Committee for Health, Social Services & Public Safety

Review of Health Inequalities Report

Committee powers and membership

The Committee for Health, Social Services and Public Safety is a Statutory Departmental Committee established in accordance with paragraphs 8 and 9 of the Belfast Agreement, section 29 of the Northern Ireland Act 1998 and under Standing Order 46.

The Committee has power to:

- Consider and advise on Departmental budgets and annual plans in the context of the overall budget allocation;
- Consider relevant secondary legislation and take the Committee stage of primary legislation;
- Call for persons and papers;
- Initiate inquiries and make reports; and
- Consider and advise on any matters brought to the Committee by the Minister for Health, Social Services and Public Safety.

The Committee has 11 members including a Chairperson and Deputy Chairperson and a quorum of 5.

Membership

Ms Sue Ramsey MLA (Chairperson)
Mr Jim Wells MLA (Deputy Chairperson)
Mr Roy Beggs MLA
Ms Paula Bradley MLA
Mr Mickey Brady MLA
Ms Pam Brown MLA
Mr Gordon Dunne MLA
Mr Sam Gardiner MLA
Mr Kieran McCarthy MLA
Mr Conall McDevitt MLA
Ms Maeve McLaughlin MLA

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Background to the Review

On 4 July 2012 the Committee held an evidence session with the Public Health Agency on the issue of health inequalities. The Committee learned that although the general health of the population has been improving, the rate of improvement is not equal and is not the same for everyone. Health outcomes are worse in the most deprived areas of Northern Ireland than in the region generally and there continues to be a large difference across various measures, for example – life expectancy, drug and alcohol related mortality, suicide, teenage pregnancy, smoking during pregnancy, respiratory mortality, cancer mortality. The main social determinant of health is poverty.

The Committee was aware that the Department was in the process of producing a new public health strategy. It therefore believed that a review on health inequalities would be a timely piece of work which could feed into the Department's development of the new strategy. It therefore agreed at its meeting on 4 July 2012 to carry out a review on health inequalities.

The Department's draft strategy - "Fit and Well: Changing Lives 2012 – 2022" was published in August for public consultation. This document sets out the 10-Year Public Health Strategic Framework for Northern Ireland. The public consultation ran until 31 October 2012 and the Strategy is expected to be published in the spring of 2013.

Terms of Reference

The Committee agreed the following terms of reference:

"To identify effective interventions to address health inequalities in other countries/regions which could be applied in Northern Ireland, with a particular focus on early years interventions".

Committee Consideration

The Committee held five evidence sessions with a range of expert witnesses who provided information on approaches to tackling health inequalities in various countries and regions. The Committee heard from:

- The Institute of Public Health in Ireland
- Dr Erio Ziglio from the World Health Organisation

- The Triple P Project based in the Midlands, Republic of Ireland
- The Young Ballymun Project
- The Scottish Centre for Social Research.

The minutes of evidence of these sessions are at Appendix 1.

The Committee also wrote to all the Northern Ireland government departments to ask them for details of programmes they currently run to tackle inequalities in early years. The responses are included in Appendix 2.

The Chairperson and deputy Chairperson also carried out a study visit to Cuba as part of the review. The report of the visit is at Appendix 3.

The Committee also considered three papers from Assembly Research and Information Service entitled “Health Inequalities in Northern Ireland”, “Health Inequalities in Northern Ireland by Constituency”, and “Health Inequalities – Review for Committee for HSSPS”. These can be found at Appendix 4.

Recommendations

1. **The Department should place the new public health strategy within the context of a wider governmental strategy for the development of Northern Ireland as a region. It should actively work to form partnerships with other areas of government, including departments not traditionally associated with health matters – such as the Department of Enterprise, Trade and Investment, the Department of Regional Development and the Department of Agriculture and Rural Development. The Department should also actively look at where it could form partnerships with other sectors to access European structural funds.**

   One of the key points made by Dr Ziglio in his evidence to the Committee was that a reduction in health inequity could not be achieved by solely working within the health sector. He argued that for a public health strategy to be successful it must also provide added value to local and regional development. His experience had been that countries which place health promotion and tackling health inequalities within an overall development strategy have more success.

Dr Ziglio provided an example of how this approach had worked in Slovenia. Slovenia had major problems and poor indicators in terms of health and unemployment. However, over a ten year period it has made significant improvements in reducing both health inequalities and unemployment. Slovenia did this by identifying three sectors – health, agriculture and tourism – and producing a strategic plan involving the three sectors. For example, the three sectors worked together in the prevention of agricultural accidents and improving the physical environment. This had benefits for each of the sectors individually and for all three sectors collectively. Dr Ziglio made the point that this approach is different from the traditional idea of departments working as silos and seeing other departments as competitors for limited resources.

Dr Ziglio also suggested that Northern Ireland should look more closely at how to maximize European structural funding opportunities. He believed that the trend had been for most of the funding in health to go into buildings. However, if health could partner with other sectors there may be more of an opportunity to access funds.

2. **Consideration should be given to creating thematic approaches to government departments, whereby health is grouped alongside other sectors.**

As discussed above, Dr Ziglio provided an example of how the health, tourism and agriculture sectors had worked together in Slovenia to produce positive outcomes in terms of health inequalities. He also referred to the approach being taken in Scotland whereby a thematic approach is taken to government departments. For example, in Scotland Cabinet Ministers have responsibility for broad areas such as Health and Wellbeing, and Finance, Employment and Sustainable Growth. Dr Ziglio stated that this set-up is well suited to smaller countries or regions, such as Scotland or Northern Ireland, and that the World Health Organisation is working closely with the Chief Medical Officer in Scotland, Sir Harry Burns, to monitor the success of this approach.

3. **Consideration should be given to creating a Department for Children and Young People in order to place a greater focus on early years interventions.**

The evidence presented by Young Ballymun emphasized that their approach was to put the child at the centre of the picture in terms of designing appropriate services for the community. They also pointed to the fact that Young Ballymun was funded by the

Department of Children and Youth Affairs in the Republic of Ireland, and suggested that the existence of such a department helped secure a more intense focus on the needs of children. The Scottish Centre for Social Research also drew attention to the fact that in Scotland there is a Minister for Children and Young People, and again made the point that this creates a focus on looking at the needs of children.

4. **The new public health strategy should recognize parenting as having a significant influence over long-term public health issues and should adopt a "progressive universalism" approach to supporting parenting projects.**

The Institute of Public Health in Ireland, Young Ballymun, and the Triple P Project all stated that more attention needed to be given to supporting parenting. Young Ballymun argued that there was a lack of recognition in society that parenting is an energy intensive job, and is a skill that can be learned, rather based on innate knowledge. This in turn can deter people from seeking support as they feel that because they are a parent, they should automatically know how to parent.

The Triple P Project made the point that the home environment can alter a child's biology. If there are problems around aggression, violence or inconsistent parenting, this will change the structure of the infant's brain. Early childhood experiences expose a child to toxic stress which increases the likelihood of later risky behaviours. However, early supportive relationships with parents can act as a protective factor and counteract negative events. The finding from the Growing Up in Scotland survey conducted by the Scottish Centre for Social Research also revealed that while material circumstances dominate in terms a child's outcomes, there are a few factors that can protect children. These were mainly around parenting and included having parents who seek support and advice, the home learning environment, and parent-child activities.

Young Ballymun similarly made the point that anti-social behaviours have their roots in early infancy. They therefore provide an enriched baby development clinic to help nurture the parent/infant bond.

The Triple P Project advocated for parenting support programmes to be available to all parents. A survey in the Republic of Ireland revealed that only 30% of children with behavioural problems were from the lower socioeconomic group – it is a problem that

affects families from every socio-economic group. Therefore, to really address the issue, they believe there needs to be universal access to programmes. The point was also made that this approach helps take away the stigma of attending a parenting programme. However, a progressive universalism approach means that while access is available to all, more resources are put into reaching the most vulnerable groups.

5. **The Safeguarding Board for Northern Ireland should look at parenting as a wider tool for safeguarding the physical, mental and emotional well-being of children and young people.**

The Safeguarding Board for Northern Ireland (SBNI) came into force in September 2012. The Committee for Health, Social Services and Public Safety scrutinized the legislation which created the SBNI in 2010. While the main focus of the SBNI is to ensure the effectiveness of agencies involved in child protection, it does have wider powers in terms of promoting the safeguarding of children more generally.

The Committee is of the view that given the impact of parenting on a child's outcomes, that the SBNI should examine this issue in their work programme.

6. **The Department should consider bringing forward legislation supporting those whose wish to breastfeed given its benefits as an early years intervention.**

The Institute of Public Health in Ireland made a clear link between breastfeeding rates and health inequalities. They stated that while it is accepted that breastfeeding provides the best nutrition and is associated with the optimal physical and brain development of young children, significant inequalities in breastfeeding remain. In a comparison of babies born in the least and most deprived areas of Northern Ireland, babies in the least deprived areas were twice as likely to receive the benefits of breast milk. Furthermore, in Northern Ireland, the rates of initiating breastfeeding are lower than those in Great Britain, and the duration of breastfeeding is shorter and falls off more quickly. In Northern Ireland, only 15% of babies are breastfed up to 6 months. During the study visit to Cuba, the delegation learned that the rate in Cuba is 95%.

The Institute of Public Health in Ireland raised the issue of legislation on breastfeeding and referred to the situation in Scotland where legislation has been passed which protects the rights of women who breastfeed in public places. In their view such a step has helped to change the culture to make breastfeeding the norm.

The Institute of Public Health in Ireland also made the point that investment needed to be made during pregnancy by way of getting women to think about breastfeeding before they have their baby, as well as getting support in communities.

7. **The new public health strategy should identify all assets (physical and human resources) already in existence in Northern Ireland which could be used to tackle health inequalities, and provide up-skilling for health professionals where needed.**

The evidence presented by both Dr Ziglio and the Young Ballymun project both made reference to the importance of identifying assets. Dr Ziglio stated that often the focus of policy makers in the field of health inequalities is on the problems in communities, rather than the opportunities for change. He was of the view that Northern Ireland has a range of strong assets that could be used to tackle health inequalities, including good infrastructure, good human resources and good social networks.

Young Ballymun argued that there needs to be more emphasis on identifying community resources and strengths. In terms of their own project, they had discovered that one of their key assets was the potential in parents to drive change for their children. Young Ballymun also discussed the need to change how mainstream services are currently provided so that they are actually used by those who need them most. This can be done by up-skilling health professionals so that they understand the needs of the community they are working in. A similar point was made by the Scottish Centre for Social Research. Their findings show that a range of services often need to be provided to meet different groups' needs. For example, they found that teenage women prefer to go to ante-natal classes which are attended by other teenage women. Therefore, if only a general ante-natal class is provided by a health authority, teenage women may not attend. Health professionals need to be made aware of such preferences.

8. **The new public health strategy should prioritize funding for projects which involve collaboration between partner organisations, to ensure a co-ordinated and more effective approach to particular issues.**

   All of the witnesses emphasized the importance of collaboration, whether between sectors, communities or organisations delivering services of the ground. Young Ballymun made the point that a partnership approach should be a requirement for a project to be funded, in order to avoid potential duplication, and also to bring together a wide range of skills and expertise.

9. **The Department should consider increasing the percentage of the overall health and social care budget spend on prevention to 6% within the next decade.**

   Dr Ziglio made the point that even though the argument is now generally accepted that investing in prevention saves money further down the line, there was still a reluctance by governments to direct resources to prevention. The average spend in European countries on prevention is 3% - in his view it would be achievable to double this to 6% within a decade.

Appendix 1

Minutes of Evidence Relating to the Report

Northern Ireland Assembly

Committee for Health, Social Services and Public Safety

OFFICIAL REPORT (Hansard)

Health Inequalities Review: Institute of Public Health in Ireland

3 October 2012

NORTHERN IRELAND ASSEMBLY

Committee for Health, Social Services and Public Safety

Health Inequalities Review: Institute of Public Health in Ireland

3 October 2012

Members present for all or part of the proceedings:
Ms Sue Ramsey (Chairperson)
Mr Jim Wells (Deputy Chairperson)
Ms Paula Bradley
Mr Mickey Brady
Ms Pam Brown
Mr Gordon Dunne
Mr Samuel Gardiner
Mr Kieran McCarthy
Ms Maeve McLaughlin

Witnesses:

Dr Helen McAvoy	Institute of Public Health in Ireland
Mr Owen Metcalfe	Institute of Public Health in Ireland
Dr Joanna Purdy	Institute of Public Health in Ireland

The Chairperson: You are more than welcome. Thank you for the briefing paper that you sent to the Committee and for taking the time to come up to brief us as we look at health inequalities. I will hand over to you to make the introductions and give your presentation, and we will then open up the session for questions or comments.

Mr Owen Metcalfe (Institute of Public Health in Ireland): Thank you very much, Chair. I welcome this opportunity. I am the director of the Institute of Public Health in Ireland. With me today are Dr Helen McAvoy and Dr Joanna Purdy, who are members of the team in the institute. I will give a short introduction on the background to the institute, its orientation and some of its work. My colleagues will then provide more detail on the specific issue under discussion today, the early years.

Some of you will be familiar with our history. We were established in 1998 to bring about increased support for co-operation on public health on the island of Ireland. The issue under discussion today is of particular importance and relevance to us. Since the beginning, we have sought to place an emphasis on health inequalities. Simply put, we believe that, for example, the fact that males living in the 10% least deprived areas can expected to live, on average, almost 12 years longer than their counterparts in the 10% most deprived areas is unfair and unjust. Since we were established 14 years ago, we have tried to address the issue of health inequalities through our all work. It is of great comfort and solace to us to know that the issue is now being prioritised.

Our work in looking at and focusing on health inequalities is built on three strands, the first of which is health information and health intelligence. We want to improve the analysis of existing data sets and be able to advise on their content to support better decision-making for better health. An example of

the work that we do in that area is Health Well and its community profiles. So if, for example, you want to find out the levels of smoking in a particular local government district or breastfeeding rates in a particular area, you can go to the Health Well and explore the information and data available there. If you want to look at what policies to address some aspect of health are available for young people, you can also turn to the Health Well.

The second strand is our evidence-based policy development to support Departments and agencies, their strategies and plans. We prepare consultation responses, and particularly relevant to the issue of early years were our recent submissions to the Northern Ireland breastfeeding and maternity strategies. We try to give people the information that we feel will help them in their decision-making process during policy development phases. We have also been critically and centrally involved in the development of the Fit and Well strategy and, in parallel to that, the Your Health is Your Wealth strategy. Those are public health strategies that have been developed, North and South, and it is a happy coincidence of timing that, in the next few months, we will have two brand new public health strategies on the island that will provide the guidance for the future of public health. We also work with the Public Health Agency (PHA), and we are delighted that the early years issue also receives priority in its strategic framework.

The final strand of our work is capacity-building, in which we try to equip people with the skills and vision necessary to see their policies through a health lens. We have done this through concrete training in health impact assessment, but we also produce evidence reviews to highlight and emphasis the relationship between areas such as transport, the environment and, critically in relation to this topic, education and health. So decision-makers can pick up our review and find central evidence that supports the relationship between those areas.

We are very pleased to be here. I will now ask Dr McAvoy to carry on and detail more specifics in the types of areas that we have looked at and explored.

Dr Helen McAvoy (Institute of Public Health in Ireland): Thank you, Owen. To give you a bit of an overview of what I hope to cover in the next few minutes, I will set out some of the concepts and evidence that underpin the role of early years in tackling health inequalities; discuss some findings from the data in the Northern Ireland context; look at the current policy landscape around early years in Northern Ireland; and set out some considerations for policy development.

I will start with the conceptual piece. Giving every child the best start in life has become a priority theme for a number of Governments seeking to reduce health inequalities. This has come from the work of the World Health Organization's Commission on Social Determinants of Health. When it looked at the evidence, it became very clear that early years must now form a central foundation of all health inequality policies. The foundations of all aspects of human development — physical, psychological, social and emotional — are laid down in early childhood. We know that babies and infants thrive where there is good early nutrition; a warm, loving family; and frequent exposure to environments conducive to safe physical play, learning and social interaction. As parents and grandparents of young children, you will probably know that already.

International evidence for early years intervention goes well beyond that. It hinges on two critical factors, the first of which is that there is good evidence that it works. The experimental evidence from a large number of studies, largely conducted in the US and starting in the 1950s and 1960s, shows that early years interventions are very effective and show positive outcomes not just in the short term but in the long term. The second critical factor is that investing in early years is good value for money. Later interventions in, for example, adolescence, although still important, are considerably less effective. Many early years interventions are estimated to have very high benefit-cost ratios and rates of return, which is certainly piquing the interest of economists as well as public health professionals.

In the US, it has been estimated that for every dollar spent on early years childhood intervention, the return is $16. Some financial modelling analysis has been done for the Scottish Government, and it estimated that the total potential annual saving accruing from investment in improving early years outcomes in Scotland could be as much as £5·4 million. So the evidence tells us that, if society intervenes early enough, it can raise a range of abilities for disadvantaged children, equipping them better to thrive, not only at school and later in the workplace, but in many other aspects of their adult lives, including relationships and their ability to parent well in due course. Some of the outcomes now known to be positively associated with early years interventions include better educational attainment; reduced risk of teenage pregnancy, antisocial behaviour and criminality; and better mental health. In addition, it is now becoming apparent that a number of soft skills are associated with early years, such as self-confidence, self-esteem and the ability to relate and have good relationships.

I presented a snapshot of data on early years interventions in Northern Ireland in the briefing paper, and I will comment on just one or two of those. We know that child poverty can threaten optimal early years development in direct and indirect ways. At present, using the relative income poverty measure, about 21% of children in Northern Ireland are considered to live in poverty. Children living in lone-parent families, those in families with large numbers of children and those with unemployed parents are at greatest risk, but we also know that there is a significant issue with children growing up in families that would be considered working poor.

An analysis of the Northern Ireland sample of the millennium cohort study (MCS), a longitudinal study of infants that looks at outcomes at the age of five across the UK, gives us some good news. At age five, children in Northern Ireland fared, on average, better than those in England, Scotland and Wales in cognitive scores, educational assessments, behavioural assessments and general health. However, there were issues in Northern Ireland households with the home learning environment. Common themes across the countries in the UK were that low birth weight, child poverty and disadvantage were associated with poor child development in all jurisdictions.

The health and social care inequalities monitoring system in the Department of Health, Social Services and Public Safety (DHSSPS) produces a lot of data on pregnancy and early years. The common theme is that young children in poor communities have not benefited to the same extent from gains in population health. An example of that is infant mortality; that is, deaths occurring the first year of life. In Northern Ireland, such deaths have reduced dramatically in the past 20 years, as they have in many other European countries. However, the reduction has not been shared equally. There is, in fact, evidence of some small increases in infant mortality in the most deprived areas of Northern Ireland over the past decade. We know that a healthy environment in the womb is critical to infants having a good starting point in their early developmental years. In Northern Ireland, as is the case with many other countries across the UK and Europe, women from disadvantaged circumstances are more likely to have a low-birth-weight baby. Low-birth-weight babies in Northern Ireland are predicted to have worse educational, cognitive, behavioural and general health outcomes at age five. That is, in part, related to issues such as higher smoking rates in pregnancy among disadvantaged mothers, but there are other factors as well.

We know that breastfeeding provides the very best nutrition and is associated with the optimal physical and brain development of young children, yetsignificant inequalities in breastfeeding remain. In a comparison of babies born in the least and most deprived areas of Northern Ireland, babies in the least deprived areas were twice as likely to receive the benefits of breast milk. Owen referred to the longer term outcomes in health inequalities and life expectancy, but another important point is that adverse early years experiences, particularly in the more extreme cases of abuse or neglect, place young people and adults at significant risk of mental ill health and suicide. Some of the most sizeable inequality gaps between deprived areas in Northern Ireland overall were found in the number of admissions of young people and adults for self-harm. We need to think about the role of early years in promoting resilience and good mental health right from the beginning.

In the policy landscape, in general, an early years focus in government policy requires a commitment to enhancing the quality of disadvantaged families' early education and community environments. We need better outcomes from improved early years services environments, but those need to be backed up by government policies that are strong on protecting young families' incomes, good housing and access to education, employment and social protection, particularly in the domain of child poverty.

A draft early years strategy is under consideration by the Department of Education. We understand that Minister O'Dowd is committed to developing a strategy that sets out a road map for securing better outcomes for young children through a focus on education and linking of early years services with a new foundation stage in the first years of primary school. He has also said that there is a commitment in the strategy to focus on disadvantaged areas, and we certainly welcome that.

It is also envisaged that the early years strategy will mark out synergies and integrate well with existing strategies that have a focus on early years, including the children and young people strategy, the literacy strategy and the child poverty strategy. It has been proposed that, to some extent, the Delivering Social Change framework set out in the Programme for Government could be a key mechanism for delivering on the aspirations in early years outcomes across a number of strategies.

In health, the implementation of Fit and Well, the 10-year public health strategic framework for Northern Ireland, currently out for consultation, will be critical. That proposes a life-course approach but set outs the early years as a strategic priority for reducing health inequalities, including a focus on

pregnancy and pre-birth determinants of child health. It is critical that, as well as supporting the growth of new and innovative, locally based early years services — we have seen that happening in recent years — we need to enhance the established public health programmes that already support good health in the early years, including our programmes of childhood vaccination, child health screening and developmental assessment.

Improving outcomes in the early years will also be enhanced by adequate resourcing to support the implementation of key public health strategies, particularly in the domains of maternity care, breastfeeding, overweight and obese children, physical activity and play. Success in tackling inequalities in child health must be an important goal of early years work across all Departments.

It is of interest that an early years strategy is also being developed by the Department of Children and Youth Affairs in the Republic of Ireland. In Scotland, an early years framework was published a number of years ago, and there is much to learn from its experience to date. Australia has published its national early years childhood development strategy, but it is fair to say that, globally, this area is still in an early stage of development.

As for the implications for policy, the commitment to achieve more equitable child development in the early years must be a priority at a whole-of-government level. There should be endorsement by and support from the Northern Ireland Executive, the Office of the First Minister and deputy First Minister (OFMDFM) and other Departments, because all Departments have a role, and accountability will be critical. Despite the challenges posed by the recession, a clear focus must be maintained on tackling child poverty. We need to consider carefully the economic and social circumstances of families with young children within the tough budgetary decisions on social protection and the allocation of resources.

Consideration should be given to increasing the proportion of overall expenditure allocated to the early years. Where that is not possible because of budgetary constraints, at the very least, expenditure should be focused progressively across the social gradient, giving preferential resourcing to disadvantaged areas.

Early years education is also very important, as is the level and quality of its provision. That should be subject to continuous quality cycles and development, again with a focus on socially disadvantaged families, and performance management systems to support the outcomes that we expect in socially disadvantaged areas. For a long time, we had very little information about what happened in the early years. There were surveys of schoolchildren but very little information on what happened in the years before children attended the state school system or before they were able to answer a questionnaire. That is improving with time. In particular, longitudinal studies of childhood, such as the MCS, tell us a lot about the current situation and about what we can expect from policy changes in the future. It is critical that we continue to resource and develop our longitudinal studies and look at research and evaluation to find out which services work best in which settings. That will be the key to developing evidence-based policy in the long term.

Mr Metcalfe: I would just like to add that Dr McAvoy is from a health background, and Dr Purdy is from an education background. We regard the combination of abilities in both areas as essential and an indicator of the requirement to provide joined-up thinking across Departments. So we brought Dr Purdy along to answer any specific education questions that might arise.

The Chairperson: The paper is very interesting. We are looking at the whole issue of health inequalities. I am conscious that you are not here to speak on behalf of a Department, either North or South, and I remind members of that. Some of our constituencies probably have bigger pockets of health inequality than others, but, in my view, health inequalities have not changed over the past number of years. It struck me that other Departments have a responsibility. When we go back a number of years to the public health agenda and the Investing for Health strategy, all Ministers gave a commitment and signed up to do what they thought would help to improve public health and tackle health inequalities. So I agree with you that accountability is critical and that other Departments have a role. Unfortunately, the Health Department deals with the outcomes.

In my constituency — I know that it happens in other constituencies — it seems that, when there is a pilot project to target health inequalities, whether through early intervention, the juvenile justice system or mental health breakfast clubs, the community sees the benefits and then has to battle to get the money. I am of the view that we tend to put money together in a piecemeal way for those types of projects and do not recognise the serious benefits of early intervention. Importantly, we now have, as you said, two public health policies on the island. Is the necessary commitment being shown through

the involvement of our Public Health Agency here in the North and through what is happening in the Executive? Health inequalities have not changed this year, so do you think that we will now start to see changes?

Mr Metcalfe: It is gradually dawning on people that health inequalities are part of everybody's remit. It is not just DHSSPS's responsibility to address health inequalities, but it has taken a long time to get that message across to all Departments. That is why we stress that one of the best things that you can do in this area is have the appropriate policy in place. That policy must be mandated from the very top, at Executive level, with accountability through the various Departments. There are indications in the consultation document for Fit and Well that all Departments will step up to the plate and play their role to identify specific actions that they have to undertake to participate in making a difference. That is welcome.

Tackling inequalities is difficult; there is no doubt about that. There are challenges for every Department, but that must, and hopefully will, remain a central plank of Fit and Well and the PHA's strategic framework. Accountability is critical, but we must also look for an ongoing commitment to the type of programmes that have been shown to make a difference. Although we talked about them being pilots, I noticed that Sure Start and Roots of Empathy are getting traction, and there is commitment to extend support for these vital programmes. You cannot just hit something piecemeal; you have to have a strategic plan, and inequalities have to be central to a lot of areas. However, you have to prioritise what you can address in each area, especially when there are tight resource constraints. It is disheartening to notice that the gap is not narrowing, but we are forever hopeful of that continued commitment and engagement and cross-party and cross-departmental support for prioritising the issue.

The Chairperson: We have a priority because we are a Committee that looks after health, social services and public safety. However, other Committees have priorities, and although we all know that public health is a cross-departmental issue — in fact, it should be an Executive priority — other Committees are faced with their own priorities. There is a battle to change the mindset about what public health actually is. It is about being proactive.

Given the current spend on the public health agenda in general, do you believe that, as things sit, there is a focused approach to targeting health inequalities?

Mr Metcalfe: That has happened in Investing for Health and Fit and Well. Commitment and accountability mechanisms could be stronger.

The Chairperson: From other Departments?

Mr Metcalfe: From every Department, yes. There is a requirement to engage continuously with those Departments. We have met and worked with many Departments in the context of our health impact assessment training, and we need ongoing commitment from those Departments. A mechanism such as the ministerial group on public health is, potentially, extremely valuable for getting that sign-up, engagement and continuous commitment. I see that as virtually an exemplary mechanism across Europe and something that needs to be examined, explored, built on, developed and continued.

The Chairperson: I have asked the Committee Clerk to find out when that ministerial group last met, because we had a ministerial subgroup on suicide and self-harm and it was 18 months before it met. If there is no commitment at that level, we need to look at that.

You mentioned the focus on maternity care a few times, and you mentioned the breastfeeding strategy. Is there enough focus on maternity care, even after birth, to encourage new mothers to get involved in breastfeeding? You cannot drive a car unless you have a licence. Is there the same type of commitment when there is a new birth?

Dr McAvoy: We have made a submission to the consultation on developing a new 10-year framework for breastfeeding, and I was very heartened to see the quality of the consultation document and the commitment to make this a 10-year policy goal, because we have not had that same level of commitment to breastfeeding previously.

In Northern Ireland, the rates of initiating breastfeeding are lower than those in GB, and the duration of breastfeeding is shorter and falls off more quickly. We are doubly disadvantaged, and we need to look at both issues. One issue is changing the culture between feeding babies naturally and bottle-feeding,

and there are issues around some of the legislation on breastfeeding. Scotland brought in legislation that protects the rights of women who breastfeed in public places, for example, and although those things are not the be all and end all, they are small steps towards changing the culture to make breastfeeding the norm. It is interesting that we have a strategy that talks about normalising something that is actually normal.

The Chairperson: I raised that issue, and the pre-birth issue, last week. We have been advised, and we are waiting for confirmation, that the National Institute of Health and Clinical Excellence guidelines state that any woman who is due to have a caesarean section should get an antibiotic. My information is that that never happens. There are small measures that do not cost a lot of money but could save an awful lot in the long run.

Dr McAvoy: There has been some analysis of breastfeeding figures, North and South. Some hospitals have invested in the promotion of breastfeeding, but we also need investment during pregnancy by way of getting women to think about this before they have their baby as well as getting support in communities. We need extra development at that level, along with what happens in the hospitals, because hospitals can get very rushed and busy with other things. Something has to happen during the time the woman is pregnant. She has to be encouraged, not just through interfacing with the health services, but by the community in which she lives. The support that she gets from other women, in her family and in her community, can help her when making that decision.

The Chairperson: Are members content that we get that information from the ministerial group on public health?

Members indicated assent.

Mr McCarthy: Thank you very much for your presentation and briefing paper. I have a couple of questions: page 5 of your presentation references the MCS. Will you give us an update on how that is going and what has been learned so far? I think you mentioned that we came out on top for age five, which is interesting.

Secondly, page 3 of your paper draws attention to the fact that parents with long-standing illnesses and mental distress are linked to worse health outcomes for children. The Fit and Well strategy that you both mentioned emphasises that we have a disproportionately high prevalence of mental ill-health, so general support for parents, including those who are already suffering with mental health problems, including alcohol-related illnesses, is key to ensuring that our children grow up as healthy as possible.

A lot of good work is going on already, as you mentioned, in Sure Start. We also have Home-Start and we had Life Start, which unfortunately fell by the wayside because of a lack of funding. Home-Start is struggling, too, but it does excellent work. It would be useful to know whether you think we could learn anything from the other jurisdictions you mentioned in your document; for instance, the South of Ireland, Scotland, Australia or any other countries.

Dr McAvoy: The millennium cohort study is a longitudinal study carried out across the UK that follows children on a regular basis from birth upwards. What is useful about it is that it allows each of the UK jurisdictions to compare with each other using the same survey methodology. This report from 2010 is a report on the consequences of childhood disadvantage in Northern Ireland for children aged five, and it was commissioned by the Office of the First Minister and deputy First Minister. It provides a very good overview of the factors that are related to childhood disadvantage at that age. The beauty of longitudinal studies is that you can follow the children over time as they get older and you can see, not just the short-term outcomes as they enter school, but how they get on in school as they progress.

There is a longitudinal study in the Republic of Ireland called 'Growing Up in Ireland'. It came in a little later than the millennium cohort study, but there are several North/South comparisons that examine how children are progressing across the two surveys over time. It is a very useful comparative tool, particularly in highlighting some of the differences in the way early childcare and education are structured. I think that it will be very informative.

To the best of my knowledge, those studies are still enjoying the support of some government funding. I hope that they continue to do so.

There are particular issues around the mental health of parents because of the economic situation at this particular time. There may be redundancies in the family, or people may be in very low-paid employment. Incomes are going down, which puts stress on families to meet their needs, including those of their children. We have done some work around men's health, in particular, and the impact of unemployment on their physical and mental health. Owen would be best placed to explain that.

You are correct in identifying the role of alcohol and the harm it causes through mental illness and the effect it can have on the family unit. I think we need to get tough on alcohol, and this is a priority both North and South. The institute will be involved in some North/South co-operation work on alcohol in the coming months, and we are watching with great interest some of the developments from the minimum alcohol pricing Bill in Scotland.

As to your last point about looking at what is happening in other jurisdictions, it will be very interesting to see what comes out of the Republic of Ireland's strategy, which is being operated by the Department of Children and Youth Affairs. I know there was a children and young people's unit in OFMDFM, though I am not sure about the status of that unit now. The early years strategy is now being led by the Department of Education, and I hope that it will still have an eye to all these other important outcomes in early years that are directly and indirectly related to education. One of the strong elements of the Scottish approach was that they commissioned a piece of work that looked at the economics, savings and benefits derived from early years investments. I think that helped them to get their strategy across the line and to get investment at a time when finance Departments had to decide what to invest in.

Mr McCarthy: It is about trying to convince people that, by investing early, they can save in the long run.

Dr McAvoy: Yes. When it comes to decisions, money talks, and I think looking at the economics involved is important. I am not an economist but I can read enough of it to understand when something makes good economic sense.

Mr Metcalfe: I have one further point to make about examples of good practice. It is worth having a look at what has been happening in New Zealand, which has a 10-year plan that concentrates on early years and on the educational components of what happens to young people in centres. One critical thing about this is that it is not just about education in isolation. In the centre, you also have the allied services from health — so you have your physiotherapist and your practice nurse and such people. It is a 10-year plan, and it involves several departments. It is already showing a lot of returns on investment.

Mr McCarthy: Would it be worth the Committee having a trip to New Zealand? *[Laughter.]*

The Chairperson: Let us hope that the media have picked up on the fact that Kieran McCarthy proposed that. *[Laughter.]*

Mr McCarthy: One member.

The Chairperson: And a one-way ticket. *[Laughter.]*

Mr Metcalfe: You could start with Scotland.

Mr Brady: Thank you for your presentation. It was very comprehensive. You spoke about inequalities. Males in less deprived areas live, on average, 12 years longer. It strikes me that you have a very comprehensive public health strategy, North and South, and there is a certain irony in that we are now facing benefit cuts through welfare reform.

There are social welfare policies in the South, such as single working-age payments, which are probably just as draconian if not more so than what we are facing. I am not sure how you equate the fundamentals of people living on benefit and who are in the most deprived areas. The reason they are on benefits is because they live in the most deprived areas, and it is the same in the South. There seems to be a certain irony in that you are doing a very good job but are fighting against the tide because all this stuff is coming at us. It will undoubtedly create even more inequalities, particularly in health, because people cannot afford to eat and heat their houses. It is affecting the most vulnerable — the young, teenagers and older people.

Obviously, it is not your fault, because you are in a different sphere. The point has been made about a cross-departmental approach. Pam and I sit on the Committee for Social Development, which is dealing with the cuts, and on this Committee. There is so much overarching stuff involved with those two Committees. If there were proper cross-departmental feed-in, maybe some of the problems could be alleviated by mitigating the effects of the changes. On the one hand, you can have Sure Start and all of that doing a very good job, but when those kids get home, if there is not enough money to feed them, clothe them properly or heat the house, there will be huge problems.

Dr McAvoy: It is a big challenge. Ireland and Northern Ireland have had some difficulties in comparing well on child poverty rates. The OECD looked at this across Europe and examined different policies on childhood, the distribution of income and the prioritisation of the types and location of children's services. With that evidence, and the review of child poverty undertaken in the Republic of Ireland, it seemed clear that income is definitely part of the solution to child poverty, but so is investment in the local neighbourhood, as regards access to play, and in local health services, the local social services and family support services. A dual approach is needed to tackle child poverty. It is not just about income, but income is certainly important. Where income is taken away from families, we need to think about cushioning them from the effects of that as regards the design and delivery of local support services.

Obviously, this is a very difficult economic climate, North and South, and tough decisions will have to be taken. At the moment, we spend the majority of our money on children in their secondary school years and a minority of the money in their early years. From what the economists and the research are telling us, it now looks as though it might be smarter to spend more money in the early years and spend perhaps a little less, or in different ways, in the later years of childhood. That is one way of configuring things. What we need to consider in the early years is that many children will be at home for most of the day — they may go to an early childcare service for a few hours in the day — so we need to think about the resources needed in the home and not just leave it to families to meet those needs.

Mr Brady: The ages, particularly of lone parents, are going down. It is difficult for lone parents to be available for work if they have a one-year old, yet we do not have any childcare provision worth talking about. There are plenty of crèches, which are extremely expensive, but childcare provision in England and Wales is a statutory right under legislation, and local authorities have to provide it. We do not have that here, yet the same "standards" are going to be imposed here as in Britain. There is no doubt that this is going to create more problems than it solves.

Dr Joanna Purdy (Institute of Public Health in Ireland): I will pick up on your point about affordable childcare. If childcare is not affordable, it makes working impossible and it does not make it an easy decision. Our Prime Minister has spoken about making benefits less attractive and going out to work the more attractive option. In order to do that, we want to make the economic climate such that jobs are available but that those jobs do pay, and that there is incentive to work, balanced with affordable childcare. You are right; it is very expensive.

Mr Brady: Statistics that came out yesterday suggest that there are 5·8 applicants for every job in the North. We are not going to solve that problem easily. If someone accesses the childcare element of working tax credit, their child has to be looked after by a registered childminder. If your granny, your auntie or your sister registers, they also have to look after at least one other child who is not related to them, which seems to defeat the whole purpose. Initially, working tax credit was introduced to encourage lone parents to get back to work. It has done the complete opposite. That is just an observation.

Dr Purdy: I take your point, and I agree.

The Chairperson: *[Inaudible.]* the work we are trying to do.

Ms Maeve McLaughlin: Thank you for your presentation. I have just a couple of points to make. Initially, it struck me that improving the analysis of the data sets is critical. I recognise that from my constituency as regards Derry and the wider north-west. When we were working our way through a regeneration process, some obstacles related to some Departments releasing information, and perhaps storing information but not collating it. That provides real challenges. I am listening carefully to what you are saying about that having improved. That is good.

In our process, which I am most familiar with, through the regeneration, the learning was that regeneration is economic, physical and social, and that you cannot separate those if you are going to have a meaningful process and outcomes. One of the catalyst projects for us was early intervention in health and education. You can have the best schools in the world — and we have a really good schools estate here — but if you do not have early intervention directed to the child or the wider family before the child is seven, forget about it. That links with infancy and mental health, and some of the issues that spring from that are quite stark.

I listened to the economics involved, and you mentioned the Scottish model and the — I think — £5·4 million savings made through intervention processes. I know that Kieran asked a similar question, but I am interested to know whether the island of Ireland has looked at these costings. Ultimately, the economic argument is critical.

You noted that young children in poor communities have not benefited, and that is right. They have not benefited from any of the wider changes in public health. Key to this — and you referred to it yourself — is preferential resourcing to disadvantaged communities. That has to be key to what we do. It has to be about targeting resources. Then, importantly, and I know this can be quite technical, it is about measuring outcomes. One thing that we have learned, and 51% of our population is in high social need, is that in order to change patterns and outcomes, you need to monitor and manage. You need to have a framework in place that can do that. The programme, projects and initiatives across health or education cannot just be somebody's idea. They have to be evidence-based and we have to be moving towards actually changing the outcomes for tens of thousands of residents.

What I picked up was that commitment and accountability could be stronger. Performance monitoring and outcomes-based monitoring have to kick in. I have looked at the health inequality information that the Department has supplied. If you take it by constituency, how will programmes such as Transforming Your Care or Fit and Well target the three most deprived constituencies? I have not received that answer yet. I welcome the fact that there is a change in the data sets and a shift in the thinking, because a lot of this was about thinking, the mindset of early intervention and the potential that it has longer term, but I think that the frameworks around measuring and monitoring all of this are critical.

Mr Metcalfe: I will respond to a couple of those points quickly. If you go to 'The Health Well' section of www.publichealth.ie and look at the analysis of the data sets there, I think you will find them very valuable with respect to local government district profiles. Secondly, the Economic and Social Research Institute in Ireland did a piece of work and estimated the return on the investment at 7:1. Helen quoted the American piece of work showing 15:1 or 16:1 — that for every dollar, you got a $15 return. The Economic and Social Research Institute did a piece of work that estimated that for every euro invested in early years, you got a €7 return. You might want to look at that piece of work in that context.

Ms Maeve McLaughlin: Was that 7:1?

Mr Metcalfe: That was the return on investment in early years.

Ms Maeve McLaughlin: Was that across the island?

Mr Metcalfe: No; it was in the Republic of Ireland. It was done by the Economic and Social Research Institute. I am not aware of a similar analysis or piece of work having been done in the North.

The Chairperson: I think that Barnardo's did a similar piece of work one or two years go.

Mr Metcalfe: The targeting and measuring you referred to is an essential part of the work, and it has to go hand in hand with accountability measures. The difficulty is in how you protect the vulnerable during that period of development. Unless you can protect them, you will head into greater inequalities with greater costs to society across a range of measures, whether it is in crime, teenage pregnancy, drug misuse, etc. In societal terms, it is well worthwhile not making societies more unequal. Rather we should try to make them more equal. That is even more critical at this time.

Dr McAvoy: I want to respond to what you said about school performance. The Programme for International Student Assessment study is a fairly big study that looks at school performance across a number of different countries. One of the key factors in early school performance appears to be

whether a child has attended early years education before school. It is a great leveller for school readiness.

One of the important aspects of early years that we may need to look at is having some sort of school readiness standard when children start school. Often, those things are more of the social, emotional and behavioural aspects of children in junior infants or P1, such as whether they can sit in their seats, concentrate, take instruction and toilet themselves. All those basic life skills need to be as valued as much as, maybe, the ability to count, and so on. We need to look at school readiness in a more holistic way. Although everyone is not destined to succeed and do fantastically well in their exams, it is important that school provides them with the opportunities for self-esteem, self-confidence and being able to make their feelings known. Those kinds of soft skills are critical in the workplace, particularly for children who, maybe, are not destined to do full state examinations or whatever. I think that we need to value the soft skills as well as the hard things we already measure.

Mr Dunne: Thank you very much for your presentation. On page 4 of your paper, you referred to teenage mothers facing particular challenges, and we certainly find that to be a big issue. You state:

> *"The teenage birth rate in the most deprived areas was around twice that of Northern Ireland as a whole."*

That is an quite an alarming statistic. We are all concerned about the number of teenage parents. It is not just about the mums; the parenting issues need to be addressed. Young people have no parenting skills, and we need to concentrate on providing them with such skills. Is the system fit for purpose to support those young people? Years ago, people were supported in their homes by health visitors and social services. Are the services fit for purpose?

Secondly, the issue of absenteeism was in the media quite a bit this week, especially among young people in loyalist working-class areas. Is there an interrelationship between education and health inequalities? If so, how can that be addressed?

Mr Metcalfe: I will take the second question, and perhaps the others might have something to say about teenage mothers, the birth rate and whether the services are fit for purpose. There is a very distinct relationship between education and inequalities. The more education you have, the better chances you have of getting on in life, of earning more, etc. Education and health —

Mr Dunne: They are very interrelated.

Mr Metcalfe: Inextricably linked, yes; they are very interrelated. It goes back to the point the Chair made at the very start that this is not just the remit or responsibility of one Department. That is why we produced 'Health Impacts of Education: A Review' a couple of years ago, just showing what the links are and how people in education can deal with those issues.

I do not know whether Joanna or Helen would like to talk about — Joanna, do you have anything to say about the services?

Dr Purdy: I cannot comment specifically on absenteeism, but I can comment on the general point of educational and health inequalities, which links back to Maeve's point. I am thinking about looking at outcomes. If we take, for example, literacy standards, the Communication and Education Together project in the Belfast Education and Library Board area has been running for a number of years now. Speech and language therapists support teachers and classroom assistants to provide children with the necessary strategies to help them overcome any literacy difficulties. There are opportunities there for health and education to work together. That has been a very successful programme, so much so that although it started out targeting the most deprived children and those with the lowest literacy levels in the Belfast Board area, it has now grown.

In the briefing document, Helen mentioned the family nurse partnership, which supports young mothers, and I know that there are proposals to extend the support for young mothers in the most deprived areas of Belfast. The professionals and practitioners who work in those areas recognise that those young women need greater support to develop their parenting skills. That support and how it can be best delivered is being considered.

Dr McAvoy: They say that parenthood is tough, but teenage parenthood is very tough. I do not know enough about the set-up of different services in different areas to say whether they are fit for purpose.

However, I do know a little about the evidence of what works to reduce the risk of teenage parenthood at a population level and what works to preserve good outcomes for the babies of teenage mothers.

A review that was undertaken of programmes in Canada showed that teenage mothers are at a higher risk of having low-birth-weight babies. That may be because they present very late to health services, or there may be issues with smoking or other health behaviours as they come to terms with the fact that they are pregnant. Where they looked at different programmes, the programmes that were integrated, which were linked to opportunities for teenage mothers to link into education, employment, apprenticeships and childcare, seemed to work better, not just in the long-term outcomes for the mothers and the children but directly in pregnancy. Mothers who enrolled in those programmes at an early stage were at a lower risk of having low-birth-weight babies. Therefore, there seems to be something about locally appropriate, integrated services that do not just look at a teenage mother from a health perspective, like they would in an antenatal clinic, but at the other aspects of her life, such as her aspirations for her future employment, earning capacity and education. Those integrated services seem to work quite well, both short term and long term.

Mr Gardiner: I will be very brief, because my question about early years strategies was stolen by my colleague at the end of the Table, so I am not going to labour you any longer in relation to that. However, I would like to express my gratitude to you for coming and for the professional way you have handled the meeting and your answers.

Mr Wells: Thank you for your presentation. I do not know whether any of you were at the PHA seminar in the Long Gallery during the previous term of the Assembly. At that, we heard graphic information from Glasgow and from a professor from Dundee University with a name that I cannot pronounce. Perhaps someone else could pronounce it. It is a Polish name.

The Chairperson: It was Professor Suzanne Zeedyk.

Mr Wells: Yes. It was very gripping stuff. It was also very depressing, to be honest, but it was, perhaps, one of the most effective seminars we have ever had in this Building. The message was that if we do not intervene early, the chances of recovering the situation later on in life are not only extremely difficult but incredibly expensive. The graph showed just how much you needed to spend to get the tiniest response. Your message is very similar to that. The question is this: are there any quick hits here? This obviously requires a fundamental change of emphasis as to how we do things. It is a very long-term programme that will be slow and difficult to measure. However, are there any single quick hits? For instance, if every person in a deprived area gave up smoking, could we quantify the impact of that on health outcomes? Equally, could we quantify the impact if everyone gave up heavy drinking and became a social drinker or if we eliminated soft drugs from our deprived areas? What is the big hit here? What is the thing that, if we could concentrate on it immediately while we are developing a much longer-term strategy, would produce the best outcomes?

Mr Metcalfe: Very particularly, making inroads into poverty is probably the single biggest thing that you can do. Smoking, drinking and drug misuse are almost products of the environment. You can address lifestyle, but you also need to address the social determinants of health. To get people out of the poverty trap, you need to address housing, education, transport and all those types of things. If there were a magic bullet, I think that we would have seen it. What struck me about, say, going back to the New Zealand thing again, is that that was a 10-year strategy; it is long term. In Sweden, they adopted public health goals that had a 10-year cross-departmental, cross-party sign up, so it was not something that could just give a very immediate win.

Helen, I do not know whether you have examples of specific interventions that can give a quick return. Having worked in the area for 25 years, I think all the evidence seems to be saying that there are no magic bullets. It is very much for the long haul, and it is very much about the whole of government — cross-department alliances — that will make a difference in societal terms.

Mr Wells: That brings us to what Mr Brady was saying earlier: the trend is going in the other direction. The Welfare Reform Bill will certainly not leave deprived communities with more income. That is the one thing guaranteed. Therefore, the trend for unemployment and benefits is going the wrong way. Because of the principle of social security parity, we do not have an awful lot of say on the issue; we are very much tied by that. On the basis that it will take a very long time to turn the tanker, it is not mutually exclusive to look at one or two issues to see if, for instance, the police are having a real crackdown on drug abuse and drug trafficking. If we manage to crack that, which is unlikely, do we know statistically what outcomes that would produce?

Mr Metcalfe: In respect of long-term population health, if you could stop smoking, that would be a major win. Again, that is a long-term agenda.

Mr Wells: You talked about housing. We have created some brand new state-of-the-art housing estates in, for instance, Poleglass. Those estates have not been long built. Yet, the same social problems and outcomes are arising in the comparatively new, well-insulated and well-provided-for working-class estates as they are in the very poor, older deprived areas. It does not seem that you can buy your way out of the problem by providing good housing. Certainly, my experience in South Down is that you still get terribly difficult problems in very modern estates, and Downpatrick has many of these.

The Chairperson: I think the issue, Jim, in fairness, is that that is what we have been doing. We have been building estates, not communities, and we have not been building facilities. You mentioned Poleglass; it was years before it got any community facilities, shops or health centres. That is the mindset that we needed to break.

Mr Wells: I accept that, Madam Chair, but what I am saying is that building new houses alone does not solve the problem.

The Chairperson: No.

Mr Wells: So I am trying to think is there anything that can be done quickly to try to help address this huge inequality, which is so stark in Northern Ireland. Literally, you can have people on one side of a road living long, healthy lives, and the others dying far too young.

Dr McAvoy: I think that we need to look at the relative contribution of health behaviours, such as higher rates of smoking, alcohol use, and so on. When that is broken down in complex analyses, it is shown that that is only part of the issue. Health behaviours are very important in determining how long you live, how long you live in good health, your risk of dying before the age of 65, and so on. However, there are other factors related to poverty and disadvantage that are not captured. So, a focus on health behaviours alone may not bring you the return that you expect for health inequalities.

As for quick wins, I would have to really think about that one. I do not have anything off the top of my head. I think there is a particular issue around the thinking now about the importance of early years in health inequalities. I think that we need to look at the balance of investment that we spend across our children and what years we really want to — whether we want to rebalance that investment more towards early years and less towards the years in middle childhood and adolescence.

Mr Metcalfe: The types of societies that do best — generally speaking, the ones that have the greatest life expectancy and the greatest health life expectancy — are probably the Scandinavian countries and northern Europe. There, there is a premium on redistribution and, if you like, addressing and targeting the more disadvantaged sections of society. There are very definite minimum standards that seem to be higher there than in other countries. Where you can reduce that gap, you seem to get better societies on the whole, but that is not an overnight solution.

Mr Wells: On page 4 of the paper, you mention family nurse partnerships. I hope that I did not miss this, as I came in slightly late to your presentation. I understand that the Western Trust is looking at that option, which is quite exciting, but also very labour-intensive and expensive. Is there any evidence of that working elsewhere in the British Isles or Europe? Have we any examples of how that particular high-intensity-type relationship succeeds or otherwise?

Mr Metcalfe: I do not have an example. Do you know, Joanna?

Dr Purdy: I am not aware of any evaluations of those types of partnerships, just off the top of my head.

Mr Wells: If it does work — and, on paper, it looks like a good idea — I shudder to think what it would cost to carry it out on a Northern Ireland-wide basis. You would be devoting an awful lot of family nurse time to vulnerable families, and although I am absolutely certain that they would benefit from that level of care and attention, to roll that out for all the thousands and thousands of vulnerable families in Northern Ireland — I just would worry. That is why I am looking to see whether there is any

quick option that we can at least try in order to start to bridge the gap without solving the whole problem. I would say that, in five years' time, the economic disparities will be greater in those families, rather than lesser, because of the two forces of the economic downturn and welfare reform, which is dedicated to taking benefit out of those communities in very large numbers. You have to realise that that is going to leave them in a worse position as far as early years is concerned. There is not a lot you can do about that.

Mr Metcalfe: It is indicative of the direction in which we have to travel. We have to be actually working across Departments, but with a long-term commitment. The places that we know about where there has been progress have taken that joined-up approach and have really addressed what we call the determinants, not just one determinant like housing, but things like fuel poverty, food poverty, income redistribution — across the board. It is of particular concern that those kinds of benefits might be addressed in a manner that would target the most disadvantaged and make them even more susceptible to vulnerability.

Mr Wells: Also, is there any evidence that the breakdown of the standard family is causing greater problems in early years? Following the recent riots that occurred in England — in London — they found that something like 60% of those arrested had no identifiable father figure, because the father either was never present or had long since left, leaving a young mother to raise children in very difficult circumstances. To put it another way; even if we spend all this money, but the family structure continues to break down, will that be an inexorable trend that will continue to cause problems?

Dr McAvoy: On that point, in the millennium cohort study, one of the factors that was different in Northern Ireland as opposed to England, Scotland and Wales, was that there was slightly more involvement by the mother's partner in child-rearing. There seems to be something slightly better about that situation in Northern Ireland. I am not saying that it is universally the case, but the figures here seem to indicate that mothers' partners, be they husbands or otherwise, were more involved in child-rearing, and I thought that was interesting.

Mr Wells: That may simply show that the breakdown in the nuclear family in Northern Ireland is simply lagging behind the rest of the United Kingdom, and that we are rapidly heading towards the same predicament. Clearly, for a young man in particular, if there has been no father figure, it must be incredibly difficult to set boundaries and discipline and to provide the wherewithal to raise the child properly. There is obviously a lot more poverty in single-parent families. All the indications would state that family relationships are breaking down in Northern Ireland, albeit maybe a decade behind the level of the rest of the UK. Certainly in parts of the Republic, in places like Limerick and Dublin, there has been a dramatic fall in the number of standard family units. Regardless of whether you see this as a moral issue, there is no doubt that it is easier to rear children and have good health outcomes if there are two people bringing in an income or helping to protect and rear the children. That is just a fact of life. It is much more difficult as a single person. Is that another issue coming along the line in Northern Ireland?

Mr Metcalfe: Probably, but we do not know. We do not have the data to support what the differences are at the moment. We have information about lone-parent families, but in societal terms, we do not have enough data to address the question that you are raising.

Dr McAvoy: We know that children do better in traditional family units, but there are often things driving those units in the first place. However, from my perspective, the lone parent group is a very diverse one. Certainly, there are the young never-marrieds, but there are also separated and divorced groups, and there are widows and widowers in that mix of lone parents, and I think we need to look at the different challenges that those families face. They are different, and they face different challenges at different stages of their lives. They are not universally young, unmarried mothers; they are a diverse group, and they are becoming increasingly diverse. For example, the age of lone parents is higher than it used to be. They are quite often never-marrieds who may have their first baby in their thirties, for example. I think we need to better understand lone parents in order to configure an approach as to supporting them.

The Chairperson: We also need to make sure that we do not send out the message that lone parents are the cause of all ills in society. The point was made that 60% of the ones involved in the riots in England have no father figure, but 40% of them did.

Mr Wells: Some of those effects are quite ephemeral. There was a father that they could identify, but not much more.

The Chairperson: I know, but 40% of them did. There were also people from very affluent families involved in those riots. It is not always people from socially disadvantaged backgrounds. I am proud to say that I am from a socially disadvantaged area. Granted, I am not a lone parent, nor did I come from that, but we need to be careful and remember that it is easy to brand people.

Jim, as regards the point you made around family nurse partnerships, we will get more information on that from the Department.

Ms Brown: Thank you all for your presentation today. It has been very interesting. A lot of questions have been asked, and I do not have much really to ask. I just want to make a comment about the necessity of early intervention. I was at the same event that Jim was at where we saw examples from Scotland that were absolutely horrific. Obviously, a cross-departmental look at the whole issue will be the best thing that we can do. Obviously, that has to be looked at. Education is vital, and we know what a big thing this fuel poverty issue is as well.

In your presentation you talked about child poverty, and you noted there that around four in 10 poor children are working poor, where the family has at least one adult in paid employment. We are becoming increasingly aware of that struggle that people who are maybe not on benefits are having. I also want to ask about obesity. How serious a problem is it recognised as? We are all aware of smoking and drinking, but a lot of people who are very against smoking and drinking are quite happy to eat themselves to death. How seriously do you think that is being treated on the whole?

Mr Metcalfe: The figures for overweight and obesity among young people, both North and South, are scary. Maybe 25% of three- or four-year-olds are overweight or obese. That needs to be a priority. The consequences of that for all types of health problems later on are immense. Again, it is not something that can be addressed by one Department. Everything that we say here points to the imperative for that cross-departmental approach to addressing obesity through parenting, food availability, distribution and maybe legislation. All those things have a role to play. There is not a simple, single solution or fix for the issue of obesity. It is really challenging.

Ms Brown: You see the whole health inequality issue, I am sure, as a long-term project. There is very little that you can do quickly and immediately that will have any lasting impact. It is about a whole change of lifestyle and education, and breaking that cycle.

Dr McAvoy: One of the areas that is certainly worth looking at, and which spans a number of things here, is around parenting programmes and supported parenthood. There have been a number of programmes, some funded by Atlantic Philanthropies, both in the Republic of Ireland and Northern Ireland, that are in various phases of their evaluations. Some of the early findings are coming out from those. They are, methodologically, very robust studies of children whom we know are living in Ireland and Northern Ireland, so we have a good degree of confidence in what is coming out from them. Some of them are in deprived areas of Northern Ireland and the South. One of the early messages that seem to be coming out is that parenting programmes seem to be working quite well. The programme for life evaluation is one that I particularly have in mind, in the ability of the parent to support good nutrition in the home, physical activity and home safety. We know that parenting programmes in disadvantaged communities have good outcomes internationally, but we always like to have data from our own communities to be able to stand over it with some confidence. Investing in parenting programmes seems to be working quite well in the evaluations to date. The challenge will be to look at the findings from those studies that were funded by Atlantic Philanthropies and draw together the knowledge from those for future development and endorsement of programmes by government in due course. That is the stage that we are at with that.

The Chairperson: Pam, as you know, during the last mandate, the Committee held an inquiry into obesity and other associated eating disorders, so we did get an update. We can get a further update from the Department on where the recommendations are sitting.

I want to make a few points. This has been a very interesting presentation and discussion. You have probably highlighted a lot of the reasons why we have decided to look at health inequalities. It is not just a health issue. Other Departments have a role to play. I said at the start — and you mentioned it during the course of your presentation — that other Departments have good projects. I have a concern — I am sure a lot, if not all, members share it — that some projects are piecemeal, some are

still in pilot mode years after they were set up, and some do not even come out of the community that they were piloted in, whether that is around literacy or numeracy or a lot of that stuff. That leads to further problems. We also need to highlight the fact that there have been great projects in the community and voluntary sector. However, they were seen as pilot projects. Jim and others mentioned a quick fix or a quick win, and some of those projects were winning. You talked about the Atlantic Philanthropies: the virtual reality babies were having an impact on teenage parenthood in some communities, and the likes of Sure Start and breakfast clubs and all of that stuff. However, the concern is that they were seen as pilot projects, and it then became a battle for community groups and Departments to sustain them or spread them to other constituencies.

Maeve made points about changing the mindset, and others said that it is about the individual mindset and about individuals changing their lifestyle. It is also about changing the mindset in the statutory sector and, indeed, in Departments. Monitoring the outcomes is crucial, but there has to be a commitment from all the Departments, and it is important that organisations such as yours work closely with us in this phase of us looking at health inequalities and, if there are models of best practice, steer us in that direction. If there is information that you think we need, let us know.

The joint meeting between us and the Health Committee in Leinster House was interesting. Again, there was information you provided there, and we can possibly look at some of the projects that can happen around the border corridor areas or the projects that are happening in constituencies in the Twenty-six Counties. We can learn the lessons from there, if need be. On behalf of the Committee, I thank you again for the paper and the presentation. Stay in touch and help us through this.

Ms Maeve McLaughlin: It would be useful, for the economics of this, if we could get an accurate figure for island-wide savings from early intervention. I know that an analysis has been done here, and a number seem to have been done throughout the Twenty-six Counties. It is very important to get that island-wide figure as a benchmark of the savings that can be made if we invest early.

Mr Metcalfe: We will have a look. Thank you very much, Chair. We welcome the Committee's attention to the issue. That probably goes without saying, but thank you anyway.

Northern Ireland Assembly

Committee for Health, Social Services and Public Safety

OFFICIAL REPORT (Hansard)

World Health Organization European Health Strategy

25 October 2012

NORTHERN IRELAND ASSEMBLY

Committee for Health, Social Services and Public Safety

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Members present for all or part of the proceedings:
Ms Sue Ramsey (Chairperson)
Mr Jim Wells (Deputy Chairperson)
Ms Paula Bradley
Ms Pam Brown
Mr Gordon Dunne
Mr Kieran McCarthy
Mr Conall McDevitt

Witnesses:

Ms Joan Devlin	Belfast Healthy Cities
Dr Erio Ziglio	World Health Organization

The Chairperson: This is a single-issue meeting. We agreed to do this when we found out that a conference was taking place. We are piggybacking on that conference, and I thank you for coming here and meeting the Committee. I will hand over to you to do the introductions and make your presentation. I will then open it up for questions and comments. I really appreciate the fact that you have taken the time out to speak to us. We are looking at health inequalities, and any expertise that we get from you is more than welcome. Thank you.

Ms Joan Devlin (Belfast Healthy Cities): Thank you very much for the invitation. We are very pleased to be here. Most of you will be aware that Belfast is one of almost 100 cities that are designated to the World Health Organization (WHO) European Healthy Cities Network. Belfast Healthy Cities is the organisation that is responsible for delivering, in partnership with a range of partners at a local level and at Department level, a range of requirements that are laid down by the World Health Organization. We are now coming to the end of 25 years of Belfast being a healthy city and, as part of that, we are having a lecture series to celebrate it.

We also look at developing training and capacity and exchanging the knowledge from some of the best practice that is in WHO Europe. We were delighted that Erio was able to come today and be the keynote speaker for the first lecture in the series. We have six lectures, and we have a number of international speakers who are renowned for their work across the world on social determinants of health and health inequalities. Erio is the WHO expert on this.

Dr Erio Ziglio (World Health Organization): Thank you. Can you understand my accent?

Mr McCarthy: You are all right. We are used to those sorts of accents.

Dr Ziglio: Thank you for the invitation. I am delighted to be here. I was in Northern Ireland for the first time many years ago, in 1978. Every eight or 10 years, I have come back, and I can see a lot of progress in this part of Europe.

As you know, my responsibility in the European office of the World Health Organization is mainly on areas that are related to social and economic development. I do not deal with viruses or bacteria, but my responsibility is in an area that can create a lot of problems for health. It includes poverty, which is not a bacteria or a virus but has a tremendous impact on health. It includes stigmas and social exclusion. My responsibilities are mainly in those areas.

I will cover three areas in 10 minutes, if that is OK with you. First, I will spend a minute on the context of thinking about health. Can we produce health and reduce health inequities in Europe, which has 900 million people and 53 countries? Can we do that in a way that is equitable and that, hopefully, results in good news for the economy, given the situation in which we find ourselves in Europe?

I will say a few words about Health 2020, and I have a copy of the small version of that policy document. You might know that, two years ago, we proposed to our 53 countries that they accept us working with them to have a policy framework that can be used to think about health, promote health and reduce health inequities. I know that those are big goals in your Fit and Well strategy. If that can be done with a clear vision while agreeing on some principles and values, a framework can be set that can be adapted to different situations in Europe. It is one thing to do it in Russia and another to do it in this country; it is one thing to do it in Portugal and another in Tajikistan. We were surprised when the countries said yes and welcomed this. I am delighted to report to you that, after two years of hard work, negotiation, discussion and participation with countries, this policy framework has been adopted. I have two copies for you. There is a short version of about 13 pages and a bigger version for technical people, such as public health experts. I hope that this can be a good tool to inspire countries and to inspire development.

I will finish by sharing with you some lessons and promising practices that a country such as yours could be interested to know about. If you are interested, we can follow that up after the meeting. Will that be OK?

The Chairperson: Yes.

Dr Ziglio: On the context, it is quite clear that, if you want to produce health and reduce health inequity, you cannot think that you can do it just in the health sector. We have to be able to manage different kinds of situations, conditions, opportunities and challenges.

I have been working with the WHO for more than 20 years. I am delighted that Europe is the only region of the WHO where there has been an agreement on health. We have something on which we can agree a vision on values, principles and priorities. Other regions, such as the Pan American Health Organization regional office of the World Health Organization and the regional offices for the western Pacific and Asia and Africa do not have that. I am quite proud that we have tried somehow to be united on that. We are the only sector that is doing this. I have not seen this done in education, housing or social security, so it is good news. Now, the issue is to implement it.

There are several reasons why we have done this. Let me share two of those with you. First, Europe has 53 countries and 900 million people. Undoubtedly, in the past couple of decades, with some exceptions, there has been some improvement in health and well-being. The problem is that that improvement has not been equal among those 53 countries and within them. I can see that you have the same issue in Northern Ireland. I saw some data from Northern Ireland, on Belfast in particular, that shows that there is a difference in average life expectancy of 6·6 years between one part of Belfast and another. You find that kind of average in most high-income western countries. My slide shows trends in life expectancy in Europe, including the trend in the United Kingdom. You can see the trend among the 53 countries, for the 15 countries that comprised the European Union before May 2004 and for the countries the countries that joined the EU in 2004 or 2007. From that graph, you can see that there are big differences between parts of the EU. If you look inside those countries, you will also find big differences. Undoubtedly, you will not be surprised that the policy of promoting health and reducing health inequity is central. It is also central to your Fit and Well strategy.

You work on the Health Committee, so I do not need to convince you of the second reason. We find that there are new demands from citizens and new challenges and opportunities. Now, there is the issue of lower economic growth and the austerity policy that countries are facing, and we want to

ensure that we do not lose the gains that we made in the past decade. There are other reasons, but those are the main reasons why we have tried to have a policy framework on which we all agree.

I have finished that part, and, if you do not mind, I will share with you some good practices and lessons. My job involves providing a lot of technical assistance to countries. My work is at the national level and the subnational level. At a subnational level, my main work is to look to work at the first level of policymaking below national level. In Germany, it is the Länder; in Spain, it is the autónomas; and, in Switzerland, it is the cantons. I work at both levels, and I also work closely with the Healthy Cities Network at a local level. If you want to implement something such as this, it is not something that is just for the capital or to be done at a national level. It has to be done as part of the country's strategic policy.

I will now look at some innovations and lessons from both levels. First, I do not know whether you will agree on this, but I can see some potential for sustainable development in the area of promoting health and reducing health inequity. That has to be done within an overall strategic plan for the country. For example, a strategic plan should address at least three questions. The first two are: where do we produce health in Northern Ireland?; and what strategy will deliver the highest equitable health gains for our population? The third question is really key. You will have many strategies to select from, and you have to ask which strategy will deliver good results for health and provide added value to local and national development. There are not many, but with those countries that try to put the issue of promoting health within this overall strategic approach, I can see that the development is more sustainable. When that is not there, you usually find that there is good commitment in countries in Europe. People really want to do something, but, at the end of the day — sorry if I am not being very diplomatic — you find a little project here and a little project there. Health inequity is a big issue, as you will know, and we cannot address it with isolated, fragile, time-based little projects.

I can give an example. I always think about which country you would be interested in that would be comparable to you, so I would definitely recommend looking at what is happening in Slovenia right now. It is a country with a population of a little bit more than Northern Ireland. It has 1·9 million people, and I think you have a population of 1·7 million. The dark part of the picture on the right hand side is an area called Mura. It had the worst indicators around health, unemployment and young people moving to big cities, etc. It had a huge problem. After 10 years of work, you can see that this is now a part of the country where health inequities are getting the best record. Unemployment has been reduced, and it is now below average. Therefore, it is doing well. What happened there? I was personally involved. First, I asked about the future of that part of the country? For a number of reasons, they identified three sectors: health, agriculture and tourism. I can give you more details later if you want. They tried to have a plan where health, agriculture and tourism worked together. But, and this is perhaps the main message, they were not just about looking at what is good for tourism, what is good for health and what is good for agriculture. They tried to have an agreement among the three sectors, through which, one day you had to go to the Government, both national and local, to discuss the allocation of resources, money and technology. They try somehow to support each other. For example, there are many relationships between agriculture and tourism, but we in health do not care too much about what they do. But we in health are going to support them when they talk about allocations, as long as tourism is going to support relationships between health and agriculture. The prevention of accidents in agriculture is a big issue.

Agriculture is going to support issues relating to health and tourism, so they have a bargaining framework, and they have worked miracles. They got the idea of looking at all sorts of issues and having targets so that everything is good for social capital, agriculture, health and tourism. Everything that can improve the physical environment is good for the three areas. They have an overall plan that is a little bit different from the traditional one where people plan on health, agriculture people plan on health, tourism plans on health, and they fight when they have to go for the allocation of resources, and, during an economic recession, they fight even more. So, I thought that that was a good example. If you are interested, I can leave one of their reports with you. It contains much more data on that.

Another issue relates to how we can strengthen our health system, given the fact that we are going to see increased vulnerability. We are documenting all sorts of practices there. If I have read correctly your Fit and Well strategy, I can see that you have two main priorities. One is young people, and the other one is vulnerable groups. What I see in Europe is a lot of emphasis on access. People should have access to services. That is wonderful, but it is not enough. I am sure you have probably solved this issue here in Northern Ireland if you have police being contacted because they would like to give you visibility of your work. We need to monitor treatment because, very often, people get the same access, but they do not necessarily get the same treatment for the same condition. Very often, you can have the same access and the same treatment but, for a number of social issues, you can have

different outcomes or costs, be it financial cost or other types of costs. So, what I am saying is that, when we talk about strengthening the health system to deal with vulnerable people, we need some way to monitor performance, at least, in those four areas. Most of the evidence that I have seen in Europe relates only to access. Access is crucial. However, the other three areas are also crucial. If you want more experience of that, I could give you examples of vulnerable groups in Spain. Perhaps, I will come back to that if you are interested.

Allow me to conclude with two more examples. The first is that, perhaps because of the economic crisis, I see that, in Europe, typical sectoral behaviour is going to change. Sectors will be forced to change. We in health will continue to work as we have done. The same is happening in other sectors. The idea that everyone is in their own boat is over. It is much more likely that we will see examples of when sectors can work a little bit better together. I know that you are familiar with what is happening in south Australia and in Scotland, where there have been interesting developments in the Government's approach. There are two important things. I do not know whether you also have examples in your country. There will be more opportunities for integrated budgets and joint funding. Let me be clear about what I mean. I do not know what vulnerable groups there are in Northern Ireland. In several EU countries, one vulnerable group could be the Roma population or migrants with low incomes. When you have to deal with health issues for such groups, very often, at least four policy sectors are crucial. Our own sector is one. Then, there is the issue of housing, which is very important for people in the vulnerable group. Another important area is employment. Another area is education, particularly if they have children. I see innovation in some countries where those four sectors have put their budgets together. It is not that the health sector will give A and the other sector will give B; they pool their budgets together. That can also an impact on funding for human resources. Perhaps a person in public health can be 50% financed by the National Health Service and another 50%, perhaps, by the local development agency or employment area. In Europe, I see those things coming up more and more. Some are related to the economic crisis. Some could be related, perhaps, because it is the right way to go.

Finally, with regard to something that we will see in the afternoon, I think that we will also have to look a little at the way in which we structure our public health programmes. Do you know who the person in the picture is?

The Chairperson: Ray Charles.

Dr Ziglio: It is Ray Charles. I was in a meeting like this, and I asked, "Who is this person? Do you know him?" They replied, "Yes. It is Nelson Mandela." *[Laughter.]* I usually tell this story because it is a fantastic story about public health and it is an important lesson. You probably know that, a few years before he died, Ray Charles put his money into a foundation. It is called the Ray Charles Foundation, which you can google. What is surprising is that people like me and, perhaps, you, who come from the health sector, would expect him to put his money where his problem was — prevention of blindness, new research on the recreation of the macular tissue in the eye or that kind of thing. If you are a social worker, you might do something on poverty and health. He put his money where his main asset is, and his main asset is his ears. He is blind. He said, "You health people, leave me alone. You cannot do anything for me. Can you do something about my ears? If you can do something about my ears, I will be interested." All his money is used for the prevention of hearing impediments. If he could hear, he could compose his music, he could be connected, and he could get on with his life.

Assets are a very important thing for health promotion and reduction of health inequities. We tend to look mainly at where the problems are. All our documentation is about problems, problems, problems, and we have to keep that. However, where there are problems, there are also opportunities. People see the light and see something that can be done. My office is working to look at what salutogenic assets can be found in people, communities and social networks that are good for people's health. We try to somehow to bring that together with our more technical public health expertise. There is a big area of innovation there, because these assets can go from individuals to society. I will talk more about that later.

That could be an interesting issue for a country like yours. No matter where you are in Northern Ireland, you have data on the deficit, mortality, morbidity, etc. Deficit levels can be high or low. However, you also have assets. As I said, I come here every seven or eight years. I see a lot of development in this country. It is not paradise, but I can see that the country is developing. You still have problems, but it is good to see that development. You were probably able to do all that because you have a good infrastructure and good human resources. You have quite a lot of local talent. You

have the institutions that are working and, therefore, able to attract this kind of development. I hope that you have good social networks and good levels of social cohesion, solidarity, and so on.

All those things can help to build your public health programmes, particularly in the area of health inequities, by bringing these things in rather than leaving them out. They are free; they do not cost anything. They are there, and they need to be mobilised. Ideally, you want to have a very high level of assets that produce health and a very low deficit. This is a tool that we use a lot in countries now. When I go to a country, I do not ask where the problems are, because I have the data. Instead, I ask this: where are the possibilities to develop?

I will stop there, because I do not want to go over my time. I hope that I have been able to give you a few ideas of the innovation that I have seen in Europe. As far as the World Health Organization and the new policy is concerned, the policy and vision is good but we need know-how and practical examples. We need pioneering on the implementation side. We need new research in this area. I would be delighted if we could have good co-operation with you, perhaps as a follow-up to your Fit and Well strategy. I hope that it was not confusing. I will be delighted to take up any issues that you want.

The Chairperson: OK, Erio and Joan, thanks very much. That was thought-provoking and raised some issues for me. I will go through some of them. You might not be aware of the specific detail — Joan can probably help you out with some of that — but we, as a Committee, are keen to look at the issue of health inequalities. You mentioned the Department's Fit and Well strategy. Prior to that — 10 years ago — we had an Investing for Health strategy. It seems that, while there has been a targeted approach and a bit of success on specifics, the areas in which we suffer health inequalities have not changed.One or two of the issues may be targeted. We all have a vision of what we think needs to be done to get to that point, but we are slightly different, in the sense that we have our own local government in the form of the Assembly, Ministers, the Executive and all the connected agencies. Sometimes the strategy that local government could follow is not necessarily a health strategy. In my working life, I have found that, even if new houses are being built, there is not a health focus on those houses. There is not a focus on play facilities, community facilities or even traffic-calming measures, so, for a long time, we have been working outside of that partnership approach. I can see some positive difference, and that is important.

I have a concern that, a number of years ago, the British Medical Association (BMA) said that health was underfunded to the tune of £200 million a year.

Dr Ziglio: Can you repeat that?

The Chairperson: It said that the health budget here was underfunded to the tune of £200 million a year. We are dealing with the legacies of underfunding in health, of coming out of the conflict and of social deprivation and health inequalities. All are connected. It has taken us a while to get to the stage at which we need to have a partnership approach.

That is where I am coming from on this. It strikes me that, in your presentation, you talked about an integrated approach. I know that officials are here. We have had battles both at constituency level and at Assembly level. Departments have been battling one other to see who funds stuff. Breakfast clubs and after-school clubs are examples, and the integrated services for children and young people was a classic example. It seems that, although we have the vision and the good work happening, when it gets to a senior level it is all about, "You are not getting my money." We need to look at that issue.

How can we convince people at those levels that it is not about health spending all of education's money or all the Department for Social Development's money? It is about a collective working arrangement to implement the Investing for Health strategy that we had in place 10 years ago. We are now into the Fit and Well strategy. How can we make changes? It would be interesting to get the information on Slovenia, with which you made a comparison. How can we convince the people who have the vision and the tools to deal with it without involving politics or without them protecting their own wee corner? How can Europe, through the World Health Organization, advise or guide us or give us the tools to convince people?

Dr Ziglio: The countries that I work with have to deal with those kinds of issues. I do not want to be misunderstood. I have put a lot of emphasis on the issue of integration and working between sectors. If you want to have governance for health, we have to do a lot of work in the health sector. We also

need to ensure somehow that we work with other sectors, even from a selfish point of view, Sue. If you think about it, many of the problems that we find in primary healthcare are not really caused by our sector but by failures in other sectors. They are very fragile sectors, and the mistakes that are made have to be dealt with by the health sector.

Having said that, I think that the health sector has to put its own house in order to a certain extent. There are a number of things that we could do before talking to other sectors.Let me give you a couple of examples. We find many countries in Europe where the health sectors are still creating a lot of problems for green policy and the environment. That is because their health sectors use a lot of energy. When you build a hospital, you create a lot of traffic if you do not plan everything together. There may be an ineffective way of managing hospital waste, and so on. It is a huge area and, we as a sector have to clean up our own house.

In addition, we are all probably underfunded, although health sectors still have a big budget, from an economic point of view. From the point of view of utilisation of human resources and land, we are heavy users. In that respect, we should talk to sectors that do things differently.

You are interested in the Slovenian example, and I am not surprised. I am happy that I brought it as an example. The health sector there was very underfunded. There was very little money there. Things changed when development issues were agreed on. It was asked, "What is the future here? How shall we contribute?" What is unbelievable is that the people who are engaged in health were those who were able to steer that development. They were unable to work together to create an infrastructure to utilise resources from the regional and structural funds of the EU. We helped them a little bit with that, but now they are the experts, and we use them to educate other countries. It was possible, somehow, to move forward and have objectives through which everyone can recognise themselves. If you just go to some of the sectors and say, "You should do more for health", people will respond, "Look, I already have a lot of problems in my own sector."

Those are the efforts that we have to make. Those countries in Europe that try so hard to promote the health and development agenda right, I can see some interesting innovation.

Ms Devlin: At the minute, we also have the health equity sub-network meeting here. One of the issues that was discussed yesterday by the guys from Norway and Denmark was the use of an economic tool that looks at the costs of inequalities in each of the sectors. The tool operates on four levels. I do not know the full detail of it, because we heard about it only yesterday. However it is something that we could share with you.

Dr Ziglio: The economic argument is important, and we have a lot of evidence for that. On the one hand, you can also say that there was a lot of evidence in the area of prevention. If you invest in prevention, it is good for the economy, for our own sectors, and so on. On the other hand, we still have an average of 3% of the health budget invested in prevention. The economic argument is important, but we need something in addition to it.

The Chairperson: Do you find that there is a collective targeted approach from governments? When you are targeting health and inequalities, for example, is a targeted economic approach taken to specific areas where there are health inequalities, and would that turn around those areas? If there is a focused approach to bring in inward investment or create jobs, does it mitigate health inequalities?

Dr Ziglio: Let me be sure that I understood your question fully. Are you asking whether economic targets are linked to health targets?

The Chairperson: When you talk about health inequalities, you find that they are mostly located in areas of high social need. If an economic approach were taken to the areas of high social need, would health inequalities start to change, simply because there had been investment? Even though that is not a health issue, investment has been made.

Dr Ziglio: We have to put the issue of economic development under the microscope. There is a lot to it. We need to look at which countries' economic development can have an impact locally. If you remember, there are three questions on my strategic plan. Economic development comes and goes, and then the community can become very frustrated, because there has been big economic change, with tax incentives and so on. The global market will bring a lot of changes, but then that community goes backwards. Therefore, we need somehow to talk about economic improvement that is stable and local.

I go back to the example of Slovenia, but there are other examples. The three sectors mentioned there were very aware of the future. If you look at that country's geographical position, you see that tourism could be a big resource. Agriculture there was very backward. It was not very efficient. However, that meant that the countryside was very unpolluted and uncontaminated. Slovenia set out to reorganise completely the countryside locally, and in such a way that it would become an attraction for tourism and such things. The sectors did not fight over resources. Tourism and agriculture interests usually fight a lot over human use of resources, such as water. However, that was locally based. Then, developments on economic and health targets for promoting health and the eradication of inequities become more stable and locally owned.

Mr McDevitt: Thank you very much for your time. I am very interested in the idea of health diplomacy. I have skimmed through your Health 2020 report. I notice that paragraph 17 talks about Health Ministers and public health agencies becoming advocates and leaders for change across portfolio areas beyond health. You sit at WHO level. I wonder what really good examples you can point to of institutional governance arrangements that have allowed Health Ministers to go beyond simply being able to say the right things to having policy, financial or constitutional levers that mean that they can actually do the right things.

Dr Ziglio: What you just mentioned — governance — is actually the central issue of the policy, and perhaps the key issue for the future.

Let me say something about health diplomacy. It came mainly from work in dealing with those regions. As I explained earlier, the first level of policymaking is regional. To some extent, it is a little bit like your situation, although you would not call yourself a region. Many issues that you have to deal with here are perhaps particular to Northern Ireland. Other issues relate mainly to the UK. Others relate mainly to the European Union. There are many issues and regulations that, to a certain extent, you cannot really control. Some issues can be global, such as those that relate to epidemics, and so on.

People who work at that level ask us about diplomacy, because, to a certain extent, they need to be supported in that area. Even if you get support and have experience of dealing with issues at EU level, you have to deal with global issues. Having said that, if the Health 2020 policy is implemented, your level is absolutely crucial. Therefore, the area of health diplomacy is one in which we would like to provide support to countries and to people such as you through that network.

On the issue of governance, we have commissioned a number of studies to inform the policy. One relates to health inequities. One relates to governance, because there are big changes in that area. Things are changing very quickly. I would be delighted to leave it here with you. It is called, 'Governance for health in the 21st century'. We made a distinction between "health governance" and "governance for health". Governance is in the sectors. Governance for health is the issue that you mentioned — how we deal with other sectors.

Ms Devlin: On the Healthy Cities Network, I want to add that the health committee in the municipality of Horsens in Denmark, which has authority over all the sectors, consists of the chair of every other committee. It is a bit like the concept of the ministerial group on health here, but it is its committee, and I think that it is a really interesting idea. It reflects the inter-sectoral nature.

Mr McDevitt: I do not want to hog the questioning, but we are having a debate about health and, separately, a debate about institutional reform. Of course, they are not joined up, because why would you want to join things up, eh?

I am interested in whether you notice across Europe in jurisdictions and regions — we consider ourselves to be region, and it is quite OK to talk about this place as a region — a thematic approach at government level rather than a departmental or silo approach. For example, in Scotland, Ministers have moved away from simply running Departments to running themes. Have you noticed that, and, if so, have you any observations on it?

Dr Ziglio: First, entities of the size of Northern Ireland are potentially in a much better situation than any other because of their size. We discussed that earlier. Europe is interesting, in that it has 53 countries. It is amazing that 25% of those countries have a population of five million — the size of Scotland — or less. Twenty per cent of the European countries have a population of three million or

less. That is an interesting situation. Population size matters in public health, and it matters on the issue that you are mentioning.

On the issue of having the kind of innovative infrastructural development of how the Government work, Scotland is an interesting country. We have an agreement with the Scottish Government and the Chief Medical Officer, Sir Harry Burns, to analyse this, because those kinds of innovative things are not much known. Everyone is struggling to find their own way.

They have agreed to look at that. They have a very interesting approach, but, to be sustainable, you have to look at the details and ask whether it works downwards. Perhaps it works at a national Scottish level, but what is the relationship between the national level and the local authorities? The local authorities, perhaps more so than in Northern Ireland, have probably more jurisdiction over health matters, social issues, and so on. There has to be a two-way road. In some countries, there is a good framework at national level, and they know a lot about national level but not how that is implemented below that.

Mr McCarthy: Thank you very much for your presentation. Earlier, you mentioned prevention, and I would have thought that that was the number one priority. Out of the 53 countries, are there any where you can pinpoint where investment has been made in early prevention jointly from the health and education budgets, resulting in a reduction of incidences of inequalities?

Joan, you mentioned the Healthy Cities Network. We must not forget about having healthy rural communities. I represent a rural area. It is fine to concentrate on cities, but there are health inequalities in rural areas. Elderly, vulnerable people are sitting totally isolated and not knowing where to go, and that is a very important point. The main thing is prevention. For instance, getting kids to stop doing preventable things such as smoking and drinking can prevent illness in later years. Have you come across any area or region that has invested in early prevention that has paid off?

Dr Ziglio: There are many examples. I will mention quickly three issues. The evidence is there to a certain extent, but it is not 100%. There are a lot of opportunities for preventative work that works, and the financial resources can be utilised better in our sector.

We did another study on prevention to inform this policy. We decided not to get WHO to do the study, because everybody says, "Of course WHO says that." Therefore, we asked the Organisation for Economic Co-operation and Development (OECD) to do it. The evidence is very clear, and the lesson was this: what are the barriers preventing us from working on that evidence? It makes sense and is good, so why do we still have only 3% of the total amount invested in that area? There is a huge issue with inequities, because that 3% does not benefit everyone in the same way. People such as us perhaps get the best service, but others do not. The issue of rural areas is a huge problem in some countries.

I am going to Brazil, and when I come back, I will go to Poland. When Poland joined the EU, around 40% of its human resources was linked to agriculture. Now, because of the EU, that has had to go down to 4% or 5%. I do not know what the percentage is in Northern Ireland; it may be 3% or 4%. Where do you find those people? Agriculture is rural, so you have to invent rural economies. Furthermore, how will the health system work in those areas? Those are huge issues. You are absolutely right that most of our data are on urban issues, and for good reason. However, we also need to look above those. In some countries, rural issues are more important than others.

Finally, the key is this: can we double the percentage of resources for prevention from 3% to 6%? If we take whole budgets into consideration, that should be feasible. I think that it would be possible to do that. We are not talking about changing everything. We are talking about going from 3% to 6% in, let us say, a decade.

What we can see in Europe is a trend towards at least trying to get the health budgets more balanced between hospital-based services and territorial services. Do you know what I mean by primary healthcare and territorial services? I think that rural areas will benefit a lot from that. Take, for example, Italy: the management of its system is basically sub-national. Therefore, in some regions, 48% of the total budget is hospital-based and over 50% is territorial. There are big issues in respect of the rural situation. However, in Italy, the issue is more about mountains — the Alps — than rural areas.

Ms Devlin: To add to that, we do a piece of work through the UK Healthy Cities Network. There is a guy called Dr Derek Cox — Erio, you probably know him — who has done some very good work in Scotland on rural inequalities, and that will be useful as a reference.

Mr Dunne: Thank you very much for your presentation. I see Slovenia here and a triangle. What does the "D" represent in the triangle? Is that the output?

Dr Ziglio: No, it works in this way. Usually when we work with other sectors, we say, "Let us go for a win-win-win situation." Those wins will be good for health, for agriculture and for tourism. We usually stop there. However, what they tried to do is look at other decisions where one sector cannot be affected. Decisions B and C, for example, would benefit only two out of the three sectors. Therefore, Slovenia put in place a package on which the sectors agreed, shook hands and said, "You have to support the decisions on agriculture and tourism, but, of course, you want to make sure that those decisions do not damage health." When we look at the location, resource, and so on, we are there together. If someone does not play ball, the whole partnership collapses. I found it interesting, because we usually just look at D. In the real world, not everyone wins; sometimes they can lose. If one sector is losing, do we have some kind of compensation or some way of making sure that they do not pull out of the partnership?

Sorry, perhaps I was not able to give you an answer.

Mr Dunne: That is OK. Is health a priority at the top of the pyramid?

Dr Ziglio: No, that is just my bias. *[Laughter.]*

Mr Dunne: Fair enough. Good.

What about funding? The argument is that there is not enough budget, yet we spend about £4·6 billion on health in Northern Ireland. Many argue that we spend enough but do not manage it properly. Is that the key to success? Is it about trying to manage resources more effectively and efficiently? You obviously want to see more going into prevention and education. Is that vital for that to succeed and for trying to address inequalities?

Dr Ziglio: We should have a whole day for this big issue. In a nutshell, first, we are a part of the world where there are not perhaps as much resource as some people would like, but there are resources. I am dealing with countries that spend $50 per capita on health.

Secondly, you are hinting at whether we can do more with what we have. Doing more with what we have also means that, in the way in which we analyse it, we need to judge the performance of the health system or the impact of the financial, technological and human resources on health equity. It should somehow benefit everyone in the same way, but, at the same time, some people who are worse off have an acceleration of their health status in comparison. Otherwise, you would still have a big gap. We can do much more on that issue with what we have. That is also why I humbly suggest that we need to monitor not just access but treatment and outcomes.

Thirdly, in many European countries, we will expect more money for our sector. Mind you, a number of countries in Europe are going to do that because they do not actually have the big problems that we have. The budgets of Turkey and Azerbaijan are almost double, because, fortunately for them, the economic recession is not a big issue. In other countries, we cannot expect there to be a big increase in the next 10 years. It might be that we need to see which kind of mobilisation of resources we can do. That is why I was pushing — it is my bias, for which I apologise — the fact that we need to think more about development. There are still a lot of financial resources that we in the health sector could somehow try to utilise.

You are very good in this part of the world with the structural funds. Are you satisfied with your work in that area? What part of that could have been utilised to create good news for the health sector? I do not remember the data right now, but 80% of all that money goes into infrastructure, which is OK. The money that is channelled into health is also our own responsibility. How do we do a good job? It goes mainly into buildings, maintenance, refurbishment and things like that. Perhaps we need that in some countries, but we could still do a better job. Resources could be mobilised through partnerships with other sectors or through utilising resources that come from the EU through those kinds of structural funds or cohesion funds. We are not really used to doing that. Other sectors do that better than us, so we should learn from what they do.

You have to package it within a development. Otherwise, the door is closed. You cannot go to the structural funds for some of the health issues, because you will be met with a no.

The Chairperson: There are a number of things happening in the Department and there are policies, such as Fit and Well and Transforming your Care and even, indeed, the review of public administration, which is being done by another Department.

We have a sizeable budget, but a sizeable percentage of that budget is spent on wages over which you have no control. A number of stakeholders are also involved in the whole issue of health, social services and public safety, and that needs to be managed properly. So, the Committee is trying to get to the very bottom. We have been told that over £10 million a day is spent on health, and we are trying to find out where that £10 million is being spent. You still cannot follow the actual pound, and we are doing a bit of work on following that pound. That work is ongoing. However, parallel to that, we also want to look at health inequalities.

We are not a Committee that is shy and will not challenge other Departments — we have done that with regard to the issue of suicide and self-harm. Suicide and self-harm is not solely an issue for the Department of Health. Other Departments have a role to play, and we have done that as a Committee.

We are being proactive, in the sense that we are looking outside our box. If we believe that we need to challenge, criticise or commend another Department for its role that helps us do our job, we will do that. Today was very useful. It allowed us to look outside of that. However, I cannot let today go without asking a question, but you might not have the answer. About three years ago, the World Health Organization (WHO) put out a statement that is still interesting in this day and age. It said that women are still dying in the world because men are in charge. Are health inequalities an issue because men are still in charge? I thought that it was a very stark statement coming from an organisation like yours. Is there a need to change, considering that 51% of the world population is made up of women?

Mr McDevitt: That would be post-feminist and post-patriarchy, Chair, yes. *[Laughter.]*

The Chairperson: Putting out that statement three years ago would have been an issue. We are 10 years on from Investing for Health, and —

Mr McDevitt: We all support your area, if it is OK? She is right.

The Chairperson: The reason I said that is that when I referred to it in a debate in here, people did not believe me. I cannot miss the opportunity to ask your opinion on it.

Dr Ziglio: For those of you who do not know, the WHO is a technical agency affiliated to the United Nations. The countries pay a fee to be members. The director general is a women from Hong Kong, China, and the European region is headed by Ms Zsuzsanna Jakab, who is really committed to that policy. She really gets the countries involved. It is not easy to get a policy like this. It is very ambitious and very inspirational. At the end of the day, all the signs and the evidence can be there and it is technically OK, but, at the end of the day, it is a political document, so it is not easy.

I have a question for you, if I may? In the area of health inequality, I can see some strange things happening in the countries. You have your Fit and Well strategy. In my view, it is an interesting document. Personally, I would like Slovenia and Scotland to utilise your document — a country that tries so hard to put some priority in place on the issue of health inequalities. The way in which you approach health inequalities here is mainly geographical, rather than looking at social classes and so on.

Do you have an example here to avoid the following kind of crazy situation that I see in Europe? It is like this: there is an area that is very deprived. You can expect that health inequalities there are very high. It has very bad data to a certain extent: unemployment, education and so on. You want policy to put more priorities in that area. That makes sense. However, there is a tendency, mainly from the local politicians — I am sorry; I am not diplomatic, as you can see. *[Laughter.]* Local politicians, on the one hand, say, "That is OK; it is good that more resources will come in." However, they are not so happy to show their success. Why? Because, if they show that success, they will have less money. So we are caught into a kind of situation, in some European countries, where basically we want to

show success, but that success is not good news, to a certain extent. So, we need to change the mentality, because if you do not do that, you will create dependency. The last thing our communities and cities want is to become dependent.

Do you find that your mechanism of implementation — how you do this — avoids this strange dysfunctional behaviour that you have?

The Chairperson: I will allow members to answer for themselves. I do not, because I do not like it. I am very proud of where I live, and of the fact that I represent where I live. I am proud for my family.

To take that one step further, the media has a part to play in that. We notice how quickly and easily the media — whether it is a local paper or the radio and TV — prefer a bad news story to a good news story. Some of that is to blame, too. It is the "broken window" syndrome. The more you tell people that they are this or that, the more they start to believe it.

So it is a partnership approach. I think that the MLAs who are here are all very keen to promote the good stuff that comes out of our constituencies. It is a level of how we get others to buy in and say that our constituencies are good and the people are good, hardworking and decent. We have our problems, but we work very hard to deal with it — *[Inaudible due to mobile phone interference.]*

Mr McDevitt: Chair, I think that Erio raises a very important point. Often, a Government funds a crisis response, so a crisis response needs a crisis to generate the income. I think that we are as guilty here, as anywhere else in the European Union, of sometimes building responses around crises and magnifying the crises or adding on bits to them. That is not just in health policy. It is a problem that we have struggled with in funding our transition towards peace in interface areas. You need to ask yourself a basic question: does the funding perpetuate the problem, or does it deal with it? Sometimes, it is perpetuating the problem, if we are frank and honest about it.

I think that the other problem that we have here is that we are very siloed. We are very good at writing good strategies but very bad at living them. The Minister of Health has very little authority beyond the Department of Health. You will find that he or she — whoever it may be, it does not matter who the individual is — goes looking for other parties to make strategic investments in health, they will not do it.

That then creates a culture in health that is about getting stuff in to do stuff that health can do, which, oftentimes, means spending money not quite in the best or right way. If you look at the proportion of our Budget that we spend on public health, that is the real giveaway: it is miniscule and it is not going to go up. The only way it would go up is if we started using education interventions, social development interventions, economic development interventions and some cohesion funding, to be able to increase it.

You are very right to challenge us in that way, and we know that is a problem. We do.

Mr Wells: Apologies; I am sorry that I could not be here for all of your presentation. It is a very great honour for this Committee to have such an expert giving evidence.

I think we are unlikely to be in a position where the problem that you outlined would arise, because we are well behind the rest of Europe, in my opinion, in tackling this issue. We have only had a Public Health Agency for three or four years, and we are only now beginning to take this issue really seriously. We have not yet cracked the really hard core areas; for instance, 31% of our manual labourers smoke, and we have a huge obesity problem. I would love to think we could have the problem of being so successful that we had to hand money back, or of finding it more difficult to claim money for health, but I am afraid that I think that that would be many years down the line. I think the Department is beginning to get quite professional and well organised on this.

Like Conall, unfortunately I think we need to be placing far more emphasis on money in the public health agenda, but I think that is unlikely in the present situation. I do not think that, in my lifetime, we will have an issue with being so successful in our public health agenda that we are forced to hand money back, or not get any extra resources. If only that was the case. There are many indicators that Northern Ireland, has real problems ahead in this field. We all agree that early interventions are absolutely essential, but that is a very long-term process and will not produce a quick hit, as we would say. We will not get a return from that for many years to come. The recession, which has of course

hit all of Europe, has not helped. If only we were facing that problem. I do not think that we are immediately, but hopefully we will someday.

Dr Ziglio: Thank you. First, it was a pleasure and an honour for me to be here with you, the people that are at the forefront of the issue. This issue of the silos is something I see a lot. I have seen some innovation, but I would like the next time I am here to see 10 examples like Slovenia. I was thinking about something that is the — *[Inaudible.]* — like Northern Ireland, I would have perhaps three.

This has opened up an opportunity for a new kind of co-operation among countries. I tell my organisation that, to implement a policy such as Health 2020, we need to open up different ways of co-operation, and that will also be very pragmatic in producing the kind of know-how that we have, and to move a little bit away from this silos mentality. We will be delighted to see how the reality of Northern Ireland can be; perhaps you can discuss with us the kind of co-operation you want.

You are a credible country in Europe. In that regard, we tend to get good examples from Scandinavian countries and so on that have a lot of stability and not so many social or economic issues. That is good, but it is very difficult for me to be credible when I go to some other countries to use an example from Sweden and Norway and so on. I have an example from a country that has suffered and that did not get everything so easy in life. The kind of situation we find in Europe with these new countries, because there have been 21 new countries in Europe since 1990, is that some of them have come out of conflict with a lot of problems. Information that they can relate to is very good. I think you are very credible on things.

I also think that you have a lot of talents in this country. There is talent in this country. The quality of your resources in many areas is really good. Perhaps you do not see that because you are from here, but when I come here, I see these developments. On the other hand, I agree with Jim, we are dealing with issues that are very complex. You have been brave to put the issues of health inequities in your strategy; not just to suggest a rationalisation of hospitals or of primary health care. It is a big issue, and you do your work right because we need to address this issue. Yes, it will take time. It will probably take time. However, I think that for a country like yours and of that size, it would be good if people working in public health find a way of sitting at the table where decisions are made about the country's development. It is a big issue. That is what will make the changes that we need.

The Chairperson: One of the positives that has come out of the Committee looking at health inequalities is the fact that the Minister has agreed to hold off on publishing until we come back after Christmas. That may be a sign of the genuine partnership approach between a Committee, a Minister and a Department. It is better than us publishing what we believe after the strategy has been put in place. I do not think that you will get any argument between us and the Department about that. There is no division. We know that we need to tackle health inequalities. It is probably just about the way that that is gone about and how we get to that stage. That is one the of the positives of the exercise that we are doing.

This session was very useful. I apologise that, as there are other Committees going on, members have had come to in and out to make quorums. On behalf of the Committee, I thank you for giving up your time. I know that you came over for another reason and we piggybacked on that. It was very useful, so thank you very much. Joan, thank you for allowing us to have him.

Ms Devlin: Thanks. It was a good opportunity.

Northern Ireland Assembly

Committee for Health, Social Services and Public Safety

OFFICIAL REPORT (Hansard)

Review of Health Inequalities: Triple P Project

7 November 2012

NORTHERN IRELAND ASSEMBLY

Committee for Health, Social Services and Public Safety

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

Witnesses:

Mr Eamonn Farrell	Health Service Executive
Mr Conor Owens	Health Service Executive
Mr Joseph Ruane	Health Service Executive

The Chairperson: On behalf of the Committee, thanks very much for coming and for your briefing paper. Joseph, I will hand over to you to introduce your team and make your presentation, after which there will be questions and comments from members.

Mr Joseph Ruane (Health Service Executive): First, I would like to acknowledge the invitation and thank you for giving us the opportunity to be here. About 12 years ago, I assisted this Committee as a trainee manager, and it is great to be back here after so long.

I am the integrated services area manager for the midlands, which covers Longford/Westmeath, Laois and Offaly. I took up that role in 2007. One of the projects that was running at that time and had a potential that excited me was the Triple P positive parenting programme. Thankfully, we have been able to keep it going five years later. Conor Owens is the director of the project, and Eamonn Farrell is the family support service manager in the midlands. They will be able to go into further detail on the project.

I have four key messages. First, we face significant challenges in resources and staffing in the health service in the South, and we need to challenge how we are using those resources so that we use them as effectively and efficiently as possible to the benefit of the population. Second is the importance of partnership and working with local communities and families to build up resilience and add synergies. Thirdly, whatever we are doing must be evidence based. Fourthly, the project must satisfy those three headings.

Mr Conor Owens (Health Service Executive): Thank you very much for giving us this opportunity to present to you. I will outline what I hope to cover in the presentation and talk about why parenting

should be looked at and dealt with as a public health issue. I will present evidence to support that based on biology, economics and equality, so that the strategy targets specifically areas of inequality and strategies that work for early years. After that, I will give a quick overview of the project that we are running in Longford/Westmeath, which is a universal access parenting programme for all parents with children who are seven or younger.

Longford/Westmeath is in the midlands. It has a semi-rural population of 130,000. Like all areas, it has been significantly hit by the recession over the past few years. Over that period, the unemployment rate has risen from 4% to 14%. It has actually gone past 14% — the paper you have, unfortunately, is out of date in that respect. The prevalence of social and emotional behavioural problems for children is quite high; it is approximately 20% overall. In specific areas, such as conduct disorder, you are looking at even higher levels. Approximately 40% of the population in Longford/Westmeath are in receipt of a medical card. Overall, the problem that we identified is that a disturbingly large number of children develop significant social and emotional behavioural problems. The concerning thing is that the vast majority of them are preventable. It is not that we just have to learn how to cope with them; we can prevent them. I will come back to the traditional argument of a distinction between prevention and intervention.

Mr Eamonn Farrell (Health Service Executive): Do you want to explain why you mention the medical card?

Mr Wells: Everybody has a medical card up here.

Mr Owens: Apologies. I mentioned the medical card because we use it as an indicator of family income. If you are below a certain threshold, you will qualify for a medical card, which means that you are entitled to free GP visits. It is used as an indicator of financial income.

It is interesting how many economists have come to this work and provided quite a lot of insights. The economist James Heckman said:

> *"Investing early allows us to shape the future; investing later chains us to fixing the missed opportunities of the past."*

Roughly translated, we have the evidence that prevention works. We have the evidence that intervening later, when there is conduct disorder or behavioural problems like that, results in huge financial costs.

We traditionally talk about how the environment, neighbourhoods and parenting affect children and how they come with a biological investment or reservoir from birth. The research shows us now really clearly that the home environment alters the biology. If parenting is aggressive or if there are significant problems around aggression, violence and inconsistencies in the home, that will change the structure of an infant or young child's brain. That means that, afterwards, you are dealing with much more significant and established problems. Remediation is then very difficult. Intervening early with evidence-based parenting strategies means that you do not necessarily have to go down that route. You are looking at the brain adapting towards self-regulation instead of impulsiveness.

Research was done in this area in the States. Interestingly, it was initially done by a for-profit private insurance company called Kaiser Permanente. It wanted to find out how it could make more profit. It looked at the areas in which big insurance claims were coming in. The first area that it looked at was obesity. It tracked 3,000 families over 50 years. It discovered that the adults who had what are called adverse childhood experiences in their early years had a significantly higher risk of developing obesity. It then used the same methodology for other areas, like ischaemic heart disease, depression and alcoholism. It found that there is a far higher likelihood of an adult suffering from those or engaging in those types of behaviours if they had those adverse childhood experiences (ACEs). Adverse childhood experiences are things like exposure to violence, exposure to trauma, separation, a parent having addiction issues or a parent being in trouble and perhaps being in prison. Those things are not that uncommon.

This slide is about depression. You can see quite clearly that the more ACEs you are exposed to, the higher the likelihood that you will be depressed as an adult. Remember, that research was done on a population in America who could afford health insurance and who could retain it over a long period. So it was an advantaged population. The figures are even higher for a disadvantaged population.

You can see that heart disease, when controlled for other factors, was still highly linked to childhood experiences. What early childhood experiences do is expose a child to toxic stress, which alters the development of the brain and increases the likelihood of engaging in risky types of behaviours, leading to depression, heart disease, drug addiction and such behaviours. What the research clearly shows is that early supportive relationships from parents are a protective factor and can counteract those events. Such relationships can push a child's trajectory back up to health. I just wanted to go over those to show how important early relationships are and how those right the child's brain and development.

Support for population-level parenting with young children has come from multiple sources, such as the Institute of Medicine in America, the Council of Europe, the UN report, the World Health Organization, the National Institute for Health and Clinical Excellence guidelines, and the National Academy for Parenting Practitioners. All those authoritative groups have said quite clearly that the evidence, on an effectiveness and financial efficiency basis, is that we need to look at that area.

As a result, we set up our programme in Longford/Westmeath. We decided that we wanted to work at a population level but to have access for all parents. We did that using — I think you have this in your 'Fit and Well' document — the idea of progressive universalism. It is not that we offer it straight off to everybody, but there is access for everybody. However, there are some groups that we dedicate more resources to than others. It is like a scale: those with a higher level of need will receive more, but those without an identified high level of need will still have access. I will come to that point in a second. Traditionally, a lot of our services have been geared towards lower socio-economic groupings, because we are clear on the types of problems that are there. I will show evidence now that if you want to improve the quality of life for children and their families, you need to go outside those groups, because the majority of children are in the other socio-economic groups.

The first argument against a public health approach is that we are in a time of recession, with limited resources, so although it would be really nice to do take the universal approach, we cannot afford it. I believe that the universal approach would save significant amounts of money, and I will quote some evidence to show that. To take a public health approach, the problem needs to be really common. We have at least a 20% prevalence rate in the community. From a survey we did in the Republic, we found that 30% of children with social and emotional behavioural problems, identified by the parents, were from the lower socio-economic group. So 70% were not. Therefore, if you want to change or improve the quality of life for children in your population and you do a fantastic job for the parents in the lower socio-economic group, we can guarantee that you will fail to achieve a population effect. The caveat is that, although 30% of the children with social and emotional behavioural problems are in the lower socio-economic group, life is much tougher in that group. The reason why it is 30% is that, population wise, it is a small group. There is a higher density and more prevalence of problems in that group, but if you look at the real numbers across the population, you see that the majority of children with those problems are not in the lower socio-economic group. That is why we argue for the population approach, because it goes right across.

Any of you who have done any work with targeted groups will know that it is difficult to engage a targeted group. It does not automatically appeal to anyone to feel as though they are in a targeted group. If I came to any of you who are parents and said that I had a fantastic parenting programme that I think that you would really like, your first reaction would be, "Why are you saying that to me? What does that say about your expectation of my abilities?" So, ironically, by offering it across the population, you actually get quicker access to the targeted population because they see that it is not specifically about them. It is something for everybody, so that makes it more palatable for them to become engaged. There is less stigmatisation.

A really interesting piece of research was done by a guy called Steve Aos from the Washington State Institute for Public Policy in America. Some of you are familiar with him. Basically, he does the 'Which?'-type reports on the effectiveness of evidence-based programmes. In his analysis, he showed that the Triple P universal programme had a return of $6.06 for every dollar that was invested. The interesting thing about that was that its return was higher than that of targeted parenting delivery to clinical groups. The reason behind that is: by doing a universal programme, you pick up many children who have not been identified by the system. You stop them having to come into the system. You start to have a preventative effect. That is what the population piece does; it combines prevention and intervention at the same time. Therefore, it is not two services or funding streams. It happens at the same intervention.

The remarkable thing about that figure of $6.06, which was way ahead of the figure for any of the other specific parenting interventions, is that they measured that only on out-of-home placements,

accident and emergency services and child residential places. They did not take into account the figures for reduced conduct disorder, reduced parental depression or improvement in ability for school readiness. They did not take any of those factors into account. So that figure is a very conservative estimate of the saving that could be achieved when you use the public health approach.

I have a cartoon that I use on most of the times I talk about this issue. I think that it is particularly important. *[Laughter.]* When I first saw it, I thought, "Poor Lassie. What is Lassie doing?" However, when you think about the services that we are all connected with, you realise that it is actually a bit more complicated than that. With regard to help-seeking behaviour, the person who is shown drowning there is just asking for help. They have not been informed about the specific type of help that they want to get or what they actually need to access. Lassie is doing what Lassie does best; she has gone to get help. The guy on the right who is helping Lassie is doing his best. He is probably really good at what he is doing. However, what he is doing is not what Lassie needs. That man's manager has someone who works really hard. However, he has not directed him specifically to what he should be doing. This is where the argument for evidence-based work comes from. You need to have normalising of the issues and promote help-seeking behaviour. The service that is offered needs to be immediate, effective and exactly what the person needs. Leadership for the man who is sitting there needs to be really clear about what needs to be done and achieved.

At the start, I mentioned the rationale for population piece. The 'Every Family' study was done in Brisbane in Australia. It was the first population parenting programme that was done anywhere in the world. Its survey found that 16% of children with social and emotional behavioural problems were from the lower-class category. The rest were not. So, if you want to improve quality of life for children and families, and have a good early years strategy and promote reductions in inequalities, you need to go across the spectrum. You need to offer a broader service.

When some people see that, one of their first reactions could be that each of those social categories will have a different way of evaluating their children's behaviour. There might be more laxness in one particular group than in another. That is a fair argument. However, when we look at the way parents cope with difficulties in parenting, this is what they found in the survey. There is a remarkable similarity in the strategies used by parents across the different socio-economic groupings. Whether it is threatening, shouting or hitting, most parents react in the same way.

Traditionally, when we talk about parenting, people think of a group. That would hugely over service need and be hugely expensive. So Triple P is a multi-level intervention that requires different levels of resources for each of the five levels. The first level is about parent information, so it requires very little resources. You are looking at websites, podcasts, newspaper articles and things like that. I hope that some of you received the 'tip paper' that we sent up.

The next level is concerned with brief advice. We do that in schools with an hour-and-a-half talk. Again, that is evidence-based and has been shown to work.

The next level is a two-hour stand-alone intervention into common problems. Again, it conducts surveys based on the problems that parents face. So, in the small discussion groups the topics are: dealing with disobedience, managing and fighting aggression, sleep routines, and hassle-free shopping. Those were the four topics identified in surveys as being really important. We missed the boat on hassle-free shopping. Everyone smiled when we offered a way to address the problem and most of them said, "No, we do not really want to do it. We do our shopping online" or "We go on our own". So we have missed the boat on that. Parents have given up on that one.

There are some concerns that we came across when we started to deliver. I will go through them quickly, as they seemed to come up quite commonly. One was that parenting is a soft issue and is not core business. Parenting is generally seen as a piece in itself. However, we are approaching it by asking what some of the best proven interventions are for children with attention deficit and hyperactivity disorder, children with conduct disorder, children with mild levels of behavioural and emotional problems, children at risk of depression, parents with depression and parents with impulsiveness. There is one common theme in all of those: parenting. No one would argue that those issues are not the core business of a health service. So one of the really good things about parenting is that it reaches so many different core pieces of a health service's work. You deal with multiple problems at one time.

A really common concern was that the programme would not work here. We have the evidence from Longford/Westmeath to show that it does. The common line is, "That works fine in Australia, I am sure, but they do not know our parents." That is not true. Parenting principles are just the same.

Another common line was, "Irish parents do not do groups. We will moan to ourselves and keep our problems quiet." That is not true. The level in which we have had the highest recruitment has been the groups. So parents do participate in groups. It is also said, "It is a nice idea, but it is poor timing and expensive." Again, if you look at the Steve Aos stuff on financial returns, they will be delivered within a two-year time frame. This is not about services for the future; it is about immediate measures. When people traditionally talk about prevention, they think about a saving that will accrue to justice in 10 to 15 years. The evidence shows that that is true, but there is more to it than that. You will have savings accruing pretty much straight away.

In answer to the concern about poor timing, in your line of work, you meet people every day. How many parents do you meet that are under pressure? With the recession, what levels of depression and stress are you seeing in parents? When the work that we are replicating was done in Australia, there was a 26% decrease in maternal depression rates. That is huge. You see on the doorsteps the impact that depression can have within a family. It can be devastating.

The last concern we came across was, "We do not have money. We need to be focusing on treatment. Wait until we have money for prevention." Treatment and prevention can be the same thing. We have parents coming to groups who are doing OK but want to learn more tips on protecting their children in the future. We have parents in the same groups whose children are in the clinical range, which is great because it means that you do not have to stigmatise through screening. One of the key lessons that we learned is that parents like the programme. Word of mouth is spreading, and, in fact, our highest source of referrals is through word of mouth. Partnership is essential. No one organisation is totally acceptable to the population. Each organisation has skills and contacts that can be exploited. Marketing is really important. Staff selection is crucial. When we talk about evidence-based work, some people say that we do not have money to add another service. My query would be whether those people have evidence that all the services being provided are working. For those that are not working, there should perhaps be a reorientation of their resources to services that are working.

This has been unsolicited, unedited feedback that we received from parents who went through parenting groups. We took their comments and put them into a word cloud, and that is what they are saying about their experience of going through the programme. To date, approximately 3,000 parents have self-referred into the programme.

Thank you very much. That was a whirlwind, so apologies.

The Chairperson: Thanks very much. Your presentation was very interesting. Some of us have been involved for a number of years with children and young people. Professor Heckman has been here before, and we have listened to him. He makes a lot of sense. Sometimes, we are afraid to spend money, even though we know that it will save us money in the long term, but that is the way we are today. I agree with you: the old African proverb about it taking a whole village to raise a child is very important.

We are the Health Committee; we are here to scrutinise the work of the Department of Health, Social Services and Public Safety (DHSSPS). However, there are times when other Departments have a responsibility for health inequalities. It just so happens that our Department has to deal with the illness that is associated with health inequalities. You mentioned a partnership approach a few times. How do you get people to adopt that genuine partnership approach when every Department here is chasing the one pound and has its own priorities as well?

The Office of the First Minister and deputy First Minister plays a central role for children and young people. I am talking about targeting poverty and the 10-year strategy around children and young people. Those fall outside our remit. We are trying to tackle health inequalities and the stuff that you mentioned based on what other Departments should or should not do. We are in a coalition Executive, and that probably makes it a wee bit harder as well.

I do not know whether you heard me earlier referring to two Departments. In fairness, we are still waiting on responses from other Departments. We wrote to them all to ask whether they have any health inequality strategy. They replied no. There is an issue about mindset. Although the Department of Finance and Personnel may not have a specific strategy to tackle health inequalities, it is doing a lot of work by funding stuff, such as funding the Department of Enterprise, Trade and Investment around job regeneration and all that stuff. I agree with you on the universal population approach to the constituency, and I agree with you on the whole issue of all being able to avail themselves of it in the constituency. We have a sizeable percentage of people who are working poor.

They suffer the same things, but they are still working poor. How did you go about convincing people that a genuine partnership approach from the constituency, the voluntary sector, the community sector and the statutory agencies is needed?

Mr J Ruane: When we started this, which was around six or seven years ago, it was contained. It is like what we were saying about here: it was in a particular Department or section in our own health services. The first point was selling the programme in that sector and, in doing that, pulling all the separate Departments together to look at it in the context of what it could offer to each of them. It was important to have that piece in there to work on. We had to sell it to people in our own Department first to get them on board. Without that support, we would not get anywhere. It is about trying to find the leadership that exists to put this in place. That was key.

It took time to pull different sectors and Departments together. Within health, you have, for example, psychology and public health nursing. Each element looks at its own sector, but there was benefit for everyone in this, as Conor showed in the slides, whether in mental health or education. It is about bringing that message to people to pull them together.

Getting that piece in there is what we were working to achieve first. We said that health services could not deliver it on their own, either because of the stigma of approaching them or because people do not want to be associated with them. It is about engaging the external agencies that have access to the communities that we want to reach. We want to reach the community and every parent out there whom we can support and help, wherever they are.

Working to bring in the external agencies, such as the community representatives and organisations, was probably a lesser task than the initial task inside the Department. It was about bringing all those people together to show them that they had the majority role to play in reaching the communities that we were trying to get to engage in the project. Even though we, as a health service, are a very big organisation, without the component parts coming together it would not go anywhere.

A certain number of people took up that offer and a certain number said, "No thanks; that is not ours." We had to leave it with them and hope that, at some stage, they would see the benefit of it and ask to join in. That did happen over time, and we got a growing number of partners. When we started, we were looking at one, two or three community groupings that were responsible for delivering local development initiatives, which is nothing to do with parenting. We told them that what they do has a lot to do with it and that this project could help with that work.

That piece of work was about identifying people with leadership qualities in those communities, bringing them on board and developing the work. We started with Health Service Executive (HSE) services only and then had perhaps two or three external agencies, some of which we looked to deliberately, because we knew of their involvement in the community. Currently, we have 10 different organisations and are oversubscribed with partnerships.

The Chairperson: How do you get other Departments to buy into it? I will give you two examples: in the previous mandate, there was a battle in this Assembly between DHSSPS and the Department of Education to see who was going to fund breakfast clubs and after-school clubs. That is what it boiled down to. There was a great project in my constituency called the integrated services for children and young people programme. The junior Ministers said that they would love to roll it out in their constituencies, but it is down to a battle over who will fund it. It is about the statutory role of genuine partnership approach.

Mr J Ruane: We were lucky at the time, in that the Health Service Executive covered the entirety from childhood to adulthood. It was the responsibility of one Department in the main, although obviously there were linkages with education. There was a strategy for children's services committees, which was the coming together in specific counties of the local council, the guards, the education authorities and health providers. There was a framework there with which we could engage.

We are, however, now entering challenging times. Where there was one Department dealing with children, encompassing everything to do with health services, we are now moving towards the separation of the child and family services into a separate Department, the Department of Children and Youth Affairs, under Minister Frances Fitzgerald. There will be a challenge, and our focus will be on ensuring that the work continues that has been done between the two Departments on health and the new developments on children and families. If we are not focused on the importance of that, we

could end up saying that there is a child and families agenda, and we should let that Department look after that. There was a benefit at the start.

Conor emphasised that, ultimately, when money is being spent in whatever Department, we have to ask whether it is being spent as efficiently and effectively as possible. For example, with the children's services committee in the midlands — in Longford/Westmeath — we found out that the health service and councils were giving money to some voluntary groups. Suddenly, groups were receiving money, and we did not realise the total money given. We were able to look at that and say whether one group was good and should continue over another one. Therefore, there was focus.

The key thing that has been there and has to continue is transparency, both in the HSE and with the staff. Eamonn is understating the challenges that existed internally in the system. People said that it was the social worker's job; the child and adolescent mental health service's job; or the public health nurse's job. Ultimately, we were forced to say, "Look, this makes sense. It is evidence-based. We will take the leadership call. We need to do this." The other thing is that we had support locally in the community. Local public representatives, families and educationalists viewed that as positive.

Mr Owens: I will add a little bit to that. The work that we did started in local areas and moved up to the policymakers. If the Minister were to look at an idea like that, one really important thing is scale and to have all Departments looking at not a large piece but a small manageable area, because systems are very good at surviving as they are. It is very difficult to change a system. If you introduce an evidence-based programme into a system, it is very difficult.

What we achieved through the local management and leadership was that a number of people became a core team and delivered the programme. It was almost like a spur on the side of the main system to get established and get buy-in from the local community for people to see that the programme is what people want and is helpful. We are now entering the phase in which that programme moves back to being aligned with the major systems. Therefore, I would look not at the idea of starting such a programme in an established service but at having it slightly on the side so that people get a remit to do the work and to build up expertise in it. As such, the programme gets a reputation for actually working.

The immediacy of positive feedback from parents has helped us enormously. So many arguments are dissolved when people hear someone say that they attended the programme and that it was good. Even though they are very difficult systems to change, people in those systems all respond to hearing that something was good, that parents liked it and that it changed something for children.

At that level, where things such as the 'tip paper' come in, it is about promoting local ownership and showing people that this is something that our service is delivering of which we can be proud. The aim of a public health piece such as this is that the community takes ownership of it. Again, you do that through partnership. The community wants it and drives it. However, there are difficulties in trying to get co-ordination. You will hear an awful lot of talk about effectiveness and efficiencies. An effective and efficient programme will not ensure that the piece that has to go with that survives. You have to have strong leadership and a good implementation plan. That is where the work of political leadership and local leadership comes into play: to pick specific sides and to give something a chance to prove that it works and is useful. If it does not work, stop doing it. It is the same for existing services. Eamonn and another colleague, Joe Whelan, did a survey. We found that there were 17 different parenting programmes.

Mr Farrell: There were 17 on offer prior to our commencing this piece of work to find out what was happening out there. People had been trained in 17 different programmes. However, even though substantial resources had gone into them, very few were being delivered or being delivered effectively.

Mr Owens: All of that was out there. Parents want to know that it is something that works. When we started the evidence-based programme, parents responded to it very quickly. We were training people in one programme, not 17 programmes. When you have that focus, you get people to deliver a lot more, and frequently, and then you get a critical mass.

Mr Beggs: First, I declare an interest as a member of Horizon Sure Start in Carrickfergus and as a member of the Carrickfergus locality group, which deals with some of these sorts of issues.

Fascinatingly, you talked about James Heckman, who has been well known for a long time and is a Nobel laureate economist. We tabled a motion on the issue four or five years ago. Steve Aos was

also in this Building. One name that you did not mention was Harry Burns, who is the Chief Medical Officer for Scotland. Four years ago, he delivered a presentation to the Northern Investing for Health Partnership. Two days previous, he delivered the same presentation to the entire Scottish Executive. He was trying to reduce health inequalities in Scotland, and he came to the conclusion, exactly as you did by using evidence-based, scientific programmes, that it was about early years investment. That is very relevant, and I hope that our Chief Medical Officer takes a similar position.

You mentioned the medical card. I would be interested to know what level of salary that takes in.

Mr J Ruane: Around €30,000 or €40,000.

Mr Owens: It is also related to the number of children that you have.

Mr Farrell: Generally speaking, it is under €35,000, give or take. It is means-tested.

Mr Beggs: You mentioned that your programme is for nought to seven years. Interestingly, in Northern Ireland, the investment is in nought to four years old. Will you explain why you think it is important for that older age group to be included?

Mr Owens: Originally, we started with three to seven years old. The rationale being that there is a major transition then, because children are preparing to go to school and are becoming established in school. We thought all the research pointed to the fact that that is a really important, critical phase with lifetime consequences. However, we got such buy-in from other sections that we brought our age range down. We are preparing to start delivering in another two counties, and, again, the age range there is nought to seven. Again, we widened the range from four to seven to cover that transition into school, because school readiness is incredibly important. The more work that we can do around that, the more that teachers will be able to teach, rather than having to tell John or Mary to sit down, concentrate, play in a reciprocal manner, or whatever. All those skills are built up through parenting, and that is why that time is so important.

You mentioned Harry Burns. I remember that he said that we know what works but that we just do not do it. He was talking about early years and parenting. In Glasgow, he has supported and been involved in setting up the same kind of work that we do, expect that he does it for nought to 16 years, while we do it for nought to seven years. That is being run at population level right across the city of Glasgow.

Mr Beggs: I fully support what you are doing. It is great.

What about outcomes? How long has your programme been running? What savings are you achieving? At the end of the day, you need to convince people to pool resources. Do you need more and ongoing resources to get better outcomes? You said that you are making, if I picked you up right, 20% savings. What cash flows are required to fund that, kick it off and enable it to happen?

Mr Owens: We started in September 2011. We have had one interim report, and our final report will come out in June next year. Our interim report — it was interim, so there is a health warning attached to all its results — showed was that our outcomes were in line with, if not slightly ahead of, international research.

Mr Beggs: You started in two thousand and —

Mr Owens: In 2011 — sorry, in 2010. We have been up and running for just over two years , so it was 2010. The project will run for two and half years, and the evaluation will continue to roll out after that.

As to outcomes, what we are showing is that, with parents who have children in the clinical range, for those who attend the group, over 50% are no longer in the clinical range as a result of going through a parenting group. We are not working directly with the children; we are working just with the parents.

Mr Beggs: Is money starting to flow from other parts of the health service to widen out the service elsewhere?

Mr Owens: We are expanding into a further two counties, so we will then be delivering in over four counties.

Mr J Ruane: And we will have a doubling of the population brief.

Mr Beggs: What was the initial investment made to kick this off? What was the annual investment to service 130,000 people?

Mr Owens: The majority of the investment is in staff. The HSE reoriented a number of posts, and I think that that is key to sustainability. You cannot be inventing new posts, so there is a reorientation based on evidence, need and interpretations. We are lucky in that we attracted some money from the Department of Children and Youth Affairs and got some money from Atlantic Philanthropies to cover the research and evaluation.

As to the whole overall pot, I do not have the answer for that yet. We will have it come June. What we have discovered is that we have got a lot smarter in the way in which we deliver. We will have an economic evaluation piece on the next two counties. We have learnt ways to increase efficiencies enormously. One of the ways to do that is through partnerships, where partner organisations free up staff. We have a core team, whose job is to deliver, train and mentor full-time. We have other organisations that release staff. We have an agreement for 110 hours a year, and we supervise and mentor those staff, and they deliver. Therefore, we are not using just the HSE resources but are getting community resources, and getting the savings from that.

I think that it will be a while before we see savings in referrals, simply because services do not reach everyone who needs them. We hope to show savings, and believe that we will. We carried out a population survey at the start, so we know the prevalence rates for different behavioural problems, levels of concern, levels of parental stress and depression, and quality of relationships. We have those for Longford/Westmeath and for matched controlled areas. We will be carrying out that survey again in February of next year, and that will hopefully show a decrease in prevalence rates. That is where the major savings will be.

Australia, as I said, showed a decrease of 26% in maternal depression rates, which I thought was startling. Think about it: if you had an economist who could cost that in possible work days lost, visits to GPs and medication, the figures would be huge.

Mr Wells: I have three questions. First, you mentioned the feedback from the parents group. Let me give you an example: I am a vegetarian, and vegetarians live seven years longer than meat eaters. That is an absolute fact. It is utterly meaningless, because vegetarians tend to be exercise freaks, do not drink or smoke and do not do a lot of things that affect life expectancy. Therefore, vegetarianism may have nothing to do with life expectancy; rather vegetarians are just that type of people.

Similarly, there is a bit of self-selection here. Obviously, the people who have the drive and impetus voluntarily to register for the programme are probably the people who will have an active interest in making it work, and therefore are likely to keep at it and get that type of result. What is happening to the people out there who have not the motivation to register?

Mr Owens: This is great, because I have an answer for this one. *[Laughter.]* There is a strange thing called the law of diffusion of innovations. It states that 16% of people are early adapters to anything. They are the people who will sign up very quickly. They will come along, and they are self-starters, motivated and want the best. We reckon that, based on our stats, we got that percentage 13 months ago. After that, we are working on people who are not early adapters.

However, we have to change the message in order to recruit those people and get them interested in coming forward and self-selecting. This is where the marketing piece is so important. The early adapters respond to fliers and opportunity. They will take it. Then there are others who, after that, responded to word of mouth. We discovered that that was the driver for recruitment — not fliers, posters, podcasts or anything like that. We needed to change our recruitment strategy to try to get people who had gone through programmes to start talking to other people about those programmes. That is what people are doing now, which increases our reach into those areas.

With the progressive universalism piece, there are geographical areas where we know there is a higher level of need than there is in other areas, and we dedicate more resources to those areas. We find out what services are available, whether it is a community mothers group or whatever. Wherever

people have a good connection, we go in and talk to those people. We get them involved in observing and taking part in programmes. They then talk to people whom they know.

Therefore, there is a group that is easy to recruit, and there is a group that is harder to recruit. If you are taking the public health approach, you have to recruit from the different groups and not just take the people who come to your door. One of the arguments that we have heard is that we are running groups that are not full. There might be a group that has eight parents in it but could take 12 parents. Some people will ask why we do not expand our age range so that we can get more parents in. Our answer has been no. Although we know we will get more parents in if we expand our age range, we will only ever deliver to the parents who are quick to self-select and will never develop the skills and recruitment skills for the populations that require that bit more effort or convincing or that are that bit more wary of services and authority structures.

We have stuck to our age group, and that has made life a bit harder for us, because we have had to figure out ways of recruiting those harder-to-reach groups. We conducted a survey at the start, the results of which were really interesting. I am not sure of the exact figure, but the vast majority of parents said, "Of course we want evidence-based programmes to be readily available to everybody. They are fantastic. We have to have them." Then, when they were asked whether they would attend one, the answer was no. They said that they were for other people, not for them. If you go back to the Lassie cartoon in the slides, there is a piece about normalising everyday problems in parenting that stresses that they are not a sign of incompetence or of not being able to do something. That is just the way that parenting is. At times it is fantastic, while at other times it is stressful.

The next piece is about promoting help-seeking behaviour and evidence-based parenting. Then, there is the opportunity with Triple P. There are a lot of steps involved. It is not just a case of offering the parenting programme; rather, there is a whole strategy that needs to go in beforehand, and there is a strategy for different populations as well.

Mr Wells: That is an interesting response. I was surprised at your graph. If you ask me where the problems lie, in my constituency they are in the sink estates, which contain the difficult, hard-core, poor and vulnerable communities. You are saying that if you went to the leafy suburbs of Blackrock or Dublin 4, you have as high a level of —

Mr Owens: In real numbers. There are fewer sink estates than there are other estates. In sink estates, you will have a higher density of problems. For example, of 10 people, a high number of them will have the problems that we are talking about. However, you might have 100 people in the other estates and 15 children with social, emotional and behavioural problems. When you add up the numbers, there is a higher level, but we are not talking about the percentages.

Mr Wells: It is more of a problem in the sink estates.

Mr Owens: Absolutely. Life is much harder in those estates. It is just that, overall, fewer children come from such estates.

Mr Wells: It is surprising that you are identifying high instances of problems in what we would call middle-class, leafy suburbia. You are seeing people in those areas who have problems parenting.

Mr Owens: Think of people whom you know.

Mr Wells: I do not know any such people with those problems. I just wonder whether the breakdown of the standard family unit, which is clearly affecting all parts of the community, is the explanation. Is that the issue that is causing a lot of difficulties? Obviously, it is much more difficult to provide parenting if you have been through a bitter divorce or separation. Is that the common factor? The common factor cannot be economic, because many areas that are quite affluent are still showing instances of very poor parenting.

Mr Owens: We got the answers so that we could categorise people into different socio-economic groupings. We also asked people about their ability to pay bills and what pressures they were under financially. A lot of people in the leafy suburbs are, behind closed doors, struggling. That would be a huge stress. I agree with you: if you have resources, life is going to be a lot easier, and there is a greater likelihood that you are going to be able to do higher-quality parenting, but it is not guaranteed.

There are people with great levels of resources who are very poor at handling stress or who just find the whole idea of the relationship around parenting difficult.

Mr Wells: This is a common theme. We have heard some dramatic presentations on this issue. We had an incredible one in June from a lady from Dundee with a Polish name, which I cannot pronounce, so I am not going to attempt it, but she gave very dramatic statistics as to the importance of early intervention. The point that she made is the same as yours: that we have to do this or we will be storing up huge problems that society will have to pay for at a later stage.

The problem we face here is that we are firefighting now. We are trying to pay the bills that keep the cancer wards open and keep the Fire Service going and pay the social workers. We are told that if we invest an awful lot of money now, there will be a payback, but there are a few problems with that. First of all, that payback could be a very long time, and we are trying to pay the bills now. Secondly, much of the payback would be to budgets that we do not control. We have a different system to the Republic, and much of our social welfare is paid directly from London and does not come out of our grant at all. You have a unified system in Longford and Westmeath. To be purely mercenary about it, how many years do you think it would take to get a return on this expenditure?

Mr Owens: The great thing about Heckman's work is that it has come purely from that economic model. I hope that you got the document. On page 10, it goes into the impacts in South Carolina. They rolled out the service across 18 counties, and each county had a population of between 100,000 and 120,000 people. They found that, within two years, on a purely economic level, they made back all their financial investment. That was not a long-term thing. That needs to be qualified. Where they made most of that back was in a decrease in the number of children needing to be taken into residential care. The cost of a child going into residential care is significant, and they were able to decrease the number of children going into residential care.

Mr Wells: We would not see some of what would come back. London would save it, because of the system that we have. It would be a saving to the UK but not a saving to Northern Ireland. However, two years strikes me as very optimistic.

Mr Owens: It is remarkable. It is so remarkable that the study was funded by the Centers for Disease Control and Prevention in America. It is now funding a replication of it on a much larger scale. If this continues to hold, this is quite dramatic.

Mr Wells: The other question is, of course — I do not think I have been to Longford or Westmeath that often, but it is a largely rural area in the midlands —

Mr Owens: It is semi-rural.

Mr Wells: Would the same model apply to inner Limerick, Dublin or Belfast?

Mr Owens: It goes back to the common concerns that it does not work here. It is in Glasgow, and it is being used in Brisbane. It is used in city populations, but we are not using it in city populations. Our evidence base is going to be semi-rural, but there are 127 independent studies on Triple P. A significant number of those are city populations.

The Chairperson: At the minute, I just have Gordon, so —

Mr Farrell: I am conscious that Roy asked a question earlier about costs. I am not saying that it is of any huge benefit, but when we budgeted for the research component three years ago, our budget for the delivery, roll out and everything was somewhere short of €2 million. We have come in under budget, and a huge percentage of that budget was allocated towards the research component. It was not new moneys. It was reorientation of resources from Department members and the people — *[Inaudible.]*

The Chairperson: At the minute, I have Gordon and Maeve. Do any other Members want to come in? We just need to be careful of the time.

Mr Dunne: Thanks very much for your presentation. You are very welcome. Would it be fair to say that it is basically a case of prevention rather than cure? Obviously, it is prevention and investment at a very early stage. How do you justify the funding? Is it an issue to justify it? We are certainly under

pressure. Acute services are always in demand, and cancer care is growing in demand. How can you justify funding the project in that regard?

The other thing — this has been touched on — is parents. In many cases, there are single-parent families. Is that a priority? The commitment of both parents is probably a big issue of time and effort to get involved in the programmes. Maybe we could get some more information on how they are worked out locally. Do GPs have a role? Health visitors? We would like more information on how it goes out into the community.

Mr J Ruane: If this had developed 10 years ago in Longford/Westmeath, business cases would have been done by the Department of Health seeking additional staff. It would have said that it could not be done without another 10 staff. That was the method and model; we did our business, and that was it. There has been a reality check over the past five years. There is no more money coming down; you have what you have, and you decide whether to continue it as it is or to rejig it. We made the call over the past number of years. Arguably, we jumped; we took a leap of faith. When I say "leap of faith", it was based on evidence that has already been gathered elsewhere.

We absolutely accept all of the concerns that Conor outlined about whether it will work in Ireland. Initial work went on, and it proved positive. Social workers, public health nurses and various colleagues with a psychology background were doing clinical work. We made the call to say, "Well, actually, you were doing that full time. Now I want you to do half time on this." That creates tension and anxieties in the system. The immediate thing is, well, we absolutely needed Conor or Eamonn full time, and he is going to go away. That has to be managed. The reality in the system in the South at the moment is that we lost about 3,500 staff a number of years back through early redundancy. Our figure for the health service has to go from about 101,000 staff down to 95,000 staff. The same arguments are going to be there; staff are going to go, what are you going to do? The fundamental question is whether it is important and evidence based. Once you take those things, you then have to prioritise, knowing that the work that we previously did must stop, or the way in which we did work in the past, having reviewed it, can be done more efficiently and effectively. That is where the resources have happened. Had it been done and developed in the boom times, it may not have got off. That is the irony.

Mr Owens: In order to take a decision on services now, it is really scrutinised and thought through. The public health nurses are really central to the work that we do.

Mr Farrell: They are the equivalent, I think, to your health visitors.

Mr Owens: Yes. We have a number of them trained up, and we have dedicated Triple P clinic time. The public health nurses became involved. When they were doing developmental checks, the parents were saying, "That child is fine, but the four-year-old over there is driving me mad and I cannot stop him hitting his sister." Those concerns came up again and again. The public health nurses found themselves spending time addressing those topics with the parents. They were trading off what they had read or what their colleagues had told them, or their own hard-earned experience. They did not have an evidence-based practice, and an evidence base was really important.

In some cases, it was not that we were asking them to do more work; it was that time was being filtered off to deal with those requests. We are now offering them a structured way in which that can be done. It can be done through groups as well; the public health nurses run small-group discussions around dealing with disobedience and night-time routines. Many parents or mothers were coming to a public health nurse and saying, "I am going back to work in six weeks' time, and the child is still not sleeping. What am I going to do?" It is about things like that. The topics that we talk about in it are ordinary, everyday things, like what you do when you are on the phone and the child comes pulling at your trouser leg, saying "I want a biscuit." Or, children are in the back of the car and they kick off when you are driving somewhere. Things like that. They sound ordinary and mundane; they are really common. However, these are the things that start to build up and can lead to problems. That can be the time when a parent can turn around and give a child a clout or shout something at them, and 10 minutes later be going, "Oh my God. Why did I say that?" Or not, maybe.

However, we are not going for the dramatic. It is the ordinary; and we are trying to get it across to every parent, using the existing services and the public health nurses. The GPs get regular updates from us, and they promote the programme. So, again, it is community ownership; as much promotion as possible. The GPs are going to be really important to us in the New Year, because there is an

addition to what we are doing. We are starting a childhood obesity programme, and we are doing that through parenting, rather than directly through the child.

Mr Dunne: It is a big issue. It is connected to lack of exercise and sports.

Mr Owens: Absolutely huge.

What we are finding is that there are all these strategies around healthy eating and exercise for children, but children are used to getting their treats or food in a certain way. So the parents need additional skills, at times, to help them to cope with that. Our target is really the ordinary, and we believe that that will decrease the clinical.

As I said earlier, the prevention and the clinical mix in the same groups. If you had a group referred from a community psychiatric team, you might decide to keep that as a closed group, depending on the levels of their problems. Generally, we have open groups. We have found that in some particular geographical areas that parents have said, "Yes, we want to do this, but we do not want anyone from outside our area to be part of it." And that is fine.

The Chairperson: Can I just remind members that we need to finish this in 10 or 15 minutes, but we are going to continue it over the lunchtime break. Other members want to come in on this particular part.

Mr Dunne: That is grand. Thanks very much. It was very interesting.

Ms Maeve McLaughlin: Thank you for your informative presentation. I believe that this is about redirecting and reprofiling resources. We have to do that within a current policy context as well. Increasingly, I find that there is a general shift in health, at senior policy level, to more community primary-based health programmes. Within that, and central to it, is early intervention and early years. One of the things that struck me — the economic impact is a critical tool for us to have the information. The thing that struck me was that representatives of the Institute of Public Health in Ireland were here a number of weeks ago, and they gave a very detailed presentation, but specifically — and I am looking for clarification on this — they talked about the Scottish model. They said £5·6 million had been saved in the Scottish economy as a result of early intervention. They also talked of the American model, 15:1 or 16:1, and about research that had been done in the Twenty-six Counties of an investment of 7:1. So I think it critically important. I will go further: we need an island-wide figure that allows us to make the case which does not exist currently. Maybe you could clarify that. Where are the differentials in the information that we are receiving?

Mr Owens: I think that you have put your finger on something critical. The Steve Aos figure that I quoted was from April of this year. If you go back to his previous figure for the same type of work, you will find that they are hugely higher. He rejigged his methodology, and there are basic assumptions made in cost-benefit analysis. People use different assumptions, and they can make enormous differences on those investment ratio figures, whether it is 6:1, 70:1. It needs an economist to compare the assumptions or to try to get the raw data to have the same assumption. I will tell you the reason why I was particularly taken with Steve Aos. I was a bit disappointed when I saw $6 for $1, compared with some of the other ones that I have I read about. However, he applied the same methodology to lots of different evidence-based programmes so that you could compare not the headline figure but the relationship between the figures for different programmes, and the one for universal Triple P was way ahead of the vast majority of other programmes. So, from that, I took it that, whatever your economic assumptions are, there was a higher return for universal access to Triple P than there was for the majority of other programmes.

Ms Maeve McLaughlin: That is useful to know. It is important that we have that tool, so that we can lobby collectively.

Mr Owens: We wanted to do an economic analysis when we started ours, but there was nothing to compare it against. So we were concerned about coming up with a figure that might look very high and about the fact that we would have nothing to compare it against.

Ms Maeve McLaughlin: It is a shift from early years to 0-7. I have looked at some of the information on the whole issue of brain formation, the impact and the stages and all that — technical, but incredibly important. What obstacles, if any, were there, because I have found locally in my

constituency that there are some obstacles to differences between early years and going at it from 0-7? It is a shift. People looked at early years, and it was three, the going into school age group. This is a change, so have there been any obstacles, and how did you overcome those?

Mr Owens: The obstacle that we came across was a repeated request for an expansion of the age and a repeated pressure for the teen version. There was pressure from public health nurses for the pre-birth period. I do not think there is an ideal age range. I think that it needs to be based on a common definition and a common rationale for why you are picking an age. We picked that age because it is a key transition time between home and school, but I think that any range is fine as long as it is within early years. With 0-4, I think that you miss some of the transition into school. I am not sure of the age of entry to school. For us, the child has to go between the ages of four and six. We carried it up to seven to get it established there. As long as it is within that kind of time frame of under seven or under six, I think that that is where you will get the highest returns and where you will get the prevention piece. It may not quickly reduce your waiting lists. The reason behind that is that there are so many hidden hurdles to getting on a waiting list. You have to want to be on a waiting list. With the public health approach, you are providing universal access, so you are getting people who may not have been on your waiting list.

Ms Maeve McLaughlin: Finally, I know that part of the learning, again back to constituency but in terms of regeneration, was that early intervention is viewed as a catalyst. It is interesting that is has actually been platformed through the City of Culture events next year, which are critically important as well, in respect of the learning about targeting resources to where they are most needed and the huge debates about the word itself. The whole concept there that you are talking about — progressive universalisation — is an interesting one. How are the outcomes measured? I will give you an example of why I am asking that. Over the past year and a half, in some of the programmes in part of the constituency that I represent, which is an area of high social need, the teenage birth rate has dropped by 50%. That shocked everybody in the sector. They were going, "How did that happen?" One of the obstacles, I find, is that people say, "You cannot really measure those outcomes, because there are all sorts of outside factors that may impact a person and their family. So how do you do that?" This is a critical piece of work that we can demonstrate. We hear clearly what you are saying, but it is important that we look at models for how we measure those outcomes, particularly in that sector.

Mr Owens: I think that we have to put our hands up and say that we were extremely fortunate to get external funding for a robust evaluation. Part of our work now is to say that we will not have those resources available to us in the future. So, when we look at the next two counties, we are thinking about the minimum data set that we will need, based on our experience. What systems will we need in order to streamline it as much as possible? You cannot operate on a really good, continuous, solid evaluation. You have to shrink it down over time in order to make it manageable and make it part of ordinary work and practice. That is the only way that it stands a chance of going to scale. The last thing that you want is a really good project that has not evolved to the point where we can fit it back into mainstream systems. We have to shrink elements like that and pick out what is core. What is the data set? What information will be enough for managers and political people to say that it is worth continuing?

Mr Farrell: In the context of measurement tools, the range that we have used is all recognised clinically and internationally. So, nothing is being used that is not a recognised measurement tool in the context of pre- and post- or measuring outcomes through general health questionnaires, strengths and difficulties questionnaires, relationship indexes and all of those things. They are all recognised tools.

Mr Owens: We are shrinking the data set and putting into it only three questionnaires.

Mr McCarthy: That is exactly what I was going to ask. I think that you said that you have been on the go since 2010. You have obviously done excellent work. Is there a cut-off point? Will the programme continue for a couple or three years, or what?

Mr Farrell: The cut-off point for the research component — the collection and measuring of data — is the end of 2012. However, the programme will continue. We had always factored in a sustainability element, which was the partnership approach in terms of having resources and that they would continue to deliver. So, the programme will continue. Not only will it continue, but it is expanding into these other two counties as well. A few new elements are being added into it. There is commitment to that.

Mr McCarthy: Finally, what will your role be when the programme is finished? Will you be looking over their shoulders to see whether they are carrying on the good work that you started?

Mr Farrell: f it is successful, we will be in the background. Its sustainability should not depend on any of us to be there at all. Our hope and aim is to do ourselves out of a piece of work if it is successful.

Mr Owens: Currently, our next piece of work is to produce implementation manuals, so that it is not reliant on individuals. We will come up with those manuals because you have to have leadership, an evidence-based programme and economic analysis. They all come under the heading of implementation. Lots of people here in the North are developing quite an expertise in implementation, such as the Centre for Effective Services, Barnardo's and the Parenting Forum Northern Ireland. Those groups are already doing that kind of work.

Mr McCarthy: Thanks very much.

The Chairperson: We will continue this over the lunch break. Formally, for the record, I want to take this opportunity to thank you for coming today and delivering your presentation. The more presentations that we get on this issue, the more it starts to set in that, as a Health Committee, we have a duty to look at health inequalities, not necessarily outcomes. It is our responsibility. In fairness to the Minister, he has agreed to hold off the publication of his strategy until we have finished our report. That in itself is a good sign that there is a genuine partnership approach at that level between the Department, the Minister and the Committee. As I have said, we will continue this discussion. I will suspend this part of the meeting. We will head to the Members' private dining room, where we can discuss the issue further. Thank you.

Northern Ireland Assembly

Committee for Health, Social Services and Public Safety

OFFICIAL REPORT (Hansard)

Review of Health Inequalities: Youngballymun Project

7 November 2012

NORTHERN IRELAND ASSEMBLY

Committee for Health, Social Services and Public Safety

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Members present for all or part of the proceedings:
Ms Sue Ramsey (Chairperson)
Mr Jim Wells (Deputy Chairperson)
Mr Roy Beggs
Mr Mickey Brady
Mr Samuel Gardiner
Mr Kieran McCarthy
Ms Maeve McLaughlin

Witnesses:
Ms Eleanor McClorey Youngballymun

The Chairperson: I will hand straight over to Eleanor for her introduction and presentation, after which we will move to questions and comments. Thanks very much for travelling up and doing this for us.

Ms Eleanor McClorey (Youngballymun): Thank you very much, Madam Chairperson, and thanks a million for the invitation. Youngballymun expresses its appreciation to the Committee. On a personal note, as a Northern Irish person, I am absolutely delighted to be back, and it is really nice to share with the Committee the experience that we have developed in Youngballymun over the past few years.

I am the chief executive of Youngballymun, and my work background is in children's services. When I finished my studies in the field of education, I worked for a couple of years with young people in Belfast who had been expelled from school. I returned to live in Dublin and spent a number of years working with young homeless people, which involved street work and hostel-based work. I spent a decade working with Barnardos in the Republic of Ireland, developing community-based children's services in west Tallaght, which was a very marginalised and isolated part of the city at the time. More recently, for the past five years, I have been part of the team working on the prevention and early intervention strategy.

With all the decades of work and knowledge that I have built up and the commitment that I have to change and equality, particularly social equality for children and families, the past five years have been groundbreaking. The work has completely transformed my understanding of how to deliver much more effective service strategies for children — strategies that will lead to much more equal health and educational outcomes for children and families, even in societies like ours, North and South, where there are huge gaps in income and deeply embedded structural inequality.

I look forward to sharing some of that experience with you and hearing your questions and thoughts on it. If I am not going quickly enough, just tell me to keep it moving, because the main thing is that you get a chance to ask some questions.

The community strategy population of approximately 20,000 is a very young one, and it is an area that has a huge experience of urban disadvantage and consolidated structural poverty, which is about social welfare dependency, early school leaving and other similar factors that can really take hold of a community and be replicated because of the way things are.

The Chairperson: Sorry, Eleanor, this session is being broadcast live, so we cannot turn the lights off for your PowerPoint presentation because of the cameras.

Ms McClorey: The strategy is about prevention and early intervention. Prior to Youngballymun, my understanding of services was based on responding to difficulty and crisis: a problem is identified, then you figure out a response. The problem can be relatively minor or incredibly complex. It can be, for example, non-attendance at school, early school leaving, high-risk dabbling in alcohol or illegal drugs, or homelessness. So you have a crisis or a difficulty, you respond to that and you figure out what to do about it.

Prevention and early intervention takes a dramatically different approach to what were traditionally considered social difficulties or social issues. You look at resources, you look at community need, you look at community strengths and you look at community resources. You look at the potential and the incredible resources with which we come into life as infants and toddlers, and you look at the extraordinary potential in parents to drive change for their children, and you start to tap into all of that in a very planned and strategic way. Instead of waiting for developmental delays and difficulties to emerge, you begin proactively to support child development across the life cycle. You engage with parents and other service providers, such as public health nurses, speech and language therapists, primary care teams, home and family support services, teachers, education support services, etc, to deliver a co-ordinated change strategy in a designated area of disadvantage. So prevention and early intervention across the life cycle is a very structured, carefully thought out, well-developed strategy. It is not a series of ad hoc services funded by one arm of government and a few non-governmental organisations doing whatever they do in the same area without co-ordination and without a strategic plan.

Youngballymun is not a stand-alone entity. We do not deliver any services directly ourselves. I hope that some of you will visit us in Ballymun some day and meet the local teachers and those working in health services and the early years centres, etc. That is where all the work to change things for children is happening. Those agencies, practitioners, parents and families are driving the change process. Alongside them is multidisciplinary, cross-sectoral, cross-community, integrated and strategic delivery.

We are at a stage now where there has been quite a high level of interest in this work, even though we are a small area-based, local strategy. Obviously, it is a wonderful opportunity to meet you here today and to address you, but there is also interest from other communities around the Republic of Ireland, and, indeed, some interest from Northern Ireland.

What is different about Youngballymun as a prevention and early intervention strategy across the life cycle is that it starts with pregnancy, infancy and toddlerhood. We have an infant mental-health strategy for nought- to three-year olds and their parents. Infancy is the time of the most incredible potential for any of us who are interested in health, social services, education or public safety. Very often, many of the antisocial behaviours that threaten our public spaces — indeed, maybe even threaten us as we go about our day-to-day affairs in public spaces — have their roots in early infancy and toddlerhood. It is about building parents' capacity really to attach with their children, to sensitively attune to their infants' emerging development and needs and to parent responsively. Of course, we all strive to be responsible parents, but, in Ballymun, we change the emphasis to being responsive parents, especially during infancy and toddlerhood.

Being responsive encourages infant brain development, social and emotional development and inner security, all of which create a secure platform for all later development, including up to the various ages and stages that we around this table have reached. It is also the age and stage at which there is the least public service attention to the needs of children. The incredibly simplistic perspective that we tend to have about nought-to threes is that they feed, sleep, cry or crawl. What is there to it? Just make sure that parents mind their children and take them for their inoculations, etc. In Youngballymun, the exploration of prevention, early intervention, evidence-informed strategies and the importance of infancy has absolutely transformed the agency and community's understanding of the role of our nought-to-threes in the development of our community. We want children in Ballymun to thrive in school, to achieve, to complete their education, to move into a job or further education of their

choice, to enjoy their lives as adults and to be productive citizens. The foundations of that are not laid at the age of 12, nine, seven or five; they are laid in infancy and toddlerhood. That is where we, as public service providers, really need to focus our attention.

I will say less about the other three elements, simply because there tends to be more public sector acceptance of the importance of quality early years practice. Decades before I did, others made the case for quality early years provision. The case has been very well made, and, thankfully, we are now in an era, North and South, in which we are starting really to invest in early education, the three- to five-year-olds.

Let us think about the strategy for pro-social behaviour and language and literacy for primary-school-age children. Currently, for any child, particularly those in socio-economically disadvantaged communities, many of the difficulties and challenges that they and their parents face start to emerge in the very early schooldays. The primary 1 schoolteacher or junior infants teacher starts to notice that x or y little child is not settling into the learning environment in the way in which they need to in order to thrive. Their behaviour is more difficult to manage than it needs to be. Perhaps their parents are reticent about getting involved or opening up to teachers or other professionals in their child's life.

In Ballymun, across the 11 primary schools that we work with, we recognise that the pro-social behaviour strategies for children, teachers and parents must be integrated. There are other programmes, but the one that we found really works at a whole community level is Incredible Years, which is an evidence-based manualised programme. Training is provided for teachers, and a curriculum is taught to the children. Dina is in the classroom and there are puppets, so it is a very colourful, child-centred and play-oriented programme. It is a very engaging curriculum for young primary-school children. There is also an Incredible Years parenting programme, and I will say a little bit at the end of my presentation about the measurable outcomes from the evaluation of these programmes.

The children enjoy the curriculum enormously and gain measurably in their pro-social behaviour by following it. Teachers recount that the whole-school approach of pro-social behaviour means that everybody's behaviour, attitudes, language and how they talk to each other and to the children change through the culture of this programme. The teachers report that they are satisfied with it. Of course, the parenting programme has very positive impacts for parents by reducing their stress and depression levels and increasing their confidence.

The combination of those three elements means that you have a health-focused parental/child strategy for years nought to three across the whole community. In a way, it is an enriched baby development clinic. Elements of the clinic focus on the infant's social and emotional development and the parents' well-being. Particular attention is paid to nurturing the parent/infant bond. When those children move into their early years settings, they have a much stronger foundation for social interaction with their peers and for learning. That is reinforced in an early years setting with an evidence-based curriculum, such as HighScope, which is the curriculum that we promote and that meets national quality assurance framework standards. In the Republic of Ireland, those standards are called Siolta — obviously, Northern Ireland has quality standards for early years settings as well. The result is quality early years provision and children aged five and six moving into the primary-school system who are ready and able to learn and who are able to engage, and you have parents who understand their child's development trajectory.

Moving through primary school, the curriculum gets layered down. We recommend a very focused teaching of literacy. My only other visit to Stormont was with Tim Shanahan. The Committee hosted a visit by Barnardo's Northern Ireland and Dr Tim Shanahan, the subject of which was the teaching of literacy, particularly to children in socio-economically disadvantaged communities. He recommends the structured curriculum for the teaching of literacy. We follow the balanced literacy framework. The teachers in Ballymun teach across that curriculum and have whole-school literacy plans built around that framework. It does not require special training for teachers; it requires a focus on each element of the curriculum. It also requires teachers to ensure that they teach across that curriculum, particularly oral language and fluency, which can be an area of children's language development that is impaired, particularly among those in or at risk of poverty.

Finally, we come to the age and stage of the strategy that attracts most attention — teenagers. We are always incredibly anxious about our teenagers. It is a very challenging phase of development. However, we have all gone through it and come out the other side. We then look at our children, our nieces and nephews or our neighbours' kids going through their teenage years, with all the strains and challenges that large-scale change brings. However, if children move into adolescence with a firm

foundation laid down in infancy, toddlerhood and childhood, their journey through it will be easier for them and for those who love them, and it will be much more productive and constructive. Of course, we know now, North and South, that children who had challenging childhoods are much more likely to have difficult and, indeed, traumatic adolescence, with all the severe mental-health issues, etc, that can come to the fore in that age group.

Therefore, prevention and early intervention is all about layering down the elements required for a healthy, productive, human life: human personal and social relationships; economic productivity; and being a constructive citizen. It is about all of the attributes, pro-social behaviours and intellectual development that are required for that. So taking a very planned and carefully thought through strategic, mapped-out approach to that is the model of work to which Youngballymun is committed.

I will just recap: the essential elements are infant mental health, quality early years education with proactive parental engagement and a strongly embedded pro-social behaviour, language and literacy strategy at home, at school and in community service settings. I am very happy to discuss with you how all that gets done. Certainly, it requires thinking through but it is not overly complicated or difficult. It is also important to integrate adolescent mental-health practices into youth service strategies and into the transition to secondary school.

We also work collaboratively with other organisations — I know that my colleague Conor Owens was here this morning — with the wider prevention and early intervention partners and with government and research institutes to promote and sustain prevention and early intervention. Currently, ours is a 10-year change strategy, but we want that to become embedded in national and international policy and practice after that time.

I can also say a little bit about our early findings, if you would like me to, or perhaps you would prefer to ask some questions about what you have heard first.

The Chairperson: That was very useful, particularly on the back of this morning's presentation. It might be better to move on to questions, as I am sure that members will ask you about measurable outcomes, and so on.

You said that you have a 10-year strategy. Who funds the project?

Ms McClorey: We are jointly funded by the Government in the Republic of Ireland, through the Department of Children and Youth Affairs, and Atlantic Philanthropies.

The Chairperson: Have they funded you for the full 10 years?

Ms McClorey: It is a 10-year change strategy with dedicated funding for the first five years. We are in transition just now and are, we hope, moving into the final four years of our work.

The Chairperson: There is a lot of good work going on in our constituencies, albeit that sometimes it is designed for small communities. However, one of the criticisms here is that groups are funded for only a year and spend half of that year trying to find other funding. Either that or a project is funded for only two years and then not re-funded, even though all the evidence shows that it worked.

I know Ballymun very well. You said that you are jointly funded, and you talked about a holistic approach. When it comes to work that happens in education, if health is taking the lead in that holistic approach, how do you get over the barrier of another Department or statutory agency being involved?

Ms McClorey: You have to take a whole-community approach to change for children and families and try imaginatively to put the child in the centre of the picture. Regardless of our political responsibilities to government or in delivering services, our focus is on how we deliver sustainable change for the child and their family at a community level.

We set up a series of cross-sectoral service design teams. We did not have health, education or youth and community sitting on its own. Those cross-sectoral teams looked at the needs, from the needs analysis, as they related to each age and stage of development, from nought-to-threes, three-to-fives, moving into primary school, and so on. We took a holistic approach to looking at the needs of the child and the family across each developmental stage. A cross-sectoral planning group sat down with a facilitator to look at the needs and at the national and international evidence of what works. It was about finding strategies and programmes that would deliver measurable results in a relatively

short period. Although we had a 10-year change strategy, we had funding for the first five years. There is not much point in saying to government and Atlantic Philanthropies at the end of the five years that we are still figuring it out because it is very complicated. It is very complicated, but you have to get your strategy moving and keep it moving, so multi-sectoral planning is critical.

The Chairperson: During your presentation, I wrote down some of our Departments that are responsible for some of the areas that you talked about. There is a project in my constituency called Integrated Services for Children and Young People. That became a battleground over who was going to fund it. All evidence has shown that it works, and all evidence has shown that it is similar to your project, which works. Ministers who visited the project promoted its being rolled out in other constituencies. The battle was over who would take the lead on it, and that is just one of the issues that the people in the community and voluntary sector have to deal with. There is our Department, the Department of Education (DE), the Department for Social Development (DSD) and the Office of the First Minister and deputy First Minister (OFMDFM); and there is European money, charity money, council money and Department of Justice money.

Ms McClorey: Those are political systems that you have collectively set up.

The Chairperson: Departments still work in silos. Rather than seeking an outcome that benefits us all, they say that they will do only what they are supposed to do and will not go beyond that.

Ms McClorey: This Committee is well positioned to influence that. To move beyond that impasse in the Republic of Ireland, the Department of Children and Youth Affairs was established. Although that does not take away from the responsibilities of the Health Department or Education Department, it sends a very strong signal. The Minister is Frances Fitzgerald, and it is a very young Department, having been up and running for just over a year. That sends a very strong signal that, right now in the Republic of Ireland, there is a focus on an integrated response to the needs of children and that the entire Government are accountable for delivering the kind of co-operation that children deserve, require and, as I am sure that we all agree, are entitled to from adults like us. You are right: it is about getting our houses in order.

The Chairperson: There are new developments in Ballymun, with the high-rises coming down, and so on. I was down in Ballymun about two or three months ago, and the changes can be seen almost from day to day. Have the new development and regeneration had a positive impact on what you are trying to do? Is it helpful that you are there trying to take a holistic approach to the child and sending the message to other agencies that they have to come in and build communities rather than just building houses?

Ms McClorey: I have heard many people make comments similar to your final one on building communities. It is not that people did not want the old physical environment to be transformed — in fact, the community fought long and hard to get that regeneration process up and running — but it is not enough just to change the housing layout or the type of housing that people live in. You have to tackle the psycho-social development of the child, family and community. Obviously, another strand in all of that is economic renewal. Although that is not the remit of Youngballymun, employment, et cetera, is a very important aspect. Many people have said to me that the social regeneration is as important as the physical regeneration.

The Chairperson: You talked about the schools in and around the Ballymun area. I think that you said that there were 15.

Ms McClorey: There are 11.

The Chairperson: Is that 11 schools in total?

Ms McClorey: Those are all the primary schools in the area.

Mr McCarthy: Thanks very much for your presentation. You mentioned a youth mental-health strategy. Will you give us a bit more information about that, particularly any evidence-based results that you may have? Is there anything there that could be recommended to us?

Ms McClorey: At this point, I do not have any evidence-based results from that strategy to report. However, the strategy is about reconfiguring mental-health services to make them more accessible

and more youth friendly. Working across the community, particularly with a local partner — in our case it is our regional youth service, Ballymun Regional Youth Resource — it relocates some mental-health provision to a youth centre located in a community context. That provision might include what were traditionally been seen as specialist addiction and other services, such as mental health, bereavement and counselling services. Now, in Ballymun, there are rooms in the youth centre in which young people can avail of particular psychological and mental health services without having to go to the city centre or into a designated health facility, which they might feel is not as relaxed or youth-friendly an environment as it could be. That is one aspect of it.

The second key aspect is upskilling and building awareness and competence in the adults who work with young people in the community, so that their understanding of mental health issues is much more developed and they have a much better knowledge and skills base in mental health issues from which to relate to young people.

One youth worker described to me how our physical health goes up and down. If children twist their ankles, fall over, or whatever, you can have a conversation with them about how their health is, physically. Increased competence in mental health means that you can be more relaxed, more available, and more confident in your conversations with young people about their feelings and emotions, particularly if those feelings and emotions are going up and down or if they are scared or worried about how they are feeling.

The other aspect of upskilling is that the youth sector has a much greater understanding about how the mental health sector operates, who is who is in it, and about how to engage with mental health practitioners and create a more seamless culture for young people.

Finally, we are working on a young parents strategy. It is for very young parents, so that they will be linked into our infant mental health strategy. As well as getting assistance as young people, they will get very specific assistance as young parents. That is a flavour of the youth mental health strategy.

Mr McCarthy: Do you find that it is advantageous to have it combined in the Ballymun area, rather than going outside?

Ms McClorey: Absolutely. We have a wonderful health centre, but it is quite a daunting building. It is a three-storey building, with large premises, and there can be problems with finding your way around it, for instance. The local youth centre is much more young person-friendly.

Mr McCarthy: What about results in relation to working partnerships with other organisations? Has that proved to be useful and beneficial to the young people in Ballymun?

Ms McClorey: Yes. We start with infancy, which is where we always bring the attention. Although the need does not express itself dramatically when children are very young, that is when the gaps, the problems and the issues are being set up. We bring together our practitioners in home and family support services, public health nursing, speech and language and primary care and psychology, and think through how to maximise impact with infants, toddlers and their parents.

We have looked internationally, and we have our enriched child development clinic. It is called the parent/child psychological support programme, and it is run by our public health nurse team. A lot of collaboration and cross-sectoral training is required.

We find that when you identify the needs of the child, and if you do an audit, even a small amount of research, into attachment levels, oral language in early childhood, delays or difficulties, or if you start to look at any kind of study on parental stress or depression, you start to get a factual picture of how children and parents are in a particular community.
Obviously, Youngballymun is particularly preoccupied with children in, or at risk of, poverty or area-based disadvantage. An awful lot of what we are talking about would be incredible as a whole-community, public health or education strategy. However, collaboration requires people to work together, and funders should incentivise and reward collaboration, so that money follows effective working, as opposed to money just following anything. It can currently be a case of: "Whatever you are willing to do. It does not really matter. We would like you to collaborate, but sure if you will not, what can we do?"

One thing that Youngballymun has really shown me is the need to take a much more proactive approach to what is needed for children and putting their entitlements at the top of the page. The rest of us should line up around that, because that is our job. We are here to collaborate around that.

Mr McCarthy: OK. Thank you very much.

Mr Beggs: Thank you for your presentation. You indicated that you are about five years into the project, or are coming up to that stage, and that you are bidding for your next five years.

What firm outcomes can you definitively demonstrate? What are the successes and failures of the project that we can learn from and use on a wider basis?

Ms McClorey: I will refer to some of the findings and data, just to get the facts accurate for you. That is important.

We have several studies at the moment. We have a first evaluation study completed on our Write Minded literacy strategy. We have the first study completed on the Incredible Years programme. So, just to put it in context, we are looking at whole-community strategies. We are not targeting specific people or anything like that. We are trying to get a whole community uptake of this strategy.

So, in the primary schools, in junior and senior infants, teachers now administer a strengths-and-difficulties questionnaire (SDQ), which is a clinically reliable research tool, to look at things such as hyperactivity, peer problems and pro-social behaviour. The early findings are very encouraging. We are seeing statistically significant reductions in children's mean scores on hyperactivity and peer-problem subscales of the SDQ. We are also seeing statistically significant increases in mean scores on the pro-social behaviour subscale and significant reductions in the total difficulty subscale. So, the picture emerging from the Incredible Years programme is that children's pro-social behaviour skills and competence is growing. They are being enhanced measurably and significantly by this two-year curriculum in the classroom, and behaviour overall, the pro-social skills, are being supported.

The outcomes of parents who complete the parenting programme are monitored through the Beck Depression Inventory and the Parent Stress Index. These demonstrate statistically significant reductions in maternal depression and parental stress in the period under review for the Incredible Years study.

We have set up data collection systems that will allow us to continue to gather data and monitor it and we will be producing update reports. At least every year, we will be able to produce another analysis of the previous year's cohort of children, or the parents who have come through the parenting programme. We will be able to provide an update on whether we are maintaining the effectiveness that we have secured at the beginning and say whether it is improving or decreasing. Monitoring efficacy is really important in delivering change for children. You really need to know what kind of changes you are achieving.

In relation to literacy, there are early indications that pupil-reading outcomes across the 11 primary schools are really improving. This is evidenced by the fact that the 2010-11 cohort of first class pupils — roughly equivalent to primary 3 here — has significantly higher literacy scores than previous measures, taken of pupils in the same class, in the school years 2008-09 and in 2005-06. The 2010-11 cohort achieved significantly higher scores than the 2008-09 cohort. The kids who came along a few years later got the full benefit of the balanced literacy framework, the different literacy curriculum and the pro-social behaviour curriculum in the classroom. This has created the conditions that have allowed their literacy levels to improve measurably. We continue to collect literacy data. We will track the children and others year on year, and we will provide updates on them. The early indications are very significant.

Mr Beggs: I should have put this on record: I declare an interest as a member of Horizon Sure Start, which works in a similar area. You said that the population of Ballymun is about 20,000. What is the cost of the programme?

Ms McClorey: We were given a budget of €15 million for the first five years. In fact, that budget has —

The Chairperson: How much?

Ms McClorey: It was a budget of €15 million over five years.

Mr Wells: That is £12 million. It is a huge amount.

Ms McClorey: It is, but I will just —

The Chairperson: But there is a population of 20,000 people.

Ms McClorey: Yes. I will give you a comparison, Jim.

The Chairperson: I thought that you said €50 million.

Ms McClorey: We did a non-scientific but fairly reasonable analysis of present government spend in the Ballymun community in the schools, the health services, the primary care team, the public health nurse team and the youth and community sector. We did not go into justice at all or anything to do with any kind of criminality or antisocial behaviour; it was just the regular year-on-year health, education and youth and community sector investment. Conservatively, it runs at a minimum of about €37 million a year. Take any community in Belfast or other large city and do a grid over a population of 20,000. Add up what you spend on babies' early health, on the health service and the staff there, on the building and the upkeep, on the early years centres, on primary schools and secondary schools, and on the youth and community sector. With the investment in Northern Ireland, you probably spend far more. At the minute, we conservatively estimate that government spends €37 million every year, and the outcomes for those children are not good on average statistically. That is not to say that there are not incredible children and families in Ballymun who move through life wonderfully, but we are looking at averages and those kinds of things.

The strategy is about transforming the way in which the mainstream service does its work. It is not a stand-alone strategy; it is not a special project where we do something here while you fund everybody else there. It is about driving change for children in disadvantaged communities. We must change the way in which primary care, health services, speech and language therapy, parenting supports, literacy, teaching, the quality in the curriculum and early years centres are delivered. The investment of €15 million over what has effectively been six and a half years is actually a minute proportion of that. This is about upskilling, training and building the capacity of practitioners so that, when our change strategy is over, they will drive that change without an agent such as Youngballymun. That is the cycle of change we are on. Youngballymun is a temporary change agent.

We and government are very fortunate. The partnership with the Atlantic Philanthropies means that government is being asked to invest only 50% of the total, and yet investment is being made in teachers, public health nurses, speech and language therapists, and the youth and community sector to transform practice, collaboration and ways of working together. So, it is a very strategic and intelligent investment in change. It is extraordinarily cost-effective.

The Chairperson: When you break it down over five years, it is, you know —

Mr Beggs: A lot of it will have been for set-up costs in bringing about the change. What do you think the long-term running costs will be? Is this a one-off investment over a five- or 10-year period? Ultimately, will the normal service kick in after that?

Ms McClorey: That is the model. It is designed to be mainstreamed through regular service providers. I said that you would not come to Ballymun and see us working in a little centre somewhere. This is a whole-community change strategy. Of course, to drive that kind of change across the public sector and the youth and community sector and, as Mr McCarthy said earlier, to get that level of collaboration, you have to be able to invest in training and development and drive that change strategy forward. It is about looking at what you are spending now, what you are getting for it and how you can get different kinds of outcomes from the investment you are making.

Mr Gardiner: Thank you very much for your presentation. It was very interesting. Would you like to elaborate a bit more on parental well-being?

Ms McClorey: When we think about our own physical and mental health, we know that we all have ups and downs and that some days are better than others. Well-being is quite fluid. However, if you think about poverty and the risk of poverty, the particular environmental risks to health and mental

health that go with poverty — particularly where it is concentrated in areas in which there are high levels of unemployment and social welfare dependency and, perhaps, a poor environmental context, with lots of pressures from traffic and noise and antisocial behaviour and other things, — mean that there can be extraordinary collective stresses on parental mental health. If you have young children who have particular needs that you are not able to meet very well and do not know why, parenting becomes a very onerous and depressing task and one that engenders quite a lot of anger and resentment. When you get into that field, parenting becomes very difficult.

As a society, one of the things that we do very poorly is to recognise that parenting is highly skilled and highly energy-intensive. It requires 17, 18, 19 or 20 years of focused commitment, and it is required however the parent feels, whether their job is going well or not, whether they have a job or not, and regardless of health, ill-health or family bereavements. Whatever is going on, the parenting process continues. As a society, we draw a veil over that. We make sure that people do all types of tests to drive a car and have tests for health and safety and road safety, but, when it comes to parenting our children, we still try to tell ourselves that it is something biological and that, when you have a child, a switch goes on inside you and you know how to be a parent. All of us who are parents know that this is not the case. It is trial and error, you struggle, and children have different temperaments and needs.

Youngballymun has taken a very constructive approach to partnership with parents. We tell them that parenting is a really tough job that we are all trying to do so well, and that there are resources and things that they can know that will make parenting much more enjoyable, relaxing and supportive. We ask them to get involved with us in that kind of parenting.

As some of you have mentioned, Ballymun is an area in which people have had a lot of challenges and where health services have not been as supportive as they might have been. However, seven out of 10 newborns are brought by their parents to our very intensive baby development clinic, where a lot of the focus is on parental/child engagement and interaction from birth. We then take that on in the early years centres, where there is much more parental engagement and where a parenting programme kicks in when the children start primary school. It is really about enforcing the message that parenting is a skill that you learn. The skills change as children move through the life cycle and we all need to develop those skills and competences.

One of the biggest breakthroughs that we, as a society, could make would be to take parenting seriously. It is not about patronising people and saying that if parents have difficulties they need to do a parenting programme. Not at all. It is about parenting, so that you know what you are doing and enjoy what you are doing. It is also about meeting other parents, interacting, and seeing your children thrive. That has been one of the most dynamic aspects of the work of Youngballymun.

Mr Gardiner: I see a gap there with parenting, and I think you would agree with me. Parents have got to be encouraged and helped more. You are doing an excellent job; I am not knocking you for that. However, I think that more concentration should be put on parenting.

Ms McClorey: The first home visit is made by a public health nurse when babies are six weeks' old. At three months, babies come to the clinic, and the parent/child activity, the process and the support start at that stage.

Another aspect of our work is that the local drugs task force has just decided to resource a parent support worker. This means that if any parents are particularly challenged with alcohol and drugs issues, they will have a dedicated person to help them to link in with the Ready Steady Grow service. We make sure that the service reaches every parent.

Mr Gardiner: That is good. I am glad to hear that, but I think that there is more work to be done.

Ms McClorey: I agree with you.

Mr Brady: Thanks very much. It was a very interesting presentation. Ballymun is an interesting place. I first went there in the 1960s when it was just built and it was portrayed as a very innovative housing development. However, within a couple of years, it, literally, went down the pan.

The Committee for Social Development went to Fatima Mansions and Ballymun about four years ago and —

Ms McClorey: I know Fatima Mansions very well.

Mr Brady: We went to see how social housing had been transformed in those areas through mixed tenure housing, etc.

It is good to see an organisation such as yours working in Ballymun. A civil servant from Dublin City Council showed the Committee around during our visit, and I had an altercation with him. He talked about the lower classes and almost implied that the houses built in Ballymun were too good for the people who lived there. It is a good to see an organisation such as yours doing such good work. It is an area of high deprivation and one that has very high social welfare dependency. Obviously, the austerity cuts and the single working age payment, which is much the same as what we will have here with welfare reform, will make your job much more difficult. They are the people who are going to suffer. Do you have any opportunity to consult with the Department on social welfare issues? You are dealing with a Department that deals with children and young people particularly.

The other thing that I found interesting — and Kieran and others mentioned it — was your work on infant mental health. We hear a lot about adolescent mental health, but you never really hear about infant mental health. It seems to be a very important issue. It is the early developmental stages that can have such an impact on a child's life and on that of their parents. To use that old phrase, the two are inextricably linked. What you are doing about that is interesting.

Some of what I have said is an observation, but I am interested in infant mental health in particular, and in the whole concept of changes in social welfare and how they might impact your work. Do you have any opportunity to consult with the Department of Social Protection through the Department of Children and Youth Affairs? Is there a link? Sue mentioned that a lot of Departments work in isolation and in silos. You talked about multidisciplinary teams and, from what you have said, that all gels and works very well when they come together.

Ms McClorey: It is not so much that we would work collaboratively with the Department of Social Protection, but we certainly have an opportunity to make our views known to them, and we do. In the context of the programme for government and the Republic of Ireland's commitment to area-based strategies to tackle child poverty, we make it clear that children in and at risk of poverty and their parents, by definition, must be protected from any further negative impact of whatever budgetary decisions the Government feel that they have to make regarding the fiscal situation that we are in. It is one thing to say that, but it is another thing to be able to achieve it or influence change in that way. However, there is no doubt that increasing anxiety about making ends meet is a huge burden on parents who are trying to proactively parent their children and protect them from stress and anxiety. It is also about them being available to their children and to be playful, relaxed and interactive. This is very hard to do when you are consumed with anxiety about money and rent.

Mr Brady: We have been talking about displaced costs with respect to the so-called welfare reform. We take money off people, make their lives harder and increase their stress and anxiety levels, and that cost then has to be borne by the health service. It is probably similar to what is happening in the South.

Ms McClorey: In that particular provision in the programme for government, the area-based strategy is to tackle child poverty. Obviously, we have to find something in the Government's commitments that we can speak to in order to influence their thinking, but it is important that social services agencies such as ours make things very clear. We are a member of the Children's Rights Alliance and have a very close alignment with Barnardo's in the Republic of Ireland, which has a very highly developed policy unit. There is a lot of analysis of the impact on children. We use that work and quote and reference it or support other like-networks of which we are a part. However, it is a part of what we must do to ensure that positive outcomes for children are achieved.

Mr Wells: I was not surprised about the vast amount of money involved on the basis of it not being good value. It never ceases to amaze me. We are told about the dreadful economic situation that the Irish Republic is in. However, time and again, we see projects getting levels of funding that we dream of, to be honest. Twenty thousand people would be the equivalent of Downpatrick, and I cannot imagine, in any set of circumstances, where we could obtain funding for that type of project.

Ms McClorey: The socio-economic profile would not be the same as Downpatrick, Jim. That is the first thing. The second thing is that the initial commitment was made in 2007 under the previous Government before the crash and before the election. The present different Government have

continued that commitment and that partnership. A referendum on children's rights is coming up on Saturday. The Republic of Ireland is striving to look honestly at its past in relation to how it has treated children, particularly the most vulnerable children. I see this as a time when the Government strive to make amends and start to put things right that have not, historically, been addressed. In the latter stages of the previous Government, they created the partnership with Atlantic Philanthropies around prevention and early intervention, and the present Government continue in that commitment. I strongly welcome the effort that is being made by the Minister for Children and the Department of Children and Youth Affairs. It is not just about the amount of money; it is about the focus of the investment. This is not about funding services; this is about pioneering prevention and early intervention, driving changed outcomes, and making sure that if you are going to spend money on a primary school education for a child that that child leaves school able to read well, has a reading age of about 10, 11, 12 or 13 and can function in a secondary school environment. There is no point in the Northern Ireland Assembly or the Dáil spending money on services that are not delivering outcomes for children and young people. So, part of this whole change agenda is about looking at the evidence of what works. Let us try to get into the classroom and health services the practices that deliver real outcomes. That means that policymakers and funders, like yourselves at government level, who fund mainstream services, will be getting outcomes for your whole community and particularly for children in areas of greatest disadvantage.

What happens right now is that, too often, no investment is made early on and there is no investment in prevention. Then we look at 14-, 15-, 16- and 17-year-olds and spend extraordinary sums of money on activities that will not necessarily improve their quality of life.

Mr Wells: I think the case is unanswerable. Investment at this level definitely produces huge payback both economically and in the lives of children and parents. It is an unanswerable point. My difficulty, as I said to the previous witnesses, is that we spend most of our time, in our present situation here, firefighting — trying to keep hospital wards open and social workers in position. The payback time cited by your colleagues from Longford/Westmeath was a very surprising just over two years. Have you done any economic appraisal of the payback time in your project? I hate to bring it down to pounds, shillings and pence — I am showing my age, there. I hate to do it that way. Do you remember pounds, shillings and pence?

The Chairperson: Probably.

Mr Wells: No one else in the room can remember it but me and Mickey.

Mr Brady: All right, Jim. You probably still have farthings. *[Laughter.]*

Mr Wells: Given the fact that it produces significant savings, have you looked to see when you would get repayment, as it were, or a payback on the investment in Ballymun?

Ms McClorey: Yes, we have of course. Value for money and efficiency is really important to us. The problem is that we do not have a lot to compare it with. In business as usual, North or South, in all the mainstream services that you are funding, no one has done an economic appraisal, and we do not know what the value-for-money return is on them. It could be far better than anything that we are doing for all we know, but there is no appraisal done. It is unlikely.

Of course, even though we are a very young strategy, we have conducted a conservative value-for-money study, based only on a small body of outcomes. Obviously, we hope that, the longer the time lag and the more children who come through the strategy in those classrooms, the greater the return on investment will be. You have to remember that we are investing in changing a system, not continuing to spend.

At the minute, Just Economics in London, the UK-based company that conducted the value-for-money study, envisages that there will be a return for government of €4 for every €1 invested and that the strategy will have paid for itself in its first five years. Therefore, thereafter, there will be a return to the Exchequer. You make the investment, if you look at it that way, and already we are, technically speaking, paying for ourselves. The ratio is 4:1. For every €1 they spend on us, they will get a €4 return. However, that return is obviously based on the life cycle. Children do not start to cost the state more until they start moving into ill health, antisocial behaviour or, particularly, care. Any kind of institutional, social-service type care or incarceration will cost. There are particular things that drive up costs for the state.

Therefore, the big indicators are: secure attachment, pro-social behaviour and literacy. Those will be the great predictors of not costing the state a lot and making a return as a productive citizen. So, obviously, if you can get a job and pay tax, you are funding the rest of us. That is how it goes. But, yes, there is a return of a ratio of 4:1.

Mr Wells: Since you started this project, there has, as you pointed out, been a huge recession. We are in the middle of a recession, and we are about to have a huge change in our social welfare policy in terms of benefits and entitlements. That will probably have a more profound effect on vulnerable areas than even the recession. If you did not have a job to start with, whether there is a recession or not is somewhat academic. However, if you find that your basic income is being cut or removed, you really do have a problem.

Have you found it more difficult to achieve your outcomes, given that you have lived through a time of great boom and now one of great bust, as it were? If you started in 2007, the real slump had not begun.

Ms McClorey: No, it had not.

Mr Wells: Now, you are out in the pit of it. Has that made it more difficult?

Ms McClorey: Obviously, we all can have hindsight. We all should have been able to see it, but we did not. However, had I envisaged the catastrophic social consequences of what was coming down the road when starting Youngballymun in 2007, I would have thought that it would probably be impossible to even get it off the ground. Other people mentioned the level of collaboration and cutbacks and reductions. We talked, over lunch, about the reduction in public sector pay, embargoes on —

Mr Wells: That is in the Republic, by the way, not in the North, just in case anybody gets any strange ideas.

Ms McClorey: It is the plan Jim had. *[Laughter.]* Of course, I am joking.

The Chairperson: Do you want to repeat that for the record?

Mr Brady: Watch this space.

Ms McClorey: We were talking about the reductions in staff numbers in the health services and education supports to teachers; support services that had been available were taken away, etc. There is also the pressure on parents. What Youngballymun — it is a cast of thousands with all those partners — is demonstrating is that our focus now is on delivering for the children of Ballymun, and the adult community is largely united in that purpose.

Yes, things are tough for parents. They are tough for public sector workers in another way. However, the satisfaction that we are experiencing is in parents telling me about just the difference in their relationship with their child, the happiness and different atmosphere in the family home. This strategy is making a contribution to their well-being that they can experience. They are very committed to continuing to participate and to make that continue.

Similarly, for teachers and public health service nurses. It is very hard on them. They are giving 120% and more to deliver these kinds of outcomes and measurable improvements. They are giving everything to this at a very difficult time when they are, perhaps, not being recognised or rewarded. I would not have thought it was possible, to be honest, but it is possible because people are doing it; because the benefits are tangible and real. You can experience and see them whether you are a parent, nurse or teacher. There is a different kind of satisfaction in being part of a very big change project. If you are a primary-school teacher, you are playing such a central role in that. You are delivering that literacy change, so there is something very important about that.

Mr Wells: We have heard from Westmeath, Longford and yourselves. There are other areas — Limerick is an example — where there is huge deprivation. Are projects such as this studded all over the Republic, or are we dealing with just the two?

Ms McClorey: There is a whole range. In the prevention and early intervention programme that we are funded under, for example, there are two other strategies, one in Tallaght West and one in Darndale. There are other prevention and early intervention initiatives such as the one that you met with this morning. In Limerick, there is a social regeneration strategy also under way, and indeed —

The Chairperson: Sorry, there are a number of projects but we just thought that —

Mr Wells: Yes, I know that we cannot hear about them all. I am just interested to know whether it is widespread.

The Chairperson: We have somebody coming from Scotland on the 28th as well, so we are trying to look at —

Ms McClorey: May I just say that the Republic's present Programme for Government includes a commitment to developing area-based strategies to tackle child poverty. We hope that the learning from prevention, early intervention, and this kind of integrated life cycle based on incremental health and parental engagement, etc, will feed directly into that plan when it is rolled out.

The Chairperson: OK, Eleanor. Like the presentation that we had earlier, yours is useful and interesting. It allows members to get into their head where other Departments fit into the health inequalities issue. On behalf of the Committee, I thank you for your briefing paper, which will be useful for our report, and for coming here today. We hope to have our report done this side of Christmas, and that ties in with what the Department is doing. It is good to meet you and thanks for coming.

Ms McClorey: If some of you ever want to come down to Ballymun for day to see any of the work or talk directly to the other sectors — whether health, education, youth and community, or whatever — we will be delighted to host a visit.

The Chairperson: That is great; thank you.

Ms McClorey: I will leave a brochure of our work with each member of the Committee.

The Chairperson: Thank you Eleanor.

Northern Ireland Assembly

Committee for Health, Social Services and Public Safety

OFFICIAL REPORT (Hansard)

Review of Health Inequalities: Scottish Centre for Social Research

28 November 2012

NORTHERN IRELAND ASSEMBLY

Committee for Health, Social Services and Public Safety

Review of Health Inequalities: Scottish Centre for Social Research

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Members present for all or part of the proceedings:
Ms Sue Ramsey (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 Conall McDevitt

Witnesses:
Mr Paul Bradshaw Scottish Centre for Social Research

The Chairperson: I welcome Paul Bradshaw, the research director of the Scottish Centre for Social Research. Thanks very much for taking the time to come over and talk to us. The paper you provided is interesting reading. I hand over to you to make your presentation, and we will then open it up to members for comments or questions.

Mr Paul Bradshaw (Scottish Centre for Social Research): I am very glad to be here today and I thank you for the invitation. I am here to talk mainly about findings from the Growing Up in Scotland study, or GUS, as we more commonly refer to it. It is a major longitudinal research project tracking the lives of several cohorts of Scottish children through their early years and beyond. The study is funded by the Scottish Government and is undertaken by ScotCen Social Research, an independent social research institute, which I work for.

A longitudinal research project is simply one that follows a discrete group of individuals over time. The individuals followed in such a study are usually linked in some way. In the case of GUS, the children in each of the three groups that participate are linked by their dates of birth in that they are all born within the same 12-month period. We have around 3,000 children who were born in the 2002-03 child cohort, 5,000 who were born in 2004-05, our first birth cohort, and 6,000 who were born in 2010-11, our second birth cohort. The size of our birth cohorts means that around one in 10 of the children who were born within the specified year in Scotland are included in the study.

I have been invited here today as part of the Committee's ongoing consideration of health inequalities. We define those as the unequal socioeconomic patterning of health outcomes and risk factors that disadvantage those in less affluent circumstances. Data from GUS can tell us not only about the differences in the patterns of children's outcomes and their experience of risk factors but, because of its longitudinal design and its focus on the early years period, the study is uniquely placed to provide

understanding of the influence of children's early circumstances and experiences on those outcomes and how different levels of exposure to key risk factors and changes to this exposure over time among children living in different circumstances affect their health outcomes. Similarly, data from the survey has also been used to identify factors that appear to protect children in disadvantaged circumstances from experiencing negative outcomes. Those are factors associated with resilience.

As members may have seen from the briefing we prepared or, indeed, from any of the existing reports produced from the study, data from GUS have already provided significant insight to that end in relation to child physical and mental health and cognitive development. For example, our findings have explored differences in a range of physical health measures over the first six years of children's lives. The findings show that children from the lowest income households and those living in more deprived areas are around twice as likely to be reported with poorer health as children in the highest income households and those living in the least deprived neighbourhoods. In addition, by age six, differences in levels of overweight and obesity are evident between children in the lower and higher income households.

In respect of mental health — social, emotional and behavioural development, and cognitive ability — significant differences between children from advantaged and disadvantaged backgrounds are already apparent by age three and tend to persist at age five. Worryingly, other research conducted over a longer period suggests that such gaps tend to grow wider as children make their way through primary school and persist through adolescence and beyond.

As well as differences in outcome measures, our research shows stark variations in risk factors, such as maternal smoking, lack of breast feeding and poorer diet. In several cases, it is the difference in exposure to those risk factors between children in different circumstances that explain the differences in their outcomes. Not all children from disadvantaged backgrounds suffer from poor health. However, our research suggests that those who do not suffer from poor health tend to have parents who are themselves healthier, who take a greater interest in their children's development, who are more open to seeking help and support, and who are more satisfied with the services and facilities in their local area. As such, it would seem that as well as improving children's material circumstances, it is important to improve those related issues at the individual, family and neighbourhood level to bring about a step change in reducing health inequalities.

Furthermore, it is clear that tackling health inequalities requires input at many levels from a wide range of actors. This is not just the responsibility of the health service or other service providers alone.

Our study is now in its eighth year. The next report will be published in February next year. That report uses data from the new birth cohort and will provide a comprehensive picture of the lives of children, born in Scotland in 2010-11, at age 10 months. Among other things, it will contain comparisons of the circumstances of those children with our earlier cohort born in 2004-05. That is a unique resource, providing a range of stakeholders with invaluable evidence about the experiences of and outcomes for children and families. Its value continues to grow, as with each round of data collection, it becomes possible to map further and more fully the varied and complex pathways taken by children as they move through the early years into later childhood and beyond.

Of course, none of that would be possible without the ongoing support and participation of the families and children involved, to whom we are extremely grateful. I hope that members have had a chance to consider my briefing paper and perhaps some of the reports from the study. I am happy to answer any questions.

The Chairperson: OK, Paul. Thanks very much. The Committee is looking at health inequalities. However, other Departments and Ministers are delivering policies and strategies that could impact on health inequalities. We happen to be the Health Committee, and we deal with the outcome of health inequalities. Take a look at some of our other Departments here: the Office of the First Minister and deputy First Minister has a duty to look at things such as child poverty, and other Departments have to look at the 0-6 strategy, which does not necessarily allow the Health Department to get in at that age.

What struck me was the key theme in your briefing paper that health inequalities often emerge in the very early stages of life and sometimes continue throughout a person's life. Through the Growing Up in Scotland study, are you looking at the child from an early age? If so, does that allow you to then look at the responsibilities of other Departments for a specific part of that child's life?

Mr Bradshaw: Yes; sure. The study itself is funded by the Scottish Government education directorate. We get contributions to the development and content of the study from a range of

Departments, covering those concerned with communities, child poverty and inequalities and health. In the early-years period, there is a lot of convergence of interests from across Departments, because we know that child poverty affects child health, and we know that early education is a key source of service delivery to young children. So, there is very much a collective effort and contribution to the content of the study, with the results of the study relevant across multiple areas.

The Chairperson: You talked about the 3,000 children in the study who were born in 2002-03, the 5,000 who were born in 2004-05, and the 6,000 who were born in 2010-11. Is that the complete number of births in Scotland?

Mr Bradshaw: Yes, so in Scotland —

The Chairperson: So, it is a universal approach to the births of new babies.

Mr Bradshaw: About 50,000 children are born in Scotland in any 12-month period. We sampled about 10% of those births in the equivalent 10-month period. For a survey of this nature, that is a larger than necessary sample to produce valid and robust statistics. We used large numbers because, within that 5,000 or 6,000, there are some key subgroups of particular interest that we wanted to isolate and look at the results for. Examples of those subgroups are teenage mothers, lone parents, families who live in the most deprived areas and families who are on lower incomes. We need large numbers at a total level to have a large enough number of people in those subgroups to separate them out and look at outcomes and pathways for children in those groups.

The Chairperson: We received a number of presentations from groups, and as you have probably found to an extent in Scotland, one of the issues is that people on benefits might be living next door to people who are working but who are the working poor. They live in the same area, their kids attend the same school and they have the same lack of amenities or social gatherings. On one side, one family is on benefits, and on the other, they are working but are working poor. I was interested that some of the presentations that we received, especially the ones from County Longford and Ballymun in Dublin, took a universal approach to the area rather than looking at lone parents or kids who are in a family that is on benefits. They took an approach to the area and targeted some of the kids there. Are you doing something similar to that?

Mr Bradshaw: Our responsibility on GUS is simply to collect the data, and it is for other people to use the findings to decide how they will target interventions or policies.

The Chairperson: Sorry to stop you there. Is the data that you collect specific either to lone parents or to parents who are on benefits?

Mr Bradshaw: No, it is a fully representative sample of all children who were born in Scotland within the 12 months across all geographical areas in Scotland, including the Highlands and the islands. In each local authority area, there is a mix of people living in deprived and non-deprived areas, so the data is representative of the general distribution of these issues across the Scottish population.

Mr Gardiner: What has been the Scottish experience of where good local schools have made a material difference in the life expectations of the health of the children? Do schools make a difference? If they do, how does that work and how do they make a difference? I notice that you said that children whose parents have degree-level education are 18 months ahead of children in the use of language compared with parents who have no qualifications. To what extent can this 18 months be made up, or is there a ceiling on the children's potential level of attainment because behavioural factors have become so ingrained since an early preschool age?

Mr Bradshaw: On your first point around the impact of schools and the question of whether schools can make a difference, we are at too early a stage in the research to look at that. Our oldest cohort, the child cohort, is around age nine, but we have not collected any data from them since they were six, at which point they had only just started primary school. Those in our birth cohort are aged around eight at the moment, and are in primary 3, their third year of primary school, but we are only collecting data from them at the moment. It will really only be after that point of data collection that we will be able to start looking at whether attending different sorts of schools or a school with particular characteristics has an impact.

What we do have some data on at the moment is the potential impact of preschool education on children's health, particularly their cognitive ability. We looked at changes in a child's cognitive ability between the ages of three and five — during the period when the vast majority of children in Scotland attend 12·5 hours of statutory preschool education per week. That research suggested that children who attended particular types of preschool — that which is provided by what we call partnership nurseries, which are privately run nurseries that offer preschool education on behalf of the local authority — appeared to make more progress in their cognitive ability during that period, compared to children who attended nursery classes attached to local authority primary schools.

That was an additional finding to some of the main research that we were looking at, but it is certainly enough of a finding to suggest that further research on the differential impact of different types of preschool on different children would be warranted. That is something that we are looking to do. Arguably, we have some evidence to suggest that preschool education can make a difference to children's outcomes by the time they enter school, but we do not have anything to talk conclusively about the impact of primary schools.

To address the gap that exists between children in more and less advantaged circumstances in their cognitive ability by age five, the figure that you quoted — the 18-month gap — exists at the point of entry to primary school. Other research suggests that it is very difficult to reduce that gap from the point of entry to primary school, but it is certainly not impossible. What we do know, however, is that the earlier you address these issues, the more cost effective that intervention is and the greater the impact. If you are aware of the gap by age three and can address it in that age three to age five gap before they enter primary school, there is a better chance that those children will do better throughout their school career. The earlier the better is what all the evidence seems to be suggesting now. That is not to say that we should give up on those kids who are behind at entry to primary school. There is plenty of excellent work being done during that period, too.

Mr Wells: There seems to be a pattern emerging in the evidence that we are receiving from a wide variety of sources within the UK and Ireland. I was on the Shankill yesterday, and someone told me that their analysis shows that in the most vulnerable communities, the average child aged four has 300 words in his vocabulary, while someone on the Malone Road, which is the posh end of the country as far as Northern Ireland is concerned, would have almost 3,000. Have you done any analysis on vocabulary to indicate the development of children at that age?

Mr Bradshaw: Yes, we have, although we used a different measure. The figure that we have just discussed — the 18-month developmental gap — is based on a vocabulary assessment at age five. We ask the children in our study to complete a cognitive, educational assessment from the British ability scales called 'Naming Vocabulary', which tests their expressive language abilities. Essentially, it is a booklet that contains a series of pictures of items, and the child is asked to name each item. The more items they can name, the higher the expressive language ability is. We have measured that at age three and age five. The gap already starts to get quite evident between children in more and less disadvantaged circumstances using that measure at age three, and it persists at age five. There is not really any change in it during that period.

Mr Wells: In paragraph 3.3, which deals with resilience, you state a number of factors that clearly help outcomes. I am surprised that there is no mention of a father figure or two parents. Following the riots that broke out in August 2011, 60% of those convicted of such activity had no identifiable father figure living in the house or, in fact, had no knowledge of who their father was, never mind identifying with them. Could it be argued that the breakdown of the two-parent family is a major determinant in the sense that that places a huge burden on the single parent, who may be quite young? It is often the woman is who left literally holding the baby. Is that a determinant of outcomes?

Mr Bradshaw: Absolutely. We did some quite interesting work, which was published, I think, two years ago, on the occurrence of significant events in children's lives and how those led to the experience of key factors that affected child outcomes. One of the significant events we looked at was parental separation. What we found was that parental separation was very closely associated with a significant reduction in income and maternal mental health, and we know that income poverty and maternal mental health are linked to child outcomes.

In an analysis, we usually include some measure of what we call "family type", whether the child lives in a couple family or a lone-parent family, and what we very often find when we include that measure alongside measures of household income and parental education is that the differences between the socioeconomic circumstances of single-parent and couple families tend to explain the differences in

child outcomes for children in those different families, rather than the fact that the child has no contact with their father per se. Certainly, the trauma and circumstances that parental separation creates in a lone-parent household tend to be associated with those factors, which then lead to poorer child outcomes.

Mr Wells: We have taken evidence from a wide range of bodies. I think that Sue already mentioned the fact that we had a very interesting contribution from representatives of Ballymun, which is a very difficult 20,000-person social housing area in Dublin, and a very interesting parallel was drawn with Longford, which is in the centre of the Republic of Ireland. Are you exchanging information with other groups? Are you doing this in complete isolation, or is there any cross-fertilisation?

Mr Bradshaw: Not at all. The study is publicly funded, and we have a responsibility to share our findings as widely as possible. We have a dedicated dissemination programme and a dissemination officer to do that. We host, for example, an annual free event every year to publicise our findings. It is attended by upwards of 150 delegates, who are predominantly in voluntary sector practice-based positions. People such as health visitors, midwives and those offering parenting and family support services take our findings and apply them to the services and support that they deliver in local areas on a day-to-day basis. They apply and use them for the benefit of those services.

We have spoken in circumstances such as this to over half the local authorities in Scotland; early years workers; the associations of directors of social work; head teachers' associations; educational psychologists; nutritionists; midwives; infant psychologists; and psychiatrists. The study findings are very widely disseminated, and we aim to make them as useful to policy and practice as possible.

Mr Wells: Finally, and this might be an unfair question, but given where you are coming from, I have to ask it. There is a view about the Scottish devolution model of the thematic ministerial positions. As you know, here in Northern Ireland, we have 12 Departments and, therefore, 12 silos, and have five parties that viciously guard their Ministers' budgets and powers. Scotland perhaps has a more mature democracy in the sense that you have cross-cutting themed ministerships to try to deliver for local people, children, etc, and we would aspire to that some day. Do you feel — and this is the ultimate leading question — that that model gives you a better opportunity to deal with early intervention than our model? If you want, you can claim the Fifth Amendment on that one.

Mr Bradshaw: I do not know enough about how the system works in Northern Ireland to make any useful comment on that. However, in recent years, the Scottish Government have worked very hard to push early intervention and to encourage discussion on it. In the past year, they have taken useful, practical steps to address those issues at the earliest stages.

Mr Wells: Who takes the lead on that in the Scottish Executive?

Mr Bradshaw: Our Minister for Children and Young People takes some lead on that. However, a semi-independent early years task force is now being created. It includes people such as the Chief Medical Officer, Harry Burns; the Children's Commissioner; and key figures in public health administration who are responsible for an early years fund, which is distributed through a series of working groups and subgroups. They are adopting a method known as the early years collaborative, which is based on the Scottish patient safety initiative from a few years ago. That approach requires the Scottish Government to bring together key actors from local authorities who are concerned with children in early years and early years services in order to talk about and identify good practice, as well as how funding might be spent. They rely on those local authority workers to take that work back and devise, with community planning partnerships, what policies they will deliver. That is in its very early stages.

Mr Wells: That is very interesting and useful.

Mr Beggs: Again, I declare an interest as a member of Horizon Sure Start, which does work in this area. In your paper, you present evidence that a gap in early years is opening up and say that that is already apparent, by age three, in the ability of children, depending on whether they are more or less advantaged. Later on, you indicate that an enriched home learning environment was repeatedly found to be an important factor in influencing children's early cognitive outcomes. Has your analysis pinpointed good and bad practice so that the Scottish example has been able to evolve and improve?

Mr Bradshaw: Yes, to some extent. The evidence that we produced regarding the impact of the home learning environment or parent-child activities on cognitive outcomes confirmed evidence that already existed in the UK, particularly from the evaluation of the effective provision of pre-school education — EPPE) — which you may have heard of. That was run in England and Wales and started in the early 1990s. It found that the home learning environment had a significant impact on early cognitive outcomes. I think that our evidence has confirmed that, using Scottish data from Scottish families, and has, therefore, influenced some policies directed at improving parent-child home learning activities, particularly among disadvantaged families. Therefore, I would like to think that our evidence has influenced and continues to influence the development of those policies.

Mr Beggs: One of the most disadvantaged groups is young children whose parents do not avail themselves of early years interventions, parenting skills and other services. Have you uncovered any specific ideas to improve their engagement?

Mr Bradshaw: Yes, to some extent. One of our reports looked particularly at the differences in the support and advice that different types of families appear to draw on or prefer. There is a wariness among disadvantaged families of very formal support and services, which, I think, we expected. Ante-natal classes are a great example of a support service delivered to pregnant mothers, but we found very early on that teenage mothers do not like the idea of classes; they do not like sitting and sharing their experiences with other mothers. That suggests that approaches delivered on a peer-group basis, with mothers of their own age or in a smaller group, or one-to-one contact would be more acceptable to mothers in those circumstances. We found that some families will take it upon themselves to seek out support and will rely on online services or telephone helplines. Some will prefer one-to-one contact with mainstream health and support services; others will need something less formal but will prefer one to one, such as a service in Scotland that provides voluntary home-visiting family support. It is not attached to a formal health service, but it provides professional support and advice where necessary.

A range of such programmes is being delivered in Scotland just now. For example, there is an ongoing pilot of the Family Nurse Partnership, which you may have heard about. It is a dedicated, intensive home-visiting support service, specifically for first-time teenage mums. It is being delivered in Lothian and Fife as a pilot at the moment. Contrast that with the Triple-P – Positive Parenting Program — being delivered in Glasgow. It is a universal, seminar-based support and advice programme for the parents of children entering primary 1 all over Glasgow. All the parents are invited to three seminars, but Triple-P will offer more dedicated and intensive support to different types of parents at different levels. Therefore —

The Chairperson: We got a presentation on the Triple-P programme from County Longford.

Mr Bradshaw: It is delivered internationally. However, other parenting advice and support services that offer a wide range of services are being delivered more widely across Scotland. That is necessary because universal services are definitely not used universally, and not all families regard them as acceptable.

The Chairperson: Kieran, are you looking to come in?

Mr McCarthy: Not really. The only thing that comes to mind is obesity. I suppose that it can apply to anywhere, but you say that it is one of the outcomes in the most deprived areas. Why would that necessarily be? You would have thought that in a deprived area, with not so much cash for good meals, etc, those people would be out rather than in front of a screen playing with their modern technology and, therefore, not be obese.

Mr Bradshaw: I do not think that we have fully worked that out yet. The report tends to suggest that obese children in such circumstances have poorer diets; they consume high-energy foods, such as snacks, chocolates and crisps, from an early age. There also seems to be some suggestion that the parents of such children exhibit poor health behaviours: lower physical activity, more sedentary behaviours and more sitting round watching television, for example, and that has an impact on the behaviour of the children and, therefore, their weight. We have not quite got to the bottom of that yet. We are still looking at it, but those are the sorts of things coming through.

Mr McCarthy: Right. OK; thanks.

The Chairperson: Manufacturers need to take those issues on board. There is less money for fresh fruit and veg, yet manufacturers can sell 100 pizzas for £1.

Mr Bradshaw: Yes.

The Chairperson: There is a multitude of factors.

Mr Bradshaw: There is also the question of access to leisure services as well as simply having the resources to pay for them, which differs for families.

Ms Brown: Thanks for your interesting presentation. I find it interesting that in one of your points about resilience, you mention a mother aged 35 or older. I am 40 years old, and my youngest child is 16. Is there evidence that young mothers cope less well mentally?

At the age of 20, 21 and 24, I was physically very strong and had three children. I would be much stronger mentally now — although physically unable to have a child — to deal with raising children. Is there any evidence around the mental health issue?

Mr Bradshaw: Off the top of my head, I cannot quite remember. A couple of years ago, we produced a report that looked specifically at maternal mental health. We will have considered maternal age, but I cannot remember what the precise finding associated with that was. However, the finding that I have included is unusual for us, because although we tend to find considerable differences between younger mothers and older mothers, normally, when we account for the differences in the socioeconomic circumstances of those mothers, age is not a factor. It has to do with the fact that younger mothers tend to have poorer education, lower incomes, be out of employment and, generally, have more chaotic lives. That is what explains the difference in outcomes rather than age per se. We are looking specifically at that because we are doing additional analysis that is very focused on the differences between younger mothers and older mothers, and mental health will be one of the issues that we will specifically look at in that analysis. Therefore, we will have concrete findings on that early next year.

Ms Brown: I was at home for eight years with my children; I was with them 24/7 when I was married. My husband was working all the time, and I might as well have been on my own apart from the fact that I had good financial support. An enriching home learning environment was mentioned, but a mother who is on her own most of the time can find that it is difficult to provide even that. Even when a mother has financial backing, it is difficult to divide yourself so many ways. Is there anything around that? Sometimes, it might be easier for an older woman who works and who earns a good salary to send her children to childcare where they will get the stimulation and education that might be easier to get outside the home. Naturally, you would think that a mother being at home with the children is, ultimately, the best scenario, but I am not sure that that is the case. There could be a happy medium.

Mr Bradshaw: Interestingly, an enriching home environment is not based on specific parent-and-child activities but is simply a measure of how many times the child has been read to over a week or has done activities involving painting and drawing. It does not account for who they have done that with. Therefore, there is a suggestion that it is the child's experience of those activities, either in the home or with a grandparent, a childcare provider or somewhere else, that makes the difference. We also know that the strength and warmth of the parent-child relationship is very important. That suggests that parents do not need to have a great deal of time to spend with their children but that they do need to make the effort to spend some time with their children. Parents who engage in such activities and building that relationship tend to have children who have better outcomes, irrespective of their socioeconomic circumstances.

The Chairperson: Throughout your presentation and in answer to the questions, you mentioned some of the key factors. Every time that Jim mentions that 60% of the people who were involved in the riots in England came from a single-parent household, I think that it is my duty to mention that 40% did not come from that background. It is important to say that there are a number of factors. It is like yin and yang; every time that he says something, I have to respond to it. A multitude of factors determines the outcome of a child's life. Can you give us more details on the key factors that can protect children and make them more resilient throughout their life?

Mr Bradshaw: When we tried to identify the factors associated with resilience, we found that very few persist after you account for material circumstances such as income, parents' education, area

deprivation and social class. All the things that affect children's material circumstances are very important. What remains after those factors have been taken into account is that parents who have better physical and mental health and well-being tend to have healthier kids.

Parents who are more comfortable seeking advice and support is a factor that seems to be associated with children in disadvantaged circumstances avoiding negative outcomes. The home learning environment and, in fact, parenting as a whole, appears to have an influence. We have evidence to suggest that, irrespective of background, children who have a better parent-child relationship and who experience higher levels of parent-child activities tend to have better outcomes, particularly for their cognitive development.

We also have some interesting evidence around satisfaction with local services. We are not quite sure about the direction of that relationship. It could simply be that parents who are more open to seeking support go out and find those services and, therefore, are more satisfied. It could also be that parents whose children have poorer outcomes simply do not have access to services and, therefore, are less satisfied. I do not think that we have quite got to the bottom of that yet. However, satisfaction with your local area and having access to resources and services that you need locally appears to make a difference.

The Chairperson: Is it better to take a universal approach to communities rather than a targeted approach for a specific part of a community? I am thinking about where I live, where you have teenage parents, single parents, two-parent families, people on benefits and people who work. The kids in that community go to the same schools and take part in the same activities. A universal approach might help the outcomes for the area.

Mr Bradshaw: If by universal you mean a service that is available in the community for anybody to use, that is important. However, we need to acknowledge that not all parents will use a universal service. It is important to have a range of services available that are suited to the different needs, circumstances and attitudes of parents. There have been programmes that have sought to provide services that are universal but which are targeted by area, such as Sure Start. One of the key difficulties that Sure Start found was that when it opened a universal service in a disadvantaged area, it tended to be used more by the advantaged families from those areas. It is important to acknowledge that, make sure that you are aware of who is using it and who is not using it, and deliver something suitable.

The Chairperson: Are you aware of similar studies here?

Mr Bradshaw: In Northern Ireland?

The Chairperson: Across the island.

Mr Bradshaw: The Economic and Social Research Institute in Dublin is running an almost identical study called Growing Up In Ireland; it draws a sample from the Republic of Ireland, but it is, in many respects, identical to us. It has two cohorts. The parents of a birth cohort are first questioned at nine months, and there is then a much older cohort aged nine at the start. It has two waves of data and a whole range of evidence.

As regards similar data specific to children living in Northern Ireland, there is a millennium cohort study, which has a sample of Northern Irish children. I cannot remember the numbers, but it has perhaps 1,500 children, all of whom were born in 2000 or 2001 and who will now be aged about 11. In fact, they will just have had some data collection at age 11. As a UK-wide study, it covers Scotland, England, Wales and Northern Ireland and has a range of comparative data looking at outcomes across the four countries. It also has data specifically on the subsample of children living in Northern Ireland, and that can be analysed. There are other relevant studies.

The Chairperson: OK. That is quite useful. I remember hearing about that millennium study.

Mr Bradshaw: It is a bit further ahead and is already looking at outcomes at the later stage.

Mr Dunne: I apologise that I missed your presentation. Funding is a big issue. How do you continue to justify your expenditure? There is always the argument that there should be more funding at the

sharp end for acute services, for example. Is it a constant battle to justify your work and increased funding for the budget involved?

Mr Bradshaw: I would not say that it is a constant battle to justify the budget for undertaking this research. However, we have to ensure that the findings and data from our research are widely disseminated; we are required to demonstrate impact; and we have to show how our findings have been used to make a difference to policy and practice. We spend a great deal of time ensuring that people are aware of our study and that they are using the findings to influence policy and practice.

The findings from the study are used to influence discussions and debates on policy at central government level. They are also used by voluntary-sector organisations in seeking support for their delivery from local authorities and to influence their discussions with government on how their funding is placed. We continue to demonstrate how the findings are being used, which justifies the money being spent. We respond to a tender. Our funders at the education directorate need to make a case for that continued funding being available, and we contribute to that.

Mr Dunne: Northern Ireland and Scotland have a history of high rates of heart disease. From your study or your experience, what similar initiatives have been taken to try to address that issue?

Mr Bradshaw: There is nothing on that from our study as yet, but it is definitely something that we will be interested in looking at as our children get older. My organisation is also responsible for undertaking the Scottish health survey, which collects a lot of information about the incidence of heart disease and related issues. It is capable of teasing out some of the issues affecting Scotland and, in fact, specific areas of Scotland. We talk about the Glasgow effect. There is specific ongoing research comparing health outcomes for adults in Glasgow with those in Liverpool and Manchester. Those three cities have very similar socioeconomic histories and circumstances, yet Glasgow seems to do much worse in those specific outcomes. The Scottish survey has not quite got to the bottom of that yet, but some dedicated research is ongoing. I imagine that that will be relevant to the comparison between Scotland and Northern Ireland.

Mr Dunne: Is there evidence that exercise and fitness early in life reduces the risk of poor health later?

Mr Bradshaw: There is no doubt that physical activity is important in ensuring good health. We do not have a lot of evidence to suggest that at the moment, but other studies do.

Mr Dunne: We are made aware, more and more, of the need for everyone to exercise, and society needs to get a grasp of that.

Mr Bradshaw: What our findings suggest is that exercise in isolation is not enough to improve health outcomes; a combination of diet and physical activity is ideal in ensuring better health. Simply raising physical activity levels will not necessarily have the desired impact. If you can do that alongside improving diet, it will definitely make a difference.

The Chairperson: I think that it is universally accepted that early intervention has a positive impact not only on individuals but on communities and society.

Paul, this has been very useful and so, as I said, was your paper. It has allowed us to factor in some of the work being done in different areas. We are looking at health inequalities, notwithstanding some of the difficulties that we have with Ministers looking after their own Departments. Issues that concern children cut across all Departments.

On behalf of the Committee, I want to thank you for providing us with this information and for coming over to speak to us. If you think that there is any other information that might be useful to us in our work, feel free to point us in the right direction. Thank you.

Mr Bradshaw: You are welcome. Thank you.

Appendix 2

Written Responses from Government Departments Relating to the Report

Assembly Section

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Fax No: 02890 523600
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Department of
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Dr Kathryn Bell
Clerk
Committee for Health, Social Services and Public Safety
Room 414
Parliament Buildings
Stormont

Our Ref –OCQ18/11-15

29 October 2012

Dear Kathryn,

I am writing in response to your letter of 18 October regarding the Committee for Health, Social Services and Public Safety's review of Health Inequalities.

I can inform you that the Department of Finance and Personnel does not have any policies in place to tackle inequalities in early years.

Yours sincerely,

NORMAN IRWIN

31 October 2012

Dr Kathryn Bell
Clerk, Committee for Health, Social Service and Public Safety
Room 414 Parliament Buildings
Ballymiscaw
Stormont
BELFAST
BT4 3XX

Dear Kathryn

Thank you for your 18 October letter in respect of tackling inequality.

The Department does not have any specific programmes aimed at tackling inequalities in early years.

I am copying this letter to the Clerk of the ETI Committee.

Yours Sincerely

DAVID MCCUNE
DETI Assembly Liaison Officer
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FROM THE MINISTER FOR HEALTH,
SOCIAL SERVICES AND PUBLIC SAFETY
Edwin Poots MLA

Department of
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Ms Sue Ramsey, MLA
Chair
Assembly Committee for Health, Social Services and
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Room 414
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Our Ref: AGY/677/2012

Date: 6 November 2012

Dear Ms Ramsey

CORRESPONDENCE DATED 18 OCTOBER 2012 - REQUEST FOR LIST OF GOVERNMENT FUNDED PROGRAMMES TO TACKLE INEQUALITIES IN EARLY YEARS

You wrote to me on 18 October asking for details of programmes in place to tackle inequalities in early years.

The attached provides information on DHSSPS/HSC funded programmes, including key programmes/services being piloted and those being implemented more widely and universally.

The recent announcement of funding to be made available under the Delivering Social Change Framework will provide an opportunity now to strengthen this focus on early years interventions through additional support for parenting programmes and the establishment of ten Family Support Hubs.

I hope this is helpful.

Edwin Poots MLA
Minister for Health Social Services and Public Safety

RESPONSE TO CORRESPONDENCE DATED 18 OCTOBER ON PROGRAMMES TO TACKLE INEQUALITIES IN EARLY YEARS

Background

There is a growing body of evidence which supports the view that improving long-term outcomes for the whole population begins with ensuring that every child has the best possible start in life, and with a focus on ensuring that children who are the most vulnerable and at risk are especially supported.

Policy/ Strategic Overview

Policies and strategies such as Families Matter, and 'Fit and Well' provide context and direction for the range of programmes and services being supported, covering the period from conception to starting school, and beyond.

Fit and Well

In addition, in line with national and international evidence, the new public health strategic framework proposes as a priority to "Give Every Child the best start." "Fit and Well – Changing Lives " also proposes "Support for Families and Children" as a priority area for collaboration across departments and sectors, with the aim of enhancing support through incremental development of targeted and universal programmes. If endorsed this would provide strategic direction to reinforce action to tackle inequalities across the social gradient in early years.

Delivering Social Change

On 10 October 2012 OFMdFM announced six significant signature programmes under the Delivering Social Change framework and the Department has been given lead responsibility for two of these projects. The funding to be made available under this Framework will provide an opportunity to strengthen the focus on early years interventions through additional support for parenting programmes and the establishment of ten Family Support Hubs.

Healthy Child, Healthy Future

DHSSPS introduced a revised Child Health Promotion Programme (0-19 years) known as **'Healthy Child, Healthy Future: A Framework for the Universal Child Health Promotion Programme in Northern Ireland'** in June 2010. The framework is central to securing improvements in child health for all children aged 0-19 years, across a range of issues, including health protection, health improvement and surveillance. The framework sets out a core programme of child health contacts that every family can expect, wherever they live in Northern Ireland and every child and parent has access to a universal or core programme of preventative care with additional or targeted services for those with specific needs and risks. (Annex 2)

Safeguarding remains a key element of **Healthy Child, Healthy Future** with the focus being on prevention, assessment, identification, and support for identified needs and vulnerable families.
http://www.dhsspsni.gov.uk/healthychildhealthyfuture.pdf

Healthy Futures

'Review of Health Visiting and School Nursing: Healthy Futures', (2010-2015), (launched March 2010), provides direction in relation to the primary role of health visiting and school nursing regarding the promotion of health and wellbeing for children and young people aged 0-19 years, through universal service provision, the need for integrated children's services and clarifies that health visitors should work with the most complex and challenging families, through increased intensive home visiting across the 0-19 age range with the implementation of appropriate evidence based parenting programmes.
http://www.dhsspsni.gov.uk/healthy_futures_2010-2015.pdf

Family Nurse Partnership (FNP) programme

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

At present the FNP programme is being tested within a small scale test site within the WHSCT. The test site employs 4 WTE family nurses and a supervisor and has capacity to accommodate 100 clients.

Speech, Language and Communication Therapy Action Plan: Improving Services for Children and Young People (2011/12-2012/13)

The Speech, Language and Communication Therapy Action Plan *Improving Services for Children and Young People* 2011/12-2012/13 was published in March 2011.

Speech, language and communication are crucial to every child's ability to succeed in life. The ability to communicate is an essential life skill for all children and young people which underpin social, emotional and educational development.

Regional Hidden Harm Action Plan

The **Regional Hidden Harm Action Plan (2008)** considers the needs of children and young people living with parents with alcohol and drug abuse issues. The plan recommends the use of specific parenting programmes targeted to substance abusing parents (for example the Strengthening Families programme).

Families Matter

Families Matter (DHSSPS, 2009), acknowledges that all parents can benefit from opportunities to learn new skills and share knowledge and experiences, regardless of their circumstances, age of child or existing risks. The strategy recommends that a wide range of professional and high quality programmes and support networks should be in place to provide for all level of need and to provide better outcomes for children and young people. Positive parenting is also promoted widely to ensure parents have the skills to deal with their child's behaviour in a positive way and to consider alternatives to physical punishment. The strategy also demonstrates a commitment to Sure Start programmes, acknowledging their vital role in strengthening families in the early stages. Sure Start funding is currently provided by the Department of Education. It should be noted that DHSSPS are in the process of revising this Families Matter strategy document.

Early Years Programmes in NI delivered and/or commissioned through Health and Social Care

The **Health and Social Care Board** supports the Children (Northern Ireland) Order (1995) focus on non-intervention and therefore the importance of maintaining children at home with their family wherever possible. Their commissioning plan 2011-2012 again recognises the importance of Early Intervention for families and supports the development of Family Support Hubs alongside the roll out of a range of parenting programmes across the Trust areas.

The **Public Health Agency**, through a Child Development Project Board, has initiated and supported a range of programmes addressing the needs of children and young people experiencing inequalities. Membership of the Child Development Board is drawn from across the PHA, Health and Social Care Board, Health and Social Care Trusts, education, academia and the community and voluntary sector. The Project Board specifically agrees action on effective evidenced based interventions. This includes the introduction of new programmes to Northern Ireland, expansion and development of existing programmes and the application of relevant research and evaluation to those programmes to inform wider learning and development. Securing a strategic approach to early child development and family support is an important priority for the PHA.

Notably, in their NI Children and Young People's Plan, the **Children and Young People's Strategic Partnership (CYPSP)** (which is led by the Health and Social Care Board) also endorses Article 18 of the UNCRC in conjunction with their focus on Early Intervention. Several of the Area Based Outcomes Groups have prioritised support for parenting skills in their proposed action plans.

The PHA is a member of the Children and Young People's Strategic Partnership at both regional and local levels. These agendas mutually reinforce the need for a focus on outcomes in programmes and processes which build on existing and new practice.

The CYPSP will oversee the development of the multi-agency Family Support Hubs to improve coordination of family support services and to ensure that all families have access to appropriate and timely services.

A **Family Support Hub** is a multi-agency network of statutory, community and voluntary organizations that either provide early intervention services or work with families who need early intervention services.

The network accepts referrals of families who need early intervention family support and uses their knowledge of local service providers and the Family Support Database to signpost families with specific needs to appropriate services.

Hubs believe in helping families to develop the skills to help themselves. They look at the needs of families and work to match families' needs to the best possible service or services that can help.

Hubs direct families to the services they need. This can be a service provided by a Hub member or a service provided by an organisation not directly involved with the Hub but associated with it.

The attached annexes provide information on programmes for 0-4 in Northern Ireland in respect of whether they are targeted (Annex 1) or universal (Annex 2)

and comments on their evidence base. This information may not include the totality of programmes commissioned at a local level by Locality Planning Groups which are specific to the requirements of their local communities. These Groups are part of the sub-structure of the Children and Young People's Strategic Partnership.

Early Years (0-4) Programmes in NI delivered and or commissioned through Health and Social Care

Annex 1

Key 0-4 year old programmes in Northern Ireland

Targeted Programmes

Programme	Outline	Evidence base	Key Outcomes	Trust areas of delivery
Early Intervention Family support such as those provided by "Homestart"	This programme aims to increase confidence and independence in families through visits in their own home from volunteers with parenting experience themselves. Volunteers will offer advice, support and practical help to improve parents' skills and emotional health and well-being.	Home-Start programmes have been evaluated locally and nationally, reporting varying degrees of success. Programmes have been shown to produce a high level of parent satisfaction; however improved outcomes for the children and families involved have been less obvious. There is concern that families most at risk may be less likely to agree to this type of support.	• Increased parental confidence and knowledge • Improved parental well-being • Improved parent-child relationships	**All areas**
Integrated Services for Children and Young People	Integrated Services for Children and Young People (North and West Belfast) has developed a holistic approach to meet the needs of	Quaesitum 3 year Formative Evaluation undertaken and produced.	• Increased parental confidence • Increased parental knowledge of education	**West Belfast and Shankill**

Programme	Outline	Evidence base	Key Outcomes	Trust areas of delivery
	vulnerable families by coordinating and providing services which link closely with existing services across education, health and social care and community sectors. The programme has grown out of a commitment to meeting complex needs by working with parents and children and intervening early to ensure that an integrated approach is developed to meet their needs. The programme typically addresses educational disadvantage, employability alongside health concerns		issues • Improved communication skills for both parent and child • Improved children's interaction with other children	
New Parent Programme	The New Parent Programme is an intensive home visiting service for first time parents assessed as being vulnerable and delivered by the health visiting team. The programme emphasises links with other support programmes such as Sure Start and aims to act as a connection between these local support and the most vulnerable and hard to reach parents.		Outcomes include: • Improved maternal well-being • More secure baby attachment • Improved parental self-efficacy • Increased breast feeding rates • Positive engagement with young fathers	**South Eastern**

Programme	Outline	Evidence base	Key Outcomes	Trust areas of delivery
Incredible Years	Developed by Dr Carolyn Webster-Stratton, Director of the Parenting Clinic at the University of Washington, in 1984. The programme aims to reduce behaviour problems and to promote problem solving skills, social competence and emotional regulation. Programmes are aimed at parents or teachers of children aged 0-12. The IY series is a set of eight developmentally based training programmes for parents (five programmes), teachers (one programme), and children (two programmes).	All the programmes have been well evaluated globally by independent researchers using **RCT** studies, and have been shown to be highly effective. In particular studies have shown the importance of delivering the programme to fidelity for effective outcomes. In the UK, studies have been completed by Kings College London, Bangor University, and Trinity College among others.	• Reduction in anti-social behaviour and aggression • Increased praising behaviour and positive affirmation by parents and teachers • Positive change in emotional and behavioural difficulties • Increase in pro-social behaviours and problem solving • Improved social competence • Improved positive family communication • Improved parent interaction with teachers and classroom • Improved school readiness and engagement in school activities	**All Trust areas**
Strengthening Families	The Strengthening Families programme was developed in 1983 by Dr Karol Kumpher, Professor of Psychology at the University of Utah, and was originally designed to reduce risk factors for children in families with a history of parental drug and alcohol	The programme has been widely evaluated, both in the USA and globally as its implementation has spread. Results have been consistent across the evaluations, particularly when comparing the original Lutra programme	• Delayed onset or long-term prevention of adolescent substance abuse • Lowered levels of aggression • Reduction in anti-social behaviours in young people	**Belfast** **Northern** **South Eastern** **Western**

Programme	Outline	Evidence base	Key Outcomes	Trust areas of delivery
	abuse. The core aim was to improve the family environment by helping parents to develop discipline techniques and to understand the importance of rewards and positive attitudes in their children. Since its initial conception, prevention and treatment versions have been developed to provide programmes for low- and high-risk families across different age groups. The programme uses separate structured sessions for parents & children to allow both to work on parenting and life skills, followed by a joint parent-child session where both have the opportunity to practice their new skills through experiential exercises.	with the revised Oxford Brookes (UK) model.	• Increased resistance to peer pressure • Improved stress management skills in young people • Development of positive family relationship and parent/child communication skills • Increased parental confidence and skills • Increased ability of parents/caregivers to set appropriate limits and show affection and support to their children	
Mellow Parenting	An intensive parenting programme for parents of children under the age of 5 which uses video feedback and other techniques to teach parenting skills and promote	The Mellow Parenting programmes are based on theories of child development including social learning theory,	• Improved parent-child interaction • Increased positive parenting skills • Accelerated improvement in	**Southern** **South Eastern**

Programme	Outline	Evidence base	Key Outcomes	Trust areas of delivery
	positive relationships in vulnerable and hard to reach families with complex needs. The core programme has various adaptations including Mellow Bumps, Mellow Babies & Mellow Dads to target specific groups.	attachment theory, behavioural theory and cognitive behavioural theory. Local impact of programmes is evaluated by delivering bodies using standardised pre- and post- measures.	maternal well-being for mothers experiencing post-natal depression (Mellow Babies) • Improved child behaviour	
Family Nurse Partnership	FNP is a structured, intensive home visiting programme delivered to first time teenage parents by Family Nurses. It is a preventive programme, with a psycho-educational approach, focusing on adaptive change. It benefits children and families who have the poorest outcomes i.e. mothers with low psychological resources(low educational achievement, limited family support and poor mental health).It is a licensed programme with fidelity measures to ensure replication of the original research .	FNP is based on attachment theory, ecological theory and self-efficacy theory. RCTs have been conducted across USA with significant outcomes, and a large scale **RCT** is ongoing across the UK with results expected in 2013.	Initial outcomes for the FNP based on UK evaluation includes: • Early signs that clients now have aspirations for the future and cope better with pregnancy, labour & parenthood • Reduction in smoking during pregnancy • Breast feeding initiation rate higher than national rate • Significant improvement in self-esteem linked to positive behaviour change in mothers • Improvement in regular use of birth control and subsequent spacing out of future pregnancies • Increase in return to education and employment for parents	**Western** **Southern** **Belfast Trust currently recruiting**

Programme	Outline	Evidence base	Key Outcomes	Trust areas of delivery
Love Takes Time to Grow	Health visitors promote healthy attachments between babies and the primary care giver using specifically designed resources.	Attachment theory Such as Svanberg 2002 Early Intervention Report Graham Allen 2011	Early identification of parents and babies at risk of attachment difficulties using evidence based information.	**Southern Trust**
Family Support Hubs	Multi-agency network of statutory, community and voluntary organizations that either provide early intervention services or work with families who need early intervention services		• Improve access to early intervention family support services by matching the needs of referred families to family support providers. • Improve coordination of early intervention family support services by creating a collaborative network of community, voluntary and statutory providers. • Improve awareness of early intervention family support services. • Assess the level of unmet need for early intervention family support services and inform the Trust Outcomes Group.	Northern Outcomes Area Larne/Carrickfergus, Ballymena, Magherfelt/Cookstown, Coleraine Southern Outcomes Area Newry, Craigavon/Banbridge, Armagh/Dungannon South Eastern Outcomes Area Lisburn, Downpatrick, Bangor Western Outcomes Area Shantallow, Waterside, Creggan, Dry Arch (Dungiven), Strabane, Omagh, Fermanagh

Annex 2

Universal Programmes

Programme	Outline	Evidence base	Areas of delivery
Healthy Child, Healthy Future	Offers every family with children a programme of screening, Immunisations, developmental reviews, and information and guidance to support parenting and healthy choices so that children and families achieve their optimum health and wellbeing.	Health for All Children, 4thEdition, David M. B. Hall & David Elliman, Oxford Medical Publications, 2003.	**Regional**

Programme	Outline	Evidence base	Areas of delivery
Speech, Language and Communication Therapy Action Plan: Improving Services for Children and Young People (2011/12-2012/13)	The Speech, Language and Communication Therapy Action Plan focuses on health and social care services for children and young people with potential speech, language and communication difficulties. Included in the SLT Action Plan are the particular needs of children in the 0-4 years age group. A regional project to develop a model to standardise Speech, Language and Communication input into SureStart is underway.	The Bercow Report: A Review of Services for Children and Young People (0-19) with Speech, Language and Communication Needs (2008) Speech and Language Therapy Task Force Report (2008)	**Regional**
Parenting NI Helpline and advice service	Confidential support and guidance available to all when needed	Early Intervention evidence base on support for families	**Regional**
Universal Services for Breastfeeding .	**Maternity and health visiting services** provide breastfeeding information and support to all pregnant	Breastfeeding Strategy in NI (DHSSPSNI) 2012	**Regional**

Programme	Outline	Evidence base	Areas of delivery
	women and new mothers within the framework of the Breastfeeding Strategy for Northern Ireland and Healthy Child, Healthy Future.		

Parent/Early Childhood Education Programmes

Alongside these evidence based programmes, many organisations are delivering supplementary parental support and guidance through a range of programmes and courses. Many of these focus specifically on parenting skills while others offer more practical skills. Selections of these are highlighted below.

Cook it! is a community nutrition education programme supporting parents to develop knowledge and skills in healthy eating and cooking, and the safe handling of food.

Baby massage encourages skin to skin contact with mother and baby and therefore encourages attachment.

Parent Craft programmes are delivered across health trusts to expectant parents and provide practical advice on preparing for the birth and looking after baby.

Dads to lads is a parenting scheme delivered to young first time fathers in Belfast, helping them through issues such as self-esteem, anger-management and sex-education and ultimately helping them to deal with the pressures of fatherhood.

Barnardo's Preparing for Release programme helps prisoners prepare for returning to family life after release.

Barnardo's Being a mum/dad programme help parents who are in prison to develop sustained and positive relationships with their children and to better understand the issues that their child will be facing.

Health Promoting Homes programme involves the Cook it! programme, physical fitness coaching and a personal development, self esteem and assertiveness course. The programme is delivered in various sites across Northern Ireland and is free to parents of children under 4 years of age.

Hanen 'You make a difference' programme This parent-toddler programme, developed in Canada, helps parents to foster and enrich their child's language and literacy development and social skills through the use of everyday routines and activities.

Parental Separation Support Programmes offer advice, guidance and support for children

Parenting NI:

Parent's Anger Management Programme (PAMP) allows parents to explore their reaction to anger and how their anger impacts on the children and how to identify the triggers and find positive ways of managing their anger.

Parenting Apart is aimed at parents who have separated, are separating, divorced or thinking of divorce. The programme will provide practical advice and guidance on what children need to know, and what parents can do to meet their needs.

Managing Children's Challenging Behaviour helps parents to understand why children can be disruptive and recognise the triggers to behaviour. The course gives practical tips on how to reinforce positive behaviour.

In addition Some Early years providers have commissioned the PEAL (Parents early years and learning) this trains practitioners in how to engage directly with parents and children's learning.

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To: Kathryn Bell
Clerk to the Committee for Health, Social Services and Public Safety

From: Peter McCallion
Clerk to the Committee for Education

Date: 23 November 2012

Subject: Health Inequalities in Early Years

At its meeting on 23 November 2012, the Committee noted the attached correspondence from the Department of Education responding to your query of 18 October 2012 regarding health inequalities in early years.

The Committee agreed to forward the Department's reply to you.

Regards

Peter McCallion
Committee Clerk
Enc.

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9 November 2012

Dear Peter

HEALTH INEQUALITIES IN EARLY YEARS

I refer to your letter of 25 October 2012 attaching correspondence dated 18 October 2012 from the Clerk of the Committee for Health, Social Services and Public Safety.

Under the "Universal interventions focusing on child development and parenting" the Department would include the Education Works Advertising Campaign which the Minister launched on 17th September.

The Department's Curriculum Sports Programme, which is delivered by the IFA and GAA on behalf of the Department, focuses on pupils in Foundation Stage and Key Stage 1. The Programme has been in operation since 2007/08 and the annual budget for the Programme is £1.5m, divided equally between the IFA and GAA. During the 2011/12 school year the programme was delivered in 567 schools this year, reaching over 39,000 pupils.

The Programme is targeted at our youngest pupils in areas of greatest disadvantage and aims to encourage their participation in enjoyable physical activities to support a healthy lifestyle and to raise their confidence, self-esteem and motivation to learn.

Indications are that it has been very successful and has provided positive outcomes. An evaluation by the Education and Training Inspectorate reflected that one of the strengths of the programme is the inclusive nature of the work in schools, ensuring active participation of all children, including those with special needs and newcomer children.

Sure Start Programme

Sure Start provides services in at least the top 20% most disadvantaged wards and Super Output areas as measured by the NIMDM 2010. In areas with Sure Start schemes, all families with children under the age of 4, including pregnant women, have access to a range of services including early education and play, childcare, healthcare and family support. There are 35 projects delivering services to approx 34,000 children and their families.

Sure start Developmental Programme for 2-3 Year Olds

The Sure Start Developmental Programme for 2-3 Year Olds is delivered by Sure Start projects to the children in their penultimate pre school year who are likely to benefit most from this support, to help ensure they are prepared for pre – school. There are currently 142 Programmes being delivered to approx 1679 children and their families.

Pre-School Education Programme

The Department's Pre-School Education Programme has, since 1999, included a statutory admissions criterion which requires all pre-school providers to give priority to children from socially disadvantaged backgrounds, currently defined as being children with a parent who is in receipt of income support or income based jobseeker's allowance, although this definition is under review. All pre-school settings are required to apply admissions criteria if oversubscribed with applications. The admissions criterion specified in regulations is intended to ensure that pre-school education is targeted at children who will benefit most from a year of pre-school experience.

I trust this is helpful to the Committee.

Yours sincerely

Veronica

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Your ref: CSD/017/2011/NS
Our reference: SUB/1143/2012

12 November 2012

Dear Kevin

Thank you for your letter of 26 October 2012 regarding correspondence from the Committee for Health, Social Services and Public Safety regarding Social Gradient Inequalities in the early years.

The Department through its Neighbourhood Renewal Investment Fund supports a range of projects specially designed to tackle inequalities in the early years. I have attached for your convenience a table detailing the programmes currently being supported and the targeted age range.

Yours sincerely

Alison Chambers

Alison Chambers
Neighbourhood Renewal & RPA
Urban and Community Policy Directorate

EARLY INTERVENTION PROJECTS FUNDED THROUGH THE NEIGHBOURHOOD RENEWAL INVESTMENT FUND

Name and Objectives	Target Audience/Group	Associated Timeframes	Running Costs/Budget
Shantallow Community Residents Association - 'Youth Educated in Safety' Project - To reduce the number of accidents involving young people, reduce the number of incidents of anti-community behaviour involving young people, help reduce the fear of crime and anti-social behaviour in local residents and improve relationships between residents and public bodies and particularly between young people and the emergency services.	Nursery/Primary School Children (3-11)	1 April 2012 to 31 March 2015	£23,376.97 per annum
Dunluce Family Centre - to deliver the provision of a **Lifestart Programme**, a dedicated home-based early years parenting programme for parents with children from birth to 5 years which provides home based visits with information and materials for their child's development, parental practices, model play and learning activities to develop each child to their full potential and to prevent educational disadvantage. It also aims to deliver a Parent Education Programme-community based education for the parents to increase their self confidence, to undertake new skills, thereby increasing their employability and social skills.	Birth - 5 years old	1 April 2012 to 31 March 2015	£66,262.56 per annum
Creggan Pre-School & Training Trust Ltd - to provide childcare, education and training to local residents while working in partnership with statutory agencies to meet the needs of parents and their children by providing flexible, community based support and to encourage parents/carers of children availing of their childcare facilities to participate in the educational, training, parenting support programmes and activities available to them. Services delivered include a Community Playgroup, Crèche, Parent & Toddlers Group, Drop-In Centre, Adult Education/Training Courses and Sure Start Programme.	2 - 16 years old	1 April 2012 to 31 March 2015	£112,659.63 per annum
DSD-Northern Ireland Housing Executive-Social Education Project-the project aims to forge links between the NIHE and local schools and to liaise with local schools to enhance existing links with community groups, other statutory bodies and the voluntary sector with the aim of encouraging social responsibility within the local community, to empower young people within their local community, to provide awareness training to local schools and community groups, to encourage awareness within schools and community groups of the benefits of caring for the environment and to develop projects as required, for example Historical, Social, Anti-Social Behaviour, Health & Safety in the Home, etc.	6 - 16 years old	1 April 2012 to 31 March 2015	£11,630.13 per annum (50% linked cost)
Gingerbread NI - One Plus Centre- the project aims to provide support as, a one stop shop for one parent families. The One Plus Centre functions as a 'community hub' with open access for lone parents seeking support, information, advice, training and childcare available under one roof. The Centre provides a safe space for one parent families and those who work to support them-family welfare professionals, health and social workers, etc to come together and promote a partnership approach between families and support professionals. As well as being an open facility for all lone parents to use, the Centre accepts referrals from agencies working with vulnerable one parent families.	0 - 4 years old	1 April 2012 to 31 March 2015	£42,572.92 per annum

Name and Objectives	Target Audience/Group	Associated Timeframes	Running Costs/Budget
ETHOS Project - The project aims to address a gap in early intervention provision and intervention at levels 1 and 2 of the Hardiker Model, i.e. families who are experiencing some level of difficulty and who require support on a short-term basis and also to inform a longer term strategy that reduces the likelihood of these cases escalating to levels 3 and 4 which cannot be dealt with at community level but requires action from Health and/or Education authorities. Referrals have come from local schools and issues faced by clients include marital breakdown, debt management, managing behavioural problems at home/school, domestic violence, parenting skills, drugs and alcohol issues, bullying harassment.	5 - 16 years old	1 April 2012 to 31 March 2015	£29,205.38 per annum (linked cost)
GSAP - Talking to our babies - the project is a new community led, early intervention pilot programme targeted at children aged 0-3 years old, their parents/carers, individual working in the area with the target groups and the wider community to help tackle the growing number of children aged 3 and 4 years old who are presenting at Nursery School/Primary Schools in the Outer North/Greater Shantallow area with speech, language and communication difficulties. The programme will raise awareness of the importance of communication in the early years, enhance parenting/carers communication skills and the skills of those working with children aged 0-3 years old, help to influence attitudes and practice within the home and the wider community and help to integrate and promote existing services for families with children aged 0-3 years old by promoting and signposting families to local agencies that currently provide language enrichment services.	0-3 years old	29 Oct 12 to 31 March 2015	£46,391.22 per annum

Name and Objectives	Target Audience/Group	Associated Timeframes	Running Costs/Budget
GSAP - ASPIRE- Aspire is a pilot programme which will strive to enable relationships to be built between positive adult role models and vulnerable young people often through the medium of extracurricular activity. GSAP expect to secure maximum participation on the programme (minimum of 65 pupils) with consultation/support and active involvement of parents, pupils, school and community in the planning, development and implementation of the programme. The interests, ability, needs of all pupils will be taken into consideration in the development of the programme and all efforts will be made to remove any barriers that would prevent a pupil from participating. The programme will be decided and agreed by the steering group after the programme co-ordinator consults with parents, pupils, teachers, school pastoral care team and potential delivery agents from the community, voluntary and statutory agencies all in place by end of the first term.	Year 8 School Pupils (11-12)	15/10/12 - 31/03/12	£29,173.88 per annum
Dunluce Family Centre - Early Intervention and family support project to deliver the provision of early intervention by the form of provision of Family support (Element 1) working with young children from the ages of 4 to 5 yrs who have been identified as underachieving and preparing them for the transformation from Nursery School to Primary School which is a major transformation in young children's lives. Also working with the parents to assist their children's development. Both in school setting and the home setting. Provision of which provides home based visits with information and materials for the children to assist their development. (Element 2) children from 5 yrs up - provision of Family Support and training programmes to assist in development of their young lives.	4 - 5 Years re Element 1. 5years upwards Element 2.	1 Oct 12 to 31 Mar 15 Element 1 1 Oct 12 to 31 Mar 13 Element 2.	£73,355.56

Name and Objectives	Target Audience/Group	Associated Timeframes	Running Costs/Budget
Tullycarnet Primary School - Enhanced Nurture Group	Primary school children. (4-11) Maximum 10 per class	1/4/2011 – 31/3/2015	£430,007.00
Tullycarnet Community Support Services - Pre-School education	32 children aged 3-4 years	1/04/12 - 31/03/2015	£68,465.10
An Droichead - Early Years	26 pre-school playgroup places and a childcare facility for a further 26 children	1/04/12 - 31/03/2015	£142,322.40
Newtownards Road Women's Group - CAREW II Family and Childcare Services	32 crèche & 32 pre-school children	1/04/12 - 31/03/2015	£269,836.92
Rathcoole Primary School Nurture Unit	50 primary school children per year	14/09/11 – 30/06/14	£209,592.27
Upper Ardoyne Community Partnership – Wheatfield Primary School	Primary 1 – 7 pupils	1/4/12 – 31/3/15	£135,991.00
Benview Community Centre	Primary 7 and Year 11 - 15 pupils	1/4/12 - 31/3/14	£64,972.00
New Life Counseling - New Life Services are delivered through its 4 projects	children aged 5 – 11; young people aged 12 – 24; adults aged 25 yrs or over; families	1/4/12 – 31/3/15	£344,645.28

Name and Objectives	Target Audience/Group	Associated Timeframes	Running Costs/Budget
Forum for Action on Substance Abuse / Suicide Awareness (FASA)	Children, Young People, Adults, families	01/04/2012 – 31/03/2015	£989,548.56
Colin Early Intervention Community Project (CEIC). The full set of draft outcomes for the CEIC is attached below.	Children, young people and families.	1/11/2011 – 31/3/2015	DSD Neighbourhood Renewal Investment Fund grant of £225,460 for the period 1/11/2011-31/3/2015 in respect of salaries & overheads. The CEIC is also funded by: - DOJ - £75,000, - Atlantic Philanthropies - £700,000, - SEHSCT/ PHA - £270,000 & DENI - £120,000.
Craigavon Inclusion in Education. Objectives: To enhance the motivation and achievement of disengaged young people + those about to become disengaged, identify causes of unexplained absence and develop action plan to address these.	Secondary school year 8 to year 12	01/07/2011 - 31/03/2015	£490,750

Name and Objectives	Target Audience/Group	Associated Timeframes	Running Costs/Budget
Craigavon – Youth Engagement + Objectives: To enhance the motivation and achievement of young adults, about to disengage from education or who have left education already i.e. 'NEETs'	**4 Themes –** Youth Engagement: Target Groups: 13-25 year olds Educational attainment and Pre-Employment Support - Target Groups: 14-16 year olds. Health and wellbeing - Target Groups: 13-19 year olds. Improved delivery of programme - Target Groups: 14 – 18 year olds.	26/09/2011-31/03/2015	£464,855
Craigavon Training and Employment Opportunity Programme Objectives: To improve, through the provision of mentoring, the motivation and achievement of those engaged in the Southern Regional College School Partnership Programme and those who progress to FE and Training programmes.	Post primary 14 – 16 yrs	01/09/2011 - 31/03/2015	This is 1 element of a programme valued at £348,580.00
Armagh - Social Renewal Education programme. Objectives: Improved reading levels, improvements in school attendance, reductions in suspensions + referrals to behaviour support, improve family learning, improve take up of existing youth services	Preschool, primary and post primary	01/04/11-30/06/13	£260,800

Name and Objectives	Target Audience/Group	Associated Timeframes	Running Costs/Budget
Armagh - Social Renewal Education programme. Objectives: Improved reading levels, improvements in school attendance, reductions in suspensions and referrals to behaviour support, improve family learning, promote pro-social behaviour, improve take up of existing youth services.	Preschool, primary and post primary	01/04/11-30/06/13	£260,800
Armagh Training and Employment Opportunity Programme – Objectives: To improve, motivation and achievement of young people engaged in the SRC School Partnership Programme and those who progress to FE and Training programmes.	Post primary 14 – 16 yrs	01/09/11 to 30/06/13	This is 1 element of a programme valued at £129,067
Newry Training and Employment Opportunity Programme Objectives: To improve, the motivation and achievement of those engaged in the SRC School Partnership Programme and those who progress to FE and Training programmes.	Post primary 14 – 16 yrs	01/09/2011 - 31/03/2014	This is 1 element of a programme valued at £178,410.00
Newry - Social Renewal Education programme Objectives: Improved reading levels, improvements in school attendance, reductions in suspensions and referrals to behaviour support, improve family learning, promote pro-social behaviour, improve take up of existing youth services.	Preschool, primary and post primary	01/09/2011 - 31/03/2015	£465,839.00
Newry Outdoor Education Programme: Objectives: involve young people in sport, create opportunities for training, improve health & quality of life, open up opportunities to access sport, address social exclusion, enhance self confidence, reduce crime levels.	Primary and post primary	01/07/2012 - 31/03/2015	£95,900.00
Kilcooley P.S. Nurturing Project 2011-2015. Objectives: To improve attendance, reduce the incidents of pupil suspensions, encourage parental involvement.	Primary school children	01/04/2011 - 31/03/2015	£280,00

Name and Objectives	Target Audience/Group	Associated Timeframes	Running Costs/Budget
Kilcooley Women's Centre Childcare Fund. Objectives: To provide childcare provision to facilitate adult training and education.	Pre- school	01/04/2012 - 31/03/2013	£30,472
Wellbeing Programme Objectives: Assist vulnerable parents and children, support parents to access education, develop and provide network of health and family support services to enhance parenting skills, improve mental and emotional well being and improve outcomes for children.	Pre-school (antenatal – 4 years) and primary school	01/04/2011 - 31/03/2015	£272,210
Downpatrick St Colmcille's Primary School Nurture Group Objectives: To improve attendance, reduce number of pupil suspensions, develop partnership with parents, reduce disruptive behaviour in class and school, and raise attainment of 75% of pupils in the nurturing process to the level of their peers.	Primary school	01/01/2012 - 31/03/2015.	£60,245 per year (total £218,739)
Downpatrick - Parents - Partners in Literacy Learning Objectives: Improved speech & language skills & literacy skills, increased parental involvement in speech & language & reading partnership.	Pre- school, primary school and secondary school	31/01/2012 - 30/06/2014.	£354,290.34
Kilcooley - SEH&SCT - Family Health and Wellbeing To provide parents with help from the antenatal stage to ensure children have a good start in life and are sustained into later life by strengthening services at crisis points in their lives and at the transition stages of home to pre-school, pre-school to primary and from primary school to post primary.	From conception pre-school through primary school and post primary	29/10/12 - 31/3/15	£121,044

Name and Objectives	Target Audience/Group	Associated Timeframes	Running Costs/Budget
Coleraine Community Education Programme - This is a project to improve the educational outcomes of young people in Coleraine's NRA, and will develop and improve contact between parents, pupils and schools to contribute to improve children's educational achievement, target ethnic minority families residing in the NRA's - signpost parents and families to other services. It will develop links between all stakeholders enabling pupils and parents to have better access to a wide range of services and networks in the local area; provide opportunities for parents to engage with their child's school so that they can support their child's learning; offer programmes to pupils and parents that will impact health and fitness; monitor individual pupil academic progress against existing baselines using various tools such as INCAs, Key Stage and GCSE results.	4 - 18 year olds	01/04/12 - 31/03/13	£150,590.92
Causeway Enterprise Agency - Schools Are The Business - This project promotes enterprise and entrepreneurship to pupils in the Coleraine NRA via three interlinking elements and facilitated by local successful entrepreneurs. The programme aims to liberate and stimulate the creativity of pupils with a series of creative challenges, develop enterprising skills and to raise self confidence and self belief of participants and encourage them to tackle challenges "head on". Students participating in the business development activity will be involved in a simulation of a complete business process from initial concept through design production marketing and promotion.	4-18 year olds	01/04/012 - 30/09/13	£11,247.31

Name and Objectives	Target Audience/Group	Associated Timeframes	Running Costs/Budget
Focus On Family - Integrated Nurturing Project. - The Integrated Nurturing Project seeks to enhance the nurturing provision within the Ballysally estate. It seeks, through a collaborative approach to provide a joined up, cradle to grave service. It is delivered by a partnership comprising Focus on Family, Ballysally Primary School, Ballysally Pres. Church, Ballysally Nursery School and Coleraine Surestart.. The project seeks to raise educational attainment through targeted support, services and interventions from a very early age through to adulthood (Early Years support, children's nurturing, youth activities, homework clubs positive educational experience and accredited adult training etc.)	Coleraine Neighbourhood Renewal Residents	01/04/012 - 31/03/13	£137,282.78
Northern Area Health Co-ordinators project, NHSCT delivered, employing Health Co-ordinators for the 3 NRAs within Northern Division (Ballymena/Coleraine/Ballyclare). Health Co-ordinators will deliver a programme of interventions and activities which will tackle health and inequalities in these NRAs. Health Action Plans to include programmes to be delivered, delivery agent and number of participants for each area will be developed, delivered, reviewed and evaluated throughout the period of this project.	All residents within the Ballymena/Coleraine/ Ballyclare NRA	01/07/12 - 31/03/15	£346,529.83

Name and Objectives	Target Audience/Group	Associated Timeframes	Running Costs/Budget
Barnardo's Jigsaw Project provides 3 PS's &1 High School in Ballymena NRA with 3 specialised workers to deliver a programme of interventions to enable current barriers between teachers, parents & pupils to be removed with the long term aim of improving educational outcomes for the pupils and improving health/well being of those involved. Interventions include parenting programmes & info sessions, one to one support for parents in relation to parenting skills/abilities, health education initiatives for parents/pupils, access to education, advice and/or treatment referral on substance misuse or other dependency issues for parents/pupils or relating to physical or mental health issues, working with parents/pupils to improve school attendance, working with teachers to improve behaviour in the classroom/school, improving parental attendance at parent/school meetings, essential skills training for parents, transition workshops for P7 pupils, workshops/groupwork focusing on social, emotional or behavioural issues.	Primary School (5 - 11) and High School age (11 - 18) with parent engagement	01/04/12 - 31/03/15	£231,195.00
Ballee Community Childcare Services, delivered by Ballee Community Childcare, provides 48 preschool and 24 after school child care places as well as providing employment opportunities for 4 full time and 3 part time staff in this area of high unemployment. The provision of these facilities is a fundamental part of the Ballee community offering the child a "head start" on education in an environment that offers fun, security and attention.	Preschool age (3 -4) and Primary School Age (5 - 11)	01/04/12 - 31/03/15	£79,514.10
Omagh Health project 2011 - 2014 - element funded through "Breakthru" to raise awareness of harmful drinking and drug abuse as well as parent engagement	adults and young people with parent engagement	01/04/2011 - 31/03/2014	£61,818.68

Name and Objectives	Target Audience/Group	Associated Timeframes	Running Costs/Budget
Devenish Homework and Activities club. During the school terms the club is focused on homework support A healthy snack is provided each day for each child attending and the feedback from this has been very positive it has transpired that sometimes this is the only food some one of the children get until bed time During the school holidays the activities element of the club runs a number of activities ranging from educational visits to recreational activities including team building, football and swimming. This element of the project is crucial as many of these children come from deprived households and would not have the opportunities to experience these things due to financial constraints.	8-12 year olds	01/04/2011 – 31/03/2014	£184,373.27

CENTRAL MANAGEMENT BRANCH

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Dr Kathryn Bell
Clerk to the Committee for Health, Social Services and Public Safety
Room 410
Parliament Buildings
Ballymiscaw
BELFAST
BT4 3XX

Your reference: DALO 7/1/2012
Our reference: DALO 7b/1/2012

19 November 2012

Dear Kathryn

CORRESPONDENCE FROM THE COMMITTEE FOR HEALTH, SOCIAL SERVICES AND PUBLIC SAFETY (DHSSPS) REGARDING HEALTH INEQUALITIES IN EARLY YEARS

You wrote to the Clerk to the Committee for Regional Development on 18 October 2012 asking for details of programmes in place to tackle inequalities across the social gradient in the early years. The letter has been passed to me for reply.

The Department for Regional Development and its Arms Length Bodies maintain and develop infrastructure and services vital to the people of Northern Ireland such as roads, public transport, water and sewerage services.

As such, the Department does not have any specific programmes to tackle inequalities in early years in the areas you have identified. You may however be interested to note that Translink offers discounts to children using bus and rail travel, to encourage lifelong use of Public Transport services.

The content of this letter is fully disclosable under FOI.

Yours sincerely

Alan

ALAN DOHERTY
Departmental Assembly Liaison Officer

CC: Clerk to the Committee for Regional Development

Corporate and European Services Division
Central Management Branch

Dr Kathryn Bell
Clerk to the Committee for Health,
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Room 244
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Our Ref:
Your Ref:
Date: 21 November 2012

Dear Kathryn

REVIEW OF HEALTH INEQUALITIES

Thank you for your letter of 18 October, received via the Committee for Agriculture and Rural Development on 7 November.

In response to the HSSPS Committee's request for details of DARD programmes put in place to tackle inequalities in early years I would advise that DARD does not hold primary responsibility for childcare service provision. Following on from the work of the Rural Childcare Stakeholder Group in 2008 and the development of the Rural Anti-Poverty and Social Inclusion Framework in 2008/09 DARD launched a rural Childcare Programme in 2009. The aim of this was to enhance the rural evidence base for development of future policies and priorities in childcare. Following assessment, 19 projects received funding of approximately £1.2m. All project activity ceased on 31 March 2011. The Rural Childcare Programme was an innovative pilot run as part of the Department's wider anti poverty and social inclusion budget.

DARD is represented on a cross departmental working group led by OFMDFM which aims to bring forward a childcare strategy for all citizens in NI, including those living in rural areas. DARD has provided OFMDFM with the evaluation of the Rural Childcare pilot programme which will assist their work.

While there are no plans to reopen the Rural Childcare Programme, there are ongoing opportunities under Axis 3 of the Rural Development Programme 2007-2013 for childcare project infrastructure expansion or piloting of new initiatives. A commitment in this Programme

states that (through promotion of the RDP and beneficiary monitoring arrangements) at least 5% of the Axis 3 of the NI Rural Development Programme (2007-2013) funding is spent on projects that specifically benefit children and young people in rural areas (ie under 25 years).

I would be grateful if you would bring this to the attention of the Committee.

Yours sincerely

Joe Cassells
Departmental Assembly Liaison Officer

cc Stella McArdle, Clerk to the Committee for Agriculture and Rural Development

Office of the
First Minister and
Deputy First Minister
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Alyn Hicks
Clerk
Committee for OFMDFM
Room 416
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BELFAST
BT4 3XX

3 December 2012

Dear Alyn

OFMDFM Programmes to Tackle Inequalities in Early Years

In response to your letter of 25 October, following a request from the Clerk of the Committee for the Department of Health, Social Services and Public Safety to provide details of programmes put in place by OFMDFM to tackle inequalities in early years, please find attached a reply from OFMDFM officials for onward transmission to Dr Bell.

Yours sincerely

Signed Conor McParland

CONOR McPARLAND
Departmental Assembly Liaison Officer

Office of the
First Minister and
Deputy First Minister
www.ofmdfmni.gov.uk

Dr Kathryn Bell
Clerk
Committee for Health, Social Services and Public Safety
Room 414
Parliament Buildings
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Stormont
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BT4 3XX

3 December 2012

Dear Kathryn,

Thank you for your letter of 18th October 2012 requesting details of any programmes put in place by this Department to tackle inequality in early years.

While OFMDFM has limited opportunity to deliver specific programmes, it seeks through the development and delivery of a number of overarching strategies and frameworks such as the Child Poverty Strategy, the Children and Young People Strategy and the forthcoming Childcare Strategy, to direct and integrate the approach of departments to ensure that cross-cutting issues such as child poverty and children's health and well-being are tackled in an effective and co-ordinated manner across Government.

In particular, the Delivering Social Change framework, which is led jointly by the Ministerial Sub-Committee on Children and Young People and the Executive Sub-Committee on Poverty and Social Inclusion, seeks to co-ordinate key actions between Government Departments in order to deliver a sustained reduction in poverty and associated issues across all ages, improve children and young people's health, well-being and life opportunities and break the long-term cycle of multi-generational problems.

In addition to this more strategic role, this Department does fund limited interventions in a small number of critical areas including the provision of assistance to after-school projects which aims to assist school-age children across the social spectrum. However, the only assistance which could be seen to be aimed specifically at the age-group you have identified is through the Contested Spaces programme which aims primarily to promote and improve

the relations between and across the interface / contested space communities in a number of pilot areas. The programme provides disadvantaged interface / contested space communities with opportunities to shape and influence how children and youth services are provided, in a way that encourages reconciliation, increases participation of communities in policy making and contributes to better outcomes for children, young people and families.

One of the main focus areas of the programme is on early years and parenting programmes which concentrate on young children and parents living in interface / contested space communities. Initiatives supported seek to bring about improvements in the quantity and quality of shared pre-school provision and/or to implement, on a shared basis, an evidence-based programme that improves and enhances parenting skills.

Given the nature of this programme, I would suggest it be listed under the first heading provided: **Model targeted early childhood interventions.**

I hope this is of assistance.

Yours sincerely

Signed Conor McParland

CONOR McPARLAND
Departmental Assembly Liaison Officer

Appendix 3

Report on the Study Visit to Cuba

Overview of study visit to Cuba 1st to 7th December 2012

By NI Assembly HSSPS Committee delegation Ms Sue Ramsey MLA (Chairperson), Mr Jim Wells (deputy Chairperson) and Dr Kathryn Bell (Clerk)

Saturday 1st December

At 18.30 the delegation arrived in Havana and was received in José Marti International Airport Havana by a delegation led by Professor José de Jesús Portilla García (International Health) Ministry of Public Health Cuba. Also present were Dr Herenia Polo and Lic Michael Angelo from the National Health Workers Union (on behalf of the General Secretrary Dr Maria Isabel Martinez) and Dr Una Lynch from Sonrisa Solutions Ltd, Banbridge.

The group was accompanied to the Hotel Melia Havana by Professor Portilla and Dr Lynch.

Sunday 2nd December

Professor Portilla collected the delegation from their hotel at 09.30 and together with Una Lynch they were taken on a tour of historical and tourist sites in Havana city centre.

These included: the original walled city, el Cristo de Havana (the Christ of Havana), Capitolio (original) Revolution Square and Hemmingway's.

At 17.00 accompanied by Una Lynch the group went to the García Lorca/Grand Theatre in Havana to see a performance of the Cuban symphony orchestra, accompanied by pianist Frank Fernandez and a flamenco dance troupe. Tickets for the event cost 25 CUC (£15.60) the Cubans paid 10 Cuban Pesos (approximately 24p) to attend the performance.

Following the concert the group travelled in a 10 peso (24p) machina (the machinas are the classic pre-1959 cars and used as communal taxis, primarily by Cubans) to dinner in a private house (apartment) in Central Havana. Over the course of the evening the delegation met and talked with people living in the apartment and their neighbours downstairs about living conditions in Cuba.

Monday 3rd December

08.00 Sports centre Camilo Cienfuegos, Vedado: The delegation observed an aerobics class in action and spoke at length with the instructors. Classes are run at the centre throughout the day for people of all age groups and abilities. The instructors shared the programme and explained how people with health problems such as diabetes, high blood pressure, arthritis and depression are referred by their doctor and encouraged to participate. Children with disabilities (physical and cognitive) participate in classes in the afternoon and children from a nearby school also use the complex to develop advanced sporting skills (team sports including volley ball and netball). All classes are free of charge and the instructor is employed by the state. One of the leaders will travel in the near future to Venezuela to work for two years building a similar programme there.

08.45 Grandparents Circle and Tai Chi Group Calle 17

The Chairperson and deputy Chairperson spoke at length with men and women who participate in these groups (Monday to Friday). The members ranged in age from people in their 50s to people in their 80s. The members were enthusiastic about the benefits of exercise and the social element of their group. The group is peer led, but an instructor visits twice a week to ensure they are doing the correct sort of exercises. A doctor also visites every couple of weeks to check participants' blood pressure etc. Dental health emerged as an unexpected but important topic of conversation when it emerged that a woman of 87 years was missing only two teeth (both at the back). Similarly all the group members had excellent dental health.

11.00 Registration for the conference

12.00 Visit the City of Sport in Havana – the delegation visited a large sports complex on the outskirts of Havana catering for wide range of sports including basket ball, track sports and swimming.

16.00 Official opening of the conference

The conference was officially opened by the Cuban Minister of Health, and television cameras were present to record the proceedings. The conference was attended by 1500 delegates from 45 countries, and 22 Health Ministers were present.

The delegation looked at emergency field (tent) hospitals used by Cubans in Haiti, Pakistan and other areas affected by natural disasters, which had been pitched at the conference venue.

The delegation toured the exhibition stands present at the conference. They had a detailed discussion with an organisation that provides services for children with disability. The group has opened an innovative centre within the grounds of the Zoo. It has a major focus on animal therapy (horses in particular) and improving dental care. Practitioners are treating adults with learning disability within the centre as well as children.

17.00 Key note address Transformations in the Cuban Health System 1959 - 2012 **Minister Public Health** Dr Roberto Morales Ojea.

20.00 Cultural Gala for Conference delegates Evening of dance in Melia Theatre, Havana. The Chairperson was invited by a member of the organising Committee to address the conference on 5 December on the challenges facing Northern Ireland's health system. The Chair accepted the invitation.

Tuesday 4th December

09.00 Plenary session at conference on social determinants of health and well being

Chaired by Jose A Portal Vice Minister, Cuba. The presenters were : Jorge Venegas Minister Health Uruguay, Eduardo Bustos, Vice Minister Argentina, Fernando Gonzalez, Vice Minister Cuba and Paulo

Buss, Director of Brazil's Centre for Global Health.

11.00 Visit to Policlinic and family doctor's surgery (consultorio) in the Municipality of Plaza de la Revolution. Visit hosted by Dr Jorge Sosa, Director of the Policlinic.

A delegation from the USA Public Health Association joined the delegation for a PowerPoint presentation from Dr Sosa on the structure and work of the centre. An extensive tour of the policlinic and consultorio (GP surgery) allowed the opportunity to meet and talk with staff and patients.

The delegation learned that healthcare is a political strategy of the state, and that the foundation of the system is primary care. In 1984 Cuba introduced the system of a family doctor & nurse service. They did this because there were changes in epidemiology and because they believed they had tended too much towards super-specialisation.

The family doctor is a competent clinician who provides health services, carries out research, communicates, educates, carries out health administration and interprets the human condition. It is a role with many facets. The family doctor and nurse both live in the community they are serving.

The key elements of the Cuban system are – the political will of the state, professionals being grouped in teams, free access, General Medicine, access to specialities, home hospitalization (care in the home where possible as this guarantees rest and isolation from catching other infections in a hospital. It also keeps the patient in their own environment which they prefer and encourages family responsibility).

There are four objectives within the Cuban system – promotion, prevention, healing and rehabilitation.

The area in which this policlinic was situated had 16 family doctors/nurses attached to it, covering a population of 17,598 and 4,627 families. The human resources for this area were 236 workers including 67 doctors, 14 of who are working overseas at present. The policlinic has partnerships with 16 countries.

The delegation learned that the policlinic area has had a rate of zero in terms of infant mortality in the last 15 years, and has had no maternal deaths in the same period. Great emphasis is put on care of pregnant women. The breastfeeding rate is 95% for women breastfeeding up to 6 months.

The delegation learned that most older people are cared for by their family. If they have no family they are cared for by a social assistant.


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14.30 Return to conference center. The delegation spoke to the Bayer medical representative in Cuba and was introduced to Professor Francisco Ochoa, one of the founders of the Cuban health system.

19.00 Working dinner and preparation of paper to be presented next day by the Chairperson.

<u>Wednesday 5th December</u>

08.30 The delegation attended the conference and were introduced to the Minister of Public Health Dr Roberto Morales Ojea by Maria Isabel Martinez (Health workers Union).

09.00 Ms Sue Ramsey MLA addressed the 1,400 conference delegates in the plenary session of the conference. A copy of the speech can be found at the back of this report

Title of the session was *Universal coverage and challenges for health systems.*

Chairperson: Cristina Luna, Vice Minister Cuba

Presenters: (in addition to Sue Ramsey) Carissa Etienne, Director designate (Jan 2013) Pan American Health Organisation, currently Assistant Director General Health Systems at WHO; Daisy Corrales Minister of Health, Costa Rica; and Segio Gama de Costa Lobo Minister for Health, East Timor.

11.00 Professor Portilla accompanied the group on a short visit into Old Havana.

19.30 Ms Sue Ramsey MLA and Mr Jim Wells were guests at a dinner hosted by the Minister of Public Health (Dr Roberto Morales Ojea) and attended by the 22 Ministers attending the conference.

Thursday 6th December

08.30 Visit to the Latin American School of Medicine (ELAM) with Professor Portilla**.** Dr Maria Isabel Martinez also joined the group.

The ELAM visit was hosted by Dr. Maritza Gonzalez Bravo the Vice Director of the School. The delegation met and spoke at length with students from a wide range of countries including Uruguay, Nicaragua, Peru, Tongo, Rwanda, New York City and India.

ELAM was founded after Hurricane Mitch in 1998. There was a need for help for the region after the hurricane hit. The Cuban government recognized that many of the health problems that followed in the wake were not due to the hurricane but due to the lack of capacity of health professionals, particularly for people living in rural areas. ELAM was set up as a centre to prepare doctors from other countries across the world who would then go back to their own countries and practice medicine. This was seen as more sustainable than simply sending Cuban doctors into a region when there was a natural disaster. (Cuba does still send in teams of doctors to disaster zones – e.g.

earthquake in Pakistan, Haiti in 2010)

The first students enrolled on 15/11/99 and they were initially from Central America where the hurricane had hit. To date there have been 16,327 graduates from ELAM from 98 different countries.

The young people attend ELAM are selected in their own countries and receive a scholarship. No account of their social or economic background is taken in terms of the selection process. Their fees and board and lodging in paid for by the Cuban government, and they also receive 100 pesos a month in spending money. Many of the students which the delegation spoke to explained that they would not have been able to afford to study medicine in their own countries.

When the doctors graduate they return to their own country to practice medicine.

13.00 Visit to San Francisco Cathedral old Havana with Professor José Portillo.

13.30 Official farewell lunch hosted by Dr Maria Isabel Martinez Cuban Health Workers' Union. Lunch was attended by Professor José Portillo, Dr Lazaro Delgado (senior anaesthetist), Dr Raquel Toledo Padillo (Obstetrician) and Dr Herenia Polo (Forensic medicine). The delegation discussed the structure of trade unions in Cuba.

15.00 visit to **John Lennon Park** Havana. The Chairperson and deputy Chairperson met with local people who participate in the daily tai chi sessions (70-100 people).

16.30 Official farewell at José Marti International airport Havana. Professor José Portilla (MINSAP), Dr Herenia Polo (Health Workers Union) and Dr Una Lynch (Sonrisa Solutions Ltd, Banbridge) accompanied the delegation to the airport.

Chairperson's address to Conference – 05.12.2012

Good Morning Delegates and Ministers.

Thank you for inviting me to speak at your conference this morning. I am very honoured and humbled to be among so many experts in the field of health from so many different countries.

My name is Sue Ramsey and I am the Chairperson of the Committee for Health at the Parliament in the North of Ireland. I am visiting Cuba for a week, and I am accompanied by my colleague Mr Jim Wells who is Vice Chairperson of the Health Committee. I am also accompanied by Dr Una Lynch who has organised our visit to Cuba and Dr Kathryn Bell who clerks my Committee.

I am known as someone who speaks very fast, but I will try and speak slowly today so I hope you understand me.

I would like to give you some background on the health system which we have in the North of Ireland. I will then discuss some of the current challenges which we are facing.

Our model of healthcare is based on the idea of a National Health Service – or NHS - which was a model developed in England in the 1940s.

The key principles of our model are that services are available to everyone and throughout their lives – we talk about services from the cradle to the grave. And the other principle is that services should be free at the point of delivery – in other words people should not pay for health services.

After 30 years of conflict in the North of Ireland, political parties got involved in peace talks and agreed a negotiated agreement in 1998. We established our own Parliament as part of the Good Friday Agreement and we have had our own government for 14 years.

We have had our ups and downs and it has been a long hard road to get to this point but thankfully we have. It is not perfect but we are talking and working together – 10 years ago this trip would not have been possible.

We have 12 government Departments and a 5 party coalition government.

I am from a different political party than the Health Minister but we both see the benefits to all our people of co-operation and working together.

My role is to both challenge the Minister and to support him.

Health policy is decided by our own government, which means that there is local accountability in terms of how we as politicians take decisions.

Currently we have a population of 1.8 million. We spend £4.6 billion per year on health and social care. We employ 70,000 staff in health and social care – 1 in 10 of the population work

in our health service.

I will now talk about some of the challenges we are facing in terms of how we deliver healthcare to our population.

While the health of our people has been steadily improving over the last 30 years in terms of life expectancy, infant mortality rates, survival rates for cancer and other such measures, the rate of improvement has not been the same across the population.

The reality is that improved health has not been shared equally across all people in our society. So we have a major problem with health inequalities. For example, the life expectancy of someone living in the most affluent area is around 10 years more than someone living in the most economically deprived area – even though these people may live in the same city and only 2 or 3 miles away from each other.

Across a range of measures, people living in economically deprived areas are likely to experience poor outcomes in terms of mental health, suicide, alcohol and drug use, heart disease and so on.

This is an issue which our government has been aware of since the Parliament came into operation in 1998 and we have been trying to address it.

A new strategy is currently being developed by our Health Minister. My Committee is working in parallel and is carrying out an inquiry into health inequalities so that we can contribute to that strategy and propose any necessary changes. We are investigating the importance of early years interventions and giving every child no matter where they live the best start in life.

We know there is evidence that states that programme for babies, infants, young children and their parents can be very effective at preventing health problems later in life. As part of our inquiry we want to learn from other countries and regions about early years programmes which have been successful in tackling health inequalities.

We are happy to take ideas or strategies that work in other countries and apply them in our own system.

We have therefore come to Cuba and to this conference to understand what we can learn from other countries. We have spent some time studying the Cuban system and we are very interested in some of the structures in place in Cuba.

We have learned that in Cuba there is a lot of attention given to women during pregnancy and after the child is born, and we are impressed with the high breast feeding rates of 95%. Unfortunately our rate is much much lower at 16%.

There also is a strong emphasis on primary care – the family doctors and nurses and the polyclinics. I have also noticed that there is a big focus on relationships between family

doctors and nurses and the patients – they live in the same neighbourhoods and the doctors know their patients very well. I would assume that this allows health problems to be identified very quickly, and interventions to take place earlier.

I will be going back home full of ideas and to talk to our Public Health Agency and our Minister of Health to see whether we can apply some of the Cuban principles to our system.

At home, one of the problems we have is a lack of co-ordination between the government departments. We need to convince Ministers that health is the responsibility of everyone right across government – whether in Education, the Environment, Economic Development, Rural Development, Leisure and the Arts.

But we also face many other problems as well as health inequalities. I will mention just a few:-

- We have an ageing population who needed to be cared for. More and more people are being diagnosed with dementia which requires more complex care.
- We have very long waiting lists for outpatient appointments with consultants – for example dermatology, orthopaedics. Some people are waiting 9 months to get a first appointment. The demand from patients is outstripping the supply.
- We have very long waiting in some of our Emergency Departments in our hospitals. People are waiting a long time to be seen and also to be admitted into the hospital. There is also the problem that people are coming to an Emergency Department when they could be treated by a doctor in the community or by a pharmacist – however, we seem to have a lack of co-ordination between our primary and secondary care.
- We are spending a lot of money of pharmacy and drugs.

However, we are now at a crossroads in terms of our health system and we have the opportunity for change.

Our Health Minister has done a review of the system and has produced a strategy called Transforming Your Care. This Strategy was published one year ago and we are now at the stage of trying to turn strategy into action.

The key principles of the Strategy are:

- A shift from services in hospitals to more services and treatment in primary care settings and local communities.
- Caring for people in their own homes for as long as possible – particularly older people.
- More focus on prevention and early intervention.
- Health professionals working in multi – disciplinary teams called Integrated Care Partnerships – so doctors, nurses, physiotherapists, occupational therapists would work in a more integrated way.
- A centralisation of acute services into major hospitals.

However, we now face the challenge of implementing this vision.

There is resistance among some health professionals to new ways of working. We also know that people become attached to their own local buildings and hospitals and need to be reassured that the services delivered in the community or in the home can be just as effective.

I know that in Cuba in 1984 there was a similar process of change and that the poly clinic structure was set up. I would be keen to learn more about how the changes were made, and how commitment was obtained from health professionals and local people. This is something I hope to discuss with my fellow delegates over the next few days.

I hope I have given you a useful insight into the health system in the North of Ireland. Our delegation will be happy to discuss our system in more detail with any of you later in the day.

Once again, I would like to thank the organisers of the conference for inviting me to speak and thank you for listening.

Appendix 4

Assembly Research Papers Relating to the Report

Health Inequalities in Northern Ireland

1 Introduction and Overview

This briefing paper has been prepared in response to your query regarding health inequalities in Northern Ireland (NI) and presents an introduction to the subject in terms of how health inequalities in NI are monitored, strategies and programmes to tackle them and the outcome of these.

The Institute of Public Health in Ireland (IPH) refers to health inequalities as:

> *Preventable and unjust differences in health status experienced by certain population groups. People in lower socio-economic groups are more likely to experience chronic ill-health and die earlier than those who are more advantaged.*[1]

Health Inequalities are observed along a social gradient – the better your social circumstances, the better your chance of enjoying good health and a longer life. The IPH also highlight that health inequalities also exist between genders and ethnic groups.[2]

The causes of health inequalities are complex but are strongly driven by the social, economic and environmental conditions in which people live and work. These conditions are known as the social determinants of health and are thought to be largely the result of public policy.[3]

Many of the key health behaviours significant to the development of chronic disease follow the social gradient, for example, smoking, obesity, lack of physical activity, poor nutrition, abuse of drugs and alcohol; along with other factors such as mental illness, low breastfeeding rates and poor oral and sexual health.[4]

From birth, people are exposed to a wide range of social, economic, psychological and

[1] Social Determinants and Health Inequalities, Institute of Public Health in Ireland, www.publichealth.ie/service/social-determinants-health-inequalities

[2] Social Determinants and Health Inequalities, Institute of Public Health in Ireland, www.publichealth.ie/service/social-determinants-health-inequalities

[3] Social Determinants and Health Inequalities, Institute of Public Health in Ireland, www.publichealth.ie/service/social-determinants-health-inequalities

[4] Make Healthier Choices Easier, HSC Public Health Agency, http://www.publichealth.hscni.net/directorate-public-health/health-and-social-wellbeing-improvement/make-healthier-choices-easier

environmental experiences which change as they go through the different stages of life. Each of life's transitions can affect health, however, people who are disadvantaged are at greater risk. Disadvantages tend to congregate among the same people, accumulate through life and can be passed on from generation to generation.[5]

In Northern Ireland, the key strategy for tackling health inequalities is the ten year cross-departmental public health strategy '*Investing for Health',* published in 2002. The Strategy contains a framework for action which is based on partnership working amongst Departments, public bodies, local communities, voluntary bodies, District Councils and social partners. The key aims of the strategy are to improve life expectancy across the population and to reduce health inequalities. This strategy was reviewed in 2009 and whilst progress has been made, challenges relating to health inequalities still remain. The key outcomes of this strategy are discussed further in section 4.

Investing for Health contained a number of lifestyle strategies, mainly led by the DHSSPS, covering a wide range of issues such as smoking, obesity, alcohol and drug misuse, suicide and sexual health. The specific work of the DHSSPS and Public Health Agency (PHA) in tackling health inequalities through these strategies and other programmes is discussed further in section 2 of this briefing.

Investing for Health sits alongside *Lifetime Opportunities*, the Anti-Poverty and Social Inclusion Strategy for Northern Ireland.[6]

Investing for Health is to be succeeded by a new ten year public health strategy which is in development and will be launched in 2012. It will be a cross-government, outcome-based strategic framework and will take account of social, economic and legislative changes since the previous strategy was written. It will continue to focus on improving the overall health and well-being of the NI population whilst aiming to reduce evident health inequalities. It will adopt a life-course approach and will focus on those determinants which evidence shows are the most powerful in reducing health inequalities, for example, early years interventions. Particular notice is to be taken of the 'Marmot Review' – the Strategic Review of Health Inequalities in England 2010.[7]

In addition to the strategies mentioned above and the programmes of the PHA to address health inequalities, the DHSSPS has developed a monitoring system – the **Health and Social Care Inequalities Monitoring System (HSCIMS)**, to determine the nature and extent of health inequality in NI. The HSCIMS produces regular annual

[5] The Annual Report of the Chief Medical Officer for the Northern Ireland 2010, Deprivation and health inequalities, page 5, http://www.dhsspsni.gov.uk/cmo-annual-report-2010.pdf
[6] *Lifetime Opportunities*, the Anti-Poverty and Social Inclusion Strategy for Northern Ireland (2006), OFMDFM, http://www.ofmdfmni.gov.uk/antipovertyandsocialinclusion.pdf
[7] Developing a new Public Health Strategy for Northern Ireland- Update September 2011, http://www.dhsspsni.gov.uk/newsletter-public-health-strategy.pdf

updates on the extent on inequality experienced by those living in the 20% most deprived areas and that experienced by those living in rural areas when compared with the regional average. A summary of results from the *Third Update Bulletin* (2009) and *Sub-regional Inequalities – HSC Trusts* (2010) is included at section 3 below. The fourth update bulletin is due to be published in June 2012.[8]

2. Strategies and Programmes to Tackle Health Inequalities

2.1 DHSSPS Lifestyle Strategies

Investing for Health embraces a number of DHSSPS lifestyle strategies covering a wide range of issues such as smoking, obesity, alcohol and drug misuse, suicide and sexual health. Although these strategies are aimed at the general population (with specific targeted areas to tackle health inequalities), many of the key health behaviours significant to the development of chronic disease follow the social gradient, for example, smoking, obesity, lack of physical activity, poor nutrition and abuse of drugs and alcohol.[9]

The cost to the health service of **alcohol misuse** in NI may be as high as £122 million per year and £48 million to social services and there is clear evidence from around the world that there is a link between the affordability of alcohol and the level of consumption.[10] Following on from the *New Strategic Direction for Alcohol and Drugs 2006-2011* an updated five year action plan the *New Strategic Direction for Alcohol and Drugs Phase 2 2011-2016* was published in December 2011 to continue the work and deal with emerging concerns such abuse of over-the-counter drugs and 'legal highs'.[11]

With regards to **obesity**, the first results from the 2010/11 Health Survey NI were published in November 2011. Of 4,000 people surveyed, 59% of adults were obese (36%) or overweight (23%). A cross-Departmental Framework for Preventing and Addressing Overweight and Obesity in Northern Ireland 2012-2022 – *A Fitter Future for All*[12] has been issued and seeks to address a number of key issues including:

Increasing the levels of breastfeeding;

Encouraging participation in physical activity and increased access to physical activity

[8] NI Health and Social Care Inequalities Monitoring System, Sub-regional Inequalities – HSC Trusts 2010 (July 2010), NISRA, DHSSPS, Foreword, http://www.dhsspsni.gov.uk/subreg_inequalities_monitoring_1.pdf
[9] Make Healthier Choices Easier, HSC Public Health Agency, http://www.publichealth.hscni.net/directorate-public-health/health-and-social-wellbeing-improvement/make-healthier-choices-easier
[10] The Annual Report of the Chief Medical Officer for the Northern Ireland 2010, Alcohol and drug misuse, page 6, http://www.dhsspsni.gov.uk/cmo-annual-report-2010.pdf
[11] The New Strategic Direction for Alcohol and Drugs Phase 2 2011-2016 (December 2011) DHSSPS, http://www.dhsspsni.gov.uk/new_strategic_direction_for_alcohol_and_drugs_phase_2__2011-2016_
[12] Cross-Departmental Framework for Preventing and Addressing Overweight and Obesity in Northern Ireland 2012-2022 – *A Fitter Future for All*, DHSSPS, http://www.dhsspsni.gov.uk/framework-preventing-addressing-overweight-obesity-ni-2012-2022.pdf

facilities for children and their families; and

Active travel and the obesogenic environment.

The life course stages through which this Framework has directed its outcomes are:

Pre-conception, Antenatal, Maternal and Early Years;

Children and Young People; and

Adults and General Population.

With regard to **smoking**, in NI, around 340,000 people aged 16 and over smoke. There is a strong relationship between smoking and health inequalities, with more people dying of smoking-related illnesses in disadvantaged areas of NI than in more affluent areas. In February 2012, the Health Minister, Edwin Poots, launched a *Ten Year Tobacco Control Strategy* for Northern Ireland.[13] The Strategy has three main objectives: to reduce the numbers of people in Northern Ireland taking up smoking; to encourage more smokers here to quit; and to afford greater protection for the whole population from tobacco-related harm. In launching the strategy, the Minister noted the good progress made in recent years in NI, with achievements such as the introduction of smoke-free legislation; the increase in age-of-sale requirements; and the development of smoking cessation services.[14]

With regard to promoting **positive mental health and tackling suicide**, the DHSSPS is working on a new Mental Health and Wellbeing Promotion Strategy to be published in 2012. It will focus on interventions to promote positive mental health at various stages in the life course and in various settings such as schools and workplaces. There will be a major focus on the early years as the evidence shows this is where greatest gains can be made.[15]

With regard to **sexual health**, many factors linked to deprivation can influence sexual health such as poverty, unemployment, poor education, alcohol and drug misuse and social exclusion.[16] The DHSSPS strategy in this regard is the Sexual Health Promotion Strategy and Action Plan 2008-2013.[17] The DHSSPS and PHA have established a multi-agency sexual health improvement network to oversee implementation of the

[13] Ten Year Tobacco Control Strategy (2012), DHSSPS, http://www.dhsspsni.gov.uk/tobacco-strategy-consultation.pdf

[14] Health Minister Edwin Poots today launched a new ten-year tobacco control strategy for Northern Ireland, 28/02/12, DHSSPS Press Release, http://www.northernireland.gov.uk/index/media-centre/news-departments/news-dhssps/news-dhssps-february-2012/news-dhssps-280212-health-minister-launches.htm

[15] The Annual Report of the Chief Medical Officer for the Northern Ireland 2010, Alcohol and drug misuse, page 8, http://www.dhsspsni.gov.uk/cmo-annual-report-2010.pdf

[16] The Annual Report of the Chief Medical Officer for the Northern Ireland 2009, Sexual Health, page 20, http://www.dhsspsni.gov.uk/cmo-annual-report-2009.pdf

[17] Sexual Health Promotion Strategy and Action Plan 2008-2013, DHSSPS, http://www.dhsspsni.gov.uk/dhssps_sexual_health_plan_front_cvr.pdf

strategy including training, prevention, education and access to services.[18]

2.2 Public Health Agency (PHA) Programmes

The PHA has acknowledged that inequalities may worsen in this difficult economic climate and, in order to make best use of its resources, the PHA has been systematically examining evidence of best practice and effectiveness. The PHA has set out four key themes to its work around health and social wellbeing improvement[19]:

1. Give every child and young person the best start in life;
2. Ensure a decent standard of living for all;
3. Build sustainable communities; and
4. Make healthy choices easier.

1. Give every child and young person the best start in life:

International evidence from economists, psychologists, child development specialists and others suggests that priority should be given to investing in services that provide support during pregnancy and the first five years of a child's life. Economists have demonstrated that such investment brings a 9-10 fold return on every £1 invested in terms of a more educated and skilled adult workforce and avoiding the costs of criminal behaviour and a range of other poor health and social outcomes.[20]

In connection with this approach the PHA has introduced two programmes in particular to Northern Ireland – Family Nurse Partnership (FNP) and Roots of Empathy:

Family Nurse Partnership (first developed at University of Colorado, USA) - FNP is a voluntary preventive programme for teenage mothers. It offers intensive and structured home visiting, delivered by specially trained 'family nurses', from early pregnancy until the child is two. FNP is being tested across England, Scotland and now on one test site in Northern Ireland. The first phase of FNP is being introduced across the Western Health and Social Care Trust (HSCT) area. The PHA advocate that this programme has been shown to achieve better educational attainment, less antisocial behaviour, less child abuse and fewer young people entering the criminal justice system. Elsewhere, FNP has proven to be not only cost-effective, but cost-

[18] The Annual Report of the Chief Medical Officer for the Northern Ireland 2009, Sexual Health, page 20, http://www.dhsspsni.gov.uk/cmo-annual-report-2009.pdf
[19] Health and Social Wellbeing Improvement, Public Health Agency, www.publichhealth.hscni.net/directorate-public-health/health-and-social-wellbeing-improvement
[20] Health and Social Wellbeing Improvement, Public Health Agency, http://www.publichealth.hscni.net/directorate-public-health/health-and-social-wellbeing-improvement/give-every-child-best-start-life

saving, with every £1 spent on the programme producing savings of £2.88 in the longer term[21];

Roots of Empathy - This is an evidence-based classroom programme that has been shown to reduce levels of aggression among school children, while also improving social and emotional competence and increasing empathy. A parent and baby from the local community visit the classroom on a monthly basis throughout the year. A trained instructor coaches students to observe the baby's development and label the baby's feelings. The aim is to develop 'emotional literacy' so that children become more competent in understanding their own feelings and the feelings of others. The South Eastern HSCT and Belfast HSCT, together with local stakeholders, have engaged with 27 primary schools to deliver Roots of Empathy in this pilot phase, which is focused on schools serving more disadvantaged communities[22].

2. Ensure a decent standard of living for all

The PHA highlight that poverty and economic inequality are bad for health, with poverty an important risk factor for illness and premature death. It affects health directly and indirectly in many ways including - financial strain, poor housing, poorer living environments, poorer diet and limited access to employment, other resources, services and opportunities. Poor health can also cause poverty. It is well established that the poorest people live the shortest lives with the worst health[23].

Persistent poverty in Northern Ireland (21% before housing costs) is double that in Great Britain (9%) and in January 2010, 43,000 children in NI were living in severe poverty. There are a number of reasons for higher persistent poverty in Northern Ireland: high levels of unemployment, high rates of disability and limiting long-term illness, low wages, poor quality part-time jobs and obstacles to working mothers.[24]

Across NI the PHA is working in partnership with voluntary and statutory sector partners on a range of initiatives to support vulnerable groups. Its work includes the Advice 4 Health project, a collaboration between the Northern Investing for Health (IfH)

[21] Health and Social Wellbeing Improvement, Public Health Agency, Family Nurse Partnership, http://www.publichealthagency.org/directorate-public-health/health-and-social-wellbeing-improvement/family-nurse-partnership
[22] Health and Social Wellbeing Improvement, Public Health Agency, Roots of Empathy, http://www.publichealthagency.org/directorate-public-health/health-and-social-wellbeing-improvement/roots-empathy
[23] Health and Social Wellbeing Improvement, Public Health Agency, Ensure a decent standard of living for all, http://www.publichealthagency.org/directorate-public-health/health-and-social-wellbeing-improvement/ensure-decent-standard-living-all
[24] Health and Social Wellbeing Improvement, Public Health Agency, Ensure a decent standard of living for all, Poverty, http://www.publichealthagency.org/directorate-public-health/health-and-social-wellbeing-improvement/poverty

Partnership and the Citizens Advice Bureau with four specialist workers supporting vulnerable groups across a range of Health and Social Care settings. Another programme coordinated by the PHA aims to improve the health and wellbeing of people living in the top 30% of rurally deprived super output areas by making them aware of, or helping them access, local services, grants or benefits.[25]

In terms of fuel poverty, the PHA have established a regional fuel poverty and health network to develop a more strategic approach to fuel poverty and health across the region. Benefit maximisation schemes across Northern Ireland have also improved household incomes. These schemes take referrals from HSC.[26]

3. Build sustainable communities

Building sustainable communities is one of the core themes proposed by Sir Michael Marmot in his 2010 report *Fair society, healthy lives*. Community development is the key component of the PHA's approach to building sustainable communities. In all areas of the PHA's Health and Social Wellbeing Improvement Division, more than 50% of the programme budget is devoted to enabling the community and voluntary sectors to provide a range of services. Significant investment goes towards services that address[27]:

Mental health promotion and suicide awareness and prevention;

Prevention of obesity;

Smoking cessation;

Reducing drug and alcohol misuse;

Reducing teenage pregnancy.

4. Make healthier choices easier

Many of the key health behaviours significant to the development of chronic disease follow the social gradient, for example, smoking, obesity, lack of physical activity, lack

[25] Health and Social Wellbeing Improvement, Public Health Agency, Ensure a decent standard of living for all, Poverty, http://www.publichealthagency.org/directorate-public-health/health-and-social-wellbeing-improvement/poverty

[26] Health and Social Wellbeing Improvement, Public Health Agency, Ensure a decent standard of living for all, Fuel Poverty, http://www.publichealthagency.org/directorate-public-health/health-and-social-wellbeing-improvement/poverty

[27] Health and Social Wellbeing Improvement, Public Health Agency, Building sustainable communities, http://www.publichealthagency.org/directorate-public-health/health-and-social-wellbeing-improvement/build-sustainable-communities

of nutrition, drug-taking, alcohol abuse and mental illness, along with other factors such as breastfeeding and poor oral and sexual health. The PHA commissions a range of programmes to address these concerns. A brief outline of the PHA's work in some of the key areas is outlined below:

Tackling childhood obesity - During 2009–10, the PHA developed an action plan for obesity to ensure evidence-based approaches. A public information campaign on physical activity, which aims to encourage children to be more active, was launched in September 2010. The PHA continues to work in partnership with primary and secondary care, leisure services and healthy living centres to provide physical activity/exercise referral schemes. In partnership with Safefood, the DE and the DHSSPS, the PHA produced a new leaflet Are you packing a healthy lunch?, which was distributed to every child in primary school.[28]

Improving wellbeing through peace of mind - The PHA campaign to promote Lifeline, the free helpline for those in distress or despair, has led to increased public awareness of the Lifeline number 0808 808 800. A website www.lifelinehelpline.info was also launched. An award-winning PHA public information campaign encouraging young men to open up and talk about their feelings was re-run during 2010. The next phase of the PHA campaign will include a focus on issues that can have a negative impact on the mental health and wellbeing of individuals, families and communities, including the economic downturn.[29]

Stopping smoking - The PHA highlights that it has been at the fore in ensuring that smoking cessation support is available to smokers who want to quit; ensuring that young people don't start smoking, through programmes like 'Teenage Kicks' and 'Smokebusters'; protecting non-smokers from the dangers of second-hand smoke; and through the 'No Smoking Day' campaign, it also encourages smokers to use it as an opportune time to quit.[30]

Highlighting the dangers of emerging drugs - The emergence of legal highs in the latter part of 2009 and 2010 presented challenges for the PHA in ensuring accurate information was available. The PHA developed a legal highs factsheet for parents and those working with young people; produced a bulletin on mephedrone; issued regular press statements on emerging drugs of concern; supported local communities, groups and schools by providing information and advice through its range of additional drug and alcohol services; developed materials for young people

[28] Health and Social Wellbeing Improvement, Public Health Agency, Tackling childhood obesity, http://www.publichealth.hscni.net/directorate-public-health/health-and-social-wellbeing-improvement/tackling-childhood-obesity

[29] Health and Social Wellbeing Improvement, Public Health Agency, Improving wellbeing through peace of mind, http://www.publichealth.hscni.net/directorate-public-health/health-and-social-wellbeing-improvement/improving-wellbeing-through-peace-

[30] Health and Social Wellbeing Improvement, Public Health Agency, Stopping smoking, http://www.publichealth.hscni.net/directorate-public-health/health-and-social-wellbeing-improvement/stopping-smoking

on legal highs; and funded specific training programmes on legal highs and other emerging drugs of concern.[31]

Averting an alcohol crisis – The focus of the PHA currently is to support the measures proposed by the NI Assembly to introduce a minimum per unit price for alcohol and banning irresponsible drinks promotions.[32]

3. DHSSPS – Monitoring Health Inequalities in NI - Health and Social Care Inequalities Monitoring System (HSCIMS)

As previously mentioned, the **Health and Social Care Inequalities Monitoring System (HSCIMS)** comprises a basket of indicators which are monitored over time to assess area differences in mortality, morbidity, utilisation of and access to health and social care services in NI. Inequalities between the 20% most deprived areas (using NISRA 2005 NI Multiple Deprivation Measure) and NI as a whole are measured. Results for the most rural areas are also compared against NI overall.[33]

The HSCIMS third update bulletin (2009) demonstrated that overall health outcomes in deprived areas continue to be generally worse than in NI as a whole, although there have been relative improvements across a number of indicators. For example, the relative inequality gaps for infant mortality and cancer incidence more than halved over the period measured[34] and there were improvements in the gaps for hospital admissions. However, while a reduction in hospital admissions in deprived areas might indicate improved health outcomes, as other health outcome indicators have remained relatively worse in deprived areas, it probably indicates poorer access in these areas.[35]

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[31] Health and Social Wellbeing Improvement, Public Health Agency, Highlighting the dangers of emerging drugs, http://www.publichealth.hscni.net/directorate-public-health/health-and-social-wellbeing-improvement/highlighting-dangers-emerging-drug

[32] Health and Social Wellbeing Improvement, Public Health Agency, Averting an alcohol crisis, http://www.publichealth.hscni.net/directorate-public-health/health-and-social-wellbeing-improvement/averting-alcohol-crisis

[33] NI Health and Social Care Inequalities Monitoring System, Third Update Bulletin 2009, DHSSPS, Project Support Analysis Branch, Information Analysis Directorate, Introduction and Methodology, page 1, http://www.northernireland.gov.uk/news/news-dhssps/news-dhssps-october-2009/news-dhssps-29102009-third-update-bulletin.htm

[34] 'The period' referred to varies for the indicator being considered and is that defined in Table 1.2 of the NI Health and Social Care Inequalities Monitoring System, Third Update Bulletin 2009, http://www.northernireland.gov.uk/news/news-dhssps/news-dhssps-october-2009/news-dhssps-29102009-third-update-bulletin.htm

[35] NI Health and Social Care Inequalities Monitoring System, Third Update Bulletin 2009, DHSSPS, Project Support Analysis Branch, Information Analysis Directorate, Executive Summary, http://www.northernireland.gov.uk/news/news-dhssps/news-dhssps-october-2009/news-dhssps-29102009-third-update-bulletin.htm

There have also been improvements in the inequality gaps for self-harm admissions, smoking during pregnancy, breastfeeding on discharge from hospital and dental registrations, however, the health gaps in a number of these areas still remain large.[36]

Male and female life expectancy were 4.4 years and 2.6 years lower in deprived areas compared to NI overall.

The most sizeable inequality gaps between deprived areas and NI overall were in[37]:

Alcohol-related deaths (121% higher) – the alcohol-related death rate rose by around 10% between 2005 and 2008 across NI as a whole, despite some minor fluctuations in the gap, the deprived death rate has remained around 120% higher than the NI rate;

Drug-related deaths (113% higher) – Although the number of such deaths is relatively low, the standardised death rate increased steeply (by almost 40%) across NI between 2005 and 2008 and the rate in deprived areas was consistently more than twice the NI rate during the period;

Admissions for self-harm (94% higher) – although the standardised admission rate for self-harm has improved in deprived areas over recent years it still remains almost twice that in NI overall (inequality gaps for male and female in 2008/09 stood at 117% and 76%);

Teenage births (80% higher) – the teenage birth rate to girls aged under 20 dropped in both deprived areas and NI generally, with a larger decrease in deprived areas which led to an inequality gap decrease from 92% in 2001 to 80% in 2008;

Suicide (73% higher) – Since 2005 the number of registered suicides has grown substantially in NI as a whole, between 2001 and 2005 the gap between deprived areas and NI narrowed from 65% to 39% but since then the gap has risen again to 73% higher in 2008;

Respiratory death rates (66% higher) – Although respiratory mortality in deprived areas fell by 28% from 2001 to 2008, the gap between the deprived rate and NI as a whole rose from 58% to 66% with some evidence of a levelling off since then; and

Lung cancer incidence (65% higher) –the difference in lung cancer incidence rates as a whole has narrowed from being 81% higher in 1999 to 65% higher in 2006. The

[36] NI Health and Social Care Inequalities Monitoring System, Third Update Bulletin 2009, DHSSPS, Project Support Analysis Branch, Information Analysis Directorate, Executive Summary, http://www.northernireland.gov.uk/news/news-dhssps/news-dhssps-october-2009/news-dhssps-29102009-third-update-bulletin.htm

[37] NI Health and Social Care Inequalities Monitoring System, Third Update Bulletin 2009, DHSSPS, Project Support Analysis Branch, Information Analysis Directorate, Executive Summary and pages 4-11 http://www.northernireland.gov.uk/news/news-dhssps/news-dhssps-october-2009/news-dhssps-29102009-third-update-bulletin.htm

female lung cancer rate in deprived areas was 76% higher than in NI and the male rate was 58% higher.

With regard to rural areas, the bulletin shows that health outcomes in rural areas tend to be better than in Northern Ireland as a whole and this is most evident in[38]:

Drug related deaths (49% lower in rural areas);

Admissions to hospital for self-harm (47% lower);

Alcohol-related mortality (45% lower); and

Teenage births (41% lower).

Life expectancy in rural areas was 1.3 and 0.6 years higher for males and females respectively than in NI generally.

There has been a relative narrowing of the gap for all cancer incidence rates. In 1999 the cancer incidence was 13% lower in rural areas than in NI as a whole but due to incidence rising faster in rural areas than in NI generally the gap stood at 9% in 2006.

Conversely, rural areas fared worse than NI overall for ambulance response times (almost double the regional average) - as the improvement in response times in rural areas has been modest compared to overall regional improvement, meaning that rural response times have increased relatively from being 67% higher than NI generally, to being 95% higher than NI generally.

Over the period 2001/02 to 2008/09 elective hospital admissions increased by 42% in rural areas compared to 22% increase across NI generally. Given the better health observed in rural areas this relative increase probably represents decreasing access to elective care within urban areas.[39]

With regard to specific HSC Trusts, the report entitled *NI Health and Social Care Inequalities Monitoring System, Sub-regional Inequalities – HSC Trusts 2010*, outlines the subregional inequality gaps between the health outcomes experienced in the most deprived areas of each HSC Trust and the HSC Trust as a whole. Health outcomes were generally worse in the most deprived areas within a Trust than the overall Trust itself. The Executive Summary from the subregional report is included in its entirety in Appendix 1.

[38] NI Health and Social Care Inequalities Monitoring System, Third Update Bulletin 2009, DHSSPS, Project Support Analysis Branch, Information Analysis Directorate, Executive Summary and pages 14-20 http://www.northernireland.gov.uk/news/news-dhssps/news-dhssps-october-2009/news-dhssps-29102009-third-update-bulletin.htm

[39] NI Health and Social Care Inequalities Monitoring System, Third Update Bulletin 2009, DHSSPS, Project Support Analysis Branch, Information Analysis Directorate, Executive Summary and pages 14-20 http://www.northernireland.gov.uk/news/news-dhssps/news-dhssps-october-2009/news-dhssps-29102009-third-update-bulletin.htm

4. Review of Investing for Health – Outcomes/Impact and Emerging Themes

The *Investing for Health Strategy Review, Final Report* was published in September 2010.[40] Subsequent to the Review of the Strategy, and as stated in the introduction, *Investing for Health* (IFH) is to be succeeded by a new ten year public health strategy which is in development and will be launched in 2012.

The original IFH Strategy was published in 2002 and contained two wide ranging goals and seven objectives. The two goals sought to improve the health of people and to reduce inequalities in health through the achievement of the seven objectives that focused on the wider determinants of health including poverty; education; the environment; reducing deaths and injuries from accidents; promoting positive mental health and well-being; and encouraging people to make healthy choices. Priority was given to initiatives which would also help to reduce inequalities in health.

Given the cross-Departmental nature of IFH, structures were established to support its delivery both across Departments and at a local level. Following reform of health and social care structures the functions and responsibility for all IFH Partnerships and the four Health Action Zones was transferred to the PHA in April 2009.

The DHSSPS allocated £2.5-2.9m per annum between 2002-03 and 2008-09 for the operation of the *Investing for Health Partnerships* and the delivery of local actions plans. The Partnerships also successfully levered in funds from other organisations.[41]

The Review noted that since the publication of IFH, a considerable amount of evidence has emerged to support the rationale for tackling the social determinants of health as the key to addressing health inequalities and improving outcomes for society as a whole. These societal influences, such as early childhood care, education, employment and working conditions, access to health services, housing, income, social exclusion and unemployment, all impact on health. It is envisaged that this increased emphasis on the social determinants of health will enhance the traditional public health focus on disease prevention and behavioural risk factors. Early childhood interventions are now seen as a particularly important area that can help reduce societal inequalities rooted in poverty.[42]

With regard to the effectiveness of Investing for Health, the Review highlighted that improvements had been made to the levels of life expectancy in Northern Ireland since

[40] *Investing for Health Strategy Review, Final Report*, FGS McClure Watters, September 2010, http://www.dhsspsni.gov.uk/health_development-final_report_-_september_2010.pdf
[41] *Investing for Health Strategy Review, Final Report*, FGS McClure Watters, September 2010, paragraph 2.1, http://www.dhsspsni.gov.uk/health_development-final_report_-_september_2010.pdf
[42] *Investing for Health Strategy Review, Final Report*, FGS McClure Watters, September 2010, paragraph 2.2.6, http://www.dhsspsni.gov.uk/health_development-final_report_-_september_2010.pdf

2002 and in addition, significant progress had been made towards achieving the 14 targets set out in IFH.

Three of the four targets set to be achieved by 2004 were achieved within the timescale. Of the 10 targets to be achieved by 2010, two were on track to be achieved, four were not on track to being achieved and four were not directly comparable to the baseline as the method of recording data had changed since 2002. The targets set were considered to be challenging so the Review concluded that IFH had achieved a considerable amount in many areas in a relatively short time scale, while challenges remained in relation to health inequalities.[43]

Five of the targets were impact targets with short timescales[44]:

The target to reduce the percentage of pupils who achieve no GCSEs in the 25% of secondary schools with the highest percentage FSME[45] from 8.5% to 5% by 2005-06 was successfully achieved.

The target set for the percentage of children achieving the expected level in Key Stage 2 English and Maths was not met by 2005-06, although improvements were made compared to the baseline figures;

The target to reduce the level of fuel poverty by 2004 was achieved.

The target on the number new dwelling starts by housing associations fell short of the target by a small amount (239 new dwelling starts).

The target to reduce the concentrations of the seven main air pollutants by 2005 was not achieved. The margin by which it failed was small and considerable improvements had been made over the time period.

The outcome targets with longer timescales looked likely, at the date of publishing of the Review, to have varied levels of success[46]:

The target to increase life expectancy for men 77.5 years and for women to 82.6 years, was on track to being met by 2010 if the trends in improvements continued;

The target to reduce the proportion of people with a potential psychiatric disorder to 19% by 2010 was on track to be achieved, based on data for 2006;

The level of obesity was unlikely to be reduced below the baseline figures by 2010. However, the Review noted that the rise in obesity levels is a global problem;

[43] *Investing for Health Strategy Review, Final Report*, FGS McClure Watters, September 2010, paragraph 2.5.4, http://www.dhsspsni.gov.uk/health_development-final_report_-_september_2010.pdf
[44] *Investing for Health Strategy Review, Final Report*, FGS McClure Watters, September 2010, paragraph 2.4.1, http://www.dhsspsni.gov.uk/health_development-final_report_-_september_2010.pdf
[45] FSME – Free school meal entitlement
[46] *Investing for Health Strategy Review, Final Report*, FGS McClure Watters, September 2010, paragraph 2.4.1, http://www.dhsspsni.gov.uk/health_development-final_report_-_september_2010.pdf

The gap in life expectancy between the most deprived areas and the Northern Ireland average at 1998-00 was 3.1 years for men and 2.5 years for women. It was predicted to be to 3.6 years for men and 2.2 years for women in 2009-11, suggesting that gaps in life expectancy are forecast to narrow for women but widen for men (the actual figures, already mentioned above, published by the HSCIMS third update bulletin (2009) were 4.4 years for men and 2.6 years for women)

In 2003, the proportion of children living in low income households (after housing costs) was 26%. In 2009, this proportion remained unchanged at 26%.

The Review analysis at a Departmental level highlighted that a significant number of areas only started to progress from 2006. There had also been a significant level of strategy and policy work in 2009 which had not had time to work through into outputs or impacts at the time of the Review. The Review noted that Departments had a strong focus on reporting activities rather than achievements or outcomes.[47]

In summary, the causes of health inequalities are complex but it is known that they are strongly driven by the social, economic and environmental conditions in which people live and work. These conditions are known as the social determinants of health.[48] Alongside these determinants, many of the key health behaviours significant to the development of chronic disease follow the social gradient, for example, smoking, obesity, lack of physical activity, poor nutrition, abuse of drugs and alcohol; along with other factors such as mental illness, low breastfeeding rates and poor oral and sexual health.[49]

In NI the overarching policy driver in this area is *Investing for Health* and it is to be succeeded by a new ten year public health strategy to be launched in 2012. It will be a cross-government, outcome-based strategic framework and will take account of social, economic and legislative changes since the previous strategy was written. It will continue to focus on improving the overall health and well-being of the NI population whilst aiming to reduce evident health inequalities. This briefing has aimed to give an overview of how health inequalities are being monitored and measured in NI; how the

[47] *Investing for Health Strategy Review, Final Report*, FGS McClure Watters, September 2010, paragraph 2.4.1, http://www.dhsspsni.gov.uk/health_development-final_report_-_september_2010.pdf
[48] Social Determinants and Health Inequalities, Institute of Public Health in Ireland, www.publichealth.ie/service/social-determinants-health-inequalities
[49] Make Healthier Choices Easier, HSC Public Health Agency, http://www.publichealth.hscni.net/directorate-public-health/health-and-social-wellbeing-improvement/make-healthier-choices-easier

current *Investing for Health* Strategy has performed over the past decade; and the DHSSPS strategies to tackle some of the key lifestyle areas and related activities of the PHA.

Appendix 1 - NI Health and Social Care Inequalities Monitoring System, Sub-regional Inequalities – HSC Trusts 2010, Executive Summary

Health outcomes were generally worse in the most deprived areas within a Trust than the overall Trust area itself.

Belfast HSC Trust

- The largest subregional inequality gaps between the health outcomes experienced in the most deprived areas in Belfast Trust and the Trust itself occurred in alcohol related mortality (103%), self-harm admissions to hospital (96%) and teenage birth rates (93%).
- In addition, there were still other relatively large inequality gaps cross many areas (14 of all 33 indicators examined for the Belfast Trust showed gaps of 40% or greater).
- More encouragingly, gaps were relatively small for mood and anxiety disorders, cancer incidence, elective admissions (although this might be an indication of worsening access in the most deprived areas) and infant mortality rates.
- There were a number of noticeable improvements over recent years in the gaps that existed in Belfast Trust – the size of the infant mortality, hospital admission rates (all, emergency and elective), cancer mortality, cancer incidence, mood and anxiety disorders and dental registration rates inequality gaps all declined.
- Conversely some inequality gaps widened over time, most notably for male life expectancy, respiratory mortality, self-harm admissions, smoking during pregnancy and breastfeeding on discharge from hospital.

Northern HSC Trust

- The largest inequality gaps in the Northern Trust occurred in teenage births (86%), alcohol related deaths (76%) and admission rates to hospital for self-harm (67%).
- Of the 33 health indicators analysed, 7 showed relatively large gaps (i.e. greater than 40% in magnitude) between the 20% most deprived areas in the Northern Trust and the Trust itself.
- More than two-thirds of the health indicators analysed showed only relatively small inequality gaps (i.e. less than 20% in magnitude).
- There were improvements in most of the Northern Trust inequality gaps over time, for instance, the gaps for infant mortality and cancer mortality virtually disappeared.

However the relative gaps for male life expectancy, lung cancer incidence, ambulance response times and mood and anxiety disorders all remained fairly consistent over time, while the gaps for suicide and teenage births both increased over the period under review.

South-Eastern HSC Trust

The largest health inequality gap occurred in alcohol related mortality where the death rate in the most deprived South Eastern Trust areas was almost double (98% higher) that in the wider Trust.

There were also large differences in health outcomes for teenage births (77%) and smoking during pregnancy (75%).

In all, 6 of the 33 indicators analysed showed relatively large inequality gaps (of greater than 40%). Conversely 20 indicators had relatively small gaps of less than 20% in magnitude with the smallest gaps occurring in outcomes for life expectancy (for bo*th males and females), mood and* anxiety disorders, cancer incidence, elective admission rates and childhood immunisation.

For most of the indicators, the inequality gap in the South Eastern Trust area remained broadly constant over time. However there were improvements in the gaps for infant mortality, hospital admission rates (all admissions, emergency admissions, circulatory disease and self-harm), cancer mortality, smoking during pregnancy and breastfeeding on discharge from hospital.

Gaps for teenage births and amenable mortality actually increased over the period.

Southern HSC Trust

The largest inequality gaps in the Southern Trust area occurred in alcohol related mortality (94%), self-harm admissions (68%) and smoking during pregnancy (64%).

Overall 6 of the 33 indicators analysed in this report showed relatively large inequality gaps of 40% or more whereas two-thirds of the indicators showed relatively small gaps (i.e. less than 20% in magnitude).

Over time notable improvements in Trust inequality gaps within the Southern Trust Area occurred in teenage births, suicide and self-harm admissions to hospital. In fact, most of the inequality gaps improved with the exception of female life expectancy, cancer incidence, hospital admissions for circulatory disease, smoking during pregnancy, smoking related mortality and dental registrations which remained fairly constant.

Gaps widened for circulatory deaths, alcohol related deaths, amenable deaths and

ambulance response times.

Western HSC Trust

The largest Western Trust inequality gaps occurred in alcohol related mortality (112%) and self-harm admissions (89%), teenage births (76%) and smoking during pregnancy (71%).

Overall 7 of the 33 indicators had gaps of 40% or greater. Irrespective of the direction, gaps in 19 of the indicators were of a magnitude of less than 20%.

Within the Western Trust, there was a narrowing of the gaps for most of the indicators over time. The most notable reduction (proportional terms) in Trust inequality gaps occurred for circulatory admissions, cancer mortality and lung cancer incidence.

The gaps for male life expectancy, elective hospital admissions and alcohol related mortality all remained broadly similar, while those for ambulance response *times and suicide widened over* their respective periods.

Health Inequalities in Northern Ireland by Constituency

1 Introduction

This Briefing Paper reviews the available evidence on health inequalities in Northern Ireland by Assembly Area / Parliamentary Constituency. The paper begins with a brief analysis of the Northern Ireland Multiple Deprivation Measure (NIMDM), a suite of indicators which reflect inequalities in areas such as health. This is followed by an examination of 11 key health indicators at constituency level.

2 Key Details

- There is a well-established association between deprivation and ill-health. Analysis of the Northern Ireland Multiple Deprivation Measure (NIMDM) 2010 by constituency reveals that Belfast West, Belfast North and Foyle are the most deprived constituencies, while North Down, Strangford and South Antrim are the least deprived.
- In general, multiple deprivation tends to be more intense in the urban constituencies of Belfast and Derry / Londonderry than in rural constituencies. This is also true of health inequalities.
- In terms of health, life expectancy is lowest in three Belfast constituencies (West, North and East) and highest in Lagan Valley, North Down and South Down. The gap between Belfast West and Lagan Valley is 6.6 years for males and 3.7 for females.
- In 2010, Belfast West had the highest percentage of teenage births (8.5 per 100 live births), followed by Belfast North (8.4) and East Londonderry (7.1). North Down, Mid-Ulster (3.1) and Fermanagh and South Tyrone (2.9) had the lowest percentage.
- Belfast North and Belfast West had the highest rates for self-harm, and were nearly twice as likely to present to hospital than the Northern Ireland average. Conversely, residents of North Antrim, Lagan Valley and East Londonderry were around half as likely to self-harm as the Northern Ireland average.
- Belfast East had the highest suicide rate (25.4 per 100,000 population), followed by Belfast North (24.7) and Foyle (24.3). Fermanagh and South Tyrone (12.5), East Antrim (10.1) and Mid-Ulster (9.2) had the lowest rates.
- Belfast West had the highest proportion of individuals (14.0%) using prescribed medication for mood and anxiety disorders, followed by Belfast North (13.8%) and Foyle / Belfast East (12.8%).
- GP list sizes are largest in the rural constituencies, particularly in the West of Northern Ireland, and smallest in the urban constituencies of Belfast and Derry / Londonderry.
- Alcohol-related mortality was significantly higher in the urban constituencies of Belfast North, Belfast West and Foyle than in rural constituencies.
- Belfast West, Belfast North and Foyle have the highest standardised death rates for all three main causes of death (i.e. cancer, circulatory and respiratory diseases).

- Belfast West (24.0%) has the highest percentage of disability benefit recipients, followed by Belfast North (20.9%) and West Tyrone (18.8%).

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3 Multiple Deprivation and Urban / Rural differences

As there is a well-established association between health inequality and multiple deprivation [50], it is helpful to begin by reviewing the overall extent of multiple deprivation by constituency.

Table 1 presents the overall Multiple Deprivation 2010 rank for each of the 18 Assembly Areas in Northern Ireland [51]. The table shows that Belfast West, Belfast North and Foyle are the most deprived constituencies while North Down is the least deprived [52].

Table 1: Multiple Deprivation by Constituency

AA NAME	Extent [53] (%)	Multiple Deprivation Rank (1 = most deprived)
Belfast West	76	1
Belfast North	59	2
Foyle	43	3
West Tyrone	23	4
Belfast South	20	5
Belfast East	19	6
Upper Bann	18	7
Newry and Armagh	17	8
East Londonderry	14	9

[50] A series of official reports, beginning with the Black Report (1980), Acheson Report (1998) and Marmot Review (2010), have identified a social class gradient in health. In general, persons in the higher social classes typically live longer and enjoy better health than those from the lower social classes. Class can be considered a proxy for poverty and deprivation.

[51] The Northern Ireland Multiple Deprivation Measure (NIMDM) 2010 identifies small area concentrations of multiple deprivation across Northern Ireland. The NIMDM 2010 is constructed from 52 different indicators relating to seven types or 'domains' of deprivation, namely: Income, Employment, Health, Education, Proximity to Services, Living Environment and Crime and Disorder. See NISRA (2010) Northern Ireland Multiple Deprivation Measure 2010: Assembly Area Profiles. Available at: http://www.nisra.gov.uk/deprivation/archive/Updateof2005Measures/NIMDM_2010_Assembly_Area_Profiles.pdf

[52] When reading the table it is important to note that the NIMDM 2010 rank at Assembly Area level is a summary indicator. This obscures the fact that the degree of multiple deprivation will often vary widely within a constituency. In Belfast East, for example, the Stormont 2 Super Output Area (SOA) is ranked 889 (out of 890), while Ballymacarrett 3 SOA is raked 23rd.

[53] "Extent" measures the percentage of the Assembly Area population living within the 30 per cent most deprived SOAs in Northern Ireland (out of 890). All of the people living in the 10 per cent most deprived SOAs are included, plus a diminishing proportion of the population of those Super Output Areas in the next two 10 per cent bands.

East Antrim	10	10
North Antrim	9	11
Mid Ulster	9	12
South Down	7	13
Lagan Valley	7	14
South Antrim	5	15
Strangford	5	16
Fermanagh and South Tyrone	5	17
North Down	3	18
Northern Ireland	**18**	

In general, Table 1 also reveals that multiple deprivation tends to be more pronounced in urban constituencies (such as Belfast and Derry/Londonderry) than in rural constituencies. This is also true of health inequalities.

According to the Northern Ireland Health and Social Care Monitoring System (2009), health outcomes in rural areas generally tend to be much better than in Northern Ireland overall [54]. In the 2009 update, it was found that:

- drug related deaths were 49 per cent lower in rural areas, admissions to hospital for self-harm (47% lower), alcohol related mortality (45% lower), and teenage births (41% lower).
- Life expectancy in rural areas was 1.3 and 0.6 years higher for males and females respectively than in Northern Ireland generally.
- Rural areas also had considerably lower mortality due to respiratory disease and lung cancer incidence than that experienced in the wider region, as well as a lower proportion of mothers that smoked during pregnancy.
- Conversely, rural areas fared worse than Northern Ireland overall for ambulance response time (which was almost double the regional average), and experienced higher elective hospital admissions and hospital admissions for circulatory disease.

[54] DHSSPS (2009) **Health and Social Care Inequalities Monitoring System, Third Update Bulletin 2009**. Available at http://www.dhsspsni.gov.uk/inequalities_monitoring_update3.pdf

In general, while health inequalities are not as pronounced as the observed differences between deprived areas and Northern Ireland, there are noticeable rural differences for many of the indicators.

4 Health Inequalities by Constituency

Having outlined some general points relating to health inequalities, this section will examine those inequalities in more detail.

4.1 Life Expectancy

Life expectancy refers to the expected years of life at birth based on the mortality rates of the period in question. Table 2 presents life expectancy data by Assembly Area for the period 2007 – 2009 [55]. Life expectancy values for Northern Ireland as a whole are 76.8 years for males and 81.4 for females.

The table shows that life expectancy is lowest in three Belfast constituencies (West, North and East) and highest in Lagan Valley, North Down and South Down. In Belfast West, the life expectancy of males (72.3 years) is four and one half years less than the Northern Ireland average (76.8), while the life expectancy of females (78.4) is three years lower than the regional average (81.4). The gap between Belfast West and Lagan Valley (highest life expectancy) is 6.6 years for males and 3.7 for females.

Table 2: Life Expectancy by Constituency, 2007 – 2009

Assembly Area	Male	Female
Belfast West	72.3	78.4
Belfast North	73.0	79.5
Belfast East	75.2	80.4
Foyle	75.2	80.4
Newry and Armagh	76.4	81.1
West Tyrone	76.5	81.2
Belfast South	76.6	81.4
Mid Ulster	76.9	82.3
Fermanagh & South Tyrone	76.9	81.8
Upper Bann	77.3	82.6

[55] NINIS (2011) **Life Expectancy 2007 – 2009**. Available at: http://www.ninis.nisra.gov.uk/mapxtreme/viewdata/Health_and_Care/Health/Life_Expectancy/Life_Expectancy_2007-2009.xls

East Antrim	77.7	81.2
East Londonderry	77.9	83.0
Strangford	78.2	83.1
North Antrim	78.2	82.4
South Antrim	78.4	82.8
South Down	78.5	82.1
North Down	78.5	81.5
Lagan Valley	78.9	82.1
Northern Ireland	**76.8**	**81.4**

4.2 Births to Teenage Mothers

Table 3 presents the number of births to teenage mothers (aged 13 – 19) by constituency in 2010. In Northern Ireland as a whole, there were 1,265 such births, representing 5 per cent of all live births [56].

The table shows that Belfast West had the highest percentage of teenage births (8.5 per 100 live births), followed by Belfast North (8.4) and East Londonderry (7.1). North Down, Mid-Ulster (3.1) and Fermanagh and South Tyrone (2.9) had the lowest percentage.

Taken together, four constituencies (Belfast West, Belfast North, East Londonderry and Foyle) accounted for over a third (35.2%) of all teenage births during 2010.

Provisional figures for 2011 (published in April 2012) show that the number of teenage births has fallen to 1,170 (4.6% of all live births) – the lowest number in the past 35 years [57].

Table 3: Births to Teenage Mothers by Assembly Area 2010

Assembly Area	All Births 2010	Number of births to Teenage Mothers 2010	Per cent

[56] NISRA / NINIS (2011) **Births 2010**. Available at: http://www.ninis.nisra.gov.uk/mapxtreme/viewdata/Population_and_Migration/Population/Births/Births_2010.xls

[57] NISRA (2012) **Statistical Bulletin: Births in Northern Ireland 2011**. Available at: http://www.nisra.gov.uk/archive/demography/publications/births_deaths/births_2011.pdf

Belfast West	1,533	130	8.5
Belfast North	1,575	133	8.4
East Londonderry	1,217	87	7.1
Foyle	1,462	95	6.5
Belfast East	1,221	79	6.5
Upper Bann	1,915	101	5.3
South Antrim	1,409	73	5.2
East Antrim	1,050	54	5.1
Strangford	995	47	4.7
Belfast South	1,321	62	4.7
South Down	1,647	65	3.9
Lagan Valley	1,401	55	3.9
Newry and Armagh	1,781	65	3.6
North Antrim	1,361	49	3.6
West Tyrone	1,283	44	3.4
North Down	1,049	33	3.1
Mid Ulster	1,562	48	3.1
Fermanagh and South Tyrone	1,533	45	2.9
Northern Ireland	**25,315**	**1,265**	**5.0**

4.3 Hospital Admissions for Self-harm

Since 2004 – 05 there has been an average of around 4,700 admissions to hospital for self-harm each year, of which females account for approximately 54 per cent [58]. The Standardised Admission Ratio [59] for self-harm has improved relatively in deprived areas over recent years but still remains almost twice that of Northern Ireland overall.

[58] DHSSPS (2009) *Op. cit.*

[59] **Standardised Admission Ratio** (SAR) is a measure of how much more (or less) likely an individual is to be admitted to an acute hospital in a geographic area compared with the Northern Ireland average, having taken into account the area's age and gender profile. For example, in Table 4 the SAR for Northern Ireland is set as a baseline (100), while the SAR for Upper Bann is 137. This means that a resident of Upper Bann is 37 per cent more likely to be admitted to a local hospital for self-harming compared with Northern Ireland overall.

Table 4 presents data on hospital admissions for self-harm over the complete five year period, 2004/2005 – 2008/09 [60]. The table shows that residents of Belfast North and Belfast West had the highest rates over the five-year period, and were nearly twice as likely to present to hospital for self-harm as the Northern Ireland average. Conversely, residents of North Antrim, Lagan Valley and East Londonderry were around half as likely to self-harm as Northern Ireland overall.

Table 4: Standardised Admission Ratios for Self-harm, 2004/-5 – 2008/09

Assembly Area	Standardised Admissions Ratio Male	Standardised Admissions Ratio Female	Standardised Admissions Ratio All Persons
Belfast North	208	170	187
Belfast West	192	180	185
Upper Bann	145	130	137
Belfast East	123	138	131
Foyle	126	113	119
Belfast South	107	93	99
South Down	96	96	96
Newry and Armagh	93	93	93
North Down	77	102	90
Strangford	79	96	88
West Tyrone	74	87	80
Mid Ulster	76	77	77
Fermanagh and South Tyrone	73	77	75
East Antrim	68	73	70
South Antrim	68	70	69
North Antrim	66	65	65
Lagan Valley	64	66	65
East Londonderry	57	58	58

[60] Personal Communication (2012) **Self-harm Admissions by Westminster Parliamentary Constituency, 2004/5 – 2008/9.** Project Support Analysis Branch, DHSSPS, 2 May 2012

Northern Ireland	**100**	**100**	**100**

4.4 Suicide Rates

Since 2005, the number of suicides registered in Northern Ireland has grown substantially, from 213 to 313 in 2010, an increase of 47 per cent[61]. This has meant that the crude suicide rates in both deprived areas and Northern Ireland as a whole have also risen sharply.

Table 5 presents the latest published suicide data by Assembly Area (2010) [62]. The crude suicide rate for Northern Ireland as a whole was 17.4 per 100,000 population. The table shows that Belfast East had the highest rate (25.4), followed by Belfast North (24.7) and Foyle (24.3). Fermanagh and South Tyrone (12.5), East Antrim (10.1) and Mid-Ulster (9.2) had the lowest rates.

Table 5: Deaths from Suicide and Suicide Rates, 2010

Assembly Area	Deaths from suicide and undetermined intent 2010	Crude Suicide Rate per 100,000 pop
Belfast East	23	25.4
Belfast North	25	24.7
Foyle	25	24.3
Lagan Valley	23	22.9
Belfast West	20	22.0
East Londonderry	19	19.5
Belfast South	20	19.3
North Antrim	20	18.7
South Down	20	18.2
Strangford	16	17.7
North Down	13	14.4

[61] NINIS (2007) **Death by suicide and undetermined intent 2005**. Available at: http://www.ninis.nisra.gov.uk/mapxtreme/viewdata/Health_and_Care/Health/Deaths_By_Cause/Deaths_by_Suicide_Undetermined_Intent_2005.xls

[62] [62] NINIS (2011) **Death by suicide and undetermined intent 2010**. Available at: http://www.ninis.nisra.gov.uk/mapxtreme/viewdata/Health_and_Care/Health/Deaths_By_Cause/Deaths_by_Suicide_Undetermined_Intent_2010.xls

Upper Bann	17	14.4
Newry and Armagh	16	14.1
South Antrim	13	13.1
West Tyrone	12	12.9
Fermanagh and South Tyrone	13	12.5
East Antrim	9	10.1
Mid Ulster	9	9.2
Northern Ireland	**313**	17.4

4.5 Mood and Anxiety Disorders

The number of individuals suffering from mood or anxiety disorders in Northern Ireland can be estimated using prescription data by GP practice for anxiolytic and anti-depressant drugs. This data is then attributed to geographical area using the GP practice list.

Table 6 presents an estimate of the percentage of the population in each Assembly Area in April 2009 [63] who were receiving prescribed drugs for mood and anxiety disorders.

Table 6: Estimated Percentage of Population with Mood and Anxiety Disorders , April 2009

Assembly Areas	Per cent on Prescribed Drugs for Mood and Anxiety Disorders
Belfast West	14.0%
Belfast North	13.8%
Foyle	12.8%
Belfast East	12.8%
Upper Bann	11.9%
East Londonderry	11.1%
North Antrim	10.9%

[63] Personal Communication (2012) **Mood and Anxiety Disorders by Westminster Parliamentary Constituency, April 2009.** Project Support Analysis Branch, DHSSPS, 2 May 2012. Mood and Anxiety drugs are identified using the British National Formulary (BNF) codes 4.1.2 and 4.

East Antrim	10.7%
South Antrim	10.7%
West Tyrone	10.6%
South Down	10.4%
Strangford	10.3%
Mid Ulster	10.2%
Belfast South	10.1%
North Down	10.0%
Newry and Armagh	9.9%
Lagan Valley	9.8%
Fermanagh and South Tyrone	9.3%
Northern Ireland	**11.1%**

The table shows that Belfast West had the highest proportion of individuals (14.0%) using prescribed medication for mood and anxiety disorders, followed by Belfast North (13.8%) and Foyle / Belfast East (12.8%). Newry and Armagh (9.9%), Lagan Valley (9.8%) and Fermanagh and South Tyrone (9.3%) had the lowest proportion. In Northern Ireland as a whole, an estimated one-in-nine (11.1%) of the population were using anti-anxiety and anti-depressant drugs in 2009.

4.6 General Practitioners (GPs)

Table 7 presents data on the number of GPs and the average list size by Assembly Area in April 2011 [64]. The table shows that GP list sizes are largest in the rural constituencies, particularly in the West of Northern Ireland, and smallest in the urban constituencies of Belfast and Derry / Londonderry. A notable exception is North Antrim, which has the second smallest list size (1,461 patients per GP).

Table 7: Number of GPs and Average List Size , April 2011

Assembly Area	Number of	Number of	Average GP

[64] NINIS (2012) **Number of GPs 2011**. Available at: http://www.ninis.nisra.gov.uk/mapxtreme/viewdata/Health_and_Care/Health/GP_Numbers/Number_of_GPs_2011.xls

	GPs	Registered Patients	List Size
Mid Ulster	47	86,745	1,846
Upper Bann	71	130,352	1,836
West Tyrone	54	98,187	1,818
South Down	60	102,558	1,709
South Antrim	48	81,620	1,700
East Londonderry	59	99,687	1,690
Lagan Valley	52	87,744	1,687
Fermanagh and South Tyrone	72	120,886	1,679
North Down	53	86,310	1,628
Newry and Armagh	78	126,150	1,617
Belfast North	92	148,237	1,611
Strangford	50	78,879	1,578
East Antrim	46	72,469	1,575
Foyle	75	117,683	1,569
Belfast West	77	117,280	1,523
Belfast South	78	115,961	1,487
North Antrim	77	112,532	1,461
Belfast East	75	106,049	1,414
Northern Ireland	**1,164**	**1,889,329**	**1,623**

Source: Business Services Organisation (2011)

4.7 Alcohol-related Deaths

Alcohol-related deaths have been increasing in Northern Ireland since 2005 when mortality stood at 246. By 2010, crude deaths had risen to 284. Despite some minor fluctuations, death rates in deprived constituencies have been consistently higher than in less deprived areas.

Table 8 contains data on alcohol-related deaths by constituency for the full period 2001 – 2010 . A total of 2,533 persons died in Northern Ireland from alcohol-related causes during this period, a crude death rate of 14.6 per 100,000 population [65].

An examination of crude death rates during the full period reveals that alcohol-related mortality was significantly higher in the urban constituencies of Belfast North, Belfast West and Foyle than in rural constituencies. In Belfast North, for example, the death rate during this period (27.9) was almost twice the regional average and three times higher than the corresponding rate in Fermanagh and South Tyrone (9.2) [66].

Table 8: Alcohol-related Mortality by Constituency 2001 - 2010

Assembly Area	Total Alcohol-related Deaths 2001 - 2010	Crude Death Rate per 100,000 pop (2001 – 2010)
Belfast North	261	27.9
Belfast West	219	23.8
Foyle	187	20.2
Strangford	149	19.8
Belfast South	163	17.1
Belfast East	166	15.3
East Antrim	140	15.1
North Down	134	13.7
Newry and Armagh	128	12.9
North Antrim	116	12.7
South Down	118	11.6
East Londonderry	103	11.2
Upper Bann	119	10.9
West Tyrone	106	10.4
South Antrim	117	10.4

[65] The Crude Alcohol death rate per constituency is calculated by diving the total number of alcohol-related deaths (2001 – 2009) by the total population mid-year estimates (2001 – 2009), then multiplying by 100,000. For details of methodology, see DHSSPS (2009), page 1, *Op. Cit.*

[66] NINIS (2011) **Alcohol Related Deaths 2001 – 2010**. Available at: http://www.ninis.nisra.gov.uk/mapxtreme/viewdata/Health_and_Care/Health/Alcohol/Alcohol_Related_Deaths_2001-2010.xls

Mid Ulster	93	10.4
Lagan Valley	106	10.0
Fermanagh and South Tyrone	108	9.2
Northern Ireland	**2,533**	**14.6**

Source: General Registrar Office Death Files

4.8 Disease Prevalence

GP practices throughout Northern Ireland maintain clinical registers (lists of patients with various conditions) as part of the payments procedure under the Quality and Outcomes Framework (QOF) system.

Table 8 presents the most recent published data (31 March 2011) concerning prevalence rates (per 1,000 patients) for seven clinical areas. The prevalence rate for **chronic heart disease** (CHD) is highest in Belfast East (48), followed by East Antrim and North Down (46). Belfast South (32), Foyle and Newry and Armagh (33) have the lowest rates. The overall Northern Ireland rate is 40. For **chronic obstructive pulmonary disease** (COPD), often associated with smoking, the highest rates are found in Belfast North / Belfast West (23) and Foyle (20). The Northern Ireland prevalence rate is 17 per 1,000 patients.

North Down has the highest **cancer** prevalence rate (18), followed by Belfast East (17). The lowest rates are found in Foyle (12) and Belfast West / Mid-Ulster / Newry and Armagh (13). The Northern Ireland cancer rate is 14 per 1,000 patients. Prevalence rates for **mental health** are relatively high in Belfast East and Belfast South (10), with Strangford and Lagan Valley having the lowest rates (6).

Asthma prevalence rates are highest in East Antrim (69), Strangford (65) and Belfast West (64) and lowest in Fermanagh and South Tyrone (51), North Antrim / Newry and Armagh / and West Tyrone (55). The Northern Ireland rate is 59. **Obesity** rates (per 1,000 patients aged 16+) are highest in West Tyrone (142), East Londonderry (135) and East Antrim (131). Belfast South (84) and North Down (96) have the lowest rates. The overall Northern Ireland rate is 114.

Prevalence rates for **diabetes mellitus** are highest in East Antrim (59) and Belfast East (55), while the lowest rates can be found in Belfast South (40) and Mid-Ulster / Newry and Armagh (43). The Northern Ireland rate is 49 per 1,000 patients.

Table 9: Disease Prevalence Rates (per 1,000 patients) for Seven Clinical Areas by Constituency, 31 March 2011

Assembly Area	CHD Prevalence	COPD Prevalence	Cancer Prevalence	Mental Health Prevalence	Asthma Prevalence	Obesity Prevalence (per 1,000 patients aged 16+)	Diabetes Prevalence (per 1,000 patients aged 17+)
Belfast East	48	18	17	10	58	111	55
Belfast North	45	23	14	9	60	121	53
Belfast South	32	14	14	10	57	84	40
Belfast West	40	23	13	9	64	105	48
East Antrim	46	19	16	7	69	131	59
East Londonderry	39	16	14	8	57	135	53
Fermanagh and South Tyrone	37	16	15	8	51	116	49
Foyle	33	20	12	9	62	117	44
Lagan Valley	39	14	15	6	60	110	51
Mid Ulster	39	15	13	8	61	106	43
Newry and Armagh	33	14	13	9	55	108	43
North Antrim	42	17	15	7	55	122	51
North Down	46	14	18	7	59	96	48
South Antrim	38	15	14	8	60	108	50
South Down	38	14	14	8	63	112	49

Strangford	46	15	16	6	65	115	54
Upper Bann	39	15	15	7	56	113	48
West Tyrone	39	17	14	9	55	142	51
Northern Ireland	**40**	**17**	**14**	**8**	**59**	**114**	**49**

4.9 Standardised Death Rates (SDR)

The standardised death rate (SDR) is a crude death rate (per 100,000 population) that has been adjusted for differences in age composition between the local area (constituency) and a standard population. Standardisation enables robust comparisons to be made across constituencies.

Table 10 lists the standardised death rates by constituency (per 100,000 population) for those under 75 years in respect of cancer, circulatory and respiratory diseases during the five year period, 2005 – 2009 [67]. The table shows that, for the under-75s, the overall Northern Ireland SDRs were as follows: cancer (117 per 100,000), circulatory diseases (80) and respiratory disease (27).

Over the five-year period, Belfast West, Belfast North and Foyle had the highest standardised death rates for all three main causes of death (i.e. cancer, circulatory and respiratory diseases). For example, Belfast West had a standardised death rate for cancer of 168 per 100,000 compared with the overall Northern Ireland rate of 117.

At the other end of the scale, Lagan Valley, North Down and North Antrim (among others) had SDRs well below the respective Northern Ireland values.

[67] Cancer, all circulatory diseases, and all respiratory diseases remain the three largest causes of death in Northern Ireland, and accounted for 70 per cent of all deaths in 2011 (General Registrar Office).

Table 10: Standardised Death Rates for Under-75s (per 100,000 pop.) by Constituency, 2005 – 2009

Assembly Areas	Cancer			Circulatory Diseases			Respiratory Diseases		
	All	Male	Female	All	Male	Female	All	Male	Female
Belfast West	168	191	147	119	159	83	45	56	35
Belfast North	147	161	135	103	135	73	39	46	32
Foyle	134	135	131	100	134	65	42	45	39
Belfast East	122	145	101	81	109	56	30	35	24
Newry and Armagh	121	124	117	82	112	50	25	29	20
Upper Bann	121	129	112	81	103	58	25	30	19
East Antrim	118	127	108	76	98	53	27	26	28
Mid Ulster	116	118	112	80	103	53	17	16	17
South Antrim	114	125	100	68	88	46	26	26	26
West Tyrone	112	121	100	83	101	63	24	25	23
Fermanagh Sth. Tyrone	111	118	102	77	101	51	26	29	23
South Down	110	105	114	73	89	55	21	24	19
East Londonderry	109	110	108	73	95	50	20	19	21
Belfast South	108	123	95	71	91	52	23	27	20
Strangford	106	118	92	72	93	50	25	23	26
North Antrim	102	108	95	74	97	51	22	26	18
Lagan Valley	99	107	90	62	73	51	22	25	19
North Down	99	100	98	67	87	47	24	26	21
Northern Ireland	**117**	**125**	**108**	**80**	**103**	**56**	**27**	**29**	**24**

Note: cells with red borders indicate constituencies with either the highest or lowest values.

4.10 Standardised Mortality Ratio (SMR)

The Standardised Mortality Ratio (SMR) for the under-75s, which is based on five years data (2005-2009), is a measure of how much more or less likely a person aged under 75 is to die in a constituency compared with the Northern Ireland average, having taken account of the area's age and gender profile.

Local mortality rates can vary for many reasons, such as deprivation, health behaviours, or the socio-economic make up of the local population. These local factors can vary from the Northern Ireland picture and thus influence overall mortality rates.

Table 11 shows the SMR (provisional) for all deaths by constituency and gender over the period 2005 – 2009 [68]. Belfast West had the largest SMR (149) in the under-75s, with mortality levels 49 per cent higher than the overall Northern Ireland level (100). Belfast North (132) and Foyle (123) also had SMRs which were substantially higher than the Northern Ireland average.

Table 11: Standardised Mortality Ratio by Constituency and Gender, 2005 - 2009

Assembly Area	Under 75 SMR (All deaths)		
	Male	Female	All
Belfast West	156	140	149
Belfast North	134	128	132
Foyle	122	126	123
Newry and Armagh	107	101	105
Belfast East	110	94	103
Fermanagh and South Tyrone	102	96	100
West Tyrone	99	99	99
Mid Ulster	97	96	97
East Antrim	93	101	96
Upper Bann	94	97	95
Belfast South	95	90	93
East Londonderry	90	94	92

[68] Personal Communication (2012) **Standardised Mortality Ratios by Constituency and Gender, 2005 – 2009.** Project Support Analysis Branch, DHSSPS, 4 May 2012.

South Antrim	88	95	91
South Down	83	101	90
Strangford	91	89	90
North Antrim	89	85	88
North Down	82	86	84
Lagan Valley	80	86	82
Northern Ireland	**100**	**100**	**100**

In contrast, the constituencies of North Antrim, North Down and Lagan Valley had the lowest SMRs. Lagan Valley, for example, had a standardised death rate18 per cent lower than the Northern Ireland average.

4.11 Disability Benefits

One indicator of health inequality, is the number of persons in receipt of disability benefits. Table 12 presents data on those receiving one or more disability benefits as a proportion of the constituency population at February 2011[69].

Belfast West (24.0% of estimated resident population) has the highest percentage of disability benefit recipients, followed by Belfast North (20.9%) and West Tyrone (18.8%). The constituencies of Lagan Valley (12.4%), South Antrim (12.1%) and North Down (11.9%) had the lowest proportion [70].

[69] The range of disability benefits included is as follows: Attendance Allowance, Disability Living Allowance, Incapacity Benefit, Severe Disablement Allowance and Employment and Support Allowance. The estimated resident population of each constituency is drawn from the 2010 Mid-year population estimates.

[70] NINIS (2011). **Multiple Disability Benefit Recipients 2011**. Department for Social Development, February 2011. Available at: http://www.ninis.nisra.gov.uk/mapxtreme/viewdata/Social_and_Welfare/Social_Security/Multiple_Disability_Benefits_Recipients/MDB_Recip_2011.xls

Table 12: Per cent of population in receipt of one or more disability benefits by constituency, Feb 2011

Assembly Area	Per cent of Population
Belfast West	24.0
Belfast North	20.9
West Tyrone	18.8
Foyle	17.7
Mid Ulster	15.9
Upper Bann	15.8
Newry and Armagh	15.7
Belfast East	15.5
South Down	14.8
Fermanagh and South Tyrone	14.5
East Londonderry	14.2
North Antrim	13.2
East Antrim	13.1
Strangford	12.9
Belfast South	12.5
Lagan Valley	12.4
South Antrim	12.1
North Down	11.9
Northern Ireland	15.2

5 Summary

Section 3 showed that the constituencies of Belfast North, Belfast West and Foyle have high rates of multiple deprivation, while North Down, Lagan Valley, Strangford, South Antrim and Fermanagh and South Tyrone have considerably lower rates. A similar pattern emerged when health inequalities are examined.

A review of 11 health-related indicators in Section 4, which ranged from life expectancy to suicide rates, from the prevalence of mood and anxiety disorders to disability benefit uptake, shows that health inequalities are most pronounced in the urban constituencies of Belfast North, Belfast West and Foyle. With the exception of General Practitioner list size, the rural constituencies generally fare much better. This is particularly true of North Down, Lagan Valley, North Antrim, Strangford and Fermanagh and South Tyrone, where indicator rates are generally well below the regional average.

Northern Ireland Assembly

Research and Information Service
Briefing Paper

Paper 140/12 | 20th September 2012 | NIAR 542-12

Dr Janice Thompson

Health Inequalities – Review by Committee for HSSPS

1. Background

On 4 July 2012 the Committee held an evidence session with Public Health Agency on the issue of health inequalities. This revealed that although the general health of the population has been improving, the rate of improvement is not equal across the population and that health outcomes are worse in the most deprived areas of Northern Ireland than in the region generally. There are continuing large differences across various measures, for example – life expectancy, drug and alcohol related mortality, suicide, teenage pregnancy, respiratory and cancer mortality.

At that meeting the Committee agreed to undertake a short review to identify effective interventions to address health inequalities. The findings of the review would then be used to feed into the Department's consultation and continued development of the new DHSSPS 10-Year Public Health Strategy, *Fit and Well: Changing Lives 2012 – 2022*, which was published in August for public consultation until 31 October 2012.

RalSe had previously prepared two papers on the issue of health inequalities (which were included in the Committee pack for the meeting of 12th September 2012), entitled "*Health Inequalities in Northern Ireland*" and "*Health Inequalities in Northern Ireland by Constituency*". These provide useful background on the issue in Northern Ireland.

This paper has been prepared specifically in relation to the Committee's review and is to assist the Committee to identify on which areas of health inequalities it wishes to focus.

2. Introduction to Health Inequalities

The Institute of Public Health in Ireland (IPH) refers to health inequalities as:

> *Preventable and unjust differences in health status experienced by certain population groups. People in lower socio-economic groups are more likely to experience chronic ill-health and die earlier than those who are more advantaged.*[1]

The Marmot Review (2010) – *Strategic Review of Health Inequalities In England post-2010* - carried out by Sir Michael Marmot and his team at University College London (UCL), noted that inequalities in health arise because of inequalities in society,

> *In the conditions in which people are born, grow, live, work and age. So close is the link between particular social and economic features of society and the distribution of health among the population, that the magnitude of health inequalities is a good marker of progress towards creating a fairer society.*[2]

The causes of health inequalities are complex but are strongly driven by the social, economic and environmental conditions in which people live and work. These conditions are known as the **social determinants of health** and are thought to be largely the result of public policy.[3]

From birth, people are exposed to a wide range of social, economic, psychological and environmental experiences which change as they go through the different stages of life. Each of life's transitions can affect health. However, people who are disadvantaged are at greater risk. Disadvantages tend to congregate among the same people, accumulate through life and can be passed on from generation to generation.[4]

Prior to the Marmot Review the House of Commons Health Committee published its Health Inequalities Inquiry (2009) and found that although the health of all groups in England is improving, over the previous decade the "*health of the rich is improving*

[1] Social Determinants and Health Inequalities, Institute of Public Health in Ireland, www.publichealth.ie/service/social-determinants-health-inequalities

[2] Fair Society, Healthy Lives, The Marmot Review, Strategic Review of Health Inequalities in England post-2010, Executive Summary, page 10, http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review

[3] Social Determinants and Health Inequalities, Institute of Public Health in Ireland, www.publichealth.ie/service/social-determinants-health-inequalities

[4] The Annual Report of the Chief Medical Officer for the Northern Ireland 2010, Deprivation and health inequalities, page 5, http://www.dhsspsni.gov.uk/cmo-annual-report-2010.pdf

more quickly than that of the poor".[5] The Inquiry highlighted several reasons why the poorest in society are less likely to adopt beneficial health behaviours including[6]:

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

The Inquiry also highlighted that socioeconomic factors appear to go beyond the "*direct influence socio-economic circumstances may have on lifestyle as ….people from high socioeconomic classes who smoke live longer than those from lower socioeconomic classes who smoke.*"[7]

The Marmot Review highlighted that variation in health status is not only evident at the extreme ends of the socioeconomic spectrum but follows a gradient, with overall health tending to improve with each step up the socioeconomic ladder. The **social gradient of health** runs across society and although the greatest health differences are seen between the most and the least deprived, the gradient exists across the population.[8]

According to the Marmot Review, it is unlikely that that the social gradient in health will be eliminated completely but it should be possible to have a shallower social gradient than at present,

> *To reduce the steepness of the gradient in health, actions must be universal, but with a scale and intensity that is proportionate to the level of disadvantage….**proportionate universalism**. Greater intensity of action is likely to be needed for those with greater social and economic disadvantage, but focusing solely on the most disadvantaged will not reduce the health gradient, and will only tackle a small part of the problem*[9]

Many of the key health behaviours significant to the development of chronic disease follow the social gradient, for example, smoking, obesity, lack of physical activity, poor nutrition, abuse of drugs and alcohol; along with other factors such as mental illness, low breastfeeding rates and poor oral and sexual health.[10]

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[5] House of Commons Health Committee, Health Inequalities, Third Report of Session 2008-09 Volume I, March 2009, page 5
[6] House of Commons Health Committee, Health Inequalities, Third Report of Session 2008-09 Volume I, March 2009, page 23-24
[7] House of Commons Health Committee, Health Inequalities, Third Report of Session 2008-09 Volume I, March 2009, page 24
[8] Fit and Well, Changing Lives – 2012-2022, A 10-Year Public Health Strategic Framework for Northern Ireland, A Consultation Document, DHSSPS, August 2012, paragraph 2.11
[9] Fair Society, Healthy Lives, The Marmot Review, Strategic Review of Health Inequalities in England post-2010, Executive Summary, page 10
[10] Make Healthier Choices Easier, HSC Public Health Agency, http://www.publichealth.hscni.net/directorate-public-health/health-and-social-wellbeing-improvement/make-healthier-choices-easier

In Northern Ireland (NI), the key strategy for tackling health inequalities will now be the new 10-Year cross-departmental public health strategic framework ***Fit and Well: Changing Lives 2012 – 2022*** (August 2012). It is a cross-government, outcome-based strategic framework and takes account of social, economic and legislative changes since the previous 10- year strategy, *Investing for Health*, was published in 2002.

Fit and Well will continue to focus on improving the overall health and well-being of the NI population whilst aiming to reduce evident health inequalities. It will adopt a life-course approach and will focus on those determinants which evidence shows are the most powerful in reducing health inequalities, for example, early years interventions. It takes particular notice of the findings of the Marmot Review.[11] The new strategy is further discussed in section 5.

To better monitor health inequalities in NI, the DHSSPS has established the **Health and Social Care Inequalities Monitoring System (HSCIMS)**. Using particular indicators, the HSCIMS produces regular annual updates on the extent on inequality experienced by those living in the 20% most deprived areas and that experienced by those living in rural areas when compared with the regional average. Information from the Fourth Update Bulletin of the HSCIMS is included in section 3 below.

3. Health Inequalities in Northern Ireland

The following information is extracted from the *NI Health and Social Care Inequalities Monitoring System, Fourth Update Bulletin* (June 2012).[12]

Health inequality gaps are the largest between the most and least deprived areas of NI. Although the inequality gaps follow similar trends to those gaps seen between the most deprived areas and NI as a whole, the observed gaps are much larger and males and females in the most deprived areas could expect to live on average, almost 8 years and 5 years less respectively than their counterparts in the least deprived areas in NI.

The largest gaps between the most and least deprived areas of NI occurred in alcohol related hospital admissions (457%), alcohol related mortality (440%), self-harm admissions (368%), hospital admissions for drug related mental health and behavioural disorders (368%), teenage births (341%), drug related mortality (334%), smoking during pregnancy (247%) and suicide (234%).

[11] Developing a new Public Health Strategy for Northern Ireland- Update September 2011, http://www.dhsspsni.gov.uk/newsletter-public-health-strategy.pdf

[12] DHSSPS, *NI Health and Social Care Inequalities Monitoring System, Fourth Update Bulletin* (June 2012), Executive Summary, http://www.dhsspsni.gov.uk/inequalities_monitoring_update4-2.pdf

The most noticeable improvements in health gaps over time between the most and least deprived areas of NI have occurred for drug related mortality, self-harm admissions, teenage births, smoking during pregnancy and infant mortality.

Some gaps have widened over time, the most evident increases occurred in hospital admissions for drug related mental health and behavioural disorders, alcohol related mortality, suicide and both respiratory and circulatory death rates.

Health outcomes are also generally worse in the most deprived areas in NI when compared with those measured generally in NI overall and large differences continue to exist for a number of different health measures:

- Hospital admissions for drug related mental health and behavioural disorders and drug related mortality showed similar inequality gaps with rates in deprived areas for both more than double the regional figure (138% and 123% higher respectively).
- Alcohol related hospital admissions was 130% higher in the most deprived areas compared to NI overall. The figures for alcohol related mortality were 124% higher; for self-harm admissions, 116% higher and for suicide 82% higher.
- Sizeable gaps also exist for teenage births (93%), smoking during pregnancy (73%) and respiratory mortality (72%).

Comparing the change in health inequalities over time shows that there have been a **number of reductions in inequality gaps over time between the most deprived areas and NI overall**, such as for infant mortality where rates in the most deprived areas reduced relatively from being two-fifths higher to being almost identical to that in the wider region. Other notable improvements occurred in all cancer and lung cancer incidence rates, teenage births, smoking during pregnancy, emergency hospital admission rates and dental registration rates. However the DHSSPS noted that despite these relative improvements, many of these observed health gaps still remain sizeable.

Some gaps increased despite improvements in health outcomes in the most deprived areas as they occurred at a slower pace than in NI overall, for example, in mortality rates for respiratory diseases, circulatory diseases and smoking related causes.

Gaps also widened where health problems grew in deprived areas faster than elsewhere such as in hospital admissions for drug related mental health and behavioural disorders, drug related mortality, suicide and childhood obesity.

Health outcomes are generally better in rural areas when compared with those in the region generally. Males in rural areas could expect to live 1.6 years, and females, 1.7 years on average, longer than their counterparts in NI as a whole.

The Marmot Review clearly highlighted that central to the Review was a life course perspective as,

> *"disadvantage starts before birth and accumulates throughout life …Action to reduce health inequalities must start before birth and be followed through the life of the child…For this reason* ***giving every child the best start in life (Policy Objective A) is our highest priority recommendation"***[15]

The DHSSPS has taken particular note of the findings and recommendations of the Marmot Review in the new proposals for the 10-Year Public Health Strategy, *Fit and Well*, outlined in more detail in the next section.

5. New 10-Year Public Health Strategic Framework for NI, *Fit and Well, Changing Lives – 2012-2022*

Investing for Health (2002) was the Department's first 10-year cross-cutting public health strategy and contained a framework for action based on partnership working and a number of lifestyle strategies. The key aims were to improve life expectancy across the population and to reduce health inequalities.

The strategy was reviewed in 2009 and whilst progress has been made, challenges relating to health inequalities still remain. There was mixed success in terms of evidence of health improvement outcomes (although this is no different to the experience of the rest of the UK and beyond) but a key area of success is noted as the commitment by local stakeholders to local delivery through cross-sectoral partnerships.[16] The review of *Investing for Health* concluded that there was a need for a new updated strategic direction to build on the previous strategy and *Fit and Well* is that successor and is now published for consultation.

In developing the consultation document, *Fit and Well*, the DHSSPS gave due consideration to the Marmot Review and the prominence it gave to the impact of the determinants of health across the life course and its six cross-cutting policy recommendations (listed above in section 4), with the highest priority being given by Marmot to giving every child the best start in life.[17] The DHSSPS also noted the importance that Marmot placed on tackling the social gradient of health inequalities with '**proportionate universalism**'. The DHSSPS also noted that policies to date that have achieved overall improvements in key determinants such as living standards or smoking,

[15] Fair Society, Healthy Lives, The Marmot Review, Strategic Review of Health Inequalities in England post-2010, Executive Summary, page 14, http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review

[16] Fit and Well, Changing Lives – 2012-2022, A 10-Year Public Health Strategic Framework for Northern Ireland, A Consultation Document, DHSSPS, August 2012, paragraph 1.10

[17] Fit and Well, Changing Lives – 2012-2022, A 10-Year Public Health Strategic Framework for Northern Ireland, A Consultation Document, DHSSPS, August 2012, paragraph 2.10

> *"have often increased inequalities in these major influences on health. Therefore it is important to distinguish between the overall level and the social distribution of health determinants and interventions."*[18]

Chapter 5 of *Fit and Well* describes the 'whole systems' approach that the DHSSPS is advocating acknowledging that many of the social determinants of health lie outside the direct influence of the health system. There is a growing recognition across government of the importance of the life course approach and the need for cross-government collaboration, for example, Child Poverty Action Plan and the Children and Young People Strategy.[19]

The DHSSPS highlights that the proposed *Fit and Well* framework sets out a wide range of life course and population outcomes, the emphasis is on the most disadvantaged in society and that "*actions must take account of the social gradient and the need for more focused effort or 'proportionate universalism' (ie to reduce the gradient there is a need for universal actions, but with additional provision for additional need) to tackle the health inequalities that exist in our society*".[20]

To take this direction forward the DHSSPS have proposed two strategic priorities for *Fit and Well*[21]:

1. **Early Years –** there is overwhelming evidence that children's life chances are heavily based on their development in the first years of life and "*it is vital that children are given the best possible start in life in order to break the cycle of disadvantage that correlates to poor outcomes throughout life and across generations.*" Early years generally refers to programmes and service that intervene and support early in a child's life (aged between 0 and 5 years of age, including prenatal care).[22]

   The need for this priority is underlined by the fact that in NI has high levels of child deprivation - 21% of children in NI live in relative income poverty and Sure Start caters for 34,000 children aged 0–4 in particularly disadvantaged areas (almost 30% of the 0–4 population).[23]

[18] Fit and Well, Changing Lives – 2012-2022, A 10-Year Public Health Strategic Framework for Northern Ireland, A Consultation Document, DHSSPS, August 2012, paragraph 2.13
[19] Fit and Well, Changing Lives – 2012-2022, A 10-Year Public Health Strategic Framework for Northern Ireland, A Consultation Document, DHSSPS, August 2012, paragraphs 5.1, 5.4, 5.5
[20] Fit and Well, Changing Lives – 2012-2022, A 10-Year Public Health Strategic Framework for Northern Ireland, A Consultation Document, DHSSPS, August 2012, paragraph 6.9
[21] Fit and Well, Changing Lives – 2012-2022, A 10-Year Public Health Strategic Framework for Northern Ireland, A Consultation Document, DHSSPS, August 2012, paragraph 6.9
[22] Early years interventions to address health inequalities in London – the economic case, Greater London Authority GLAEconomics, mayor of London, January 2011, Executive Summary, page 5 http://www.london.gov.uk/sites/default/files/Early%20Years%20report%20OPT.pdf
[23] Fit and Well, Changing Lives – 2012-2022, A 10-Year Public Health Strategic Framework for Northern Ireland, A Consultation Document, DHSSPS, August 2012, paragraph 7.1

It has been commented that improving the health outcomes for children and young people can only be achieved by enhancing the quality of their environments, particularly their family environments and the communities in which they live.[24]

2. **Supporting Vulnerable People and Communities –** the DHSSPS proposes more focus to reduce the health inequalities experienced by vulnerable people within NI including - vulnerable children who experience learning or physical disabilities, neglect and other adverse social and environmental factors; people with disabilities; travellers; migrant populations; the homeless; prisoners; refugees; immigrants; and people living in areas of deprivation.

The DHSSPS considers these two broad areas as priorities as they are *"reflective of demographic trends and the evidence base in relation to addressing health inequalities"*.[25]

As already discussed in section 4, the Marmot Review also considered that the highest priority should be *"giving every child the best start in life"*.[26]

6. Taking Forward the Committee Review

The HSSPS Committee wish to undertake a short review to identify effective interventions to address health inequalities. The findings of the review would then be used to feed into the Department's consultation and continued development of the new 10-Year Public Health Strategy, *Fit and Well*. To take this forward the Committee may wish to focus its review on a specific area, for example either a relevant key policy area highlighted by the Marmot Review, where giving every child the best start in life is the highest priority recommendation, or focus on an area of priority for the DHSSPS from *Fit and Well* where the two key priorities are also the Early Years and Supporting Vulnerable People and Communities.

It is beyond the scope of this paper to look into a full range of examples of good practice in all the specific areas highlighted above. However, to further assist the Committee's consideration it may be useful to consider the recommendations of the recent review carried out on the social determinants of health for the World Health Organisation (WHO) led by Michael Marmot of the Institute of Health Equity, University College London, *"the results of the review are clear: with the right choice of policies, progress can be made across all countries, including those with low incomes"*.[27] The

[24] The Right Start to a Healthy Life, Levelling-up the Health Gradient Among Children, Young People and Families in the European Union – What Works? EuroHealthNet, Edited by I. Stegeman and C Costongs, March 2012, http://www.sante.public.lu/publications/sante-fil-vie/petite-enfance/right-start-healthy-life-levelling-up-health-gradient-children/right-start-healthy-life-levelling-up-health-gradient-children.pdf

[25] Fit and Well, Changing Lives – 2012-2022, A 10-Year Public Health Strategic Framework for Northern Ireland, A Consultation Document, DHSSPS, August 2012, paragraph 6.10

[26] Fit and Well, Changing Lives – 2012-2022, A 10-Year Public Health Strategic Framework for Northern Ireland, A Consultation Document, DHSSPS, August 2012, paragraph 2.10

[27] Report on social determinants of health and the health divide in the WHO European Region (September 2012), WHO, Regional Office for Europe, Executive Summary, page 1.

final review report was presented to the 62nd Session of the WHO Regional Committee for Europe (10-13 September 2012). This WHO EU Review highlighted the highest priorities for action to be[28]:

- **The Life Course –** within the life course the highest priority is for countries to ensure a good start to life for every child (as highlighted by the Marmot Review for England and the DHSSPS *Fit for Life* document;
- **Wider Society –** actions that create or reassert societal cohesion and mutual responsibility;
- **Macro-level context –** the wider influences that shape lives, health and rights, including the priority to address the health effects of the current economic crisis; and
- **Systems –** refocusing delivery systems to whole of government and whole of society approaches which requires greater coherence of action across all sectors, (the whole systems approach is advocated in the DHSSPS *Fit and Well* document).

The Review team of this WHO EU Review has been contacted by RalSe to source further detail for the Committee on good practice in tackling health inequalities referred to for various EU countries (including evidence from Denmark, Norway, Poland, Slovenia, Spain, Sweden and others) with regard to both action at a national level and other evidence at a subnational level including the WHO European Healthy Cities Network.[29]

In the UK there is much work on going to tackle health inequalities, including the work of the Public Health Agency in NI, particularly in connection with interventions in the early years, which was highlighted in a previous RalSe paper (in Committee pack for meeting of 12th September), entitled *Health Inequalities in Northern Ireland* (NIAR 308-12, May 2012).

As one of the key policy areas highlighted by Marmot and by the DHSSPS is a focus on giving every child the best start in life, so as an example of possible directions that could be considered in that area, this paper takes an initial look at some research work that has been published in this area in the EU, Scotland and London.

***Tackling the Gradient* (2009-2012)** was a collaborative **EU** research project involving 12 institutions from nine countries[30] in Europe. The Gradient project had the overall

http://www.euro.who.int/__data/assets/pdf_file/0004/171337/RC62BD05-Executive-summary-Report-on-social-determinants-of-health-and-the-health-divide-in-the-WHO-European-Region.pdf

[28] Report on social determinants of health and the health divide in the WHO European Region (September 2012), WHO, Regional Office for Europe, Executive Summary, pages 5-8, http://www.euro.who.int/__data/assets/pdf_file/0004/171337/RC62BD05-Executive-summary-Report-on-social-determinants-of-health-and-the-health-divide-in-the-WHO-European-Region.pdf

[29] http://www.euro.who.int/en/what-we-do/health-topics/environment-and-health/urban-health/activities/healthy-cities/who-european-healthy-cities-network

[30] Belgium, Czech Republic, Germany, Iceland, Norway, Spain, Slovenia, Sweden and UK.

goal of identifying what measures could be taken to level-up the socio-economic gradients in health among children and young people in the EU.[31]

The project discovered that a critical step in levelling-up the health gradient is to look at policies through a "Gradient Evaluation Lens" and the project developed such a tool which highlights key factors that policy makers and practitioners must consider to ensure measures are 'gradient friendly'.

Another Gradient outcome is insight into the fact that community social capital matters to the health of children and young people and that this was a previously understudied area.

Gradient outcomes also support the premise that the nature of welfare state matters and countries that invest most in family friendly policies have more level socio-economic gradients. The project highlighted that the evidence base of what works to level-up the health gradient in children "*is thin*", examples of policies and interventions cited include:

- Social protection policies – linked to the need to improve living standards and conditions - including active labour market interventions, social assistance through child benefits, income supports, scale and quality of early childcare services and the education system generally. These are all areas where governments can take measures to ensure greater equity among children. The project highlighted that social systems must place strong emphasis on family policies that support parent's capacity to care for their children ("*income and job security are, for example, a precondition of positive parenting*");
- Policies that encourage maternal employment – it is mostly well-educated mothers in high socioeconomic groups that are in paid employment, "*any active labour market policy to enhance maternal employment must be paired with provision of high quality day-care centres, with subsidised fees based on ability to pay*";
- Educational interventions – there is a strong correlation between educational status and health status. Equity issues in schools manifest in early school leaving and gaps in outcomes. The project cites Dutch and Swedish policy to tackle truancy and early school leaving;
- Health policies and interventions –several health interventions were identified in the seven EU member states that took part in this part of the Gradient project that directly contributed to levelling-up the health gradient (although the project acknowledged that the evidence was not strong) – including a preventative dental care project in all kindergarten and schools in Germany; A French Mother and Child Protection Programme and an obesity prevention study in North Western Germany.

[31] Tackling the Gradient: Applying Public Health Policies to Effectively Reduce Health Inequalities amongst Families and Children, Drivers for Health Equity, EuroHealthNet, http://health-gradient.eu/other-research/gradient/

In 2010, **the Scottish Government** published *Growing up in Scotland: Health inequalities in the early years*. The analysis by the Scottish Centre for Social Research[32] looked at a wide range of outcome measures such as birth weight, experience of long-term health problems, accidents and wider developmental problems. It also looked at risk factors such as maternal smoking, diet and physical activity levels.

Among the findings were that inequalities in exposure to risk factors were generally larger than was evident for the outcomes, however within the outcomes looked at – behavioural, psychosocial and linguistic problems showed much starker inequalities than physical ones such as poor general health.

The work reinforced the evidence that there are strong associations between child outcomes and maternal health and behaviours such as smoking, disability and parenting ability. How disadvantaged children avoided negative outcomes in some cases through 'resilience' was also investigated, for example social support and neighbourhoods provided an important source of resilience. Other factors within households also were associated with avoiding negative outcomes, despite disadvantage, including consumption of fruit and vegetables and higher levels of physical activity.

Overall the analysis concluded that although the focus on early years was important, policy making needs to be *"alive to the fact that tackling health inequalities in children also requires action to address the health inequalities experienced by their parents and wider families"*.

In **London**, the case for improving health inequalities across the social gradient is highlighted by data showing that a greater proportion of people in London live in deprived areas and the health of children is generally worse compared to the rest of England. The Mayor of London's Health Inequalities Strategy sets out *"an ambitious and long-term commitment to promote effective parenting, early years development and readiness for learning…and to promote evidence-based programmes in family support early interventions and mainstream delivery in London"*.

As part of this strategy, Greater London Authority (GLA) Economics have developed an economic case for early years interventions in London. The GLA believe that the evidence shows that *"well designed and implemented early years programmes can have significant benefits in terms of life-long health, educational attainment, social, emotional and economic wellbeing and reduced involvement in crime that far outweigh their costs"*.[33]

[32] Growing up in Scotland: Health inequalities in the early years, Scottish Government, 2010, http://www.scotland.gov.uk/Publications/2010/04/28103009/0

[33] Early Years Interventions to address Health Inequalities in London - the Economics Case, GLAEconomics, January 2011, http://www.london.gov.uk/sites/default/files/Early%20Years%20report%20OPT.pdf

GLA Economics highlight that the most robust evidence of costs and benefits of early years programmes comes from the US and show that some home visiting programmes and pre-school programmes are particularly effective, especially for disadvantaged groups.[34] These include the Nurse Family Partnership (a voluntary preventative programme for teenage mothers), which is being already being tested in certain places across England, Scotland and NI, and was referred to in the previous RaISe paper *Health Inequalities in Northern Ireland* (NIAR 308-12, May 2012).

[34] Early Years Interventions to address Health Inequalities in London • the Economics Case, GLAEconomics, January 2011, http://www.london.gov.uk/sites/default/files/Early%20Years%20report%20OPT.pdf