals and communities should be fully involved in decision making on matters relating to health**
- **All citizens should have equal rights to health, and fair /equitable access to health services and health information according to their needs**

Principles

- **To target social inequalities**
- **To tackle social exclusion**
- **To combat discrimination and injustice**
- **To encourage community involvement in improving health, especially in disadvantaged neighbourhoods**
- **To work in partnership with local and interest group communities**
- **To improve employment opportunities and income levels of those who are most disadvantaged**
- **To promote coping skills in individuals, families and communities**
- **To engage individuals in their social context**
- **To maximise opportunities for individuals, families and communities to protect and improve their own health**
- **To focus public policies generally towards improving health and well-being**
- **To base actions on the best available evidence**

Within Health and Social Care these principles align with the ethos of Personal and Public Involvement which requires that patients, clients, carers and communities must be put at the centre of decision making in health and social care.

Question 2: **Do you agree with the Overarching Vision, values and principles? Are there any other values that should be included, or you feel are important?**

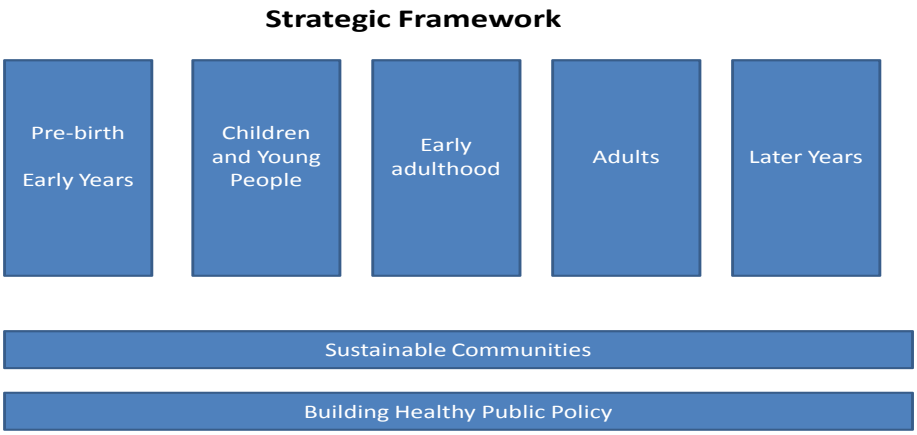
6.4 In line with current thinking and evidence, and to promote structure and organised action the Framework will adopt a **life course approach**. Five broad life course stages are proposed. These are:

- **Pre-birth and Early Years (0-5 years)**
- **Children and Young people (broadly school-age, 5-16)**
- **Early Adulthood (17-24)**
- **Adults (working age, 25-64)**
- **Later Years (65+)**

6.5 Further detail on each of the life stages will be found in Chapter 7 which provides a policy aim, brief rationale, long and short term outcomes to be achieved. **While age ranges are suggested against these life stages, it is acknowledged that different definitions and ranges have been adopted by various policies and strategies, and for the purpose of organising certain services. The age ranges in this framework are meant as a *guide* and not intended to be definitive, nor to override ranges that have been adopted for other specific purposes.**

6.6 The strategic framework can be graphically depicted as shown in the figure below, with interventions focussing on achieving outcomes based on meeting the specific needs of each life stage and to assist transition between these.

6.7. Underpinning and supporting interventions which run along the life course are those which seek promote **Sustainable Communities and to Build Healthy Public Policy**. Engaging and promoting supportive, sustainable communities is an important strategy for tackling health inequalities and mitigating the risk factors for poor health. By considering health impacts across all policy domains options that contribute to health improvement can be considered. It will be essential to continue to monitor, learn, research and improve the evidence base to inform practice and ensure resources are used effectively.



Question 3: **Is the approach taken – ie life course stages and underpinning themes, appropriate?**

Outcomes Approach

6.8 The Framework will also follow an outcomes approach, where outcomes are the changes, benefits or other effects that happen as a result of policies or activities.

By taking an outcome approach to improving health and well-being and reducing the current level of health inequalities, the focus is on what can be achieved over the next ten years in terms of the benefits that can be realised by our society. At Chapter 7 the framework sets out for the lifestage and underpinning themes policy aims, long term outcomes to aspire to over the period to 2022, and outcomes to achieve by 2015. The advantage of this approach is that it enables coherence in planning both within Departments and across Government. It also challenges us to focus on impact and not just on output.

It is proposed to review these in line with PFG and budget periods so that efforts can be maximised.

Strategic Priorities

6.9 Whilst the framework sets out a wide range of life course and population outcomes it is important to emphasise that a focus on the most disadvantaged in society, whatever their age group, or wherever they are living is inherent to achieving the vision and aims of this framework. Action must take account of the "social gradient" and the need for more focussed effort or "proportionate universalism" (ie to reduce the gradient there is a need for universal actions, but with additional provision for additional need) to tackle the health inequalities that exist in our society.

Despite the complexity of their causes and effects the key point is that socioeconomic inequalities should be largely avoidable. A society that can reduce these inequalities is likely to achieve strong health gains.

Therefore **two strategic priorities** are proposed:

- ***Early Years***

There is now overwhelming evidence nationally and internationally that children's life chances are most heavily predicated on their development in the first years of life. It is vital that children are given the best possible start in life in order to break the cycle of disadvantage that correlates to poor outcomes throughout life and across generations. This starts from ante natal care, and includes childhood development, support for good parenting and opportunities for learning. Disadvantaged people tend to come from disadvantaged families. Family factors and personal experience of lower income, and fewer opportunities for education and employment may mean less satisfactory early development before and after birth, less opportunity for health literacy, and a greater influence of family and friends towards unhealthy behaviours such as smoking, heavy alcohol use and a poor diet.

**Major reports include the Allen Report (2010), "The Foundation Years: preventing poor children becoming poor adults" Frank Field (2010), and Child Poverty in Perspective, (UNICEF 2007)*

- ***Supporting Vulnerable People and Communities***

More focused effort will be required to reduce the health inequalities experienced by vulnerable people within the Northern Ireland population. For example (this list is not exhaustive) -

- Vulnerable children include those who experience learning or physical disabilities, neglect and other adverse social environmental factors. These "children in need" are defined as those who need additional services in order to attain a reasonable standard of health and development.
- People with disabilities
- Travellers
- Migrant populations

- People who are homeless
- Prisoners/Refugees/Immigrant populations
- People living in areas of deprivation

6.10 These are proposed as priorities as they are reflective of demographic trends and the evidence base in relation to addressing health inequalities, and are considered vital to achieving the aims of the framework. They are also generally consistent with the overall direction and priorities espoused in the Programme for Government 2011-15, "Building a Better Future" and the "Delivering Social Change" programme, and will contribute to promoting and upholding children's rights as defined by the UN Convention on the Rights of the Child (UNCRC) and the rights of persons with disabilities as defined by the UN Convention on the Rights of Persons with Disabilities (UN Disability Convention).

6.11 In developing or implementing programmes, regardless of target population or setting, cognisance must be taken of acknowledged and where possible evidenced good practice.

Question 4: **Are these the right strategic priorities – ie Early Years and Supporting Vulnerable People and Communities? Are there alternatives that should be considered, and can you provide information to support this view?**

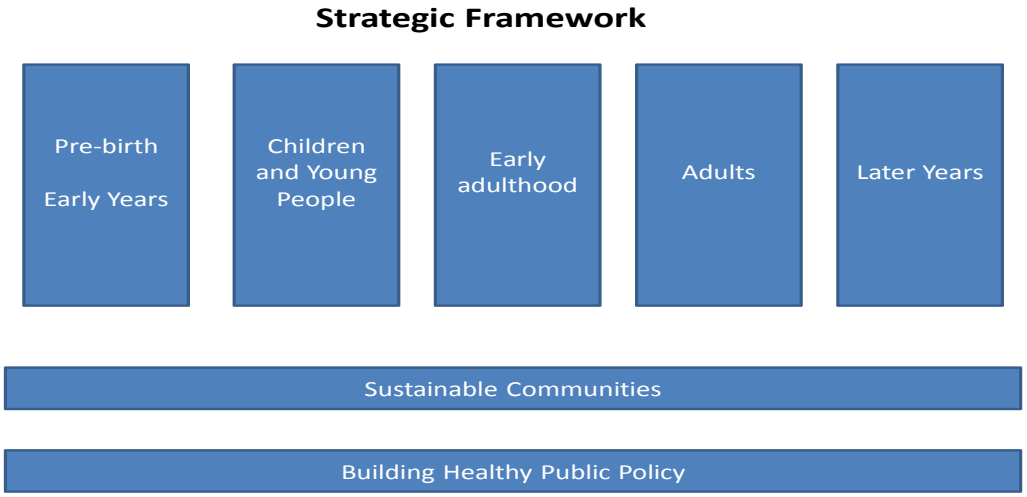
Chapter Seven

Strategic Framework Themes and Outcomes

This chapter provides information on the challenges for each life stage and underpinning theme, and includes long term aspirational outcomes and outcomes for 2012 – 2015 to address these.

Life Stages

7.1 For each of the life stages and underpinning themes there follows a policy aim, brief rationale, long term and specific outcomes for 2012-2015. The focus of the framework is on the key outcomes for each lifestage and underpinning theme. **This aligns much of the current or planned government effort but does not encompass everything that could be or is being done.**



Pre birth and Early Years 0-5*

Policy Aim

- **Give every child the best start**

Rationale

- The total population in Northern Ireland (NI) is estimated to be 1,799 million
  (mid-year estimate 30 June 2011)
- Of this 382,000 are children aged under 16
- In 2009/10 there were 25,000 births
- We have high levels of child deprivation - 21% of children in NI live in relative income poverty

- Sure Start caters for 34,000 children aged 0–4 in particularly disadvantaged areas (almost 30% of the 0–4 population).
- Overall, the uptake rate of MMR immunisation has improved since monitoring began in 2004/05 when it was recorded as being 88%. The latest uptake rate of MMR immunisation for children at 24 months was 92% in 2010/11.
- Despite sizeable year-on-year fluctuation in the NI infant mortality rate, it can be seen to be generally improving however at a slower than in the rest of the UK. Provisional figures for 2011 show 110 infant deaths in NI

* Ref : para 6.5 The age ranges in this framework are meant as a *guide*

7.2 What happens to children in their earliest years says much about our society and is key to outcomes in adult life. This is now supported by a wide range of research evidence from education, health, justice and economic experts. This evidence shows that individuals and communities benefit from the strong attachment and emotional links that are created by good parenting and positive early life experience. Positive early year's experiences give children the best start in life and help to prepare children to get the most out of education.

7.3 A large part of the pattern for a person's future adult life is set by age 3. At age 3, children at higher risk of poor outcomes can be identified on the basis of their chaotic home circumstances, their emotional behaviour, their negativity and poor development. These children face many risks, and improving early years support is key to improving child protection. By the time such children reach adulthood, these children are more likely to have poor health outcomes, be unemployed, have criminal convictions, have substance misuse problems and have experienced teenage pregnancy.

7.4 Children's dispositions and attitudes to learning are acquired early and it is important to ensure that these foundations are positive. The coherence between a child's experience within the education setting, what they experience before and after arriving at the setting can vary considerably. The importance of working in partnership with parents and care givers to enable them to provide continuity in their child's early experiences from home to pre-school and to encourage a positive home learning environment is clear.

7.5 From pregnancy through early childhood, all of the environments in which children live and learn, and the quality of their relationships with adults and care givers, have a significant impact on their cognitive, emotional and social development. A wide range of policies, including those directed toward early care and education, primary health care, child protective services, adult mental health, and family economic supports, among many others, can promote the safe, supportive environments and stable, caring relationships that children need.

7.6 In respect of poverty and deprivation, as one goes from the bottom to the top of family SES in virtually all societies, child developmental outcomes, on average, improve. This is the "social gradient effect". Family SES has an impact on outcomes as diverse as low birth weight, risk of dental caries,

cognitive test scores, difficulties with behaviour and socialization, and risk of disengagement from school.

7.7 Children born into low SES families are more likely to be exposed to – and affected by – conditions that are adverse for development, such as homelessness, poor living conditions or unsafe neighbourhoods. In addition low levels of parental education and literacy affect the knowledge and skill-base of children's caregivers.

7.8 To address these health inequalities action must therefore start from the very earliest stage, given what we know about the differential affects of the conditions within which children are born and grow. Society will benefit from a coordinated effort particularly between the Health and Education sectors to support and promote positive development of the intellectual, emotional and social skills of young children before primary school entry. This must also include support for parents to be empowered and enabled to avail of every opportunity to fulfil their role as first educators. This is essential if we are to stand any chance of breaking the close links between early disadvantage and poor outcomes throughout life.

7.9 Effective approaches to early years and early intervention policy will also contribute strongly to promoting and upholding children's rights as defined by the UN Convention on the Rights of the Child (UNCRC) and indeed those rights must underpin all policy for children.

Support for Families and Children

7.10 The Independent Report on Early Intervention (2011) *argues that the benefits of early intervention are that the next and succeeding generations are prepared and made ready for school, work, parenthood and for life in general, creating a virtuous, rather than a vicious, cycle. This is evidenced by international studies that have shown that the effects of poverty and deprivation can be reduced by using sustainable interventions including early interventions, supporting parenting, increasing continued access to support and interventions to support pathways to education.

Research has shown that preventative strategies and early intervention are cost effective and there is evidence to support the view that resources invested in early years will result in proportionately greater benefits.
In Northern Ireland there is a range of work underway, ie a number of strategic policies and programmes are relevant and this framework will seek to encourage synergy with these eg Children and Young People's strategy, Families Matter, Child Health Promotion Programme – Healthy Child, Healthy Future, Early Years strategy (under development), Maternity strategy, Delivering Social Change, Reducing Offending etc.

**Early Intervention: The Next Steps, An Independent Report to HM Government, Graham Allen MP, Jan 2011*

In order to address these issues the Framework has therefore developed three long-term outcomes –

Long Term Outcomes

- ***Children have safe and supportive family, living, play and learning environments***
- ***Children are prepared for school and later life***
- ***Children to have achieved their full potential in respect of cognitive, linguistic, emotional, behavioural and physical outcomes***

Question 5: **Do you wish to make any comments on the aims and outcomes for the Pre-birth and Early Years lifestage? Are there any gaps and do you have evidence to support your view?**

EARLY YEARS: PRE-BIRTH AND EARLY YEARS		
POLICY AIM: **GIVE EVERY CHILD THE BEST START**		
Long Term Outcome	Outcomes 2012 - 2015	KEY PARTNERS
Outcome 1 Children have safe and supportive family, living, play and learning environments	1. Positive parenting promoted and supported, with a particular emphasis on people deemed vulnerable or in areas of disadvantage, through implementation of a range initiatives, including: • advice and support to women and their partners before and during pregnancy and to parents and guardians of children 0-4 on a range of health related issues, including smoking cessation, alcohol and drug misuse, nutrition and breastfeeding • antenatal and neonatal screening • integrated family support services, including Family Support Hubs • information and support for separated and separating families, including families with a parent in prison • effective family based Child Maintenance arrangements in place for relevant children	DHSSPS/HSC/ CYPSP/ other Departments
	2. Children and families (including teenage parents) who require additional support have access to an agreed regional menu of evidence based parenting programmes with universal and targeted approaches, including the further introduction of the Family Nurse Partnership programme.	DHSSPS/HSC
	3. Access to appropriate high quality safe, sustainable, accessible hospital, primary & community health services (including pharmacy, dental and ophthalmic) for children	DHSSPS/HSC
	4. Improved opportunities for play and leisure as part of the Delivering Social Change Delivery Framework.	Departments led by OFMDFM
	5. Improved safeguarding outcomes for children	DHSSPS/HSC
	6. Stable secure relationships are provided for looked after children including increased usage of kinship carers.	DHSSPS/HSC

	7. Reduction in the number of children killed or seriously injured in road collisions	DOE
	8. Reduction in accidental injuries and deaths in the home	DHSSPS/PHA/Local Government
	9. Free travel on Translink bus and rail services is maintained for children under the age of 5.	DRD
	10. Improved availability of high quality, accessible and affordable childcare through a new Childcare Strategy	Departments led by OFMDFM
	11. A sustained long term reduction in poverty and an improvement in young people's health, wellbeing and life opportunities, through the delivery of a range of key actions, by way of the Delivering Social Change Delivery Framework	Departments led by OFMDFM
	12. The Neighbourhood Renewal Investment Fund will, in line with priority needs identified in Neighbourhood Action Plans, support a range of programmes across the 'life course' which seek to address the social and economic determinants of deprivation	DSD
Outcome 2 Children are prepared for school and later life	1. High quality Sure Start services maintained in designated areas of disadvantage, to support parenting and services for children aged 0-4	DE /DHSSPS/HSC
	2. At least one year of pre-school education available to every family that wants it.	DE
	3. Learning and development linked more effectively through relevant strategies and policies and around early intervention and early years.	DE/DHSSPS
	4. Every child has the opportunity to take part in a Libraries Early Year activity	DCAL
	5. Eye health issues in children will be assessed and identified in readiness for starting school through a comprehensive visual examination	DHSSPS/HSC

Outcome 3 Children to have achieved their full potential in respect of cognitive, linguistic, emotional, behavioural and physical outcomes	1. All children and families are offered the full range of health protection, health promotion, surveillance and screening and immunisation programmes through the Child Health Promotion Programme, *Healthy Child, Healthy Future*, and their needs assessed at the earliest opportunity to identify those who require additional and targeted support of broader services	DHSSPS/ HSC
	2. Families with infants with a learning and/or physical disability have access to generic/ mainstream programmes and specialist early intervention services	DHSSPS/ HSC
	3. Increased breastfeeding rates particularly for those least likely to breastfeed, including young mothers and those in lower socio-economic groups	DHSSPS/ HSC
	4. Targeted support for eligible low income, nutritionally vulnerable pregnant women and young families through the continued delivery of the Healthy Start Scheme	DHSSPS/ HSC
	5. Increased percentage meeting the CMO Physical Activity Guidelines for early years	DHSSPS/ PHA/DCAL
	6. Increased support for children born to or living with substance misusing parents or carers through the implementation of the PHA/HSCB Hidden Harm Action Plan	DHSSPS/ HSC
	7. Improved outcomes for young children with speech, language and communication needs, through the implementation of speech, language and communication therapy action plan	DHSSPS/ HSC
	8. Caries prevention for children at risk through development and implementation across all Trusts of an evidence-based regional programme	DHSSPS/ Dental services

Children and Young People - 5-16*

Policy Aim

- **Enable all children and young people to develop the skills and capacity to reach their full potential and have control over their lives**

Rationale

7.11 Investment in promoting the growth and development of young children is particularly apt for Northern Ireland as we have one of the youngest populations within the European Union (22% of population are under 16 years and 27% are under 19 years), combined with rapid changes in family structure and the composition of society.

- We also have high levels of child deprivation
- Around 26% of 16 year olds here have (in the previous year) experienced serious personal, emotional, behavioural or mental health problems; with this figure increasing to 43% for 16 year olds from "financially not well-off backgrounds".
- Mental ill health is unique in that half of lifetime cases of mental illnesses begin by age 14
- 5% of children aged 5-10 years have a conduct disorder. Conduct disorder at age 7 to 9 is associated with increased risk of criminal offending, mental health disorders, and substance dependence in late adolescence and early adulthood.
- Over 4,800 children in NI have been identified as living in homes where high risk domestic violence is an issue (MARAC reporting period Jan 2010 – May 2012)
- Around 8% of 11-16 year olds are current smokers
- Bullying leads to poor mental health and wellbeing on the part of the victim. Perpetrators also carry a higher risk of tendency to violence into their adult lives.
- In 2010 there were 1,265 births to mothers aged under 20 years; of which 145 births were to mothers aged under 17 years.
- Of the 1,435 16 year olds who took part in the 2011 Young Life and Times* survey 26% reported that they had sex – lessons at schools were identified as the most helpful source of information about sexual matters (42% of respondents) followed by friends (18%) and respondent's mother (12%)

*ARK. Young Life and Times Survey, 2011 [computer file]. ARK www.ark.ac.uk/ylt [distributor], May 2012.

* Ref : para 6.5 The age ranges in this framework are meant as a *guide*

While there has been in recent years a growing recognition of the crucial importance of the early (or 'foundation') years for individuals' future life chances, Marmot also emphasised the importance of sustaining effective, evidence-based interventions across the life course.

A similar insight is reflected in UNICEF's most recent report on The State of the World's Children. In focusing on adolescence not only as a time of vulnerability but also as an age of opportunity, it notes that lasting change in the lives of children and young people can only be achieved by complementing the commitment to the first decade of life with similar recognition of the importance of the second.

7.12 Growing up is a time in life of considerable health and social needs. Sustaining good emotional, cognitive and physical development beyond early and into teenage years, through the period of education, is vital for future health and wellbeing and social outcomes such as educational attainment, employment and income prospects etc. dn include mention of mental health/ resilience/ coping skills.

7.13 How children progress at school is clearly important to social development over their life course. Schools are key to the achievement of the aims of improving population health and wellbeing and reducing health inequalities. They are vitally important settings for personal and social development, and the development of lifeskills and behaviours which will influence later life chances. Individuals who perform well at school are more likely to adopt healthier lifestyle behaviours and to have positive mental health. Whilst investment in early years is crucial, it needs to be combined with sustained commitment to children and young people throughout their years of education in order to reduce health and education inequalities.

7.14 Evidence shows that children who start off well at school are more likely to achieve good qualifications that lead to a job with good income and social status which, in turn, affects health and life expectancy. Conversely children growing up in poorer families where parents have lower levels of qualifications are less likely to be 'school ready' than children in more affluent households. Children who do not thrive at school are more likely to become disengaged, try 'risky behaviour' such as smoking and drinking at an early age and are less likely to obtain good qualifications.

7.15 This reinforces the argument that intervention activities aimed at reducing health inequalities have to tackle inequalities in the broad socioeconomic context underlying child and adolescent environments. Reducing educational inequalities should therefore be a key outcome in any strategy to reduce social and health inequalities. Note should also be taken of the interaction between social determinants and educational outcomes and in this respect it is acknowledged that many influences lie outside the school environment and include family background, neighbourhood and peers. There is evidence, for example, that suggests that it is families rather than schools that have the most influence on educational attainment. Therefore schools and families together are important for promoting the development of children – physically, socially, and emotionally as well as cognitively.

7.16 Success in learning at school is rooted in the stimulation and encouragement received at home, in the family and in the community. If parents do not have these skills then it is more likely that children fall behind and disadvantage is

passed on. This emphasises the importance of support during early years to aid the transition to more formal learning at school, and of maintaining support involving the family, communities and social networks.

7.17 The importance of positive mental health and wellbeing for successful learning is recognised within the Northern Ireland curriculum which now has an increased emphasis on the promotion of mental wellbeing. The education sector therefore has a keen interest in developing the emotional and interpersonal skills of pupils and students. Personal Development and Mutual Understanding (at primary level) and Learning for Life and Work at (post-primary level) provide discrete areas of learning designed to encourage pupils to: improve their self-esteem; manage factors that influence emotional health; be attuned to the feelings of others; and to lead healthy lives including eating healthily and being active.

7.18 The main approach to sexual health and teenage pregnancy issues in the school setting is through Relationship and Sexuality Education (RSE), which has statutory status within the Revised Curriculum NI. The delivery of RSE recognises the ethos of the school and is appropriate to the ability/development/age of the young people. The messages are broadly based and will look at the development of the whole person including decision making skills, confidence building, trust in themselves and others etc.

7.19 Adolescence is a critical transitional period that includes the biological changes of puberty and the need to negotiate key developmental tasks, such as increasing independence and normative experimentation. Adolescents and young adults are particularly sensitive to contextual influences. Factors such as the influence of family, peer group, school, neighbourhood, and developmental changes such as increased need for privacy and independence, can either support or challenge young people's health and well-being. Addressing the positive development of young people, for example promotion of social competences and abilities such as empathy, self confidence, self worth, aspiration and connectedness, facilitates adoption of healthy behaviours and helps to ensure a healthy and productive future adult population.

7.20 Effective collaboration between health and education is vital to supporting children and young people to achieve their full potential. This is reflected in a number of aspects of the Curriculum and in joint actions contained in for example strategies such as the Obesity Prevention Framework "A Fitter Future for All", New Strategic Direction for Alcohol and Drugs Phase 2, Protect Life, Care Matters etc

Examples include –

- In addition to the curriculum changes, a Pupils' Emotional Health and Wellbeing Programme is being developed, initially for the post-primary sector, addressing how a pupil's emotional health and wellbeing is promoted by the school. The Programme is a joint health and education

initiative and is to be an ongoing effort with new products added and existing ones refreshed as time goes on. The aim is to ensure consistent good practice in schools on approaches to the promotion of positive emotional health and wellbeing. The Programme is also to act as the "glue" integrating the services that have an impact on pupil's emotional health and wellbeing.

- An independent counselling service has also been available to post-primary pupils since September 2007 and work is underway to determine the support that should be made available to primary and special schools.

- DE identifies personal and social development as the central theme of youth work. The Education and Library Boards' youth services have identified working with young people on health and well-being issues as a priority issue.

In support of this therefore, the following long-term outcomes are proposed:

Long Term Outcomes

- ***Children and young people have safe and supportive family, living, play and learning environments***
- ***Children and young people are supported through teenage years and ready for adulthood/ work / further education***
- ***Children and young people have achieved their full potential in respect of social and emotional development and physical and mental health outcomes***

Question 6: **Do you wish to make any comments on the aims and outcomes for the Children and Young People lifestage? Are there any gaps and do you have evidence to support your view?**

CHILDREN AND YOUNG PEOPLE		
POLICY AIM: **ENABLE ALL CHILDREN AND YOUNG PEOPLE TO DEVELOP THE SKILLS AND CAPACITY TO REACH THEIR FULL POTENTIAL AND HAVE CONTROL OVER THEIR LIVES**		
Long Term Outcomes	Outcomes 2012 - 2015	KEY PARTNERS
Outcome 1 Children and young people have safe and supportive family, healthy living, play and learning environments	1. Positive parenting promoted and supported, with a particular emphasis on people deemed vulnerable or in areas of disadvantage, through implementation of a range initiatives, including: • advice and support to parents and guardians on a range of health related issues, including smoking cessation, alcohol and drug misuse and nutrition • integrated family support services, including Family Support Hubs • information and support for separated and separating families, including families with a parent in prison • effective family based Child Maintenance arrangements in place for relevant children	DHSSPS/HSC/ CYPSP/ other Departments
	2. Improved opportunities for play and leisure as part of the Delivering Social Change Delivery Framework.	Departments led by OFMDFM
	3. Arrangements for proof of identity strengthened to prevent underage alcohol sales and strengthen the penalties for those convicted of underage sales.	DSD/DHSSPS
	4. Access to appropriate high quality safe, sustainable, accessible hospital, primary & community health services (including pharmacy, dental and ophthalmic).	DHSSPS/HSC
	5. Improved safeguarding outcomes for children	DHSSPS/HSC
	6. Increased access to One-Stop-Shop services, in areas of identified need, to those young people affected by substance misuse, but also addressing issues such as suicide and self-harm; mental health and wellbeing; sexual health; relationship issues; resilience; and coping skills	DHSSPS/HSC
	7. Pregnant teenagers have access to tailored maternity services and schemes such as 'Family Nurse Partnerships'	DHSSPS/HSC

	8. Stable secure relationships are provided for looked after children/ young persons including increased usage of kinship carers.	DHSSPS/HSC
	9. Reduction in child casualties on farms through tailored information delivered in rural primary schools.	DETI/HSE/DE/DARD
	10. Reduction in the number of children killed or seriously injured in road collisions	DOE
	11. Reduction in accidental injuries and deaths in the home	DHSSPS/PHA/Local Government
	12. Children and young people who are victims of sexual violence will be supported with specialist, co-ordinated care in the immediate aftermath of a sexual assault, rape or childhood sexual abuse.	DHSSPS/DOJ and other statutory and voluntary sector partners
	13. Improved children's health and wellbeing through improving their environment by developing cross-departmental delivery plan to implement the UK Children's Environment and Health Strategy	DHSSPS/DOE/ other Departments
	14. Travel – - provision of concessionary fares (ie half fares) is maintained for children and young people up to their 16th birthday - provision of free travel to school for those children who live beyond walking distance from their nearest suitable school by Education and Library Boards is maintained (subject to the outcome of any review of the scheme as announced by the Minister of Education in the NI Assembly on 10 October 2011)	DRD DE
	15. A sustained long term reduction in poverty and an improvement in young people's health, wellbeing and life opportunities, through the delivery of a range of key actions, by way of the Delivering Social Change Delivery Framework	Departments led by OFMDFM
	16. The Neighbourhood Renewal Investment Fund will, in line with priority needs identified in Neighbourhood Action Plans, support a range of programmes across the 'life course' which seek to address the social and economic determinants of deprivation	DSD

Outcome 2 Children and young people are supported through teenage years and ready for adulthood/ work/ further education	1. Through implementation of "Every School a Good School" and the Literacy and Numeracy Strategy - • Increased proportion of school leavers achieving at least 5 GCSEs at A* – C or equivalent including GCSE English and maths • Increased proportion of school leavers from disadvantaged backgrounds achieving at least 5 GCSEs at A* – C or equivalent including GCSE English and Maths	DE
	2. Access through implementation of the Entitlement Framework to a broad and balanced range of courses that have coherent pathways to HE, FE, training or employment and that meet the needs of the local economy	DE
	3. Early identification and intervention to support children and young people with special educational needs through pilot approaches and building capacity in line with the Review of SEN & Inclusion	DE
	4. Support those with Additional Educational Needs eg Looked After Children, Travellers, Newcomers and School Age Mothers to include – • Full roll out of Personal Education Plans (PEPs) process for all Looked After Children in school and training • Development of guidance for schools on promoting the attendance of pupils from disadvantaged backgrounds	DE/DHSSPS
	5. For looked after children and young people – • Greater involvement in the preparation of their care and personal education plans • Improved engagement in special interests, leisure and extra-curriculum activities • Regular school attendance by all children and young people in care.	DE/DHSSPS
	6. Young people provided with an awareness of the financial implications of parenthood	DE
	7. Children and young people supported to reach their full potential through publication and implementation of Priorities for Youth Policy	DE

	8. Increased proportion of young people in education, employment or training through development and implementation of a cross-departmental Strategy (NEETs).	DEL,DE and others
	9. Every child has an opportunity to visit a museum or take part in a museum outreach programme	DCAL
Outcome 3 Children and young people have achieved their full potential in respect of social and emotional development and physical and mental health outcomes	1. Implementation of the Pupils' Emotional Health and Wellbeing Programme across the primary and post primary sectors	DE
	2. Rollout of the Roots of Empathy Programme in primary schools	DHSSPS/ PHA
	3. Reduced numbers of children and young people taking up the smoking habit	DHSSPS/PHA/DE
	4. Fewer children and young people exposed to the dangers of second hand smoke	DHSSPS/PHA
	5. Increased percentage meeting the CMO Physical Activity Guidelines	DHSSPS/PHA/DCAL
	6. By 2014 every child provided with an opportunity to participate in 2 hrs/ week of extracurricular sport and physical recreation	DCAL
	7. Reduction in the percentage of children and young people getting drunk and regularly using illicit substances through the implementation of the *New Strategic Direction for Alcohol and Drugs Phase 2* and the *Young People's Drinking Action Plan*.	DHSSPS/PHA/DE
	8. Increase in numbers of young people delaying first sexual experience	DHSSPS/PHA
	9. Further reductions in the rates of births to teenage mothers across NI but particularly in Neighbourhood Renewal areas	DHSSPS/PHA/DSD/DE
	10. Increased awareness of care in the sun	DHSSPS/PHA/DE
	11. Reduction in the percentage of children and young people who are overweight or obese through the implementation of A Fitter Future for All and, pending Executive agreement, the Food in Schools Policy.	DHSSPS/PHA/DE

	12. Children and young people have confidential access to health advice which is evidence based and meets their needs.	HSC
	13. Caries prevention for children (at risk) through development and implementation across all Trusts of an evidence-based regional programme.	DHSSPS/Dental services
	14. High uptake levels of vaccination programmes, including of HPV, and of diabetic retinopathy screening to those aged 12 and over with diabetes	DHSSPS/HSC
	15. Assessments developed within justice system to direct young people with mental health and/or communication problems to appropriate services outside of justice	DOJ
	16. Improved outcomes for children and young people with speech, language and communication needs, including young offenders, through the implementation of speech, language and communication therapy action plan.	DHSSPS/HSC
	17. Mental and physical wellbeing of children and young people in contact with mental health services or with a learning disability improved through implementation of the Mental Health and Learning Disability Service Frameworks and the Bamford Action Plan	DHSSPS/HSC
	18. Access to Arts health intervention programs to aid recovery from illness and address mental health problems	DCAL

Early Adulthood 17-24*

Policy Aim

- **To enable young adults to grow, manage change and maximise their potential**

Rationale

7. 21

- 16% of the respondents in the 16-24 age group showed signs of a possible mental health problem by scoring highly on the GHQ12 (2010/11), around one in ten males (9%) compared with around one in five females (21%)
- During 2010 54% of the new STI diagnoses for which age group information is available occurred in young people under age 24
- In respect of road traffic collisions during 2011/12 casualties aged between 16-24 years of age accounted for 23.1% of all fatalities compared with 31.0% in 2010/11. Within this age group, males aged 16-24 accounted for 15.4% of all fatalities in 2011/12 compared with 27.6% the previous year*
- The NI economic inactivity rate for those aged 16-64 stands at 27.4%. This is significantly higher than the UK average rate (23.0%) and is the highest of the twelve UK regions. Unadjusted figures estimate that 32% of the economically inactive, aged 16-64, in NI are students. (May 2012, Monthly Labour Market report, NISRA)
- Unemployment rate for 18-24 year olds is estimated at 17.9% up 0.1percentage point over the year.
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*Police recorded Injury and Road Traffic Collision and Casualties NI 2011/12

* Ref: para 6.5 The age ranges in this framework are meant as a *guide*

7.22 Early adulthood presents particular challenges for public health both in terms of lifestyle behaviours and the growing heterogeneity of the group. As children grow into adults, they face very different opportunities and challenges – some will be moving into further or higher formal education, others may be leaving education and seeking work for the first time. Some will be moving into their own accommodation others will stay at home. It is also a time of developing relationships. Thus the social and economic context of their lives is changing – for many it is a new and different world.

7.23 It is a time of adjusting to new responsibilities and the transition can involve positive and negative features, such as increased freedom or independence, but also increased stress. While it is generally a time of peak health it is often associated with risk taking behaviour with small realisation of the potential impact on future health. Maintaining healthy behaviours and sustaining good physical, sexual health and positive mental health through this period into adulthood is important to prevent the onset of diseases and conditions such as heart disease, respiratory disease, raised blood pressure, diabetes etc .

7.24 A recent report by the Patient Client Council (PCC) analysed the views of a number of young people (16-21.) In response to a question on priorities for health and social care, health promotion was included as one of ten priorities identified. Young People said –

"*People need to be educated to live healthier lifestyles so that they do not need treatment for conditions caused by obesity, smoking, drinking alcohol and drug abuse."*

There is a need to build on key messages that have come from young people and to continue the focus on health education through schools and into further and higher education establishments in conjunction with relevant Departments, education providers, student organisations etc. using methods and media appropriate for this age group.

7.25 The level of educational attainment and entry into the world of work are vitally important issues for young people, since they strongly influence whether they are 'on track' to progress into a fulfilling and healthy adulthood. Evidence shows that those with higher attainment, in particular those educated to degree level, are not only to be more likely to be in full time employment than those with lower educational attainment, but also less likely to smoke and be overweight and more likely to exercise regularly and eat healthily.

7.26 Young people are the group most likely to be unemployed and to be in low-skilled jobs, in addition the number and type of jobs available to those with low level skills is increasingly on the decline with growth of jobs predominantly in employment which requires higher skills. Young people who do poorly at school are at risk of becoming "NEET" (Not in Education, Employment or Training) which can have a significant negative impact on their life chances and future health and wellbeing.

7.27 Young people who are more socially deprived generally have lower educational attainment and experience greater levels of mental health problems, teenage pregnancies and injuries, display higher levels of risky behaviours or associated problems (smoking and drinking). New Youth Access in the UK research indicates that mental health problems are far more common among 18–24 year old NEETs than those who are in education, employment or training; and that stress related illness, loss of confidence and worry, as a result of social welfare problems, are more common among those who are NEET.

7.28 The evidence points to the importance of providing the opportunities for young people to acquire higher levels of skills and qualifications and work based learning routes beyond the compulsory education age of 16. Ensuring that young people receive individualised support to gain skills involves starting before they leave school and maintaining the support through the transitional years up to 25.

7.29 Participation in post-compulsory education or training, or in other activities which provide purpose, or opportunities to gain experience and skills such as volunteering, has potential benefits relevant to a range of health outcomes, such as stimulating personal development, confidence and self - efficacy, increasing job chances and career progression, healthier behaviour etc. A key role for policy makers is to ensure young people have support to gain knowledge, skills and qualifications during the transition into adulthood to help them achieve their full potential and improve their life chances.

In support of this therefore, the following long-term outcomes are proposed:

Long Term Outcomes

- **Young adults have safe and supportive healthy living, learning, working and social environments and opportunities for participation in community life**
- **Young adults have access to training or employment opportunities and are equipped for work or further education**
- **Young adults have good physical and mental health and wellbeing**

Question 7: **Do you wish to make any comments on the aims and outcomes for the Young Adults lifestage? Are there any gaps and do you have evidence to support your view?**

EARLY ADULTHOOD		
POLICY AIM: **ENABLE YOUNG ADULTS TO GROW, MANAGE CHANGE AND MAXIMISE THEIR POTENTIAL**		
Long Term Outcomes	Outcomes 2012 - 2015	KEY PARTNERS
Outcome 1 Young adults have safe and supportive healthy living, learning, working and social environments, and opportunities for participation in community life.	1. Increased access to One-Stop-Shop services, in areas of identified need, to those young people affected by substance misuse, but also addressing issues such as suicide and self-harm; mental health and wellbeing; sexual health; relationship issues; resilience; and coping skills	DHSSPS/HSC
	2. Arrangements for proof of identity strengthened to prevent underage alcohol sales and strengthen the penalties for those convicted of underage sales introduced	DSD/DHSSPS
	3. Young people have access to appropriate high quality, safe, sustainable and accessible hospital, primary & community health services (including pharmacy, dental and ophthalmic), including a managed transition to the adult service where appropriate.	DHSSPS/HSC
	4. Relevant outcomes in Care Matters are taken forward aimed at reducing exclusion and marginalisation - Young people in and leaving care are maintained in higher and further education - Current employability services for each Trust area are enhanced providing dedicated education and training support. - Young people in and leaving care are maintained in suitable, affordable and safe accommodation with financial support whilst in higher education/ training - Provision of fostering services for 18+ in care is continued - Provision of a point of contact - adviser up to age 25	DHSSPS/DEL/HSC
	5. Young pregnant women have access to tailored maternity services and, where appropriate, to schemes such as 'Family Nurse Partnerships'	DHSSPS/HSC
	6. Young adults at risk of offending diverted through PSCPs working collaboratively with local government and relevant Departments	DOJ

	7. Rehabilitation and re-integration of young offenders in custody.	DOJ
	8. Reduction in accidental injuries and deaths in the home	DHSSPS/PHA/Local Government
	9. Reduction in the number of young people (aged 16 to 24) killed or seriously injured in road collisions, and in the number of killed or seriously injured casualties resulting from collisions involving drivers under the age of 25	DOE
	10. Young people who are victims of sexual violence will be supported with specialist, co-ordinated care in the immediate aftermath of a sexual assault, rape or childhood sexual abuse	DHSSPS/DOJ and other statutory and voluntary sector partners
	11. Travel – - Half fare travel on bus and rail services for young adults who have certain disabilities is maintained. (Concessionary Fares Scheme). - Free travel for those who are Registered Blind is maintained - Commercial discounts for travel by those young adults in further education by Translink are maintained.	DRD
	12. A sustained long term reduction in poverty and an improvement in young people's health, wellbeing and life opportunities, through the delivery of a range of key actions, by way of the Delivering Social Change Delivery Framework	Departments led by OFMDFM
	13. The Neighbourhood Renewal Investment Fund will, in line with priority needs identified in Neighbourhood Action Plans, support a range of programmes across the 'life course' which seek to address the social and economic determinants of deprivation	DSD
Outcome 2 Young adults have access to training or employment opportunities and are equipped for work or further education	1. Young people are provided with careers advice and support as required to enable them to make effective career/learning choices.	DEL
	2. From post 16 young people will have access to a broad and balanced range of courses including Essential Skills that have coherent pathways to HE/FE training or employment and that meets the needs of the local economy.	DEL

	3. Through raising attainment levels and aspirations a wider group of young people have an opportunity to access suitable further and higher education provision	DEL/DE
	4. The Social Investment Fund (SIF) will support communities, including young people, to **Build Pathways to Employment**, by tackling educational under achievement and barriers to employment; tackling skills deficits and promoting job brokerage, widening access to the labour market, promoting business start up and increasing sustainability through social enterprise.	OFMDFM/others
	5. People with health and disability related barriers to employment are assisted to improve their chances of finding and sustaining employment through the provision of specialist employment services and programmes.	DEL
	6. Young people in the 16 and 17 year old age group (up to age 24 in special circumstances) who have left school will be provided with a guarantee of a training place	DEL
	7. Increased proportion of young people in education, employment or training through development and implementation of a cross-departmental Strategy (NEETs).	DEL/others
	8. Children and young people up to the age of 19 with special educational needs continue to be supported and prepared for the transition to adulthood	DE
	9. Young people supported to reach their full potential through publication and implementation of Priorities for Youth Policy	DE
	10. Tailored health and safety information will be made available to all young people entering the world of work for the first time	DETI/HSE
Outcome 3 Young adults have good physical and mental health and wellbeing	1. Improved mental wellbeing among young adults	DHSSPS/ PHA/Others
	2. Reduction in the levels of deliberate self harm	DHSSPS/PHA /Others

	3. Reduction in the differential in suicide rates between young adults in deprived areas and the NI average	DHSSPS/PHA /Others
	4. Reduction of Sexually Transmitted Infections (STIs) including HIV, and reduction in births to teenage mothers.	DHSSPS/PHA/Others
	5. Reduction in the harm suffered by young people in relation to the consumption of alcohol, and the harm caused to others, by young people's drinking through the implementation the *New Strategic Direction for Alcohol and Drugs Phase 2* and the *Young People's Drinking Action Plan*.	DHSSPS/PHA/Others
	6. Reduction in the percentage of young adults who are overweight or obese through the implementation of *A Fitter Future for All*	DHSSPS/PHA/Others
	7. Increased percentage of this age group meeting the CMO Physical Activity Guidelines	DHSSPS/PHA/DCAL
	8. Increased number of young people and adults with learning disabilities participating in sport and recreation and leisure activities.	DCAL
	9. Increased numbers of young people who are members of at least one sports club	DCAL
	10. Increased awareness of care in the sun and risks associated with sun bed usage	DHSSPS/PHA/others
	11. Improved access to contemporary health and wellbeing advice, information and support appropriate to early adulthood needs, including through greater use of modern communication technology	DHSSPS/HSC/Others inc eg NUS - USI
	12. Improved mental and physical wellbeing of young adults in contact with mental health services and/ or with a learning disability through implementation of the Mental Health and Learning Disability Service Frameworks and the Bamford Action Plan.	DHSSPS/HSC

	13. Young adults with long term conditions have access to information and patient education and support programmes that will help them manage their condition more effectively, optimise health and well-being and quality of life and prevent or minimise deterioration of their condition.	DHSSPS/HSC
	14. Access to Arts health intervention programmes to aid recovery from illness and address mental health problems	DCAL

Working Age Adults 25 – 64*

Policy Aim

- **Enable working age adults to have a full and satisfying life and social wellbeing**

Rationale

- Almost a quarter of respondents (23%) in the 35-44 age-group showed signs of a possible mental health problem by scoring highly on the GHQ12 , 18% of males compared with 27% of females. (2010/11)
- Research draws attention to association of unemployment with a two to three-fold increased risk of suicide among men
- Smoking prevalence is now 24% among the general population, it remains high amongst manual workers at 30%
- 59% of adults measured for the Health survey 2010/11 were either overweight (36%) or obese (23%)
- 1 in 4 females and 1 in 9 males will experience domestic violence in their lifetime
- The NI employment rate (estimated at 67.6% for those aged 16 – 64) remained below the UK average (70.5%) and was the third lowest rate among the twelve UK regions
- Unemployment rate Jan-March 2012 was estimated at 6.7%, down 0.9 percentage points over the quarter and year, with nos of unemployed estimated at 57,000.
  (Monthly Labour market bulletin – May 2012)

* Ref : para 6.5 The age ranges in this framework are meant as a *guide*

7.30 Adulthood is shaped by how we have grown up, and in turn influences how well we will live in later years. A large majority of adults in Northern Ireland now enjoy good health, and in general the population can expect to live longer. However there are still many challenges in respect of health inequalities, increasing long term damage related to health behaviours such as poor diet, low levels of physical activity, smoking and alcohol consumption etc.

7.31 As well as physical health it is clear that mental health is a major public health concern in Northern Ireland, necessitating a strong strategic drive to prevent mental illness (where possible) and to promote positive mental wellbeing in the general population.

7.32 Mental illness is now regarded as the most common form of illness and disability. It accounts for a larger share of the overall burden of disease in the UK than any other health condition. Estimates of the burden of poor mental health range from 9%[5] to 23%[6] of the total health burden in the UK. There is

also evidence to suggest that Northern Ireland has up to 20% higher levels of psychiatric morbidity than the rest of the UK.

7.33 Wider influences have a profound impact on people's physical and mental health. Poverty, poor education, poor housing, living in a workless household, and exposure to violence in childhood impact on later mental health and individual emotional resilience [Refs: Nurse, J and Campion, J (2006) *Mental Health and Wellbeing in the South East 2006* www.sepho.org.uk. Marmot, M and Wilkinson, R. (eds) (2003) *Social determinants of health: The solid facts.* WHO]. When experienced during adult lives, these wider factors also have a profound influence on health and well-being. For example, people's working lives – whether they experience unemployment or job security – matter to their health.

7.34 Being without work is rarely good for health - there is a clear link between unemployment and poorer health. "Good" work is linked to positive health outcomes – purposeful, paid work is vital and protective of health - there is evidence that employment status is also a factor, with those in higher status jobs being healthier. However jobs that are insecure, low paid and that fail to protect workers from stress and danger make people ill. This relationship between health and work is being recognised as integral to the prosperity and wellbeing of individuals, their families, workplaces and wider communities. Support for employers to provide a safe and healthy working environment and to promote health in the workplace will contribute not just to workforce health but to business performance.

7.35 Addressing the needs of those who are long term sick or disabled is also essential – innovative ways of supporting people who are long term sick or disabled to make the transition into paid work will be an important step towards a healthy population and strong economic workforce, and can make a significant contribution to delivering targets to aid economic recovery and growth.

7.36 Lifelong learning also has the potential for impacting on health inequalities – both in terms of providing skills and qualifications to enhance employment opportunities and also there is evidence that participation in adult learning in itself impacts on confidence, self efficacy which have been shown to be associated with health behaviours. The evidence also suggests that adult education increases social capital which is in turn associated with better health. [Marmot 108]

7.37 Adults of working age also face stressful transitions, in particular the move from work to retirement, with the accompanying life changes and adjustments this brings. There is evidence that preparation for retirement, maintaining contacts and participation in society all help to maintain health and wellbeing well into later years.

7.38 There is a range of work underway in Northern Ireland through DEL's programmes to support learning and skills development, and to help people into employment, including those with disabilities. In addition work being taken

forward under HSENI's "Health and Safety at work: Protecting Lives not stopping them" published in 2011, will contribute to the aims of this framework.

7.39 DCAL works to enhance quality of life by seeking to unlock the full potential of the culture, arts and leisure sectors. Participation in such interests are an essential part of a healthy lifestyle, initiatives which encourage and engage people in positive cultural and leisure activities help forge the link between physical and mental well-being and the formation of lifelong habits.

In support of this therefore, the following long-term outcomes are proposed:

Long Term Outcomes

- **Adults have safe and supportive healthy living, learning, working and social environments and opportunities for participation in community life.**
- **Adults have access to opportunities for good employment or development and are equipped for later years and retirement.**
- **Adults have good physical and mental health and wellbeing.**

Question 8: **Do you wish to make any comments on the aims and outcomes for the Working Age Adults lifestage? Are there any gaps and do you have evidence to support your view?**

ADULTS OF WORKING AGE		
POLICY AIM: **ENABLE WORKING AGE ADULTS TO HAVE A FULL AND SATISFYING LIFE AND SOCIAL WELLBEING**		
Long Term Outcomes	Outcomes 2012 -2015	KEY PARTNERS
Outcome 1 Adults have safe and supportive healthy living, learning, working and social environments and opportunities for participation in community life	1. Increased proportion of those on benefits in receipt of work focused benefits or on a support programme to enable them to move into work 2. Benefit Uptake Programme to ensure people have the opportunity to potentially maximize their income levels 3. Adults understand the financial implications of parenthood and are providing financial support to children of current and /or previous relationships. 4. NICS to act as an exemplar to other public sector organizations in NI as regards approach to employee health and wellbeing, through the implementation of 3yr NICS well programme 5. More businesses to have workplace health initiatives to secure o Improved mental wellbeing o reduction in the number of reportable work related injuries o Prevention, control and management of key occupational health issues o Awareness raising and advisory campaigns to highlight the dangers of carbon monoxide and promote appropriate management of the risk o Appropriate control of risks to the public from harmful organisms encountered in, or associated with workplaces such *as legionella sp, E.coli sp* etc. 6. Assist 17,000 vulnerable people to live as independently as possible through Supporting People Programme 7. Reduction in accidental injuries and deaths in the home. 8. Reduction in the number of people seriously injured or killed in road collisions.	DSD DSD DSD DFP DETI/HSE/PHA/ Business sector DSD/NIHE/DHSSPS DHSSPS/PHA/LOC GOVT DOE

	9. Victims of sexual violence will be supported with specialist, co-ordinated care in the immediate aftermath of a sexual assault, rape or childhood sexual abuse	DHSSPS/DOJ and other statutory and voluntary sector partners
	10. Adults have access to appropriate high quality, safe, sustainable and accessible hospital, primary & community health services (including pharmacy, dental and ophthalmic).	DHSSPS/HSC
	11. Improved safeguarding outcomes for vulnerable adults	DHSSPS/HSC
	12. Carers are supported to ensure they are not socially excluded as a result of their caring role.	DHSSPS/HSC
	13. Adult victims of domestic violence and their children are protected and supported through collaborative working between relevant statutory and voluntary agencies. This includes multi-agency Risk Assessment Conferences (MARAC) and Adult Safeguarding procedures	DHSSPS/DOJ/PSNI
	14. Reduced re-offending through provision of resettlement and rehabilitation support that addresses the needs of adult offenders/ex-offenders, particularly in relation to accommodation, skills and employment, and health and social care (both in prison, with continuity of care in the community)	DOJ and others
	15. People feel safer, have reduced fear of crime and increased confidence through delivery of Community Safety programmes PCSPs work collaboratively with the community and relevant agencies at local level	DOJ
	16. Travel – - provision of half fare concession is maintained for adults under the age of 60 who have certain disabilities - Free travel for those who are registered blind is maintained. - provision of Concessionary Fares is maintained for persons aged 60-64 which enable them to travel free by public transport in NI. (Concessionary Fares Scheme)	DRD
	17. The Neighbourhood Renewal Investment Fund will, in line with priority needs	DSD

	identified in Neighbourhood Action Plans, support a range of programmes across the 'life course' which seek to address the social and economic determinants of deprivation	
Outcome 2 Adults have access to opportunities for good employment, or development, and are equipped for later years and retirement	1. Increase employment and prosperity for all by delivering those commitments set out in the Northern Ireland Economic Strategy. 2. Contribute to rising levels of employment by supporting the promotion of 25,000 new jobs by March 2015 3. Reduce economic inactivity through development and implementation of a strategy for skills, training, incentives and job creation. 4. Continued access by older learners to FE provision including Essential Skills, subject to demand locally, for their economic and/or social benefit. 5. All citizens as required, provided with careers advice and support to enable them to make effective career/ learning choices. 6. All citizens who avail of Employment Service programmes and services are supported towards employment 7. Up-skill the working age population by delivering over 200,000 qualifications. 8. Develop the competence of those working in the agri-food industry through programmes of industry training, knowledge and technology transfer and benchmarking	All Departments DETI/Invest NI DEL/DETI DEL DEL DEL DEL DARD
Outcome 3 Adults have good physical and mental health and wellbeing	1. Improved awareness amongst unemployed of the impact of unemployment on mental health and wellbeing 2. Improved awareness of frontline HSC staff of impact of redundancy and unemployment on mental health and wellbeing 3. Health professionals, particularly within primary care and A and E, trained and encouraged to undertake brief alcohol advice/intervention programmes across NI	DHSSPS/PHA DHSSPS/HSC DHSSPS/HSC

	4. Reduction in the percentage of adults who smoke, with a particular focus on manual workers	DHSSPS/HSC
	5. Reduction in the percentage of adults who drink above the sensible drinking guidelines	DHSSPS/PHA
	6. Reduction in the percentage of adults who are overweight or obese	DHSSPS/PHA/DCAL
	7. Increased percentage of this age group meeting the CMO Physical Activity Guidelines.	DHSSPS/PHA/DCAL
	8. Reduction in STIs including HIV	DHSSPS/PHA
	9. More men presenting with early symptoms of health problems to their GPs	DHSSPS/PHA/GPs
	10. Ensure women are as healthy as possible at the start of their pregnancy through the full implementation of the Maternity Strategy which will provide direction for an effective tailored Maternity Service pathway	DHSSPS/PHA
	11. Adults have access to contemporary public health advice, information and services, including promotion of self-care, sign-posting to appropriate support and integrated care of complex conditions	DHSSPS/HSC
	12. High uptake of screening programmes offered to eligible men and women	DHSSPS/PHA
	13. Targeted public health campaigns delivered regarding preventative hearing and sight loss, emphasizing the linkages between smoking, obesity, diabetes and sight loss and the importance of regular sight testing	DHSSPS/PHA
	14. Mental and physical wellbeing of adults in contact with mental health services and with a learning disability improved through implementation of the Mental Health and Learning Disability Service Frameworks and the Bamford Action Plan	DHSSPS/HSC
	15. Support through Health in Mind (Libraries) for people affected by mental health Issues	DCAL

	16. Access to Arts health intervention programmes to aid recovery from illness and address mental health problems and those with disabilities to have access to the Arts	DCAL
	17. Carers' needs are assessed to ensure their own health and wellbeing does not suffer as a result of their caring role.	DHSSPS/HSC
	18. Adults with long term conditions have access to information and patient education and support programmes that will help them manage their condition more effectively, optimise health and well-being and quality of life and prevent or minimise deterioration.	DHSSPS/HSC

Later Years 65 +*

Policy Aim

- **To enable people in later years to have a satisfying and active life**

Rationale

- In Northern Ireland we have the fastest growing elderly population in the UK. Currently, over a quarter of a million men and women are of a pensionable age, which is nearly one in six of our population. By 2028 that will have increased to nearly one in five and by 2050 nearly one in four.
- With a growing elderly population, research has identified that older people with mental health problems are an ever increasing group of people who are often isolated and marginalized from the local community.
- Latest information shows that 62% of both males and females aged 65-74, reported having a long–standing illness; for the 75+ age group the figures are 67% for males and 72% for females.
- Cold damp housing can cause respiratory or cardiovascular diseases and may contribute to additional winter deaths among older people.
- The 2009 House Condition Survey reported the level of fuel poverty in Northern Ireland as 44% (302,310 households).
- The rate of fuel poverty in age groups 60-74 years was reported as 53%, and in 75 years plus age group was reported as 76%.
- 83% of older people who live alone need to spend more than 10% of their income on energy costs and therefore are living in fuel poverty.

* Ref: para 6.5 The age ranges in this framework are meant as a *guide*

7.40 Longer life expectancy is something to celebrate. Many older people enjoy good health and continue to make a significant contribution to society as carers, learners, workers and volunteers. Older people can be a precious resource for their families, communities and the economy. However, for too many, old age brings with it a high risk of social isolation and poverty, with limited access to affordable, good quality services.

7.41 Health expenditure increases with age, so keeping those in later years fit and well is a priority, both for them and for society. The health and social care system has a role in enabling older people to live as full and healthy a life as possible and caring for the most vulnerable when needs change. Services must therefore continue to reform and modernise to respond to growing demand with an increased emphasis on personal, community based services.

7.42 In respect of disadvantage, a study in Wales reported that there were statistically significant negative health outcomes for older people (mortality, coronary heart disease/stroke, self-rated health/quality of life, limiting long-term illness and disability). These outcomes were associated with disadvantage across a range of measures including area deprivation, income, social class, widowhood, housing tenure and car ownership. However, only low social class and low income were strongly associated with poor health

outcomes. These strong associations were shown across a range of health measures.

7.43 If ageing is to be a positive experience, longer life must be accompanied by continuing opportunities for health, participation and security. The World Health Organization has adopted the term “active ageing” to express the process for achieving this vision.

“Active ageing is the process of optimizing opportunities for health, participation and security in order to enhance quality of life as people age.”

7.44 The word “active” refers to continuing participation in social, economic, cultural etc affairs, not just the ability to be physically active or active within the workforce. This is typically referred to as *social engagement*, which is defined as the maintenance of many social connections and a high level of participation in social activities. Active ageing aims to extend healthy life expectancy and quality of life for all people as they age, including those who are frail, disabled and in need of care.

7.45 The adoption of healthy lifestyles and actively participating in one’s own care are important at all stages of the life course and it is not too late to adopt such lifestyles in the later years. On the contrary, engaging in appropriate physical activity, healthy eating, not smoking and using alcohol and medications wisely in older age can prevent disease and functional decline, extend longevity and enhance one’s quality of life.

7.46 An active ageing approach to policy and programme development has the potential to address many of the challenges of both individual and population ageing. In particular active ageing promotes mental health and social connections as being as important as improving physical health status, with maintaining independence as one grows older a key goal – this approach is based on the recognition of the human rights of older people and the United Nations Principles of independence, participation, dignity, care and self-fulfilment.

7.47 The achievement of active ageing requires a broad approach to health improvement which includes:

- Initiatives to address the social, economic and environmental factors that influence health, involving a multi-sectoral approach to maintaining and promoting health, independence and well-being in old age
- Availability of integrated health promotion activities of specific benefit to older people, tailored where necessary to reflect diversity, lifestyles, individual identified needs and choice
- Within a conducive environment, support for individuals to take more responsibility for their own health and wellbeing, recognising that since much health-related behaviour itself is socially determined, it is people’s circumstances that are the most important determinant of health.
- Access to mainstream health promotion and disease prevention programmes.

- Older people should have timely access to universal primary care services, and equal access to screening and prevention programmes for common health problems such as coronary heart disease, diabetes and cancer, including smoking cessation schemes and hypertension management.
- Older people are able to avail themselves of services which can mitigate the effects of disability arising from sensorineural loss such as deteriorating eyesight and hearing through regular check ups, timely intervention and appropriate aids.

7.48 The appointment of an Older People's Commissioner for Northern Ireland is a clear recognition of the need for advocacy and co-ordinated services and actions in support of older people.

In support of this therefore, the following long-term outcomes are proposed:

Long Term Outcomes

- **people in later years have safe and supportive healthy living, learning and social environments and opportunities for participation in community life**
- **people in later years are supported to live independently**
- **people in later years enjoy good health and mental wellbeing**

Question 9: **Do you wish to make any comments on the aims and outcomes for the Later Years lifestage? Are there any gaps and do you have evidence to support your view?**

LATER YEARS		
POLICY AIM: **ENABLE PEOPLE IN LATER YEARS TO HAVE A SATISFYING AND ACTIVE LIFE**		
Long Term Outcomes	Outcomes 2012 - 2015	KEY PARTNERS
Outcome 1 People in later years have safe and supportive healthy living, learning, and social environments and opportunities for participation in community life	1. Benefit Uptake Programme to ensure people have the opportunity to potentially maximize their income levels. 2. People in later years feel safer, have reduced fear of crime and increased confidence through delivery of Community Safety programmes– PCSPs work collaboratively with the community and relevant agencies at local level 3. Older people have access to appropriate high quality, safe, sustainable and accessible hospital, primary & community health services (including pharmacy,dental and ophthalmic). 4. Establishment of Nutrition Coalition to take forward Public Campaigns to identify people at risk of malnutrition. 5. Establishment of a Farm Safety Partnership aimed at eliminating the high proportion of work-related deaths amongst older farmers, and raise awareness through “Stay Farm Safe” campaign. 6. Reduction in accidental injuries and deaths particularly from falls in the home. 7. Reduction in number of people aged over 70 killed or seriously injured in road collisions 8. Improved safeguarding outcomes for vulnerable adults 9. Travel – • Provision of Concessionary Fares is maintained for persons aged 65 and over, using SMARTPASS, which enables them to travel free by public transport in NI and ROI (Concessionary Fares Scheme) • Provision of Door to Door Services are maintained so that people with	DSD DOJ DHSSPS/HSC DHSSPS/PHA DETI/HSE DHSSPS/PHA/Local Government DOE DHSSPS/HSC DRD

	disabilities or reduce mobility can access a local urban transport service.	
	10. Development in partnership with key stakeholders, of an integrated, fully accessible public transport system to enable older people and people with disabilities to travel by bus, train, taxi, private and community transport, in safety and in comfort, and to move easily between these modes. (Accessible Transport Strategy)	DRD
Outcome 2 People in later years are supported to live independently	1. People with a long term condition offered access to appropriate support programmes relevant to their needs, including innovative application of connected health	DHSSPS/HSC
	2. Continued access by older learners to FE provision including Essential Skills for their economic and/or social benefit.	DEL
	3. Supporting People Programme to assist 17,000 vulnerable people to live independently as possible.	DSD/NIHE/DHSSPS
	4. Older people manage their own health through health promotion, integrated services and advice and help to use medicines safely and to optimal benefit.	DHSSPS/Pharmacy
	5. Uplift in research and development activity, including pilots and clinical trials, and to develop; • Additional diagnostic solutions for long term conditions, including dementia • New drugs and therapies, to treat long-term conditions • Solutions that promote wellness, specifically targeting the prevention of chronic disease.	DETI
	6. Uplift in research and development activity to develop solutions that allow people to live independently at home, including pilots	DETI/InvestNI/DHSSPS
	7. Leveraging the Tele-monitoring NI project as a “Patient Innovation Network” to pilot new monitoring, diagnostic and wellness programmes.	DETI

Outcome 3 People in later years enjoy good health and mental wellbeing	1. Promotion of healthy active ageing, including further opportunities for more active promotion of health and wellbeing in nursing and care settings	OFMDFM/DHSSPS/DSD/HSC and other Departments
	2. Improved awareness amongst Primary Care professionals of the prevalence of conditions common amongst older people such as depression	DHSSPS/PHA/ GPs
	3. Increased percentage of this age group meeting the CMO Physical Activity Guidelines for later years	DHSSPS/PHA?DCAL
	4. Raised awareness of symptoms and signs of skin cancer	DHSSPS/PHA
	5. Improved mental and physical health of older adults with a learning disability through the implementation of the Learning Disability Service Framework and the Bamford Action Plan 2012- 2015.	DHSSPS/HSC
	6. Improved mental and physical wellbeing of older adults in contact with mental health services through implementation of the mental health service framework and the Bamford Action Plan 2012-2015	DHSSPS/HSC
	7. Older people have access to contemporary and appropriate public health advice, information and Services	DHSSPS/PHA/GPs/Pharmacy
	8. High uptake rates of seasonal flu and pneumococcal immunisation programmes, and of screening programmes offered to eligible men and women	DHSSPS/PHA
	9. Older people with long term conditions have access to information and patient education and support programmes that will help them manage their condition more effectively, optimise health and well-being and quality of life and prevent or minimise deterioration	DHSSPS/HSC
	10. Development of programmes to increase dental services utilisation among people in later years	DHSSPS/HSC /Dental services

	11. Deliver targeted public health campaigns regarding preventative hearing and sight loss, emphasizing the linkages between smoking, obesity, diabetes and sight loss and the importance of regular sight testing	DHSSPS/PHA
	12. Enhance the chances of recovery of patients suffering ischaemic strokes by increasing the use of thrombolysis through the ongoing implementation of the Northern Ireland Stroke Strategy recommendations.	DHSSPS/HSC
	13. Those affected by long standing conditions to have access to Arts health intervention programmes to aid recovery from illness and address mental problems	DCAL

Underpinning Themes

Sustainable Communities

Policy Aim

- **Promote healthy safe, sustainable places and thriving communities**

Rationale

- Our community is changing – we have a growing and ageing population, and we face a growth in chronic conditions
- As in the rest of the UK health outcomes for people living in deprived areas here are generally worse than the NI average
- Mortality related to smoking, alcohol, and suicide is much greater in our most disadvantaged communities, and there are higher mortality rates for CHD, lung cancer, respiratory disease, chronic liver disease and other cancers
- There are strong links between social deprivation and teenage pregnancies, with the birth rate (2008-10)in the 20% most deprived areas more than six times that in the least deprived areas
- Children from low income families and deprived areas tend to achieve lower examination results than those from more affluent areas – the proportion of children leaving school in 2009/10 with no formal qualifications was almost six times that in the least deprived areas
- 6,122 families presented as homeless during the year 2009/10
- Proportion of respondents from the 20% most deprived areas reporting high levels of worry about burglary, car crime or violent crime was double that reported from those in the 20% least deprived areas.

7.49 People's health and wellbeing is influenced by the environment in which they live. This includes both the direct and indirect effects of chemical, physical (including ionising and non-ionising radiation, and noise) and biological hazards on health and well-being; and encompasses some aspects of the physical and social environment that influence health and wellbeing, such as the quality of housing and the neighbourhood environment, urban development, land use, access to green space and transport.

7.50 Over the next century our climate is predicted to change in ways that will have an important and largely negative effect on health as well as the environment. There will be unavoidable changes to the climate which will require many communities to adapt.

7.51 The main impacts on health and wellbeing for people in Northern Ireland, especially the vulnerable, are likely to be those associated with more frequent extreme weather events, particularly flooding; higher summer temperatures including heatwaves and water shortages; and an increase in the levels of ozone related summer air pollution. The number of deaths and hospital admissions attributable to cold weather is projected to decline as winters become milder and air pollution and its associated health impacts may also decrease in winter.

7.52 There are a number of different groups that might be considered potentially more vulnerable than the rest of the population to the effects of extreme weather events experienced in recent years, including flooding, prolonged freezing temperatures and wildfires, for example:

- older people and pensioners;
- people with disabilities or chronic health problems;
- lower income groups;
- geographic communities living in areas more susceptible to the affects of these events.

7.53 Longer term, co-ordinated adaptation planning and responses will be required to ensure that those most vulnerable in the community are able to be identified and supported, and that adaptation strategies address the potential for climate change impacts to exacerbate existing health inequalities.

7.54 As well as the physical factors, the communities and social networks to which people belong also have a significant impact. Support from families, friends and communities is associated with better health. Social capital – the links that connect people within communities, can promote resilience and support against difficulties and help bring added control over people's lives.

7.55 Engaging and promoting supportive, sustainable communities is an important strategy for tackling health inequalities and mitigating the risk factors for poor health. It will be vitally important to work in partnership with communities, Local Government and other key agencies in seeking ways to both tackle environmental factors and build social capital. The importance of social support also extends to the broader community. The array of values and norms of a society influence in varying ways the health and well being of individuals and populations.

7.56 In addition, social stability, recognition of diversity, community safety, good working relationships, and cohesive communities provide a supportive society that reduces or avoids many potential risks to good health.

7.57 The influence of social conditions and lifestyle behaviours on health and wellbeing is evident when the health outcomes of those living in the poorest communities is compared with those living in more affluent communities. Tackling disadvantage is of cross cutting importance and a key aim of the Programme for Government and theme of many strategies such as Neighbourhood Renewal, the Tackling Rural Poverty and Social Isolation Framework Rural Poverty Programme, Community Safety strategy etc.

In support of this therefore, the following long-term outcomes are proposed:

Long Term Outcomes

- **Healthy, sustainable and safe physical environments and supportive services**

- **Improved community capacity and social capital**
- **Communities health and wellbeing improved, particularly those of most disadvantaged areas**

Question 10: **Do you agree that this is an important underpinning theme, and with the associated aims and outcomes? If not what suggestions would you make?**

SUSTAINABLE COMMUNITIES		
POLICY AIM: **PROMOTE HEALTHY, SAFE SUSTAINABLE PLACES AND THRIVING COMMUNITIES**		
Long Term Outcomes	Outcomes 2012 - 2015	KEY PARTNERS
Outcome 1 Healthy, sustainable and safe physical environments and supportive services	1. Publication of an Urban Regeneration and Community Development Policy framework which sets out the Executive's agreed objectives and outcomes which will directly contribute to sustainable communities. 2. Bring forward a new approach to regeneration which will build on what we know works and will aim to improve the effectiveness and efficiency of regeneration and community development investment, aiming towards a renewed focus on ensuring that regeneration tackles the underlying economic challenges 3. Urban centres created to bring divided communities together which are sustainable, welcoming and accessible to live, work and relax in peace, through Strengthened Communities and Vibrant Urban Areas 4. Strengthened rural communities through Rural Community Development Support Programmes 5. The Neighbourhood Renewal Investment Fund will, in line with priority needs identified in Neighbourhood Action Plans, support a range of programmes across the 'life course' which seek to address the social and economic determinants of deprivation 6. Reduce the gap between Neighbourhood Renewal Areas and non-Neighbourhood Renewal Areas on key deprivation indicators of health, community safety, education and worklessness. In addition, DSD will respond to issues impacting negatively on areas outside Neighbourhood Renewal Areas through the Areas at Risk Programme 7. Targeted approaches to addressing disadvantaged and vulnerable communities through : • addressing dereliction and deprivation in some of the areas most in need and departmental interventions, including preventative interventions, to help	DSD DSD DSD/NIHE/DOE DARD/Others DSD DSD DSD

	alleviate those most in need and suffering fuel poverty • improve thermal efficiency of Housing Executive stock and ensure full double glazing in its properties.	
	8. Policing and community safety concerns addressed through PCSPs' constructive engagement with local communities	DOJ
	9. Compliance with statutory health based Air Quality objectives and targets	DOE
	10. A high quality of drinking water maintained and compliance with waste water standards improved	DOE
	11. A single, strategic planning policy document to be published which will, inter alia, address how health and well being considerations are taken into account within the planning system	DOE
	12. Legislation for a new council led community planning process introduced along with a power of well being	DOE
	13. Reconfigure network of Health and Social care services to include bring services closer to communities, eg through Primary Care Hubs	DHSSPS/HSC
	14. Policy formulated and co-ordinated for the orderly and consistent use of land with the objective of furthering sustainable development and promoting or improving well-being	DOE
	15. Protection of, access to and sustainable use of the natural and built heritage and forests to contribute to health and wellbeing	DOE/ DARD
	16. Protection of, access to and sustainable use of publicly owned land in NI for Sport and Physical recreation	DCAL
	17. Production of a Northern Ireland Climate Change Adaptation Programme/Plan to help protect the population and the built and natural environment from the negative impacts of climate change	DOE/Other Departments

	18. Societal and environmental benefits secured through preventing waste and increasing recycling and re-use, through the Northern Ireland Waste Management Strategy	DOE
	19. Harmful effects of exposure to environmental noise are minimized, in line with the Environmental Noise Directive (END) by designating and protecting Quiet Areas (DOE)	DOE
	20. Access to decent, affordable, sustainable homes and housing support services, including delivery of 8,000 social and affordable homes, supported by a new Northern Ireland Housing Strategy and reformed structures	DSD/NIHE
	21. Reduction in levels of homeless through implementation of strategy on Homelessness	DSD
	22. Reformed welfare system to tackle the root causes of poverty and mitigate the negative impact of individual reforms	DSD
	23. Benefit Uptake Programmes delivered to ensure people have the opportunity to maximise their income levels.	DSD
	24. Safer roads using a range of initiatives including road safety engineering, traffic calming and further enhancement of the pedestrian and cycling network.	DOE
	25. Through implementation of an Active Travel Strategy, increased opportunities for sustainable transport options such as walking and cycling and promotion of a number of demonstration projects to show, inter alia, the health and well being benefits of active travel.	DRD
	26. Reduction in accidental injuries and deaths through continued delivery of home accident interventions in the community	DRD/Others
	27. Reduction in number of pedestrians and child pedestrians killed or seriously injured per capita in 10 per cent most deprived areas compared with 10 per cent least deprived.	DHSSPS/PHA/Local Government

	28. Improved transportation infrastructure and services to help achieve a modern, sustainable, safe transport system which actively contributes to social inclusion and everyone's quality of life.	DOE
	29. Transition to a fully accessible transport network in partnership with key stakeholders that enables older people and people with disabilities to participate more fully in society, enjoy greater independence and experience a better quality of life. [The transport programme for people with disabilities ie door to door, concessionary fares and rural transport fund will contribute to achieving accessible transport]	DRD
	30. The provision of Rural Transport Fund Services is maintained to enable people in rural areas improved access to work, healthcare and recreational activities.	DRD
	31. Delivery of aspects of the £80 million Social Investment Fund	OFMDFM
	32. Implement support arrangements for the voluntary advice services to help ensure that citizens have free access to advice at the point of need	DSD
Outcome 2 Improved community capacity and social capital	1. Collaborative working with local government, other agencies, partnerships, community sector etc to bring about improved health and well being, particularly of communities in disadvantaged areas and of vulnerable people, through accessible targeted evidence based interventions	DHSSPS/HSC/DSD/OFMDFM
	2. Social clauses included in procurement contracts for supplies, services, construction, to include employment opportunities for the unemployed, apprenticeships, student placements.	DFP
	3. Targeted interventions in areas of disadvantage to promote the financial responsibility that parents have for their children	DSD
	4. Ensure that everyone has an opportunity to volunteer and that volunteering is representative of the diversity of the community. (DSD)	DSD/others
	5. Invest in social enterprise growth to increase sustainability in the broad community sector	DSD/others

	6. Continued financial support, through the Extended Schools programme, to those schools operating in the most disadvantaged areas in responding to the identified needs through positive engagement with families, sharing facilities with the local community and establishing close links with statutory and voluntary agencies. 7. Publication of community relations strategy which sets out the strategic framework for improving community relations and building a united community.	DE OFMDFM
Outcome 3 Communities health and wellbeing improved, particularly those of most disadvantaged areas	1. Increased % of overall health budget to public health 2. Investment of £7.2m in programmes to tackle obesity. 3. Throughout life people have access to contemporary and appropriate public health advice, information and services and are supported to develop the skills to manage their own health, including the ability to manage medicines effectively. 4. Proposals developed and brought forward on how alcohol is priced (including consideration to minimum unit pricing); promoted; labelled; and advertised 5. Increased support for breastfeeding in public by increasing the number of premises displaying “breastfeeding welcome” signage 6. High uptake rates for immunization and vaccination programmes across all areas and communities 7. High uptake rates of screening programmes across all areas and target populations	DHSSPS DHSSPS DHSSPS/HSC DHSSPS/ DSD DHSSPS/PHA DHSSPS/PHA DHSSPS/PHA

Building Healthy Public Policy

Policy Aim

- **Ensure health is a consideration in the development of public policies**

Rationale

7.58 There is a growing acknowledgement of the impact of public policies and programmes on each other. At policy level this framework highlights the need for public policy to be "Healthy Public Policy" ie for public policy to support movement towards improved and equitable health, and for policy to be joined – up.

7.59 The term **Health in All Policies** (HiAP) is increasingly being used to describe an approach which emphasises the *connections* and *interactions* between health and policies from other sectors. HiAP explores policy options that contribute to the goals of non-health sectors and improve health outcomes. Essentially these are about promoting health across all sectors of Government, reflecting the fact that social determinants of health are influenced by many Government Departments.

7.60 By considering health impacts across all policy domains such as agriculture, education, the environment, housing, transport and finance, population health can be improved and the growing economic burden of the health and social care system can be reduced. It is in this context that Health Impact Assessments, and HiAP approaches can play a particular role.

7.61 Health Impact Assessment (HIA) is one tool which supports the development of healthy public policy and is a means of assessing the health impacts of proposals in diverse sectors using quantitative, qualitative and participatory techniques. HIA is a practical approach used to judge the potential health effects of a policy, programme or project on a population, particularly on vulnerable or disadvantaged groups. Recommendations are produced to influence the decision-making process with the aim of maximising the proposal's positive health effects and minimising its negative health effects.

This is an approach which has been promoted to policy-makers across Government Departments in Northern Ireland with some evidence of use. DHSSPS will work with Institute of Public Health in Ireland (IPHI) and departments to review processes.

1. Examples:

A recent example of a HIA carried out on a Departmental policy was on the Cardiovascular Service Framework which was one of the first service frameworks to be developed and implemented. It was seen as useful to apply an HIA to this

process to help increase the learning outcomes and evidence base which could then be applied to other service frameworks under development.

The HIA was also able to help identify and assess the Framework's potential to increase health equity across the population in Northern Ireland. It underpinned the importance of participation of both service providers and users in HSC design and delivery. It reinforced the need for putting people and communities at the centre of HSC services and aligning these with individuals' life experience and the patient journey. It also identified barriers to health improvement and ways to overcome these. Further information can be found at: www.publichealth.hscni.net/publications/putting-health-inequalities-focus-northern-ireland-cardiovascular-service-framework-sum

At a local level, Cooperation and Working Together (CAWT) conducted a HIA on a Northern Ireland Housing Executive proposal to demolish and redevelop the housing estate, Dove Gardens. The HIA brought together a range of stakeholders including representatives from the local community. **Download the final Health Impact Assessment Dove Gardens report here.** A review of the impact of the HIA is due to be published shortly.

Long Term Outcome

- **Public Policy supports improved and equitable health and wellbeing outcomes**

Outcome (2012 – 2015)

- **Reviewed processes implemented by all departments to ensure healthy public policies**

Question 11: **Do you agree that this is an important underpinning theme, and with the associated aims and outcomes? If not what suggestions would you make?**

Chapter Eight

Priority Areas for Collaboration

8.1 The issues and intended outcomes outlined in Chapter 7 illustrate the various linkages and inter-dependencies that exist between government programmes. It needs to be acknowledged that there are already, as a result, many issues on which there is inter- departmental and interagency collaboration, and this needs to continue and be built upon. However there are increased expectations about a more coherent, cross-Government approach to tackling a wide range of socio- economic issues in Northern Ireland.

8.2 Delivering Social Change is a comprehensive new delivery framework which aims to deliver the following two outcomes:

(i) a sustained reduction in poverty and associated issues, across all ages; and:

(ii) an improvement in children and young people's health, wellbeing and life opportunities thereby breaking the long-term cycle of multi-generational problems.

The Programme's longer term objective is to lay the basis for sustained social improvement for children and young people with a reduction in intergenerational poverty. This means Ministers working together within the context of a longer term view which encompasses the next Comprehensive Spending Review and Programme for Government period, and the years beyond.

The Executive's focus on economic growth will complement this Programme in terms of improving the outcomes for children and young people.

8.3 To support change the Delivering Social Change Children and Young People Programme will identify those strategic objectives which relate specifically to the needs of children and young people. It will aim to balance immediate action and longer term strategic planning and focus on a small number of **Flagship Programmes** through which efforts across Departments will be focussed to produce real dividends**.** These programmes will take full account of the principles of the Children and Young People Strategy, the Child Poverty Strategy and the Play and Leisure Strategy as well as the United Nations Convention on the Rights of the Child. They must however be seen in the context of a broader range of actions which are planned or underway in the context of the Programme for Government 2011-2015.

8.4 This Public Health framework needs to fit with, enhance and add value to work already underway or planned, for example through other strategies such as Delivering Social Change. It is therefore proposed to explore a number of areas for enhanced joint working at strategic and other levels.

8.5 These proposed priority areas for joint working cut across lifestages and themes both in terms of how they might be developed and targeted, and the benefits that could accrue for the whole population through more focussed collaborative effort. They take account of the current socio- economic context, and therefore dovetail with and contribute to the aspirations and priorities of the Programme for Government – Building a Better Future. **They are still at a developmental stage and will require further detailed collaborative work, but are included at this stage to seek views and further input in the consultation period.**

8.6 The proposed priority areas for enhanced joint working are as follows

1. **Support for Families and Children**
2. **Equipped for Life**
3. **Employability**
4. **Volunteering/Giving back**
5. **Use of Space and Assets**
6. **Using Arts, Sports and Culture**

Some description of each proposed priority area follows together with some illustrative examples of initiatives, or programmes which could contribute.

1. <u>Support for Families and Children</u>

8.7 This would cover early years, childhood development and support for parenting. It would aim to enhance support through ***incremental development of targeted and universal programmes****, including for ante and post-natal care, with a particular focus on children at risk of missing key development stages. It would also include, for example, expanding formal early learning programmes for two year olds and their parents from disadvantaged backgrounds supporting them to fulfil their role as first educators, and strategically expanding positive parenting programmes. Closer joint working would seek to ensure providers (statutory and community) are well connected and would therefore contribute more generally to building capability and social capital within communities.*

This collaboration could include the roll–out of programmes and initiatives, subject to positive evaluation, such as Family Nurse Partnership, New Parent Programme, Incredible Years, Strengthening Families.

Partners would include – DHSSPS and Health Sector, DE and Education Sector, OFMdFM, DSD, DOJ, Sure Start, Family Support Hubs, Communities, Children and Young People's Strategic Partnership, Community and Voluntary sector.

Relevant Lifestages / Themes which would benefit- Early Years, Children & Young People, Early Adulthood, Working Age, Sustainable Communities

Example - Proposed incremental development of targeted and universal programmes

8.8 Investment in children's early years forms an essential building block for achievements in later life. To add focus to the Early Years and strengthen the work underway to "Give Every Child the best start" it is proposed that consideration should be given to rolling out a **structured three-tier approach** where each element will complement each other and for which the evidence base shows the potential to make a real difference over time, subject to positive evaluation in the Northern Ireland setting.

8.9 It should be noted that the approach described below does not describe the entirety of the potential collaboration within this priority area. This approach will link with and enhance for example Delivering Social Change, DE extension of SureStart and formal early learning programmes, and at regional and local level the work of the Children and Young People's Strategic Partnership and Locality Groups.

- **Family Nurse Partnership (FNP) [Tier 1]**

8.10 The FNP programme is an intensive preventive programme for vulnerable, first time young parents that begins in early pregnancy and ends when the child reaches 2 years of age. The programme goals are to improve antenatal health, child development and parents' economic self-sufficiency. It is a licensed, structured programme (through Professor David Olds, University of Colorado, USA) delivered by specially trained family nurses who have mainly been drawn from health visiting and midwifery or mental health and school nursing.

8.11 Thirty years of research and development in the US has shown significant and consistent short and long-term benefits for children and families including for disadvantaged first time parents and their children, with robust evidence that the programme delivers on a wide range of outcomes including, health, wellbeing, self sufficiency, school readiness, reducing antisocial behaviours, improving educational attainment, a reduction in child abuse and in the number of young people entering the criminal justice system. A number of economic evaluations have also shown significant cost benefits.

8.12 The PHA and HSCB have jointly provided funding to initiate a small FNP test site (Phase 1) within Northern Ireland in the WHSCT, and there is a PFG commitment to roll the programme out to a further test site.

8.13 The programme in NI is targeted to teenage mothers but an option is to ultimately expand the programme to include a wider group of women. Ultimately, the vision is to secure funding to enable around **10%** of new mothers to receive this programme but this capacity would have to be built gradually over 5-7 years.

- **Enhanced Support for Parents (NPP) [Tier 2]**

8.14 One example of enhanced support for parents is the New Parent Programme which is an intensive home visiting programme for vulnerable first time mothers (and fathers) currently being delivered in the SE Trust area, as detailed further below. The main focus of the programme is facilitating a strong attachment between mother and baby.
The programme is delivered over 27 visits from 20 weeks gestation until the baby is 2 years old. Referrals are received mainly from midwives.
The NPP is delivered by health visitors as part of the statutory health visiting service, but with a much reduced caseload (in the context of proportionate universalism).

8.15 Currently over 100 mothers are receiving the programme, 50 mothers having either finished the programme or are in the later stages. Over 50% of mothers on the New Parent Programme are mothers who have experienced a range of issues including mental health, domestic violence, disability, recent trauma, adverse childhood experiences (including being in care) and addiction issues.

8.16 In rolling out the structured three tier approach, it is proposed that **tier 2** would be based on enhanced support to **40%** of mothers who do not meet the criteria for FNP, but need additional support. If FNP provides intensive support, some other parents need more support than is possible through universal health visiting or other services.

8.17 Taking the learning from existing enhanced support programmes, a programme for parents should be tested in a longitudinal research trial to quantify the outcomes and subject to positive evaluation, be rolled out systematically in a way which complements and is integrated with other programmes in the pursuit of better outcomes for all vulnerable children born in Northern Ireland.

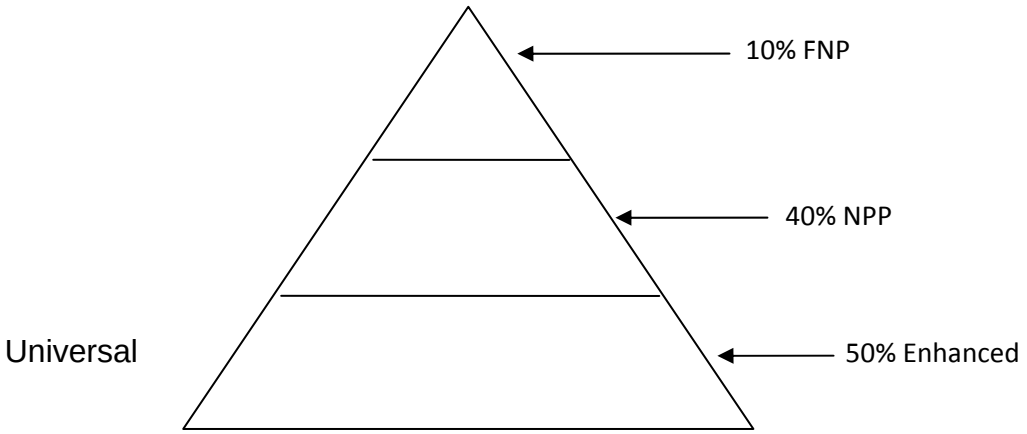
- **Enhanced Universal Services [Tier Three]**

8.18 As well as intensive and enhanced support, routine services for the remaining **50%** of parents can also be improved. Specifically, priorities would be to:

- Introduce or expand parenting programmes to make them more available to parents of children of all ages. The purpose is to help parents learn skills in positive parenting.
- Revise the information provided currently to parents in the ante and postnatal periods to include more information and education on child brain development and how to optimise brain development
- Provide training for key health and social care professionals on child brain development and infant mental health
- Introduce paid peer support workers to give support to mothers on breastfeeding; this is in light of feedback from mothers that they do not get enough support postnatally.

8.19 For all Tiers, new or enhanced programmes would be fully integrated with existing statutory services including health visiting, Sure Start centres,

midwifery and statutory family support (social services). The coordinating role of Family Support hubs could facilitate that integration and ensure that families are put in touch with the support available in their area.



"Support for families and children"

Example – The Incredible Years Parenting Programme was developed by Carolyn Webster-Stratton within the University of Washington Parenting Clinic. The programme, aimed at children aged 3 to 12 years, is founded on social learning theory and consists of at least 12-weekly, two-hour group sessions delivered by skilled practitioners.
The Incredible Years Programme aims to:

- Promote positive parenting
- Improve parent-child relationships
- Reduce critical and physical discipline and increase the use of positive strategies
- Help parents to identify social learning theory principles for managing behaviour
- Improve home-school relationships

The programme uses a collaborative approach, encouraging parents to learn from each other.

Example - Strengthening Families is a 14 week evidence-based training programme that focuses on parenting skills, children's life skills and family life skills. It is targeted at high-risk families with young teenagers aged 12–16 years. Parents and children participate in the programme both separately and together. Transport, a creche and a family meal are all provided on a weekly basis as part of the programme.

Originally developed in the United States, Strengthening Families has been successfully adapted for use in a wide range of countries including the UK and is one

of the few evidence-based family programmes that has been shown to have proven short-term and long-term effects.

- Strengthening Families shows promise in the long-term prevention of alcohol misuse in young people.
- The National Institute for Health and Clinical Excellence (NICE) has highlighted Strengthening Families as a programme worth exploring in public health interventions.

The programme is running in the following HSCT areas:

- Belfast (with funding from Belfast City Council);
- South Eastern (with funding from the PHA);
- Western (with funding from Cooperation and Working Together (CAWT) – via the European Union's INTERREG IVA Cross-border Programme – and the PHA).

All the parents and young people who have participated in these programmes have reported that their family life and functioning have improved as a result of attending. Improving how parents and children communicate with each other is a major focus of the programme.

2. <u>Equipped for Life</u>

8.20 This area of work would aim to ensure that that no child leaves school without achieving minimum educational standards, lifeskills (eg in relation to managing finances, as well as health and wellbeing) and citizenship. This should also apply to all population groups, for example including the disabled and across lifestages.

It could include support for parents of children who are struggling at school, eg the use of Parent Support Officers, "Big Brother Big Sister," remedial work for young offenders, Extended Schools and Full Service programmes.
Partners could include – DE, DHSSPS, DSD, Training Programmes /Employment Service.

Relevant Lifestages / Themes which would benefit – Children & Young People, Early Adulthood, Working Age, Later Years, Sustainable Communities.

Example - The Extended School (ES) programme aims to reduce underachievement and improve the life chances of disadvantaged 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 achieves their full potential.

Linked closely with Extended Schools, **Full Service provision** enables key agencies to come together and deliver comprehensive and integrated support services working across a range of statutory and voluntary organisations and

community groups which aim to address the education, employability and health and well-being needs of pupils, parents and the whole community.

Example – Parent Support Officers act as links between teachers / schools and families and can provide support in relation to eg attendance & punctuality, family relationships, health issues, challenging behaviour, confidence building, parenting skills and educational support.

Example - Big Brothers Big Sisters is an internationally renowned youth mentoring programme that forms friendships between a young person, frequently from a one parent family or an at risk young person, and an adult volunteer. The volunteers act as friend, mentor and confidante.

First established in the US in 1904, it is now operating in 26 countries around the world. The charity has made a huge difference to the lives of both mentor and child and has an impressive track record. A recent survey of 959 boys and girls in eight US states (half were assigned a mentor, the other half served as a control group) had impressive results. After 15 months, those with a mentor were 52 per cent less likely to truant, 46 per cent less likely to experiment with drugs and 33 per cent less likely to hit someone. There were also reported improvements in self-esteem and better marks at school.

3. <u>Employability</u>

8.21 *This would aim to provide opportunities to gain work experience, targeting unemployed particularly young and long term. It would look at the use of social clauses, and how to support their implementation, and the potential contribution of public (eg HSC) and private sector organizations.*
Partners could include – Further and Higher Education, Employment and Learning, DHSSPS and HSC sector, Public Sector, including Local Government, Private Sector, Community and Voluntary sector, Social Development.
Relevant Lifestages / Themes which could benefit– Children & Young People, Early Adulthood, Working Age, Sustainable Communities.

Example - Care into Career: Looked After Children - Flowing from the Care Matters Strategy, the Health and Social Care Board and the Department for Employment and Learning jointly established an inter-departmental group, recently re-branded Care into Career, to better address the employability needs of young people affected by care.

The Group aims to improve outcomes in education, training and employment for care experienced young people. This has involved joint working and partnership agreements between DEL (e.g. the Careers Service and HSC Trusts), DENI, Health & Social Care Board and Trusts, as well as voluntary sector partners who support young people in education, training and employment. Whilst Health Trusts, as the corporate parent, have a primary responsibility for helping young people to achieve economic independence and stability in adult life through promoting gateways to employment the Group supports the Employability Service which they offer.

One of the more practical outworkings of the Partnership Agreement is that all young people with a care background should receive timely and appropriate support in career planning and decision-making through seamless joint working arrangements.

Example - Belfast Health & Social Care Trust, Mental Health Service Users – The Mental Health service has been encouraging service users into employment through a number of initiatives, including the introduction of Individual Placements and Support. Working closely with the HR department, local voluntary groups and DEL, a number of service users have been recruited into posts within the Mental Health Service. Applicants have had to meet the essential criteria for the posts and following interview, some were offered permanent posts. For others, there was feedback and offers of work experience to assist with future applications. The jobs are in a variety of areas where it is hoped that they will be able to utilise their skills and abilities as well as their own personal experience of mental illness. Through DEL's Workable NI scheme they will be able to access the level of support they need.

4. Volunteering / Giving Back

8.22 This would aim to promote lifeskills structured volunteering, utilising resources of those with skills and expertise and seeking to promote the transfer of knowledge and skills. It would aim to build capacity, capability and self esteem in the young, promote social inclusion and intergenerational activity – this should not replace employment but be additional. There could be a re-generation element to this area of collaboration, by seeking to promote ownership and pride in neighbourhoods and communities.

Partners could include –DHSSPS and HSC sector, DSD, DE, DEL, OFMDFM, Public Sector, including Local Government, Private sector, Community and Voluntary sector.
Relevant Lifestages / Themes which could benefit – Children & Young People, Early Adulthood, Working Age, Later Years, Sustainable Communities.

Examples –Time to read time to count, Street by Street (East Belfast), Roots of Empathy, Special Olympics, Mount Vernon.

Example - Time to Read, Time 2 Count, and Time to Compute, co-ordinated through Business in the Community (BITC), are a set of mentoring programmes that link children at Key Stage 2 in primary schools (8-11 years of age) with an individual adult mentor—a positive role model from the world of work.

The programmes provide companies, businesses, and public sector organisations in Northern Ireland with an opportunity to use their employees to impact positively on outcomes for children, and to be active in supporting schools in their local communities.

Although the focus of the programmes may be on improving children's reading and literacy attainment, their numeracy capabilities and their ICT skills, evidence has shown that the support of a volunteer for a set time each week during the school year also impacts very positively on each child's confidence and self-esteem, on their enjoyment of learning, and on their ability to interact with an adult

Example - Street By Street is a street based community safety project working across east Belfast as a friendly but strategic bid to curb anti-social behaviour, and which empowers local people to help resolve local issues.

'Street by Street' works through locally based volunteers, including for example local Community Associations, who build relationships with young people on the street during the evenings, letting them know someone is looking out for them and is around to talk to. Older members of the community have said this has also made them feel safer.

Example - "Roots of Empathy" is a classroom-based programme that aims to develop empathy in primary school children and improve their mental wellbeing by reducing aggression levels and raising social and emotional competence. Local parents volunteer to bring their babies into the classroom over a school year to enable pupils to "adopt" the baby and become involved in its development, thereby developing pupil's sense of empathy to others. Trained facilitators are also involved in this approach and can be volunteers.

The programme is endorsed by the World Health Organisation and is currently being delivered in Canada, the USA, New Zealand and the Isle of Man. The programme, which has proven to reduce levels of aggression and bullying amongst children, will be delivered to 50 new schools in 2012/13 bringing the total to 100 schools and benefiting 2,200 children across NI. This is potentially an area for strategic development as a programme centrally supporting the school curriculum.

Example - Mount Vernon Integrated Locality Planning Pilot
The Integrated Locality Planning Initiative in Mount Vernon aims to develop a model which will enable the commissioning - in partnership with the local community - of more locally appropriate and locally managed services and which will enhance prevention and deliver better outcomes for local people.

This pilot programme is developing community-based supports that will reduce the need for statutory services in Mt Vernon. It is doing this through the development of a social enterprise to create and use social capital in the community, with a view to reinvesting a percentage of any savings made back into the community. The focus initially is on health, and local people have identified several changes which would improve their quality of life. These changes, such as going to the local cafe for lunch, going shopping, being able to visit a spouse's grave, could potentially be provided by local people.

A social worker has now been seconded 1.5 days a week to work with vulnerable people in Mt Vernon to ascertain the services they currently receive and potential improvements that could be made, with a view to creating 'living plans'. A community facilitator is carrying out an audit of social capital in the community – ie identifying the volunteering that already takes place, as well as working with the local community to explore what additional help local people could offer. Training will be offered to volunteers, with a view that this might potentially provide a pathway to employment.

Example - London City Year offers young people the chance to volunteer full time for a whole year in inner city schools as tutors, mentors and role models.

City Year delivers a combination of breakfast club provision, one-to-one tutoring support, enforcement of school behaviour policies and fun after-school clubs rolled into one.

City Year strives to achieve a 'double-impact'. It aims to have a transformative effect on the lives of the children that it works with, but also on the lives of the volunteers. It is committed to developing the skills and confidence of the young people that join the programme. All of the volunteers benefit from the Leadership After City Year development programme which includes more than 300 hours of professional training and support across the year and the opportunity to carry out work shadowing days with corporate sponsors.

5. Use of Space and Assets

8.23 This refers to "Place" and would bring together for example consideration of utilisation of physical spaces and building community capacity and social assets. It would include the use of premises, design and use of space to ensure age friendly, healthy spaces. It would also seek to bring together and maximise the resources invested in an area.

Partners could include – All statutory agencies working in geographical areas (including in particular Local Government, Strategic Investment Board, respective communities and business sector organisations.
Relevant Lifestages / Themes which could benefit – Children & Young People, Early Adulthood, Working Age, Later Years, Sustainable Communities.

Examples – Community Use of Schools, Public Realm schemes, Irvinestown model, Belfast Healthy Ageing Strategic Partnership (HASP).

Example – Community Use of Schools
The Department of Education by means of existing legislation and a range of policies such as Extended Schools, Full Service programmes, Every School a Good School and guidance for Boards of Governors enables and encourages use of schools outside of the traditional school day.

The schools estate is a significant public resource which offers a range of potential social benefits (including health) to local communities if used more

widely. DE is committed to promoting greater use of school premises in order to meet the needs of pupils, their parents and families and the wider community.

Example – DSD Public Realm schemes
DSD Public Realm schemes often include enhanced environment for running/walking/cycling and sports related events (eg often in Squares/Public Spaces).

The Department designed and implemented the £9m **Londonderry City Centre Public Realm Scheme**, which was completed in November 2010. This scheme, focussing on the Guildhall Square, Waterloo Place and surrounding streets has significantly enhanced the main civic and ceremonial space within the city centre through the installation of high quality paving, new street furniture and lighting as well as the addition of a bespoke multi-functional water feature. This area now provides a neutral space in which city centre users, local people and visitors alike can meet, socialise and enjoy a wide variety of events.

The opening of the £14m **Peace Bridge** in June 2011 has provided direct access from the city centre to the former military base at Ebrington and onwards to St Columb's Park where a wide range of sporting, recreational and leisure facilities are available. The Bridge has also linked walkways on both sides of the River Foyle and the Department has recently completed public realm enhancements on the west bank at Queen's Quay providing a popular space that both walkers and cyclists can enjoy.

Example – Irvinestown. Community based activity within the Irvinestown Community has now expanded to serve a much wider rural catchment area and has undergone significant organic growth.

ICP (Irvinestown Community Partnership) was established in 1996. ICP acts as a community forum, ensuring ARC actively listens and responds to need in relation to social issues, to support groups and to work on joint projects.

ARC - was Northern Ireland's first Healthy Living Centre, opened in 2001. ARC Healthy Living Centre Ltd is managed by a, representative, voluntary board of Directors. The Company was formed in November 2000 to undertake the management of the ARC Healthy Living Centre capital build (completed in September 2001), and to oversee the ongoing operation of the centre and associated programmes. The project seeks to strategically engage with agencies to influence policy, whilst operating direct service delivery projects that address poverty and respond to the needs of rurally marginalized people.

Irvinestown Trustee Enterprise Company Ltd - ITEC - is a non-profit making company which delivers capital projects. ITEC aims to increase economic development and employment opportunities in the town and surrounding hinterland by active community participation in job creation and the promotion and creation of further job opportunities; to work in partnership with other agencies to target and address social need and improve the conditions of

community life. ITEC has a pool of “voluntary expertise” and this human resource capital is used to design, implement and evaluate economic development.

ARC and ITEC work together actively promoting partnership and collaboration; promoting good relations within and/or between communities and addressing issues of community concern through the provision of therapeutic interventions and focused programmes.

ARC Healthy Living comprises of 55,000 square foot of work space. 55 members of staff provide services to around 16,000 clients though 36 groups covering all manner of health, social and economic issues. These services are delivered with the help of over 100 volunteers and seek to promote the holistic health care needs addressing physical, psychological, social, educational, environmental factors and ensuring accessibility of services through rural transport initiatives and childcare provision.

In 2010 ITEC and ARC Healthy Living Centre Ltd (ARC) were awarded the Social Enterprise Mark which identifies them as trading for social and environmental purposes.

Example - Belfast Healthy Ageing Strategic Partnership (HASP) brings together key agencies and age sector organisations working for older people to support and develop the voice of older people and on four key issues –

- Joined up information and advice
- Community capacity building
- Combating social isolation
- Home support services / care and repair.

Recent progress includes:

The Greater Belfast Seniors Forum, which combines the strength of six individual local older people’s forums, was officially launched in October 2011. Forum members are regularly involved in advocacy for older people on issues such as fuel poverty, sheltered housing and housing adaptations and the Reablement programme.

Some140 staff and volunteers from a wide range of organisations have been trained in combating isolation with older people over the last two years and a case study will be included in Combating Loneliness: a guide for local authorities

HASP has worked on an intergenerational project with residents from Brookvale Fold in North Belfast. The partnership is also looking at the use of assistive technology/telecare for older people.

6. Using Arts, Sports and Culture

8.24 *This would further explore the potential impact of Sports, Arts, cultural activities on issues such as engagement (particularly of vulnerable, at risk or hard to reach groups,) inclusion, creativity, therapeutic and environmental benefits, also possible intergenerational benefits as well as on physical and mental health and wellbeing. It could consider for example the use of Arts, Sports and Culture, for example in key settings such as integrated community/health settings, to support those excluded from education to re-engage, to promote re-generation and participation.*

Examples – "Art for All", Artscare, Active 8, Special Olympics.

Relevant Lifestages / Themes – Children & Young People, Early Adulthood, Working Age, Later Years, Sustainable Communities

Partners – Further and Higher Education, Employment and Learning, DHSSPS and HSC sector, Public Sector, including Local Government, Private sector, Community and Voluntary sector, Social Development

Example – Arts for All works at a grass roots level with members of community in North Belfast to build and strengthen relationships. It provides opportunities for those who have limited or no chance to be creative to express ideas.

Through art projects participants are given the confidence to express themselves without feeling intimidated. Fostering such environments allows those to speak who may previously have isolated from the wider environment.

Example - Arts Care founded in 1991, is a unique Arts and Health Charity based in Northern Ireland. In partnership with Health and Social Care Trusts throughout Northern Ireland, Arts Care engages 19 Artists-in-Residence, a team of Northern Ireland Clown Doctors and many project artists who facilitate and co-ordinate participatory workshops and performances. Believing in the benefits of creativity to well-being, Arts Care makes all forms of art accessible to patients, clients, residents and staff in health and social care settings.

In recent years, research has shown that Art in health and social care can for example:

- Develop self-confidence and self-esteem
- Positively affect the culture of hospitals
- Improve staff and patient relationships and morale
- Improve social skills
- Help communication on many levels
- Strengthen hospital communities
- Decrease social isolation
- Enhance mental and physical health and well-being

Example - Active 8 is a SportNI run social marketing campaign, inspired by the London 2012 Olympic and Paralympic Games, which seeks to raise awareness among primary school children and young people of the importance of taking part in at least 60 minutes of physical activity every day and of eating a healthy and balanced diet. Activ8 promote 8 Activ8 steps towards an active lifestyle namely:-

- Move Your Body
- Be Part of a Team
- Create Your Own Game
- Involve Your Family
- Eat Well
- Go Outdoors
- Be a Leader and
- Measure Your Success

SportNI have a range of Activ8 Programmes to help promote the Chief Medical Officers' recommendations for being active through sport and physical activity. These include Activ8 Children's Club Coach, Activ8 Community Coaches, Activ8 Wildcats and Activ8 Eat Well programme.

Activ8 Eatwell works with the Food Standards Agency and to date has engaged with 145 schools. All Activ8 programmes have been awarded the prestigious London 2012 Inspire Mark, the Badge of London 2012 Inspire Programme which recognises exceptional and innovative projects inspired by the 2012 Games. To date there are 100,000 children engaged with Activ8 which is now in its 5th phase.

Example - Special Olympics - The Special Olympics is an International programme of year round sports training and athletics in a variety of sports for all children and adults with a learning disability.

In the north the Special Olympics programme, operates through Special Olympics Ulster (SOU), one of the regional arms of Special Olympics Ireland. SOU has over 2,000 active registered athletes participating in 15 different sports. These athletes are supported by 3,792 volunteers in 64 different clubs throughout the north.

By the very nature of the services it provides, the work of SOU cuts across the remits of a number of departments including OFMdFM, DCAL, DHSSPS, DE and DSD. In recognition of the movement's wider importance and value, OFMdFM, DCAL, DE, DSD and DHSSPS have agreed to provide almost £2.3m of Exchequer funding to SOU over the 4-year period 2011/2015. Each Department has committed a one-fifth portion (£459k) of this funding which is being delivered through Sport NI. Funding for SOU does not solely cover the delivery of sporting benefits; it covers delivery of services provided through SOU which further core aims of each of the relevant departments:

- DCAL - increased participation in sport;

- DHSSPS - health benefits for disabled people;
- DSD - volunteering and active citizenship;
- DE - provision of opportunities to actively participate in public life; and
- OFMDFM - provision of equal opportunities to those with intellectual disabilities

Achievement of targets is monitored through an Inter-Departmental Oversight Group which DCAL chairs. SOU anticipate that as a result of funding from the Executive, it will be able to expand the number of clubs and reach out to a large number of people who are not yet engaged in its activities.

Example – DSD Neighbourhood Renewal
Under the Neighbourhood Renewal Programme DSD has awarded both capital and revenue funds to develop/improve community recreation and leisure facilities (e.g. Multi-use Games Areas (MUGAs), football pitches, indoor facilities and equipment) and to run sporting programmes in these areas.

Example – Sport in the Community
DSD's Voluntary and Community Unit is funding a joint application, on behalf of the Irish Football Association and Ulster GAA seeking support for a Sport in the Community programme focussed on Volunteer Development and Community Capacity building through both organisations. The proposal targets support for volunteering and community development within and across their membership over a three year period (April 2012-March 2015).

Question 12: Do you agree with the Priority Areas proposed for collaboration? If not, have you alternatives to suggest and can you provide information to support your views?

PART THREE – TAKING IT FORWARD

Chapter Nine - Implementation and Governance

Introduction

9.1 So far this document has developed a direction and framework designed to deliver progress in support of transforming Northern Ireland into a society **"Where all people are enabled and supported in achieving their full health potential and well-being."** The breadth and depth of the Framework clearly reflects that the range of factors affecting health and wellbeing extends far beyond the remit and control of any one individual, organisation or sector. It is also clear that collectively, departments, local government, public agencies, the business sector, community and voluntary sectors can all play a part in supporting the achievement of the outcomes. **Co-ordinated partnership working across a wide range of stakeholders remains crucial.**

Whole System Approach

9.2 The document has already argued that a whole system approach is necessary which creates effective linkages and communication across the range of sectors and the various levels of the system. This approach is supported by evidence of good practice, and also highlighted in the review of Investing for Health.

9.3 The aims of the Investing for Health structures, ie at regional level the Ministerial Group on Public Health (MGPH - a group chaired by the Minister for Health and comprised of senior officials of all other government departments) and at local level 4 cross-sectoral Investing for Health Partnerships (at former HSS Board level), were to provide strategic direction and leadership, and co-ordination of actions. The Review commented that the level of engagement through partnership working at local level was an area of success for Investing for Health. It also found however that while efforts were made to create linkages between and across these structures, the communication particularly between the regional and local levels could be strengthened in order to enhance implementation in a more integrated and connected way.

9.4 In addition, since the publication of Investing for Health in 2002 many more overarching strategies have been published, supported by cross – departmental groups and in many cases local partnerships. In such circumstances there is a risk of system overload, with consequent waste of effort, and dilution of collaboration.

9.5 A further key development since 2002 has been the reform of the Health system, and in particular the establishment under the HPSS (Reform) Act (Northern Ireland) 2009 of the Regional Agency for Public Health and Social Wellbeing (PHA). The Agency now brings together the range of public health

functions and public health expertise under one organisation which has both a regional and local presence. A key purpose is to strengthen co-ordination of health improvement actions at regional and local levels and support better inter-sectoral working, in particular with local government, to tackle the underlying causes of poor health and health inequalities.

9.6 There is now both an opportunity and a challenge to build on the foundations laid by Investing for Health, and improve cohesion and co-ordination across local delivery models, between the local and regional level and with and across government. **In other words to develop a whole system delivery model and implementation plan.**

9.7 Clearly then there are a number of points and issues to be considered in developing implementation and monitoring arrangements for the whole framework. These include:

- The ongoing need for an overarching strategic group to provide direction, monitor and drive delivery
- The role of individual Departments/ partner organisations in the planning and delivery of their specific outcomes
- How to manage governance and accountability in a system typically geared towards vertical funding streams
- The ongoing need for partnership arrangements to identify and address local issues, including support for building local social capital
- The opportunity now to strengthen linkages between regional and local delivery, and how this can feed into and inform strategic direction
- How best to ensure appropriate connections to planning, delivery and monitoring mechanisms at both regional and local level
- How best to manage those outcomes where there is a range of delivery partners

Initial Proposal

9.8 In the first instance it is recognised that there is a need for leadership, clarity and an effectively linked system to ensure the priority of public health as a whole government issue. At the **strategic level** it is therefore necessary to consider –

- how to link more closely at Ministerial/ Executive level
- how to link with other cross – departmental groups/structures to ensure clarity and alignment, to maximise effort and avoid duplication
- how to link performance monitoring with that of Programme for Government.

9.9 It is proposed that the Minister for Health, Social Services and Public Safety will continue to steer the implementation process on behalf of the Executive and will have lead responsibility for working with other Ministers as necessary to deliver results at strategic level.

9.10 It is proposed that the DHSSPS Minister would continue to be supported by the MGPH as the key strategic group through which cross-government public health issues are taken forward. The role and terms of reference of this group will be reviewed and updated, to include taking account of linkages with other cross- departmental groups, including relevant Ministerial sub-committees and structures established to take forward underpinning strategies. Collectively MGPH will monitor and make recommendations to drive forward overall progress.

9.11 There will need to be consideration given to co-ordination of implementation beyond government departments at **regional and local** levels, as well as ensuring all parts of the system are connected. This should include developing a relationship which connects with and informs MGPH. It is recognised that local assessment of need and the development and delivery of services, programmes and initiatives to meet those, in line with the direction provided by this framework, will be vital to achieving health and wellbeing. At **local level** it is recognised that there many structures, partnerships and engagement arrangements in place already, including Investing for Health Partnerships, joint working arrangements with Local Government, etc and it is anticipated that these will evolve over time, particularly in view of the need to align with local community planning and delivery structures in the future. It will be for the PHA to ensure, engaging and working with partner organisations, that local arrangements remain fit for purpose and are effectively linked with other relevant partnerships*.

9.12 However it is considered that there would be benefit in having a **regional** delivery structure/board comprised of representation from HSC, relevant statutory agencies including Local Government, community and voluntary sector network bodies etc which could gather and disseminate best practice, review and direct action, monitor and report on progress to the strategic level. In view of the reasons for the establishment of the PHA - ie to enhance capacity for public health and strengthen inter-sectoral working **we will look to this Agency to play the lead role in developing proposals for regional and local delivery, including developing regional and local implementation plans.**

*** An example is the Children and Young People's Strategic Partnership** which brings together key agencies at a strategic level to plan and integrate children's services.

The Partnership is cross-sectoral consisting of the leadership of all key agencies who have responsibility for improving outcomes for children and young people including; health, social services, education, policing, housing as well as representatives from the voluntary and community sectors. Key to the achievement of securing "Integrated family support services in partnership with others" – will be that the Children and Young Peoples Strategic Partnership (CYPSP) works in a collaborative and structured manner with relevant Departments.

CYPSP has also established Locality Groups at HSC Trust level. It will be particularly important that these are aligned at local level with other key local partnership arrangements eg local Health Improvement Partnerships, PCSPs and other relevant local programmes (DOJ) and ultimately over time local community planning arrangements

Governance

9.13 The recognition that improving population health and addressing health inequalities is an agenda for numerous agencies, has led to an increase in interagency working for delivering shared health improvement targets and outcomes. However, the complexity in respect of implementation is also apparent in respect of governance structures - particularly at the interfaces of interagency and inter-sectoral working.
In many respects the issues surrounding governance are mainly concerned with clarity over accountability, and another piece of immediate work concerning the Strategic Framework will be to develop clear lines of accountability and governance.

Short Term Outcome

- **Proposals for the implementation and governance of the Framework developed – December 2012**

Question 13: Do you agree with the proposed implementation and governance arrangements –

- **at strategic level**
- **at regional level**
- **at local level?**

If not, what alternatives would you suggest and why?

Funding

9.14 The PHA total allocation of around £81m (2012/13) is currently allocated to taking forward health improvement and health protection programmes and service development in support of increased emphasis across HSC services in respect of the "shift left" or preventive agenda. This amount includes funding allocated to meet commitments contained in a number of underpinning strategies and programmes, for example New Strategic Direction for Alcohol and Drugs Phase 2, Obesity Prevention Framework "A Fitter Future for All" etc. In addition in recognition of the importance of ill health prevention and health improvement the Programme for Government contains a commitment **"to allocate an increasing percentage of the overall health budget to public health."**

9.15 It should be noted that many other departments, agencies and organisations (such as Big Lottery) invest in programmes and initiatives that will contribute to meeting the outcomes of this framework.

9.16 This framework should be used to help inform investment in effective programmes and interventions, and in particular in light of current financial constraints, it is recommended that opportunities are taken to maximise existing resources and effort. This may in some cases mean a review of how funding is allocated.

Question 14: In addition, are there other potential sources of funding we should be pursuing?

Monitoring, Research and Evaluation

9.17 Since the publication of Investing for Health there has been much progress in relation to development of indicators, data collection and information systems, such as the Department's Health and Inequalities Monitoring system and the Northern Ireland Neighbourhood Information Service (NINIS), which provides a very useful tool both for policy makers and for those involved in planning and delivery at local level. These and other data collection systems, will help inform the identification and agreement of a number of key high level indicators which, routinely collected, will facilitate monitoring of progress over time against this framework, and also help to promote the whole systems approach. It will also be important to ensure that monitoring arrangements link with those put in place to monitor PFG implementation.

9.18 It will also be important to ensure that monitoring data will continue to be underpinned by more detailed local level data and trend analysis as facilitated by systems such as NINIS.

9.19 It will be essential to ensure that policies and programmes are evaluated, and that resources are properly targeted at activities and programmes shown by research and evaluation as effective, or potentially so as evidenced elsewhere. Innovation will also be necessary to meet specific challenges and sound arrangements for monitoring and evaluation should be an integral part of the design of any new intervention or service.

9.20 High quality research and information is needed to support and inform both policy and practice. Given the range of issues and interactions that impact on health and wellbeing it will be important to ensure that there is a strategic and inclusive approach to research, that it is multi-disciplinary and multi-sectoral, that it addresses the determinants of health and health inequalities and the effectiveness of policies and interventions.

9.21 The infrastructure for public health research in Northern Ireland has developed in Northern Ireland since the publication of Investing for Health. In 2008 a partnership led by Queen's University was successful in acquiring

national funding to establish one of five Centres of Excellence across the UK to strengthen research into complex public health issues such as obesity, smoking and health inequalities. The Centre plays an important role in bringing together leading experts from a range of disciplines working in partnership with practitioners, policy makers and wider stakeholders to research complex public health issues which are likely to have a significant impact on the health of people in Northern Ireland. The Centre works in partnership with the Public Health Agency, Institute of Public Health in Ireland, the Community Development and Health Network and W5 (the interactive Discovery Centre provides a direct educational link with the general public).

9.22 Data and Research Groups have been established to take work forward to:

- Develop a set of high level indicators to facilitate monitoring of progress on the outcomes of this framework and wider health outcomes over time, and to help promote the whole system approach across all sectors
- Advocate for systematic development and use of record linkage beyond what is already available in Northern Ireland to support population level research and evaluation
- Make recommendations on research needs/gaps, linking policy and practice with local research capabilities
- Make recommendations on the feedback of data and research and their implementation in practice
- Make recommendations on evaluation of key pilots such as Family Nurse Partnership with a view to longer term applicability

Long Term Outcome

- **Policy, research and practice supported by robust data and evidence base**

Short Term Outcome

- **Key high level indicators agreed – December 2012**

Question 15: Do you agree with the proposed actions for the Data and Research groups? If not, what alternatives would you suggest and why?

Chapter Ten – Role and Responsibilities of DHSSPS and Health and Social Care

10.1 This framework highlights the importance of the contributions other departments, agencies and sectors can make to improving health and reducing health inequalities. However given the overall mission and responsibilities of the Department of Health, Social Services and Public Safety and the bodies that constitute Health and Social Care (HSC) it is appropriate that these bodies and their workforce take a lead role in planning, commissioning and co-ordinating action for health improvement and in working in partnership with others to this end.

10.2 Since the recent Health and Social Care reform public health and wellbeing has been placed firmly at the centre of the new system, with a greater emphasis on prevention, early intervention and support for vulnerable people; and a greater focus on tackling health inequalities. It is vitally important that all organisations and individuals within the HSC system work collaboratively to effectively fulfil their respective roles and responsibilities in reducing inequalities in health.

DHSSPS

10.3 The Department of Health Social Services and Public Safety (DHSSPS) has a statutory responsibility to promote an integrated system of health and social care designed to secure improvement in:

- the physical and mental health of people in Northern Ireland;
- the prevention, diagnosis and treatment of illness; and
- the social wellbeing of the people in Northern Ireland

DHSSPS is also responsible for establishing arrangements for the efficient and effective management of the Fire and Rescue Services in Northern Ireland.

DHSSPS discharges these duties both by direct departmental action and through its arm's length bodies which make up the Health and Social Care sector.

Strategic Priorities for Health, Social Services and Public Safety

10.4 For the overall health, social services and public safety system, the Minister has identified the following key strategic priorities:

- To improve and protect health and well-being and reduce inequalities, through a focus on prevention, health promotion and earlier intervention;
- To Improve the quality of services and outcomes for patients, clients and carers;

- To develop more innovative, accessible and responsive services, promoting choice and by making more services available in the community;
- To improve productivity, by ensuring effective and efficient allocation and utilisation of all available resources in line with priorities.
- To Improve the design, delivery and evaluation of health and social care services through involvement of individuals, communities and the independent sector;
- To ensure that the most vulnerable in our society, including children and adults at risk of harm, are looked after effectively across all our services.

The principal service objectives for health and social care arm's length bodies derive from these strategic priorities and are set out in detail in the Health and Social Care Commissioning Plan Direction 2012.
In addition there are a number of policies, strategies and service frameworks which inform direction and service delivery, many of which are referenced in the outcomes framework.

Health and Social Care Sector.

10.5 The Health and Social Care system now includes in total 17 Arms Length Bodies. Two key regional bodies are:

Health and Social Care Board (HSCB)

10.6 **HSCB** has a range of functions including commissioning, performance management and service improvement, and resource management. Commissioning is the process of securing the provision of Health and Social Care and other related interventions. Each year the HSCB is responsible for producing a commissioning plan for the provision of health and social care services in line with the Minister's priorities and in full consultation and agreement with the PHA. It is supported in this task by 5 Local Commissioning Groups.

The emphasis on public health input to the commissioning process is a major change to the HSC system and it offers opportunities to make real progress. Working with the PHA, the roles and responsibilities of the HSCB (including LCGs) in health improvement and tackling health inequalities are to:

- ensure commissioning plans are comprehensive and include measures to improve health and wellbeing outcomes and tackle health inequalities; and
- ensure effective integration of contracts and service level agreements relating to health improvement with overall commissioning plans.

10.7 The HSC Review Report 'Transforming Your Care' (TYC) was published in December 2011 and proposes significant and major changes across all areas of Health and Social Care in Northern Ireland. It has presented a compelling case for change to ensure the health service is safe, resilient and sustainable for the long-term and that care is delivered to patients in the right place, at the right time, by the right people.

10. 8 Implementing TYC is about improving the quality and accessibility of services and meeting the challenges and demands of having a growing and aging population. The new approach will be to bring services closer to people at home and in the community and to reduce the dependence on hospital care.

Public Health Agency (PHA)

10.9 The overall aim of the **PHA** is to protect and improve the health and wellbeing of the population and to reduce health inequalities. It has been established to bring renewed focus on these key public health goals - in particular to address health inequalities and to co-ordinate and strengthen efforts at both regional and local levels. It has the lead role in integrating and supporting health improvement across all parts of the HSC system, for example through influencing wider service provision, as well as working with other sectors to address the social determinants of health.

10.10 PHA operates at both regional and local level working within and beyond the HSC sector with Local Government and other agencies, community, voluntary and business sectors. In respect of the health system's efforts to improve health and tackle health inequalities this agency represents the key development since the publication of the Investing for Health strategy, and is expected to make a major and key contribution to the achievement of the outcomes of this framework.

Ways in which the PHA can strengthen efforts include –

- Forging partnerships at regional level with relevant departments and agencies to support efforts on the wider determinants;
- Building the evidence base and commissioning targeted, evidence based health improvement programmes;
- Influencing commissioning of services and service design to ensure appropriate weight is given to tackling health inequalities;
- developing integrated approaches;
- identifying and scaling up effective work that is underway;
- ensuring proportionate action benefits areas and groups most affected by health inequalities;
- ensuring that action to address health inequalities is woven into all regional and local HSC policies and action plans and their implementation;
- ensuring that everyone working in the Health and Social Care system acts as an advocate for health improvement;
- supporting the HSC workforce to use every interaction with the public to promote and demonstrate health and wellbeing
- Engaging with and supporting the development of the capacity and skills of local communities
- Ensuring access to coherent and up to date information about health, and promoting health literacy

- Building on and strengthening partnership working with other sectors, particularly local government, in support of the wider determinants of health;
- Developing and implementing cross-sectoral health improvement plans working alongside government reform.

Health and Social Care Trusts

10.11 At a sub-regional level there are 5 **Health and Social Care Trusts:**

- Belfast Health and Social Care Trust;
- Northern Health and Social Care Trust;
- South Eastern Health and Social Care Trust;
- Southern Health and Social Care Trust; and
- Western Health and Social Care Trust

The five HSC Trusts are established to provide goods and services for the purposes of health and social care.

In respect of health and wellbeing improvement the **Trusts (HSCTs)**

- deliver health improvement programmes and services in line with commissioning plans;
- participate (and provide local leadership) in the design, development, delivery, monitoring and evaluation of local programmes in response to local needs;
- work with communities, other statutory organisations, community and voluntary groups and the private sector at local level to support them in their efforts to improve health and reduce inequalities and to adapt programmes to local needs;
- acute settings also offer important opportunities for integrating health promotion with health care. Small interventions at the point of care have the potential to make a difference, in addition patients, carers, visitors and HSC staff can benefit from health promotion measures in key hospital areas including A&E departments, maternity wards and canteens.

The Patient and Client Council

10.12 The roles and responsibilities of the **Patient and Client Council (PCC)** in health and wellbeing improvement are 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 the HSCB on health and wellbeing improvement.

Business Services Organisation

10.13 The **Business Services Organisation (BSO)** provides a range of business support and specialist professional services to other health and social care bodies. BSO provides access to relevant data and information on population health and wellbeing which contributes to the activities of the other parts of the system. It is also responsible for monitoring the system's compliance with section 75 of the Northern Ireland Act (Equality Legislation). These are key contributions to the efforts of the overall system in tackling health inequalities.

Contribution of Health and Social Care Services and Professionals

10.14 The broad range of Health and Social Care Services and Professionals should each contribute to the achievement of the aims of this framework in many ways through daily contact with individual members of the public and with local communities. The following highlights the contribution of some key services –

Primary Care, Family Practitioners and other professionals

10.15 The HSCB also commissions Primary Care and Family Practitioner services which are central to the Health and Social Care system and are a key opportunity to promote health improvement initiatives including immunisation, early intervention and primary and secondary prevention on issues such as smoking, diet, exercise, alcohol, emotional wellbeing etc. In addition they act as the first point of contact and as a gateway to wider services. With appropriate support, this role should include signposting to services beyond the HSC that address the social determinants of health and wellbeing (for example benefits, and debt management advice).

A recent BMA report published in Oct 2011 " Social determinants of health – What can Doctors do? " suggests that doctors not only act as clinicians but as community leaders, raising understanding of the impacts of social determinants on health, and as advocates and researchers within and beyond their own locality

Role of nurses midwives and allied health professionals

10.16 Public health activity is wide-ranging including health promotion, protection, education and prevention to include public policy and community empowerment. Nurses, midwives and allied health professionals are becoming increasingly active across all these areas. This can be evidenced in their role in the pre-conceptual (before pregnancy) period through to end of life care where prevention, promotion and early intervention are key elements to the delivery of effective services.

10.17 Public health approaches are used to educate service users, improve health outcomes and to minimise risk from harm. In addition some Public Health approaches are opportunistic and proactive across a range of activities including substance misuse, promotion of healthy lifestyles, emotional health

and wellbeing, long term disease management, prevention and safeguarding the public across the lifespan.

10.18 Some nursing roles focus more clearly on public health issues and nurses working in these areas are known as specialist community public health nurses who work with both individuals and communities. In addition to their duties as a nurse, they deal with issues regarding local population health, including policy development. These nurses/midwives are registered on the professional nursing and midwifery register as specialist community public health nurses and include health visitors, school nurses and occupational health nurses.

Social Care

10.19 Social care, alongside health, seeks to improve the social well-being of the population of NI. Poor social well-being, be it the experience of poor parenting, social isolation, anti-social behaviour, or vulnerability are all closely associated with a range of factors including poverty, poor housing, poor educational attainment and discrimination.

10.20 Social work and social care work with a wide range of disadvantaged, marginalised, excluded and vulnerable groups in society and play a significant role in tackling the social determinants of ill health and improving and safeguarding the social well-being of individuals, families and communities including protecting the most vulnerable from abuse and exploitation. The Department's **Strategy for Social Work** sets out a strategic framework for social work practice which articulates how social workers contribute to the public health agenda and work to counteract or minimise the impact of inequalities.

10.21 The range of services provided under the remit of social care is diverse and include services that are aimed at enabling and empowering people to take as much control of their lives as possible so that they can lead fuller lives within their communities.

Pharmacy

10.22 Current policy which has also been backed up by a recommendation in the Transforming Your Care report is for a wider role for pharmacists in public health.

Four main themes have been identified for outcomes which are common to all life stages: Access; Self Care; Signposting and Integrated Care.

Access- Throughout life people have access to contemporary public health advice, information and services provided by pharmacists in their communities.
Community pharmacies are neighbourhood resources for health promotion, advice and services at times and in places convenient to their needs.

Self Care - People develop the skills to manage their own health supported by pharmacists through health promotion, advice and help with medicines. Pharmacies support people to identify their own health needs and control how they access and use health information and services through participation in community partnerships such as BCPP*. Information and advice from pharmacists also supports people to manage long term conditions and to optimise the benefits they gain from their treatment.

Sign-Posting - People may, with their consent, be referred by a pharmacist to other healthcare professionals or social services to access further care and support appropriate to their needs which the pharmacist cannot provide.

Integrated Care - Older People and those managing complex health conditions have access to pharmaceutical services specific to their needs which are integrated between secondary and primary care.

Dental

10.23 A shift in emphasis from repairing the effects of disease to prevention should reduce levels of dental disease and help reduce inequalities in oral health. Such a shift should reduce the morbidity from oral diseases and improve the oral health of the population. Given the association of oral disease with general health, wider health benefits may also be achievable. Some schemes are already in place and a major clinical trial on the use of fluoride varnish in general practice is planned.

10.24 The new primary dental care system will ensure access to appropriate dental care and aim to encourage attendance and improve service utilisation among those groups with historically low levels of dental attendance so reducing inequities. Older adults have the poorest levels of dental attendance. There is also a projected increase in treatment needs in this group due to demographic changes. Regular asymptomatic attendance should also be encouraged as these patients, by virtue of their age, are at greatest risk of developing oral cancer. It will also ensure access to appropriate care for patients with special needs

Summary

10.25 While the range of factors which influence social inequalities in health extend far beyond DHSSPS and the HSC, the sector has a major contribution to make to help create and support the conditions within which individuals, families and communities can feel empowered to maximise opportunities for good health and wellbeing, and to minimise premature illness and death across the population.

10.26 HSC efforts must combine integrated planning, commissioning and working processes including community development, collaboration, partnership working and individual effort. In this respect the PHA has a significant and vital role –

(i) to ensure that across the system there is capacity and a strong co-ordinated focus on health inequalities and health and social wellbeing improvement, and

(ii) to promote improved partnership working with government departments, Local Government, education, community and voluntary and other sectors on the wider social determinants of health

(iii) to ensure that the capacity of its workforce to deliver on Public Health objectives is maintained and enhanced through appropriate training, education and development across all of the three domains of Public Health and across the range of disciplines. The PHA should also act as an exemplar and provide a leadership role with respect to developing public health skills and expertise with partner organisations across Northern Ireland

Chapter 11 - Government Departments and Agencies

11.1 **Government Departments** have collaborated positively in the development of this framework - they and their agencies will be key partners in the delivery of the outcomes within this framework, and in taking forward the priority areas for enhanced collaboration being proposed. In addition each department has provided a more general summary of the key ways in which it can make a positive contribution towards addressing factors which impact on health and wellbeing.

DSD

11.2 The mission of the Department for Social Development is *'Together tackling disadvantage, building sustainable communities'.* The wide ranging work of the Department and its Non-Departmental Public Bodies has far reaching effects on the lives of everyone in Northern Ireland. The vast majority of our work is focused on the most disadvantaged citizens, families and communities in Northern Ireland. Unemployment and poverty go together and have particularly damaging consequences, not least, on people's health. Through social security; child maintenance; provision of social housing; addressing homelessness; supporting our poorest communities through the neighbourhood renewal programme; and working with partners in the voluntary and community sector, we aim to tackle unemployment and worklessness and to ensure that our most vulnerable citizens are supported and protected. For example the Department provides services to the pensioner needing support with fuel payments, those with disabilities needing support, individuals and families facing unemployment, parents living apart and needing to agree support for their children, people seeking appropriate housing they can afford, and interventions in communities with significant social and economic problems.

The Department also plays a key role in bringing divided communities together by creating urban centres which are sustainable, welcoming and accessible to live, work and relax in peace. Over the last 5 years we have invested some £xxm in schemes to improve the landscape in public areas and promote private sector investment in towns and city centres in Northern Ireland. This work will continue in support of the government's priority to build a strong and shared community with its inevitable impact both on job creation and general improvements to mental and physical improvement across society.

In addition, over the coming years we will be developing more effective financial and social policies which are relevant to the needs of different generations, where dependence on welfare benefits and social housing has become a life choice, where pensioner poverty is an inevitable consequence and where social legislation such as regulation of the liquor trade and gambling needs to be amended to protect people's health and welfare.

In summary, over the next few years the Department will be working with the Executive through the Programme for Government to:

- get people into work;
- ensure that our poorest communities can participate in the growth of our economy and help lift them out of poverty;
- look at ways of building the social economy;
- amend social legislation; and
- explore new models for urban regeneration.

The Department will play its part in contributing to the Executive's top priority to create more jobs through our housing programme and encouraging social enterprises in our poorest communities. The Department aims to improve the quality of life and well-being of individuals and families and engender a sense of hope and aspiration for a better future. The aim is to build strong, sustainable communities, which are economically prosperous, socially connected and make the best use of resources.

DETI

11.3 DETI's overarching goal is "***"to facilitate growing a competitive and export led economy"***. The Department's actions are focused on supporting the ultimate aim of the NI Economic Strategy to improve the competiveness of the NI economy in order to increase employment and wealth opportunities for all.

By working to improve the competitiveness of the NI economy and grow the NI private sector the Department, and its agencies, will promote increasing levels of employment and prosperity. The NI Economic Strategy recognises the positive 2-way relationship between prosperity and public health, whereby improved health & well-being outcomes generally deliver improvements in economic performance for both individuals and society as a whole.

Critical to the delivery of a more competitive and export led economy will be stimulating investment in innovation, R&D and creativity. DETI will work across a range of sectors to develop our existing research strengthens in support of the widening and deepening of our export base. DETI, in partnership with key stakeholders, is currently developing an Innovation, R&D and Creativity Strategy which will include steps to strengthen collaboration between researchers & business and to improve the commercialisation of our knowledge base across a range of priority sectors.

Directly related to the objectives of the Public Health Framework, a "Connected Health and Prosperity" MOU was launched on the 6th of December 2011 by the DETI and DHSSPS Ministers. The Memorandum defines a partnership between DETI, Invest NI and DHSSPS to deliver health and economic benefits from collaborative working, focused on Connected Health.
The Memorandum will facilitate both DHSSPS and DETI/Invest NI to develop and agree annually a programme of work in Connected Health. In the first year this will take account of 4 priority areas:

- Targeted Connected Health R&D and Innovation funding - including optimising assets across the various organisations;
- The development of the NI Connected Health Eco System, along with international linkages;
- Collaboration with international regions, particularly within Europe and North America, for mutual gain; and
- Promoting the Connected Health agenda internationally, particularly within Europe and North America.

The NI Economic Strategy also recognises that one of NI's key assets remains its people. DETI, through the HSENI works ***"to significantly reduce the number of work-related fatalities, injuries and cases of ill health in Northern Ireland."*** HSENI, alongside the district councils, are committed to a joint long-term strategy for the better regulation of health and safety at work in Northern Ireland.

"Health and safety at work: protecting lives, not stopping them", was published in February 2011 and its objectives link to many of the long-term outcomes of the public health strategy, particularly those relating to safe and healthy living and working environments.

One of the goals set out in the Strategy is to "focus on key health issues in the workplace that will bring about a reduction in the number of cases of work-related ill health". HSENI has a statutory duty to promote and enforce the management of risk and the prevention of work-related ill health and this is where it will devote the majority of its effort. Both strategically and operationally, HSENI will primarily address "the prevention of ill health caused by or made worse by work".

HSENI adopts an approach to workplace health issues which focuses on specific occupational diseases where there is a clear link between occupational exposure and the disease being likely to result in death or long term life limiting disability (e.g. cancers, asbestosis, severe musculoskeletal diseases) or where there is high prevalence and simple cost effective measures to eliminate or reduce the risk (e.g. noise induced hearing loss, hand arm vibration syndrome and dermatitis).

Strategic Links between NI Economic Strategy & Public Health

The NI Economic Strategy, published in March 2012, identifies the Executive's economic policy priorities and the following economic vision for 2030:

"An economy characterised by a sustainable and growing private sector, where a greater number of firms compete in global markets and there is growing employment and prosperity for all".

Increased prosperity will create opportunities for all sectors of the economy and help the Executive tackle disadvantage and the wider effects of

deprivation. The Economic Strategy was endorsed by the NI Assembly and recognises that delivering growth and prosperity requires co-ordinated action from all sectors of the economy and includes specific commitments from all Executive Departments.

The NI Economic Strategy notes that the most important asset for the NI economy remains our people and recognises the importance of improving skills levels throughout the economy while also taking actions which will tackle issues which limit individual's opportunities to secure employment.

The NI Economic Strategy explicitly recognises the positive link between prosperity and health outcomes. Healthier people are more productive and improved health & well-being will lead to positive economic outcomes for both individuals and wider society. The NI Economic Strategy explicitly notes that implementation of strategies which deliver improved health outcomes will enhance individual's opportunities to secure employment and make a positive contribution to delivery of our wider economic goals.

DEL

11.4 The Department for Employment and Learning's (DEL) overall aim is to promote learning and skills, to prepare people for work and to support the economy. It is responsible for further and higher education, training and skills, employment programmes and employment law. In pursuing its aim the Department's key objectives are:

- to promote economic, social and personal development through high quality learning, research and skills training; and
- to help people into employment and promote good working practices.

As the Programme for Government (PfG) acknowledges, up-skilling the workforce is critical to the attraction and creation of the new high quality jobs that the local economy needs. However, skills and employment are not just good for the economy, they are good for social inclusion and for improving health inequalities.

DEL has a range of programmes and services in place which contribute to meeting the needs of people with disabilities and, in particular, its Pathways to Work and Condition Management Programmes provide an innovative approach to help people with health conditions and disabilities to consider their options for returning to work. Also, through a suite of other programmes eg Workable (NI) and Access to Work, the Department provides support for people with more complex and enduring health conditions.

The Department also contributes, where possible, to the related health objectives around combating domestic and sexual violence, suicide prevention and promoting targets to reducing obesity and preventing tobacco and drug misuse.

DARD

11.5 DARD's vision is for a thriving and sustainable rural economy, community and environment. The work of the Department supports the aim of the Public Health Strategic Framework by focussing its interventions on improving the economic return for the farm family household, including those who derive their main income from farming and those who contribute to farming or who are seeking training or employment off farm, and, through the Forest Service, providing access to the countryside for informal recreation.

DARD also has a responsibility towards rural communities and aims to strengthen the sustainability of rural communities through the Rural Development Programme, the Rural White Paper Action Plan and the Tackling Rural Poverty and Social Isolation Framework.

The Tackling Rural Poverty and Social Isolation Framework supports a package of measures worth up to £16 million to support vulnerable people in rural communities. This framework aims to tackle the root causes of social isolation and provides measures that will help those in poverty throughout rural Northern Ireland. DARD have identified collaborative working practices in the design, delivery and funding of this framework, working with rural stakeholders, other government departments and agencies and a range of community and voluntary organisations. Examples of this collaborative approach include the development and delivery of a Rural Communities Health Check Programme, the Maximising Access in Rural Areas (MARA) Project both of which involve the Public Health Agency, Health Trusts and DHSSPS. Over a 3 year period 12/13 - 14/15 it is anticipated that over 12,000 rural households will benefit from the MARA Project and over 8,000 rural dwellers will avail of the Health Checks Programme.

DARD, through the Forest Service, places high priority on making its forests accessible to the public and, through the NIRDP, supports landowners and local government to do the same. Successive Public Opinion Surveys report a strong demand for this service, suggesting as many as 15 million forest and woodland visits each year.

DARD is committed, through the activity of the Forest Service, to work in partnership with public and private sector operators to improve the quality of visitor experience which, by promoting exercise, will have a positive impact on the health and well being of individuals and communities.

DFP

11.6 - HR practice - Employee Health and Wellbeing

The Executive recently published the Programme for Government (PfG) 2011-15. Priority 5: Delivering High Quality and Efficient Public Services gives a key commitment to further reduce the levels of sickness absence across the Northern Ireland Civil Services (NICS). By adopting the NICS WELL programme as a corporate approach to employee health and wellbeing not

only will the NICS be playing its part in meeting that commitment, but it will also act as an exemplar to other public sector organisations in Northern Ireland.

Looking more widely, the NICS WELL approach is consistent with current best HR practice in both private and public organisations in addition to supporting local public health strategies and wider European and global settings approaches to promoting population health. The NICS WELL programme is part of a three year programme to be formally launched in April 2012.

- Use of social clauses in procurement contracts

The Programme for Government (PfG) 2011-15 contains a key commitment to include social clauses in public procurement contracts for supplies, services and construction. In construction procurement, social clauses have been in place since April 2009. The current clauses[7], which were refined in the light of experience and the changing economic environment, have been in place since September 2011 and include:-

- For every £0.25m of labour value the contractor has to provide 13 person weeks of employment opportunities through DEL Steps to Work or equivalent.
- 5% of the contracting team's workforce is to be employed on formally recognised paid apprenticeships. (The contracting team consists of the contractor and first tier subcontractors.)
- The Contractor has to provide employment opportunities for student(s) on a University or Further Education College construction related course.
- One student placement of 40 weeks duration to be included in contracts with a labour value of £2m to £5m; and two student placements if the labour value is greater than £5m.

To enable monitoring of the application of social clauses in construction contracts a web based database has been procured by Central Procurement Directorate (CPD). This will enable contractors' performance to be monitored by project managers. (These reports are now a requirement in Government construction contracts). A Procurement Guidance Note on social clauses, which will cover supplies, services and construction contracts, is being prepared by CPD.

DRD

11.7 DRD's planning, roads and transportation responsibilities help promote social inclusion and the social networks which have the potential to influence health and well being.

For example DRD's New Approach to Regional Transportation has, at its core, a move towards greater sustainability which will contribute positively to

growing the economy, improving the quality of life for all and reducing the transport impacts on the environment.

The Rural Transport Fund (RTF) supports transport services designed to give people in rural areas improved access to, for example, work, education, local healthcare, shopping and recreational activities and thus assists in reducing their social isolation. Currently DRD supports Rural Community Transport Partnerships to offer a range of complementary transport services to rural dwellers across Northern Ireland. These services include the Dial-a-Lift Service which is supported by DARD under the Accessible Rural Transport Scheme and allows people living in rural areas, who are members of the partnerships and who hold a valid SmartPass, to avail of free or half fare transport when using the Dial-a-Lift service. This is a pilot scheme which is being jointly evaluated by DRD and DARD and this will inform the departments on the way forward. In addition DRD will continue to work, under the auspices of the Maximising Access in Rural Areas (MARA) project, with the Public Health Agency, Social Security Agency and DARD to address poverty and social exclusion in rural areas.

The Northern Ireland Concessionary Fares Scheme was established to promote social inclusion by improving public transport accessibility through free and concessionary fares for members of the community who are most vulnerable or liable to social exclusion. It does this through providing free travel and half fare travel for all eligible residents on rail and bus services operated by Translink and private bus companies who are members of the Scheme.

In addition, DRD's Active Transport Policies, which promote cycling or walking, have direct health promoting benefits. The Accessible Transport Strategy aims 'to have an accessible transport system that enables older people and people with disabilities to participate more fully in society, enjoy greater independence and experience a better quality of life'. The current Action Plan for the period 2009-12 has a large number of objectives designed to improve the accessibility of the transport system. A draft Action Plan for 2012-15 will be released for public consultation early in 2012. The Active Travel Strategy aims to increase the average distances travelled by walking and cycling here to levels more in line with other regions of the UK. DRD seeks to do this by demonstrating that walking and cycling are safe, healthy, flexible, inexpensive and sociable means of travel and by setting out ways in which opportunities for active travel can be significantly improved. In this regard DRD has plans to support a number of active travel demonstration projects over the next 3 years

DOE

11.8 DOE's vision is to make Northern Ireland 'a better place to live, work and invest' and aims to protect and improve the environment, promote well being and deliver a strong and effective local government to support a thriving economy.

DOE through its Environmental Policy, Road Safety, Local Government and Planning divisions and the Northern Ireland Environment Agency continue to make a significant contribution to the health and well being of the people of Northern Ireland.

Safeguarding the environment is a crucial part of maintaining public health and contributing to wellbeing and DOE has a primary role in maintaining environmental quality of Northern Ireland's air, water land and built and natural heritage, through developing policy and introducing and enforcing relevant legislation.

Protection of, and access to, Northern Ireland's natural and built heritage contributes to health and well being. Societal and environmental benefits are achieved through preventing waste and increasing recycling and re-use, while exposure to ambient noise is minimised in line with the Environmental Noise Directive, by the designation and protection of Quiet Areas. DOE works with local councils and other relevant authorities like Roads Service to ensure that EC Air Quality standards are upheld, and where there are problems with local air quality, DOE works with these bodies in their formulation of Air Quality Action Plans. Work on climate change mitigation looks to uphold and protect the quality of our environment, particularly for future generations, while a comprehensive Climate Change Adaptation Programme aims to help protect the population as well as the natural and built environment from the negative impacts of climate change.

The orderly and consistent use of land is a key aim of Planning Policy, with the objective of furthering sustainable development and promoting or improving well-being. A comprehensive and fundamental review of planning policy will result in more strategic, simpler and shorter policy which will be needed in advance of planning powers transferring to councils. Local Government Division is working towards legislation which will facilitate a new council-led community planning process.

Roads Safety Division is working towards reducing road casualties in line with strategic road safety targets for relevant age groups."

DCAL

11.9 The Department of Culture, Arts and Leisure (DCAL) is the Government Department responsible for arts and creativity, museums, libraries, sport, inland waterways and inland fisheries, linguistic diversity, archives, and for advising on National Lottery distribution. DCAL's mission is to enhance the quality of life in Northern Ireland by seeking to unlock the full potential of the culture, arts and leisure sectors.

The Public Health Strategic Framework explicitly recognises that many of the social determinants of health lie outside the direct influence of the health system. Quality of life in terms of culture, arts and leisure opportunities is increasingly recognised as one of those determinants. Indeed it is now widely accepted that a vibrant and sustainable culture, arts and leisure sector is an

essential foundation for a healthy society. Initiatives that encourage and engage people in positive cultural and leisure activities help forge the link between physical and mental well-being and the formation of healthy, lifelong habits. In addition, they can do much to help people cope with transitions in their lives when their interests in culture, arts and leisure are likewise expected to change, develop and evolve over time.

DCAL therefore strongly believes that participation in culture, arts and leisure is an essential part of a healthy lifestyle and adds value to individuals' and communities' well-being and self-esteem. The Department also considers culture, arts and leisure to be an integral element of the broader preventative healthcare agenda and can also result in savings in health provision in the longer term.

DE

11.10 It is clear that educational achievement is a significant determinant of health and there is a strong relationship between socio-economic background and educational achievement. Low levels of educational achievement are linked to poor health. Higher educational achievement contributes directly to better health, prepares young people for work and improves their life chances.

The vision of the Department of Education (DE) is to educate and develop the young people of Northern Ireland to the highest possible standards, providing equality of access to all. DE exists to ensure that every learner fulfils her or his full potential at each stage of the development.

The vision is supported by the Minister's five priorities for the education sector:

- Raising standards for all
- Closing the performance gap, increasing access and equity
- Developing the education workforce
- Improving the learning environment
- Transforming education management

The Department's primary focus is on raising standards, particularly in literacy, numeracy and ICT, for all pupils, removing barriers to learning, and closing the gap in performance between pupils from different social backgrounds.

Education has a key role to play in preparing children and young people for work and improving their life chances. To that end, the Minister for Education is seeking to implement a framework of policies which have a strong focus on raising standards and on tackling underachievement. This is in order to secure improved educational outcomes for all our young people and, particularly, the most disadvantaged pupils.

'Every School a Good School – a policy for school improvement' (ESaGS) is the overarching policy for raising standards and tackling underachievement. It is a pupil-centred policy and is based on the premise that every school is capable of improvement and that schools themselves are best placed to

identify areas for improvement and to implement changes that can bring about better outcomes for pupils. The policy reflects that too often, underachievement is related to socio-economic disadvantage and compounded by poverty of aspiration; it therefore stresses the importance of having high expectations for every child and promoting a culture of aspiration and achievement. The policy therefore puts a clear focus on high-quality support to help schools improve and to help teachers overcome the various barriers to learning faced by children in the classroom.

The aims of the Department's Literacy and Numeracy Strategy - 'Count, read: Succeed' are to raise overall standards of achievement in literacy and numeracy and to close the gaps in achievement. The strategy includes milestone targets (2012 and 2015) as well as long-term targets (2020) for the levels of achievement.

Through the Entitlement Framework, all young people at KS4 and post-16 will be guaranteed access to a broader and more balanced range of courses that have coherent progression pathways to HE, FE, training or employment and that meet the needs of the local economy. Young people should be supported in making informed choices by high quality careers education, information, advice and guidance.

Ensuring children and young people achieve their educational potential is of paramount importance to the Department of Education and will improve their life chances. However, we are also mindful of the role education plays in their personal development, emotional and physical health and wellbeing both through the curriculum and pastoral care systems. Indeed School Development Planning Regulations require schools to have strategies in place to promote pupil health and wellbeing and provide for the special, additional or other individual educational needs of pupils. There are a number of policy and strategy developments within the Department which support schools in achieving this. These include:

- the Revised Curriculum and Youth Work Curriculum;
- Early Years Strategy, Pre-School education and Sure Start;
- Review of SEN & Inclusion;
- Support for Additional Educational Needs;
- Pupils' Emotional Health and Wellbeing programme;
- Nutritional Standards for school meals and other food and drinks provided in schools & Food in School Policy;
- Extended Schools and Full Service Schools and
- Anti poverty measures such as Free School Meals and School Uniform grants.

The Revised Curriculum includes a Personal Development and Mutual Understanding strand for primary pupils and Learning for Life and Work strand for post-primary pupils which allow pupils to explore issues such as the benefits of healthy eating and physical activity, the influences on their physical and emotional health and ways of developing their self-esteem.

The flexibility of the revised curriculum allows for links to be made between curriculum areas such as supporting healthy living through, for example: Home Economics, a statutory requirement at Key Stage 3, which should provide pupils with opportunities to explore ways to achieve a healthy eating; Personal Development which should provide opportunities to address issues such as obesity, feelings and emotions, relationships and sexuality and drugs and alcohol awareness; and Physical Education which is compulsory through all Key Stages.

The youth work curriculum adopts a holistic approach to matters relating to the health and well-being of young people, focussing on a number of key areas including self esteem, physical and mental health and risky behaviour. Youth workers aim to educate young people by imparting knowledge about key issues relating to their health and well being as well as helping them to develop the skills they need to act on that knowledge and lead more healthy lives. A new Priorities for Youth document is being developed which will set a new framework for the delivery of youth work within education. The new policy will contribute to the DE vision of every child fulfilling his or her potential and improve the focus on targeting disadvantage and addressing the needs of those most at risk of underachievement.

It is widely recognised that the early years of a child's life have a powerful influence on the rest of their lives. The Early Years 0-6 Strategy aims to set out a vision and plan for ensuring better outcomes for children by improving the provision and quality of services to the youngest children, their parents and families.

It is also true that some children and young people face barriers to learning for a variety of reasons. Through the Review of Special Educational Need (SEN) and Inclusion, it is intended to pilot approaches and build capacity to promote early identification and intervention to support children and young people with special educational needs. Support is also offered to children and young people with Additional Educational Needs eg looked after children, travellers, newcomers and school aged mothers.

The Pupils' Emotional Health and Wellbeing Programme, currently in development, will be a vehicle for bringing together the range of activities occurring at school level which contribute to a positive outcome for pupils. It will contribute to the building of resilient emotional health and well being of pupils. It links with all support/curriculum matters such as counselling, pastoral care, suicide prevention, anti bullying policy, discipline and healthy schools in a consistent and coherent way. The Programme will address how a pupil's emotional health and well being is promoted by the school, what support systems are available to help a pupil under stress and what support is available to a school in the event of crisis. Vulnerable pupils will benefit from the improved pastoral care within the schools and the effective links with external agencies.

Over the last number of years DE and the Department of Health, Social Services and Public Safety (DHSSPS) have been working with schools, key

partner organisations and agencies to improve the nutritional standards of the food that is provided in schools and to encourage, promote and support children and young people to make healthy food choices. Nutritional standards for schools lunches have been compulsory since September 2007and the Nutritional Standards for Other Food and Drinks in Schools which were introduced in April 2008. Both departments are working to finalise an overarching Food in Schools Policy which advocates a whole-school approach to **all** food and drinks provided in schools, that everyone is aware of their responsibilities and that all children develop knowledge and skills necessary to make healthy food choices now and in later life.

Furthermore there are a number of initiatives which target children from low income families and who in general are subject to low achievement, such as Free School Meals' Entitlement, the Targeting Social Need element of the Schools' Budget and Full Service/Extended Schools which are extremely important. The focus of these interventions is on improving lives not only in the short-term but also the longer term opportunities for these children.

DOJ

11.11 The mission of the Department of Justice is building a fair, just and safer community. The Justice Minister is committed to reshaping the justice system, to building a safer, shared community with lower levels of crime, and a better quality of life for everyone in Northern Ireland.

It is clear that the causes of health inequalities are closely aligned with those of offending. As part of his reform agenda, the Justice Minister David Ford has commissioned work to develop a comprehensive Strategic Framework for Reducing Offending. This Strategic Framework sets out how Government and its partners can prevent people from becoming involved in criminal behaviour in the first instance and prevent re-offending of those who do come into contact with the justice system. Our Departmental approaches to public health and reducing offending need to be aligned if we are to progress our respective preventative agendas.

Looking at early years, DHSSPS plays a key role in early intervention; a poor start in life could result in vulnerable individuals subsequently entering the justice system.

Later in the life course, those involved in the criminal justice system often have complex mental health, substance misuse problems and social care needs, all of which come as a cost to DHSSPS. With responsibility for commissioning and delivering prison healthcare, DHSSPS also has a significant role to play in reducing re-offending. Supporting and treating victims of crime is also within the remit of the health service.

Fear of crime is a complex issue, linked to a range of personal, environmental and socio-economic factors, including age, gender, health and income levels. Whilst young males are most likely to be victims of crime, and are the most

vulnerable group to crime, others are more vulnerable to the effects of crime, especially older and vulnerable people, and less able to cope with falling victim to a crime than other groups.

Fear of crime has been linked to reduced mental and physical health.

These negative impacts often arise from a reduced willingness to be out and about, which reduces opportunities for hobbies, physical activity, social contacts and other activities that support mental and physical health.

The Community Safety Strategy includes a commitment to reduce the fear of crime and help older and vulnerable people feel safer. The Strategy highlights the importance of building confidence at regional and local level, promoting intergenerational practice to build trust between young and old and improving our understanding of the fear of crime and delivering tailored projects to address it.

It is clear that joint working between the DOJ and DHSSPS can deliver significant benefits for both Departments and society in Northern Ireland.

OFMDFM

11.12 A key commitment within the Programme for Government is to ***'Deliver a range of measures to tackle poverty and social exclusion through the Delivering Social Change delivery framework.'*** Delivering Social Change is a comprehensive new delivery framework which aims to deliver the following two outcomes:

(i) a sustained reduction in poverty and associated issues, across all ages; and:

(ii) an improvement in children and young people's health, wellbeing and life opportunities thereby breaking the long-term cycle of multi-generational problems.

The Programme's longer term objective is to lay the basis for sustained social improvement for children and young people with a reduction in intergenerational poverty. This means Ministers working together within the context of a longer term view which encompasses the next Comprehensive Spending Review and Programme for Government period, and the years beyond.

The Executive's focus on economic growth will complement this Programme in terms of improving the outcomes for children and young people.

The framework is being led by Ministers through the Executive Ministerial Sub-Committee on Children and Young People and the Sub-Committee on Poverty and Social Inclusion. Once a year, the Sub-Committees will hold a joint meeting to be chaired by the First Minister and deputy First Minister.

The Executive Ministerial Sub-Committees are supported by the Delivering Social Change Programme Board. This Board will oversee the delivery of the delivery framework, ensuring that key milestones and targets are achieved. The Board oversees a family of projects, monitoring in particular project formation and delivery. Each of the projects within this family of projects will have its own Project Board and include representatives from key Departments and organisations.

Delivering Social Change Children and Young People Programme

To support change the Delivering Social Change Children and Young People Programme will identify those strategic objectives which relate specifically to the needs of children and young people. It will aim to balance immediate action and longer term strategic planning and focus on a small number of **Flagship Programmes** through which efforts across Departments will be focussed to produce real dividends**.** These programmes will take full account of the principles of the Children and Young People Strategy, the Child Poverty Strategy and the Play and Leisure Strategy as well as the United Nations Convention on the Rights of the Child. They must however be seen in the context of a broader range of actions which are planned or underway in the context of the Programme for Government 2011-2015.

Cross-government/ multi-sectoral working - Example

11.13 This framework seeks to influence implementation of policies and strategies between government departments, agencies and other sectors for mutual benefit.

An example of a project which furthers the aims of a number of departments in this respect is the MARA project funded by DARD and co-ordinated by the PHA with a number of partners, and which is implemented at local level through community facilitators. One of the aims of this project is to support and empower those who are isolated in rural areas to access services and benefits which are appropriate for their circumstances.

MARA Project

The MARA project is a cross departmental regional project funded by DARD through the Tackling Rural Poverty and Social Isolation Framework and managed by the Public Health Agency (PHA). Other key organisations involved include, DSD (Social Security Agency and Fuel Poverty Unit), DRD, NIHE, DHSSPS and local community and voluntary organisations.
The overall aim of the MARA project is to improve the health and wellbeing of rural dwellers in Northern Ireland by increasing access to services, grants and benefits by facilitating a co-ordinated service to support rural dwellers living in or at risk of poverty and social exclusion.

The MARA project proactively targets vulnerable households in identified rural communities using a community development approach. Community Lead organisations across a number of designated zones/SOAs recruit and train

enablers to undertake household visits and go through services available (local and regional) in the local directory of services, a copy of which is left in the household pack following the visit.

The MARA project in Phase I targeted the top 88 (30%) most deprived rural Super Output Areas (SOAs) in Northern Ireland in 2010/11,a total of 4,135 household visits were completed and over 10,000 onward referrals were made to various departments and agencies eg home safety checks, benefit entitlement checks, energy efficiency checks, occupational therapy assessments for disabled facilities grants, community transport and public transport (smart pass).

Evidence from Phase I of the project suggested that visiting people in their own homes and using a "personal touch" encouraged people to avail of services and grants which they would not otherwise have known about or been able to apply for. An independent post project evaluation which included a Social Return on Investment (SROI) identified £8.62 leverage for every one pound invested by DARD and the PHA.

Using lessons from Phase 1 the project is now being rolled out into the remaining 70% (198) rurally deprived SOAs in Northern Ireland over the next 3 years to include approx 12,000 home visits - target groups include, older people, carers, disabled people, lone parents, ethnic minorities, lone adults, farming families and/or low income families.

CHAPTER 12 – KEY PARTNERS

12.1 In addition to collaboration across government departments, inter-agency and inter-sectoral partnership working is crucial to the vision of this framework, including the continued involvement of statutory organisations such as Housing Executive, Education and Library Boards, Health and Social Care Trusts etc. There are already many excellent examples of partnerships and partnership working taking forward innovative approaches to create the conditions for improved health and wellbeing, and a number of key partners whose continued engagement remains vital.

Local Government

12.2 Local government makes a crucially important contribution to health and wellbeing, in particular to creating healthy safe, sustainable places and thriving communities. Participation and support from local decision makers in pursuit of this aim is essential, as they play a major role in shaping services around many of the physical, environmental, economic and social conditions which affect people's lives.

12.3 Local elected representatives can have a major influence at community level in tackling the root causes of inequalities by supporting policies and actions that effectively improve living conditions and life chances in their constituencies, and that work towards building capacity and social capital within their communities. In relation to services, in addition to Environmental Health service which works to protect and improve health and quality of life, the contribution to health and wellbeing of many services provided by Councils can be maximised, for example –

- community services, for example working to support community development, arts, cultural activities, building good relations
- economic development and regeneration - support for small business and social economy
- parks and leisure services – support for healthy lifestyles
- land use– eg access to green space
- waste management – attractive, safe environment promotes wellbeing and quality of life
- licensing and community safety – helping to create environments which are perceived as safe and welcoming.

12.4 Local Government reform proposals would see the introduction of statutory powers to support councils in leading a community planning process to provide for integrated planning and delivery of local services. It is intended that councils would work with and through a range of organisations and partnerships to prioritise and deliver effective and efficient services tailored to meet the needs of local citizens. It is also proposed that councils be given a general power to promote well-being.

12.5 Councils have continued to be engaged in local "Investing for Health" structures and initiatives, and since 2009 in local joint working arrangements

with Public Health Agency. The local joint working arrangements, which have been operating around the proposed new council geographies (or “clusters”,) have been aimed at supporting councils implementation of their future power of well-being and community planning role and the development of local inter-sectoral partnerships.

12.6 Maintaining and strengthening inter-sectoral working, particularly between Health and Social Care and local government, is key to enhancing efforts to improve health and well-being and reduce health inequalities. This framework identifies priorities and a direction, which will be relevant to the public health element of community planning and for joint working arrangements between the Public Health Agency and district councils on local delivery.

Community and Voluntary Sectors

12.7 The Concordat between the Voluntary and Community Sector and the Northern Ireland Government (2011) recognises the vital contribution of the voluntary and community sectors. The role of these sectors in enabling and empowering people to improve their health and wellbeing is recognised, and in particular the crucial role of the sectors in identifying, engaging with and supporting those who are isolated, disengaged and vulnerable.

12.8 Alongside universal statutory approaches this framework re-emphasises the importance of working with and supporting community and/or interest group based activities and encourages the development of community assets and capacity. Local communities make considerable contributions to tackling the health and health inequalities issues that are relevant to them through providing tailored services and support, information and advice in their own localities. Voluntary organisations likewise play a vital role in representing and supporting particularly vulnerable interest groups.

12.9 Regional voluntary agencies and community support networks also provide essential infrastructural support and are well placed to support public participation in decision making.

These sectors should continue to be represented on local level partnership arrangements and appropriate representation on any new regional structure should be assured.

Business Sector

12.10 Many partners within the business sector can also make important contributions. In England this has been recognised through DOH England’s collaboration with the sector in promoting “Public Health Responsibility Deals” to promote for example socially responsible information for consumers about food etc. Within the sector there are many potential partners for example in the media, sports and leisure businesses, retailers, town planners etc. who could contribute in many ways for example to promote or support healthy choices, promote access to green spaces, and contribute to promote the health and wellbeing of their etc. Business in the Community NI is a

membership organisation which works to support companies committed to doing business in a way which helps them impact positively on their “People, the Planet and the Place.”

12.11 A key statutory responsibility for employers is to protect the health and safety of their workforce. There is now also clear evidence that doing more than that ie to actively promote health at work and provide good working conditions contributes not just to workforce health but also to improved business performance and productivity.

Other Partnerships

12.12 A number of other relevant partnership arrangements exist at both regional and local levels in relation to health and/or to take forward other government strategies and programmes. In the interests of population health, and to ensure effort is maximised, it will be important to ensure that there are appropriate and effective linkages and information sharing between and across structures.

Annex A

'Fair Society, Healthy Lives' - The Marmot Review

Background

1. A number of significant reports have presented evidence locally, regionally and globally on health inequalities which reinforce the argument that addressing this issue requires co-ordinated action across the social determinants of health. In February 2010, the Marmot Review Team published 'Fair Society, Healthy Lives.' This was the culmination of an independent review into health inequalities in England which Professor Sir Michael Marmot, a globally recognised epidemiologist, was asked to chair by the Secretary of State for Health. The Review followed the publication of the global Commission on Social Determinants of Health also chaired by Sir Michael Marmot and published by the World Health Organisation.

2. The purpose of the Marmot Review was to build on current health inequalities work through a review of the global evidence and inform the development of a post 2010 cross – government health inequalities strategy for England. Although it includes the role of the Health sector, its major focus is on those factors that governments and societies can influence that lies outside the direct control of "Health".

3. The full independent report "Fair Society, Healthy Lives" brings together a substantial body of national and international evidence in support of the social determinants approach and provides a thorough analysis of the status and impact of health inequalities in England. It highlights the fact that much of the incidence of premature death or illness is preventable, and proposed priority objectives and policy recommendations backed by the evidence.

Key Messages

4. The key messages of the review are:

   - **reducing health inequalities is a matter of fairness and social justice** – people living in different social circumstances experience avoidable differences in health, wellbeing and length of life. Inequalities in health result from inequalities in society – in the conditions in which people are born, live, work and age, and therefore taking action to reduce inequalities in health requires action across the whole of society.

   - **action should focus on reducing the social gradient in health** – the review looked at the difference in life expectancy between those living in the poorest and those in the richest neighbourhoods in England and found on average a 7 year gap. It also found that people in poorer areas not only die sooner but spend more of their shorter lives with a disability – the average difference is 17 years. But even excluding the poorest and richest five per

cent to gap in life expectancy between low and high income is 6 years and in disability – free life expectancy is 13 years. This shows that the relationship between social circumstances and health is a graded one – the social gradient in health.

The review illustrates that focusing on the most disadvantaged alone will not reduce health inequalities but will require an approach that addresses inequalities across all social groups – to reduce the steepness of the gradient actions must be universal but with a scale and intensity proportionate to the level of disadvantage.

- **action on health inequalities requires action across all the determinants of health** – the Commission on Social Determinants of Health concluded that social inequalities in health arise because of inequalities in the conditions of daily life and the fundamental drivers that give rise to them: inequities in power, money and resources. These social and economic inequalities underpin the range of interacting factors that shape health and well-being. A central message of this Review, therefore, is that action is required across all these social determinants of health and needs to involve all central and local government departments as well as the third and private sectors.

  Persisting inequalities across other key domains point to the inter-relationship between health and social inequalities - addressing continued inequalities in early child development, in young people's educational achievement and acquisition of skills, in sustainable and healthy communities, in social and health services, and in employment and working conditions will have multiple benefits that extend beyond reductions in health inequalities

- **reducing health inequalities will have economic benefits –** the review looked not just at costs in human terms but also in economic terms. Economic benefits will accrue from reducing losses from illness associated with health inequalities – these account for productivity losses, reduced tax revenue, high welfare payments and increased treatment costs

- **health and the fair distribution of health and well being is as important a measure of our country's success as economic growth and GDP –** the review argues that the fair distribution of health , well-being and sustainability are important social goals. The central ambition of the review is to create the conditions for people to take control over their lives – if the conditions in which people are born, grow, live, work and age are favourable and more equitably distributed then they will have more control in ways that will influence their own health and health behaviours and those of their families.

Key Recommendations

5. A **framework for action** is recommended based on **twin aims** -

   - to improve health and well-being for all ***and*** to reduce health inequalities.

   To achieve this **two policy goals** are suggested: -

   - to create an enabling society that maximises individual and community potential, *and*
   - to ensure social justice, health and sustainability are at the heart of all policies.

   Recommendations are grouped into **six policy objectives**:

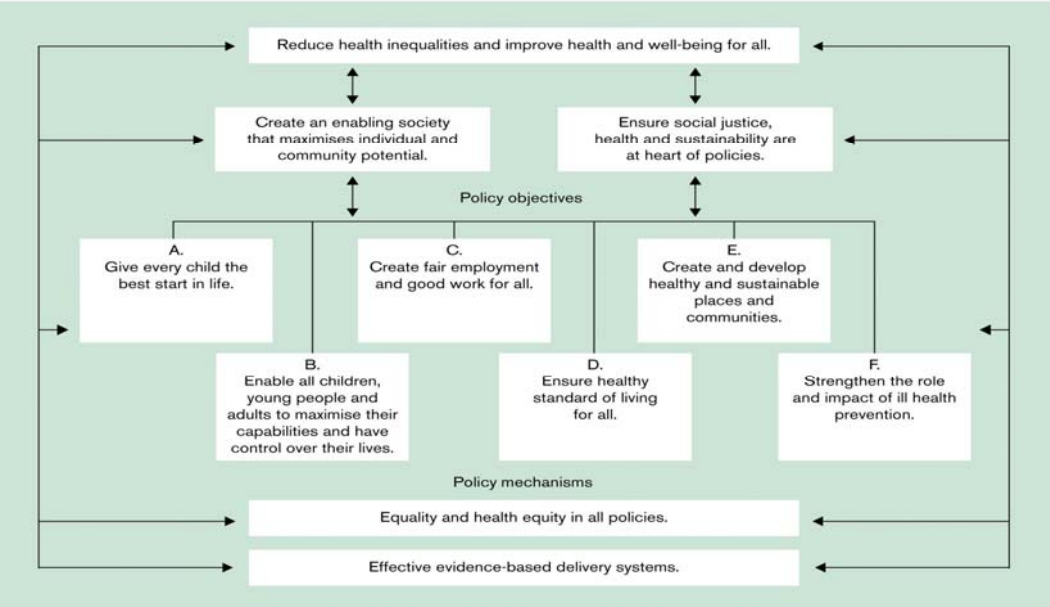
   - Give every child the best start in life
   - Enable all children young people and adults to maximise their capabilities and have control over their lives
   - Create fair employment and good work for all
   - Ensure healthy standard of living for all
   - Create and develop healthy and sustainable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

   These policy objectives are underpinned **by two policy mechanisms**:

   - Considering equality and health equity in all policies, across the whole of government, not just the health sector, *and*
   - effective evidence-based interventions and delivery systems.

   The conceptual framework is illustrated in {*Figure 1*}

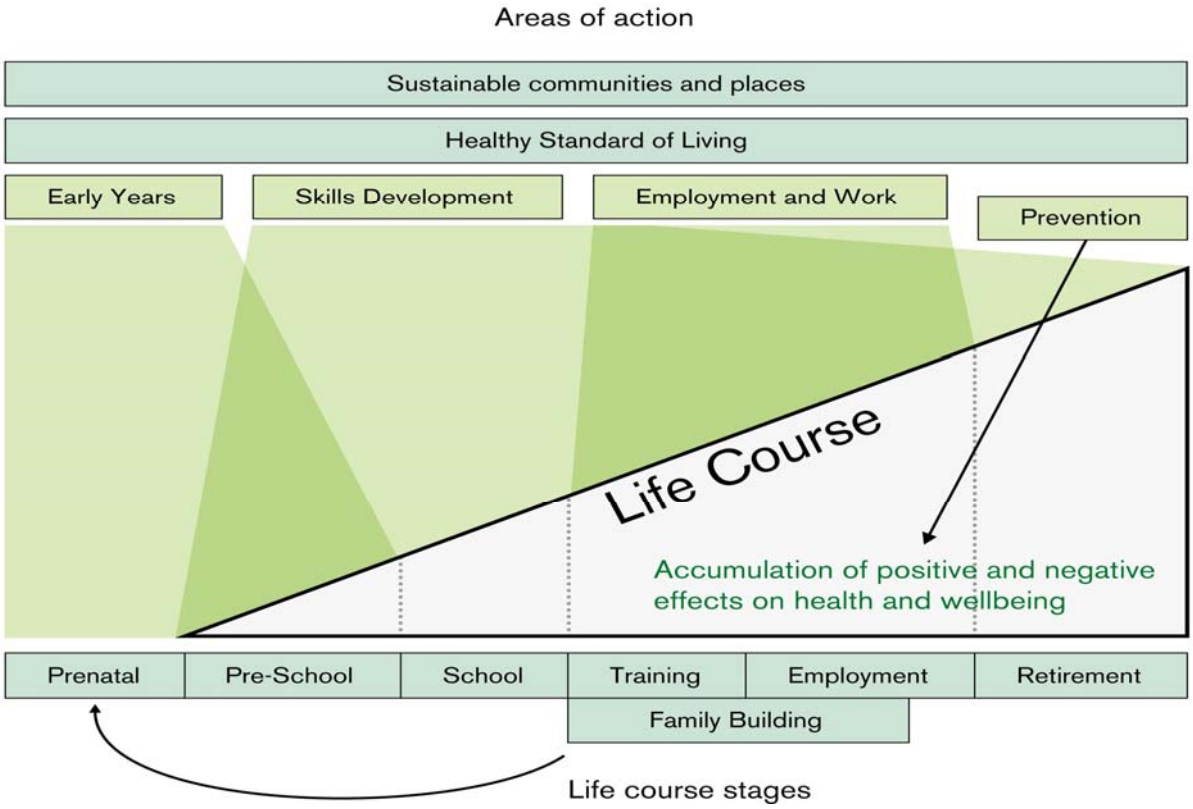
Figure 4 The Conceptual framework



Action across the Life Course

6. The review recommends that the policy objectives need to be viewed in the context of a **Life Course approach.** {*Figure 2*}

Figure 5 Action across the life course



The reasons for this are that –

- Individual development occurs throughout life from birth to death
- Social and biological influences on development start at conception, or earlier, in terms of genetic effects. These accumulate through pregnancy to influence the health of the child at birth.
- From birth an individual is exposed to a wide range of experiences – social, economic, psychological and environmental and these change as they progress through the different stages of life – pre-school, school, employment/ training, family-building and retirement.
- It is the accumulation of these experiences and interactions that influence social development, behaviour, health and well-being of the individual.
- These effects may be either **protective** – increasing esteem, life skills, resilience and resistance to ill health and encouraging 'healthy behaviours' – *or* **hazardous** – destroying self-regard, undermining social skills and the ability to learn and creating the conditions for mental and physical ill health.

The logic then is to take action across each stage of the life course, with two related purposes:

- To affect the ways in which socially determined influences impact on the individual, with the aim of maximising the positive and minimising negative effects. Some actions and factors (those affecting early years, work and employment) will be focused on specific stages of the life course. Others (skills development) will span several and others still (community, place and standard of living) will impact in different ways, but at every stage of life.

- To prevent the risks to health that have already accumulated over previous stages of the life course. This is in recognition of the need to improve the health and well-being of existing generations, including the oldest, who have a lifetime of accumulated experience and risks to health.

7. Since disadvantage starts before birth and accumulates throughout life, the review argues that action to reduce health inequalities must start before birth and be followed through the life of the child. Only then can the close links between early disadvantage and poor outcomes throughout life be broken.
   For this reason the Marmot Review placed the highest priority on the recommendation to give every child the best start in life.

Annex B

Health 2020

At the sixtieth session of the WHO Regional Committee for Europe, Member States and partners gave WHO/Europe a strong, clear mandate to develop the new European health policy, Health 2020, to accelerate progress towards achieving the European Region's health potential by 2020.

Its purpose is to strengthen health systems, revitalize public health infrastructures and institutions, engage the public and a range of health actors, and develop coherent and evidence-based policies and governance solutions capable of tackling health threats and sustaining improvements over time.

Health 2020 will build partnerships for action and capture promising innovations to tackle the complex determinants and drivers of health and health equity. This, in turn, will shape commitments and the capacity to develop effective policy interventions and governance responses both now and in the future.

As a policy umbrella, Health 2020 will also help to ensure coordination and coherence across all work that WHO/Europe, Member States and partners carry out on behalf of and with the population.

Annex C

SUPPORTING STRATEGIES

Accessible Transport Strategy
Active Travel
Ageing in an Inclusive Society
Areas at Risk
Bamford Action Plan 2012-15
Breastfeeding Strategy
Cancer Prevention, Treatment & Care
Cardiovascular Health & Wellbeing
Care Matters
Child Care Strategy
Children First
Child Maintenance Policy
Child Poverty Action Plan
Children & Young People's Health & Wellbeing
Children & Young People Strategy
Climate Change Adaptation Plan
Community Pharmacy Strategy
Concordat between Voluntary and Community Sector and the NI government
Co-operating to Safeguard Children
Count, Read: Succeed – *A Strategy to Improve Outcomes in Literacy & Numeracy(March 2011)*
Delivering Social Change for Children & Young People
Essential Skills for Living Strategy (2002)
EU Social Fund Programme
Every School a Good School – *a Policy for School Improvement (April 2009)*
Families Matter
Further Education Means Business Strategy
Healthy Futures
Healthy Start
Health & Safety / Workplace Health
Hidden Harm Action Plan *(NSD for Alcohol & Drugs)*
Home Accident Prevention strategies & frameworks
Homelessness Strategy *(DSD)*
Improving Dementia Services in NI – *A Regional Strategy*
Improving Stroke Services in NI – *July 2008*
Join In, Get Involved – Build a Better Future
Learning Disability
Maternity Strategy *(due 2012)*
Mental Health & Learning Disability Service Frameworks
Mental Health Promotion & Protect Life *(due 2012)*
Mental Health & Wellbeing
NEETS Strategy *(published May 2012)*
Neighbourhood Renewal Strategy
New Strategic Direction for Alcohol & Drugs
New Urban Regeneration & Community Development Strategic Framework
NI Forestry: A Strategy for Sustainability & Growth

Obesity Prevention Framework
Oral Health
Policy Position Statement on the Establishment & Management of NIEA Country Parks *(DOE)*
Personal & Public Involvement (PPI)
Preparing for Success – *DE/DEL Joint Strategy for Careers Education, Information, Advice & Guidance*
Priorities for Youth
Programme for Government 2011-2015: Building a Better Future
Public Realm Programme
Quality 2020
Reducing Offending *(due 2012)*
Regional Strategy for Widening Participation in Higher Education
Regional Transport Strategy
Regulation of Licensed Trade
Respiratory Health & Wellbeing
Road Safety
Rural Development Plan
Rural Transport Fund
Rural White Paper Action Plan
Safeguarding and Social Care
Services Frameworks
Sexual Health Promotion
Skin Cancer Prevention
Small Pockets of Deprivation
Social Security Welfare Reform Programme
Sports Matters
Supporting People
Tackling Rural Poverty & Social Isolation Framework
Tackling Sexual Violence & Abuse
Tackling Violence at Home
Tobacco Control Strategy
Town Centre Regeneration
Transforming Your Care
Transport Strategy
UK Forestry Standard Guidelines: Forests & People Good Practice Requirements 19-21
UK Plan for Rare Diseases *(to be published 2012)*
Urban Regeneration & Community Development Strategic Framework
Volunteering Strategy – Get Involved, Join In
Welfare Reform / Universal Credit
Workplace Health

Annex D

Equality Impact Assessment

EQUALITY CONSIDERATIONS NORTHERN IRELAND ACT 1998

All Departments and designated public authorities in Northern Ireland have been required by Section 75 of the Northern Ireland Act 1998 to have due regard to the need to promote equality of opportunity:

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

In addition, but without prejudice to the above, there is an obligation to have regard to the desirability of promoting good relations between persons of different religious belief, political opinion or racial group.

Each Department and designated public authority must also screen policies and programmes to identify those that are likely to have an impact on equality of opportunity and/or good relations. Where the screening process identifies it as necessary a full Equality Impact Assessment is conducted. Engagement of the public and representatives of the nine equality categories is a key element of this work. The results of each Equality Impact Assessment must be published.

This is not aimed directly at inequalities in health status, or at the main determinants of health. Nevertheless, the implementation of this requirement complements and reinforces "*Fit and Well – Changing Lives"* by mainstreaming equality considerations into the policy process.

The proposals in this paper are intended as a strategic framework to provide direction for improving the health and well-being status of the whole population and the reduction of inequalities in health in Northern Ireland. In particular it will improve the health of the most disadvantaged in society who experience worst health. The framework advocates that action must take account of the social gradient and the need for more focussed effort or "proportionate universalism" ie additional provision for additional need.

The framework is intended to drive delivery through an evidence based lifecourse approach and framework of priority areas for action. It references a range of planned policies and activities by departments which it relies on to deliver its aims and outcomes and which themselves will be subject to due regard to the need to promote equality of opportunity.

The development of this framework and its priorities has been informed by evidence of the factors that affect health and available data and information on population health inequalities including on population groups identified as being at risk (– this is summarised in Chapter 4.)

Given the aims of this framework to improve health and wellbeing of the population generally and reduce inequalities in health, it is not envisaged that any of the categories will be adversely affected however to ensure maximum benefit it is considered that further EQIA at a strategic level should be undertaken simultaneously with the development of the final framework – in this way the EQIA will inform the process and influence the final strategic direction.

As part of the consultation, the Department therefore welcomes your views on following questions:

Question 16: **Are the actions/proposals set out in this consultation document likely to have an adverse impact on any of the nine equality groups identified under Section 75 of the Northern Ireland Act 1998? If yes, please state the group or groups and provide comment on how these adverse impacts could be reduced or alleviated in the proposals.**

Question 17: **Are you aware of any indication or evidence – qualitative or quantitative – that the actions/proposals set out in this consultation document may have an adverse impact on equality of opportunity or on good relations? If yes, please give details and comment on what you think should be added or removed to alleviate the adverse impact.**

Question 18: **Is there an opportunity to better promote equality of opportunity or good relations? If yes, please give details as to how.**

Question 19: **Are there any aspects of this action plan/Policy where potential human rights violations may occur?**

The Department will consider all responses carefully before finalising the strategic level Equality Impact Assessment.

Annex E

SUMMARY OF CONSULTATION QUESTIONS: "Fit and Well – Changing Lives"

Aims (page 11)

Question 1: **Are these aims still valid? If not, what alternatives should be considered?**

Vision, Values & Principles (page 58)

Question 2: **Do you agree with the Overarching Vision, values and principles? Are there any other values that should be included, or you feel are important?**

Life Course Approach (page 59)

Question 3: **Is the approach taken – ie life course stages and underpinning themes – appropriate?**

Strategic Priorities – Early Years and Supporting Vulnerable People and Communities (page 61)

Question 4: **Are these the right strategic priorities – ie Early Years and Supporting Vulnerable People and Communities? Are there alternatives that should be considered, and can you provide information to support this view?**

Chapter 7 – Strategic Framework – Themes and Outcomes

Pre-Birth & Early Years Lifestage (page 65)

Question 5: **Do you wish to make any comments on the aims and outcomes for the Pre-birth and Early Years lifestage? Are there any gaps and do you have evidence to support your view?**

Children & Young People Lifestage (page 72)

Question 6: **Do you wish to make any comments on the aims and outcomes for the Children and Young People lifestage? Are there any gaps and do you have evidence to support your view?**

Young Adult Lifestage (page 80)

Question 7: **Do you wish to make any comments on the aims and outcomes for the Young Adults lifestage? Are there any gaps and do you have evidence to support your view?**

Working Age Adult Lifestage (page 88)

Question 8: **Do you wish to make any comments on the aims and outcomes for the Working Age Adults lifestage? Are there any gaps and do you have evidence to support your view?**

Later Years Lifestage (page 96)

Question 9: **Do you wish to make any comments on the aims and outcomes for the Later Years lifestage? Are there any gaps and do you have evidence to support your view?**

Underpinning Theme – Sustainable Communities (page 103)

Question 10: **Do you agree that this is an important underpinning theme, and with the associated aims and outcomes? If not what suggestions would you make?**

Underpinning Theme – Building Healthy Public Policy (page 110)

Question 11: Do you agree that this is an important underpinning theme, and with the associated aims and outcomes? If not what suggestions would you make?

Chapter 8 - Priority Areas for Collaboration (page 125)

Question 12: **Do you agree with the Priority areas proposed for collaboration? If not have you alternatives to suggest, and can you provide information to support your views?**

Chapter 9 – Implementation and Governance (page 129)

Question 13: Do you agree with the proposed implementation and governance arrangements –

- **at strategic level**
- **at regional level**
- **at local level?**

If not, what alternatives would you suggest and why?

Funding (page 130)

Question 14: In addition, are there other potential sources of funding we should be pursuing?

Monitoring Evaluation & Research (page 131)

Question 15: Do you agree with the proposed actions for the Data and Research groups? If not, what alternatives would you suggest and why?

Annex D – Equality (page 167)

Question 16: **Are the actions/proposals set out in this consultation document likely to have an adverse impact on any of the nine equality groups identified under Section 75 of the Northern Ireland Act 1998? If yes, please state the group or groups and provide comment on how these adverse impacts could be reduced or alleviated in the proposals.**

Question 17: **Are you aware of any indication or evidence – qualitative or quantitative – that the actions/proposals set out in this consultation document may have an adverse impact on equality of opportunity or on good relations? If yes, please give details and comment on what you think should be added or removed to alleviate the adverse impact.**

Question 18: **Is there an opportunity to better promote equality of opportunity or good relations? If yes, please give details as to how.**

Question 19: **Are there any aspects of this action plan/Policy where potential human rights violations may occur?**

Annex F

How to Respond to the Consultation Paper

The Department welcomes your responses and comments on any aspect of this document. They should reach the Department by no later than **5.00pm on Wednesday 31st October 2012.**

A response can be submitted by letter, e-mail or via the Department's website.

Details are:

"Fit and Well – Changing Lives" Consultation
Health Development Policy Branch
Department of Health, Social Services and Public Safety
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BT4 3SQ
Tel: (028) 90 522059
E-mail: fitandwellconsultation@dhsspsni.gov.uk
Website: www.dhsspsni.gov.uk

Please ensure that responses are clearly marked '*A Response to the Consultation on Fit and Well – Changing Lives*'.

Additional copies of the document, free of charge, can be obtained by contacting the address above or from the 'Consultations' section of the Department's website.

Versions of this document, in other languages, large type, Braille and audiocassette may be made available on request.

Freedom of Information Act 2000 - Confidentiality of Consultations
The Department will publish a summary of responses following completion of the consultation process. Your response, and all other responses to this consultation, including personal information, may be published or disclosed on request in accordance with the access to information regimes (these are primarily the Freedom of Information Act 2000 (FOIA), the Data Protection Act 1998 (DPA).

The Department can only refuse to disclose information in exceptional circumstances. Before you submit your response please read the paragraphs below on the confidentiality of consultations and they will give you guidance on the legal position about any information given by you in response to this consultation.

The Freedom of Information Act gives the public a right of access to any information held by a public authority, namely the Department in this case. This right of access to information includes information provided in response to a consultation. However, it does have the responsibility to decide whether any information provided by you in response to this consultation, including information about your identity should be

made public or be treated as confidential. If you do not want information about your identity to be made public, please include an explanation in your response.
If we receive a request for disclosure of the information we will take full account of your explanation, but we cannot give an assurance that confidentiality can be maintained in all circumstances. The Lord Chancellor's Code of Practice on the Freedom of Information Act provides that:

- The Department should only accept information from third parties in confidence if it is necessary to obtain that information in connection with the exercise of any of the Department's functions and it would not otherwise be provided;
- The Department should not agree to hold information received from third parties 'in confidence' which is not confidential in nature; and
- Acceptance by the Department of confidentiality provisions must be for good reasons, capable of being justified to the Information Commissioner.

For further information about confidentiality of responses please contact the Information Commissioner's Office (or the web site at: http://www.informationcommissioner.gov.uk/). For further information about this particular consultation, please contact the Health Development Policy Branch at the above address.

An automatic confidentiality disclaimer generated by your IT system will not, of itself, be regarded as binding on the Department.