Northern Ireland Assembly

Committee for Health, Social Services and Public Safety

OFFICIAL REPORT (Hansard)

Health Inequalities

4 July 2012

NORTHERN IRELAND ASSEMBLY

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Members present for all or part of the proceedings:
Ms Sue Ramsey (Chairperson)
Ms Paula Bradley
Ms Pam Brown
Mr Gordon Dunne
Mr Samuel Gardiner
Mr John McCallister
Mr Kieran McCarthy

Witnesses:

Dr Michael McBride	Department of Health, Social Services and Public Safety
Dr Carolyn Harper	Public Health Agency
Dr Eddie Rooney	Public Health Agency

The Chairperson: I welcome Michael, Eddie and Carolyn. You have presented us with paperwork; thank you for that. Please make your presentation, and we will open the meeting to questions and comments by members. Thank you for attending.

Dr Michael McBride (Department of Health, Social Services and Public Safety): Thank you for the invitation. It is very timely, given that we plan to move forward with the consultation on the new public health framework Fit and Well: Changing Lives, subject to its being on the agenda for tomorrow's Executive meeting. I have handed round some bullet points to aid the discussion of points that I want to highlight by way of introduction. Then, as we progress, the best course of action is to open it up to questions and answers, in relation to either the consultation on the new framework or on any specific actions that are taken forward. It is being led by the Public Health Agency.

As to the overall context of the public health challenge that we face, it is fair to say that although general health has been improving as measured by a range of indicators, the rate of improvement is not equal and is not the same for everyone. That is starkly pointed out in both the material forwarded by colleagues in the Public Health Agency, in the agency's annual report, and in the evidence and information in the draft consultation document.

Health outcomes are worse in the most deprived areas of Northern Ireland than in the region generally, and there continue to be large differences across different measures: rates of life expectancy, drug- and alcohol-related mortality, suicide, teenage pregnancy, smoking during pregnancy, respiratory mortality or cancer mortality. Those inequalities exist.

The Committee is familiar with 2002's 'Investing for Health', which was the Executive's key strategy for tackling health inequalities. Our strategic review of it was published recently . It affirmed that much of

the strategy's approach remains relevant but that a new strategic direction is required. The new draft framework, Fit and Well: Changing Lives, has been informed by the review of Investing for Health; by examining international and national evidence, particularly the Marmot report, 'Fair Society Healthy Lives'; and by a growing body of evidence on early years. That work, and indeed the framework, has been informed by the work of the Public Health Agency over the past three years.

It incorporates the following features: it is firmly based on the values of 'Investing for Health'; it is strategic, in that it is high-level; it focuses primarily on cross-government elements to ensure integration and cohesiveness across government in addressing the wider social determinants on which it remains focused; and it continues to emphasise health inequalities but is mindful that there is a social gradient across society. Some of the new elements are the proposed life-course approach, which is supported by a growing body of evidence, the key priorities, which I will come to; and its proposed outcome focus.

It is, as I say, a strategic, overarching framework. It brings together a strategic direction and seeks to link and reinforce relevant government policy and strategy, much of which is being undertaken at present as those policies relate to some of the wider determinants of health. Now the challenge, and the challenge for all governments, is to align that with other policy developments. For example, Delivering Social Change is a key policy area that is being developed, and we need to ensure that the new public health framework Fit and Well: Changing Lives fully aligns with it. We have been working closely with other Department over the past year, and we have had very positive engagement from all other Departments in the development of that.

The next slide sets out the key approach that we are taking to the new framework. It is built on the life-course approach: pre-birth to early years; children and young people; early adulthood; adults; and later years. The two underpinning themes — sustainable communities and building health public policy — are entirely cross-cutting and independent of the life-course approach. The reason and rationale for that is to recognise the fact that biological factors, developmental and other experiences set individuals on trajectories that influence health and well-being and competency over their life course. As people move from each of those key transitions, there can be opportunity to intervene and to move people into a more or less disadvantaged path. We also need to bear in mind that the people who have been disadvantaged in the past, particularly those who have been disadvantaged in early years, are at greater risk of remaining disadvantaged in later years. Those disadvantaged in later life tend to come from families that have been disadvantaged in early life, and those are often transgenerational.

A population level of framework emphasises the importance of developing people's potential and coping skills and the importance of creating and supporting environments that support and promote health. It underpins and acknowledges the influence of the communities to which people belong and the importance of engaging. Actively promoting and maintaining sustainable communities is a key strategy for tackling the issues.

I will not go through the detail of the third slide; however, key policy objectives are outlined for each age range. As you will see from the material from the Public Health Agency, it is already taking forward work in many of those areas, including early years.

The next slide shows the strategic priorities. Although we are taking this forward at a population level, it is important that we continue to address some key strategic priorities. An overwhelming body of evidence shows that approaches in early years and addressing the issues that determine children's changes are an important opportunity to intervene. It is vital that children be given the best possible start in life in order to break the cycle of disadvantage, which, as I have said, correlates to poor outcomes throughout life and across generations.

We have also identified a strategic priority: supporting vulnerable people and communities. You will see that a range of vulnerable people and communities has been identified in the consultation document. It is not an exhaustive list, and we need to bear in mind that there will be geographical variation, and the needs of particular groups may be greater or lesser: for example, ethnic minorities may be concentrated in particular geographies. Local commissioners and partnership arrangements will identify and address those specific needs.

In the slide headed "Implementation — Whole Systems Approach", we have given the range of factors that influence health and well-being, and partnership working remains absolutely key to that. That is informed by the review of Investing for Health, and we describe in the consultation document what we

refer to as a whole systems approach to ensure that there is more coherence across government, regional and local levels.

The slide below indicates priority areas for collaboration, although those are at the formative stage. It is work that has been identified from which there would truly be benefits that would cut across life stages and promote intergenerational activity. In many of the areas, it reinforces the work of several Departments. We are putting that forward in the consultation document to seek views.

The final slide shows the approach that has been taken in Queensland, Australia. We have looked extensively at the international evidence. The information provided neatly summarises the complexity of taking forward a whole systems approach, which we have discussed here previously. There are complexities and clear interdependencies involved in addressing health and health inequalities. Through the consultation and taking the new framework to the next stage, we hope to develop a similar localised model, bespoke for Northern Ireland.

Finally, we have had positive engagement from all Departments across government on informing the development of this. As I said, the Minister has had constructive bilateral meetings with all Ministers on the development of the new framework, Fit and Well. We hope that, subject to any final considerations, this will be on the Executive's agenda tomorrow, with a view to going to consultation over the summer. We are mindful that it is the summer, so we will have an extended consultation. I am happy to discuss with you our plans to ensure that we make that a fully engaged consultation, with key stakeholders involved.

I will pause there.

The Chairperson: Thank you — I was going to call you Andrew.

Dr McBride: I am the better-looking one.

The Chairperson: You are the better-looking one. I hope that Andrew is not listening.

Mr Gardiner: You have made his day.

The Chairperson: Michael, are you saying that it is on the agenda for the Executive tomorrow? I heard you say, hopefully, hopefully, hopefully.

Dr McBride: We have set ourselves a very challenging time frame on this. We started from a standing start last July, when the Minister wrote to Executive colleagues seeking their endorsement to develop the new framework. His intention was communicated to the Health Committee at that time. We secured agreement at the ministerial group on public health in September. We have been working flat out with, at the Department's level, key stakeholders from the statutory sector, the voluntary and community sector and other Departments to develop that in the interim.

The Chairperson: Is it on the agenda for the Executive tomorrow?

Dr McBride: I do not anticipate there being any substantive changes from Departments, but we have not had final agreement. I understand that there is an extensive agenda for the Executive tomorrow, as you can imagine, given that it is the last meeting before recess. I remain hopeful and optimistic.

The Chairperson: Will you let us know where that sits?

Dr McBride: Yes.

The Chairperson: We are going into summer, and there will need to be a lengthy consultation exercise. However, if it is not on the agenda, it will be put back for a while. It would be useful to find that out.

Let us move on to the specifics. I am very supportive of the Public Health Agency and its work; it was during my time on the previous Committee, and I know the arguments that were made then. I have seen some of its work, especially in my own constituency. Nevertheless, on one level, there needs to be a change of mindset in some professional organisations. That is starting to happen. Without going into the detail — Eddie is aware of what I am talking about — I can see that starting to happen, tying in

with the community and voluntary sector. I do not want to come across as not supportive of the public health agenda, but I do have questions.

During the presentation from the Minister, John McCallister raised the issue of early intervention. If I am right, we are now just over 10 years into the Investing for Health strategy. In my constituency, and others, health inequalities, in the main, have not reduced. There are good programmes. I do not want to focus on my constituency, but the programmes in it are the ones that I know most about, although I am sure that there are similar programmes in other constituencies. When programmes seem to be working, the rug is pulled from under them. There were regional programmes around musical therapy, which did good work with adults with a disability, but they seem to have been pulled. There are breakfast club programmes, and we have had the argument about whether health or education should fund them. Sure Start is the same. We see the benefits of those programmes. Although there does not seem to be a decrease in health inequalities, such programmes stop them getting worse. I am not saying that the inequalities are not bad; they are.

There is an issue around integrated services for children and young people. As I am led to believe it, the question is: who funds that? Everyone agrees that the programmes are doing good work, but at your level we get into: "We know that you are doing good work, but you are not getting our money." It is as if fear were stopping anybody taking the lead.

We are talking about a public health agenda for which programmes have been introduced. I am not for one minute saying that that is not needed, but there is a split for me when we talk about, for example, bowel screening. Bowel screening is good for public health, but it is available generally and to everybody. I cannot see the strategy to tackle health inequalities outside the public health agenda. Good work is being done, but where is the strategy to target specific health inequalities? Additional focus is needed in all areas. In all areas, there are pockets of social deprivation and health inequalities. What is the overall budget of the Public Health Agency? How much of it is used to target programmes on health inequalities?

I have two other points, Michael. You mentioned the ministerial group and said that the Minister had spoken to other Ministers and that there had been a bilateral meeting. How often does the ministerial group meet, and when was its last meeting? In your presentation, what did you mean about the "social gradient"?

Dr McBride: I will pick up on those final issues, and Eddie and Carolyn will address the other specific issues. The ministerial group on public health has met regularly. The last meeting was in the past number of weeks to sign off and agree the revised and updated consultation document on the new public health strategy. In the past year, there have been regular and fully attended meetings of the ministerial group on public health. I can provide written confirmation of the dates of those meetings in due course.

The Chairperson: That is OK; I take your word for it.

Dr McBride: The support from departmental colleagues and other stakeholders has been significant. We ran a number of workshops to inform the development of the strategy.

You are absolutely right about the high-level commitment. Look at the international evidence in the WHO review of the social determinants of health; look at the Marmot review. The clear evidence is that, to address health inequalities, you need to do much more than just address poverty and income differential across society. It is about the distribution of other important issues; for example, where social power and political influence lie, as well as many other things. That is why the new framework needs to sit at the heart of government, and we have discussed here before the significance of seeing public health feature prominently in the Programme for Government.

The Programme for Government contains clear commitments to increase the percentage spend in the health budget on public health. There are other significant contributions where public health will inform some of the priorities 1, 2 and 3 in the Programme for Government. There are significant tie-ins with and links to the new economic framework. In work being taken forward by other Departments at policy level, we are seeing that the work on Investing for Health in 2002 has informed and supported how other Departments address the wider social determinants. In our work with DSD and in the Department of Education's work with the Department of Justice, we are seeing a much more cohesive approach across government to dealing with the wider issues.

The Chairperson: I do not doubt that. The commitment is there at Executive level, but everybody around this table would say that when it comes down to ground level, on programmes that would make a difference, it becomes a battle to get Departments to take a joined-up approach.

Dr McCormick: That is why I want to take it down a level and hand over to Eddie and Carolyn. Take, at random, say pages 65 and 66 of the consultation document. The policy aim, "Give every child the best start" identifies a 10-year outcome that we want to achieve. The key aspirational outcome is:

"Children have safe and supportive family living, play and learning environments".

That is what we have identified as an outcome in 2012-13. Therefore, in this Programme for Government period we have agreed with each Department what it will do and on what it will lead in order to support achieving that outcome in the short term, over the next three years of the Programme for Government period, which fully aligns with the budgetary period.

As you say, aspirations are all very well. However, unless we translate them into working collectively across government on the programmes and initiatives that we agreed would support and assist us in addressing the social determinants and unless we can agree priorities and evidence-based work programmes, we will miss a significant opportunity. We have had significant buy-in from Departments in identifying that. The consultation document shows that we have identified key partners.

The next stage is to translate it into the sort of approach that John asked me about the previous time I was here. In the current economic climate we do not have the resources to squander by duplicating effort. We need to target resources across government on interventions that work. If you take that down a level, what is being done by the Public Health Agency can be seen as the physical manifestation of that in some of the programmes that it is supporting.

Dr Eddie Rooney (Public Health Agency): I agree with where you started from. The agency was set up with the big task of improving the health and well-being of everybody and reducing health inequalities. We are seeing good progress on improved life expectancy and in coping with preventable illnesses. The issue causing us greatest concern is the gap in health outcomes between rich and poor. Although there are areas where the graph is heading in the right overall direction — in some it is narrowing and others widening — we are nowhere near the point of suggesting to the Committee that we have cracked this, know how to or that we are on the path to do so.

I have had the rare privilege of being in on just about every stage of this agenda as the policy has developed inside and outside the system. I was involved in the original Investing for Health and very heavily involved in the first days of the ministerial group on public health. At that time, we pretty much knew what the task was. We struggled with the "how" , particularly around how to harness and to realise a joined-up approach. I am probably more optimistic now than I have ever been that the debate has progressed. International work, such as the Marmot review, has given us the evidence base to show that, on a practical level, things can be done, and that, if the will is there, we can address some of the issues. They are not easy. Difficult as it is to deal with issues such as healthy choices, they are still more accessible than dealing with some of the crucial drivers, such as social determinants. Of those, the greatest is poverty.

Those issues are not easy for us, and we have so much more work to do to harness them. It is not a health issue by any means; it goes fundamentally into the nature of our society, how we put the health and well-being of our citizens at the top of the agenda and how we pool our efforts to do something about that. We are learning that game. It has been a long journey. We do not have it right by any means, but we are rigorously pursuing every ounce of experience and knowledge to start tackling the fundamental issues. As well as dealing with the service issues, we are working closely with the Department of Agriculture and Rural Development and others to deal with poverty. We have such a long way to go. I am more optimistic than ever before because refreshing this has put a bit more energy into the intersectoral agenda. This is the right time to do it, and there is a big prize at the end.

The Chairperson: I probably tortured you some years ago about where the Investing for Health strategy was. There seemed to be a blockage to its coming out, so I am happy that you are excited about it. The evidence needs to be there. What is your overall budget, Eddie? Is a percentage of it specifically to target health inequalities?

Dr Rooney: Our overall budget from the agency point of view is £81 million for this year. You have to remember our function: prevention, including the work on quality and safety in our services. We work closely with trusts on screening so that we get early intervention, detection and action. We deal with the healthy choices and the key issues of preventable disease, particularly around obesity, alcohol, drugs and mental health. Beyond that, we deal with fundamental issues around the social infrastructure and tackling social determinants as well as the link with citizens. We would happily give you a breakdown of the budget and show you in some detail where we put the money. The health improvement budget is approximately £30 million this year. The bulk will go into more than 600 voluntary and community sector groups that work on each of the areas and are defined by what their focus is, such as mental health, suicide prevention and right through all the other health choice issues.

The Chairperson: In case I forget, I commend you for the proactive approach that you took during the recent flooding. It was useful that all that information was released.

Dr Rooney: Thank you very much.

The Chairperson: I did not want to forget about that.

Dr Carolyn Harper (Public Health Agency): As well as in the health improvement world, the inequalities agenda is embedded in health protection and in the immunisation and screening programmes, for example, to make sure that the uptake rate for immunisation programmes is as good in deprived areas as it is in affluent ones. Similarly, it is to make sure that screening amongst migrant women, women with disabilities and so on is the same. All the teams are tasked with looking at that agenda. Equally, the inequalities agenda is written through each programme team, so it affects the commissioning with the board, what the board does with its £4 billion, and the commissioning of services in the commissioning plan. Whether acute, maternity or older people's services, each team has been asked to keep in mind the inequalities agenda to make sure that there is access to services for all groups.

Dr McBride: If the question is whether we are spending enough on public health, the answer, clearly, is no. That is why it is reassuring to see a commitment in the Programme for Government to the spend, with an increasing percentage of the health budget going on public health. With regard to who will be held to account, I have been asked by the Minister to be the senior responsible officer to be held to account by OFMDFM with regard to securing that increasing percentage of spend. A mechanism and an accountability process are in place to ensure that that happens. There is the evidence base of the effectiveness of that approach. Public health is extremely cost-effective: screening programmes, immunisation programmes for preventing ill health, the human cost, the economic cost and the cost to the health service are money well spent. We make very effective use of public health resources, and we will make very effective use of the increased expenditure that we have been tasked with directing to public health over the Programme for Government period.

The Chairperson: How does the social gradient fit in?

Dr McBride: The social gradient is about the gap that exists, and not necessarily just the gap between the rich and the poor. You will see it represented graphically in the consultation document. For each stage you go up the social gradient with regard to your being better off, your health outcomes, measured by life expectancy or a range of other health determinants, are better. It is right across the population; it is not just the extremes. There is the 12-year difference in life expectancy for men and the eight-year difference for women between the 10% most deprived compared to the 10% least deprived. You are talking about 12-year and eight-year differences for life expectancy, and it is not just at those extremes; it is right across the social gradient. As your social status and income improve, so will your life expectancy and general health. That is right across the spectrum. It is not just about addressing those at the extreme; it is taking a targeted approach right across the population, which the consultation and the new framework propose.

The Chairperson: I am conscious that other members want to ask questions. However, with regard to the budget, there is £81 million and £30 million is set aside for health improvement. Is that different from my idea of tackling health inequalities or does that health improvement go back to the point that I made earlier that introducing the screening programme will be beneficial to everybody, but it is not actually targeting health inequalities?

Dr Harper: Yes; our total spend on inequalities is greater than the £31 million that we spend specifically on health improvement. The health improvement programmes tend to be targeted at the health start in life and at lifestyle issues, such as smoking, obesity, alcohol, mental health and sexual health. There is the developing sustainable communities — getting people involved — and tackling social isolation agenda. There are also the employability and poverty schemes, such as fuel poverty, food poverty and so on. Such schemes tend to come from the health improvement budget. However, even in screening and health protection, we talk about an early best start to life. Our high immunisation rates for all children here give them the best start. We try to take that into account across all the programmes.

The Chairperson: I assume that you can answer this question, Michael: what was the Public Health Authority's involvement in the population plans at regional and local level?

Dr Harper: Perhaps I will take that. I go back to the work that we do with the board. Our staff — professional advisers, including health improvement and other staff — wrote a number of what we are calling commissioner specifications, where we are basically saying this is what we want to see in the population plans, setting the — standards is not quite the right word, but these are the main things that we want to see reflected in the population plans. Now that those plans have come back, the next stage for us, along with board colleagues, is to review the plans against what we said we expected to see. There are some challenging questions at this stage. It is recognised that more work needs to be done on the population plans. One of the tests for Transforming Your Care and the population plans is the extent to which we see an explicit shift of funding from the higher-cost services and settings and how we currently provide services to invest in the strategic programmes, such as parenting and early start programmes, and employability or other schemes — public health programmes — and equally into programmes to improve access to mental health services, for example. There are developments there that are sorely needed. Using that shift and transfer to realise such transformation is a test for TYC.

The Chairperson: The reason I am trying to tease that out is because after this I am going to propose to the Committee that we look at it in more depth. You talk about the health inequalities that are embedded in acute care and elderly care, and I accept that, but there are issues there. A lot of the health inequalities are related to areas of social need. Some of them are related to people from the elderly generation and some are related to children. I do not want to come across as flippant. I am teasing it out because I want to go somewhere with it, but, by saying that they are embedded, does that mean that, if there is a waiting list in the acute sector for hip replacements, people from socially deprived areas or migrant workers are prioritised, or is it a general list?

Dr Harper: On elective services, people are treated on clinical priority first — whichever case is most severe, regardless of background. That is right and proper. After that, people are treated in strict chronological order.

The Chairperson: Which is right, and I am not objecting to that, but it does not —

Dr Harper: So, in that sense, they are not prioritised. I think that what we need to get to is to have services whereby the waiting time essentially suits the patient and their family arrangements. To get to that point you have to have the same capacity in the service as demand, so if you get 100 referrals every week, you need to have the capacity to see 100 referrals every week. There are some specialties in which we know that there is a shortfall between demand and capacity and the board has been commissioning additional capacity from the independent sector, for example. That is where we need to get to, so that, regardless of who you are and where you are coming from, you get treatment much more quickly than we are able to deliver at the moment.

Dr McBride: I absolutely accept all of that, but then we are back to the wider prevention agenda. We have increasing levels of obesity and type 2 diabetes. The Minister has announced his intention to review diabetes, and I come from chairing the first meeting of that group today. If you look at the impacts on renal dialysis beds, we know that 50% of the renal dialysis capacity is devoted to managing people with diabetes and renal failure as a result of their diabetes. The approach should not be to keep building more renal dialysis beds. What we should be doing is beginning to address some of the underlying causes that we have discussed in terms of the challenges around increasing levels of physical activity, improving diet, reducing levels of obesity right across society and seeking to turn off what is driving the increased rates of type 2 diabetes.

The Chairperson: I think you can see where I am trying to go on this. We are not going to solve it today. We did not solve it in 10 years of Investing for Health.

Dr McBride: No.

The Chairperson: What I am trying to say is that there needs to be a specific focus on targeting health inequalities in parallel with the public health agenda. I am conscious that colleagues want to speak, so I will allow them to do that.

Dr McBride: I ask you to read the consultation document. It is in draft form and is subject to consideration and approval by the Executive. One of the key things that we are very keen to do is engage with the Committee to facilitate engagement with other Committees and MLAs during the consultation period. It is a very readable document. It has the evidence base around all the issues that you have just highlighted, the approach that we are seeking to take forward, and working with other Department is clearly articulated in that. The need to join it up with the Programme for Government and to see what other Departments are doing to translate that into co-ordinated action is there.

The Chairperson: I was very supportive of Investing for Health.

Dr McBride: The Committee's continuing support would be very welcome, particularly during the consultation period.

Mr Gardiner: Thank you for your presentation. How do you intend to support vulnerable people and communities?

Dr McBride: There are specific approaches for each of the life courses. The evidence, national and international, for the approaches to early years is irrefutable. We already know that there are effective evidence-based programmes. We know that some of those have already been progressed by the Public Health Agency. We talked before in the Committee about family nurse partnerships and new parenting programmes, and there is a range of other very good examples that are funded at present. Indeed, some of those are highlighted in the consultation document.

Mr Gardiner: Percentage wise, what would be your success rate?

Dr McBride: I can give you some local examples. We have the family nurse partnerships in several trust areas. One of the key measures for very young parents is the rates of breast feeding. Caroline, will you give some of the key successes.

Mr Gardiner: Are you referring to early years?

Dr Harper: Yes. The breast-feeding rate for teenage mums is about 35%, and for mums going through the programme it is at 50%. That is a significant improvement. There are many advantages, which are not just physical: there are the emotional and bonding relationship advantages that stand the child in good stead through later life.

We have introduced a one-stop shop for migrants.

Mr Gardiner: Where is that based?

Dr Harper: It is in the Belfast area, but we hope to extend it to other areas with a higher migrant population.

Mr Gardiner: When do you intend to introduce that?

Dr Harper: It is in place at the moment in Belfast.

Mr Gardiner: It is in Belfast, but where else throughout Northern Ireland?

Dr Harper: It depends on funding, and we are still working through the detail of our investments for 2012-13. However, if it is not in 2012-13, it will certainly be in 2013-14. We want to test and evaluate the model in Belfast first, learn from it, refine it if necessary and roll it out elsewhere.

Dr Rooney: We have been targeting to get programmes where we have evidence of the return. Those are being rigorously monitored. There are projects such as the family nurse partnership and empathy issues that are dealing with early years where the benefits internationally are very clear, not only in health benefits but right across from education and other key elements regarding social engagement. We have deliberately chosen programmes that have had rigorous evaluation in order to get a better handle on that. That is one of the challenges. We have to show that it works and be able to show the return. We realise that, and we realise that, at a time of pressure, it is not enough for us just to do things because they are good to do.

Mr Gardiner: That is why I asked the question, as it could be very difficult to police.

Dr McBride: You are absolutely right. I apologise for the fact that you do not have the document before you. It is not helpful for me to keep referring to it. With regard to early years, improved safeguarding outcomes for children is a key objective in the next three years for this Department and the HSC. We have agreed with colleagues in DSD about the neighbourhood renewal fund and are aligning that with neighbourhood action plans with regard to children having safe and supportive family living at their play and living environments, and the aims of the specific strategic priority are attached to that. Specific action has been agreed over the next three years involving the Department, the HSC, the service and other Departments on promoting positive parenting. We have agreed and discussed approaches with colleagues in the Department of Education and the Department of Justice. That is absolutely the point that, I think, the Chair made and you, again, made: how do we, across Departments, identify the evidence-based programmes that work, pool our resources and ensure that we have not only a common connectedness right across Departments but common delivery mechanisms at a regional and local level that work and deliver? The consultation document gives some examples of those mechanisms in policy approaches and, indeed, models on the ground, such as those that Carolyn referred to. Indeed, in the consultation, we are seeking views and other examples of that.

Similarly, again, a significant amount of work on sustainable communities has already been taken forward by other Departments. The consultation document has identified a number of key areas on which we are seeking views about how we can further build on the work that has already been implemented. I think that you will see in the consultation document that this is not just pie-in-the-sky stuff. It is about where the public health framework — Fit and Well: Changing Lives — can add real value and make practical differences.

Mr Gardiner: That is why I am asking the question. I want action on it, not just something printed and nothing done about it.

Dr McBride: This is not just another glossy document that signifies nothing and delivers nothing.

Mr Gardiner: As long as it is not, and I have your assurance on that.

The Chairperson: OK. For information, the Roots of Empathy programme that was mentioned in the last presentation I am well aware of, because I was at an event about it a number of weeks ago. Is that happening in all schools?

Dr Rooney: No.

Dr Harper: It involves 1,900 pupils in just under 90 schools; about 86 schools at the minute. The plan is to roll that out again in 2013-14 and 2014-15. I think that it goes back to your original question. You have examples of good practice at a local level or from international evidence, and what we want to do is roll them out strategically, systematically and at scale so that we start to see a difference. It is about taking a good idea and working it up at scale. Set a core direction and be consistent with that.

The Chairperson: Is the Department of Education funding any of that?

Dr Harper: Certainly, the education and library boards are represented on our implementation team. So they are —

The Chairperson: Do you fund it, or does the Department of Education play a part?

Dr Harper: We fund it at this stage.

Dr McBride: I just want to reassure you, getting to the point behind the question, that the Minister has had a number of bilaterals with Minister O'Dowd. Minister O'Dowd made, I believe, an important statement on early years yesterday. There has been ongoing engagement on the whole early years programme to ensure a completely integrated approach, involving not only the Department of Education and us but the Department of Justice, because it sees real benefits in terms of reducing offending rates.

The Chairperson: I see the benefits.

Dr McBride: I just want to reassure members. Eddie is an old hand at this. I am not; I have been working with government for six years. I detect a very fundamental and significant shift in how Departments are working right across to address these issues in a much more integrated way than, certainly, I have experienced in the past.

The Chairperson: I know that I am hogging most of this, but I am the Chair, so get over it; that is for Gordon's benefit. The reason why I asked is that I get a bit agitated when I go back a number of years and look at the Executive programme funds; that was supposed to be additional money to target specific programmes. However, with the wisdom of some of our senior civil servants, it was never additional money going into communities. Some Departments used it to fund programmes that they should have funded. Now, the Public Health Agency was set up to target and tackle health inequalities in public health. Is it being used to fund programmes that other Departments should be funding? That is something that we will probably look at in more detail. If it is the case, another Department is off the hook, and it is not additional money going into target areas.

Dr McBride: I accept that. Very briefly, I think that every single Department is currently funding policy areas and policy delivery on areas that improve the health of the population in Northern Ireland. You could argue that, in that those improve the health of the population and addresses the inequalities, we should, therefore, be funding the entirety of them. Whilst there is £81 million that has been specifically allocated to the Public Health Agency and taken forward on the programmes that Eddie and Carolyn outlined, there are other government policies and other Departments' policy areas: DSD policy; DOJ policy; Department of Education policy; some of the work that we talked about around people's emotional health and well-being, trying to address some of the issues and drivers in terms of mental health problems and rates of suicide in some deprived communities, which the Department of Education is leading on and we are working with it on that.

If you look at the consultation document, you will see the huge range of work, across a range of areas and across all Departments, addressing those social determinants. It goes back to my introductory comments: from 2002, Investing for Health has informed other Departments' approaches to those wider determinants.

Dr Rooney: I assure you, Chair, that, from the point of view of an implementation body, co-operation on the ground is greater now than I have ever seen. That is not to try to squeeze money out of each sector to cross-fund, but to pool resources together. That is happening in all areas, but particularly in Belfast, in relation to us, Belfast City Council and, indeed, the health and social care trust. We now co-locate and co-plan. We have common programmes. Between us, we are putting much more resource together and aligned simultaneously. We are starting to see the dividends of that. That is very much the drive. There will always be that space. From the Public Health Agency's point of view, we are meant to be pushing the boundaries. We are a research organisation, and a very large research organisation. We are meant to be putting that learning in. We will certainly invest in the areas that we think are genuinely groundbreaking, if only, to take Sam's earlier point, to prove that those things can make a difference. However, it will always be with the intent of making sure that we do get those mainstreamed. That is going to be the challenge.

I was around for the Executive programme funds as well. I did not say much about that in Committee. The issue there, for many involved, was that you took the pot and did your thing. That is the change. That is where this strategic framework is so important. It is really about us living the joined-up

element. It really does crank it up an extra gear for us. The framework has not been as evident and was not as strong in the past.

The Chairperson: Your enthusiasm settles me a bit.

Mr McCarthy: There is not much left to say.

It has been pointed out that some health inequality gaps have increased as improvements in health outcomes in deprived areas have occurred at slower rate, notably for respiratory and circulatory diseases, plus smoking, which you mentioned, Michael. Surely, that means that it is of the utmost importance that the Department and the HSCB recognise the need to do much more to reduce those particular health inequalities.

Under key points, the document lists health inequalities in the most deprived areas compared with Northern Ireland, and health inequalities in the most deprived areas compared with the least deprived areas. I note that drug- and alcohol-related illnesses and mortality are major issues in health inequalities. Can you give further details and comment on how you will be tackling those problems?

Dr McBride: Remind me of the first one again.

Mr McCarthy: It was about respiratory diseases and smoking.

Dr McBride: Carolyn can pick that up. Again, it is in the material that my Public Health Agency colleagues provided and, indeed, in the PHA's annual report, which Carolyn announced.

Look at the differential rates of smoking. We have made significant progress, from a population prevalence of smoking at 31% some years ago to a population average now of about 24%. That still means that 300,000 people in Northern Ireland smoke. The percentage for manual workers and unskilled manual workers is 31%. What do we do about that? The tobacco action plan, which we published last year, identified three priority areas: young people; pregnant women who smoke; and those in deprived areas. The Public Health Agency, through specifically targeted programmes and smoking cessation services, looked at a range of very innovative programmes to ensure access to such smoking cessation schemes, in the workplace, at taxi ranks etc, or available online. Maybe Carolyn can speak to that. The outworking of that is the differential rate in lung cancer. We have 2,300 avoidable deaths each year in Northern Ireland as a result of cancer. That is seven per day as a result of smoking, 48 a week, directly as a consequence of smoking. The burden of that impact is felt particularly acutely in areas that are most deprived and disadvantaged because of the differential rate in smoking. That is why the efforts of Public Health Agency colleagues and the programmes that they have in place are skewing towards addressing those target populations through screening and immunisation programmes, as Carolyn said earlier.

Dr Harper: You are right, that is an absolute priority. Smoking is thought to account for up to 50% of the life expectancy gap, so we have prioritised it. Additional funding has gone into it. We have three main elements to our approach. One is the public information campaigns. There is good evidence that sustained, repeated campaigns reduce smoking rates. The second element, as Michael mentioned, are the support services, targeting pregnant women through antenatal services, for example, as well as the groups Michael mentioned. The third element is enforcement of the legislation around the ban on smoking and underage sales. There are a number of policy developments in the pipeline which will also help.

Has any of that had any effect? So far, we have seen in Northern Ireland a 47% increase in the number of people availing themselves of stop smoking services. That increase is in single figures or the low teens in other GB countries. We have seen a marked increase, which is encouraging.

Alongside the smoking issue is the early years agenda and the development programmes. It has been well shown that if you have adverse experiences in childhood, you are probably three to four times more likely to smoke later on. There are a lot of complex reasons why people smoke. It is not enough just to give support, as we are doing, but to tackle that other issue.

Mr McCarthy: Are you committed to keeping your foot on the pedal and not relaxing?

Dr Rooney: Yes, Kieran, and the approach is important. The analysis that we have gives us a clear indication of the key factors driving that gap. If we take into account coronary heart disease, lung cancer and suicide prevention — issues that have been of major concern for the Committee and for us — that helps us to target where we will make the biggest difference. That does not mean just dealing with the diseases or their symptoms. To tackle any one of those, we have to get into what is driving the issues in the first place. So, each becomes a gateway to look far deeper into what is driving that difference between communities. However, the three also interrelate, and that is the approach we are taking. We are not trying a scattergun approach.

Dr McBride: You asked what underpins the issues of drugs and alcohol. Between 2001-05 and 2006-2010, we had a 10% increase in deaths from alcohol-related liver disease in Northern Ireland; a 10% increase in deprived communities and a 10% reduction in the least deprived areas. If you compare the overall figures in the latter period, the death rate from liver disease as a result of alcohol consumption is something like 37·2% per 100,000 in deprived areas, compared with 14·6% for the Northern Ireland average. So, double the Northern Ireland average. If you look at the differential in the least deprived areas, the rate of deaths due to alcohol-related liver disease in the most deprived areas is five to six times that of the least deprived.

That gives a tangible manifestation and it is the same whether we look at deaths as a result of smoking; circulatory disease; cancer, as Carolyn highlighted in her report; the challenges around mental health, as Eddie said, with regard to suicide; or obesity and obesity-related diseases. There is still that social gradient and those health inequalities. The Minister spoke to the Committee when, back in January, he launched the new strategic direction on drugs and alcohol, the key focus of which is on reducing population consumption of alcohol. We are taking that work forward jointly with DSD, and it will include the consultation on minimum unit pricing and a ban on irresponsible promotions.

Where drugs are concerned, the key issues that remain a real challenge for us include the so-called legal highs and the use of prescription drugs. That is also highlighted in the new strategic direction, and there is a range of other drug-related issues. We see the same differential when it comes to deaths from drug-related causes, because there is a higher representation of deaths as a result of drugs misuse in the most deprived areas compared with the least deprived areas.

There is a recurring theme throughout all those strategies about addressing the needs of those who are most disadvantaged in society. That goes back to Sam's point about the importance of having that as an underpinning theme. We take a population-based approach, because we need to improve everyone's health. The social gradient means that there are differentials across the spectrum, but we also need to specifically target those who are most disadvantaged and to continue our efforts in that area.

Mr Dunne: Thank you for coming along today. We are impressed with the work that you have done to date. To me, it is an example of collaborative working. Do you feel that you are getting support across the board from other agencies and Departments for what you are doing?

Dr McBride: There has been outstanding co-operation and support from all the other Departments in developing the new public health framework, Fit and Well, which will go out for consultation. There has been significant senior representation from all Departments, and, as Eddie mentioned, there is a real sense of momentum.

Mr Dunne: Am I right that that has been going on for about a year?

Dr McBride: It has been going on for a year, and that is why I am enthusiastic to get the consultation out and to ensure that we can use your good offices to engage with other Committees and MLAs during the consultation period. I think that we need to maintain that momentum over the summer and to hit the ground running again after the holidays.

My sense is that several things are in our favour now. The Programme for Government has provided a new focus and clarity of purpose, particularly when it comes to the way in which Departments are working and are now required to work. There are a number of key areas; we mentioned Delivering Social Change, which looks at addressing the wider determinants of poverty, particularly outcomes, for children and young people right across the piece.

Along with our Public Health Agency colleagues, we are engaged in a much more integrated and joined-up way of working. Eddie commented on how that is reflected on the ground. The key for us in

this area is the fact that we have the Public Health Agency. We now have a single regional body, where we had disparate groups in the past. That then brings a regional focus to this work. We have a central point that provides very visible leadership for implementation and for addressing the public health and health protection challenges that we face. I think that we have now a very significant opportunity to build on that. You may want to expand on that point, Eddie.

Dr Rooney: I just want to echo that, Michael. I have found that the language of joined-up working has an energy that turns it into action. I am outside the central departmental system now, but, as an implementation body, we are getting more engagement than we have ever had in the past right across the sectors. We are seeing that in Delivering Social Change. The key focus is on harmonising across those areas with a real determination to turn that into action. From our point of view, that is what we are about. We are an implementation body. We like to talk, but we have a job to do at the end of it that has to have an impact on lives.

Mr Dunne: Very good. The important thing is the delivery and getting the services down to those who are in need, such as single parents who live in deprived areas or large estates such as Kilcooley. How do you get the message out to them? It is so important that this is rolled out right down to single individuals who are in need. That will be its success.

Dr McBride: It goes back to the examples that Carolyn gave in response to Sam's question; it is about the real practical workings out. The point is that we do not just talk about this; it is about what action on the ground it will translate to and how we will know the difference. Part of the consultation document poses the question of how we will spot the difference. We need be able to monitor and evaluate the strategy and be assured that it is delivering. If it is not delivering, we need to do something different. It is to do with the question that you posed the previous time, John, about how we know whether the strategy is being effective.

Mr McCallister: Just to follow nicely on from that point, it is about getting to the target audience at all times. That is not to say that you should take your eye off the ball and say that everything is all right in leafy suburbia and that we do not need to do anything. Michael, you gave us some fairly shocking statistics in some of your answers. When you break it down, it seems that, by the time that we all head to bed, seven people will have passed away today because of smoking. That is a pretty shocking figure, and it is a pretty damning indictment on society across the board that that still happens today. The same is true of the figures for respiratory problems and the fact that they are five or six times more prevalent in our more deprived areas than affluent areas. That is the situation across the board. The Chair has been talking about this issue for many years. She, Sam and I were very involved in passing the legislation that set up the Public Health Agency. The argument then was that it was so important to take a public health agenda to a new level. Rather than being just a nice add-on somewhere, it had to be taken to a different level, because it was too important not to get right.

The big challenge will be in getting the help to the right target audience, such as into the communities and the individual homes in which it is needed. There will be homes that the state does not need to be involved in or for which the services do not need to be provided, but it is about getting them into where we need that help and support. From being out with programmes like Home-Start, I know that things can go badly wrong for people, such as a bereavement or an illness. Even for families in nice middle-class areas, things can go badly wrong. So, it is about making sure that you have support and interventions to help. That is why many Committee members have been supportive of things such as the Home-Start programmes. All our problems do not occur in single-parent families. Some of them will do remarkably well and will not require any help. So, it is about getting to the target audience. One of your biggest challenges is getting a strategy from that level and cascading it down to every home or family that needs our support.

Dr Rooney: I could not agree more. It relates to where Sue started at the beginning of the session. We have the stats for all the areas that we are dealing with, but it is not about the statistics. We cannot get away from it; we are part of the system that we talk about. It is us — our families and our friends. The evidence that comes to us does not come through several layers of official reports; it happens throughout the year, and it is real. It is happening now. Michael's point was that, when you start to put this into what happens around us, we do not see it all the time, but we know that it is there. The big drive for us is that, when we know that it is there, we cannot walk away from it. That is the lock-in for us. As an organisation, we are fairly young, but we are also part of an administrative body, so we appreciate that we have an awful lot to learn. A lot of that is also about bridging to the community that we serve. When we target the areas that we are talking about today, there is no doubt

about the communities that we are talking about. Indeed, we can narrow it down to households in every corner of the country.

There is a real challenge for us to make this real. There is a real determination to do that. I have to say that Michael has heavily emphasised to us that we are not in this to play a strategic game. The document has to be brought to life, and our role, as an implementation body, will be to do that. That will be the challenge that the Department puts to us. I will be held to account by the Department, and Michael and myself will also be held to account for it here. That is the way that it should be.

Mr McCallister: The challenge is getting buy-in. I was on the Education Committee when presentations were given on the 0-6 strategy. One of my big criticisms was that there is not really an educational context for children until they hit the age of at least three, so we were never going to have a big impact. However, health can have a determining effect before that age. You need others to be involved in identifying some of the problem areas. You could probably guess how well people will do even from going into homes and seeing the number of books that are there.

Dr McBride: Absolutely. The 2011 Prince's Trust report gave the percentage of households that do not have books. There is also a very stark statistic in that report showing that one in three parents does not read to their children. That beggars belief for most of us, but does it mean that they are bad parents? Clearly, it does not. We need to understand why that happens. Is it because there are issues relating to income and, therefore, the affordability of and access to books? Are there issues with those parents' educational attainment, the literacy skills that they left school with and their feelings about their adequacy or ability to read to their children?

It also says something about a knowledge of good parenting skills, which, again, takes us back to the programmes that both Eddie and Carolyn discussed and how they can be taken forward. It comes back to your point about how we, at departmental level, engage with colleagues in the Department of Education. In the Department of Health, we ensure that we work with the Department of Education on the early years strategy, and that work involves our Minister and Minister O'Dowd. We need to ensure that what we are doing in the Department of Health and what is being doing in the Department of Education are joined up and that the work is seamless. You should not see the joins at the receiving end. I keep using the term because it needs to creep into everyday parlance, but the Fit and Well — Changing Lives framework has to be about not seeing the joins between what is done at the government level and regional and local implementation. We need to use the evidence-based approaches that we know will deliver.

As a member of the public, I do not really care what is in the strategy. That said, I want people to respond to the consultation. I want to hear from members of the public about the things that work and about how we can ensure that we integrate it all better. I have made this point several times, but I look to the Committee for its support in our engagement during the consultation period with other Committees, Departments and MLAs on the shared agenda that is outlined in the document.

The Chairperson: OK, John. I want a wee bit of information before we finish. Carolyn, will the Roots of Empathy strategy be rolled out across other schools?

Dr Harper: Yes. There is a phased implementation during which advice will be taken from the originator, the founder and the support team in Canada. The constraint at the minute —

The Chairperson: Can you provide us with information about the targets?

Dr Harper: Yes, I will give you the numbers.

The Chairperson: As I said, I propose that the Committee looks at that in more detail and considers other areas. My view is that, because we also have a role to play as a Committee, we can feed in to the whole strategy of public health. We are a conduit between the constituents, that is, the people whose lives you are proposing to make a difference to, and our role as legislators here. Hopefully, we can do a bit of work over the summer and from September onwards.

On behalf of the Committee, I thank you for coming today and for the information that you provided. Will you update us on what is happening after the Executive meeting tomorrow, Michael?

Dr McBride: I am happy to do that. As I said, and, with a fair wind, if the strategy is considered and approved for consultation, we will be very happy to engage with you during the consultation period or towards the end of it. We would welcome further discussion on how we can use your good offices to inform the consultation and get engagement with other Members.

The Chairperson: Thank you.