Workshop 4
November
2016

Good Health and Wellbeing Task and Finish Group

Chair: Hugh Nelson, Northern Health and Social Care Trust

This is a working document and will be subject to future re-drafts and augmentation as the work of the Task and Finish group progresses. As such, none of the content should be read as the official and agreed position or view of Mid and East Antrim Borough Council, the MEA Community Planning Partnerships or any Community Planning Partner.

www.midandeastantrim.gov.uk/community/community-planning

Mid & East Antrim Borough Council

This report has been produced as a follow up to the first and second workshops for the Good Health and Wellbeing Task and Finish Working Group, which met in early and Mid-September 2016. These workshops brought together a range of stakeholders from across the sectors to discuss the priorities for the Mid and East Antrim Borough Council Community Plan.

The overarching objective for this Task and Finish Group is:

'Improving health, including the wider determinants and causes of ill health'

By the end of the Task and Finish process the group will produce a paper detailing the strategic priorities and actions in this theme over the next 10-15 years and a summary of how this theme can contribute to other cross cutting themes such as good relations, infrastructure, sustainable development, environment, etc.

This paper will be forwarded to the Community Planning Strategic Alliance who will use it to inform the priorities and actions within the final Community Plan for Mid and East Antrim.

This paper outlines the key priority areas which were identified by the Task and Finish Group in the first and second workshops. It is important to note here that the focus of the Task and Finish Groups is around collaborative gain; what can be achieved through working together, or that is not already being done well by other agencies, and that this has shaped the selection of priorities.

The paper will present each priority individually and with the following structure, which reflects the evidence based approach taken:

- What success will look like for each priority;
- The current challenge, including upon who and where we should focus;
- Statistical evidence to support the selection of this issue as a priority (much of the evidence can be applied across each of the issues raised);
- Actions which would allow progress to made towards achieving success in each strategic priority
- How the outcomes for this priority tie in with the Northern Ireland programme for government and the development of indicators to track progress.

Under the banner of 'Good health and Wellbeing' there are also several strategic infrastructure projects that are either ongoing, or are being considered. These are:

- Sheltered Housing Developments to support the needs of older people and those with disabilities.
- Open space developments and recreational developments to support more active lifestyles.
- Integrated public open space and housing development.
- Leisure provision.

1 Prevention and early intervention

1.1 What success would look like

'Everyone has access and support to proactive services at the earliest stage'

The following statements set out what success will look like in Mid and East Antrim as we realise the vision over the lifetime of the Community Plan:

- Everyone has good emotional resilience
- Longer, healthier and more active lives for all
- Mid and East Antrim has a network of community health champions and peer support

1.2 The challenge

The challenge is to adopt a deeper focus within health and related services, which looks to focus on the prevention of ill health, rather than the downstream treatment, through a programme of upstream, early intervention. This is vital as there are high rates of death from preventable causes in the borough, with a particular concentration around specific diseases which lend themselves to early intervention.

Factors relating to wider social, economic, environmental and cultural determinants of ill health are of vital importance in this. As such the Community Plan for Mid and East Antrim will seek to develop health information in a clear format from an early age, and this 'health education' would be broad, to include material around food budgeting, cooking and nutritional guidance.

1.3 The evidence

Personal Wellbeing

Data for personal wellbeing also provides some evidence around the general health of an area, including mental health. The table below shows data for Mid and East Antrim from 2012/13 to 2015/16. Residents in Mid and East Antrim reported having the highest life satisfaction (8.39 out of 10) and worthwhile levels (8.63) and are the second happiest (8.22) across all local authorities in the UK. Mid and East Antrim residents were ranked 3rd least anxious behind Antrim and Newtownabbey and Mid Ulster. The respondents comprised of 160 residents from Mid and East Antrim. Due to the relatively small sample size it should be noted that the findings are subject to a degree of uncertainty. Therefore, they should be interpreted as providing a good estimate, rather than an exact measure of personal wellbeing in the Borough.

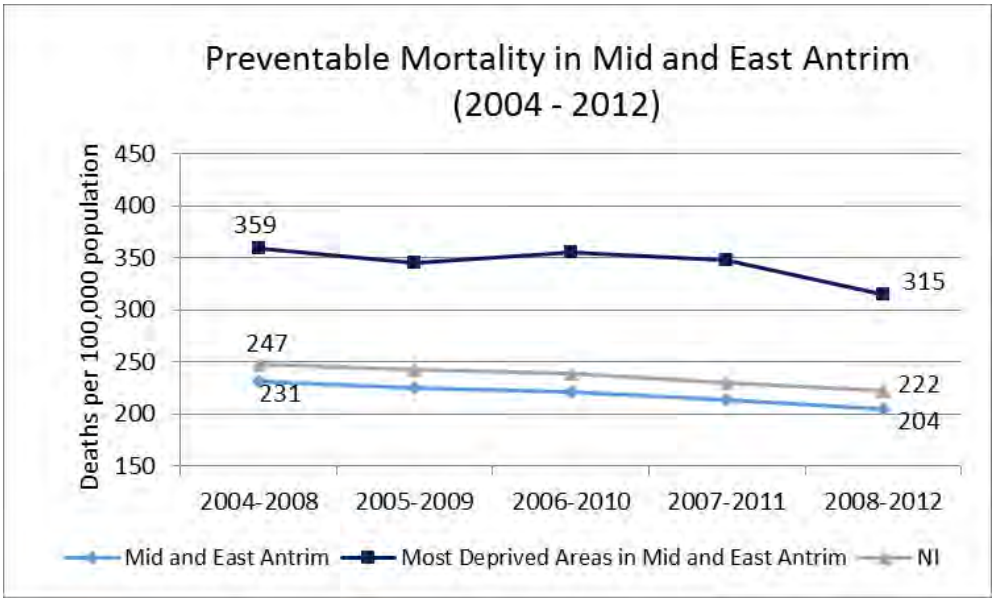
Personal Wellbeing Measures	2012/13	2013/14	2014/15	2015/16		
				MEA	*NI*	Rank across 11 Councils
Life Satisfaction	7.94	7.87	8.17	8.39	*7.85*	Most satisfied
Worthwhile	8.11	8.2	8.28	8.63	*8.00*	Most worthwhile
Happiness	7.68	7.88	8.03	8.22	*7.70*	Happiest
Anxiety	2.81	2.5	2.33	2.18	*2.78*	3rd least anxious

Source: ONS (Labour Force Survey)

Preventable deaths

The evidence base suggests that a concentration of particular diseases is leading to a high proportion of total preventable mortality in the borough. A death is preventable if, in the light of understanding of the determinants of health at the time of death, all or most deaths from that cause (subject to age limits if appropriate) could be avoided by public health interventions in the broadest sense.

The standardised preventable death rate has decreased in Mid and East Antrim, from 231 deaths per 100,000 population in 2004/08, to 204 in 2008/12 and remained below the NI average (see chart below). In 2008/12 Mid and East Antrim had the 5th lowest standardised preventable death rate out of the 11 councils.



Common diseases

The three main causes of deaths in the council in 2014 were cancer, circulatory diseases and respiratory diseases (see table below). These accounted for 70% of all deaths and were also the most common in each of the district councils and NI as a whole. Many of these conditions are caused or exacerbated by individual actions, and lend themselves to an early intervention approach.

Cause of Death	Mid and East Antrim			*NI*
	2012	2013	2014	*2014*
Malignant Neoplasms - cancer	27.49	28.66	27.85	*29.45*
Circulatory Diseases - heart disease, stroke, blood clots	28.95	27.13	26.65	*25.34*
Respiratory Diseases - pneumonia, asthma, bronchitis, influenza	12.37	13.52	15.08	*13.65*
External Causes - road traffic accidents, falls	4.81	4.62	4.80	*4.78*
Deaths from suicide and undetermined intent - fires, poisoning, assault	1.80	1.86	1.46	*1.83*
Other	24.57	24.21	24.16	*24.96*

The most commonly recorded medical conditions data for Mid and East Antrim shows a similar picture, of lifestyle related illnesses, all of which could be reduced through an early intervention approach. In 2014/15, 15% of patients in Mid and East Antrim had high blood pressure, 12% were on the obesity register, and 6% had diabetes (see table below). These conditions are also the most common in each of the district councils and Northern Ireland overall.

When compared with the other councils, Mid and East Antrim had some of the highest prevalence rates for these conditions. In particular, it was the highest for diabetes and high blood pressure and second highest for obesity and heart disease.

The Most Commonly Recorded Medical Conditions (2014/15)

Condition	% of total registered patients in Mid and East Antrim	*% of total registered patients in NI*	Rank
High Blood Pressure	14.70	*13.19*	highest
Obesity	12.02	*10.90*	2nd highest
Diabetes	6.31	*5.56*	highest
Asthma	6.17	*6.03*	4th highest
Heart Disease	4.29	*3.84*	2nd highest
Cancer Register	2.06	*2.04*	6th highest

Smoking cessation

In 2014/15, Mid and East Antrim had the lowest percentage of people who successfully quit smoking at 4 weeks, at 51.1% compared to 58.5% in Northern Ireland.

Smoking Cessation (2014/15)

District Council	People setting a quit date	Successfully quit (self-report) at 4 weeks	Successfully quit (self-report) at 4 weeks (%)
Northern Ireland	21779	12742	58.51
Antrim and Newtownabbey	1211	674	55.66
Ards and North Down	1240	714	57.58
Armagh City, Banbridge and Craigavon	2076	1350	65.03
Belfast	4209	2441	57.99
Causeway Coast and Glens	1820	1000	54.95
Derry City and Strabane	2913	1720	59.05
Fermanagh and Omagh	1512	935	61.84
Lisburn and Castlereagh	864	493	57.06
Mid and East Antrim	1222	624	51.06
Mid Ulster	1705	1027	60.23
Newry, Mourne and Down	2186	1291	59.06

1.4 Activity mapping

In the second workshop, the Task and Finish Group was asked to complete a quick scoping exercise to allow better understanding of who is already involved in working on this particular strategic priority, and also what is not currently being addressed. These are the outputs of that discussion.

Who is involved:

- There has been some activity mapping through Tackling Inequalities in Health Project (TIHP)
- Children's Locality Group under the Children and Young People's Strategic Partnership(CYPSP) is active in addressing the mental and physical needs of children
- Community pharmacies are increasingly pro-active in early intervention
- Sports NI partnership Active Communities programme has come to an end and is replaced with the Every Body Active 2020 programme
- Self-Harm Intervention Programme (SHIP) service - Public Health Agency project to tackle self-harm
- MEA Council provides leisure facilities including outdoor gyms
- The Youth Service provided through the Education Authority
- Everybody Active 20:20 (for young girls and older people and addresses life course transition)
- Hearty Lives Programme in Carrickfergus a partnership based programme to address maternal and childhood obesity has now come to an end
- The Northern Obesity Partnership and Northern Physical Activity partnership jointly address obesity, nutrition and active lifestyle

What is not being addressed:

- Schools providing, in a consistent and thorough way, an early start to a healthy lifestyle through activity and education in primary schools
- There is a gap for prevention of self-harm provision for under 18s
- Underlying causes of highly prevalent conditions of diabetes, obesity and heart disease
- Youth service provision for 13 years old and above (there is a sharp drop off in engagement at this age)
- A successor programme to build on the learning and experience from Hearty Lives
- Development and nurturing of health champions in communities
- Health Literacy and related support on lifestyle and nutrition around the 70% of preventable deaths (cancer, circulatory disease and respiratory disease)

1.5 Actions

In Workshop 3 the Task and Finish Group discussed actions for each strategic priority, which would contribute towards achieving success, as defined by the statements in 1.1. Some of these actions are to improve existing behaviour or practice and others are new.

- Early years to adulthood roadmap research project - this would detail where services intervene from pre-birth, through to adulthood and identify any potential gaps.
- Longitudinal study which takes a more holistic approach to health education - this is in response to the feeling that emotional wellbeing and resilience in young people is not measured, at the expense of academic results. Preventative programmes are vital in this, to help avoid children falling through the gaps in provision. In addition, support must extend beyond a school setting, and beyond activities that are necessarily linked directly to the curriculum.
- Pilot healthy eating activity to tackle obesity and other prevalent issues in the borough.
- Mindfulness for young children, including primary and nursery needs to be normalised.

1.6 Indicator development

National outcomes	Local outcomes	Indicators	Baseline	Target
We enjoy long, healthy, active lives We give our children and young people the best start in life		Life expectancy	In 2011/13 Female life expectancy was 82.9 (82.4 NI) Male life expectancy was 78.4 (78.1 NI)	
		The preventable mortality rate	204 deaths per 100,000 pop in 2008/12 (222 NI)	
		The percentage of people reporting the most commonly recorded medical conditions	In 2014/15 14.7% high blood pressure (13.2% NI) 12.0% obesity (10.9% NI) 6.3% diabetes (5.6% NI)	

2 HEALTH AND WORK

2.1 What success would look like

'Mid and East Antrim is a productive place with opportunities for all and with work places that are for health as well as wealth'

The following statements set out what success will look like in Mid and East Antrim as we realise the vision over the lifetime of the Community Plan:

- Healthy work for healthy people - including mind and body
- Work opportunities for all (this would include work experience, volunteering, self-employment, further education, adult education)
- Residents are able to live healthy and productive lives (including going beyond formal work)
- Alternative economic activities are valued
- Workplace health is considered a form of wealth

2.2 The challenge

The challenge is to ensure that the people in work in Mid and East Antrim are experiencing positive health and wellbeing outcomes as a result of employment - equipping them to be more ready for work, and be more productive in work.

There are particular challenges around the most deprived areas in the borough, especially where this correlates with high levels of unemployment, or areas where there have been losses of industrial positions in the past, which have not been adequately replaced. In addition, access to employment is important, with interconnectivity between towns and poor rural links an issue. However, it was considered that the growth of tourism may provide opportunities where currently there is a lack.

There have been many reports which establish a link between employment and health. However, there is increased momentum around this link, as the idea of 'good jobs' gathers momentum. 'Good jobs' are those that provide a living wage on a secure contract, offer opportunities for an individual to progress, provide training and support, take place in a safe working environment, and include fair terms and conditions of employment. With this in mind, it was considered that health and safety at work should change, from merely looking at accident prevention, to also consider mindfulness. This would be a step towards addressing the stigma of mental health in the workplace which is still widespread.

2.3 The evidence

Employment statistics

The table below indicates that levels of employment in the borough are broadly comparable with the other councils in Northern Ireland. However, the extent to which this employment is benefitting the mental and physical health of the population requires further research.

LGD 2014	All usual residents, aged 16-74	Part-time employee (%)	Full-time employee (%)	Self-employed (%)	Unemployed (%)	Full-time student (%)
Northern Ireland	1,313,420	13.1	35.6	8.9	5.0	3.7
Antrim and Newtownabbey	100,388	13.9	40.7	7.5	3.8	4.1
Armagh, Banbridge and Craigavon	143,476	13.2	37.7	9.5	4.7	3.0
Belfast	245,963	12.9	34.7	5.4	5.6	5.4
Causeway Coast and Glens	102,820	12.6	31.4	10.7	5.6	3.4
Derry and Strabane	107,019	12.5	29.2	7.5	7.4	3.8
Fermanagh and Omagh	81,188	12.3	33.9	12.3	4.8	2.7
Lisburn and Castlereagh	97,837	13.8	41.4	8.6	3.3	3.4
Mid and East Antrim	98,559	13.7	39.0	8.7	4.2	3.0
Mid Ulster	98,977	12.5	34.9	11.7	4.7	3.0
Newry, Mourne and Down	122,324	13.0	32.9	11.5	5.6	3.3
North Down and Ards	114,869	14.0	37.4	9.4	3.9	2.9

Deprivation

Three of the four areas in Mid and East Antrim which are classed as being in the top 20% most deprived areas in Northern Ireland in terms of health are also deprived in terms of employment. These are Northland, Ballee and Sunnylands. Castle Demesne is also deprived in terms of health, however not in terms of employment.

2.4 Activity mapping

In the second workshop, the Task and Finish Group was asked to complete a quick scoping exercise to allow better understanding of who is already involved in working on this particular strategic priority and also what is not currently being addressed. These are the outputs of that discussion.

Who is involved:

- Public Health Agency (PHA) Workplace Health and Wellbeing Service
- Northern Health and Social Care Trust Farm Families programme
- Citizen's Advice
- Department of Employment and Learning
- Acceptable Enterprises (AEL)
- Men's Shed Project
- Churches and other religious bodies (these places often have a long-term commitment to a place – not footloose)
- GPs
- Community Planning Partners with workplace health and wellbeing strategies/plans
- Action Mental Health
- Training organisations
- Social Enterprise Hubs
- People Plus
- Community Pharmacies

- Trade Unions

What is not being addressed:

- Trade unions can get involved with workplace issues but there are questions around access to a union in particular trades
- On the commissioning front, there needs to be a requirement for medical practitioners to engage with communities (for example, pharmacists and GPs need training in community development)
- No Social Value Act or similar legislation in Northern Ireland
- Coordinating activity is necessary as it is not currently well joined up. There is duplication in the system and projects with the same aims should merge.
- The community feel that things are 'done to' them and need to be empowered to champion and address their local issues.
- Collective community health issues are not well addressed. Patients are dealt with as individuals and there needs to be a wider awareness of the causes of disease and helping people to care for themselves preventively.
- Being responsive to changing needs and extending cohorts and geographies for projects.

2.5 Actions

In Workshop 3 the Task and Finish Group discussed actions for each strategic priority, which would contribute towards achieving success, as defined by the statements in 1.1. Some of these actions are to improve existing behaviour or practice and others are new.

- Healthy work for healthy people, including mind and body: with a programme for educating employers around vulnerable people and civic responsibility. It is important the people with mental health issues are not disadvantaged in the workplace, this may be best achieved through the development of a programme for educating employers in this subject area. In larger organisations the individuals who have undertaken this training could act as mental health champions, and also provide support to SMEs to ensure that all types of businesses have training in this field.
- A work / life balance charter: statutory agencies provide standards for good work life balance and good health and wellbeing. This could take the form of a set of standards for the borough, which could be agreed collaboratively. This would include more flexible contracts and offer more part-time, or reduced hours contracts, and guidance around the use of technology in a home setting. Smaller businesses could then be encouraged to participate after the statutory bodies have taken a lead in this area.
- Procurement power: ensure corporate social responsibility is written into procurement practices. Use of procurement power (including grants) to ensure ideas on corporate social responsibility, work life balance and working conditions are embedded. This could include aspects such as taking on apprentices, paying a living wage, supporting the voluntary sector, providing training and development opportunities for employees etc.

2.6 Indicator development

National outcomes	Local outcomes	Indicators	Baseline	Target
We have more people working in better jobs		The percentage of the population who are in employment	In 2015, 73.9% of the working age population are in employment (68.4% NI)	

3 HEALTHY PLACES AND LIFESTYLES

3.1 What success would look like

'Residents will be more active, more often, and the inequalities in lifestyle related conditions will narrow'

The following statements set out what success will look like in Mid and East Antrim as we realise the vision over the lifetime of the community plan:

- Facilities in the community will be accessible to all
- Mid and East Antrim provides a suitable environment to engage and motivate people to make positive lifestyle choices
- Outdoor space will be good quality and useable
- Community groups will be able to use space to engage and motivate the community
- The community will have access to information around healthy lifestyles

3.2 The challenge

The challenge is to ensure that at a borough wide level, individuals' lifestyles are conducive to healthy and happy lives and that the environment in which they live supports this. In terms of lifestyles, it has been said that 'diet is the new smoking' and this is supported by evidence of increasing rates of diabetes, high blood pressure and obesity. There is crossover here in relation to the prevention and early intervention agenda, but it will also be important to educate communities that a healthy lifestyle is also a personal responsibility. There are also groups that are underrepresented in provision, these include those with a physical or sensory disability, women and older people.

In terms of healthy places, there are some localities where a concentration of shops and fast food outlets and a lack of access to healthy alternatives are limiting the nutritional options for individuals. When this is combined with difficulties in accessing services and a limited access to good quality mixed use green space, the environment is not conducive to a healthy lifestyle. It was considered that the focus here should be on smaller areas, with a neighbourhood level approach, which considers deprivation, but recognises that need in this area may not be entirely captured by this measure.

3.3 The evidence

Lifestyles

There is a mixed picture across the council in terms of particular lifestyle choices and the impact this has on health and wellbeing. For example:

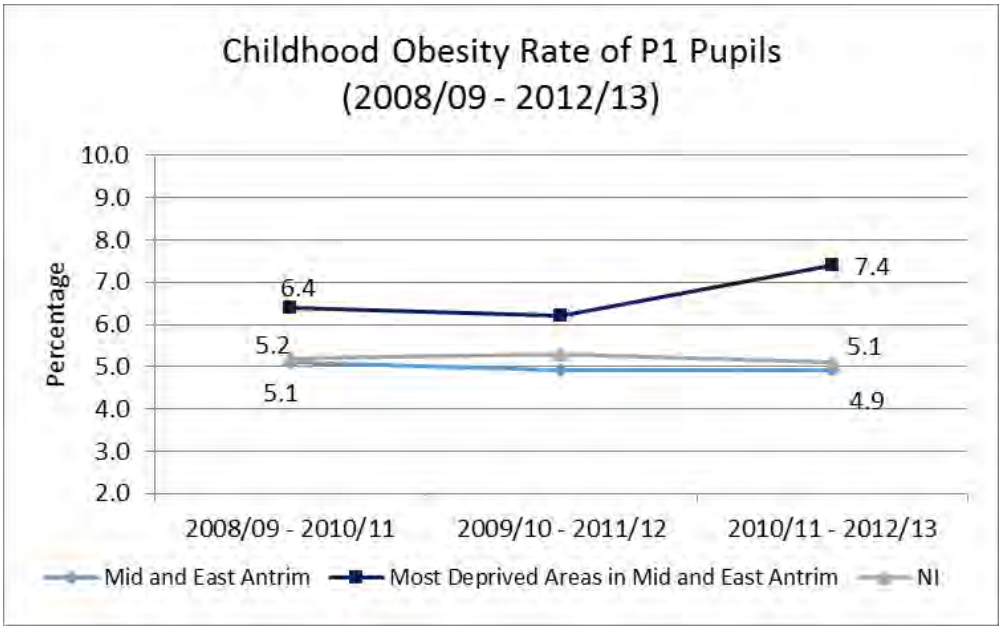
- The admission rate for alcohol related causes in the council has fallen by 9% and remained lower than the Northern Ireland average which has increased by 3%.

- Between 2008/09 and 2012/13, the inequality gap in this admission rate widened from 115% to 127%. This was the result of a relatively larger improvement in the council as a whole (9%) than in the most deprived areas (4%).

- The admission rate for drug related causes has also fallen and remained lower than the Northern Ireland average.

The importance of healthy lifestyles from a young age

The Task and Finish Group identified the importance of early intervention to allow parents and children to make educated choices around nutrition and exercise. The childhood obesity rate of P1 pupils in Mid and East Antrim has fallen from 5.1% in 2008/09, to 4.9% in 2012/13 (see graph below). This is below the 5.2% Northern Ireland average and 3rd lowest across the councils.



Poor quality housing

There has been a renewed focus on the importance of good quality housing in achieving positive health and wellbeing outcomes. In 2009, the quality of housing accommodation in Mid and East Antrim was the second worst across the 11 councils, behind only Antrim and Newtownabbey. Only 47% of houses in Mid and East Antrim were considered to be satisfactory compared to 66% in Northern Ireland (see table below).

	Mid and East Antrim	*Northern Ireland*	Rank
Unfit Dwellings (%)	4	*2.4*	2nd highest
Defective Dwellings (%)	6.9	*2.9*	2nd highest
Acceptable Dwellings (%)	41.9	*28.8*	2nd lowest
Satisfactory Dwellings (%)	47.2	*65.9*	2nd lowest

The Northern Ireland House Condition Survey examines the condition and energy efficiency of homes in the owner occupied, private rented and social sectors, not just Housing Executive properties.

Participation in sport

Based on results from the Continuous Household Survey over a 3-year average between 2011/12 and 2013/14, 55% of residents in Mid and East Antrim reported having participated in sport during the 12 months prior to the survey. Mid and East Antrim was ranked 4th highest across the 11 councils and above the Northern Ireland average of 53% (see table below).

Sport Participation (2011-13)

District Council	Sport participation in last 12 months (%)
Northern Ireland	53
Lisburn and Castlereagh	62
Antrim and Newtownabbey	59
Ards and North Down	58
Mid and East Antrim	55
Belfast	54
Armagh City, Banbridge and Craigavon	51
Mid Ulster	50
Fermanagh and Omagh	50
Causeway Coast and Glens	48
Newry, Mourne and Down	48
Derry City and Strabane	44

Sport Northern Ireland have produced a report, 'Encouragement & Inspiration' which details the key findings for the experiences of sport and physical activity for children and young people across the 11 district council areas in 2015.

In terms of the percentage of young people in Mid and East Antrim who are physically active at the recommended level or above (60 minutes a day, 7 days a week):

- For P7 pupils this is 35%, the highest rate in Northern Ireland, (The national average at 32%, and the lowest is 28% in Fermanagh & Omagh)
- For 16 year olds, this proportion is just 8% and is ranked 5th of the council areas (this is just below the 9% figure for Northern Ireland, with a range from 5% in Derry & Strabane, to 20% in Ards & North Down)

There is also data around active travel to school or work undertaken in a normal week:

- In Mid and East Antrim 51% of 16 year olds walk or cycle to school or work, this is the 2nd highest proportion in the council areas (Belfast city is top with 58%). The average across Northern Ireland is 42%.
- For P7 pupils, the proportion who walk or cycle to school in Mid and East Antrim is 48%, this ranks 4th of the councils. The average across Northern Ireland is 49% and ranges

from 40% in both Newry City, Mourne & Down and Fermanagh & Omagh, to 63% in Belfast City.

Where Mid and East Antrim does appear to fall behind, is the proportion of young people who participate in organised sports activities / gym outside school:

- For P7 pupils this is 74%, which ranks 7th out of the council areas. For Northern Ireland, the average is 74% and ranges from 14% in Mid Ulster, to 80% in Lisburn City & Castlereagh
- For 16 year olds in Mid and East Antrim the figure is 45%, which ranks 10th of the council areas. For Northern Ireland, the average is 52% and the range is from 44% in Newry City, Mourne & Down to 66% in Causeway Coast & Glens.

Finally, the report contained data around the top 5 barriers to participation in sport, which is detailed in the table below. Mid and East Antrim records figures that are broadly similar with the Northern Ireland averages, although it was reported that 16 year olds find that difficulties with, or a lack of transport and the costs of participation are proportionally less of a barrier to participation that the Northern Ireland average.

Percentage %								
	Not enough time		Not having anyone to go with		Difficulty with/lack of transport	Costs involved	Not knowing where the activities take place	
	P7	16 year olds	P7	16 year olds	16 year olds	16 year olds	P7	16 year olds
NORTHERN IRELAND	25	68	15	23	26	24	38	13
Antrim & Newtownabbey	23	65	15	24	22	22	42	11
Ards & North Down	24	59	17	22	28	25	41	11
Armagh City, Banbridge & Craigavon	23	75	16	23	26	18	40	6
Belfast City	29	66	15	24	19	34	32	19
Causeway Coast & Glens	28	68	16	19	32	30	36	16
Derry City & Strabane	24	71	16	20	29	25	37	13
Fermanagh & Omagh	26	71	15	23	30	30	38	18
Lisburn City & Castlereagh	27	70	16	25	26	29	36	16
Mid & East Antrim	23	70	14	19	20	20	41	11
Mid Ulster	26	68	14	22	27	19	39	14
Newry City, Mourne & Down	23	68	11	28	28	19	40	12

The 2010 Northern Ireland sport and physical activity survey data has also been presented in a summary report for each borough. For Mid and East Antrim, it indicates the participation (at least 30 minutes of at least moderate intensity in the last 7 days) of various groups (figures for Northern Ireland are in brackets):

- People with disabilities 17% (19%)
- Social class ABC1 50% (44%)
- Social class C2DE 41% (30%)
- Male 50% (43%)
- Female 38% (31%)
- 30-49 years old population 57% (42%)
- 50+ years old population 20% (21%)

3.4 Activity mapping

In the second workshop, the Task and Finish group was asked to complete a quick scoping exercise to allow better understanding of who is already involved in working on this particular strategic priority and also what is not currently being addressed. These are the outputs of that discussion.

Who is involved:

- ❑ Building Communities Pharmacy Project
- ❑ Public Health Agency (PHA)
- ❑ Space and Place
- ❑ Rivers Agency
- ❑ Forestry Service
- ❑ Education Authority
- ❑ Housing Executive (NIHE)
- ❑ Active Communities Programme, now known as Everybody Active 2020
- ❑ Hearty Lives Programme Carrickfergus
- ❑ North and South Antrim Community Networks

What is not being addressed?

- ❑ Area specific provision (more could be done here but is likely funding dependent)
- ❑ The ability of communities to access funding pots
- ❑ Imaginative use of outdoor space
- ❑ More recreational opportunities
- ❑ Health literacy which empowers people and communities
- ❑ Nurturing champions and volunteers to enhance community capacity
- ❑ There is a reduction in the number and scale of schemes for young people due to funding
- ❑ The private rented sector and poor accommodation
- ❑ There is a lack of continuation funding, it seems that there is an outputs focus rather than an outcomes focus
- ❑ There are individuals, communities and groups that are not being reached

3.5 Actions

In Workshop 3 the Task and Finish Group discussed actions for each strategic priority, which would contribute towards achieving success, as defined by the statements in 1.1. Some of these actions are to improve existing behaviour or practice and others are new.

- Incentive scheme to encourage physical activity - Cost should never be prohibitive. For example, there is a flexible pricing policy at Carrickfergus Leisure Centre, where certain activities are free to those in education and senior citizens. Facilities should also be improved or extended, such as cycling infrastructure.
- Make better use of existing physical resources - There are good examples of where this is happening, such as Ashfield Girls School in Belfast, where sporting facilities are available to the public following the school day. We need a new approach to ensure that new build schools allow for community access in their design. There is also work to be done around ensuring that everyone can access existing green and open spaces. In addition, it should be possible to join up libraries to other facilities, such as Carnlough, where the heritage centre and library are in one building.
- Creating greenways / pathways between areas / facilities / housing, and reclaiming existing outdoor spaces (use of Play Rangers).
- Produce an active travel plan for the borough including a focus on students, which could be considered an early intervention.
- New building control standards for zero carbon new homes.
- 'Design out' crime within open space areas.
- Support the development of urban growing within Mid and East Antrim through policy improvements, eg Brighton and Hove Policy PAN06 which requires developers to leave space for allotments.

3.6 Indicator development

National outcomes	Local outcomes	Indicators	Baseline	Target
We enjoy long, healthy, active lives We give our children and young people the best start in life We care for others and we help those in need		Sport participation rate in the past year	55% in 2011-13 (NI 53%)	
		Childhood obesity rate of P1 pupils	4.9% in 2010/11 - 2012/13 (NI 5.1%)	
		The percentage of defective or unfit dwellings	10.9% in 2009 (NI 5.3%)	

4 RESPONDING TO AN AGEING SOCIETY

4.1 What success would look like

'Older people are able to live active lives and feel comfortable and supported in their community, where they are treated with dignity and respect'

The following statements set out what success will look like in Mid and East Antrim as we realise the vision over the lifetime of the Community Plan:

- Older people feel valued
- Older people are treated with dignity and respect
- The older members of the community are active
- Housing in Mid and East Antrim meets the specific needs of an older population
- There are opportunities for lifelong learning
- Older people have a voice in the democratic processes
- Connectivity and access to transport allows services to be accessible
- There is a suitable signposting service to disseminate advice

4.2 The challenge

The challenge is to ensure that services and communities can respond to the ageing population that we have throughout the borough, including rural and urban settlements. This is particularly true of groups that can be considered more vulnerable such as those on low incomes, those who live on their own, or those experiencing prolonged ill health.

Accessibility of services may be an issue in future, as reorganisation leads to concentration and therefore modifies individuals' proximity to services. The changing demographic will also lead to different challenges in terms of illnesses, for example a rise in cases of dementia and Alzheimer's and an increase in demand for residential and home care services. A further challenge will be to work with educators to allow service providers to become health literate and understand these challenges.

In addition, there must be a renewed focus on the suitability of housing for an ageing population, with considerations around aids and adaptations. Finally, there must also be a concerted effort to 'link the generations', where currently there is limited interaction and much misunderstanding.

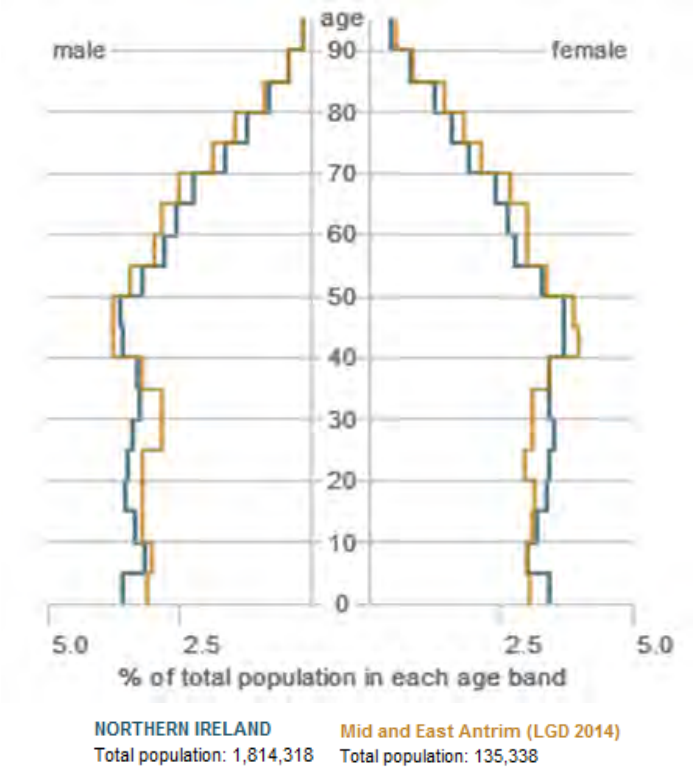
4.3 The evidence

An ageing population

In terms of the overall population profile, there has been a marginal decline since 2001 (-7.0% and -6.2%) in the 0-15 and 16-39 age groups (see diagram below). However, there has been significant growth in the 40-64 and 65+ age groups, (which now represent 20.1% and 38.2% respectively). The comparative growth of the latter two age groups can be attributed to a 75% decline in deaths under for those under 75.

The present median age of 40 is higher than the Northern Ireland average and that trend will continue in the medium term- an older age profile for residents than Northern Ireland as a whole. The sex ratio is 48.7% male, 51.3% female.

In a projection to 2030, it is expected that the 65+ cohort will continue to grow faster (40.9%) but with decline in the 0-15 (-4.5%), 16-39 (-4.5%) and 40-64 (-4.8%) age bands, whilst the overall population of Mid and East Antrim Council area is expected to grow to 142,164 by 2030.



Housing that meets the needs of a changing demographic

An increasingly elderly population creates specific demands of the local housing supply. Moving forward, it will be important to ensure that the housing provision reflects the level of need of the population; however, the 2011 census reported that just 11% of homes had been adapted.

Based on findings from the Northern Ireland House Condition Survey in 2009, 43.2% of households in Mid and East Antrim were in fuel poverty. This was slightly lower than the Northern Ireland average of 43.7%, and ranked 6th lowest out of the 11 councils.

In addition, the Age friendly profiles from Northern Ireland Neighbourhood Information Service (NINIS) show that 5% of the 65+ population of Mid and East Antrim live in communal establishments (as of 2011). For Northern Ireland as a whole this figure is 4%.

Health outcomes

Results from the 2011 Census show that in Mid and East Antrim 49.7% of residents aged 65 and over stated their general health was either good or very good (47.9% Northern Ireland) and was ranked 4th highest across the 11 councils. The borough had the 2nd lowest percentage of residents aged 65 and over reporting bad or very bad health, 11.5% compared to 13.1% in Northern Ireland.

Between 2008 and 2014 there appears to be no trend in the council in terms of excess winter deaths, as Mid and East Antrim has ranged from being ranked lowest across the 11 councils on the Excess Winter Deaths Index in 2013 and 2010 but among the highest in 2014 and 2012 (see diagram below).

	Mid and East Antrim		*Northernm Ireland*		Rank
	Excess Winter Deaths	Excess Winter Deaths Index	*Excess Winter Deaths*	*Excess Winter Deaths Index*	
2008	67.5	19.42	*1040*	*23*	4th lowest
2009	95.5	27.40	*940*	*21*	8th lowest
2010	17	4.45	*740*	*16*	lowest
2011	49	13.03	*500*	*11*	9th lowest
2012	109.5	29.80	*560*	*12*	11th lowest
2013	-7.5	-1.88	*593*	*13*	lowest
2014	91	24.00	*873*	*18*	10th lowest

This method defines the winter period as December to March, and compares the number of deaths that occurred in this winter period with the average number of non-winter deaths occurring in the preceding August to November and the following April to July. The Excess Winter Mortality index is calculated as the number of excess winter deaths divided by the average non-winter deaths expressed as a percentage.

A further indicator of health outcomes for older people is data around the number of hospital admissions for those aged 70 and over with a primary diagnosis of any fracture of the arm, hip, leg or shoulder. This residence based data in the table below shows the raw numbers for each council area, and indicates that there has been an increase in admissions between 2012/13 and 2014/15 in Mid and East Antrim of 19.5%. Northern Ireland over the same period has seen an increase in admissions of 7.4%.

	2012/13	2013/14	2014/15
Antrim & Newtownabbey	347	325	400
Ards & North Down	412	420	345
Armagh, Banbridge & Craigavon	476	452	520
Belfast	840	894	947
Causeway Coast & Glens	330	356	386
Derry & Strabane	141	152	177
Fermanagh & Omagh	209	314	259
Lisburn & Castlereagh	358	341	361
Mid & East Antrim	364	398	435
Mid Ulster	237	288	273
Newry, Mourne & Down	446	344	365
Invalid/Missing/Unknown	31	43	33
Northern Ireland	4,191	4,327	4,501

Source; NISRA, DoH, Hospital Inpatient System

Civic participation and employment

Data from the Age friendly profiles from NINIS gives an insight into the participation of the 65+ year old population in Mid and East Antrim in society and the economy:

- 10% are economically active (9% Northern Ireland)
- 50% provide unpaid care (46% Northern Ireland)
- 10% undertook unpaid voluntary work (11% Northern Ireland)
- 63% have no qualifications (64% Northern Ireland)

4.4 Activity mapping

In the second workshop, the Task and Finish Group was asked to complete a quick scoping exercise to allow better understanding of who is already involved in working on this particular strategic priority and also what is not currently being addressed. These are the outputs of that discussion.

Who is involved:

- Northern Ireland Health Executive
- Mid and East Antrim Age well Partnership
- Churches
- Volunteers
- Good morning schemes
- CVS
- Community navigators - compile resources for older people in the area

What is not being addressed?

- No connectivity - there are visits into homes regularly but thinking is not joined up so information gathered is not passed on to other agencies
- Age Friendly society approach to make a real difference to daily living
- Few services are funded in a sustainable manner
- Homes adaptable to cope with practical issues of ageing
- People need more support with practical living and emotional support

- Access to social activities with peers
- Transport and moving around
- There needs to be more investment in resources and information for volunteers
- Loneliness and isolation
- Intergenerational opportunities
- Support for carers
- There is a gap in terms of groups working together to target the hard to reach and develop the services of the future
- Opportunities for acting ageing through volunteering etc
- Information needs to be produced in different formats
- There seems to be a divorce between social concerns and health

4.5 Actions

In Workshop 3 the Task and Finish Group discussed actions for each strategic priority, which would contribute towards achieving success, as defined by the statements in 4.1. Some of these actions are to improve existing behaviour or practice and others are new.

- Co-design process – working with local clusters/networks for a partnership approach. Model will be piloted in April but there is a need to do more of this.
- Age friendly communities – for example a 'Dementia Friendly Community' was launched in Coleraine and needs to spread into other areas. Dementia Friendly Communities is a programme which facilitates the creation of dementia-friendly communities across the UK.
- Health literacy and education - get into schools and educate pupils on issues such as dementia etc. CCEA initiative is being launched in November. Create health literacy for the elderly to explain complex conditions in layman's terms.
- Reduce bureaucracy – pilot process to simplify governance and application process for funding. The more governance there is, then greater need for staff and therefore need more money. Move away from funding core costs as it creates difficulties for many groups.
- Recognition of carers – people need to recognise that they are carers and therefore have support available, including access to benefits.
- Community navigator – person centred care by agencies working collaboratively. Increase knowledge in community and if have concerns then know where to go.
- Carers should not have to pay to use leisure centres when they are escorting someone they care for. Some other leisure centres currently do this but it needs to be consistent across all councils. Training needed for leisure centre staff.

4.6 Indicator development

National outcomes	Local outcomes	Indicators	Baseline	Target
We enjoy long, healthy, active lives We care for others and we help those in need We have high quality public services		The proportion of the over 65 population reporting they are in good health	49.7% in 2011 (NI 48.0%)	
		Hospital admissions of the over 65 population due to accidents	512 admissions in 2013/14	
		The excess winter mortality index of winter deaths (the number of excess winter deaths divided by the average non-winter deaths, expressed as a %)	24% in 2014 (NI 18%)	
		Fuel poverty	43.2% in 2009 (NI 43.7%)	

5 DEPRIVATION AND HEALTH

5.1 What success would look like

'Breaking the cycle of deprivation and poor health and wellbeing outcomes'

The following statements set out what success will look like in Mid and East Antrim as we realise the vision over the lifetime of the Community Plan:

- An increase in life expectancy in deprived areas
- A more self-sufficient community
- Integrated services that work for people and deliver innovative solutions
- Services that focus on early intervention
- Have services in place to aid the most deprived and / or vulnerable
- Early intervention, integration and innovation to encourage caring communities, improve health outcomes and eradicate deprivation

5.2 The challenge

The challenge is to respond to the concrete link that has been established between levels of deprivation and poor health and wellbeing outcomes, and deliver services in a manner that is able to reduce the inequality in outcomes. There is stark evidence that deprivation reduces life expectancy and increases the risk of developing life limiting and life shortening conditions. Therefore, the particular geographies of focus should be Neighbourhood Renewal Areas.

There is no one solution to this challenge, however, there is an overlap with the ideology of early intervention and prevention which is covered earlier in this paper, as such there should be a renewed focus on the early years.

5.3 The evidence

Deprivation in the borough

There is a strong link made between deprivation and poorer health and wellbeing outcomes in the data for Mid and East Antrim and in wider literature.

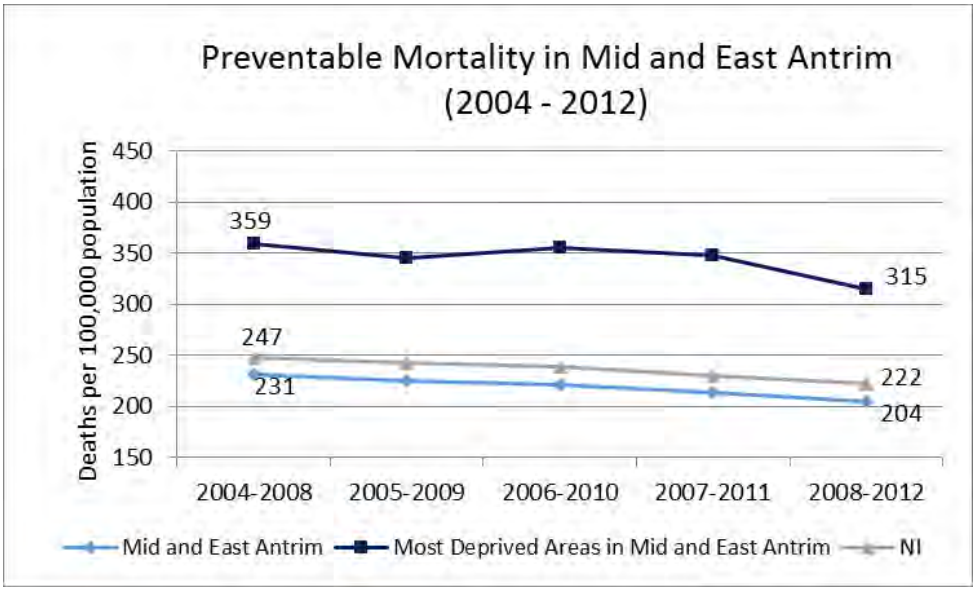
- Of the 65 Super Output Areas making up the Mid & East Antrim Local Government District (LGD), 10 (15%) are classed as being in the 20% most deprived areas in Northern Ireland and just over a quarter of areas (17) are among the least deprived.
- Health outcomes are worse in the most deprived areas in Mid and East Antrim across all indicators.
- In terms of health Northland, Ballee, Ballyloran and Sunnylands are the 4 most deprived areas in Mid and East Antrim; whereas Galgorm 2, Bluefield 1, Ballyloughan and Knockagh are the 4 least deprived areas in Mid and East Antrim.

Super Output Areas	Multiple Deprivation Measure Rank
Northland	93
Ballee	94
Ballyloran	113
Sunnylands	122
Antiville	128
Moat	131
Craigy Hill	135
Ballykeel	146
Love Lane	156
Dunclug	160

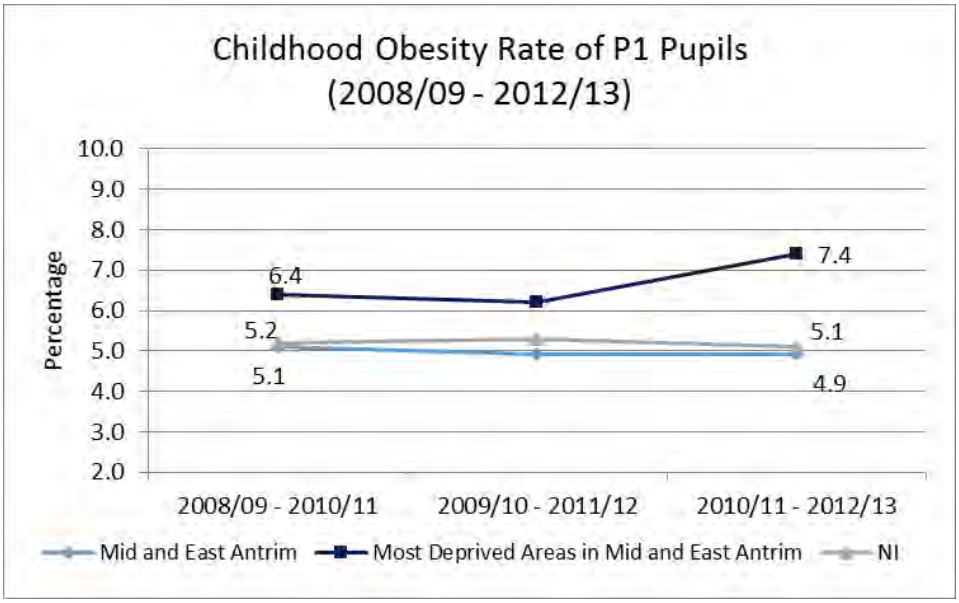
With 1 being the most deprived to 890 being the least deprived.

The link between deprivation and particular health outcomes

- Males in the 20% most deprived areas in Mid and East Antrim could expect to live 4.3 years fewer than in the LGD as a whole. For females, the life expectancy is 2.5 years less.
- In the most deprived areas within the LGD, the preventable mortality rate was 54% higher than the council as a whole (see chart below).



- In terms of hospital admissions for drug issues, in 2012/13 the inequality gap between the most deprived LGD areas and the LGD average was 126%.
- In the 20% most deprived areas in Mid and East Antrim, the childhood obesity rate has increased from 6.4% to 7.4% (see chart below). This indicates that the environment in which the children are raised has an influence.



The Department of Health have published sub-regional health inequalities (2015) that looked at 26 health outcomes, and compared the Super Output Areas in Mid and East Antrim which are among the most deprived 20% of Northern Ireland, with the council area as a whole, and also with Northern Ireland.

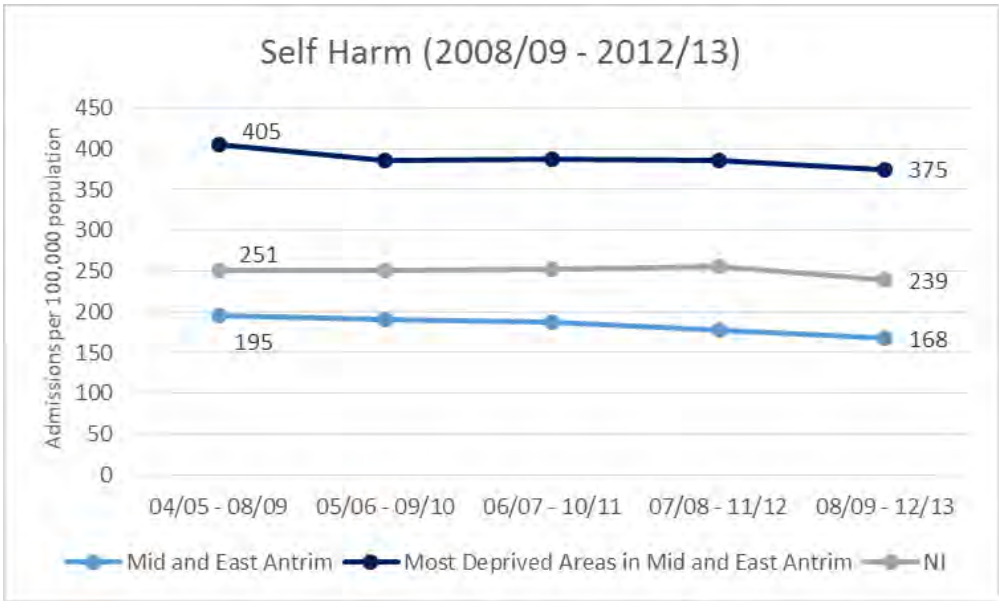
Details of each of the 26 outcomes including key findings are available in the report, however the following table shows the inequality gaps between the areas in Mid and East Antrim in the 20% most deprived nationally, and the borough as a whole for several key outcomes. For every measure, the most deprived areas have an inequality over the borough as whole.

Measure	Inequality gap of areas in most deprived 20% nationally compared to			
	60% + (very large)	40 -60% (large)	20-40% (Medium)	0-20% (Small)
Standardised admission rate for alcohol (per 100,000 population) 2010-13	127%			
Standardised admission rate for drugs (per 100,000 population) 2010-13	126%			
Standardised admission rate for self-harm (per 100,000 population) 2010-13	123%			
Crude suicide rate (per 100,000 population) 2008-12	79%			

Teenage birth rate (births per 1,000 females) 2010-12	72%			
Standardised death rate preventable (per 100,000 population) 2008-12		54%		
Potential life years lost (years lost per 100 population) 2010-12		51%		
P1 childhood obesity (proportion obese) 2010-13		51%		
Standardised death rate smoking (per 100,000 population) 2008-12		48%		
Standardised prescription rate mood and anxiety (prescriptions per 1,000 population) 2012			30%	
Standardised death rate respiratory (per 100,000 population) 2008-12			25%	
Standardised admissions rate emergency (admissions per 100,000 population) 2008-12			22%	
Standardised death rate cancer (deaths per 100,000 population 2008-12)				17%
Breastfeeding on discharge (proportion breastfeeding) 2013				16%
Male life expectancy at birth 2010-12				6%
Standardised admission rate all (Admissions per 100,000 population) 2012/13				5%
Female life expectancy at birth 2010-12				3%

Deprivation and self-harm

The earlier section which covers deprivation, illustrated the link between deprivation and ill health. However, it is important to note that this extends beyond physical ailments, and also encompasses mental health. For example, in 2012/13 there were 168 admissions for self-harm related causes per 100,000 population in the council (see graph below). This was the 3rd lowest across the 11 councils. In Mid and East Antrim, this admission rate has fallen by 14% between 2008/09 and 2012/13, and remained lower than the Northern Ireland average, which has fallen by 5%. However, the inequality gap between the most deprived LGD areas and the LGD average standardised admission rate for self-harm widened from 108% in 2004/05, to 123% in 2012/13. Therefore, self-harm is becoming less prevalent in the least deprived areas but higher in the deprived ones.



5.4 Activity mapping

In the second workshop, the Task and Finish Group was asked to complete a quick scoping exercise to allow better understanding of who is already involved in working on this particular strategic priority and also what is not currently being addressed. These are the outputs of that discussion.

Who is involved:

- Family Nursing Partnership
- Sure Start
- Home Start
- Larne Parental Care Team
- Barnardo's
- PAKT - Parents and Kids Together
- Contact Centres
- Family Group Conference
- YMCA
- EDCO
- Daisy Project (Drugs & Alcohol)
- Neighbourhood Renewal Officers
- CAMHS - Child and Adolescent Mental Health Service
- PAL (Patient Advice and Liaison Service) and PIPS (Public Initiative for the Prevention of Suicide)
- The Willows, Ballymena
- MENCAP
- Larne Care Centre
- Mid And East Antrim Age Well Partnership
- Carrick Community Forum
- Larne Community Development Programme
- Food Banks
- Early Years Providers (nurseries, childcare)

- Breakfast Clubs
- HOPE centre
- Addictions NI
- Women's Aid

What is not being addressed?

- Softer schemes such as buddy schemes (those which take children along to a sports club etc.)
- Support for deprived communities to change drug and alcohol culture
- Social enterprise targeting for deprived areas
- Resilience building in deprived areas
- Rural regeneration and poverty schemes
- Benefits maximisation
- Intergenerational worklessness/unemployment
- Flagship regeneration scheme in each deprived area, chosen through local consultation
- Connected community of deprived and at risk areas

5.5 Actions

In Workshop 3 the Task and Finish Group discussed actions for each strategic priority, which would contribute towards achieving success, as defined by the statements in 5.1. Some of these actions are to improve existing behaviour or practice and others are new.

- Utilising open space, such as allotments. There are some good examples of existing best practice which should be shared. For example, the Flagship Regeneration programme in Dunclug. The Ballymena North Partnership have also used Big Lottery funding to develop waste ground into a children's play area and outdoor gym. This could lead into the development of an Allotment Strategy, or something similar, and would tie in with the healthy eating and food miles agenda.
- Resilience and mental health – agencies need to learn to work together and leave the silo approach to working behind. It is important in future to target different groups, and take forward the idea of collaborative gain (with a key model here the 'Together for you' £3 million partnership project).
- Rural deprivation – There is an issue with deprivation and health in some rural communities and the Task and Finish Group feels that it is getting worse. However, there was a sense there are several activities currently available and that community assets can be better utilised. These include the Money Advice Service which is working in partnership with the council to look at oil purchasing schemes for rural regions.
- Open door strategy – All agencies should have the ability to use facilities for the good of the community. This would give space for rural communities to set up their own enterprises, or to host community groups.
- There are issues around alcohol and drug misuse and suicide. There are leaflets distributed currently, but this action is deemed to be insufficient. Existing practices include Ballymena North Partnership who have held workshops about suicide to raise awareness of the issue, and in some areas residents have increased their reporting of drug incidences. However, there

is a feeling that people in certain localities are not aware of the support available to them, particularly in areas where there is a higher concentration of people whose first language is not English, or where there is a transient community. A possible action would be to examine best practice within the Borough and roll this out, together with a partnership approach to raising awareness of these issues.

- Credit Union - There are issues with low household income which can be solved through ensuring that people are claiming the full benefits to which they are entitled. This is particularly important as welfare reform is making it harder to get a crisis loan. Therefore, a credit union is a good alternative, and certainly preferable to engagement with unscrupulous loan companies. In future, more information regarding credit unions is necessary, as is an approach which looks to identify those vulnerable to high risk borrowing. In order to ensure that signposting is informed and successful, a register of agencies must be created.
- Leadership and management team - Maximise the use of people who are already on the ground, and ensure that there is a database created so that staff can signpost people to the most appropriate service, and allow us to make use of all the services that are out there. Locality managers in deprived areas could take the lead on this and be supported by different partners. Hubs could act as the focal point for this activity and would see communities coming together. These facilities could be run by voluntary organisations with expertise in areas that would contribute to the strategic priorities.

5.6 Indicator development

National outcomes	Local outcomes	Indicators	Baseline	Target
We have a more equal society We enjoy long, healthy, active lives We give our children and young people		Inequality gap in standardised admission rate due to alcohol	127% gap between the council as a whole and the 20% most deprived areas (124% NI)	The… rate by deprivation quintile
		Inequality gap in standardised admission rate due to drugs	126% (106% NI)	
		Inequality gap in standardised admission rate due to self-harm	123% (110% NI)	
		Inequality gap in crude suicide rate	79%	

the best start in life We care for others and we help those in need			(88% NI)	
		Inequality gap in teenage birth rate	72% (108% NI)	
		Inequality gap in standardised preventable death rate	54% (62% NI)	
		Inequality gap in standardised avoidable death rate	52% (61% NI)	
		Inequality gap in potential years lost	51% (56% NI)	
		Inequality gap in P1 childhood obesity rate	51% (29% NI)	
		Inequality gap in standardised death rate due to smoking	48% (53% NI)	
		Inequality gap in standardised amenable death rate	42% (49% NI)	

Mid and East Antrim Borough Council would like to acknowledge the support from CLES in the production of this document. CLES has been retained by the Council to support the task and finish working group process.