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Committee for Finance and Personnel

OFFICIAL REPORT (Hansard)

Absenteeism in the Public Sector: Institute of Public Health in Ireland

26 March 2014

NORTHERN IRELAND ASSEMBLY

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Members present for all or part of the proceedings:
Mr Daithí McKay (Chairperson)
Mr Dominic Bradley (Deputy Chairperson)
Ms Michaela Boyle
Mrs Judith Cochrane
Mr Leslie Cree
Mr Paul Girvan
Mr John McCallister
Mr Ian McCrea
Mr Mitchel McLaughlin
Mr Adrian McQuillan
Mr Peter Weir

Witnesses:

Mrs Teresa Keating	Institute of Public Health in Ireland
Dr Elizabeth Mitchell	Institute of Public Health in Ireland
Dr Joanna Purdy	Institute of Public Health in Ireland

The Chairperson: From the Institute of Public Health, I welcome to the meeting Dr Elizabeth Mitchell, director of development and capacity building; Mrs Teresa Keating, public health policy development officer; and Dr Joanna Purdy, who is also a public health policy development officer. Members have received a paper from the institute. Will you perhaps talk us through that to start with, and we will then go into questions?

Dr Elizabeth Mitchell (Institute of Public Health in Ireland): Yes. I hope that everyone received the paper that we sent. I want to thank the Committee for inviting the Institute of Public Health to give evidence on measures to promote health and well-being in the workplace. I will start by introducing my colleagues Joanna Purdy and Teresa Keating, and explain their areas of expertise. Joanna's experience is primarily in the field of food and nutrition, but she has also done a lot of work on active travel. Teresa's expertise covers active travel and the health impacts of education and employment.

By way of introduction, I will say just a few words about the institute. We support policymakers and practitioners in the area of public health across the two jurisdictions in Ireland, with a particular focus on health inequalities. At the heart of our approach is the importance of action across the social determinants of health, such as education, employment and the environment. In my presentation, I will outline a few of the key areas relating to health and well-being measures to reduce sickness absence.

First, why is workplace health important? From the employer's perspective, a healthy workforce is needed for the effective delivery of services. Sickness absence decreases productivity and has significant financial implications. The main causes of sickness absence in the public sector are mental health problems and musculoskeletal conditions, such as back pain. Chronic long-term conditions, such as heart and chest disease and diabetes, are also significant causes of longer-term absence, particularly among older workforces. Mental ill health accounts for about 29% of total sickness absence in the Northern Ireland Civil Service and a similar proportion in the health and social care sector.

I will turn to evidence on what works. Workplace health and well-being interventions cover a range of key issues, such as health and safety, mental well-being, lifestyle behaviour change and organisational good practice. I will not cover health and safety at work today, although it is a very important aspect.

Evidence on what works has recently been reviewed in a report that looked at the effectiveness of interventions to improve workplace health and well-being. The authors concluded that approaches to improving the health of employees are effective in a number of areas. Health promotion and wellness programmes, especially multicomponent programmes covering a range of lifestyle issues, such as physical activity, diet and smoking cessation, appear to be the most effective, at least in the short term, especially if they are designed in collaboration with staff and with the support of senior management. With regard to mental health programmes, the evidence is strong for interventions to reduce stress in the workplace, and there is moderate evidence in the short term for interventions targeted at people with an existing diagnosis of depression. Although there are a number of promising interventions, the evidence of effectiveness for back pain and musculoskeletal problems does not appear particularly strong at present.

I will highlight some of the areas for action, starting with physical activity. By way of context, the percentage of adults in Northern Ireland who achieve the Chief Medical Officer's recommended levels of 150 minutes of physical activity a week has reduced from 38% in 2010-11 to 35% in 2011-12. It has also been reported quite widely recently that our population has the lowest levels of cycling and walking in Europe.

The easiest and most acceptable forms of physical activity are those that can be incorporated into our everyday life, such as brisk walking and cycling. Increasing physical activity reduces overweight and obesity and has additional benefits for heart and musculoskeletal conditions and mental health. There are many opportunities for promoting physical activity in the workplace, some of which have no or very little cost. They include simple prompts to increase stair use rather than lifts; involving employees in organising workplace activities, such as walking programmes, yoga, dancing or whatever activity people are interested in; supporting discounted membership of local gyms or leisure facilities; and encouraging staff to walk or cycle to work.

I will say a brief word on the cycle to work scheme. It provides tax relief on the purchase of bikes and cycle safety equipment and saves about half the cost on average. It is a very worthwhile initiative, but it is only part of the solution to increasing cycling to work. There is a need to ensure better access to secure, weather-protected cycle racks and changing facilities and showers in the workplace. In addition, we need to address concerns about the dangers from road traffic. Overall, Northern Ireland needs to develop a safer cycling infrastructure. That will require an integrated policy approach, including planning, financing and implementation as well as monitoring and evaluation.

The second area of interest is healthy eating in the workplace. I want to give you a couple of facts. According to the most recent health survey findings in 2012-13, 37% of adults in Northern Ireland were overweight and a further 25% were obese. So, nearly two thirds of the adult population were overweight or obese. Promoting healthy eating is an important aspect of any workplace health programme and key to that is the provision of healthy eating choices in workplace canteens and other outlets. A very good example of a local policy is the food in schools policy, which was published last year by the Department of Education and the Department of Health, Social Services and Public Safety. That is aimed at creating a significant change in food provision and the promotion of healthy eating in schools. Also of note is the Caloriewise scheme, which the Food Standards Agency (FSA) in Northern Ireland piloted in 2012 in a number of food premises, including those in three of the local health trusts. The aim is to provide consumers with more information about calories in the different foods on offer in catering establishments so that they can make informed choices. Another local example of good practice is that the Food Standards Agency in Northern Ireland, in conjunction with DFP's Central Procurement Directorate, has updated existing procurement guidance on integrating sustainable development into the procurement of food and catering services for the public sector.

The final area that I want to highlight is mental health and well-being in the workplace. Again, I want to give you a couple of facts. One in four people will experience a mental health problem each year, and mental illness is the largest cause of disability. Risks posed to mental health in the workplace are not as visible as those posed to physical health, but they are no less serious. For employers, the benefits of workforces with good mental well-being include enhanced job performance and productivity, increased commitment and job satisfaction, staff retention and lower levels of absence. So what can employers do to promote a positive work environment and reduce stress at work? As a basic building block, employers should have policies in place to improve working conditions; for example, human resource policies that cover health and well-being, work/life balance and the prevention of bullying and harassment in the workplace. Encouraging early detection and intervention, raising awareness and understanding of mental health issues among managers and the rest of the workforce are also very important. There should be practical support for people with known mental health problems, including appropriate measures for disabled members of staff or those returning to work after a long period of absence. Stress management programmes and what is provided will vary according to the settings and the nature of the work, and many organisations avail themselves of employee assistance programmes, often provided by external agencies.

In conclusion, the benefits of improving health and well-being in the workplace extend far beyond reducing the cost of absence or poor performance. The key message is that systematic, coordinated, comprehensive approaches, which involve staff in planning and senior management in support, are essential for promoting health and well-being in the workplace. Creating an environment where people actively chose to walk and cycle as part of everyday life can have significant benefits. Employers can do their part to support this. Real improvements can be achieved when active travel is integrated into transport planning and that will ultimately have a positive effect not just on our environment, workforce and population, but on the economy.

The implementation of healthy eating in the workplace has been shown to be more effective when delivered in conjunction with other health-promoting activities in conjunction with links with other external agencies, and consultation and engagement with the main parties involved. Most employers now recognise that poor mental health is, by some margin, the single most important cause of sickness absence in the workforce. They acknowledge the importance of having proactive programmes in place.

The institute would like to make the following recommendations to the Committee. We think that, in order to promote and maintain a safe environment for active travel to work, pedestrian and cyclist safety should be a key focus of infrastructural investment. The work of a broad range of governmental and other agencies will be required to achieve this. In addition to the cycle to work scheme, further uptake of that form of travel to work could be facilitated by the increased availability of secure, weatherproof cycle parking facilities, not just at workplaces but at schools and public transport hubs, and by access to changing rooms and showers.

The principles and learning of whole-school approaches to healthy eating could be adapted for workplaces. Two practical measures to support staff in eating more healthily in the workplace could be implemented across the Northern Ireland Civil Service and Health and Social Care (HSC). These are the implementation of the procurement guidance that I mentioned and the rolling out of the Caloriewise scheme in staff restaurants across those organisations. Public sector employees should ensure that they have comprehensive programmes in place to promote mental health and well-being and to support employees with mental health problems. That is the end of my formal presentation. We are happy to answer any questions.

The Chairperson: Thank you very much, Dr Mitchell. This is an interesting area. Members and the Committee may have taken a narrow view in the past of sickness absence rates and how to deal with them. This is a more holistic view of the factors that affect staff health. Environment, transport options, eating, smoking and work/life balance are all huge issues, and we need to take those into account in how we reduce these absence rates.

On improvements to pedestrian and cyclist safety, the same cities are always mentioned: Copenhagen, Amsterdam and so on. However, Dublin has introduced a new cycle scheme in the city. London is the most obvious example, as well as places such as Cambridge. How have their public service employees' health rates improved as a result of that improved infrastructure?

Dr Mitchell: I will ask Teresa, who is based in Dublin, to speak specifically about that city, but I will also ask Joanna to speak because she attended a workshop on Monday organised by Belfast Healthy Cities, which highlighted some of the benefits of the Copenhagen example.

Mrs Teresa Keating (Institute of Public Health in Ireland): There are a number of schemes in Dublin. The cycle to work scheme there has been in place for a number of years and is similar to the scheme in Northern Ireland, where there is a tax incentive to purchase a bicycle. There has been no formal evaluation of the cost-effectiveness of the scheme in Dublin. However, cycling rates have improved significantly. In the five years from 2005 to 2010, they increased by 35%, and the evidence of a number of new bicycle shops has been quoted as one of the positive spin-offs of that scheme.

Cycling is by no means particularly safe in Dublin. However, infrastructural and policy changes such as the 30 kph speed limit along the quays have made significant improvements to cycle safety, as has general driver awareness and education. There has been quite a big campaign through the Road Safety Authority to promote and recognise cyclists on the road. There have been a number of infrastructural changes, but it certainly would not be held up as a gold standard, as other places might.

One final thing to note is the Dublinbikes scheme, and we could look at how that might be implemented in Belfast and the benefits that it could bring, recognising that a lot of commuters have long journeys to work. One of the benefits of that bike hire scheme is that a lot of the hubs are located near travel exchanges. Therefore, there is the possibility to get a bus or train and then hop on a bike for the remainder of your journey, particularly if you work close to a hub.

Dr Mitchell: Joanna can tell us a little bit about the learning from Monday's workshop.

Dr Joanna Purdy (Institute of Public Health in Ireland): Many European cities are cited as good examples of best practice in cycling infrastructure. As was mentioned at the presentation on Monday, 36% of the workforce commutes to Copenhagen by bicycle, and there has been an increase of 10% in cycling in the past 10 years. Much of that increase has come about through the structural changes that they have implemented such as widening cycle lanes and putting structural barriers in place to protect cyclists from motorists. Teresa mentioned the reduction in speed limits, and that is another feature of the Copenhagen system, where a 20 kph speed limit is in place during rush hour, which obviously facilitates cyclists much better. In Copenhagen, they are reporting, based on the number of cyclists who are cycling for work and study purposes, that cycling reduces overall mortality by 3% and has led to an increase of five years in life expectancy. Those are important health benefits emerging from the lifestyle and commuting changes that have been brought about by those infrastructural developments.

Dr Mitchell: It is worth highlighting that the level of cycling in Northern Ireland is 1% compared with 36% of people in Copenhagen who cycle to work. That 1% is the overall cycling level, so we have a fair way to go.

The Chairperson: I was looking over the figures in the report last night. The number of people doing the 150 minutes recommended physical activity a week has reduced from 38% to 35%, and the population has the lowest level of cycling and walking in Europe. That is an appalling statistic, and we have the debate so often about the obesity time bomb that we face. It does not seem to have been getting any better in the previous three years. There is reference to various pieces of guidance. DFP's Central Procurement Directorate has updated procurement guidance on integrating sustainable development into the procurement of food and catering services. When it comes to food and catering services, we sometimes pay lip service to healthy eating. You could go to an event in the Long Gallery about healthy eating but, at the end of it, there might be a reception with sausage rolls and chicken goujons, which does not really make sense. Is guidance enough or do we need to put something on a statutory footing?

Dr Mitchell: There is always a debate about whether guidance is enough, but then we get into the argument that adults should be able to make their own choices. There is a balance to be achieved, but we can do a lot through effective implementation of the guidelines, which aim to increase the healthiness of the ingredients and the materials that are purchased throughout catering services in the public sector. That means that, without even having to think about it, you are automatically making things a bit healthier by reducing salt, fat or sugar content, and that makes things easy.

We also mentioned the Caloriewise scheme, which is important because it provides consumers with the information to make their own choices. You may have been eating something quite happily but if you have information about the calorie content of that food, you may be surprised and decide that you need to look for something healthier. Information is key, and rolling out the Caloriewise scheme would help.

The Chairperson: Could you elaborate on that a bit more?

Dr Mitchell: Yes. I will ask Joanna to expand on it as well. Caloriewise was developed by the Food Standards Agency. In Northern Ireland, the FSA conducted a pilot in 2012 in, I think, 12 catering establishments, some of which were in the private sector. Three health and social care trusts used it in their staff restaurants. As far as I know, it has evaluated well and there are plans to roll it out in Southern Ireland as well as in Northern Ireland. Some of the health and social care trusts that implemented the pilot have continued to operate it since. Further work is also being done by the Food Standards Agency here and the Food Safety Authority of Ireland (FSAI) on helping catering managers to work out the calorie content of foods. That tool will be available to help with the implementation of Caloriewise. A very simple recommendation would be to roll that out progressively across the public sector in Northern Ireland in staff restaurants and canteens.

Dr Purdy: I will just add two points. The first is to do with the roll-out of the scheme and support for caterers and catering establishments. The Food Safety Authority of Ireland has worked closely with the FSA in Northern Ireland to develop the calorie calculator, which catering companies and catering managers will use to work out the calorie content of their menus. That is a very complex process when you get down to the nitty-gritty of how much oil is absorbed in various cooking processes and how much fat is released. They have worked very hard to develop that tool, which is due to be launched by the FSAI in April. That will be followed in Northern Ireland within the next year — most likely during this calendar year — and then across the UK.

The Food Standards Agency in Northern Ireland and the FSAI in the Republic are leading on this and see it as setting the trend as a global tool that will be available for calorie information for consumers. However, it is also important to pick up on the point about catering establishments, particularly in the health and social care sector. The Caloriewise scheme is being rolled out in restaurants that are open to employees and visitors alike, as well as day patients who use hospital and health and social care facilities. Therefore, the scheme is applicable not only to those who use the facilities regularly but to the wider population, so it will help consumers to make informed choices. I think that that, coupled with broader issues, such as front-of-pack nutrition labelling, is contributing to a greater awareness of what we are eating and to making an informed choice around our food in the supermarket and catering establishments.

Mr McCallister: I have several points. I was last in Craigavon Area Hospital as a visitor when my son was born nine or 10 weeks ago. I did not see any sign about calories; the food on offer was pretty much chips, particularly in the evening. You commented on vending machines. If you even walk around this Building, you do not have far to go to be tempted by vending machines. Does that have a role? I accept, Elizabeth, your point that you are probably trying to find the balance between the nanny state becoming an all-encompassing body and how we improve health.

I also would not mind to hear your comments on how we are managing long-term conditions or helping people with long-term conditions to manage them in a better way. When I was a member of the Health Committee, there was a lot of talk about how you would do almost first aid for mental health. Have we made any progress in rolling that out, even in the Northern Ireland Civil Service, never mind large private sector employers? What about the role of absenteeism for people who have other caring responsibilities, particularly parents or someone who is looking after an elderly relative? That is bound to have a knock-on effect for absenteeism. Is that coming into our sickness figures, or are we counting those separately? Those are just a few thoughts to get you —

Dr Mitchell: To get us going. Thank you.

Mr McCallister: Judith has a degree in nutrition. She was telling me all about this.

Mrs Cochrane: Clearly, I do not pay attention to it.

Dr Mitchell: I will probably do them in reverse order, if that is all right. It is widely known that there are higher levels of sickness absence among female staff. The main burden of caring often falls on them as well. There is no doubt that hidden in the sick absence figures are probably elements of people having to take time off for caring responsibilities. That can be addressed through increasing access to good childcare and also support for caring for older or disabled family members.

Mr McCallister: Of course, there are times when, if a child is sick, you are not meant to take them to childcare.

Dr Mitchell: Exactly. Sometimes, that is a problem. There are definitely difficulties around that. Family-friendly policies and employers who understand working responsibilities and allow flexibility can help with that as well.

Mental health first aid has been rolled out quite widely, particularly in the health and social care sector. For example, the Ambulance Service has been rolling it out for its staff. It has found benefits in not only its ability to deal with the service users but engagement with other members of staff. There are definite positive benefits from that. A lot of training organisations provide training in mental health first aid. There are similar schemes that help people to talk and raise the issues of mental health, help to increase awareness and help with how to respond and signpost to other services.

Mr McCallister: Just on that, we have battled for many years now over the stigma around mental health. Are we making progress on that, or is there still reluctance from some employers or employees to say that they have a mental health problem? They are almost hiding it behind something else because they think that it is a long-term difficulty or that somebody is going to be very problematic to deal with in the workplace. What sort of evidence is there around the mental health issue?

Dr Mitchell: There is quite a lot of evidence that there is still significant stigma about mental illness, not just in the workplace but in wider society. There have been a number of high-profile campaigns organised by various organisations; for example, some in the community and voluntary sector and the Royal College of Psychiatrists. Indeed, work has been done by the Public Health Agency, and you will be aware of its campaigns using high-profile local celebrities, such as Lynda Bryans, to highlight the fact that mental health problems can happen to anyone. It has also used high-profile sports personalities and players across a range of sports. Boxing is an example, because men often keep their mental health problems to themselves perhaps more than women. A number of things are happening on that, and the Public Health Agency is doing work on it.

It is also worth mentioning that the Department of Health, Social Services and Public Safety is producing a new suicide prevention strategy and will broaden it to include more aspects of positive mental health promotion. One of the sections will be on promoting mental health in the workplace. That will provide a strong strategic context for that work.

I will pick up on your next point, which was about what we are doing about chronic conditions. Again, I refer to the condition management programme. The programme has been funded since 2007 by the Department for Employment and Learning. It offers work-focused health rehabilitation to individuals living with a range of physical or mental health problems and who are in receipt of sickness-related benefits. The programme is delivered regionally by a range of HSC healthcare professionals, occupational therapists, physiotherapists and mental health nurses.

Currently, two of the trusts in Northern Ireland are also offering a pilot of that programme to jobseeker's allowance claimants with health conditions. There has also been a pilot for DEL via the welfare department extending that to civil servants, and some of the trusts have been extending it to their own staff.

It is usually a 12-week programme, which provides things such as help for people to understand their condition, to improve their functional ability and to increase confidence to improve the prospects of returning to work or staying in work. It provides advice sessions that can cover things such as self-esteem, confidence building, assertiveness skills, stress management, pain management, fatigue management, managing anxiety, managing depression, lifestyle management and managing chronic pain. So, there is quite a bit of focus on the mental health aspects.

One of the things about this is the fact that we should be trying to get this in earlier. Often, there has been a tendency to wait until people have been on benefits or have a disability for six months before offering them the programme. These pilots, through which we are trying to support people to stay in work rather than them having to go off work, are the way to go in the future. This is a promising area for the future.

Mr McCallister: Finally, on this point and leading on from that, what impact do waiting lists in the health service, for example, have on the length of time that people are off work? For example, if you

have a mental health issue and you have to wait for six months or a year before you see somebody, or if somebody has a physical condition, for example, a bad knee, and has to wait a certain time, that is bound to have a knock-on effect.

Dr Mitchell: You are right. Long waiting lists may have an impact. Priority often has to be given on the basis of clinical need so that people who are suffering most need to be seen first. However, cognisance should be taken of people's circumstances. Some employers provide schemes where staff have access to diagnostic facilities or intervention procedures so that they can address that problem.

Mr Girvan: Thank you for your presentation. I apologise for being slightly late. My question is in connection with a culture that has probably built up over many years. As far as Northern Ireland is concerned, a large number of people who are prescribed antidepressants seem to be on them not only for a short time but there seems to be a repeat prescription approach, where it is a lifelong condition, as opposed to trying to deal with the source. Has any work been undertaken on that? I appreciate that more people are out of work because of stress and, as a consequence, they say that they need antidepressants to deal with it. A number of people are prescribed fluoxetine or whatever else, and they are on it for life. Many of us end up dealing with people who have lost their job, and we do appeals for them because of it. You end up doing a DLA appeal, and you find out that they went off work with stress and, as a consequence, they have never gone back to work. Has any work been done on dealing with GPs and how they seem to just reach for the prescription pad and dish this out as a rule to sort out all problems? That probably does take it away from the GP's door for a period, because the person is probably in a fairly zoned-out position for quite a while.

Dr Mitchell: You are quite right. The levels of prescribing antidepressants here are high compared with the rest of the UK. That is something that is being tackled —

Mr Girvan: Not only UK; we are one of the highest worldwide.

Dr Mitchell: Yes, our rates are certainly high.

With respect to the workplace, it is increasingly being recognised that programmes such as cognitive behavioural therapy, like a talking therapy, should be offered as an alternative — early intervention is important — rather than waiting until people go off work with stress. It is important for workplaces to try to bring in stress management programmes and support employees through that route. Cognitive behavioural therapy is interesting. It can be provided by an online programme, either on its own or in conjunction with a therapist who has an overview of the CBT online. That means that a therapist can support a large number of people who are going through the programme online just with some direction rather than taking up a lot of time with individual therapy sessions. That is a promising area, and I think it can be provided. It has been trialled in Northern Ireland and it is available. Beating the Blues is the name of the programme that is being used. I think that that is another promising area for trying to address the high levels of prescribing antidepressants. That is from one angle.

The other angle that the Health and Social Care Board will take forward is GP education and support. Having access to talking therapies is an important angle for GPs. If there is something else that GPs can refer patients to rather than reaching for the prescription pad, it would be a part of the solution.

Mr Girvan: Look at what happens in the private sector as opposed to the public sector. We are dealing primarily with absenteeism in the public sector because that is an area that we have some control over. The fact is that there is a 70% increase between public sector and private sector. Have any studies been done about why? Have we created a culture within our public sector that encourages the bullying and the other aspects? We are aware of people who, for one reason or another, put themselves forward as whistle-blowers. There was the case yesterday associated with this, where somebody went forward as a whistle-blower and, as a consequence of putting their head above the parapet, they end up being targeted and subsequently having to stay off work and take extended leave periods. That is a very big problem. In one of the major employers, and I am thinking of the health service, that is one of the key areas where that seems to go on and it seems to be endemic. Has any work ever been done on that?

Dr Mitchell: Work has been done. This has been looked at nationally and, I am sure, internationally. One of the factors is that, in the public sector, the workforce tends to be a bit older than in the private sector. Of course, with older employees, you get more chronic conditions and more absence. It is

very variable. Gender and age differences are important, and also the balance between long-term sick and short-term sick.

An important building block for any employer is having in place the policies to address the issues that you raised — harassment, bullying and stress — that are related to conditions in the workplace. It is important that policies are not just in place but are supported and implemented by staff. Training for line managers and senior managers about the importance of this in the overall impact on motivation, productivity and efficiency is very important.

Ms Boyle: Thank you for your presentation. I congratulate John on the birth of his baby son and commend him for raising childcare issues.

Mr Mitchel McLaughlin: He is an expert on childbirth as well. *[Laughter.]*

The Chairperson: At least he got to the hospital this time. *[Laughter.]*

Ms Boyle: The report has a particular focus on cycling and walking to work. As someone who represents a rural area, and having spoken to a number of disability organisations, I know the barriers to work for people with disabilities, particularly mobility issues. Was there a piece of work or an evaluation done on what more public transport can do to assist with this? Was there a conversation between employers and the public sector about transport? It has improved in city areas but not in rural areas. Are there any differences between North and South in public transport? Is it better in the South or the North?

Dr Mitchell: I will probably come to Teresa to answer this in the main. It is an important issue in a region such as Northern Ireland, which has a high proportion of rural areas and where transport is a particular difficulty. Often, the infrastructure does not lend itself to walking or cycling even if the distances are appropriate for that. That means that public transport has a key role to play, particularly integrating public transport. There is talk of a public transport hub in Belfast, which would be a major step forward, particularly if it builds in safe and secure cycling facilities. I understand that Belfast City Council is planning to have something like the Dublin bike scheme. Those will help where people are travelling in from rural areas to a hub and are then able to avail themselves of walking or cycling to get to their workplace. I will hand over to Teresa about the experience in the South.

Mrs Keating: I echo what Elizabeth said. It is obviously a very important issue. I am not aware of any differences in access for disabled people to public transport in the South. Although these approaches are important, we need to recognise the issue of rural locations. That is reflected in the Northern Ireland travel survey regarding modes of transport to work. It is significantly lower in east and west compared with Belfast regarding walking, cycling, bus or train, and the car is predominant.

The flip side is that, even in areas with good public transport and where people have short journeys to work, there is still significant reliance on the car. Even to work on that cohort who are amenable to change would have a significant impact on overall workplace health.

Dr Mitchell: I will bring Joanna in on that point.

Dr Purdy: The commute to school is an important dimension because of the number of parents and children involved. Sustrans is running an active schools travel programme. Over three years, it will involve 180 schools in its active travel to school programme, where children are encouraged to cycle, scoot or walk to school. It also includes, for those who are located a little further away from the school, park and stride. That involves parking a little further away from the school rather than involving all that congestion and the safety issues of parking at the school gate. There is also park and cycle, which involves parking further away but cycling the last leg of the journey. So, some good work is going on that encompasses rural areas, where, we understand, there are obviously greater challenges with public transport. That in itself is helping to bring about a cultural change in how we view travel and our daily commutes.

Ms Boyle: That is good to know. Thank you.

Mr Mitchel McLaughlin: You are very welcome. Personally, I am regretting that I did not meet you about 30 years ago.

I get the arguments, and I get the principles and the benefits of it as they have been laid out. I think that the evidence will demonstrate that there is a clear benefit from these workplace initiatives. I am coming at this on the basis that I understand that, and I support it. In fact, I support it strongly. We have local initiatives in this Building such as, when the lifts go out, they are not repaired. I am thinking about the one that goes into the basement where the canteen is. So, you can see that that is a very subtle ploy. *[Laughter.]* Long-term sickness is an issue in the public service. Our long-term sickness rates are higher than the comparable workplace experience, particularly in Britain, and are higher than those in the South. That may have some relationship with the conflict and with being in a post-conflict society. It is bound to have some connection, even though the science does not really help us much in determining that. That may be the explanation for why we are higher in the context of similar occupations and workplace experience. The programme that you described seems primarily to be aimed at the active workforce. Have we considered delivering this support to staff who are out on long-term sickness? Perhaps that is being done. If so, does it demonstrate some benefit through earlier return to work?

Dr Mitchell: The responsibility for people who are off long-term on sick or disability rests with the Department for Employment and Learning. It has had a condition management programme in place for a number of years. The programme works with the health service to support people who are out of work and bring them back to work, and it covers a range of physical and mental health conditions. Probably well over 50% of it relates to mental health issues, or mental health combined with a physical health problem. There have been a number of pilots in the Civil Service. Dr Ken Addley, who I believe is coming to present evidence to the Committee, will probably be able to tell you more about the evaluation of that for civil servants and about bringing them back to work through the condition management programme. Health trusts have also been piloting it, and it certainly has shown very promising signs of bringing people back to work and supporting them back to work. Anecdotally, a lot of people have said that they would not have been able to come back to work if they had not had the support of the programme.

Mr Mitchel McLaughlin: Are your remarks in the context of this region?

Dr Mitchell: Yes, they are for Northern Ireland. I think that two or three of the trusts have been piloting it, and, where we find out things like that, which work, it is important that we try them, mainstream them, roll them out and demonstrate to others that they work so that they will introduce them. I think that getting in earlier before people have gone off on long-term sick is one of the key things about this. The earlier you can get in and support people, the more you will do to prevent long-term absence.

Mr Mitchel McLaughlin: I can see that. The fact that this has now been brought forward might mean that we are, just possibly, still a bit early in the learning curve to be able to properly quantify it. I have no doubt whatsoever that it will be beneficial. It is nearly like applied science for people who have become sick, either through stress or through some physical disability that has emerged over the period of their work experience. We have quite close monitoring of sickness levels, and there have been fairly genuine efforts across the piece to reduce those statistics. I think, at the level of short-term sickness there may have been measurable impacts, but the long term seems to be the explanation that is offered for the stubbornness of the high incidence of absence that we have. So you are indicating that there is in fact some —

Dr Mitchell: There are some promising programmes.

Mr Mitchel McLaughlin: Pilot programmes. And have evaluations been done?

Dr Mitchell: Evaluations have been done. It is based on work elsewhere, so there is experience from elsewhere that has been brought in to Northern Ireland and used here. The evidence shows that if people are off for six months the chance of them getting back to work is quite low, and if they are off for a year then I think the chances of them getting back to work are negligible, so early intervention is important. You are right. A lot has been done to manage sickness absence. What we need to do is complement that with programmes to improve health and well-being and to help intervene where people have a long-term condition and need support. If we had a three-pronged approach, I think that would help to drive down the overall levels of sickness.

Mr Mitchel McLaughlin: I have to say that I was not expecting to hear that. Does your work indicate that, if people are out on long-term sickness for a year, they are very unlikely to come back?

Dr Mitchell: Yes.

Mr Mitchel McLaughlin: I presume that we are going to hear the outcomes of those evaluations at some stage, because I think there would be beneficial impacts of delivering those supports to staff who are already out because of sickness and whatever stress kind of reasons.

Dr Mitchell: I have a contact in the health service if it would be useful, if you would like to follow up on the practical experience of delivering it.

The Chairperson: Following on from that, the Committee is looking at the area of flexible working at the moment, and I think we have found a fair bit of resistance in some of the comments that have been made by senior members of the Department. Do you have a particular view of flexible working, how it affects sickness levels within the Civil Service and what the benefits of it would be in a fuller roll-out of options regarding that?

Dr Mitchell: I do not have any hard figures, so I suppose you could say it is more of a gut feeling that, particularly when we come to issues of disability, if people could be permitted to work partly in their own home — distance working, which, I think, often the work in the Civil Service may lend itself to, whether it is working with a laptop provision or whatever, with modern communication technology, which I think could be supported — that would be beneficial. I suppose it is about having the mindset to recognise where those opportunities are available. I think the experience is that staff appreciate that and do not abuse it. There are probably some concerns that, if people are not under somebody's eagle eye, they are not cracking on at the job. I do not think experience bears that out. Our own organisation is quite supportive of home working and being flexible about that, so we are practicing what we preach.

Mr Cree: Can I ask you three different questions? First, has any work been done in analysing the problems of people who are on the benefits system and when, in fact, the incidence of mental health kicks in, caused by the stress of the whole process?

Dr Mitchell: Stress of dealing with the benefits system, or —

Mr Cree: Particularly the tribunals system, yes.

Dr Mitchell: I am sure there is, but I do not have that to hand at the moment.

Mr Cree: It would be interesting to see that, if such a thing exists.

Dr Mitchell: OK, we will look into that and can certainly come back to the Committee with information on that.

Mr Cree: Thank you for that. The other is perhaps a little more light-hearted. Is any work being done on the substances that are added to food and the proliferation of them, many of them working against each other — salts, sugars and all of the other enhancers and preservatives? If anyone takes the time to read a label, they will find it incredible what is added. What is the cumulative effect of all those things on health? Maybe some of them are embalming fluids, I do not know. *[Laughter.]* You mentioned fats, Dr Mitchell. The ordinary person hears that fats and saturated fats are bad for you. Recently we heard that that is not the case at all and they are actually good for you. Sugar is a bad one now. However, follow that line back and you will find all these contradictions, such as about margarines and butter and soya being another component on the wrong side of the fight against cancer. Yet, they are all in there. Are you doing anything about that?

Dr Mitchell: I would love to be able to solve that one. This contradictory evidence is one of the issues about food and nutrition. People do get confused, but one of the basic principles is that getting back to food produced locally and prepared in the home, with fewer additives and preservatives, is bound to improve the overall standards of nutrition and reduce levels of obesity.

Mr Cree: Is that not a bit naive in today's modern, fast life?

Dr Mitchell: The corollary is that if we do not do something about this, levels of obesity and diabetes are going to overwhelm our society. It behoves us to try and do something about it. There is a lot of

advice on food and nutrition, and if you follow the basics you will not go far wrong. John McCallister mentioned vending machines, and there are the important issues of sugary drinks and all those others. I will bring in Joanna, because she did her PhD on issues closely related to this.

Dr Purdy: Thank you, Liz. I did some work looking at reducing the salt content of processed ready meals, which are among the biggest food categories with a high salt content because of the amount of processing and a reduction in flavour that is compensated for by cheap and readily available salt. Interestingly, my study revealed that we were able to reduce by 30% the salt content of a cottage pie, which is a standard home-made meal and also a common ready meal, before consumers noticed the difference in taste. There is no difference in the sensory quality of the product's taste, flavour or any of its other attributes that you would experience as you eat it.

Food systems technology to compensate for any reduction in salt for preservation is well advanced. We no longer need salt as a preserving agent; technology has well surpassed that. So, there is certainly the scope to reduce, and under a number of government schemes, retailers and manufacturers have made a commitment to reducing the salt, fat and sugar content of foods. I also endorse Liz's point about going back to cooking from scratch, where we can. That will come through as, under the procurement guidelines, food is sourced locally. We need to ensure that the food that we cook is grown and produced in Northern Ireland. Doing that will, in itself, skill up people and deliver nutritional and health benefits, as well as benefiting the economy. We will put money back into our own economy by closing that loop in the food production cycle as well. So, there are many benefits.

I had a couple of thoughts on the vending machine issue. The food in schools work is a good example of how to tackle vending. There is some good and pragmatic information available within the food in schools policy, and all the supporting documentation, around replacing the high-sugar and high-fat foods that populate many vending machines. I share your concerns about the impact of those on diet and how easily available they are. There are many counterarguments about the economic benefits that those bring to organisations as well. That has to be weighed up in the context of the long-term economic impact to the health service from the negative health effects. Funding has also been awarded for Belfast to be established as a sustainable food city. Is that the correct title, Liz?

Dr Mitchell: Yes.

Dr Purdy: Part of that project involves looking at healthy vending. There will be work taking place in the next year, and that will be rolled out — I think it is a three-year project — over the next three years that will encompass healthy vending. It is an area that we need to look at, particularly in leisure facilities, so that we are not counteracting the health messages about physical activity by stocking vending machines with very unhealthy high-fat and high-sugar foods.

Mr Cree: I did not ask you anything about vending machines.

Dr Purdy: No, but I wanted to pick up on an earlier point.

Mr Cree: We have covered that point. My point was to do with the contradiction about what is good for you and the changed circumstances that are continually appearing. For example, I would value your opinion on the latest one, which is that wheat is bad for you and breads are bad for you. What do you have to say about that?

Dr Purdy: A lot of evidence is produced on a daily basis and it is contradictory, but we need to very rigorous in how we examine some of those studies. Those are not necessarily primary research studies but are meta-analysis or a systematic review of existing work. One needs to look very carefully at the nature of the studies that are being published. It is important to say that the media pick up headlines and sensationalise particular facts, and that then presents conflicting messages to consumers. I would recommend that we go back to the Department of Health and Food Standards Agency guidelines on healthy eating, which are being analysed by senior scientific officers who have a high level of expertise in those areas. They represent government perspective, and what is published in those is what we recommend that everyone here and consumers adhere to.

Mr Cree: It trails quite a bit behind the news that is coming out.

I am sure that you know about the five-a-day campaign and how that is being promoted as a healthy thing. Did you realise that that was initiated by the fruit growers in California to sell more fruit?

Mr Girvan: Nonsense.

Mr Cree: It is a fact.

Dr Mitchell: There is no doubt that they are very supportive of it, but there is also evidence of increasing health benefits from having five portions a day of fruit or vegetables in the diet, and anything you can do to increase fibre is beneficial to health, including to prevent bowel cancer. There are numerous health benefits from increasing fruit and vegetable consumption. In Northern Ireland, our uptake is particularly low, I am afraid, and there are particular challenges in getting children to take their recommended levels.

The Chairperson: How low are we, comparatively?

Mr Cree: Three and a half a day.

Dr Mitchell: You are jesting, but I think most people probably manage to scrape by on a couple of portions.

Dr Purdy: It is probably about half the recommended intake.

The Chairperson: How does that compare with Britain or the South?

Dr Mitchell: We are lower. I can send you exact statistics on that. Teresa, do you have figures for the South with you?

Mrs Keating: I do not, but they are quite similar. They are marginally better with schoolchildren, and again there is a drop-off in the teenage years in fruit and veg consumption.

Mr D Bradley: Morning. It still is morning, yes? I am just looking at the BBC website, and it is announcing the launch of a new website to highlight warning signs of mental health problems in children. It says that 850,000 children in the UK have a diagnosed mental health condition and that 75% do not receive the help that they need. When it comes to trying to deal with illnesses and causes of absenteeism in the workforce, is it by and large too late, because many of the causes of these have been ingrained from an early age? The focus, therefore, should be on early intervention and early prevention, so that we would have less to do when it comes to the workplace.

Dr Mitchell: I think that you are absolutely right that the seeds of many adult mental health problems are sown in childhood. The more that we can do to support children and adolescents with developing mental resilience, the more we will do to lessen the impact of that in adult life. We have got the situation, of course, where we are where we are, and we cannot ignore those people who are already in the workforce and suffering mental health problems.

Mr D Bradley: The same applies to unhealthy eating and other factors.

Dr Mitchell: Yes, and the positive signs are that we have this new food in schools policy. It looks at the whole educational side, as well as at what food is actually served in schools. We also have the pupils' emotional health and well-being (PEHAW) policy which, again, is a joint policy between the Department of Education and the Department of Health. It aims to address those very issues in schoolchildren. It aims to promote positive mental health, put in place services for children who already have mental health concerns, and signpost them to counselling services and other things. So, there is work ongoing on that. As always, more can be done, I have no doubt. Having good policies is not enough. They need to be implemented and evaluated.

Mr D Bradley: I know that events are held in many workplaces to emphasise measures that can be taken to combat stress, promote healthy eating, reduce blood pressure and so on. We had a very good one here. I think it was the Food Safety Authority of Ireland that promoted it with MLAs. It was over eight weeks, and several of us took part and benefited from it. However, the problem with those things is that, when the programme ceases, people are liable to lapse into whatever habits they had

before. Is it possible to extend the benefits of workplace events further so that you avoid the lapse into previous habits?

Dr Mitchell: Yes, I think it is. There is a good example in the Department of Health, where I worked previously. It has had a workplace health and improvement programme in place for a number of years. It started with the kind of events that you are talking about. They would have a health fair, and people could go and get their blood pressure checked and experience other screening techniques. Over the years, we have developed it. We have a range of things in place. We offer smoking cessation programmes, weight management programmes, walking competitions, things to promote physical activity, sampler 8-week programmes for yoga or Pilates, for example, in the workplace at lunchtime. The employer allows people to go at lunchtime to participate. It is encouraging people into trying new ways of getting physically active. It also runs healthy eating weeks and promotes information on healthy eating. There is a range of things that can be done in the workplace, and you need the commitment of senior management to support that. You also need the involvement of the staff in developing the programme so that it is meeting their concerns. If employers consider it as part of their managing of sickness absence and getting behind it, we will get good results from it.

Mr D Bradley: Paul mentioned the private sector and what we can learn from it. I believe that, in some cases, the bigger companies employ private health screening firms, and they have regular screening of employees for various illnesses from blood pressure and heart performance and so on. Is that something that we could do more of?

Dr Mitchell: Look again at the Northern Ireland Civil Service. The occupational health service provides a programme through which it will assess people's levels of fitness and screen them, and it will repeat that on a regular basis so that people can see whether they are improving or getting worse. I think that there are mechanisms for doing that in-house, and that means that you do not necessarily have to go to a private provider, for instance, to get it. The report that I mentioned earlier, which recently reviewed the evidence, was from the City of London Corporation. It looked at all of the big banking and financial sector employers and what they were doing in terms of best practice and what worked for them. Many of them availed themselves of the kind of services that you are talking about.

Mr D Bradley: So, you are learning from what happens in other sectors.

Dr Mitchell: Yes. You can certainly learn from good practice, but I think the messages coming through are very similar. There are multicomponent programmes that deal with physical activity provision, smoking cessation and mental health and well-being. They are supported by senior management, and they have got engagement of the staff in designing the programme. Those are the elements of success. Then there is condition management, where you identify people with disabilities or illness, and support them to try to keep them at work or get them back to work early.

Mr D Bradley: Thanks.

The Chairperson: The Committee is always referring back to the issue of preventative spending: invest now to save five, six, seven years down the line and realise a saving for the public purse. Do you see your work being involved very much in promoting preventative spending? We have also looked at the area of well-being, and I know that the Minister is looking at that too. There is also the fact that some Departments see themselves as silos. So, a lot of people think that if you are an organisation about health, you belong with the Department of Health, and it is nothing to do with DRD or DOE in terms of planning etc. Is there still a degree of work to do, or are Departments, whether it is the Department of Agriculture with food, the Department of the Environment with planning, or DRD in particular with regard to transport, beginning to realise that they have health responsibilities, as much as the Department of Health?

Dr Mitchell: Yes. I will answer that from two perspectives. First, the Department of Health is developing a new public health strategic framework, which, hopefully, will be published in the near future. All Departments have been involved in the development of that and agreeing to outcomes that they can contribute to, improving health outcomes and well-being for the future.

The other aspect is across Departments as employers. They have a good framework in place for that preventative aspect. It is about making sure that all senior managers across Departments give emphasis to implementing it effectively. There are good models there for them to follow, and it is a

question of putting a small amount of resources into making these programmes effective and putting them in place across all Departments.

The Chairperson: OK, members, happy enough? Elizabeth, Joanna, Teresa, thank you very much.