Northern Ireland Assembly

Committee for Health, Social Services and Public Safety

OFFICIAL REPORT (Hansard)

Fit and Well Public Health Strategy: DHSSPS Briefing

18 September 2013

NORTHERN IRELAND ASSEMBLY

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Members present for all or part of the proceedings:
Ms Maeve McLaughlin (Chairperson)
Mr Jim Wells (Deputy Chairperson)
Mr Roy Beggs
Mr Mickey Brady
Ms Pam Brown
Mr Gordon Dunne
Mr Samuel Gardiner
Mr Kieran McCarthy
Mr David McIlveen

Witnesses:

Dr Elizabeth Mitchell	Department of Health, Social Services and Public Safety
Dr Eddie Rooney	Public Health Agency

The Chairperson: Elizabeth, you are very welcome, as is Dr Eddie Rooney, chief executive of the Public Health Agency (PHA). I will hand over to you to give your presentation, and then we will move to members' questions.

Dr Elizabeth Mitchell (Department of Health, Social Services and Public Safety): Thank you very much. I am grateful to Eddie for joining me today. I think that it would be helpful for members to hear about the very positive opportunities for significant action on public health and tackling health inequalities from the perspective of the Public Health Agency.

First, I would like to illustrate how we have responded to your report and your recommendations, how that has helped to shape what will be the finalised framework and how we have responded to the comments that we got back from the public consultation. Since the start of the year, we have received your report, there was an Assembly debate in February, and the Minister formally responded to you in June. As you know, he broadly welcomed your recommendations in replying to the debate and promised to give further consideration to them and come back to you. We continued work on the draft strategy with other Departments and key stakeholders over the summer months. We hope to finalise that work shortly and proceed to seek Executive approval for publication. We will take on board any further comments during this meeting.

To set out the context, we all appreciate that, as a general population, we are enjoying longer lives. However, it is concerning that the gap in life expectancy that Investing for Health set out to tackle still remains. We are not alone in that. If we look around the world, the gap has not narrowed or has, indeed, widened between the most affluent and the most deprived communities in many places. In that context, the Committee's inquiry has been extremely helpful because it focused on what has been

done in other countries and other jurisdictions to tackle those health inequalities and the underlying issues of access and other factors that determine our health.

As we have proposed, the new framework will take a whole-systems approach, which is very much in line with the EU framework for public health, Health 2020. We are saying that, in order to improve the public's health, we need to tackle societal issues and influences — including education, literacy, employment, working conditions, housing and income — if we are to achieve a fair distribution of health and well-being across our population.

The framework highlights that the Department needs to continue to build strategic alliances across all parts of government in tackling many of the public health issues and inequalities that we face. As you know, the ministerial group on public health has been the focal point for such work since Investing for Health. However, there are many other connections with other Departments across a range of issues. The ministerial coordination group on suicide prevention is meeting this afternoon, and that is why the Chief Medical Officer, Dr McBride, could not be here to talk about the Fit and Well strategy. He is supporting the Minister at the ministerial group. That group has been trying to tackle the societal issues that influence what leads to suicide and self-harm in our society. At each meeting, we receive a progress report on what has been done since the previous meeting from each Department and the Ministers who are in attendance. The previous meeting was in January this year, so there will be an update from each Department on ongoing areas of work. There has been good work with the Department of Agriculture and Rural Development (DARD), the Department of Culture, Arts and Leisure (DCAL) on the influence that sport can have, and we have had discussions with our colleagues in the Department for Regional Development (DRD) about issues related to events that happened in Derry recently. That work is continuing.

There is a wide range of other issues that we interact with other Departments on, such as fuel poverty, neighbourhood renewal, employment and rural issues. The paper submitted to you in June gives examples of some of those areas of work.

Beyond Departments, the Public Health Agency and the wider health and social care system, local government and the voluntary and community sectors have been and will continue to be key partners in delivering the framework. In particular, the reform of local government presents an opportunity to strengthen collaboration with district councils and focus on where they can help us in addressing health inequalities. The Public Health Agency has been working very closely with groups of local councils, individual councils and the Society of Local Authority Chief Executives in an effort to ensure that public health remains firmly on their agenda during and beyond the reform process. Eddie will be happy to say more about that later in the session and talk about what is happening on the ground.

Obviously, there are many other organisations — trade unions, professional bodies, advocacy groups, philanthropic organisations and other funders — that can make important contributions to the health of the public, and we need to make sure that we maintain effective links with them. The framework will set out implementation and governance arrangements that will ensure a strong, strategic lead from Ministers, and it will try to secure a joined-up approach across Departments, with the Public Health Agency engaged in driving activity at a regional level and coordinating local delivery. We recognise that those groups also need to make effective links into other strategic groups, such as the children and young people's partnerships.

In the revised framework, we have taken on board the comments that emerged from the consultation, particularly that there was confusion because, perhaps, there were too many priorities and themes, and the life-course approach meant that it was complex and difficult to understand and follow. We have simplified that. We have maintained a thematic approach, very much in keeping with the recommendations in your report. We have reordered the approach, starting with a focus on the wider economic and societal issues and moving down through communities. We have reduced the number of life stages to the best start in life for young children, and then looking at the rest of the life course more holistically to make sure that people are equipped throughout their life. We have looked at empowering healthy choices, the importance of information, and giving people knowledge on which they can base their own decision-making. We also have a new theme, which is about developing collaboration across different sectors.

Within each of those themes are a number of outcomes that lend themselves to a cross-sectoral or thematic approach across Departments and organisations. We hope to give an example of that, which Eddie can talk about later. One of the areas where we think there is a good opportunity for collaboration and the use of the thematic approach is the use of physical space, which leads into the whole area of physical activity, active travel, age-friendly towns and cities, access to green space, help

with social isolation and the general appearance of our neighbourhoods. We think that a number of key Departments and their outside agencies could work together on that, not only improving the public health but doing things across wider society. As I said, Eddie will be glad to give you a flavour of that later.

The Committee highlighted and emphasised the importance of children, young people and the early years. The public consultation endorsed that, and we know that it was highlighted in the national and international evidence given to you in your inquiry. The importance of parenting has been emphasised. So we have kept that in as one of our major themes. As you are aware, work is ongoing across government with the Office of the First Minister and deputy First Minister (OFMDFM). The Delivering Social Change programme has already given £5 million in funding to the Department to increase direct family support and support for parents, and to strengthen our capacity to intervene early in children's lives. A further recent example was the Executive's commitment through the establishment of a £25 million early intervention fund, with equal contributions from the Delivering Social Change programme, Atlantic Philanthropies and a number of Departments, including ours. It is proposed that our Department will lead on the implementation of that fund, which will start in April of next year. The details of that are being worked on by officials.

The Committee highlighted the importance of proportionate universalism: it is not just about targeting all of our resources on the most disadvantaged. There is a great social gradient, and there are levels of disadvantage reflected right across that. We endorse that approach and agree that it applies to many of the determinants of health, not just in relation to, for example, children and early years interventions.

The framework will identify some groups, particularly in the outcomes, for whom targeted action is required, but we recognise that that often needs to be taken on a programme-by-programme basis or at local level. So we have kept it at fairly high level in the framework.

Assets and recognising our assets was an issue highlighted in your report. We entirely agree with you and endorse the fact that that is a very important way forward. There are very important assets in our communities — in the people, the resources, the open spaces, the public areas and the local networks, and in using all of our public, non-profit and, indeed, private sector assets where we can and where appropriate. In taking this forward, we plan to try to map those assets by working with other interested Departments and agencies and exploring how we can use them more effectively and in a more joined-up way.

We are continuing to progress the commitment to increase the percentage of the overall health budget. I will come back next week with other departmental officials to talk to you about the Programme for Government commitments, including commitment 22, so I do not propose to go into that in detail today.

I want to highlight the fact that we took on board the Committee's recommendation that we look more widely at, for example, European structural funds and other sources of funding that can be used for the good of public health. The Department is certainly taking that on board, as are the Public Health Agency and the Health and Social Care Board (HSCB). We can probably learn a lot from local government about how to make successful applications for those kinds of funds.

You also made recommendations about the Safeguarding Board for Northern Ireland's (SBNI) role in parenting. We will take that forward as an issue with SBNI and with social care colleagues in the Department.

Another recommendation was that we introduce legislation to promote breastfeeding. As you may be aware, we published our new breastfeeding strategy in June. In that is a key strategic action to introduce legislation. Our officials have already started to scope the policy detail of the legislation. We anticipate consulting on it before the end of this mandate with a view to introducing legislation in the next mandate.

In conclusion, we welcome the Committee's report and its recommendations and found it extremely helpful. We have taken on board those recommendations that are within our gift. We recognise that you, along with the public consultation comments, have helped us to sharpen the focus of the framework.

We know that changes in public health are long-term goals and that we face many challenges, but, as Eddie will say, there are many opportunities at the moment and, hopefully, with your support, we can

avail ourselves of those. Your support for a whole-systems approach has given us a renewed mandate to work across government and with other sectors. We look forward to continuing to work with you in taking forward the implementation of the strategic framework.

Dr Eddie Rooney (Public Health Agency): I will not delay members' questions, Chair, but I would just like to pick up on the final issue from where Liz left off. Our challenge in the Public Health Agency is to translate the joined-up policy into effective collaborative action on the ground. I believe that we have probably the strongest opportunity that we have had for a long time to get coherence across sectors.

We have all been through a period of immense change with the review of public administration (RPA). However, with work on community planning and education coming on board and, critically, the developments that have been happening over the past four and a half or five years in the health sector, alongside direct developments, particularly with local government but right across sectors, it has been about developing a different mood and trying to develop stronger relationships in advance of the full implementation of RPA. We have learnt a lot, and the relationships are probably stronger than ever. We are well placed and have a stronger drive to renew the commitment from the top levels of government to drive a strategic agenda that is close to all our hearts.

The Chairperson: I thank both of you for that. I would like to make a number of comments. I believe that this represents a hugely important strategic approach to the whole notion of public health and how we ensure that there is more of a coordinated approach among Departments. Although a number of issues have been picked up from the Committee's recommendations, others have not. One of the overarching pieces that is missing is the criticism, which is very clear in the 'Fit and Well' report, which says that the framework is vague on the whole, particularly on actions to effectively tackle poverty, income inequality and discrimination, all of which, as we know, are root causes of health inequalities, and your report states that, too.

One of the Committee's recommendations was a focus on early intervention and prevention. Again, the Committee did not pluck figures from the air. The recommendation from the World Health Organization was an increase in the preventative budget to 6%, yet we are told here that we will get 1·9%. How does that 1·9% tackle this report's criticism about health inequalities?

Dr Mitchell: That is the increase that we have already achieved in public health spending. Your recommendation was 6% by — I need to look and see what the date was. Obviously, we are coming into a period in which there will be renewed discussions and a new spending review. We will have to make the case within that for resources for public health. A case will have to be made for resources to be allocated to Northern Ireland in the overall block.

That case has still to be made, and, with your support, we will fight for it. We also need to recognise that when we make comparisons about the amount of spend on prevention, we base that on the funding of the Public Health Agency. We recognise that it is much harder to capture the spend on funding and commissioning by the Health and Social Care Board, what the trusts spend and what goes through primary care, the GPs. A lot of what we do for prevention and early intervention is captured through those channels. The other factor is that our budget encompasses social care. When we compare ourselves with other jurisdictions and countries, we are not comparing like with like because their funding is purely for health. We have to recognise those factors. We have to take an integrated approach and recognise that it is not just the spend of the Public Health Agency, although that is easier for us to track and monitor.

We are trying to get a better handle on the overall spend on prevention and early intervention. We recognise that that can be within a social care context, a mental health context, the acute sector and, indeed, in primary care. We want to push up the spending and shift left. Transforming Your Care has endorsed that and recognised the importance of prevention, early intervention and shifting care into the community and nearer to people's homes. That is the strategic drive, certainly for Health and Social Care (HSC).

When it comes to tracking some of the wider determinants of health, doing something about poverty or income means that we need to work with other Departments. The Department of Health cannot do that on its own. We will take measures where we can and, for example, we are looking at trying to ensure that we use social clauses to their best effect in public procurement and the contracting of services. We will do what we can to contribute, but we recognise that it is a bigger thing for the whole of the Executive. We will work to try to contribute to the economic strategy and the growth of Northern

Ireland. We recognise that probably one of the best things that you can do for your population and your economy is to have a healthy population. Improving health improves life in general for everyone.

The Chairperson: Elizabeth, I think that we need to get an overall total figure for what is spent on early intervention and prevention. I listened to what you said, but being able to extrapolate the figures from the various sectors in health to give us a total percentage spend on intervention should not be rocket science.

Dr Mitchell: I appreciate that it should not be rocket science. However, it is often more complex than is realised. That is because of the way that we collect information and allocate the funding through programmes of care and not according to whether it is preventative, curative or for rehabilitation. So it is difficult to extract some of that. We also need to consider what proportion of staff time is taken up with prevention and early intervention. A health visitor, for example, may have a range of activities, a lot of which may be about promoting health and preventing disease. However, she will have other activities that relate to, for example, the safeguarding of children. So it is about how you allocate the proportion of those individuals' time and account for that across different programmes. It sounds like we are making an excuse, but there are genuine reasons why getting that information is more difficult and takes quite a lot of teasing out.

The Chairperson: OK. I still think that this needs to be accessible so that, collectively, a case can be made for an increase in that percentage.

Dr Mitchell: I have to say that our finance colleagues are working with us on trying to get a better handle on that.

The Chairperson: I have a couple more quick comments. Do we have a timeline, timescale or process for how the early intervention fund of £25 million will be targeted and delivered?

I understand that 10 of the family support hubs that come under Delivering Social Change will be announced by the Department. How will the process of identifying location, need and objective need be taken into account?

Finally — you can lump these questions together — I am aware of a number of groups that provide very valuable services as part of the critical work on suicide prevention and awareness. I have heard that there are to be new procurement processes. The concern is that smaller groups that do valuable work might well be squeezed out because of these new processes. What are the Department and the PHA doing to build the capacity of such groups to ensure that they will be ready to procure and tender when these services come on stream?

Dr Rooney: I will start with the third issue because it is one that is very close to us. The Public Health Agency will go to procurement across all its services. We are extremely keen to ensure that the outworking of that procurement does not weaken the community capacity that has been so important — in many cases, that has built up over generations in our communities. That is crucial to the delivery. We have often referred to the voluntary and community sector, particularly the community end, as our front line in public health, and we are very conscious of that. We currently fund over 600 groups, some of which are very small, that are scattered and deal with all sorts of issues. That is an awful lot, and it can also be a very fragmented way of getting impact on the ground. We have to look at the effectiveness of that, but, in doing so, we have to look at it in the spirit of what Liz is saying and, indeed, what the Committee said about making sure that we have strong community capacity. That will be right at the front of our minds as we go through the procurement process, and we certainly will take that on board.

The Chairperson: What about the family support hubs?

Dr Mitchell: I will have to come back to you on the family support hubs because I do not have a lot of detail. The Health and Social Care Board is leading on the implementation, and, in line with the priorities of the outcomes groups, trying to enhance existing early intervention services and planning for additional investment to support those. I believe that the board is ready to move to procurement. Some developmental infrastructure has been put in place to take that forward. If you are content, we will come back to you on that.

The Chairperson: What about the early intervention fund?

Dr Mitchell: I have not been directly involved with the early intervention fund. My briefing says £25 million from April, but it does not tell me how long that is for.

Dr Rooney: We are working with the Health and Social Care Board and the social care side of the Department. We were working with them last week and will work with them again next week on the development of the fund and how that will be rolled out. At the moment, that can be put through the Department.

The Chairperson: The first of a number of members who have indicated that they have a question is Kieran.

Mr McCarthy: Thanks, Chair, and congratulations on your appointment as Chair of the Health Committee.

Thank you both very much for your presentation. You must be absolutely gutted about the news on our airwaves over the past couple of days, particularly the news about children and young people. Elizabeth, you mentioned children and young people on a number of occasions. How can this have happened? We had a report from Barnardo's in, I think, 2011, and we are now in 2013, but nothing seems to have been done to prevent that horrible abuse of our young people. Is there any immediate action that you, as chief health officials, can take?

The Chairperson: Sorry, Kieran, but I just want to say that it is no problem if either witness wants to comment on that, but it is not specifically within the remit of the Fit and Well agenda. I understand the connection that you are making, Kieran, and I am happy to hear what the officials have to say if they wish to contribute, but it is not specific to today's brief.

Dr Mitchell: Kieran, you are right: it is extremely important, and I regard it as a very important issue for our children and young people. I think that the Committee will have the opportunity to take further evidence on that issue next week.

The Chairperson: I should clarify that the Committee is seeking to get the researcher who produced the publication for Barnardo's to give evidence to the Committee. So there will be an opportunity for questions then, Kieran.

Dr Mitchell: Eddie may have something to add.

Dr Rooney: My response to Kieran is on the broad principle rather than the current specific example, but it applies to all our interventions for children and young people. We have a here-and-now issue across our areas, as is the case with mental health and suicide prevention. We have to deal with the issues that are facing us today to make sure that, when crises arise, they are responded to. That is not really where we want to be in any aspect of our early intervention. We need to deal with the long-term issues as well, many of which are deeply rooted in the culture of our society and have been growing over years. We have to do both. A critical issue for us is tackling some of the underlying issues that cut across all the areas, cultural issues and the position of children in our society, to make sure that we do something for the generation born now — the 25,000 this year. We need to intervene now. We do not want to be able to predict their health outcomes as being the same as for the current and previous generations. So we have to deal with this on multiple fronts.

Mr McCarthy: Will you give us an assurance that the strategic framework will address the health inequalities suffered by those with mental health problems, which you mentioned, and learning disability problems, including discrimination? We all know that mental health has been the Cinderella of the health service. People with mental health problems are more likely to have physical ill health and vice versa. Will you give us an assurance that that will be tackled? The Bamford report is almost 10 years old and has not been fully implemented. There is real concern that it will fall by the wayside. Will you give us an assurance that that will be one of your priorities?

Dr Mitchell: I assure you that mental health promotion and suicide prevention are among our top priorities. You are absolutely right: there has been an under-recognition of the impact of mental health on physical health and public health in general. It is an area that is receiving growing attention, not just in Northern Ireland but across the whole of these islands. We will be working with Public Health England and Healthy Ireland to try to tackle some of the issues. We are working to bring forward a new mental health promotion strategy, which will pick up in much more detail on some of the

mental health issues. I agree with you on the importance of learning disability — we will certainly pick up on that — discrimination and social exclusion. Many of the areas in which we propose to take action will address a wide sweep of those, but we propose to focus on those who are most vulnerable, whether it is because of mental illness or because they have been in the criminal justice system. We will focus on where we need to prioritise our resources.

Mr McCarthy: So that is an assurance. Thank you very much.

The Chairperson: Gordon is next with a question.

Mr Dunne: Thanks very much, Chair, and we wish you well in your duties.

Eddie, I have a question on engaging the whole community in exercise. I declare an interest as a local councillor. We have a great range of leisure facilities right across the Province. A lot of money has been invested in them, but, in many cases, they are not used as efficiently or effectively as they could be. What can you do to encourage their greater use by the general public? Time and again, we realise that lack of exercise and bad diet are major factors in poor public health. Why not invest some of your money not for the benefit of local councils but to encourage the public to get into the way of exercising regularly in those facilities?

Dr Rooney: You have hit the nail on the head of one of the key issues that has occupied and been at the centre of our discussions with local government. We have been involved in intensive discussions over a prolonged period with local government. There has been a lot of direct activity right across the country with local government. In our latest work, we came up with a joint priority: the utilisation of space and existing social assets to improve health and well-being. We are conscious that it is not only physical buildings but, in many cases, natural assets; for example, the Comber greenway. There are assets running through the heart of communities that are in great need, but there is a lack of utilisation of those assets. For us, the joint priority is really about mobilising the population to get active around their assets. We are trying to supplement that in areas that do not have natural assets.

We have been working very closely with Belfast City Council in particular on outdoor gyms. We have also done that in Strabane and many other areas as a way of enhancing that environment, not only because it helps increase physical activity but because there is a strong sense of community ownership. We are seeing a ripple effect from that into opening up other aspects of ownership to communities, with physical activity being one of the key benefits. From our point of view, there are huge benefits to be derived, because physical activity is so important to all people who want to improve their health and well-being, and that is what we have been set up to do. That has very much been the focus of our work with local government. It is a common issue, because it cuts right across all local government and, indeed, the Public Health Agency. It really does give us a good foundation to build on, and we are determined to build on it.

Mr Dunne: Should we see evidence of local government working out such programmes?

Dr Rooney: Yes.

Mr Dunne: That should happen soon?

Dr Rooney: You will see that.

Mr Dunne: Has social enterprise been looked at? Are you engaging with our local communities and trying to bring ownership to them?

Dr Rooney: Again, we have a number of examples, and I have been to look at some of them right across the country. If we look at the building blocks of what makes a healthy community, we see that a relatively small number are direct health programmes. So much of it is around issues of building not only community pride but employment and training opportunities. That is at the heart of the public health strategy and, indeed, work internationally, which shows that that is how you get the benefits.

Social enterprise and, increasingly, issues around social franchise are about building the mechanisms in communities to help them to take greater control, have greater involvement, have a greater impact at local level and make the interface between a community and a massive and very complex network of statutory bodies that the community deals with. It is a critical issue on our agenda to work with

other statutory bodies to make that an easier way in which to access the resources and to give impact to those resources. From our point of view, the bonus is that it really enhances community capacity, makes our job easier and gives us a greater chance to have an impact on the ground. I have been around some of the areas with members of this Committee, and I know that some of our areas are very advanced and have been for a long time. Mickey, that is the case in your neck of the woods, but other communities have not benefited. I think that there is a real issue to consider about sharing those benefits and that learning.

Mr Dunne: Good. Finally, I welcome the farm families health checks programme. There is a reluctance now for farmers and farming communities to access GPs and the general health facilities that are there, so bringing them to the farmers and the community is to be welcomed. That is a positive move, and we support you fully on that.

Mr Brady: Thank you very much for the presentation. Eddie, I will follow on from your point about the community and voluntary sector, and I declare an interest as a non-executive committee member of the Confederation of Community Groups. There is some feedback from the report that the voluntary and community sector feels that its contribution is insufficiently recognised. As someone who worked in the voluntary sector for many years, I think that that is probably true. You mentioned that some funding is being given to 600 groups. There is the physical aspect, and Gordon talked about sport centres and leisure facilities. When I visited the Newry University of the Third Age (U3A) recently for its registration week, I saw that it was dealing with people aged 50 and over. Something like 400 people registered in that week. It offers all sorts of courses, such as photography, languages and yoga. U3A is a big contributor to well-being in the community.

That contribution needs to be recognised. Will steps be taken to address that? It is not all about funding. It is also about recognising the worth that those organisations have and what they put back into the community. Without them, there would be a dearth of such facilities. A big vacuum would be left in communities if those organisations were not there. Some of them have paid workers, but those are very few. In many cases, all the work is voluntary, but a lot of work goes into it.

Dr Rooney: We could not do our job without that voluntary work in communities. It is not done through just the big organisations. The work happens in local communities all over the place, and it is absolutely essential. One of our challenges is to make sure that, from the Department's point of view, the strategy reinforces that need and that, on the implementation side, we give effect to it. Mickey, it is a very important part of my role, and I do get around the different communities.

Mr Brady: I will finish by making the point that there has been a volunteer bureau in Newry for many years. It is very effective and successful and is now incorporated into Volunteer Now. It has lost staff and is in the process of losing its premises through a lack of funding. It does a sitter service and a befriending service and makes early morning calls to older people to ensure that they are fit and well and will answer the phone. All of that is under attack because of a lack of funding.

Those are issues that need to be addressed. If the voluntary and community sector is to play such an important part under Transforming Your Care, it is organisations such as that that will be at the forefront. Unfortunately, the infrastructure is being undermined. If you lose that experience, that will be problematic in the future.

Dr Mitchell: Eddie has highlighted that to us, and we recognise it as well. As I mentioned, we are trying to ensure that we use the social clauses as much as we can in procurement and contracting and that, in recognition of the issue that you are talking about, we do not have the unintended consequence of removing support and capacity from our community and voluntary sector.

We picked up on social enterprise as an important issue in the framework. We have also picked up on the importance of volunteering as a specific issue. Volunteering is about not just the value that it gives to us — it is one of our assets — but the value that it can give to the individual through engagement and participation.

Mr Brady: The point is that it is Department for Social Development (DSD) funding that is being withdrawn. That highlights the importance of interdepartmental cooperation and the fact that one Department is not necessarily always aware of the impact that a lack of funding has on other work.

Dr Mitchell: That brings us back to the importance of trying to do some sort of assessment of the social impact and health impact of major policy decisions. As you say, those can have unintended consequences further down the line.

I also wanted to say that, as well as working with leisure centres, we engage with libraries, museums and a range of other organisations so that we recognise the wider contribution of the arts and other creativity to health.

Mr D McIlveen: Thank you for the information. I made what I think is quite an interesting discovery. The Assembly often receives a lot of criticism that it is too male-dominated — that there are too many men here. However, since 1998, there has not been one single Assembly question asked on andrology services. That is very telling and shows the extent to which men's health issues can be brushed under the carpet. I see that women and children are very well catered for in the strategy. What efforts will the Department make to reach out to men on their health issues? Could there be more in the strategy to deal with that issue?

Dr Mitchell: It is interesting, because if you look at suicide, which is one issue that we deal with, there is a preponderance of male suicides, particularly in deprived areas. Therefore, there are clearly issues on which it is very important to have a gender perspective. There has been a lot of work done. Eddie can perhaps pick up on the work that has been done with young men on those issues, working with people who have perhaps tried in the past to take their own life or have self-harmed. There is also work going on in initiatives called Men's Sheds.

We have been talking about other issues, such as how you get men engaged. Is it through things such as active travel schemes, cycling or mending cycles? We are looking at that. We recognise that men often engage in some of the damaging health behaviours and that there is often a cluster of those damaging behaviours. It might be substance misuse, tobacco use, lack of physical activity or poor diet. We are absolutely not trying to brush men's health under the table. We will be tackling it, and I know that our colleagues in the Public Health Agency will be as well.

Mr Beggs: Thank you for your presentation. I want to go back to asking about the community and voluntary sector and its importance in improving public health. I declare my own involvement in the Carrickfergus Community Drug and Alcohol Advisory Group (CCDAAG) and Horizon Sure Start.

I have certainly seen local areas with a very weak community infrastructure. Those tend to be the areas with 40% of pregnant mothers who smoke. I think one ward, the Old Warren, has 55% of pregnant mothers smoking. The community sector has a vital part to play in addressing that so that there is community knowledge and a degree of peer pressure created and so that everyone is fully aware of the dangers, rather than have those dangers go over everyone's head. We could have DSD and, to a degree, council involvement in community development. We could have a degree of health service involvement. We could even have Office of the First Minister and deputy First Minister (OFMDFM) involvement, but how and when is all that going to be properly coordinated so that there is one focused involvement to try to regenerate or get community engagement?

Dr Mitchell: Community planning will hopefully be part of the answer to that.

Dr Rooney: I think that we have a real opportunity here. It has been very much at the back of a lot of the very detailed work that we have been doing, particularly but not exclusively with local government. We recognise that we are dealing with the same citizens, the same problems and the same issues, because whatever we fail to do as a society, we all, one way or another, pick that up as a community. Therefore, there is no point in us saying that we are doing our bit. It has been a real challenge for us to look at particular areas that have a long way to go on community development, because it is not an easy self-start, and we need to be able to pool our resources to give them the best chance to get on to that development ladder. It is a community development ladder.

I do not think it is just a question of handing the responsibility for the issues that we are dealing with over to communities in those areas. They are hard issues for them. An equal response is required from the statutory services to complement that, because we also have to change the way in which we think on the other side of the house in health. That goes right down to issues such as the impact of health visitors, how we organise services and the relationship that builds up with the community. That has been behind some of the initiatives that we have been developing.

We have been looking at the same issue in education through some of our early intervention work, such as Roots of Empathy, which is now in 90 schools, and we are trying to put those building blocks in place so that there is a direct link into the community, but that is not done in isolation. It is also about bringing in the statutory services to do things in a different way with communities. That is one of our challenges. Some areas have done it in a different — although not necessarily better — way, but they have come at it from a different way to get things joined up. One such example is the One Plan in the Chair's area, where all those diverse responsibilities are taken and an attempt is made to forge them into a common plan and agenda that all of us can relate to. It is hard work, but I think that is where health needs to get to as well. If we do not do that, the danger is that we will put in the effort, but the amount of energy that we put in may not be enough to really make the break and give people the break that we feel is needed. That is why we must bring in the other sectors. However, to have that impact, we are also explicitly saying that we must think differently about how we do our business and relate to other sectors. It has to be done, because if we do not manage to effect that change at local level, ultimately, we will be back with the Committee in another 10 years having the same conversation.

Mr Beggs: I appreciate that response. I will ask another quick question, if I may. Mention has been made of the farm families health checks programme, and there is the maximising access in rural areas (MARA) project which is happening in the rural community. One other programme that has been listed is the older people's rural project, which provides low-level support in the rural west. Why is that happening only in the rural west? If there is a need to support isolated rural communities, those also exist in the glens of Antrim, the Antrim hills and the Mournes. There are lots of rural areas, so why is there a project operating solely in the rural west?

Dr Rooney: I think that that goes back to the origins of programmes. All sorts of initiatives have sprung up in different areas, and we have not discouraged that, because out of it we have had some rich ideas. Our clear objective to understand what is good, take it and spread it. That will be one of the key issues and challenges for the strategy. If we look across the board, you will find that many projects had their origins in specific geographic areas because folk got together and created a good initiative. That is not how we want things to stay. We really want the good ideas to flourish and develop, and we would like them to be in the mainstream of what we do in future.

I would need to look into the history of that specific project. I am very happy to come back to you on that question.

Dr Mitchell: There is a general point to be made about learning what is working, evaluating that and trying to scale it up. Where we see there is good practice, we try to spread it more widely, while being sensitive to local issues.

The Chairperson: OK. I thank you both for the presentation. It is obviously important work that takes a strategic approach. I hope that the comments that have been made here will be taken on board, specifically the Committee's view that the preventative budget needs to be increased for early intervention. However, we look forward to the Executive endorsement of the strategy and its publication. Please keep us informed.