

**Consultative  
Document**

**A Five Year  
Physical Activity Strategy  
and Action Plan**

**June 2004**

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## **CHAPTER 1**

### **WHY WE NEED A STRATEGY**

#### **Introduction**

- 1.1 We live in inactive times when many people take to their cars rather than walk and parents are naturally reluctant to let their children play in the street because of the dangers posed by ever increasing volumes of traffic. We also spend lengthy periods sitting in front of computers or the television.
  
- 1.2 In the past, people lived active lifestyles, in many cases through their employment. This is no longer the case with a recent survey classifying 25% of the population as physically inactive or sedentary<sup>1</sup>. This has potentially serious consequences for our health, placing us at risk of developing, for example, coronary heart disease, Type 2 diabetes, obesity and high blood pressure. It also places additional demands on the health and personal social services.
  
- 1.3 We need to reverse this trend if we are to improve people's lives and this will require changes in both policy and culture. As with all lifestyle issues, it is important to establish good habits as early as possible and to support the retention and development of those habits in later life.

#### **Background**

- 1.4 It was largely against this background that the first Northern Ireland Physical Activity Strategy, "Be Active – Be Healthy" 1996-2002, was published in March 1996. The overall aim of the Strategy was to increase levels of health-related physical activity,

particularly among those who exercise least.

1.5 The Strategy set targets to:

- reduce by 2002 the proportion of men and women aged 16+ who were classified as sedentary from 20% to 15%; and
- to increase by 2002 the proportion of men and women aged 16+ who achieved recommended age-related physical activity levels from 30% of men and 20% of women to 35% of men and 25% of women in these age groups.

1.6 A Northern Ireland Physical Activity Implementation Group (NIPAIG) was established to oversee the implementation of the Strategy. An Action Plan (1998-2002) was published in 1998 and identified key activities across various sectors including health, education, environment, agriculture, voluntary and community. A Physical Activity Co-ordinator was employed within each Health and Social Services Board to progress the Strategy at a local level.

#### *Programme for Government*

1.7 More recently, the *Programme for Government* identified working for a healthier people as one of five overarching priorities. This included commitments to increase physical activity and to provide opportunities for more active lifestyles by developing cycle and pedestrian networks and to promote the benefits of sport.

#### *Investing for Health*

1.8 The cross-departmental public health strategy *Investing for Health*, was published in March 2002 and sets out how these

commitments are to be met. The strategy outlines the approach to improving health and wellbeing, reducing health inequalities and also provides a framework for efforts to achieve this. It identifies physical activity as a key determinant of good health and gives a commitment to review the existing Physical Activity Strategy.

- 1.9 Other initiatives already underway or planned have relevance to physical activity. Examples of these include CREST's work on diabetes and obesity, the Workplace Health Strategy, the Promoting Mental Health Strategy and Action Plan, the Tobacco Action Plan, the impending Food and Nutrition Strategy & Action Plan, local fall prevention strategies, the Northern Ireland Cycling Strategy, the Northern Ireland Walking Action Plan, the development of the Long Term Athlete Development (LTAD) model and the Community Support Programme.

### **Review of Strategy**

- 1.10 The review, which was commissioned by DHSSPS in August 2002, concluded that there was a continuing need for a Physical Activity Strategy, with *SMART* (Specific, Measurable, Achievable, Realistic and Timebound) aims, objectives and targets. In addition, the review recommended that the Strategy's targets should link with *Investing for Health* targets and individual departmental targets contained within the Programme for Government. The review recommendations are summarised in Annex 1.

## **Definition of Physical Activity**

1.11 The World Health Organisation's (WHO) short definition of physical activity is:

**"all movements in everyday life, including work, recreation, exercise, and sporting activities"**.

While physical activity can be used to describe a variety of activities, it is also used to describe a more specific form of activity more closely identified with 'active living' whereby physical activity is integrated into daily living and leisure pursuits.

Examples of active living include taking the stairs instead of the lift, cycling to work, chair or bed based exercises for the frailer person, as well as a variety of leisure and recreational sports.

1.12 There is no clear dividing line between health-enhancing physical activity and sport; indeed they form part of a continuum from casual participation to elite sport. The Long Term Athlete Development model<sup>2</sup> while premised on good practice in the development of talented athletes is equally applicable to the concept of "physical literacy" in all-young people. The development of physical literacy enables young people to develop skills that will increase their chance of a lifetime involvement in physical activity, including sport. This is a key element in tackling a range of issues including childhood obesity and improving the quality of PE experienced by pupils.

## **Recommended Levels**

1.13 For an average sedentary adult, at least 30 minutes of cumulative moderate physical activity everyday or on most days of the week is sufficient to obtain health benefits<sup>3</sup>. WHO also advises that children and young people need an additional 20 minutes vigorous physical activity three times a week<sup>4</sup>. Increasing the

time, intensity or frequency of physical activity will result in greater health benefits.

**Table 1 Types of Physical Activity<sup>4</sup>**

<b>Moderate</b>	<b>Vigorous</b>
Walking briskly	Jogging
Walking downstairs	Walking upstairs
Dancing	Fast dancing
Biking	Biking up a hill
Swimming	Aerobics
Gardening	Skipping
Housework e.g. washing floors or windows	Sports e.g. football, hockey etc.

### **The State of Our Health**

- 1.14 There is no doubt that, throughout the last century, there have been real improvements in our health. Life expectancy here has increased from 47 years for men and women born in 1900, to 74.8 and 79.8 respectively in 1999-2001. Although this improvement is welcome, the state of our health remains a matter of serious concern, particularly when compared to other countries in Western Europe.
- 1.15 In Northern Ireland, diseases of the circulatory system including ischaemic heart disease cause 40% of deaths and a total loss of over 21,000 years of life<sup>5</sup>. Physical inactivity is a major contributor to these diseases.

### *Obesity*

1.16 The number of people who are obese in Northern Ireland is increasing. Almost half of all men and more than one third of women are overweight with a further one fifth of men and one quarter of women classed as obese<sup>6</sup>. Among 12 year olds in Northern Ireland, one in three boys and one in four girls carry excess weight<sup>7</sup>. It is recognised that the fundamental causes of obesity are a lack of physical activity and poor diet. Obesity is a major risk factor for Type 2 diabetes.

### *Type 2 Diabetes*

1.17 Although more commonly diagnosed in people aged over 40, Type 2 diabetes (previously referred to as non-insulin dependent diabetes or adult-onset diabetes), is increasing among children and young people in Northern Ireland. Diabetes UK estimates that in Northern Ireland, there are 70,000 people with diabetes; of whom 25,000 are unaware they have the condition. Evidence indicates that it is possible to prevent Type 2 diabetes, or at least delay its onset, by tackling excess weight and obesity.

### *Other Risks to Health*

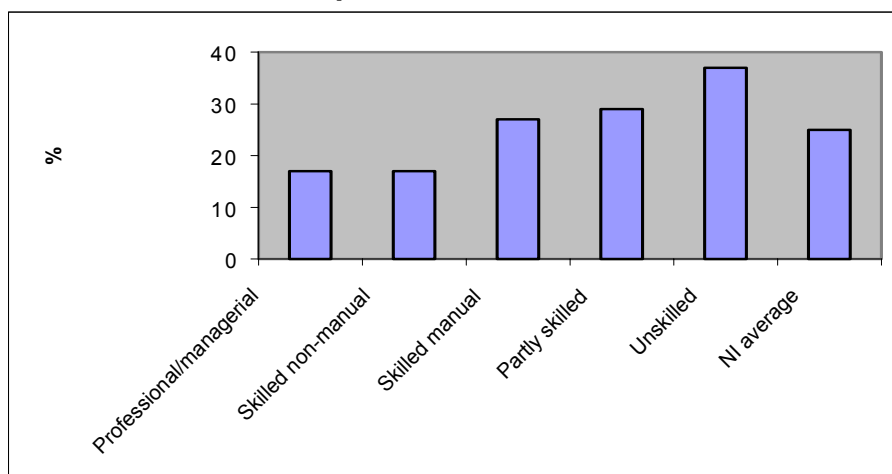
1.19 Physical inactivity is an underlying cause of death, disease and disability. In addition to obesity and Type 2 diabetes, those who are physically inactive or sedentary are at risk of:

- coronary heart disease;
- high blood pressure;
- colon cancer;
- osteoporosis; and
- stroke<sup>8,9,10</sup>.

## Inequalities

- 1.20 Some groups of people are at greater risk of being inactive, for example older people and those with a limiting long-standing illness.
- 1.21 A recent survey found that people in the lower socio-economic groups are more likely to be physically inactive<sup>1</sup> (Figure 1). Sedentary levels were highest in the unskilled socio-economic group (37%) and lowest in the professional/managerial and skilled non-manual socio-economic groups (17%).

**Figure 1. Proportion of People who are sedentary by Socio-economic Group.**



## Benefits of Physical Activity

- 1.22 Physical activity improves our health and helps prevent disease. It need not be strenuous to achieve health benefits. Being active, even for short periods can provide health benefits to everyone, regardless of age, weight, health condition or disability. Sedentary people, especially those with pre-existing health conditions, who wish to increase their physical activity, can, under appropriate guidance or supervision, gradually build up to the

desired level of activity. Additional health benefits can be attained through greater amounts of physical activity.

1.23 The specific benefits of regular physical activity include:

- improved health;
- the maintenance of healthy bones, muscles and joints;
- weight control;
- improved posture, balance, flexibility and strength;
- a reduction in falls and injuries; and
- a reduction in symptoms of anxiety and stress and the promotion of self-esteem.<sup>8 9,10,11.</sup>

1.24 There are other indirect benefits, for example:

- physical activity, among children and young people especially, can help to prevent or control risk-taking behaviours such as violence, unhealthy eating, tobacco, alcohol or other substance use<sup>11</sup>;
- active travel, particularly walking and cycling, is also one of the solutions to reducing traffic congestion and air pollution; and
- studies suggest that physical activity programmes at work reduce absenteeism by up to 20% and that physically active employees take 27% fewer days sick leave<sup>12</sup>
- the maintenance of independent living in later life<sup>8</sup>.

### **Barriers to Physical Activity**

1.25 Some people choose to be active for general health; for others the motivation may be physical fitness, weight control, social contact or just enjoyment. Those who remain inactive invariably give reasons such as:

- too busy (40%);

- not having enough time (39%);
- too tired (33%);
- lack of motivation (33%); and
- limiting health reasons (31%)<sup>1</sup>.

1.26 Attitudes to physical activity may also be influenced by barriers such as a lack of opportunities to participate, concern about personal safety or in accessing parks, sports and leisure facilities, footpaths and cycle lanes.

### **Economic Cost of Physical Inactivity**

1.27 Inactive lifestyles currently account for at least 2,200 premature deaths in Northern Ireland each year. A report on the cost benefits of the 1996 - 2002 Physical Activity Strategy<sup>13</sup>, updated to 2003, suggests that by reducing inactivity in the adult population from 20% to 15%:

- 358 lives can be saved each year -
  - 236 deaths from CHD;
  - 108 deaths from stroke; and
  - 14 deaths from colon cancer.
- total lifetime economic worth - £410million;
- 3,031 expected number of life years;
- equivalent to 8<sup>1/2</sup> years of extra life; and
- 190,000 sick days per annum - equivalent to £18 million lost productivity per annum and a direct cost saving to the health service of at least £6 million annually.

The analysis used a very cautious approach by including the three most robust links between physical inactivity and morbidity. The inclusion of other less defined linkages to ill health, through sedentary lifestyle's contribution to obesity, high blood pressure and Type 2 diabetes, would have considerably increased estimated savings. Nevertheless, these estimates of the economic costs of disease related to physical inactivity are consistent with other economic benefit studies of physical activity.

### **Equality, Targeting Social Need and Human Rights**

- 1.28 Section 75 (S 75) of the Northern Ireland Act 1998 requires public authorities in carrying out their functions to promote equality of opportunity between persons of different religious belief, political opinion, racial group, age, marital status, sexual orientation, gender, disability and persons with dependants or without.
- 1.29 Following the review of the 1996 Physical Activity Strategy an Equality Impact Assessment (EQIA) was carried out and is attached as a separate document. The assessment has been taken into account in the development of the new Strategy.
- 1.30 The New Targeting Social Need (New TSN) policy aims to tackle poverty and exclusion by targeting the efforts and available resources of public agencies towards the people, groups and areas objectively defined as being in greatest social need. New TSN includes a special focus on tackling the problems of unemployment, but also targets inequalities in health, housing, education and other policy areas. Paragraph 1.21 highlights the link between physical inactivity and those in the lower socio-economic groups.

1.31 The Human Rights Act 1998 came fully into force in October 2000. It provides additional focus and emphasis to the rights and freedoms of individuals guaranteed under the European Convention on Human Rights. There are some 18 Convention rights and protocols, which range from Right to Life to the Right to Education. The Act requires legislation, wherever enacted, to be interpreted as far as possible in a way which is compatible with the Convention rights; makes it unlawful for a public authority to act incompatibly with the Convention rights; and if it does, allows a case to be brought in a court or tribunal against the authority. DHSSPS will ensure that the Physical Activity Strategy is compatible with the Human Rights Act.

## CHAPTER 2

### AIM OF THE STRATEGY

2.1 The overall aim of this Strategy is:

**”to promote the benefits of regular physical activity and to encourage everyone in Northern Ireland to participate in daily activity, with particular emphasis on those who are inactive.”**

### Introduction

2.2 As Chapter 1 makes clear, it is vital that everyone recognises the risks to health of physical inactivity and tries to make the relatively small changes necessary to eliminate those risks. Experience in other areas has shown that even moderate lifestyle changes can take many years to achieve and the Working Group acknowledges that this 5 year Plan, following on from the 1996 strategy, merely represents the next, albeit important, phase of a long-term strategy to increase physical activity levels.

2.3 The overall aim will be pursued through a concerted partnership approach involving the statutory, voluntary and community sectors. It will also be important to develop close links with the business community to address physical inactivity in the context of workplace health issues.

### Values and Principles

2.4 This Strategy adopts the framework of values and principles set out in the *Investing for Health* Strategy. These include:

- health as a fundamental human right;

- actively pursuing equality of opportunity and the promotion of social inclusion;
- reducing social inequalities;
- encouraging community involvement in improving health, especially in disadvantaged neighbourhoods;
- partnership working with local and interest group communities; and
- maximising opportunities for individuals, families and communities to protect and improve their own health.

### **Objective**

2.5 The key objective is **to increase the number of people participating in physical activity**. This objective will be met by:

- raising awareness of the benefits of physical activity;
- providing appropriate and accessible information to enable people to make preferred activity choices; and
- providing safe, accessible and appealing opportunities for activities to meet individual needs, preferences and life circumstances.

### **Outcomes**

2.6 If successful, this will lead to a reduction in ill health, including a reduction in obesity levels as well as in the incidence of diabetes which, in turn, will contribute to the reduction in preventable deaths and diseases and improvement in wellbeing outcome set out in the Northern Ireland Priorities and Budget document for 2004-2006.

## Priorities

- 2.7 The Strategy aims to promote participation in physical activity across the entire population. Differences in levels of physical activity exist among the various population groups. For example, research in Northern Ireland indicates that sedentary levels for people aged over 65 are higher than the overall average here and that people with certain health conditions are less physically active than those without<sup>1</sup>. Furthermore, as indicated in paragraph 1.21, people in lower socio-economic groups are more likely to be physically inactive.<sup>1</sup>
- 2.8 It is therefore important when developing and delivering interventions and services that the needs of older people are taken into account. It is also important to encourage good habits among children and young people. In addition, the needs of those with a disability, including those with mental ill-health; those from a black and minority ethnic community; and those from the lower socio-economic groups will also need to be addressed.

## Targets

- 2.9 The targets in *Investing for Health* include:
- to improve the levels of life expectancy here towards the levels of the best EU countries, by increasing life expectancy by at least 3 years for men and 2 years for women between 2000 and 2010; and
  - to stop the increase in the levels of obesity in men and women so that by 2010 the proportion of men who are obese is less than 17%, and of women, less than 20%”.

## **Physical Activity Strategy Targets**

2.10 The following targets, which have been developed to help achieve the *Investing for Health* target, will be used to measure the overall aim of the Physical Activity Strategy:

- *to increase to 80% by 2010 the proportion of people who are physically active;*

Baseline: 75% in 2001 – Health & Social Wellbeing Survey.

- *to increase to 75% by 2010 the proportion of people in lower socio-economic groups who are physically active;*

Baseline: 69% of people who are partly skilled or unskilled were physically active in 2001 - Health & Social Wellbeing Survey.

- *to increase to 55% by 2010 the proportion of people aged 65 and over who are physically active.*

Baseline 49% in 2001 – Health & Social Wellbeing Survey.

2.11 These targets are likely to be best achieved by promoting physical activity in a number of settings including leisure, sport, community, care centres and travel to work/school. It should be noted that targets set in other Government strategies will contribute to the achievement of the physical activity targets set out in this document.

## **Taking the Strategy forward**

2.12 The Strategy comprises a number of actions to support the overall aim and key objective grouped under the following headings:

- policy development to create a supportive environment;
- raising awareness;

- improving knowledge and skills; and
- research and evaluation.

2.13 Chapter 3 sets out the actions to be taken, target dates and the main partners.

## CHAPTER 3

### ACTION PLAN

#### Action 1

The **Department of Health, Social Services and Public Safety (DHSSPS)** will establish a multi-agency group to manage the implementation of the Strategy and Action Plan.

Target date: Within 3 months of Physical Activity Strategy Publication.

#### Action 2

The **Implementation Group** will report progress on the implementation of the Strategy to the **Ministerial Group on Public Health**.

Target date: Annually

### Policy Development to Create a Supportive Environment

- 3.1 The 1996 Physical Activity Strategy recognised that each Department has a role to play in ensuring that people are encouraged and supported to achieve optimal health. One of the Strategy's objectives was therefore 'to encourage the development of public policies which reduce the number of people who are physically inactive'. Since its establishment NIPAIG, which includes representatives from various statutory and voluntary organisations, has worked to influence public policies relating to physical activity and contribute to their development, for example, the Walking Action Plan and Cycling Strategy which both compliment the overall objectives of the Regional Transport Strategy for Northern Ireland. However, the review of the 1996 Strategy highlighted the need to maximise opportunities to further influence public policies.

- 3.2 *Investing for Health* contains a framework for action to improve health and reduce health inequalities through partnership working. It also commits departments and their agencies to incorporate health impact assessments within all new major policies and programmes. This approach will necessitate building upon existing multi-agency working and strengthening inter-sectoral partnerships to ensure, as far as possible, that optimum use is made of policies and programmes in tackling a range of lifestyle issues, including physical activity.
- 3.3 As outlined in paragraph 3.1, NIPAIG has already recognised the importance of inter-sectoral collaboration in tackling a range of issues relating to physical inactivity. It will therefore be important to maintain and build upon existing intersectoral cooperation.

### **Action 3**

**Government Departments and their Agencies** will, in developing all major policies and programmes, assess the impact on health, including the benefits of promoting physical activity.

Target date: Ongoing

### **Action 4**

**DHSSPS & the Department of Education (DE)**, in partnership with the **Health Education Liaison Group**, will further develop the Health Promoting Schools' concept, with a view to promoting physical activity.

Target date: Ongoing

### **Action 5**

**DE** will ensure that physical education is a mandatory component of the curricula for all key stages.

Target date: September 2005

### **Action 6**

**Health and Social Services (HSS) Boards & Trusts** with **Investing for Health Partnerships** will further develop policies and programmes across the population to promote physical activity taking account of the particular needs of children and young people, older people, those with a disability, those from a black and minority ethnic community, those in care settings and those from a lower socio-economic group.

Target date: Ongoing

### **Action 7**

The **Department for Regional Development (DRD)** will assist the NI Walking Forum in implementing the NI Walking Action Plan in partnership with other relevant departments/agencies.

Target date: Ongoing

### **Action 8**

**DRD** will further promote and implement the cycling strategy in partnership with other relevant departments/agencies.

Target date: Ongoing

### **Action 9**

**DRD** will continue to develop and implement initiatives such as "Travelwise Safer Routes to School" in partnership with other relevant departments/agencies.

Target date: Ongoing

### **Action 10**

**Health & Safety Executive NI** and **DHSSPS**, in partnership with the **Health Promotion Agency (HPA)**, will develop the concept of health promoting workplaces, which will include promoting the benefits of physical activity.

Target date: Ongoing

### **Action 11**

The **Department of Agriculture and Rural Development** will continue to promote public access to its forest estate and is working to remove barriers to access for under represented sectors of society.

Target date: Ongoing

### **Action 12**

The **Department of Culture, Arts and Leisure**, in partnership with the **Sports Council for Northern Ireland** will continue to promote participation in sport and physical activity.

Target date: Ongoing

## **Raising Awareness**

- 3.4 As illustrated in Chapter 1, physical inactivity has potentially serious consequences for all of us. Since 1996, many initiatives have been launched to promote the important role of physical activity in our daily lifestyle. These include media coverage through, for example, the “Go Walking” advertisement, under the “Get a life, get active” campaign, the “Get Active in the Community Cash Grant Award” scheme and the Age Concern “Actively Ageing Well” programme.
- 3.5 However, as with all lifestyle issues, key messages will need to be constantly reviewed and updated to ensure that the

importance of being active is conveyed to the whole population. The success of ongoing messages delivered through various public information initiatives will need to be assessed by regularly measuring the number of people, in different settings, who participate in various forms of activity, known to help protect against illness.

### **Action 13**

**DHSSPS** in partnership with the **HPA, Government departments, local councils** and the **voluntary and community sectors**, will further develop a phased accessible physical activity public and professional information campaign which promotes the benefits of physical activity, including the health, economic and social benefits.

Target date: Ongoing

### **Action 14**

**DHSSPS**, in conjunction with the **HPA**, will continue to promote opportunities for physical activity in the community through, for example, the Cash Grant Award Scheme and the Actively Ageing Well programme. Any interventions will promote equality of opportunity by taking account of the needs of all vulnerable groups.

Target date: Ongoing

### **Action 15**

**DHSSPS** will seek opportunities to promote physical activity through local, national and international collaboration.

Target date: Ongoing

## **Improving Knowledge and Skills**

- 3.6 Training and professional development were recognised as very important to the successful implementation of the 1996 Physical Activity Strategy. As part of the 1998-2002 Action Plan, the Health Promotion Agency developed a range of professional development and training programmes across all sectors. These included conferences, seminars and short courses.
- 3.7 The review of the 1996 strategy identified professional development and training successes within the health sector. However, the review also found that there had been less impact on, and involvement of, other organisations from the public and private sector. As many organisations and their representatives are in a position to make an effective contribution to the promotion of physical activity, it is essential that information and support is made available to them.

### **Action 16**

The **Health Promotion Agency**, in partnership with **HSS Boards and Trusts, Investing for Health Partnerships**, the **Sports Council, local councils** and the **voluntary/community sectors** will continue to deliver physical activity training programmes based on best practice, for example, the physical activity toolkit and exercise referral schemes.

Target date: Ongoing

### **Action 17**

The **Health Promotion Agency** in partnership with **HSS Boards and Trusts** will collate and disseminate information on local and regional examples of cross–sectoral activity, which is accessible to all vulnerable groups.

Target date: Ongoing

### **Action 18**

The **HPA** and the **Sports Council** will promote co-operation and collaboration among professionals working in the related fields of exercise, health, recreation and sport.

Target date: Ongoing.

## **Research and Evaluation**

- 3.8 The need for research was considered a priority in the 1996 strategy. The review of the strategy noted that although valuable research to inform and evaluate strategy initiatives has been undertaken, the objective to establish a programme of research and evaluation to support the implementation of the strategy has not been fully realised.
- 3.9 It is important that the Strategy's objectives and targets as outlined in Chapter 2 are monitored and evaluated. There are existing surveys that regularly monitor adult and young people's levels of physical activity. These include the Health and Social Wellbeing Survey, the Young Person's Behaviour and Attitudes Survey, and the Northern Ireland Travel Survey. It will be important to explore opportunities to strengthen research links

across Government departments [see Chapter 4, paragraph 4.5].

**Action 19**

The **HPA**, in partnership with other stakeholders, will establish a database of evaluated interventions and effective approaches.

Target date: March 2006

**Action 20**

**DHSSPS** will collect data on obesity through the Health and Social Wellbeing Survey.

Target date: September 2005

## **CHAPTER 4**

### **MAKING IT HAPPEN**

#### **Introduction**

4.1 As highlighted in Chapter 2, this Strategy is part of a long-term vision to increase physical activity levels amongst the population of Northern Ireland. It will take time and partnership working between Government departments, statutory, voluntary and community organisations and others, in a variety of settings, to achieve the overall aim. If the key objective in Chapter 2 is to be met, it is essential that appropriate structures are in place to oversee the programme of action. The Action Plan's success will also require sufficient resources and systematic arrangements for monitoring and accountability.

#### **Resources**

4.2 The Department of Health, Social Services and Public Safety has made £500,000 available to promote physical activity in 2004/05 and will continue to provide financial support to assist with implementation of the new Strategy and Action Plan.

#### **Implementation**

4.3 In 1998, the Ministerial Group on Public Health (MGPH) established the inter-sectoral Northern Ireland Physical Activity Implementation Group (NIPAIG), to drive forward the 1996 Physical Activity Strategy. The review of the strategy made recommendations with regard to future implementation e.g. structure, processes etc (see Annex 1).

4.4 To implement these recommendations and enable the re-constituted Implementation Group to provide a strategic steer,

focus upon issues from a regional perspective and identify opportunities for collaboration, it must, as a first step, critically review the operational structures of NIPAIG. This review must include an assessment of existing reporting mechanisms, content and frequency of meetings and the use of sub-groups. It must also examine how each representative can promote physical activity within his or her organisation as well as how best to integrate this work with other complementary strategies.

### **Monitoring Progress**

4.5 The MGPH will be responsible for the overall monitoring of this Strategy and Action Plan. The Implementation Group will report progress to MGPH annually. The Strategy will be reviewed after five years. To enable the Group to fulfil its monitoring role, it will wish to take account of existing survey findings as outlined in paragraph 3.9 and also the need for any additional research. This may include research on interventions specifically aimed at increasing physical activity levels amongst different population groups, and in a variety of settings, as well as drawing comparisons with other countries.

4.6 To assist the Implementation Group, the following subsidiary targets have been set: -

- *to increase by 2010 the number of people who participate in sports or other physical activity by 1% per annum.*

Baseline: 78% in NI Omnibus Survey 2003.

- *to increase by 2010 the % of people cycling or walking to work.*

Baseline: 1% cycled to work and 11% walked to work in 1999/00 - NI Travel Survey.

- *to increase by 2010 the % of people aged 16 and over who walked two miles or more, at least once a week in the last 4 weeks.*

Baseline: 21% in 2001 - Health & Social Wellbeing Survey

- *to increase by 2010 the % of people aged 65 and over who walked 2 miles or more, at least once a week in the last four weeks.*

Baseline: 13% in 2001 - Health & Wellbeing Survey.

- *to increase by 2010 the % of pupils who take part in sports or other physical activity at least once or twice a week (excluding on-site school-based activity)*

Baseline: 84% in 2000 – Young Person’s Behaviour & Attitudes Survey

## **Roles and Responsibilities**

4.7 As outlined in paragraph 4.1, successful implementation of the Physical Activity Strategy and Action Plan will require building on existing partnerships and creating new opportunities, with input from many organisations and individuals ranging from Government departments, statutory bodies, the voluntary sector and local communities. (Annex 2 details the roles and responsibilities of each organisation).

## **ANNEX 1**

### **PHYSICAL ACTIVITY STRATEGY 1996-2002 REVIEW FINDINGS**

DHSSPS commissioned Capita Consulting in August 2002 to conduct a review of the Physical Activity Strategy 1996-2002. The review recommendations are linked to the key findings and also based on the outcome of two workshops the Capita team facilitated with the Project Steering Group. The recommendations of the review are summarised below and categorised under broad headings.

#### **The Need for a Future Strategy**

- The requirement exists to develop a future Physical Activity Strategy.

#### **Future Strategy Aims, Objectives and Targets**

- Future Strategy aims, objectives and targets should be *SMART* (Specific, Measurable, Achievable, Realistic and Timebound.). Targets should also link with *Investing for Health* targets and individual departmental targets contained within *Programme for Government*. Targets should be formally signed-off with individuals departments with clearly identified resources (human and financial).
- The baseline sources for evaluating the progress of future Strategy targets must be identified at the outset of the Strategy.
- Development of 'kitemark' indicators to support the processes of development of interventions, evaluation tools etc.
- Re-examination of Strategy target groups and activities.

- Continued emphasis on the importance of physical activity and the current guidelines.

### **Addressing the Equality Agenda**

- The future Strategy development should include engagement with appropriate stakeholders to ensure the promotion of equality of opportunity.

### **Format of Future Strategy**

- The future Strategy document should be 'user friendly' and contain in one document the aim, objectives and targets. Matters of detail should be confined to appendices. The Strategy language should also encourage the concept of physical activity as a 'lifestyle' issue.

### **Timeframe for Future Strategy**

- The future Strategy should contain a 15-20 year vision, with SMART targets subject to review every 3-5 years.

### **Future Structure, Framework, Processes and Roles and Responsibilities**

- Clear definitions of the roles and responsibilities of all stakeholders with responsibility to implement the future Strategy and development of an induction programme for new members of Strategy groups.
- Some of the Steering Group members in the workshops and discussions during this review expressed the view that radical re-engineering of the current framework that underpins the Physical Activity Strategy could not be undertaken in isolation from

reviewing the wider frameworks that support *Investing for Health* and other complementary health promotion strategies. A wide ranging review of this nature is outside the terms of reference of this review of the Physical Activity Strategy. However, the Capita team recommend that the outcome of discussions referred to above are highlighted at a Departmental level.

- Maintenance of NIPAIG and the current Strategy sub-groups. However, definition of the skill mix required for each of the current Strategy groups, review of the membership of all groups, effective utilisation of individual stakeholder inputs to Strategy groups and use of working groups for particular initiatives were required.
- Rotation of the Chairmanship of Strategy groups.
- Clear definition of terms of reference for each of the Strategy groups with a focus on new Strategy objectives and targets.
- Development of an annual planning cycle (aligned with Strategy targets) with workplans for all Strategy groups and local implementation structures.

### **Increasing Resourcing Opportunities**

- Endorsement of the DHSSPS objective to move to a three-year funding allocation for the Strategy as a matter of urgency.
- Continued efforts to secure funding from local partners.
- NIPAIG to lead identification of potential joint initiatives and opportunities for alternative funding from sources including the New Opportunities Fund, Executive Programme Funds and all Ireland funding sources.

- Implementation of a Strategy monitoring framework.
- Development of a clear Strategy research agenda with identified resources and incorporation of research targets into annual workplans.

### **Future Monitoring and Reporting Mechanisms and Communication**

- Early identification of Strategy target monitoring sources
- Strategy objectives and targets subject to regular evaluation and monitoring
- Development and implementation of a standard monitoring and evaluation framework to be adopted on a cross-departmental/cross-agency basis
- Strategy targets to be monitored on a quarterly basis

### **Addressing Strategy Research**

- Strengthen research links with Research and Development office and maximise opportunities for all Ireland research.

### **Influencing Public Policies**

- Identification of a series of actions designed to influence public policies.

### **Legislating for Change**

- Introduction of legislation to support the promotion of physical activity in Northern Ireland using vehicles such as the new regulations for the independent sector.

## ANNEX 2

### ROLES AND RESPONSIBILITIES

1. The **Department of Health, Social Services and Public Safety** is responsible for the health and well-being of the population and therefore has a key role to play in delivering the aims of the Strategy and Action Plan. The Minister for DHSSPS chairs the **Ministerial Group on Public Health**, which comprises senior officials from all Government departments. MGPH is responsible for coordinating and monitoring the implementation of the *Investing for Health* Strategy, including the Physical Activity Strategy and Action Plan. Departmental representatives on MGPH will be responsible for monitoring the progress of the bodies for which they are responsible.
2. The **Health and Personal Social Services** has a key role in developing physical activity programmes. This involves collaboration between Health Boards, Trusts and primary care as well as the voluntary and community sectors. In recognition of the multi-sectoral approach required to effect improvement in health, Boards have established Investing for Health Partnerships.
3. The **Investing for Health Partnerships** are comprised of the key voluntary, community and statutory organisations in the local area. Within the statutory sector, **local councils, the Housing Executive, Education and Library Boards and Health and Social Services Trusts** are included. Beyond these core members, the composition of the Partnerships is determined locally and is likely to evolve over time. These multi-sectoral

partnerships will ensure that action to improve health is properly coordinated and that a long-term cross-sectoral plan is developed to improve the health and wellbeing of the population in line with the *Investing for Health Strategy*.

4. The **Health Promotion Agency for Northern Ireland** has a regional responsibility for health promotion. It will work closely with DHSSPS, the HPSS and others in developing its contribution in the promotion of physical activity.
5. The **Department of Education** is responsible for securing the place of health education in schools and in the Youth Service. Health education is currently a cross-curricular theme for all pupils up to age 16.
6. **Education and Library Boards** are responsible for ensuring the delivery of health education across all sectors from early years to post-16s and in the youth service from age 8 to age 25.
7. **Department for Regional Development** is responsible for maintaining and enhancing a range of essential infrastructure services including transportation and roads. It co-operates with other departments/agencies in helping to take forward physical activity programmes relating to walking and cycling strategies.
8. **Department of Agriculture and Rural Development** is responsible for the development of the agri-food, forestry and fishing industries and aims to conserve and enhance the rural environment through the promotion of environmentally responsible management of activities in relation to these industries and drainage. It is also the lead Department for rural

development in Northern Ireland. It continues to promote access to its forest estate for health enhancing physical activity.

9. **Department of Culture, Arts and Leisure** is responsible for the central administration and promotion of sporting matters. Its role is to set the legal, financial and policy framework for the delivery of services by the Sports Council for Northern Ireland.
10. **Sports Council for Northern Ireland** is a lead facilitator in the development of sport and works with partners to increase and sustain participation in sport, especially among young people. The Council aims to create sporting opportunities for all those who want to get involved in sport at a level of their choosing. It has statutory responsibility for distributing funds generated by the National Lottery.
11. The **Health and Safety Executive for Northern Ireland** is an Executive Non-Departmental Public Body, sponsored by the **Department of Enterprise, Trade and Investment**. It is the lead body responsible for the promotion and enforcement of health and safety at work standards in workplaces.
12. The **Department of the Environment** aims to improve the quality of life in Northern Ireland, now and for the future, by promoting a better and safer environment and supporting effective and efficient local Government; to protect, conserve and enhance the natural environment and build heritage; improve the quality of life of people here by planning and managing development in ways which are sustainable and which contribute to creating a better environment; to reduce road casualties; and to support a system

of local government which meets the needs of residents and rate payers.

13. **Local Councils** have many statutory functions bearing directly on health and quality of life. They have statutory responsibility to provide recreation facilities for their communities and as a consequence a wide range of facilities are offered both for the recreational participant and for organised sports clubs and schools. Through the provision of local facilities and programmes district councils can make a crucial contribution to the Strategy aims and objectives.
  
14. **Employers** have an important role to play in promoting physical activity in the workplace. Healthy workplace policies which advocate the provision and promotion of physical activity, present an important opportunity as many jobs are increasingly sedentary. Workplace initiatives have the potential to increase physical activity levels.
  
16. The **Voluntary and Community Sectors** have important roles to play in the promotion of healthy lifestyles and in reducing health inequalities by providing services, support, information and advice. Voluntary/Community groups can actively support the identification and provision of physical activity initiatives for sedentary groups. They can provide and promote programmes to increase participation and develop facilities within localities.

## ANNEX 3

### MEMBERSHIP OF WORKING GROUP

<b>Name</b>	<b>Organisation</b>
Dr Brian Gaffney	[Chair] Health Promotion Agency
Dr Naresh Chada	DHSSPS
Mrs Pat Osborne	DHSSPS
Mr Jim Gibson	DHSSPS
Mr Casper Swales	DHSSPS
Ms Pauline Donnan	DHSSPS
Ms Helen Johnston	CCEA
Mr Malcolm Beatty	DARD
Mr Jack Palmer	DCAL
Mr Ashley Waterworth	DE
Ms Juliet Whitford	DEL
Mr Andy Bready	DRD
Mr Terry Eakin	DOE
Mrs Siobhan Weir	Health Promotion Agency
Dr Paula Kilbane	[representing Health & Social Service Boards]
Ms Claire Keatinge	Age Concern
Mr Shaun Ogle	Sports Council Northern Ireland
Ms Monica Wilson	Disability Action
Ms Tansy Hutchinson	NI Council for Ethnic Minorities
Mr George Cullen	DHSSPS [Secretariat]
Mr Kieran Blaney	DHSSPS [Secretariat]

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