



# MAKING LIFE BETTER

**A WHOLE SYSTEM  
STRATEGIC FRAMEWORK  
FOR PUBLIC HEALTH**

**2013-2023**

**June 2014**





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**MAKING LIFE BETTER**

## **THE MAKING LIFE BETTER CHARTER**

### **Our Objective**

The Northern Ireland Executive is committed to creating the conditions for individuals, families and communities to take greater control over their lives and be enabled and supported to lead healthy lives.

### **Our Approach**

Our approach to public health focuses on working collaboratively with individuals, communities and partner organisations to address the factors that impact on health and wellbeing in Northern Ireland. We are also committed to ensuring that there are effective mechanisms in place to ensure protection of the community from current and future threats to public health.

### **Social justice, equity and inclusion**

People in different social circumstances experience different levels of health. We will focus on addressing the challenges of disadvantage and inequality that afflict society and work to close the gap in health between those who are least and most disadvantaged.

### **Engagement and Empowerment**

We want individuals and communities to be active in improving their own health. This means that we will work with people to address agreed priorities and build on the assets we have in our communities to improve health. As far as possible we will devolve responsibility and activity to community levels of working. Information about the state of health and wellbeing in Northern Ireland and the ways that health can be improved will be made available to the public.

### **Collaboration**

Our Programme for Government (PFG) 2011/15 sets the broader context for working together. It recognises the inter-relationship between health, disadvantage, inequality, childhood development and education, employment, the social and physical environment, and economic growth.

Building a healthier Northern Ireland will hinge largely on what is done collaboratively, through both policy and practice, to influence these wider factors that impact on lives and choices. Everyone has a role to play. We look to everyone to play their part, including individuals and communities as well as the public, private and third sectors.



## **MAKING LIFE BETTER**

### **Evidence and Effectiveness**

We must use existing resources wisely to have a positive impact on health and wellbeing. We will focus on action which is informed by evidence to help us ensure that public money is spent on actions that will achieve better health and wellbeing for all our people and reduce health inequalities.

### **Addressing Local Need**

We will support joint working at local level between councils, statutory bodies, community and voluntary sectors and others, to optimise opportunities to plan and shape services around the needs of local communities in order to create communities that are healthy, safe, united and thriving.

### **Our Resources**

We will seek to maximise the benefit that we can achieve with our resources and make effective use of the public health budget. We will also promote better use of public resources generally, as well as those of our partners, in order to achieve better health and wellbeing.

We will work collaboratively with partners across Northern Ireland and in other countries to build and share public health capacity to achieve greater impact in public health actions. Where appropriate, we will advocate for changes to national policies in order to achieve local improvements in health and wellbeing.

**Rt Hon Peter D. Robinson MLA**  
First Minister

**Martin McGuinness MLA**  
deputy First Minister

Signed by First and deputy First Ministers on behalf of the Executive



## **FOREWORD**

International evidence demonstrates that improving population health and wellbeing requires the involvement of the whole of Government and all of society, individually and as communities.

We have seen many health improvements as a result of actions in areas such as better housing, safer roads and safer workplaces. Action to address poverty and inequality is also key to the successful delivery of this framework.

Many studies relate health and health inequalities to the conditions in which people are born, grow, live, work and age. There are no doubt challenges ahead in creating the conditions which will enable us all to achieve our full health and wellbeing potential.

A recently published “Review of the social determinants and the health divide in the WHO European Region” states that in countries with the best health and narrowest health inequities the evidence suggests “this is related to a long and sustained period of improvement in the lives people are able to lead – socially cohesive societies, increasingly affluent, with developed welfare states and high quality education and health services.”

I welcome the support of my Executive colleagues in this long-term aspiration. We have assets on which to build and which will help set us on a new trajectory. There will be opportunity through local government reform, for example, to strengthen the already significant contribution at local level, working with local communities to create thriving communities and healthy, safe and sustainable places.

As Minister of Health, I am determined to play my part in making life in Northern Ireland better and in giving everyone a fair chance to lead a healthy life. I will continue to progress legislation, strategies and programmes which contribute to better health and tackle health inequalities. I will collaborate with other Ministers to promote a whole of Government approach to health improvement, and to promote greater coherence of action across all sectors and at all levels of delivery. I would like to thank all those who contributed to the development of the framework, either in drafting or through the consultation process. I hope that the energy and expertise shown so far can be maintained as we move forward in implementing the framework over the next ten years.



**MAKING LIFE BETTER**

Through collaborative effort and through individual choices and action, I believe that we can make life better in Northern Ireland – for ourselves, our families and our communities.

**Edwin Poots MLA**

Minister of Health, Social Services and Public Safety



## EXECUTIVE SUMMARY

### Part One – Context

1. This ten year public health strategic framework provides direction for policies and actions to improve the health and wellbeing of people in Northern Ireland. The framework builds on the *Investing for Health Strategy* (2002/12) and retains a focus on the broad range of social, economic and environmental factors which influence health and wellbeing. It brings together actions at government level and provides direction for implementation at regional and local level.
2. While in general the health of people in Northern Ireland has been improving over time, health inequalities remain. Too many people still die prematurely or live with conditions they need not have. This situation is not unique to Northern Ireland.
3. In addition to factors such as health behaviours and the provision of health and social care services, population health is to a larger extent affected by economic, social and environmental factors. A number of the priorities outlined in the Programme for Government (PFG) 2011/2015 acknowledge the interrelationship between health, disadvantage, inequality, the social and physical environment, and longer term economic growth.
4. The proposed new framework *Fit and Well – Changing Lives* was consulted on in 2012. A summary of the consultation responses has been published on the DHSSPS website. In addition, the Assembly Health Committee conducted an inquiry into health inequalities, which reported in January 2013 with 9 recommendations. These included the need for a focus on thematic work across government; emphasis on early years interventions and parenting; legislation to support breastfeeding, identification of assets and upskilling for health professionals; funding for projects and increasing spend on ill health prevention. This final framework - “Making Life Better” - builds on “Fit and Well – Changing Lives” and has been re-shaped to take into account the feedback received through the consultation, the Health Committee report and subsequent cross-sectoral discussions.



## Part Two – The Framework

### Vision and Aims

5. Through strengthened co-ordination and partnership working in a whole system approach, the framework will seek to create the conditions for individuals and communities to take control of their own lives and move towards a vision for Northern Ireland where **All people are enabled and supported in achieving their full health and wellbeing potential. The aims are to achieve better health and wellbeing for everyone and reduce inequalities in health.**

### Values

6. A shared set of values is proposed to underpin action –

<b>Social justice, equity and inclusion</b>	All citizens should have the right to the highest attainable standard of health.
<b>Engagement and empowerment</b>	Individuals and communities should be fully involved in decision making on matters relating to health, and empowered to protect and improve their own health, making best use of assets.
<b>Collaboration</b>	Public policies should contribute to protecting and improving health and wellbeing, and public bodies should work in partnership with local and interest group communities.
<b>Evidence - Informed</b>	Actions should be informed by the best available evidence and should be subject to evaluation.
<b>Addressing Local Need</b>	Action should be focused on individuals, families and communities in their social and economic context

### A Thematic Approach

7. The consultation document proposed a **life course approach** to reflect the findings of the *Strategic Review of Health Inequalities in England post 2010* (the Marmot Review), and structured action around five life course stages, with underpinning themes of **sustainable communities** and **building healthy public policy**.



8. Consultation identified a qualified welcome for the life course approach, but also concern that overemphasis on the life course stages detracted from important messages about tackling the underlying social determinants of health that apply across the life course. In addition, the Health Committee's report on health inequalities supported a thematic approach.
9. In light of this the framework has been re-structured around 6 themes:
  1. Giving Every Child the Best Start
  2. Equipped Throughout Life
  3. Empowering Healthy Living
  4. Creating the Conditions
  5. Empowering Communities
  6. Developing Collaboration
10. "Giving Every Child the Best Start" and "Equipped Throughout Life", take account of particular needs across the life course and cover childhood and adulthood, with emphasis given to children and young people, and to supporting individuals' transitions into and through adulthood and older age. "Empowering Healthy Living" addresses support for individual behaviours and choices, including embedding prevention across Health and Social Care services.
11. "Creating the Conditions" and "Empowering Communities" address the wider structural, economic, environmental and social conditions impacting on health at population level, and within local communities. These will align with key government strategies such as those to develop the economy, tackle poverty and promote community relations.
12. "Developing Collaboration" considers strengthening collaboration for health and wellbeing at regional and local levels. This theme identifies three areas of work (in relation to **food, space/environments and places, and social inclusion**) around which a number of partners have been developing collaborative approaches. These areas have been recognised as being of importance in improving health and reducing health inequalities. They have the potential to bring together communities and relevant organisations at local level, supported where necessary at regional level.

### **Outcomes and Supporting Actions**

13. For each of the six themes long-term outcomes have been set with strategic supporting actions and commitments over the current budgetary



period that work towards these. They include actions which are particularly relevant to influencing the determinants of health and wellbeing. It is intended that departmental commitments will be updated on a rolling basis over the period of the framework.

14. The framework is not just about actions and programmes at government level. There are many good examples of joint working underway at a local level that remain relevant. The framework reaffirms and updates the mandate to strengthen collaboration and promote better communication and co-ordination across the system.

### The Gradient Approach

15. In order to achieve the aims of better health and wellbeing for everyone and reduced inequalities in health, the overriding approach must be to take account of the need for greater intensity of action for those with greater social, economic and health disadvantage. This applies right across the social gradient, as recognised by Marmot, and requires action to improve universal services as well as more targeted services for those in greater need.
16. There are some groups of the population who are particularly at risk and for whom targeted action is likely to be necessary, regardless of their socioeconomic status. For this reason, later sections of this framework, which set out the actions to be taken across government over the next few years, identify some particularly vulnerable groups. It is important to acknowledge however that this does not represent all that can be done to identify and support those for whom more targeted action may be required. Decisions on targeted action must be taken at a delivery level and take account of identified need.

### Part Three - Implementation

17. The framework recognises:
  - the key roles of DHSSPS and the wider Health and Social Care system;
  - importance of collaboration across government departments; and
  - that inter-agency and inter-sectoral partnership working is vital.

It seeks to create a **whole system approach** across the various levels of the system at which work needs to be taken forward.

18. At strategic level the framework illustrates the inter-connectedness of many government policies and programmes. It highlights opportunities to



strengthen these linkages through, for example, consideration of health and health equity in policy making, and governance and monitoring which develops a sense of coherence flowing through to implementation at delivery level.

19. This will require clear lines of communication and accountability, and clarity on how governance and implementation is to work. Connections with other relevant structures, strategies and initiatives need to be managed and maximized.

### Structures

20. At strategic level a **Ministerial Committee for Public Health** will be established. Key functions will be to provide strategic leadership, direction and coherence with other key strategic programmes and structures, such as Programme for Government (PFG), NI Economic Strategy and Delivering Social Change, agree shared goals and priorities and oversee implementation on behalf of the Executive. This group will be chaired by the Minister for Health, Social Services and Public Safety and supported and informed by the All Departments Officials Group (ADOG).
21. The **All Departments Officials Group** (ADOG), chaired by the Chief Medical Officer, will comprise senior officials from all departments. It will inform and make recommendations to the Ministerial Committee; co-ordinate collaborative working at departmental level; connect with the Regional Project Board, directing, or supporting action as appropriate; and monitor and report on progress.
22. The **Regional Project Board**, led by the Public Health Agency (PHA) will focus on strengthening collaboration and co-ordination to deliver on shared strategic priorities across sectors at a regional level, and on supporting implementation at a local level. Membership of the group will comprise the Chief Officers of relevant statutory agencies, and include representation from local government, the community and voluntary sector and the private sector.
23. This Group will be informed by and will support **Local Partnerships** of key statutory, private, community and voluntary bodies, based on an agreed geographic coverage. These should be developed from existing local arrangements and include a balance of statutory and non-statutory partners. The initial focus will be to collaborate on the three areas of work outlined under “**Developing Collaboration**” (in relation to **food, space/ environments and places, and social inclusion**).



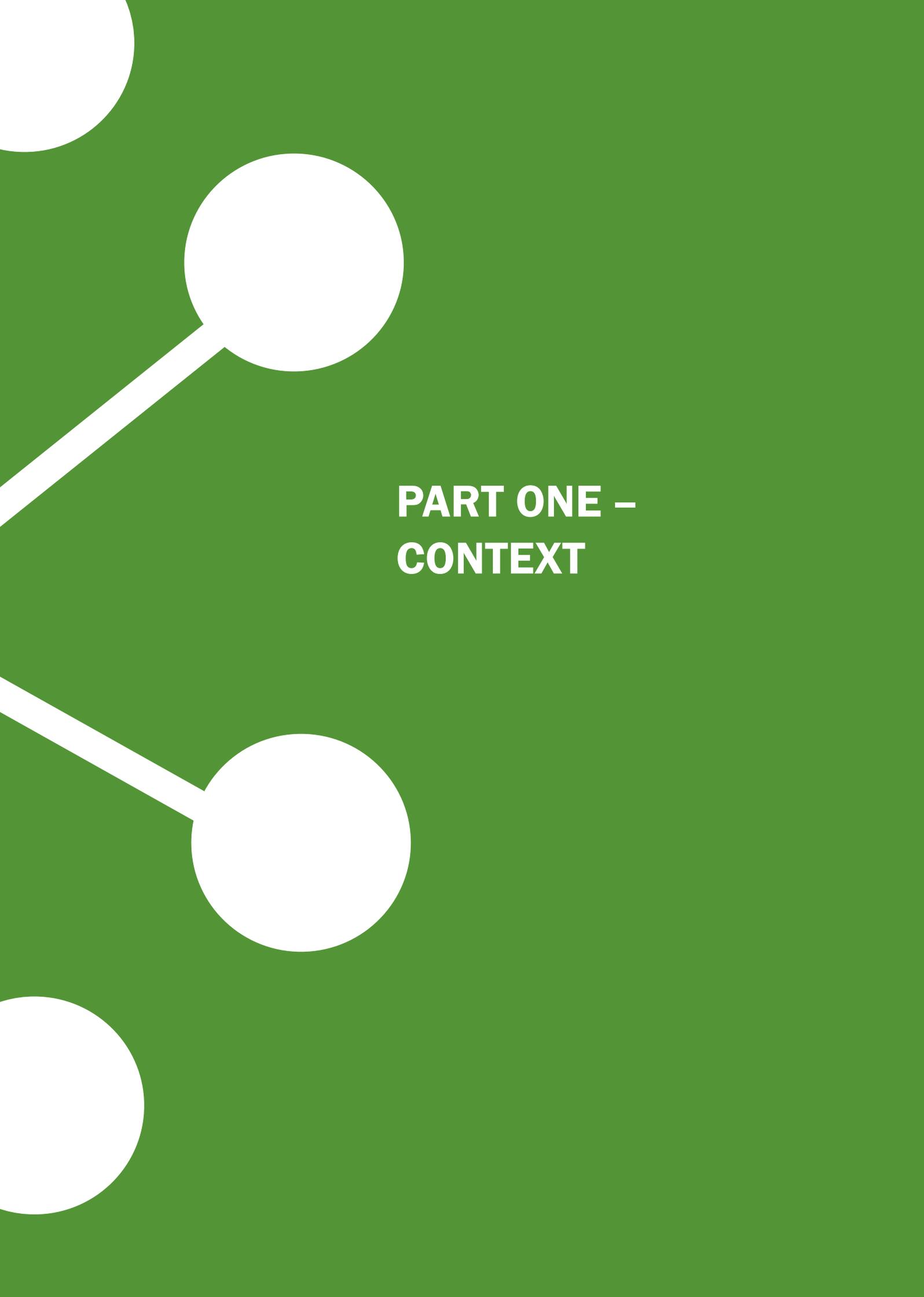
24. The Partnerships' role will focus on local delivery and will be to identify local opportunities for partnership working based on local need; drive local interventions/services to support those most in need and ensure regional priorities are reflected in local plans.
25. These arrangements should link into and align with local **community planning** arrangements over time. The productive joint working arrangements between the PHA and councils will be maintained and built upon, as well as ensuring strong linkages with others through the new community planning process.

### **Resources**

26. The actions committed to are supported by funding from across Government. This is underpinned by the Executive's commitment through PFG to allocate an increasing percentage of the overall health budget to public health (measured in terms of the PHA budget), with the aim of allocating an additional £10m by 2014/15 compared with the 2011/12 baseline.
27. The framework commits to developing better mechanisms to monitor spend on prevention across the HSC. In addition, it will be important to continue to collaborate with other departments as appropriate, to deliver relevant cross-cutting programmes. Many other sources of funding, including local government and philanthropic organisations, contribute to programmes that will deliver the aims of the framework. Opportunities to pool resources should be explored. In the current financial climate, it is vital that resources are used to optimum effect. This will include careful targeting of resources to meet greatest need with the aim of reducing health inequalities.

### **Monitoring**

28. Overall activity will be reported on annually. The framework also identifies a number of high-level indicators which will serve as proxy measures to monitor progress towards the outcomes, and which will be used to measure progress over time. Many of these will measure the scale of inequalities in addition to overall levels. Recognising the influence of the wider socioeconomic determinants of health, a number of the indicators derive from the strategies of other Departments. It will be important to improve the availability and use of data on an ongoing basis.

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**PART ONE –  
CONTEXT**



## CHAPTER 1 – INTRODUCTION

- 1.1 In general, the health of the Northern Ireland population has been improving over time. Social, economic, environmental and health improvements have meant that people are living longer than before – between 1981 and 2010<sup>i</sup> life expectancy has increased here for both men and women by 8 and 6 years respectively. Advances in treatment and care have also meant that chronic conditions can be managed differently to secure better quality of life for longer.
- 1.2 Unfortunately not everyone has had an equal chance of experiencing good health and wellbeing. Too many still die prematurely or live with conditions that could be prevented. This is particularly the case for those who are disadvantaged, leading to a gap in health between those who live in more affluent circumstances and those whose circumstances are deprived.
- 1.3 An illustration of this is provided by the “Barcode” [Figure 1] which shows the variation in life expectancy of people in each of Northern Ireland’s electoral wards ranked by level of deprivation. (White bars represent those wards where life expectancy is lower than the NI average, black represents those where life expectancy is higher than the NI average, and grey represent wards where life expectancy is similar to the NI average). The general trend is that people are more likely to live longer the more affluent their circumstances, although as illustrated this is not always the case. There are wards towards either end of the scale where life expectancy does not follow the general trend. (Further information about health and health inequalities in Northern Ireland is at Annex A.)

**Figure 1:** Male Life Expectancy<sup>i</sup> in Electoral Wards by level of deprivation.<sup>ii</sup>



- i Life expectancy is calculated using a 3-year rolling average. The year presented relates to the mid-point of the three years.
- ii Despite ward-level life expectancy estimates being based on 11 years of data, they are subject to a degree of fluctuation due to the small numbers involved. In addition, it should be noted that small area estimates for life expectancy are normally calculated separately for each gender and there are a number of limitations to the data when estimating overall life expectancy at this level.



1.4 In 2002 the Northern Ireland Executive recognised the importance of the social, economic, physical and cultural environment to health and published a cross-cutting public health strategy, *Investing for Health*<sup>1</sup>. A review of *Investing for Health* (2010)<sup>2</sup> highlighted key areas of success, for example the extent to which local stakeholders had been energized and inspired to work for health improvement, providing a good foundation on which to build. It also found that much of its approach remains relevant, but that the current, more developed evidence base and the changed socio-economic context needed to be reflected in an updated public health strategy.

1.5 *Investing for Health* sought to reduce health inequalities – avoidable differences in health status between different population groups. The last ten years have not seen a noticeable narrowing of the gap in health status between those living in the most deprived areas and the Northern Ireland average. Northern Ireland is not unique in this – health inequalities have widened in many countries across the world.

1.6 A proposed new ten year public health framework, *Fit and Well – Changing Lives 2012-22*<sup>3</sup>, was published for consultation from mid-July 2012 to mid-November 2012.

In addition to publication on the Department’s website, the Department engaged with a number of network organisations and partnerships to seek the views of key stakeholder sectors and population groups. Including reports by the network organisations, a total of 141 responses were received, with many of these directing the department to additional evidence, views and recommendations.

1.7 There was a general welcome for the framework aims of improving health and reducing inequalities in health, and for a “whole of society” approach across government and other sectors at various levels. Some key sectors, in particular the community and voluntary sector and local government, felt that their contribution was insufficiently recognised and this has been strengthened in the revised framework.

1.8 Respondents generally felt that the document was too long and complex, with too many priorities. It was also the view that, by concentrating on life stages, there was insufficient focus on actions to address the social and economic determinants that are shown to impact most powerfully on health and inequalities across life stages. Feedback also pointed out that there was no recognition of the potential of legislation as a lever for change.



1.9 A summary of the responses to the consultation, with an indication of how these have been reflected in this final version of the framework, is available on the DHSSPS website. One obvious change is the framework's revised title – **“Making Life Better”** – which is intended to reflect that effort is required on a number of fronts, and that health and quality of life are inextricably linked.

1.10 At the same time as the consultation, the NI Assembly Health Committee conducted an inquiry into health inequalities<sup>4</sup> which took evidence from a range of expert witnesses nationally and internationally. The Committee's report called for greater joined up working across Departments, including those not traditionally associated with health matters, and recommended a thematic approach across Departments to tackle inequalities. Recommendations in relation to the importance of early years interventions and for provision of support for parents were made. Identifying all assets that can be used to tackle inequalities and prioritising funding to support collaborative working were also recommended. The Committee called for an increasing share of the overall health and social care budget to be devoted to prevention.

The Committee's report, published in January 2013, and the DHSSPS response are also available on the DHSSPS website.

1.11 Following on from the consultation process, in 2013 two cross-sectoral workshops were held to consider the feedback received on “Fit and Well – Changing Lives” and to explore how this should influence the final framework. The outcomes of all of these processes and subsequent cross-sectoral discussions have informed this revised framework “Making Life Better.”

1.12 Importantly, the framework also draws on the updated evidence base and direction provided by a number of key reports and policies, including –

- World Health Organisation Commission on the Social Determinants of Health 2008<sup>5</sup>
- Fair Society, Healthy Lives – Strategic Review of Health Inequalities in England post 2010 (the Marmot Review)<sup>6</sup>
- Health 2020 – European policy framework and strategy, WHO 2012<sup>7</sup>
- Strengthening public health services and capacity: an action plan for Europe<sup>8</sup>



- Review of social determinants and the health divide in the WHO European Region, WHO, 2013<sup>9</sup>

#### Impact of Inequalities

- Approximately **one fifth** of the NI population are in relative poverty. In 2011-2012 there were approximately 379,000 people (21% of the population), including almost 95,000 children (22%) in relative poverty<sup>iii</sup>.
- Between 2009 and 2011, on average **5,500** premature deaths<sup>iv</sup> per year occurred which accounted for **38%** of all deaths over the same period and an average of **17** potential years of life lost per person.

iii derived from Family Resources Survey NI, DSD

iv deaths of those aged under 75 years

### What the Framework Seeks to Achieve

- 1.13 Through strengthened co-ordination and partnership working in a whole system approach, this framework will seek to create the conditions for individuals and communities to take control of their own lives, and move towards a vision for Northern Ireland where:-

*“All people are enabled and supported in achieving their full health and wellbeing potential.”*

The framework aims to:

*“Achieve better health and wellbeing for everyone and reduce inequalities in health.”*

- 1.14 The vision and aims make clear that a societal effort is required. Many contributions need to be made at all levels – from government, to regional and local levels – and in many settings, such as communities, workplaces, schools, and homes.
- 1.15 The framework provides strategic direction for co-ordinated action by identifying themes and outcomes to guide planning and implementation for the next ten years. However, it is also intended to be a “living” document.” Short-term commitments are included for the current PFG and budgetary period which will be reviewed and updated on a rolling basis over the ten year period of this framework.



#### Northern Ireland at a glance

- Average male life expectancy was now 77.5 years (2009/11), and female life expectancy was 82.0 – an increase of 8 and 6 years respectively since 1980/82.
- In the same period the gender gap in life expectancy decreased by 2 years to 4.4 years.
- The absolute gap in life expectancy between the 10% most and least deprived areas (2009/11) was 10.7 years for males and 7.7 years for females.
- Coronary heart disease, cancer and respiratory disease continue to be the main causes of death for both sexes.
- Northern Ireland has a 25% higher overall prevalence of mental illness than England – 1 in 5 adults here have a mental condition at any one time.
- During 2009/11 the suicide rate in males was 25.1 deaths per 100,000 population and in females 7.4, with the suicide rate in the 10% most deprived areas almost five times that within the 10% least deprived areas.
- In 2011/12 almost a fifth (19%) of adults (18 and above) stated they drank in excess of weekly recommended drinking limits.
- Hospital admission rates due to alcohol-related causes in the most deprived areas were consistently more than **double** the NI rate in 2008-10, and between **five and six times** the admission rate in the least deprived areas throughout the period.
- 61% of adults surveyed in 2011/12 were either overweight or obese (68% of males and 56% of females), and a tenth of both boys and girls aged 2-15 were also assessed as being obese.
- In 2011/12 of those surveyed, 25% of adults were smokers, with a proportion of 30% in the 20% most deprived areas.



Some estimated costs-

- The impact of the misuse of alcohol on society is estimated at some £900 million each year – almost £250 million of these costs are borne by the Health and Social Care Sector<sup>v</sup>.
- Loss to the local economy as a result of obesity is estimated at £400 million, £100m of these costs were direct healthcare costs<sup>vi</sup>.
- DHSSPS has estimated the 2011/12 hospital costs of treating diseases, of which smoking could be a contributory factor, as £164 million<sup>vii</sup>.

v Social Costs of Alcohol Misuse in Northern Ireland for 2008/09, Research commissioned by Public Health Information and Research branch, DHSSPS

vi The Cost of Overweight and Obesity on the Island of Ireland – Safefood, November 2011

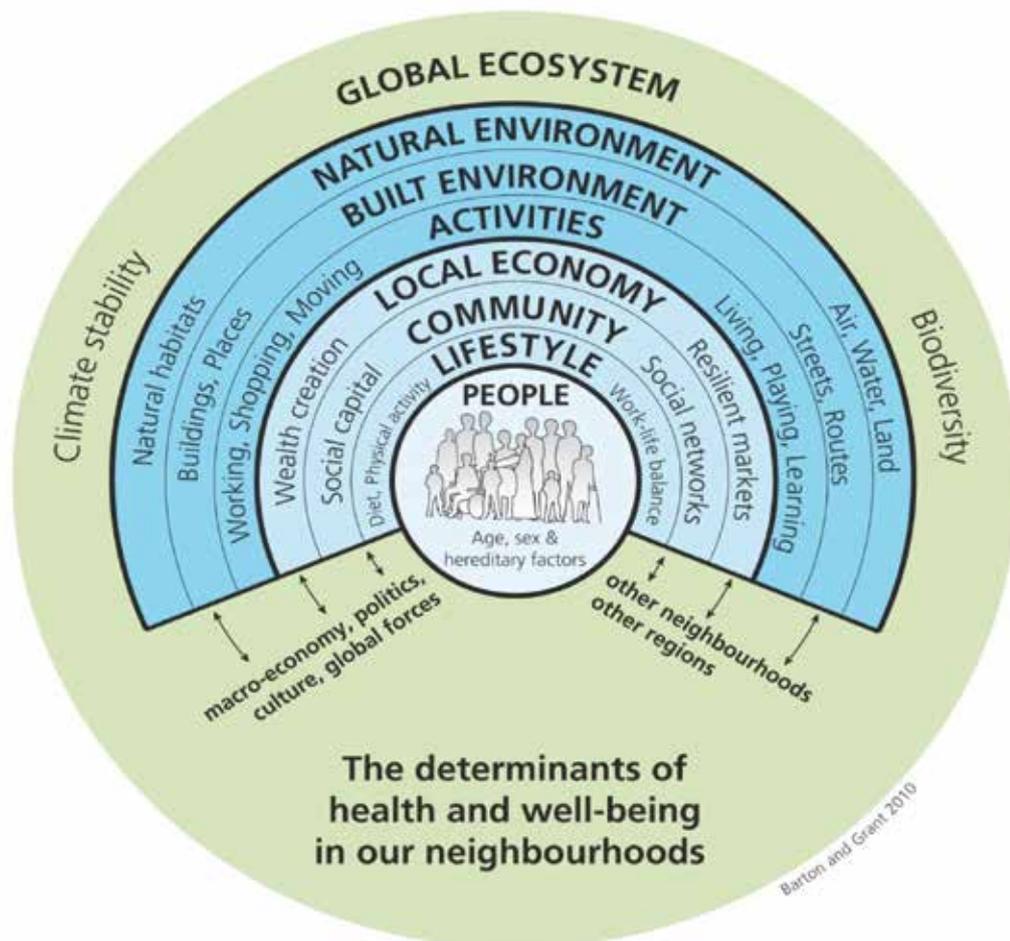
vii Methodology adopted from report by the Tobacco Advisory Group of the Royal College Of Physicians



## CHAPTER 2 – WHAT DETERMINES HEALTH AND WELLBEING

- 2.1 Health is more than just the absence of disease – it is a state of “complete physical, mental and social wellbeing”<sup>10</sup>. Wellbeing has physical, cognitive, social and emotional dimensions, and is influenced by development across the life course. The World Health Organisation (WHO) defines mental health as a “state of wellbeing in which the individual realises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community”.<sup>11</sup>
- 2.2 While genetic make-up plays some part in people’s chances of leading long and healthy lives, there are many more factors which interact to influence health and wellbeing at various stages in their lives<sup>12</sup>. This is illustrated in the figure below, which has been developed from earlier work by Dahlgren and Whitehead, 1993<sup>13</sup>.

**Figure 2:** Health Map for the Local Human Habitat





2.3 Health and wellbeing is about so much more than health and social care. A recent American study<sup>14</sup> ranked factors determining the best health outcomes for local populations. According to the study:

- Social and economic issues such as education, employment and violent crime accounted for 40%;
- Health behaviours (alcohol, tobacco and sexual behaviour) accounted for 30%; and
- Clinical services, including quality of and access to health care, accounted for 20%.

In other words health is affected more by economic, social and environmental factors than by anything else.

### **Health Inequalities**

2.4 In 2008 the World Health Organisation (WHO) Commission on the Social Determinants of Health completed a two-year investigation into the social causes of health inequalities. The report concluded that health inequalities cannot be fully explained by variation in income alone. In addition to income, the Report concluded that health inequalities are caused by inequitable distribution of more fundamental social, political and economic forces, the ‘social determinants of health’ already referred to, much of which is outside of the remit of health ministries.

2.5 The Marmot Review into health inequalities (*Fair Society, Healthy Lives – A Strategic Review of Health Inequalities in England 2010*) presented a substantial body of evidence on health inequalities. The Review’s findings reinforce that addressing health inequalities requires co-ordinated action across the social determinants of health. Both this and the 2008 reports affirm that inequalities in health arise because of inequalities in society – “in the conditions in which people are born, grow, live, work and age”.

2.6 This evidence has since been supplemented by WHO’s publication in 2013 of the “Review of social determinants and the Health Divide in the WHO European Region”. The experience of countries in the European Region shows that there are widespread inequities in health between and within societies – there should therefore be two clear aims: *“Improving average health and reducing health inequities by striving to bring the health of less – advantaged people up to the level of the most advantaged”*.



## **Life Course**

- 2.7 Central to the Marmot review is a life course perspective. There is an accumulation of advantage and disadvantage across the life course and each of life's transitions can affect health by moving people onto a more or less advantaged path. The review emphasised that action to reduce health inequalities must start before birth, and be continued 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" was the review's highest priority recommendation.
- 2.8 Health 2020 and the "Review of social determinants and the health divide in the WHO European Region" re-emphasise the life course approach as the recommended way to planning action on the social determinants of health. Whilst the life course approach begins with the important early stages of life – pregnancy and early child development – action is needed at every stage and continues with school, the transition to working life, employment and working conditions and circumstances affecting older people.

## **Social Gradient**

- 2.9 Studies such as those mentioned above show that there is a social gradient in health. The social gradient in health means that health gets progressively better as the socioeconomic position of people and/or communities improve. This pattern is also evident in the Northern Ireland population (illustrated in Annex A). The social gradient of health exists across the whole population, while the most profound differences in health can be seen between the most and least disadvantaged. To reduce the steepness of the gradient, it is important to act across the whole gradient, and to address the needs of people at the bottom of the social gradient, and those who are most vulnerable, with a view to bringing the health of the least advantaged up. To achieve this, actions are needed that are universal, but implemented with a scale and intensity proportionate to the level of social and health needs. This is known as *proportionate universalism*. It must be acknowledged however that "more of the same" does not always work, and in some cases a different or new approach may be required.



- 2.10 It has been argued<sup>15</sup> that health promotion initiatives and improvements in technology and service delivery can increase inequalities - because people in 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, and to seek to avoid public health interventions increasing inequalities.



## CHAPTER 3 – WIDER CONTEXT

3.1 Government policies and programmes have a significant impact on health and wellbeing. A number of key policies are highlighted in this and later chapters which illustrate the inter-relationships between various government programmes and the ways in which they benefit population health and wellbeing.

### Wider Public Policy and a Whole System Approach

3.2 The aims of this Framework and the challenges being addressed are not unique to Northern Ireland. In recent years many governments have increasingly come to realise that they can achieve health, social and economic goals by actively exploring the mutual benefits in sectors such as education, employment, environment, transport and agriculture. Major determinants of ill health can be addressed, and major assets for health can be harnessed by engaging non-health sectors. Collaboration in such a way, alongside engagement of communities and individuals, is a “whole system approach” to health and wellbeing.

3.3 Health 2020 is a joint commitment by the WHO Regional Office for Europe and the 53 European member states to a new common policy framework, which can be adopted and adapted to the different realities within the region. Behind Health 2020 lies the idea that health and wellbeing are essential for human, social and economic development, and of vital concern for the lives of every person, family and community. It reflects a renewed commitment to public health with shared goals to “*significantly improve the health and well-being of populations, reduce health inequalities, strengthen public health and ensure people-centred health systems that are universal, equitable, sustainable and of high quality*”.

3.4 Health 2020 argues strongly that all parts of government need to work together through increased whole-of-government working to recognize risk patterns and identify solutions, share responsibility across policy fields and sectors and act at multiple levels. Health 2020 proposes a set of areas for policy action and for inclusion in strategies for reducing health inequities, to include:-

- action on social determinants across the life course, with the highest priority given to ensuring the best start to life for every child;
- promotion of cohesion and resilience at local level through a whole of society approach;



- addressing links between environmental social and economic factors:  
and
- focusing on whole of government and whole of society delivery and governance.

3.5 These themes are also reflected in the English White Paper *Healthy Lives, Healthy People – Our Strategy for Public Health in England*<sup>16</sup> published in November 2010. In response to Professor Sir Michael Marmot’s Review the White Paper outlined the cross- government framework to enable local government and local communities to be at the heart of improving health and wellbeing and tackling inequalities for their populations. A new integrated public health service – Public Health England – has since been created to strengthen public health across national and local government levels.

3.6 In March 2013, the Republic of Ireland published *Healthy Ireland - Framework for Improved Health and Wellbeing 2013- 2025*<sup>17</sup>. The framework draws on existing policies but proposes new arrangements to ensure effective co-operation and collaboration and to implement evidence- based policies at government, sectoral, community and local levels. A key shift through Healthy Ireland is towards a whole government/ whole society approach.

### **Northern Ireland Policy context**

3.7 The Northern Ireland Executive’s *Programme for Government 2011-2015: Building a Better Future*<sup>18</sup> sets out the key goals for government and outlines a number of Executive commitments to achieve its key priority of “a vibrant economy which can transform our society while dealing with the deprivation and poverty which has affected some of our communities for generations”.

3.8 PFG recognises the relationship between health, disadvantage, inequality, the social and physical environment, and economic growth. These inter-relationships require that departments work together to produce policies and plans consistent with the five priorities. This framework will be one of the “building blocks” for the achievement of a number of priorities identified in PFG, particularly Priority 2, Creating Opportunities, Tackling Disadvantage and Improving Health and Wellbeing and a key element in efforts to build a “shared and better future for all”.



### **Context for Implementation**

#### **Wider public sector**

3.9 Effective co-ordination at strategic and delivery levels between this framework and other key government strategies will be vital to ensure maximum impact. Key examples include:-

- *NI Economic Strategy;*
- *Anti-poverty Strategy and Action Plans;*
- *Children and Young People's Strategy and Action Plans;*
- *Delivering Social Change;*
- *Together: Building a United Community; and*
- *Active Ageing Strategy*

3.10 For *Making Life Better* to succeed there is a need for policy coherence and consideration of health and health equity in policy making. Co-ordinated implementation across and beyond government departments and agencies at regional and local levels is also required, ensuring all parts of the system are connected. Efforts must be renewed to strengthen links and maximise resources, particularly during a time of financial constraint coupled with ongoing reform of public administration.

#### **Development of new public health legislation**

3.11 A review of the Public Health Act (NI) 1967 has been commissioned to ascertain whether the Act (which deals largely with health protection) still remains fit for purpose. Subject to Executive approval for the review to be carried out, it will put forward proposals for updating the current legislation, in line with reforms carried out in other jurisdictions which reflect an 'all hazards' approach. The 1967 Act is outdated and requires modernisation to enable government to deal effectively with 21<sup>st</sup> Century threats to public health. A review of the legislation, resulting in an updated statute, will provide an important mechanism for the delivery of a broader strategy for public health.

#### **The Health and Social Care System**

3.12 Health is increasingly acknowledged as having a significant influence on the economic aspects of society and on social cohesion. The health care industry is one of the world's largest and most rapidly growing sectors. It is a major employer encompassing a wide range of services, manufacturers and suppliers. At the same time expenditure on health poses a greater challenge than ever before, posing a threat to the long –



term sustainability of the health care system. Chronic disease affects the labour market and productivity at work, and the development of expensive medical technologies and treatments drive up the cost of managing chronic diseases and multiple morbidities. These cost pressures provide a strong economic case for action and investment to promote health and prevent disease.

- 3.13 The capacity and efficiency of health and social care systems is an important health determinant. The sector plays many roles in improving population health and addressing inequalities in health determinants: a direct leadership role, as a large employer, and as an influencer, mediator and collaborator. Since the recent Health and Social Care Reform in Northern Ireland, public health and wellbeing has been placed firmly at the centre of the system, with greater emphasis on prevention, early intervention, and on addressing health inequalities. It is vitally important that all organisations and individuals within the Health and Social Care system work coherently together to fulfil their respective roles and responsibilities in support of the vision and aims of this framework and related strategies.
- 3.14 The Department of Health Social Services and Public Safety (DHSSPS) has a statutory responsibility to promote an integrated system of health and social care (HSC) 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
- 3.15 The department takes this forward both by direct action and through its Arms Length Bodies which make up the sector.
- 3.16 Under the Health and Social Care (Reform) Act (NI) 2009 (the Act) the Health and Social Care Board (HSCB) supported by 5 Local Commissioning Groups (LCGs) has delegated statutory responsibility for commissioning the range of health and social care services on behalf of the entire population of Northern Ireland. The HSCB has the capacity therefore to greatly influence improvements to population health, and has a statutory duty to co-operate with the PHA in carrying out its commissioning function.
- 3.17 At sub-regional level there are 5 Health and Social Care Trusts which provide services as commissioned by the HSCB and PHA. The Act places a statutory duty on the PHA and Health and Social Care (HSC) Trusts to work to “improve the health and social well-being of, and reduce health



inequalities between, people in Northern Ireland”.

3.18 In addition all the main HSC bodies have a statutory duty of public involvement and consultation – Personal and Public Involvement (PPI). This requires them to involve people at a personal and public level, ensuring everyone, including vulnerable groups, can influence decisions about service design and delivery.

3.19 Key strategic priorities have been identified for the overall Health and Social Care system. These also reflect the Department’s specific commitments to the wider PFG:

- to improve and protect health and wellbeing 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 through the provision of safe, resilient and sustainable services;
- to improve the management of long-term conditions in the community with a view to improving the quality of care provided, and reducing the incidence of acute hospital admissions for patients with one or more long term conditions;
- to improve the design, delivery and evaluation of health and social care services through involvement of individuals, communities and the independent sector;
- to improve productivity, by ensuring effective and efficient allocation and utilisation of all available resources in line with priorities; and
- to ensure that the most vulnerable in society, including children and adults at risk of harm, are looked after effectively across all services.

3.20 A number of key policies and strategies also inform service direction including –

- Quality 2020<sup>19</sup>, which aims to protect and improve the quality of services and achieve excellence, based on three key components – safety, effectiveness, and patient and client focus;
- Service Frameworks which set out the type of service that patients



and users should expect, and aim to secure better integration of service delivery along the whole pathway of care from prevention of disease/ill health to diagnosis/treatment and rehabilitation, and on to end of life care.

- 3.21 A further key report, *Transforming Your Care (TYC): A Review of Health and Social Care in Northern Ireland*<sup>20</sup> published in December 2011, set out proposals for the future shape of services across the range of service areas. Both the original review and subsequent consultation and implementation documents include a focus on prevention and earlier interventions as a key part of the model of care closer to home, with helping people to stay healthy and make good health decisions a central goal. TYC is a key element of the wider, holistic approach to tackling inequalities.

### **Role of Public Health Agency**

- 3.22 The PHA was established to bring renewed focus on public health goals and has the lead role in integrating and supporting health improvement across all parts of the Health and Social Care system. It also has a general responsibility for promoting improved partnership working with local government, other public sector organisations and the voluntary and community sectors to bring about improvements in public health and social wellbeing and for anticipating the new opportunities offered by community planning. The PHA operates at both regional and local levels. The PHA will make a major contribution to the co-ordination of the delivery of the aims of this framework.

### **Role of the Institute of Public Health**

- 3.23 The Institute of Public Health in Ireland (IPH) was established in 1998 and promotes cooperation for public health on the island of Ireland through:

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

The IPH has had a lead role in promoting the application of Health Impact Assessment through the development of practical tools, training, research and facilitating networking opportunities.

### **Local Government**



- 3.24 There is a key interface between public health, health and social care and the role of local government. Local government will continue to be a natural partner in helping to deliver health improvements and address health inequalities at the community level. The joint working arrangements that exist between the PHA and district councils in support of health and wellbeing improvement, and the commissioning responsibilities of Local Commissioning Groups of the Health and Social Care Board, need to be visible in the proposed new community planning responsibilities of councils. This framework provides a mandate for the joint working arrangements between the PHA and local councils on local delivery, and sets a direction for the public health element of community planning.
- 3.25 The reform of local government is a priority of the PFG. The Executive's vision for local government is of one that is "strong and dynamic, creating communities that are vibrant, healthy, prosperous, safe, sustainable, and which has the needs of all people at its core". Local government reform will reduce the number of councils from 26 to 11, modernise and streamline public administration, and transfer a number of functions and powers from central government departments to the new councils. It is being managed in line with the 2015 timetable proposed in the Executive's Programme for Government 2011/2015.
- 3.26 The functions being transferred to councils include planning, aspects of urban regeneration, local economic development and tourism. Councils will also have a new duty to make arrangements for community planning. The integration through community planning of the functions being transferred and councils' existing functions should provide a productive joined up approach which optimises opportunity and makes best use of all the assets available. It will change the way cities, towns and rural areas are planned, and place a sharper focus on sustainable local economic development.
- 3.27 Community planning will bring councils, statutory bodies and the community and voluntary sector together to develop and implement a shared vision for promoting the wellbeing of an area. Councils will set up a community planning partnership to provide leadership to the process. This will include organisations, central government departments and agencies operating in their area that will work in partnership with them to plan and provide services at the local level, and contribute to PFG objectives at the regional level. Departments will also be required to promote and encourage community planning and have regard to the councils'



community plans in planning the delivery of services.

- 3.28 The broader range of powers, combined with partnership working with other Departments and agencies operating in their area, means that Councils will be able to better co-ordinate service delivery and avoid duplication, and will lead to more efficient, high quality services. Within the reconfigured, larger Council areas care must be taken not to lose the necessary focus on the most disadvantaged areas.
- 3.29 Although DHSSPS will not be transferring any functions to local government in 2015, maintaining and strengthening inter-sectoral working between local government and Health and Social Care is key and will provide an important opportunity to maximise the potential for improving the health and wellbeing of communities and tackling health inequalities at the local level.

### **Community and Voluntary Sector**

- 3.30 Tackling inequalities in health cannot be achieved by statutory agencies alone. This framework will seek to create the conditions for individuals and communities to take control of their own lives, and can only be achieved in full partnership with local communities, communities of interest, volunteers, and the community and voluntary sectors to aid the development of policies and actions that are applicable to the issues faced by communities.
- 3.31 Community and voluntary organisations play a vital role in enabling and empowering people to improve their health, and in representing and supporting particularly vulnerable interest groups. Development of community capacity and social capital, and drawing on the strengths or assets within communities, will be key to making progress.
- 3.32 A key government aim is to ensure a vibrant and sustainable voluntary and community sector that can thrive and work closely with Government in the design and delivery of policy and services in the interests of the people of Northern Ireland. This framework fully supports the shared values and principles in the Concordat between the Voluntary and Community sector and the Northern Ireland Government (2011)<sup>21</sup>.



“Working effectively together will help, for example, to develop sustainable, safer communities, ensure a well protected and valued environment, contribute to economic growth, tackle poverty, disadvantage and inequality, and assist in the promotion of health and well being.”

*Concordat between the Voluntary and Community Sector and the NI Government 2011*

- 3.33 Within the health and social care sector, the Health and Social Care Board and PHA have produced “Working in Partnership – Community Development Strategy for Health and Wellbeing 2012 – 2017.”<sup>22</sup> This recognises community development as a practice which “assists the process of people acting together to improve their shared conditions, both through their own efforts and through negotiation with public services.” The strategy aims to strengthen communities and improve health and social wellbeing by placing an increasing emphasis on community development, prevention and early intervention. It provides guidance and direction on how community development approaches are to be taken forward within health and social care, with an expectation that every HSC organisation incorporates a clear and transparent community development approach into their programmes.
- 3.34 In the Health and Social Care context, community development also links with mechanisms to improve services and care. The statutory duty of public involvement and consultation – Personal and Public Involvement (PPI)<sup>23</sup> - on Health and Social Care organisations is a central component of the agenda to improve health and social care provision.
- 3.35 The empowerment of communities, assisted by implementation of community development approaches and PPI, will be key to improving health and reducing inequalities in health. Partnership working with grassroots community and voluntary sector organisations will help release and support the energy within communities, and encourage further development of community capacity to address local needs (see also Chapter 9 – Empowering Communities).



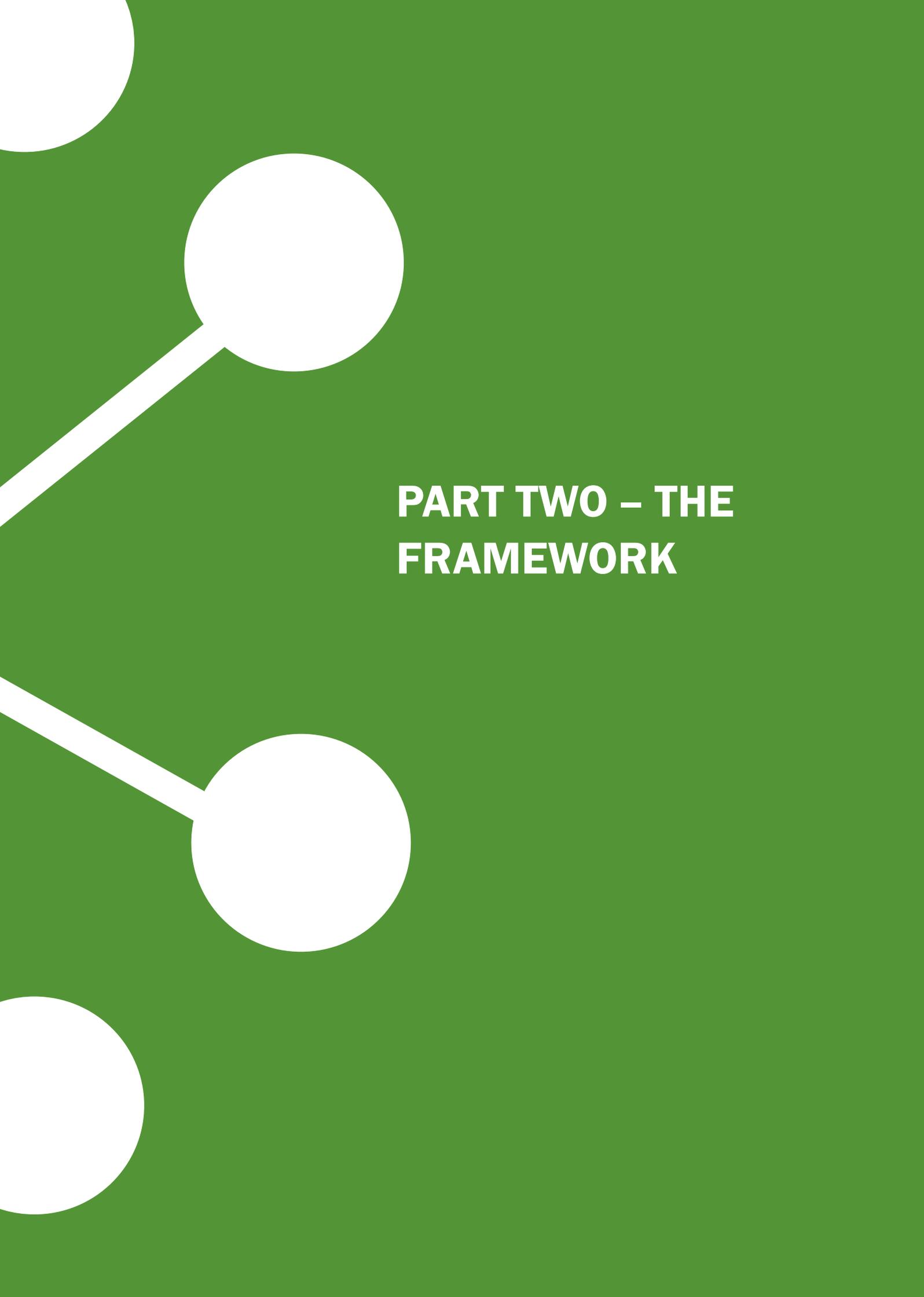
### **Other Organisations and Partnerships and Business sector**

- 3.36 A variety of partnership arrangements already exist at both regional and local levels in relation to health, or to take forward other government strategies and programmes which impact on health. Both Belfast and Derry are part of the WHO Health Organisation Healthy Cities Network\*. Belfast Healthy Cities has recently celebrated 25 years of advocacy and effort on behalf of the city and has a reputation as a key contributor to the Healthy Cities Network. There are many other organisations, including professional bodies, trade unions, advocacy and/or philanthropic organisations, sporting and cultural organisations, and funding bodies, which make important contributions. Appropriate and effective linkages and information sharing with and between such organisations will be beneficial to population health.
- 3.37 Many partners within the business sector can play a key role. In England this has been recognised through DOH England’s collaboration with the sector in promoting “Public Health Responsibility Deals” to promote socially responsible approaches, including for example in relation to consumer information about food. Northern Ireland stands to benefit from these wider relationships and will continue to advocate through relevant networks.
- 3.38 Retailers, media, sports and leisure businesses can contribute in many ways to promote or support healthy choices. 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”.

\* The WHO European Healthy Cities Network consists of cities around the WHO European Region that are committed to health and sustainable development: more than 90 cities and towns from 30 countries. They are also linked through national, regional, metropolitan and thematic Healthy Cities networks. A city joins the WHO European Healthy Cities Network based on criteria that are renewed every five years.



**MAKING LIFE BETTER**

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## **PART TWO – THE FRAMEWORK**



## CHAPTER 4 – VISION, AIMS, VALUES AND THEMES

### Vision and Aims

- 4.1 Through strengthened co-ordination and partnership working in a whole system approach, this framework will seek to create the conditions for individuals and communities to take control of their own lives and move towards a vision for Northern Ireland where –

**“All people are enabled and supported in achieving their full health and wellbeing potential.”**

The aims of the framework are to:

**“Achieve better health and wellbeing for everyone and reduce inequalities in health”**

### Values and Principles

- 4.2 While values and principles of *Investing for Health* still have merit, the consultation highlighted that some of the concepts did not reflect current thinking or language. The values and principles have been revised to provide a shared set of values to underpin action at strategic and local levels:

<b>Social justice, equity and inclusion</b>	All citizens should have the right to the highest attainable standard of health.
<b>Engagement and empowerment</b>	Individuals and communities should be fully involved in decision making on matters relating to health, and empowered to protect and improve their own health, making best use of assets.
<b>Collaboration</b>	Public policies should contribute to protecting and improving health and wellbeing, and public bodies should work in partnership with local and interest group communities.
<b>Evidence - Informed</b>	Actions should be informed by the best available evidence and should be subject to evaluation.
<b>Addressing Local Need</b>	Action should be focused on individuals, families and communities in their social and economic context.



4.3 The “**right to health**” has been enshrined in the World Health Organisation (WHO) Constitution<sup>24</sup> and in international and regional human rights treaties, such as the UN Convention on the Rights of the Child, including *General Comment No 15 (2013)*, Convention on the Elimination of all forms of Discrimination Against Women, and Convention on the Rights of Persons with Disabilities<sup>25</sup>.

4.4 The right refers to the “*highest attainable standard of physical and mental health*” as a fundamental right of every human being, and means that governments must create conditions in which everyone can be as healthy as possible – such actions range from ensuring the availability, affordability and accessibility of health services to taking public health measures for healthy and safe working conditions, adequate housing and nutritious food and other conditions for protecting and promoting health. Citizens, in turn, need to understand the value of their health and contribute actively to creating better health in society at large.

***“The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without the distinction of race, religion, political belief, economic or social condition. (WHO Constitution)”***

4.5 At the heart of human rights is the recognition that they are universal, that everybody should be treated equally and with dignity, and that all human rights are interrelated, interdependent and indivisible. Health 2020 asserts that “human rights standards and principles - such as participation, equality, non-discrimination, transparency and accountability - should be integrated into all stages of the health programming process and should guide health policy making.”

4.6 Health inequalities result from social inequalities. Reducing health inequalities that are preventable by reasonable means is a matter of fairness and social justice requiring action across society. This aligns with the PFG priority of addressing the challenges of disadvantage and inequality that afflict society, and working to close the gap in health between those who are least and most disadvantaged.

4.7 Promoting equality of opportunity is fundamental to the achievement of the aims of this framework. The social determinants of health affect Section 75 groups differently, for example the social and economic roles performed by men and women significantly affect the health risks to which they are exposed over the life course. Evidence shows that inequalities based on race, disability, age, religion or belief, gender, sexual orientation and gender identity can interact in complex ways with socioeconomic



position in shaping people's health and wellbeing. A key purpose of this framework is to set out a strategic direction and actions that will actively pursue health equity and social inclusion. Tackling the major inequalities in health and wellbeing and their causes will help promote equality of opportunity and good relations.

- 4.8 The value of community development as a process to empower and bring about changes to individuals, communities and wider society founded on social justice, equality and inclusion is recognised. Adopting an asset-based approach, an aim of this framework is to equip and enable individuals, families and communities to address the issues affecting their health and wellbeing and make healthy choices (see also Chapter 10 – Developing Collaboration)

This approach goes hand in hand with the statutory duty of public involvement and consultation - Personal and Public Involvement (PPI) on Health and Social Care organisations in empowering people to make decisions about services and care.

### **Themes**

- 4.9 The consultation document *Fit and Well – Changing Lives* proposed a life course approach to reflect the Marmot Review findings, and structured action around five life course stages, with underpinning themes of “sustainable communities” and “building healthy public policy”. The document also proposed two strategic priorities – Early Years and Vulnerable People and Communities.

- 4.10 In the responses to the consultation there was a qualified welcome for the life course approach. There was concern that overemphasis on the life course stages detracted from important messages about tackling the underlying social determinants of health that apply across the life course. In particular, respondents highlighted the need to mitigate the effects of poverty, support people through welfare reform and into employment. In addition the Health Committee's report on health inequalities supported a thematic approach. In the consultation responses, there was general support for making early years a priority, and Giving Every Child the Best Start is retained in the framework as a theme.



4.11 In light of this feedback the Framework has been re-structured around the following themes:

- Giving Every Child the Best Start
- Equipped Throughout Life
- Empowering Healthy Living
- Creating the Conditions
- Empowering Communities
- Developing Collaboration.

4.12 “Giving Every Child the Best Start” and “Equipped throughout Life” take account of the particular needs across the life course and have been broadened to cover childhood and adulthood. They address the key social determinants at each stage. Particular emphasis is given to children and young people, and to supporting individuals’ transitions into and through adulthood and older age. “Empowering Healthy Living” addresses support for individual behaviours and choices, and embedding prevention in Health and Social Care services. The next two themes address the wider structural, economic, environmental and social conditions impacting on health - at population level, and within local communities.

4.13 “Developing Collaboration” considers strengthening collaboration for health and wellbeing at regional and local levels. A number of strategic actions are identified, and in addition it identifies three areas of work around which a number of partners have been developing collaborative approaches.

4.14 For each theme, key long-term outcomes have been set. These are outlined in the next series of Chapters along with strategic supporting actions and commitments over the next 2-3 years that work towards these outcomes. These include actions planned either as PFG commitments or business commitments of particular departments; all are relevant to influencing the determinants of health and wellbeing. Progress on these supporting actions will be monitored and, in due course, the actions will be updated in line with PFG and budget periods.

4.15 However this is not just about actions and programmes at government level. It is acknowledged that there are many good examples of joint working underway amongst key partners such as public sector agencies, local government, the community and voluntary sector, local communities and the private sector. The framework reaffirms and updates the mandate to strengthen collaboration at all levels, and promote better communication and co-ordination across the system.



### **The Gradient Approach**

- 4.16 There was less consensus in the consultation response on the second priority (“Vulnerable People and Communities”) with many responses suggesting additional vulnerable population groups. The groups and communities within society who require targeted support vary depending on need and the issue being addressed. Furthermore, the findings from the Marmot and other reviews highlight the social gradient that exists across the entire socioeconomic spectrum. These reviews call for universal action, but with a scale and intensity proportionate to the level of disadvantage – proportionate universalism.
- 4.17 In order to achieve the aims of better health and wellbeing for everyone, and reduced inequalities in health, the overriding approach must be to take account of the need for greater intensity of action for those with greater social, economic and health disadvantage. This applies right across the social gradient and requires action to improve universal services as well as more targeted services for those in greater need. This is with a view to narrowing the health gap by bringing up the level of health of the groups of people who are worse off.
- 4.18 There are some groups of the population who are particularly at risk and for whom targeted action is likely to be necessary, regardless of their socioeconomic status. The gradient approach adopts a combination of broad universal measures with strategies targeted at high- risk groups. For this reason, later sections of this framework, which set out the actions to be taken across government over the next few years, identify some particularly vulnerable groups. It is important to acknowledge however that this does not represent all that can be done to identify and support those for whom more targeted action may be required. Decisions on targeted action must be taken at a delivery level and include careful targeting of resources to meet greatest need, with the aim of reducing health inequalities.



## CHAPTER 5 – GIVING EVERY CHILD THE BEST START

Key long term outcomes:

- 1 Good quality parenting and family support**
- 2 Healthy and confident children and young people**
- 3 Children and young people skilled for life**

5.1 What happens to children in their earliest years is key to outcomes in adult life. This is supported by a wide range of research evidence from education, health, justice and economic experts<sup>26</sup>. Individuals and communities benefit from the strong attachment and emotional links that are created by good parenting and positive early life experiences. These give children the best start in life and help to prepare children to get the most out of education and social interactions.

### **1 GOOD QUALITY PARENTING AND FAMILY SUPPORT**

5.2 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. The importance of working in partnership with parents and care givers to enable them to encourage a positive home environment, and to provide continuity in their child's early experiences from home to pre-school, is clear.

5.3 Research shows that a shift in emphasis towards co-ordinated support for children in their early years is the most likely route to breaking the cycle of disadvantage and reducing inequalities in health. This is consistent with obligations under the Child Poverty Act 2010. In view of this, and supported by recommendations by the Health Committee for greater focus on early years interventions, this framework places the highest emphasis on the significance of parenting and family support as providing the foundation for realising the potential of children and young people, and for longer term public health and wellbeing.

5.4 The need to shift investment towards early intervention services and programmes for children and families has been recognised more widely across government, for example through two projects underway with funding from the Delivering Social Change



programme to support the development of an additional 10 Family Support Hubs, and a number of targeted parenting programmes over the 2012/13–2014/15 period.

- 5.5 A collaborative approach is required to bring about the incremental development of universal and targeted programmes to include ante and post natal care and parenting programmes. This progression will need to be co-ordinated to link with a number of relevant strategic programmes such as: Children and Young People’s strategy, Delivering Social Change, DE policy and programmes for early years and school age children (such as Learning to Learn: A Framework for Early Years Education and Learning), Families Matter, Child Health Promotion Programme, Maternity and Breastfeeding strategies.
- 5.6 On behalf of a collective of government departments, it is proposed that DHSSPS will lead the implementation of an Early Intervention Transformation Programme from 2014, subject to funding being approved. It is intended that this Programme will facilitate a systemic change in how services are provided to children and families in Northern Ireland in order to measurably improve outcomes. The emphasis will be on intervening early in a child’s life, or at the stage when family difficulties are emerging, so that they can be successfully addressed before problems become entrenched.
- 5.7 In terms of delivery, the Children and Young People’s Strategic Partnership, which brings together key agencies to plan and integrate children’s services, in partnership with the Child Development Board established by the PHA to review and advise on evidence, will be key to taking forward this co-ordinated approach. This work reports to and is guided by the Ministerial Sub- committee for Children and Young People.
- 5.8 A review of the Families Matter Strategy will seek to consolidate and further strengthen efforts to ensure that parents and families continue to receive the information, support, and gain the skills they need to help their children reach their full potential. It will aim to address the barriers that hard to reach families experience in accessing services, address the potential stigma associated with using family support services and raise awareness and uptake of relationship support and family mediation.
- 5.9 *Bright Start - The Executive’s Programme for Affordable and Integrated Childcare (A Strategic Framework and Key First Actions)* sets out the framework, principles and a range of key first actions



to help deliver the establishment of an improved and expanded system of childcare, with a key aim of supporting the development of children and young people, and enabling children and young people from all backgrounds, including the most deprived, to avail of life opportunities.

## OUTCOME **1** GOOD QUALITY PARENTING AND FAMILY SUPPORT

### Actions and Commitments 2013 – 2015

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#### A Promote and support positive parenting through –

- establishment of Family Support Hubs and systematic expansion of a range of initiatives and evidence based parenting support programmes, *with a particular focus on children in need and children in families in areas of disadvantage and experiencing inter-generational unemployment*
- establishment of a cross-departmental/sectoral Early Intervention Transformation Programme
- roll-out of Family Nurse Partnership programme
- implementation of the PHA/HSCB Hidden Harm Action Plan
- improved safeguarding outcomes for children
- parents and other relatives who can play a role in the lives of children who are in care or on the edge of care
- improved availability of high quality, accessible and affordable childcare through a new Childcare Strategy
- implementation of an infant mental health training plan
- implementation of the Education Works campaign and website

#### Key Partners

DHSSPS / OFMDFM / HSC / PHA / CYPSP / DSD / SSA / DE / DOJ / DEL  
Safeguarding Board/ Community and Voluntary sector



**OUTCOME 1 GOOD QUALITY PARENTING AND FAMILY SUPPORT**  
Continued

**Actions and Commitments 2013 – 2015 Continued**

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- B** Ensure appropriate family based financial support to children through –
- effective Child Maintenance arrangements in place
  - encouraging and enabling families to take financial responsibility for their children
  - providing information and support for separated and separating families

**Key Partners**

DSD

**Healthy and confident children and young people**

***Family Nurse Partnership***

*The Family Nurse Partnership programme, an intensive preventive home visiting programme, is being introduced to Northern Ireland. It aims to improve antenatal health, child health and development and parents' economic self-sufficiency. Over the next few years it will be offered to around 500 first time young parents from early pregnancy until their child is 2 years old. The programme can deliver tangible outcomes which have been evidenced through 30 years of research in the US'.*

**2 HEALTHY AND CONFIDENT CHILDREN AND YOUNG PEOPLE**

- 5.10 An updated programme for 0-19 year olds, known as “Healthy Child – Healthy Future (HCHF): a Framework for the Universal Child Health Promotion Programme in Northern Ireland,”<sup>27</sup> was issued in 2010. The framework is central to securing improvements in child health for all children aged 0-19 years, across a range of issues. The framework sets out a core programme of child health contacts that every family can expect, with access to a universal programme of preventative care and additional services for those with specific needs and risks, e.g. neonatal blood spot screening, childhood immunisations, family health assessment, growth monitoring, infant feeding and family nutrition, routine inquiry etc. HCHF aims to identify and respond to families in need at the earliest opportunity.



15% of women in Northern Ireland smoke throughout pregnancy and reflects the general increase in the number of young women who smoke. The risk of complications for the baby includes premature delivery, low birth-weight and cot death. To aid behavioural change, consistent advice should be given to any woman who is smoking and pregnant. Smoke Free Wombs is an exciting initiative by midwives in the South Eastern HSC Trust to encourage mums-to-be to stop smoking. "Smoke Free Wombs" uses Facebook, a powerful DVD, and cartoon images to try and get the message across that smoking harms the unborn child.

Midwives are asking mums-to-be to sign a pledge to work in partnership with them to give up. Mums-to-be will receive a letter outlining how smoking can harm babies in the womb, and offering the opportunity to meet with the Health Improvement Midwife. Women are provided with consistent information through face-to-face contact, phone support, text message and Facebook. Since this initiative began, data suggests a 52% increase in referral to no smoking programmes and that the "quit" rate has trebled.



- 5.11 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.
- 5.12 Growing up is a time in life of considerable health and social needs. Whilst investment in early years is crucial, it needs to be combined with sustained commitment to children and young people throughout their school years. How children progress at school beyond early and into teenage years is clearly important to emotional, cognitive, physical and social development throughout their life. Schools are vitally important settings for personal and social development, and the development of life skills and behaviours which will influence later life chances. Implementation of programmes such as nurture provision, a short term early intervention addressing barriers to effective learning; and iMatter, the Pupil's Emotional Health and Wellbeing Programme in post-primary schools, will make a key contribution to building confidence, empathy, self esteem and resilience, and social skills.



- 5.13 Adolescence is a critical transitional period that includes biological change and the need to negotiate key development tasks such as increasing independence and normative experimentation. Adolescents and young adults are particularly sensitive to influences such as family, peer group, school, neighbourhood, and developmental changes can either support or challenge young people's health and wellbeing. Promotion of positive social competences and abilities such as self worth, aspiration and connectedness, not only facilitates healthy behaviours but also helps to ensure a healthy and productive future adult population.
- 5.14 Effective collaboration between the health and education sectors, from early years right through school, is crucial to supporting children and young people's development, in terms of their personal and social development, their educational attainment and future life outcomes.

## OUTCOME **2** HEALTHY AND CONFIDENT CHILDREN AND YOUNG PEOPLE

### Actions and Commitments 2013 – 2015

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- A** Ensure high quality public health and social care services are provided for all children and young people, from ante natal care onwards to include –
- the full range of health protection, health promotion, surveillance and screening and immunisation programmes
  - implementation of the breastfeeding strategy including support programmes for those least likely to breastfeed
  - additional and tailored support to those who need it, *for example families with children with a learning or physical disability, young children with speech, language and communication needs, traveller children*
  - targeted support for low income, vulnerable pregnant women and young families through the continued promotion and delivery of the Healthy Start scheme

#### Key Partners

DHSSPS / HSC



**OUTCOME 2 HEALTHY AND CONFIDENT CHILDREN AND YOUNG PEOPLE Continued**

**Actions and Commitments 2013 – 2015 Continued**

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- B** Children are cognitively, emotionally and socially ready to benefit from education by the time they start P1 through –
- linking learning and development more effectively through relevant strategies and policies around early intervention and early years, for example implementing ‘Learning to Learn – A Framework for Early Years Education and Learning’ to strengthen and develop early years education and learning services
  - maintaining high quality Sure Start services in designated areas of disadvantage, to support parenting and services for children aged 0-4; and evaluating through a review how effectively the Programme is making a difference to young children and their families, especially the most disadvantaged
  - making at least one year of pre-school education available to every family that wants it - *children from socially disadvantaged circumstances likely to experience barriers to learning identified for targeted action*

**Key Partners**

DE / DHSSPS/ others

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- C** Maximise opportunities for every child and young person to develop confidence, personal resilience and basic skills required for life through for example –
- ensuring all children’s and young people’s settings (such as schools, colleges and youth organisations) provide environments which support good health and wellbeing through, for example, implementation of anti-bullying policies, promotion of healthy eating and physical activity
  - continuing development and implementation of the “iMatter” programme across post-primary schools and special schools
  - Delivering Social Change Nurture Units Project – establish 20 new Nurture Units within Primary Schools, to address early emotional and behavioural difficulties among children in Years 1-3 – *children who have missed early nurture experiences, and their parents identified for targeted action*



**OUTCOME 2 HEALTHY AND CONFIDENT CHILDREN AND YOUNG PEOPLE Continued**

**Actions and Commitments 2013 – 2015 Continued**

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**C** Continued –

- implementation of Priorities for Youth policy

**Key Partners**

DE / DHSSPS / PHA / Local government / Community and voluntary sector

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**D** Increase parents and children’s awareness of child internet safety

**Key Partners**

Departments led by OFMDFM / DHSSPS / Safeguarding Board for NI.

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**E** For looked after children and young people ensure –

- greater involvement in the preparation of their care and personal education plans
- improved engagement in special interests, culture and leisure and extra-curriculum activities
- regular school attendance by all children and young people in care

**Key Partners**

Departments led by OFMDFM / DHSSPS / Safeguarding Board for NI.

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**F** Promote the benefits of play and leisure and increase the opportunities for children and young people to enjoy it

**Key Partners**

Departments led by OFMDFM/ Local government / DE / DHSSPS / HSC



### **Rhythm and Rhyme**

*Libraries, for example, play a key role in early years development through activities such as “Rhythm and Rhyme”.*

*Many Northern Ireland Branch libraries host Rhythm and Rhyme sessions for babies and toddlers accompanied by parents and carers. Each session lasts around 30 minutes and gives the adults and children time to have fun together. The session is led by a member of staff, and carers and children are invited to participate at whatever level they wish. Musical instruments are also used to add a noisy dimension. Rhythm and Rhyme sessions are an excellent opportunity for parents/carers to meet up at the library and discover how much babies and toddlers love songs and rhymes. They are also a great way to help children’s talking and listening skills. Good rhymers make good readers.*

### **3**

#### **CHILDREN AND YOUNG PEOPLE SKILLED FOR LIFE**

- 5.14 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 quality of life. Conversely, children growing up in poorer families are less likely to do well at school and in later life outcomes, than those from more affluent backgrounds. As well as affecting educational achievement, children who do not thrive at school are more likely to become disengaged, and try “risky behaviour” such as smoking and drinking at an early age.
- 5.15 Inequalities in education outcomes are subject to a similar social gradient as those for health. As with health inequalities, reducing education inequalities involves understanding the interaction between the social influences on education, including family background, and the local community context, as well as the school context. Evidence on the most important factors influencing educational attainment suggest that it is families that have the most influence rather than schools, and that closer links between schools, the family, and the local community are needed.
- 5.16 Sustained commitment to children and young people throughout their years of education will be vital to reducing inequalities in both health and education. Raising standards of educational attainment especially in areas of social need has a positive impact on improving employability and reducing social exclusion.



- 5.17 Further support for young people is vital in the form of broader skills development for work and training, including management of relationships, advice on continuing education, budgeting and debt management, parenting etc. Without life skills and readiness for work, young people will not be able to make the most of opportunities and take control over their lives.
- 5.18 Outside the formal education setting, effective youth work provides young people with valuable opportunities to build self esteem, learn new skills, develop new relationships, and helps them to develop as active citizens and members of their communities. While relevant for all young people, youth work can be particularly relevant for those who are at risk of disengaging from society or disaffected at school. “Priorities for Youth” outlines a framework for youth work within education to support young people to mature to reach their potential as valued individuals and responsible citizens.

### OUTCOME 3 CHILDREN AND YOUNG PEOPLE SKILLED FOR LIFE

#### Actions and Commitments 2013 – 2015

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- A** Through implementation of “Every School a Good School” and the Literacy and Numeracy strategy –
- increase the proportion of primary pupils achieving at the expected level in Key Stage Two in both Communication and Using Maths
  - address numeracy and literacy issues at transition between primary and post primary school through provision of a professional development programme for teachers of English and Mathematics across Key Stages 2 and 3
  - increase the proportion of school leavers achieving at least 5 GCSEs at A\* – C or equivalent, including GCSE English and Maths
  - increase the proportion of school leavers from disadvantaged backgrounds achieving at least 5 GCSEs at A\* – C or equivalent including GCSE English and Maths

#### Key Partners

DE / Education sector / OFMDFM



**OUTCOME 3 CHILDREN AND YOUNG PEOPLE SKILLED FOR LIFE**  
Continued

**Actions and Commitments 2013 – 2015 Continued**

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- B** Provide young people with an awareness of budget management including the financial implications of parenthood

**Key Partners**

DE / others

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- C** Provide young people with access to –

- a broad and balanced range of courses, including Essential Skills, that have coherent pathways to HE, FE, training or employment, and that meet the needs of the local economy

**Key Partners**

DE / DEL / FE / HE

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- D** Identify and intervene early to support children and young people up to age 19 with special or additional educational needs through –

- pilot approaches and building capacity in line with the Review of Special Education Needs (SEN) & Inclusion
- 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 attendance

**Key Partners**

DE / DHSSPS / HSC

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- E** Provide 100 Shared Summer Schools for post primary young people to create opportunities as a step towards greater sharing in education

**Key Partners**

OFMDFM / DE



### **Active School Travel**

*Recent research by University College London showed that children in Northern Ireland are the least physically active in the UK. Half of 7 year old children here are not getting the recommended one hour of physical activity each day (recommended through the Chief Medical Officers guidelines for physical activity: Start Active, Stay Active) and this is posing real, long term risks to their health and wellbeing.*

*To help combat these worrying statistics the Department for Regional Development (DRD) and the DHSSPS/PHA jointly fund an Active School Travel initiative, to be delivered through Sustrans, which was launched in October 2013 at St. Joseph's School at Ballyhackamore. This was launched with participation from staff and pupils from both St. Joseph's and Strandtown Primary Schools and aims to encourage more children to walk and cycle to school. The Active School Travel Programme will be delivered to at least 60 schools per year (180 in total) over a three year period to encourage pupils to adopt walking and cycling as their main mode of transport to and from school.*

**<http://www.ucl.ac.uk/news/news-articles/0813/22082013-Half-of-UK-7-year-olds-sedentary-Dezateux>**

**[https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/216370/dh\\_128210.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216370/dh_128210.pdf)**

**Key Strategies/ strategic programmes** – Families Matter, Co-operating to Safeguard Children, Healthy Child Healthy Future, Breastfeeding strategy – A Great Start 2013 – 2023, Children and Young People's strategy, Child Poverty Action Plan, Delivering Social Change Framework/Signature Programmes, Revised Curriculum, Learning to Learn – A framework for Early Years Education and Learning, iMatter programme, School Improvement policy - Every School a Good School, Raising numeracy and literacy levels – Count, Read: Succeed, Entitlement Framework, A Fitter Future for All, Healthy Food for Healthy Outcomes – Food in Schools policy, Education Works campaign, Bright Start - Childcare strategy, Priorities for Youth, Pathways to Success, Community Family Support Programme, Essential Skills for Living, Hidden Harm Action Plan, Child Maintenance programmes, Play and Leisure Policy statement and Play and Leisure Implementation Plan, Care Matters, Transforming Your Care, Making it Better - A Strategy for Pharmacy in the Community.



## CHAPTER 6 – EQUIPPED THROUGHOUT LIFE

Key long term outcomes:

- 4 Ready for adult life**
- 5 Employment, life-long learning and participation**
- 6 Healthy active ageing**

6.1 Initiatives which encourage and engage people at any age in social, cultural, sport and leisure activities impact on both physical and mental health and wellbeing, as well as on such issues as creativity, social inclusion, and good relations. They can also support interaction across generations. In addition to individual and wider societal benefits, there are environmental benefits to be gained. Participation in such interests offers lifelong enjoyment and fulfilment and is an essential part of healthy living.

6.2 Volunteering also benefits individuals, communities and wider society. It helps to connect and support people, and to progress issues or interests. It also helps individuals develop new skills, and utilises the resources of those with skills and expertise to promote the transfer of skills to others. Volunteering has the potential to build capacity, capability and self esteem in the young, and also promote social inclusion and intergenerational activity.

### **4 READY FOR ADULT LIFE**

6.3 As children grow into adults, they face very different opportunities and challenges – some will be moving into further or higher education, others may be leaving education and seeking work for the first time. Within the health system it is also a time of transition from childrens' to adults' services, with the need to become more self reliant. Some will be moving into their own accommodation. It is also a time of developing relationships. The social and economic context of their lives is changing – for many it is a new and different world, exciting and also challenging. It is a time of adjusting to new responsibilities and the transition can involve positive and negative experiences, with increased freedom or independence, but also increased stress.



**Ready for Adult Life**

**Down Community Arts**

*Based in Downpatrick, Down Community Arts provides a programme called “Healthy Headz” targeted at young people from Ballynahinch, Saintfield, Crossgar and Killyleagh identified through the Youth Service of SEELB as being at risk, marginalised or unattached to existing provision. The programme aims to address areas such as anti-social behaviour, drug and alcohol misuse, mental, sexual and physical health, self-confidence and community ownership.*

- 6.4 While it is generally a time of peak health<sup>28</sup>, it is often associated with risk taking behaviour – such as alcohol and drug misuse – with little realisation of the potential impact on future health. Maintaining healthy behaviours and sustaining good physical, sexual and mental health through this period into adulthood is important.
- 6.5 Young people are the group most likely to be unemployed and to be in low-skilled, low paid jobs. The number and type of jobs available to those with low level skills is increasingly in decline, with jobs growth predominantly in employment which requires higher skills. 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.
- 6.6 DEL’s “Access to Success” aims to widen participation in higher education by students from groups who are currently under-represented, in particular students from disadvantaged backgrounds and those with disabilities and learning difficulties.
- 6.7 A key concern relevant to the current economic climate is the high number of young people who are not in employment, education or training (NEETS). This has the potential to impact negatively on longer term outcomes for this group in terms of their future economic status and ultimately their health and wellbeing. DEL leads on the ‘Pathways to Success’ Strategy which is the Executive’s formal strategy for addressing their needs. This has a particular focus on helping those young people who face barriers to participation.



- 6.8 DEL's Employment Service and a range of other government programmes will also work to address this and the wider issue of unemployment through a range of schemes (including those targeted at particular groups such as young care leavers, people affected by drug/alcohol misuse, etc). In addition, through the new "Building a United Community" a number of planned initiatives, such as the "United Youth Programme" will benefit this group. Other key mainstream DEL provision, such as the Careers Service, will continue to support young people in identifying and progressing towards their career goals.

#### OUTCOME 4 READY FOR ADULT LIFE

##### Actions and Commitments 2013 – 2015

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- A** Provide young people with access to –
- careers information advice and guidance as required, to enable them to make effective career/learning choices
  - a guarantee of a training place for those in the 16 and 17 year old age group (up to age 24 in special circumstances) who have left school
  - opportunities to gain Essential Skills qualifications in literacy, numeracy and ICT from entry level to level 2 that will help young people improve their employability as well as overall quality of life

##### Key Partners

DEL

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- B** Make tailored health and safety information available to all young people entering work for the first time

##### Key Partners

DETI / HSE

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- C** Promote employability schemes in public and private sectors targeted at young and long term unemployed

##### Key Partners

DEL / others



**OUTCOME 4 READY FOR ADULT LIFE Continued**

**Actions and Commitments 2013 – 2015 Continued**

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- D** Implement the cross-departmental “Pathways to Success” Strategy for young people not in education, employment or training. (NEETS)

**Key Partners**

DEL / DE / others

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- E** Development and delivery of the United Youth Programme offering young people employment, work experience, volunteer and leisure opportunities along with a dedicated programme designed to foster good relations and a shared future

**Key Partners**

DEL / OFMDFM / DE

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- F** PCSPs work collaboratively with local government and relevant partners to intervene early with young people at risk of offending

**Key Partners**

DOJ / Local government / other local partners

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- G** Take forward relevant outcomes in Care Matters aimed at reducing exclusion and marginalisation –

- maintain appropriate support for young people in and leaving care in higher and further education
- enhance current employability services for each Trust area providing dedicated education and training support
- maintain young people in and leaving care in suitable, affordable and safe accommodation with financial support whilst in higher education/training
- continue to provide fostering services for 18+ in care and provide a point of contact adviser up to age 25

**Key Partners**

DHSSPS / DEL / HSC



**5 EMPLOYMENT, LIFE-LONG LEARNING AND PARTICIPATION**

- 6.9 Adults in Northern Ireland now generally enjoy better health and can expect to live longer than previous generations. However there are still many challenges in respect of health inequalities, including increasing long term damage related to health behaviours such as poor diet, low levels of physical activity, smoking, and alcohol consumption for many.
- 6.10 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 promote positive mental health and wellbeing in the general population. This will be taken forward through the development of a new cross-departmental strategy to promote positive mental health in the Northern Ireland population. (see Chapter 7)
- 6.11 Being a parent is a life-changing experience which can be wonderful and challenging at the same time. Good parenting is a key life skill – chapter 5 outlines the importance to both individuals and society as a whole, of giving every child the best start through positive and nurturing early life experiences and through maintaining strong, loving and respectful family relationships as they grow. Supporting and empowering the current generation of parents to shape the next is of vital importance to building a better future for Northern Ireland society. Early intervention initiatives in schools, such as Roots of Empathy<sup>29</sup>, also help to build the capacity of the next generation for responsible citizenship and responsive parenting.
- 6.12 There is a clear link between work and the health of individuals and their families. Being in good employment is protective of health<sup>30</sup>. Conversely, unemployment and poor quality employment contribute to poor health. Employment with a reasonable wage is the best path out of disadvantage and poverty, therefore getting people into such work is of critical importance for reducing health inequalities. However, jobs need to be sustainable and be of sufficient quality, to include not only a decent living wage, but also opportunities for development, the flexibility to enable people to balance work and family life, and protection from working conditions that can damage health.



- 6.13 In addition to supporting the growth of the labour market and ensuring access to good jobs, there must be support for overcoming the barriers to employment – for example through employability schemes, investing in work experience and qualifications, and in education, childcare and health condition management.

**Employment, lifelong learning and participation**

**CAWT – Travellers**

*Co-operation and Working Together (CAWT) is the cross border health and social care partnership, comprising the Health Service Executive in the Republic of Ireland and the Southern and Western Health & Social Care Trusts, the Health and Social Care Board and the PHA in Northern Ireland.*

*The CAWT Social Inclusion Project is focused on reducing health inequalities for specific groups, one of which is travellers who are the most marginalised ethnic minority in Ireland with the worst health indicators. The project includes training programmes for twenty Travellers. One update reported that of the 18 participants who completed the Employment and Skills Training, three were working full time in community development, youth work and HGV driving. Another four were completing work placements in the Southern Trust and HSE DNE areas.*

*After the EU funding phase, the PHA and Western Local Commissioning Group planned to build on the work done by the project to promote social inclusion for Travellers and to create a steering group with representation from interested agencies, to help build the infrastructure to support work to improve Travellers' health and wellbeing.*

- 6.14 Lifelong or adult learning has the potential to impact on health inequalities by providing skills and qualifications to enhance employment opportunities, and also by improving self esteem and confidence, which have been shown to be associated with healthier behaviours. Evidence which informed the Marmot Review also suggests that adult education increases social capital, which is in turn associated with better health. DEL's Essential Skills for Living Strategy aims to ensure that all working age adults have the opportunity to gain recognised qualifications from Entry Level to Level 2 in Literacy, Numeracy, and Information Communication



Technology (ICT), to help them gain employment as well as promoting greater economic development, social inclusion and cohesion.

- 6.15 DEL's Skills Strategy "*Success Through Skills – Transforming Futures*" aims to raise the skills level of the whole workforce, raise productivity and increase levels of social inclusion, by enhancing the employability of those currently not in the labour market. DEL and its key providers, such as the Further Education colleges, will provide developmental opportunities to support those who wish to enter the Northern Ireland workforce, as well as those already in work.
- 6.16 Childcare is a critical enabler to help parents into work, move families out of poverty and help to break the cycle of inter-generational deprivation. Supported by an affordable, flexible and accessible childcare sector, parents can access work, improve their workplace skills and their employability, or continue to be economically active. *Bright Start – The Executive's Programme for Affordable and Integrated Childcare* sets out the framework, principles and a range of key first actions, to move towards the establishment of an improved and expanded system of childcare.

## OUTCOME 5 EMPLOYMENT, LIFE-LONG LEARNING AND PARTICIPATION

### Actions and Commitments 2013 – 2015

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- A** Contribute to rising levels of employment by supporting the promotion of 25,000 jobs by 2015 as set out in the Northern Ireland Economic Strategy

**Key Partners**

DETI / DEL

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- B** Provide all citizens as required, with careers information advice and guidance to enable them to make effective career/learning choices

**Key Partners**

DEL

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- C** Support all citizens who avail of Employment Service programmes and services towards employment

**Key Partners**

DEL



**OUTCOME 5 EMPLOYMENT, LIFE-LONG LEARNING AND PARTICIPATION Continued**

**Actions and Commitments 2013 – 2015**

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**D** Up-skill the working age population by delivering over 200,000 qualifications

**Key Partners**

DEL / FE

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**E** Provide continued access by adult learners to FE provision including Essential Skills, subject to demand locally, for their economic and/or social benefit

**Key Partners**

DEL / FE

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**F** Through “**Access to Success**” the NI Strategy for Widening Participation in Higher Education provide support to the most able but least likely people from disadvantaged backgrounds to raise their aspirations, and educational attainment, in order that they can progress to the higher education provision that is right for them, irrespective of their personal or social background (particular focus on people identified as under-represented in higher education)

**Key Partners**

DEL / DE / HEIs / FECs / and others

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**G** Assist people with mental and physical health and disability related barriers to employment to improve their chances of finding and sustaining employment through the provision of appropriate services and programmes

**Key Partners**

DEL / DHSSPS / HSC Third sector specialist disability organisations

***Employment, lifelong learning and participation***

***Men’s Shed***

*The ‘Men’s Shed’ concept has gained popularity in Northern Ireland in recent years, as a way to promote social interaction and wellbeing of men.*

*The Shed is a space for men to come together to work on DIY projects, learn new skills and socialise. It provides a safe, friendly and inclusive*



*environment where older people can feel more supported and secure in their own community and within their own peer group. Participants can, among other things, work on a meaningful project at their own pace, in their own time and in the company of other men. The primary objective is to use the facility and the support network generated, as a means to advance the health and wellbeing of the participants by encouraging them to become involved in a broader range of programmes targeted at addressing their specific needs.*

*The Men's Shed is open to men aged 50 years and over. There are Men's Shed in Ballymena and Armagh.*

## 5 HEALTHY ACTIVE AGEING

- 6.17 Longer life expectancy is a positive outcome to be welcomed. 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 valuable resource for their families, communities and the economy. However, for some, old age brings with it a high risk of social isolation and poverty, including fuel poverty, with limited access to affordable, good quality services. Many care for a partner, which can bring physical and psychological burdens, while others living alone can feel isolated. Older people living in rural areas may be particularly vulnerable to social isolation and in need of support and access to services.
- 6.18 It is important for older people to be able to maintain active independent lives, with access to all the income and benefits to which they are entitled, and opportunities to engage in social and educational activities. There is a need to ensure that future policies, programmes and investment across government are “age friendly” and complementary to each other. Areas such as housing, transport, access to community services, safety, opportunities for lifelong learning and employment can have a major impact on the health and wellbeing of older people. A new cross-cutting strategy is under development to promote and enable “active ageing”.



### **Healthy Active Ageing**

#### **Silver Surfer's Day**

*For a number of years a "Silver Surfer's Day" has been run for the over 50s in local libraries.*

*Organised by Business in the Community in partnership with the Department of Finance and Personnel and Libraries NI, business volunteers are on hand to help and provide invaluable advice to those wishing to get to grips with technology and surf the internet with free training.*

*"Silver Surfers" learn how to set up an e-mail account, send e-mails, bank online, access government services through the nidirect website, shop etc. "Silver Surfers' Day" encourages people to go online, addressing barriers, promoting the benefits of accessing the Internet, and seeing the convenience of online public services. Library services are free for everyone, with free computer and internet use for library members.*

- 6.19 To meet the challenges of ageing populations, including older people with disabilities, there needs to be an increased emphasis on health promotion, disease prevention and physical and mental rehabilitation, which incorporates a life-long approach to positive health. Action should focus on:
- advancing health and wellbeing into older age;
  - reducing inequalities experienced by older people;
  - promoting the inclusion and full involvement of older people in society and their local communities; and
  - improving the provision, quality and safety of services and care to address the needs of people as they age.



### **Me Unlimited**

*In 2011 a report from the Princess Royal Trust for Carers found that:*

- *70% of older carers suffer poor health because of their caring role;*
- *65% have a long-term health problem or disability; and*
- *69% reported that caring has an adverse impact on their mental health.*

*A social economy initiative “Me Unlimited”, has been commissioned by the PHA to provide tailored personal development programmes to support older carers. The programme aims to build coping, resilience and self-management and self-care skills, encouraging carers to plan for a positive future. Older carers of people with dementia and isolated older male carers have been among those to benefit.*

6.20 “Transforming Your Care” promotes the home as the “hub” of care for older people where it is safe and appropriate to do so. This will include developing Integrated Care Partnerships\* to support the provision of joined up care and support for frail older people, developing safe, suitable alternatives to statutory residential accommodation and working to address carers’ needs.

6.21 Work is already under way in Belfast to establish “age friendly<sup>31</sup>” environments, which can support both older people and those with children, and we wish to encourage the new Councils being established here to commit to the WHO “age friendly” approach. There is a need to consider how the concept can be extended to other communities, including those in more rural areas. This issue is also considered in Chapter 10 in relation to “space and place”.

\* Integrated Care Partnerships “are multi-sector collaborative networks of health and social care providers that come together to respond innovatively to the assessed care needs of local communities.”



OUTCOME **6** HEALTHY ACTIVE AGEING

**Actions and Commitments 2013 – 2015**

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- A** Improve job outcomes by providing temporary work for those aged 50+ who are unemployed and claiming benefit through the Steps to Work – Step Ahead 50+

**Key Partners**

DEL

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- B** Promote healthy active ageing, through opportunities to participate including for example through volunteering and opportunities for learning

**Key Partners**

OFMDFM / DHSSPS / DEL / DCAL/ DSD / HSC other Departments / Volunteer Now / Local government / Community and Voluntary and Business sectors

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- C** Delivery of the cross-cutting Active Ageing Strategy which will promote age friendly environments using the WHO Age Friendly Environments programme

**Key Partners**

OFMDFM and DOE in association with PHA and Councils

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- D** Promote home as the “hub” of care for frail older people through the outworking of TYC

**Key Partners**

DHSSPS / HSC / Community and Voluntary Sector

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- E** Take forward public engagement to promote good nutrition.

**Key Partners**

DHSSPS / PCC / Nutrition Coalition



**Key Strategies/ strategic programmes** – Essential Skills for Living, Success through Skills – Transforming Futures, Access to Success – an Integrated Regional Strategy for widening Participation in Higher Education, Further Education means Business, Pathways to Success, Build Pathways to Employment, Employment Service programmes, Training for Success / Bridge to Employment / Youth Employment scheme, draft Economic Inactivity strategy, Delivering Social Change Signature Programmes, Community Family Support Programme, NI Economic strategy, Reducing Offending strategy, Care Matters, Join In – Get Involved, Sport Matters, Draft Active Ageing strategy, Transforming Your Care, Making it Better – A Strategy for Pharmacy in the Community, Promoting Good Nutrition – A Strategy for good nutritional care for adults in all care settings in Northern Ireland 2011-2016.



## CHAPTER 7 – EMPOWERING HEALTHY LIVING

Key long term outcomes:

- 7 Improved health and reduction in harm
- 8 Improved mental health and wellbeing, and reduction in self harm and suicide
- 9 People are better informed about health matters
- 10 Prevention embedded in services

### 7 IMPROVED HEALTH AND REDUCTION IN HARM

#### Healthy Behaviours

- 7.1 People’s behaviours – whether they smoke, how much they drink, what they eat, whether they take regular exercise – are widely recognised as affecting their health and risk of dying prematurely. Recent work by the *Kings’ Fund: Clustering of unhealthy behaviours over time (2012)*<sup>32</sup> which looked at the prevalence and co-distribution of risk factors associated with smoking, excessive use of alcohol, poor diet and low levels of physical activity, found that a significant minority of people in western developed countries have three or more risk factors. This trend is more common in some groups than others - several studies have found a consistent socio-demographic gradient in the prevalence of multiple risk factors, with men, younger age groups and those in lower socio economic groups and with lower levels of education being more likely to exhibit multiple lifestyle risks.
- 7.2 This work argues for a move away from a silo approach to promoting particular healthy behaviours, towards interventions which adopt a more holistic and integrated approach. The “clustering” of lifestyle with medical risk factors is the most important issue related to risk and will require integrated approaches which take account that many people will present with several risk factors at the same time.
- 7.3 *The House of Commons Health Committee’s Health Inequalities inquiry (2009)*<sup>33</sup> highlighted several reasons why the poorest in society are less likely to adopt beneficial health behaviours. These included:



- lack of information;
- lack of material resources to live healthily;
- environments in which they live may make it difficult, for example smoking tends to be more “ heavily entrenched in those from lower socio-economic groups which makes positive change harder”; and
- more difficult lives including problems such as low income, lack of employment or personal safety concerns – these may mean that changing health behaviour is unlikely to be a major priority.

7.4 Men and women are prone to different diseases and prevalence of health behaviours. In addition some population groups such as ethnic minorities including travellers, LGB&T, people with disabilities face specific challenges to their health and wellbeing including vulnerability to certain conditions and to broader issues such as social exclusion. Programmes and services at regional and local level should be accessible and address specific needs and risk factors, including those of vulnerable groups.

### **Health Protection**

7.5 Population screening programmes have a key role to play in early detection of disease and a range of programmes are currently available in Northern Ireland. Organised screening programmes are only established on the recommendation of the UK National Screening Committee and according to the best available evidence. Any condition being considered as a screening programme must meet a number of stringent criteria before it is recommended by the Committee.

In Northern Ireland the following screening programmes are in place:

- Abdominal Aortic Aneurysm (AAA) Screening
- Antenatal Screening
- Breast Cancer Screening
- Cervical Cancer Screening
- Bowel Cancer Screening
- Diabetic Retinopathy Screening
- Newborn Screening



Work needs to continue to address any potential inequalities in the uptake and coverage of all screening programmes.

- 7.6 Vaccination programmes are the best and most effective way to prevent someone becoming sick from various infectious diseases. In Northern Ireland as in the rest of the UK, vaccination policy is informed by the Joint Committee on Vaccination and Immunisation (JCVI), an independent expert advisory committee that advises the four UK Health Ministers. In formulating its advice and recommendations, the Committee's aim is to ensure that the greatest benefit to public health is obtained from the most appropriate vaccination and immunisation strategies. Young babies are most vulnerable to infections and therefore the majority of vaccination programmes are aimed at babies and children. There is also an annual seasonal flu vaccination programme and in 2013 a shingles vaccination programme aimed at those aged between 70 and 79 was introduced.
- 7.7 Antimicrobial resistance (AMR) has been recognised for many years and efforts have been made to arrest or mitigate the development of resistance by using antibiotics more appropriately and effectively in both humans and animals. However, the threat of AMR is now a priority internationally, across the UK and in Northern Ireland. DHSSPS published the Strategy for Tackling Antimicrobial Resistance in July 2012. Link - <http://www.dhsspsni.gov.uk/star-doc.pdf>
- This is in line with the UK 5-year AMR strategy published in September 2013. Actions include improving infection prevention and control to prevent cases of infection occurring in the first place; educating professionals and the public to use antimicrobials appropriately; improving the monitoring and surveillance of resistant organisms, and research. Everyone has their part to play, and coordination of efforts is crucial.
- 7.8 The Department's role as Lead Government Department for the health and social care consequences arising from emergencies places a responsibility on it to respond at a strategic level and maintain a state of readiness to address and mitigate certain threats and hazards which have the potential to affect Northern Ireland.
- 7.9 In Northern Ireland four regional statutory bodies have lead roles and responsibilities in relation to food safety, diet and nutrition: the Department of Health, Social Services and Public Safety; the Food



Standards Agency in Northern Ireland, which is a non-ministerial government department; the PHA, and the Food Safety Promotion Board ('Safefood') which is a Northern Ireland-Republic of Ireland implementation body established under the terms of the 1998 Belfast Agreement. Other bodies have a remit in this field, including other government departments and local authorities, who are responsible for certain enforcement functions. In 2012, at the behest of the Health Minister for Northern Ireland, a review was carried out with the aim of ensuring that the lead bodies would work effectively, would complement each other and would provide maximum value for money in respect of the provision of high quality scientific and policy advice relating to food safety, diet and nutrition. The recommendations of the review are being implemented. These include arrangements to strengthen coordination between the four lead bodies concerned.

## OUTCOME **7** IMPROVED HEALTH AND REDUCTION IN HARM

### Actions and Commitments 2013 – 2015

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- A** Develop and implement strategies, action plans and targeted programmes to –
- reduce the number of people who:
    - smoke;
    - are overweight or obese;
    - drink above the recommended alcohol limits;
    - misuse drugs.
  - reduce the number of births to teenage mothers, particularly in disadvantaged areas
  - reduce sexually transmitted infections (STIs) including HIV
  - increase breastfeeding rates
  - improve oral health through a regional caries prevention programme, and programmes to increase dental services utilisation
  - reduce preventable hearing and sight loss



**OUTCOME 7 IMPROVED HEALTH AND REDUCTION IN HARM**  
**Continued**

**Actions and Commitments 2013 – 2015**

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**A** Continued –

- halt the rise in the incidence of skin cancer
- encourage more proactive ill health prevention amongst men

**Key Partners**

DHSSPS / PHA / DE / DCAL / DSD / other public bodies including local government, community and voluntary sector.

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**B** Achieve and maintain high uptake rates of screening programmes, immunization and vaccination programmes across all areas and target populations, and introduce new vaccination programmes in line with expert advice

**Key Partners**

DHSSPS / HSCB / PHA / Trusts

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**C** Establish a group to coordinate efforts to tackle antimicrobial resistance in both human and veterinary medicine

**Key Partners**

DHSSPS / DARD

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**D** Maintain state of readiness for emergencies through management and replenishment of regional stockpile of health countermeasures and any associated vaccination programme

**Key Partners**

DHSSPS / HSCB / PHA / Trusts / BSO



**OUTCOME 7 IMPROVED HEALTH AND REDUCTION IN HARM**  
Continued

**Actions and Commitments 2013 – 2015**

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- E** Develop and deliver a joint healthcare and criminal justice strategy to improve the health and wellbeing of offenders and reduce the risk of poor health (including mental health problems) leading to offending or reoffending

**Key Partners**

DHSSPS / DOJ / HSCB / PHA / HSCTs

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- F** Ensure a co-ordinated approach across lead bodies with responsibility for food safety, diet and nutrition

**Key Partners**

FSA / DHSSPS / PHA / FSPB

**8 IMPROVED MENTAL HEALTH AND WELLBEING, AND REDUCTION IN SELF HARM AND SUICIDE**

7.10 New policy is under development to set the strategic direction to improve mental health and wellbeing and reduce self harm and suicide. In the meantime, a broad range of programmes and services are in place to promote positive mental health and reduce suicide. These include the Lifeline service, support for community-led initiatives, “gatekeeper” training, education and awareness programmes, and intervention on deliberate self harming. DHSSPS is working with DARD and DCAL on a joint initiative to promote mental health awareness and help-seeking behaviour through rural networks, sporting and cultural organisations. The Health In Mind project delivered by Libraries NI promotes positive mental health and wellbeing through the provision of information, activities, learning and reading resources. The project aims to reduce the stigma attached to mental illness. Departments of Education and Health, Social Services and Public Safety have also worked together to promote mental health awareness through the pupil’s emotional health and wellbeing programme (“iMatter”). Progress on all of these areas is reported regularly to a Ministerial Co-ordination Group.

7.11 In the context of an ageing population, dementia is growing as a public health issue. It is intended that the new positive mental health promotion policy will address two main tasks in relation



to dementia: firstly, public health efforts to prevent/ delay dementia as far as possible and to encourage early diagnosis; and secondly, improving the mental wellbeing of people who have dementia.

**OUTCOME 8 IMPROVED MENTAL HEALTH AND WELLBEING, REDUCTION IN SELF HARM AND SUICIDE**

**Actions and Commitments 2013 – 2015**

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- A** Develop new policy to promote positive mental health, reduce self harm and suicide

**Key Partners**

DHSSPS / other Departments / HSC / Voluntary and Community sector.

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- B** Increase resilience and improve mental wellbeing in children and young people through implementation of initiatives outlined in theme 1 including eg Family Support, Roots of Empathy, iMatter (pupil’s emotional health and wellbeing programme) – *particular focus on children and young people from families at risk*

**Key Partners**

DE / DHSSPS / PHA

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- C** Reduce the levels of self harm through roll out of successfully evaluated approaches, *focussing in particular on people who repeatedly self harm, people treated at A&E for injuries due to deliberate self harm*

**Key Partners**

DHSSPS / PHA / HSC / others

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- D** As part of the joint healthcare and criminal justice strategy, work to identify and support people with mental ill-health or other vulnerabilities who have offended. *Young people with mental health / communication problems in the juvenile justice system identified for targeted action.*

**Key Partners**

DoJ / DHSSPS / PHA / HSCB / HSC Trust

**Sport’s Support for ‘Protect Life,’ Suicide Prevention Strategy and Action**



### **Plan**

*SportNI, an arms-length body of DCAL, has developed a 'Suicide Awareness through Sport Communications Strategy' with the support of the PHA and Lifeline. This was launched in June 2012. The purpose of the Communications Strategy is to raise awareness of suicide within the sporting community; provide suicide awareness training to sports providers; and encourage sport and sports personalities to support public information campaigns. A range of activities are now being undertaken by sport in support of the Protect Life Strategy.*

*The 'Suicide Awareness Through Sport Communications Strategy' will continue to be developed and strengthened in line with experience and new ideas emerging from sports organisations, counselling service groups and other stakeholders and partners.*

### **Health in Mind**

*Health in Mind brings together Libraries NI, Aware Defeat Depression, Action Mental Health, MindWise and CAUSE, who work together and use their expertise to support people to learn more about mental health and how to look after their wellbeing.*

*Health in Mind is an innovative partnership project which brings together four mental health charities and Libraries NI. By working together and using their expertise in new and fresh ways, it aims to give adults affected by poor mental health, the chance to improve their lives.*

*Funded by the Big Lottery and Learn Programme until 2015.  
For further information: [www.healthinmindni.net/about/](http://www.healthinmindni.net/about/)*



**9 PEOPLE ARE BETTER INFORMED ABOUT HEALTH MATTERS**

*“Health Literacy – the cognitive and social skills which determine the motivation and ability of individuals to gain access to, understand and use information in ways that promote and maintain good health.” – Nairobi, WHO, 2009*

- 7.12 Health literacy means more than being able to read pamphlets; it empowers people to make healthier choices, decide to change their life style and take action. Some published definitions<sup>34</sup> present health literacy as a set of individual capacities that allow the individual to acquire and use new information. Health literacy is dynamic, being influenced by both the individual and the health care system.
- 7.13 Everyone has a personal responsibility for making decisions which can impact on their own health and wellbeing, but some may need more support than others, for example, when there are conflicting messages. Health and social care professionals including the independent Family Practitioner Services can help and guide people to make appropriate choices - the role of all professionals is not just about treatment when people are ill. It also encompasses supporting people to stay well and live more healthily, including those already living with a condition. This may be through giving them information and support about healthy living and guiding them to any further help they may need. The potential of the front-line workforce needs to be maximised. To this end, DHSSPS is considering the workforce implications and recommendations following England’s strategy *“Healthy Lives, Healthy People”* and the associated Public Health Workforce Strategy.
- 7.14 In many cases it may be that individuals could be supported by a different service either within or outside of the Health and Social Care system, or perhaps by a wider public or community-based service. It will be important that HSC professionals look to build linkages to support services beyond their own specialty, and beyond the HSC to be able to signpost access to appropriate help.



- 7.15 Improving health literacy aims to influence not only individual lifestyle decisions, and decisions about treatment and self care, but also raise awareness of the determinants of health, and encourage individual and collective actions – at all levels of society - which may lead to a modification of these determinants. Improving health literacy needs to go beyond a narrow concept of health education and individual behaviour, and address the environmental, political and social factors that determine health.

**OUTCOME 9 PEOPLE ARE BETTER INFORMED ABOUT HEALTH MATTERS**

**Actions and Commitments 2013 - 2015**

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- A** Empower people to make healthier choices and informed decisions about their health by improving health literacy. This will include –
- providing appropriate and accessible health information (making greater use of modern communication technology) and advice to all, which is evidence informed and tailored to meet specific needs, and which
    - encourages more people to present with early symptoms of health problems to HSC services
    - promotes self-care, and sign-posts to appropriate support through, for example patient education/self management programmes

*This should have a specific focus on groups at risk of developing conditions, and those with conditions who are at risk of exacerbating or developing complications. It will be important that appropriate links are made with the work being taken forward through Integrated Care Partnerships as part of TYC.*

**Key Partners**

DHSSPS / PHA / HSC / Local government / Community and Voluntary sectors, others including eg NUS – USI

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- B** Promote healthy active ageing, including further opportunities for more active promotion of health and wellbeing in nursing and care settings

**Key Partners**

DHSSPS / HSC / others



**OUTCOME 9 PEOPLE ARE BETTER INFORMED ABOUT HEALTH MATTERS**

**Actions and Commitments 2013 - 2015**

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- C** Develop and deliver a Community Resuscitation Strategy to focus a drive to increase the number of people, of all ages, trained in Emergency Life Support skills and to coordinate the use of available resources

**Key Partners**

DHSSPS / PHA / DE / DCAL community and voluntary sector

**One-Stop-Shops**

*In 2009, the PHA developed a pilot programme of 4 'One Stop Shop' drop in services for children and young people that provide information, education, sign-posting and, where appropriate, referral to specialist services. The programme sought to address a range of issues including but not exclusively: substance misuse; suicide and self harm; mental health and wellbeing; sexual health; relationship issues; resilience; and coping with school/employment.*

*Following positive evaluation, the PHA has been rolling out a range of 'One-Stop-Shops' across Northern Ireland. There are now eight services as follows:*

- Carrickfergus YMCA – Carrickfergus
- FUEL – Enniskillen
- Magnet Centre – Newry
- FASA – Belfast
- FASA – Bangor
- Dove House – Londonderry
- Opportunity Youth – Ballymena
- REACT – Banbridge



**10 PREVENTION EMBEDDED IN SERVICES**

- 7.16 The HSC's role in preventing poor health and promoting healthy living is vital to reduce health inequalities, but also to sustain the HSC into the future. The ethos of supporting individuals, families and communities to maintain and improve their health needs must be fully embedded as a normal way of working right across all organisations, environments and activities within the HSC system. This is not just in day to day interactions with every member of the public, but also as part of commissioning and designing health services. Service Frameworks are a key reference point for commissioning and designing services to secure better integration of service delivery along the whole pathway of care from prevention of disease /ill health to diagnosis / treatment and rehabilitation, and on to end of life.
- 7.17 Commissioners must ensure that health improvement and addressing health inequalities are embedded within commissioning plans. Healthcare providers must build the promotion of good health into service and pathway design, contracts and service delivery and ensure that it is both integral to the care they provide and the work that they do with their communities. This also includes ensuring that health settings are health promoting for those receiving treatment or care, visiting and for those working there. Health organisations should also consider their contribution to tackling the wider determinants of health through, for example, providing opportunities for volunteering, work experience and employment, or employability schemes, and through maximising the use of social clauses in procurement contracts.
- 7.18 *"Transforming Your Care: Review of Health and Social Care in Northern Ireland"* set out key proposals for change across a range of service areas, including mental health services, services for older people, acute services and primary care. It also includes a focus on prevention, and earlier interventions, as part of the model of Integrated care closer to home. Key outcomes for TYC include:
- more services will be provided locally with opportunities to access specialist hospitals where needed;
  - more people will be cared for at home, where it's safe and appropriate to do so;



- doctors, nurses, social workers and everyone providing care will work together in partnership to help keep people healthy;
- people will get support to stay healthy, make good health decisions or manage their own conditions; and
- investment in new technology will help people stay at home or receive care locally rather than in hospitals.

7.19 HSC efforts must combine integrated planning, commissioning and service delivery including community development and engagement approaches, collaboration, and personal effort.

## OUTCOME 10 PREVENTION EMBEDDED IN SERVICES

### Actions and Commitments 2013 - 2015

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- A** Increase the emphasis on prevention and early intervention in the commissioning and delivery of Primary, Community, and Secondary Care services including –
- health professionals, particularly within primary care and Emergency departments, trained and encouraged to undertake substance misuse brief interventions and suicide prevention/mental health promotion intervention programmes across NI
  - arrangements for Primary and Community sector to deliver accessible sexual health services
  - strengthening the focus on improving the mental and physical health and wellbeing of those in contact with mental health services or with a learning disability
  - encouraging public health and patient education/self management interventions alongside clinical approaches for people with long term conditions, for example diabetes

### Key Partners

DHSSPS / HSCB / PHA / Trusts / GPs



OUTCOME 10 PREVENTION EMBEDDED IN SERVICES Continued

**Actions and Commitments 2013 - 2015**

- B** Continue implementation of Integrated Care Partnerships with an initial focus on frail elderly and aspects of long term conditions, namely stroke, diabetes and respiratory conditions and end of life and palliative care in respect of these areas of initial focus

**Key Partners**

DHSSPS / HSC / other partners inc community and voluntary sector

- C** Increase the share of the health budget spend on prevention and early intervention and develop mechanisms to monitor this across the HSC, in line with the PFG commitment

**Key Partners**

DHSSPS / HSCB / PHA / Trusts

**CAWT (Co-operation and Working together for Health Gain and Social Wellbeing in Border Areas)**

*CAWT has been taking forward a GP training scheme. This training provided practical tips in carrying out consultations with a range of minority groups such as Travellers, LGBT, the hearing impaired, those with sight loss etc. The participating GPs commented that the session provided much that they had been unaware of previously in terms of knowledge and attitude.*

**Key Strategies/ strategic programmes** - Protect Life, Tobacco Control Strategy, New Strategic Direction for Alcohol and Drugs, A Fitter Future for All, Teenage Pregnancy and Parenthood strategy, Sexual Health Promotion strategy, Breastfeeding - A Great Start, Strategy for Tackling Antimicrobial Resistance, Sport Matters, Transforming Your Care, Making it Better - A Strategy for Pharmacy in the Community, Long Term Conditions Policy Framework, Strategy for improving the lives of those with disabilities 2012 - 2015, NI Civil Contingencies Framework, UK Influenza Pandemic Preparedness Strategy (DHSSPS as NI lead), Programme for Government Commitment 44 - patient education for people with long term conditions, Programme for Government Commitments 22 - investment in public health and 45 investment to tackle obesity.



## CHAPTER 8 – CREATING THE CONDITIONS

Key long term outcomes:

- 11 A decent standard of living**
- 12 Making the most of the physical environment**
- 13 Safe and healthy homes**

- 8.1 This theme focuses on the wider economic and environmental determinants that provide the fundamental conditions to support good health and wellbeing. These include the economy, which affects employment and income levels, the wider physical environment and infrastructure, and living conditions.
- 8.2 This theme is confined to policies and programmes which are within the remit of the NI Executive. Where appropriate DHSSPS and the Executive will advocate for changes to national policies in order to bring about improvements in the health and wellbeing of the Northern Ireland population.
- 8.3 There is growing recognition of the impact and mutual reliance of public policies on each other and the need therefore for inter-connectedness, reinforcement and cross-cutting collaboration both in policy development and implementation. Creating the conditions for good health and wellbeing will require a “whole system” approach across government and through intersectoral working, which ensures that connections between relevant initiatives are maximised. Chapter 11 considers this issue further, including the option of establishing thematic sub-groups where it may be considered beneficial.

### **11 A DECENT STANDARD OF LIVING**

- 8.4 The *WHO* asserts that poverty is the single largest determinant of health, and ill health is an obstacle to social and economic development. The Executive has made the economy the top priority in the 2011-2015 PFG with the challenge to re-build the Northern Ireland labour market and rebalance the economy to increase living standards.



- 8.5 Health is a key factor in productivity, economic development and growth. Both the PFG and the *NI Economic Strategy* acknowledge the inter-relationship between prosperity and population health. Healthier people are more productive and improved health and wellbeing will contribute to positive economic outcomes for both individuals and wider society. At the same time enhancing employability, skills development, incentives and job creation, vital to promoting a vibrant economy, are conducive to improved population health. In addition to efforts to promote employment and prosperity, action is needed to mitigate the impact of poverty and the potential for negative impact of welfare reforms, and to provide more opportunities for work experience and employment. Other commitments on improving benefit uptake and improving budget management skills aim to support individuals and families to maximise their income.

## OUTCOME 11 A DECENT STANDARD OF LIVING

### Actions and Commitments 2013 – 2015

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- A** Increase employment and prosperity for all by delivering the commitments set out in the Northern Ireland Economic Strategy

**Key Partners**

All Executive Departments

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- B** Reduce economic inactivity through development and implementation of a strategy for skills, training, incentives and job creation, and careers advice

**Key Partners**

DEL / DETI / others

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- C** Mitigate the impact of poverty and the potential for negative impact of individual welfare reforms through –

- delivering a range of key targeted actions, by way of the Delivering Social Change Framework, including the Social Investment fund
- reduce the number of births to teenage mothers, particularly in disadvantaged areas

**Key Partners**

OFMDFM / DSD / DHSSPS / DE / DEL / DETI / DARD / others



**OUTCOME 11 A DECENT STANDARD OF LIVING Continued**

**Actions and Commitments 2013 – 2015**

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**C** Continued –

- publishing and implementing a plan for improving uptake of benefits to ensure people have the opportunity to maximise their income levels

**Key Partners**

DSD

- developing and implementing a new discretionary support service to help people most in need through the provision of immediate financial assistance and encouraging longer term financial independence

**Key Partners**

DSD / SSA

- developing a financial capability strategy to ensure people have budget management skills

**Key Partners**

DETI

- developing a co-ordinated strategic approach to address food poverty.

**Key Partners**

DHSSPS / DSD / FSA / PHA / DARD / other departments / Safefood / Local government / other sectors

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- D** Provide more opportunities for work experience and employment through, for example, maximising the use of social clauses in procurement contracts, and the potential contribution of employability schemes through public and private sector organisations – *this focuses on the unemployed, particularly the young and long term*

**Key Partners**

Government departments / public agencies inc HSC / Local government etc.



**Mitigating the impact of poverty and social isolation in rural communities**

*MARA (Maximising Access in Rural Areas)*

*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 PHA. Other key organisations involved include DSD (Social Security Agency and Fuel Poverty Unit), DRD, NIHE, DHSSPS and local community and voluntary organisations.*

*The MARA project aims to improve the health and wellbeing of rural dwellers in Northern Ireland living in or at risk of poverty, and social exclusion by increasing access to services, grants and benefits.*

*The project proactively targets vulnerable households in identified rural communities using a community development approach. Community lead organisations across a number of designated zones recruit and train enablers to undertake household visits and highlight services available (local and regional) using the local directory of services, a copy of which is left in the household pack following the visit. Target groups include older people, carers, disabled people, lone parents, ethnic minorities, lone adults, farming families and/or low income families.*

*The MARA project in Phase I targeted the 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 e.g. 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 identified £8.62 leverage for every £1 invested.*

*Using lessons from Phase 1, the project is now being rolled out into the remaining 70% (198) rurally deprived SOAs in Northern Ireland over 3 years to include approx 12,000 home visits.*



**12 THE PHYSICAL ENVIRONMENT**

- 8.6 Health and wellbeing is also influenced by the wider physical environment. This includes the direct and indirect effects of chemical, physical and biological hazards on health and wellbeing. It also encompasses aspects of the physical and social environment that influence individuals' health and wellbeing, such as the quality of housing and the neighbourhood environment, urban development, land use, and transport.
- 8.7 Physical environments can be designed to promote health and wellbeing through 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. A range of actions recognise the importance of making the most of the physical environment in promoting healthy and active living. This includes the preparation of a new single strategic planning policy statement, which will reinforce the positive role that planning can play through an approach to the development and use of land that is supportive to the health and wellbeing of people generally.

**OUTCOME 12 MAKING THE MOST OF THE PHYSICAL ENVIRONMENT**

**Actions and Commitments 2013 - 2015**

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- A** Protect and promote good health and wellbeing through –
- improving air quality to achieve objectives and targets established to protect health, and alerting those more likely to be affected when levels of air pollution are high
  - providing high quality drinking water which is clean and safe, and ensure that waste water is treated in a manner that will not harm the environment and will be if no danger to plant and animal life
  - preventing waste and increasing recycling and re-use, through the Northern Ireland Waste Management Strategy
  - minimizing the harmful effects of exposure to environmental noise, in line with the Environmental Noise Directive (END) by designating and protecting Quiet Areas

**Key Partners**

DOE / Local government



**OUTCOME 12 MAKING THE MOST OF THE PHYSICAL ENVIRONMENT**  
**Continued**

**Actions and Commitments 2013 - 2015**

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- B** Enhance the capacity of our physical infrastructure to protect, support and provide access to healthy and active living and wellbeing through –
- completing work on the current Planning Policy Statement (PPS) programme and publish a single, strategic planning policy document which will, inter alia, address sustainable development and how health and wellbeing considerations are taken into account within the planning system
  - formulating and co-ordinating policy for the orderly and consistent use of land with the objective of furthering sustainable development and promoting or improving wellbeing
  - producing guidance on urban stewardship and design to promote a positive sense of place encompassing local involvement, distinctiveness, visual quality and potential to encourage social and economic activity which are fundamental to a richer and more fulfilling environment
  - promoting “safe by design” approaches
  - promoting age friendly environments
  - addressing dereliction through the Social Investment Fund to make areas more appealing for investment and for those living there
  - ensuring easier access to and sustainable use of publicly owned land including forests for sport and physical recreation
  - implementation of an Active Travel Strategy Action Plan, providing increased opportunities for sustainable transport options such as walking and cycling and promotion of a number of demonstration projects

**Key Partners**

DRD / DOE / OFMDFM / DARD / DCAL / DOJ / DHSSPS / Local government



**OUTCOME 12 MAKING THE MOST OF OUR PHYSICAL ENVIRONMENT**  
Continued

**Actions and Commitments 2013 - 2015**

- C** Improve transportation infrastructure and services to help achieve a modern, sustainable, safe and fully accessible transport system which actively contributes to social inclusion and everyone's quality of life – this has a particular focus on older people and people with disabilities

**Key Partners**

DRD

- D** Produce a Northern Ireland Climate Change Adaptation Programme that will contribute towards building Northern Ireland's resilience to a changing climate.

**Key Partners**

DOE lead / all other depts. including DHSSPS

- E** Carry out a cross-departmental review of the implementation of the UK Children's Environment and Health Strategy in NI

**Key Partners**

DHSSPS / DOE / other depts and agencies

***Making the most of our physical environment***

*Regenerated Lapwing Way Park in Clooney Estate, Londonderry.*

*A collaboration between the DSD - under its Neighbourhood Renewal programme, Clooney Estate Residents Association, Groundwork NI, Ulster Garden Villages, the Garfield Weston Foundation and the City Council in Londonderry has brought the Lapwing Way park back into full usage for children and families within the Clooney Estate and surrounding areas of the Waterside.*

*Green spaces are vital in communities to encourage community cohesion and promote healthy lifestyles. Projects like this are also instrumental in renewing civic pride in local communities.*

*Lapwing Way's regeneration has ensured that this outdoor space, which greatly enhances the physical appearance of the Clooney Estate as a whole,*



*remains a safe, secure, sustainable and neutral environment for children to play, and a vital space which can be utilised by the entire family and generations to come.*

*Derry City Council will continue to oversee the planning, designing and delivery of regenerated play spaces under their Parks Development Programme, and the success of the work of Clooney Residents Association at Lapwing Way will be a model for further projects, a good example of the benefit of the collaborative approach in which associations, funding and support agencies worked together for the benefit of the overall community.*

### 13 SAFE AND HEALTHY HOMES

8.8 Housing design, accessible housing and planning that involve communities can improve social cohesion and address some of the most fundamental determinants of health for disadvantaged individuals and communities. Warm secure housing is vital for mental and physical wellbeing. Efforts will continue to deliver affordable homes, reduce levels of homelessness and to tackle Northern Ireland's high rates of fuel poverty.

### OUTCOME 13 SAFE AND HEALTHY HOMES

#### Actions and Commitments 2013 – 2015

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**A** Deliver 8,000 social and affordable homes as set out in the PFG

#### Key Partners

DSD / NIHE

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**B** Improve the quality of the housing stock through –

- undertaking a review of the statutory fitness standard for homes in all tenures
- reviewing support for repair and improvement in the Private Housing sector with the aim of providing a new scheme to assist homeowners to deal with deterioration in their properties
- addressing dereliction and deprivation
- interventions that help those most in need and/or in fuel poverty



**OUTCOME 13 SAFE AND HEALTHY HOMES Continued**

**Actions and Commitments 2013 – 2015**

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**B** Continued –

- improving thermal efficiency of housing stock and ensure full double glazing in all Housing Executive properties
- reviewing policy and associated legislation regulating standards within Housing of Multiple Occupation (HMO) to improve physical and safety standards and occupant behaviour

**Key Partners**

DSD / NIHE / others

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- C** Deliver practical support through the Supporting People Programme which targets older people, people with disabilities and people with learning disabilities to live independently

**Key Partners**

DSD / NIHE / DHSSPS / HSC Board / PHA / HSCTs / OFMDFM

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- D** Develop a new strategy to reduce unintentional injuries and deaths resulting from accidents in the home. Children and older people identified for targeted action

**Key Partners**

DHSSPS / PHA / Local government / Community and Voluntary sectors / NIFRS / HSCTs / HSENI / NIHE



**OUTCOME 13 SAFE AND HEALTHY HOMES Continued**

**Actions and Commitments 2013 – 2015**

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- E** Reduce levels of homelessness and mitigate the effects of homelessness by providing support and services to those who are homeless

**Key Partners**

DSD / DHSSPS / HSC / others

**Key Strategies/ strategic programmes** - Programme for Government, NI Economic Strategy, Lifetime Opportunities Anti-poverty strategy, Tackling Rural Poverty and Social Isolation, Delivering Social Change Framework, Social Economy strategy, Success through Skills –Transforming futures, Air, Water and Waste Management strategies, Planning Policy, Accessible Transport Strategy, Active Travel Strategy, Local Government Reform programme, Road Safety strategy, Housing and Homelessness strategies, New Strategic Direction on Alcohol and Drugs, Tobacco strategy, Transforming Your Care, (Draft) Active Ageing Strategy, Strategy to improve the lives of those with disabilities 2012 - 2015.



## CHAPTER 9 – EMPOWERING COMMUNITIES

Key long term outcomes:

- 14 Thriving communities
- 15 Safe communities
- 16 Safe and healthy workplaces

### 14 THRIVING COMMUNITIES

- 9.1 The communities and social networks to which people belong also have a significant impact on health and wellbeing. Support from families, friends and communities is associated with better health. Social capital – the links that connect people within communities - can promote resilience against difficulties and give people a feeling of control over their own lives.
- 9.2 In recent years there has been a growing recognition of the added value that participation in sport, arts and cultural activities can bring to communities. In addition to direct physical and mental health and wellbeing benefits, sports, arts and culture provide common interest and inspiration which promotes cohesion and good relations. Sports and cultural activities provide a vehicle for building social capital and creating resilient communities, and they provide opportunities for engagement, particularly of vulnerable or hard to reach groups, and for creativity. They can also generate intergenerational and environmental benefits.
- 9.3 It will be important to work in partnership with communities, local government and other key agencies in seeking ways both to tackle community issues and to build social capital. A number of policies and programmes operate in urban and rural communities to tackle disadvantage – including Delivering Social Change, the Urban Regeneration and Community Development Framework, and the Tackling Rural Poverty and Social Isolation Framework.

#### Local Government Role

- 9.4 Local government already makes a vital contribution to creating healthy, safe, sustainable places and thriving communities and this contribution will be further enhanced through the new arrangements



put in place by Local Government Reform. Local decision makers will play a major role in planning and shaping services around many of the physical, environmental, economic and social conditions which affect people's lives. Councils will lead and facilitate the community planning process by effective and genuine engagement with citizens and by building cross sectoral partnerships.

- 9.5 Local government also has a 'hands on' role in the provision of arts, leisure and community services and has regulatory functions relating to environmental health and health and safety. Its role in good relations, regeneration and planning means that it has a unique "place shaping" role which in itself is critical in creating the right conditions for thriving communities.

#### **Capacity building**

- 9.6 Community development is a practice which assists the process of people acting together to improve their shared conditions both through their own efforts and through negotiation with public services. It is recognised as an effective way to address imbalances in power and work with marginalised people. Its commitment to collective ways of addressing problems can be used to bring about change based on equality and inclusion, and can be used to enable people to improve the quality of their own lives, the communities in which they live and societies of which they are part.
- 9.7 Community development produces multiple health and wellbeing benefits precisely because it fosters the interconnections of all issues affecting a community as well as building social capital. Building bonds between individuals and communities is known to be a protective factor promoting health and wellbeing and increasing resilience. Community development projects can have dual impact – they can address a health, or social issue, while at the same time the values and processes involved begin to tackle some of the social and political processes which deal with the unequal distribution of the determinants of health. Community development is therefore a natural tool in efforts to reduce health inequalities.
- 9.8 There are many excellent examples of local people taking the initiative on the issues which are important to them. However there is a need for further community development to enable people to organise and work together.



- 9.9 The Voluntary and Community Unit (VCU) in the DSD plays a lead role, on behalf of the NI Executive Departments, in supporting a vibrant, effective and efficient Voluntary and Community Sector (VCS), which is well placed to deliver key services to often disadvantaged communities. Much of the work of VCU is geared to supporting the VCS at a regional level across Northern Ireland, or through local councils, thereby enabling the VCS to deliver vital and important services on behalf of government. Key priorities are to promote collaboration, empowering and strengthening communities, increase community participation and ensuring high quality voluntary advice services which are readily available and free at the point of need.
- 9.10 The Volunteering Strategy acknowledges the contribution that volunteering makes, both in benefits to those who volunteer and to wider communities. Volunteering is a shared experience, it is rewarding and of benefit to the volunteer in building skills, confidence and extending social networks. Volunteering is of benefit to society in contributing to the building of social capital and progressive social change.
- 9.11 Within Health, the implementation of “Working in Partnership – Community Development Strategy for Health and Wellbeing 2012-2017” will make a vital contribution to this framework. The aim is to strengthen communities and improve health and wellbeing by placing increasing emphasis on community development, prevention and early intervention. This approach will be adopted at a range of levels - with individuals, communities – recognising the different needs of rural and urban communities, and with specific groups in need to ensure the active engagement of those most marginalised.
- 9.12 The Building Change Trust is resourced through a National Lottery grant of £10 million as an investment for community capacity building and promotion of the voluntary and community sector in Northern Ireland. The Trust supports the sector through the delivery of and learning from a range of programmes including commissioned work, awards programmes and other interventions.
- 9.13 In order to empower and mobilise local people and communities to address issues for themselves, learning needs to be shared across communities and funders to ensure that benefit from actions can be demonstrated on a consistent basis. This requires a move to a shared understanding of evaluation techniques and tools, with a focus on outcomes. Work already underway through Community



Evaluation Northern Ireland (CENI) will contribute to greater collaboration in this area.

## OUTCOME 14 THRIVING COMMUNITIES

### Actions and Commitments 2013 – 2015

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- A** Strengthen and promote thriving communities which are welcoming, accessible and safe, and which support social inclusion through –
- the Urban Regeneration and Community Development Policy framework which sets out clear priorities through policy objectives and supporting actions for operational programmes (*includes targeted action for disadvantaged and areas at risk*)
  - supporting the development of shared and safely accessible commercial centres in our towns and cities

#### Key Partners

DSD / NIHE / DOE

- the new duty of community planning which will see councils, statutory bodies and the community and voluntary sectors work together to develop and implement a shared vision for promoting the wellbeing of an area
- delivery of Rural Community Development Support programmes

#### Key Partners

DOE / Local government / other depts and sectors / DARD / others

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- B** Develop more cohesive and engaged communities by developing volunteering and active citizenship, and empower local people

#### Key Partners

DSD / DHSSPS

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- C** Through the Social Investment Fund, support communities 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 – *focus on targeted areas and population groups*

#### Key Partners

OFMDFM / DEL / DE / DETI / others



**OUTCOME 14 THRIVING COMMUNITIES Continued**

**Actions and Commitments 2013 – 2015 Continued**

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- D** Promote healthy and thriving communities at local level, *with a particular focus on disadvantaged areas*, through –
- maximising collaboration to tackle determinants of health
  - increasing access to and use of sports, arts and other leisure programmes
  - maximising land/green space/woodlands use at local level to promote outdoor activities, allotments etc
  - increasing access to public facilities for use by the local community
  - supporting investment in social enterprise growth to increase sustainability of social enterprises and the broader community sector
  - supporting the growth of the local economy through encouraging people to buy local and use local services and facilities

**Key Partners**

DHSSPS / DSD / DCAL / DETI / PHA / HSC / Arts Council NI / Sport NI / National Museums and Libraries NI / Local government / Education / community and voluntary sector

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- E** Through the Extended Schools programme, which enables those schools that draw pupils from some of the most disadvantaged areas to provide a range of services and programmes which focus on improving educational outcomes, reducing barriers to learning and providing additional support, to help improve the life chance of disadvantaged children and young people

**Key Partners**

DE / DCAL / PHA / HSC

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- F** Through the Community Education Initiatives Programme fund community based organisations working with local schools in *areas of social deprivation and under attainment* to help address the high levels of educational under-attainment

**Key Partners**

DE



**OUTCOME 14 THRIVING COMMUNITIES Continued**

**Actions and Commitments 2013 – 2015 Continued**

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- G** Implement the new good relations strategy “Together: Building a United Community” which sets out the strategic framework for improving good relations. *Children and young people, communities of interface areas and areas of contested space identified for targeted action*

**Key Partners**

All relevant Departments and stakeholders

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- H** Implement support arrangements for the voluntary advice services to help ensure that citizens have access to quality advice which is free at the point of need

**Key Partners**

DSD

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- I** Ensure that everyone has an opportunity to volunteer and that volunteering is representative of the diversity of the community

**Key Partners**

DSD / DCAL / DHSSPS / HSC / others

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- J** Maintain provision of Rural Transport Fund Services to enable people in rural areas improved access to work, healthcare and recreational activities

**Key Partners**

DRD

**Measuring Change, an approach for the Voluntary and Community Sector - CENI**

*The current economic climate, coupled with increasing social need, places an even greater imperative on public funders to show the impact of their investments and for funded projects to evidence the outcomes of their activities.*

*The Concordat (i) and a recent Public Accounts Committee report on creating effective partnerships (ii) recommend that greater emphasis be given to evaluating and demonstrating the outcomes being delivered by the sector: ‘It is important that Government and the Sector work collaboratively to develop output and outcome measures’.*



*The focus on outcomes is not new and there has been a long history of efforts to grapple with the issue of outcome measurement. However, due to multiple factors this remains difficult.*

*Community Evaluation NI (CENI) has been working for many years to support the voluntary and community sector to evidence the difference it is making. Measuring Change is an approach which helps organisations and funders to capture outcomes. It enables funders and organisations to capture and use outcomes data to improve delivery, inform planning and make more effective use of resources.*

*It has been applied in a range of community settings to capture difficult to measure outcomes of programmes.*

- i Concordat between the Voluntary and Community sector and the NI Government, DSD 2011
- ii Public Accounts committee, Report on Creating Effective Partnerships between Government and the Voluntary and Community sector, Jan 2012

## 15 SAFE COMMUNITIES

9.14 The 2012 Community Safety strategy *Building Safer, Shared and Confident Communities* recognises that addressing crime, disorder and the fear of crime in communities cannot be achieved by the Department of Justice or the justice system alone. Policing and Community Safety Partnerships (PCSPs) at council level provide new opportunities for statutory agencies, local political leaders, voluntary and community groups and local communities to work together to build safer communities.

9.15 Good relations across all communities are also essential to building a prosperous, peaceful and safe society. Key strategic projects within the strategy *'Together: Building a United Community'* focus on housing, regeneration and deprivation, and young people not in education, employment, or training; all have relevance to the aims of this framework.



**OUTCOME 15 SAFE COMMUNITIES**

**Actions and Commitments 2013 – 2015**

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- A** PCSPs work collaboratively with the community and relevant agencies at local level and deliver Community Safety programmes so that people feel safer, have reduced fear of crime and increased confidence

**Key Partners**

DOJ / Local government

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- B** Develop and implement a revised joint Domestic and Sexual Violence and Abuse Strategy to provide victims and witnesses with protection and support, and bring perpetrators to justice

**Key Partners**

DHSSPS / DOJ / PSNI / Safeguarding Board / other statutory and voluntary sector partners

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- C** Reduce the numbers of people of all ages killed or seriously injured in road collisions through implementation of road traffic collision prevention programmes

**Key Partners**

DOE / PSNI / other partners

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**16 SAFE AND HEALTHY WORKPLACES**

9.16 A key statutory responsibility for employers is to protect the health and safety of their workforce. Control of risks is important in all work areas but particularly so in some – for example the construction and farming environments. A good working environment, where people are protected and valued, has the potential to increase wellbeing, and there is clear evidence that actively promoting health at work contributes not just to workforce health but also to improved business performance and productivity through, for example, reduction in illness-related absence, increased motivation among staff and improved working atmosphere, leading to more flexibility, better communications and improved use of resources.

9.17 Effective workplace health programmes can make a real difference to the health and wellbeing of employees, businesses and the communities in which people live and work. Support systems to



encourage and maximise the commitment of employers to health and wellbeing and share effective practice will need to be in place.

## OUTCOME 16 SAFE AND HEALTHY WORKPLACES

### Actions and Commitments 2013 – 2015

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- A** Support more businesses to provide workplace health and wellbeing programmes to secure –
- improved physical and mental wellbeing
  - reduction in the number of reportable work related injuries
  - prevention, control and management of key occupational health hazards
  - awareness raising and advisory campaigns to highlight the dangers of carbon monoxide and promote appropriate management of risk
  - appropriate control of risks to the public from harmful organisms encountered in, or associated with workplaces such as *legionella sp*, *E.coli sp*

#### Key Partners

DETI / HSE / PHA / Business sector / Local government

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- B** Implement initiatives to improve safety, and reduce casualties and work-related deaths on farms including through –
- the work of the Farm Safety Partnership
  - tailored information delivered in rural primary schools
  - “Stay Farm Safe” awareness raising campaign

*Older farmers and children identified for targeted action*

#### Key Partners

DETI / HSE / DARD / DE / Farm Safety Partnership



## Safe and Healthy Workplaces

### Credit Union in Londonderry

*The PHA-sponsored Healthy Workplace Award 2013 was presented to Derry Credit Union Limited at the Derry/Londonderry Business Awards.*

*Derry Credit Union Limited has established a health promotion committee made up of staff, management, directors and volunteers.*

*The committee has organised and delivered more than 150 workshops, activities and events around health and wellbeing. The majority of these activities are offered during the working day and staff rotas are drawn up to accommodate those who wish to participate.*

*Activities to date have included stress management workshops, healthy eating sessions, taster sessions in yoga and Tai Chi. Staff have also been able to avail of bi-annual cardiac risk assessments and one-to-one consultations with a fitness instructor, and have been given information on foot and eye care, cancer awareness, mental health first aid, and smoking cessation sessions.*

*In addition, the credit union established a quiet room, a refuge from the hustle and bustle, where staff can listen to calming music and relax. Staff members are also encouraged to get involved in gardening and space has been made available outside the premises to grow vegetables.*

**Key Strategies/ strategic programmes** – Community Safety, Strategic Framework for Reducing Offending, Together – Building a United Community, Urban Regeneration and Community Development Policy Framework, Strengthened Communities and Vibrant Urban areas, People and Place - Neighbourhood Renewal, Areas at Risk programme, Community Asset Transfer framework, Tackling Poverty and Social Isolation, Rural Development Programme, Rural Transport Fund, Delivering Social Change – Social Investment Fund / Build Pathways to Employment, Tackling Domestic and Sexual Violence and Abuse Action Plan, Join In - Get Involved, Sport Matters, Extended Schools and Community Education Initiatives Programme, Transforming Your Care, Workplace Health, (Draft) Active Ageing Strategy, Making It Better - A Strategy for Pharmacy in the Community.



## CHAPTER 10 – DEVELOPING COLLABORATION

Key long term outcomes:

- 17 A Strategic Approach to Public Health**
- 18 Strengthened collaboration for health and wellbeing**

### **17 A STRATEGIC APPROACH TO PUBLIC HEALTH**

- 10.1 Earlier chapters have outlined the continued need for collaboration on issues that influence health and wellbeing, and the importance of seeking to strengthen this and integrate public health principles more systematically across all parts of society.

There are already a number of strategies and programmes underway which address the wider determinants, which include objectives relating to health and wellbeing, and which engage people and organisations working together to achieve improvements. It will be important to consolidate and build on those connections to ensure maximum benefit for population health. In line with Health 2020, and widely welcomed by the response to the consultation on “*Fit and Well – Changing Lives*”, a key aim of this framework will be to put in place strengthened collaboration for health through a “whole system approach”. This will require improved cohesion and communication between all levels of the system, and arrangements to achieve this are covered further in Chapter 11.

- 10.2 The framework will be delivered in the context of local government reform, which will take place from 1 April 2015. The new Councils will be responsible for Community Planning with a duty to plan for the ‘economic, social and environmental well-being’ of council districts. This provides an opportunity to redefine and strengthen the way in which the health and social care sector, local government and others work together to improve health and wellbeing and reduce health inequalities. The good working relationships that have been established under Investing for Health form a strong base for this work.



*Belfast Strategic Partnership for Health and Wellbeing*

*The Belfast Strategic Partnership (BSP) was set up in 2011 by the PHA, Belfast City Council and Belfast Health and Social Care Trust to address the significant levels of inequality across the Belfast area.*

*The Partnership has been set up in order to:*

- Support a citywide collaborative approach across sectors to better address the inequalities and health and wellbeing challenges faced within Belfast; and*
- Set the strategic direction for health and wellbeing improvement in Belfast, through the development of agreed priorities for the city and the alignment of corporate plans and resources of the key service providers.*

*It includes representatives from the following sectors:*

- Statutory sector – Belfast City Council, PHA, Belfast Health and Social Services Trust, Northern Ireland Housing Executive, Police Service of Northern Ireland and the Education sector;*
- Private sector;*
- Community and voluntary sector, including representation from the five Belfast Area Partnership Boards and community nominees; and*
- Local Elected Members.*



**Active Belfast** is one of the BSP's key projects. The Active Belfast project aims to promote healthy living and increase physical activity. A range of activities have been set up to encourage a healthier lifestyle for example:

- **Community gardens** - A community garden is a shared project where people from all age groups, abilities and backgrounds come together to grow their own fruit, flowers and vegetables. Community gardens have been opened at a number of locations around Belfast including Whiterock Leisure Centre, Finlay Park and Knocknagoney Linear Park. Benefits include learning new skills, making friends, improving diet, relieving stress, saving money on groceries, keeping active and getting outdoors.
- **Cycling and walking routes**, orienteering opportunities and eco trails
- **Outdoor gyms** throughout the city to provide access to a free fitness workout.

### Health in All Policies

- 10.3 The “whole system” governance and implementation arrangements will aim to ensure that health and health equity are considered coherently across ministerial and departmental policy making through a “Health in All Policies” approach.
- 10.4 The term Health in All Policies (HiAP)<sup>35</sup> describes an approach which emphasises the connections and interactions which work in both directions between health and policies from other sectors. Health Impact Assessment (HIA) is a practical tool used to support HiAP by judging the potential health effects of a policy, programme or project on a population, particularly on vulnerable or disadvantaged groups. HIA can inform the decision-making process with the aim of maximising the proposal’s positive health effects and minimising its negative health effects. HIA has been promoted to policymakers across Government departments in Northern Ireland with some evidence of use. There have also been examples of HIA at local level, for example in relation to housing programmes. DHSSPS will continue to work with departments and with the IPH, who provide support for HIA, to review and strengthen processes in support of a Health in All Policies approach, and with other sectors such as local government to support wider implementation.



- 10.5 To safeguard the interests of future generations from the perpetuation of social and economic inequities it will be important to identify the links between environmental, social and economic factors and apply the principles of sustainable development to policies and their implementation.

### Research

- 10.6 Building capacity for research and strengthening the evidence base relating to public health issues will be vital to secure health benefits across all socioeconomic groups. The NI Public Health Research Network and collaborations such as the Centre of Excellence for Public Health and the European Centre for Delivering Social Change will seek to maximise research effort. Evaluation and sharing the learning across government from action taken to address the wider determinants will also be crucial. Such learning will inform future investment.

### Legislation

- 10.7 Legislation in relation to issues such as tobacco control and road safety has been an effective mechanism to secure health improvements and this approach will continue. The Breastfeeding Strategy "*Breastfeeding – A Great Start*" proposes the introduction of legislation to support mothers' breastfeeding their children in public places in Northern Ireland, subject to public consultation, and consideration is being given to introducing minimum unit pricing for alcohol.
- 10.8 There are examples from other jurisdictions of legislation being used in a broader way to promote and protect public health and the need for similar legislation will also be considered here. A review of the Public Health Act (NI) 1967 has been commissioned to ascertain whether the Act (which deals largely with health protection) still remains fit for purpose. It is proposed that the review will put forward recommendations for updating the current legislation and will examine how to promote a broader strategy for public health.



### Supporting the development of the wider Public Health Workforce

- 10.9 Public health interventions are delivered by people who work in a range of settings, which includes the Health and Social Care sector but also comprises community and voluntary and Local government activity. It is important to recognise that if the aspirations of this framework are to be fulfilled then public health capacity and competency amongst those working towards improving public health across different sectors and from whatever professional background should be supported and developed. For example, nursing will have a key role in the public health outcomes to be delivered. This will encompass all of the existing roles e.g. surveillance, screening, health promotion, but will be much more focused on building community capacity, advocacy, social development and contributing to future policy development.
- 10.10 Across the UK, a range of initiatives to support professional development and to make public health “everybody’s business”, have been initiated. These include the UK Public Health Register (UKPHR), the development of the Public Health Skills and Career Framework (PHSCF) and PHORCaST - Link - <http://www.phorcast.org.uk/> - a web based resource to support career development and skills and training for the wider public health workforce.
- 10.11 In April 2013 the DOH England published a workforce strategy to support England’s strategy “*Healthy Lives, Healthy People*”. DHSSPS will examine the actions arising from this strategy including examples of innovation and good practice, and consider how this can be utilised to develop public health capacity and competency in the wider public health workforce in Northern Ireland.



**OUTCOME 17 A STRATEGIC APPROACH TO PUBLIC HEALTH**

**Actions and Commitments 2013 – 2015**

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- A** Establish governance, implementation, engagement and monitoring arrangements at strategic, regional and local levels which interconnect to create a whole system approach

**Key Partners**

DHSSPS and PHA lead / all other relevant partners

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- B** Create the conditions and processes for all departments and other relevant bodies to develop public policies which support improved health and wellbeing and a reduction in health inequalities, including a review of health impact assessment processes

**Key Partners**

DHSSPS lead / all other relevant partners

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- C** Strengthen collaboration North / South, East / West and internationally, particularly across Europe, on areas of mutual interest

**Key Partners**

DHSSPS / DOHs in England, Scotland, Wales, ROI / PHA / PHE / IPH / WHO / Healthy Cities organisations

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- D** Maximise the spend on prevention and early intervention through –

- increasing the share of the health budget spend on prevention and early intervention and developing mechanisms to monitor this across the HSC

**Key Partners**

DHSSPS / HSCB / PHA / Trusts

- securing the reallocation of resources from hospitals into the community envisaged in TYC and the PFG commitment
- monitoring funding contributions of other partners to improving health and tackling health inequalities

**Key Partners**

DHSSPS / PHA / others



**OUTCOME 17 A STRATEGIC APPROACH TO PUBLIC HEALTH**  
**Continued**

**Actions and Commitments 2013 – 2015 Continued**

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**E** Promote a planned and co-ordinated approach to research and development (R&D) activity to support improved public health

**Key Partners**

DHSSPS / DETI / DSD / PHA / others (including universities)

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**F** Consider and implement legislative change to support public health Including in relation to –

- tobacco control
- misuse of alcohol and drugs
- promotion and support of breastfeeding

**Key Partners**

DHSSPS

- road safety

**Key Partner**

DOE

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**G** Review the Public Health Act (Northern Ireland) 1967, consult on proposed changes and update as appropriate

**Key Partners**

DHSSPS

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**H** Assess the actions and recommendations arising from the public health workforce strategy associated with Healthy Lives, Healthy People and consider how good practice and innovation can be utilised to develop public health capacity and competency in the wider public health workforce in Northern Ireland.

**Key Partners**

DHSSPS / PHA / others



**Key Strategies / strategic programmes** - Programme for Government, NI Economic Strategy, Lifetime Opportunities Anti-poverty strategy, Tackling Rural Poverty and Social Isolation, Delivering Social Change Framework, Social Economy strategy, Success through Skills –Transforming futures, Air, Water and Waste Management strategies, Planning Policy, Accessible Transport Strategy, Active Travel Strategy, Local Government Reform programme, Road Safety strategy, Housing and Homelessness strategies, New Strategic Direction on Alcohol and Drugs, Tobacco Control strategy, Breastfeeding - A Great Start, Transforming Your Care, Making it Better - A Strategy for Pharmacy in the Community, Making it Better - A Strategy for Pharmacy in the Community, (Draft) Active Ageing Strategy, Strategy to improve the lives of those with disabilities 2012- 2015.

## 18 STRENGTHENED COLLABORATION FOR HEALTH AND WELLBEING

### Asset – Based Approach

- 10.12 Historically, approaches to the promotion of population health have been based on a “deficit” model. That is, a focus on identifying the problems and needs of populations that require professional resources and high levels of dependence on public services. It is no doubt important and necessary to identify levels of needs and priorities, but this model tends to define communities and individuals in negative terms, without consideration of what is positive and works well in particular populations.
- 10.13 Recently an asset – based<sup>36</sup> approach to community development has been gaining momentum. This focuses on the factors or resources which enhance the ability of individuals, communities and populations to maintain and sustain health and wellbeing and meet identified needs, rather than a focus on the “deficits” or problems, needs and deficiencies such as deprivation, crime, anti-social behaviour, exclusion, illness and health-damaging behaviours. Assets can operate at the level of the individual, family or community as protective and promoting factors to buffer against life’s stresses. The report “A Glass Half Full - how an asset approach can improve community health and well-being”<sup>37</sup> demonstrates that when practitioners begin with a focus on what communities have (their assets) as opposed to what they don’t have ( their deficits) a community’s ability in addressing its own needs increases, as does its capacity to lever in external support.



10.14 Adopting an asset-based approach, an aim of this framework is to equip and enable individuals, families and communities to address the issues affecting their health and wellbeing and make healthy choices. “People” assets vary across communities; some have stronger support and social networks than others. “Physical” assets also vary across localities. In line with a Health Committee recommendation, it is intended to work collaboratively across government agencies and with other organisations to map assets (both physical and social) which could be used to tackle inequalities in health. This will assist in informing the ongoing implementation of the framework and development of a whole system approach, and may be replicated at other levels of delivery.

**Assets may include:**

- *the practical skills, capacity and knowledge of local individuals, families and groups;*
- *the passions and interests of local people that give them energy for change;*
- *the networks and connections – known as ‘social capital’ – in a community, including friendships, neighbourliness and volunteering;*
- *the effectiveness of local community groups and voluntary associations;*
- *the resources of public, private, voluntary and community sector organisations that are available to support a community; and*
- *the physical and economic resources of a place that improve wellbeing.*

(National Institute for Health and Clinical Excellence, 2009)

**Local Partnership Action**

10.15 The actions outlined in this framework involve a range of government departments and other agencies. Many of the actions are inter-linked and require delivery at local as well as strategic or regional level. Three further areas of work have been identified around which a number of partners have been developing collaborative approaches and which lend themselves particularly to local partnership action.



These are:

- **Food – GROW and EAT;**
- **Space and place – MOVE and MEET; and**
- **Social inclusion – CONNECT FOR A BETTER LIFE.**

10.16 These issues are particularly relevant to current public health challenges and to tackling health inequalities. They inter-relate and overlap. They are included with the aim of building momentum and galvanising communities and relevant organisations at local level, supported where needed by coordination at regional level. Their inclusion provides a focus for collective action over the next three years – the intention is that this work will provide a foundation on which to build in the next wave of actions under this 10 year framework.

#### **(a) Food - GROW AND EAT**

##### **Why?**

10.17 Food impacts on people's lives on a daily basis in many ways. Eating is essential for survival, but food can be a source of enjoyment and a focus for social engagement. For some it is part of their cultural identity. Good healthy food can be a means to achieve broader goals of improving health and wellbeing, reducing social isolation and increasing civic engagement. It engages individuals and communities in a fundamental way that can cut across socio-economic groups and cultural boundaries.

##### **Food facts from Health Survey NI 2011-12**

*61% of adults measured were either overweight (37%) or obese (23%)*

*10% of children aged 2-15 years were assessed as being obese*

*Rates of obesity tend to rise in association with increasing social disadvantage*

*86% of respondents said they were aware of the advice to have at least 5 portions of fruit or vegetables each day, but only 33% of respondents met this guideline*

*87% of respondents in households had enough of the kinds of food that they wanted to eat*



**Food facts from Health Survey NI 2011-12 continued**

*A further 12% had enough to eat but not always the kind of food they wanted*

*7% of respondents in the past year ate less because they felt that there was not enough money to buy food*

*1% of respondents sometimes did not have enough to eat while 0.4% of respondents often did not have enough to eat*

*1% of respondents did not eat for a full day because there was not enough money for food; around half of this proportion said that this happened almost every month*

10.18 In the current economic climate, food poverty is becoming an increasingly important issue. Food poverty is a complex aspect of poverty that has health and social consequences. It is defined as the “inability to access a nutritionally adequate diet and the related impacts on health, culture and social participation.” Households experiencing food poverty consume less nutritionally-balanced diets and suffer from higher rates of diet-related chronic diseases such as heart disease, diet related cancers, and overweight and obesity.

10.19 Currently there is no agreed measure of food poverty across Ireland to inform practice and policy. IPH, using Living Costs and Food Survey data for Northern Ireland, reported that 14.8% of NI households were at risk of food poverty in 2009. Members of the Food Poverty Network, co-chaired by Food Standards Agency in Northern Ireland and Safefood in ROI, have been tasked with developing a food poverty indicator based on routinely available data. This will potentially provide a North/South indicator and allow for comparison.

**Food Waste**

*In the UK 7.2m tonnes of food and drink is thrown away from homes each year.*

*NI shoppers could save around £480 per year per household by cutting down on food waste\**

\* Household Food and Drink Waste in the UK (WRAP 2009)



10.20 Local developmental work should aim to –

- increase access to healthy foods and reduce risk of obesity and malnourishment in a way that promotes dignity, builds health and community and tackles inequalities at a local level for all ages.

This could be taken forward for example through support for initiatives such as community gardens and allotments, community cafes offering free or low cost healthy meals, community farmers' markets, food co-operatives.

Key features of such initiatives could include offering a range of participation opportunities to learn how to grow, cook and choose healthy food; building on existing community assets and linking them, and strengthening capacity and skills.

#### **Community Food Initiative**

*The Community Food Initiative funded by SafeFood and managed by Healthy Food for All Ireland, aims to support community projects in promoting greater access to affordable and healthy food. Two NI projects are among those receiving funding through the 2013-15 programme.*

#### **Incredible Edible Cloughmills**

*The Incredible Edible Network is a network whose members believe that providing access to healthy, local food can enrich their communities. Typically their work involves setting up community growing plots, reaching out to schools and children and backing local food suppliers. This reflects the movement's drive to provide access to good local food for all through:*

- working together
- learning – from field to classroom to kitchen
- supporting local growers, retailers and outlets

*Incredible Edible Cloughmills is one such group which seeks to reconnect people and food. It is constantly evolving by putting people at the heart of decision making and action, and aims to improve wellbeing by making 5 actions a reality in its community – connecting, being active, taking notice, learning and giving.*



### **Fareshare**

*FareShare sources surplus, 'fit for purpose' food and drink from retailers and manufacturers throughout Ireland and redistributes it to local charities feeding hungry and vulnerable people in the community. Food is distributed through **Community Food Members (CFMs)** to disadvantaged groups such as the homeless and vulnerably housed people. This enables these organisations to reinvest funds into other much needed services such as housing advice, training and support. In NI FareShare works in partnership with the Council for the Homeless Northern Ireland with contributions from local retailers and food producers.*

### **(b) Space and place - MOVE AND MEET**

#### **Why?**

- 10.21 The physical and social characteristics of communities and the extent to which they enable and promote healthy behaviours can make a major contribution to improving health and reducing social inequalities in health.
- 10.22 Many reports note how the quality of both the natural and built environments impact on, for example, mental health and wellbeing, obesity, and health inequalities, and on the development and sustainability of social networks and communities. People with poorer health often live in environments which support unhealthy lifestyles, for example, lacking in green space with limited access to environments for walking or cycling, or for children to play, and more likely to pose a threat to health through higher rates of crime or risks from traffic.
- 10.23 Much can be done to create safe, health-enabling neighbourhoods and environments for everyone. Physical environments can be designed or maximised to promote health and wellbeing through, for example, providing access to services, green spaces including woodlands and forests, opportunities for being physically active and for safe social interaction. At a broader geographical level opportunities may exist for "joining up" planning and provision of for example transport, walkways, cycle paths, existing infrastructure or services to better connect communities and increase access.



10.24 Active travel – journeys using physical activity, such as walking and cycling – has a role to play in improving and achieving a fairer distribution of health as well as bringing economic benefits to the individual. Making neighbourhoods more “walkable” and making roads more cycle-friendly could make a significant difference to people’s levels of physical activity. This would link with DRD’s *Building an Active Travel Future for Northern Ireland (2013)* Action Plan which contains measures that will be taken by government departments, local authorities and voluntary bodies to encourage more cycling and walking and less dependency on private cars up to 2015. The establishment of a Cycling Unit in DRD is also aimed at ensuring that cycling provision is a key element in both transport strategy and delivery.

35% of respondents to the 2011/12 Health Survey were classified as meeting the recommended level of physical activity<sup>1</sup>, with males (40%) more likely than females (31%).

73% of journeys in Northern Ireland are made by car, 16% are walked whilst a very small proportion of journeys (1%) are cycled (Travel Survey Northern Ireland 2010/12).

### Aim

10.25 Work should aim to –

- maximise the use of physical assets to increase access to and use of safe, sustainable, health nurturing spaces and places, and opportunities for social interaction in a way that builds health and community and tackles inequalities at a local level for all ages.

Ways to do this might include for example – maximising and promoting shared use of public and community facilities; public realm schemes; greenways or routes, woodlands and forests for walking, cycling, running etc; green gyms / outdoor gyms; allotments.

Key features of such initiatives could include; incorporating promotion of health and wellbeing, social inclusion and safety in design and use of such spaces and assets; improving links with and capacity between planning, regeneration, public health and community safety; increasing physical activity and improving mental health and wellbeing; promoting age friendly environments.



### **WHO Healthy Urban Planning and Age-friendly Environments**

*The WHO International Healthy Cities movement has developed the concept of Healthy Urban Planning focussing on people, and how they use buildings and their surroundings, rather than simply on the urban fabric. An aim is to ensure environments are accessible, and support active participation in the city, for people of all ages. This underpins each phase of the Healthy Cities roll-out. Belfast and Londonderry are part of the Healthy Cities movement.*

*The Age-friendly Environments Programme aims to address the environmental and social factors that contribute to active and healthy ageing. Making cities and communities age-friendly is one of the most effective local policy approaches for responding to demographic ageing. Physical and social environments are key determinants of whether people can remain healthy, independent and autonomous long into their old age. WHO provides guidance and promotes the generation and dissemination of knowledge on how to assess the age-friendliness of a city or community, how to integrate an ageing perspective in urban planning and how to create age-friendly urban environments.*

### **Knowledge Exchange, Spatial Analysis and Healthy Urban Environments**

*The KESUE project, led by the School of Planning, Architecture and Civil Engineering at Queens University Belfast, aims to maximise the policy impact of research undertaken on walkability, particularly the development of a Real Walkability Network. Initially generated as part of the Physical Activity and Rejuvenation of Connswater (PARC) project, based on a study area of East Belfast, this project has extended the applicability of the developed policy tools to cover the two main cities of Northern Ireland, Belfast and Londonderry, so that the model then covers 37% of the population and some of the most deprived communities in the region. The project has disseminated the use of this model to practitioners to increase the evidence base for interventions in the built environment aimed at promoting physical activity.*

*The value of the Project is reflected in the large number of public bodies that have been willing to become partners, including Belfast and Derry City Councils, DRD, DHSSPS, PHA and Belfast Healthy Cities.*





### **Comber Greenway**

*The Comber Greenway is a traffic free walking and cycling route running from Comber to Belfast along the old railway line (which closed in 1950).*

### **Groundwork**

*Groundwork engages and motivates people to improve their quality of life by investing in people and place through supporting community-led regeneration. Daisy Hill Wood, owned by Newry and Mourne District Council and managed by the Woodland Trust, is a main feature on the hill above Newry city. Originally it was a plant nursery from 1890 to 1990 and most of the current wood has resulted from the planting of exotic species during that period. The aim of the M&S Greener Living Project was to encourage local people to use the wood both as an educational and as a recreational resource.*

*A local community group – Daisy Hill Nursery Woods Conservation Group was set up. Members of the group met every Saturday from October to March and carried out various practical tasks to make access safer for walkers, to remove invasive species, which prevent trees from regenerating naturally, and to plant native trees and shrubs.*

### **Belfast Health and Social Care Trust**

*The Belfast Health and Social Care Trust planted nearly 10 hectares of new native woodland at its Knockbracken site in south Belfast and a launch day was held in March 2013 for the Trust staff and patients. The woodland is open to all and additional access has been created to encourage community use.*

*The Trust had wanted to find a way to make best use of the land available to maximise health and therapeutic benefits for patients, staff, visitors and the local people whilst also providing good quality wildlife habitats. Options were explored and, in partnership with Woodland Trust and with support from Forest Service Woodland Grant Scheme, it was decided to plant almost 20,000 trees. The new community woodland is now an asset for both the Trust and the local community.*



**(c) Social inclusion – CONNECT FOR A BETTER LIFE**

**Why?**

- 10.26 In addition to physical places, the communities and social networks to which people belong have a significant impact on health and health inequalities. Social capital can provide a source of resilience against particular risks of poor health, helping people get through economic or other difficulties, and contributing to wellbeing and as a result to other outcomes.
- 10.27 There are links between poverty and social exclusion, but not everyone who is poor is socially excluded. Many people living in poverty are supported through social, family and community support networks. Not everyone who is socially excluded is poor. Poverty may not be the main issue, for example, for people from minority ethnic groups, people with a disability, or mental health problems, people who are homeless or lesbian, gay, bisexual and transgender people.
- 10.28 Those living in rural areas may have difficulties in accessing the types of services that other people take for granted and feel isolated. Loneliness and social isolation among older people is also a growing problem. Social networks and social participation act as protective factors against dementia or cognitive decline over the age of 65.
- 10.29 Exclusion is driven by unequal power relationships, which can be economic, political, social or cultural. Exclusion can operate at individual, household, group or community level. Community involvement can be the key to successful policy and/or action to reverse exclusion.

- The Marmot Review identified that individuals who are socially isolated are between 2 - 5 times more likely to die prematurely than those who have strong social ties.
- Social exclusion can lead to alcohol misuse, poor mental health, lack of physical activity, greater disadvantage, higher levels of social isolation and reduced uptake of services and support.



## Aim

10.30 Work in this area should aim to –

- bring together and maximise the resources invested in an area to ensure people of all ages have access to support networks and opportunities to participate, and to build individual and community resilience, capacity and social capital.

This could be taken forward for example through targeted support for particularly vulnerable population groups locally, befriending schemes, schemes to promote access to services and advice, assisted transport, arts and cultural programmes, reading schemes etc.

Key features would include securing the participation of the individuals/groups at risk of exclusion, building individual and community resilience, building on and linking community assets.

### **Fab Lab**

*Ashton Community Trust (Belfast) in partnership with the Nerve Centre (Derry/Londonderry) jointly launched the first Fab Labs in Northern Ireland in May 2013. The concept was originally set up in the Massachusetts Institute of Technology to inspire people and entrepreneurs to turn their ideas into new products and prototypes by giving them access to a range of advanced digital manufacturing technologies.*

*The two Northern Ireland Fab Labs will offer support on a local basis to communities, entrepreneurs, students, artists, small businesses and anyone who wants to create something totally unique through access to manufacturing technology from precision laser cutters and 3D printers to electronic circuit fabrication equipment.*

*Fab Lab is a prime example of positive social intervention. The project will deliver on a number of levels, for example encouraging greater levels of positive cross-community contact - people from all communities can come together and develop their creative and entrepreneurial skills, as an educational tool helping children and young people to turn their ideas into reality, and by increasing the capacity and employment potential for people living within deprived areas.*



*Funded by PEACE III managed by Special European Union Programmes Body, the project will also link into and share experiences with the worldwide network of Fab Labs.*

### **Words Alive**

*The “Words Alive” group is a creative writing group established as a means of encouraging socially isolated people aged 60+ to come together to discuss their shared interest in reading, storytelling and recalling old memories. The members have published their first anthology Pen to Paper in 2012. The group is planning to reach out to other isolated older people by doing readings of their work in nursing and residential homes. The group also plans to secure funding to enable it to engage with the local Polish community.*

### **Keep Warm**

*The PHA works with partner organisations such as Homeplus, the Welcome Centre, Rosemount House and the Salvation Army to provide protection against cold weather by delivering Keep Warm packs to rough sleepers and homeless people in Belfast.*

### **Ardoyne Library Read Aloud**

*Ardoyne Library sits at the heart of its community and provides a welcoming space for local people. Following on from a learning initiative, an informal group of mostly senior male users evolved and were offered the chance to try ‘Read Aloud’ reading from a number of authors and poets over four, weekly sessions.*

*The common experience of reading is as a solitary activity that takes the reader on a journey based on their own experiences and perceptions of the world. Reading and discussing great literature or poetry in a group context can create a different and unexpected journey of discovery. How someone else interprets a line, a word, or the intent behind a passage can be very different from what an individual reads into it. It can be insightful, thought provoking, and encourages respect for others’ opinions.*

*Read Aloud allows thoughts, connections and understanding to emerge. Group members can choose to join in, or not, and at times the reading will stop to allow discussion about parts of the text – what it might mean – or for reflecting on similar experiences. The effects are subtle and can be profound.*



*Research is uncovering an intimate connection between reading and wellbeing. The scientific findings indicate that being read to, stimulates thought and memory and encourages the sharing of ideas, feelings, hopes and fears.*

*Reading for the individual is a therapeutic activity but reading with others is a shared pleasure and rewarding experience for both the reader and the listener. Encouraged by a request from group members, Read Aloud workshops are continuing with the Ardoyne Library Group on a monthly basis.*

## OUTCOME 18 STRENGTHENED COLLABORATION FOR HEALTH AND WELLBEING

### Actions and Commitments 2013 - 2015

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- A** Maximise opportunities to strengthen local collaboration through the joint working arrangements between PHA and local government, and the outworking of local government reform and the new statutory duty of Community Planning process

**Key Partners**

DHSSPS / DOE / PHA / Local government

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- B** Work collaboratively across government agencies to map assets (physical and people) which could be used to tackle inequalities in health

**Key Partners**

DHSSPS / DSD / other departments and agencies

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- C** Improve availability and use of data across all levels and sectors for the purposes of identifying priorities, planning action, monitoring trends and evaluating which actions are the most effective

**Key Partners**

Departments / agencies / Local government / other sectors

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- D** In partnership with relevant departments, agencies, other sectors, local government and communities, develop and implement regional programmes to address health and wellbeing priorities in line with this framework

**Key Partners**

DHSSPS / PHA lead-partners at regional and local levels



**OUTCOME 18 STRENGTHENED COLLABORATION FOR HEALTH AND WELLBEING Continued**

**Actions and Commitments 2013 - 2015 Continued**

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- E** Maximise opportunities for local partnership action working with local communities to –
- establish a network of community led gardens and allotments which promote health and wellbeing
  - develop child friendly spaces through a neighbourhood approach to community safety
  - promote health and wellbeing of older people in their own homes through a home visitation scheme

**Key Partners**

PHA to lead with local government, police and community safety partnerships, community and voluntary sector and other partners

**Key Strategies / strategic programmes** - NI Economic Strategy, Lifetime Opportunities Anti-poverty strategy, Delivering Social Change Framework, Tackling Rural Poverty and Social Isolation, Rural Development Programme, Rural Transport Fund, Local Government Reform programme, Community Safety, Strategic Framework for Reducing Offending, Community Relations – Together, Building a United Community, Urban Regeneration and Community Development Policy Framework, Strengthened Communities and Vibrant Urban areas, planned Community Asset Transfer framework, Social Economy strategy, Build Pathways to Employment, Success through Skills – Transforming futures, Air, Water and Waste Management strategies, Planning Policy, Accessible Transport Strategy, Active Travel Strategy, Road Safety strategy, Housing and Homelessness strategies, New Strategic Direction on Alcohol and Drugs, Tobacco Control strategy, Transforming Your Care, Join In - Get Involved, Sport Matters, Extended Schools, Workplace Health, (Draft) Active Ageing Strategy, A Fitter Future for All.



**MAKING LIFE BETTER**



**PART THREE –  
GOVERNANCE AND  
IMPLEMENTATION**



## **CHAPTER 11 – MAKING IT WORK**

- 11.1 Health 2020 argues that, in order to improve population health and wellbeing and reduce health inequalities, all parts of government need to work together to recognise risk patterns and identify solutions, act at various levels, and share responsibility across policy fields and sectors.
- 11.2 At strategic level this framework emphasises the inter-connectedness of many government policies and programmes, and the mutual benefits and shared goals that can be achieved by working together effectively. It is clear that there are opportunities to strengthen these linkages through governance and monitoring which develops a sense of coherence flowing through to implementation at delivery level.
- 11.3 The reform of local government will also provide an opportunity to strengthen the already significant contribution at local level to improving health and reducing health inequalities. The productive joint working arrangements between the PHA and councils will be maintained and built upon, as well as ensuring strong linkages with others through the new community planning process.
- 11.4 A whole system approach is required, with clear lines of communication, accountability and clarity on how governance and implementation is to work. Connections with other relevant strategies and initiatives need to be managed and maximised. Collaboration should be embedded in every aspect of governance and monitoring, and with clear recognition of and relevant linkage with structures and partnerships which will contribute - examples are Children and Young People’s Strategic Partnership, and Public Health Local Government Steering Group.

### **Governance and Implementation**

- 11.5 This chapter outlines the governance and implementation arrangements for “Making Life Better”. These arrangements reflect the concerns raised in the Investing for Health Review on disconnect between strategic direction and local implementation. Key roles, responsibilities, monitoring and reporting mechanisms are also outlined. In promoting a thematic whole system approach it may be beneficial to establish additional thematic sub – groups to tackle particular issues. These may be at any level within the proposed structure.



### **Strategic Level - Ministerial Committee for Public Health**

11.6 At strategic level, a Ministerial Committee for Public Health to be chaired by the Minister for Health, Social Services and Public Safety will be established. The key functions will be to provide strategic leadership at government level, provide direction and coherence with other key strategic programmes and structures, such as Delivering Social Change, and oversee implementation on behalf of the Executive. The Ministerial Committee will be supported and informed by the All Departments Officials group (ADOG)

### **All Departments Officials Group (ADOG) for Public Health**

11.7 The ADOG, chaired by the Chief Medical Officer, will comprise senior officials from every department. Its role will be to:

- inform and make recommendations to the Ministerial Committee;
- develop and support a Health in All policies approach to promote coherence;
- co-ordinate collaborative working at departmental level;
- connect with the Regional Project Board, directing, or supporting action as appropriate; and
- monitor and report on progress.

This group will report to the Ministerial Committee. The chair of the Regional Project Board (see below) will be a member of and report to this group.

### **Regional Project Board for Public Health**

11.8 The Regional Project Board, to be chaired by the Chief Executive of the PHA, will focus on strengthening collaboration and co-ordination to deliver on the strategic priorities across sectors at a regional level, and on supporting implementation at a local level.

11.9 Membership of the group will comprise the Chief Officers of relevant statutory agencies. There will also be representation from local government, the community and voluntary sector and the private sector.



11.10 The primary focus of this group will be to drive implementation of agreed priorities through:

- building connections between strategic drivers and local implementation;
- driving forward opportunities for regional initiatives that cut across common themes;
- directing, providing co-ordination for and monitoring the work of local partnerships;
- examination of emerging data, evidence and best practice in terms of addressing health and social wellbeing inequalities; and
- providing advice and recommendations to the ADOG and Ministerial Committee on emerging issues and potential areas for policy and legislative consideration and joint working.

11.11 This Group will be informed by and will support local partnerships. It may also be supported through the establishment as appropriate of thematic sub-groups or time bound working groups on priority themes. The Group will report through the Chair to the ADOG. Individual members will also be required to make effective links into their relevant Department/organisation in terms of emerging issues and implementation.

11.12 In conjunction with local level partnerships the Regional Board will develop an Implementation Plan, focussed on strengthening co-ordination in relation to the priorities identified in this framework.

### **Local Level Partnerships**

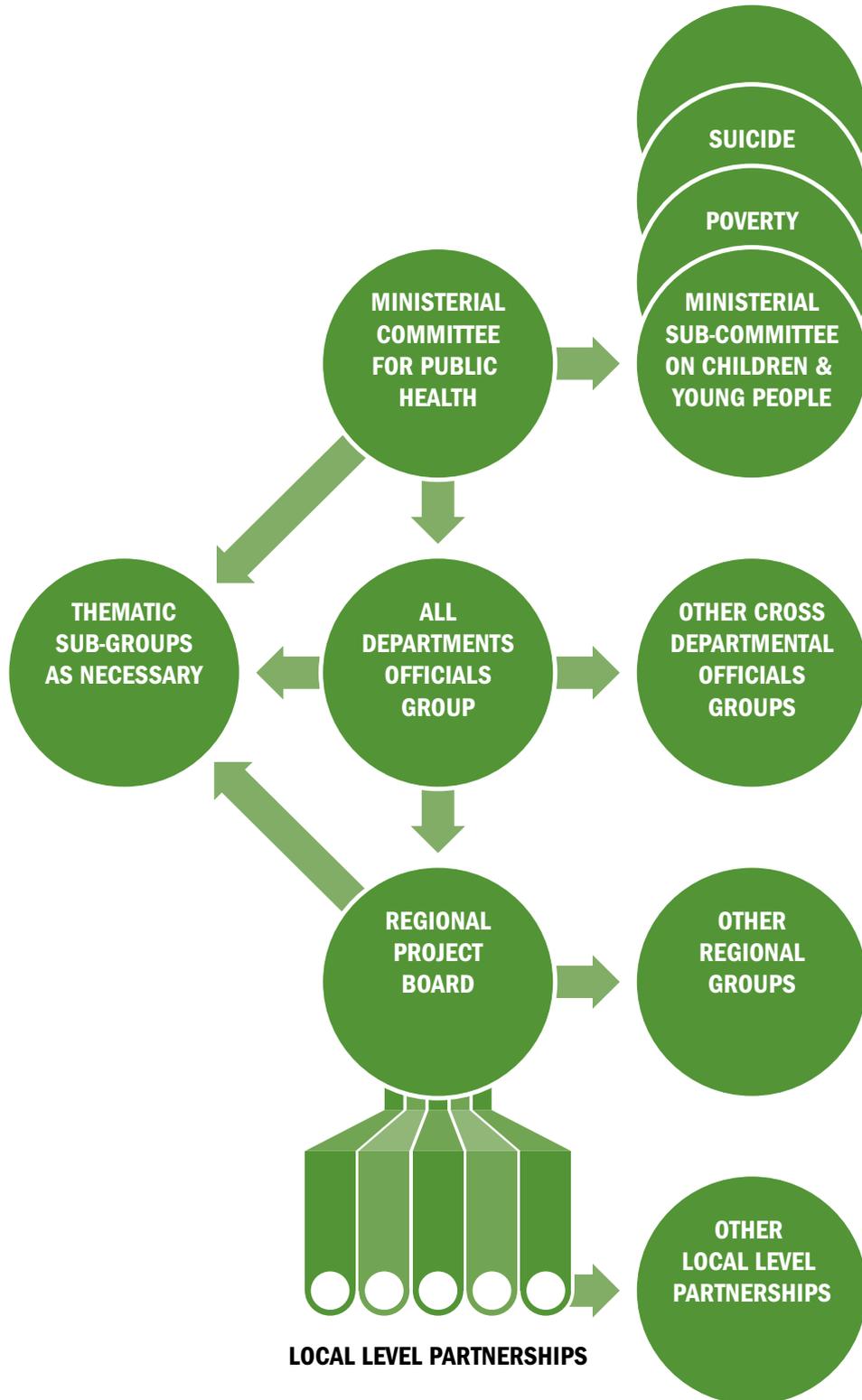
11.13 Local strategic partnerships of key statutory, private, community and voluntary bodies will be established based on an agreed geographic coverage. Each Partnership should in the first instance be developed from existing local arrangements and include a balance of statutory and non-statutory partners. The initial focus will be to collaborate on the three areas of work outlined in Chapter 10.



- 11.14 The partnerships' role will focus on local delivery and will be to:
- identify local opportunities for collaboration and partnership working based on local need;
  - drive local interventions/services to support those most in need;
  - develop and promote new ways of working and models of intervention and test concepts;
  - ensure regional priorities are reflected in local plans;
  - ensure that local priorities are fed into the strategic process; and
  - report to the Regional Project Board (the Chair of the local partnership will be a member of the Regional Project Board).
- 11.15 These arrangements should link into and align with local Community Planning arrangements over time. New legislation will place a duty on councils to lead the community planning process and on other public bodies to participate. Departments will also be required to promote and encourage community planning and have regard to the councils' community plans in planning the delivery of services.
- 11.16 Legislation will establish a statutory link between the community plan and the local development plan. This will ensure that issues relating to the general wellbeing of the community will be taken into account in the preparation of a council's local development plan.



**Figure 3:** Making Life Better - Governance and Implementation



Local strategic partnerships established on an agreed geographic coverage, and including a balance of statutory and non-statutory partners.



## **Monitoring Framework**

- 11.17 To support the proposed structures a monitoring framework will be developed to include:
- reports from local partnerships to Regional Project Board;
  - reports from Regional Project Board on regional and local activity with advice and recommendations to ADOG;
  - reports from ADOG to the Ministerial Committee on strategic issues, key indicator trends, overall activity and provide advice and recommendations; and
  - an annual report on overall progress.
- 11.18 *It is not the intention to duplicate reporting where other mechanisms are already in place, for example, there are already reporting processes for PFG commitments.*
- 11.19 Through the Data and Research Groups established to support the framework, a set of key indicators has been agreed to facilitate high-level monitoring of progress. The indicators are linked to the framework's themes and will serve as proxy measures to monitor progress towards the outcomes - the indicators with baseline positions are listed in Annex B. This set of indicators may be expanded as work progresses. Data and Research Groups will continue to support the monitoring of progress. Members will also work to secure better record linkage and make recommendations on research and evaluation to inform the framework's implementation and evaluation.
- 11.20 DHSSPS Information and Analysis Directorate will undertake the role of collating and publishing updates on the key indicators including on those relating to the social determinants. The Health and Social Care Inequalities Monitoring system maintained by DHSSPS and such services as that provided through the Northern Ireland Neighbourhood Information Service (NINIS) will continue to be useful tools supporting policy and service planning and delivery. It will be important to improve the availability and use of data on an ongoing basis across all levels and sectors for the purposes of identifying priorities, planning action, monitoring trends and evaluating which actions are the most effective.



11.21 Effective communication will be required across all levels if the framework is to achieve results. An “Engagement and Communications” strategy will be developed by the Regional Board in collaboration with the All-departments Officials Group to support implementation and monitoring of the framework.

### **Funding**

11.22 Funding from across government is already committed to supporting the strategic actions identified in Chapters 5-10 of this framework. This is underpinned by the Executive’s commitment through PFG to allocate an increasing percentage of the overall health budget to public health (measured in terms of the PHA budget), with the aim of allocating an additional £10m by 2014/15 compared with the 2011/12 baseline.

11.23 The framework commits to developing better mechanisms to monitor spend on prevention across the HSC. In addition it will be important to continue to collaborate with other departments, exploring opportunities to pool resources or leveraging funding as appropriate to deliver relevant cross-cutting programmes such as the MARA project, and Parent Support programmes through Delivering Social Change. Many other sources of funding, including local government and philanthropic organisations, contribute to programmes that will deliver the aims of this framework. In the current financial climate, it is vital that resources are used to optimum effect. This will include careful targeting of resources to meet greatest need with the aim of reducing health inequalities.

### **Early Action**

11.24 Over the next three years:

- the structures outlined above will be put in place and processes developed to ensure a whole system approach;
- the actions committed to in the framework will be advanced;
- local developmental work on the three key areas outlined in Chapter 10 will be taken forward; and
- progress will be monitored and outcomes evaluated.



All of this will inform the next wave of actions to advance the long-term vision:

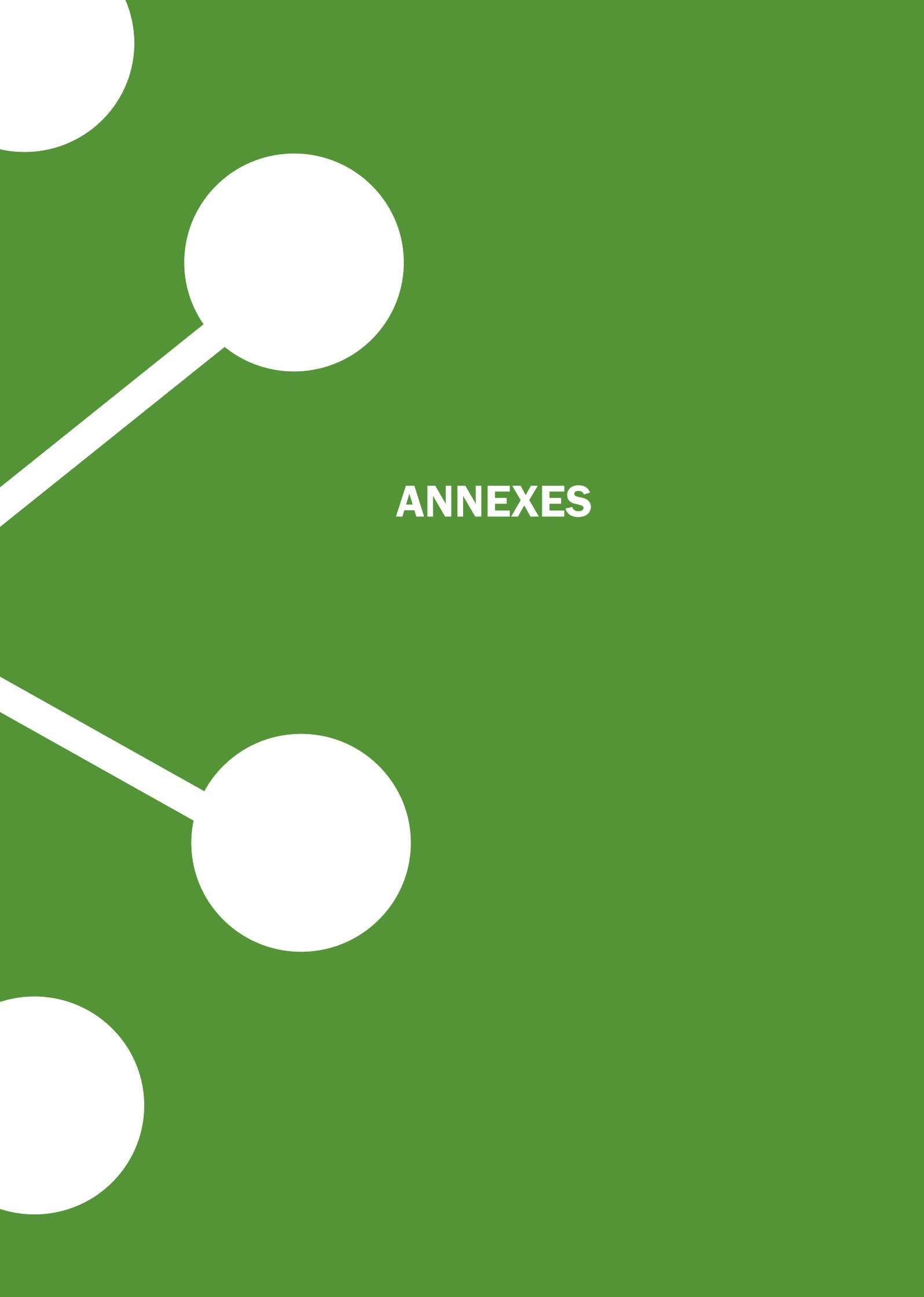
**“All people are enabled and supported in achieving their full health and wellbeing potential”**

and aims:

**“Achieve better health and wellbeing for everyone and reduced inequalities in health”**



**MAKING LIFE BETTER**

The image features a solid green background. On the left side, there are three white circles of varying sizes. Two of these circles are connected to each other and to a third circle further up by thick white lines, forming a partial network or path. The word "ANNEXES" is centered in the right half of the image in a bold, white, sans-serif font.

# ANNEXES



## ANNEX A - HEALTH AND HEALTH INEQUALITIES

1. The consultation document Fit and Well – Changing Lives set out a detailed analysis of the current health challenges and of the underlying social determinants. It also covered information on health and wellbeing of particular vulnerable groups. This Annex summarises and updates some key data.
2. Northern Ireland currently has a population of around 1.8 million people. This is the fastest growing population in the UK and is projected to rise by 111,000 (6%) by 2020 to around 1.9million.

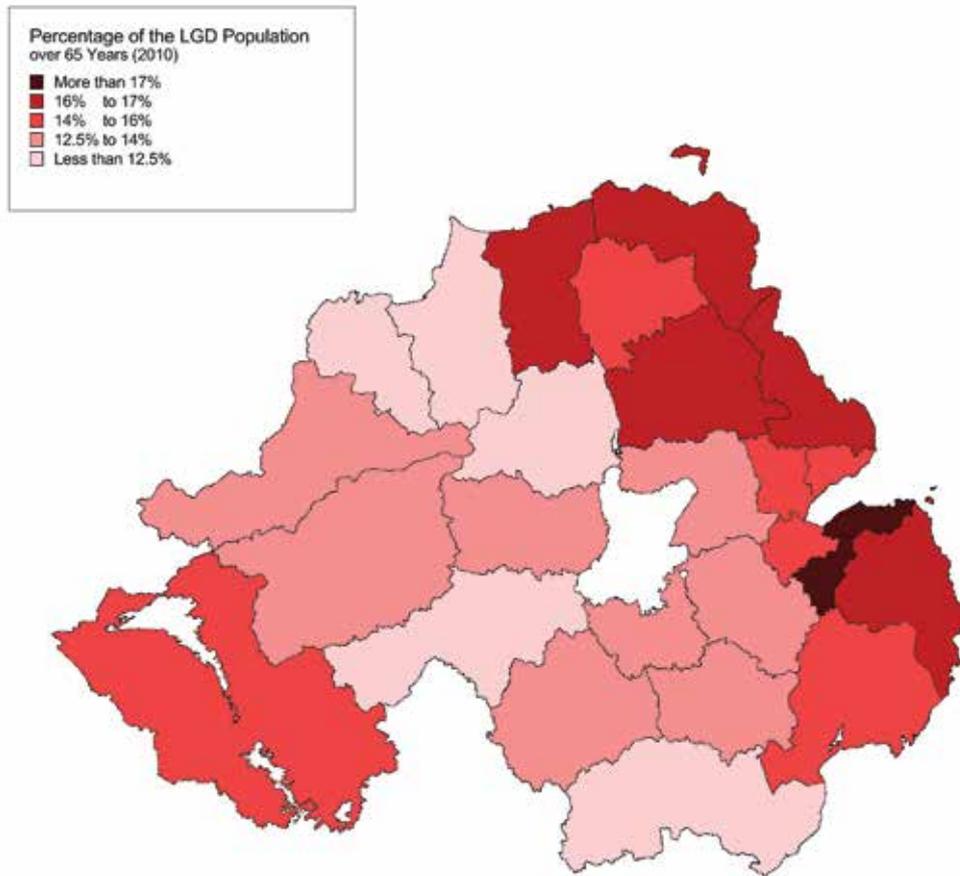
**Figure 4:** Number (percentage) of population by age group in 2010 and 2020 (projected)

AGE BAND	2010	2020
0 - 15	382,000 (21%)	398,000 (21%)
16 - 64	1,157,000 (64%)	1,175,000 (62%)
65+	260,000 (14%)	327,000 (17%)
85+	30,000 (1.6%)	44,000 (2.3%)

3. During this period, the age profile of the population is expected to gradually become older. The number of people aged 85 and over is also projected to increase, from 30,000 (1.6% of the total population) to 44,000 (2.3% of the total population). An ageing population is a significant achievement, reflecting advances in health and quality of life. A key challenge will be to enable older people to remain in good health for as long as possible.
4. In addition to these overall trends, there are also significant demographic differences within the region, for example, some localities have higher than NI averages of older people, or young children, which can put disproportionate pressure on local services and communities. These differences make targeting interventions a local rather than a regional matter.



**Figure 5:** Map of NI population 2010 – % of population aged over 65 years (LGD)



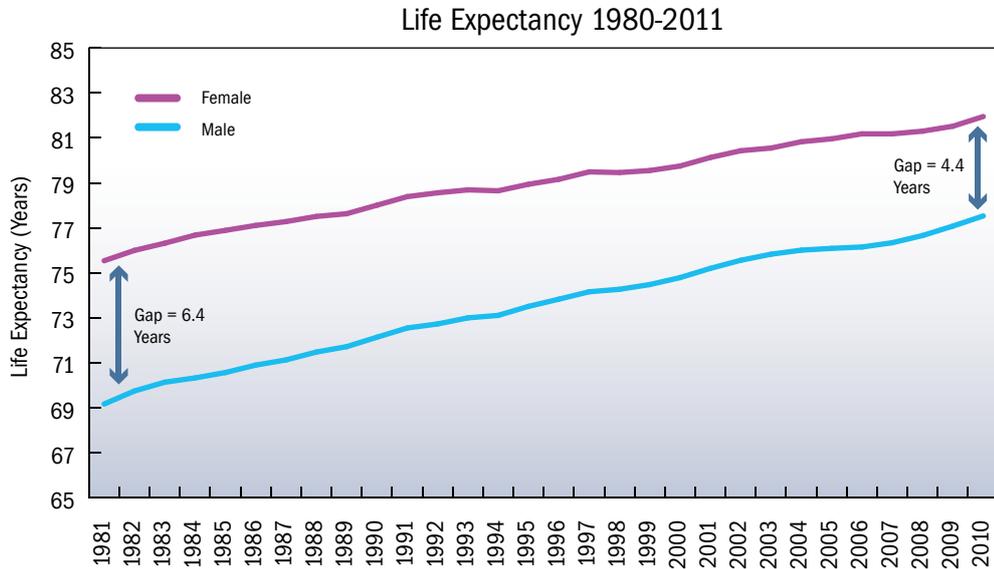
## Life Expectancy

5. Since the 1980s life expectancy (used internationally as a measure of population health) has increased steadily for both males and females and is projected to continue to increase. Between 1980/82 and 2009/11<sup>1</sup>, male life expectancy has increased by over 8 years, from 69.2 to 77.5, and female life expectancy has increased by over 6 years, from 75.5 to 82.0. During this time, the gender gap has decreased by 2 years, from 6.4 to 4.4 (Figure 6). Healthy life expectancy – the number of years an individual might expect to live in good health – shows similar patterns to overall life expectancy.

1 Life expectancy is calculated using a 3-year rolling average. The year presented relates to the mid-point of the three years.

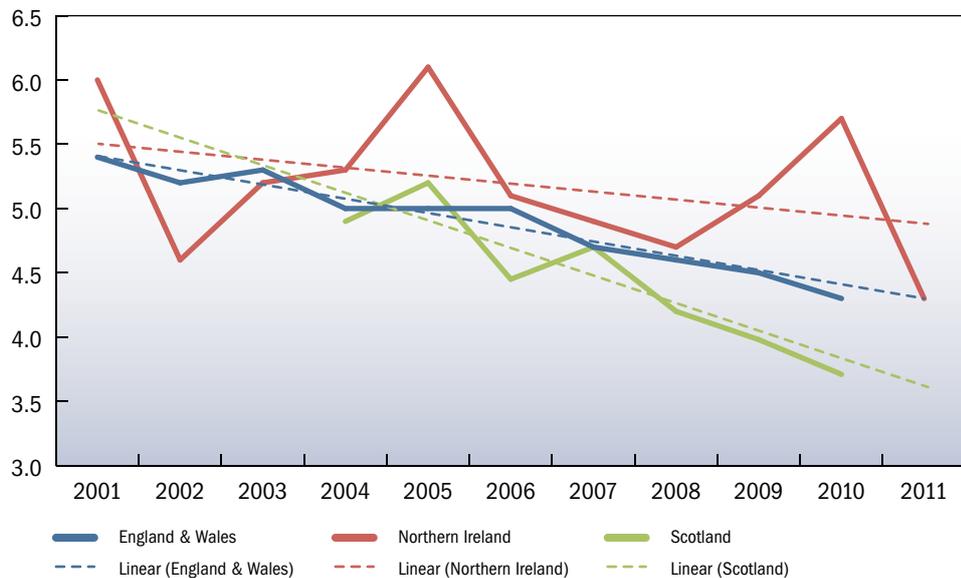


**Figure 6:** Life Expectancy for men and women in Northern Ireland 1980 – 2011



6. 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 rate than in the rest of the UK (Figure 7).

**Figure 7:** UK Infant Mortality Rates (2001-2011)

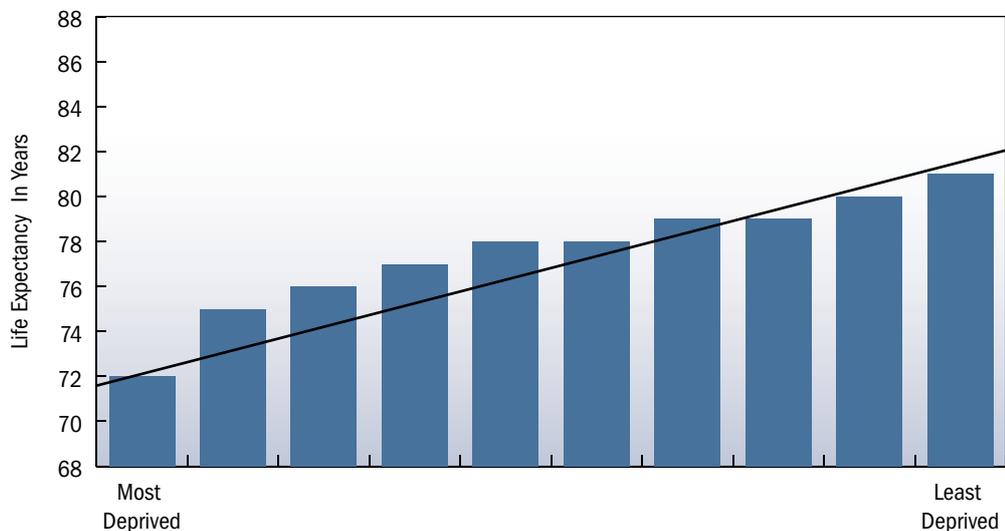




### Health Inequalities

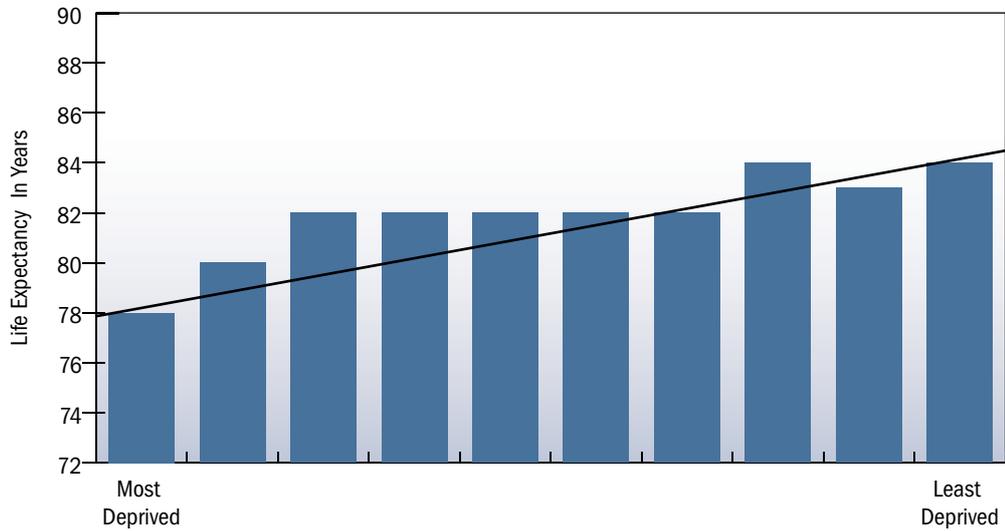
7. While there has been general improvement in health, not everyone has been able to avail fully of the benefits of this progress. Evidence shows that inequalities based on race, disability, age, religion or belief, gender, sexual orientation and gender identity can interact in complex ways with socioeconomic position in shaping people's health. Some vulnerable groups and communities, for example people with learning disabilities or travellers, have significantly poorer life expectancy than would be expected based on their socioeconomic status alone. For many of these groups poorer health outcomes are linked to wider social determinants such as access to education and employment.
8. Figures 8 and 9 show that the absolute gap in life expectancy in men between the 10% most and least deprived areas (2009/11) was 10.7 years, while the female life expectancy gap stood at 7.7 years.

**Figure 8:** Life Expectancy of men in Northern Ireland ranked by deprivation (2009-11)





**Figure 9:** Life Expectancy of women in Northern Ireland ranked by deprivation (2009/11)



**Figure 10:** Male Life Expectancy Deprivation Gap: Proportion of Contributing Causes (2008 - 10)

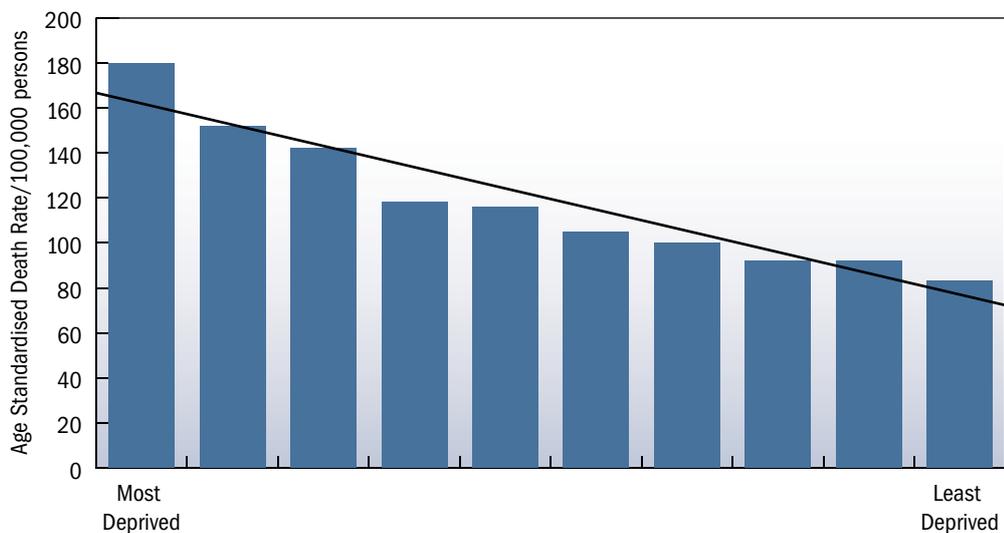


Figure 10 illustrates the decomposition analysis of the gap in life expectancy at 2008 – 10. The size of each sphere represents the proportion of the gap in life expectancy between deprived and non deprived areas attributable to each cause of death. Where appropriate, these causes are further broken down into sub-categories, the sum of which is equal to that cause. Causes contributing less than 0.01 years are not displayed.



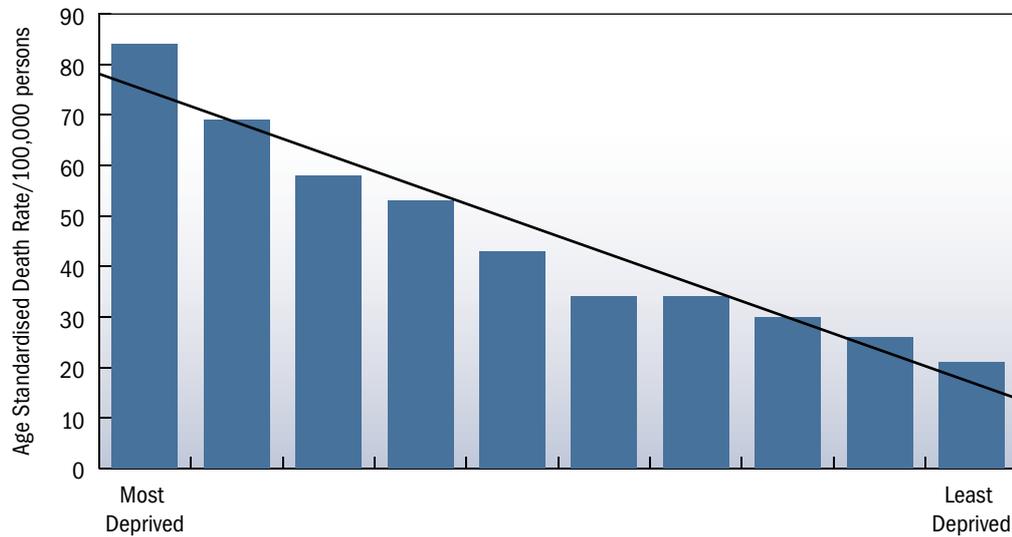
9. Male mortality rates for all overarching causes of death were higher in the 20% most deprived areas of Northern Ireland than in the 20% least deprived areas. In total, male life expectancy in deprived areas of Northern Ireland was 7.6 years less than in the least deprived areas. More than half of this gap is accountable to circulatory diseases and cancer, contributing 2.0 years and 1.8 years respectively. Coronary heart disease is responsible for over 65% of the circulatory disease gap, at 1.3 years. Other notable causes include suicide (0.9 years), respiratory disease (0.7 years), digestive diseases (0.7 years) and accidental deaths (0.6 years).
10. 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 11:** Death rates from Cancer in people under 75 years in Northern Ireland ranked by deprivation (2007/11)

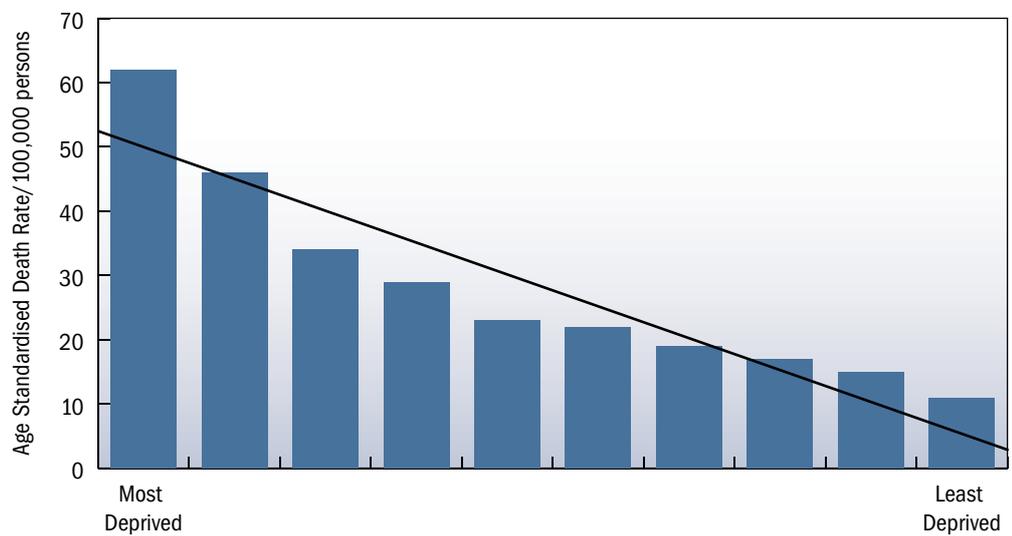




**Figure 12:** Death rates from Coronary Heart Disease in people under 75 years in Northern Ireland ranked by deprivation (2007-11)



**Figure 13:** Deaths rates from Respiratory Disease in people under 75 years in Northern Ireland ranked by deprivation (2007-11)



11. Figures 11, 12 and 13, shows there is a notable increase in death rates from cancer, CHD and respiratory disease as level of deprivation increases.



## **Mental Health**

12. Mental illness is one of the major causes of ill health and disability in Northern Ireland which has 25% higher overall prevalence compared to England. One in five adults in NI has a mental health condition at any one time. Mental ill health is more prevalent in areas of deprivation. 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.
13. Mental wellbeing is related to, but not the same as, the absence of mental illness. It is possible to have a diagnosed mental illness and still be coping well with life and enjoying a high level of wellbeing. Likewise, someone can have poor mental wellbeing but have no clinically identifiable mental illness. However, in populations where individuals have higher mental wellbeing, fewer people tend to develop mental illness. The Warwick-Edinburgh Mental Wellbeing Scale is a measure of the positive mental health of people over time and has been included in the annual NI Health Survey and, for the first time, in the Young Person's Behaviour and Attitudes Survey. Results from the 2010/2011 and 2011/12 surveys have provided a baseline for monitoring mental wellbeing trends over the coming years (see Annex B).
14. There were 289 deaths by suicide in NI in 2011. During 2009/2011 there was an average annual suicide rate of 16.1 deaths per 100,000 population. The suicide rate in males was 25.1 deaths per 100,000 population, and the suicide rate in females was 7.4 deaths per 100,000 population. During this period, the suicide rate in the 10% most deprived areas was almost five times that within the 10% least deprived areas. A similar picture emerges when examining self-harm admissions to hospital over the same period, with the rate in the 10% most deprived areas over five times that in the 10% least deprived areas.

## **Wider Determinants**

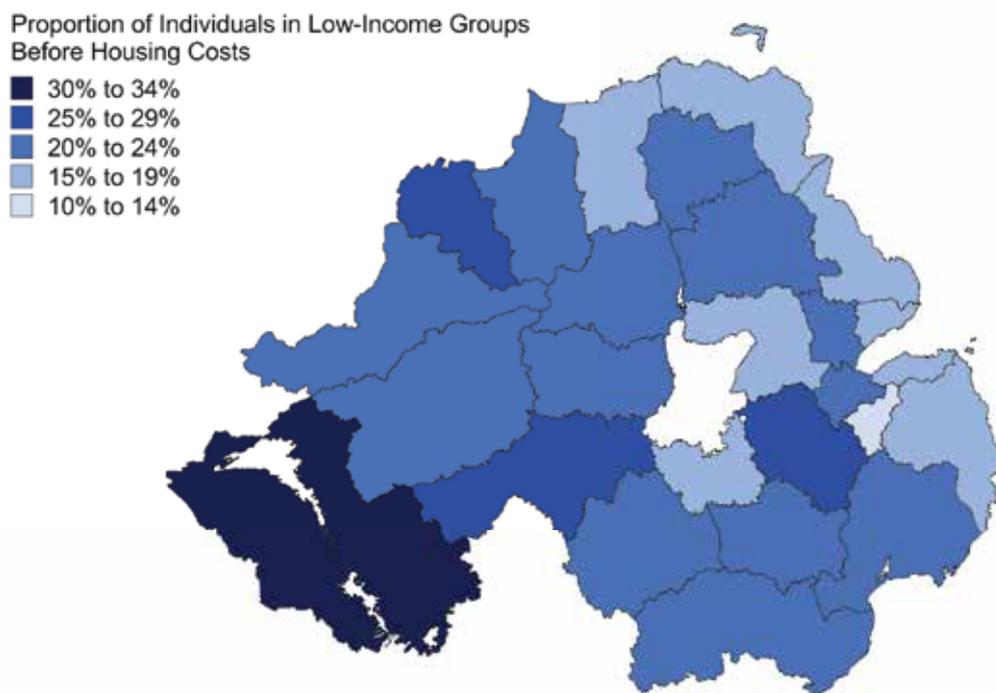
15. A wide range of socio-economic and environmental factors, such as poverty, neighbourhood deprivation, housing conditions, employment, education and physical environment, impact on the level of control people have in their lives and the choices they are in a position to make, and therefore on health and wellbeing and health inequalities.



16. Poverty is the greatest risk factor for health and wellbeing, affecting health in many ways, for instance, by creating barriers to buying nutritious food, heating one's home, or participating in activities and social interaction. People living in poverty are less likely to feel in control of their lives and more likely to face damaging stresses. They are also more likely to leave school with few or no qualifications.

**In 2011/12, the percentage of individuals in relative poverty (before housing costs) was 21%, broadly similar to that in 2002/03 (20%). The percentage of children in relative poverty in 2011/12 was 23%, compared with 25% in 2002/03.**

**Figure 14:** Percentage of individuals in relative poverty\* by Local Government District, 2009/10 -2011/12



\* Relative poverty is measured as having income of less than 60% of the UK median.

17. Education impacts on health in many ways – on self-esteem, social skills, training and employment opportunities and income. Inequalities in educational attainment are as stark as those in health and follow a similar social gradient, for example:

*In 2011/12, 67.9% of school leavers not entitled to free school meals achieved at least 5 GCSEs at A\*-C or equivalent including GCSE English and Maths, compared with 34.1% of school leavers entitled with free school meals.*



**“A strong positive relationship exists between education and health outcomes whether measured by death rates (mortality), illness (morbidity), health behaviours or health knowledge.”**

***IPH – Health impacts of education – a review 2008***

18. There is a clear link between employment and health. Unemployment has both short and long term effects on health, through lower self esteem, reduced social integration, anxiety and depression. Employment on the other hand is generally protective of health, however insecure work or adverse working conditions can impact negatively. Under-employment, where people are working part-time hours because they cannot find full time jobs, can place a strain on family finances and damage career prospects.

**The Northern Ireland economic inactivity rate decreased each year from 30.1% in 2009 to 27.6% in 2012.**

**Northern Ireland’s unemployment rate for 2011 was estimated at 7.3%, an increase of 0.2 percentage points from the figure for 2010 (7.1%) and an increase of 0.6 percentage points from the figure in 2009 (6.7%).**

**The long-term unemployment rate (1 year and over) increased from 37.6% in 2007 to 46.8% in 2012. During this time, the percentage of 16 to 24 year olds that were not in employment, full-time education or training increased from 15.6% to 22.1%.<sup>2</sup>**

19. Good quality, warm, secure housing is also vital to both mental and physical health, with the very young and very old most vulnerable to the impacts of fuel poverty.

**In 2011, more than two fifths (42.0%) of homes in Northern Ireland were in fuel poverty. During this time, 3.7% of Social Housing dwellings were classed as non-decent homes.**

**According to the Northern Ireland Housing Executive, as at 31st March 2013, the social housing waiting list amounts to 41,356 households, of whom around 22,414 are considered to be in housing stress, including 9,878 households deemed to be statutorily homeless.**



20. Physical surroundings – the quality of the built and natural environment - buildings, green spaces, roads and walkways - have a significant impact on health and wellbeing, for example, on mental health and levels of obesity. They can also influence social networks and sense of belonging. Wider environmental factors – air and water quality for example – are also important to health.

**Between 2007 and 2011, Northern Ireland air quality fluctuated slightly year on year but remains at a high standard.**

**During this time, Northern Ireland water quality improved year on year and is at a high standard in terms of compliance with regulations for drinking water standards (99.83%).**

21. Globalisation and increased movement between countries can impact on the rate and spread of disease or infection. The emergence of novel viruses and continuing risk attached to future occurrences of pandemic influenza necessitates that a state of readiness is maintained to minimise adverse impact to public health.
22. Antimicrobial resistance (AMR) is regarded by WHO as one of the top three global threats to human health. Antimicrobials are medicines used to treat infections caused by bacteria, viruses or fungi, and so comprise antibiotics, antivirals and antifungals. The organisms evolve and survive by developing resistance to the antimicrobials. When that happens antimicrobials are no longer effective; simple infections become untreatable, and many complex medical procedures that depend on antibiotic cover become impossible to perform.
23. Factors such as increased international travel, including medical treatment abroad, an ageing population who are moving between care in hospitals and the community, and the use of antimicrobials in veterinary medicine contribute to the rapid spread of resistant organisms between countries, throughout healthcare systems and between animals and humans.



### **Impact of the Past**

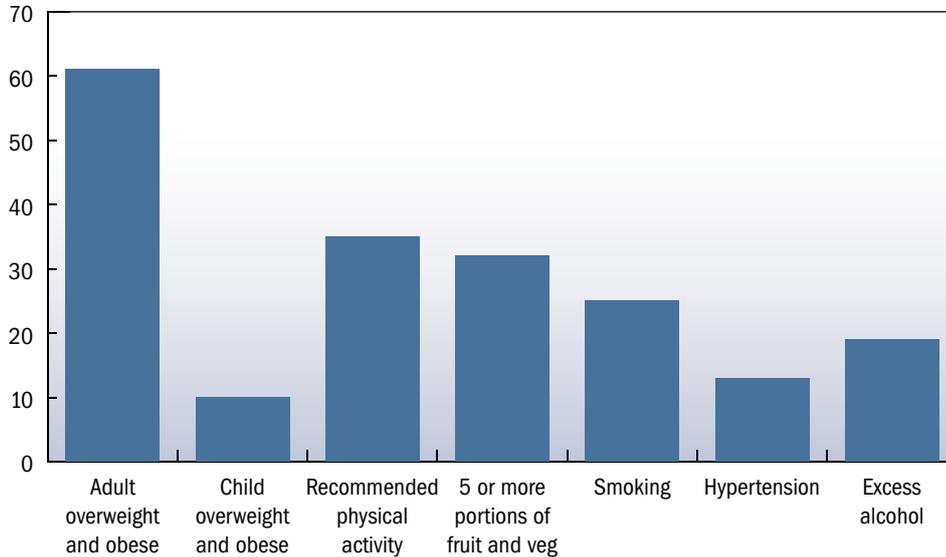
24. It is important to acknowledge that a particular challenge for the health and wellbeing of Northern Ireland society is the need to deal with the consequences of the past. A history of sectarianism, intolerance and violence has left a legacy of hurt and division, and physical and mental scars that must be addressed in building a better and healthier future.
25. The Childhood in Transition Report<sup>38</sup> points to a number of specific factors that influence the present day lives of young people as a result of their direct or indirect exposure to the past conflict and the sectarianism that continues to exist. The legacy of the conflict continues to impact on everyday lives - local research indicates that Northern Ireland has high levels of, (often untreated), Post Traumatic Stress Disorder as a result of the 'Troubles'. Use of anti-depressants has a higher prevalence amongst those living close to peace walls<sup>39</sup>, suggesting that people living in these areas have worse than expected mental health.
26. Society here has seen a number of significant milestones in achieving change and research demonstrates that there is strong desire across communities to continue working towards a more shared and positive future.<sup>40</sup>

### **Health Behaviours and Risk Factors**

27. A recently published study<sup>41</sup> reported that the three risk factors that account for the greatest disease burden in the United Kingdom are dietary risks, tobacco smoking, and high blood pressure. In 2010 the leading risk factor for both children under 5 and adults aged 15-49 years was tobacco smoking. Tobacco smoking as a risk factor for children is due to second-hand smoke exposure.



**Figure 15:** Health Behaviours and Risk Factors in Northern Ireland



\* 2011/12 Health Survey, Adult Drinking patterns survey 2011. Adult Drinking patterns survey 2011

1. Data for adults and children's weight, recommended physical activity, eating 5 or more portions of fruit and vegetables, smoking and excess alcohol relate to the Health Survey Northern Ireland 2011/12.
2. Data for hypertension come from the Quality and Outcomes Framework 2013.
3. 2011/12 Health Survey, Adult Drinking patterns survey 2011. Adult Drinking patterns survey 2011
4. In adults, a Body Mass Index of between 25 and 29.9kg/m<sup>2</sup> is considered overweight.
5. A Body Mass Index of 30kg/m<sup>2</sup> or above is considered obese.
6. 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.

28. The Health Survey Northern Ireland 2011/12 reported that a quarter of adults (aged 16 and above) smoked (27% males and 23% females). Similarly, almost a fifth (19%) of adults (aged 18 and above) stated that they drank in excess of the weekly recommended drinking limits. Over three-fifths (61%) of respondents were either overweight<sup>3</sup> (37%) or obese<sup>4</sup> (23%). A higher proportion of males were either obese or overweight (68%) than females (56%). A tenth of both boys and girls aged 2-15 years were also assessed as being obese.

Over a third (35%) of respondents were classified as meeting the recommended level of physical activity<sup>5</sup>, with males (40%) more likely than females (31%) to fulfil this. Similarly, almost one-third of respondents (32%) reported consuming the recommended 5 or more portions of fruit



and vegetables per day. Females (36%) were more likely to meet this recommendation than males (26%).

Figures from the 2013 Quality and Outcomes Framework (QOF) reported that there were 245,730 patients in NI with established hypertension which represented 13% of all GP registered patients.

### Clustering of risk factors

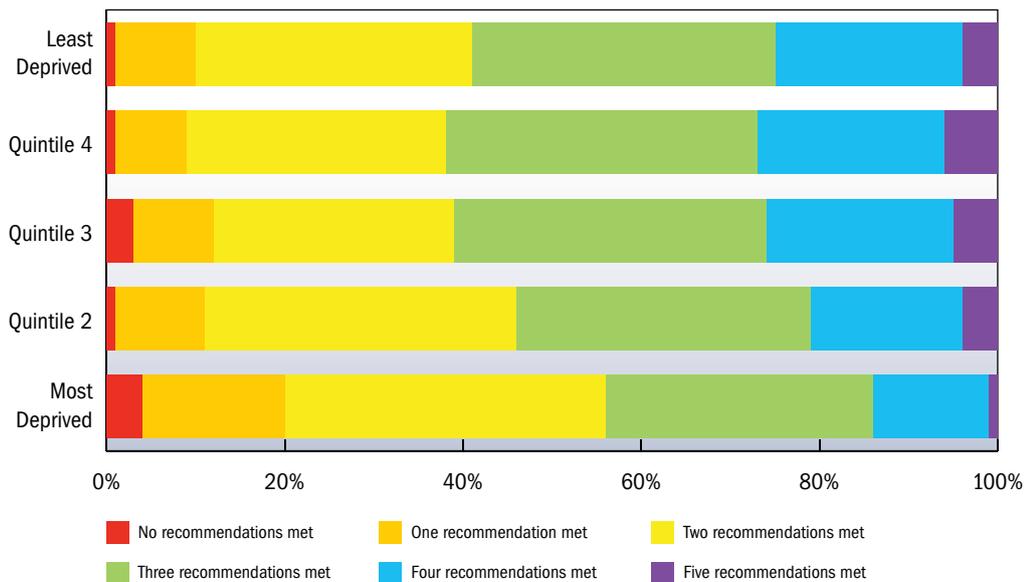
29. Much of the available information on health behaviours focuses on the prevalence of specific individual risk factors. While this provides a useful insight, often these risk factors occur alongside one another. Recent work by the *Kings' Fund: Clustering of unhealthy behaviours over time (2012)* which looked at the prevalence and co-distribution of risk factors associated with smoking, excessive use of alcohol, poor diet and low levels of physical activity, found for example that:
- a significant minority of people in western developed countries have three or more risk factors:
  - multiple risk factors are not randomly distributed across populations but are more common in some groups than others;
  - the overall proportion of the population engaging in three or more risk factors is declining, but mainly among those in higher socio-economic and educational groups; and
  - several studies have found a consistent socio-demographic gradient in the prevalence of multiple risk factors, with men, younger age groups and those in lower social classes and with lower levels of education being more likely to exhibit multiple lifestyle risks.
30. The Health Survey Northern Ireland 2010/11 looked at lifestyle choices based on five guidelines that can help individuals stay healthy or improve their health:
1. Ensuring alcohol intake is within weekly guidelines.
  2. Not being overweight or obese by maintaining a Body Mass Index (BMI) of less than 25 kg/m<sup>2</sup>.
  3. Eating at least five portions of fruit and vegetables a day.



- 4. Meeting the recommended weekly level of physical activity. In 2010/11 the guidelines recommended exercising for at least 30 minutes 5 days a week. This has since changed to 150 minutes per week.
- 5. Not smoking cigarettes.

As shown in Figure 13, just over half of respondents (57%) met three or more of the lifestyle choice recommendations (50% of males and 61% of females), while 2% did not meet any of the recommendations. However, respondents in more deprived areas were less likely to meet the lifestyle choice recommendations when compared with those in less deprived areas.

**Figure 16:** Number of lifestyle choice recommendations met by deprivation quintile in Northern Ireland



Health Survey NI 2010/11



### Further Information

31. Baselines for key indicators identified for monitoring progress, are at Annex B.

In addition, reports of the Health and Social Care Inequalities Monitoring System can be found at the link below:

**[http://www.dhsspsni.gov.uk/index/stats\\_research/stats-equality.htm](http://www.dhsspsni.gov.uk/index/stats_research/stats-equality.htm)**

### Notes

- It should be noted that figures included in this document may be subject to change in the future due to the revision of small area population estimates produced by the Northern Ireland Statistics and Research Agency (NISRA) and an update to the age standardisation model.



## **ANNEX B - KEY INDICATORS AND BASELINES**

A set of key high level indicators, to be monitored annually where possible, will help inform the monitoring process.

These include a small number of overarching indicators, and indicators which relate to each of the framework’s themes, as follows

<b>Key Overarching Indicators</b>					
<b>Indicator</b>	<b>Description</b>	<b>Baseline Period</b>	<b>Baseline</b>	<b>Source</b>	<b>Availability</b>
Life Expectancy	Differential between NI average and most disadvantaged areas for men and women.	2009 – 2011	In 2009-2011, the differential between the NI average and the 20% most deprived areas was 4.5 years for males and 2.8 years for females.	IAD (NI HSCIMS)	Annual (March)
	Healthy Life Expectancy between NI average and most disadvantaged areas for men and women.	2008/09 – 2010/11	Between 2008/09 and 2010/11, the differential between the NI average and the 20% most deprived areas was 7.2 years for both males and females.	IAD (NI HSCIMS)	Annual (March)
	Disability Free Life Expectancy between NI average and most disadvantaged areas for men and women.	2008/09 – 2010/11	Between 2008/09 and 2010/11, the differential between the NI average and the 20% most deprived areas was 5.4 years for males and 5.0 years for females.	IAD (NI HSCIMS)	Annual (March)
<b>1. Give Every Child the Best Start</b>					
<b>Indicator</b>	<b>Description</b>	<b>Baseline Period</b>	<b>Baseline</b>	<b>Source</b>	<b>Availability</b>
Infant Mortality	Number of children dying before their first birthday per 1,000 live births	2007 - 11	For the period 2007 to 2011, the infant mortality rate was 4.9 per 1000 live births, with a rate of 5.2 within the 20% most deprived areas.	IAD (NI HSCIMS)	Annual (December)



<b>1. Give Every Child the Best Start - continued</b>					
<b>Indicator</b>	<b>Description</b>	<b>Baseline Period</b>	<b>Baseline</b>	<b>Source</b>	<b>Availability</b>
Smoking During Pregnancy	Proportion of mothers smoking during pregnancy in NI and the most disadvantaged areas	2012	In 2012, 16.5% of expectant mothers in Northern Ireland smoked during their pregnancy, with a rate of 29.6% within the 20% most deprived areas.	IAD (NI HSCIMS)	Annual (March)
Breastfeeding	Proportion of mothers breastfeeding on discharge and differential between NI average and most deprived.	2012	In 2012, 42.3% of mothers discharged were breastfeeding, including those partially breastfeeding and those breastfeeding only. The differential between the NI average and the 20% most deprived areas was 14.6 percentage points.	IAD (NI HSCIMS)	Annual (March)
Educational Attainment	Proportion of primary pupils achieving at the expected levels in Key Stage Two assessment in Communication and Using Mathematics	2012/13	<p>In 2012/13:</p> <ul style="list-style-type: none"> <li>- 77.1% of pupils achieved at or above the expected level in Communication at KS2 in 2012/13</li> <li>- 78.5% of pupils achieved at or above the expected level in Using Maths at KS2 in 2012/13</li> </ul> <p>NOTE: 2012/13 data are based on the new Levels of Progression; these results are not directly comparable with Key Stage Assessment outcomes from previous years. The Department of Education also recognises that these new arrangements will need time to embed and has recommended caution in analysing data and benchmarking performance from the first year's implementation.</p>	DE (CCEA)	Annual (December)



**1. Give Every Child the Best Start - continued**

Indicator	Description	Baseline Period	Baseline	Source	Availability
Educational Attainment	Proportion of school leavers achieving at least 5 GCSEs at A*-C or equivalent, including GCSE English and Maths.	2011/12	In 2011/12, 62.0% of school leavers achieved at least 5 GCSEs at A*-C or equivalent, including GCSE English and Maths. The differential between the NI average and the 10% most deprived areas was 21.9 percentage points.	DE (NI School Leavers Survey)	Annual (May)

**2. Equipped throughout Life**

Indicator	Description	Baseline Period	Baseline	Source	Availability
Unemployment	Long Term Unemployment Rate: proportion of unemployed that have been unemployed for one year or longer.	2012	The long-term unemployment rate in 2012 was 46.8%.	DFP (Labour Force Survey)	Annual (October)
	Proportion of 16 to 24 year olds who are not in employment, full time education or training (NEETS).	2012	In 2012, 22.1% of 16 to 24 year olds were not in employment, full time education or training.	DFP (Labour Force Survey)	Annual (October)

**3. Empowering Healthy Living**

Indicator	Description	Baseline Period	Baseline	Source	Availability
Smoking	Proportion of adults (aged 18 and over) who smoke and proportion in the most deprived areas	2011/12	In 2011/12, of those surveyed in Northern Ireland, 25% were smokers, with a proportion of 39% in the 20% most deprived areas	IAD (Health Survey)	Annual (March)
Alcohol-related Admissions	Standardised rate for alcohol-related admissions in NI and the most disadvantaged areas	2009/10 – 2011/12	For the period 2009/10 to 2011/12, the standard rate for alcohol-related admissions was 618 per 100,000 of the population, with a rate of 1,413 within the 20% most deprived areas.	IAD (NI HSCIMS)	Annual (March)



**3. Empowering Healthy Living - continued**

Indicator	Description	Baseline Period	Baseline	Source	Availability
Adults who drink above sensible drinking guidelines	Proportion of adults who drink above the sensible drinking guidelines suggested, and proportion in the most disadvantaged areas.	2011/12	In 2011/12, of those adults surveyed in Northern Ireland, 19% drink above the sensible drinking guidelines suggested, with a proportion of 24% in the 20% most deprived areas.	IAD (Health Survey)	Annual (March)
Teenage Births	The teenage birth rate for mothers under the age of 17 – NI and most deprived areas	2011	In 2011, the teenage birth rate for mothers under the age of 17 was 2.2 per 1,000 females, with a rate of 4.6 per 1,000 females within the 20% most deprived areas.	IAD (NI HSCIMS)	Annual (March)
Adult Obesity	Percentage of adults surveyed classified as obese, and proportion in the most disadvantaged areas.	2011/12	In 2011/12, of those adults surveyed in Northern Ireland, 23% were classified as obese, with a proportion of 25% in the 20% most deprived areas.	IAD (Health Survey)	Annual (March)
Childhood Obesity	Percentage of children surveyed classified as obese.	2011/12	In 2011/12, of those children surveyed in Northern Ireland, 10% were classified as obese.	IAD (Health Survey)	Annual (March)
Mental Health and wellbeing	Mean Warwick-Edinburgh Mental Wellbeing Scale by deprivation quintile	2011/12	The 2011/12 Health Survey results indicate a mean score of 50:  Quintile 1 (most deprived) – 48 Quintile 2 – 50 Quintile 3 – 51 Quintile 4 – 51 Quintile 5 – 52	IAD (Health Survey)	Annual (March)*
Suicide	Crude suicide Rate in NI and the most disadvantaged areas	2009 – 11	For the period 2009-11, the crude suicide rate in Northern Ireland was 16.1 suicides per 100,000 of the population, with a rate of 30.1 within the 20% most deprived areas.	IAD (NI HSCIMS)	Annual (March)



**3. Empowering Healthy Living - continued**

Indicator	Description	Baseline Period	Baseline	Source	Availability
Blood Pressure/ Hypertension	Number of patients with established hypertension and % of GP registered patients with established hypertension	2013	Figures from the 2013 QOF reported that there were 245,730 patients in NI with established hypertension which represented 13% of all GP registered patients.	IAD (QOF)	Annual (April)
Long term conditions	Number of people with one or more long term condition attending structured patient education/self management programmes	2011/12	An audit of structured patient education/ self management programmes showed that in 2011/12 there were 10,189 attendances at structured patient education/self management programmes in Northern Ireland	IAD (QOF)	Annual (June)

**4. Creating the Conditions**

Indicator	Description	Baseline Period	Baseline	Source	Availability
Investment in public health	Amount invested in public health.	2011/12	In 2011/12, the PHA Resource outturn was £77.2 million.	PHA Annual Audited Accounts	Annual (June)
Poverty	Percentage of individuals in low-income groups before housing costs	2009/10 - 2011/12	For the period 2009/10 -2011/12, 21% of the population were in relative poverty (Before Housing Costs).	DSD (Households Below Average Income Report)	Annual (February)
Child Poverty	Percentage of children in low-income groups before housing costs.	2009/10 - 2011/12	For the period 2009/10 -2011/12, 23% of children were in relative poverty (Before Housing Costs).	DSD (Households Below Average Income Report)	Annual (February)



<b>4. Creating the Conditions - continued</b>					
<b>Indicator</b>	<b>Description</b>	<b>Baseline Period</b>	<b>Baseline</b>	<b>Source</b>	<b>Availability</b>
Economic Inactivity	Economic Inactivity Rate: proportion of the working-age population that is not in the labour force.	2012	In 2012, the economic inactivity rate in Northern Ireland was 27.6%.	DFP ( <i>Labour Force Survey</i> )	Annual (October)
Housing Standards	Proportion of social housing dwellings classified as non decent homes.	2011	In 2011, the Non Decency Rate of Social Housing Dwellings was 3.7%.	DSD ( <i>House Condition Survey</i> )	3 Years
Air Quality	Annual mean concentration level of Nitrogen Dioxide at urban background sites and urban roadside sites.	2011	In 2011, the annual mean concentration level of Nitrogen Dioxide was 22.0 µg/m <sup>3</sup> at urban background sites and 35.2 µg/m <sup>3</sup> at urban roadside sites.	DOE (Nitrogen Dioxide Survey)	Annual (February)
	Annual mean concentration level of particulate matter (PM 10).	2011	In 2011, the annual urban background sites mean concentration level of particulate matter was 21.3 µg/m <sup>3</sup> .	DOE (Particulate Matter Survey)	Annual (February)
	Annual mean concentration level of Benzo(a) pyrene at monitored sites.	2011	In 2011, the annual mean concentration level of Benzo(a)pyrene was 0.86 ng/m <sup>3</sup> at Lisburn Dunmurry High School, 0.95 ng/m <sup>3</sup> at Derry Brandywell, and 1.12 ng/m <sup>3</sup> at Ballymena Ballykeel.	DOE (Benzo(a) pyrene Survey)	Annual (February)
	Annual number of ozone breaches (days) at monitored sites.	2011	In 2011, there were 4 ozone breach days at Belfast site, 12 at Lough Navar and 9 at Derry.	DOE (Nitrogen Dioxide Survey)	Annual (February)



**4. Creating the Conditions - continued**

Indicator	Description	Baseline Period	Baseline	Source	Availability
Water Quality	Annual percentage compliance of Water Utility Sector Waste Water Treatment Works.	2011	In 2011, the overall Water Utility Sector WWTW had a 93% compliance with numeric standards.	DOE (WWTW Survey)	Annual (February)
	Annual percentage mean zonal compliance of drinking water quality	2011	In 2011, the mean zonal compliance with Northern Ireland water regulations drinking water standards was 99.83%.	DOE (Drinking Water Quality Survey)	Annual (February)

**5. Empowering Communities**

Indicator	Description	Baseline Period	Baseline	Source	Availability
Social Capital	Proportion of respondents having volunteered in the past year	2012	29% of respondents to the 2013 NI Omnibus Survey stated that they had volunteered in the past year.	DSD (NI Omnibus Survey 2013)	Annual (February)
Road Collisions	Number Killed or Seriously Injured (KSI) casualty numbers per capita	2012	In 2012, there were 843 casualties (killed or seriously injured) as a result of road traffic collisions in Northern Ireland.	PSNI (PSNI Collision Report Form)	Annual (March)

**Notes**

- It should be noted that figures included in this document may be subject to change in the future due to the revision of small area population estimates produced by the Northern Ireland Statistics and Research Agency (NISRA) and an update to the age standardisation model.
- Health Survey runs annually though topics may not be included every year.



## **ANNEX C - GLOSSARY**

<b>ADOG</b>	All Departments Officials Group
<b>AMR</b>	Antimicrobial Resistance
<b>BMI</b>	Body Mass Index
<b>BSP</b>	Belfast Strategic Partnership
<b>CAUSE</b>	Regional charity run by carers for carers
<b>CAWT</b>	Co-operation and Working Together
<b>CCEA</b>	Council for the Curriculum Examinations and Assessment
<b>CENI</b>	Community Evaluation Northern Ireland
<b>CFC</b>	Community Food Centres
<b>CFI</b>	Community Food Initiatives
<b>CFM</b>	Community Food Members
<b>CHD</b>	Coronary Heart Disease
<b>CMP</b>	Condition Management Programme
<b>DARD</b>	Department of Agriculture and Rural Development
<b>DCAL</b>	Department of Culture, Arts and Leisure
<b>DE</b>	Department of Education
<b>DEL</b>	Department for Employment and Learning
<b>DETI</b>	Department of Enterprise, Trade and Investment
<b>DFP</b>	Department of Finance and Personnel
<b>DHSSPS</b>	Department of Health, Social Services and Public Safety
<b>DIY</b>	Do It Yourself
<b>DNE</b>	Dublin North East
<b>DOE</b>	Department of the Environment
<b>DOH</b>	Department of Health
<b>DRD</b>	Department for Regional Development
<b>DSC</b>	Delivering Social Change
<b>DSD</b>	Department for Social Development
<b>END</b>	Environment Noise Directive
<b>EU</b>	European Union
<b>FASA</b>	Forum for Action on Substance Abuse and Suicide Awareness
<b>FE</b>	Further Education
<b>FEC</b>	Further Education College
<b>FUEL</b>	Youth Organisation, Enniskillen
<b>GCSE</b>	General Certificate of Secondary Education
<b>GP</b>	General Practitioner
<b>HEI</b>	Higher Education Institution
<b>HCHF</b>	Healthy Child Healthy Future
<b>HGV</b>	Heavy Goods Vehicle
<b>HIA</b>	Health Impact Assessment
<b>HiAP</b>	Health in All Policies
<b>HMO</b>	Houses in Multiple Occupation
<b>HSC</b>	Health and Social Care



<b>HSCB</b>	Health and Social Care Board
<b>HSCT</b>	Health and Social Care Trust
<b>HSE</b>	Health and Safety Executive
<b>ICT</b>	Information and computer technology
<b>IDeA</b>	Improvement and Development Agency
<b>INTERREG</b>	an initiative that aims to stimulate cooperation between regions in the European Union
<b>IPH</b>	Institute of Public Health in Ireland
<b>JCVI</b>	Joint Committee on Vaccination and Immunisation
<b>LCG</b>	Local Commissioning Group
<b>LGBT</b>	Lesbian, Gay, Bisexual and Trans-gender
<b>LGD</b>	Local Government District
<b>MARA</b>	Maximising Access (to services, grants and benefits) in Rural Areas
<b>NEETS</b>	Young People not in education, employment or training
<b>NHS</b>	National Health Service
<b>NI HSCIMS</b>	Northern Ireland Health and Social Care Inequalities Monitoring System
<b>NIHE</b>	Northern Ireland Housing Executive
<b>NINIS</b>	Northern Ireland Neighbourhood Information System
<b>NISRA</b>	Northern Ireland Statistics and Research Agency
<b>NUS-USI</b>	National Union of Students-Union of Students of Ireland
<b>OFMdFM</b>	Office of the First Minister and deputy First Minister
<b>PARC</b>	Physical Activity and Rejuvenation of Connswater
<b>PCC</b>	Patient Client Council
<b>PCSP</b>	Policing and Community Safety Partnerships
<b>PEACE III EU</b>	Programme for Peace and Reconciliation in NI and the border region of Ireland, 2007 - 2013
<b>PFG</b>	Programme for Government
<b>PHA</b>	Public Health Agency
<b>PHE</b>	Public Health England
<b>PHORCaST</b>	Public Health Online Resource for Careers, Skills and Training
<b>PHSCF</b>	Public Health Skills and Careers Framework
<b>PPS</b>	Planning Policy Statement
<b>PSNI</b>	Police Service of Northern Ireland
<b>QOF</b>	Quality and Outcomes Framework
<b>REACT</b>	Family Support Services, Banbridge
<b>ROI</b>	Republic of Ireland
<b>SEELB</b>	South Eastern Education and Library Board
<b>SOA</b>	Super Output Areas
<b>SSA</b>	Social Security Agency
<b>SUDS</b>	Sustainable Drainage System
<b>TYC</b>	Transforming Your Care
<b>UKPHR</b>	United Kingdom Public Health Registry



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<b>UNCRC</b>	United Nations Convention on the Rights of the Child
<b>VCS</b>	Voluntary and Community Sector
<b>VCU</b>	Voluntary and Community Unit
<b>WHO</b>	World Health Organisation
<b>WWTW</b>	Waste Water Treatment Works
<b>YMCA</b>	Young Men's Christian Association



## ANNEX D - BIBLIOGRAPHY / REFERENCES

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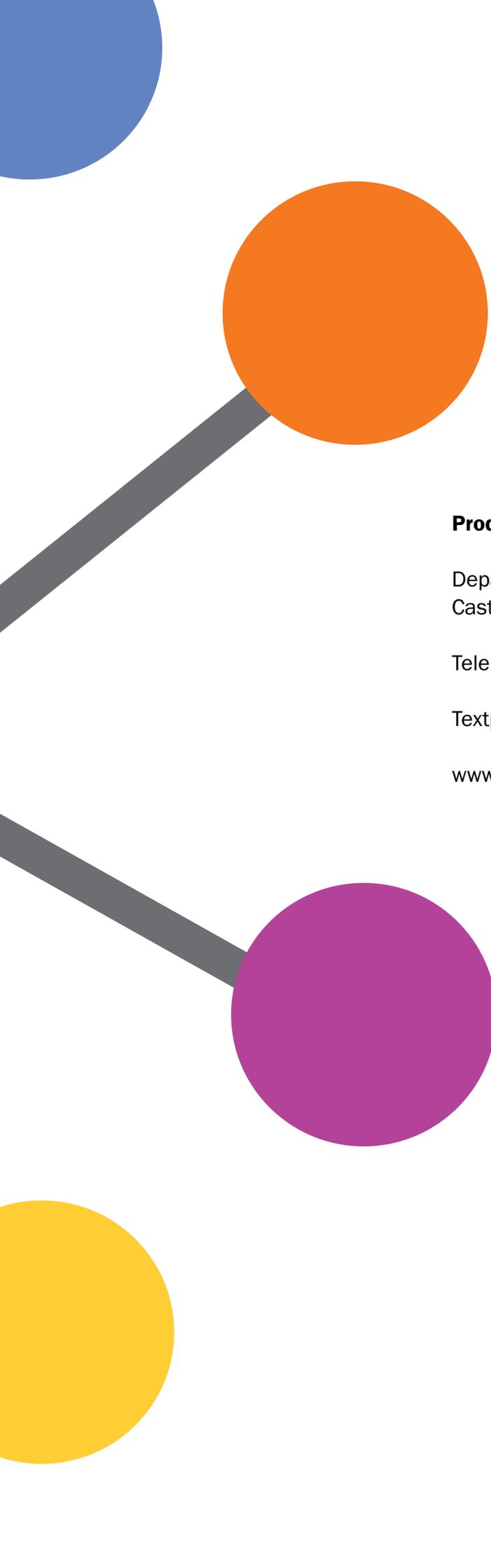
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