

**Community Development and Health Network response to:**

DHSSPSNI Fit and Well Changing Lives 2012 – 2022

A 10-Year Public Health Strategic Framework for Northern Ireland

Consultation Document

Dated: 26th October 2012

Community Development and Health Network is a network and membership organisation operating throughout Northern Ireland. CDHN seek to address health inequalities through a community development approach. CDHN views a strong public health framework as an integral part of achieving this aim. We welcome the release of the ten year public health framework “Fit and Well- Changing lives.” This is CDHN’s response.

**Introduction**

This framework seeks to building on the aims, objectives and success of Investing for Health while addressing some of the challenges encountered during its implementation. This approach is welcomed by CDHN.

CDHN broadly agrees with the aims, vision, values and principles of “Fit and Well – Changing Lives.”

Chapters one through to six provide the background and context, local, national and international, in which this framework will sit. CDHN are pleased to see a description and outline of the wider determinants of health and how these impact on health and contribute to health inequalities.

CDHN would query why crime and domestic violence have been listed as wider determinants of health. Undoubtedly these impact on health but they are outcomes of the interaction of determinants such as built environment, community and family support, economy and lifestyle and should be listed under these rather than as individual determinants.

CDHN feel that there is insufficient reference to either the on-going economic crisis or welfare reform, either the changes which have already occurred or the reforms which are currently going through the Executive.

The framework highlights poverty as "the greatest risk factor for health and wellbeing." Given the possible implications of the continuing crisis and implementation of welfare reform, this may prove to be an even greater challenge over the coming years and therefore requires greater consideration. This framework provides some insights into the effects of poverty and financial difficulties, including fuel poverty. CDHN would like to see the framework address more of these issues including financial exclusion and the poverty premium.

Financial exclusion is the “process where by people encounter difficulties accessing and/or using financial services and products in the mainstream market that are appropriate to their needs.” (NIPSA, 2011)This is a concern as those unable to access mainstream products often turn to less scrupulous and/or illegal providers, thus increasing their vulnerability. This in turn leads to the poverty premium. “In essence the poor pay more, because being excluded from mainstream products means having to pay higher charges” (Consumer focus). Changes to social security system have already been introduced, including the removal of mortgage payment help for those who have been on JSA for over two years. Support for those in work has also been altered. Working tax credit, an income supplement for those on a low income has seen a three year freeze in how it is calculated, childcare support for those receiving working tax credit has been reduced from 80% to 70%. Such changes at a time of economic downturn has meant that there has been “an increase in number of people in in-work poverty since 2004/05 of 30,000” (Hossin et al, 2011). CDHN would like to see the framework show greater consideration of these factors both in terms of setting the scene and in the outcomes, as these have a huge potential for increasing social inequality and thus health inequalities. Greater application of proportionate universalism would help in tackling these issues and therefore should receive greater coverage in a public health framework.

**COMMUNITY DEVELOPMENT, HEALTH AND HEALTH INEQUALITIES**

Community development upholds the values and principles of social justice, equality, empowerment, collective action and working and learning together, and it is through these values and approaches that communities are able to address health inequalities. Community development is therefore a natural tool in the fight to reduce health inequalities and ally of public health and health equity movement. It is for this reason that CDHN are disappointed these principles and community development approaches are not absolutely central to the document and more importantly the outcomes. The review of IfH recommended that upstream approaches should be central to any follow-on strategy.

Social justice is a core community development value. The Health Equity movement lead by WHO, has seen the establishment of the Commission on Social Determinants of Health and the bringing forth of the Rio Declaration. A declaration which the UK government has signed up to and which “Fit and Well” refers to as a guiding policy. This movement seeks to ensure equity in health outcomes and has social justice at its core, further strengthening the argument for community development approaches to be fully integrated into “Fit and Well”.

“A commitment to social justice lies at the heart of public health. This commitment is to the advancement of human well-being. It aims to lift up the systematically disadvantaged and in doing so further advance the common good by showing equal respect to all individuals and groups who make up the community”(Gostin & Powers)

There are many points in the framework where empowerment, partnership and engagement are discussed but it does not always make clear how these can be enacted and achieved. It is here that CDHN feel community development could be a real asset. Good community development can help in “developing ‘local solutions to local problems’ and therefore creating buy-in for the community in doing so” and this was one of the successes of IfH. CDHN would like the DHSPSSNI to examine and included relevant elements of the recently published Community Development Strategy for Health and Wellbeing and the Strategic Framework for Community Development.

 **APPROACH OF FRAMEWORK**

CDHN agree with the lifecourse approach, though we would like to raise some concerns around the division and make-up of the lifestages. “Children and young people” and “adults” are both very broad ranging stages, and feel that this could present some difficulties which are not fully addressed in the document. For example the social, emotional and educational needs of children change as they progress from primary into secondary school and how these changes are to be met are not clear in the short term outcomes.

“Adults” ranges from 25 – 64, and chronic conditions often onset in the later years of this stage. For example average age for onset of type 2 diabetes is over the age of 40,(Diabetes U.K) arthritis 47. These conditions change not only the health needs of the person but also their social, physical needs as well as employment opportunities. Again how such changes are to be addressed is not clear in the outcomes.

As stated CDHN are in favor of the lifecourse approach as encompassed within the strategic framework, especially as it is underpinned by the theme of sustainable communities. Though we would caution that achieving healthy sustainable communities is unlikely if there is not real engagement and involvement with communities. Having healthy public policy is an admirable aspiration, and to achieve this CDHN would advocate that a statutory duty be placed on all departments to use tools such as health impact assessments and health equity auditing. This is especially pertinent given that it was a recommendation of the review of IfH:“Consideration should also be given to a mandatory requirement for all Departments to conduct HIAs and/or the Health in All policies approach in their policy development processes.”

The diagram representing the framework is clear seems incomplete as it does not illustrate where the strategic priorities and areas for collaboration fit in terms of the framework. CDHN would have concerns that having rigid stages may entrench further silo working, causing negative impacts when people are transitioning between stages. A stronger link between the lifestages and the areas for collaboration could help prevent this.

Clearly representing the areas of collaboration and strategic priorities within the strategic framework diagram would also help with understanding where these fit in terms of the framework

Fit and Well makes explicit the rationale for choosing the areas for collaboration and the strategic priorities, but not what the implications will be, in terms of increased investment, resources and/or support. CDHN seek clarification on these areas.

There are areas in which the discourse of the framework appears to be value led and require some changes to be made. Examples include pg 15 “poverty for instance is a key determinant for poor education outcomes, as well as poor health, and perhaps linked to a greater propensity to be involved in criminal behavior”

Pg 61 Prisoners, refugees and immigrant populations are combined in one bullet point. They should each have their own bullet point as there are clear differences in the groups.

CDHN would advocate for the title to be changed as it infers that physical health is paramount. This framework encompasses aspects of health and wellbeing beyond the physical state of an individual and the title should reflect this.

**UNDERSTANDING AND DELIVERING THE FRAMEWORK**

Overall it is clear that a lot of work has gone into creating this framework, however it is let down by a lack of cohesiveness which can make it cumbersome for those working outside the policy arena. The framework would appear more cohesive if the groups listed in “supporting vulnerable people and groups” reflected those identified as “at risk groups.”

There are four separate descriptions of the wider determinants, the Barton and Grant diagram, the summary table linking to health outcomes, Health 2020 diagram and section 2 – Wider determinants. CDHN feel that the framework could be strengthened if one was used throughout and the link between the wider determinants and outcomes made more explicit. Recommendation one of the review of Ifh was that the new framework would “ be built around the evidence of the impact of key determinants model in respect of improving both physical and mental health and well-being. The strategy should distinguish those determinants that the evidence base shows are most powerful in reducing health inequalities and should have a clear focus on upstream interventions in this regard.” The current format of the framework can make it difficult to see how this recommendation is being implemented as the outcomes tables included are difficult to read and have no clear link back to the wider determinants. CDHN feel that this could be achieved and the framework made more cohesive if the Barton and Grant diagram was used throughout and used as the foundation of the outcomes section. Below is an example of what this could look like if the outcome tables for each lifestage were replaced with the following table:

 **Life stage/underpinning theme**

**Aim**:

|  |  |  |  |
| --- | --- | --- | --- |
|  | Outcome | Method/process/action | Key Policy link  |
| People |  |  |  |
| Lifestyle |  |  |  |
| Community |  |  |  |
| Local economy |  |  |  |
| Activities |  |  |  |
| Built environment |  |  |  |
| Natural environment |  |  |  |
| Global environment |  |  |  |

It would be hoped that such an approach would encourage buy-in from other departments as they could clearly see how their remit may impact on health and wellbeing. If DHSSPSNI feel that the current format is adequate CDHN would advocate that the short term outcomes be reviewed, with a view to significantly reducing the number and ensuring they are SMART.

**Implementation and Governance**

With regards the implementation and governance of the framework, CDHN would recommend that this aspect of the framework requires urgent clarification.

CDHN would welcome the establishment of regional board. We would like to see similar detail in how other partnerships will be established and work. The framework could benefit from clarifying how it will be building on and/or be changing from IfH with regards partnership, especially the IfH partnerships and the links built up with local government. Building on these were recommendations of the IfH and an enhanced description of these areas of working would strengthen the framework.

CDHN argue that an accountability structure should have been developed prior to the framework going out to consultation and that failure to do this means that the document is left lacking and reduces its level of credibility. Simultaneously reducing the impetus on other departments to buy in to the framework and take responsibility for their effect on health and wellbeing.

CDHN thank the DHSSPSNI for the work gone into the framework and the opportunity to feedback on it and are more than happy to discuss any of the points raised in more detail.